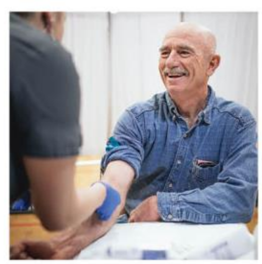
St. Luke's Magic Valley Community Health Needs Assessment 2019



St. Luke's Magic Valley collaborated with St. Luke's Jerome in conducting this CHNA.

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Table of Contents

Introduction

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

- Address and improve high priority health needs in the communities we serve by collaborating with mission-aligned partners.
- Foster a culture of health resulting in reduced healthcare costs for patients, communities, and healthcare providers.
- Build a firm foundation for community health improvement within St. Luke’s Health System that enables us to transform community health now and for future generations.
- Strengthen and expand the continuum of care and support throughout our communities: at schools, worksites, food banks, farmers markets, social service providers, etc. – ensuring people have access to the health resources they need.
- Support and strengthen the array of community resources, organizations and providers actively addressing community health issues by studying, advocating for, and deploying best practices and sharing what we learn.
- Build trust with our communities, partners, providers and other health care systems by collecting and promoting data and outcome metrics that substantiate the impact and value our community health investments provide.

We will achieve these objectives through the use of the following tools:

Analysis & Planning	Program Development	Community Partnership	Strategic Grant-making	Marketing & Social Media	Assessment & Reporting
Capacity Building	Service & Volunteerism	Policy & Advocacy	Education & Training	Community Engagement	Formative Research

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 complete copy of our 2019 CHNA is available on our public website.

St. Luke’s Magic Valley Medical Center collaborated with St. Luke’s Jerome in conducting this CHNA.

Executive Summary

The St. Luke's Magic Valley 2019 Community Health Needs Assessment (CHNA) provides a comprehensive analysis of our community's most important health needs. Addressing our health needs is an essential opportunity to achieve improved population health, better patient care, and lower overall health care costs.

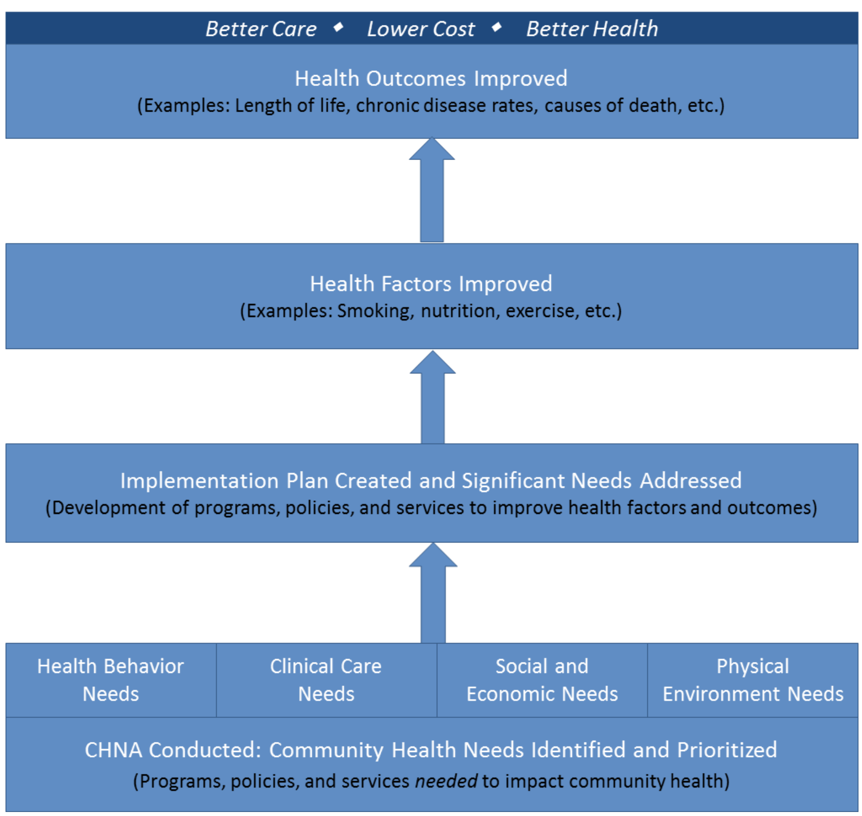
In our CHNA, we divide our health needs into four distinct categories: 1) health behaviors; 2) clinical care; 3) social and economic factors; and 4) physical environment. Each identified health need is included in one of these categories.

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

- In-depth interviews with a diverse group of dedicated community representatives
- An extensive set of national, state, and local health indicators collected from governmental and other authoritative sources

The chart, below, provides a summary of our approach to improving community health.

St. Luke's Approach to Improving Community Health



Significant Community Health Needs

Health needs with the highest potential to improve community health are those ranking in the top 10th percentile of our prioritization system. After identifying the top ranking health needs, we organize them into groups that will benefit by being addressed together as shown below:

Group #1: Improve the Prevention and Management of Obesity and Diabetes

Group #2: Improve Mental Health

Group #3: Improve Access to Affordable Health Insurance

We call these high ranking needs our “significant health needs” and provide a summary of each of them next.

Significant Health Need #1: Improve the Prevention and Management of Obesity and Diabetes

Obesity and diabetes are two of our community's most significant health needs. Over 60% of the adults in our community and more than 25% of the children in our state are either overweight or obese. Obesity and diabetes are serious concerns because they are associated with poorer mental health outcomes, reduced quality of life, and are leading causes of death in the U.S. and worldwide. [1]

Impact on Community

Obesity costs the United States about $150 billion a year, or 10 percent of the national medical budget.[2] Besides excess health care expenditure, obesity also imposes costs in the form of lost productivity and foregone economic growth as a result of lost work days, lower productivity at work, mortality and permanent disability. [3] Diabetes is also a serious health issue that can even result in death.[4] Direct medical costs for type 2 diabetes accounts for nearly $1 of every $10 spent on medical care in the U.S. [5] Reducing obesity and diabetes will dramatically impact community health by providing an immediate and positive effect on many conditions including mental health; heart disease; some types of cancer; high blood pressure; dyslipidemia; kidney, liver and gallbladder disease; sleep apnea and respiratory problems; osteoarthritis; and gynecological problems.

[1] https://www.cdc.gov/obesity/adult/causes.html
[2] http://www.cdc.gov/cdctv/diseaseandconditions/lifestyle/obesity-epidemic.html
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5409636/
[4] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System
[5] America's Health Rankings 2015-2018, www.americashealthrankings.org

How to Address the Need

Obesity is a complex health issue to address. Obesity results from a combination of causes and contributing factors, including both behavior and genetics. Behavioral factors include dietary patterns, physical activity, inactivity, and medication use. Additional contributing social and economic factors include the food environment in our community, the availability of resources supporting physical activity, personal education, and food promotion.

Obesity and type 2 diabetes can be prevented and managed through healthy behaviors. Healthy behaviors include a healthy diet pattern and regular physical activity. The goal is to achieve a balance between the number of calories consumed from foods with the number of calories the body uses for activity. According to the U.S. Department of Health & Human Services Dietary Guidelines for Americans, a healthy diet consists of eating whole grains, fruits, vegetables, lean protein, low-fat and fat-free dairy products and drinking water. The Physical Activity Guidelines for Americans recommends adults do at least 150 minutes of moderate intensity activity or 75 minutes of vigorous intensity activity, or a combination of both, along with 2 days of strength training per week. [6]

St. Luke's intends to engage our community in developing services and policies designed to encourage proper nutrition and healthy exercise habits. Echoing this approach, the CDC states that "we need to change our communities into places that strongly support healthy eating and active living." [7] These health needs can also be improved through evidence-based clinical programs.[8]

Affected Populations

Some populations are more affected by these health needs than others. For example, low income individuals and those without college degrees have significantly higher rates of obesity and diabetes.

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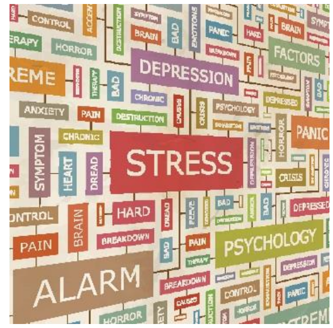
[6] https://www.cdc.gov/obesity/adult/causes.html

[7] http://www.cdc.gov/cdctv/diseaseandconditions/lifestyle/obesity-epidemic.html

[8] America's Health Rankings 2015-2018, www.americashealthrankings.org

Significant Health Need #2: Improve Mental Health



Improving mental health ranks among our community's most significant health needs. Idaho has one of the highest percentages (21.6%) of any mental illness (AMI) in the nation and shortages of mental health professionals in all counties across the state. [9] Although the terms are often used interchangeably, poor mental health and mental illness are not the same things. Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. A person can experience poor mental health and not be diagnosed with a mental illness. We will address the need of improving mental health, which is inclusive of times when a person is experiencing a mental illness.

Mental illnesses are among the most common health conditions in the United States.

- More than 50% of Americans will be diagnosed with a mental illness or disorder at some point in their lifetime.
- One in five will experience a mental illness in a given year.
- One in five children, either currently or at some point during their life, have had a seriously debilitating mental illness.
- One in twenty-five Americans lives with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression. [10]

Impact on Community

Mental and physical health are equally important components of overall health. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Mental illness, especially depression, increases the risk for many types of physical health problems, particularly long-lasting conditions like stroke, type 2 diabetes, and heart disease.

How to Address the Need

Mental illness often strikes early in life. Young adults aged 18-25 years have the highest prevalence of mental illness. Symptoms for approximately 50 percent of lifetime cases appear by age 14 and 75 percent by age 24. Not only have one in five children struggled with a

[9] Mental Health, United States, 2009 - 2016 Reports, SAMHSA, www.samhsa.gov

[10] https://www.cdc.gov/mentalhealth/learn/index.htm

serious mental illness, suicide is the third leading cause of death for young adults.[11]

Fortunately, there are programs proven to be effective in lowering suicide rates and improving mental health. [12] The majority of adults who live with a mental health problem do not get corresponding treatment.[13] Stigma surrounding the receipt of mental health care is among the many barriers that discourage people from seeking treatment.[14] Increasing physical activity and reducing obesity are also known to improve mental health.[15]

Our aim is to work with our community to reduce the stigma around seeking mental health treatment, to improve access to mental health services, increase physical activity, and reduce obesity especially for our most affected populations**.** It is also critical that we focus on children and youth, especially those in low income families, who often face difficulty accessing mental health treatment. In addition, we will work to increase access to mental health providers.

Affected Populations
Data shows that people with lower incomes are about three and a half times more likely to have depressive disorders.[16]

[11] https://www.nimh.nih.gov/health/statistics/mental-illness.shtml
[12]https://www.samhsa.gov/suicide-prevention/samhsas-efforts
[13]Substance Abuse and Mental Health Services Administration, Behavioral Health Report, United States, 2012 pages 29 - 30
[14] Idaho Suicide Prevention Plan: An Action Guide, 2011, Page 9
[15] http://www.cdc.gov/healthyplaces/healthtopics/physactivity.htm, http://www.cdc.gov/obesity/adult/causes.html
[16] Idaho 2011 - 2016 Behavioral Risk Factor Surveillance System

Significant Health Need #3: Improve Access to Affordable Health Insurance

Our CHNA process identified affordable health insurance as a significant community health need. The CHNA health indicator data and community representative scores served to rank health insurance as one of our most urgent health issues.

Impact on Community

Uninsured adults have less access to recommended care, receive poorer quality of care, and 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.[17]

Based on the evidence to date, the health consequences of the uninsured are real. [18] Improving access to affordable health insurance makes a remarkable difference to community health. Research studies have shown that gaining insurance coverage through the Affordable Care Act (ACA) decreased the probability of not receiving medical care by well over 20 percent. Gaining insurance coverage also increased the probability of having a usual place of care by between 47.1 percent and 86.5 percent. These findings suggest that not only

[17] University of Wisconsin Population Health Institute. *County Health Rankings* 2010-2018. Accessible at www.countyhealthrankings.org.

[18] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881446/

has the ACA decreased the number of uninsured Americans, but has substantially improved access to care for those who gained coverage. [19]

How to Address the Need:
We will work with our community partners to improve access to affordable health insurance especially for the most affected populations. In November 2018, Idaho passed a proposition to expand Medicaid. In the coming years, we will see how much the resulting legislation increases the percentage of people who have health insurance and the positive impact it has on health.

Affected populations:
Statistics show that people with lower income and education levels and Hispanic populations are much more likely not to have health insurance.[20]

[19] https://www.ncbi.nlm.nih.gov/pubmed/28574234
[20] Ibid

Other Health Needs

Our full CHNA provides a ranked list of all the health needs we identified through our CHNA process along with representative feedback, trend, severity, and preventative information pertaining to the health needs.

Next Steps

The main body of this CHNA provides more in-depth information describing our community's health as well as how we can make improvements to it. St. Luke's will collaborate with the people, leaders, and organizations in our community to develop and execute on an implementation plan designed to address the significant 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 Magic Valley Regional Medical Center Overview

Background

The new St. Luke's Magic Valley Regional Medical Center (SLMVRMC) opened to the public in 2011, but our history dates back to 1918, when we opened our doors to serve the needs of early settlers. Like then, we still serve the needs of people from eight southern Idaho counties and parts of northern Nevada.

Our mission and values have remained firm and our vision of a healthy community has remained clear.

A new Magic Valley Medical Center facility was constructed in the early 1950s, followed by a $27 million construction and renovation project in 1983.

In 2002, Magic Valley Medical Center and the Twin Falls Clinic and Hospital forged a partnership to bring improved medical care to south central Idaho. The new partnership expanded our medical staff to more than 160 multi-specialty physicians.

In 2006, the residents of Twin Falls County voted to partner Magic Valley Regional Medical Center with St. Luke’s Boise, Meridian, and Wood River. Joining St. Luke's Health System (SLHS) and changing our name to St. Luke's Magic Valley Medical Center meant that patients would still receive the same high standard of care with the added backing of an Idaho-based, locally-governed health system. It also led to the construction of a brand new, state-of-the-art hospital— the most technologically advanced hospital in the state.

Accredited by the Joint Commission on Accreditation of Healthcare Organizations, St. Luke's Magic Valley Medical Center serves a population of more than 180,000 and provides medical expertise and services to smaller hospitals as a referral center.

Mission, Vision, and Core Values

All St. Luke's medical centers and clinics are committed to our overall mission, vision, and values.

Our mission is "To improve the health of people in the communities we serve."

Our vision is "To be the community's trusted partner in providing exceptional, patient-centered care."

Our core values are:

icare

- **I**ntegrity
- **C**ompassion
- **A**ccountability
- **R**espect
- **E**xcellence

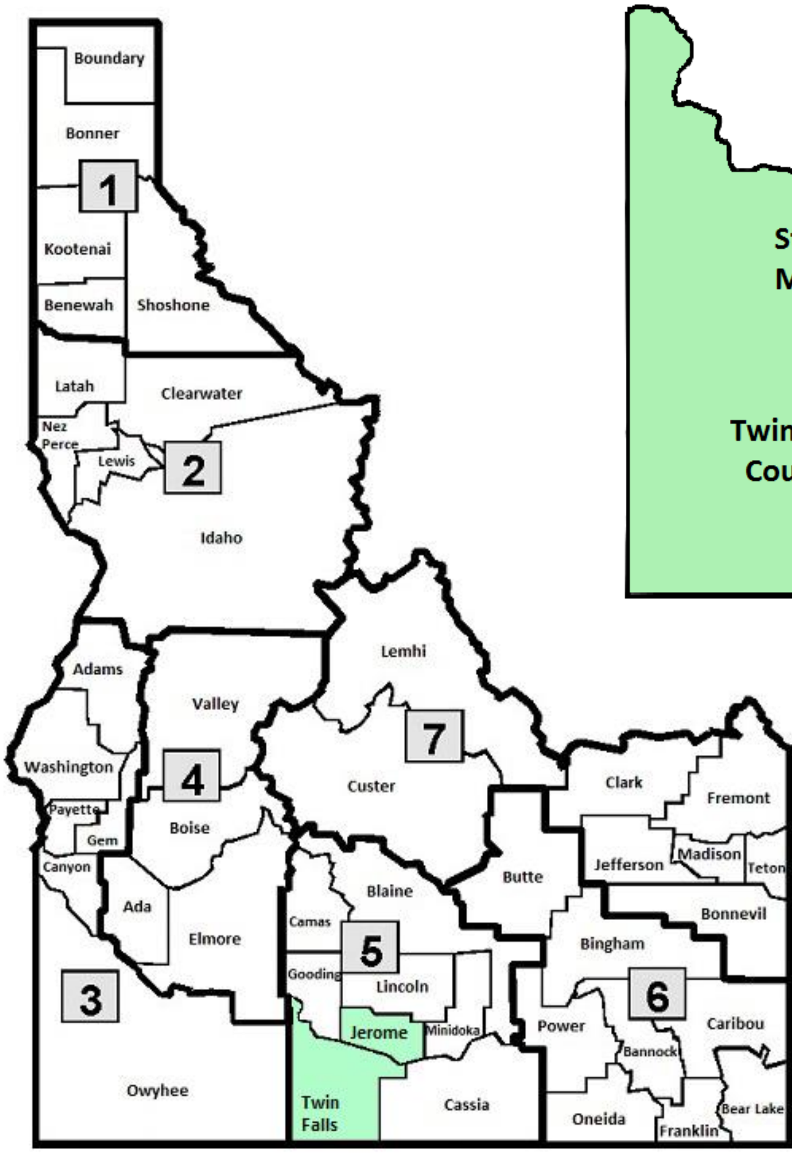
Governance Structure

Each St. Luke's medical center is responsive to the people it serves, providing a scope of service appropriate to community needs. Our volunteer boards include representatives from each St. Luke's service area, helping to ensure local needs and interests are addressed.

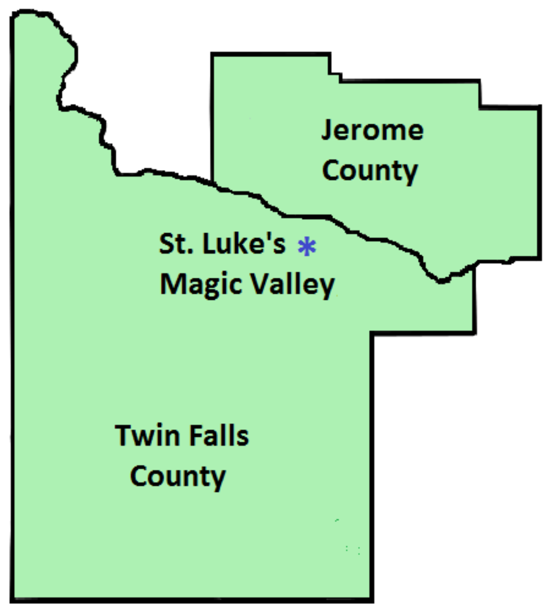
The Community We Serve

This section describes our community in terms of its geography and demographics. Twin Falls and Jerome 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 we use in selecting this area as the community we serve was to include the entire population of the counties where at least 70% of our inpatients reside. The residents of these counties comprise about 74% of our inpatients with approximately 61% of our inpatients living in Twin Falls County and 13% in Jerome County. Twin Falls and Jerome counties are part of Idaho Health District 5, as shown in the maps below.

Idaho Health District Map [21]



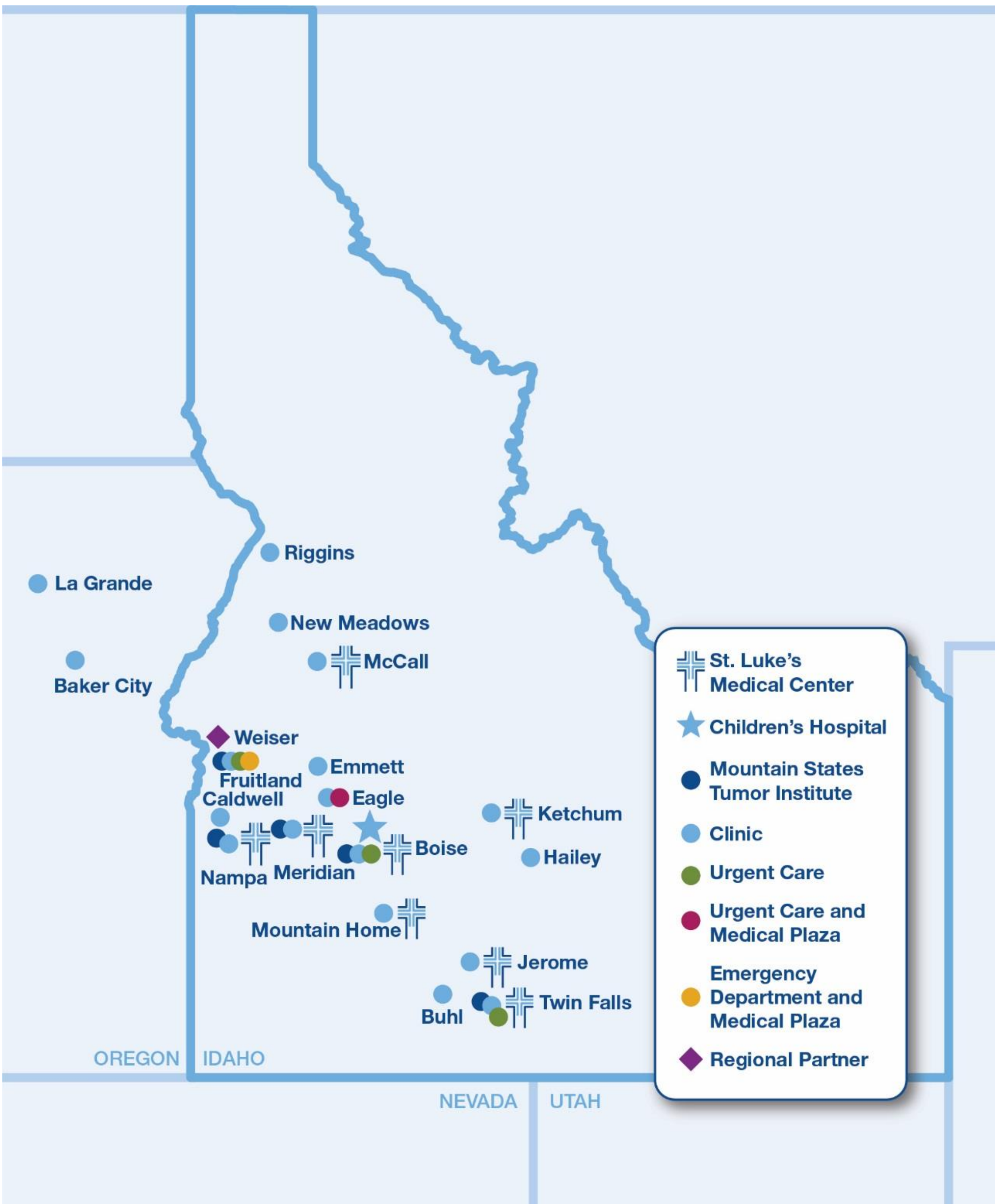
Jerome and Twin Falls County Map



[21] Idaho Behavioral Risk Factor Surveillance System Annual Report 2016

Our patients in the surrounding counties of southwestern Idaho, northern Nevada, and eastern Oregon 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 St. Luke's. 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 96% white population while the nation as a whole is 78% white. The Hispanic population in Idaho represents 12% of the overall population and about 20% of our defined service area. Jerome County is approximately 34% Hispanic, and Twin Falls County is 16% Hispanic.

Population by Race and Ethnicity 2016[22]

Residence	Total Population	Race				Ethnicity	
		White	Black	American Indian or Alaska Native	Asian or Pacific Islander	Non-Hispanic	Hispanic
Service Area	106,508	101,868	1,021	1,858	1,761	85,346	21,162
Jerome	22,994	22,064	199	565	166	15,107	7,887
Twin Falls	83,514	79,804	822	1,293	1,595	70,239	13,275
Idaho	1,683,140	1,596,443	20,021	34,218	32,458	1,475,397	207,743
National (000)	323,127	252,702	45,307	4,630	20,487	265,657	57,470
Service Area		96%	1%	2%	2%	80%	20%
Jerome		96%	1%	2%	1%	66%	34%
Twin Falls		96%	1%	2%	2%	84%	16%
Idaho		95%	1%	2%	2%	88%	12%
National		78%	14%	1%	6%	82%	18%

[22] Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare (1/2018). The bridged-race 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 March 17, 2018.

Population Growth 2000-2016

Idaho experienced a 30% increase in population from 2000 to 2016, ranking it as one of fastest growing states in the country.[23] Twin Falls and Jerome counties have followed that trend, experiencing a 29% increase in population within that timeframe.[24] St. Luke's Magic Valley is working to manage the volume and scope of services in order to meet the needs of a growing population.

Region	Population April 2000	Population April 2016	Percent Change
Service Area	82,626	106,508	29%
Idaho	1,293,953	1,683,140	30%
United States	281,421,906	323,127,513	15%

Aging

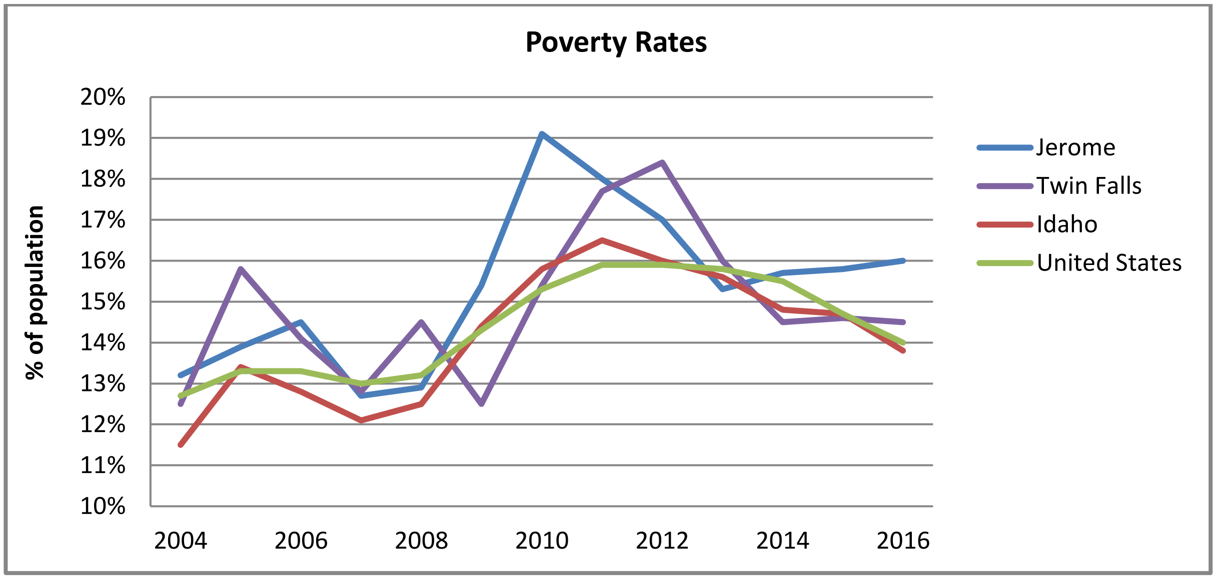
Over the past ten years the population in all age groups have increased proportionately about equally. Currently, about 15% of the people in our community are over the age of 65. [25]

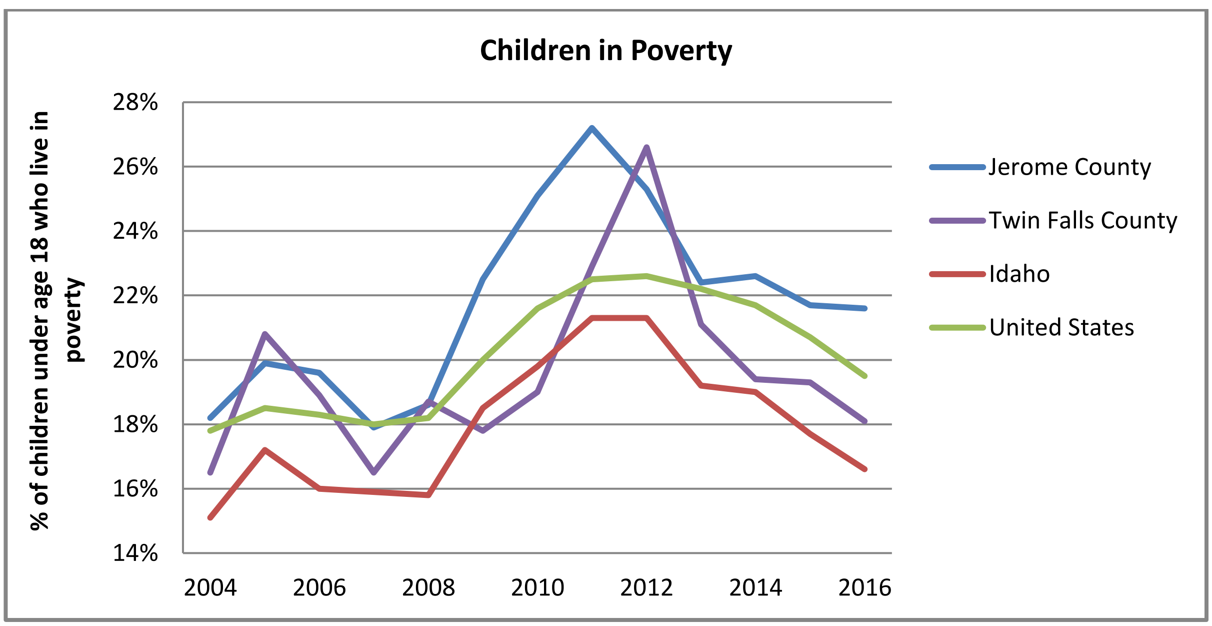
Year	Population by Age			
	Age 0-19	Age 20-44	Age 45-64	Age 65+
2000	26,476	27,228	17,499	11,423
Percent of Total	32%	33%	21%	14%
2010	31,057	31,645	23,689	13,213
Percent of Total	31%	32%	24%	13%
2016	32,919	34,180	23,950	15,459
Percent of Total	31%	32%	22%	15%

[23] U.S. Census Bureau: http://quickfacts.census.gov/qfd/index.html 2016
[24] Idaho Vital Statistics County Profile 2016
[25] Ibid

Poverty Levels

The official United States poverty rate increased from 12.5% in 2003 to 14% in 2016. Our service area poverty rate is higher than the national average. The poverty rate in our community for children under the age of 18 is also higher than the national average. Although poverty have declined in our service area, poverty rates in Jerome County are still above the levels they were at prior to the recession in 2008.[26]

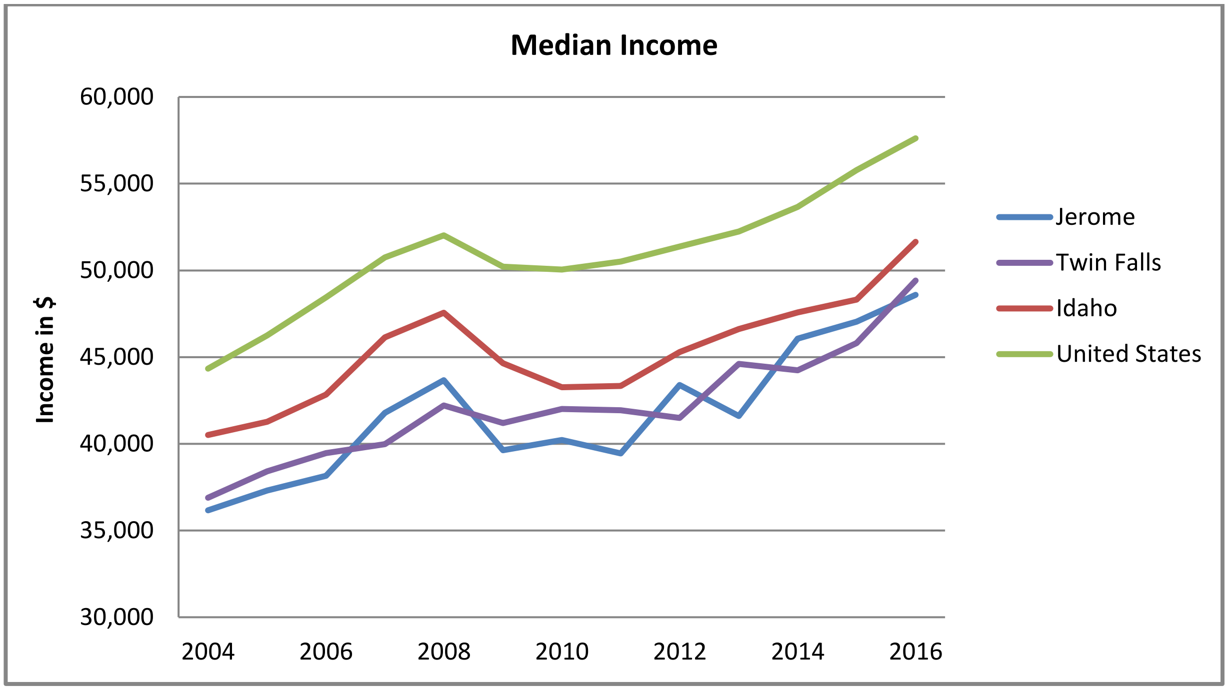




[26] Small Area Income and Poverty Estimates (SAIPE) http://www.census.gov/did/www/saipe/data/statecounty/data/index.html

Median Household Income

Median income in the United States has risen by 33% since 2004 and at approximately the same rate in our service area during that period. However, median income in our service area is well below the national median and lower than Idaho's median income.[27]



[27] Ibid

Community Health Needs Assessment Methodology

St. Luke's 2019 Community Health Needs Assessment (CHNA) is designed to help us better understand and meet our most significant community health challenges. The methodology used to accomplish this goal is 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 improved population 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 factors; 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 gather a wide range of additional community health outcome and health factor measures** from national, state, and local perspectives. We include these supplemental measures in our CHNA to ensure a comprehensive appraisal of the underlying causes of our community's most pressing health issues.

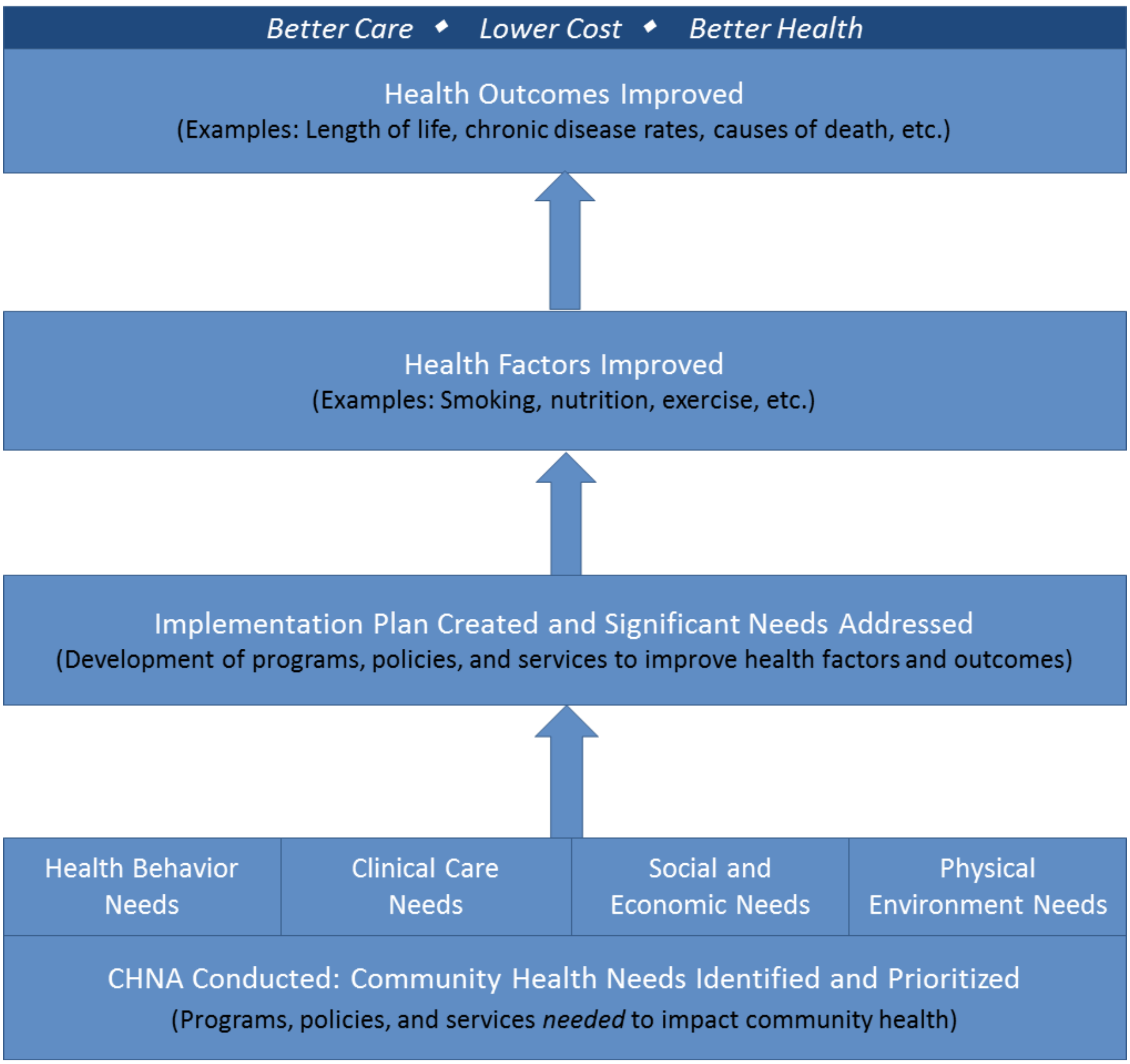
3. Community input is at the center of our CHNA process. In-depth **interviews are conducted with a diverse group of representatives** possessing extensive knowledge of

community health and wellness. Our community representatives help us define our most important health needs and provide valuable input on programs and legislation they feel would be effective in addressing the needs.

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

The chart, below, provides a summary of our approach to improving community health.

St. Luke's Approach to Improving Community Health



Health Outcome and Health Factor Research Scoring System

As described in the previous section, 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. This section provides additional detail on how we accomplish this.

- 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 is better or worse than the national average. The worse the community health outcome is relative to the national average, the higher the assigned value because there is more room 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.

Health Factor Score **Low score = Low potential for health impact High score = High potential for health impact**					
Health Factor Name	**Trend: Better/Worse**	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Example factor	**0 to 4 points**	**0 to 4 points**	**0 to 4 points**	**0 to 4 points**	**0 to 16 points**

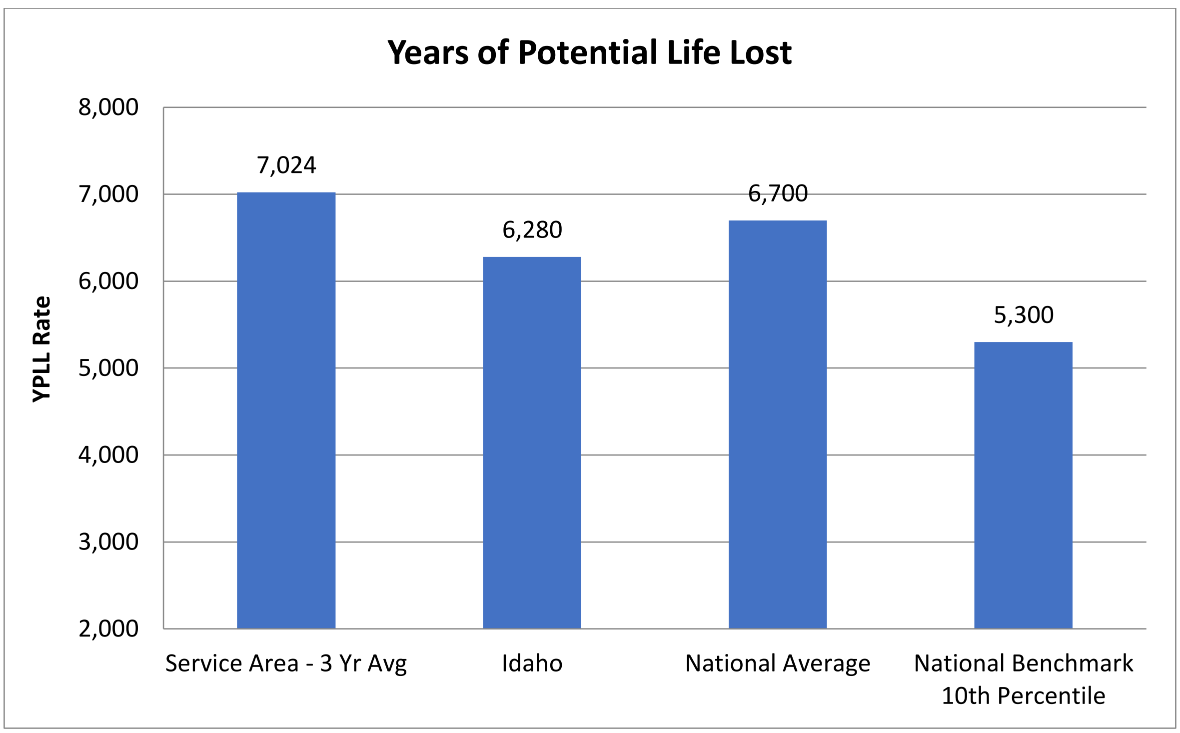
Health Outcome Measures and Findings

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 the *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.



The chart above shows our service area YPLL for 2016 is slightly above the national average.[28]

[28] Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare (1/2015) (Idaho and county data)

Morbidity Measures

Morbidity is a term that refers to how healthy people feel while alive. To measure morbidity, the *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)

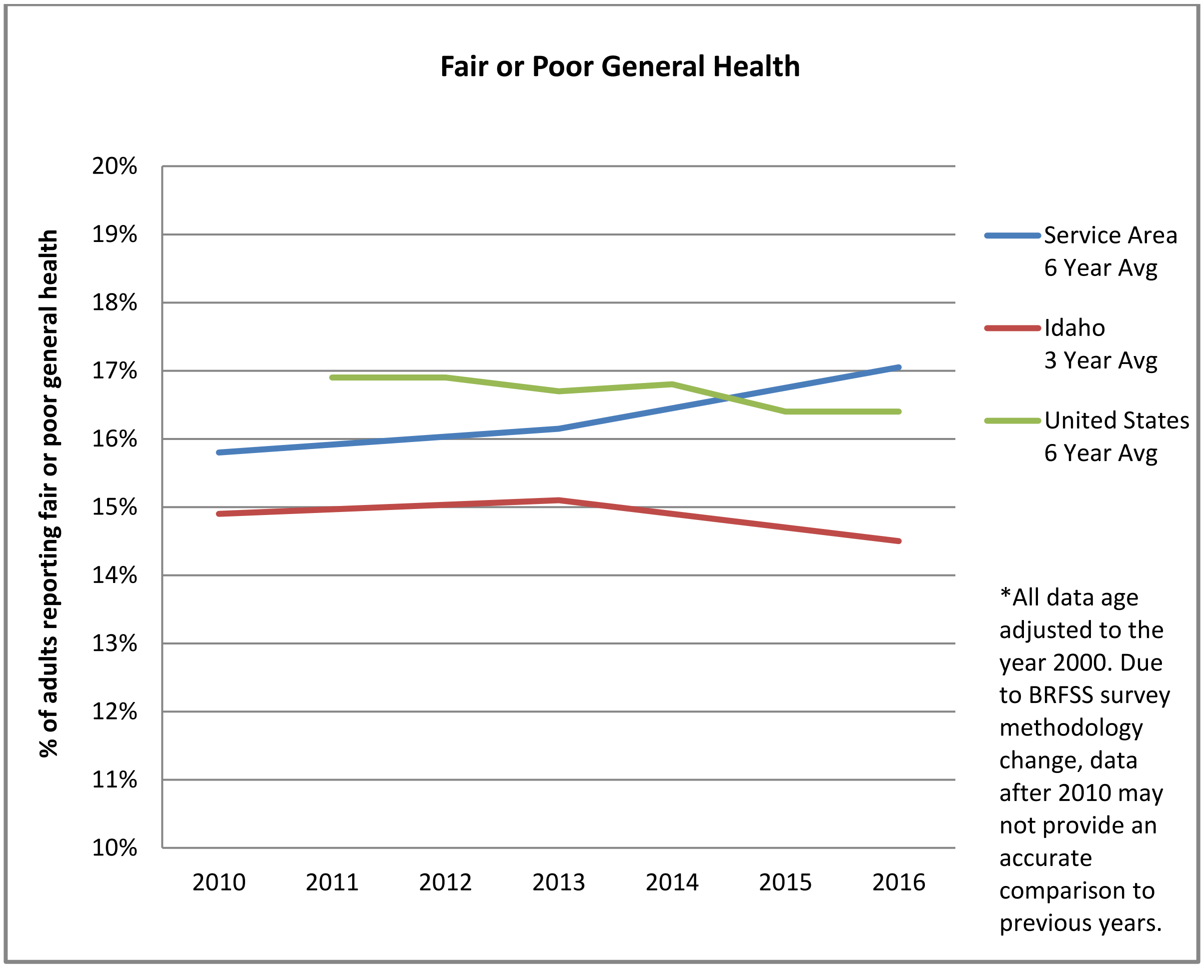
Understanding the health related quality of life of the population helps communities identify unmet health needs. Three measures from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) are used to define health-related quality of life: 1) The percent of adults reporting fair or poor health, 2) the average number of physically unhealthy days reported per month, and 3) 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.[29]

[29] University of Wisconsin Population Health Institute. *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.

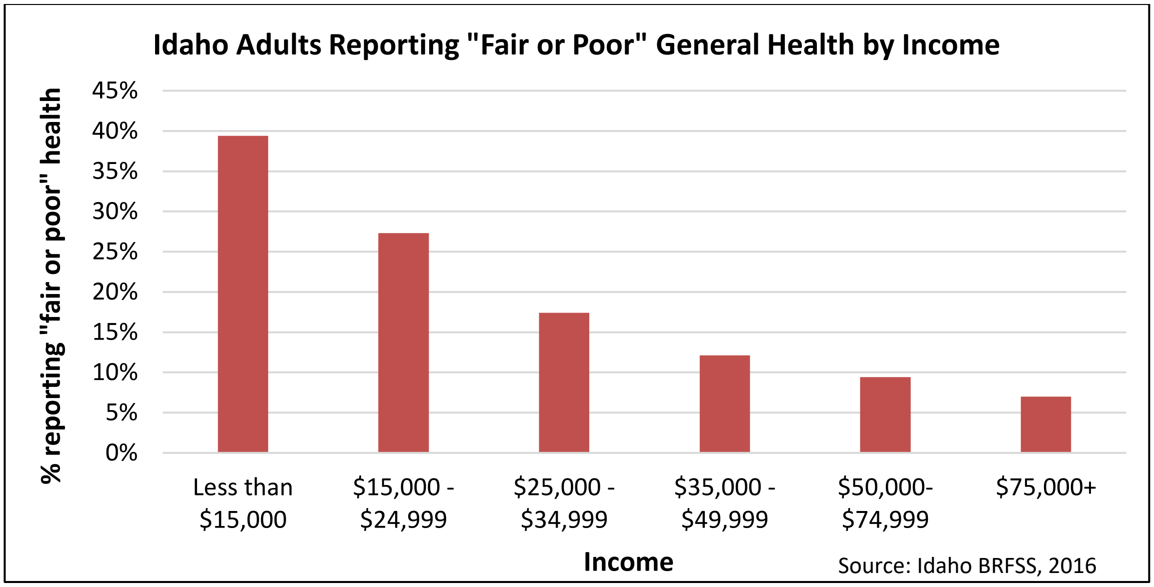
- **"Fair or Poor" General Health**

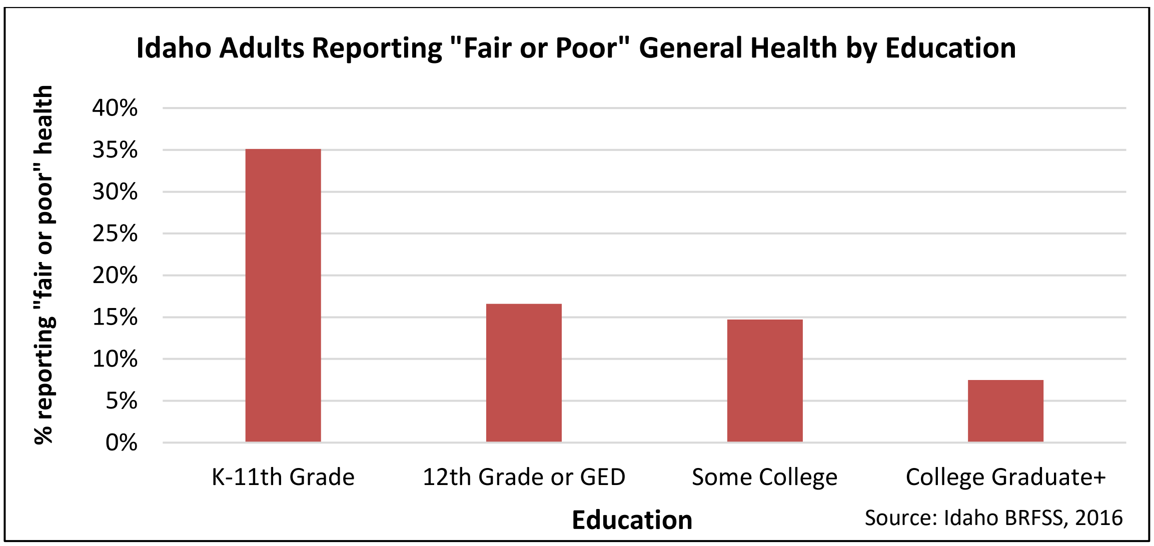
Fourteen point five percent (14.5%) of Idaho adults reported their health status as fair or poor in 2016, which is approximately the same as in 2010. For our service area, the percent of people reporting fair or poor health is about 17% in 2016, which is slightly above the national average of 16.4%.[30]

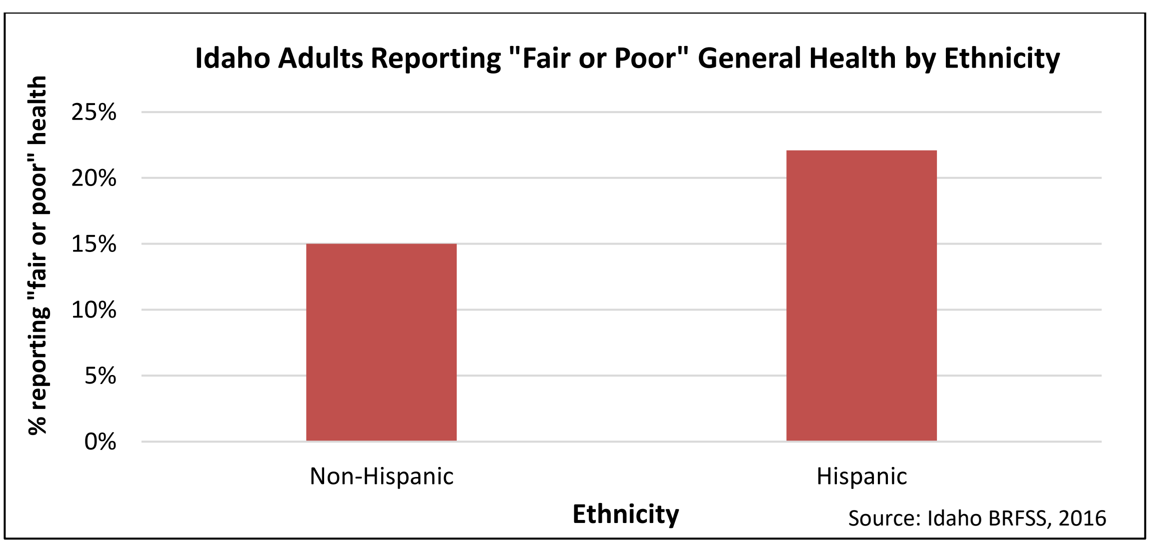


The charts below show that income and education greatly affect the levels of reported fair or poor general health. For example, people with incomes of less than $15,000 are five times more likely to report fair or poor general health than those with incomes above $75,000. In addition, Hispanics are significantly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

[30] Idaho and National 2004 - 2016 Behavioral Risk Factor Surveillance System

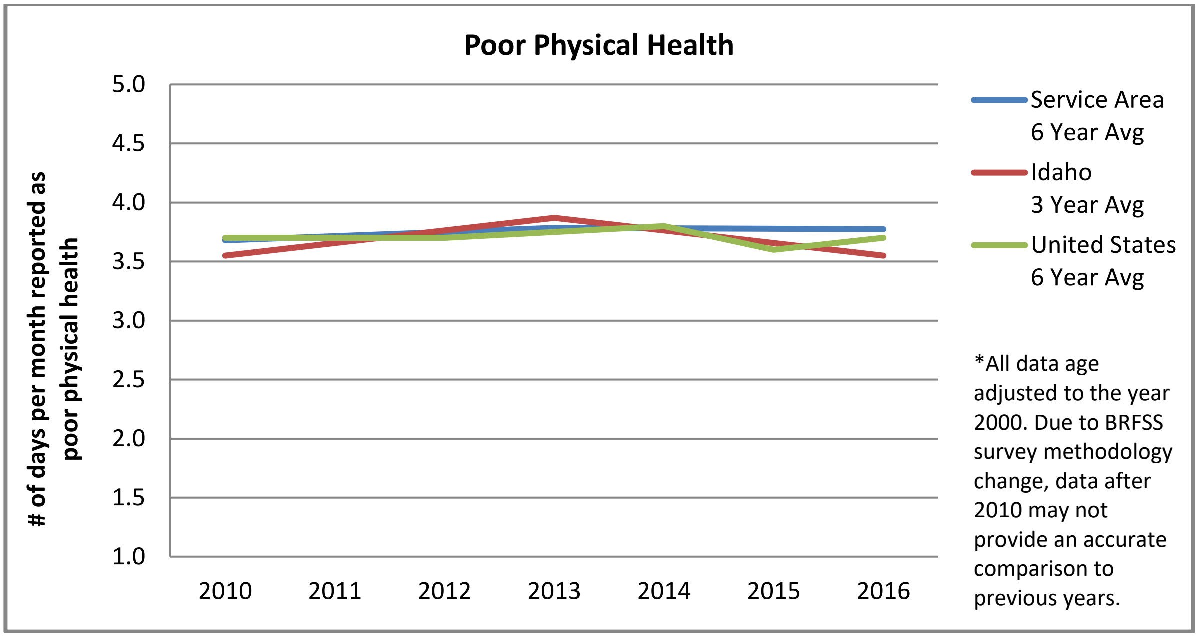

Idaho Adults Reporting "Fair or Poor" General Health by Income
% reporting "fair or poor" health
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Less than $15,000
$15,000 - $24,999
$25,000 - $34,999
$35,000 - $49,999
$50,000- $74,999
$75,000+
Income
Source: Idaho BRFSS, 2016


Idaho Adults Reporting "Fair or Poor" General Health by Education
% reporting "fair or poor" health
40%
35%
30%
25%
20%
15%
10%
5%
0%
K-11th Grade
12th Grade or GED
Some College
College Graduate+
Education
Source: Idaho BRFSS, 2016


Idaho Adults Reporting "Fair or Poor" General Health by Ethnicity
% reporting "fair or poor" health
25%
20%
15%
10%
5%
0%
Non-Hispanic
Hispanic
Ethnicity
Source: Idaho BRFSS, 2016

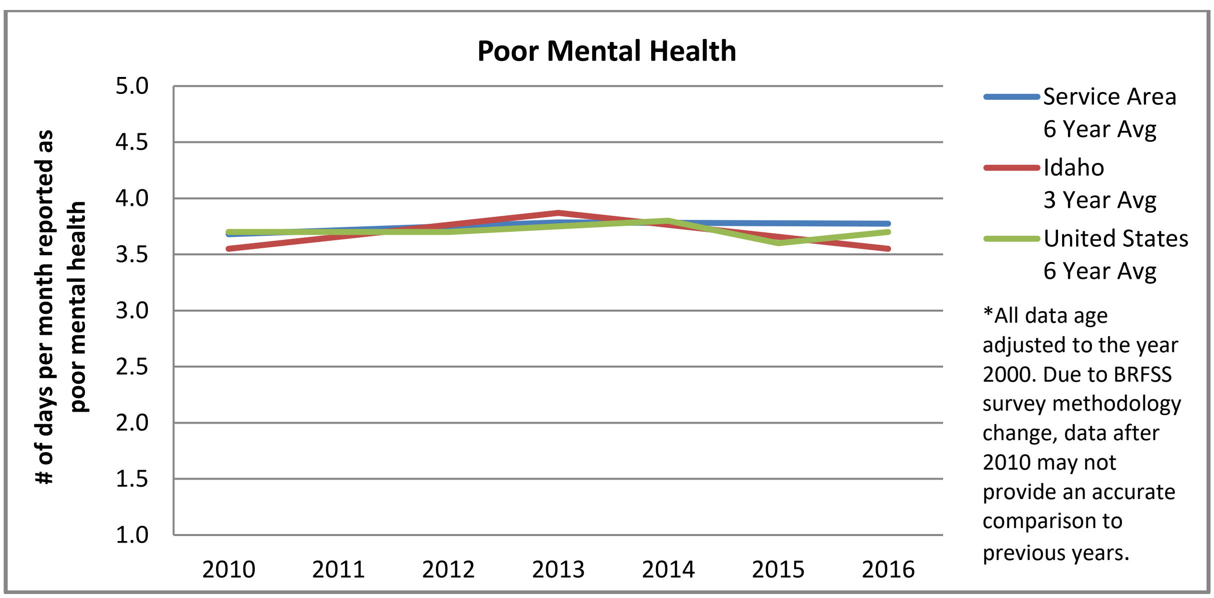
- **Poor Physical Health Days**

  The number of reported poor physical health days for our service area is about the same as the national average.[31] The national top 10th percentile (best) is 3 days.[32]



- **Poor Mental Health Days**

  The number of poor mental health days is also about the same as the national average for our service area. The national top 10th percentile is 3.1 days per month.



[31] Idaho 2016 Behavioral Risk Factor Surveillance System
[32] *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.

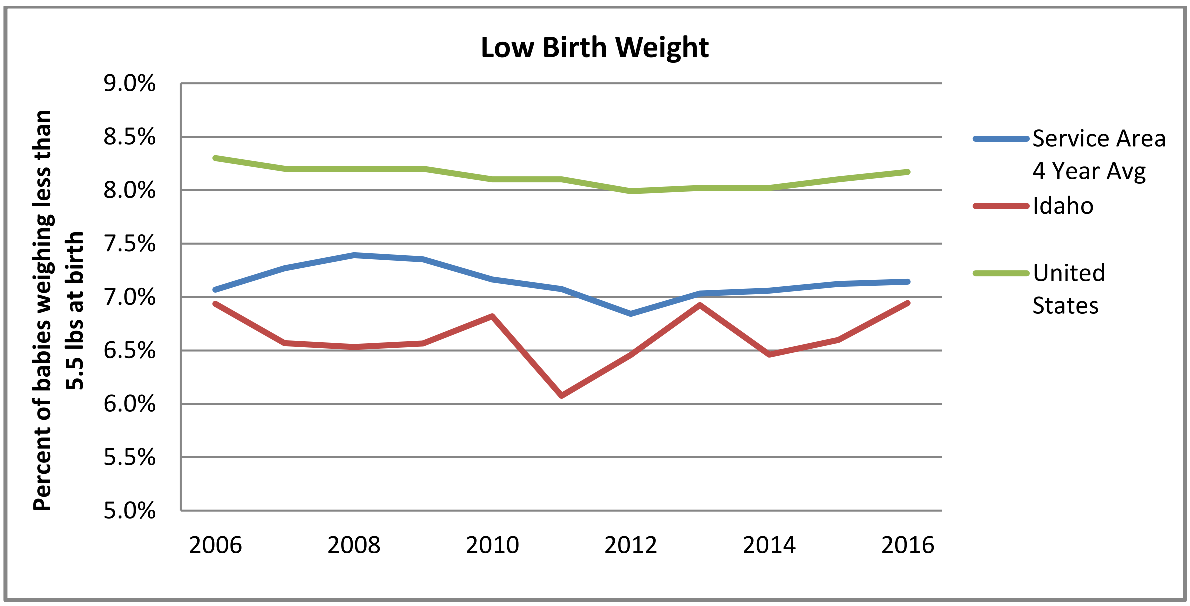
- **Low Birth Weight**

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.[33]

The percent of LBW babies in our service area and in Idaho is significantly below (better than) the national average.[34] 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:[35]

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



Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S.	Severe/ Preventable	Magnitude: Root Cause	Total Score
Low Birth Weight	2	0	2	3	7

[33] University of Wisconsin Population Health Institute. *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.

[34] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Births: Data 2004 - 2016

[35] America's Health Rankings 2015-2018, www.americashealthrankings.org

County Health Rankings Health Outcomes Ranking for Our Community

The *County Health Rankings* ranks the counties within each state on the health outcome measures described above. Twin Falls County's 2018 overall outcome rank is 17th and Jerome County's rank is 31st out of a total of 42 counties in Idaho.[36] 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.

[36] University of Wisconsin Population Health Institute. *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org

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.

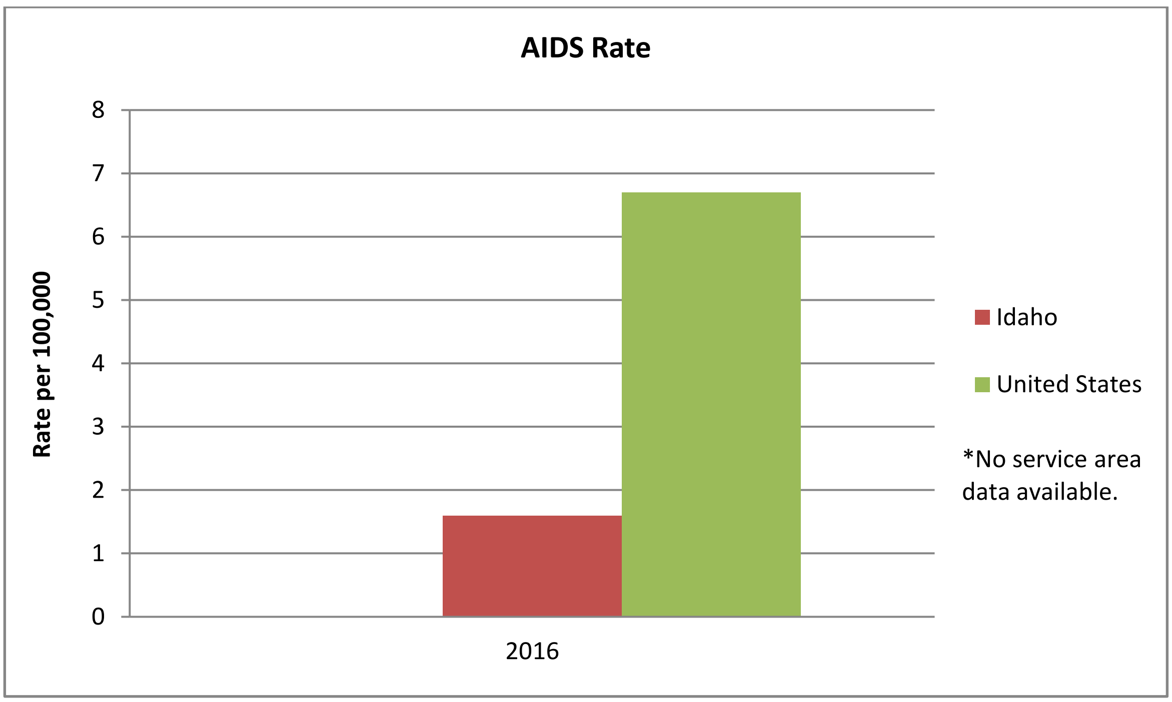
Chronic Disease Prevalence

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.[37] The trend in Idaho has been relatively flat from 2004.[38]

The risk of contracting HIV is particularly high for young, gay, bisexual, and other men who have sex with men (MSM). In 2014, gay and bisexual men accounted for an estimated 70% (26,200) of new HIV infections in the United States. African Americans are more likely to have HIV than any other racial/ethnic group in the United States (US). At the end of 2014, an estimated 471,500 African Americans were living with HIV (43% of everyone living with HIV in the United States).[39] Young people in the US are also more at risk for HIV infection accounting for 21% of all new HIV infections in 2016. 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.[40]



Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S.**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Aids	**2**	**0**	**3**	**2**	**7**

[37] www.statehealthfacts.org
[38] www.healthandwelfare.idaho.gov/Portals/0/Health/Disease/STD%20HIV/2016_Facts_Book_FINAL.pdf
[39] http://www.cdc.gov/HIV/TOPICS/
[40] http://www.cdc.gov/hiv/youth/

- **Arthritis**

In 2016, 22% of Idaho adults had ever been told by a medical professional that they had arthritis. The prevalence of arthritis in our service area is higher than the national average and the trend is increasing. The prevalence of arthritis in our service area is about the same as the national average and has not changed significantly since 2005. 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:

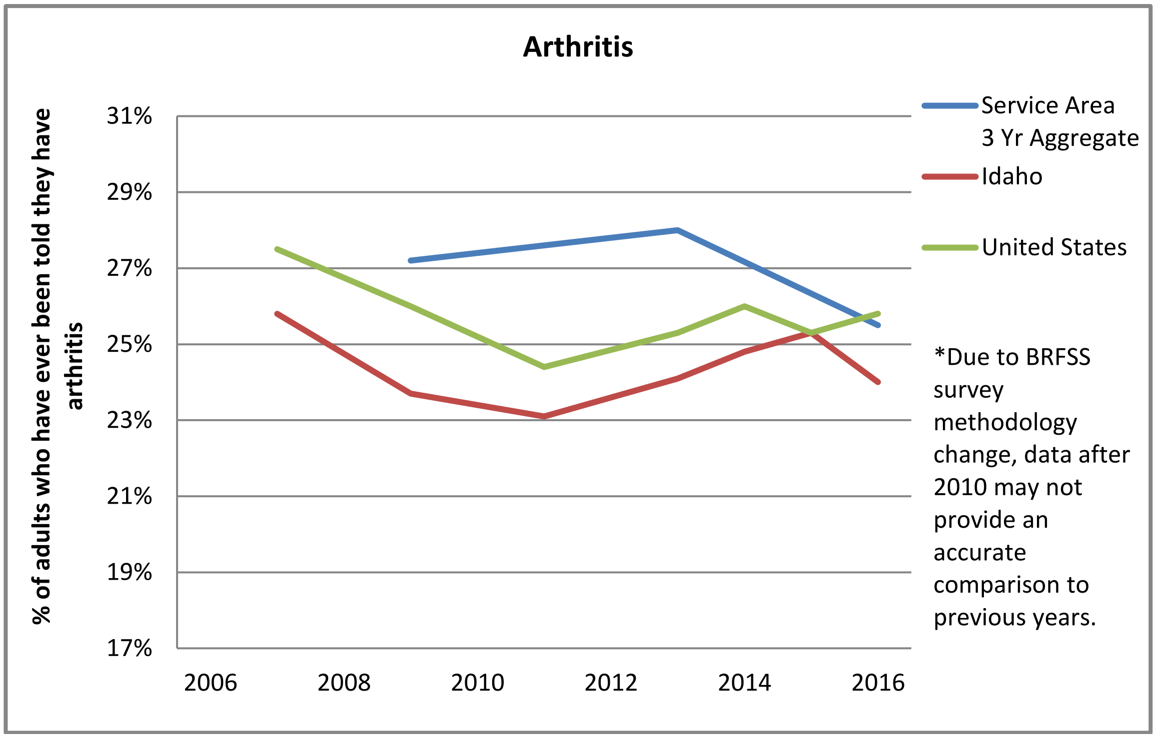
- Idaho residents with incomes below $25,000 per year were more likely to have arthritis than those with incomes of $25,000 or higher (34% compared with 31%).
- Hispanics were significantly less likely than non-Hispanics to have been diagnosed with arthritis (8.8% compared with 25.4%).
- Overweight adults (BMI ≥ 25) were more likely to have arthritis compared to those who were not overweight.[41]

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.[42]

[41] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System

[42] Arthritis Foundation, http://www.arthritis.org/preventing-arthritis.php

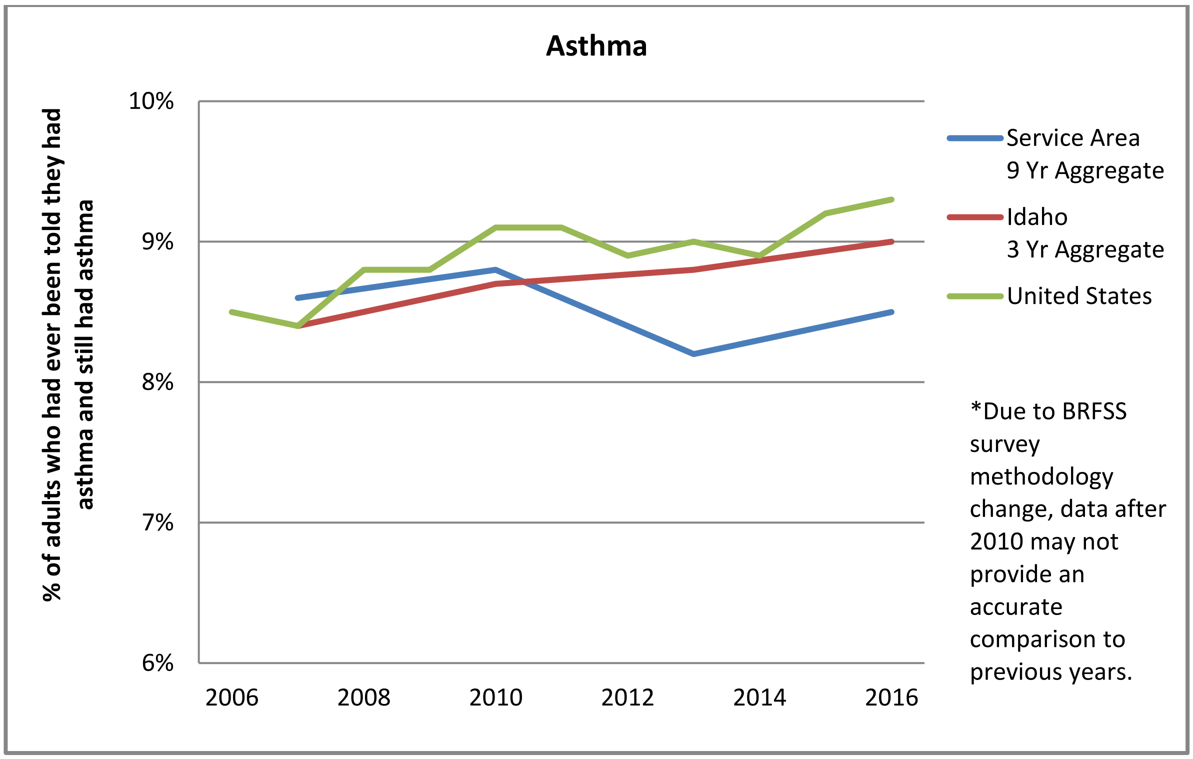


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S.**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Arthritis	**2**	**2**	**2**	**0**	**6**

- **Asthma**

The percentage of people with asthma in our service area is about the below the national average. 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). Females, unemployed, and non-college graduates are more likely to have current asthma. [43]

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.[44]

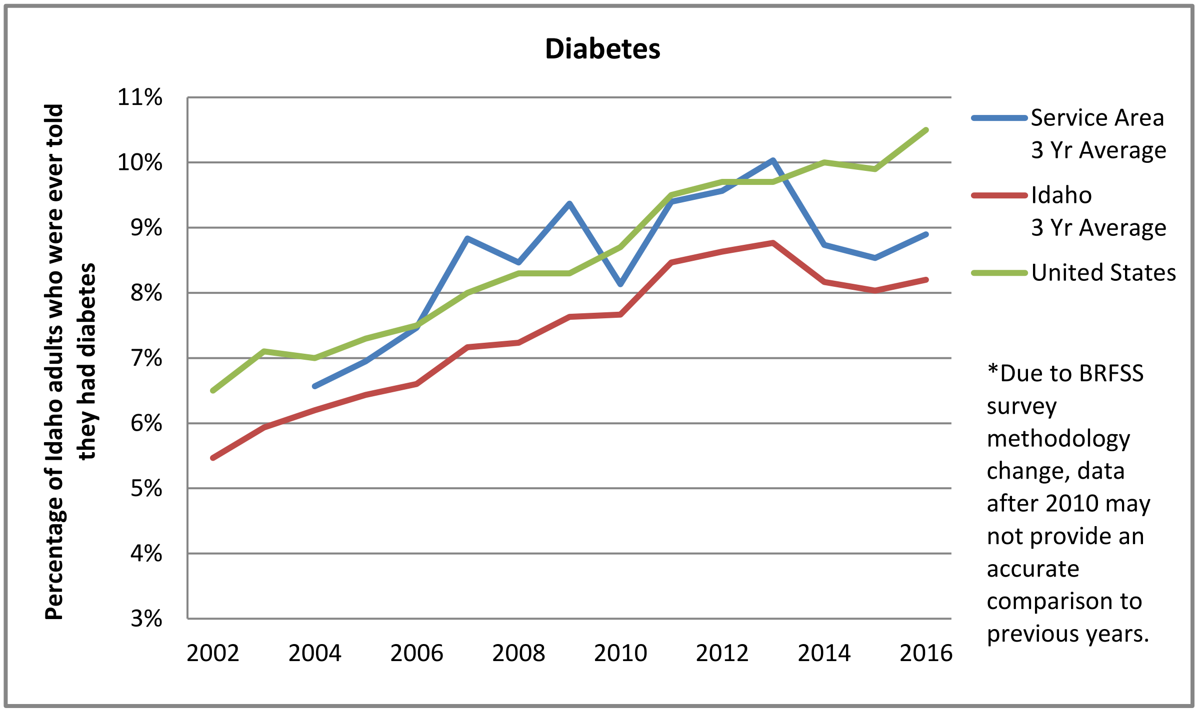


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Asthma	**2**	**1**	**2**	**0**	**5**

[43] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System
[44] http://www.nhlbi.nih.gov/health//dci/Diseases/Asthma/Asthma_Treatments.html

- **Diabetes**

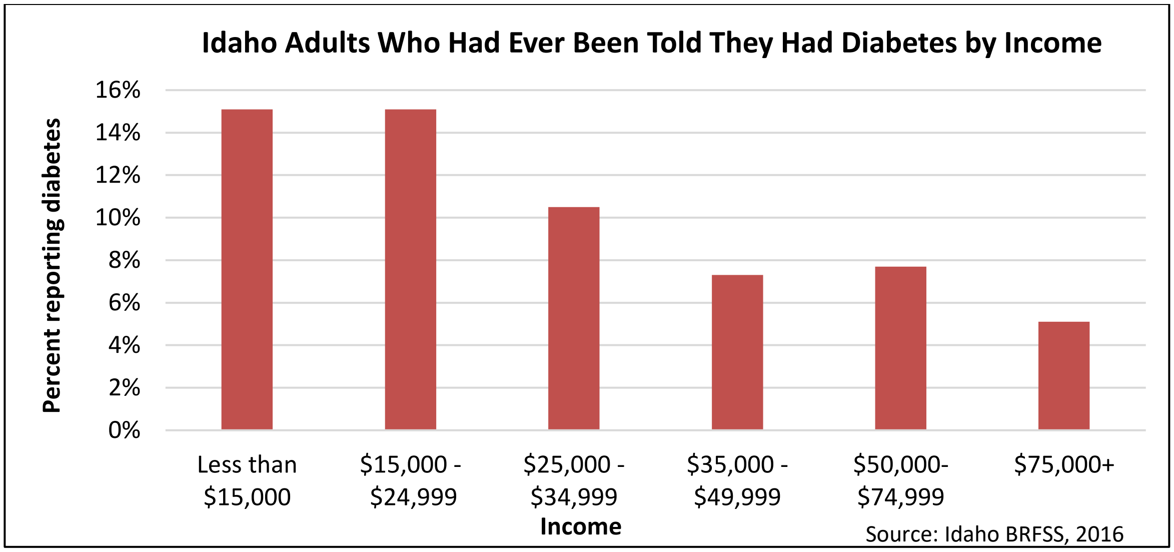
About 9% of the people in our community report that they have been told they have diabetes. The percent of people living with diabetes in our service area and in the United States is up by over 40% since 2002, indicating an opportunity for greater focus on prevention. Diabetes is a serious health issue that can contribute to heart disease, stroke, high blood pressure, kidney disease, blindness and can even result in limb amputation or death.[45] Direct medical costs for type 2 diabetes exceed $200 billion and account for $1 of every $10 spent on medical care in the U.S. [46]

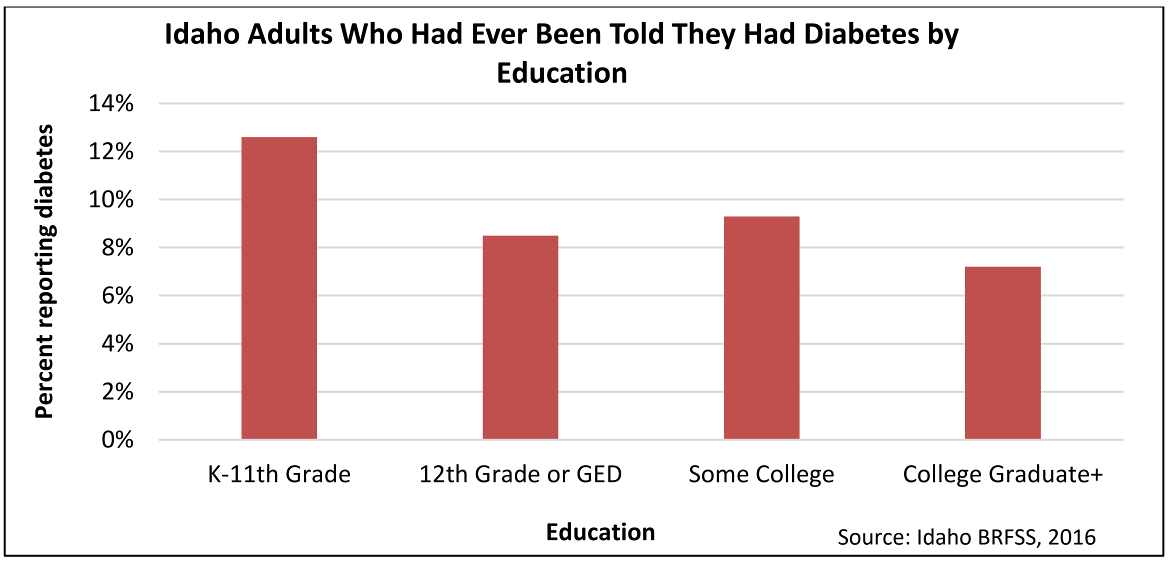


Other Highlights:

- Overweight (BMI ≥ 25) adults reported diabetes about three times as often as those who were not overweight.
- Approximately 59 percent of all diabetes health care expenditures are attributable to seniors. Educating older adults on diabetes management throughout the aging process and implementing physician guidelines tailored for older adults can minimize the health impact of diabetes.
- Those with a high school diploma or less education were significantly more likely to have diabetes than college graduates.[47]

[45] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System
[46] America's Health Rankings 2015-2018, www.americashealthrankings.org
[47] Ibid.





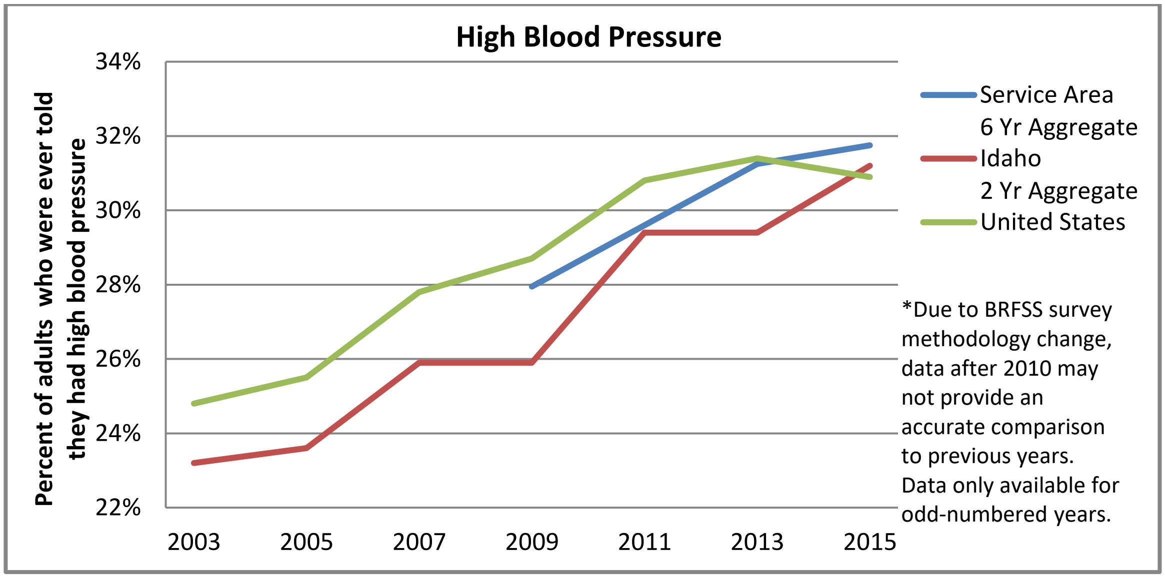
Studies indicate that the onset of type 2 diabetes can be prevented through weight loss, increased physical activity, and improving dietary choices. Diabetes can be managed through regular monitoring, following a physician-prescribed care regiment, adjusting diet, and maintaining a physically active lifestyle.[48]

Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Diabetes	**2**	**1**	**3**	**4**	**10**

[48] America's Health Rankings 2018, www.americashealthrankings.org

- **High Blood Pressure**

The incidence of high blood pressure in the United States has continued to rise steadily over time. Currently, about one in every three Americans suffers from high blood pressure. Blood pressure rates in our service area are slightly above the national level and the long-term trend is not improving. High blood pressure is a major risk factor for heart disease, stroke, congestive heart failure, and kidney disease.[49]



- Those with incomes below $35,000 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).
- 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.[50]

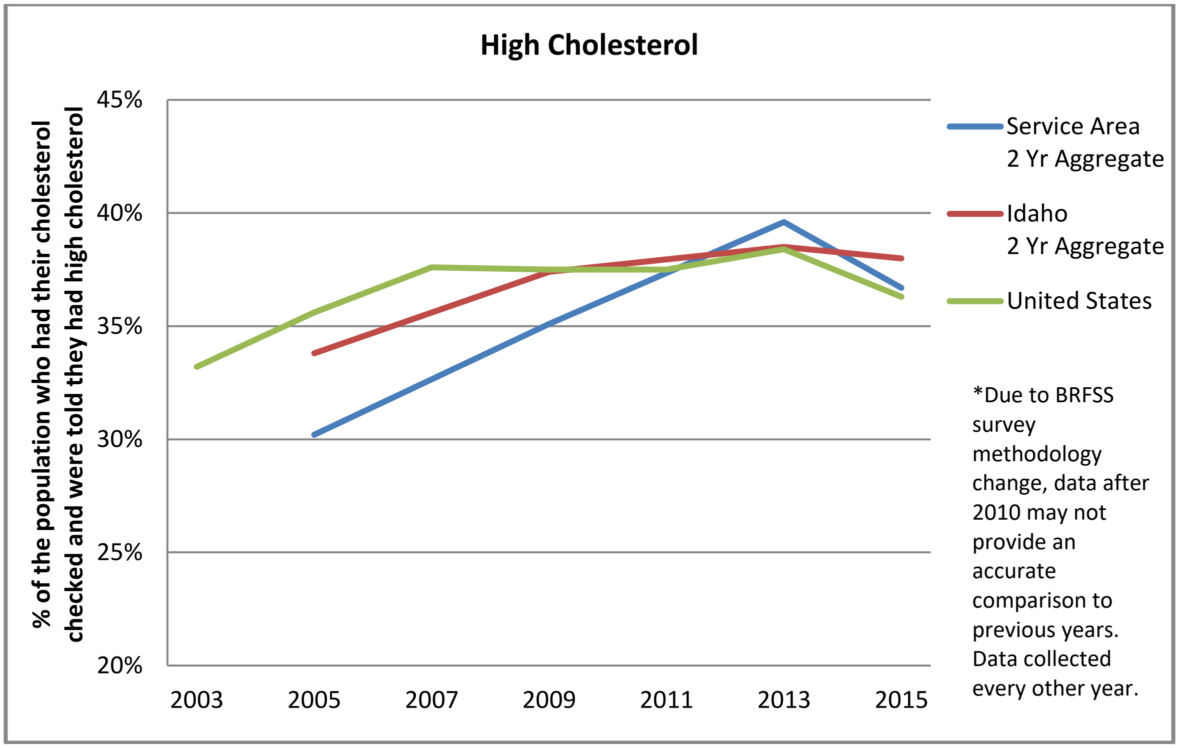
Healthy blood pressure may be maintained by changing lifestyle or combining lifestyle changes with prescribed medications.[51]

Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S.**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
High Blood Pressure	**4**	**2**	**3**	**2**	**11**

[49] Ibid
[50] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System
[51] America's Health Rankings 2015-2018, www.americashealthrankings.org

- **High Cholesterol**

Among those who had ever been screened for cholesterol in our service area, approximately 36% reported that they were told their cholesterol was high in 2016, which is about the same as the national average. The percentage of screened adults with high cholesterol has increased in our service area, Idaho, and nationally since 2005. Sustained, increased cholesterol levels can lead to heart disease, heart attack, and other circulatory problems.[52]



Other Highlights:

- Prevalence of high cholesterol decreased with higher levels of education.
- 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.
- Those who were overweight were significantly more likely to have high cholesterol than those who were not overweight.
- Adults aged 55 and older were significantly more likely to have had high blood cholesterol levels as those under age 55.[53]

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[52] Ibid.
[53] Idaho 2011 - 2016 Behavioral Risk Factor Surveillance System

While some factors that contribute to high cholesterol are out of our control, like family

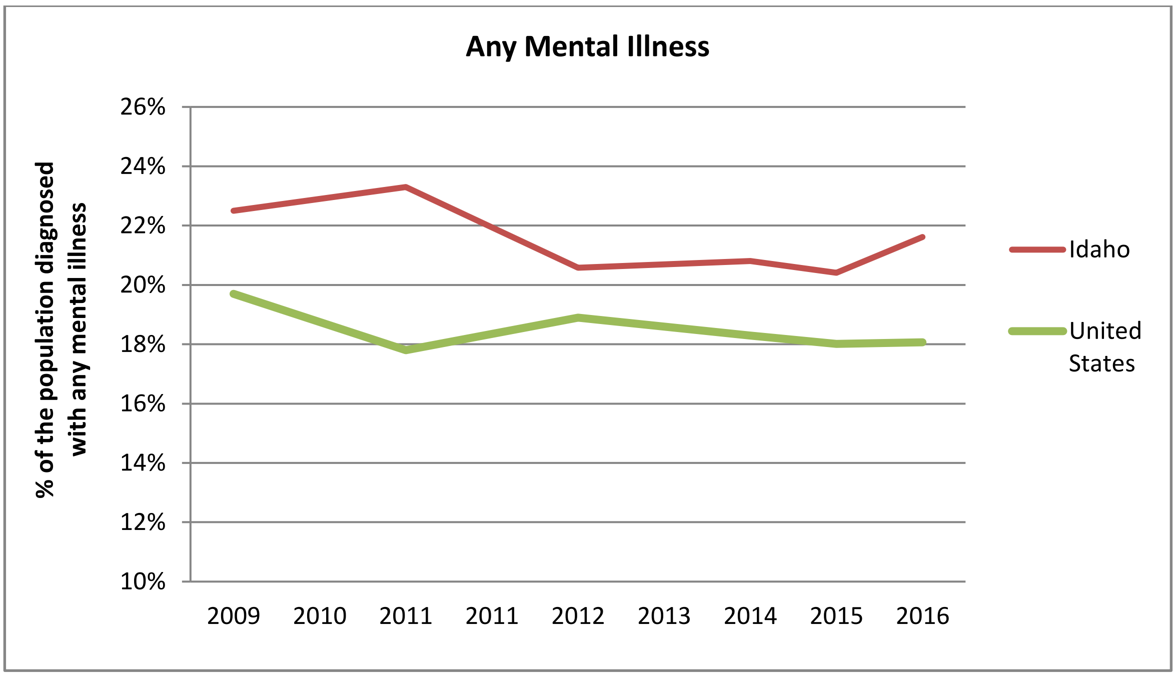
history, there are many things a person can do to keep cholesterol in check, such as following a healthy diet, maintaining a healthy weight, and being physically active. For some individuals, a physician-recommended pharmacological intervention may be necessary.[54]

Health Factor Score **Low score = Low potential for health impact** **High score = High potential for health impact**					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
High Cholesterol	**4**	**2**	**3**	**2**	**11**

[54] America's Health Rankings 2018, www.americashealthrankings.org

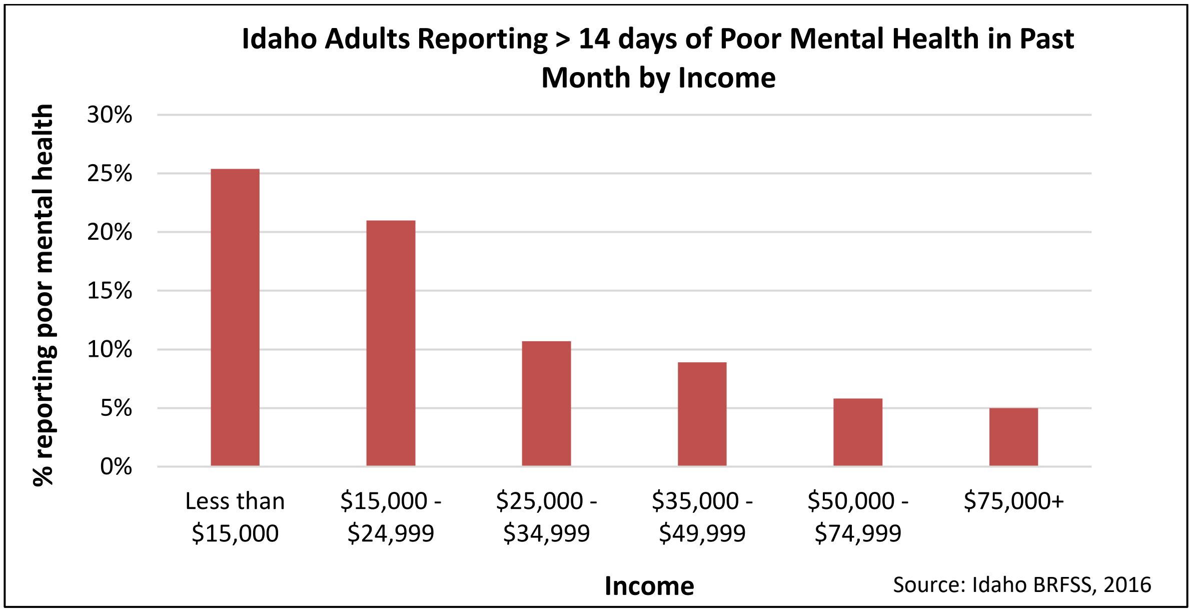
- **Mental Illness**

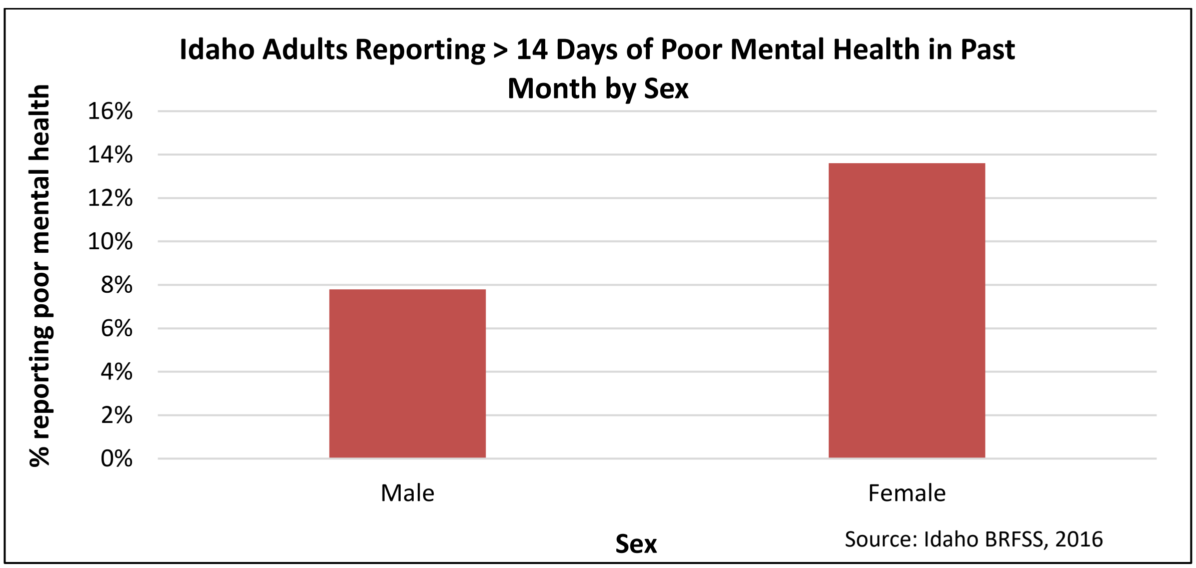
Community mental health status can help explain suicide rates as well as aid us in understanding the need for mental health professionals in our service area. The percentage of people age 18 or older having any mental illness (AMI) was 21.62% for Idaho in 2016. This was the fourth highest percentage of mental illness in the nation. The percentage of people having any mental illness for the United States as a whole was 18.07%.[55]



[55] Mental Health, United States, 2009 - 2016 Reports, SAMHSA, www.samhsa.gov

The charts below show that people with lower incomes are about three and a half times more likely to have depressive disorders, and women are more likely than men to be diagnosed with a depressive disorder.[56]





Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Mental Illness	**2**	**4**	**3**	**4**	**13**

[56] Idaho 2011 - 2016 Behavioral Risk Factor Surveillance System

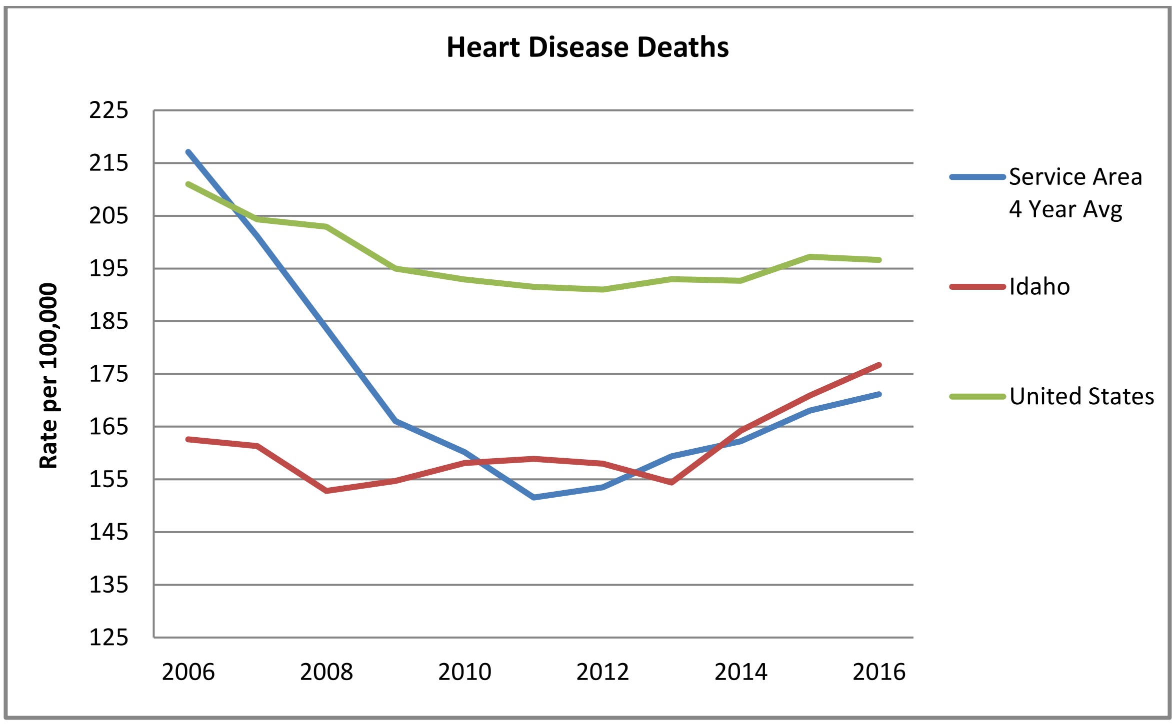
Top 10 Causes of Death

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.

- **Diseases of the Heart**

  The long, steady decline in heart disease death rates since 2000 shows signs of reversing. [57] It's also important to note that 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 and is now the leading cause of death in Idaho as well.[58] The death rate from heart disease in our service area is 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.[59]

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[57] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[58] America's Health Rankings 2015-2018, www.americashealthrankings.org
[59] Ibid.

Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Heart disease deaths	**2**	**0**	**4**	**2**	**8**

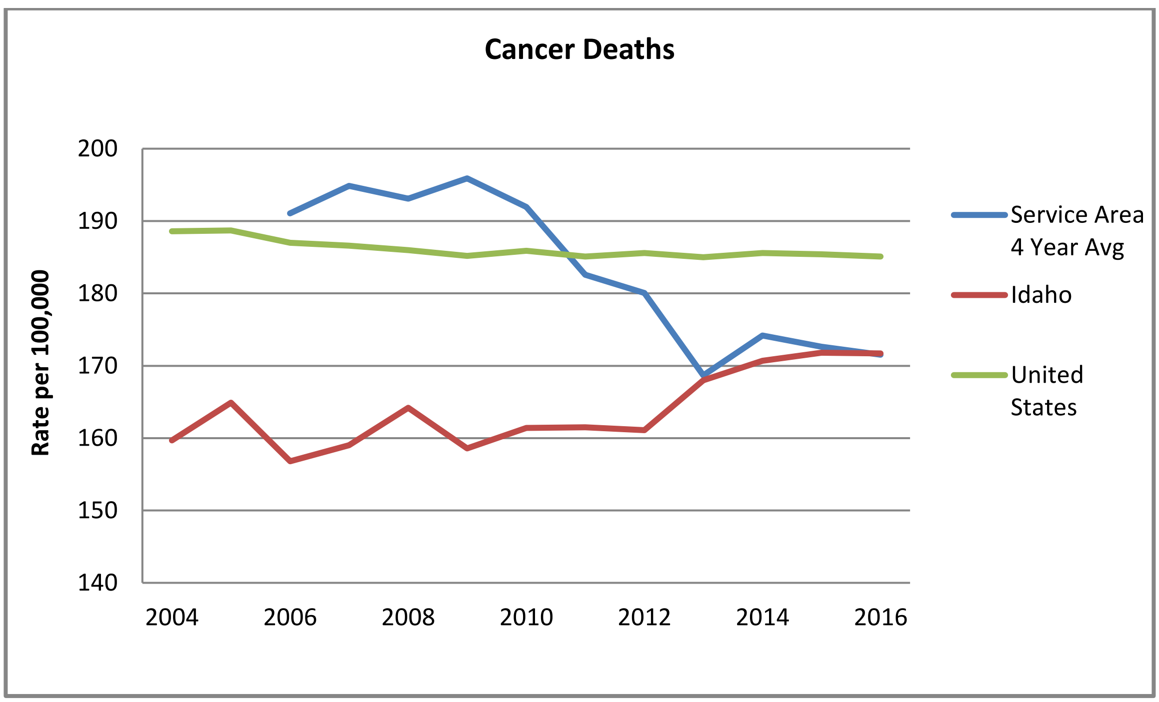
- **Cancer (malignant neoplasms)**

Cancer is the second leading cause of death in Idaho and 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. Over 20% 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. Many individuals face financial challenges because of lack of insurance or underinsurance, resulting in high out-of-pocket expenses.[60]

The chart below shows that the cancer death rate in our service area is below the national average. The trend for cancer deaths is down nationally and in our service area for a number of years.[61]



[60] Comprehensive Cancer Alliance for Idaho, Idaho Comprehensive Cancer Strategic Plan 2004-2010, www.ccaidaho.org
[61] Idaho Vital Statistics Annual Reports, Years 2003 - 2016, National Vital Statistics Report - Deaths: Data 2016

If tobacco use, poor diet, and physical inactivity were eliminated, the CDC estimates that 40% of cancers would be prevented. Therefore, opportunities exist to reduce the risk of developing some cancers.[62]

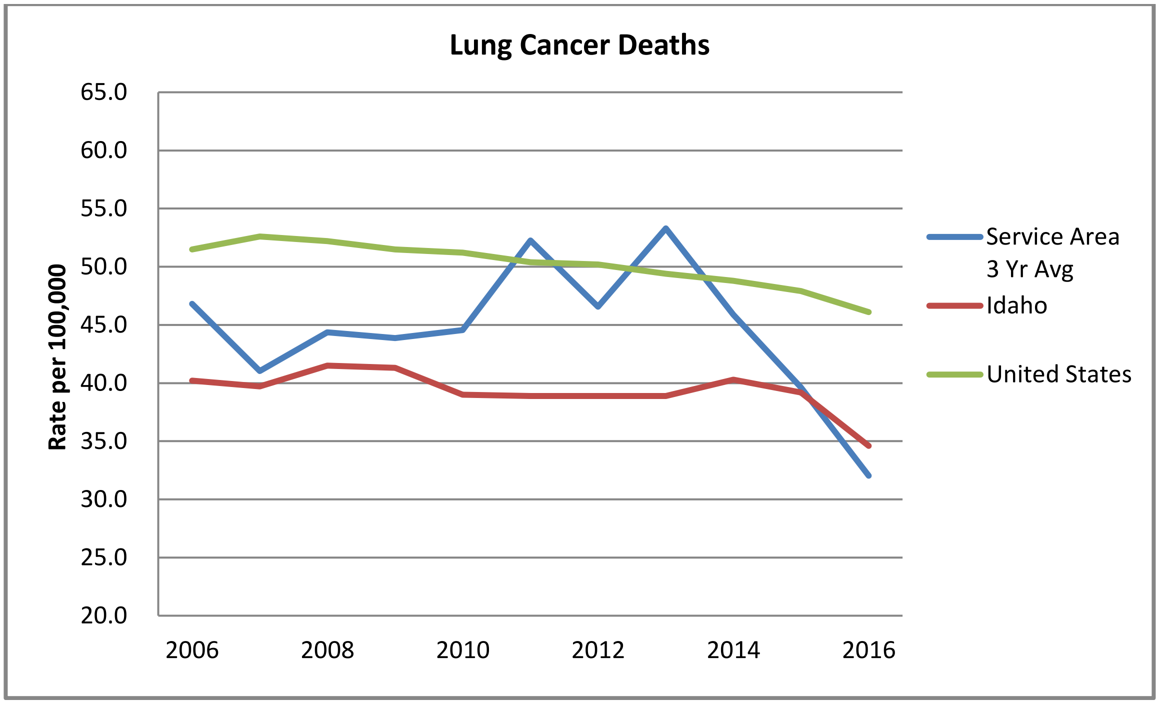
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Cancer	**1**	**1**	**3**	**1**	**6**

Although our service area's cancer rate is now below the national average, 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 collected data on the most common forms of cancer on the following pages.

[62] America's Health Rankings 2015-2018, www.americashealthrankings.org

- **Lung Cancer**

Lung cancer is the leading cause of cancer death in Idaho. However, the lung cancer death rate in our service area is below the national average.[63] Current science does not support population-based efforts to screen for lung cancer. More than 80% of lung cancers are a result of tobacco smoking.[64]

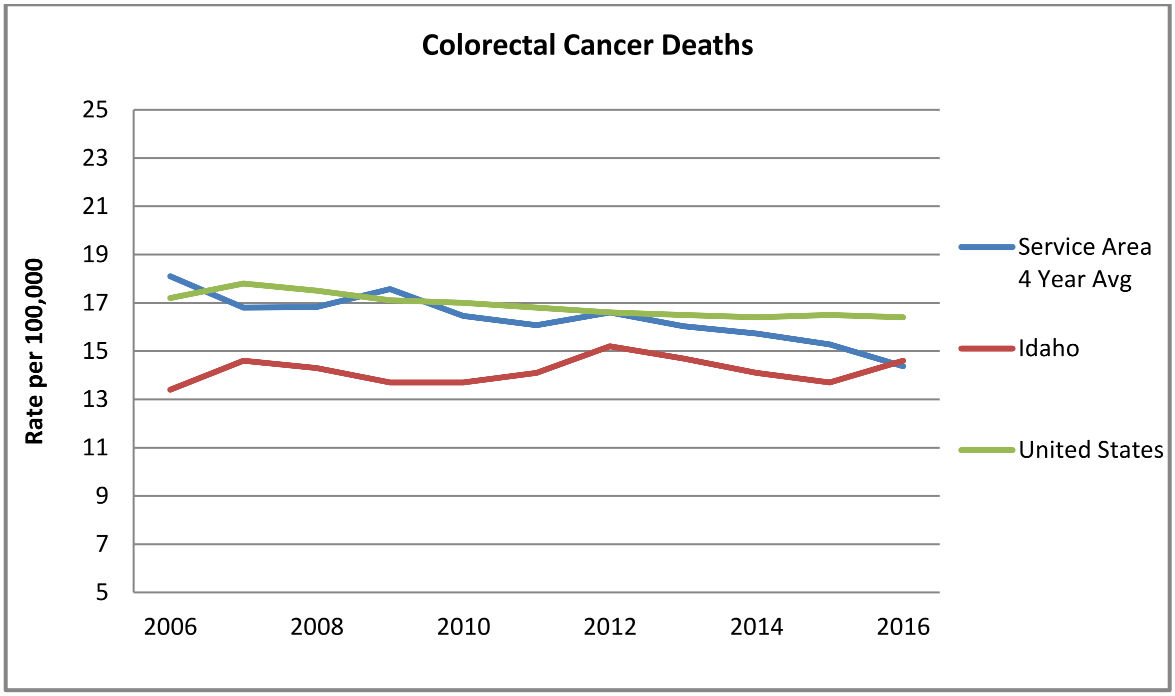


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Lung Cancer	0	0	4	1	5

[63] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[64] Comprehensive Cancer Alliance for Idaho, Idaho Comprehensive Cancer Strategic Plan 2004-2010, www.ccaidaho.org

- **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 and the national trend is down slightly. Our community's death rate is now below the national average.[65] 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.[66]

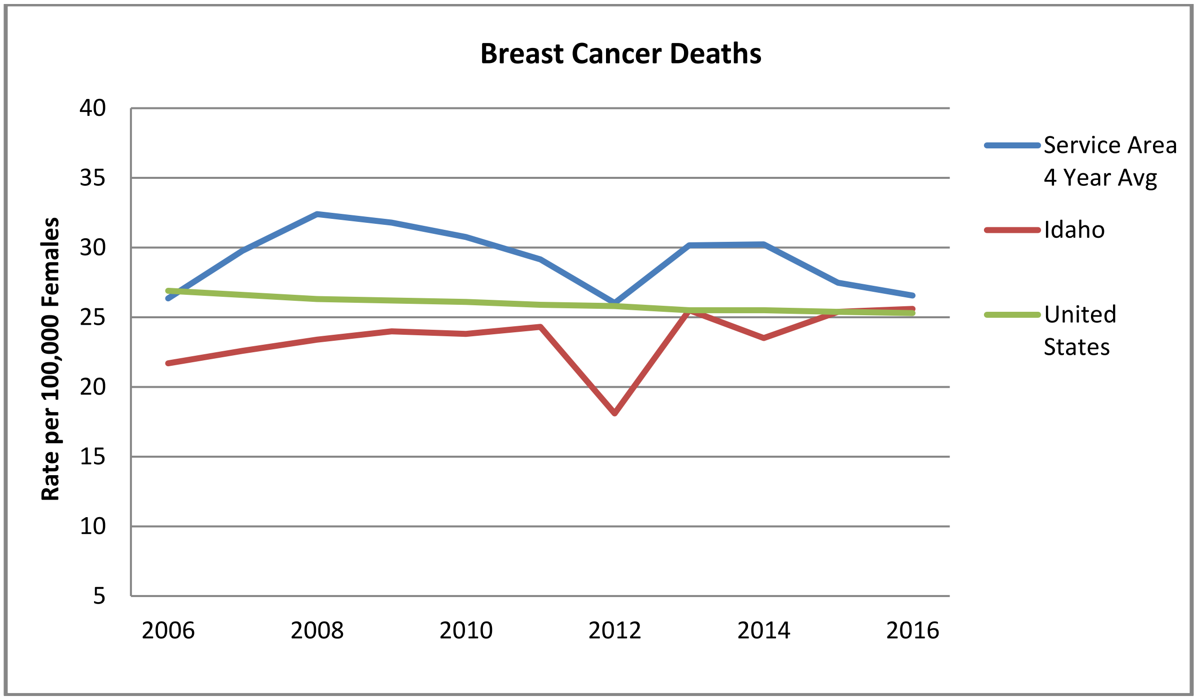


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude	Total Score
Colorectal Cancer	1	1	4	0	6

[65] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[66] America's Health Rankings 2015- 2018, 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 slightly above the national average.[67] Although nationally breast cancer rates have continued to rise since 1980, there has been a 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%). [68]

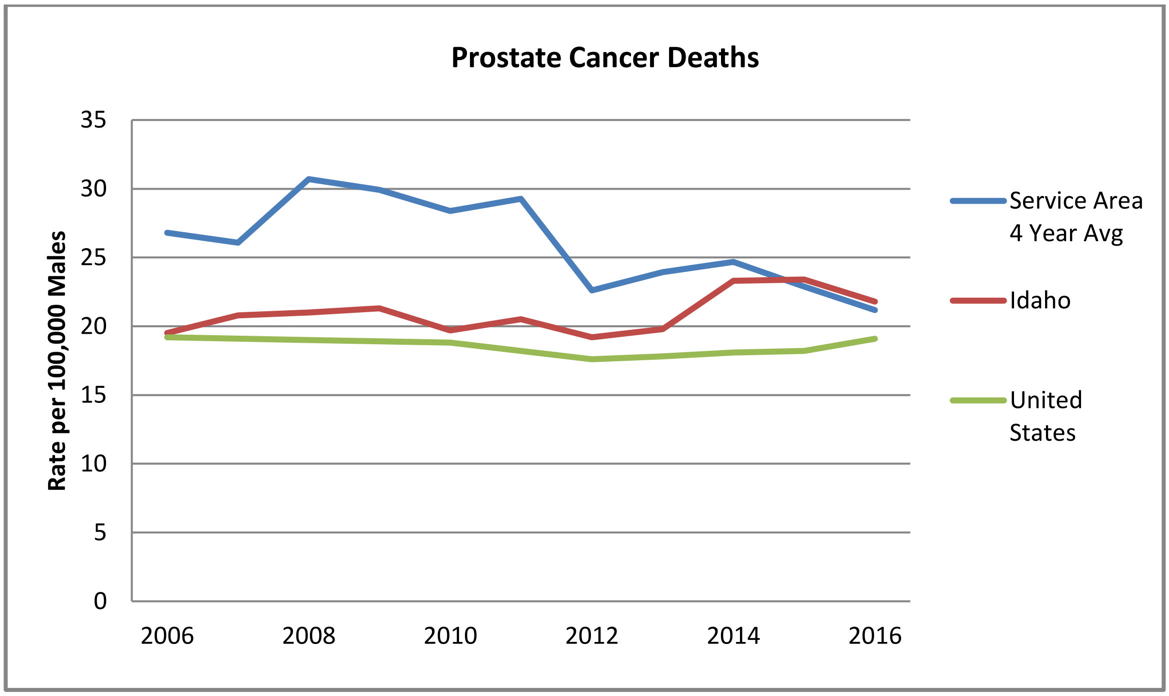


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Breast Cancer	2	2	4	1	9

[67] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[68] America's Health Rankings 2015-2018, 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 trend for the prostate cancer deaths is relatively flat, and the death rate is above the national average.[69] 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.[70]

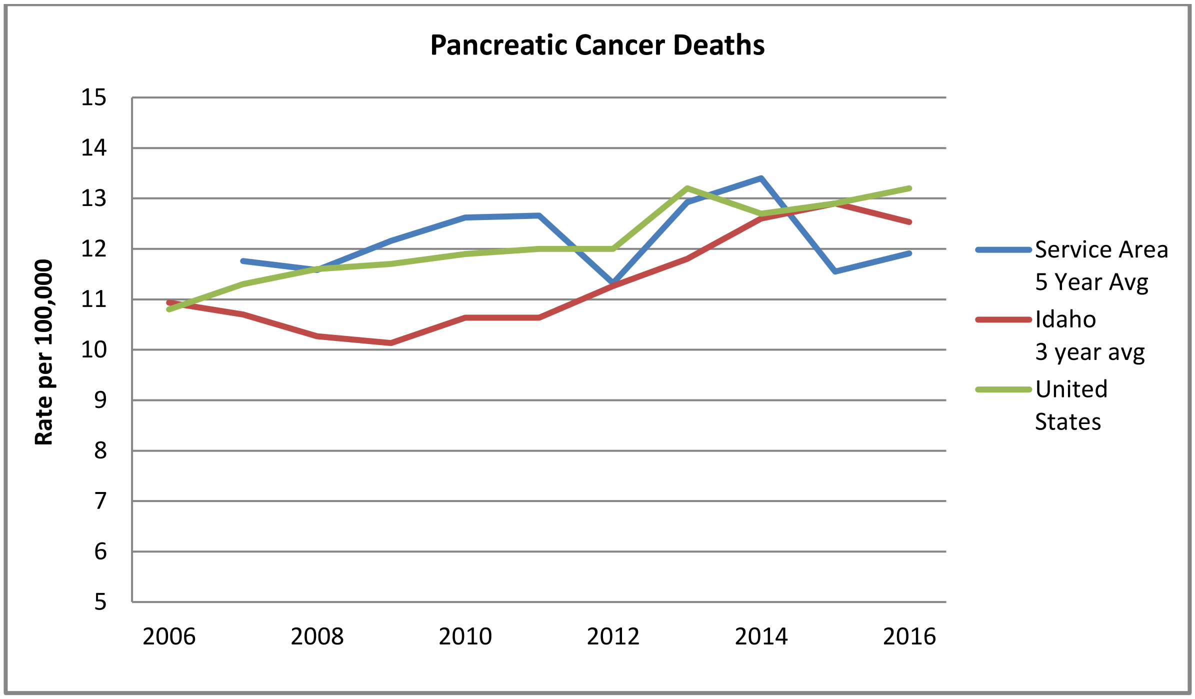


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Prostate Cancer	**2**	**3**	**3**	**0**	**8**

[69] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[70] Comprehensive Cancer Alliance for Idaho, Idaho Comprehensive Cancer Strategic Plan 2004-2010, www.ccaidaho.org

- **Pancreatic Cancer**

In our service area, the pancreatic cancer death rate is currently slightly below the national average.[71] 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.[72]



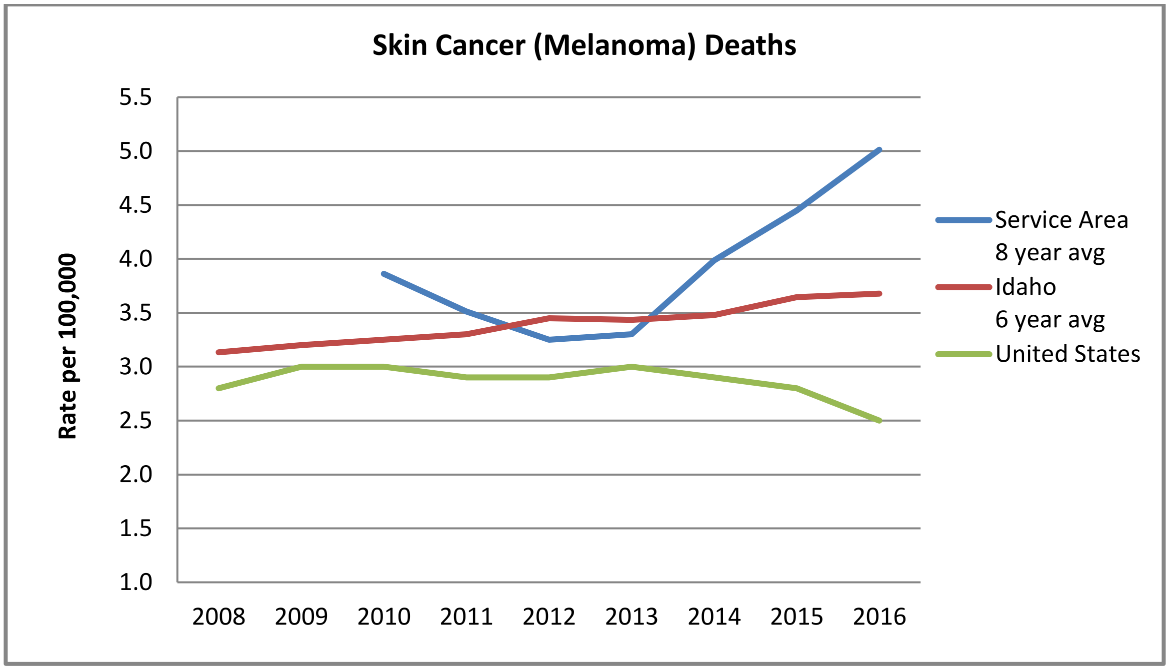
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude	Total Score
Pancreatic Cancer	2	2	1	0	5

[71] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[72] Comprehensive Cancer Alliance for Idaho, Idaho Comprehensive Cancer Strategic Plan 2004-2010, www.ccaidaho.org

- **Skin Cancer (melanoma)**

More people are diagnosed with skin cancer each year in the U.S. than all other cancers combined. In 2012, more than three million people in the U.S. were treated for skin cancer, the most recent year new statistics were available. About 1 in 5 Americans will develop skin cancer during their lifetime. In the past decade (2008 – 2018) the number of new melanoma cases diagnosed annually has increased by 53 percent. [73]

The chart shows that melanoma death rates are higher in Idaho and much higher in our service area than in the rest of the nation.[74]



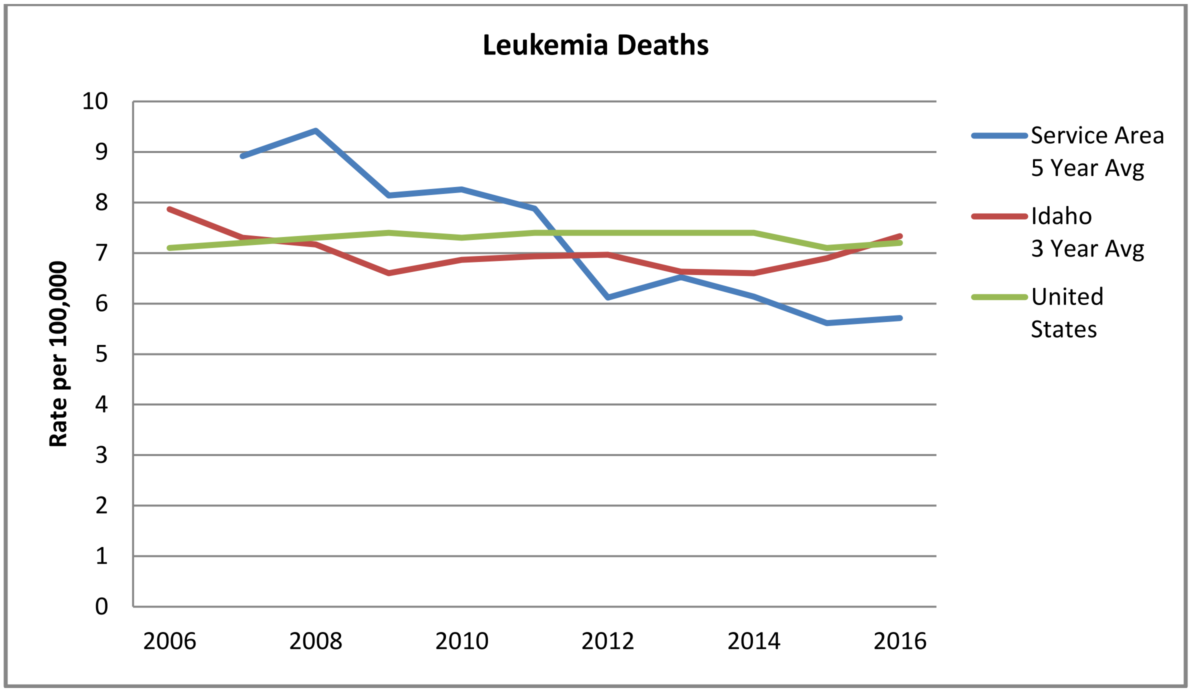
Exposure to ultraviolet (UV) radiation appears to be the most significant factor in the development of skin cancer. Skin cancer is largely preventable when sun protection measures are used consistently. These results highlight the need for effective interventions that reduce harmful UV light exposure. [75]

Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Skin Cancer Death Rate	4	4	4	0	12

[73] https://www.skincancer.org/skin-cancer-information/skin-cancer-facts
[74] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[75] https://www.skincancer.org/skin-cancer-information/skin-cancer-facts

- **Leukemia**

The leukemia death rate in our service area is lower than the national average and the trend is down.[76] Leukemia is a cancer of the bone marrow and blood. Scientists do not fully understand 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.[77] Because the causes are not well understood, evidence-based preventive programs are not available (other than avoiding the risk factors described above).

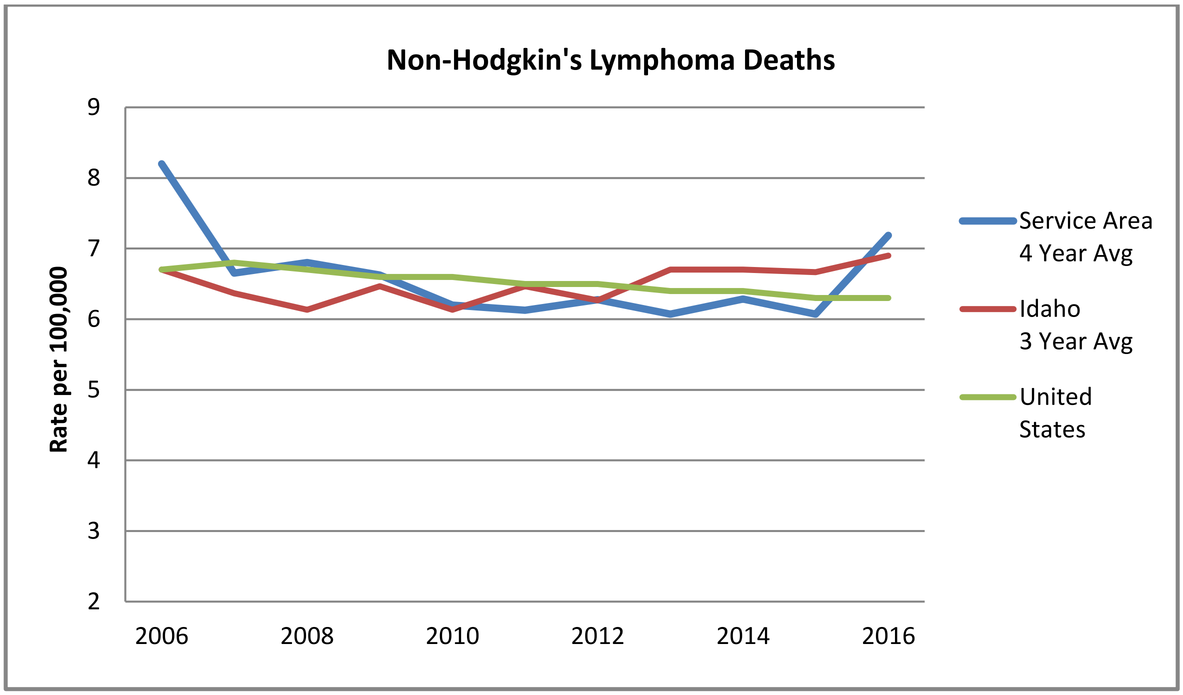


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Leukemia	**1**	**1**	**1**	**0**	**3**

[76] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[77] 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, and the trend is flat. [78] Lymphoma is a general term for cancers that start in the lymph system; mainly the lymph nodes. The causes of lymphoma are unknown.[79] Because the causes are not understood, evidence-based preventive programs are not available.

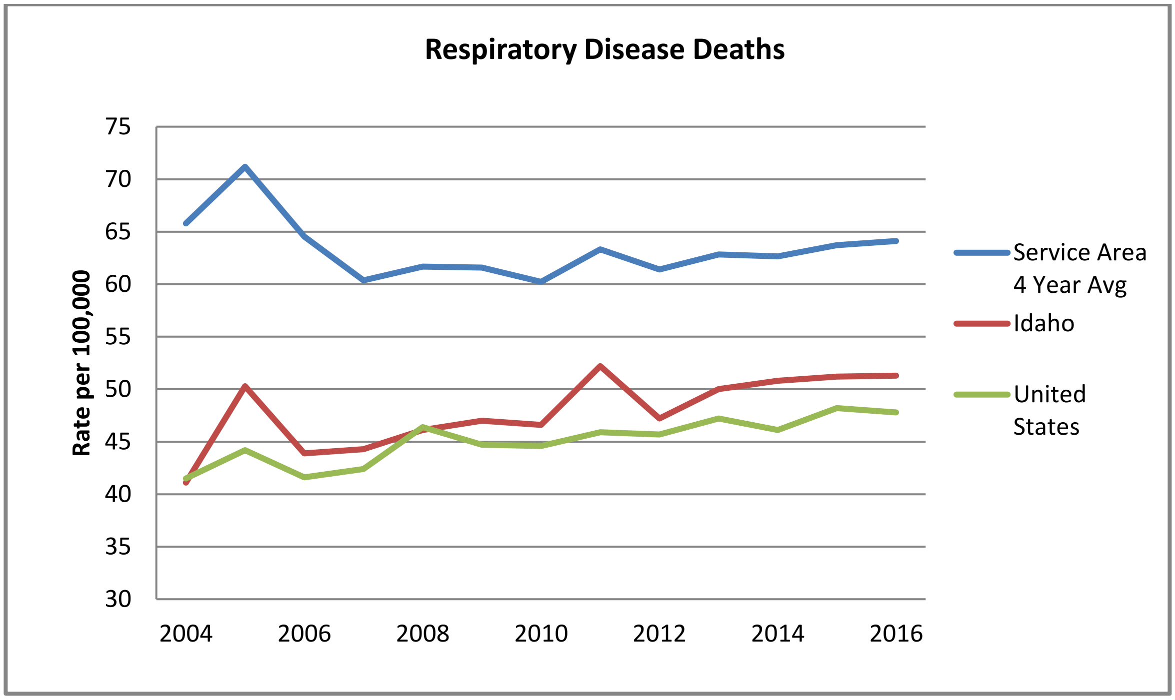


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Non-Hodgkin's lymphoma	**2**	**2**	**1**	**0**	**5**

[78] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[79] www.cdc.gov/Features/HematologicCancers/

- **Chronic Lower Respiratory Diseases**

The chronic lower respiratory diseases death rate in our service area is much higher than the national average and the trend has been flat. Chronic lower respiratory diseases are the third leading cause of death in Idaho.[80] 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. [81]

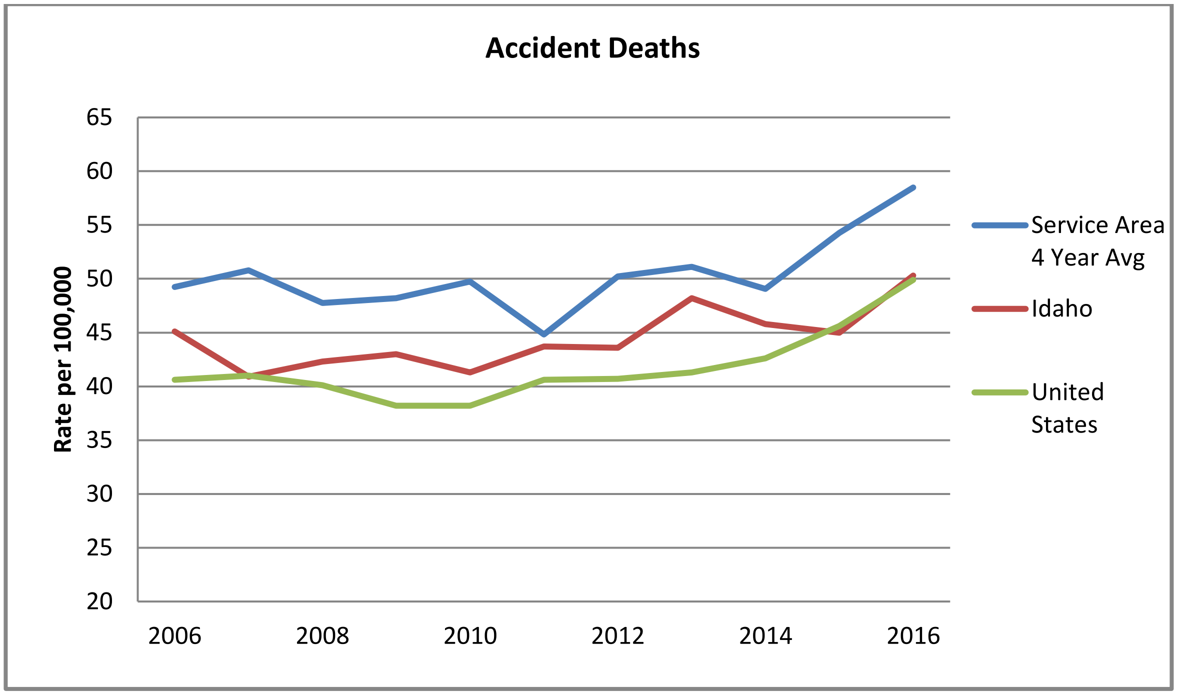


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Respiratory disease deaths	2	4	4	0	10

[80] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[81] www.lung.org/associations/states/wisconsin/news/chronic-lower-respiratory.html

- **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 well above the national average and the trend is up.[82]

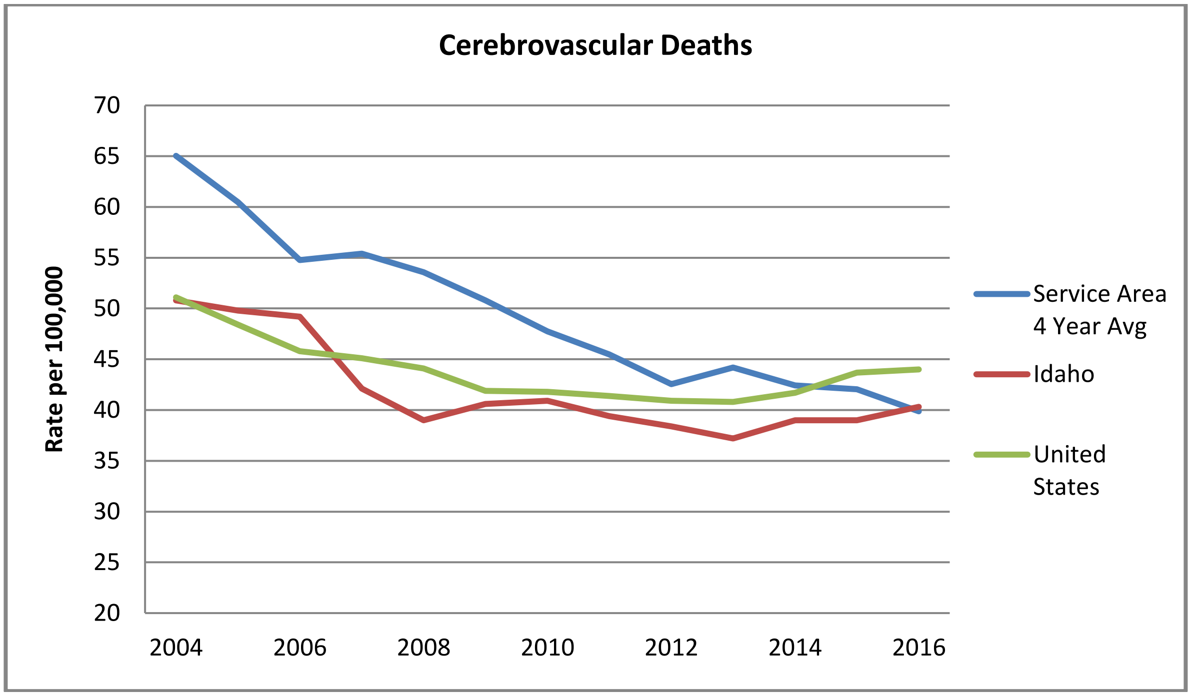


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude	Total Score
Accidental deaths	3	4	4	0	11

[82] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016

- **Cerebrovascular Diseases**

The number of deaths due to cerebrovascular diseases has decreased substantially over the past 10 years. However, they are still the fifth leading cause of death in Idaho and the nation. In our service area, the cerebrovascular diseases death rate is down significantly since the year 2000 and is now about the same as the national average.[83] 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. [84]



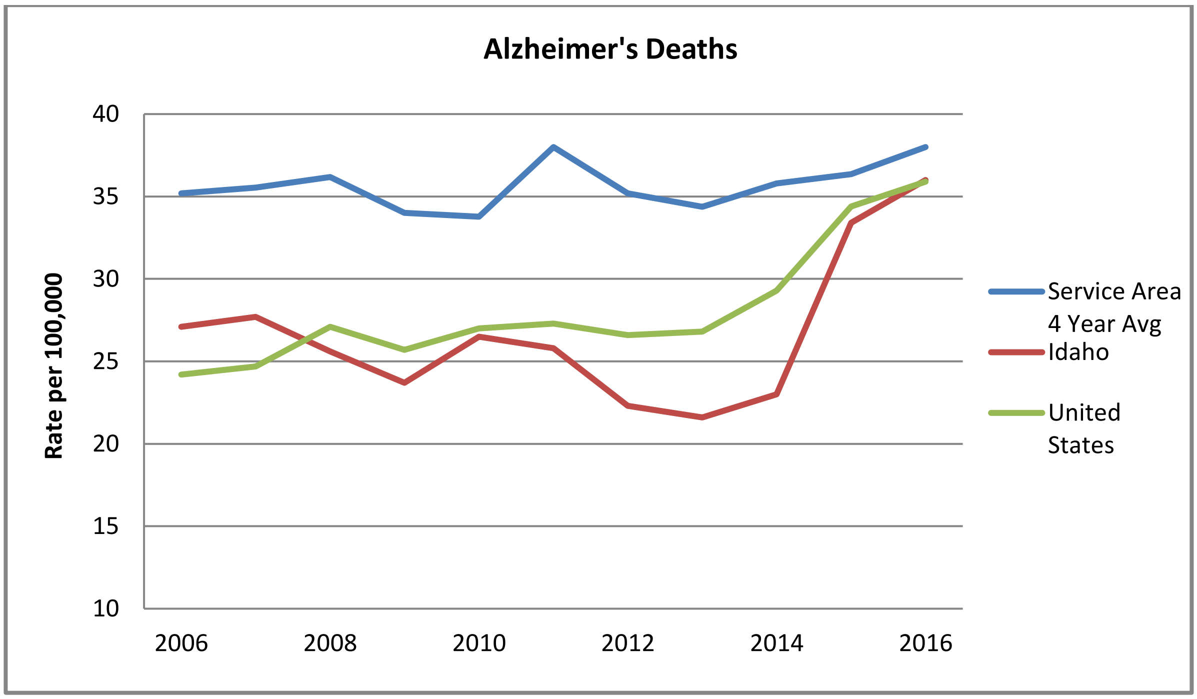
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Cerebrovascular Deaths	0	2	4	1	7

[83] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[84] America's Health Rankings 2015-2018, www.americashealthrankings.org

- **Alzheimer's disease**

Alzheimer's is the sixth leading cause of death in Idaho. Nationally, the death rate from Alzheimer's has increased over the past 10 years. The death rate in our service area has been relatively flat and is now about the same as the national rate.[85]

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.[86]

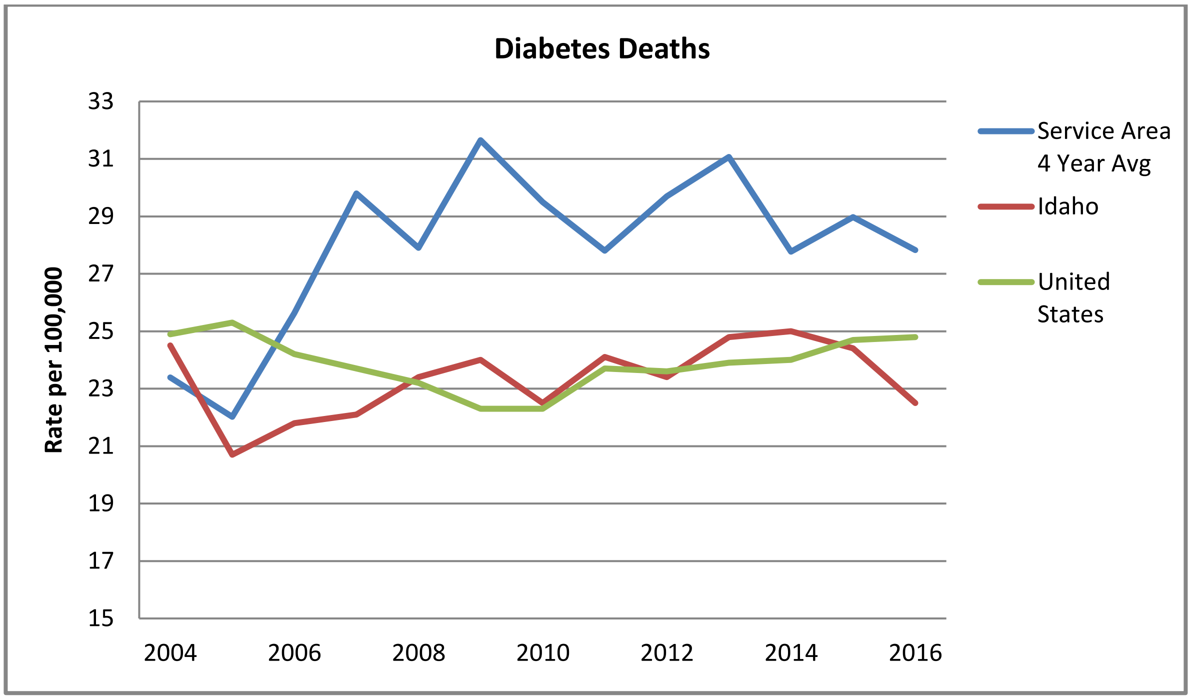


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Alzheimer's Deaths	2	2	2	1	7

[85] Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[86] 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 higher than the national average and has been trending flat over the last 10 years. Diabetes is a serious health issue that can contribute to heart disease, stroke, high blood pressure, kidney disease, blindness and can even result in limb amputation or death.[87]

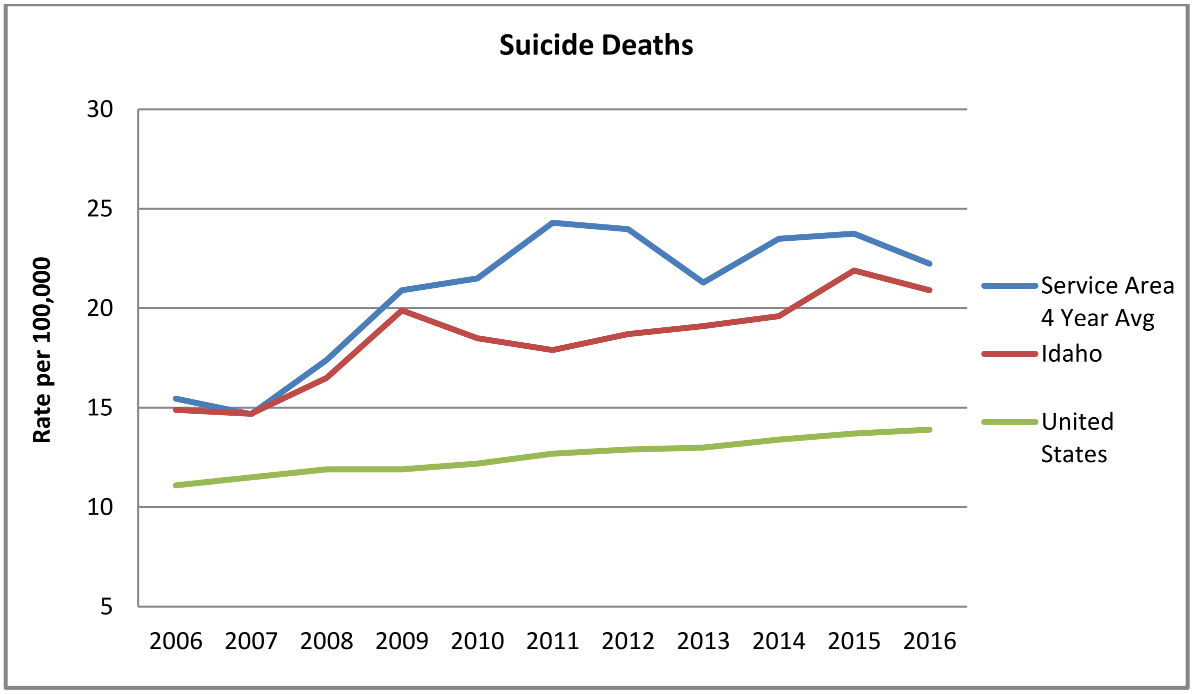


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Diabetes Deaths	2	4	3	4	13

[87] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016

- **Suicide**

Idaho consistently is listed in the top 10 states in the country for its rate of suicide. Suicide is the eighth leading cause of death in Idaho. The suicide death rate per 100,000 people in Idaho was 20.9 in 2016 which is about 50% higher than the national average rate of 13.9. The suicide rate in our service area was 22.2, which is 60% higher than the national average. As shown in the chart below, the suicide rate in our service area, Idaho, and the nation has been trending up.



The suicide rate for males is about four times higher than the rate for females.[88] U.S. male veterans are twice as likely to die by suicide as males without military service. Many suicides can be prevented by ensuring people are aware of warning signs, risk factors, and protective factors.[89]

Health Factor Score					
	Trend: Better/Worse	Prevalence versus U.S.	Severe/ Preventable	Magnitude: Root Cause	Total Score
Suicide	3	4	4	1	12

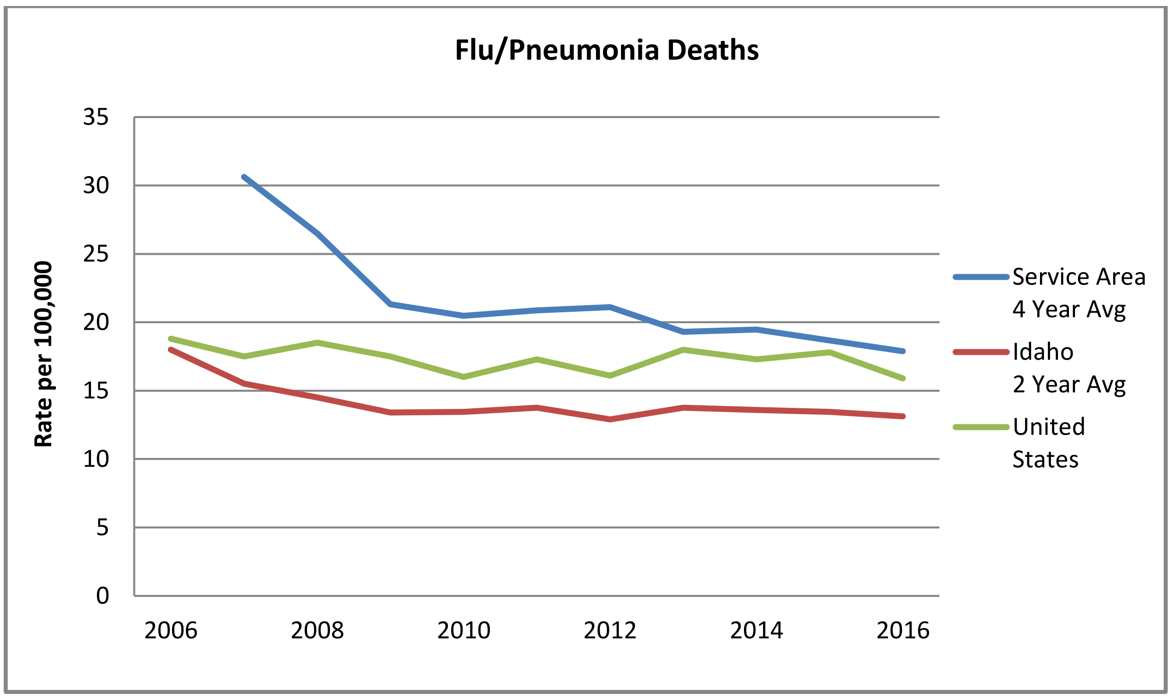
[88] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[89] Idaho Council on Suicide Prevention, Report to Governor C.L. Otter, November 2009

- **Influenza and Pneumonia**

The death rate from flu and pneumonia has been flat in our service area and is about the same as the national average.[90]

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.[91]

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.[92]



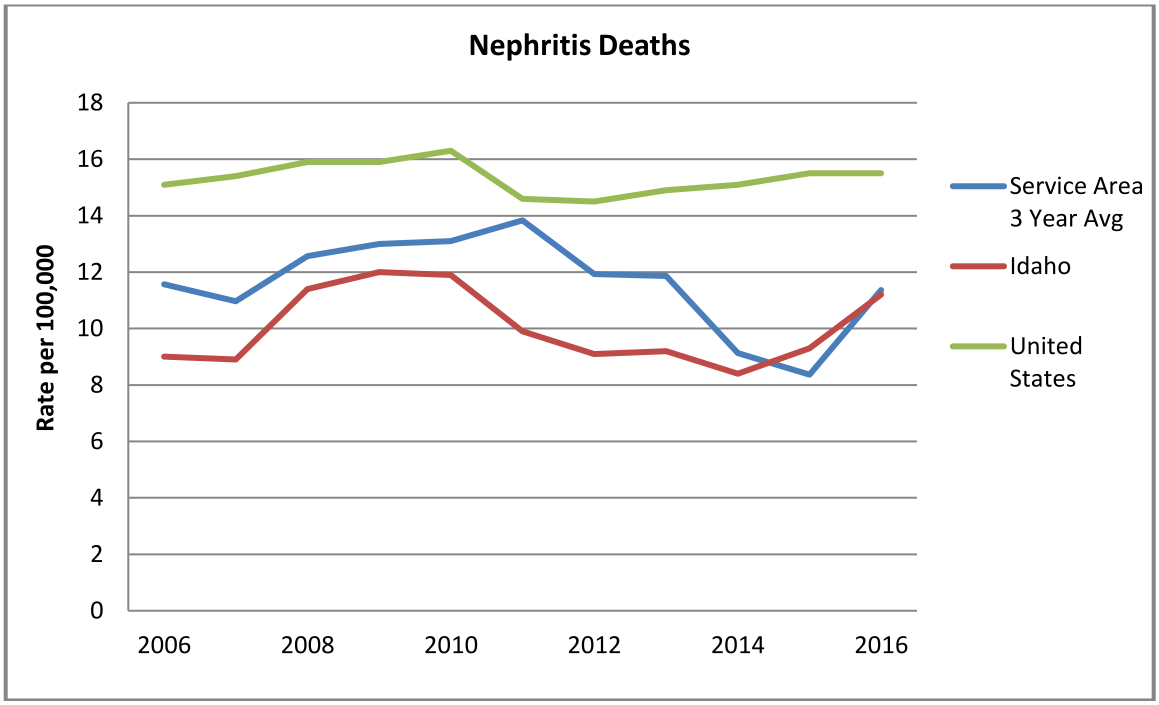
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Flu/ Pneumonia	**1**	**2**	**4**	**0**	**7**

[90] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[91] http://www.cdc.gov/flu/keyfacts.htm
[92] http://www.cdc.gov/Features/Pneumonia/

- **Nephritis**

The death rate from nephritis is lower in our community than it is nationally. The nephritis death rate increases have started to level off both in the nation and our service area over the past ten years.[93]

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.[94]



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.

[93] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[94] 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 additional steps:

- 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.[95]

Health Factor Score **Low score = Low potential for health impact** **High score = High potential for health impact**					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Nephritis Deaths	**2**	**0**	**4**	**0**	**6**

[95] 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 wellbeing.[96] The *County Health Rankings* uses four categories of health factors:

- Health behaviors
- Clinical care
- Social and economic factors
- Physical environment

In addition to *County Health Ranking* measures, we collect 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 are determined by the Idaho 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 utilize is 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

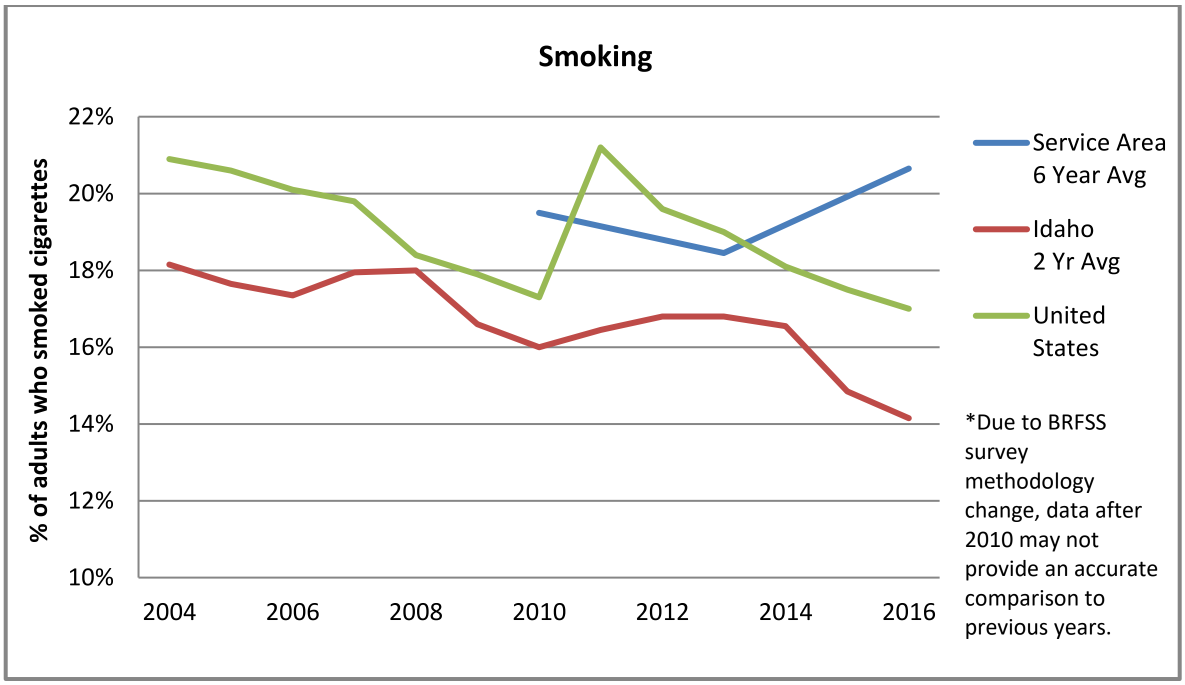
The *County Health Rankings* measures for community health behavior are described on the following pages. This next section also includes the trends for each indicator in our community and, when possible, compares our local data to state and national averages.

[96] University of Wisconsin Population Health Institute. *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.

- **Adult Smoking**

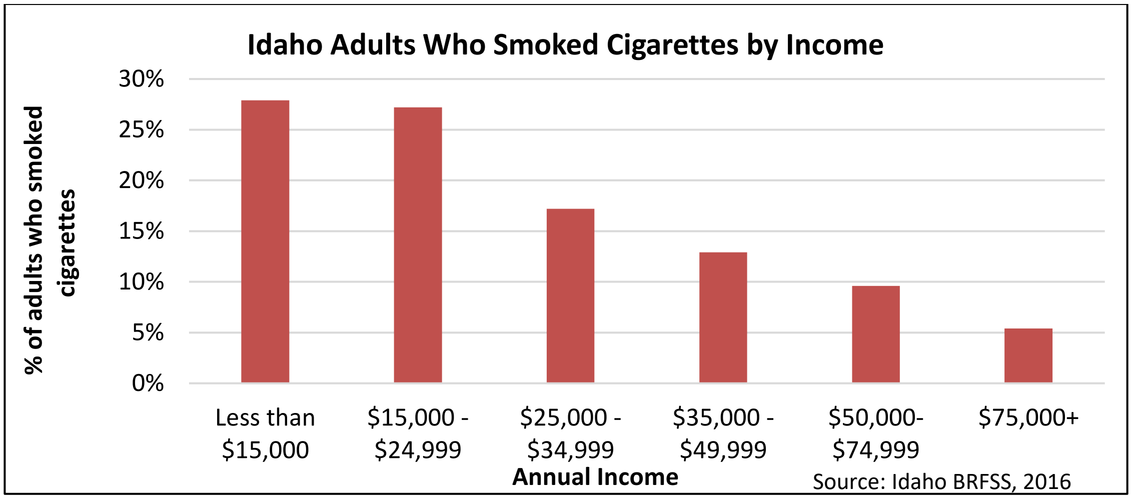
The relationship between tobacco use, particularly cigarette smoking, and adverse health outcomes is well known. In fact, cigarette smoking is the leading cause of preventable death. Smoking causes or contributes to cancers of the lung, pancreas, kidney, and cervix. An average of 1,500 people die each year in Idaho as a direct result of tobacco use.[97]

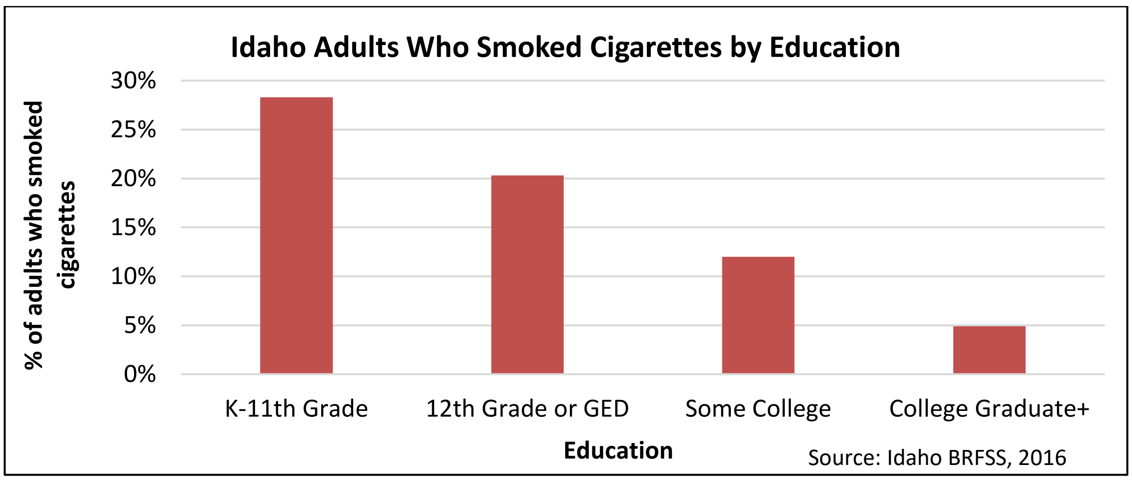
County-level measures from the Behavioral Risk Factor Surveillance System (BRFSS) provided by the CDC are used to obtain the number of current adult smokers who have smoked at least 100 cigarettes in their lifetime. The trend for smoking nationally and in Idaho is down. However, the percent of adults who smoked in our service area is above the national average and may be rising. [98]

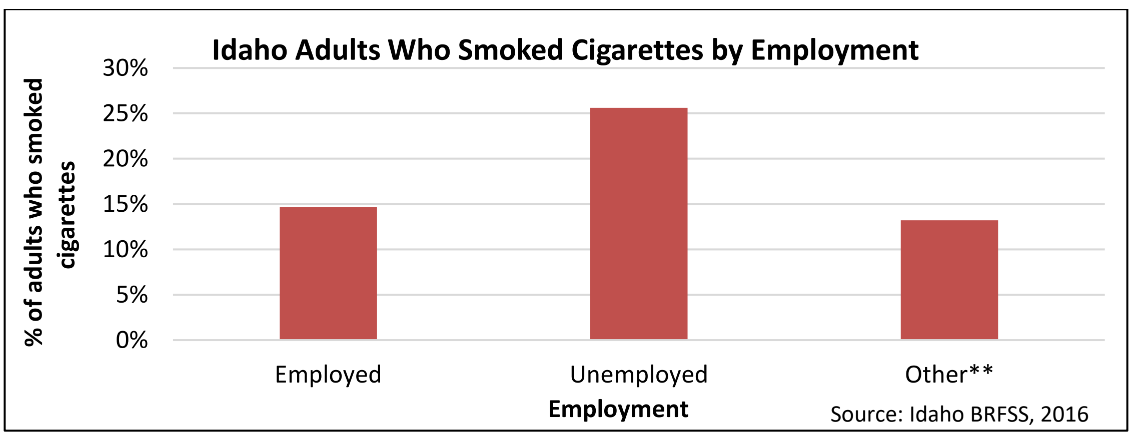


The percent of people who smoke declines significantly with higher levels of income and education as well as for those who are employed, as shown in the charts below.

[97] Comprehensive Cancer Alliance for Idaho, Idaho Comprehensive Cancer Strategic Plan 2004-2010, www.ccaidaho.org
[98] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System







Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Smoking	**2**	**4**	**4**	**4**	**14**

Diet and Exercise

Unhealthy food intake and insufficient exercise have economic impacts for individuals and communities. Estimates for obesity-related health care costs in the US range from $147 billion to nearly $210 billion annually, and productivity losses due to job absenteeism cost an additional $4 billion each year. Increasing opportunities for exercise and access to healthy foods in neighborhoods, schools, and workplaces can help children and adults eat healthy meals and reach recommended daily physical activity levels. [99]

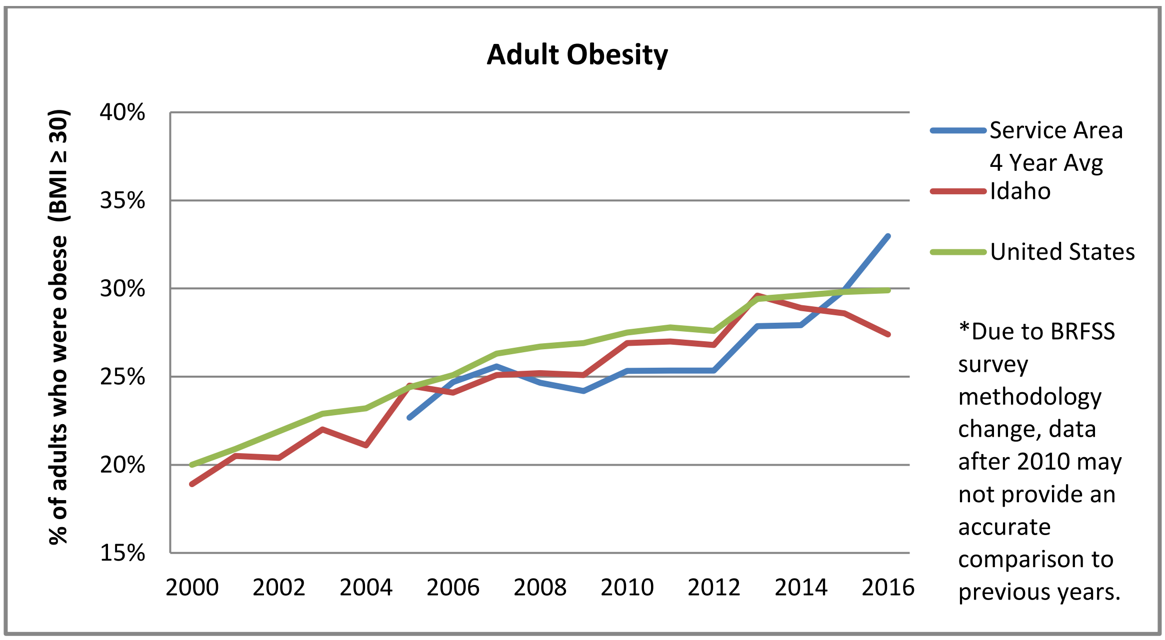
Four measures are recommended by the *County Health Rankings* to assess diet and exercise: Adult obesity, food environment index, physical inactivity, and access to exercise opportunities. Each of these measures are described in the following pages.

[99] University of Wisconsin Population Health Institute. *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.

- **Adult Obesity**

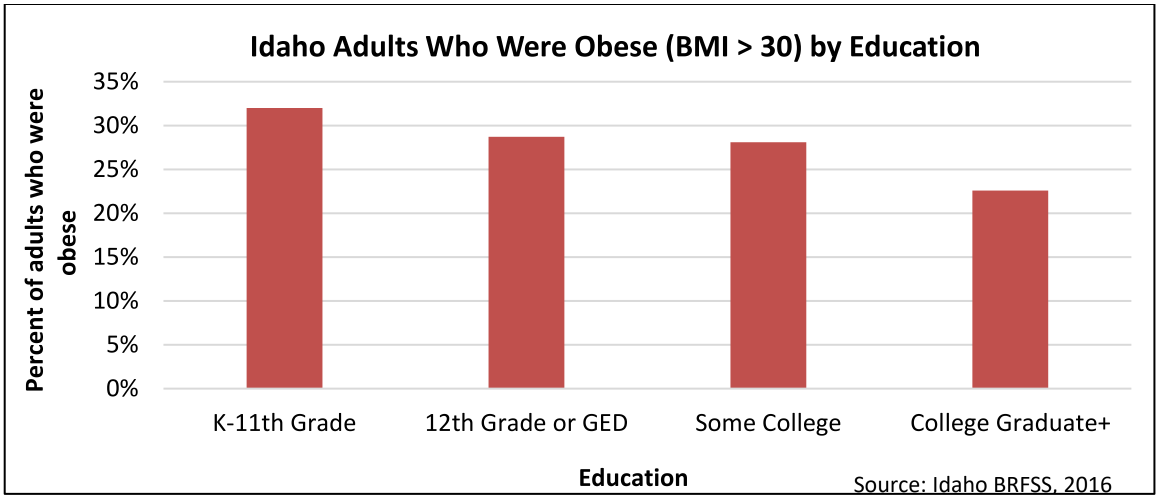
The obesity measure represents the percent of the adult population that has a body mass index greater than or equal to 30. Obesity is used as a key health factor because it is an issue that can be addressed within communities by changing unhealthy conditions that contribute to poor diet and exercise. 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.[100] It has many long-term negative health effects, many of which can start in adolescence as 70 percent of obese adolescents already have at least one risk factor for cardiovascular disease. Obesity is one of the greatest health threats to the United States. [101] By one estimate, the U.S. spent $190 billion on obesity-related health care expenses in 2005 accounting for 21% of all medical spending.[102]

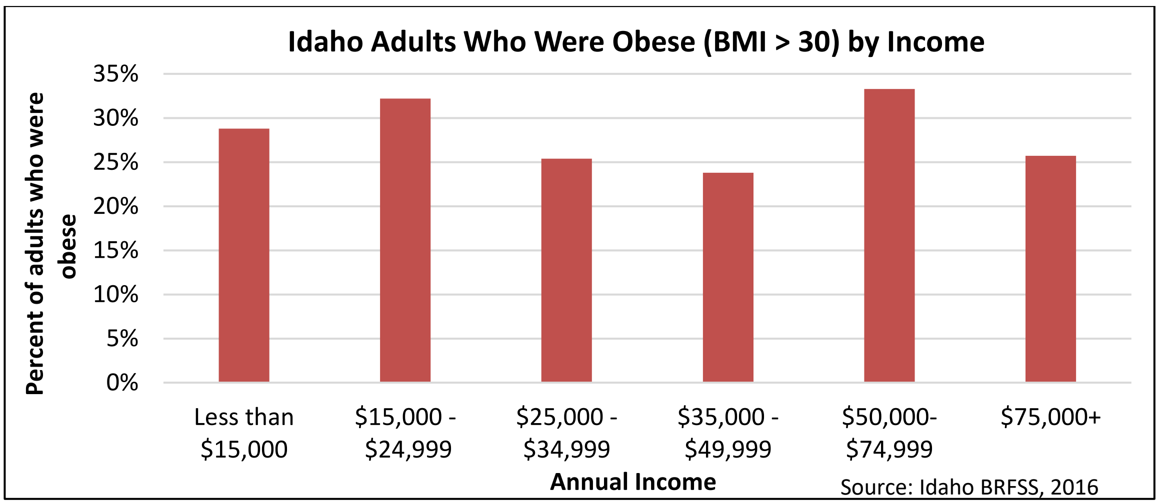
The trend for obesity has been increasing steadily for the past 10 years, nationally and in our community. Obesity in our community is now higher than the national average. The top 10th percentile (best) communities nationally have obesity rates at or below 26%.[103]

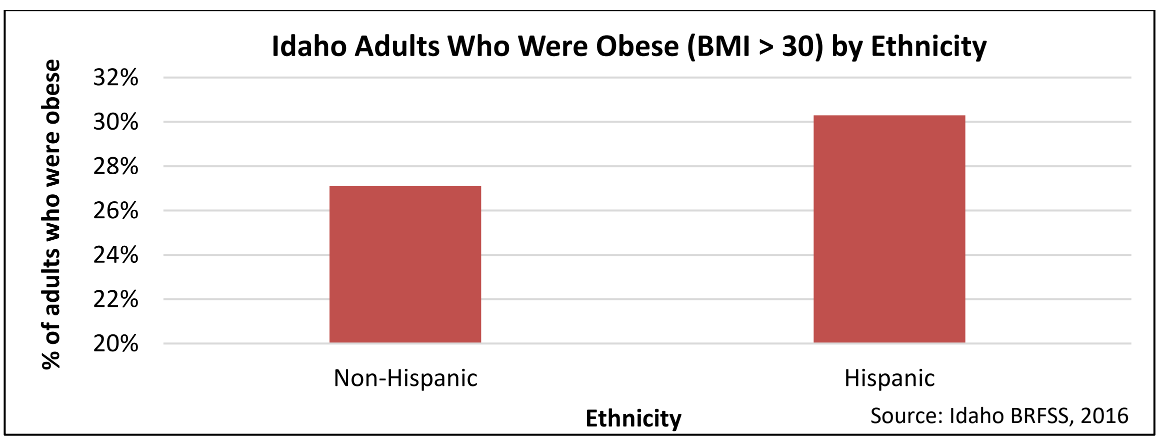


In Idaho, those without a college degree and Hispanic populations are somewhat more likely to be obese. [104]

[100] University of Wisconsin Population Health Institute. *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.
[101] America's Health Rankings 2015-2018, www.americashealthrankings.org
[102] http://www.hsph.harvard.edu/obesity-prevention-source/obesity-consequences/economic/
[103] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System
[104] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System







Health Factor Score					
	Trend: Better/Worse	**Prevalence versus U.S.**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Obese Adults	**4**	**3**	**4**	**4**	**15**

- **Food Environment Index**

  The food environment index is a measure ranging from 0 (worst) to 10 (best) which equally weights two indicators of the food environment.

  1) Limited access to healthy foods estimates the proportion of the population who are low income and do not live close to a grocery store. Living close to a grocery store is defined differently in rural and non-rural areas; in rural areas, it means living less than 10 miles from a grocery store whereas in non-rural areas, it means less than 1 mile. Low income is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size.

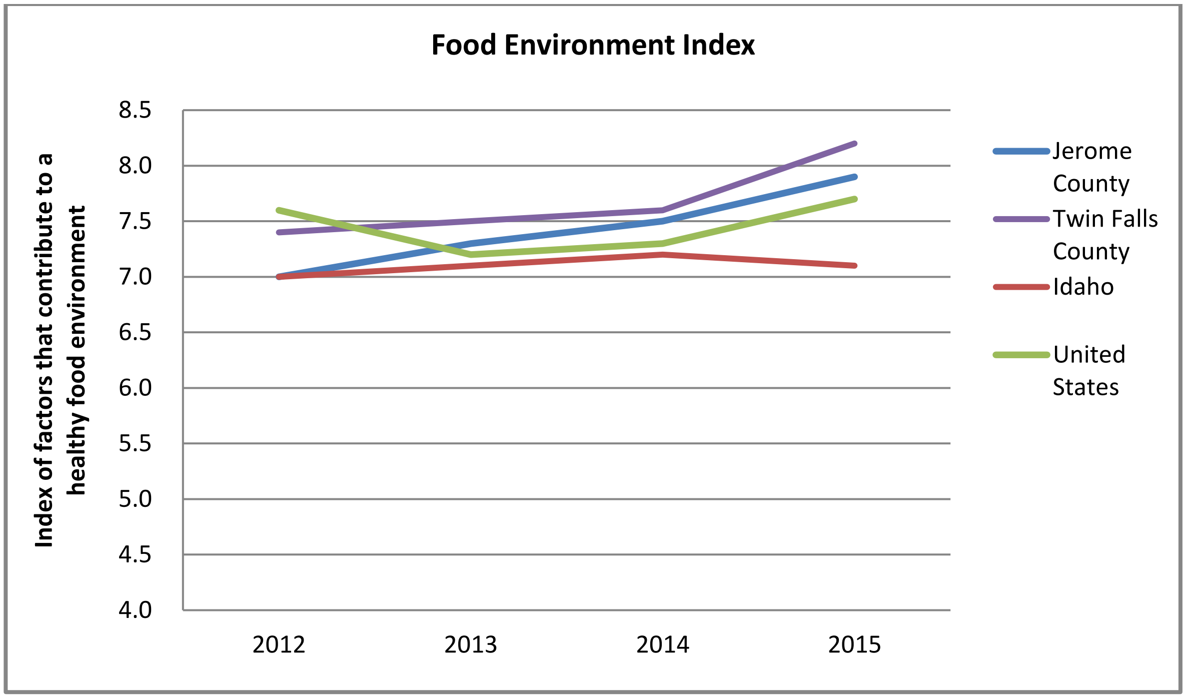
  2) Food insecurity estimates the percentage of the population who did not have access to a reliable source of food during the past year. A 2-stage fixed effect model was created using information from the Community Population Survey, Bureau of Labor Statistics, and American Community Survey.

  There are many facets to a healthy food environment. This measure considers both the community and consumer nutrition environments. It includes access in terms of the distance an individual lives from a grocery store or supermarket. There is strong evidence that residing in a "food desert" is correlated with a high prevalence of overweight, obesity, and premature death. Supermarkets traditionally provide healthier options than convenience stores or smaller grocery stores. The additional measure, limited access to healthy foods, included in the index is a proxy for capturing the community nutrition environment and food desert measurements.

  Additionally, low income can be another barrier to healthy food access. Food insecurity, the other food environment measure included in the index, attempts to capture the access issue by gaining a better understanding of the barrier of cost. Lacking constant access to food is related to negative health outcomes such as weight-gain and premature mortality. In addition to asking about having a constant food supply in the past year, the module also addresses the ability of individuals and families to provide balanced meals further addressing barriers to healthy eating. The consumption of fruits and vegetables is important but it may be equally important to have adequate access to a constant food supply.[105]

[105] University of Wisconsin Population Health Institute. *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.

The chart below shows that the food environment index levels for our community and Idaho are about the same as the national average. An index level of 8.4 or above is the top 10% nationally.

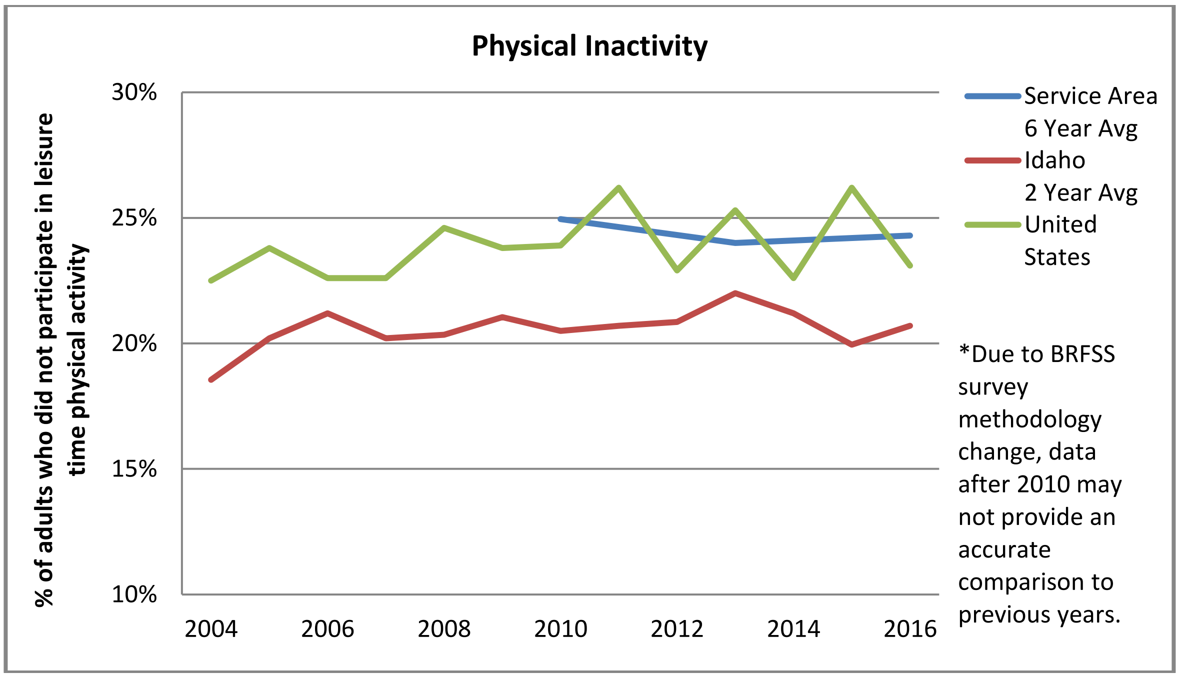


Health Factor Score					
	Trend: Better/Worse	Prevalence versus U.S.	Severe/ Preventable	Magnitude: Root Cause	Total Score
Food Environment Index	2	2	2	3	9

- **Physical Inactivity: Adults**

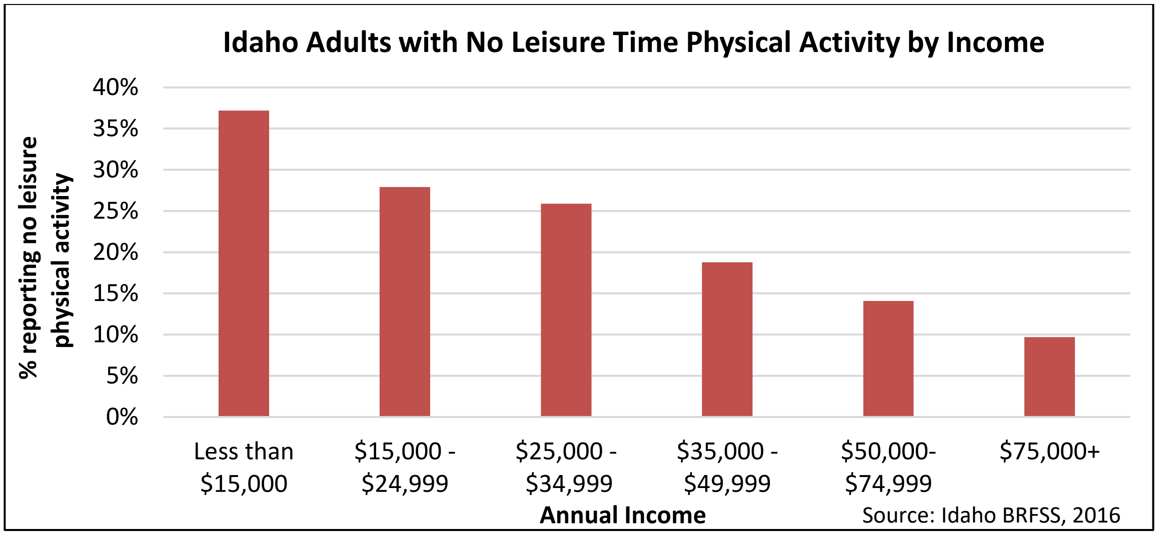
Increased physical activity is associated with lower risks of type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality. A person is considered physically inactive if during the past month, other than a regular job, they did not participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise. Half of adults and nearly 72% of high school students in the US do not meet the CDC's recommended physical activity levels, and American adults walk less than adults in any other industrialized country. [106]

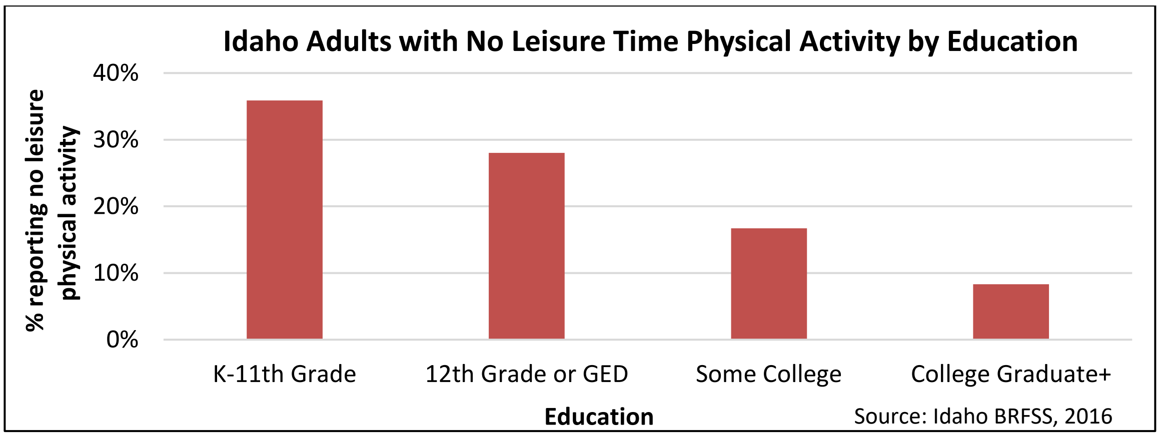
As shown in the chart below, physical inactivity in our community is about the same as the national average. The top 10th percentile (best) is 20%.[107]

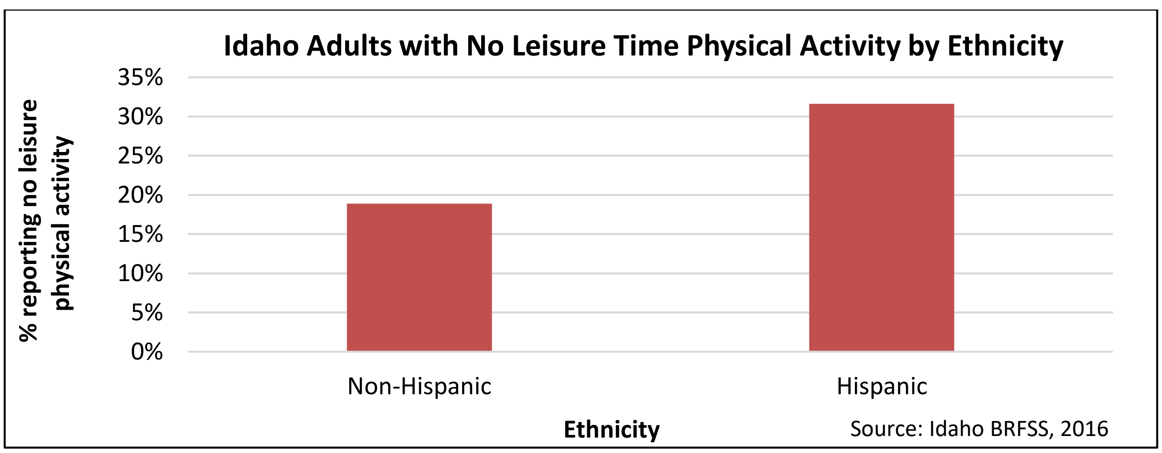


Physical inactivity is significantly higher among people with annual incomes below $50,000, those without a college degree, and among Hispanics, as shown in the charts below. [108]

[106] University of Wisconsin Population Health Institute. *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.
[107] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System
[108] Ibid.







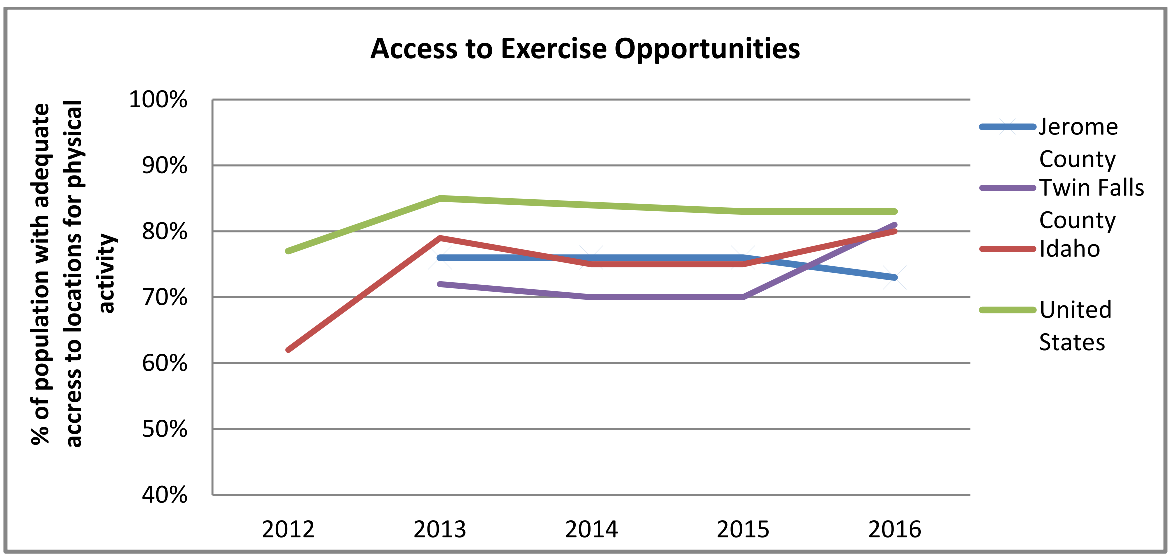
Health Factor Scoring					
	Trend: Better/Worse	Prevalence versus U.S.	Severe/ Preventable	Magnitude: Root Cause	Total Score
Physical inactivity Adults	2	2	2	3	9

- **Access to Exercise Opportunities**

The role of the built environment is important for encouraging physical activity. Individuals who live closer to sidewalks, parks, and gyms are more likely to exercise. Access to exercise opportunities measures the percentage of individuals in a county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities. Parks include local, state, and national parks. Recreational facilities include businesses identified by the NAICS code 713940, and include a wide variety of facilities including gyms, community centers, YMCAs, dance studios and pools.

This is the first national measure created which captures the many places where individuals have the opportunity to participate in physical activity outside of their homes. It is not without several limitations. First, no dataset accurately captures all the possible locations for physical activity within a county. One location for physical activity that is not included in this measure are sidewalks which serve as common locations for running or walking. Additionally, not all locations for physical activity are identified by their primary or secondary business code. [109]

The chart, below, shows access to exercise opportunities in our community is below the national average. The top ten percent nationally is 92%.



Health Factor Scoring					
	Trend: Better/Worse	Prevalence versus U.S.	Severe/ Preventable	Magnitude: Root Cause	Total Score
Access to Exercise Opportunities	2	3	2	3	10

[109] University of Wisconsin Population Health Institute. *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.

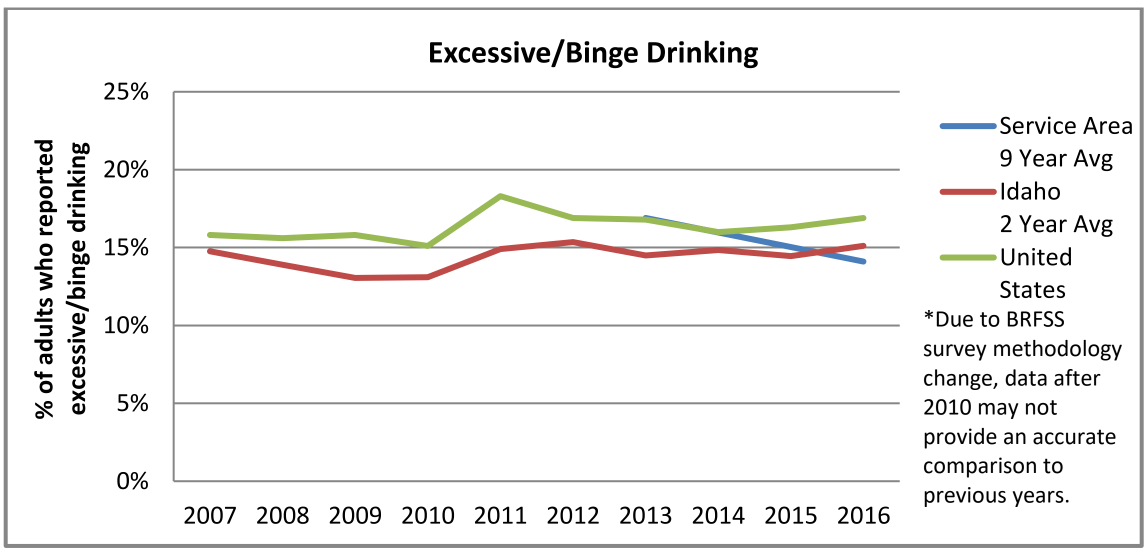
Alcohol Use

Two measures are combined to assess alcohol use in a county: Percent of excessive drinking in the adult population and the percentage of motor vehicle crash deaths with alcohol involvement.

- **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. It is the third leading lifestyle-related cause of death for people in the US.[110]

  The percent of people engaging in excessive drinking in our service area is slightly below the national average. The top 10th percentile (best) is 10% nationally. Our community is well above that level.[111]

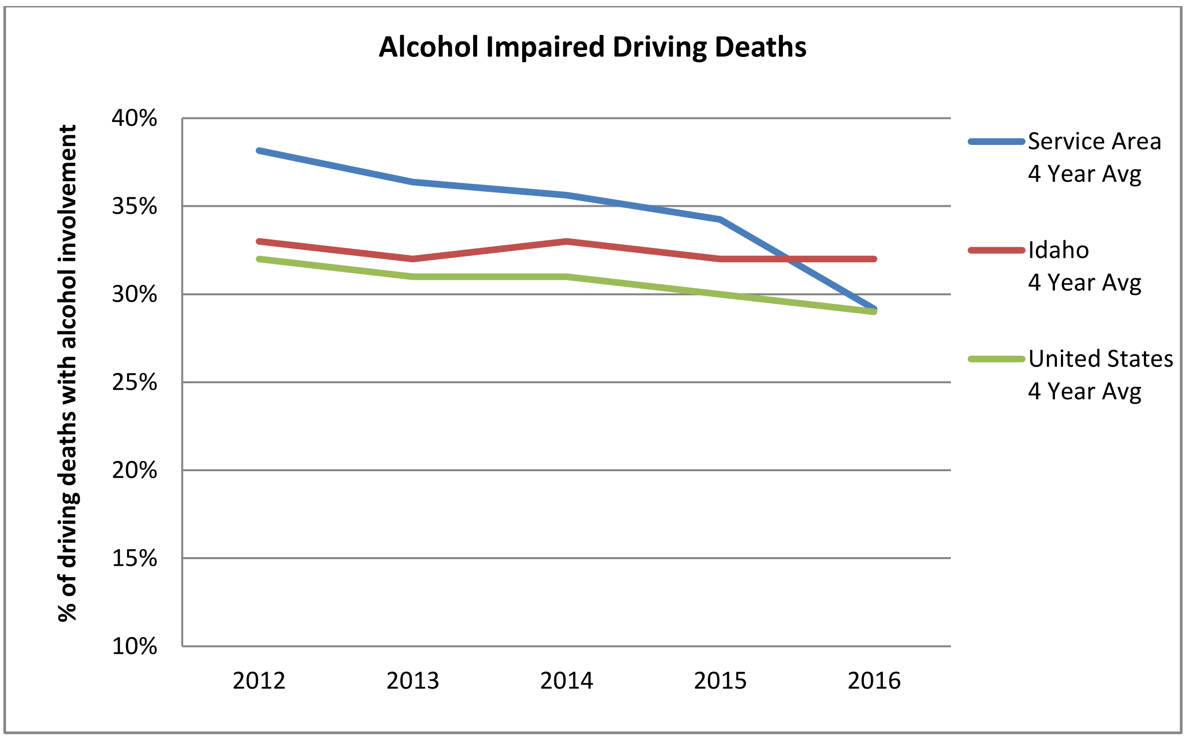


Health Factor Scoring					
	Trend: Better/Worse	Prevalence versus U.S.	Severe/ Preventable	Magnitude: Root Cause	Total Score
Excessive Drinking	2	2	3	2	9

[110] University of Wisconsin Population Health Institute. *County Health Rankings* 2012-2018. Accessible at www.countyhealthrankings.org.
[111] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System

- **Alcohol Impaired Driving Deaths**

Alcohol-impaired driving deaths is the percentage of motor vehicle crash deaths with alcohol involvement. Alcohol-impaired driving deaths directly measures the relationship between alcohol and motor vehicle crash deaths. One limitation of this measure is that not all fatal motor vehicle traffic accidents have a valid blood alcohol test, so these data are likely an undercount of actual alcohol involvement. Another potential limitation is that even though alcohol is involved in all cases of alcohol-impaired driving, there can be a large difference in the degree to which it was responsible for the crash (i.e. someone with a 0.01 BAC vs. 0.35 BAC). The data source is the Fatality Analysis Reporting System (FARS), which is a census of fatal motor vehicle crashes. Our alcohol-impaired driving death rate is about the same as the national level. The top 10th percentile (best) is 14% nationally.[112]



Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Motor vehicle crash death rate	**1**	**2**	**4**	**1**	**8**

112 Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016

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**

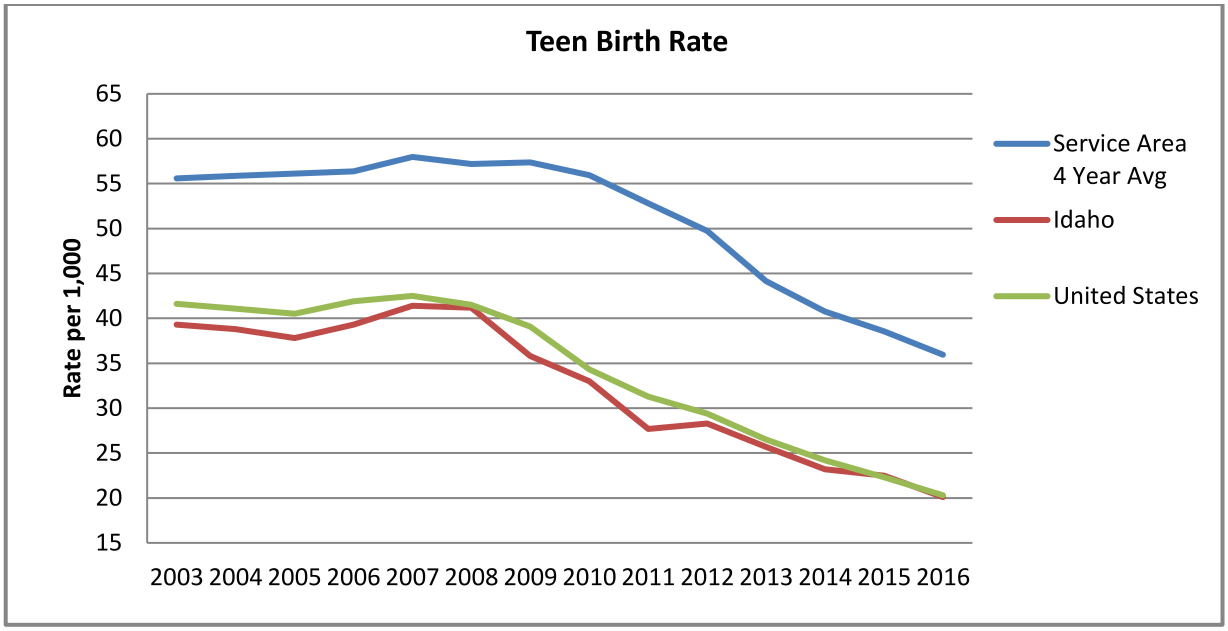
  Evidence suggests teen pregnancy significantly increases the risks for repeat pregnancy and for contracting a sexually transmitted infection (STI), both of which can result in adverse health outcomes for mother and child as well as for the families and community. A systematic review of the sexual risk 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.[113]

  Although our rate of teen pregnancy is decreasing, it is significantly above the national average. The national top 10th percentile rate is 15.[114]

[113] University of Wisconsin Population Health Institute. *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.

[114] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016

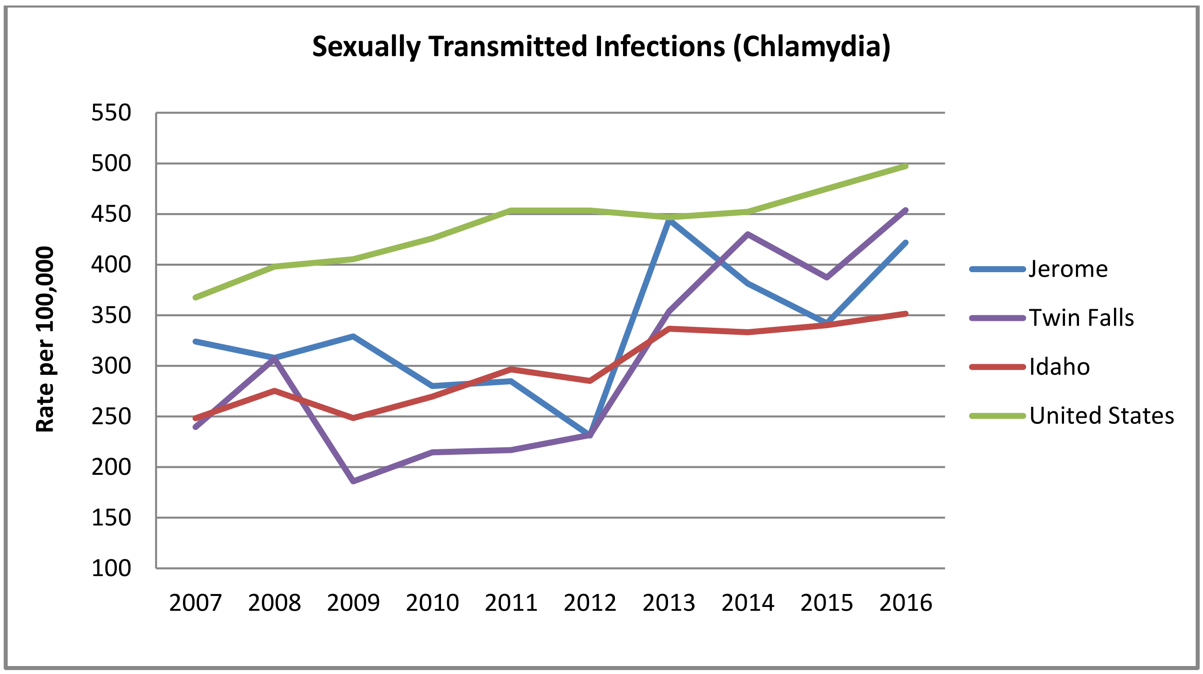


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Teen birth rate	1	4	2	3	10

- **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.[115]

The rate of chlamydia infections has increased over the past ten years both in our community and nationally. Although our community is below the national average, we are still above the national top 10th percentile rate of 145.1.[116]



Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Sexually Transmitted Infections	**3**	**1**	**3**	**3**	**10**

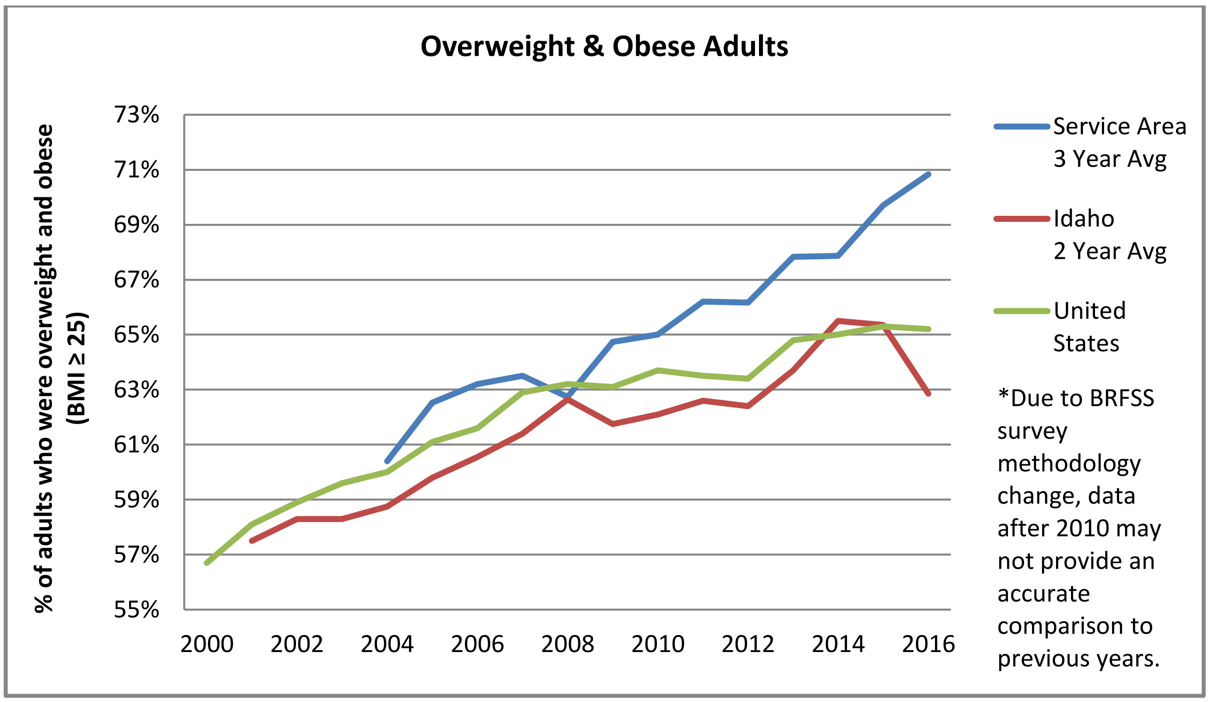
[115] *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.
[116] National data source: 2015 Sexually Transmitted Diseases Surveillance, table 1 http://www.cdc.gov/std/. Idaho and Service Area Source: Idaho Reported Sexually Transmitted Disease, 2004-2012 http://www.healthandwelfare.idaho.gov/Portals/0/Health/Disease/STD%20HIV/2010_Facts_Book_FINAL.pdf

Additional Health Behavior Factors

- **Overweight and Obese Adults**

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

The trend for overweight and obese adults has been increasing steadily for the past 10 years, nationally and even more so in our community.[117]



Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Overweight or Obese Adults	4	4	4	4	16

[117] Idaho and National 2002 - 2016 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.[118] Overweight children and adolescents:

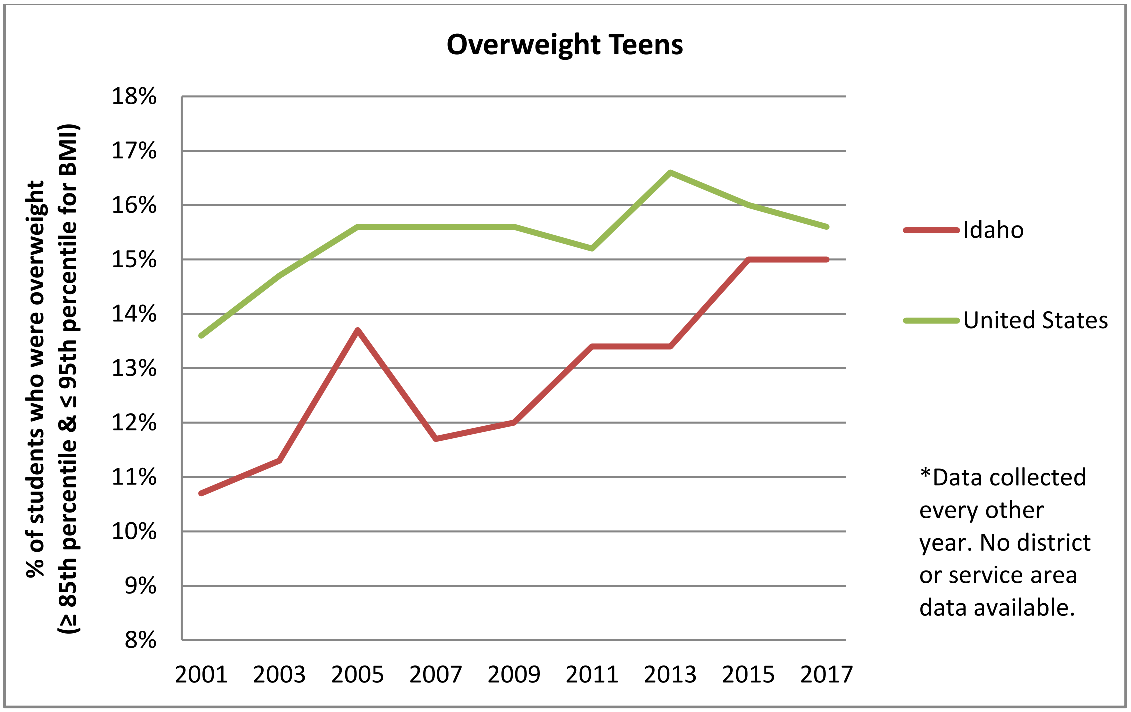
  - Are more likely than other children and adolescents to have risk factors associated with cardiovascular disease (e.g., high blood pressure, high cholesterol and type 2 diabetes).
  - Are more likely to be obese as adults.
  - Are more likely to experience other health conditions associated with increased 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.

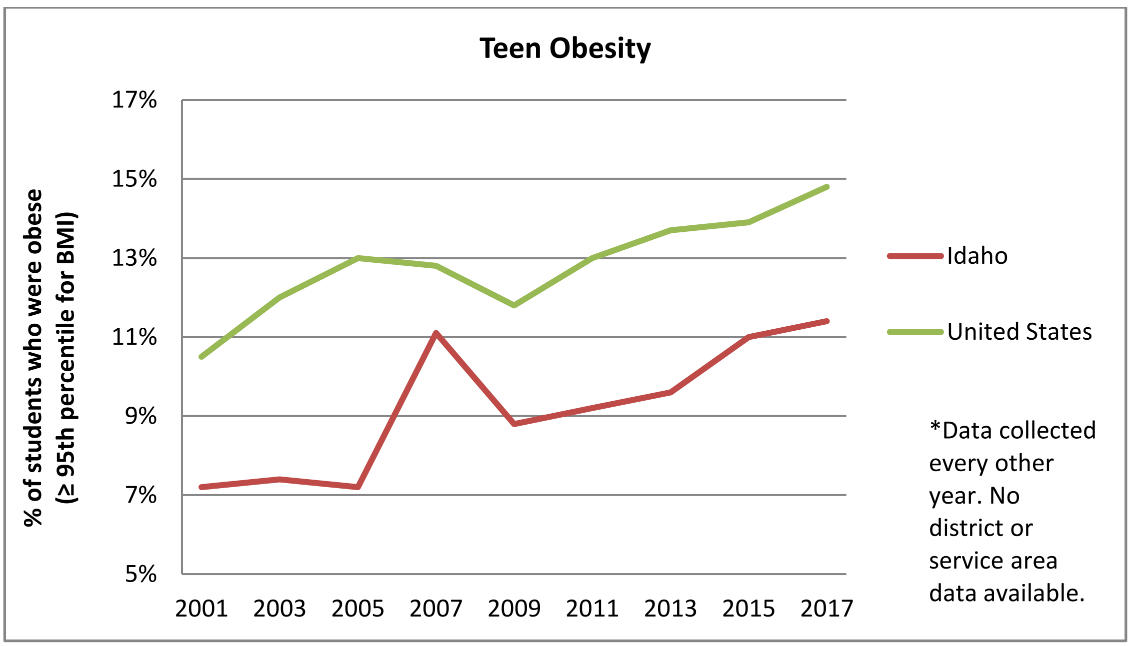
  Some methods of preventing and treating overweight children are:

  - 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.[119]

  The percent of overweight or obese teens in Idaho is lower than the national average. 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.[120]

[118] Overweight In Adolescence Gives Increased Mortality Rate, ScienceDaily (May 20, 2008)
[119] American Heart Association, Understanding Childhood Obesity, 2011 Statistical Sourcebook, PDF
[120] Youth Risk Behavior Survey , United States, 2001 – 2017, www.cdc.gov/yrbs/



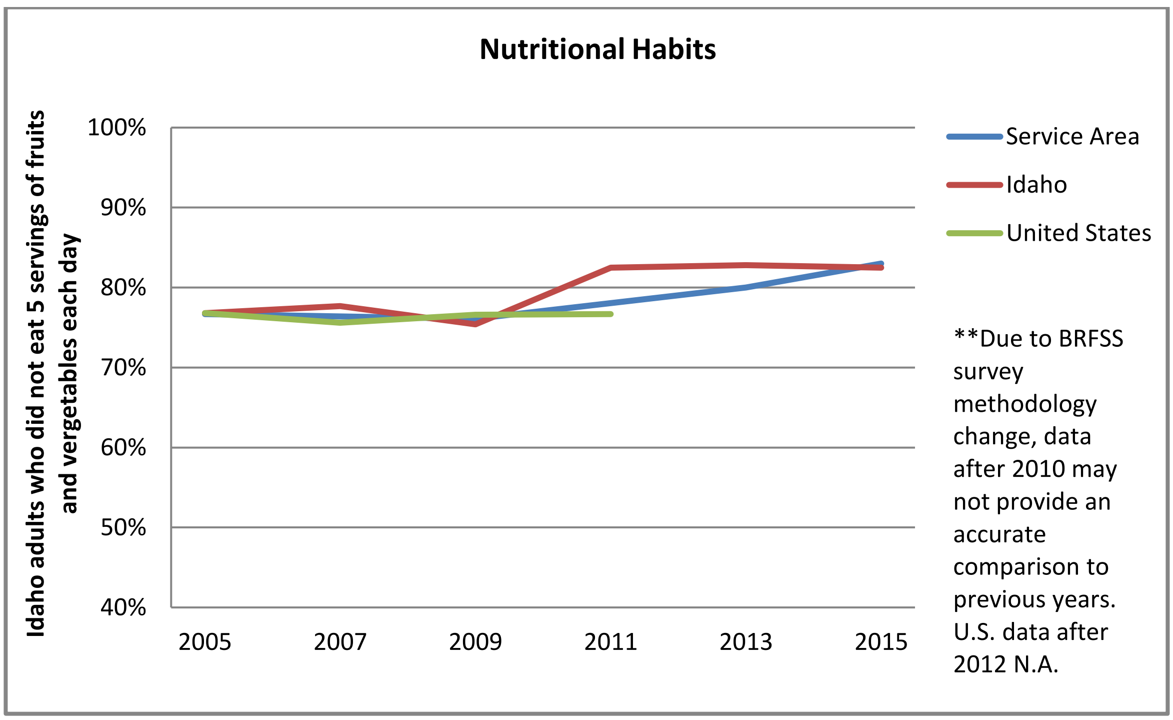


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Obese Teens	4	1	4	4	13

- **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. 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.[121] These data are collected through the Behavioral Risk Factor Surveillance System.

As shown in the chart below, about 80% of the people in our service area did not eat the recommended amounts of fruits and vegetables. The national average was about 77%. The trend appears to have changed marginally in recent years, but that may be due to a change in the BRFSS survey methodology starting in 2011. There are no large differences in nutritional habits based on income or education.[122]

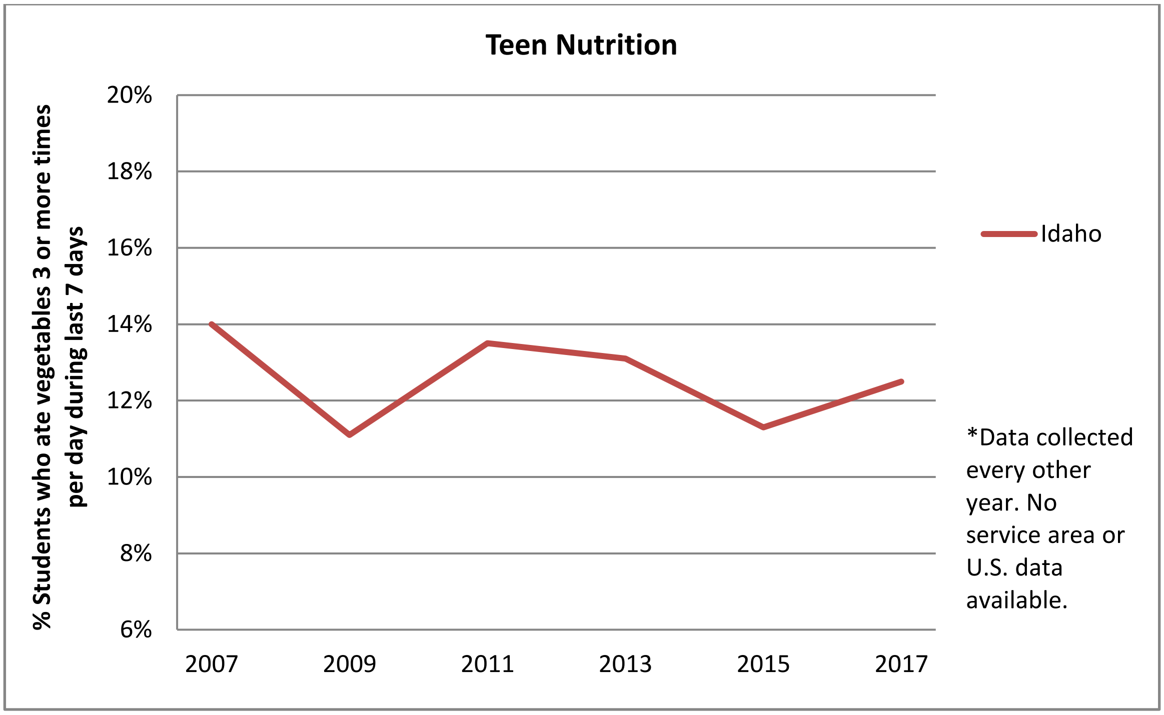


Health Factor Scoring					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Nutritional habits adults	2	2	2	3	9

[121] America's Health Rankings 2015-2018, www.americashealthrankings.org
[122] Idaho and National 2002 – 2016 Behavioral Risk Factor Surveillance System

- **Nutritional Habits: Youth – Fruit and Vegetable Consumption**

More than 80% of Idaho youth do not eat the recommended amount of fruits and vegetables.[123]



Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Nutritional habits youth	**2**	**2**	**2**	**3**	**9**

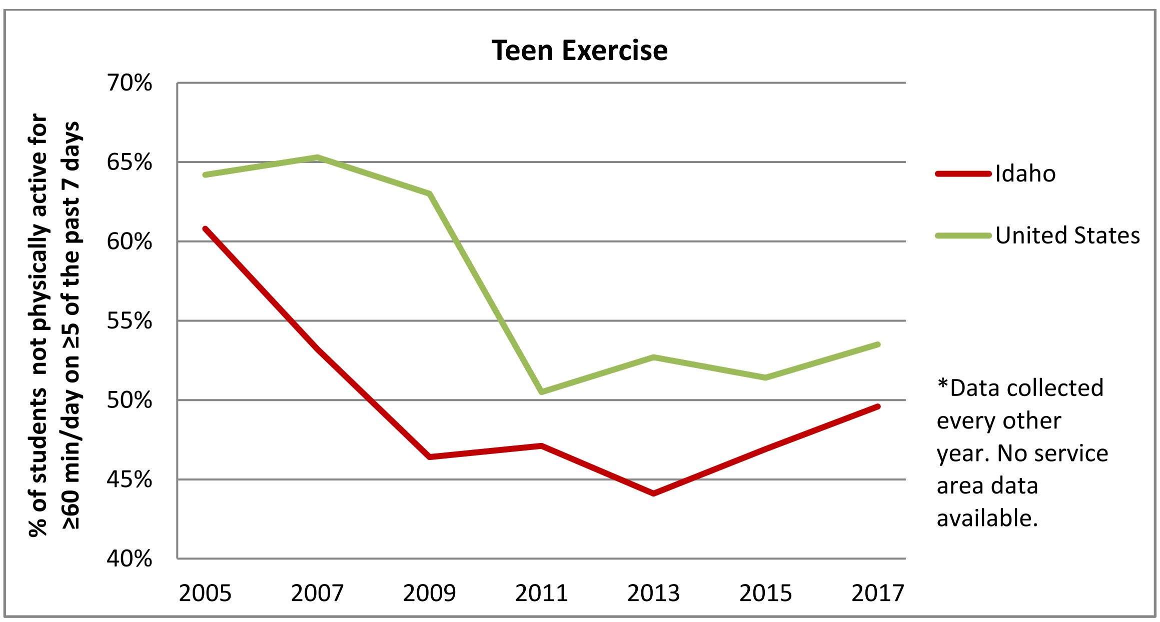
[123] Youth Risk Behavior Survey ,Idaho and United States, 2001 – 2017, www.cdc.gov/yrbs/

- **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. As a result, 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 in 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.[124]

The chart below shows that about 50% of Idaho teens do not exercise as much as recommended, which is better than the national average. The trend in Idaho has been relatively flat over the past ten years.[125]

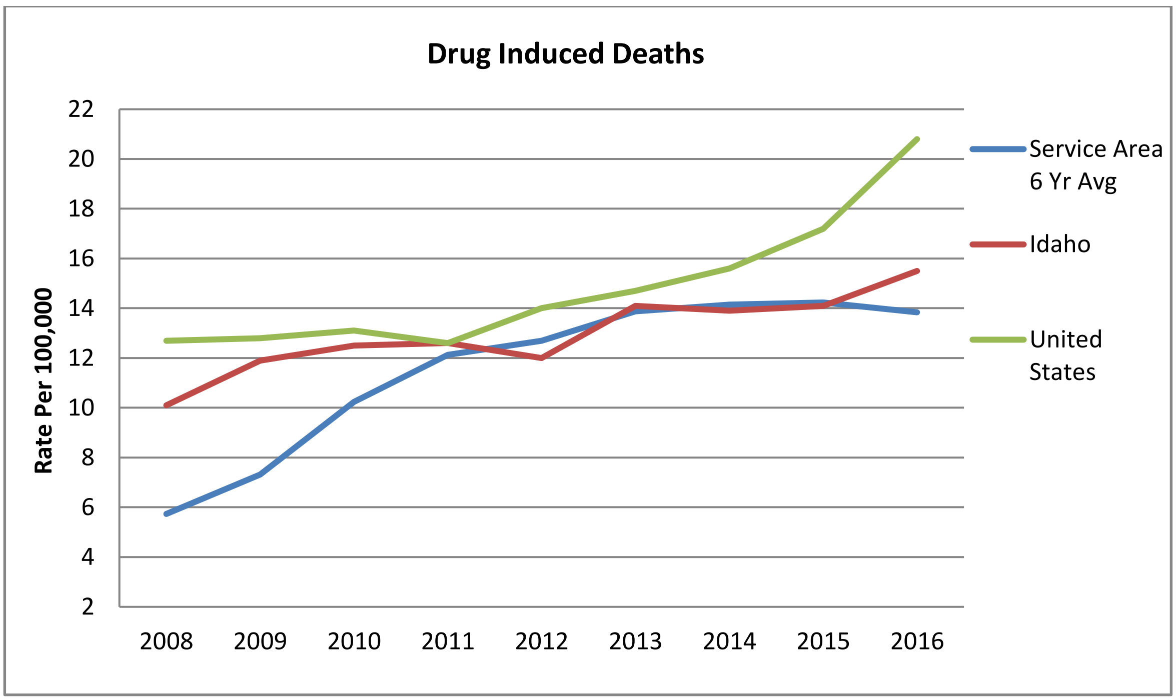


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Teen exercise	2	2	2	4	10

[124] American Heart Association, Understanding Childhood Obesity, 2011 Statistical Sourcebook, PDF
[125] Youth Risk Behavior Survey , United States, 2001 – 2017, www.cdc.gov/yrbs/

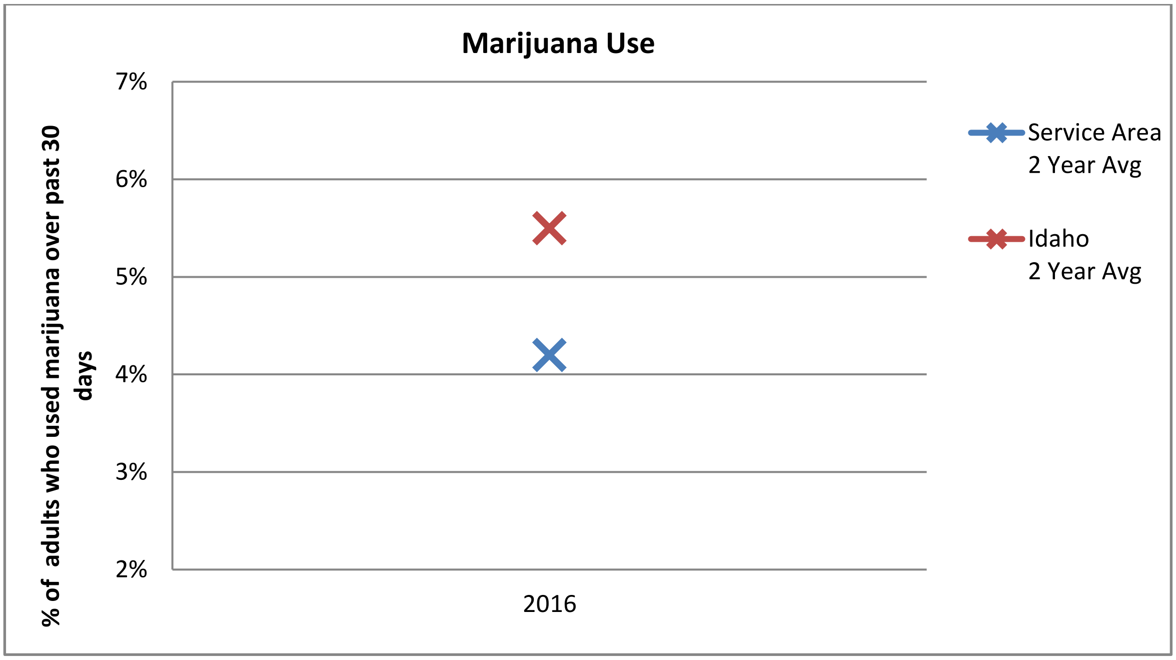
- **Drug Misuse**

Drug abuse or misuse has harmful and sometimes devastating effects on individuals, families, and society. Negative outcomes that may result from drug misuse include overdose and death, falls and fractures, and, for some, initiating injection drug use with resulting risk for infections such as hepatitis C and HIV. This issue is a growing national problem in the United States. Prescription drugs are misused and abused more often than any other drug, except marijuana and alcohol. This growth is fueled by misperceptions about prescription drug safety, and increasing availability.[126] One way to measure the size of the problem is to look at the rate of drug induced deaths over time. While the rate of drug induced deaths is not as high in our community as it is in the nation as whole, the rate has more than doubled since 2008. [127]



[126] https://www.samhsa.gov/topics/prescription-drug-misuse-abuse
[127] Idaho Vital Statistics Annual Reports, Years 2005 - 2016, National Vital Statistics Report - Deaths: Data 2016

Another way to gauge the extent of drug abuse in our community is to look at the percent of people who use marijuana. The percent of people who reported using marijuana in our service area is lower than those who reported using it in Idaho as a whole.[128]



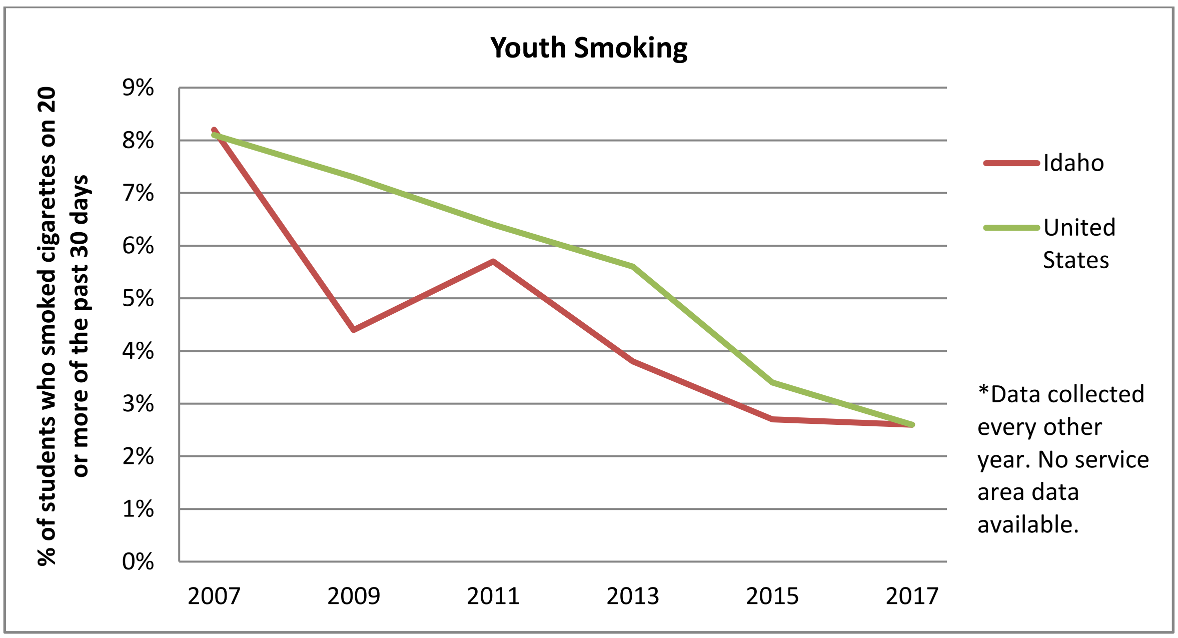
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Drug misuse	**4**	**1**	**4**	**3**	**12**

[128] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System

- **Youth Smoking**

In 2017, approximately 2.6 percent of Idaho Youth reported smoking 20 or more of the past 30 days. This is the same as the national rate. During 1997–2017, a significant decrease occurred overall in the prevalence of current tobacco use among Idaho and our nation's youth. In addition, the percentage of Idaho students who used electronic vapor products on one or more of the past 30 days decreased from 24.8% in 2015 to 14.3% in 2017. [129]

Prevention efforts must focus on young adults ages 18 through 25, too. Almost no one starts smoking after age 25. Nearly 9 out of 10 smokers started smoking by age 18, and 99% started by age 26. Progression from occasional to daily smoking almost always occurs by age 26. This is why prevention is critical. Successful multi-component programs prevent young people from starting to use tobacco in the first place and more than pay for themselves in lives and health care dollars saved. Strategies that comprise successful comprehensive tobacco control programs include mass media campaigns, higher tobacco prices, smoke-free laws and policies, evidence-based school programs, and sustained community-wide efforts. [130]



Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Youth Smoking	0	2	4	4	10

[129] Idaho and Nation Youth Risk Behavior Survey 2001 -2017
[130] http://www.surgeongeneral.gov/library/reports/preventing-youth-tobacco-use/factsheet.html

Clinical Care Factors

County Health Rankings Clinical Care Factors

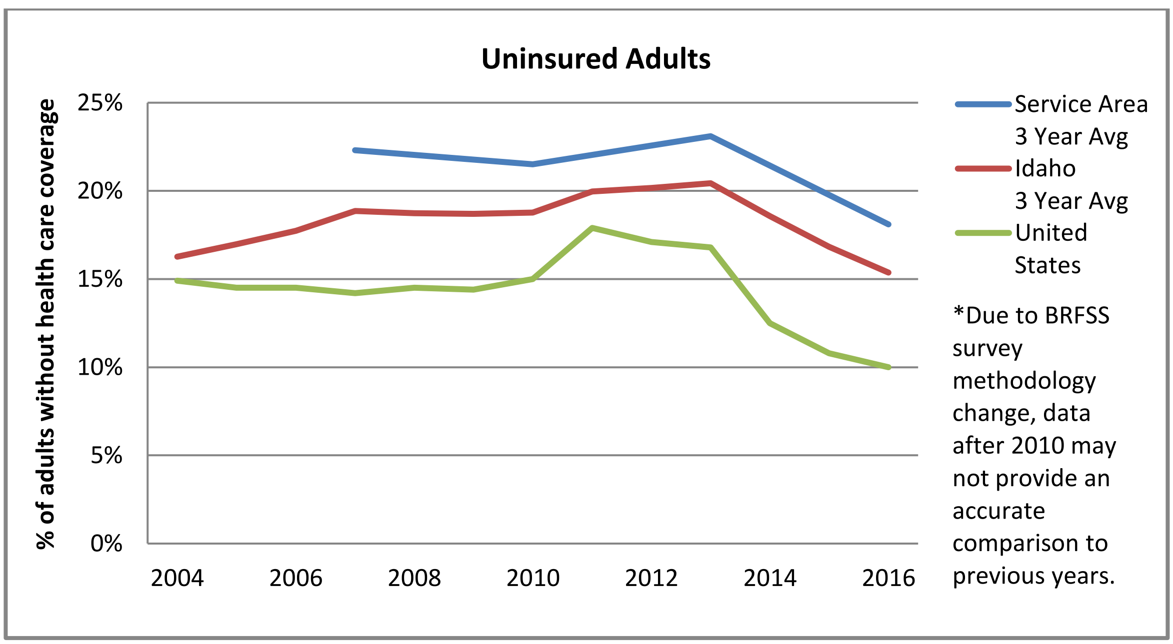
Health Care Access

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

- **Uninsured Adults**

  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.[131]

  The chart below shows the number of adults without health care coverage has been trending down for the past few years nationally and in our service area. The percentage of uninsured in Idaho and our service area is much higher than the national average. [132]

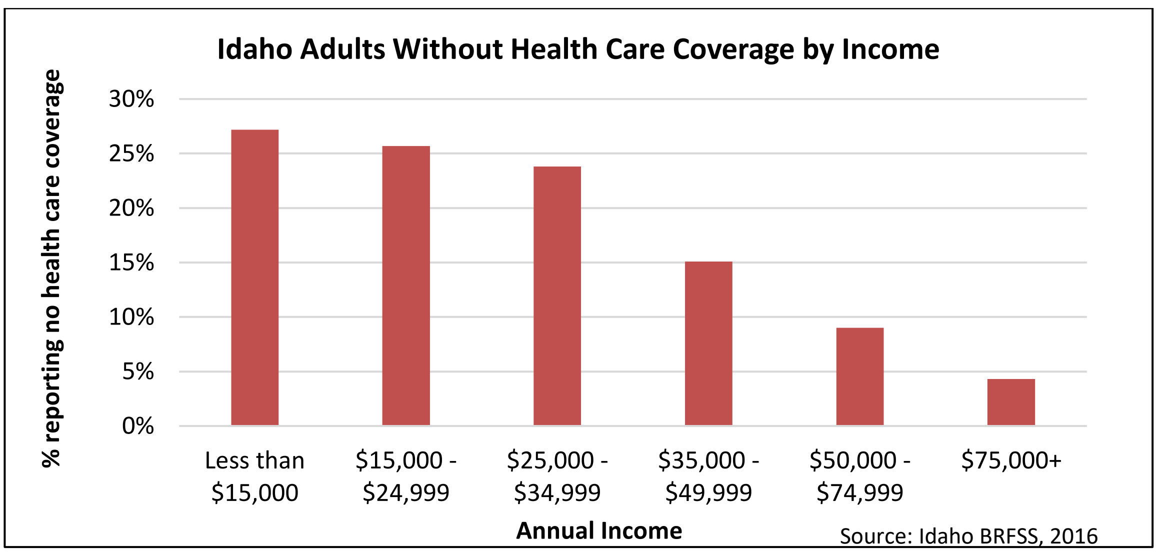


[131] University of Wisconsin Population Health Institute. *County Health Rankings* 2010-2018. Accessible at www.countyhealthrankings.org.

[132] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System

The chart above shows that on a national basis the 2010 Affordable Care Act (ACA) lowered the percentage of uninsured adults starting in 2014. The goal of the ACA is to improve health outcomes and eventually lower health care costs through insuring a greater proportion of the population. One of the major provisions of the ACA is the expansion of Medicaid eligibility to nearly all low-income individuals with incomes at or below 138 percent of poverty. However, over 20 states chose not to expand their programs. The ACA did not make provisions for low income people not receiving Medicaid and does not provide assistance for people below poverty for other coverage options.[133] This is often referred to as the "coverage gap."[134] In November 2018, Idaho passed a proposition to expand Medicaid. In November 2018, Idaho passed a proposition to expand Medicaid. In the coming years, we will see how much the resulting legislation increases the percentage of people who have health insurance and the positive impact it has on health.

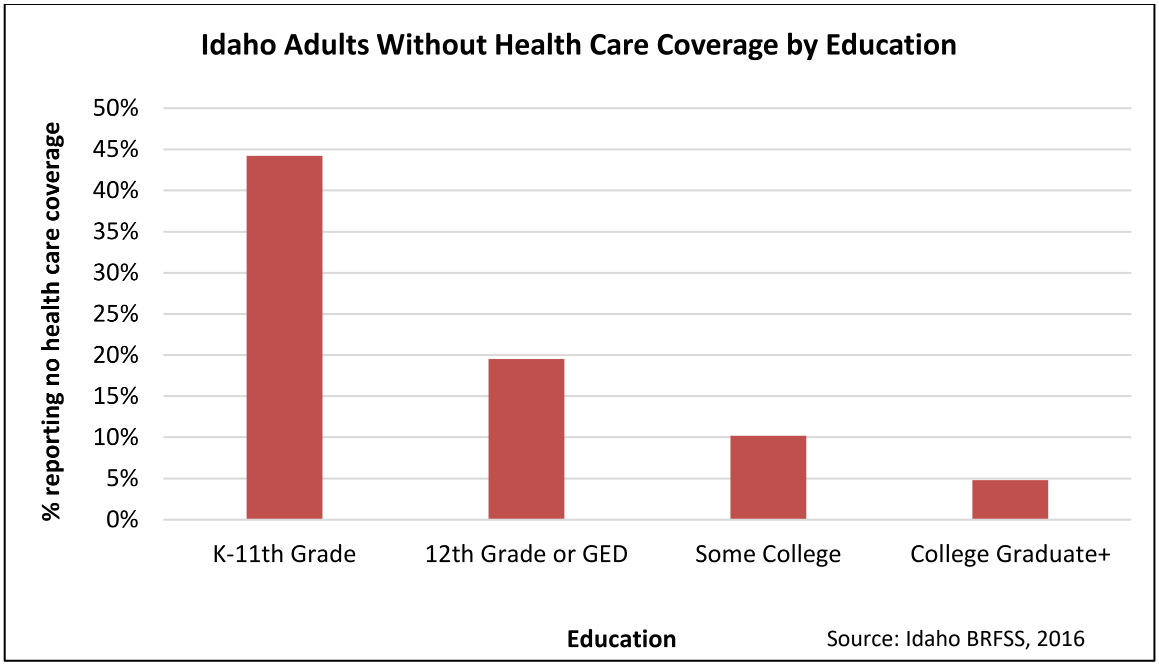
The charts below show that income and education greatly affect the likelihood of people having health insurance. For example, those with incomes of less than $25,000 are about 10 times more likely to report being without health care coverage than those with incomes above $75,000. In addition, Hispanics are more than twice as likely to not have health insurance coverage as non-Hispanics. [135]

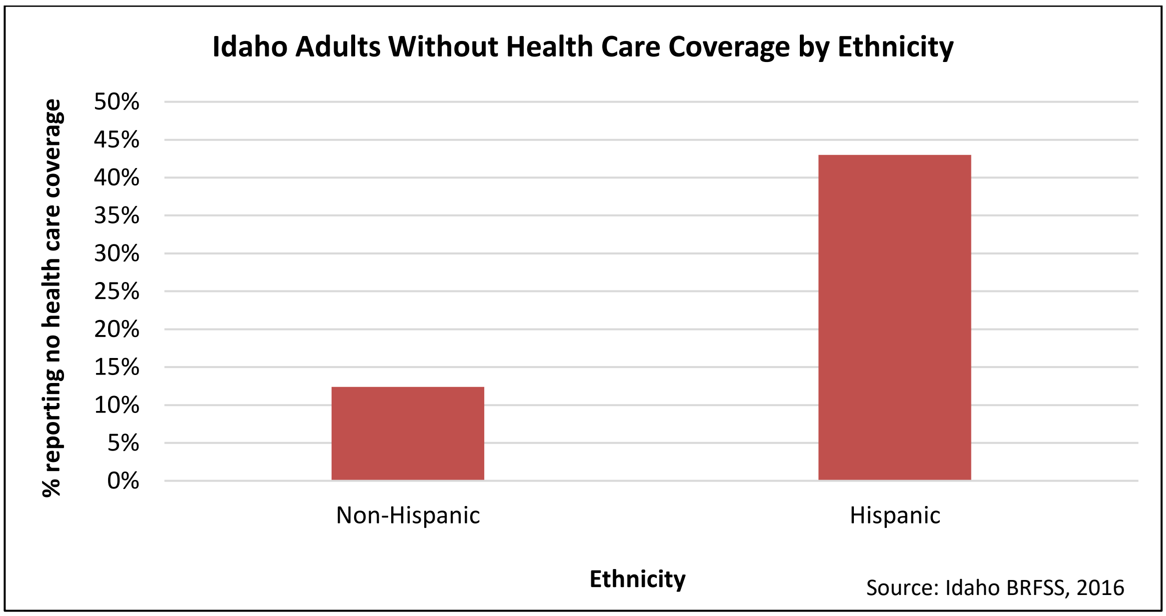


[133] The Coverage Gap: Uninsured Poor Adults in States that do not Expand Medicaid, April 2015, The Kaiser Commission on Medicaid and the Uninsured, Rachel Garfield

[134] The Coverage Gap: Uninsured Poor Adults in States the do not Expand Medicaid, April 2015, The Kaiser Commission on Medicaid and the Uninsured, Rachel Garfield

[135] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System



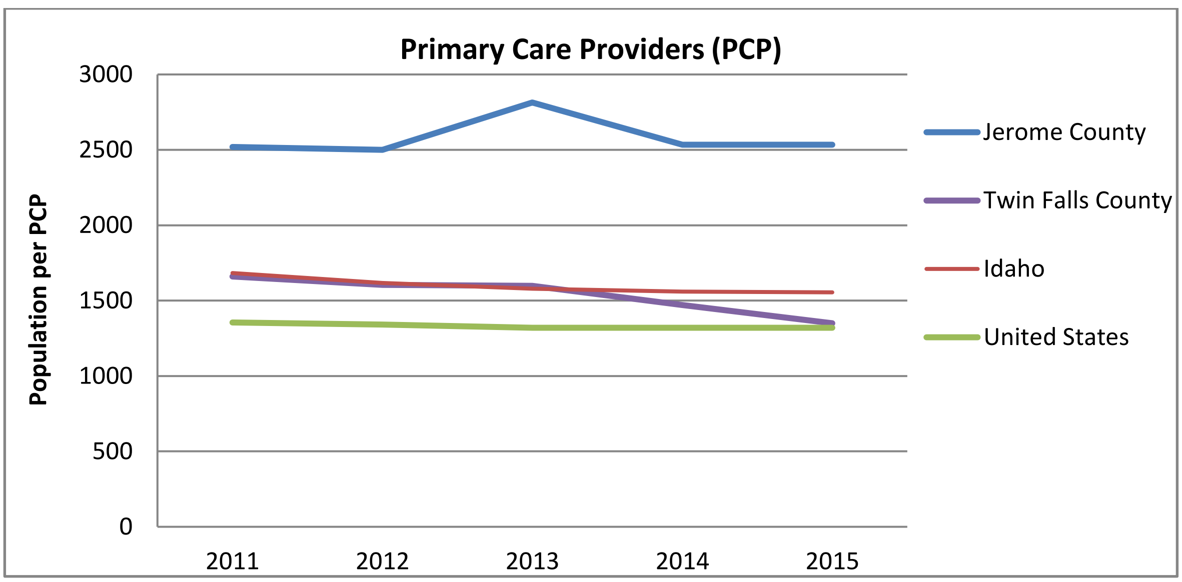


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Uninsured adults	**2**	**4**	**4**	**3**	**13**

- **Primary Care Providers**

The second measure of health care access reports the ratio of population in a county to primary care providers (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) through the County Health Rankings. 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%.[136]

The chart below shows the population to primary care provider ratio is higher than the national average in Twin Falls County and significantly higher in Jerome County.



Health Factor Score					
	Trend: Better/Worse	Prevalence versus U.S.	Severe/ Preventable	Magnitude: Root Cause	Total Score
Primary care physicians	2	4	2	3	11

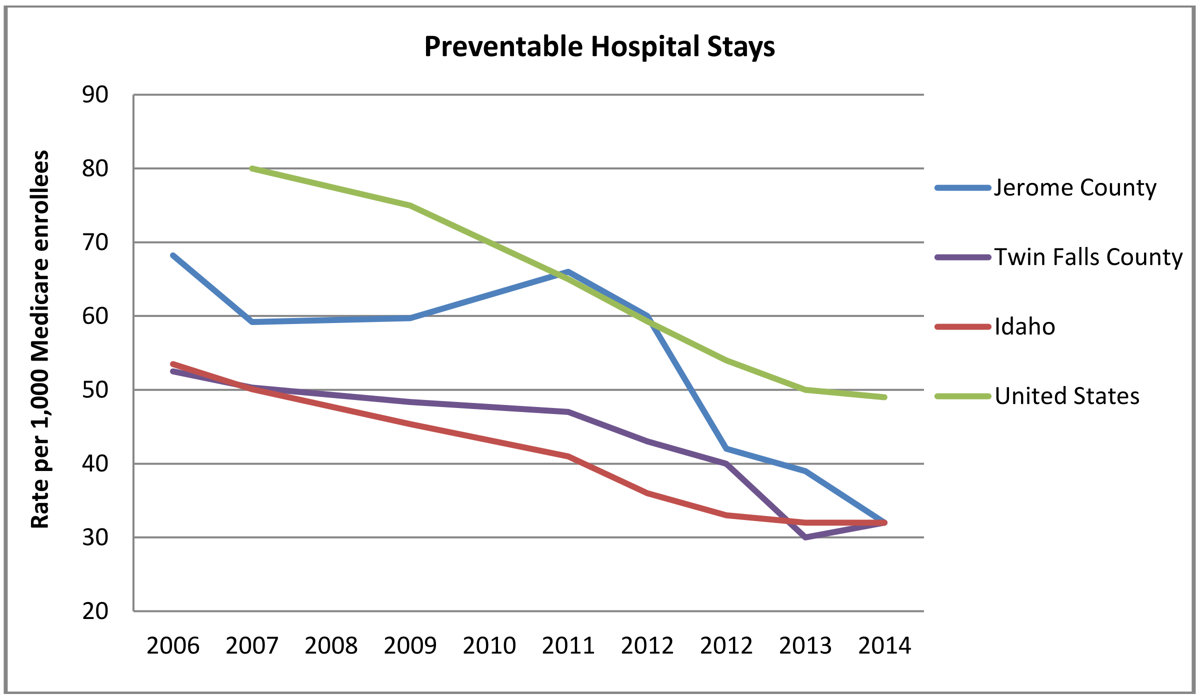
[136] University of Wisconsin Population Health Institute. *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.

Health Care Quality

- **Preventable Hospital Stays**

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

The rate of preventable hospital stays for our service area is the same as the national average is much better than the national average in our community. The national top 10th percentile (top 10th percentile rate is 35). This indicates a high level of health care quality in our community. [137]



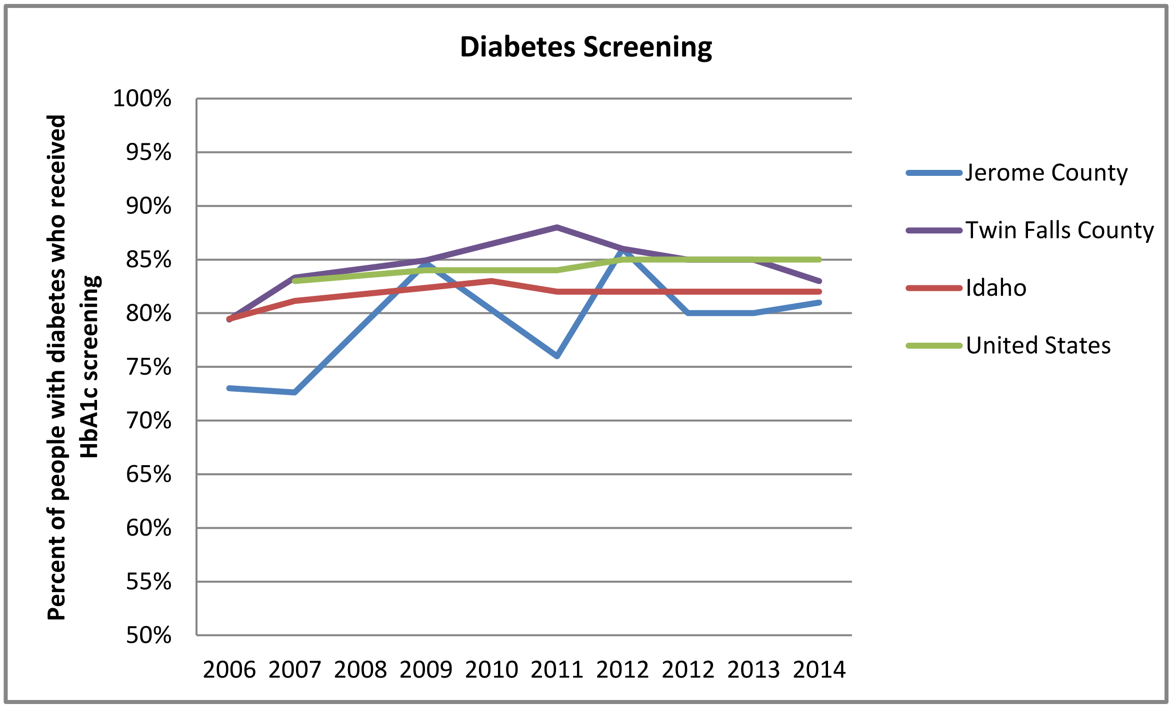
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S.**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Preventable Hospital Stays	**0**	**0**	**2**	**4**	**6**

[137] Ibid.

- **Diabetes Screening**

The second measure of health care quality, diabetes screening, encompasses the percent of diabetic Medicare enrollees receiving 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.[138]

The chart shows the trend for diabetes screening is improving slightly nationally and in our service area. The percent of people receiving A1c screening is about the same in our service area as in the nation.



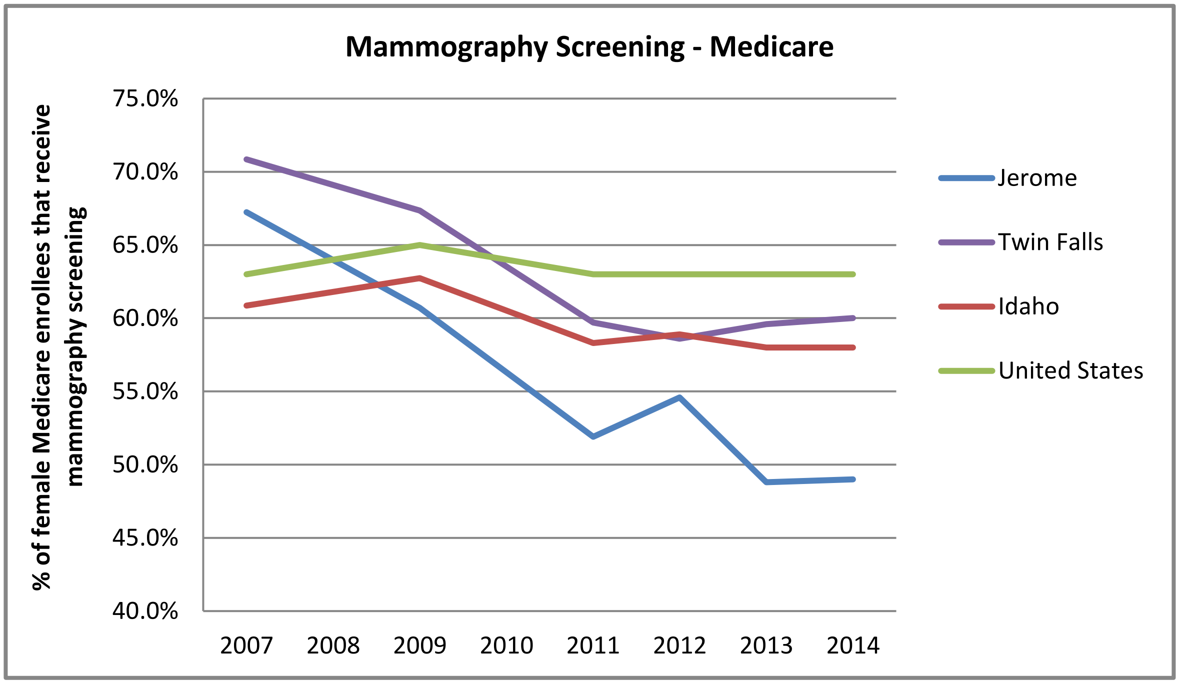
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Diabetes screening	1	2	3	3	9

[138] University of Wisconsin Population Health Institute. *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.

- **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.

In our community, the trend for the overall percent of women aged 67 to 69 receiving mammography screenings has been down for the past several years. [139]

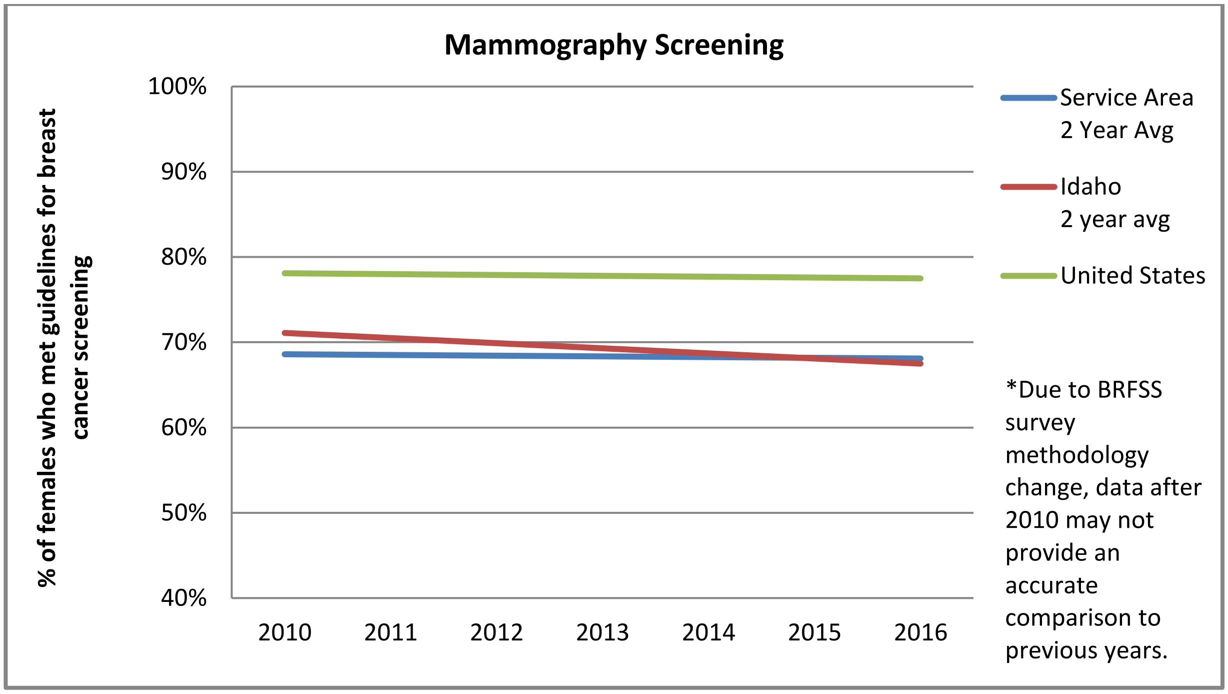


The data underlying this measure comes from the Dartmouth Atlas, a project that documents variations in health care throughout the country through use of Medicare claims data.

The National Cancer Institute has guidelines for mammography screening. To obtain the percentage of Idaho women who met the guidelines, we use data from BRFSS. As shown in the chart on the following page, the percentage has not changed significantly over the past decade. Women with annual incomes of less than $25,000 are significantly less likely to have had a mammogram and breast exam in the last two years.[140]

[139] University of Wisconsin Population Health Institute. *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.

[140] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System



Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Mammography screening	3	4	4	1	12

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. Our service area has a lower percent of people receiving cholesterol checks than the national average.[141]

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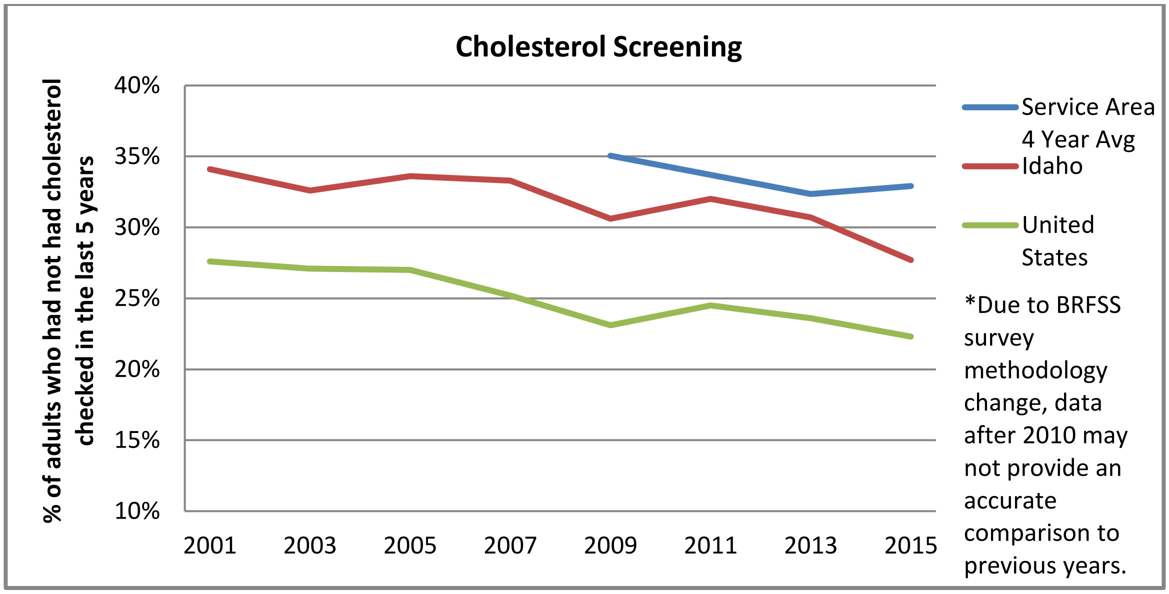
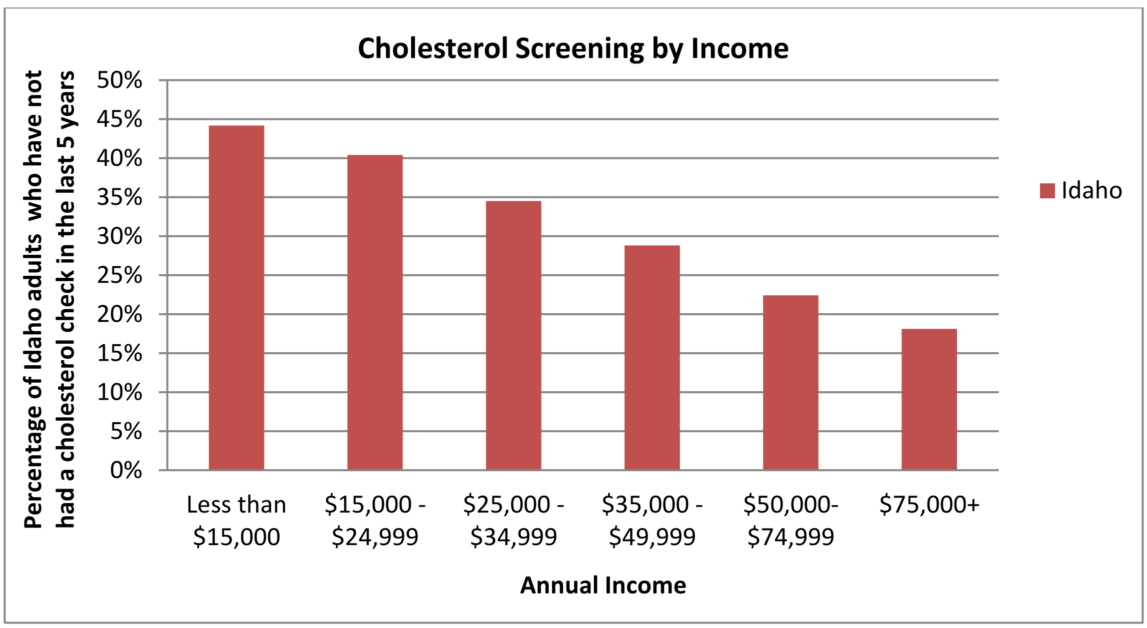
[141] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System



Lower income people, those without college educations, and Hispanics are significantly less likely to have their cholesterol checked. [142]



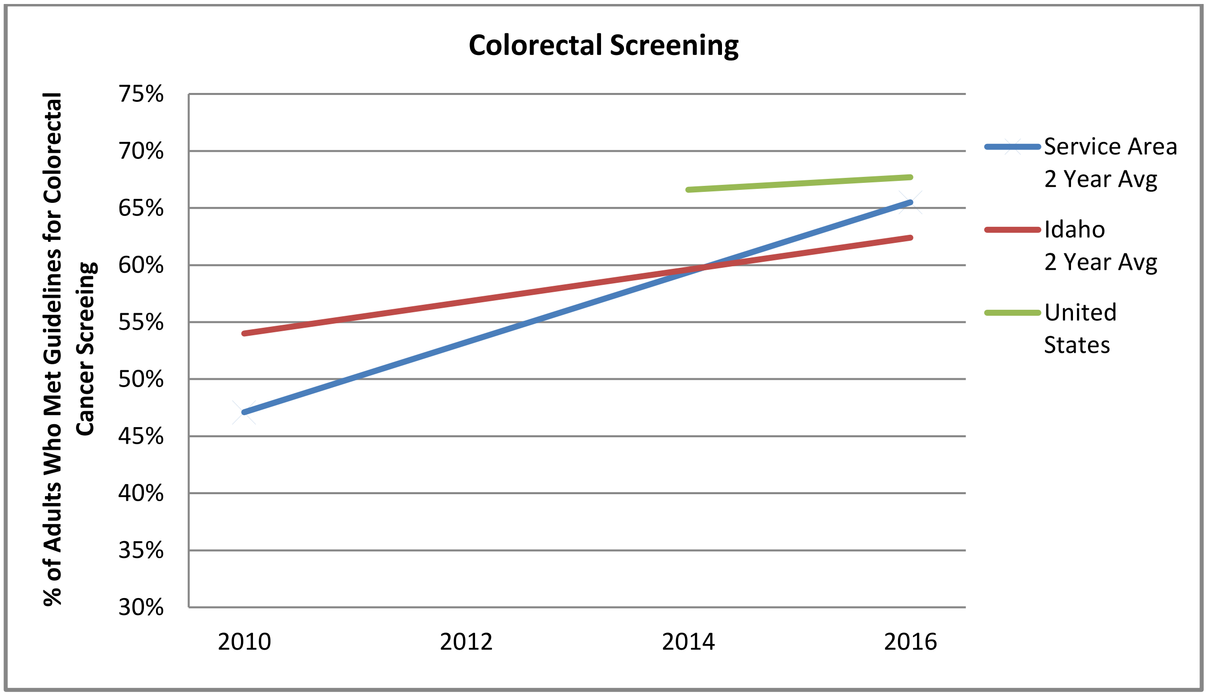
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Cholesterol Screening	2	4	3	2	10

[142] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System

- **Colorectal Screening**

The five-year survival rate of people diagnosed with 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 10 years. The percent of people age 50 and older receiving colorectal screening in our service area is about the same as the nation as a whole.[143]



People with annual incomes of less than $25,000 are significantly less likely to have ever had a colonoscopy when compared to people with higher incomes or with a college education. [144]

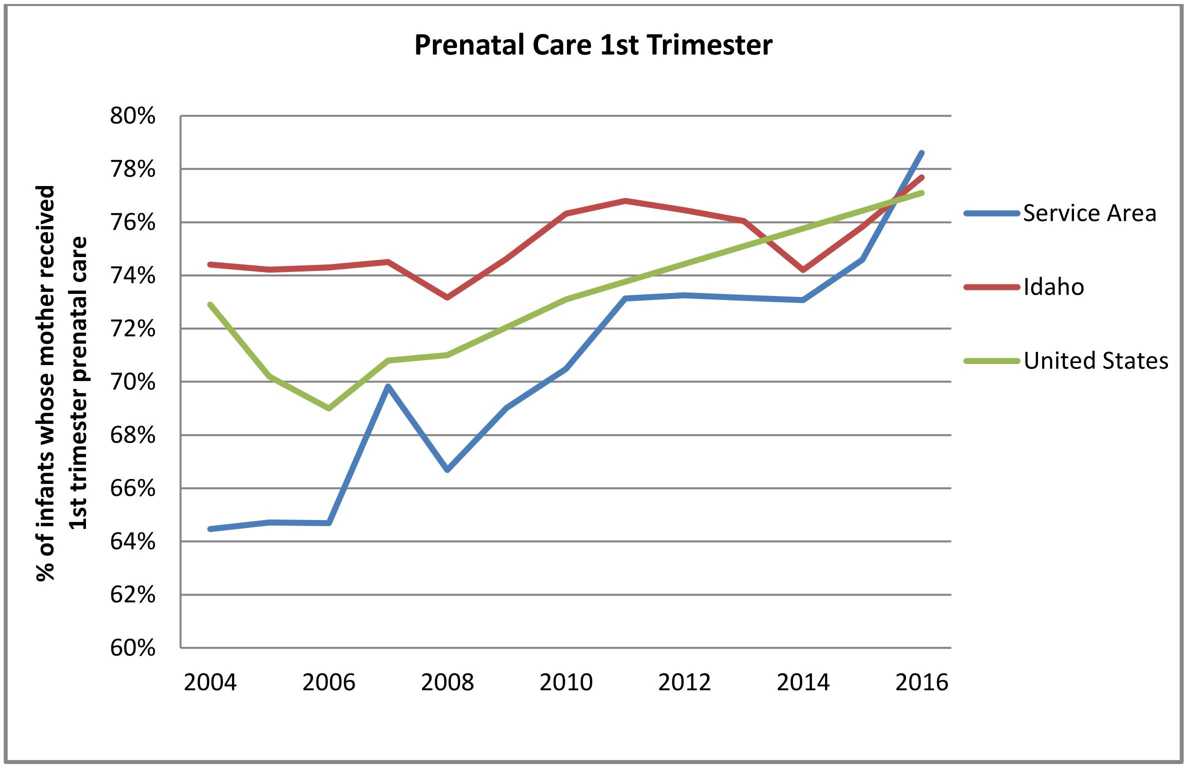
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Colorectal Screening	0	2	4	0	6

[143] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System
[144] 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 that 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.[145]

As shown in the chart below, a slightly higher percentage of women in our community have received early prenatal care compared to the nation as a whole. The trend in our service area for receiving early prenatal care has been increasing.[146]



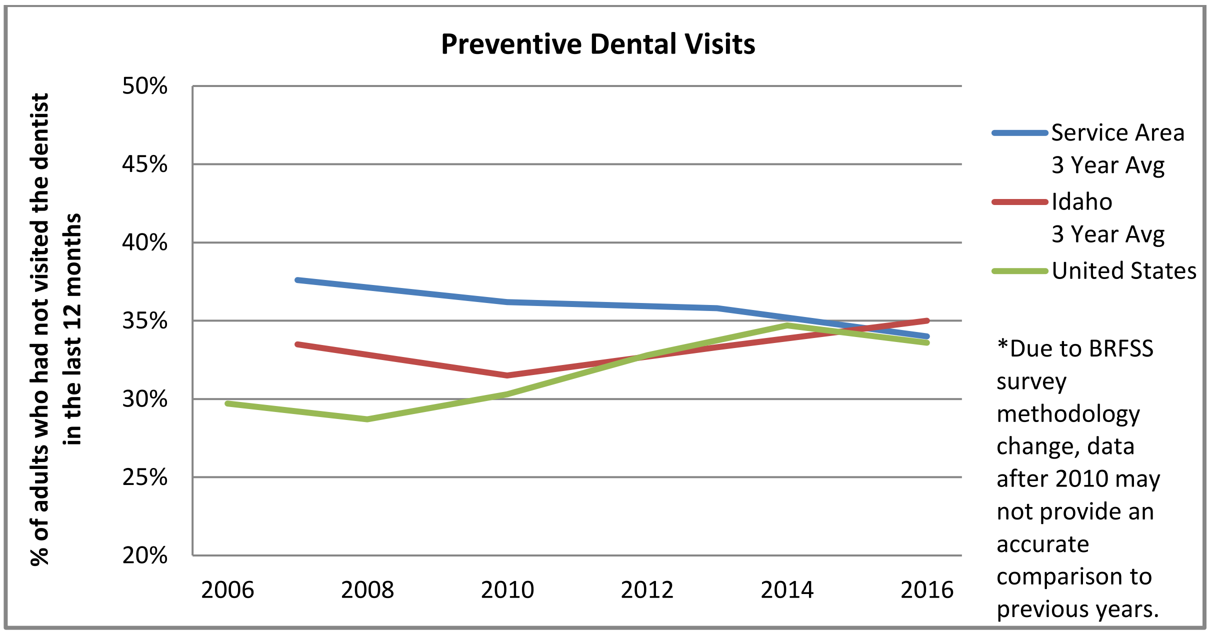
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Prenatal care 1st Trimester	0	2	3	3	8

[145] America's Health Rankings 2015-2018, www.americashealthrankings.org
[146] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016

- **Dental Visits**

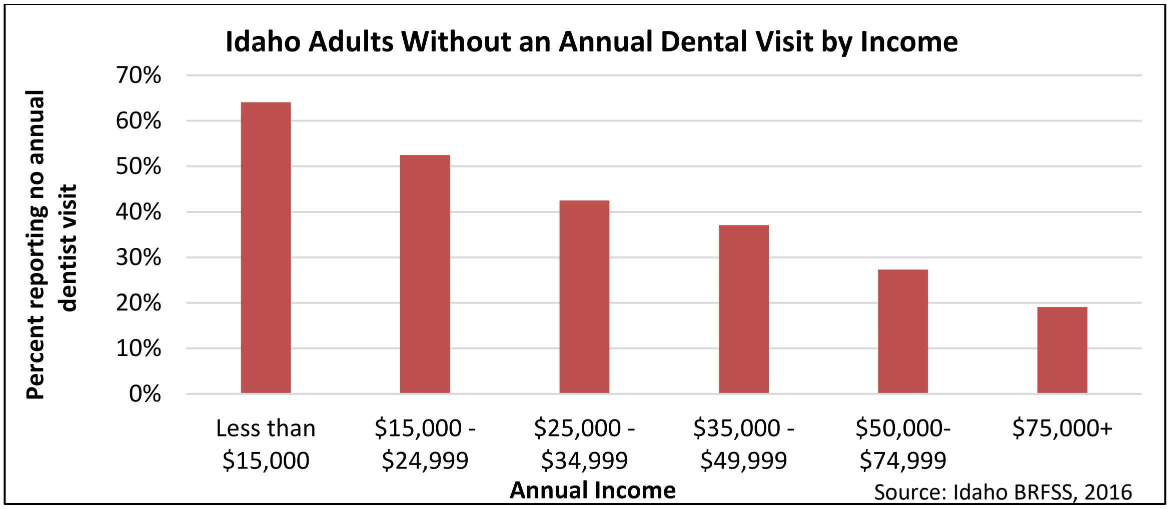
Oral health is vital to a comprehensive preventive health program. Nearly one-third of all adults in the U.S. have untreated tooth decay, while one in seven adults aged 35 to 44 years has gum disease. This increases to one in every four adults aged 65 years and older. Oral cancers, if caught early, are more responsive to treatment. Annual dental visits are one part of a healthy regimen of oral care.[147]

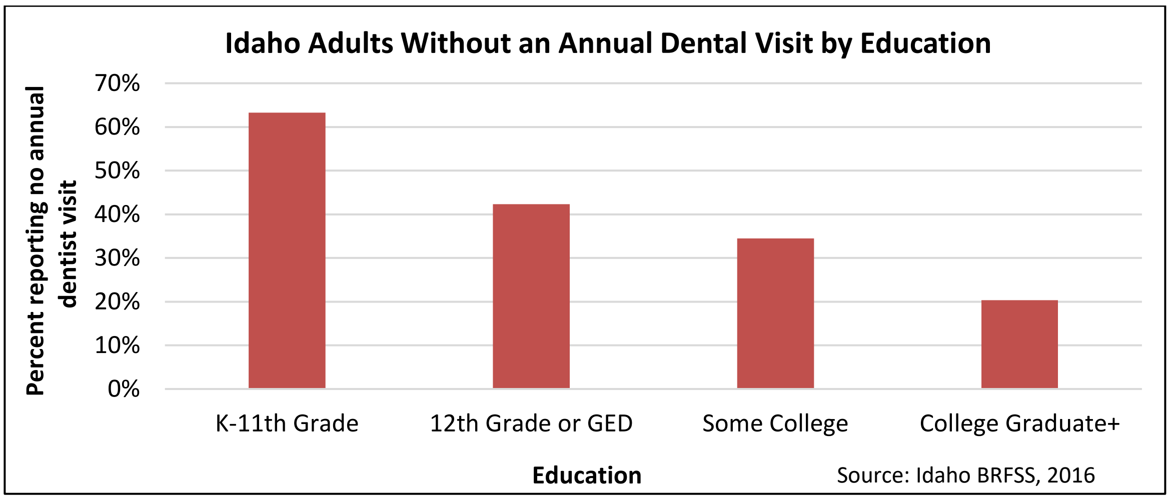
According to the Behavioral Risk Factor Surveillance System surveys, the percentage of people not receiving preventive dental visits in our service area is about the same as it is in the nation as a whole. The trend appears to be flat over the past several years in our service area.[148]

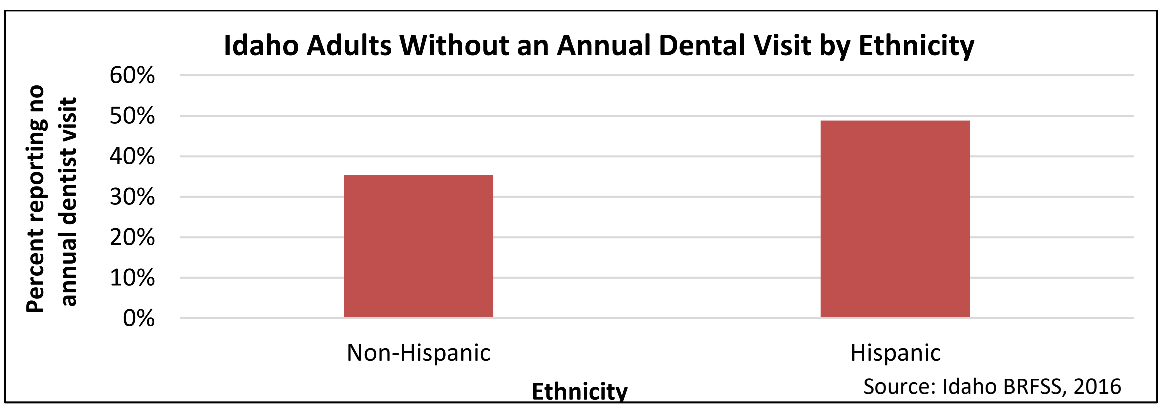


Those with incomes below $25,000 are significantly less likely to have preventive dental visits than those with higher incomes. In addition, those with less than a college degree are significantly less likely to have preventive dental visits. [149]

[147] America's Health Rankings 2015-2018, www.americashealthrankings.org
[148] Idaho and National 2002 – 2016 Behavioral Risk Factor Surveillance System
[149] Ibid.





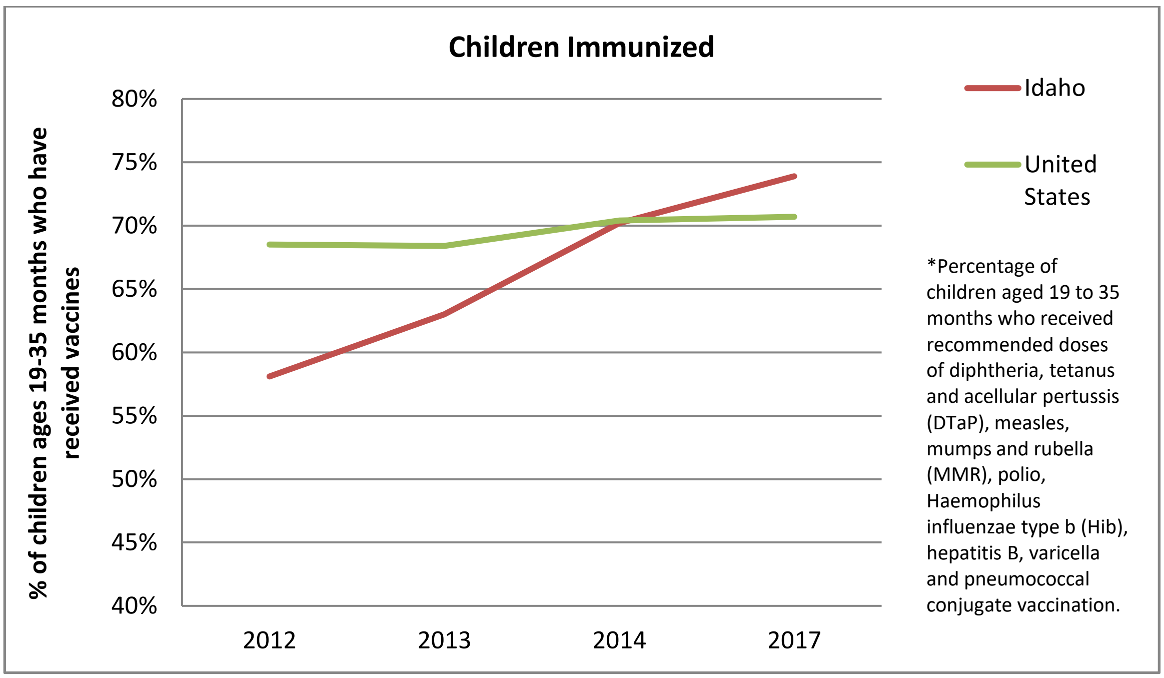


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Dental Visits	**2**	**2**	**3**	**2**	**9**

- **Childhood Immunizations**

In the U.S., 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: DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV. The immunization rate in Idaho has been improving over the past five years and is now higher than the national average.[150]



There are proven methods to increase the rate of vaccinations that include ways to increase demand or improve access through provider-based innovations.[151]

Health Factor Scoring					
	Trend: Better/Worse	Prevalence versus U.S.	Severe/ Preventable	Magnitude: Root Cause	Total Score
Childhood immunizations	0	2	3	2	7

[150] America's Health Rankings 2015-2018, www.americashealthrankings.org
[151] Ibid

- **Mental Health Service Providers**

  Jerome and Twin Falls counties both are listed as mental health professional shortage areas as of June 2017.[152] Our shortage of mental health professionals is especially concerning given the high suicide and mental illness rates in Idaho as documented in previous sections of our CHNA.

  According to The State of Mental Health in America 2018 study, one out of four (24.7%) of the people in Idaho with a mental illness report that they are not able to receive the treatment they need. According to this study, Idaho's rate of unmet need is the fourth highest in the nation. "Across the country, several systematic barriers to accessing care exclude and marginalize individuals with a great need. These include the following:

  - Lack of adequate insurance
  - Lack of available treatment providers
  - Lack of treatment types
  - Insufficient finance to cover costs [153]

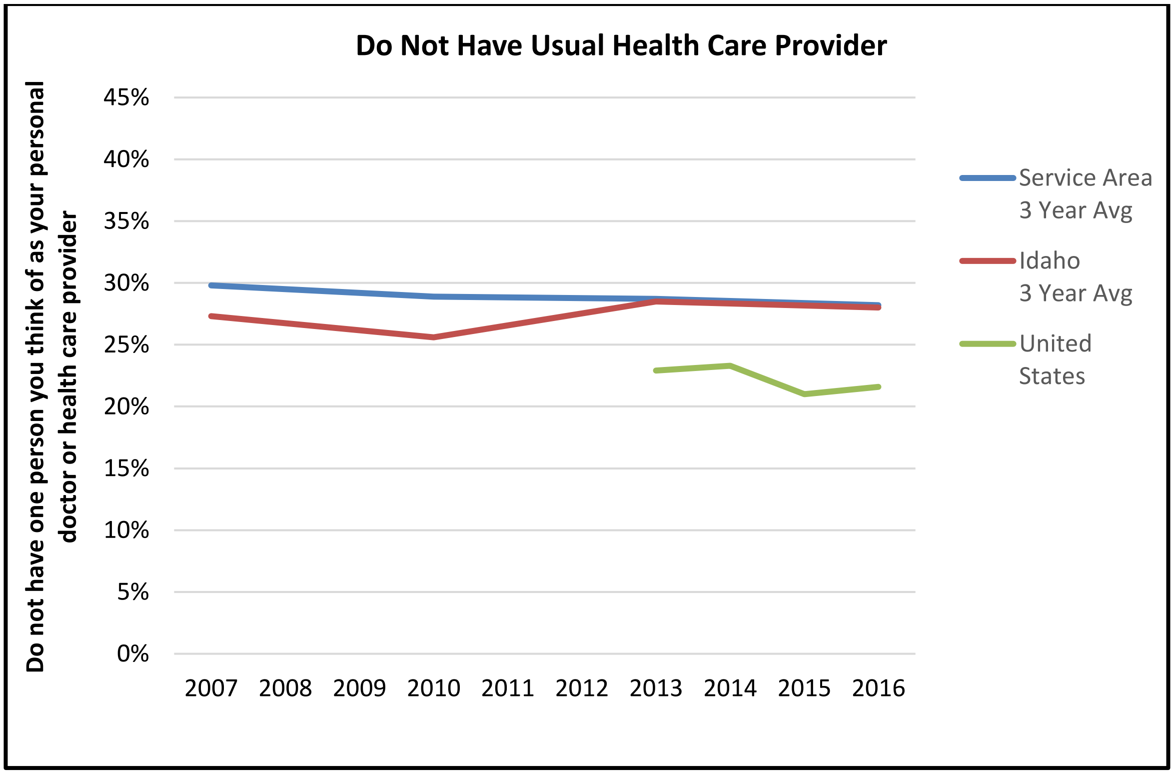
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Mental health service providers	**2**	**4**	**4**	**2**	**12**

[152] Health Services and Resource Administration Data Warehouse, Mental Health Care HPSAs PDF http://datawarehouse.hrsa.gov/hpsadetail.aspx#table
[153] http://www.mentalhealthamerica.net/issues/mental-health-america-access-care-data

- **Medical Home**

Today's medical home is a cultivated partnership between the patient, family, and primary provider in cooperation with specialists and support from the community. The patient/family is the focal point of this model, and the medical home is built around this center. Care under the medical home model must be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. [154]

One way to measure progress in the development of the medical home model is to study the percentage of people who do not have one person they think of as their personal doctor. The graph below shows the percentage of people in our service area without a usual health care provider is higher than it is in the nation as a whole.[155]



Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
No usual health care provider	**2**	**3**	**2**	**3**	**10**

[154] http://www.hrsa.gov/healthit/toolbox/Childrenstoolbox/BuildingMedicalHome/whyimportant.html
[155] Idaho and National 2002 – 2016 Behavioral Risk Factor Surveillance System

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 jobs that pay higher incomes. Access to health care is a particularly important resource that is often 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.

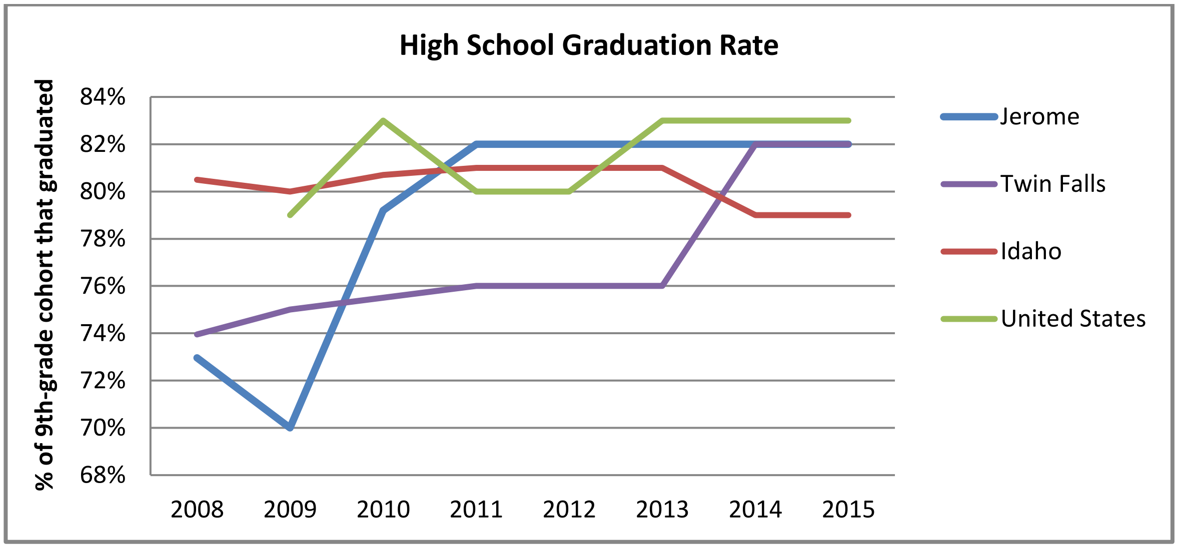
  Health literacy can help explain an individual's health behaviors and lifestyle choices. There is a striking difference between health literacy levels based on education. Only 3% of college graduates have below basic health literacy skills, while 15% of high school graduates and 49% of adults who have 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.

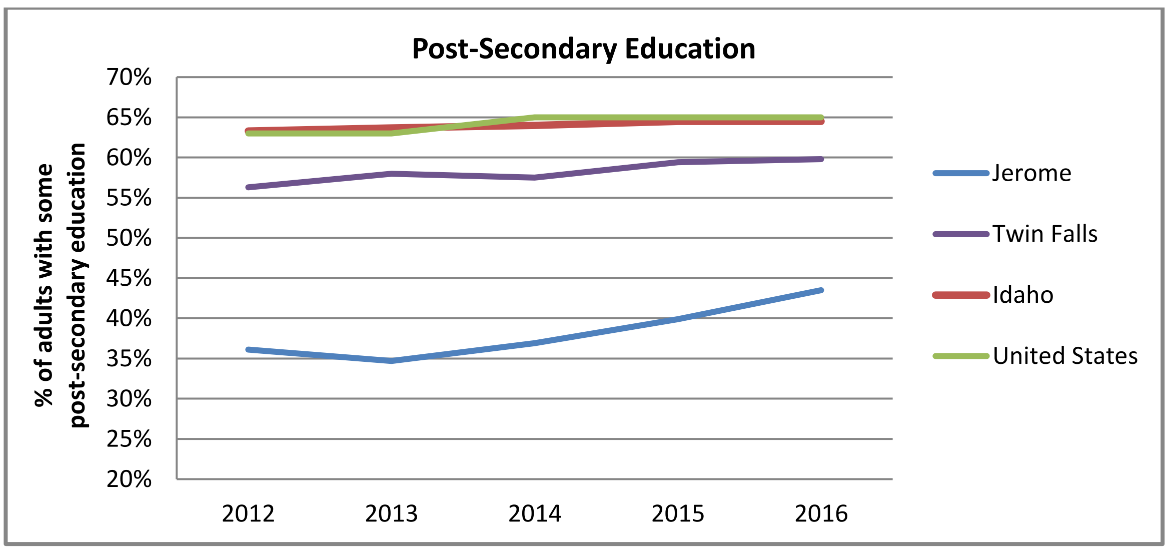
  One's education level affects not only his or her health, but education can have multigenerational implications that make it an important measure for the health of future generations. Evidence links maternal education with the health of her children. The education of parents affects their children's 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 high school graduation data was collected from state Department of Education websites. The second measure reports the percentage of the population ages 25-44 with some post-secondary education. These data sets are provided by the American Community Survey (ACS).[156]

The high school graduation rate for our community is about the same as the national average. Post-secondary education is below the national average for Jerome County.





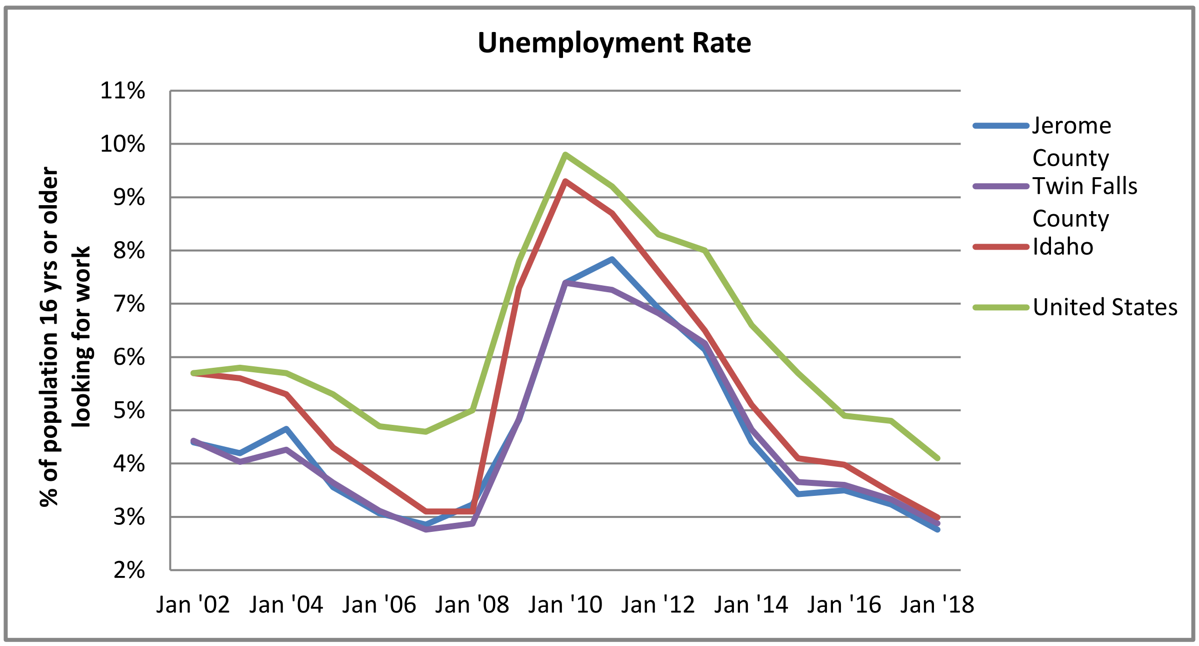
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Education	0	2	2	3	7

[156] University of Wisconsin Population Health Institute. *County Health Rankings* 2012-2018. Accessible at www.countyhealthrankings.org.

- **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.[157]

The unemployment rate in Idaho and our service area has been trending down since 2011 and is now at the longer term, healthier rate.[158]



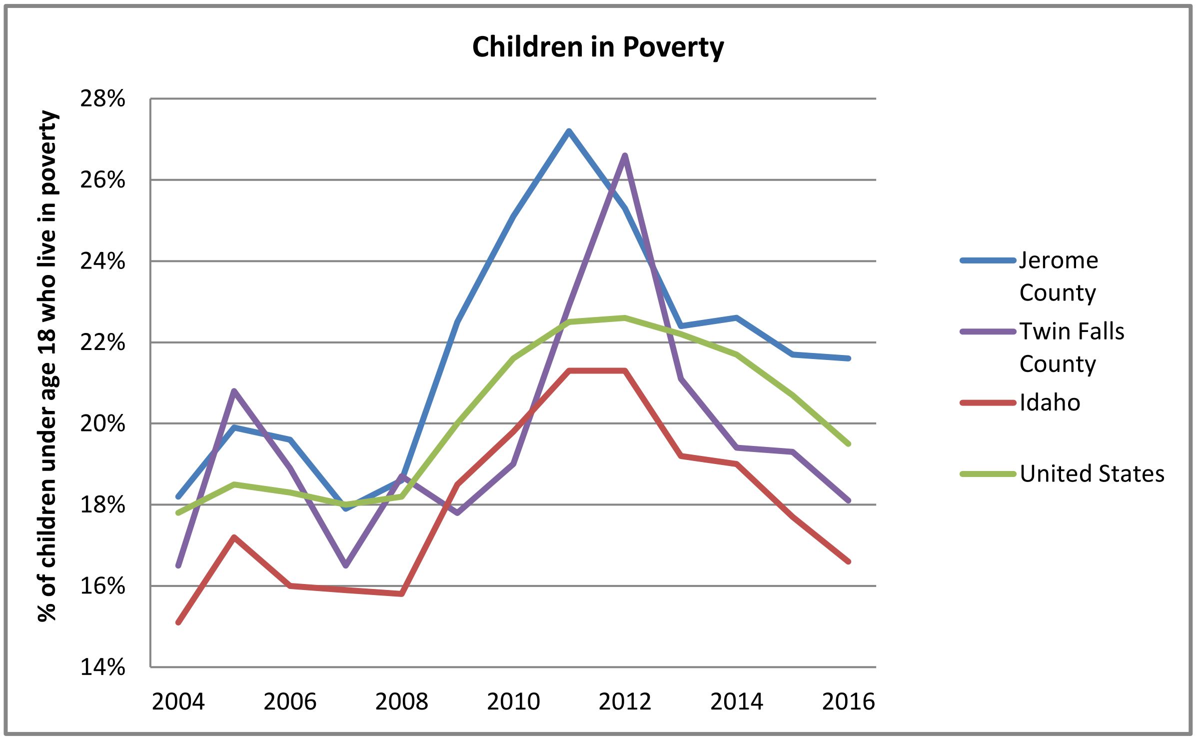
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Unemployment	0	1	1	4	6

[157] University of Wisconsin Population Health Institute. *County Health Rankings* 2012-2018. Accessible at www.countyhealthrankings.org.
[158] National Source: National Bureau of Labor Statistics, www.bls.gov. Idaho Source: Idaho Department of Labor www.bls.gov

- **Children in Poverty**

Income and financial resources enable individuals to obtain health insurance, pay for medical care, afford healthy food, safe housing, and access other basic goods. A 1990s study showed that if poverty were considered a cause of death in the United States, 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).[159]

The trend is improving in our community. Overall, the prevalence of children in poverty in our service area is now about the same as the national average.[160]



Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Children in Poverty	**2**	**2**	**3**	**3**	**10**

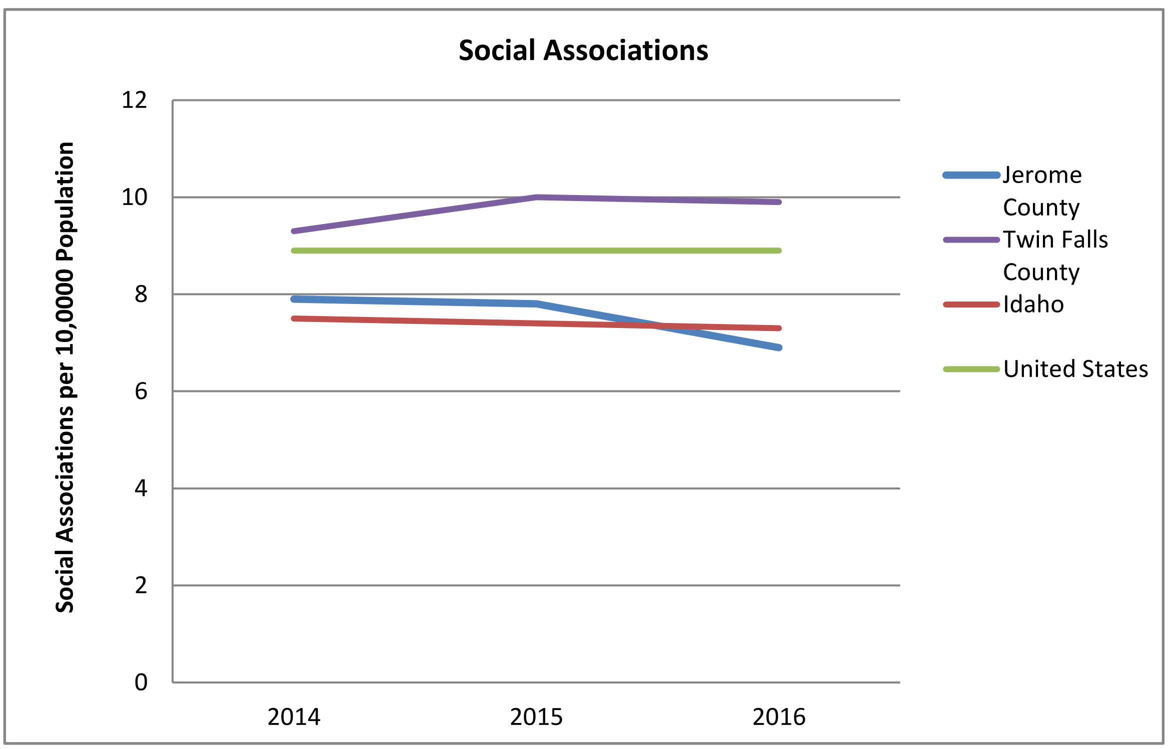
[159] University of Wisconsin Population Health Institute. *County Health Rankings* 2012-2018. Accessible at www.countyhealthrankings.org.
[160] Source: Small Area Income and Poverty Estimates (SAIPE. http://www.census.gov/did/www/saipe/data/statecounty/data/index.html

- **Inadequate Social Support**

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) social associations defined as the number of membership associations per 10,000 population. This county-level measure is calculated from the County Business Patterns 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.[161]

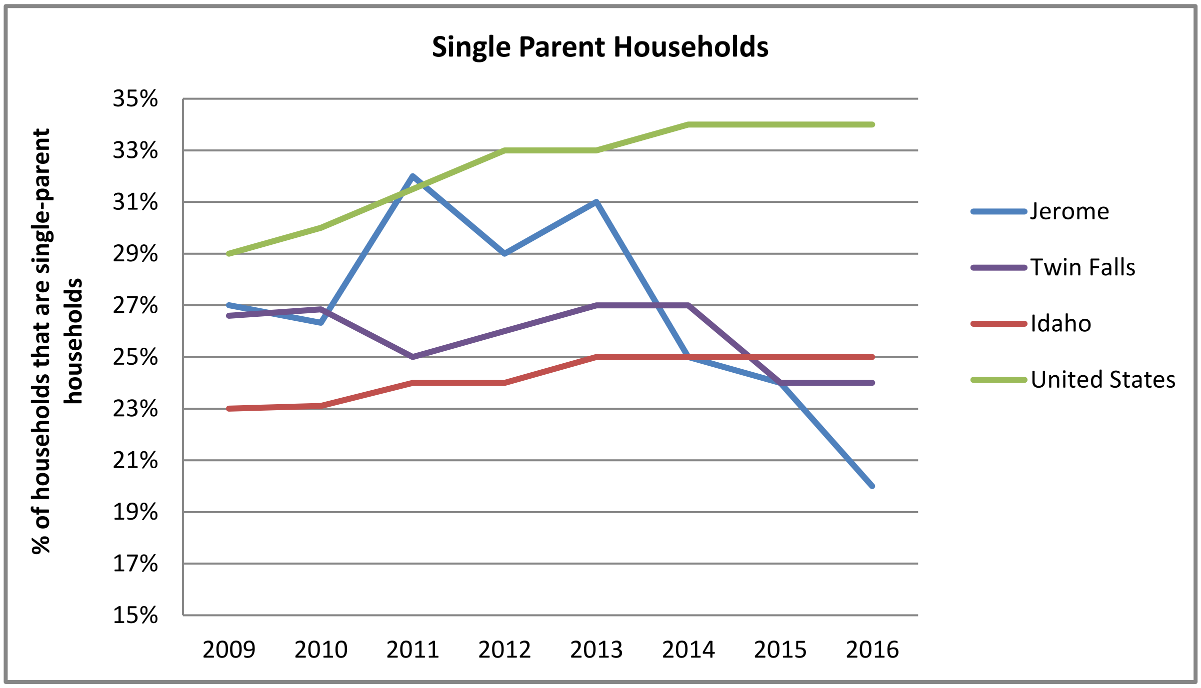
Adopting and implementing policies and programs that support relationships between individuals and across entire communities can benefit health. The greatest health improvements may be made by emphasizing efforts to support disadvantaged families and neighborhoods, where small improvements can have the greatest impacts. Social associations per 10,000 population in Twin Falls County is above the national average and below the national average in Jerome County.[162]



[161] University of Wisconsin Population Health Institute. *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.
[162] 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.[163]



Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Inadequate social support	**1**	**1**	**2**	**3**	**7**

[163] Ibid

Community Safety

Injuries through accidents or violence are the third leading cause of death in the United States, and the leading cause for those between the ages of one and 44. Accidents and violence affect health and quality of life in the short and long-term, for those directly and indirectly affected.

Community safety reflects not only violent acts in neighborhoods and homes, but also injuries caused unintentionally through accidents. Many injuries are predictable and preventable; yet about 50 million Americans receive medical treatment for injuries each year, and more than 180,000 die from these injuries.

Car accidents are the leading cause of death for those ages five to 34, and result in over 2 million emergency department visits for adults annually. Poisoning, suicide, falls, and fires are also leading causes of death and injury. Suffocation is the leading cause of death for infants, and drowning is the leading cause for young children.

In 2012, more than 6.8 million violent crimes such as assault, robbery, and rape were committed in the nation. Each year, 18,000 children and adults are victims of homicide and more than 1,700 children die from abuse or neglect. The chronic stress associated with living in unsafe neighborhoods can accelerate aging and harm health. Unsafe neighborhoods can cause anxiety, depression, and stress, and are linked to higher rates of pre-term births and low birth-weight babies, even when income is accounted for. Fear of violence can keep people indoors, away from neighbors, exercise, and healthy foods. Businesses may be less willing to invest in unsafe neighborhoods, making jobs harder to find.

One in four women experiences intimate partner violence (IPV) during their life, and more than 4 million are assaulted by their partners each year. IPV causes 2,000 deaths annually and increases the risk of depression, anxiety, post-traumatic stress disorder, substance abuse, and chronic pain.

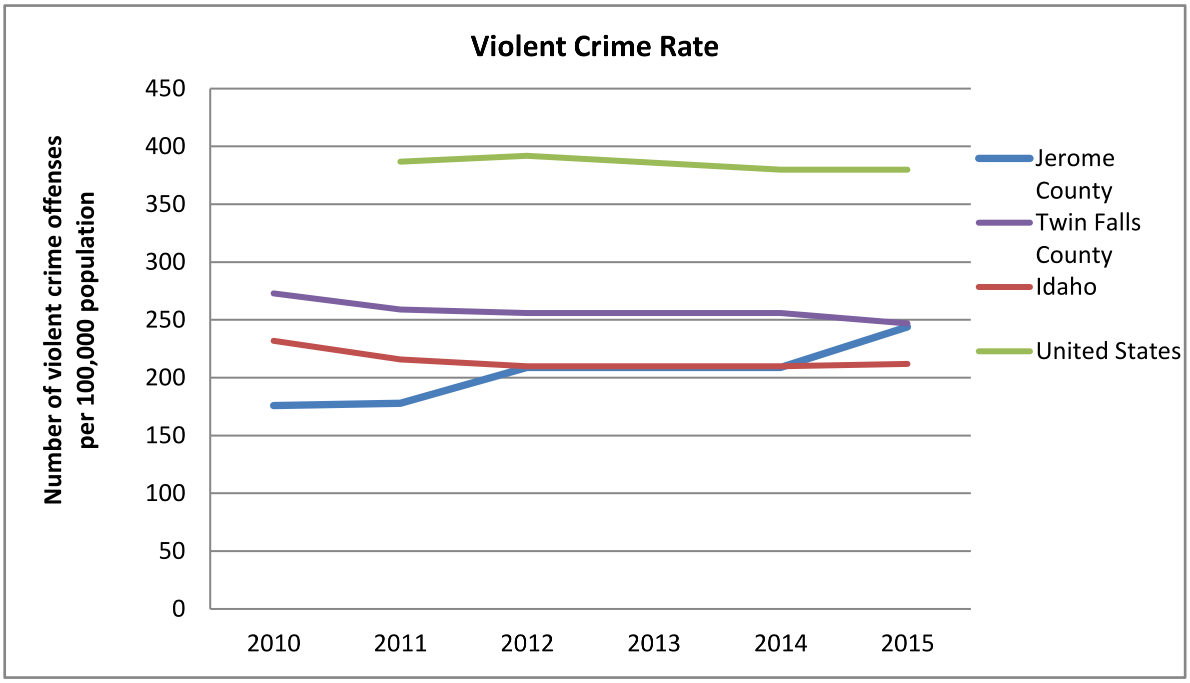
Injuries generate $406 billion in lifetime medical costs and lost productivity every year, $37 billion of which are from violence. Communities can help protect their residents by adopting and implementing policies and programs to prevent accidents and violence. [164]

[164] Ibid.

- **Violent Crime**

Violent crime rates per 100,000 population are included in our CHNA. In the FBI's Uniform Crime Report, violent crime is composed of four offenses: murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault. Violent crimes are defined as those offenses which involve force or threat of force.

Violent crime rates in Idaho and our community are significantly better than the national average.[165]



Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Violent Crime	2	0	2	2	6

[165] Ibid

Physical Environment Factors

County Health Rankings Physical Environment Factors

Air and Water Quality

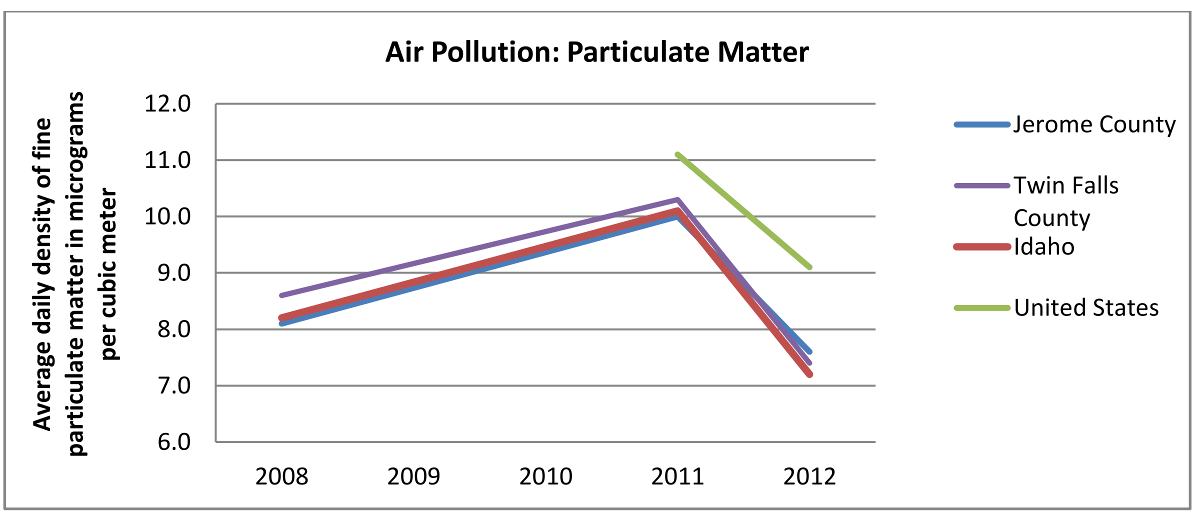
Clean air and water support healthy brain and body function, growth, and development. Air pollutants such as fine particulate matter can harm our health and the environment. Air pollution is associated with increased asthma rates and can aggravate asthma, emphysema, chronic bronchitis, and other lung diseases, damage airways and lungs, and increase the risk of premature death from heart or lung disease. Using 2009 data, the CDC's Tracking Network calculates that a 10% reduction in fine particulate matter could prevent over 13,000 deaths in the US.

A recent study estimates that contaminants in drinking water sicken up to 1.1 million people a year. Improper medicine disposal, chemical, pesticide, and microbiological contaminants in water can lead to poisoning, gastro-intestinal illnesses, eye infections, increased cancer risk, and many other health problems. Water pollution also threatens wildlife habitats.

Communities can adopt and implement various strategies to improve and protect the quality of their air and water, supporting healthy people and environments.[166]

- **Air Pollution Particulate Matter**

  Air pollution-particulate matter is defined as the average daily measure of fine particulate matter in micrograms per cubic meter (PM2.5) in a county. Idaho and our service area have air pollution-particulate matter levels below the national average.[167]

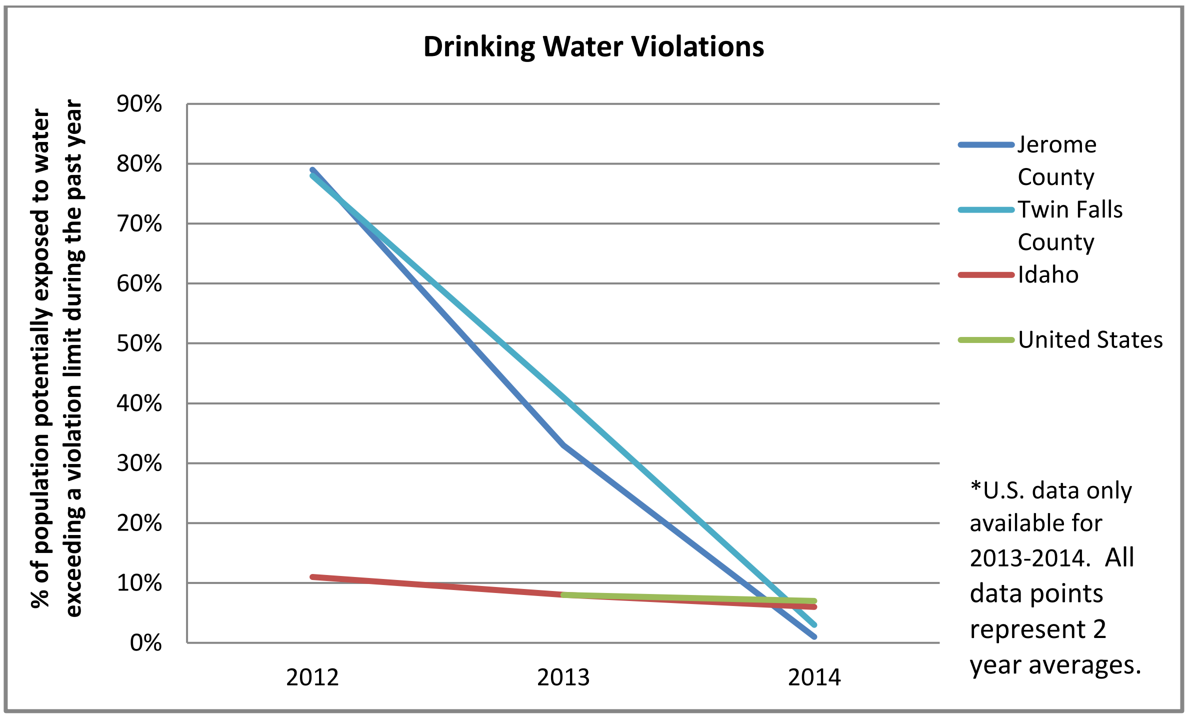


[166] Ibid
[167] Ibid

Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Air pollution	2	1	2	2	7

- ## Drinking Water Violations

The EPA's Safe Drinking Water Information System was utilized to estimate the percentage of the population getting drinking water from public water systems with at least one health-based violation. Our service area has drinking water violation rates that are now below the national average.[168]



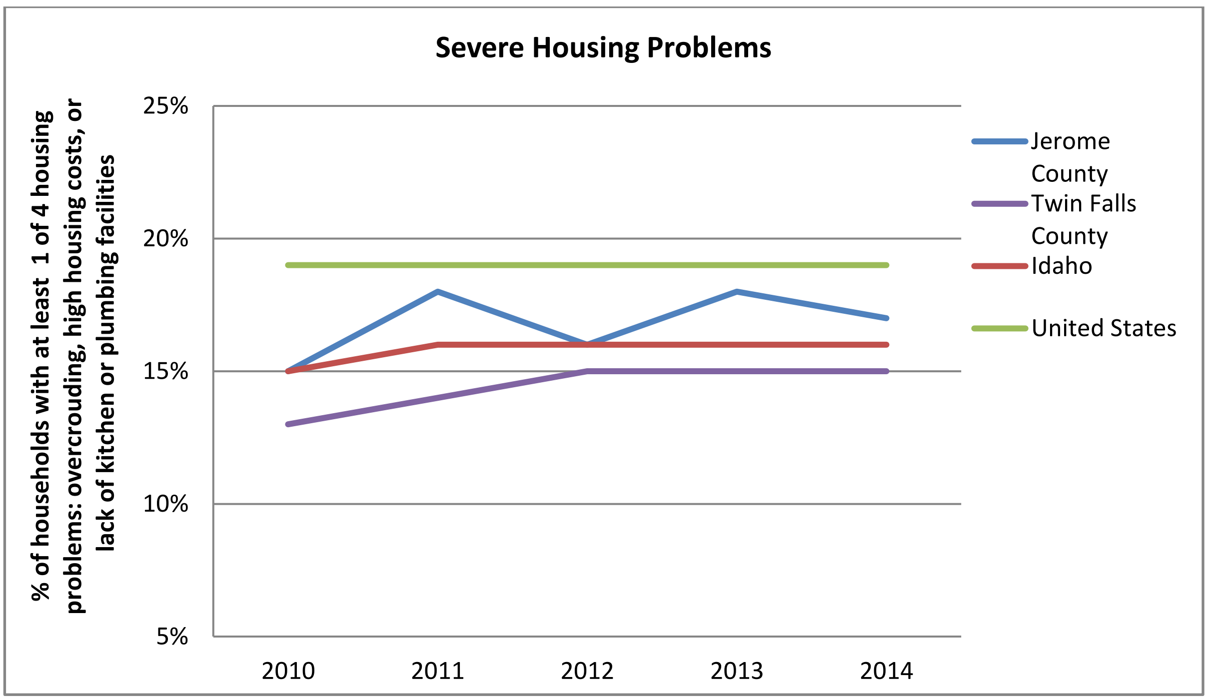
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Drinking Water Violations	0	2	2	2	6

[168] Ibid

- **Severe Housing Problems**

The U.S. Census Bureau "CHAS" data (Comprehensive Housing Affordability Strategy), demonstrate the extent of housing problems and housing needs, particularly for low income households. There are four housing problems that are tracked in the CHAS data: 1) housing unit lacks complete kitchen facilities; 2) housing unit lacks complete plumbing facilities; 3) household is severely overcrowded; and 4) household is severely cost burdened. A household is said to have a severe housing problem if they have 1 or more of these 4 problems. Severe overcrowding is defined as more than 1.5 persons per room. Severe cost burden is defined as monthly housing costs (including utilities) that exceed 50% of monthly income. [169]

Idaho and our service area in general have a lower percentage of housing problems than the national average. However, the trend appears to be getting slightly worse.



Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Severe Housing Problems	2	1	1.5	3	7.5

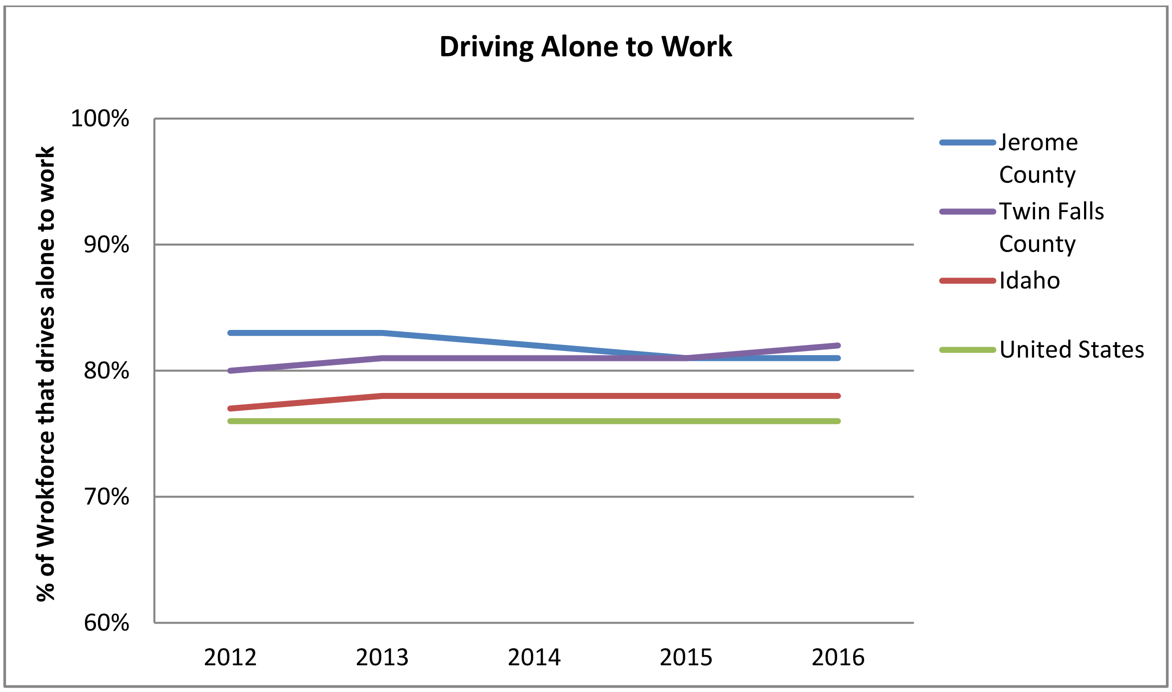
[169] Ibid

- **Driving Alone to Work**

This measure represents the percentage of the workforce that primarily drives alone to work. The transportation choices that communities and individuals make have important impacts on health through active living, air quality, and traffic accidents. The choices for commuting to work can include walking, biking, taking public transit, or carpooling. The most damaging to the health of communities is individuals commuting alone. In most counties, this is the primary form of transportation to work.

The American Community Survey (ACS) is a critical element in the Census Bureau's reengineered decennial census program. The ACS collects and produces population and housing information every year instead of every ten years. The *County Health Rankings* use American Community Survey data to obtain measures of social and economic factors.

Our community has more people driving to work alone than the national average.[170]



Health Factor Scoring					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Driving Alone to Work	**2**	**3**	**1**	**2**	**8**

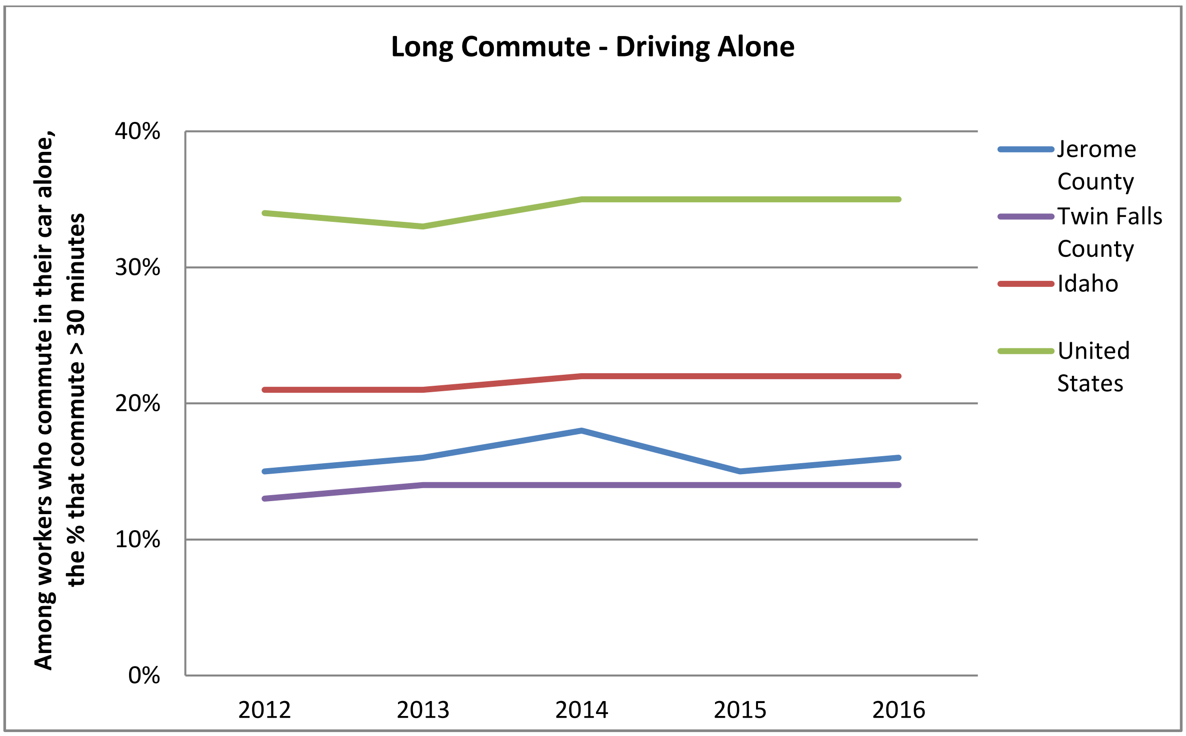
[170] Ibid

- **Long Commute**

This measure estimates the proportion of commuters, among those who commute to work by car, truck, or van alone, who drive longer than 30 minutes to work each day. A 2012 study in the American Journal of Preventive Medicine found that the farther people commute by vehicle, the higher their blood pressure and body mass index. Also, the farther they commute, the less physical activity the individual participated in.

Our current transportation system also contributes to physical inactivity—each additional hour spent in a car per day is associated with a 6 percent increase in the likelihood of obesity.

The percent of people in our community with a long commute to work is much lower than the national average.



Health Factor Scoring					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Long Commute	2	0	1	2	5

Community Input

Community input for the CHNA is obtained through two methods:

- First, we conduct in-depth interviews with community representatives possessing extensive knowledge of health and affected populations in our community.
- Second, feedback is collected from community members regarding the 2016 CHNA and the corresponding implementation plan. We use this input to compile and develop the 2019 CHNA. Community members have an opportunity to view our CHNA and provide feedback utilizing the St. Luke's public website.

Community Representative Interviews

A series of interviews with people representing the broad interests of our community are conducted in order to assist in defining, prioritizing, and understanding our most important community health needs. Many of the representatives participating in the process have devoted decades to helping others lead healthier, more independent lives. We sincerely appreciate the time, thought, and valuable input they provide during our CHNA process. The openness of the community representatives allow us to better explore a broad range of health needs and issues.

The representatives we interview have significant knowledge of our community. To ensure they come from distinct and varied backgrounds, we include multiple representatives from each of the following categories:

Category I: Persons with special knowledge of public health. This includes persons from state, local, and/or regional governmental public health departments with knowledge, information, or expertise relevant to the health needs of our community.

Category II: Individuals or organizations serving or representing the interests of the medically underserved, low-income, and minority populations in our community. Medically underserved populations include populations experiencing health disparities or at-risk populations not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers.

Category III: Additional people located in or serving our community including, but not limited to, health care advocates, nonprofit and community-based organizations, health care providers, community health centers, local school districts, and private businesses.

Appendix I contains information on how and when we consulted with each community health representative as well as each individual's organizational affiliation.

Interview Findings

Using the questionnaire in Appendix II, we asked our community representatives to assist in identifying and prioritizing the potential community health needs. In addition, representatives were invited 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 secondary research and by our community representatives during the interview process. Each potential need is scored by the community representatives on a scale from 1 to 10. A high score signifies the representative believes the health need is both important and needs to be addressed with additional resources. Lower scores typically mean the representative believes the need is relatively less important or that it is already being addressed effectively with the current set of programs and services available.

The community representatives' scores are added together and an average is calculated. The average representative score is shown in the second column of the table below. Finally, the representatives' comments as well as suggested solutions regarding each need are summarized in the third column of the table.

Health Behavior Needs		
Potential Health Needs	**Average Score**	**Summary of Community Representatives' Comments**
Access to healthy foods	**6.6**	Many community representatives believe that there is some access to healthy foods, but there is a huge issue with accessibility to the farmers markets due to location. It is only open on Saturdays during the summer season. The other concern is affordability. Representatives would like to see education given to teach people how to shop healthy on a fixed budget. Many recommended forming partnerships with faith based organizations and other agencies to grow and promote community gardens.
Cancer prevention/education programs	**5.5**	"As society ages, cancer will become the most prominent cause of death in our communities." Some representatives believe that, until

		recently, cancer was not something people wanted to talk about. However, they feel that conversations are starting to happen and screenings are becoming more available to the general population. The key is marketing these screenings well and working aggressively to educate all populations on prevention. In addition, community representatives shared that there is a need for support groups, exercise programs, and general activities for cancer survivors.
Exercise programs/education/opportunities	**5.1**	"Exercise is the single most important thing a person can do for their health." Although, there are programs and fitness centers, they are not affordable for all populations. We need to educate people on the importance of exercise and motivate them to get involved with their health. If people understood the positive impact exercise has on life, they would be more willing to create a plan allowing them to be active in a way that is affordable and in alignment with their work and family schedules.
Nutrition Education	**5.7**	We have education on nutrition available. The challenge is getting people to attend and then being able to access and afford the nutritional choices they learn about. Community representatives suggest better advertising to bring up the attendance in current free classes as well as marketing to the Hispanic community. We have a large Hispanic population, and we are not effectively reaching out to them.
Safe sex education programs	**5.8**	Our community's conservative nature makes it challenging to deliver safe sex education programs. Unless it is being addressed in homes, there is not a lot being done on this topic. Schools are limited on what they can discuss and

		promoting abstinence is about all they can do.
Substance abuse services and programs	**6.0**	Community representatives agree that there are substance abuse programs available, but they are not adequate for the demand or applicable for all the different needs. "The opioid epidemic is getting so bad that we need to start educating people on the damage this is doing to families, neighborhoods and community." We need preventative services for our youth. If we don't begin making this a priority, it will only get worse.
Tobacco prevention and cessation programs	**4.4**	Tobacco programs are being offered state wide. If people want help, there are resources. What we lack are local support groups and addressing the new trend on vaping. This form of nicotine use appears to be socially acceptable, not just in adults, but also in our youth. The overall consensus of representatives is prevention education for our youth is very important.
Weight management programs	**6.4**	"Obesity rates are very high." In order to be successful at weight management, a culture shift and the desire to change will be required. Many people don't start looking into this until they have a health problem. Although there are some programs available many people are unaware or can't afford them. One of the most important things we can do is create awareness in our youth by providing preventative education in schools.
Wellness and prevention programs (for conditions such as high blood pressure, skin cancer, depression, etc.)	**5.7**	Wellness and prevention are an important component to quality of life. Unfortunately, the people who most need to seek this out, don't. If you have a primary care provider, then potential health hazards get identified. Others who may not have health insurance or

		are underinsured, wait until there is a problem before they seek help. There are screenings available for some conditions; however, many conditions are not covered. In addition, the screenings that are available are often not offered at a time that is convenient for the work force and non-English speaking population. It is suggested that heath care systems look at ways to do this more effectively.

Clinical Care Access and Quality Needs		
Potential Health Needs	**Average Score**	**Summary of Community Representatives' Comments**
Affordable care for low income individuals	**6.2**	There are clinics and hospitals that offer sliding scale fees to uninsured individuals needing health care. What becomes an issue for these individuals is advanced care needs. If during a visit, a chronic or advanced illness is detected, this could potentially put the patient in financial ruin.
Affordable dental care for low income individuals	**6.0**	"Two things that play a major role in predicting your economic success is body weight and dental care." We are fortunate to have a college that allows families to go in and have free cleanings and exams to help train the students. But for the most part, it is generally a two month wait to get into a sliding scale fee clinic. We need to take care of all people so everyone has the same economic opportunities.
Affordable health insurance	**8.2**	Community representatives acknowledge that there is a large population that fall in the category of being "in the gap" and are unable to afford health insurance. The working poor are the largest group in this gap.

		These families make too much money to get help through Medicaid and not enough to pay the monthly premiums to have health insurance. "We must get ALL people affordable health insurance." This is important. People are dying too young and they don't go to the doctor. If people are not healthy, they do not have the same economic opportunities as those that are.
Availability of behavioral health services (providers, suicide hotline, etc)	**7.8**	Community representatives expressed a concern about the lack of behavioral health providers and services. As we see a growing number of people with behavioral health issues, we need to create a team model to address this. Awareness is so important along with empowering the health care community to know what to do. We need to integrate mental health and physical health. They are both connected. The majority of interviewees believe that it is important to find a way to prevent and change the way behavioral health is being addressed. Educating our youth on behavioral health and letting them know it is okay to talk about and seek help could potentially be a helpful measure toward suicide prevention.
Availability of primary care providers	**6.0**	There is a vast shortage in primary care providers, especially in rural areas. Many people are waiting extended periods of time to get in to see their provider. Some people are unable to establish a provider because many providers are not taking new patients. This shortage affects all population; Insured, underinsured, and uninsured. Community representatives agree, as our communities continue to grow, this problem will get worse. We need to develop a plan to incentivize primary

		care providers to want to come to rural areas and care for those populations.
Chronic disease management programs	**5.7**	Representatives stated that if you are insured and have a primary care provider, chronic condition issues will be managed. However, for the uninsured and populations that don't speak English, chronic conditions will most likely go undetected until there is a crisis.
Immunization programs	**3.2**	Representatives stated that if you are insured and have a primary care provider, chronic condition issues will be managed. However, for the uninsured and populations that don't speak English, chronic conditions will most likely go undetected until there is a crisis.
Improved health care quality	**4.7**	Representatives acknowledge that most providers do a good job with providing quality care. The issue is the lack of primary care providers, which creates a problem with access and time. If doctors don't have enough time scheduled to spend with their patients, it is difficult for them to see the full picture. To improve health care quality, the patient also needs to take responsibility for their health and advocate for their needs.
Integrated, coordinated care (less fragmented care)	**5.4**	Integrated/coordinated care is being worked on, but it is difficult because there are a variety of electronic medical record programs being used. Often times it appears that physicians are not collaborating and treating as a team. Utilizing electronic medical records in the way they are intended to be used could prevent duplication and provide an overall better experience for the patient.
Prenatal care programs	**4.5**	Most representatives believe that if you are under the care of a physician

		prenatal care is very well addressed. There are low cost programs available. However, in low income or uninsured populations, access could be a problem because these individuals may not know how to navigate through the system to find what is available to them.
Screening programs (cholesterol, diabetic, mammography, etc)	**5.0**	“These screenings save lives.” Although there are occasional health fairs, they do not capture the majority of the people who could benefit from these screenings. Individuals who have jobs that provide these services will get them. For many populations this is not a priority, because they are in survival mode not preventative mode. We need to create an effective way to promote screenings to all populations including those with language barriers. We need to have health fair events more regularly to meet the needs, which will allow better access for the working poor.

Social and Economic Needs		
Potential Health Needs	**Average Score**	**Summary of Community Representatives' Comments**
Children and family services	**6.0**	The overall consensus is that people need help learning how to parent. “We say failure isn’t costly, but, in this situation, it is very costly if children are not being parented well.” Supporting families and providing adequate services to teach parenting skills will pay high dividends down the road. It was also noted that, in the Hispanic population, the children speak both Spanish and English. So, when parents struggle with cultural change, the children become their navigators and are

		burdened with a lot of adult responsibilities. This also results in parents losing some control of the family.
Disabled services	**5.3**	Representatives agree that disabled services are something that are being worked on but we are a little behind the curve and it is slow moving. One large issue that was mentioned "The biggest issue for this population is transportation."
Early learning before kindergarten (such as a Head Start type program)	**5.9**	It is recognized by community representatives that early learning is a problem. Statistics show that a large number of kindergarteners do not meet the benchmark when they start school. Parents struggle with knowing how to get their children ready for kindergarten. Preparedness for kindergarten is a key element to success. "Idaho needs to fund preschool as a public school option." This will make it possible for all children to have the same educational opportunities. Currently access relies on your social economic status. If you can't afford to pay for it or you don't qualify for head start, your children do not get to attend preschool. "We need to treat this problem seriously because these children are our future."
Education: Assistance in gaining good grades in kindergarten through high school	**6.3**	Community representatives know that achieving good grades is important. Although there are some programs in place, we still need to do more. Teachers are overwhelmed with trying to meet test score outcomes and dealing with behavioral issues. There is awareness that if a student is not at the correct reading level by the third grade, they most likely will not attend college. "We don't have a culture that encourages kids to thrive." We need to identify students that are falling behind and help them.
Education: College education support and assistance programs	**4.1**	"50% of students in Idaho do not go on to college. We are not educating effectively. We may be getting the financial piece in place, but we are not getting the students to understand why higher education is important. This also causes a huge workforce issue." "Any post-

		secondary education is important. Many kids see successful parents and grandparents that did not get a degree. We need to make students aware of trade schools, certifications, and other skills that will help them be more successful.”
Elder care assistance (help in taking care of older adults)	**5.2**	Community representatives recognize that elder care assistance will become a growing problem as our population ages. Many family members are becoming in home care givers because there is a work force shortage, and it is expensive to hire an in home care giver.
End of life care or counseling (care for those with advanced, incurable illness)	**4.9**	Representatives acknowledge that in some areas we have good end of life care services but in other areas we need more services. It was also noted that there is not a lot available for the English as a second language population. “We are talking about end of life care now but end of life care bankrupts families. We need to educate people and talk about death. It is not something we can escape.”
Homeless services	**6.6**	Representatives believe the homeless population is growing and that there is a need for additional resources to help these people. The resources available now are not organized and target women and children. When it comes to the male homeless population, the services are very limited.
Job training services	**4.8**	It is recognized by community representatives that we have good trade programs through CSI such as welding, fork lift CDL and CNA, and dental assistant programs. The low income populations need support and encouragement even once they get a job. Retention is important. Often times this population will quit their job because of lack of lack of support. We need more career focused training. We have a lot of factories that require specialized training.
Legal Assistance	**5.8**	In the area of legal services, representatives feel there is a large need. We do not have

		enough resources for low income individuals and immigration services.
Senior services	**4.8**	Seniors are our largest growing demographic. Representatives feel we need to focus more on senior services and be aware that their needs are changing and help meet those needs. They also realize that funding continues to be cut, which brings additional challenges to those trying to coordinate services. “We have some fantastic people trying to help seniors, but they struggle with funding and volunteers.”
Veterans’ services	**5.0**	Many representatives believe that Twin Falls is doing a spectacular job with veteran services. “We moved our vet service officer to a full time position. We centralized all vet services to one location. The Twin Falls Veteran’s Council is also housed in this building.” Other representatives are concerned that we do not take care of our veterans as a whole population. “We do a terrible job of this when it comes to the social aspect. We must be sure our veterans are not hungry, alone and without proper mental health services.”
Violence and abuse services	**6.6**	Many representatives believe that violence and abuse go hand in hand with mental health as well as substance abuse. “We have no focus on prevention.” The services we do offer are mainly for the victims. Many felt we need programs to help people understand and control their anger.

Physical Environment Needs		
Potential Health Needs	**Average Score**	**Summary of Community Representatives' Comments**
Affordable housing	**7.6**	Representatives across the board expressed concern for the lack of affordable housing. Multiple families are living in one home just to get by. With the shortage in housing inventory, it is difficult to recruit a work force for our growing economy, because there is nowhere to live.
Healthier air quality, water quality, etc.	**3.5**	Although it is recognized that this is a dairy county and the air gets a little stagnant, most representatives say: "There is great environmental awareness in our county, and we take care of our resources." As for water quality, it could be better, but we meet the standards.
Healthy transportation options (sidewalk, bike paths, public transportation)	**5.8**	Some areas are great for walkability and other areas are terrible. Many representatives believe that, although healthy transportation options are not perfect, they are being worked on. "The City and County are working on improving transportation with new policy. When new construction is planned, they are required to have a sidewalk. We now have a three mile bike path. It takes time, but we are beginning to address it."
Transportation to and from appointments	**7.3**	Representatives share that we are in a period of thinking about transportation options and what it should look like. As the community continues to grow, we will be required to have a fixed public transportation route in place. Currently transportation is a struggle in our county.

Utilizing community representative input

The community representative interviews are used in a number of ways. First, our representatives' input ensures a comprehensive list of potential health needs is developed. Second, the scores provided are an important component of the overall prioritization process. The community representative need score is 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 representative input has significant influence on the overall prioritization of the health needs.

There are a number of reoccurring themes that frame the way community representatives believe we can improve community health. These themes act as some of the underlying drivers for the way representatives select and score each potential health need. A summary of some of these themes is provided below.

- Many representatives feel the largest determining factor in community health is a person's social/economic status. These representatives hold the belief that the best way to improve the health of the people in our community is to offer more social programs such as affordable universal health insurance, expanding Medicaid, and/or offering more clinics that charge based on the ability for a person to pay. These representatives see a significant negative impact to community health when people are uninsured or underinsured. Some feel that programs related to changing health behaviors to help with needs such as weight loss, diabetes, and tobacco use, are not effective. They believe most uninsured/underinsured people only seek help for health issues after a health crisis has occurred. They do not believe there is good evidence that behavioral change programs are able to motivate most people to change. They feel that, unless people want to change, they won't. Leaders with this view tended to give low scores to potential health behavior needs.

- Many representatives feel the largest determining factor in community health is how people behave. These leaders believe social programs will remain unaffordable unless we hold people accountable to a central wellness component. They think that unless people take responsibility for their own wellness, we will continue to see rising health care costs and poor community health. In their view, the key to better community health is to provide prevention and youth education programs capable of influencing long term health behavior. Without accountability for healthy behavior, they feel social programs create unhealthy dependencies that could be passed on from generation to generation.

- Finally, some leaders feel that neither social programs nor health behavior programs will solve the health care crisis our nation faces. These leaders believe we need a profound reorganization of our health care system, making it more efficient and cost-effective. For example, these leaders think we needed a single health care advisor to coordinate each person's care using the patient centered medical home (PCMH) model. Others believe we need to do away with the fee-for-service model entirely.

The varied beliefs and opinions of community representatives underscore the complexity of community health. Nevertheless, the representatives shared insights bring into focus an appropriate course of action that can lead to 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 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 substance abuse. 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 often last a lifetime.

- Finally, our health care system needs to be more efficient. There is evidence that patient care 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 representative 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 representative and health factor scores is described in the steps below.

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

   First, each health representative need is matched to one or more health factors or outcomes. For example, the health need “wellness and prevention programs” 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 representative score is added to its related health factor score to arrive at a combined total score. This process effectively utilizes both the community representative information and the secondary health factor data to create a transparent and balanced approach for prioritization. The community representative 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 total score for wellness programs for diabetes is 21 and the total score for wellness programs for arthritis is only 12, it becomes clear that wellness and prevention programs for diabetes have a higher potential population health impact. Combining the representative and health factor scores can also help prioritize adult versus teen needs allowing us to build programs for the most affected population groups.

Out of the over 60 health needs and factors we analyze in our CHNA, five have scores of 18.7 or higher. These health needs represent **the top 10th percentile** and **are considered to be our significant, high priority health needs**. These high priority needs are highlighted in dark orange in the summary tables found on the following pages. A total of nine health needs have scores of 17.5 or higher representing the top 15th percentile. We highlighted these in the lighter shade of orange to make it easy to identify the next level of high ranking needs.

The summary tables provide each health need’s prioritization score as well as demographic information about the most affected populations. Demographic data defining 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 obesity, diabetes, and mental illness. Diabetes and obesity rank as high priority needs because they 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 of any mental illness (AMI) in the nation. Our community representatives provided relatively high scores for these needs as well.

Some populations are more affected by these health needs than others. For example, people with lower income and educational levels in our community have higher rates of diabetes and obesity.

Health Behavior Needs Summary Table

Table Color Key
Dark Orange = High priority: Total score in the top 10th percentile
Light Orange = Total score in the top 15th percentile
White = Total score below the 15th percentile

Identified Community Health Needs	Related Health Factors and Outcomes	Populations Affected Most*	Total Score
Weight management programs	Obese/Overweight adults	No college degree, Hispanic	22.4
	Obese/Overweight teenagers	Income <$35,000, Hispanic	19.4
Wellness and prevention programs	Diabetes	Income < $50,000, No high school diploma	18.7
	Mental illness		18.7
	Obese/Overweight adults	No college degree, Hispanic	21.7
Tobacco prevention /cessation programs	Smoking adult	Income < $35,000, No high school diploma	18.4
Substance abuse services	Drug misuse	Unemployed, incomes <$50,000, males < 34 years old	18
Wellness/prevention	Suicide		17.7
	Skin cancer		17.5

Health Behavior Needs Summary Table, Continued

Identified Community Health Needs	Related Health Factors and Outcomes	Populations Affected Most*	Total Score
Access to healthy foods	Food environment		15.6
Exercise programs/education/ opportunities	Exercise opportunity		15.1
	Adult physical activity	Income < $50,000, Hispanic, No college	14.1
	Teen exercise		15.1
Nutrition education	Adult nutrition	No college	14.7
	Teen nutrition		14.7
Safe sex education programs	STDs		15.8
	Teen birth rate		15.8
Substance abuse services and programs	Excessive drinking	Income <$35,000, No high school diploma, Males 18-34	15
	Alcohol impaired driving deaths		14
Tobacco prevention and cessation programs	Smoking teen		14.4
Wellness, prevention, and education programs for cancer	Cancer - all		11.5
	Breast cancer	Female, Age 40+	14.5
	Colorectal cancer		11.5
	Leukemia		8.5
	Lung cancer	Income < $35,000, No high school diploma	10.5
	Non-Hodgkin's lymphoma		10.5
	Pancreatic cancer		10.5
	Prostate cancer	Male age 60+	13.5

Health Behavior Needs Summary Table, Continued

Identified Community Health Needs	Related Health Factors and Outcomes	Populations Affected Most*	Total Score
Wellness and prevention programs	Accidents		16.7
	AIDS	African American, Males <24	12.7
	Alzheimer's	Age 65 +	12.7
	Arthritis	Income < $35,000, Non- Hispanic, No college, Overweight, Age 65 +	11.7
	Asthma	Income < $35,000	10.7
	Cerebrovascular diseases		12.7
	Flu/pneumonia		12.7
	Heart disease		13.7
	High blood pressure	Income < $35,000, No college, Overweight, Age 65 +	16.7
	High cholesterol	Income < $35,000, No high school diploma, Age 55+	16.7
	Nephritis		11.7
	Respiratory disease		15.7

* Information on affected populations included in table when known.

Clinical Care Category Summary

High priority clinical care needs include: Affordable health insurance; increased availability of behavioral health services; and chronic disease management for diabetes. Affordable health insurance and the availability of behavioral health services scored as top health needs by our community health representatives. In addition, affordable health insurance ranks as a top priority need because our service area has a relatively high percentage of people who are uninsured. Availability of behavioral health services also ranked as a top priority because our community has a shortage of behavioral health professionals. Diabetes chronic disease management ranks high because we have a high percentage of people dying of diabetes in our community, and it is a contributing factor to a number of other health concerns.

As shown in the table below, high priority clinical care needs are often experienced most by people with lower incomes and those who have not attended college.

Clinical Care Needs Summary Table

Table Color Key
Dark Orange = High priority: Total score in the top 10th percentile
Light Orange = Total score in the top 15th percentile
White = Total score below the 15th percentile

Identified Community Health Needs	Related Health Factors and Outcomes	Populations Affected Most*	Total Score
Affordable health insurance	Uninsured adults	Income < \$50,000, Hispanic, No college	21.2
Availability of behavioral health services (providers, suicide hotline, etc)	Mental health service providers	Income < \$50,000	19.8
Chronic disease management programs	Diabetes	Income < \$50,000, No high school diploma	18.7

Clinical Care Needs Summary Table, Continued

Identified Community Health Needs	Related Health Factors and Outcomes	Populations Affected Most*	Total Score
Affordable care for low income individuals	Children in poverty	Income < $50,000, Age < 19	16.2
Affordable dental care for low income individuals	Preventative dental visits		15
Availability of primary care providers	Primary care providers		17
Chronic disease management programs	Arthritis	Income < $35,000, Non-Hispanic, No college, Overweight, Age 65 +	11.7
	Asthma	Income < $35,000	10.7
	High blood pressure	Income < $35,000, No college, Overweight, Age 65 +	16.7
Immunization programs	Children immunized		10.2
	Flu/pneumonia		10.2
Improved health care quality	Preventable hospital stays		10.7
Integrated, coordinated care (less fragmented care)	No usual health care provider		15.4
	Preventable hospital stays	Refugees, Hispanics, Age 65 +	11.4
Prenatal care programs	Prenatal care 1st trimester	Hispanic, No high school diploma	12.5
	Low birth weight		11.5
Screening programs (cholesterol, diabetic, mammography, etc)	Cholesterol screening	Income < $35,000, No high school diploma, Age 55 +	15
	Colorectal screening	Income < $35,000, No college, Age 50+	11
	Diabetic screening		14
	Mammography screening	Income < $50,000	17

* Information on affected populations included in table when known.

Social and Economic Factors Category Summary

In the social and economic category, children and family services had the highest ranking.

Social and Economic Needs Summary Table

Table Color Key
Dark Orange = High priority: Total score in the top 10th percentile
Light Orange = Total score in the top 15th percentile
White = Total score below the 15th percentile

Identified Community Health Needs	Related Health Factors and Outcomes	Populations Affected Most*	Total Score
Children and family services	Children in poverty	Income < $35,000	16
	Inadequate social support		13
Disabled services *			13.3
Early learning before kindergarten (such as a Head Start type program)	High school graduation rate		12.9
Education: Assistance in achieving good grades in kindergarten through high school	High school and college education rates		13.3
Education: College education support and assistance programs	High school and college education rates		11.1
Elder care assistance (help in taking care of older adults)			13.2
End of life care or counseling (care for those with advanced, incurable illness)			12.9

Social and Economic Needs Summary Table, Continued

Identified Community Health Needs	Related Health Factors and Outcomes	Populations Affected Most*	Total Score
Homeless services	Unemployment rate		12.6
Job training services	Unemployment rate		10.8
Legal assistance			13.8
Senior services	Inadequate social support	Age 65 +	11.8
Veterans' services	Inadequate social support		12
Violence and abuse services	Violent crime rate		12.6

* Information on affected populations included in table when known.

Physical Environment Category Summary

In the physical environment category, affordable housing and transportation to and from appointments had the highest rankings. These needs received relatively high scores from our community representatives.

Physical Environment Needs Summary Table

Table Color Key
Dark Orange = High priority: Total score in the top 10th percentile
Light Orange = Total score in the top 15th percentile
White = Total score below the 15th percentile

Identified Community Health Needs	Related Health Factors and Outcomes	Populations Affected Most*	Total Score
Affordable housing	Severe housing problems	Income < $50,000	15.1
Healthier air quality, water quality, etc	Air pollution particulate matter		12.5
	Drinking water violations		10.5
Healthy transportation options (sidewalk, bike paths, public transportation)	Long commute		10.8
	Driving alone to work		13.8
Transportation to and from appointments		Income < $35,000, Rural populations, Age 65 +	15.3

* Information on affected populations included in table when known.

Significant Health Needs

We analyze over 60 potential health needs and health factors during our CHNA process. Measurably improving even one of these health needs across our entire community's population requires a substantial investment in both time and resources. Therefore, we believe it is important to focus on the needs having the highest potential to positively impact community health. Using our CHNA process, health needs with the highest potential to improve community health are those needs ranking in the top 10^{th} percentile of our scoring system. The following needs rank in the top 10^{th} percentile:

- Prevention and management of obesity for children and adults
- Prevention and management of diabetes
- Prevention and management of mental illness
- Availability of behavioral health services
- Affordable health insurance

After identifying the top ranking health needs, we organize them into groups that will benefit by being addressed together as shown below:

Group #1: Improve the Prevention and Management of Obesity and Diabetes

Group #2: Improve Mental Health

Group #3: Improve Access to Affordable Health Insurance

We call these groups of high ranking needs our "significant health needs" and provide a description of each of them next.

Significant Health Need # 1: Improve the Prevention and Management of Obesity and Diabetes

Obesity and diabetes are two of our community's most significant health needs. Over 60% of the adults in our community and more than 25% of the children in our state are either overweight or obese. Obesity and diabetes are serious concerns because they are associated with poorer mental health outcomes, reduced quality of life, and are leading causes of death in the U.S. and worldwide. [171]

Impact on Community

Obesity costs the United States about $150 billion a year, or 10 percent of the national medical budget.[172] Besides excess health care expenditure, obesity also imposes costs in the form of lost productivity and foregone economic growth as a result of lost work days, lower productivity at work, mortality and permanent disability. [173] Diabetes is also a serious health issue that can even result in death.[174] Direct medical costs for type 2 diabetes accounts for nearly $1 of every $10 spent on medical care in the U.S. [175] Reducing obesity and diabetes will dramatically impact community health by providing an immediate and positive effect on many conditions including mental health; heart disease; some types of cancer; high blood pressure; dyslipidemia; kidney, liver and gallbladder disease; sleep apnea and respiratory problems; osteoarthritis; and gynecological problems.

How to Address the Need

Obesity is a complex health issue to address. Obesity results from a combination of causes and contributing factors, including both behavior and genetics. Behavioral factors include dietary patterns, physical activity, inactivity, and medication use. Additional contributing social and economic factors include the food environment in our community, the availability of resources supporting physical activity, personal education, and food promotion.

Obesity and type 2 diabetes can be prevented and managed through healthy behaviors. Healthy behaviors include a healthy diet pattern and regular physical activity. The goal is to achieve a balance between the number of calories consumed from foods with the number of calories the body uses for activity. According to the U.S. Department of Health & Human Services Dietary Guidelines for Americans, a healthy diet consists of eating whole grains, fruits, vegetables, lean protein, low-fat and fat-free dairy products and drinking water. The Physical Activity Guidelines for Americans recommends adults do at least 150 minutes of moderate intensity activity or 75 minutes of vigorous intensity activity, or a combination of both, along with 2 days of strength training per week. [176]

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[171] https://www.cdc.gov/obesity/adult/causes.html
[172] http://www.cdc.gov/cdctv/diseaseandconditions/lifestyle/obesity-epidemic.html
[173] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5409636/
[174] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System
[175] America's Health Rankings 2015-2018, www.americashealthrankings.org
[176] https://www.cdc.gov/obesity/adult/causes.html

St. Luke's intends to engage our community in developing services and policies designed to encourage proper nutrition and healthy exercise habits. Echoing this approach, the CDC states that "we need to change our communities into places that strongly support healthy eating and active living." [177] These health needs can also be improved through evidence-based clinical programs.[178]

Affected Populations

Some populations are more affected by these health needs than others. For example, low income individuals and those without college degrees have significantly higher rates of obesity and diabetes.

[177] http://www.cdc.gov/cdctv/diseaseandconditions/lifestyle/obesity-epidemic.html

[178] America's Health Rankings 2015-2018, www.americashealthrankings.org

Significant Health Need #2: Improve Mental Health

Improving mental health ranks among our community's most significant health needs. Idaho has one of the highest percentages (21.6%) of any mental illness (AMI) in the nation and shortages of mental health professionals in all counties across the state. [179] Although the terms are often used interchangeably, poor mental health and mental illness are not the same things. Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. A person can experience poor mental health and not be diagnosed with a mental illness. We will address the need of improving mental health, which is inclusive of times when a person is experiencing a mental illness.

Mental illnesses are among the most common health conditions in the United States.

- More than 50% of Americans will be diagnosed with a mental illness or disorder at some point in their lifetime.
- One in five will experience a mental illness in a given year.
- One in five children, either currently or at some point during their life, have had a seriously debilitating mental illness.
- One in twenty-five Americans lives with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression. [180]

Impact on Community

Mental and physical health are equally important components of overall health. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Mental illness, especially depression, increases the risk for many types of physical health problems, particularly long-lasting conditions like stroke, type 2 diabetes, and heart disease.

How to Address the Need

Mental illness often strikes early in life. Young adults aged 18-25 years have the highest prevalence of mental illness. Symptoms for approximately 50 percent of lifetime cases appear by age 14 and 75 percent by age 24. Not only have one in five children struggled with a serious mental illness, suicide is the third leading cause of death for young adults.[181]

Fortunately, there are programs proven to be effective in lowering suicide rates and improving mental health. [182] The majority of adults who live with a mental health problem do not get corresponding treatment.[183] Stigma surrounding the receipt of mental health care

[179] Mental Health, United States, 2009 - 2016 Reports, SAMHSA, www.samhsa.gov
[180] https://www.cdc.gov/mentalhealth/learn/index.htm
[181] https://www.nimh.nih.gov/health/statistics/mental-illness.shtml
[182] https://www.samhsa.gov/suicide-prevention/samhsas-efforts
[183] Substance Abuse and Mental Health Services Administration, Behavioral Health Report, United States, 2012 pages 29 - 30

is among the many barriers that discourage people from seeking treatment.[184] Increasing physical activity and reducing obesity are also known to improve mental health.[185]

Our aim is to work with our community to reduce the stigma around seeking mental health treatment, to improve access to mental health services, increase physical activity, and reduce obesity especially for our most affected populations**.** It is also critical that we focus on children and youth, especially those in low income families, who often face difficulty accessing mental health treatment. In addition, we will work to increase access to mental health providers.

Affected Populations
Data shows that people with lower incomes are about three and a half times more likely to have depressive disorders.[186]

[184] Idaho Suicide Prevention Plan: An Action Guide, 2011, Page 9
[185] http://www.cdc.gov/healthyplaces/healthtopics/physactivity.htm, http://www.cdc.gov/obesity/adult/causes.html
[186] Idaho 2011 - 2016 Behavioral Risk Factor Surveillance System

Significant Health Need #3: Improve Access to Affordable Health Insurance

Our CHNA process identified affordable health insurance as a significant community health need. The CHNA health indicator data and community representative scores served to rank health insurance as one of our most urgent health issues.

Impact on Community

Uninsured adults have less access to recommended care, receive poorer quality of care, and 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.[187]

Based on the evidence to date, the health consequences of the uninsured are real. [188] Improving access to affordable health insurance makes a remarkable difference to community health. Research studies have shown that gaining insurance coverage through the Affordable Care Act (ACA) decreased the probability of not receiving medical care by well over 20 percent. Gaining insurance coverage also increased the probability of having a usual place of care by between 47.1 percent and 86.5 percent. These findings suggest that not only has the ACA decreased the number of uninsured Americans, but has substantially improved access to care for those who gained coverage. [189]

How to Address the Need:

We will work with our community partners to improve access to affordable health insurance especially for the most affected populations. In November 2018, Idaho passed a proposition to expand Medicaid. In November 2018, Idaho passed a proposition to expand Medicaid. In the coming years, we will see how much the resulting legislation increases the percentage of people who have health insurance and the positive impact it has on health.

Affected populations:

Statistics show that people with lower income and education levels and Hispanic populations are much more likely not to have health insurance.[190]

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[187] University of Wisconsin Population Health Institute. *County Health Rankings* 2010-2018. Accessible at www.countyhealthrankings.org.

[188] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881446/

[189] https://www.ncbi.nlm.nih.gov/pubmed/28574234

[190] Ibid

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 with trusted partners to improve community health outcomes and well-being toward the goal of attaining the healthiest community possible.

Future Community Health Needs Assessments

We intend to reassess the health needs of our community on an ongoing basis and conduct a full community health needs assessment once every three years. St. Luke's next Community Health Needs Assessment is scheduled to be completed in 2022.

History of Community Health Needs Assessments and Impact of Actions Taken

In our 2016 CHNA, St. Luke's Magic Valley identified three groups of significant health needs facing individuals and families in our community. Each of these groups is shown below, along with a description of the impact we have had on addressing these needs over the past three years.

Group 1: Improve the Prevention & Management of Obesity and Diabetes
Two of the highest ranking health needs in our 2016 CHNA were prevention and management of obesity and diabetes for children and adults. Because these needs reinforce one another, we grouped them together.

Over the last three years, St. Luke's Magic Valley has engaged hundreds of individuals in weight loss, nutrition, and fitness programs. These programs ranged from free body- mass index screenings for both community members and St. Luke's employees to YEAH! a wellness program that promotes healthier lifestyles for children and their families, and many other programs and partnerships.

YEAH! (Youth Engaged in Activities for Health) is a physical activity, nutrition and behavior change program that helps participating children and families create a healthier lifestyle. In 2016, there was a 65% completion rate with 95% of the children who completed the program showing improvement in at least 1 area of weight, waist circumference and/or BMI. In 2017 one on one sessions took place for families with a Registered Dietitian to address health concerns as larger scale strategies were investigated for the program. The St. Luke's YEAH team identified a school based program to pursue over the next few years. St. Luke's Magic Valley has identified schools with interest in partnership as well as local sustainability partners including the YMCA of Magic Valley, South Central Public Health Department and the Mountain States Tumor Institute Community Health team.

Also supporting youth weight management is the annual Kids Fest community event. St. Luke's has continued to be a sponsor of this event in partnership with KMVT. St. Luke's aims to provide information on eating well, moving more and maintaining a healthy weight with over 10 booths at the event. At the 2018 event there were an estimated 4000 participants that attended and 108 individuals who completed the fun run/walk. From 2016 to 2018 participation grew by over 1000 participants. The fun run has fluctuated each year, but has remained over 100 participants at each event.

St. Luke's participation in the Walking Challenge has offered a great way to engage with our communities and students as well. In 2016 and 2017 St. Luke's Magic Valley and Jerome had 14 individuals competing for steps and engaging in walking with our local schools to increase visibility to the importance of walking for our health. In 2018 St. Luke's Magic Valley and Jerome continued to support the program with 2 teams competing to raise money for their local school. Administrators, Physicians and Community Health personnel made efforts to walk with our local schools and visit with the students about the impact walking can have on health. Over the course of this CHNA period, St. Luke's Magic Valley also had the chance to donate funds to Rock Creek, Jefferson and Horizon Elementary Schools to establish walking paths. These were all completed by September of 2018. At Rock Creek Elementary school, they had a ribbon cutting that coinciding with a healthy family night in October 2018. This funding has supported local schools and the community with infrastructure to building healthier children and families. At Rock Creeks event, students tracked their steps and logged over 951,000 steps on the healthy family night alone! St. Luke's is proud to support such wonderful projects that support our community and has seen what a positive impact it can have to connect with students.

St. Luke's is a major sponsor of the Magic Valley Health Fair, an annual event that provides health education and screening and promotes healthy living. As an example, in from 2016 to 2018, St. Luke's has utilized the local health fair to kick off a weight loss challenge. During that time local participation increased from just 40 participants to 168. Of the 168 who signed up in 2018, there were 150 people who signed up at the health fair alone. Typically, during each weight loss event we have about 1/3 of participants who achieve the final goal of 7% weight lost by year end. Of the 107 Magic Valley participants in 2017, 44 of them achieved the goal and ended up losing over 1000 total pounds. This program is done in partnership with many community organizations including College of Southern Idaho, YMCA of the Magic Valley and Lincoln County Recreation Center. Now in the last year of our 2016 Implementation Plan for the 2016 CHNA cycle, we project there have been over 1,500 people that have participated in this annual event across the state of Idaho.

Also effective in motivating people to lose weight and maintain weight loss are programs targeting employee populations. The St. Luke's Occupational Health and Wellbeing Department is a population health and well-being initiative that aims to engage, educate and empower employees and their families, while creating a supportive, safe environment to achieve their optimal health and resiliency.

From 2017-2018, St. Luke's employees and spouses have seen a 75% improvement in hypertension compliance, 68% improvement in pre-hypertension compliance, 49% improvement in Pre-diabetes compliance, 44% improvement in diabetes compliance, 12% improvement in tobacco use compliance and 9% improvement in BMI compliance. St. Luke's Healthy U, a program provided free of charge to our employees and their spouses. Engagement in the program is high at 94% for eligible employees and 83% for spouses.

Occupational Health and Wellbeing engages with many employer groups in the Magic Valley as well. The department went live on the medical record, EPIC, in August of 2018. This has allowed for screenings to be a part of a patient's medical record and creates more visibility and integration with providers. This allows patients to receive their screening results immediately and securely though MyChart. It also allows for direct referrals to be made to programs that may help patients achieve their goals.

In October 2018 St. Luke's participated in College of Southern Idaho Employee and Spouse Health Fair. Occupational Health and Wellbeing nurses provided flu shots for benefit eligible employees and spouses during this time and answered wellness related questions. Collaboration with the college continues to be a priority. The City of Twin Falls continues to provide annual wellness screenings for their employees and spouses enrolled on Select Health Plan as well with 95% involvement in 2016, 98% in 2017 and 98% in 2018.

Lastly our clinics have continued to screen for Body Mass Index (BMI) during regular physician visits and routine checkups. When patients are identified as being overweight or obese, primary care physicians (PCP) provide counseling and direction towards local weight management programs. Our PCP's have achieved 42% of all patients being screened for BMI.

Within our CHNA, we have grouped together the prevention and management of diabetes and weight management because we believe coordination of these programs will produce the best results.

Diabetes continues to be a nationwide health challenge for patients and medical practitioners alike, yet in the rural communities of southcentral Idaho, we are making a positive impact through a number of programs and by recruiting greatly needed physician specialists:

- In the primary care physician clinic setting, St. Luke's Clinics continue efforts to improve CMS MSSP composite scores for patients with diabetes, and have implemented a FY 2016 goal that 15% or fewer of their patients with diabetes will have a hemoglobin A1C >9. Clinics in the Magic Valley have continued to improve in this area, our rates for 2016 rates were at 18%, by the end of FY18 11% of patients had an A1C >9 and current rates are at 10%. Further bolstering this effort is the implementation of a Team-Based Model of Care (physicians, nurse practitioners, certified RN diabetes educators, and dietitians) for patients diagnosed with diabetes and of scorecards that enable providers to measure their effectiveness in diabetes management and make improvements where indicated.

- In partnership with our primary care clinic providers, our Diabetes Management team (diabetes educators and nurse practitioners) provides free, monthly community classes to individuals at high risk or who have been identified with having pre-diabetes. Through early identification, education, and behavior modification, individuals at risk for developing type II diabetes can be empowered with the tools to avoid the disease.
- In 2016, St. Luke's Magic Valley successfully recruited a full-time endocrinologist who began practice in April. Dr. Malone has been a physician champion spearheading an initiative with local primary care providers to utilize diabetic registries to reach out to patients with an A1C >9.0 to 1) receive diabetes education and 2) regularly check blood sugars, both of which are shown to reduce A1C's. In addition, by FY18 all primary care providers completed the Diabetes Care Pathway Guideline (CPG), an educational program designed to standardize the delivery of evidence based care for diabetes.

Through various programs and tactics tailored to children, adults, and employee populations, we are making a difference for our community when it comes to making lifestyle choices that support good health, and a strong commitment to our CHNA goals is helping us to continue down this important path. Our Community Health Improvement Fund also supports local organizations who are working to make a difference on the obesity and diabetes rates in our community. See the table below with all organizations funded over the past three years that impact obesity and diabetes efforts:

Organization	**Program**	**Description**	**Awareness & Outcomes**	**Youth Participants**	**Community Participants**
Ageless Senior Center	Senior Center Meal Program	Healthy meals at a low cost			
Boys & Girls Club of Magic Valley	Triple Play Fitness and Healthy Habits Programs	Program for age 5-18 to increase activity, learn nutrition information and behavior change tools.	Increased activity and pre and post evaluation of knowledge of health topics.	175	
Boys & Girls Club of Buhl	Triple Play Fitness and Healthy Habits Programs	Program for age 5-18 to increase activity, learn nutrition information and	Increased activity and pre and post evaluation of	100	

		behavior change tools.	knowledge of health topics.		
Family Health Services	Walk with a Doc Program	Implement the Walk with Doc program.	Creates a platform to prevent an increase in cardiovascular disease and diabetes. Targets at-risk families and link them to activities designed to naturally increase physical activity, educate about healthy diet and nutrition and offer strategies for sustainable weight loss for the entire family.		
Gooding Senior Center	Home Delivered Meals	Cover the cost of home delivered meals for seniors who are in need but unable to pay.	Necessary nourishment and companionship from those providing meals.		
Gooding Volunteer Group	Playground Project	Replace unsafe playground equipment as a part of the park revitalization program.	New playground equipment		
Helping Hearts & Hands	Meal Program	Provide additional resources to buy food in bulk qualities when it is on sale at	Meals to people in need.	2045	3034

		local suppliers and transportation costs for the Idaho Foodbank deliveries.			
Heritage Academy Charter School	Heritage Healthy Play Program	Create an accessible playground and fitness area.	Increase activity for children.		
Idaho Food Bank	Cooking Matters	Educating people how to cook.	Build the skills needed to make healthy meals, educate on importance and provide tools to do so.		315
Idaho Food Bank	Mobile Pantry	Support the Mobile Pantry program that provides food assistance in rural communities to relieve hunger and promote health.	Mobile Pantry provides a refrigerated truck full of food to communities that do not have other means of food assistance. The program collaborates with local organizations and volunteers to distribute this food in 11 communities in the Magic Valley.		2412/ quarter
Jerome Food Ministry	Food Pantry & Soup Kitchen	Purchase 4 new trailer tires for an enclosed trailer and operational costs. New surveillance	Minimize food waste by providing nutritious & healthy meals/food in a safe &		1457 meals/ month

		system and help with operational costs.	wholesome dining/shopping experience while fostering respect		
Jerome Senior Citizen Center Inc.	Senior Center Meal Program	Provide meals to seniors 5 days per week and home delivered meals 7 days a week.	Allow Jerome's seniors to stay independent longer, help ensure adequate nutrition with fresh food and provide daily exercise programs to help with weight management and stability. We also provide socialization activities to help alleviate boredom, depression and loneliness.		550 meals/ week
Jerome Recreation District	Summer Kids Camp	Educate and encourage kids in fitness and nutrition at a free camp that builds self-esteem and a healthy lifestyle.	Improved health and nutrition for children and families who attend.	130	
Jerome School District	Middleschool Workout Room Makeover	New equipment for the workout space.	Provide education and opportunity to be active to combat obesity in Jerome’s teens.		

Magic Valley YMCA	Meals	Provide healthy meals at the YMCA Day Camp		40-60	
Minidoka Senior Center	Senior Center Meal Program	Purchase packaging and increase food sources			214 meals/day
Mustard Seed Ministries	Install a commercial kitchen & software program.	Generating resources to meet the physical, spiritual and emotional needs of the community.	Funds will be used to assist with installation of a commercial kitchen and provide a space to hold Cooking Matters education classes for low income members of the community. The software will also allow for better tracking.		3909/year
Salvation Army	All About KIDS - Keeping In Desirable Shape	Enhance the opportunities provided to children through our program "It's all about KIDS – Keeping In Desirable Shape.	The purpose of this project is to build opportunities to provide low income children access to healthy food options, and receive exercise.		
Twin Falls Senior Center	Meals on Wheels	Meals on Wheels for homebound elderly and those who are 50 and over who don't qualify for Medicaid or Medicare.			1467/meals /quarter

West End Senior Center	Senior Center Meal Program	Provide nutritious, healthy meals to the most vulnerable, isolated homebound seniors to better sustain their quality of physical and mental health.			8000-9000 meals/year
South Central Public Health Department: WIC	World Breastfeeding Week	Promote the health and benefits of breastfeeding through education, awareness, and support during World Breastfeeding Week.	Awareness and decreased stigma around breastfeeding.		

Group 2: Improve Mental Health & Reduce Suicide
Programs to address mental illness and availability of mental health services providers were identified as high-priority community health needs. Suicide prevention and substance abuse were ranked above the median. Programs designed to serve these needs have been grouped together because we believe they reinforce one another.

Depression screening and integration of Behavioral Therapists in primary care have been two priority focus areas. Below is the detailed information on the accomplishment of these focus areas.

<u>Depression Screenings:</u>

This focus of this program expanded greatly from the initially proposed area of focus, following a TJC Sentinel Event Alert, published in February 2016. This Alert noted great concern for the risk of suicide, and indicated the need to more effectively screen, assess risk, provide treatment as well as assure for proper discharge and follow up care for those determined to be at risk. This article noted the need to focus upon several patient care areas within which assessment of risk should be completed, including Primary Care, Behavioral Health and Inpatient/Emergency Department settings. As such, our program implementation changed in order to reflect this need.

<u>Inpatient and Emergency Department Environments of Care</u>: In order to incorporate these recommendations in these environments, patients (12 years and older) seen in the Emergency Department and those admitted to the hospital in Jerome and Magic Valley (as well as across the St. Luke's Healthcare System) are screened for risk of self-harm. If their screen is positive, appropriate precautionary steps are taken in order to assure for safety of the patients, as well as assuring for appropriate disposition for care while in our facilities and for post treatment care as well.   A joint workgroup of representatives from Behavioral Health, Emergency Department, Nursing Center of Excellence, Compliance, and other department across the healthcare system came together in order to develop and implement this process, which began in July 2017. Initial as well as continuous review of these processes, indicated nearly 100% compliance with this screening process. As such, the continuous monitoring of compliance with this screening process was delegated to the local departmental leaderships.

Primary Care Environment of Care: In order to effectively and efficiently incorporate these recommendations into the Primary Care setting, the decision was made to incorporate both the depression screening and risk screening into one tool, which would accomplish both tasks at one time. A screening tool was put together (the PHQ3) utilizing two screening questions for depression and one screening question for self-harm risk. If a patient has a positive score for depression, they are then administered a more thorough depression screening (the PHQ9). If a patient scores positive for self-harm risk, the provider then administers a more thorough assessment of risk (the Columbia Suicide Severity Rating Scale).

A joint workgroup of Primary Care and Behavioral Health team members worked together in order to implement this process, and it was successfully accomplished in July 2018. In this process, all patients between 12-17 years of age are screened for depression and risk of self-harm. In addition, all patients 18 years and older are screened every 12 months. In addition to the screening process, it also necessitated a joint effort between these two service lines to assure the appropriate level of care for those who screened positively for both depression and suicide, and in particular for those at high risk for suicide. This has led to the creation of emergent appointment slots available daily, specifically set aside for these Primary Care providers.

Future Work: Future work in this area is ongoing in the Behavioral Health Clinics. Although the Jerome Buhl, and Magic Valley Behavioral Health Clinics have a screening process in place for depression and suicide, there is a wide variance in terms of how this is approached across the system. In order to align these with best practices and reduce variation, a Behavioral Health Service Line workgroup, including representatives from across the system, are developing a screening process, aligned with that stood up in the Primary Care setting.

In addition, the Behavioral Health Clinic at the Renaissance Plaza was recently approved to implement a pilot program, utilizing electronic tablets (e.g., IPads) to administer the screening instruments to patients. This will reduce the time associated with these tools. As well, it will greatly enhance the manner within which this data can be displayed for both the provider and the patient, allowing the patient to see their progress as they move forward in their treatment.

In the future, additional screening will also be explored for implementation in specialty clinics. As we are aware, many of our patients are seen regularly in clinics such as Cardiology, Endocrinology and even the Pain Clinic. They may actually see these providers more than their Primary Care provider. As such, it is imperative to assure that these patients, many of whom may be at a higher risk for depression and suicide, based upon their chronic medication conditions, are also screened appropriately.

Data:

Introducing a new screening process to the large numbers of clinics and providers across our system, is a monumental task. It involves the engagement of our Primary Care providers and their clinical staff to the need for this screening process, yet within a myriad of other required/mandated screening processes already in place. In addition, it involves the education of our providers to the new processes, workflows and standards of practice associated. Recognizing these hurdles, the initial goal for our Primary Care clinics for the completion of these screening measures was set at 80%.

A recent review of the data (10/1/18 to 4/16/19) in regard to the depression screening process within the Magic Valley, Jerome, and Buhl Clinics, revealed the following:

Percentage of Pediatric PHQ3 screenings completed based upon criteria (Patients aged 12-17):

Across all clinics: 73.9%

Percentage of Pediatric patients further assessed for Depression with the PHQ9 based upon positive depression result of the PHQ3:

Across all clinics: 97.7%

Percentage of Adult PHQ3 screenings completed based upon criteria (no screening in the past 12 months):

Across all clinics: 53.9%

Percentage of Adult patients further assessed for Depression with the PHQ9 based upon positive depression result of the PHQ3:

Across all clinics: 98.7%

(**** This data is based only upon the standardized process put in place as part of this Depression/Risk Screening workflow. Providers documenting in another fashion, not part of this standardized process, would not be included in this data ****)

Although certainly additional work is necessary in order to reach the state goal, positive progress is clearly evidenced in the data provided.

Of note, data is not available for review in regard to the suicide risk screening process as of yet, as the process for culling this data from Epic is still being built.

Behavioral Health Integration into Primary Care:

The integration of Behavioral Health Care Providers into Primary Care settings has occurred with two different types of providers. The first, co-located therapists, were the first type of integrated behavioral health providers utilized in Magic Valley and Jerome, and provide traditional therapy services within a primary care clinic setting, although they are available for consultation for the primary care providers on an "as needed" basis, they are generally quite busy meeting with patients throughout the day.

The second, collaborative care managers, serve a different, yet equally important role. They also provide therapy services, but in a short-term focused therapy model (generally 3-4 sessions). In addition, they are available for "warm hand offs" from the Primary Care Providers in their clinic, to help with immediate care needs, consultation to providers for mental health treatment decision making, as well as coordination of care with other appropriate behavioral health services. In addition, they coordinate communication between a Psychiatrist or Psychiatric Nurse Practitioner and the primary care providers within their clinic, for consultation for medication management-based issues.

At the current time, the following clinics are supported with Integrated Behavioral Healthcare Providers:

1. Jerome Family Medicine Clinic: 1 Co-located therapist
2. Magic Valley Physicians Center (Family Medicine and Pediatrics): 1 Collaborative Care Manager
3. Magic Valley Internal Medicine/Endocrinology Clinic: 1 Collaborative Care Manager
4. Magic Valley Primary Care Clinic (Family Medicine and Internal Medicine): 1 Co-located therapist
5. Buhl Family Medicine Clinic: 1 Co-located therapist

Future: Future expansion work in this area is ongoing within the local Magic Valley Behavioral Health leadership team in conjunction with the Behavioral Health Service Line leadership team. All these providers have been widely accepted within their clinics, and as a result, their schedules continue to be maximized. As a result, the need for their services continues to escalate.

Ironically, the integration of these providers has also led to an increase in the already maxed access capacity of our Specialty Behavioral Health Clinics (Psychiatrists, Psychologists and Master's Level Therapists). This is due to the identification of patients seen within our Primary Care Clinics, of whom need a higher level of care than is provided in this setting. However, Behavioral Health, like other clinics across our healthcare system, are plagued by a lack of available clinic space within which to expand. As such, we simply cannot gain access to additional space for placement of these providers. Although our Primary Care colleagues continue to request more assistance, they also struggle with the challenge of where to place these providers. As such, this continues to be an area of focus.

In the future, continued placement of integrated Behavioral Health Care Providers is anticipated. Although certainly a focus will continue to be upon placement within Primary

Care Clinics, similar to the concerns noted with Depression/Risk screening, a need for behavioral health care providers is also needed within many of our specialty clinics. As such, exploration into these clinics will also be further explored.

Other work in this area continues as well, including:

- A women's weight management group, overseen by an LCSW, employs group therapy as a powerful treatment strategy with dramatic and lasting results. The group has enabled women to lose weight by making lifelong behavioral changes that enhance their emotional well-being and reduce the effects of medical conditions such as diabetes. In addition, it has significantly increased access to care for patients seeking services.
- St. Luke's Clinic Behavioral Health Services providers developed a suicide education and prevention program and presented these standard protocols to counselors, teachers, and administrators in the Kimberly and Twin Falls School Districts. In 2018 the team has expanded this support to include Jerome School District.
- LCSWs have participated in the annual St. Luke's Magic Valley and Jerome health fairs, providing attendees with depression and anxiety education.

The St. Luke's Community Health Improvement Fund has also supported many organizations working to make a difference around mental health and suicide. See the list of organizations that were supported over the last three years below:

Organization	**Program**	**Description**	**Awareness & Outcomes**	**Youth Participants**	**Community Participants**
CSI Head Start/Early Headstart	BCBRS Services	Provide mental health services to children who need social/emotional support.	Improved social and emotional performance. Improved problem solving and self-regulation.	9	
Family Health Services	Behavioral Health Counselor Embedded in Primary Care	Assist with the costs associated with a current pilot program to integrate a	Provide brief interventions on-demand to better prevent, detect, and		

		Behavioral Health Counselor in the primary care.	manage mental illness and reduce suicide.		
Family Health Services	Suicide Risk Assessment	Pilot and implement a suicide risk assessment and early intervention process into primary care visits across south central Idaho.	Early detection of depression or suicide risk and intervention.		2649
Fifth Judicial District CASA Program, Inc.	Fostering Futures	This program prepares older youth (age 14-18) for a successful transition from foster care to independence (funds to be used for training & mileage only).			
Idaho Children's Trust Fund	Prevent Child Abuse	Increase the capacity of adults in the Magic Valley to recognize, prevent, and respond appropriately to child sexual abuse.	Reduce the incidence of child abuse.		

Jubilee House Ministries	Recovery Program	Build holistic, faith-based recovery programs focused on identification and response that prevent recidivism, decline and suicide.	Decrease risk of suicide and prevent recidivism.		
Kids Count Too! Inc.	Bereavement Support for Youth	Provide bereavement support for children, teens and their families through group events and community education programs.			
Rising Starts Therapeutic Riding Center Inc.	Hippotherapy	Help mitigate the costs of providing hippotherapy.	Equine assisted activities are noted for increasing the physical, mental, emotional and developmental capabilities of individuals with disabilities and medical issues of many kinds.	40	

Twin Falls County Safe House	Homeless Youth Care	Assist Magic Valley youth and families in crisis by improving access to youth group home care and referral services	Provide 40 days of care to at-risk, economically disadvantaged and in crisis youth at the Safe House	2	
Twin Falls County Treatment & Recovery Center		Provide 67 days of care at the state licensed Safe House/Group Home, in Twin Falls to improve the health, safety and development of at-risk and economically disadvantaged youth from throughout the Magic Valley.	Provide assessments, behavioral health treatment, recovery support services and aftercare for 50 low incomes and "at risk" individuals to reduce recidivism and escalating crime; helping 50% of graduates from behavioral health treatment and/or service goal programs to not recidivate for similar offenses measured at 3 months'		102

			post-entry and 3 months' post-graduation.		
Twin Falls Mental Health Advocates	Harmony PSR Services	Meals for those who attend services M-Th.	Provide and demonstrate a well-balanced and nutritious meal. This is a very important aspect of the whole wellness health approach that Harmony utilizes with their clients.	25/day	
Twin Falls Optimist Foundation, Inc.	Optimist Youth House	Home for youth that age out of foster care.	Provide an environment for this group of youth to become healthy productive citizens in our community.		
Voices Against Violence	Counseling: Individual & Group	Provide individual and group counseling services for victims of crime in a six-county region	To empower individuals who have experienced violence		663 average/year

		of Southern Idaho.			

Group 3: Improve Access to Affordable Health Insurance
Several barriers to access were ranked above the median, including: Unaffordable health care, dental care, and health insurance; lack of services for low-income children and families; inadequate numbers of primary care providers; and transportation to and from appointments. We are looking at these as a group so that we can provide a more comprehensive approach to the programs we have implemented to address these challenges.

To help ensure that everyone in our community can access the care they need when they need it, St. Luke's provides care to all patients with emergent conditions, regardless of their ability to pay—and St. Luke's Financial Care Program supports our not-for-profit mission. St. Luke's Magic Valley provided $78,603,000 in FY 2016, $85,343,000 in FY 2017, and $82,511,000 in FY 2018 for unreimbursed services (charity care at cost, bad debt at cost, Medicaid, and Medicare). In future years, we plan to continue to promote financially accessible healthcare and individualized support for our patients.
Over the past three years, we have further supported access to care by decreasing transportation barriers and implementing an electronic health records system.

In FY 2016 St. Luke's Magic Valley went "live" with *my*StLuke's, our integrated electronic health records (EHR) system. Across the St. Luke's Health System, investments of approximately $175 million supported this platform allowing providers from the outpatient and inpatient environments to collaboratively treat patients across the continuum. This $175 million investment helps allow providers from the outpatient and inpatient environments to collaboratively treat patients across the continuum. This has helped to increase standardization on several fronts, such as order sets and workflows. This investment helps improve patient outcomes and lower costs by reducing avoidable errors and average length-of-stay, remediating medication conflicts, reducing adverse drug events, and reducing duplicate testing. Plus, this portal allows patients to make appointments electronically and view diagnostic results and other parts of their medical record—all of which helps to provide access to care when and where it is needed.

Prevention is the best and least costly medicine, and free health screenings and lab tests at the Magic Valley Health Fair assist low-income families by providing education that will help them make informed lifestyle decisions that can help prevent the need to access healthcare services. Safe Kids Magic Valley is dedicated to educating low-income women, families, and caregivers on the importance of using the appropriate car seat, and partners with South Central Public Health to teach WIC (Women, Infants, Children) car seat safety classes. Approximately 17% and 36% of the people in Twin Falls and Jerome county area are Hispanic, and Safe Kids education is provided bilingually to support this substantial population. From October 2016 through April 2019, Safe Kids provided services to over 1000 clients.

To expand primary care access in our communities, we have implemented these strategies:

- A robust **primary care recruitment and retention program** to assess the needs for primary care physicians and develop strategies for recruitment and retention. In 2017 through April 2019, we recruited 3 advanced practice providers in family medicine, and 2 advanced practice provider in pediatrics.
- A **team-based model of care** that integrates NPs, PAs, nurse midwives, and certified RN diabetes educators into our primary care clinics.
- St. Luke's has expanded **Quick Care urgent care clinic** in Twin Falls to provide services 365 days of the year with expanded hours of 8:00a.m. to 10:00p.m. St. Luke's Quick Care is the same cost as standard physician office visit, and a fraction of the cost of an emergency room visit.
- We are **enhancing the efficiency of our primary care clinics**, thus enabling our providers to see more patients per day. Strategies include space planning to improve patient flow, refining our scheduling process, and implementing ambulatory electronic health records.
- St. Luke's Magic Valley and St. Luke's Jerome **partner with the Family Medicine Residency of Idaho** to provide a rural training site for 4 residents, providing critical training for physicians while supporting patient care and expanding access to primary care services. From October 2017 through May 2019 the resident physicians cared for a combined total of 4,363 patients at St. Luke's Jerome Family Medicine and St. Luke's Physician Center, as well as a total of 4,115 patients seen in St. Luke's Magic Valley and St. Luke's Jerome hospitals.
  Beginning in July 2019 our number of residents in the Magic Valley will increase to 6 residents as we will have our intern residents spending their first year here instead of Boise, where they have historically been before coming to the Magic Valley for their second and third year of residency.

St. Luke's Magic Valley's mission is to improve the health of people in our region and our Community Health Improvement Fund (CHIF) provides financial support for organizations that share our mission and align with our identified community health priorities. The total amount of CHIF grants awarded in FY 2017, FY 2018, and FY 2019 was $849,750. This grant continues to support local organizations that are improving access for community as well. See the list of supported organizations over the three years provided below:

Organization	**Program**	**Description**	**Awareness & Outcomes**	**Youth Participants**	**Community Participants**
Community Council of Idaho Inc.	Hearing & Vision Screener	Purchase a Vision Screener and a Hearing Screener at			

		the Twin Falls Center.			
CSI Office on Aging	Senior Companion Program	Provide reimbursement to volunteers who provide transportation and companionship to the frail, elderly homebound clients within the eight counties of the Magic Valley.	Transportation and access to necessities.		
CSI Head Start	Education	Provide staff training in order to become a fully endorsed Early Head Start organization through Aim Early Idaho (the Idaho Infant and Early Childhood Mental Health Association).			
CSI Refugee Center	English Learning Classes	Provide English language learning	English skill development.		85

		opportunities through the Community English partnership for New Americans program.			
Family Health Services	Dental Program	Upgrade dental endoscopy and hygiene equipment in our Twin Falls Dental Clinic and a new medical refrigerator to ensure proper storage and refrigeration of vaccines in the medical clinic in Fairfield, Idaho.			3180
Family Health Services	Walk with a Doc Program	Implement the Walk with Doc program as a platform to prevent an increase in cardiovascula r disease and diabetes.	Provide education and engagement with FHS patients on healthy eating, activity and behavior change.		
Filer School District	AED's	AED's in each building of the school district.	Provide lifesaving support if needed within that setting.		

Hospice Visions	Residential Home	Provide hospice and palliative care for the uninsured, underinsured, indigent and homeless residents of South Central Idaho at the "Visions of Home" hospice residential home.			90
Interlink Volunteer Caregivers	Volunteer Mileage Reimbursement	Funds will be used to reimburse volunteers for mileage that provide transportation for health related appointments.	Increased rides to needed services like medical care.		816
Jerome Interfaith Association	Emergency Response Support	To process emergency request of assistance for food, emergency shelter, gas, prescriptions and other aid for those who have no other options.	Increase access to emergent supports in times of need for those who reach out to interfaith leaders in the community.		

Living Independence Network Corporation	Transportation	Provide people with disabilities and seniors accessible affordable transportation.	Increased rides to needed services like medical care.		3637 rides/quarter
Magic Valley Rehab Services	Program Access	Improve access to services at MVRS for people with disabilities.	Provide any of the following: developmental therapy, adult day health services, supported employment work services or any combination of these, with a goal of assisting at least 20 or individuals over the 12-month period.		20
Sleep in Heavenly Peace	Bunk Beds	Beds for children without.	Provide a safe, stable place to sleep. Provide child something to call their own.	200/year	
South Central Public Health District WIC	Car Seats	Car seats for WIC participants who would not be able	Provide safety for child when transported.		

		to access one otherwise.			
Stanton Healthcare	Health Brochures & Pregnancy with Early Child Development Classes in Spanish	Educational information to the public through brochures and classes.	Educational materials to our clients to increase positive parenting skills and healthier lifestyles.		
Wellness Tree Community Clinic	Life Choices Program	(Funds to be used for medical supplies and equipment)	To provide an educational program that offers a practical approach to supporting self-management and better choices that is respectful of cultures, elicits the patient's perspective, enable's collaboration and develops into a new healthier lifestyle for the patient.		2600/year

As evidenced above, through programs, services, financial support, and collaborative partnerships, St. Luke's Magic Valley is making a substantial impact on the health and well-being of the communities we serve.

Resources Available to Meet Community Needs

This section provides a basic list of resources available within our community to meet some of the needs identified in this document. The majority of resources listed are nonprofit organizations. The list is by no means conclusive and information is subject to change. The various resources have been organized into the following categories:

Abuse/Violence Victim Advocacy & Services
Behavioral Health and Substance Abuse Services
Children & Family Services
Community Health Clinics and Other Medical Resources
Dental Services
Disability Services
Food Assistance
Government Contacts
Homeless Services
Hospice Care
Hospitals
Housing
Legal Services
Public Health Resources
Refugee/Immigrant Services
Residential Care/Assisted Living Facilities
Senior Services
Transportation
Veteran Services
Youth Programs

Abuse/Violence Victim Advocacy & Services

CARES (Children at Risk Evaluation Services)
2550 Addison Avenue East Suite G
Twin Falls, ID 83301
Phone: 208-814-7750
www.stlukesonline.org

Idaho Coalition Against Sexual and Domestic Violence
E. Mallard Drive, Suite 130
Boise, Idaho 83706
Phone: (208) 384-0419
info@engagingvoices.org
Description: The Idaho Coalition Against Sexual & Domestic Violence works to be a leader in the movement to end violence against women and girls, men and boys – across the life span before violence has occurred – because violence is preventable.

Idaho Council on Domestic Violence and Victim Assistance
Phone: (208) 332-1540
Toll-Free: 1-800-291-0463
http://icdv.idaho.gov/
Description: The Idaho Council on Domestic Violence and Victim Assistance funds, promotes, and supports quality services to victims of crime throughout Idaho.

Idaho Domestic Violence Hotline
Phone: 1-800-669-3176

Ike Kistler Safe House & Project Safe Place
650 Addison Ave. West Suite 200
Twin Falls, ID 83301
Phone: 208-735-8087

Office on Aging – College of Southern Idaho
315 Falls Ave
Twin Falls, ID 83301
Phone: 208-736-2122
Adult Protection Services Phone: 1-800-574-8656
https://sites.google.com/site/csiofficeonaging/services/adult-protection

Voices against Violence
212 2nd Ave West, Suite 200
PO Box 2444
Twin Falls, ID 83301
Phone: 208-733-0100
Phone: 24-hour crisis line: 208-733-0100
https://www.vavmv.org/
Description: Voices Against Violence, formerly known as the Crisis Center of Magic Valley, Inc. has been providing supportive services to victims of domestic violence and sexual assault for over 30 years in the eight counties of South Central Idaho that is called "Magic Valley." The goal of Voices Against Violence is to rebuild lives by providing resources and tools to establish independence and freedom from abuse.

Behavioral Health and Substance Abuse Services

Al-anon - District 4
Phone: 24 Hour Information and Answering Service - (208) 352-7119
www.al-anon-idaho.org
Description: The Al-Anon Family Groups are a fellowship of relatives and friends of alcoholics who share their experience, strength, and hope, in order to solve their common problems.

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Alcoholics Anonymous – Idaho Area 18
Phone: 208-733-8300
http://www.idahoarea18aa.org/main/meetings.htm
Description: Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.

Crisis Center of South Central Idaho
570 Shoup Ave. W
Twin Falls, Idaho 83301
Toll Free: 1-866-737-1128
Fax: 1-208-717-3167
www.CCOSCI.org
Open 24 hours/day, 365 days/year
Crisis Center of South Central Idaho provides emergency substance abuse and mental health services for adults (18 years old and older). All services are provided without charge to patients in need. Referrals and connections are made to appropriate community resources.

Drug Free Idaho, Inc.
333 N Mark Stall Place
PO Box 500
Boise, ID 83704
Phone: 208-570-6406
www.drugfreeidaho.org
Description**:** Drug Free Idaho is a nonprofit organization that works to create a drug free culture within workplaces, schools and communities. We focus on preventing substance abuse, enriching families, and positively impacting our community.

Family Health Services
826 Eastland Drive
Twin Falls, Idaho 83301
Phone: 208-734-1281
www.fhsid.org
Description: Private not-for-profit organization that provides behavioral health care to all (not based on their ability to pay). Locations in Twin Falls, Burley and Jerome.

Idaho Department of Health & Welfare – Twin Falls Office
Behavioral Health Services/ Mental Health Services
828 Harrison Street
Twin Falls, Idaho 83301
Phone: 208-736-2177 (Adults)
Phone: 208-732-1630 (Children)
www.healthandwelfare.idaho.gov
Description: Services for adults and children who are in need of mental health treatment. People will not be denied services based on inability to pay. A discounted sliding fee schedule is available based on family size and incomes.

Idaho Suicide Prevention Hotline
24-hour hotline: 1-800-273-8255

Narcotics Anonymous
Magic Valley Help Line: 866-738-6224
www.sirna.org
Description**:** NA is a nonprofit fellowship or society of men and women for whom drugs had become a major problem.

Regional Mental Health Services
24-hour hotline: 208-734-4000

SAMHSA (Substance Abuse and Mental Health Services Administration)
Phone: 24-hour hotline - 1-800-662-HELP
www.samsha.gov
Description: The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

St. Luke's Behavioral Health Services
132 5th Ave. West, Suite 2
Jerome, ID 83338
Phone: 208-814-9800

414 Shoup Avenue W., Suite B
Twin Falls, ID 83301
Phone: 208-814-9100

www.stlukesonline.org
Description: St. Luke's Clinic Behavioral Health Services is dedicated to providing compassionate expertise during times of psychiatric instability, allowing you to work closely with a personalized care team that also includes medication providers and your local primary care doctor. Our psychiatrists, psychologist, counselors, and nurses are trained to care for patients from childhood through the end of life. Our providers specialize in the treatment of mental illness with a focus of wellness.

St. Luke's Canyon View Behavioral Health Services
St. Luke's Magic Valley
228 Shoup Avenue West
Twin Falls, ID 83301
Phone: 208-814-7900
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.

Treatment and Recovery Clinic (TARC) - Twin Falls County
630 Addison Ave. West
Twin Falls, Idaho 83301
Phone: 208-736-5048
Description: The TARC strives to provide a holistic approach to family healing and the development of associated competencies through the use of Alcohol and Substance Use Disorder Treatment, Recovery Support Services, Behavior Specific Groups, and Wrap-Around services to individuals in the community.

The Walker Center
Outpatient Drug & Alcohol Treatment
762 Falls Avenue
Twin Falls, Idaho 83301
Phone: 1-208-734-4200
www.thewalkercenter.org
Description: The Walker Center's outpatient treatment program for drug and alcohol abuse provides adults, adolescents and their families with the tools to create and maintain a substance-free lifestyle.

Children & Family Services

Child Protection Reporting
24-hour hotline: 1-855-552-5437

Community Council of Idaho – Felipe Cabral
1122 Washington St. So.
Twin Falls, Idaho 83301
Phone: 208-734-8419
http://www.communitycouncilofidaho.org/
Description: The Community Council of Idaho, Inc. (CC Idaho) is a rural-centered, multi-service nonprofit organization. They are the largest nonprofit serving Latinos in the state. Their purpose is to improve the social and economic status of local communities through workforce preparation, education, cultural awareness, civil rights advocacy, and well-being services.

Family Health Services
Various locations in Twin Falls and Jerome County

325 Martin Street	114 Pioneer Ct.
Twin Falls, Idaho 83301	Jerome, ID 83338
Phone: 208-732-7447	Phone: 208-324-3471

www.fhsid.org
Description: Family Health Services provides high-quality, culturally sensitive primary medical and dental care, behavioral health, and social services that are affordable and accessible to the people of South Central Idaho.

Idaho Department of Health & Welfare – Children & Family Services
601 Pole Line Road
Twin Falls, Idaho 83301
Phone: 208-734-4000
www.healthandwelfare.idaho.gov

Idaho Department of Health & Welfare – Self Reliance Benefits Program
601 Pole Line Road
Twin Falls, Idaho 83301
Phone: 1-877-456-1233
www.healthandwelfare.idaho.gov

South Central Public Health District
1020 Washington Street N.
Twin Falls, Idaho 83301
Phone: 208-737-5900
www.phd5.idaho.gov
Description: Offices in Twin Falls, Bellevue, Burley, Gooding, Jerome, Rupert and Shoshone

South Central Community Action Partnership
550 Washington Street South
Twin Falls, Idaho 83301
Phone: 208-733-9351
www.sccap-id.org
Description: SCCAP provides a wide range of support services in an effort to help individuals and families build bridges towards self-sufficiency.

St. Luke's Magic Valley – Safe Kids Magic Valley
601 Pole Line Road W.
Twin Falls, Idaho 83303
Phone: 208-814-7640
Description: Over 20 years of preventing accidental injuries through bike, car, home, pedestrian, ATV, helmet, agriculture, and child safety.

United Way of South Central Idaho
102 Main Ave S
Suite 5 Second Floor,
Twin Falls, ID 83301
http://www.unitedwayscid.org/
Description: United Way of South Central Idaho fights for the health, education and financial stability of every person in every community throughout South Central Idaho.

Community Health Clinics and Other Medical Resources

Family Health Services
Various locations in Twin Falls and Jerome County

325 Martin Street	114 Pioneer Ct
Twin Falls, Idaho 83301	Jerome, ID 83338
Phone: 208-732-7447	Phone: 208-324-3471

www.fhsid.org
Description: Family Health Services provides high-quality, culturally sensitive primary medical and dental care, behavioral health, and social services that are affordable and accessible to the people of South Central Idaho. Clinics located in Twin Falls, Buhl, Burley, Fairfield, Jerome, Kimberly and Rupert.

Planned Parenthood
200 2nd Avenue N.
Twin Falls, Idaho 83301
Phone: 1-800-230-7526

The Wellness Tree
173 Martin Street
Twin Falls, Idaho 83301
Phone: 208-734-2610
http://www.wellnesstreeclinic.org/
Description: Free acute/short term regular medical care for those at or below the poverty level and with no medical insurance or other resources.

South Central Public Health District
1020 Washington Street N.
Twin Falls, Idaho 83301
Phone: 208-737-5900
www.phd5.idaho.gov
Description: Offices in Twin Falls, Bellevue, Burley, Gooding, Jerome, Rupert and Shoshone

Stanton Healthcare
718 Shoshone St. East
Twin Falls, ID 83303
Phone: 208-734-7472
www.stantonmv.org
Description: Help pregnant women, individuals, and families with life affirming options in an environment that promotes physical, spiritual and emotional well-being, at no charge.

St. Luke's Clinic Multi-Specialty Services
115 5th Avenue W.
Jerome, Idaho 83338
Phone: 208-814-9840
www.stlukesonline.org/jerome

St. Luke's Clinic Physician Center
775 Pole Line Road West, Suite 105 & 111
Twin Falls, Idaho 83301
Phone: 208-814-8000
www.stlukesonline.org/clinic/family_medicine/main/

St. Luke's Clinic & Multi-Specialty Services
625 Poleline Road West
Medical Plaza 2
Twin Falls, ID 83301
Phone: 208-814-1000

St. Luke's Jerome Family Clinic
132 5th Avenue W.
Jerome, Idaho 83338
Phone: 208-324-4301
www.stlukesonline.org/jerome

St. Luke's Jerome Medical Center
709 N. Lincoln Avenue
Jerome, Idaho 83338
Phone: 208-324-4301
www.stlukesonline.org/jerome

Dental Services

College of Southern Idaho Dental Clinic
397 North College Road
Twin Falls, ID 83301
Phone: 208-732-6751
http://hshs.csi.edu/dental_hygiene/

Family Health Services Dental Clinic
Various locations in Twin Falls and Jerome County

114 Pioneer Ct.
Jerome, ID 83338
Phone: 208-324-3471

826 Eastland Drive
Twin Falls, Idaho 83301
Phone: 208-732-7447

www.fhsid.org
Description: Dedicated to providing quality, affordable dental care. Clinics located in Twin Falls, Buhl, Burley, Jerome, Kimberly and Fairfield.

The Wellness Tree
173 Martin Street
Twin Falls, Idaho 83301
Phone: 208-734-2610
http://www.wellnesstreeclinic.org/

South Central Public Health District
1020 Washington Street N.
Twin Falls, Idaho 83301
Phone: 208-737-5900
www.phd5.idaho.gov

Disability Services

Community Connections Inc.
212 2nd Avenue West
Twin Falls, ID 83301
Phone: 208-733-0655
http://www.cciidaho.com/

Community Partnerships of Idaho
1092 Eastland Drive North Suites A & B
Twin Falls, Idaho 83301
Phone: 208-735-2134
www.mycpid.com

Gwen Neilsen Anderson Rehabilitation Center
St. Luke's Magic Valley Medical Office Plaza
775 Pole Line Road W., Suite 303
Twin Falls, Idaho 83301
Phone (208) 814-3755
www.stlukesonline.org

Idaho Department of Health & Welfare – Adult Developmental Disability Care Management
601 Pole Line Road
Twin Falls, Idaho 83301
Phone: 1-877-456-1233
www.healthandwelfare.idaho.gov

Idaho Department of Health & Welfare – Developmental Disabilities Program - Infant Toddler
803 Harrison Street
Twin Falls, Idaho 83301
Phone: 208-736-3024
www.healthandwelfare.idaho.gov

Living Independence Network (LINC)
182 Eastland Drive North, Suite C
Twin Falls, ID 83301
Phone: 208-733-1712

Magic Valley Rehabilitation Services
484 Eastland Drive South
Twin Falls ID, 83301
Phone: 208-734-4112
www.mvrehab.org

Positive Connections, LLC
1373 Fillmore Street
Twin Falls, ID 83301
Phone: 208-733-9999
www.positiveconnectionsusa.com

St. Luke's Magic Valley – Children's Rehabilitation

St. Luke's Magic Valley Addison Clinic
2550 Addison Avenue E. Suite D
Twin Falls, Idaho 83301
Phone (208) 814-7950

St. Luke's Magic Valley Medical Plaza 1
801 Poleline Road W., Suite 3802
Twin Falls, ID 83301
Phone: 208-814-3450

St. Luke's Magic Valley – Adult Outpatient Therapy Clinic
St. Luke's Magic Valley Medical Office Plaza 1
775 Pole Line Road W., Suite 202
Twin Falls, Idaho 83301
Phone (208) 814-2570
St. Luke's Magic Valley Medical Plaza 2
625 Poleline Rd. West Suite B
Twin Falls ID, 83301
Phone: 208-814-5300

Government Contacts

City of Buhl
203 Broadway Ave North
Buhl, ID 83316
Phone: 208-543-5650
www.cityofbuhl.us

City of Filer
300 Main Street
Filer, ID 83328
Phone: 208-326-5000
http://www.cityoffiler.com/

City of Hansen
388 Main Street South
Hansen, ID 83334
Phone: 208-423-5158
http://www.cityofhansen.org/

City of Kimberly
132 Main Street North
Kimberly, ID 83341
Phone: 208-423-4151
http://www.cityofkimberly.org/

City of Murtaugh
106 4th Street N.
Murtaugh, ID 83344
Phone: 208-432-6682

City of Twin Falls
321 2nd Ave East
Twin Falls, ID 83301
Phone: 208-735-4357
http://www.tfid.org/

Twin Falls County
425 Shoshone Street
Twin Falls, ID 83301
http://twinfallscounty.org/

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

Food Assistance

Idaho Foodbank – South Central Food Assistance
https://idahofoodbank.org/

Idaho Department of Health & Welfare – Food Assistance
601 Pole Line Rd
Twin Falls, ID 83301
Phone: 877-456-1233
www.healthandwelfare.idaho.gov

La Posada
355 4th Avenue W.
Twin Falls, Idaho 83301
Phone: 208-734-8700

Mustard Seed
702 Main Ave. North
Twin Falls, ID 83301
Phone: 208-733-9515
Description: The client assistance office provides aid to families in need of spiritual, financial, nutritional, clothing and living expenses.

Salvation Army – Twin Falls
348 4th Avenue N.
Twin Falls, Idaho 83301
Phone: 208-733-0569

South Central Community Action Partnership
550 Washington Street South
Twin Falls, Idaho 83301
Phone: 208-733-9351
www.sccap-id.org
Description: SCCAP provides a wide range of support services in an effort to help individuals and families build bridges towards self-sufficiency.

West End Ministerial Association (WEMA)
Emergency Food Pantry
908 Maple Street
Buhl, ID
Phone: 208-329-2393

Homeless Services

South Central Community Action Partnership
550 Washington Street South
Twin Falls, Idaho 83301
Phone: 208-733-9351
www.sccap-id.org
Description: SCCAP provides a wide range of support services in an effort to help individuals and families build bridges towards self-sufficiency.

Valley House Homeless Shelter
507 Addison Ave West
Twin Falls, ID 83301
Phone: 208-734-7736

The Safe House
Shelter
183 Rose Street
Twin Falls, ID 83301
Phone: 208-735-8087

Office
526-M Shoup Ave. West
Twin Falls, ID 83301

http://www.twinfallscounty.org/safe_house/

Hospice Care

Idaho Quality of Life Coalition – South Central Region
http://www.idqol.org/
Description: The Idaho Quality of Life Coalition (formerly the Idaho End-of-Life Coalition) stands alone for consistent leadership and innovation in hospice and

palliative care. Improved care, conditions, and access to quality end-of-life care is our vision.

Hospice Visions, Inc.
1770 Park View Drive
Twin Falls, Idaho 83301
Phone: 208-735-0121
http://www.hospicevisions.org/

Idaho Home Health & Hospice
222 Shoshone St. East
Twin Falls, ID 83301
Phone: 808-734-4061
https://lhcgroup.com/locations/idaho-home-health-of-twin-falls/

St. Luke's Home Care & Hospice
601 Pole Line Road West
Twin Falls, ID 83301
Phone: 208-814-7600
www.stlukesonline.org

Hospitals

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

St. Luke's Jerome Medical Center
709 N. Lincoln Ave.
Jerome, ID 83338
Phone: 208-324-4301
www.stlukesonline.org

St. Luke's Magic Valley Medical Center
801 Pole Line Road West
Twin Falls, ID 83301
Phone: 208-841-10000
www.stlukesonline.org

Housing

Community Council of Idaho

El Milagro Housing Project
1122 S. Washington Street
Twin Falls, Idaho 83301
Phone: 208-736-0962

Colonia de Colores
406 Gardner Ave.
Twin Falls, ID 83301
Phone: 208-734-2301

http://www.communitycouncilofidaho.org/housing

Idaho Housing & Finance
844 Washington St. North, Suite 300
Twin Falls, ID 83301
Phone: 208-734-8531
www.idahohousing.com
Description: Provides services for home ownership, rental housing and homelessness assistance.

South Central Community Action Partnership
550 Washington Street South
Twin Falls, Idaho 83301
Phone: 208-733-9351
www.sccap-id.org
Description: SCCAP provides a wide range of support services in an effort to help individuals and families build bridges towards self-sufficiency.

Legal Services

Disability Rights Idaho
4477 Emerald St, Suite B-100
Boise, ID 83706
Phone: (208) 336-5353
www.disabilityrightsidaho.org
Description: Disability Rights Idaho (DRI) provides free legal and advocacy services to persons with disabilities.

Idaho Commission on Human Rights
317 West Main Street
Boise, ID 83735
Phone: (208) 334-2873
www.humanrights.idaho.gov
Description**:** The Idaho Commission on Human Rights administers state and federal anti-discrimination laws in Idaho in a manner that is fair, accurate, and timely. Our commission works towards ensuring that all people within the state are treated with dignity and respect in their places of employment, housing, education, and public accommodations.

Idaho Law Foundation - Idaho Volunteer Lawyers Program & Lawyer Referral Service
525 W. Jefferson Street
Boise, Idaho 83702
Phone: (208) 334-4510
www.isb.idaho.gov/ilf/ivlp/ivlp.html
Description**:** Using a statewide network of volunteer attorneys, IVLP provides free civil legal assistance through advice and consultation, brief legal services and representation in certain cases for persons living in poverty.

Idaho Legal Aid Office
475 Polk Street
Twin Falls, ID 83301
Phone: 208-734-7024
www.idaholegalaid.org/office/twinfalls
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.

State of Idaho Court Assistance Office – 5th Judicial District
427 Shoshone St. North
Twin Falls, Idaho 83303
Phone: 208-736-4137

Public Health Resources

2-1-1 Idaho CareLine
Phone: 2-1-1 or (800) 926-2588
www.211.idaho.gov
Description: A free statewide community information and referral service program of the Idaho Department of Health and Welfare. This comprehensive database includes programs that offer free or low cost health and human services or social services, such as rental assistance, energy assistance, medical assistance, food and clothing, child care resources, emergency shelter, and more.

Family Health Services
1102 Eastland Drive N.
Twin Falls, Idaho 83301
Phone: 208-734-1281
www.fhsid.org
Description: Not-for-profit organization which provides behavioral health care to all not based on their ability to pay. Locations in Twin Falls, Burley and Jerome.

Idaho Department of Health & Welfare – Twin Falls Office
Behavioral Health Services/ Mental Health Services
828 Harrison Street
Twin Falls, Idaho 83301
Phone: 208-736-2177 (Adults)
Phone: 208-732-1630 (Children)
www.healthandwelfare.idaho.gov

South Central Public Health District
1020 Washington Street N.
Twin Falls, Idaho 83301
Phone: 208-737-5900
www.phd5.idaho.gov
Description: Offices in Twin Falls, Bellevue, Burley, Gooding, Jerome, Rupert and Shoshone.

Refugee/Immigration Services

CSI (College of Southern Idaho) Refugee Center
1526 Highland Ave. East
Twin Falls, ID 83301
Phone: 208-736-2166

Fax: 208-736-4711
http://www.csi.edu/

La Posada Inc.
355 4th Avenue West
Twin Falls, ID 83301
Phone: 208-734-8700
https://www.laposadainc.org/
Description: Our organization's mission is to work with our communities to provide assistance to those less fortunate in South Central Idaho and Northern Nevada. To this end, we provide immigration assistance within immigration law, counseling, emergency assistance, low-income taxpayer clinic, notary services and Spanish and English translations.

Residential Care/ Assisted Living Facilities

Alpine Manor
1135 Imperial Street
Twin Falls, ID 83301
Phone: 208-734-1794

100 Polk St. E
Kimberly, ID 83341
Phone: 208-423-5417

Applegate Retirement Estates
1541 East 4250 N
Buhl, ID 83316
Phone: 208-543-4020

Ashley Manor
Parkview #1 Memory Care Center
1818 Park View Dr.
Twin Falls, ID 83301
Phone: 208-933-4404

Parkview #2
1814 Park View Dr.
Twin Falls, ID 83301
Phone: 208-933-4406

Ashley Manor Buttercup Memory Care Center
1210 Buttercup Trail
Kimberly, ID 83341
Phone: 208-423-5971

Ashley Manor Lincoln Memory Center
101 15th Ave. East
Jerome, ID 83338
Phone: 208-324-1354

Birchwood Retirement Center
641 Rimview Drive

Twin Falls, ID 83301
Phone: 208-734-4445

Bridgeview Estates
1828 Bridgeview Blvd.
Twin Falls, ID 83301
Phone: 208-736-3933

Brookedale Twin Falls
1367 Locust St. North
Twin Falls, ID 83301
Phone: 208-735-0700

Canyons Retirement Community
1215 Cheney Dr. West
Twin Falls, ID 83301
Phone: 208-358-9624

Country Cottage
3652 N. 2500 E.
Twin Falls, ID 83301
Phone: 208-736-1856

Country Living
1852 E. 3900 N.
Buhl, ID 83316
Phone: 208-326-6560

Creekside Care Center, Holley Homes
222 6th Ave. West
Jerome, ID 83338
Phone: 208-324-4941

DeSano Place
1015 E. Ave. K
Jerome ID, 83338
Phone: 208-595-2675

Desert Rose Retirement Estates
983 Gallup
Twin Falls, ID 83301
Phone: 208-734-1866

Grace Assisted Living

1803 Parkview Drive
Twin Falls, ID 83301
Phone: 208-736-0808

Heritage Retirement Center
622 Filer Ave. West
Twin Falls, ID 83301
Phone: 208-733-9064

Northern Light
964 Blake Street
Twin Falls, ID 83301
Phone: 208-734-3537

Purple Sage Manor
1827 Kimberly Rd.
Twin Falls, ID 83301
Phone: 208-733-8027

River Rock Assisted Living
1063 Burley Ave.
Buhl, ID 83316
Phone: 208-543-5161

Rosetta Assisted Living Center
1177 Eastridge Ct.
Twin Falls, ID 83301
Phone: 208-734-9422

St. Luke's Jerome - Transitional Care Services
709 N. Lincoln Ave.
Jerome, ID 83338
Phone: 208-324-6138
www.stlukesonline.org

St. Luke's Home Care
601 Pole Line Road West
Twin Falls, ID 83301
Phone: 208-814-7600
www.stlukesonline.org

Stoney Creek Living Center
3808 N. 2538 E.
Twin Falls, ID 83301
Phone: 208-736-5705

Syringa Place
1880 Harrison St. North
Twin Falls, ID 83301
Phone: 208-733-7511

Willowbrook
1871 Julie Lane
Twin Falls, ID 83301
Phone: 208-736-3727

Woodland Estates
19937 C U.S. Highway 30
Buhl, ID 83316
Phone: 208-543-9050

Woodstone Assisted Living
491 Caswell Ave. West
Twin Falls, ID 83301
Phone: 208-734-6062

Senior Services

Ageless Senior Citizens Kimberly Senior Center
310 Main North
Kimberly, ID 83341
Phone: 208-423-4338

Alzheimer's Idaho
13601 W. McMillan Road, #249
Boise, Idaho 83713
Phone: (208) 914-4719
www.alzid.org
Description: Alzheimer's Idaho is a standalone nonprofit 501(c)3 organization providing a variety of services and support locally to our affected Alzheimer's population and their families and caregivers.

CSI (College of Southern Idaho) Office on Aging
315 Falls Ave
Twin Falls, ID 83301
Phone: 208-736-2122
www.officeonagingcsi.edu

East End Providers
229 Main St. North
Kimberly, ID 83341
Phone: 208-539-2958
Description: Provides free clothing and food year round.

Filer Senior Center
222 Main Street
Filer, ID 83328
Phone: 208-326-4608

Homestyle Direct
2032 Highland Ave. East
Twin Falls, ID 83301
Phone: 1-866-735-0921

Idaho Aging & Disability Resource Center (ADRC)
Phone: 1-800-926-2588
http://aging.idaho.gov/adrc/

Over 60 & Getting Fit
College of Southern Idaho
Phone: 208-732-6745
http://education.csi.edu/te/over60andGettingFit/
Description: A free physical activity program for seniors offered at numerous locations: CSI Gymnasium, Jerome Recreation Center, Filer Elementary, Buhl Middle School (old gym), Gooding ISDB, CSI Burley Outreach Center, Rupert Civic Gym, Blaine County Campus Gym, Hagerman High School and Shoshone High School (old gym).

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

Silver & Gold Senior Center
203 Wilson Street
Eden, ID 83325
Phone: 208-825-5662

Twin Falls Senior Federation

530 Shoshone St
Twin Falls, ID 83301
Phone: 208-734-5084
West End Senior Center
1010 Main
Buhl, ID 83316
Phone: 208-543-4577

Transportation

Idaho Transportation Department – District 3
8150 Chinden Blvd.
Boise, Idaho 83707
Phone: 208-332-7191

Interlink Volunteer Caregivers
650 Addison Ave. West Suite 201
Twin Falls, ID 83301
Phone: 208-733-6333
https://ivcsouthernidaho.com/
Description: Interlink Volunteer Caregivers (IVC) is a non-profit organization providing volunteer assistance to the disabled, chronically ill, and elderly, as well as respite care for homebound caregivers. IVC serves all 8 counties in South Central Idaho. Our goal is to help people live independently in their own homes as long as possible.

Trans IV Buses (College of Southern Idaho)
315 Falls Avenue
Twin Falls, Idaho 83303
Phone: 208-736-2133
Description: Trans IV Buses have been providing personalized public transportation to the people of the Magic Valley since October 1979. A variety of services are offered to meet the need of working commuters, students, agency clients, the elderly, and the disabled.

Veteran Services

American Legion Post 7
447 Seastrom Street
Twin Falls, ID 83301
Phone: 208-733-7527
http://www.legion.org/

American Legion Post 47
207 Main Street

Filer, ID 83328
http://www.legion.org/

Idaho Veterans Services
www.veterans.idaho.gov

Twin Falls County Veterans Officer
650 Addison Avenue West, Suite 1077
Twin Falls, Idaho 83303
Phone: 208 734-9091
www.twinfallscounty.org/veterans/

Veterans Crisis Line
Phone: 1-800-273-8255

Twin Falls Idaho Community Based Outpatient Clinic
260 2nd Ave E.
Twin Falls, ID 83301
Phone: 208-732-0959
www.boise.va.gov/locations/Twin_Falls_Idaho

Youth Programs

4-H Youth Development – Twin Falls County Extension Office
630 Addison Ave. W. Suite 1600
Twin Falls, Idaho 83301
Phone: (208) 734-9590
Description: 4-H programs provide hands-on activities in science and technology; visual, cultural and theater arts; crafts; financial literacy; nutrition; food preparation; health and physical activity.

Boys and Girls Club of Magic Valley
999 Frontier Road
Twin Falls, ID 83301
Phone: 208-736-7011
Fax: 208-324-3380
http://www.bgcmv.com/
Description: Offering a wide range of activities including various sports and leisure programs to meet the diverse needs of the community.

Magic Valley Youth Services
1869 Addison Ave. E.
Twin Falls, Idaho 83301
Phone: 208-734-4435

Salvation Army – Youth Enrichment Programs
648 4th Avenue N.
Twin Falls, Idaho 83301
Phone: 208-733-8720
Description: Programs that offer a wide variety of activities including arts and crafts, academic programs, sports, reading clubs, workshops and other recreational, leisure, cultural, social and civic activities for school-age children and youth in out-of-school hours.

Twin Falls Parks & Recreation Department
136 Maxwell Ave.
Twin Falls, ID 83301
Phone: (208) 736-2265

YMCA of Twin Falls
1751 Elizabeth St.
Twin Falls, ID 83301
Phone: 208-733-4384
http://www.ymcatf.com/

DISTRICT 5 COMMUNITY RESOURCE GUIDE

South Central Public Health District
Updated Regularly
https://phd5.idaho.gov/

Appendix I: Community Representative 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 our community health representatives as well as each individual's organizational affiliation. We interviewed community representatives in each of the following categories and indicated which category they were in.

Category I: Persons with special knowledge of public health. This includes persons from state, local, and/or regional governmental public health departments with knowledge, information, or expertise relevant to the health needs of our community.

Category II: Individuals or organizations serving or representing the interests of the medically underserved, low-income, and minority populations in our community. Medically underserved populations include populations experiencing health disparities or at-risk populations not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers.

Category III: Additional people located in or serving our community including, but not limited to, health care advocates, nonprofit and community-based organizations, health care providers, community health centers, local school districts, and private businesses.

Community Representatives Contacted

1. **Affiliation:** Family Medicine Residency of Idaho
   Date contacted: 4/13/2018
   How input was obtained: Phone interview & questionnaire
   Health representative category: Category II and III
   Populations represented:
   _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
   _X_ Veterans

2. Affiliation: Idaho Department of Health and Welfare
Date contacted: 4/10/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Categories I and II
Populations represented:
_X_ Children
_X_ Disabled
_X_ Low income individuals and families
_X_ Populations with chronic conditions
_X_ Refugees
_X_ Those with behavioral health issues

3. Affiliation: Idaho Department of Labor
Date contacted: June 2018 through August 2018
How input was obtained: Phone and email
Health representative category: Categories III

4. Affiliation: Idaho Health and Welfare
Date contacted: September 2017 through April 2018
How input was obtained: Phone conversations, emails
Health representative category: Category I

5. Affiliation: Idaho Health and Welfare
Date contacted September 2017 through April 2018
How input was obtained: Phone conversations, emails
Health representative category: Category I

6. Affiliation: College of Southern Idaho
Date contacted: 3/13/2018
How input was obtained: Phone interview and questionnaire
Health representative category: III
Populations represented:
_X_ Children
_X_ Disabled
_X_ Hispanic population
_X_ Low income individuals and families
_X_ Migrant and seasonal farm workers
_X_ Refugees
_X_ Senior citizens
_X_ Those with behavioral health issues
_X_ Veterans

7. Affiliation: College of Southern Idaho Office on Aging
Date contacted: 3/4/2018

How input was obtained: Phone interview and questionnaire
Health representative category: II and III
Populations represented:
_X_ Disabled
_X_ Low income individuals and families
_X_ Populations with chronic conditions
_X_ Senior citizens
_X_ Veterans

8. **Affiliation:** Family Health Services
Date contacted: 3/16/2018
How input was obtained: Phone interview and questionnaire
Health representative category: II and III
Populations represented:
_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
_X_ Veterans

9. **Affiliation:** Jerome Recreation District
Date contacted: 3/5/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category III
Populations represented:
_X_ Children
_X_ Disabled
_X_ Hispanic population
_X_ Low income individuals and families
_X_ Migrant and seasonal farm workers
_X_ Populations with chronic conditions
_X_ Senior citizens
_X_ Veterans

10. **Affiliation:** Jerome School District #261
Date contacted: 3/7/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category III

Populations represented:
_X_ Children
_X_ Disabled
_X_ Hispanic population
_X_ Homeless
_X_ Low income individuals and families
_X_ Migrant and seasonal farm workers
_X_ Those with behavioral health issues

11. **Affiliation:** Jerome Senior Center
Date contacted: 4/2/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category II and III
Populations represented:
_X_ Children
_X_ Low income individuals and families
_X_ Senior Citizens

12. **Affiliation:** Interfaith Association & Renew Fellowship- Jerome, ID
Date contacted: 3/14/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category II and III
Populations represented:
_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_ Senior citizens
_X_ Those with behavioral health issues
_X_ Veterans

13. **Affiliation:** Wellness Tree Community Clinic
Date contacted: 3/15/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category II and III
Populations represented:
_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_ Senior citizens
_X_ Those with behavioral health issues
_X_ Veterans

14. Affiliation: South Central Public Health
Date contacted: 4/25/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Categories I and II
Populations represented:
_X_ Children
_X_ Hispanic population
_X_ Low income individuals and families
_X_ Migrant and seasonal farm workers
_X_ Populations with chronic conditions
_X_ Senior citizens
_X_ Those with behavioral health issues
_X_ Veterans
_X_ Teens/Adolescents

15. Affiliation: St. Luke's Disease Management and Education
Date contacted: 4/3/2018
How input was obtained: Phone interview and questionnaire
Health representative category: III
Populations represented:
_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
_X_ Veterans
_X_ Pregnancy and diabetes patients

16. Affiliation: United Way of South Central Idaho
Date contacted: 3/6/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category II
Populations represented:
_X_ Children

_X_ Disabled
_X_ Homeless
_X_ Low income individuals and families
_X_ Senior citizens

17. **Affiliation:** College of Southern Idaho - Refugee Center
Date contacted: 3/9/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category II
Populations represented:
_X_ Children
_X_ Disabled
_X_ Low income individuals and families
_X_ Refugees
_X_ Senior citizens
_X_ Those with behavioral health issues

18. **Affiliation:** Twin Falls School District
Date contacted: 3/6/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category III
Populations represented:
_X_ Children
_X_ Disabled
_X_ Hispanic population
_X_ Homeless
_X_ Low income individuals and families
_X_ Migrant and seasonal farm workers
_X_ Refugees
_X_ Those with behavioral health issues

19. **Affiliation:** Twin Falls County
Date contacted: 3/7/2018
How input was obtained: Phone interview and questionnaire
Health representative category: II and III
Populations represented:
_X_ Low income individuals and families
_X_ Migrant and seasonal farm workers
_X_ Populations with chronic conditions
_X_ Those with behavioral health issues

20. **Affiliation:** La Posada, Inc.
Date contacted: 3/13/2018

How input was obtained: Phone interview and questionnaire
Health representative category: Category II
Populations represented:
_X_ Hispanic population
_X_ Homeless
_X_ Low income individuals and families
_X_ Migrant and seasonal farm workers
_X_ Seniors
_X_ Those with behavioral health issues

21. **Affiliation:** South Central Community Action Partnership (SCCAP)
Date contacted: 4/10/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category II
Populations represented:
_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
_X_ Veterans

22. **Affiliation:** City of Jerome
Date contacted: 4/11/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category II and III
Populations represented:
_X_ Children
_X_ Hispanic population
_X_ Low income individuals and families
_X_ Senior citizens

23. **Affiliation:** La Perrona Radio Station
Date contacted: 3/12/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category II
Populations represented:
_X_ Disabled
_X_ Hispanic population

_X_ Low income individuals and families
_X_ Populations with chronic conditions

24. Affiliation: City of Twin Falls
Date contacted: 3/8/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category II and III
Populations represented:
_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
_X_ Veterans

25. Affiliation: St. Luke's Health Partners Board Director
Date contacted: 3/16/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category III
Populations represented:
_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
_X_ Veterans

26. Affiliation: Boys and Girls Club of Magic Valley
Date contacted: 3/12/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category II and III
Populations represented:
_X_ Children
_X_ Homeless

_X_ Low income individuals and families
_X_ Refugees

27. Affiliation: College of Southern Idaho
Date contacted: 3/8/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category III
Populations represented:
_X_ Children
_X_ Hispanic population
_X_ Low income individuals and families
_X_ Migrant and seasonal farm workers
_X_ Those with behavioral health issues

28. Affiliation: YMCA of Magic Valley
Date contacted: 4/11/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category III
Populations represented:
_X_ Children
_X_ Hispanic population
_X_ Low income individuals and families
_X_ Migrant and seasonal farm workers
_X_ Populations with chronic conditions
_X_ Senior citizens

29. Affiliation: Muztagh Schools, Rural School District
Date contacted: 3/9/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category III
Populations represented:
_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_ Senior citizens
_X_ Those with behavioral health issues

Appendix II: Community Representative Interview Questions

Representative Name:

Title:

Affiliation:

Date:

Thank you for agreeing to participate in St. Luke's 2019 Community Health Needs Assessment. We will utilize the information you provide to help us better understand and address the health needs of our community.
In our community health needs assessment, we will publish the names of the organizations that participated in our interviews, but we will not publish your name or title.

1) Can you please provide us with a brief description of your professional experience particularly as it relates to community health, social, or economic needs?

2) 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).

3) Through your experience, do you feel you understand and can represent the 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

______ Other, please specify________________________________

______ Other, please specify________________________________

4) 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 means you believe addressing this need with additional resources would make a large impact to the health of people in our community. A low score means that you believe this item is not an important health need or that it is already being addressed effectively with programs or services in our community.

As you score each need, please describe any programs, legislation, organizations, or other resources you believe are effective in helping us identify or address these health needs.

Health behavior (potential needs)

_____ Cancer prevention programs/education
_____ Exercise programs/education/opportunities
_____ Greater access to healthy foods
_____ Help with weight management (to reduce levels of obesity and diabetes)
_____ Nutrition education
_____ Safe sex education programs
_____ Substance abuse services and programs
_____ Tobacco prevention and cessation programs
_____ Wellness and prevention programs (for conditions such as high blood pressure, skin cancer, depression, etc.)

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

_____
_____
_____

Notes on programs, legislation, organizations, and resources:

Clinical care access and quality (potential needs)

______ Affordable health insurance

______ Affordable health 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 (for diabetes, asthma, arthritis, etc.)

______ Immunization programs

______ Improved health care quality

______ Integrated, coordinated care (less fragmented care)

______ Prenatal care programs

______ Screening programs (cholesterol, diabetes, mammography, colorectal, etc.)

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

______

______

______

Notes on programs, legislation, organizations, and resources:

Social and economic (potential needs)

______ Children and family services
______ Disabled services
______ Early learning before kindergarten (such as a Head Start type program)
______ Elder care assistance (help in taking care of older adults)
______ End of life care or counseling (care for those with advanced, incurable illness)
______ Help achieving good grades in kindergarten through high school
______ College education support and assistance programs
______ Homeless services
______ Legal assistance
______ Job training services
______ Senior services
______ Veterans' services
______ Violence and abuse services

Please describe and score any additional social/economic needs:

______
______
______

Notes on programs, legislation, organizations, and resources:

Physical environment (potential needs)

_____ Affordable housing
_____ Healthier air quality, water quality, etc.
_____ Transportation to and from appointments, grocery stores, etc.
_____ Healthy transportation options (sidewalks, bike paths, etc.)

Please describe and score any additional physical environment needs:

_____
_____
_____

Notes on programs, legislation, organizations, and resources:

Appendix III: Summary Scoring Table: Representative Scores Combined with Related Health Outcomes and Factors

Health Behavior Category

Community Identified Needs	Rep. Score	Related Health Factors and Outcomes	Health Factor Score	Total Combined Score
Access to healthy foods	6.6	Food environment	9	15.6
Exercise programs/education	5.1	Access to exercise opportunities	10	15.1
		Adult physical activity	9	14.1
		Teen exercise	10	15.1
Nutrition education	5.7	Adult nutrition	9	14.7
		Teen nutrition	9	14.7
Safe-sex education programs	5.8	Sexually transmitted infections	10	15.8
		Teen birth rate	10	15.8
Substance abuse services and programs	6	Excessive drinking	9	15
		Drug misuse	12	18
		Alcohol Impaired driving deaths	8	14
Tobacco prevention and cessation programs	4.4	Smoking adult	14	18.4
		Smoking teen	10	14.4
Weight management programs	6.4	Obese/Overweight adults	16	22.4
		Obese/Overweight teenagers	13	19.4

Wellness, prevention, and education programs for cancer	5.5	Cancer - all	6	11.5
		Breast cancer	9	14.5
		Colorectal cancer	6	11.5
		Leukemia	3	8.5
		Lung cancer	5	10.5
		Non-Hodgkin's lymphoma	5	10.5
		Pancreatic cancer	5	10.5
		Prostate cancer	8	13.5
		Skin cancer (melanoma)	12	17.5
Wellness and prevention programs	5.7	Accidents	11	16.7
		AIDS	7	12.7
		Alzheimer's	7	12.7
		Arthritis	6	11.7
		Asthma	5	10.7
		Cerebrovascular diseases	7	12.7
		Diabetes	13	18.7
		Flu/pneumonia	7	12.7
		Heart disease	8	13.7
		High blood pressure	11	16.7
		High cholesterol	11	16.7
		Mental illness	13	18.7
		Nephritis	6	11.7
		Obese/overweight adults	16	21.7
		Respiratory disease	10	15.7
		Suicide	12	17.7

Clinical Care Category

Community Identified Needs	Rep. Score	Related Health Factors and Outcomes	Health Factor Score	Combined Score
Affordable care for low income individuals	6.2	Children in poverty	10	16.2
Affordable dental care for low income individuals	6	Dental visits, preventative	9	15
Affordable health insurance	8.2	Uninsured adults	13	21.2
Availability of behavioral health services (providers, suicide hotline, etc)	7.8	Mental health service providers	12	19.8
Availability of primary care providers	6	Primary care providers	11	17
Chronic disease management programs	5.7	Arthritis	6	11.7
		Asthma	5	10.7
		Diabetes	13	18.7
		High blood pressure	11	16.7
Immunization programs	3.2	Children immunized	7	10.2
		Flu/pneumonia	7	10.2
Improved health care quality	4.7	Preventable hospital stays	6	10.7
Integrated, coordinated care (less fragmented care)	5.4	No usual health care provider	10	15.4
		Preventable hospital stays	6	11.4
Prenatal care programs	4.5	Prenatal care 1st trimester	8	12.5
		Low birth weight	7	11.5
Screening programs (cholesterol, diabetic, mammography, etc)	5	Cholesterol screening	10	15
		Colorectal screening	6	11
		Diabetic screening	9	14
		Mammography screening	12	17

Social and Economic Category

Community Identified Needs	Rep. Score	Related Health Factors and Outcomes	Health Factor Score	Combined Score
Children and family services	6	Children in poverty	10	16
		Inadequate Social Support	7	13
Disabled services *	5.3	* See note below	8	13.3
Early learning before kindergarten (such as a Head Start type program)	5.9	High school graduation rate	7	12.9
Education: Assistance in achieving good grades in kindergarten through high school	6.3	High school and college education rate	7	13.3
Education: College education support and assistance programs	4.1	High school and college education rate	7	11.1
Elder care assistance (help in taking care of older adults) *	5.2	* See note below	8	13.2
End of life care or counseling (care for those with advanced, incurable illness) *	4.9	* See note below	8	12.9
Homeless services	6.6	Unemployment rate	6	12.6
Job training services	4.8	Unemployment rate	6	10.8
Legal assistance *	5.8	* See note below		5.8
Senior services	4.8	Inadequate Social Support	7	11.8
Veterans' services	5	Inadequate Social Support	7	12
Violence and abuse services	6.6	Violent crime rate	6	12.6

* Disabled services, elder care, end of life care, and legal assistance did not have an objective health factor measure associated with it. Therefore, we used a health factor value equal to the middle range of scores.

Physical Environment Category

Community Identified Needs	Rep. Score	Related Health Factors and Outcomes	Health Factor Score	Combined Score
Affordable housing	7.6	Severe housing problems	7.5	15.1
Healthier air quality, water quality, etc	3.5	Air pollution particulate matter	9	12.5
		Drinking Water	7	10.5
Healthy transportation options (sidewalk, bike paths, public transportation)	5.8	Long commute	5	10.8
		Driving to work alone	8	13.8
Transportation to and from appointments *	7.3	* See note below	8	15.3

* Transportation to and from appointments did not have an objective health factor measure associated with it. Therefore, we used a health factor value equal to the middle range of scores.

Appendix IV: Data Notes

A number of health factor and outcome data indicators utilized in this CHNA are based on information from the Behavioral Risk Factor Surveillance System (BRFSS). Starting in 2011, the BRFSS implemented a new weighting method known as raking. Raking improves the accuracy of BRFSS results by accounting for cell phone surveying and adjusting for a greater number of demographic differences between the survey sample and the statewide population. Raking replaced the previous weighting method known as post-stratification and is a primary reason why results from 2011 and later are not directly comparable to 2010 or earlier. BRFSS data is derived from population surveys. As such, the results have a margin of error associated with them that differs by indicator and by the population measured. For smaller populations, we aggregated data across two or more years to achieve a larger sample size and increase statistical significance. For margin of error information please refer to the CDC for national BRFSS data and to Idaho BRFSS for Idaho related data.