St. Luke's McCall Community Health Needs Assessment 2019

St Luke's®

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Introduction

The St. Luke's McCall Community Health Needs Assessment (CHNA)* is designed to help us better understand the most significant health challenges facing the individuals and families in our service area. 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.

Executive Summary

The St. Luke's McCall 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.

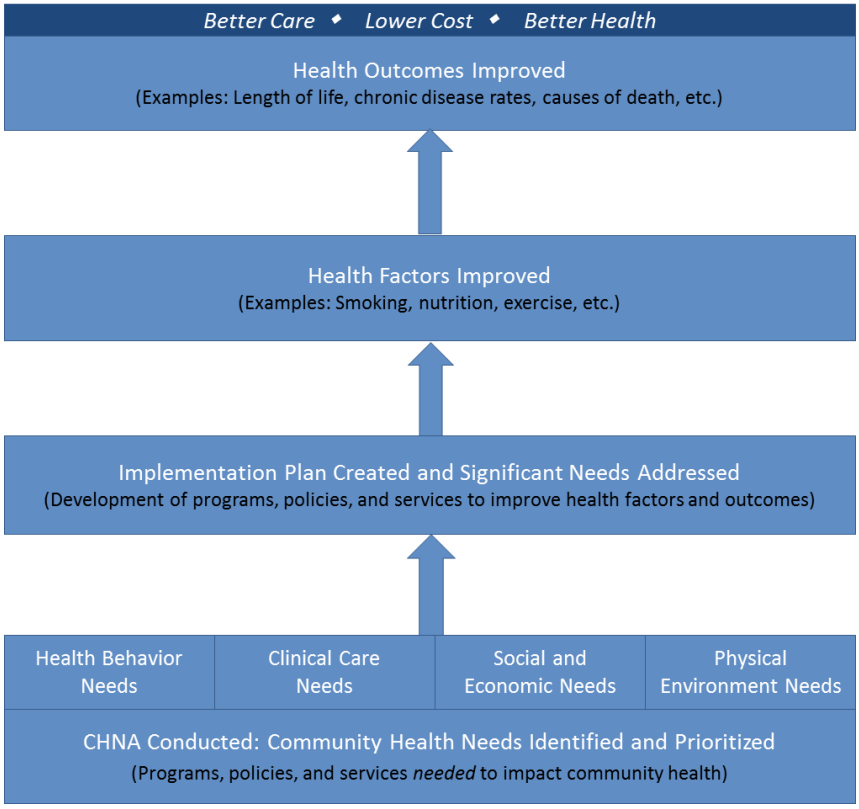
In our CHNA, we divide our health needs into four distinct categories: 1) health behaviors; 2) clinical care; 3) social and economic factors; and 4) physical environment. Each identified health need is included in one of these categories.

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

Group #2: Improve Mental Health

Group #3: Reduce Substance Abuse: Drug Misuse and Excessive Drinking

Group #4: Improve Access to Affordable Dental Care

Group #5: Improve Access to Affordable Health Care and 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

Obesity is one of our community's most significant health needs. Over 67% of the adults in our community and more than 25% of the children in our state are either overweight or obese. The percent of overweight/obese individuals is now higher in our community than it is in the nation as a whole and it is going up at a faster rate. Obesity is a serious concern because they it is associated with poorer mental health outcomes, reduced quality of life, and is a leading cause 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] Reducing obesity 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/

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 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. [4]

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." [5] These health needs can also be improved through evidence-based clinical programs.[6]

Affected Populations

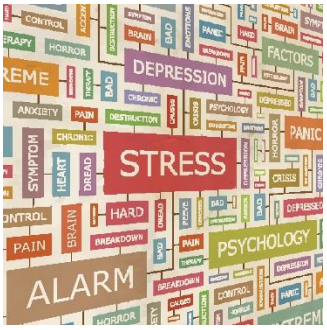
Some populations are more affected by these health needs than others. For example, low income individuals and those without college degrees have significantly higher rates of obesity.

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

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

[6] 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.[7] 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.[8]

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

[7] Mental Health, United States, 2009 - 2016 Reports, SAMHSA, www.samhsa.gov
[8] https://www.cdc.gov/mentalhealth/learn/index.htm

serious mental illness, suicide is the third leading cause of death for young adults.[9]

Fortunately, there are programs proven to be effective in lowering suicide rates and improving mental health. [10] The majority of adults who live with a mental health problem do not get corresponding treatment.[11] Stigma surrounding the receipt of mental health care is among the many barriers that discourage people from seeking treatment.[12] Increasing physical activity and reducing obesity are also known to improve mental health.[13]

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.[14]

[9] https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

[10]https://www.samhsa.gov/suicide-prevention/samhsas-efforts

[11]Substance Abuse and Mental Health Services Administration, Behavioral Health Report, United States, 2012 pages 29 - 30

[12] Idaho Suicide Prevention Plan: An Action Guide, 2011, Page 9

[13] http://www.cdc.gov/healthyplaces/healthtopics/physactivity.htm, http://www.cdc.gov/obesity/adult/causes.html

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

Significant Health Need #3: Reduce Substance Abuse: Drug Misuse and Excessive Drinking

Reducing substance abuse ranks among our community's most significant health needs. Approximately 25% of the people in our community participated in excessive/binge drinking in 2016 - a rate that is far higher than the national average. Our community representatives also provided substance abuse with one of their higher scores. The rate of deaths due to drug misuse has been climbing in our community and across the nation. An in-depth analysis of 2016 U.S. drug overdose data shows that America's overdose epidemic is spreading geographically and increasing across demographic groups. Drug overdoses killed 63,632 Americans in 2016. Nearly two-thirds of these deaths (66%) involved a prescription or illicit opioid. [15]

Impact on Community

Reducing drug misuse can have a positive impact on society on multiple levels. Directly or indirectly, every community is affected by drug misuse and addiction, as is every family. This includes health care expenditures, lost earnings, and costs associated with crime and accidents. This is an enormous burden that affects all of society - those who abuse these substances, and those who don't. 50% to 80% of all child abuse and neglect cases substantiated by child protective services involve some degree of substance abuse by the child's parents.[16]

In 2015, over 27 million people in the United States reported current use of illicit drugs or misuse of prescription drugs, and over 66 million people (nearly a quarter of the adult and adolescent population) reported binge drinking in the past month. Alcohol and drug misuse

[15] https://www.cdc.gov/media/releases/2018/p0329-drug-overdose-deaths.html
[16] http://archives.drugabuse.gov/about/welcome/aboutdrugabuse/magnitude/

and related disorders are major public health challenges that are taking an enormous toll on individuals, families, and society. Neighborhoods and communities as a whole are also suffering as a result of alcohol- and drug-related crime and violence, abuse and neglect of children, and the increased costs of health care associated with substance misuse. It is estimated that the yearly economic impact of substance misuse is $249 billion for alcohol misuse and $193 billion for illicit drug use.[17]

Drug addiction is a brain disorder. Not everyone who uses drugs will become addicted, but for some, drug use can change how certain brain circuits work. These changes make it more difficult for someone to stop taking the drug even when it's having negative effects on their life and they want to quit. [18]

How to Address the Need

We can address drug misuse through both prevention and treatment. Health care practitioners, communities, workplaces, patients, and families all can contribute to preventing drug abuse. The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Prevention Week Toolkit contains many valuable ideas.

Treatment can incorporate several components, including withdrawal management (detoxification), counseling, and the use of FDA-approved addiction pharmacotherapies. Research has shown that a combined approach of medication, counseling, and recovery services works best. [19] In addition, recent studies reveal that individuals who engage in regular aerobic exercise are less likely to use and abuse illicit drugs. These studies have provided convincing evidence to support the development of exercise-based interventions to reduce compulsive patterns of drug intake. [20] Organizations, such as the Phoenix Gym in Colorado, have shown they can help people addicted to drugs and alcohol recover. Health and Human Services Secretary Tom Price praised the Phoenix Gym for its ability to help participants remain sober. [21]

Affected Populations

Data shows that males under the age of 34 and people with lower incomes are more likely to have substance abuse problems. [22] Prescription drug misuse is growing most rapidly among our youth/young adults, adults older than age 50, and our veterans.[23]

[17] https://addiction.surgeongeneral.gov/executive-summary
[18] https://www.drugabuse.gov/related-topics/health-consequences-drug-misuse
[19] https://www.samhsa.gov/prescription-drug-misuse-abuse/specific-populations
[20] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3276339/
[21] https://www.denverpost.com/2017/08/02/trump-health-chief-tours-colorado-springs-gym/
[22] Idaho 2011 - 2016 Behavioral Risk Factor Surveillance System
[23] https://www.samhsa.gov/prescription-drug-misuse-abuse/specific-populations

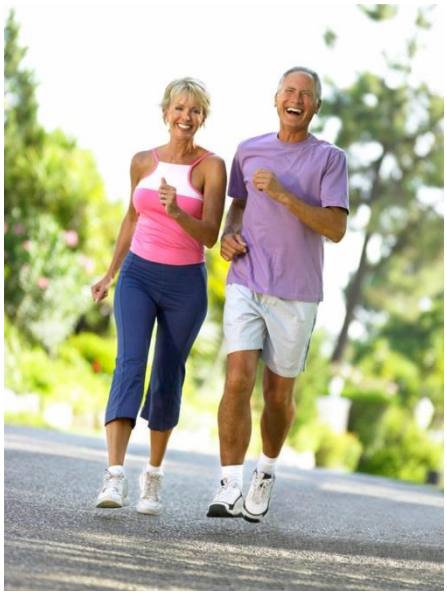
Significant Health Need #4: Improve Access to Affordable Dental Care

Our community representatives provided one of their highest scores for improving access to affordable dental care. Backing up their assessment, in 2016, nearly 45% of the adults in our community did not have a dental visit over the last year according to a survey conducted by BRFSS. [24] These factors served to rank affordable dental care as one of our most important health issues.

Impact on Community

Oral health is essential to general health and well-being. Poor oral health can cause pain and suffering that devastate overall health and result in financial and social costs that diminish quality of life and burden society. Oral health means much more than healthy teeth. It means being free of chronic oral-facial pain, throat cancers, oral soft tissue lesions, birth defects such as cleft lip and palate, and scores of other diseases and disorders that affect the craniofacial tissues. These are tissues whose functions we often take for granted, yet they represent the very essence of our humanity. They allow us to speak and smile; smell, taste, touch, chew, and swallow; and convey feelings and emotions through facial expressions. They also provide protection against microbial infections. Therefore, individuals with craniofacial conditions may experience loss of self-image and self-esteem, anxiety, depression, and social stigma; these in turn may limit educational, career, and marital opportunities and affect other social relations.

New research is also pointing to associations between chronic oral infections and heart and lung diseases, stroke, low-birth-weight, and premature births. Associations between periodontal disease and diabetes have long been noted. Put simply, we cannot be healthy without oral health. [25]



How to Address the Need:

Safe and effective disease prevention measures exist that everyone can adopt to improve oral health and prevent disease. These measures include daily oral hygiene procedures and other lifestyle behaviors, community programs such as community water fluoridation and tobacco cessation programs, and provider-based interventions such as the placement of dental sealants and examinations for common oral and pharyngeal cancers. The evidence for an association between tobacco use and oral diseases has been clearly delineated in numerous Surgeon General reports on tobacco, and the oral effects of nutrition and diet are

[24] Idaho and National 2002 – 2016 Behavioral Risk Factor Surveillance System
[25] https://www.nidcr.nih.gov/research/data-statistics/surgeon-general#overview

presented in the Surgeon General's report on nutrition. [26]

More can be done to ensure that the messages of oral health promotion and disease prevention are getting through to the most affected populations. We will work with our community partners to call attention to these measures and use them to improve oral health in our community.

Affected populations:
Research shows "a silent epidemic" of oral diseases is affecting our most vulnerable citizens—poor children, the elderly, and many members of racial and ethnic minority groups.[27]

[26] Ibid
[27] Ibid

Significant Health Need #5: Improve Access to Affordable Health Care and Affordable Health Insurance

Our CHNA process identified access to affordable health care and access to affordable health insurance as significant community health needs. The CHNA health indicator data and relatively high community representative scores served to rank them as some of our most urgent health issues.

Impact on Community

Access to affordable health insurance and health care are important indicators of health especially for the poor. The richest people in our society live between 10 to 15 years longer than the poorest according findings in the medical journal Jama.[28] According to the Gallup-Healthways Well-Being Index, Americans in poverty are significantly more likely than those who are not to struggle with a wide array of chronic mental and physical health problems.[29]

Further, 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.[30]

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[28] https://jamanetwork.com/journals/jama/fullarticle/2513561

[29] http://www.gallup.com/poll/158417/poverty-comes-depression-illness.aspx

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

Based on the evidence to date, the health consequences of the uninsured are real. [31] 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. [32]

How to Address the Need:
We will work with our community to improve access to comprehensive, high-quality health care services 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.[33]

[31] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881446/
[32] https://www.ncbi.nlm.nih.gov/pubmed/28574234
[33] 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 McCall Overview

Background

St. Luke's McCall (SLM) has been committed to serving the needs of a growing region for over 62 years. Founded in 1956 as a community hospital called McCall City Hospital, the hospital has evolved through various management and funding structures to its current non-profit status and membership in St. Luke's Health System (SLHS).

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

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

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

SLM has 290 full- and part-time employees, 62 hospital volunteers, and a 16-member community board. On average, St. Luke's McCall sees 6,500 emergency room patients annually, and an additional 56,000 patients for all other outpatient services. Our average daily in-patient census is 4.4.

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:

Integrity
Compassion
Accountability
Respect
Excellence

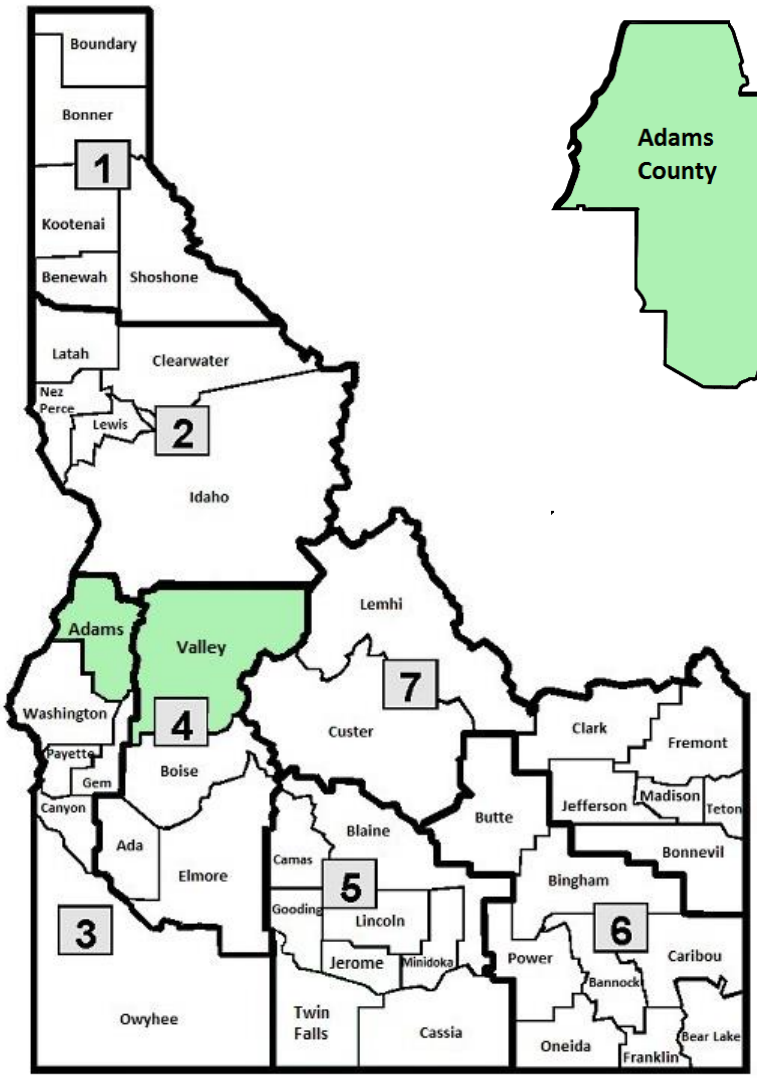
Governance Structure

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.

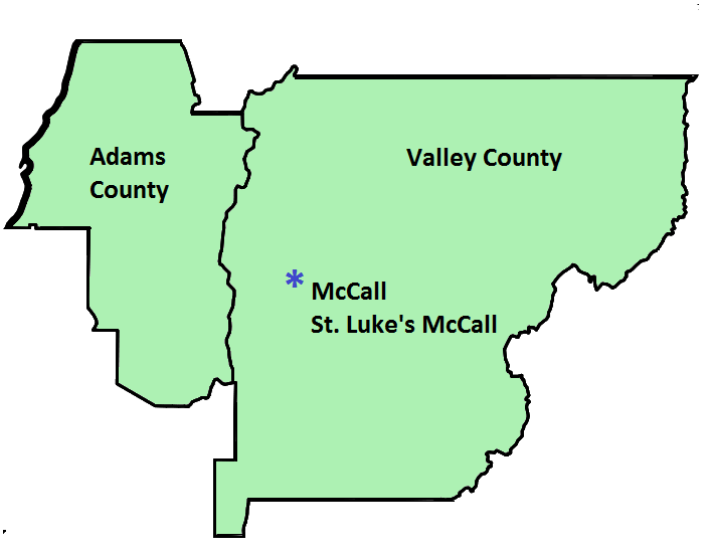
The Community We Serve

This section describes our community in terms of its geography and demographics. Adams and Valley counties represent the geographic area used to define the community we serve also referred to here as our primary service area or service area. The criteria we use in selecting this area as the community we serve is to include the entire population of the counties where at least 70% of our inpatients reside. The residents of these counties comprise about 80% of our inpatients with approximately 61% of our inpatients living in Valley County and 19% in Adams County. Adams and Valley counties are part of Idaho Health Districts 3 and 4, as shown in the maps below.

Idaho Health District Map [34]



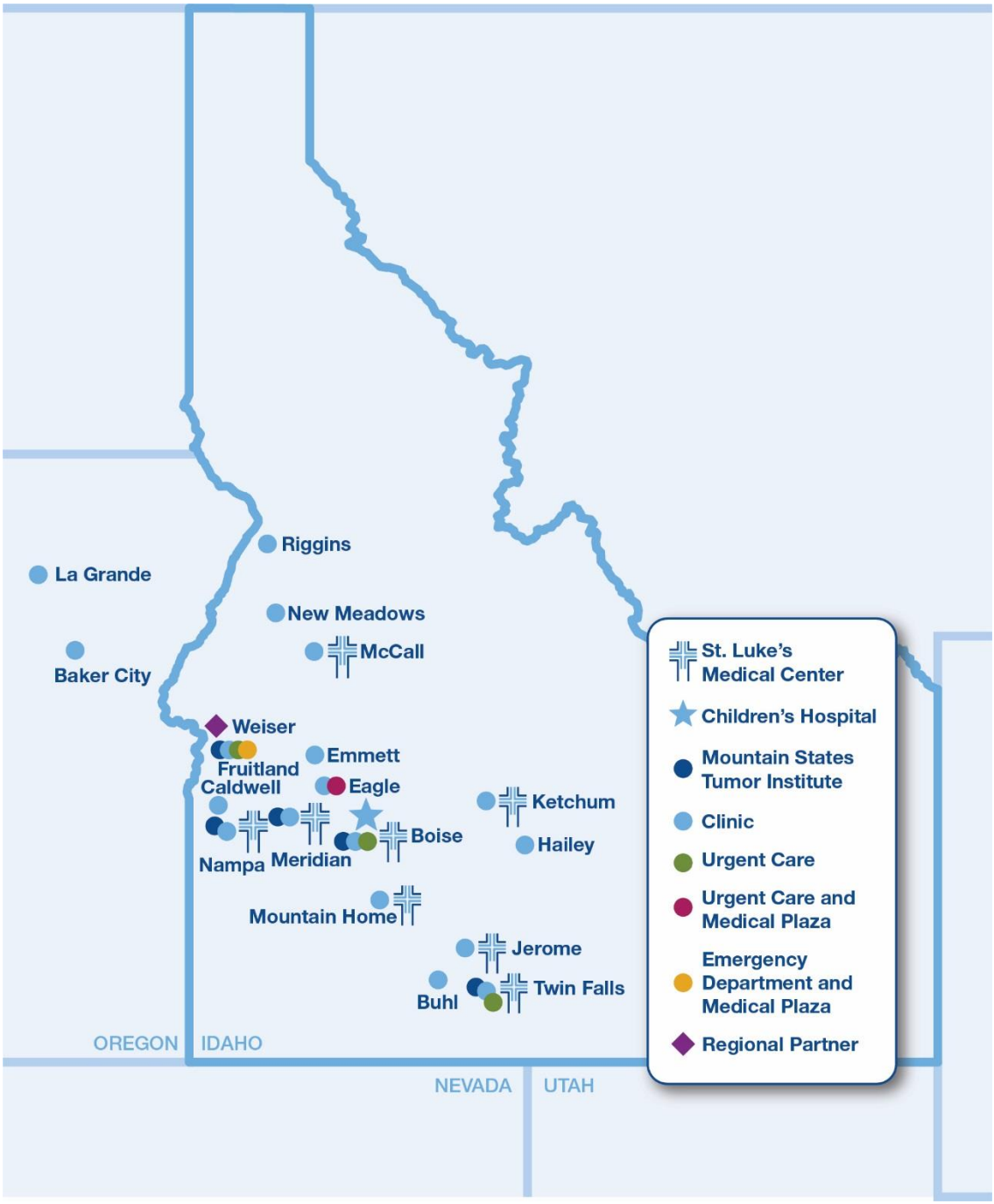
Adams and Valley County Map



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

Our patients in the surrounding counties of southwestern Idaho 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 95% white population while the nation as a whole is 78% white. The Hispanic population in Idaho represents 12% of the overall population and about 4% of our defined service area. Adams County is approximately 3% Hispanic, and Valley County is 5% Hispanic.

Population by Race and Ethnicity 2016[35]

Residence	Total Population	Race				Ethnicity	
		White	Black	American Indian or Alaska Native	Asian or Pacific Islander	Non-Hispanic	Hispanic
Service Area	14,396	14,016	100	190	90	13,767	629
Adams	3,900	3,779	34	61	26	3,764	136
Valley	10,496	10,237	66	129	64	10,003	493
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		97%	1%	1%	1%	96%	4%
Adams		97%	1%	2%	1%	97%	3%
Valley		98%	1%	1%	1%	95%	5%
Idaho		95%	1%	2%	2%	88%	12%
National		78%	14%	1%	6%	82%	18%

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.[36] Adams and Valley Counties have followed that trend, experiencing a 29% increase in population within that timeframe.[37] St. Luke's McCall 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	11,127	14,396	29%
Idaho	1,293,953	1,683,140	30%
United States	281,421,906	323,127,513	15%

Aging

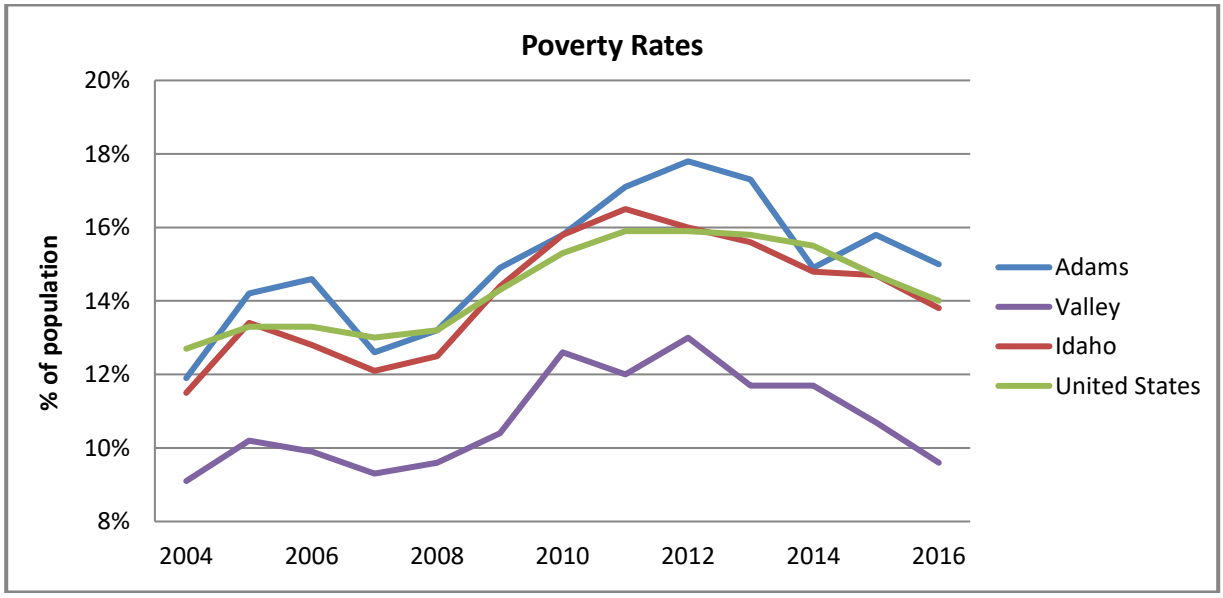
Over the past ten years the 65 plus year old age group was the fastest growing segment of our community. Currently, about 24% of the people in our community are over the age of 65. [38] According to the U.S. Census, about 15% of the people in the U.S. are over age 65.[39]

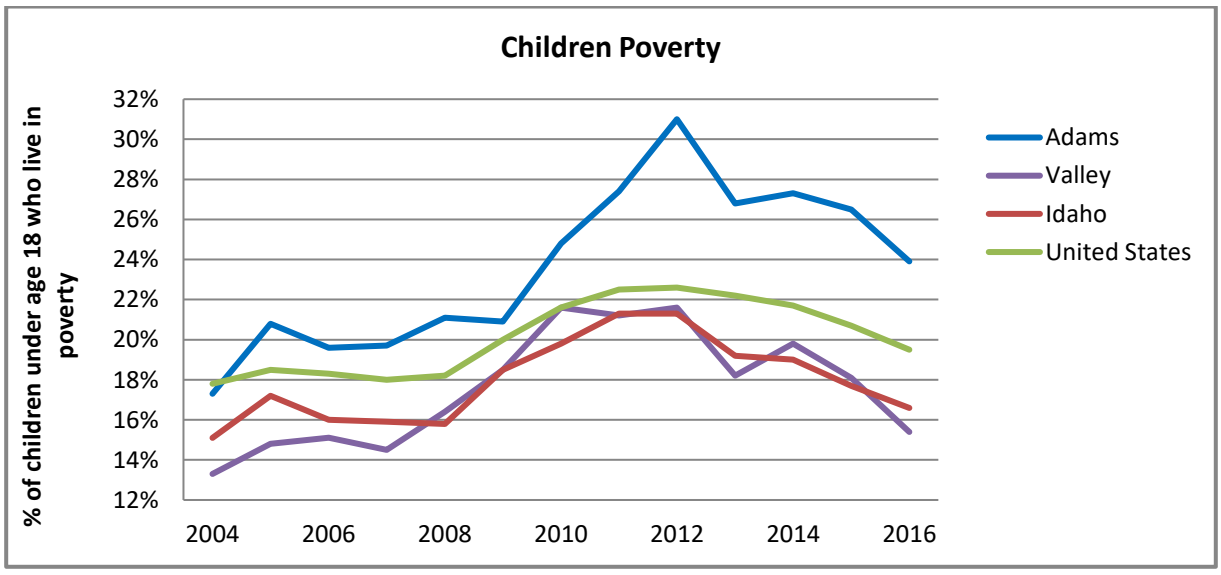
	Population by Age			
Year	Age 0-19	Age 20-44	Age 45-64	Age 65+
2000	2,851	2,979	3,602	1,695
Percent of Total	26%	27%	32%	15%
2010	2,937	3,433	4,981	2,487
Percent of Total	21%	25%	36%	18%
2016	2,797	3,479	4,640	3,480
Percent of Total	19%	24%	32%	24%

[36] U.S. Census Bureau: http://quickfacts.census.gov/qfd/index.html 2016
[37] Idaho Vital Statistics County Profile 2016
[38] Ibid
[39] http://www.census.gov/acs/www/data/data-tables-and-tools/index.php

Poverty Levels

The official United States poverty rate increased from 12.5% in 2003 to 14% in 2016. The poverty rate in Valley County is currently well below the national average at 9% but above the national average in Adams County. The poverty rate in our community for children under the age of 18 is again below the national average for Valley County and above the national average for Adams County. Although both Adams and Valley county childhood poverty rates are declining, Adam County's is still above where it was prior to the recession in 2008.[40]

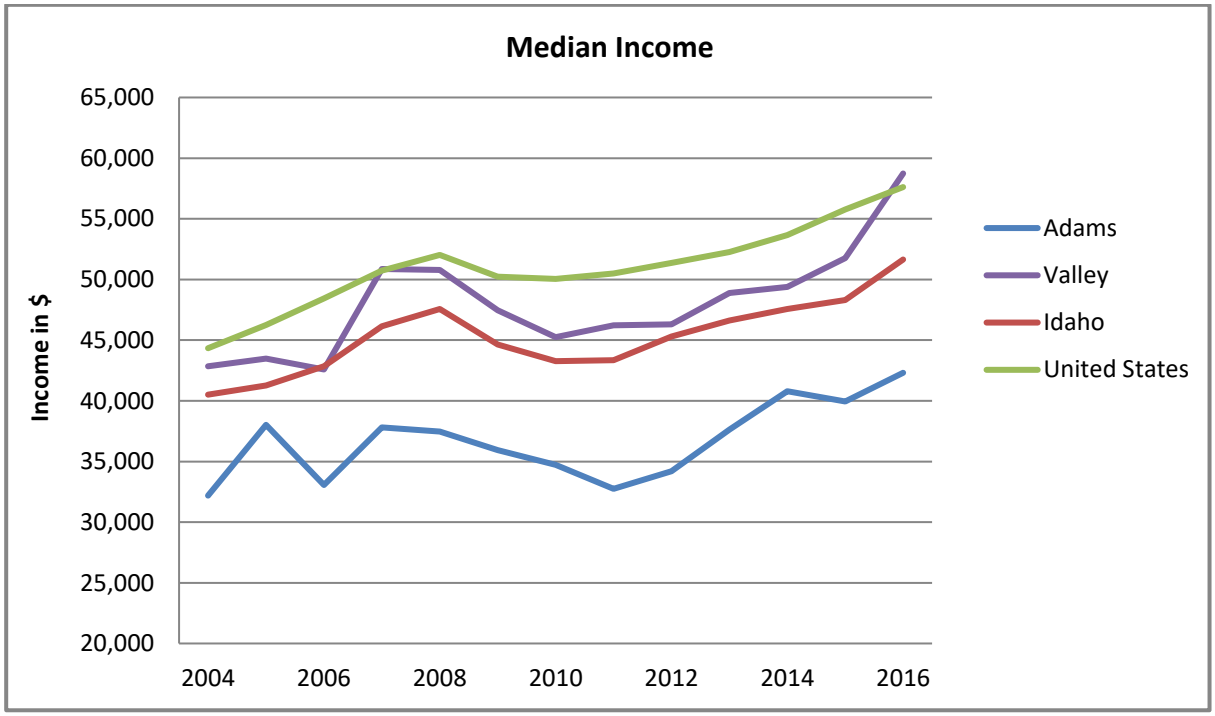




[40] Small Area Income and Poverty Estimates (SAIPE)
http://www.census.gov/did/www/saipe/data/statecounty/data/index.html

Median Household Income

Median income in the United States has risen by 33% since 2004. Growth in income in our service area during that period was also over 30%. Median income in Adams County is well below the national median and lower than Idaho's median income. Median income in Valley County is slightly above than the national median income.[41]



[41] 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.

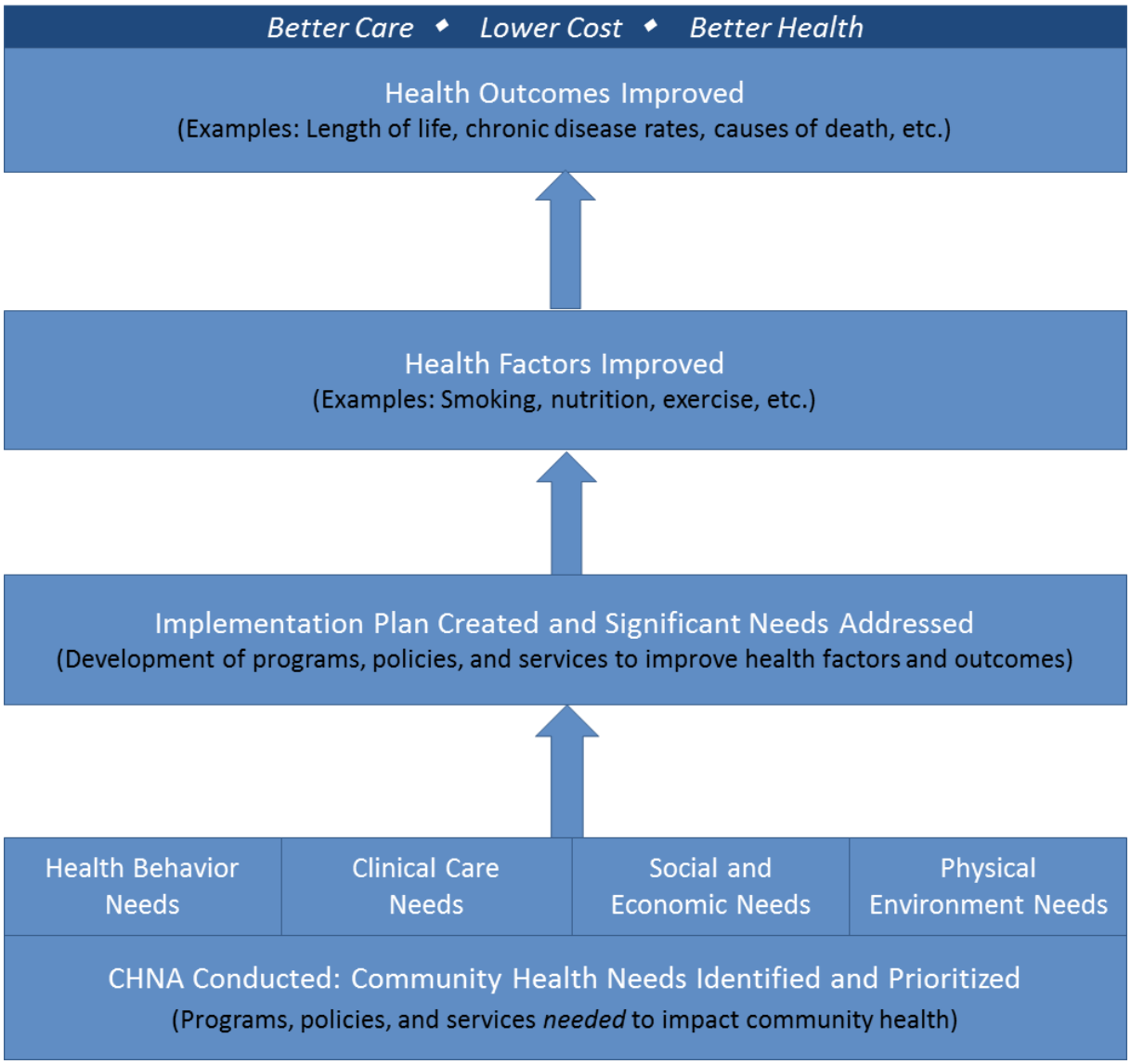
3. Community input is at the center of our CHNA process. In-depth **interviews are conducted with a diverse group of representatives** possessing extensive knowledge of

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**

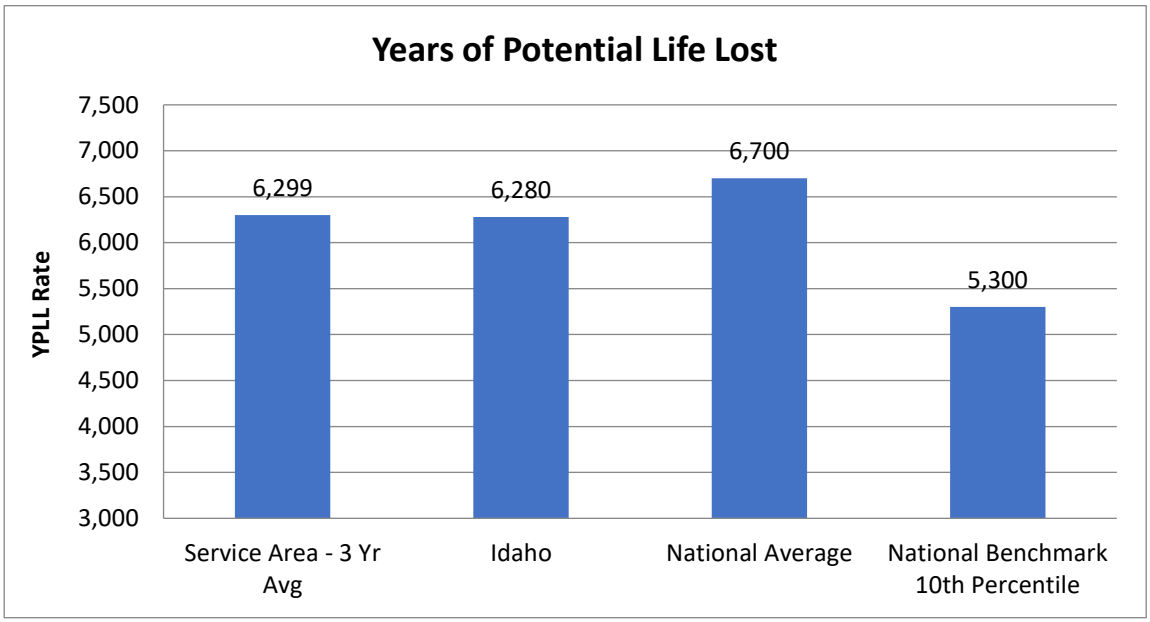
Health Outcome Measures and Findings

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 lower (better) than the national average.[42] This indicates that on average people in our service area are not dying prematurely.[43]

[42] *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org (used for national YPLL top 10% 2010 - 2012 average)

[43] 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)

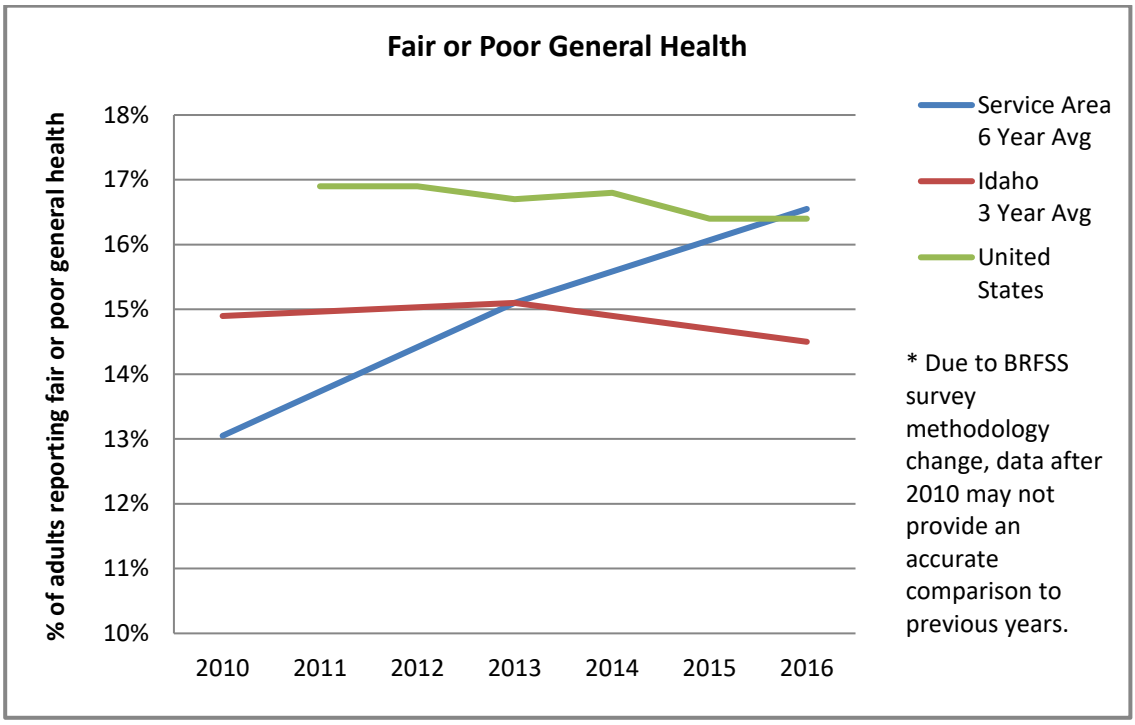
Understanding the health related quality of life of the population helps communities identify unmet health needs. Three measures from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) are used to define health-related quality of life: 1) The percent of adults reporting fair or poor health, 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.[44]

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

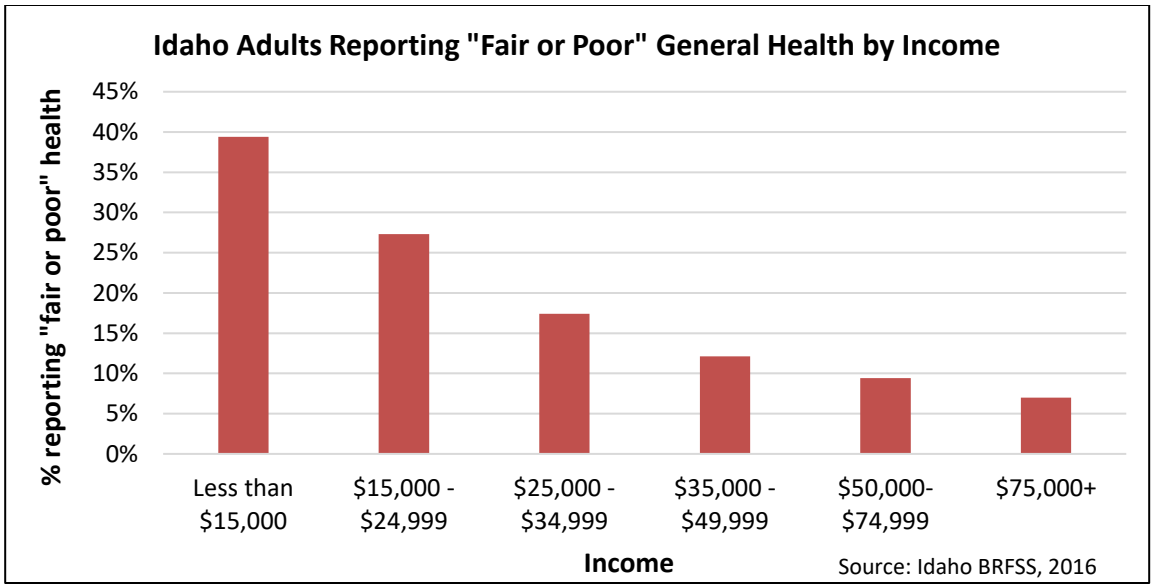
- **"Fair or Poor" General Health**

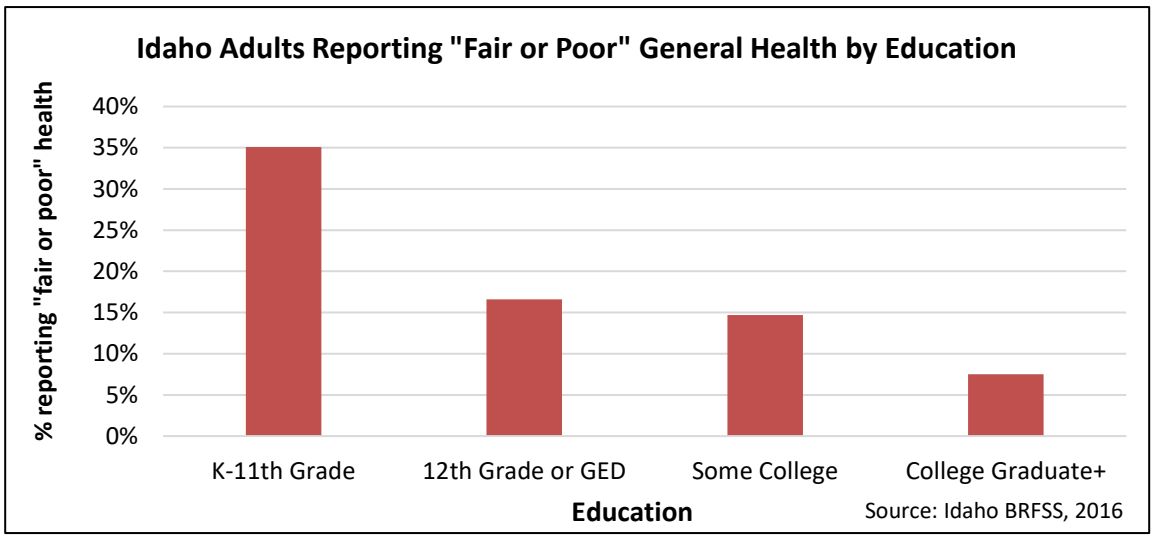
Fourteen point five percent (14.5%) of Idaho adults reported their health status as fair or poor in 2016, which is approximately the same as in 2010. For our service area, the percent of people reporting fair or poor general health is 16.4% in 2016, which is about the same as the national average of 16.4%.[45]

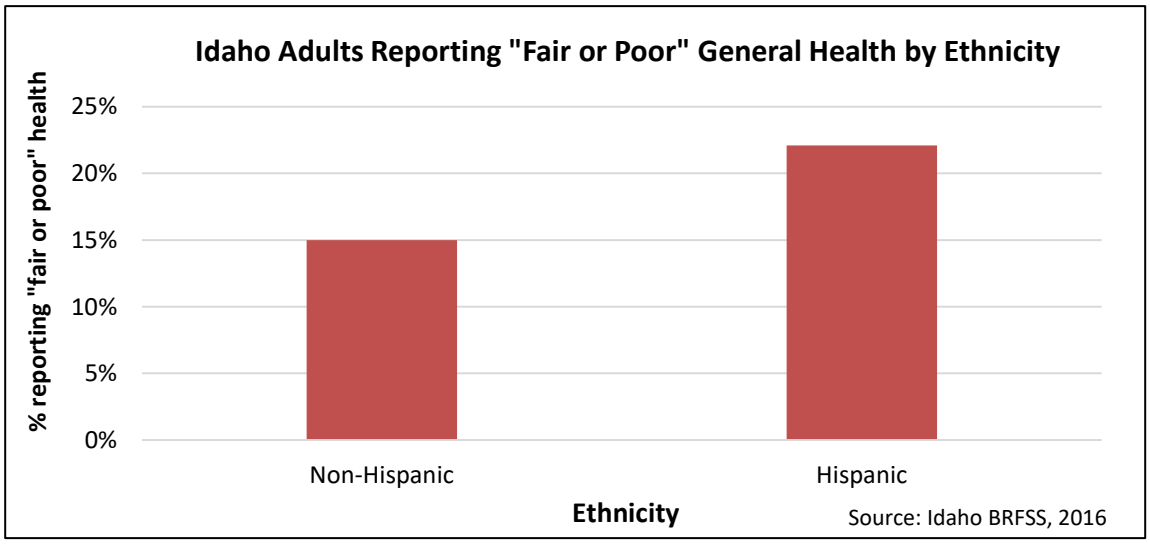


The charts below show that income and education greatly affect the levels of reported fair or poor general health. For example, people with incomes of less than $15,000 are five times more likely to report fair or poor general health than those with incomes above $75,000. In addition, Hispanics are significantly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

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

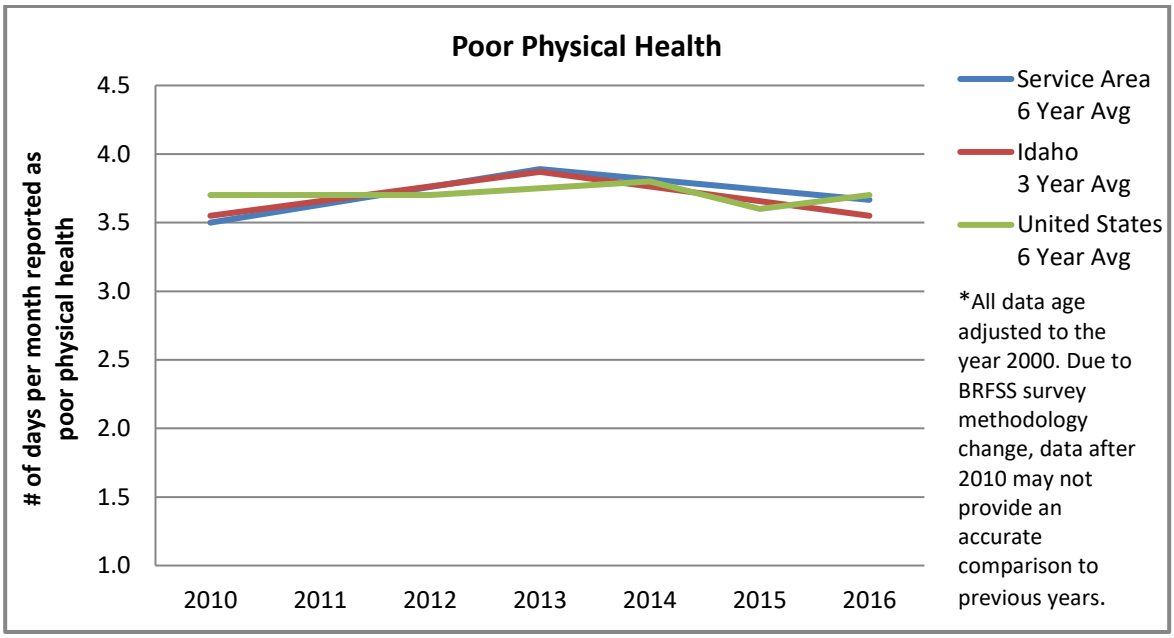

Idaho Adults Reporting "Fair or Poor" General Health by Income
% reporting "fair or poor" health
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Less than $15,000
$15,000 - $24,999
$25,000 - $34,999
$35,000 - $49,999
$50,000- $74,999
$75,000+
Income
Source: Idaho BRFSS, 2016


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

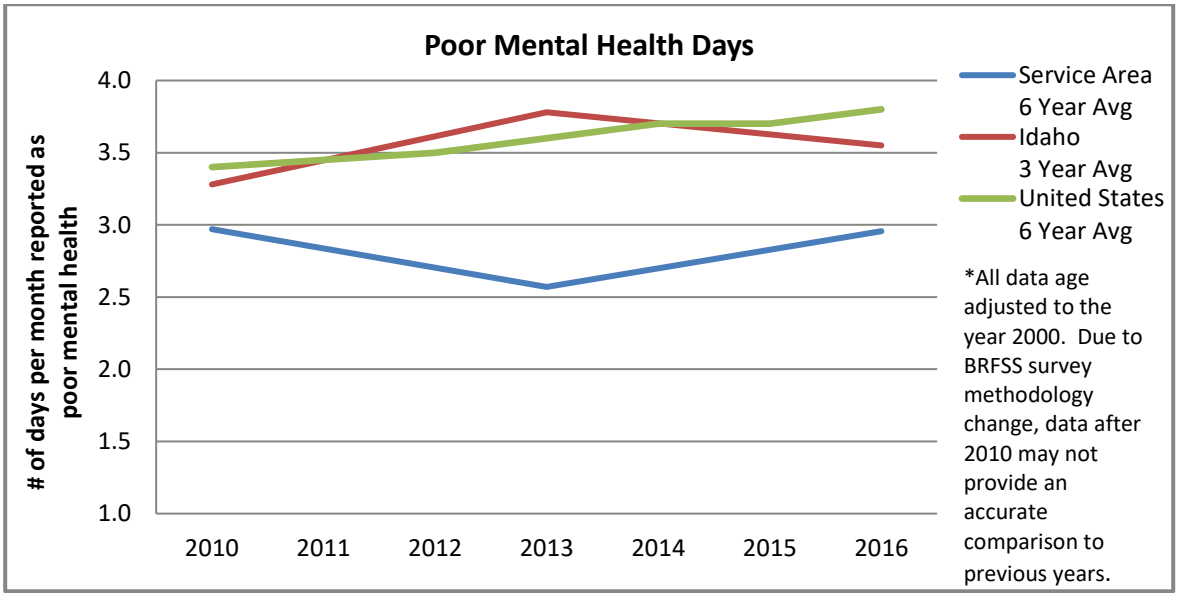
- **Poor Physical Health Days**

The number of reported poor physical health days for our service area is about the same as the national average. [46] The national top 10th percentile (best) is 3 days.[47]



- **Poor Mental Health Days**

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



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

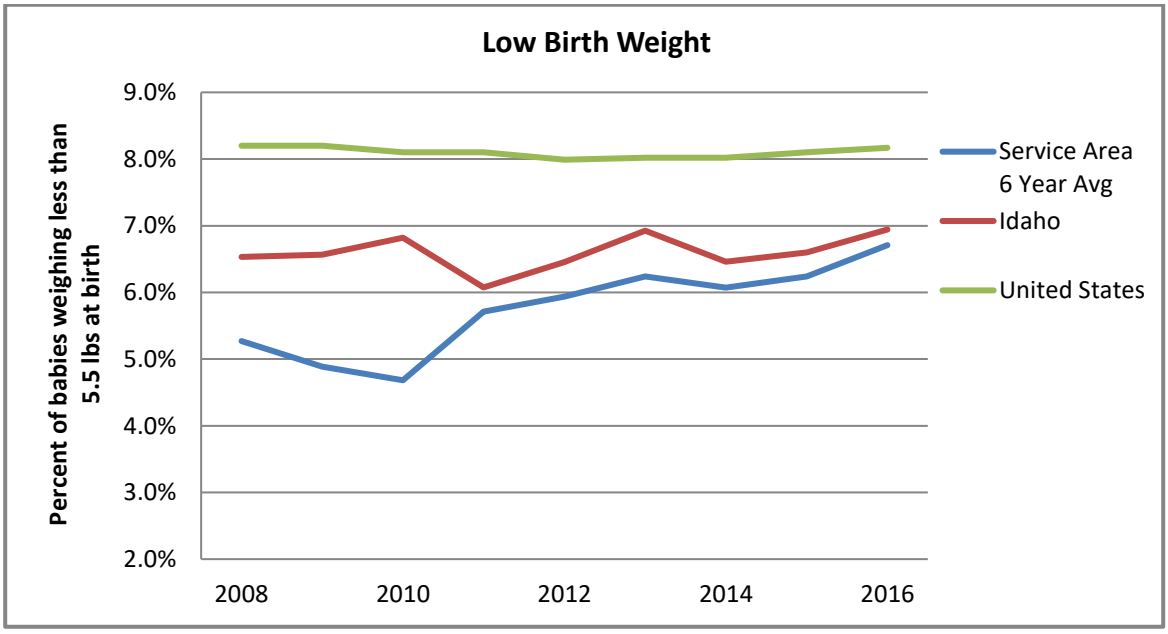
- **Low Birth Weight**

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.[48]

The percent of LBW babies in our service area and in Idaho is significantly below (better than) the national average.[49] This is a key indicator of future health. The national top 10th percentile for LBW is 6.0% and our service area is getting close to that level.

Low birth weight can be addressed in multiple ways, including:[50]

- 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	**3**	**1**	**2**	**3**	**9**

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

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

[50] 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. Adam County's 2018 overall outcome rank is 27th and Valley County's rank is 2nd out of a total of 42 counties in Idaho.[51] 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.

[51] 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.

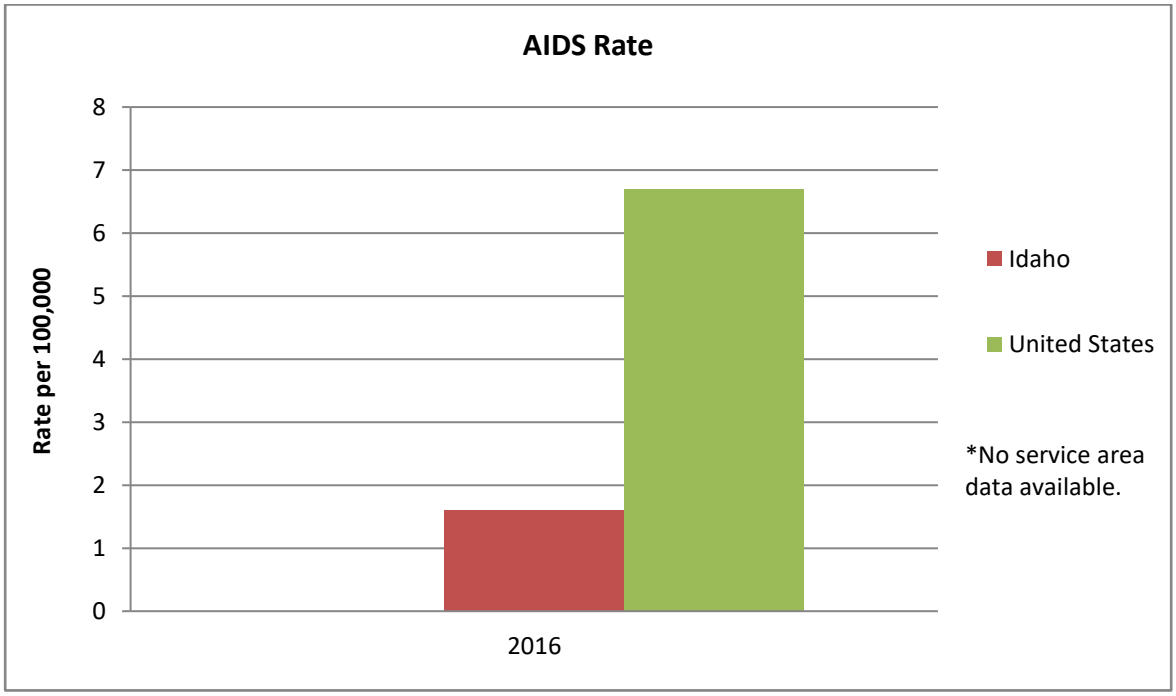
Chronic Disease Prevalence

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. [52] The trend in Idaho has been relatively flat from 2004.[53]

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).[54] 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.[55]



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**

[52] www.statehealthfacts.org
[53] www.healthandwelfare.idaho.gov/Portals/0/Health/Disease/STD%20HIV/2013_Facts_Book_FINAL.pdf
[54] http://www.cdc.gov/HIV/TOPICS/
[55] http://www.cdc.gov/hiv/youth/

- **Arthritis**

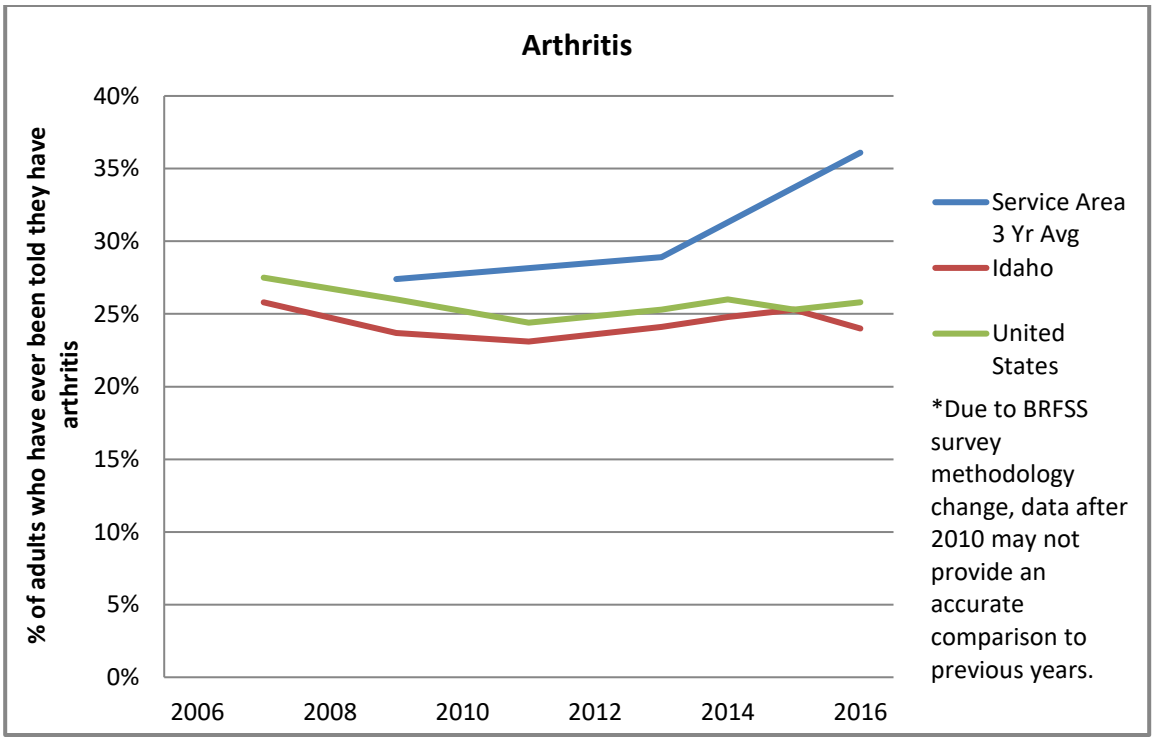
  In 2016, 22% of Idaho adults had ever been told by a medical professional that they had arthritis. The prevalence of arthritis in our service area is higher than the national average and the trend is increasing. This may partly be caused by the aging populationin our service area. The percentage of people age 65 or older in our service area is significantly higher than the national average and has been increasing over the past ten years. 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.[56]

  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.[57]

[56] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System
[57] Arthritis Foundation, http://www.arthritis.org/preventing-arthritis.php

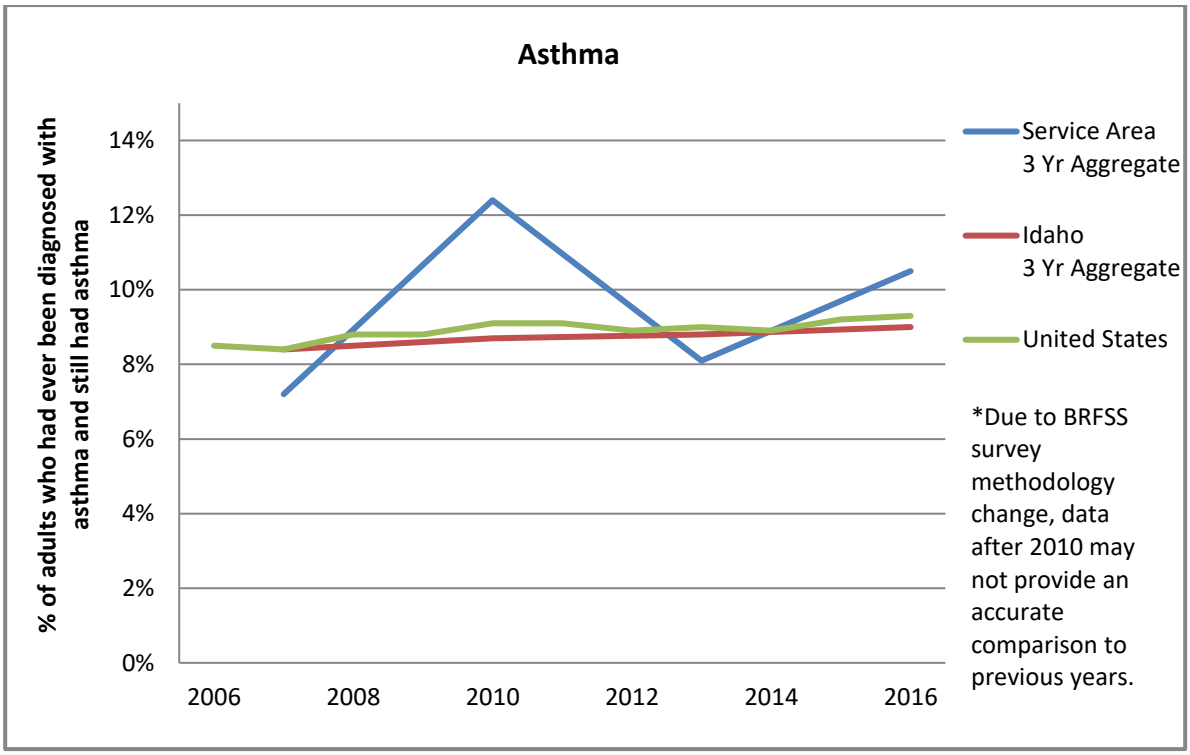


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S.**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Arthritis	**3**	**4**	**2**	**0**	**9**

- **Asthma**

The percentage of people with asthma in our service area is about the same as 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. [58]

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.[59]

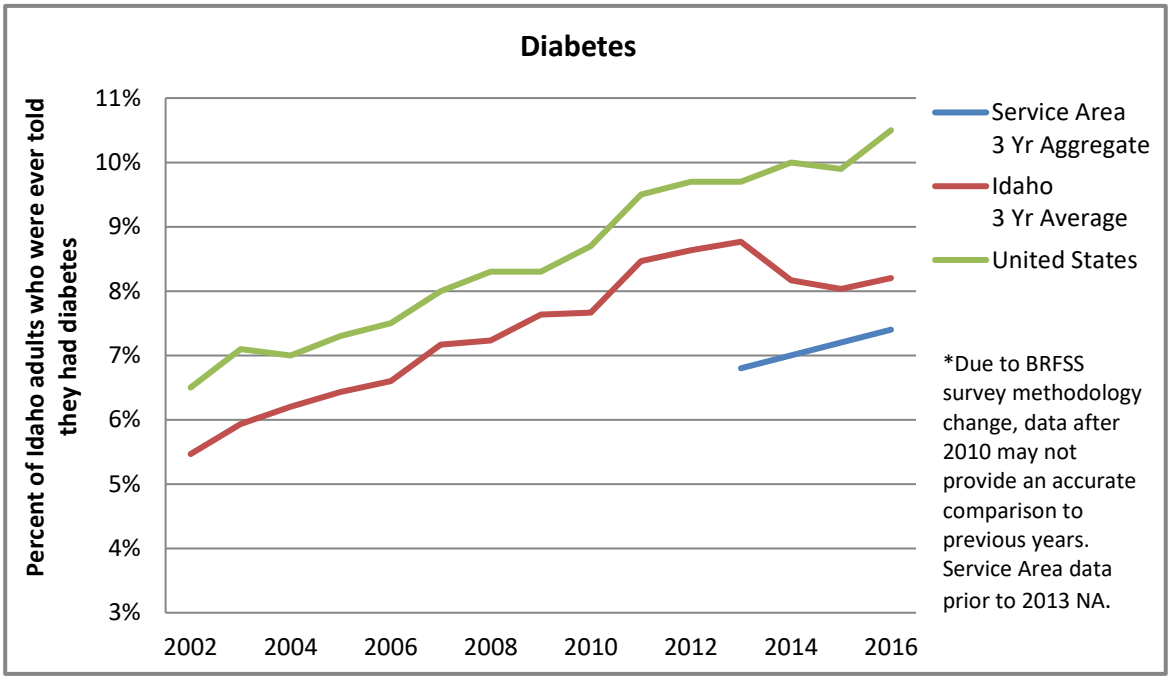


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Asthma	**2**	**2**	**2**	**0**	**6**

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

- **Diabetes**

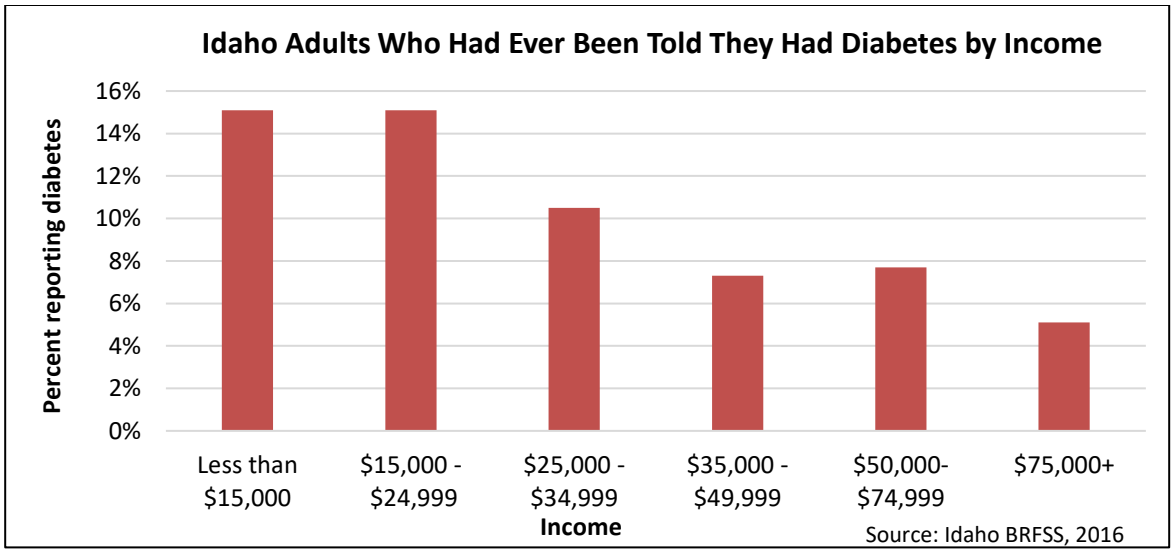
About 7.4% of the people in our community report that they have been told they have diabetes, which is well below the national average. The percent of people living with diabetes in Idaho and in the United States is up by about 40% over the past ten years, indicating an opportunity for greater focus on prevention. Diabetes is a serious health issue that can contribute to heart disease, stroke, high blood pressure, kidney disease, blindness and can even result in limb amputation or death.[60] 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. [61]

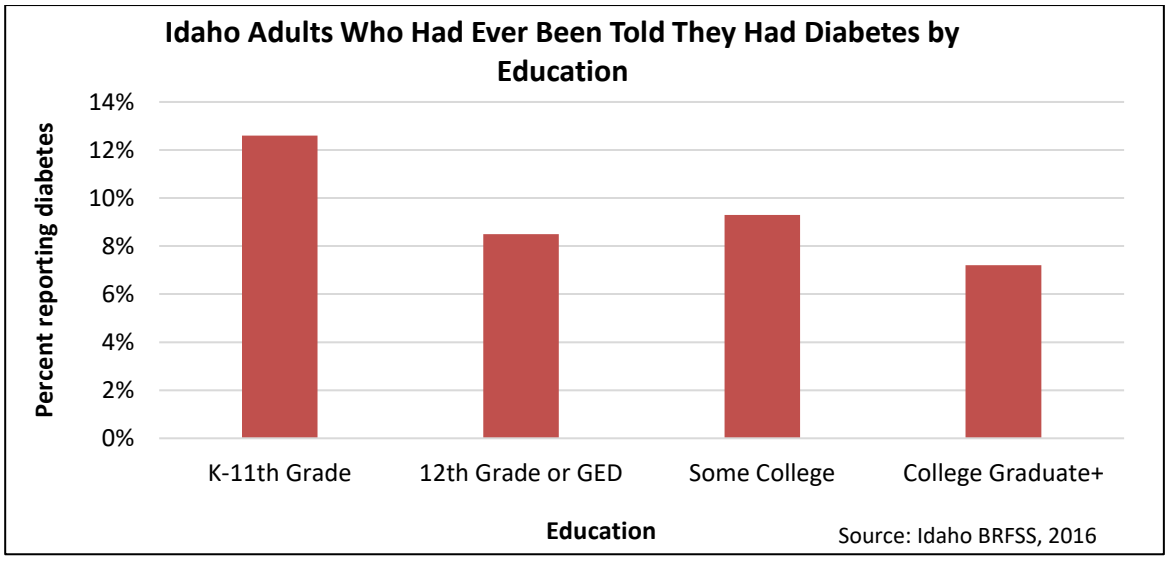


Other Highlights:

- 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.[62]

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





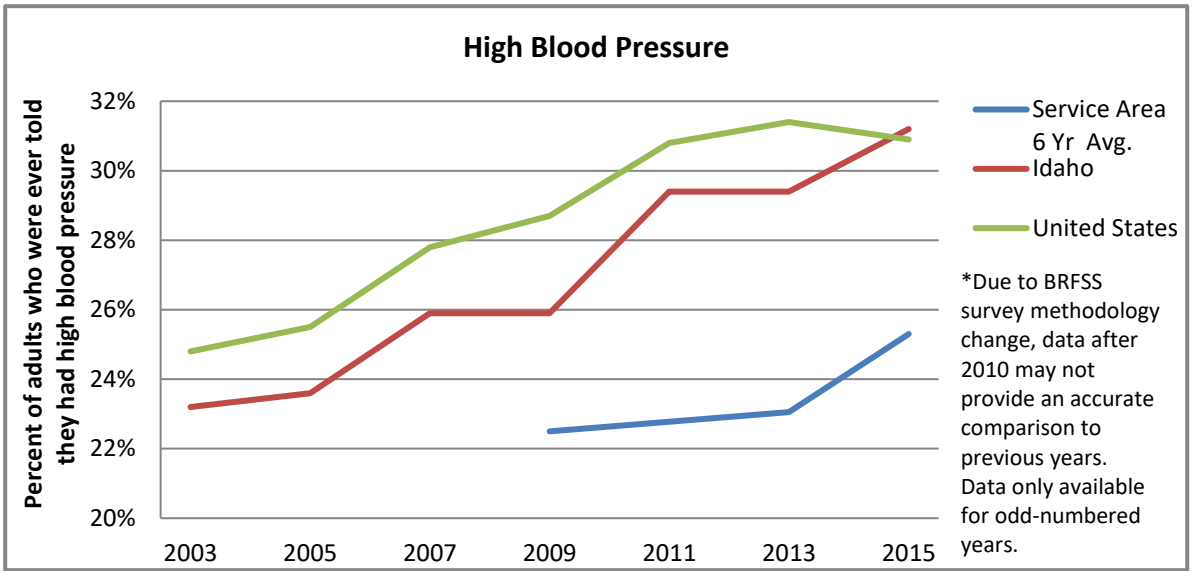
Studies indicate that the onset of type 2 diabetes can be prevented through weight loss, increased physical activity, and improving dietary choices. Diabetes can be managed through regular monitoring, following a physician-prescribed care regiment, adjusting diet, and maintaining a physically active lifestyle.[63]

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	**4**	**0**	**3**	**4**	**11**

[63] America's Health Rankings 2015-2018, 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 well below the national national average. High blood pressure is a major risk factor for heart disease, stroke, congestive heart failure, and kidney disease.[64]



- 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.[65]

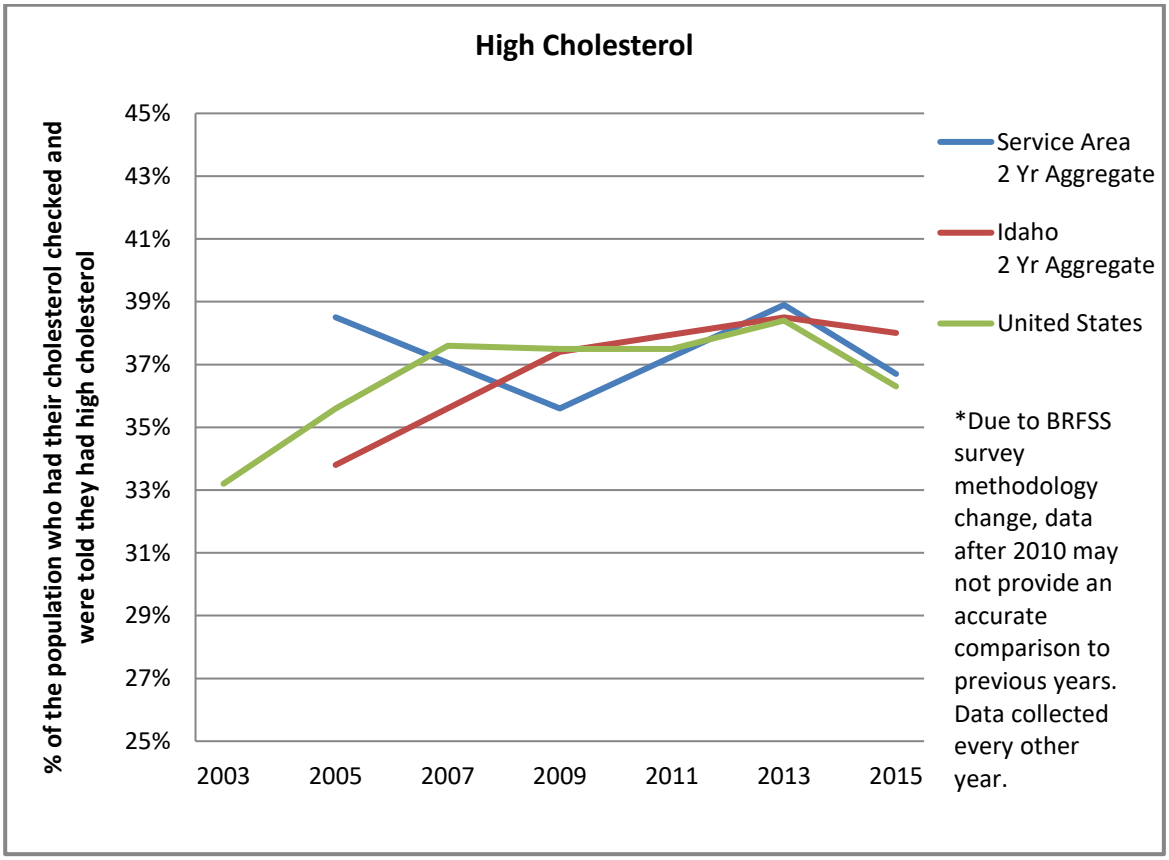
Healthy blood pressure may be maintained by changing lifestyle or combining lifestyle changes with prescribed medications.[66]

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	**3**	**0**	**3**	**2**	**8**

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

- **High Cholesterol**

Among those who had ever been screened for cholesterol in our service area, 36.7% reported that they were told their cholesterol was high in 2016, which is a about the same as the national average. The percentage of screened adults with high cholesterol has increased in Idaho and nationally since 2005. Sustained, increased cholesterol levels can lead to heart disease, heart attack, and other circulatory problems.[67]



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.[68]

[67] Ibid.
[68] Idaho 2011 - 2016 Behavioral Risk Factor Surveillance System

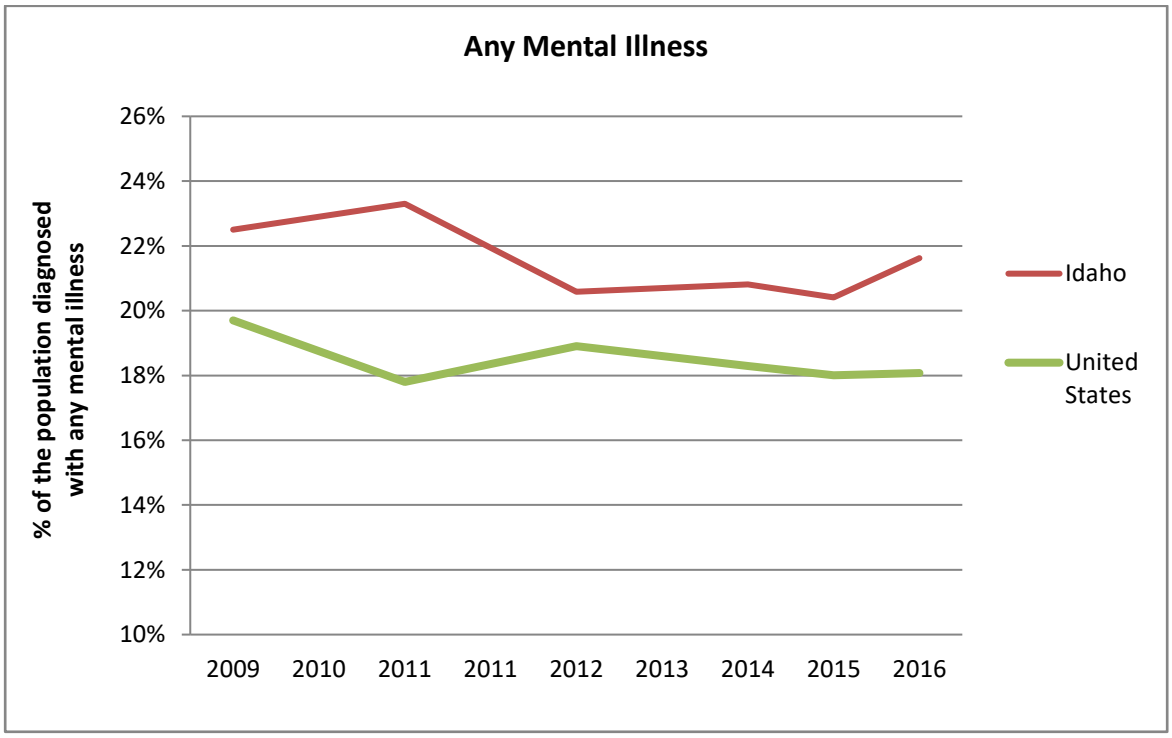
While some factors that contribute to high cholesterol are out of our control, like family history, there are many things a person can do to keep cholesterol in check, such as following a healthy diet, maintaining a healthy weight, and being physically active. For some individuals, a physician-recommended pharmacological intervention may be necessary.[69]

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	**2**	**2**	**3**	**2**	**9**

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

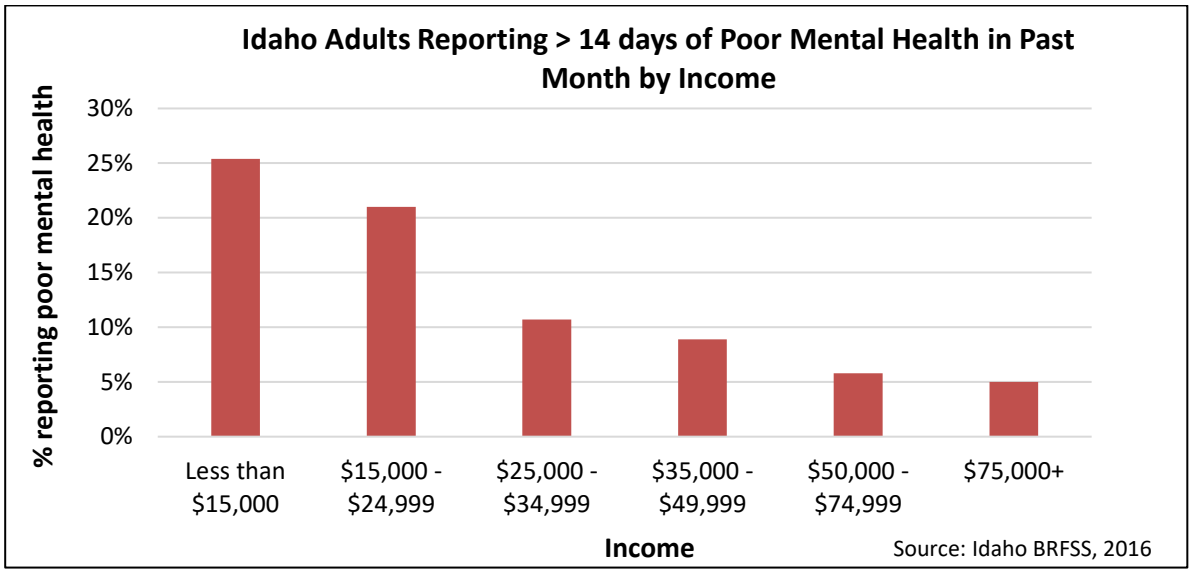
- **Mental Illness**

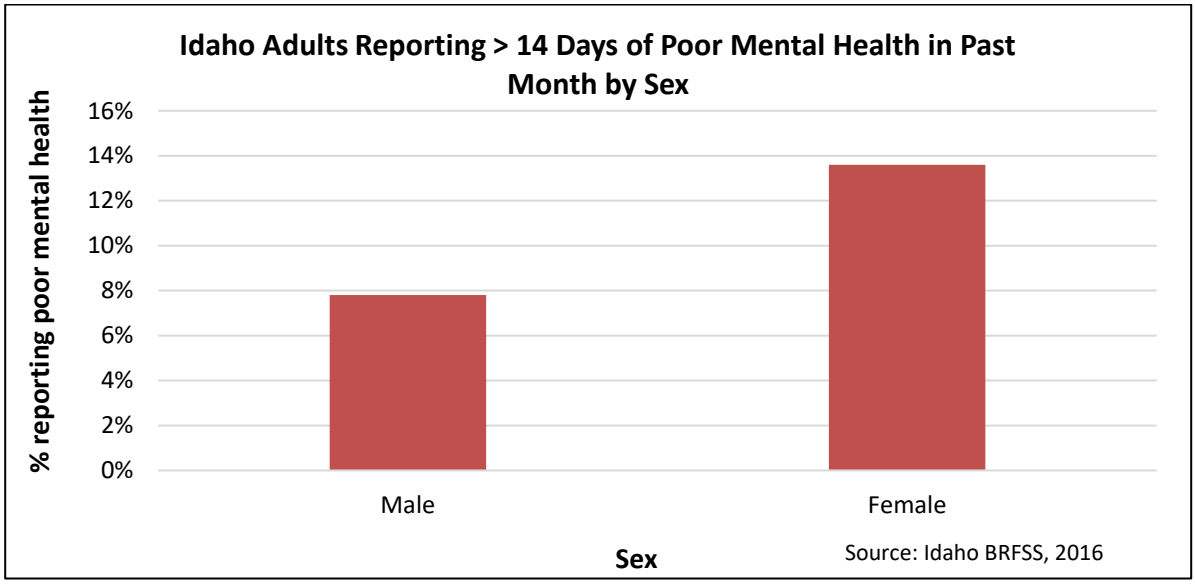
Community mental health status can help explain suicide rates as well as aid us in understanding the need for mental health professionals in our service area. The percentage of people age 18 or older having any mental illness (AMI) was 21.62% for Idaho in 2016. This was the fourth highest percentage of mental illness in the nation. The percentage of people having any mental illness for the United States as a whole was 18.07%.[70]



[70] Mental Health, United States, 2009 - 2016 Report, 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. [71]





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**

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

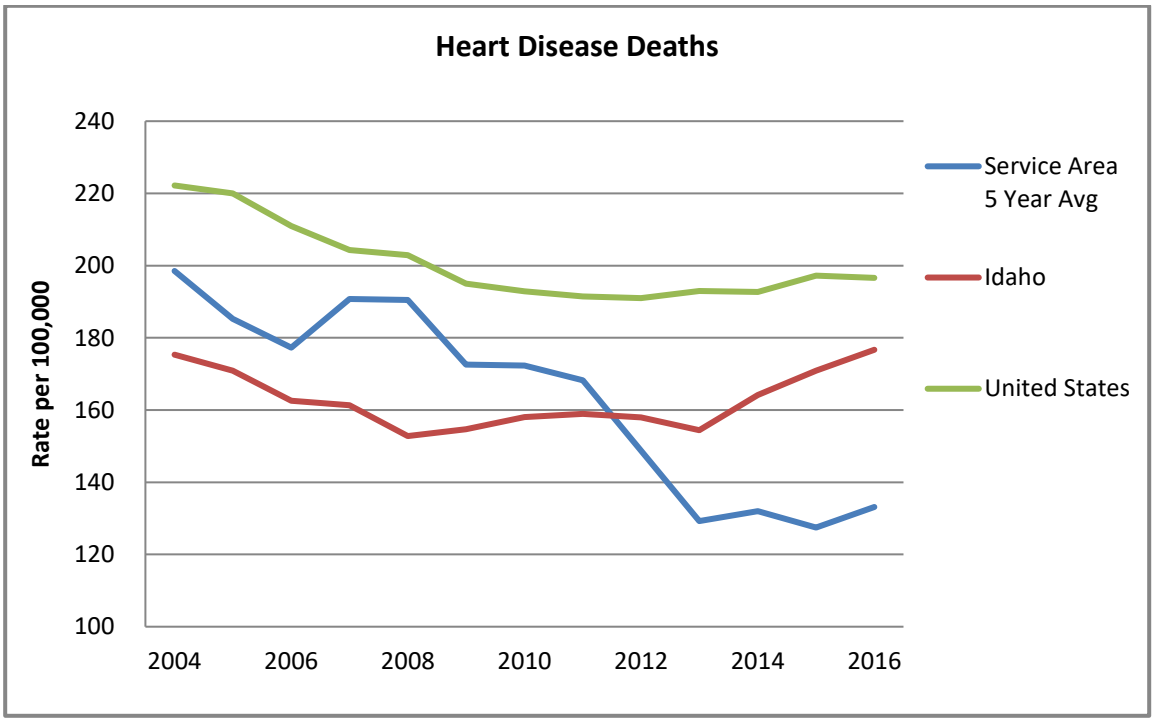
Top 10 Causes of Death

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 heart disease death rate has been in steady decline over the past 10 years. [72] It's important to note that even though mortality rates are declining, many individuals are living with chronic cardiac disease as new procedures prolong their lives.

  Heart disease remains the leading cause of death in the United States for both men and women and is now the leading cause of death in Idaho as well.[73] The death rate from heart disease in our service area is approximately 30% below the national average.



  Heart disease is a long-term illness that many individuals can manage through lifestyle changes and healthcare interventions. However, many interventions place a burden on affected individuals by constraining options and activities available to them and can result in costly and ongoing expenditures for health care. It's important to keep cholesterol levels and blood pressure in check to prevent heart disease.[74]

[72] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[73] America's Health Rankings 2015-2018, www.americashealthrankings.org
[74] 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	**0**	**0**	**4**	**2**	**6**

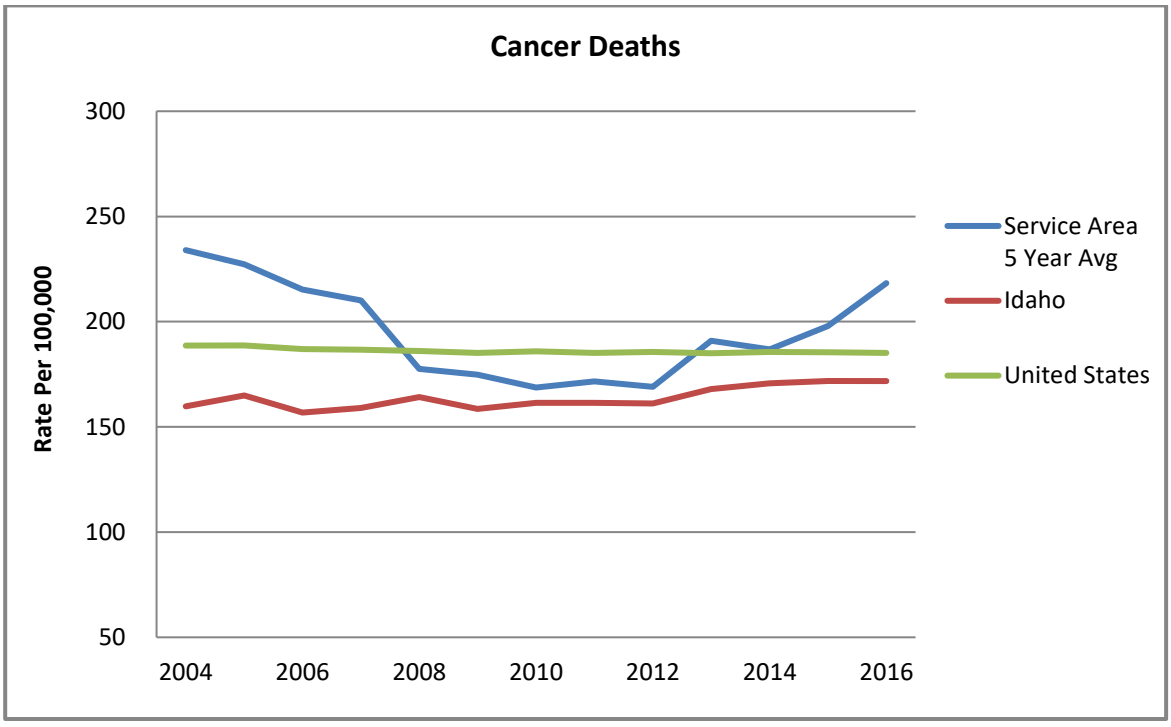
- **Cancer (malignant neoplasms)**

  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.[75]

  The chart below shows the cancer death rate in our service area is above the national average. The trend for cancer deaths is down nationally but has been rising in our service area for the past ten years.[76]



[75] Comprehensive Cancer Alliance for Idaho, Idaho Comprehensive Cancer Strategic Plan 2004-2010, www.ccaidaho.org

[76] 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.[77]

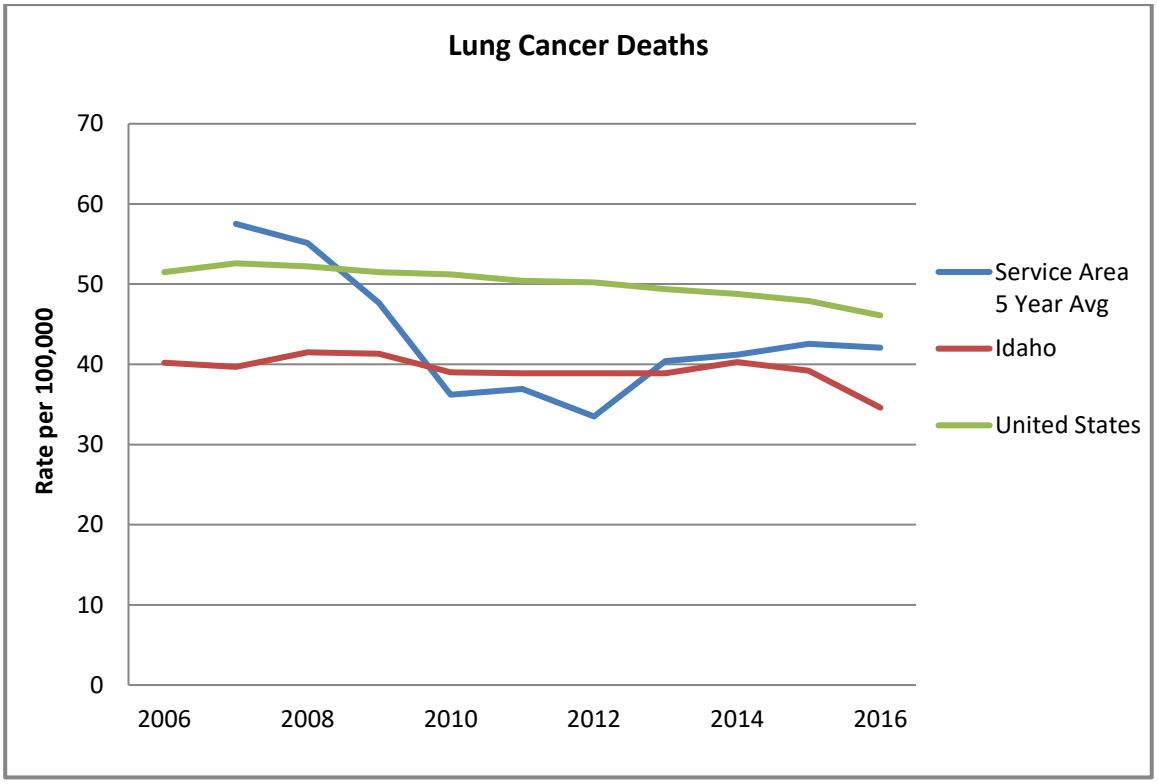
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Cancer	**3**	**3**	**3**	**1**	**10**

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

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

- **Lung Cancer**

Lung cancer is the leading cause of cancer death in Idaho. The lung cancer death rate in our service area is slightly below the national average.[78] 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.[79]

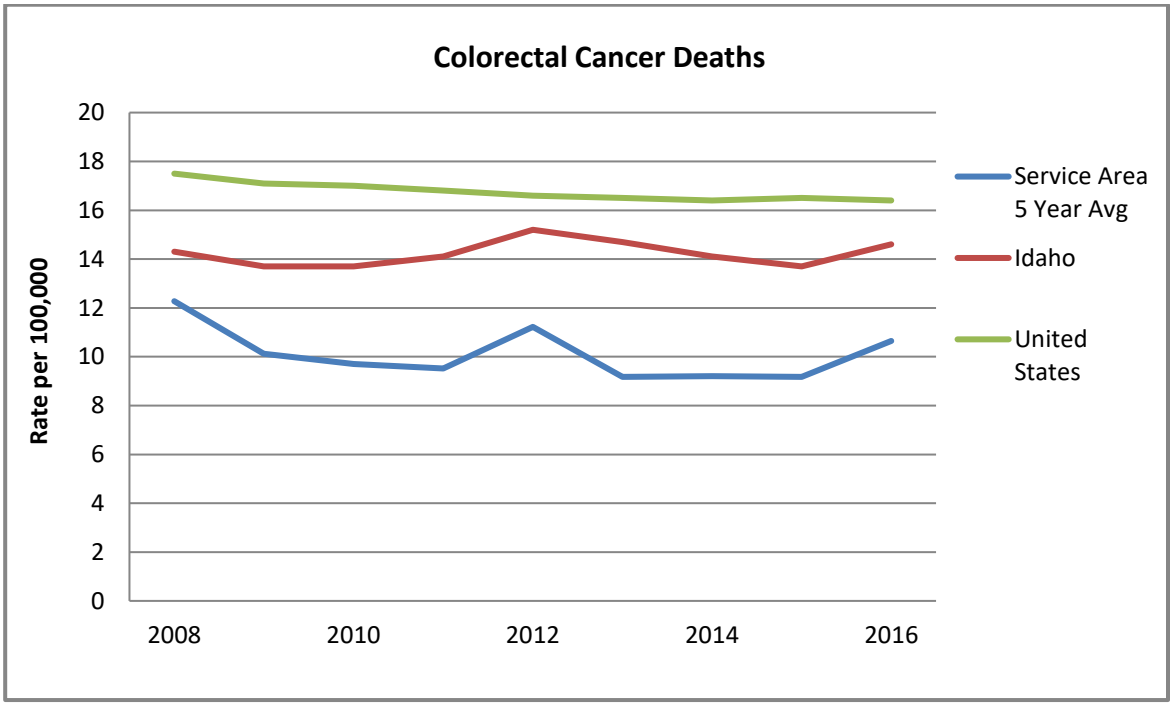


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Lung Cancer	**2**	**2**	**4**	**1**	**9**

[78] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[79] 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 is flat, and the death rate is below the national average.[80] 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.[81]

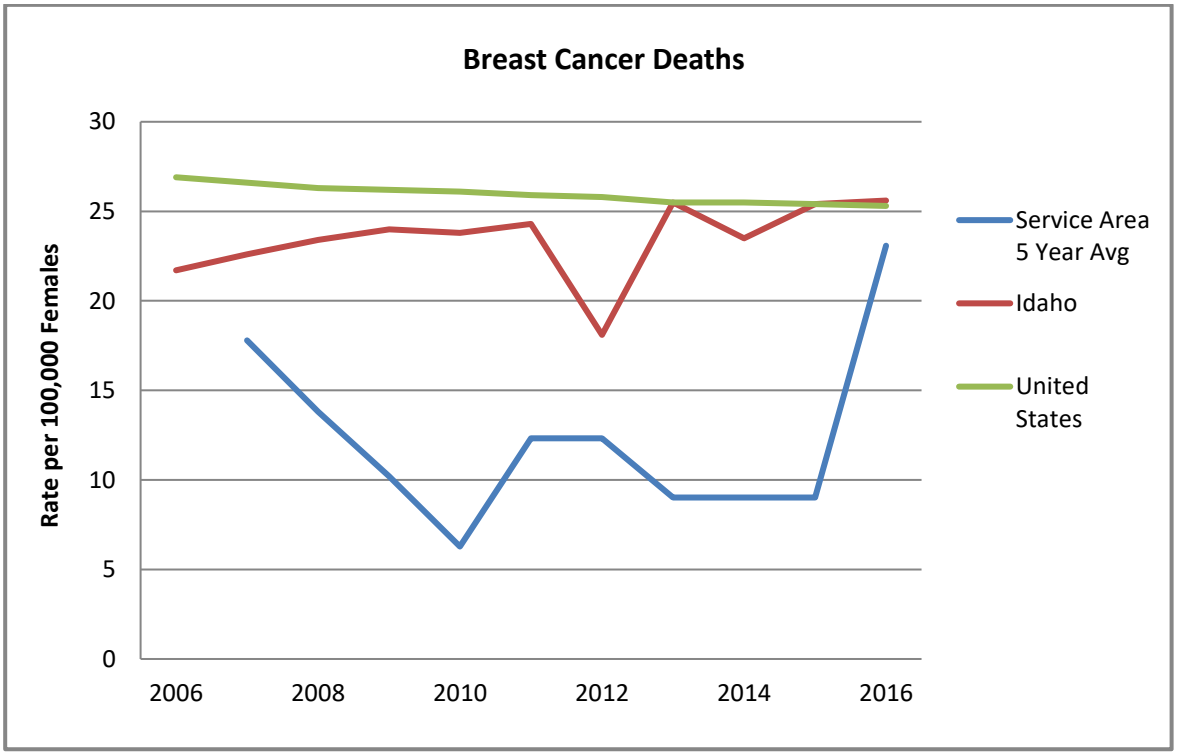


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude**	**Total Score**
Colorectal Cancer	**2**	**1**	**4**	**0**	**7**

[80] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[81] America's Health Rankings 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 Idaho and our service area is about the same as the national average. [82] 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%). [83]

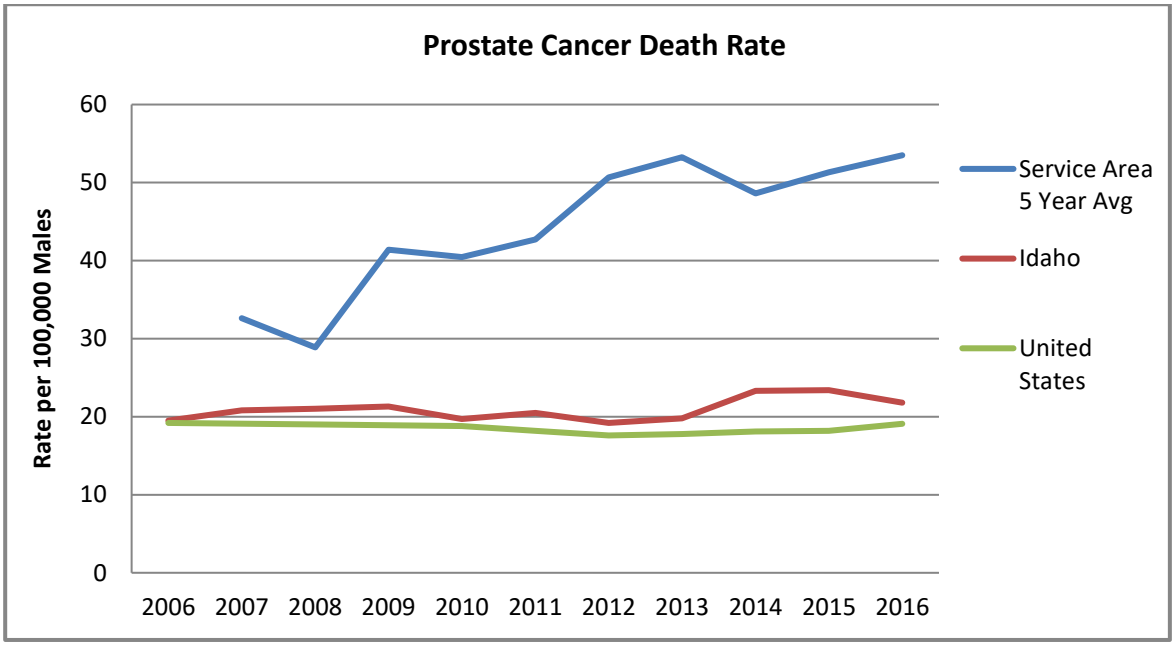


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Breast Cancer	**2**	**2**	**4**	**1**	**9**

[82] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[83] America's Health Rankings 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 prostate cancer death rate has been increasing rapidly and is now about three times the national average.[84] This may partly be caused by the aging populationin our service area. The percentage of people age 65 or older in our service area is significantly higher than the national average and has been increasing over the past ten years. Currently, about 19% of the people in our community are over the age of 65. [85] According to the U.S. Census, about 14% of the people in the U.S. are over age 65. 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.[86]

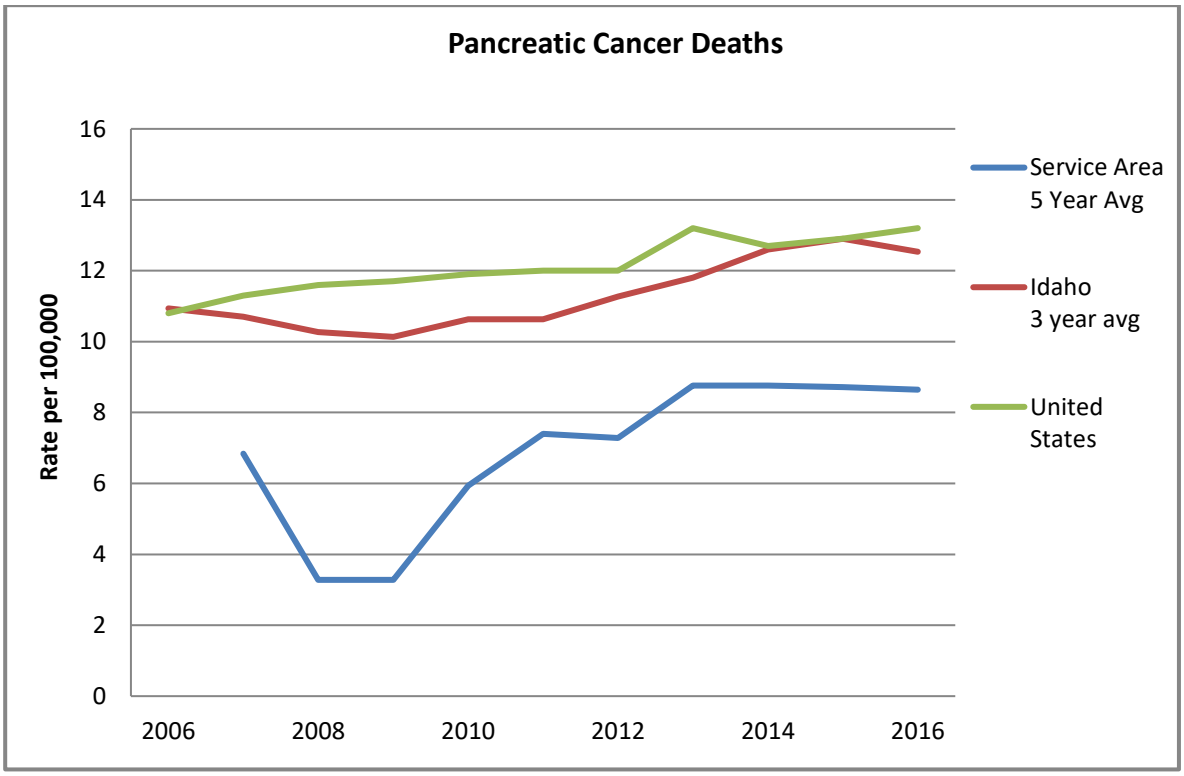


Health Factor Score Low score = Low potential for health impact — High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Prostate Cancer	**4**	**4**	**3**	**0**	**11**

[84] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[85] Ibid
[86] 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 below the national average. [87] 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.[88]



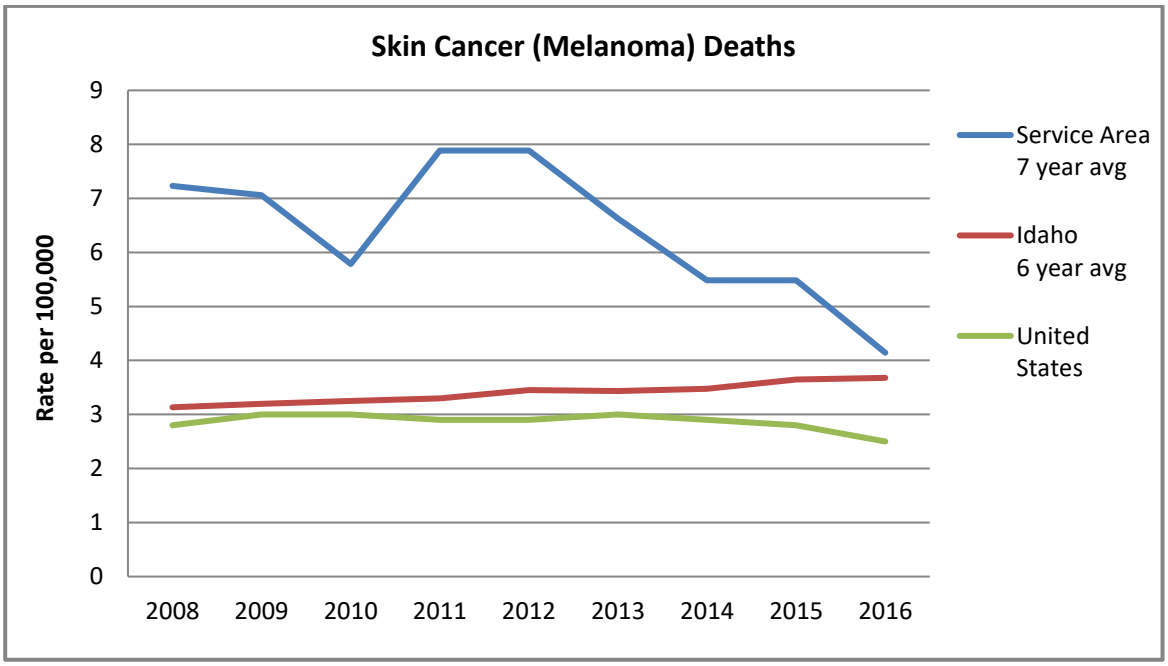
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude**	**Total Score**
Pancreatic Cancer	**3**	**0**	**1**	**0**	**4**

[87] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[88] 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. [89]

The chart shows that melanoma death rates are higher in Idaho and our service area than in the rest of the nation.[90]



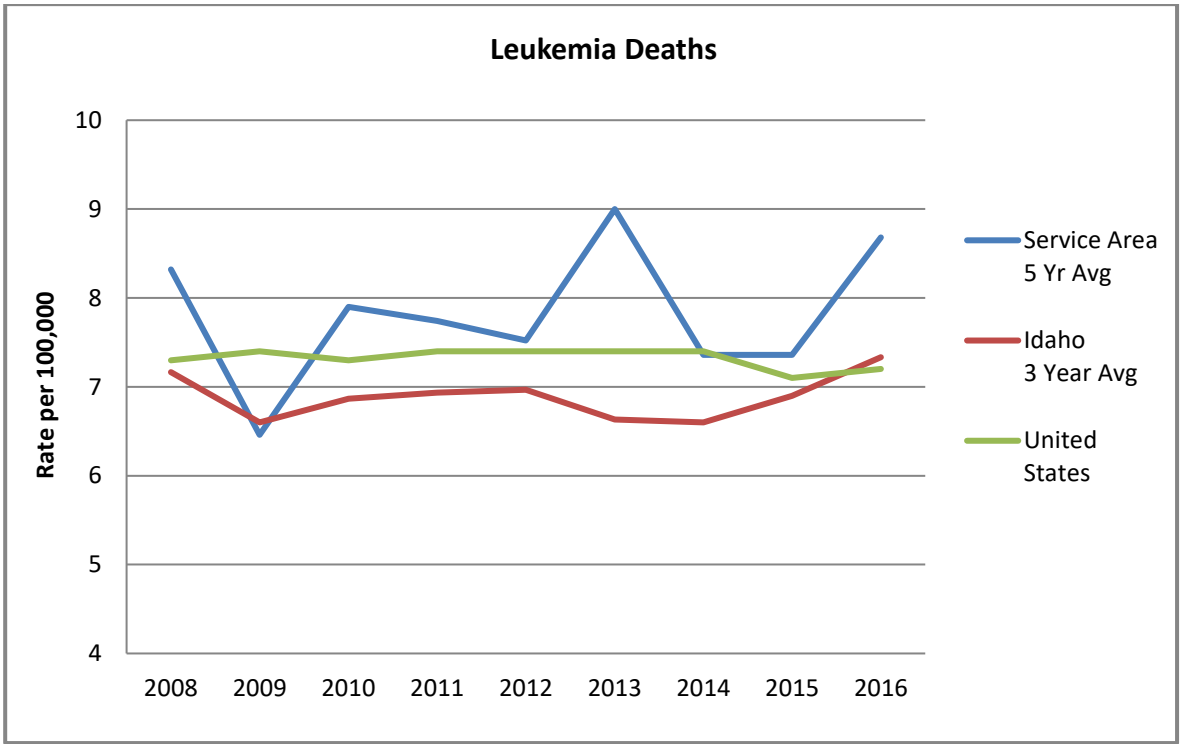
Exposure to ultraviolet (UV) radiation appears to be the most significant factor in the development of skin cancer. Skin cancer is largely preventable when sun protection measures are used consistently. These results highlight the need for effective interventions that reduce harmful UV light exposure. [91]

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	**0**	**4**	**4**	**0**	**8**

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

- **Leukemia**

The leukemia death rate in our service area is higher than the national average and the trend may be increasing. [92] 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.[93] Because the causes are not well understood, evidence-based preventive programs are not available (other than avoiding the risk factors described above).

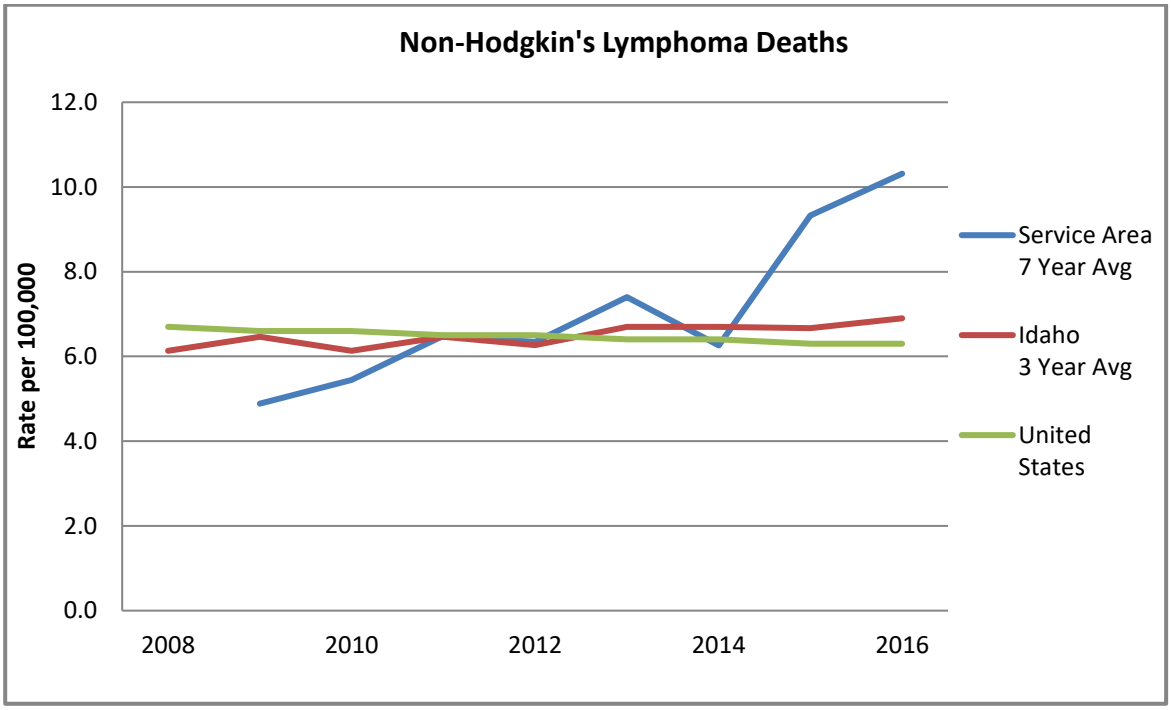


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Leukemia	**2**	**3**	**1**	**0**	**6**

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

- **Non-Hodgkin's Lymphoma**

The non-Hodgkin's lymphoma death rate in our service area is higher than the national average, and the trend is increasing.[94] Lymphoma is a general term for cancers that start in the lymph system; mainly the lymph nodes. The causes of lymphoma are unknown.[95] Because the causes are not understood, evidence-based preventive programs are not available.

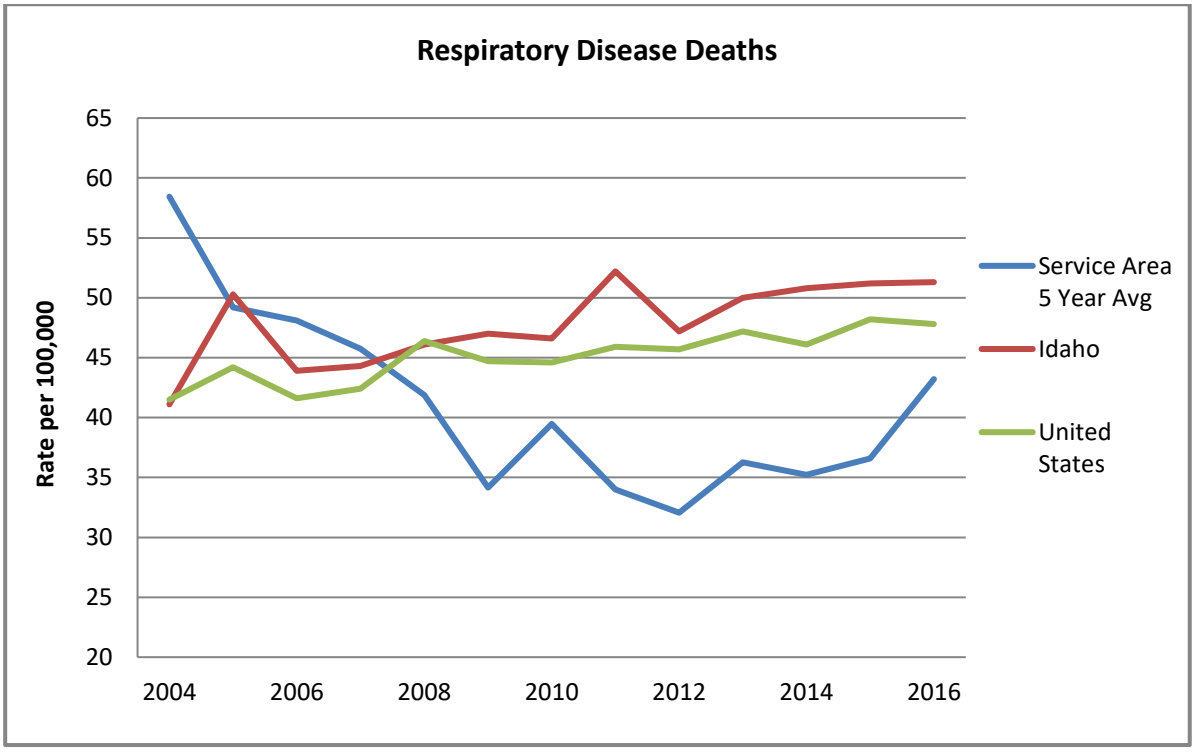


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Non-Hodgkin's lymphoma	**4**	**4**	**1**	**0**	**9**

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

- **Chronic Lower Respiratory Diseases**

The chronic lower respiratory diseases death rate in our service area is about the same as the national average and the trend is flat since 2008. Chronic lower respiratory diseases are the third leading cause of death in Idaho.[96] 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. [97]

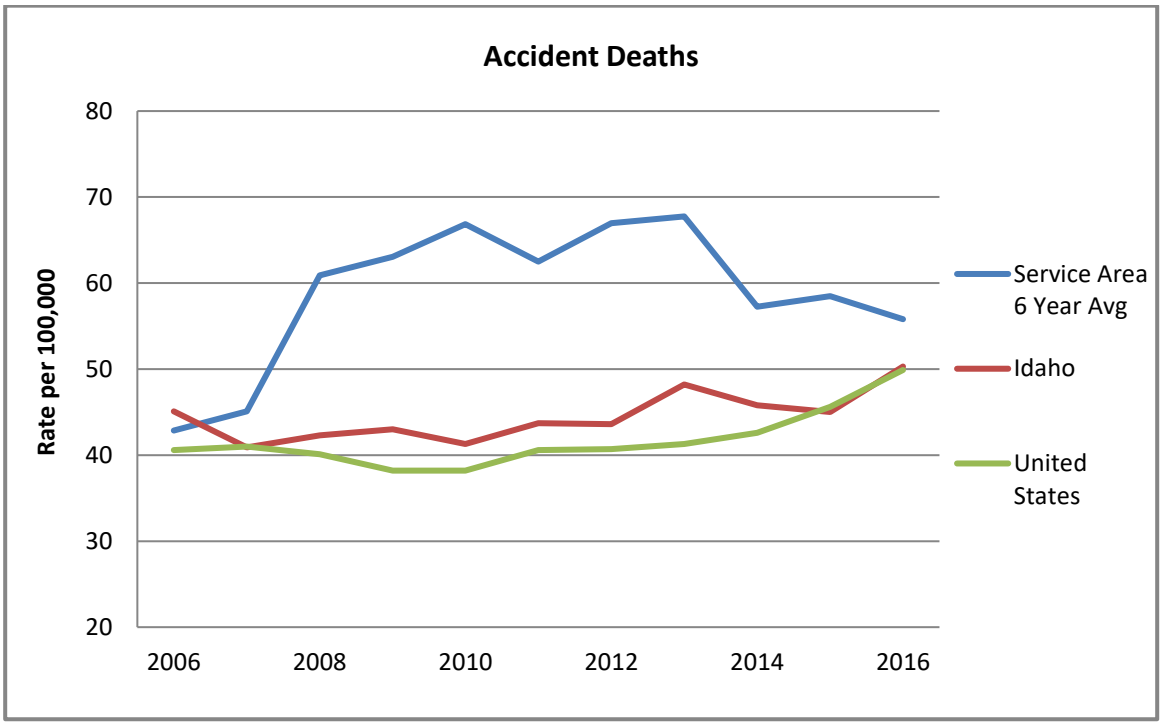


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Respiratory disease deaths	**2**	**2**	**4**	**0**	**8**

[96] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[97] 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 above the national average, and the trend has been flat since 2008.[98]

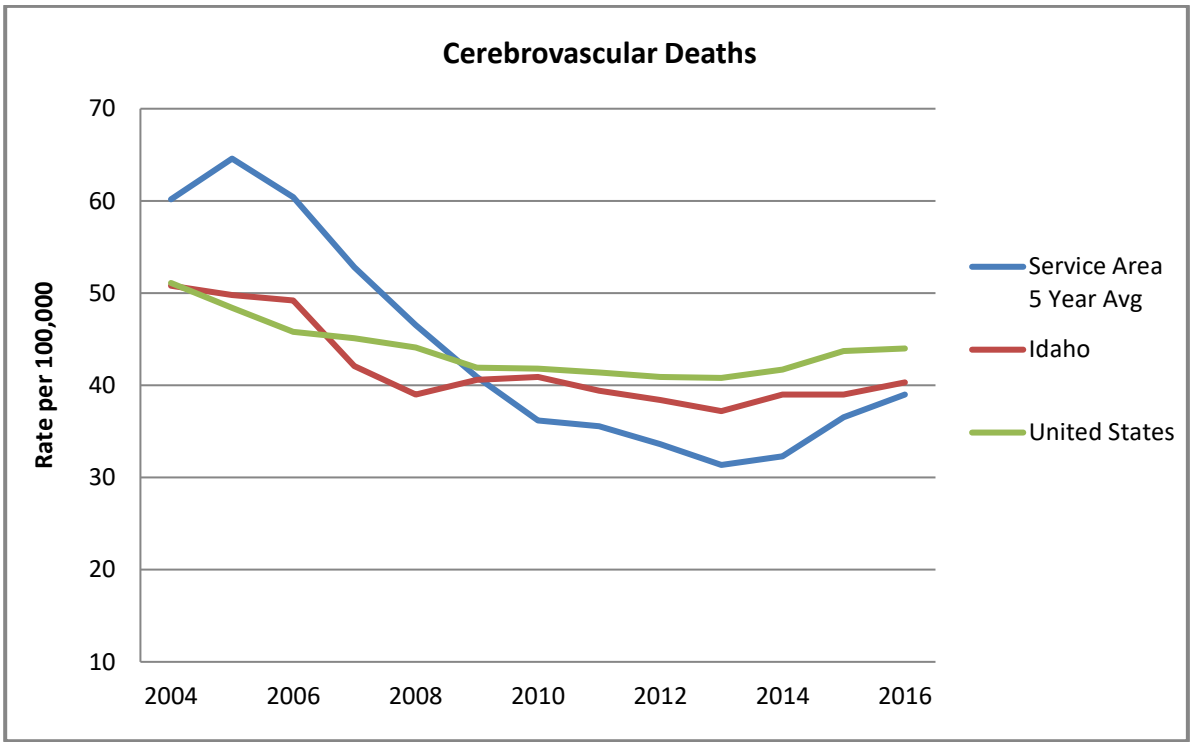


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude**	**Total Score**
Accidental deaths	**2**	**3**	**4**	**0**	**9**

[98] 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 since the year 2000 and is lower than the national average.[99] 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. [100]



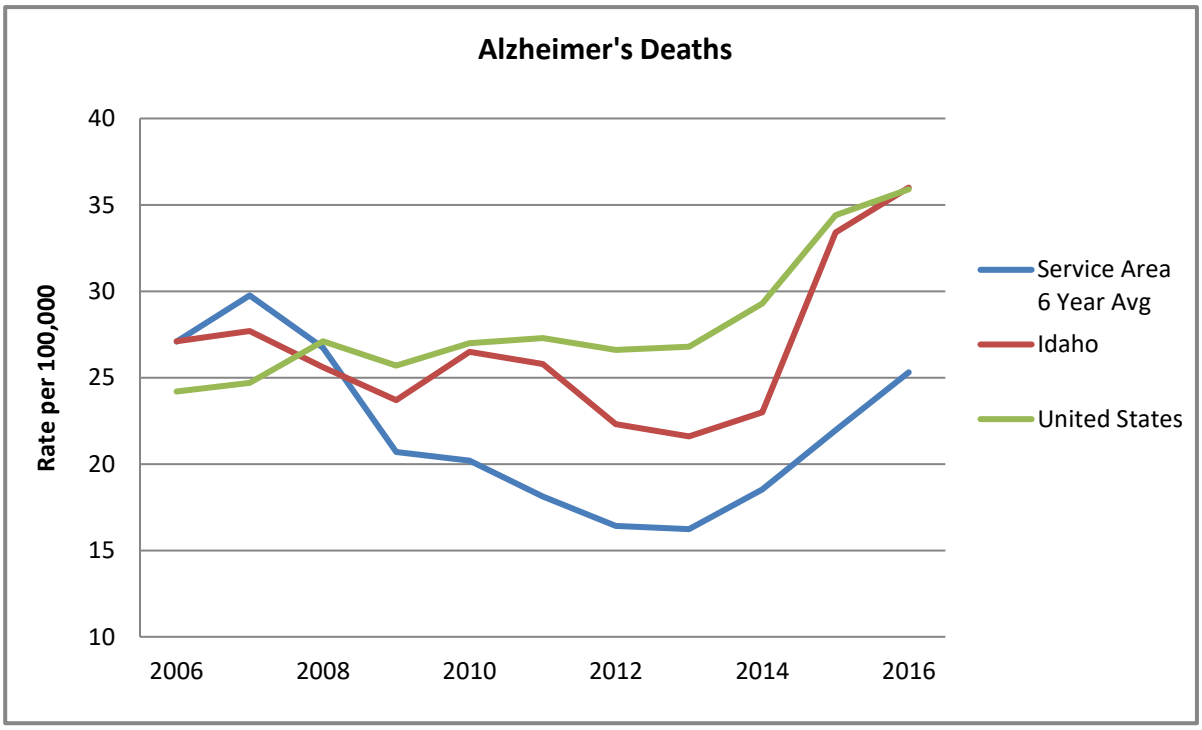
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Cerebrovascular Deaths	**2**	**1**	**4**	**1**	**8**

[99] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[100] America's Health Rankings 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. However, the death rate in our service area is about the same as it was in 2008 and is well below the national rate.[101]

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.[102]

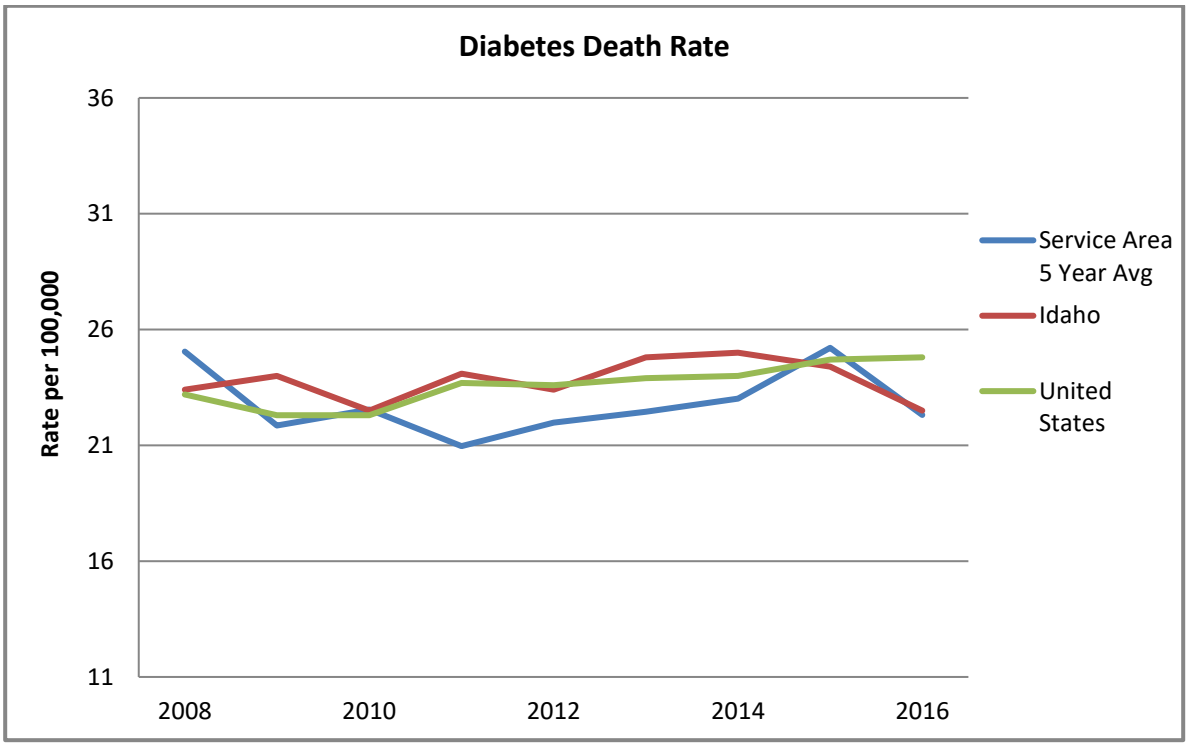


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Alzheimer's Deaths	**2**	**0**	**2**	**1**	**5**

[101] Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[102] 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 about the same as the national average. While the rate of people dying from diabetes has been flat over the past 10 years, the number of people living with diabetes is increasing significantly as shown earlier in our CHNA. Diabetes is a serious health issue that can contribute to heart disease, stroke, high blood pressure, kidney disease, blindness and can even result in limb amputation or death.[103]

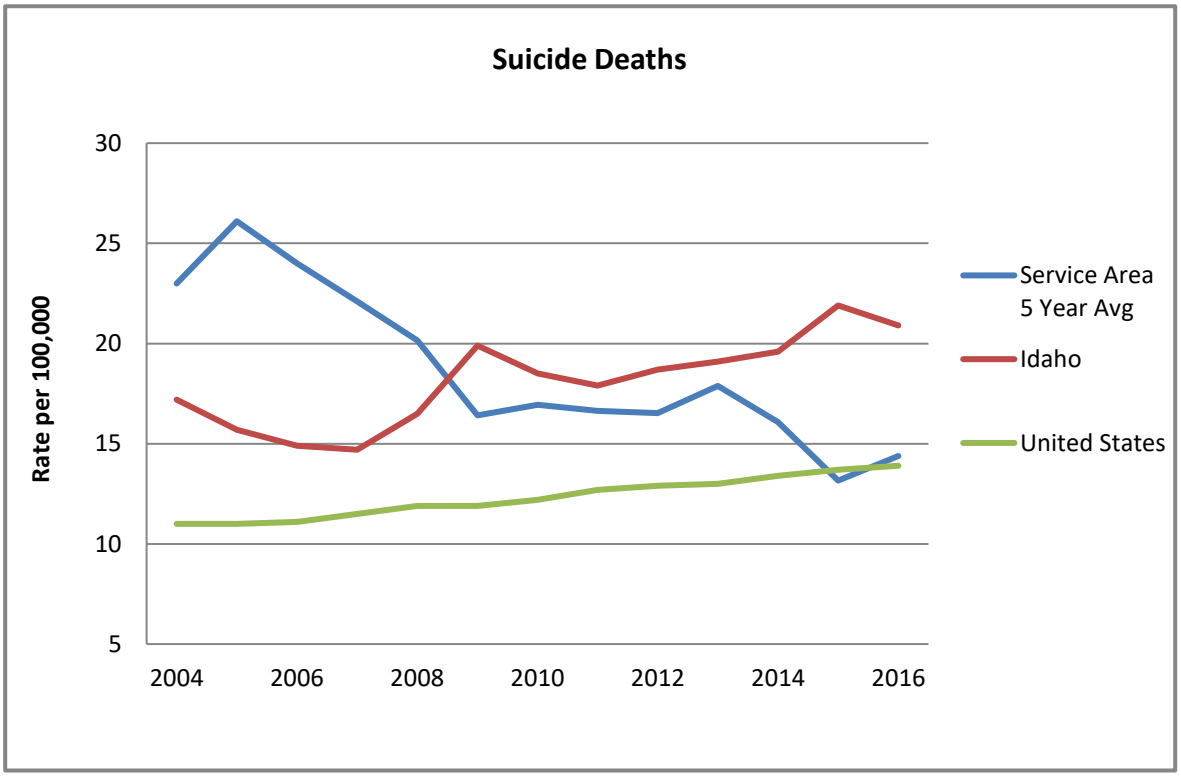


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Diabetes Deaths	**2**	**2**	**3**	**4**	**11**

[103] 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 13.9, which is about the same as the national average. As shown in the chart below, the suicide rate in Idaho and the nation has been trending up. It has been relatively flat in our service area since 2009.



The suicide rate for males is about four times higher than the rate for females.[104] 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.[105]

	Health Factor Score				
	Trend: Better/Worse	Prevalence versus U.S.	Severe/ Preventable	Magnitude: Root Cause	Total Score
Suicide	**2**	**2**	**4**	**1**	**9**

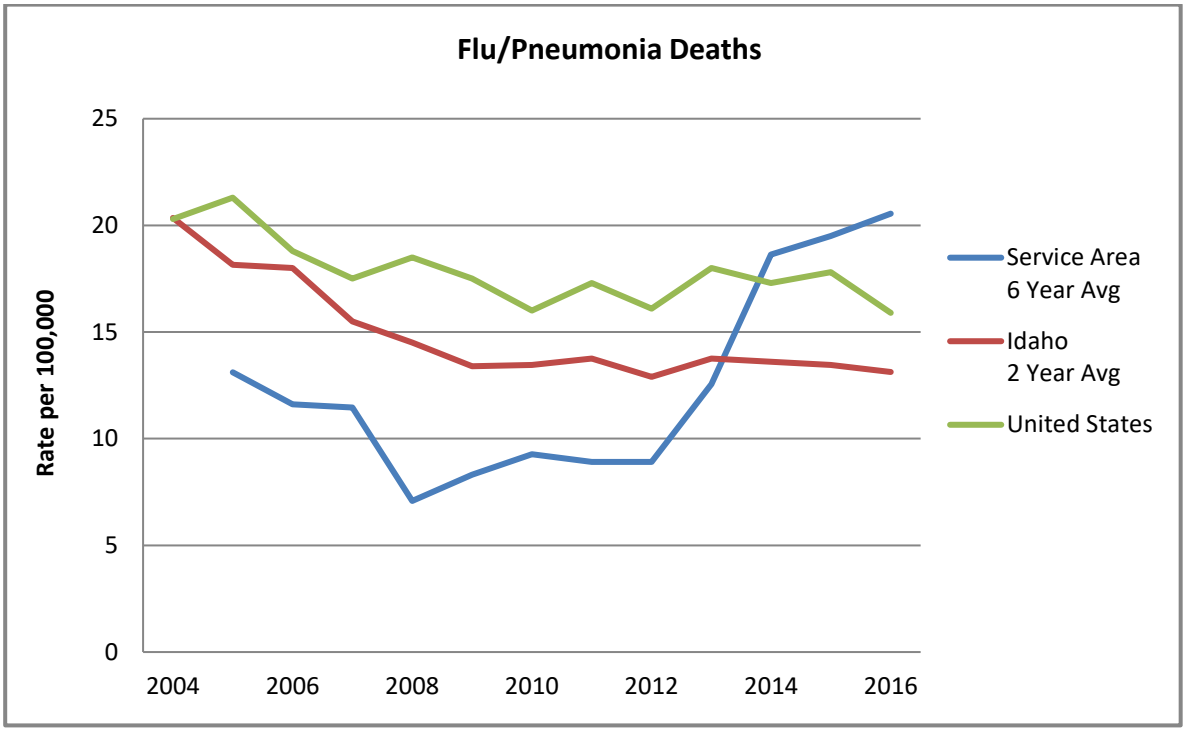
[104] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[105] Idaho Council on Suicide Prevention, Report to Governor C.L. Otter, November 2009

- **Influenza and Pneumonia**

The death rate from flu and pneumonia have been increasing in our service area since 2008 and are now higher than the national average.[106]

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.[107]

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.[108]



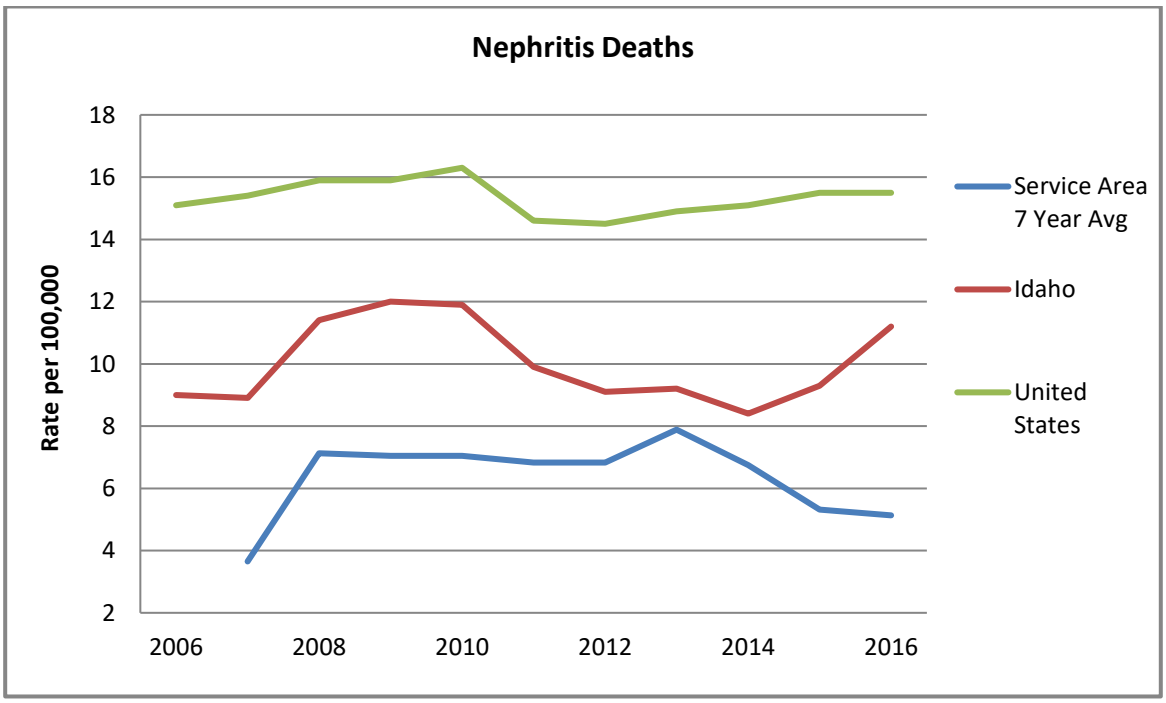
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Flu/ Pneumonia	**4**	**3**	**4**	**0**	**11**

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

- **Nephritis**

The death rate for nephritis is much 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.[109]

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.[110]



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.

[109] Idaho Vital Statistics Annual Reports, Years 2000 - 2016, National Vital Statistics Report - Deaths: Data 2016
[110] 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.[111]

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**

[111] 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.[112] 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

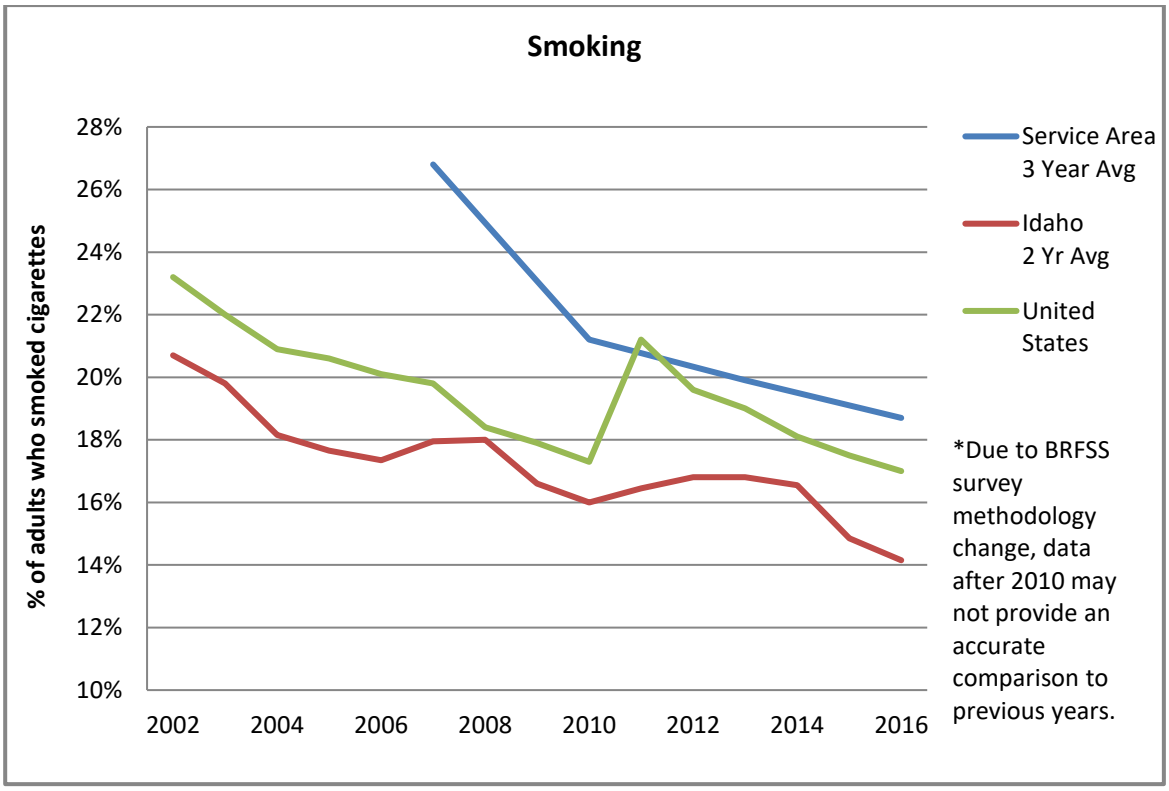
The *County Health Rankings* measures for community health behavior are described on the following pages. This next section also includes the trends for each indicator in our community and, when possible, compares our local data to state and national averages.

[112] 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.[113]

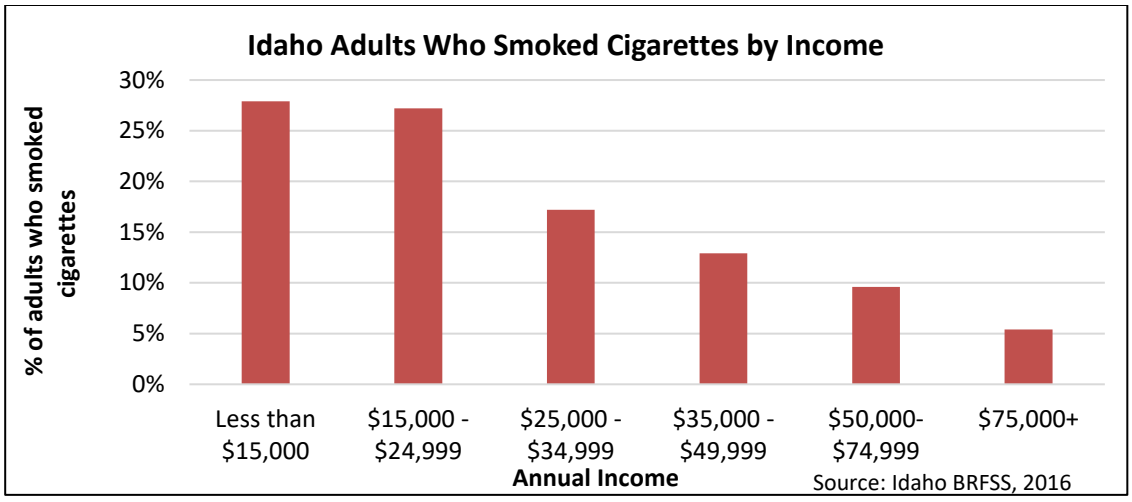
County-level measures from the Behavioral Risk Factor Surveillance System (BRFSS) provided by the CDC are used to obtain the number of current adult smokers who have smoked at least 100 cigarettes in their lifetime. The trend for smoking nationally and in our community is down. The percent of adults who smoked in our community is slightly above the national average and well above the average for Idaho. [114]

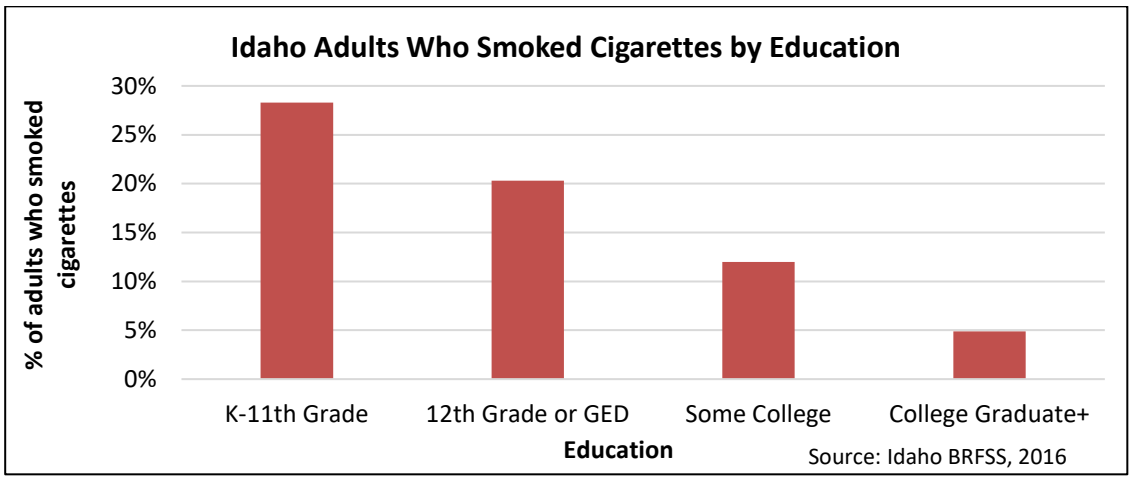


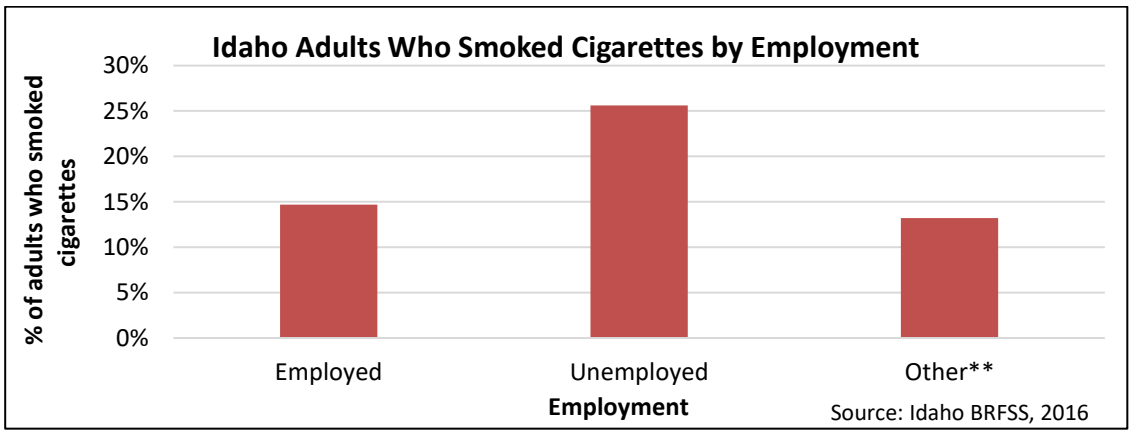
The percent of people who smoke declines significantly with higher levels of income and education as well as for those who are employed, as shown in the charts below.

[113] Comprehensive Cancer Alliance for Idaho, Idaho Comprehensive Cancer Strategic Plan 2004-2010, www.ccaidaho.org

[114] 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	**0**	**3**	**4**	**4**	**11**

Diet and Exercise

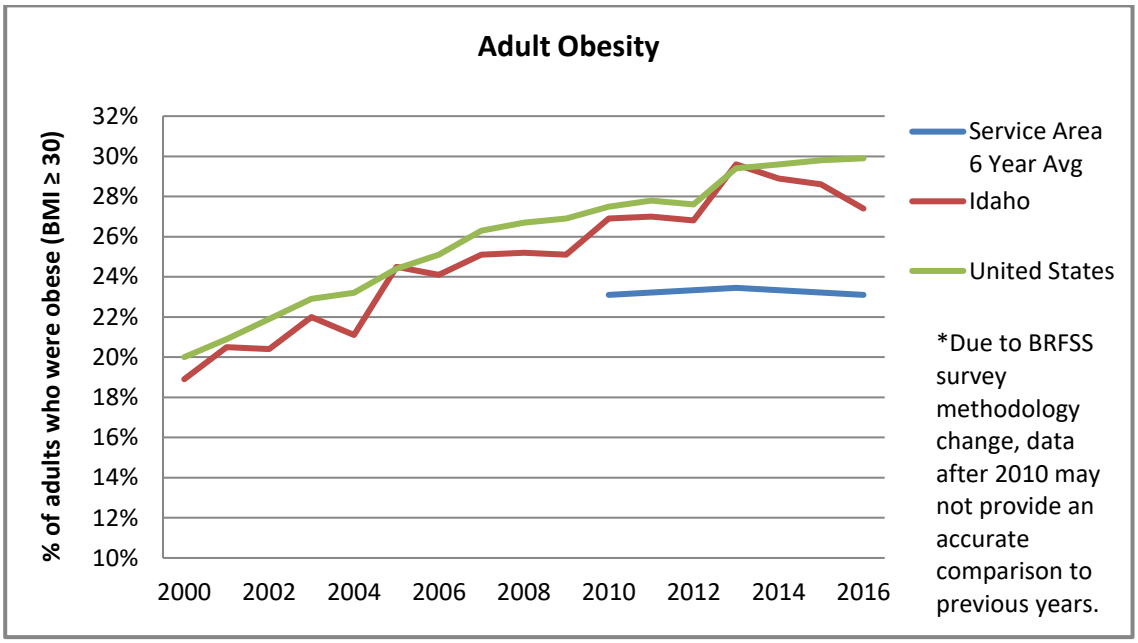
Unhealthy food intake and insufficient exercise have economic impacts for individuals and communities. Estimates for obesity-related health care costs in the US range from $147 billion to nearly $210 billion annually, and productivity losses due to job absenteeism cost an additional $4 billion each year. 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.

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.

- **Adult Obesity**

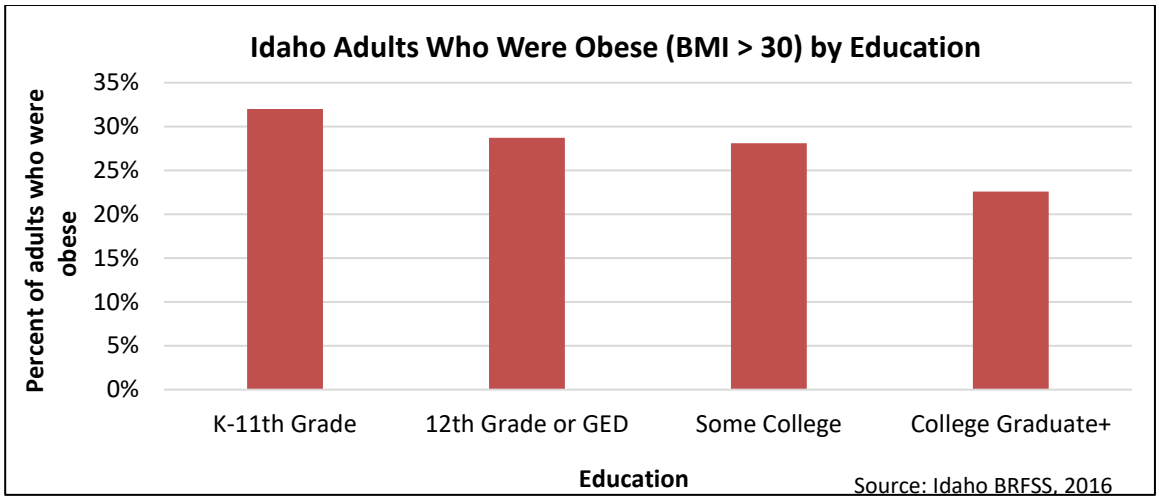
The obesity measure represents the percent of the adult population that has a body mass index greater than or equal to 30. Obesity is used as a key health factor because it is an issue that can be addressed within communities by changing unhealthy conditions that contribute to poor diet and exercise. 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.[115] 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. [116] By one estimate, the U.S. spent $190 billion on obesity-related health care expenses in 2005 accounting for 21% of all medical spending.[117]

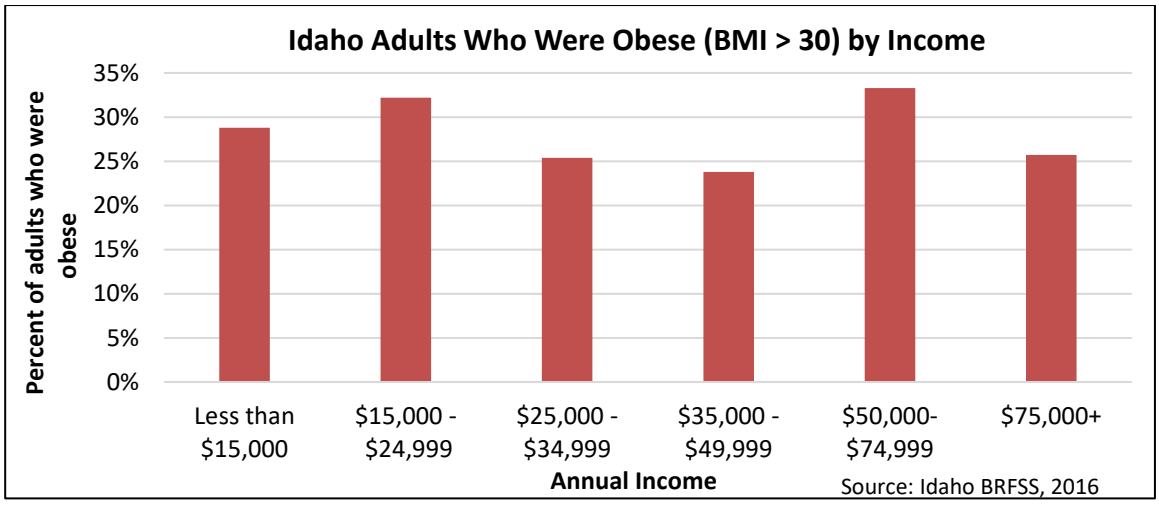
The trend for obesity has been increasing steadily for the past 10 years, nationally and in Idaho. The obesity rate in our community is 23.1%. The top 10th percentile (best) communities nationally have obesity rates at or below 26%.[118]

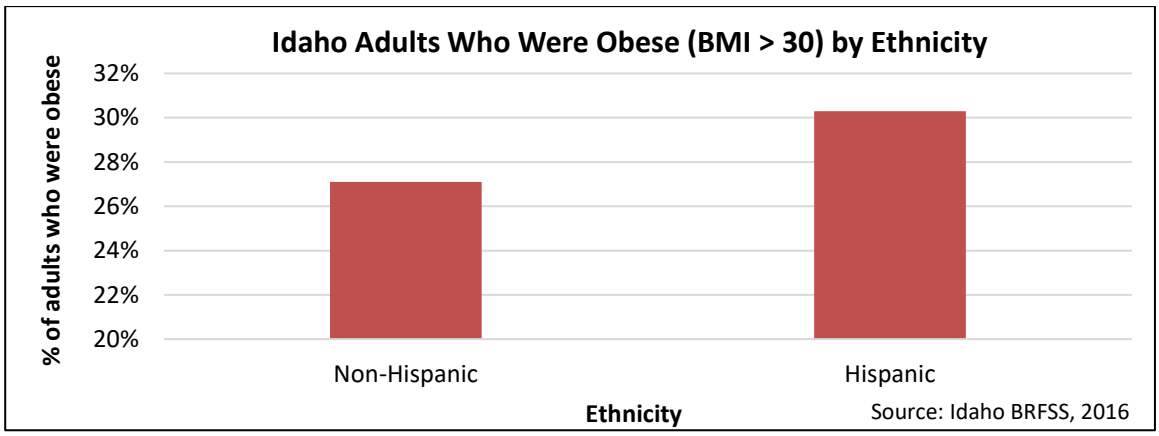


In Idaho, those without a college degree and Hispanic populations are somewhat more likely to be obese. [119]

[115] University of Wisconsin Population Health Institute. *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.
[116] America's Health Rankings 2015- 2018, www.americashealthrankings.org
[117] http://www.hsph.harvard.edu/obesity-prevention-source/obesity-consequences/economic/
[118] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System
[119] 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	2	0	4	4	10

- **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.

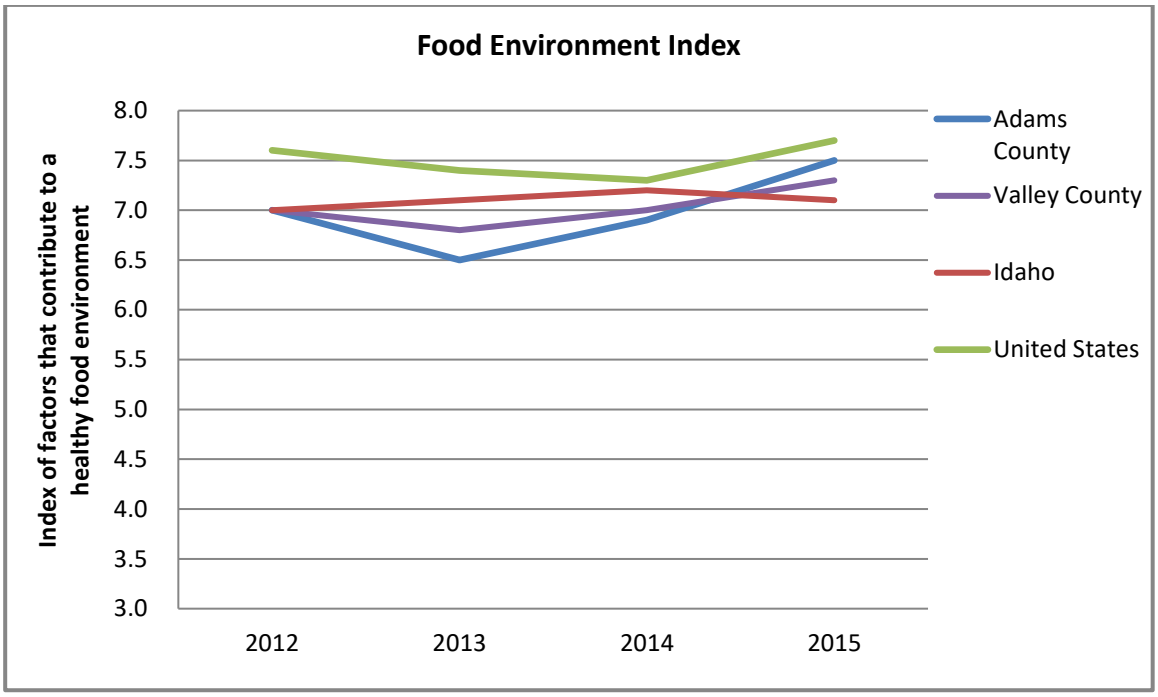
  2) Food insecurity estimates the percentage of the population who did not have access to a reliable source of food during the past year. A 2-stage fixed effect model was created using information from the Community Population Survey, Bureau of Labor Statistics, and American Community Survey.

  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.[120]

[120] 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.

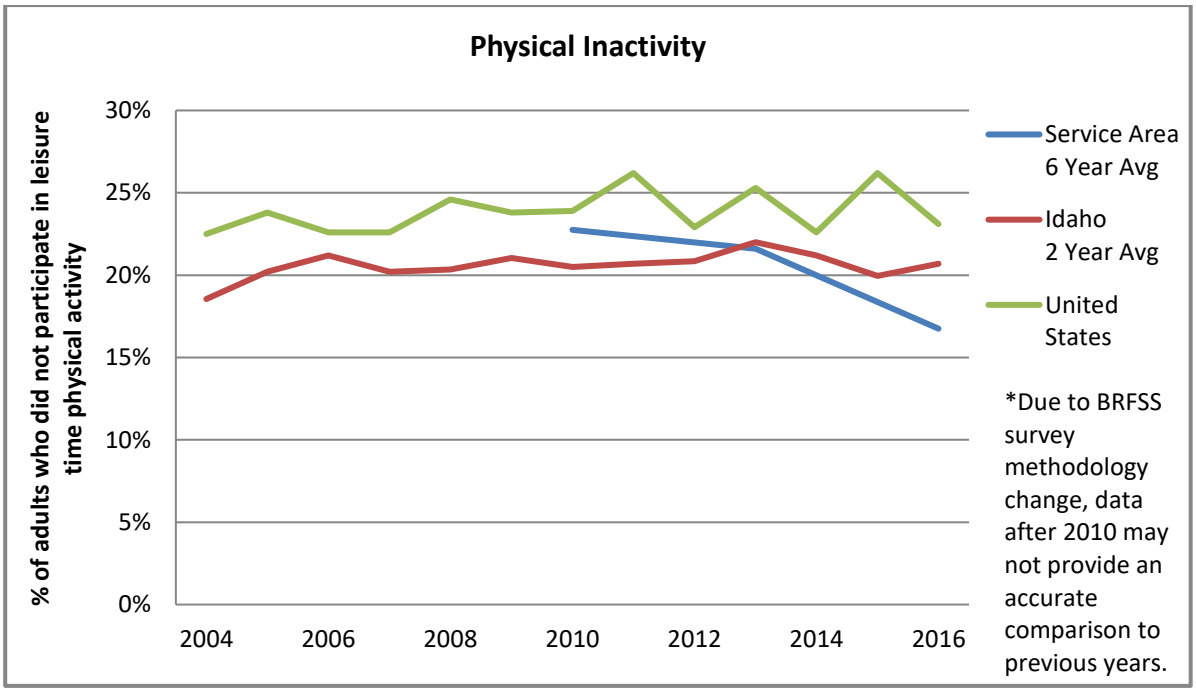


	Health Factor Score				
	Trend: Better/Worse	**Prevalence versus U.S.**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Food Environment Index	**2**	**2**	**2**	**3**	**9**

- **Physical Inactivity: Adults**

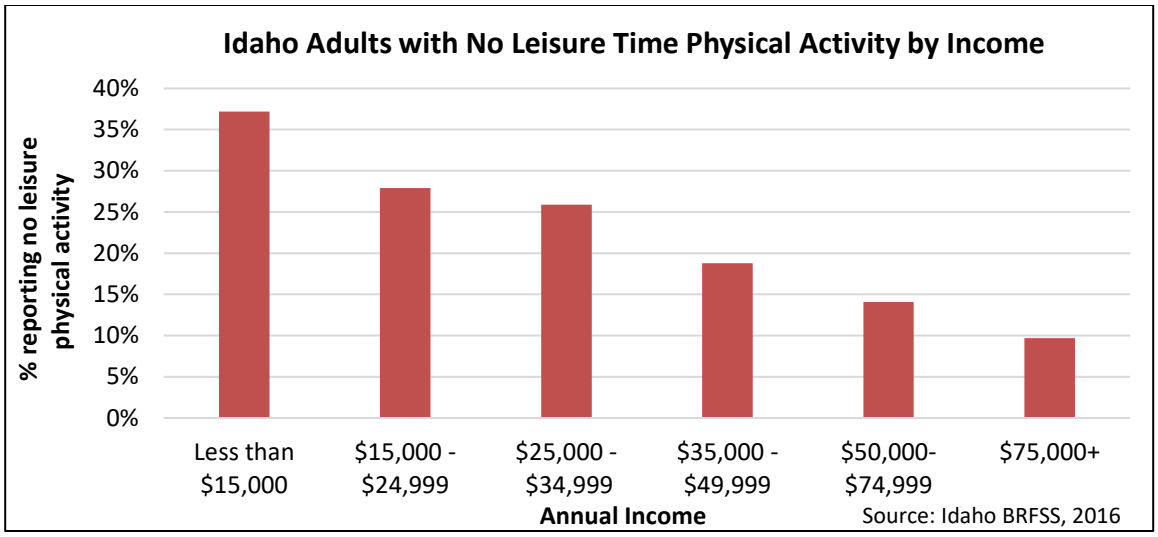
Increased physical activity is associated with lower risks of type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality. A person is considered physically inactive if during the past month, other than a regular job, they did not participate in any physical activities 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. [121]

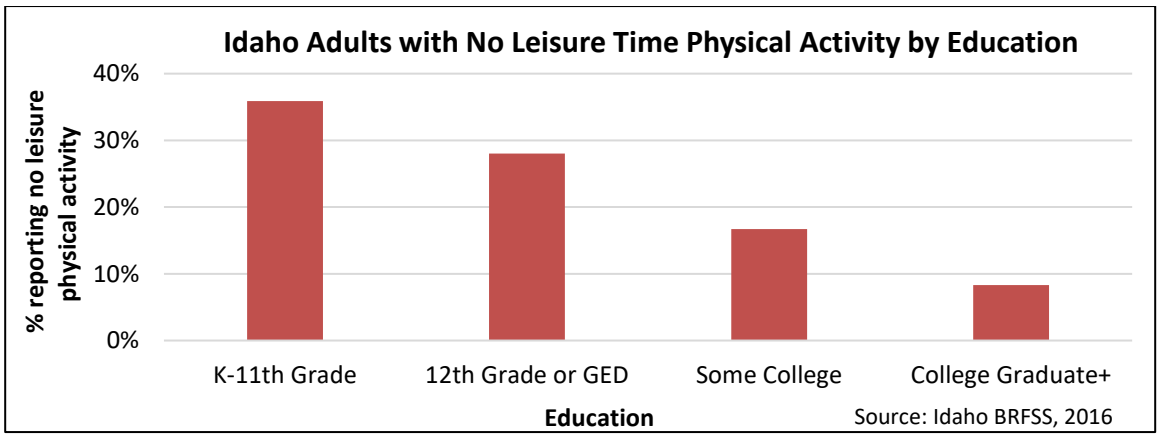
As shown in the chart below, physical inactivity in our community is lower (better) than the national average and in the top 10th percentile. The top 10th percentile (best) is 20%.[122]

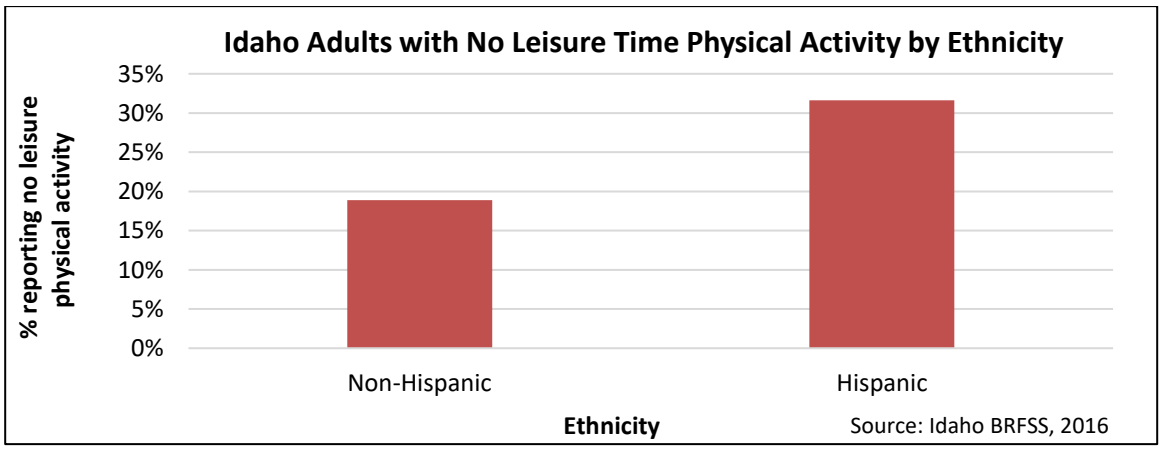


Physical inactivity is significantly higher among people with annual incomes below $50,000, those without a college degree, and among Hispanics, as shown in the charts below. [123]

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







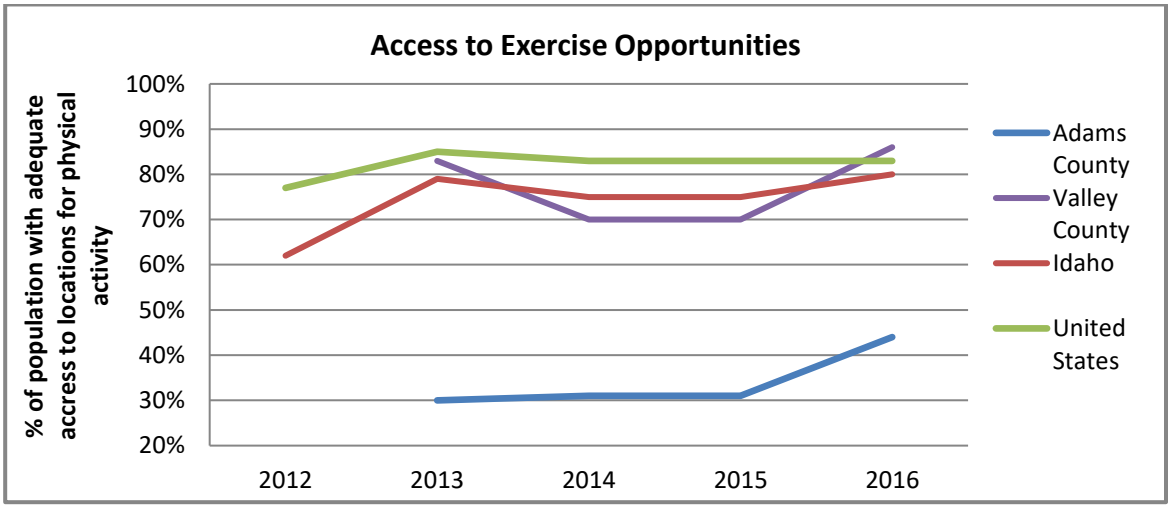
Health Factor Scoring					
	Trend: Better/Worse	**Prevalence versus U.S.**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Physical inactivity Adults	**1**	**0**	**2**	**3**	**6**

- **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. [124]

The chart, below, shows access to exercise opportunities in our community is lower than the national average. It is about the same as the national average for Valley County and below the national average for Adams County. 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**	**2**	**2**	**3**	**9**

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

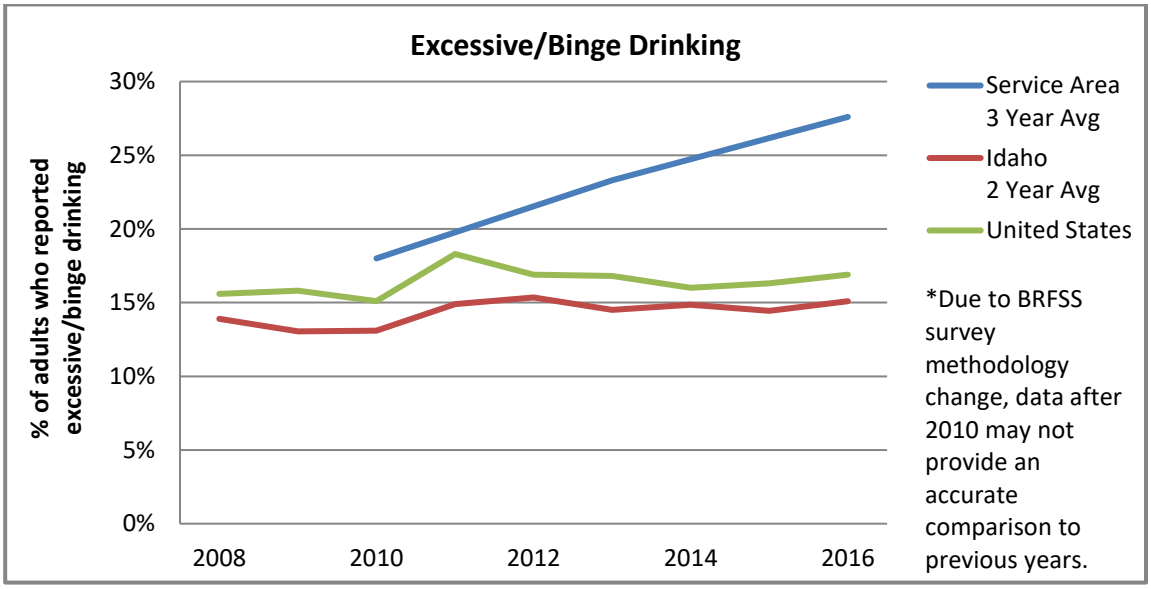
Alcohol Use

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.[125]

  The percent of people engaging in excessive drinking in our service area is above the national average with the trend increasing over the past ten years. The top 10th percentile (best) is 10% nationally. Our community is well above that level.[126]



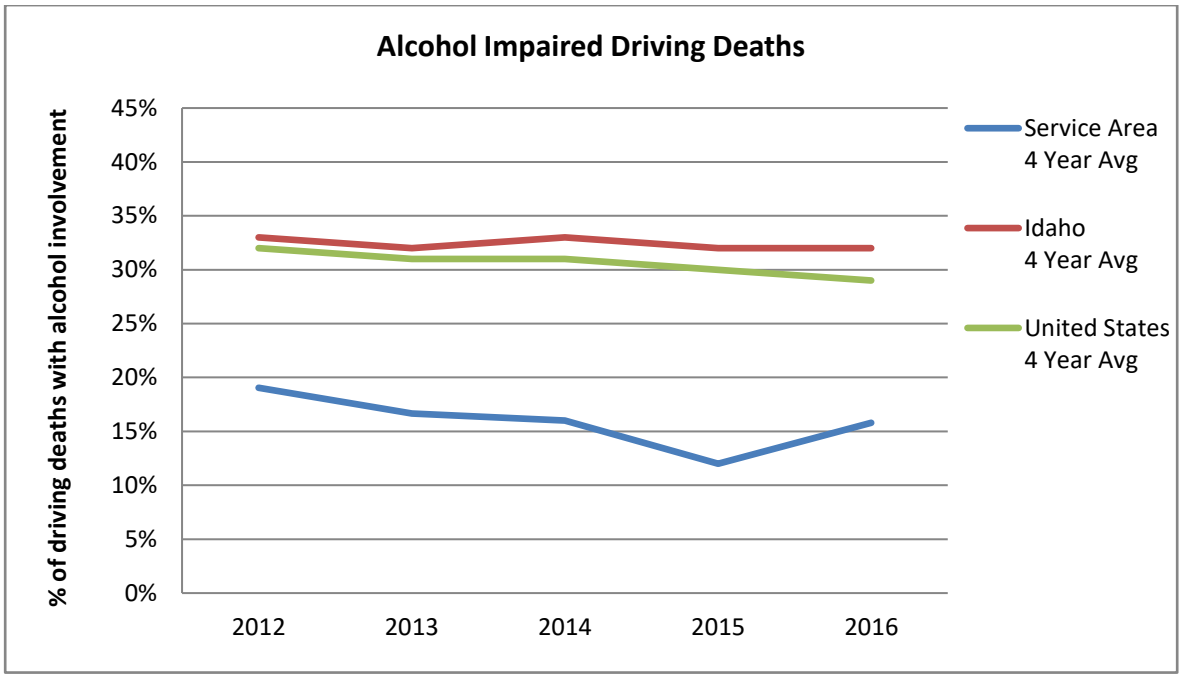
Health Factor Scoring					
	Trend: Better/Worse	Prevalence versus U.S.	Severe/ Preventable	Magnitude: Root Cause	Total Score
Excessive Drinking	**4**	**4**	**3**	**2**	**13**

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

[126] 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 slightly below the national level. The top 10th percentile (best) is 14% nationally.[127]



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	**2**	**0**	**4**	**1**	**7**

[127] 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**

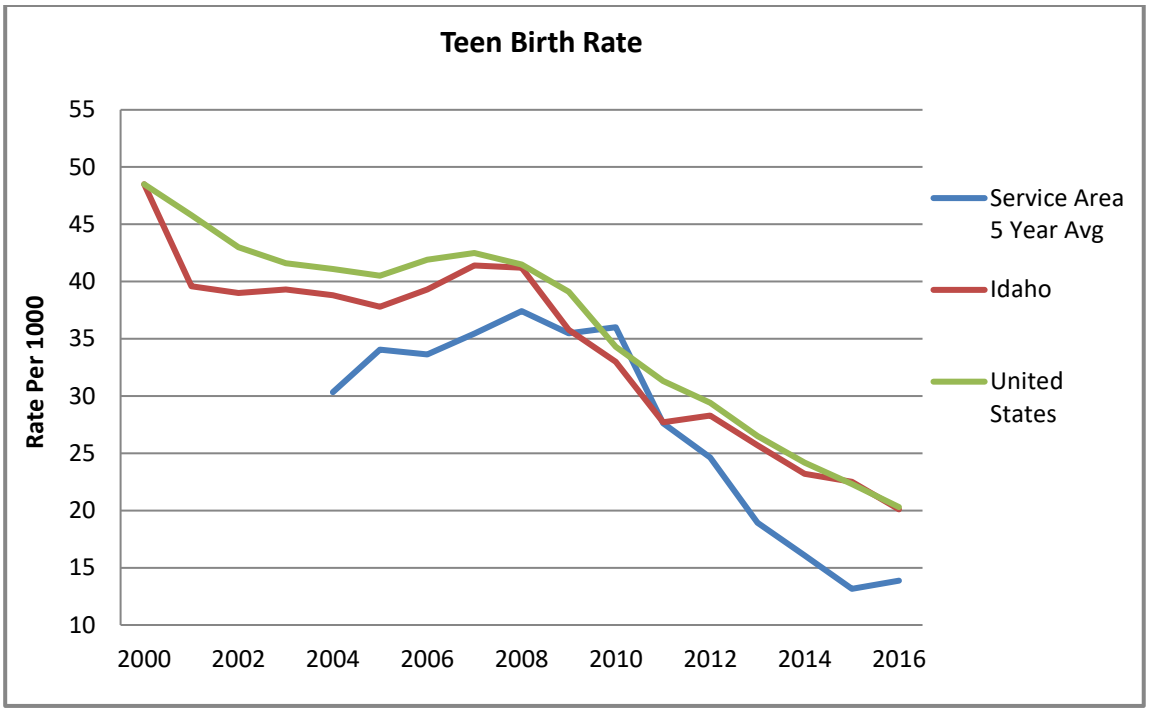
  Evidence suggests teen pregnancy significantly increases the risks for repeat pregnancy and for contracting a sexually transmitted infection (STI), both of which can result in adverse health outcomes for mother and child as well as for the families and community. A systematic review of the sexual risk 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.[128]

  Our rate of teen pregnancy is decreasing and in the top 10th percentile nationally (top 10th percentile< 15).[129]

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

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

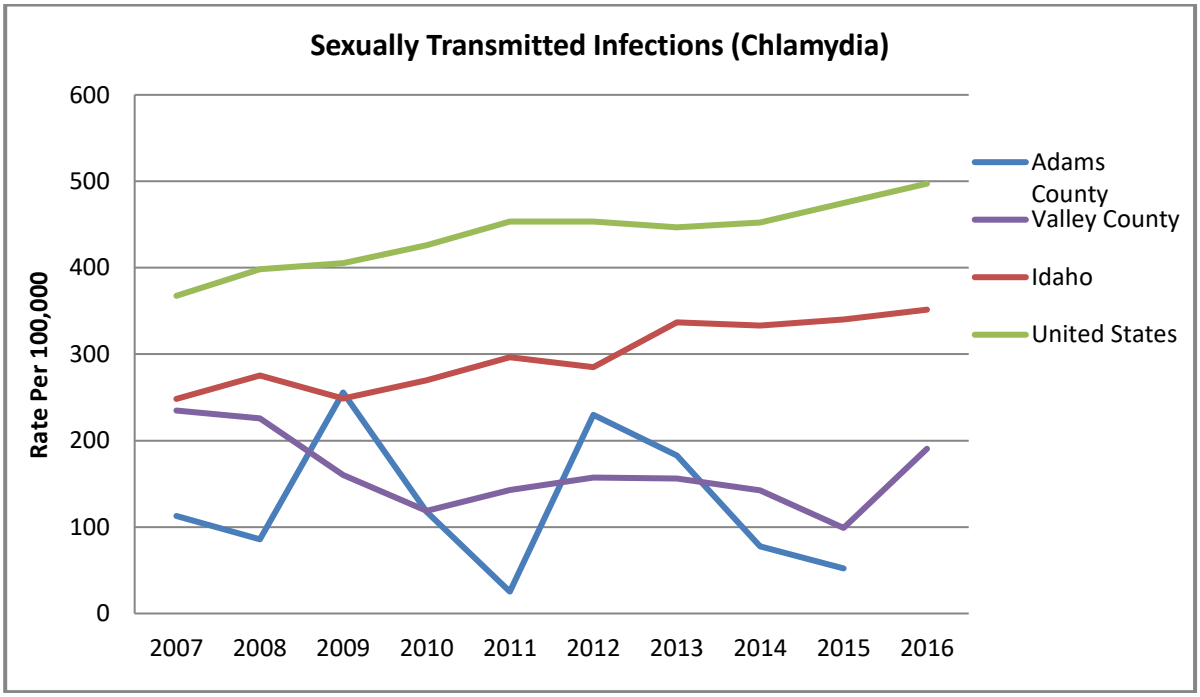


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Teen birth rate	**0**	**0**	**2**	**3**	**5**

- **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.[130]

The rate of chlamydia infections has increased significantly over the past ten years both in Idaho and nationally. However, the rate in our community is well below the national average. The national top 10th percentile rate is 145.1.[131]



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	**2**	**0**	**3**	**3**	**8**

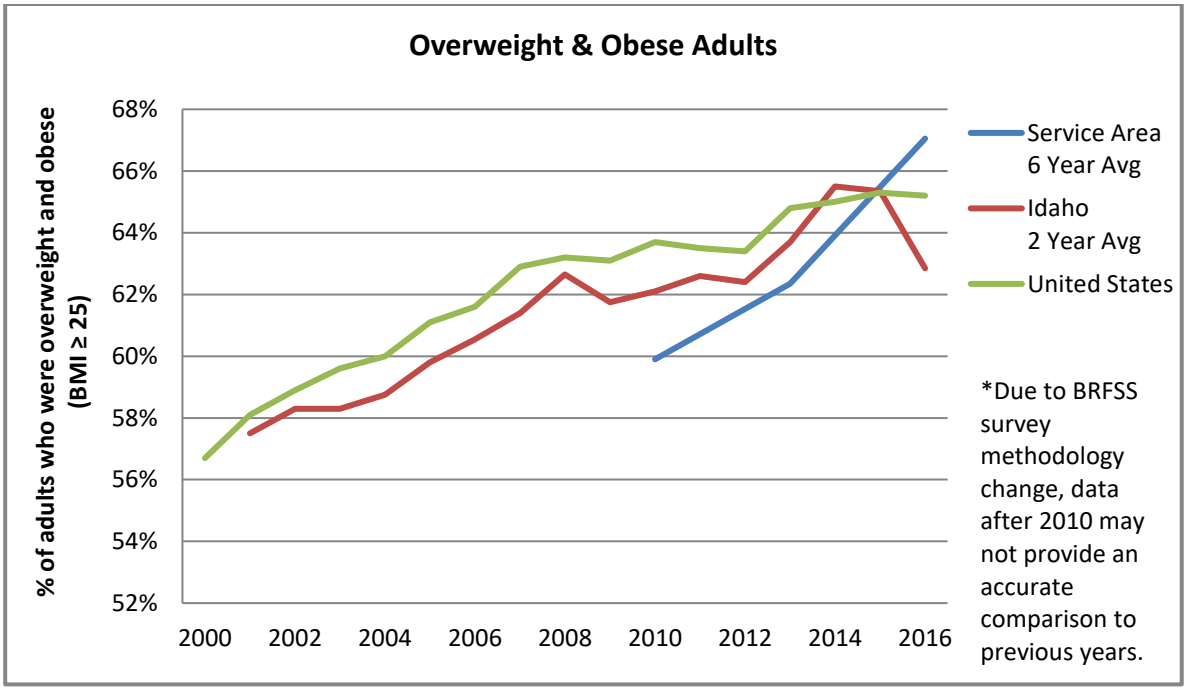
[130] *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.
[131] National data source: 2015 Sexually Transmitted Diseases Surveillance, table 1 http://www.cdc.gov/std/.
Idaho and Service Area Source: Idaho Reported Sexually Transmitted Disease, 2004-2012
http://www.healthandwelfare.idaho.gov/Portals/0/Health/Disease/STD%20HIV/2010_Facts_Book_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 is increasing and the rate in our community is now above the national average.[132]



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**	**3**	**4**	**4**	**15**

[132] 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.[133] Overweight children and adolescents:

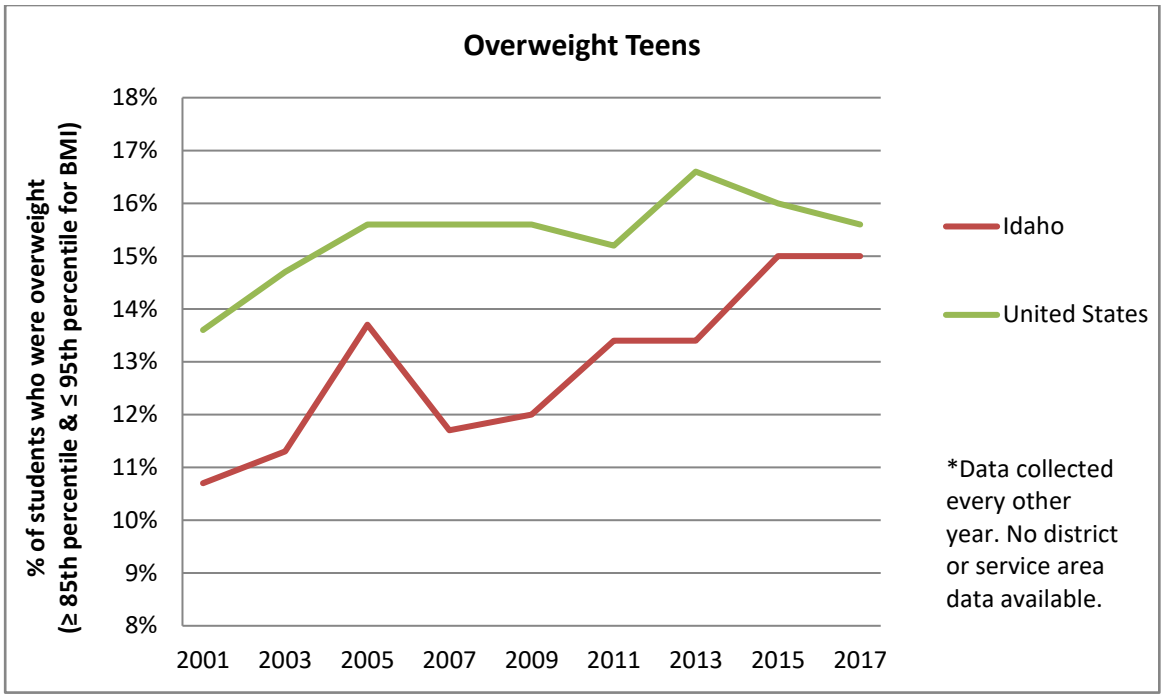
  - Are more likely than other children and adolescents to have risk factors associated with cardiovascular disease (e.g., high blood pressure, high cholesterol and type 2 diabetes).
  - Are more likely to be obese as adults.
  - Are more likely to experience other health conditions associated with increased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

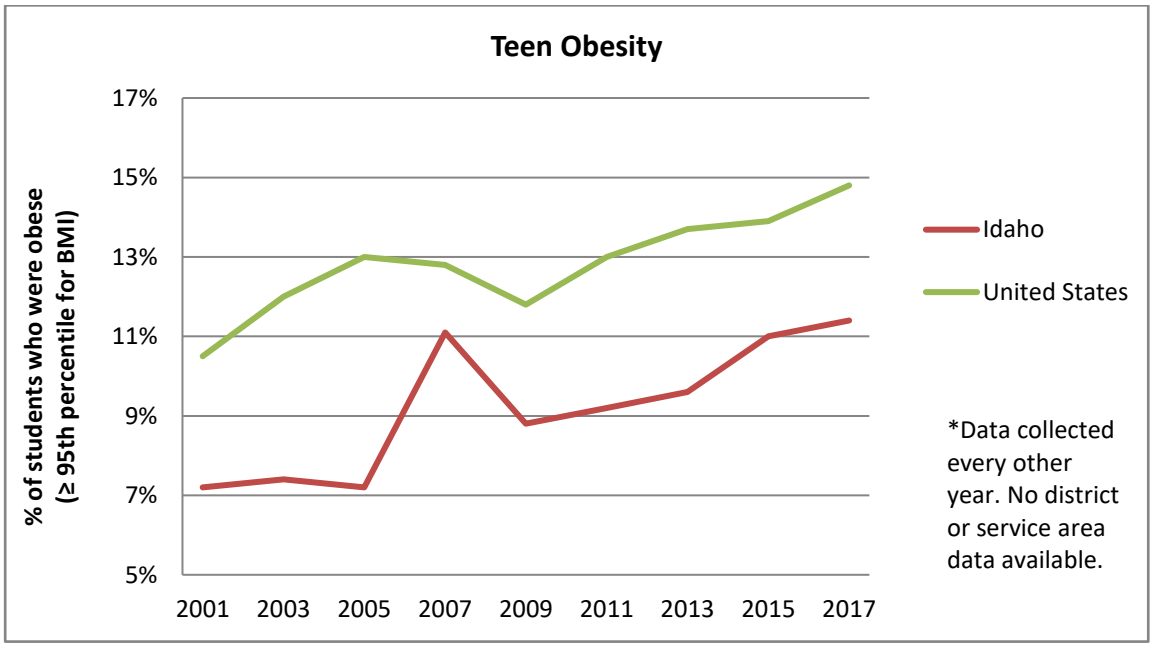
  Some methods of preventing and treating overweight children are:

  - 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.[134]

  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.[135]

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



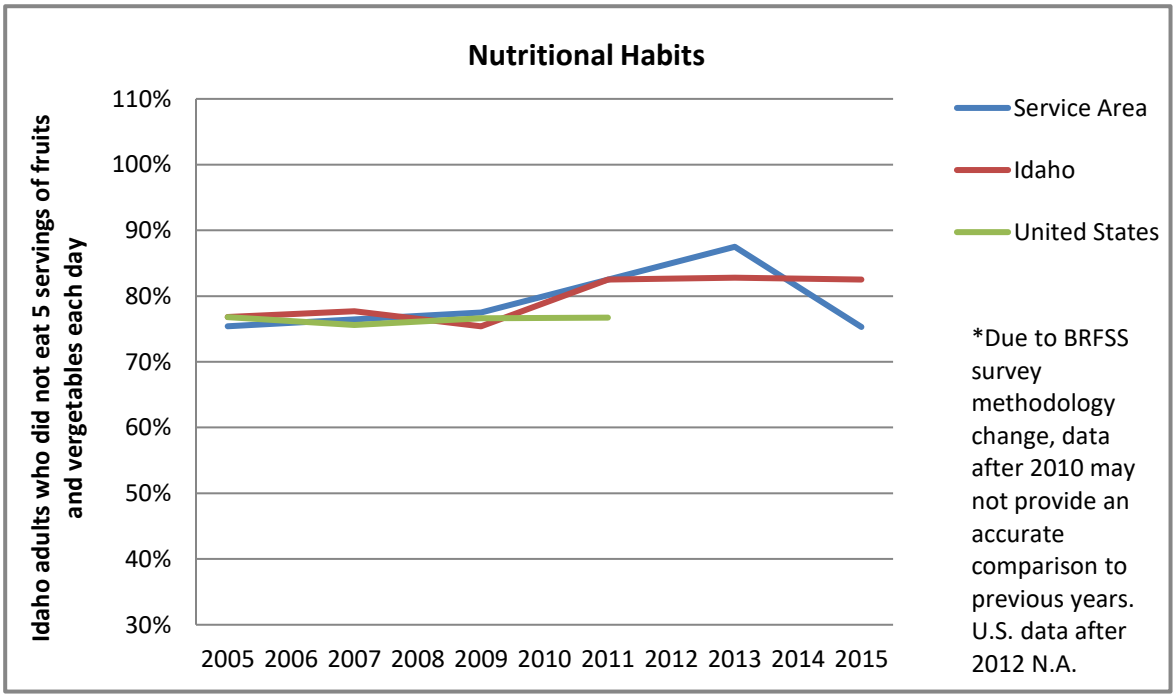


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Obese Teens	**4**	**1**	**4**	**4**	**13**

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

As shown in the chart below, about 75% 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 is flat in our community. There are no large differences in nutritional habits based on income or education.[137]

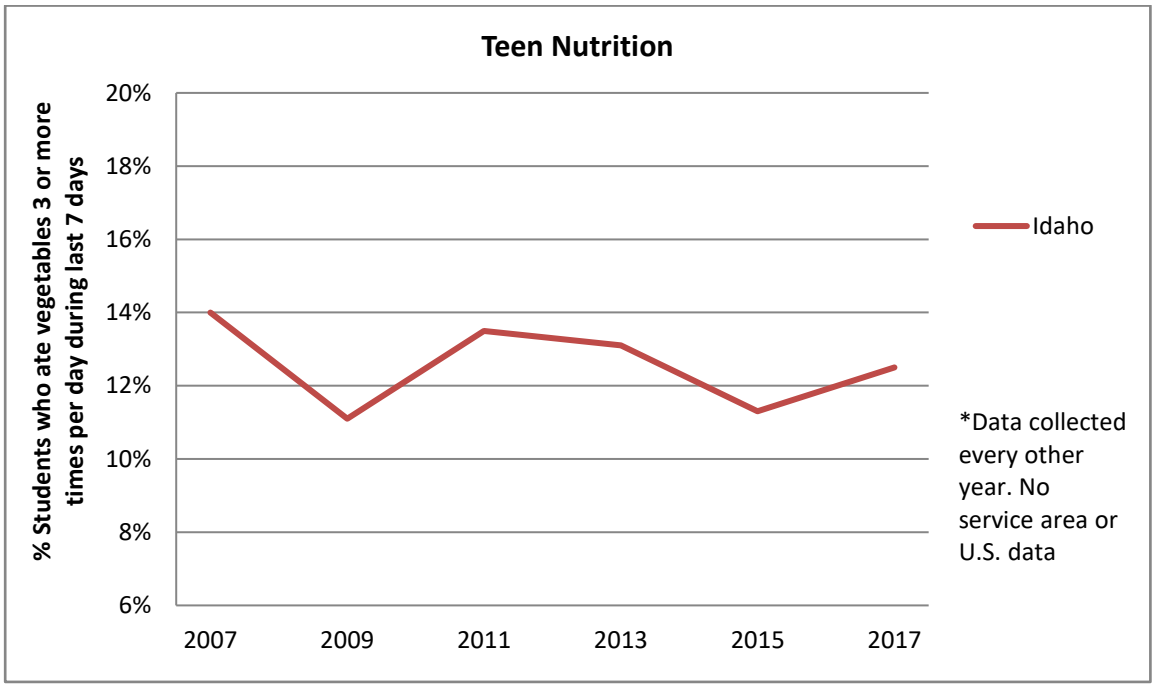


Health Factor Scoring					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Nutritional habits adults	**2**	**2**	**2**	**3**	**9**

[136] America's Health Rankings 2015-2018, www.americashealthrankings.org
[137] 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.[138]



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**

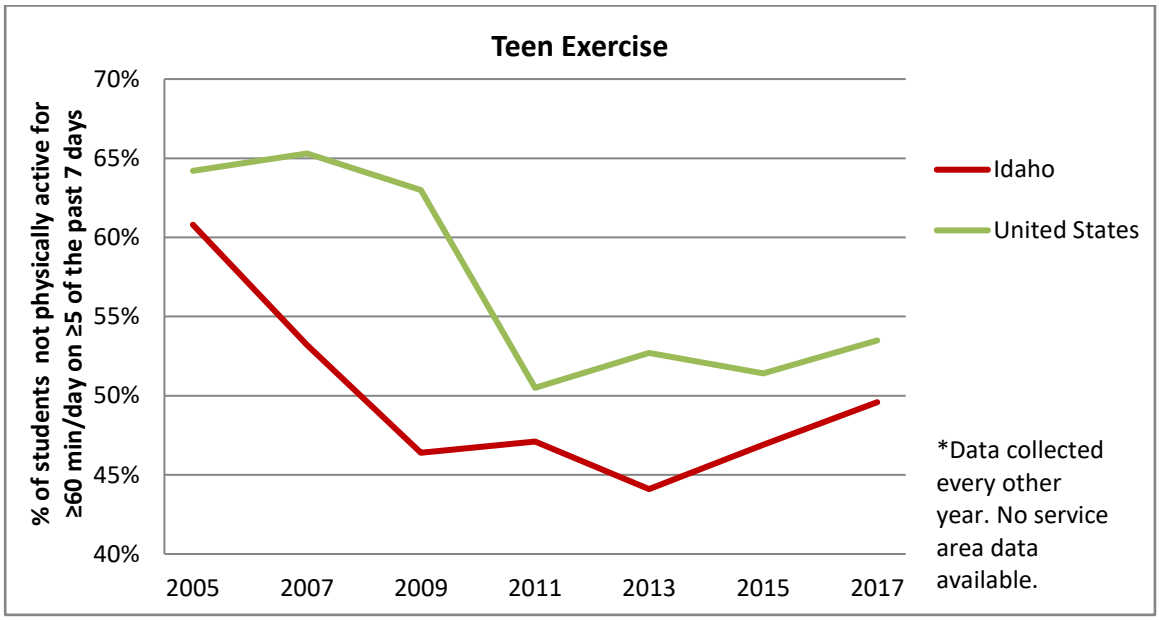
[138] Youth Risk Behavior Survey ,Idaho and United States, 2001 – 2017, www.cdc.gov/yrbs/

- **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.[139]

The chart below shows that about 45% 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 four years.[140]

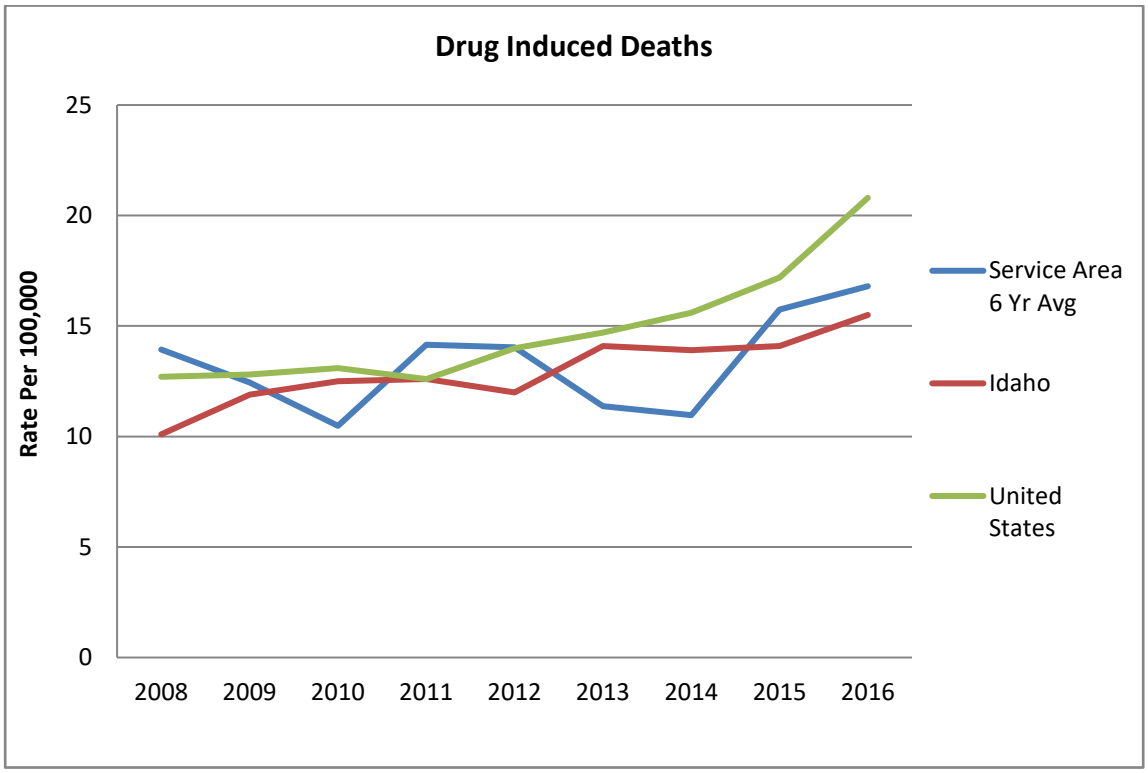


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Teen exercise	**2**	**2**	**2**	**4**	**10**

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

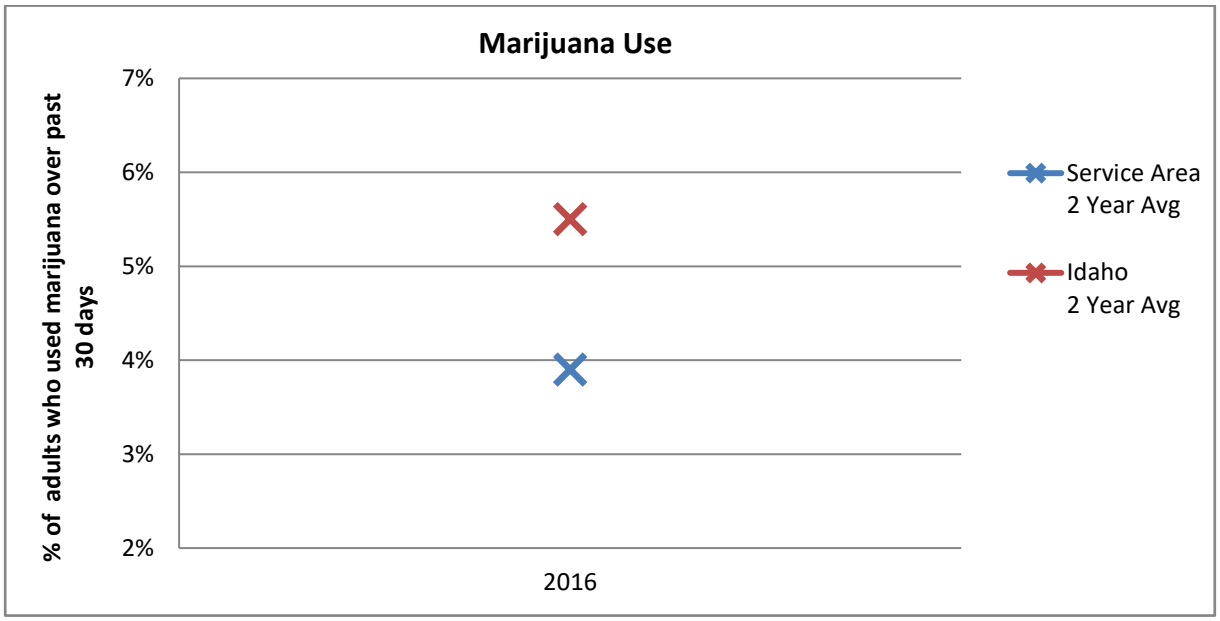
- **Drug Misuse**

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.[141] One way to measure the size of the problem is to look at the rate of drug induced deaths over time. The rate of drug induced deaths is lower in our community as it is in the nation as whole, and the rate has been rising. [142]



[141] https://www.samhsa.gov/topics/prescription-drug-misuse-abuse
[142] 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.[143]



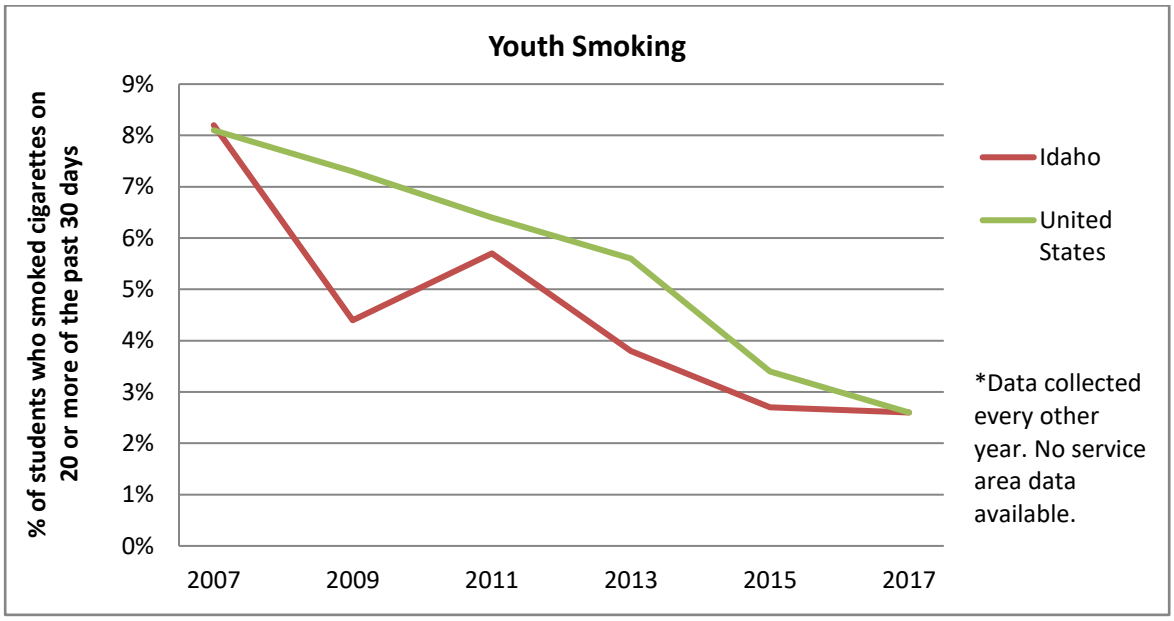
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Drug misuse	**3**	**1**	**4**	**3**	**11**

[143] 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 moreof 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. [144]

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. [145]



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**

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

Clinical Care Factors

County Health Rankings Clinical Care Factors

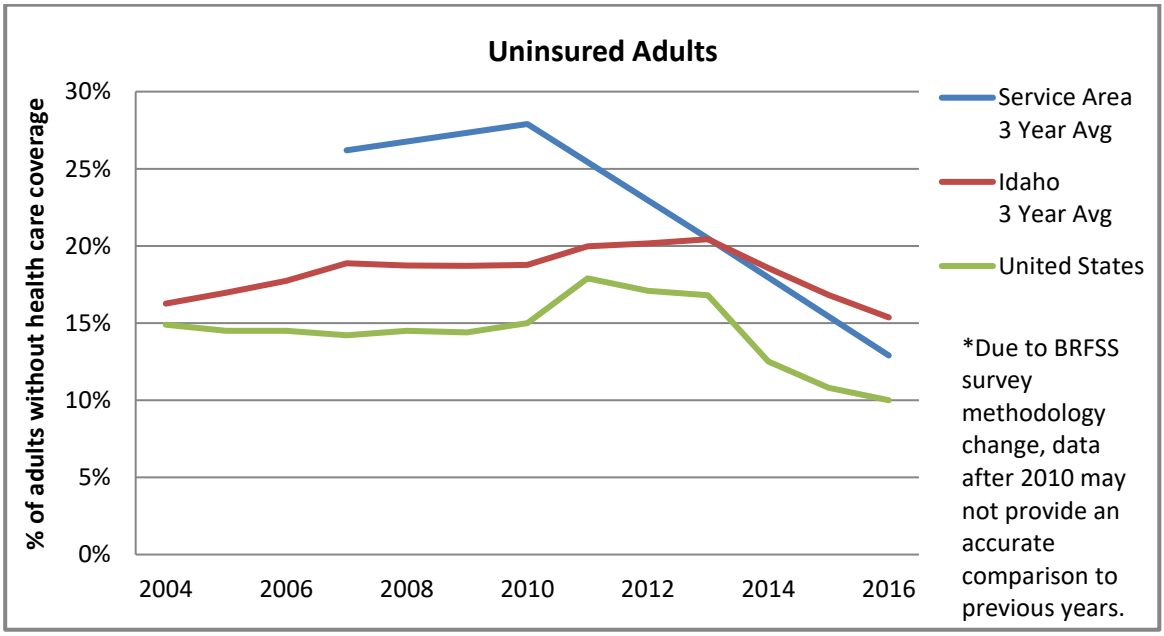
Health Care Access

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.[146]

  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 higher than the national average.[147]

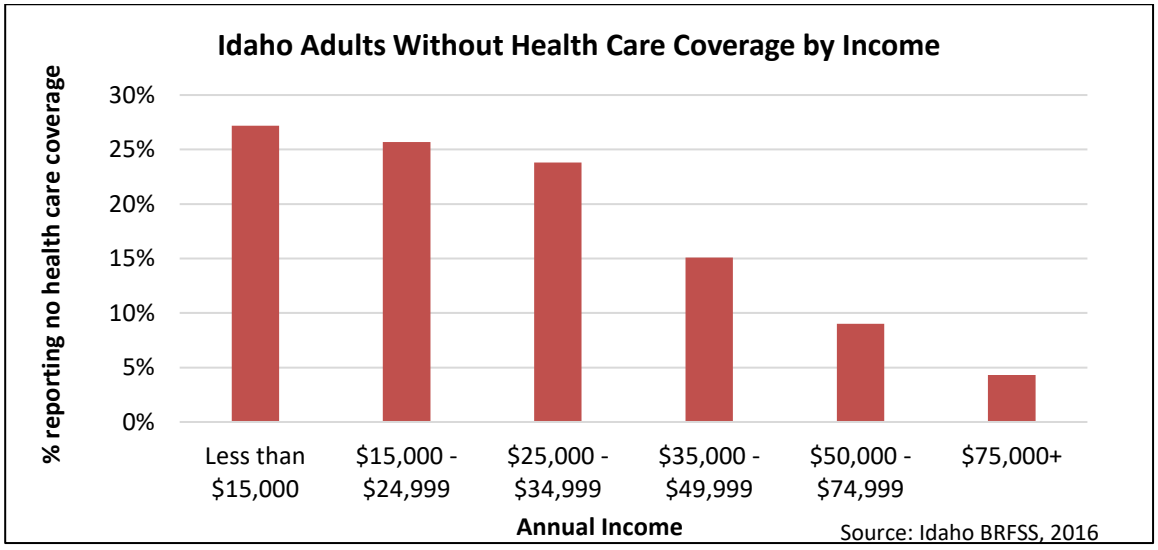


[146] University of Wisconsin Population Health Institute. *County Health Rankings* 2010-2018. Accessible at www.countyhealthrankings.org.

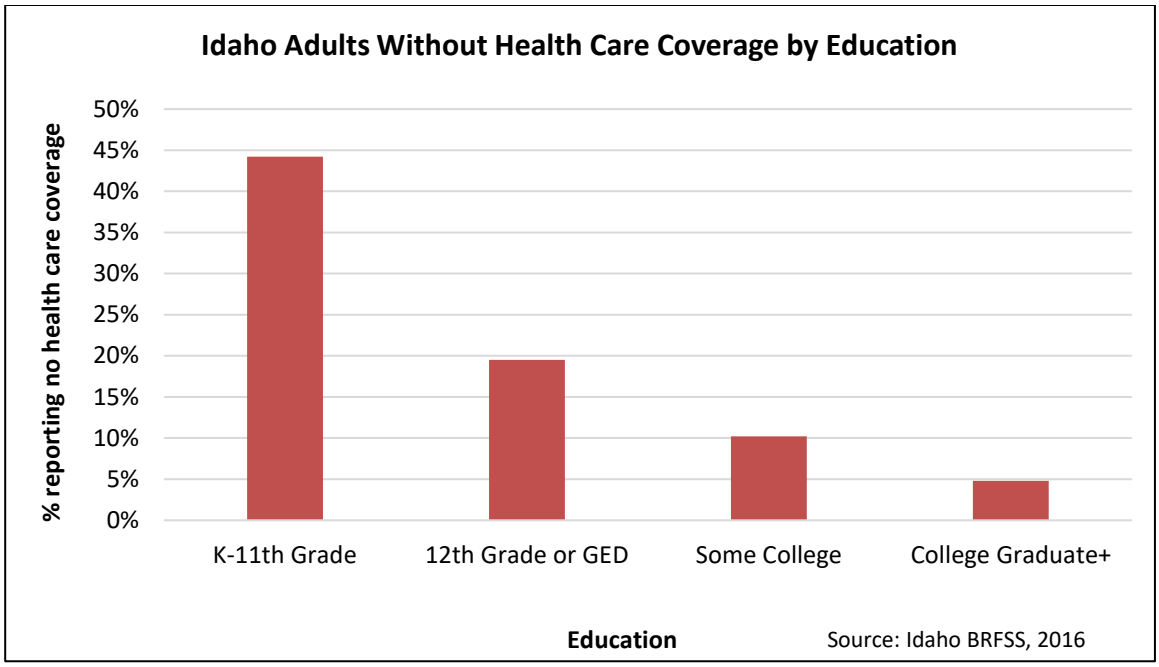
[147] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System

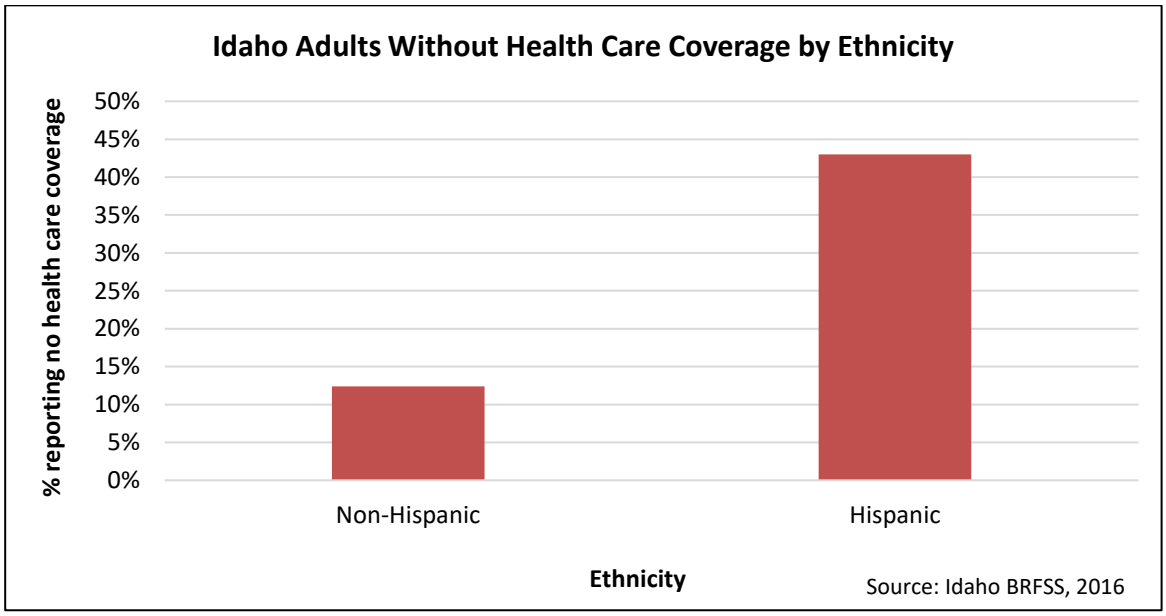
The chart above shows that on a national basis the 2010 Affordable Care Act (ACA) lowered the percentage of uninsured adults starting in 2014. The goal of the ACA is to improve health outcomes and eventually lower health care costs through insuring a greater proportion of the population. One of the major 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.[148] This is often referred to as the "coverage gap."[149] 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. [150]



[148] 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
[149] 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
[150] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System



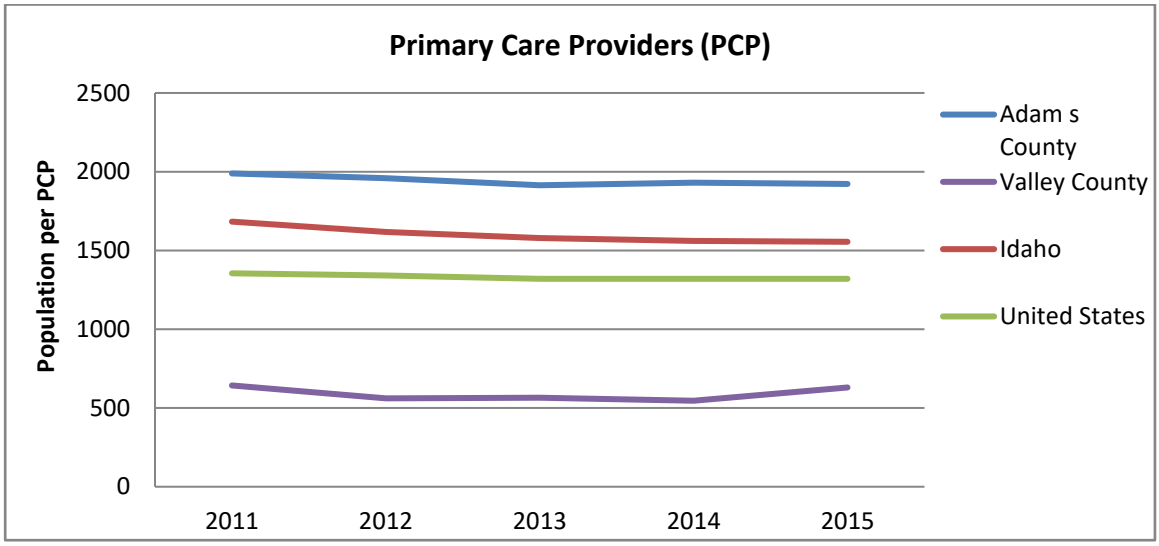


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Uninsured adults	**0**	**3**	**4**	**3**	**10**

- **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%.[151]

The chart below shows the population to primary care provider ratio was significantly better than the national average for Valley County, but it is above (worse than) the national average in Adams County.



Health Factor Score					
	Trend: Better/Worse	**Prevalence versus U.S.**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Primary care physicians	**2**	**3**	**2**	**3**	**10**

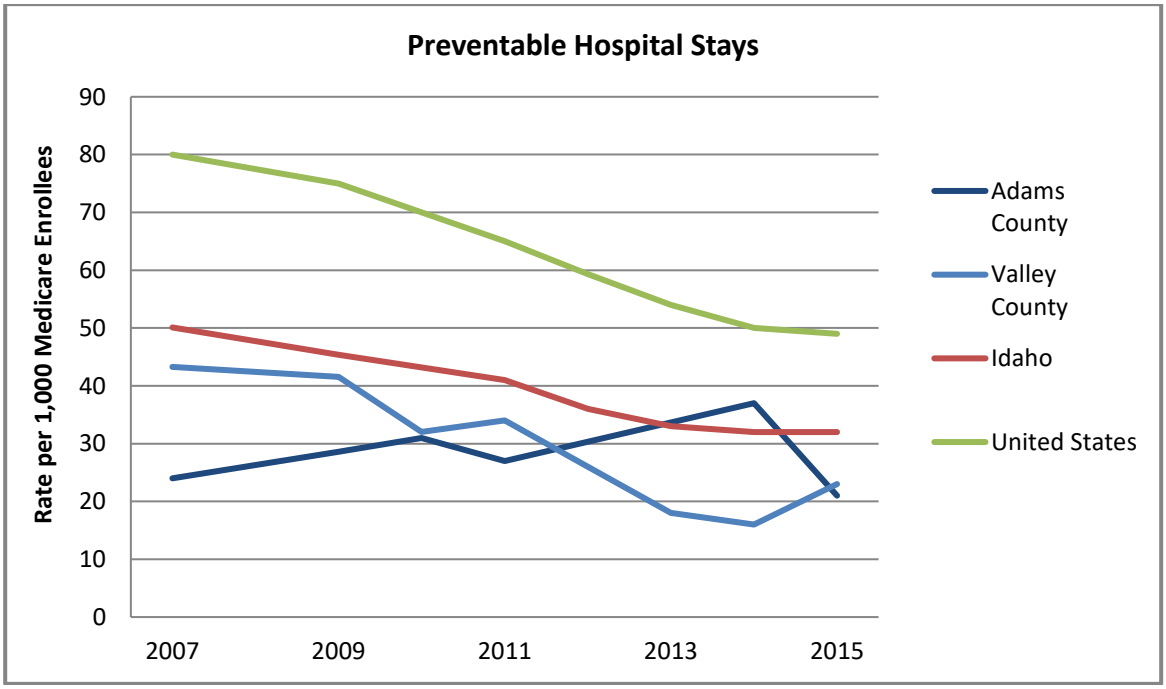
[151] University of Wisconsin Population Health Institute. *County Health Rankings* 2018. Accessible at www.countyhealthrankings.org.

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 significantly below (better than) the national average and is even well below (better than) the national top 10th percentile (top 10th percentile rate is 35). The trend is also improving over time in our service area and nationally. This indicates a high level of health care quality in our service area. [152]



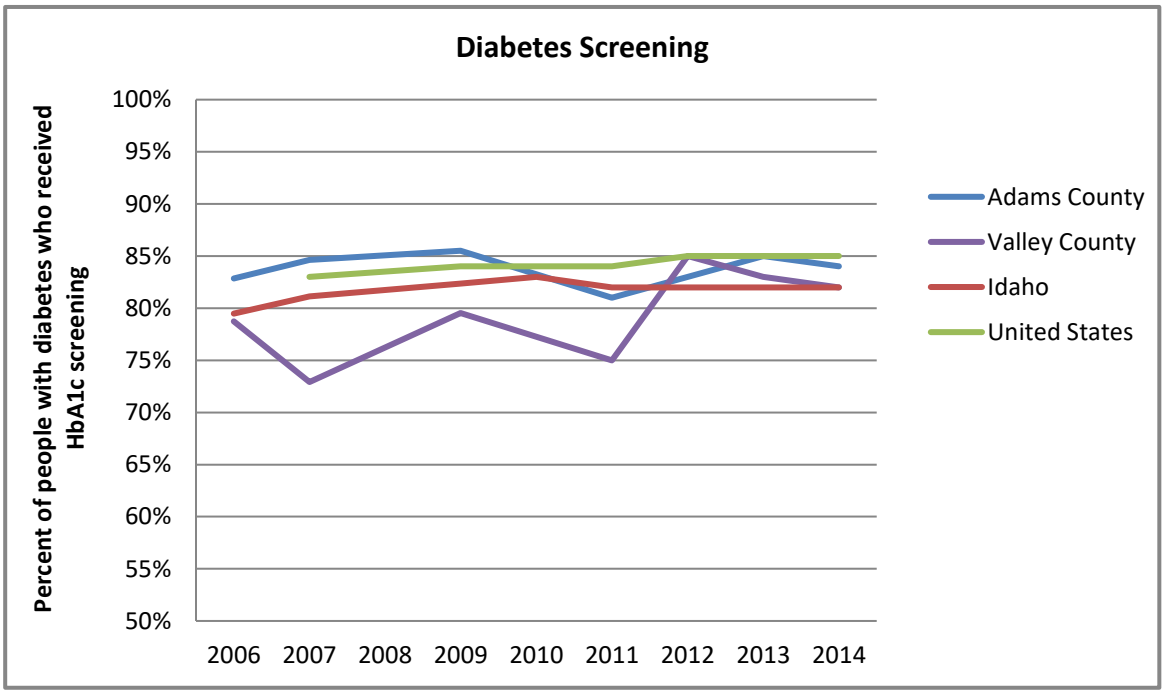
Health Factor Score Low score = Low potential for health impact — High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S.	Severe/ Preventable	Magnitude: Root Cause	Total Score
Preventable Hospital Stays	**1**	**0**	**2**	**4**	**7**

[152] 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.[153]

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



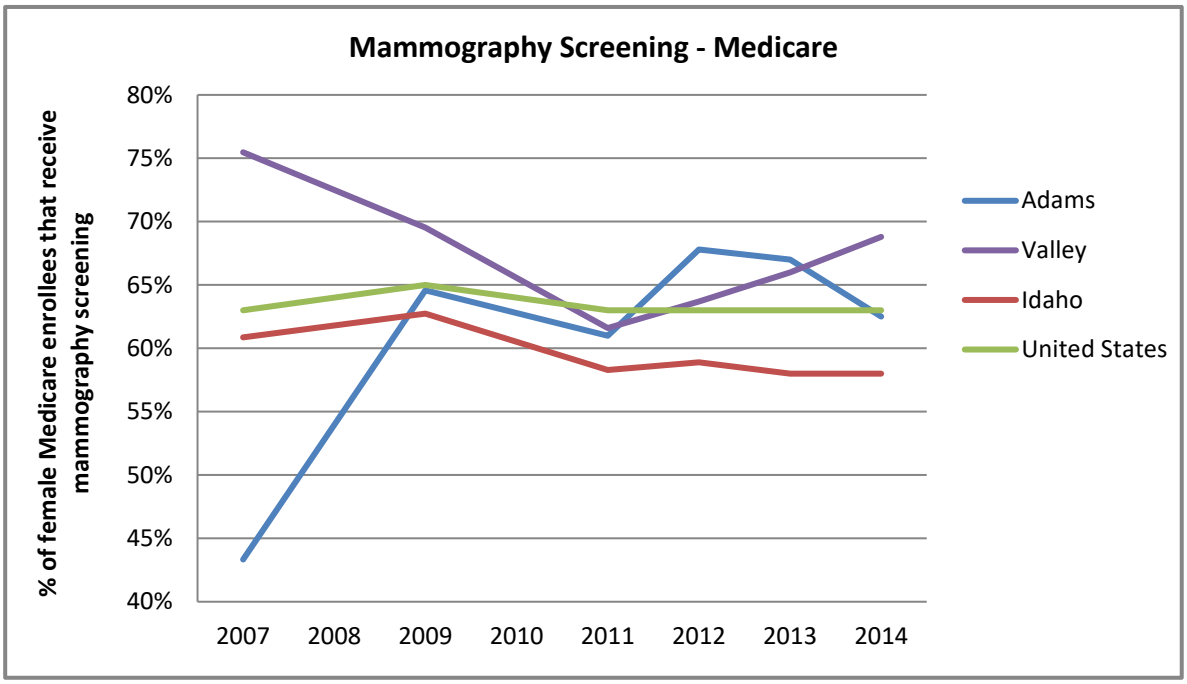
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Diabetes screening	**2**	**2**	**3**	**3**	**10**

[153] 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.

The trend for the overall percent of women aged 67 to 69 receiving mammography screenings has been flat for the past several years. The percent for our community is about the same as the national average.[154]

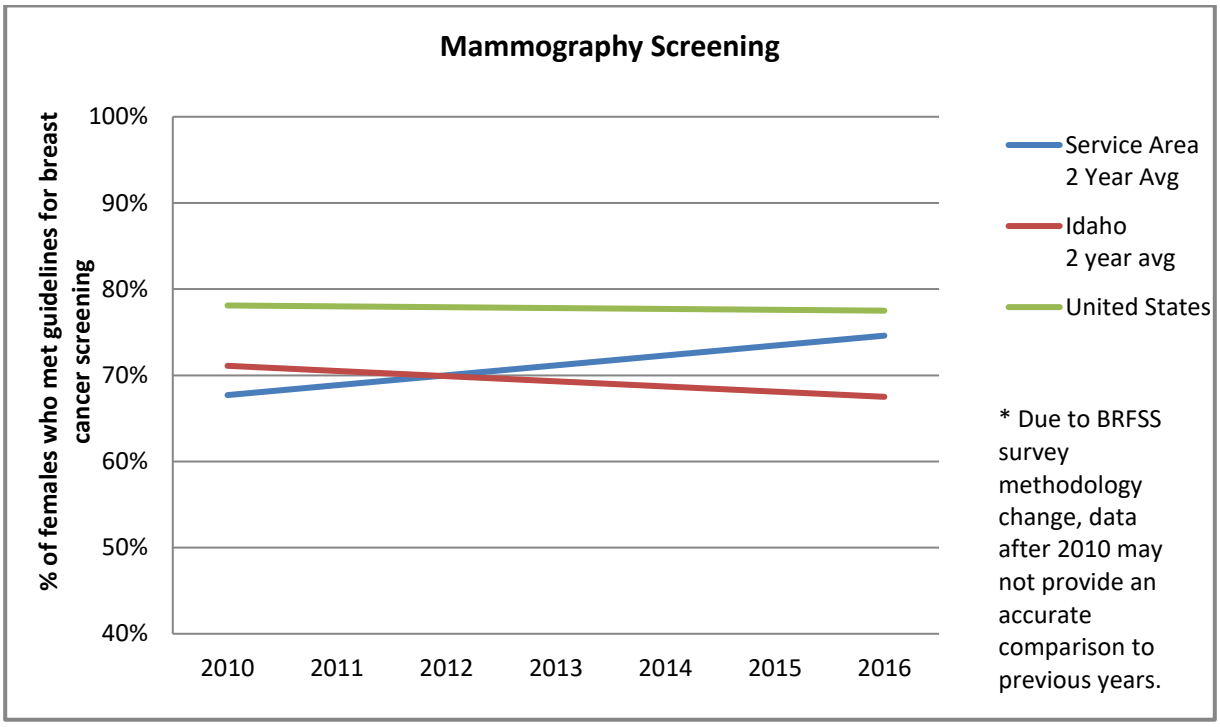


The data underlying this measure comes from the Dartmouth Atlas, a project that documents variations in health care throughout the country through use of Medicare claims data.

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 increased over the past two years and overall is consistent with the percentage of women ages 65 to 67 receiving breast

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

cancer screenings. 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.[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**
Mammography screening	**1**	**2**	**4**	**1**	**8**

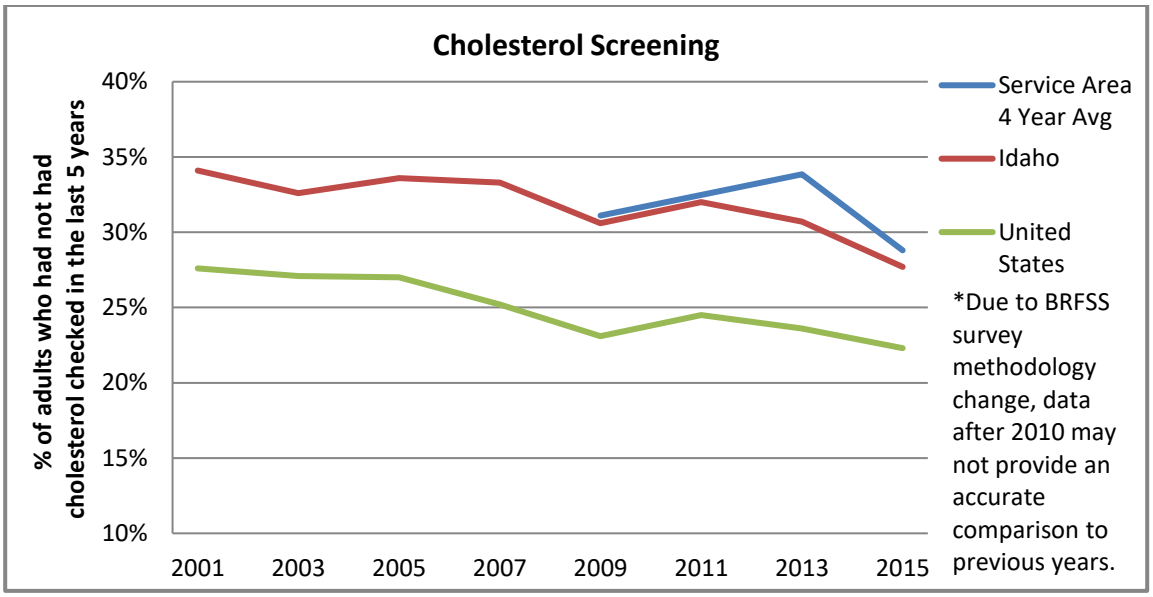
Additional Clinical Health Factors

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

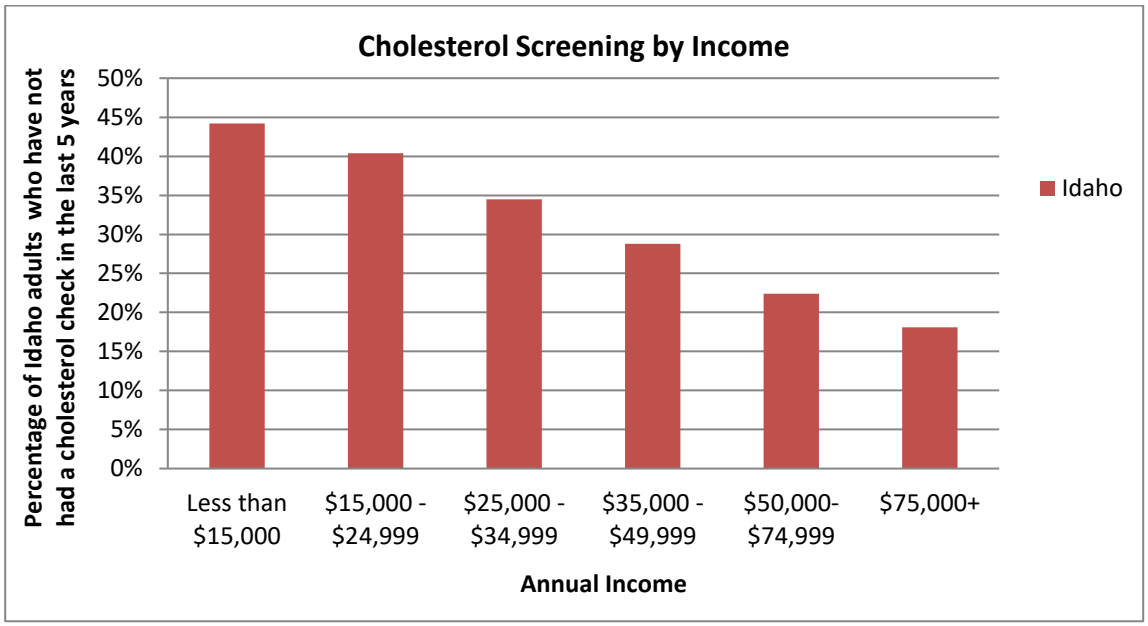
- **Cholesterol Screening**

  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 Idaho and national averages.[156]

[155] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System
[156] 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. [157]



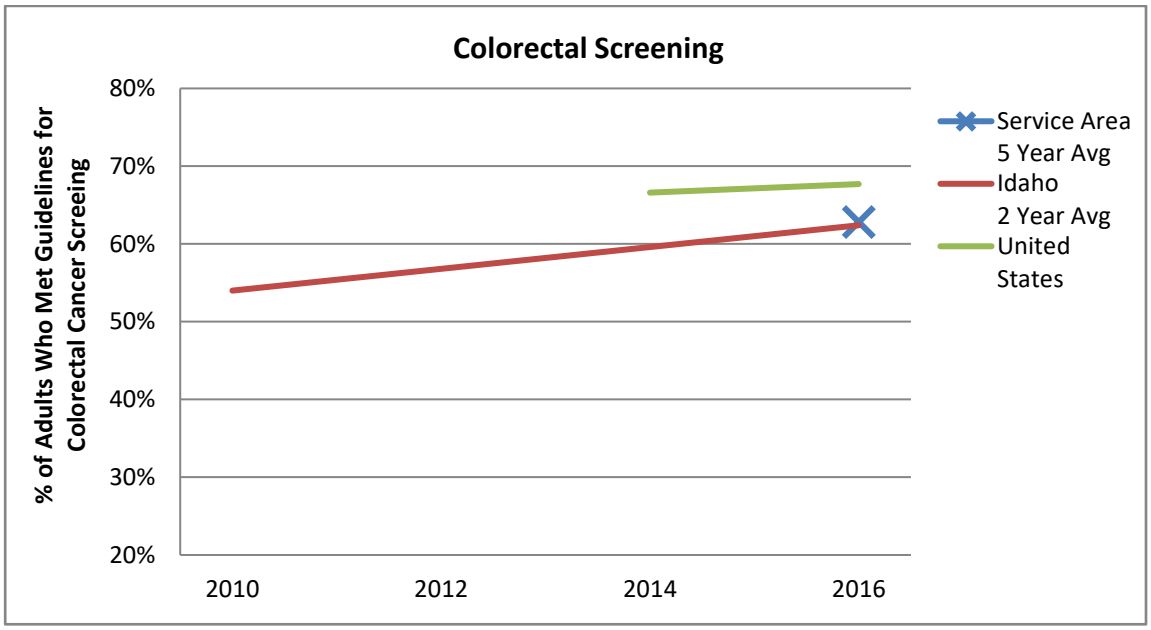
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Cholesterol Screening	**2**	**4**	**3**	**2**	**11**

[157] 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 nationally over the past 10 years. The percent of people 50 and older receiving colorectal screening in our service area is about the same as the nation as a whole.[158]



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. [159]

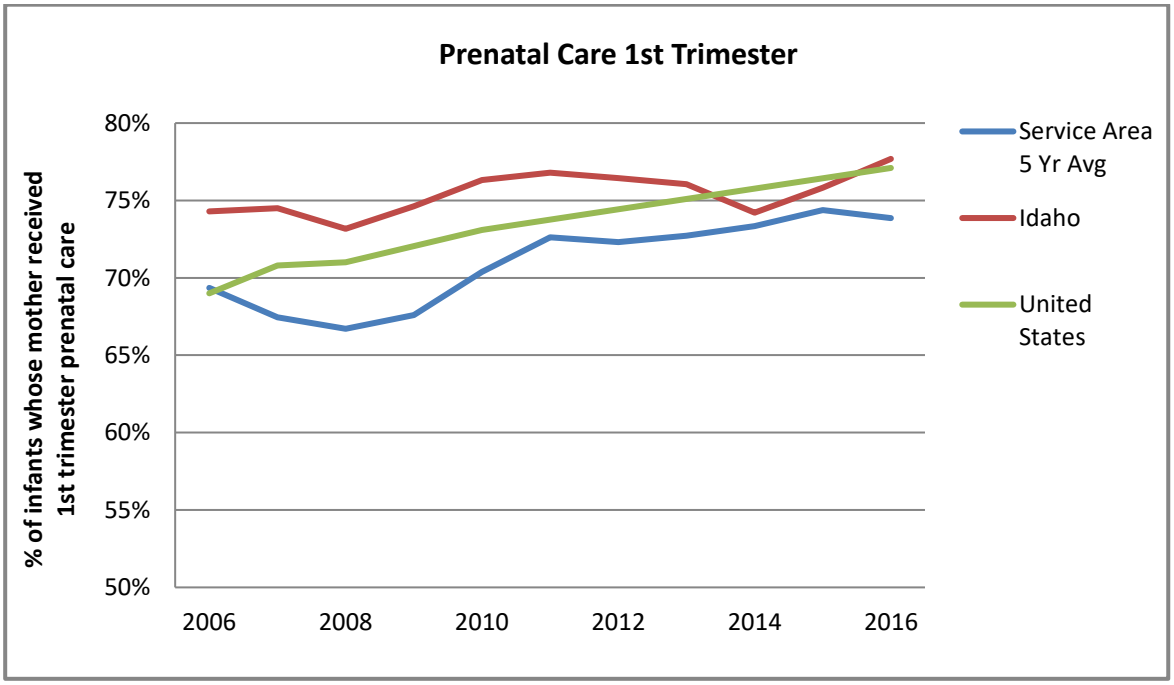
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Colorectal Screening	**1**	**2**	**4**	**0**	**7**

[158] Idaho and National 2002 - 2016 Behavioral Risk Factor Surveillance System
[159] 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.[160]

As shown in the chart below, a slightly lower 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 had been decreasing from 2004 to 2008 but has increased from 2009 through 2016. Approximately 70% of women in our service area received early prenatal care in 2016. [161]



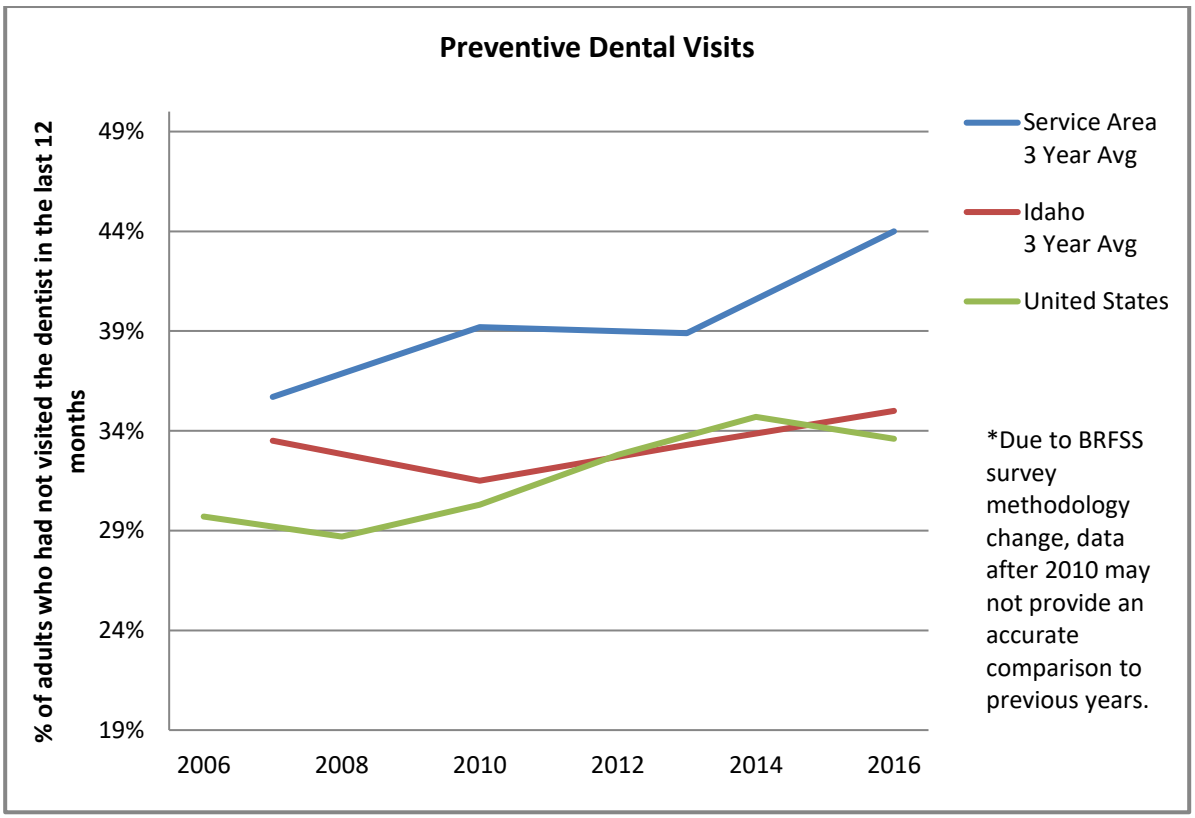
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Prenatal care 1st Trimester	**1**	**2**	**3**	**3**	**9**

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

- **Dental Visits**

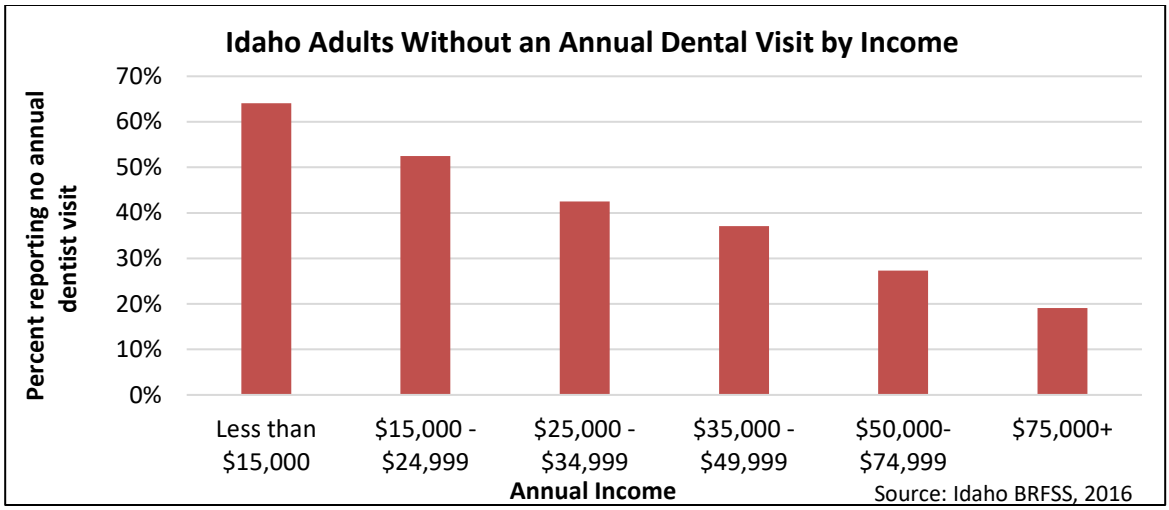
Oral health is vital to a comprehensive preventive health program. Nearly one-third of all adults in the U.S. have untreated tooth decay, while one in seven adults aged 35 to 44 years has gum disease. This increases to one in every four adults aged 65 years and older. Oral cancers, if caught early, are more responsive to treatment. Annual dental visits are one part of a healthy regimen of oral care.[162]

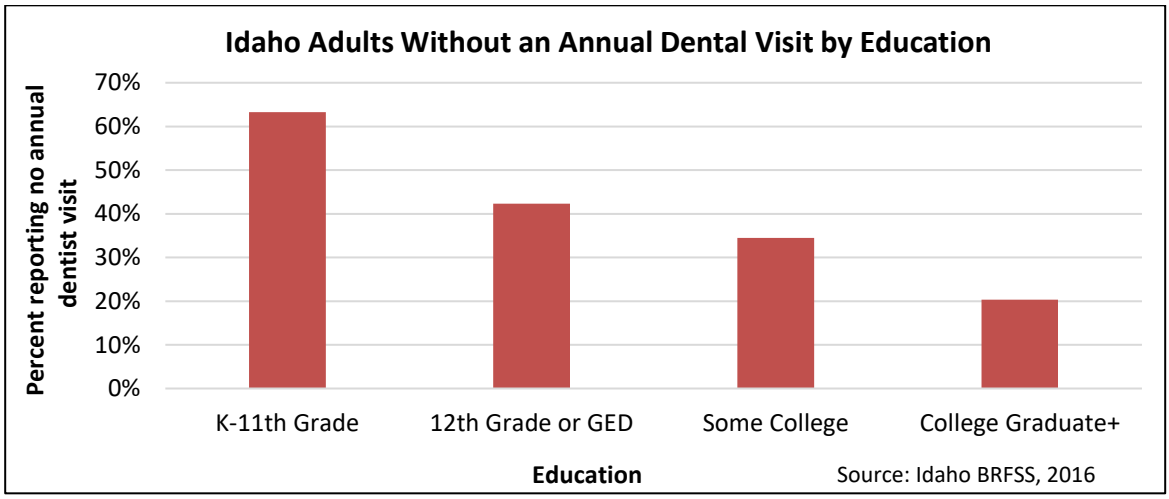
According to the Behavioral Risk Factor Surveillance System surveys, the percentage of people not receiving preventive dental visits in our service area is higher than it is in the nation as a whole. The trend has been worsening over the past ten years in our service area.[163]

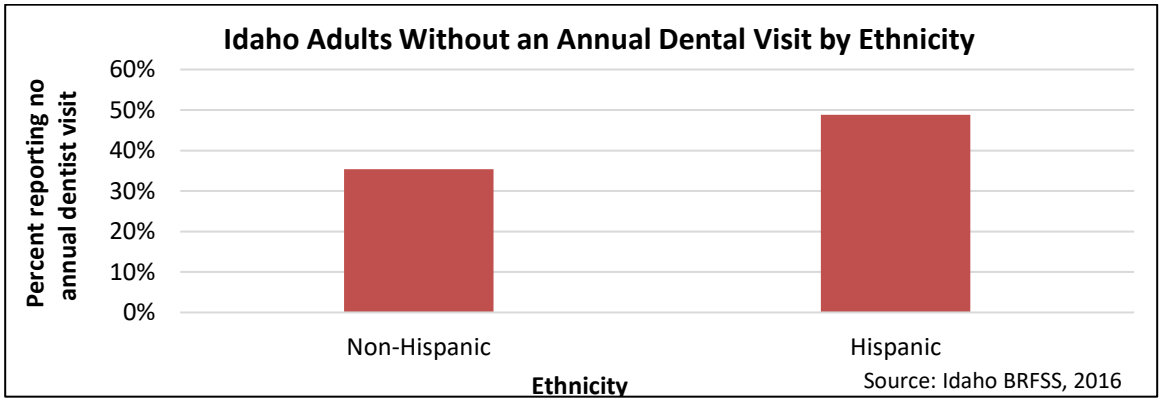


Those with incomes below $25,000 are significantly less likely to have preventive dental visits than those with higher incomes. In addition, those with less than a college degree are significantly less likely to have preventive dental visits. [164]

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





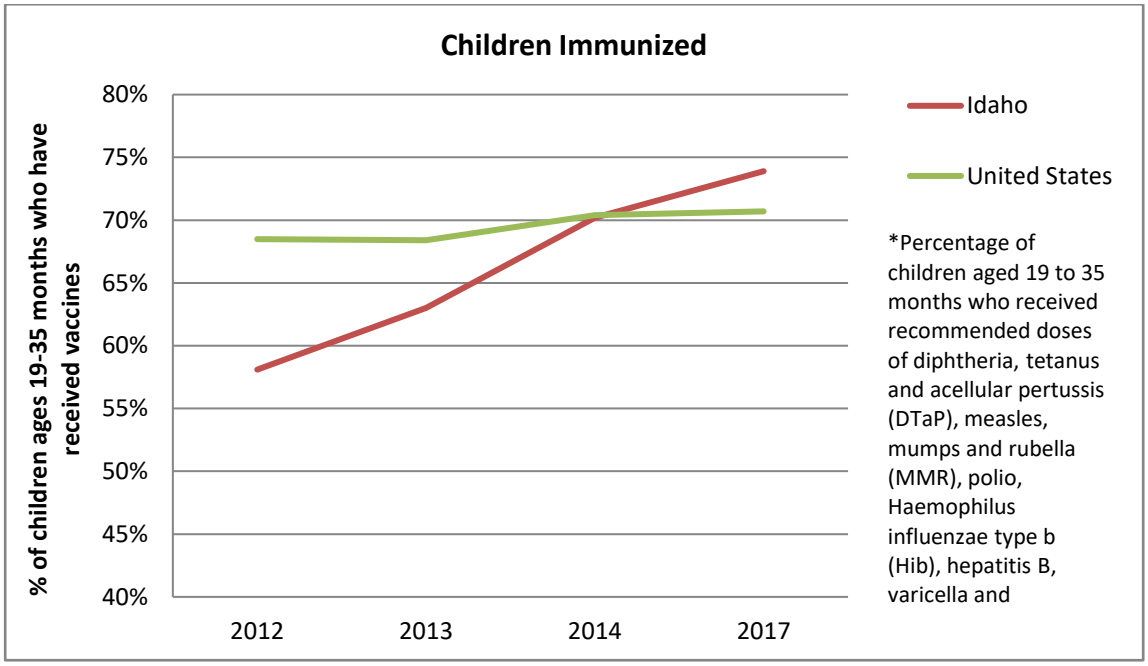


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Dental Visits	**4**	**4**	**3**	**2**	**13**

- **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.[165]



There are proven methods to increase the rate of vaccinations that include ways to increase demand or improve access through provider-based innovations.[166]

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

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

- **Mental Health Service Providers**

  Adams and Valley counties both are listed as mental health professional shortage areas as of June 2017.[167] 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 [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**
Mental health service providers	**2**	**4**	**4**	**2**	**12**

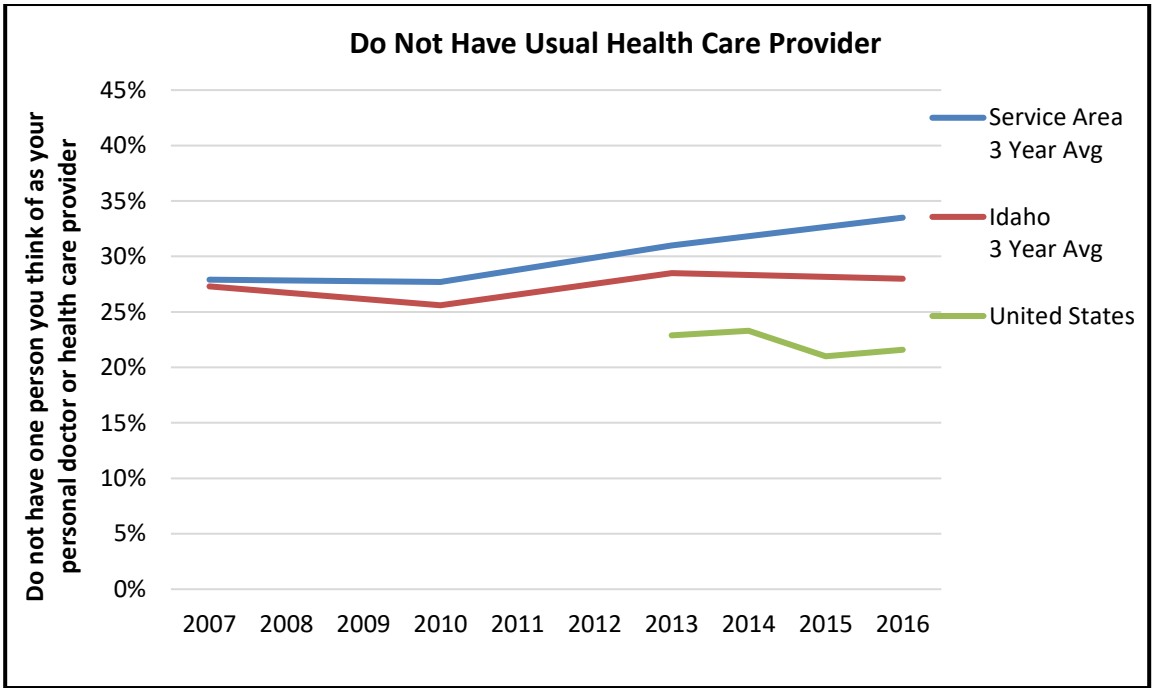
[167] Health Services and Resource Administration Data Warehouse, Mental Health Care HPSAs PDF http://datawarehouse.hrsa.gov/hpsadetail.aspx#table

[168] 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. [169]

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.[170]



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	**3**	**4**	**2**	**3**	**12**

[169] http://www.hrsa.gov/healthit/toolbox/Childrenstoolbox/BuildingMedicalHome/whyimportant.html
[170] 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.

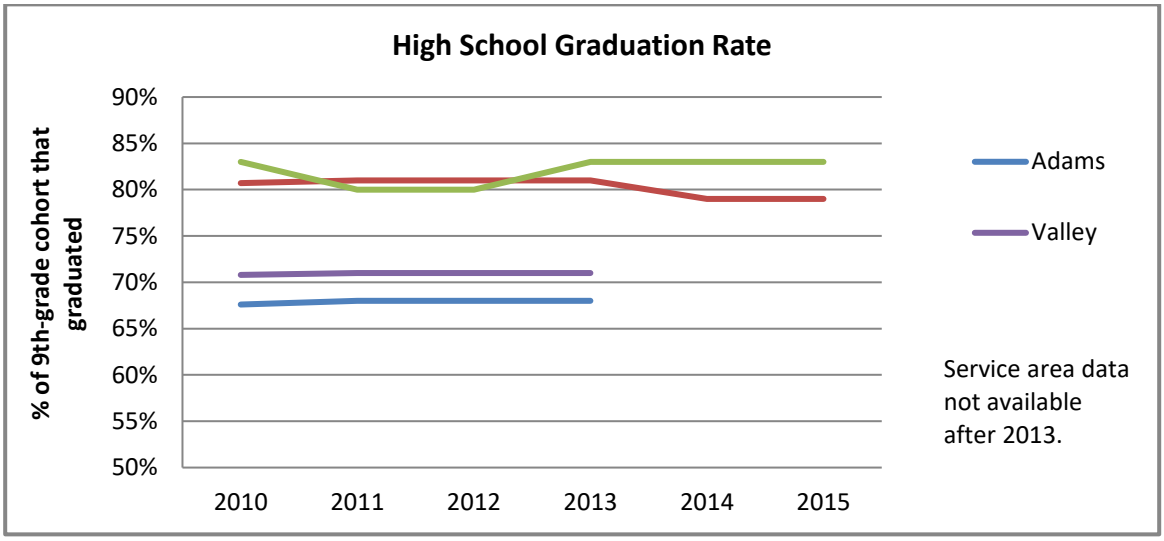
  One's education level affects not only his or her health, but education can have multigenerational implications that make it an important measure for the health of future generations. Evidence links maternal education with the health of her children. The education of parents affects their children's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

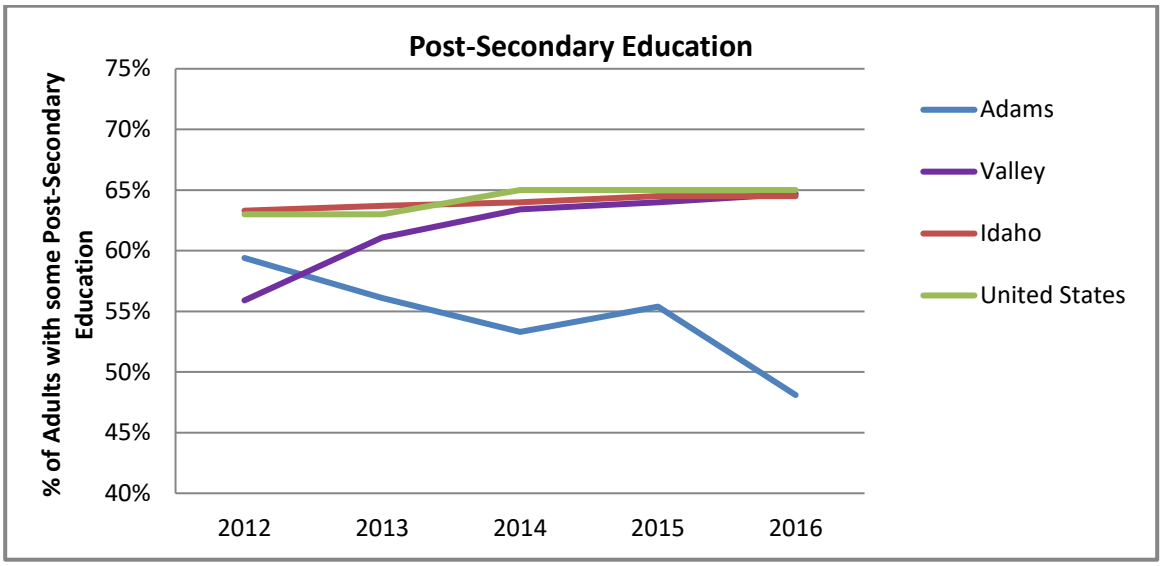
  Finally, education influences a variety of social and psychological factors. Evidence shows the more education an individual has, the greater his or her sense of personal control. This is important to health because people who view themselves as possessing a high degree of personal control also report 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).[171]

The high school graduation rate for our community is well below the national average. Post-secondary education is below the national average for Adams County.





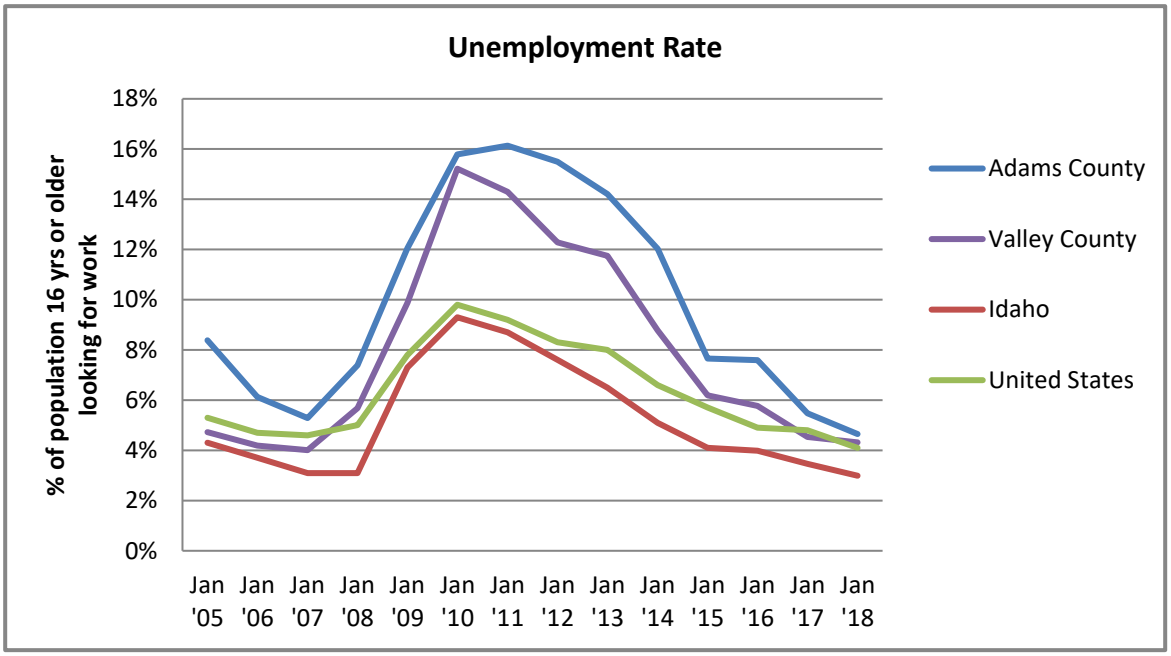
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Education	**2**	**4**	**2**	**3**	**11**

[171] 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.[172]

The unemployment rate in Idaho and our service area has been trending down since 2011 and is at the longer term, healthier rates for our area.[173]



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**	**2**	**1**	**4**	**7**

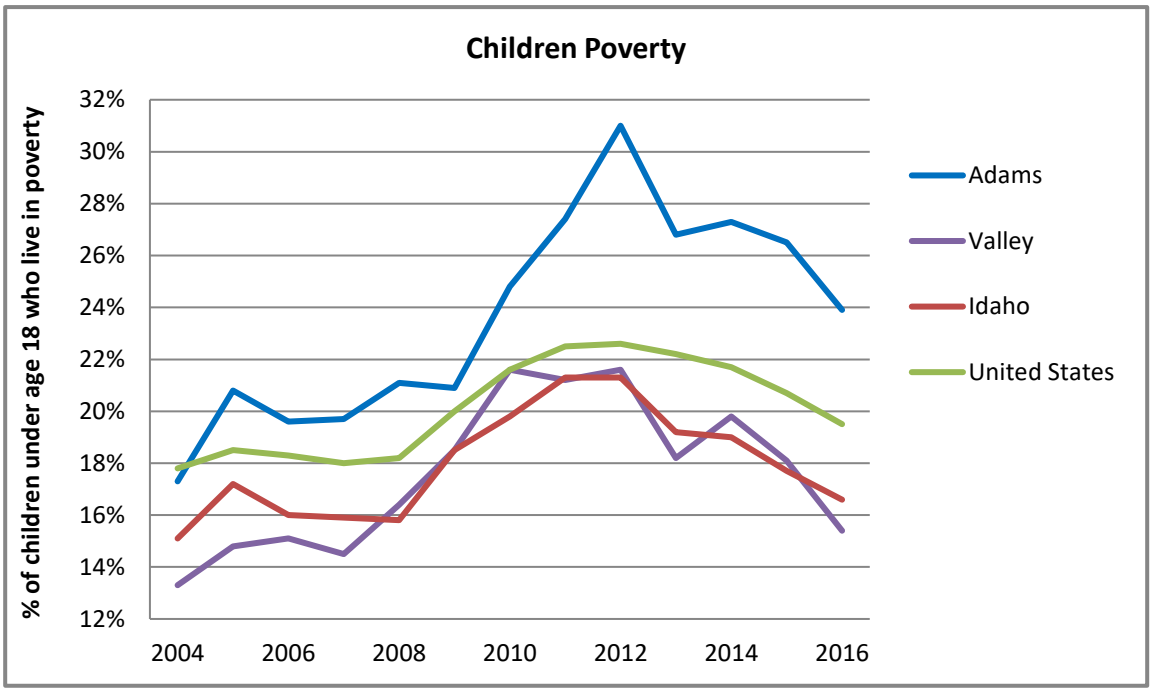
[172] University of Wisconsin Population Health Institute. *County Health Rankings* 2012-2018. Accessible at www.countyhealthrankings.org.

[173] 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).[174]

Although the trend has started to improve, the percent of children in poverty increased since 2004 both nationally and in our service area. The prevalence of children in poverty in Valley County is well below the national average, but for Adams County the percent of children in poverty is above the national average.[175]



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	**3**	**2**	**3**	**3**	**11**

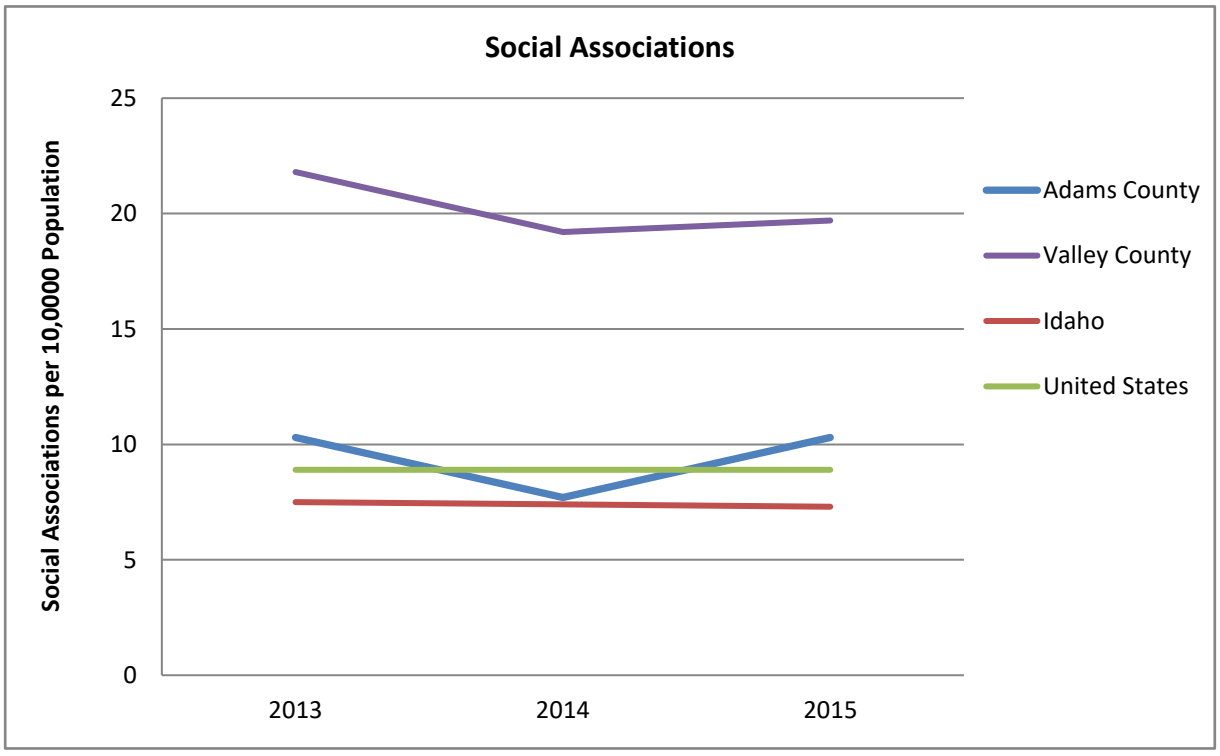
[174] University of Wisconsin Population Health Institute. *County Health Rankings* 2012-2018. Accessible at www.countyhealthrankings.org.
[175] Source: Small Area Income and Poverty Estimates (SAIPE. http://www.census.gov/did/www/saipe/data/statecounty/data/index.html

- **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.[176]

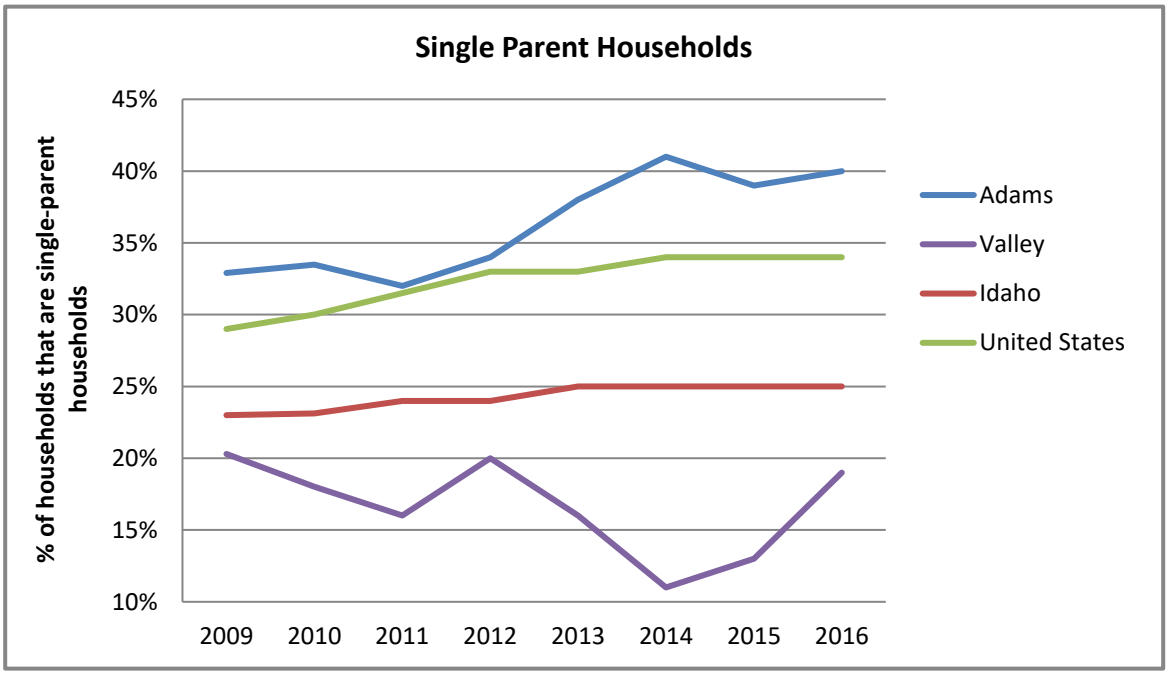
  Adopting and implementing policies and programs that support relationships between individuals and across entire communities can benefit health. The greatest health improvements may be made by emphasizing efforts to support disadvantaged families and neighborhoods, where small improvements can have the greatest impacts. Social associations per 10,000 population in Valley County is well above the national average and about the same as the national average in Adams County.[177]



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

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 Valley County and above the national average for Adams County.[178]



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	**2**	**2**	**2**	**3**	**9**

[178] 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.

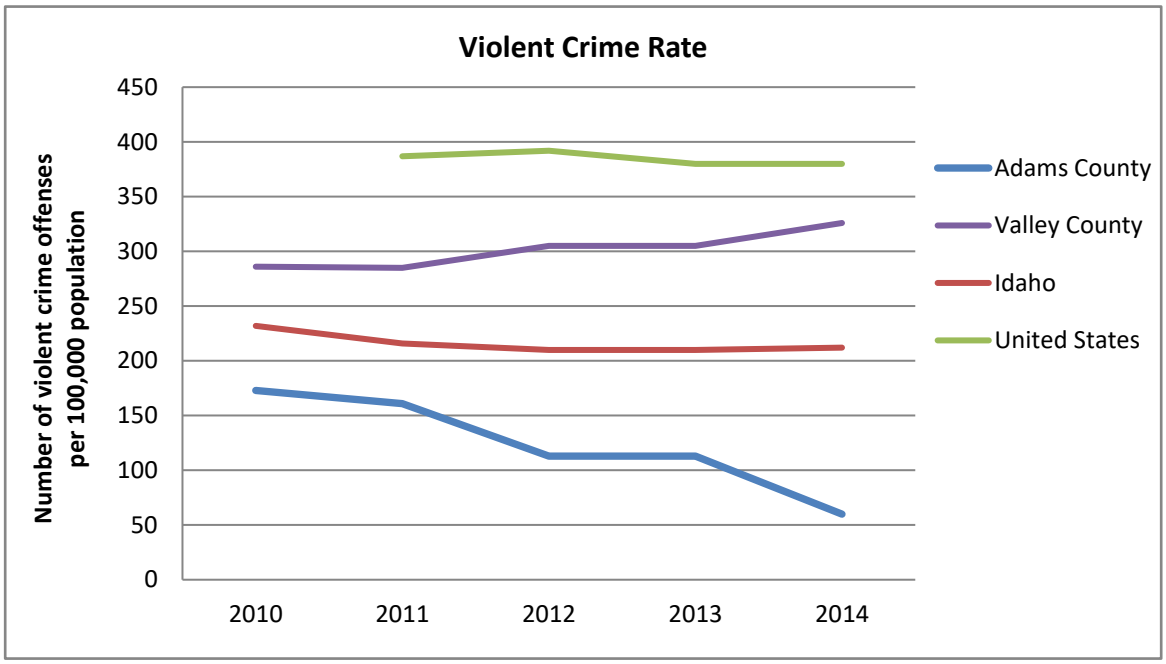
Injuries generate $406 billion in lifetime medical costs and lost productivity every year, $37 billion of which are from violence. Communities can help protect their residents by adopting and implementing policies and programs to prevent accidents and violence. [179]

[179] 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. [180]



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**

[180] Ibid

Physical Environment Factors

County Health Rankings Physical Environment Factors

Air and Water Quality

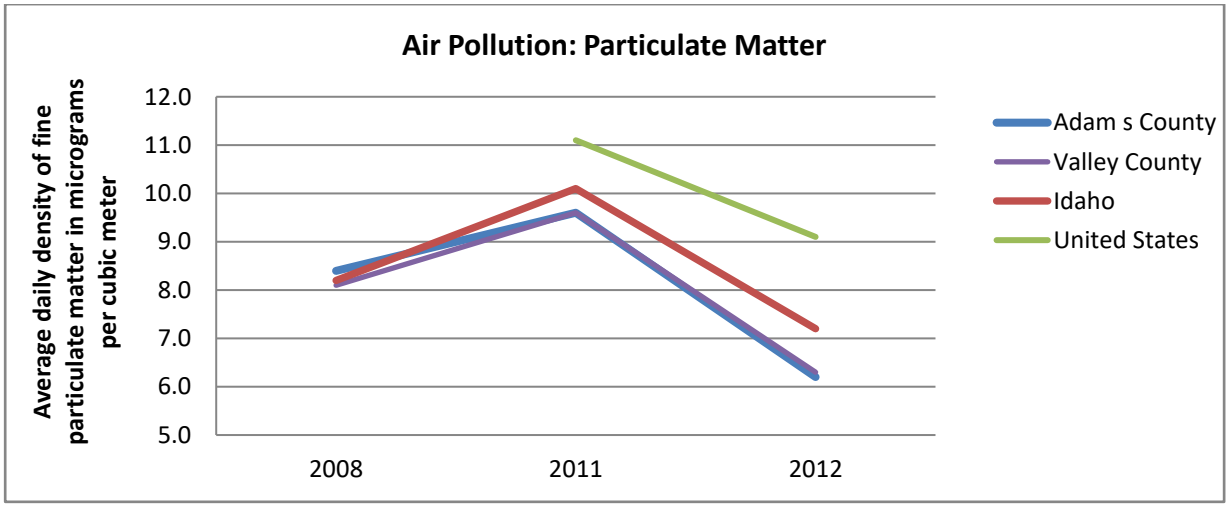
Clean air and water support healthy brain and body function, growth, and development. Air pollutants such as fine particulate matter can harm our health and the environment. Air pollution is associated with increased asthma rates and can aggravate asthma, emphysema, chronic bronchitis, and other lung 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.[181]

- **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.[182]

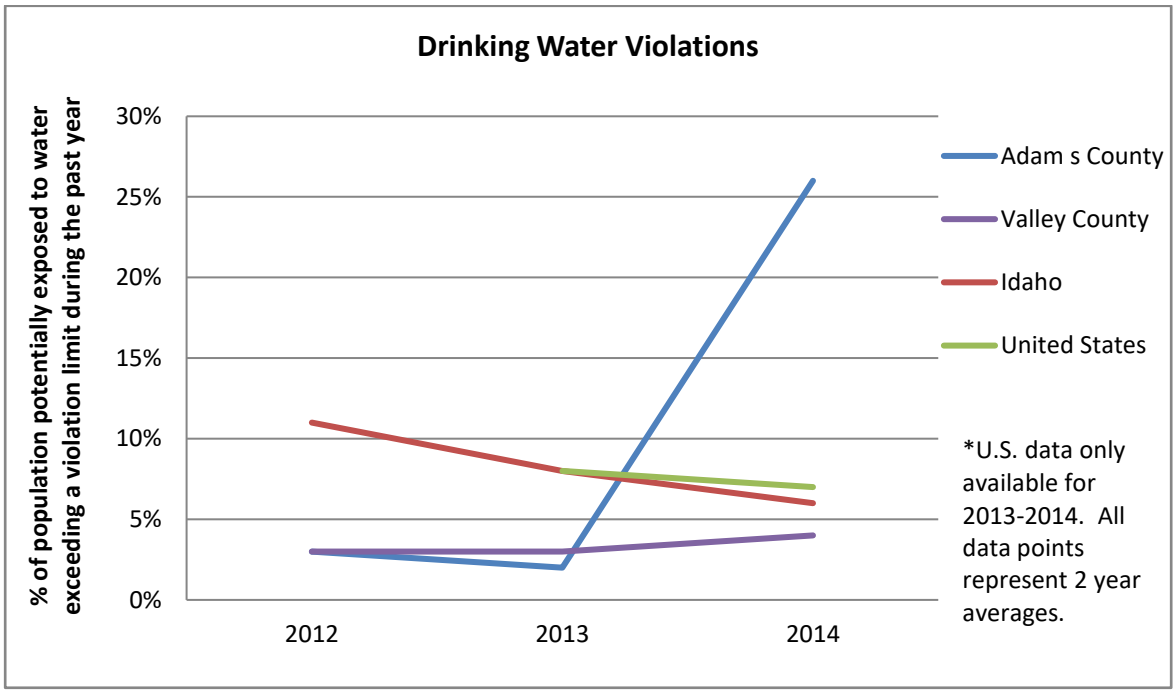


[181] Ibid
[182] Ibid

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	**1**	**0**	**2**	**2**	**5**

- **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 normally below the national average, although Adams County had violations above the national average in 2014.[183]



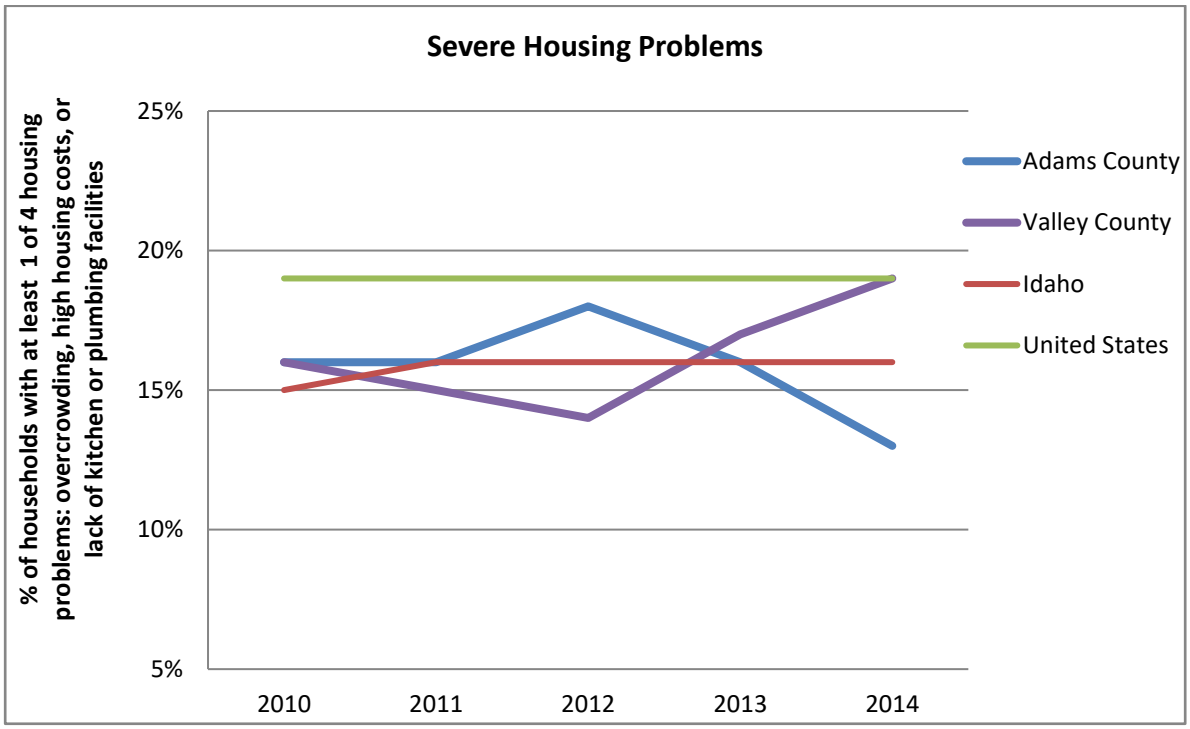
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Drinking Water Violations	**3**	**2**	**2**	**2**	**9**

[183] 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. [184]

Idaho and our service area in general have a slightly lower percentage of housing problems than the national average.



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**	**2**	**1.5**	**3**	**8.5**

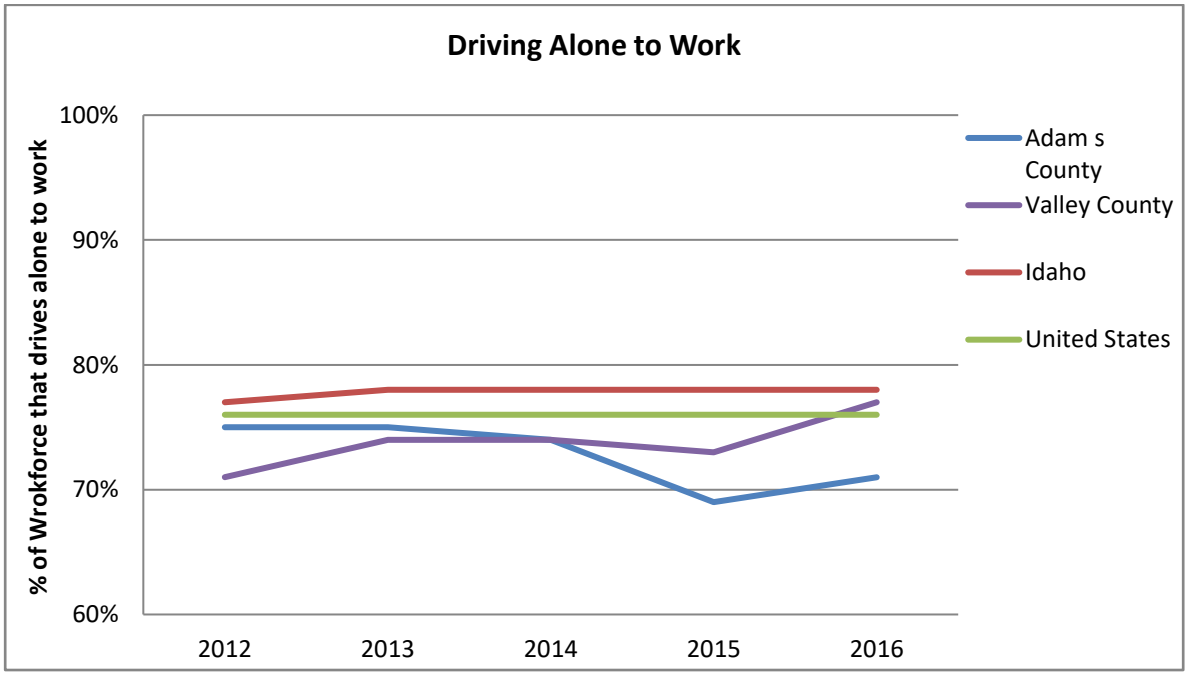
[184] Ibid

- **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 service area has approximately the same percent of people driving to work alone as the national average.[185]



Health Factor Scoring					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Driving Alone to Work	**2**	**2**	**1**	**2**	**7**

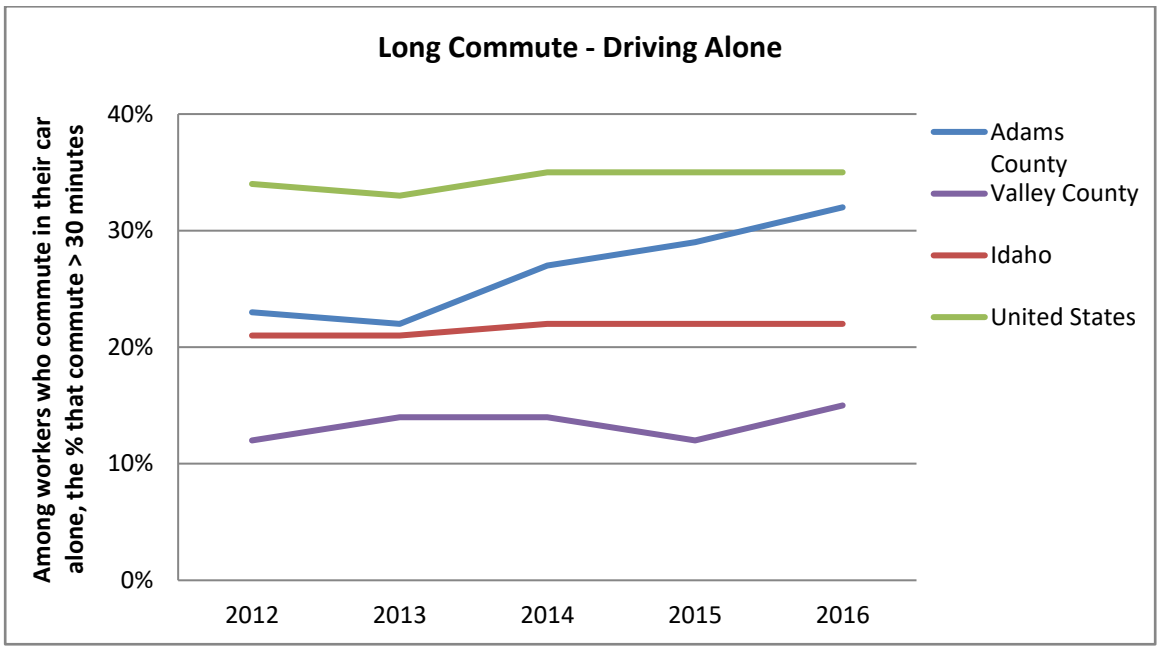
[185] Ibid

- **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 with a long commute to work is much lower than the national average in our community.



Health Factor Scoring					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Long Commute	**3**	**0**	**1**	**2**	**6**

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	**5.5**	McCall does have access to healthy foods, but in other parts of our community it is very expensive and limited. Many representatives think that it needs to be more affordable and accessible.
Cancer prevention/education programs	**5.5**	"As society ages, cancer will become the most prominent cause of death in our communities." Some community representatives state that we need to do better educating people on cancer prevention. It is suggested that we have support groups and more access to treatment locally.
Exercise programs/education/opportunities	**4.8**	"Exercise is the single most important thing a person can do for their health." 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	**5.6**	Many representatives feel that we need to educate people on how to cook and shop. “We need to educate folks on how to cook and what food to buy.”
Safe sex education programs	**4.7**	Some schools do well at educating about safe sex, but other schools do not. “We are lacking in the healthy relationship component. We need to address this first and then address safe sex.” “We teach this in middle school and high school. “
Substance abuse services and programs	**6.7**	Substance abuse is a big problem in our community. Community representatives agree that there are some substance abuse programs available, but often with a cost associated with it. They are not adequate for the demand or applicable for all the different needs. They would like to see more services throughout all communities.
Tobacco prevention and cessation programs	**5.4**	Representatives believe that there are tobacco cessation programs, but they need to be better advertised and we need to better address vaping and chewing tobacco.
Weight management programs	**6.4**	We need to do more to help people with their weight. “We are not doing this well when 60% of the population is overweight and 33% is obese. We are the second heaviest country in the world.”
Wellness and prevention programs (for conditions such as high blood	**4.9**	Wellness and prevention are an important component to quality of life.

pressure, skin cancer, depression, etc.)		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. “Low income and the gap population are not able to take care of themselves as well as they should, but if there were affordable options they might.”

Clinical Care Access and Quality Needs		
Potential Health Needs	**Average Score**	**Summary of Community Representatives' Comments**
Affordable care for low income individuals	**6.2**	Representatives are aware that there are some sliding fee programs available that are scaled to fit people’s income, but feel health care, in general, is not affordable. “We try to help people so their needs can be met, but nothing is affordable in health care.”
Affordable dental care for low income individuals	**7.9**	Affordable dental care is a big problem here. “Two things that play a major role in predicting your economic success are body weight and dental care.” In some areas there is affordable dental care for kids, but no programs for adults. It was noted that there are not any dentists that take Medicaid in the county. “I am questioning if this is a social and ethical problem as well. We need to take care of ALL people.”
Affordable health insurance	**8.2**	Affordable health insurance is a huge issue. 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 is 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)	**6.6**	In rural areas we need to have greater access to mental health services. We need to see how to get more providers here. Although there are more social workers in the area than we have had in the past, representatives expressed that there is still a need for psychiatric providers to help with medication management and diagnostic assessments.
Availability of primary care providers	**4.3**	Representatives report that there are enough primary care providers available in most areas, but access and affordability are an issue for the more rural communities.
Chronic disease management programs	**5.3**	Representatives agree there is a need for chronic disease management programs. For now unless you have a primary care provider to help with this, there are very limited programs.
Immunization programs	**3.2**	Overall, representative think immunization programs are adequate in the county especially for our youth. They would like to have traveling vaccines available and do better with adult vaccinations.
Improved health care quality	**3.4**	Most representatives believe health care quality is very good in our community. Some representatives acknowledge we could still make some

		improvement in health care quality. "Our doctors are good but they don't see the variety of illness as in the Valley." Some representatives expressed a concern about over prescribing medication.
Integrated, coordinated care (less fragmented care)	**4.3**	Representatives recognize that this is being worked on and agree it has improved. "We are working on this, but there are gaps. We need to remember how important it is to keep working on this."
Prenatal care programs	**3.7**	It was mentioned that prenatal care programs are fragmented. An example that was provided stated "WIC and nurse partnerships are not connected."
Screening programs (cholesterol, diabetic, mammography, etc)	**4.6**	Overall, representatives believe we do a good job providing screening programs. However, some representatives feel that we do not have enough screening programs, and the ones we do have are not advertised well. It was also suggested that we need to do better with men's preventative health.

Social and Economic Needs		
Potential Health Needs	**Average Score**	**Summary of Community Representatives' Comments**
Children and family services	**6.1**	Representatives recommend that we have more support for families. "We need to encourage families to stay together. We need to teach about family structure. These services are not available. Parents need to be parents first and friends second.
Disabled services	**6.4**	Representatives feel that there is a lot of work that could be to improve disabled services. Many feel that we are not

		welcoming and there is not an agency specific for helping this population. “We don’t make them feel welcome.”
Early learning before kindergarten (such as a Head Start type program)	**5.6**	Although there are some programs available for early learning before kindergarten, representatives state that they are not always affordable. “We have it available but you have to pay for it. Not all people can afford it.”
Education: Assistance in gaining good grades in kindergarten through high school	**4.9**	In some areas of the County we do a good job, representative’s share, but there is a need for afterschool programs to target all populations. “In the high school we are ranked in the top 5.”
Education: College education support and assistance programs	**4.6**	Representatives believe that all students should informed on the importance of higher education after graduation. “Educate students about options, trade school, vocational schools. Not everyone is college bound.”
Elder care assistance (help in taking care of older adults)	**6.7**	Elder care is a struggle. There is a shortage of workers and it is often unaffordable. “We don’t have a lot of options for our aging population.”
End of life care or counseling (care for those with advanced, incurable illness)	**4.3**	Representatives state that there is not a hospice facility, but they feel that there are organizations that take good care of assisting individuals with end of life care. “I would like to see a hospice center.” “Religious organizations offer this.”
Homeless services	**8.3**	Homeless services is a huge need in our area. Representatives share that it is not feasible to be homeless here. “We don’t have a large homeless population because the weather is too cold.” “We generally give them a bus ticket to get out of town. That’s about it. If they have an illness, we will help them seek medical attention.”
Job training services	**5.7**	“We need to teach customer service to our resort town workers.” Job training services are exclusive to on the job training with an employer. The Department of Labor helps with this.

Legal Assistance	**6.8**	
Senior services	**4.8**	Most people believe senior services are adequate for the current population. Some representatives share that we need to do better at keeping our seniors engaged. There is so much potential to grow in the area of providing more activities for seniors.
Veterans' services	**5.3**	Overall, representatives feel veterans are being cared for well. Some community representatives acknowledge that we could to do more for our veterans. "We have an increase in veterans, and we need more services." "They have to go to Boise, because we have very little available to help them."
Violence and abuse services	**5.9**	Representatives see domestic violence and abuse is a problem in some parts of the community. Representatives recognize that there are not a lot of violence and abuse services. There is no help available to get the perpetrators rehabilitated. We need to help these folks.

Physical Environment Needs		
Potential Health Needs	**Average Score**	**Summary of Community Representatives' Comments**
Affordable housing	**8.2**	Representatives agree that there is not affordable housing. The subsidized housing that is available is still overpriced, so it does not fill up. Many homes are used as vacation homes and rented out short term. The working class population often times double up with family members to afford rent. "There are no homes for our work force so families are living together to pay rent." We struggle with hiring people in our county because there is nowhere for them to live.
Healthier air quality, water quality, etc.	**2.4**	Representatives say the air and water quality is good with the exception of air quality during fire season.

Healthy transportation options (sidewalk, bike paths, public transportation)	**5.3**	"McCall does well with healthy transportation, because we have the financial resources. But in the smaller rural towns, it is not so good."
Transportation to and from appointments	**5.3**	McCall has good transportation system in place, but for the rest of the county it is an issue. "In McCall we have free transit during the day. There are a couple of busses that go to Donnelly and Cascade, but only twice a day. If someone is on Medicaid they can get transportation for a doctor's appointment."

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, seven have scores of 17.7 or higher. These health needs comprise **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 16.7 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 identifies when certain populations, such as 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, mental illness, and substance abuse. Our community health representatives provided relatively high scores for these needs. In addition, overweight/obesity ranks as high priority needs because it is trending higher, is now higher than the national average, and is a contributing factors to a number of other health concerns. Mental illness also ranks high because Idaho has one of the highest percentages of any mental illness (AMI) in the nation.

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 substance abuse 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
Wellness and prevention programs	Obese/Overweight adults	No college degree, Hispanic	19.9
Weight management programs	Obese/Overweight adults	No college degree, Hispanic	21.4
	Obese/Overweight teenagers	Income <$35,000, Hispanic	19.4
Wellness and prevention programs	Mental illness		17.9
Substance abuse services and programs	Excessive drinking	Income <$35,000, No high school diploma, Males 18-34	19.7
	Drug misuse	Unemployed, incomes <$50,000, males < 34 years old	17.7

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		14.5
Exercise programs/education/ opportunities	Exercise opportunity		13.8
	Adult physical activity	Income < $50,000, Hispanic, No college	10.8
	Teen exercise		14.8
Nutrition education	Adult nutrition	No college	14.6
	Teen nutrition		14.6
Safe sex education programs	STDs		12.7
	Teen birth rate		9.7
	Alcohol impaired driving deaths		13.7
Tobacco prevention and cessation programs	Smoking adult	Income < $35,000, No high school diploma	16.4
	Smoking teen		15.4
Wellness, prevention, and education programs for cancer	Cancer - all		15.5
	Breast cancer	Female, Age 40+	14.5
	Colorectal cancer		12.5
	Leukemia		11.5
	Lung cancer	Income < $35,000, No high school diploma	14.5
	Non-Hodgkin's lymphoma		14.5
	Pancreatic cancer		9.5
	Prostate cancer	Male age 60+	16.5
	Skin cancer		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		13.9
	AIDS	African American, Males <24	11.9
	Alzheimer's	Age 65 +	9.9
	Arthritis	Income < $35,000, Non- Hispanic, No college, Overweight, Age 65 +	13.9
	Asthma	Income < $35,000	10.9
	Cerebrovascular diseases		12.9
	Diabetes	Income < $50,000, No high school diploma	15.9
	Flu/pneumonia		15.9
	Heart disease		10.9
	High blood pressure		12.9
	High cholesterol	Income < $35,000, No high school diploma, Age 55+	13.9
	Nephritis		10.9
	Respiratory disease		12.9
	Suicide		13.9

* Information on affected populations included in table when known.

Clinical Care Category Summary

High priority clinical care needs include: Affordable care for low income individuals, affordable health insurance, increased availability of behavioral health services, and affordable dental care. All of these were ranked as top health needs by our community representatives. In addition, affordable health insurance ranks as a top priority need because our service area has a high percentage of people who are uninsured. Availability of behavioral health services also ranked as a top priority because Idaho has a shortage of behavioral health professionals.

As shown in the table below, high priority clinical care needs are often experienced most by people with 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 care for low income individuals	Children in poverty	Income < $50,000, Age < 19	18.2
Affordable health insurance	Uninsured adults	Income < $50,000, Hispanic, No college	18.2
Availability of behavioral health services (providers, suicide hotline, etc)	Mental health service providers	Income < $50,000	18.6
Affordable dental care for low income individuals	Preventative dental visits		20.9

Clinical Care Needs Summary Table, Continued

Identified Community Health Needs	Related Health Factors and Outcomes	Populations Affected Most*	Total Score
Availability of primary care providers	Primary care providers		14.3
Chronic disease management programs	Arthritis	Income < $35,000, Non-Hispanic, No college, Overweight, Age 65 +	13.3
	Asthma	Income < $35,000	11.3
	Diabetes	Income < $50,000, No high school diploma	16.3
	High blood pressure	Income < $35,000, No college, Overweight, Age 65 +	13.3
Immunization programs	Children immunized		10.2
	Adolescents immunized		10.2
	Flu/pneumonia		10.4
Improved health care quality	Preventable hospital stays		16.3
Integrated, coordinated care (less fragmented care)	No usual health care provider		11.3
	Preventable hospital stays	Refugees, Hispanics, Age 65 +	12.7
Prenatal care programs	Prenatal care 1st trimester	Hispanic, No high school diploma	12.7
	Low birth weight		15.6
Screening programs (cholesterol, diabetic, mammography, etc)	Cholesterol screening	Income < $35,000, No high school diploma, Age 55 +	11.6
	Colorectal screening	Income < $35,000, No college, Age 50 +	14.6
	Diabetic screening		12.6
	Mammography screening	Income < $50,000	13.3

* Information on affected populations included in table when known.

Social and Economic Factors Category Summary

Children and family services for low-income populations is the highest ranking social and economic factor. The trend for children living in poverty in our service area drives this need.

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	17.1
Children and family services	Inadequate social support		15.1
Disabled services *			14.4
Early learning before kindergarten (such as a Head Start type program)	High school graduation rate		16.6
Education: Assistance in achieving good grades in kindergarten through high school	High school and college education rates		15.9
Education: College education support and assistance programs	High school and college education rates		15.6

Social and Economic Needs Summary Table, Continued

Identified Community Health Needs	Related Health Factors and Outcomes		Total Score
Elder care assistance (help in taking care of older adults)			14.7
End of life care or counseling (care for those with advanced, incurable illness)			12.3
Homeless services	Unemployment rate		15.3
Job training services	Unemployment rate		12.7
Legal assistance			14.8
Senior services	Inadequate social support	Age 65 +	13.8
Veterans' services	Inadequate social support		14.3
Violence and abuse services	Violent crime rate		11.9

* Information on affected populations included in table when known.

Physical Environment Category Summary

In the physical environment category, affordable housing had the highest ranking. Affordable housing received a high score 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		Total Score
Affordable housing	Severe housing problems	Income < $50,000	16.7
Healthier air quality, water quality, etc	Air pollution particulate matter		7.4
	Drinking water violations		11.4
Healthy transportation options (sidewalk, bike paths, public transportation)	Long commute		11.3
	Driving alone to work		12.3
Transportation to and from appointments		Income < $35,000, Rural populations, Age 65 +	13.3

* 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 10th percentile of our scoring system. The following needs rank in the top 10th percentile:

- Prevention and management of obesity for children and adults
- Prevention and management of mental illness
- Availability of behavioral health services
- Reduce substance abuse: drug misuse and excessive drinking
- Affordable dental care
- Affordable health care
- 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

Group #2: Improve Mental Health

Group #3: Reduce Substance Abuse: Drug Misuse and Excessive Drinking

Group #4: Improve Access to Affordable Dental Care

Group #5: Improve Access to Affordable Health Care and 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

Obesity is one of our community's most significant health needs. Over 67% of the adults in our community and more than 25% of the children in our state are either overweight or obese. The percent of overweight/obese individuals is now higher in our community than it is in the nation as a whole and it is going up at a faster rate. Obesity is a serious concern because they it is associated with poorer mental health outcomes, reduced quality of life, and is a leading cause of death in the U.S. and worldwide. [186]

Impact on Community

Obesity costs the United States about $150 billion a year, or 10 percent of the national medical budget.[187] 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. [188] Reducing obesity 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 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. [189]

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

[186] https://www.cdc.gov/obesity/adult/causes.html
[187] http://www.cdc.gov/cdctv/diseaseandconditions/lifestyle/obesity-epidemic.html
[188] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5409636/
[189] https://www.cdc.gov/obesity/adult/causes.html

eating and active living." [190] These health needs can also be improved through evidence-based clinical programs.[191]

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.

[190] http://www.cdc.gov/cdctv/diseaseandconditions/lifestyle/obesity-epidemic.html
[191] 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. [192] 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. [193]

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.[194]

Fortunately, there are programs proven to be effective in lowering suicide rates and improving mental health. [195] The majority of adults who live with a mental health problem do not get corresponding treatment.[196] Stigma surrounding the receipt of mental health

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

care is among the many barriers that discourage people from seeking treatment.[197] Increasing physical activity and reducing obesity are also known to improve mental health.[198]

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.[199]

[197] Idaho Suicide Prevention Plan: An Action Guide, 2011, Page 9

[198] http://www.cdc.gov/healthyplaces/healthtopics/physactivity.htm, http://www.cdc.gov/obesity/adult/causes.html

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

Significant Health Need #3: Reduce Substance Abuse: Drug Misuse and Excessive Drinking

Reducing substance abuse ranks among our community's most significant health needs. Approximately 25% of the people in our community participated in excessive/binge drinking in 2016 - a rate that is far higher than the national average. Our community representatives also provided substance abuse with one of their higher scores. The rate of deaths due to drug misuse has been climbing in our community and across the nation. An in-depth analysis of 2016 U.S. drug overdose data shows that America's overdose epidemic is spreading geographically and increasing across demographic groups. Drug overdoses killed 63,632 Americans in 2016. Nearly two-thirds of these deaths (66%) involved a prescription or illicit opioid. [200]

Impact on Community

Reducing drug misuse can have a positive impact on society on multiple levels. Directly or indirectly, every community is affected by drug misuse and addiction, as is every family. This includes health care expenditures, lost earnings, and costs associated with crime and accidents. This is an enormous burden that affects all of society - those who abuse these substances, and those who don't. 50% to 80% of all child abuse and neglect cases substantiated by child protective services involve some degree of substance abuse by the child's parents.[201]

In 2015, over 27 million people in the United States reported current use of illicit drugs or misuse of prescription drugs, and over 66 million people (nearly a quarter of the adult and adolescent population) reported binge drinking in the past month. Alcohol and drug misuse and related disorders are major public health challenges that are taking an enormous toll on individuals, families, and society. Neighborhoods and communities as a whole are also suffering as a result of alcohol- and drug-related crime and violence, abuse and neglect of children, and the increased costs of health care associated with substance misuse. It is estimated that the yearly economic impact of substance misuse is $249 billion for alcohol misuse and $193 billion for illicit drug use.[202]

Drug addiction is a brain disorder. Not everyone who uses drugs will become addicted, but for some, drug use can change how certain brain circuits work. These changes make it more difficult for someone to stop taking the drug even when it's having negative effects on their life and they want to quit. [203]

How to Address the Need

We can address drug misuse through both prevention and treatment. Health care practitioners, communities, workplaces, patients, and families all can contribute to

[200] https://www.cdc.gov/media/releases/2018/p0329-drug-overdose-deaths.html
[201] http://archives.drugabuse.gov/about/welcome/aboutdrugabuse/magnitude/
[202] https://addiction.surgeongeneral.gov/executive-summary
[203] https://www.drugabuse.gov/related-topics/health-consequences-drug-misuse

preventing drug abuse. The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Prevention Week Toolkit contains many valuable ideas.

Treatment can incorporate several components, including withdrawal management (detoxification), counseling, and the use of FDA-approved addiction pharmacotherapies. Research has shown that a combined approach of medication, counseling, and recovery services works best. [204] In addition, recent studies reveal that individuals who engage in regular aerobic exercise are less likely to use and abuse illicit drugs. These studies have provided convincing evidence to support the development of exercise-based interventions to reduce compulsive patterns of drug intake. [205] Organizations, such as the Phoenix Gym in Colorado, have shown they can help people addicted to drugs and alcohol recover. Health and Human Services Secretary Tom Price praised the Phoenix Gym for its ability to help participants remain sober. [206]

Affected Populations

Data shows that males under the age of 34 and people with lower incomes are more likely to have substance abuse problems. [207] Prescription drug misuse is growing most rapidly among our youth/young adults, adults older than age 50, and our veterans.[208]

[204] https://www.samhsa.gov/prescription-drug-misuse-abuse/specific-populations
[205] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3276339/
[206] https://www.denverpost.com/2017/08/02/trump-health-chief-tours-colorado-springs-gym/
[207] Idaho 2011 - 2016 Behavioral Risk Factor Surveillance System
[208] https://www.samhsa.gov/prescription-drug-misuse-abuse/specific-populations

Significant Health Need #4: Improve Access to Affordable Dental Care

Our community representatives provided one of their highest scores for improving access to affordable dental care. Backing up their assessment, in 2016, nearly 45% of the adults in our community did not have a dental visit over the last year according to a survey conducted by BRFSS. [209] These factors served to rank affordable dental care as one of our most important health issues.

Impact on Community

Oral health is essential to general health and well-being. Poor oral health can cause pain and suffering that devastate overall health and result in financial and social costs that diminish quality of life and burden society. Oral health means much more than healthy teeth. It means being free of chronic oral-facial pain, throat cancers, oral soft tissue lesions, birth defects such as cleft lip and palate, and scores of other diseases and disorders that affect the craniofacial tissues. These are tissues whose functions we often take for granted, yet they represent the very essence of our humanity. They allow us to speak and smile; smell, taste, touch, chew, and swallow; and convey feelings and emotions through facial expressions. They also provide protection against microbial infections. Therefore, individuals with craniofacial conditions may experience loss of self-image and self-esteem, anxiety, depression, and social stigma; these in turn may limit educational, career, and marital opportunities and affect other social relations.

New research is also pointing to associations between chronic oral infections and heart and lung diseases, stroke, low-birth-weight, and premature births. Associations between periodontal disease and diabetes have long been noted. Put simply, we cannot be healthy without oral health. [210]

How to Address the Need:

Safe and effective disease prevention measures exist that everyone can adopt to improve oral health and prevent disease. These measures include daily oral hygiene procedures and other lifestyle behaviors, community programs such as community water fluoridation and tobacco cessation programs, and provider-based interventions such as the placement of dental sealants and examinations for common oral and pharyngeal cancers. The evidence for an association between tobacco use and oral diseases has been clearly delineated in numerous Surgeon General reports on tobacco, and the oral effects of nutrition and diet are presented in the Surgeon General's report on nutrition. [211]

More can be done to ensure that the messages of oral health promotion and disease prevention are getting through to the most affected populations. We will work with our

[209] Idaho and National 2002 – 2016 Behavioral Risk Factor Surveillance System
[210] https://www.nidcr.nih.gov/research/data-statistics/surgeon-general#overview
[211] Ibid

community partners to call attention to these measures and use them to improve oral health in our community.

Affected populations:
Research shows "a silent epidemic" of oral diseases is affecting our most vulnerable citizens—poor children, the elderly, and many members of racial and ethnic minority groups.[212]

[212] Ibid

Significant Health Need #5: Improve Access to Affordable Health Care and Affordable Health Insurance

Our CHNA process identified access to affordable health care and access to affordable health insurance as significant community health needs. The CHNA health indicator data and relatively high community representative scores served to rank them as some of our most urgent health issues.

Impact on Community
Access to affordable health insurance and health care are important indicators of health especially for the poor. The richest people in our society live between 10 to 15 years longer than the poorest according findings in the medical journal Jama.[213] According to the Gallup-Healthways Well-Being Index, Americans in poverty are significantly more likely than those who are not to struggle with a wide array of chronic mental and physical health problems.[214]

Further, 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.[215]

Based on the evidence to date, the health consequences of the uninsured are real. [216] 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. [217]

How to Address the Need:
We will work with our community to improve access to comprehensive, high-quality health care services 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

[213] https://jamanetwork.com/journals/jama/fullarticle/2513561
[214] http://www.gallup.com/poll/158417/poverty-comes-depression-illness.aspx
[215] University of Wisconsin Population Health Institute. *County Health Rankings* 2010-2018. Accessible at www.countyhealthrankings.org.

[216] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881446/
[217] https://www.ncbi.nlm.nih.gov/pubmed/28574234

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.[218]

[218] 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 McCall identified four priority health needs facing individuals and families in our two-county region: prevention and management of obesity, mental health programs, access to affordable care, and tobacco use prevention. Programs addressing each of these high priority needs are highlighted below, along with a description of the impact achieved over the past three years.

The health impact in this report includes only outcomes from programs which St. Luke's McCall is the predominant or sole financial and administrative provider. A few programs are listed under two health need groupings. These programs are multi-faceted and designed to improve two or more sets of needs. In these cases, the attendance numbers are not double counted.

Three-year aggregate impacts from 2017 to 2019

1. Participation: 41,000 distinct health improvement touches from all classes, foot clinics, health fairs, fitness activities, support groups, educations, screenings conducted solely by St. Luke's McCall. Considering that the population of our entire service area is only 14,000 residents, we are exceptionally proud of this. This number does not include participation at programs for which St. Luke's McCall was a contributing partner or through grant programs St. Luke's McCall helped secure. For example, not included are 9,000 unique student and parent attendances per year at life skills and drug avoidance educations made possible by $160,000 in annual grants administered by St. Luke's McCall.

A sample year (2017) of attendance at community health improvement activities is included below. Years 2018 and 2019 are very similar.

FY 2017 St. Luke's McCall Attendance Data for Community Health Improvement Activities

Program	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JUL	AUG	SEPT	YTD TOTALS
Bp Screenings	58	51	42	46	44	48	51	51	45	56	45	**65**	602
Cancer Support	5	4	5	4	5	3	5	7	6	4	5	**5**	58
Childbirth Ed.	28	22	0	32	9	0	20	0	0	18	18	**44**	191
Community Classes	40	207	98	140	60	123	398	167	700	800	700	**400**	3833
Diabetes Ed.	180	98	75	115	110	191	214	146	150	130	155	**155**	1719
Diabetes Screening	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Foot Clinic	98	102	84	78	83	90	82	102	61	110	89	**110**	1089
Heart Disease Ed.	70	45	62	71	56	144	166	180	167	170	156	**119**	1406
Nutrition Classes	30	13	25	25	50	44	144	30	18	11	16	**52**	458
Partnership Bldg	38	40	60	38	36	120	107	106	100	36	30	**36**	747
School Based Ed.	134	40	62	88	126	208	300	116	245	0	0	**24**	1343
Skin CA Screening	0	0	0	0	0	0	0	55	0	0	0	**0**	55
Stress Management	73	70	53	64	50	45	61	50	81	79	97	**35**	758
Wt. Management	55	112	200	340	60	110	220	51	31	10	67	**58**	1314
Workplace Wellness	0	76	150	36	0	10	15	130	211	45	52	**22**	747
total year													**14320**
total month	801	879	916	1077	689	1136	1783	1191	1815	1469	1430	**1125**	

2. Financial: St. Luke's McCall total allocations for community health Improvement was $740,000* for targeted health improvement programs: includes supplies, wages, promotions, travel. *Net expenses after subtracting program revenues
$320,000 in outside grants that fund local health improvement initiatives (mental health services, youth substance abuse prevention, cancer support, dental care, breast care)
$9,000,000 (estimated) equally split between Charity Care (medical services pre-approved to be provided for free) and bad debt (fees written off as uncollectable).
$270,000 in community grants from St. Luke's McCall Auxiliary to community non-profits with a health improvement mission.

3. Staffing. St. Luke's McCall employees 2.8 full time equivalent employees dedicated to non-revenue-producing community health improvement initiatives.

Group 1: Improve the Prevention and Management of Obesity

Adult, adolescent and youth weight management programs were ranked as high priority health needs. According to the CDC, the key to achieving and maintaining a healthy weight is adopting a lifestyle centered on healthy eating, regular physical activity, and balancing the

number of calories you consume with the number of calories your body uses. Therefore, our weight management programs include physical activity and nutrition components as well as behavior change education. There is great diversity in patient needs when it comes to weight management. No single program can address the entire range of patient medical needs, schedules, or preferences. Accordingly, St. Luke's McCall has chosen to offer a number of weight loss programs designed to meet the wide variety of patient circumstances. Excess stress is also shown to correlate with excess weight. We conducted numerous stress management programs but reported those programs and attendance under mental health programs.

- **Programs**:
  - **Develop a Short and Long Term, Region-Wide Plan to Promote Walkability and Destination Hiking.** Walking activities St. Luke's McCall conducted include:
    - Trek to the North Pole
    - Valley County Pathways Celebration Walk
    - Life in the Flash Lane- 2 miles of snowshoeing into Blue Moon yurt
    - Mayor's Walk
    - Walking Talking Tuesday nutrition series
    - Sponsored two school cancer walk events
    - Helped promote Relay for Life
    - Met with Cascade Aquatics and Fitness Center leaders to design walking events in Cascade
    - Wrote letter of Support for City of McCall to continue pathways master plan
    - Provided and promoted ski walking poles on plowed golf course paths.
    - Ongoing process of exploring how to implement physician walking prescriptions
    - Met with SLHS physician leading Complete Health Improvement Program (CHIP) to offer CHIP in our service area through physician referral
    - Worked with at least 7 key partners in advocating, promoting, and organizing walking
    - Sponsored McCall Streakers for $500 (Event with 467 women participants)
    - Sponsored Cross country Ski day for Cascade
    - Attended and sponsored free ski day at Ponderosa State Park

  - **Promote a Healthy Food Culture**
    - **Nutrition and Fitness Programs for Schools**
      - **After school programs.** St. Luke's McCall's wellness team frequently provides the education and activities for after school programs (grade schools) to include nutrition, emotional control, exercise, and gardening. 25 programs a year, average of 30 attending.
      - **Strive for 5.** Coupon Program at Elementary schools- coupons for produce at Farmers markets for area school Children. Sponsored by St. Luke's McCall and matched by private donors.

- **Nutrition and food preparation classes for high need demographics.** Women Infant Children (WIC), Western Idaho Community Action Partnership (WICAP), HeadStart. 10 group presentations per year.
- **Healthy recipe distribution at food pantries.** St. Luke's McCall's Community Health Coordinator learns what food items will be distributed the following week at the food pantry and then prints and distributes healthy recipes utilizing available items. At times all the recipe items are included in a pre-packaged bag. 60 bags or recipes leave the pantries per week.
- **Nutrition and food preparation classes at community gardens.** In conjunction with University of Idaho Master Gardeners, we co-present a 6-class series on healthy food growing and storing. Average of 40 attendees per class. Class series is offered annually.
- **Sugar Sense and Adult nutrition classes.** The St. Luke's McCall's dietitian presents nutrition classes in the workplace, schools and public gatherings. 250 participants annually.
- **Food Pantry Makeovers**. Semi-annual meetings with Pantry volunteers to train them on putting healthier foods out to recipients.
- **$10 a bag for produce at Ridley's grocery stores.** Our community health coordinator made arrangements with Ridley's grocery store and Central District Health Department whereby shoppers with food assistance purchasing programs could use their coupons in exchange for a large bag of mixed fresh produce.
- **Administration of Donnelly Farmers Market**. Developed to improve healthy food access to area food desert. Accept SNAP benefits for fresh produce.

- **Education classes on various nutrition, weight management, and exercise topics**
  - **Best U.** Three-month weight loss program. Conducted 2-3 times a year with 8 -12 participants. Open to employees and public.
  - **Yoga and Meditation classes.** Average 1,000 attendances per year for seniors, people with disabilities, or recovering from illness/injury.
  - **Walking Talking Tuesdays.** Get people walking and socializing with short health topic presentations. 300 participants per year.
  - **Find your Fit.** Health and mental wellness programs. Partnership with Cascade Recreation and Aquatic Center. 6-class series offered 3 times per year to 25 people per session.

Group 2: Improve Mental Health and Reduce Substance Abuse

Programs for mental illness, the dearth of mental health providers, and substance abuse were identified as a high priority community health need. Idaho has one of the highest incidences of mental illnesses in the nation (22.5% of the population during a one-year period), and Valley and Adams counties are no exception. To help address this challenge, St. Luke's McCall provides and funds various mental health services for adults and children and has increased the much-needed access to care for people with mental and behavioral health needs.

We grouped mental health and substance abuse together because they frequently co-occur and share causative factors. Our mental health interventions are designed to cover a broad assortment of mental health disorders and levels of severity, ranging from mild depression and anxiety to conditions requiring clinical diagnosis and intervention. A significant part of our successes in this priority health need resulted from the large amount of dedicated annual grants St. Luke's McCall Foundation generated for these purposes.

Average annual attendance at mental health and substance abuse programs: 1,950

Programs:

- **Prevention of Youth Drug Abuse**
    - **Administration of Youth Advocacy Coalition.** A .75 FTE St. Luke's employee administers this highly active coalition which organizes 40 events for youth yearly. $100,000 annual budget. Majority of funding is from a grant.
- **Providing Alternative Healthcare Stress Reduction and Mindfulness Modalities**
    - **Yoga and meditation classes**. Average 1,000 attendances per year for seniors, people with disabilities, or recovering from illness/injury. There is a fee for these classes, but the primary purpose is to provide the service. It is slightly subsidized by St. Luke's McCall.
    - **Ear Acupuncture.** Offered to the public for $5 per session as a means of stress reduction. Cost to provide service is subsidized by St. Luke's McCall. 270 participants per year.
- **Slate of single classes on various mental health topics.** Life Purpose, Life Balance
- **Workforce Wellness Programs (Walking, nutrition, mental resilience).** At the invitation of businesses, St. Luke's McCall provides employee health education at the workplace. School faculties, Forest Service, and Brundage Mountain Resort are sights where we made multiple appearances. Total attendance at all sites was 450.
- **Youth Summits:** We conducted very well attended community focus groups for stakeholders in youth physical, mental, and emotional health in McCall, Cascade, New Meadows, and Riggins. Total attendance was 110.

Group 3: Improve Access to Affordable Health Care and Affordable Health Insurance

The programs in this section address the needs that center on barriers to access: affordable care and affordable health insurance.

Programs:

- **Financial aid and charitable care.** 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 McCall

provided $3,637,000 in FY 2016, $5,428,000 in FY 2017, and $2,774,000 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.

- **Leading and Administering Valley County Health Improvement Coalition (VAHIC).** For two of the three years this report covers St. Luke's McCall's and Central District Health Department's program managers co-chaired a 11-member coalition which sought to identify and promote regional opportunities to improve health. "The mission of the Valley Adams Health Improvement Coalition is to create a physical, social and economic environment that supports, encourages and educates regional residents and visitors to attain their optimal level of health, happiness, and quality of life, and to be a role model for other counties aspiring to improve public health and quality of life." The coalition's four priorities are domestic violence prevention, walkable environments, improved nutrition, and youth tobacco prevention. St. Luke's McCall provided VAHIC approximately $2,000 in annual program expenses and $4,000 for professional non-profit administrative leadership.

- **Grant writing for Health Improvement Programs**
    - **Auxiliary Community Health Grants**. St. Luke's McCall Auxiliary grants $80,000 to $100,000 annually to local health-minded non-profit organizations. This is not money from the hospital, but it is money from within the St. Luke's umbrella.
    - **Grant writing.** St. Luke's McCall contributes $20,000 annually in salaries to write grants for health-enhancing programs.
- **Prevention and Screenings for Chronic Conditions**
    - **Senior Foot Clinics.** Information about diabetes is presented at foot clinics and providers check for foot neuropathy as a symptom of diabetes. Providers also check blood pressure and make referrals when needed.
    - **Free screenings for chronic conditions**
        - **Depression screenings.** All primary care patients take a two-question screening for depression during clinic appointments. Number of screenings performed in clinic visits not included in total health improvement visits.
        - **Blood Pressure Screenings.** Partnership with Donnelly and Cascade Fire and EMS and Community Health EMS (CHEMS) teams to offer Fired Up 50+ BP checks and wellness checks at Farmers markets.
        - **Skin Cancer Screening.** St. Luke's McCall's Integrative Medicine Clinic and Center for Health promotion host a free skin cancer screening. 40 to 60 people attend annually.
        - **Free mammograms.** Through grants, we were able to promote and provide free baseline (and some diagnostic mammograms) to every woman in our service area who has been avoiding recommended exams due to finances.

- **Free flu shots**. Funding provided to Community Medical Fund to provide 100 free vaccinations without appointments in public places.
- **Brighter Smiles**. Grant funding for 90 to 100 people annually to receive free or reduced dental care
- **Breast Buddies**. Breast care nurse traveled to all of our regional communities and hosted an ice cream social with women willing to become breast buddies. Breast buddies encourage all women to get recommended screenings. 21 women attended and became breast buddies.

- **Childbirth Education.** We provide a 6-session childbirth education taught by OB nurses for all expecting parent. The fee of $50 per couple is much less than the actual cost of providing the course materials and instruction. Fees are waived if attendees is unable to pay. We teach the course four times a year with an average attendance of 10 people.
- **Child Car seat check and free installation.** A trained car seat installer from the hospital inspects infant car seats when mother and child leave the hospital and installs a free car seat if needed. We pay for three days of training for the installer.
- **Free Community Health Improvement Services Offered at Clinic**
  - **Extended hours for family medicine clinic**. Extended from 8:30am to 5:00pm weekdays to 8:00am to 7:00pm weekdays. Clinic opened 9:00am to 2:00pm Saturdays for day-of and walk-in appointments. Added 50 clinic visits weekly on weekdays and 12 clinic visits on Saturday.
  - **Embedded behavioral health providers in the clinics**. In comparison with previous model of providing mental and behavioral health services, this model added 20 new clinic visits per week.
  - **Increased visiting physician services**. As a convenience to the people we serve, and not as a source of net revenue, St. Luke's McCall began providing the following visiting physician specialists: pediatric cardiology, oncology, pediatric psychiatric and motor development, and therapy services for youth speech and motor skills.
  - **Complex Care Coordination.** In 2014, St. Luke's McCall absorbed the entire patient population of McCall's previous free clinic (community Care Clinic) and continued providing services to this high care, low income cohort. Our charity care increased substantially as a result, but, as was our intent, patient care improved.
  - **Hope and Healing**. Emotional and financial support for cancer patients and families. Now at $10,000 annual support and assisting 20 people.
  - **Patient Navigators in clinics and hospital**. During this three year period we added three financial navigators to help people navigate their way to the care they need (much of the navigation is getting people rides, encouraging them to attend appointments, connecting them with financial aid and social services, and processing their Medicare and Medicaid application. In some cases we recover greater revenues from having these patient navigators, but the real bottom line is that a large cohort of health needing individuals receives the care they need.

Group 4: Prevent and Reduce Tobacco Use

Tobacco use, smoking and smokeless, was identified as a high priority need in our 2016 CHNA, however vaping had not yet surfaced as a significant problem. We selected two approaches to prevent tobacco use, both approaches targeting minors, and one approach to help current users to quit. Our first approach was to rely on the time-proven, evidence-based tobacco prevention courses

- **Programs**:
  - **School Base Tobacco Prevention Educations.** For all three years in this Implementation Plan cycle our service area received a $60,000 per year grant to reduce drug use. This enabled us to present smoking prevention messages in every school in our service area on an almost weekly basis.
  - **Planning Best Tobacco Prevention Interventions for Service Area.** We had planned to research and add additional smoking prevention activities in the third year of this Implementation Plan cycle. We didn't for three reasons: 1) we felt our other smoking prevention interventions were successful, 2) it became apparent that the new nicotine issue with minors was vaping and we needed to research and address this issue.
  - **Smoking cessation counselor in primary care clinics.** St. Luke's McCall embedded a tobacco cessation counselor in our primary clinics and established a physician referral system that was a warm handoff with financial options to suit any patient's circumstances.

Conclusion

St. Luke's McCall continues to believe in and make a large commitment to better community health. We are one of the few Critical Access Hospitals that funds and operates a Center for Health Promotion with a staff of 2.8 FTEs.

The County Health rankings for Valley County are exceptionally high (highest in Idaho in 2017, 2nd in 2018, and 6th in 2019); the rankings for Adams County are unsatisfactory (20th, 27th, and 30th).

Valley County is fortunate to have exceptional partners in community health: a Central District Health Department office, a University of Idaho field campus that educates 3,000 K1 through K12 annually, numerous summer camp facilities and organizations, the highest rated public high school and elementary school in Idaho, a high proportion of wealthy residents who support community projects, and a well-developed outdoor recreation industry. Conversely, Adams County has perennially been the lowest socio-economic county in Idaho.

We make a concerted effort to “share the wealth” of Valley County across county borders, but the dearth of social and health services in Adams County undermines health.

In the interest of improving Policy, Systems and Environment, St. Luke’s McCall undertook the following initiatives which are not listed in our 2017-2019 CHNA Implementation Plan

- **Took a lead role in preparing Valley/Adams Counties’ entry into America’s Best Community Contest (ABC).** St. Luke’s McCall helped fund ($1,500) our region’s entry fee into this contest and developed our entry platform based on improving community health. We advanced to the final 8 out of 357 entries and received $150,000 to implement our 22 community initiatives, all of which impact health and quality of life. Our success in this contest brought incredible public awareness to the importance of community health to all citizens.
- **West Central Mountains Leadership Academy**. St. Luke’s McCall sponsored ($1,000) and helped establish the West Central Mountains Leadership Academy which is a Chamber of Commerce activity convened to resolve community quality of life issues.
- **Change Tool.** With our key partner Central District Health Department, we implemented the CDC’s Change Tool which involved interviewing 34 local businesses, schools and agencies to learn their recommendations for creating a healthier community and engaging them in solutions.

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 non-profit 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
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Residential Care/Assisted Living Facilities
Senior Services
Transportation
Veteran Services
Youth Programs

Abuse/Violence Victim Advocacy & Services

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

Rose Advocates (Adams County)
204 Council Avenue
Council, Idaho 83612
Phone: (208) 253-4949
http://www.roseadvocates.org/
Description: Crisis intervention, emergency services, counseling and support for victims of sexual or domestic violence.

Rose Advocates (Valley County)
106 Park Street # 112
McCall, Idaho 83638
Phone: (208) 630-5014
211 Idaho Street
Cascade, Idaho 83611
Phone: (208)382-5310
Description: Crisis intervention, emergency services, counseling and support for victims of sexual or domestic violence.

Behavioral Health and Substance Abuse Services

Adams County Health Center
205 North Berkley
Council, Idaho 83612
Phone: (208) 253-4242
https://www.achcid.org/mental-health.html
Description: Adams County Health Center, Inc. is a Federally Qualified Health Center that seeks to provide high quality health care services to residents of Adams County and the surrounding area, regardless of social or economic status.

Al-anon - District 3
Phone: 24 Hour Information and Answering Service - (208) 344-1661
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.

Alcoholics Anonymous – Idaho Area 18
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.

Cascade Medical Center
402 Lake Cascade Parkway
Cascade, Idaho 83611
Phone: (208) 382-4242
http://www.cascademedicalcenter.net/

Central District Health – McCall Office
703 1st Street
McCall, Idaho 83638
Phone: (208) 634-7194
www.cdhd.idaho.gov

Idaho Department of Health and Welfare – Mental Health Services
Phone: (208) 334-0808
http://www.healthandwelfare.idaho.gov/

Idaho Department of Health and Welfare – Substance Use Services
Phone: 1-800-922-3406
http://www.healthandwelfare.idaho.gov/

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

Narcotics Anonymous
Help Line: **(**208) 391-3823
http://www.sirna.org/
Description**:** NA is a nonprofit fellowship or society of men and women for whom drugs had become a major problem. We are recovering addicts who meet regularly to help each other stay clean.

Regional Mental Health Services
24-Hour Crisis Line: 1-800-600-6474

SAMHSA (Substance Abuse and Mental Health Services Administration)
Phone: 24-hour hotline - 1-800-662-HELP
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 Clinic – Integrative Medicine
203 Hewitt Street
McCall, Idaho 83638
Phone: (208) 634-1400
http://www.stlukesonline.org/clinic/integrative_medicine/mccall/

Children & Family Services

Central District Health – McCall Office
703 1st Street
McCall, Idaho 83638
Phone: (208) 634-7194
www.cdhd.idaho.gov

Idaho Department of Health and Welfare - Child Protection Services
Phone: Statewide - 1-855-552-KIDS
http://www.healthandwelfare.idaho.gov/
Description: To report suspected child abuse, neglect or abandonment.

Idaho Department of Health and Welfare - Children & Family Services
Phone: (208) 587-6800
http://www.healthandwelfare.idaho.gov/
Description: Child Protection, Foster Care Licensing, Adoptions

Idaho Department of Health and Welfare – Cash assistance, Food Stamps, Medicaid
Phone: 1-877-456-1233
http://www.healthandwelfare.idaho.gov/
Description: (Food Stamps, Family Medical/Medicaid Assistance, Idaho Child Care Program, Temporary Assistance for Families in Idaho (TAFI), Aid for the Aged, Blind & Disabled (AABD), Personal Care Services, Home and Community Based Services and Nursing Home Assistance)

Shepherd's Home
260 N. Mission
McCall, Idaho 83638
Phone: (208) 634-1152
www.shepherds-home.org
Description: Residency at the Shepherd's Home falls into three categories; Emergency Placement, Respite Care, and Long Term Care.

Western Idaho Community Action Partnership – serving Valley & Adams County
315 S. Main Street
Payette, Idaho 83661
Phone: (208) 642-99086
http://www.idahocommunityaction.org/partnerships/partnershipswicap/

Southwest District Health
http://www.swdh.org/default.asp

Community Health Clinics and Other Medical Resources

Adams County Health Center
205 North Berkley
Council, Idaho 83612
Phone: (208) 253-4242
https://www.achcid.org/mental-health.html
Description: Adams County Health Center, Inc. is a Federally Qualified Health Center that seeks to provide high quality health care services to residents of Adams County and the surrounding area, regardless of social or economic status.

Cascade Medical Center
402 Lake Cascade Parkway
Cascade, Idaho 83611
Phone: (208) 382-4242
http://www.cascademedicalcenter.net/

Central District Health – McCall Office
703 1st Street
McCall, Idaho 83638
Phone: (208) 634-7194
www.cdhd.idaho.gov

Idaho Department of Health & Welfare
www.healthandwelfare.idaho.gov
Description: Idaho State Department of Health and Welfare oversees Medicaid, food stamps, child welfare, mental health, and other programs.

St. Luke's McCall Medical Center
1000 State Street
McCall, Idaho 83638
Phone: (208) 634-2221
http://www.stlukesonline.org/mccall/

Dental Services

Adams County Health Center
205 North Berkley
Council, Idaho 83612
Phone: (208) 253-4242
https://www.achcid.org/mental-health.html
Description: Adams County Health Center, Inc. is a Federally Qualified Health Center that seeks to provide high quality health care services to residents of Adams County and the surrounding area, regardless of social or economic status.

Central District Health – McCall Office
703 1st Street
McCall, Idaho 83638
Phone: (208) 634-7194
www.cdhd.idaho.gov

Disability Services

Disability Rights Idaho
4477 Emerald Street, Suite B-100
Boise, Idaho 83706-2066
Phone: (208) 336-5353
Description**:** DisAbility Rights Idaho assists people with disabilities to protect, promote and advance their legal and human rights, through quality legal, individual, and system advocacy.

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

Idaho Department of Labor
1505 N. McKinney
Boise, Idaho 83704-8533
Phone: (208) 327-7333
http://labor.idaho.gov/dnn/idl/DisabilityDetermination.aspx

Idaho Department of Health and Welfare
Children Developmental Disability Services
Adult Developmental Disabilities Care Management
Phone: (208) 364-1825
http://healthandwelfare.idaho.gov/Medical/DevelopmentalDisabilities

MYST (Mentoring Youth Supporting Teens) – Yellow Lantern
http://mystmentoring.org/

Educational Services

McCall College
106 E. Park Street #220
McCall, ID 83638
Phone: (208) 634-3456

Food Assistance

Idaho Foodbank – Southwestern Idaho
Phone: (208) 336-9643
http://idahofoodbank.org/locations/southwestern-idaho/
Description: The Idaho Foodbank is an independent, donor-supported, nonprofit organization founded in 1984, and is the largest distributor of free food assistance in Idaho. From warehouses in Boise, Lewiston and Pocatello, the Foodbank has distributed more than 135 million pounds of food to Idaho families through a network of more than 230 community-based partners. These include rescue missions, church pantries, emergency shelters and community kitchens. The Foodbank also operates direct-service programs that promote healthy families and communities through good nutrition.

Idaho Health and Welfare - Idaho Food Stamp Program
Phone: 1-877-456-1233
http://healthandwelfare.idaho.gov/
Description: The Idaho Food Stamp Program helps low-income families buy the food they need in order to stay healthy. An eligible family receives an Idaho Quest Card, which is used in card scanners at the grocery store. The card uses money from a Food Stamp account set up for the eligible family to pay for food items.

Western Idaho Community Action Partnership – Valley County Services
110 W. Pine
P.O. Box 129
Cascade, Idaho 83611
Phone: (208) 382-4577
http://www.wicap.org/ValleyCoCent.aspx

Government Contacts

Adams County
Adams County Courthouse
201 Industrial
Council, Idaho 83612
www.co.adams.id.us.com

City of Cascade
105 S. Main Street
Cascade, Idaho 83611
(208) 382-4279
www.cascade.id.us

City of Council
501 N. Galena
Council, Idaho 83612
Phone: (208) 253-4201
www.councilidaho.net

City of Donnelly
169 Halferty Street
Donnelly, Idaho 83615
Phone (208) 325-8859
http://www.cityofdonnelly.org/

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

City of New Meadows
401 Virginia Street
New Meadows, Idaho 83654
Phone: (208) 347-2171
http://www.newmeadowsidaho.us/

Valley County
219 N. Main St.
Cascade, Idaho 83611
Phone: (208) 382-7100
www.co.valley.id.us.com

Homeless Services

Western Idaho Community Action Partnership
110 Moser/P.O. Box 337
Council, Idaho 83612
Phone: (208) 253-4300
110 W. Pine/P.O. Box 129
Cascade, Idaho 83611
Phone: (208) 382-4577
http://www.idahocommunityaction.org/partnerships/partnershipswicap/

Hospice Care

Idaho Quality of Life Coalition
PO Box 496
Boise, Idaho 83701
Phone: (208) 841-1862
www.idqol.org
Description: Advocating for quality of life through advance planning education and excellence in hospice and palliative care.

National Hospice and Palliative Care Organization
Phone: 1-800-646-6460
Description: The National Hospice and Palliative Care Organization (NHPCO) is the largest nonprofit membership organization representing hospice and palliative care programs and professionals in the United States.

St. Luke's Homecare and Hospice - serving Adams, Idaho, Valley, and Washington counties
301 Deinhard Lane
McCall, Idaho 83636
Phone: (208) 630-2440
Description: Skilled home health and hospice services

Hospitals

Cascade Medical Center
402 Lake Cascade Parkway
Cascade, Idaho 83611
Phone: (208) 382-4242
http://www.cascademedicalcenter.net/

St. Luke's McCall Medical Center
1000 State Street
McCall, Idaho 83638
Phone: (208) 634-2221
www.mccallhosp.org

Housing

Southwestern Idaho Cooperative Housing Authority
Phone: (208) 585-9325
http://www.sicha.org/

Description: Southwestern Idaho Cooperative Housing Authority (SICHA) provides rental assistance to qualified low income families in Adams, Boise, Canyon, Elmore, Gem, Owyhee, Payette, Washington and Valley counties in Southwest Idaho.

Legal Services

Disability Rights Idaho
4477 Emerald St, Suite B-100
Boise, Idaho 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
1109 Main St, Ste. 450
Boise, Idaho 83702
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 Services
1447 S. Tyrell Lane
Boise, Idaho 83706
Phone: (208) 345-0106
1104 Blaine Street
Caldwell, Idaho 83605

Phone: (208) 454-2591
www.idaholegalaid.org
Description**:** Idaho Legal Aid Services, Inc. (ILAS) provides free legal services to low income Idahoans. Every year, we help thousands of Idahoans with critical legal problems such as escaping domestic violence and sexual assault, housing (including wrongful evictions, illegal foreclosures, and homelessness), guardianships for abused/neglected children, legal issues facing seniors (such as Medicaid for seniors who need long term care and Social Security), and discrimination issues. Our Indian Law Unit provides specialized services to Idaho's Native Americans. The Migrant Farmworker Law Unit provides legal services to Idaho's migrant population.

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.

Central District Health – McCall Office
703 1st Street
McCall, Idaho 83638
Phone: (208) 634-7194
www.cdhd.idaho.gov
Description: Idaho Central District Health provides community health programs including Women, Infants, and Children (WIC), prevention for a range of health conditions, as well as immunization programs. District 4 provides services for Ada, Boise, Elmore, and Valley counties.

Family Medicine Residency of Idaho
Administration Office
777 N. Raymond Street
Boise, Idaho 83704
Phone: (208) 954-8742
www.fmridaho.org
Description: Provide health services to the underserved in a high quality federally designated teaching health center and patient-centered medical home.

Idaho Department of Health and Welfare, Region 3 & Region 4
http://www.healthandwelfare.idaho.gov/
Description: Idaho State Department of Health and Welfare Region 3 oversees Medicaid, food stamps, child welfare, mental health, and other programs for Adams, Canyon, Gem, Owyhee, Payette, and Washington counties.

Southwest District Health

www.swdh.org
Description: Our team is made up of dedicated medical, dental, environmental, and technical professionals, and support staff all working side-by-side as a team toward one common goal: To prevent disease, disability and premature death; To promote healthy lifestyles and protect and promote the health of people and their environment in Adams, Canyon, Gem, Owyhee, Payette, and Washington Counties.

Western Idaho Community Action Partnership
110 Moser/P.O. Box 337
Council, Idaho 83612
Phone: (208) 253-4300
110 W. Pine/P.O. Box 129
Cascade, Idaho 83611
Phone: (208) 382-4577
http://www.idahocommunityaction.org/partnerships/partnershipswicap/

Refugee Services

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

Residential Care/Assisted Living Facilities

Cascade Medical Center
402 Lake Cascade Parkway
Cascade, Idaho 83611
Phone: (208) 382-4242
Description: Cascade Medical Center is able to provide long term skilled and intermediate care through our critical access swing beds.

Idaho Aging & Disability Resource Center (ADRC)

Phone: 1-800-926-2588
http://aging.idaho.gov/adrc/

Idaho Health and Welfare – Regional Medicaid Services
Phone: (208) 334-0940
www.healthandwelfare.idaho.gov

McCall Rehabilitation and Care Center
418 Floyde Street,
McCall, Idaho 83638
Phone: (208) 634-2112
Description: The Center offers these specialized services to residents and customers who need them including: Alzheimer's care, hospice care, mental healthcare services, resident centered care and respite care.

Senior Services

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 non-profit 501(c)3 organization providing a variety of services and support locally to our affected Alzheimer's population and their families and caregivers.

Cascade Senior Center
409 N. School St.
Cascade, Idaho 83638
Phone: (208) 382-4256

Council Senior Center
103 S. Main
Council, Idaho 83612
Phone: (208) 253-4282

Idaho Care Planning Council
http://www.careforidaho.org/index.htm

Idaho Commission on Aging (ICOA)
341 W. Washington
Boise, Idaho 83702
Phone: (208) 334-3833
701 S. Allen Ste. 100
Meridian, Idaho 83642
Phone: (208) 332-1769
http://www.idahoaging.com/

McCall Senior Center
701 1st St.
McCall, Idaho 83638
Phone: (208) 634-5408

New Meadows Senior Center
102 N. Commercial
New Meadows, Idaho 83654
Phone: (208) 347-2363

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.

Transportation

Treasure Valley Transit – Mountain Community Transit
Phone: (208) 634-0003
http://www.treasurevalleytransit.com/mccall.php

SW Idaho Transit
Phone: 1-800-273-4462

Veteran Services

Adams County Veteran Services Officer
Phone: (208) 257-3418
Description: Provides information on where and how to receive benefits for veterans.

American Legion – Post 60
105 E. Mille Street
Cascade, Idaho 83611
Phone: (208) 382-3694
www.idaholegion.com

Idaho Veterans Network
2333 Naclerio Lane
Boise, Idaho 83705
Phone: (208) 440-3939
www.idahoveteransnetwork.org
Description**:** Idaho Veterans Network is an all-volunteer group comprised mostly of Iraq and Afghanistan combat veterans who assist other younger veterans who are in crisis, mostly from PTSD, Traumatic Brain Injury, and combat related injuries by providing mentoring, advocacy, referral, and ongoing support and friendship to the veterans and their families.

Idaho Veterans Services
www.veterans.idaho.gov

Veterans Administration Medical Center
500 Fort Street
Boise, Idaho 83702
Phone: (208) 422-1000
www.boise.va.gov
Description: The Boise VA Medical Center delivers care to the veterans population in its main facility in Boise, Idaho and also operates Outpatient Clinics in Twin Falls, Caldwell, Mountain Home and Salmon, Idaho; as well as in Burns, Oregon.

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

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

Youth Programs

4-H Youth Development - Valley County Extension Office
108 W Pine Street
Cascade, Idaho 83611
Phone: (208) 382-7190
http://extension.uidaho.edu/valley/
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.

4-H Youth Development – Adams County Extension Office

203 S Galena
Council, Idaho 83612
Phone: (208) 253-4279
http://extension.uidaho.edu/valley/
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.

McCall Parks and Recreation
3336 Deinhard Lane
McCall, Idaho 83638
http://www.mccall.id.us/departments/parks-and-recreation.html

MYST (Mentoring Youth Supporting Teens) – Yellow Couch Teen Center
302 N. Third Street
McCall, Idaho 83638
http://mystmentoring.org/
Description: MYST exists to *CONNECT* Junior High and High School students with responsible, caring adults, to *BUILD* positive mentoring relationships and *GUIDE* students to wise, constructive choices that will help them to be purposeful and positive *CONTRIBUTORS* in their communities. *CONNECT – BUILD – GUIDE – CONTRIBUTE – REPEAT*

Payette Lakes Community Association
PO Box 1118
McCall, Idaho 83638
Phone: (208) 634-3418
http://PLCA4Kids.org
Description: Payette Lakes Community Association (PLCA) is a non-profit 501(c)(3) corporation operating in McCall, Idaho. PLCA provides a safe environment after

school which promotes education, social enrichment, and character development of youth.

Southern Valley County Recreation District
208 North Main Street
Cascade, Idaho 83611
Phone: (208) 382-5136
http://www.svcrec.org/

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.

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_ Hispanic population
   _X_ Low income individuals and families
   _X_ Populations with chronic conditions
   _X_ Refugees
   _X_ Senior citizens
   _X_ Those with behavioral health issues

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:** Central District health Department
   Date contacted: 4/12/2018
   How input was obtained: Phone interview and questionnaire
   Health representative category: Category I and II
   Populations represented:
   _X_ Children
   _X_ Hispanic population
   _X_ Low income individuals and families
   _X_ Migrant and seasonal farm workers
   _X_ Refugees
   _X_ Those with behavioral health issues

4. **Affiliation:** Southwest District Health, Idaho District 3
   Date contacted: 4/9/2018
   How input was obtained: Phone interview and questionnaire
   Health representative category: Categories I and II
   Populations represented:
   _X_ Children
   _X_ Disabled
   _X_ Hispanic population
   _X_ Low income individuals and families
   _X_ Migrant and seasonal farm workers
   _X_ Senior citizens

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

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

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

8. **Affiliation:** Cascade Medical Center

Date contacted: 3/19/2018
How input was obtained: Phone interview and questionnaire
Health representative category: III
Populations represented:
_X_ Children
_X_ Low income individuals and families
_X_ Populations with chronic conditions
_X_ Senior citizens
_X_ Those with behavioral health issues

9. **Affiliation:** McCall Office, Central District Health, District 4
Date contacted: 4/12/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Categories I and II
Populations represented:
_X_ Children
_X_ Low income individuals and families
_X_ Populations with chronic conditions

10. **Affiliation:** McCall Donnelly School District
Date contacted: 3/20/2018
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_ Populations with chronic conditions
_X_ Those with behavioral health issues

11. **Affiliation:** Adams County Health Center (FQHC)
Date contacted: 3/21/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category II and II
Populations represented:
_X_ Children
_X_ Disabled
_X_ Hispanic population
_X_ Low income individuals and families
_X_ Populations with chronic conditions
_X_ Senior citizens
_X_ Those with behavioral health issues
_X_ Veterans

12. **Affiliation:** St. Luke's McCall, Home Health and Hospice, Idaho Dep. of Health and Welfare

Date contacted: 3/29/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category I and III
Populations represented:
_X_ Low income individuals and families
_X_ Populations with chronic conditions
_X_ Senior citizens
_X_ Those with behavioral health issues

13. **Affiliation:** Valley County
Date contacted: 3/22/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category II and III
Populations represented:
_X_ Children
_X_ Disabled
_X_ Low income individuals and families
_X_ Populations with chronic conditions
_X_ Senior citizens
_X_ Those with behavioral health issues
_X_ Veterans

14. **Affiliation:** St. Luke's McCall
Date contacted: 3/30/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category III
Populations represented:
_X_ Children
_X_ Disabled
_X_ Low income individuals and families
_X_ Populations with chronic conditions
_X_ Senior citizens
_X_ Those with behavioral health issues
_X_ Veterans

15. **Affiliation:** McCall Donnelly School District
Date contacted: 3/30/2018
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_ Populations with chronic conditions
_X_ Senior citizens
_X_ Those with behavioral health issues

16. Affiliation: City of McCall
Date contacted: 4/17/2018
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

17. Affiliation: Valley County
Date contacted: 3/20/2018
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_ Migrant and seasonal farm workers
_X_ Populations with chronic conditions
_X_ Refugees
_X_ Senior citizens
_X_ Those with behavioral health issues
_X_ Veterans

18. Affiliation: Riggins Idaho primary health care clinic
Date contacted: 4/16/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category III
Populations represented:
_X_ Children

_X_ Disabled
_X_ Hispanic population
_X_ Low income individuals and families
_X_ Populations with chronic conditions
_X_ Senior citizens
_X_ Those with behavioral health issues
_X_ Veterans

19. Affiliation: Idaho Health and Welfare
Date contacted: 3/26/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category I
Populations represented:
_X_ Children
_X_ Disabled
_X_ Hispanic population
_X_ Homeless
_X_ Low income individuals and families
_X_ Populations with chronic conditions
_X_ Senior citizens
_X_ Those with behavioral health issues

20. Affiliation: City of New Meadows
Date contacted: 3/21/2018
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

21. Affiliation: Donnelly Fire and EMS
Date contacted: 3/26/2018
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

22. Affiliation: Payette Lakes Medical Clinics
Date contacted: 3/19/2018
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
_X_ Veterans

23. Affiliation: Central District Health Department, District 3
Date contacted: 3/27/2018
How input was obtained: Phone interview and questionnaire
Health representative category: Category I
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

Appendix II: Community Representative Interview Questions

Representative Name:

Title:

Affiliation:

Date:

Thank you for agreeing to participate in St. Luke's 2015/2016 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	5.5	Food environment	9	14.5
Exercise programs/education	4.8	Access to exercise opportunities	9	13.8
		Adult physical activity	6	10.8
		Teen exercise	10	14.8
Nutrition education	5.6	Adult nutrition	9	14.6
		Teen nutrition	9	14.6
Safe-sex education programs	4.7	Sexually transmitted infections	8	12.7
		Teen birth rate	5	9.7
Substance abuse services and programs	6.7	Excessive drinking	13	19.7
		Drug misuse	11	17.7
		Alcohol Impaired driving deaths	7	13.7
Tobacco prevention and cessation programs	5.4	Smoking adult	11	16.4
		Smoking teen	10	15.4
Weight management programs	6.4	Obese/Overweight adults	15	21.4
		Obese/Overweight teenagers	13	19.4

Wellness, prevention, and education programs for cancer	5.5	Cancer - all	10	15.5
		Breast cancer	9	14.5
		Colorectal cancer	7	12.5
		Leukemia	6	11.5
		Lung cancer	9	14.5
		Non-Hodgkin's lymphoma	9	14.5
		Pancreatic cancer	4	9.5
		Prostate cancer	11	16.5
		Skin cancer (melanoma)	8	13.5
Wellness and prevention programs	4.9	Accidents	9	13.9
		AIDS	7	11.9
		Alzheimer's	5	9.9
		Arthritis	9	13.9
		Asthma	6	10.9
		Cerebrovascular diseases	8	12.9
		Diabetes	11	15.9
		Flu/pneumonia	11	15.9
		Heart disease	6	10.9
		High blood pressure	8	12.9
		High cholesterol	9	13.9
		Mental illness	13	17.9
		Nephritis	6	10.9
		Obese/overweight adults	15	19.9
		Respiratory disease	8	12.9
		Suicide	9	13.9

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	12	18.2
Affordable dental care for low income individuals	7.9	Dental visits, preventative	13	20.9
Affordable health insurance	8.2	Uninsured adults	10	18.2
Availability of behavioral health services (providers, suicide hotline, etc)	6.6	Mental health service providers	12	18.6
Availability of primary care providers	4.3	Primary care providers	10	14.3
Chronic disease management programs	5.3	Arthritis	8	13.3
		Asthma	6	11.3
		Diabetes	11	16.3
		High blood pressure	8	13.3
Immunization programs	3.2	Children immunized	7	10.2
		Flu/pneumonia	7	10.2
Improved health care quality	3.4	Preventable hospital stays	7	10.4
Integrated, coordinated care (less fragmented care)	4.3	No usual health care provider	12	16.3
		Preventable hospital stays	7	11.3
Prenatal care programs	3.7	Prenatal care 1st trimester	9	12.7
		Low birth weight	9	12.7
Screening programs (cholesterol, diabetic, mammography, etc)	4.6	Cholesterol screening	11	15.6
		Colorectal screening	7	11.6
		Diabetic screening	10	14.6
		Mammography screening	8	12.6

Social and Economic Category

Community Identified Needs	Rep. Score	Related Health Factors and Outcomes	Health Factor Score	Combined Score
Children and family services	6.1	Children in poverty	11	17.1
		Inadequate Social Support	9	15.1
Disabled services *	6.4	* See note below	8	14.4
Early learning before kindergarten (such as a Head Start type program)	5.6	High school graduation rate	11	16.6
Education: Assistance in achieving good grades in kindergarten through high school	4.9	High school and college education rate	11	15.9
Education: College education support and assistance programs	4.6	High school and college education rate	11	15.6
Elder care assistance (help in taking care of older adults) *	6.7	* See note below	8	14.7
End of life care or counseling (care for those with advanced, incurable illness) *	4.3	* See note below	8	12.3
Homeless services	8.3	Unemployment rate	7	15.3
Job training services	5.7	Unemployment rate	7	12.7
Legal assistance *	6.8	* See note below	8	14.8
Senior services	4.8	Inadequate Social Support	9	13.8
Veterans' services	5.3	Inadequate Social Support	9	14.3
Violence and abuse services	5.9	Violent crime rate	6	11.9

* 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	8.2	Severe housing problems	8.5	16.7
Healthier air quality, water quality, etc	2.4	Air pollution particulate matter	5	7.4
		Drinking Water	9	11.4
Healthy transportation options (sidewalk, bike paths, public transportation)	5.3	Long commute	6	11.3
		Driving to work alone	7	12.3
Transportation to and from appointments *	5.3	* See note below	8	13.3

* 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.