St. Luke's Jerome Community Health Needs Assessment

2016

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

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Introduction

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

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

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

For the purpose of sharing the results of this assessment with the community we serve, a complete copy is available on our public website.

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

Executive Summary

The St. Luke's Jerome 2016 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.

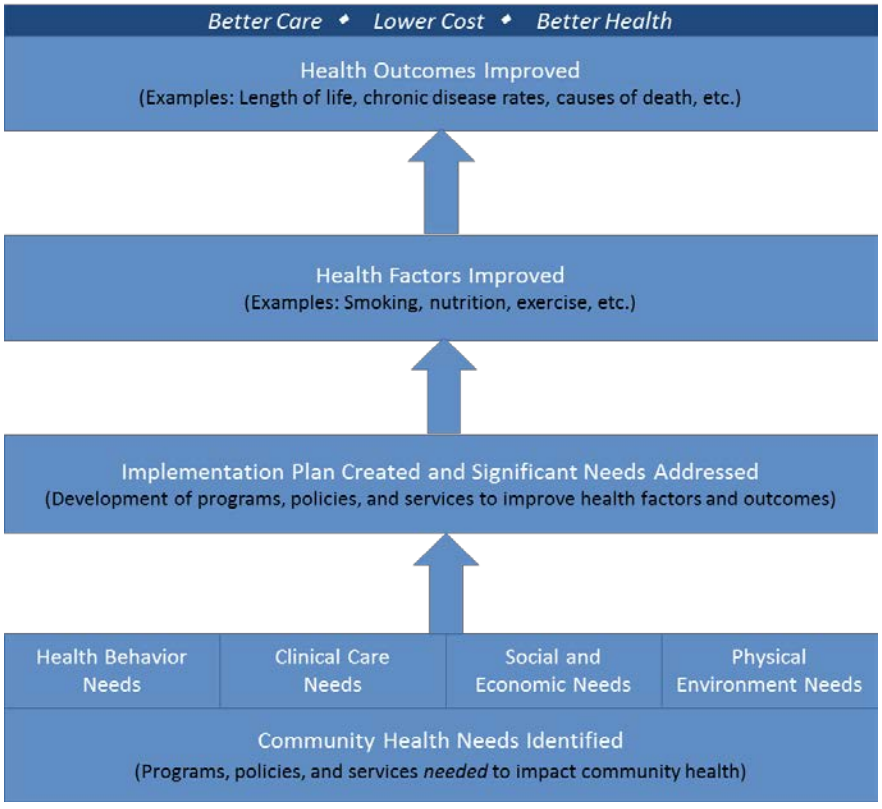
In our CHNA, we divide our health needs into four distinct categories: 1) health behaviors; 2) clinical care; 3) social and economic factors; and 4) physical environment. Each identified health need is included in one of these categories.

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 graphical summary of the approach used to develop our CHNA.

St. Luke's Approach to Improving Community Health



Significant Community Health Needs

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

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

Group #2: Improve Mental Health and Reduce Suicide

Group #3: Improve Access to Affordable Health Insurance

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

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

Our CHNA prioritization process identified prevention and management of obesity and diabetes as two of our community's most significant health needs. About 30% of the adults in our community and one in ten children in our state are obese. According to the Centers for Disease Control (CDC): "Obesity is a national epidemic and a major contributor to some of the leading causes of death in the United States." Obesity costs the United States about $150 billion a year, or 10 percent of the national medical budget.[1] Diabetes is also a serious health issue that can contribute to heart, kidney and many other diseases and can even result in death.[2] Direct medical costs for type 2 diabetes accounts for nearly $1 of every $10 spent on medical care in the U.S. [3]

Impact on Community

Reducing obesity and diabetes will dramatically impact community health by providing an immediate and positive effect on many conditions including mental health; heart disease; some types of cancer; high blood pressure; dyslipidemia; kidney, liver and gallbladder disease; sleep apnea and respiratory problems; osteoarthritis; and gynecological problems (infertility and abnormal menses).

[1] http://www.cdc.gov/cdctv/diseaseandconditions/lifestyle/obesity-epidemic.html
[2] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System
[3] America's Health Rankings 2015, www.americashealthrankings.org

How to Address the Need

Obesity and diabetes can be prevented and managed by engaging our community in developing services and policies designed to encourage proper nutrition and healthy exercise habits. These needs can also be improved through evidence-based clinical programs.[4]

Extremely promising outcomes are now being reported in some communities. Remarkably, from 2011 through 2014, Lee County, Florida, reduced adult obesity levels from 29.3% to 24.8% and childhood obesity dropped from 31.6% to 20.7%. These results were accomplished through extensive community leadership and involvement. A Lee Memorial Hospital representative commented: "We believe these improvements can be sustained and improved further."[5] Echoing this approach, the CDC states that "we need to change our communities into places that strongly support healthy eating and active living." [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 and diabetes.

[4] America's Health Rankings 2015, www.americashealthrankings.org

[5] http://www.naplesnews.com/community/bonita-banner/lee-memorial-healthy-lee-earns-prestigious-national-award_58687398

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

Significant Health Need #2: Improve Mental Health and Reduce Suicide

Improving mental health and reducing suicide rank among our most significant health needs. This is because our community representatives scored mental health and the availability of behavioral health providers as some of our most significant health needs. In

addition, Idaho has one of the highest percentages (23.3%) of any mental illness (AMI) in the nation, shortages of mental health professionals in all counties across the state, and suicide rates that are consistently higher than the national average. Depression is the most common type of mental illness, affecting more than 26% of the U.S. adult population. It has been estimated that by the year 2020, depression will be the second leading cause of disability throughout the world.

Impact on Community

Good mental health is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." It is estimated that only about 17% of U.S. adults are considered to be in a state of optimal mental health.[7]

[7] http://www.cdc.gov/mentalhealth/basics.htm

How to Address the Need

The majority of adults who live with a mental health disorder do not get corresponding treatment. Furthermore, less than one-third of adults get minimally adequate care.[8] Stigma surrounding the receipt of mental health care is among the many barriers that discourage people from seeking treatment.[9] In addition, increasing physical activity and reducing obesity are also known to improve mental health. [10]

Therefore, our aim is to work with our community to reduce the stigma around seeking mental health treatment, to improve access to behavioral health services, increase physical activity, and reduce obesity especially for our most affected populations**.**

Affected Populations

Data shows that people with lower incomes are about three and a half times more likely to have depressive disorders.[11]

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

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

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

[11] Idaho 2011 - 2013 Behavioral Risk Factor Surveillance System

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

Barriers to access are issues that prevent people from receiving timely medical care. They include things such as the lack of transportation to doctors' appointments, the availability of health care providers, and the cost of care. Our CHNA process identified the following high ranking barrier to access:

- Affordable health insurance

The health indicator data and community representative scores have ranked this barrier to access as one of our community's most significant health needs. A recent study showed that nearly 19 percent of U.S. adults do not receive medical care or delay medical care because they are concerned about the cost or worried that their health insurance would not pay for treatment.[12]

Impact on community:
Improving access to affordable health insurance can make a remarkable difference to community health. 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.[13] Further, 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

[12] Kullgren JT, et al. Nonfinancial barriers and access to care for US adults. *Health Serv Res* online, 2011.
[13] http://www.gallup.com/poll/158417/poverty-comes-depression-illness.aspx

Medicine reports that the uninsured population has a 25% higher mortality rate than the insured population.[14]

How to Address the Need:
We will work with our community to improve access to affordable health insurance options.

Affected populations:
Statistics show that people with lower income and education levels and Hispanic populations are much more likely not to have health insurance.[15]

[14] University of Wisconsin Population Health Institute. *County Health Rankings* 2010-2015. Accessible at www.countyhealthrankings.org.

[15] 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 Jerome Overview

Background

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

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

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

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

St. Luke's Jerome is fortunate to have caring and committed volunteers, more than 100 physicians on the medical staff, and a dedicated governing board comprised of independent civic leaders who volunteer their time to serve.

Mission, Vision, and Core Values

All 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 our region."

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

Our core values are:

Integrity
Compassion
Accountability
Respect
Excellence

Governance Structure

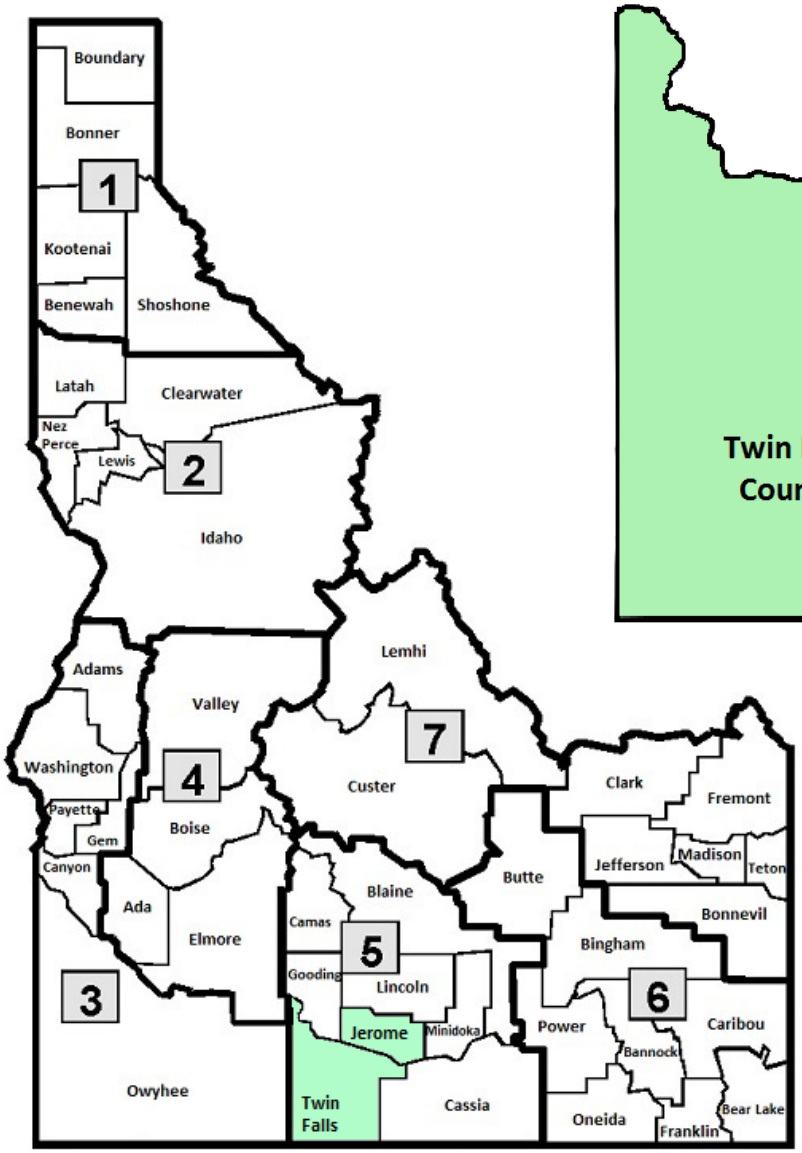
Each St. Luke's medical center is responsive to the people it serves, providing a scope of service appropriate to community needs. Because leaders from within the community have the best insight into the needs of their own families, friends, and neighbors, local control is one of the tenets of St. Luke's.

Local boards have oversight over their business affairs and have decision-making authority. Our volunteer boards include representatives from each St. Luke's service area, helping to ensure local needs and interests are addressed.

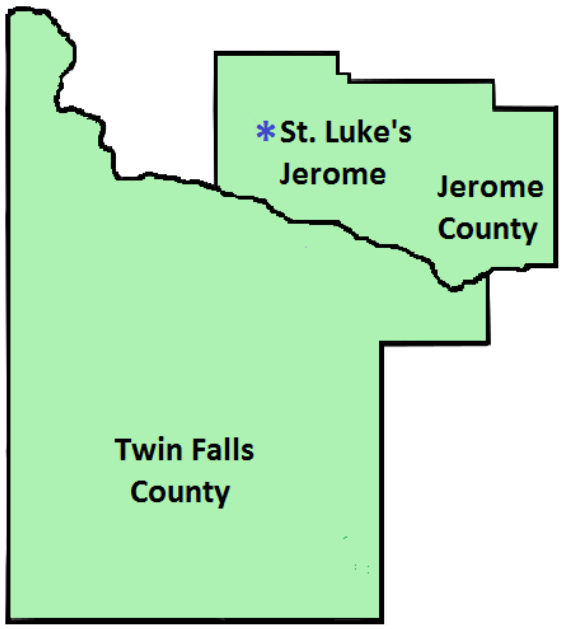
The Community We Serve

This section describes our community in terms of its geography and demographics. Jerome and Twin Falls counties represent the geographic area used to define the community we serve also referred to here as our primary service area or service area. The criteria we use in selecting this area as the community we serve was to include the entire population of the counties where at least 70% of our inpatients reside. The residents of these counties comprise about 75% of our inpatients with approximately 62% of our inpatients living in Jerome County and 13% in Twin Falls County. Twin Falls and Jerome counties are part of Idaho Health District 5, as shown in the maps below.

Idaho Health District Map [16]



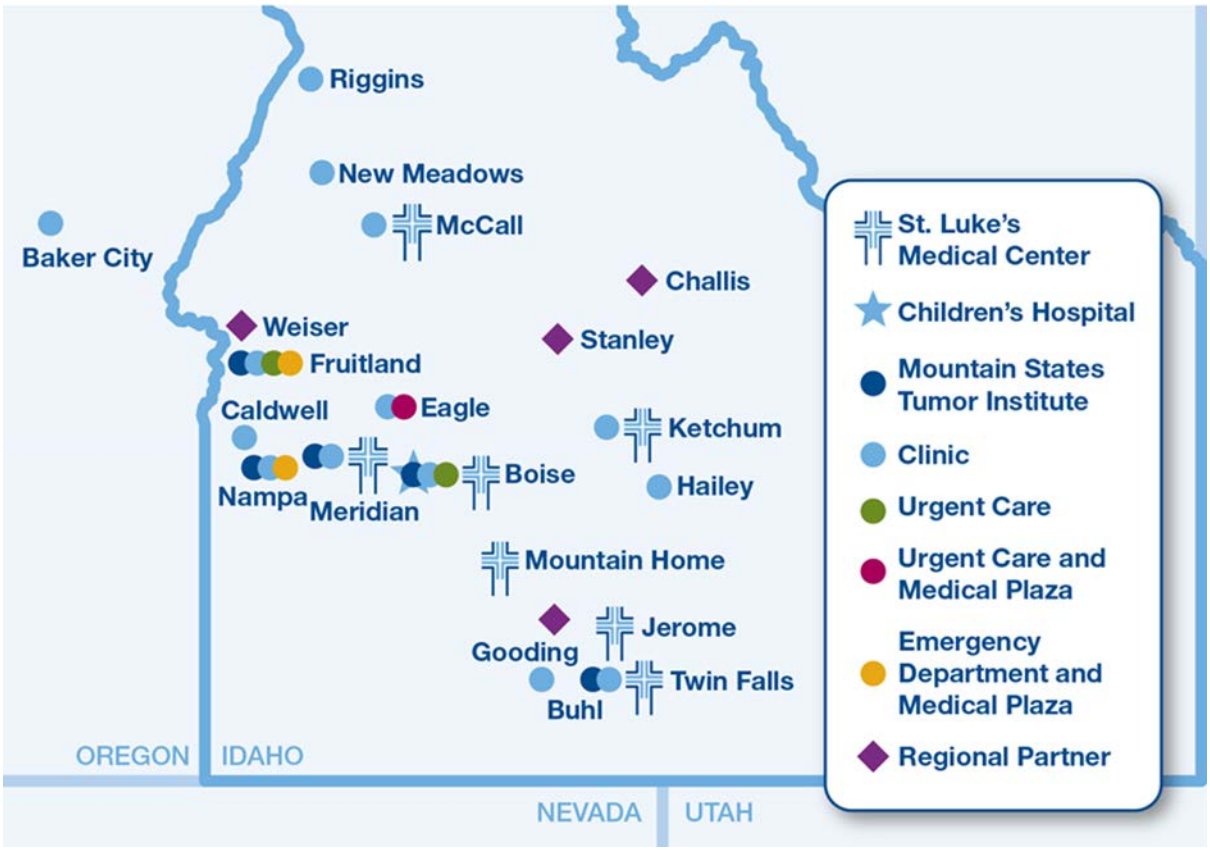
Jerome and Twin Falls County Map



[16] Idaho Behavioral Risk Factor Surveillance System Annual Report 2012

Our patients in the surrounding counties of southwestern Idaho, northern Nevada, and eastern Oregon are important to us as well. To help us serve these patients, we have built positive, collaborative relationships with regional providers where legal and appropriate. A philosophy of shared responsibility for the patient has been instrumental in past successes and remains critical to the future of St. Luke's. Partnerships, such as those shown below, allow us to meet patients' medical needs close to home and family.

St. Luke's Regional Relationships Map



Community Demographics

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

Both Idaho and our service territory are comprised of about a 96% white population while the nation as a whole is 78% white. The Hispanic population in Idaho represents 12% of the overall population and about 19% of our defined service area. Jerome County is approximately 34% Hispanic, and Twin Falls County is 15% Hispanic.

Population by Race and Ethnicity 2013[17]

Residence	Total Population	Race				Ethnicity	
		White	Black	American Indian	Asian or Pacific Islander	Not Hispanic or Latino	Hispanic or Latino
Community/ Service Area	102,471	98,283	944	1,761	1,483	83,175	19,296
		96%	1%	2%	1%	81%	19%
Jerome County	22,514	21,604	201	553	156	14,970	7,544
		96%	1%	2%	1%	66%	34%
Twin Falls County	79,957	76,679	743	1,208	1,327	68,205	11,752
		96%	1%	2%	2%	85%	15%
Idaho	1,612,136	1,533,351	18,002	31,792	28,991	1,421,886	190,250
		95%	1%	2%	2%	88%	12%
National (000)	316,129	245,499	41,624	3,910	17,354	262,057	54,071
		78%	13%	1%	5%	83%	17%

[17] Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare (1/2015). 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, 2015.

Population Growth 2000-2013

Idaho experienced a 25% increase in population from 2000 to 2013, ranking it as one of fastest growing states in the country.[18] Twin Falls and Jerome Counties have followed that trend, experiencing a 24% increase in population within that timeframe.[19] St. Luke's Jerome 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 2013	Percent Change
Service Area	82,626	102,471	**24%**
Idaho	1,293,953	1,612,136	**25%**
United States	281,421,906	316,129,839	**12%**

Aging

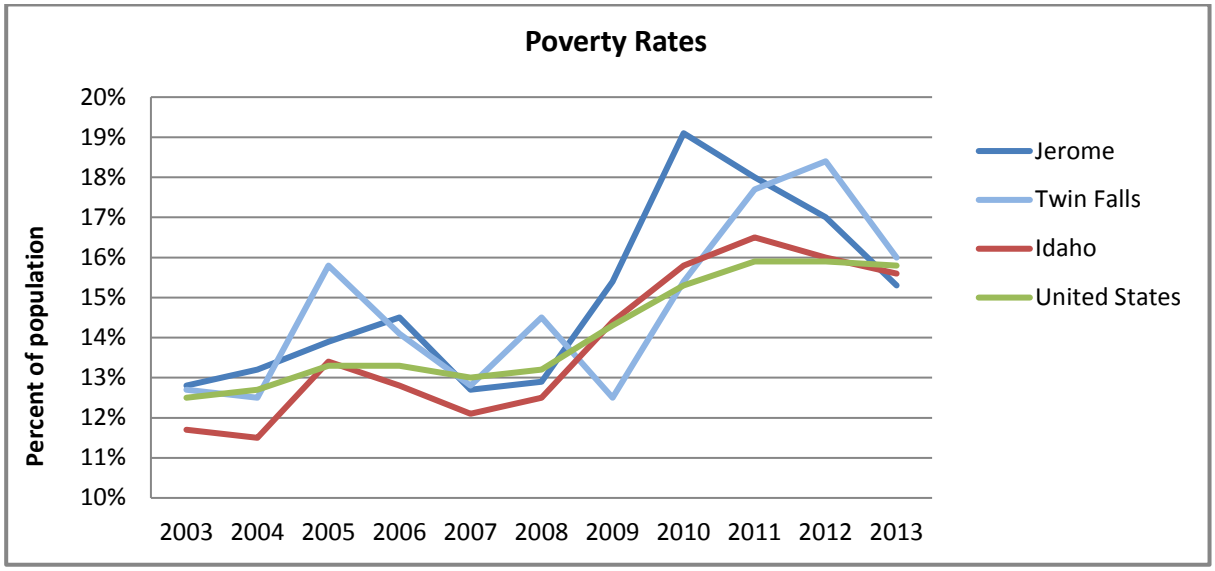
Over the past ten years the 45 to 64 year old age group was the fastest growing segment of our community. Currently, about 14% of the people in our community are over the age of 65. [20]

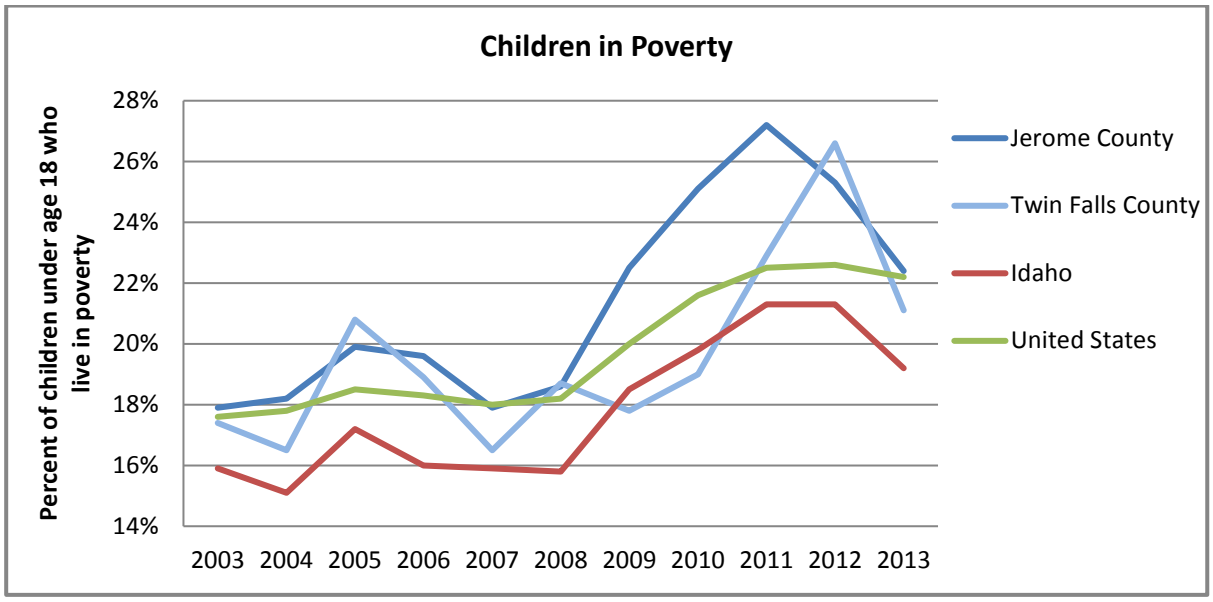
Year	Population by Age			
	Age 0-19	Age 20-44	Age 45-64	Age 65+
2000	26,365	26,951	18,082	11,384
Percent of total	32%	33%	22%	14%
2013	31,163	32,038	23,606	13,651
Percent of total	31%	32%	23%	14%

[18] U.S. Census Bureau: http://quickfacts.census.gov/qfd/index.html 2013
[19] Idaho Vital Statistics County Profile 2013
[20] Ibid

Poverty Levels

The official United States poverty rate increased from 12.5% in 2003 to 15.6% in 2013. Our service area poverty rate is now about the same as the national average due to a substantial decrease over the last three years. The poverty rate in our community for children under the age of 18 is also about the same as the national average. Although poverty has started declining in our service area, poverty rates are still above the levels they were at prior to the recession in 2008.[21]

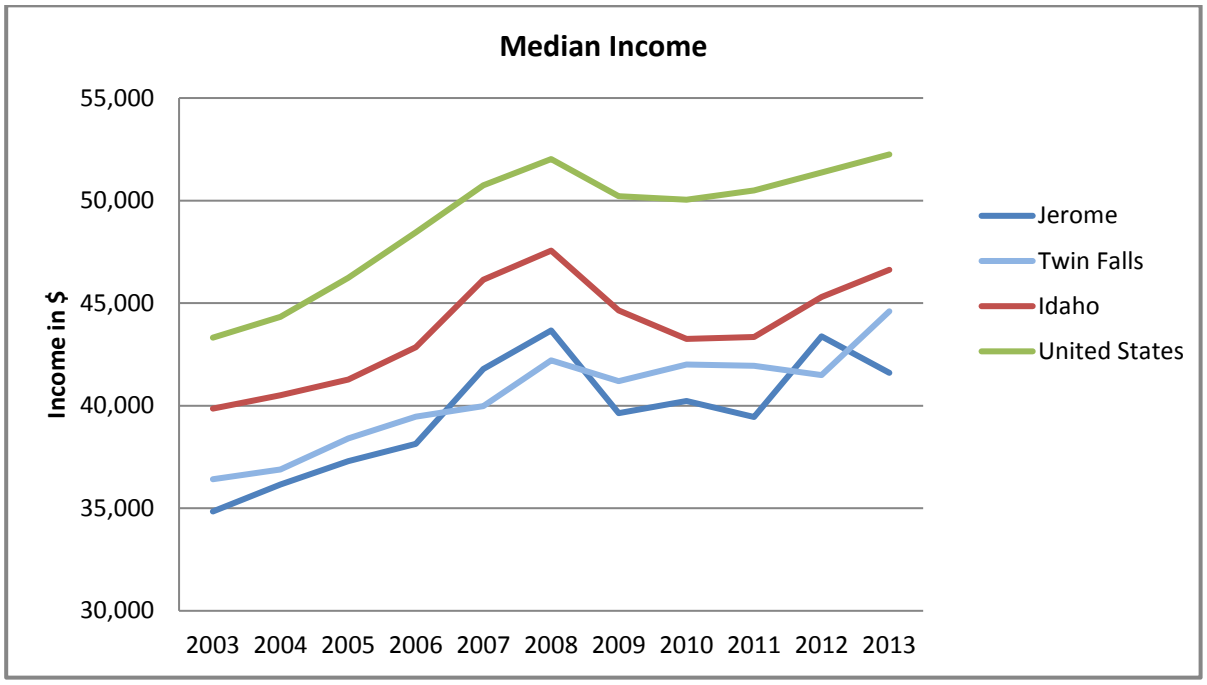




[21] Small Area Income and Poverty Estimates (SAIPE)
http://www.census.gov/did/www/saipe/data/statecounty/data/index.html

Median Household Income

Median income in the United States has risen by 20% since 2003 and at approximately the same rate in our service area during that period. However, median income in our service area is well below the national median and lower than Idaho's median income.[22]



[22] Ibid

Community Health Needs Assessment Methodology

St. Luke's 2016 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.

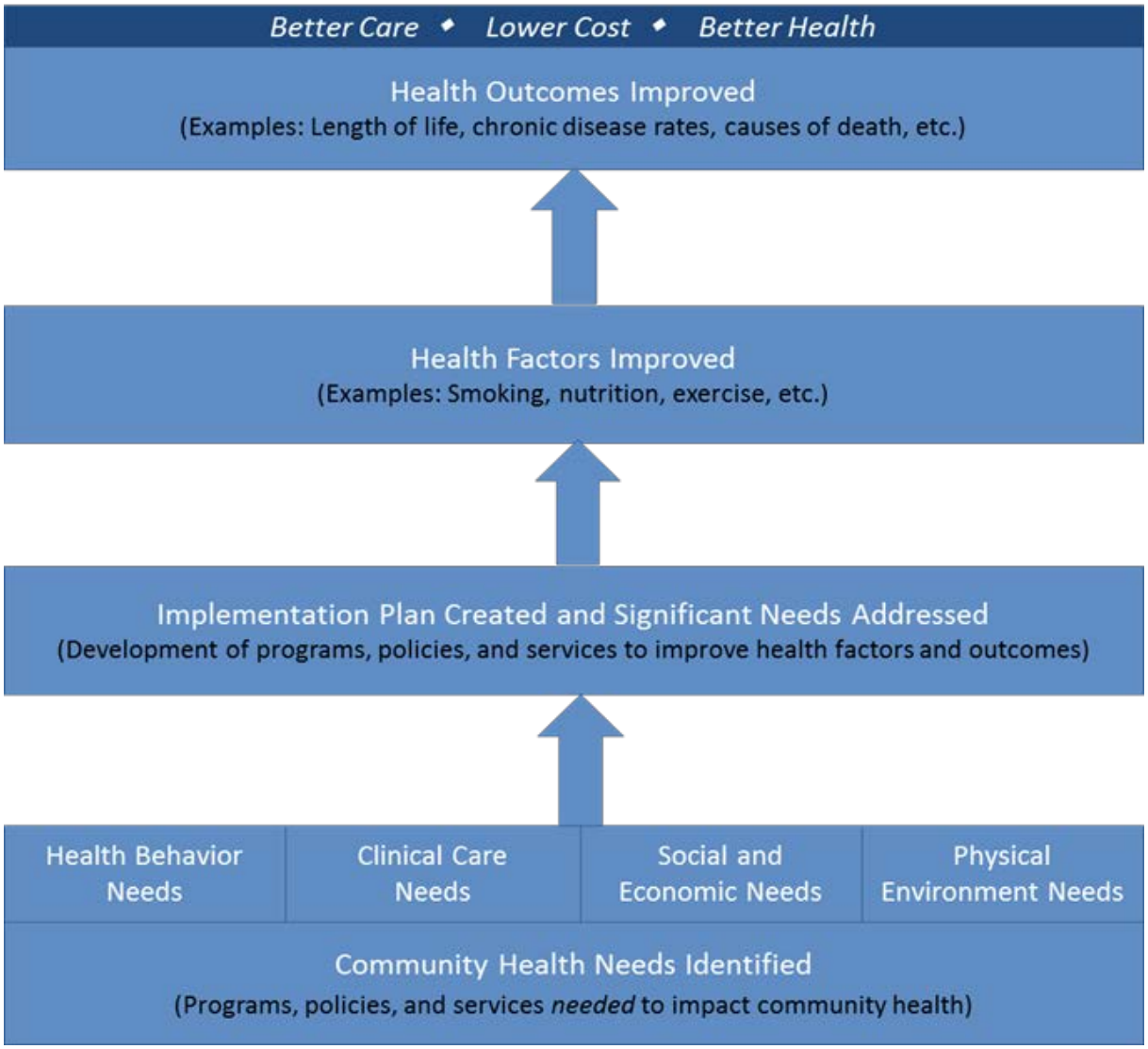
3. Community input is at the center of our CHNA process. In-depth **interviews are conducted with a diverse group of representatives** possessing extensive knowledge of

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 graphical summary of the approach used to develop our CHNA.

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**

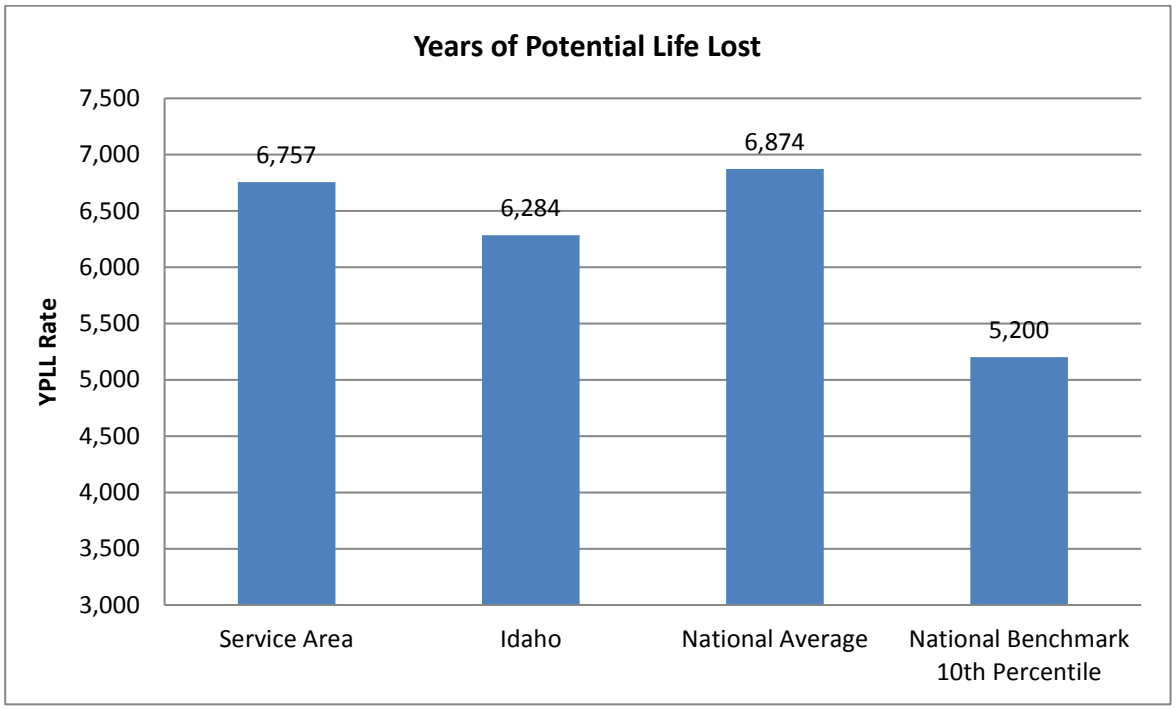
Health Outcome Measures and Findings

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 2013 is about the same as the national average, indicating that on average people in our service area are not dying prematurely.[23]

[23] 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)

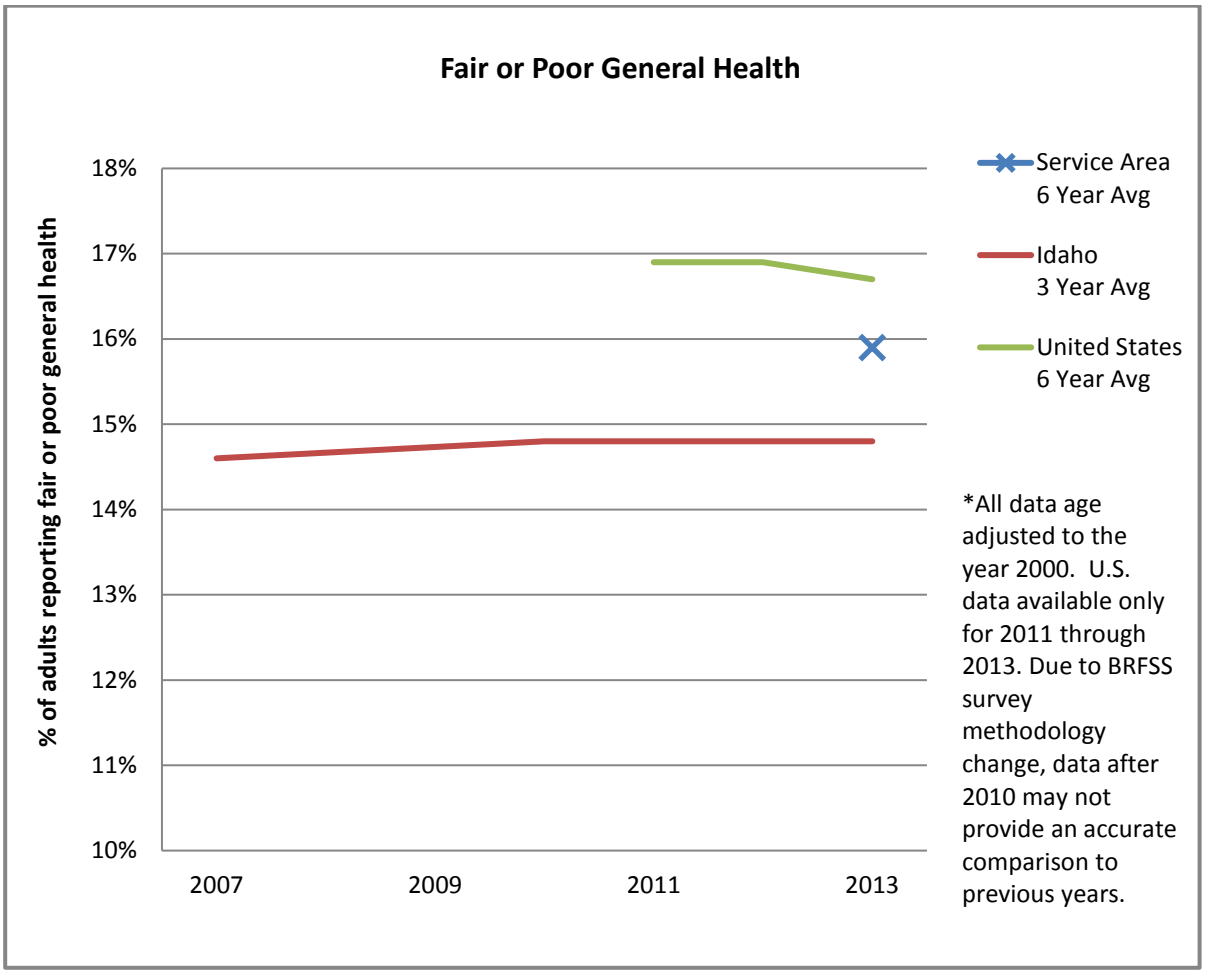
Understanding the health related quality of life of the population helps communities identify unmet health needs. Three measures from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) are used to define health-related quality of life: 1) The percent of adults reporting fair or poor health, 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.[24]

[24] University of Wisconsin Population Health Institute. *County Health Rankings* 2015. Accessible at www.countyhealthrankings.org.

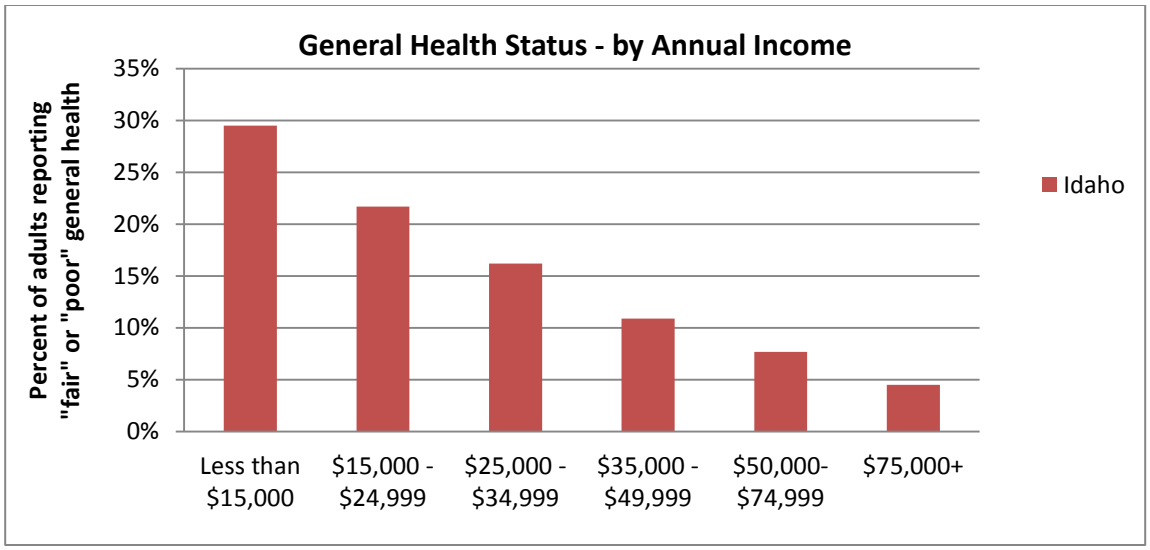
- **"Fair or Poor" General Health**

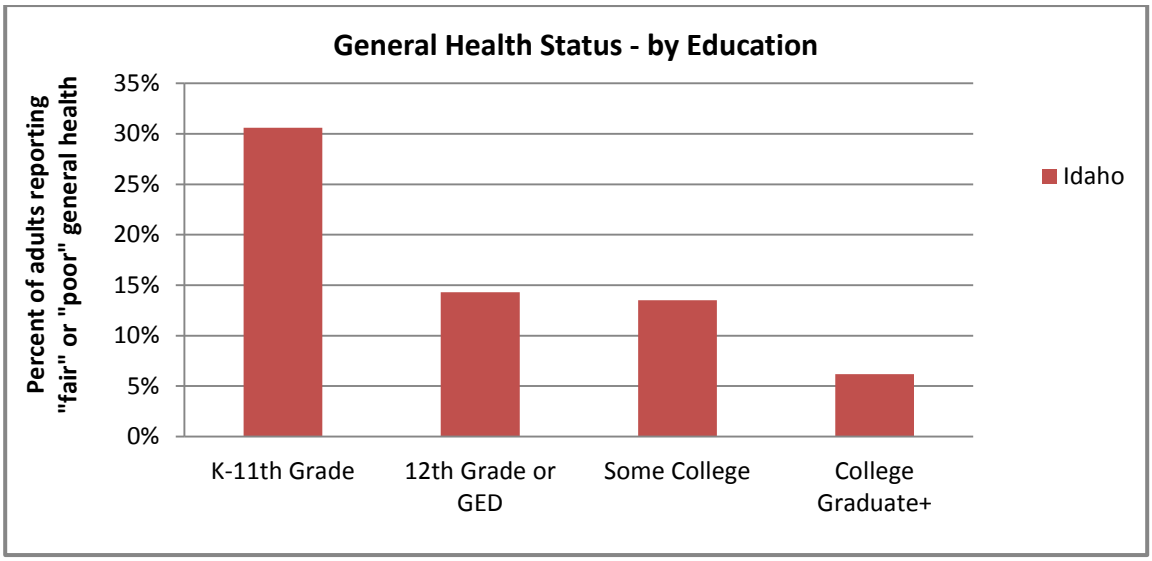
Fourteen point eight percent (14.8%) of Idaho adults reported their health status as fair or poor in 2013, which is approximately the same as in 2007. For our service area, the percent of people reporting fair or poor health is about 16% in 2013, which is slightly below the national average of 16.8%.[25]

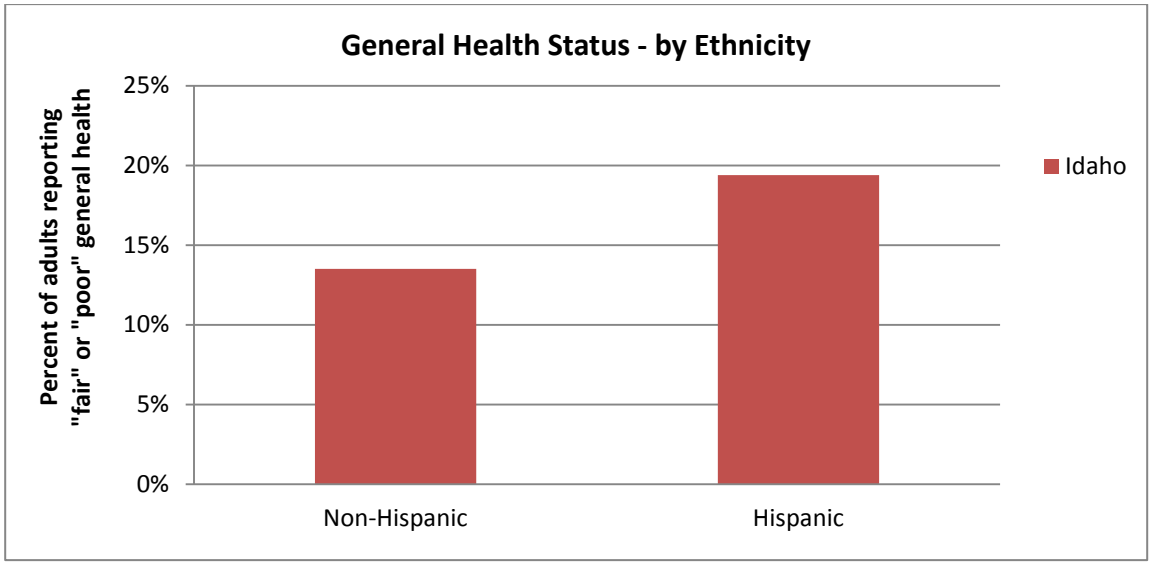


The charts below show that income and education greatly affect the levels of reported fair or poor general health. For example, people with incomes of less than $15,000 are seven times more likely to report fair or poor general health than those with incomes above $75,000. In addition, Hispanics are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

[25] Idaho and National 2004 - 2013 Behavioral Risk Factor Surveillance System

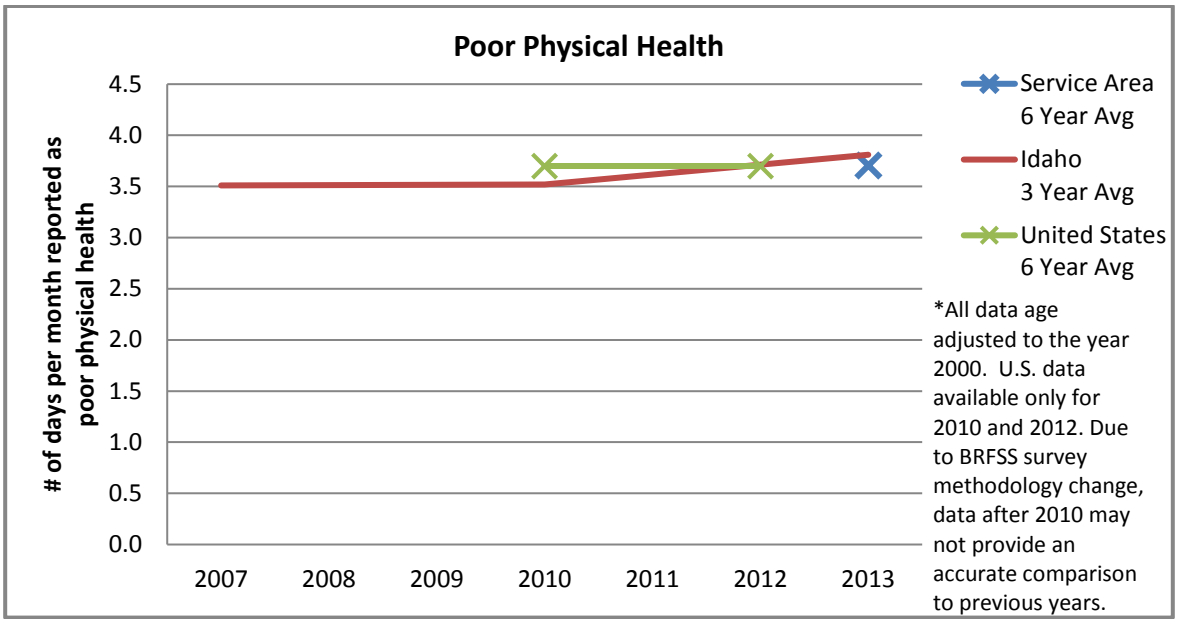

General Health Status - by Annual Income
Percent of adults reporting "fair" or "poor" general health
35%
30%
25%
20%
15%
10%
5%
0%
Less than $15,000
$15,000 - $24,999
$25,000 - $34,999
$35,000 - $49,999
$50,000- $74,999
$75,000+
Idaho


General Health Status - by Education
Percent of adults reporting "fair" or "poor" general health
35%
30%
25%
20%
15%
10%
5%
0%
K-11th Grade
12th Grade or GED
Some College
College Graduate+
Idaho


General Health Status - by Ethnicity
Percent of adults reporting "fair" or "poor" general health
25%
20%
15%
10%
5%
0%
Non-Hispanic
Hispanic
Idaho

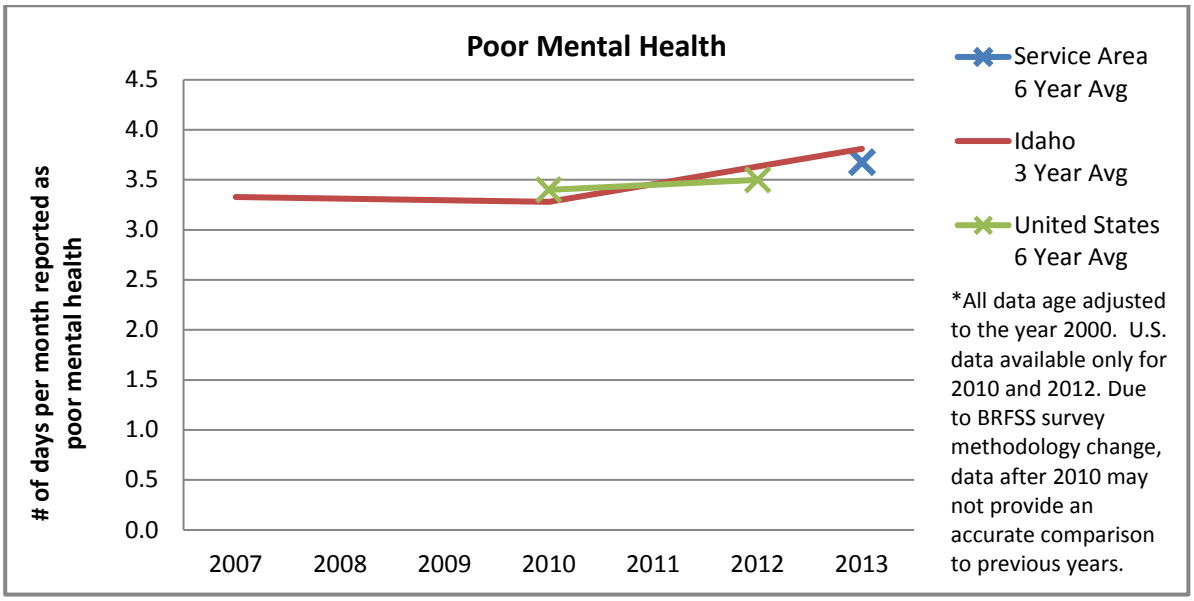
- **Poor Physical Health Days**

The number of reported poor physical health days for our service area is about the same as the national average. [26] The national top 10th percentile (best) is 2.5 days.[27]



- **Poor Mental Health Days**

The number of poor mental health days is above the national average for our service area. The national top 10th percentile is 2.3 days per month.



[26] Idaho 2013 Behavioral Risk Factor Surveillance System

[27] *County Health Rankings* 2015. Accessible at www.countyhealthrankings.org.

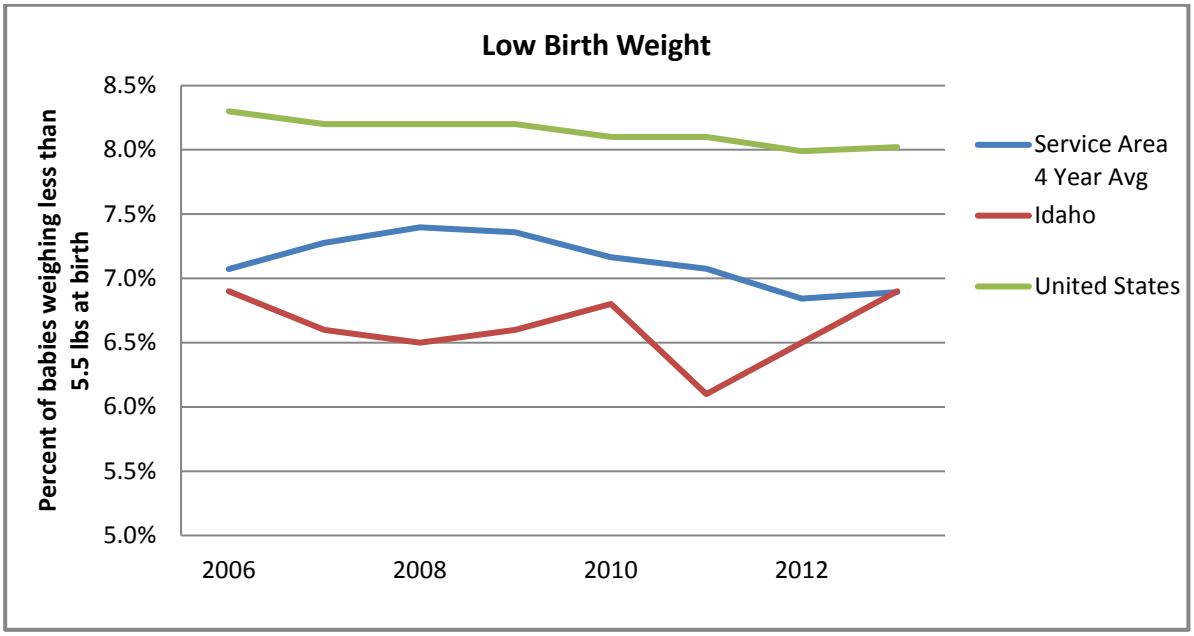
- **Low Birth Weight**

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.[28]

The percent of LBW babies in our service area and in Idaho is significantly below (better than) the national average.[29] This is a key indicator of future health. The national top 10th percentile for LBW is 6.0%.

Low birth weight can be addressed in multiple ways, including:[30]

- 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	**1**	**0**	**2**	**3**	**6**

[28] University of Wisconsin Population Health Institute. *County Health Rankings* 2015. Accessible at www.countyhealthrankings.org.

[29] Idaho Vital Statistics Annual Reports, Years 2000 - 2015, National Vital Statistics Report - Births: Data 2004 - 2015

[30] America's Health Rankings 2015, www.americashealthrankings.org

County Health Rankings Health Outcomes Ranking for Our Community

The *County Health Rankings* ranks the counties within each state on the health outcome measures described above. Twin Falls County's 2015 overall outcome rank is 20th and Jerome County's rank is 21th out of a total of 42 counties in Idaho.[31] 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.

[31] University of Wisconsin Population Health Institute. *County Health Rankings* 2015. 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.

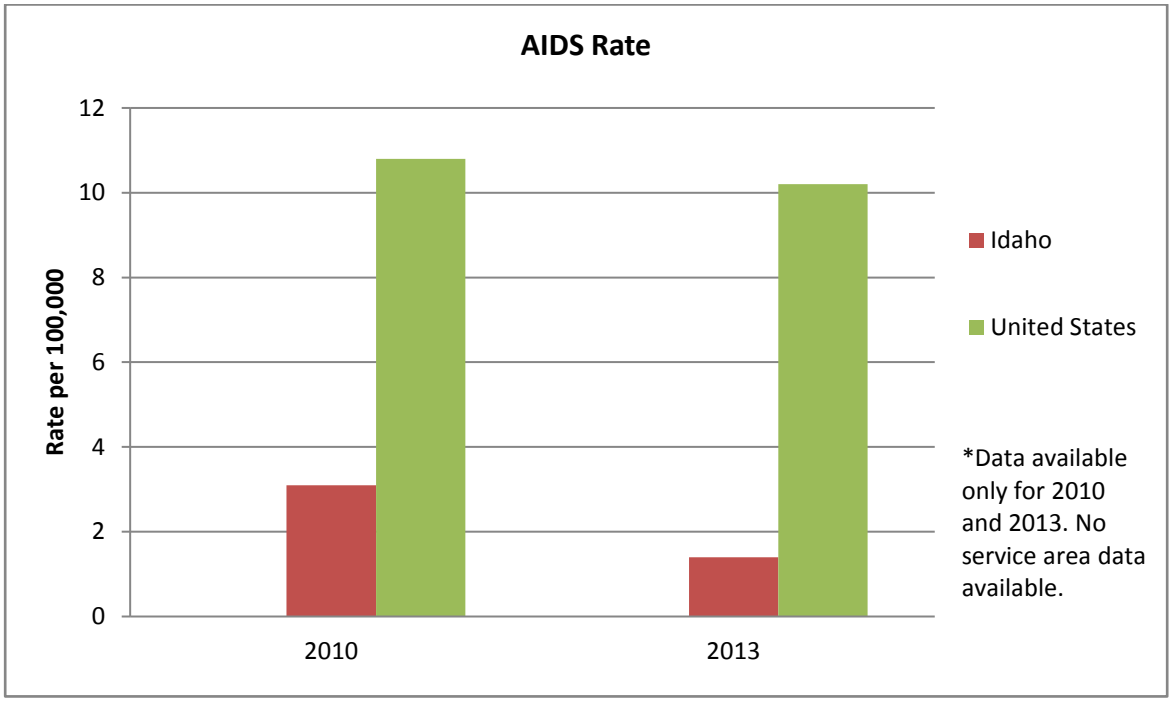
Chronic Disease Prevalence

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. [32] The trend in Idaho has been relatively flat from 2004 to 2013.[33]

African Americans are more likely to have HIV than any other racial/ethnic group in the United States (US). In 2010, African Americans accounted for 44% of new HIV infections while representing only 12% of the population. In 2010, African American men accounted for 70% of the estimated new HIV infections among all African Americans.[34] Young people in the US are also more at risk for HIV infection accounting for 26% of all new HIV infections in 2010. This risk is particularly high for young, gay, bisexual, and other men who have sex with men (MSM). HIV prevention programs, including education on abstinence and safe sex, will be helpful to younger people who did not benefit from the outreach conducted in the 1980s and 1990s.[35]



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**

[32] www.statehealthfacts.org
[33] www.healthandwelfare.idaho.gov/Portals/0/Health/Disease/STD%20HIV/2013_Facts_Book_FINAL.pdf
[34] http://www.cdc.gov/HIV/TOPICS/
[35] http://www.cdc.gov/hiv/youth/

- **Arthritis**

  In 2010, 24.1 % of Idaho adults had ever been told by a medical professional that they had arthritis. The prevalence of arthritis in our service area is above the national average and has not changed significantly since 2005.

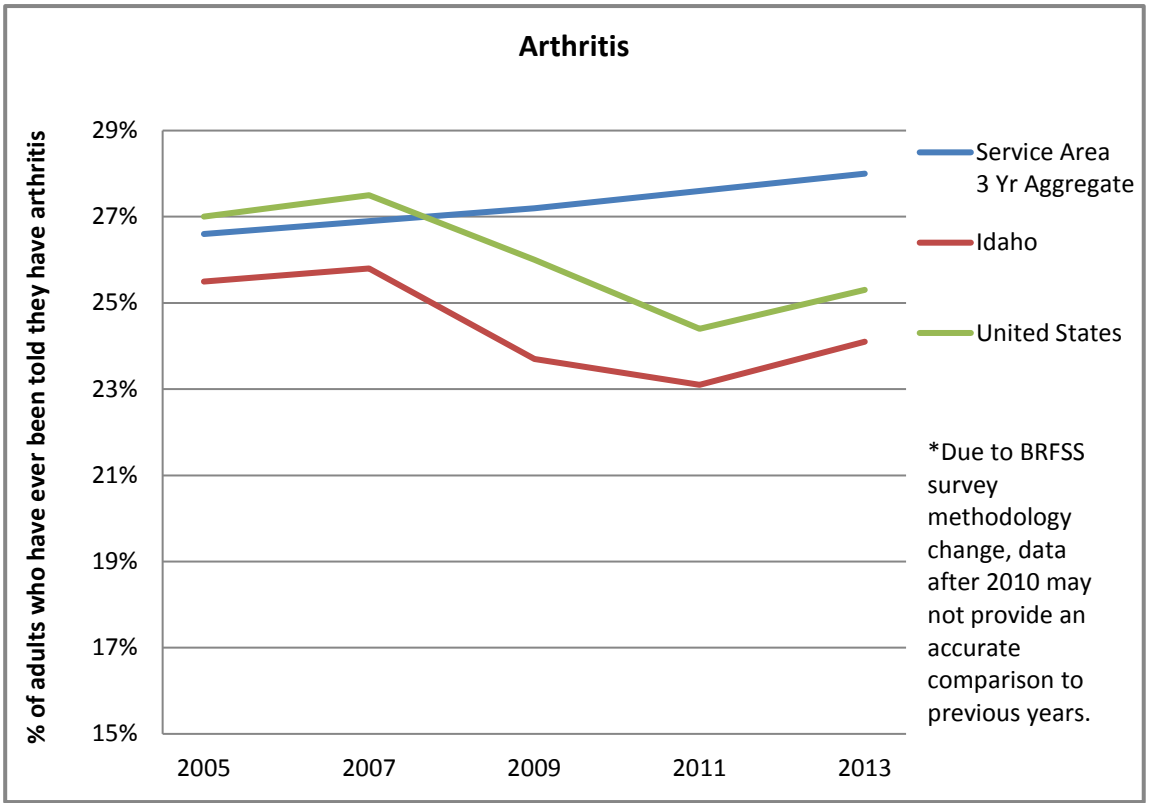
  The majority of those with arthritis (54.5%) reported that their activities were limited due to health problems. The likelihood of having arthritis increases with age. More than half of those surveyed ages 65 and older had been diagnosed with arthritis.

  Other Highlights:
  - Idaho residents with incomes below $50,000 per year were more likely to have arthritis than those with incomes of $50,000 or higher (25% compared with 18.7%).
  - Hispanics were significantly less likely than non-Hispanics to have been diagnosed with arthritis (14.5% compared with 23.8%).
  - Overweight adults (BMI ≥ 25) were more likely to have arthritis compared to those who were not overweight.[36]

  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.[37]

[36] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System
[37] Arthritis Foundation, http://www.arthritis.org/preventing-arthritis.php

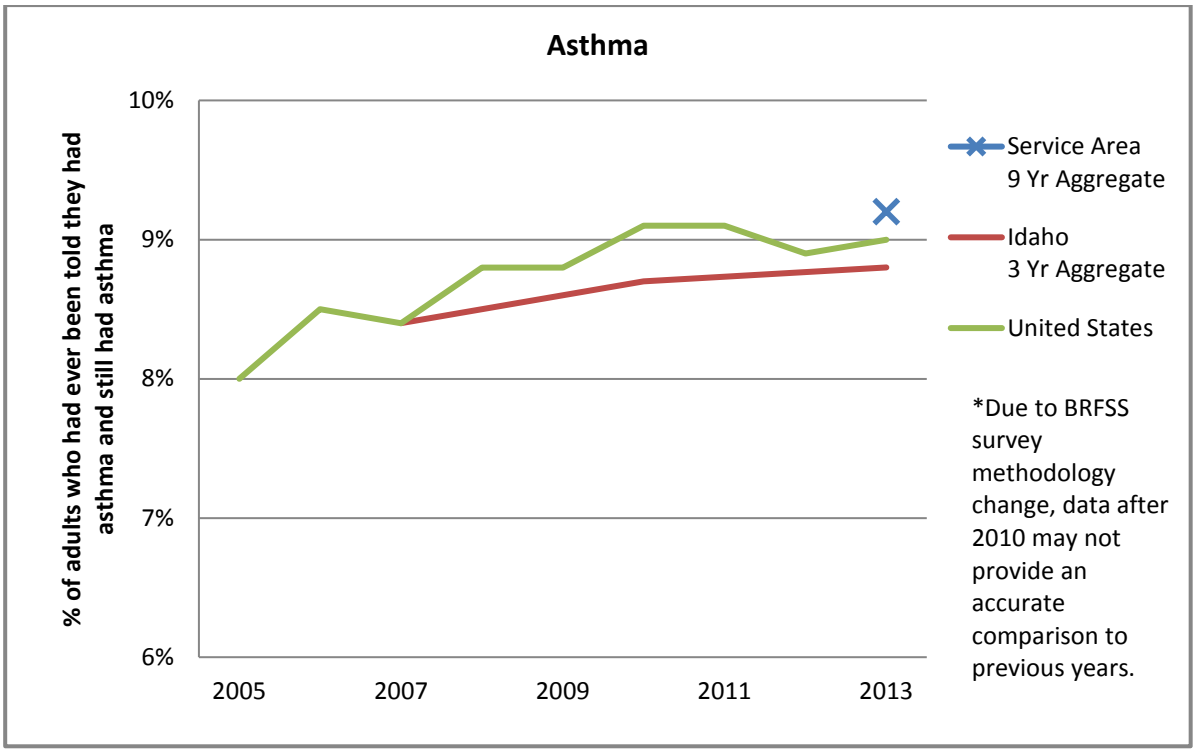


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S.**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Arthritis	**2**	**3**	**2**	**0**	**7**

- **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. [38]

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.[39]

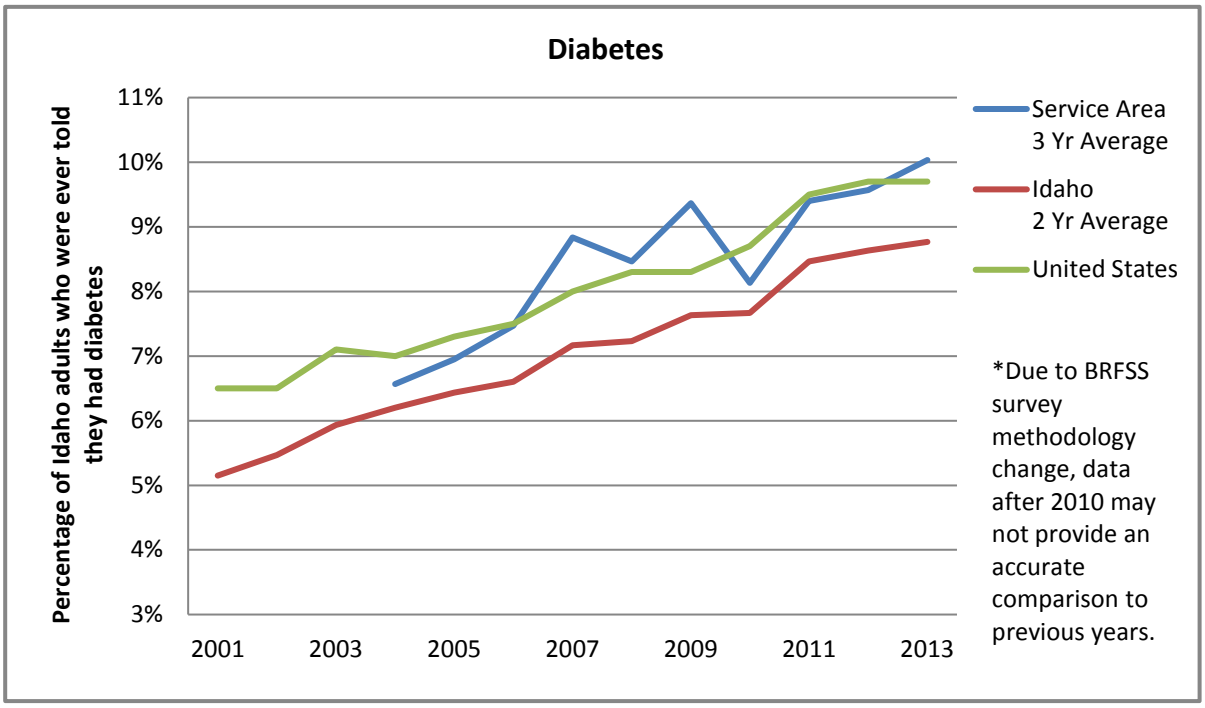


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Asthma	**2**	**2**	**2**	**0**	**6**

[38] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System
[39] http://www.nhlbi.nih.gov/health//dci/Diseases/Asthma/Asthma_Treatments.html

- **Diabetes**

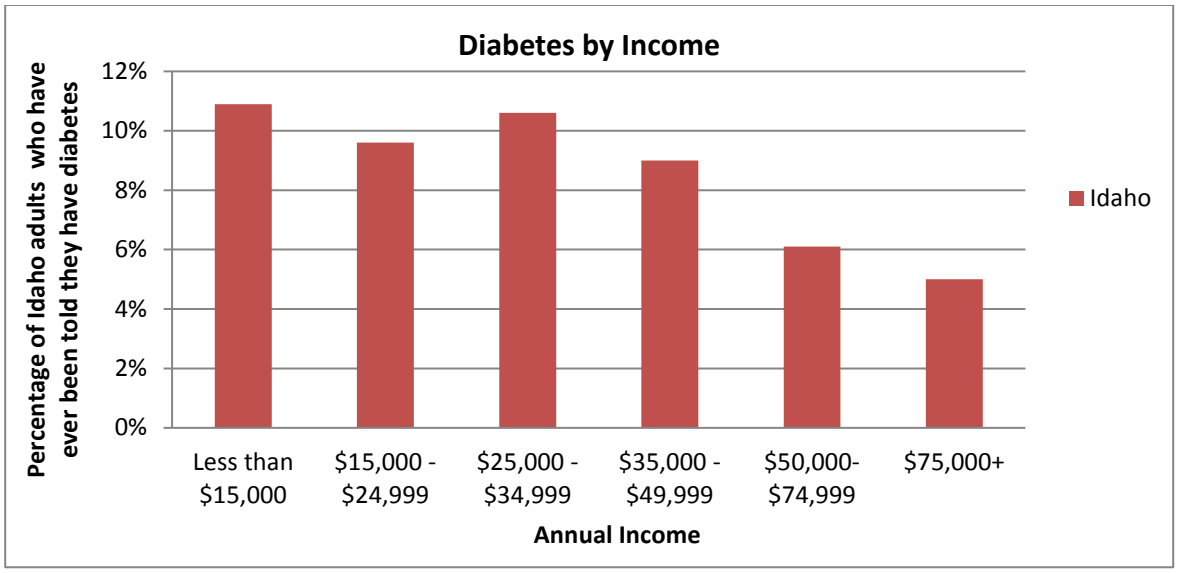
About 8% of the people in our community report that they have been told they have diabetes. The percent of people living with diabetes in our service area and in the United States is up by about 50% over the past ten years, indicating an opportunity for greater focus on prevention. Diabetes is a serious health issue that can contribute to heart disease, stroke, high blood pressure, kidney disease, blindness and can even result in limb amputation or death.[40] Direct medical costs for type 2 diabetes exceed $100 billion and account for $1 of every $10 spent on medical care in the U.S. [41]

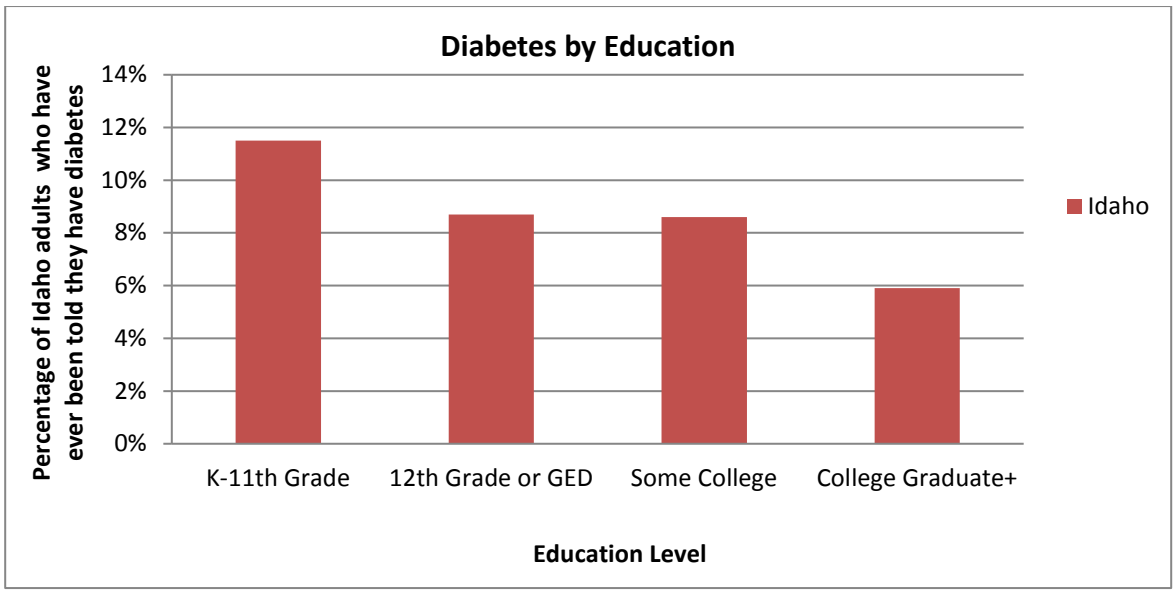


Other Highlights:

- Overweight (BMI ≥ 25) adults reported diabetes more than three times as often as those who were not overweight. Among overweight adults, 10.6% had diabetes compared with 3.4% of those who were not overweight or obese.
- Those who did not engage in leisure time physical activity reported diabetes more than twice as often as those who did have leisure time physical activity.
- Those with a high school diploma or less education were significantly more likely to have diabetes than college graduates.
- Those with lower incomes were more likely to have diabetes than those with mid-level or high incomes.[42]

[40] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System
[41] America's Health Rankings 2015, www.americashealthrankings.org
[42] Ibid.





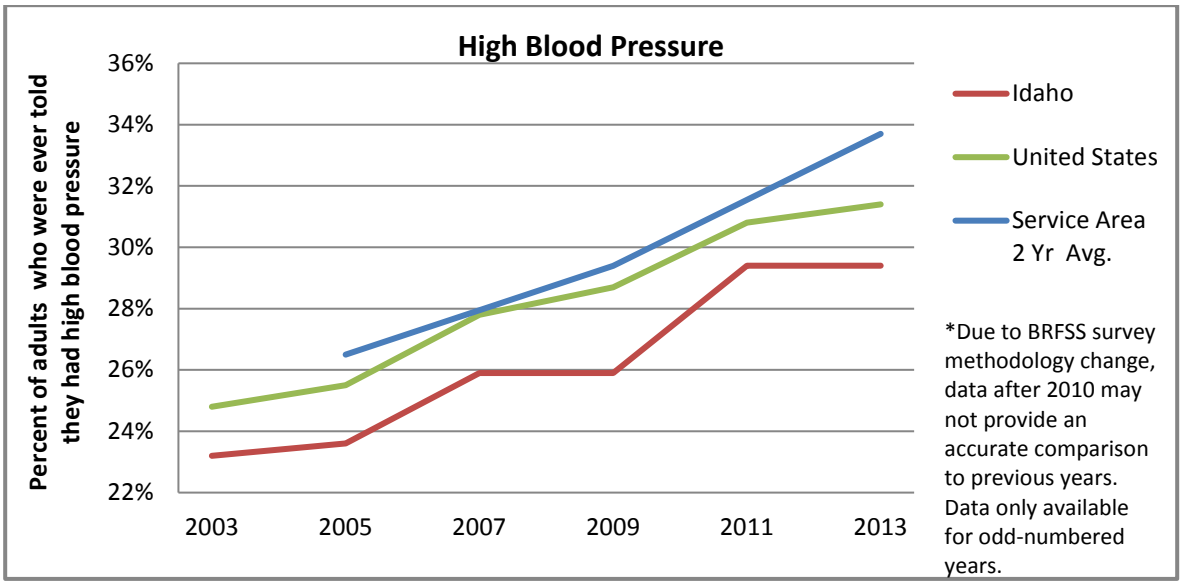
Studies indicate that the onset of type 2 diabetes can be prevented through weight loss, increased physical activity, and improving dietary choices. Diabetes can be managed through regular monitoring, following a physician-prescribed care regiment, adjusting diet, and maintaining a physically active lifestyle.[43]

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**	**2**	**3**	**4**	**13**

[43] America's Health Rankings 2015, 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 above the national level and the long-term trend is not improving. High blood pressure is a major risk factor for heart disease, stroke, congestive heart failure, and kidney disease.[44]



- 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.[45]

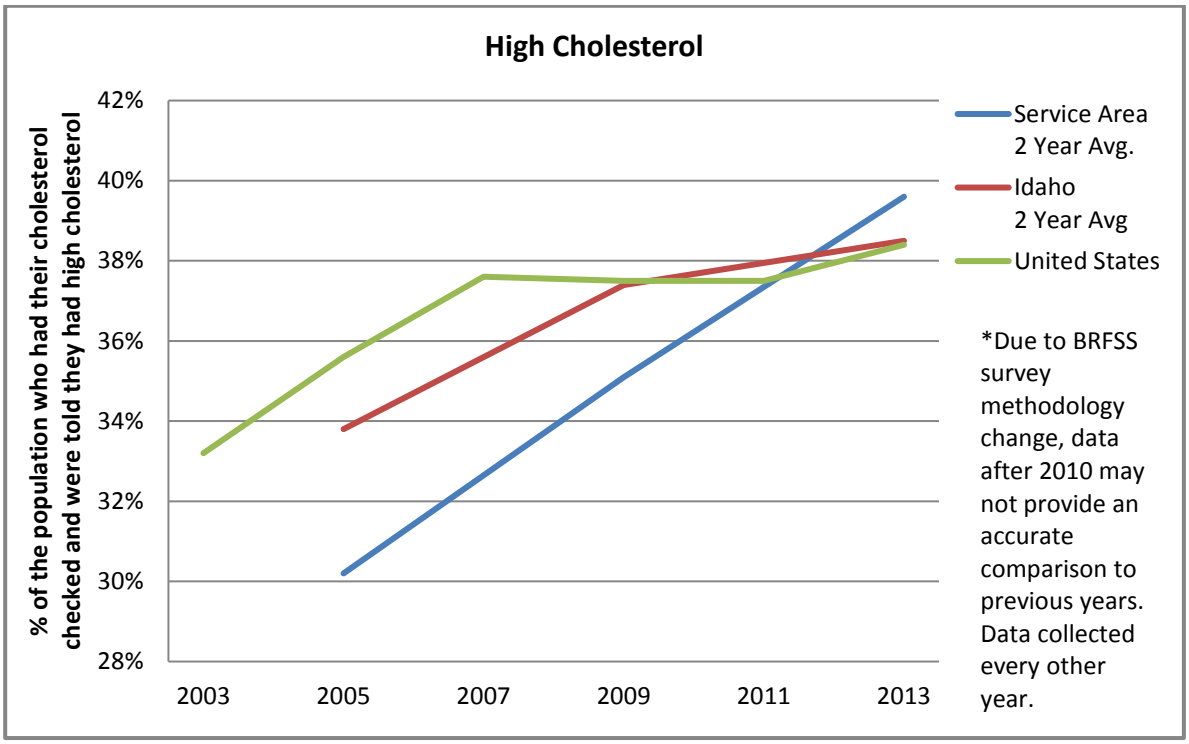
Healthy blood pressure may be maintained by changing lifestyle or combining lifestyle changes with prescribed medications.[46]

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

[44] Ibid
[45] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System
[46] America's Health Rankings 2015, www.americashealthrankings.org

- **High Cholesterol**

Among those who had ever been screened for cholesterol in our service area, approximately 40% reported that they were told their cholesterol was high in 2013, which is about the same as the national average. The percentage of screened adults with high cholesterol has increased in our service area, Idaho, and nationally since 2005. Sustained, increased cholesterol levels can lead to heart disease, heart attack, and other circulatory problems.[47]



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 almost twice as likely to have had high blood cholesterol levels as those under age 55.[48]

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

[47] Ibid.
[48] Idaho 2011 - 2013 Behavioral Risk Factor Surveillance System

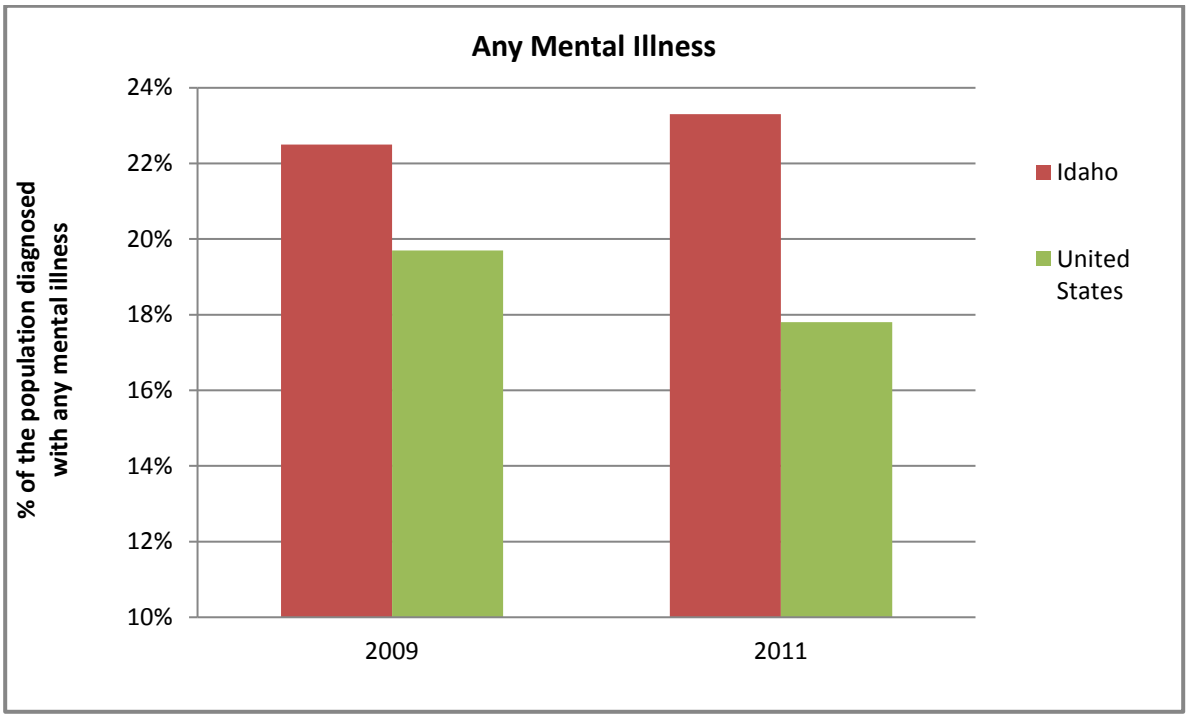
history, there are many things a person can do to keep cholesterol in check, such as following a healthy diet, maintaining a healthy weight, and being physically active. For some individuals, a physician-recommended pharmacological intervention may be necessary.[49]

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

[49] America's Health Rankings 2015, www.americashealthrankings.org

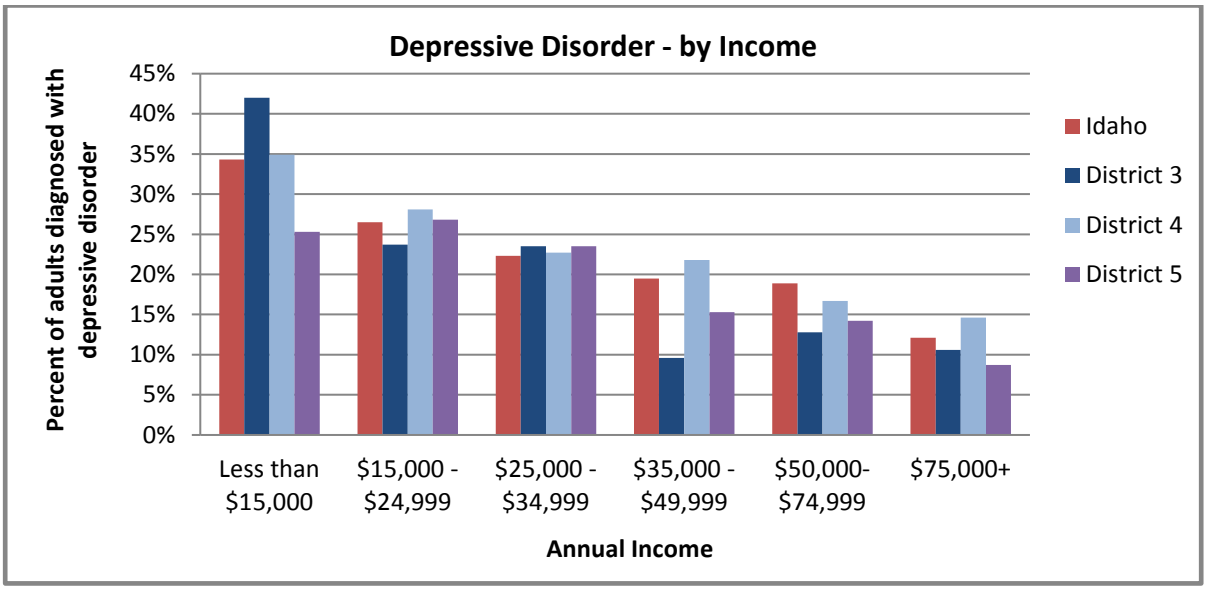
- **Mental Illness**

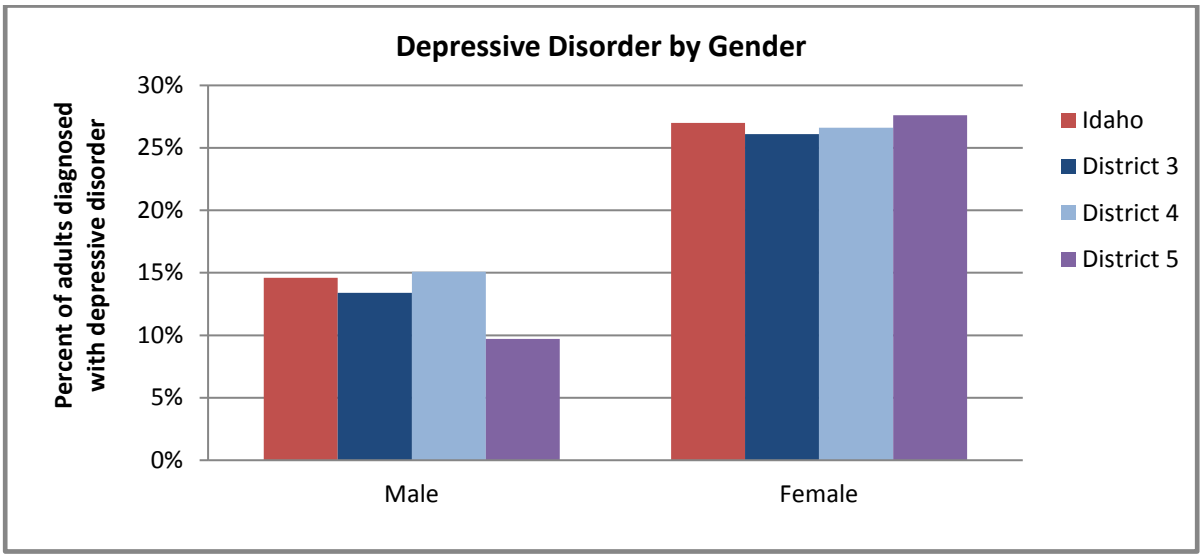
Community mental health status can help explain suicide rates as well as help us understand the need for mental health professionals in our service area. The percentage of people age 18 or older having any mental illness (AMI) (2009-2011 latest years available) was 23.3% for Idaho. This was the third highest percentage of mental illness in the nation. The percentage of people having any mental illness for the United States as a whole was 17.8%.[50]



[50] Mental Health, United States, 2012 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. [51]





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

[51] Idaho 2011 - 2013 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.

- **Cancer (malignant neoplasms)**

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

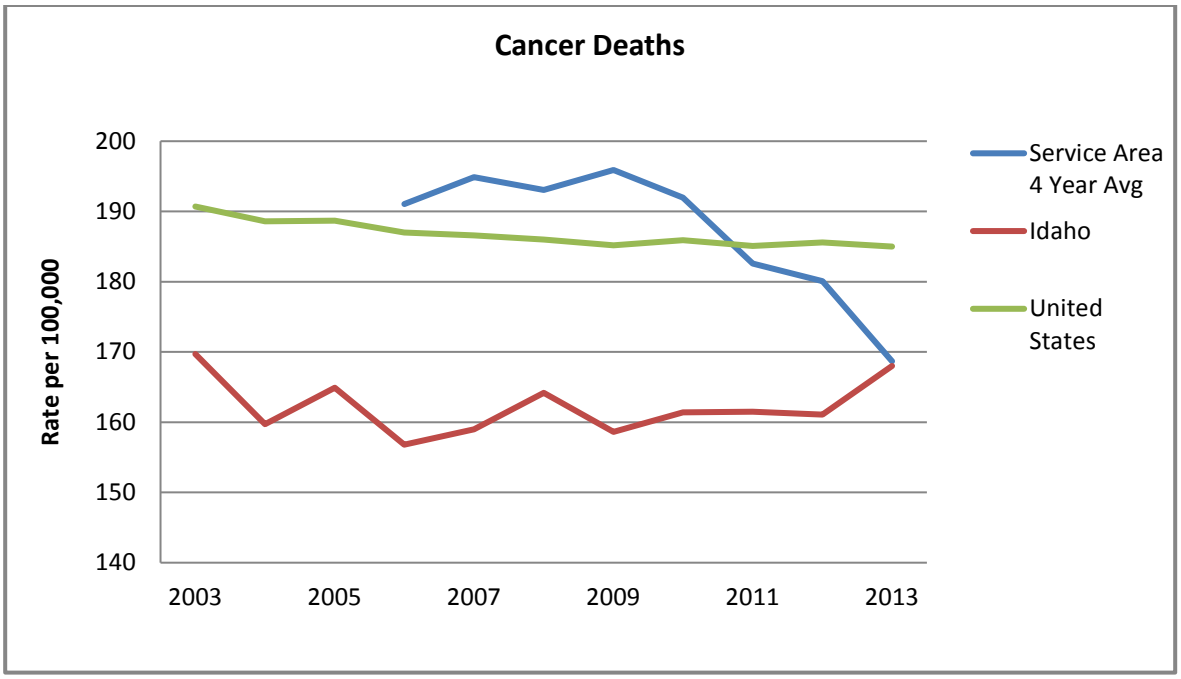
  Although cancer may occur at any age, it is generally a disease of aging. Nearly 80% of cancers are diagnosed in persons 55 or older. Cancer is caused both by external factors such as tobacco use and exposure, chemicals, radiation and infectious organisms, and by internal factors such as genetics, hormonal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

  Cancer is among the most expensive conditions to treat. Many individuals face financial challenges because of lack of insurance or underinsurance, resulting in high out-of-pocket expenses.[52]

  The chart below shows that the cancer death rate in our service area is below the national average. The trend for cancer deaths is down nationally and in our service area for a number of years.[53]

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

[53] Idaho Vital Statistics Annual Reports, Years 2003 - 2013, National Vital Statistics Report - Deaths: Data 2013



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.[54]

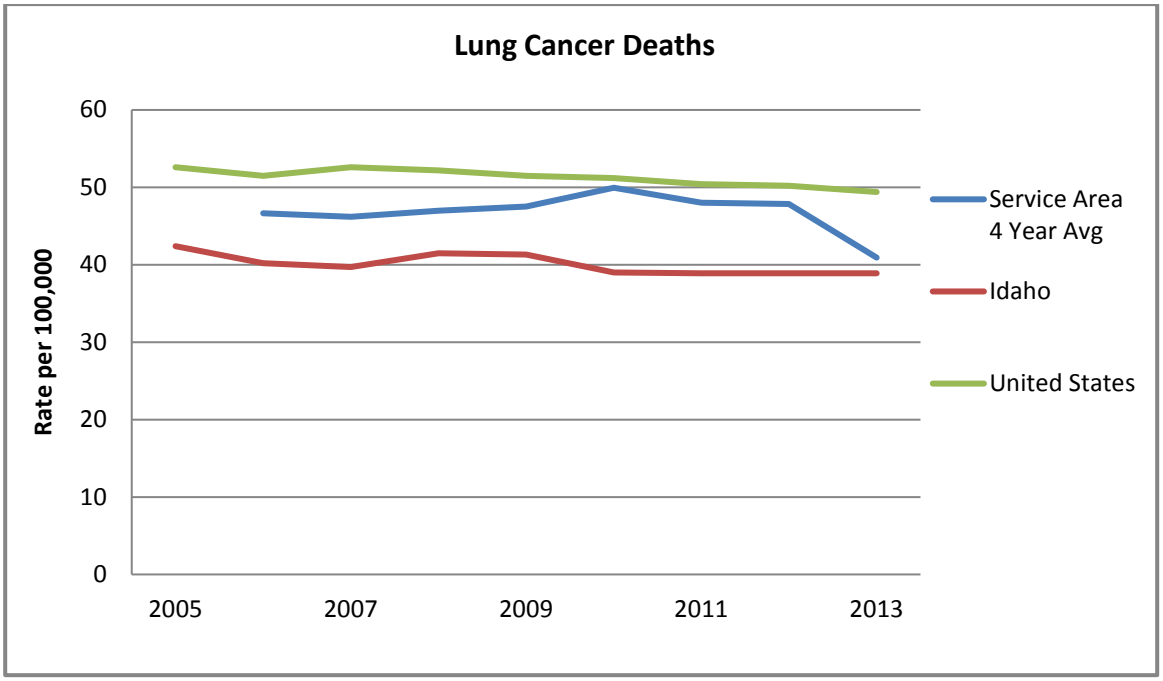
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Cancer	**1**	**1**	**3**	**1**	**6**

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

[54] America's Health Rankings 2011, www.americashealthrankings.org

- **Lung Cancer**

Lung cancer is the leading cause of cancer death in Idaho. However, the lung cancer death rate in our service area is below the national average.[55] 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.[56]

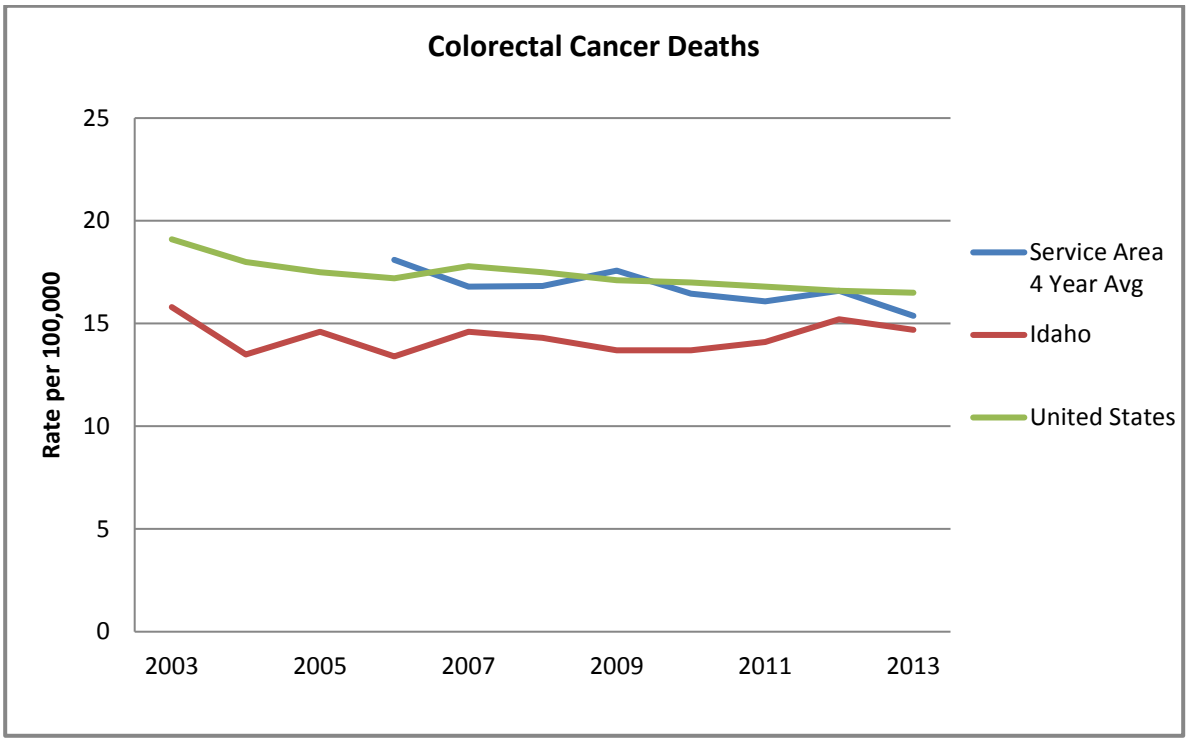


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Lung Cancer	**2**	**2**	**4**	**1**	**9**

[55] Idaho Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2012
[56] Comprehensive Cancer Alliance for Idaho, Idaho Comprehensive Cancer Strategic Plan 2004-2010, www.ccaidaho.org

- **Colorectal Cancer**

In Idaho, colorectal cancer is the second most common cancer-related cause of death among males and females combined. The trend for colorectal cancer deaths in our service area and the national trend is down slightly. The death rate is now about the same as the national average.[57] 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.[58]

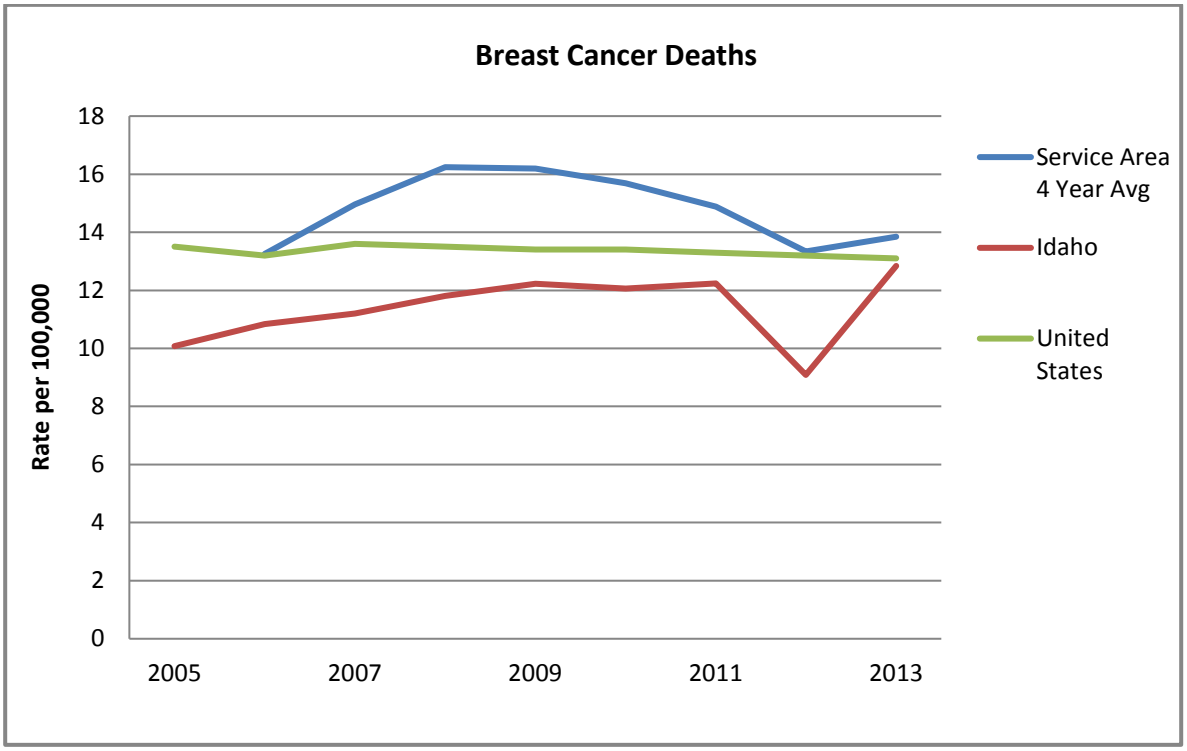


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude**	**Total Score**
Colorectal Cancer	**2**	**2**	**4**	**0**	**8**

[57] Idaho Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2012
[58] America's Health Rankings 2015, www.americashealthrankings.org

- **Breast Cancer**

Breast cancer is the second leading cause of cancer death, after lung cancer among Idaho women. The breast cancer death rate in our service area is slightly above the national average.[59] 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%). [60]

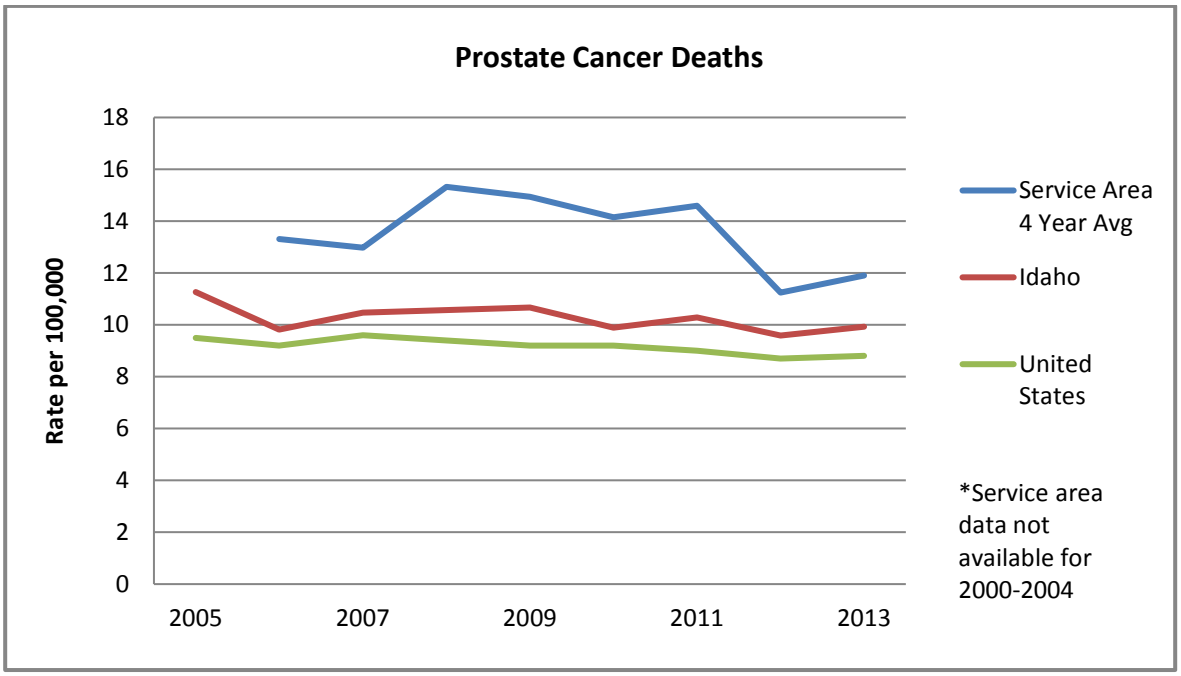


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Breast Cancer	**2**	**3**	**4**	**1**	**10**

[59] Idaho Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2012
[60] America's Health Rankings 2015, www.americashealthrankings.org

- **Prostate Cancer**

Prostate cancer is the second overall cause of death in Idaho men and is the most common cancer among males. In our service area, the trend for the prostate cancer deaths is relatively flat, and the death rate is well above the national average.[61] 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.[62]

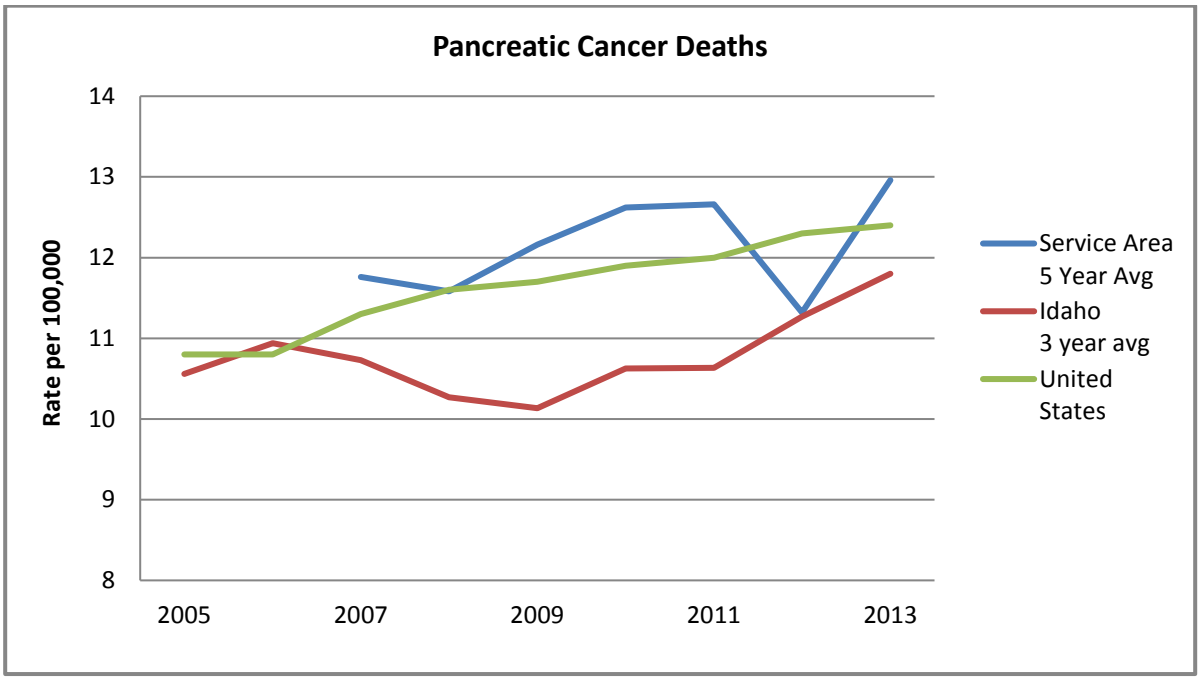


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Prostate Cancer	**2**	**4**	**3**	**0**	**9**

[61] Idaho Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2012
[62] 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 about the same as the national average. [63] 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.[64]



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

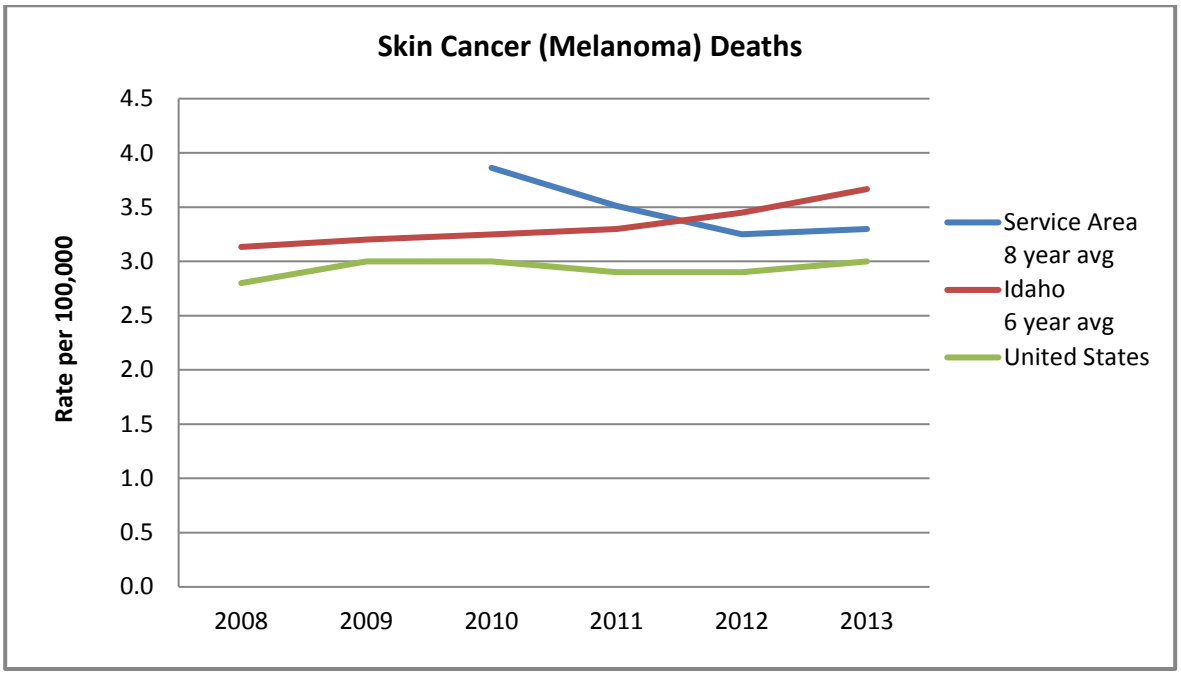
[63] Idaho Vital Statistics Annual Reports, Years 2000 - 2010, National Vital Statistics Report - Deaths: Data 2010
[64] Comprehensive Cancer Alliance for Idaho, Idaho Comprehensive Cancer Strategic Plan 2004-2010, www.ccaidaho.org

- **Skin Cancer (Melanoma)**

In 2008, more than 1 million people were diagnosed with skin cancer, making it the most common of all cancers. More people were diagnosed with skin cancer in 2008 than with breast, prostate, lung, and colon cancer combined. About 1 in 5 Americans will develop skin cancer during their lifetime. For people born in 2005, 1 in 55 will be diagnosed with melanoma— nearly 30 times the rate for people born in 1930. [65]

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

The chart shows that melanoma death rates are higher in Idaho and our service area than in the rest of the nation.[66]



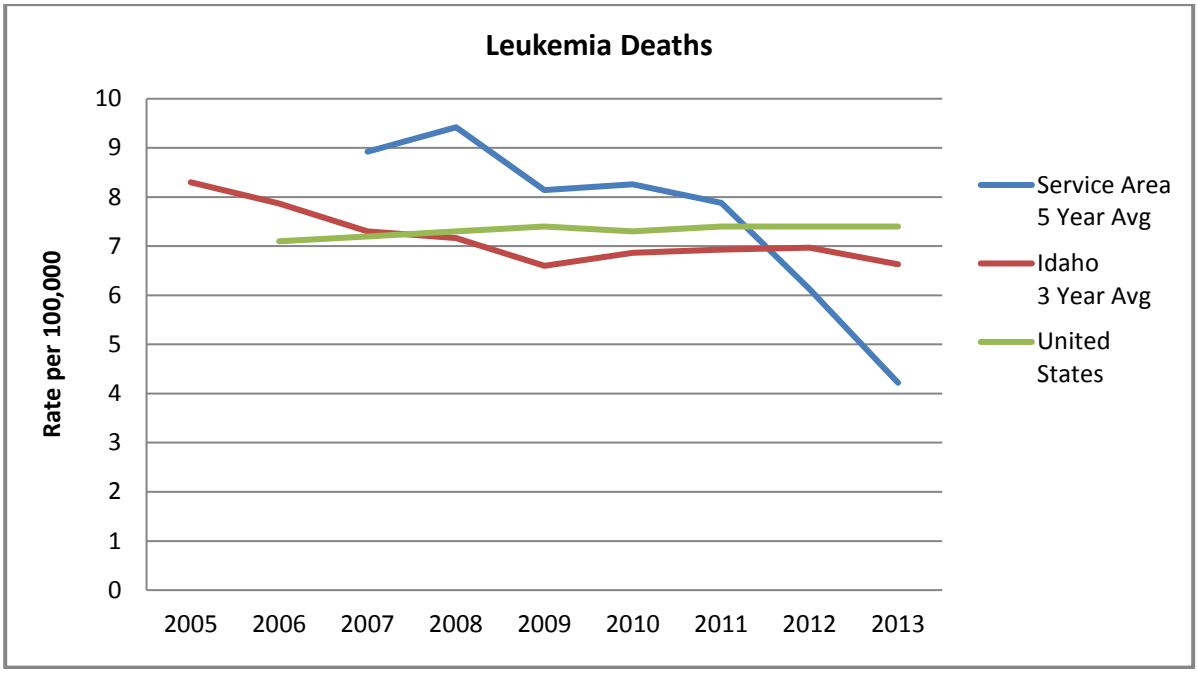
Exposure to ultraviolet (UV) radiation appears to be the most significant factor in the development of skin cancer. Skin cancer is largely preventable when sun protection measures are used consistently. These results highlight the need for effective interventions that reduce harmful UV light exposure.[67]

[65] www.epa.gov/sunwise/statefacts.html
[66] Idaho Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2012
[67] Comprehensive Cancer Alliance for Idaho, Idaho Comprehensive Cancer Strategic Plan 2004-2010, www.ccaidaho.org

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	**2**	**3**	**4**	**0**	**9**

- **Leukemia**

The leukemia death rate in our service area is lower than the national average and the trend is down. [68] 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.[69] Because the causes are not well understood, evidence-based preventive programs are not available (other than avoiding the risk factors described above).

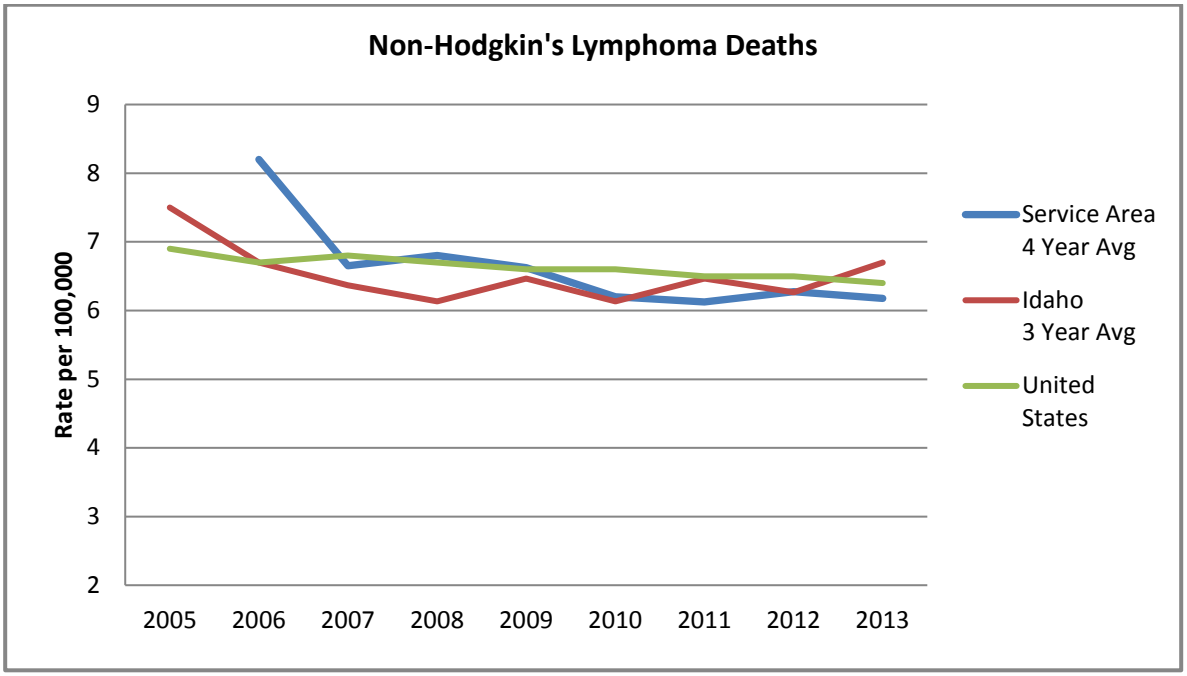


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Leukemia	**1**	**1**	**1**	**0**	**3**

[68] Idaho Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2012
[69] www.cdc.gov/Features/HematologicCancers/

- **Non-Hodgkin's Lymphoma**

The non-Hodgkin's lymphoma death rate in our service area is about the same as the national average, and the trend is flat. [70] Lymphoma is a general term for cancers that start in the lymph system; mainly the lymph nodes. The causes of lymphoma are unknown.[71] Because the causes are not understood, evidence-based preventive programs are not available.



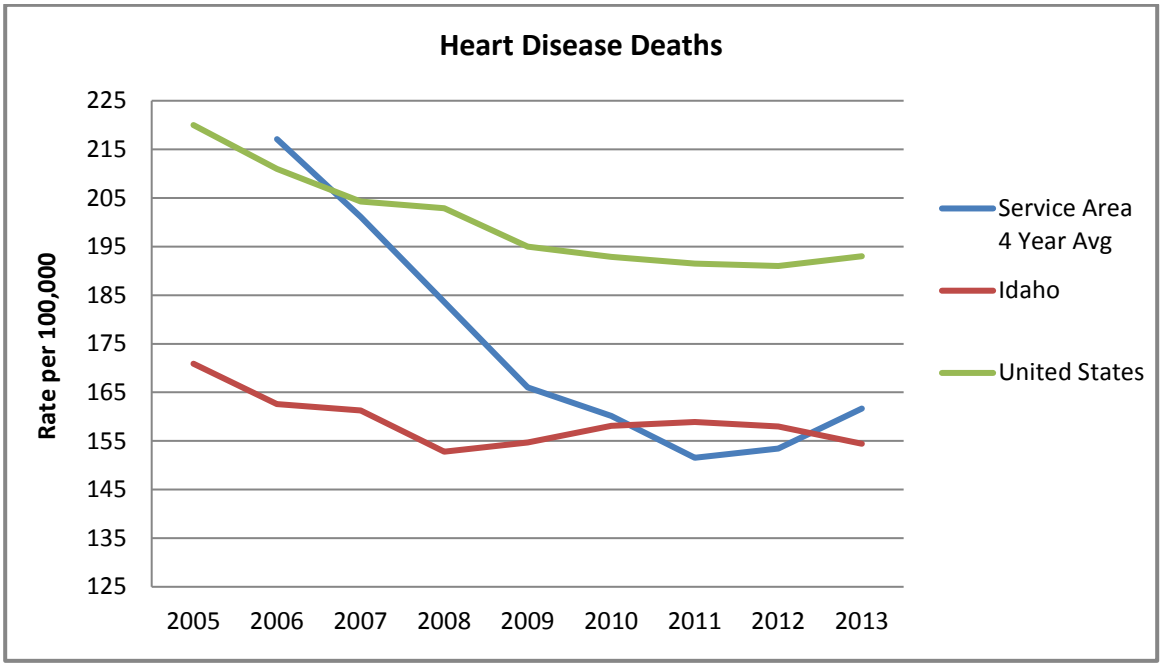
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Non-Hodgkin's lymphoma	**2**	**2**	**1**	**0**	**5**

[70] Idaho Vital Statistics Annual Reports, Years 2000 - 2010, National Vital Statistics Report - Deaths: Data 2010
[71] www.cdc.gov/Features/HematologicCancers/

- **Diseases of the Heart**

The heart disease death rate has been declining 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. It is the second leading cause of death in Idaho.[73] The death rate from heart disease in our service area is well below the national average.



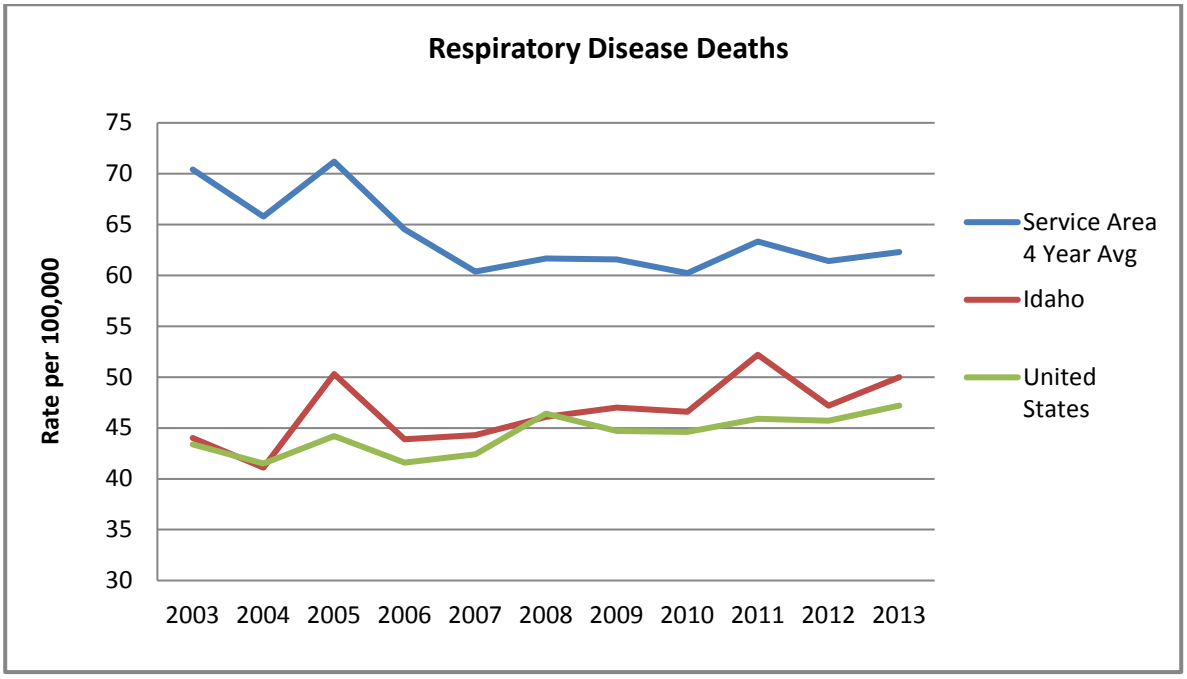
Heart disease is a long-term illness that many individuals can manage through lifestyle changes and healthcare interventions. However, many interventions place a burden on affected individuals by constraining options and activities available to them and can result in costly and ongoing expenditures for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

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

[72] Idaho Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2012
[73] America's Health Rankings 2011, www.americashealthrankings.org
[74] Ibid.

- **Chronic Lower Respiratory Diseases**

The chronic lower respiratory diseases death rate in our service area is much higher than the national average and the trend has been flat. Chronic lower respiratory diseases are the third leading cause of death in Idaho.[75] 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. [76]

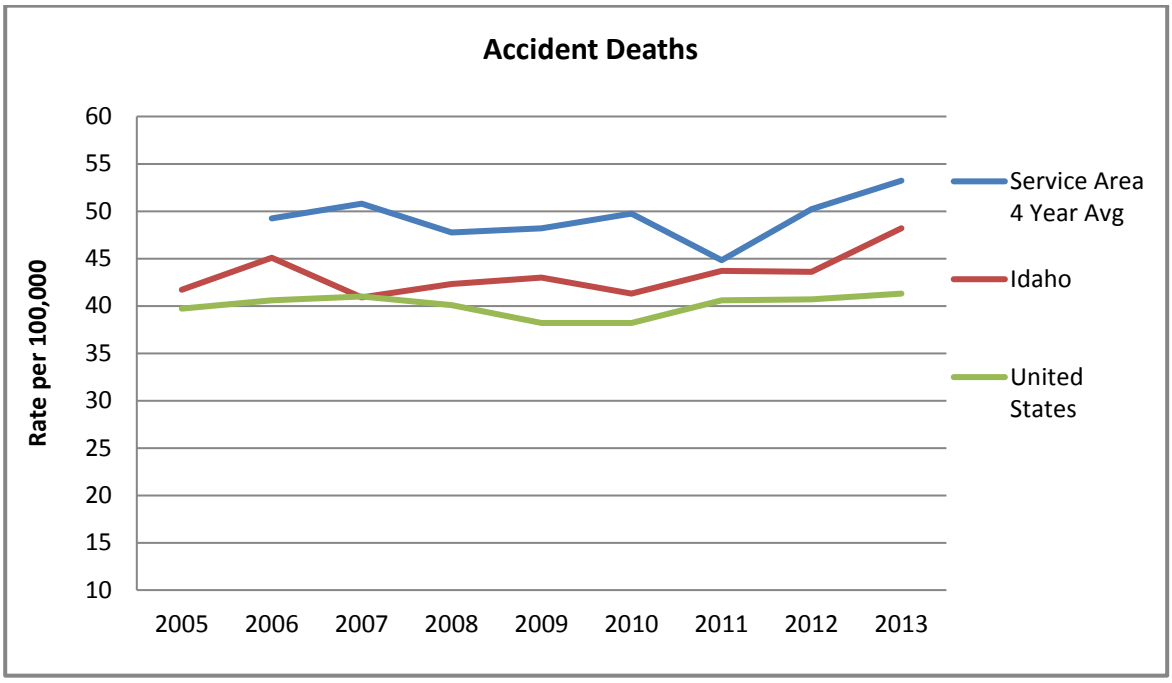


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Respiratory disease deaths	**2**	**4**	**4**	**0**	**10**

[75] Idaho Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2012
[76] www.lung.org/associations/states/wisconsin/news/chronic-lower-respiratory.html

- **Accidents**

Accidents are the fourth leading cause of death in Idaho and include unintentional injuries, which comprise both motor vehicle and non-motor vehicle accidents. The accident death rate in our service area is well above the national average and the trend is relatively flat.[77]

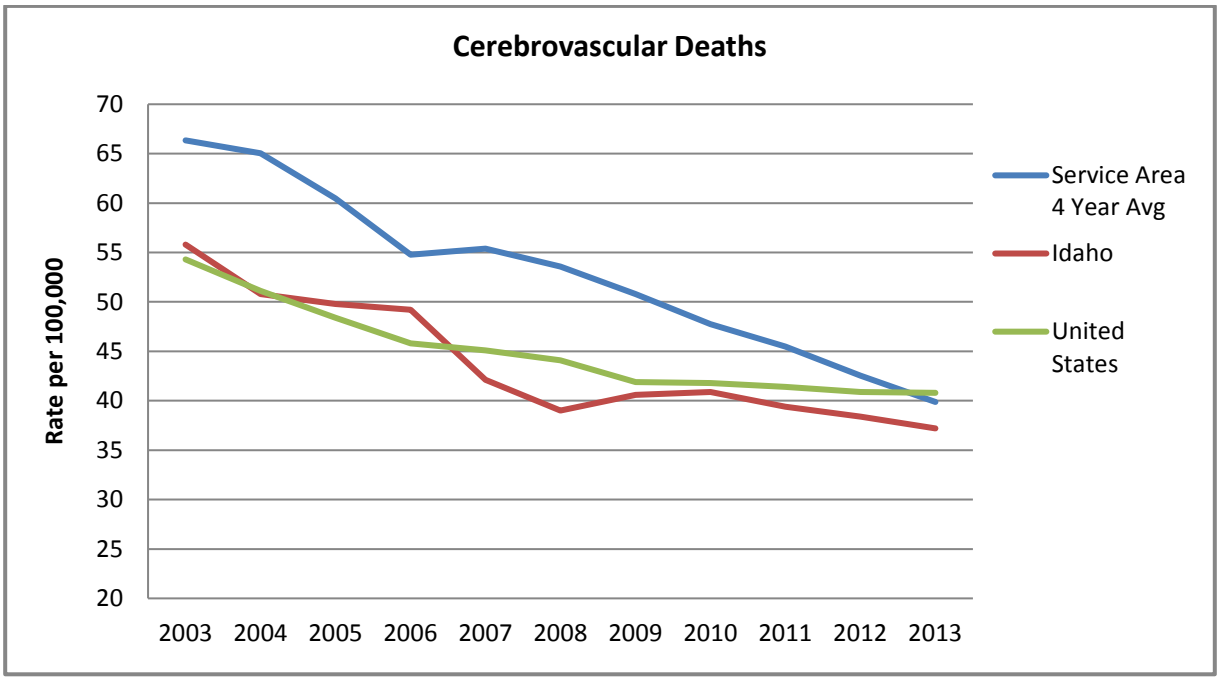


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude**	**Total Score**
Accidental deaths	**2**	**4**	**4**	**0**	**10**

[77] Idaho Vital Statistics Annual Reports, Years 2000 - 2010, National Vital Statistics Report - Deaths: Data 2010

- **Cerebrovascular Diseases**

The number of deaths due to cerebrovascular diseases has decreased substantially over the past 10 years. However, they are still the fifth leading cause of death in Idaho and the nation. In our service area, the cerebrovascular diseases death rate is down significantly since the year 2000 and is now about the same as the national average.[78] 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. [79]

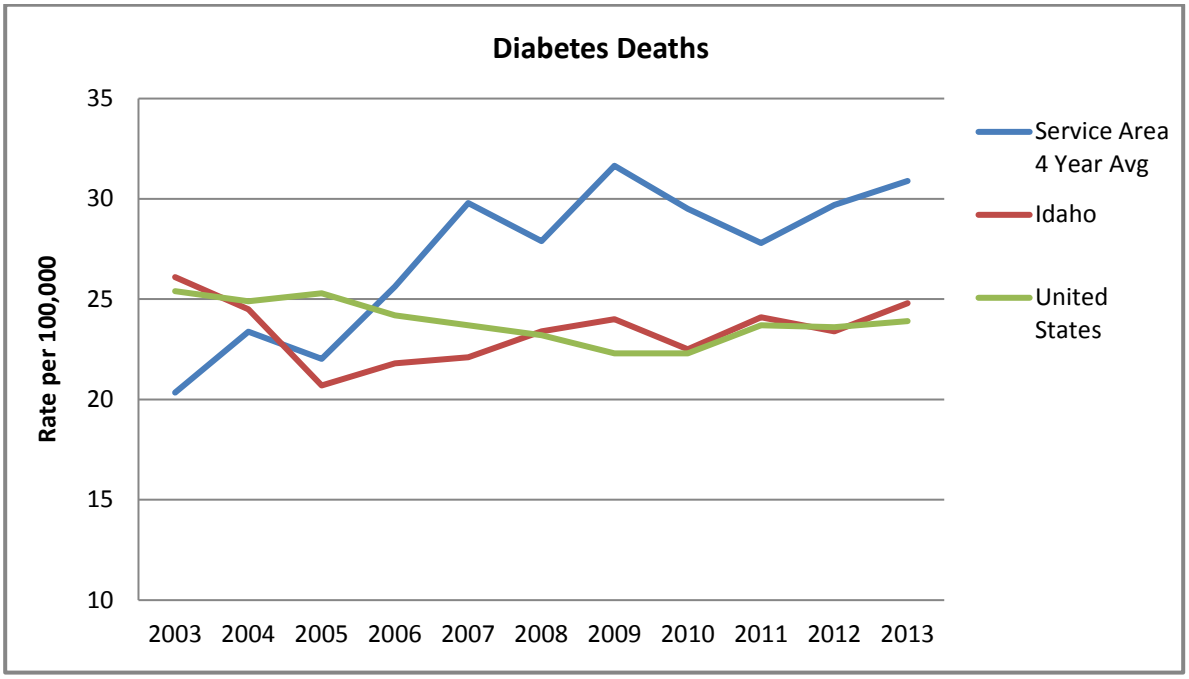


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Cerebrovascular Deaths	**0**	**2**	**4**	**1**	**7**

[78] Idaho Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2012
[79] America's Health Rankings 2015, www.americashealthrankings.org

- **Diabetes Mellitus**

Diabetes is the sixth leading cause of death in Idaho. The death rate from diabetes in our service area is significantly higher than the national average and has been trending up over the last 10 years. Diabetes is a serious health issue that can contribute to heart disease, stroke, high blood pressure, kidney disease, blindness and can even result in limb amputation or death.[80]



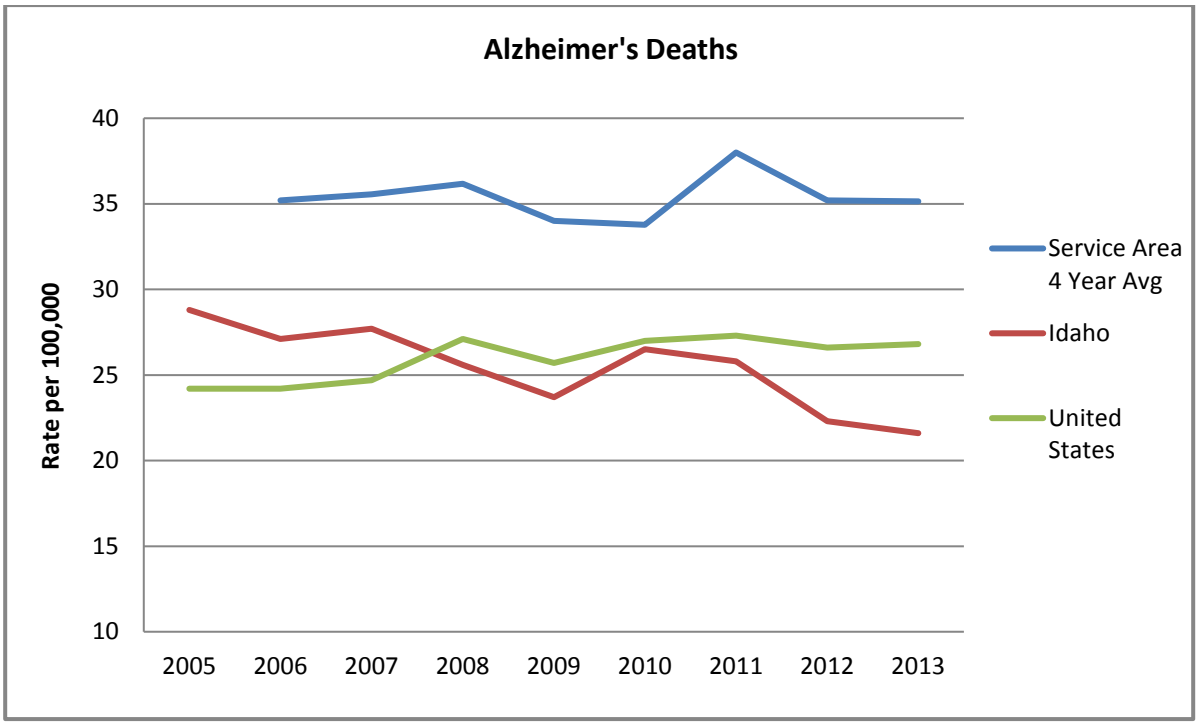
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Diabetes Deaths	**3**	**4**	**3**	**4**	**14**

[80] Idaho Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2012

- **Alzheimer's disease**

Alzheimer's is the seventh leading cause of death in Idaho. Nationally, the death rate from Alzheimer's has increased over the past 10 years. The death rate in our service area has been flat but is still well above the national rate.[81]

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.[82]

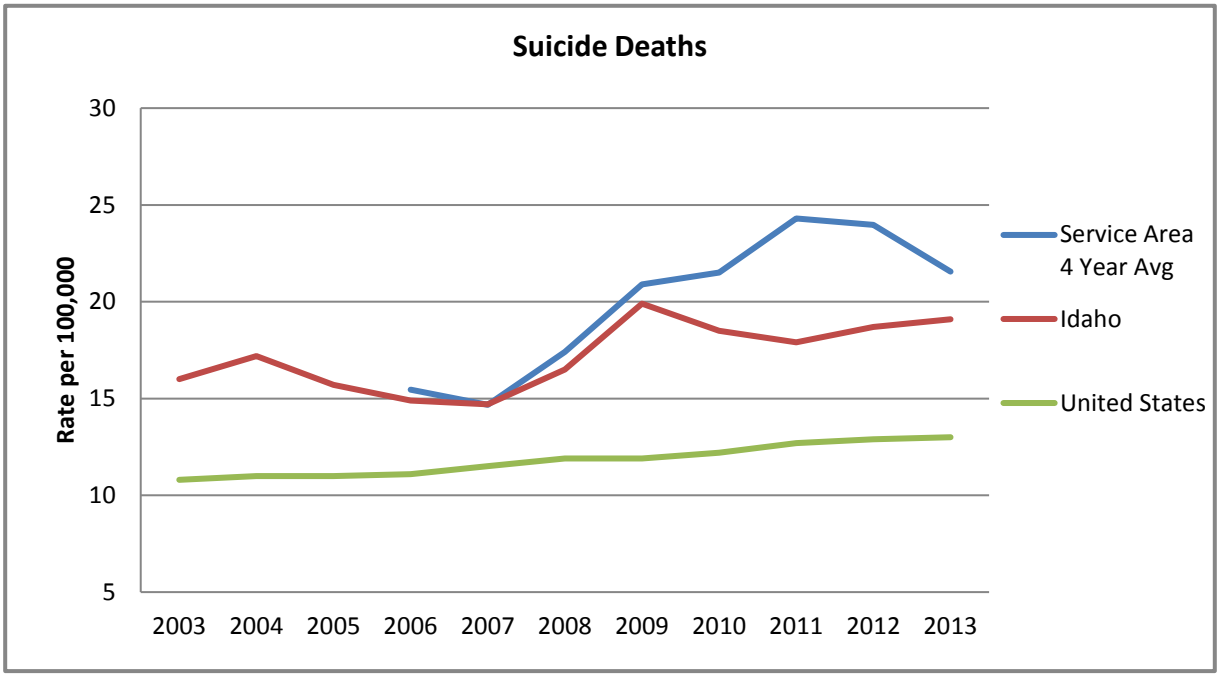


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Alzheimer's Deaths	**2**	**3**	**2**	**1**	**8**

[81] Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2012
[82] Alzheimer's Association, www.alz.org

- **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 19.1 in 2013 which is about 50% higher than the national average rate of 12.9. The suicide rate in our service area was 21.6, which is 67% higher than the national average. As shown in the chart below, the suicide rate in our service area, Idaho, and the nation has been trending up.



The suicide rate for males is about four times higher than the rate for females.[83] 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.[84]

Health Factor Score					
	Trend: Better/Worse	**Prevalence versus U.S.**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Suicide	**4**	**4**	**4**	**1**	**13**

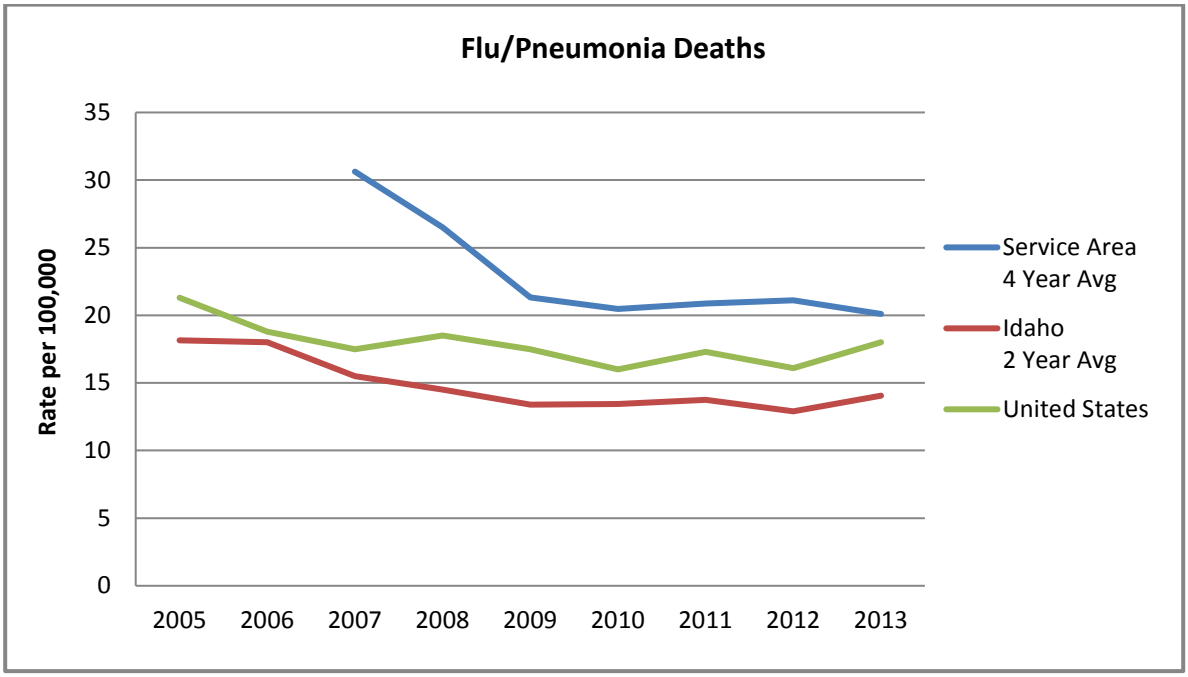
[83] Idaho Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2013
[84] Idaho Council on Suicide Prevention, Report to Governor C.L. Otter, November 2009

- **Influenza and Pneumonia**

The death rate from flu and pneumonia has been flat in our service area and is higher than the national average.[85]

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.[86]

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.[87]



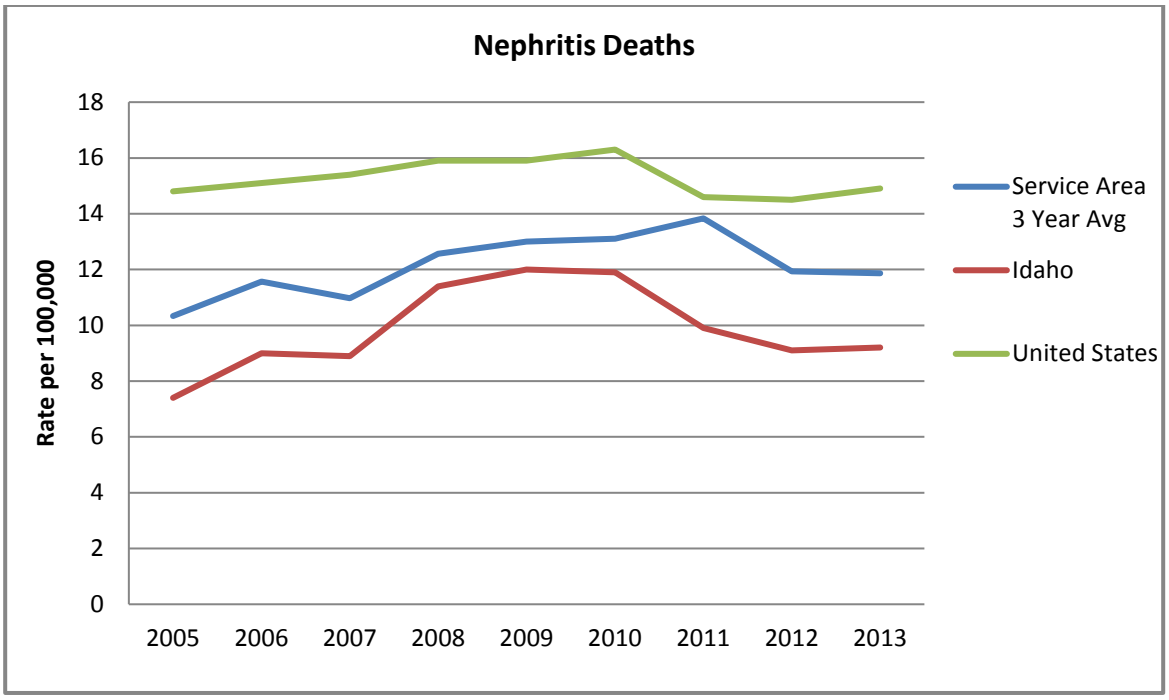
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Flu/ Pneumonia	**2**	**3**	**4**	**0**	**9**

[85] Idaho Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2012
[86] http://www.cdc.gov/flu/keyfacts.htm
[87] http://www.cdc.gov/Features/Pneumonia/

- **Nephritis**

The death rate from nephritis is lower in our community than it is nationally. The nephritis death rate increases have started to level off both in the nation and our service area over the past four years.[88]

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.[89]



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.

[88] Idaho Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2012
[89] 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.[90]

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

[90] 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.[91] 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

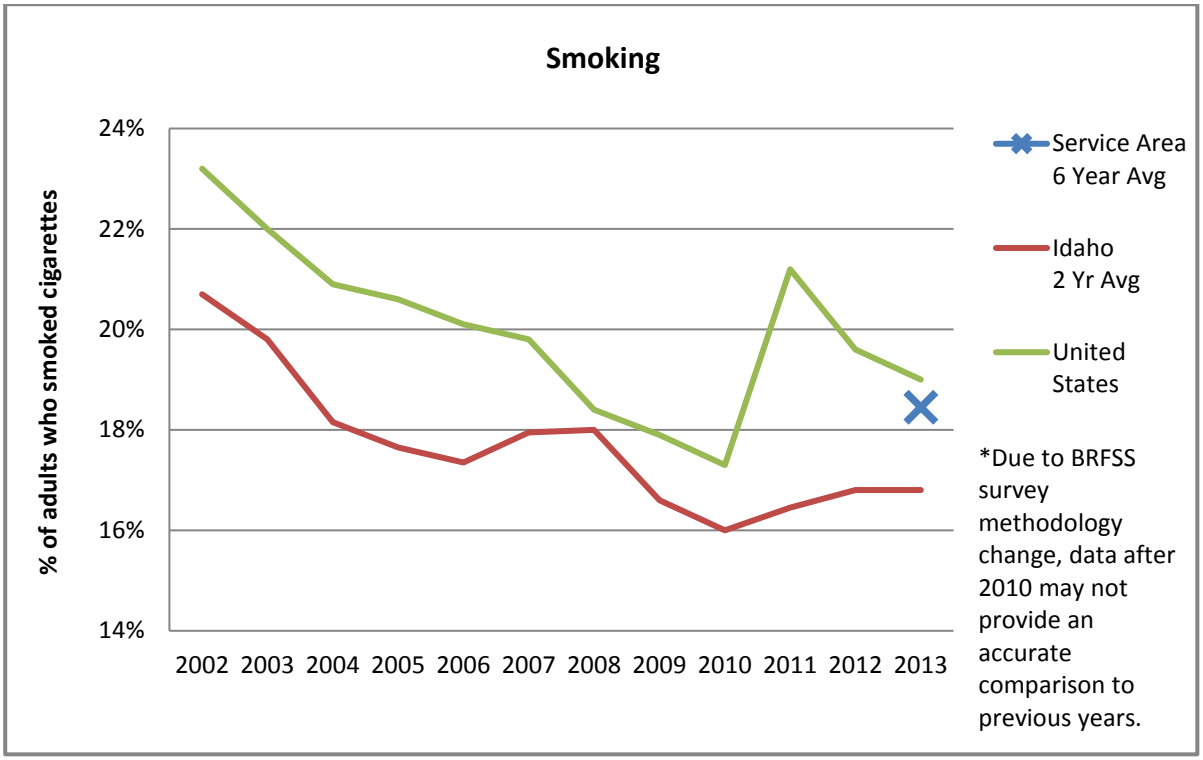
The *County Health Rankings* measures for community health behavior are described on the following pages. This next section also includes the trends for each indicator in our community and, when possible, compares our local data to state and national averages.

[91] University of Wisconsin Population Health Institute. *County Health Rankings* 2015. 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.[92]

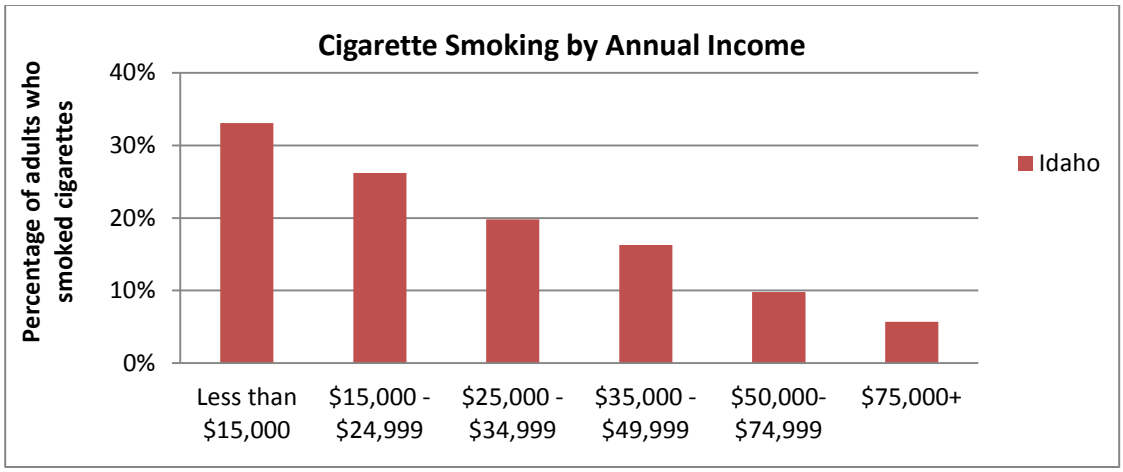
County-level measures from the Behavioral Risk Factor Surveillance System (BRFSS) provided by the CDC are used to obtain the number of current adult smokers who have smoked at least 100 cigarettes in their lifetime. The trend for smoking nationally and in Idaho is down. Looking at the last couple of years it appears as though the trend is flattening out or is rising; however, this is more likely due to a change in the BRFSS survey methodology starting in 2011. The percent of adults who smoked in our service area is slightly below the national average. [93]

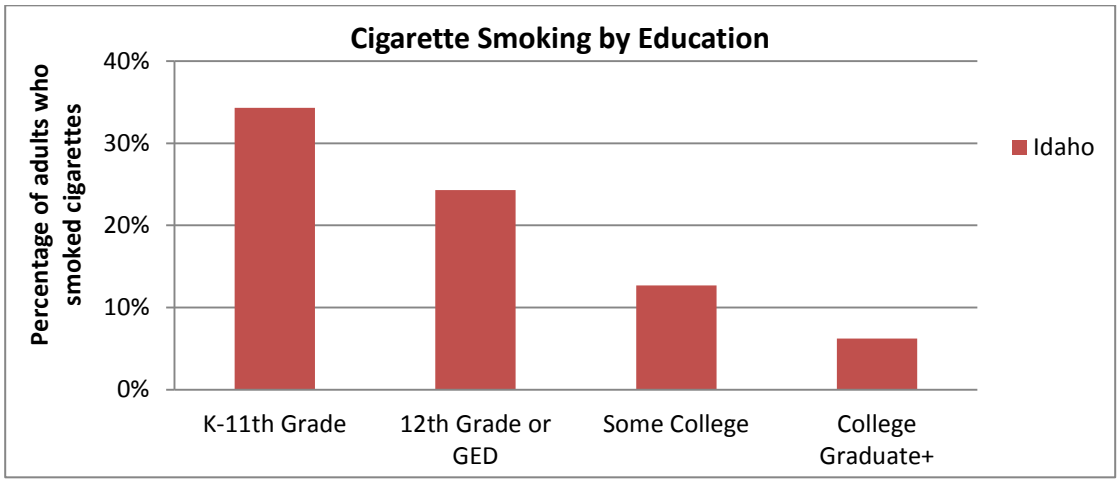


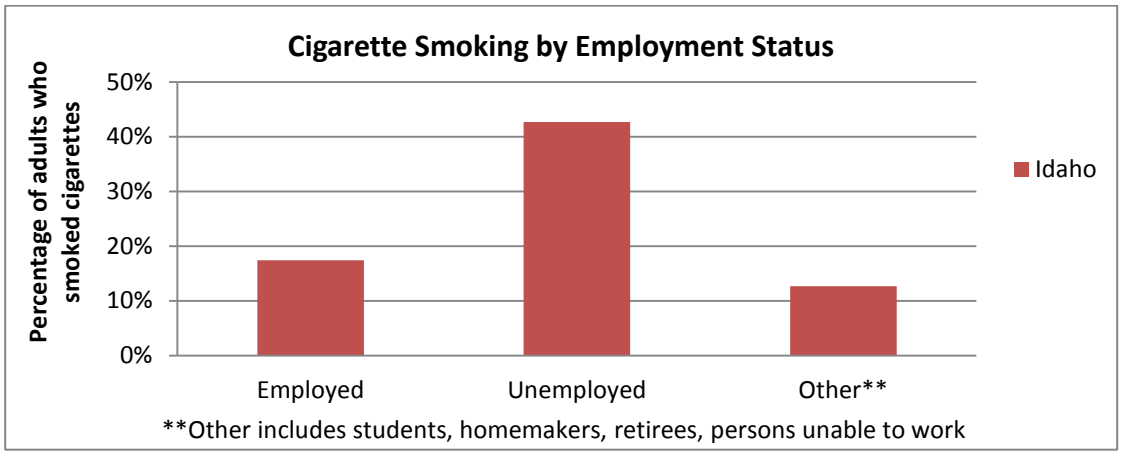
The percent of people who smoke declines significantly with higher levels of income and education as well as for those who are employed, as shown in the charts below.

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

[93] Idaho and National 2002 - 2013 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	**1**	**2**	**4**	**4**	**11**

Diet and Exercise

Unhealthy food intake and insufficient exercise have economic impacts for individuals and communities. Current 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. [94]

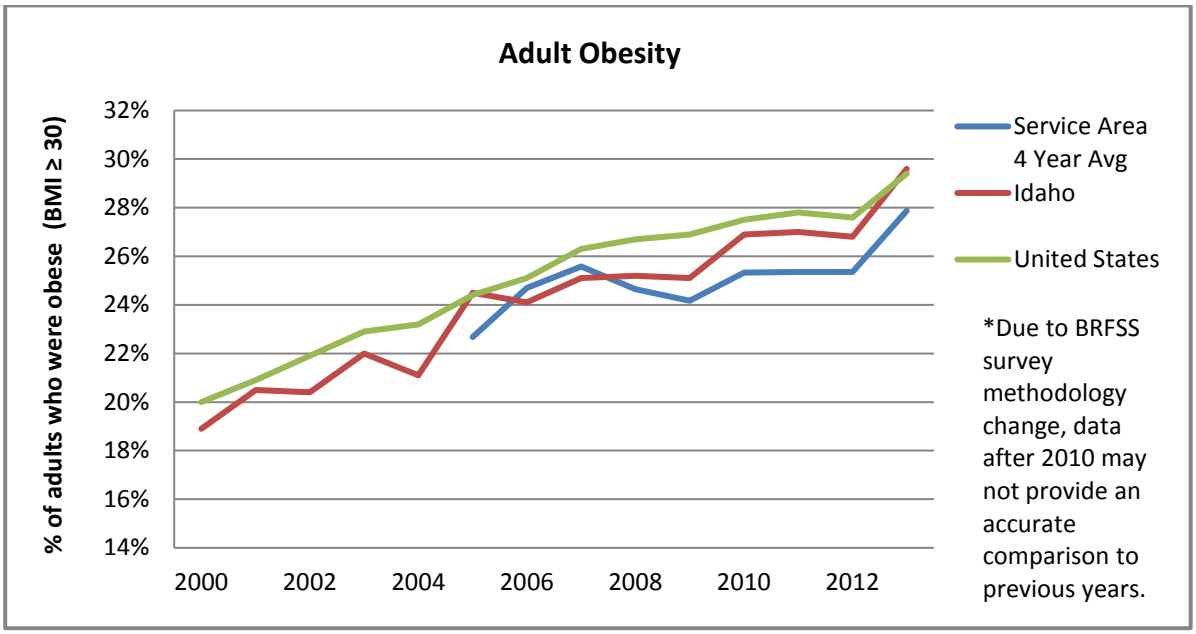
Four measures are recommended by the *County Health Rankings* to assess diet and exercise: Adult obesity, food environment index, physical inactivity, and access to exercise opportunities. Each of these measures are described in the following pages.

[94] University of Wisconsin Population Health Institute. *County Health Rankings* 2015. Accessible at www.countyhealthrankings.org.

- **Adult Obesity**

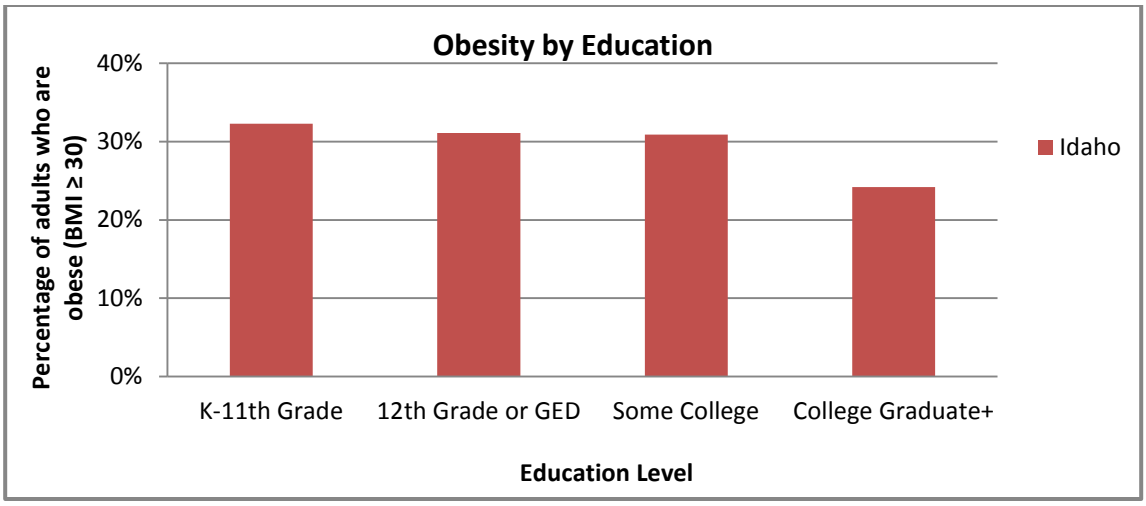
The obesity measure represents the percent of the adult population that has a body mass index greater than or equal to 30. Obesity is used as a key health factor because it is an issue that can be addressed within communities by changing unhealthy conditions that contribute to poor diet and exercise. Being overweight or obese increases the risk for a number of health conditions: Coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep apnea and respiratory problems, osteoarthritis, gynecological problems (infertility and abnormal menses), and poor health status.[95] 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. [96] By one estimate, the U.S. spent $190 billion on obesity-related health care expenses in 2005 accounting for 21% of all medical spending.[97]

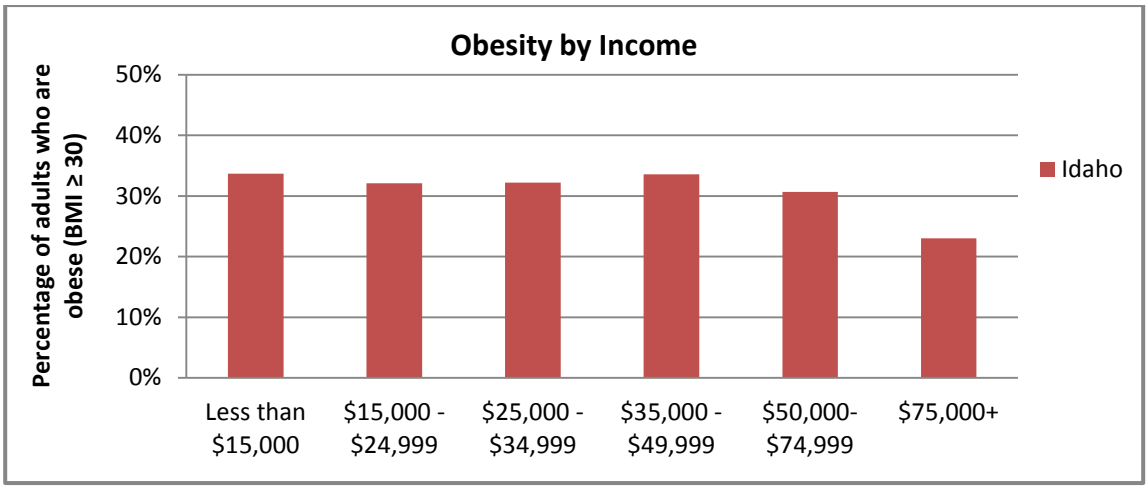
The trend for obesity has been increasing steadily for the past 10 years, nationally and in our community. Obesity in our community is now approaching the national average. The top 10th percentile (best) communities nationally have obesity rates at or below 25%.[98]

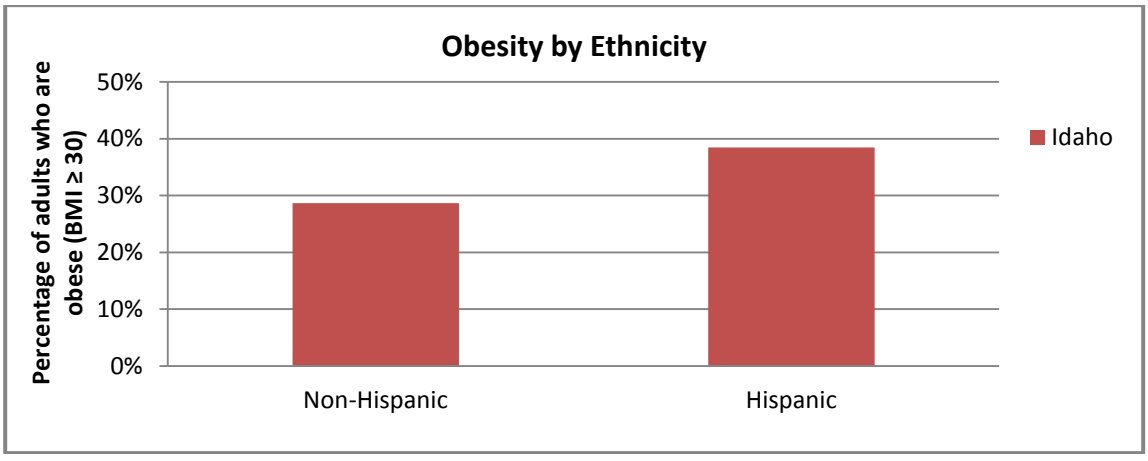


In Idaho, those without a college degree, with incomes below $75,000, and Hispanic populations are more likely to be obese. [99]

[95] University of Wisconsin Population Health Institute. *County Health Rankings* 2015. Accessible at www.countyhealthrankings.org.
[96] America's Health Rankings 2015, www.americashealthrankings.org
[97] http://www.hsph.harvard.edu/obesity-prevention-source/obesity-consequences/economic/
[98] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System
[99] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System







	Health Factor Score				
	Trend: Better/Worse	Prevalence versus U.S.	Severe/ Preventable	Magnitude: Root Cause	Total Score
Obese Adults	**4**	**2**	**4**	**4**	**14**

- **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.

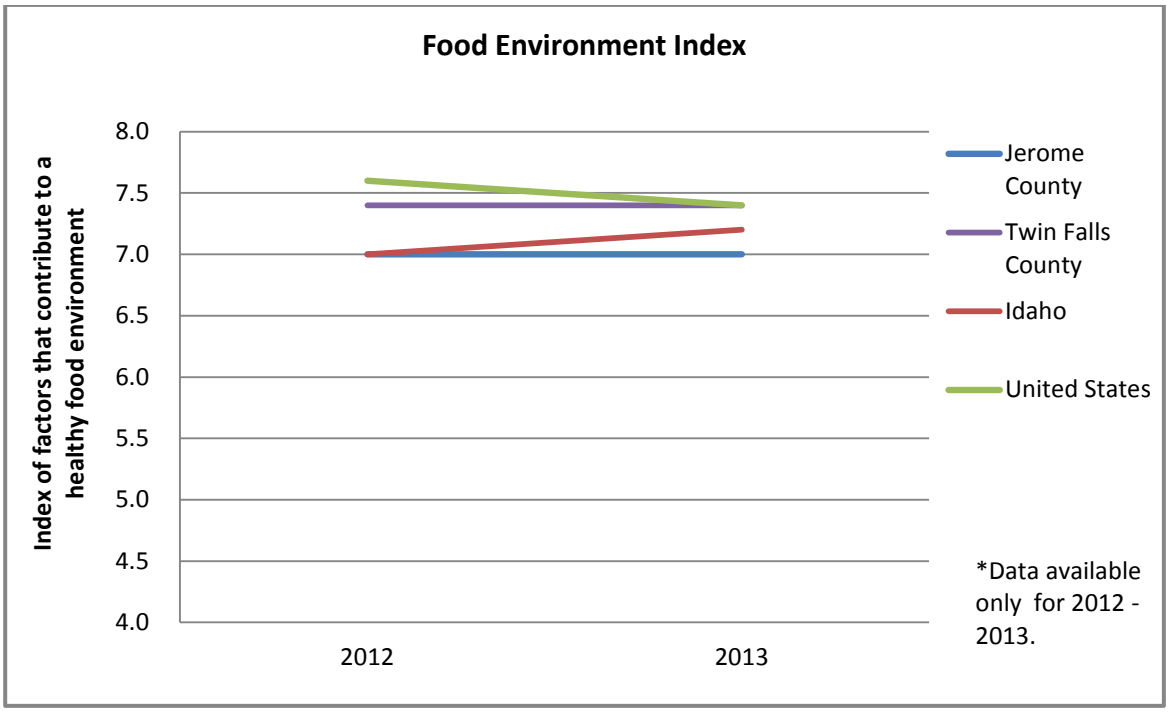
  2) Food insecurity estimates the percentage of the population who did not have access to a reliable source of food during the past year. A 2-stage fixed effect model was created using information from the Community Population Survey, Bureau of Labor Statistics, and American Community Survey.

  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.[100]

[100] University of Wisconsin Population Health Institute. *County Health Rankings* 2015. 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.

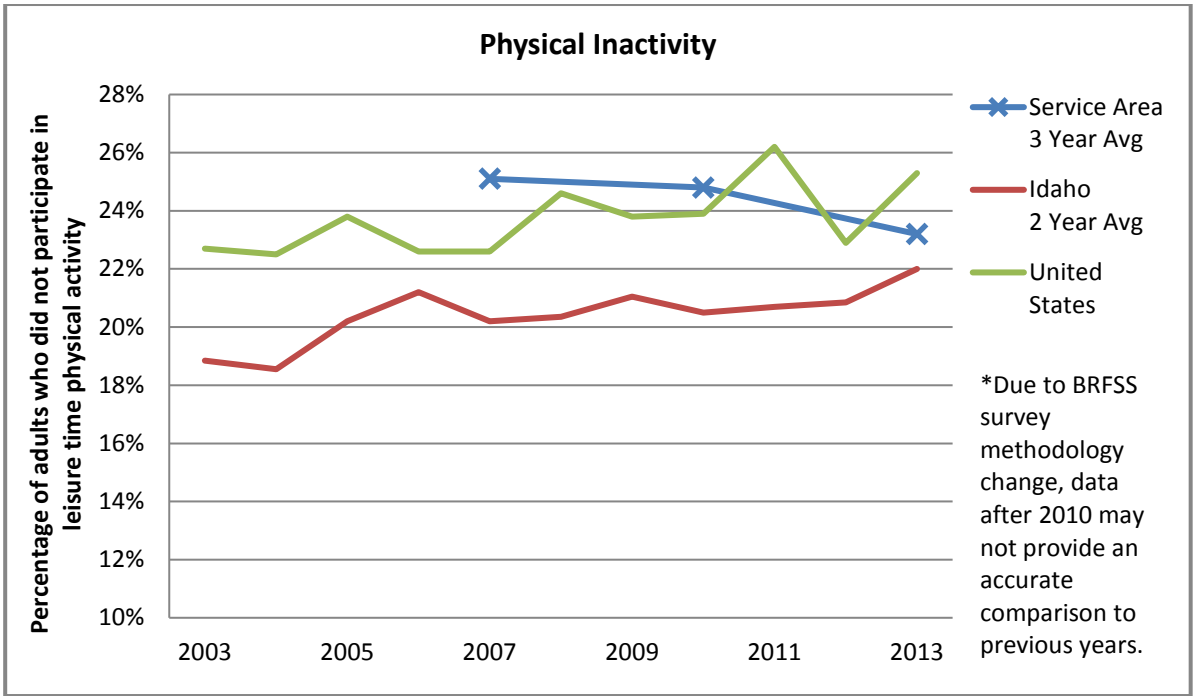


	Health Factor Score				
	Trend: Better/Worse	**Prevalence versus U.S.**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Food Environment Index	**2**	**2**	**2**	**3**	**9**

- **Physical Inactivity: Adults**

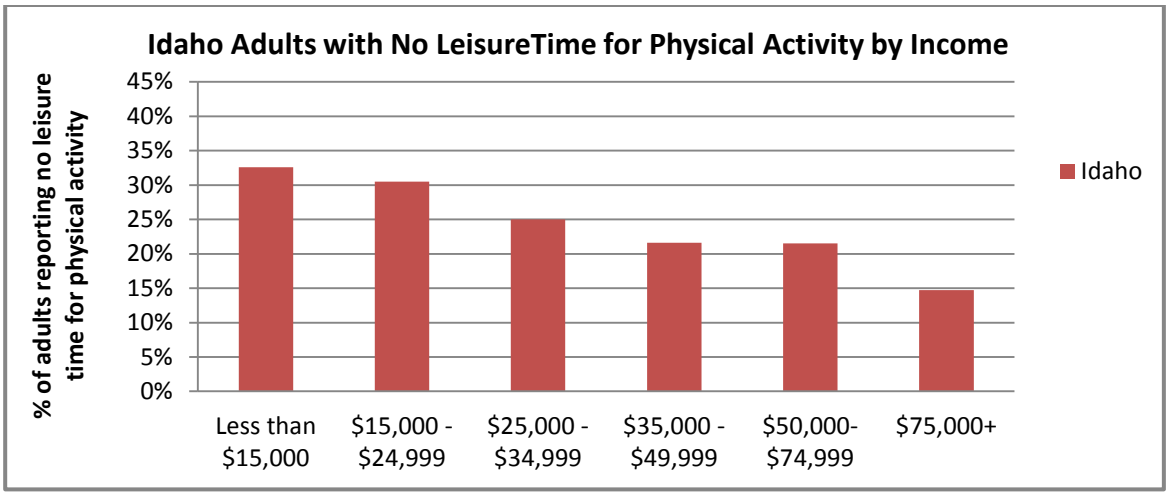
Increased physical activity is associated with lower risks of type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality. A person is considered physically inactive if during the past month, other than a regular job, they did not participate in any physical activities 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. [101]

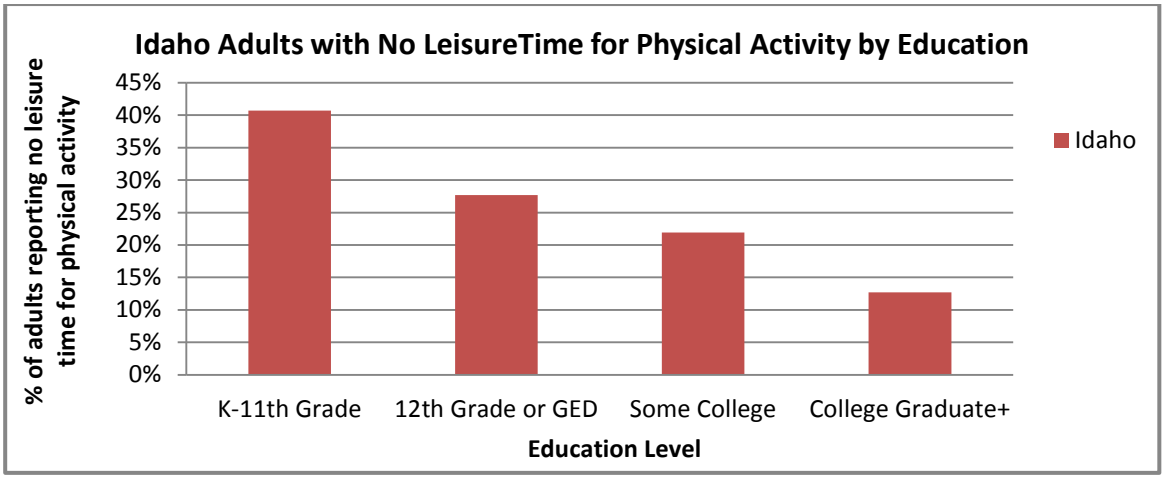
As shown in the chart below, physical inactivity in our community is about the same as the national average. The top 10th percentile (best) is 20%.[102]

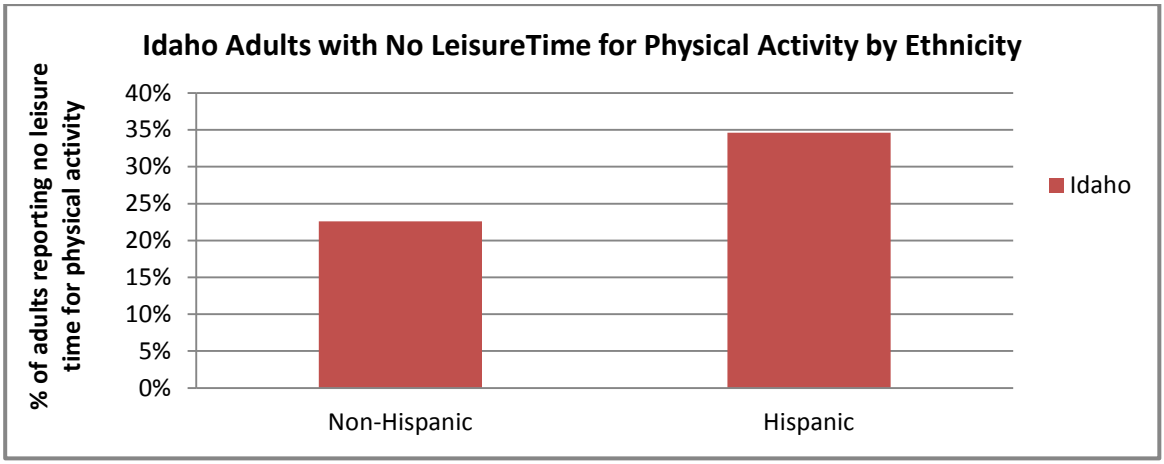


Physical inactivity is significantly higher among people with annual incomes below $50,000, those without a college degree, and among Hispanics, as shown in the charts below. [103]

[101] University of Wisconsin Population Health Institute. *County Health Rankings* 2015. Accessible at www.countyhealthrankings.org.
[102] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System
[103] Ibid.







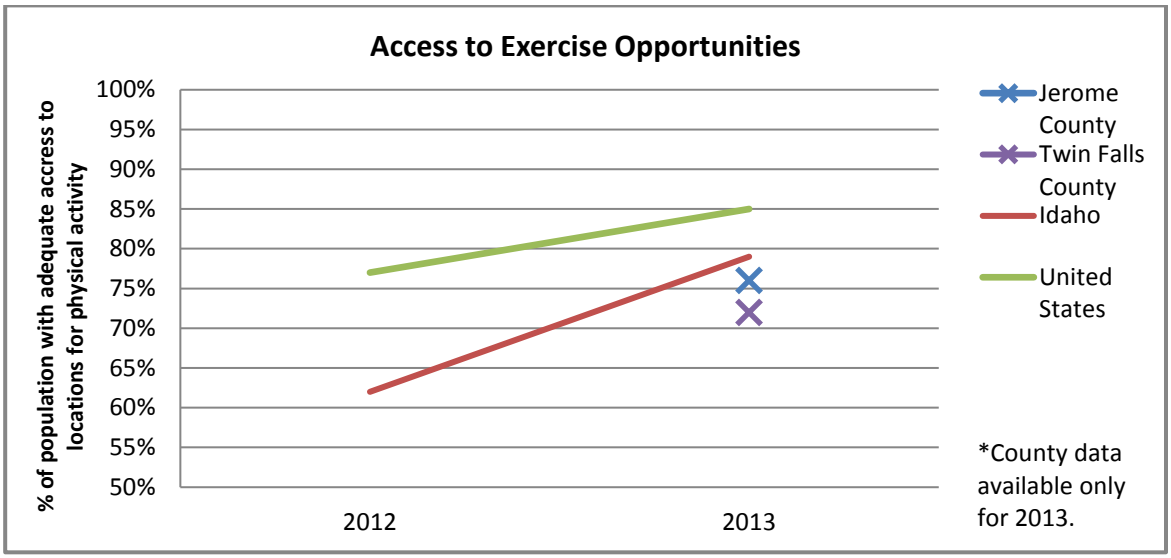
Health Factor Scoring					
	Trend: Better/Worse	Prevalence versus U.S.	Severe/ Preventable	Magnitude: Root Cause	Total Score
Physical inactivity Adults	**2**	**2**	**2**	**3**	**9**

- **Access to Exercise Opportunities**

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

This is the first national measure created which captures the many places where individuals have the opportunity to participate in physical activity outside of their homes. It is not without several limitations. First, no dataset accurately captures all the possible locations for physical activity within a county. One location for physical activity that is not included in this measure are sidewalks which serve as common locations for running or walking. Additionally, not all locations for physical activity are identified by their primary or secondary business code. [104]

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



Health Factor Scoring					
	Trend: Better/Worse	Prevalence versus U.S.	Severe/ Preventable	Magnitude: Root Cause	Total Score
Access to Exercise Opportunities	**2**	**3**	**2**	**3**	**9**

[104] University of Wisconsin Population Health Institute. *County Health Rankings* 2015. Accessible at www.countyhealthrankings.org.

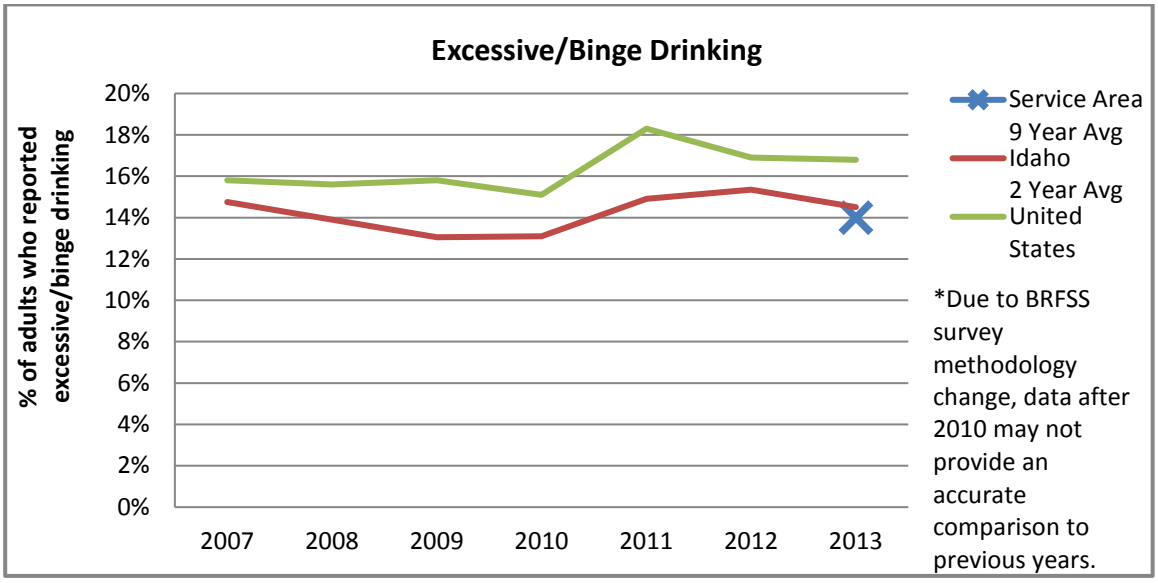
Alcohol Use

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.[105]

  The percent of people engaging in excessive drinking in our service area is below the national average. The top 10th percentile (best) is 10% nationally. Our community is well above that level.[106]



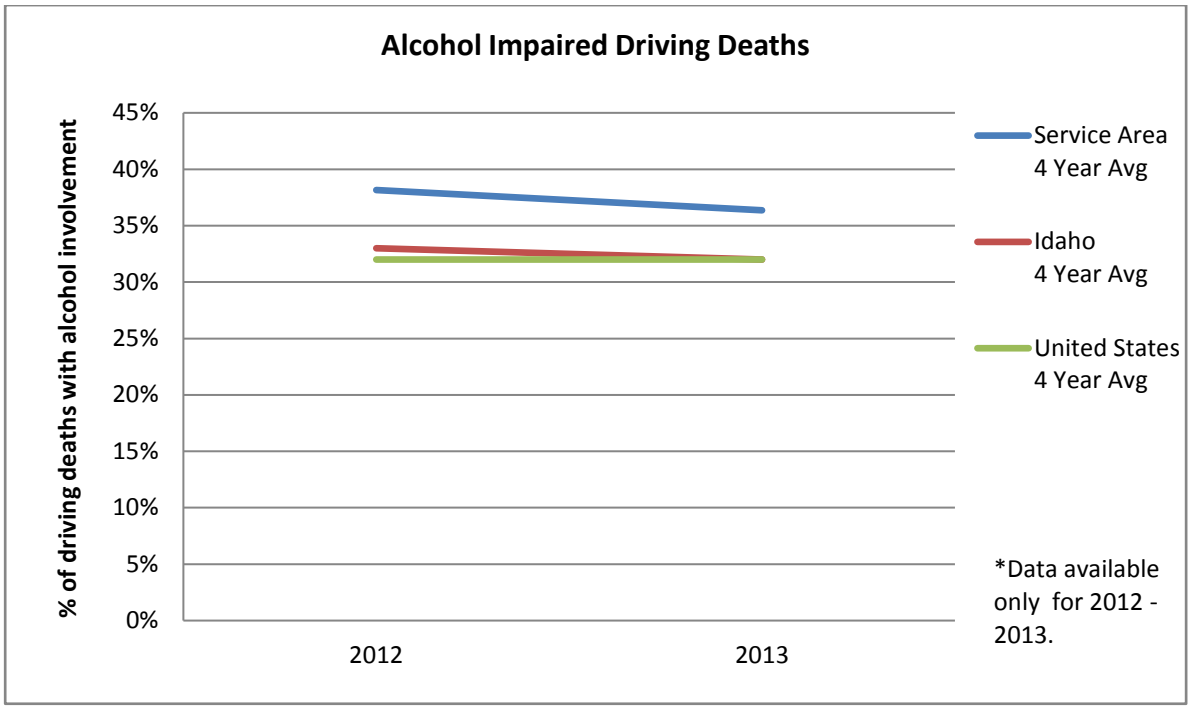
Health Factor Scoring					
	Trend: Better/Worse	Prevalence versus U.S.	Severe/ Preventable	Magnitude: Root Cause	Total Score
Excessive Drinking	**2**	**1**	**3**	**2**	**8**

[105] University of Wisconsin Population Health Institute. *County Health Rankings* 2012-2015. Accessible at www.countyhealthrankings.org.

[106] Idaho and National 2002 - 2013 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 above the national level. The top 10th percentile (best) is 14% nationally.[107]



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**	**2**	**4**	**1**	**9**

[107] Idaho Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2013

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**

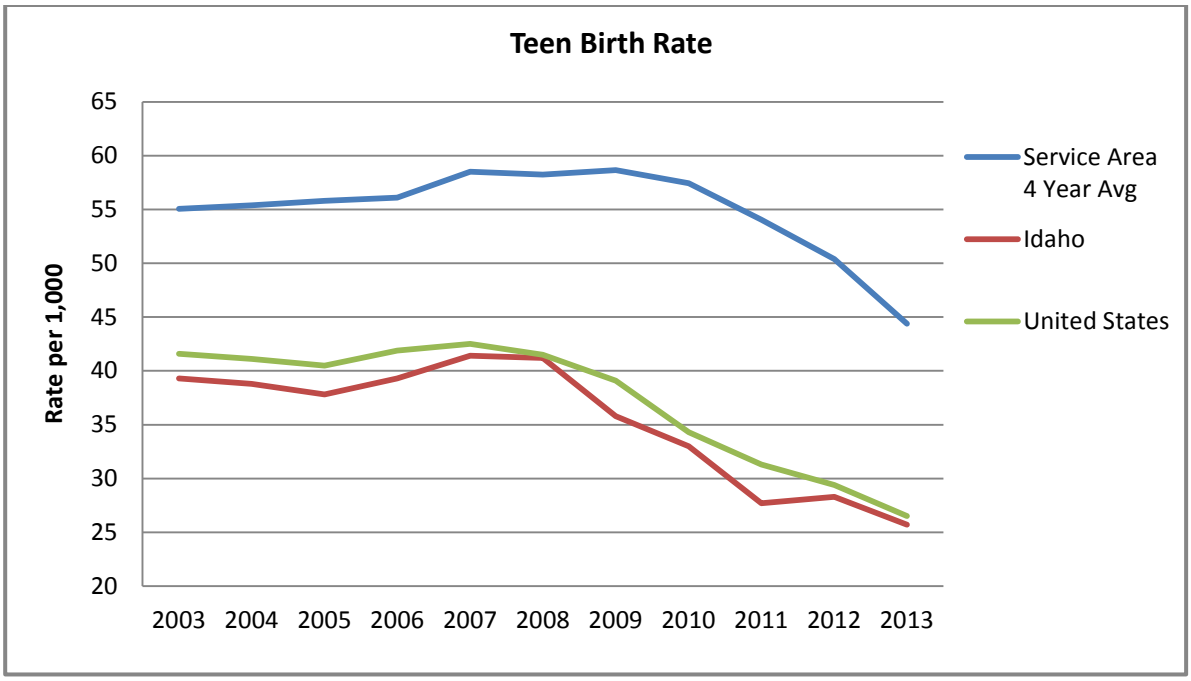
  Evidence suggests teen pregnancy significantly increases the risks for repeat pregnancy and for contracting a sexually transmitted infection (STI), both of which can result in adverse health outcomes for mother and child as well as for the families and community. A systematic review of the sexual risk 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.[108]

  Although our rate of teen pregnancy is decreasing, it is significantly above the national average. The national top 10th percentile rate is 19.5.[109]

[108] University of Wisconsin Population Health Institute. *County Health Rankings* 2015. Accessible at www.countyhealthrankings.org.

[109] Idaho Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2013

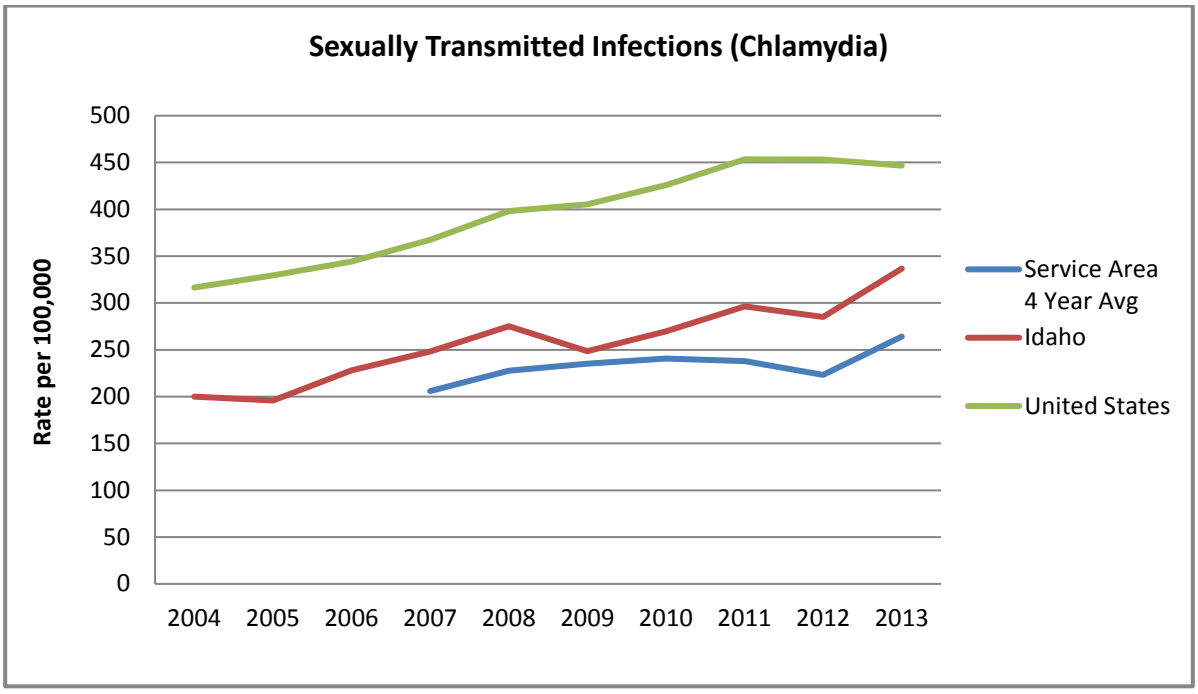


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Teen birth rate	**1**	**4**	**2**	**3**	**10**

- **Sexually Transmitted Infections**

Sexually transmitted infections (STI) data are important for communities because the burden of STIs is not only on individual sufferers, but on society as a whole. Chlamydia, in particular, is the most common bacterial STI in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain. Additionally, STIs in general are associated with significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, pelvic inflammatory disease, involuntary infertility, and premature death.[110]

The rate of chlamydia infections has increased over the past ten years both in our community and nationally. Although our community is below the national average, we are still above the national top 10th percentile rate of 138.2.[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**
Sexually Transmitted Infections	**2**	**1**	**3**	**3**	**9**

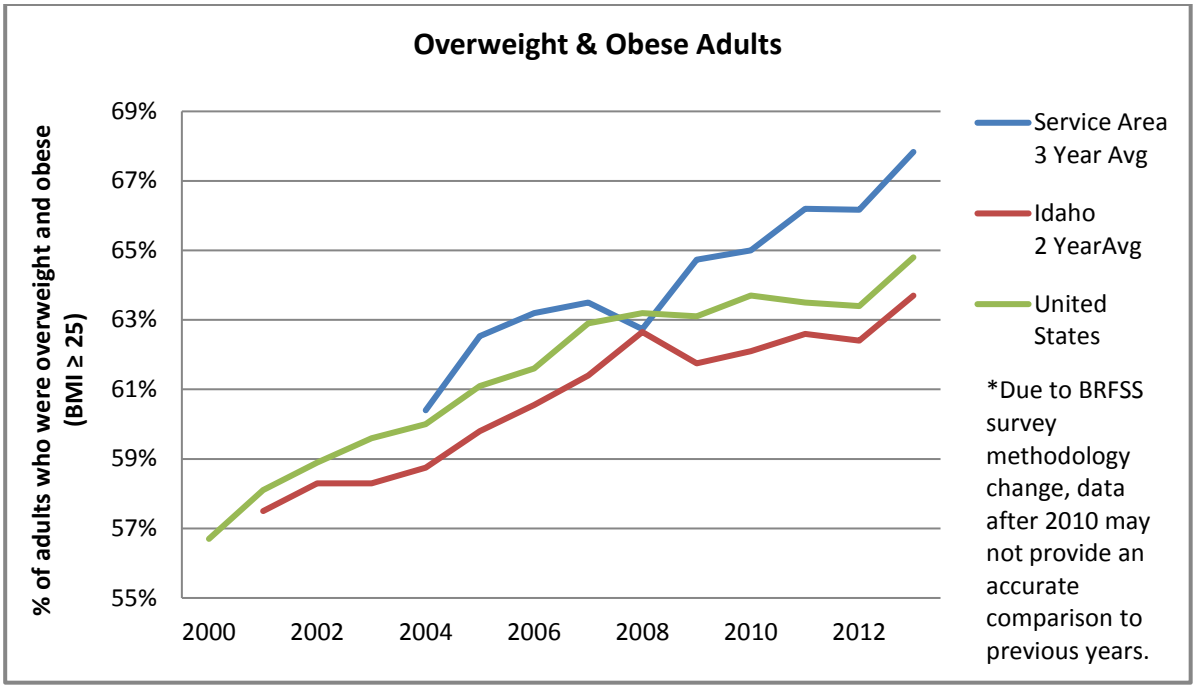
[110] *County Health Rankings* 2015. Accessible at www.countyhealthrankings.org.
[111] National data source: 2015 Sexually Transmitted Diseases Surveillance, table 1 http://www.cdc.gov/std/. Idaho and Service Area Source: Idaho Reported Sexually Transmitted Disease, 2004-2012 http://www.healthandwelfare.idaho.gov/Portals/0/Health/Disease/STD%20HIV/2010_Facts_Boo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

Additional Health Behavior Factors

- **Overweight and Obese Adults**

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

The trend for overweight and obese adults has been increasing steadily for the past 10 years, nationally and in our community.[112]



Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Overweight or Obese Adults	**4**	**3**	**4**	**4**	**15**

[112] Idaho and National 2002 - 2010 Behavioral Risk Factor Surveillance System

- **Overweight and Obese Teens**

  We included the percentage of obese and overweight teenagers in our community to ensure an understanding of youth health behavior risks. People who were already overweight in adolescence (14-19 years old) have an increased mortality rate from a range of chronic diseases as adults: endocrine, nutritional and metabolic diseases, cardiovascular diseases, colon cancer, and respiratory diseases. There were also many cases of sudden death in this group.[113] Overweight children and adolescents:

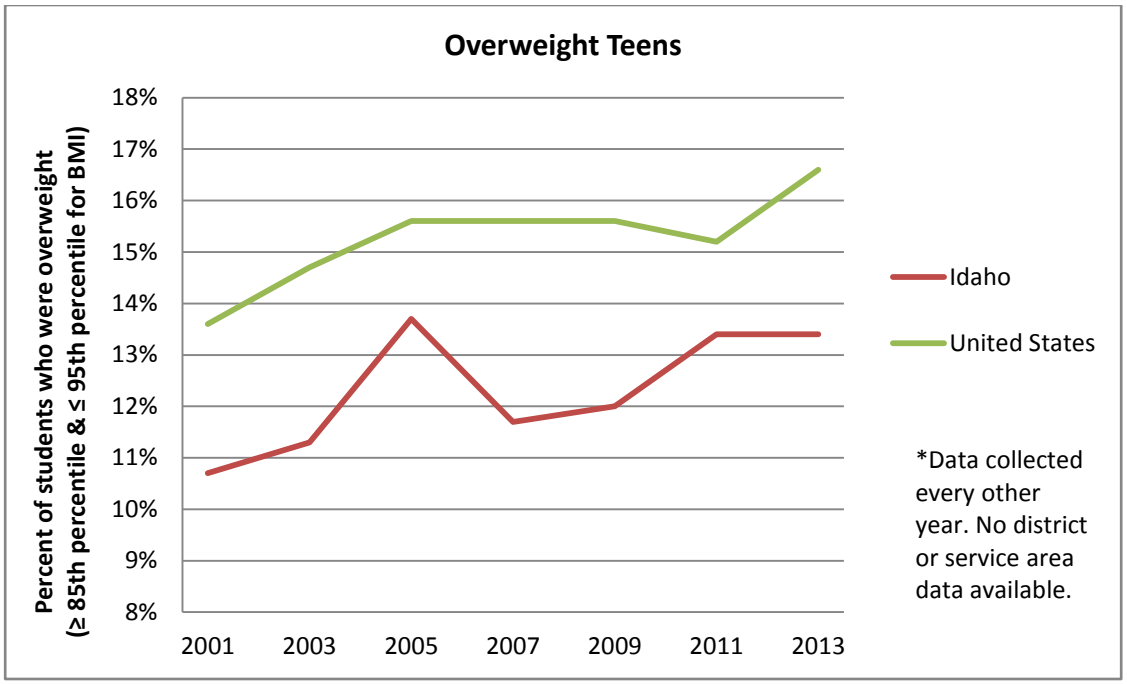
  - Are more likely than other children and adolescents to have risk factors associated with cardiovascular disease (e.g., high blood pressure, high cholesterol and type 2 diabetes).
  - Are more likely to be obese as adults.
  - Are more likely to experience other health conditions associated with increased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

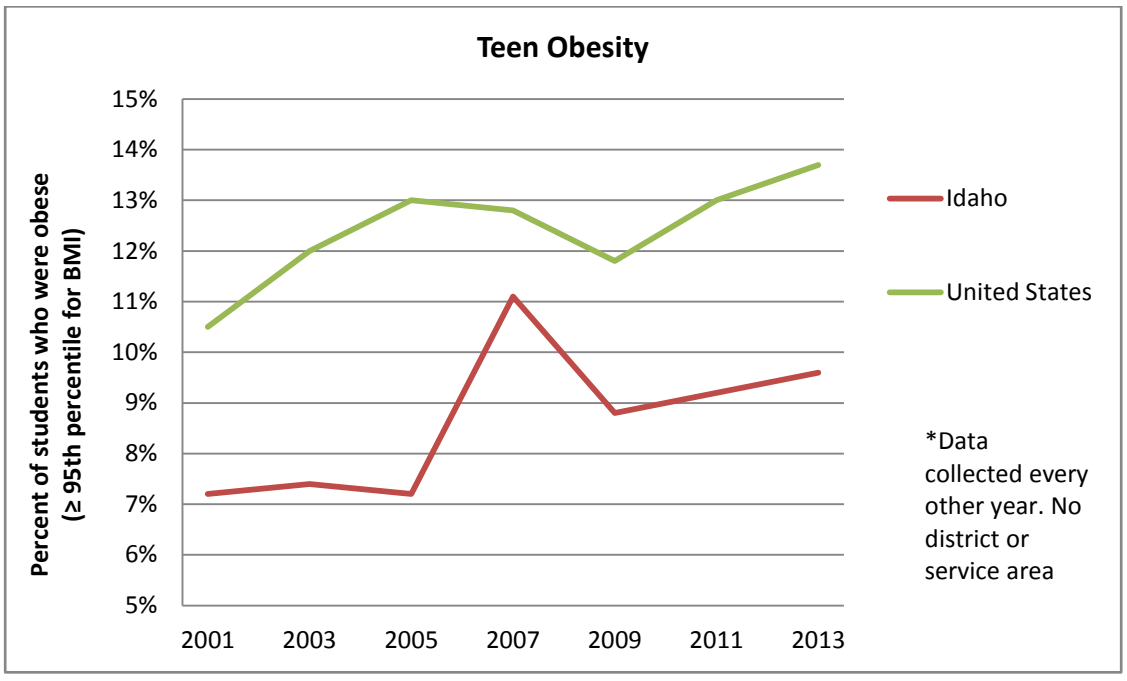
  Some methods of preventing and treating overweight children are:

  - 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.[114]

  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.[115]

[113] Overweight In Adolescence Gives Increased Mortality Rate, ScienceDaily (May 20, 2008)
[114] American Heart Association, Understanding Childhood Obesity, 2011 Statistical Sourcebook, PDF
[115] Youth Risk Behavior Surveillance , United States, 2001 – 2013, www.cdc.gov/yrbs/



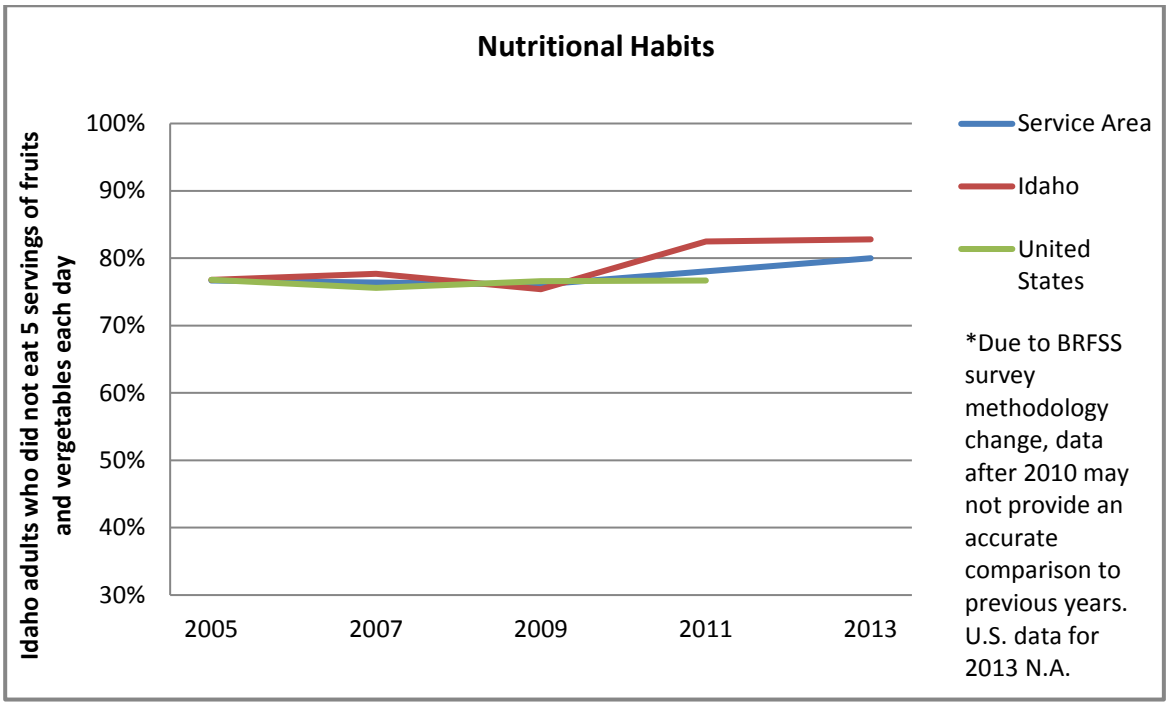


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Obese Teens	**4**	**1**	**4**	**4**	**13**

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

As shown in the chart below, about 80% of the people in our service area did not eat the recommended amounts of fruits and vegetables. The national average was about 77%. The trend appears to have changed marginally in recent years, but that may be due to a change in the BRFSS survey methodology starting in 2011. There are no large differences in nutritional habits based on income or education.[117]

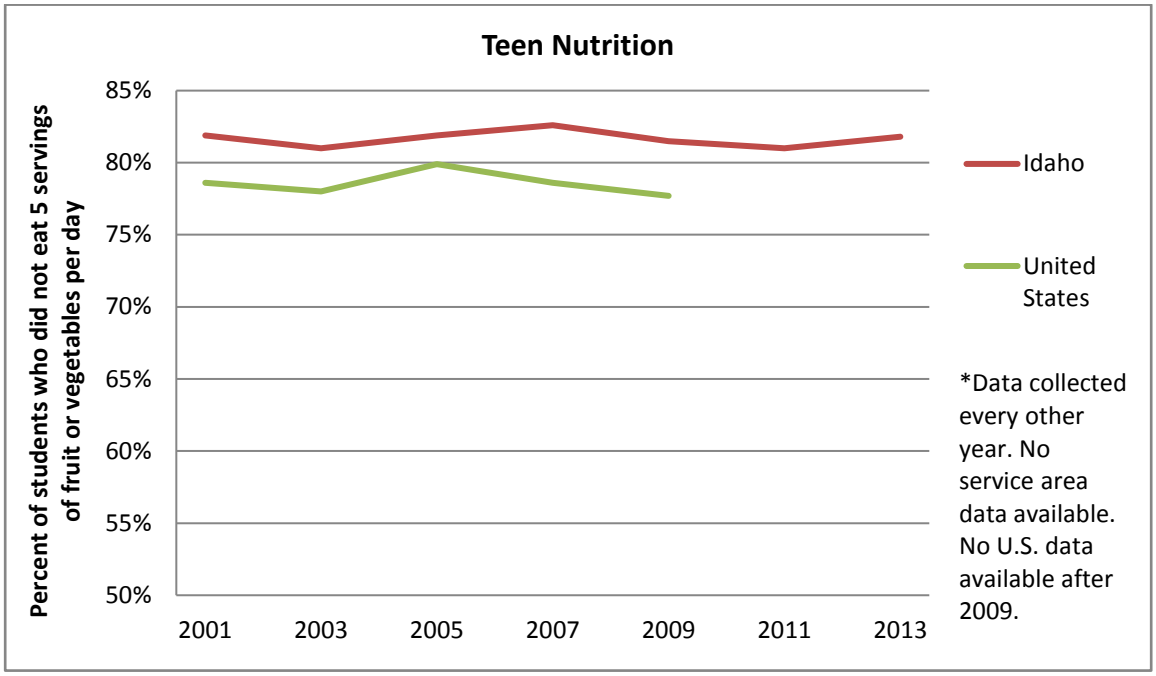


Health Factor Scoring					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Nutritional habits adults	**2**	**2**	**2**	**3**	**9**

[116] America's Health Rankings 2011-2015, www.americashealthrankings.org
[117] Idaho and National 2002 – 2013 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. This is slightly worse than the national average and has been relatively flat for the past 10 years.[118]



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**	**3**	**2**	**3**	**10**

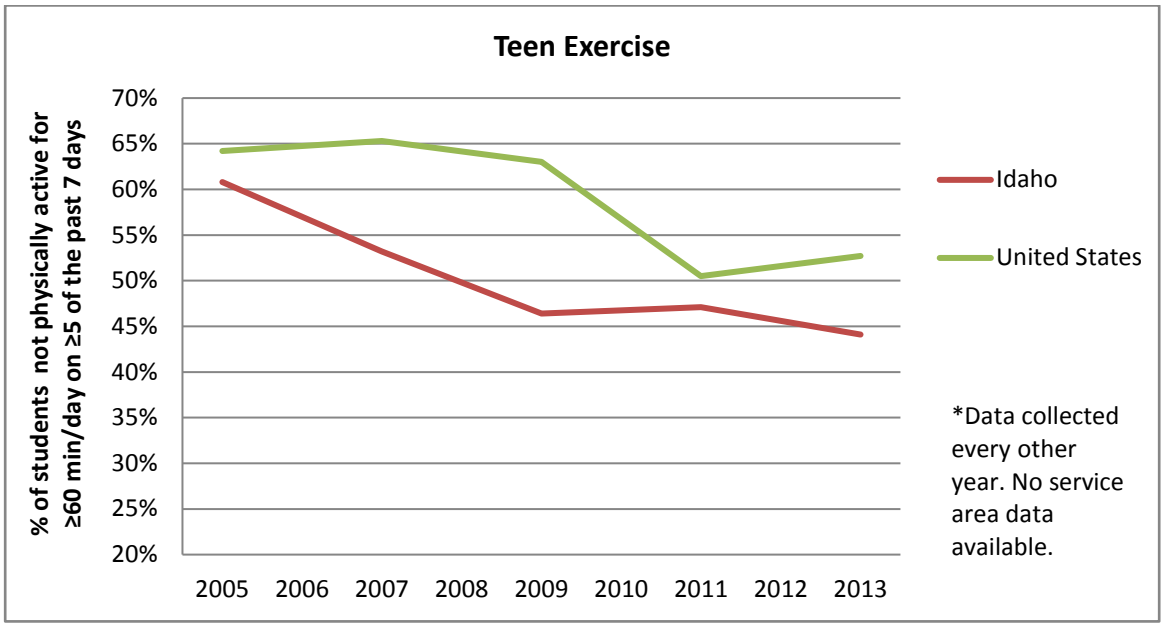
[118] Youth Risk Behavior Surveillance ,Idaho and United States, 2001 – 2013, www.cdc.gov/yrbs/

- **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.[119]

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.[120]

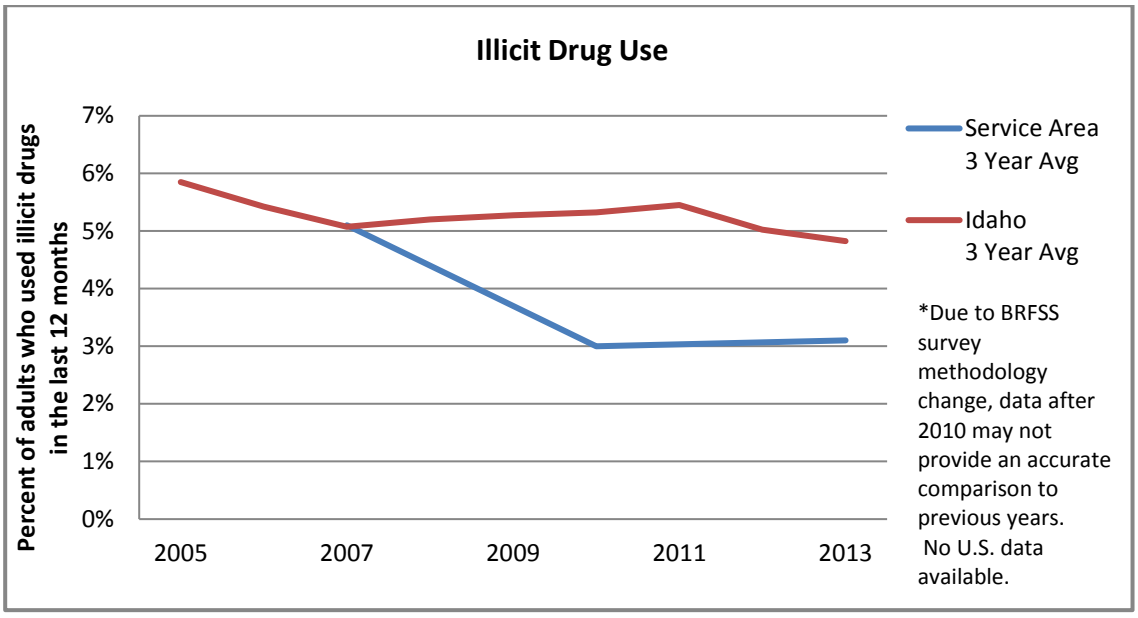


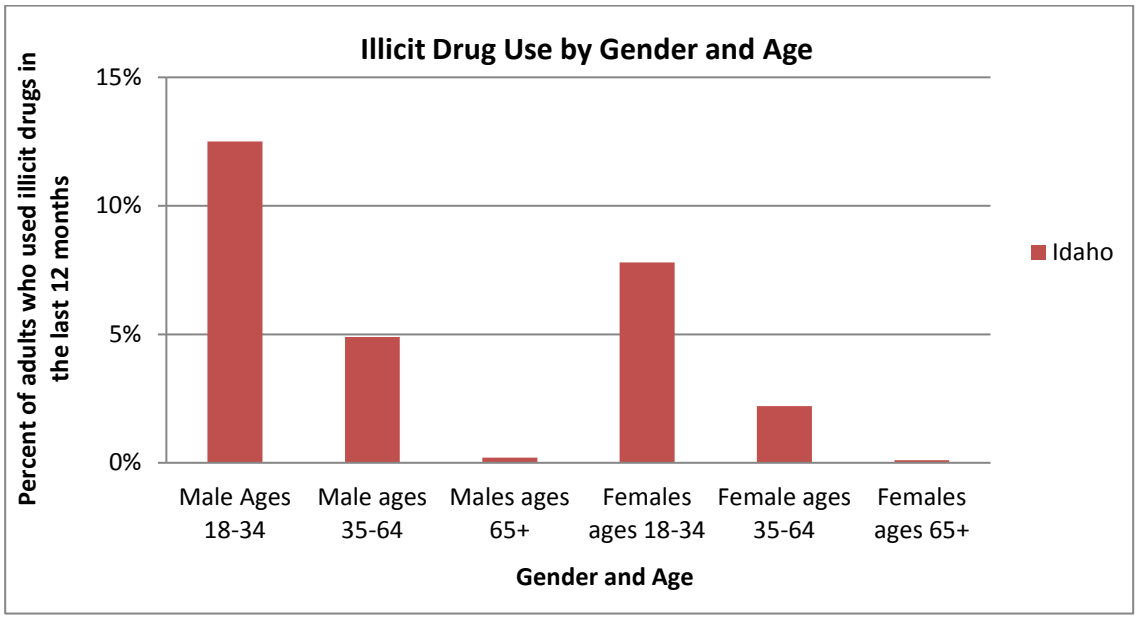
Health Factor Score Low score = Low potential for health impact — High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Teen exercise	**2**	**1**	**2**	**4**	**9**

[119] American Heart Association, Understanding Childhood Obesity, 2011 Statistical Sourcebook, PDF
[120] Youth Risk Behavior Surveillance , United States, 2001 – 2013, www.cdc.gov/yrbs/

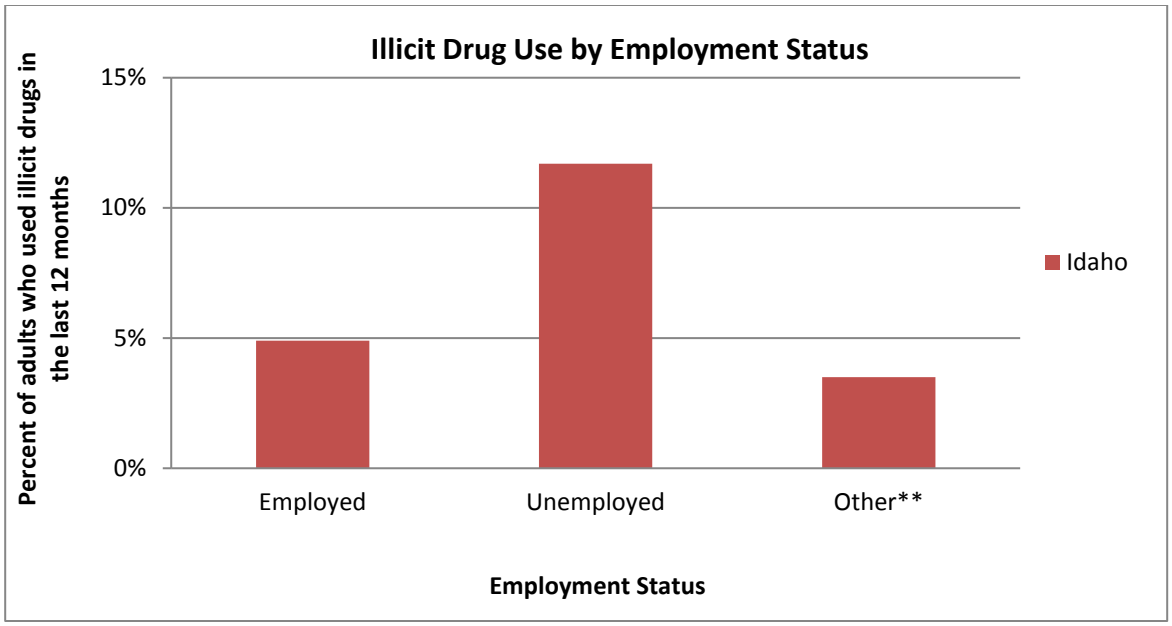
- **Illicit Drug Use**

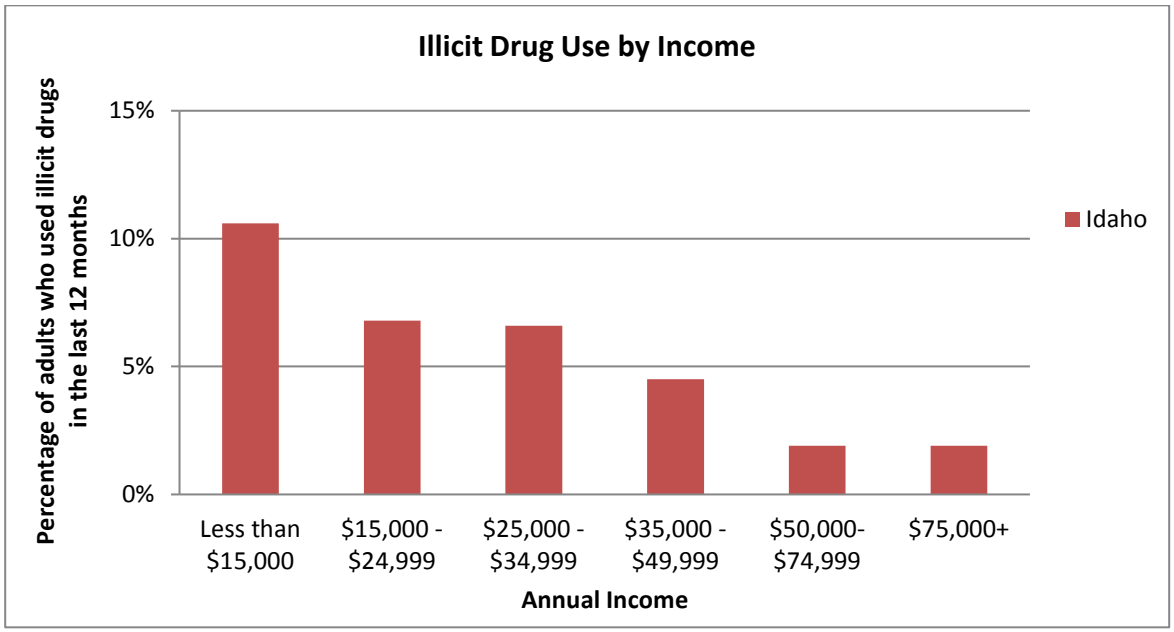
The use of illicit drugs has harmful and sometimes devastating effects on individuals, families, and society.[121] The percent of people who reported using illicit drugs in our service area is about the same as in Idaho. Illicit drug use is significantly higher among males less than 34 years old, the unemployed, and those with incomes of less than $50,000 annually.[122]





[121] www.samhsa.gov/newsroom/advisories/1109075503.aspx
[122] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System



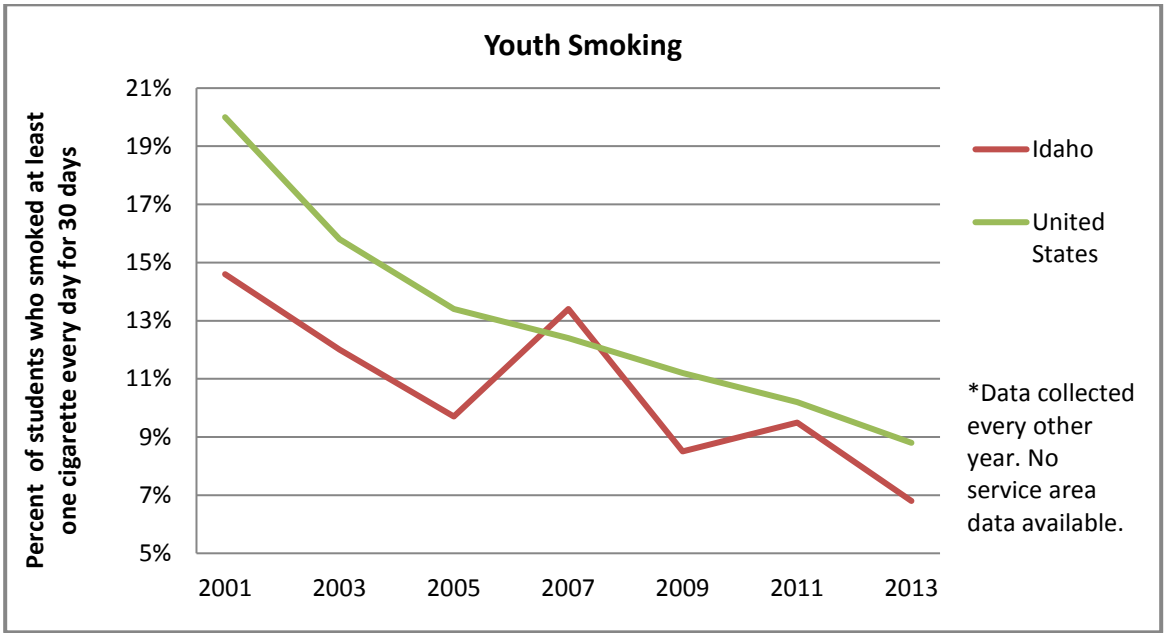


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Illicit drug use	**1**	**2**	**4**	**3**	**10**

- **Youth Smoking**

In 2013, approximately 6.8 percent of Idaho Youth reported smoking at least one cigarette every day for 30 days. This is well below the national rate of 8.8%. During 1997–2013, a significant linear decrease occurred overall in the prevalence of current tobacco use among Idaho and our nation's youth. However, the progress has been slowing over the past ten years.[123]

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. [124]



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	**1**	**1**	**4**	**4**	**10**

[123] Idaho and Nation Youth Risk Behavior Surveillance 2001 -2013

[124] http://www.surgeongeneral.gov/library/reports/preventing-youth-tobacco-use/factsheet.html

Clinical Care Factors

County Health Rankings Clinical Care Factors

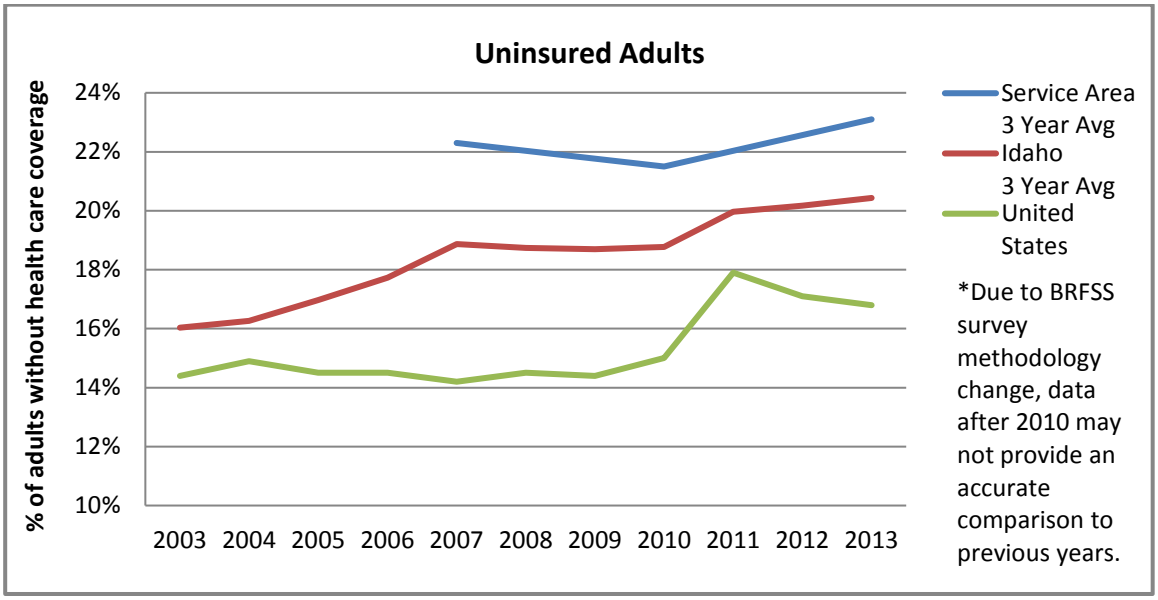
Health Care Access

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.[125]

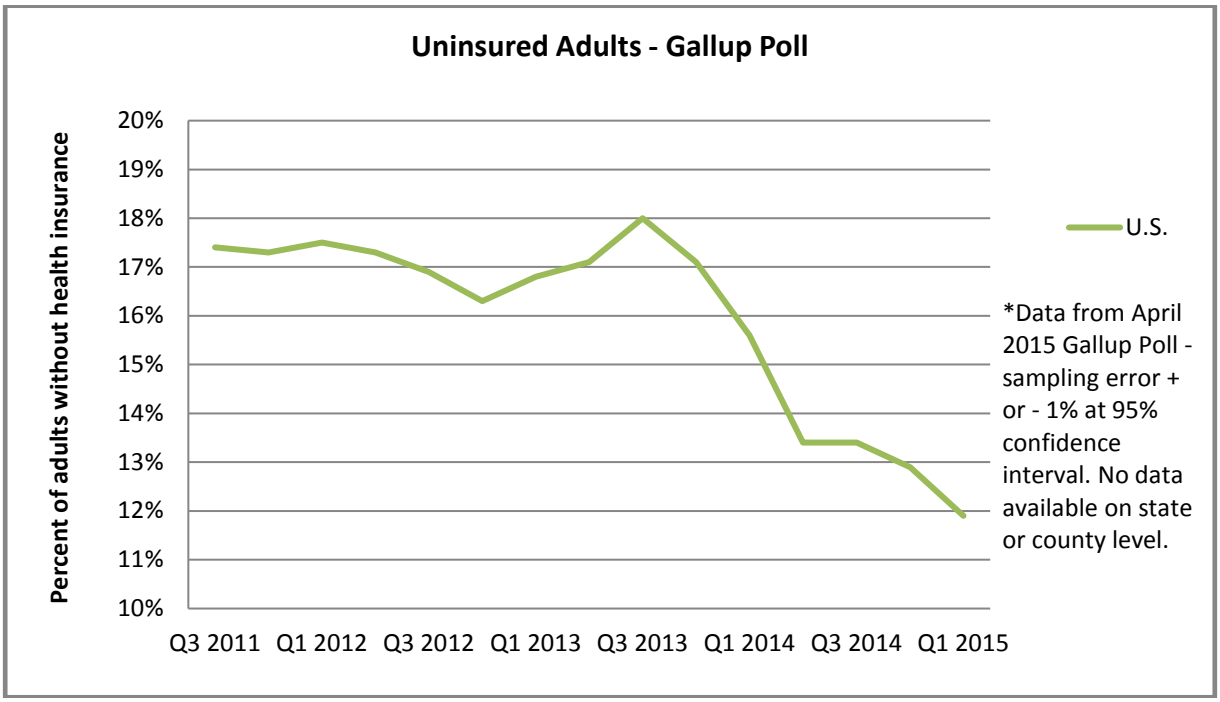
  The chart below shows the number of adults without health care coverage has been trending up for the past ten years nationally and in our service area. The percentage of uninsured in Idaho and our service area is higher than the national average.[126]



[125] University of Wisconsin Population Health Institute. *County Health Rankings* 2010-2015. Accessible at www.countyhealthrankings.org.

[126] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System

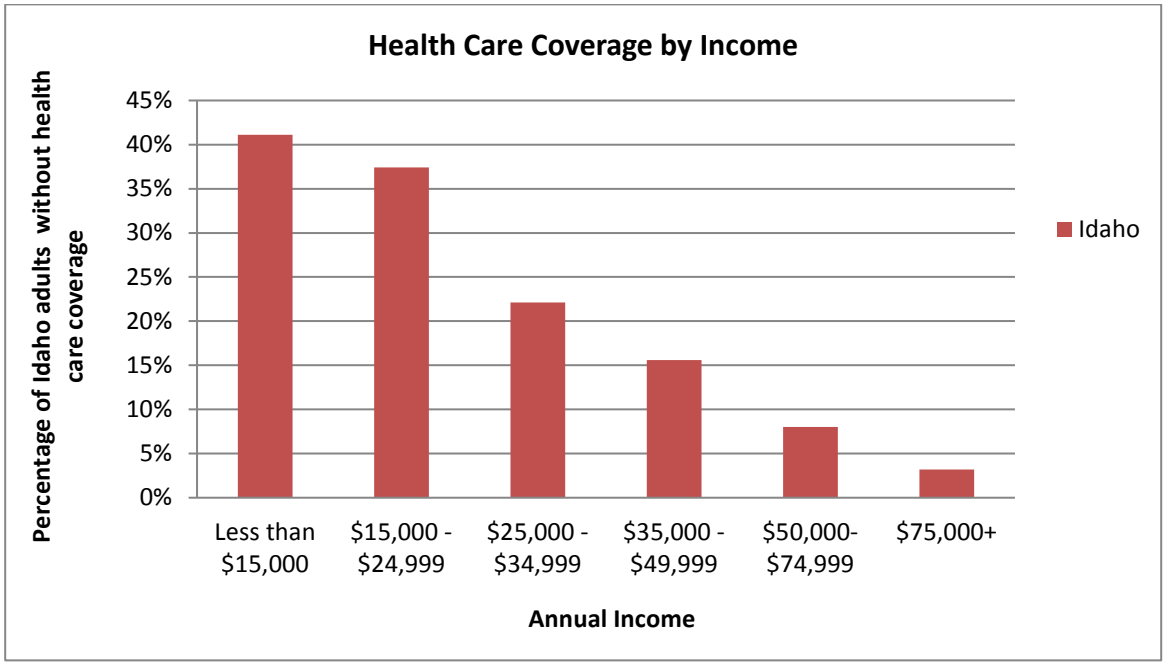
A Gallup Poll administered quarterly provides more recent data on uninsured adults. The graph below shows that on a national basis the 2010 Affordable Care Act (ACA) dramatically lowered the percentage of uninsured adults starting in 2014. One of the major provisions of the ACA is the expansion of Medicaid eligibility to nearly all low-income individuals with incomes at or below 138 percent of poverty. However, as of March 2015, 22 states had not expanded 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.[127] As of June 2015, Idaho is one of the states that opted not to expand Medicaid. Consequently, many adults in Idaho fall into a "coverage gap."

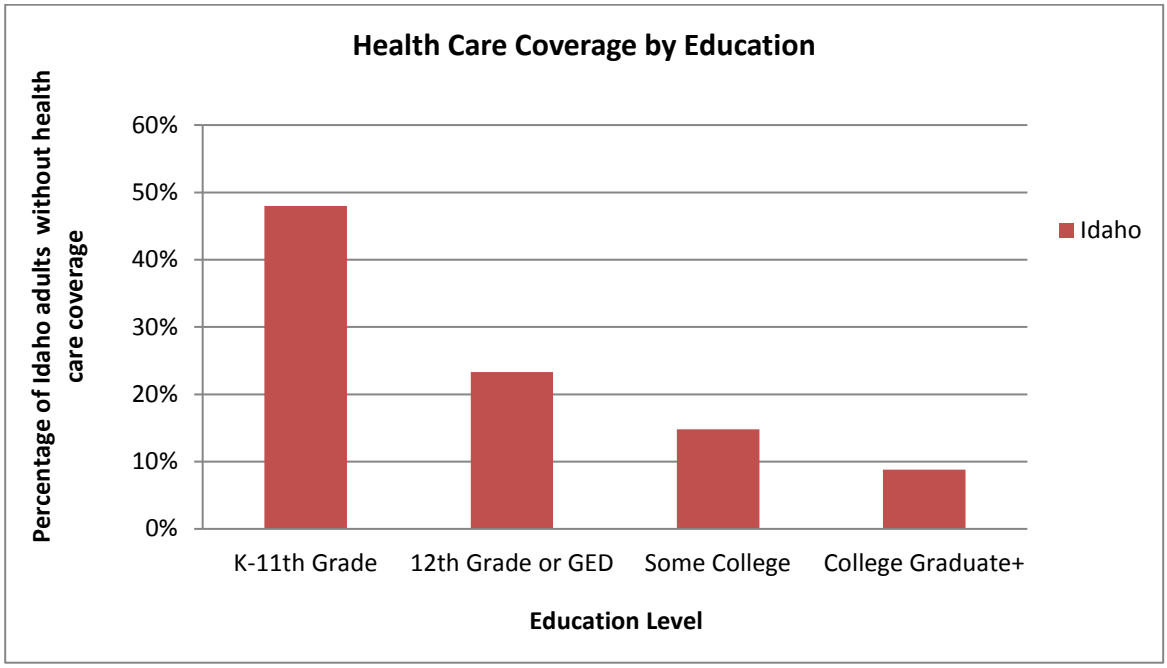


The goal of the ACA is to improve health outcomes and eventually lower health care costs through insuring a greater proportion of the population. *24/7 Wall St*. conducted a study showing the percentage point decline in uninsured rates for each state from 2012 through 2015. In Idaho, the percent of uninsured people declined 6.6 percentage points, which is a larger improvement than the nation as a whole. The percentage of all Americans without health insurance declined 5.7 percentage points.[128]

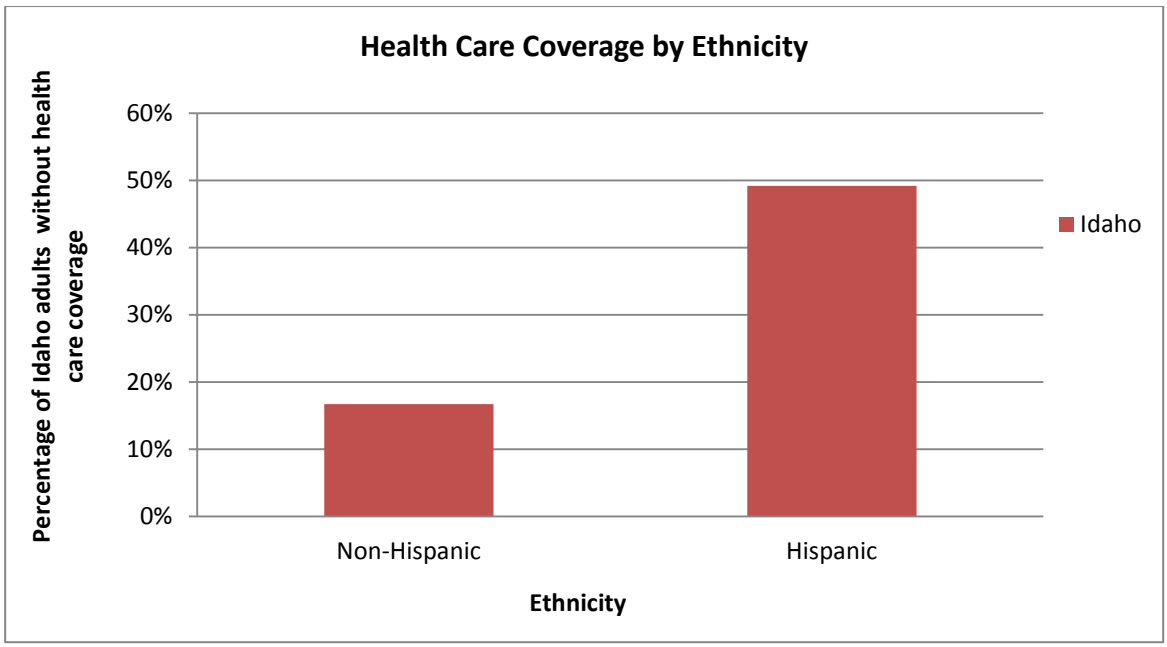
[127] The Coverage Gap: Uninsured Poor Adults in States the do not Expand Medicaid, April 2015, The Kaiser Commission on Medicaid and the Uninsured, Rachel Garfield
[128] 24/7 Wallst.com

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. [129]





[129] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System

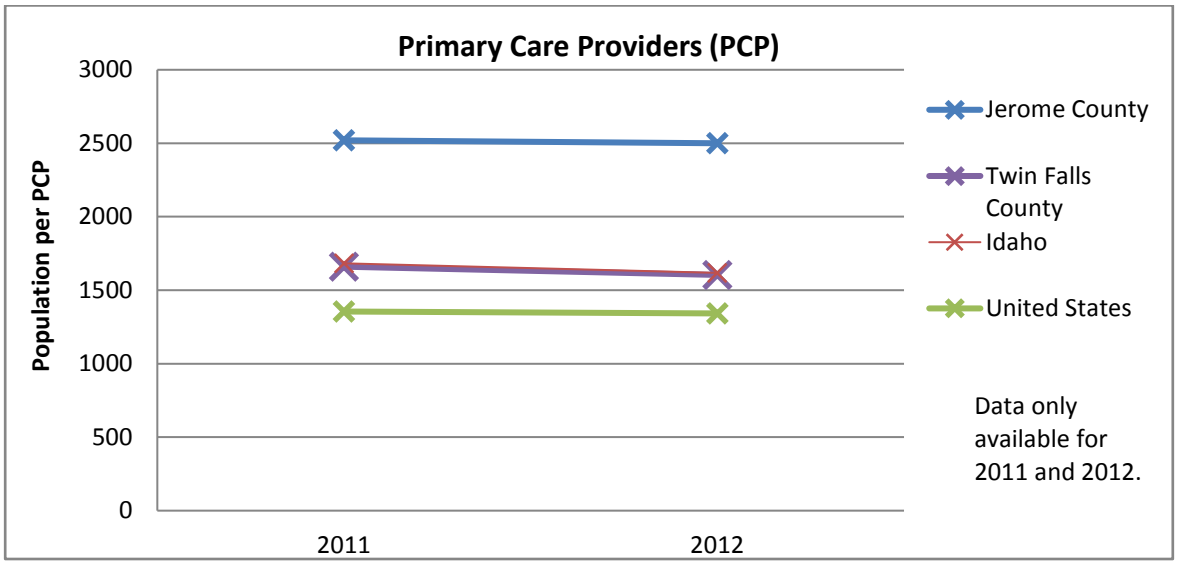


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Uninsured adults	**1**	**4**	**4**	**3**	**12**

- **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%.[130]

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



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

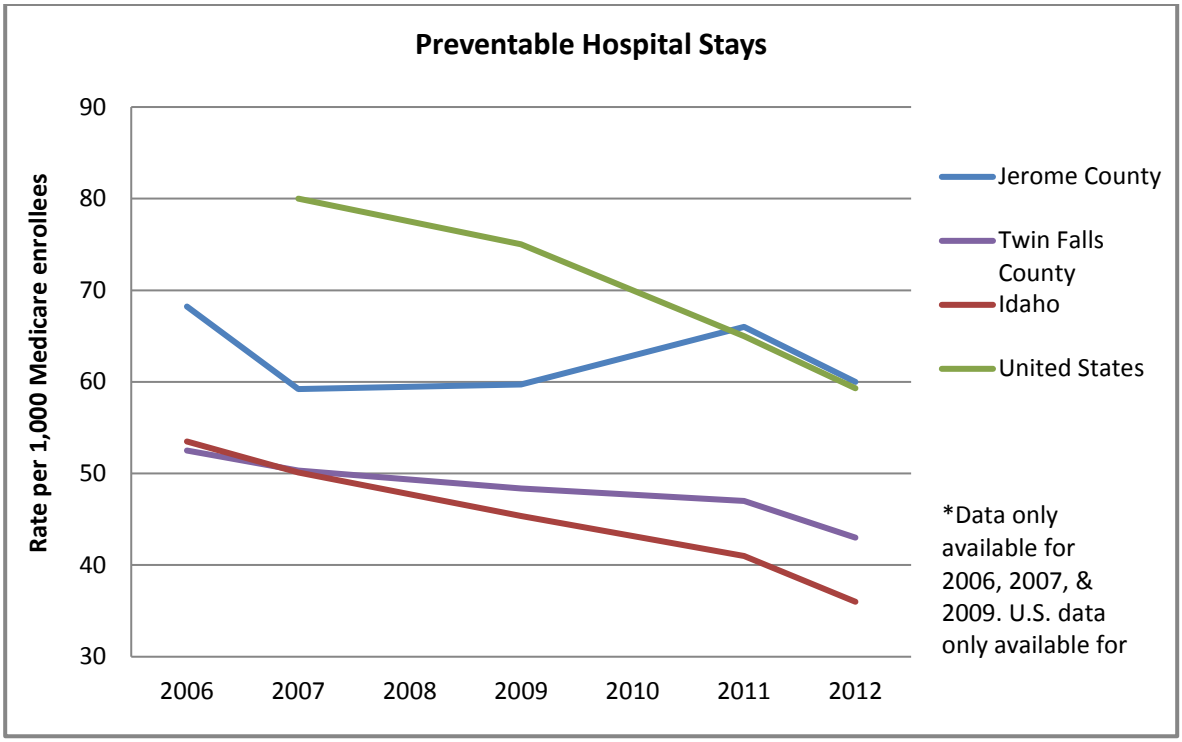
[130] University of Wisconsin Population Health Institute. *County Health Rankings* 2015. Accessible at www.countyhealthrankings.org.

Health Care Quality

- **Preventable Hospital Stays**

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

The rate of preventable hospital stays for our service area is the same as the national average for Jerome County and much better than the national average in Twin Falls County. The national top 10th percentile (top 10th percentile rate is 41.2). [131]



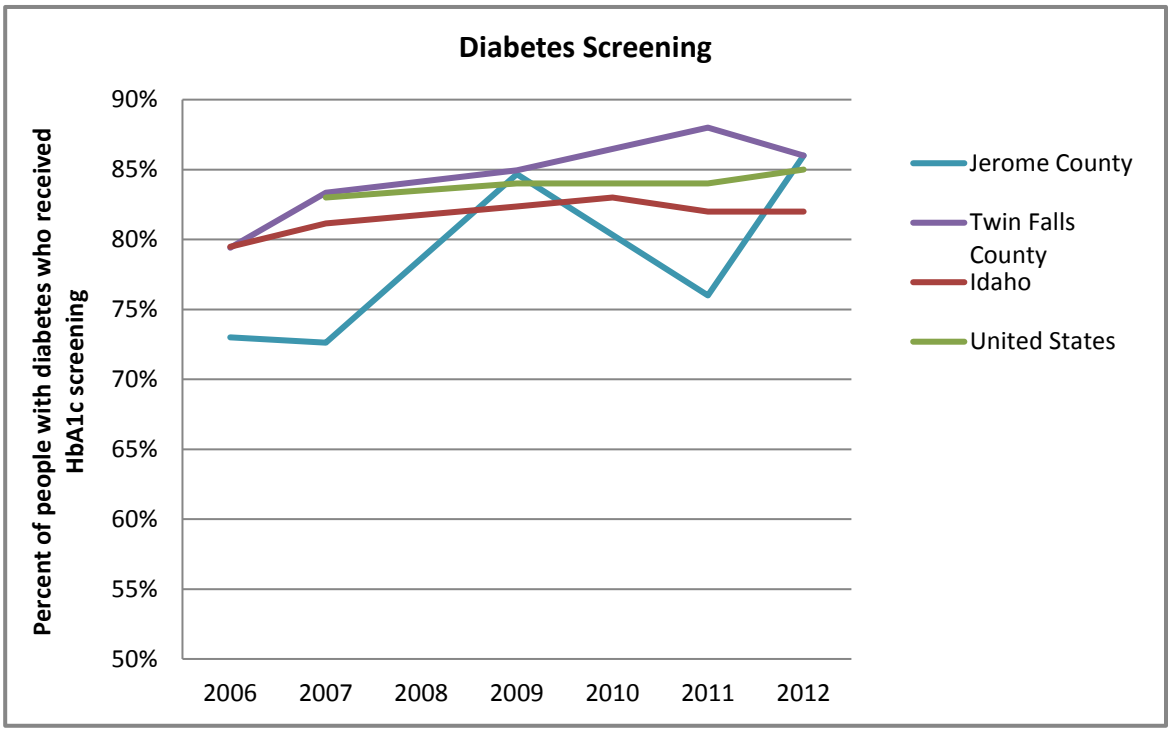
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S.	Severe/ Preventable	Magnitude: Root Cause	Total Score
Preventable Hospital Stays	**2**	**1**	**2**	**4**	**9**

[131] 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.[132]

The chart shows the trend for diabetes screening is improving slightly nationally and in our service area. The percent of people receiving A1c screening is about the same in our service area as in the nation.[133]



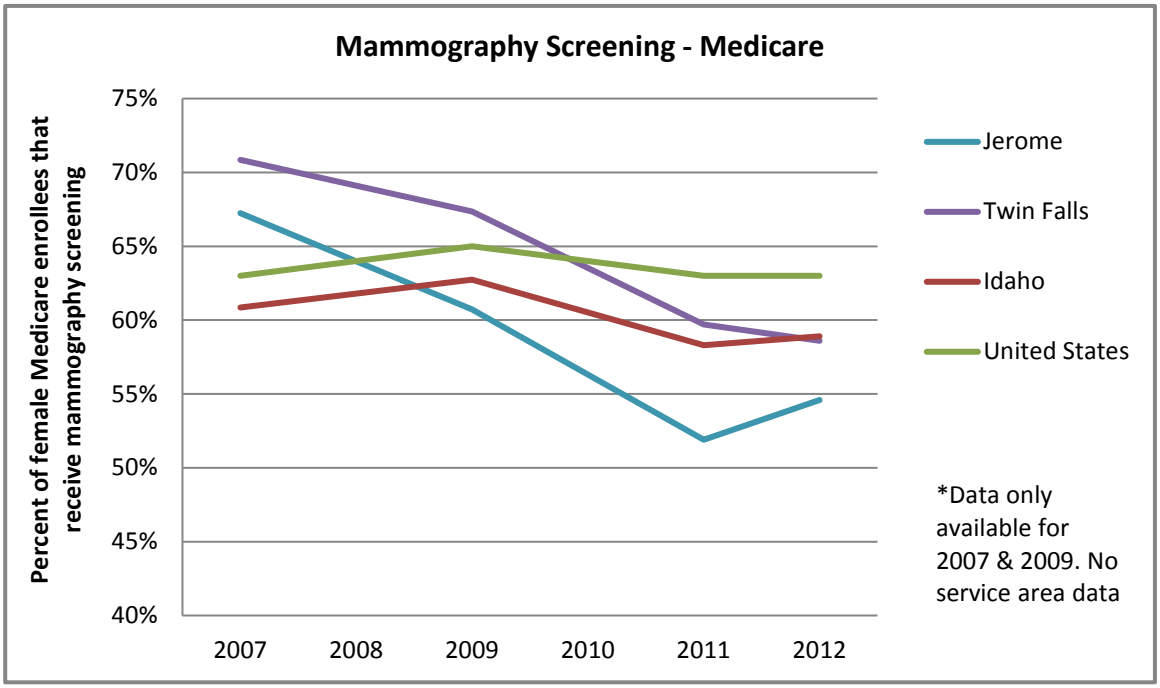
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Diabetes screening	**1**	**2**	**3**	**3**	**9**

[132] University of Wisconsin Population Health Institute. *County Health Rankings* 2015. Accessible at www.countyhealthrankings.org.
[133] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System

- **Mammography Screening**

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

In our community, the trend for the overall percent of women aged 67 to 69 receiving mammography screenings has been down for the past several years. [134]

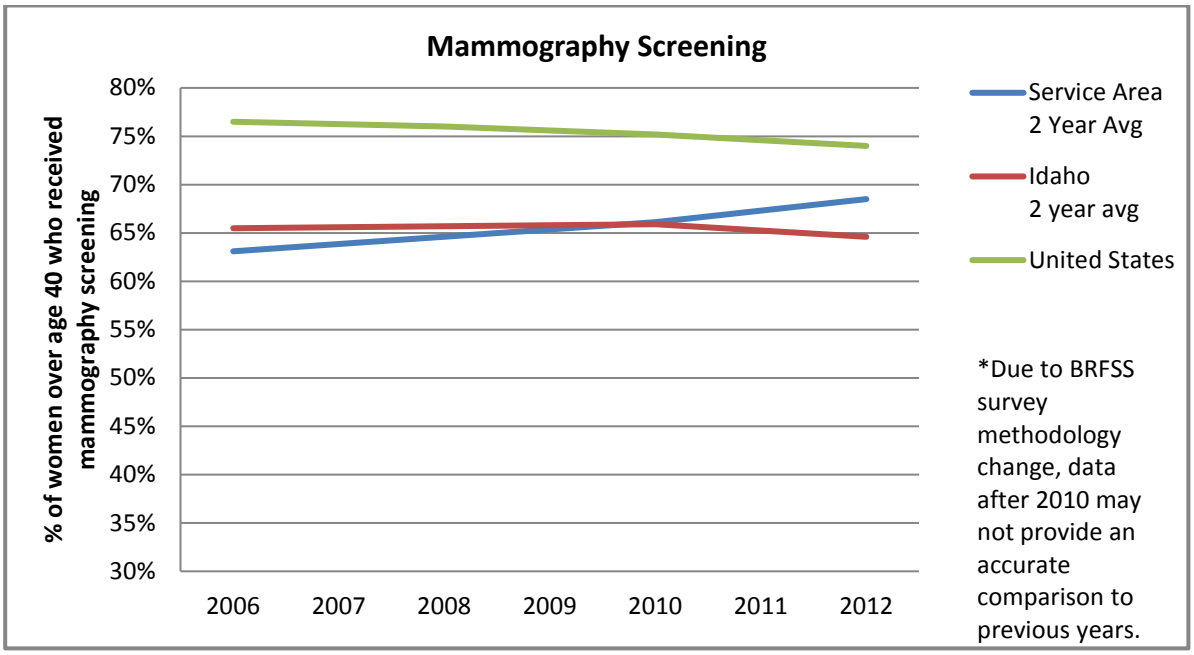


The data underlying this measure comes from the Dartmouth Atlas, a project that documents variations in health care throughout the country through use of Medicare claims data.

The National Cancer Institute recommends that women age 40 and older receive screening for breast cancer with mammography every one to two years. To obtain the percentage of Idaho women age 40 and older who received this breast cancer screening, we used data from BRFSS. As shown in the chart on the following page, the percentage has not changed significantly over the past decade. Women with annual incomes of less

[134] University of Wisconsin Population Health Institute. *County Health Rankings* 2015. Accessible at www.countyhealthrankings.org.

than $25,000 are significantly less likely to have had a mammogram and breast exam in the last two years.[135]



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	**2**	**3**	**4**	**1**	**10**

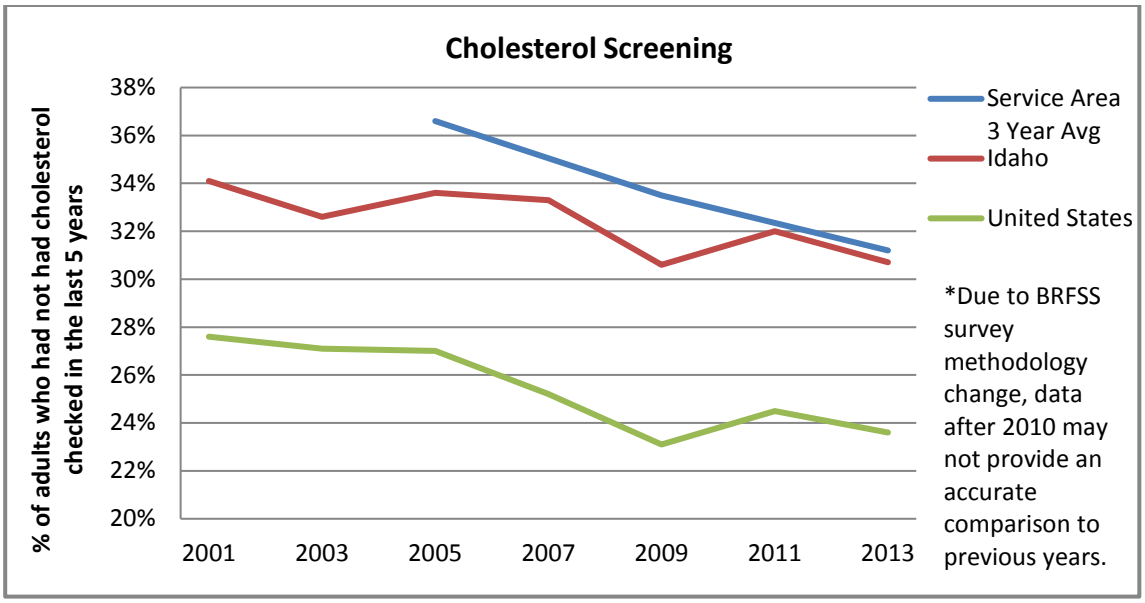
Additional Clinical Health Factors

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

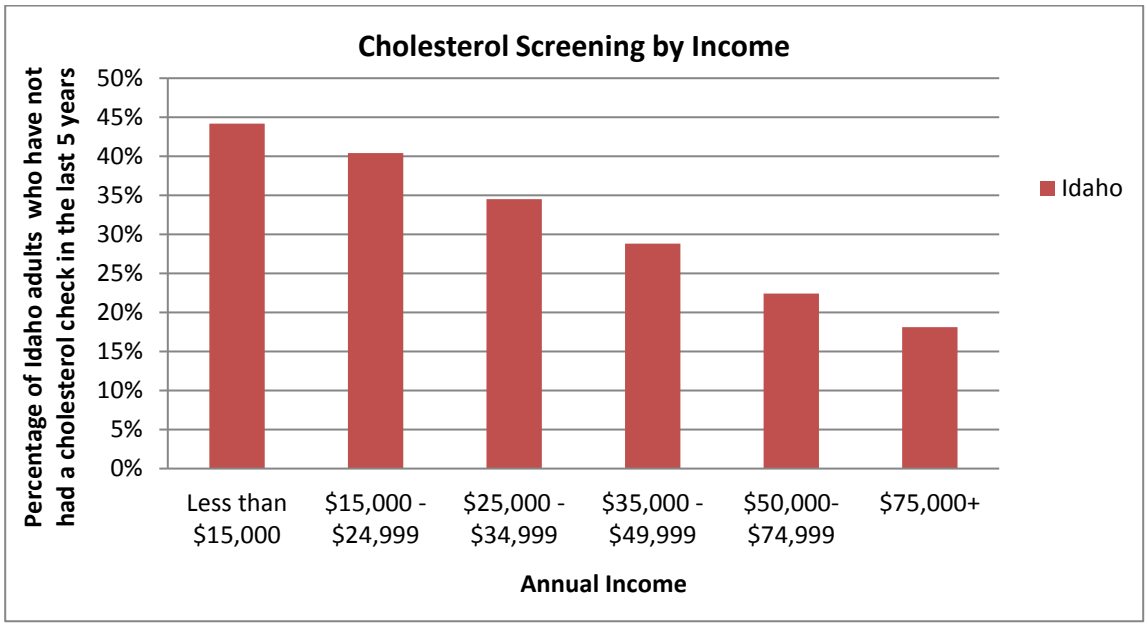
- **Cholesterol Screening**

  Cholesterol screening is important for good health because knowing cholesterol levels can spur actions to control it. Idaho is ranked 49th in the nation for cholesterol screening.[136] Our service area also has a lower percent of people receiving cholesterol checks than the national average.[137]

[135] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System
[136] America's Health Rankings 2015, www.americashealthrankings.org
[137] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System



Lower income people, those without college educations, and Hispanics are significantly less likely to have their cholesterol checked. [138]



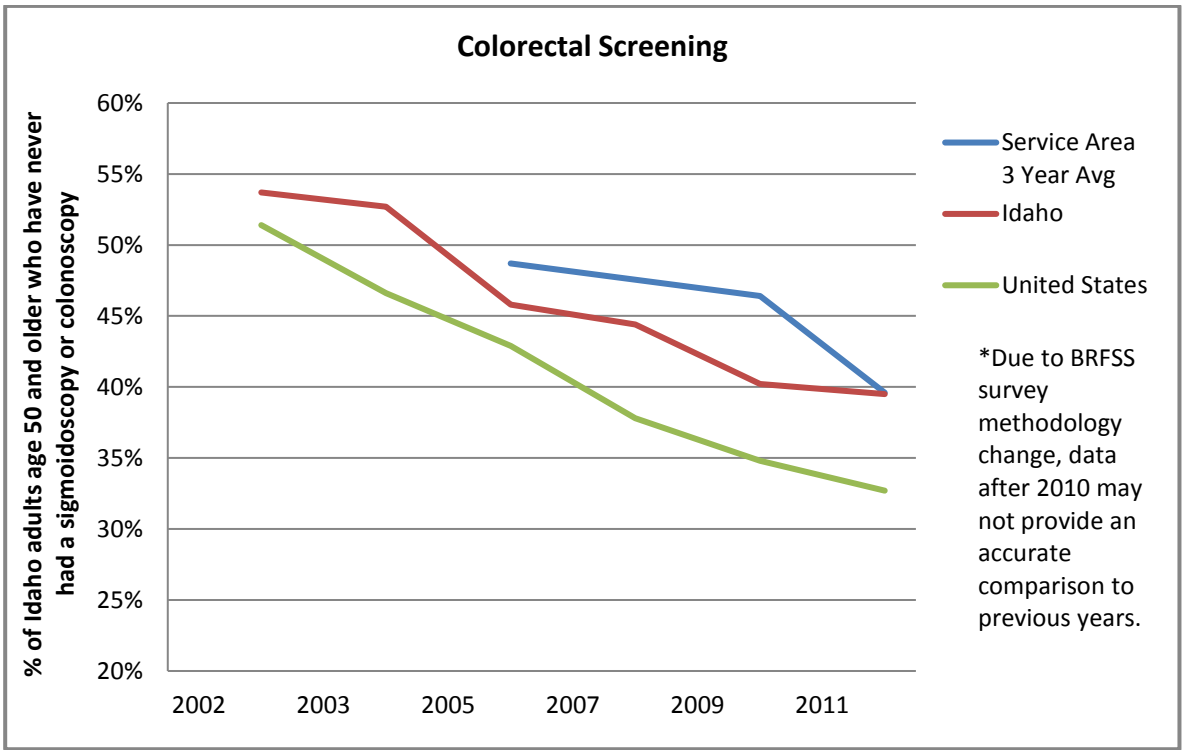
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Cholesterol Screening	**1**	**4**	**3**	**2**	**10**

[138] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System

- **Colorectal Screening**

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

The trend for people receiving colorectal screening has been improving over the past 10 years. The percent of people age 50 and older who never received a colorectal screening in our service area is higher than the nation as a whole.[139]



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. [140]

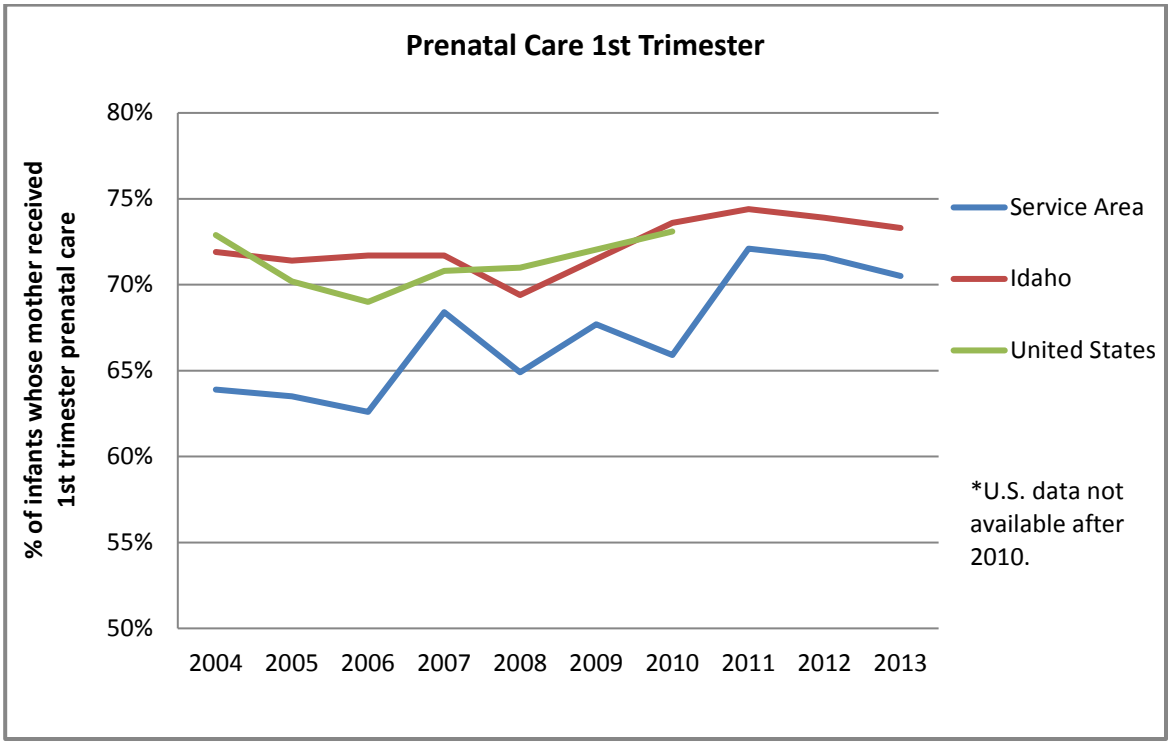
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Colorectal Screening	**1**	**3**	**4**	**0**	**8**

[139] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System
[140] 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.[141]

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 has been increasing.[142]



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

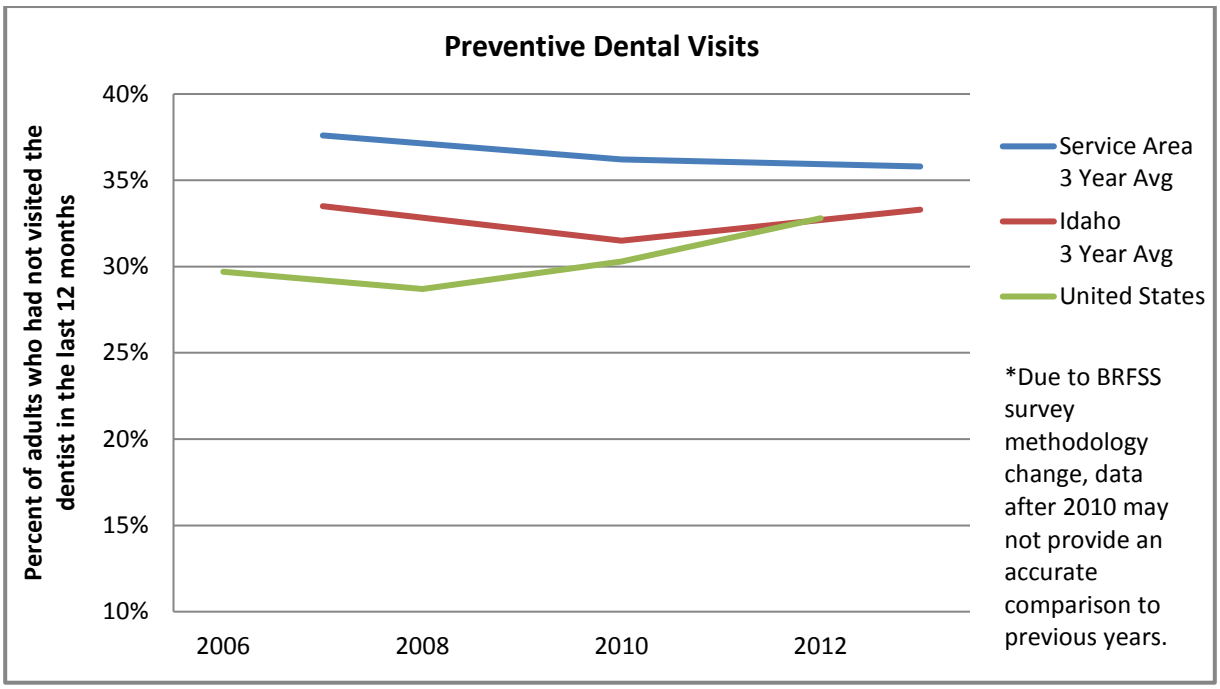
[141] America's Health Rankings 2012, www.americashealthrankings.org

[142] Idaho Vital Statistics Annual Reports, Years 2000 - 2013, National Vital Statistics Report - Deaths: Data 2013

- **Dental Visits**

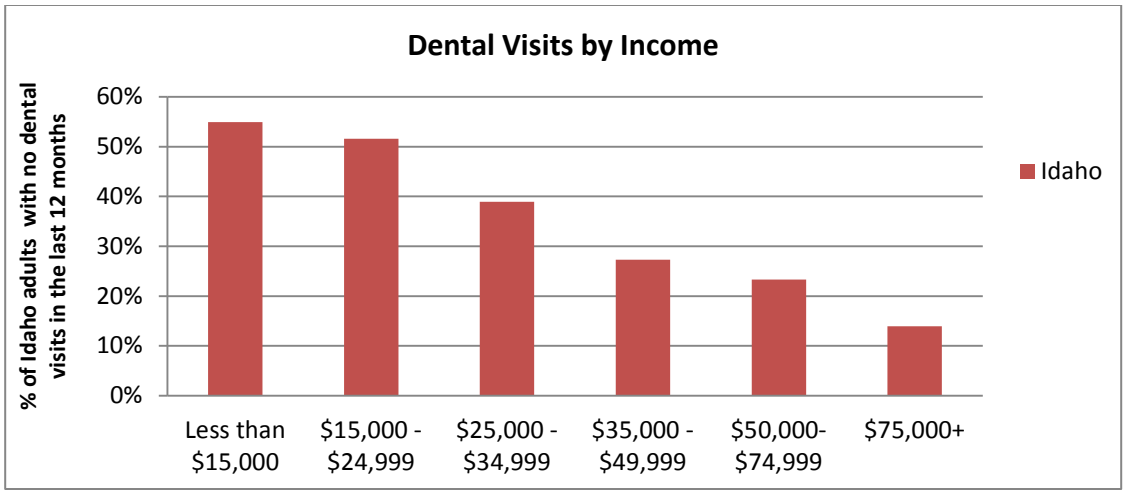
Oral health is vital to a comprehensive preventive health program. Nearly one-third of all adults in the U.S. have untreated tooth decay, while one in seven adults aged 35 to 44 years has gum disease. This increases to one in every four adults aged 65 years and older. Oral cancers, if caught early, are more responsive to treatment. Annual dental visits are one part of a healthy regimen of oral care.[143]

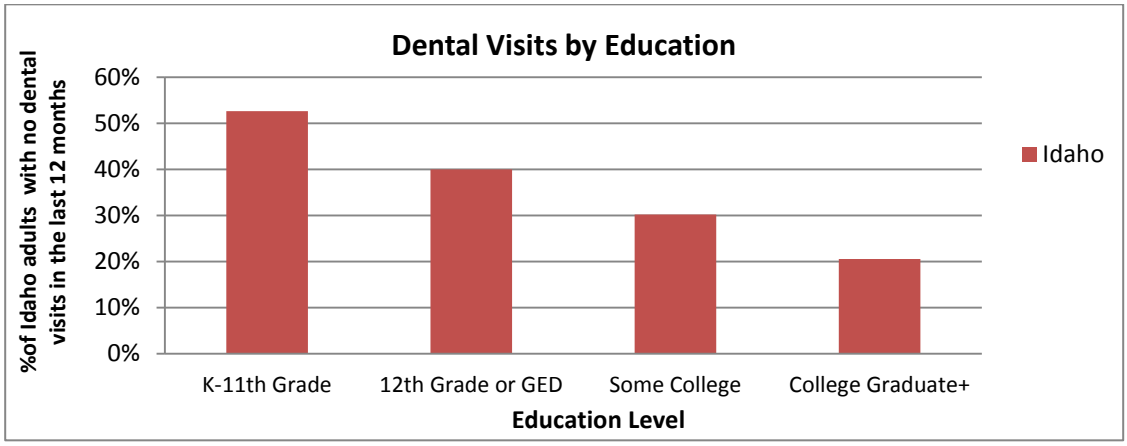
According to the Behavioral Risk Factor Surveillance System surveys, the percentage of people not receiving preventive dental visits in our service area is about the same as it is in the nation as a whole. The trend appears to have been improving slightly over the past ten years in our service area.[144]

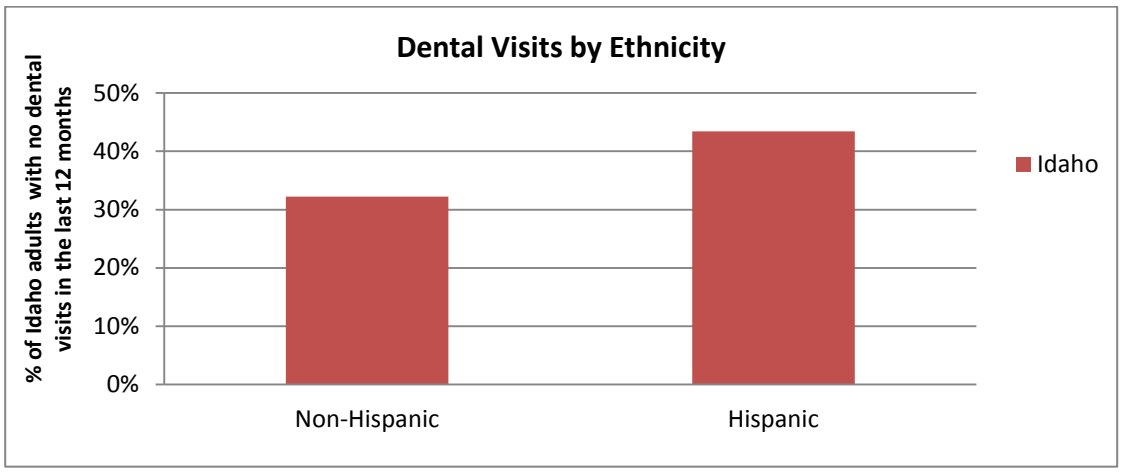


Those with incomes below $25,000 are significantly less likely to have preventive dental visits than those with higher incomes. In addition, those with less than a college degree are significantly less likely to have preventive dental visits. [145]

[143] America's Health Rankings 2015, www.americashealthrankings.org
[144] Idaho and National 2002 – 2013 Behavioral Risk Factor Surveillance System
[145] Ibid.





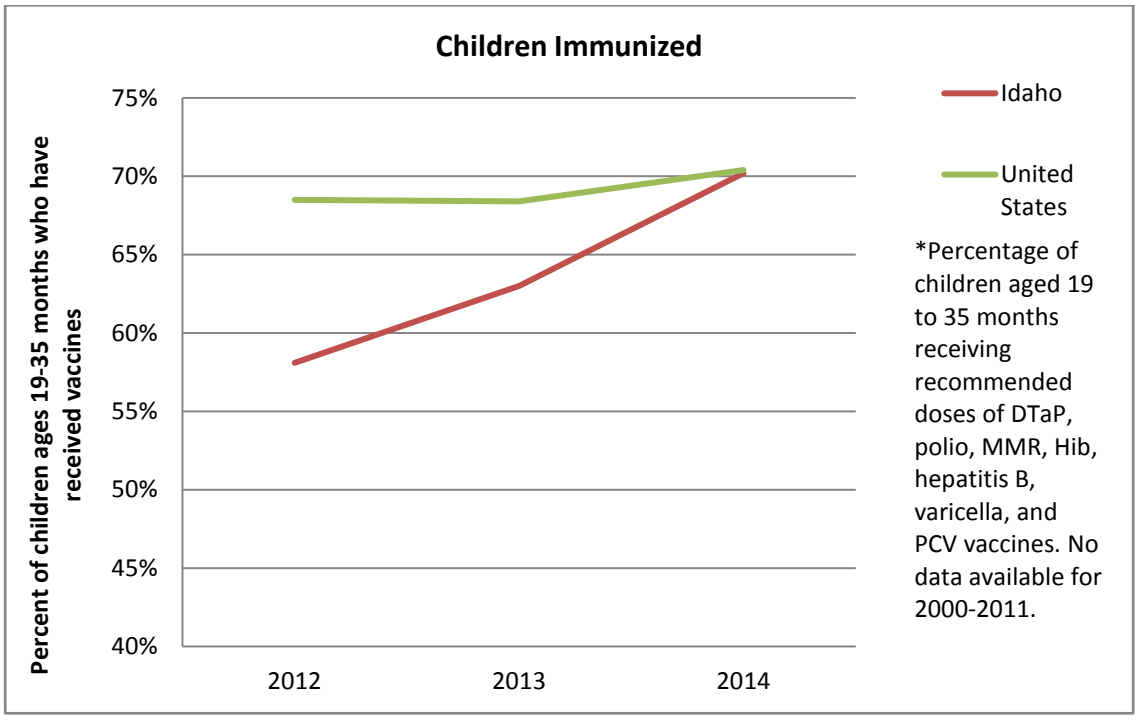


Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Dental Visits	**2**	**2**	**3**	**2**	**9**

- **Childhood and Adolescent Immunizations**

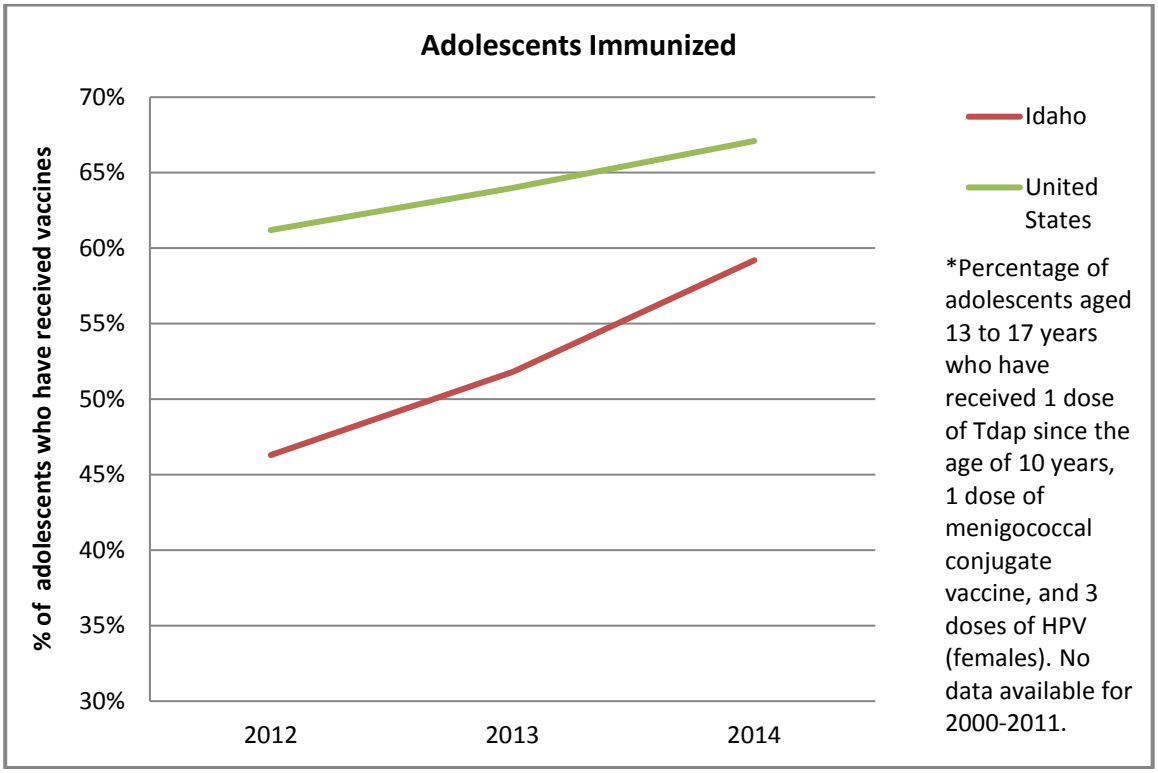
  In the U.S., vaccines have reduced or eliminated many infectious diseases that once routinely killed or harmed many infants, children, and adults. However, the viruses and bacteria that cause vaccine-preventable disease and death still exist and can be passed on to people who are not protected by vaccines. 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 two years and in 2014 was about the same as the national average. In the past, Idaho's immunization rates have often been among the worst in the nation.[146]



[146] America's Health Rankings 2015, www.americashealthrankings.org

The chart, below, shows the percentage of adolescents aged 13 to 17 years who have received 1 dose of Tdap since the age of 10 years, 1 dose of meningococcal conjugate vaccine, and 3 doses of HPV (females).



While Idaho immunization rates are approximately the same as the national average for children, we are below the national average for adolescents. As children age, immunity from the childhood vaccine DTaP diminishes, and a Tdap booster is needed at age 11 or 12 years to maintain protection against tetanus, diphtheria, and pertussis. This booster provides protection for the immunized teen, as well as those that they come into contact with, which is especially important for infants and the elderly.

There are proven methods to increase the rate of vaccinations that include ways to increase demand or improve access through provider-based innovations.[147]

Health Factor Scoring					
	Trend: Better/Worse	**Prevalence versus U.S.**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Childhood immunizations	**1**	**3**	**3**	**2**	**9**

[147] Ibid

- **Mental Health Service Providers**

  Jerome and Twin Falls counties both are listed as mental health professional shortage areas as of March 2012.[148] 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.

  Specifically, the rate of psychiatrists per 100,000 people in Idaho was 5.2 in 2009. This remains the lowest rate of psychiatrists in the nation and less than half of the national average of 11 psychiatrists per 100,000 people. Idaho's rate of psychologists was 10.7 per 100,000 in 2011, which represented only about one third of the national average of 30.7. The rate of family therapy counselors in Idaho was also below the national average. However, the rate of general counselors and licensed clinical social workers were both above the national average in 2011.[149]

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**

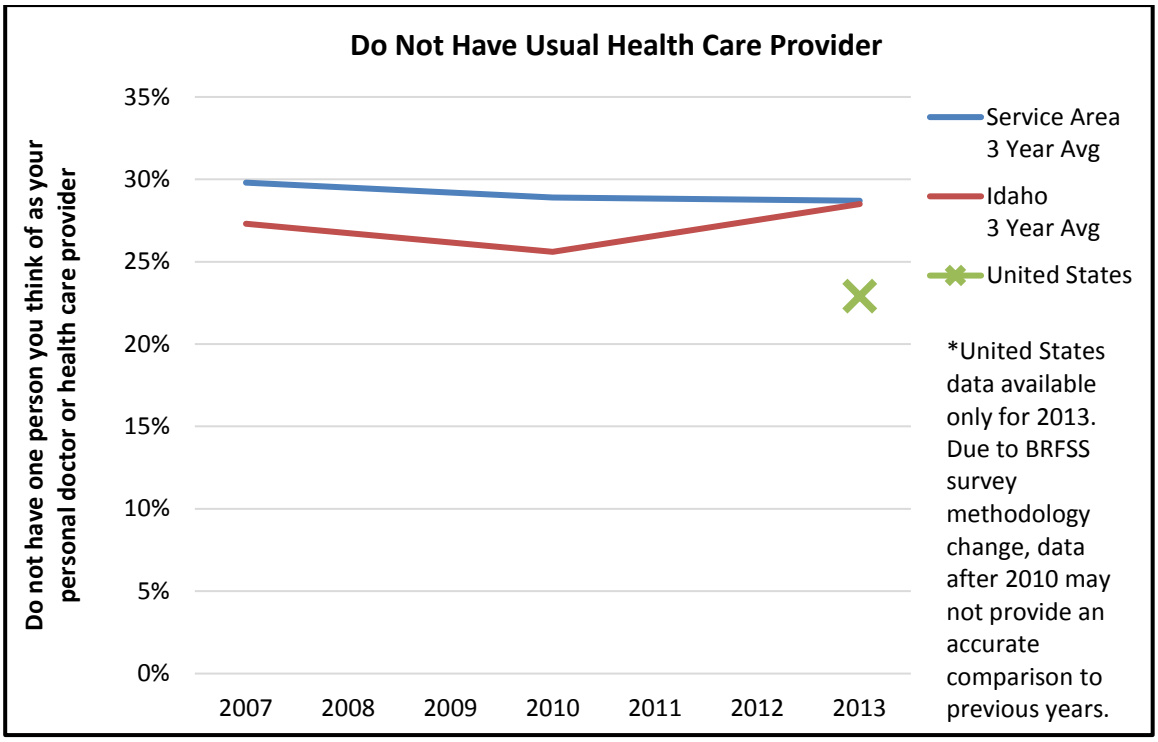
[148] Health Services and Resource Administration Data Warehouse, Mental Health Care HPSAs PDF http://datawarehouse.hrsa.gov/hpsadetail.aspx#table

[149] Mental Health, United States, 2012 Report SAMHSA www.samhsa.gov

- **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. [150]

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.[151]



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

[150] http://www.hrsa.gov/healthit/toolbox/Childrenstoolbox/BuildingMedicalHome/whyimportant.html
[151] Idaho and National 2002 – 2013 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.

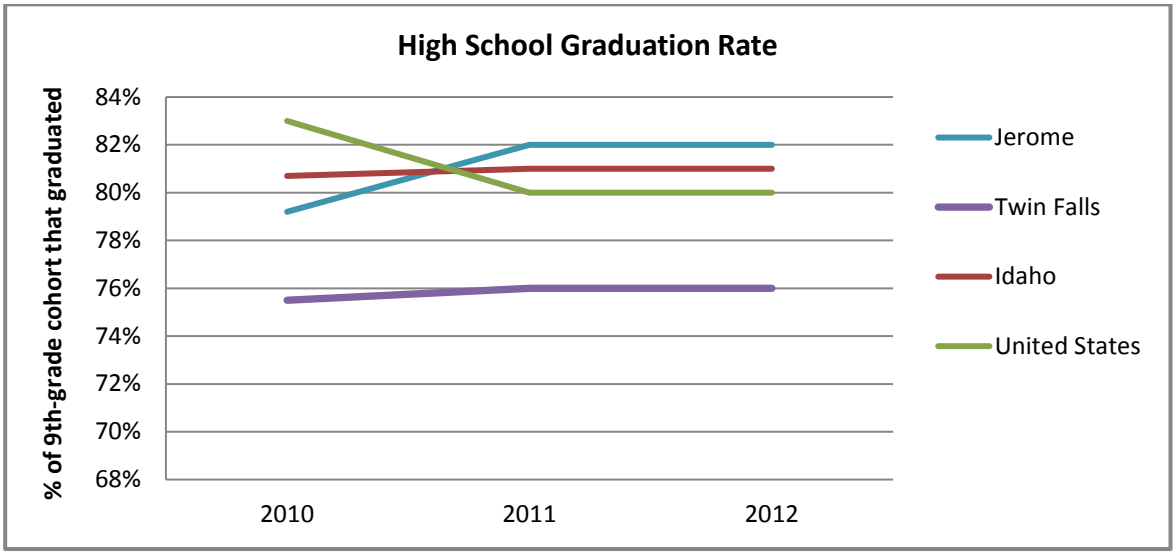
  One's education level affects not only his or her health, but education can have multigenerational implications that make it an important measure for the health of future generations. Evidence links maternal education with the health of her children. The education of parents affects their children's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

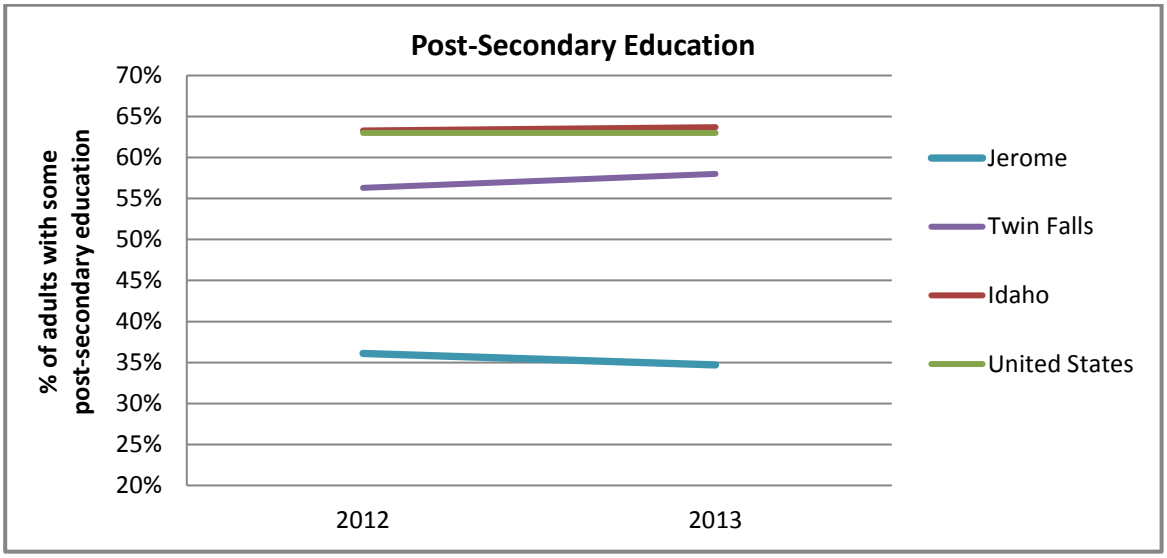
  Finally, education influences a variety of social and psychological factors. Evidence shows the more education an individual has, the greater his or her sense of personal control. This is important to health because people who view themselves as possessing a high degree of personal control also report 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).[152]

The high school graduation rate for Twin Falls County is below the national average. Post-secondary education is significantly below the national average for Jerome County.





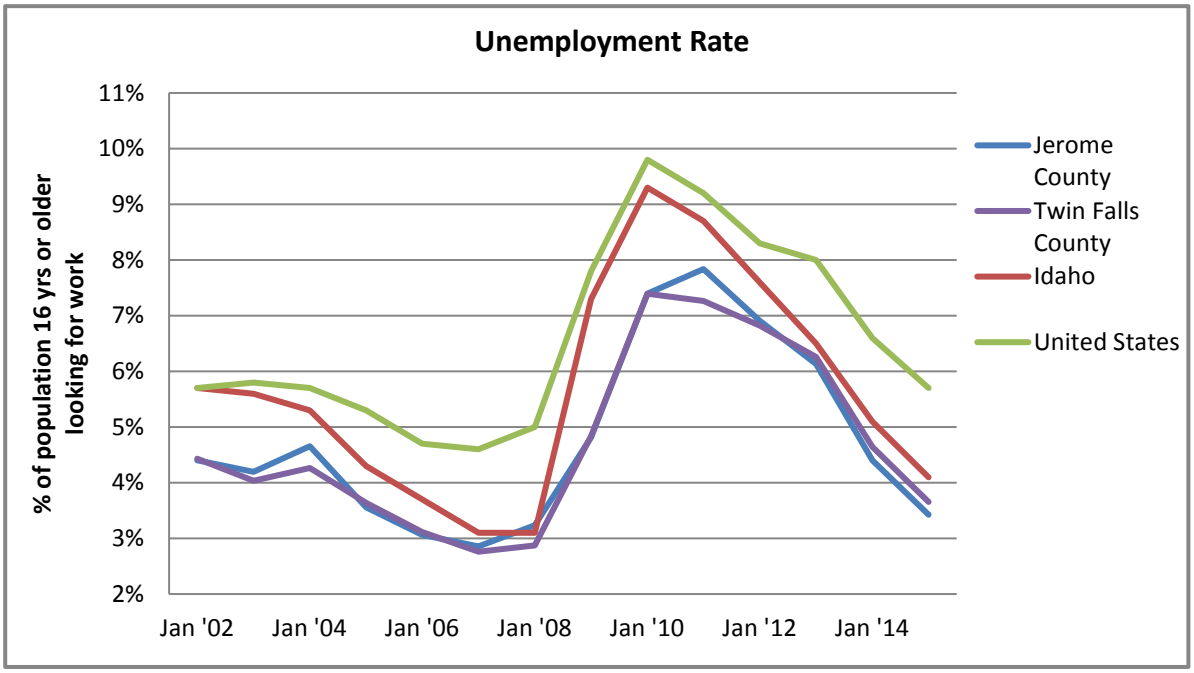
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Education	**2**	**3**	**2**	**3**	**10**

[152] University of Wisconsin Population Health Institute. *County Health Rankings* 2012-2015. 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.[153]

The unemployment rate in Idaho and our service area has been trending down since 2011 and is approaching the longer term, healthier rates for our area.[154]



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

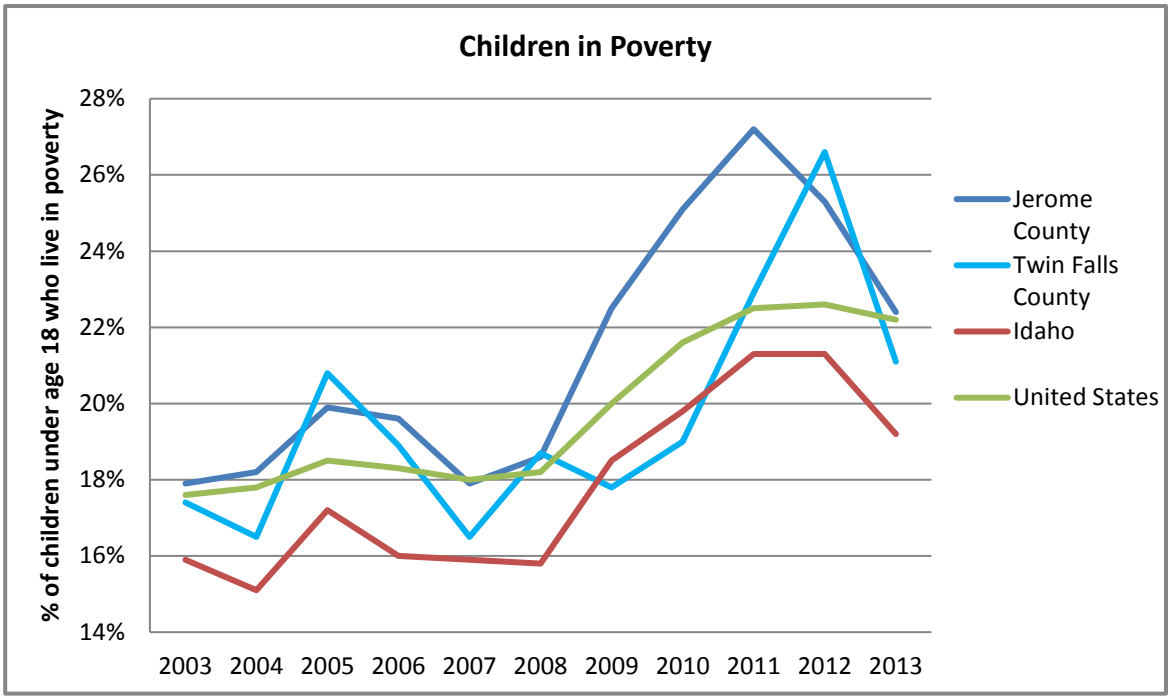
[153] University of Wisconsin Population Health Institute. *County Health Rankings* 2012-2015. Accessible at www.countyhealthrankings.org.

[154] 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).[155]

Although the trend has started to improve, the percent of children in poverty increased since 2008 both nationally and in our service area. The prevalence of children in poverty in our service area is now about the same as the national average.[156]



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**

[155] University of Wisconsin Population Health Institute. *County Health Rankings* 2012-2015. Accessible at www.countyhealthrankings.org.

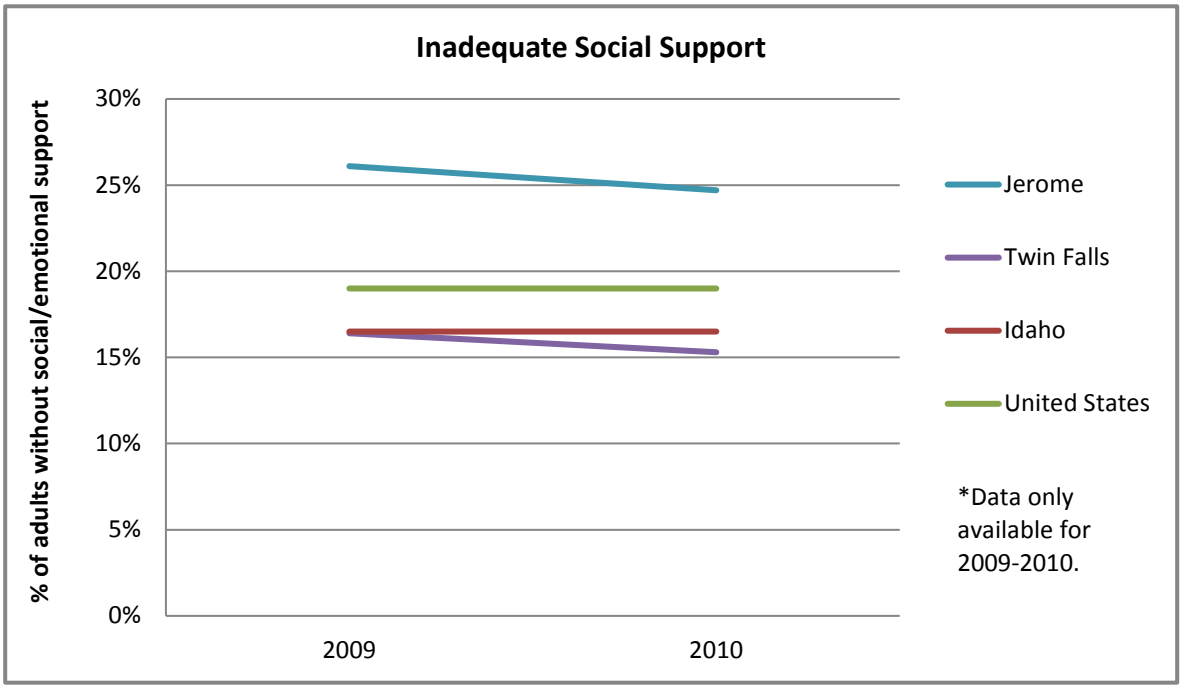
[156] Source: Small Area Income and Poverty Estimates (SAIPE. http://www.census.gov/did/www/saipe/data/statecounty/data/index.html

- **Inadequate Social Support and Single-Parent Households**

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

The association between socially isolated individuals and poor health outcomes has been well-established in the literature. One study found that the magnitude of risk associated with social isolation is similar to the risk of cigarette smoking for adverse health outcomes. The social isolation measure reports the percentage of adults without social/emotional support.[157]

The percent of people with inadequate social support in Twin Falls County is below the national average. However, Jerome County's is well above the national average.[158]

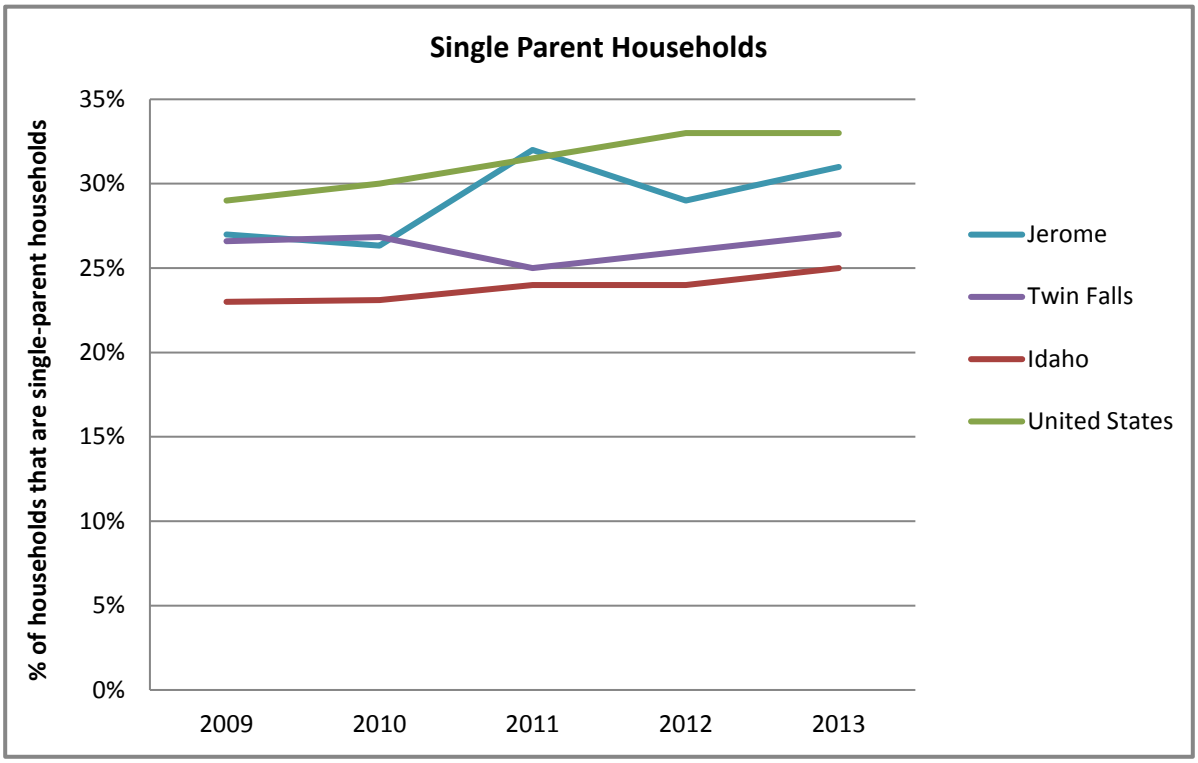


Similar to socially isolated individuals, adults and children in single-parent households are at risk for both adverse health outcomes such as mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors (including smoking and excessive alcohol use). Not only is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

[157] University of Wisconsin Population Health Institute. *County Health Rankings* 2012. Accessible at www.countyhealthrankings.org.
[158] Ibid

but mortality risk also is higher. Likewise, children in these households also experience increased risk of severe morbidity and all-cause mortality.

The percent of people living in single parent households is slightly below the national average for our service area.[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**
Inadequate social support	**2**	**2**	**2**	**3**	**9**

[159] 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.

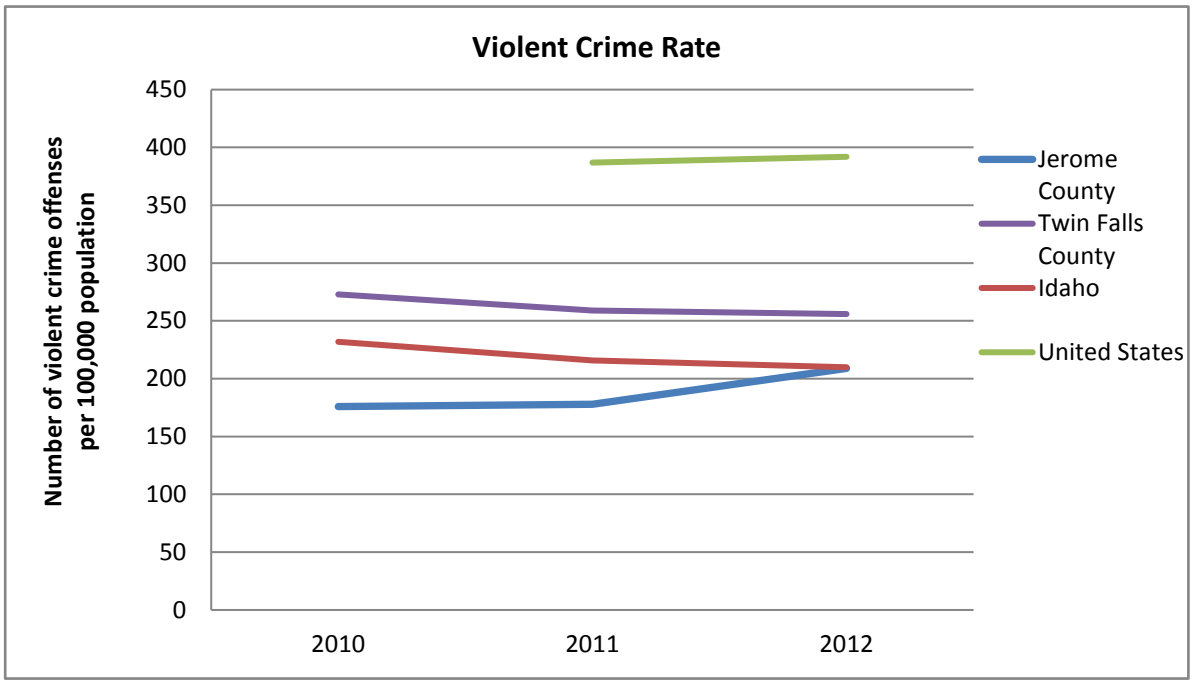
Injuries generate $406 billion in lifetime medical costs and lost productivity every year, $37 billion of which are from violence. Communities can help protect their residents by adopting and implementing policies and programs to prevent accidents and violence. [160]

[160] 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. [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**
Violent Crime	**2**	**0**	**2**	**2**	**6**

[161] Ibid

Physical Environment Factors

County Health Rankings Physical Environment Factors

Air and Water Quality

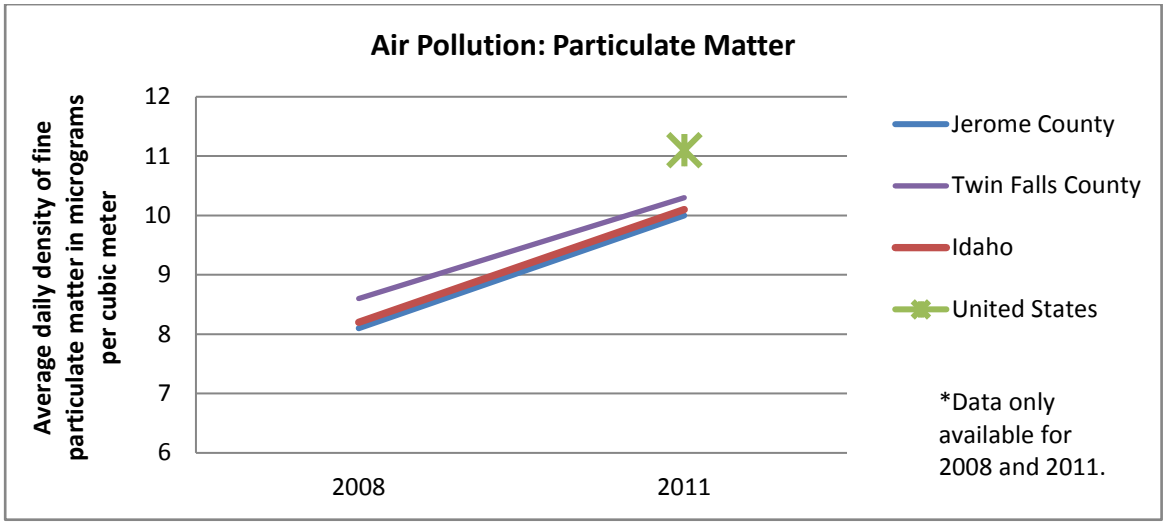
Clean air and water support healthy brain and body function, growth, and development. Air pollutants such as fine particulate matter can harm our health and the environment. Air pollution is associated with increased asthma rates and can aggravate asthma, emphysema, chronic bronchitis, and other lung 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.[162]

- **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.[163]

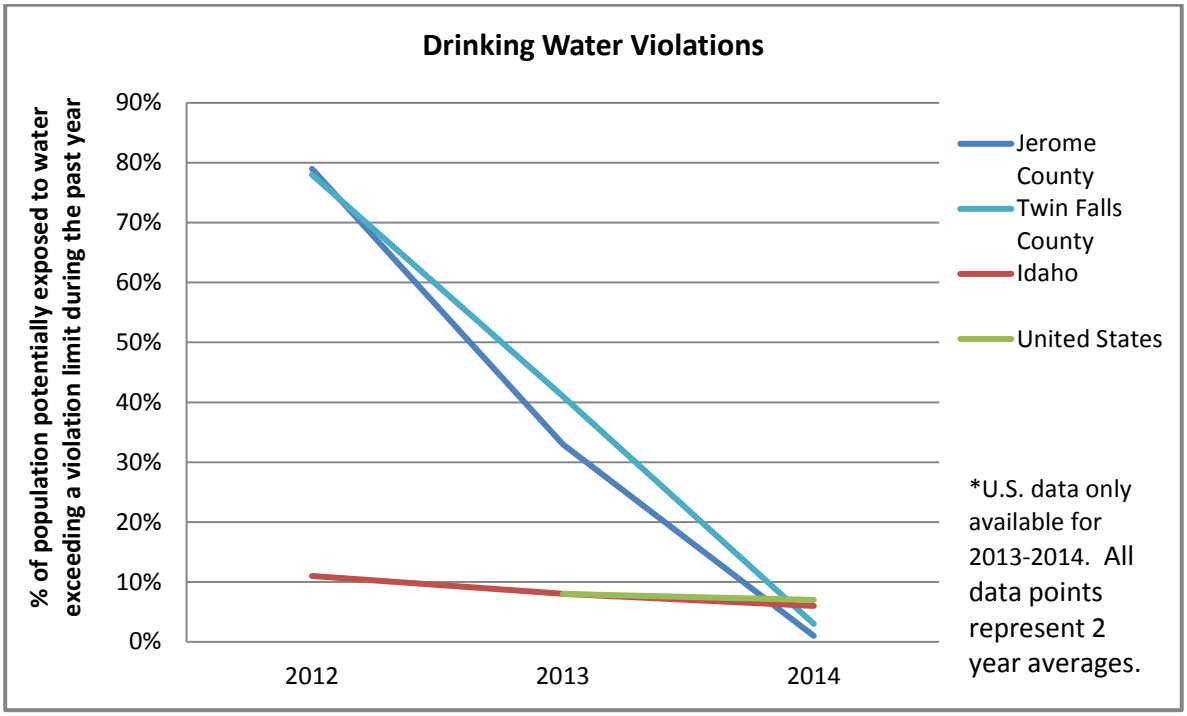


[162] Ibid
[163] Ibid

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

- **Drinking Water Violations**

The EPA's Safe Drinking Water Information System was utilized to estimate the percentage of the population getting drinking water from public water systems with at least one health-based violation. Our service area has drinking water violation rates that are now below the national average.[164]



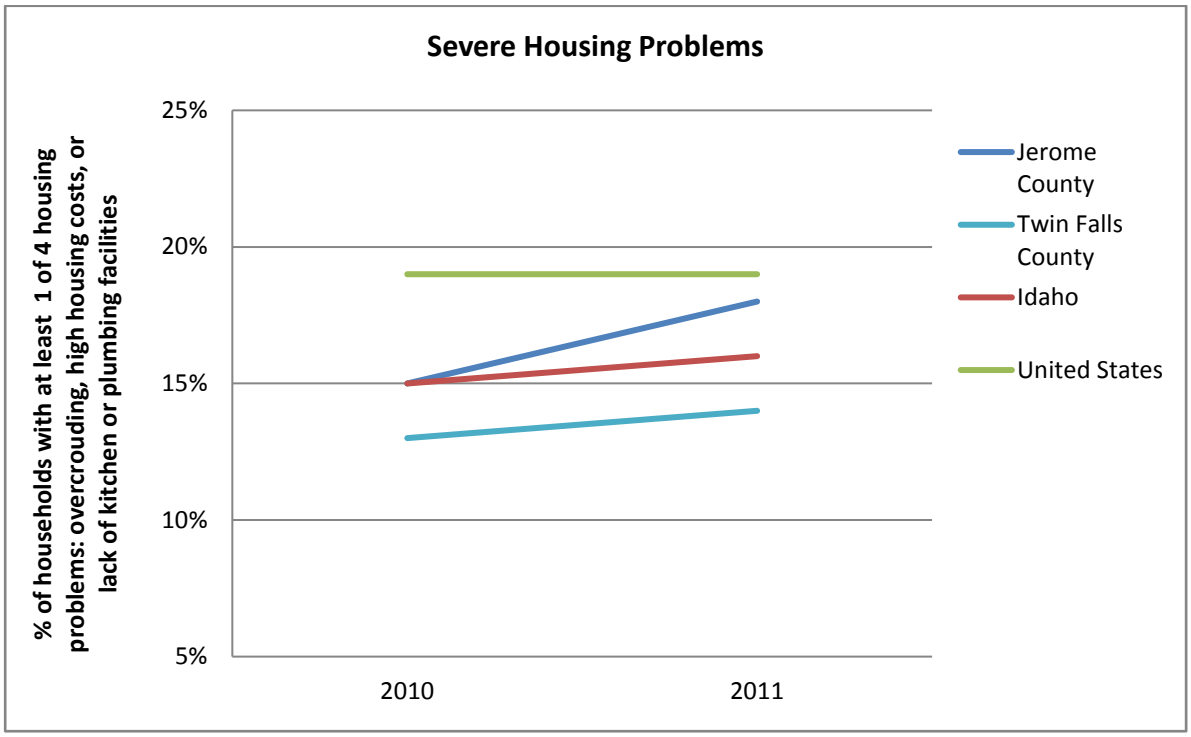
Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	Prevalence versus U.S. Average	Severe/ Preventable	Magnitude: Root Cause	Total Score
Drinking Water Violations	**1**	**2**	**2**	**2**	**7**

[164] 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. [165]

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



Health Factor Score Low score = Low potential for health impact High score = High potential for health impact					
	Trend: Better/Worse	**Prevalence versus U.S. Average**	**Severe/ Preventable**	**Magnitude: Root Cause**	**Total Score**
Severe Housing Problems	**3**	**1**	**1.5**	**3**	**9.5**

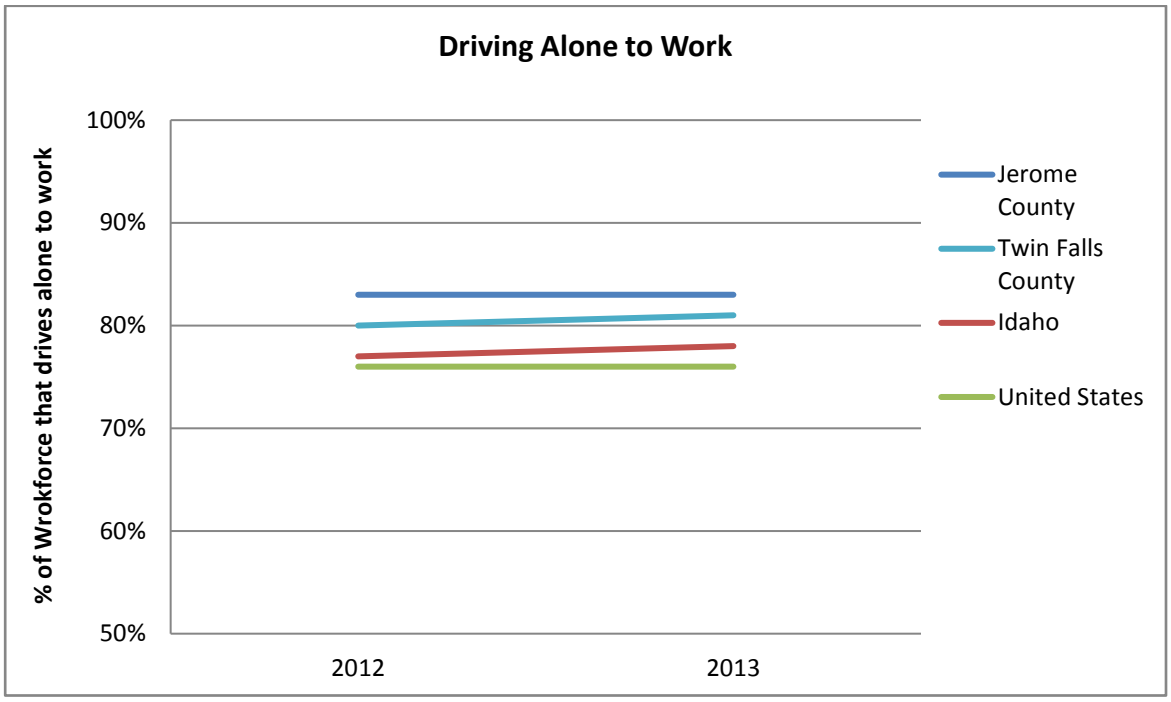
[165] Ibid

- **Driving Alone to Work**

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

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

Our community has more people driving to work alone than the national average.[166]



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

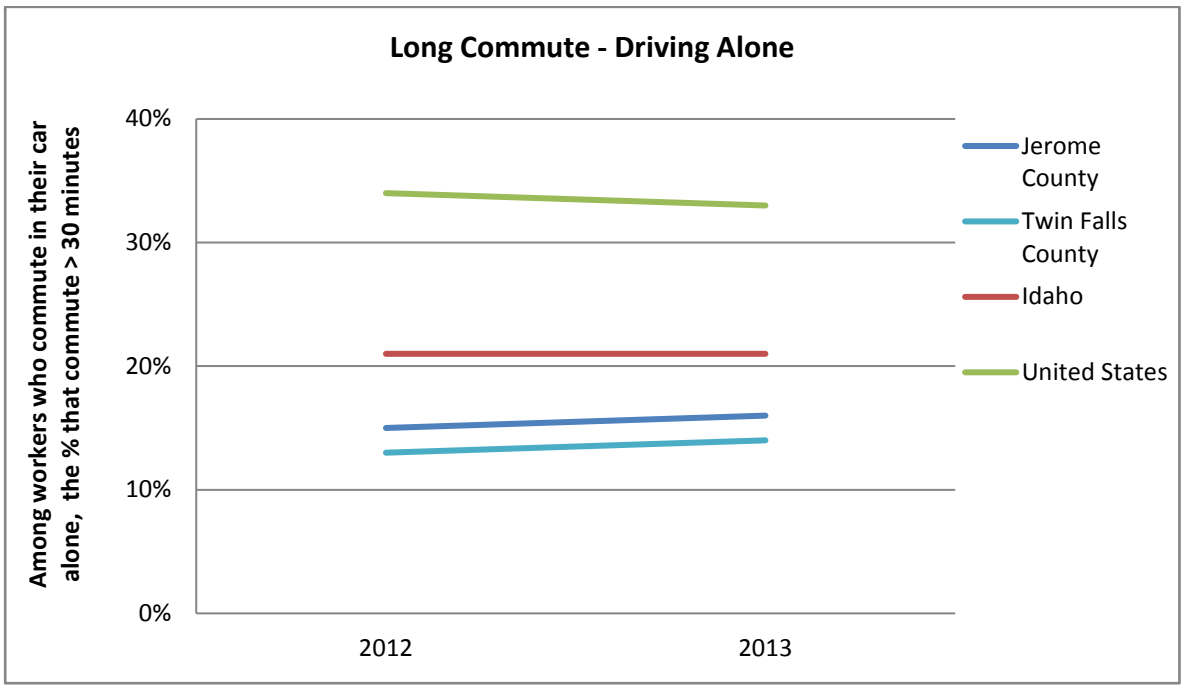
[166] Ibid

- **Long Commute - Driving Alone**

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

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

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



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

Community Input

Community input for the CHNA is obtained through two methods:

- First, we conduct in-depth interviews with community representatives possessing extensive knowledge of health and affected populations in our community.
- Second, feedback is collected from community members regarding the 2013 CHNA and the corresponding implementation plan. We use this input to compile and develop the 2016 CHNA. Community members have an opportunity to view our CHNA and provide feedback utilizing the St. Luke's public website.

Community Representative Interviews

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

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

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

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

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

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

Interview Findings

Using the questionnaire in Appendix II, we asked our community representatives to assist in identifying and prioritizing the potential community health needs. In addition, representatives were invited to suggest programs, legislation, or other measures they believed to be effective in addressing the needs.

The table below summarizes the list of potential health needs identified through our secondary research and by our community representatives during the interview process. Each potential need is scored by the community representatives on a scale from 1 to 10. A high score signifies the representative believes the health need is both important and needs to be addressed with additional resources. Lower scores typically mean the representative believes the need is relatively less important or that it is already being addressed effectively with the current set of programs and services available.

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

Health Behavior Needs		
Potential Health Needs	**Average Score**	**Summary of Community Representatives' Comments**
Access to healthy foods	6.8	Most representatives believe that our community generally has access to healthy foods. This is especially true given the rich agricultural and farming environment. The high cost of some healthy foods can be a prohibiting factor to access. However, many interviewees believe personal choice to purchase healthy foods plays the most significant role. Suggestions: • Community gardens, particularly for the Hispanic population, would be beneficial. • Local food pantries have a need for healthier foods to distribute.

Exercise programs/education/opportunities	6.8	There are numerous organizations creating affordable opportunities for all ages to have access to organized exercise. We acknowledge the need to sustain parks and sidewalks to encourage exercise. There is also a need for more organized fitness opportunities in rural areas. Lack of transportation can also prohibit access to programs.
Nutrition Education	7.6	There are nutrition education opportunities available through the local colleges, medical clinics and also imbedded into a robust summer program for youth. We see a need for preparation and nutrition education particularly in the refugee community. Suggestions: • A course covering how to eat healthy on a budget. • Education around how to prepare healthy meals with the food provided by the local food pantry.
Safe sex education programs	7.0	Teen pregnancy rates are relatively high in this region. Honest conversations around safe sex need to be conducted beyond school and in the home with parents. There is a particular need for education and awareness in the Hispanic community.

Substance abuse services and programs	7.8	There are insufficient resources and facilities to combat substance abuse. Programs and facilities are overcapacity and underfunded by the state. Substance abuse, particularly the misuse of prescription drugs, is prevalent. The services available are often cost prohibitive to those without insurance or living on low incomes. We need more and affordable treatment options. Suggestion: • Offer education to the community regarding prevention and what to do when one suspects substance abuse by a peer.
Tobacco prevention and cessation programs	6.9	There are numerous free or subsidized programs for people wanting to quit smoking. Most believe that even with these resources and education, smoking is still pervasive. E-cigarettes are rampant in some communities and a gateway to tobacco use. Suggestion: • Tobacco use is extremely difficult to quit. There needs to be more focus on the youth to prevent individuals from ever starting.
Weight management programs	7.4	"This is a nationwide crisis, and especially rampant in Twin Falls and Jerome." There are a number of services and programs available that address weight management, obesity, diabetes, etc. but participation rates are low. There is a need to create greater awareness around these programs and specifically focus on early prevention with youth. Suggestions: • Instead of expecting people to attend an offsite program, we need to go directly

		to the people - e.g., schools and employers. • The experience needs to be more interactive and collaborative, less lecture.
Wellness and prevention programs (for conditions such as high blood pressure, skin cancer, depression, etc.)	8.3	"Everyone should have skin in the game. Wellness and prevention should be embedded into communities – schools, employers, etc." It's very evident that our community values wellness and prevention programs. There is a need to create more awareness as to what programs are currently available and how one can attend. Suggestions: • Wellness and prevention programs that address mental health and depression. • Take programs directly to the people via employers and schools.

Clinical Care Access and Quality Needs		
Potential Health Needs	**Average Score**	**Summary of Community Representatives' Comments**
Affordable care for low income individuals	8.2	There are multiple options for healthcare facilities that operate on a sliding scale or offer free or subsidized services. However, capacity in these clinics is limited. There is a need for more volunteers to help meet the demand. Suggestions: • A low-cost, 24 hour urgent care alternative to the emergency room. People cannot afford to go to the emergency room so they opt to live with injuries and conditions without receiving care.

Affordable dental care for low income individuals	8.4	"Idaho is in a state of crisis when it comes to oral health. People simply can't afford to prioritize dental work." There are multiple options for low-cost, basic dental care, but the providers cannot keep up with the demand. Suggestions: • "At the very least, there needs to be a no-cost/low-cost option for dental emergencies."
Affordable health insurance	8.4	Affordable health insurance remains one of our largest needs especially for the low income working population who simply cannot afford to pay high premiums. Those who do not qualify for Medicaid coverage, but still are below 138% of the federal poverty level do not receive federal subsidies to purchase health insurance. This gap in coverage has resulted in a significant amount of people who are uninsured. Suggestions: • Expand Medicaid in the state of Idaho to assure the "gap" population has affordable access to health care. • Create more opportunities to educate our community on the value of health insurance and how to use the exchange to purchase insurance.
Availability of behavioral health services (providers, suicide hotline, etc.)	9.0	Behavioral health services are a top need in the county. "There is a great, ongoing need for comprehensive mental health programs." With the recent loss of multiple behavioral health professionals in the community, the demand and strain on the remaining providers continues to grow. Government reimbursement for behavioral health care is minimal. In order to retain professionals and staff,

		there is a need for more support and funding from the state. Community representatives specifically express the need for *affordable* services and for a children's behavioral health professional. Suggestion: • Provide more education to the general public on how to recognize behavioral health challenges and how to appropriately respond.
Availability of primary care providers	7.0	As the population continues to grow, we are starting to experience long wait times to see a primary care physician. People are recognizing the challenge and importance of retaining and adding physicians to the area. There are especially long waits for those who are uninsured, low-income, in need of specialty care and/or are a member of the refugee population. Suggestion: • Given the shortage of physicians, we need to better utilize nurse practitioners, physician assistants and registered nurses.
Chronic disease management programs	7.2	"This is one of the most important needs and ways St. Luke's can positively affect the community they serve. Chronic disease management is how we get to the heart of the individual and their health." When considering chronic disease management, we need to think ahead with regard to how we will manage the influx of our aging population. Suggestions: • Focus on services for the elderly population – e.g., Alzheimer's and

		dementia programs. • Instead of approaching patients with multiple specialty care programs, focus on each patient's wellness as a whole.
Immunization programs	5.3	Immunization programs are readily accessible and important. There is a need to continue to provide education and awareness around the choice to be immunized. Suggestions: • "There may be a compromised, better approach to immunizations if the schedule for immunizations were slowed down and dispersed." • There is a need for more support from the clinical side to assure parents know what they are opting out of when not immunizing their children for school.
Improved health care quality	6.3	Overall people are very satisfied with the quality and level of care they are receiving. "We are seeing some amazing transformations. There is a good use of data, good standards and good movement. However, there is always room for improvement." Suggestion: • There is a desire to spend more time with the physician. "Physicians need to help patients get to a place where they own their health. This takes time."

Integrated, coordinated care (less fragmented care)	7.1	The community is starting to see improvements in their coordination of care. People are very pleased with the new electronic medical record. The health system needs to focus on integration and continue to improve. Suggestion: • Physicians and staff need to become more versed with the electronic medical record and patient portal.
Prenatal care programs	5.3	Prenatal care programs are very strong and provide easy to access for all. Suggestion: • Offer early childhood development courses to young, new families.
Screening programs (cholesterol, diabetic, mammography, etc.)	6.6	Community members stress the importance of screenings and the benefits of prevention. There are health fairs and numerous screening programs provided in the county. The screenings need to be affordable and accessible to attract the affected population. Participation at these events vary. There is a need to build greater awareness of these services. Suggestions: • More depression screenings for adolescents and teens. • Annual screenings for the refugee population. Provide further education and routine screenings. • Greater follow up on the results of the screening. Direct patients to an appropriate physician or professional once diagnosed.

Social and Economic Needs		
Potential Health Needs	**Average Score**	**Summary of Community Representatives' Comments**
Children and family services	7.0	There are services available, but the demand continues for specific programs, particularly for young parents. “Young families are in desperate need for education and anything that empowers them as parents.” It is important to grow programs, but also to continue to create awareness around the programs currently available. Suggestions: • Provide parenting and child development courses. • Create a safe house for children in crisis, ages 12 to 17. • Provide additional summertime child care opportunities. • Offer opportunities for refugee parents to collaborate with each other more. • Create Foster family support and reprieve programs.
Disabled services	6.8	“We do a good job transitioning people and providing recovery to those who have a disability as a result of a tragic accident. We don’t do a good enough job for those who have been disabled since birth.” It is important to integrate people with disabilities into our community through work and social programs. This keeps everyone active, contributing and building self-worth and esteem. Suggestion: • Improve Americans with Disabilities Act (ADA) accessibility.

Early learning before kindergarten (such as a Head Start type program)	6.2	The community places a great deal of importance on the opportunity for early learning and pre-kindergarten programs. Statistics are showing that a significant portion of Idaho children are not at benchmark upon entering school and these same students are challenged to ever catch up in school and in life. Currently, the programs are at or over capacity, but fortunately the community has recently received a grant to create more. Suggestions: • Increase support from the Idaho legislature. • Existing programs need to be expanded so all children can qualify no matter their family's income level.
Education: Assistance in achieving good grades in kindergarten through high school	7.5	The majority of community members indicated that many schools and students in the area are struggling. "There is a huge need for more support from around the community and in the home." "Schools are trying their best, but there are some challenging factors between the English as a second language (ESL) students and low income population." The community is invested in the lives of the children and dedicated to help students reach their full potential. There are after school programs, an active Boys and Girls Club as well as alternative school opportunities. Suggestions: • Increase wages for educators. • Greater focus on helping males through high school graduation. • Provide tutoring services for all students regardless of one's family income level.

		• Encourage parents to be greater involved with their children.
Education: College education support and assistance programs	6.7	Idaho universities and community colleges are doing a very good job of promoting further education. The state is also putting more funding into college support and assistance programs. The focus needs to go beyond entering college. We need to provide ongoing support to complete college. Even with scholarships and loans, tuition can still be overwhelming for many.
Elder care assistance (help in taking care of older adults)	6.8	At this time there are sufficient services and facilities to cover the need for elder care assistance. However, with the growth of the aging population we acknowledge the need will continue to increase. Facilities are already being challenged to find and sustain sufficient staff levels to meet the demand. While options are available, affordable services and facilities may be limited. Suggestions: • Elders need advocacy. Oftentimes elder abuse is going unreported and the victims have little capacity or resources. • Provide respite care services for families.
End of life care or counseling (care for those with advanced, incurable illness)	6.4	We are starting to see palliative care gaining more attention. A disproportionate amount of health care costs come down to the very last weeks of life. St. Luke's and The Community Coalition, amongst other organizations, are recognizing the need for change in terms of how we approach end of life care. Suggestions: • Decision making and counseling needs

		to begin earlier, before the patient is in hospice care. • "St. Luke's does a good job with offering assistance around living wills. We need more programs like this."
Homeless services	7.1	There are a few very good services available to provide assistance to homeless individuals and families. However, "these services run on a shoe string and are dependent on volunteers." The Valley House is currently trying to expand to meet the need. Women and children have a few resources and options. There is a need for more resources for single men.
Job training services	7.1	The College of Southern Idaho offers a very good job training program that covers a variety of career tracks. The South Central Community Action Partnership also has a 'Work for Success' program that provides professional clothing to those interviewing. Suggestions: • Create a program specific to training people with disabilities. • Provide a program for experienced workers who are changing career tracks.
Legal Assistance	6.1	Legal Aid services are available, but overwhelmed by demand. There are also local attorneys who offer pro-bono services. The Veteran's Justice Program offers assistance to U.S. veterans and the Office on Aging contracts with Legal Aid to address the needs of the elderly. We are seeing the need for immigration legal assistance.
Senior services	6.2	"There is community support for seniors. There is a need to continue the good work." There are multiple organizations

		that offer services to our senior community; The Senior Center, Senior Commission, Office on Aging, Meals on Wheels, etc. The College of Southern Idaho offers a successful "Over 60 and Getting Fit" exercise class that is very well attended. Suggestions: • Latino seniors would benefit from having bilingual and bicultural services available to them.
Veterans' services	6.6	Twin Falls has an outpatient Veterans Affairs (VA) clinic to serve the region. The VA also has select services that travel from town to town to serve the veteran population in rural areas. There is a need for further education to veterans regarding how to use their benefits.
Violence and abuse services	8.0	"Violence and abuse is endemic to Idaho." Though there are multiple services to address the problem, the issue is far too pervasive. People who are falling victims to violence and abuse are from all ethnicities, socio-economic levels, religions, and both men and women. Violence and abuse services are needed particularly in the refugee population. "There are some pervasive cultural beliefs that are difficult to work through." There are not enough resources to cover the need. The Crisis Center is over capacity and in need of a larger facility. Suggestions: • Build a safe house for children in crisis, ages 12 to 17. • Create adult protective services and advocacy for elder rights.

Physical Environment Needs		
Potential Health Needs	**Average Score**	**Summary of Community Representatives' Comments**
Affordable housing	7.7	Creating affordable housing is an ongoing challenge. Wage levels do not reflect the high cost of rent. Two plus bedroom apartments are particularly difficult to come by for families. There is not enough affordable housing to cover the need and wait lists are in place.
Healthier air quality, water quality, etc.	5.1	"The city is doing a phenomenal job. As the community continues to grow we need to monitor air and water. We cannot be complacent." The community acknowledges the importance of monitoring and sustaining the aquifer levels. Recent well tests were conducted in rural areas that were needed and effective.
Healthy transportation options (sidewalk, bike paths, public transportation)	8.1	"The city is working aggressively on sidewalks, bike and public transportation improvements." Public transportation is one of the largest needs in the community. Trans IV offers transportation, but is strained by funding to build a more robust system.
Transportation to and from appointments	8.3	"Transportation is a huge barrier to treatment." This is particularly a challenge for people who live outside Twin Falls. The area is rural and people need to travel long distances to receive care. There are a handful of organizations that offer services, but the routes are very limited and only offered to certain population groups.

		Suggestions: • Provide a mobile clinic to reach community members who cannot travel into town. • Provide a shuttle between Jerome and Twin Falls. • Create a partnership between the Office on Aging and St. Luke's to develop a van transit system that is dedicated only to getting people to and from medical appointments.

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.

Emphasis on prevention vs. disease management

Many of the community representatives strongly believe that prevention is the most effective approach to improving community health and wellness. For items such as obesity, tobacco use and substance abuse, they recommend allocating resources to youth education and other prevention oriented programs. In contrast, many representatives see great value in helping people stabilize their current chronic condition(s) in order to improve health. They believe providing chronic disease management resources is the most effective route to improved health for the community at large.

The impact of added community resources vs. behavioral choice

Numerous representatives believe that added social services, medical resources and/or improved physical environment are the best ways to address people in need. For example, they believe low-cost children's services, greater access to exercise opportunities, additional psychiatrists and an improved transportation system would help raise the level of health and wellness in the community. However, there are a significant number of people who believe that regardless of how many opportunities are made available, improving health often

comes down to personal choice. Added programs provide little benefit unless individuals are ready to make healthy choices and invest in their own health.

Hub vs. rural locations

Not surprisingly, residents who live near a hospital and other major facilities respond differently than those who live in rural areas and have to make considerable efforts to seek care. Some residents who live in rural areas expect and advocate for more resources to improve and grow their communities. Others believe that limited services are inherent to living in a relatively smaller town.

These perspectives demonstrate the complexity and intricacies of community health. There is wisdom to be gained by listening and carefully reviewing each of the philosophies and experiences shared in the interviews. We invite further input from community members by visiting the St. Luke's public web page and submitting your thoughts. St. Luke's highly values your feedback and will consider the insights provided to shape and implement future change.

Community Health Needs Prioritization

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

1. Matching Health Needs to Related Health Factors

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

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

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

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

Out of the over 60 health needs and factors we analyze in our CHNA, five have scores of 20 or higher. These health needs represent **the top 10th percentile** and **are considered to be our significant, high priority health needs**. These high priority needs are highlighted in dark orange in the summary tables found on the following pages. A total of eight health needs have scores of 19 or higher representing the top 15th percentile. We highlighted these in the lighter shade of orange to make it easy to identify the next level of high ranking needs.

The summary tables provide each health need's prioritization score as well as demographic information about the most affected populations. Demographic data defining affected populations is important because it tells us when people with low incomes, no college education, or ethnic minorities suffer disproportionately from specific health conditions or from barriers to health care access.

Health Behavior Category Summary

Our community's high priority needs in the health behavior category are wellness and prevention programs for obesity, diabetes, mental illness, and suicide. Diabetes and obesity rank as high priority needs because both are trending higher and are contributing factors to a number of other health concerns. Mental illness ranks high because Idaho has one of the highest percentages of any mental illness (AMI) in the nation. Our community representatives provided relatively high scores for these needs as well.

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

Health Behavior Needs Summary Table

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

Identified Community Health Needs	Related Health Factors and Outcomes	Populations Affected Most*	Total Score
Weight management programs	Obese/Overweight adults	Income <$75,000, Hispanic, no college degree	22.4
	Obese/Overweight teenagers	Income <$35,000, Hispanic	20.4
Wellness and prevention programs	Diabetes	Income < $50,000, No high school diploma	22.3
	Mental illness		21.3
	Obesity	Income <$75,000, Hispanic, No college degree	22.3
	Suicide		21.3
Wellness and prevention programs	High blood pressure	Income < $35,000, No college, Overweight, Age 65 +	19.3
	High cholesterol	Income < $35,000, No high school diploma, Age 55+	19.3

Health Behavior Needs Summary Table, Continued

Identified Community Health Needs	Related Health Factors /Outcomes	Populations Affected Most*	Total Score
Access to healthy foods	Food environment		15.8
Exercise programs/education/ opportunities	Access to exercise opportunities		15.8
	Adult physical activity	Income < $50,000, Hispanic, No college	15.8
	Teen exercise		15.8
Nutrition education	Adult nutrition	No college	16.6
	Teen nutrition		17.6
Safe sex education programs	Sexually transmitted infections		16
	Teen birth rate		17
Substance abuse services and programs	Excessive drinking	Income <$35,000, No high school diploma, Males 18-34	15.8
	Illicit drug use	Unemployed, incomes <$50,000, males < 34 years old	17.8
	Alcohol impaired driving deaths		16.8
Tobacco prevention and cessation programs	Smoking adult	Income < $35,000, No high school diploma	17.9
	Smoking teen		16.9
Wellness and prevention programs	Accidents		18.3
	AIDS	African American, Males <24	15.3
	Alzheimer's	Age 65 +	16.3

Health Behavior Needs Summary Table, Continued

Identified Community Health Needs	Related Health Factors /Outcomes	Populations Affected Most*	Total Score
Wellness and prevention programs	Arthritis	Income < $35,000, Non- Hispanic, No college, Overweight, Age 65 +	15.3
	Asthma	Income < $35,000	14.3
	Breast Cancer	Female, Age 40+	18.3
	Cerebrovascular diseases		15.3
	Colorectal cancer		16.3
	Flu/pneumonia		17.3
	Heart disease		16.3
	Leukemia		11.3
	Lung cancer	Income < $35,000, No high school diploma	17.3
	Nephritis		15.3
	Non-Hodgkin's lymphoma		13.3
	Pancreatic cancer		13.3
	Prostate cancer	Male age 60+	17.3
	Respiratory disease		18.3
	Skin cancer (melanoma)		17.3

* Information on affected populations included in table when known.

Clinical Care Category Summary

High priority clinical care needs include: Affordable health insurance; increased availability of behavioral health services; and chronic disease management for diabetes. Affordable health insurance and the availability of behavioral health services scored as top health needs by our community health representatives. In addition, affordable health insurance ranks as a top priority need because our service area has a 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. Diabetes chronic disease management ranks high because the percentage of people with diabetes is trending higher, and it is a contributing factor to a number of other health concerns.

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

Clinical Care Needs Summary Table

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

Identified Community Health Needs	Related Health Factors and Outcomes	Populations Affected Most*	Total Score
Affordable health insurance	Uninsured adults	Income < $50,000, Hispanic, No college	20.4
Availability of behavioral health services (providers, suicide hotline, etc)	Mental health service providers	Income < $50,000	21
Chronic disease management programs	Diabetes	Income < $50,000, No high school diploma	21.2
Affordable care for low income individuals	Children in poverty	Income < $50,000, Age < 19	19.2

Clinical Care Needs Summary Table, Continued

Identified Community Health Needs	Related Health Factors and Outcomes	Populations Affected Most*	Total Score
Affordable dental care for low income individuals	Preventative dental visits		17.4
Availability of primary care providers	Primary care providers		18
Chronic disease management programs	Arthritis	Income < $35,000, Non-Hispanic, No college, Overweight, Age 65 +	14.2
	Asthma	Income < $35,000	13.2
	High blood pressure	Income < $35,000, No college, Overweight, Age 65 +	18.2
Immunization programs	Children immunized		14.3
	Adolescents immunized		14.3
	Flu/pneumonia		14.3
Improved health care quality	Preventable hospital stays		15.3
Integrated, coordinated care (less fragmented care)	No usual health care provider		17.1
	Preventable hospital stays	Refugees, Hispanics, Age 65 +	16.1
Prenatal care programs	Prenatal care 1st trimester	Hispanic, No high school diploma	15.3
	Low birth weight		11.3
Screening programs (cholesterol, diabetic, mammography, etc)	Cholesterol screening	Income < $35,000, No high school diploma, Age 55 +	16.6
	Colorectal screening	Income < $35,000, No college, Age 50+	14.6
	Diabetic screening		15.6
	Mammography screening	Income < $50,000	16.6

* Information on affected populations included in table when known.

Social and Economic Factors Category Summary

In the social and economic category, children and family services and education had the highest ranking. These needs also received relatively high scores from our community representatives.

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	18
	Inadequate social support		16
Disabled services *			14.8
Early learning before kindergarten (such as a Head Start type program)	High school graduation rate		16.2
Education: Assistance in achieving good grades in kindergarten through high school	High school and college education rates		17.5
Education: College education support and assistance programs	High school and college education rates		16.7
Elder care assistance (help in taking care of older adults)			14.8
End of life care or counseling (care for those with advanced, incurable illness)			14.4

Social and Economic Needs Summary Table, Continued

Identified Community Health Needs	Related Health Factors and Outcomes	Populations Affected Most*	Total Score
Homeless services	Unemployment rate		14.1
Job training services	Unemployment rate		14.1
Legal assistance			14.1
Senior services	Inadequate social support	Age 65 +	15.2
Veterans' services	Inadequate social support		15.6
Violence and abuse services	Violent crime rate		14

* 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 relatively 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	Populations Affected Most*	Total Score
Affordable housing	Severe housing problems	Income < $50,000	17.2
Healthier air quality, water quality, etc	Air pollution particulate matter		14.1
	Drinking water violations		12.1
Healthy transportation options (sidewalk, bike paths, public transportation)	Long commute		13.1
	Driving alone to work		16.1
Transportation to and from appointments		Income < $35,000, Rural populations, Age 65 +	16.3

* 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 diabetes
- Prevention and management of mental illness
- Availability of behavioral health services
- Prevention of suicide
- Affordable health care (top 15th percentile)
- Affordable health insurance

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

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

Group #2: Improve Mental Health and Reduce Suicide

Group #3: Improve Access to Affordable Health Insurance

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

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

Our CHNA prioritization process identified prevention and management of obesity and diabetes as two of our community's most significant health needs. About 30% of the adults in our community and one in ten children in our state are obese. According to the Centers for Disease Control (CDC): "Obesity is a national epidemic and a major contributor to some of the leading causes of death in the United States." Obesity costs the United States about $150 billion a year, or 10 percent of the national medical budget.[167] Diabetes is also a serious health issue that can contribute to heart, kidney and many other diseases and can even result in death.[168] Direct medical costs for type 2 diabetes accounts for nearly $1 of every $10 spent on medical care in the U.S. [169]

Impact on Community

Reducing obesity and diabetes will dramatically impact community health by providing an immediate and positive effect on many conditions including mental health; heart disease; some types of cancer; high blood pressure; dyslipidemia; kidney, liver and gallbladder disease; sleep apnea and respiratory problems; osteoarthritis; and gynecological problems (infertility and abnormal menses).

How to Address the Need

Obesity and diabetes can be prevented and managed by engaging our community in developing services and policies designed to encourage proper nutrition and healthy exercise habits. These needs can also be improved through evidence-based clinical programs.[170]

Extremely promising outcomes are now being reported in some communities. Remarkably, from 2011 through 2014, Lee County, Florida, reduced adult obesity levels from 29.3% to 24.8% and childhood obesity dropped from 31.6% to 20.7%. These results were accomplished through extensive community leadership and involvement. A Lee Memorial Hospital representative commented: "We believe these improvements can be sustained and improved further."[171] Echoing this approach, the CDC states that "we need to change our communities into places that strongly support healthy eating and active living." [172]

Affected Populations

[167] http://www.cdc.gov/cdctv/diseaseandconditions/lifestyle/obesity-epidemic.html
[168] Idaho and National 2002 - 2013 Behavioral Risk Factor Surveillance System
[169] America's Health Rankings 2015, www.americashealthrankings.org
[170] America's Health Rankings 2015, www.americashealthrankings.org
[171] http://www.naplesnews.com/community/bonita-banner/lee-memorial-healthy-lee-earns-prestigious-national-award_58687398
[172] http://www.cdc.gov/cdctv/diseaseandconditions/lifestyle/obesity-epidemic.html

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

Significant Health Need #2: Improve Mental Health and Reduce Suicide

Improving mental health and reducing suicide rank among our most significant health needs. This is because our community representatives scored mental health and the availability of behavioral health providers as some of our most significant health needs. In addition, Idaho has one of the highest percentages (23.3%) of any mental illness (AMI) in the nation, shortages of mental health professionals in all counties across the state, and suicide rates that are consistently higher than the national average. Depression is the most common type of mental illness, affecting more than 26% of the U.S. adult population. It has been estimated that by the year 2020, depression will be the second leading cause of disability throughout the world.

Impact on Community

Good mental health is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." It is estimated that only about 17% of U.S. adults are considered to be in a state of optimal mental health.[173]

How to Address the Need

The majority of adults who live with a mental health disorder do not get corresponding treatment. Furthermore, less than one-third of adults get minimally adequate care.[174] Stigma surrounding the receipt of mental health care is among the many barriers that discourage people from seeking treatment.[175] In addition, increasing physical activity and reducing obesity are also known to improve mental health.

Therefore, our aim is to work with our community to reduce the stigma around seeking mental health treatment, to improve access to behavioral health services, increase physical activity, and reduce obesity especially for our most affected populations**.** [176]

Affected Populations

Data shows that people with lower incomes are about three and a half times more likely to have depressive disorders.[177]

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[173] http://www.cdc.gov/mentalhealth/basics.htm

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

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

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

[177] Idaho 2011 - 2013 Behavioral Risk Factor Surveillance System

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

Barriers to access are issues that prevent people from receiving timely medical care. They include things such as the lack of transportation to doctors' appointments, the availability of health care providers, and the cost of care. Our CHNA process identified the following high ranking barrier to access:

- Affordable health insurance

The health indicator data and community representative scores have ranked this barrier to access as one of our community's most significant health needs. A recent study showed that nearly 19 percent of U.S. adults do not receive medical care or delay medical care because they are concerned about the cost or worried that their health insurance would not pay for treatment.[178]

Impact on community:
Improving access to affordable health insurance can make a remarkable difference to community health. 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.[179] Further, 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.[180]

How to Address the Need:
We will work with our community to improve access to affordable health insurance options.

Affected populations:
Statistics show that people with lower income and education levels and Hispanic populations are much more likely not to have health insurance.[181]
ucation levels and Hispanic populations are much more likely not to have health insurance.[182]

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[178] Kullgren JT, et al. Nonfinancial barriers and access to care for US adults. *Health Serv Res* online, 2011.
[179] http://www.gallup.com/poll/158417/poverty-comes-depression-illness.aspx
[180] University of Wisconsin Population Health Institute. *County Health Rankings* 2010-2015. Accessible at www.countyhealthrankings.org.

[181] Ibid
[182] 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 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 2019.

History of Community Health Needs Assessments and Impact of Actions Taken

In our 2013 CHNA, St. Luke's Jerome identified five groups of significant health needs facing individuals and families in our community. Each of these groups is shown below, along with a description of the impact we have had on addressing these needs over the past three years.

Group 1: Weight Management, Nutrition, and Fitness Programs

One of the highest ranking health needs in our 2013 CHNA was weight management for obese children and adults. Nutrition and fitness programs were also ranked above the median. Because these needs reinforce one another, we grouped them together.

Over the last three years, St. Luke's Jerome has engaged hundreds of individuals in weight loss, nutrition, and fitness programs. These programs ranged from body mass index (BMI) screenings in clinics and at health fairs to YEAH!, a wellness program that helps participating children and their families to create healthier lifestyles. In 2015, 94% of YEAH! kids showed improvement in at least one area of weight--waist circumference or BMI. Also supporting youth weight management is the annual Sports Screening Night, a partnership between St. Luke's Clinic – Jerome Family Medicine and the Jerome School District, which provides middle school and high school students with the opportunity to receive reduced-cost screenings for health concerns.

Held annually, St. Luke's Jerome Health Fair helps address the challenges of obesity and obesity-related illness by promoting healthy lifestyles, strong exercise and eating habits, and

healthcare education, as well as providing access to discounted laboratory tests. Last year, more than 500 community members attended the Health Fair and by the end of our three-year CHNA cycle we project 1,500 people will have attended.

And, a program provided free of charge to our employees, St. Luke's Healthy U, has proved meaningful when it comes to motivating people to lose weight and maintain their weight loss: from 2014 to 2015, health measures for both the areas of obesity and waist circumference improved by 7% among St. Luke's Jerome employees.

Through a variety of tactics tailored to children and adults, we are making a difference for our community when it comes to making lifestyle choices that support good health, and a strong commitment to our CHNA goals is helping us to continue down this important path.

Group 2: Diabetes

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

Diabetes continues to be a nationwide health challenge for patients and medical practitioners alike, yet in the rural community of Jerome, Idaho, we are making inroads:

- In the physician clinic setting, St. Luke's Jerome Family Medicine continues its efforts to improve CMS MSSP composite scores for patients with diabetes, and has implemented a FY 2016 goal that 15% or fewer of their patients with diabetes will have a hemoglobin A1C >9. In FY 2014 alone, Jerome Family Medicine patients with diabetes improved their CMS MSSP composite score from a baseline of 18% to a measurement of 21%. Further bolstering this effort is the implementation of a Team-Based Model of Care (physicians, nurse practitioners, certified RN diabetes educators, and dietitians) for patients diagnosed with diabetes and of scorecards that enable our providers to measure their effectiveness in diabetes management and make improvements where indicated.
- Augmenting the above-mentioned health screenings (including blood glucose and hemoglobin A1C) provided to 1,500+ participants at the St. Luke's Jerome Health Fair is St. Luke's Jerome's partnership with the Magic Valley Diabetes Coalition. This partnership brings to the community a free, annual clinic called "Head to Toe." The clinic offers eye screenings, foot exams, blood pressure and hemoglobin A1C testing, and nutrition education to people with diabetes who are either newly diagnosed, have no insurance, or have high-deductible insurance. By the end of our 3-year CHNA cycle, we project that more than 60 people will have taken advantage of this unique diabetes self-management opportunity.

Group 3: Behavioral Health Programs

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

From depression screening to a new behavioral health clinic, St. Luke's Jerome is helping to provide much-needed access to care for people with mental and behavioral health needs in our community:

- Over the past three years, St. Luke's Jerome Family Medicine has continued to screen its patients for depression, because early detection can result in decrease of acuity, patients can receive more appropriate and effective treatment, and ED visits and hospitalizations can be decreased. In FY 2014, the goal to screen >50% of patients was exceeded (62%), and this vital health screening continues today. In addition, REACH education for primary care providers continues, training providers to identify behavioral health issues vs. developmental concerns, with a focus on early intervention.
- In January 2015, St. Luke's Jerome Family Medicine added integrated behavioral health with the hiring of a licensed clinical social worker who provided bilingual services to more than 200 patients last year. This service has particularly important impact because not only is behavioral health a high-ranked need, but the Hispanic population in St. Luke's Jerome's service area is about 30% (the Hispanic population in Idaho represents 11% of the overall population).

  Idaho has one of the highest percentages (22.5%) of any mental illness (AMI) in the nation, and our service area is no exception. In FY 2016, in keeping with our commitment to addressing the greatest needs identified in our CHNA, the Family Medicine clinic will add a second behavioral health provider if our current patient capacity exceeds our ability to provide services.

Group 4: Barriers to Access

A number of barriers to access were ranked above the median including: Unaffordable health and dental care and health insurance; lack of services for low-income children and families; and inadequate numbers of primary care providers. We are looking at them as a group so that we can provide a more comprehensive picture of the programs required to address these challenges.

St. Luke's Jerome's service area poverty rate is above the national average. The poverty rate for children under age 18 is also above the national average. This means that the impact of providing affordable care and services for children and families cannot be overstated.

One way we are making a significant difference is the Smiles 4 Kids program, which provides local children with the dental care they need. While the average dental office sees 2,000

patients per year, Smiles 4 Kids has an active patient list of approximately 16,000. From FY 2013 through August 2015, 433 patients were treated at St. Luke's Jerome through the Smiles for Kids program. As the demand for Smiles 4 Kids services continues to grow, St. Luke's Jerome continues its commitment to provide access to the Operating Room and anesthesia for this purpose.

By decreasing transportation barriers, we are increasing access to care. From bus fare and taxi vouchers to gas cards, our Transportation Assistance program assists low-income patients with trips to and from medical appointments. In FYs 2014 and 2015 combined, more than $500 was allotted and additional resources have been allocated for FY 2016.

Prevention is the best and least costly medicine, and free health screenings and lab tests at St. Luke's Jerome Community Health Fair (see details in above sections), and free car-seat checks through Safe Kids, further assist low-income families by providing education and information that will help them make informed lifestyle decisions that can help prevent the need to access healthcare services. Safe Kids education is provided bilingually, further supporting our substantial Hispanic population. Through August 2015, Safe Kids provided services to 311 clients, with a FY 2016 goal to increase that number to at least 389.

We are also assisting patients through our Financial Care program. The impact from the program in helping patients using Medicare or Medicaid or who have low incomes in FY 2015 is estimated to have amounted to more than $1.5 million in charity care and bad debt.

In 2016, we will continue to promote accessible, affordable healthcare and individualized support for our patients, allowing improved access for thousands of patients with low incomes or those using Medicaid and Medicare.

Having sufficient primary care providers is critical to providing children and family services, and St. Luke's Jerome's primary care providers see patients of all ages. In support of ensuring an adequate number of healthcare providers for our community, St. Luke's Jerome Family Medicine partners with the Family Medicine Residency of Idaho to provide a rural training site for 3-4 resident physicians. This continuity program helps provide critical training for physicians and supports patient care. From October 2014 through August 2015, the resident physicians cared for 2,203 patients in Jerome and we expect the numbers to increase through FY 2016. We have also hired an additional provider and are actively recruiting for another.

Over the past three years, we have further supported access to care by:

- Implementing an electronic health record that has tools to improve health and wellness screening and assist with chronic disease and weight management. Our FY 2016 goal is to continue with Stage II Meaningful Use, along with implementation of a St. Luke's Health System-wide electronic health record system that encompasses both inpatient and outpatient records.
- Following a robust primary care provider recruitment and retention program to address the significant shortage of these providers in Jerome.

- Utilizing a Team Based Model of Care.
- Opening a 7-days-a-week urgent care clinic in the neighboring city of Twin Falls that provides a lower-cost alternative for non-emergent medical conditions.
- Making our primary care clinics more efficient, enabling our providers to see more patients per day. These strategies include space planning that improves patient flow, bettering our scheduling process, and, as noted above, implementing an electronic health records system.

Program Group 5: Additional Health Screening and Education Programs Ranking Above the Median

We recognize the importance of affordable screenings for early detection and preventable health issues. This is especially important in our service area, where a large portion of the population is low-income and lacking health insurance.

St. Luke's Jerome is actively addressing the remaining health needs that rank above the median--high cholesterol, mammography screening, respiratory disease, and safe sex education programs—by:

- Developing a survey tool that assists the consumer with healthcare activation and engagement activities to improve their health.
- Offering reduced-cost lipid screening and information about affordable mammography at our annual Health Fair (see impact details Weight Management, Nutrition, and Fitness Programs section above).
- Preventing accidental childhood injuries, the leading cause of death in children aged 14 and under in the Magic Valley, with the Safe Kids program (see impact details in the Barriers to Access section above).

Provision of digital mammography. In 2013, St. Luke’s Jerome installed a digital mammography unit at the hospital, which helps to provide early breast cancer detection with high resolution images and shorter wait times. Approximately 1,500 mammograms were provided in FYs 2013 and 2014 combined. Our goal for FYs 2015 and 2016 is to increase the number of annual mammograms provided by 5% and we are on track to accomplish this.

Resources Available to Meet Community Needs

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

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

Abuse/Violence Victim Advocacy & Services

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

Crisis Center of Magic Valley
PO Box 2444
Twin Falls, ID 83301
Phone: 208-733-0100
Phone: 24-hour crisis line: 208-733-0100
http://www.crisiscenterofmagicvalley.com/
Description: The Crisis Center of Magic Valley, Inc. (CCMV) has been providing supportive services to victims of domestic violence and sexual assault for over 30 years in the eight counties of South Central Idaho that is called "Magic Valley." The goal of the Crisis Center of Magic Valley is to rebuild lives by providing resources and tools to establish independence and freedom from abuse.

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

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

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

Ike Kistler Safe House & Project Safe Place
Phone: 208-735-8087

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

Behavioral Health and Substance Abuse Services

Al-anon - District 4
Phone: 24 Hour Information and Answering Service - (208) 592-3198
www.al-anon-idaho.org
Description**:** The Al-Anon Family Groups are a fellowship of relatives and friends of alcoholics who share their experience, strength, and hope, in order to solve their common problems.

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

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

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

Idaho Department of Health & Welfare – Twin Falls Office
Behavioral Health Services/ Mental Health Services
828 Harrison Street
Twin Falls, Idaho 83301

Phone: 208-736-2177 (Adults)
Phone: 208-732-1630 (Children)
www.healthandwelfare.idaho.gov

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

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

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

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

St. Luke's Behavioral Health Services
414 Shoup Avenue W., Suite B
Twin Falls, ID 83391
Phone: 208-814-9100
www.stlukesonline.org
Description: St. Luke's Clinic Behavioral Health Services is dedicated to providing compassionate expertise during times of psychiatric instability, allowing you to work closely with a personalized care team that also includes medication providers and your local primary care doctor. Our psychiatrists, psychologist, counselors, and nurses are trained to care for patients from childhood through the end of life. Our providers specialize in the treatment of mental illness with a focus of wellness.

St. Luke's Canyon View Behavioral Health Services
St. Luke's Magic Valley
228 Shoup Avenue West
Twin Falls, ID 83301
Phone: 208-734-6760
www.stlukesonline.org
Description: Provides treatment for adolescents, adults, and seniors. Offering intensive inpatient programs that address acute psychiatric issues in addition to

medical detoxification from alcohol and drugs. We utilize individual, family, and group counseling to address personal, family, emotional, psychiatric behavioral and addition-related problems.

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

The Walker Center
Outpatient Drug & Alcohol Treatment
762 Falls Avenue
Twin Falls, Idaho 83301
Phone: 1-208-734-4200
www.thewalkercenter.org

Children & Family Services

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

Community Council of Idaho – Felipe Cabral
1122 Washington St. So.
Twin Falls, Idaho 83301
Phone: 208-734-8419
http://www.communitycouncilofidaho.org/

Family Health Services
Various locations in Twin Falls and Jerome County
325 Martin Street
Twin Falls, Idaho 83301
Phone: 208-732-7447
114 Pioneer Ct
Jerome, ID 83338
Phone: 208-324-3471
www.fhsid.org
Description: Family Health Services provides high-quality, culturally sensitive primary medical and dental care, behavioral health, and social services that are affordable and accessible to the people of South Central Idaho.

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

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

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

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

St. Luke's Magic Valley – Safe Kids Magic Valley
601 Pole Line Road W.
Twin Falls, Idaho 83303
Phone: 208-814-7640

United Way of South Central Idaho
102 Main Ave S
Suite 5 Second Floor,
Twin Falls, ID 83301
http://www.unitedwayscid.org/

Community Health Clinics and Other Medical Resources

Family Health Services
Various locations in Twin Falls and Jerome County
325 Martin Street
Twin Falls, Idaho 83301
Phone: 208-732-7447
114 Pioneer Ct
Jerome, ID 83338
Phone: 208-324-3471
www.fhsid.org
Description: Family Health Services provides high-quality, culturally sensitive primary medical and dental care, behavioral health, and social services that are affordable and accessible to the people of South Central Idaho. Clinics located in Twin Falls, Buhl, Burley, Fairfield, Jerome, Kimberly and Rupert.

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

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

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

St. Luke's Clinic Multi-Specialty Services
115 5th Avenue W.
Jerome, Idaho 83338
Phone: 208-324-4301
www.stlukesonline.org/jerome

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

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

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

Dental Services

CSI Health Sciences & Human Services Dental Program
315 Falls Avenue
Twin Falls, ID 83301
Phone: 208-732-6722

Family Health Services
Various locations in Twin Falls and Jerome County
325 Martin Street
Twin Falls, Idaho 83301
Phone: 208-732-7447
114 Pioneer Ct
Jerome, ID 83338
Phone: 208-324-3471
www.fhsid.org
Description: Dedicated to providing quality, affordable dental care. Clinics located in Twin Falls, Buhl, Burley, Jerome, Kimberly and Fairfield.

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

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

Disability Services

Community Partnerships of Idaho
1201 Falls Avenue East, Suite 34
Twin Falls, Idaho 83301
www.mycpid.com

Idaho Department of Health & Welfare – Adult Developmental Disability Care Management
601 Pole Line Road
Twin Falls, Idaho 83301
Phone: 208-736-3024
www.healthandwelfare.idaho.gov

Idaho Department of Health & Welfare – Developmental Disabilities Program - Infant Toddler
803 Harrison Street
Twin Falls, Idaho 83301
Phone: 208-736-2182
www.healthandwelfare.idaho.gov

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

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

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

St. Luke's Magic Valley – Adult Outpatient Therapy Clinic
St. Luke's Magic Valley Medical Office Plaza
775 Pole Line Road W., Suite 303
Twin Falls, Idaho 83301
Phone (208) 814-2570

St. Luke's Magic Valley – Pediatric Outpatient Therapy Clinic
St. Luke's Magic Valley Medical Office Plaza
801 Pole Line Road W., Suite 3802
Twin Falls, Idaho 83301
Phone (208) 814-3450

Government Contacts

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

Jerome County
300 N. Lincoln Avenue
Jerome, ID 83338
Phone: 208-644.2710
www.jeromecounty.org

Food Assistance

Idaho Foodbank – South Central Food Assistance
http://idahofoodbank.org/locations/south-central-idaho-food-assistance/

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

South Central Community Action Partnership
2730 Tucker Ct. Suite B
Jerome, Idaho
Phone: 208-324-8856
www.sccap-id.org
Description: SCCAP provides a wide range of support services in an effort to help individuals and families build bridges towards self-sufficiency.

Homeless Services

CATCH – Charitable Assistance to Community's Homeless
1201 Falls Avenue, Suite 16
Twin Falls, Idaho 83301
Phone: 208-736-7654
Description: CATCH of Twin Falls was officially launched in November 2013, and is quickly becoming a vital link for families experiencing homelessness in south central Idaho. In 2014, the Twin Falls program had the capacity to serve 22 homeless families.

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

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

Safe Harbor
213 5th Ave. W
Twin Falls, ID 83301
Phone: 208-735-8787

Hospice Care

Idaho Quality of Life Coalition – South Central Region
http://www.idqol.org/
Description: The Idaho Quality of Life Coalition (formerly the Idaho End-of-Life Coalition) stands alone for consistent leadership and innovation in hospice and palliative care. Improved care, conditions, and access to quality end-of-life care is our vision.

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

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

Hospitals

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

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

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

Housing

Community Council of Idaho
El Milagro Housing Project
1122 S. Washington Street
Twin Falls, Idaho 83301
Phone: 208-736-0962
Colonia de Colores
406 Gardner Ave.
Twin Falls, Idaho 83301
Phone: 208-734-2301
http://www.communitycouncilofidaho.org/housing

Housing Authority of the City of Jerome
100 N. Fillmore Street
Jerome, Idaho
208-733-5765

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

Legal Services

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

Idaho Commission on Human Rights
1109 Main St, Ste. 450
Boise, ID 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 Office
475 Polk Street
Twin Falls, ID 83301
Phone: 208-734-7024
www.idaholegalaid.org/office/twinfalls
Description: Provides free legal services to low income Idahoans. Every year we help thousands of Idahoans with critical legal problems such as escaping domestic violence and sexual assault, housing (including wrongful evictions, illegal foreclosures, and homelessness), guardianships for abused/neglected children, legal issues facing seniors (such as Medicaid for seniors who need long term care and Social Security), and discrimination issues. Our Indian Law Unit provides specialized services to Idaho's Native Americans. The Migrant Farm Worker Law Unit provides legal services to Idaho's migrant population.

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

Public Health Resources

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

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

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

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

Refugee/Immigration Services

CSI (College of Southern Idaho) Refugee Center
1526 Highland Ave. East
Twin Falls, Idaho 83301
Phone: 208-736-2166
Fax: 208-736-4711
http://www.csi.edu/

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

Residential Care/ Assisted Living Facilities

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

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

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

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

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

Jerome Senior Center
520 N. Lincoln Avenue
Jerome, Idaho 83338
Phone: 208-324-5642

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

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

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

Veteran Services

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

Jerome County Veterans Officer
300 N. Lincoln
Jerome, Idaho 83301
Phone: 208-644-2708

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

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

Youth Programs

4-H Youth Development - Jerome County Extension Office
600 2nd Avenue West
Jerome, Idaho 83338
Phone: (208) 324-7578
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.

Jerome Recreation District
2032 S. Lincoln Avenue
Jerome, Idaho 83338
Phone: (208) 324-3389
www.jeromerecreationdistrict.com

Appendix I: Community Representative Descriptions

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

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

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

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

Community Representatives Contacted

1. **Affiliation:** U.S. Department of Veterans Affairs – Boise VA Medical Center
   Date contacted: April 8, 2015
   Interview method: Phone interview and questionnaire
   Health representative category: Category I & III
   Populations represented:
   _X_ Veterans

2. **Affiliation:** Family Medicine Residency of Idaho
   Date contacted: March 31, 2015
   Interview method: Phone interview & questionnaire
   Health representative category: Category II & III
   Populations represented:
   __X___ Children
   __X___ Disabled
   __X___ Hispanic population
   __X___ Homeless
   __X___ Low income individuals and families
   __X___ Migrant and seasonal farm workers

__X___ Populations with chronic conditions
__X___ Refugees
__X___ Senior citizens
__X___ Those with behavioral health issues
__X___ Veterans

3. **Affiliation:** Idaho Department of Health and Welfare
   Date contacted: April 7, 2015
   Interview method: Phone interview and questionnaire
   Health representative category: Category I & 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

4. **Affiliation:** Idaho Office of Refugees
   Date contacted: April 23, 2015
   Interview method: Phone interview and questionnaire
   Health representative category: Category II & III
   Populations represented:
   __X___ Children
   __X___ Disabled
   __X___ Low income individuals and families
   __X___ Populations with chronic conditions
   __X___ Refugees
   __X___ Senior Citizens
   __X___ Those with behavioral health issues

5. **Affiliation:** Community Council of Idaho
   Date contacted: May 14, 2015
   Interview method: Phone interview and questionnaire
   Health representative category: Category II & III
   Populations represented:
   __X___ Children
   __X___ Hispanic Population
   __X___ Low income individuals and families
   __X___ Migrant and seasonal farm workers

6. **Affiliation:** Idaho Department of Labor
   Date contacted: February 2015 – May 2015
   How input was obtained: Phone and email
   Health representative category: Category III

7. **Affiliation:** Idaho Health and Welfare
   Date contacted: Numerous times between October 2014 and January 2015
   How input was obtained: Phone conversations, emails, in person meeting
   Health representative category: Category I

8. **Affiliation:** Idaho Health and Welfare
   Date contacted: Numerous times between October 2014 and January 2015
   How input was obtained: Phone conversations, emails, in person meeting
   Health representative category: Category I

9. **Affiliation:** College of Southern Idaho
   Date contacted: April 28, 2015
   How input was obtained: Phone interview and questionnaire
   Health representative category: Category II & III
   Populations represented:
   __X___ Children
   __X___ Disabled
   __X___ Hispanic population
   __X___ Low income individuals and families
   __X___ Migrant and seasonal farm workers
   __X___ Refugees
   __X___ Senior citizens
   __X___ Those with behavioral health issues
   __X___ Veterans

10. **Affiliation:** College of Southern Idaho - Office on Aging
    Date contacted: May 1, 2015
    How input was obtained: Phone interview and questionnaire
    Health representative category: Category II & III
    Populations represented:
    __X___ Disabled
    __X___ Low income individuals and families
    __X___ Populations with chronic conditions
    __X___ Senior citizens
    __X___ Veterans

11. **Affiliation:** Family Health Services
    Date contacted: April 30, 2015
    How input was obtained: Phone interview and questionnaire
    Health representative category: Category II & III
    Populations represented:
    __X___ Children
    __X___ Disabled
    __X___ Hispanic population
    __X___ Homeless
    __X___ Low income individuals and families
    __X___ Migrant and seasonal farm workers
    __X___ Populations with chronic conditions
    __X___ Refugees
    __X___ Senior citizens
    __X___ Those with behavioral health issues
    __X___ Veterans

12. **Affiliation:** Jerome Recreation District
    Date contacted: April 29, 2015
    How input was obtained: Phone interview and questionnaire
    Health representative category: Category II & III
    Populations represented:
    __X___ Children
    __X___ Disabled
    __X___ Hispanic population
    __X___ Low income individuals and families
    __X___ Migrant and seasonal farm workers
    __X___ Populations with chronic conditions
    __X___ Senior citizens
    __X___ Veterans

13. **Affiliation:** Jerome School District #261
    Date contacted: May 1, 2015
    How input was obtained: Phone interview and questionnaire
    Health representative category: Category II & III
    Populations represented:
    __X___ Children
    __X___ Disabled
    __X___ Hispanic population
    __X___ Homeless
    __X___ Low income individuals and families
    __X___ Migrant and seasonal farm workers
    __X___ Those with behavioral health issues

14. Affiliation: Jerome Senior Center
Date contacted: April 27, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Children
__X___ Low income individuals and families
__X___ Senior Citizens

15. Affiliation: Interfaith Association & Presbytery of the West - Jerome, ID
Date contacted: April 28, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & 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

16. Affiliation: Wellness Tree Community Clinic
Date contacted: April 27, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Disabled
__X___ Hispanic population
__X___ Homeless
__X___ Low income individuals and families
__X___ Migrant and seasonal farm workers
__X___ Populations with chronic conditions
__X___ Senior citizens
__X___ Those with behavioral health issues
__X___ Veterans

17. Affiliation: South Central Public Health
Date contacted: May 6, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Categories I and II
Populations represented:
__X___ Children
__X___ Hispanic population
__X___ Low income individuals and families
__X___ Migrant and seasonal farm workers
__X___ Populations with chronic conditions
__X___ Senior citizens
__X___ Those with behavioral health issues
__X___ Veterans
__X___ Teens/Adolescents

18. Affiliation: St. Jerome Catholic Church
Date contacted: May 4, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Children
__X___ Disabled
__X___ Hispanic population
__X___ Low income individuals and families
__X___ Migrant and seasonal farm workers
__X___ Populations with chronic conditions
__X___ Senior citizens
__X___ Those with behavioral health issues
__X___ Veterans

19. Affiliation: St. Luke's Clinic Behavioral Health Services & Canyon View Health Services
Date contacted: May 8, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Children
__X___ Homeless
__X___ Low income individuals and families
__X___ Populations with chronic conditions
__X___ Refugees
__X___ Those with behavioral health issues

20. Affiliation: St. Luke's Disease Management and Education
Date contacted: May 8, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Children
__X___ Disabled
__X___ Hispanic population
__X___ Homeless
__X___ Low income individuals and families
__X___ Migrant and seasonal farm workers
__X___ Populations with chronic conditions
__X___ Refugees
__X___ Senior citizens
__X___ Those with behavioral health issues
__X___ Veterans
__X___ Pregnancy and diabetes patients

21. Affiliation: United Way of South Central Idaho
Date contacted: April 30, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Children
__X___ Disabled
__X___ Homeless
__X___ Low income individuals and families
__X___ Senior citizens

22. Affiliation: College of Southern Idaho - Refugee Center
Date contacted: May 12, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Children
__X___ Disabled
__X___ Low income individuals and families
__X___ Refugees
__X___ Senior citizens
__X___ Those with behavioral health issues

23. Affiliation: Crisis Center of Magic Valley
Date contacted: May 12, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Children
__X___ Low income individuals and families
__X___ Refugees

24. Affiliation: Twin Falls School District
Date contacted: April 30, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Email: dobbswi@tfsd.org, lucasmi@tfsd.org
Phone: 208-732-7502
Populations represented:
__X___ Children
__X___ Disabled
__X___ Hispanic population
__X___ Homeless
__X___ Low income individuals and families
__X___ Migrant and seasonal farm workers
__X___ Refugees
__X___ Those with behavioral health issues

25. Affiliation: Twin Falls County
Date contacted: April 24, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Low income individuals and families
__X___ Migrant and seasonal farm workers
__X___ Populations with chronic conditions
__X___ Those with behavioral health issues

26. Affiliation: La Posada, Inc.
Date contacted: May 1, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Hispanic population
__X___ Homeless
__X___ Low income individuals and families

__X___ Migrant and seasonal farm workers
__X___ Seniors
__X___ Those with behavioral health issues

27. Affiliation: South Central Community Action Partnership (SCCAP)
Date contacted: May 12, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Children
__X___ Disabled
__X___ Hispanic population
__X___ Homeless
__X___ Low income individuals and families
__X___ Migrant and seasonal farm workers
__X___ Populations with chronic conditions
__X___ Refugees
__X___ Senior citizens
__X___ Those with behavioral health issues
__X___ Veterans

28. Affiliation: Jerome County
Date contacted: April 30, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Hispanic population
__X___ Senior citizens
__X___ Veterans

29. Affiliation: City of Jerome
Date contacted: April 27, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Children
__X___ Hispanic population
__X___ Low income individuals and families
__X___ Senior citizens

30. Affiliation: La Perrona Radio Station
Date contacted: April 28, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Disabled
__X___ Hispanic population
__X___ Low income individuals and families
__X___ Populations with chronic conditions

31. Affiliation: Valley House Homeless Shelter
Date contacted: May 14, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Children
__X___ Disabled
__X___ Hispanic population
__X___ Homeless
__X___ Low income individuals and families
__X___ Migrant and seasonal farm workers
__X___ Populations with chronic conditions
__X___ Refugees
__X___ Senior citizens
__X___ Those with behavioral health issues
__X___ Veterans

32. Affiliation: City of Twin Falls
Date contacted: May 7, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Children
__X___ Disabled
__X___ Hispanic population
__X___ Homeless
__X___ Low income individuals and families
__X___ Migrant and seasonal farm workers
__X___ Populations with chronic conditions
__X___ Refugees
__X___ Senior citizens
__X___ Those with behavioral health issues
__X___ Veterans

33. Affiliation: St. Luke's Clinic Cardiology & LDS Church
Date contacted: April 29, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Children
__X___ Disabled
__X___ Hispanic population
__X___ Homeless
__X___ Low income individuals and families
__X___ Migrant and seasonal farm workers
__X___ Populations with chronic conditions
__X___ Refugees
__X___ Senior citizens
__X___ Those with behavioral health issues
__X___ Veterans

34. Affiliation: Boys and Girls Club of Magic Valley
Date contacted: May 6, 2015
How input was obtained: Phone interview and questionnaire
Health representative category: Category II & III
Populations represented:
__X___ Children
__X___ Homeless
__X___ Low income individuals and families
__X___ Refugees

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)

   _____ Greater access to healthy foods
   _____ Exercise programs/education/opportunities
   _____ 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 care health 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

_____ Healthy transportation options (sidewalks, bike paths, public transportation)

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

Identified Community Health Needs	Repre-sentative Score	Related Health Factors and Outcomes	Health Factor Score	Total Combined Score
Access to health foods	6.8	Food environment	9	15.8
Exercise programs/education/opportunities	6.8	Access to exercise opportunities	9	15.8
		Adult physical activity	9	15.8
		Teen exercise	9	15.8
Nutrition education	7.6	Adult nutrition	9	16.6
		Teen nutrition	10	17.6
Safe sex education programs	7.0	Sexually transmitted infections	9	16
		Teen birth rate	10	17
Substance abuse services and programs	7.8	Excessive drinking	8	15.8
		Illicit drug use	10	17.8
		Alcohol impaired driving deaths	9	16.8
Tobacco prevention and cessation programs	6.9	Smoking adult	11	17.9
		Smoking teen	10	16.9
Weight management programs	7.4	Obese/Overweight adults	15	22.4
		Obese/Overweight teenagers	13	20.4

Wellness and prevention programs	8.3	Accidents	10	18.3
		AIDS	7	15.3
		Alzheimer's	8	16.3
		Arthritis	7	15.3
		Asthma	6	14.3
		Breast cancer	10	18.3
		Cerebrovascular diseases	7	15.3
		Colorectal cancer	8	16.3
		Diabetes	14	22.3
		Flu/pneumonia	9	17.3
		Heart disease	8	16.3
		High blood pressure	11	19.3
		High cholesterol	11	19.3
		Leukemia	3	11.3
		Lung cancer	9	17.3
		Mental illness	13	21.3
		Nephritis	7	15.3
		Non-Hodgkin's lymphoma	5	13.3
		Obesity	14	22.3
		Pancreatic cancer	5	13.3
		Prostate cancer	9	17.3
		Respiratory disease	10	18.3
		Skin cancer (melanoma)	9	17.3
		Suicide	13	21.3

Clinical Care Category

Identified Community Health Needs	Repre-sentative Score	Related Health Factors and Outcomes	Health Factor Score	Combined Score
Affordable care for low income individuals	8.2	Children in poverty	11	19.2
Affordable dental care for low income individuals	8.4	Dental visits, preventative	9	17.4
Affordable health insurance	8.4	Uninsured adults	12	20.4
Availability of behavioral health services (providers, suicide hotline, etc)	9.0	Mental health service providers	12	21
Availability of primary care providers	7.0	Primary care providers	11	18
Chronic disease management programs	7.2	Arthritis	7	14.2
		Asthma	6	13.2
		Diabetes	14	21.2
		High blood pressure	11	18.2
Immunization programs	5.3	Children immunized	9	14.3
		Adolescents immunized	9	14.3
		Flu/pneumonia	9	14.3
Improved health care quality	6.3	Preventable hospital stays	9	15.3
Integrated, coordinated care (less fragmented care)	7.1	No usual health care provider	10	17.1
		Preventable hospital stays	9	16.1
Prenatal care programs	5.3	Prenatal care 1st trimester	10	15.3
		Low birth weight	6	11.3
Screening programs (cholesterol, diabetic, mammography, etc)	6.6	Cholesterol screening	10	16.6
		Colorectal screening	8	14.6
		Diabetic screening	9	15.6
		Mammography screening	10	16.6

Social and Economic Category

Identified Community Health Needs	Repre-sentative Score	Related Health Factors and Outcomes	Health Factor Score	Combined Score
Children and family services	7.0	Children in poverty	11	18
		Inadequate social support	9	16
Disabled services *	6.8	* See note below	8	14.8
Early learning before kindergarten (such as a Head Start type program)	6.2	High school graduation rate	10	16.2
Education: Assistance in achieving good grades in kindergarten through high school	7.5	High school and college education rates	10	17.5
Education: College education support and assistance programs	6.7	High school and college education rates	10	16.7
Elder care assistance (help in taking care of older adults) *	6.8	* See note below	8	14.8
End of life care or counseling (care for those with advanced, incurable illness) *	6.4	* See note below	8	14.4
Homeless services	7.1	Unemployment rate	7	14.1
Job training services	7.1	Unemployment rate	7	14.1
Legal assistance *	6.1	* See note below	8	14.1
Senior services	6.2	Inadequate social support	9	15.2
Veterans' services	6.6	Inadequate social support	9	15.6
Violence and abuse services	8.0	Violent crime rate	6	14

* 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

Identified Community Health Needs	Repre-sentative Score	Related Health Factors and Outcomes	Health Factor Score	Combined Score
Affordable housing	7.7	Severe housing problems	9.5	17.2
Healthier air quality, water quality, etc	5.1	Air pollution particulate matter	9	14.1
		Drinking water violations	7	12.1
Healthy transportation options (sidewalk, bike paths, public transportation)	8.1	Long commute	5	13.1
		Driving alone to work	8	16.1
Transportation to and from appointments *	8.3	* See note below	8	16.3

* 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.