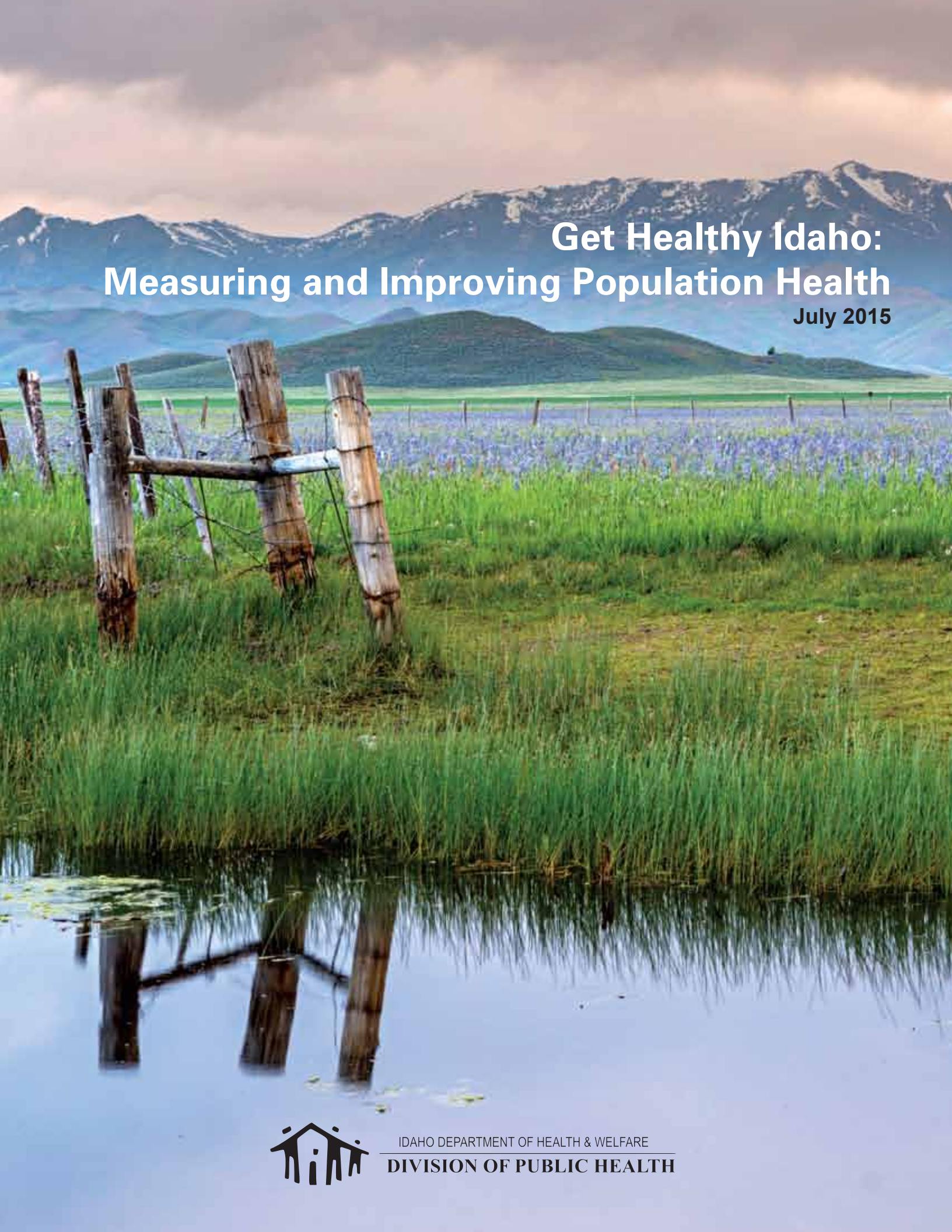
Get Healthy Idaho: Measuring and Improving Population Health

July 2015



IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Acknowledgments

The Idaho Department of Health and Welfare, Division of Public Health would like to acknowledge the contributions of the following organizations to the Get Healthy Idaho initiative and thank them for their continued support:

American Heart Association
Bingham Memorial Hospital
BSU Health Sciences
Central District Health Department
Eastern Idaho Public Health District
Idaho Academy of Family Physicians
Idaho Chapter – American Academy of Pediatrics
Idaho Department of Health and Welfare, Division of Behavioral Health
Idaho Department of Health and Welfare, Division of Public Health
Idaho Department of Health and Welfare, Division of Support Services
Idaho Healthcare Coalition
Idaho Health Professional Education Council and Family Medicine Residency of Idaho
Idaho Hospital Association
Idaho Primary Care Association
Idaho State University, Meridian
Jannus, Inc. – formerly Mountain States Group
Panhandle Health District 1
Public Health – Idaho North Central District
Qualis Health
St. Alphonsus Health System
St. Luke's Health System
South Central Public Health District
Southeastern Public Health
Southwest District Health
Terry Reilly Health Services
United Way of Treasure Valley
University of Idaho

Table of Contents

Acknowledgments 2

Table of Contents 3

Message from the State Health Officer 4

Introduction 5

Idaho Demographics 5

Get Healthy Idaho: Assessment Overview 6

State Healthcare Innovation Plan (SHIP) 7

Identification of Population Health Priorities 8

Advancing Population Health 9

Cross-Cutting Initiatives 11

Get Healthy Idaho Plan for Improving Population Health 14

- Access to Care 14
- Diabetes 17
- Tobacco Use 19
- Obesity 21

Appendix A: Get Healthy Idaho – Part 1: Population Health Assessment 23

- Idaho Population Health Assessment Summary 24
- Demographics and Social Determinants of Health 28
- Public Health District Map 31
- Leading Causes of Death 32
- Leading Health Indicators 39
- Idaho Professional Shortage Area Maps 73
- Community Health Assessment Summaries 78
- Statewide Partner Meeting Information 90
- Acronyms 96

Message from the State Health Officer

Welcome to the *Get Healthy Idaho: Measuring and Improving Population Health*! *Get Healthy Idaho* consists of two integral parts: an annual plan to improve population health and an assessment of the current state of the health of Idahoans. *Get Healthy Idaho* is a five year plan, with progress on the plan objectives reported annually. The 2016 annual plan focuses on four health priorities:

1. Access to Healthcare,
2. Diabetes,
3. Tobacco, and
4. Obesity.

With *Get Healthy Idaho,* you will see the beginning of a shift in strategies from traditional clinical based approaches, to innovative patient centered approaches and community-wide approaches. It is our intent over this five year period to build a plan based on broad population health measures and community constructs. In this first year plan, you will see the foundation for advancing the measurement of population health being built.

The *Get Healthy Idaho* assessment is the most comprehensive review of the health of Idahoans in more than a decade. This information provides the foundation for understanding the health of our residents and communities.

Idaho is often recognized as a state with business assets, natural beauty and an active, healthy lifestyle ideal for raising a family. These traits continue to draw people and businesses to the state. In order to maintain the level of healthful living we enjoy in our state and communities, it is imperative we periodically engage stakeholders to evaluate the state of health of our communities through an assessment. While the assessment highlights areas of particular concern, it also provides insight into the assets that exist across the state and within communities that can be used to address some of the areas of opportunities.

Within this document, you will also find a listing of measures identified as Idaho's Leading Health Indicators. These indicators form the framework of *Get Healthy Idaho* and dovetail with the overarching State Healthcare Innovation Plan (SHIP). The SHIP is a four-year statewide initiative testing a model to improve health care, improve health outcomes, and lower health care costs through primary care practice transformation into patient centered medical homes.

Get Healthy Idaho sets forth a process that is comprehensive, inclusive, transparent and on-going. The Division of Public Health is committed to this process and to the health of all Idahoans, both current and future. We thank you for your interest in this report and Idaho's future.

In Good Health!

Elke Shaw-Tulloch, MHS
Administrator
Division of Public Health

Get Healthy Idaho: Measuring and Improving Population Health

Introduction

Get Healthy Idaho: Measuring and Improving Population Health is a new initiative of the Department of Health and Welfare (DHW), Division of Public Health (DPH) that consists of two integral parts: a statewide, comprehensive population health assessment that provides a foundation for understanding the health of Idahoans and communities; followed by a population health improvement plan that focuses public health efforts to address specific priority areas. The intended outcome of *Get Healthy Idaho* is to improve the health of all Idahoans through broader partnerships to deliver the outlined strategies.

Get Healthy Idaho supports the Division of Public Health Strategic Plan central challenge - to advance public health's influence within the changing health system. It supports the identified priority areas of the Strategic Plan to define and promote the role of public health and achieve public health accreditation. This work satisfies Public Health Accreditation Board (PHAB) standards 1.1 (statewide health assessment) and 5.2 (statewide health improvement plan). Additionally, the State Healthcare Innovation Plan (SHIP) Model Test Grant requires the development and implementation of a population health improvement plan. *Get Healthy Idaho* serves dual roles to meet both the requirements of PHAB and the SHIP Model Test Grant. *Get Healthy Idaho* will be reviewed and updated annually from perspectives of both the data and the identified strategies and will transform as the SHIP transforms.

The priorities identified in the *Get Healthy Idaho* population improvement plan, will help shape the focus of public health over the next five years, including priorities outlined in the SHIP and those identified by the *Get Healthy Idaho* population health assessment.

Idaho Demographics

Idaho is a large western state with impressive mountain ranges, large areas of high desert and massive expanses of forested terrain. Idaho contains the second largest wilderness area in the lower 48 states, the Frank Church – River of No Return Wilderness, which covers almost 2.4 million acres. Geography and distance impact both the demographic characteristics and social determinants of health within Idaho. Idaho is ranked 39th of the 50 United States for total population and 14th for geographic size. The 2013 estimated population for Idaho was 1,612,136 and because of its large size and relatively small population, Idaho remains one of the most rural states in the nation. With approximately 19.0, people per square mile Idaho ranks 44th of the 50 states in population density. The national average population density is 87.4 people per square mile, a four-fold greater density than Idaho. Thirty four of Idaho's 44 counties are rural with 19 of these considered frontier, having fewer than six people per square mile.

Idaho has seven population centers throughout the state with approximately 66 percent of the population residing in one of these populated areas. Delivering adequate health services to the entire state remains a challenge in this very rural environment.

To facilitate the availability of public health services, contiguous counties in Idaho have been aggregated into seven public health districts (see map page 31). These seven areas are defined by geographic barriers as well as transportation routes and population centers. As reflected in the priorities, access to health care and other services have been identified as barriers to improving health outcomes for Idaho residents.

Get Healthy Idaho: Assessment Overview

The *Get Healthy Idaho population health* assessment was conducted during the summer and fall of 2014, with an in-person meeting of stakeholders in November, 2014. To conduct the assessment, data were gathered from a variety of sources. Idaho's Leading Health Indicators document (page 40), developed by the Division of Public Health, was used as the framework for the core data of the assessment. The Leading Health Indicators document offers a consistent approach to assess the health of Idahoans and provides a way to determine if health status is changing and/or improving over time.

Community level data in the format of local public health and hospital community health needs assessments, other health assessments such as the Maternal and Child Health (MCH) Five Year Needs Assessment and the Primary Care Needs Assessment were collected and summarized. Issues and outcomes were arranged and grouped to align with the seven local public health district jurisdictions across Idaho. The PHAB standards also informed the data refining process. PHAB identifies what it considers core public health programs and, as data were assessed, only data that fell within the framework of PHAB were prioritized to move forward for consideration in the health improvement plan.

The top six public health issues in rank order, identified in the *Get Healthy Idaho* assessment were:

1. Healthcare Access
2. Obesity
3. Heart Disease and Stroke
4. Vaccine Preventable Diseases
5. Exercise
6. Suicide

Idaho Bureau of Rural Health & Primary Care

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

State Healthcare Innovation Plan (SHIP)

SHIP is a national undertaking by the Center for Medicare and Medicaid Innovation (CMMI) to re-design the healthcare delivery and payment system and create new models across states. In Idaho, the goal of the SHIP is to re-design the healthcare system, evolving from a fee-for-service, volume-based system to a value-based system of care that rewards improved health outcomes. The foundational goal is to increase access to and coordinate care among primary care providers; practice patient-centered medical care, and create the broader medical neighborhoods of specialists, hospitals, behavioral health professionals, long-term care providers, public health services and other ancillary medical care and social services. Idaho received a CMMI Model Test Grant to implement the SHIP. This grant is administered by the Department of Health and Welfare, but advised by the Governor-appointed Idaho Healthcare Coalition (IHC). Public health is central to these efforts and will lead the seven Health Collaboratives (HCs) that will be created to locally support provider practices as they transform and address regional population health issues. The Population Health Workgroup, a workgroup of the Idaho Healthcare Coalition, will advise on the model test grant as well as the *Get Healthy Idaho* initiative.

A requirement of CMMI model test grant is the development and implementation of a population health improvement plan focused on the three priority areas of:

1. Comprehensive Diabetes Care
2. Obesity in Children
3. Tobacco Cessation Intervention

Identification of Population Health Priorities (2015 to 2020)

The Division of Public Health reviewed the outcomes of the population health assessment through the lens of the SHIP Model Test Grant and the requirement to address diabetes, obesity in children and tobacco use. Division leadership identified four health priorities for the first year of *Get Healthy Idaho* as:

1. Access to Care,
2. Diabetes,
3. Tobacco, and
4. Obesity.

The public health issues of the SHIP and *Get Healthy Idaho* have obvious overlap. **Access to care** was the number one priority of the assessment and is foundational to the SHIP. Therefore, as healthcare transformation unfolds in Idaho, it makes sense that access to care is a first year priority. Even though **Diabetes** was not identified as a priority health issue of the population health assessment, the economic burden and morbidity estimations of diabetes in Idaho make it a first year priority. **Tobacco use** is a major behavioral risk factor that impacts heart disease and stroke directly, the third ranked priorities of the population health assessment. By adopting tobacco use as a year one priority, the priority health issues of heart disease and stroke may be impacted. The Time Sensitive Emergency (TSE) System of Care was approved and funded by the Idaho Legislature in 2014. TSE will directly impact three of the top five leading causes of death in Idaho: trauma, stroke, and heart attack. The outcomes associated with a comprehensive TSE system of care are improved patient outcomes, reduced frequency of preventable death, and improved quality of life of the patient. Finally, **obesity** was identified as a priority issue for both the SHIP and the population health assessment. An obvious connection to obesity is exercise, the fifth priority health issue of the population assessment. Exercise will be addressed through the strategies developed to address obesity.

The population health assessment, evaluated contributing risk factors to the identified priority health issues. As expected, several risk factors, high-risk populations and resources/assets overlapped priority areas. Three priority areas (heart disease and stroke, obesity and exercise) share many contributing factors including lack of exercise, lack of fruits and vegetables, limited education, access to transportation, access to preventive medicine, depression, cultural influences and genetics. In addition, heart disease and stroke, obesity and exercise share similar high-risk populations including people with diabetes, Hispanics, Native Americans, those living in poverty, rural Idahoans, those with limited education and those suffering from depression. In general, resources vary by geographic area but similar resources for heart disease and stroke, obesity and exercise include community education, healthcare providers, weight loss programs and nutrition programs.

Vaccine preventable disease and suicide were not identified as year one priorities, however work to address these issues continues in the Division. The 2015 Legislature passed a Senate Concurrent Resolution (SCR) 104 acknowledging the importance and severity of the incidence of suicide in Idaho and directing a review of the resources and opportunities available to address suicide. While vaccine preventable diseases and suicide lack the same amount of overlap as the other health priority areas, there are still similarities among them, including lack of preventive services, limited access to providers, lack of insurance, low socioeconomic status and those living in rural areas.

Advancing Population Health

Major models of healthcare reform focus primarily on controlling the costs of care and improving patient's outcomes and experience. Population health measures tend to focus on clinical preventive services but do not address "up-stream" or higher-level determinants of health. Clinical services account for a relatively small impact on population health. To improve the health of a broadly defined population, integration of clinical services, public health and community based initiatives is necessary.

Knowing that a balanced portfolio of measures will include both practice- and community-wide measures *Get Healthy Idaho* has adopted John Auerbach's (Associate Director for Policy, Centers for Disease Control and Prevention) method for analyzing the measures of health at the patient level, clinic-community level and community-wide level. Auerbach refers to these levels as buckets and defines these as:

- Bucket #1 – Traditional Clinical Approaches. The focus is on an individual and has a patient construct. Typical clinical services done in a one-on-one patient interaction would be at this level.
- Bucket #2 – Innovative Clinical Care. The focus is a patient construct with a narrow population view such as a practice or an accountable care organization. The patient centered medical home is an innovative clinical mode that provides linkages which support patients in the community.
- Bucket #3 – Community-wide Health. The focus is on a broad population, such as a Health District or the state of Idaho, and has a community construct. Community-wide health initiatives typically have a policy focus.

St. Maries, Idaho Middle School STAND grant assists with smoke free ordinance for a local park.
American Lung Association – Support Teens Against Nicotine Dependency (STAND)

The following table defines these three levels of services and includes disease and risk factor examples.

Bucket #1: **Traditional Clinical Approaches**	**Bucket #2:** **Innovative Clinical Care – Patient Centered**	**Bucket #3:** **Community-wide Health**
Focused on an individual patient construct	Focused on an individual patient construct with a narrow population view	Focused on a broad population; community construct
Typical clinical services done in a one-on-one patient interaction	Linkages that support patients in the community	Broader, mostly policy focused
ASTHMA Example		
Diagnosis, treatment, asthma action plan, medication, clinical guidance	Community Health Worker (CHW) conducts a home visit to assess asthma triggers, post-clinical counseling, conducts limited remediation in the home; focus is on linkages and referrals	Community standards on housing, reducing environmental exposures, air quality regulations, reducing smoking rates, smoking policies
HEART DISEASE Example		
Blood pressure management, aspirin adherence, cholesterol screening, tobacco use screening	Linking CHWs and Community Health Emergency Medical Services (CHEMS) to patients after clinical care; increase the health capacity of the individual	Community prevention to reduce need for treatment with policies like tobacco control, sodium reduction, trans fat elimination
TOBACCO Example		
Screening patients for smoking, ensuring smoking cessation referral, physician/patient counseling	Linkages that support patients in community, linking patient to cessation class or QuitLine/QuitNet (QL/QN)	Practices and policies to lower smoking rates statewide

Cross-Cutting Initiatives

The Division of Public Health makes every effort to integrate and collaborate within the Division and Department, as well as with external partners to maximize positive impacts to population health measures. Idaho's Leading Health Indicators focus the work and assure that a population health perspective is maintained that spans the life course. Large initiatives that are impacting population health outcomes in Idaho in 2015 are briefly described below. Where appropriate, links have been added to access more detailed information on these initiatives. Throughout the population health improvement plan you will see these initiatives noted under cross-cutting initiatives. This is a shorthand notation to acknowledge the synergistic impact of multiple initiatives.

State Healthcare Innovation Plan (SHIP)

http://healthandwelfare.idaho.gov/Medical/StateHealthcareInnovationPlan/tabid/2282/Default.aspx

In December 2014, the Idaho Department of Health and Welfare received a state innovation model test grant for $39,683,813. The grant, from the Center for Medicare and Medicaid Innovation, will fund a four-year model test that began on Feb. 1, 2015, to implement the Idaho State Healthcare Innovation Plan (SHIP). During the grant period, Idaho will demonstrate that the state's entire healthcare system can be transformed through effective care coordination between primary care providers practicing patient-centered care, and the broader medical neighborhoods of specialists, hospitals, behavioral health professionals, long-term care providers, and other ancillary care services. The goal of the SHIP is to redesign Idaho's healthcare system, evolving from a fee–for-service, volume-based system to a value-based system of care that rewards improved health outcomes.

Chronic Disease Prevention Grant (a.k.a. 1305)

State and Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health is commonly referred to by the federal grant number, 1305. The primary purpose of this funding is to support statewide implementation of cross-cutting approaches to promote health and prevent and control chronic diseases and their risk factors. This grant addresses four chronic disease programs: Diabetes; Heart Disease and Stroke Prevention; Nutrition, Physical Activity and Obesity and School Health.

Outcomes related to health promotion activities that are addressed include:

- increased adoption of healthy food service guidelines/nutrition standards;
- increased adoption of physical education/physical activity in schools;
- increased adoption of physical activity in early care and education sites and worksites;
- increased reporting of blood pressure and A1C measures;
- increased awareness of high blood pressure among patients;
- increased awareness of pre-diabetes among people at high risk for type 2 diabetes and,
- increased participation in diabetes self-management education programs.

In addition, the following outcomes related to implementation activities that are addressed include:

- increased consumption of nutritious food and beverages and increased physical activity across the life span;
- increased breastfeeding initiation, duration, and exclusivity;

- improved medication adherence for adults with high blood pressure and adults with diabetes;
- increased self-monitoring of high blood pressure tied to clinical support;
- increased use of diabetes self-management and primary prevention programs;
- improved prevention and control of hypertension;
- improved prevention and control of diabetes,
- and improved prevention and control of overweight and obesity.

Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality
http://mchb.hrsa.gov/infantmortality/coiin/

CoIIN is a public-private partnership to reduce infant mortality and improve birth outcomes. Participants learn from one another and national experts, share best practices and lessons learned, and track progress toward shared benchmarks. CoIIN builds on the success of multiple public and private investments to improve birth outcomes. The following are common strategies of CoIIN:

- Promote infant safe sleep practices;
- Improve perinatal regionalization (a geographically-targeted approach to assure risk-appropriate care for mothers and infants);
- Reduce elective delivery at less than 39 weeks of pregnancy;
- Expand access to inter-conception care (between pregnancies) through Medicaid, and;
- Promote smoking cessation among pregnant women.

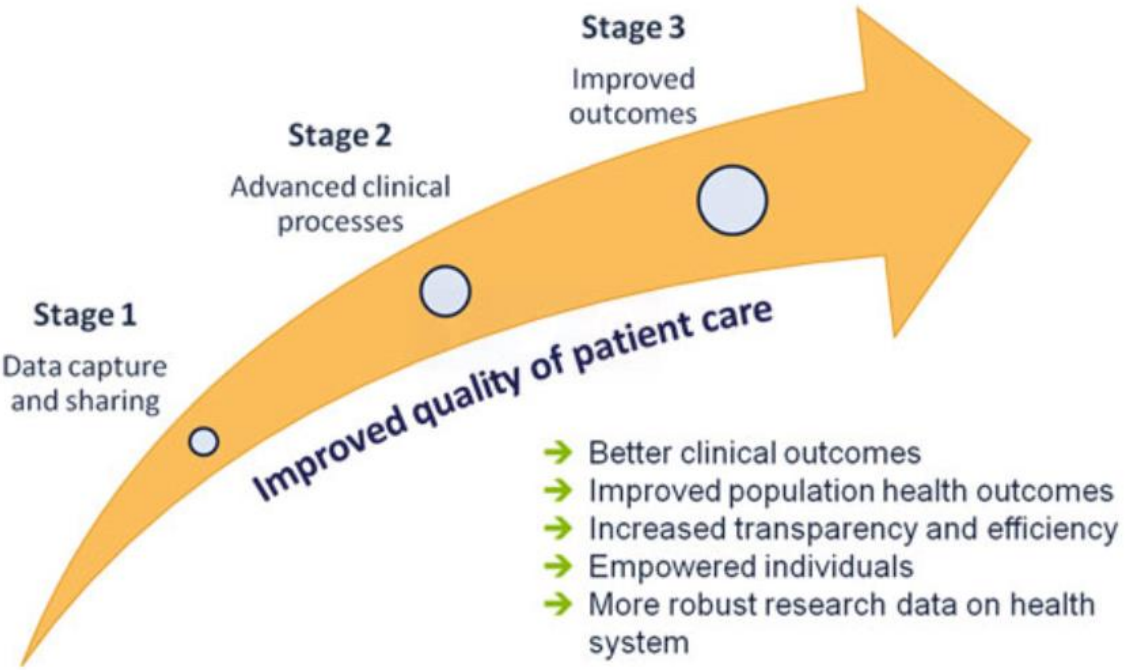
The two strategies selected to reduce infant mortality are smoking cessation among pregnant women and promoting safe sleep practices for infants.

Meaningful Use Program

The goals of the Centers for Medicare and Medicaid Services Meaningful Use Electronic Health Record (EHR) Incentives and Certification Program are to leverage certified EHR technology to:

- improve health care quality, safety, efficiency, and reduce health disparities;
- engage patients and families;
- improve care coordination, and population and public health, and
- maintain privacy and security of patient health information.

Starting in 2009 with the Meaningful Use Program's inception of Stage 1, Idaho Public Health has partnered with providers and hospitals to help them meet the requirements of public health reporting to receive Medicare incentives. Since the Idaho Medicaid Program's implementation of Meaningful Use in July 2011, the Division of Public Health has worked with providers and hospitals to receive Medicaid incentive payments by meeting public health reporting requirements. Idaho is currently working with health care providers throughout Idaho to electronically receive laboratory reports for reportable diseases and conditions, immunization registry data, emergency department syndromic surveillance data, and cancer registry data. With Meaningful Use, there is increased opportunity to reduce disparities, control chronic diseases, and build a healthcare system that promotes well-being and is accountable for both individual health and the health of communities.



Get Healthy Idaho – Plan for Improving Population Health

State Fiscal Year (SFY) 2016

Health Priority: ACCESS TO CARE

Five Year Goal: Increase Access to Health Care Services

SMART Objective: Initiate three efforts to identify or address barriers facing Idaho's underserved areas and populations by December of 2016

Strategy 1: Review and renew health care shortage areas.

	Measure	Baseline	Target	Who	Cross Cutting Initiatives	Data Source
	Number of designated areas qualifying as dental, mental, primary care Health Professional Shortage Areas	0 (CY15)	70	Bureau of Rural Health and Primary Care (BRHPC)	SHIP	Provider data
	Number of designated areas qualifying as Medically Underserved Areas.	0 (CY15)	54	BHRPC	SHIP	SHIP Report

Strategy 2: Develop and implement Community Health Emergency Medical Services (CHEMS) programs.

	Measure	Baseline	Target	Who	Cross Cutting Initiatives	Data Source
	Number of Idaho EMS agencies recruited to participate in the CHEMS initiative	2(CY15)	3	Bureau of EMS & Preparedness (BEMSP), BRHPC, Idaho State University	SHIP	SHIP Report
	Number of paramedics receiving formal CHEMS trainings	0 (CY15)	12	BEMSP, BRHPC, EMS Physician Commission, CHEMS Taskforce	SHIP	SHIP Report

Strategy 3: Recruit new and existing primary care medical homes (PCMH) to participate in the SHIP.						
	Measure	**Baseline**	**Target**	**Who**	**Cross Cutting Initiatives**	**Data Source**
	Number of primary care clinics recruited to participate in the SHIP PCMH transformation.	13(CY15)	55	Idaho Healthcare Coalition (IHC), BRHPC, Public Health Districts (PHDs), IDHW	SHIP	SHIP Report
	Number of Regional Health Collaboratives established	0(CY15)	7	BRHPC, PHDs, IHC, IDHW	SHIP	SHIP Report

Idaho's Challenges and Opportunities: Access to Care

Idaho is the 11th largest state in the nation and 39th in population size with 1,567,582 people based on the 2010 decennial census. The state's per capita income is significantly less than the national average ($22,581 compared to $28,051) and the poverty rate is above the national average (15.1% compared to 14.9%).

The Idaho Department of Commerce defines rural as any county that does not have a population center with 20,000 persons or greater, this definition includes 35 of Idaho's 44 counties. Based on 2010 Census data, on average, there are 19 persons per square mile in the state of Idaho, and 18 of Idaho's 44 counties have a frontier classification (fewer than 6 people per square mile, National Center for Frontier Communities[1]).

Using 2013 data from U.S. Department of Health and Human Services, CQ Press ranks Idaho 13th nationally in percent of population lacking access to primary care services at 17.4%, 6.5% greater than the national average (SAGE Publications, Inc., 2013). Idaho also ranks 48th out of 50 states with 70 physicians per 100,000 population according to CQ Press, well under the national rate of 98 physicians per 100,000 population (SAGE Publications, Inc., 2012).

Primary Care: There are 43 Health Professional Shortage Area (HPSA) designations for geographic areas and population groups across the state of Idaho. These designations cover 96.36% of the state's total land area: approximately 60.54% of Idaho's geography is designated as a population group HPSA, while 35.82% is designated as a geographic HPSA in the primary care discipline.

Dental Health: There are 43 HPSA designations for geographic areas and populations across the state of Idaho. These designations cover a total of 97.01% of the state's land area: approximately 78.18% of Idaho's geography is designated as a population group HPSA, while 18.83% is designated as a geographic HPSA in the dental discipline.

[1] http://www.frontierus.org/2010census.php

Mental Health: There are 7 HPSA designations, which encompass all 44 counties, for geographic areas and populations across the state of Idaho. Due to the severe shortage of mental health professionals across the state, the Idaho Primary Care Office reviews the state's geography on a regional basis. As a geographic HPSA, these mental health designations encompass 100% of Idaho's land area and population.

Health Priority: DIABETES

Five Year Goal: Reduce the economic burden of diabetes in Idaho and improve the quality of life for those who have or are at risk for diabetes

SMART Objective: Increase by 10% the availability of educational opportunities for Idahoans to manage modifiable risk factors associated with diabetes or pre-diabetes by July 2016

Strategy 1: Increase the number of CDC-recognized Diabetes Prevention Programs (DPP) and American Diabetes Association (ADA) or American Association of Diabetic Educators (AADE) Diabetes Self-Management Education (DSME) Programs						
	Measure	**Baseline**	**Target**	**Who**	**Cross Cutting Initiatives**	**Data Source**
	Number of ADA/AADE DSME programs where DSME classes are offered	28 (SFY15)	33	Division of Public Health Diabetes Prevention and Control Program (DPCP) and Heart Disease and Stroke Prevention Program (HDSP)	1305 SHIP	ADA/AADE Registry
	Number of CDC-recognized DPPs.	3 (SFY15)	9	DPCP	1305 SHIP	CDC Registry

Strategy 2: Increase referrals to CDC-recognized Diabetes Prevention Programs and ADA/AADE Diabetes Self-Management Education Programs						
	Measure	**Baseline**	**Target**	**Who**	**Cross Cutting Initiatives**	**Data Source**
	Number of persons with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized DPP	89 (SFY14)	300	DPCP	1305 SHIP	Diabetes Prevention Recognition Program (DPRP) State Level Report, January 201
	Number of people with diabetes who have at least one encounter at an ADA/AADE DSME Program	6,534 (SFY13)	8,000	DPCP	1305 SHIP	ADA/AADE

Idaho's Challenges and Opportunities: Diabetes

Effectively managing diabetes will help Idahoans living with diabetes lead more productive and healthier lives. An estimated 100,000 Idaho adults, or 8.4% of the adult population, live with diabetes and an estimated 84,000 Idaho adults, or 7.5% of the adult population, live with pre-diabetes. Diabetes is the seventh leading cause of death in Idaho and about one third of Idaho adults living with diabetes do not know they have the disease. The direct medical cost of diagnosed cases of diabetes in Idaho is estimated as more than $172 million annually. Improperly managed diabetes often leads to costly diabetes related complications and has a tremendous impact on Idaho's Medicaid program as well as other Idaho health insurers. Most diabetes can be prevented or delayed if a range of risk factors is eliminated particularly physical inactivity, unhealthy diets, tobacco use and alcohol misuse. Numerous studies demonstrate that diabetes treatments and therapies improve diabetes control and reduce the incidence of complications due to diabetes. With affordable access to evidence-based, community-based diabetes prevention programs many people with pre-diabetes can prevent or significantly delay the onset of type 2 diabetes. With proper management and treatment, individuals with diabetes can live healthy, productive lives.

Health Priority: TOBACCO USE

Five Year Goal: Reduce tobacco use in Idaho.

SMART Objective: Increase the percentage of Idaho adult smokers that have attempted to quit smoking in the past 12 months from 61.3% to 66.3% by July 2016.

Strategy 1: Increase referrals to cessation services						
	Measure	**Baseline**	**Target**	**Who**	**Cross Cutting Initiatives**	**Data Source**
	Number of women 21-64 years of age referred for QuitLine/QuitNet (QL/QN), cessation classes	708 (SFY14)	825	Women's Health Check (WHC) Program, PHDs, Primary Care Providers	SHIP, CoIIN, MCH Measures	Women's Health Check Real Time (WHCRT) Database
	Number of 18-24 year olds who registered for QL/QN cessation services (1-call, multi-call, online)	852 (SFY15)	895	Project Filter, PHDs	SHIP	IDHW

Strategy 2: Promote the use of nicotine replacement therapy (NRT) for appropriate individuals enrolled in cessation services						
	Measure	**Baseline**	**Target**	**Who**	**Cross Cutting Initiatives**	**Data Source**
	Number of 18 – 24 year olds that were shipped 8 weeks of Nicotine Replacement Therapy (NRT)	281 (SFY15)	295	Project Filter	SHIP	Project Filter
	Proportion of registrants ordering NRT through the Idaho QL/QN	73% (SFY15)	75%	Project Filter	SHIP	Project Filter

Idaho's Challenges and Opportunities: Tobacco Use

Tobacco use is the single most preventable cause of disease, disability and death in the United States, resulting in an estimated 480,000 people dying prematurely from smoking or exposure to secondhand smoke (U.S. Department of Health and Human Services, 2014). Smoking kills more people than alcohol, AIDS, car accidents, illegal drugs, murders, and suicides combined. Comprehensive strategies have been identified and proven effective for preventing youth from starting, helping smokers quit, and reducing secondhand smoke exposure, making the fight against tobacco use a winnable battle. High tobacco taxes, smoke-free or tobacco-free policies, well-funded youth prevention programs and regulation of tobacco products are proven ways to reduce death and disease caused by tobacco use. Tobacco use remains the leading preventable cause of death and disease in Idaho. Idaho's most recent Behavioral Risk Factor Surveillance Survey (BRFSS 2013) indicates the current smoking rate is 17.2%. While this is lower than the national average of 18.1%, the rate has not changed significantly over the last five years. Data from the Centers for Disease Control and Prevention (CDC, 2014) show the Idaho youth smoking rate to be 12.2% with approximately 1,400 youth under 18 becoming new daily smokers each year. The economic burden incurred in Idaho from smoking has reached $508 million in total medical costs ($83 million covered by Medicaid) and $358 million in lost productivity from premature death each year (CDC, 2014). This amount does not include health costs caused by exposure to secondhand smoke, smoking-caused fires, smokeless tobacco use, or cigar and pipe smoking. Tobacco use also imposes additional costs such as workplace productivity losses and damage to property. Despite a continued focus on eliminating tobacco-related health disparities, the prevalence of tobacco use and subsequent health consequences continue to disproportionately impact specific populations. American Indians/Alaskan Natives, Hispanics and Latinos, members of the lesbian, gay, bisexual, transgender (LGBT) community, those of low socio-economic status, those living with mental illness, Medicaid enrollees, and veterans represent Idaho population groups that experience tobacco-related health disparities

Health Priority: OBESITY

Five Year Goal: Reduce the burden of obesity in Idaho (28.6% obese, overweight + obese=62.5%)

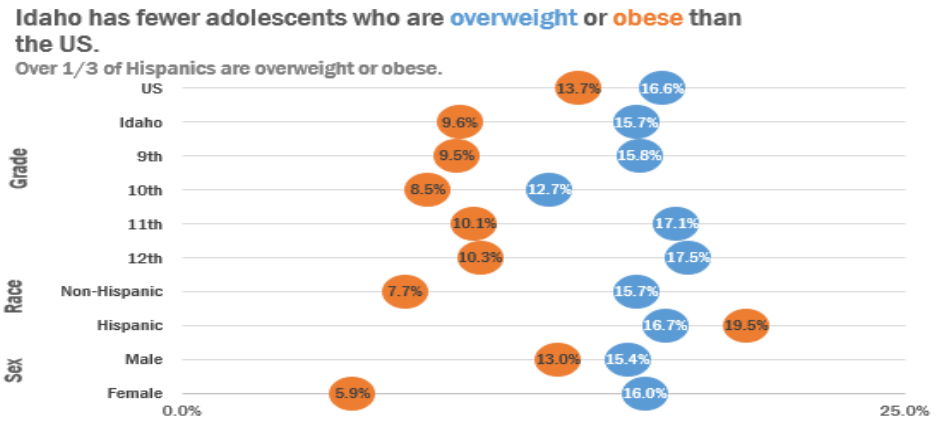
SMART Objective: Decrease the percentage of children who are overweight / obese from 27.8 to 26.8 by July 2016

Strategy: Increase healthy options for infants and children through education and collaboration						
	Measure	**Baseline**	**Target**	**Who**	**Cross Cutting Initiatives**	**Data Source**
	Number of childcare providers who have attended Let's Move trainings	170	280	IPAN, PHDs, IAEYC	1305, MCH Annual Report	IPAN
	Percent of children on WIC age 2-5 who are obese	7%	6%	Special Supplemental Nutrition Program for Women, Infants and Children (WIC), PHDs	SHIP	WIC Information System Program (WISPr)
	Percent of children on WIC age 2-5 who are overweight	9%	8%	WIC, PHDs	SHIP	WISPr
	Percent of women on WIC who initiated breastfeeding at birth	86% (SFY13)	90%	WIC, Birthing Hospitals and Centers, Primary Care Providers, Regional Breastfeeding Coalitions	MCH Annual Report, SHIP	WISPr
	Percent of women on WIC who are still breastfeeding at 3 months	52% (SFY13)	55%	WIC, Birthing Hospitals and Centers, Primary Care Providers, Regional Breastfeeding Coalitions	MCH Report	WISPr

Idaho's Opportunities and Challenges: Obesity

Idaho, like most states, is seeing a steady increase in the percentage of its population that is overweight or obese. Overweight and obesity are both labels for ranges of weight that are excessive for a certain height. Due to the difficulty of measuring body fat directly, overweight and obesity are estimated by body mass index (BMI). Adults with a BMI between 25.0 and 29.9 are considered overweight and those with a measure of 30 and greater are considered obese. Childhood and adolescent BMI measures take sex and age into consideration. Most obesity data is self-reported through the BRFSS. Alarmingly, the majority of Idahoans are considered overweight or obese (62.5%). The breakout is 35.8% overweight and 26.8% obese. Across Idaho, males are more overweight than females (69.6% compared with 54.9%) and more obese than females (27.3% compared with 26.2%). Overall, Idaho children are less overweight or obese than national rates (27.8% vs. 31.3%), but Hispanic children are significantly more overweight and obese than white, non-Hispanic children (37.3% vs. 26.2%). Idaho schools are not required to collect height and weight data or report BMI. However, during the 2011-2012 school year, the Division's Bureau of Community and Environmental Health conducted the Idaho 3rd Grade BMI Assessment. That assessment found 29.7% of 3rd graders to be overweight or obese. Childhood overweight and obesity rates range from 10 to 50 percent in communities across Idaho. Many of the leading causes of preventable disease and death, including heart disease, stroke, type 2 diabetes and certain types of cancer are obesity related. A 2012 Robert Wood Johnson Foundation Trust for America's Health Report estimated that Idaho spends more than $2.7 billion in costs due to obesity, which are projected to rise to more than $3 billion by 2030. The Report also estimates that a five percent decrease in obesity would save Idaho $1.2 billion by 2020 and $3.3 billion by 2030.

An early and effective intervention to promote the healthy weight of children is breastfeeding. Prolonged breastfeeding has been shown to decrease the risk of overweight in children (http://pediatrics.aappublications.org/content/113/2/e81.short). Breastfeeding longer than six (6) months postpartum provides several health benefits to both the infant and the mother. Typically, during the time period after the birth of the infant up to three (3) months postpartum is when women tend to stop breastfeeding. There are several factors that impact the decision to stop breastfeeding. However, with focused support during this critical period, many women can be encouraged to continue to breastfeed. While Idaho generally has good breastfeeding rates, improving in this area can have multiple and long term benefits for both mothers and children. Continued education and policy efforts physical activity, nutrition and the built environment will be critical in reducing obesity and improving health across the lifespan.



Get Healthy Idaho: Measuring and Improving Population Health

Part 1: Health Assessment

April 2015

IDAHO DEPARTMENT OF HEALTH & WELFARE

DIVISION OF PUBLIC HEALTH

Idaho Population Health Assessment Summary 2014

Introduction

In April 2014, Division of Public Health leadership developed a strategic map that illustrates its commitment to advancing Public Health's influence in the changing health system in Idaho. To accomplish this goal, the Division committed to working closely with partners, both within the Idaho Department of Health and Welfare and across the state, to better understand the health issues of Idahoans, the underlying factors that impact health, and the resources and gaps that provide a wealth of untapped opportunity.

The population health assessment presented here, is the most comprehensive assessment of the health of Idahoans in more than a decade. With the completion of the assessment, the Division will respond with a coordinated effort that distributes the power of partnerships to the most remote communities of the state through a plan to improve population health. The leadership within the Division of Public Health leads these efforts known as *Get Healthy Idah*o.

Assessment Process Overview

Multiple frameworks were researched to inform the creation of this health assessment. Two frameworks, in particular, provided structure and guidance to the process: "The Community Health Assessment Toolkit", published by the Association for Community Health Improvement and the "Planning and Conducting Needs Assessments: A Practical Guide", by Wilkin and Altschuld.

Data were gathered from a variety of resources. Idaho's Leading Health Indicators document, developed by the Division, was used as the framework for the core data of the assessment. The Leading Health Indicators document offers a consistent approach to assess the health of Idahoans and provides a way to determine if health status is changing and/or improving over time. The Idaho Leading Health Indicators was finalized in the spring of 2014. This is important to note because much of the work Idaho is doing to assess population health and develop coordinated plans is evolving.

Community level data in the format of local public health and hospital community health needs assessments available between June and October of 2014 were collected and analyzed. Information from these assessments was compiled to align with the existing seven Public Health Districts. Additionally, the Division identified other health assessments currently underway that complement the community health needs assessments. These assessments include the Maternal and Child Health Five Year Needs Assessment and the Primary Care Needs Assessment. The Public Health Accreditation Board (PHAB) standards also informed the data refining process. PHAB identifies what it considers core public health programs and, as data were assessed, only data that fell within the framework of PHAB were prioritized to move forward for consideration in the health improvement plan.

On November 17, 2014, the Division hosted the Idaho Health Assessment Statewide Partner Meeting at Boise State University. Representation included state and local public health agencies, healthcare systems, community based organizations, higher education, rural health clinics, and statewide health associations. The partners were given a list of fourteen top health issues that arose during the initial data compilation, referred to as the master list. Partners participated in selecting priority issues utilizing a nominal group technique that reduced the list down to six issues, and finally ranked the issues. From

there, the group had a targeted discussion identifying the contributing factors, high risk populations, resources and gaps for each priority issue.

Once completed, the final draft of the health assessment was sent back to all partners initially invited to the statewide partner meeting for review. The document was also uploaded to the Department of Health and Welfare's website for a two-week period soliciting general public review and comment. Print and social media were utilized to notify partners and the general public that the document was available for comment.

Findings

The master list of fourteen health issues included: Asthma, Alzheimer's Disease, Cancer, Diabetes, Exercise, Health Care Access, Heart Disease and Stroke, Vaccine Preventable Diseases, Obesity, Prenatal Care, Poor Nutrition, Suicide, Tobacco Use and Unintentional Injury.

Following the group voting process, the top six public health issues in priority order are:

1. Healthcare Access
2. Obesity
3. Heart Disease and Stroke
4. Vaccine Preventable Diseases
5. Exercise
6. Suicide

Once the list of six was complete, the partners discussed the contributing factors, high risk populations and resources/assets for each individual priority. Results for each priority area are presented in the Data Section, Statewide Partner Meeting Information (page 90).

As expected, several risk factors, high-risk populations and resources/assets overlapped priority areas. Three priority areas (Heart Disease and Stroke, Obesity and Exercise) share many contributing factors including lack of exercise, lack of fruits and vegetables, limited education, access to transportation, access to preventative medicine, depression, cultural considerations and genetics. In addition, Heart Disease and Stroke, Obesity and Exercise share similar high-risk populations including people with diabetes, Hispanics, Native Americans, those living in poverty, rural Idahoans, those with limited education and those suffering from depression. In general, resources vary by geographic area but similar resources for Heart Disease and Stroke, Obesity and Exercise include community education, healthcare providers, weight loss programs and nutrition programs.

While Healthcare Access, Vaccine Preventable Diseases and Suicide lack the same amount of overlap, there are still similarities among them, including lack of preventive services, limited access to providers, lack of insurance, low socioeconomic status and those living in rural areas.

Future Model

The landscape is changing rapidly in Idaho. Since the beginning of the population health assessment work, Idaho applied for and received a grant to develop a State Healthcare Innovation Plan (SHIP) as well as a model testing grant to test the proposed innovation model to transform healthcare in Idaho. The work that Idaho will be doing over the next four years to improve health care, improve the health of the population and reduce health care costs will build upon strengths, fill gaps and implement innovative change. Moving forward, it is anticipated that Get Healthy Idaho will serve as the foundation to satisfy both requirements for Public Health Accreditation as well as the model test grant. Internally, the process of reviewing data and improvement planning around the identified priorities will become a central focus of public health business. It will also become part of strategic planning discussed quarterly within the Division of Public Health and throughout the Department of Health and Welfare.

The partner base of this initiative will grow to include the Population Health Work Group of the Idaho Healthcare Coalition, charged with leading the implementation of the state innovation model testing grant. The Idaho Healthcare Coalition consists of representatives from the Idaho Health Care Council, the Idaho Medical Home Collaborative, others from the healthcare community, private and public health insurers, public health, behavioral health, the Idaho Hospital Association, the Idaho Medical Association, policy makers and consumers.

Following a Plan, Do, Study, Act Model, the process will include at least one annual face-to-face partner meeting with three goals: 1) to review the status of the current population health assessment and improvement plan, 2) to discuss new and emerging health issues from both state and local perspectives, and 3) to have an active and engaged dialogue among partners. The annual meeting will be an opportunity for partners to provide input on what is working and what is not, to share their perspectives and guide the creation of goals for the coming year. At this meeting an update on the Idaho Leading Health Indicators and the identified priorities of Get Healthy Idaho will be discussed. It will be a time to update partners on work that has been achieved and work that is planned, assess new assets and resources, and identify emerging issues that may be part of future improvement plans.

Data

Data collected and reviewed for the population health assessment came from a number of sources. The following sections include detail on the data reviewed.

Demographics and Social Determinants

These provide an overview of demographic and other issues that impact health.

Leading Causes of Death

The Leading Causes of Death section presents the leading causes in rank order for the state and then by sex and age. Data on years of potential life lost are also presented.

Idaho Leading Health Indicators

Trends and demographic data are presented for Idaho's Leading Health Indicators.

Health Professional Shortage Area Maps

These maps depict the most recent data on health professional shortage areas for primary care, mental health, and dental health. A population density map is also presented.

Community Health Assessment Summaries

Twenty-two local community health assessments were reviewed and abstracted. Data were summarized on a regional basis.

Statewide Partner Meeting Information

Valuable information was collected at the statewide partner meeting in November. These tables summarize information collected from participants on contributing factors, high risk populations and resources and assets for the identified priorities.

Demographics and Social Determinants

Get Healthy Idaho: Measuring and Improving Population Health

Demographics and Social Determinants of Health

Idaho is a large western state with impressive mountain ranges, large areas of high desert and massive expanses of forested terrain. Idaho contains the second largest wilderness area in the lower 48 states, the Frank Church – River of No Return Wilderness, which covers almost 2.4 million acres. Geography and distance impact both the demographic characteristics and social determinants of health within Idaho. Idaho is ranked 39th of the 50 United States for total population and 14th for geographic size. The 2013 estimated population for Idaho was 1,612,136 and because of its large size and relatively small population, Idaho remains one of the most rural states in the nation. With approximately 19.0, people per square mile Idaho ranks 44th of the 50 states in population density. The national average population density is 87.4 people per square mile, a four-fold greater density than Idaho. Thirty four of Idaho's 44 counties are rural with 19 of these considered frontier, having fewer than six people per square mile.

Idaho has seven population centers throughout the state with approximately 66 percent of the population residing in one of these populated areas. Delivering adequate health services to the entire state remains a challenge in this very rural environment.

The racial groups that comprised Idaho's population in 2013 were: (a) white, 93.7 percent; (b) black, 0.8 percent; (c) American Indian/Alaska Native, 1.7 percent; and (d) Asian or Pacific Islander, 1.4 percent. It is estimated that 2.2 percent of Idahoans identify as being of two or more races. Persons of Hispanic or Latino origin comprised 11.8 percent of Idaho's total population (US Census Bureau). Idaho is home to six federally recognized tribes: Coeur d'Alene Tribe, Kootenai Tribe of Idaho, Nez Perce Tribe, Shoshone-Bannock Tribes, the Northwestern Band of the Shoshone Nation, and the Shoshone-Paiute Tribe. Idaho also has two refugee centers located in Ada County in southwest Idaho and Twin Falls County in south central Idaho.

According to the 2013 American Community Survey: Five Year Profile Tables, 15.5 percent of Idahoans were living below the poverty level; placing Idaho 22nd out of the 51 states and District of Columbia.

The most recent economic recession significantly impacted small business in Idaho, in addition to some of the major industries including construction and logging. Unemployment rose steadily and rapidly from 2.7 percent of the labor force being unemployed (seasonally adjusted) in 2007 to a high of 8.8 percent in 2010. In recent years, Idaho's economy has stabilized with an unemployment rate of 3.6 percent in December of 2014. Idaho's per capita income in 2013 was $36,146. Idaho is an important agricultural state, producing nearly one-third of the potatoes grown in the United States. Wheat, sugar beets, and alfalfa hay are also major crops. Other industries contributing to Idaho's economy include information technology, mining, lumber, tourism and manufacturing.

The most recent national data indicate that the percentage of Idahoans over the age of 25 who have graduated from high school is higher than the national average (88.8 percent and 86.0 percent, respectively). However, college attendance rates are among the nation's lowest with under 52 percent of Idaho's 2013 high school graduates enrolled in a two- or four-year college (National Student Clearinghouse). A quarter (25.1 percent) of Idahoans over the age of 25 hold a bachelor's degree or higher, compared with the national average of 28.8 percent.

To facilitate the availability of public health services, contiguous counties in Idaho have been aggregated into seven public health districts (see map on next page). These seven areas are defined by geographic barriers as well as transportation routes and population centers. As reflected in the priorities, access to health care and other services have been identified as barriers to improving health outcomes for Idaho residents.

Idaho does not have a private or public medical or osteopathic school within the state for the training and development of physicians. In 2014, 100 percent of Idaho was a federally-designated mental health professional shortage area, 96.4 percent of Idaho was a federally-designated shortage area in primary care, and 97.0 percent of Idaho was designated a dental health professional shortage area. Idaho had 70 primary care physicians per 100,000 population in 2012, ranking 49th of 50 states (Bureau of Rural Health and Primary Care, Division of Public Health, Idaho Department of Health and Welfare).

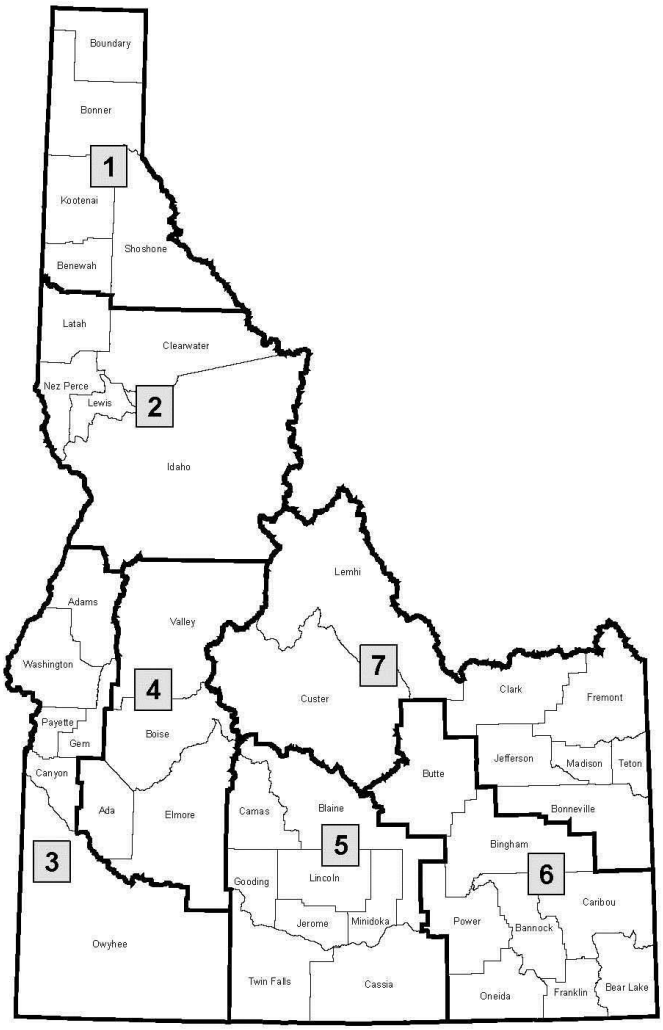
In 2014, the Idaho Hospital Association membership directory reported 48 member hospitals (this includes one in Ontario, Oregon and one in Clarkston, Washington). Twenty-seven of these hospitals are critical access hospitals, owning fifty-five clinics. These clinics include primary care and specialty services and may be co-located with the hospital as well as remote clinics.

Idaho Medicaid enrollment averaged 252,598 participants per month in State Fiscal Year (SFY) 2014 (July-June), an increase of 5.5 percent from 2013. The rate of growth continues to decline compared to the Medicaid growth experienced during the peak of the recession and is now more closely approaching a growth pattern for a normal economy. The enrollment increase in SFY2014 can be attributed primarily to the Affordable Care Act (ACA) requiring people to have insurance coverage. Once past the ACA enrollment period, Idaho expects to return to a 2 to 3 percent enrollment growth rate (Facts, Figures and Trends 2014-2015, Idaho Department of Health and Welfare).

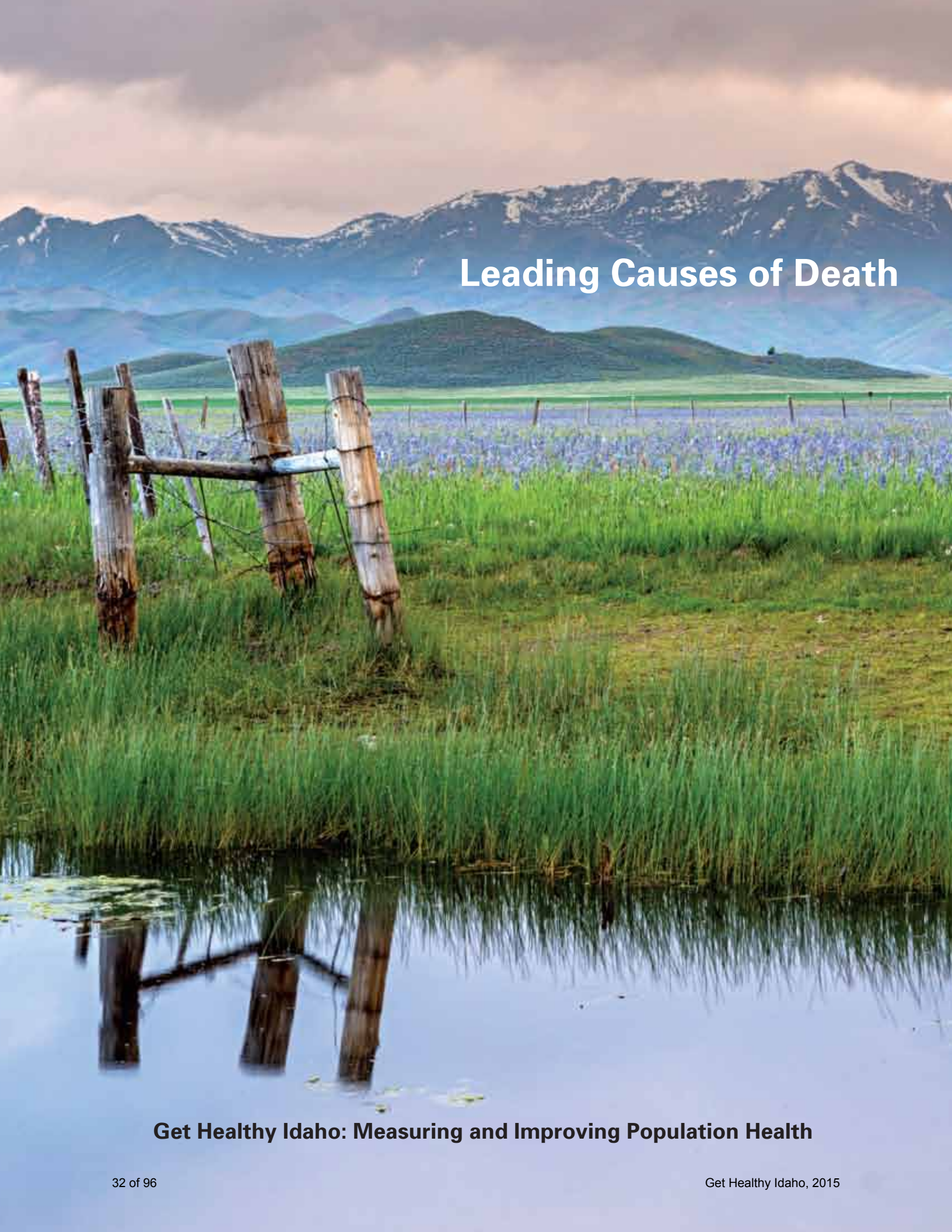
In November of 2014, Your Health Idaho began operating as Idaho's fully state-based health insurance marketplace. For the 2015 coverage year, eligibility and enrollment was conducted by Your Health Idaho and the Idaho Department of Health and Welfare (the state Medicaid/CHIP agency). For the 2014 coverage year, Idaho was third in the nation per capita for the number of residents who selected health insurance plans just behind Vermont and Florida (State of Idaho, Your Health Idaho).

Appendix A: Get Healthy Idaho: Part 1 Assessment

Idaho Public Health Districts



Panhandle Health District	Public Health - Idaho North Central District	Southwest District Health	Central District Health Department	South Central Public Health District	Southeastern Idaho Public Health	Eastern Idaho Public Health
PHD 1	PHD 2	PHD 3	PHD 4	PHD 5	PHD 6	PHD 7
Benewah Bonner Boundary Kootenai Shoshone	Clearwater Idaho Latah Lewis Nez Perce	Adams Canyon Gem Owyhee Payette Washington	Ada Boise Elmore Valley	Blaine Camas Cassia Gooding Jerome Lincoln Minidoka Twin Falls	Bannock Bear Lake Bingham Butte Caribou Franklin Oneida Power	Bonneville Clark Custer Fremont Jefferson Lemhi Madison Teton



Leading Causes of Death

Get Healthy Idaho: Measuring and Improving Population Health

IDAHO RESIDENT DEATHS
Leading Causes of Death to Idahoans
Cause-Specific Crude and Age-Adjusted Rates
2013 Idaho and 2012 U.S.

RANK FOR IDAHO AND CAUSE OF DEATH	DEATHS		DEATH RATES[1]			
			Crude		Age-Adjusted[2]	
	Number	Percent	Idaho[3]	U.S.[4] 2012	Idaho[3]	U.S.[4] 2012
ALL CAUSES	12,426	100.0%	770.8	810.2	730.2	732.8
1. Malignant neoplasms (cancer)	2,709	21.8%	168.0	185.6	156.3	166.5
2. Diseases of heart	2,489	20.0%	154.4	191.0	145.0	170.5
3. Chronic lower respiratory diseases	806	6.5%	50.0	45.7	46.5	41.5
4. Accidents (unintentional injury)	777	6.3%	48.2	40.7	47.7	39.1
5. Cerebrovascular diseases	600	4.8%	37.2	40.9	35.5	36.9
6. Diabetes mellitus	400	3.2%	24.8	23.6	23.5	21.2
7. Alzheimer's disease	348	2.8%	21.6	26.6	21.0	23.8
8. Intentional self-harm (suicide)	308	2.5%	19.1	12.9	19.2	12.6
9. Influenza and pneumonia	259	2.1%	16.1	16.1	15.1	14.4
10. Chronic liver disease and cirrhosis	212	1.7%	13.2	11.1	11.9	9.9
11. Nephritis, nephrotic syndrome and nephrosis	148	1.2%	9.2	14.5	8.8	13.1
12. Parkinson's disease	143	1.2%	8.9	7.6	8.9	7.0
13. Essential hypertension & hypertensive renal disease	134	1.1%	8.3	9.3	7.9	8.2
14. Septicemia	96	0.8%	6.0	11.4	5.5	10.3
15. Pneumonitis due to solids and liquids	89	0.7%	5.5	5.7	5.3	5.1
All other causes	2,908	23.4%	NA	NA	NA	NA

1. Rates are per 100,000 population.
2. Age-adjusted rates are artificial measures developed to eliminate the bias inherent in differing age compositions, thus allowing comparisons between geographic regions. Idaho and U.S. age-adjusted rates were calculated using the 2000 U.S. population estimate as the standard population.
3. Idaho rates are based on the July 1, 2013 population estimates.
4. U.S. crude and age-adjusted rates are 2012 final for leading causes of death. Rates are calculated using the 2000 Census.

NA: Age-adjusted rates not calculated for causes with fewer than 20 deaths; crude and age-adjusted rates not applicable for all other causes.

Source: Idaho Department of Health and Welfare, Division of Public Health, Vital Statistics, 2013

IDAHO RESIDENT DEATHS
Leading Causes of Death to Idahoans by Sex
Cause-Specific Crude and Age-Adjusted Rates[1]
2013 Idaho and 2012 U.S.

MALES						
	Deaths		Crude Rate		Age-Adjusted[2]	
RANK FOR IDAHO AND CAUSE OF DEATH	Number	Percent	Idaho[3]	U.S.[4]	Idaho[3]	U.S.[4]
ALL CAUSES	6,402	100.0%	793.2	824.5	834.7	865.1
1. Malignant neoplasms (cancer)	1,442	22.5%	178.7	197.9	181.5	200.3
2. Diseases of heart	1,353	21.1%	167.6	202.3	178.2	214.7
3. Accidents (unintentional injury)	464	7.2%	57.5	51.8	59.4	52.6
4. Chronic lower respiratory diseases	399	6.2%	49.4	43.8	51.3	47.2
5. Cerebrovascular diseases	267	4.2%	33.1	34.1	36.8	37.1
6. Intentional self-harm (suicide)	244	3.8%	30.2	20.6	30.7	20.4
7. Diabetes mellitus	227	3.5%	28.1	25.0	28.7	25.5
8. Chronic liver disease and cirrhosis	145	2.3%	18.0	14.6	16.6	13.4
9. Influenza and pneumonia	119	1.9%	14.7	15.5	16.5	17.3
10. Alzheimer's disease	117	1.8%	14.5	16.6	17.4	19.8
11. Parkinson's disease	89	1.4%	11.0	9.1	12.8	10.7
12. Nephritis, nephrotic syndrome and nephrosis	80	1.2%	9.9	14.7	11.4	16.0
13. Essential hypertension & hypertensive renal disease	59	0.9%	7.3	7.7	8.2	8.2
14. Pneumonitis due to solids and liquids	51	0.8%	6.3	6.3	7.2	7.1
15. Septicemia	47	0.7%	5.8	10.9	5.8	11.4
All other causes	1,299	20.3%	NA	NA	NA	NA

FEMALES						
	Deaths		Crude Rate		Age-Adjusted[2]	
RANK FOR IDAHO AND CAUSE OF DEATH	Number	Percent	Idaho[3]	U.S.[4]	Idaho[3]	U.S.[4]
ALL CAUSES	6,024	100.0%	748.3	796.4	636.0	624.7
1. Malignant neoplasms (cancer)	1,267	21.0%	157.4	173.7	136.3	142.1
2. Diseases of heart	1,136	18.9%	141.1	180.2	116.5	135.5
3. Chronic lower respiratory diseases	407	6.8%	50.6	47.6	43.2	37.8
4. Cerebrovascular diseases	333	5.5%	41.4	47.6	34.2	36.1
5. Accidents (unintentional injury)	313	5.2%	38.9	30.0	36.7	26.4
6. Alzheimer's disease	231	3.8%	28.7	36.4	23.6	26.1
7. Diabetes mellitus	173	2.9%	21.5	22.2	18.8	17.7
8. Influenza and pneumonia	140	2.3%	17.4	16.7	14.0	12.5
9. Essential hypertension & hypertensive renal disease	75	1.2%	9.3	10.8	7.4	8.0
10. Nephritis, nephrotic syndrome and nephrosis	68	1.1%	8.4	14.4	7.2	11.1
11. Chronic liver disease and cirrhosis	67	1.1%	8.3	7.8	7.5	6.7
12. Intentional self-harm (suicide)	64	1.1%	7.9	5.5	8.0	5.4
13. Parkinson's disease	54	0.9%	6.7	6.1	5.9	4.7
14. Septicemia	49	0.8%	6.1	12.0	5.2	9.5
15. Pneumonitis due to solids and liquids	38	0.6%	4.7	5.1	3.8	3.9
All other causes	1,609	26.7%	NA	NA	NA	NA

NA: not applicable.

1. Rates are per 100,000 population per gender.
2. Age-adjusted rates are artificial measures developed to eliminate the bias inherent in differing age compositions, thus allowing comparisons between geographic regions. Idaho and U.S. age-adjusted rates were calculated using the 2000 U.S. population estimate as the standard population.
3. Idaho rates are based on July 1, 2013 population estimates based on 2010 census.
4. U.S. gender-specific crude and age-adjusted rates are 2012 final data. Rates are calculated using the 2010 Census provided to the National Center for Health Statistics by the U.S. Bureau of the Census.

Source: Idaho Department of Health and Welfare, Division of Public Health, Vital Statistics, 2013

IDAHO RESIDENT DEATHS
Ten Leading Causes of Death by Age Group and Number of Deaths
2013

RANK	AGE GROUP												ALL AGES
	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65-74	75+	
1	Congenital malformations (25)	Accident (15) (Trans: 6 MVA: 6 All Other: 9)	Accident (7) (Trans: 4 MVA: 4 All Other: 3)	Accident (9) (Trans: 4 MVA: 4 All Other: 5)	Accident (24) (Trans: 17 MVA: 17 All Other: 7)	Accident (49) (Trans: 32 MVA: 31 All Other: 17)	Accident (82) (Trans: 41 MVA: 38 All Other: 41)	Accident (86) (Trans: 32 MVA: 27 All Other: 54)	Malignant neoplasms (194)	Malignant neoplasms (502)	Malignant neoplasms (719)	Diseases of heart (1,605)	Malignant neoplasms (2,709)
2	Short gestation and low birth weight (21)	Assault (Homicide) (2)	(Tie) Malignant neoplasms; Septicemia (2 each)	(Tie) Malignant neoplasms; Intentional self-harm (Suicide) (2 each)	Intentional self-harm (Suicide) (21)	Intentional self-harm (Suicide) (26)	Intentional self-harm (Suicide) (49)	Malignant neoplasms (52)	Diseases of heart (116)	Diseases of heart (285)	Diseases of heart (426)	Malignant neoplasms (1,216)	Diseases of heart (2,489)
3	Sudden infant death syndrome (15)	(Tie) Chronic lower respiratory diseases; Pneumonitis due to solids and liquids; Influenza and pneumonia; Congenital malformations (1 each)			Diseases of heart (2)	Malignant neoplasms (7)	Diseases of heart (16)	Intentional self-harm (Suicide) (41)	Accident (114) (Trans: 48 MVA: 44 All Other: 66)	Accident (103) (Trans: 43 MVA: 36 All Other: 60)	Chronic lower respiratory diseases (232)	Chronic lower respiratory diseases (446)	Chronic lower respiratory diseases (806)
4	Complications of placenta, cord & membranes (11)		(Tie) Intentional self-harm (Suicide); Influenza and pneumonia (1 each)		(Tie) Congenital malformations; Malignant neoplasms; Assault (Homicide); Pregnancy, childbirth, and the puerperium (1 each)	Assault (Homicide) (6)	Malignant neoplasms (13)	Diseases of heart (34)	Intentional self-harm (Suicide) (65)	Chronic lower respiratory diseases (101)	Diabetes mellitus (86)	Cerebrovas-cular diseases (442)	Accident (777) (Trans: 280 MVA: 258 All Other: 497)
5	Maternal complications of pregnancy (7)					Diseases of heart (5)	Chronic liver disease and cirrhosis (6)	Diabetes mellitus (18)	Chronic liver disease and cirrhosis (53)	Chronic liver disease and cirrhosis (82)	Cerebrovas-cular diseases (84)	Alzheimer's disease (324)	Cerebrovas-cular diseases (600)
6	Accident (5) (Trans: 1 MVA: 1 All Other: 4)					Diabetes mellitus (2)	Assault (Homicide) (5)	Chronic liver disease and cirrhosis (14)	Diabetes mellitus (27)	Diabetes mellitus (65)	Accident (76) (Trans: 33 MVA: 31 All Other: 43)	Accident (207) (Trans: 19 MVA: 19 All Other: 188)	Diabetes mellitus (400)
7	(Tie) Neonatal hemorrhage; Intrauterine hypoxia and birth asphyxia (3 each)					(Tie) Cerebrovas-cular diseases; Influenza and pneumonia; Pregnancy, childbirth, and the puerperium (1 each)	Diabetes mellitus (3)	Cerebrovas-cular diseases (8)	Chronic lower respiratory diseases (22)	(Tie) Cerebrovas-cular diseases; Intentional self-harm (Suicide) (46)	Chronic liver disease and cirrhosis (39)	Diabetes mellitus (199)	Alzheimer's disease (348)
8							(Tie) Pregnancy, childbirth, and the puerperium; Legal intervention (2 each)	Assault (Homicide) (6)	Cerebrovas-cular diseases (19)		Intentional self-harm (Suicide) (36)	Influenza and pneumonia (188)	Intentional self-harm (Suicide) (308)
9	(Tie) (2 each)[2]							Congenital malformations (4)	Viral hepatitis (12)	Viral hepatitis (31)	Influenza and pneumonia (33)	Parkinson's disease (124)	Influenza and pneumonia (259)
10							Tie (1 each)[3]	Chronic lower respiratory diseases (3)	Influenza and pneumonia (6)	Influenza and pneumonia (24)	Nephritis, nephrotic syndrome (27)	Essential hypertension (109)	Chronic liver disease and cirrhosis (212)
Residual[1]	26	3	3	3	2	8	35	55	159	301	474	2,081	3,518
Total	126	24	16	16	53	106	218	321	787	1,586	2,232	6,941	12,426

Note: Number of deaths in parentheses. 'Accident' is a shortened ICD-10 title for 'Accident (unintentional injuries)'. 'Trans' is short for 'Transportation Accident.' 'MVA' is short for "Motor Vehicle Accident".

1. Residual: Total number of deaths for all other leading causes not listed and all other causes not ranked for leading cause of death.

2. Tie at rank 9 for < 1: Newborn affected by other maternal conditions; Influenza and pneumonia; Hydrops; Diarrhea and gastroenteritis of presumed infectious origin; Assault (homicide) (2 each).

3. Tie at rank 10 for aged 25-34: Pneumonitis; Chronic lower respiratory diseases; Influenza and pneumonia; Nephritis, nephrotic syndrome and nephrosis; Congenital malformation (1 each).

Source: Idaho Department of Health and Welfare, Division of Public Health, Vital Statistics, 2013

IDAHO MALE RESIDENT DEATHS
Ten Leading Causes of Death by Age Group and Number of Deaths
2013

RANK	AGE GROUP												ALL AGES
	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65-74	75+	
1	Congenital malformations; Sudden infant death syndrome; Short gestation and low birth weight (12)	Accident (9) (Trans: 4 MVA: 4 All other: 5)	Accident (4) (Trans: 1 MVA: 1 All other: 3)	Accident (8) (Trans: 3 MVA: 3 All other: 5)	(Tie) Accident (Trans: 9 MVA: 9, All Other: 5); Intentional self-harm (Suicide) (14 each)	Accident (34) (Trans: 22 MVA: 21 All other: 12)	Accident (55) (Trans: 24 MVA: 22 All other: 31)	Accident (50) (Trans: 29 MVA: 25 All other: 21)	Malignant neoplasms (90)	Malignant neoplasms (282)	Malignant neoplasms (371)	Diseases of heart (746)	Malignant neoplasms (1,442)
2		Assault (Homicide) (2)		Intentional self-harm (Suicide) (2)		Intentional self-harm (Suicide) (20)	Intentional self-harm (Suicide) (45)	Malignant neoplasms (32)	Diseases of heart (80)	Diseases of heart (209)	Diseases of heart (279)	Malignant neoplasms (653)	Diseases of heart (1,353)
3						Malignant neoplasms (5)	Diseases of heart (9)	Intentional self-harm (Suicide) (31)	Accident (75) (Trans: 38 MVA: 35 All other: 37)	Accident (74) (Trans: 36 MVA: 31 All other: 38)	Chronic lower respiratory diseases (116)	Chronic lower respiratory diseases (215)	Accident (464) (Trans: 200 MVA: 183 All other: 264)
4	Complications of placenta, cord & mem-branes (10)					Assault (Homicide) (4)	Malignant neoplasms (7)	Diseases of heart (26)	Intentional self-harm (Suicide) (47)	Chronic liver disease and cirrhosis (57)	Diabetes mellitus (51)	Cerebrovas-cular diseases (182)	Chronic lower respiratory diseases (399)
5	Maternal complications of pregnancy (5)					Diseases of heart (3)	Chronic liver disease and cirrhosis (5)	Diabetes mellitus (14)	Chronic liver disease and cirrhosis (32)	Chronic lower respiratory diseases (55)	Accident (44) (Trans: 23 MVA: 21 All other: 21)	Alzheimer's disease (107)	Cerebrovas-cular diseases (267)
6	Accident (3) (Trans: 0 MVA: 0 All other: 3)						Assault (Homicide) (4)	Chronic liver disease and cirrhosis (10)	Diabetes mellitus (17)	Diabetes mellitus (49)	Cerebrovas-cular diseases (41)	Accident (94) (Trans: 11 MVA: 11 All other: 83)	Intentional self-harm (Suicide) (244)
7	(Tie) Neonatal hemorrhage; Intrauterine hypoxia and birth asphyxia (2 each)						(Tie) Diabetes mellitus; Legal intervention (2 each)	Assault (Homicide) (4)	Chronic lower respiratory diseases (11)	Intentional self-harm (Suicide) (32)	Intentional self-harm (Suicide) (32)	Diabetes mellitus (93)	Diabetes mellitus (227)
8								(Tie) Viral hepatitis; Congenital malformations (2 each)	Cerebrovas-cular diseases (9)	Cerebrovas-cular diseases (29)	Chronic liver disease and cirrhosis (28)	Influenza and pneumonia (81)	Chronic liver disease and cirrhosis (145)
9									Viral hepatitis (7)	Viral hepatitis (26)	Septicemia (15)	Parkinson's disease (76)	Influenza and pneumonia (119)
10									Influenza and pneumonia (5)	Influenza and pneumonia (13)	Influenza and pneumonia (14)	Nephritis, nephrotic syndrome (62)	Alzheimer's disease (117)
Residual[1]	20	5	4	3	3	5	21	29	85	174	261	814	2,024
Total	75	16	8	13	31	71	150	205	458	1,000	1,252	3,123	6,402

Note: Causes of death with one death are not shown. Number of deaths in parentheses. 'Accident' is a shortened ICD-10 title for 'Accident (unintentional injuries)'. 'Trans' is short for "Transportation Accident"; 'MVA' is short for 'Motor Vehicle Accident', and is a subset of transportation Accident.

1. Residual: Total number of deaths for all other leading causes not listed and all other causes not ranked for leading cause of death.

Source: Idaho Department of Health and Welfare, Division of Public Health, Vital Statistics, 2013

IDAHO FEMALE RESIDENT DEATHS
Ten Leading Causes of Death by Age Group and Number of Deaths
2013

RANK	AGE GROUP												ALL AGES
	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65-74	75+	
1	Congenital malformations (13)	Accidents (6) (Trans: 2 MVA: 2 All other:4)	Accidents (3) (Trans: 3 MVA: 3 All other:0)		Accidents (10) (Trans: 8 MVA: 8 All other: 2)	Accidents (15) (Trans: 10 MVA: 10 All other: 5)	Accidents (27) (Trans: 17 MVA: 16 All other: 10)	Accidents (36) (Trans: 3 MVA: 2 All other: 33)	Malignant neoplasms (104)	Malignant neoplasms (220)	Malignant neoplasms (348)	Diseases of heart (859)	Malignant neoplasms (1,267)
2	Short gestation and low birth weight (9)		(Tie) Malignant neoplasms; Septicemia (2 each)		Intentional self-harm (Suicide) (7)	Intentional self-harm (Suicide) (6)	Diseases of heart (7)	Malignant neoplasms (20)	Accidents (39) (Trans: 10 MVA: 9 All other:29)	Diseases of heart (76)	Diseases of heart (147)	Malignant neoplasms (563)	Diseases of heart (1,136)
3	Sudden infant death syndrome (3)					(Tie) Diseases of heart; Malignant neoplasms; Assault (Homicide) (2 each)	Malignant neoplasms (6)	Intentional self-harm (Suicide) (10)	Diseases of heart (36)	Chronic lower respiratory diseases (46)	Chronic lower respiratory diseases (116)	Cerebrovas-cular diseases (260)	Chronic lower respiratory diseases (407)
4	(Tie) Accidents; Maternal complications of pregnancy, Newborn affected by other maternal conditions; Assault (Homicide) (2 each)						Intentional self-harm (Suicide) (4)	Diseases of heart (8)	Chronic liver disease and cirrhosis (21)	Accidents (29) (Trans: 7 MVA: 5 All other:22)	Cerebrovas-cular diseases (43)	Chronic lower respiratory diseases (231)	Cerebrovas-cular diseases (333)
5							Pregnancy, childbirth, and the puerperium (2)	(Tie) Diabetes mellitus; Chronic liver disease and cirrhosis (4 each)	Intentional self-harm (Suicide) (18)	Chronic liver disease and cirrhosis (25)	Diabetes mellitus (35)	Alzheimer's disease (217)	Accidents (313) (Trans: 80 MVA: 75 All other: 233)
6									Chronic lower respiratory diseases (11)	Cerebrovas-cular diseases (17)	Accidents (32) (Trans: 10 MVA: 10 All other: 22)	Accident (113) (Trans: 8 MVA: 8 All other: 105)	Alzheimer's disease (231)
7								Cerebrovas-cular diseases (3)	(Tie) Diabetes mellitus; Cerebro-vascular diseases (10 each)	Diabetes mellitus (16)	Influenza and pneumonia (19)	Influenza and pneumonia (107)	Diabetes mellitus (173)
8								(Tie) Chronic lower respiratory diseases; Congenital malformation; Assault (Homicide); Pregnancy, childbirth and the puerperium (2 each)		Intentional self-harm (Suicide) (14)	Nephritis, nephrotic syndrome (15)	Diabetes mellitus (106)	Influenza and pneumonia (140)
9									Viral Hepatitis (5)	Influenza and pneumonia (11)	Chronic lower respiratory diseases (11)	Hypertension (67)	Hypertension (75)
10									(Tie) (3 each)[2]	Nephritis, nephrotic syndrome (9)	(Tie) Alzheimer's; Septicemia (9 each)	Parkinson's disease (48)	Nephritis, nephrotic syndrome (68)
Residual[1]	18	2	1	3	5	8	22	23	66	123	196	1,247	1,881
Total	51	8	8	3	22	35	68	116	329	586	980	3,818	6,024

Note: Causes of death with one death are not shown. Number of deaths in parentheses. 'Accidents' is a shortened ICD-10 title for 'Accidents (unintentional injuries)'. 'Trans' is short for Transportation Accident"; MVA is short for 'Motor Vehicle Accidents', and is a subset of transportation accidents. Hypertension includes essential hypertensive renal disease.

1. Residual: Total number of deaths for all other leading causes not listed and all other causes not ranked for leading cause of death.

2. Tie at rank 10 for age group 45-54: Nephritis, nephrotic syndrome; In situ neoplasms, benign neoplasms of uncertain or unknown behavior, Pregnancy, childbirth, and the puerperium (3 each).

Source: Idaho Department of Health and Welfare, Division of Public Health, Vital Statistics, 2013

YEARS OF POTENTIAL LIFE LOST BEFORE AGE 75
Ten Leading Causes of Death Based on Premature Mortality[1]
Total Population and by Sex
2013

Rank	Cause of Death	Persons Aged Less than 75 Years		Years of Potential Life Lost (YPLL) Before Age 75		
		Number of Deaths	Percent of Deaths	Average Number of YPLL per Death	Total Number of YPLL	YPLL Rate[2]
	Total	5,485	100.0%	17.4	95,526.5	6,283.8
1.	Malignant neoplasms (cancer)	1,493	27.2	12.4	18,501.5	1,217.0
2.	Accidents (unintentional injury)	570	10.4	31.5	17,933.0	1,179.6
	-Nontransport accidents	309	5.6	30.0	9,270.5	609.8
	-Transport accidents	261	4.8	33.2	8,662.5	569.8
	--Motor vehicle accidents	239	4.4	33.9	8,092.5	532.3
3.	Diseases of heart	884	16.1	12.7	11,251.0	740.1
4.	Intentional self-harm (suicide)	287	5.2	31.2	8,940.5	588.1
5.	Certain conditions originating in perinatal period	63	1.1	74.5	4,693.5	308.7
6.	Chronic liver disease and cirrhosis	194	3.5	18.0	3,488.0	229.4
7.	Chronic lower respiratory diseases	360	6.6	8.9	3,193.0	210.0
8.	Diabetes mellitus	201	3.7	14.6	2,933.5	193.0
9.	Congenital malformations	48	0.9	49.4	2,370.0	155.9
10.	Cerebrovascular diseases	158	2.9	11.4	1,795.0	118.1
	All other causes	1,227	22.4	16.6	20,427.5	1,343.7
	Total Males	3,279	100.0%	18.0	59,104.5	7,704.5
1.	Accidents (unintentional injury)	370	11.3	31.5	11,656.0	1,519.4
	-Transport accidents	189	5.8	31.3	5,917.5	771.4
	--Motor vehicle accidents	172	5.2	31.9	5,484.0	714.9
	-Nontransport accidents	181	5.5	31.7	5,738.5	748.0
2.	Malignant neoplasms (cancer)	789	24.1	12.4	9,749.5	1,270.9
3.	Diseases of heart	607	18.5	12.9	7,841.5	1,022.2
4.	Intentional self-harm (suicide)	224	6.8	31.3	7,005.0	913.1
5.	Certain conditions originating in perinatal period	42	1.3	74.5	3,129.0	407.9
6.	Chronic liver disease and cirrhosis	132	4.0	17.9	2,358.0	307.4
7.	Diabetes mellitus	134	4.1	14.9	1,999.0	260.6
8.	Chronic lower respiratory diseases	184	5.6	8.9	1,641.0	213.9
9.	Congenital malformations	21	0.6	52.8	1,108.5	144.5
10.	Cerebrovascular diseases	85	2.6	12.4	1,055.5	137.6
	All other causes	691	21.1	16.7	11,561.5	1,507.1
	Total Females	2,206	100.0%	16.5	36,422.0	4,836.5
1.	Malignant neoplasms (cancer)	704	31.9	12.4	8,752.0	1,162.2
2.	Accidents (unintentional injury)	200	9.1	31.4	6,277.0	833.5
	-Nontransport accidents	128	5.8	27.6	3,532.0	469.0
	-Transport accidents	72	3.3	38.1	2,745.0	364.5
	--Motor vehicle accidents	67	3.0	38.9	2,608.5	346.4
3.	Diseases of heart	277	12.6	12.3	3,409.5	452.8
4.	Intentional self-harm (suicide)	63	2.9	30.7	1,935.5	257.0
5.	Certain conditions originating in perinatal period	21	1.0	74.5	1,564.5	207.8
6.	Chronic lower respiratory diseases	176	8.0	8.8	1,552.0	206.1
7.	Congenital malformations	27	1.2	46.7	1,261.5	167.5
8.	Chronic liver disease and cirrhosis	62	2.8	18.2	1,130.0	150.1
9.	Diabetes mellitus	67	3.0	13.9	934.5	124.1
10.	Cerebrovascular diseases	73	3.3	10.1	739.5	98.2
	All other causes	536	24.3	16.5	8,866.0	1,177.3

1. Ranking based on total number of years of potential life lost (YPLL).
2. YPLL rate: Total number of years of potential life lost per 100,000 population aged less than 75 years. See Technical Notes for methodology.

Source: Idaho Department of Health and Welfare, Division of Public Health, Vital Statistics, 2013

Idaho Leading Health Indicators

Get Healthy Idaho: Measuring and Improving Population Health

Idaho Leading Health Indicators

Topic Area	Leading Health Indicators
Overweight/ Obesity	• Percentage of adolescents* overweight/obese (source: YRBS) (HP2020 Reference: NWS-10) • Percentage of Idaho adults who are overweight/ obese (BRFSS) (NWS-9)
Tobacco Use	• Percentage of adolescents who currently smoke (YRBS) (TU-2.2) • Percentage of Idaho adults who are current smokers (BRFSS) (TU 1.1) • Percentage of Idaho adults who use smokeless tobacco (BRFSS) (TU 1.2)
Immunization	• Percentage of 19-35 month olds who received 4+doses of DTAP(NIS) (IID-7.1) • Percentage of adolescents aged 13 to 15 years reported having been vaccinated with 3 or more doses of the HPV vaccine (NIS) (IID 11.4) • Annual incidence of pertussis (Reportable diseases) (IID - 1.6 (<1 yr) & 1.7 (11-18 yrs))
Infectious Disease	• Annual incidence rate of enteric diseases reportable to public health (cryptosporidiosis, shigellosis, listeriosis, salmonellosis, STEC, giardiasis). (RD) (FS- 1.1 & 1.4) • Annual incidence of STDs (does not include HIV – chlamydia, gonorrhea, syphilis). (RD) (STD-1, STD-2, STD-6, & STD-7)
Perinatal Care	• Percentage of Idaho mothers who received adequate prenatal care (VS) (MCH-10.2) • Percentage of Idaho resident live births with low birth weight (VS) (MCH-8.1,8.2) • Percentage of Idaho resident live births with pre-term delivery (VS) (MCH-9.1)
Injury/Suicide	• Percentage of adolescents who have attempted suicide (YRBS) (MHMD-2) • Suicide death rates (VS) (MHMD-1) • Injury fatalities ages 1-44(VS) (IVP-1)
Chronic Disease	• Coronary heart disease prevalence (BRFSS) (HDS-2) • Coronary heart disease rate of death (VS)(n/a) • Stroke prevalence (BRFSS) (HDS-3) • Stroke death rates (VS)(n/a) • Diabetes prevalence (BRFSS) (D-15)
Health Status/ Behaviors	• Percentage of Idaho adults who consume five or more servings of fruits and vegetables a day. (BRFSS) (Under-Dev.) • Percentage of Idaho adults aged 50 to75 years of age who receive colorectal cancer screening based on the most recent guidelines.***(BRFSS) (C-16) • Percentage of women aged 50-74 who receive a breast cancer screening based on the most recent guidelines.***(BRFSS)(C-17) • Percentage of Idaho adults with no leisure time physical activity. (BRFSS) (PA-1) • Percentage of Idaho adults who have not visited the dentist in the past 12 months. (BRFSS) (OH-7)
Access/ Systems	• Percentage of Idaho adults without health care coverage. (BRFSS) (AHS-1) • Percentage of Idaho adults without a usual health care provider. (BRFSS) (AHS-2) • Number of active primary care physicians per 100,000. (AMA)(AHS-3)
Reproductive Health	• Adolescent pregnancy rates ages 15-17 (VS) (FB 8.1) • Percentage of adolescents that had sexual intercourse for the first time at 15 years old or younger. (YRBS) (FP9.3)

*YRBS population is students in grades 9-12

YRBS overweight : students who were >+85th percentile but <95th percentile for body mass index, based on sex and age specific reference data from the 2000 CDC growth charts

YRBS Obese students who were >=95th percentile for body mass index based on sex and age specific reference data from the 2000 CDC growth charts

YRBS current smoker: Smoked cigarettes on at least 1 day in the 30 days before the survey

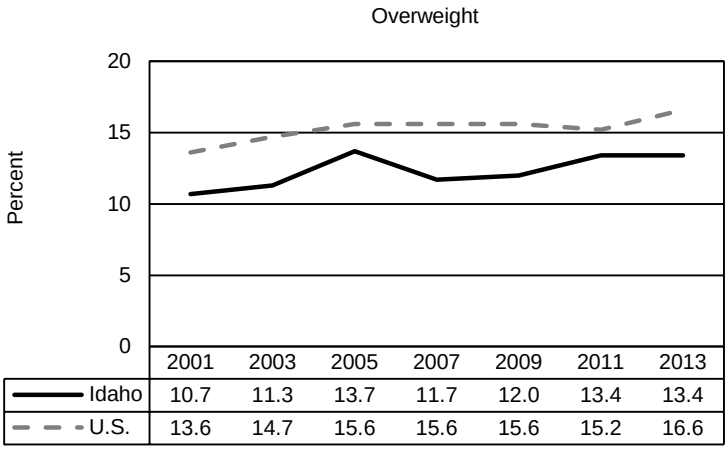
***These guidelines based on the US Preventive Services Task Force

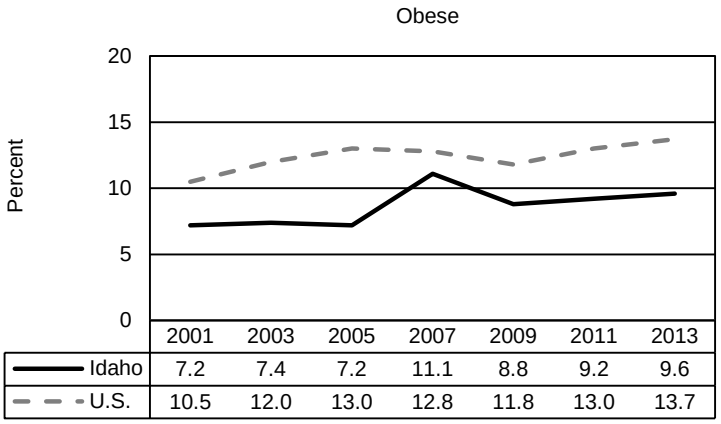
Topic Area: Overweight/Obesity

Percentage of Idaho adolescents who are overweight/obese

2013

	Percent Overweight	Percent Obese
U.S.	16.6	13.7
Idaho	15.7	9.6
Grade		
9th	15.8	9.5
10th	12.7	8.5
11th	17.1	10.1
12th	17.5	10.3
Ethnicity		
Non-Hispanic	15.7	7.7
Hispanic	16.7	19.5
Sex		
Male	15.4	13.0
Female	16.0	5.9





- Male students (13%) were significantly more likely to be obese than female students (6%).
- Female students (35%) were significantly more likely than male students (23%) to describe themselves as overweight.
- Hispanic students (20%) were significantly more likely to be obese than White students (8%).
- Among female students; 17% went without eating for 24 hours, 6% took diet drugs, and 5% vomited or took laxatives in order to lose weight.

Overweight: Greater or equal to the 85th but less than the 95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth charts.

Obese: Greater or equal to the 95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth charts.

Source: Idaho Department of Education, 2013 Youth Risk Behavior Survey

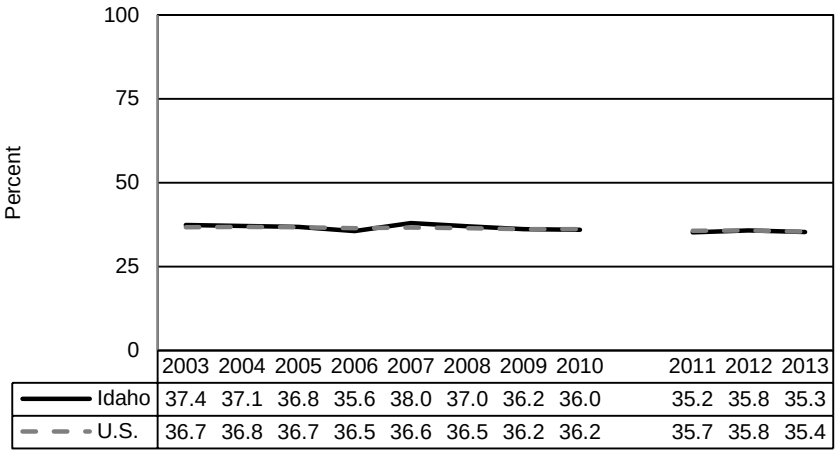
Topic Area: Overweight/Obesity

Percentage of Idaho adults who are overweight

2013

	Percent
U.S.[1]	35.4
Idaho	35.3
Public Health District	
PHD 1	35.8
PHD 2	30.8
PHD 3	36.6
PHD 4	37.4
PHD 5	34.1
PHD 6	34.6
PHD 7	32.8
Age	
18-24	30.5
25-34	30.0
35-44	35.5
45-54	36.7
55-64	38.3
65+	39.8
18-34	30.2
35-64	36.9
65+	39.8
Ethnicity	
Non-Hispanic	35.7
Hispanic	32.3
Sex	
Male	41.4
Female	28.9
Income	
Less than $15,000	30.9
$15,000 - $24,999	30.2
$25,000 - $34,999	38.2
$35,000 - $49,999	36.1
$50,000-$74,999	36.3
$75,000+	37.5

[1] U.S. median prevalence



- Being overweight was associated with being male: 41.4% vs 28.9% for females.
- Idaho adults with an annual household income of $25,000 or greater had higher prevalence of being overweight (37.0%) than those with household incomes less than $25,000 (30.5%).
- 6.3% of overweight individuals had also been diagnosed with diabetes.
- 49.5% of Maternal and Child Health Community Health Survey respondents listed overweight/obesity as an important issue in their community.

Overweight: BMI 25.0-29.9

Due to changes in BRFSS methodology in 2011, data from 2011 and later are not directly comparable to 2010 and earlier.

Source: Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2013

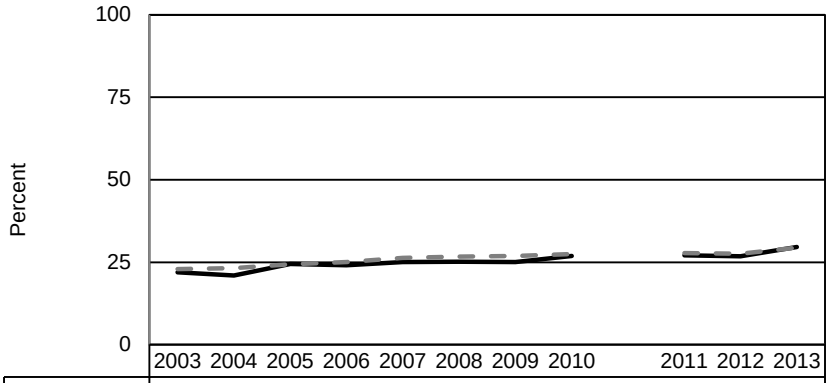
Topic Area: Overweight/Obesity

Percentage of Idaho adults who are obese

2013

	Percent
U.S.[1]	29.4
Idaho	29.6
Public Health District	
PHD 1	28.7
PHD 2	29.4
PHD 3	34.0
PHD 4	25.1
PHD 5	33.3
PHD 6	27.9
PHD 7	33.8
Age	
18-24	16.8
25-34	27.6
35-44	32.5
45-54	34.4
55-64	35.1
65+	29.9
18-34	22.7
35-64	34.0
65+	29.9
Sex	
Male	31.2
Female	27.9
Ethnicity	
Non-Hispanic	28.7
Hispanic	38.5
Income	
Less than $15,000	33.7
$15,000 - $24,999	32.1
$25,000 - $34,999	32.2
$35,000 - $49,999	33.6
$50,000-$74,999	30.7
$75,000+	23.0

[1] U.S. median prevalence



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Idaho	22.0	21.0	24.5	24.1	25.1	25.2	25.1	26.9	27.1	26.8	29.6
U.S.	22.9	23.2	24.4	25.1	26.3	26.7	26.9	27.5	27.8	27.6	29.4

- Idaho adults with an annual household income of less than $50,000 had a higher prevalence of obesity (32.8%) than those with household incomes of $50,000 or greater (26.4%).
- 28.9% of obese individuals did not participate in any form of leisure time physical activity.
- 12.5% of obese individuals reported consuming five or more servings of fruits and vegetables daily.
- Adults who were obese had a greater prevalence of having additional health conditions:
    - 45.1% also had high blood pressure.
    - 5.7% had been diagnosed with angina or coronary heart disease.
    - 5.4% had reported ever having a heart attack.
    - 16.4% had been diagnosed with diabetes.

Obese: BMI 30.0+

Due to changes in BRFSS methodology in 2011, data from 2011 and later are not directly comparable to 2010 and earlier.

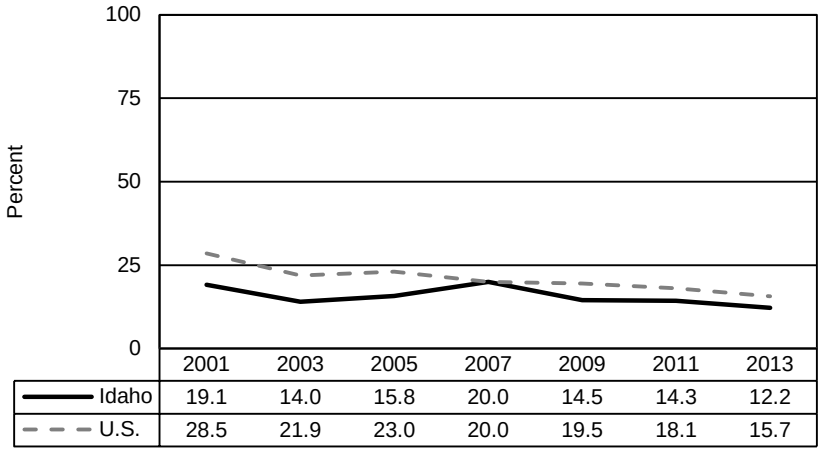
Source: Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2013

Topic Area: Tobacco Use

Percentage of Idaho adolescents who currently smoke

2013

	Percent
U.S.	15.7
Idaho	12.2
Grade	
9th	6.4
10th	8.4
11th	13.7
12th	21.7
Ethnicity	
Non-Hispanic	12.0
Hispanic	14.2
Sex	
Male	12.8
Female	11.4



- One-third (33%) of all high school students have tried cigarette smoking, and 7% smoked a whole cigarette before age 13.
- 4% of students smoked on 20 or more of the past 30 days (i.e. frequent smokers).
- Hispanic students (6%) are significantly more likely than White students (2%) to report having smoked on school property during the past 12 months.
- Among students who do smoke, 55% tried to quit at least once during the previous 12 months.

Source: Idaho Department of Education, 2013 Youth Risk Behavior Survey

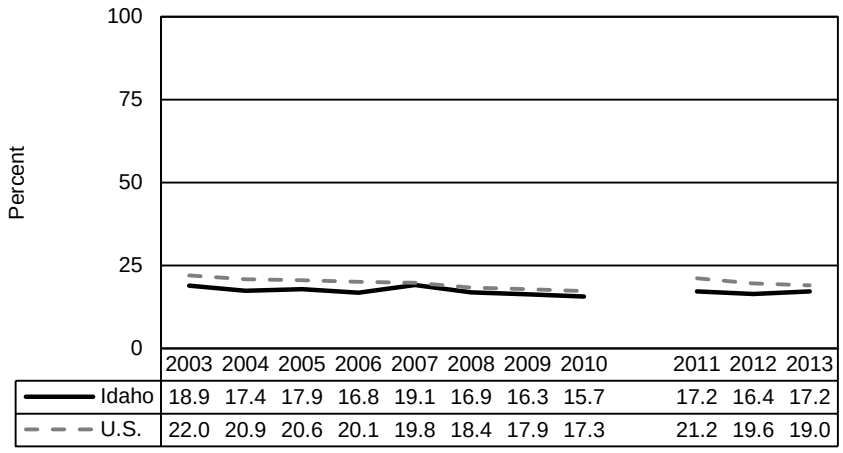
Topic Area: Tobacco Use

Percentage of Idaho adults who are current smokers

2013

	Percent
U.S.[1]	19.0
Idaho	17.2
Public Health District	
PHD 1	18.6
PHD 2	15.2
PHD 3	19.7
PHD 4	18.3
PHD 5	16.3
PHD 6	14.9
PHD 7	13.6
Age	
18-24	18.5
25-34	22.9
35-44	19.9
45-54	20.2
55-64	14.8
65+	8.2
18-34	20.9
35-64	18.3
65+	8.2
Ethnicity	
Non-Hispanic	17.3
Hispanic	16.0
Sex	
Male	19.4
Female	15.0
Education	
K-11th Grade	34.3
12th Grade or GED	24.3
Some College	12.7
College Graduate	6.2

[1] U.S. median prevalence



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Idaho	18.9	17.4	17.9	16.8	19.1	16.9	16.3	15.7	17.2	16.4	17.2
U.S.	22.0	20.9	20.6	20.1	19.8	18.4	17.9	17.3	21.2	19.6	19.0

- Unemployed individuals had a higher prevalence of smoking (42.7%) than individuals who were employed, students, homemakers, retirees, or unable to work (15.7%).
- Being a current smoker was associated with lower levels of education: 34.3% for those with K-11th grade, 24.3% for high school graduates/GED, 12.7% for some college, and 6.2% for college graduates.
- 30.7% of Maternal and Child Health Community Health Survey respondents identified tobbaco use as a risky behavior seriously impacting community health.

Current smoker: Individual that has smoked at least 100 cigarettes in their lifetime and currently smoke everyday or somedays.

Due to changes in BRFSS methodology in 2011, data from 2011 and later are not directly comparable to 2010 and earlier.

Source: Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2013

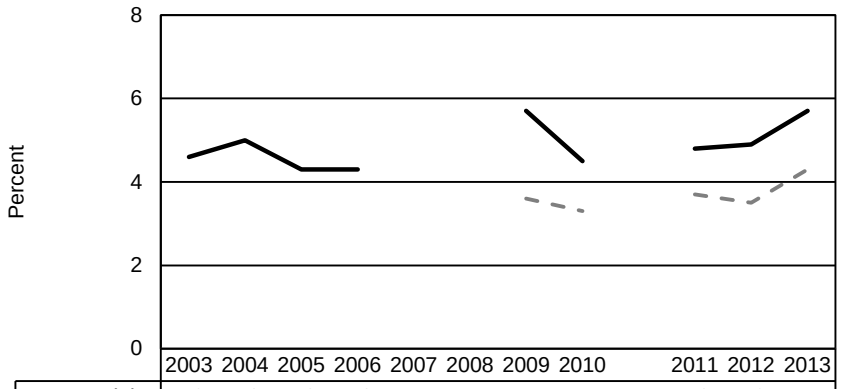
Topic Area: Tobacco Use

Percentage of Idaho adults who use smokeless tobacco

2013

	Percent
U.S.[1]	4.3
Idaho	5.7
Public Health District	
PHD 1	6.5
PHD 2	7.7
PHD 3	5.8
PHD 4	6.0
PHD 5	6.7
PHD 6	3.6
PHD 7	3.1
Age	
18-24	7.0
25-34	9.0
35-44	8.5
45-54	5.6
55-64	2.8
65+	1.8
18-34	8.1
35-64	5.6
65+	1.8
Ethnicity	
Non-Hispanic	5.9
Hispanic	3.3
Sex	
Male	10.8
Female	0.5
Education	
K-11th Grade	7.9
12th Grade or GED	8.0
Some College	4.3
College Graduate	3.7

[1] U.S. median prevalence



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Idaho	4.6	5.0	4.3	4.3	N/A	N/A	5.7	4.5	4.8	4.9	5.7
U.S.	N/A	N/A	N/A	N/A	N/A	N/A	3.6	3.3	3.7	3.5	4.3

N/A: Data unavailable for year

- Current smokeless tobacco users were primarily male.
- Adults with lower levels of education had greater prevalence of smokeless tobacco use: 8.0% for high school education or less vs. 4.1% for those with some college or college graduates.
- Adults age 65 and older have significantly lower prevalence of smokeless tobacco use (1.8%) than younger age groups (8.1% for ages 18-34, 5.6% for ages 35-64).

Due to changes in BRFSS methodology in 2011, data from 2011 and later are not directly comparable to 2010 and earlier.

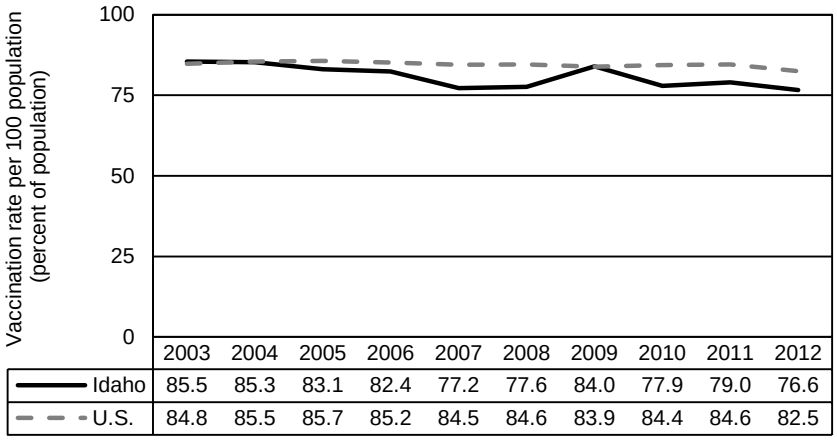
Source: Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2013

Topic Area: Immunization

Percentage of Idaho children 19 through 35 months of age who received 4+ doses of DTaP

2013

	Rate[1]
U.S.	82.5
Idaho	76.6



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Idaho	85.5	85.3	83.1	82.4	77.2	77.6	84.0	77.9	79.0	76.6
U.S.	84.8	85.5	85.7	85.2	84.5	84.6	83.9	84.4	84.6	82.5

- The Idaho immunization rate of 82.5% of 19-35 month olds that had 4+ doses of DTaP ranks Idaho 19th among the 50 states in 2013.
- The DTaP vaccine includes components that protect against diphtheria, tetanus, and pertussis.
- The four-dose DTaP series is recommended to be administered at 2, 4, 6, and 15-18 months of age.
- An additional booster dose of DTaP is recommended at 4-6 years of age (approximately at school-entry age).

[1]Rate per 100 population (percent of population)

Note: Vaccination rate estimates for the United States and Idaho are from the National Immunization Survey (http://www.cdc.gov/nchs/nis.htm)

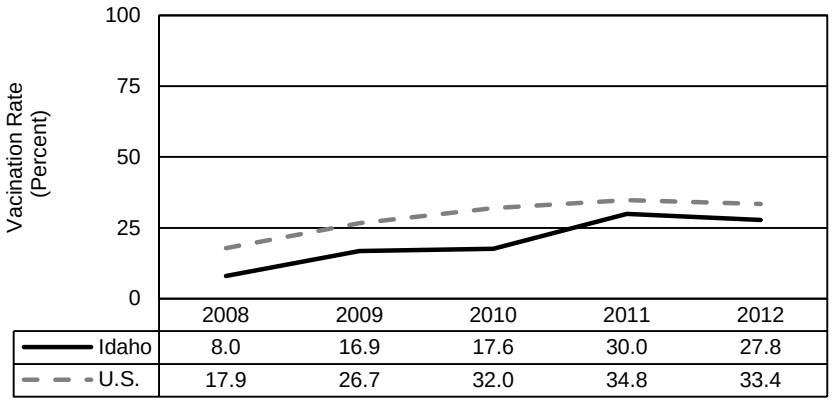
Source: Idaho Department of Health and Welfare, Division of Public health, Epidemiology Program, 2014

Topic Area: Immunization

Percentage of Idaho female adolescents aged 13 through 17 years reported having been vaccinated with 3 or more doses of HPV vaccine

2013

	Rate[1]
U.S.	33.4
Idaho	27.8



- The Idaho immunization rate of 33.45% of female adolescents aged 13-17 that received 3+ doses of HPV vaccine ranks Idaho 40th among the 50 states.
- The quadrivalent ("quad" = four) HPV vaccine protects against two HPV strains that together account for 70% of cervical cancers. The other two components protect against HPV strains that cause other cancers and genital warts.
- This vaccine is administered in a 3-dose series recommended to start at age 11 years and be completed over the course of six months.
- The HPV vaccine is also recommended for males of the same age as of 2011. Idaho does not have sufficient data to calculate stable estimates of 3+ doses of HPV vaccine among Idaho boys.
- A 9-valent HPV (9vHPV) vaccine was approved by the FDA in December 2014. The additional five components included in the 9vHPV vaccine increases the amount of strains protected against in about 90% of cervical cancers.

[1]Rate per 100 population (percent of population)

Note: Vaccination rate estimates for the United States and Idaho are from the National Immunization Survey (http://www.cdc.gov/nchs/nis.htm)

Source: Idaho Department of Health and Welfare, Division of Public health, Epidemiology Program, 2014

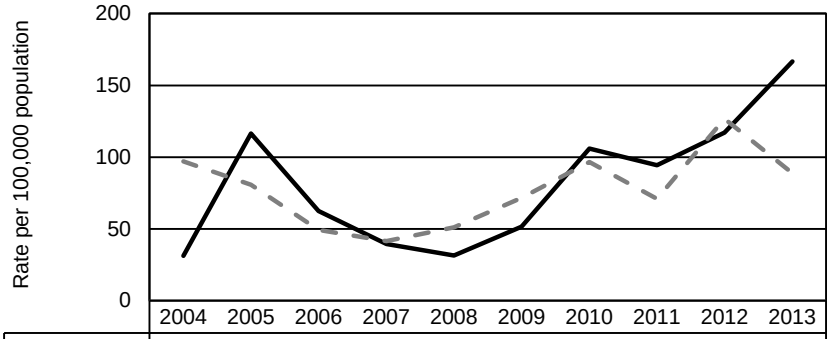
Topic Area: Immunization

Incidence rate of pertussis (whooping cough) reported to public health in Idaho

2013

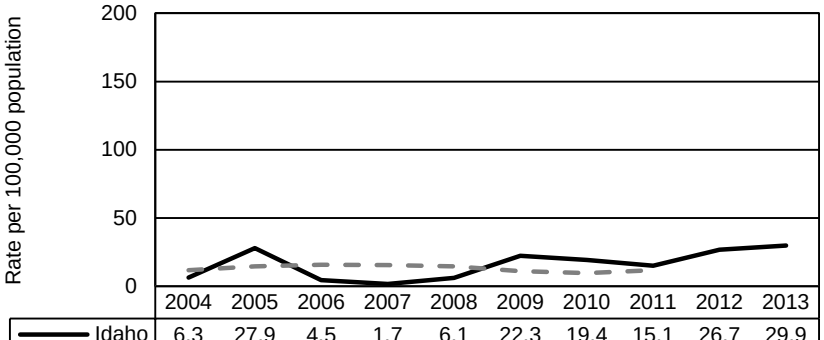
	Rate[1]
U.S.	7.7
Idaho	14.7
Public Health District	
PHD 1	23.0
PHD 2	40.3
PHD 3	9.9
PHD 4	4.6
PHD 5	13.2
PHD 6	23.7
PHD 7	15.4
Sex	
Male	14.0
Female	15.4
Age	
<1	167.5
1-4	37.2
5-9	37.4
10-14	39.6
15-17	25.7
18-34	5.2
35-54	4.8
55+	3.6
Burden on Infants	**Percentage of all cases**
Less than or equal to 2 months	6.3%
2 months to 1 year	9.3%

Age-specific incidence rate of pertussis: <1 year of age



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Idaho	31.2	116.5	62.4	39.6	31.5	51.6	105.9	94.4	117.2	166.7
U.S.	97.1	80.8	49.4	41.6	51.2	71.6	96.7	70.9	126.7	88.7

Age-specific incidence rate of pertussis: 11-18 years of age



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Idaho	6.3	27.9	4.5	1.7	6.1	22.3	19.4	15.1	26.7	29.9
U.S.	11.7	14.5	15.7	15.5	14.6	11.1	9.7	11.9	N/A	N/A

- Pertussis incidence peaks every 3 to 5 years and continues to be considerably higher than other vaccine-preventable diseases in the United States and Idaho.
- More than half (51.5%) of all pertussis cases in 2013 were outbreak associated with disease incidence rates highest among Idaho infants.
- Among outbreak-associated cases of pertussis in infants aged 6 months or younger occurring in the last ten years in Idaho, 56.3% of the infants were hospitalized. One-quarter (24.4%) were less than two months of age, and therefore too young at the time of diagnosis to have received the first recommended dose of DTaP.

[1]Rate per 100,000 population

N/A: Data Not Available

Note: Cases include all reports of disease to Idaho public health officials received January 1 through December 31, 2013 that meet the surveillance case definition for a confirmed or probable case of pertussis.

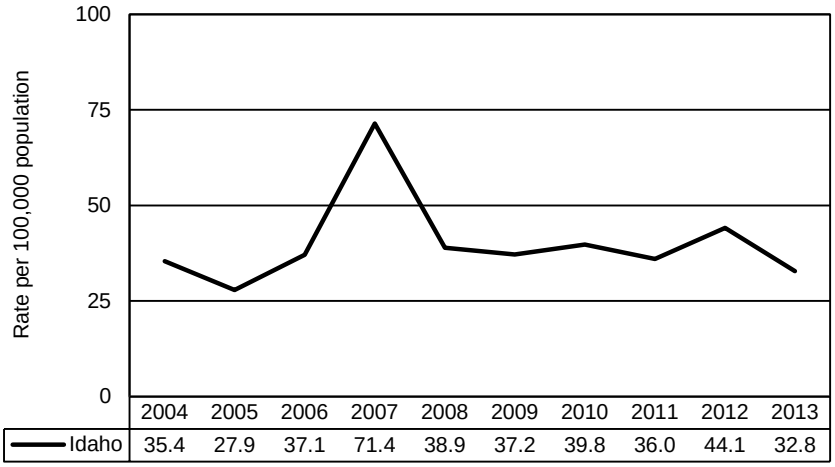
Source: Idaho Department of Health and Welfare, Division of Public health, Epidemiology Program, 2014

Topic Area: Infectious Disease

Incidence rate of specified enteric diseases reported to public health in Idaho

2013

	Rate[1]
U.S.	N/A
Idaho	33.2
Public Health District	
PHD 1	22.5
PHD 2	36.6
PHD 3	36.4
PHD 4	26.1
PHD 5	73.1
PHD 6	23.7
PHD 7	26.0
Sex	
Male	34.4
Female	32.0
Age	
<1	81.0
1-4	78.8
5-9	44.7
10-14	29.7
15-17	35.7
18-24	34.0
25-34	33.0
35-44	27.9
45-54	25.4
55-64	20.4
65+	26.4
Adult/Child	
0-17	48.2
18+	27.7



- Enteric infections enter the body through the mouth and intestinal tract and are usually spread through contaminated food and water or by contact with surfaces or items that have been contaminated with vomit or feces.
- Enteric disease can be caused by viruses, bacteria, or parasites.
- Enteric diseases included here are cryptosporidiosis, giardiasis, listeriosis, salmonellosis, shigellosis, and Shiga-toxin producing *Escherichia coli* (STEC).
- Generally, young children, babies, people with disabilities and elderly individuals are most at risk for enteric diseases as well as those with weakened immune systems.
- Outbreaks of enteric diseases occur every year. In 2013, approximately one-quarter (25.5%) of all cases of enteric illness reported to public health officials in Idaho was associated with an outbreak.

[1]Rate per 100,000 population

N/A: Data Not Available

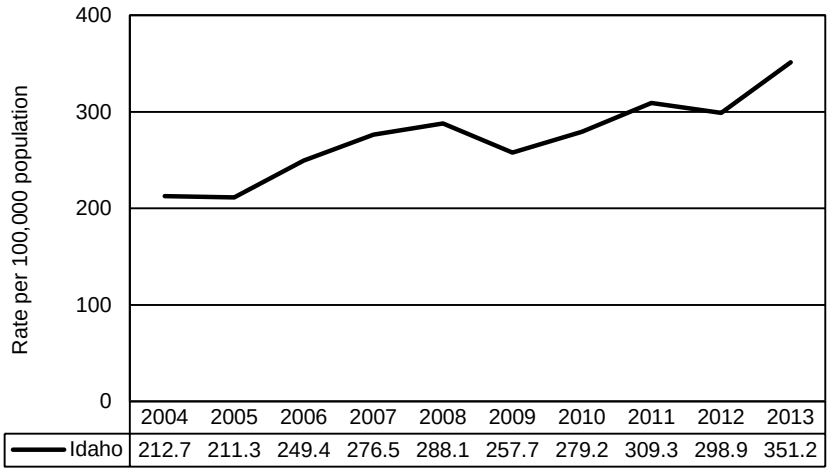
Note: 2013 cases include all reports of disease to Idaho public health officials received January 1 through December 31, 2013 that meet the surveillance case definition for a confirmed or probable case of cryptosporidiosis, giardiasis, listeriosis, salmonellosis, STEC, and shigellosis.

Source: Idaho Department of Health and Welfare, Division of Public health, Epidemiology Program, 2014

Topic Area: Infectious Disease

Incidence rate of specified sexually transmitted diseases (STDs) reported to public health in Idaho 2013

	Rate[1]
U.S.	N/A
Idaho	351.2
Public Health District	
PHD 1	367.3
PHD 2	360.3
PHD 3	433.5
PHD 4	416.5
PHD 5	333.6
PHD 6	296.8
PHD 7	150.5
Sex	
Male	208.8
Female	494.6
Age	
<18	149.6
18-24	2,108.2
25-34	370.1
35-44	152.9
45+	14.2



- Sexually transmitted diseases (STDs) are very common in the United States—half of all sexually active people will get an STD by age 25. These diseases can be passed from one person to another through intimate physical contact and sexual activity.
- The incidence rate of STDs is highest among people aged 18-24 in both the United States and Idaho.
- STDs can be caused by viruses or bacteria.
- STD data here includes *chlamydia trachomatis* infections, gonorrhea, and syphilis.
- The symptoms of STDs can vary widely. In some cases, an infected person might not know they have the disease. The sequelae (consequences) of the disease can range from none to death.
- Because STDs are important preventable causes of pelvic inflammatory disease (PID) and infertility, the Centers for Disease Control and Prevention recommends annual chlamydia and gonorrhea screening of all sexually active women younger than 25 years, as well as older women with risk factors such as new or multiple sex partners, or a sex partner who has a sexually transmitted infection.

[1]Rate per 100,000 population

N/A: Data Not Available

Note: 2013 cases include all reports of disease to Idaho public health officials received January 1 through December 31, 2013 that meet the surveillance case definition for a confirmed or probable case of *chlamydia trachomatis* infection, gonorrhea, and syphilis

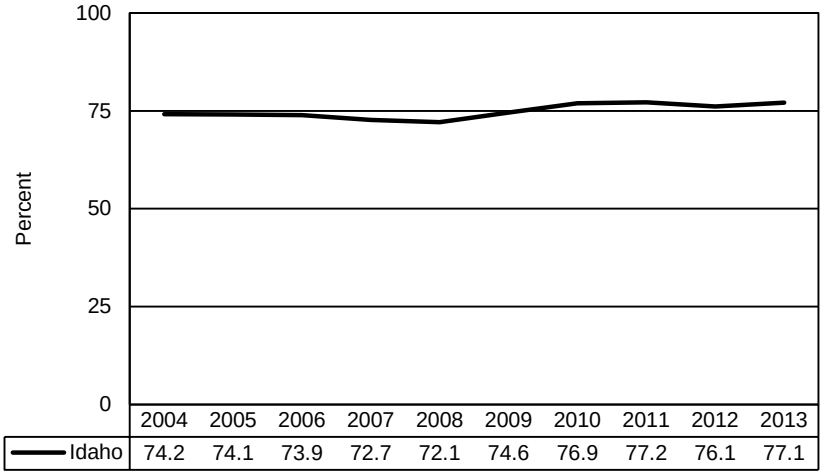
Source: Idaho Department of Health and Welfare, Division of Public health, Epidemiology Program, 2014

Topic Area: Perinatal Care

Percentage of Idaho mothers who received adequate prenatal care

2013

	Percent
U.S.	N/A
Idaho	77.1
Public Health District	
PHD 1	78.8
PHD 2	76.4
PHD 3	72.3
PHD 4	82.7
PHD 5	74.0
PHD 6	80.6
PHD 7	72.9
Age	
<15	36.4
15-17	62.4
18-19	68.0
20-24	73.0
25-29	78.6
30-34	81.6
35-39	80.0
40-44	75.8
45+	71.1
Ethnicity	
Non-Hispanic	78.5
Hispanic	69.4
Race	
White	78.0
Black	62.3
American Indian	62.4
Asian Pacific Islander	75.3
Other race/ Multiple Race	70.5
Birth Weight	
2,500/+ Grams	76.8
<2,500 Grams	81.7
Plurality	
Singleton	76.7
Twin	89.0
Triplet or higher	78.3



- The Adequate Prenatal Care Utilization Index (APNCU) determines adequate care based on when prenatal care was initialized, and the number of visits completed based on the expected number of visits for each pregnancy.
- This data is for Idaho resident mothers who received "adequate+" care. Adequate+ care includes both adequate and intensive prenatal care.
- In 2013:
  - 41.9% of mothers received adequate care.
  - 35.2% of mothers received intensive care.
  - 17,115 mothers received adequate+ care.
  - 74.0% of mothers who reported being on WIC received adequate+ care.
  - 84.4% of preterm births received adequate+ care.
  - 76.3% of term births received adequate+ care.
  - 69.8% of mothers who reported smoking at any time during pregnancy received adequate+ care, while 78.0% of mothers who did not smoke at any time during pregnancy received adequate+ care.
  -
  - 81.5% of twin births received intensive care while 7.5% received adequate care.

N/A: Data Not Available

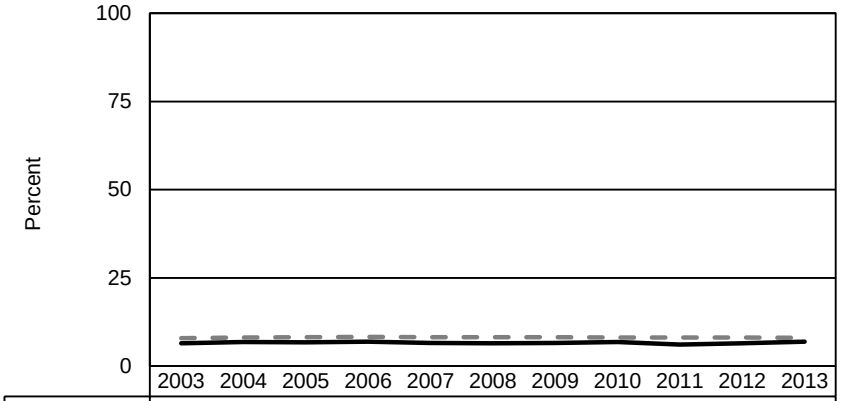
Source: Idaho Department of Health and Welfare, Division of Public Health, Vital Statistics, 2013

Topic Area: Perinatal Care

Percentage of Idaho resident live births with low birth weight

2013

	Percent
U.S.[1]	8.0
Idaho	6.9
Public Health District	
PHD 1	6.2
PHD 2	6.6
PHD 3	6.8
PHD 4	6.5
PHD 5	7.4
PHD 6	7.9
PHD 7	7.1
Age	
<15	20.0
15-17	7.7
18-19	9.1
20-24	6.3
25-29	6.4
30-34	7.0
35-39	8.2
40-44	10.2
45+	10.5
Ethnicity	
Non-Hispanic	6.9
Hispanic	7.0
Race	
White	6.7
Black	7.5
American Indian	6.8
Asian Pacific Islander	8.7
Other race/ Multiple Race	9.4
Length of gestation	
Preterm < 37 weeks	46.6
Term 37+ weeks	2.3



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Idaho	6.5	6.8	6.7	6.9	6.6	6.5	6.6	6.8	6.1	6.5	6.9
U.S.	7.9	8.1	8.2	8.3	8.2	8.2	8.2	8.1	8.1	8.1	8.0

- Low birth weight: infants who weighed less than 2,500 grams at birth.
- In 2013 there was a total of 1,547 live births to Idaho residents that were of low birth weight.
- Of singleton births to Idaho residents, 5.2% were less than 2,500 grams (low birth weight), while 55.5% of twins and 87.0% of triplet or higher order births were less than 2,500 grams.
- 2013 Adequate Prenatal Care Utilization (APNCU) and low birth weight:
    - Intensive: 12.8% of births that received intensive prenatal care were low birth weight.
    - Adequate: 2.6% of births that received adequate prenatal care were low birth weight.
    - Intermediate: 3.3% of births that received intermediate prenatal care were low birth weight.
    - Inadequate: 6.4% of births that received inadequate prenatal care were low birth weight.
    - No care: 12.7% of births that received no prenatal care were

[1] Preliminary 2013 U.S. Data

N/A: Data Not Available

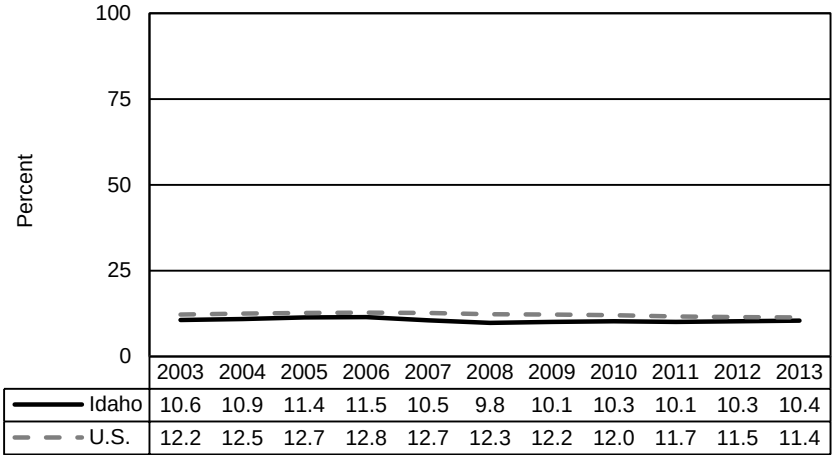
Source: Idaho Department of Health and Welfare, Division of Public Health, Vital Statistics, 2013

Topic Area: Perinatal Care

Percentage of Idaho resident live births with pre-term delivery

2013

	Percent
U.S.[1]	11.4
Idaho	10.4
Public Health District	
PHD 1	8.4
PHD 2	9.9
PHD 3	11.9
PHD 4	10.4
PHD 5	10.5
PHD 6	11.1
PHD 7	10.1
Age	
<15	45.5
15-17	12.3
18-19	13.5
20-24	9.5
25-29	9.5
30-34	10.8
35-39	12.2
40-44	15.1
45+	10.5
Ethnicity	
Non-Hispanic	10.2
Hispanic	11.8
Race	
White	10.0
Black	12.6
American Indian	15.0
Asian Pacific Islander	12.4
Other race/ Multiple Race	14.8
Birth Weight	
2,500+ Grams	6.0
<2,500 Grams	70.3
Plurality	
Singleton	8.6
Twin	64.0
Triplet or higher	87.0



- Pre-term delivery is defined as deliveries that occurred at less than 37 completed weeks gestation.
- In 2013:
  - There were 2,333 pre-term live births to Idaho residents.
  - 13.4% of mothers who reported smoking at any time during pregnancy delivered pre-term.
  - 19.9% of mothers who did not receive any care during pregnancy delivered pre-term.
  - 21.7% of mothers who received intensive care during pregnancy delivered pre-term.
  - 2.6% of mothers who received adequate care during pregnancy delivered pre-term.

[1] Preliminary 2013 U.S. Data

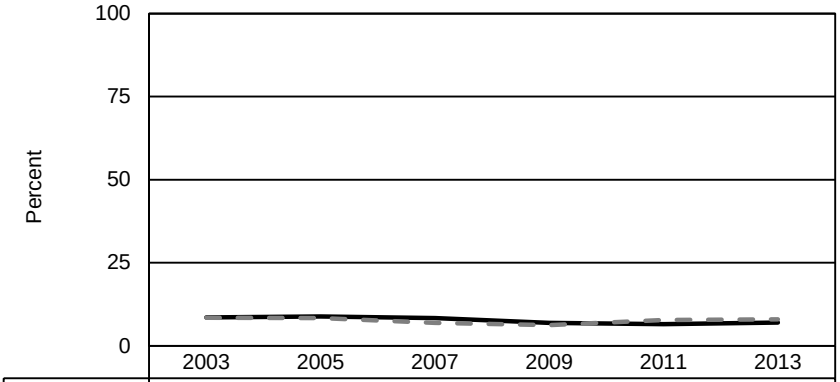
Source: Idaho Department of Health and Welfare, Division of Public Health, Vital Statistics, 2013

Topic Area: Injury/Suicide

Percentage of Idaho adolescents who have attempted suicide

2013

	Percent
U.S.	8.0
Idaho	7.0
Grade	
9th	8.3
10th	7.6
11th	6.0
12th	5.7
Ethnicity	
Non-Hispanic	6.2
Hispanic	9.8
Sex	
Male	5.1
Female	8.9



	2003	2005	2007	2009	2011	2013
Idaho	8.6	8.9	8.4	6.9	6.5	7.0
U.S.	8.5	8.4	6.9	6.3	7.8	8.0

- In 2011, suicide was the 2nd leading cause of injury related deaths among youth aged 10 to 19 in Idaho, and 27 Idahoans between the ages of 10 and 19 committed suicide.
- Female students (21%) were significantly more likely than male students (11%) to have seriously considered attempted suicide during the previous 12 months.
- Female students (24%) were also significantly more likely than male students (12%) to report they had purposely tried to hurt themselves without wanting to die, such as cutting themselves on purpose one or more times during the past 12 months.
- Hispanic students (37%) were significantly more likely than White students (27%) to report they felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities within the previous 12 months.

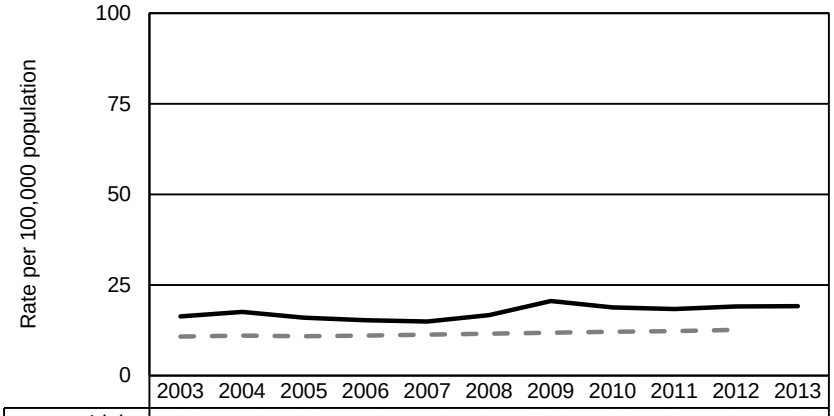
Source: Idaho Department of Education, 2013 Youth Risk Behavior Survey

Topic Area: Injury/Suicide

Idaho suicide death rates

2013

	Rate[1]
U.S. (2012)	12.6
Idaho	19.2
Public Health District	
PHD 1	18.5
PHD 2	13.0
PHD 3	22.3
PHD 4	15.9
PHD 5	22.7
PHD 6	28.0
PHD 7	15.7
Age	
10-14	2.5
15-24	20.8
25-34	23.1
35-44	20.8
45-54	32.4
55-64	23.5
65-74	27.4
75-84	23.2
85+	22.1
Race and Ethnicity	
Non-Hispanic	21.1
White	21.8
Black	N/A
American Indian/Alaska Native	N/A
Asian/Pacific Islander	N/A
Hispanic	N/A



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Idaho	16.3	17.6	16.0	15.3	14.9	16.7	20.6	18.8	18.4	19.1	19.2
U.S.	10.8	11.0	10.9	11.0	11.3	11.6	11.8	12.1	12.3	12.6	N/A

- In 2013 suicide was the 8th leading cause of death to Idaho residents.
- Suicide accounts for 2.5% of all deaths to Idaho residents.
- Mechanism (percentage of suicide deaths):
  - Firearm (64.9%).
  - Poisoning (17.5%).
  - Hanging, strangulation, & suffocation (12.3%).
  - Jumping from high place (1.3%).
  - Drowning (0.6%).
  - Cutting (sharp object) (0.6%).
  - All other means (2.6%).
- Total mean age at death due to suicide: 46.0 years.
- Mean age at death for males due to suicide: 46.4 years.
- Mean age at death for females due to suicide: 44.3 years.

[1]Age-adjusted rate: Number of deaths per 100,000 population in the corresponding group. Age-adjusted rates are calculated using the 2000 U.S. population estimate as the standard population.

N/A: Data Not Available

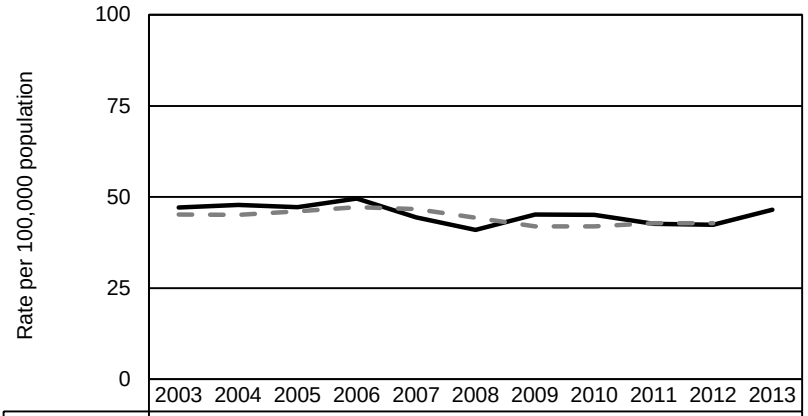
Source: Idaho Department of Health and Welfare, Division of Public Health, Vital Statistics, 2013

Topic Area: Injury/Suicide

Idaho injury fatalities ages 1-44

2013

	Rate[1]
U.S. (2012)	42.8
Idaho	46.5
Public Health District	
PHD 1	43.8
PHD 2	67.7
PHD 3	44.3
PHD 4	31.7
PHD 5	45.8
PHD 6	73.6
PHD 7	52.2
Age	
1-9	11.7
10-14	9.1
15-19	41.4
20-24	73.2
25-29	81.0
30-34	59.6
35-39	67.6
40-44	71.6
Race and Ethnicity[2]	
Non-Hispanic	49.9
White	49.4
Black	41.5
American Indian/Alaska Native	96.3
Asian/Pacific Islander	38.1
Hispanic	27.2
Intent of Injury (percentage of Injury Deaths)	Percent
Unintentional	60.3%
Intentional self-harm	31.0%
Assault	4.4%
Undetermined	3.5%
Legal Intervention	0.7%



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Idaho	47.1	47.8	47.2	49.6	44.4	41.0	45.2	45.1	42.6	42.4	46.5
U.S.	45.2	45.1	46.1	47.2	46.7	44.3	41.9	41.9	42.8	42.8	N/A

- In 2013 injury fatalities of 1- 44 year olds accounted for:
  - 59.8% of all deaths.
  - 63.2% of all deaths to males.
  - 53.5% of all deaths to females.
- In 2013 the statewide prevalence of those that did not always use a seatbelt was 22.0%.[3]
- There is a significant difference between gender and seatbelt use; 28.9% of males reported not always wearing a seatbelt, compared to 15.3% of females.[3]

[1]Age-specific rate: Number of deaths per 100,000 population aged 1-44 years.

[2]Total for race and ethnicity includes one death each for other race male, multiple race male, and ethnicity not stated female

[3]Data from Behavioral Risk Factor Surveillance System (BRFSS)

Source: Idaho Department of Health and Welfare, Division of Public Health, Vital Statistics, 2013

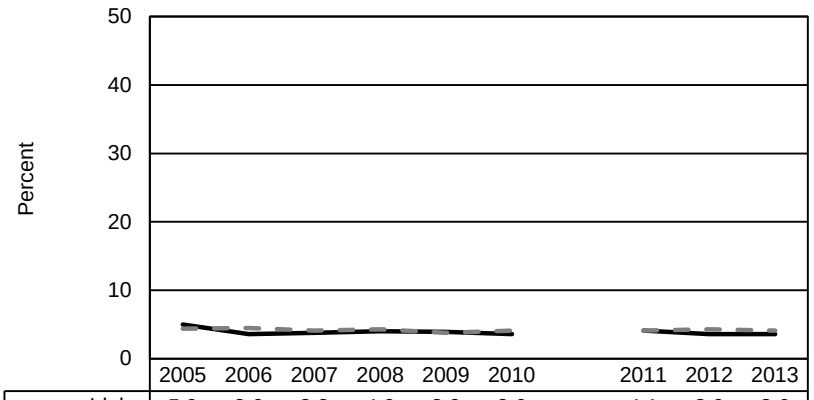
Topic Area: Chronic Disease

Idaho coronary heart disease prevalence

2013

	Percent
U.S.[1]	4.1
Idaho	3.6
Public Health District	
PHD 1	5.2
PHD 2	4.1
PHD 3	4.6
PHD 4	3.4
PHD 5	2.2
PHD 6	3.1
PHD 7	2.6
Age	
18-24	0.5
25-34	0.5
35-44	1.0
45-54	1.5
55-64	5.5
65+	11.7
18-34	0.5
35-64	2.7
65+	11.7
Ethnicity	
Non-Hispanic	3.8
Hispanic	2.2
Sex	
Male	4.5
Female	2.7
Income	
Less than $15,000	5.8
$15,000 - $24,999	3.7
$25,000 - $34,999	3.9
$35,000 - $49,999	4.0
$50,000-$74,999	2.7
$75,000+	2.9

[1] U.S. median prevalence



	2005	2006	2007	2008	2009	2010	2011	2012	2013
Idaho	5.0	3.6	3.8	4.0	3.9	3.6	4.1	3.6	3.6
U.S.	4.4	4.5	4.1	4.3	3.8	4.1	4.1	4.3	4.1

- Idaho males have a significantly greater prevalence of coronary heart disease compared to females.
- Prevalence of coronary heart disease increases with age.
- Adults with an annual household income of less than $50,000 had higher prevalence of coronary heart disease (4.2%) when compared to adults with a household income of $50,000 or greater (2.8%).
- Among those diagnosed with coronary heart disease:
  - 78.6% also had high blood pressure.
  - 36.7% had also been diagnosed with diabetes.
  - 45.6% were considered obese.

Coronary heart disease includes angina and coronary heart disease diagnosis.

Due to changes in BRFSS methodology in 2011, data from 2011 and later are not directly comparable to 2010 and earlier.

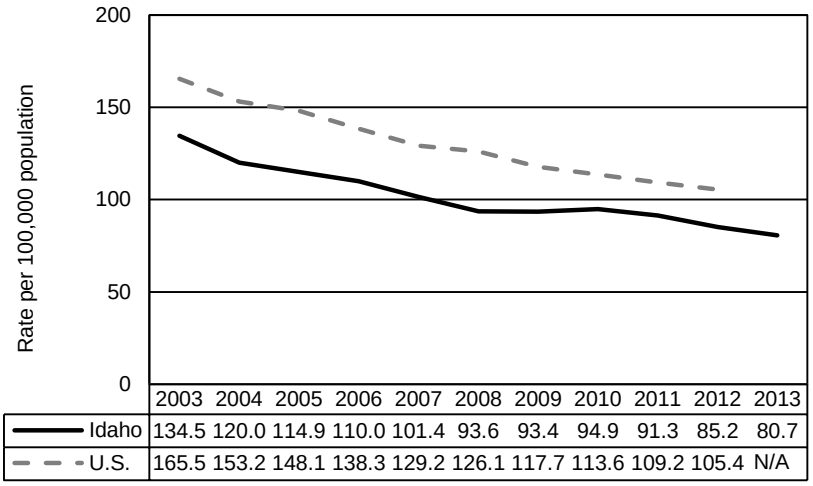
Source: Idaho Department of Health and Welfare, Division of Public Health, Vital Statistics, 2013

Topic Area: Chronic Disease

Idaho coronary heart disease (Ischemic) rate of death

2013

	Rate[1]
U.S. (2012)	105.4
Idaho	80.7
Public Health District	
PHD 1	81.2
PHD 2	94.8
PHD 3	82.4
PHD 4	76.3
PHD 5	87.6
PHD 6	73.8
PHD 7	77.5
Age	
<15	N/A
15-24	0.4
25-34	1.9
35-44	9.1
45-54	32.9
55-64	99.0
65-74	205.0
75-84	523.2
85+	1,857.2
Race and Ethnicity[2]	
Non-Hispanic	82.4
White	81.6
Black	N/A
American Indian/Alaska Native	N/A
Asian/Pacific Islander	N/A
Non-Hispanic other race	N/A
Hispanic	41.3
Sex	
Male	110.2
Female	55.7



- Ischemic heart disease is a sub-set of the cause of death category "Diseases of heart". Ischemic heart disease is not ranked for leading cause of death; Diseases of heart is ranked for leading cause of death.

- Deaths due to coronary heart disease accounted for:
  - 11.2 % of all deaths.
  - 13.3% of deaths to males.
  - 9.0% of deaths to females.

- The mean age at death due to coronary heart disease was 76.8 years old.

- The mean age at death for males due to coronary heart disease was 74.0 years old.

- The mean age at death for females due to coronary heart disease was 81.2 years old.

- Cause (percentage of Ischemic heart disease deaths):
  - Acute myocardial infarction 47.3%.
  - Other acute ischemic heart disease 1.7%.
  - Other forms of chronic ischemic heart disease 51.0%.

[1]Age-adjusted rate: Number of deaths per 100,000 population in the corresponding group. Age-adjusted rates are calculated using the 2000 U.S. population estimate as the standard population.

[2]Total for race and ethnicity includes one death each for other race male, multiple race male, and ethnicity not stated female

N/A: Data Not Available; Not applicable; age-adjusted rates not calculated for groups with fewer than 20 deaths.

Source: Idaho Department of Health and Welfare, Division of Public Health, Vital Statistics, 2013

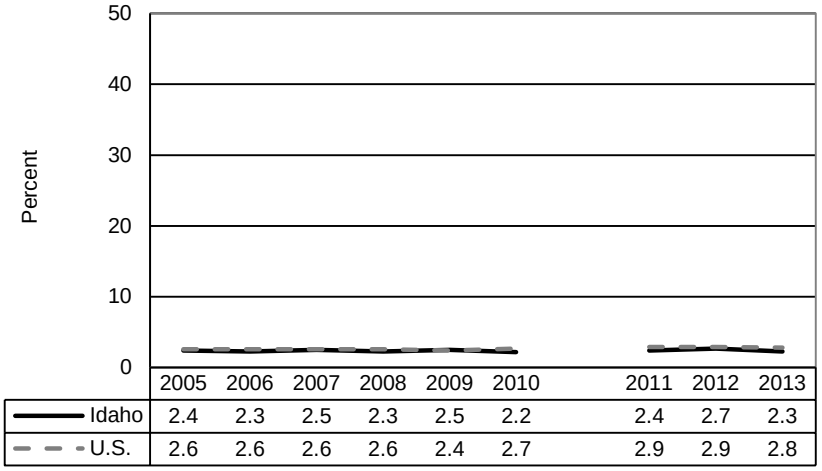
Topic Area: Chronic Disease

Idaho stroke prevalence

2013

	Percent
U.S.[1]	2.8
Idaho	2.3
Public Health District	
PHD 1	3.1
PHD 2	3.6
PHD 3	2.9
PHD 4	0.8
PHD 5	2.8
PHD 6	2.5
PHD 7	2.4
Age	
18-24	0.0
25-34	1.2
35-44	1.2
45-54	1.2
55-64	2.1
65+	7.0
18-34	0.7
35-64	1.5
65+	7.0
Ethnicity	
Non-Hispanic	2.3
Hispanic	1.7
Sex	
Male	2.0
Female	2.5
Income	
Less than $15,000	4.2
$15,000 - $24,999	3.8
$25,000 - $34,999	2.4
$35,000 - $49,999	1.4
$50,000-$74,999	1.6
$75,000+	0.6

[1] U.S. median prevalence



	2005	2006	2007	2008	2009	2010	2011	2012	2013
Idaho	2.4	2.3	2.5	2.3	2.5	2.2	2.4	2.7	2.3
U.S.	2.6	2.6	2.6	2.6	2.4	2.7	2.9	2.9	2.8

- Public Health District 4 has a significantly lower rate of stroke when compared to the statewide prevalence.
- Prevalence of stroke increases with age.
- The mean age of death due to stroke was 80.1 years.
- In 2013, stroke was the 5th leading cause of death in Idaho.
- Adults with an annual household income of less than $35,000 had a higher prevalence of stroke (3.5%) compare to adults with a household income of $35,000 or greater (1.1%).

Due to changes in BRFSS methodology in 2011, data from 2011 and later are not directly comparable to 2010 and earlier.

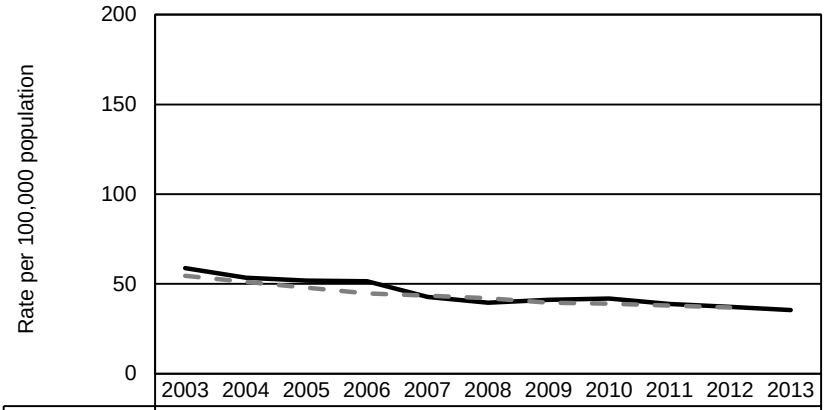
Source: Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2013

Topic Area: Chronic Disease

Idaho stroke death rates

2013

	Rate[1]
U.S. (2012)	36.9
Idaho	35.5
Public Health District	
PHD 1	43.7
PHD 2	40.7
PHD 3	34.9
PHD 4	27.3
PHD 5	37.7
PHD 6	36.5
PHD 7	35.3
Age	
<15	N/A
15-24	0.4
25-34	N/A
35-44	4.1
45-54	9.5
55-64	23.5
65-74	64.0
75-84	253.1
85+	1,024.4
Race and Ethnicity	
Non-Hispanic	35.9
White	35.8
Black	N/A
American Indian/Alaska Native	N/A
Asian/Pacific Islander	N/A
Hispanic	N/A
Sex	
Male	36.8
Female	34.2



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Idaho	58.8	53.5	51.8	51.5	42.7	39.5	41.1	41.9	38.9	37.3	35.5
U.S.	54.6	51.2	48.0	44.8	43.5	42.1	39.6	39.1	37.9	36.9	N/A

- Age-adjusted rate for stroke by sex:
  - Males- 36.8 per 100,000 males.
  - Females- 34.2 per 100,000 females.
- In 2013 stroke (cerebrovascular diseases) was the 5th leading cause of death in Idaho.
- In 2013 stroke accounted for:
  - 4.8% of all deaths in Idaho.
  - 4.2% of deaths to males.
  - 5.5% of deaths to females.
- The mean age at death due to stroke was 80.1 years.
- The mean age at death for males due to stroke was 78.1 years.
- The mean age at death for females due to stroke was 82.4 years.
- Cause (percentage of stroke deaths)
  - Subarachnoid hemorrhage 5.3%.
  - Intracerebral and other intracranial hemorrhage 18.7%.
  - Cerebral infarction 4.5%.
  - Stroke, not specified as hemorrhage or infarction 53.2%.
  - Other cerebrovascular disease and their sequelae 18.3%.

[1]Age-adjusted rate: Number of deaths per 100,000 population in the corresponding group. Age-adjusted rates are calculated using the 2000 U.S. population estimate as the standard population. N/A: Not applicable; age-adjusted rates not calculated for groups with fewer than 20 deaths.

N/A: Not applicable; age-adjusted rates not calculated for groups with fewer than 20 deaths.

Source: Idaho Department of Health and Welfare, Division of Public Health, Vital Statistics, 2013

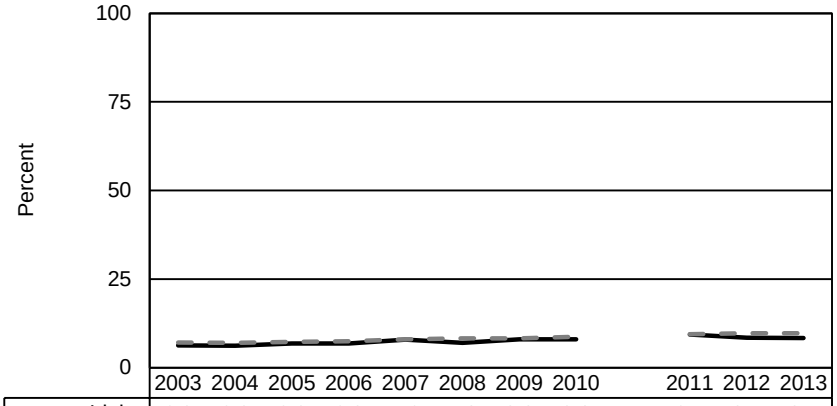
Topic Area: Chronic Disease

Idaho diabetes prevalence

2013

	Percent
U.S.[1]	9.7
Idaho	8.4
Public Health District	
PHD 1	7.0
PHD 2	9.7
PHD 3	11.1
PHD 4	6.3
PHD 5	9.1
PHD 6	10.4
PHD 7	8.2
Age	
18-24	1.7
25-34	2.2
35-44	4.3
45-54	8.2
55-64	13.2
65+	18.8
18-34	2.0
35-64	8.6
65+	18.8
Ethnicity	
Non-Hispanic	8.4
Hispanic	7.2
Sex	
Male	9.4
Female	7.3
Income	
Less than $15,000	10.9
$15,000 - $24,999	9.6
$25,000 - $34,999	10.6
$35,000 - $49,999	9.0
$50,000-$74,999	6.1
$75,000+	5.0

[1] U.S. median prevalence



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Idaho	6.3	6.2	6.8	6.8	7.9	7.0	8.0	8.0	9.4	8.5	8.4
U.S.	7.1	7.0	7.3	7.5	8.0	8.3	8.3	8.7	9.5	9.7	9.7

- Prevalence of diabetes increases significantly with age.
- Adults with an annual household income of less than $50,000 had a greater prevalence of diabetes (9.9%) than adults with household income of $50,000 or more (5.5%).
- Students, homemakers, retirees, and those unable to work had a greater rate of diabetes (14.7%) than employed or unemployed adults (5.0%).
- Diabetes diagnosis was associated with not being a college graduate: 9.1% vs. 5.9% for college graduates.
- In 2013, diabetes mellitus was the 6th leading cause of death in Idaho.
- In 2013, diabetes mellitus was responsible for 400 deaths in Idaho, or 3.2% of all causes of death.

Diabetes: Does not include women told they had diabetes only during pregnancy.

Due to changes in BRFSS methodology in 2011, data from 2011 and later are not directly comparable to 2010 and earlier.

Source: Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2013

Topic Area: Health Status/Behaviors

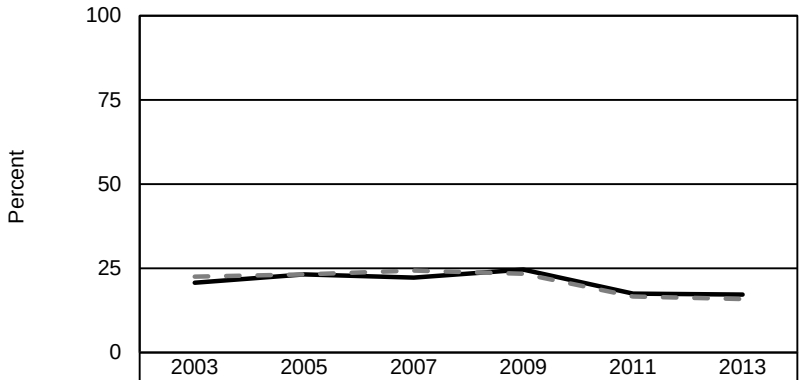
Percentage of Idaho adults who consume five or more servings of fruits and vegetables a day

2013

	Percent
U.S.[1]	15.9
Idaho	17.2
Public Health District	
PHD 1	14.6
PHD 2	16.7
PHD 3	15.8
PHD 4	21.0
PHD 5	18.2
PHD 6	17.9
PHD 7	11.6
Age	
18-24	13.0
25-34	20.6
35-44	20.1
45-54	18.1
55-64	16.1
65+	14.3
18-34	17.3
35-64	18.1
65+	14.3
Ethnicity	
Non-Hispanic	16.4
Hispanic	23.7
Sex	
Male	11.7
Female	22.5
Employment	
Employed	17.6
Unemployed	10.0
Other[2]	17.9

[1] U.S. median prevalence

[2] Other includes students, homemakers, retirees, and persons unable to work



	2003	2005	2007	2009	2011	2013
Idaho	20.7	23.2	22.3	24.6	17.5	17.2
U.S.	22.6	23.2	24.4	23.4	16.7	15.9

- The prevalence of adults consuming at least five servings of fruits and vegetables per day in Public Health District 7 was significantly lower than the statewide value.
- The percentage of females eating five or more servings of fruits and vegetables a day was significantly higher than males.
- Consumption of five or more daily servings of fruits and vegetables was higher among individuals who were employed, students, homemakers, retirees, or unable to work (17.7%).
- Of those who reported eating five or more servings of fruits and vegetables a day, 85.6% also reported participating in some form of leisure time physical activity.

Due to changes in BRFSS methodology in 2011, data from 2011 and later are not directly comparable to 2010 and earlier.

Source: Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2013

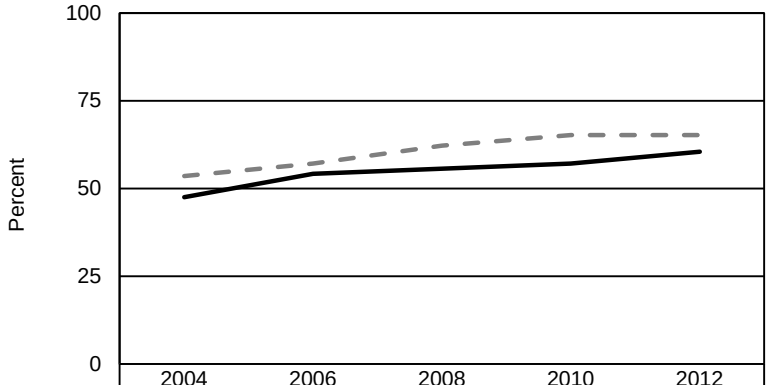
Topic Area: Health Status/Behaviors

Percentage of Idaho adults aged 50 to 75 years who receive colorectal cancer screening based on the most recent guidelines

2012

	Percent
U.S.[1]	65.2
Idaho	60.5
Public Health District	
PHD 1	57.5
PHD 2	64.4
PHD 3	59.1
PHD 4	66.0
PHD 5	56.1
PHD 6	62.7
PHD 7	54.4
Ethnicity	
Non-Hispanic	61.1
Hispanic	45.8
Sex	
Male	62.9
Female	58.3
Income	
Less than $15,000	53.9
$15,000 - $24,999	54.3
$25,000 - $34,999	53.9
$35,000 - $49,999	62.5
$50,000-$74,999	59.5
$75,000+	69.9

[1] U.S. median prevalence



	2004	2006	2008	2010	2012
Idaho	47.5	54.2	55.6	57.1	60.5
U.S.	53.5	57.1	62.2	65.2	65.2

- The U.S. Preventative Task Force Services recommends adults aged 50 - 75 receive colorectal cancer screening with either high-sensitivity fecal occult blood testing every year, a sigmoidoscopy every 5 years with high-sensitivity fecal occult blood testing every 3 years, or a screening colonoscopy every 10 years.
- The percentage of people meeting colorectal cancer screening guidelines was greater (64.3%) among those with an annual household income of $35,000 or higher.
- In 2013, the total death rate for colon, rectal, and anus cancer for Idaho residents, was 14.7 per 100,000 population.
- Colon, rectal, and anus cancers were responsible for 237 deaths to Idaho residents in 2013.

Due to changes in BRFSS methodology in 2011, data from 2011 and later are not directly comparable to 2010 and earlier.

Source: Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2012

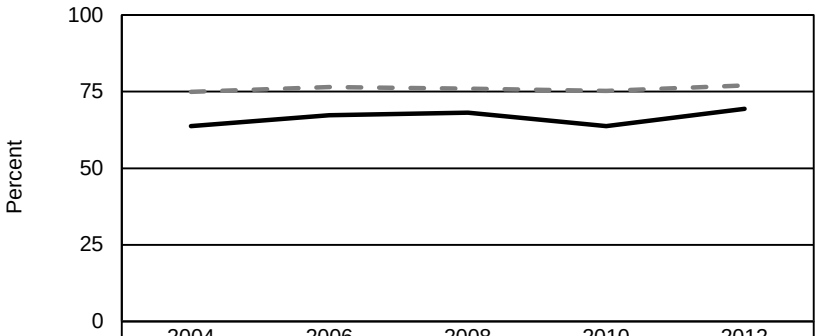
Topic Area: Health Status/Behaviors

Percentage of Idaho adults aged 50 to 74 years who receive a breast cancer screening based on the most recent guidelines

2012

	Percent
U.S.[1]	77.0
Idaho	69.4
Public Health District	
PHD 1	74.7
PHD 2	68.8
PHD 3	61.8
PHD 4	70.4
PHD 5	71.9
PHD 6	67.2
PHD 7	68.6
Ethnicity	
Non-Hispanic	69.6
Hispanic	N/A
Income	
Less than $15,000	50.4
$15,000 - $24,999	59.9
$25,000 - $34,999	60.6
$35,000 - $49,999	79.7
$50,000-$74,999	68.9
$75,000+	91.8

[1] U.S. median prevalence



	2004	2006	2008	2010	2012
Idaho	63.7	67.3	68.1	63.8	69.4
U.S.	74.9	76.5	76.0	75.2	77.0

- The U.S. Preventive Services Task Force recommends women aged 50 - 74, and who have no special risk factors, receive breast cancer screening with a mammography every two years.
- The percentage of women meeting recommended breast cancer screening guidelines was greater (76.7%) in those with an annual household income of $35,000 or greater.
- In 2013, the death rate due to breast cancer in Idaho resident females was 25.5 per 100,000 females.
- 205 Idaho resident females died from breast cancer in Idaho in 2013.

N/A: Sample size insufficient for reliable estimate (n<50)

Due to changes in BRFSS methodology in 2011, data from 2011 and later are not directly comparable to 2010 and earlier.

Source: Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2012

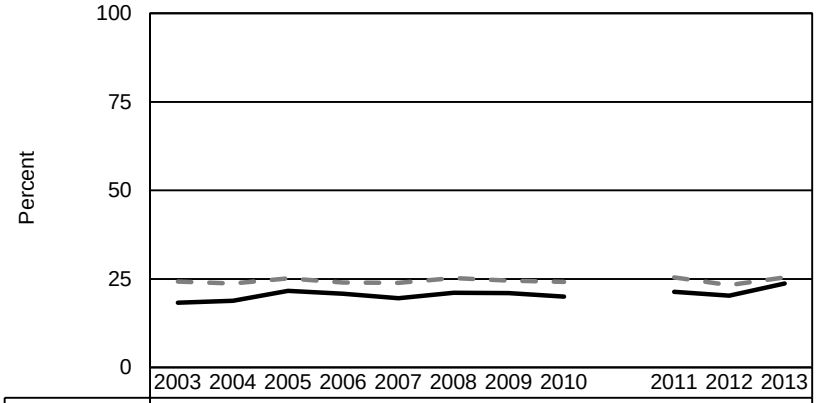
Topic Area: Health Status/Behaviors

Percentage of Idaho adults with no leisure time physical activity

2013

	Percent
U.S.[1]	25.4
Idaho	23.7
Public Health District	
PHD 1	23.2
PHD 2	22.6
PHD 3	31.3
PHD 4	18.8
PHD 5	27.1
PHD 6	24.1
PHD 7	23.0
Age	
18-24	17.1
25-34	21.1
35-44	23.2
45-54	26.8
55-64	25.6
65+	27.0
18-34	19.4
35-64	25.2
65+	27.0
Ethnicity	
Non-Hispanic	22.6
Hispanic	34.6
Sex	
Male	23.9
Female	23.5
Education	
K-11th Grade	40.7
12th Grade or GED	27.7
Some College	21.9
College Graduate	12.7

[1] U.S. median prevalence



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Idaho	18.3	18.8	21.6	20.8	19.6	21.1	21.0	20.0	21.4	20.3	23.7
U.S.	24.3	23.7	25.2	24.0	23.9	25.3	24.5	24.2	25.4	23.3	25.4

- Public Health District 3 had a significantly greater percentage of individuals not participating in leisure time physical activity when compared to the statewide value.
- Individuals with an annual household income of less than $35,000 had a higher rate (25.3%) of not participating in leisure time physical activity during the past month compared to those with household incomes of $35,000 or greater (15.5%).
- Lack of leisure time physical activity was associated with lower education levels: 40.7% for K-11th Grade, 24.4% for high school graduate/GED or some college, and 12.7% for college graduates.
- Hispanics were less likely to have participated in leisure time physical activity during the past month when compared to non-Hispanics.

Leisure time physical activity: Any physical activity or exercise other than your regular job.

Due to changes in BRFSS methodology in 2011, data from 2011 and later are not directly comparable to 2010 and earlier.

Source: Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2013

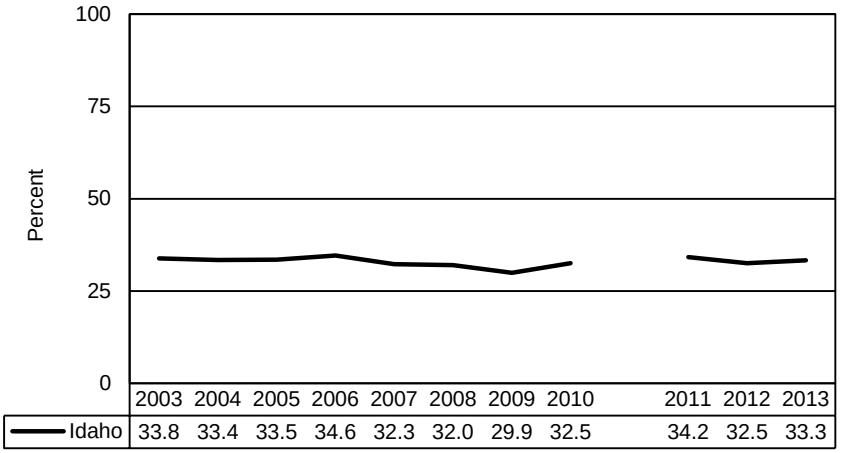
Topic Area: Health Status/Behaviors

Percentage of Idaho adults who have not visited the dentist in the past 12 months

2013

	Percent
U.S.	N/A[1]
Idaho	33.3
Public Health District	
PHD 1	36.3
PHD 2	36.2
PHD 3	35.6
PHD 4	31.5
PHD 5	31.9
PHD 6	32.8
PHD 7	31.3
Age	
18-24	33.2
25-34	39.2
35-44	32.6
45-54	33.5
55-64	28.0
65+	33.8
18-34	36.7
35-64	31.4
65+	33.8
Ethnicity	
Non-Hispanic	32.2
Hispanic	43.4
Sex	
Male	35.5
Female	31.2
Income	
Less than $15,000	54.9
$15,000 - $24,999	51.6
$25,000 - $34,999	38.9
$35,000 - $49,999	27.3
$50,000-$74,999	23.3
$75,000+	13.9

[1] U.S. median unavailable for this measure



- The percentage of those who have not visited a dentist in the past 12 months was higher among individuals with an annual household income of less than $35,000 (48.3%).
- Not visiting a dentist in the past 12 months was associated with being unemployed: 48.1% vs. 31.1% for employed individuals and 34.4% for students, homemakers, retirees, and those unable to work.
- The prevalence of not visiting a dentist in the past 12 months was lower among college graduates (20.5%) compared to non-college graduates (37.1%).
- The percentage of individuals who have not visited a dentist in the past 12 months was significantly higher among the Hispanic population.

Due to changes in BRFSS methodology in 2011, data from 2011 and later are not directly comparable to 2010 and earlier.

Source: Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2013

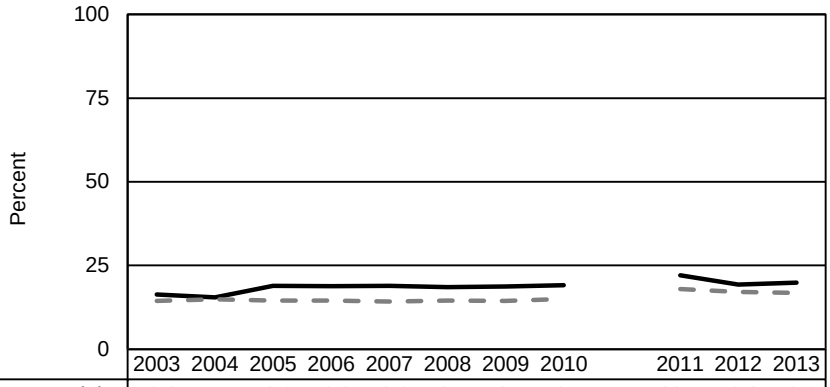
Topic Area: Access/Systems

Percentage of Idaho adults without health care coverage

2013

	Percent
U.S.[1]	16.8
Idaho	19.9
Public Health District	
PHD 1	18.8
PHD 2	16.3
PHD 3	22.6
PHD 4	17.6
PHD 5	26.2
PHD 6	20.2
PHD 7	19.2
Age	
18-24	24.8
25-34	30.7
35-44	24.8
45-54	22.5
55-64	17.2
65+	2.1
18-34	28.1
35-64	21.5
65+	2.1
Ethnicity	
Non-Hispanic	16.7
Hispanic	49.2
Sex	
Male	22.4
Female	17.4
Income	
Less than $15,000	41.1
$15,000 - $24,999	37.4
$25,000 - $34,999	22.1
$35,000 - $49,999	15.6
$50,000-$74,999	8.0
$75,000+	3.2

[1] U.S. median prevalence



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Idaho	16.3	15.5	18.9	18.8	18.9	18.5	18.7	19.1	22.1	19.3	19.9
U.S.	14.4	14.9	14.5	14.5	14.2	14.5	14.4	15.0	17.9	17.1	16.8

- Public Health District 5 had a significantly greater percentage of those without health care coverage when compared to the state value.
- Lack of health care coverage was associated with younger age groups.
- The percentage of those without health care coverage was significantly higher among the Hispanic population.
- The percentage of those without health care coverage was higher among males compared to females.
- Prevalence of not having health care coverage increased with lower annual household income: 38.7% for less than $25,000, 18.5% for $25,000-$49,999, and 5.4% for $50,000 or greater.
- Unemployed individuals had the greatest prevalence of not having health care coverage (51.8%).
- Not having health care coverage was associated with lower levels of education: 48.0% for K-11th grade, 23.3% for high school graduate/GED, 14.8% for some college, and 8.8% for college

Health care coverage: Having health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Due to changes in BRFSS methodology in 2011, data from 2011 and later are not directly comparable to 2010 and earlier.

Source: Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2013

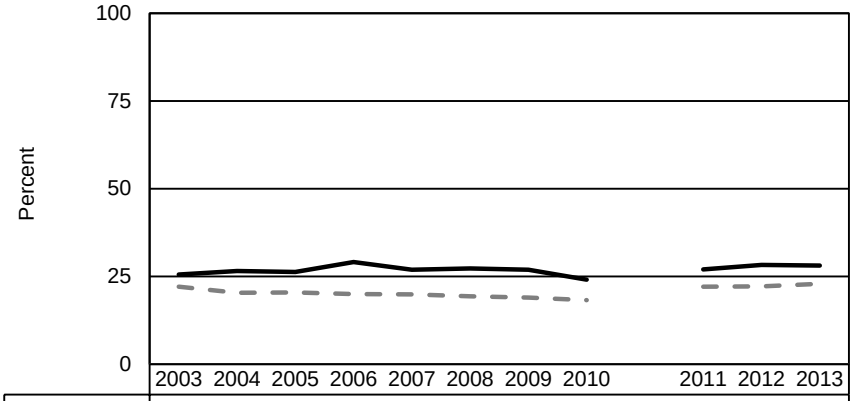
Topic Area: Access/Systems

Percentage of Idaho adults without a usual health care provider

2013

	Percent
U.S.[1]	22.9
Idaho	28.1
Public Health District	
PHD 1	23.4
PHD 2	28.8
PHD 3	29.8
PHD 4	28.2
PHD 5	24.2
PHD 6	29.6
PHD 7	33.0
Age	
18-24	48.4
25-34	43.8
35-44	31.3
45-54	26.2
55-64	16.3
65+	7.1
18-34	45.8
35-64	24.6
65+	7.1
Ethnicity	
Non-Hispanic	26.7
Hispanic	41.0
Sex	
Male	37.5
Female	18.8
Education	
K-11th Grade	42.1
12th Grade or GED	31.9
Some College	24.2
College Graduate	21.3

[1] U.S. median prevalence



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Idaho	25.6	26.6	26.3	29.1	26.9	27.3	26.9	24.1	27.0	28.3	28.1
U.S.	22.1	20.4	20.5	20.0	19.9	19.4	19.0	18.3	22.1	22.2	22.9

- Younger age groups had a greater percentage of those without a usual health care provider.
- The prevalence of those without a usual healthcare provider was greater among the Hispanic population.
- Those without a usual health care provider were primarily male.
- The percentage of individuals without a usual health care provider was greater among those an annual household income of less than $35,000 (34.7%) compared to those with a household income of $35,000 or greater (22.7%).
- Not having a usual healthcare provider was associated with employment status: 46.4% for unemployed, 33.7% for employed and 15.3% for students, homemakers, retirees, and those unable to work.
- The prevalence of not having a usual healthcare provider was higher among those with lower levels of education: 35.0% for K-11 and high school graduates, 23.1% for those with some college or college graduates.

Due to changes in BRFSS methodology in 2011, data from 2011 and later are not directly comparable to 2010 and earlier.

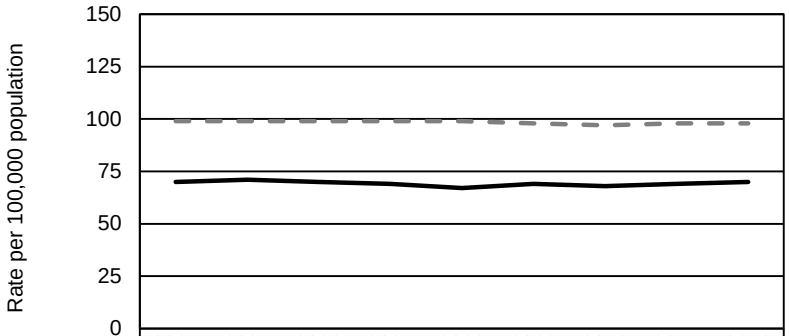
Source: Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2013

Topic Area: Access/Systems

Number of active primary care physicians per 100,000 population in Idaho

2013

	Rate[1]
U.S.	98
Idaho	70



	2004	2005	2006	2007	2008	2009	2010	2011	2012
Idaho	70	71	70	69	67	69	68	69	70
U.S.	99	99	99	99	99	98	97	98	98

- Idaho had 65.7 primary care physicians per 100,000 population in 2012, ranking 46th of 50 states.[2]
    - 24.6% of active physicians in the state are also aged 60 or older, ranking Idaho 44th in the nation. [2]

- Based on data from the AAMC Matriculating Student Questionnaire (2013) administered to incoming students accepted to Liaison Committee on Medical Education (LCME) medical schools,[2]
    - 32.9% of respondents indicated that they were considering a career in primary care medicine.
    - 25.5% of respondents had plans to work primarily in an underserved area.
    - 2.7% of respondents expressed intent to practice medicine in a small town or rural location.
    - 0.2% of respondents indicated hopes of working in Idaho following completion of medical training.

- Percentage of Idaho's land mass designated as a Health Professional Shortage Area (HPSA):
    - Primary Care: 96.4%.
    - Dental: 97.01%.
    - Mental Health: 100%.

- Idaho does not have a private or public medical or osteopathic school within the state for the training and development of physicians.

- Legal residents of Idaho totaled less than 0.34% of the nation's medical school matriculants, or just 65 of the 19,059 medical school students during the 2012-2013 academic year.[3]

[1] Rate per 100,000 population

[2]Association of American Medical Colleges. (2013, December). 2013 msq all schools summary report. Association of American Medical Colleges. Retrieved August 8, 2014, from Association of American Medical Colleges: https://www.aamc.org/download/363478/data/msq2013report.pdf

[3]Center for Workforce Studies. (2013). 2013 state physician workforce data book. Center for Workforce Studies. Washington, D.C.: American Association of Medical Colleges. Retrieved July 17, 2014, from Association of American Medical Colleges: https://www.aamc.org/download/362168/data/2013statephysicianworkforcedatabook.pdf

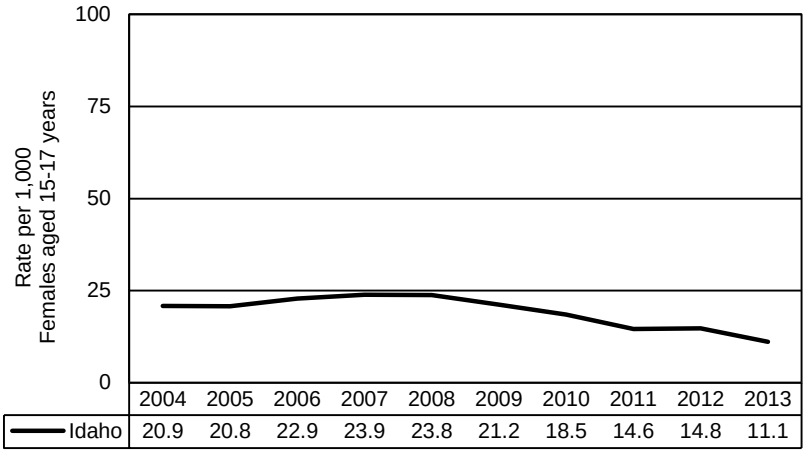
Source: American Medical Association (AMA), 2013

Topic Area: Reproductive Health

Idaho adolescent pregnancy rates ages 15-17

2013

	Rate[1]
U.S.	N/A
Idaho	11.1
Public Health District	
PHD 1	9.7
PHD 2	10.5
PHD 3	13.4
PHD 4	7.9
PHD 5	16.3
PHD 6	11.1
PHD 7	11.3
Age	**Percent**
Total	100.0%
15	11.2%
16	27.7%
17	61.1%
Race/Ethnicity	**Rate[1]**
Non-Hispanic	8.6
White	7.8
Black	9.0
American Indian	37.4
Asian	14.1
Other/Multiple	N/A
Hispanic	23.3
Percent of Pregnancies	**Percent**
Total	100.0%
Births	82.9%
Abortions	16.5%
Stillbirths	0.5%
Married[2]	**Percent**
Yes	10.9%
No	89.1%



- In 2013 there were 11.1 pregnancies per 1,000 Idaho resident females aged 15-17 years.
- In 2013, there was a total of 375 pregnancies to Idaho resident 15-17 year olds.
- Births: 9.2 per 1,000 females Aged 15-17 years.
- Abortions: 1.8 per 1,000 females Aged 15-17 years.
- Stillbirths: 0.1 per 1,000 females Aged 15-17 years.
- From 2004 to 2013, there was nearly a 47% decrease in the rate of adolescent pregnancies for 15 to 17 year old females.

[1]Pregnancy rate: number of pregnancies per 1,000 females aged 15-17 years.

[2]If marital status was unknown, marital status was included with not married status.

N/A: Data Not Available

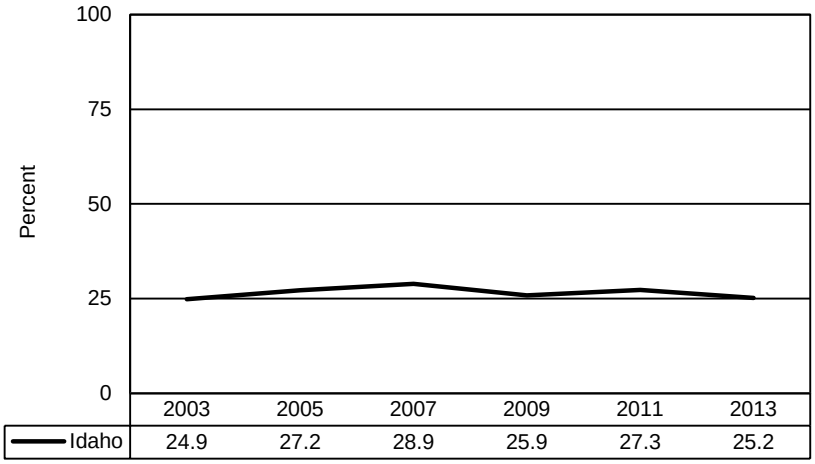
Pregnancies include live births, induced abortions, and reportable stillbirths (only those fetal deaths with a gestational period of 20+ weeks or which weigh 350+ grams are required to be reported under Idaho law).

Source: Idaho Department of Health and Welfare, Division of Public Health, Vital Statistics, 2013

Topic Area: Reproductive Health

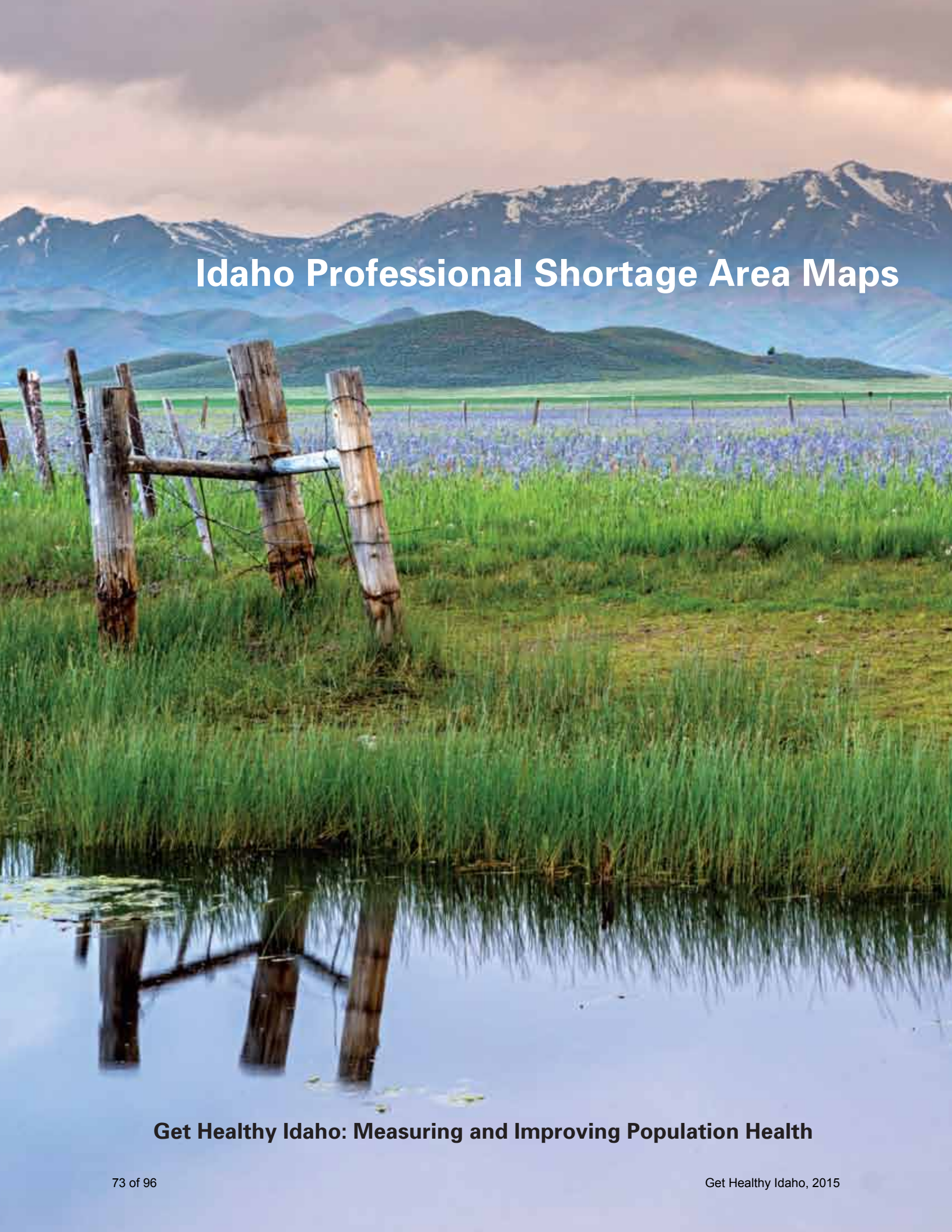
Percentage of Idaho adolescents that had sexual intercourse for the first time at 15 years old or younger
2013

	Percent
U.S.	N/A
Idaho	25.2
Grade	
9th	18.8
10th	24.3
11th	28.8
12th	29.8
Ethnicity	
Non-Hispanic	22.6
Hispanic	35.6
Sex	
Male	23.8
Female	26.6



- 29% of Idaho high school students had sexual intercourse at least once during the previous 3 months.
- Among Idaho high school students who had sexual intercourse during the previous 3 months, 20% reported they drank alcohol or used drugs beforehand.
- Among high school students who had sexual intercourse during the previous 3 months, 43% reported they or their partner did not use a condom.
- Although not statistically significant, Hispanic students (7%) were more than twice as likely as White students (3%) to have had sex for the first time before age 13.

Source: Idaho Department of Education, 2013 Youth Risk Behavior Survey

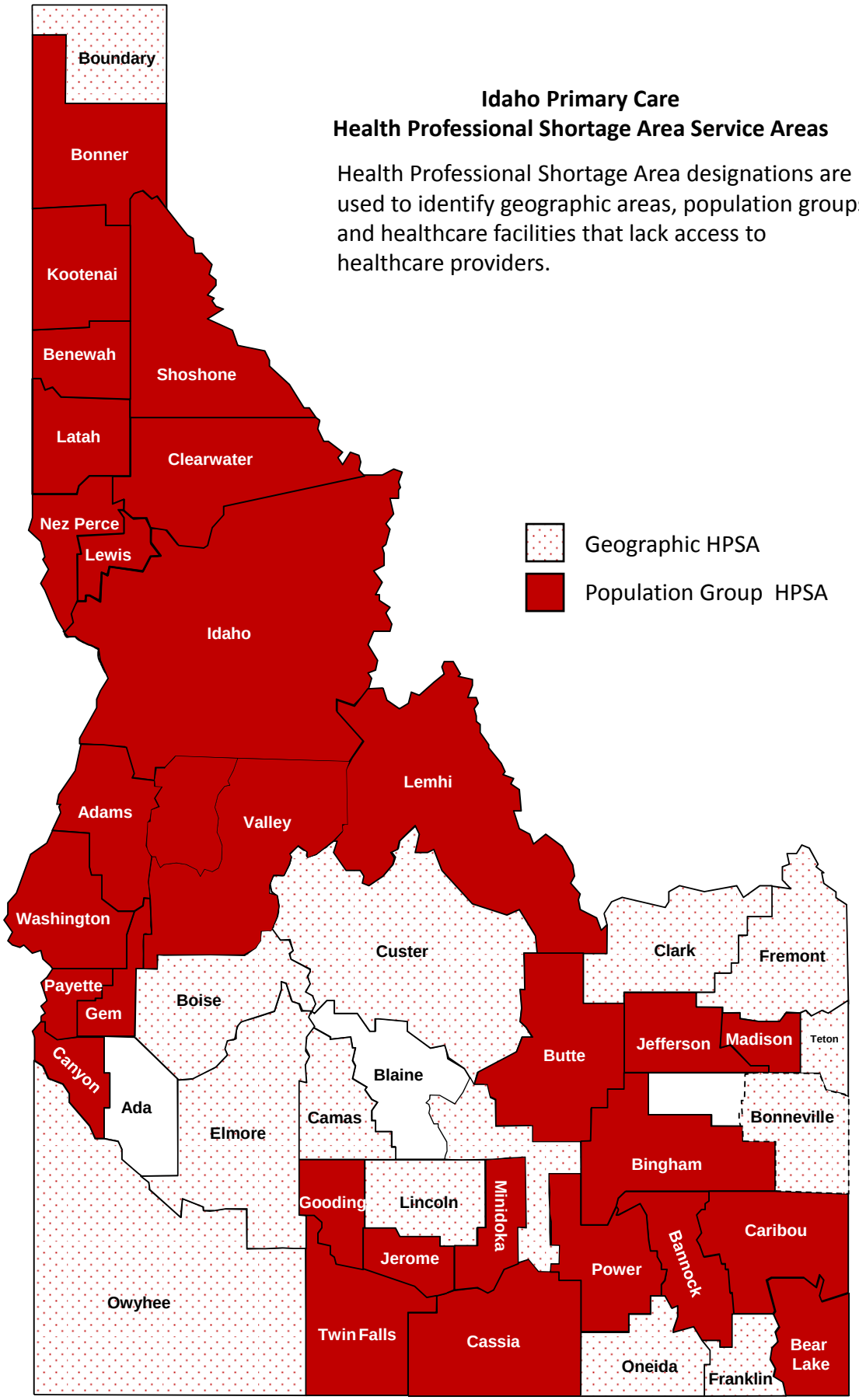


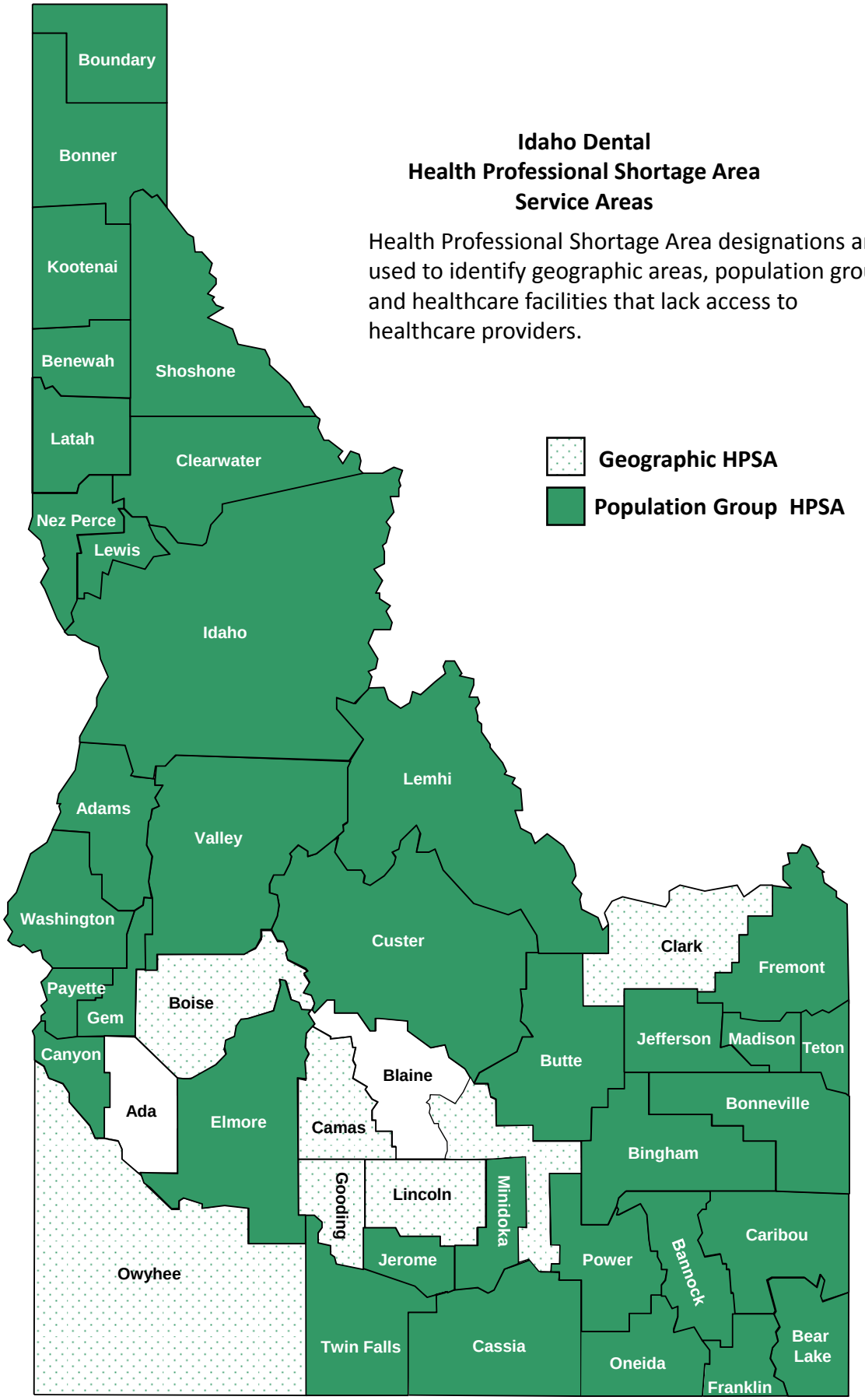
Idaho Professional Shortage Area Maps

Get Healthy Idaho: Measuring and Improving Population Health

Idaho Primary Care
Health Professional Shortage Area Service Areas

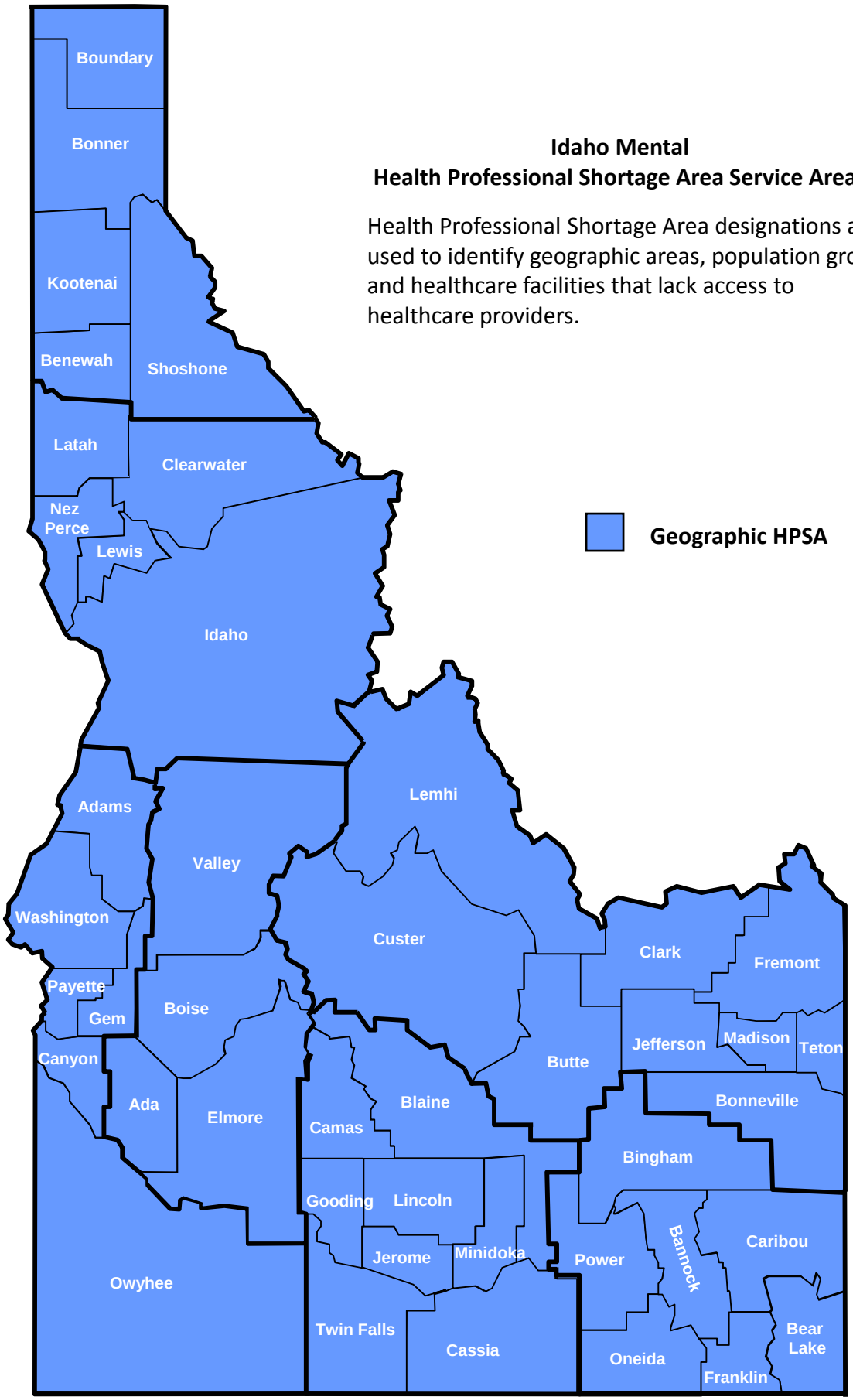
Health Professional Shortage Area designations are used to identify geographic areas, population groups, and healthcare facilities that lack access to healthcare providers.

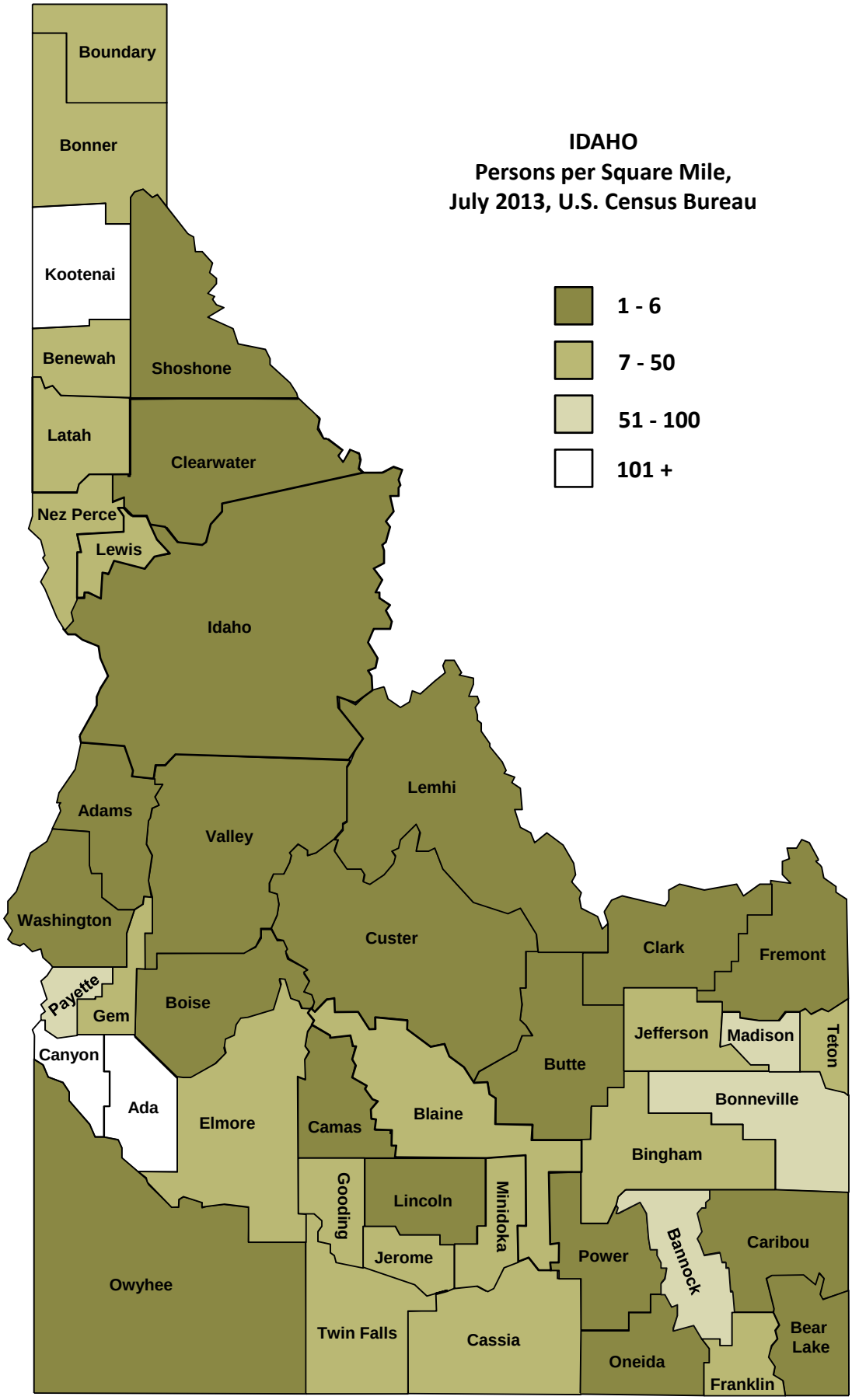



Boundary
Bonner
Kootenai
Benewah
Shoshone
Latah
Clearwater
Nez Perce
Lewis
Idaho
Lemhi
Adams
Valley
Washington
Custer
Clark
Fremont
Payette
Gem
Boise
Canyon
Ada
Elmore
Camas
Blaine
Butte
Jefferson
Madison
Teton
Bonneville
Bingham
Gooding
Lincoln
Minidoka
Caribou
Power
Bannock
Jerome
Owyhee
Twin Falls
Cassia
Oneida
Franklin
Bear Lake
Idaho Dental
Health Professional Shortage Area
Service Areas
Health Professional Shortage Area designations are used to identify geographic areas, population groups, and healthcare facilities that lack access to healthcare providers.
Geographic HPSA
Population Group HPSA

Idaho Mental
Health Professional Shortage Area Service Areas

Health Professional Shortage Area designations are used to identify geographic areas, population groups, and healthcare facilities that lack access to healthcare providers.




IDAHO
Persons per Square Mile,
July 2013, U.S. Census Bureau
1 - 6
7 - 50
51 - 100
101 +
Boundary
Bonner
Kootenai
Benewah
Shoshone
Latah
Clearwater
Nez Perce
Lewis
Idaho
Lemhi
Adams
Valley
Washington
Custer
Clark
Fremont
Payette
Gem
Boise
Jefferson
Madison
Teton
Canyon
Butte
Ada
Elmore
Camas
Blaine
Bonneville
Bingham
Gooding
Lincoln
Minidoka
Caribou
Jerome
Power
Bannock
Owyhee
Twin Falls
Cassia
Oneida
Bear Lake
Franklin

Community Health Assessment Summaries

Get Healthy Idaho: Measuring and Improving Population Health

Region: Panhandle

COMMUNITY HEALTH ASSESSMENT REVIEW	
Population/ Community Served	These results are a summation of community health assessments completed in the Panhandle Public Health region.
Priority health issues identified in assessments	Substance abuse, illicit drug use, diabetes, mental health, tobacco use, obesity, suicide, physical inactivity, teen pregnancy and teen birth rate, cancer related mortality, child neglect and abuse.
Positive population measures. What's working?	Low crime, good jobs and healthy economy, access to health care.
Populations, sub groups or geographic areas prioritized.	Adults who are obese and/or have diabetes, pregnant teens.
Factors identified that contribute to higher health risks and poorer health outcomes	Long distances for health services, rural areas lack sidewalks, fitness centers/recreational areas.
Gaps in services, community resources, funding etc.	Physician and dental shortage areas, decreased funding in teen pregnancy prevention.
Assets and resources identified to address health issues	Many resources are listed for each county which include hospital/clinic locations, 'things to do and see', but they are not tied to health issues.
Data used in the assessment	County Health Rankings; National Vital StatisticsSystem-Mortality (NVSS-M); www.census.gov; Advisory group from Public Health District 1 and 2.

COMMUNITY HEALTH ASSESSMENT REVIEW	
Population/ Community Served	These results are a summation of community health assessments completed in the North Central Public health district.
Priority health issues identified in assessments	Mental health, suicide, alcohol abuse, drug abuse, affordability of healthcare, access to healthcare, physician shortage, lack of dentists, obesity, overweight, lack of child health and prevention resources, physical activity, nutrition, tobacco use and primary prevention/cessation, teen pregnancy, cancer, diabetes, diabetes care and management, smoking, heart disease and stroke.
Positive population measures. What's working?	Low cancer mortality, heart disease mortality, diabetes mortality, flu/pneumonia mortality, moderately good environmental quality driven by low air pollution; low crime; good jobs and healthy economy, access to health care.
Populations, sub groups or geographic areas prioritized.	Adult persons who are obese and/or have diabetes; pregnant teens.
Factors identified that contribute to higher health risks and poorer health outcomes	Heavy alcohol consumption and high access to liquer stores, above average population living in poverty, lower life expectancy, high tobacco use, low cancer screenings, low socioeconomic status, poor nutrition and lack of physical activity, low quality of clinical care, high preventable hospital stay rates, long distances to health services, rural areas lack sidewalks, fitness centers/recreational areas.
Gaps in services, community resources, funding etc.	No palliative care, physician and dental shortage areas, decreased funding in teen pregnancy prevention.
Assets and resources identified to address health issues	24 pages of local resources provided to address each prioritized issue; the majority are hospital/clinic facilities and local community-based organizations. 15 page resource compendium provided in appendix was created as resource to address identified health priorities. Many resources are listed for each county which include hospital/clinic locations, 'things to do and see', but not explicitly tied to health issues. Each county page has extensive list of some hospital/clinic resources along with list of 'things to do and places to see', but not explicitly tied to health issues. Additional resources noted include: Public Health Department, Federally Qualified Health Centers (FQHC), Community Clinics, Veterans Administration (VA), HIS.
Data used in the assessment	County Health Rankings; communityhealth.hhs.gov; Truven Market Planner; getpalliativecare.org; caringinfo.org; healthmetricsandevaluation.org; UWPHI County Health Rankings; Behavioral Risk Factor Surveillance System (BRFSS); National Vital Statistics System-Mortality (NVSS-M); www.census.gov; community health needs survey; focus groups

COMMUNITY HEALTH ASSESSMENT REVIEW	
Population/ Community Served	These results are a summation of community health assessments completed in the Southwest Public Health district.
Priority health issues identified in assessments	Obesity, high cholesterol, diabetes, poor nutrition habits, asthma, tobacco use, Sexually Transmitted Infections (STI's), adult physical inactivity, teen births, high blood pressure, binge drinking, tobacco use, alcohol use, unsafe sex, mental illness, chronic disease, cancer, lung cancer, female breast cancer, prostate cancer, colon cancer, motor vehicle crashes, higher cost of healthy food options, fruit and vegetable consumption, physical inactivity, prenatal care, lack of health insurance coverage, lack of medical home, high cost of oral health, hypertension, cholesterol, mental health, suicide.
Positive population measures. What's working?	Years of Potential Life Lost (YPLL) is significantly lower than the national average, Low Birth Weight is below the national average, Supplamental Nutrition Assistance Program (SNAP), cash public assistance, active health resource guide, Preschool through college (P-16) coalition, suicide prevention efforts, Treasure Valley Education Partnership (TVEP), Bank On Treasure Valley, 2-1-1 Idaho Careline.
Populations, sub groups or geographic areas prioritized	Overweight/obese adults, those who have not graduated high school, unemployed, earn a low income, males 18-34, do not engage in regular physical activity, use tobacco.
Factors identified that contribute to higher health risks and poorer health outcomes	Low rates of cervical and colorectal cancer screenings, mammography screenings, college graduation, access to primary care adn oral health care. High rates of unemployment, poverty/children living in poverty, percentage of single parent households, uninsured, aging population, unbanked and under banked families, hypertension, high cholesterol, Prenatal care, access to health care services, mental health services, health insurance coverage, medical home, physical activity, preventative medical and dental services, public transportation, access to healthy food options, poor nutritional habits, inadequate social support, high cost of dental health, a decrease in median household income.
Gaps in services, community resources, funding etc.	Lack of the following: weight management programs, nutrition education, substance abuse services and programs, sex education, wellness prevention programs, education and access to preventive services, affordable health insurance, chronic disease management programs, mental health services, prenatal care, post-secondary education, community hubs, in-home service, Central One-Stop Shop, communication of community resources, lack of public transportation, and basic lack of knowledge of available resources, education levels.

Assets and resources identified to address health issues	Abuse/violence advocacy & services, after school programs / youth mentoring, at-risk youth services, behavioral health and substance abuse services, childcare, chiropractic services, dental services, disability services, educational services, government contacts, homeless services, housing services, hospice services, hospitals, legal services, low income medical resources, nursing homes, public health resources and referral and miscellaneous, services, refugee services, senior services, veteran services,Gem County Health Connection, Gem Economic Development Assoc., 1, 3, and 5 year action plan of activities and a sustainability plan through IPAN, utilize the Change Tool to support and implement programs and policies, full time advanced EMS, No Sun For Baby class, Look Good Feel Better, Smart 911 education, tobacco cessation, community sharps collection, car seat distribution, CPR class, mammogram promotions, prescription medication drop-off, School Improvement Management Systems training, colon cancer awareness, prenatal classes, Walter Knox Memorial Hospital Health and Safety In The Sun.
Data used in the assessment	Behavioral Risk Factor Surveillance System (BRFSS); Department of Health and Welfare (DHW) Vital statistics; Community Health Needs Rankings; Key informant interviews with local organizations and leaders; University of Wisconsin Population Health Institute; www.census.gov; County Health Rankings; Outdoor activities; colleges/universities: Northwest Nazarene University, College of Western Idaho, Boise State University Hispanic Cultural Center; United Way; University of Wisconsin Population Health Institute; Robert Wood Johnson Foundation, • Boise Independent School District #1 • Meridian Joint School District #2 • Kuna Joint School District #3 • Independent LEA #454 – Rolling Hills Public Charter School (K-8) • Independent LEA #455 – Compass Public Charter School • Independent LEA #456 – Falcon Ridge Public Charter School (K-8) • Independent LEA #459 – DaVinci Charter School • Independent LEA #475 – Sage International School of Boise Nampa School District#131 • Caldwell School District#132 • Wilder School District#133 • Middleton School District#134l • Notus School District#135 • Melba Joint School District#136 • Parma School District#137 • Vallivue School District#139 • Independent LEA #451 – Victory Charter School • Independent LEA #458 – Liberty Charter School • Independent LEA #463 – Vision Charter School • Independent LEA #478 – Legacy Charter School • Independent LEA #481 – Heritage Community Charter School

COMMUNITY HEALTH ASSESSMENT REVIEW	
Population/ Community Served	These results are a summation of community health assessments completed in the Central District Public Health region.
Priority health issues identified in assessments	Alcohol use and abuse, binge drinking, substance abuse, illicit drug use, vehicle crashes, accidents, diabetes, mental health, safe-sex education, tobacco use, tobacco prevention, weight management, obesity, wellness /prevention, high cholesterol, skin cancer, suicide, physical inactivity, hypertension, nutrition, low fruit and veg consumption, asthma, skin cancer, high teen birth rate, sexaully transimitted infections, senior services, high percent of the population reporting fair or poor general health, health care access including mental health, lack of health insurance coverage, lack of medical home, , lack of healthy safe and nurturing relationships, high cost of oral health, lack of access to health food, lack of prenatal care.
Positive population measures. What's working?	Availability of outdoor recreation, access to healthy foods, good air quality, low levels of violence and abuse, veterans services, prenatal care programs, community exercise programs, Years of Potential Life Lost lower than national average, low level of low birth weight, SNAP, CASH public assistance, P-16 Project, suicide prevention efforts, Treasure Valley Education Partnership, Bank On Treasure Valley, 211, emergency food assistance, clinics with sliding fee scales, emergency shelter, legal assistance, transportation assistance, crisis child care, elder care assistance, long term comprehensive care for people with disabilities.
Populations, sub groups or geographic areas prioritized	Young children, ages 18-64, income < $35,000, no high school diploma, adults, low income, individuals without a high school diploma, children in poverty.
Factors identified that contribute to higher health risks and poorer health outcomes	**Lack of:** education support, prenatal care, physical activity, public transportation, providers accepting public insurance, screening programs, social support. **High percentage/rate of:** hypertension, high cholesterol, suicide, children in poverty, preventable hospital stays,uninsured adults, poor mental health days, people living in poverty, unbanked and under banked families,mammography screening, high level of access to fast food. Decrease in median household income (with inflation adjustment lower than it was in 1980).
Gaps in services, community resources, funding etc.	**Lack of access to:** Mental health providers, affordable health insurance, job training services, nutrition education, affordable healthcare, behavioral health services, primary care provider, children and family services, healthy foods, health care services, mental health, health insurance coverage, affordable dental services, medical home, transportation to and from appointments, chronic disease management, Medicaid dentists, immunization education and low cost options, funding for transportation to Boise for specialty services, prenatal care 1st trimester, wellness and prevention programs, mammography screening. **Lack of:** job training services, safe sex programs, Community hubs, In-Home Service, Central One- Stop Shop, recreational facilities, ability to advertise and increase community participation in education and physical activity programs, communication of community resources, public transportation, basic knowledge (i.e. available resources, education levels), nutrition education, substance abuse services and programs, tobacco prevention programs, publicizing current opportunities, creative wellness programs for young ages, consulting access for safety-net providers.

Assets and resources identified to address health issues	Adequate senior services, high level of flu and pneumonia immunizations, Boise State University, branch location for other universities, outdoor activities, colleges Northwest Nazarene University, College of Western Idaho, Hispanic Cultural Center, education and exercise opportunities but people are not aware. YMCA, Boise VA Medical Center, safety-net clinics, sliding fee scale providers.
Data used in the assessment	County Health Rankings, United Way, Saint Al's, expert interviews, University of Wisconsin Population Health Institute, Youth Risk Behavior Surveillance, affected population surveys, Idaho Economics, the Robert Wood Johnson Foundation, Boise Independent School District #1 Meridian Joint School District #2 Kuna Joint School District #3 Independent LEA #454 – Rolling Hills Public Charter School (K-8) Independent LEA #455 – Compass Public Charter School Independent LEA #456 – Falcon Ridge Public Charter School (K-8) Independent LEA #459 – DaVinci Charter School Independent LEA #475 – Sage International School of Boise Nampa School District#131 Caldwell School District#132 Wilder School District#133 Middleton School District#134 Notus School District#135 Melba Joint School District#136 Parma School District#137 Vallivue School District#139 Independent LEA #451 – Victory Charter School Independent LEA #458 – Liberty Charter School Independent LEA #463 – Vision Charter School Independent LEA #478 – Legacy Charter School Independent LEA #481 – Heritage Community Charter School, County Health Rankings United Way, Saint Al's, expert interviews, University of Wisconsin Population Health Institute, Youth Risk Behavior Surveillance, Affected population surveys, Idaho Economics, exercise facilities

COMMUNITY HEALTH ASSESSMENT REVIEW	
Population/ Community Served	These results are a summation of community health assessments completed in the South Central Public Health district.
Priority health issues identified in the assessment	**High Priority Clinical Care Needs**: Affordable care; affordable health insurance; availability of behavioral health services, more providers accepting public health insurance; screening programs; chronic disease management (diabetes); screening programs (mammography), chronic disease, access to healthcare for low income populations, access to behavioral health services for low income populations, shortage of specialists, primary care providers, **Social and Economic Needs**: Children and family services, education support and assistance programs; homeless services, teen pregnancy/children in poverty. **High Priority Community Identified Needs**: Substance abuse services and programs; weight management; wellness/prevention; exercise programs/education; safe-sex education programs; tobacco cessation programs,access to public transportation, physical inactivity, services for aging population, ambulance response time; weekend pharmacy/lack of pharmacy; dental care.. **High Priority Health Behavior Needs:** Exercise programs/education (adult physical activity); nutrition education (teen nutrition); safe-sex education programs (sexually transmitted infections, teen birth rate); substance abuse services and programs; wellness and prevention (breast cancer, high cholesterol, lung cancer, respiratory disease, suicide).
Positive population measures. What's working?	In Gooding county: Low birthweight percentages are lower low smoking rates; low rates of excessive drinking; low percentage of low birth-weight babies; low breast cancer death rates; low melanoma death rates; low rates of poor physical and mental health days experienced; low asthma rates; low diabetes rates; low cancer death rates; low skin cancer death rates; low heart disease death rates; low respiratory disease death rates; low Alzhiemer's death rates; low diabetes death rates; low rates of obesity; low rates of Sexually Transmitted Infections; low overweight/obesity rates; high rates of mammography screening; low rate of children living in poverty; high rate of access to recreational facilities. Other counties in the region experience: slightly higher rate of cancer deaths; high rate of lung cancer deaths; high rate of breast cancer deaths; high rate of prostate cancer deaths; high rate of respiratory disease rates; high rate of accident deaths; high rate of cerebrovascular deaths; high rate of Alzheimer's deaths; high rate of diabetes deaths; high suicide death rates; high rates of physical inactivty; high vehicle crash death rates; high teen birth rate; high rates of preventable hospital stays; low cancer screening rates.
Populations, sub groups or geographic areas prioritized	Uninsured People with income level less than $15,000; Hispanics; Gooding County. People with income level less than $35,000; Those with lower educational attainment (especially no high school diploma); Males 18-34

Factors identified that contribute to higher health risks and poorer health outcomes	Health indicators: Overweight/Obesity; high blood cholesterol; diabetes; fruit and vegetable consumption low; low engagement in physical activity in both adults and teens; low colon cancer screening; high teen birth rates; high percentage of children living in poverty; high rates uninsured; high obesity rates; high rate of poor mental health days; high rates of preventable hospital stays; low access to primary care physicians, alcohol use; smoking. Clinical Care: availability of primary care providers; chronic disease management; immunization programs; improved health care quality; integrated coordinated care; prenatal care programs; screening programs Social and Economic Needs: children and family services; disabled services; homeless services; job training services; senior services; veteran's services; violence and abuse services,Low health literacy. Physical Environment: availability of recreation and exercise facilities; healthier air quality, water quality, etc. High alcohol and illicit drug use; high vehicle crash death rates; higher rates of overweight (but not obesity); mental illness; teen exercise; sexually transmitted infections; teen birth rate; smoking; accidents; breast cancer; cerebrovascular diseases; suicide. High alcohol and illicit drug use; high vehicle crash death rates; higher rates of overweight (but not obesity); mental illness; teen exercise; sexually transmitted infections; teen birth rate.
Gaps in services, community resources, funding etc.	Lack of funding for proper worksite wellness programs; there aren't enough providers in the community; no suicide hotline and staff aren't trained to address mental health problems; funding for a program that seemed to successfully help people stay on medications was dropped due to cuts in funding. No public transportation.
Assets and resources identified to address health issues	Implement Intermountain's diabetes education/lifestyle coaching program to help improve the health of people identified as at-risk for diabetes referred by Family Health Services Clinic; provide additional community education and diabetes education events to help promote awareness of diabetes in the Cassia community. There is a large list of resources available in the North Canyon CHA … too many to list here and it is not abvious to me, which should be included here and which should be left out. See North Canyon CHA for the list if needed. • Intermountain provided $7.6 million in charity care for low-income mental health patients (defined as Medicaid/uninsured with mental disorders and / or substance abuse issues) in more than 2,700 cases in 2012; • Collaborative partnerships exist in all urban communities to link uninsured people with community-based behavioral health providers; • Intermountain provides grants to Community Health Centers and safety net clinics of $2.3 million annually for comprehensive health services inclusive of mental health. A list of resources is identified beginning on page 135 of the community health needs assessment. A list of resources is identified beginning on page 133 of the community health needs assessment.
Data used in the assessment	BRFSS (Idaho and Utah); Focus group data (primary data) US Census Data (ESRI, 2012 source) County Health Rankings Idaho Vital Statistics Affected population surveys and focus groups In-depth interviews with community leaders

COMMUNITY HEALTH ASSESSMENT REVIEW	
Population/ Community Served	These results are a summation of community health assessments completed in the Southeast Public Health district.
Priority health issues identified in the assessment	The following were the "Key Outcomes" identified in the CHA: low-cost services; outreach for patients who do not access preventative care; communication with the community to address negative perceptions; a continued emphasis on patient satisfaction; follow-up with patients who have been referred to other providers for care; and, the development of a resource guide for both hospital and community services. accident prevention, suicide prevention, increase physical activity levels, increase prenatal care access and education, increase availability of health resources in spanish, increase preventative screening rates, increase public awareness of existing resources
Positive population measures. What's working?	Slightly lower rates of asthma; lower binge drinking rates; slightly lower illicit drug use rates; higher rates of prostate screening; slightly lower rate of no dental visits. low rates of binge drinking
Populations, sub groups or geographic areas prioritized	None were identified.
Factors identified that contribute to higher health risks and poorer health outcomes	Lack of preventative care; limited financial resources within the community; delaying treatment until a problem has become severe; alcohol, drug, and tobacco use. lowest life expectancy in state, high unemployment rate, physician shortage, low vegetable consumption, high levels of inactivity
Gaps in services, community resources, funding etc.	Mental health resources; resources for low-income families; affordable medications; home health care; psychiatric care across the lifespan.
Assets and resources identified to address health issues	Very few specific resources were identified except Bingham Memorial Hospital; chiropractors, naturopaths, nursing homes, free clinic, and speciallists such as ENTs and orthopedics.
Data used in the assessment	Idaho BRFSS Idaho Vital Records One-on-one interviews and focus groups with healthcare providers and administrators Interviews and focus groups with community stakeholders Census Vital Statistics Bureau, DHW Network of Care County Health Ranking

COMMUNITY HEALTH ASSESSMENT REVIEW	
Population/ Community Served	These results are a summation of community health assessments completed in the District 7 Public Health District. The only CHA reviewed was Teton Vally Health Care, Inc.
Priority health issues identified in the assessment	Affordability of health services; mental health/suicide; alcohol abuse/substance abuse; palliative care and hospice; accidents; prevention/wellness; compliance behavior; Alzheimer's; cancer; stroke. Public Input included lack of availability/access to mental health services; affordability of health care services; obesity and the need for a prevention/wellness resource center. Among the priority population, the following were identified as priority issues: addiction (alcohol and substance abuse); severe and persistent mentally ill conditions; lack of insurance; sexual assault; cancer services.
Positive population measures. What's working?	In general, residents of Teton County are healthier than most of Idaho. Premature death rates are lower; obesity rates are lower; teen birth rates are lower; smoking, physical inactivity, and Sexually Transmitted Infection values are lower; education metrics better than average in Idaho; mammography screening.
Populations, sub groups or geographic areas prioritized	Uninsured persons; low-income persons, and minority groups. Other 'vulnerable' populations included people who have no high school diploma; are unemployed; are severely work disabled; have major depression; or are recent drug users.
Factors identified that contribute to higher health risks and poorer health outcomes	Conclusions based on observations from Teton County compared to all other Idaho counties, in terms of health needs: low birth-weight births; excessive drinking; motor vehicle crash death rates; percentage of uninsured is very high; infant mortality; suicide; coronary heart disease rates, stroke rates.
Gaps in services, community resources, funding etc.	The Teton Valley Health Care CHA provided. Access full assessment here: http://issuu.com/tvhealthcare/docs/tvhc_chna_complete
Assets and resources identified to address health issues	There were many resources listed beginning on page 29 of the CHA. Access full assessemnt here: http://issuu.com/tvhealthcare/docs/tvhc_chna_complete

Data used in the assessment	County Health Rankings; www.communityhealth.hhs.gov; Truven Market Planner; www.capc.org www.getpalliativecare.org; www.caringinfo.org iweb.nhpco.org; www.healthmetricsandevaluation.org; www.dataplace.org; www.cdc.gov; www.CHNA.org; www.datawarehouse.hrsa.gov; www.worldlifeexpectancy.com/usa-health-rankings; community and health care surveys;

Statewide Partner Meeting Information

Get Healthy Idaho: Measuring and Improving Population Health

Statewide Partner Meeting Information

HEALTH PRIORITY	CONTRIBUTING FACTORS	HIGH RISK POPULATIONS	RESOURCES/ASSETS
HEALTHCARE ACCESS	Funding Provider to population ratio Insurance status Lack of Medicaid expansion Geographic location Cost of healthcare Unemployment Lack of value on preventative care Transportation Cultural barrier Medicare / Medicaid acceptance	Uninsured Low Socioeconomic Statue (SES) People with disabilities People with behavioral health issues Lesbian, gay, bisexual, transgender (LGBT) Rural Working poor Refugees Adolescents Hispanic Elderly Homeless Tribal Transitions from pediatric to adult care Undocumented workers Non-English speakers	Community Health Centers Churches Rural Health Clinics Family Residency Programs Telemedicine Indigent Program Idaho Health Insurance Exchange (Your Health Idaho) Nurse Practitioners Physician Assistants Federally Qualified Health Centers (FQHC) Patient Centered Medical Homes (PCMH) Internet resources Community Para-medicine Transportation authority Community outreach Refugee agencies Non-profit health systems Local Public Health Districts (PHDs) Community health workers / promotoras Indian Health Services Veteran Affairs Medical Center (VAMC) Patient assistance programs Idaho Health Data Exchange (IHDE) Bureau of Rural Health and Primary Care Free clinics

Statewide Partner Meeting Information

HEALTH PRIORITY	CONTRIBUTING FACTORS	HIGH RISK POPULATIONS	RESOURCES/ASSETS
OBESITY	Lack of fruits and veggies Income Lack of exercise Food deserts Education Built environment / walkability Depression Culture Chronic conditions Fast food Genetics Cost of healthy food School lunch programs Media's role in promoting unhealthy food Food insecurity Nutrient density Increased screen time Lack of active transportation options Fear of an unsafe environment (parents) Lack of skills - shopping, cooking, gardening Reduced recess/PE Encourage healthy options, including at school Affluence Technology taking away the need to go outside	Everyone Poor Uneducated < a college education Morbidly obese Native Americans & Hispanics Rural Children Diabetics Physical disability Chronic disease Depression Those with multiple jobs	WIC HEAL (Healthy Eating, Active Living) Idaho Local farmer's markets Bike paths Good urban planning promoting friendly built environment Let's Move Campaign Play 60 Campaign Community Gardens YMCA Go Noodle Boys & Girls Clubs Cooking Matters classes Bariatric Centers of Excellence School PE SNAP Ed Nutrition works Food Banks School lunch programs Senior meal programs Transportation authority Insurance incentives Worksite wellness programs Community Ed Weight Watchers Registered Dieticians Extramural sports programs Parks and Recreation Department

Statewide Partner Meeting Information

HEALTH PRIORITY	CONTRIBUTING FACTORS	HIGH RISK POPULATIONS	RESOURCES/ASSETS
HEART DISEASE & STROKE	Tobacco Family history Lack of exercise Hypertension High cholesterol Lack of fruits and veggies Stress Age and gender Diabetes Education on risk factors Access to health care Lack of access to preventative care Basic medication management Income Built environment / walkability Depression Culture Chronic conditions Fast food Genetics Cost of healthy food Media's role in promoting unhealthy food Increased screen time Lack of active transportation options Affluence Technology taking away the need to go outside	Geriatric Metabolic syndrome Post-menopausal women Children - diabetes, hypertension, obesity African Americans Hispanic Males Smokers Anyone with unmanaged risk factors Poly-pharmacy	American Heart Assoc. Tobacco cessation - Quitline / Quitnet Healthcare providers Community education Screening programs Automated External Defibrillators (AED) Time Sensitive Emergencies (TSE) Posting of calories/apps/ technology

Statewide Partner Meeting Information

HEALTH PRIORITY	CONTRIBUTING FACTORS	HIGH RISK POPULATIONS	RESOURCES/ASSETS
VACCINE PREVENTABLE DISEASES	Cost Misinformation Fear Access to care Medicare reimbursement issues for adults Legal framework around exemptions Lack of awareness of need, (i.e. no longer see the diseases) Comfort with risk - influenza kills thousands every year but people still don't get flu shots Record keeping Provider education Culture	Adults - especially older Kids Poor Wealthy Well educated North Idaho Rural communities Immuno-compromised College kids Migrant workers	VFC (Vaccines For Children) provider status Local PHDs Local medication assistant programs Pharmacists School nurses Employee wellness program Vaccine Assessment Fund Immunization Registry Community Para-medicine Idaho Immunization Program Idaho Immunization Coalition Idaho Immunization Policy Commission Media Employee mandates
HEALTH PRIORITY	**CONTRIBUTING FACTORS**	**HIGH RISK POPULATIONS**	**RESOURCES/ASSETS**
EXERCISE	Chronic disease Physical limitations Built environment Lack of understanding what exercise can be Lack of social support Time - multiple jobs, economic constraints Lack of worksite policies in support Reduced/eliminated PE classes Intimidation (if you are not fit) Parental fear, lack of safe environment Age Community culture Poverty	Older adults Children Disabilities Overweight /obese Latch-key kids Everyone Poor Uneducated (less than a college education) Morbidly obese Native Americans & Hispanics Rural Children Physical disability Chronic disease Depression Those with multiple jobs	Insurance incentives Worksite wellness programs Community education Extramural sports programs Parks and Recreation HEAL Idaho Bike paths Good urban planning promoting friendly built environment Let's Move Campaign Play 60 Campaign YMCA Go Noodle Boys & Girls Clubs School PE Apps Fit & Fall Proof Program Shared use spaces Boise Bicycle Project (also in other towns)

Statewide Partner Meeting Information

HEALTH PRIORITY	CONTRIBUTING FACTORS	HIGH RISK POPULATIONS	RESOURCES/ASSETS
SUICIDE	Depression Domestic abuse Isolation Stigma Bullying Access to unsecured firearms Lack of access to mental health care Family history Trauma Substance abuse Chronic disease Pain Perceived lack of belonging Age Hopelessness Sexual orientation Male Medication side effects Lack of coordinated / integrated care Sexual abuse Provider education for primary care folks to screen Post-Traumatic Stress Disorder (PTSD) Lack of mobile crisis units	Adolescents Geriatrics Middle aged men Lesbian, gay, bisexual, transgender (LGBT) Mental health disorders Veterans Poor management of psychotropic meds Substance abuse Low income/poverty Incarcerated People with previous suicide attempt Native Americans	Suicide Prevention Action Network – SPAN Idaho Question Persuade Refer (QPR) Training Idaho Lives Project / Sources of Strength Sheriff /police distribute gunlocks Clergy Patient Centered Medical Homes (PCMH) Veterans Affairs Program Hotline Mobile Crisis Teams Suicide Prevention Roundtable Teachers / school counselors Primary care providers Speedy Foundation Live Wilder Achieving Zero Suicide in the Inland Northwest (WA state) Inpatient psych programs Outpatient Emergency Departments

Acronym Dictionary

1305 – Shorthand for the federal grant titled "State and Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health". 1305 is the federal grant number.

ADA / AADE – American Diabetes Association / American Association of Diabetic Educators

BRH-PC – Bureau of Rural Health and Primary Care.

CDC – Centers for Disease Control and Prevention

CHEMS – Community Health Emergency Medical Services

CoIIN – Collaborative Improvement and Innovation Network to Reduce Infant Mortality

CY – Calendar Year, January 1 through December 31

DPP – Diabetes Prevention Programs

DSME – Diabetes Self-Management Education

DPRP – Diabetes Prevention Recognition Program

EMS – Emergency Medical Services

HC –Health Collaborative

IAEYC – Idaho Association for the Education of Young Children

IDHW – Idaho Department of Health and Welfare

IHC – Idaho Healthcare Coalition

ISU – Idaho State University

NRT – Nicotine Replacement Therapy

PCMH – Patient Centered Medical Home

PHD – Public Health District

QL / QN – QuitLine / QuitNet

SHIP – State Healthcare Innovation plan

SFY – State Fiscal Year, July 1 through June 30

WHCRT – Women's Health Check Real Time database

WIC -- Special Supplemental Nutrition Program for Women, Infants and Children

WISPr – WIC Information System Program