Executive Report

2015 Community Health Needs Assessment

Mercy Iowa City Service Area

(Cedar, Iowa, Johnson, Muscatine, and Washington Counties, Iowa)

Prepared for:

Mercy Iowa City

By:

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Professional Research Consultants, Inc.

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Introduction

Professional Research Consultants, Inc.

Project Overview

Project Goals

This Community Health Needs Assessment is an indicator-based assessment which will serve to help determine the health status, behaviors and needs of residents in the service area of Mercy Iowa City. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This assessment was conducted on behalf of Mercy Iowa City by Professional Research Consultants, Inc. (PRC). PRC is a nationally recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes secondary research (mining existing health-related data); qualitative data input includes primary research gathered through two Key Informant Focus Groups.

Secondary Data Indicators

This assessment incorporates secondary data posted for the targeted counties as part of the *Community Health Status Indicators (CHSI): Information for Improving Community Health* web portal project supported through the US Department of Health and Human Services, Centers for Disease Control and Prevention and available at http://wwwn.cdc.gov/communityhealth:

> *CHSI 2015 is an interactive web application that produces health profiles for all 3,143 counties in the United States. Each profile includes key indicators of health outcomes, which describe the population health status of a county and factors that have the potential to influence health outcomes, such as healthcare access and quality, health behaviors, social factors and the physical environment.*
>
> *The social factors and the physical environment are especially important because they represent the conditions in which people are born, work, and play. Neighborhoods with affordable healthy food, safe and accessible housing, and quality employment opportunities can positively influence behaviors and help to create healthy lifestyles. The World Health Organization and others call the living conditions that can affect health and quality of life the "social determinants of health".*
>
> *Healthy People (HP) 2020 highlights the importance of addressing the social determinants of health by including as one of its four overarching goals, "Create social and physical environments that promote good health for all." CHSI 2015 supports this goal by including a broad range of indicators, including multiple indicators related to the social and physical environment. CHSI 2015 includes many of the 42 most recommended health metrics for community health assessment.*

Key Informant Focus Groups

As part of this Community Health Needs Assessment, 2 focus groups were held with 17 local key informants on November 5, 2015. The focus group participants included physicians, a public health representative, other health professionals, a social service provider, business leaders and other community leaders.

Key Informant Type	Number Invited	Number Participating
Physicians	7	3
Public Health Representatives	5	1
Other Health Providers	7	2
Social Services Representatives	7	1
Other Community Leaders	32	10

A list of recommended participants for the focus groups was provided by Mercy Iowa City. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall. Focus group candidates were first contacted by letter to request their participation. Follow-up phone calls were then made to ascertain whether or not they would be able to attend. Confirmation calls were placed the day before the groups were scheduled to insure a reasonable turnout.

Final participation included representatives of the organizations outlined below. Through this process, input was gathered from a representative of public health, as well as several individuals whose organizations work with low-income, minority (including African American, Hispanic, and Asian residents), or other medically underserved populations (specifically, the uninsured/underinsured and non-English speakers).

- 4Cs Community Coordinated Child Care
- City of North Liberty
- Community Foundation of Johnson County
- Iowa City Area Chamber of Commerce
- Iowa City Area Development Group
- Iowa City Free Medical Clinic
- Johnson County Ambulance
- Johnson County Public Health Department
- Johnson County Senior Center
- Johnson County Sheriff's Office
- Mercy Clinics
- Mercy Pediatric Clinic
- Mercy Physician Hospital Organization
- Oaknoll Adult Retirement Community

- St. Patrick's Catholic Church
- United Way of Johnson and Washington Counties

Discussions centered around needs for Johnson County, Iowa. Audio from the focus groups sessions was recorded, from which verbatim comments in the addendum of this report are taken. There are no names connected with the comments, as participants were asked to speak candidly and assured of confidentiality.

NOTE: These findings represent qualitative rather than quantitative data. The groups were designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.

Information Gaps

While this assessment includes a great deal of valuable information, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, the data reflected in this report offer very limited, if any, opportunity to segment by smaller geographies or by population characteristics, potentially limiting the ability to identify the primary and chronic disease needs and other health issues of subpopulations, such as uninsured persons, low-income persons, and minority groups. In terms of content, this assessment was designed to provide a broad picture of the health of the overall community; however, there are certainly medical conditions that are not specifically addressed.

Summary of Findings

Significant Health Needs of the Community

The following "areas of opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in Healthy People 2020. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

Areas of Opportunity Identified Through This Assessment	
Access to Healthcare Services	• Primary Care Physician Ratio (Cedar County)
Cancer	• Cancer Deaths (Cedar and Iowa counties)
Environmental Health	• Annual Average PM2.5 Concentration (Iowa County)
General Health	• Overall "Fair/Poor" Health Status (Iowa County)
Heart Disease & Stroke	• Heart Disease Deaths (Washington County) • Stroke Deaths (Cedar and Muscatine counties)
Injury & Violence	• Violent Crime Rate (Muscatine and Washington counties)
Maternal, Infant, & Child Health	• Preterm Births (Cedar and Muscatine counties) • Teen Births (Muscatine County)
Mental Health	• Depression in Older Adults (Cedar and Iowa counties) • Inadequate Social Support (Iowa and Muscatine counties) • *Mental Health ranked as the top concern in the focus group.*
Nutrition, Physical Activity & Weight	• Adult Obesity (Cedar and Muscatine counties) • Limited Food Access (Muscatine County)
Sexually Transmitted Diseases	• Gonorrhea Incidence (Cedar, Muscatine, Washington counties) • Syphilis Incidence (Johnson County)
Social Determinants	• Single-Parent Households (Muscatine County) • High Housing Costs (Washington County) • On-Time High School Graduation (Washington County)
Substance Abuse	• Binge Drinking (Johnson County)

Indicators underlined above are those for which the Service Area Median rate/percent is higher than the US median.

Prioritization of Health Needs

On January 26, 2016, Professional Research Consultants, Inc. (PRC) presented findings from this Community Health Needs Assessment to the hospital Board. This presentation highlighted the significant health issues identified from the research, including the top health concerns among community stakeholders and those data indicators for which service area counties were in the bottom quartile among peer counties (see Areas of Opportunity above).

In consideration of these and other data, as well as of the hospital's ability to have meaningful impact, the following were identified as priorities for action:

1. **Access to Primary Care**
2. **Mental Health**
3. **Cancer**
4. **Obesity**

Mercy Iowa City will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the priority health needs in the community.

Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the Mercy Iowa City service area, including comparisons between each of the 5 service area counties and national benchmarks. These data are grouped to correspond with the Focus Areas presented in Healthy People 2020.

Reading the Summary Tables

In the following charts, Mercy Iowa City Service Area Median results are shown in the larger, blue column.

The green columns [to the left of the Service Area Median column] provide comparisons between the 5 service area counties and US data, identifying differences for each as "better than" (), "worse than" (), or "similar to" () the related national benchmark.

The columns to the right of the Mercy Iowa City Service Area column provide comparisons between Service Area Median data and any available national findings and Healthy People 2020 targets. Again, symbols indicate whether the service area compares favorably (), unfavorably (), or comparably () to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Social Determinants	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Children In Single-Parent Households (Percent)	25.8	19.6	26.2	35.3	21.0	25.8	30.8	
High Housing Costs (Percent)	19.4	23.4	33.5	26.1	25.2	25.2	27.3	
On Time High School Graduation (Percent)	95.0	93.9	88.4	84.2	85.3	88.4	83.8	
Poverty (Percent)	8.5	8.5	16.1	13.8	9.7	9.7	16.3	
Unemployment (Percent)	4.1	4.6	3.3	4.7	3.7	4.1	7.1	
Housing Stress (Percent)	20.5	23.5	34.3	27.0	23.5	23.5	28.1	

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

Indicators bordered in red are those for which the county is in the bottom quartile among peer counties.

better | similar | worse

Overall Health	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Female Life Expectancy (Years)	83.2	82.3	83.5	81.0	81.8	82.3	79.8	
Male Life Expectancy (Years)	77.9	77.6	78.3	76.5	76.7	77.6	75.0	
Adult Overall "Fair/Poor" Health Status (Percent)	5.3	18.4	7.6	11.7	10.4	10.4	16.5	

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

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better | similar | worse

Access to Health Services	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Uninsured (Percent)	8.9	8.3	9.9	11.7	12.1	9.9	17.7	
Cost Barrier To Care (Percent)	9.2		4.7	7.0	12.3	8.1	15.6	9.0
Older Adult Preventable Hospitalizations (Rate Per 1,000 Medicare Enrollees Age 65+)	61.9	56.2	48.5	51.2	48.7	51.2	71.3	
Primary Care Provider Access (Rate Per 100,000 Persons)	16.3	55.1	271.4	51.4	54.9	54.9	48.0	

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

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better | similar | worse

Cancer	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Age-Adjusted Cancer Deaths (Rate Per 100,000 Persons)	159.0	175.9	158.8	182.9	168.3	168.3	185.0	161.4
Cancer (Rate Per 100,000 Persons)	484.1	507.5	473.6	471.0	473.0	473.6	457.6	
Adult Female Routine Pap Tests (Percent)	85.2	79.2	84.3	81.4	73.5	81.4	77.3	93.0

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

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better | similar | worse

Chronic Kidney Disease	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Age-Adjusted Chronic Kidney Disease Deaths (Rate Per 100,000 Persons)			5.1			5.1	17.5	

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

Indicators bordered in red are those for which the county is in the bottom quartile among peer counties.

better | similar | worse

Dementias, Including Alzheimer's Disease	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Age-Adjusted Alzheimer's Disease Deaths (Rate Per 100,000 Persons)	13.1	28.1	22.7	15.0	24.2	22.7	27.3	
Alzheimer's Diseases/Dementia (Percent)	8.9	9.6	9.2	7.8	9.2	9.2	10.3	

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

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better | similar | worse

Diabetes	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Age-Adjusted Diabetes Deaths (Rate Per 100,000 Persons)	12.3	14.9	13.7	21.7	26.8	14.9	24.7	
Adult Diabetes (Percent)	5.9	6.8	5.1	5.6	5.5	5.6	8.1	

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

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better | similar | worse

Environmental Health	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Annual Average PM2.5 Concentration (Micrograms Per Cubic Meter)	12.0	11.0	10.7	12.5	11.4	11.4	10.7	
Living Near Highways (Percent)	1.4	0.8	3.0	2.6	0.5	1.4	1.5	

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

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better | similar | worse

Heart Disease & Stroke	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Age-Adjusted Coronary Heart Disease Deaths (Rate Per 100,000 Persons)	123.3	101.8	101.3	128.6	135.7	123.3	126.7	103.4
Age-Adjusted Stroke Deaths (Rate Per 100,000 Persons)	54.5	32.8	37.2	52.0	35.0	37.2	46.0	34.8

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

Indicators bordered in red are those for which the county is in the bottom quartile among peer counties.

better | similar | worse

HIV	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
HIV (Rate Per 100,000 Persons)		36.9	167.7	35.2	44.3	40.6	105.5	

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

Indicators bordered in red are those for which the county is in the bottom quartile among peer counties.

better | similar | worse

Injury & Violence Prevention	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Age-Adjusted Motor Vehicle Deaths (Rate Per 100,000 Persons)			6.5	12.2	13.0	12.2	19.2	12.4
Age-Adjusted Unintentional Injury Deaths, Including Motor Vehicle (Rate Per 100,000 Persons)	34.7	44.1	26.4	35.6	41.9	35.6	50.8	36.0
Age-Adjusted Unintentional Injury, Excluding Motor Vehicle (Rate Per 100,000 Persons)	20.6	23.8	19.7	22.3	28.9	22.3	31.6	23.6
Violent Crime (Rate Per 100,000 Persons)	81.0	140.3	235.9	430.5	336.1	235.9	199.2	

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

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better | similar | worse

Maternal, Infant & Child Health	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Preterm Births (Percent)	12.0	9.8	10.4	13.0	10.8	10.8	12.1	11.4
Teen Births (Rate Per 1,000 Females Age 15-19 Years)	17.1	19.4	10.9	47.6	27.5	19.4	42.1	36.2

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

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better | similar | worse

Mental Health & Mental Disorders	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Older Adult Depression (Percent)	14.9	14.4	13.8	13.1	13.2	13.8	12.4	
Inadequate Social Support (Percent)	12.3	25.8	13.9	21.3	13.6	13.9	19.6	

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

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better | similar | worse

Nutrition, Physical Activity & Weight	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Adult Obesity (Percent)	37.3	27.6	19.6	33.7	30.1	30.1	30.4	
Adult Physical Inactivity (Percent)	22.1	26.5	14.9	25.5	22.4	22.4	25.9	32.6
Access To Parks (Percent)	32.0	19.0	67.0	44.0	23.0	32.0	14.0	
Recreation Access (Rate Per 1,000 Persons)	0.2	0.1	0.1	0.1	0.1	0.1		
Limited Access To Healthy Foods (Percent)	2.7	2.2	3.7	7.2	2.3	2.7	6.2	

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

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better | similar | worse

Respiratory Diseases	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Age-Adjusted Chronic Lower Respiratory Disease (CLRD) Deaths (Rate Per 100,000 Persons)	36.6	26.8	34.0	45.5	41.7	36.6	49.6	
Older Adult Asthma (Percent)	3.6	3.3	3.1	2.5	2.2	3.1	3.6	

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

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better | similar | worse

Sexually Transmitted Diseases	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Gonorrhea (Rate Per 100,000 Persons)	32.6	6.1	81.9	46.7	50.3	46.7	30.5	
Syphilis (Rate Per 100,000 Persons)			5.3			5.3		

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

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better | similar | worse

Substance Abuse	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Adult Binge Drinking (Percent)	19.8	17.3	20.6	20.1	15.3	19.8	16.3	

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

Indicators bordered in red are those for which the county is in the bottom quartile among peer counties.

better | similar | worse

Tobacco Use	Each County vs. US Median: Cedar County	Iowa County	Johnson County	Muscatine County	Washington County	Service Area Median	Service Area Median vs. Benchmarks: vs. US Median	vs. Healthy People 2020
Adult Smoking (Percent)	18.2	12.2	13.3	21.4	17.5	17.5	21.7	12.0

Note: In the green section, each county is compared against the US median. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator.

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better | similar | worse

Data Indicators

Professional Research Consultants, Inc.

Social Factors

Income & Employment

Income

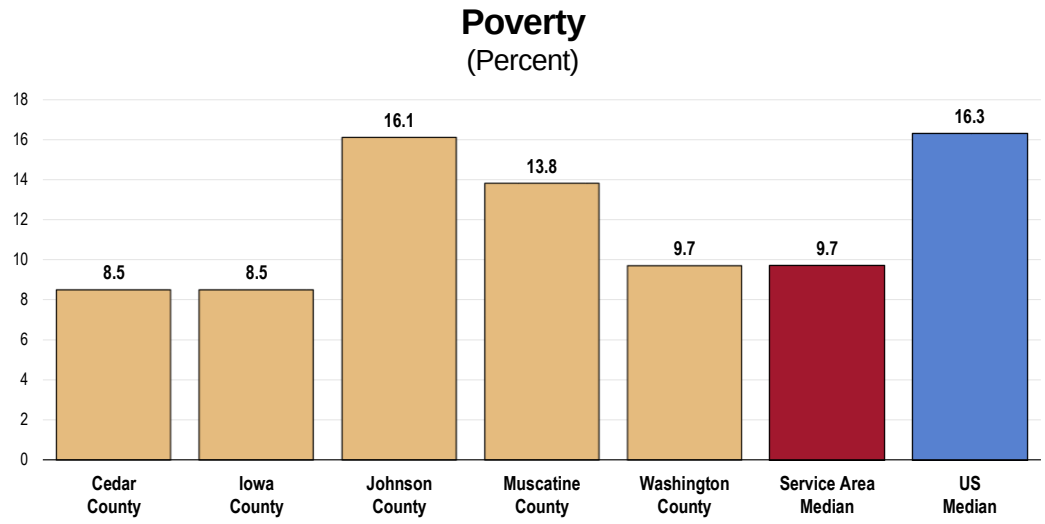
Low-income and minority neighborhoods are less likely to have access to recreational facilities and full-service grocery stores and more likely to have higher concentrations of retail outlets for tobacco, alcohol, and fast foods. Adolescents who grow up in neighborhoods characterized by concentrated poverty are more likely to be a victim of violence; use tobacco, alcohol, and other substances; become obese; and engage in risky sexual behavior.

- CITATION: National Prevention Council, National Prevention Strategy, Washington, DC: US Department of Health and Human Services, Office of the Surgeon General, 2011. Available at http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf

Poverty

A service area median of 9.7% of the population lives below the federal poverty level.

- Better than the US median percentage.
- Locally highest in Johnson and Muscatine counties.



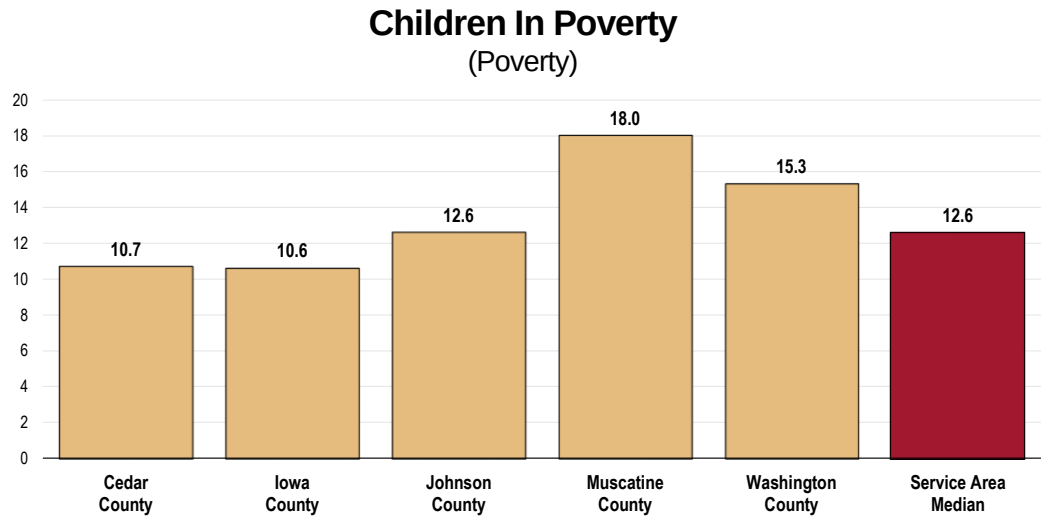
Sources:
- The US Census Bureau's Small Area Income and Poverty Estimates (SAIPE)
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- The US Census Bureau, with support from other federal agencies, created the Small Area Income and Poverty Estimates (SAIPE) program to provide more current estimates of selected income and poverty statistics than those from the most recent decennial census. The main objective of this program is to provide updated estimates of income and poverty statistics for the administration of federal programs and the allocation of federal funds to local jurisdictions. These estimates combine data from administrative records, intercensal population estimates, and the decennial census with direct estimates from the American Community Survey to provide consistent and reliable single-year estimates. These model-based single-year estimates are more reflective of current conditions than multi-year survey estimates. At the county level, SAIPE provides estimates on children ages 5-17 in families in poverty, children under age 18 in poverty, all people in poverty, and median household income. Estimates are created for school districts, counties, and states.
- Data Years: 2012

Children In Poverty

A median 12.6% of children in the service area lives below the federal poverty level.

- Locally highest in Muscatine and Washington counties.



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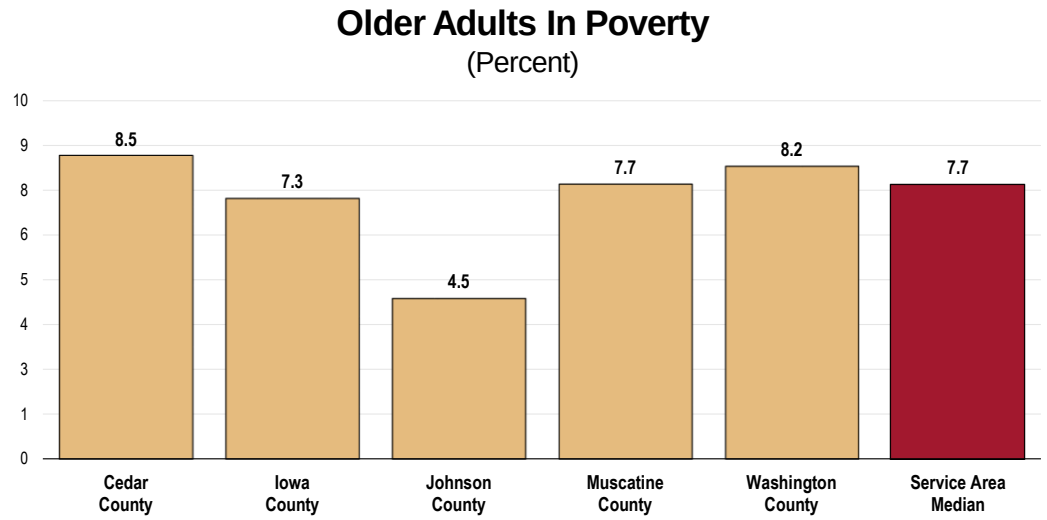
- Data Years: 2012

Older Adults In Poverty

A service area median of 7.7% of the senior population (age 65+) lives below the federal poverty level.

- Favorably low in Johnson County.



Sources:
- American Community Survey. Available at www.census.gov/acs/www/
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Poverty statistics in American Community Survey products adhere to the standards specified by the Office of Management and Budget in Statistical Policy Directive 14. The Census Bureau uses a set of dollar value thresholds that vary by family size and composition to determine who is in poverty. Further, poverty thresholds for people living alone or with nonrelatives (unrelated individuals) vary by age (under 65 years or 65 years and older). The poverty thresholds for two-person families also vary by the age of the householder. If a family's total income is less than the dollar value of the appropriate threshold, then that family and every individual in it are considered to be in poverty. Similarly, if an unrelated individual's total income is less than the appropriate threshold, then that individual is considered to be in poverty.
- Data Years: 2008-2012

Unemployment

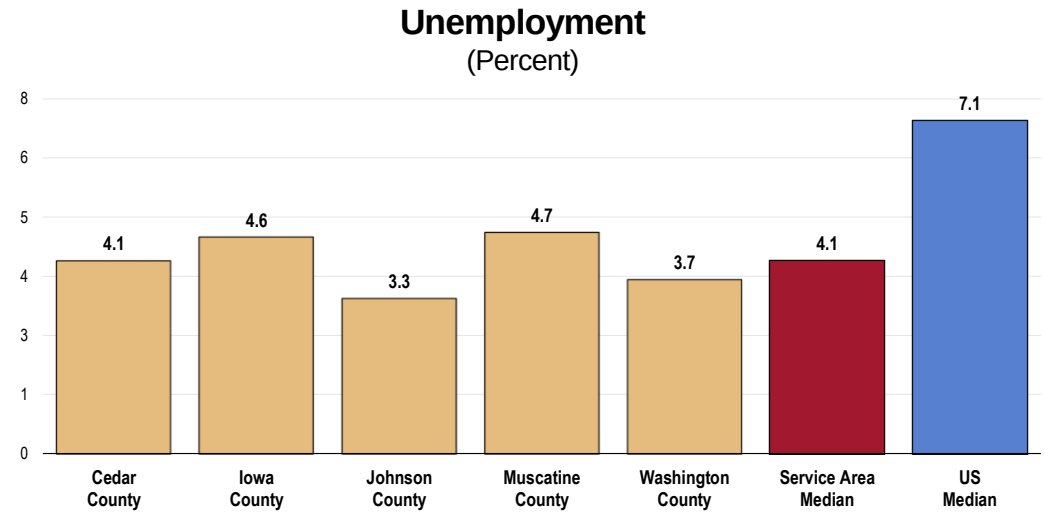
Unemployment

The association between unemployment and poor physical and mental health is well established. Unemployed persons tend to have higher annual illness rates, lack health insurance and access to healthcare, and have an increased risk for death.

- CITATION: Centers for Disease Control and Prevention, Unemployment — United States, 2006 and 2010. MMWR 2013;62(Suppl 3):27-31. Available at http://www.cdc.gov/mmwr/pdf/other/su6203.pdf

A service area median of 4.1% of the population is unemployed.

- Well below the US median percentage.
- Locally highest in Iowa and Muscatine counties.



Sources:
- Local Area Unemployment Statistics. Bureau of Labor Statistics. Available at: www.bls.gov/lau/lauov.htm
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- The Local Area Unemployment Statistics (LAUS) program is a Federal-State cooperative effort in which monthly estimates of total employment and unemployment are prepared for Census regions and divisions, states, counties, metropolitan areas, and many cities by place of residence. The concepts and definitions underlying LAUS data come from the Current Population Survey (CPS), the household survey that is the official measure of the labor force for the nation. Estimates for the sub state labor market areas are produced through a building-block approach known as the "Handbook method." This procedure also uses data from several sources, including the CPS, the Current Employment Statistics program, State UI systems, and the decennial census, to create estimates that are adjusted to the statewide measures of employment and unemployment. Below the labor market area level, estimates are prepared using disaggregation techniques based on inputs from the decennial census, annual population estimates, and current Unemployment Insurance systems.
- Data Years: 2013

Violent Crime

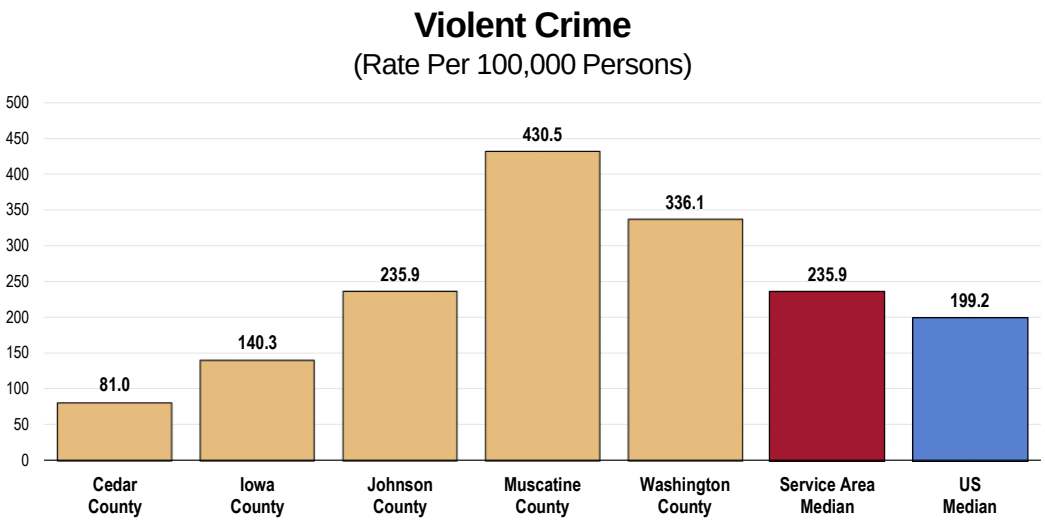
Violence

Witnessing or being a victim of violence (e.g., child maltreatment, youth violence, intimate partner and sexual violence, bullying, elder abuse) are linked to lifelong negative physical, emotional, and social consequences.

- CITATION: National Prevention Council, National Prevention Strategy, Washington, DC: Available at Available at http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf

The median violent crime rate in the service area is 235.9 per 100,000 people.

- Higher than the US median rate.
- Locally highest in Muscatine and Washington counties, both of which rank in the bottom quartile among peer counties.



Sources:
- United States Department of Justice. Federal Bureau of Investigation. Uniform Crime Reporting Program Data: County-Level Detailed Arrest and Offense Data, 2012. ICPSR35019-v1. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2014-06-12. http://doi.org/10.3886/ICPSR35019.v1
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- The violent crime rate is calculated as the sum of murder, forcible rape, robbery, and aggravated assaults over the three-year period divided by the aggregate population of areas covered by agencies reporting crimes, and then multiply 100,000. Two suppression rules may apply. First, the data is suppressed if the population covered by agencies reporting crimes during that year is less than 50% of the actual county population as reported by the census. The county-level population estimates were from the 2013 Census vintage estimates. Second, if the coverage indicator for the year is less than 80%, the data is also suppressed. The coverage indicator is a measure of the percent of agencies in a county reported crimes and how many months they reported crimes for. Assuming fewer than three years of data are suppressed; the remaining years of data are used to construct the estimate. If data from all three years are excluded, no estimate is reported.
- Data Years: 2010-2012

Education

Education

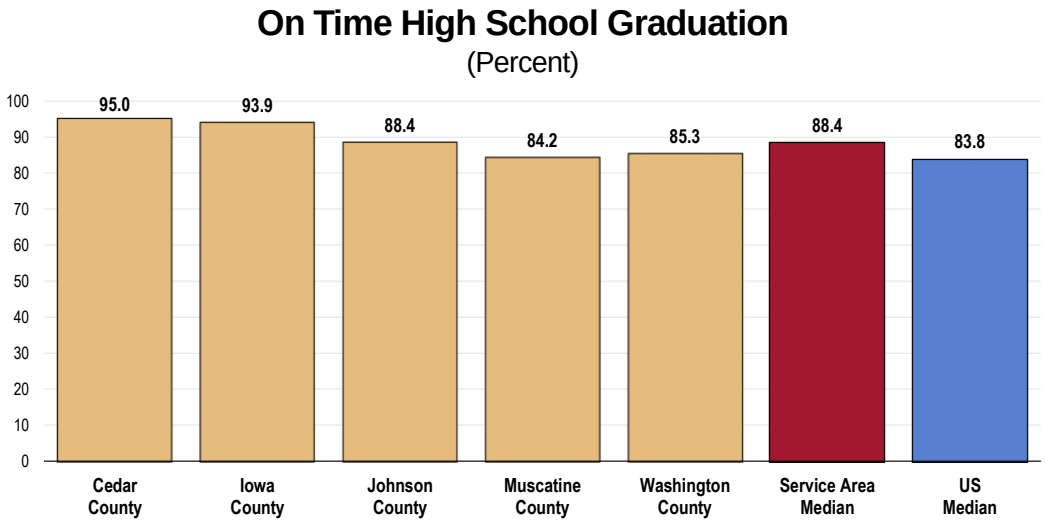
Education, employment, and health are linked. Without a good education, prospects for a stable and rewarding job with good earnings decrease. Education is associated with living longer, experiencing better health, and practicing health-promoting behaviors such as exercising regularly, refraining from smoking, and obtaining timely health checkups and screenings.

- CITATION: National Prevention Council, National Prevention Strategy, Washington, DC: US Department of Health and Human Services, Office of the Surgeon General, 2011. Available at http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf

On Time High School Graduation

A median total of 88.4% of the service area population graduated from high school on time.

- Better than the US median percentage.
- The Washington County percentage is in the bottom quartile among its peer counties.



Sources:
- The on-time graduation rates can be found through the US
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- States are required to report graduation data to Department of Education under Title I, Part A of the Elementary and Secondary Education Act (ESEA). From the beginning of 9th grade (or the earliest high school grade), students who are entering that grade for the first time form a cohort that is "adjusted" by adding any students who subsequently transfer into the cohort and subtracting any students who subsequently transfer out, emigrate to another country, or die. Adjusted Cohort Graduation Rates at the Local Education Agency (school district) level were available for all states except Idaho, Kentucky, and Oklahoma (where data were either missing or there were large gaps).
- Data Years: 2010-2011

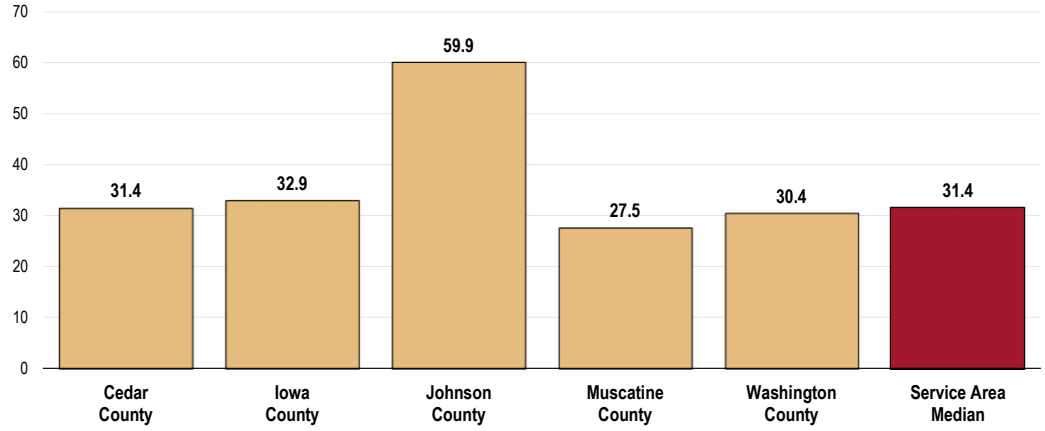
Associates Level Degree Or Higher

A service area median of 31.4% of the population has attained at least an Associate degree.

- Locally highest in Johnson County.

Associate Level Degree Or Higher

(Percent)



Sources:
- American Community Survey. Available at www.census.gov/acs/www/
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- The category "Associate Degree" included people whose highest degree is an associate degree, which generally requires 2 years of college level work and is either in an occupational program that prepares them for a specific occupation or an academic program primarily in the arts and sciences.
- Data Years:2008-2012

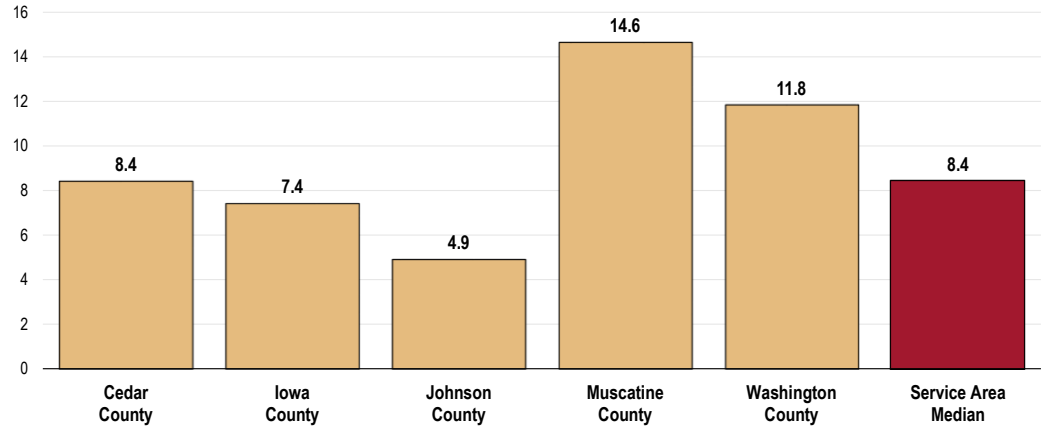
No High School Diploma

A service area median of 8.4% of the population (age 25+) does not have a high school diploma.

- Unfavorably high in Muscatine and Washington counties.

No High School Diploma

(Percent)



Sources:
- American Community Survey. Available at www.census.gov/acs/www/
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Data on educational attainment were derived from a sample of the population 25 years old and over. Passing the test of General Educational Development (G.E.D.) is considered equivalent to receiving a high school diploma. The indicator includes individuals who reported completing the 12th grade but not receiving a diploma.
- Data Years: 2008-2012

Family Structure

Family Structure

Children living in nuclear families—that is, in families consisting of two married adults who are the biological or adoptive parents of all children in the family—were generally healthier, more likely to have access to healthcare, and less likely to have definite or severe emotional or behavioral difficulties than children living in nonnuclear families.

- CITATION: Blackwell DL. Family structure and children's health in the United States: Findings from the National Health Interview Survey, 2001–2007. National Center for Health Statistics. Vital Health Stat 10(246). 2010. Available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_246.pdf

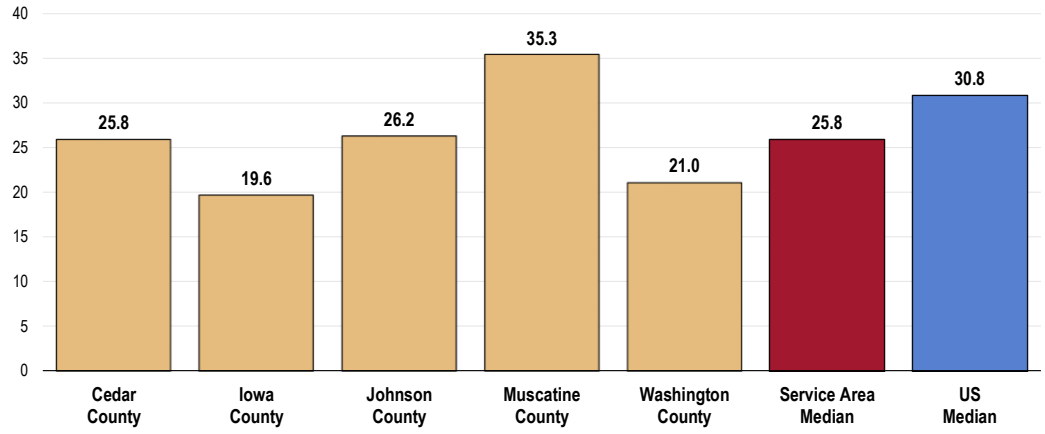
Children In Single-Parent Households

A median total of 25.8% of service area households with children are led by single parents.

- Lower than the US median percentage.
- The Muscatine County percentage is in the bottom quartile among its peer counties.

Children In Single-Parent Households

(Percent)



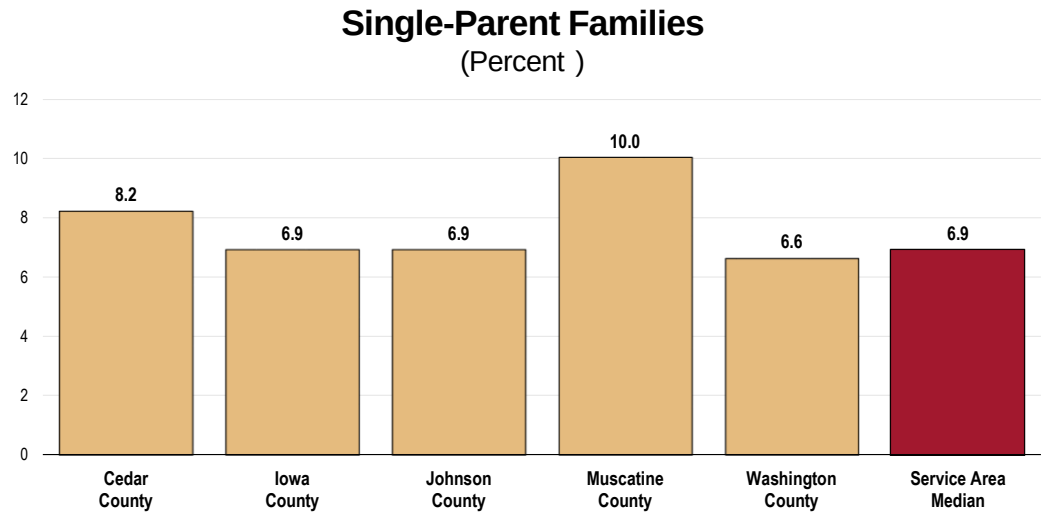
Sources:
- American Community Survey. Available at www.census.gov/acs/www/
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- The estimate for percent of children in single-parent households was created by adding the ACS variables, "male single householders with own children under 18 years" and "female single householders with own children under 18 years" and dividing by the "total households with own children under 18 years." A family householder is a householder living with one or more individuals related to him or her by birth, marriage, or adoption. Spouse is defined as a person married to and living with a householder who is of the opposite sex of the householder. The category "husband or wife" includes people in formal marriages, as well as people in common-law marriages. Own child is defined as a never-married child under 18 years who is a son or daughter by birth, a stepchild, or an adopted child of the householder. A limitation of this estimate is that "Spouse" does not include same-sex married couples even if the marriage was performed in a state issuing marriage certificates for same-sex couples.
- Data Years: 2008-2012

Single-Parent Families

A median 6.9% of service area households are led by single parents.

- Locally highest in Muscatine County.



Sources:
- American Community Survey. Available at www.census.gov/acs/www/
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- This estimate for the percent of families with a single head of household was created by adding the ACS variables, "other family, male householder, no wife present" with "other family, female householder, no husband present" and dividing by the "total family households." A family consists of a householder and one or more other people living in the same household who are related to the householder by birth, marriage, or adoption. All people in a household who are related to the householder are regarded as members of his or her family. A family household may contain people not related to the householder, but those people are not included as part of the householder's family in tabulations. Thus, the number of family households is equal to the number of families, but family households may include more members than do families. A household can contain only one family for purposes of tabulations. Not all households contain families since a household may be comprised of a group of unrelated people or of one person living alone – these are called nonfamily households. Families are classified by type as either a "married-couple family" or "other family" according to the sex of the householder and the presence of relatives. The data on family type are based on answers to questions on sex and relationship that were asked of all people.. Married-Couple Family – A family in which the householder and his or her spouse are listed as members of the same household. Male Householder, No Wife Present – A family with a male householder and no spouse of householder present. Female Householder, No Husband Present – A family with a female householder and no spouse of householder present. A limitation of the estimate is that family households and married-couple families do not include same-sex married couples even if the marriage was performed in a state issuing marriage certificates for same-sex couples. Same-sex couple households are included in the family households category.
- Data Years: 2008-2012

Social Support

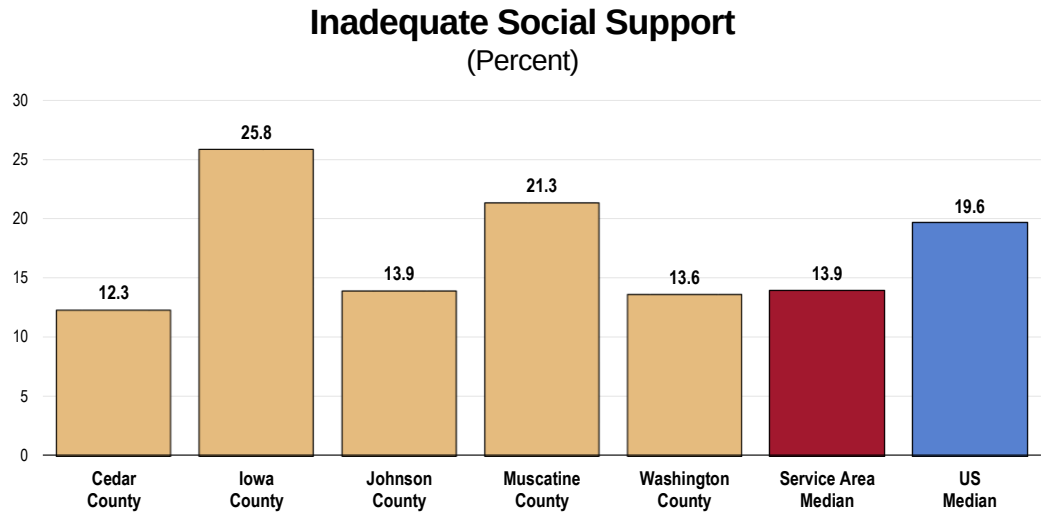
Social Support

Social relationships are fundamental to emotional fulfillment, behavioral adjustment, and cognitive function. Social isolation predicts morbidity and mortality from cancer, cardiovascular disease, and a host of other causes.

- CITATION: Hawkley, L. and J. Cacioppo (2003). "Loneliness and pathways to disease." Brain, behavior, and immunity 17 Suppl 1: S98-105.

A service area median of 13.9% of the population receives inadequate social support.

- Better than the US median percentage.
- Locally highest in Iowa and Muscatine counties (both of which are in the bottom quartile among their peer counties).



Sources:
- Behavioral Risk Factor Surveillance System (BRFSS). Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Based on the BRFSS question "How often do you get the social and emotional support you need?" Persons were considered to be receiving sufficient emotional/social support if they reported getting social/emotional support all or most of the time.Estimates based on fewer than 50 cases or with a confidence interval half-width of 10% or more ((upper CI-lower CI/100) >10) are considered unreliable and are not displayed.In 2011, two methodological refinements were made to the Behavioral Risk Factor Surveillance System (BRFSS). The first was to expand the sample to include data received from cell phone users. This change was made to reflect the population better. The second change was to modify the statistical method to weight BRFSS survey data. The new approach simultaneously adjusts survey respondent data to known proportions of demographics such as age, race and ethnicity, and gender. Prior to 2011, the weighting method was post stratification, while in 2011 it is raking. Raking is better able to account for more demographic characteristics and multiple sampling frames. Because of these changes, data collected in 2011 and later cannot be appropriately compared to previous data, although new results should better reflect the health status of the United States. In order to create multi-year estimates, two changes were made to the new data. First, respondents who only have cell phones were removed. Second, weights were created specifically for this purpose using the post stratification method. Those two changes make the 2011 data similar to the pre-2011 data and allowed multi-year estimates to be created, even though these estimates will not be as representative of the US population as the single-year estimates using 2011 data without these changes. The BRFSS estimates are age adjusted to the 2000 US Census standard populaton (age groups: 18-44, 45-54, 55-64, 65-74, 75+).
- Data Years: 2006-2012

Affordable Housing

Affordable Housing

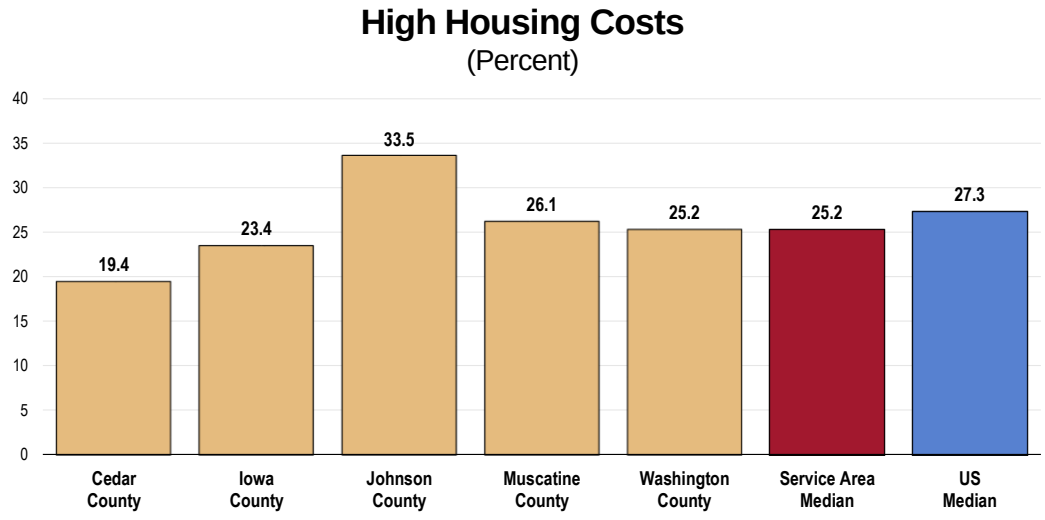
Affordability of housing is linked to the health and well-being of individuals and families. When a market lacks a sufficient supply of affordable housing, lower-income families are often forced to limit expenditures for food, medical care, and other necessities in order to pay rent.

- CITATION: L. Freeman. America's affordable housing crisis: a contract unfulfilled. Am J Public Health, 92 (2002), pp. 709–712 Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447149/

High Housing Costs

A service area median of 25.2% of the population lives with high housing costs.

- Lower than the US median percentage.
- Locally highest in Johnson County; Washington County is in the bottom quartile among its peer counties.



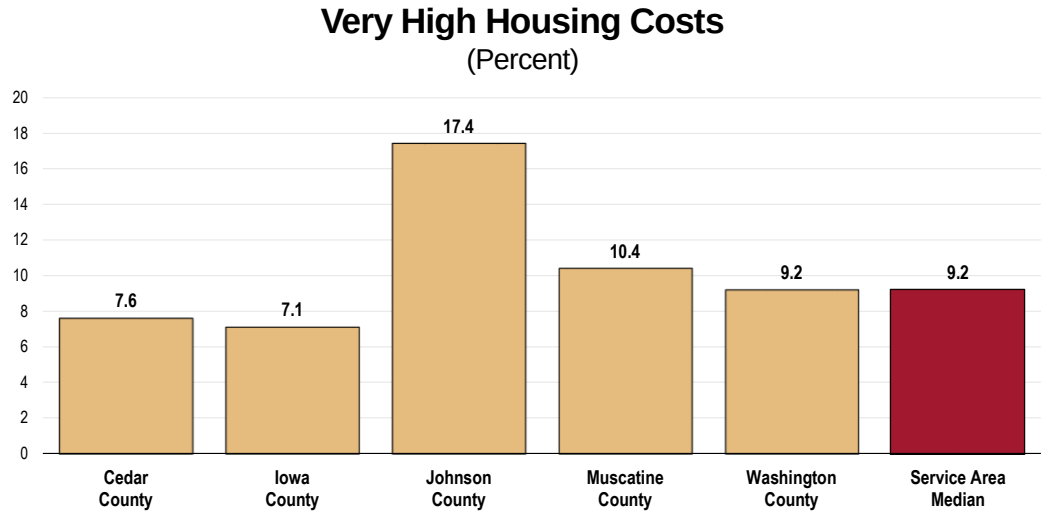
Sources:
- American Community Survey. Available at www.census.gov/acs/www/
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Monthly owner costs come from ACS data on mortgage, second mortgage and/or home equity loans, real estate taxes, homeowners insurance, condo fee (if applicable), mobile home cost (if applicable), utilities (electricity, gas, water and sewer, and other utilities.) Monthly gross rent costs come from ACS data on contract rent and utilities (electricity, gas, water and sewer, and other utilities.)
- Data Years: 2008-2012

Very High Housing Costs

A service area median of 9.2% of the population lives with very high housing costs.

- Locally highest in Johnson County.



Sources:
- American Community Survey. Available at www.census.gov/acs/www/
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Monthly owner costs come from ACS data on mortgage, second mortgage and/or home equity loans, real estate taxes, homeowners insurance, condo fee (if applicable), mobile home cost (if applicable), utilities (electricity, gas, water and sewer, and other utilities.) Monthly gross rent costs come from ACS data on contract rent and utilities (electricity, gas, water and sewer, and other utilities.)
- Data Years: 2008-2012

General Health Status

Overall Health Status

Health-Related Quality of Life

Health-related quality of life (HRQOL) measures of perceived physical and mental health and function have become an important component of health surveillance and are generally considered valid indicators of service needs and intervention outcomes. Self-assessed health status also proved to be more powerful predictor of mortality and morbidity than many objective measures of health.

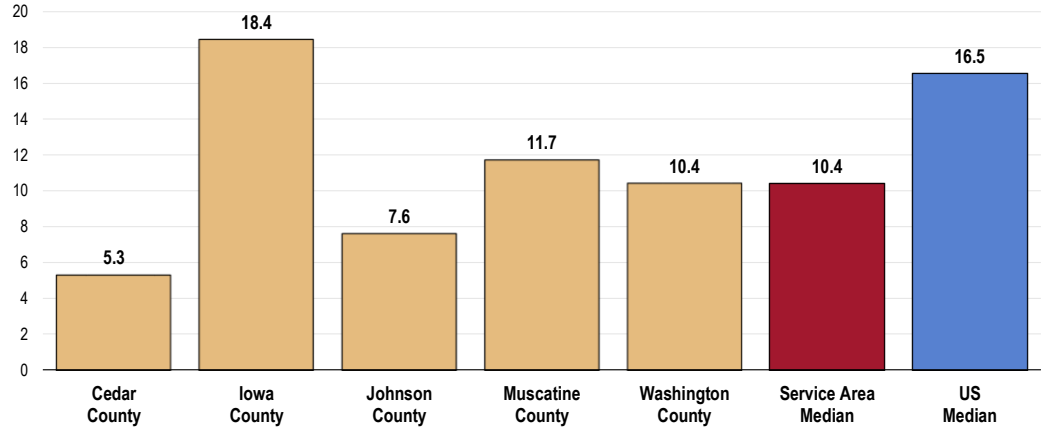
- CITATION: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. Available at http://www.cdc.gov/hrqol/concept.htm#1

Adult Overall Health Status

A service area median of 10.4% of the population lives with "fair" or "poor" overall health.

- Lower than the US median percentage.
- Locally highest in Iowa County (which is in the bottom quartile among its peer counties).

Adult Overall Health Status ["Fair/Poor" Health]
(Percent)



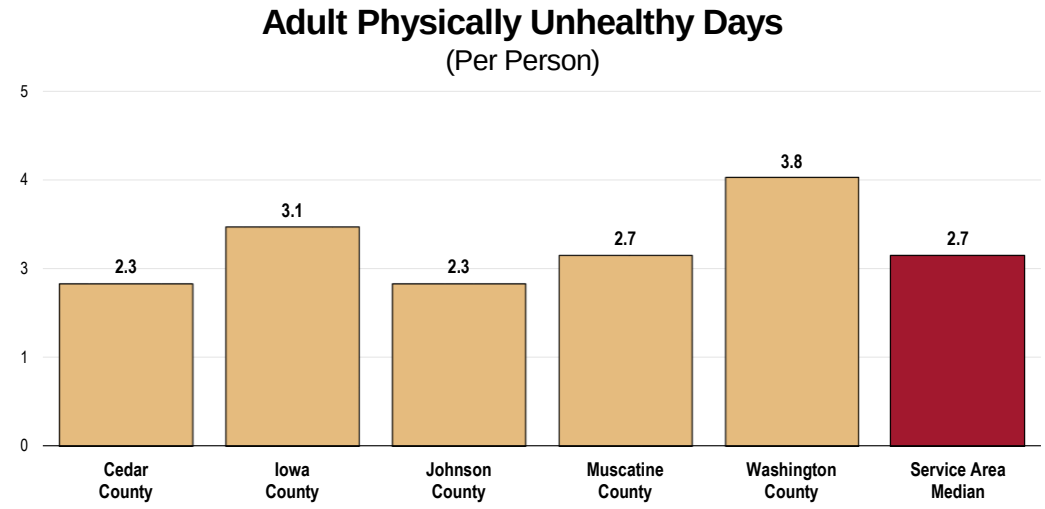
Sources:
- Behavioral Risk Factor Surveillance System (BRFSS). Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Based on the BRFSS question : "Would you say that in general your health is— Excellent, Very good, Good, Fair, Or Poor?" In 2011, two methodological refinements were made to the Behavioral Risk Factor Surveillance System (BRFSS). The first was to expand the sample to include data received from cell phone users. This change was made to reflect the population better. The second change was to modify the statistical method to weight BRFSS survey data. The new approach simultaneously adjusts survey respondent data to known proportions of demographics such as age, race and ethnicity, and gender. Prior to 2011, the weighting method was post stratification, while in 2011 it is raking. Raking is better able to account for more demographic characteristics and multiple sampling frames. Because of these changes, data collected in 2011 and later cannot be appropriately compared to previous data, although new results should better reflect the health status of the United States. In order to create multi-year estimates, two changes were made to the new data. First, respondents who only have cell phones were removed. Second, weights were created specifically for this purpose using the post stratification method. Those two changes make the 2011 data similar to the pre-2011 data and allowed multi-year estimates to be created, even though these estimates will not be as representative of the US population as the single-year estimates using 2011 data without these changes. Estimates based on fewer than 50 cases or with a confidence interval half-width of 10% or more ((upper CI-lower CI/100) >10) are considered unreliable and are not displayed. This Indicator uses Age-Adjustment Groups: 18-44, 45-54, 55-64, 65-74, 75+
- Data Years: 2006-2012

Adult Physically Unhealthy Days

Service area residents experienced a median average of 2.7 physically unhealthy days in the past month.

- Locally highest in Iowa and Washington counties.



Sources:
- Behavioral Risk Factor Surveillance System (BRFSS). Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

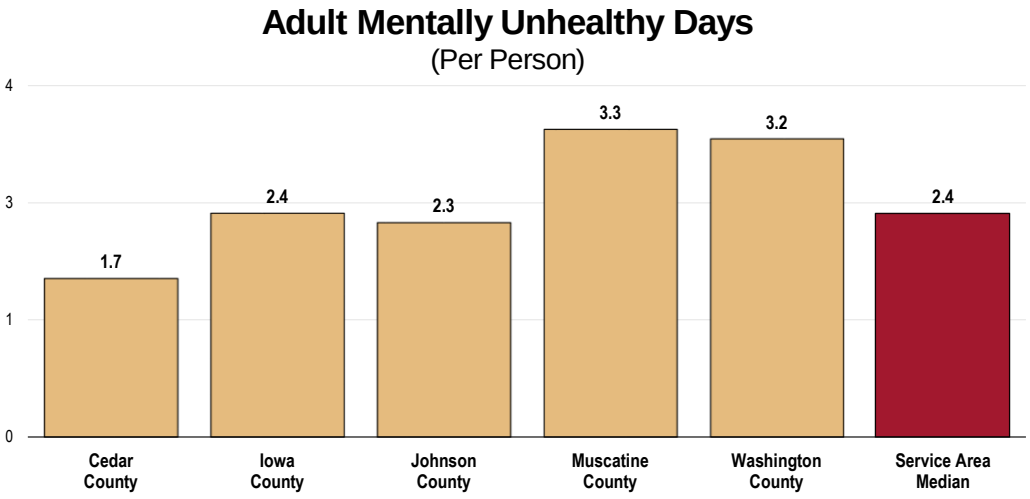
Notes:
- Based on the BRFSS question: "Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?" For year 2002, data only available for: Alaska, California, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Minnesota, Missouri, New Jersey, New Mexico, New York, North Carolina, Oregon, Rhode Island, South Carolina, Texas, Utah, Virginia, Washington, and Wyoming. All 50 states available for all other years reported. Estimates based on fewer than 50 cases or with a confidence interval half-width of 10% or more ((upper CI-lower CI/100) >10) are considered unreliable and are not displayed.In 2011, two methodological refinements were made to the Behavioral Risk Factor Surveillance System (BRFSS). The first was to expand the sample to include data received from cell phone users. This change was made to reflect the population better. The second change was to modify the statistical method to weight BRFSS survey data. The new approach simultaneously adjusts survey respondent data to known proportions of demographics such as age, race and ethnicity, and gender. Prior to 2011, the weighting method was post stratification, while in 2011 it is raking. Raking is better able to account for more demographic characteristics and multiple sampling frames. Because of these changes, data collected in 2011 and later cannot be appropriately compared to previous data, although new results should better reflect the health status of the United States.In order to create multi-year estimates, two changes were made to the new data. First, respondents who only have cell phones were removed. Second, weights were created specifically for this purpose using the post stratification method. Those two changes make the 2011 data similar to the pre-2011 data and allowed multi-year estimates to be created, even though these estimates will not be as representative of the US population as the single-year estimates using 2011 data without these changes. This Indicator uses Age-Adjustment Groups: Age Range: 18-44, 45-54, 55-64, 65-74, 75+
- Data Years: 2006-2012

Mental Health

Adult Mentally Unhealthy Days

Service area residents experienced a median average of 2.4 mentally unhealthy days in the past month.

- Locally highest in Muscatine and Washington counties.



Sources:
- Behavioral Risk Factor Surveillance System (BRFSS). Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Based on the BRFSS question "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" For year 2002, data only available for: Alaska, California, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Minnesota, Missouri, New Jersey, New Mexico, New York, North Carolina,Oregon, Rhode Island, South Carolina, Texas, Utah, Virginia, Washington, and Wyoming. All 50 states available for all other years reported. Estimates based on fewer than 50 cases or with a confidence interval half-width of 10% or more ((upper CI-lower CI/100) >10) are considered unreliable and are not displayed. In 2011, two methodological refinements were made to the Behavioral Risk Factor Surveillance System (BRFSS). The first was to expand the sample to include data received from cell phone users. This change was made to reflect the population better. The second change was to modify the statistical method to weight BRFSS survey data. The new approach simultaneously adjusts survey respondent data to known proportions of demographics such as age, race and ethnicity, and gender. Prior to 2011, the weighting method was post stratification, while in 2011 it is raking. Raking is better able to account for more demographic characteristics and multiple sampling frames. Because of these changes, data collected in 2011 and later cannot be appropriately compared to previous data, although new results should better reflect the health status of the United States). In order to create multi-year estimates, two changes were made to the new data. First, respondents who only have cell phones were removed. Second, weights were created specifically for this purpose using the post stratification method. Those two changes make the 2011 data similar to the pre-2011 data and allowed multi-year estimates to be created, even though these estimates will not be as representative of the US population as the single-year estimates using 2011 data without these changes. This Indicator uses Age-Adjustment Groups: Age Range: 18-44, 45-54, 55-64, 65-74, 75+.
- Data Years: 2006-2012

Older Adult Depression

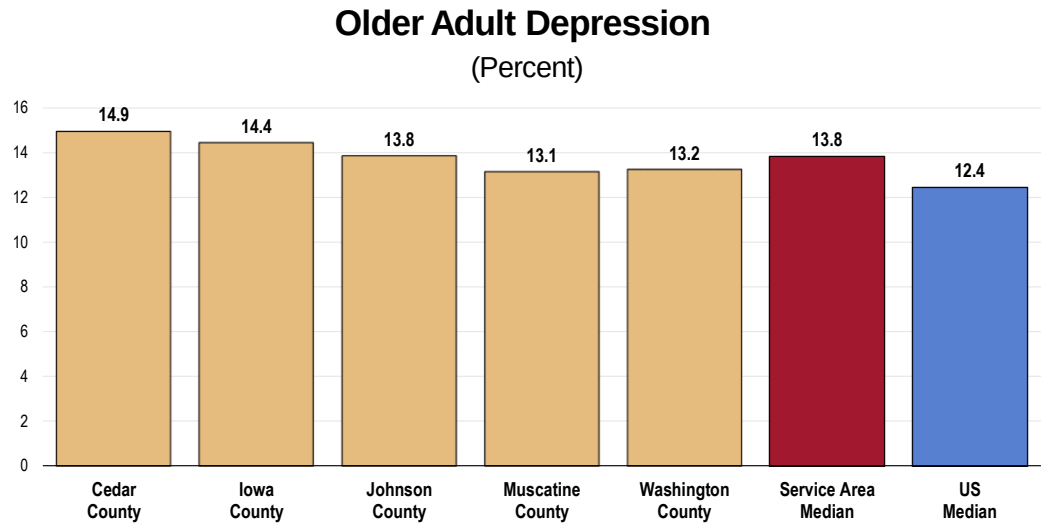
Depression

Depression is characterized by depressed or sad mood, diminished interest in activities which used to be pleasurable, weight gain or loss, psychomotor agitation or retardation, fatigue, inappropriate guilt, difficulties concentrating, as well as recurrent thoughts of death. But depression is more than a "bad day"; diagnostic criteria established by the American Psychiatric Association dictate that five or more of the above symptoms must be present for a continuous period of at least two weeks. As an illness, depression falls within the spectrum of affective disorders.

- CITATION: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. Available at http://www.cdc.gov/mentalhealth/basics/mental-illness/depression.htm

A median 13.8% of service area seniors are being treated for depression.

- Higher than the national median.
- The Cedar and Iowa County percentages are in the bottom quartile among their peer counties.



Sources:
- Medicare Chronic Conditions Report, Center of Medicare and Medicaid Services.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Chronic conditions for adults age 65 and older, were identified through Medicare administrative claims. Medicare beneficiaries were considered to have a chronic condition if the CMS administrative data had a claim indicating that they were receiving a service or treatment for the specific condition. Beneficiaries may have more than one of the chronic conditions listed. Data is suppressed if there are fewer than 11 Medicare beneficiaries in the county.
- Data Years: 2012

Mortality & Morbidity

Life Expectancy

Life Expectancy

Between 2000 and 2007, life expectancies in more than 80% of United States counties fell in standing against the average of the 10 nations with the best life expectancies in the world.

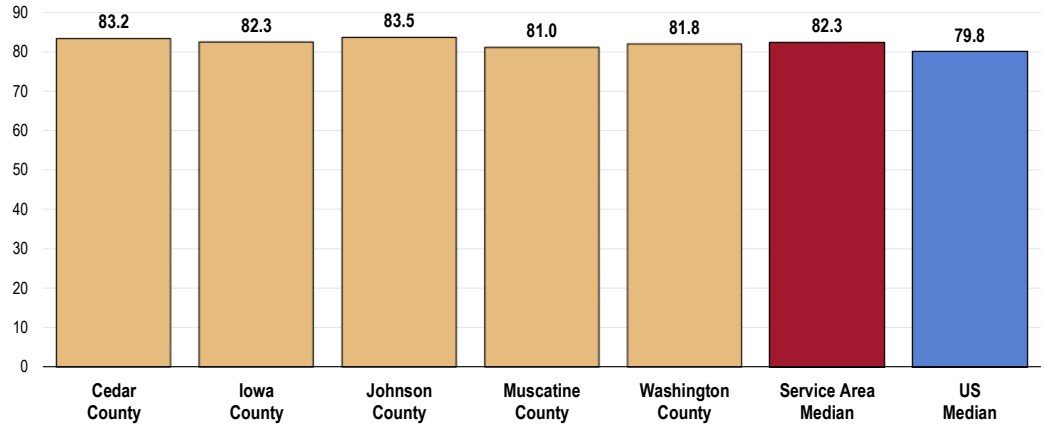
- CITATION: Kulkarni, S., et al. (2011). "Falling behind: life expectancy in US counties from 2000 to 2007 in an international context." Population Health Metrics 9(1): 16-16 Available at http://www.pophealthmetrics.com/content/11/1/8

Female Life Expectancy

The service area median female life expectancy is 82.3 years.

- Older than the national median.
- Locally oldest in Johnson and Cedar counties.

Female Life Expectancy
(Years)



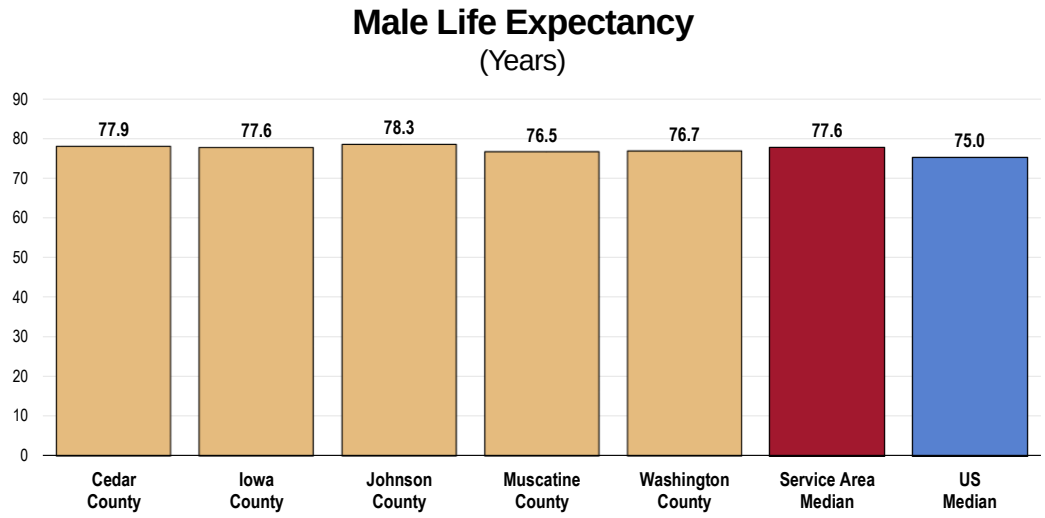
Sources:
- Life Expectancy estimates were provided by the Institute for Health Metrics and Evaluation (IMHE).
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Life expectancy estimates were calculated using a mixed-effects Poisson statistical model with time, geospatial, and covariate components and Gaussian Process Regression to estimate annual life expectancy for US counties. CITATION: See: Wang H, Schumacher AE, Levitz CE, Mokdad AH, Murray CJL. Left behind: widening disparities for males and females in US county life expectancy, 1985-2010. Population Health Metrics. 2013; 11:8. http://www.pophealthmetrics.com/content/11/1/8
- Data Years: 2010

Male Life Expectancy

The service area median male life expectancy is 77.6 years.

- Older than the national median.
- Locally oldest in Johnson and Cedar counties.



Sources:
- Life Expectancy estimates were provided by the Institute for Health Metrics and Evaluation (IMHE).
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- Data Years: 2010

Cancer

Cancer Deaths

Cancer Deaths

As it has been for many decades, cancer continues to be the second leading cause of death in the United States, accounting for more than a fifth of all deaths in 2010. Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half are expected to be alive in 5 years.

- CITATION: Murphy SL, Xu JQ, Kochanek KD. Deaths: Final data for 2010. National vital statistics reports; vol 61 no 4. Hyattsville, MD: National Center for Health Statistics. 2013. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf

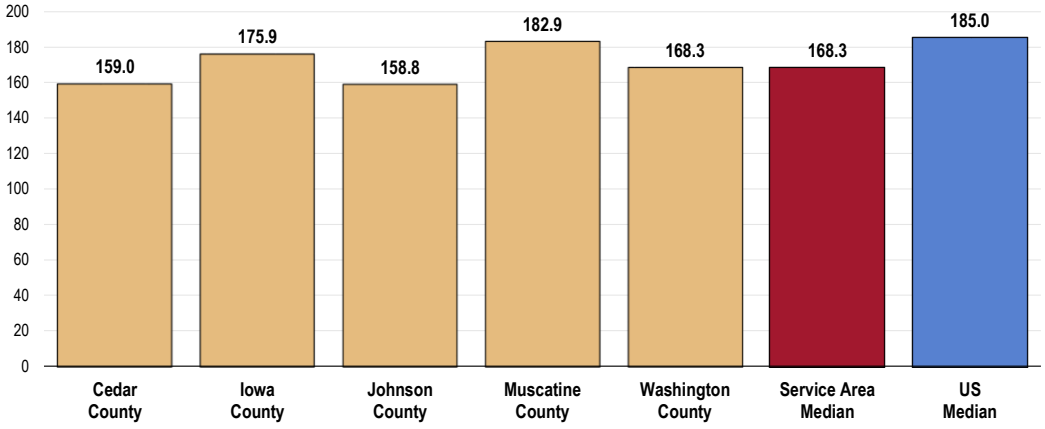
The service area experienced an annual age-adjusted median cancer death rate of 168.3 per 100,000 population.

- Below the national median rate.
- Rates are highest in Muscatine and Iowa counties.

Age-Adjusted Cancer Deaths

(Rate per 100,000 Persons)

Healthy People 2020 Target = 161.4 or Lower



Sources:
- National Vital Statistics System-Mortality (NVSS-M) Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Cancer death rates are calculated as the number of deaths assigned to ICD-10 codes C00-C97 per 100,000 population, age adjusted to the 2000 standard population. Death rates are calculated based on the sum of the resident populations for each of the data years involved (e.g. the denominator of a rate for 2008-2010 combined is the sum of the population estimates for 2008, 2009, and 2010). For census years (e.g. 2010), population counts enumerated as of April 1 are used. For all other years, populations estimates as of July 1 are used. Postcensal population estimates are used in rate calculations for years after a census year and match the data year vintage (e.g. July 1, 2011 resident population estimates from Vintage 2011 are used as the denominator for 2011 rates). Intercensal population estimates are used in rate calculations for the years between censuses (e.g. 1991-1999, 2001-2009). Race-specific population estimates for 1991 and later use bridged-race categories.
- Data Years: 2005-2011

Cancer Incidence

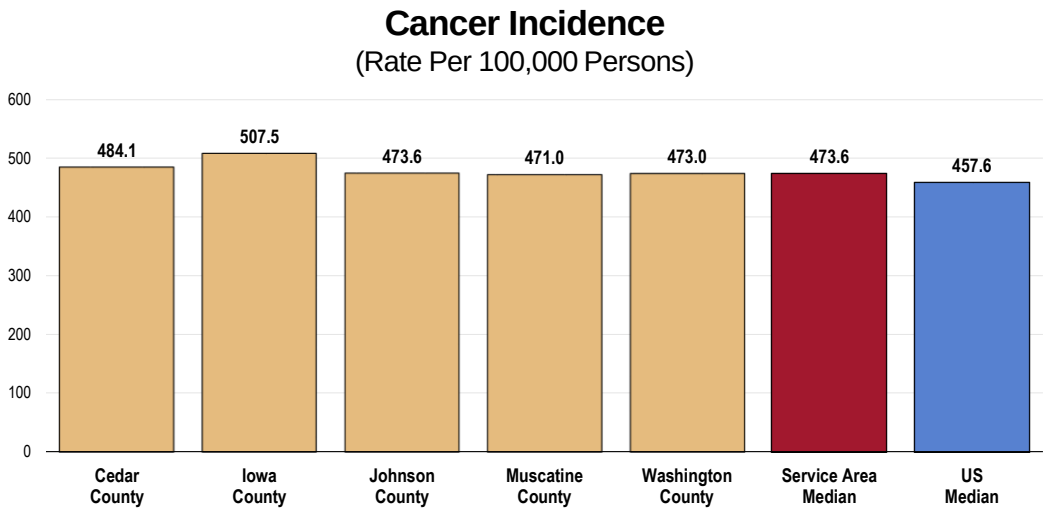
Cancer Incidence

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in 5 years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

- CITATION: US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at http://www.healthypeople.gov

The service area reports a median cancer incidence of 473.6 per 100,000 persons.

- Above the national median rate.
- Rates are highest in Iowa and Cedar counties, both of which are in the bottom quartile among their peer counties.



Sources:
- State Cancer Registry and the CDC's National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS) January 2013 data submission. Accessed from: National Cancer Institute. State Cancer Profiles.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Incidence rates (cases per 100,000 population per year) are age-adjusted to the 2000 US standard population (19 age groups: <1, 1-4, 5-9, ... , 80-84, 85+). Rates are for invasive cancer only (except for bladder which is invasive and in situ) or unless otherwise specified. Rates calculated using SEER*Stat. Population counts for denominators are based on Census populations as modified by NCI. The 1969-2011 US Population Data File is used for SEER and NPCR incidence rates. Data not available for Minnesota, Ohio, or Washington.
- Data Years: 2006-2010

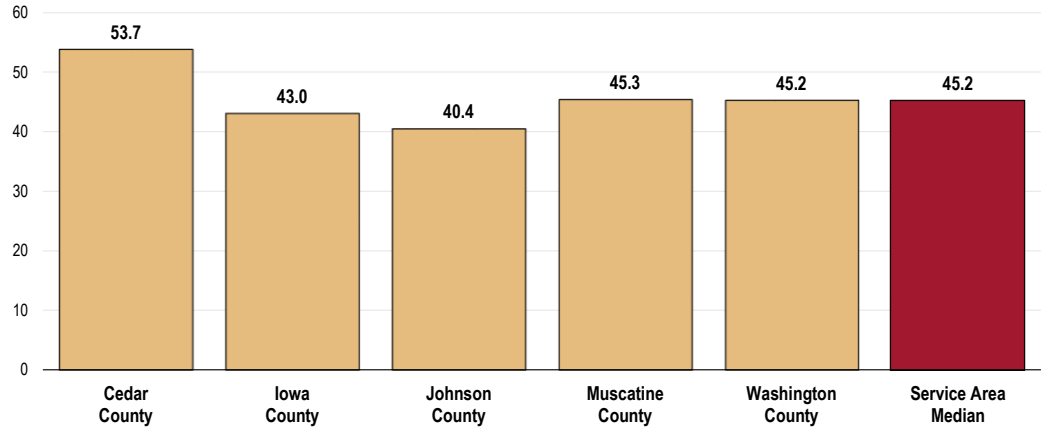
Colon and Rectum Cancer

The service area reports a median colon/rectal cancer incidence of 45.2 per 100,000 persons.

- Locally, the Cedar County rate is highest.

Colon and Rectum Cancer Incidence

(Rate Per 100,000 Persons)



Sources:
- State Cancer Registry and the CDC's National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS) January 2013 data submission. Accessed from: National Cancer Institute. State Cancer Profiles.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Incidence rates (cases per 100,000 population per year) are age-adjusted to the 2000 US standard population (19 age groups: <1, 1-4, 5-9, ... , 80-84, 85+). Rates are for invasive cancer only unless otherwise specified. Rates calculated using SEER*Stat. Population counts for denominators are based on Census populations as modified by NCI. The 1969-2011 US Population Data File is used for SEER and NPCR incidence rates. Data not available for Minnesota, Ohio, or Washington. Rates are for invasive cancer only unless otherwise specified.
- Data Years: 2006-2010

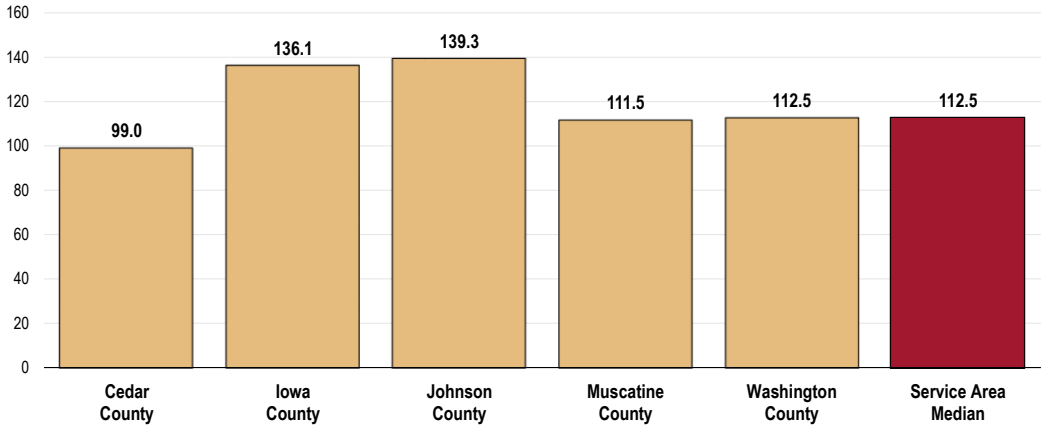
Female Breast Cancer

The service area reports a median female breast cancer incidence of 112.5 per 100,000 persons.

- Locally, the Johnson and Iowa County rates are highest.

Female Breast Cancer Incidence

(Rate Per 100,000 Persons)



Sources:
- State Cancer Registry and the CDC's National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS) January 2013 data submission. Accessed from: National Cancer Institute. State Cancer Profiles.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Incidence rates (cases per 100,000 population per year) are age-adjusted to the 2000 US standard population (19 age groups: <1, 1-4, 5-9, ... , 80-84, 85+). Rates are for invasive cancer only unless otherwise specified. Rates calculated using SEER*Stat. Population counts for denominators are based on Census populations as modified by NCI. The 1969-2011 US Population Data File is used for SEER and NPCR incidence rates. Data not available for Minnesota, Ohio, or Washington. Rates are for invasive cancer only unless otherwise specified.
- Data Years: 2006-2010

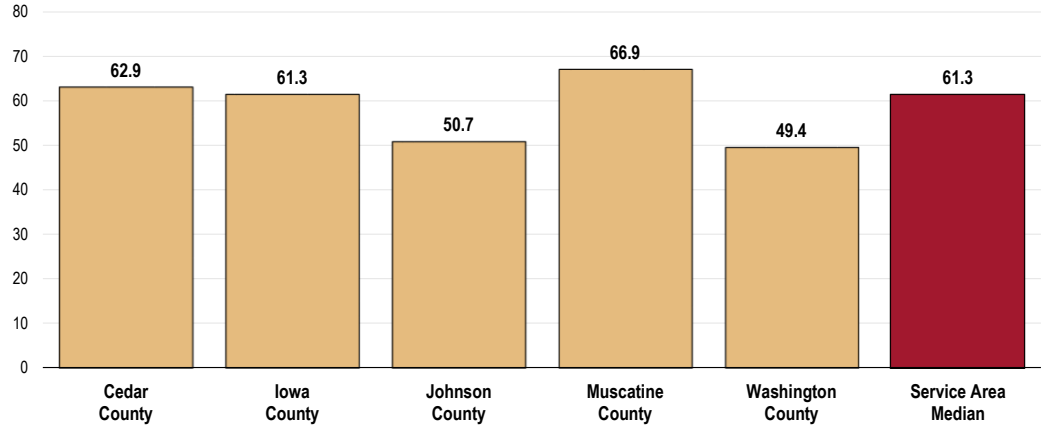
Lung & Bronchus Cancer

The service area reports a median lung/bronchus cancer incidence of 61.3 per 100,000 persons.

- Locally, the Muscatine County rate is highest.

Lung and Bronchus Cancer Incidence

(Rate Per 100,000 Persons)



Sources:
- State Cancer Registry and the CDC's National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS) January 2013 data submission. Accessed from: National Cancer Institute. State Cancer Profiles.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Incidence rates (cases per 100,000 population per year) are age-adjusted to the 2000 US standard population (19 age groups: <1, 1-4, 5-9, ... , 80-84, 85+). Rates are for invasive cancer only unless otherwise specified. Rates calculated using SEER*Stat. Population counts for denominators are based on Census populations as modified by NCI. The 1969-2011 US Population Data File is used for SEER and NPCR incidence rates. Data not available for Minnesota, Ohio, or Washington. Rates are for invasive cancer only unless otherwise specified.
- Data Years: 2006-2010

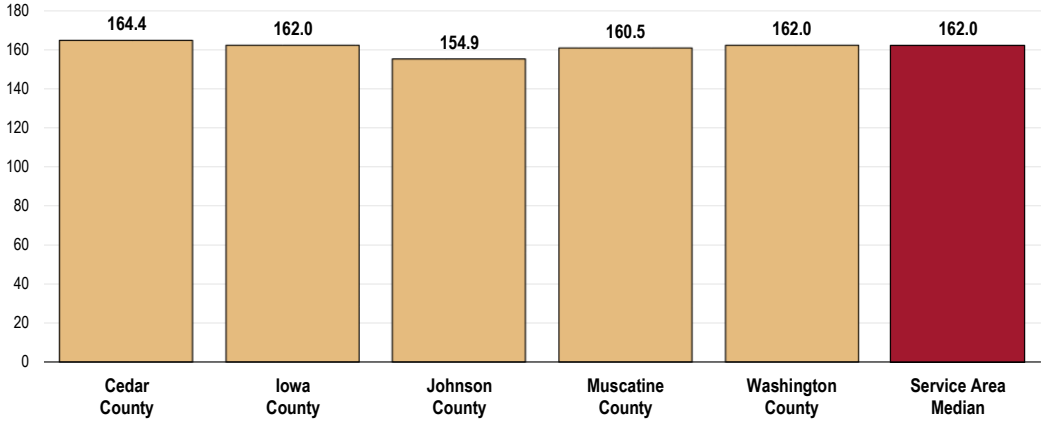
Male Prostate Cancer

The service area reports a median prostate cancer incidence of 162.0 per 100,000 persons.

- Locally, the Johnson County rate is favorably lower.

Male Prostate Cancer Incidence

(Rate Per 100,000 Persons)



Sources:
- State Cancer Registry and the CDC's National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS) January 2013 data submission. Accessed from: National Cancer Institute. State Cancer Profiles.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Incidence rates (cases per 100,000 population per year) are age-adjusted to the 2000 US standard population (19 age groups: <1, 1-4, 5-9, ... , 80-84, 85+). Rates are for invasive cancer only unless otherwise specified. Rates calculated using SEER*Stat. Population counts for denominators are based on Census populations as modified by NCI. The 1969-2011 US Population Data File is used for SEER and NPCR incidence rates. Data not available for Minnesota, Ohio, or Washington. Rates are for invasive cancer only unless otherwise specified.
- Data Years: 2006-2010

Adult Female Routine Pap Tests

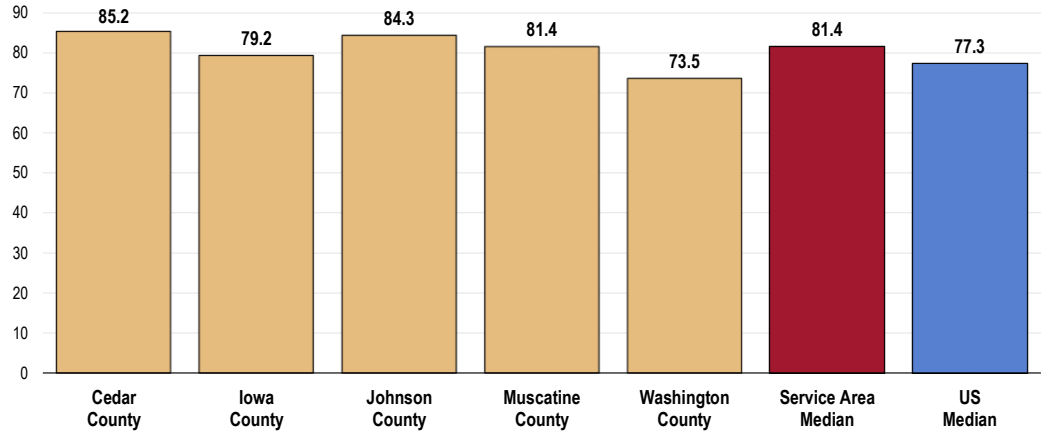
A service area median 81.4% of the female population receives routine Pap exams.

- Better than the US median percentage.
- Locally highest in Cedar and Johnson counties.

Adult Female Routine Pap Tests

(Percent)

Healthy People 2020 Target = 93.0% or Lower



Sources:
- Behavioral Risk Factor Surveillance System (BRFSS). Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Based on the BRFSS questions: "A Pap test is a test for cancer of the cervix. Have you ever had a Pap test? And " How long has it been since you had your last Pap test?" The questions regarding Pap tests are part of a series of questions asked every other year in the BRFSS questionnaire, on the even years. States have the option to include the questions in the odd years in which they are not in the standard questionnaire. For those states in those years that opt to include the questions, the estimates represent annual averages of a greater number of years. In 2011, two methodological refinements were made to the Behavioral Risk Factor Surveillance System (BRFSS). The first was to expand the sample to include data received from cell phone users. This change was made to reflect the population better. The second change was to modify the statistical method to weight BRFSS survey data. The new approach simultaneously adjusts survey respondent data to known proportions of demographics such as age, race and ethnicity, and gender. Prior to 2011, the weighting method was post stratification, while in 2011 it is raking. Raking is better able to account for more demographic characteristics and multiple sampling frames. Because of these changes, data collected in 2011 and later cannot be appropriately compared to previous data, although new results should better reflect the health status of the United States. In order to create multi-year estimates, two changes were made to the new data. First, respondents who only have cell phones were removed. Second, weights were created specifically for this purpose using the post stratification method. Those two changes make the 2011 data similar to the pre-2011 data and allowed multi-year estimates to be created, even though these estimates will not be as representative of the US population as the single-year estimates using 2011 data without these changes. The BRFSS estimates are age adjusted to the 2000 US D34 standard population (age groups: 18-44, 45-54, 55-64, 65-74, 75+)
- Data Years: 2006-2012

Heart Disease & Stroke

Cardiovascular Disease

Together, heart disease and stroke are among the most widespread and costly health problems facing the Nation today, accounting for more than $500 billion in healthcare expenditures and related expenses in 2010 alone.

- CITATION: US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at http://www.healthypeople.gov

Coronary Heart Disease Deaths

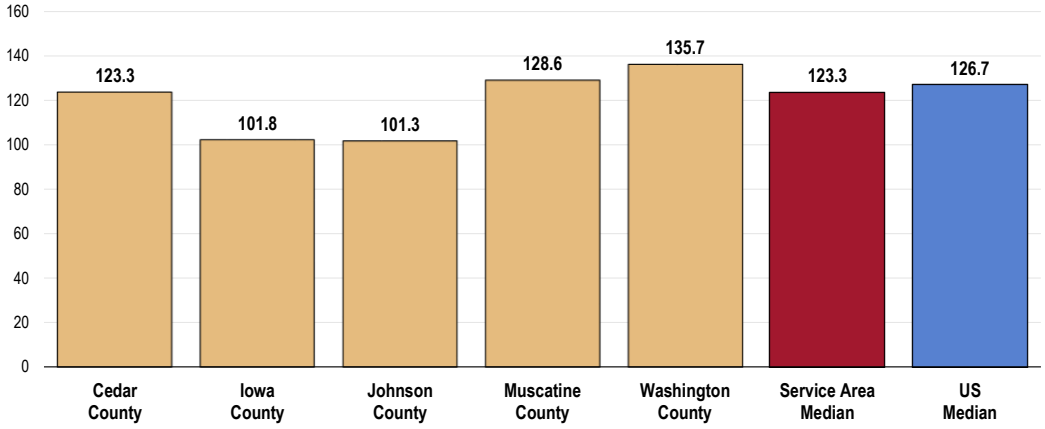
The service area reports an annual age-adjusted median coronary heart disease death rate of 123.3 per 100,000 population.

- Comparable to the US median rate.
- Note that Washington County ranks in the bottom quartile among its peer counties.

Age-Adjusted Coronary Heart Disease Deaths

(Rate per 100,000 Persons)

Healthy People 2020 Target = 103.4 or Lower



Sources:
- National Vital Statistics System-Mortality (NVSS-M) Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Heart disease death rates are calculated as the number of deaths assigned to ICD-10 codes I20-I25 per 100,000 population, age adjusted to the 2000 standard population. Death rates are calculated based on the sum of the resident populations for each of the data years involved (e.g. the denominator of a rate for 2008-2010 combined is the sum of the population estimates for 2008, 2009, and 2010). For census years (e.g. 2010), population counts enumerated as of April 1 are used. For all other years, populations estimates as of July 1 are used. Postcensal population estimates are used in rate calculations for years after a census year and match the data year vintage (e.g. July 1, 2011 resident population estimates from Vintage 2011 are used as the denominator for 2011 rates). Intercensal population estimates are used in rate calculations for the years between censuses (e.g. 1991-1999, 2001-2009). Race-specific population estimates for 1991 and later use bridged-race categories.
- Data Years: 2005-2011

Stroke Deaths

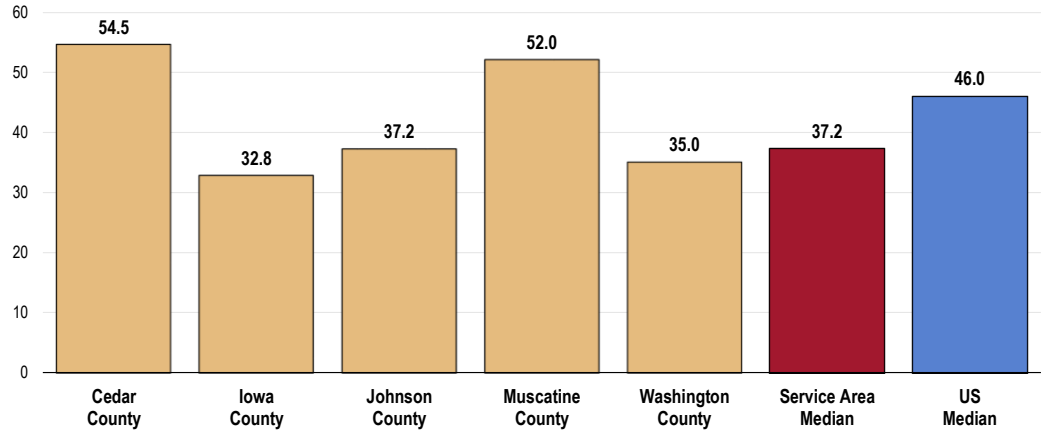
The service area reports an annual age-adjusted median stroke death rate of 37.2 per 100,000 population.

- Well below the US median rate.
- Locally highest in Cedar and Muscatine counties, both of which rank in the bottom quartile among peer counties.

Age-Adjusted Stroke Deaths

(Rate per 100,000 Persons)

Healthy People 2020 Target = 34.8 or Lower



Sources:
- National Vital Statistics System-Mortality (NVSS-M) Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Stroke death rates are calculated as the number of deaths assigned to ICD-10 codes I60-I69 per 100,000 population, age adjusted to the 2000 standard population. Death rates are calculated based on the sum of the resident populations for each of the data years involved (e.g. the denominator of a rate for 2008-2010 combined is the sum of the population estimates for 2008, 2009, and 2010). For census years (e.g. 2010), population counts enumerated as of April 1 are used. For all other years, populations estimates as of July 1 are used. Postcensal population estimates are used in rate calculations for years after a census year and match the data year vintage (e.g. July 1, 2011 resident population estimates from Vintage 2011 are used as the denominator for 2011 rates). Intercensal population estimates are used in rate calculations for the years between censuses (e.g. 1991-1999, 2001-2009). Race-specific population estimates for 1991 and later use bridged-race categories.
- Data Years: 2005-2011

Chronic Lower Respiratory Disease (CLRD)

Chronic Lower Respiratory Disease

Chronic lower respiratory diseases (CLRD) was the 3rd leading cause of death in the United States in 2010. In 2007-2009 11.8 million adults had been diagnosed with chronic obstructive pulmonary disease (COPD - the primary component of CLRD mortality). Previous research found that approximately equal numbers to those diagnosed with COPD had not yet been diagnosed. The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states.

- CITATION: Murphy SL, Xu JQ, Kochanek KD. Deaths: Final data for 2010. National vital statistics reports; vol 61 no 4. Hyattsville, MD: National Center for Health Statistics. 2013. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf

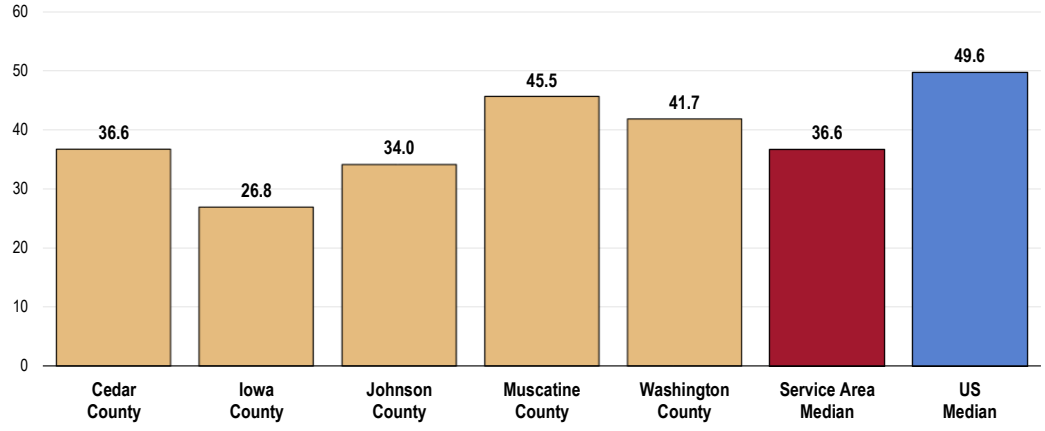
CLRD Deaths

The service area reports an annual age-adjusted median chronic lower respiratory disease (CLRD) death rate of 36.6 per 100,000 population.

- Well below the US median rate.
- Locally highest in Muscatine and Washington counties.

Age-Adjusted Chronic Lower Respiratory Disease (CLRD) Deaths

(Rate per 100,000 Persons)



Sources:
- National Vital Statistics System-Mortality (NVSS-M) Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- CLRD death rates are calculated as the number of deaths assigned to ICD-10 codes J40-J47 per 100,000 population, age adjusted to the 2000 standard population. Death rates are calculated based on the sum of the resident populations for each of the data years involved (e.g. the denominator of a rate for 2008-2010 combined is the sum of the population estimates for 2008, 2009, and 2010). For census years, April 1 census counts are used (e.g. 2010). For postcensal years, July 1 estimates from the postcensal Vintage that matches the data year are used (e.g. July 1, 2011 resident population estimates from Vintage 2011). For intercensal years, intercensal population estimates are used in rate calculations (e.g. 1991-1999, 2000-2009). Race-specific population estimates for 1991 and later use bridged-race categories.
- Data Years: 2005-2011

Unintentional Injury

Unintentional Injury Deaths (Including Motor Vehicle)

Motor Vehicle Deaths

Motor vehicle crash-related injuries are the leading cause of death among younger people aged 5 to 34 years. Motor vehicle crash fatality rates are especially high in rural areas and for residents of tribal lands, in part because of poor road maintenance, higher rates of alcohol impaired driving, lower rates of seat belt and child safety seat use, and less access to emergency response and trauma care.

- CITATION: National Prevention Council, National Prevention Strategy, Washington, DC: US Department of Health and Human Services, Office of the Surgeon General, 2011. Available at http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf

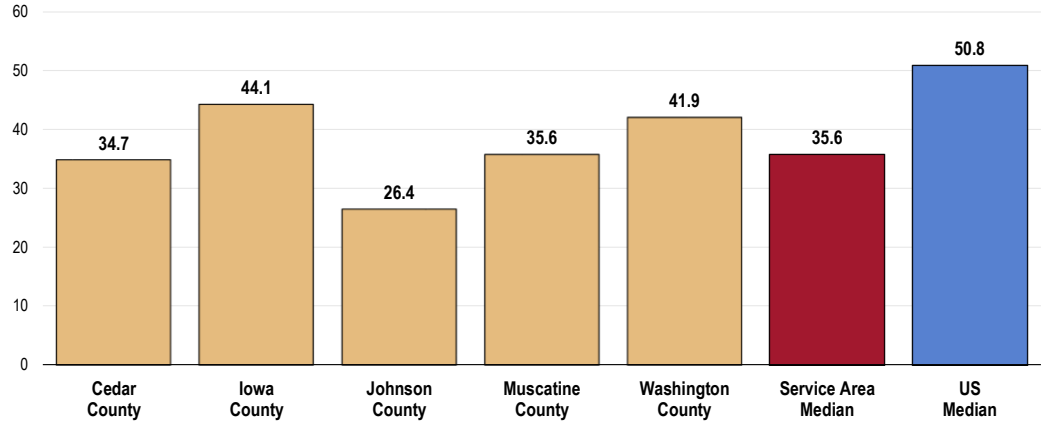
The service area reports an annual age-adjusted median unintentional injury death rate (including motor vehicle accidents) of 35.6 per 100,000 population.

- Well below the US median rate.
- Locally highest in Iowa and Washington counties.

Age-Adjusted Unintentional Injury Deaths, Including Motor Vehicle

(Rate per 100,000 Persons)

Healthy People 2020 Target = 36.0 or Lower



Sources:
- National Vital Statistics System-Mortality (NVSS-M) Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse. Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Unintentional injury death rates are calculated as the number of deaths assigned to ICD-10 codes V01–X59, Y85–Y86 per 100,000 population, age adjusted to the 2000 standard population. Death rates are calculated based on the sum of the resident populations for each of the data years involved (e.g. the denominator of a rate for 2008-2010 combined is the sum of the population estimates for 2008, 2009, and 2010). For census years (e.g. 2010), population counts enumerated as of April 1 are used. For all other years, populations estimates as of July 1 are used. Postcensal population estimates are used in rate calculations for years after a census year and match the data year vintage (e.g. July 1, 2011 resident population estimates from Vintage 2011 are used as the denominator for 2011 rates). Intercensal population estimates are used in rate calculations for the years between censuses (e.g. 1991-1999, 2001-2009). Race-specific population estimates for 1991 and later use bridged-race categories.
- Data Years: 2005-2011

Unintentional Injury Deaths (Excluding Motor Vehicle)

Injury

Unintentional injuries were the 5th leading cause of death in the United States in 2010. Unintentional injuries are the leading cause of death for Americans ages 1 to 44, as well as a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status.

- CITATION: Murphy SL, Xu JQ, Kochanek KD. Deaths: Final data for 2010. National vital statistics reports; vol 61 no 4. Hyattsville, MD: National Center for Health Statistics. 2013. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf

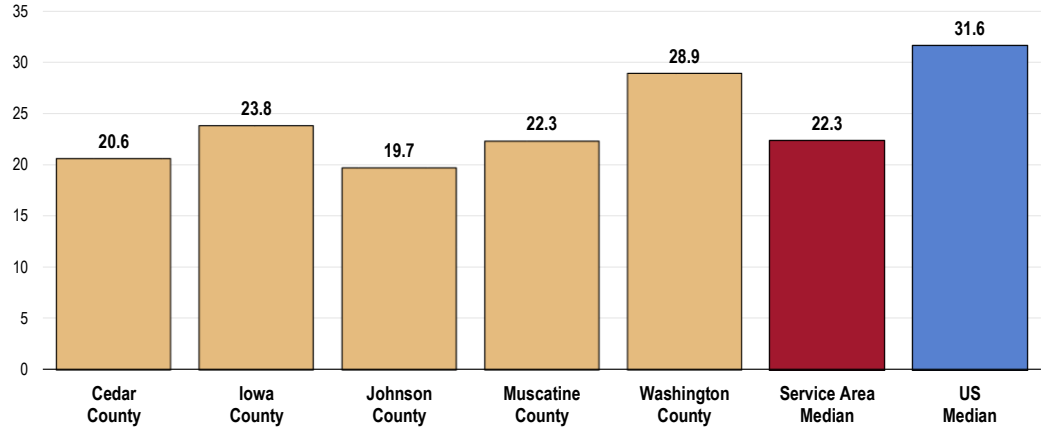
The service area reports an annual age-adjusted median unintentional injury death rate (excluding motor vehicle accidents) of 22.3 per 100,000 population.

- Well below the US median rate.
- Locally highest in Washington and Iowa counties.

Age-Adjusted Unintentional Injury, Excluding Motor Vehicle

(Rate per 100,000 Persons)

Healthy People 2020 Target = 23.6 or Lower



Sources:
- National Vital Statistics System-Mortality (NVSS-M) Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Rates are calculated based on sum of data year populations from the Vintage matching the data years. For example, for rates of data years 2004-2006 combined, the sum of 2004 population from Vintage 2004, 2005 population from Vintage 2005, and 2006 population from Vintage 2006 are used as denominator. Death due to all accidents (unintentional injuries) not related to motor vehicle accidents, ICD-9 codes: E800-E807 and E826-E949. ICD-10 codes: V01–V99, W00-W99, X00-X59, Y85, Y86 minus Motor Vehicle Injury codes. This Indicator uses Age-Adjustment Groups: <1, 1-4, 5-14, 15-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75-84, 85+
- Data Years: 2005-2011

Motor Vehicle Deaths

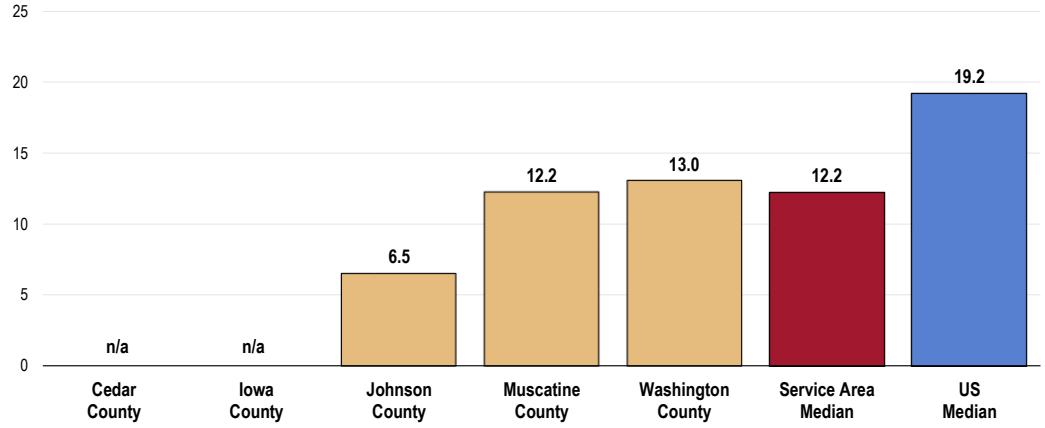
The service area reports an annual age-adjusted median motor vehicle accident death rate of 12.2 per 100,000 population.

- Well below the US median rate.
- Locally highest in Muscatine and Washington counties (rates not available in Cedar and Iowa counties).

Age-Adjusted Motor Vehicle Deaths

(Rate per 100,000 Persons)

Healthy People 2020 Target = 12.4 or Lower



Sources:
- National Vital Statistics System-Mortality (NVSS-M) Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- ICD-10 codes V02-V04 (.1, .9), V09.2, V12-V14 (.3-.9), V19 (.4-.6), V20-V28 (.3-.9), V29-V79 (.4-.9), V80 (.3-.5), V81.1, V82.1, V83-V86 (.0-.3), V87 (.0-.8), V89.2 FOR MULTIPLE DATA YEARS: Death rates are calculated based on the sum of the resident populations for each of the data years involved (e.g. the denominator of a rate for 2008-2010 combined is the sum of the population estimates for 2008, 2009, and 2010). Race-specific population estimates for 1991 and later use bridged-race categories.
- Data Years: 2005-2011

Alzheimer's Disease

Alzheimer's Disease

Alzheimer's disease is the 6th leading cause of death among adults aged 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans aged 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.

- CITATION: Murphy SL, Xu JQ, Kochanek KD. Deaths: Final data for 2010. National vital statistics reports; vol 61 no 4. Hyattsville, MD: National Center for Health Statistics. 2013. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf

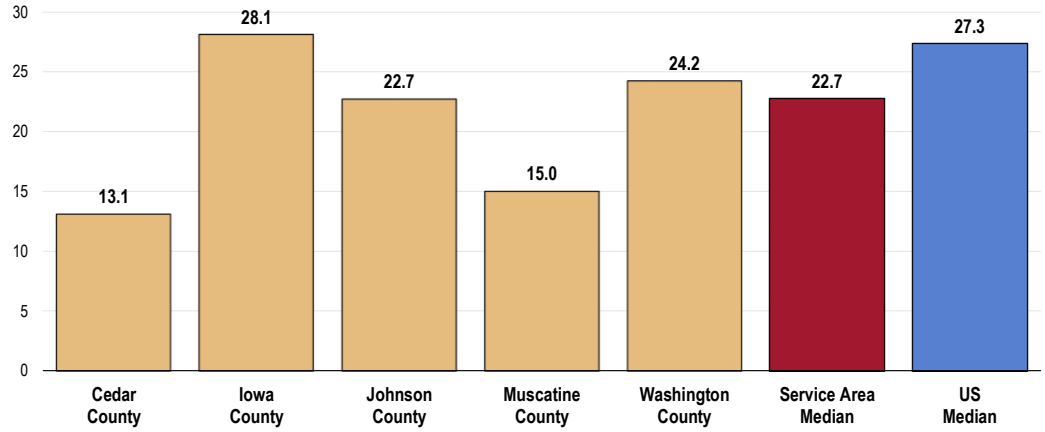
Alzheimer's Disease Deaths

The service area reports an annual age-adjusted median Alzheimer's disease death rate of 22.7 per 100,000 population.

- Below the US median rate.
- Locally highest in Iowa County.

Age-Adjusted Alzheimer's Disease Deaths

(Rate per 100,000 Persons)



Sources:
- National Vital Statistics System-Mortality (NVSS-M) Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Alzheimer's disease death rates are calculated as the number of deaths assigned to ICD-10 code G30 per 100,000 population, age adjusted to the 2000 standard population. Death rates are calculated based on the sum of the resident populations for each of the data years involved (e.g. the denominator of a rate for 2008-2010 combined is the sum of the population estimates for 2008, 2009, and 2010). For census years, April 1 census counts are used (e.g. 2010). For postcensal years, July 1 estimates from the postcensal Vintage that matches the data year are used (e.g. July 1, 2011 resident population estimates from Vintage 2011). For intercensal years, intercensal population estimates are used in rate calculations (e.g. 1991-1999, 2000-2009). Race-specific population estimates for 1991 and later use bridged-race categories.
- Data Years: 2005-2011

Prevalence of Alzheimer's Disease/Dementia

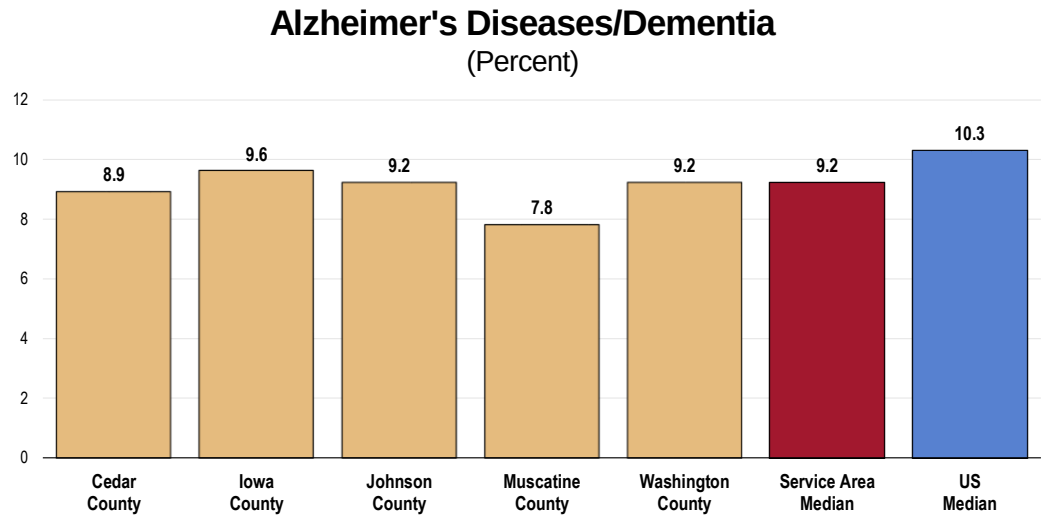
Dementia

Dementia is an umbrella term for a group of cognitive disorders typically characterized by memory impairment, as well as marked difficulty in the domains of language, motor activity, object recognition, and disturbance of executive function – the ability to plan, organize, and abstract. Generally speaking, dementia is an illness of older adults, which suggests that as successive cohorts of our population live longer, the urgency to better address dementia increases. Alzheimer's disease is perhaps the most common form of dementia, although several others exist. As many as 5 million Americans have Alzheimer's disease. Younger people may get Alzheimer's disease, but it is much less common than in older adults. The likelihood of developing Alzheimer's doubles about every five years after age 65.

- CITATION: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. Available at http://www.cdc.gov/mentalhealth/basics/mental-illness/dementia.htm

A service area median of 9.2% of the population suffers from Alzheimer's disease/dementia.

- Below the US median percentage.
- Favorably low in Muscatine County.



Sources:
- Medicare Chronic Conditions Report, Center of Medicare and Medicaid Services
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Chronic conditions for adults age 65 and older, were identified through Medicare administrative claims. Medicare beneficiaries were considered to have a chronic condition if the CMS administrative data had a claim indicating that they were receiving a service or treatment for the specific condition. Beneficiaries may have more than one of the chronic conditions listed. Data is suppressed if there are fewer than 11 Medicare beneficiaries in the county.
- Data Years: 2012

Diabetes

Diabetes

Diabetes affects an estimated 23.6 million people in the United States and is the 7th leading cause of death. Diabetes lowers life expectancy by up to 15 years and increases the risk of heart disease by 2 to 4 times. Diabetes is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness. In addition to these human costs, the estimated total financial cost of diabetes in the United States in 2007 was $174 billion, which includes the costs of medical care, disability, and premature death.

- CITATION: US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at http://www.healthypeople.gov

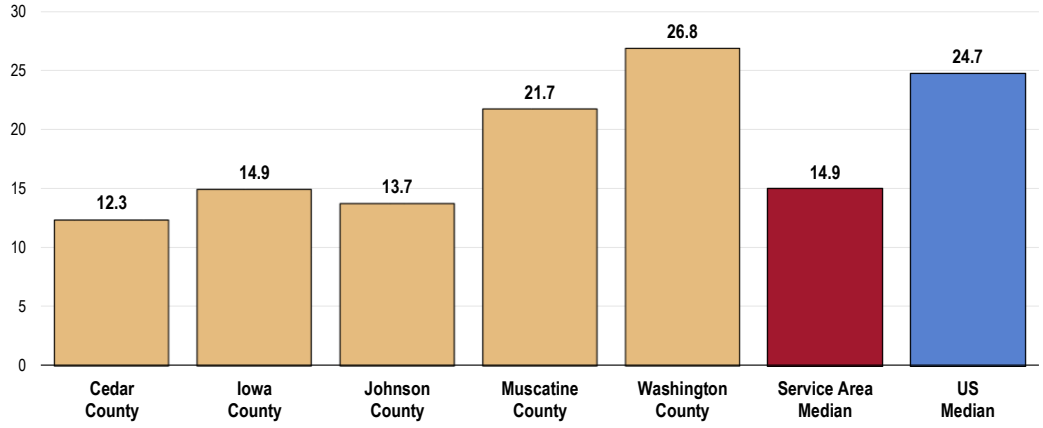
Diabetes Deaths

The service area reports an annual age-adjusted median diabetes death rate of 14.9 per 100,000 population.

- Well below the US median rate.
- Locally highest in Washington County.

Age-Adjusted Diabetes Deaths

(Rate per 100,000 Persons)



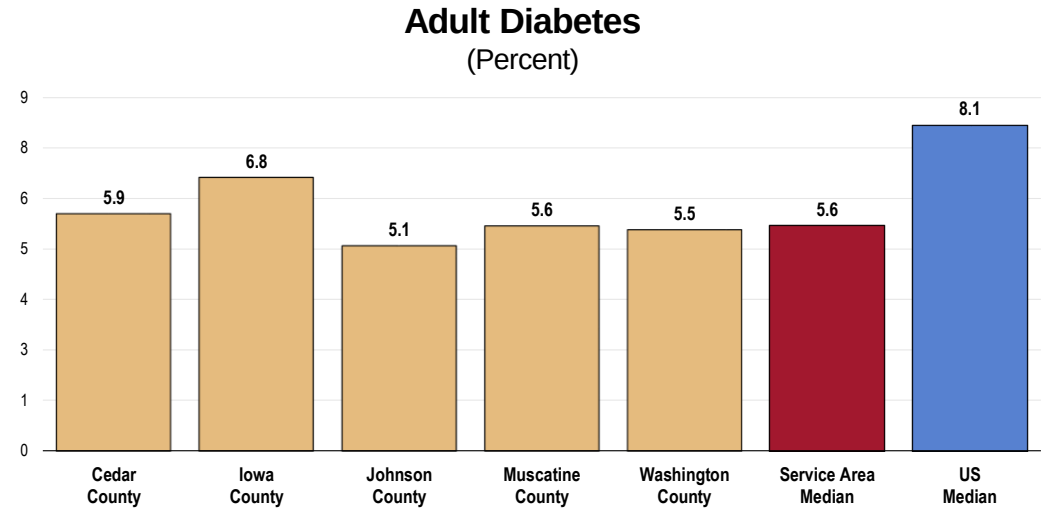
Sources:
- National Vital Statistics System-Mortality (NVSS-M) Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Number of deaths due to diabetes (ICD-10 codes E10 - E14) reported as the underlying cause of death. FOR MULTIPLE DATA YEARS: Death rates are calculated based on the sum of the resident populations for each of the data years involved (e.g. the denominator of a rate for 2008-2010 combined is the sum of the population estimates for 2008, 2009, and 2010). For census years, April 1 census counts are used (e.g. 2010). For postcensal years, July 1 estimates from the postcensal Vintage that matches the data year are used (e.g. July 1, 2011 resident population estimates from Vintage 2011). For intercensal years, intercensal population estimates are used in rate calculations (e.g. 1991-1999, 2000-2009). Race-specific population estimates for 1991 and later use bridged-race categories.
- Data Years: 2005-2011

Adult Diabetes Prevalence

A service area median of 5.6% of the population suffers from diabetes.

- Below the US median percentage.
- Locally highest in Cedar and Iowa counties.



Sources:
- National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation. Diabetes Interactive Atlas
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- The prevalence of diagnosed diabetes was estimated for adults age 20 and over, using data from CDC's Behavioral Risk Factor Surveillance System (BRFSS), and data from the US Census Bureau's Population Estimates Program. Respondents were considered to have diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" The county-level estimates using modern small area estimation techniques. This approach employs a statistical model that "borrows strength" in making an estimate for one county from BRFSS data collected in other counties. Three years of data were used to improve the precision of the year-specific county-level estimates of diagnosed diabetes. For all years, rates were age adjusted by calculating age specific rates for the following three age groups, 20–44, 45–64, 65+. A weighted sum based on the distribution of these three age groups from the 2000 census was then used to adjust the rates by age. CITATION: More information on the methodology can be found at http://www.cdc.gov/diabetes/atlas/countydata/County_Methods.html#countylevelestimates
- Data Years: 2005-2011

Kidney Disease

Kidney Disease

Chronic kidney disease (CKD) was the 8th leading cause of death in the United States in 2010. More than 10% of people, or more than 20 million, aged 20 years or older in the United States have CKD. CKD is an important risk factor for cardiovascular disease, including heart attacks, heart failure, heart rhythm disturbances, and strokes. CKD and end stage renal disease (ESRD) are very costly to treat. Nearly 25 percent of the Medicare budget is used to treat people with CKD and ESRD.

- CITATION: Murphy SL, Xu JQ, Kochanek KD. Deaths: Final data for 2010. National vital statistics reports; vol 61 no 4. Hyattsville, MD: National Center for Health Statistics. 2013. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf

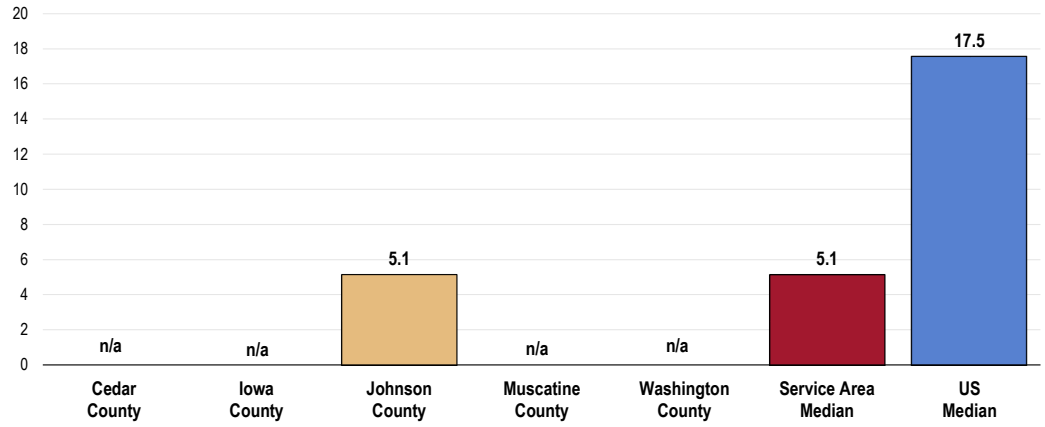
Chronic Kidney Disease Deaths

The service area (Johnson County data only) reports an annual age-adjusted median chronic kidney disease death rate of 5.1 per 100,000 population.

- Well below the US median rate.

Age-Adjusted Chronic Kidney Disease Deaths

(Rate per 100,000 Persons)



Sources:
- National Vital Statistics System-Mortality (NVSS-M) Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- CKD death rates are calculated as the number of deaths assigned to ICD-10 codes N00–N07, N17–N19, N25–N27 per 100,000 population, age adjusted to the 2000 standard population. Death rates are calculated based on the sum of the resident populations for each of the data years involved (e.g. the denominator of a rate for 2008-2010 combined is the sum of the population estimates for 2008, 2009, and 2010). For census years, April 1 census counts are used (e.g. 2010). For postcensal years, July 1 estimates from the postcensal Vintage that matches the data year are used (e.g. July 1, 2011 resident population estimates from Vintage 2011). For intercensal years, intercensal population estimates are used in rate calculations (e.g. 1991-1999, 2000-2009). Race-specific population estimates for 1991 and later use bridged-race categories.
- Data Years: 2005-2011

Asthma

Asthma

Currently in the United States, more than 23 million people have asthma. The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Annual healthcare expenditures for asthma alone are estimated at $20.7 billion.

- CITATION: US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at http://www.healthypeople.gov

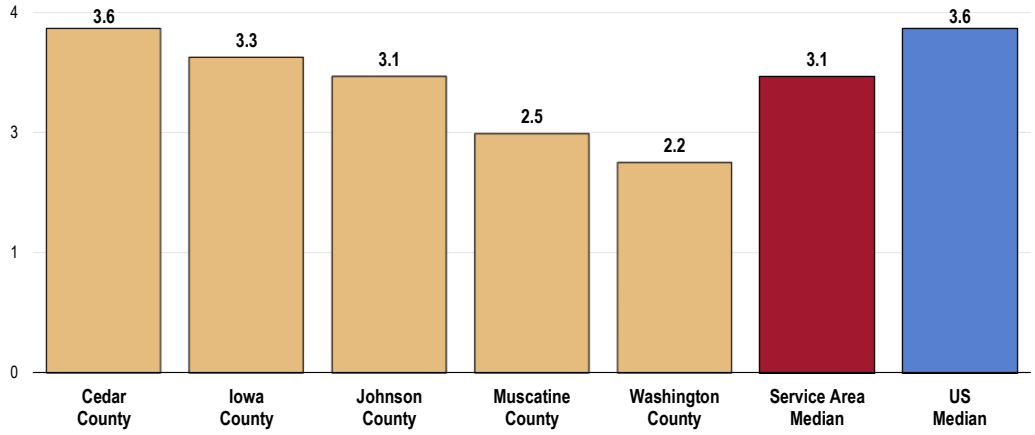
Older Adult Asthma Prevalence

A service area median of 3.1% of the population suffers from asthma.

- Below the US median percentage.
- Locally highest in Cedar and Iowa counties.

Older Adult Asthma Prevalence

(Percent)



Sources:
- Medicare Chronic Conditions Report, Center of Medicare and Medicaid Services.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Chronic conditions for adults age 65 and older, were identified through Medicare administrative claims. Medicare beneficiaries were considered to have a chronic condition if the CMS administrative data had a claim indicating that they were receiving a service or treatment for the specific condition. Beneficiaries may have more than one of the chronic conditions listed. Data is suppressed if there are fewer than 11 Medicare beneficiaries in the county.
- Data Years: 2012

HIV & Sexually Transmitted Diseases

Sexually Transmitted Diseases (STDs)

STDs

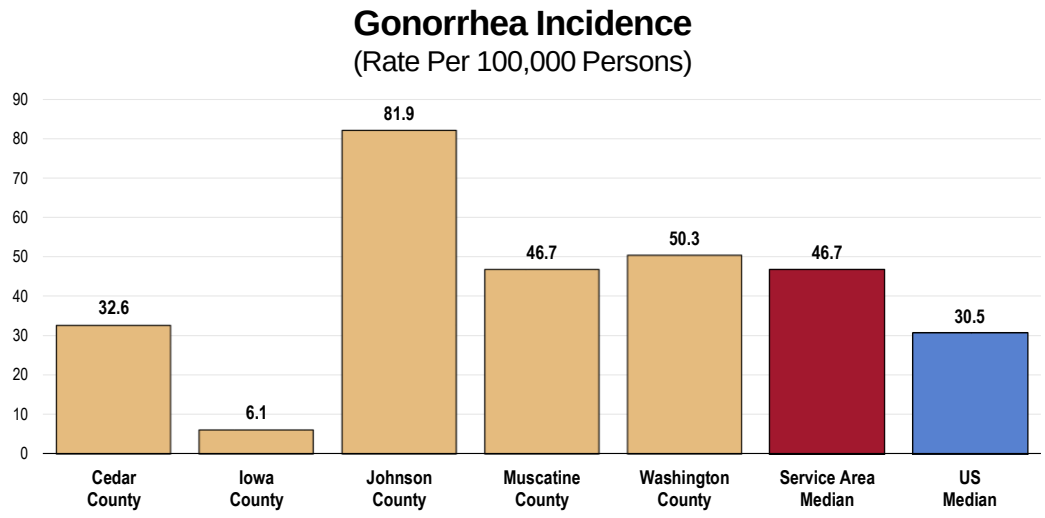
The Centers for Disease Control and Prevention (CDC) estimates that there are approximately 19 million new sexually transmitted disease (STD) infections each year—almost half of them among young people ages 15 to 24. The cost of STDs to the US healthcare system is estimated to be as much as $15.9 billion annually. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. CDC estimates that undiagnosed and untreated STDs cause at least 24,000 women in the United States each year to become infertile.

- CITATION: US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at http://www.healthypeople.gov

Gonorrhea Incidence

The service area reports a median gonorrhea incidence rate of 46.7 per 100,000 persons.

- Higher than the national median.
- Locally highest in Johnson County; note that Cedar, Muscatine, and Washington counties are in the bottom quartile among their peers.



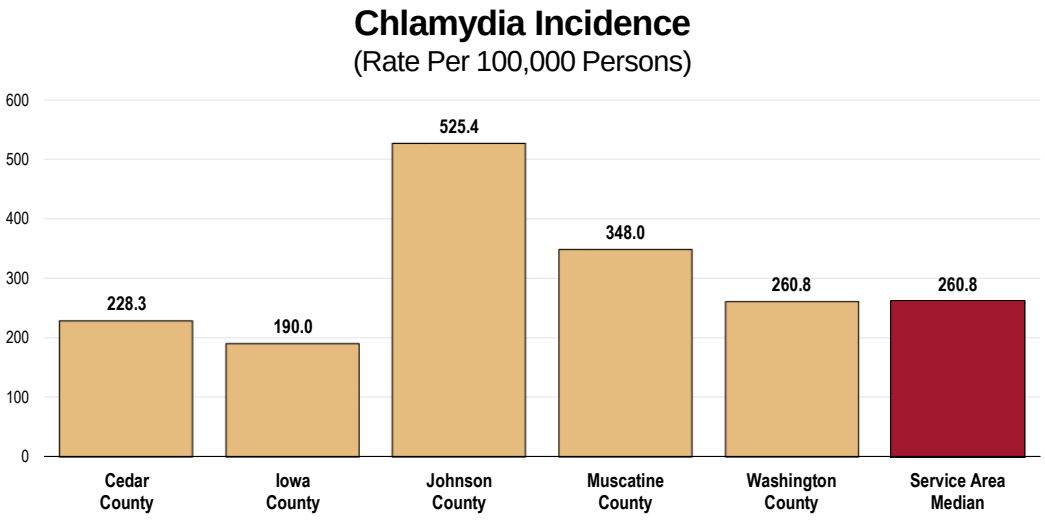
Sources:
- Centers for Disease Control and Prevention (CDC) NCHHSTP Atlas.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Nationally notifiable STD surveillance data are collected and compiled from reports sent by the STD control programs and health departments in all 50 states, the District of Columbia, selected cities, and US dependencies. Rates per 100,000 population were calculated for each STD. The population denominators used to compute rates for the 50 states and the District of Columbia were based on the National Center for Health Statistics (NCHS) bridged-race population counts for 2000–2011.
- Data Years: 2012

Chlamydia Incidence

The service area reports a median chlamydia incidence rate of 260.8 per 100,000 persons.

- Locally highest in Johnson and Muscatine counties.



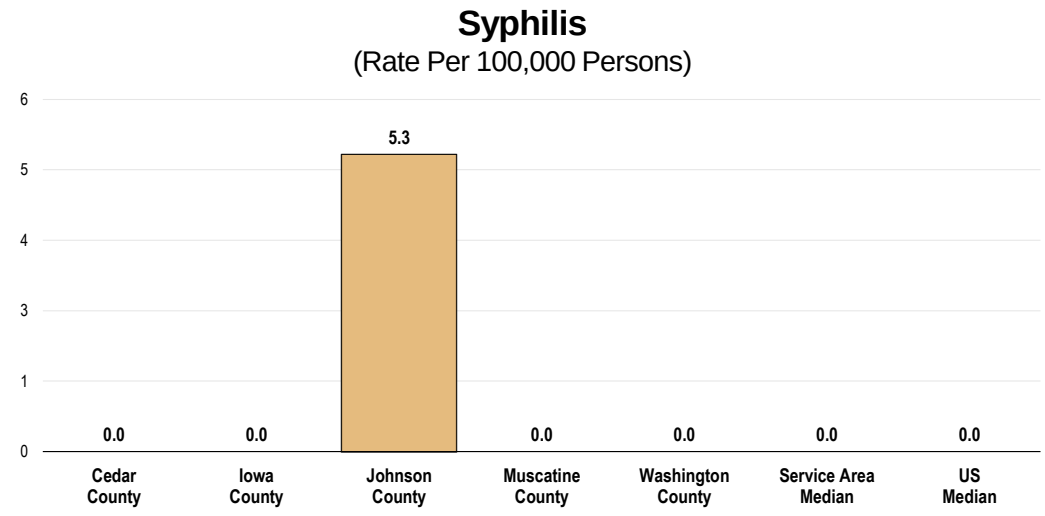
Sources:
- Centers for Disease Control and Prevention (CDC) NCHHSTP Atlas.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Nationally notifiable STD surveillance data are collected/compiled from reports sent by the STD control programs and health departments in all 50 states,the District of Columbia, selected cities, and US dependencies. Rates per 100,000 population were calculated for each STD. The population denominators used to compute rates for the 50 states and the District of Columbia were based on the National Center for Health Statistics (NCHS) bridged-race population counts for 2000–2011.
- Data Years: 2012

Syphilis Incidence

Incidence of syphilis is only noted in Johnson County, as shown below.

- The county ranks in the bottom quartile among peer counties for syphilis incidence.



Sources:
- Centers for Disease Control and Prevention (CDC) NCHHSTP Atlas.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Nationally notifiable STD surveillance data are collected/compiled from reports sent by the STD control programs and health departments in all 50 states,the District of Columbia, selected cities, and US dependencies. Rates per 100,000 population were calculated for each STD. The population denominators used to compute rates for the 50 states and the District of Columbia were based on the National Center for Health Statistics (NCHS) bridged-race population counts for 2000–2011.
- Data Years: 2012

HIV

HIV

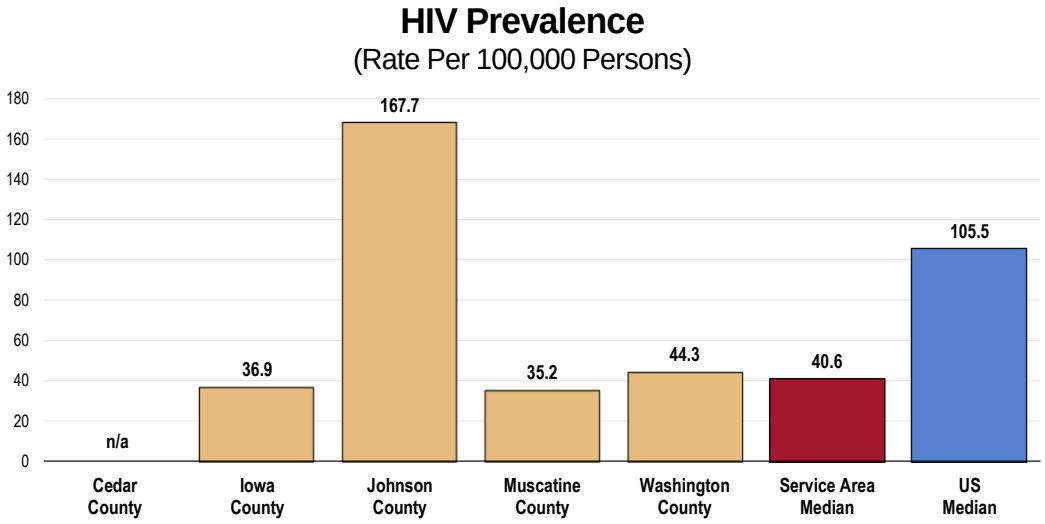
The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 out of 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

- CITATION: US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at http://www.healthypeople.gov

HIV Prevalence

The service area reports a median HIV prevalence rate of 40.6 per 100,000 persons.

- Well below the national median.
- Locally highest in Johnson County (note that data are not available for Cedar County).



Sources:
- Centers for Disease Control and Prevention (CDC) NCHHSTP Atlas.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Rates of persons living with diagnosed HIV infection have been statistically adjusted to account for reporting delays, but not for incomplete reporting. The population denominators used to compute the rates for the 50 states, the District of Columbia, and Puerto Rico were based on the Vintage 2011 file from the US Census Bureau.
- Data Years: 2011

Birth Outcomes & Risks

Preterm Births

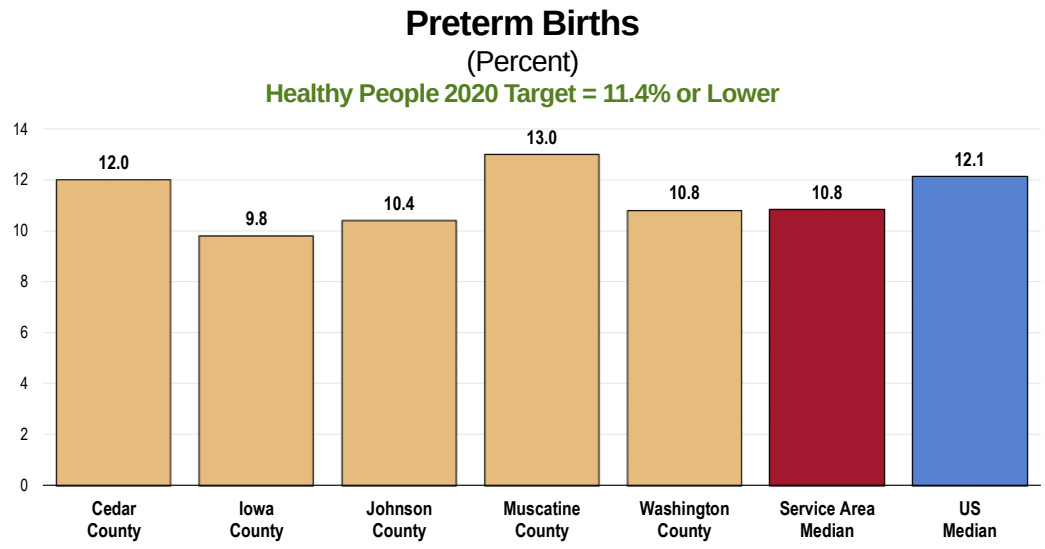
Preterm Births

In 2012, preterm birth affected more than 450,000 babies—that's 1 of every 9 infants born in the United States. Preterm birth is the birth of an infant before 37 weeks of pregnancy. Preterm-related causes of death together accounted for 35% of all infant deaths in 2010, more than any other single cause. Preterm birth is also a leading cause of long-term neurological disabilities in children. Preterm birth costs the US healthcare system more than $26 billion in 2005.

- CITATION: Centers for Disease Control and Prevention, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. Available at http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm

A service area median of 10.8% of births are preterm.

- Better than the US median percentage.
- Locally highest in Cedar and Muscatine counties, both of which are in the bottom quartile among their peer counties.



Sources:
- National Vital Statistics System-Natality (NVSS-N) Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Estimates are based on gestational age information reported on the birth certificate. The primary measure used to determine the gestational age of the newborn is the interval between the first day of the mother's last normal menstrual period (LMP) and the date of birth. It is subject to error for several reasons, including imperfect maternal recall or misidentification of the LMP because of postconception bleeding, delayed ovulation, or intervening early miscarriage. These data are edited for LMP-based gestational ages that are clearly inconsistent with the infant's plurality and birthweight, but reporting problems for this item persist and may occur more frequently among some subpopulations and among births with shorter gestations. The 1989 revision of the US Standard Certificate of Live Birth includes an item, "clinical estimate of gestation" and the 2003 revision of the birth certificate includes a comparable item "Obstetric estimate of gestation". The clinical or obstetric estimate was compared with length of gestation computed using the LMP when the latter appears to be inconsistent with birthweight. This was done for normal weight births of apparently short gestations and very low birth weight births reported to be full term. For those births, the clinical or obstetric estimate was used if it was compatible with the reported birth weight. The clinical or gestation estimate was also used if the LMP date was not reported. In 2010, the period of gestation for approximately 6 percent of all births was based on the clinical or obstetric estimate of gestation. Of these, 98 percent of the records used the clinical or obstetric estimate of gestation because the LMP date was missing. The remaining 2% of records used the clinical or obstetric estimate of gestation because it was compatible with the reported birth weight whereas the LMP-based gestation was not.
- Data Years: 2006-2012

Low Birth Weight

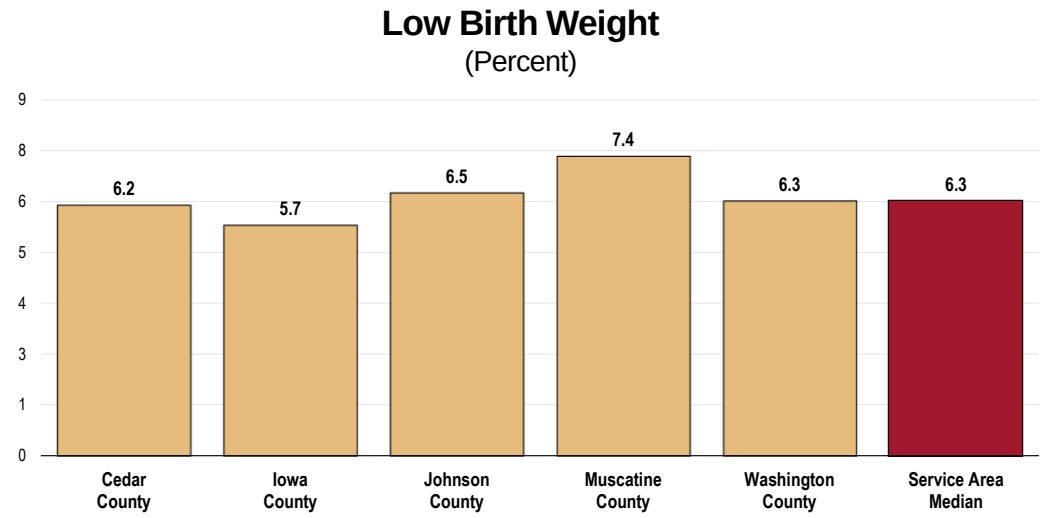
Low Birth Weight

Low birth weight (less than 2,500 grams) is the single most important factor affecting neonatal mortality and a significant determinant of post neonatal mortality. Low birth weight infants who survive are at increased risk for health problems ranging from neurodevelopmental disabilities to respiratory disorders.

- CITATION: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition and Physical Activity. Available at http://www.cdc.gov/pednss/how_to/interpret_data/case_studies/low_birthweight/what.htm

A median total of 6.3% of service area births are reported to be low birth weight.

- Locally highest in Muscatine County.



Sources:
- National Vital Statistics System-Natality (NVSS-N) Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Estimates are based on birthweight information reported on the birth certificate. Birthweight is reported in some areas in pounds and ounces, and in other areas in grams. In order to correspond to international and national benchmarks, the metric system is used in tabulating and presenting the statistics. Equivalents of the gram weights in terms of pounds and ounces are as follows: less than 1,500 grams = 3 lb 4 oz or less, 1,500-2,499 grams = 3 lb 5 oz-5 lb 8 oz, 2,500 grams or more = 5 lb 9 oz or more.
- Data Years 2006-2012

Teen Births

Teen Pregnancy

Teen pregnancy and childbearing bring substantial social and economic costs through immediate and long-term impacts on teen parents and their children.

In 2011, teen pregnancy and childbirth accounted for at least $9.4 billion in costs to US taxpayers for increased healthcare and foster care, increased incarceration rates among children of teen parents, and lost tax revenue because of lower educational attainment and income among teen mothers.

Pregnancy and birth are significant contributors to high school dropout rates among girls. Only about 50% of teen mothers receive a high school diploma by 22 years of age, versus approximately 90% of women who had not given birth during adolescence.

The children of teenage mothers are more likely to have lower school achievement and drop out of high school, have more health problems, be incarcerated at some time during adolescence, give birth as a teenager, and face unemployment as a young adult.

These effects remain for the teen mother and her child even after adjusting for those factors that increased the teenager's risk for pregnancy, such as growing up in poverty, having parents with low levels of education, growing up in a single-parent family, and having poor performance in school.

- CITATION: Centers for Disease Control and Prevention, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion Available at http://www.cdc.gov/teenpregnancy/aboutteenpreg.htm#The Importance of Prevention

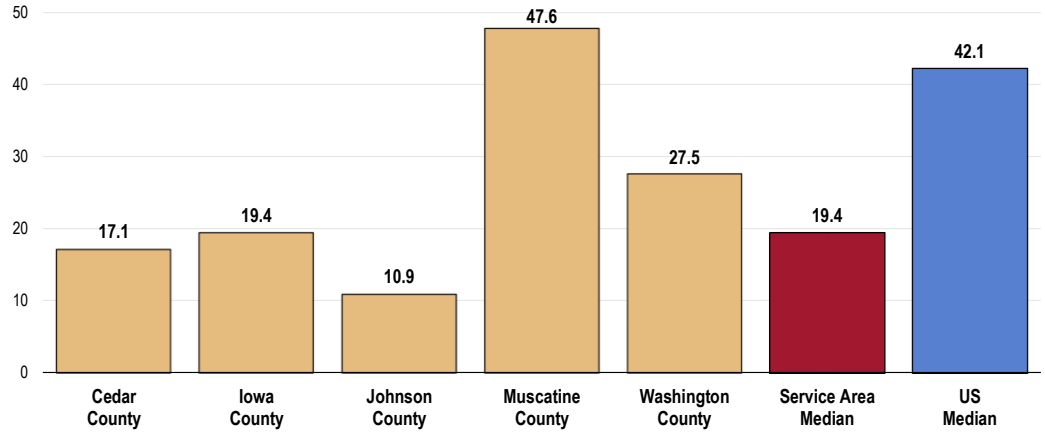
The service area reports a median teen birth rate of 19.4 per teens age 15-19.

- Much lower than the national median rate.
- Locally highest in Muscatine County, which ranks in the bottom quartile among its peer counties.

Teen Births

(Rate Per 1,000 Females Age 15-19 Years)

Healthy People 2020 Target = 36.2 or Lower



Sources:
- National Vital Statistics System-Natality (NVSS-N) Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- FOR MULTIPLE DATA YEARS: Birth rates are calculated based on the sum of the resident populations for each of the data years involved (e.g. the denominator of a rate for 2008-2010 combined is the sum of the population estimates for 2008, 2009, and 2010). For census years, April 1 census counts are used (e.g. 2010). For postcensal years, July 1 estimates from the postcensal Vintage that matches the data year are used (e.g. July 1, 2011 resident population estimates from Vintage 2011). For intercensal years, intercensal population estimates are used in rate calculations (e.g. 1991-1999, 2000-2009). Race-specific population estimates for 1991 and later use bridged-race categories. Rates based on fewer than 20 births are considered unreliable and are not shown. US natality files are compiled annually by CDC's National Center for Health Statistics and include demographic information, such as maternal age, race, and Hispanic ethnicity for all births in all 50 states and the District of Columbia.
- Data Years: 2005-2011

Health Behaviors

Nutrition, Physical Activity & Weight

Nutrition

Limited Access To Healthy Food

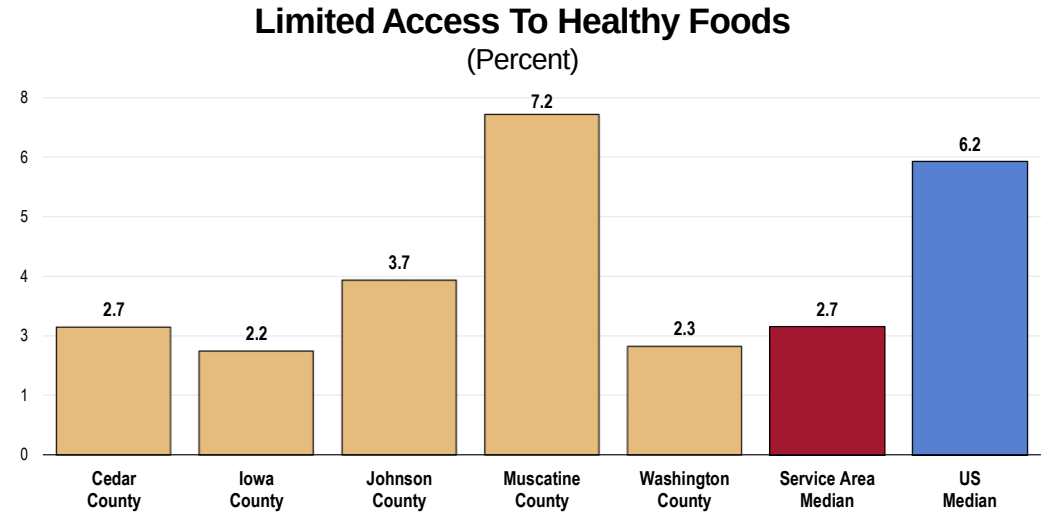
Supporting Healthy Choices

Low-income and minority neighborhoods are less likely to have access to recreational facilities and full-service grocery stores and more likely to have higher concentrations of retail outlets for tobacco, alcohol, and fast foods.

- CITATION: National Prevention Council, National Prevention Strategy, Washington, DC: US Department of Health and Human Services, Office of the Surgeon General, 2011. Available at http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf

A median total of 2.7% of service area residents have limited access to healthy foods.

- Better than the US median percentage.
- Locally highest in Muscatine County, which ranks in the bottom quartile among peer counties.



Sources:
- Economic Research Service (ERS), US Department of Agriculture (USDA). Food Access Research Atlas
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Limited access to healthy foods captures the proportion of the population who are low income and do not live close to a grocery store. Living close to a grocery store is defined differently in rural and non-rural areas; in rural areas, it means living less than 10 miles from a grocery store whereas in non-rural areas, it means less than 1 mile. Low income is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size. Stores met the definition of a supermarket or large grocery store if they reported at least $2 million in annual sales and contained all the major food departments found in a traditional supermarket, including fresh meat and poultry, dairy, dry and packaged foods, and frozen foods. This measure of food insecurity takes both proximity to healthy foods and income into account. However access to or use of food stamps among eligible families is not considered.
- Data Years: 2010

Physical Activity

Adult Physical Inactivity

Physical Activity

More than 80 percent of adults do not meet the guidelines for both aerobic and muscle-strengthening activities. Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability.

- CITATION: US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at http://www.healthypeople.gov

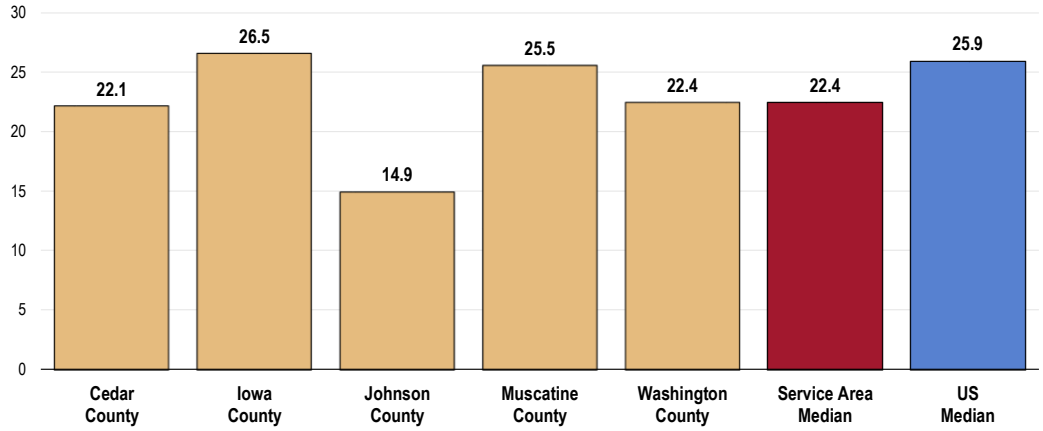
A median total of 22.4% of service area residents report physical inactivity.

- More favorable than the US median percentage.
- Locally highest in Iowa and Muscatine counties.

Adult Physical Inactivity

(Percent)

Healthy People 2020 Target = 32.6% or Lower



Sources:
- Behavioral Risk Factor Surveillance System (BRFSS). Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Based on the BRFSS question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?" Adults are classified as not engaging in leisure time physical activity if they answer "never" or "Unable to do this type of activity" to both the vigorous and moderate physical activity questions. In 2011, two methodological refinements were made to the Behavioral Risk Factor Surveillance System (BRFSS). The first was to expand the sample to include data received from cell phone users. This change was made to reflect the population better. The second change was to modify the statistical method to weight BRFSS survey data. The new approach simultaneously adjusts survey respondent data to known proportions of demographics such as age, race and ethnicity, and gender. Prior to 2011, the weighting method was post stratification, while in 2011 it is raking. Raking is better able to account for more demographic characteristics and multiple sampling frames. Because of these changes, data collected in 2011 and later cannot be appropriately compared to previous data, although new results should better reflect the health status of the United States. In order to create multi-year estimates, two changes were made to the new data. First, respondents who only have cell phones were removed. Second, weights were created specifically for this purpose using the post stratification method. Those two changes make the 2011 data similar to the pre-2011 data and allowed multi-year estimates to be created, even though these estimates will not be as representative of the US population as the single-year estimates using 2011 data without these changes. The BRFSS estimates are age adjusted to the 2000 US D34 standard population (age groups: 18-44, 45-54, 55-64, 65-74, 75+)
- Data Years: 2006-2012

Access To Physical Activity

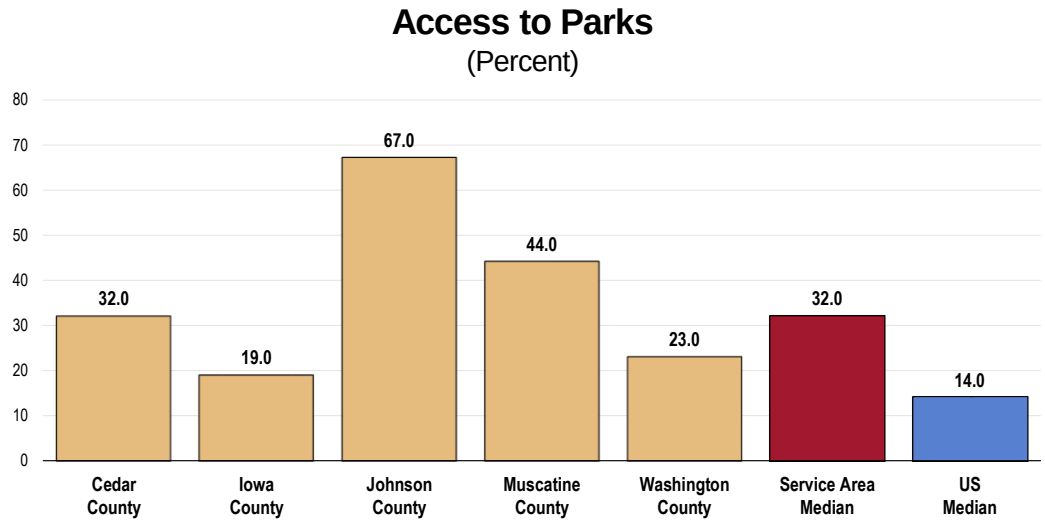
Access to Physical Activity

Safe, accessible, and affordable places for physical activity (e.g., parks, playgrounds, community centers, schools, fitness centers, trails, gardens) can increase activity levels.

- CITATION: National Prevention Council, National Prevention Strategy, Washington, DC: US Department of Health and Human Services, Office of the Surgeon General, 2011. Available at http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf

A median total of 32.0% of service area residents have access to parks.

- Much better than the national median.
- Locally highest in Johnson and Muscatine counties.

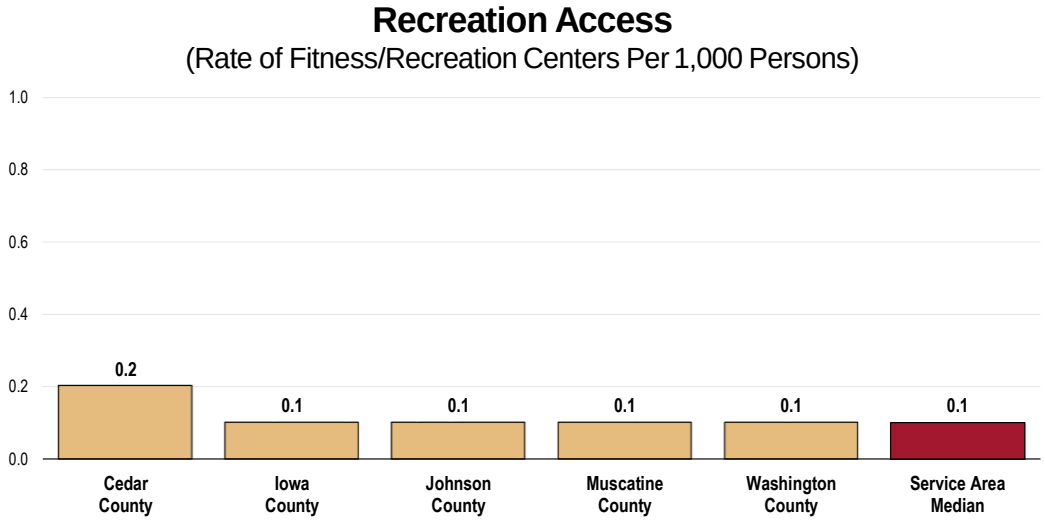


Sources:
- Centers for Disease Control and Prevention. National Environmental Public Health Tracking Network. Available at: www.cdc.gov/ephtracking
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Park data are from NAVTEQ, provider of Geographic Information Systems (GIS) data. The number of people within a buffer of ½ mile radius of a park was determined at the census block level, aggregated to county level, then divided by the total number of people in that county. If the half a mile buffer crossed county or state boundary, the population residing within this buffer is estimated and attributed to the county within which the population resides. These estimates are not attributed to the county within which the park is located.
- Data Years: 2010

A median rate of 0.1 per 1,000 service area persons have recreation access.

- Locally highest in Cedar County.



Sources:
- Economic Research Service (ERS), US Department of Agriculture (USDA). Food Access Research Atlas
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Number of "fitness and recreation centers" in a county divided by number of county residents, where "fitness and recreation centers" (defined by North American Industry Classification System (NAICS) code 713940) are establishments primarily engaged in operating fitness and recreational sports facilities featuring exercise and other active physical fitness conditioning or recreational sports activities, such as swimming, skating, or racquet sports. The method used to identify recreational facilities in the County Business Patterns data does not include YMCAs and intramural/amateur sports clubs, both of which may be important venues for physical activity, especially for low- and middle-income community members. Furthermore, this measure does not account for the opportunity to engage in fitness activities in parks or other public areas.
- Data Years: 2010

Weight

Adult Obesity

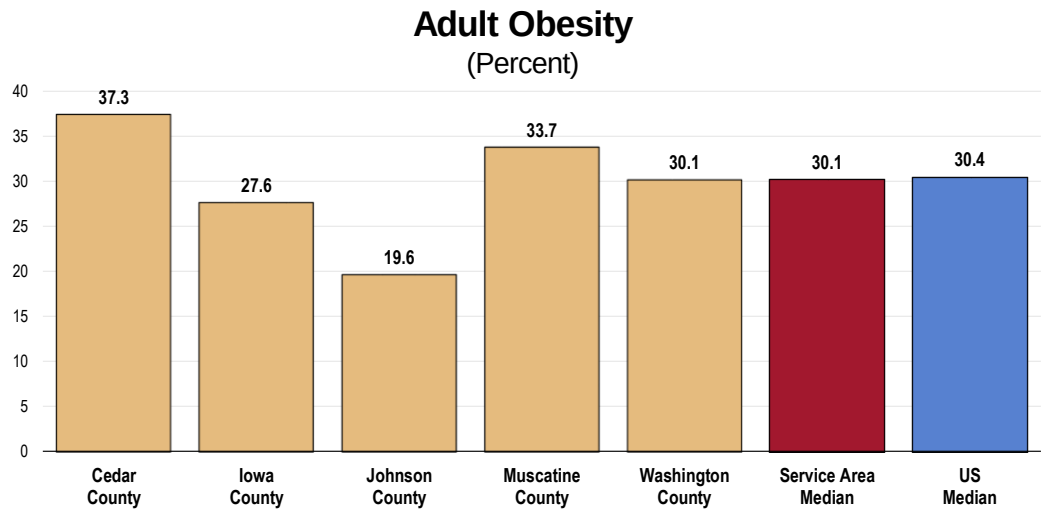
Obesity

Obesity is common, serious and costly. In 2009-2010, more than one-third of US adults (35.7%) were obese. The estimated annual medical cost of obesity in the US was $147 billion in 2008 US dollars; the medical costs for people who are obese were $1,429 higher than those of normal weight.

- CITATION: Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion. Available at www.cdc.gov/obesity/data/adult.html

A median total of 30.1% of service area residents are obese.

- Comparable to the US median percentage.
- Locally highest in Cedar and Muscatine counties, both of which are in the bottom quartile among their peer counties.



Sources:
- Behavioral Risk Factor Surveillance System (BRFSS). Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- In 2011, two methodological refinements were made to the Behavioral Risk Factor Surveillance System (BRFSS). The first was to expand the sample to include data received from cell phone users. This change was made to reflect the population better. The second change was to modify the statistical method to weight BRFSS survey data. The new approach simultaneously adjusts survey respondent data to known proportions of demographics such as age, race and ethnicity, and gender. Prior to 2011, the weighting method was post stratification, while in 2011 it is raking. Raking is better able to account for more demographic characteristics and multiple sampling frames. Because of these changes, data collected in 2011 and later cannot be appropriately compared to previous data, although new results should better reflect the health status of the United States. In order to create multi-year estimates, two changes were made to the new data. First, respondents who only have cell phones were removed. Second, weights were created specifically for this purpose using the post stratification method. Those two changes make the 2011 data similar to the pre-2011 data and allowed multi-year estimates to be created, even though these estimates will not be as representative of the US population as the single-year estimates using 2011 data without these changes. Efforts to create a new small area estimate methodology that will allow use all of the improvements instigated with the 2011 data are currently taking place. Once available, that methodology will be used for estimates provided here: Estimates based on fewer than 50 cases or with a confidence interval half-width of 10% or more ((upper CI-lower CI/100) >10) are considered unreliable and are not displayed. This Indicator uses Age-Adjustment Groups: 18-44, 45-54, 55-64, 65-74, 75+.
- Data Years: 2006-2012

Alcohol Use

Excessive Drinking

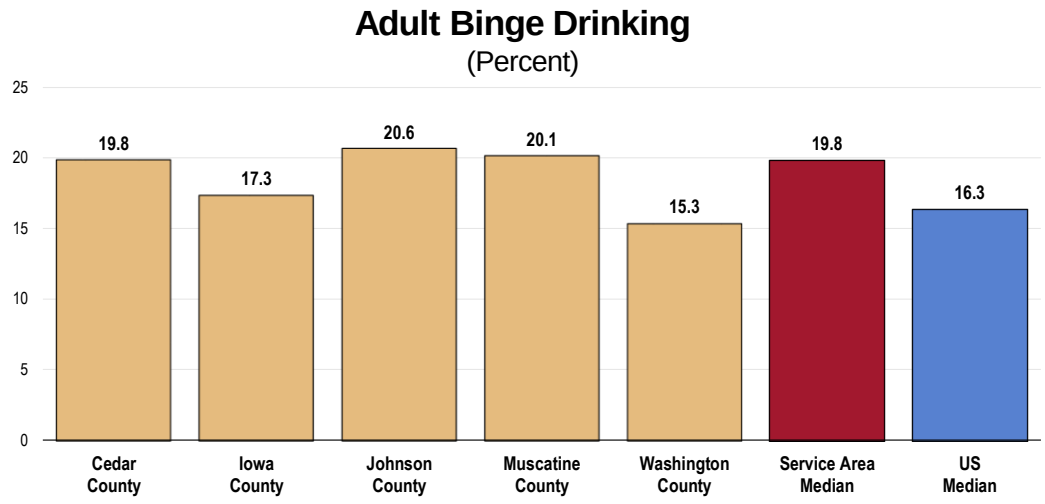
Excessive alcohol use, including underage drinking and binge drinking (drinking 5 or more drinks on an occasion for men or 4 or more drinks on an occasion for women), can lead to increased risk of health problems such as injuries, violence, liver diseases, and cancer. Approximately 80,000 deaths are attributed annually to excessive drinking. Excessive drinking is the third leading lifestyle-related cause of death in the United States.

- CITATION: National Prevention Council, National Prevention Strategy, Washington, DC: US Department of Health and Human Services, Office of the Surgeon General, 2011. Available at http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf

Adult Binge Drinking

A median total of 19.8% of service area residents are binge drinkers.

- Above the US median.
- Note that Johnson County ranks in the bottom quartile among its peer counties.



Sources:
- Behavioral Risk Factor Surveillance System (BRFSS). Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Based on the question: "Considering all types of alcoholic beverages, how many times during the past 30 days did you have [5 for men, 4 for women] or more drinks on an occasion?" In 2011, two methodological refinements were made to the Behavioral Risk Factor Surveillance System (BRFSS). The first was to expand the sample to include data received from cell phone users. This change was made to reflect the population better. The second change was to modify the statistical method to weight BRFSS survey data. The new approach simultaneously adjusts survey respondent data to known proportions of demographics such as age, race and ethnicity, and gender. Prior to 2011, the weighting method was post stratification, while in 2011 it is raking. Raking is better able to account for more demographic characteristics and multiple sampling frames. Because of these changes, data collected in 2011 and later cannot be appropriately compared to previous data, although new results should better reflect the health status of the United States (seePrevention Quality Indicators (PQI) version 4.3 software). In order to create multi-year estimates, two changes were made to the new data. First, respondents who only have cell phones were removed. Second, weights were created specifically for this purpose using the post stratification method. Those two changes make the 2011 data similar to the pre-2011 data and allowed multi-year estimates to be created, even though these estimates will not be as representative of the US population as the single-year estimates using 2011 data without these changes. The BRFSS estimates are age adjusted to the 2000 US D34 standard population (age groups: 18-44, 45-54, 55-64, 65-74, 75+)
- Data Years: 2006-2012

Tobacco Use

Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Each year, approximately 443,000 Americans die from tobacco-related illnesses. For every person who dies from tobacco use, 20 more people suffer with at least 1 serious tobacco-related illness. In addition, tobacco use costs the US $193 billion annually in direct medical expenses and lost productivity.

- CITATION: US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at http://www.healthypeople.gov

Adult Smoking

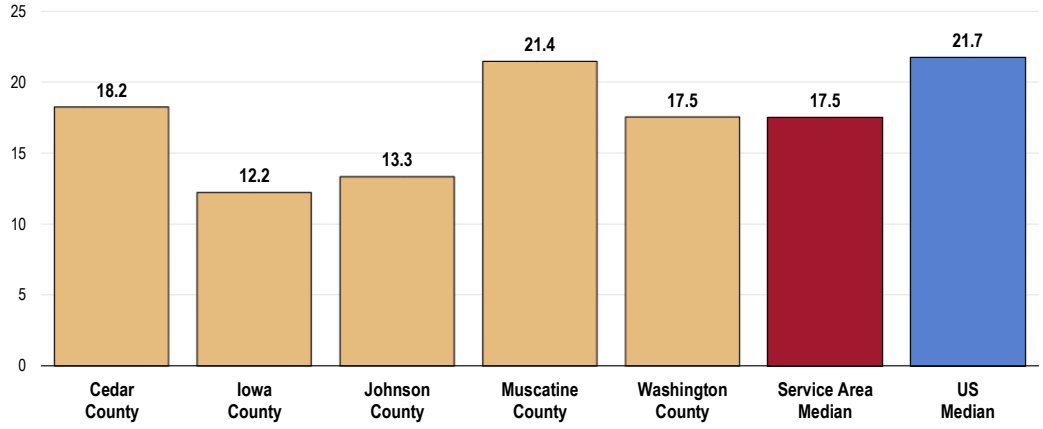
A median total of 17.5% of service area residents are smokers.

- More favorable than the US median.
- Locally highest in Cedar and Muscatine counties.

Adult Smoking

(Percent)

Healthy People 2020 Target = 12.0% or Lower



Sources:
- Behavioral Risk Factor Surveillance System (BRFSS). Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Based on the BRFSS question: "Do you now smoke cigarettes every day, some days, or not at all?" Persons are considered smokers if they reported smoking every day or some days. In 2011, two methodological refinements were made to the Behavioral Risk Factor Surveillance System (BRFSS). The first was to expand the sample to include data received from cell phone users. This change was made to reflect the population better. The second change was to modify the statistical method to weight BRFSS survey data. The new approach simultaneously adjusts survey respondent data to known proportions of demographics such as age, race and ethnicity, and gender. Prior to 2011, the weighting method was post stratification, while in 2011 it is raking. Raking is better able to account for more demographic characteristics and multiple sampling frames. Because of these changes, data collected in 2011 and later cannot be appropriately compared to previous data, although new results should better reflect the health status of the United States (seePrevention Quality Indicators (PQI) version 4.3 software). In order to create multi-year estimates, two changes were made to the new data. First, respondents who only have cell phones were removed. Second, weights were created specifically for this purpose using the post stratification method. Those two changes make the 2011 data similar to the pre-2011 data and allowed multi-year estimates to be created, even though these estimates will not be as representative of the US population as the single-year estimates using 2011 data without these changes.The BRFSS estimates are age adjusted to the 2000 US D34 standard population (age groups: 18-44, 45-54, 55-64, 65-74, 75+)
- Data Years: 2006-2012

Physical Environment

Air Quality

Air Quality

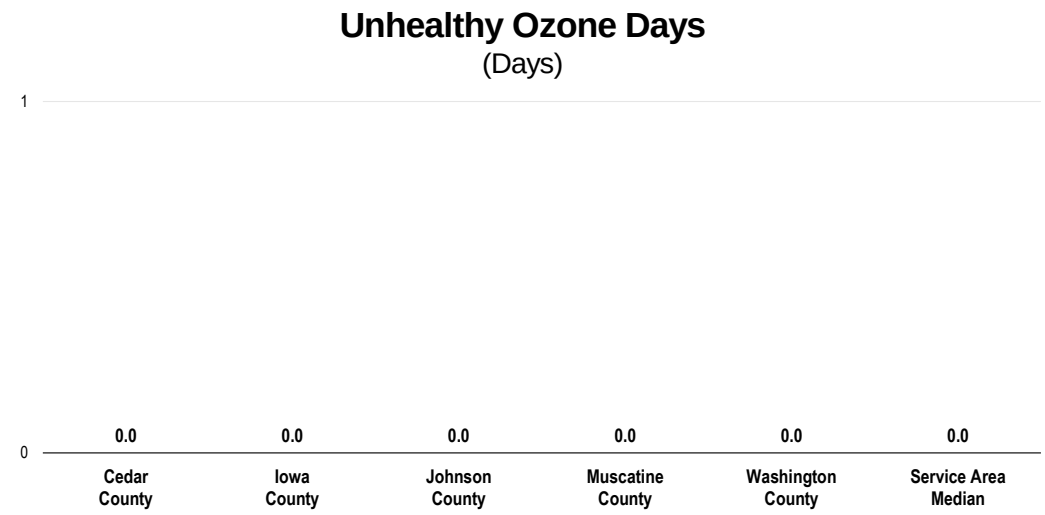
Poor air quality is linked to premature death, cancer, and long-term damage to respiratory and cardiovascular systems. Progress has been made to reduce unhealthy air emissions, but, in 2008, approximately 127 million people lived in US counties that exceeded national air quality standards.

- CITATION: US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at http://www.healthypeople.gov

Ozone

Unhealthy Ozone Days

The service area does not report any unhealthy ozone days.



Sources:
- Centers for Disease Control and Prevention. National Environmental Public Health Tracking Network. Available at: www.cdc.gov/ephtracking
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- This measure represents the number of day when the maximum ozone concentrations exceeded the regulatory standard. The monitoring data comes from the US Environmental Protection Agency (EPA) Air quality System (AQS). When AQS data are available from multiple monitors for a given county and day, the highest 8-h maximum (daily) ozone concentration among all the monitors is selected for purposes of creating daily county level data. EPA provides modeled estimates of ozone using Downscaler (DS) model, which uses a statistical approach to fuse monitoring data in areas where monitors exist, and relies on Community Multiscale Air Quality (CMAQ) modeled output in areas without monitors. DS modeled estimates are available by census tract centroid—the geographic center of the census tract. Daily county level modeled estimates are obtained by selecting the maximum value observed among all the census tracts within each county. County level ozone measures are created using monitor data when available and using modeled estimates for days and locations without such data. The 8-hour ozone National Ambient Air Quality Standard (NAAQS) is 0.075 ppm.
- Data Years: 2008

Particulate Matter

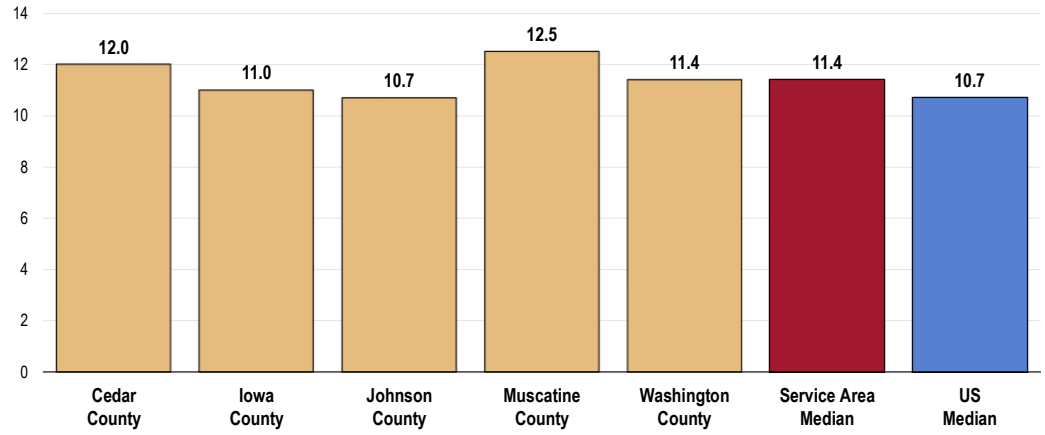
Annual Average PM2.5 Concentration

The service area reports a median annual average particulate matter (PM2.5) concentration of 11.4 micrograms per cubic meter.

- Less favorable than the national median.
- Note that Iowa County ranks in the bottom quartile among its peer counties.

Annual Average PM2.5 Concentration

(Micrograms Per Cubic Meter)



Sources:
- Centers for Disease Control and Prevention. National Environmental Public Health Tracking Network. Available at: www.cdc.gov/ephtracking
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- This measure represents the average daily amount of fine particulate matter in micrograms per cubic meter (PM2.5) in a county. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers. The monitoring data comes from the US Environmental Protection Agency (EPA) Air quality System (AQS). When AQS data are available from multiple monitors for a given county and day, the highest 8-h maximum (daily) ozone concentration among all the monitors is selected for purposes of creating daily county level data. EPA provides modeled estimates of PM2.5 using Downscaler (DS) model, which uses a statistical approach to fuse monitoring data in areas where monitors exist, and relies on Community Multiscale Air Quality (CMAQ) modeled output in areas without monitors. DS modeled estimates are available by census tract centroid—the geographic center of the census tract. Daily county level modeled estimates are obtained by selecting the maximum value observed among all the census tracts within each county. County level PM2.5 measures are created using monitor data when available and using modeled estimates for days and locations without such data. On March 18th, 2013, the EPA's annual PM2.5 standard was lowered from 15 micrograms per cubic meter to 12 micrograms per cubic meter.
- Data Years: 2008

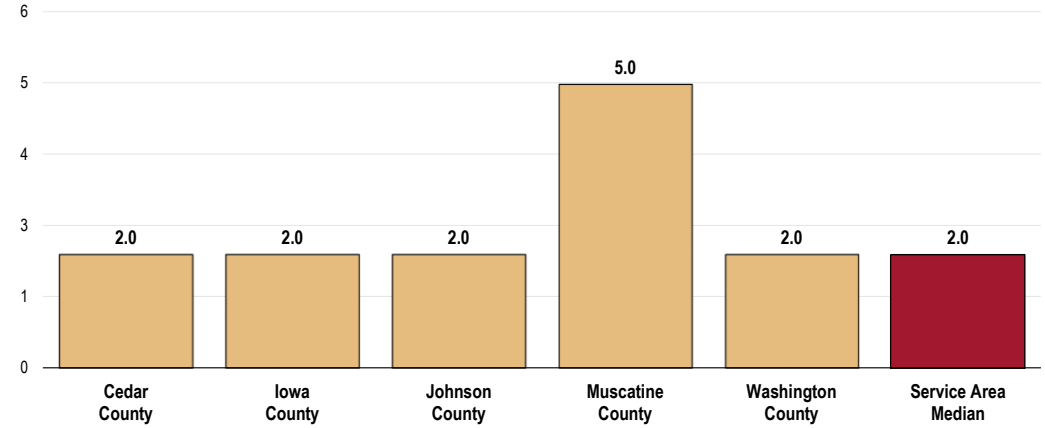
Unhealthy PM2.5 Days

The service area reports a median of 2.0 unhealthy PM2.5 days.

- Locally highest in Muscatine County.

Unhealthy PM2.5 Days

(Days)



Sources:
- Centers for Disease Control and Prevention. National Environmental Public Health Tracking Network. Available at: www.cdc.gov/ephtracking
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

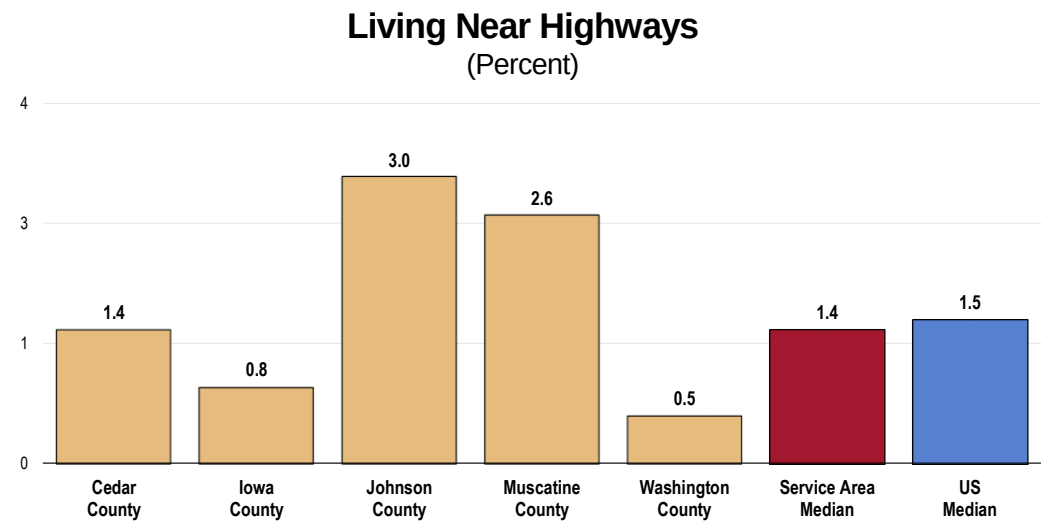
Notes:
- This measure represents the number of day when the PM2.5 concentration exceeded the regulatory standard. The monitoring data comes from the US Environmental Protection Agency (EPA) Air quality System (AQS). When AQS data are available from multiple monitors for a given county and day, the highest 24-h average (daily) PM2.5 concentration among all the monitors is selected for purposes of creating daily county level data. EPA provides modeled estimates of PM2.5 using Downscaler (DS) model, which uses a statistical approach to fuse monitoring data in areas where monitors exist, and relies on Community Multiscale Air Quality (CMAQ) modeled output in areas without monitors. DS modeled estimates are available by census tract centroid—the geographic center of the census tract. Daily county level modeled estimates are obtained by selecting the maximum value observed among all the census tracts within each county. County level PM2.5 measures are created using monitor data when available and using modeled estimates for days and locations without such data (1).
- Data Years: 2008

Traffic-Related Air Quality

Living Near Highways

A median total of 1.4% of service area residents live near a highway.

- Better than the US median.
- Locally highest in Johnson and Muscatine counties.



Sources:
- Geospatial Research, Analysis and Services Program (GRASP); Centers for Disease Control and Prevention, Agency for Toxic Substances and Disease Registry (CDC/ATSDR)
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Three data sources were used to calculate this indicator: The 2010 US census (available at http://www.census.gov/2010census), 2) 2006–2010 American Community Survey (ACS) 5-year estimates (available at http://www.census.gov/acs), and 3) 2010 (Quarter 3) road network data from NAVTEQ, a commercial data source that provides comprehensive road information for the United States (available at http://www.navteq.com). NAVTEQ is a commercial data source providing comprehensive road information for the United States (available at: www.navteq.com). Highways are defined to include roads classified as Interstates (Class 1) or as other freeways and expressways (Class 2) by the Federal Highway Administration (FHWA) Functional Classification system. These road types represent the most heavily-trafficked, controlled-access highways in the United States. Using ArcMap10 (ESRI software) buffers were created at a distance of 150 meter around the Class 1 and 2 roads. Population estimates were based on population counts within census tracts made publically available by the US Census (2010, 100% count data). The proportion of each census tract included within the buffer area was calculated and summed from the census tract level to the county level.
- Data Years: 2010

Schools Located Near Highways

No service area schools are located near highways.

Housing

Housing

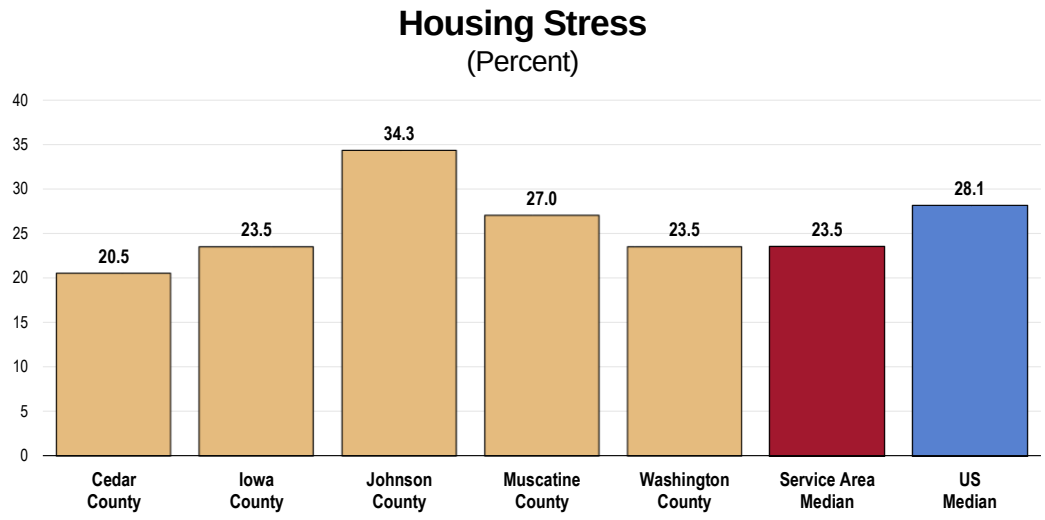
Living environments, including housing and institutional settings, can support health. Quality housing is associated with positive physical and mental well-being. How homes are designed, constructed, and maintained, their physical characteristics, and the presence or absence of safety devices have many effects on injury, illness, and mental health.

- CITATION: National Prevention Council, National Prevention Strategy, Washington, DC: US Department of Health and Human Services, Office of the Surgeon General, 2011. Available at http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf

Housing Stress

Among service area homes, a median 23.5% are considered to be stressed.

- More favorable than the US median.
- Locally highest in Johnson County.



Sources:
- The Economic Research Service of the United States Department of Agriculture. www.ers.usda.gov/data-products/county-typology-codes/documentation.aspx
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

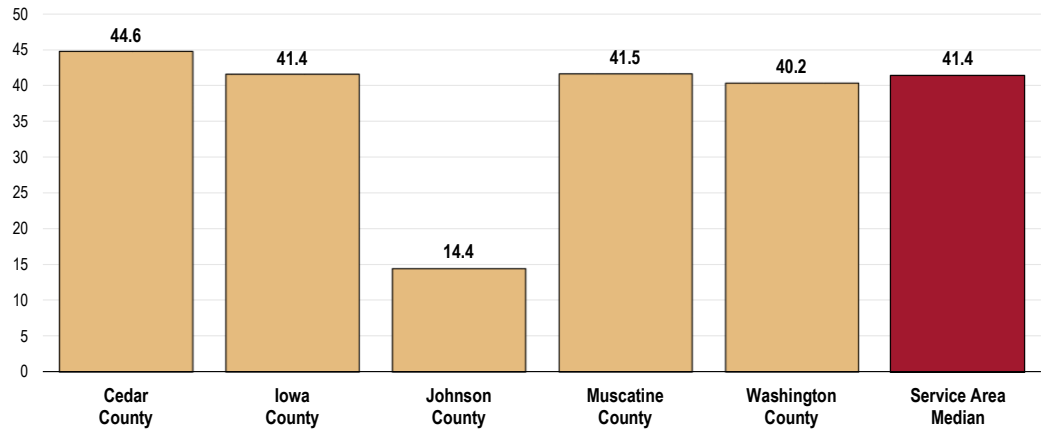
Notes:
- A house is defined as stressed if one or more of the following criteria is met: 1) housing unit lacked complete plumbing; 2) housing unit lacked complete kitchens; 3) household is overcrowded; and 4) household is cost burdened. Severe overcrowding is defined as more than 1 persons per room. Severe cost burden is defined as monthly housing costs (including utilities) that exceed 30% of monthly income.
- Data Years: 2007-2011

Housing Age

Homes Built Before 1950

A median total of 41.4% of service area homes were built before 1950.

- Locally lowest in Johnson County.



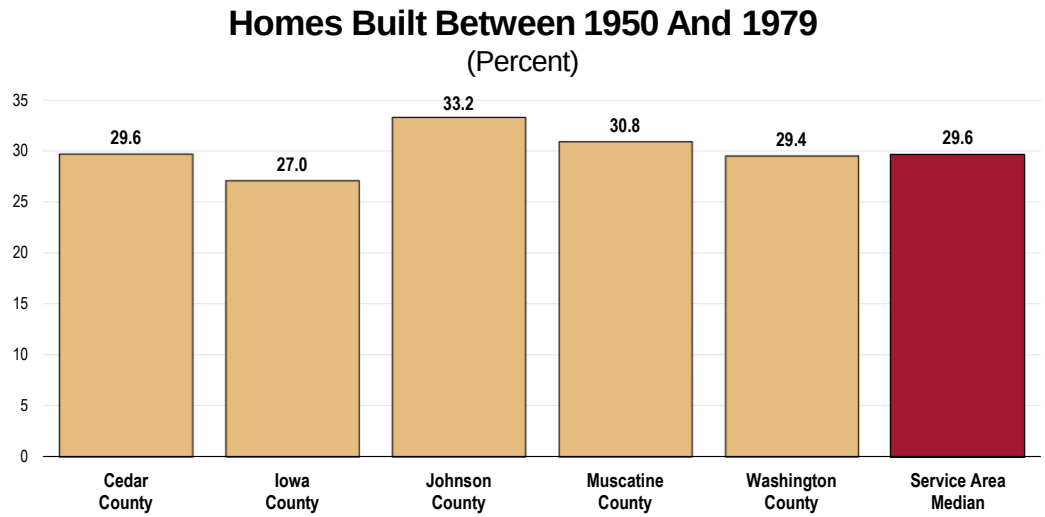
Sources:
- American Community Survey. Available at www.census.gov/acs/www/
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- The data on year structure built were obtained from Housing Question 2 in the 2012 American Community Survey. The question was asked at both occupied and vacant housing units. Year structure built refers to when the building was first constructed, not when it was remodeled, added to, or converted. Housing units under construction are included as vacant housing if they meet the housing unit definition, that is, all exterior windows, doors, and final usable floors are in place. For mobile homes, houseboats, RVs, etc., the manufacturer's model year was assumed to be the year built. The data relate to the number of units built during the specified periods that were still in existence at the time of interview. The year the structure was built provides information on the age of housing units. These data help identify new housing construction and measures the disappearance of old housing from the inventory, when used in combination with data from previous years. The data also serve to aid in the development of formulas to determine substandard housing and provide assistance in forecasting future services, such as energy consumption and fire protection.
- Data Years: 2008-2012

Homes Built Between 1950 And 1979

A median total of 29.6% of service area homes were built between 1950 and 1979.

- Locally highest in Johnson County.



Sources:
- American Community Survey. Available at www.census.gov/acs/www/
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- The data on year structure built were obtained from Housing Question 2 in the 2012 American Community Survey. The question was asked at both occupied and vacant housing units. Year structure built refers to when the building was first constructed, not when it was remodeled, added to, or converted. Housing units under construction are included as vacant housing if they meet the housing unit definition, that is, all exterior windows, doors, and final usable floors are in place. For mobile homes, houseboats, RVs, etc., the manufacturer's model year was assumed to be the year built. The data relate to the number of units built during the specified periods that were still in existence at the time of interview. The year the structure was built provides information on the age of housing units. These data help identify new housing construction and measures the disappearance of old housing from the inventory, when used in combination with data from previous years. The data also serve to aid in the development of formulas to determine substandard housing and provide assistance in forecasting future services, such as energy consumption and fire protection.
- Data Years: 2008-2012

Neighborhood Distress

Neighborhood Distress

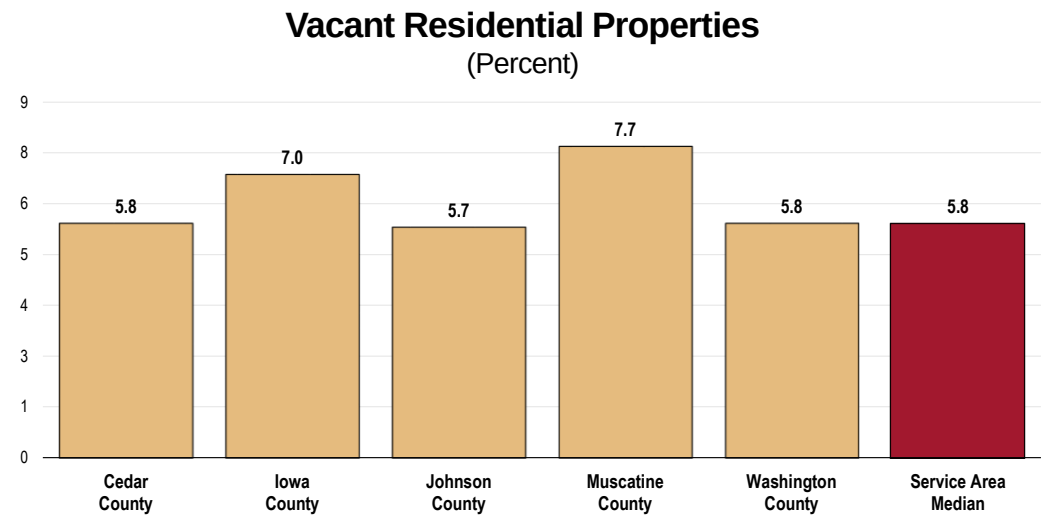
Vacant and abandoned housing is a fundamental indicator of neighborhood distress, serving to depress local property values, encourage the spread of crime, and strain municipal budgets by imposing higher service costs while reducing property tax revenues. During the worst years of the housing downturn, 4,689 census tracts (the statistical equivalent of a neighborhood) had very high vacancy rates, with more than one in five homes unoccupied. The average vacancy rate in these distressed areas was 26.0 percent in 2007–11, more than triple the US total.

- CITATION: Nicolas Retsinas, et al. "The State of the Nation's Housing 2013." Joint Center for Housing Studies, Harvard University, 2013. Available at http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/son2013.pdf

Vacant Residential Properties

A median total of 5.8% of service area homes are vacant.

- Locally highest in Iowa and Muscatine counties.



Sources:
- American Community Survey. Available at www.census.gov/acs/www/
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- A housing unit is vacant if no one is living in it at the time of interview. Units occupied at the time of interview entirely by persons who are staying two months or less and who have a more permanent residence elsewhere are considered to be temporarily occupied, and are classified as "vacant." New units not yet occupied are classified as vacant housing units if construction has reached a point where all exterior windows and doors are installed and final usable floors are in place. Vacant units are excluded from the housing inventory if they are open to the elements, that is, the roof, walls, windows, and/or doors no longer protect the interior from the elements. Also, excluded are vacant units with a sign that they are condemned or they are to be demolished.
- Data Years: 2008-2012

Healthcare Access & Quality

Financial Barriers

Healthcare Access

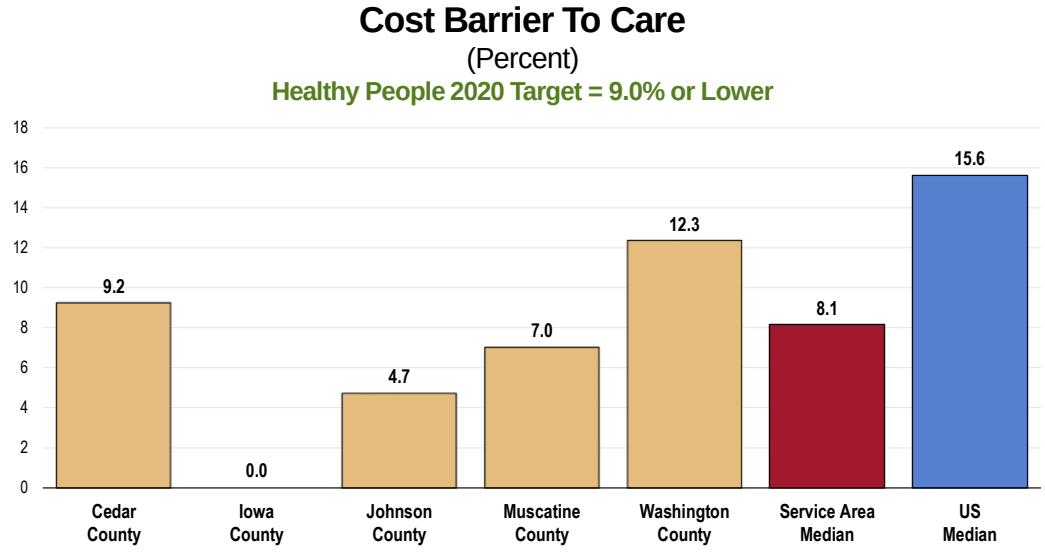
Access to comprehensive, quality healthcare services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Access to health services means the timely use of personal health services to achieve the best health outcomes and encompasses four components: coverage, services, timeliness, and workforce. Barriers to services include: 1) Lack of availability, 2) High cost, and 3) Lack of insurance coverage. These barriers to accessing health services diminish quality of care and lead to delays in receiving appropriate care, the inability to get preventive services, and hospitalizations that could have been prevented.

- CITATION: US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at http://www.healthypeople.gov

Cost Barrier To Care

A median total of 8.1% of service area residents report cost as a barrier to healthcare services.

- Well below the national median.
- Locally highest in Washington County.



Sources:
- Behavioral Risk Factor Surveillance System (BRFSS). Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Based on the BRFSS question : "Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?" In 2011, two methodological refinements were made to the Behavioral Risk Factor Surveillance System (BRFSS). The first was to expand the sample to include data received from cell phone users. This change was made to reflect the population better. The second change was to modify the statistical method to weight BRFSS survey data. The new approach simultaneously adjusts survey respondent data to known proportions of demographics such as age, race and ethnicity, and gender. Prior to 2011, the weighting method was post stratification, while in 2011 it is raking. Raking is better able to account for more demographic characteristics and multiple sampling frames. Because of these changes, data collected in 2011 and later cannot be appropriately compared to previous data, although new results should better reflect the health status of the United States (seePrevention Quality Indicators (PQI) version 4.3 software). In order to create multi-year estimates, two changes were made to the new data. First, respondents who only have cell phones were removed. Second, weights were created specifically for this purpose using the post stratification method. Those two changes make the 2011 data similar to the pre-2011 data and allowed multi-year estimates to be created, even though these estimates will not be as representative of the US population as the single-year estimates using 2011 data without these changes. The BRFSS estimates are age adjusted to the 2000 US D34 standard populaton (age groups: 18-44, 45-54, 55-64, 65-74, 75+)
- Data Years: 2006-2012

Uninsured

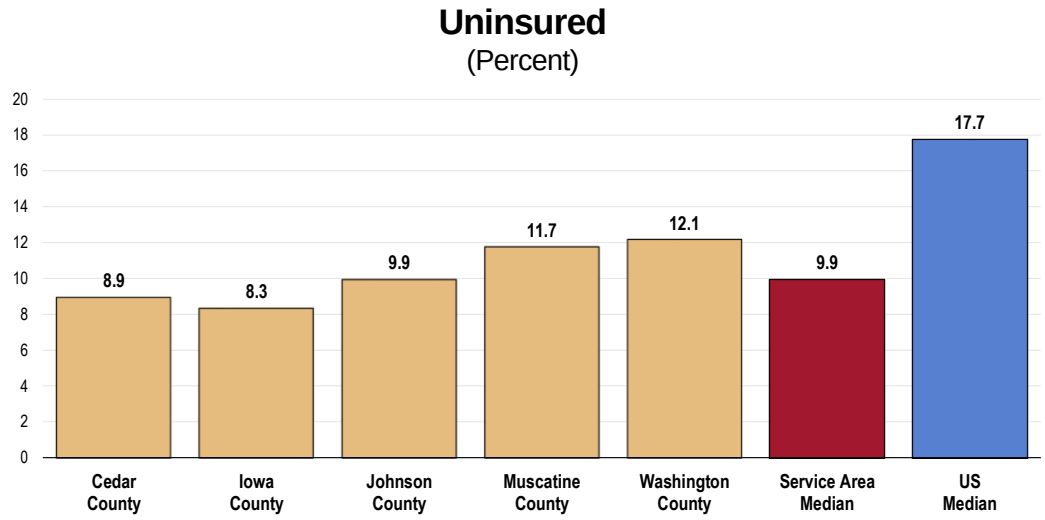
Lack of Health Insurance

In the first quarter of 2010, an estimated 59.1 million persons had no health insurance for at least part of the year, an increase from 58.7 million in 2009 and 56.4 million in 2008. Persons aged 18–64 years with no health insurance during the preceding year were seven times as likely as those continuously insured to forgo needed healthcare because of cost.

- CITATION: Centers for Disease Control and Prevention, Health Insurance Coverage — United States, 2008 and 2010. MMWR 2013;62(Suppl 3):61-64. Available at http://www.cdc.gov/mmwr/pdf/other/su6203.pdf

A median total of 9.9% of service area residents are uninsured.

- Well below the national median.
- Locally highest in Muscatine and Washington counties.



Sources:
- The US Census Bureau's Small Area Health Insurance Estimates (SAHIE).
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- This measure represents the estimated percent of the population under age 65 that has no health insurance coverage. The US Census Bureau's Small Area Health Insurance Estimates (SAHIE) program produces estimates of health insurance coverage for all states and counties. For estimation, SAHIE uses statistical models that combine survey data from the American Community Survey (ACS) with administrative records data and Census 2010 data. The models are "area-level" models because they use survey estimates and administrative data at certain levels of aggregation, rather than individual survey and administrative records.
- Data Years: 2011

Preventable Hospitalizations

Preventable Hospitalizations

Preventable hospitalizations are admissions to a hospital for certain acute illnesses (e.g., diabetes) that might not have required hospitalization had these conditions been managed successfully by primary care providers in outpatient settings. Hospitalization for diagnoses treatable in outpatient services suggests that the quality of care provided in the outpatient setting was less than ideal.

- CITATION: Centers for Disease Control and Prevention, Potentially Preventable Hospitalizations — United States, 2001–2009. MMWR 2013;62(Suppl 3):139-143. Available at http://www.cdc.gov/mmwr/pdf/other/su6203.pdf

Less than half of older adults are up-to-date on a core set of clinical preventive services (e.g., cancer screening and immunizations).

- CITATION: National Prevention Council, National Prevention Strategy, Washington, DC Available at http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf

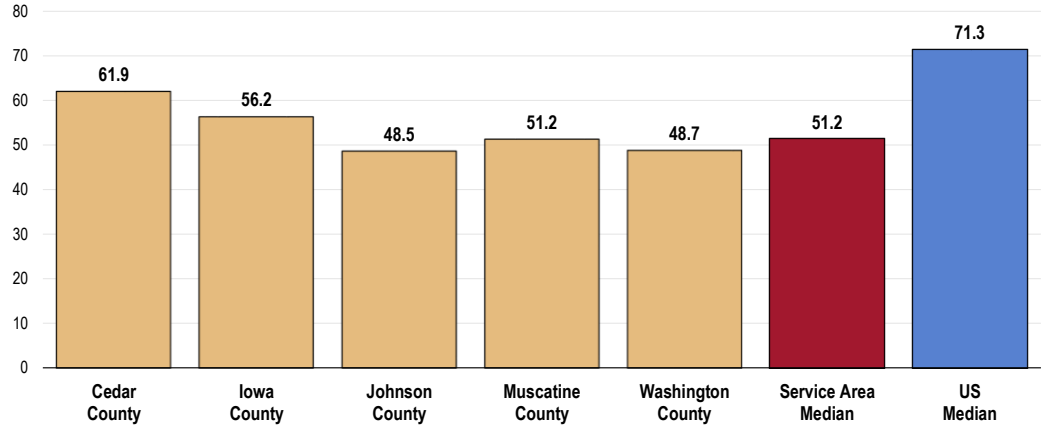
Older Adult Preventable Hospitalizations

The service area reports a median rate of 51.2 preventable hospitalizations per 1,000 Medicare enrollees (age 65+).

- Better than the national median.
- Locally highest in Cedar and Iowa counties.

Older Adult Preventable Hospitalizations

(Rate Per 1,000 Medicare Enrollees Age 65 Years Or Older)



Sources:
- Dartmouth Atlas of Health Care. Rates were provided to CDC by staff from the Dartmouth Institute for Health Policy and Clinical Practice.
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- Ambulatory care-sensitive conditions include: convulsions, chronic obstructive pulmonary disease, bacterial pneumonia, asthma, congestive heart failure, hypertension, angina, cellulitis, diabetes, gastroenteritis, kidney/urinary Infection, and dehydration. Rates are adjusted for age, sex and race using the indirect method, using the US Medicare population as the standard.
- Data Years: 2011

Primary Care

Primary Care

Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with greater patient trust in the provider, good patient-provider communication, and Increased likelihood that patients will receive appropriate care.

- CITATION: US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at http://www.healthypeople.gov

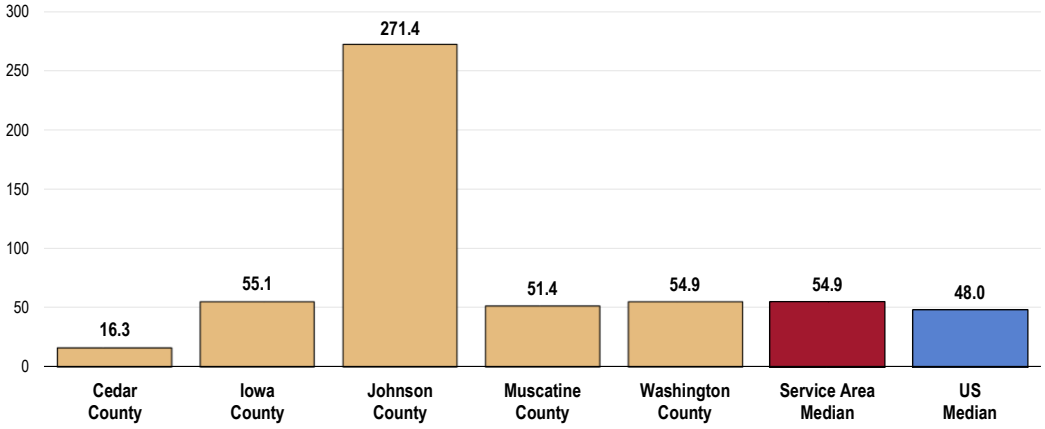
Primary Care Provider Access

The service area reports a median rate of 54.9 primary care providers per 100,000 residents.

- Better than the national median.
- Locally highest in Johnson County; note that Cedar County ranks in the bottom quartile among its peer counties for primary care provider access.

Primary Care Provider Access

(Rate Per 100,000 Persons)



Sources:
- Health Resources and Services Administration. Area Health Resources Files
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- The Health Resources and Services Administration compiles physician data from the American Medical Association Master File and from the Census Population Estimates program to report primary care provider data at the county level. Primary care physicians are those who identify as practicing general practice, internal medicine, obstetrics and gynecology, or pediatrics. CITATION: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse. http://www.healthindicators.gov
- Data Years: 2011

Oral Health

Dental Care

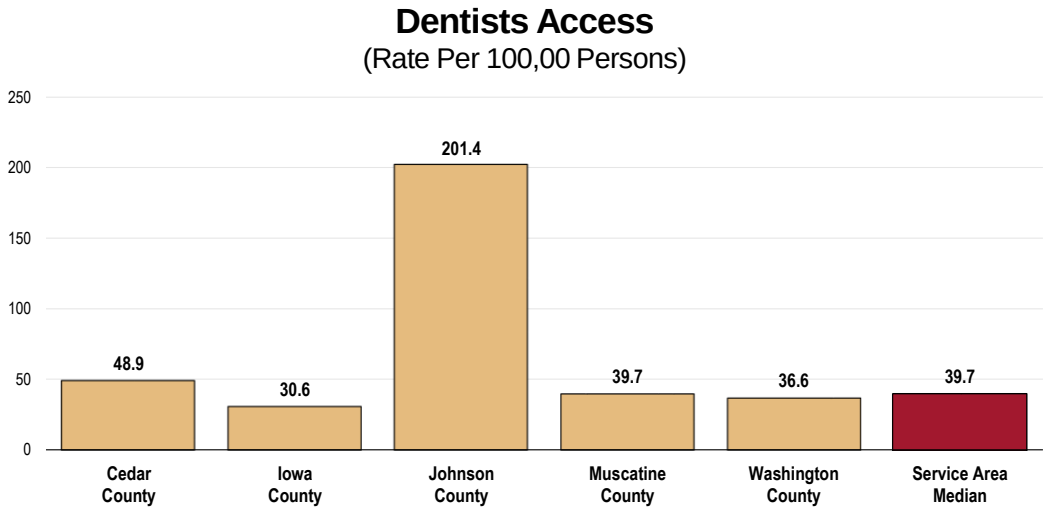
Lack of access to dental care for all ages remains a public health challenge.

- CITATION: US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at http://www.healthypeople.gov

Dentists Access

The service area reports a median rate of 39.7 dentists per 100,000 residents.

- Locally highest in Johnson County.



Sources:
- Health Resources and Services Administration. Area Health Resources Files
- Retrieved November 2015 through http://wwwn.cdc.gov/CommunityHealth.

Notes:
- The Health Resources and Services Administration compiles dentist data from the National Provider Identification data file. Dentists are classified by county, but dentists living on the edge of counties or who practice in multiple locations may see patient populations that reside in surrounding counties. CITATION: Centers for Disease Control and Prevention, National Center for Health Statistics. Health Indicators Warehouse. http://www.healthindicators.gov
- Data Years: 2011

Peer County Comparisons

Professional Research Consultants, Inc.

The following Summary Comparison Reports provide an "at-a-glance" summary of how the selected county compares with peer counties on the full set of Primary Indicators. Peer county values for each indicator were ranked and then divided into quartiles.

Cedar County, IA

CEDAR COUNTY	Better (most favorable quartile)	Moderate (middle two quartiles)	Worse (least favorable quartile)
Mortality	Alzheimer's disease deaths Cancer deaths Chronic lower respiratory disease (CLRD) deaths Diabetes deaths Female life expectancy Male life expectancy Unintentional injury (including motor vehicle)	Coronary heart disease deaths	Stroke deaths
Morbidity	Adult diabetes Adult overall health status Syphilis	Alzheimer's diseases/dementia Older adult asthma	Adult obesity Cancer Gonorrhea Older adult depression Preterm births
Health Care Access & Quality	Cost barrier to care Uninsured	Older adult preventable hospitalizations	Primary care provider access
Health Behaviors	Adult female routine pap tests Teen Births	Adult binge drinking Adult physical inactivity Adult smoking	
Social Factors	High housing costs Inadequate social support On time high school graduation Poverty Unemployment	Children in single-parent households Violent crime	
Physical Environment	Access to parks Housing stress	Annual average PM2.5 concentration Limited access to healthy food Living near highways	

- Source: US Department of Health and Human Services, Centers for Disease Control and Prevention. CHSI: Information for Improving Community Health. Summary Comparison Report. Retrieved November 2015 at: http://wwwn.cdc.gov/CommunityHealth.

Iowa County, IA

IOWA COUNTY	Better (most favorable quartile)	Moderate (middle two quartiles)	Worse (least favorable quartile)
Mortality	Chronic lower respiratory disease (CLRD) deaths Diabetes deaths Female life expectancy Male life expectancy Stroke deaths	Alzheimer's disease deaths Cancer deaths Coronary heart disease deaths Unintentional injury (including motor vehicle)	
Morbidity	HIV Preterm births Syphilis	Adult diabetes Adult obesity Alzheimer's diseases/dementia Gonorrhea Older adult asthma	Adult overall health status Cancer Older adult depression
Health Care Access & Quality	Older adult preventable hospitalizations Uninsured	Primary care provider access	
Health Behaviors	Adult female routine pap tests Adult smoking Teen Births	Adult binge drinking Adult physical inactivity	
Social Factors	Poverty	Children in single-parent households High housing costs On time high school graduation Unemployment Violent crime	Inadequate social support
Physical Environment	Limited access to healthy food	Access to parks Housing stress Living near highways	Annual average PM2.5 concentration

- Source: US Department of Health and Human Services, Centers for Disease Control and Prevention. CHSI: Information for Improving Community Health. Summary Comparison Report. Retrieved November 2015 at: http://wwwn.cdc.gov/CommunityHealth.

Johnson County, IA

JOHNSON COUNTY	Better (most favorable quartile)	Moderate (middle two quartiles)	Worse (least favorable quartile)
Mortality	Cancer deaths Chronic kidney disease deaths Chronic lower respiratory disease (CLRD) deaths Diabetes deaths Female life expectancy Male life expectancy Motor vehicle deaths Stroke deaths Unintentional injury (including motor vehicle)	Alzheimer's disease deaths Coronary heart disease deaths	
Morbidity	Adult diabetes Adult obesity Adult overall health status Alzheimer's diseases/dementia Older adult asthma	Cancer Gonorrhea HIV Older adult depression Preterm births	Syphilis
Health Care Access & Quality	Cost barrier to care Older adult preventable hospitalizations Primary care provider access Uninsured		
Health Behaviors	Adult female routine pap tests Adult physical inactivity Teen Births	Adult smoking	Adult binge drinking
Social Factors	High housing costs On time high school graduation Poverty Unemployment	Children in single-parent households Inadequate social support Violent crime	
Physical Environment	Access to parks Housing stress Limited access to healthy food	Annual average PM2.5 concentration Living near highways	

- Source: US Department of Health and Human Services, Centers for Disease Control and Prevention. CHSI: Information for Improving Community Health. Summary Comparison Report. Retrieved November 2015 at: http://wwwn.cdc.gov/CommunityHealth.

Muscatine County, IA

MUSCATINE COUNTY	Better (most favorable quartile)	Moderate (middle two quartiles)	Worse (least favorable quartile)
Mortality	Alzheimer's disease deaths Motor vehicle deaths Unintentional injury (including motor vehicle)	Cancer deaths Chronic lower respiratory disease (CLRD) deaths Coronary heart disease deaths Diabetes deaths Female life expectancy Male life expectancy	Stroke deaths
Morbidity	Adult diabetes Adult overall health status Alzheimer's diseases/dementia Older adult asthma Syphilis	Cancer HIV Older adult depression	Adult obesity Gonorrhea Preterm births
Health Care Access & Quality	Cost barrier to care Older adult preventable hospitalizations	Primary care provider access Uninsured	
Health Behaviors	Adult female routine pap tests	Adult binge drinking Adult physical inactivity Adult smoking	Teen Births
Social Factors	Unemployment	High housing costs On time high school graduation Poverty	Children in single-parent households Inadequate social support Violent crime
Physical Environment	Access to parks	Annual average PM2.5 concentration Housing stress Living near highways	Limited access to healthy food

- Source: US Department of Health and Human Services, Centers for Disease Control and Prevention. CHSI: Information for Improving Community Health. Summary Comparison Report. Retrieved November 2015 at: http://wwwn.cdc.gov/CommunityHealth.

Washington County, IA

WASHINGTON COUNTY	Better (most favorable quartile)	Moderate (middle two quartiles)	Worse (least favorable quartile)
Mortality	Motor vehicle deaths Stroke deaths	Alzheimer's disease deaths Cancer deaths Chronic lower respiratory disease (CLRD) deaths Diabetes deaths Female life expectancy Male life expectancy Unintentional injury (including motor vehicle)	Coronary heart disease deaths
Morbidity	Adult overall health status HIV Older adult asthma Syphilis	Adult diabetes Adult obesity Alzheimer's diseases/dementia Cancer Older adult depression Preterm births	Gonorrhea
Health Care Access & Quality	Primary care provider access	Cost barrier to care Older adult preventable hospitalizations Uninsured	
Health Behaviors	Adult binge drinking	Adult female routine pap tests Adult physical inactivity Adult smoking Teen Births	
Social Factors	Unemployment	Children in single-parent households Inadequate social support Poverty	High housing costs On time high school graduation Violent crime
Physical Environment	Limited access to healthy food	Access to parks Annual average PM2.5 concentration Housing stress Living near highways	

- Source: US Department of Health and Human Services, Centers for Disease Control and Prevention. CHSI: Information for Improving Community Health. Summary Comparison Report. Retrieved November 2015 at: http://wwwn.cdc.gov/CommunityHealth.

Key Informant Input: Johnson County

Social Factors

Focus group discussion related to the social determinants frequently related to the following:

- Blue Zones
- Environment
- Housing
- Poverty
- Education

Blue Zones

One standout that group participants mentioned for this community is its Blue Zones community certification. Respondents noted the attention that this has placed on health in the area and the potential it has to usher in new initiatives for health, including addressing factors that impact good health.

> *"Iowa City is now getting certified as a Blue Zones community this week. The state of Iowa Governor, Branstad, wanted Iowa to be one of the healthiest states in the nation. So we adopted a Blue Zones model, which talks about lifestyles. So it's not just nutrition and exercise, the things that you think about, but it's also connection to family and spirituality."*
>
> *"So for the community to be certified, it meant that a certain number of schools had to be certified, a certain number of businesses, restaurants, and local government had to go through this process. The city might pass policy that would be no smoking in apartment buildings or it might be more walkable communities or bike lanes. There is just this whole menu of options of things that the community could do."*
>
> *"From an educational standpoint on the Blue Zones, I think there's been a lot of publicity, and a lot of people know about what's going on. Blue Zones comes along—which is fantastic—and really put a lot of attention to the healthy lifestyles and what we can do as a community, whether it's through policy or a change in the environment. So I think from my perspective, it's a fantastic boost to our community on just an awareness level of what it takes to be a healthier community."*
>
> *"I'd like to think [our county's health is] above average, having just achieved Blue Zone designation. I think Blue Zones has helped. I think there were already some things in place that made this a good choice to go the extra mile and achieve in the different categories. I think there are still pockets that need some help, but I think, overall, there are some really good things happening here that are probably better than things that are happening elsewhere."*

Environment

Key informants feel there is a greater focus on how the environment affects health and how providers and programs could address those environmental issues in order to impact everyone.

> *"That's a push for public health right now—to try to identify and move a little further upstream from the health outcomes that we see with diabetes and stress and cardiovascular disease. To address, is it housing, is it transportation, is it income or education that is affecting those health outcomes? We can develop a program and deliver that, but does that really change our environment? So we are looking at ways to change the environment for people to be healthier."*
>
> *"We have all these great things, but then there are still pockets of our community that don't have the ability to take advantage of those environmental changes, so to speak. Indirectly they do, if we have smoking policies implemented for multi-housing that certainly affects their health. There hasn't been anything like that widespread implemented, though, unfortunately."*

Housing

Housing was a popular topic in the focus groups, particularly affordability of housing. Respondents feel that rent and housing prices have risen much more in Iowa City than in

surrounding locations, such as Cedar Rapids, but that these prices may reflect the disparate standards of living between the two locations. In addition, participants noted that affordable housing is receiving more attention than in the past. Something that has not changed, however, is its influence on disposable income and the facets that go into that, such as money for nutritious food and transportation to health appointments.

> *"When we talk to people about their health, oftentimes they will talk about housing and lack of affordable housing. It's another issue that the community could address."*
>
> *"We are in a university community. So with the student population, that drives up apartment and housing prices and then we have some high wages with the University that helps drive them up. I think there are areas of Johnson County- North Liberty being one of them- that has a nice mix and a good stock of affordable housing. But I think Iowa City is on the opposite of the spectrum with less.*
>
> *"Thirty years ago and Iowa City you wouldn't have heard affordable housing. This is one of those kind of terminologies that now is probably the number one thing that we focus on; but 30 years ago, that wasn't a topic. Why is that? What has transported it from being middle of the pack to being the number one reason? There are societal changes in Iowa City- and Johnson County, for that matter- that I think have impacted that housing mode. I think it's partly what has changed in Johnson County or Iowa City that's impacting why it's become the number one issue."*
>
> *"I think our perception is affordability depends on the community a person lives in. Certainly, what would be affordable here may be more affordable in the Cedar Rapids or Linn County area. Face it, Johnson County has a high standard of living, so it's going to take a percentage of your income to find a decent place to live. Not to degrade Linn County, but home prices in their area are substantially different from what they are here- even rent versus rent."*
>
> *"How do you define affordable housing? Because 20 years ago, it might've been that devoting 30% of your income to housing was affordable. Now I've heard recently, people are spending even up to 50% out of their income on housing. I think it's probably personal for everybody, whether they feel like it's affordable or not, but as a society community, how do we define affordability, with our responsibility to augment that housing for people?"*
>
> *"If you're paying 50% of your income for housing, you need to adjust along the way, whether it's transportation or healthy food."*
>
> *"I see people, particularly in the wintertime, coming in because they're homeless. They don't have any place to go. They want to get warm."*

Poverty

Related in part to affordable housing, poverty is also an important determinant of one's health. One participant mentioned that salaries and wages have not risen proportionally to the increases in food and housing prices, which certainly affects disposable income.

> *"I think certainly for our folks who are living in poverty, it's a big piece."*
>
> *"I think economics come into play. Disposable income has not kept up with all of the things that are important that are not included in what's called the inflation CPI (Consumer Price Index). When your salaries don't improve, and price increase in food is huge- I just think that part of that is economic, which I think the supervisors are trying to do something about."*

Education

In terms of education, group participants noted two factors at play. On the one hand, there is education about the healthcare system. Even for those with college degrees, it can be difficult to make appointments with the correct providers and coordinate care, especially with all the recent changes. Those at lower education levels might be even more disadvantaged in terms of accessing healthcare. For everyone, then, the ability to understand and access healthcare holds a very real influence on personal health.

> *"I think there's an education issue, too. I know people who have college degrees who cannot figure out how to navigate the healthcare system. I feel like it's very fractured in a lot of ways because it's hard to*

> *coordinate care. It's probably different in private practices, but to coordinate care if something needs to be done- more than what we can provide in our clinic- to try to explain to people how things work at [different places], it's overwhelming for a lot of people. And for people who don't have that ability to comprehend, it's even more daunting."*
>
> *"I think if people had the education available and just go out to make a livable wage and wouldn't have to struggle with the housing, food, and transportation- They'd be able to fix their cars, so they can drive to get to their appointments and afford a little bit of health insurance. I think if there was a way to increase the educational level of our community, that may help in a lot of different areas."*

Then on the other hand, education, itself, impacts health in terms of making healthy decisions and bringing in the income.

> *"I think I'm going to have to go with education if there was [the funding]. If we provide an opportunity for people that are in poverty to have an education – I'm not necessarily saying a 4-year Bachelor's. Even 2 years' trade school, they can go out and be a service worker, whatever it may be. They could earn a livable wage and be able to afford the healthier food that would impact mental health, and a decent place to live in a perceived safer environment, so they can get out and walk. I think if I continue to move upstream and try to identify what it is, that might affect a lot of these areas."*
>
> *"In the past, and maybe still at times presently, if kids weren't going to a four-year school, it was looked at as a failure; it's the University of Iowa, and anything less than that or a four-year school, 'you're not going to be successful.' I think that that is changing with the partnership with Kirkwood. I think that's really very good because Iowa City needs those service people, and the benefit for the community and for the individual is just tremendous."*
>
> *"Wasn't it President Obama that was pushing for free education in community colleges? It's pretty tough, but the thought process there to have community college play a larger role in our society is a good direction for us to move into."*
>
> *"It's hard to impress on these kids that it is a very honorable to be an electrician, a plumber, et cetera. You can make a very good living at that and have an exceptionally skilled trade- more than a liberal arts major."*
>
> *"Future impact would be definitely education. I believe education is the success for life down the road."*
>
> *"Education is key."*

Older Adults

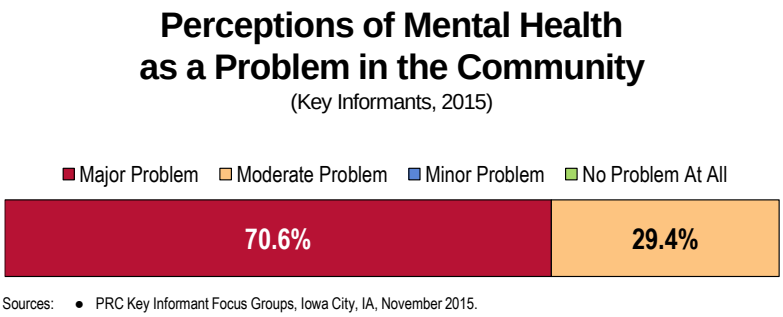
Top Concerns

Focus group discussion on older adults focused mainly on access to care. Costs for care can be exorbitant when talking about nursing home care, and several other barriers may prevent this population from accessing healthcare services.

> *"Talking about the elderly, access to quality, affordable quality health in their late 80s is an issue."*
>
> *"Residents in our nursing homes are very frail, and the cost of nursing home care for the elderly is just skyrocketing. I think with nursing homes, maybe 50-75% of residents are on Medicaid because they've depleted their assets, and they need government assistance. The whole issue of providing quality of care with what the reimbursement is for Medicaid, that's a whole other thing."*
>
> *"There are nursing homes that are for-profit and those not-for-profit. So, obviously, the for-profit are looking at the bottom line and wanting to make a profit. When you think about providing 24-hour nursing care, if you determine what it is as far as an hourly rate, it's not all that expensive. But when you're talking about 24-hour nursing care, it is."*

Mental Health

The greatest share of key informants taking part in the focus groups characterized *Mental Health* as a "major problem" in the community.



Top Concerns

Focus group participants noted several barriers that community residents encounter relative to mental health services in the community:

- Access to Services
- System Issues
- Stigma
- Culture
- Cost
- Co-Occurrences

Access to Services

Respondents' opinions were split in terms of accessing mental health services in the community. Some feel that the area is lacking providers and services specializing in mental health, which affects the amount of relevant services available. As a result, general providers might be taking on that role and likely have not received much mental health training to deal with those issues. Jails must also provide these services, instead of a licensed mental health provider.

> *"We have a social worker, and the mom can come in to see what options we can provide so that she could at least meet with her therapist on a regular basis, twice a week. So we can provide care for that, but there's so little out there to support those parents."*
>
> *"I'm not sure there are doctors to staff it. There's just a real limited number of physicians that are specializing in psychiatric care."*
>
> *"When I did my training, we got a little bit about mental health. But I spend probably half of my day doing more mental health things, and I don't feel like I was trained extensively on that at all; you had to kind of learn as you went. Because you're the person; there's nobody else that I can get them in to see. It's up to me to try and manage the situation as it needs to be managed, and that's kind of where we're all at. They do have barriers, too, 'You've got to fill out this form.' And it's six pages long, and 'we won't even schedule an appointment until you fill this out.' Well, these people aren't necessarily in the right frame of mind to be doing all that. They don't make it easy, even when you do have access."*
>
> *"When you look at this on a local, state, and national level, jails and prisons are the number one healthcare giver. That's a trend that is going to be very difficult to reverse."*

> *"Basically, if we had the funding, I would probably start in the elementary schools. A combination person that could do some mental health counseling or just overall general counseling. If a kid and a parent need some help—whether it's dental, counseling, or medical—have the ability to write out a voucher and say, 'Here, go to it.' I would put it in the hands of a person who's skilled in counseling, first off; then that person has the knowledge and knows where to refer. And let cost not be a problem."*

Others feel that there is an adequate number of mental health providers—especially compared to the rest of the state—but the wait time to schedule an appointment to see them is too long. Participants noted that individuals in a crisis situation do not have that long to wait, and they also encounter other barriers in getting to the appointment. One participant feels that implementing free counseling and referral services in schools would be a needed step. Another respondent feels that though there is more recognized mental illness, it is actually a positive that it is being recognized and hopefully treated as a result.

> *"There are a lot of mental health providers here in Johnson County, but still it's hard to get in. It takes them six weeks. There are a lot of places- psychologists and psychiatrists- that won't take Medicaid because it doesn't pay anything. There's nowhere for them to go, so they go to community mental health, and that will take them two months to get in. So they're just totally overworked."*
>
> *"When it comes to mental health and providers for mental health, we are pretty good in Johnson County. But if you look across the state on a greater issue, there's a real lack there. There's a couple of reasons for that. Doctors don't want to go into becoming psych doctors; they can't make as much money. It's not a profitable business for hospitals to be in, too, and there's a real need for additional psychiatric care and beds—both inpatient and outpatient. That's just a huge need."*
>
> *"When you're in a crisis situation, six weeks' wait is not going to work."*
>
> *"I think they can access the service. I just think that what to do with their child is the issue, while they get there. We are lucky; we have a small program that's being funded by Johnson County Board of Supervisors that does crisis care, and we can give a maximum of 72 hours in one year. It's very limited and is not enough, but it helps."*
>
> *"You have a single mom that has 1-3 kids at home, and things are not going very well. Sure, the kids are going to react. Maybe the mom needs some inpatient help or counseling; what do you do with the kids? It's just a roller coaster, how this thing keeps rolling and rolling and rolling; everybody's affected."*
>
> *"We have more medicine to treat certain conditions. We didn't make that diagnosis as much for some of those things; there just wasn't that knowledge. There was always autism, but now there's more children who are diagnosed with autism, but that's because we have better ways to detect that and we have a name for that. You always knew that there were these children that something was wrong with them and their social abilities, but you didn't have a name for it. So you can give them help, hopefully, by giving them that diagnosis- that help that they need. I think that's one reason why there is more mental illness."*

Stigma

Along the same lines as this lack of parity between general and mental health comes stigma for mental health issues. Mental health issues aren't thought about the same as physical health issues, and its chronic nature also impacts things like insurance.

> *"When you think of how we all talk about heart disease and diabetes or all of these things. Yet the brain is another organ, and you don't seem to want to talk about the fact that it doesn't always function in the same way that everybody else's might."*
>
> *"I think in Johnson County, everybody is really very supportive, and there's so many services available for people with mental illnesses as far as counseling. Again, do you have access, and can you afford it? So that stigma here, I think, is much different than other places in Iowa. But going forward, you are identified by that, and it makes a difference in applications for insurance."*
>
> *"In essence, I still see mental health as that dirty little disease you get, irrespective of all the things that you see on treating bipolar disorder, depression and all this. And it bothers me."*
>
> *"When mom calls in to the employer and says, 'Look, I've got the flu today,' the employer says, 'Fine, I understand. I can relate to that.' Mom calls in and says, 'I'm heavily depressed today.' Oh boy. The*

> *picture by the employer changes like that. That mother's got two strikes against her before she even gets out the door for her next day at work because of everybody watching over her.'*

Culture

Societal pressures and culture might also be to blame for the area's mental health problems. Participants feel there is societal and financial pressures on parents to have their children in a lot of activities. Pressure is also transferred to the children, who are pushed to be the best, in and out of school. In addition, one respondent mentioned that single parent households might also face compounded stress levels and mental health issues. In general, group participants agree that early social and emotional development would go a long way toward improving personal mental health later in life.

> *"I think our society is so different now. Everybody's trying to get ahead of everybody else. You watch these kids, and they're in all these club teams. Their parents want them to be a superstar or something. They're never just outside playing, and I think that puts a lot of financial pressure on parents. Then you need to pay for all the stuff, and I don't think that families always necessarily have good family time."*
>
> *"I think it's just very different if you think about how I grew up, versus how these kids are growing up. The pressures that are on them- They've got to get in the best schools, and they have to have perfect grades. If not, then [the perception is that] they're going to be a failure in life. There's just a lot more pressure on them. There's a lot of financial worries, and I think that translates over to the kids; they can sense that."*
>
> *"The societal change—as far as single parents- has been a major contributor, I think, to some of the expanding mental health problems."*
>
> *"If we have good social and emotional development from way young, that could have a huge impact on children. All the research shows that if they can enter into kindergarten with the skills to be successful, they just continue on a positive trajectory. But if they don't have that—even birth to three—living in stress and so on causes huge brain development issues for the long-term. I think some of it is education. I think it would really have to be like a whole comprehensive plan that families had access to counseling. As much as you look at physical development or cognitive development, you're looking at emotional and mental health issues, as well."*

Cost

Group participants are concerned with the cost of mental health services, both on the individual and on the overall system. If participants cannot afford crisis services, then they go the emergency room. In addition, some respondents feel that hospitals and insurance companies are hesitant to add inpatient beds or cover mental health services because they do not profit much from those or have different priorities; there is a lack of parity between general and mental health issues, as a result.

> *"When you are in crisis, you go to the ER, which jacks everything up for all of us as far as costs. It's too much to get in, so that's why they go to the ER. They get stabilized, and then they go on their merry way and schedule something two months out. I still say it's all about profit. Insurance companies don't want to deal with it. If Mercy Hospital in Iowa City can open up and manage, let's say, 30 psychiatric beds, and it was profitable, they would draw from many, many counties. But they're not going to do that because they can't make money out of it."*
>
> *"Even though it's just another part of the body that needs help, [insurance companies] look at it as an expensive venture to have this person on this insurance plan because it's going to be counseling and reoccurrence. So it's tough. Not everyone can afford it on an ongoing basis to pay out of pocket so that you don't have that listed on your medical record. That affects disability insurance, life insurance, or health insurance going forward. It's a big deal."*
>
> *"I wonder how much of this goes back to state legislatures and allocation of funds. Are there sections of our community or society that are being funded that could be re-allocated to mental health, for instance? If you look at the big picture and how much that's going to cost our society compared to smoking or any other of the things that the state legislature is decided to fund. We can't step into*

> *mental health or any of these other areas without that funding."*
>
> *"It's all priorities and is scary because everyone's priorities are different. It's very political."*
>
> *"We always talk about affordability, and it's easy to say. But there's that profit factor. So if the providers can't anticipate a profit, are they going to be available to provide those services?"*
>
> *"If you really are looking at [if there was extra funding], would this money do an immediate impact? It would have to be something like mental health. Some existing medical assistance."*

Co-Occurrences

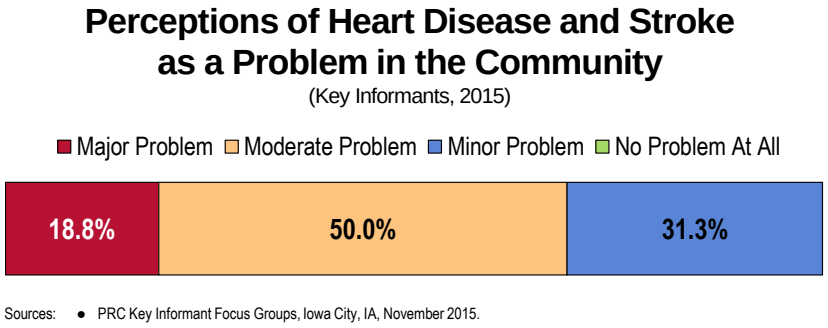
Participants noted that mental health issues often occur simultaneously with other issues, such as substance abuse and poor nutrition, or these issues might lead to those types of issues.

> *"Not as much depression, but we see a lot of depression and anxiety, which leads to certain drug use in teenagers. So it's a much bigger problem."*
>
> *"It's not always recognized. Co-occurring disorders are very common; when you have one, you often have the other. So they go somewhat hand-in-hand, I think it's fair to say."*
>
> *"If you don't have that basic ability to manage your life in stress, then those other decisions just don't matter. Although, I will say that there are certain things that I wish we could do with it, because if you eat healthy and get all your servings of fruits and vegetables, it does help your mood. It will help, but it's just not enough to change a real problem."*

Mortality & Morbidity

Heart Disease & Stroke

Half of key informants taking part in the focus groups characterized *Heart Disease & Stroke* as a "moderate problem" in the community.



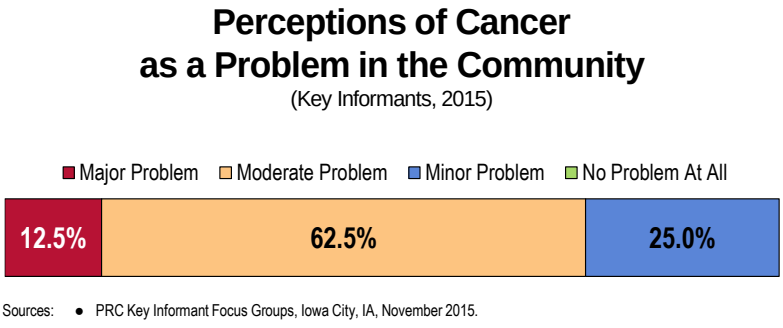
Top Concerns

Group discussion on this issue was relatively sparse, but it centered on incidence and prevalence:

> *"I think it probably mirrors our national trends of obesity and diabetes and heart disease."*
> *"Our high blood pressure diagnoses that people report continues to climb."*

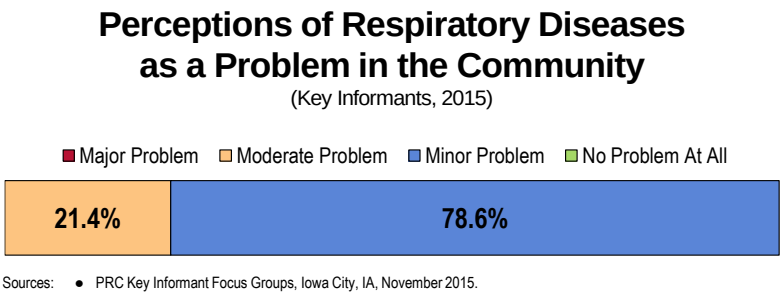
Cancer

Over 6 in 10 key informants taking part in the focus groups characterized *Cancer* as a "moderate problem" in the community.



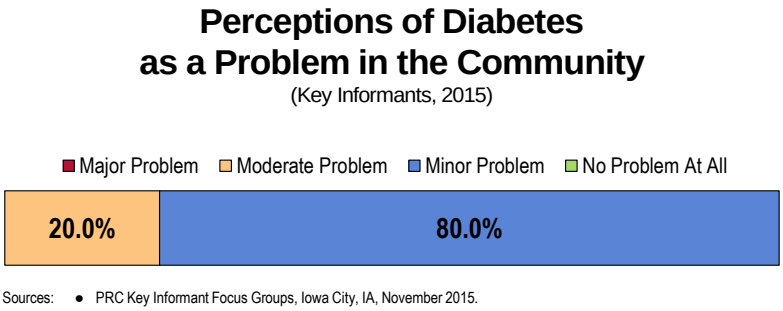
Respiratory Disease

The greatest share of key informants taking part in the focus groups characterized *Respiratory Disease* as a "minor problem" in the community.



Diabetes

The vast majority of key informants taking part in the focus groups characterized *Diabetes* as a "minor problem" in the community.



Top Concerns

Group discussion on this issue was relatively sparse, but it centered on the following issues:

- Prevalence/Incidence
- Health Programs

Prevalence/Incidence

In group discussion diabetes was lumped under chronic disease. Participants noted that these types of diseases are often preventable, but a majority of healthcare expenditures are going toward treating them. In general, respondents feel that the community is similar to the rest of the nation in terms of prevalence and incidence.

> *"Chronic disease is obviously a huge issue for our community. I've heard reports of 70% of our healthcare dollars goes to chronic disease, and those typically are things that we can control. I know that the free med [clinic] is doing a fantastic job in meeting some of those needs, but I think there's still*

> *some question on easy access."*
>
> *"I think Johnson County probably mirrors our national trends of obesity and diabetes and heart disease."*

Health Programs

Even though there are existing programs for diabetes and chronic disease education, these programs may not be available to everyone in the community, or the wait time might be weeks. In addition, some services might overlap significantly, so collaboration between programs could likely improve.

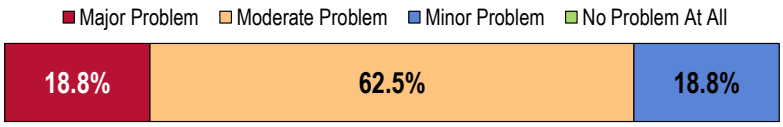
> *"We have a chronic disease program, and there's a 4-6 week waiting period to get into that."*
>
> *"We just did a quick community survey on diabetes outreach and classes. Most of the people we talked to knew of other services that were provided, but they were like Mercy: They were providing that service to their clients. It wasn't necessarily a community-wide effort that all the hospitals were working together to do a comprehensive outreach campaign on diabetes. They were doing it within their own silos. I don't know if there was a lot of overlap; there's a lot of the same services provided."*

Dementias, Including Alzheimer's Disease

A plurality of key informants taking part in the focus groups are most likely to consider *Dementias, Including Alzheimer's Disease* as a "moderate problem" in the community.

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community

(Key Informants, 2015)



Sources: • PRC Key Informant Focus Groups, Iowa City, IA, November 2015.

Top Concerns

One main was raised by group respondents in reference to this issue, namely prevalence/ incidence. Respondents were in agreement regarding dementia and its propensity to become a larger problem as the majority of the population grows older—both in terms of the aging Baby Boomers generation and the fact that people are now living longer.

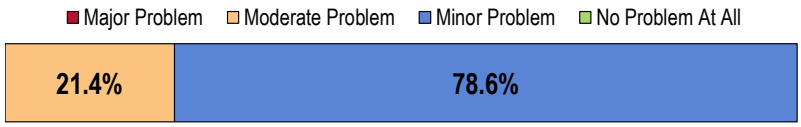
> *"The next great challenge is going to be Alzheimer's and dementia. I forget the statistic—1 in 10, maybe—baby boomers are going to develop some sort of dementia or Alzheimer's in the next decade or two. This is what I've heard."*
>
> *"We are living longer, and the result of that is going to be a higher percentage of people who suffer from dementia and Alzheimer's."*

Chronic Kidney Disease

Key informants taking part in the focus groups generally characterized *Chronic Kidney Disease* as a "minor problem" in the community.

Perceptions of Chronic Kidney Disease as a Problem in the Community

(Key Informants, 2015)



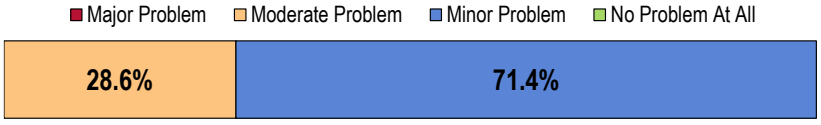
Sources: • PRC Key Informant Focus Groups, Iowa City, IA, November 2015.

Arthritis, Osteoporosis & Chronic Back Conditions

Most key informants taking part in the focus groups characterized *Arthritis, Osteoporosis & Chronic Back Conditions* as a "minor problem" in the community.

Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community

(Key Informants, 2015)



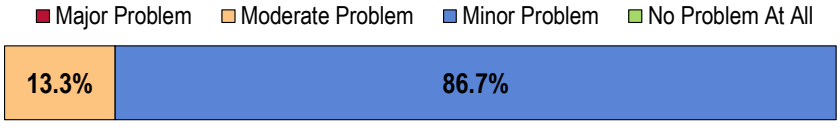
Sources: • PRC Key Informant Focus Groups, Iowa City, IA, November 2015.

Vision & Hearing

A vast majority of key informants taking part in the focus groups characterized *Vision & Hearing* as a "minor problem" in the community.

Perceptions of Hearing and Vision as a Problem in the Community

(Key Informants, 2015)



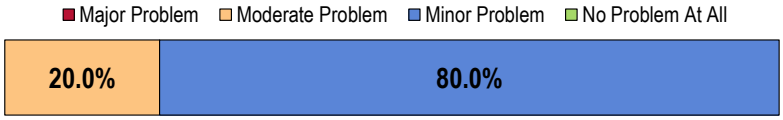
Sources: • PRC Key Informant Focus Groups, Iowa City, IA, November 2015.

Injury & Violence

A total of 8 in 10 key informants taking part in the focus groups characterized *Injury & Violence* as a "minor problem" in the community.

Perceptions of Injury and Violence as a Problem in the Community

(Key Informants, 2015)



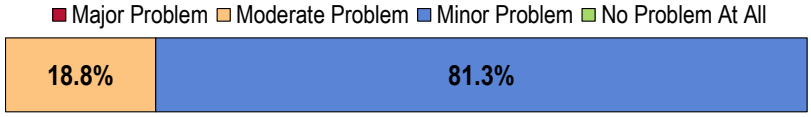
Sources: • PRC Key Informant Focus Groups, Iowa City, IA, November 2015.

Immunization & Infectious Diseases

Over 8 in 10 key informants taking part in the focus groups characterized *Immunization & Infectious Diseases* as a "minor problem" in the community.

Perceptions of Immunization and Infectious Diseases as a Problem in the Community

(Key Informants, 2015)



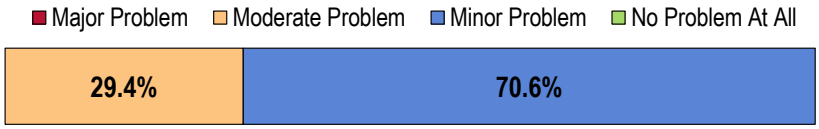
Sources: • PRC Key Informant Focus Groups, Iowa City, IA, November 2015.

HIV/AIDS

A majority of key informants taking part in the focus groups characterized *HIV/AIDS* as a "minor problem" in the community.

Perceptions of HIV/AIDS as a Problem in the Community

(Key Informants, 2015)



Sources: • PRC Key Informant Focus Groups, Iowa City, IA, November 2015.

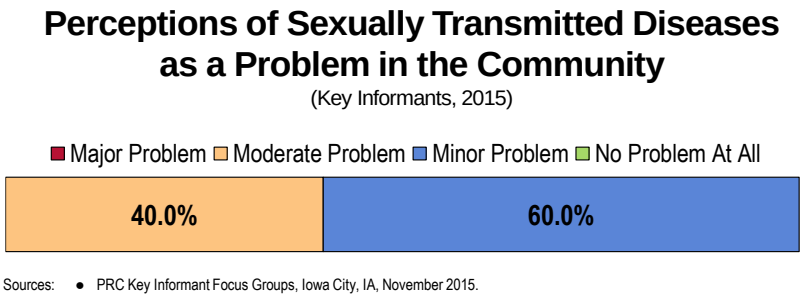
Top Concerns

Group discussion on this issue was relatively sparse, but it centered on the stigma associated with testing.

> *"The work that we do with some of our HIV clients, it's a completely free service. We've had some discussions with public health about billing—because it's not billable service—that we could recover a very small amount. And we made the decision not to bill because of the fact that the clients who comes to us for the HIV test wouldn't come if we were running that through their insurance company. They just absolutely wouldn't come in for a test because they don't want people to know that they are coming in for a test."*

Sexually Transmitted Diseases

A total of 6 in 10 key informants taking part in the focus groups characterized *Sexually Transmitted Diseases* as a "minor problem" in the community.



Top Concerns

Focus group respondents who felt that this is a notable concern in the community divided this issue into the following concerns:

- Prevalence/Incidence
- Awareness

Prevalence/Incidence

Respondents discussed the rise in the rate of sexually transmitted diseases in the community and how some of those rates exceed others across the state. In part, the large student population from the University might contribute to these rates, but group participants did not know how to explain the increase, whether an increase in sexual activity, or a decrease in safe sex education.

> *There's certainly been a rise across the state of Iowa in sexually transmitted diseases, specifically in Johnson County. Our rates are significantly higher than any other county or the state in syphilis and gonorrhea. Partly, I'm sure, because of our student population here. It's some outreach that we've done through public health, targeting specific population groups that are at high risk to that behavior. It doesn't mean that that doesn't lead to premature death as a risk behavior, but certainly something that is important to our community from a health perspective."*
>
> *"Planned Parenthood, the free medical clinic, and a lot of the clinics in town definitely see the increased [STI] rates that we have here."*
>
> *"I'm just trying to think of other things that Johnson County is doing worse than the state, and that's definitely one of the indicators that we have much higher rates than the rest of the state does."*
>
> *"It's always been higher, but certainly the last five years, we've seen an increase in the rate. I don't*

> *know if the activity has increased."*
>
> *"The public health department has condom distribution dispensers around the community, and upwards of 35,000 condoms a year are handed out for free. That's just staggering to me."*

Awareness

Participants feel that education on this topic is relegated mainly to the student population, though this focused education may have decreased recently, leading to a drop in awareness; high schools are still receiving some education on this topic. Admittedly, it is sensitive to discuss, which may explain why it's approached differently than the flu shot.

> *"I just think that the protection, awareness, and just the safe sex practices aren't being adhered to as much they were. I think part of that just goes back to education. Also, when you have increased alcohol rates and things like that, it sometimes goes up."*
>
> *"It's not an easy topic to talk about. Student Health at the University did a lot of work with the student population; it's just naturally focused on the student population, so it doesn't permeate too much into the community. It doesn't mean that we don't have non-university students with sexually transmitted disease; we certainly do."*
>
> *"I find that really interesting because it's logical, but I haven't heard anything about it. It seems like when other health issues arise in the community, we are quick to say, 'The flu's out.' So we just don't talk about it."*
>
> *"We are asked to go to high schools, just like to one or two class per year. They invite people to come in from the community with certain expertise, and we go out and do some sexual health education, as supplements to school curriculum."*

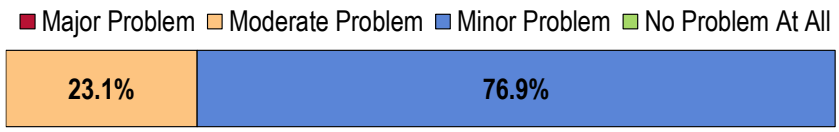
Birth Outcomes & Risks

Infant & Child Health

Just over 3 in 4 key informants taking part in the focus groups generally characterized *Infant & Child Health* as a "minor problem" in the community.

Perceptions of Infant and Child Health as a Problem in the Community

(Key Informants, 2015)



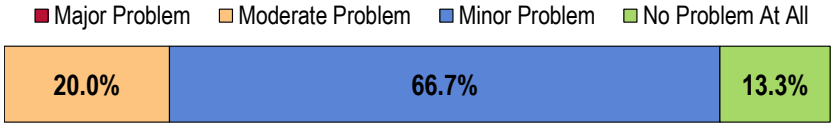
Sources: • PRC Key Informant Focus Groups, Iowa City, IA, November 2015.

Family Planning

Two-thirds of key informants taking part in the focus groups largely characterized *Family Planning* as a "minor problem" in the community.

Perceptions of Family Planning as a Problem in the Community

(Key Informants, 2015)



Sources: • PRC Key Informant Focus Groups, Iowa City, IA, November 2015.

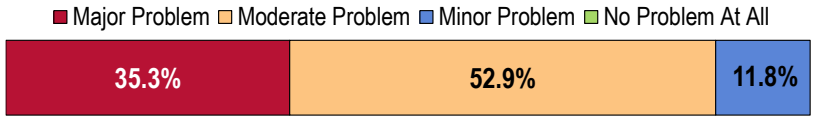
Health Behaviors

Nutrition, Physical Activity & Weight

Over half of key informants taking part in the focus groups characterized *Nutrition, Physical Activity & Weight* as a "moderate problem" in the community.

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community

(Key Informants, 2015)



Sources: • PRC Key Informant Focus Groups, Iowa City, IA, November 2015.

Top Concerns

Focus group participants noted several factors relative to this issue:

- Culture/Lifestyle
- Education
- Nutrition at School

Culture/Lifestyle

Group participants feel that local obesity rates are increasing, similar to the rest of the country; this is due, in part, to the American culture and lifestyle. Residents may cook less often than years past, eat less fresh and healthy food, and have medicine prescribed, instead of increasing physical activity. Though area obesity rates might be increasing, respondents still feel that their community is better off than the rest of the state, as well as the nation at-large.

> *"Our data tells us that our obesity rates continue to climb, not at the same steady rate as the state or the nation, but in Johnson County, our obesity rates continue to climb."*
>
> *"When it comes to situations like people coming to the pantry to get food, constantly I've heard over and over again, they'll take the carbs and not even try to take the fresh vegetables. North Liberty has tried to put together a garden program, and it was doing okay, but they just don't take the good stuff most of the time. They look for the quickie stuff, and out the door."*
>
> *"I think that's a societal issue; people don't eat the same way that I did when I was growing up. We cooked; there was a meal that was cooked every day with fresh food, and now people use fast food or starter meals, or whatever."*
>
> *"You know, 'Would you like chips, or would you like the apple?' I'll take the chips; every time I take the chips. I'm really conscious about it, but I think, 'Well, maybe next time I'll take that apple,' and I never have."*
>
> *"50 years ago when a child was hypertensive, what do they do? They sent him outside to play. Today, they put them on drugs to calm them down. I think we are now seeing the outcomes of the last 30 or 40 years of a doctor simply saying, 'Let's calm him down by the use of drugs. We've relied on the pharmaceutical solution to children, and it's now coming back to bite us."*

Education

Several points in the group were made regarding education for nutrition and physical activity.

Some participants feel that there really are few resources for child nutrition education, but there are also other factors that impact utilization for children, including cost and disengaged parents. For adults, it can be just as much of an issue to seek nutrition education for themselves as it is to seek for their child. Some adults may not have the self-efficacy to prepare healthy meals themselves or choose among unknown healthy ingredients, and they also might how the misperception that eating healthy costs more than eating the foods they are used to eating.

> *"There's more that could be done. It's definitely something that we see a lot of, this child obesity. There's not a lot of resources for people in the community to learn about healthy eating. There are places to go, but who's going to pay for it? Insurance won't cover it. You know, just getting people to participate. Because you can talk to the child, but if the parents aren't on board, nothing's going to happen."*
>
> *"We have a childcare program that deals mostly with homeless or near-homeless children. When we can get them out into the playground, where we also grow vegetables and things, the teachers always say that that's the most therapeutic, and that it's amazing the change in the children, afterwards. I don't know that we have gone to the populations and talk to them enough about what foods they like to grow and so on. Because some of the vegetables are different. So maybe that's what we need to be doing."*
>
> *"I think there are a lot of resources in the community for parents to learn about healthy eating. It's just that they would have to seek it out. I agree we need to do a better job with being proactive in getting that information out to the entire community."*
>
> *"I don't think they would know what to do with some of those vegetables. If there was some way to get parents in and teach them how to make foods with different fresh vegetables- but I think there's a lot of people who don't know how to cook with them."*
>
> *"I think that when you go to the pantry, you probably are choosing the foods that you're most comfortable with- that are certain comfort foods for you. So I think it's going to take a lot of education and so on. I do remember somebody from an ISU extension once saying that she was teaching how to cook meals at the neighborhood centers, and they were amazed at how much cheaper it was. Some of them really didn't seem to know that you could cook these meals much cheaper than, say, going to a fast food place. A lot of it I think goes back to education, but in the end, it's possible."*

Nutrition at School

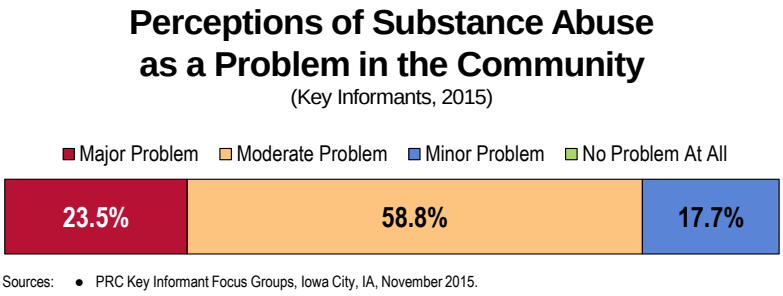
Related to education is schools. Group respondents discussed positive changes in school lunches but noted that the students may not be on board with all the changes. Other programs implemented through the schools seem to be having positive effects, including ones that introduce students to healthy snacks, gardening, and the importance of physical activity.

> *"One initiative that I perceive as really positive is happening in the Iowa City school system for lunches. There was the big push this year as far as birthdays; when my kids were in the school system, cupcakes, and all this great stuff and that's just not happening in the schools. Certainly recognizing that we celebrate birthdays, but that's at home with families and really taken the initiative to provide nutritious meals in the schools, so I think that's a very positive move. It's not going to happen overnight obviously."*
>
> *"The school lunch thing has been helpful, although, I will tell you that I hear complaints all the time from the kids. They absolutely hate it. They don't think they get enough to eat; they don't like what their choices are."*
>
> *"With the whole recycling push- 10 years ago or so- there was pressure for parents to start recycling. I think there's hope that if they do the healthier foods in the schools, there will be that, 'Can we have this at home?' I don't know that that will work."*
>
> *"One program that I think was pretty successful was Pick A Better Snack. I don't know if they do that at every school and if that was just something they were doing as a pilot project, but I did hear things about that. The kids were like, 'Hey, I tried this, and that was good.' It's just getting a lot of kids to try something as a vegetable."*
>
> *"[Schools] have a farm-to-school program that they invite local producers to come in and demonstrate*

> *food that they raise. And then they have a gentleman from New Pi Soilmates that explains composting and a lot of gardening techniques and things like that."*
>
> *"I know the Iowa City school system is doing a better job at tracking BMI so that over 5 to 10 years, they could start measuring the effects of some of the health programs that are in place. The walking school bus is fairly new. It started a number of years ago, but Blue Zones has really generated more awareness for the walking school bus."*
>
> *"There is also a program called the Two Bite Club, which is just introducing children new foods to take two bites and see if they like it."*
>
> *"I do know that schools have other programming. Girls On The Run comes into the schools and does running, which is more than just exercise. I think it's like a mentoring program."*
>
> *"Another thing with the school now, the kids will make posters on this Play 60 Program. They're just trying to teach the kids get outside. That's a good initiative. That one, I think, will be helpful in the long run."*

Substance Abuse

The greatest share of key informants taking part in the focus groups characterized *Substance Abuse* as a "moderate problem" in the community.



Top Concerns

Focus group respondents mentioned this issue briefly, mainly in terms of the younger generation. Participants are concerned that unhealthy behaviors could be set early in life, and it is a given that the culture for University students includes drinking and potentially abusing alcohol. Furthermore, one respondents noted that appearing drunk in public is more widely accepted and less of a faux pas than in years past.

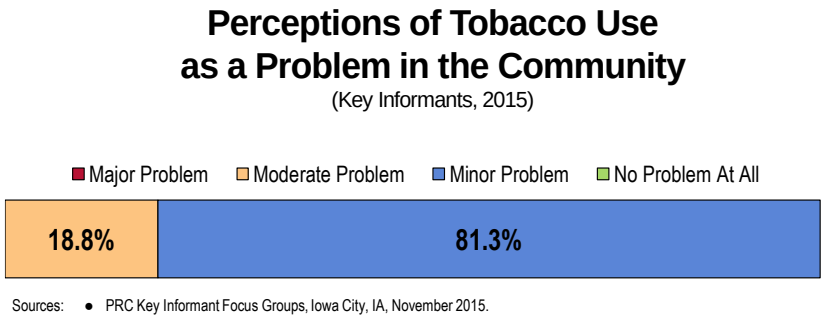
> *"I think our unique issue with alcohol or drug abuse would be just that we have a young student population, and so that set some unhealthy behaviors early. Not that I didn't drink when I was in college, but I don't think it's the same as I see now. I mean, when kids go out to the bars, they've already been drinking."*
>
> *"The University of Iowa is still #1 or #2 party school in the nation."*
>
> *"To me, it's a typical college campus."*
>
> *"I think that we are healthier than most of the state in our habits- in most areas except probably alcohol. But there's certainly room for improvement."*
>
> *"It seems to me that when I was young, if you could not hold your alcohol, it was a sign of great immaturity, and so on. So it would be hugely embarrassing to be out and not be able to manage alcohol. Whereas here, it sort of seems to be the idea of to get drunk as quickly as possible. So I've often wondered whether one doesn't have to change the sort of cultural view of the use of alcohol."*

Even with relatively new legislation in place to protect against underage students being admitted to the bars after a certain time, the problem appears to have just shifted to drinking at home.

> *"I think [the 21 ordinance has] had a positive impact, but a lot of the feedback we get is that they go elsewhere. They go to houses to drink, and things like that. It doesn't necessarily take care of the issue; it just redirects it sometimes."*

Tobacco Use

The vast majority of key informants taking part in the focus groups characterized *Tobacco Use* as a "minor problem" in the community.



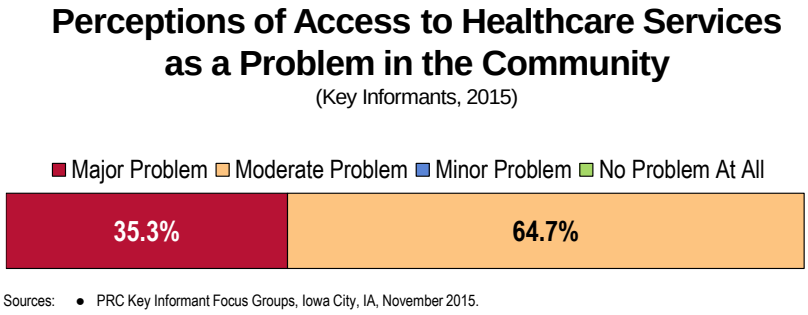
Top Concerns

Group discussion on this issue was relatively sparse, but it centered mainly on funding. Key informants realize the amount of money that is still going toward tobacco education and prevention. However, participants were not be clear how all of the funding is being applied, or if redirecting it to other problem areas would negatively affect the progress that has been made in this area.

> *"I get a grant every year for $100,000 to work on tobacco education prevention. If we look at our tobacco rates in the last 20-30 years, they've steadily been declining. But were continuing to fund that. I think it's important, because as soon as we stop funding it, they're going to start creeping back up because we do so much work with the youth and prevention."*
>
> *"Just take tobacco, for instance. With the tobacco settlements with the companies years ago, it was mandated that funding would go back into tobacco education. If that was true, the state of Iowa would disperse about $35 million to fight tobacco; currently, that funding is between $5 and $6 million. So all of the other $25 million, the state is using at their own discretion against what was mandated that it should be used for. It's going into the general fund."*

Healthcare Access

Key informants taking part in the focus groups most often characterized *Access to Healthcare Services* as a "moderate problem" in the community.



Top Concerns

Focus group participants felt strongly about healthcare access issues and much of the group discussion was devoted to this issue and centered on the following concerns:

- Lack of Resources
- Education
- Language Barriers
- Cost/Insurance
- Underserved Populations

Lack of Resources

Respondents were divided in terms of access to care, mainly in terms of what resources are available. They agreed that the local hospitals are a great asset for the community, but some feel that resources such as the free medical clinic are stretched thin, resulting in long wait times and some needs remaining unaddressed; some of the population might not even realize that this clinic exists for their use, so the awareness level could potentially be improved. Some residents also over-utilize the emergency department, whether from ignorance of available services or lack of other options.

> *"We refer a lot of people over to the free medical clinic. They have struggles like any nonprofit with capacity and hours, so you have to have an appointment. I was talking to a Sudanese group in our community, and its 4-8 weeks for them to get in to the free med. So there's a little bit of a lag time there."*
>
> *"I would say I think we have quite a few options in town with our three hospitals, because we also have a VA hospital (veterans' hospital). Then I'm really proud of our free medical clinic, and I don't know that many communities have that. I know that it's well-used, but I don't know how many people in the community know about it."*
>
> *"The access to care here is excellent. We have the university. We have the VA. We have Mercy. There are probably more doctors than are needed in this community, and there's more MRI and CT scanners than most communities have. But when I compare my day to my colleagues' day, for example, in New Jersey or California, I feel like our patient mix and population is healthier, and they're more in touch with what they need, what they want. They bring in articles to talk about preventive care or treatment options for various diseases. There's a lot of family support in this community, and just the local*

> *government has a lot of things in place for the elderly and those who may not have the ability to get access to healthcare because of economics. Yeah, I think it's a good environment."*
>
> *"I think that it's good that we have both Mercy and the University. Both of them donate certain things to the Free Medical Clinic. But there is still a big need out there. I feel like I do a lot of putting Band-Aids on things. The clinic itself doesn't have the resources to fulfill the needs that are out there."*
>
> *"We have top-notch hospitals. I mean, they're recognized worldwide. So the ability is there. The question is: Is the delivery up to the ability to give?"*
>
> *"From my perspective, having a Level I trauma center and burn center, having Mercy Hospital a Level III trauma center, both EDs are excellent. But I will reiterate on a common theme. We have a large—and getting larger—population of individuals who don't access the right kind of healthcare. And a large segment of that is because of mental health issues. They utilize an ambulance and the emergency department as their primary source of healthcare, which obviously is the most expensive healthcare you can get. That's only expanding and getting worse.*

For those without a car, transportation to appointments is also an issue, as the bus service is limited.

> *"Transportation is a big issue. Especially for the number of the older people that we have coming into North Liberty, bus service or Uber or anything you want to get is quite lacking. So if you can't get there, you can't get treated."*

Language Barriers

Participants also discussed refugees and immigrants, who may not speak English. One respondent noted that any access barrier is exponentially more of an issue if one cannot speak the common language. In general, the Spanish-speakers are better off than other languages, as the former likely can utilize interpreters at appointments, at the very least. Without an interpreter, many might resort to using their children as translators, which is not allowed at the health department.

> *"A lot of times for the people we serve, language, and transportation are both barriers that we can improve on in this community."*
>
> *"All the things as far as access goes has really impacted for people who speak a different language—or their culture is different than the majority culture. Any hurdle that you have, it's double the hurdle. That, plus some of the people that I work with—because of their document status—the accessibility to different services would be limited. So that is a factor, as well."*
>
> *"I think this increasing immigrant population—even language barriers, or knowing the questions to ask, or what services are available to them."*
>
> *"I think the language barriers play a part of this, too, but for the diversity of people who come in here and may not have an inkling of English, interpreters may not be readily available. Certainly, the Hispanic is in a better position, but persons from Sudan and other countries like that, it's hard to ask them something when you don't know how to speak to them."*
>
> *"We also have a language barrier. Over a third of our patients speak primarily Spanish, and then we have patients who speak Chinese and Arabic and French, and other dialects. So to find somebody who could provide those services, that is hard to do. And the patients aren't interested if they aren't going to understand. We have exercise equipment that they can use, but somebody has to be able to show them how to use it."*
>
> *I think it's certainly language. We certainly have fairly large refugee populations in pockets in our community, and we're seeing a trend of some Congolese refugees who speak a tribal language, Swahili, and if they have any education, maybe some French. That does for them create a lot of barriers. So language I think is an issue. I think we've done a pretty good job as a community with Spanish and Spanish-speaking access, but for other languages we have a lot of work to do and that includes for healthcare.*
>
> *"I believe the health department has a policy that they don't use the children as the translator. So if mom is ill, the child is not having to do all the translation. And I think that that, policy-wise, is a very important decision."*

Cost/Insurance

One hot topic during conversation was the Affordable Care Act and its effect on access to healthcare. On a positive note, it seems that more individuals are coming to the emergency department with some form of health insurance, which definitely helps with overall costs. While some aspects have grown better, it might now be more difficult to qualify, and many likely do not understand how to navigate the system; for those without resources, mainly monetary, it can be even more difficult, and the system continues to evolve.

> *"I think we've seen a big impact with the Affordable Care Act. Far more of our patients now have some form of health insurance. Our amount of debt from the last fiscal year has decreased significantly, and there are some other reasons for that as well. But I think some of that's because of the Affordable Care Act and access to health insurance. The amount of patients that we have with Medicaid in the last year alone has increased 30%. I don't know if it's 30% more patients, but we billed out 30% higher with Medicaid this year than we did last fiscal year. That's the most significant jump I've seen. So that's a great thing for those individuals."*
>
> *"There have been some improvements with the ACA, and some things that are worse. I have actually been seeing more patients who no longer qualify for the Affordable Care Act – Iowa Health and Wellness. I have seen some of my patients be able to get onto Iowa Health and Wellness or afford some insurance, but the premiums are going way up this year. I am expecting that we're going to be seeing people who we had been able to get into private practices in the community coming back to our clinic. In the first few months when it was being implemented, it certainly was more confusing. That settled down over time. But it certainly did not make things any easier."*
>
> *"I think that there are a lot of great things in place for people who have resources. But for a lot of our underserved populations and folks who are struggling, then that's a very different picture for them."*
>
> *"One of the new things that's happening this upcoming year is that the state has privatized Medicaid. We're going to four plans. Some potential challenges there, too, because you're talking about four different companies that you might have to interface with for that population. For the individuals and the clients themselves, I think it's going to be so confusing, because they literally have to choose from one of the four, as well."*
>
> *"It's going to create hurdles for every provider and every patient. I think it's going to create mass confusion just in wading through the contracts. I'm fortunate in that I have the county attorney's office to assist me, but small providers don't have good access to legal. There are so many questions that are still to be answered, and they expect everybody to be enrolled by the 1st of January, or if you submit claims, they're going to be denied. It's not going to happen; not by then."*
>
> *"We've had some feedback from some of the nonprofits that we work with that have said they've already seen people being taken off the lists. They might have provided them with some services, and then they find out they were off the list. So they weren't being reimbursed for services that they thought they were going to be reimbursed. It certainly is affecting the nonprofit community and the government in regards to that. Because of this change for individuals, it may be very complicated to figure out how to sign up for one of those four."*
>
> *"I see people at the University who can't afford medication, who are being turned away because there's no options."*
>
> *"Healthcare can be very expensive, and people have to make choices. I think Iowa City offers a lot, but it really helps a lot if you can afford it and if you have insurance."*

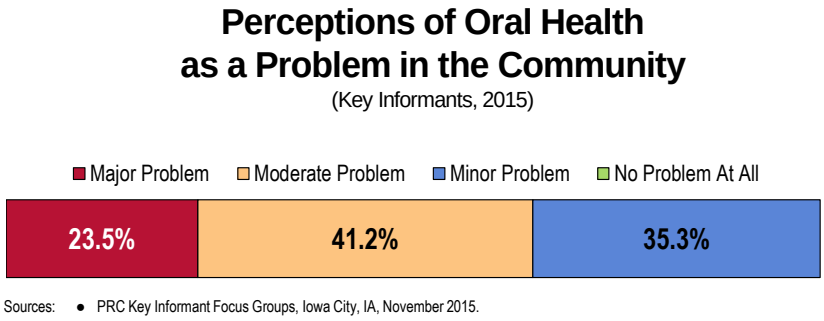
Underserved Populations

Even though participants are generally pretty positive about their community's health, they do acknowledge that some populations are underserved, whether that is in terms of income, insurance, language, or other factors that leave them vulnerable. Some respondents feel that the community has a responsibility to improve access to healthcare for these populations.

> *"I see where the need is, and there is still a lot of need. I think if you do look at average across the country and the whole general population, Iowa City is doing pretty well. But I can tell you that there are a lot of people out there who still need access to healthcare. Even more people need access to mental healthcare. A lot of people, even if they have insurance, they can't get in to see someone in mental health in a timely fashion."*
>
> *"Access I think sometimes is really a concern. It's like, which population are you really talking about? I think it is some of those more vulnerable ones. I've heard that with in terms of accessing the ERs at the right setting or getting people at the right place for care. I would give us a high grade on quality, but I think there's a still a portion of the population that just does not see that and does not benefit."*
>
> *"I love this community, and I just think there's so many wonderful things. But we have this point where we need to grab on and address some of the issues we're talking about that create barriers to access and lack of resources, and things like that. Because looking at national levels- even some Iowa levels- our community is still better off. But we're just growing, and that disparity may continue to grow. So we need to create opportunities to help the different families and community members that need that kind of access."*

Oral Health

Key informants taking part in the focus groups most often characterized *Oral Health* as a "moderate problem" in the community.



Top Concerns

Focus group respondents mentioned this issue briefly, mostly in terms of the available services. It seems that this is more of an issue for the uninsured or underinsured, as the free medical clinic has limited services, and schools may no longer be offering related programs.

> *"The Free Medical Clinic does have hygienists come in fairly frequently, but there are not a whole bunch out there. I think it's one or two days per week that they have dental services."*
>
> *"I don't know. Short answer: We don't know. I'm not sure about the schools. I do know that they have other programming though."*
>
> *"Dental care and access to dental care for anyone who doesn't have resources is a really huge challenge for our community, including children. Kids who are experiencing dental pain and other kinds of dental needs have a really hard time concentrating in school, so it affects achievement as well."*

Collaboration

Top Concerns

Some of group discussion focused on collaboration between nonprofits in the community, especially in terms of effort duplication. Group respondents feel that the community really stands out in terms of the number of nonprofits it has, but sometimes there can be too much of a good thing. It may be an issue of funding and wanting to use an idea that has been shown to be successful, but there might also be an issue of legitimately being unaware of what is currently being offered. Most participants agree that program sustainability is an important factor.

> *"I think I would say that Johnson County is rich with resources, with the coalition. I'm just amazed; I'm constantly learning new collaborations and partnerships. I've only been here for four years, but there's still so much I'm learning. I'm involved in a lot of different outreach, from a public health standpoint, but there's still things out there that I'm unaware of."*
>
> *"We've got too many nonprofits. There's probably five or six cases that I can point to that we denied a grant and said to them, 'Why don't you collaborate with another social services entity?' But, obviously, that's not what your people who form that nonprofit want to hear."*
>
> *"Nonprofits are smart enough, so all they do is they start to mission creep and offer this program that could have been offered over here, had it been funded right. I think that there's an awful lot of nonprofits out there."*
>
> *"I would say nonprofits are pretty smart about figuring out, 'If someone else is doing this, then I'm not going to spend my resources doing it."*
>
> *"There is duplication. When you have so many nonprofits, you look at sustainability of your nonprofit. If a program that you started isn't working, for whatever reason, what do you do? Mission creep. You start to look around for other things that are a profitable and a sustainable entity to you. So, you do get mission creep within the nonprofits."*
>
> *"There is a lot of duplicative effort, and money is being spent on that duplication."*

Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Healthcare Services

- *Free medical clinic*
- *Government programs*
- *Lingual services*
- *Local hospitals*
- *Local physicians*
- *School-based health clinics*
- *Transportation services*

Arthritis, Osteoporosis & Back Conditions

- *Educators*
- *Local hospitals*
- *Local physicians*
- *Prescription programs*

Cancer

- *Cancer providers*
- *Local hospitals*
- *Local physicians*

Dementias, Including Alzheimer's Disease

- *Fitness programs/opportunities*
- *Local hospitals*
- *Local physicians*

Diabetes

- *Diabetes education programs*
- *Internal medicine physicians*
- *Local hospitals*
- *Local physicians*

Family Planning

- *Local hospitals*
- *Local physicians (family physicians, obstetricians)*
- *Planned Parenthood*

Heart Disease & Stroke

- *Bike paths*
- *Health promotion projects*
- *Local hospitals*
- *Local physicians & extenders*

Mental Health

- *Community Mental Health Center*
- *CRISIS Center*
- *Local hospitals*
- *Local physicians*
- *Local psychologists & psychiatrists*
- *MECCA*
- *School-based health clinics*

Nutrition, Physical Activity & Weight

- *Bariatric medicine*
- *Blue Zones initiative*
- *Local hospitals*
- *Local physicians*
- *School-based programs*

Oral Health

- *Dental clinic*
- *Dental school*
- *Free dental clinic*
- *Local dentists*
- *Medicaid*

Substance Abuse

- *Community partnerships*
- *Local hospitals*
- *Local physicians*
- *Prelude (Mecca)*