CHI Health
A member of CommonSpirit

Community Health Needs Assessment

CHI Health Mercy – Corning, IA
2025

Adopted April 2025

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INTRODUCTION

EXECUTIVE SUMMARY

CHNA Purpose

The purpose of this Community Health Needs Assessment (CHNA) is to identify and prioritize significant health needs in the community served by CHI Health Mercy Corning. The priorities identified in this report help to guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

CommonSpirit Health Commitment & Mission

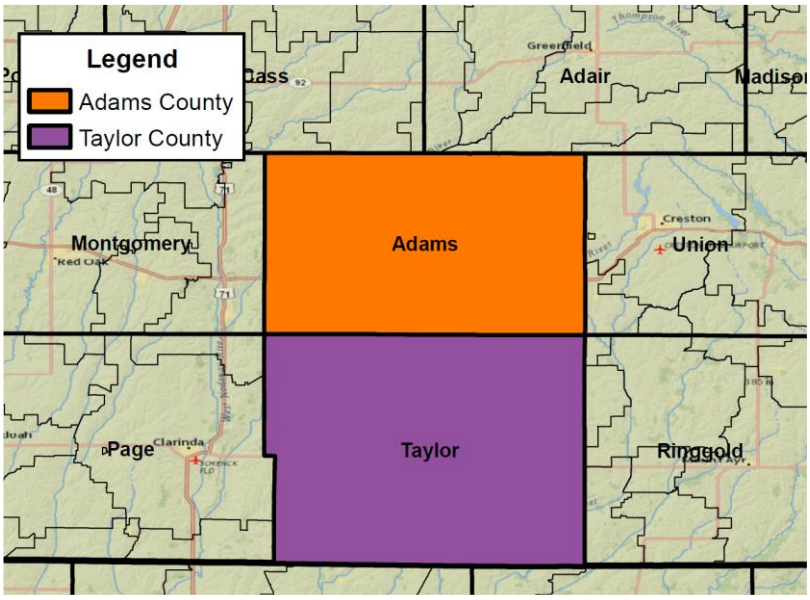
The hospital's commitment to engaging with the community, assessing priority needs, and helping to address them with community partners is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

CHNA Collaborators

This assessment was conducted solely on behalf of CHI Health Mercy Corning by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Community Definition

CHI Health Mercy Corning is a critical access hospital located in Adams County, but also serves residents from Taylor County; there are no other hospitals in either county. In light of this, CHI Health Mercy Corning identified Adams and Taylor counties as the community definition for the purposes of this CHNA. These counties also house the majority of the hospital's primary service area (ZIP Codes 50833, 50841, 50848, 50851, 50853, 50857, and 50859) which represent 80% of patients served. This community definition is illustrated in the following map.



Assessment Process & Methods

This assessment incorporates data from the PRC Online Key Informant Survey, as well as secondary research (vital statistics and other existing health-related data).

Primary Data Collection. The PRC Online Key Informant Survey allows key community leaders and providers in the area an opportunity to give extensive qualitative input about what they see as the most pressing issues in the populations they serve.

Secondary Data Collection. Secondary data provide information from existing data sets (e.g, public health records, census data, etc.) that complement the primary research findings.

Identifying & Prioritizing Significant Health Needs

Significant health needs for the community were identified through a review of the data collected for this assessment. These were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the key informants giving input to this process.

Prioritization of the health needs was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

This process yielded the following prioritized list of community health needs:

1. **BEHAVIORAL HEALTH** ► Key informants identified mental health and substance use as top health concerns in the community. Existing data revealed needs relative to the availability of mental health providers.
2. **CANCER** ► Key informants identified cancer as a top concern in the community. Cancer is a leading cause of death, and data revealed a relatively high rate of prostate cancer incidence.
3. **TOBACCO USE** ► Key informants identified this as a top concern in the community. Existing data revealed needs relative to the prevalence of cigarette smoking.
4. **HEART DISEASE & STROKE** ► Cardiovascular disease is a leading cause of death in the community and local heart disease and stroke mortality rates are relatively high.
5. **INFANT HEALTH & FAMILY PLANNING** ► The local rate of births to teenagers is relatively high (especially in Adams County).
6. **ACCESS TO HEALTH CARE SERVICES** ► Existing data revealed needs relative to the availability of primary care physicians (especially in Taylor County).
7. **INJURY & VIOLENCE** ► The local death rate associated with unintentional injury is relatively high (especially in Taylor County).
8. **RESPIRATORY DISEASE** ► Lung disease mortality is relatively high, as is the prevalence of chronic obstructive pulmonary disease.

Social determinants of health (especially housing), which impact all of the above, are also of significant concern to local key informants.

Resources Potentially Available to Meet Significant Health Needs

Measures and resources (such as programs, organizations, and facilities in the community) potentially available to address the significant health needs were identified by key informants giving input to this process. While not exhaustive, this list — which includes dozens of potential resources — draws on the experiences and wide knowledge base of those directly serving our community.

Report Adoption, Availability & Comments

This CHNA report was adopted by the CHI Health Board of Directors in April 2025. The report is widely available to the public on the hospital's website, and a paper copy is available for inspection upon request at the Administration Office of CHI Health Mercy Corning. Written comments on this report can be submitted via mail to CHI Health - The McAuley Fogelstrom Center (12809 W Dodge Rd, Omaha, NE 68154 attn. Healthy Communities); electronically at: https://forms.gle/KGRq62swNdQyAehX8 or by calling Ashley Carroll, Market Director, Community and Population Health, at: (402) 343-4548.

IRS FORM 990, SCHEDULE H COMPLIANCE

For nonprofit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2022)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	6
Part V Section B Line 3b Demographics of the community	23
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	81
Part V Section B Line 3d How data was obtained	10
Part V Section B Line 3e The significant health needs of the community	13
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	20
Part V Section B Line 3h The process for consulting with persons representing the community's interests	10
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	84

ASSESSMENT PROCESS & METHODS

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented in July and August 2024 as part of this process. A list of recommended participants was provided by CHI Health Mercy Corning; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. 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.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 45 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	1
Public Health Representatives	2
Other Health Providers	9
Social Services Providers	3
Other Community Leaders	30

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. These populations include African-American residents, Asian residents, children (including those with mental health issues), people with disabilities (including children), older residents, those who farm, Guatemalan residents, Hispanic residents, unhoused residents, immigrants/refugees, LGBTQ people, those with Medicare/Medicaid, Portuguese residents, race car drivers, those in rural areas, people with serious illness, those who are undocumented, uneducated/undereducated persons, those without health insurance, and veterans.

Final participation included representatives of the organizations outlined below.

- Adams & Taylor Public Health
- Adams County
- Akin Lumber
- Bedford Community School District
- Bedford Economic Development Corp
- Behavioral Health Coalition of Admas and Taylor County
- CHI Health
- CHI Health Clinic
- CHI Health Mercy Corning
- Clarinda Health
- Conifer Health Solutions
- Farms Bureau
- Lenox
- Lenox Community School District
- Lenox-Bedford Times
- Matura
- Media Combb
- New York Life
- Preferred Properties
- Shearer Christmas Tree Farm
- Southwest Iowa Region Mental Health & Disability Services
- Southwest Valley Community School District
- Taylor County
- Vintage Park Apartments

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the service area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Benchmark Comparisons

Iowa & National Data

Where possible, state and national data are provided as an additional benchmark against which to compare local findings.

Healthy People 2030 Objectives

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After receiving feedback from individuals and organizations and input from subject matter experts, the US Department of

Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

For the purpose of this report, “significance” of secondary data indicators (which might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, 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. In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

CHI Health Mercy Corning invited written comments on the most recent CHNA report and Implementation Strategy both in the documents and on the website where they are widely available to the public. No written comments have been received.

SUMMARY OF FINDINGS

Summary Tables:
Comparisons With Benchmark Data

The following tables provide an overview of indicators in the service area, grouped by health topic.

Reading the Summary Tables

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

- In the following tables, Service Area results are shown in the larger, gray column.
- The columns to the left of the Service Area column provide comparisons between the two counties, identifying differences for each as “better than” (), “worse than” (), or “similar to” () the opposing area.
- The columns to the right of the Service Area column provide comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the service area compares favorably (), unfavorably (), or comparably () to these external data.

SOCIAL DETERMINANTS	DISPARITY BETWEEN COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Adams County	Taylor County		vs. IA	vs. US	vs. HP2030
Linguistically Isolated Population (Percent)	0.1	2.6	1.7	1.9	3.9	
Population in Poverty (Percent)	9.5	8.5	8.9	11.1	12.5	8.0
Children in Poverty (Percent)	5.4	6.2	6.0	13.0	16.7	8.0
No High School Diploma (Age 25+, Percent)	6.0	9.0	7.8	7.0	10.9	
Unemployment Rate (Age 16+, Percent)	1.8	1.9	1.9	2.7	3.9	
Housing Exceeds 30% of Income (Percent)	20.0	15.1	17.0	23.0	30.5	25.5

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

OVERALL HEALTH	DISPARITY BETWEEN COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Adams County	Taylor County		vs. IA	vs. US	vs. HP2030
"Fair/Poor" Overall Health (Percent)	17.0	19.2	18.4	16.5	17.9	

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

ACCESS TO HEALTH CARE	DISPARITY BETWEEN COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Adams County	Taylor County		vs. IA	vs. US	vs. HP2030
Uninsured (Adults 18-64, Percent)	5.7	7.7	7.0	6.1	11.2	7.6
Uninsured (Children 0-17, Percent)	3.6	4.5	4.2	3.6	5.1	7.6
Routine Checkup in Past Year (Percent)	79.8	77.9	78.6	77.4	76.1	

ACCESS TO HEALTH CARE (continued)	DISPARITY BETWEEN COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Adams County	Taylor County		vs. IA	vs. US	vs. HP2030
Primary Care Doctors per 100,000	162.0	17.0	72.9	117.2	116.2	

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

CANCER	DISPARITY BETWEEN COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Adams County	Taylor County		vs. IA	vs. US	vs. HP2030
Cancer Deaths per 100,000	210.1	205.8	207.4	199.2	182.7	
Cancer Incidence per 100,000 (Age-Adjusted)	508.2	449.0	471.4	486.8	442.3	
Female Breast Cancer Incidence per 100,000 (Age-Adjusted)			129.3	134.7	127.0	
Prostate Cancer Incidence per 100,000 (Age-Adjusted)	136.1	132.4	133.7	120.4	110.5	
Lung Cancer Incidence per 100,000 (Age-Adjusted)	52.9	56.1	54.6	60.7	54.0	
Breast Cancer Screening in Past 2 Years (Women 50-74, Percent)	78.0	79.0	78.6	78.7	76.5	80.5
Cervical Cancer Screening in Past 3 Years (Women 21-65, Percent)	82.6	83.3	83.0	83.5	83.7	84.3
Colorectal Cancer Screening (Age 45-75, Percent)	61.3	58.4	59.5	60.9	54.1	74.4

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

DIABETES	DISPARITY BETWEEN COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Adams County	Taylor County		vs. IA	vs. US	vs. HP2030
Diabetes Prevalence (Percent)	9.3	9.7	9.5	9.4	10.0	

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

DISABLING CONDITIONS	DISPARITY BETWEEN COUNTIES: Adams County	DISPARITY BETWEEN COUNTIES: Taylor County	Service Area	SERVICE AREA vs. BENCHMARKS: vs. IA	SERVICE AREA vs. BENCHMARKS: vs. US	SERVICE AREA vs. BENCHMARKS: vs. HP2030
Disability Prevalence (Percent)	14.7	12.8	13.5	12.2	12.9	

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

HEART DISEASE & STROKE	DISPARITY BETWEEN COUNTIES: Adams County	DISPARITY BETWEEN COUNTIES: Taylor County	Service Area	SERVICE AREA vs. BENCHMARKS: vs. IA	SERVICE AREA vs. BENCHMARKS: vs. US	SERVICE AREA vs. BENCHMARKS: vs. HP2030
Heart Disease Deaths per 100,000	221.2	202.5	209.5	139.4	112.5	
Stroke Deaths per 100,000	60.8	69.7	66.4	44.6	47.7	
High Blood Pressure Prevalence (Percent)	37.0	33.7	35.0	31.1	32.7	42.6
High Blood Cholesterol Prevalence (Percent)	38.0	36.2	36.9	34.4	35.5	

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

INFANT HEALTH & FAMILY PLANNING	DISPARITY BETWEEN COUNTIES: Adams County	DISPARITY BETWEEN COUNTIES: Taylor County	Service Area	SERVICE AREA vs. BENCHMARKS: vs. IA	SERVICE AREA vs. BENCHMARKS: vs. US	SERVICE AREA vs. BENCHMARKS: vs. HP2030
Low Birthweight (Percent of Births)	6.6	6.3	6.4	6.8	8.3	
Teen Births per 1,000 Females 15-19	25.9	16.2	19.6	14.4	16.6	

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

INJURY & VIOLENCE	DISPARITY BETWEEN COUNTIES: Adams County	DISPARITY BETWEEN COUNTIES: Taylor County	Service Area	SERVICE AREA vs. BENCHMARKS: vs. IA	SERVICE AREA vs. BENCHMARKS: vs. US	SERVICE AREA vs. BENCHMARKS: vs. HP2030
Unintentional Injury Deaths per 100,000	55.3	89.6	76.7	52.0	60.2	
Violent Crimes per 100,000	115.8	160.2	147.1	283.0	416.0	

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

MENTAL HEALTH	DISPARITY BETWEEN COUNTIES: Adams County	DISPARITY BETWEEN COUNTIES: Taylor County	Service Area	SERVICE AREA vs. BENCHMARKS: vs. IA	SERVICE AREA vs. BENCHMARKS: vs. US	SERVICE AREA vs. BENCHMARKS: vs. HP2030
Mental Health Providers per 100,000			33.9	193.5	311.0	

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY BETWEEN COUNTIES: Adams County	DISPARITY BETWEEN COUNTIES: Taylor County	Service Area	SERVICE AREA vs. BENCHMARKS: vs. IA	SERVICE AREA vs. BENCHMARKS: vs. US	SERVICE AREA vs. BENCHMARKS: vs. HP2030
Fast Food Restaurants per 100,000			31.3	65.4	80.0	
Population With Low Food Access (Percent)	6.4	4.2	5.1	20.0	22.2	
No Leisure-Time Physical Activity (Percent)	18.3	17.3	17.7	19.7	19.5	21.8
Obese (Percent)	24.3	26.6	25.7	33.4	30.1	36.0

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

ORAL HEALTH	DISPARITY BETWEEN COUNTIES: Adams County	DISPARITY BETWEEN COUNTIES: Taylor County	Service Area	SERVICE AREA vs. BENCHMARKS: vs. IA	SERVICE AREA vs. BENCHMARKS: vs. US	SERVICE AREA vs. BENCHMARKS: vs. HP2030
Dental Visit in Past Year (Percent)	68.2	63.8	65.5	66.7	63.9	45.0
Dentists per 100,000	108.0	33.9	62.5	62.5	66.4	

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

RESPIRATORY DISEASE	DISPARITY BETWEEN COUNTIES: Adams County	DISPARITY BETWEEN COUNTIES: Taylor County	Service Area	SERVICE AREA vs. BENCHMARKS: vs. IA	SERVICE AREA vs. BENCHMARKS: vs. US	SERVICE AREA vs. BENCHMARKS: vs. HP2030
Lung Disease Deaths per 100,000	77.4	92.9	87.1	55.8	46.0	
Asthma Prevalence (Percent)	10.1	9.8	9.9	9.9	9.9	
COPD Prevalence (Percent)	8.1	9.0	8.7	7.0	6.8	

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

SEXUAL HEALTH	DISPARITY BETWEEN COUNTIES: Adams County	DISPARITY BETWEEN COUNTIES: Taylor County	Service Area	SERVICE AREA vs. BENCHMARKS: vs. IA	SERVICE AREA vs. BENCHMARKS: vs. US	SERVICE AREA vs. BENCHMARKS: vs. HP2030
Chlamydia Incidence per 100,000	304.6	358.5	337.9	457.2	495.0	
Gonorrhea Incidence per 100,000	82.4	34.1	52.8	139.5	194.4	

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

SUBSTANCE USE	DISPARITY BETWEEN COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Adams County	Taylor County		vs. IA	vs. US	vs. HP2030
Excessive Drinking (Percent)	18.1	19.7	19.1	23.1	18.1	

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

TOBACCO USE	DISPARITY BETWEEN COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Adams County	Taylor County		vs. IA	vs. US	vs. HP2030
Cigarette Smoking (Percent)	16.0	17.7	17.1	15.7	12.9	6.1

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

Prioritized Description of Significant Community Health Needs

Identification of Significant Health Needs

The following represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. 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 preceding section).

The significant health needs were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the key informants giving input to this process.

Community Feedback on Prioritization

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

PRIORITIZED LIST OF SIGNIFICANT HEALTH NEEDS

Priority	Significant Health Need	Key Supporting Evidence
1	BEHAVIORAL HEALTH	▪ Mental Health Provider Ratio ▪ Key Informants: *Mental Health* (especially) and *Substance Use* ranked as top concerns.
2	CANCER	▪ Leading Cause of Death ▪ Prostate Cancer Incidence ▪ Key Informants: *Cancer* ranked as a top concern.
3	TOBACCO USE	▪ Cigarette Smoking
4	HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Heart Disease Deaths ▪ Stroke Deaths
5	INFANT HEALTH & FAMILY PLANNING	▪ Teen Births (esp. Adams County)

— continued on next page —

SIGNIFICANT HEALTH NEEDS (continued)		
Priority	Significant Health Need	Key Supporting Evidence
6	ACCESS TO HEALTH CARE SERVICES	▪ Access to Primary Care Physicians (esp. Taylor County)
7	INJURY & VIOLENCE	▪ Unintentional Injury Deaths (esp. Taylor County)
8	RESPIRATORY DISEASE	▪ Lung Disease Deaths ▪ COPD Prevalence

Social determinants of health (especially housing), which impact all of the above, are also of significant concern to local key informants.

Hospital Implementation Strategy

CHI Health Mercy Corning will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found at the end of this report.

COMMUNITY DESCRIPTION

DEMOGRAPHIC SUMMARY

Note the following demographic makeup of our community.

Core Demographic Summary

	Service Area
Urbanization	59.8% Urban
Total Population Size	9,600
Race & Ethnicity — *Hispanic*	4.6%
White	93.2%
American Indian or Alaska Native	0.4%
Asian	0.3%
Black	0.2%
Median Household Income (Adams/Taylor Average)	$65,338
Percent of Population Living in Poverty (Below 100% FPL)	8.9%
Unemployment Rate (September 2024)	1.9%
Percent of People Age 5 and Older Who are Non-English Speaking	1.7%
Percent of People Without Health Insurance (Age 18-64)	7.0%
Percent of People with Medicaid	22.4%
Health Professional Shortage Area	Primary Care, Dental Health, Mental Health
Medically Underserved Areas/Populations	Yes
Number of Other Hospitals Serving the Community	None

SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

– Healthy People 2030 (https://health.gov/healthypeople)

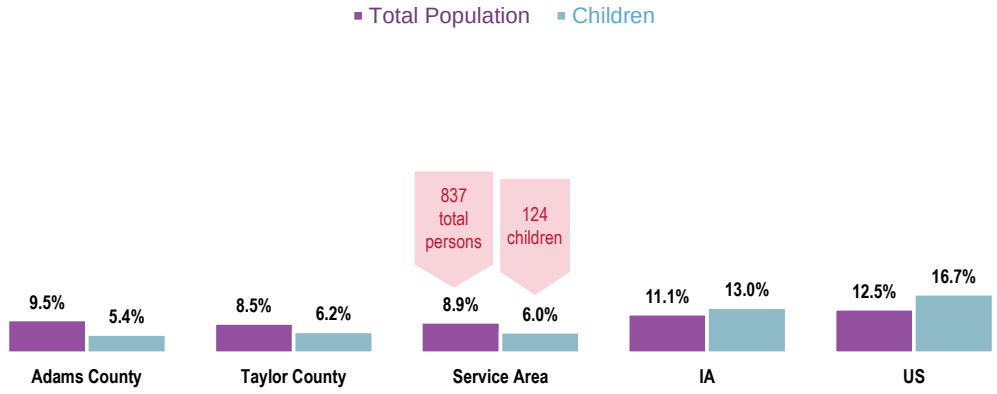
Poverty

Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to accessing health services, healthy food, and other necessities that contribute to health status. The following chart and maps outline the proportion of our population below the federal poverty threshold, as well as the percentage of children in the service area living in poverty, in comparison to state and national proportions.

Percent of Population in Poverty

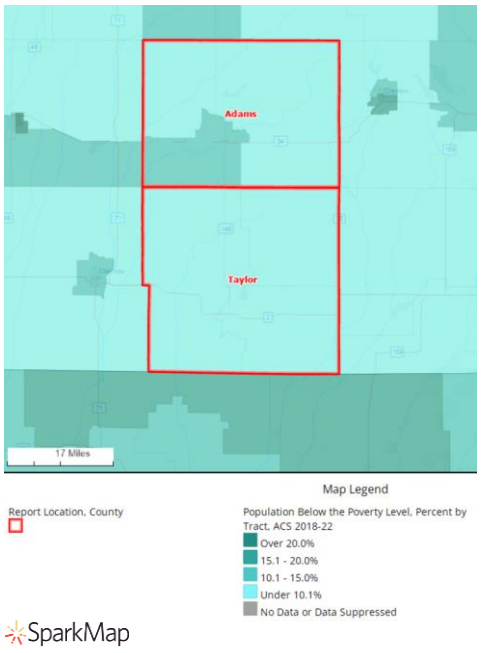
(2018-2022)

Healthy People 2030 = 8.0% or Lower

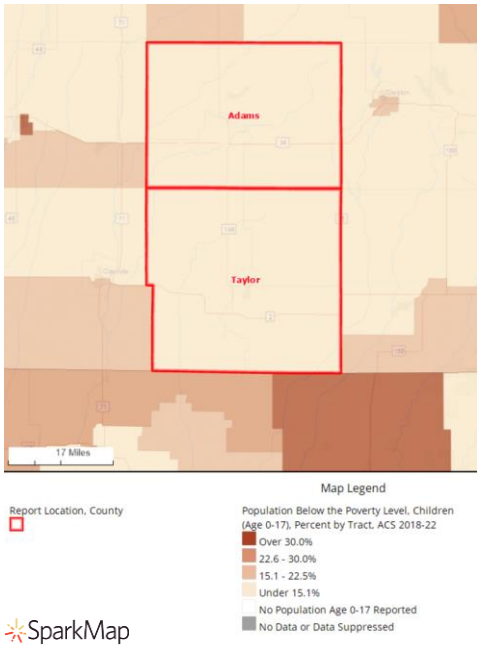


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Population Below the Poverty Level



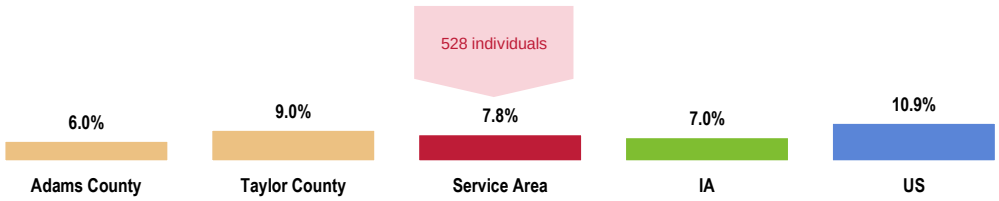
Children Below the Poverty Level



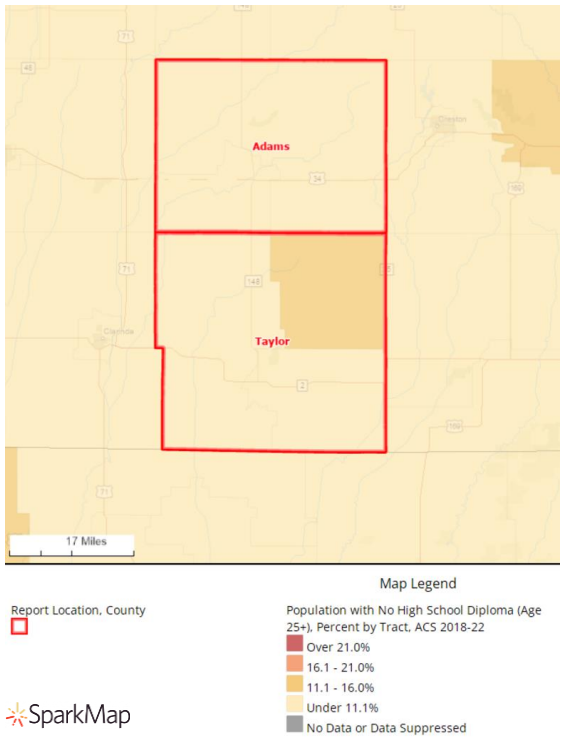
Education

Education levels are reflected in the proportion of our population age 25 and older without a high school diploma. This indicator is relevant because educational attainment is linked to positive health outcomes.

Population With No High School Diploma
(Adults Age 25 and Older, 2018-2022)

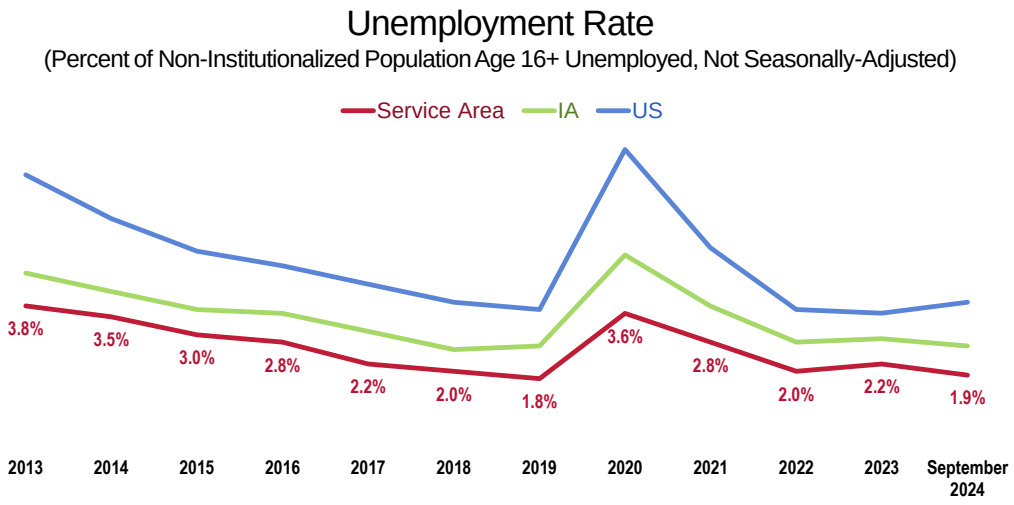


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).



Employment

Changes in unemployment rates in the service area over the past several years are outlined in the following chart. This indicator is relevant because unemployment creates financial instability and barriers to accessing insurance coverage, health services, healthy food, and other necessities that contribute to health status.

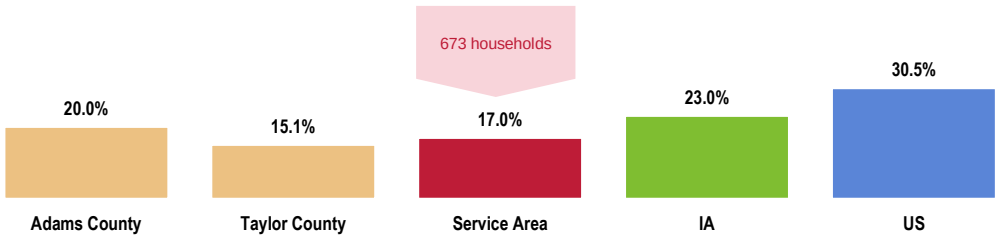


Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Housing Burden

"Housing burden" reports the percentage of the households where housing costs (rent or mortgage costs) exceed 30% of total household income.

The following chart shows the housing burden in the service area. This serves as a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels.



Sources:
- US Census Bureau, American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Social Vulnerability Index

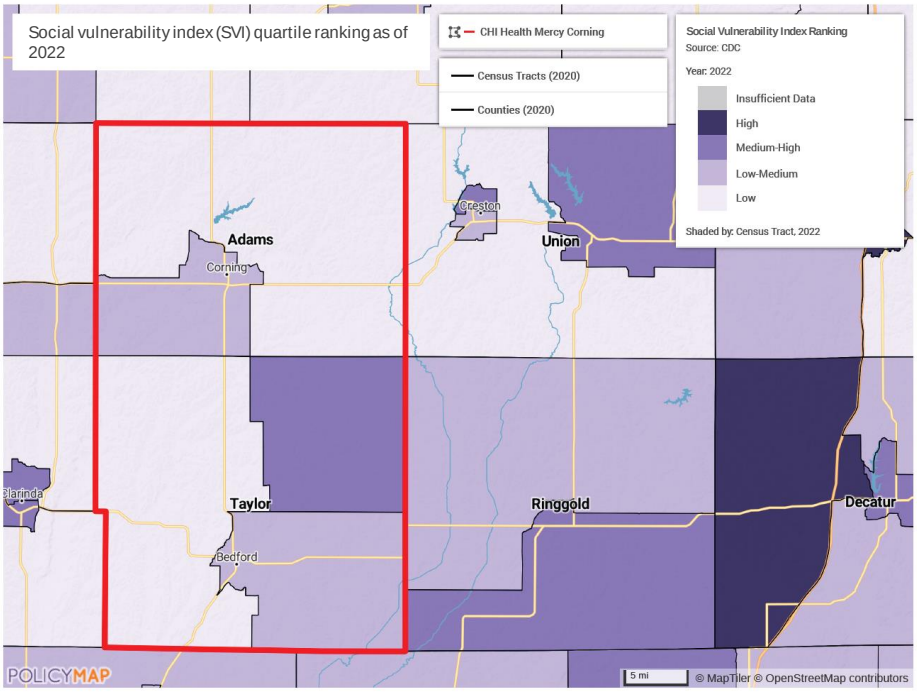
Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health. Such stresses include natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss.

The CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI) uses 16 US census variables to help local officials identify communities that may need support before, during, or after disasters.

The degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, may affect that community's ability to prevent human suffering and financial loss in the event of disaster. These factors describe a community's social vulnerability.

The social vulnerability index is a measure of the degree of social vulnerability in counties and neighborhoods across the United States, where a higher score indicates higher vulnerability.

Note those census tracts in the service area with the highest social vulnerability.



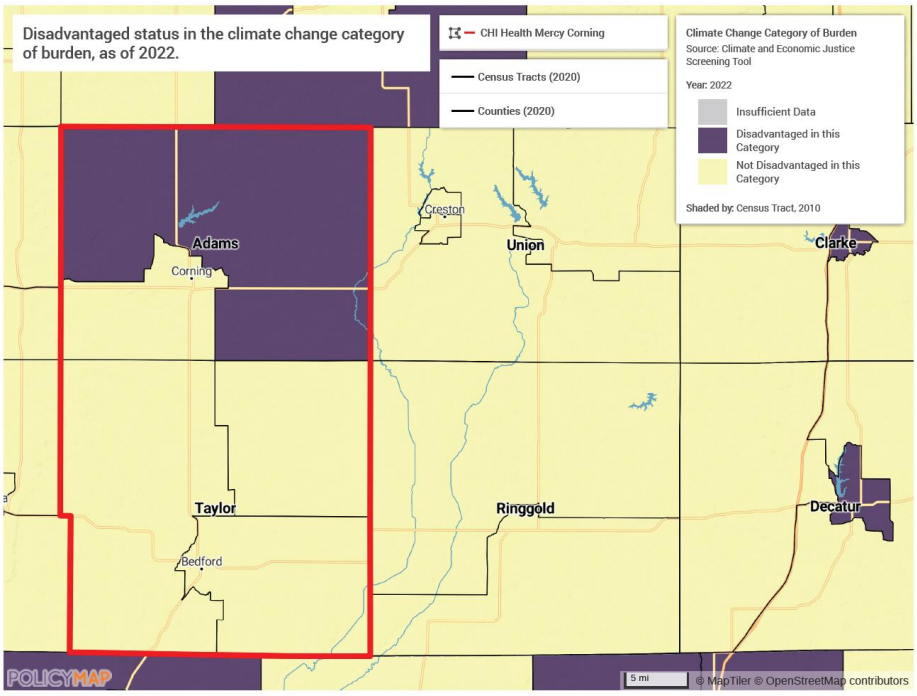
Source: Agency for Toxic Substances and Disease Registry, Centers for Disease Control and Prevention (CDC). Accessed via PolicyMap.

Climate Change Burden

The Climate and Economic Justice Screening Tool (CEJST) was developed by the Council on Environmental Quality to identify disadvantaged communities that face burdens across eight categories: climate change, energy, health, housing, legacy pollution, transportation, water and wastewater, and workforce development. CEJST combines a number of publicly available national datasets to identify disadvantaged communities.

Census tracts are considered disadvantaged if they meet the thresholds for at least one of the CEJST categories of burden or if they are on land within the boundaries of Federally Recognized Tribes. Meeting one of the CEJST categories of burden requires that a tract be at or above specified thresholds for one or more environmental, climate, housing, health or other burdens and be at or above the threshold for an associated socioeconomic burden (e.g., low income or low educational attainment). Additionally, a census tract that is completely surrounded by disadvantaged communities and is at or above the 50th percentile for low income is also considered disadvantaged.

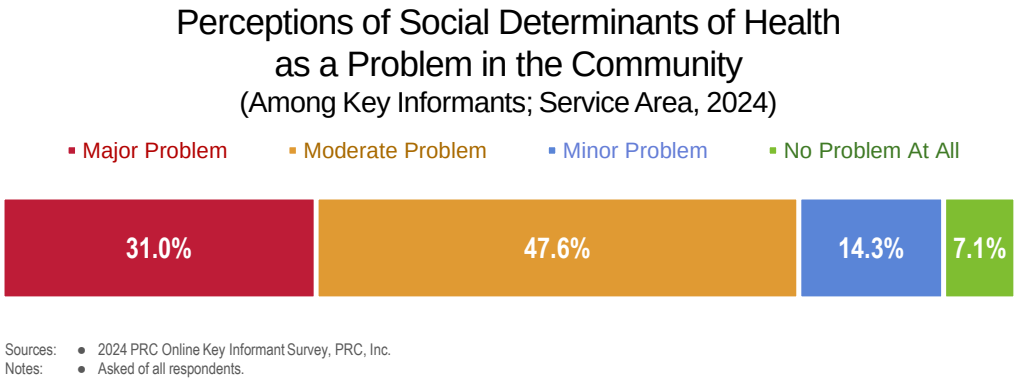
Note those census tracts in the service area with the highest burden relative to climate change.



Source: Council on Environmental Quality, Climate and Economic Justice Screening Tool (CEJST). Accessed via PolicyMap.

Key Informant Input: Social Determinants of Health

Key informants' ratings of the severity of *Social Determinants of Health* as a concern in the service area are outlined below.



Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Housing

> Available housing is limited in our communities, and there are many that need repairs. Food insecurity, limited transportation options, substance abuse. – Community/Business Leader
>
> The cost of housing and transportation has continually increased. Those with lower incomes find it difficult to pay rent, utilities and provide food. Often you are seeing people with bed bugs or chronic lice that families have no way to cover the expense of treatment. Having to drive further for basic health care needs causes many to be left untreated. Not having access to transportation or if you do have a vehicle that breaks down and there is no money for costly repairs and maintenance. There are many people who go without electricity during the summer when there are no programs available or the issue of homelessness and insecure housing. – Social Services Provider
>
> There is lack of availability of good housing in the area. – Community/Business Leader
>
> We do not have enough low-rent housing. More needs to be built!!! The one we have has a long waiting list that never seems to improve. Several have been on the list for years, and even if there has been openings, they are not notified and the apartment goes to someone else. In other words, if you are not the board's favorite you will continue to stay on the waiting list. Also, many landlords charge a lot for rent and do not do any upkeep on the houses. So many children are being home-schooled without any structure. Some have issues (dyslexia) and they are simply falling behind. They need some supervision form the local school. – Social Services Provider
>
> There is limited housing available. There is limited public transportation available. – Other Health Provider
>
> Lack of housing and, if available, lack of affordable housing. The counties have a high poverty percentage. – Social Services Provider

Impact on Quality of Life

> Social determinants of health, like adequate food, affordable housing and transportation are issues that various groups are struggling with, but more needs to be done perhaps via providing more jobs locally. – Physician
>
> A healthy person makes for a productive citizen. When basic needs are met, all benefit. – Community/Business Leader

Income/Poverty

> Health is a "normal good," meaning more of it will be purchased as income rises (economy expands). Being in a low-income area does not allow people to buy the proper foods, even if they know what is healthy – most do not. Stress from financial issues causes mental health problems, like depression, that decrease the motivation to live a healthy lifestyle. Access to affordable housing is limited, which hamstrings the economic growth of our community. – Community/Business Leader

Affordable Care/Services

> People cannot afford healthcare so they choose not to go to the doctor or the cost of healthcare is so expensive they can't afford it. – Other Health Provider

Hunger

> I believe there are students and adults in our communities that go hungry at night. – Community/Business Leader

HEALTH STATUS

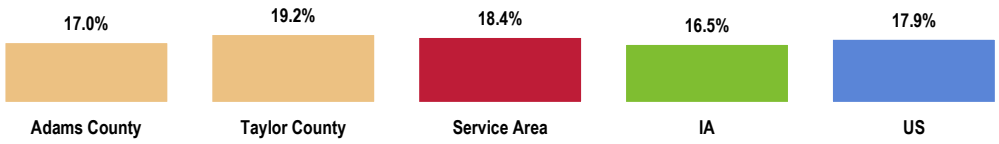
OVERALL HEALTH STATUS

The following indicator provides a relevant measure of overall health status in the service area, noting the prevalence of residents' "fair" or "poor" health evaluations. While this measure is self-reported and a subjective evaluation, it is an indicator which has proven to be highly predictive of health needs.

The CDC's Behavioral Risk Factor Survey, from which these data are derived, asked respondents:

"Would you say that in general your health is: excellent, very good, good, fair, or poor?"

Adults With "Fair" or "Poor" Overall Health
(2022)



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

MENTAL HEALTH

ABOUT MENTAL HEALTH & MENTAL DISORDERS

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

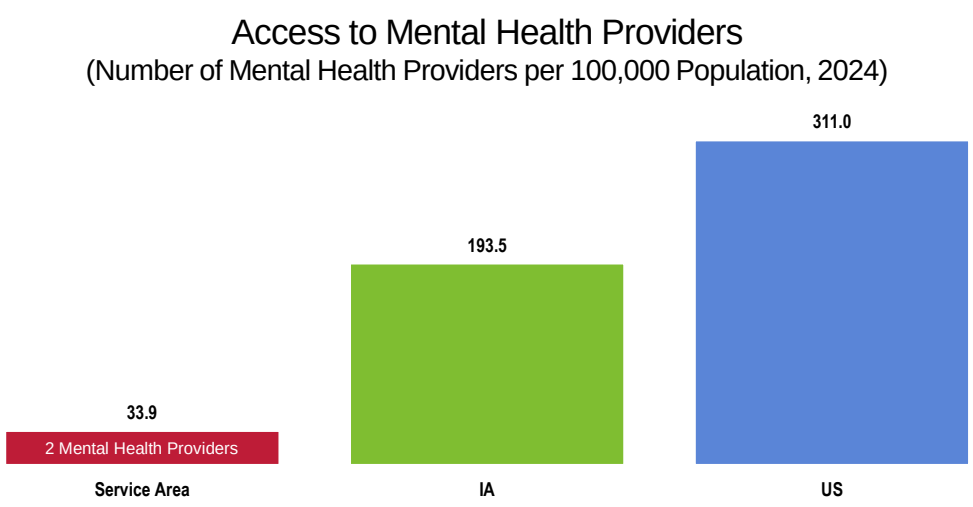
– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Providers

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care.

Note that this indicator only reflects providers practicing in the service area and residents in the service area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

The data below show the number of mental health care providers in the service area relative to the Service Area population size (per 100,000 residents). This is compared to the rates found statewide and nationally.

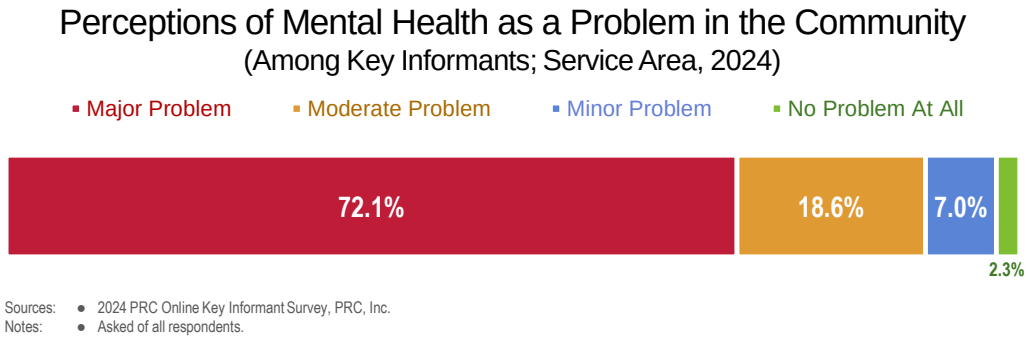


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

Key Informant Input: Mental Health

Key informants' ratings of the severity of *Mental Health* as a concern in the service area are outlined below.



Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

Places for people to get help and communicating to those who struggle that it's fine to ask for help. – Community/Business Leader

There are no local services, and many places that do accept someone in the outer areas are full. – Social Services Provider

Access to mental health services. We will have patients waiting in our Emergency Room for over 24 hours waiting for placement. – Other Health Provider

Sincere lack in mental health and behavioral health services within our community. Iowa serves one of the lowest serving states for mental health services per 100,000 people, with Adams and Taylor County in some of the lower percentiles of this. – Other Health Provider

Access to care for mental health clients. – Social Services Provider

Access to help. – Community/Business Leader

No direct facility in Taylor County for minors or adults with mental issues. They must travel to other facilities for care, and so much of the time there is a waiting list. – Community/Business Leader

Finding a therapist, psychiatrist or counselor who is available in person without having to drive a long distance. The lack of insurance or having Medicaid and being denied care due to not being able to pay. People are not seeking help because of the stigma, or because they have tried without success to find help before. – Other Health Provider

Services are not available locally. They are not in rural areas. – Community/Business Leader

Lack of facilities and doctors to help. – Community/Business Leader

Access to facilities and beds for those that need it. Resources for youth mental health. – Community/Business Leader

It's very difficult to have available beds at mental health clinics so these people can have appropriate treatment. This is especially true for those that have broken the law that are mentally ill. They seem to be sitting in jail, several months prior to having an available bed. – Community/Business Leader

Access and cost to mental health providers. Clients wanting to see someone often have to go out of town and there is often no transportation. If you don't qualify for Medicaid, many are unable to consistently afford a program. Insurance copays or spend downs are often too expensive for families unless for emergencies. VA has a good mental health program, but it too is out of town and you have to drive 30 to 90 miles to facilities. – Community/Business Leader

Access to licensed practitioners. – Community/Business Leader

Access to inpatient treatment facilities, counseling and therapists. – Community/Business Leader

There is a lack of facilities where patients can go to get the mental health treatment that they need. They end up sitting in the Emergency Rooms waiting for placement. – Other Health Provider

Access to services. – Community/Business Leader

> Timely access to professional services. – Community/Business Leader
>
> They do not have access to ongoing mental health. If a teenager threatens to commit suicide, they can be taken to a hospital and kept in their facility for 3 days and then they are discharged. There isn't any place for them to go on a longer term basis. There are more mental health counselors in the area than there was a year ago and that is good news for two counties with lower income population. – Community/Business Leader

Lack of Providers

> Not enough providers. Limited access. Limited collaboration with mental health region sources. – Public Health Representative
>
> There are very few therapists available in the area and then there is the affordability aspect. – Community/ Business Leader
>
> Lack of local shrinks. Need to travel to a larger city for a qualified shrink. – Community/Business Leader
>
> There are not enough providers to meet the demand. The demand will continue to increase as long as we continue to have unstable families with poor or absent father figures. – Physician
>
> We have two private MH practices and not enough therapists to fit the needs of our community. No mental health services at the clinic or hospital. I do not think telehealth should be the only access. In-person, MH therapists and a psychiatrist/psychologist are needed. – Community/Business Leader

Population Increase

> Too many are coming in to live here due to cheap housing and lack of employment. – Other Health Provider

Transportation

> Transportation to get to appointments. – Social Services Provider

DEATH, DISEASE & CHRONIC CONDITIONS

CARDIOVASCULAR DISEASE

ABOUT HEART DISEASE & STROKE

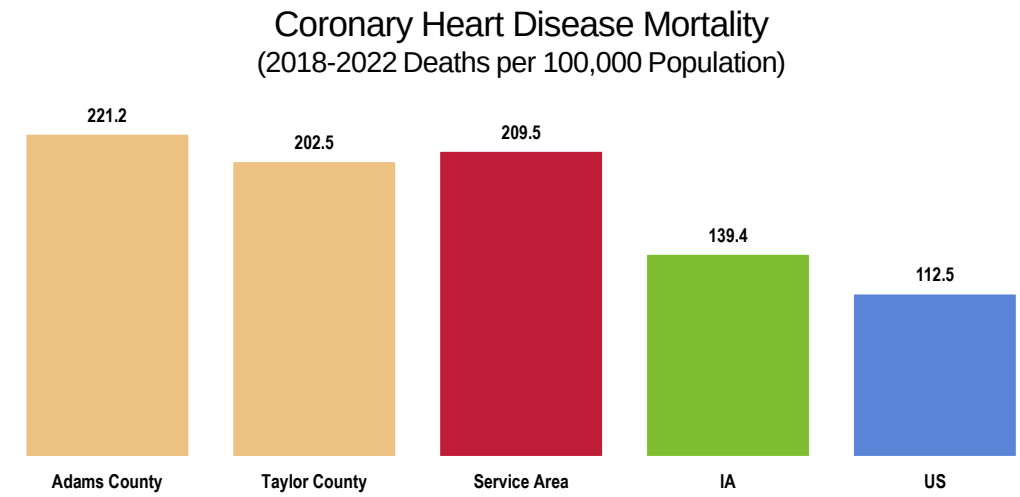
Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Heart Disease Deaths

Heart disease is a leading cause of death in the service area and throughout the United States. The chart that follows illustrates how our mortality rate compares to rates in Iowa and the US.

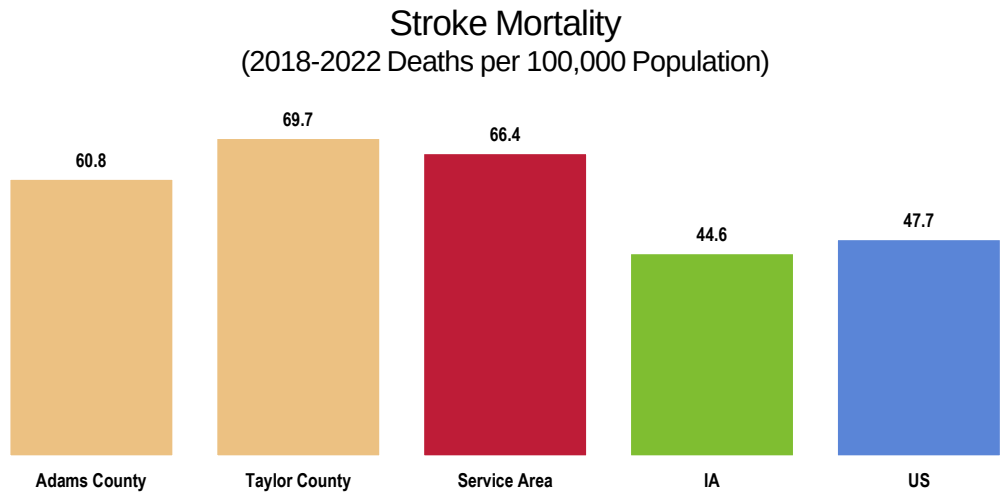


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Stroke Deaths

Stroke, a leading cause of death in the service area and throughout the nation, shares many of the same risk factors as heart disease. Outlined in the following chart is a comparison of stroke mortality locally, statewide, and nationally.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

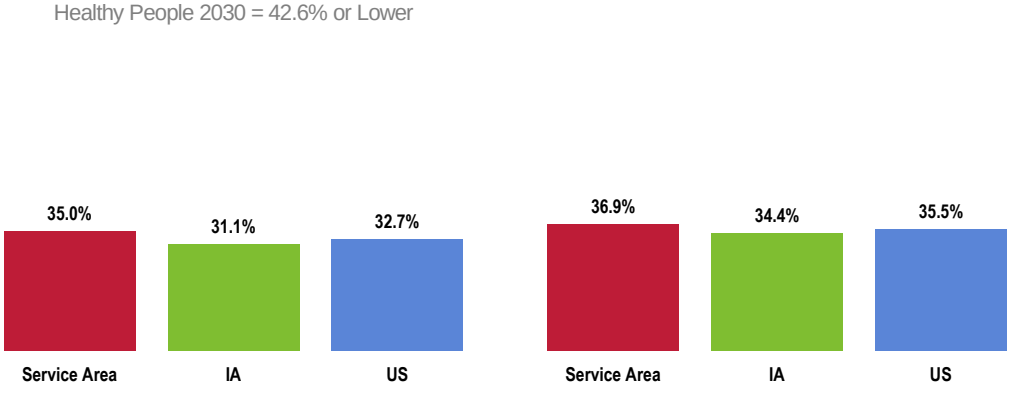
Blood Pressure & Cholesterol

The following chart illustrates the percentages of service area adults who have been told that they have high blood pressure or high cholesterol, known risk factors for cardiovascular disease.

The CDC's Behavioral Risk Factor Survey asked:

"Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?"

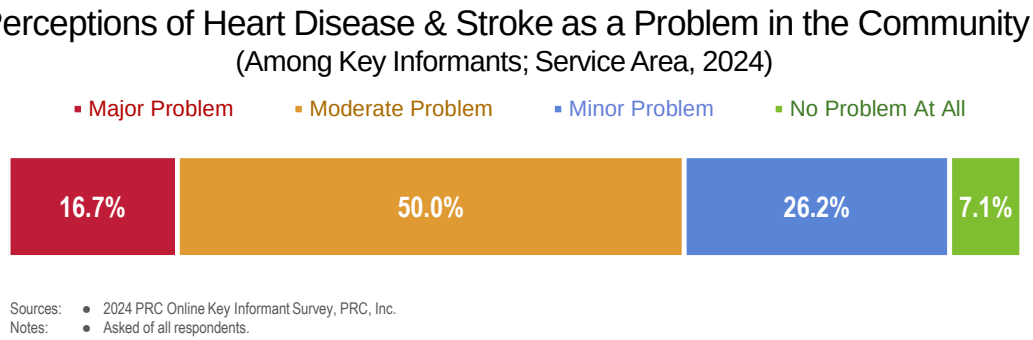
"Have you ever been told by a doctor, nurse, or other health professional that your cholesterol is high?"



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Key Informant Input: Heart Disease & Stroke

Outlined below are key informants' levels of concern for *Heart Disease & Stroke* as an issue in the service area.



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Aging Population

> Older population and an unhealthy younger population. Diabetes and obesity. – Other Health Provider
>
> An aging population contributes to a high percentage of people with heart disease and stroke. There is a higher average of smokers as well. – Community/Business Leader

Incidence/Prevalence

> I personally know people who have heart disease and stroke. – Community/Business Leader
>
> Heart disease is a leading cause of death in almost all communities. Again, specialized care is not being provided locally, creating a barrier to care. Our communities also do not have access to environments or systems that would help someone live a healthy and active lifestyle reducing their risk of heart disease or stroke. – Public Health Representative

Access to Affordable Healthy Food

> Lack of access and funding for healthy meal options, as well as low cost fitness options. – Social Services Provider

Co-Morbidities

> Weight problems and congestive heart failure go hand in hand and create problems in younger people all the time. High blood pressure and high cholesterol are common. Smoking is common. All contribute to heart disease and strokes. – Other Health Provider

Work-Related

> Many in the community are labor workers, including farmers and agricultural chemicals. Bodies are overworked and continue to be overworked into old age. – Community/Business Leader

CANCER

ABOUT CANCER

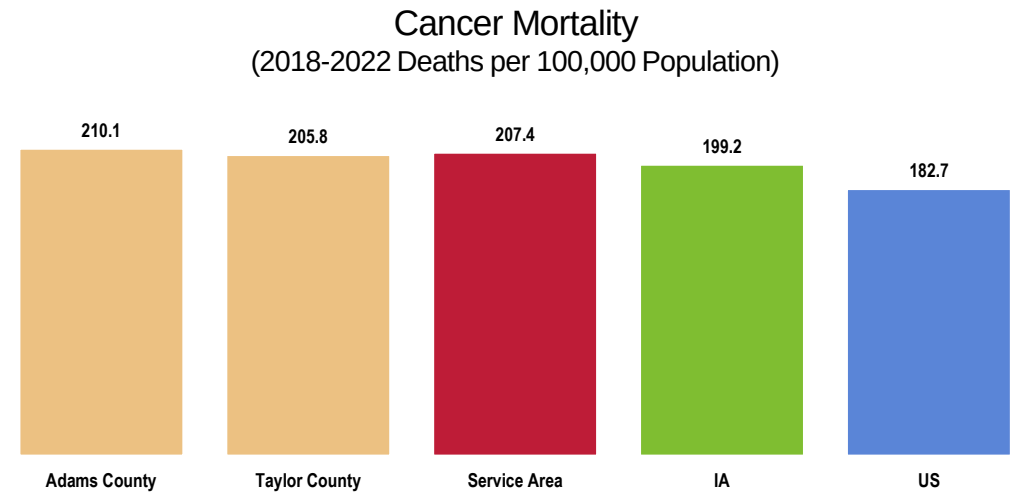
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Cancer Deaths

Cancer is a leading cause of death in the service area and throughout the United States. Cancer mortality rates are outlined below.



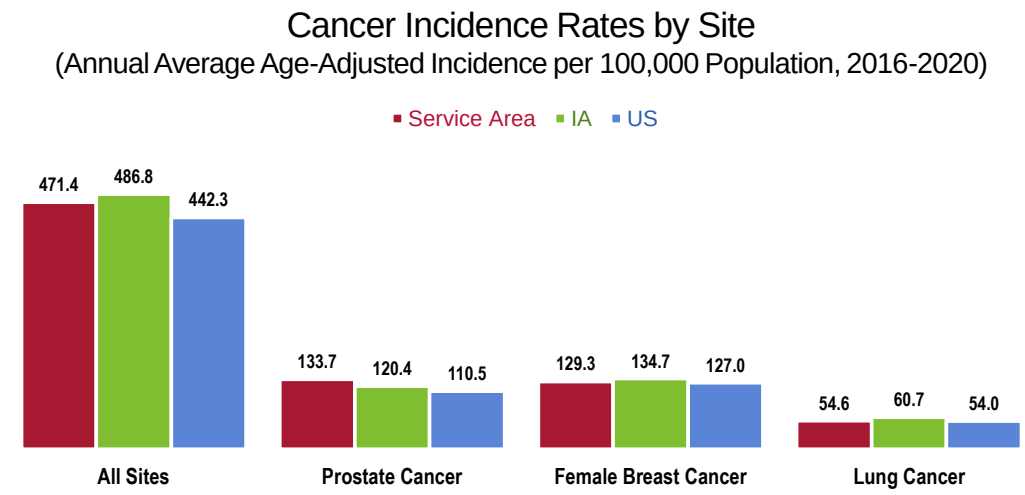
Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are age-adjusted. It is usually expressed as cases per 100,000 population per year.

It is important to identify leading cancers by site in order to better address them through targeted intervention. The following chart illustrates the service area incidence rates for leading cancer sites.



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older).

Cancer Screenings

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years. For women age 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

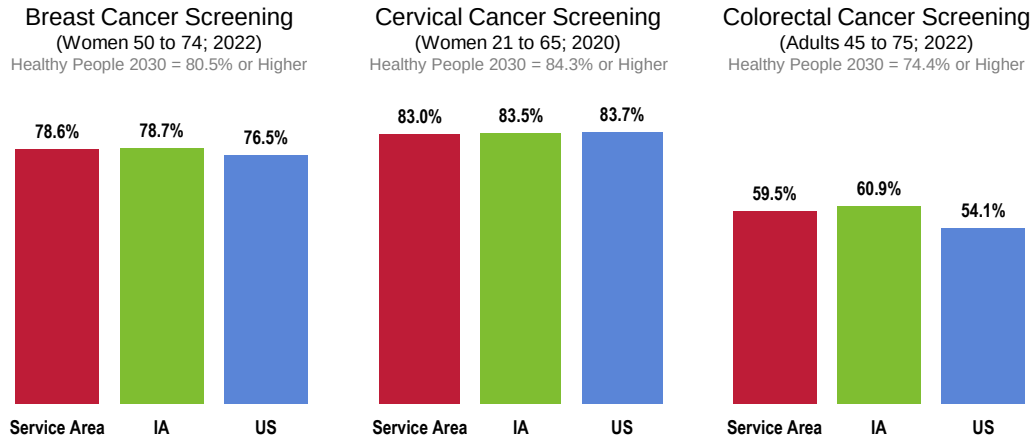
COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 45 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

The following outlines the percentages of residents receiving these age-appropriate cancer screenings. These are important preventive behaviors for early detection and treatment of health problems. Low screening levels can highlight a lack of access to preventive care, a lack of health knowledge, or other barriers.

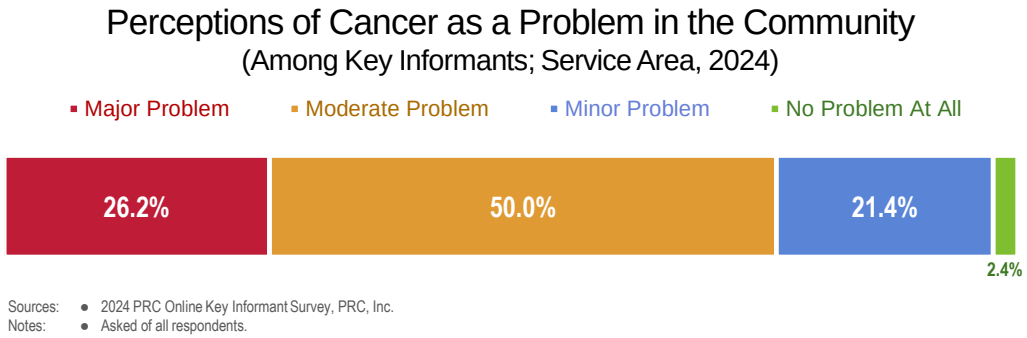


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the age group specified. Breast cancer screenings are mammograms among females age 50-74 in the past 2 years. Cervical cancer screenings are Pap smears among women 21-65 in the past 3 years. Colorectal cancer screenings include the percentage of population age 45-75 years who report having had 1) a fecal occult blood test (FOBT) within the past year, 2) a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or 3) a colonoscopy within the past 10 years.

Key Informant Input: Cancer

Key informants' perceptions of *Cancer* as a local health concern are outlined below.



Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Cancer is widespread with no guaranteed treatment. – Community/Business Leader
>
> Our community reflects all communities. Your neighbor, a friend, family, or a fellow worker, every time you turn around, someone has begun cancer treatments. – Community/Business Leader
>
> There are several ongoing cases. – Community/Business Leader
>
> Many community members suffer from a cancer diagnosis. – Other Health Provider
>
> It seems every day we hear of someone else who has cancer. Treatments like chemotherapy can be done close to home, but for surgeries and radiation therapy travel of at least 80 miles one way is needed. Not everyone has someone to drive them, can't drive themselves due to the illness, and many don't have gas money or reliable transportation even if they do have a car. – Other Health Provider
>
> Cancer is a major problem in all communities. It impacts almost everyone in one way or another. – Community/Business Leader

Aging Population

> Older population that is not exactly healthy, non-stop turnover of local doctors, including cancer specialists. – Other Health Provider
>
> Adams and Taylor County have a high percentage of older adults, and with that comes issues such as cancer. I believe cancer may be related to chemical exposure due to the rural nature of the area. – Community/Business Leader

Impact on Quality of Life

> I see cancer, as for many, a very debilitating disease. They may be given a strong drug that makes the patient ill and/or go through surgery with a recuperation time needed. They may feel ill and not able to be around their friends. The diagnosis and treatment may be hard to fit in and run with their old crowd, but life goes on. Families may need encouragement to carry on their participation in their activities. The cost of surgeries, medicines, and gas also make money a problem, especially if the patient does not have medical insurance. – Community/Business Leader

Access to Care/Services

> A wide variety of cancer treatments are not readily available locally, making travel one more burden during cancer recovery. Also, encouraging early detection intervention is a plus, but how to get people to follow through is difficult. – Community/Business Leader

RESPIRATORY DISEASE

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

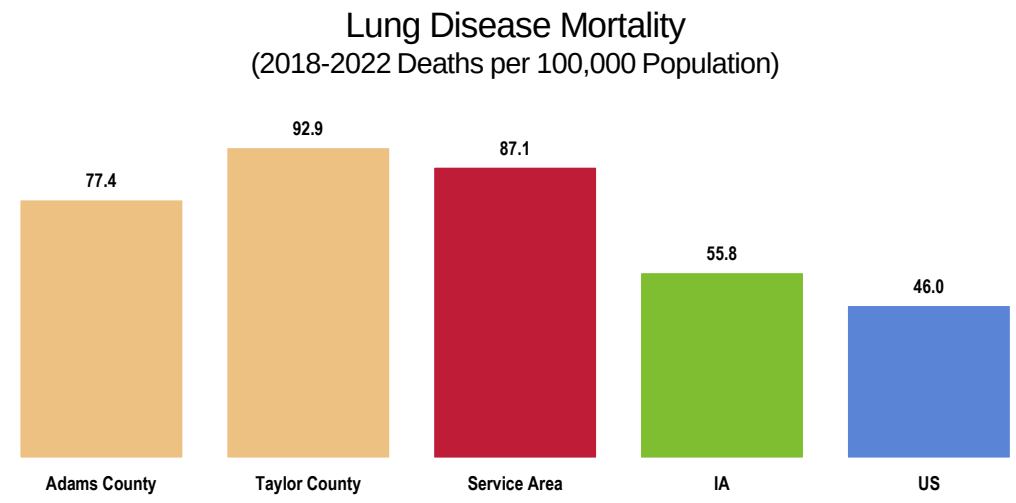
– Healthy People 2030 (https://health.gov/healthypeople)

Note that this section also includes data relative to COVID-19 (coronavirus disease).

Lung Disease Deaths

Note: Here, lung disease reflects chronic lower respiratory disease deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.

The mortality rate for lung disease in the service area is summarized below, in comparison with Iowa and national rates.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Asthma Prevalence

The following chart shows the prevalence of asthma among service area adults.

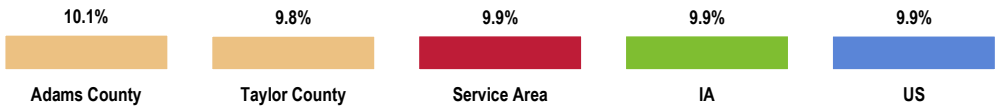
The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Has a doctor, nurse, or other health professional ever told you that you had asthma?"

"Do you still have asthma?"

Prevalence includes those responding "yes" to both.

Prevalence of Asthma
(2022)



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

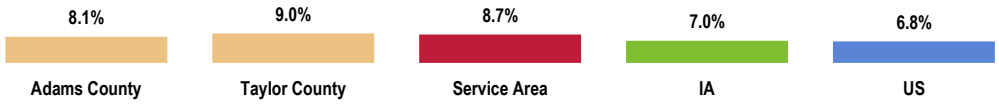
COPD Prevalence

The following chart shows the prevalence of chronic obstructive pulmonary disease (COPD) among service area adults.

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Has a doctor, nurse, or other health professional ever told you that you had COPD (chronic obstructive pulmonary disease), emphysema, or chronic bronchitis?"

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)
(2022)

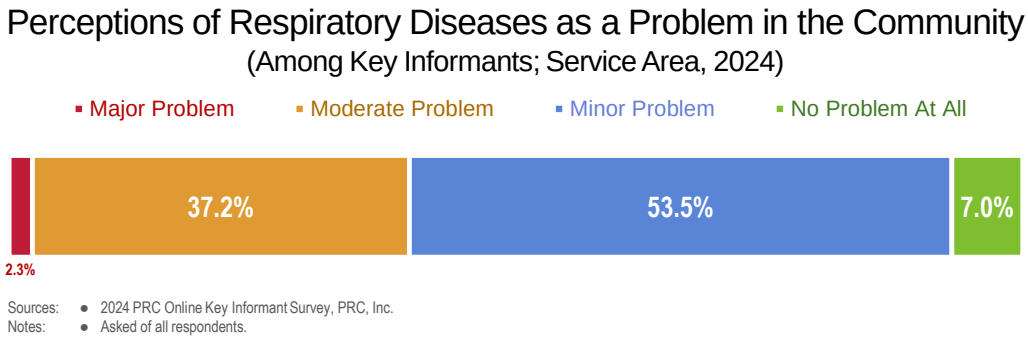


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- Includes those who have ever been diagnosed with chronic obstructive pulmonary disease (COPD), including emphysema and chronic bronchitis.

Key Informant Input: Respiratory Disease

The following outlines key informants' perceptions of *Respiratory Disease* in our community.



Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Tobacco Use

> Lots of former smokers. – Community/Business Leader

INJURY & VIOLENCE

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

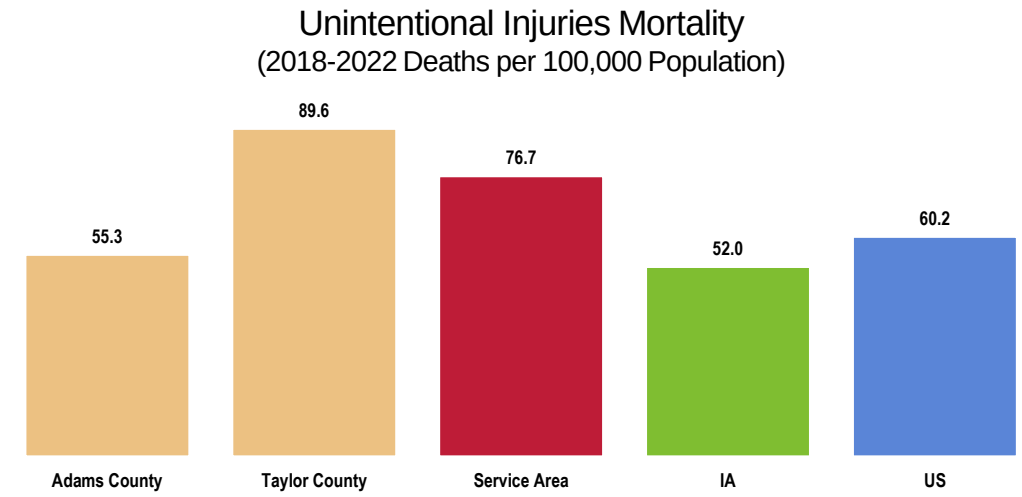
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Unintentional Injury Deaths

Unintentional injury is a leading cause of death. The chart that follows illustrates unintentional injury death rates for the service area, Iowa, and the US.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

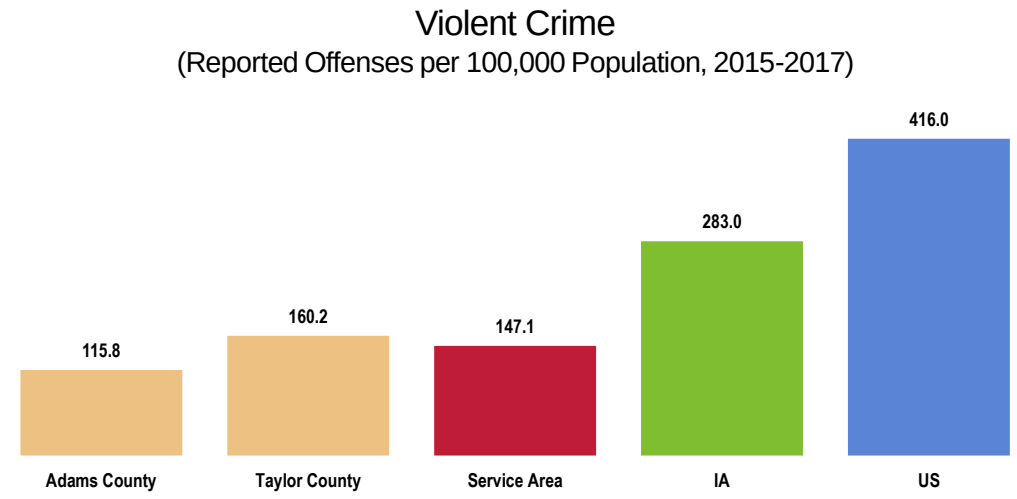
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Violent Crime Rate

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

The following chart shows the rate of violent crime per 100,000 population in the service area, Iowa, and the US.

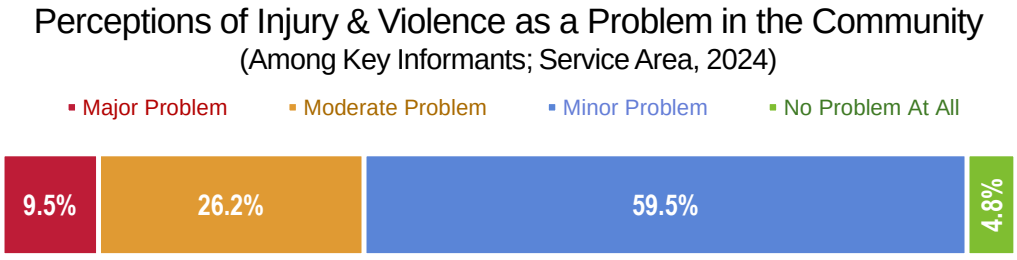


Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports (UCR).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, forcible rape, robbery, and aggravated assault.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Key Informant Input: Injury & Violence

Key informants' perceptions of *Injury & Violence* in our community:



Sources:
- 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Alcohol/Drug Use

> High rate of drug use and children living in poverty. – Social Services Provider

Incidence/Prevalence

> I have heard of several cases. – Community/Business Leader

Income/Poverty

> We have so many low income people moving to our county that have drug related issues, many of which have a violent temperament. – Community/Business Leader

DIABETES

ABOUT DIABETES

More than 30 million people in the United States have diabetes. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

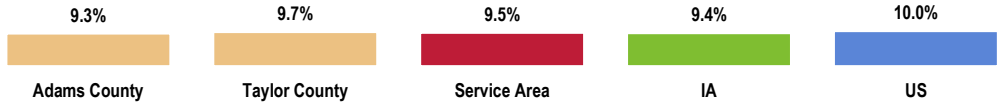
Prevalence of Diabetes

Diabetes is a prevalent and long-lasting (chronic) health condition with a number of adverse health effects, and it may indicate an unhealthy lifestyle. The prevalence of diabetes among service area adults age 20 and older is outlined below, compared to state and national prevalence levels.

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Has a doctor, nurse, or other health professional ever told you that you had diabetes?"

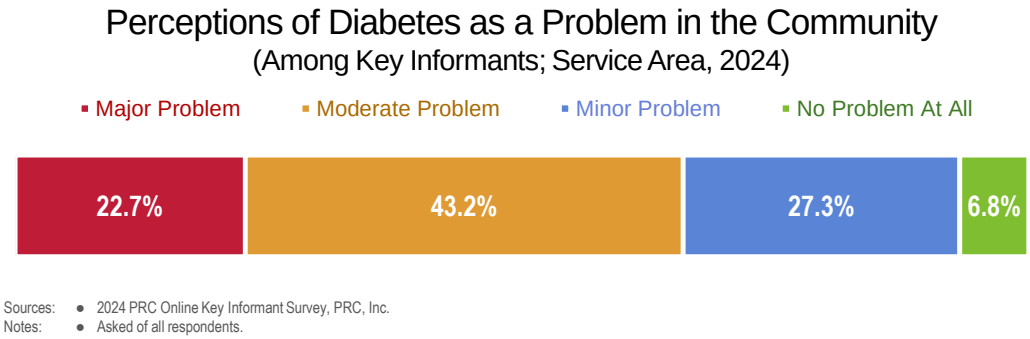
Prevalence of Diabetes
(Adults Age 20 and Older; 2021)



Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Key Informant Input: Diabetes

The following are key informants' ratings of *Diabetes* as a health concern in the service area.



Sources: • 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> Lack of education about diabetes. – Community/Business Leader
>
> Ongoing diagnosis however limited education and follow-up for continued care. More education on prevention. – Public Health Representative
>
> I feel that people with diabetes in our communities don't understand how serious of a diagnosis that is. They historically haven't received the education necessary to treat their condition and therefore view it as just something they have because they are overweight and lots of people have it so it isn't a big deal. When in reality, it is a huge deal and leads to so many other disorders that could be easily treated with diet and exercise from the beginning if they receive the proper education and treatment from the start. – Community/Business Leader

Access to Care/Services

> Health care. – Community/Business Leader
>
> Access to diabetes management support, medication, and specialized providers in a local setting are the main challenges seen in our communities. – Public Health Representative

Affordable Medications/Supplies

> Affording medication and getting the prescriptions in timely manner. Waiting days before the pharmacy orders and sends them. One elderly person even reused their injection needle and syringe for two days before receiving their order. – Community/Business Leader
>
> Paying for the medications they need. – Other Health Provider

Diagnosis/Treatment

> Early detection. – Community/Business Leader

Nutrition

> Overeating and not having access to healthy foods. – Community/Business Leader

DISABLING CONDITIONS

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

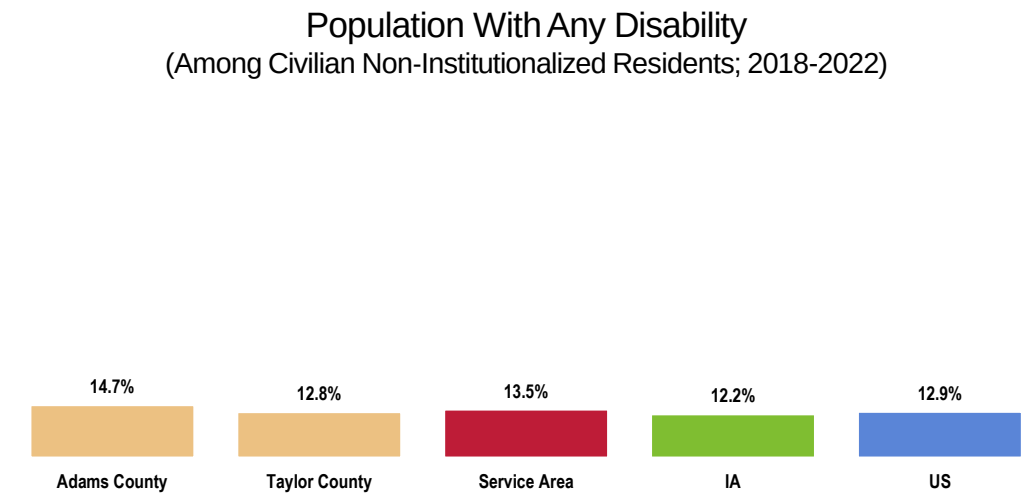
– Healthy People 2030 (https://health.gov/healthypeople)

Disability

The following represents the percentage of the total civilian, non-institutionalized population in the service area with a disability. This indicator is relevant because disabled individuals may comprise a vulnerable population that requires targeted services and outreach.

Disability data come from the US Census Bureau's American Community Survey (ACS), Survey of Income and Program Participation (SIPP), and Current Population Survey (CPS). All three surveys ask about six disability types: hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty, and independent-living difficulty.

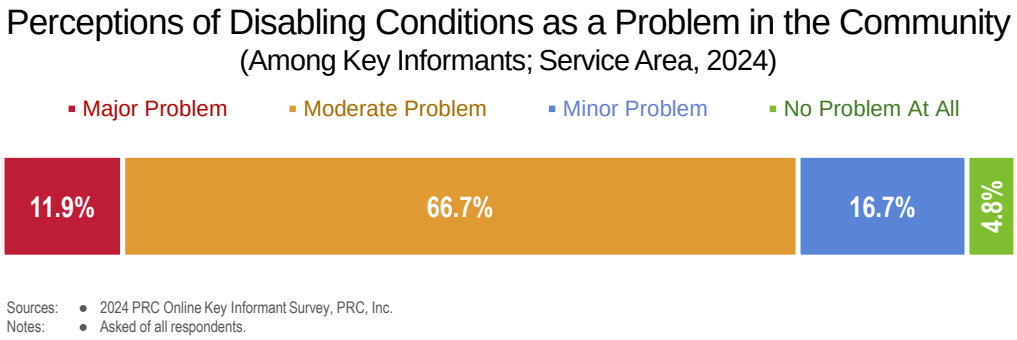
Respondents who report any one of the six disability types are considered to have a disability.



Sources:
- US Census Bureau, American Community Survey.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Key Informant Input: Disabling Conditions

Key informants' perceptions of *Disabling Conditions* are outlined below.



Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> There are several cases in the area. – Community/Business Leader
>
> There are many people I know who have dementia, early and late, and who have chronic pain and struggle with medication addiction. – Other Health Provider

Built Environment

> Our communities are not easily accessible in terms of physical accessibility and resource/service accessibility. Due to being beyond rural, being frontier, we see considerable delays in what care you can receive locally where people have limited access to transportation to travel to distant towns with more service availability. People living with disabling conditions will have to travel outside of our communities to receive the majority of their care because it does not exist locally. – Public Health Representative

Lack of Providers

> We do not have a dentist or eye doctor close by and everyone has to travel to see one. Many people do not have dental or vision insurance, so they just do without usually. It is also hard for people to find a dentist that accepts Medicaid. There is many areas that it is hard to get to, if there is a walking issue, and no one is available to help with transportation. – Social Services Provider

Access to Care/Services

> Getting diagnosed and treated requires travel, which is difficult with disabling conditions. – Community/Business Leader

Aging Population

> Due to an older population, as well as low income people in the area, they do not have access to quality health care, as there is very little choice. – Community/Business Leader

BIRTHS

BIRTH OUTCOMES & RISKS

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

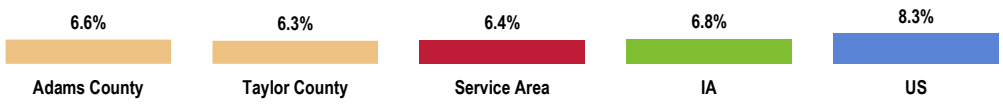
– Healthy People 2030 (https://health.gov/healthypeople)

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. The following chart illustrates the percent of total births that are low birth weight.

Low-Weight Births
(Percent of Live Births, 2016-2022)



Sources: ● University of Wisconsin Population Health Institute, County Health Rankings.
Note: ● This indicator reports the percentage of total births that are low birth weight (Under 2500g).

FAMILY PLANNING

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression … family planning services can help increase the length of time between pregnancies, which can improve health for women and their infants.

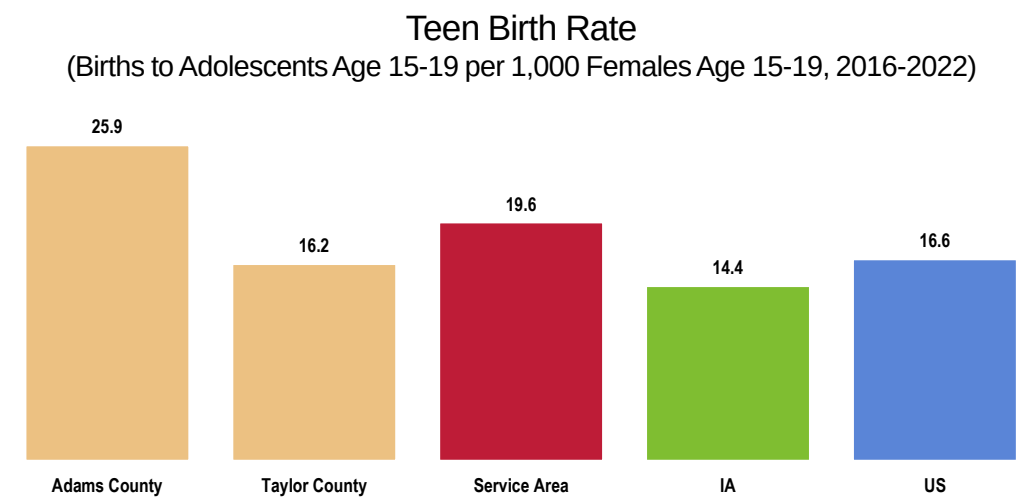
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

Here, teen births include births to women ages 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

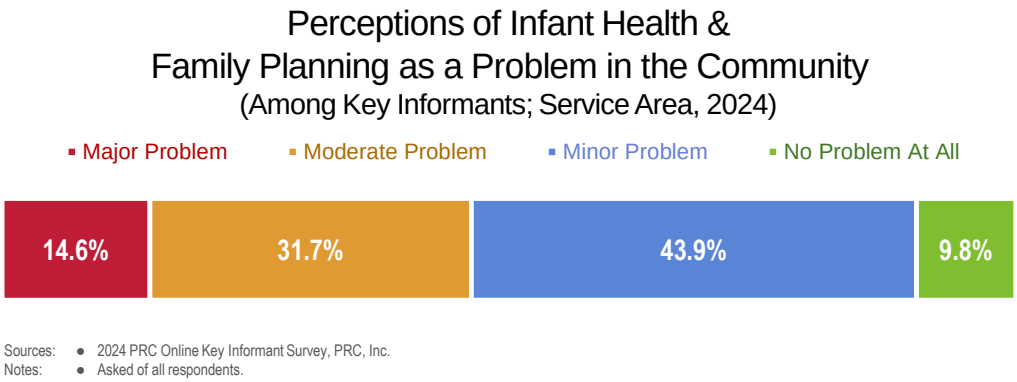
The following chart outlines the teen birth rate in the service area, compared to rates statewide and nationally. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Key Informant Input: Infant Health & Family Planning

Key informants' perceptions of *Infant Health & Family Planning* as a community health issue are outlined below.



Sources: 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> There are no services available in a close proximity for infant delivery. Patients must travel to other counties for obstetrics services. – Community/Business Leader
>
> Limited access to OBGYN care in Corning. Patients have to drive to access this service. Sometimes transportation is a barrier for these individuals. – Social Services Provider
>
> We have one pediatric doctor and no place for birthing at the hospital. It needs to be done out of town. Need more doctors to get in when there are issues. – Community/Business Leader
>
> There is no birthing hospital in Adams County and Taylor County does not have a hospital. People have to travel many miles to obtain services. Also with the new laws in Iowa, it will impact those seeking reproductive care and many will be forced to travel outside of the state. – Community/Business Leader

Income/Poverty

> Low income population, education, drug and alcohol abuse, single-parent homes. – Community/Business Leader

MODIFIABLE HEALTH RISKS

NUTRITION

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

Food Environment: Fast Food

Here, fast food restaurants are defined as limited-service establishments primarily engaged in providing food services (except snack and nonalcoholic beverage bars) where patrons generally order or select items and pay before eating.

The following shows the number of fast food restaurants in the service area, expressed as a rate per 100,000 residents. This indicator provides a measure of healthy food access and environmental influences on dietary behavior.

Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

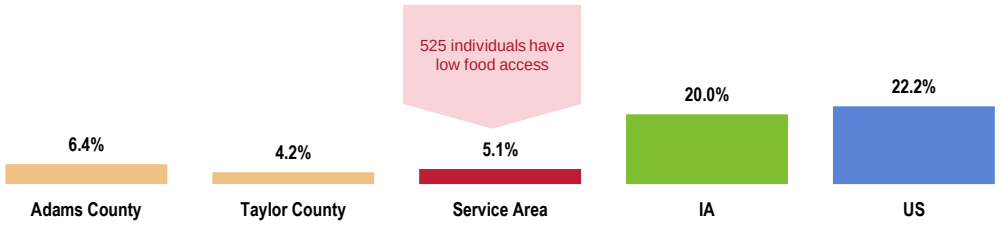
Low Food Access

Low food access is defined as living more than 1 mile from the nearest supermarket, supercenter, or large grocery store (or 10 miles in rural areas).

The following chart shows US Department of Agriculture data determining the percentage of Service Area residents found to have low food access, meaning that they do not live near a supermarket or large grocery store.

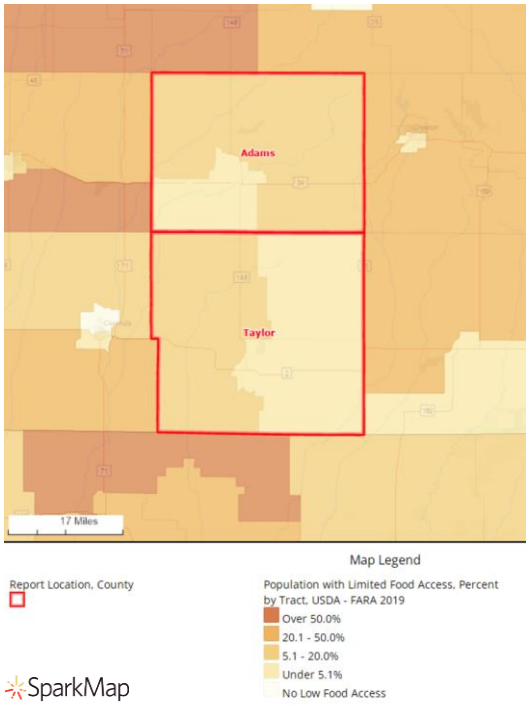
Population With Low Food Access

(Percent of Population Far From a Supermarket or Large Grocery Store, 2019)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living more than 1 mile from the nearest supermarket, supercenter, or large grocery store for urban census tracts, and 10 miles for rural ones.



PHYSICAL ACTIVITY

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

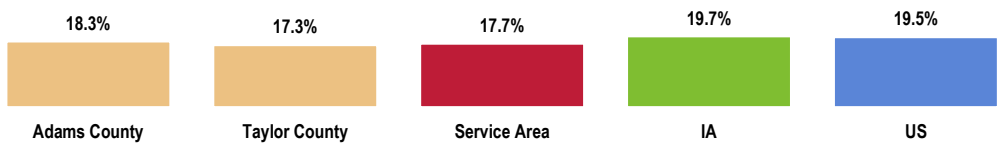
– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

Below is the percentage of service area adults age 20 and older who report no leisure-time physical activity in the past month. This measure is important as an indicator of risk for significant health issues such as obesity or poor cardiovascular health.

No Leisure-Time Physical Activity in the Past Month
(Among Adults Age 20 and Older, 2021)
Healthy People 2030 = 21.8% or Lower



Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

WEIGHT STATUS

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

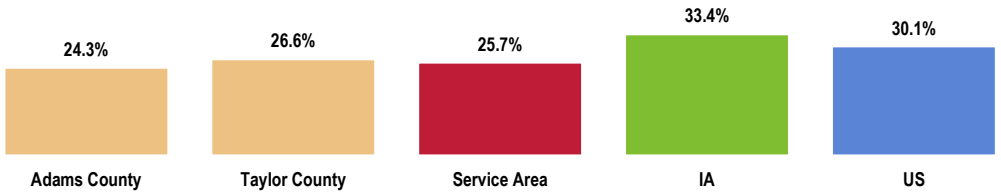
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Obesity

"Obese" includes respondents with a BMI value ≥30.0.

Outlined below is the percentage of service area adults age 20 and older who are obese, indicating that they might lead an unhealthy lifestyle and be at risk for adverse health issues.

Prevalence of Obesity
(Among Adults Age 20 and Older With a Body Mass Index ≥ 30.0, 2021)
Healthy People 2030 = 36.0% or Lower



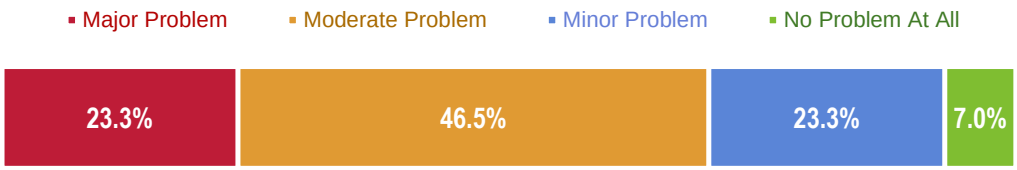
Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0.

Key Informant Input: Nutrition, Physical Activity & Weight

Key informants' ratings of *Nutrition, Physical Activity & Weight* as a community health issue are illustrated below.

Perceptions of Nutrition, Physical Activity & Weight as a Problem in the Community
(Among Key Informants; Service Area, 2024)



Sources:
- 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Obesity

> Don’t think people care about weight. – Community/Business Leader
>
> Overweight as a society. – Community/Business Leader

Awareness/Education

> Parenting, education, will power. Maybe an organization should sponsor healthy eating. – Community/Business Leader
>
> Limited nutritional knowledge, like people feeding sugar to kids. Limited access to quality fitness centers. Limited trails and sidewalk access. – Community/Business Leader

Lifestyle

> Our communities tend to have a more sedentary lifestyle than many other communities. Besides the lack of physical activity for many, people often tend to eat high caloric food. We are a poorer community and cheaper food tends to have a higher caloric value. – Community/Business Leader

Physical Activity

> Lack of physical activity options. Not many affordable healthy food options available. – Social Services Provider

Affordable Care/Services

> There is a health center, but not sure about the costs, or what is available inside. No one is helping with better choices for nutrition. The swimming pool closes down when school starts. – Social Services Provider

Affordable Medications/Supplies

> They can’t get the medications that are out there that can help people because insurance doesn’t allow it. – Other Health Provider

SUBSTANCE USE

ABOUT DRUG & ALCOHOL USE

Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

Excessive Alcohol Use

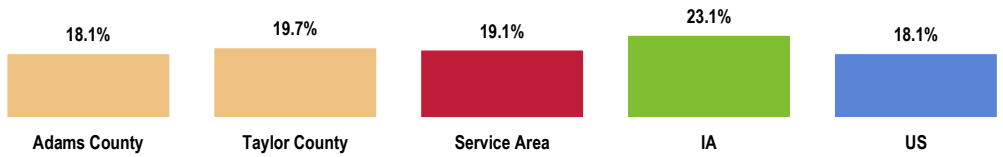
Excessive drinking includes heavy and/or binge drinking:

HEAVY DRINKING ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.

BINGE DRINKING ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

The following illustrates the prevalence of excessive drinking in the service area, as well as statewide and nationally. Excessive drinking is linked to significant health issues, such as cirrhosis, certain cancers, and untreated mental/behavioral health issues.

Engage in Excessive Drinking
(2021)

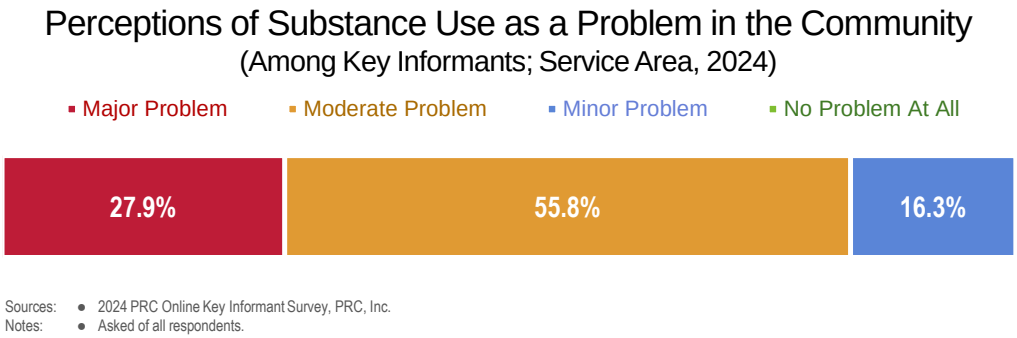


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- Excessive drinking is defined as the percentage of the population who report at least one binge drinking episode involving five or more drinks for men and four or more for women over the past 30 days, or heavy drinking involving more than two drinks per day for men and more than one per day for women, over the same time period.

Key Informant Input: Substance Use

Note the following perceptions regarding *Substance Use* in the community among key informants taking part in an online survey.



Sources: 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Lack of resources, lack of public transportation, lack of facilities. – Other Health Provider
>
> There is not a local place for people who need treatment for substance abuse. I'm not sure if there is an active Alcoholics Anonymous group meeting anymore in the area. Vaping is a major issue in Taylor County among teenagers. – Community/Business Leader
>
> Lack of inpatient treatment units. Lack of funding to pay for those treatments. – Other Health Provider
>
> The distance to any facility that could help, and if there is a facility, the wait time to be seen. – Other Health Provider
>
> There are no facilities for substance abuse to my knowledge in the communities. – Social Services Provider

Lack of Providers

> There are no providers within Adams or Taylor County. People need to drive to access this service. Transportation is a barrier, especially to those that have lost their license. – Social Services Provider
>
> Lack of providers. – Community/Business Leader

Alcohol/Drug Use

> I do not know what drugs are available as well as the physical presentation of those who are using the drugs. When parents are using drugs, I feel the youth in the home are very likely to also use drugs. Parents feel that we are invading their privacy when we try to talk to their children, even though we are just trying to help them out. – Community/Business Leader

Awareness/Education

> Knowledge of treatment centers. – Community/Business Leader

Funding

> Lack of funds and facilities for drug offenders. – Community/Business Leader

Most Problematic Substances

Note below which substances key informants (who rated this as a “major problem”) identified as causing the most problems in the service area.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Use as a “Major Problem”)	
ALCOHOL	60.0%
METHAMPHETAMINE OR OTHER AMPHETAMINES	20.0%
INHALANTS	10.0%
COCAINE OR CRACK	10.0%

TOBACCO USE

ABOUT TOBACCO USE

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking Prevalence

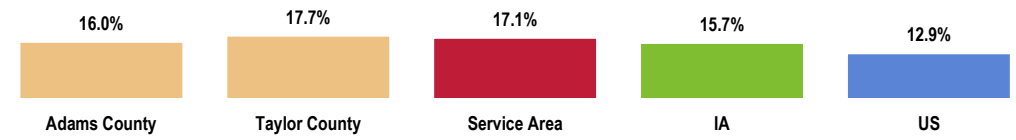
Tobacco use is linked to the two major leading causes of death: cancer and cardiovascular disease. Note below the prevalence of cigarette smoking in our community.

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Have you smoked at least 100 cigarettes in your entire life?"

"Do you now smoke cigarettes every day, some days, or not at all?"

Cigarette smoking prevalence includes those who report having smoked at least 100 cigarettes in their lifetime and who currently smoke every day or on some days.

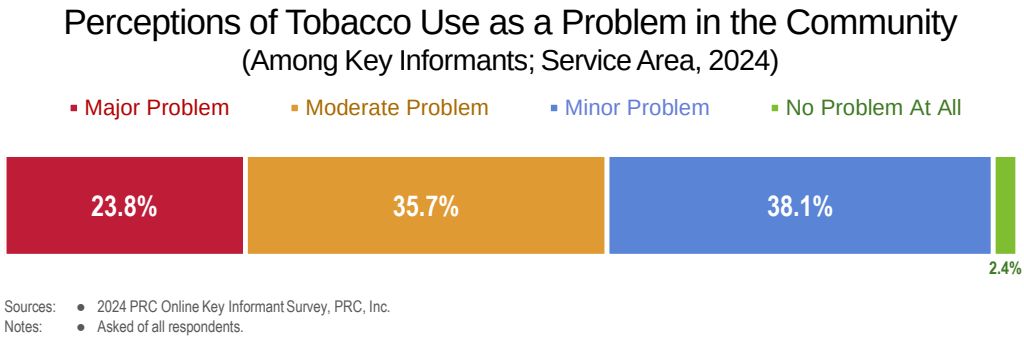


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Includes those who report having smoked at least 100 cigarettes in their lifetime and currently smoke cigarettes every day or on some days.

Key Informant Input: Tobacco Use

Below are key informants' ratings of *Tobacco Use* as a community health concern.



Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Too many people smoke. – Community/Business Leader
>
> Many people smoke. – Community/Business Leader
>
> I know so many people who smoke, and while it's not technically tobacco, with vaping being so available and accepted, addiction to nicotine is common. – Other Health Provider
>
> All events I've encountered, there are always lots of people huddling outside the doors smoking. – Social Services Provider
>
> Too much use. – Community/Business Leader
>
> When checking patients in, it's common that people smoke or use smokeless tobacco if not vaping. – Community/Business Leader

Alcohol/Drug Use

> Too many drug users, many of which smoke. Vaping is very prevalent in our teenagers. – Community/Business Leader

Cultural/Personal Beliefs

> The culture, vapes are used a lot because they can be hidden easily, it's the cool thing to do, an appetite suppressant. – Other Health Provider

E-Cigarettes

> With vaping and having stores unregulated, there has been an increase in usage. – Social Services Provider

SEXUAL HEALTH

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV.

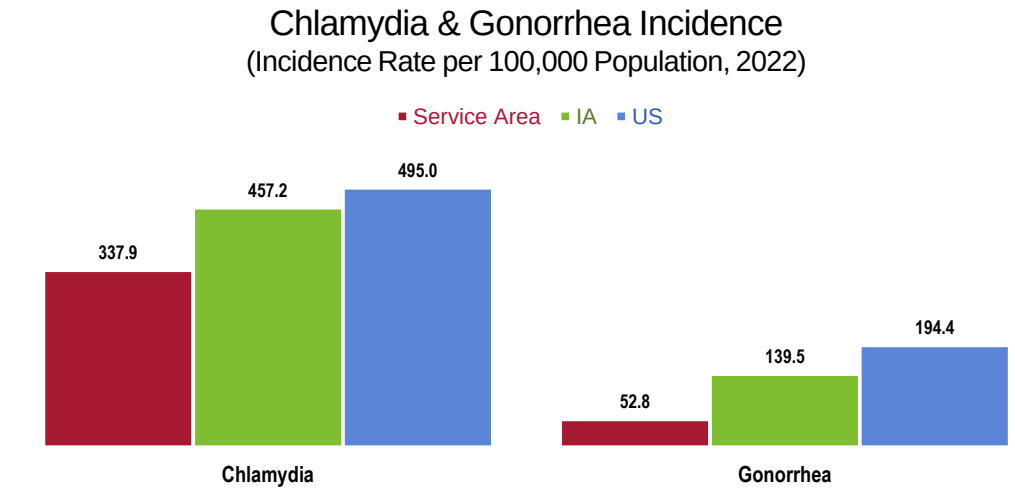
Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

Sexually Transmitted Infections (STIs)

Chlamydia & Gonorrhea

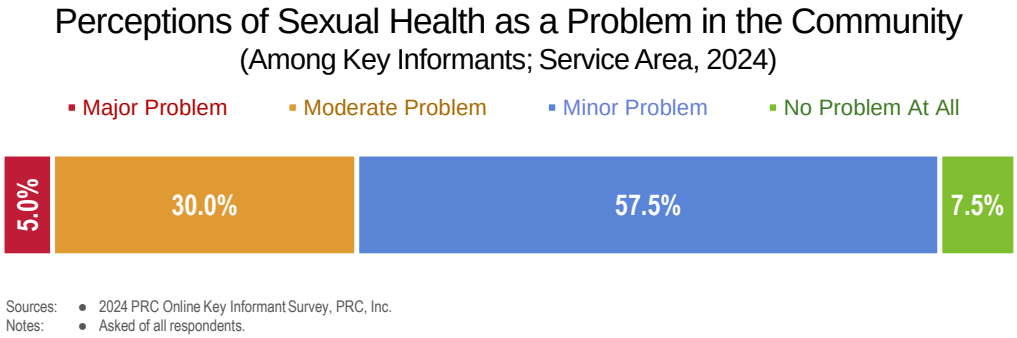
Chlamydia and gonorrhea are reportable health conditions that might indicate unsafe sexual practices in the community. Incidence rates for these sexually transmitted diseases are shown in the following chart.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

Key informants' ratings of *Sexual Health* as a community health concern are shown in the following chart.



Sources: 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

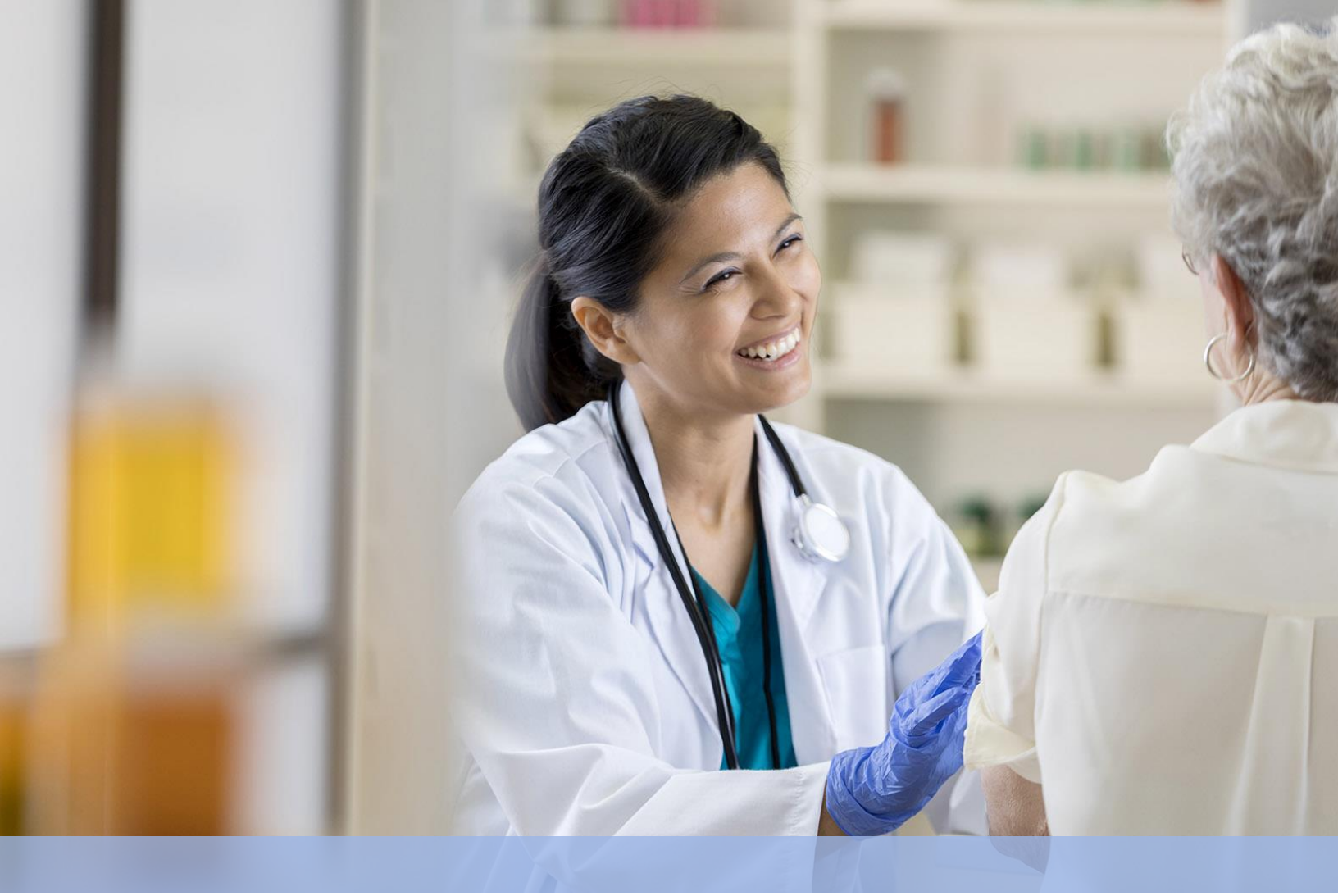
Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> I don't think there is easy access to sexual health in the doctors' offices and Emergency Rooms here. Perceived lack of privacy may be the biggest issue. Public Health does not offer any services other than mandated follow up. – Physician

Incidence/Prevalence

> The continual increase in STDs. – Social Services Provider



ACCESS TO HEALTH CARE

BARRIERS TO HEALTH CARE ACCESS

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

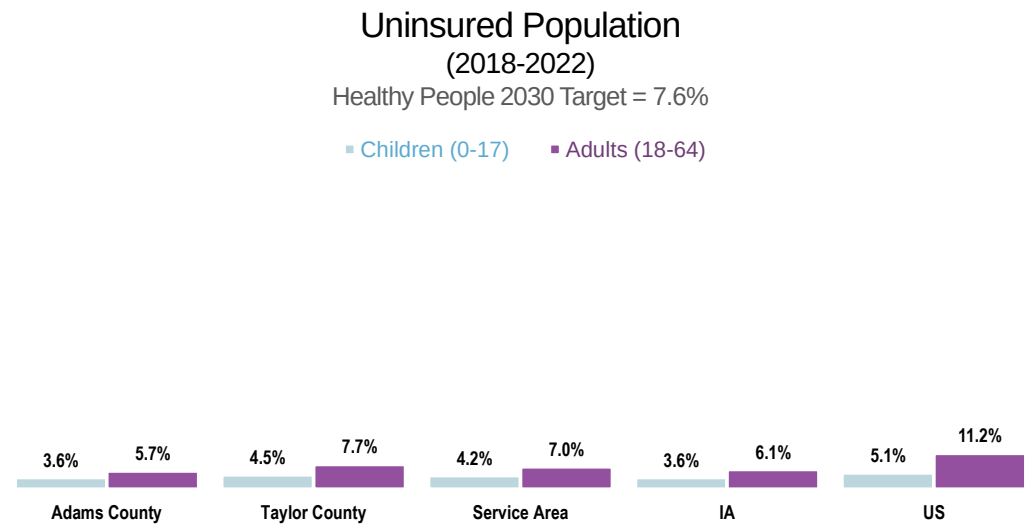
Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans.

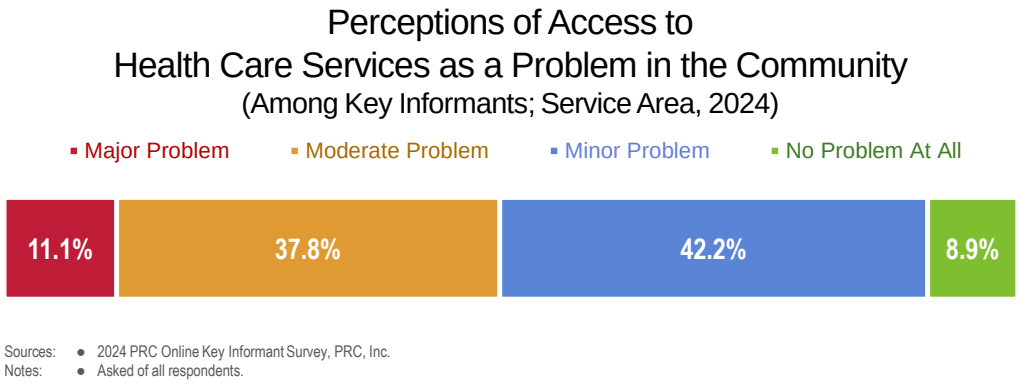
Health insurance coverage is a critical component of health care access and a key driver of health status. The following chart shows the latest figures for the prevalence of uninsured adults (age 18 to 64 years) and of uninsured children (under the age of 18) in the service area.



Sources:
- US Census Bureau, Small Area Health Insurance Estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Key Informant Input: Access to Health Care Services

Key informants' ratings of *Access to Health Care Services* as a problem in the service area is outlined below.



Sources: 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Lack of Providers

> We have a limited number of doctors and they are very busy and sometimes hard to get into for an appointment. Having specialists available would be wonderful but they prefer being in the larger hospitals and residing in the larger cities. My husband was tested locally and the test determined he probably had lung cancer. He was scheduled for a biopsy in early January. It was determined a pulmonary test was needed and scheduled for early February. He did use one of the cancer doctors from DM in getting started on a cancer program here. I just felt like he was not important to those wanting more testing, but not speeding up the process. We drove to Creston for him to have radiation treatments to tackle the problem. – Community/ Business Leader
>
> Getting and keeping healthcare workers to staff hospital departments that are not nursing. Another big challenge is the health systems taking all of the hospital profits and not re-investing them in the local facility. – Other Health Provider
>
> Availability of medical doctors and nurses. – Community/Business Leader

Lack of Specialists

> Recruiting doctors. Daily care of patients. Need a dermatologist, skin care locally. – Community/Business Leader
>
> Not having internal medicine physicians, dermatology, and other services areas that patients need. – Other Health Provider
>
> Quality health care is an issue, there are long wait times for specialists and surgeries. – Community/Business Leader

Transportation

> Transportation to doctor's appointments is hard for a person to get, if they are maybe having cancer treatment or physical therapy. – Social Services Provider

PRIMARY CARE SERVICES

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

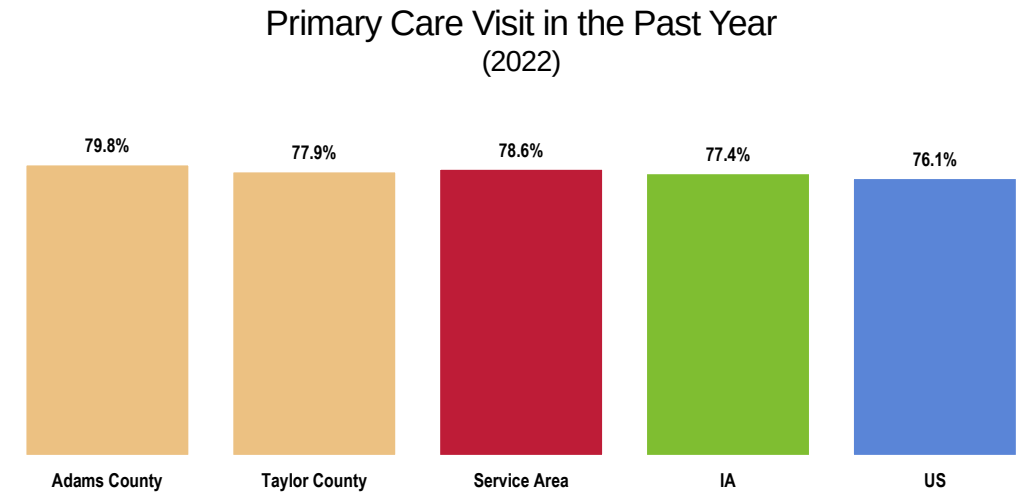
Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Primary Care Visits

The following chart reports the percentage of service area adults who visited a doctor for a routine checkup in the past year.



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

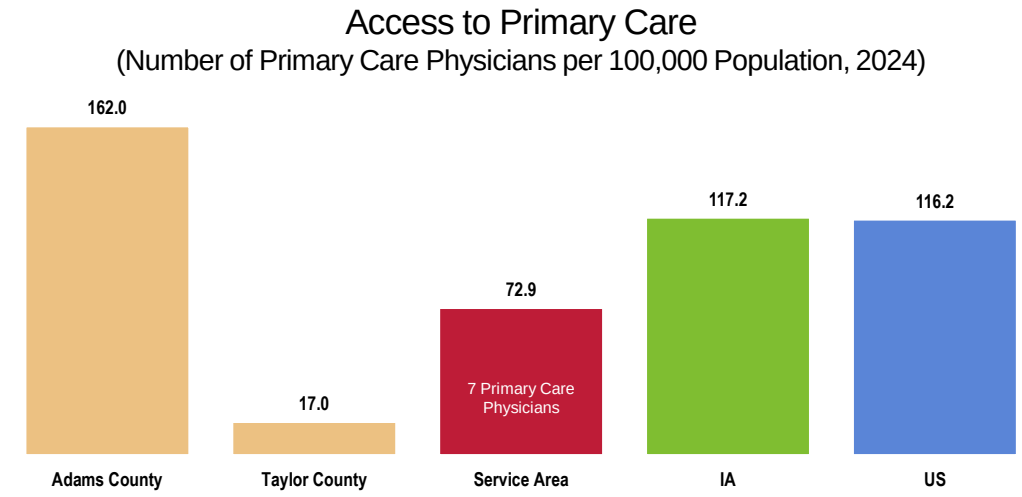
Notes:
- This indicator reports the number and percentage of adults age 18 and older with one or more visits to a doctor for routine checkup within the past one year.

Access to Primary Care

Doctors classified as “primary care physicians” by the AMA include: general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs and general pediatrics MDs. Physicians age 75 and over and physicians practicing subspecialties within the listed specialties are excluded.

Note that this indicator takes into account only primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

The following indicator outlines the number of primary care physicians per 100,000 population in the service area. Having adequate primary care practitioners contributes to access to preventive care.



Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

ORAL HEALTH

ABOUT ORAL HEALTH

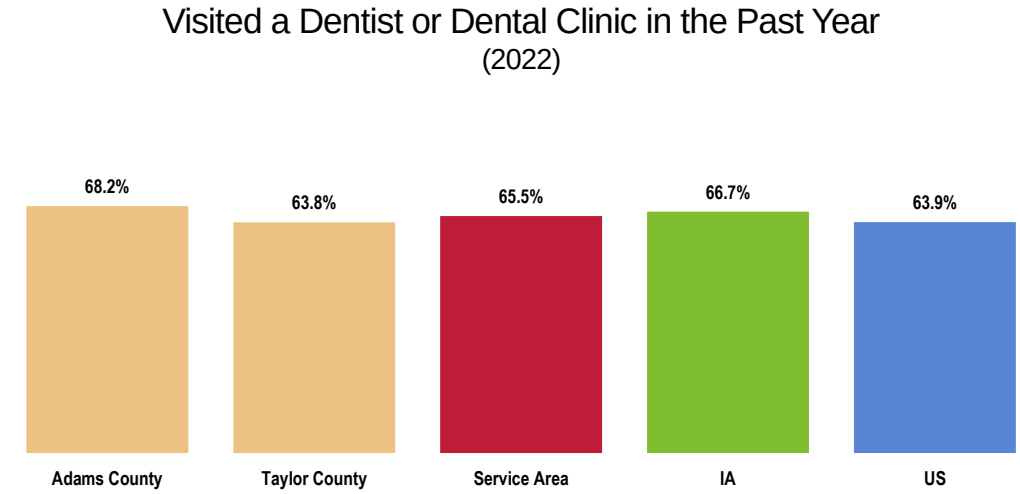
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Visits

The following chart shows the percentage of service area adults age 18 and older who have visited a dentist or dental clinic in the past year.

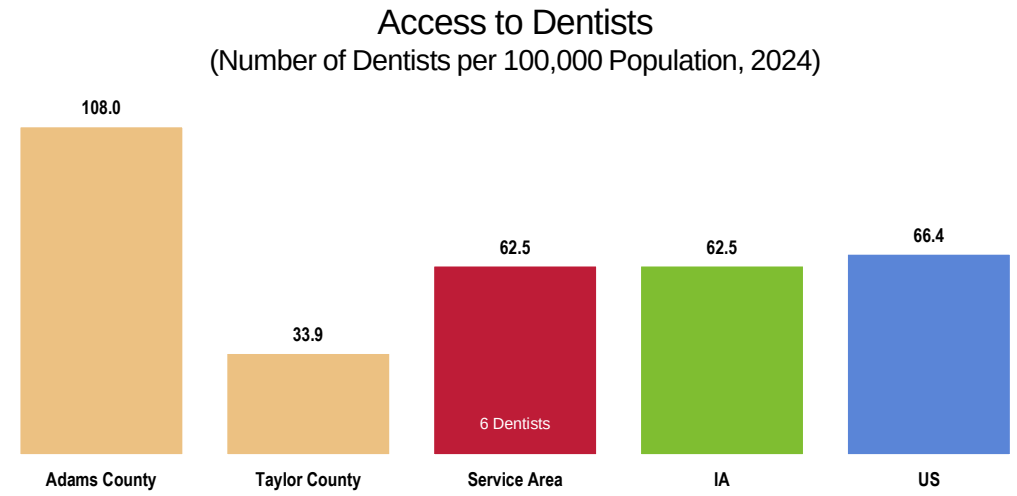


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Access to Dentists

This indicator includes all dentists — qualified as having a doctorate in dental surgery (DDS) or dental medicine (DMD), who are licensed by the state to practice dentistry and who are practicing within the scope of that license.

The following chart outlines the number of dentists for every 100,000 residents in the service area.

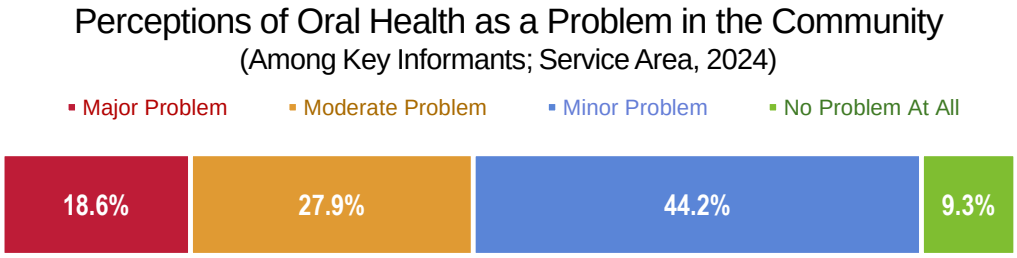


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the number of dentists per 100,000 population. This indicator includes all dentists — qualified as having a doctorate in dental surgery (DDS) or dental medicine (DMD) — who are licensed by the state to practice dentistry and who are practicing within the scope of that license.

Key Informant Input: Oral Health

Key informants' perceptions of *Oral Health* are outlined below.



Sources:
- 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care for Uninsured/Underinsured

> So many people do not have dental insurance. Mostly our older citizens on Medicare. If they would add that coverage to Medicare, they might have less health costs, because bad teeth cause so many issues. No local dentists, and you have to travel out of town. Without insurance, no one can afford it. – Social Services Provider

> The Medicaid reimbursement is so low dentist don't accept the Medicaid Providers MCNA Dental or Delta Dental or limit the number of people they see per month. People are having to go to Mt. Ayr, Osceola, Leon, Des Moines or Omaha in order to obtain dental care if this is their insurance. Again, transportation is a barrier to getting people to a provider that will accept their insurance. Iowa Medicaid only reimburses providers 20 cents on the dollar for their services. Nebraska's Medicaid reimbursement is 50 cents on the dollar for their dental providers. – Social Services Provider
>
> Oral health access to care for uninsured and underinsured. – Social Services Provider

Lack of Providers

> There are few dentists in our community and it's hard to get into them if you have an emergent issue. Currently my family has to go to a dentist in another community to seek oral care. – Community/Business Leader
>
> No dentist in town. – Community/Business Leader
>
> Very few dentists in the area. – Community/Business Leader

Affordable Care/Services

> Cost of care is often a concern. Many do not have dental insurance because it is not offered or is costly. Medicaid helps, but many providers around our community do not take it. Dentists often do not accept new patients. – Community/Business Leader

Access to Care/Services

> Difficult to get in and pricing, not all is covered by insurance. – Other Health Provider

LOCAL RESOURCES

Resources Available to Address 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 Health Care Services

- CHI Health Clinic
- CHI Health Mercy Hospital
- CHI Hospital
- Corning Medical Clinic
- Greater Regional Medical Clinic
- Gyms/Fitness Centers
- Public Health

Cancer

- CHI Health
- CHI Health Wellness Center
- CHI Hospital
- Doctors' Offices
- Emergency Medical Services
- Feed the Pack
- MATURA
- Pharmacies
- Public Health

Diabetes

- Bedford Drug and NuCara Pharmacy
- CHI Health
- CHI Health Clinic
- CHI Hospital
- Doctors' Offices
- Greater Regional Medical Clinic
- Gyms/Fitness Centers
- Insurance Companies
- Pharmacies
- Public Health
- Taylor County Public Health
- Veterans Affairs

Disabling Conditions

- Assisted Living Facilities
- Bedford Nursing and Rehab
- CHI Health Clinic
- CHI Hospital
- Doctors' Offices
- Fuller Family Dental
- Greater Regional Medical Clinic
- Lenox Care Center
- Public Health
- Taylor County Public Health
- Vintage Park Assisted Living and Memory Care

Heart Disease & Stroke

- CHI Health Clinic
- CHI Health Mercy Hospital
- CHI Health Wellness Center
- CHI Hospital
- Corning Family Chiropractic
- Corning Medical Clinic
- Doctors' Offices
- Emergency Medical Services
- Gyms/Fitness Centers
- Home Health
- Taylor County Public Health

Infant Health & Family Planning

- CHI Health
- CHI Health Clinic
- Doctors' Offices
- Early Childhood Daycare
- Greater Regional Medical Clinic
- Home Health
- Mental Health Region - Heart of Iowa
- Parents as Teachers
- Public Health

Injury & Violence

- Adams County Sheriff's Department
- Doctors' Offices
- Health Department

Mental Health

- AJ Counseling
- Aspire
- Bedford Community School
- Behavioral Health Coalition
- CHI Health
- CHI Health Clinic
- CHI Health Mercy Hospital
- Choice
- Churches
- Clarinda Clinic
- Clarinda Regional Health Center
- Corning Medical Clinic
- Counselors
- Crossroads Behavioral Health Center
- Crossroads Mental Health Center
- Doctors' Offices
- Heart of Iowa
- Hospitals
- Iowa Medicaid
- MATURA
- Mental Health Region - Heart of Iowa
- Public Health
- Regional Drug/Alcohol Treatment Program
- School System
- Senior Life Solutions
- Southern Hills Regional Mental Health
- Southern Iowa Trolley
- Southwest Iowa Families
- Taylor County Public Health
- Taylor County Sheriff's Office
- Veterans Affairs

Nutrition, Physical Activity & Weight

- Bedford Beaches Fitness Center
- Bedford Health Center
- Body Solutions Fitness Center
- CHI Health
- CHI Health Wellness Center
- Corning Medical Clinic
- Dietitian
- Farmers' Markets
- Gyms/Fitness Centers
- MATURA
- Parks and Recreation
- Taylor/Adams Health
- Wellness Center

Oral Health

- Dentists' Offices
- Fuller Family Dental
- Iowa Medicaid
- Women, Infants and Children

Respiratory Diseases

- CHI Health
- Greater Regional Medical Clinic

Sexual Health

- Doctors' Offices
- Hospitals
- Nebraska AIDS Project

Social Determinants of Health

- Adams Community Economic Development Corporation
- Bedford Area Chamber
- Bedford Community School
- Bedford Economic Development
- Bedford Housing
- CHI Health
- Crisis Intervention
- Feed the Pack
- Heart of Iowa
- Iowa State Extension
- MATURA
- Meals on Wheels
- School System
- Southern Iowa Regional Housing Authority
- Southwest Iowa Trolley
- Taylor County Public Health
- Zion Recovery Center

Substance Use

- Bedford Community School
- CHI Health Clinic
- Clarinda Clinic
- Clarinda Regional Health Center
- Crossroads Behavorial Health Center
- Crossroads Mental Health Center
- Hospitals
- Mosaic Hospital
- Public Health
- School System
- Taylor County Public Health
- Taylor County Sheriff's Office
- Zion Recovery Center

Tobacco Use

> CHI Health
> Corning Medical Clinic
> Doctors' Offices
> Public Health
> Quit Line

IMPACT OF ACTIONS TAKEN SINCE THE PRECEDING CHNA

Strategies and Program Activities by Health Need

	Health Need #1: Behavioral Health
Goals & Anticipated Impact	Goals: ● Prevent trauma and promote healthy youth development ● Promote mental health in older adults ● Provide access to behavioral health services Anticipated Impact ● Decrease youth bullying within participating schools ● Decrease child abuse,neglect and suicide in Adams and Taylor Counties ● Increase in social support and proportion of older adults reporting their mental health status is good, very good or excellent ● Increase in tele-behavioral health visits and increase in unique patients served
Community Indicators	CHNA 2022 ● 10.8% of persons in poverty in Adams County, 10.5% in Taylor County, 10.2% across Iowa ● 16.3% of children under 18 in poverty in Adams County, 10.79% in Taylor County, 13.79% across Iowa ● Average number of mentally unhealthy days reported in past 30 days in Adams County 3.7, 3.9 in Taylor County, and 3.5 in Iowa (2021 County Health Rankings)
Strategy	**Key Activities**
1.1 Expand community-based programming to prevent bullying, child abuse/ neglect and suicide	1.1.1 Support the Behavioral Health Coalition in implementing community-based programs to promote self- efficacy and prevent drivers of violence and suicide, such as: Youth Mental Health Consultation, Parents as Teachers, Coaching Boys into Men and Athletes as Leaders. FY23 Actions and Impact ● The BHCATC continued to meet monthly. There were 10 coalition meetings with an average of 15 or more members present at each meeting. 90% of coalition members indicated there is ‘always’ or ‘almost always’ a shared vision for change with a common understanding on the problem based on community assessment. The coalition expended 100% of grant dollars and maintained continuity of all program offerings, including Circle of Security training and reflective consultation targeted to the helping profession, Coaching Boys into Men and Athletes as Leaders targeted for schools, and Parents as Teacher Home Visitation targeted for families with children under age 6.

	FY23 Measures ● BHCATC o 100% of programming activities are evidence based, evidence informed, research based and/or best practice strategies. ● Circle of Security o 79 early childhood professionals, parents, and human service providers served o 86% increase in the ability to manage emotional stressors o 71% increase in staff competency and confidence o 86% increase in the ability to navigate challenging relationships o 50% increase in job satisfaction ● Coaching Boys into Men and Athletes as Leaders o 8 coaches/mentors were trained and 1 school district served o 82 youth served with 25 sessions o 96% decrease in sexual violence supportive attitudes o 86% increase in youth ability to identify abusive behaviors o 94%increase in knowledge and attitudes about healthy relationships ● Parents as Teacher Home Visitation o 47 families and 60 children served o 558 home visits completed o 94% of the families served are at or below 200% of the federal poverty level o 37% of the mothers that were screened for depression were screened positive for depression o 95% of families served improved or maintained healthy family functioning, problem solving and communication o 56% of families served improved nurturing and attachment between parents and children FY24 Actions and Impact ● The BHCATC continued to meet monthly. The coalition expended 100% of grant dollars and maintained continuity of all program offerings, including Coaching Boys into Men, Athletes as Leaders, and Second Step Child Protection Unit. FY24 Measures ● BHCATC Coalition o Meetings: 10 o Attendees: 19+ per meeting o 100% of programming activities are evidence based, evidence informed, research based and/or best practice strategies. ● Coaching Boys into Men, Athletes as Leaders, Second Step Child Protection Unit Curriculum o Youth impacted: 190 o Coaches/Mentors trained: 18 o School Districts Engaged: 2 o Educational Sessions: 27

	o Decrease in sexual violence supportive attitudes: 100% o Increase in youth ability to identify abusive behaviors: 100% o Increase in knowledge and attitudes about healthy relationships: 100% o Increase in knowledge of recognizing the grooming behaviors of potential perpetrators: 98% FY25 Results Pending
1.2 Increase social supports for older adults in mental health crisis and recovery	1.2.1 Support and expand Senior Life Solutions Program, an intensive outpatient group counseling program. FY23 Actions and Impact: ● Senior Life Solutions is an intensive outpatient mental health therapy program designed to meet the unique needs of individuals, typically 65 years and older, experiencing depression and/or anxiety related to life changes often associated with aging. FY23 Measures ● (July 1st 2022 and June 30th of 2023): ○ # Patient Census: 10-16 ○ # of Referrals: 24 ○ # of individual therapy sessions: 236 ○ average # of monthly group therapy: 100-130 FY24 Actions and Impact ● Senior Life Solutions is an intensive outpatient mental health therapy program designed to meet the unique needs of individuals, typically 65 years and older, experiencing depression and/or anxiety related to life changes often associated with aging. FY24 Measures ● Patient Census: 9-14 ● Referrals: 30 ● Group therapy sessions: 898 ● Individual therapy sessions: 245 ● Psychiatrist visits: 148 FY25 Results Pending
1.3 Expand access to Behavioral Health services for youth and adults	1.3.1 Expand behavioral health services at Mercy Corning through telehealth and the recruitment of an onsite provider. FY23 Actions and Impact ● The Behavioral Health service line posted an Integrated BH Specialist position for Corning during FY23. This position has recently been filled, with a start date planned for January 2024.

	FY23 Measures ● No measures to report. FY24 Actions and Impact ● Recruited and hired a behavioral health specialist and behavioral health advanced practice provider. FY24 Measures ● No measures to report. FY25 Results Pending
Related Activities	CHI Mercy Corning will leverage the CHI Health Behavioral Health Evaluation & Transfer Service to expand capacity for psychiatric assessment, consultation and therapy using telehealth in the Emergency Department and clinic.Hospital will explore potential collaboration with county mental health services and requirements (Southwest Iowa Mental Health and Disability Services Region).
Planned Resources	The hospital will provide financial and in kind support as well as serve as grant manager.
Planned Collaborators	● Adams & Taylor County Schools ● Early Childhood Iowa ● Crisis Intervention & Advocacy ● Southern Hills Regional Mental Health ● Physicians/clinic (referral) ● Local churches ● Matura (food bank) ● Iowa State University Extension

	Health Need #2: Healthy Lifestyles
Goals & Anticipated Impact	Goal: ● Prevent chronic disease Anticipated Impact: ● Increase in youth and adult fresh fruit and vegetable consumption and access to healthy foods ● Increase in youth and adult physical activity ● Increase in nutrition/ healthy lifestyle promotion in the community
Community Indicators	CHNA 2022 ● Unemployment - 2% (Adams), 2.3% (Taylor), 2.9% (Iowa) ● 10.8% of persons in poverty in Adams County, 10.5% in Taylor County, 10.2% across Iowa ● 16.3% of children under 18 in poverty in Adams County, 10.79% in Taylor County, 13.79% across Iowa ● Average number of mentally unhealthy days reported in past 30 days (age-adjusted) in Adams County 3.7, 3.9 in Taylor County, and 3.5 in Iowa (2021 County Health Rankings)
Strategy	**Key Activities**
2.1 Expand access to and consumption of healthy foods	2.1.1 Partner with Wellmark to implement eat better, move more and feel better strategies (i.e. farmer's market enhancements, community supported agriculture program, community gleaning and trail wayfinding, etc.). FY23 Actions and Impact ● Partnered with Wellmark Healthy Hometowns and continued to work on our Corning Master Plan of Eat Well, Move More and Feel Better Strategies. Tactics continue to be identified and refined throughout FY23, but relevant tactics include: enhancing the Corning Farmer's Market, expanding a Community Gleaning Program to provide nutritious food to individuals in need, neighborhood fruit trees and/or local farms, completion of walking trail and sidewalks for community connections so that every point in the community can be reached on walking hard surfaces now. FY23 Measures ● Partnered with Wellmark Healthy Hometowns, no meetings were held during the reporting period. FY24 Actions and Impact ● No updates to report. FY24 Measures

	• No measures to report. FY25 Results Pending
2.2 Health Equity Transformation Assessment (HETA)	2.2.1 Complete the American Hospital Association's HETA and utilize results to develop an action plan. FY23 Actions and Impact • Activity created in FY24. FY23 Measures • No measures to report. FY24 Actions and Impact • Completed the HETA assessment. Created a health equity action plan and formed a committee to advance the work, including reducing racial disparities in hypertension management.Will prioritize reducing racial disparities in hypertension management in FY25. FY24 Measures • No measures to report. FY25 Results Pending
2.3 Connection to community-based services for unmet health needs	2.3.1 Invest in community organizations focused on cardiovascular health through the implementation of the Community Health Improvement Grant (CHIG) program. FY23 Actions and Impact • Activity created in FY24. FY23 Measures • No measures to report. FY24 Actions and Impact • Awarded a CHIG to Southwestern Community College's Parents as Teachers (PAT) program. The program provides family support home visitation services to families with children prenatal through five years of age who have identified social determinants of health risk factors and who reside in Adams County. In addition to home visits, the program provides screenings, resource connections, and group connections. PAT aims to prevent mental health problems, child abuse, and domestic violence. FY24 Measures • CHIG funds awarded (1/1/24-12/31/24): $7,988 FY25 Results Pending

Related Activities	In addition to the specific strategies and key activities outlined above to address Healthy Lifestyles, CHI Health Mercy Corning operates the CHI Health Mercy Corning Wellness Center, which offers personal training, outpatient rehabilitation services and group wellness classes.
Planned Resources	The hospital will provide financial and in kind support.
Planned Collaborators	• Wellmark Healthy Hometowns • Iowa State University Extension