During 2012, a Community Health Needs Assessment (CHNA) was conducted by Mercy Medical Center – New Hampton (MMC-NH) for the 12,276 residents of Chickasaw County, IA. Chickasaw County includes its county seat, New Hampton, a town of 3,571 residents located in the midst of the rolling farmland of north-east Iowa. MMC-NH, an 18-bed Critical Access Hospital, serves New Hampton and essentially all the surrounding rural areas in Chickasaw County.

Chickasaw County is predominately rural and heavily dependent on agriculture. The county’s population dropped 5.01% from 2000 to 2010; by comparison, Iowa’s population grew 4.1% over the same time period. As an indicator, population trends are relevant because a shrinking population base affects healthcare providers and the utilization of community resources.

In general, rural populations are older, poorer and less educated than their urban counterparts, with higher prevalence of chronic diseases. Chickasaw County is no exception.

The county’s population is predominately white (98.6%). And, though median household income of $42,098 is only 83% of the Iowa state average, the 9.2% of persons below the poverty level is 23% below (i.e. better than) the Iowa average of 11.9%. 19.2% of the population is 65 years and over, compared to 14.9% in Iowa. 14.4% of the population has a Bachelor’s degree or higher, compared to 24.9% in Iowa.

(Detailed demographic, socioeconomic and health profile information can be found in Attachment A.)
The assessment process was initiated by MMC-NH. A planning team was formed consisting of representatives from hospital governance, leadership and medical staff, area employers, school districts and area health professionals. (Names and roles can be found in Attachment B.) Facilitated by Deb Lassise, an outside consultant, four separate discussion groups were held on June 12 and 13, 2012 at The Pub in New Hampton. The groups represented varying sectors in the community: social service partners, patients, community/business representatives, and industrial workers. Thirty-six letters of invitation were sent to groups 1, 2, and 3; 19 attended (63% participation.) The patient group was pulled randomly from a patient listing over the last 6 months, social service partners were a cross-section of the agencies Mercy works closely with, and community leaders/business owners were selected for their knowledge of the community. Industrial workers on group #4 were identified by their employer. The four groups are outlined in the table below:

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Four participants were from outside New Hampton (Fredericksburg, Lawler and Alta Vista); all others were from New Hampton.

The outside consultant collated and analyzed the focus group results with support from Mercy Medical Center – North Iowa’s (MMC-NI) Planning & Marketing team in Mason City.
**Methodology for Conducting the Assessment**

**Why? Issues to Address**
- Surgeon recruitment
- Physician and nursing retention
- Continue to improve access in clinics
- Meeting community needs
  - E.g. uninsured, behavioral medicine, education, Medical Home
- Facilities issues, e.g. private rooms
- Associate engagement
- Cultural diversity, e.g. Hispanic market

MMC-NH’s CHNA began with a review of the most recent public health assessment performed by the Chickasaw County Health Department. This information was updated with more recent statistics from city, county, state and national sources. New data sources were identified and incorporated, including the newly-published County Health Rankings and additional data from MMC-NH, including discharge information available through the Iowa Hospital Association, forecasts of future volumes and health needs available through the Advisory Board, and interviews with members of the hospital’s leadership, medical staff and associates.

Early in the process, MMC-NI’s planning team facilitated a brainstorming session with MMC-NH’s Board of Trustees to elicit their perceptions of the community’s needs for improved service access and availability.

Recent indicator data for comparisons was also collected from the Iowa Department of Public Health’s *Healthy Iowans: Iowa's Health Improvement Plan 2012-2016* which focuses on 39 critical health needs and provides a blueprint for addressing them. Healthy Iowans builds on health planning that is already taking place by numerous private and public sector organizations across the state. Iowa's health improvement plan provides a starting point to identify strategies and initiatives that are addressing critical health needs with the understanding that no one plan could reflect everything that is being done to tackle Iowans' needs.

The review included analysis of trends and comparisons within the community, with other like-sized communities and with statewide data from across Iowa. Based on this review, discussion topics were developed for a variety of community engagement settings, including multiple focus groups and an “IdeaScale” website for online suggestions and comments. Community settings were selected with a special emphasis on availability to those persons and areas most affected by health disparities.

Information from these focus group listening sessions was collated and presented to the Planning Team, and with the assistance of an MMC-NI facilitator, was distilled into a list of “High-Potential Opportunities” – i.e. those opportunities estimated to have the greatest positive impact on the
identified community health needs. (See Attachment C for the full list.)

The Planning Team members agreed on a set of criteria to use in evaluating the list of High-Potential Opportunities identified through the fact-finding process. The criteria included:

- The **Prevalence** or degree of customer need throughout the identified service area, measured by the number of people affected.
- The **Threat** or degree to which not addressing the need jeopardizes vital community health needs or organizational capabilities.
- **Trends** in the identified service area, i.e. is the situation worsening over time?
- The estimated **Degree of Difficulty** of addressing the need, i.e. does MMC-NH possess demonstrated skills and capabilities in this area? If not, are there community partners who do?
- The estimated community **Health Reward or Return on Investment** of a successful outcome.
- Other issues as noted.

Through a series of facilitated meetings, Planning Team members used these criteria to evaluate the list of **High-Potential Opportunities**. Rankings were shared and discussed. Team members were then given the opportunity to revise and/or amend their rankings. The rankings were summed to produce a composite ranking which was then shared with MMC-NH’s Board, physicians and associates.

The prioritization process identified 3 priority issues for the community:

1. Improving **community health** in New Hampton and Chickasaw County, with specific emphasis on three areas:
   1. Mental Health
   2. Chemical Dependency
   3. Obesity
2. Building the **community’s awareness** of available services and health improvement options/opportunities, using new communications channels and technologies.
3. Improving the **community’s access** to MMC-NH’s clinics as an alternative
to possibly inappropriate and expensive ED use, particularly during ‘off hours’ when appointment scheduling is either difficult due to capacity issues, or not available.

Though residents of New Hampton and rural Chickasaw County take great pride in their community as a place to live, work and raise families, health status data collected from various sources show that, compared to state of Iowa benchmarks, the area has significant opportunities for improvement.

Information from [County Health Rankings & Roadmaps](http://www.countyhealthrankings.org) identifies the following areas of opportunity for Chickasaw County:

- Adult smoking
- Adult obesity
- Physical inactivity
- Excessive drinking

With this information in mind, focus group discussions centered on the strategic planning focus of “developing a culture of health and well-being in Chickasaw County.” Recognizing MMC-NH serves as a partner and a leader to achieve health and wellness, the discussion was structured to review both roles.

The Community Health Needs Assessment (CHNA) completed by Chickasaw Public Health was used as a reference in discussing Mercy as a partner. Participants were asked:

- How does and how should Mercy contribute to achieve identified goals for county residents?
- What is Mercy currently doing to address goals/action steps?
Chronic diseases are more common in rural areas.

MMC-NH as a primary care and service provider was reviewed in the same manner:

- What is being done well?
- What are MMC-NH’s strengths?
- Where is the opportunity for improvement?
- What services need to be developed?

MMC-NH as a Partner:
As a partner, MMC-NH is well regarded. In review of the four CHNA goals (obesity, diabetes, dialysis, and alcohol/tobacco), input varied by group. Obesity and diabetes discussion circled and overlapped each other (see all comments). Group 1/Social Service Partners was well versed in the activities of MMC-NH—they knew the extent of collaborative work being done by the hospital. This being said, even the comment “need awareness of what is being done in hospital” was made. Overall, all groups acknowledged that MMC-NH does a lot in the community—many specific efforts were named and many questions were asked; some are unsure of all that is being done. All groups mentioned MMC-NH diabetes fair and education classes. Of note are questions about MMC-NH involvement with the Chickasaw Wellness Center (CWC). Groups recognized the issue of dialysis services and the challenges of providing this service. The issue of alcohol and tobacco brought limited discussion. It is recognized as an issue in the community. There is an awareness of the community culture, and again, a realization of the difficulty of addressing the problem

MMC-NH as a Primary Care and Health Service Provider:
The community is very pleased with MMC-NH as a primary care and service provider. When asked about the strengths of MMC-NH, with overwhelming agreement, residents applaud their new doctors and facility. Many comments were made about their young, energetic physicians. They speak positively about their mission work; there is community ownership in their efforts. They appreciate the facility that connects hospital and clinic under one roof. The table below outlines the areas of strength by number of comments
(strengths only listed in table if identified by more than one group):

<table>
<thead>
<tr>
<th>Strength</th>
<th># Comments</th>
<th>Common Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>21</td>
<td>Energetic and caring; appreciate mission work</td>
</tr>
<tr>
<td>Facility</td>
<td>14</td>
<td>New attached clinic; convenient and attractive</td>
</tr>
<tr>
<td>Services</td>
<td>10</td>
<td>Of note: ER and OB; PT mentioned several times</td>
</tr>
<tr>
<td>Staff</td>
<td>9</td>
<td>Staff is caring and professional; like local/familiar faces</td>
</tr>
<tr>
<td>Management</td>
<td>7</td>
<td>Good involvement in community; can recruit/support</td>
</tr>
<tr>
<td>Overall</td>
<td>6</td>
<td>Value presence in the community</td>
</tr>
<tr>
<td>Specialists</td>
<td>6</td>
<td>Access to specialists and local outpatient services</td>
</tr>
</tbody>
</table>

Group 4 made special note of the ability to get appointments in a timely manner and the efficiencies at the time of visits.

**Opportunities for Improvement:**
Recognizing the strong base that exists at MMC-NH, participants were asked “what improvements would you like to see made?” and “what goals should be set?” After discussion, participants were invited to vote for their top three priorities. Opportunities were listed on a flip chart; each participant had 3 stickers to cast their priority votes. The results are summarized in the table below (opportunities only listed in table if identified by more than one group):
Group 1 discussed behavioral health needs at length and was the only group to do so; 8 voted it as a priority. Group 2 listed several miscellaneous ideas. The nature of that discussion did not lend itself to a priority voting process. However, Group 2’s opportunities mirror lists from the other groups. Group 4’s list addressed continuity of care when physicians are gone for mission work as a priority (n=6). Although this issue was discussed in several groups (recognizing the pros and cons), Group 4 was the only one to identify it as a priority. These services were listed as opportunities: orthopedics, dialysis, EMS, respite care, and free clinic. Miscellaneous processes were noted as opportunities. Of note, the confusing billing system was mentioned in three groups at various points of discussion. Support groups and transportation were final areas of opportunity.

Validity and Reliability of Results:
These results represent the input from 30 Chickasaw County residents - it is important to consider the validity of these comments as they represent Mercy’s service area of Chickasaw County. All participants appeared open to addressing the formatted questions; none appeared to have a specific agenda. Approximately half of the participants were female, representing roughly half of the population. However, it is traditionally believed that women make the majority of healthcare decisions in the United States (from 58% to 67%, according to Kaiser Family Foundation and National Council for Research on Women, respectively). Also, younger adults were not represented. The proportion of older adults (65+) participating (20%) reflect the actual Chickasaw County population of 19.2% (US Census, 2011 estimate). Industrial representatives were approximately 37% of participants; actual manufacturing employment is 25.4% (US Census, 2010). Perhaps the biggest misrepresentation was in New Hampton residents. Twenty-seven percent of Chickasaw residents live in New Hampton; 87% of participants were from New Hampton. This factor needs to be considered as comments are reviewed. Balancing that disparity are the eight social service partners, several of whom have service areas beyond New
Hampton.

Reliability is demonstrated by issues and comments that are repeated in more than one group. With few exceptions (e.g. behavioral health), comments and issues were repeated in multiple groups. The top five strengths (physicians, facility, services, staff, and management) were discussed in all four groups. The top three opportunities (highest priority votes: Access/Clinic Hours, Use of Technology, Wellness/Health Promotion) received strong support by at least two groups. Considering Group 2 had no priority voting process, this is significant. Overall, there is good reason to believe these comments are representative of Chickasaw County residents.

**Summary:**
Mercy sits in a position of strength and is poised for success. Decisions made and work completed over the past years have served the community well. Overwhelmingly, all participants are happy with the hospital – its physicians, its facility, its management/staff and services. They are a valued part of the community and seen as a good corporate citizen. Participants recognize the service it provides and trust guidance given when additional/referral services are needed. This input, along with other data obtained for planning purposes, will guide the strategic process in outlining a prosperous and sustainable course.

A key learning for future CHNA planning efforts was the lack of engagement with the IdeaScale website. Though the few suggestions received were on-target and useful, the low volume of participants causes concern over whether the sample is truly representative of community attitudes and needs. Future efforts in this regard will include increased communication.

**Community Assets Identified**
Through the assessment process, a number of strong community assets (see Attachment D) were identified, including the hospital and its many community benefit programs, Chickasaw County Public Health, the Chickasaw County Mental Health Advisory Committee, Pathways Behavioral Services, the Chickasaw Wellness Center (CWC), an adequate supply of primary care physicians, a public school system with active home and school associations and numerous religious
Assessment data is summarized in Attachment E. Attachment F lists all needs identified and describes the priority-setting approach. Planning Team members committed to focus on the affirmed priorities. In summary, priority needs identified were:

- Needs From Data Review:
  - Adult smoking
  - Adult obesity
  - Physical inactivity
  - Excessive drinking

- Needs From Focus Groups:
  - Mental Health
  - Access Issues
  - Communication & Awareness

The Planning Team established three teams to develop implementation strategies for each priority. Each team’s leader is responsible for:

- Determining what other community organizations are doing regarding the priority.
- Organizing a team, including both field professionals and representative community members.
- Guiding the team’s work, including development of a work plan in the format of a Strategy A3 to mirror Mercy Health Network’s lean-inspired strategic planning format. A3 is, simply, structured scientific problem solving to:
  - Meet the CHNA goals
  - Develop/coach all employees to be better problem solvers as part of the CHNA implementation process.
  - Develop managers to be effective CHNA problem solving coaches and to become creators of more managers with the same capability. Together these goals ensure that Mercy – New Hampton will continually improve its capability to deploy strategies,
meet goals, respond to changes in the marketplace, and to solve performance problems.

- Establishing metrics, including measurable outcomes indicators.
- Assuring work is coordinated with other implementation teams, and
- Communicating appropriately with the community at-large.

MMC-NH is developing a community report card, including metrics for both New Hampton and Chickasaw County to be published on an annual basis. The Planning Team is committed to conducting another comprehensive needs assessment in 3 years.

The Planning Team also charged the organization with attempting to fill the information gaps and with developing a better understanding of the social determinants of the health issues identified in order to better understand and address the community’s health needs going forward.

This assessment will be posted on MMC-NH’s website. A copy can also be obtained by contacting MMC-NH’s administrative offices.
During 2012, a Community Health Needs Assessment (CHNA) was conducted by Mercy Medical Center – New Hampton (MMC-NH) for the 12,276 residents of Chickasaw County, IA. Chickasaw County includes its county seat, New Hampton, a town of 3,571 residents located in the midst of the rolling farmland of north-east Iowa.

Licensed for 18 beds, MMC-NH is a member of the Mercy Health Network, a faith-based, not-for-profit community health care system and offers comprehensive health care services including inpatient, outpatient, emergency and a range of primary care and specialty physician services. The majority of MMC-NH’s patients are residents of Chickasaw County.

MMC-NH has been serving residents of Iowa’s Chickasaw County and surrounding areas for nearly 100 years. Opened by the Servant Sisters of the Holy Ghost, in 1917, the hospital continues to carry out its mission to “…to enhance the health status of people we serve by ensuring access to excellent health services provided in a Christian atmosphere.”

This report summarizes plans for MMC-NH to sustain and develop new community benefit programs that (1) address prioritized needs from the 2012 Community Health Needs Assessment (CHNA) conducted by MMC-NH’s Planning Team with the support of numerous community and public health leaders, and (2) respond to other identified community health needs.
The MMC-NH Planning Team identified Chickasaw County as the appropriate target area for needs assessment and planning. In general, rural populations are older, poorer and less educated than their urban counterparts, with a higher prevalence of chronic diseases. Chickasaw County is no exception.

- 2012 Population: 12,276
- Percent change 200-201: -5.01% (IA average: 4.10%)
- Percent 65 years and over: 19.2% (IA average: 14.9%)
- Percent white: 98.6% (IA average: 93%)
- Percent BA degree or higher: 14.4% (IA average: 24.9%)
- Median household income: $42,098 (IA median: $50,451)
- Employment percent change 2000-2010: -13.3% (IA average: -0.9%)
- Adult smoking incidence: 22% (IA average: 19%)
- Adult obesity incidence: 31% (IA average: 29%)
- Physical inactivity incidence: 28% (IA average: 25%)
- Excessive drinking incidence: 32% (IA average: 20%)

(Detailed demographic, socioeconomic and health profile information can be found in Attachment A.)

Areas outside of the town of New Hampton yet within Chickasaw County have the most limited access to health services and greatest need for supportive services, e.g. transportation to care for those with chronic diseases.
MMC-NH’s implementation strategy was developed based on the findings and priorities established by the Planning Team’s CHNA and a review of the hospital’s existing community benefit activities.

MMC-NH provided leadership for the 2012 CHNA process and, through its Planning Team, gained the involvement and active participation of numerous civic and health leaders throughout New Hampton and Chickasaw County. Along with representatives of MMC-NH’s Board and Medical Staff, the Planning Team included consumers, community volunteers, the Chickasaw County Board of Supervisors, the New Hampton School District and major area employers.

Additional community input was elicited through a series of focus groups. Facilitated by an outside consultant, four separate discussion groups were held on June 12 and 13, 2012 at The Pub in New Hampton. The groups represented varying sectors in the community: social service partners, patients, community/business representatives, and industrial workers. Thirty-six letters of invitation were sent to groups 1, 2, and 3; 19 attended (63% participation); see attached letter of invitation in Attachment C. The patient group was pulled randomly from a patient listing over the last 6 months, social service partners were a cross-section of the agencies Mercy works closely with, and community leaders/business owners were selected for their knowledge of the community. Industrial workers in group #4 were identified by their employer. The four groups are outlined in the table below:

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Four participants were from outside New Hampton (Fredericksburg, Lawler and Alta Vista); all others were from New Hampton.
The outside consultant collated and analyzed the focus group results with support from MMC-NI’s Planning & Marketing team.

After completion of the CHNA in late 2012, the Planning Team formed implementation teams to respond to each of the “High-Potential Opportunities.” Each team is developing and monitoring goals and action plans.

MMC-NH’s CHNA began with a review of the most recent public health assessment performed by the Chickasaw County Health Department. This information was updated with more recent statistics from city, county, state and national sources. New data sources were identified and incorporated, including the newly-published County Health Rankings and additional data from MMC-NH, including discharge information available through the Iowa Hospital Association, forecasts of future volumes and health needs available through the Advisory Board, and interviews with members of the hospital’s leadership, medical staff and associates.

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The Planning Team members agreed on a set of criteria to use in evaluating the list of High-Potential Opportunities identified through the fact-finding process. The criteria included:

- **The Prevalence** or degree of customer need throughout the identified service area, measured by the number of people affected.
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- **Any Trends** in the identified service area, i.e. is the situation worsening over time?
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- **Other issues as noted.**

Through a series of facilitated meetings, Planning Team members used these criteria to evaluate the list of High-Potential Opportunities. Rankings were shared and discussed. Team members were then given the opportunity to revise and/or amend their rankings. The rankings were summed to produce a composite ranking which was then shared with MMC-NH’s Board, physicians and associates.

The prioritization process identified 3 priority issues for the community:

1. Improving **community health** in New Hampton and Chickasaw County, with specific emphasis on three areas:
   1. Mental Health
   2. Chemical Dependency
   3. Obesity
2. Building the community’s awareness of available services and health improvement options/opportunities, using new communications channels and technologies.
3. Improving the community’s access to MMC-NH’s clinics as an alternative to possibly inappropriate and expensive ED use, particularly during ‘off hours’ when scheduling is either difficult or not available.

Description of What MMC-NH Will Do To Address Community Needs

MMC-NH chairs three implementation teams, one dedicated to each of the three identified High-Potential Opportunities. Teams will include key staff and leaders from MMC-NH along with select community partners. Additional invitations will be extended to community residents and stakeholders who offer unique insights into barriers to access, effective solutions and necessary resources for successful implementation.

Meetings of these teams will be open to the community and appropriate notice will be given.

In addition, MMC-NH will continue to meet community needs by providing charity care, services to Medicaid recipients and the medically indigent, continuing its ongoing program of community outreach and wellness education, and by recruiting qualified health professionals to the community.
Action Plans

1. **Improving community health in New Hampton and Chickasaw County, with specific emphasis on three areas:**
   
a. **Mental Health**
b. **Chemical Dependency**
c. **Obesity**

MMC-NH currently partners with several providers of mental health and chemical dependency services in New Hampton and Chickasaw County. MMC-NH will form a team to assess the true magnitude of the underserved need, and revisit with Mercy Medical Center – North Iowa in Mason City the initiative to add mental health providers to the New Hampton community. Options to be considered include partnering locally, recruiting additional providers and the use of emerging technologies, including telemedicine. Support will be sought from local agencies and healthcare professionals, including pharmacists (important for the 65+ age group), schools and law enforcement.

2. **Building the community’s awareness of available services and health improvement options/opportunities, using new communications channels and technologies.**

Under the theory that underserved populations cannot benefit from services about which they are unaware, MMC-NH will identify current levels of awareness in New Hampton and Chickasaw County and seek to build awareness and understanding among specific at-risk populations. Emphasis will be placed on smaller communities in Chickasaw County, including Lawler and Fredericksburg. Messages will be designed to emphasize the clear consumer ‘value’ of improved health and well-being. Extensive use will be made of social media, in-person ‘annual reports’ to the community, partnerships with local government entities.

3. **Improving the community’s access to MMC-NH’s clinics as an alternative to possibly inappropriate and expensive ED use, particularly during ‘off hours’ when scheduling is either difficult or not available.**

Establishing an enduring relationship with a primary care provider has been proven to be one of the most beneficial ways of improving health status and ensuring continuity of care. MMC-NH has done an excellent job recruiting a core of dedicated, energetic family practice physicians; now the issue is maximizing access to these physicians and deflecting care from higher-cost/lower value settings like the emergency room. MMC-NH will research and address the community’s need for scheduled vs. off-hours care, possibly including a “Fast’Trak” urgent care model in the ED.
Next Steps For Priorities

For each of the priority areas listed above, MMC-NH will work with the Planning Team and community partners to:

- Identify any related activities being conducted by others in the community that could be built upon.
- Develop measureable goals and objectives so that the effectiveness of their efforts can be measured.
- Build support for the initiatives within the community and among other healthcare providers.
- Develop detailed work plans.
Priority Needs Not Being Addressed and the Reasons

MMC-NH has chosen not to directly address the community’s **Physical Inactivity** and **Access to Recreation and Fitness Facilities**. Though the 8.04 Establishment Rate Per 100,000 population is well below both Iowa’s and the country’s averages, MMC-NH believes that working with and through the Chickasaw Wellness Center (CWC) to maximize its already-excellent roster of programs and services is a more effective use of scarce community resources.

Also, though Chickasaw **County’s Percent of Medicare Enrollees With Diabetes Having An Annual Exam** (87.21%) is again below Iowa’s benchmark, as a member of the Mercy Health Network, MMC-NH believes that working within the Network’s overall strategy for managing diabetes and other chronic diseases is, again, a more effective use of scarce institutional resources. MMC-NH’s clinical team, including physicians, is playing an active role in bringing the Network’s methodologies to New Hampton and Chickasaw County.

Approval

Each year at their May Board meeting, the MMC-NH Governing Board, which includes representatives from New Hampton and Chickasaw County, reviews the prior fiscal year’s Community Benefit Report and approves the Community Benefit Implementation Strategy for addressing priorities identified in the most recent Community Health Needs Assessment and other plans for community benefit. This report was prepared for the May 20, 2013 meeting of the Governing Board.

Mercy Medical Center – New Hampton Governing Board approval:

(By name and title)

(Date)
## Demographic Characteristics

<table>
<thead>
<tr>
<th>Selected Area</th>
<th>USA</th>
<th>2012</th>
<th>2017</th>
<th>% Change 2012 - 2017</th>
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</thead>
<tbody>
<tr>
<td>2000 Total Population</td>
<td>13,141</td>
<td>281,421,906</td>
<td>12,427</td>
<td>313,095,504</td>
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<td>2012 Total Population</td>
<td>12,427</td>
<td>313,095,504</td>
<td>12,255</td>
<td>325,256,835</td>
</tr>
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<td>% Change 2012 - 2017</td>
<td>-1.4%</td>
<td>3.9%</td>
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<tr>
<td>Average Household Income</td>
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<td>$67,315</td>
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### Population Distribution

#### Age Distribution

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<thead>
<tr>
<th>Age Group</th>
<th>2012 % of Total</th>
<th>2017 % of Total</th>
<th>USA 2012 of Total</th>
<th>2012 Household Income</th>
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</thead>
<tbody>
<tr>
<td>0-14</td>
<td>2,455 19.8%</td>
<td>2,424 19.8%</td>
<td>20.2%</td>
<td>&lt;$15K 661 12.6% 13.0%</td>
</tr>
<tr>
<td>15-17</td>
<td>624 5.0%</td>
<td>529 4.3%</td>
<td>4.3%</td>
<td>$15-25K 613 11.7% 10.8%</td>
</tr>
<tr>
<td>18-24</td>
<td>974 7.8%</td>
<td>1,134 9.3%</td>
<td>9.7%</td>
<td>$25-50K 1,804 34.4% 26.7%</td>
</tr>
<tr>
<td>25-34</td>
<td>911 7.3%</td>
<td>1,102 9.0%</td>
<td>13.5%</td>
<td>$50-75K 1,273 24.3% 19.5%</td>
</tr>
<tr>
<td>35-44</td>
<td>3,572 28.7%</td>
<td>2,865 23.4%</td>
<td>28.1%</td>
<td>$75-100K 490 9.4% 11.9%</td>
</tr>
<tr>
<td>55-64</td>
<td>1,674 13.5%</td>
<td>1,831 14.9%</td>
<td>11.4%</td>
<td>Over $100K 396 7.8% 18.2%</td>
</tr>
<tr>
<td>65+</td>
<td>2,217 17.8%</td>
<td>2,379 19.3%</td>
<td>12.9%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>12,427 100.0%</td>
<td>12,255 100.0%</td>
<td>100.0%</td>
<td>Total 5,237 100.0% 100.0%</td>
</tr>
</tbody>
</table>

#### Education Level

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Pop Age 25+</th>
<th>% of Total</th>
<th>USA % of Total</th>
<th>2012 Pop</th>
<th>% of Total</th>
<th>USA % of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than High School</td>
<td>471</td>
<td>5.6%</td>
<td>6.3%</td>
<td>12,005</td>
<td>96.6%</td>
<td>62.8%</td>
</tr>
<tr>
<td>Some High School</td>
<td>466</td>
<td>5.6%</td>
<td>8.6%</td>
<td>33</td>
<td>0.3%</td>
<td>12.3%</td>
</tr>
<tr>
<td>High School Degree</td>
<td>3,969</td>
<td>47.4%</td>
<td>28.7%</td>
<td>297</td>
<td>2.4%</td>
<td>17.0%</td>
</tr>
<tr>
<td>Some College/Assoc. Degree</td>
<td>2,410</td>
<td>28.8%</td>
<td>8.5%</td>
<td>40</td>
<td>0.3%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Bachelor's Degree or Greater</td>
<td>1,058</td>
<td>12.6%</td>
<td>27.8%</td>
<td>52</td>
<td>0.4%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Total</td>
<td>8,374</td>
<td>100.0%</td>
<td>100.0%</td>
<td>12,427</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

© 2012 The Nielsen Company, © 2013 Truven Health Analytics Inc.
<table>
<thead>
<tr>
<th>People QuickFacts</th>
<th>Chickasaw County</th>
<th>Iowa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population, 2012 estimate</td>
<td>12,276</td>
<td>3,074,186</td>
</tr>
<tr>
<td>Population, 2010 (April 1) estimates base</td>
<td>12,439</td>
<td>3,046,857</td>
</tr>
<tr>
<td>Population, percent change, April 1, 2010 to July 1, 2012</td>
<td>-1.3%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Population, 2010</td>
<td>12,439</td>
<td>3,046,355</td>
</tr>
<tr>
<td>Persons under 5 years, percent, 2011</td>
<td>6.3%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Persons under 18 years, percent, 2011</td>
<td>24.0%</td>
<td>23.7%</td>
</tr>
<tr>
<td>Persons 65 years and over, percent, 2011</td>
<td>19.2%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Female persons, percent, 2011</td>
<td>49.6%</td>
<td>50.4%</td>
</tr>
<tr>
<td>White persons, percent, 2011 (a)</td>
<td>98.6%</td>
<td>93.0%</td>
</tr>
<tr>
<td>Black persons, percent, 2011 (a)</td>
<td>0.5%</td>
<td>3.1%</td>
</tr>
<tr>
<td>American Indian and Alaska Native persons, percent, 2011 (a)</td>
<td>0.1%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Asian persons, percent, 2011 (a)</td>
<td>0.4%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)</td>
<td>0.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Persons reporting two or more races, percent, 2011</td>
<td>0.4%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Persons of Hispanic or Latino Origin, percent, 2011 (b)</td>
<td>2.4%</td>
<td>5.2%</td>
</tr>
<tr>
<td>White persons not Hispanic, percent, 2011</td>
<td>96.5%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Living in same house 1 year &amp; over, percent, 2007-2011</td>
<td>92.4%</td>
<td>84.3%</td>
</tr>
<tr>
<td>Foreign born persons, percent, 2007-2011</td>
<td>1.8%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Language other than English spoken at home, percent age 5+, 2007-2011</td>
<td>4.4%</td>
<td>7.0%</td>
</tr>
<tr>
<td>High school graduate or higher, percent of persons age 25+, 2007-2011</td>
<td>88.4%</td>
<td>90.3%</td>
</tr>
<tr>
<td>Bachelor's degree or higher, percent of persons age 25+, 2007-2011</td>
<td>14.4%</td>
<td>24.9%</td>
</tr>
<tr>
<td>Veterans, 2007-2011</td>
<td>1,033</td>
<td>239,229</td>
</tr>
<tr>
<td>Mean travel time to work (minutes), workers age 16+, 2007-2011</td>
<td>20.8</td>
<td>18.6</td>
</tr>
<tr>
<td>Housing units, 2011</td>
<td>5,674</td>
<td>1,340,529</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------</td>
<td>-----------</td>
</tr>
<tr>
<td>Homeownership rate, 2007-2011</td>
<td>82.7%</td>
<td>73.0%</td>
</tr>
<tr>
<td>Housing units in multi-unit structures, percent, 2007-2011</td>
<td>8.4%</td>
<td>18.5%</td>
</tr>
<tr>
<td>Median value of owner-occupied housing units, 2007-2011</td>
<td>$92,500</td>
<td>$121,300</td>
</tr>
<tr>
<td>Households, 2007-2011</td>
<td>5,401</td>
<td>1,219,137</td>
</tr>
<tr>
<td>Persons per household, 2007-2011</td>
<td>2.27</td>
<td>2.41</td>
</tr>
<tr>
<td>Per capita money income in the past 12 months (2011 dollars), 2007-2011</td>
<td>$24,268</td>
<td>$26,110</td>
</tr>
<tr>
<td>Median household income, 2007-2011</td>
<td>$42,098</td>
<td>$50,451</td>
</tr>
<tr>
<td>Persons below poverty level, percent, 2007-2011</td>
<td>9.2%</td>
<td>11.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Business QuickFacts</th>
<th>Chickasaw County</th>
<th>Iowa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private nonfarm establishments, 2010</td>
<td>388</td>
<td>80,801¹</td>
</tr>
<tr>
<td>Private nonfarm employment, 2010</td>
<td>3,724</td>
<td>1,253,095¹</td>
</tr>
<tr>
<td>Private nonfarm employment, percent change, 2000-2010</td>
<td>-13.3</td>
<td>-0.9¹</td>
</tr>
<tr>
<td>Nonemployer establishments, 2010</td>
<td>948</td>
<td>201,448</td>
</tr>
<tr>
<td>Total number of firms, 2007</td>
<td>1,078</td>
<td>259,931</td>
</tr>
<tr>
<td>Black-owned firms, percent, 2007</td>
<td>F</td>
<td>0.8%</td>
</tr>
<tr>
<td>American Indian- and Alaska Native-owned firms, percent, 2007</td>
<td>F</td>
<td>0.2%</td>
</tr>
<tr>
<td>Asian-owned firms, percent, 2007</td>
<td>F</td>
<td>1.1%</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007</td>
<td>F</td>
<td>0.1%</td>
</tr>
<tr>
<td>Hispanic-owned firms, percent, 2007</td>
<td>F</td>
<td>0.9%</td>
</tr>
<tr>
<td>Women-owned firms, percent, 2007</td>
<td>16.4%</td>
<td>25.5%</td>
</tr>
<tr>
<td>Manufacturers shipments, 2007 ($1000)</td>
<td>278,276</td>
<td>97,592,051</td>
</tr>
<tr>
<td>Merchant wholesaler sales, 2007 ($1000)</td>
<td>210,062</td>
<td>41,068,338</td>
</tr>
<tr>
<td>Retail sales, 2007 ($1000)</td>
<td>103,931</td>
<td>39,234,649</td>
</tr>
<tr>
<td>Retail sales per capita, 2007</td>
<td>$8,537</td>
<td>$13,172</td>
</tr>
<tr>
<td>Accommodation and food services sales, 2007 ($1000)</td>
<td>7,433</td>
<td>4,737,719</td>
</tr>
</tbody>
</table>
Building permits, 2011

<table>
<thead>
<tr>
<th>Geography QuickFacts</th>
<th>Chickasaw County</th>
<th>Iowa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land area in square miles, 2010</td>
<td>504.38</td>
<td>55,857.13</td>
</tr>
<tr>
<td>Persons per square mile, 2010</td>
<td>24.7</td>
<td>54.5</td>
</tr>
<tr>
<td>FIPS Code</td>
<td>037</td>
<td>19</td>
</tr>
<tr>
<td>Metropolitan or Micropolitan Statistical Area</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

1: Includes data not distributed by county.

Download these tables - delimited | Download these tables - Excel | Download the full data set

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information
F: Fewer than 100 firms
FN: Footnote on this item for this area in place of data
NA: Not available
S: Suppressed; does not meet publication standards
X: Not applicable
Z: Value greater than zero but less than half unit of measure shown

Last Revised: Monday, 11-Mar-2013 14:12:18 EDT
Current population demographics and changes in demographic composition over time play a determining role in the types of health and social services needed by communities.

### Change in Total Population

This indicator reports the percent difference in population counts from the 2000 Census population estimate to the 2010 Census population estimate. This indicator is relevant because a positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickasaw County, Iowa</td>
<td>12,439</td>
<td>13,095</td>
<td>-5.01%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>2,926,324</td>
<td>4.10%</td>
</tr>
<tr>
<td>United States</td>
<td>308,745,538</td>
<td>281,421,906</td>
<td>9.71%</td>
</tr>
</tbody>
</table>

*Note: No breakout data available.*

*Data Source: U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 1; U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1.*

*Source geography: County.*
Social & Economic Factors

Economic and social insecurity often are associated with poor health. Poverty, unemployment, and lack of educational achievement affect access to care and a community’s ability to engage in healthy behaviors. Without a network of support and a safe community, families cannot thrive. Ensuring access to social and economic resources provides a foundation for a healthy community.

High School Graduation Rate
This indicator reports the average freshman graduate rate, which measures the percentage of students receiving their high school diploma within four years. This indicator is relevant because low levels of education are often linked to poverty and poor health.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Average Freshman Base Enrollment</th>
<th>Estimated Number of Diplomas Issued</th>
<th>On-Time Graduation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickasaw County, Iowa</td>
<td>171</td>
<td>155</td>
<td>91.10</td>
</tr>
<tr>
<td>Iowa</td>
<td>39,571</td>
<td>33,926</td>
<td>85.70</td>
</tr>
<tr>
<td>United States</td>
<td>4,024,345</td>
<td>3,039,015</td>
<td>75.50</td>
</tr>
<tr>
<td>HP 2020 Target</td>
<td></td>
<td></td>
<td>&gt;82.4</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the Healthy People 2020 Target. No breakout data available.
PHYSICAL ENVIRONMENT

A community’s health also is affected by the physical environment. A safe, clean environment that provides access to healthy food and recreational opportunities is important to maintaining and improving community health.

Grocery Store Access

This indicator reports the number of grocery stores per 100,000 population. Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. Included are delicatessen-type establishments. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores are excluded. This indicator is relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Number of Establishments</th>
<th>Establishment Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickasaw County, Iowa</td>
<td>12,439</td>
<td>2</td>
<td>16.08</td>
</tr>
</tbody>
</table>
### Grocery Stores and Supermarkets, Rate per 100,000

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Number of Establishments</th>
<th>Establishment Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickasaw County, Iowa</td>
<td>12,439</td>
<td>1</td>
<td>8.04</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,046,355</td>
<td>595</td>
<td>19.53</td>
</tr>
<tr>
<td>United States</td>
<td>308,745,538</td>
<td>64,366</td>
<td>20.85</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Data Source: U.S. Census Bureau, County Business Patterns, 2011. Source geography: County.

### Recreation and Fitness Facility Access

This indicator reports the number per 100,000 population of recreation and fitness facilities as defined by North American Industry Classification System (NAICS) Code 713940. This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.
Chickasaw County, Iowa | 12,439 | 1 | 8.04
Iowa | 3,046,355 | 347 | 11.39
United States | 308,745,538 | 29,506 | 9.56

Note: This indicator is compared with the state average. No breakout data available.
Data Source: U.S. Census Bureau, County Business Patterns, 2011. Source geography: County.

**CLINICAL CARE**

A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians, the rate of uninsurance, financial hardship, transportation barriers, cultural competency, and coverage limitations affect access.

Rates of morbidity, mortality, and emergency hospitalizations can be reduced if community residents access services such as health screenings, routine tests, and vaccinations. Prevention indicators can call attention to a lack of access or knowledge regarding one or more health issues and can inform program interventions.

**Diabetes Management (Hemoglobin A1c Test)**
This indicator reports the percentage of diabetic Medicare patients who have had a hemoglobin A1c (hA1c) test, a blood test which measures blood sugar levels, administered by a health care professional in the past year. This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Medicare Enrollees</th>
<th>Medicare Enrollees with Diabetes</th>
<th>Medicare Enrollees with Diabetes with Annual Exam</th>
<th>Percent Medicare Enrollees with Diabetes with Annual Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickasaw County, Iowa</td>
<td>2,174</td>
<td>219</td>
<td>190</td>
<td>87.21%</td>
</tr>
<tr>
<td>Iowa</td>
<td>359,222</td>
<td>36,958</td>
<td>32,973</td>
<td>89.22%</td>
</tr>
<tr>
<td>United States</td>
<td>51,875,184</td>
<td>6,218,804</td>
<td>5,212,097</td>
<td>83.81%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.


A1C Test in Past Year, Percent of Medicare Enrollees with Diabetes, 2010
- Over 88.0%
- 84.1 - 88.0%
- 80.1 - 84.0%
- Under 80.1%
- No Data or Data Suppressed
**Health Behaviors**

Health behaviors such as poor diet, a lack of exercise, and substance abuse contribute to poor health status.

**Alcohol Consumption**

This indicator reports the percentage of adults aged 18 and older who self-report heavy alcohol consumption (defined as more than two drinks per day for men and one drink per day for women). This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as cirrhosis, cancers, and untreated mental and behavioral health needs.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 18</th>
<th>Estimated Population Heavily Consuming Alcohol</th>
<th>Percent Population Heavily Consuming Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickasaw County, Iowa</td>
<td>9,476</td>
<td>2,710</td>
<td>28.60%</td>
</tr>
<tr>
<td>Iowa</td>
<td>911,283</td>
<td>174,966</td>
<td>19.20%</td>
</tr>
<tr>
<td>United States</td>
<td>89,135,163</td>
<td>13,385,866</td>
<td>15.02%</td>
</tr>
</tbody>
</table>

*Note: This indicator is compared with the state average. No breakout data available.*

## Alcohol Expenditures

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Average Total Household Expenditures (USD)</th>
<th>Average Household Alcoholic Beverage Expenditures (USD)</th>
<th>Percent Alcoholic Beverage Expenditures</th>
<th>Alcoholic Beverage Expenditures, County Rank (In-State)</th>
<th>Alcoholic Beverage Expenditures, County Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickasaw County, Iowa</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td>25</td>
<td>25.25%</td>
</tr>
<tr>
<td>Iowa</td>
<td>48,675</td>
<td>908</td>
<td>1.87%</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>United States</td>
<td>50,932</td>
<td>910</td>
<td>1.79%</td>
<td>no data</td>
<td>no data</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Data Source: [Nielsen Claritas SiteReports, Consumer Buying Power, 2011](#). Source geography: Tract.
### Fruit/Vegetable Consumption

This indicator reports the percentage of adults aged 18 and older who self-report consuming less than 5 servings of fruits and vegetables each day. This indicator is relevant because current behaviors are determinants of future health, and because unhealthy eating habits may illustrate a cause of significant health issues, such as obesity and diabetes.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 18</th>
<th>Estimated Population with Inadequate Fruit / Vegetable Consumption</th>
<th>Percent Population with Inadequate Fruit / Vegetable Consumption</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickasaw County, Iowa</td>
<td>9,162</td>
<td>no data</td>
<td>suppressed</td>
</tr>
<tr>
<td>Iowa</td>
<td>896,432</td>
<td>723,421</td>
<td>80.70%</td>
</tr>
<tr>
<td>United States</td>
<td>116,676,632</td>
<td>88,508,989</td>
<td>75.86%</td>
</tr>
</tbody>
</table>

**Note:** This indicator is compared with the state average. No breakout data available.

**Data Source:** [Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2005-2009](https://www.cdc.gov/ncidod/dbmd/brfss/).

**Source geography:** County.
### Pct. Adults Consuming Few Fruits / Vegetables 2005-09

- **Over 85.0%**
- **80.1 - 85.0%**
- **75.1 - 80.0%**
- **Under 75.1%**
- **No Data or Data Suppressed**

### Fruit/Vegetable Expenditures

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Average Total Household Expenditures (USD)</th>
<th>Average Household Fruit / Vegetable Expenditures (USD)</th>
<th>Percent Fruit / Vegetable Expenditures</th>
<th>Fruit / Vegetable Expenditures, County Rank (In-State)</th>
<th>Fruit / Vegetable Expenditures, County Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickasaw County, Iowa</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td>60</td>
<td>60.61%</td>
</tr>
<tr>
<td>Iowa</td>
<td>48,675</td>
<td>634</td>
<td>1.30%</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>United States</td>
<td>50,932</td>
<td>737</td>
<td>1.45%</td>
<td>no data</td>
<td>no data</td>
</tr>
</tbody>
</table>

*Note: No breakout data available.*

Physical Inactivity (Adult)

This indicator reports the percentage of adults aged 18 and older who self-report no leisure time for activity, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?". This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as obesity and poor cardiovascular health.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 20</th>
<th>Population with no Leisure Time Physical Activity</th>
<th>Percent Population with no Leisure Time Physical Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickasaw County, Iowa</td>
<td>4,355</td>
<td>1,250</td>
<td>27.10%</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,200,653</td>
<td>555,845</td>
<td>24.42%</td>
</tr>
<tr>
<td>United States</td>
<td>223,593,958</td>
<td>53,553,459</td>
<td>23.63%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average.

### Percent of Adults (Age 20) Physically Inactive

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 31.0%</td>
<td></td>
</tr>
<tr>
<td>28.1 - 31.0%</td>
<td></td>
</tr>
<tr>
<td>24.1 - 28.0%</td>
<td></td>
</tr>
<tr>
<td>Under 24.1%</td>
<td></td>
</tr>
</tbody>
</table>

### Adults with No Leisure-Time Physical Activity by Gender

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Males with No Leisure-Time Physical Activity</th>
<th>Percent Males with No Leisure-Time Physical Activity</th>
<th>Total Females with No Leisure-Time Physical Activity</th>
<th>Percent Females with No Leisure-Time Physical Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickasaw County, Iowa</td>
<td>1,250</td>
<td>27.10%</td>
<td>1,230</td>
<td>25.60%</td>
</tr>
<tr>
<td>Iowa</td>
<td>270,230</td>
<td>24.70%</td>
<td>285,615</td>
<td>24.16%</td>
</tr>
<tr>
<td>United States</td>
<td>23,736,266</td>
<td>21.73%</td>
<td>29,817,193</td>
<td>25.41%</td>
</tr>
</tbody>
</table>
### Soda Expenditures

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Average Total Household Expenditures (USD)</th>
<th>Average Household Soda Expenditures (USD)</th>
<th>Percent Soda Expenditures</th>
<th>Soda Expenditures, County Rank (In-State)</th>
<th>Soda Expenditures, County Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickasaw County, Iowa</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td>65</td>
<td>65.66%</td>
</tr>
<tr>
<td>Iowa</td>
<td>48,675</td>
<td>271</td>
<td>0.56%</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>United States</td>
<td>50,932</td>
<td>252</td>
<td>0.49%</td>
<td>no data</td>
<td>no data</td>
</tr>
</tbody>
</table>

*Note: No breakout data available.*

### Tobacco Expenditures

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Average Total Household Expenditures (USD)</th>
<th>Average Household Cigarette Expenditures (USD)</th>
<th>Percent Cigarette Expenditures</th>
<th>Cigarette Expenditures, County Rank (In-State)</th>
<th>Cigarette Expenditures, County Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickasaw County, Iowa</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td>89</td>
<td>89.90%</td>
</tr>
<tr>
<td>Iowa</td>
<td>48,675</td>
<td>981</td>
<td>2.02%</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>United States</td>
<td>50,932</td>
<td>810</td>
<td>1.59%</td>
<td>no data</td>
<td>no data</td>
</tr>
</tbody>
</table>

*Note: No breakout data available.*

Data Source: [Nielsen Claritas SiteReports, Consumer Buying Power, 2011](#). Source geography: Tract.
Tobacco Usage
This indicator reports the percentage of adults aged 18 and older who self-report currently smoking cigarettes some days or every day. This indicator is relevant because tobacco use is linked to leading causes of death such as cancer and cardiovascular disease.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population Age 18</th>
<th>Estimated Population Regularly Smoking Cigarettes</th>
<th>Percent Estimated Population Regularly Smoking Cigarettes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickasaw County, Iowa</td>
<td>9,476</td>
<td>1,943</td>
<td>20.50%</td>
</tr>
<tr>
<td>Iowa</td>
<td>911,283</td>
<td>167,676</td>
<td>18.40%</td>
</tr>
<tr>
<td>United States</td>
<td>207,962</td>
<td>20,796</td>
<td>10%</td>
</tr>
</tbody>
</table>

Note: This indicator is compared with the state average. No breakout data available.

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2005-2011.

Source geography: County.
<table>
<thead>
<tr>
<th>Pct. Adults Smoking All or Some Days, 2005-2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 26.0%</td>
</tr>
<tr>
<td>22.1 - 26.0%</td>
</tr>
<tr>
<td>18.1 - 22.0%</td>
</tr>
<tr>
<td>Under 18.1%</td>
</tr>
<tr>
<td>No Data or Data Suppressed</td>
</tr>
</tbody>
</table>

**FOOTNOTES**

**Change in Total Population**

**Methodology:**
The data is downloaded in text fromat from the U.S. Census Bureau's FTP site for the years 2000 and 2010. The text documents are then uploaded into a SQL database. The demographics indicators are mapped using population provided for county area (Sum Level 050). Total populations are derived directly from data provided. The rate of population change is calculated using Total Population 2010 - Total Population 2000 = Population Change.

**Data Background:**
The U.S. Census counts every resident in the United States. It is mandated by Article I, Section 2 of the Constitution and takes place every 10 years. The census collects information about the age, sex, race, and ethnicity of every person in the United States. The data collected by the decennial census determine the number of seats each state has in the U.S. House of Representatives and is also used to distribute billions in federal funds to local communities. For more information about this source, refer to the United States Census 2010 website.

**Notes:**
**Race and Ethnicity**
Statistics by race and ethnicity are not provided for this indicator.

**High School Graduation Rate**

**Methodology:**
Graduation rates are acquired for all US counties from the 2012 County Health Rankings (CHR). The 2011 County Health Rankings (CHR) used graduation rates calculated from the National Center for Education Statistics (NCES) using an estimated cohort. This measure is generally known
as the Averaged Freshman Graduation Rate (AFGR). Starting in 2012, CHR reports cohort graduation rates collected from State Department of Education websites. These rates are an improvement over the AFGR rates previously reported due to student-level outcomes tracking that accounts better for transfers, early and late completers. For 12 states, CHR continues to use NCES-based AFGRs. These states are: AL, AK, AR, CT, HI, ID, MT, NJ, ND, OK, SD and TN.

Total freshmen cohorts were compiled for all counties from school-level data, provided by NCES for academic years 2005-06 through 2007-08. Using the graduation rates from the 2012 CHR and these class sizes, the number of graduates* was estimated for each county. On-time graduation rate, or average freshman graduation rate, is re-calculated for unique service areas and aggregated county groupings using the following formula:

\[
\text{Graduation Rate} = \frac{\text{Estimated Number of Graduates}}{\text{Average Base Freshman Enrollment}} \times 100.
\]

*Average freshman graduation rate is a measure of on-time graduation only. It does not include 5th year high school completers, or high-school equivalency completers such as GED recipients. For more information on average freshman graduation rates, please review the information on page 4 of the NCES Common Core of Data Public-Use Local Education Agency Dropout and Completion Data File

Data Background:
The National Center for Education Statistics (NCES) is the primary federal entity for collecting, analyzing, and reporting data related to education in the United States and other nations. It fulfills a congressional mandate to collect, collate, analyze, and report full and complete statistics on the condition of education in the United States; conduct and publish reports and specialized analyses of the meaning and significance of such statistics; assist state and local education agencies in improving their statistical systems; and review and report on education activities in foreign countries.

Citation: Documentation to the NCES Common Core of Data Public-Use Local Education Agency Dropout and Completion Data File

The National Center for Education Statistics releases a dataset containing detailed information about every public school in the United States in their annual Common Core of Data (CCD) files. The information from which this data is compiled is supplied by state education agency officials. The CCD reports information about both schools and school districts, including name, address, and phone number; descriptive information about students and staff demographics; and fiscal data, including revenues and current expenditures.

For more information, please visit the Common Core of Data web page.

Notes:
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Grocery Store Access
Methodology:
Population figures are acquired for this indicator from the U.S. Census Bureau, 2010 Decennial Census, Summary File 1. Industry counts are acquired from the U.S. Census Bureau, County Business Patterns (2010) data file. Industries are stratified based on the North American Industry
Classification System (NAICS) a coding system used by Federal statistical agencies in classifying business establishments for the purpose of collecting, analyzing, and publishing statistical data related to the U.S. business economy. Establishment rates for each county are derived using the following formula:

\[
\text{Rate} = \frac{\text{Establishment Count}}{\text{Population}} \times 100,000
\]

The specific codes used indicators reported from the Census Bureau's County Business Patterns (CBP) are listed below.

- Grocery stores and supermarkets: 445110 and 445230
  Grocery stores are establishments engaged in selling a "general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry". Examples include supermarkets, commissaries and food stores. Convenience stores are excluded. Fruit and vegetable grocers are those locations "primarily engaged in retailing fresh fruits and vegetables". Examples include permanent produce stands and fruit or vegetable markets.

- Fast food restaurants: 722211
  Any "limited service" establishments where the customer typically orders or selects items and pay before eating. Establishments may include carryout restaurants, delicatessens, drive-ins, pizza delivery shops, sandwich shops, and other fast food restaurants

- Alcoholic beverage retailers: 445310
  Establishments engaged in "retailing packaged alcoholic beverages, such as ale, beer, wine, and liquor". Bars and other venues serving alcoholic beverages intended for immediate consumption on the premises are not included.

- Recreational Facilities: 713940
  Establishments engaged in operating facilities which offer “exercise and other active physical fitness conditioning or recreational sports activities”. Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

A complete list of NAICS codes and definitions is available using the NAICS Association’s free lookup service.

Data Background:
County Business Patterns (CBP) is an annual series that provides sub-national economic data by industry. Data for establishments are presented by geographic area, 6-digit NAICS industry, legal form of organization (U.S. and state only), and employment size class. Information is available on the number of establishments, employment during the week of March 12, first quarter payroll, and annual payroll. ZIP Code Business Patterns data are available shortly after the release of County Business Patterns. It provides the number of establishments by employment-size classes by detailed industry in the U.S.

County Business Patterns basic data items are extracted from the Business Register (BR), a database of all known single and multi-establishment employer companies maintained and updated by the U.S. Census Bureau. The BR contains the most complete, current, and consistent data for business establishments. The annual Company Organization Survey provides individual establishment data for multi-establishment companies. Data for single-establishment companies are obtained from various Census Bureau programs, such as the Economic Census, Annual Survey of Manufactures and Current Business Surveys, as well as from administrative record sources.
Citation: U.S. Census Bureau: County Business Patterns (2012).

For more information about this source, including data collection methodology and definitions, refer to the County Business Patterns.

Notes:
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

Recreation and Fitness Facility Access
Methodology:
Population figures are acquired for this indicator from the U.S. Census Bureau, 2010 Decennial Census, Summary File 1. Industry counts are acquired from the U.S. Census Bureau, County Business Patterns (2010) data file. Industries are stratified based on the North American Industry Classification System (NAICS) a coding system used by Federal statistical agencies in classifying business establishments for the purpose of collecting, analyzing, and publishing statistical data related to the U.S. business economy. Establishment rates for each county are derived using the following formula:

\[
\text{Rate} = \frac{[\text{Establishment Count}]}{[\text{Population}]} \times 100,000
\]

The specific codes used indicators reported from the Census Bureau’s County Business Patterns (CBP) are listed below.

- Grocery stores and supermarkets: 445110 and 445230
  Grocery stores are establishments engaged in selling a "general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry". Examples include supermarkets, commissaries and food stores. Convenience stores are excluded. Fruit and vegetable grocers are those locations "primarily engaged in retailing fresh fruits and vegetables". Examples include permanent produce stands and fruit or vegetable markets.

- Fast food restaurants: 722211
  Any "limited service” establishments where the customer typically orders or selects items and pay before eating. Establishments may include carryout restaurants, delicatessens, drive-ins, pizza delivery shops, sandwich shops, and other fast food restaurants.

- Alcoholic beverage retailers: 445310
  Establishments engaged in “retailing packaged alcoholic beverages, such as ale, beer, wine, and liquor”. Bars and other venues serving alcoholic beverages intended for immediate consumption on the premises are not included.

- Recreational Facilities: 713940
  Establishments engaged in operating facilities which offer “exercise and other active physical fitness conditioning or recreational sports activities”. Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

A complete list of NAICS codes and definitions is available using the NAICS Association’s free lookup service.
Data Background:
County Business Patterns (CBP) is an annual series that provides sub-national economic data by industry. Data for establishments are presented by geographic area, 6-digit NAICS industry, legal form of organization (U.S. and state only), and employment size class. Information is available on the number of establishments, employment during the week of March 12, first quarter payroll, and annual payroll. ZIP Code Business Patterns data are available shortly after the release of County Business Patterns. It provides the number of establishments by employment-size classes by detailed industry in the U.S.

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Citation: U.S. Census Bureau: County Business Patterns (2012).

For more information about this source, including data collection methodology and definitions, refer to the County Business Patterns.

Notes:
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

Diabetes Management (Hemoglobin A1c Test)
Data Background:
The Dartmouth Atlas of Healthcare is an online repository of health data and maps based on information included in the massive Medicare database maintained by the Center for Medicare and Medicaid Services (CMS). The project uses Medicare claims data in conjunction with other demographic data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. The Dartmouth Atlas of Health Care is produced and maintained by The Dartmouth Institute for Health Policy and Clinical Practice.

For more information about this source, including methodologies and definitions, refer to the Dartmouth Atlas of Healthcare website.

Methodology:
The Dartmouth Institute analyzes data drawn from enrollment and claims files from the Medicare program. Analysis is restricted to the fee-for-service population over age 65; HMO patients are not included. Indicator data tables express the proportion of Medicare Part B patients screened for medical conditions based on the following formula:

\[
\text{Percentage} = \frac{\text{[Number Screened]}}{\text{[Total Patients]}} \times 100
\]

When appropriate, statistical adjustments are carried out to account for differences in age, race and sex.
Access to the complete methodology is available in the Dartmouth Institute’s Report of the Dartmouth Atlas Project.

Alcohol Consumption

Methodology:
Indicator percentages are acquired for years 2004-2010 from Behavioral Risk Factor Surveillance System (BRFSS) prevalence data, which is housed in the Health Indicator Warehouse. Percentages are generated based on the valid responses to the following question:

"One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average?"

Respondents are considered heavy drinkers if they were male and reported having more than 2 drinks per day, or females that reported having more than 1 drink per day. Percentages are age-adjusted and only pertain to the non-institutionalized population aged 18 and up. Population numerators (number of adults) are not provided in the Health Indicator Warehouse data tables and were generated using the following formula:

\[
\text{[Heavy Drinkers]} = \left( \frac{\text{[Indicator Percentage]}}{100} \right) \times \text{[Total Population]}.
\]

Adult population figures used in the data tables are acquired from the American Community Survey (ACS) 2006-2010 five year estimates. Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the BRFSS web site. For additional information about the multi-year estimates, please visit the Health Indicator Warehouse.

Data Background:
The Behavioral Risk Factor Surveillance System (BRFSS) is

"... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households."

Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS survey data are analyzed by the CDC’s National Center for Health Statistics (NCHS). Annual risk factor prevalence data are released for those geographic areas with 50 or more survey results and 10,000 or more total population (50 States, 170 Cities and Counties) in order to maintain the accuracy and confidentiality of the data. Multi-year estimates are produced by the NCHS to expand the coverage of data to approximately 2500 counties. These estimates are maintained in the Health Indicator Warehouse, the official repository of the nation’s health data.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

Notes:
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 50, or when the standard error of the estimate exceeds 10% of the calculated value.

Alcohol Expenditures
Methodology:
Census tract level average and aggregated total household expenditures and category expenditures were acquired from the 2011 Nielsen Consumer Buying Power (CBP) SiteReports. Percent expenditures were calculated from aggregate area expenditures using the following formula:

\[
\text{Percent Expenditures} = \frac{\text{[Category Expenditures]}}{\text{[Total Area Expenditures]}} \times 100
\]

Tract-level estimates are proprietary Nielsen data restricted from public distribution and subject to terms of use agreements. Indicator data tables contain allocation summaries and thus comply with Nielsen’s definition of “output” and are available for public consumption. To generate acceptable map “output”, percent expenditures were sorted and ranked; quintiles were assigned to each tract based on national rank and symbolized within the map. Additional attributes include each tract’s within-state rank and quintile. Definitions for food-at-home categories used for consumer spending indicators are based on categories in the BLS Consumer Expenditure Survey (CEX), and are listed below.

- **Soft drinks:** Soft drink expenditures included in this category are any non-alcoholic carbonated beverages purchased for consumption at home. Soft drinks purchased at restaurants and other dining establishments are not included.
- **Alcoholic beverages:** Alcohol expenditures included in this category are any beer, wine, and liquor purchased for consumption at home. Alcohol purchased at restaurants and bars is not included.
- **Fruit and vegetables:** Fruit and vegetables expenditures included in this category are all fresh, frozen and canned fruits and vegetables purchased for consumption at home.
- **Tobacco:** Tobacco expenditures included in this category are cigarettes only; cigars and other tobacco products are not included.

Further details about the analysis used by Nielsen group can be found in the [Consumer Buying Power Methodology](#).

Data Background:
Nielsen is a publically held information company and a primary supplier of consumer spending data around the world, using both statistical analysis and field sampling techniques to produce accurate and timely information. Published annually, SiteReports provide market analysis to Nielsen customers at multiple geographic levels, spanning a wide range of topics including population demographics, household spending, and market potential. The SiteReports Consumer Buying Power (CBP) database is created using statistical models estimated from the Bureau of Labor Statistics’ Consumer Expenditure Surveys (CEX). This survey provides information on the buying habits of American consumers, including
expenditures, income, and other characteristics of the consumer unit (families and single consumers). The Consumer Expenditure Survey consists of two surveys: the quarterly Interview survey and the weekly Diary Survey. The surveys target the total non-institutionalized population (urban and rural) of the United States. The data is collected from the independent quarterly interview and weekly diary surveys of approximately 7,500 sample households. Each survey has its own independent sample, and each collects data on household income and socioeconomic characteristics. The current Nielsen Consumer Buying Power data uses a rolling five years of data from the Consumer Expenditure Survey, administered from 2005 through 2009. In addition to this data, the Nielsen Consumer Buying Power database also incorporates information from the following sources:

- Nielsen Demographic Update
- Nielsen Cartographics
- U.S. Census Bureau: Census of Retail Trade

For more information, please visit the Nielsen SiteReports website.

Notes:

Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

Fruit/Vegetable Consumption

Methodology:
Indicator percentages are acquired for years 2005-2009 from Behavioral Risk Factor Surveillance System (BRFSS) prevalence data, which is housed in the Health Indicator Warehouse. Data are based on the percentage of respondents who report regularly consuming five or more servings of fruits or vegetables each week. Fried potatoes and chips are excluded. Percentages are age-adjusted and only pertain to the non-institutionalized population aged 18 and up. Population numerators (number of adults consuming 5 servings) are not provided in the Health Indicator Warehouse data tables and were generated using the following formula:

\[
\text{[Population Consuming 5 Servings]} = \left(\frac{\text{[Indicator Percentage]}}{100}\right) \times [\text{Total Population}].
\]

Adult population figures used in the data tables are acquired from the American Community Survey (ACS) 2006-2010 five year estimates. Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the BRFSS web site. For additional information about the multi-year estimates, please visit the Health Indicator Warehouse.

Data Background:
The Behavioral Risk Factor Surveillance System (BRFSS) is "... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC’s Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households."

Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.
The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS survey data are analyzed by the CDC’s National Center for Health Statistics (NCHS). Annual risk factor prevalence data are released for those geographic areas with 50 or more survey results and 10,000 or more total population (50 States, 170 Cities and Counties) in order to maintain the accuracy and confidentiality of the data. Multi-year estimates are produced by the NCHS to expand the coverage of data to approximately 2500 counties. These estimates are maintained in the Health Indicator Warehouse, the official repository of the nation’s health data.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

Notes:
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 50, or when the standard error of the estimate exceeds 10% of the calculated value.

Fruit/Vegetable Expenditures
Methodology:
Census tract level average and aggregated total household expenditures and category expenditures were acquired from the 2011 Nielsen Consumer Buying Power (CBP) SiteReports. Percent expenditures were calculated from aggregate area expenditures using the following formula:

Percent Expenditures = [Category Expenditures] / [Total Area Expenditures] * 100

Tract-level estimates are proprietary Nielsen data restricted from public distribution and subject to terms of use agreements. Indicator data tables contain allocation summaries and thus comply with Nielsen’s definition of “output” and are available for public consumption. To generate acceptable map “output”, percent expenditures were sorted and ranked; quintiles were assigned to each tract based on national rank and symbolized within the map. Additional attributes include each tract’s within-state rank and quintile. Definitions for food-at-home categories used for consumer spending indicators are based on categories in the BLS Consumer Expenditure Survey (CEX), and are listed below.

- Soft drinks: Soft drink expenditures included in this category are any non-alcoholic carbonated beverages purchased for consumption at home. Soft drinks purchased at restaurants and other dining establishments are not included.
• Alcoholic beverages: Alcohol expenditures included in this category are any beer, wine, and liquor purchased for consumption at home. Alcohol purchased at restaurants and bars is not included.
• Fruit and vegetables: Fruit and vegetables expenditures included in this category are all fresh, frozen and canned fruits and vegetables purchased for consumption at home.
• Tobacco: Tobacco expenditures included in this category are cigarettes only; cigars and other tobacco products are not included.

Further details about the analysis used by Nielsen group can be found in the Consumer Buying Power Methodology.

Data Background:
Nielsen is a publicly held information company and a primary supplier of consumer spending data around the world, using both statistical analysis and field sampling techniques to produce accurate and timely information. Published annually, SiteReports provide market analysis to Nielsen customers at multiple geographic levels, spanning a wide range of topics including population demographics, household spending, and market potential. The SiteReports Consumer Buying Power (CBP) database is created using statistical models estimated from the Bureau of Labor Statistics' Consumer Expenditure Surveys (CEX). This survey provides information on the buying habits of American consumers, including expenditures, income, and other characteristics of the consumer unit (families and single consumers). The Consumer Expenditure Survey consists of two surveys: the quarterly Interview survey and the weekly Diary Survey. The surveys target the total non-institutionalized population (urban and rural) of the United States. The data is collected from the independent quarterly interview and weekly diary surveys of approximately 7,500 sample households. Each survey has its own independent sample, and each collects data on household income and socioeconomic characteristics. The current Nielsen Consumer Buying Power data uses a rolling five years of data from the Consumer Expenditure Survey, administered from 2005 through 2009. In addition to this data, the Nielsen Consumer Buying Power database also incorporates information from the following sources:

• Nielsen Demographic Update
• Nielsen Cartographics
• U.S. Census Bureau: Census of Retail Trade

For more information, please visit the Nielsen SiteReports website.

Notes:
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

Physical Inactivity (Adult)
Methodology:
Data for total population and estimated obese population data are acquired from the County Level Estimates of Diagnosed Diabetes, a service of the Centers for Disease Control and Prevention’s National Diabetes Surveillance Program. Diabetes and other risk factor prevalence is estimated using the following formula:

All data are estimates modeled by the CDC using the methods described below:
The National Diabetes Surveillance system produces data estimating the prevalence of diagnosed diabetes and population obesity by county using data from CDC’s Behavioral Risk Factor Surveillance System (BRFSS) and data from the U.S. Census Bureau’s Population Estimates Program. The BRFSS is an ongoing, monthly, state-based telephone survey of the adult population. The survey provides state-specific information on behavioral risk factors and preventive health practices. Respondents were considered to have diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes. Respondents were considered obese if their body mass index was 30 or greater. Body mass index (weight [kg]/height [m]2) was derived from self-report of height and weight. Respondents were considered to be physically inactive if they answered "no" to the question, "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

Three years of data were used to improve the precision of the year-specific county-level estimates of diagnosed diabetes and selected risk factors. For example, 2003, 2004, and 2005 were used for the 2004 estimate and 2004, 2005, and 2006 were used for the 2005 estimate. Estimates were restricted to adults 20 years of age or older to be consistent with population estimates from the U.S. Census Bureau. The U.S. Census Bureau provides year-specific county population estimates by demographic characteristics—age, sex, race, and Hispanic origin.

The county-level estimates were based on indirect model-dependent estimates. The model-dependent approach employs a statistical model that “borrows strength” in making an estimate for one county from BRFSS data collected in other counties. Bayesian multilevel modeling techniques were used to obtain these estimates. Separate models were developed for each of the four census regions: West, Midwest, Northeast and South. Multilevel Poisson regression models with random effects of demographic variables (age 20–44, 45–64, 65 ; race; sex) at the county-level were developed. State was included as a county-level covariate.

Citation: Centers for Disease Control and Prevention, Diabetes Data & Trends: Frequently Asked Questions (FAQ). (2012).

Rates were age adjusted by the CDC for the following three age groups: 20-44, 45-64, 65 . Additional information, including the complete methodology and data definitions, can be found at the CDC’s Diabetes Data and Trends website.

Data Background:
The Centers for Disease Control and Prevention’s National Center for Chronic Disease Prevention and Health Promotion monitors the health of the Nation and produces publically available data to promote general health. The division maintains the Diabetes Data and Trends data system, which includes the National Diabetes Fact Sheet and the National Diabetes Surveillance System. These programs provide resources documenting the public health burden of diabetes and its complications in the United States. The surveillance system also includes county-level estimates of diagnosed diabetes and selected risk factors for all U.S. counties to help target and optimize the resources for diabetes control and prevention.

Citation: Centers for Disease Control and Prevention, Diabetes Data & Trends: Frequently Asked Questions (FAQ). (2012).

Notes:
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.
Soda Expenditures

Methodology:
Census tract level average and aggregated total household expenditures and category expenditures were acquired from the 2011 Nielsen Consumer Buying Power (CBP) SiteReports. Percent expenditures were calculated from aggregate area expenditures using the following formula:

\[
\text{Percent Expenditures} = \frac{\text{Category Expenditures}}{\text{Total Area Expenditures}} \times 100
\]

Tract-level estimates are proprietary Nielsen data restricted from public distribution and subject to terms of use agreements. Indicator data tables contain allocation summaries and thus comply with Nielsen’s definition of “output” and are available for public consumption. To generate acceptable map “output”, percent expenditures were sorted and ranked; quintiles were assigned to each tract based on national rank and symbolized within the map. Additional attributes include each tract’s within-state rank and quintile. Definitions for food-at-home categories used for consumer spending indicators are based on categories in the BLS Consumer Expenditure Survey (CEX), and are listed below.

- Soft drinks: *Soft drink expenditures included in this category are any non-alcoholic carbonated beverages purchased for consumption at home. Soft drinks purchased at restaurants and other dining establishments are not included.*
- Alcoholic beverages: *Alcohol expenditures included in this category are any beer, wine, and liquor purchased for consumption at home. Alcohol purchased at restaurants and bars is not included.*
- Fruit and vegetables: *Fruit and vegetables expenditures included in this category are all fresh, frozen and canned fruits and vegetables purchased for consumption at home.*
- Tobacco: *Tobacco expenditures included in this category are cigarettes only; cigars and other tobacco products are not included.*

Further details about the analysis used by Nielsen group can be found in the [Consumer Buying Power Methodology](#).

Data Background:
Nielsen is a publically held information company and a primary supplier of consumer spending data around the world, using both statistical analysis and field sampling techniques to produce accurate and timely information. Published annually, SiteReports provide market analysis to Nielsen customers at multiple geographic levels, spanning a wide range of topics including population demographics, household spending, and market potential. The SiteReports Consumer Buying Power (CBP) database is created using statistical models estimated from the Bureau of Labor Statistics’ Consumer Expenditure Surveys (CEX). This survey provides information on the buying habits of American consumers, including expenditures, income, and other characteristics of the consumer unit (families and single consumers). The Consumer Expenditure Survey consists of two surveys: the quarterly Interview survey and the weekly Diary Survey. The surveys target the total non-institutionalized population (urban and rural) of the United States. The data is collected from the independent quarterly interview and weekly diary surveys of approximately 7,500 sample households. Each survey has its own independent sample, and each collects data on household income and socioeconomic characteristics. The current Nielsen Consumer Buying Power data uses a rolling five years of data from the Consumer Expenditure Survey, administered from 2005 through 2009. In addition to this data, the Nielsen Consumer Buying Power database also incorporates information from the following sources:

- Nielsen Demographic Update
- Nielsen Cartographics
Tobacco Expenditures

Methodology:
Census tract level average and aggregated total household expenditures and category expenditures were acquired from the 2011 Nielsen Consumer Buying Power (CBP) SiteReports. Percent expenditures were calculated from aggregate area expenditures using the following formula:

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Further details about the analysis used by Nielsen group can be found in the Consumer Buying Power Methodology.

Data Background:
Nielsen is a publically held information company and a primary supplier of consumer spending data around the world, using both statistical analysis and field sampling techniques to produce accurate and timely information. Published annually, SiteReports provide market analysis to Nielsen customers at multiple geographic levels, spanning a wide range of topics including population demographics, household spending, and market potential. The SiteReports Consumer Buying Power (CBP) database is created using statistical models estimated from the Bureau of Labor Statistics’ Consumer Expenditure Surveys (CEX). This survey provides information on the buying habits of American consumers, including expenditures, income, and other characteristics of the consumer unit (families and single consumers). The Consumer Expenditure Survey consists...
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- Nielsen Demographic Update
- Nielsen Cartographics
- U.S. Census Bureau: Census of Retail Trade

For more information, please visit the Nielsen SiteReports website.

Notes:
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

Tobacco Usage
Methodology:
Indicator percentages are acquired for years 2004-2010 from Behavioral Risk Factor Surveillance System (BRFSS) prevalence data, which is housed in the Health Indicator Warehouse. Data are based on the percentage of respondents answering the following question:

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

Respondents are considered smokers if they reported smoking every day or some days. Percentages are age-adjusted and only pertain to the non-institutionalized population aged 18 and up. Population numerators (number of adult smokers) are not provided in the Health Indicator Warehouse data tables and were generated using the following formula:

\[ \text{[Adults Smokers]} = \left( \frac{\text{[Indicator Percentage]}}{100} \right) \times \text{[Total Population]} \]

Adult population figures used in the data tables are acquired from the American Community Survey (ACS) 2006-2010 five year estimates. Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the BRFSS web site. For additional information about the multi-year estimates, please visit the Health Indicator Warehouse.

Data Background:
The Behavioral Risk Factor Surveillance System (BRFSS) is "... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC’s Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households."

Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.
The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS survey data are analyzed by the CDC’s National Center for Health Statistics (NCHS). Annual risk factor prevalence data are released for those geographic areas with 50 or more survey results and 10,000 or more total population (50 States, 170 Cities and Counties) in order to maintain the accuracy and confidentiality of the data. Multi-year estimates are produced by the NCHS to expand the coverage of data to approximately 2500 counties. These estimates are maintained in the Health Indicator Warehouse, the official repository of the nation’s health data.

For more information on the BRFSS survey methods, or to obtain a copy of the survey questionnaires, please visit the Behavioral Risk Factor Surveillance System home page.

Notes:
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data is suppressed when the total number of persons sampled (for each geographic area / population group combination) over the survey period is less than 50, or when the standard error of the estimate exceeds 10% of the calculated value.

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• John Anderson: Retired NHHS principal, Chickasaw County Supervisor.
• John Cuvelier: local business owner (insurance agency); MMC-NH board member.
• Steve Davis: Planning Team facilitator, Chief Strategy Officer for Mercy Medical Center – North Iowa.
• John Epperly, M.D.: family physician, MMC-NH board member.
• Willis Hansen:
• Carolyn Martin-Shaw: retired MMC-NH CEO and community volunteer.
• Jennifer Monteith: Coordinator of Development, MMC-NH.
• Mary Sharon Peraud: retired family physician, past MMC-NH board chair, current MMC-NI board member.
• Scott Perkins: Senior VP, Tri-Mark (manufacturer in New Hampton), member, New Hampton City Council, former MMC-NH board member.
• Laura Reicks: community volunteer and philanthropist, local business owner (restaurant), member, auxiliary board.
• Bruce Roesler: current CEO, MMC-NH.
• Jennifer Schwickerath: attorney, current MMC-NH board member.
• Sarah Updegraff: principal, NHHS.
<table>
<thead>
<tr>
<th>High Potential Opportunity</th>
<th>Customer Need</th>
<th>Competitive Threats</th>
<th>Market Trends</th>
<th>Degree of Difficulty</th>
<th>Potential Reward</th>
<th>Other Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Campaign to build image and awareness (4)</td>
<td>Brand-building</td>
<td>Hi</td>
<td>Those willing to travel or driven by access</td>
<td>Med/Hi</td>
<td>Hi</td>
<td>What’s real? M-NI presence.</td>
</tr>
<tr>
<td>Build capabilities in mental health and chem. Dep (3)</td>
<td>Access</td>
<td>Opportunity to Improve access to svcs</td>
<td>Privacy concerns of local treatment</td>
<td>Hi – provider recruitment</td>
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<td>Broad spectrum of need. Privacy an issue? Prevention our role?</td>
</tr>
<tr>
<td>Recruit a general surgeon (5)</td>
<td>Improved access to svcs</td>
<td>Outmigration</td>
<td>Critical mass</td>
<td>Hi if local. Med. if regional – shared.</td>
<td>Community perception – hi. ROI – medium.</td>
<td>Ability to recapture lost demand? Supporting clinical capabilities? Share a surgeon?</td>
</tr>
<tr>
<td>Improve clinic access, possibly including urgent care (1)</td>
<td>Improved access to svcs – timely &amp; lower cost</td>
<td>Decorah, Waverly</td>
<td>More retail</td>
<td>Medium: physician buy-in</td>
<td>Keep patient loyalty</td>
<td>Expand clinic hours? Fulfill demand?</td>
</tr>
<tr>
<td>Services to local businesses, incl. Econ dev.</td>
<td>Promoting the N.H. community</td>
<td>Skills lacking in workforce. Housing. Small town.</td>
<td>Hi</td>
<td>Hi, but long-term.</td>
<td>Where are the models?</td>
<td></td>
</tr>
<tr>
<td>Recruitment &amp; Retention (Mercy staff)</td>
<td>Promoting the N.H. comm. Skills develop. w/ low volumes</td>
<td>Loss of community commitment</td>
<td>Hi</td>
<td>Hi</td>
<td>Critical mass in OB and OR.</td>
<td></td>
</tr>
<tr>
<td>Build OB</td>
<td>Brand-building</td>
<td>Outmigration</td>
<td>Low volumes</td>
<td>Med/Hi</td>
<td>Cover sunk costs</td>
<td></td>
</tr>
<tr>
<td>Build ENT</td>
<td>2 days/no</td>
<td>Outmigration</td>
<td>Phys recruitment</td>
<td>Medium</td>
<td>Hi-patient access</td>
<td>MCC interested.</td>
</tr>
<tr>
<td>Address community health needs, esp. obesity (3)</td>
<td>Clear, demonstrated health needs from data &amp; focus groups</td>
<td>Opportunity to improve access to services</td>
<td>North IA has higher need than statewide</td>
<td>Behavior change is difficult. Involve partners.</td>
<td>High, esp. under health reform.</td>
<td>Dialysis?</td>
</tr>
<tr>
<td>Address facility needs</td>
<td>Improved facility, private rooms.</td>
<td>Outmigration</td>
<td>Private rooms are the standard of care</td>
<td>High capital needs</td>
<td>Long-term loyalty</td>
<td>Renovate in place?</td>
</tr>
</tbody>
</table>