UnityPoint Health
Allen Hospital

2025

COMMUNITY HEALTH NEEDS ASSESSMENT FOR BLACK HAWK COUNTY

Black Hawk County Public Health

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Contents

Introduction

Over the past several years, the Cedar Valley has been working together to improve community well-being and promote belonging. The origins of this work trace back to 2019, following a national report naming Waterloo–Cedar Falls as the worst place for Black Americans to live. In response, community members and organizations came together to examine local data and lived experiences, identify patterns driving inequitable outcomes, and highlight “bright spots” of resilience. Early strategies focused on bringing attention to inequities, increasing belonging and acceptance, and strengthening connections across people, organizations, and resources.

This effort led to the establishment of the Advancing Equity in the Cedar Valley coalition, with core planning partners Black Hawk County Public Health (BHCPH), the Community Foundation of Northeast Iowa, and One Cedar Valley. The coalition launched initiatives aimed at removing barriers, fostering belonging, and expanding access to resources, including:

- A Poverty Simulation with broad organizational participation
- Workplace initiatives to reduce language and cultural barriers
- Funding submissions and initial infrastructure development

At the same time, BHCPH and healthcare partners MercyOne Northeast Iowa, Peoples Community Health Clinic, and UnityPoint Health – Allen Hospital deepened their collaborative work using the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 Community Health Improvement framework. This included broadening the Steering Committee to reflect the community’s diversity and needs and leading the 2024 assessment. That process involved:

- AI tools to evaluate stakeholder relationships
- Comprehensive data and community input
- Data analysis to identify trends and challenges
- Community prioritization of issues

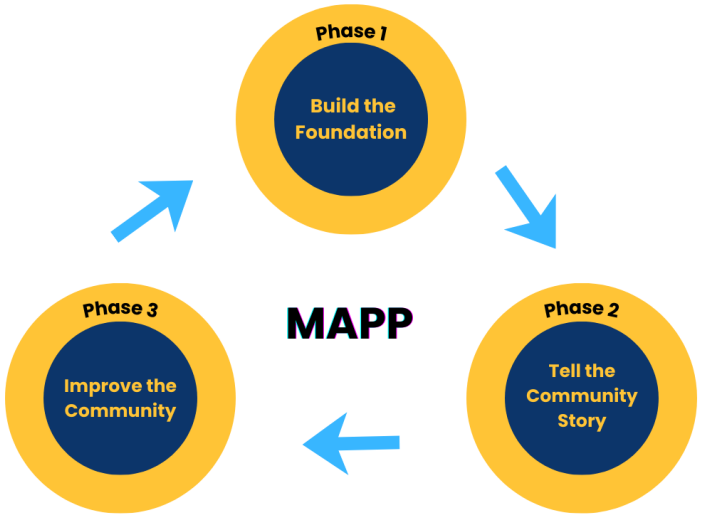
Both Advancing Equity and the Community Health Improvement Steering Committee shared a commitment to reducing barriers and expanding opportunity. In 2025, these efforts merged to form Advancing Together in the Cedar Valley, a unified coalition grounded in a shared vision: to create a place where all people want to live, feel welcome, and have opportunities to thrive. By combining resources, relationships, and momentum, Advancing Together provides a stronger foundation for long-term improvement

Now Advancing Together is actively developing and implementing selected community health improvement strategies while coordinating with partners leading other initiatives to address the top community priorities. Additionally, the coalition is building a community data hub to make information accessible, identifying metrics to track progress, and continuing to strengthen the infrastructure for collaborative action.

This work is ongoing, and it depends on partnership. Community members, healthcare providers, policymakers, and local organizations are invited to join in advancing the vision of a Cedar Valley where everyone has a fair opportunity to live well and thrive. For more information, or to share your work, please contact: publichealth@blackhawkcounty.iowa.gov

Background & Timeline

The planning process for the latest Community Health Improvement (CHI) cycle began with a comprehensive review of prior efforts and outcomes. Using lessons learned from earlier assessments, the BHCPH Core Team recommended sustaining the use of the Mobilizing for Action through Planning and Partnerships (MAPP) framework that had been used for the two previous CHI cycles in Black Hawk County. MAPP was developed by the National Association of County and City Health Officials in 2001. The framework is designed as a strategic process for assessing community health needs, prioritizing them, and identifying resources to address them. Its three phases are designed to improve community health through a collaborative and data-driven approach for communities.



BHCPH, MercyOne Northeast Iowa, Peoples Community Health Clinic, and UnityPoint Health – Allen Hospital continue their collaborative efforts for community health improvement for this planning cycle. The partners worked to design a cycle where particular attention was paid to identifying and filling in the gaps from previous cycles which included a broader range of voices and experiences from across Black Hawk County. The team paid particular attention to the evolution from MAPP 1.0 to MAPP 2.0 which followed other public health frameworks that evolved over the years to center both health equity (defined as the assurance of the conditions for best health for all people) and community engagement as well as revised the framework to be more adaptable and responsive to community needs.

Common Acronyms	
CHI	Community Health Improvement
CHA	Community Health Assessment
CHIP	Community Health Improvement Plan

Two BHCPH epidemiologists and the public health planner served as the Core Team for this assessment cycle. The health sector core planning team also included the Public Health Director, the Disease Surveillance and Investigation Program Manager, and representatives from MercyOne Northeast Iowa, Peoples Community Health Clinic, and UnityPoint Health – Allen Hospital. An Assessment Design Team provided oversight for the community survey, and overall direction for completing the assessment cycle came from the CHI Steering Committee, which merged with Advancing Together in the Cedar Valley in 2025.

Initial stages focused on understanding what had worked before, identifying new community health needs, and outlining a clear structure for engagement. The planning teams understood that achieving equitable health outcomes would not be possible without building trust, expanding representation, and establishing transparent, inclusive processes at every step. Planning extended across multiple timelines, from data review and community engagement to public meetings and issue prioritization. The entire process emphasized communication, collaboration, and shared responsibility for driving meaningful change.

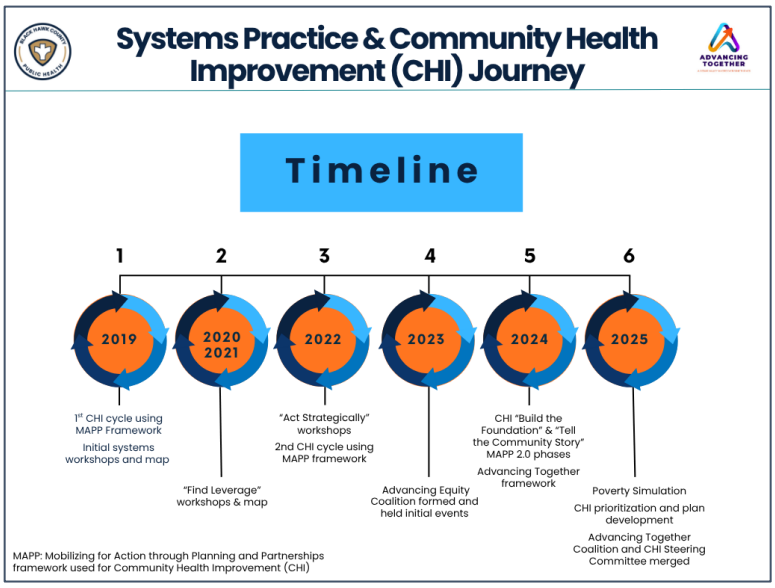
Phase 1: Build the Foundation

In preparation for this CHI cycle, the team identified the need for a clear picture of the key organizations and people involved in community health. To do this, information was gathered from the 211 community resource site and from local paper directories. Interviews were then held with stakeholders including the Iowa Health and Human Services statewide CHA/CHIP Coordinator, the Black Hawk County Sheriff, leaders from the Cedar Valley United Way and Grow Cedar Valley to identify gaps in representation. This informed the formation of a diverse Steering Committee. Finally, the team built a detailed Excel spreadsheet listing agencies in the region, then reviewed each agency's mission and scope to determine how closely they aligned with the CHI priorities.

Using a stakeholder analysis tool provided by MAPP 2.0, the team assessed each organization's influence, interest, and potential role in the process. This allowed for planning specific engagement strategies for different types of partners, from highly involved collaborators to those who might contribute in smaller but still valuable ways. By clearly understanding the local landscape, the team was able to lay the groundwork for stronger partnerships and more effective community-wide action.

Steering Committee Formation and Evolution

Beginning in early 2024, the core team's goal was to build a committee that could lead the community through the 2024 assessment process. The steering committee was intentionally composed of members that reflect the demographics of the community, not just in terms of profession or agency, but also life experience and perspective. The final Steering Committee included members from education, economic development, regional governance, healthcare, food systems, behavioral health, youth organizations, and emergency management. This wide range of input ensured a holistic and inclusive approach to decision-making and priority-setting.



Early in the process, the core team recognized that many committee members also participated in the Advancing Equity in the Cedar Valley coalition, an initiative born in 2019 to confront systemic racism and map the structural forces shaping inequity.

The Advancing Equity coalition's groundwork of community conversations, historical context, and identification of systemic barriers complements the MAPP 2.0 focus equity at the center of assessment and planning. While the coalition's detailed systems-mapping work informs understanding, the CHI cycle applies its insights more broadly. This partnership ensures health is considered within the wider social context and that community-driven solutions receive collective support across sectors. These efforts were merged in 2025 and became known as Advancing Together in the Cedar Valley.

Definition of Community, Vision, and Mission

As part of engaging and orienting the CHA Steering Committee, members participated in a facilitated discussion regarding foundational questions: “How do you define community?”, “Who is in our community?”, and “How will this help us in our CHI work?”. These questions guided the committee to agree on a shared definition.

Community

Our community includes all people who are connected to Black Hawk County, whether they live, work, play, worship, learn, or visit. Community can also mean people connected by common interests, values, cultural heritage, or geographic areas within Black Hawk County.

The vision was reaffirmed from the previous CHI cycle and modified slightly when the Steering Committee merged to form Advancing Together in the Cedar Valley. This final vision statement ensures continuity and alignment with ongoing efforts.

Vision

Advancing Together in the Cedar Valley envisions a community where all people want to live, feel welcome, and have opportunities to thrive.

To define the mission, the 2024 CHI Steering Committee discussed three guiding questions: “What are we doing?”, “Why do we do it?”, and “Who do we serve?”. The result was a focused mission statement that was modified in 2025 to also reflect the Advancing Together’s mission.

Mission

We bring together people, organizations, and resources to raise awareness, build connections, and support a community that values the well-being of all.

To ensure shared values, the Steering Committee began with the values from the previous CHI cycle and following a structured review, the following values were adopted during 2024:

- Equity
- Systems thinking
- Trusted relationships
- Community strength
- Strategic collaboration and alignment
- Data and community-informed action
- Flexibility
- Continuous work
- Transparency
- Empathy

These values provide the foundation for decisions, community engagement, and action implementation. They are meant to reflect both how organizations work together and the outcomes they hope to achieve.

Phase 2: Tell the Community Story

This phase emphasizes the need for a complete, accurate, and timely understanding of community health and well-being across all sub-populations within the community. This phase includes the assessment methods, findings, building context through issue statements and profiles to understand root causes, sharing the findings and identifying strategic priorities for community health improvement planning.

Community Health Assessments

Three assessments, the Community Status Assessment (CSA), Community Context Assessment (CCA), and Community Partner Assessment (CPA), were conducted between June and December 2024 as part of the MAPP 2.0 framework. The process was led by the CHI core team with guidance from the CHI steering committee and incorporated input from community health workers, local organizations, and subject matter experts. Each assessment was designed to balance data with meaningful community engagement.

The complete Community Health Assessment is included in **Appendix A**.

The CSA focused on a community survey and secondary data to surface disparities across ZIP codes, age groups, races, and income levels. The CCA honed in on ZIP Code 50703, examining the built environment and historical inequities through interviews and field surveys. The CPA captured insights from organizational partners on equity, language access, and data practices. Collectively, these assessments provide a comprehensive picture of the structural, environmental, and systemic factors affecting health in Black Hawk County.

Community Status Assessment Methods and Findings

The 2024 Community Status Assessment (CSA) combined a multilingual community survey with comprehensive secondary data analysis. The survey, adapted from the 2019 version with input from the CHI Steering Committee, community health workers, and local organizations, was offered both online and in print from August 5 to October 22, 2024.

To reach a broad cross-section of the community, BHCPH and partners conducted outreach through direct mail, community events, and trusted organizations. Surveys were available in Spanish, French, Marshallese, Burmese, and Bosnian, and participants received compensation for their time at over 25 outreach events. In addition, trusted community organizations such as RIYO and F.R.I.E.N.D.S. of the Community (along with BHCPH community health workers) were compensated for their expertise and time to reach community members. Individuals involved in the justice system were also included through the county jail and probation office.

BHCPH, MercyOne Northeast Iowa, Peoples Community Health Clinic, and UnityPoint – Allen Hospital all contributed funding and time for survey outreach.

A total of 1,100 community members completed the survey; 355 on paper and 745 online.

- 71% of respondents identified as female.
- 74% lived in Black Hawk County; other counties included Fayette, Bremer, Buchanan, and Grundy.
- 31.5% lived in rural areas outside Waterloo and Cedar Falls.
- Racial/ethnic composition: 1.9% American Indian/Alaska Native, 3.2% Asian, 18.4% Black/African American, 4.2% Hispanic/Latino, and 70.7% White.
- 11.9% were born outside the U.S., most commonly from the Marshall Islands, Democratic Republic of Congo, Burma, Mexico, and Bosnia.

When asked how community health has changed over the past five years, 56.8% said their community has become less healthy, up from 39.8% in 2019. This increase signals growing concerns about well-being and the conditions that shape daily life.

Community Perceptions of Health, Strengths, and Improvements
Respondents identified the following as the top contributors to a healthy community in rank order: Access to healthcare, Affordable and safe housing, jobs and a strong economy, and access to nutritious foods. Foreign-born and lower-income respondents additionally emphasized a clean environment as critical to community health.

Community Strengths	Areas for Improvement
Educational opportunities	Affordable, safe housing; safe neighborhoods and lower crime
Arts and recreation	Jobs and a healthy economy
Physical activity and exercise opportunities	Transportation access (especially among Marshallese and Burmese respondents)
Differences by income were notable. Higher-income respondents were more likely to view education and environmental quality as community strengths, while lower-income respondents saw them as areas needing improvement.	

Mental Health and Children's Well-Being
Respondents identified the top health concerns for children as:

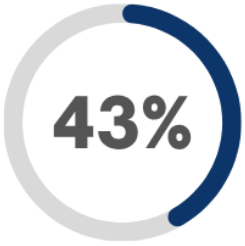
- Excessive screen time and social media use
- Bullying
- Limited access to mental health services

Among adults who needed but did not receive mental health care, the top barriers were:

- Feeling ashamed or uncomfortable discussing personal issues
- Cost of services
- Difficulty finding a provider who feels like a good fit

For respondents with incomes below $30,000, transportation, lack of insurance, and provider availability were additional key barriers.

Food Security
Food access emerged as a significant concern across many groups with concerns highest among lower-income, younger, and foreign-born respondents. Overall, food insecurity closely correlated with lower income, lower educational attainment, and non-U.S. birth.



Worried food would run out before they could buy more

Food bought didn't last and lacked $$ to buy more

Food insecurity ranged from 30% for White respondents to over 80% for Native Hawaiian or Other Pacific Islander respondents

Community Survey Summary
Community perspectives reflect a strong sense of shared values, education, recreation, and opportunity, alongside growing recognition that economic, housing, and transportation challenges shape overall health. The findings also highlight gaps that impact lower-income and refugee/immigrant communities the most, showing the need for solutions that improve well-being and opportunity for all community members.

CSA Secondary Data
Secondary data came from sources such as the Census, Iowa Department of Health and Human Services (Iowa HHS), and Northeast Iowa Food Bank (NEIFB), covering health, housing, economic, and behavioral indicators. Sources from Iowa HHS included the Behavioral Risk Factor Surveillance System (BRFSS), Iowa Hospital Association (IHA) Inpatient Outpatient data, Vital Records, and Barriers to Prenatal Care. (The NEIFB shared local food insecurity data based on data from Feeding America. Data were disaggregated by race, ethnicity, age, sex, ZIP code, income, and education to surface disparities.)

Community Partner Assessment Methods and Findings

The Community Partner Assessment (CPA), replacing the MAPP 1.0 Local Public Health Systems Assessment (LPHSA), was developed using lessons from Black Hawk County's 2019 modified LPHSA and the MAPP 2.0 handbook. The BHCPH core team focused the CPA on Diversity, Access, Community Engagement, and Data Collection/Sharing. After review by the CHI steering committee and assessment design team, the finalized survey was deployed via the Alchemer online platform to 52 organizations in the Advancing Equity in the Cedar Valley coalition. These partners were selected for their focus on reducing barriers and promoting equity.

The CPA captured how local organizations address language access, cultural relevance, and data-sharing practices. Findings have already informed initiatives led by the coalition and are guiding the development of a community data hub. The CPA results were shared with the Advancing Equity Coalition in October 2024. Items identified for action by the committee based on the CPA results and facilitated discussion included:

- Look for projects that could be piloted and replicated for greater impact.

- Build metrics related to each activity and the need for greater data sharing through the development of a data hub.
- Create forums designed to educate and increase engagement between the Cedar Valley's multicultural communities and organizations/employers. Leaders from immigrant and refugee communities noted that people in their communities are getting hired but get stuck when they have to complete all the human resource forms and aren't receiving culturally/linguistically focused orientations to their work.
- Develop a mentorship program to build leadership in the multicultural community. Existing staff and small non-profits are very active in this work but cannot meet all the needs.

Community Context Assessment Methods and Findings

The Community Context Assessment (CCA) centered on ZIP Code 50703, identified in the Community Status Assessment as a priority due to pronounced health disparities, poverty, food insecurity, and unemployment. This area also includes neighborhoods historically affected by redlining, contributing to long-term structural inequities.

The CCA began by mapping key community assets, including healthcare providers, educational institutions, non-profits, and government services. Sources such as United Way's 211, local agency directories, and planned public transit updates for September 2024 were used to analyze accessibility and coverage.

Findings from the asset mapping informed the designation of four focal regions within ZIP Code 50703 for deeper assessment. The team employed two primary methods: key informant interviews and walking/windshield surveys. Interviews with stakeholders provided insight into systemic challenges, infrastructure needs, and historical context. On-the-ground surveys captured real-time data on transportation access, sidewalk conditions, and neighborhood connectivity.

The CCA identified both community strengths and persistent challenges. Despite a strong network of local organizations, barriers related to transportation, walkability, and the effects of historical disinvestment remain. Key findings include:

- **Transportation access** is limited, with heavy reliance on public transit and carpooling.
- **Sidewalk infrastructure** is inconsistent, with gaps in connectivity and pedestrian safety.
- **Community organizations** are addressing mobility challenges through bus pass distribution and service location adjustments.
- **Historical disinvestment** continues to impact health outcomes and economic conditions.

These insights, gathered through key informant interviews and field observations, underscore the need for systemic investment and infrastructure improvements.

Limitations included ambiguity around whether feedback referred to current or proposed bus routes and the exclusion of rural areas, Cedar Falls, and western Waterloo from the assessment scope.

From Assessment to Action: Synthesizing and Sharing the Data

Following completion of the three community health assessments, the BHCPH core team initiated a structured data analysis process. The goal was to organize and interpret the large amount of information in a clear, objective, and digestible format, while avoiding early assumptions or conclusions.

Prior to meeting with the Steering Committee, a comprehensive data report summarizing findings from the CCA, CPA, and CSA community survey was compiled and shared with the Steering Committee. BHCPH's epidemiologists then compiled key secondary data findings through a rigorous process that emphasized reliability, inclusion of all data sources, and identification of both community strengths and gaps. All data sources were considered equally, ensuring that no dataset was given more weight than another.

To make the information actionable, each secondary data point was written on a sticky note and reviewed using two guiding questions:

1. Does this data indicate an improvement, gap, or difference among groups?
2. If yes, what pattern or trend does it suggest?

Using this approach, the epidemiologists organized the key data points into related groups to visualize shared themes and relationships across the assessments. They then developed visual summaries organized by broad topic areas: demographics, social drivers of health, education, food access, health promotion, mental health, and health behaviors and outcomes.

Identifying Emerging Community Themes

Using the synthesized data, the Steering Committee created an affinity diagram to identify major community themes. With facilitation from the core team, these themes were refined into issue statements describing how and why each issue occurs, the seriousness of its impact, and who is most affected.

Emerging Issue Themes

- Economic instability, especially in ZIP code 50703 and among Black/African American, Hispanic, and young adult residents.
- Limited access to affordable, nutritious food, concentrated in and around ZIP code 50703.
- Transportation barriers affecting low-income, Black/African American, and immigrant/refugee populations.
- Behavioral health challenges, particularly among individuals aged 18–24, 45–54, and those with lower income.
- Barriers to healthcare access, including cost, insurance coverage, scheduling, transportation, and language needs.
- Housing instability and lead exposure, especially in ZIP codes 50703 and 50613.
- Chronic disease burden—including cancer, diabetes, and obesity—especially among Black/African American residents in 50703.
- Infectious disease risks, influenced by declining vaccination rates and increasing syphilis cases.
- Cultural and linguistic barriers that limit access to services for residents needing language or accessibility support.
- Gaps in health literacy affecting residents with lower educational attainment, young adults, and Black and Hispanic populations.

Connecting Data Across Assessments

A key step before community prioritization of the issues was triangulation: comparing findings across the three assessments to confirm patterns and strengthen confidence in results. Given the volume of data, BHCPH's epidemiologists led this step, summarizing the findings and sorting them by theme. This approach highlighted where findings overlapped across assessments.

To support community understanding and engagement, BHCPH staff developed fact sheets for each theme and a comprehensive slide deck. These materials summarized data highlights and helped translate complex data into stories that community members could connect with.

Limitations and Strengths

While comprehensive, the assessment process faced limitations, including potential bias in data interpretation, variability in data quality (particularly for smaller population groups), and uneven digital access for the community survey. Despite these challenges, intentional engagement and multiple feedback loops helped ensure that diverse community voices informed the results and priorities.

Phase 3: Continuously Improving the Community

Phase 3 of the process focuses on developing and implementing the Community Health Improvement Plan (CHIP); a coordinated, data-driven roadmap that builds on the findings from Phases 1 and 2. The CHIP guides collaboration among community partners to align actions, target resources, and track progress toward shared goals.

The CHIP process helps the community determine where it is now, where it wants to go, and how it will get there. By addressing root causes and social determinants—or drivers—of health, this phase encourages transformational approaches that use strategic partnerships to create sustainable impact. The focus on systems change and upstream strategies reflects a shared commitment to improving conditions that influence health and well-being for all Cedar Valley residents.

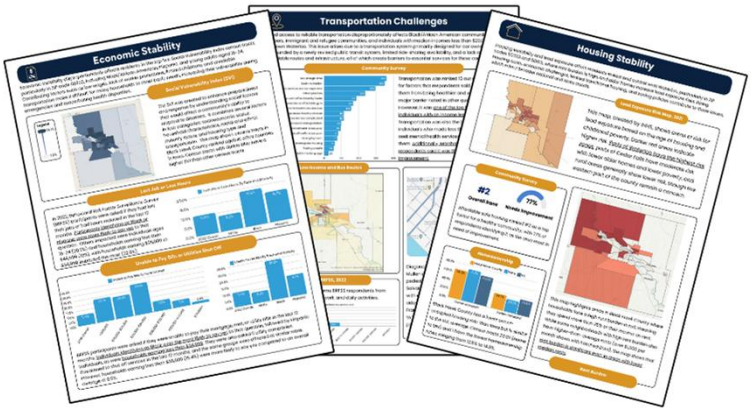
Community Engagement and Prioritization

On January 14, 2025, BHCPH, in partnership with MercyOne Northeast Iowa, Peoples Community Health Clinic, and UnityPoint Health – Allen Hospital, hosted a community-wide meeting to share findings and gather input.

Attendees, including community partners, organizations, and residents, were invited to explore each of the ten issue themes. Tables were organized by theme, and each included printed fact sheets **(Appendix B)** with issue statements, data summaries, and discussion prompts such as:

- Are we describing this issue accurately?
- What are the root causes you see?
- Existing resources to address this issue?
- Potential solutions could be explored?

68 participants added their insights and lived experience directly to the profiles, ensuring the final product reflected both data and community perspectives. During a gallery walk, participants reviewed others' contributions and recognized the interconnectedness among issues. A "sticky wall" displayed shared root causes and overlapping contributing factors, illustrating how addressing one challenge could support progress in others.



Following discussion, participants voted on priorities using rank-order voting through the Alchemer online platform. Points were assigned based on ranking (1st = 5 points, 2nd = 4, etc.), and totals were calculated to determine the top priorities. Considerations for prioritization included:

- Relevance to community members
- Common theme or connection
- Magnitude/severity
- Biggest potential for impact if addressed
- Opportunity to apply upstream strategies
- Availability and feasibility of solutions and strategies

Top Community Improvement Priority Issues

These priorities reflect community recognition that social and economic conditions strongly shape well-being and opportunity. By focusing on these areas, partners can make meaningful progress toward improving health outcomes and quality of life across the Cedar Valley.

Building Understanding of Priority Issues

Following the community's selection of the three priority areas, the next step was to deepen understanding of each issue through the development of detailed issue profiles. These profiles were built on the data and community feedback gathered during Phases 1 and 2, serving as a bridge between assessment and action.

The first activity in this process was the "A Walk in Their Shoes" poverty simulation, organized by Advancing Together in the Cedar Valley in January 2025. This immersive experience, co-facilitated by Iowa State University Extension and Outreach and Center of Attention, raised awareness of the daily challenges faced by individuals living in poverty. Volunteers, many with lived experience, played key roles in facilitating the event.

During the debriefing session, participants and volunteers reflected on their experiences and discussed the realities of poverty in the Cedar Valley. BHCPH shared how the simulation's themes intersected with the three CHIP priorities. Feedback gathered during the debrief highlighted how economic instability, housing, and transportation challenges are interrelated and collectively shape opportunities for well-being.

The Advancing Together in the Cedar Valley Coalition reviewed this feedback along with additional local data to complete the issue profiles. Across all three priorities, several common challenges emerged:

- The need for coordinated resource navigation and care systems
- Improved access to responsive, culturally informed services
- A stronger focus on addressing root causes and structural barriers

Stakeholders emphasized that barriers are often compounded for populations already experiencing social vulnerability. Community members also underscored the importance of involving people with lived experience in planning and decision-making to ensure that solutions are responsive, practical, and sustainable. Together, these insights highlight both the structural and individual factors influencing well-being in the Cedar Valley and provide a foundation for collaborative action planning that strengthens existing resources while addressing gaps in services, coordination, and accessibility.

Aligning Planning and Implementation

While the CHIP development process continued, the Core Team recognized the importance of balancing plan development with the community work already underway across the three priority areas. Rather than creating new silos or duplicating efforts, the team sought to integrate the CHIP with existing initiatives addressing the social drivers or determinants of health, a more upstream and collaborative approach to community health improvement planning.

To strengthen alignment, the Core Team connected CHIP strategies with ongoing projects and actively supported implementation while finalizing the plan. These efforts were reinforced by work to streamline infrastructure through merging the Community Health Improvement Steering Committee with the Advancing Together (formerly Advancing Equity) coalition.

For example, One Cedar Valley introduced "The Hub", an initiative closely aligned with the CHIP's Care Coordination strategy within the Economic Stability priority. Similarly, the Transportation Challenges and Housing Stability priorities were linked to existing coalition-led initiatives to enhance coordination, reduce duplication, and increase collective impact.

Throughout 2025, the coalition focused on identifying resources, assessing gaps, and determining the role it could play in advancing community health improvement through shared leadership, coordination, and advocacy.

Community Health Improvement Plan Components
Each CHIP priority area includes the following components:

1. **Issue Profile:** Summary of the issue statement, key resources, gaps, and the coalition's proposed approach.
2. **Alignment:** Connections with state and national community health improvement priorities.
3. **Goal Statement**
4. **SMART Objectives:** Specific, Measurable, Achievable, Relevant, and Time-bound objectives that guide evaluation and accountability.
5. **Strategies by Level of Influence:** Organized using the Social-Ecological Mode**l**, which recognizes that health and well-being are shaped by multiple levels of influence, from individual behaviors to broader systems. Strategies are categorized as follows:
    - Changing the Rules (Systems and Policy): Efforts that modify policies, structures, or environments to improve conditions for health and well-being.
    - Community Collaboration: Initiatives that mobilize partnerships, networks, and coalitions to create supportive environments.
    - Partnering with Organizations: Actions that enhance coordination, alignment, and service delivery across sectors.
    - Supporting Individuals: Programs and services that expand access, knowledge, and empowerment at the personal level.

Action Planning, Monitoring, and Evaluation
Action plans will be developed for each strategy and will include clear success indicators, detailed action steps, timelines, and assigned responsibilities to ensure consistent implementation and accountability.

Advancing Together will monitor progress quarterly by reviewing participation records, updates from strategy working groups, and progress reports on countywide initiatives. The coalition will also continue to gather input from residents and frontline navigators through a combination of primary data collection, such as interviews, surveys, or focus groups, and by incorporating relevant primary data reports produced by partner coalitions and community organizations. This combined approach will help identify service gaps, surface emerging needs, and provide insight into systemic challenges.

These insights, along with data from the Cedar Valley Data Hub, which will be updated annually to track long-term changes and emerging trends, will be shared across working groups to assess impact and inform adjustments to strategies. Progress updates will be communicated with community partners and the public through regular reporting mechanisms to promote transparency and a shared understanding of changes over time.

Evaluation efforts will also consider how strategies support improved access to services, expanded opportunities for community well-being, and the experiences of residents most affected by local challenges. This approach ensures that adaptations are shaped by community perspectives while remaining aligned with Iowa requirements related to language use.

Economic Stability

Economic Stability emerged as a foundational priority for improving community well-being in the Cedar Valley. Building on data and community input gathered during Phase 2, the coalition began by brainstorming, researching, and prioritizing potential strategies to address the root causes of economic instability. Using a prioritization matrix, the group evaluated strategies based on anticipated impact and level of effort, identifying those most feasible and promising to pursue and ones that are gaps in the community.

In April 2025, the Advancing Together in the Cedar Valley Coalition completed this exercise and organized potential strategies into the following quadrants:

High Effort & High Impact	Midpoint Effort & High Impact	Least Effort & High Impact
Place-based or population-focused pilots	Care coordination	Capacity building and sharing across sectors
Strengthening consumer protections and local business development to reduce predatory business presence	Reducing the cost burden of basic necessities through policies and programs for economic mobility	Human resources ecosystem mapping
Narrative change	Food sector initiatives	Health sector engagement
Education (basic English, financial/soft skills, health/digital literacy)		Integrated data collection and sharing
Policy and advocacy		
Immigrant and refugee engagement		
Behavioral health integration		

Refining the Focus

Following this exercise, the Core Team identified “Capacity Building and Sharing Across Sectors” as a high-potential strategy requiring further exploration. The team sought to better understand who was already working in this space, where gaps existed, and what specific actions could add the most value. In addition, the health sector core team including BHCPH, MercyOne Northeast Iowa, Peoples Community Health Clinic, and UnityPoint Health – Allen Hospital, began developing their collaborative CHIP roadmap to address both “health sector engagement” and “behavioral health integration”.

In August 2025, coalition members broke into small groups to explore potential directions within this broad strategy area. Participants brainstormed concrete actions, shared ideas with the larger group, and then voted to determine top priorities.

As the Core Team reviewed the results, they observed that many of the ideas generated reflected overarching themes already identified within the Economic Stability priority area, including:

- Communication and outreach—particularly centering vulnerable voices and trusted messengers.
- Language access and immigrant/refugee engagement.
- Development of a shared data hub.
- Collaboration and relationship-building among organizations.
- Inclusion of individuals with lived experience in committees and decision-making across the Cedar Valley.
- Rapid problem-solving capacity to address emerging community issues.
- Tools and training to strengthen organizational effectiveness.

These insights led the team to recommend developing a single, integrated Economic Stability roadmap built around a unifying goal. The roadmap also allows strategies to be implemented in tandem across the economic stability spectrum ensuring that key themes such as immigrant and refugee engagement, data sharing, and inclusion of lived experience are part of one cohesive framework.

The Core Team also committed to identifying evidence-based practices for engaging individuals with lived experience and immigrant and refugee communities in planning and decision-making. Meetings with local leaders and organizations already active in these spaces were planned to gather insights on current practices, unmet needs, and opportunities for collaboration.

In November 2025, the Advancing Together in the Cedar Valley Coalition approved the CHIP roadmap for the Economic Stability priority and began moving toward implementation.

Economic Stability: Issue Profile

Community partners identified economic instability as a persistent barrier to health and well-being, particularly in neighborhoods with higher social vulnerability, such as ZIP code 50703. Residents in these areas, especially Black/African American, Hispanic, and young adult populations, face intersecting challenges including low wages, limited childcare options, unreliable transportation, and generational poverty.

Stakeholders emphasized that soft skills and workforce readiness are critical for long-term employment success and that there is room to expand existing programs. Local assets such as Peoples Community Health Clinic, Hawkeye Community College, Leader Valley, Iowa Works, and Title I Services provide valuable education, job training, and coaching that strengthen workforce participation. Immigrant- and refugee-serving organizations connect residents to jobs, housing, and social support, while programs such as House of Hope, Center of Attention, and Friends of the Family offer comprehensive assistance to individuals facing financial or housing insecurity.

Despite these strengths, partners identified persistent gaps, including a shortage of mental health providers, limited childcare capacity, inadequate affordable transportation, and rising living costs that continue to outpace wages. Addressing economic instability will require coordinated efforts to align workforce development, education, and social support systems—helping all residents achieve and sustain financial security.

Alignment with National and State Health Improvement Plans
The Economic Stability objective directly aligns with national and state priorities focused on reducing poverty, increasing employment, addressing the cost of basic necessities such as food and housing, and addressing access/opportunity to care.

Healthy People 2030 Objectives

- **SDOH-01** (Social Determinants or Drivers of Health): Reduce the proportion of people living in poverty.
- **SDOH-02:** Increase employment among working-age adults.
- **SDOH-03:** Increase the proportion of children living with at least one parent who works full time.
- **SDOH-04:** Reduce the proportion of families spending more than 30% of income on housing.
- **NWS-01** (Nutrition and Weight Status): Reduce household food insecurity and hunger.
- **NWS-02:** Eliminate very low food security in children.
- **AH-09** (Adolescent Health): Reduce the proportion of adolescents and young adults who are not in school or working.
- **AHS-**01, 02, 03: Increase the proportion of people with health insurance, dental insurance, and prescription drug insurance.
- **AHS-04, 05, 06** (Access to Health Services): Reduce the proportion of people who can't get medical care, dental care, or prescription medicines when they need them.

Iowa 2023–2037 State Health Improvement Plan (SHIP)
Healthy Eating and Active Living Priority, Goal 1: Reduce barriers to affordable, nutritious foods for all people in Iowa.
Access to Care: Behavioral Health, Goal 1: Improve access to inclusive behavioral health services in Iowa

The *Partners in Action* section of the Healthy Iowans plan highlights ongoing statewide efforts related to economic stability, including:

- Goal Focus: Increasing family economic stability.
- Example Strategies: Workforce development initiatives (e.g., strengthening the direct care workforce, connecting adults in low-income families to short-term training for higher-paying jobs), diaper distribution pilot programs, and th**e** Family Development and Self-Sufficiency Program.

These collective efforts at the national and state levels provide an important framework for aligning local CHIP strategies to broader systems change.

Economic Stability Community Health Improvement Roadmap

Goal

To create a coordinated and inclusive community environment where all have opportunities for stable employment, income, and well-being through systems, policies, and partnerships that reduce economic barriers and strengthen participation in decision-making.

Objective

By December 31, 2028, strengthen community and system supports that improve economic stability for residents most affected by economic barriers, measured by:

- 100% of strategies have success indicators and action plans built by June 30, 2026 and 75% of the action plans are in-progress or completed by December 31, 2028.

Level of Intervention	Strategies
Changing the Rules (Systems and Policy)	1. Advocate for local policies and programs that reduce the cost burden of essential needs (housing, food, utilities, transportation). 2. Expand one or more existing lived experience leadership group to ensure that community members most affected by economic barriers have a voice in decision-making and program design and are compensated for their time. 3. Promote a rapid-response approach to identify and respond to emerging issues through micro-grants, events, or policy recommendations. 4. Build a collaborative resource navigation system so that community members entering through any community “door” (healthcare, housing, employment, education) are connected to aligned supports. To the extent possible, the system should include: (a) a shared process for regularly updating community resource directories that are available in multiple languages and mobile friendly formats; (b) collaboration to increase understanding of intake processes, technology platforms and case management tools used for care coordination; and (c) ongoing opportunities for cross-sector relationship-building and training.
Community Collaboration	5. Explore sustainable funding mechanisms (e.g., local, state, and national philanthropy, employer investment, grants) to strengthen coalition infrastructure and the economic stability strategies. 6. Support upstream health-related strategies that reduce long-term financial strain on households by aligning with the Health Sector CHIP objectives which include partnering with community organizations to expand prevention programs, increasing access to cancer and chronic disease screenings, and implementing multi-level behavioral health initiatives.*

	7. Host quarterly Advancing Together convenings to strengthen relationships, share progress, and identify emerging economic stability issues. 8. Develop a community data hub to centralize and make accessible reliable, place-based data to help community members, organizations, and government agencies understand local needs, track progress, and make informed decisions. 9. Expand navigator and liaison capacity to connect community members facing language, cultural, or logistical barriers to employment and wraparound supports. 10. Strengthen the ecosystem between navigators/liaisons, employers, employees, and workforce agencies to expand access to training, mentorship, and advancement opportunities.
Partnering with Organizations	11. Educate community organizations on practices that improve the accessibility of publicly available materials.
Supporting Individuals	12. Promote community employment and resource fairs and other mechanisms that connect community members to job opportunities, training programs, and wraparound supports. 13. Promote organizational compensation policies removing financial and structural barriers for community members contributing their lived experiences through participation in shared decision-making activities such as advisory boards, focus groups, and planning committees.

*****Black Hawk County Public Health, MercyOne Northeast Iowa, Peoples Community Health Clinic, and UnityPoint Health – Allen Hospital recognize that health and economic stability are deeply interconnected. These partners developed a complementary Health Sector roadmap that outlines detailed goals, objectives, and strategies to reduce the financial impact of preventable health conditions and improve access to care. Those health-related strategies are reflected in the Economic Stability priority of the community CHIP as documented on the next pages.

Health Sector Goal: *address the upstream factors affecting economic stability to reduce the burden of cancer, chronic disease, and behavioral health conditions in the community.*

The health sector's collaborative goal and objectives are grounded in the recognition that economic stability plays a critical role in shaping health outcomes. By addressing upstream factors such as income, employment, and access to services, the health sector can help reduce the burden of cancer, chronic disease, and behavioral health conditions across the community .

The four objectives represent a coordinated approach to improving overall well-being. These efforts are designed to increase access to preventive services, support healthier lifestyles, and reduce barriers that make it difficult for individuals and families to get the care they need.

Prevention/Risk Factor Reduction

Objective: By December 31, 2028, collaboratively partner with at least 5 community organizations to implement or expand prevention/risk reduction strategies in areas with higher incidence/ mortality rates for cancer or chronic diseases while advocating for policy change.

Level of Intervention	Strategies
Changing the Rules (Systems and Policies)	1. Advocate for policies that reduce exposure to known cancer risk factors at the local, state, and national levels. 2. Advocate for investments that improve the social and economic health of the community including transportation access, food security, housing stability, and economic opportunity.
Community Collaboration	3. Promote public awareness of cancer as a chronic disease and the role of modifiable risk factors. 4. Support community-wide campaigns and resources for smoking cessation and radon testing.
Partnering with Organizations	5. Support and expand free or low-cost smoking cessation programs, particularly for low-income community members. 6. Promote adoption of organizational wellness policies that support healthy behaviors.
Supporting Individuals	7. Increase awareness and motivation to reduce personal cancer and chronic disease risk behaviors. 8. Encourage participation in preventive services, such as vaccination and radon testing.

2. Early Detection and Screening
Objective: By December 31, 2028, implement at least three collaborative outreach and barrier reduction strategies to support participation in age-and-risk-appropriate screenings among community members living in areas with higher incidence/mortality rates for cancer or chronic diseases.

Level of Intervention	Strategies
Changing the Rules (Systems and Policies)	1. Advocate for expanded funding to cover gaps in free or low-cost screening programs.
Community Collaboration	2. Increase awareness of the importance of routine screenings and early detection. 3. Host or co-host community screening events in areas with higher incidence or mortality rates for cancer or chronic disease.
Partnering with Organizations	4. Collaborate to identify and eliminate barriers to screening and follow-up care (e.g., transportation, cost, appointment availability). 5. Standardize screening referral processes and follow-up systems for collaborative screening events.
Supporting Individuals	6. Encourage individuals to obtain age- and risk-appropriate screenings.

3. Reducing Social and Economic Barriers to Care – Health Sector Role
Objective: By December 31, 2028, build a community-wide system of collaboration to reduce social and economic barriers to include (1) a shared process for regularly updating community resource directories; (2) the use of technology platforms and/or case management tools to track referrals and outcomes; (3) aligned intake processes, to the extent possible; and (4) ongoing opportunities for cross-sector relationship-building and training.

Level of Intervention	Strategies
Changing the Rules (Systems and Policies)	1. Support policies that address social and economic barriers affecting treatment adherence (e.g., housing, food insecurity, transportation etc.).
Community Collaboration	2. Support systems that reduce barriers to treatment such as medical transportation, food insecurity, and housing support. 3. Ensure health sector participation in CHIP workgroups addressing transportation, food insecurity, and housing instability.
Partnering with Organizations	4. Strengthen coordination across providers to reduce care gaps.
Supporting Individuals	5. Connect patients to social and economic resources to reduce barriers to care.

4. Prevention, Education, and Barrier Reduction Related to Behavioral Health
Objective: By December 31, 2028, collaboratively implement at least two activities at each level of the socio-ecological model (policy, community, organizational, and individual) to reduce stigma, improve behavioral health literacy, and expand access to behavioral health services.

Level of Intervention	Strategies
Changing the Rules (Systems and Policies	1. Advocate for increased investment in the behavioral health workforce, crisis care, transitional services, and inpatient beds to improve timely access to care. 2. Promote policies that reduce systemic barriers to care, such as transportation, insurance coverage parity, and workforce shortages.
Community Collaboration	3. Continue collaborative education campaigns to reduce stigma, normalize behavioral health care as part of overall well-being, and promotes the benefits of seeking behavioral health support. 4. Increase public awareness of trauma, mental health, suicide prevention, and substance use disorders.
Partnering with Organizations	5. Integrate community health workers and other behavioral health navigators into the community-wide care coordination initiative.
Supporting Individuals	6. Offer community-based training opportunities that build individual capacity to recognize behavioral health concerns, reduce stigma, and connect with services (e.g., Mental Health First Aid, QPR, trauma-informed approaches).

Transportation Challenges

Through early discussions with the Advancing Together in the Cedar Valley Coalition, a collaborative approach emerged recognizing that an overarching transportation plan was already in place for the region. Rather than duplicate efforts, Advancing Together is contributing to the implementation of the FY2026–2030 Passenger Transportation Plan for the Iowa Northland Region, approved by the Black Hawk County Metropolitan Area Transportation Policy Board in November 2025.

This plan, coordinated through the Transit Advisory Committee (TAC), includes strategies to:

1. Improve accessibility and availability of public transit.
2. Promote and improve the image of the public transit system.
3. Build awareness of the existing public transportation system through education and marketing.
4. Enhance efficiency and reliability.
5. Improve fleet conditions.
6. Strengthening service for all user groups.
7. Coordinate planning and services with community organizations and workforce development partners.

Members of the Advancing Together Coalition participated in developing and prioritizing these strategies through involvement in the TAC. Building on this strong foundation, Advancing Together serves as a connector, supporter, and advocate, aligning public health priorities with existing transportation initiatives. By collaborating with the Black Hawk County MPO, Region 7 RTA, and the TAC, the coalition helps strengthen partnerships, fill gaps, and ensure transportation strategies address community-identified needs, particularly for low-income residents, older adults, people with disabilities, and immigrant and refugee communities.

Through this integrated approach, the CHIP roadmap supports implementation of shared goals, amplifies community voice, and promotes equitable access to transportation as a key driver of health and well-being.

Issue Profile

Community partners identified transportation as a critical barrier to accessing jobs, education, healthcare, and other essential services, particularly for Black/African American residents, immigrant and refugee communities, and individuals with lower incomes in downtown Waterloo. Stakeholders emphasized that the local transportation system remains largely auto-centric, limiting mobility for residents without reliable access to a car.

While recent revisions to the public transit system aim to improve service, limited routes, hours, and public awareness of available options continue to create barriers. Existing community assets, including the TAC, Iowa Northland Regional Council of Governments (INRCOG) and the Waterloo Mayor’s Homeless Task Force Transportation Subcommittee provide a strong foundation for coordinated improvement.

Additional resources such as MET Transit’s interactive map, transportation programs through Hawkeye Community College, Cedar Valley Gearheads, and non-profit (Love Inc., etc.) or

Medicaid-funded ride services offer valuable support, yet remain underutilized, due to language barriers and limited public awareness.

Partners identified unmet needs for expanded routes, weekend and third-shift service to major employers, transportation to childcare, and safer pedestrian and biking infrastructure. Expanding education about available services, fostering public-private partnerships, and investing in multi-modal transportation options were identified as key strategies to create a more equitable, efficient, and accessible transportation system for all residents.

Alignment with National and State Health Improvement Plans

Healthy People 2030 addresses transportation as a key component of the Neighborhood and Built Environment (NBE) domain, emphasizing safety, accessibility, and active transit as health-promoting strategies. The overarching goal for this topic is to promote safe and active transportation through improvements in infrastructure, systems, and community design. Relevant objectives include:

- **EH-02** (Environmental Health): Increase trips to work made by mass transit.
- **PA-10** (Physical Activity**):** Increase the proportion of adults who walk or bike to get places.
- **PA-11:** Increase the proportion of adolescents who walk or bike to get places.
- **IVP-06** (Injury and Violence Prevention): Reduce deaths from motor vehicle crashes.
- **IVP-07:** Reduce the proportion of deaths of car passengers who were not buckled in.
- **SH-01** (Sleep Health): Reduce the rate of motor vehicle crashes due to drowsy driving.

The **Iowa 2023–2037 State Health Improvement Plan (SHIP)** also prioritizes transportation as a determinant of access, activity, and safety. Two key SHIP goals are closely aligned with local efforts:

- Access to Care (Behavioral Health Goal 1): Improve access to inclusive behavioral health services in Iowa.
- Healthy Eating and Active Living (Goal 2): Increase engagement in active living among all Iowans by supporting community design and infrastructure that enable people to walk, bike, or use transit safely.

In addition, the state's *Partners in Action* report highlights transportation as a major barrier to accessing care and outlines collaborative priorities among local and state partners, including:

- Reducing Transportation Barriers to Care: Decrease missed appointments or delayed medical care due to transportation issues.
- Public Transit Services: Support Iowa's public transit agencies through funding and regulatory assistance to enhance local service capacity.
- Medicaid Transportation: Ensure access to Non-Emergency Medical Transportation (NEMT) for vulnerable populations to support healthcare access and independent living.

Together, these national and state frameworks reinforce the importance of addressing transportation challenges as a cross-cutting driver of health, well-being, and equity in the Cedar Valley.

Transportation Challenges
Community Health Improvement Roadmap

Goal

Enhance access to transportation across Black Hawk County by aligning with the Black Hawk County Metropolitan Planning Organization (MPO) and Region 7 Regional Transportation Association (RTA) Transit Advisory Committee's (TAC) public transit and passenger transportation improvement efforts, prioritizing service coordination, community engagement, and reducing barriers for system users.

Objective

By December 31, 2028, support implementation of at least five high-priority transportation strategies identified by the TAC across the areas of marketing/awareness, service improvement, and education.

Level of Intervention	Strategies
Changing the Rules (Systems and Policies)	1. Advocate for funding and policy support to improve access to transportation. 2. Support inclusion of transportation goals in city and county comprehensive plans that reduce transportation barriers for community members.
Community Collaboration	3. Support public awareness campaigns that help people understand their transportation options and build a positive image of public transit and passenger transportation. 4. Partner with community groups to host transportation education events and outreach efforts that make public transit and other modes of passenger transportation more approachable and understandable.
Partnering with Organizations	5. Work across sectors, such as housing, employment, healthcare, and education, to tackle shared transportation challenges. 6. Participate in working groups led by the Transit Advisory Committee to help carry out high-priority strategies.
Supporting Individuals	7. Expand transportation education through the use of trusted community navigators. 8. Promote tools that let riders give real-time feedback to improve the public transit and passenger transportation experience and identify personal barriers.

Housing Stability

Advancing Together in the Cedar Valley is building on the strong foundation of local efforts already underway to address housing stability. Rather than creating a separate planning process, the coalition is initially aligning with the Mayor of Waterloo's Homeless Task Force, a multi-sector initiative advancing short- and long-term strategies across six subcommittees: In-Depth Case Management, Short-Term Housing, Rental Inspections, Landlord Incentives and Protections, Tenant and Landlord Education, and Transportation Access.

This coordinated approach allows Advancing Together to strengthen partnerships, support shared goals, and elevate community voice while avoiding duplication. Alignment efforts focus on areas where missions and scopes clearly intersect, including transportation access, comprehensive case management, and addressing disparities in housing outcomes.

The coalition also plays a countywide role, monitoring needs, identifying gaps not fully addressed by the Mayor's Task Force (such as those outside Waterloo city limits, in emerging focus areas, and those related to home ownership), and developing new or extended partnerships where additional support is needed, such as with the Iowa Heartland Habitat for Humanity. Through this integrated model, the roadmap promotes equitable access to safe, stable housing and supports a more coordinated response across the system.

Issue Profile

Community partners identified housing instability as a growing challenge across Black Hawk County, especially in east and central west Waterloo (ZIP codes 50703 and 50613). These areas face high rent burdens, aging housing stock, deteriorating properties, and persistent affordability challenges. While lead exposure remains a concern in older homes, stakeholders noted that instability is more strongly linked to rental practices, absentee or out-of-state property management, and the limited availability of safe, affordable units.

Rising housing costs combined with stagnant wages continue to strain household budgets. Residents with prior evictions, credit challenges, or criminal records are at heightened risk of homelessness or prolonged housing insecurity. Community assets, including the Waterloo Mayor's Homeless Task Force, Housing Coalition, Friends of the Family, House of Hope, Peoples Community Health Clinic, Iowa Heartland Habitat for Humanity, and the Salvation Army, provide essential supports ranging from emergency shelter and transitional housing to coordinated entry, case management, and pathways to homeownership.

Emerging initiatives such as Achieve 2030, 24/7 Blac's Homeownership Program, and expanded partnerships with Iowa Heartland Habitat for Humanity and the Waterloo Housing Authority further strengthen opportunities for long-term stability. However, partners emphasized ongoing gaps in flexible funding, service coordination, mental and physical healthcare access, and supportive services that prevent many residents from breaking the cycle of homelessness.

The Waterloo Mayor's Homeless Task Force will play a central role in advancing shared strategies to address these challenges, reduce barriers, and expand safe and affordable housing options for all residents.

Alignment with National and State Health Improvement Plans

Healthy People 2030 identifies stable, safe, and affordable housing as a critical social determinant of health. Relevant objectives and focus areas include:

- **SDOH-01:** Reduce the proportion of people living in poverty, recognizing that economic constraints often contribute directly to housing instability.
- **SDOH-04:** Reduce the proportion of families that spend more than 30% of their income on housing.
- **Housing Quality:** Improve the physical quality and safety of housing environments (e.g., lead exposure, mold, structural hazards).

The **Iowa 2023–2037 State Health Improvement Plan (SHIP)** similarly highlights housing as a fundamental driver of health. SHIP emphasizes:

- The importance of location, safety, and stability of housing as essential to well-being.
- A commitment to advancing health equity and addressing structural barriers, including those linked to income, discrimination, and limited housing options.
- System-level collaboration to support stable housing across diverse communities.

The state's *Partners in Action* report further reinforces this focus by highlighting collective efforts across Iowa to improve housing conditions and reduce homelessness. Key statewide priorities include:

- Affordable Housing: Ensuring access to decent, safe, and affordable housing for residents with limited incomes.
- Support for Vulnerable Populations: Strengthening services for seniors, individuals with disabilities, and individuals and families at risk of homelessness.
- Multi-Sector Collaboration: Coordinating work across housing agencies, non-profits, healthcare organizations, and community partners to improve housing stability and access.

These national and state frameworks align directly with Advancing Together's emphasis on collaboration, equitable access, and addressing root causes of housing instability.

Housing Stability
Community Health Improvement Roadmap

Goal

Support housing stability across Black Hawk County by aligning with and enhancing multi-sector efforts to reduce homelessness and address structural barriers to stable housing, with a focus on collaboration and sustainable systems change.

Objective

By December 31, 2028, participate in and align with at least two subcommittees of the Mayor's Homeless Coalition to improve housing stability in Waterloo, while identifying and initiating at least two new initiatives that address housing-related gaps in Black Hawk County and are outside the scope of the Mayor's Homeless Coalition.

Level of Intervention	Strategies
Changing the Rules (Systems and Policy)	1. Support local and regional policies that increase access to transitional and long-term housing, such as landlord incentive programs, zoning/code changes, and funding for case management. 2. Advocate for policies that connect housing with transportation and education supports to reduce the cycle of homelessness.
Community Collaboration	3. Promote public awareness about housing instability and available resources throughout the county.
Partnering with Organizations	4. Ensure collaboration between the Advancing Together Steering Committee, the Mayor's Homeless Coalition, and other key partners to coordinate planning and action
Supporting Individuals	5. Support services that help community members access safe, affordable housing and connect them to local programs that meet their individual needs.

Acknowledgements

This document summarizes the collective work completed for the 2024 Community Health Assessment (CHA), the 2025 planning and prioritization process, and the development of the 2026–2028 Community Health Improvement Plan (CHIP) Roadmap. While this work is required of healthcare and public health organizations, it becomes meaningful and actionable only through the partnership and engagement of many organizations and community members across the Cedar Valley.

We extend our appreciation to the more than 1,100 residents who participated in the community health survey and shared their perspectives and experiences. We also thank the community health workers at BHCPH and partner organizations who played a key role in reaching community members across the Cedar Valley to ensure broad participation. Their contributions directly shaped the priorities reflected in the roadmap.

The Core Planning and Funding Partners have been essential to each phase of the community health improvement cycle. Their commitment helped guide this work through changing funding landscapes, shifts in state requirements, and the transition of responsibilities between the original CHI Steering Committee and Advancing Together in the Cedar Valley. We also acknowledge the Black Hawk County Board of Health for their ongoing support. This work has benefited from established frameworks and evidence-informed approaches, paired with local innovation to create a process that reflects our community's needs, even when the path forward has been complex.

Finally, we recognize the many partners participating in Advancing Together in the Cedar Valley and the organizations and individuals who will help implement the roadmap. Your dedication will move this work forward and bring us closer to a Cedar Valley where all people have opportunities to thrive.

CORE PLANNING AND FUNDING PARTNERS

Black Hawk County Public Health
Community Foundation of Northeast Iowa
Corporation for a Skilled Workforce
MercyOne Northeast Iowa
One Cedar Valley
Peoples Community Health Clinic
UnityPoint Health – Allen Hospital

COMMUNITY PARTNERS

Black Hawk Grundy Mental Health
Black Hawk County Departments: Emergency Management, Information Technology, Marketing, and Social Services
Black Hawk County Soil and Water Conservation District
Cedar Valley United Way
Center of Attention
City of Waterloo
City of Cedar Falls
Elevate CCBHC
Exceptional Persons Inc.
Family YMCA of Black Hawk County
F.R.I.E.N.D.S. of the Community
Friends of the Family
Grow Cedar Valley
Hawkeye Community College
House of Hope
Iowa Heartland Habitat for Humanity
Iowa Northland Regional Council of Governments
ISU Extension and Outreach
IowaWORKS
Lutheran Services of Iowa
MET Transit
Molina Healthcare
Northeast Iowa Food Bank
Operation Threshold
Otto Schoitz Foundation
Pati's Libelulas
Pathways Behavioral Services
RIYO
Salvation Army
Success Link
The River ARC
TriCounty Headstart
Veridian Credit Union
Waterloo CSD
Waterloo Public Library
World Grace
University of Northern Iowa

Acronyms

BHCPH	Black Hawk County Public Health
CCA	Community Context Assessment
CHA	Community Health Assessment
CHI	Community Health Improvement
CHIP	Community Health Improvement Plan
CPA	Community Partner Assessment
CSA	Community Status Assessment
HP2030	Healthy People 2030
Iowa HHS	Iowa Health and Human Services
MAPP	Mobilizing for Action through Planning and Partnership
NACCHO	National Association for County and City Health Officials
PHAB	Public Health Accreditation Board
SDOH	Social Drivers (or Determinants) of Health

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*Community Health Assessment (CHA) Specific Sources are listed in Appendix **A.**

Appendices

Appendix A: Community Health Assessment Report

Appendix B: Community Health Assessment Prioritization Fact Sheets

Appendix A: Community Health Assessment Report

Black Hawk County Public Health

Black Hawk County Community Status Assessment

March 2025

Table of Contents

Introduction

Framework

MAPP (Mobilizing for Action through Planning and Partnerships) is a method for community health improvement planning which encourages collaboration with community partners to increase the likelihood of long-lasting change. The community health assessment portion of MAPP version 2.0 consists of 3 assessments. The Community Status Assessment (CSA) is the quantitative assessment. It includes both primary and secondary data elements and is designed to answer the following questions:

- *What does the status of your community look like, including health, socioeconomic, environmental, and quality of life outcomes?*
- *What populations experience inequities across health, socioeconomic, environmental, and quality of life outcomes?*
- *How do systems influence outcomes?*

Purpose

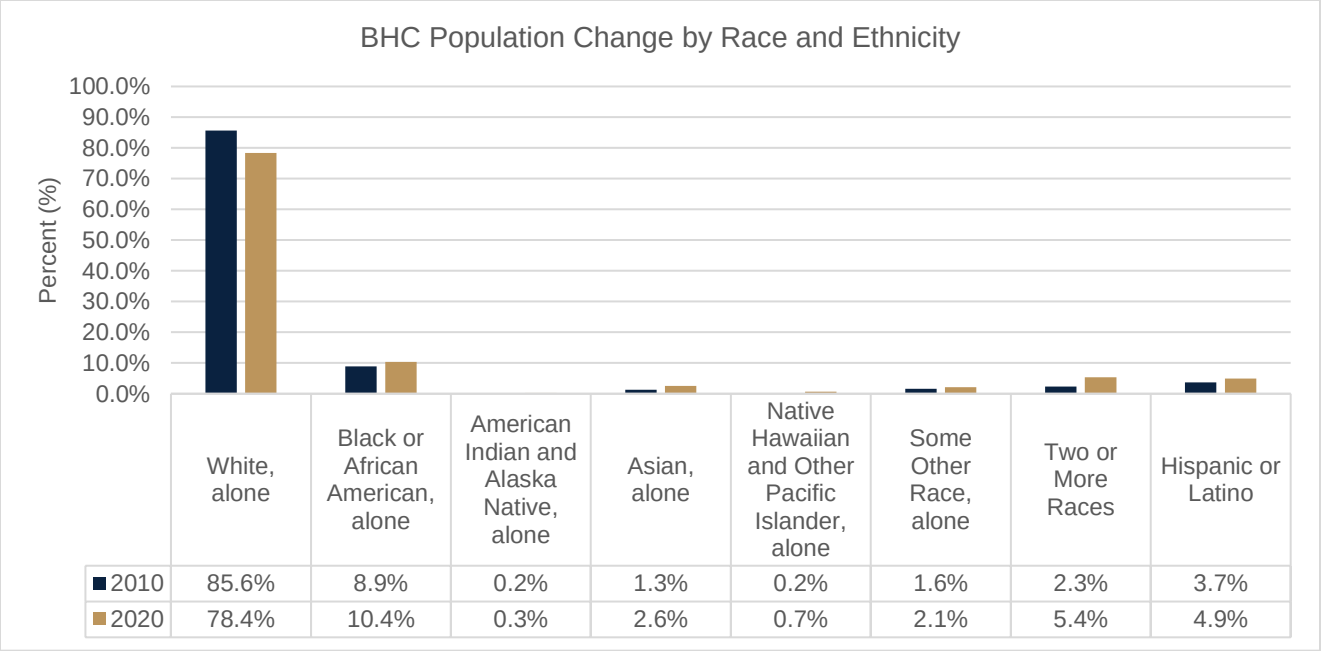
The CSA was performed to answer the previous questions to assess the overall health of Black Hawk County, Iowa. Results were intended to be used alongside the results of the other two assessments to identify the highest priority health needs for Black Hawk County, Iowa, and inform the development of the Community Health Improvement Plan (CHIP), for FY26-28.

Process and Timeline

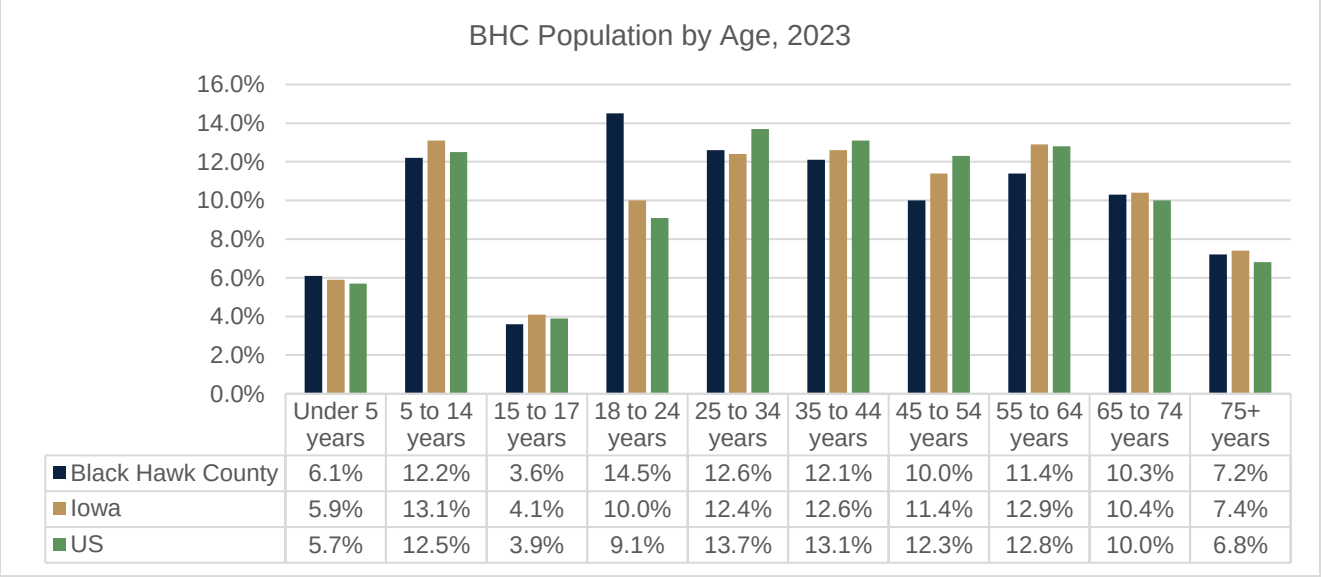
This CSA was conducted from February 2024 to December 2024. The work was led by the Community Health Improvement (CHI) core team, which includes a public health planner and two epidemiologists, in collaboration with area hospital systems, MercyOne and UnityPoint Health, and the Federally Qualified Health Center (FQHC) Peoples Community Health Clinic, as well as additional support from the broader steering committee and assessment design team. It consists of two parts, a community survey and secondary data analysis drawn from multiple sources (see References for details). The community survey was developed with the definition of community that the steering committee created, which includes individuals who live in, work in, or visit Black Hawk County (BHC), Iowa. The secondary data analysis includes individuals who are residents of BHC, Iowa. Although the secondary data analysis was started before the community survey was released, some data points were added after the community survey results were available.

Demographics

BHC is the fifth largest county in the state of Iowa. In 2023, the total population was 130,471 per the American Community Survey. The two largest cities in BHC are Waterloo and Cedar Falls, with several smaller towns and communities surrounding them. The population has become more diverse over time, as seen in the 2010 and 2020 Census data. Additionally, there is a larger proportion of 18- to 24-year-olds (14.5% in Black Hawk County compared to 10.0% in Iowa and 9.1% in the US), as seen in the 5-year American Community survey data. This can partially be explained with the presence of the public university, University of Northern Iowa (UNI) in Cedar Falls.



	White, alone	Black or African American, alone	American Indian and Alaska Native, alone	Asian, alone	Native Hawaiian and Other Pacific Islander, alone	Some Other Race, alone	Two or More Races	Hispanic or Latino
2010	85.6%	8.9%	0.2%	1.3%	0.2%	1.6%	2.3%	3.7%
2020	78.4%	10.4%	0.3%	2.6%	0.7%	2.1%	5.4%	4.9%



	Under 5 years	5 to 14 years	15 to 17 years	18 to 24 years	25 to 34 years	35 to 44 years	45 to 54 years	55 to 64 years	65 to 74 years	75+ years
Black Hawk County	6.1%	12.2%	3.6%	14.5%	12.6%	12.1%	10.0%	11.4%	10.3%	7.2%
Iowa	5.9%	13.1%	4.1%	10.0%	12.4%	12.6%	11.4%	12.9%	10.4%	7.4%
US	5.7%	12.5%	3.9%	9.1%	13.7%	13.1%	12.3%	12.8%	10.0%	6.8%

According to the Iowa Immigration Council in 2023, 5.8% of Iowa's population are immigrants, and 3.0% are US born residents with at least 1 immigrant parent. The top countries of origin for immigrants in 2023 were Mexico (23.3%), Guatemala (6.8%), and India (5.7%). The top countries of origin for refugees were Democratic Republic of the Congo (DRC) (41.5%), Venezuela (8.6%), Afghanistan (6.0%), Myanmar (5.8%), and Eritrea (5.8%). In Black Hawk County, the foreign-born population was 6.4% of the total population (2023 5-year ACS), and originated from Europe (23.7%), Asia (26.0%), Africa (20.1%), Oceania (5.6%), and the Americas (24.6%). The Iowa Department of Education provides 2020-2021 data on English language learners (ELL) in public schools within BHC. The languages spoken by ELL students is shown in the word cloud below, with the size of the word corresponding to the number of ELL students that speak that language (the size of Spanish was reduced to make room for other languages).

Methods

Community Survey Methods

The 2024 Community Survey was developed from the 2019 survey, incorporating lessons learned while maintaining a consistent framework. The CHI steering committee and the assessment design team conducted a review of the updated survey to ensure its relevance and alignment with community needs. To promote accessibility and inclusivity, the survey was translated into Spanish, French, Bosnian, Marshallese, and Burmese, then uploaded to Alchemer, a HIPAA-compliant survey platform. The survey was distributed to the public using press releases, postcards, flyers, direct mail, community partners, social media, and targeted outreach.

An important lesson learned from the 2019 survey implementation was the importance of including community members in the planning process for outreach to vulnerable populations. Community health workers and community organizations, including RIYO, F.R.I.E.N.D.S. of Community Health, BHCPH community health workers, and Veterans Affairs, were consulted to determine appropriate incentives and effective methods for engagement. They also received the necessary resources to reach their community in ways they felt worked best.

The survey was launched online on August 5, 2024, and closed on October 22, 2024. Paper copies were made available at Black Hawk County Public Health and additional community venues. Members of the CHI core team attended local events to offer the survey in person. Completed paper copies were entered into the online platform by staff. Outreach locations and events included:

- African American Fest
- BHC Courthouse
- BHC Jail
- House of Hope
- Jessie Cosby Center
- Greens 2 Go
- KWWL Health Fair
- Lincoln Park
- Living Stone Church (Congolese)
- Marshallese Churches
- Pinecrest
- The Northeast Iowa Food Bank
- Peoples Community Health Clinic (Big Tent Event & Onsite)
- Salvation Army
- UNI
- Waterloo Eastside Churches, Apartment Complexes, Retail and Schools
- Veterans Health Fair
- Waterloo Public Library

When the survey closed, a report detailing preliminary results was exported from Alchemer. The data was also analyzed in Tableau. Data was broken down by race, ethnicity, age group, gender, income, highest level of education, country of birth, and ZIP code to highlight potential disparities. All valid responses were included in the analysis, and missing data was handled by omitting only those questions left unanswered by individual respondents.

Secondary Data Analysis Methods

In addition to the survey, data was collected from a broad range of sources. Publicly available sources included the Census, the Iowa Public Health Tracking Portal, and Feeding America (see References). Most of the data was already aggregated by the data owner. This allowed for straightforward integration of results into Excel for visualization.

Additional data was shared through formal agreements with Iowa HHS and the Northeast Iowa Foodbank (NEIFB). Sources from Iowa HHS included the Behavioral Risk Factor Surveillance System (BRFSS), Iowa Hospital Association (IHA) Inpatient Outpatient data, Vital Records, and Barriers to Prenatal Care (see References for more details). The NEIFB shared local food insecurity data based on data from Feeding America. Excel, R, and Tableau were used for data cleaning and analysis. Missing answers or data values were treated the same way as they were for the community survey, by including all valid responses in the dataset but omitting individual missing values or unanswered questions.

Whenever possible, data was broken down by race, ethnicity, age group, and sex to highlight potential disparities. Income, highest level of education, and ZIP code were added when data allowed. This was done to assess any disparities among these groups. Individual years of data were displayed to show trends over time, but confidentiality remained a priority. In cases of low counts, multiple years were combined. Counts and numerators less than six or denominators less than 100 were suppressed for the same reason and are denoted by asterisks (**).

Selection Criteria

The data selection process for our final presentation was guided by a structured approach that ensured inclusivity, reliability, and a focus on identifying community strengths, weaknesses, and inequities. Our data came from two primary sources: the community survey and secondary data analysis.

All data sources were considered equally, without assigning different weights to various datasets. The focus was on pooling data together and identifying key points that highlighted disparities or trends that would be relevant for decision-making.

Once all data points were gathered, they were written on sticky notes. To categorize the information, we asked a guiding question for each data point: *does this data indicate an improvement, gap, or inequity?* If the answer was yes, the data point was included in an affinity diagram, where sticky notes were physically grouped into emerging themes. Two epidemiologists led the initial review process, analyzing the data, grouping it into themes, and creating visualizations of the data. The final secondary data points were presented in a PowerPoint alongside survey responses, with the intent of structuring the large amount of data in a digestible format.

Community Survey Findings

A total of 1,100 people participated in the community survey. Respondents varied in age, with a balanced distribution, and 71% of them were female. Most participants, about 74%, lived in BHC, ensuring that the results reflected local perspectives.

The survey included a diverse group of respondents. 1.9% identified as American Indian or Alaskan Native, 3.2% as Asian, 18.4% as Black or African American, 4.2% as Hispanic or Latino, and 70.7% as White. Additionally, 11.9% of participants were born outside the U.S., with origins from the Marshall Islands, the Democratic Republic of Congo, Burma, Mexico, and Bosnia. The survey also captured perspectives from different parts of our region, with 31.5% of respondents living in rural areas outside of Waterloo and Cedar Falls. ZIP codes from Fayette, Bremer, Buchanan, and Grundy Counties were among the locations outside of BHC represented.

The first question on the survey asked how people felt about the health of their community over the past five years. More than half, 56.8%, said they believed their community had become less healthy. This was a significant jump from 2019 when 39.8% felt the same way. These results suggest growing concerns about overall well-being and the need for focused improvements.

When asked about what makes a community healthy, people said access to healthcare, affordable and safe housing, and jobs and a healthy economy were the most important. This was slightly different from what people said in 2019, when access to nutritional foods ranked higher. In 2024, access to nutritional foods was still important but was fourth overall. Lower-income respondents and some foreign-born groups, especially those from Burma, the Democratic Republic of Congo, and the Marshall Islands, also pointed out that having a clean environment is important for a healthy community.

People also shared their thoughts on what the community is doing well and what needs improvement. The biggest improvements needed were affordable and safe housing, safe neighborhoods and lower crime, and jobs and a healthy economy. On the other hand, many felt the community was doing well in educational opportunities, arts and recreation, and physical activity or exercise opportunities. When looking at the data more closely, higher-income respondents were more likely to see educational opportunities and a clean environment as strengths, while lower-income respondents felt they needed improvement. Additionally, Marshallese and Burmese respondents highlighted access to transportation as one of the biggest areas that needs improvement.

Health concerns were a focus of the survey. The top three health issues for adults were mental illness, obesity, and aging or disability. When looking at the results by race and ethnicity, diabetes was the most common health concern for Black or African American, Marshallese, Burmese, and Congolese respondents.

Respondents felt the top health factors for children were too much screen time and social media use, bullying, and the lack of access to mental health services.

Overall, 85% of respondents reported receiving an annual health exam. By race, 88.6% of white, 86.9% of Black, 64.3% of Asian, 64% of Multiracial, and 61.3% of Native Hawaiian or Other Pacific Islander respondents reported having an exam. Among young adults (18–29 years), only 69.7% received an exam with rates increasing with age. Similarly, 75.4% of

respondents earning less than $30,000 received an exam, with higher rates at higher income levels. When broken down by educational attainment, 73.8% of respondents with a high school diploma or less received an exam versus 92.3% of respondents with associate or trade school, bachelor's, or advanced degree. Differences were also noted by country of birth with 60% of respondents born in the Marshall Islands and 68.8% born in Burma received an exam.

Overall, 68.4% of respondents visited the dentist regularly (1–2 times per year). By race, 74.1% of white, 58.2% of Black, 32.1% of Asian, 54% of Multiracial, and 51.5% of Native Hawaiian or Other Pacific Islander respondents reported regular dental visits. Only 59.6% of 18–29-year-olds visited the dentist, though rates increased with age. When looking at income, 46.9% of respondents with incomes lower than $30,000 went to the dentist regularly, with proportions increasing as income increased. Educational differences were also apparent: 52.7% of respondents with a high school diploma or less visited the dentist regularly compared to 81.1% of respondents with associates or trade school, bachelor's degree, or advanced degree. Additionally, 71.3% of U.S.-born respondents visited the dentist, versus 49.2% of those born outside the U.S.

Overall, the top 3 reasons that respondents didn’t receive mental health services when they could have used them were feeling ashamed or uncomfortable talking about personal issues, services are too expensive, and being unable to find a provider that they can connect with. For respondents with incomes below $30,000, the primary issues were difficulty finding a provider, and a tie among lack of transportation, no insurance coverage, and discomfort discussing personal issues. The top 3 reasons for those born outside of the U.S. were services are too expensive, no insurance coverage, and feeling ashamed or uncomfortable talking about personal issues.

Overall, 42.6% of respondents were worried that food would run out before they had money to buy more. By race, this concern was expressed by 33.4% of white, 58.3% of Black, 75% of Asian, 70.8% of Multiracial, 84.6% of Native Hawaiian or Other Pacific Islander, and 68.2% of Hispanic respondents. Among 18–29-year-olds, 56.2% were worried, with concerns diminishing with age. 74.1% of respondents with incomes lower than $30,000 were worried food would run out, with increasing proportions as income increased. Educational attainment played a role as well, with 66% of respondents with a high school diploma or less expressed this worry compared to 25.7% of respondents with associates or trade school, bachelor's degree, or advanced degree. Finally, 68.1% of respondents born outside the U.S. were concerned, compared to 39.2% of U.S.-born respondents.

Overall, 39.8% of respondents felt that the food they bought didn’t last and that they didn’t have money to buy more. This concern was reported by 30.3% of white, 59.0% of Black, 63.0% of Asian, 61.4% of Multiracial, 89.7% of Native Hawaiian or Other Pacific Islander, and 63.6% of Hispanic respondents. In the 18–29 age group, 50.7% experienced this issue, with rates declining among older respondents. 74.1% of respondents with incomes lower than $30,000 answered sometimes or often true to the same question, with increasing proportions as income increased. 63.2% of respondents with educational attainment at a high school diploma or less compared to 23.4% of respondents with associates or trade school, bachelor's degree, or advanced degree. Additionally, 68.1% of respondents born outside the U.S. felt that food didn’t last, compared to 36.4% of U.S.-born respondents.

While the community feels there are strong educational opportunities, arts and recreation, and physical activity or exercise opportunities, there are still needed improvements, including the need for more affordable safe housing, safer neighborhoods, and jobs and a healthy economy. The findings also highlight gaps that impact lower-income and immigrant communities the most, showing the need for focused solutions. More details on the survey and full results can be found in **Appendix A**.

Secondary Data Findings

Following the December 2024 meeting where the steering committee reviewed key data findings, results were organized into 10 themes. These themes also guide the structure of the sections, which are found in **Appendix B**. Each secondary data point will be described, including how it was disaggregated and any analyses for that question. When relevant, connections to the survey, CCA, and CPA are noted. Additional data will be made available in Tableau, scheduled for release in 2025.

Conclusion

This assessment identified ten main issues affecting our community: economic instability, inequitable food access, transportation challenges, behavioral health challenges, access to healthcare, housing instability, chronic disease, infectious disease, cultural and linguistic inclusivity, and health literacy. Economic instability places a heavy burden on people in the top five Social Vulnerability Index census tracts, especially in ZIP code 50703 and among Black/African American, Hispanic, and young adult residents. Inequitable food access is a problem in ZIP code 50703 and nearby areas, where many struggle to find and afford healthy food. Limited access to reliable transportation poses a challenge for Black/African American residents, immigrant and refugee communities, and individuals with low incomes, making it harder to reach work, school, and healthcare. Behavioral health challenges impact certain groups more, including Black/African Americans, people aged 18–24 and 45–54, and those with lower incomes. Healthcare access barriers, such as cost, insurance, scheduling, transportation, and language support, delay care and lead to poorer outcomes.

Housing instability and lead exposure put residents in east and central west Waterloo, particularly in ZIP codes 50703 and 50613, at greater risk of adverse health outcomes. Chronic diseases, including cancer, diabetes, and obesity, are especially common for Black/African American residents in ZIP code 50703. Infectious disease risks are increasing due to lower vaccination rates over time, along with a rise in syphilis and congenital syphilis cases. Cultural and linguistic inclusivity remains an important challenge, affecting education and community services, especially for those who need language or accessibility support. Health literacy concerns persist for individuals with lower education levels, young adults, Black/African American and Hispanic populations, and those in fair or poor health, potentially leading to worse health outcomes over time.

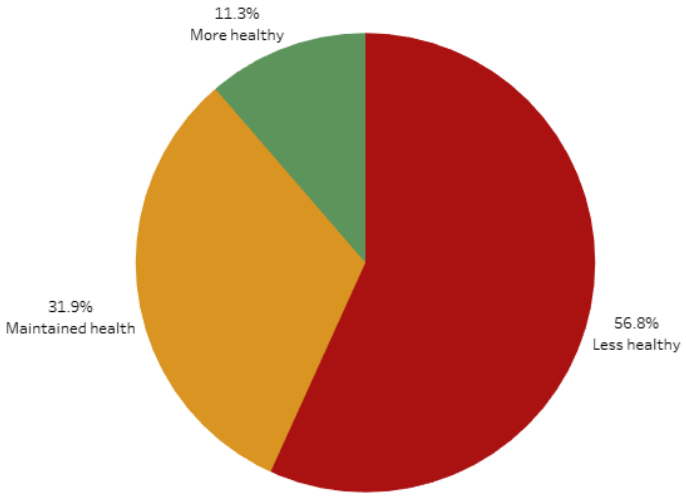
While these findings highlight urgent areas for improvement, there are some limitations. The amount of available data was large, so two epidemiologists selected what they believed to be the most important information based on selection criteria. Other analysts might have chosen different data. Whenever possible, data was broken down by specific demographics; however, if a group or sample size was too small, data was suppressed, and any breakdown of the data was limited to existing data points. Concerning the survey we conducted, the questions

sometimes allowed for subjective interpretations, though vague options were reduced when possible. Finally, most of our responses were filled out electronically, so it may not have reached everyone equally. However, we made it a priority to work with community leaders and organizations to engage historically underrepresented voices.

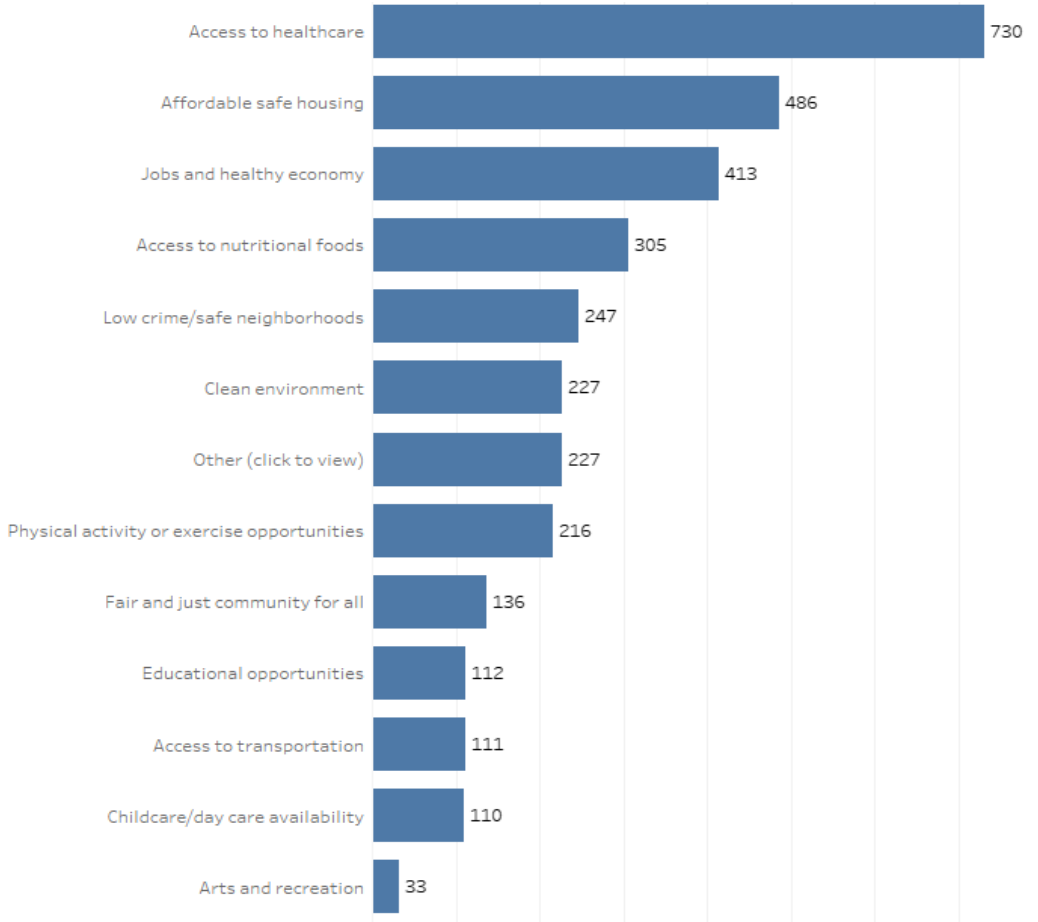
By understanding these ten issues and their impact on different groups, we hope this information guides efforts toward targeted, inclusive strategies that support the health and well-being of all community members.

Appendix A

1. Over the last 5 years, do you feel people in the community are:



2. What are the three (3) most important factors for a healthy thriving community? (Select up to three (3) boxes)



3. For each factor listed below, are we as a community doing a good job or do we need to improve? (Select one (1) of the boxes below for each row)

Factor	High Importance	Good Job	Most in Need of Improvement
Access to healthcare	68%	44%	49%
Affordable safe housing	45%	14%	77%
Jobs and healthy economy	39%	25%	69%
Access to nutritional foods	29%	38%	58%
Low crime/safe neighborhoods	23%	23%	70%
Clean environment	22%	38%	56%
Fair and just community	13%	29%	61%
Access to transportation	11%	30%	61%
Childcare	10%	19%	62%
Arts and recreation	3%	52%	32%
Educational opportunities	11%	53%	39%
Physical activity or exercise opportunities	11%	51%	42%

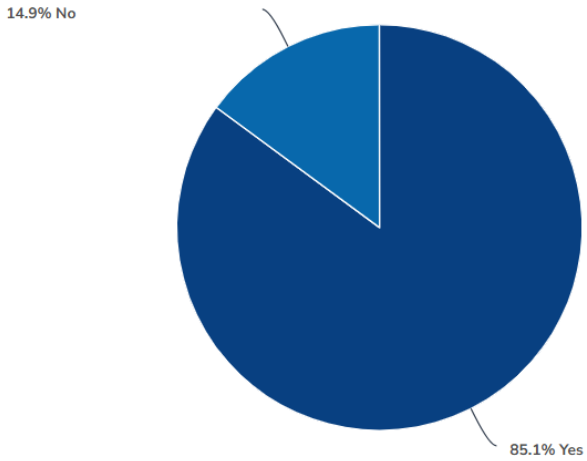
4. What do you feel are the top three (3) health problems for adults in the community? (Select up to three (3) boxes below)

Mental illness	54.4%	
Obesity	48.3%	
Aging or disability (arthritis, hearing/vision loss, dementia, etc.)	41.5%	
Diabetes	38.1%	
Substance use disorder/substance abuse	33.9%	
Cancer	29.2%	
Heart disease/stroke	25.0%	
Sexually transmitted infection	8.3%	
Injuries (falls, car accidents, drowning, violence)	8.0%	
Infectious disease	4.0%	
Other (click to view)	2.6%	

5. What are the top three (3) factors affecting children's health? (Select up to three (3) boxes below)

Screen time/social media	47.3%	
Bullying	38.8%	
Access to mental health or substance use disorder services	37.3%	
Supportive family environment	33.4%	
Access to nutritional foods	29.8%	
Access to healthcare	23.6%	
Safe living environment	22.3%	
Access to dental care	19.7%	
Substance abuse	15.3%	
Physical activity opportunities	12.9%	
Sexual behavior	7.5%	
Educational opportunities	5.6%	

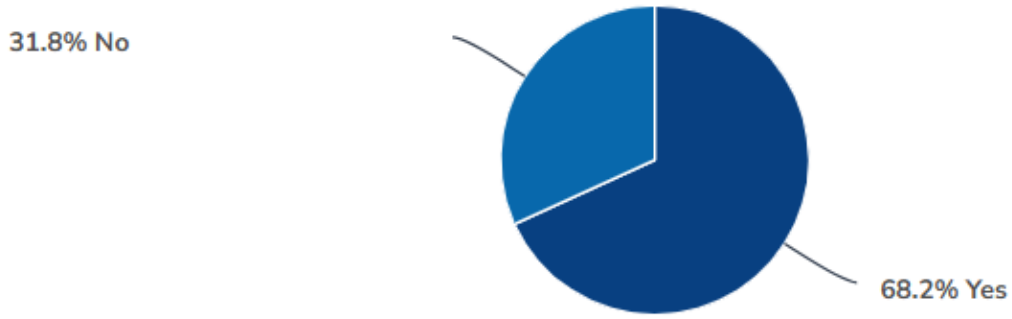
6. Do you receive an annual health exam (check-up/physical)?



7. If no, why? (Select all that apply)

Can't get an appointment for a time that works best for you	18.5%	
Don't feel you need an annual health exam	28.8%	
Cost	33.6%	
Transportation	15.8%	
Childcare	8.2%	
Interpreter services	5.5%	
Other (click to view)	16.4%	

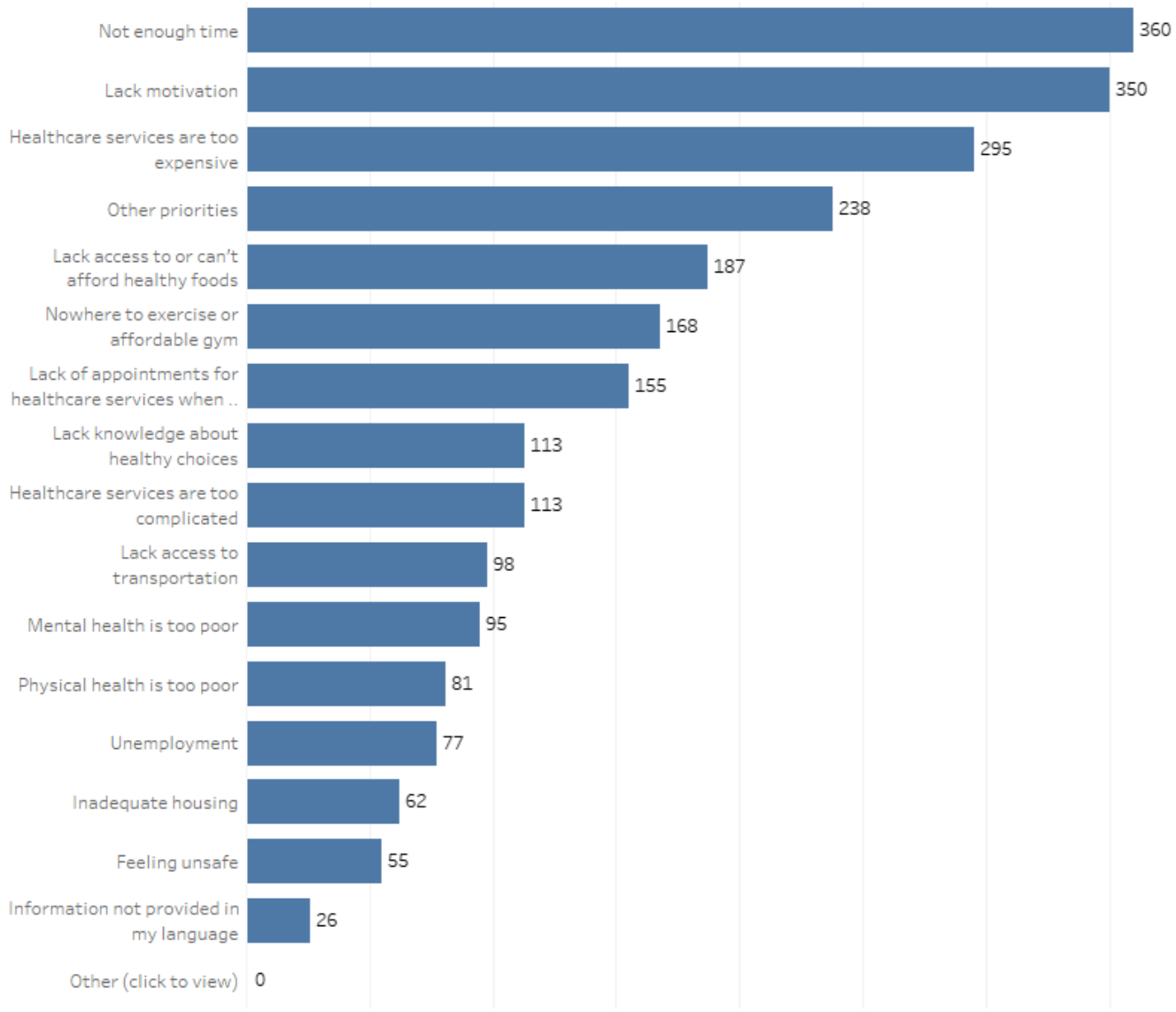
8. Do you visit the dentist regularly (1-2 times per year)?



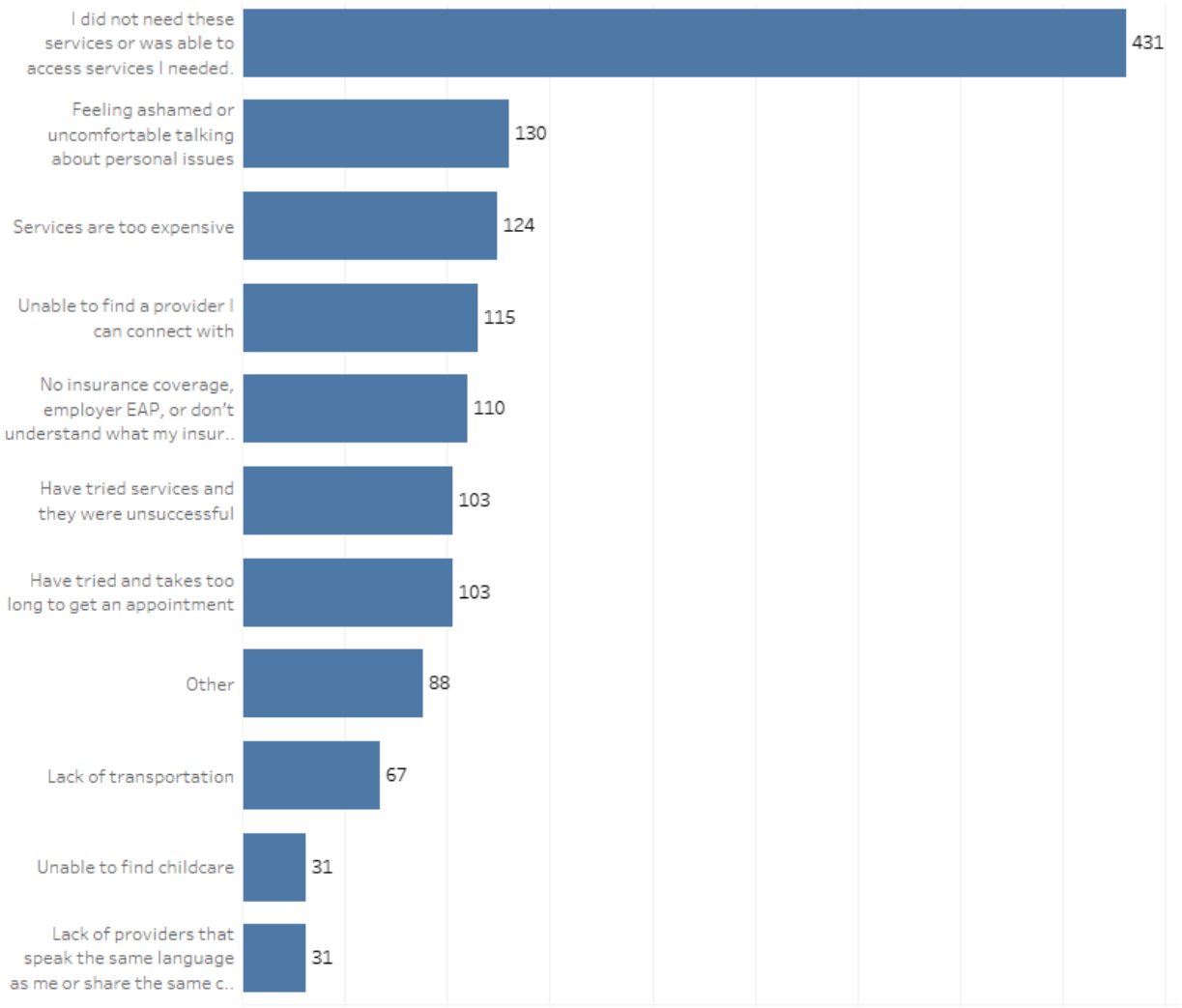
9. If no, why? (Select all that apply)

Can't get an appointment for a time that works best for you	18.7%	
Don't feel that you need to visit the dentist regularly	10.4%	
Cost	41.8%	
Transportation	10.1%	
Childcare	3.5%	
Interpreter services	3.5%	
Don't have dental insurance	27.5%	
Other (click to view)	22.8%	

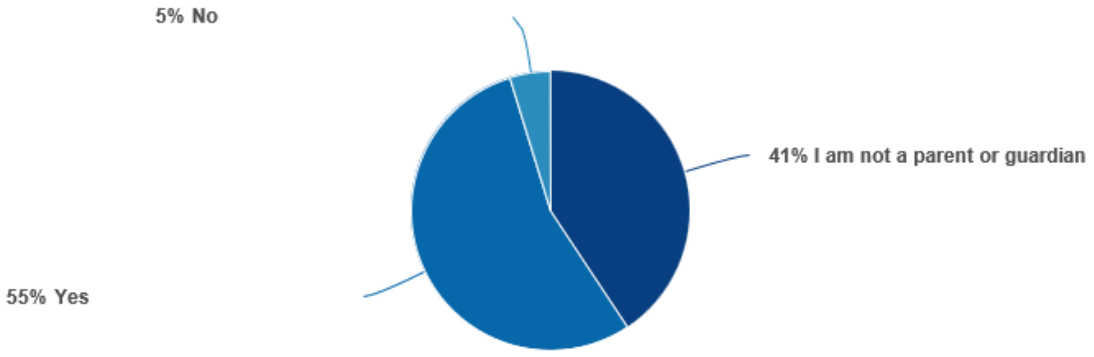
10. What prevents you from being healthier? (Select all that apply)



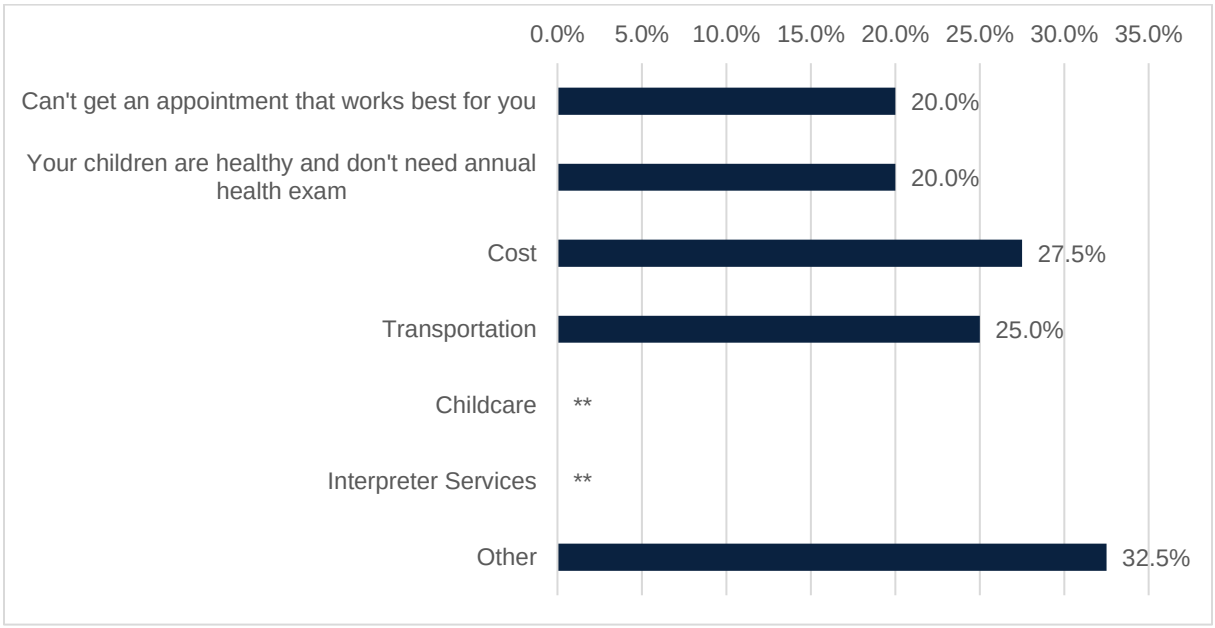
11. If you feel you could benefit from mental health or substance use disorder services but are not currently receiving them, please select your reason(s) for not accessing those services.



12. If you are a parent or guardian, do your children receive an annual health exam (check-up/physical/well child visit)?



13. If no, why? (Select all that apply)



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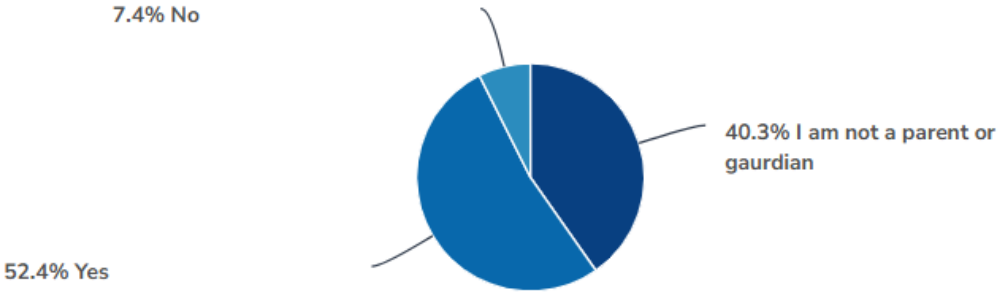
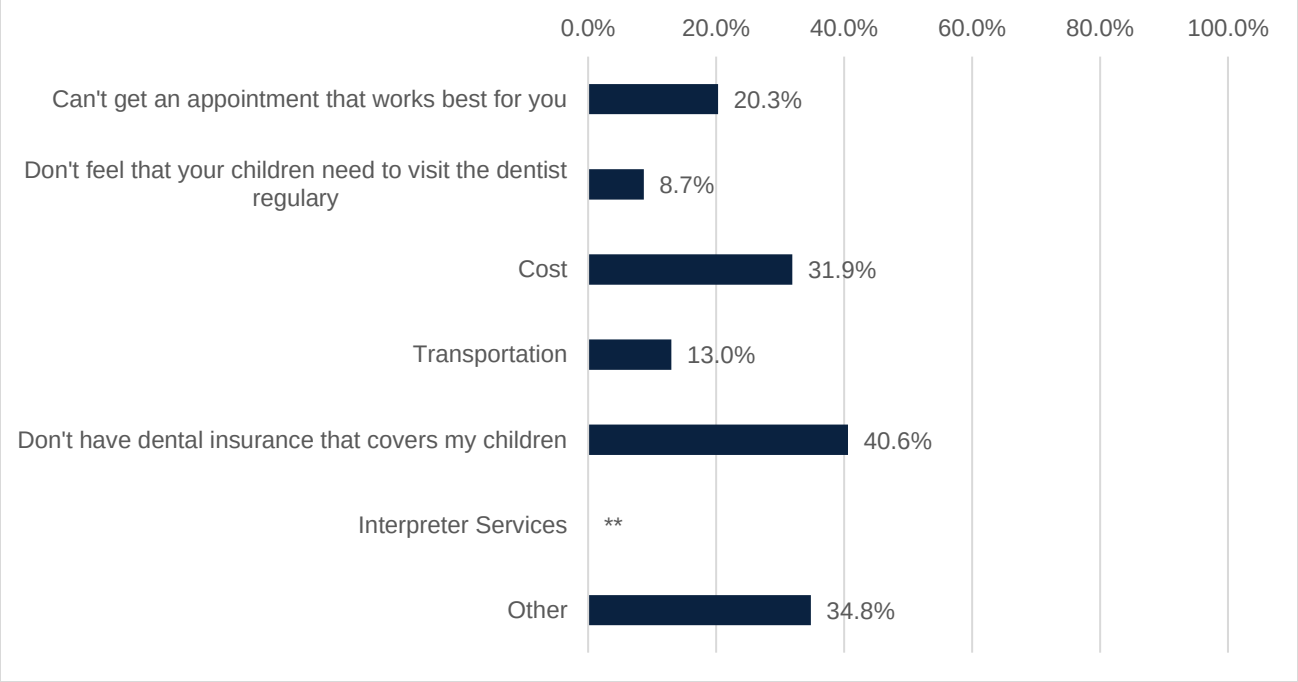
14. If you are a parent or guardian, do your children visit the dentist regularly (1-2 times per year)?



15. If no, why? (Select all that apply)



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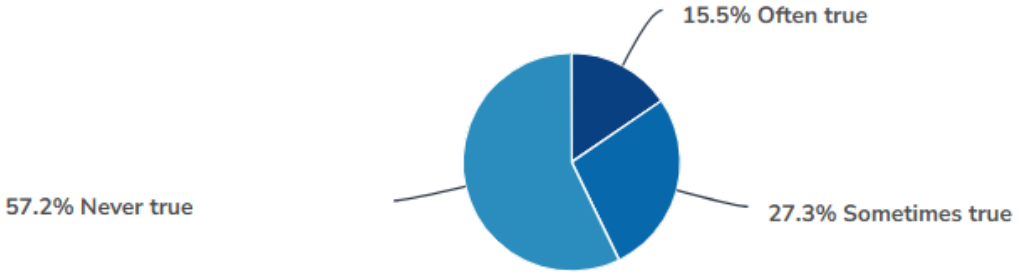
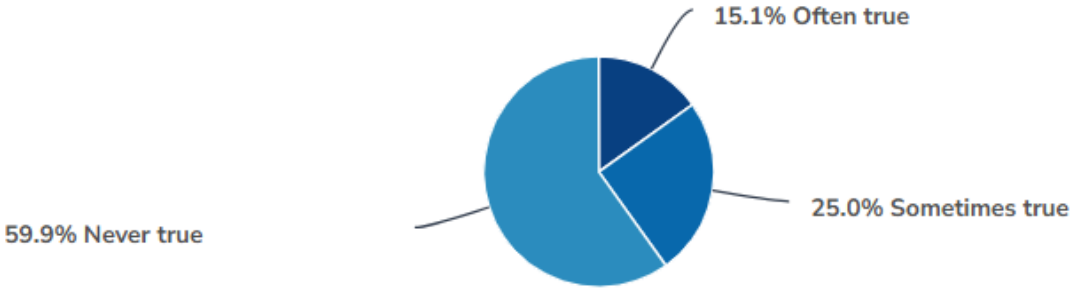
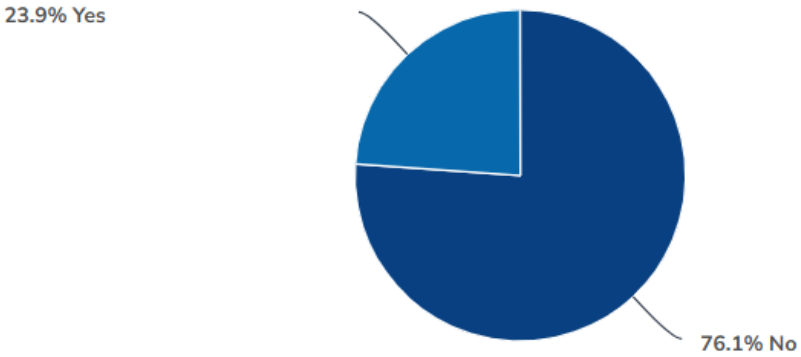
16. Within the past 12 months, you worried that your food would run out before you got money to buy more.



17. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.



18. Do you receive services from local agencies?



19. Select all the services that apply to you:

SNAP (food stamps)	66.4%	
Food assistance (pantry, community meals)	34.9%	
Free or reduced-cost health care services	24.5%	
WIC	23.7%	
Utility assistance	15.4%	
Housing assistance (rental or shelter)	13.7%	
Childcare assistance	9.1%	
Other (click to view)	6.6%	
Youth programming assistance (eg. Boys and Girls Club)	3.3%	
General financial assistance	3.3%	
Parent education services	2.5%	

20. If you were in need of assistance from local agencies but didn't receive any, was there a reason? (Select all that apply)

I wasn't in need of assistance	56.3%	
They don't offer hours that are convenient to me	4.8%	
Information is not provided in my language	2.5%	
Transportation	7.5%	
Childcare	2.7%	
Interpreter services	3.4%	
My needs exceed the maximum amount of assistance	7.7%	
I don't meet eligibility criteria for assistance	27.4%	
Other (click to view)	9.4%	

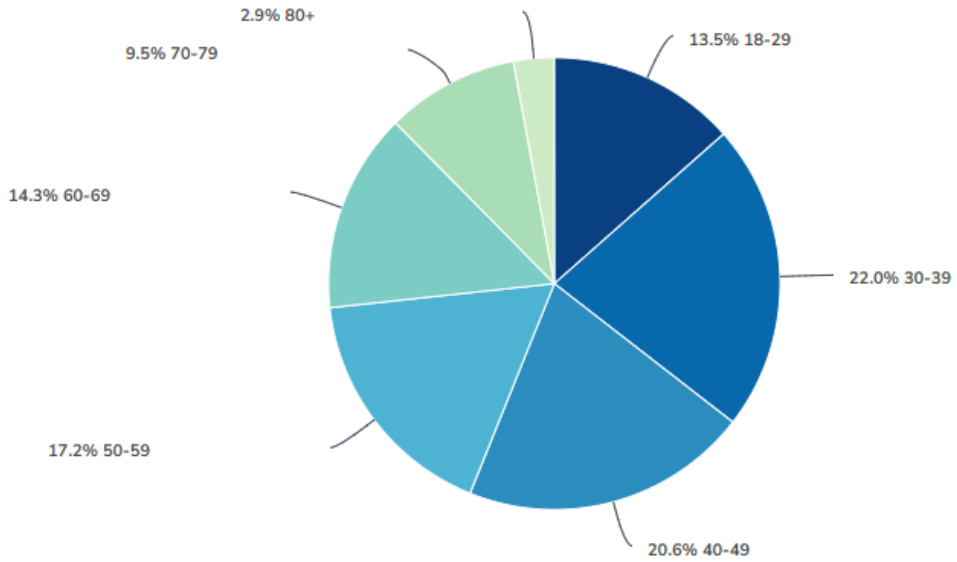
21. Who do you trust for health information? (Select all that apply)

Doctor or other health professional	89.3%	
Public Health Department	36.9%	
Television or newspaper	5.1%	
Social media	4.1%	
Internet	11.3%	
Family or friends	26.4%	
Other (click to view)	6.5%	

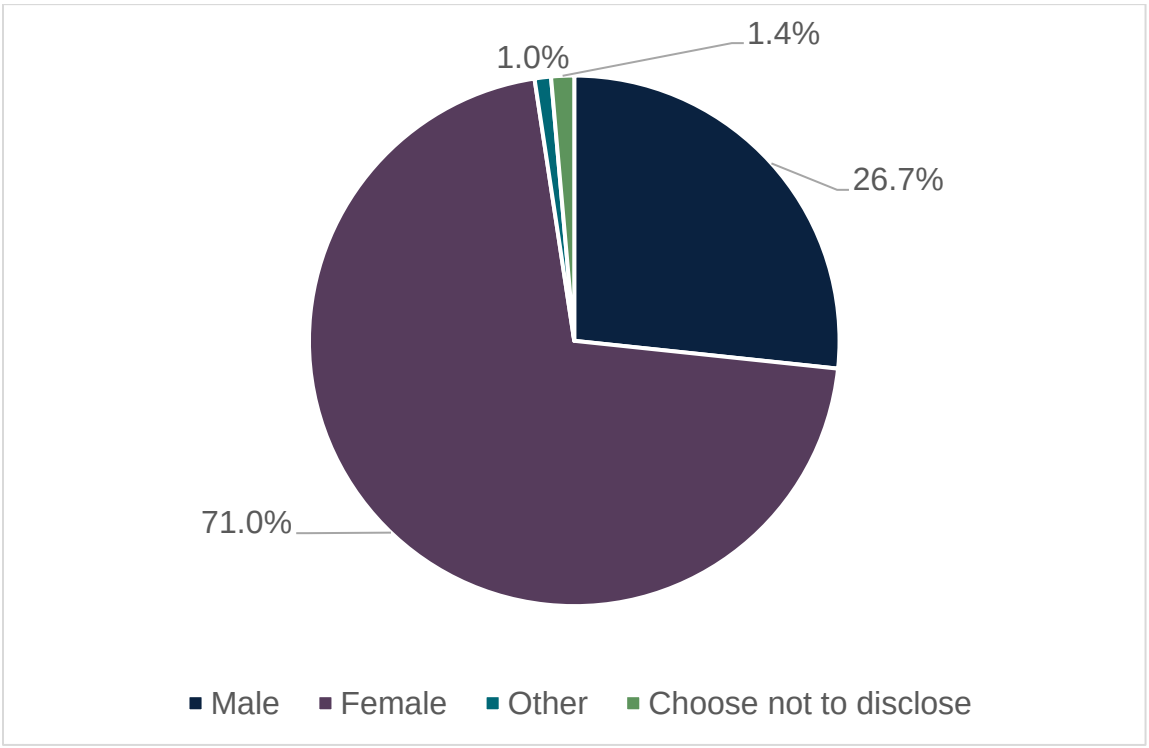
22. Which of the following emergency preparedness statements are true for you/your family? (Select all that apply)

My family has a cell phone with a charger	90.9%	
My family has a first aid kit	66.0%	
My family has signed up to obtain real-time alerts warning for disasters	46.7%	
My family has made a contact list for emergencies (kids know how to call another family member and how to use 911)	42.7%	
My family keeps a supply of bottled water and extra nonperishable food items on hand	41.4%	
My family has a weather radio, flashlight, and batteries in our home	40.7%	
My family keeps a list of current medications and important paperwork for each family member	31.5%	
My family has practiced a tornado drill at home	27.6%	
My family has discussed a central meeting place	26.0%	
My family has practiced a fire drill at home	21.0%	

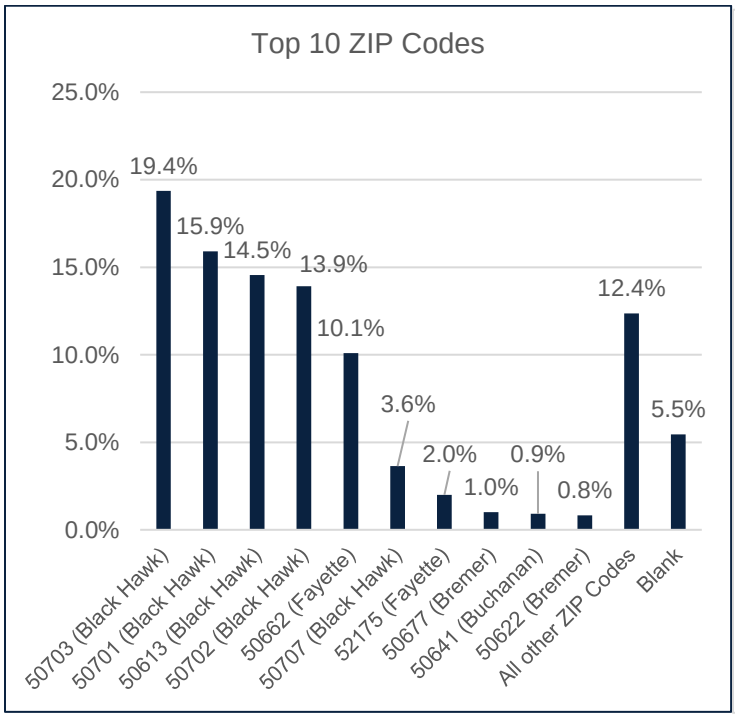
23. Age

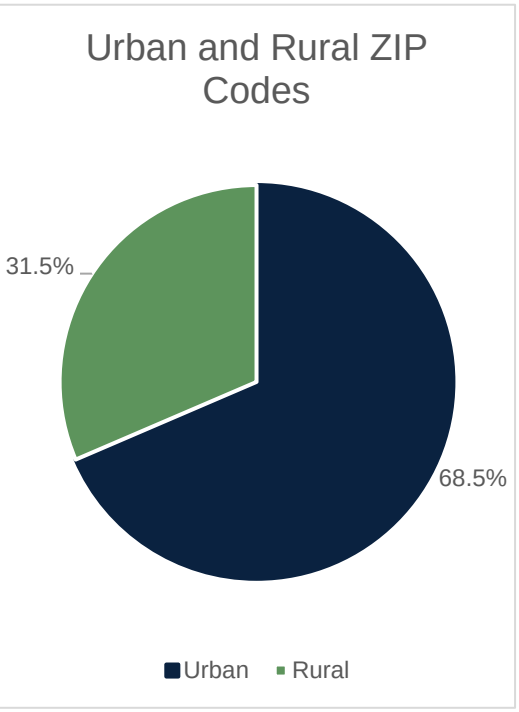


24. Gender (note: Other includes transgender male, transgender female, gender variant/nonconforming, and other – please specify to maintain confidentiality)

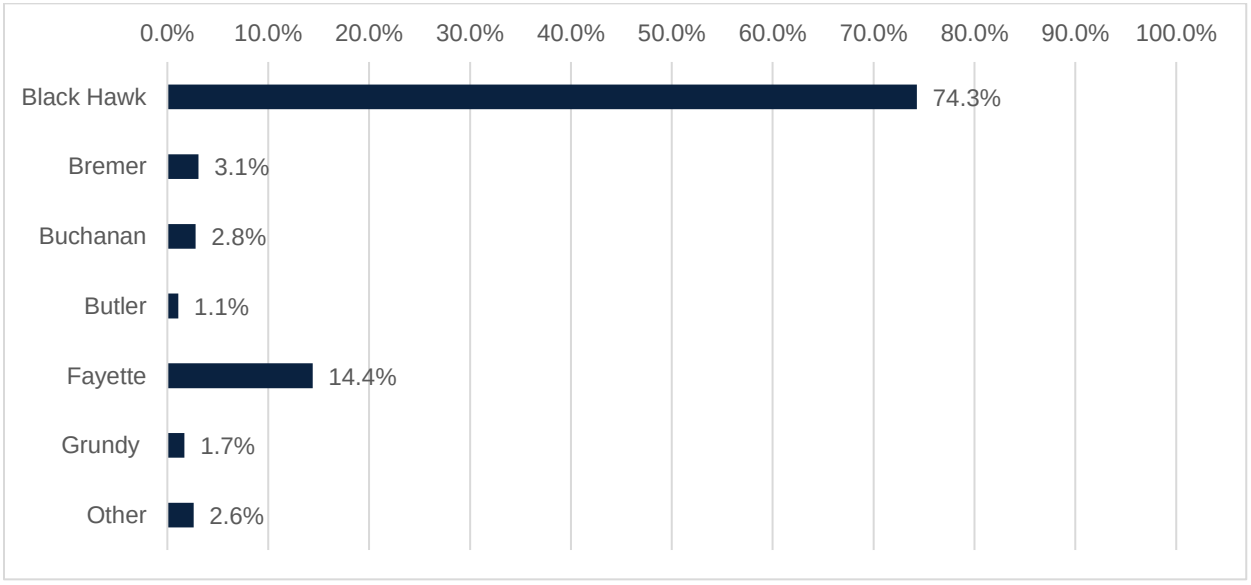


25. ZIP Code





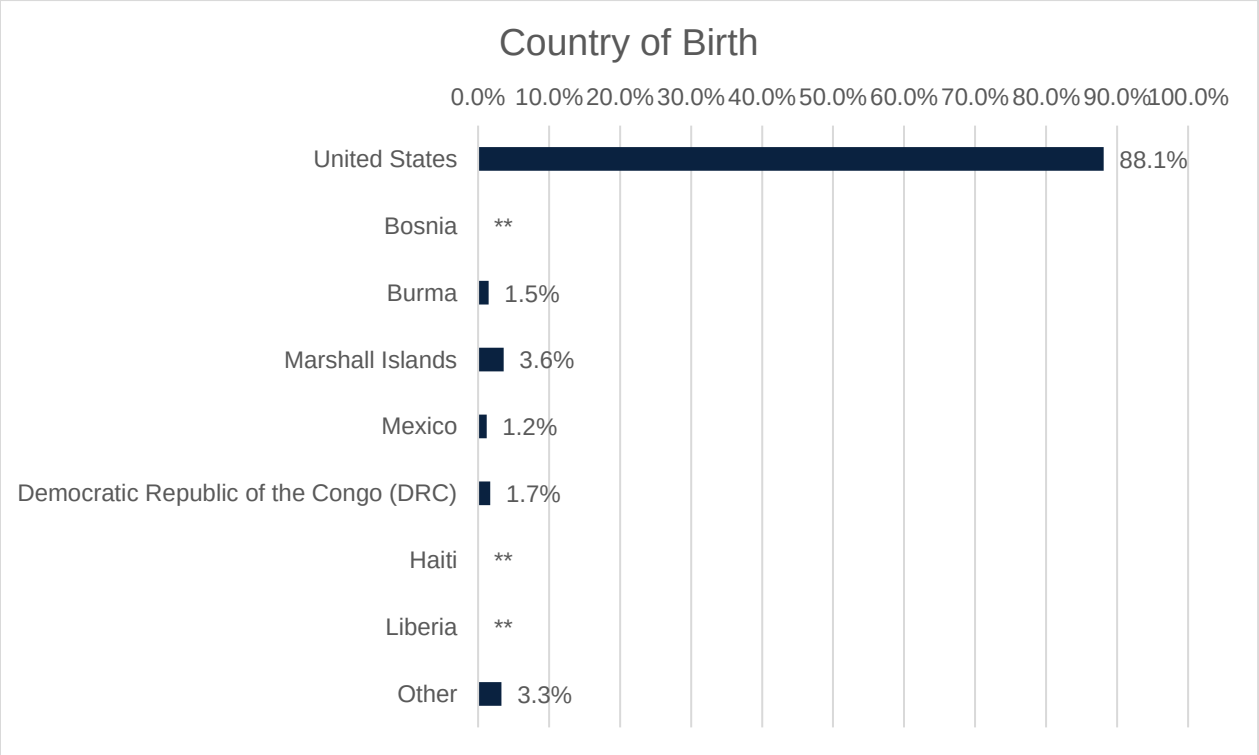
26. County of Residence



27. Race/Ethnicity (select all that apply)

American Indian or Alaskan Native	1.9%
Asian	3.2%
Black or African American	18.4%
Hispanic or Latino	4.2%
Native Hawaiian or Other Pacific Islander	3.7%
White	70.7%
Other (click to view)	2.0%

28. Country of Birth



**Data suppressed if percentage represents value less than 6 to maintain confidentiality.

29. Education

Less than 8th grade	2.3%	
Some high school, no diploma	5.6%	
High school graduate	16.2%	
High school equivalent (GED)	6.1%	
Some college, no degree	16.4%	
Associate's degree or trade/technical school training or certificate	16.5%	
Bachelor's degree	20.9%	
Advanced degree	15.9%	

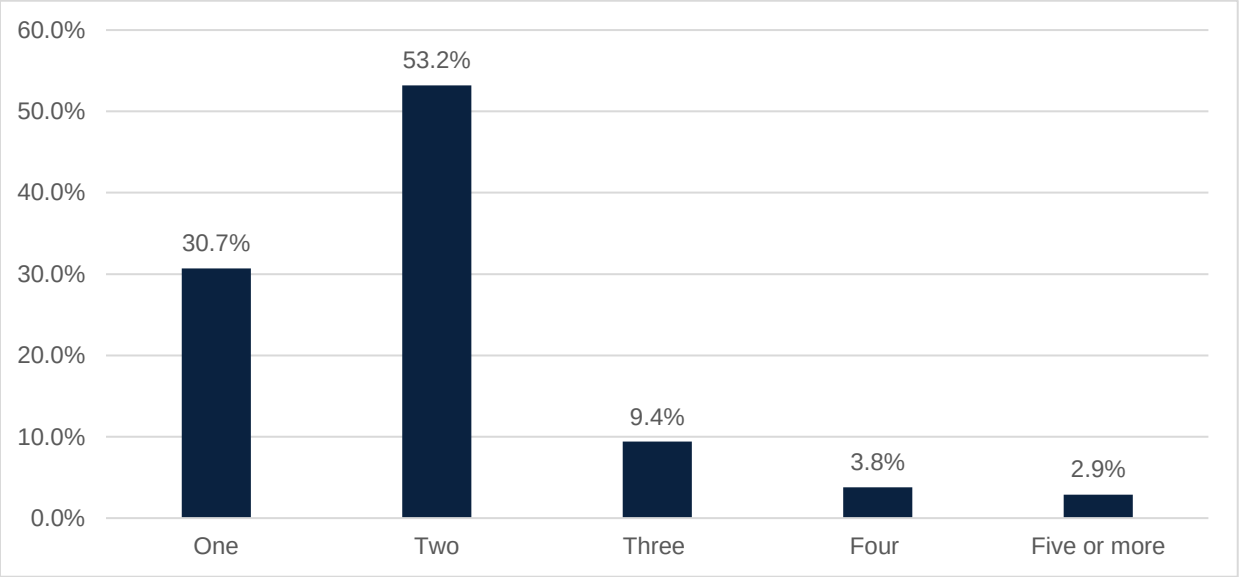
30. Health insurance status (select all that apply)

Insurance through a current or former employer (of yourself or family member)	55.7%	
Insurance purchased directly from an insurance company (by yourself or family member)	4.6%	
Insurance purchased from the Marketplace (by yourself or family member)	2.6%	
I am covered by Medicaid (Iowa Total Care, Molina, Wellpoint)	18.9%	
I am covered by Medicare	17.7%	
VA health care	2.3%	
I am not covered by health insurance	7.6%	
One or more of my children are not covered by health insurance	0.8%	

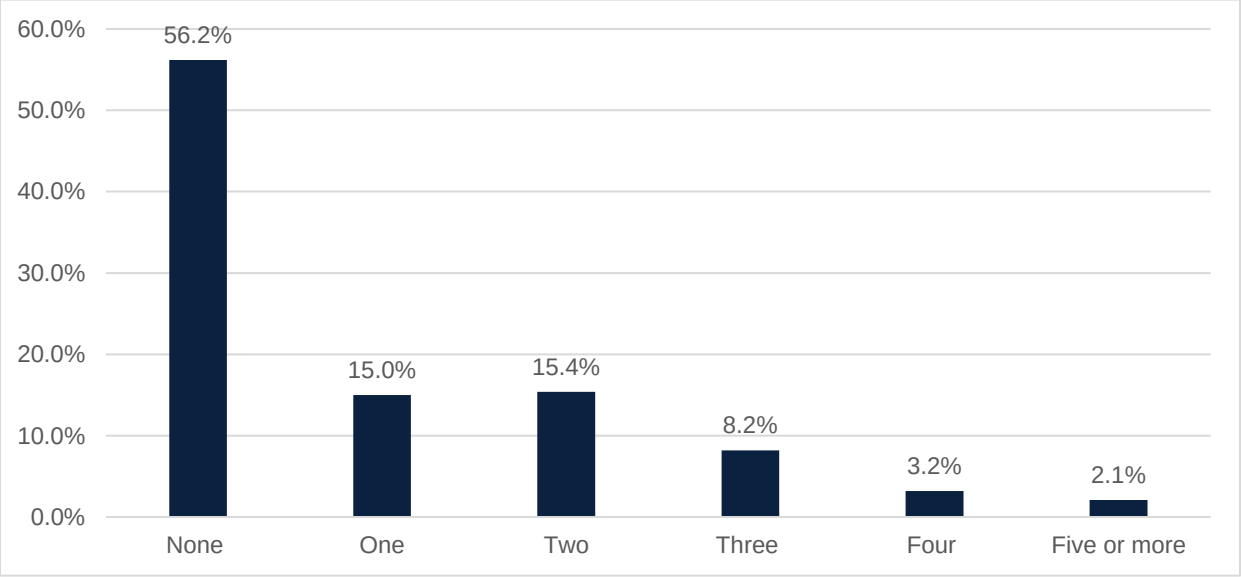
31. How well do you understand the benefits offered under your health insurance plan?

Very Well (5)	4	3	2	Not at All (1)
298 30.8%	294 30.4%	220 22.8%	109 11.3%	45 4.7%

32. Number of adults in home including yourself



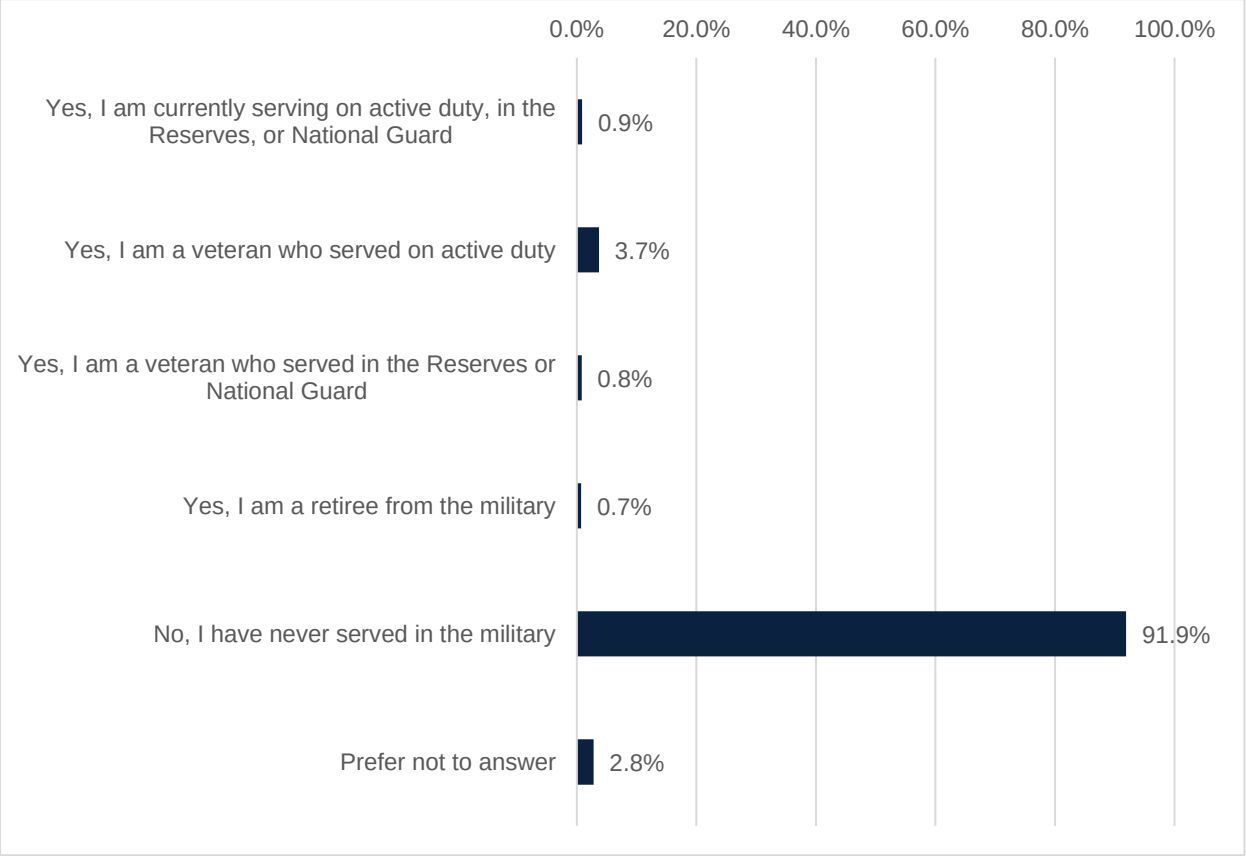
33. Number of children in home



34. What is your family's gross annual income before taxes?

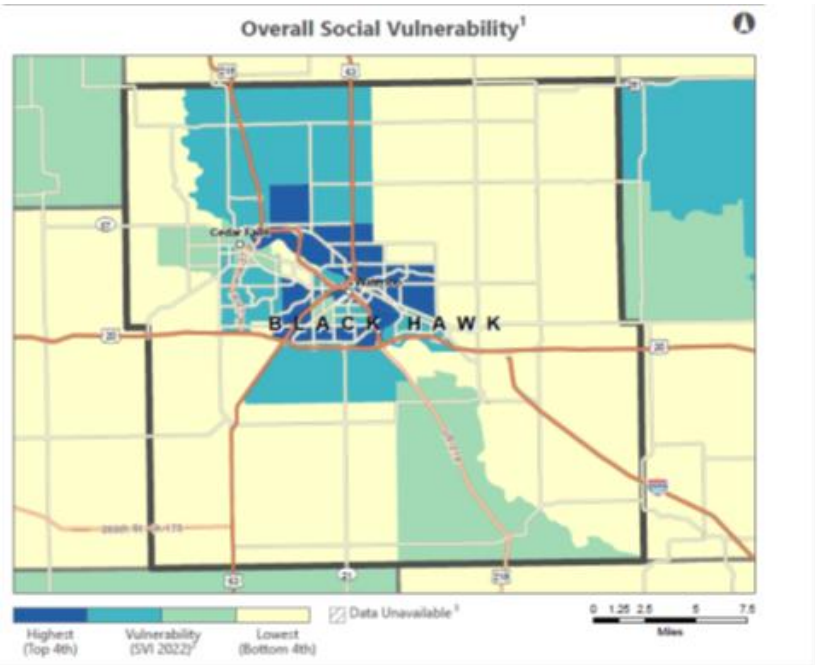
Under $15,000	17.6%
Between $15,000 and $29,999	12.4%
Between $30,000 and $49,999	16.1%
Between $50,000 and $74,999	16.2%
Between $75,000 and $99,999	13.0%
Between $100,000 and $149,000	15.2%
More than $150,000	9.5%

35. Veteran/military status (select all that apply) (note: Yes, I am currently serving on active duty and Yes, I am currently serving in the Reserves or National Guard were combined to maintain confidentiality)

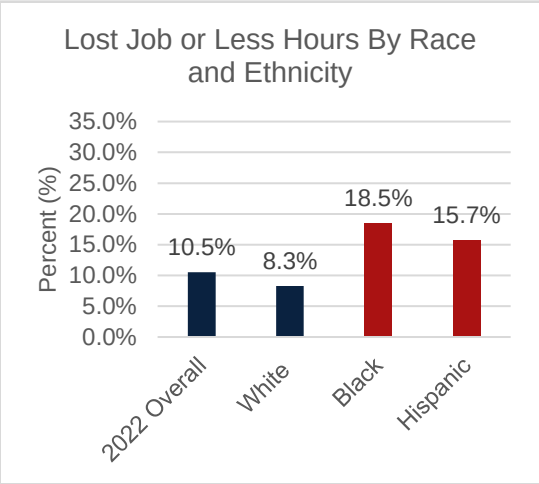


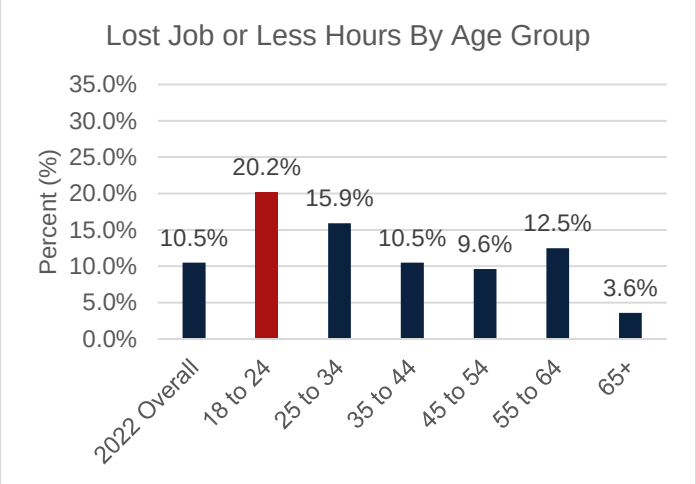
Appendix B

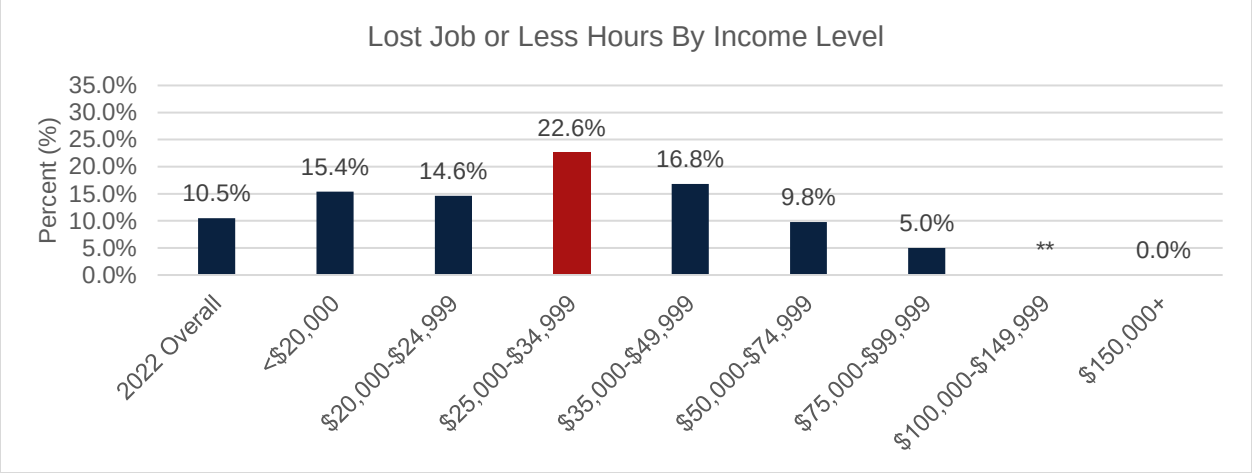
Economic Stability



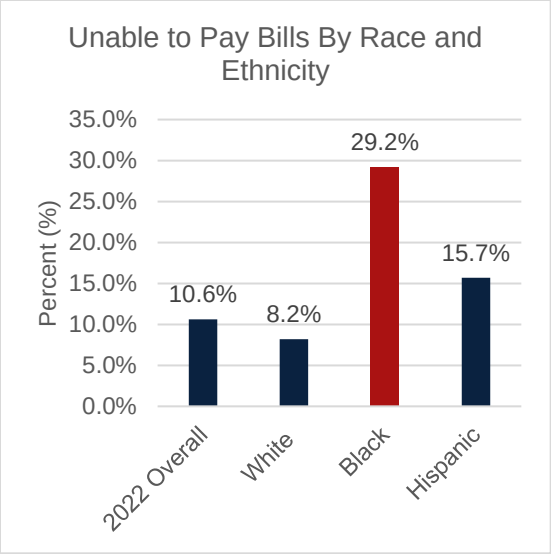
The Social Vulnerability Index measures how well communities can prepare for and respond to disasters and considers factors that affect a community's ability to recover. It focuses on four categories: socioeconomic status, household characteristics, racial and ethnic minority status, and housing type and transportation. In the map, darker colors indicate areas with higher social vulnerability.

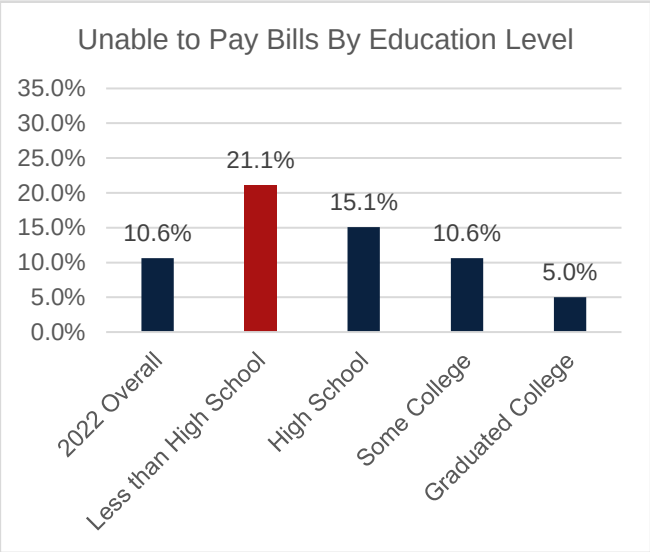


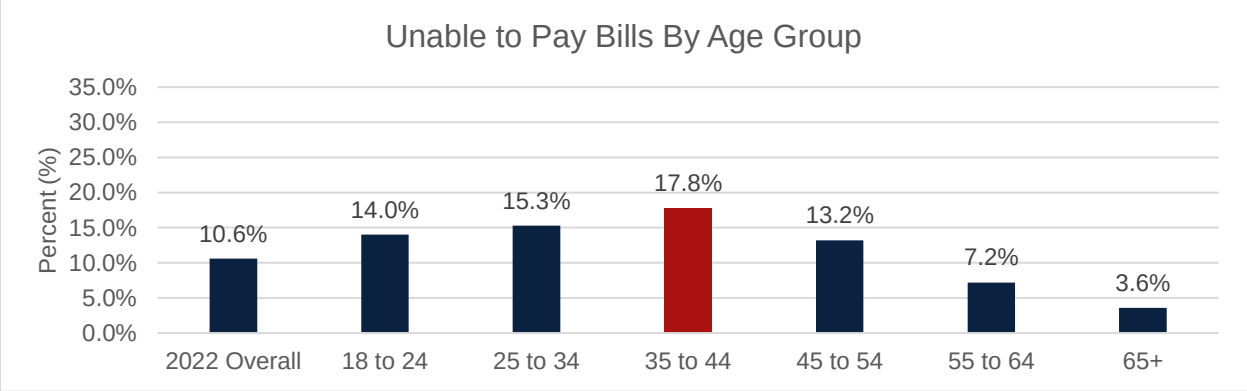


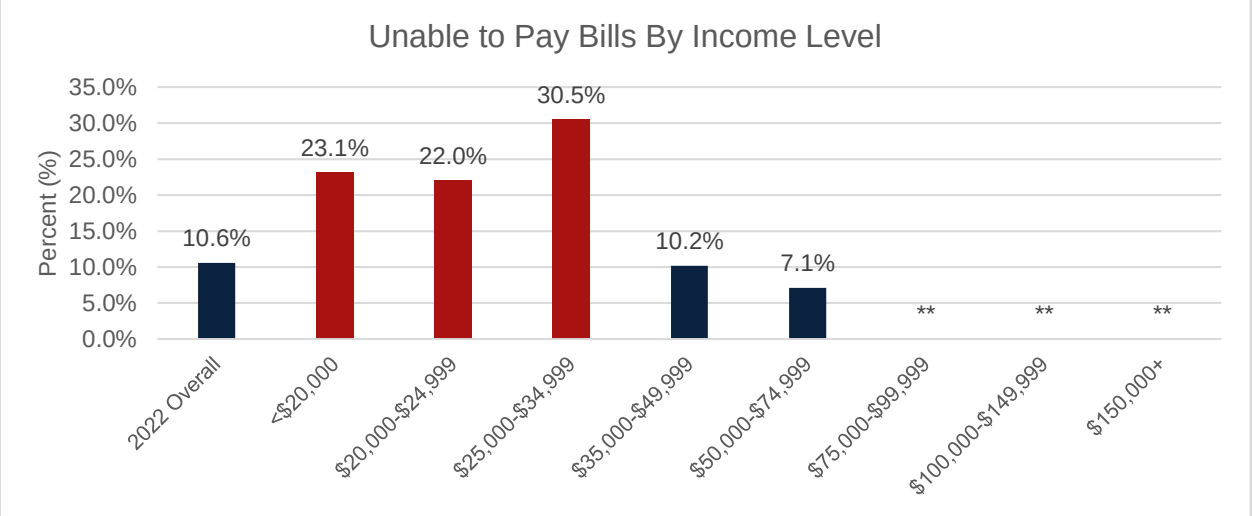


Data from the Behavioral Risk Factor Surveillance System (BRFSS) is shown above for a question about job loss or reduced work hours in the past 12 months. The figures shown reflect those who answered “Yes” and are broken down by race/ethnicity, age group, and income level. The results highlight disparities among Black and Hispanic respondents, individuals aged 18-34, and those with lower incomes. The highest proportion of job or hour reductions is within the $25,000-$34,999 income range; however, any household income under $50,000 exceeds the overall average of 10.5%.

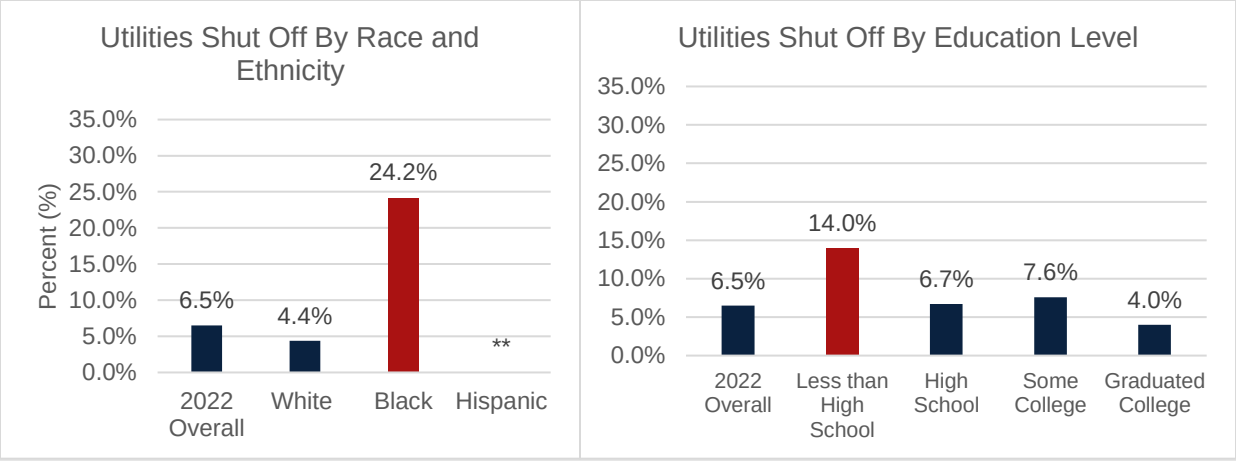


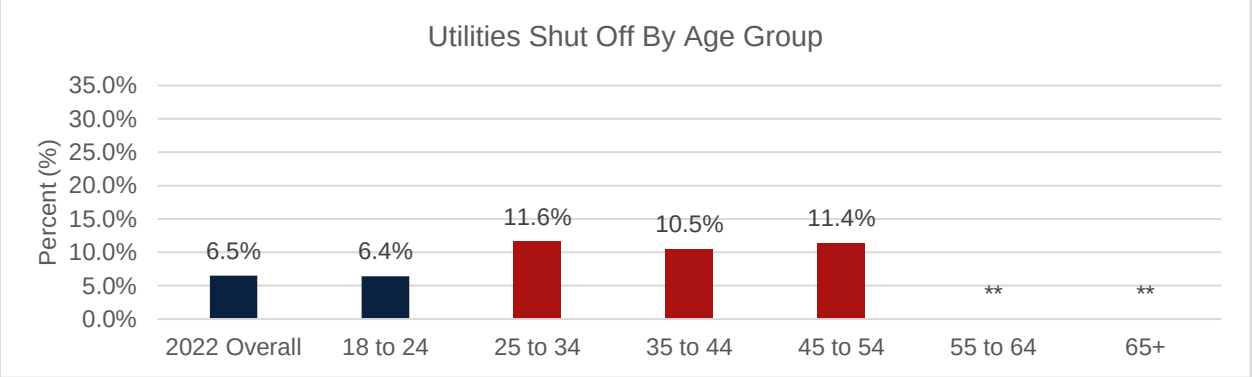


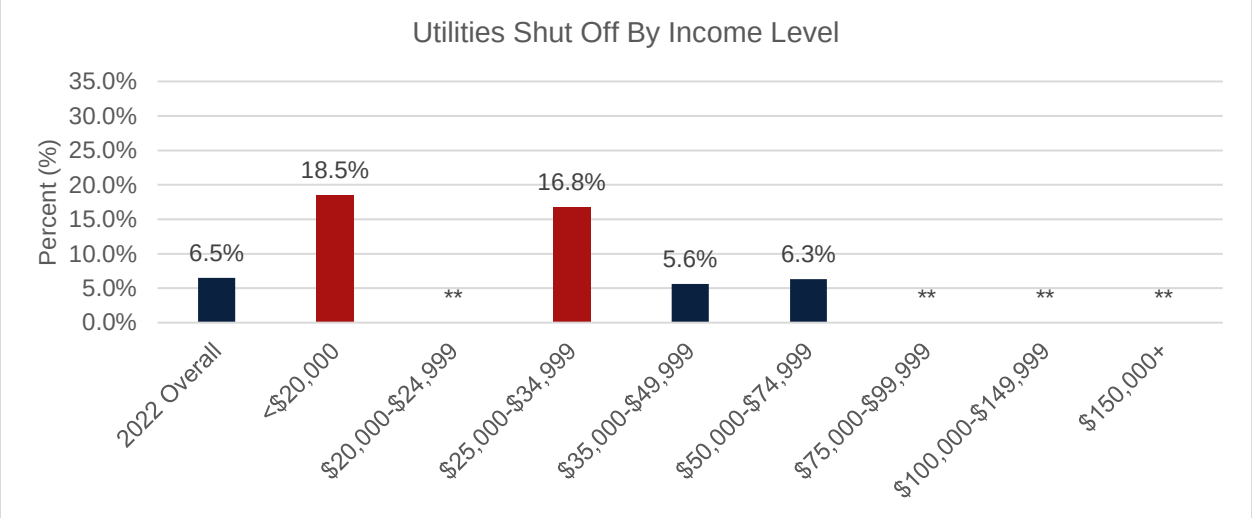




BRFSS respondents were asked if they were unable to pay their bills in the last 12 months. Results are shown for individuals who answered “Yes” to that question. Data was disaggregated by race and ethnicity, age group, income level, and education for each question. Black or African American individuals, income levels less than $34,999, those with less than a high school education, and those ages 18 to 54 were the groups showing disparities.

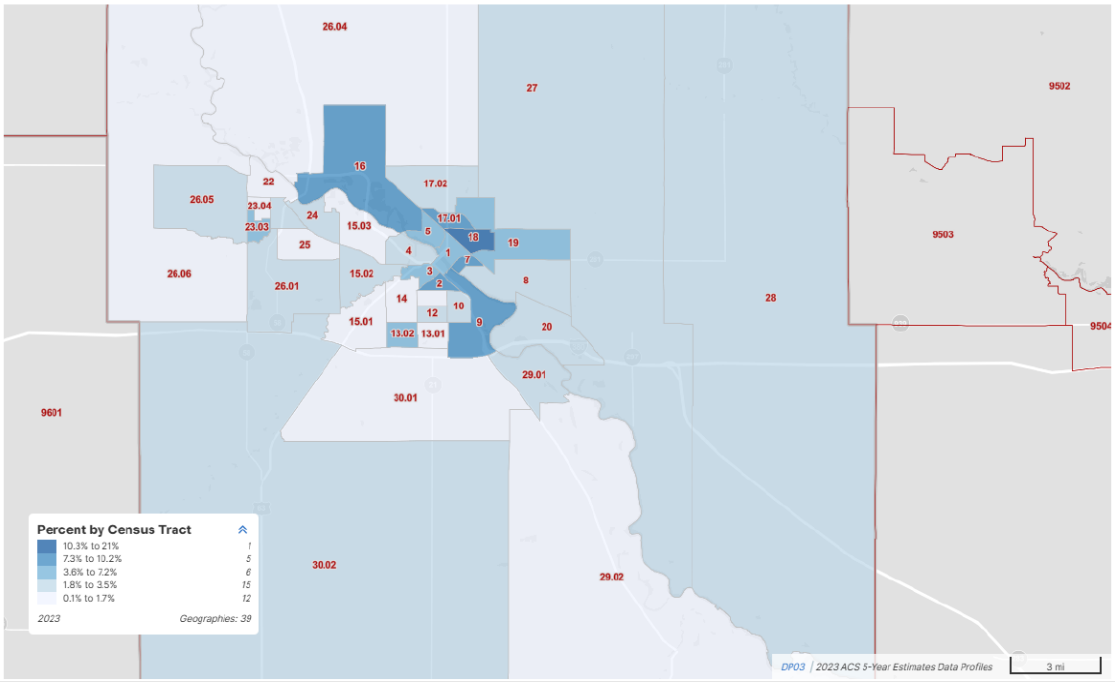




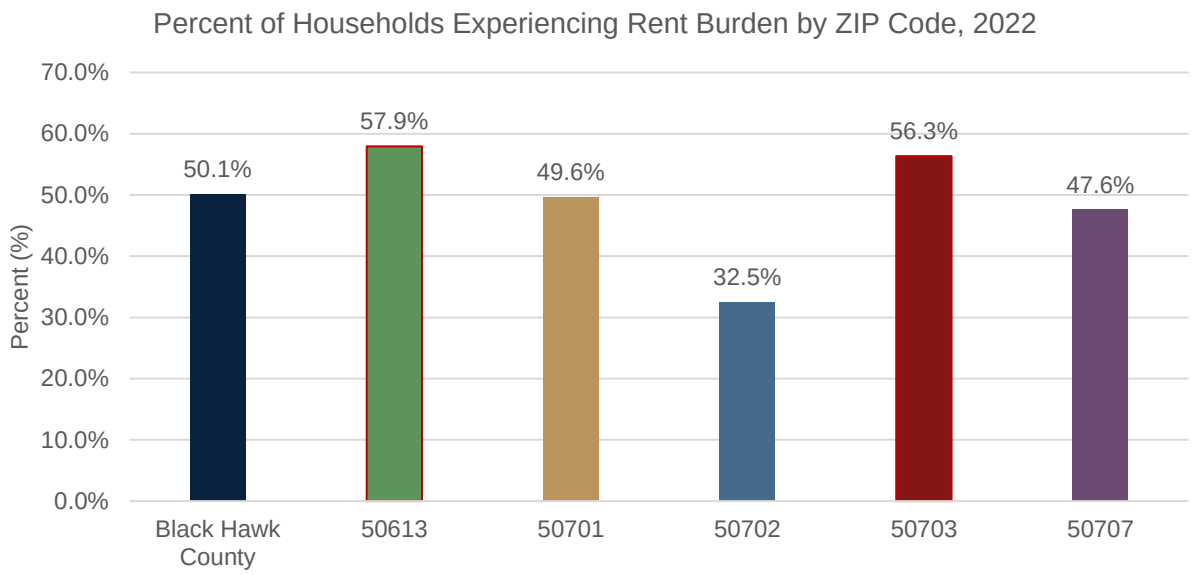


BRFSS respondents were also asked if their utilities were shut off in the last 12 months. Results are shown for individuals who answered “Yes” to that question. Data was disaggregated by the same groups as the question regarding being unable to pay the bills. The results were similar to those from the previous question, with Black or African American individuals, income levels less than $34,999, and those with less than a high school education showing disparities. The age groups affected had some slight differences with 25- to 54-year-olds more likely to have their utilities shut off.

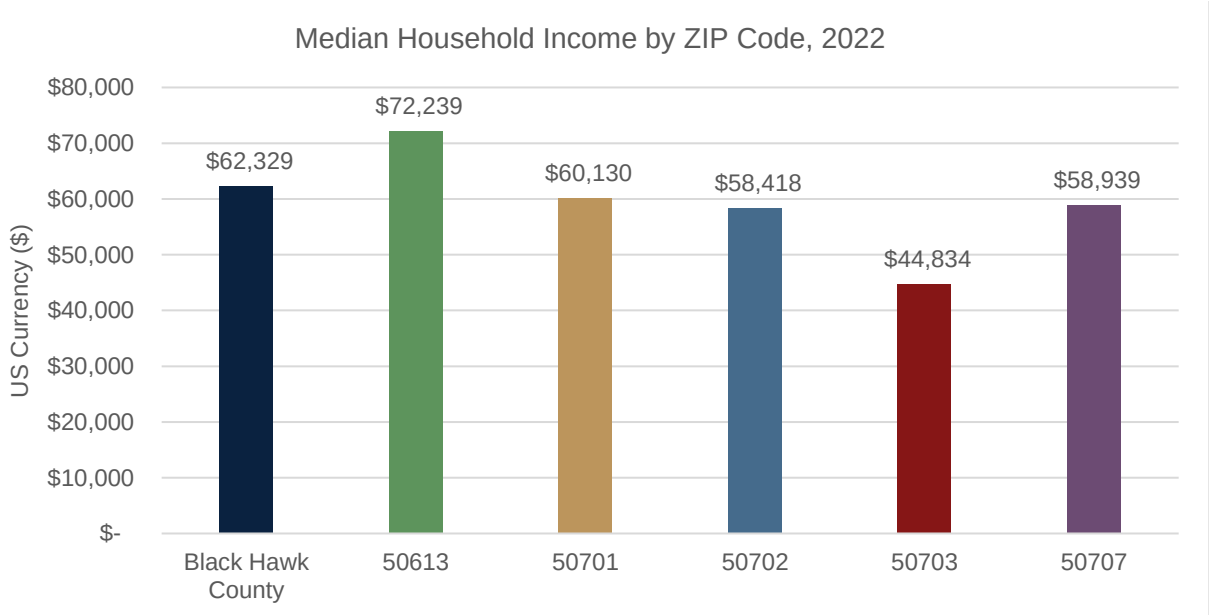
Unemployed - Civilian labor force | In labor force | Population 16 years and over | EMPLOYMENT STATUS



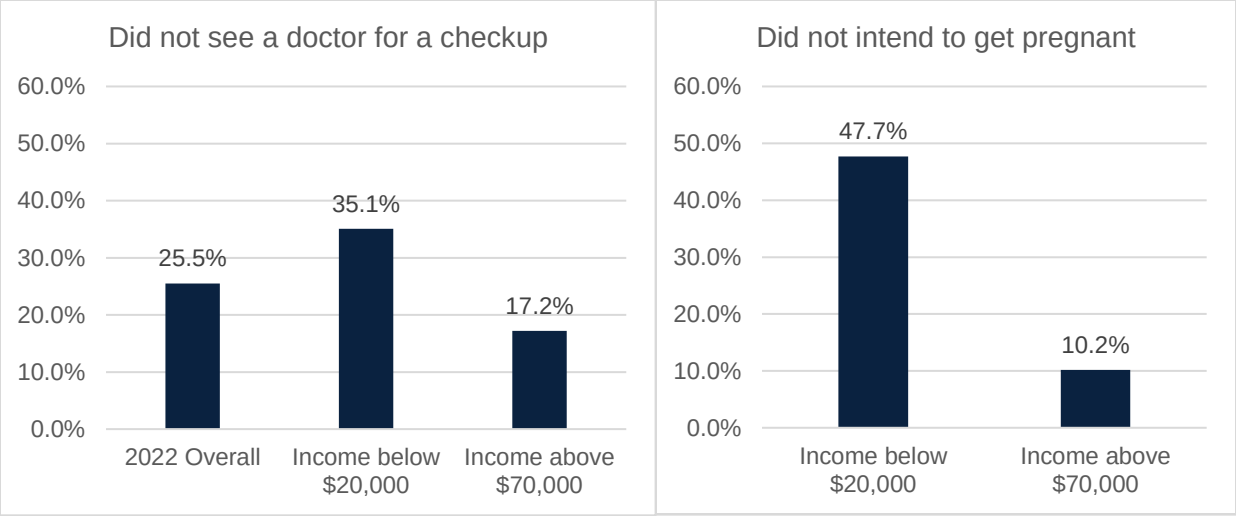
The map above displays Census data for individuals who are unemployed within the labor force, organized by census tract. Tracts 18 (21%), 9 (10.2%), 16 (9.9%), 17.01 (9.3%), 2 (9.2%), and 7 (9.2%) show the highest unemployment levels. Most of these tracts are in eastern, southern, and northern Waterloo.



Rent burden is defined as spending 30% or more of household income on rent. According to five-year Census data for 2022, ZIP codes 50703 and 50613 have the highest rates of rent burden in the county. Overall, most ZIP codes experienced an increase in rent burden from 2021 to 2022, except for 50703. Despite a slight decrease, 50703 remains considerably high.

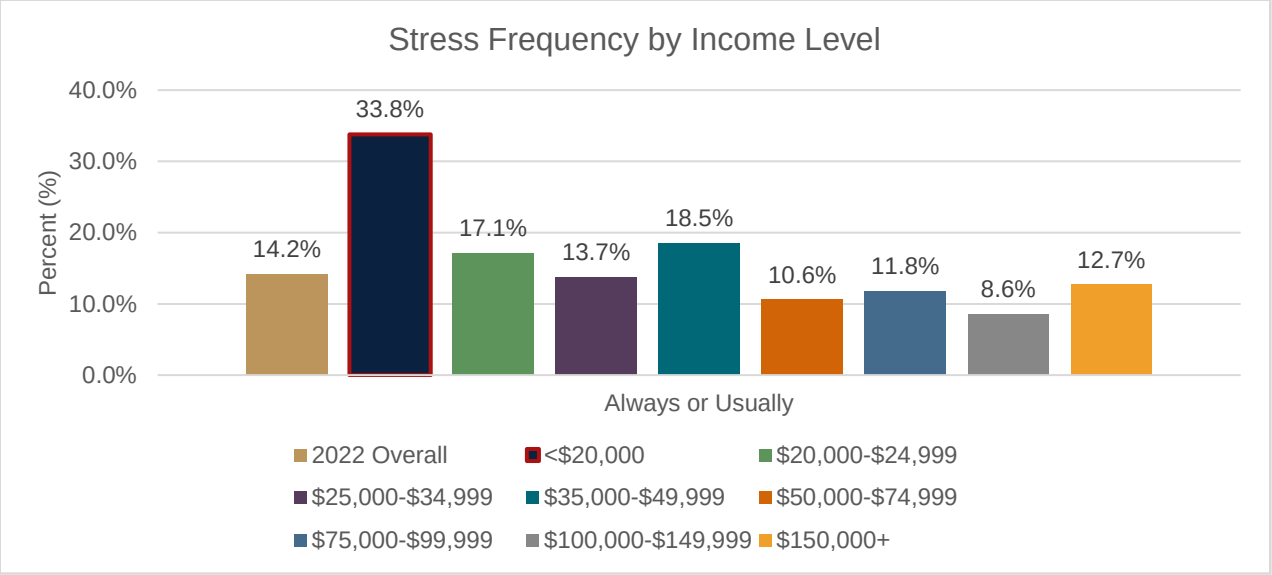


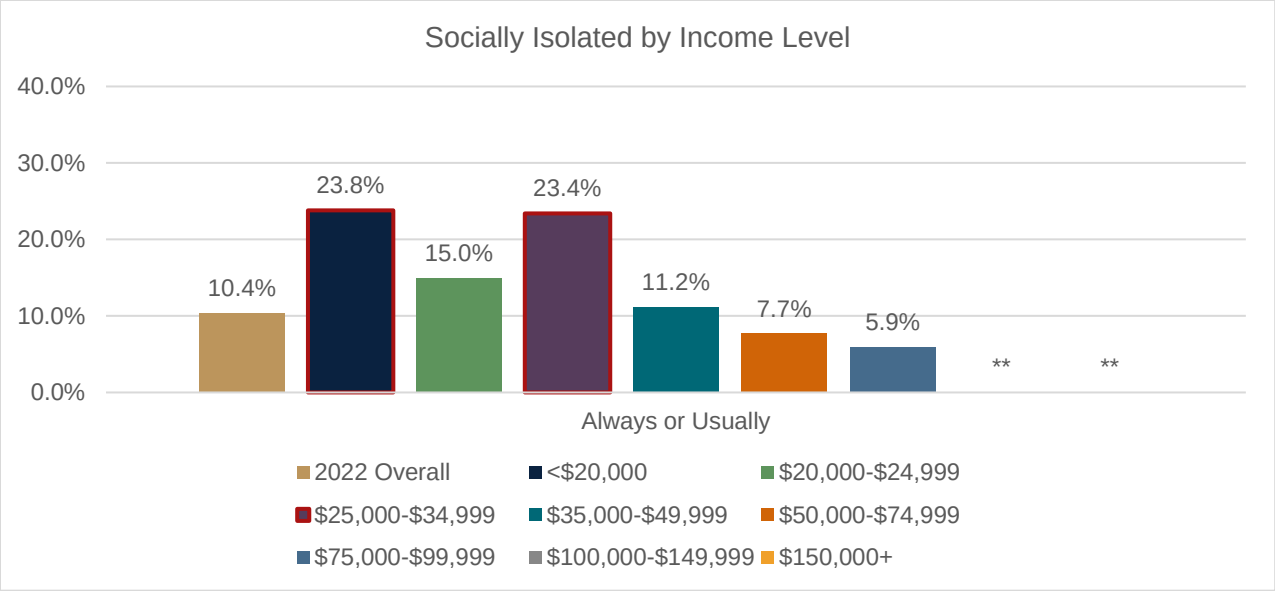
Median household income is also tracked by the Census. BHC has a lower median household income than the Iowa and U.S. averages. In BHC, median household income has risen across all ZIP codes from 2021 to 2022. However, ZIP code 50703 consistently had the lowest median household income.



The Iowa Barriers to Prenatal Care Survey is conducted at Iowa hospitals to understand the care new mothers receive during pregnancy. In 2022, 25.5% of BHC mothers surveyed did not see a doctor for a check-up 12 months before pregnancy. When looking at household incomes below $20,000, 35.1% of mothers did not see a doctor beforehand, and 47.7% of mothers at this income level reported an unintended pregnancy, compared to 10.2% of those with incomes above $70,000. Further, mothers in the lowest income bracket consistently reported the highest number of stressors. Options given for stressors included:

- A close family member was very sick and had to be hospitalized
- A family member or close friend died
- A family member or close friend had a bad problem with drinking or drugs
- I argued with my husband or partner more than usual
- I got separated or divorced from my husband or partner
- I had a lot of bills I couldn't pay
- I lost my job
- I moved to a new address
- I was homeless
- My husband or partner lost their job
- My husband or partner or I went to jail
- My husband or partner said they didn't want me to be pregnant

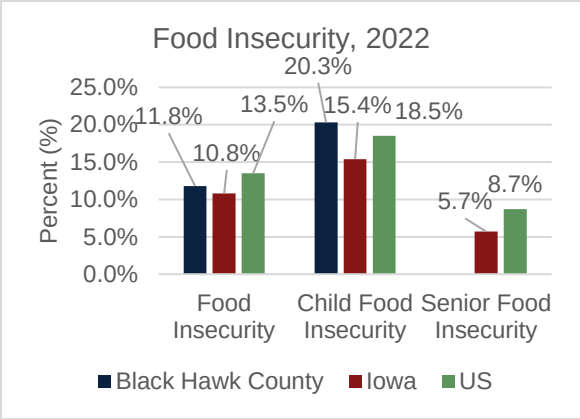


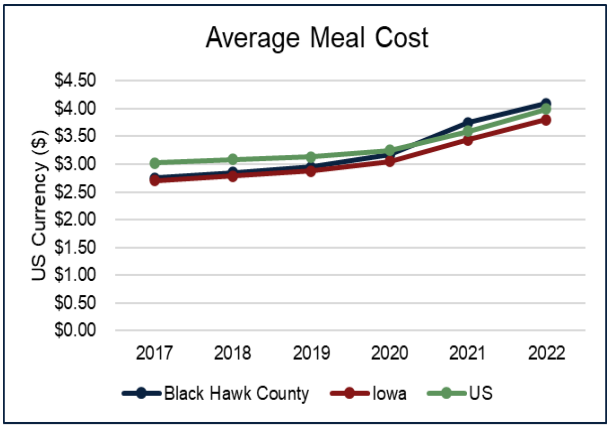


The BRFSS has four questions related to stress and social determinants of health. The graphs above focus on two of the questions: stress frequency in the past 30 days and perceived social isolation. Both were measured using five-point scales ranging from “Never” to “Always”. Responses of “Always” and “Usually” were combined, as were “Rarely” and “Never.” Data was broken down by race/ethnicity, age group, sex, and income level. Households earning under $20,000 had the highest proportion of “Always” or “Usually” responses for both questions. Differences by race/ethnicity and age group were present but less pronounced, and sex differences were minimal.

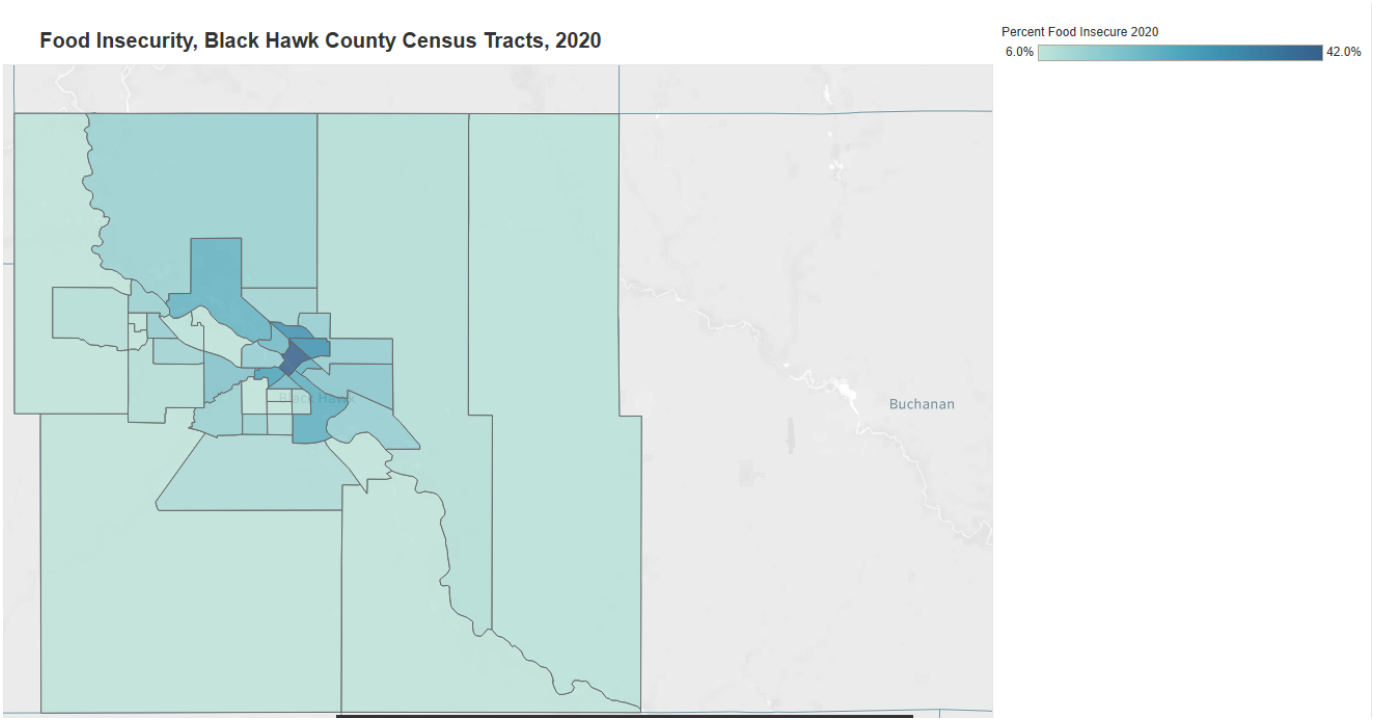
Community survey data shows that 69.1% of respondents believe that jobs and a healthy economy require improvement, ranking it third among the most important factors for a healthy community. *no image

Inequitable Food Access



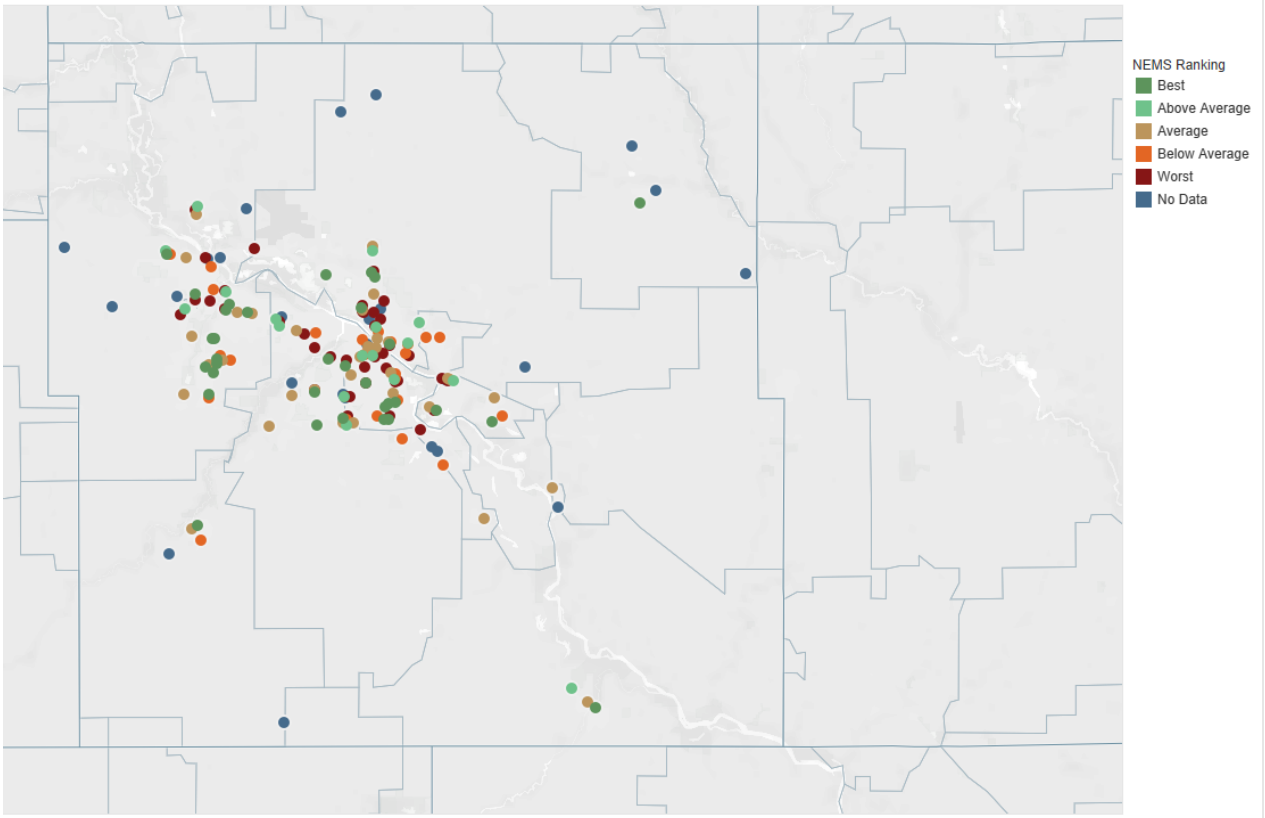


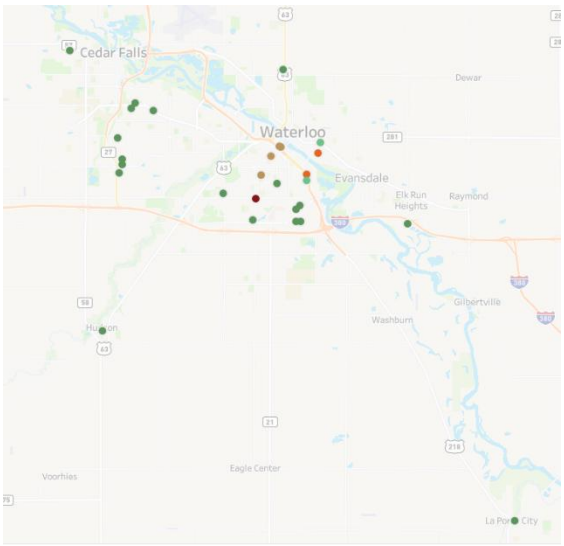
Data on food insecurity for BHC by age group and average meal cost was retrieved from Feeding America's Map the Meal Gap webpage. The average meal cost has been increasing over time since 2017, but even more since 2020. In 2022, BHC food insecurity data for children and all ages were higher than the Iowa level. While child food insecurity decreased in Iowa from 2018 to 2021, it increased in BHC from 2018 to 2020. Both overall and child food insecurity increased in 2022 at local, state, and national levels.



Food insecurity was also shown by census tract from data by Feeding America in partnership with NEIFB. Food insecurity in BHC census tracts ranged from 6% to 42%. The census tract with the highest impact is census tract 1 (42%), which is in east Waterloo.

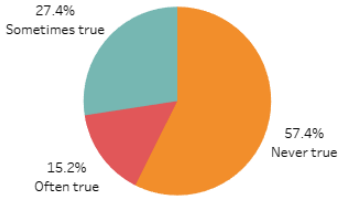
NEMS Scores, Black Hawk County, Iowa





NEMS was a survey performed by UNI that assessed the foods being offered at local establishments selling food, such as grocery stores and gas stations, but not restaurants. Based on the foods that were offered, each establishment received an overall rating of “Worst” to “Best.” The first map shows the locations and overall rating for each store assessed based on color, and the second map shows the location and overall ratings of grocery stores only. Since this data was collected, two grocery stores have closed in east Waterloo, or ZIP code 50703.

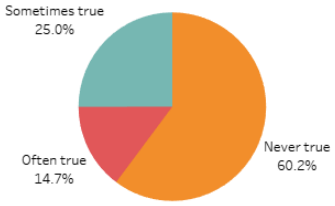
Food Would Run Out



Concerned food would run out (Sometimes or Often True)

- Ages 18 to 29: 56.2%
- Black: 58.3%
- Burma: 81.3%
- DRC: 62.5%
- Marshall Islands: 84.9%
- Income under $15k: 82.3%
- Receiving local services: 76.5%

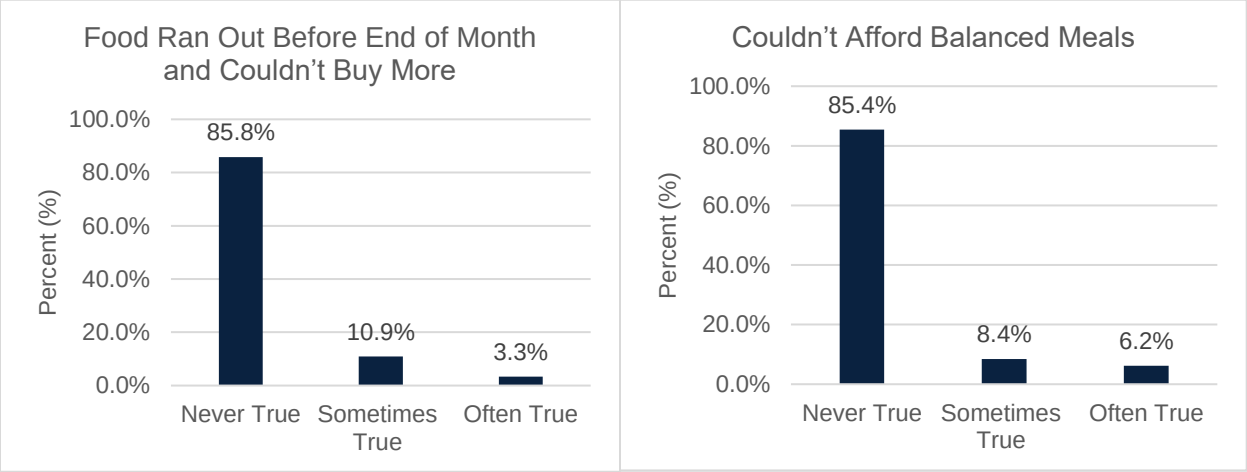
Food Didn't Last



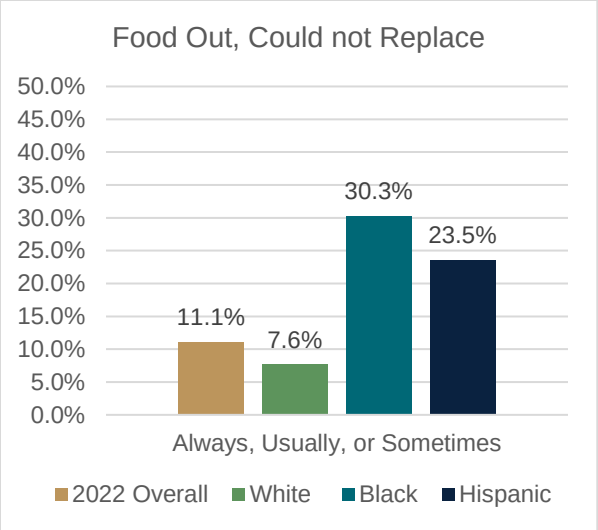
Food did run out, and I didn't have money to buy more (Sometimes or Often True)

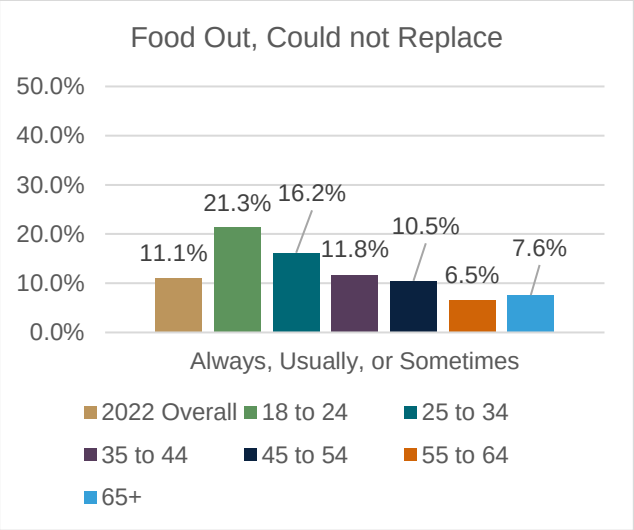
- Ages 18 to 29: 50.7%
- Black: 59%
- Burma: 73.3%
- DRC: 62.5%
- Marshall Islands: 90.3%
- Income under $15k: 80.8%
- Receiving local services: 74.2%

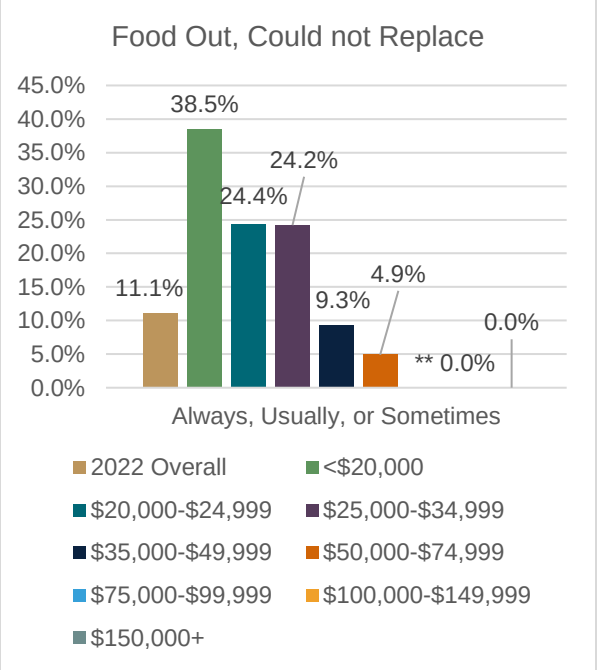
Food insecurity was assessed in the community survey through two questions, and each question was disaggregated by age, race and ethnicity, country of birth, and income level. Results shown are for individuals who answered "Sometimes True" or "Often True" for either question.

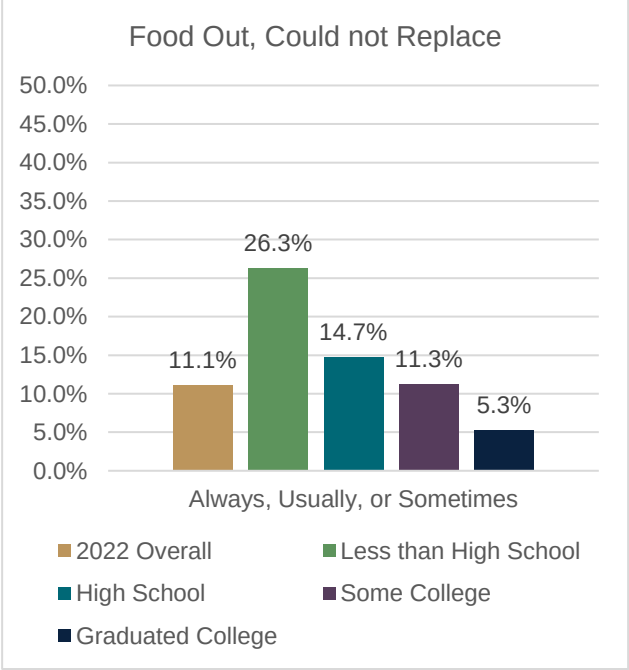


BRFSS respondents were asked similar questions in 2021 and 2022. In 2021, 14.2% answered "Sometimes True" or "Often True" to a question asking the if their food ran out before then end of the month and they couldn't buy more. Additionally, 14.6% of respondents said that it was "Sometimes True" or "Often True" that they could not afford balanced meals. Data could not be disaggregated due to a lower BRFSS sample size in 2021.

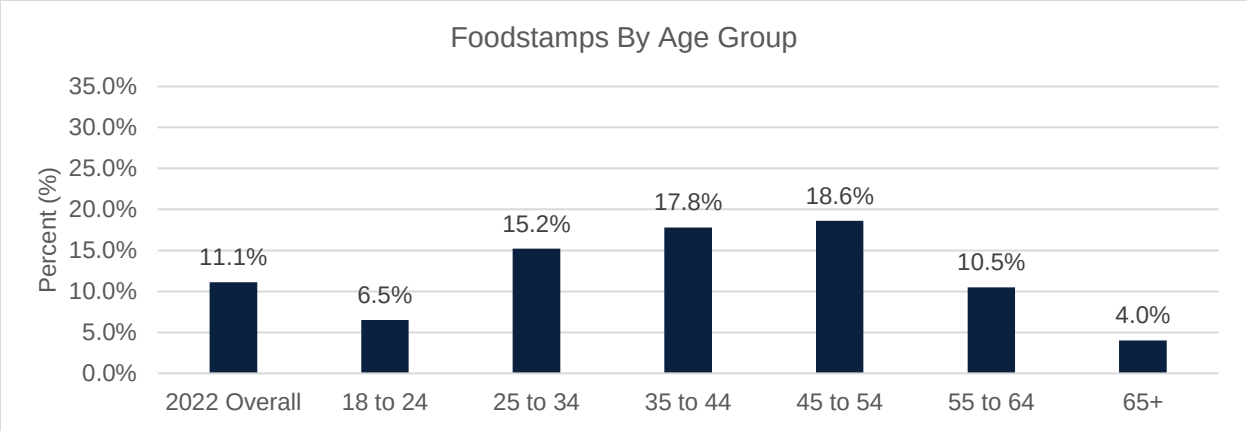


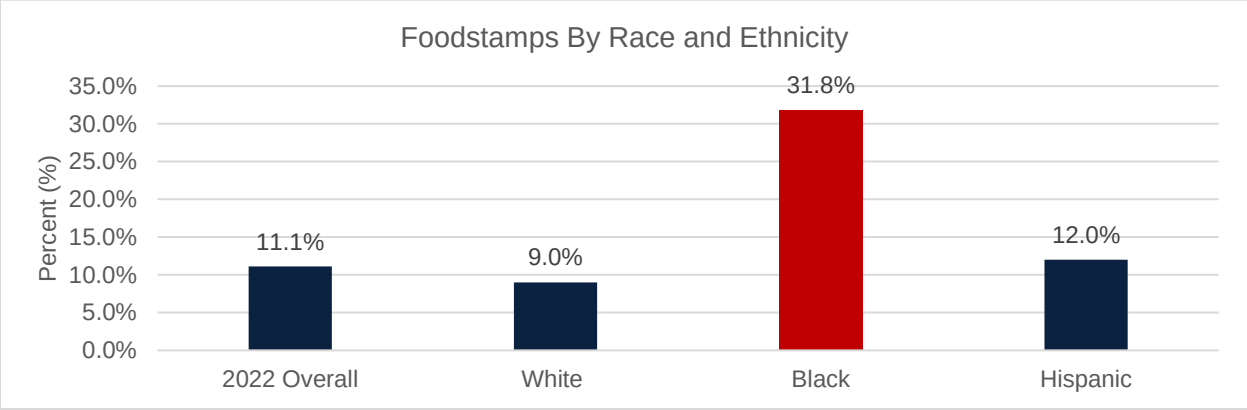


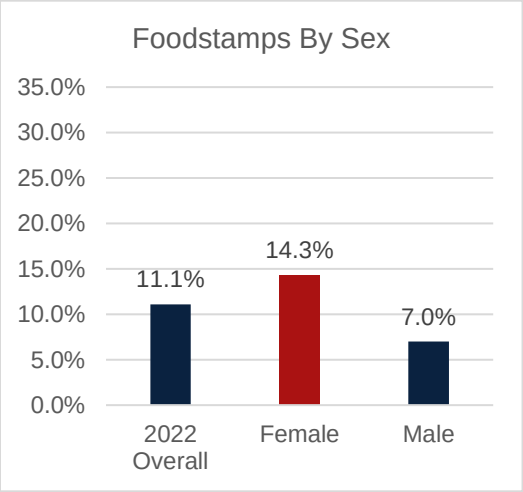


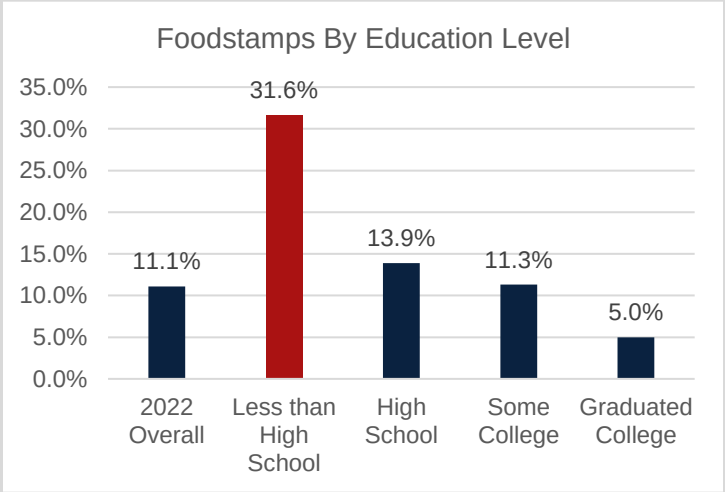


In 2022, participants were just asked if food ran out during the last 12 months, and they could not afford to buy more. Response options were a 5-point Likert scale. Those who answered Always, Usually, or Sometimes were more likely to be Black or African American, Hispanic, ages 18-24, have a lower income level, and have a lower education level. Differences by sex were minimal.

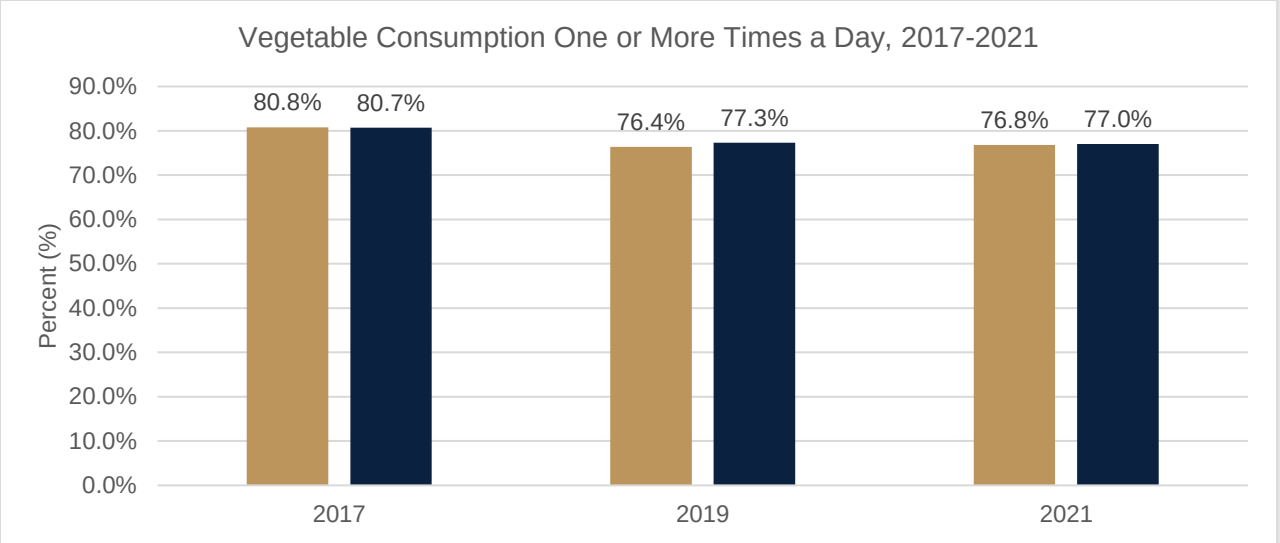


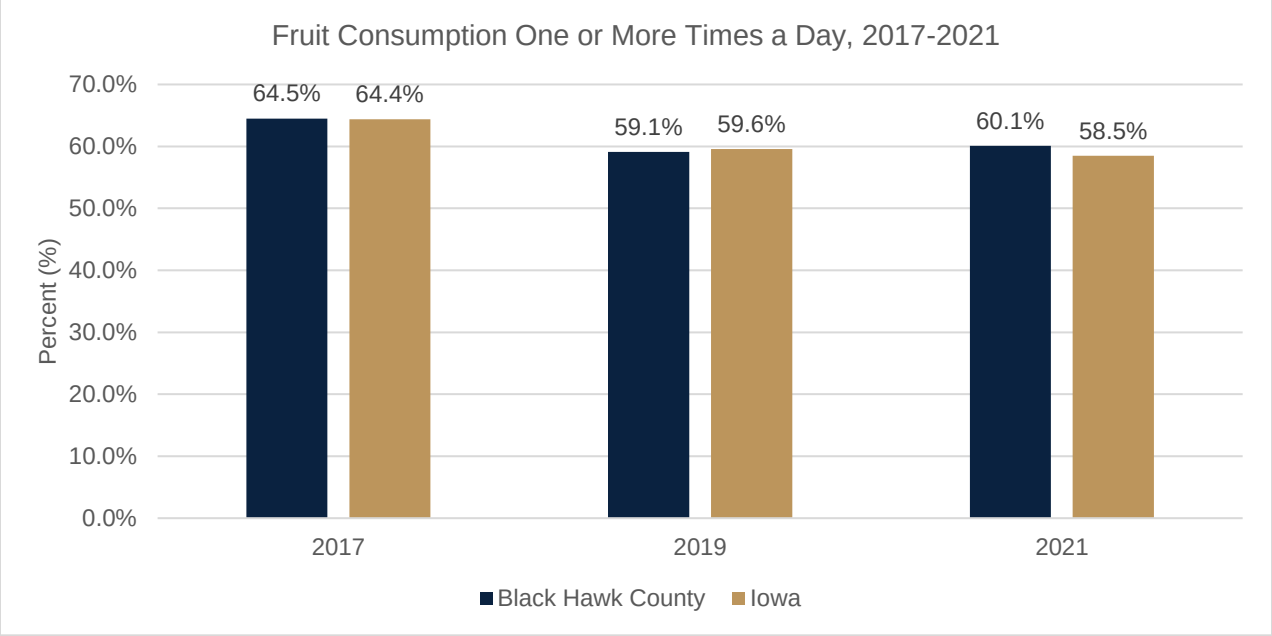






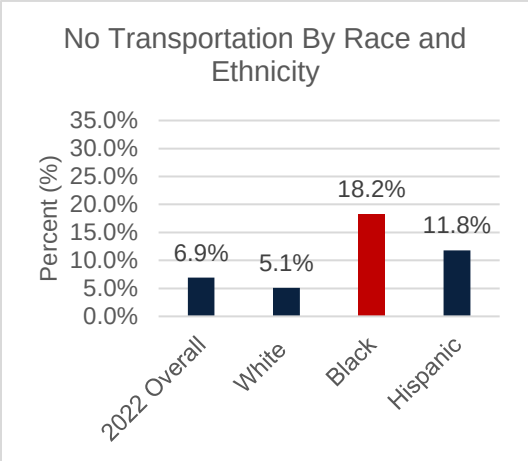
BRFSS participants were also asked if they had received any food stamps in the last 12 months. Proportions shown are the individuals who answered “yes” to that question. They were more likely to receive food stamps, if they were Black or African American, ages 25 to 54, female, or had a less than high school education. Income results were as expected, with those with lower income more likely to receive food stamps.

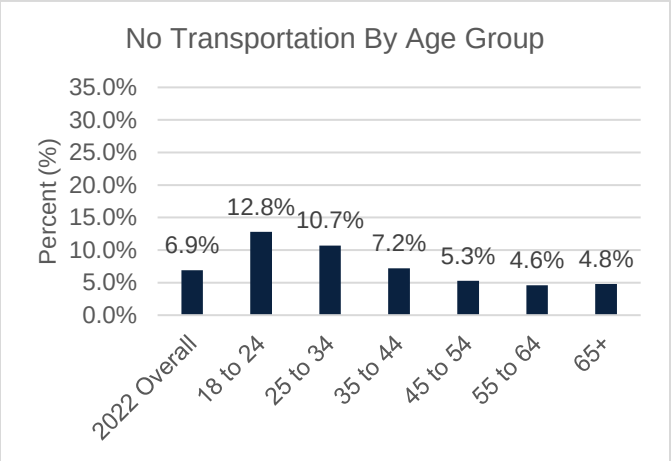


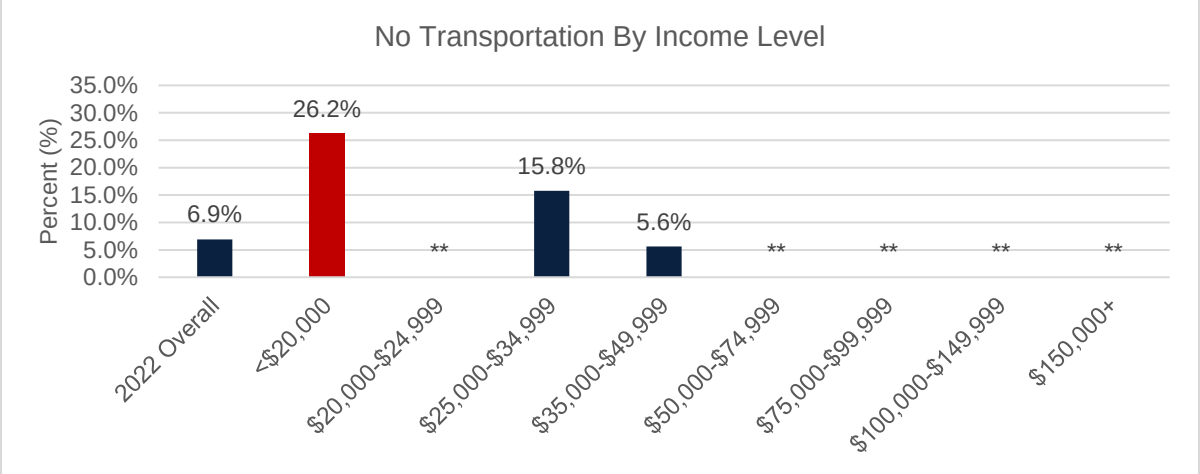


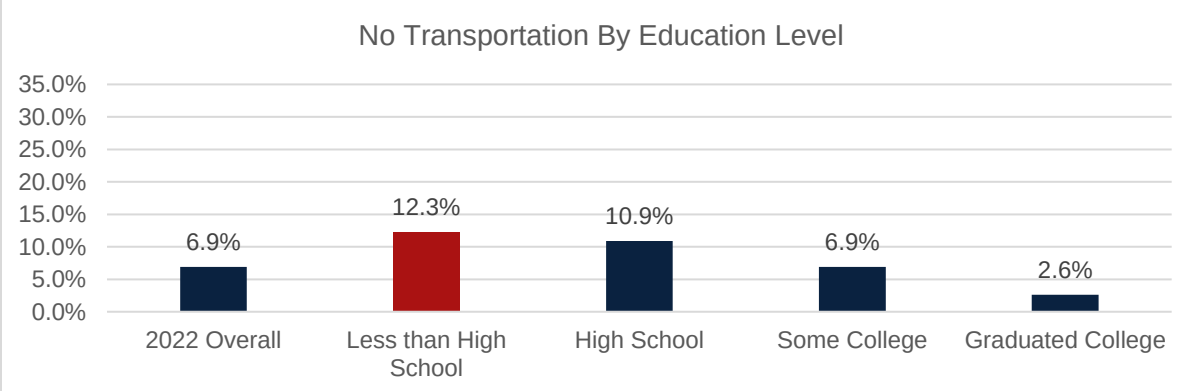
BRFSS participants were also asked how many servings of fruits and vegetables they ate daily. Data is shown for 2017, 2019, and 2021, but is not able to be disaggregated due to lower counts for each of these years. Overall, year-to-year responses for BHC and Iowa have not changed much. However, people were more likely to say that they were eating vegetables daily than fruits.

Transportation Challenges

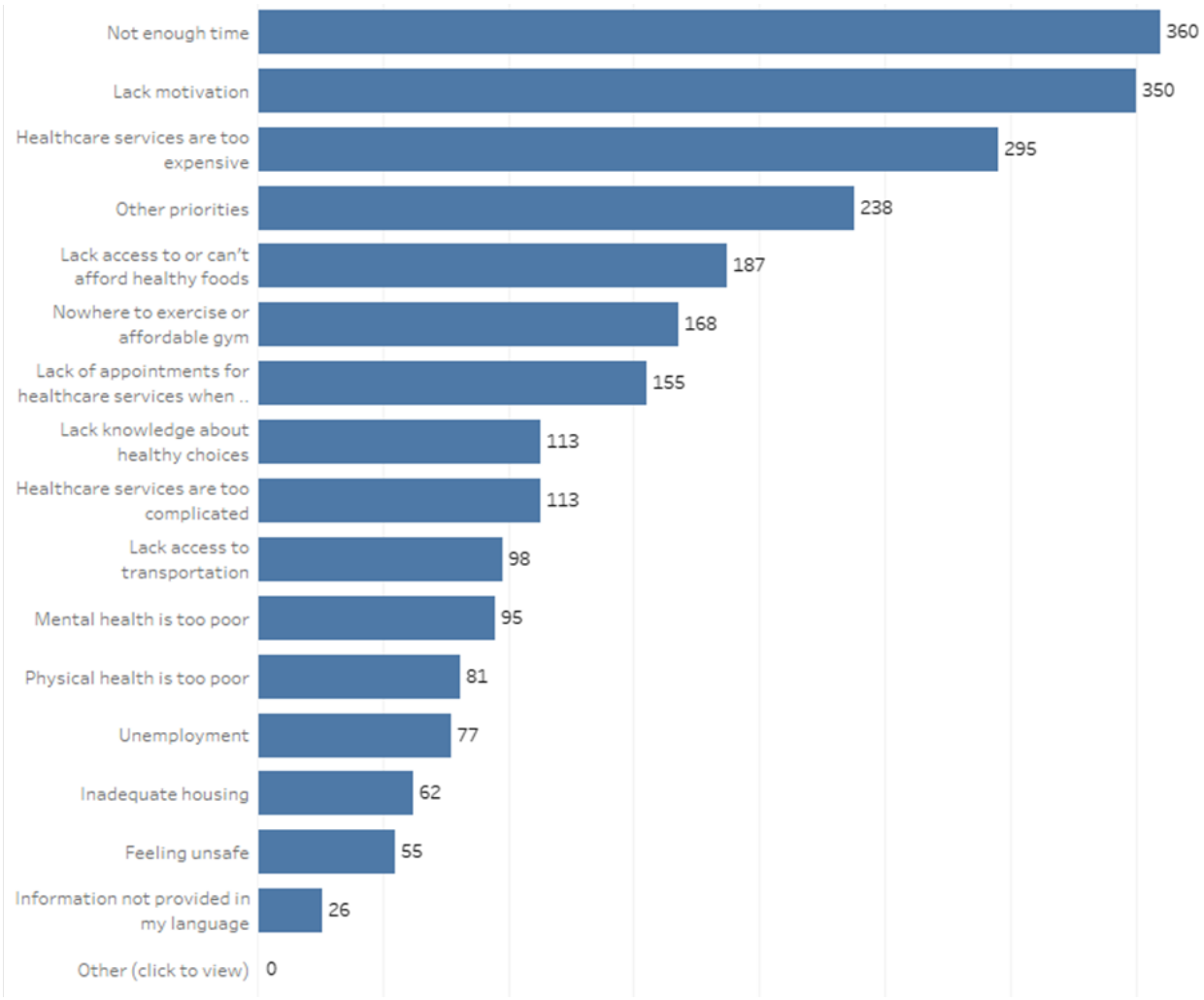




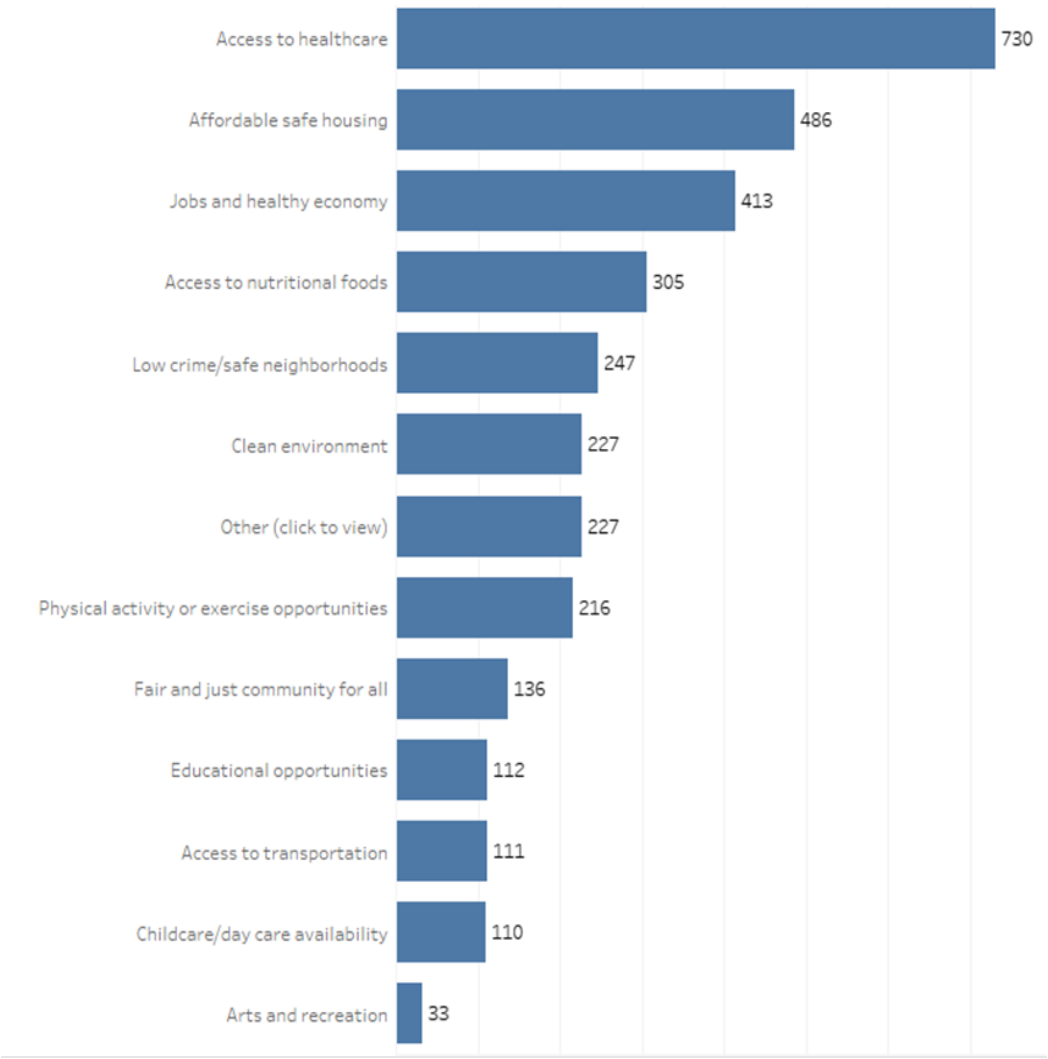




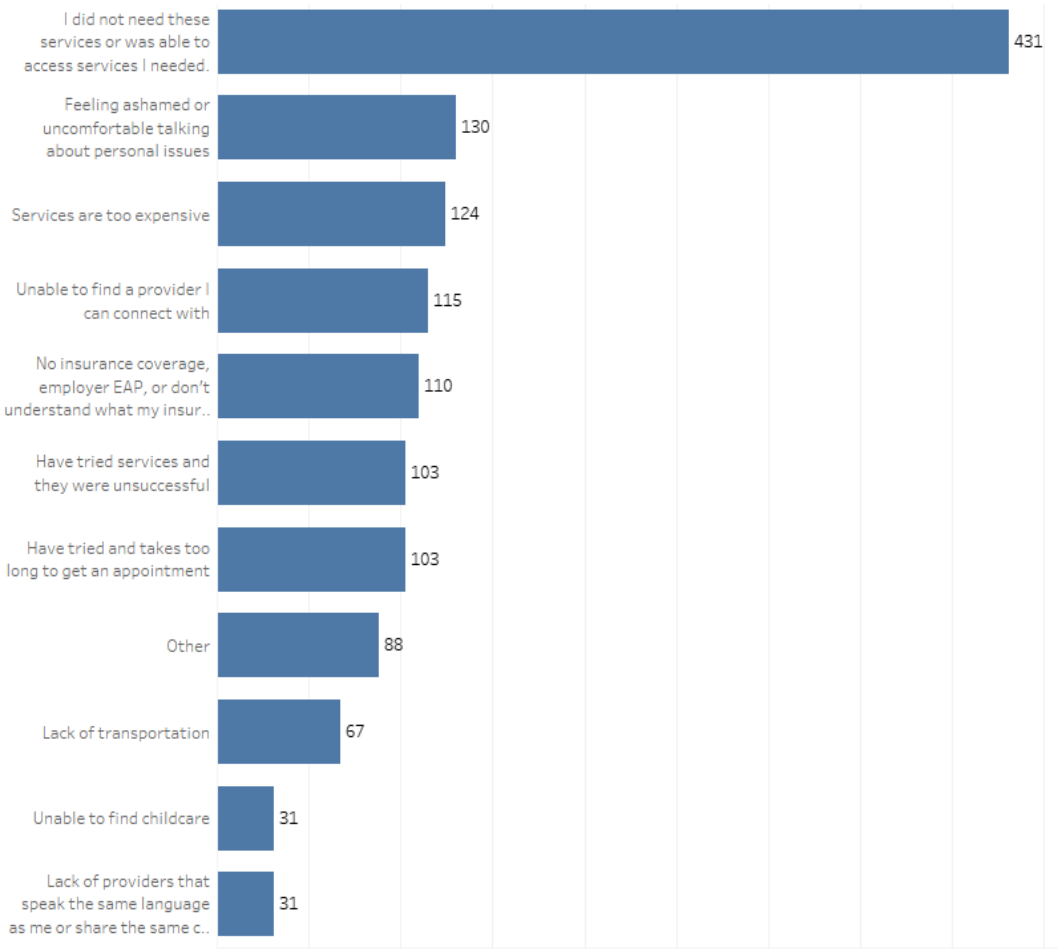
BRFSS respondents were asked if they had any problems accessing transportation in the past year for work, appointments, and any activities needed for daily living. Results shown individuals who answered “Yes” to that question. Data was disaggregated by race and ethnicity, age group, income level, and education level with disparities shown in all categories. The largest disparity was for people who make less than $20,000. Black individuals, those ages 18-24, and those with less than a high school education were also more likely to be affected.



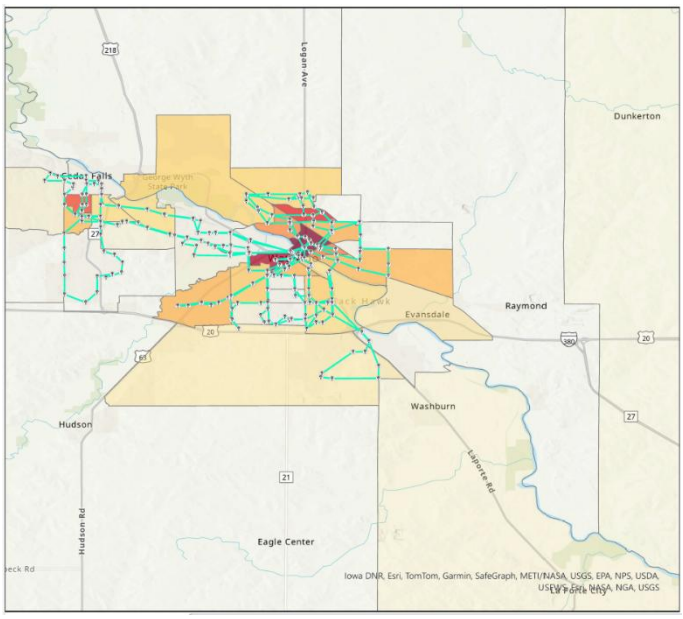
In the community survey, respondents were asked if there was anything that prevented them from being healthier. While transportation was ranked 10 of 16 in the overall results, it was the second most important factor for those with an income under $15,000.



Another question in the community survey displays issues needing improvement in order of importance. Transportation was ranked 11 of 13 in the overall results, but respondents who identified as Marshallese or Burmese indicated that it was the most needed improvement.



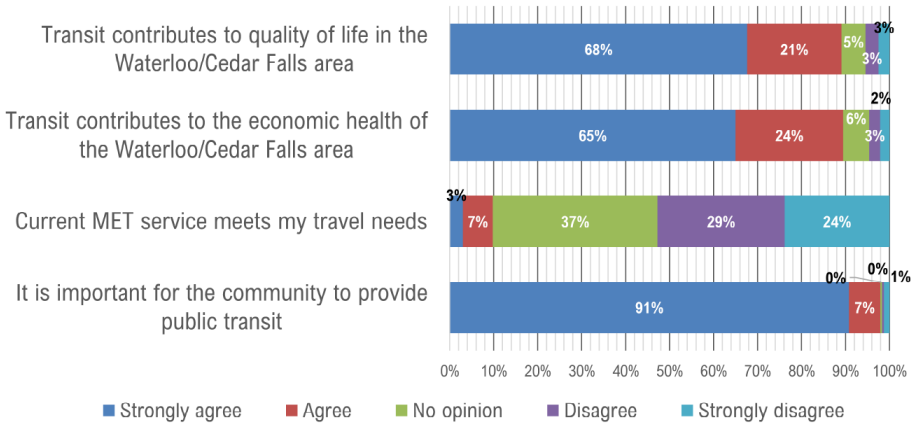
Respondents were also asked in the community survey reasons why they didn't access needed mental health services. Transportation was ranked #9 in the overall results, but it was the top reason for those with an income less than $15,000.



This map above shows the proposed new bus routes for late 2024 into 2025, which were changed in response to a survey performed by MET Transit in 2023, in which most respondents stated that current service did not meet their needs. The map also shows census tracts with the proportion of individuals with an income less than $15,000. Red census tracts have a higher proportion of with a median income of <$15,000. The map highlights that census tracts with the highest proportion of median incomes of <$15,000 have routes available.

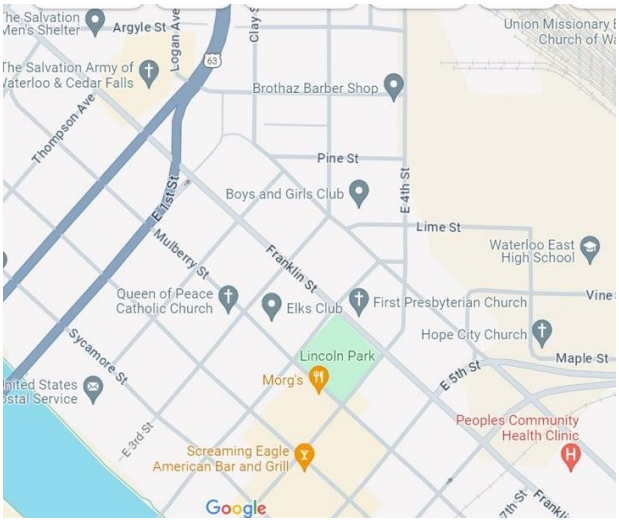
TRANSIT IS IMPORTANT TO THE COMMUNITY

Responses from March 2023 Community Survey

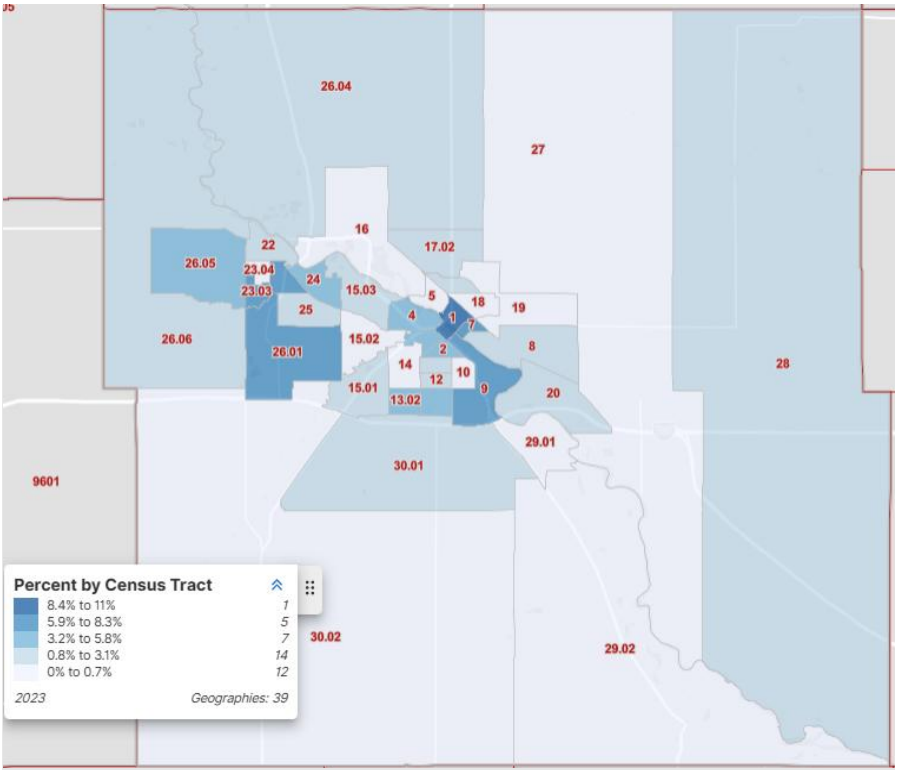


Gaps/Conflict:

- Too Few Hours
- Not Enough City Coverage
- Cannot Get Paratransit Reservation at Preferred Time (Not Enough Capacity)
- Cannot Afford the Fare
- Funding for Expansion

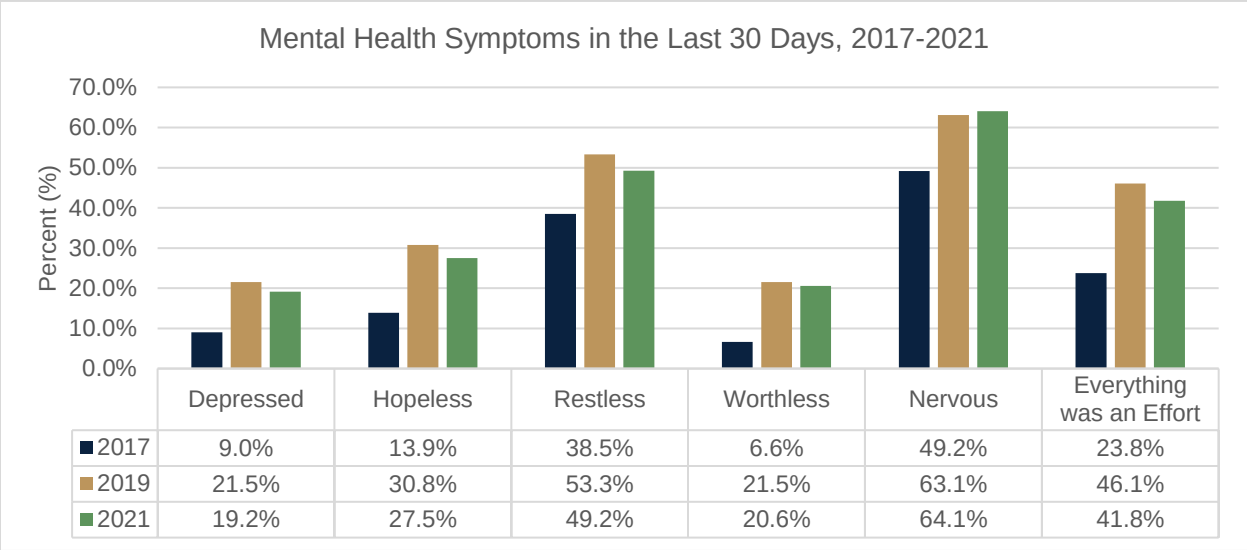


For the Community Context Assessment, pedestrian access to different frequently accessed resources in east Waterloo was assessed. Full results can be found in the Community Context Assessment Summary. It was noted that due to high-speed traffic at a busy intersection (Franklin Street and Mullen Ave), there were pedestrian safety concerns around the Salvation Army. Both the Salvation Army and Franklin Street are undergoing construction to improve safety. These actions include creating a new parking lot entrance for the Salvation Army and a sidewalk from the bus stop. Upgrades to Franklin Street will improve safety for both pedestrians and bikers.



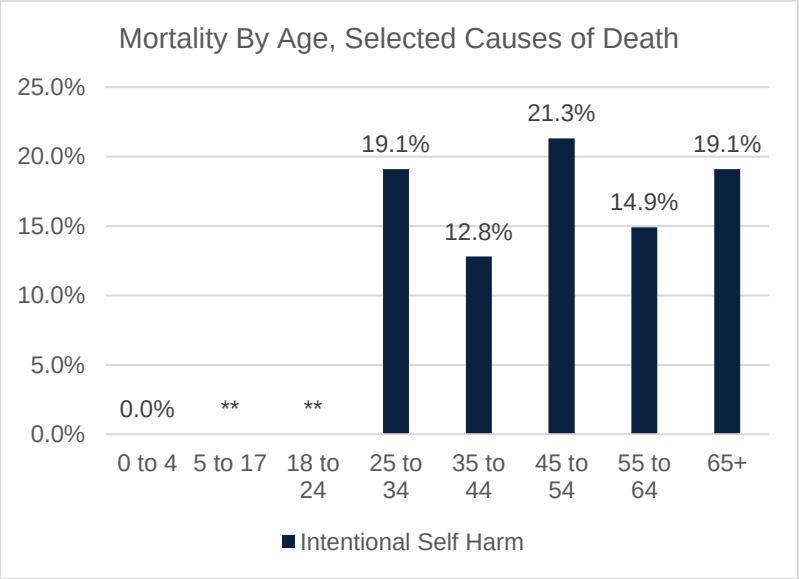
The map shows Census tracts where individuals have no vehicle available. The darker the blue, the higher the likelihood individuals had no vehicle available to them. Census tracts ranged from 0% to 11% with no vehicles available. Census tract 1 in Waterloo had the highest proportion (11%).

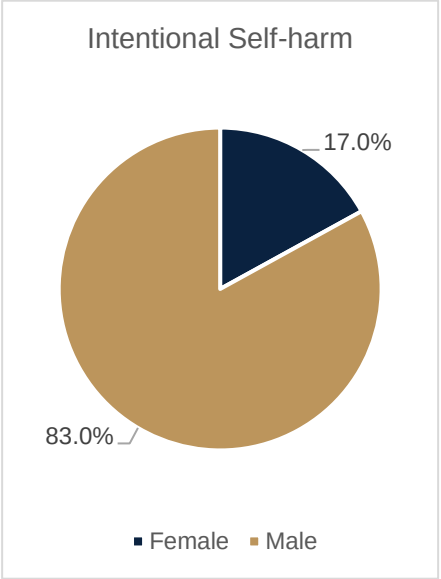
Behavioral Health: Treatment, Prevention, and Recovery



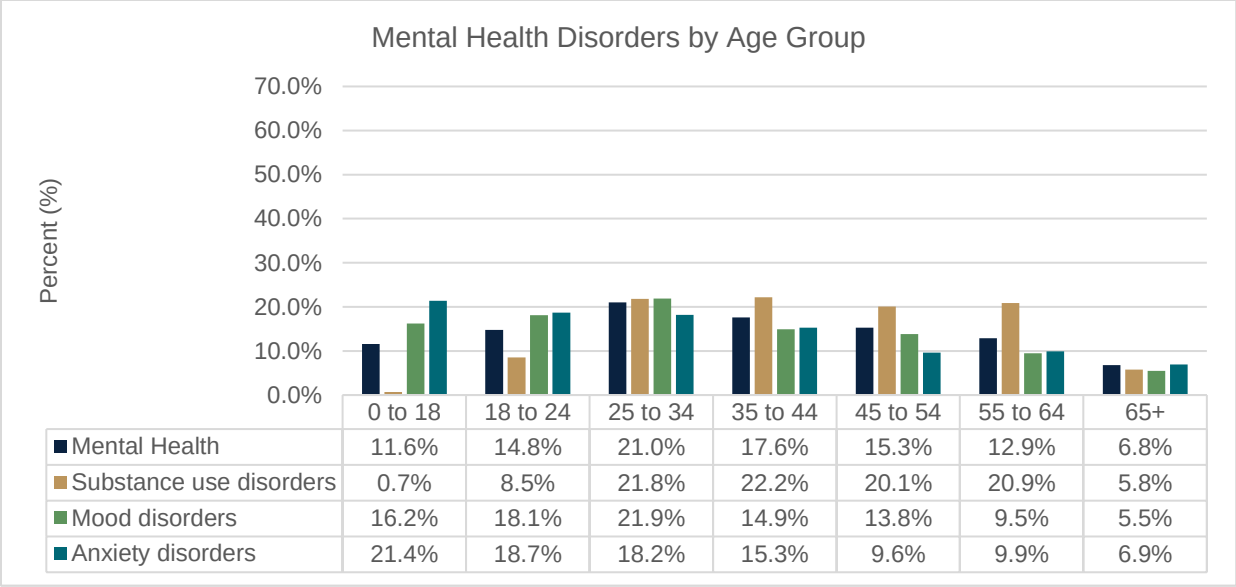
	Depressed	Hopeless	Restless	Worthless	Nervous	Everything was an Effort
2017	9.0%	13.9%	38.5%	6.6%	49.2%	23.8%
2019	21.5%	30.8%	53.3%	21.5%	63.1%	46.1%
2021	19.2%	27.5%	49.2%	20.6%	64.1%	41.8%

BRFSS participants were asked if they had experienced certain mental health symptoms in the last 30 days. Symptoms included feeling depressed, hopeless, restless, worthless, nervous, and feeling that everything was an effort. Between 2017 and 2019 there was a jump for every symptom. In 2021, proportions decreased slightly, except for nervousness which slightly increased. However, the decreases weren't significant enough to drop down again to 2017 levels, showing they are staying high.

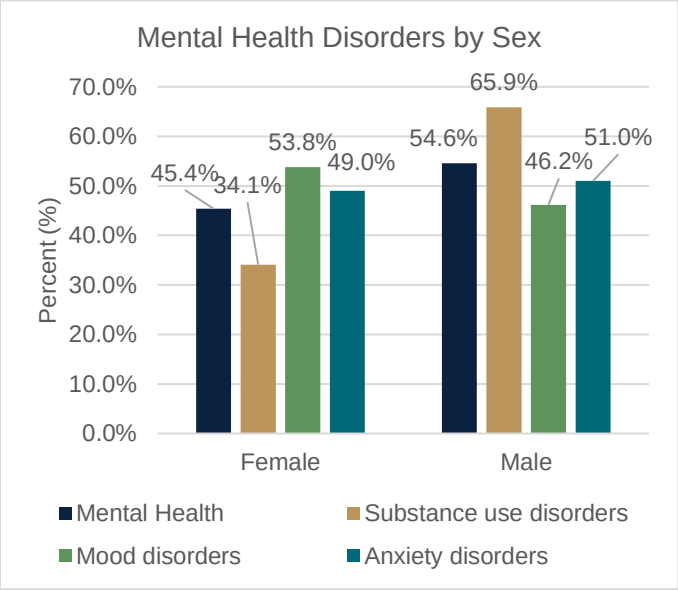




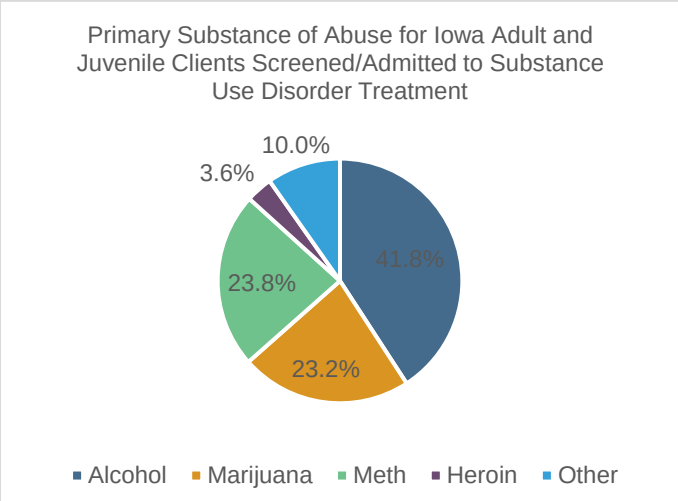
The Iowa Vital Records mortality data was broken down by the top 15 causes of death by ICD-10 code, and shown here are the results for intentional self-harm (suicide), using ICD-10 codes X60 to X84. The data showed that 83% were men. When broken down by age, there was limited data for those younger than 25. The age group with the highest proportion was 45 to 54 years, as they represent 21.3% of the intentional self-harm (suicide) numbers but make up 10% of the population based on Census counts.



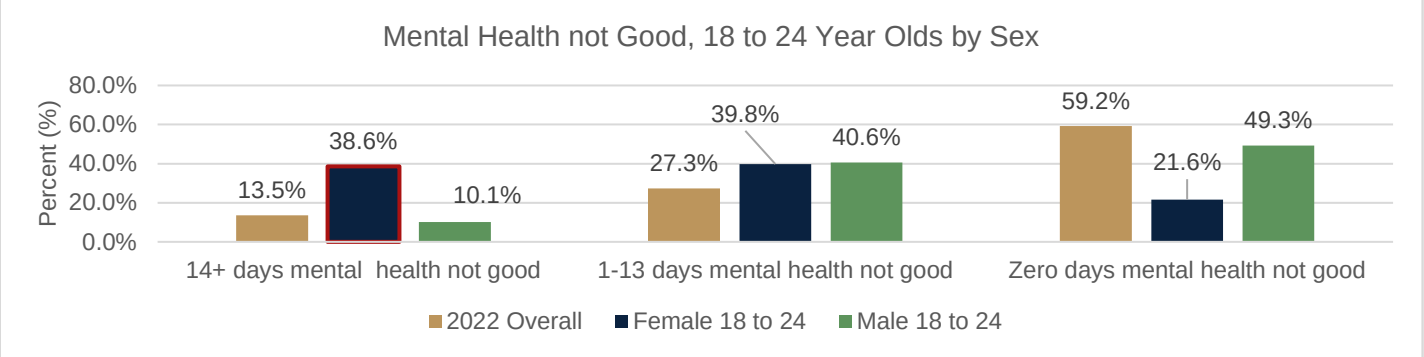
	0 to 18	18 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65+
Mental Health	11.6%	14.8%	21.0%	17.6%	15.3%	12.9%	6.8%
Substance use disorders	0.7%	8.5%	21.8%	22.2%	20.1%	20.9%	5.8%
Mood disorders	16.2%	18.1%	21.9%	14.9%	13.8%	9.5%	5.5%
Anxiety disorders	21.4%	18.7%	18.2%	15.3%	9.6%	9.9%	6.9%

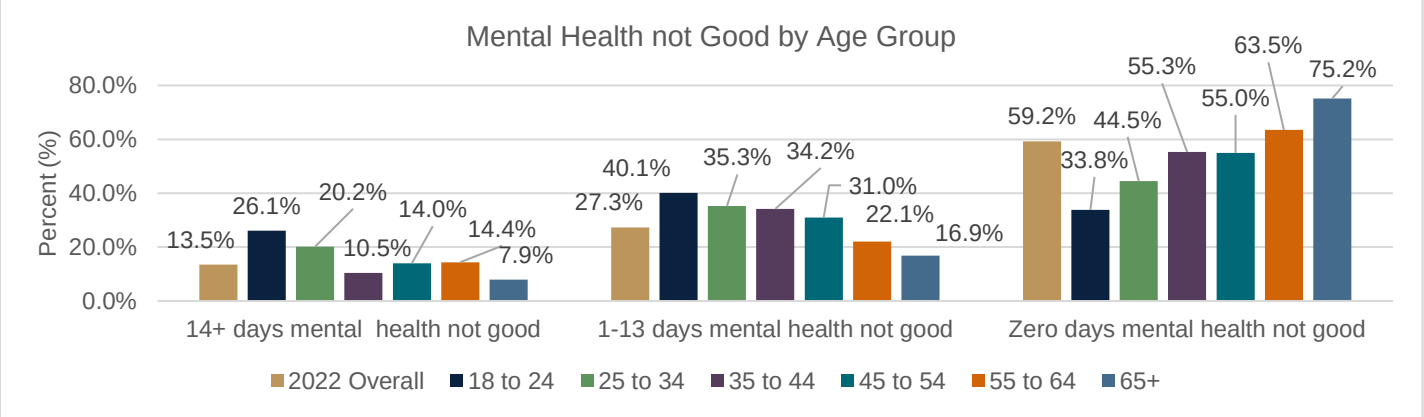


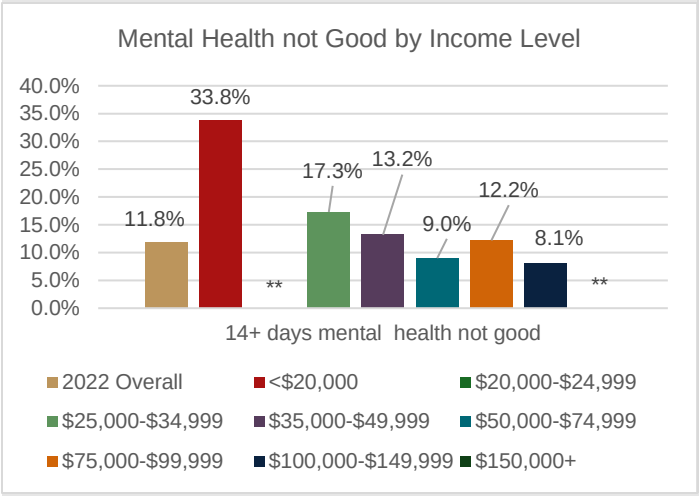
The IHA is a network of hospitals in Iowa that report data to the state based on reporting requirements. We reviewed ICD-10 codes for mental health disorders and broke them down by age and sex. For anxiety disorders (codes starting with F4), patients aged 0 to 18 made up the largest proportion. Mood disorders (codes starting with F3) had a right skewed distribution with more diagnoses in the age groups younger than 35. Substance use disorder diagnoses (codes starting with F1) were low in ages younger than 25, and higher in ages 45 to 64. Males made up 65.9% of the substance use disorder patients.

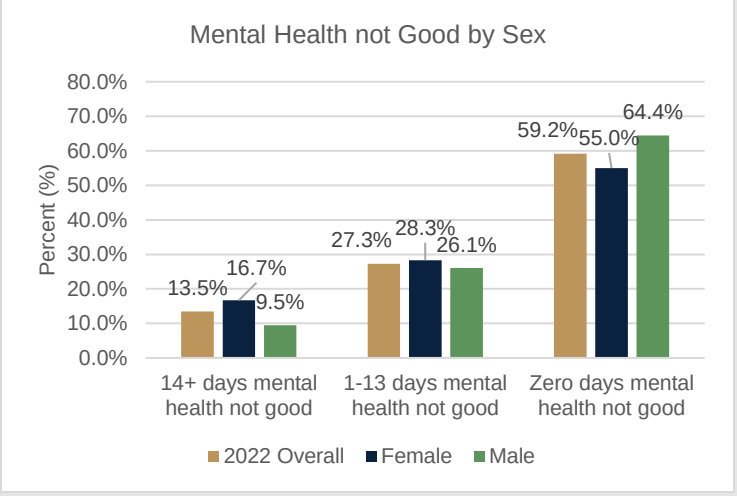


Data from the Iowa Drug Control Strategy and Drug Use Profile showed the primary substance of abuse for Iowa adult and juvenile clients screened or admitted to substance use disorder treatments. The highest proportion was alcohol at 41.8%, followed by meth at 23.8%, and marijuana at 23.2%. Heroin accounted for 3.6% and 10% for other substances.

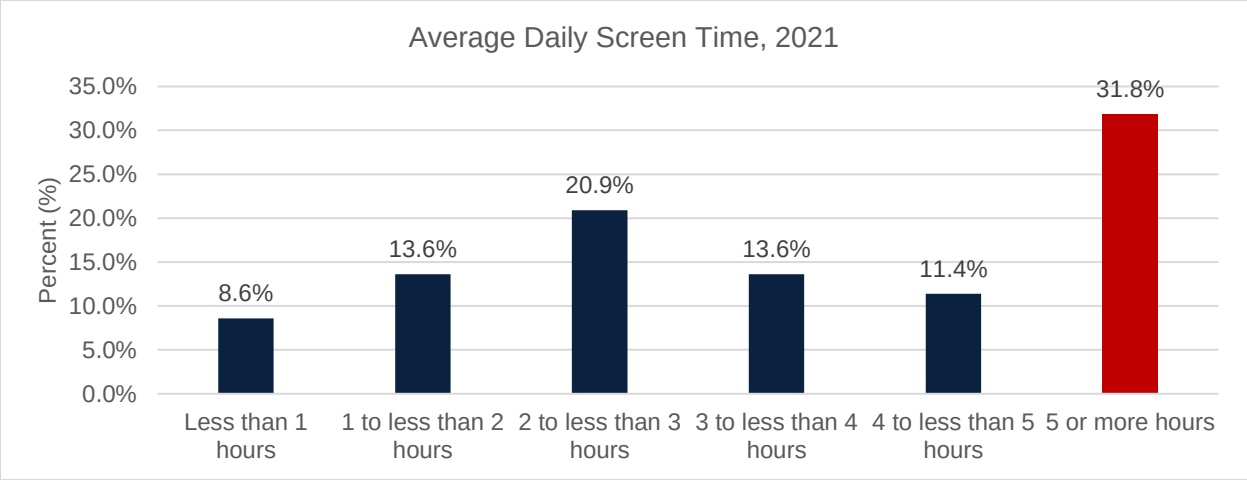




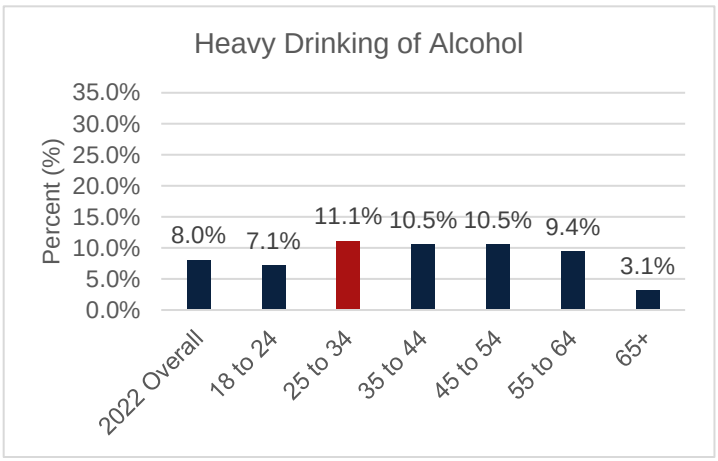


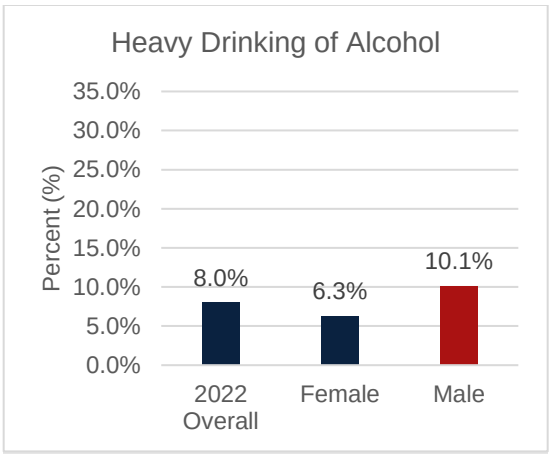


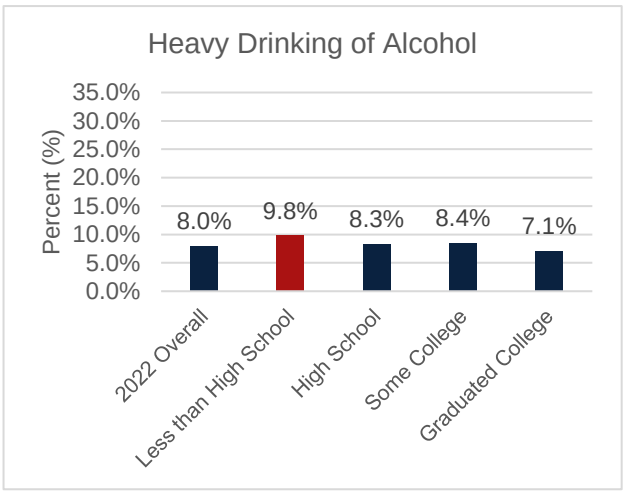
BRFSS respondents were asked if their mental health was not good, and for how many days if it was not good in the last month. Most respondents report that they had 0 days their mental health was not good. Women had more days where mental health was not good compared to men, and the same was seen for those ages 18 to 24 compared to other age groups. The demographic group that had the highest proportion for 14 or more days mental health was not good was women aged 18 to 24 at 38.6% compared to the overall proportion of 13.5%. 10.1% of men aged 18 to 24 responded with 14 or more days mental health was not good. Those with an income less than $20,000 were also more likely to say that their mental health was not good (33.8%).



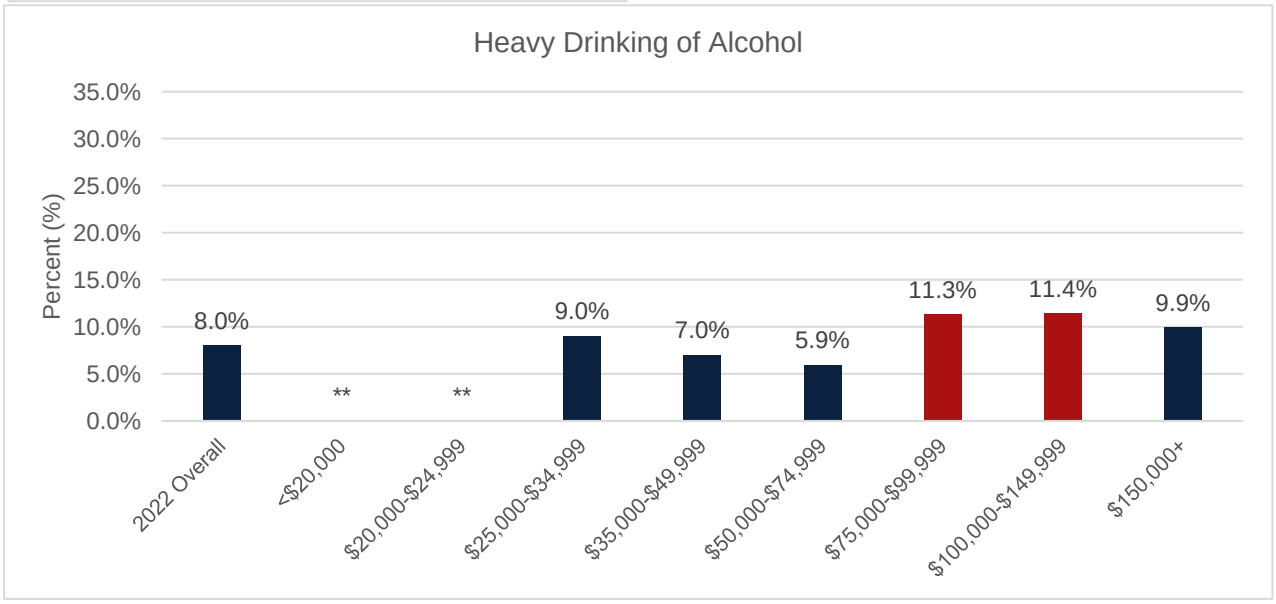
BRFSS respondents were asked about their average daily screentime (TV, phone, computer, etc.). The highest proportion is 5 or more hours (not including work time). This concern also came up in the community survey for the top health factor for children.

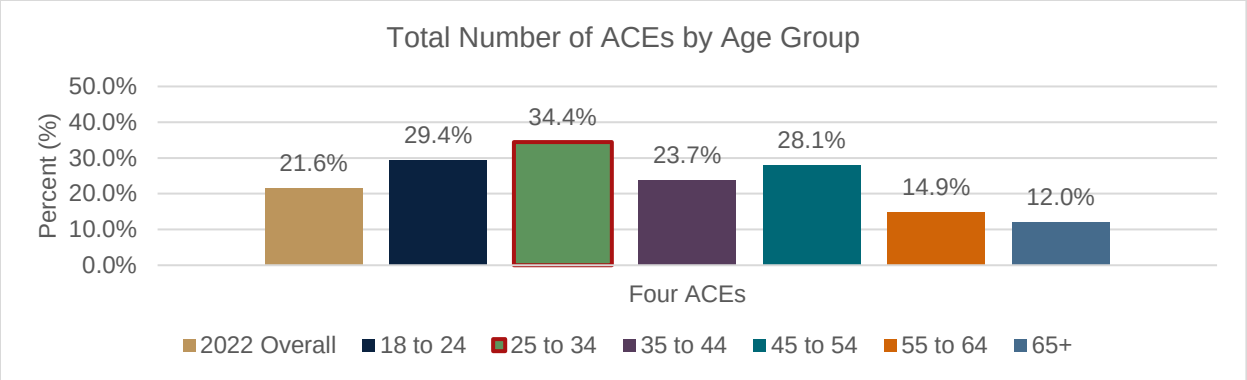


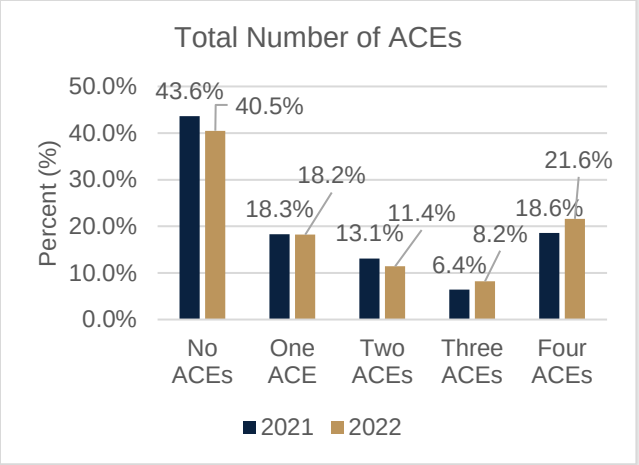


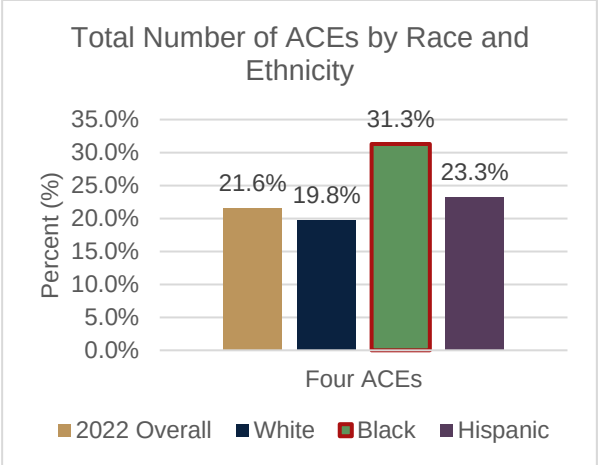


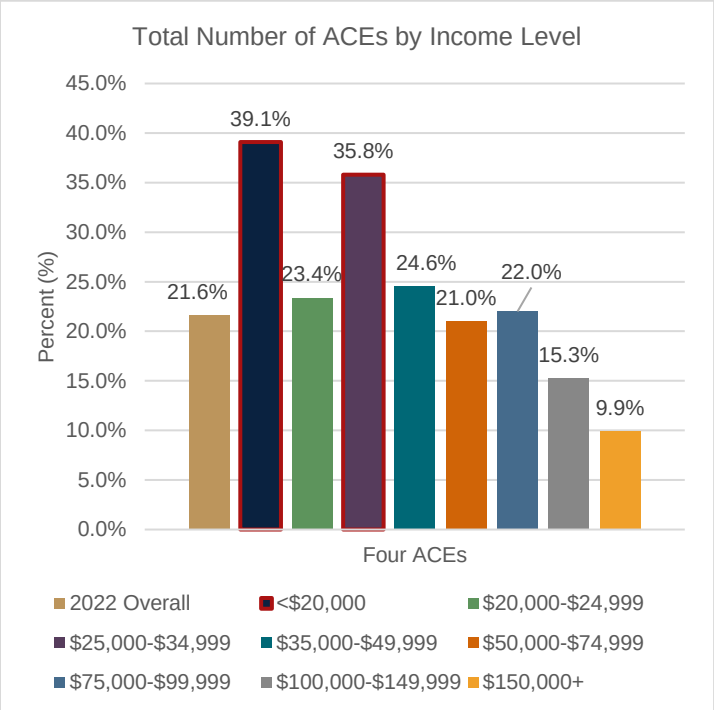
BRFSS respondents were asked about their alcohol consumption, and data displayed is for heavy drinking. The definition of heavy drinking (per BRFSS) for men is having more than 14 drinks per week, and women having more than 7 drinks per week. Additionally, women having 1 or more drinks per day and men having 2 or more drinks per day should be considered, although this definition was not used in the BRFSS data. Higher income ($75,000+) appeared to have higher proportions than incomes lower than that threshold. Men are also more likely to say that they drank heavily compared to women.



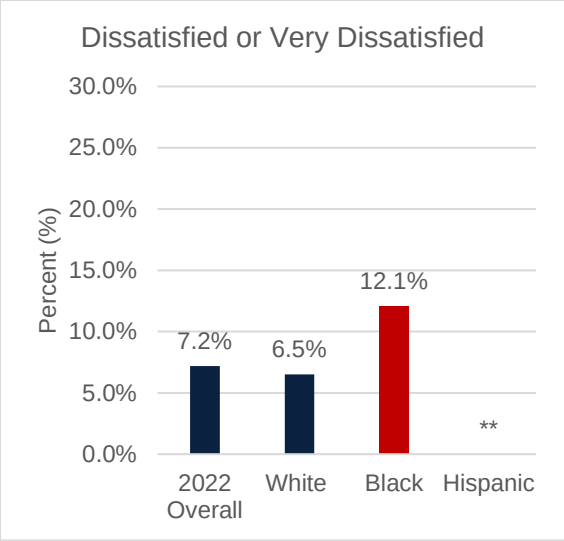


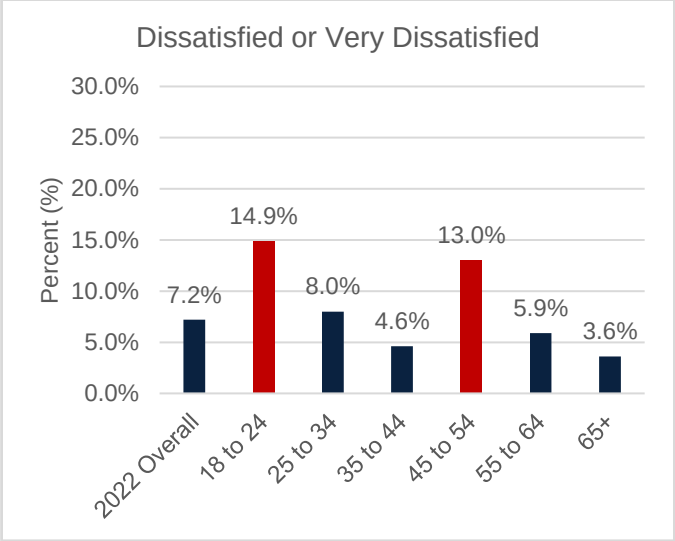


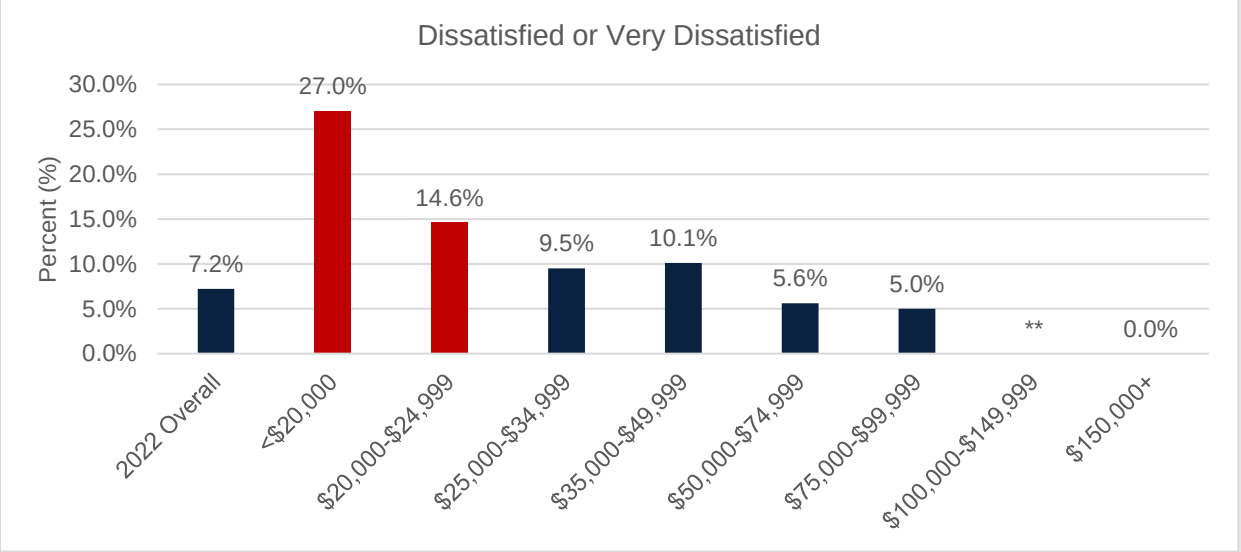




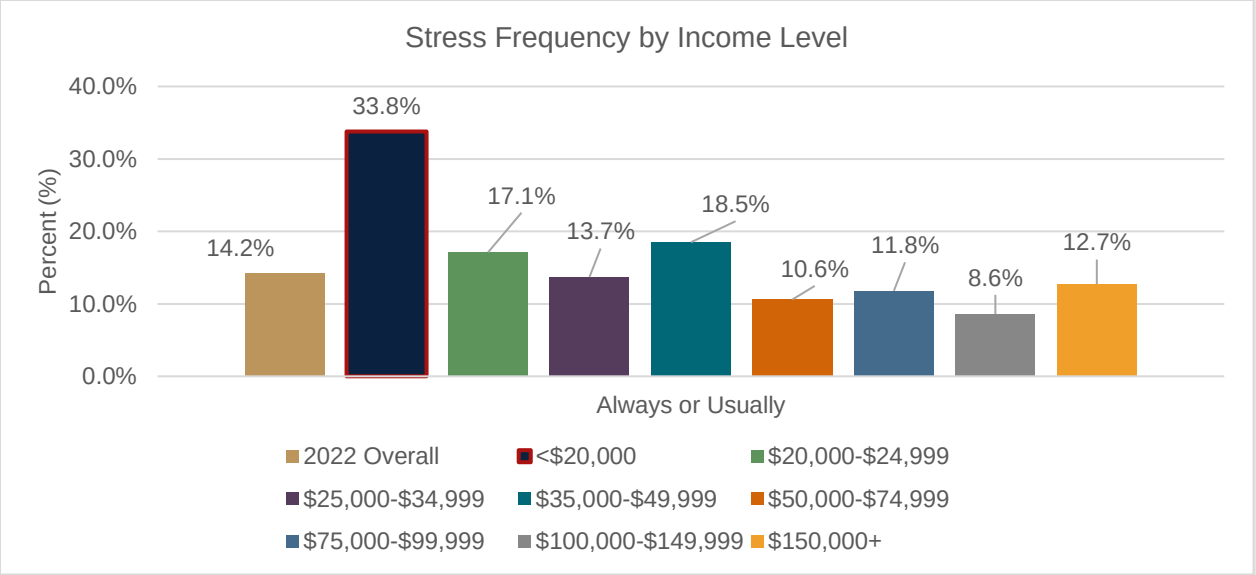
BRFSS participants were asked if they had experienced one or more adverse childhood experiences (ACEs). Those who have experienced 4+ ACEs are more at risk for adverse health outcomes. 2022 ACEs data was disaggregated by race and ethnicity, age group, and income level. Those most affected were those who were Black or African American, ages 25 to 34, and those with an income less than $20,000, followed by those with an income between $25,000 and $34,999.

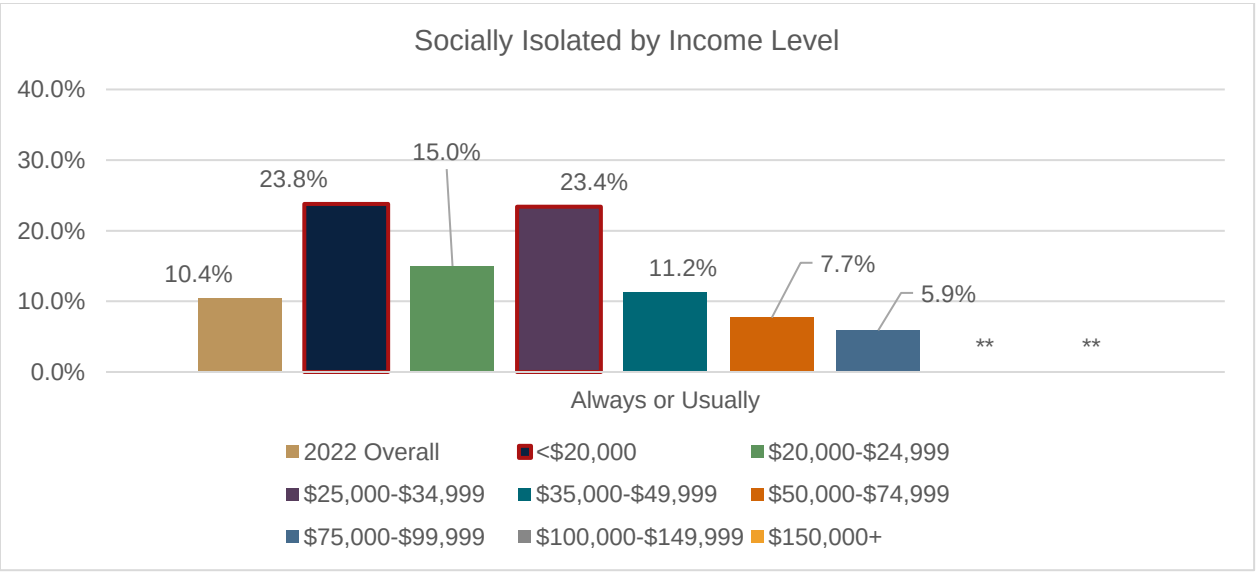






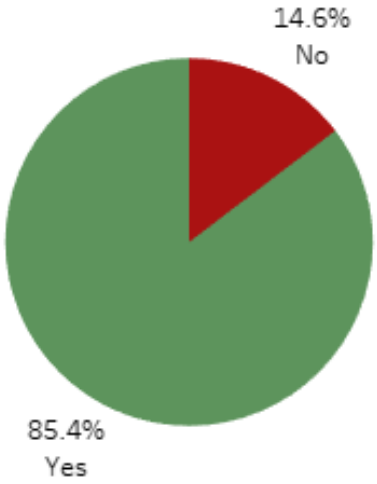
BRFSS respondents were asked if they were satisfied with their life, and response options were on a 4-point Likert scale. What is shown is the proportion of those who said that their life was dissatisfying or very dissatisfying. Those who were most affected included those who identified as Black, who were ages 18 to 24 or 45 to 64, or had an income less than $25,000. When disaggregated by sex, the difference was negligible.



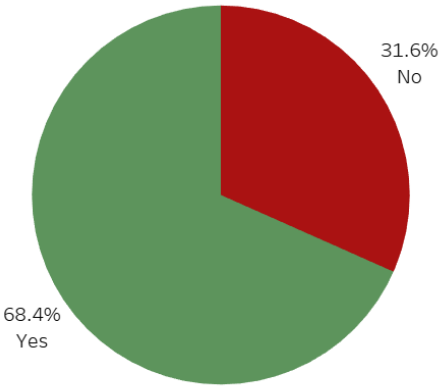


BRFSS has 4 questions related to stress and social determinants of health. The two questions shown are stress frequency within the last 30 days and how often the person felt socially isolated, both of which were represented by 5-point Likert scales. The responses representing Always and Usually were combined, as well as Rarely or Never to reduce data suppression and make the analysis more meaningful. Disaggregation was done for race and ethnicity, age group, sex, and income level. The Always or Usually response combination for income level is shown as it had some of the highest disparity levels. For both questions, income levels of <$20,000 had the highest proportion for the Always or Usually responses. For race and ethnicity and age group, while there were some differences, they were less extreme than the income level responses. Differences by sex were minimal.

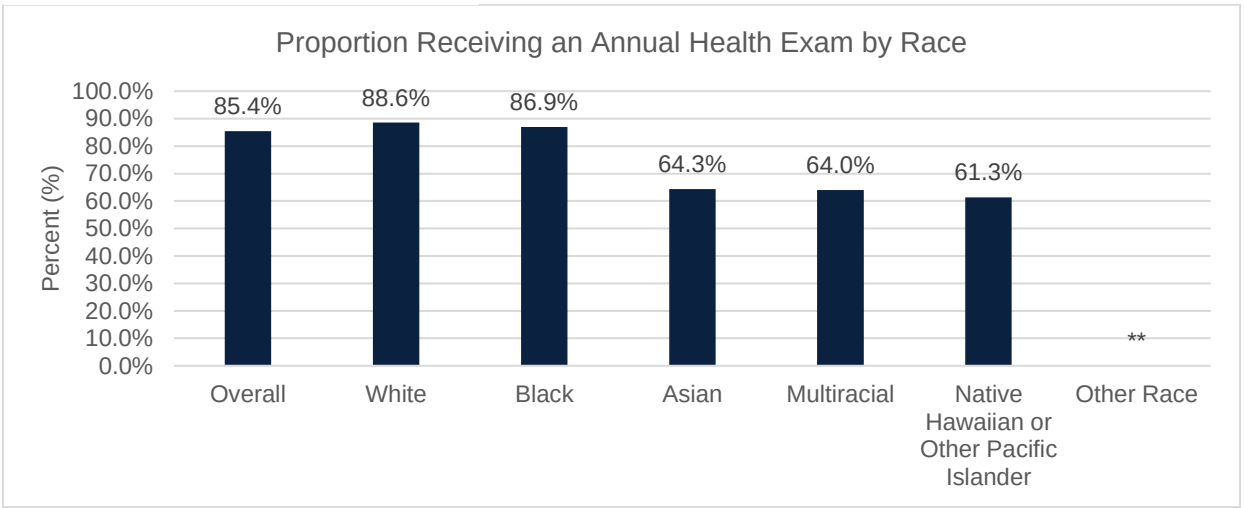
Access to Healthcare

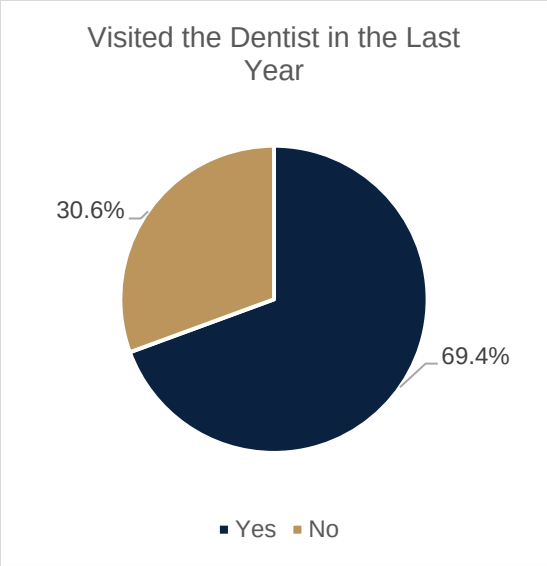


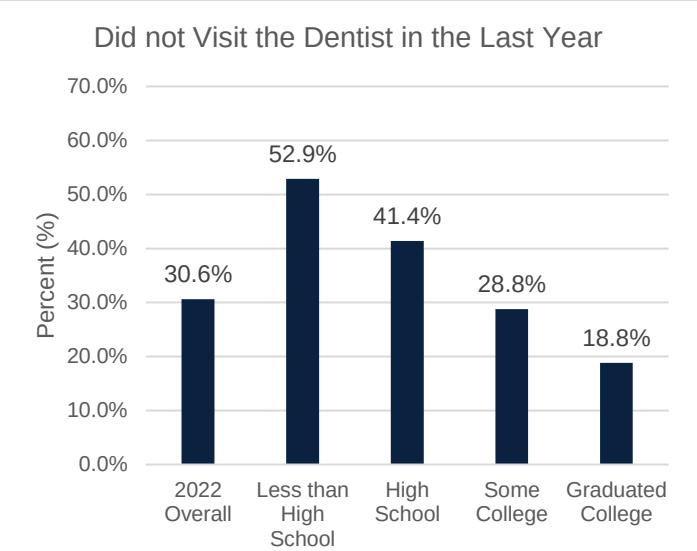
Respondents to the community survey were asked if they receive an annual health exam. If they were unable to, they had an additional question to understand their barriers. Younger age groups and people with lower income levels were less likely to visit a doctor, as well as respondents born in Burma and respondents born in the Marshall Islands. Some of the top reasons given were cost, that they don't feel like they need an annual health exam, and that they were unable to get an appointment at a time that works best for them.

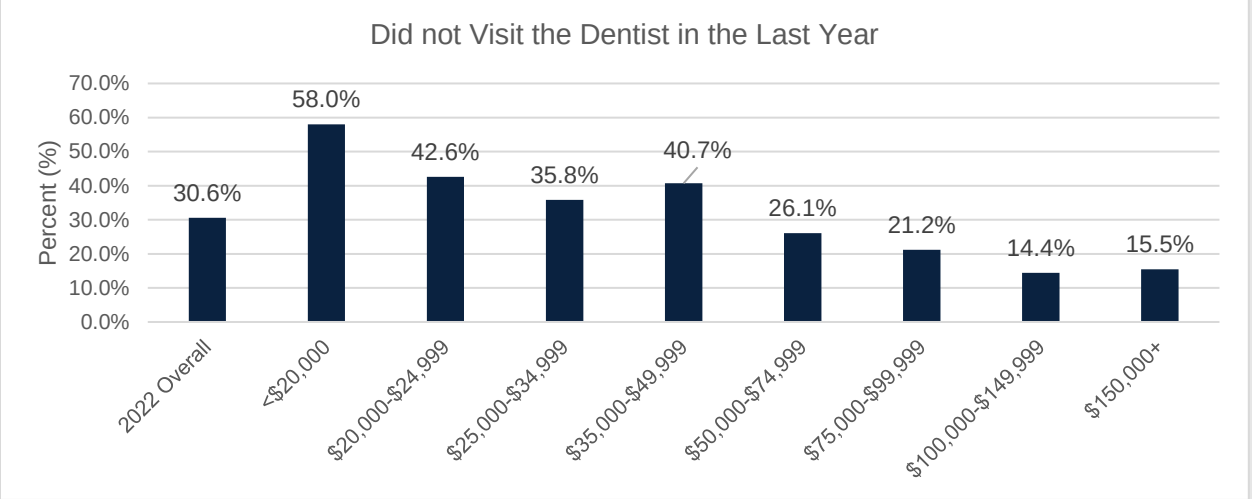


Community survey participants were also asked if they visited the dentist regularly (1-2 times a year) and what the barriers were if they had not. The groups affected the most were the same as those who were less likely to visit a doctor. The top barriers were cost, not having dental insurance, and not being able to get an appointment at a time that works best for them.

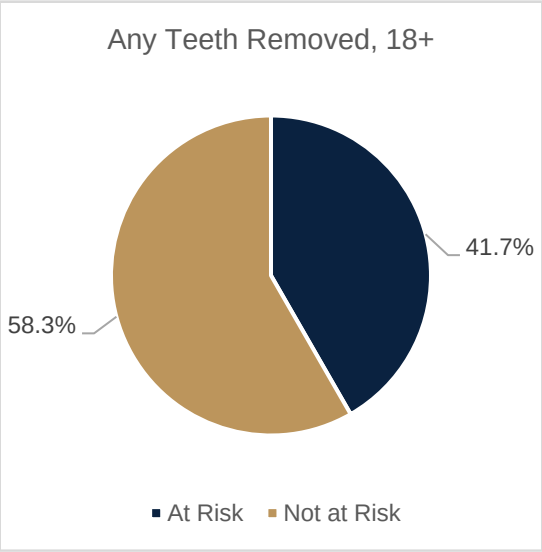


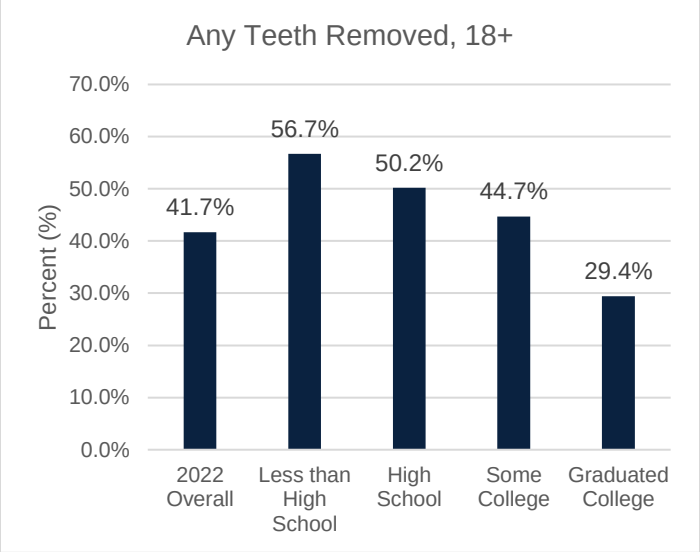


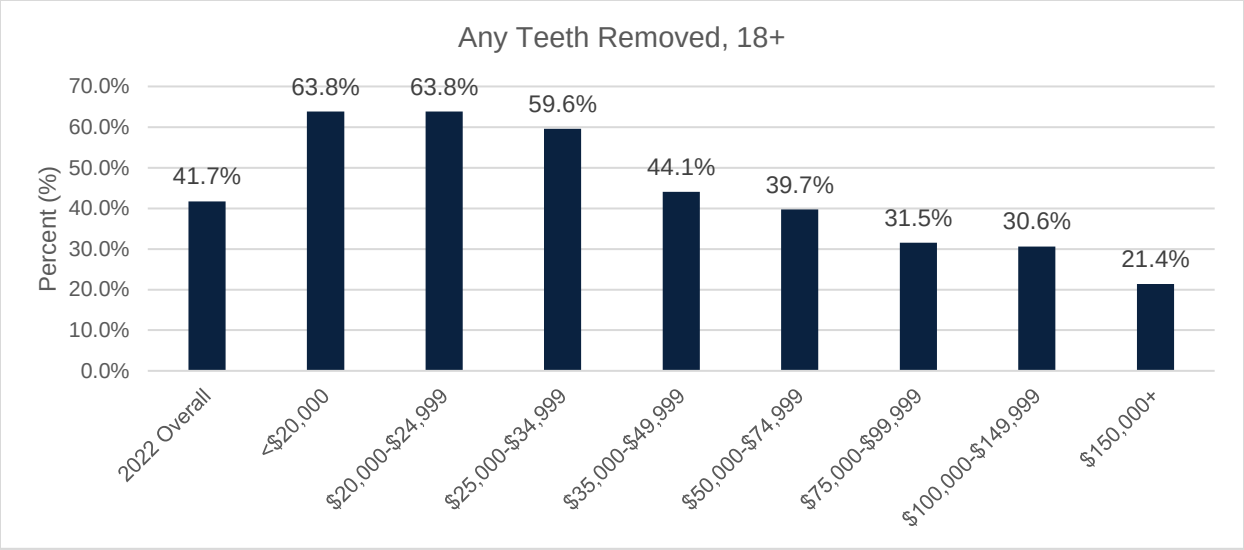




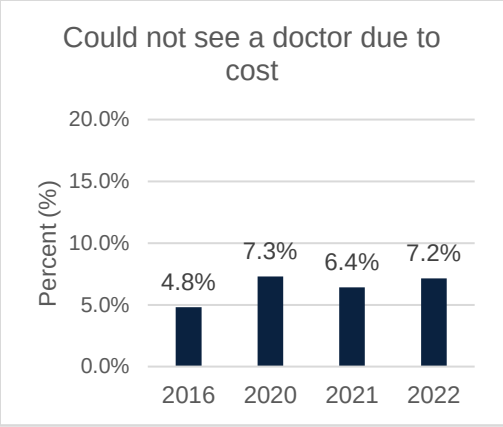
A similar question was asked in BRFSS if participants had been able to visit the dentist in the past year, with nearly the same proportion saying no. When disaggregated, the groups most affected were lower income levels and lower levels of educational attainment. Other populations that were impacted but not as significantly were: people ages 18 to 34 (39.2%), those who identified as Black (39.8%), and those who identified as Hispanic (38.3%).

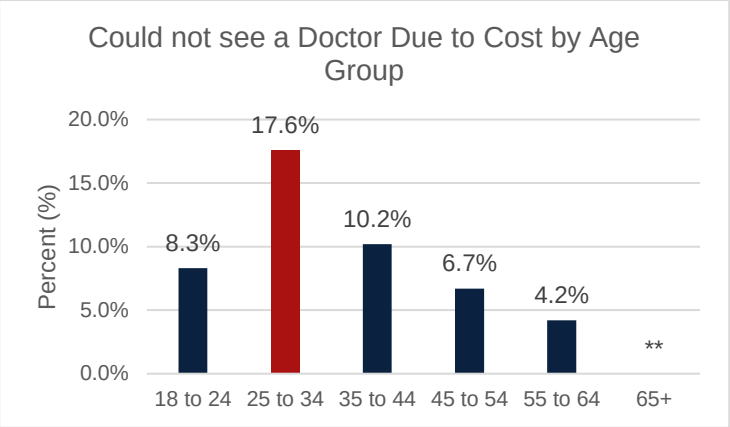


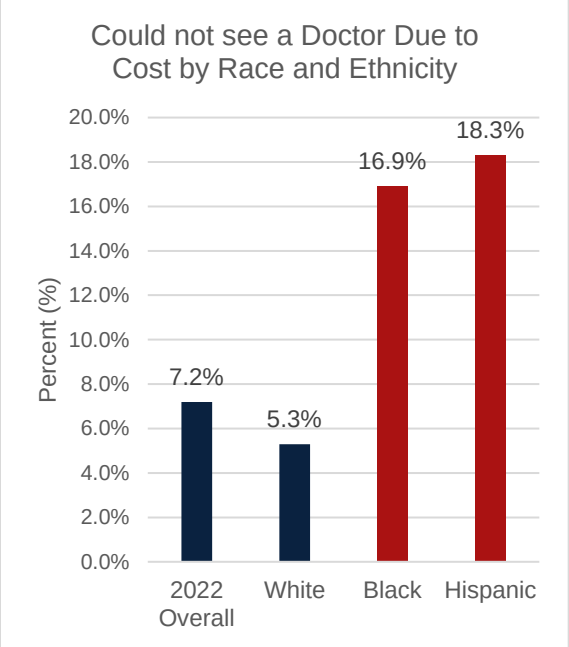


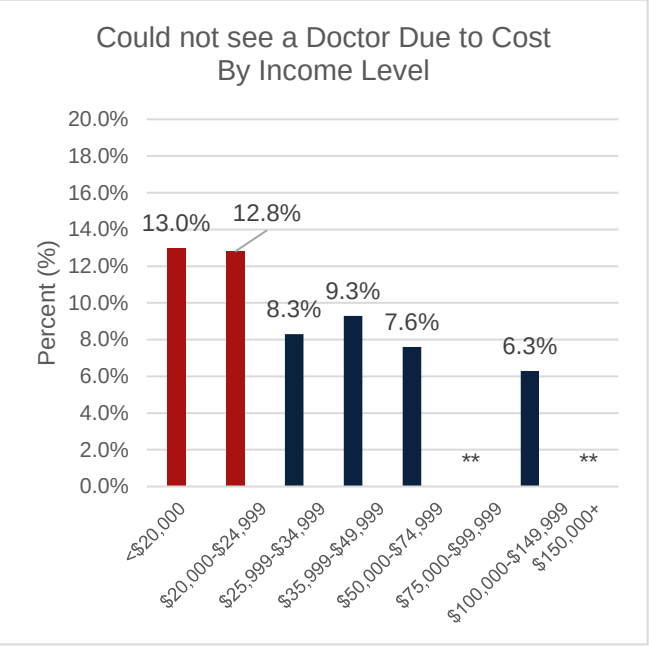


BRFSS respondents were asked if they ever had any teeth removed due to decay or gum disease (orthodontics and other causes were excluded). Those who had teeth removed for those reasons were “at risk.” Those who had less than a high school education and an income below $25,000 were the most likely to be affected. No significant differences were seen by sex or race and ethnicity. The age group most likely to be affected was 65+.

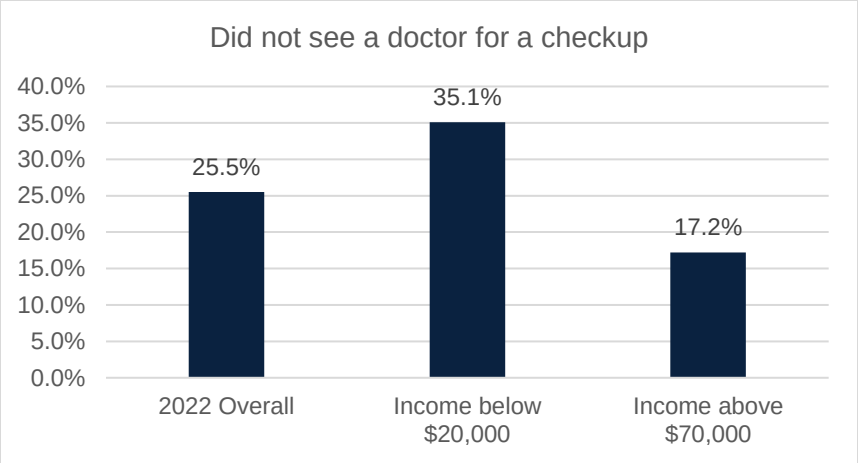




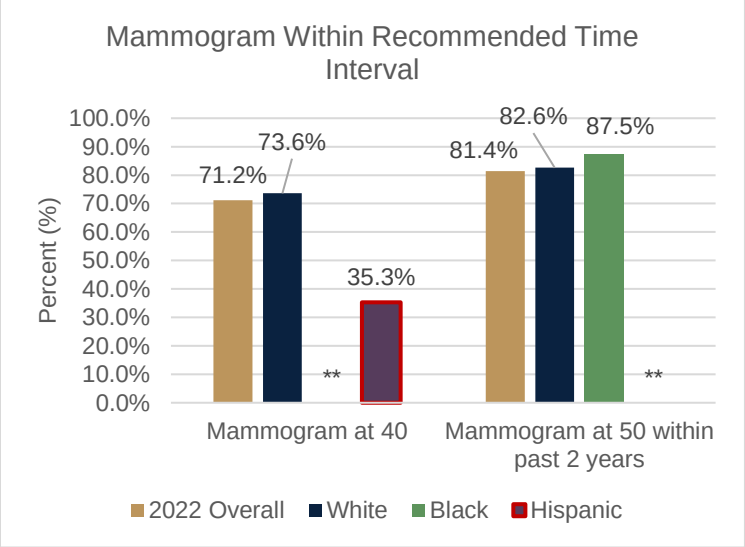


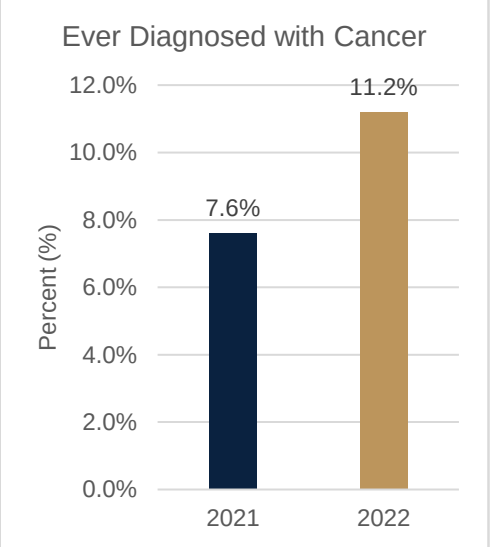


BRFSS respondents were asked if they could not see a doctor due to cost in the last year. The largest disparities were by race and ethnicity (Black or African American and Hispanic), age group (25-34), and income level (less than $25,000).

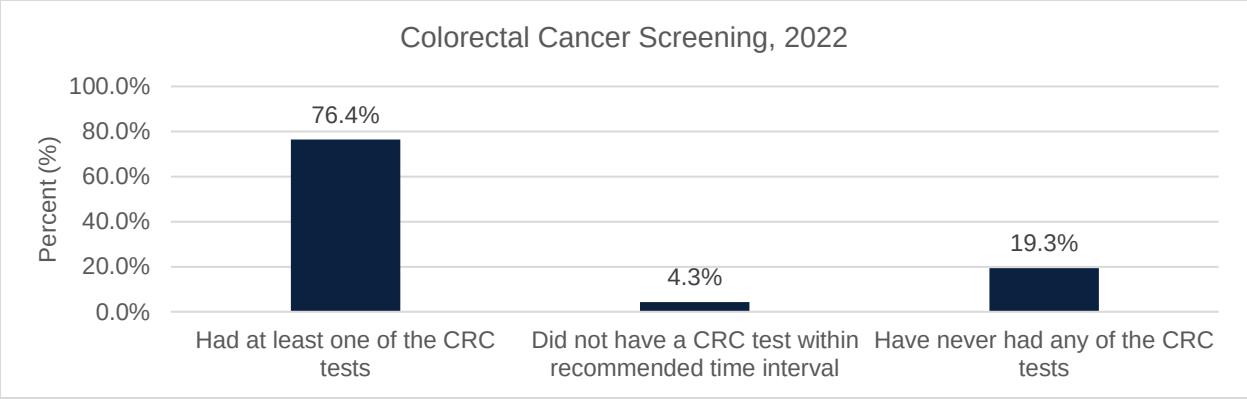


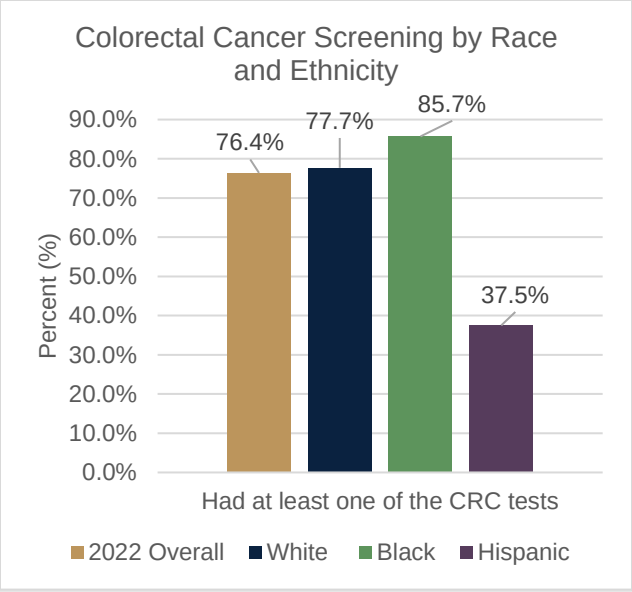
In the Barriers survey, participants were asked if they were able to see a doctor 12 months before pregnancy. On average, 25.5% were not able to see a doctor. When disaggregated by income, 35.1% of those with an income below $20,000 did not see a doctor 12 months before pregnancy compared to 17.2% for those earning above $70,000.

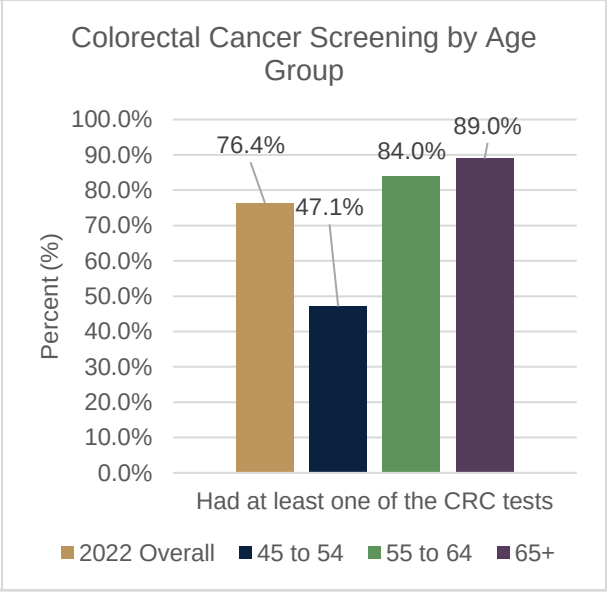




There was an increase in the proportion of BRFSS respondents diagnosed with cancer from 2021 to 2022. Respondents identifying as female were asked in 2022 if they had a breast cancer screening at ages 40 and 50 within the past 2 years. When disaggregated by race and ethnicity, Hispanic individuals were less likely to have breast cancer screening performed at age 40 than individuals of other races. No significant difference by race and ethnicity was noted for breast cancer screenings performed at 50.



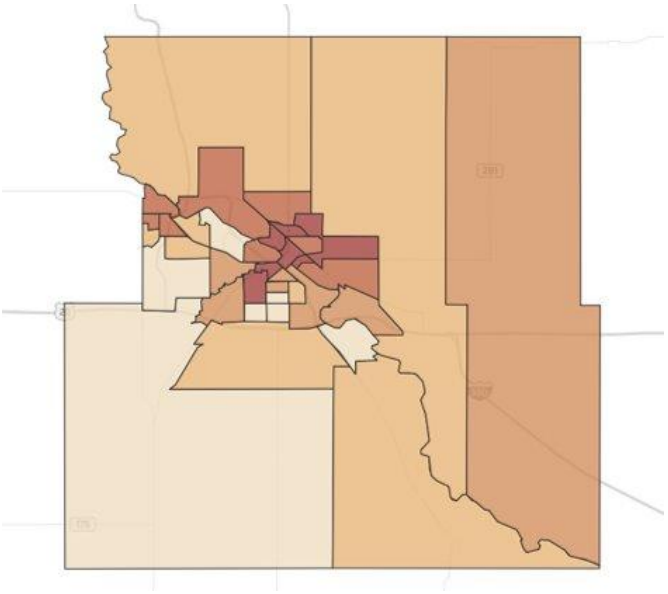




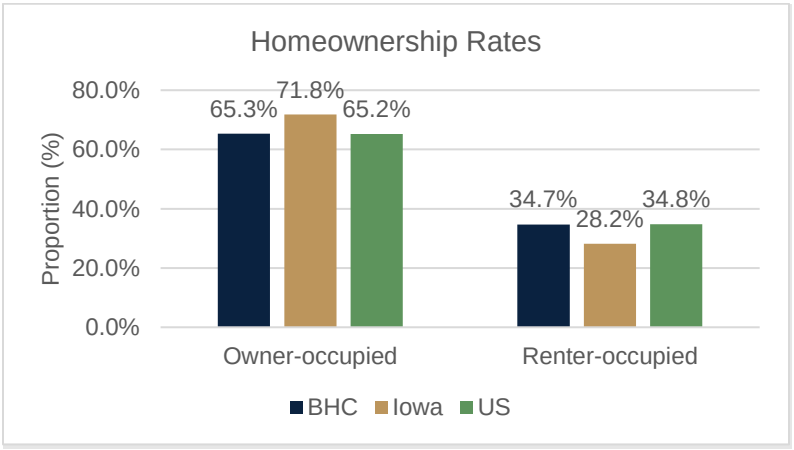
BRFSS participants were asked if they had any colorectal cancer screening in 2022. 76.4% of individuals had at least 1 test within the recommended time interval. Hispanic individuals and those aged 45-54 were the least likely to have had at least 1 screening within the recommended time interval, 37.5% and 47.1% respectively. No significant difference was shown by income level. Those with less than a high school education were the least likely to receive a screening (66.7% compared to overall average of 76.4%), but the difference was less extreme than those by race and ethnicity and age.

Housing Stability

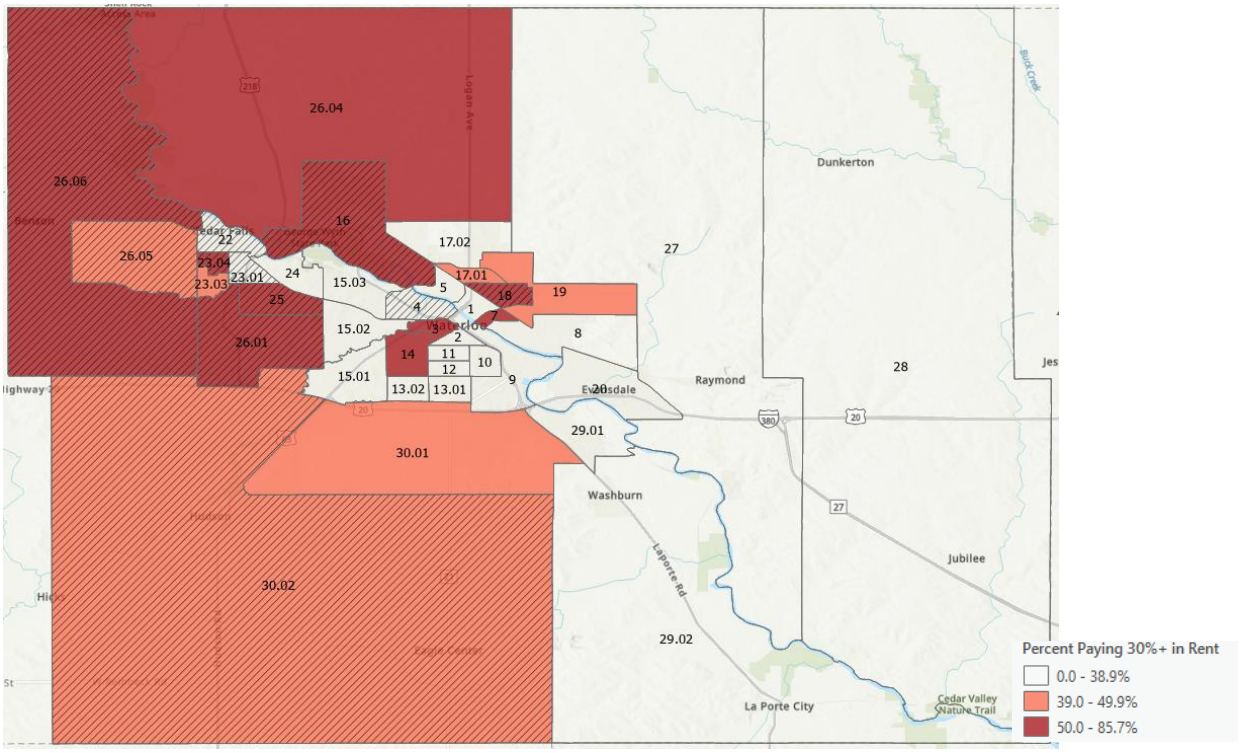
According to the community survey, safe and affordable housing ranked second among areas most in need of improvement, with 77% of respondents identifying it as a priority.



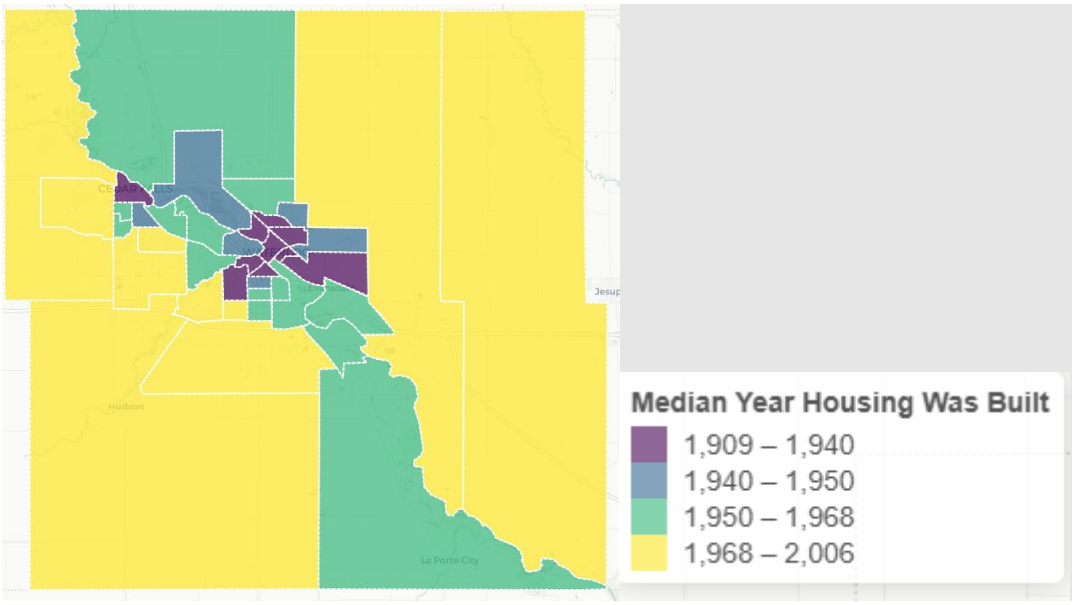
Iowa HHS created a map depicting lead exposure risk. This map highlights areas at higher risk based on age of housing (houses built before 1949) and childhood poverty. Parts of Waterloo show the highest risk. Cedar Falls has regions with moderate risk. Rural regions generally exhibit lower risk, except for the eastern portion of the county, which is at a moderate risk.



Census data shows that BHC's owner-occupied housing rate (65.3%) is lower than Iowa's (71.8%) but is similar to the U.S. average (65.2%). Census tract 23.03, encompassing UNI's campus, and tract 1 in downtown Waterloo have the lowest rates of owner-occupied housing rate (tract 23.03 at 12.5%, tract 1 at 14.5%).

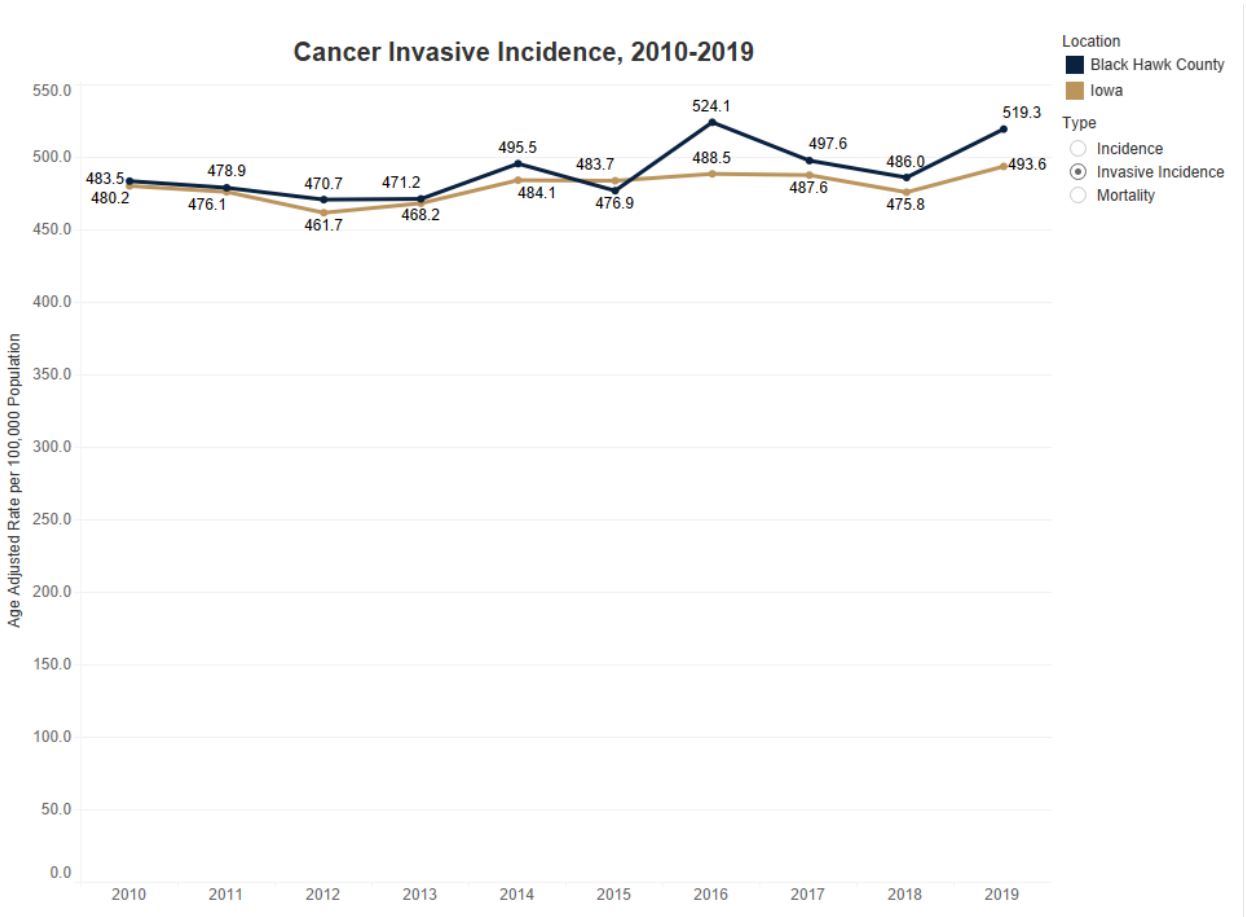


Rent burden, defined as spending over 30% of household income on rent, is prevalent in central and northwestern parts of the county. On the map, dark colors signify a higher proportion of rent burden, and census tracts with diagonal lines are tracts where rent is $1000 or higher for median rent. When examining rent burden alongside median rent by census tract, it becomes clear that even areas with lower median rent can experience significant rent burden.

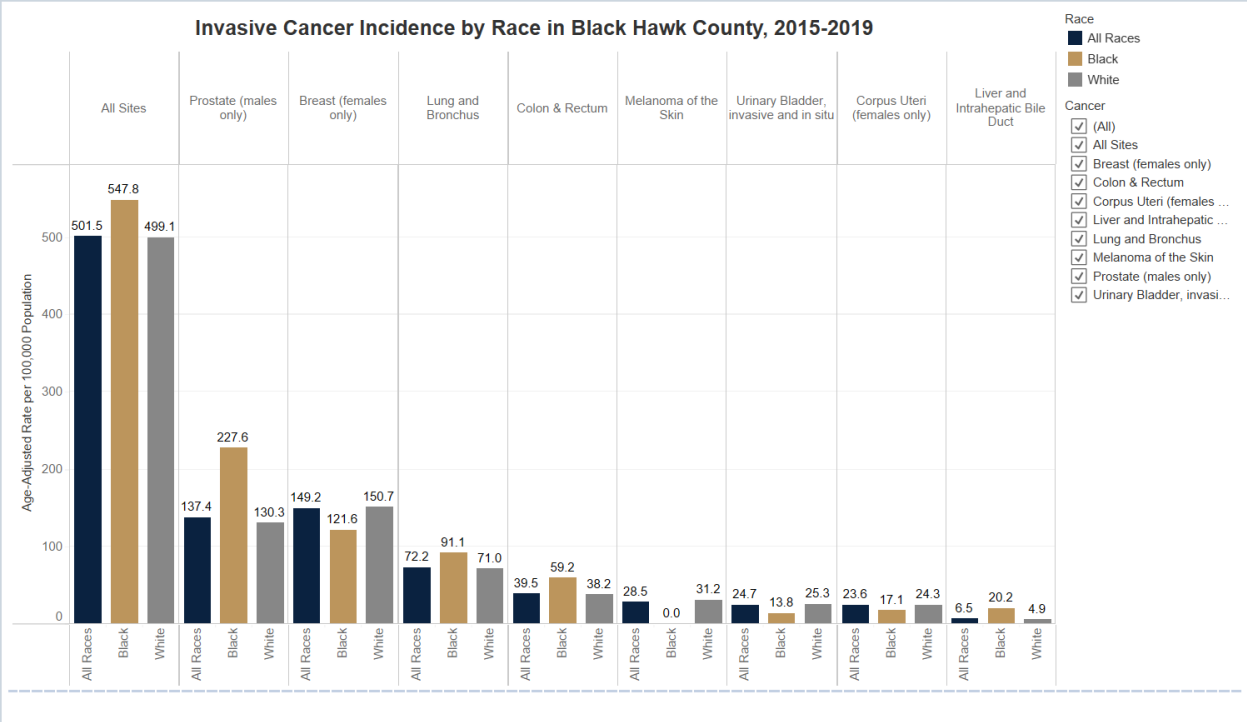


Data from the BHC assessor's office shows the median construction year of residential properties in each census tract. Housing in Waterloo tends to be older, aligning with the higher risk for lead exposure map created by Iowa HHS.

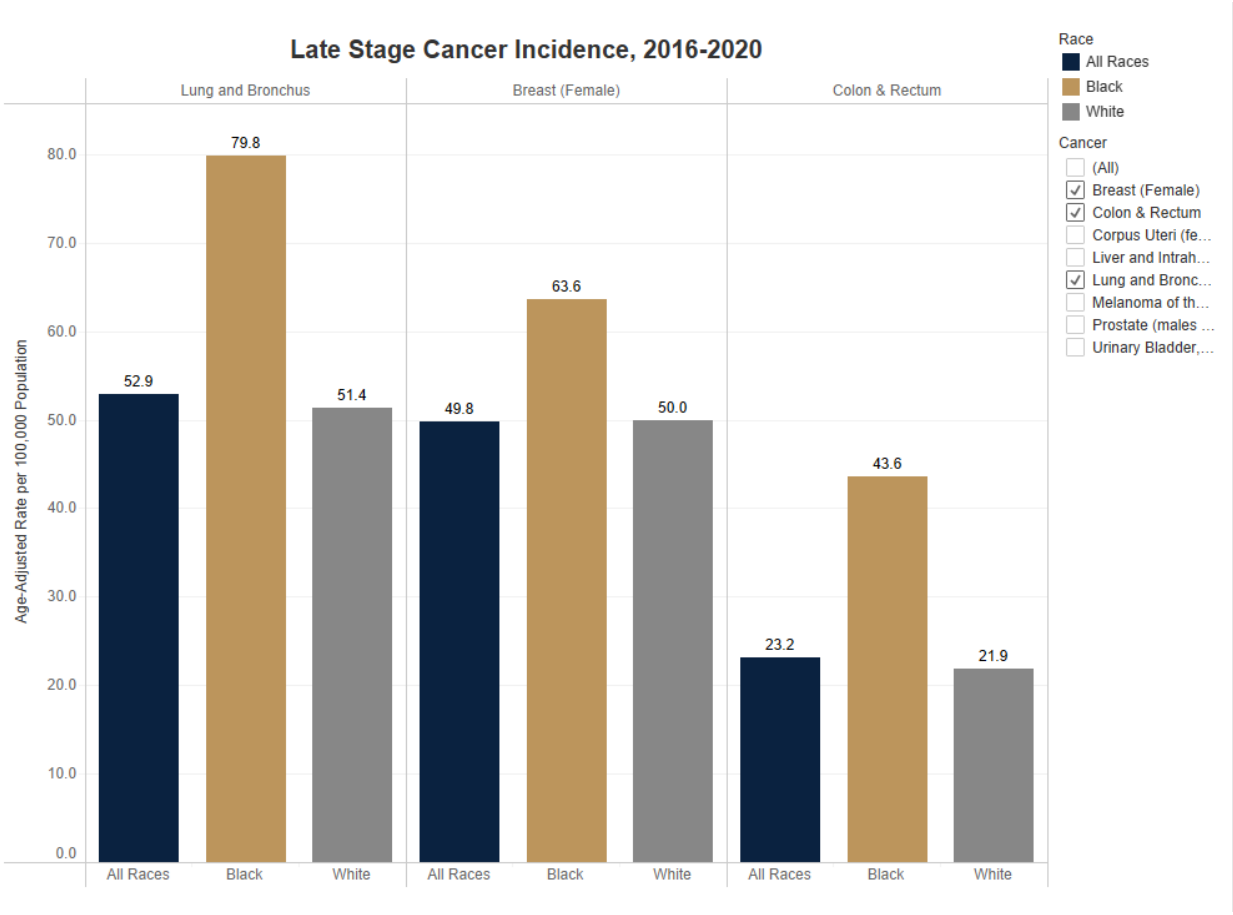
Chronic Disease



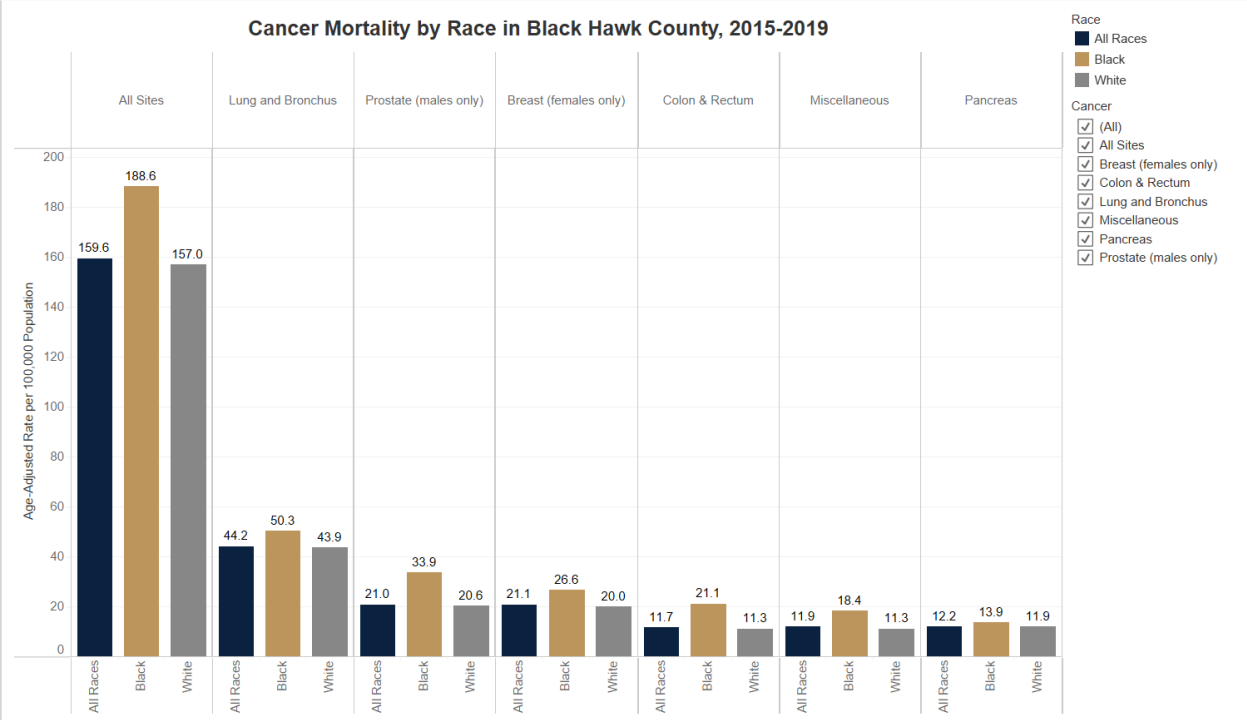
The Iowa Surveillance, Epidemiology, and End Results (SEER) Cancer Registry is a database with information on cancers diagnosed in Iowa. The data available was analyzed by the SEER Cancer Registry and released publicly. The graph above shows invasive cancer incidence (cancers diagnosed at stages 1-4) from 2010 to 2019, demonstrating an overall increase in invasive cancer incidence over time.



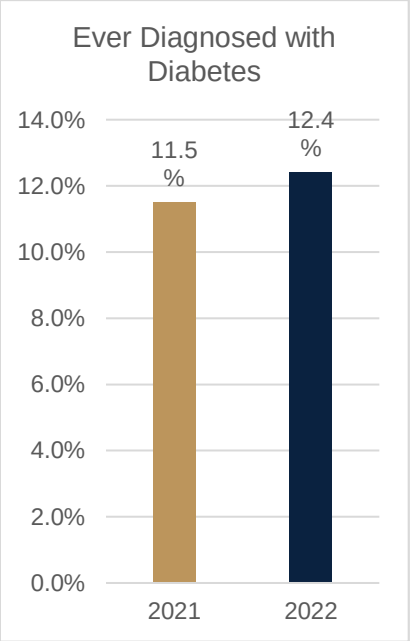
The top 6 invasive cancer rates for each race are shown above. Disparities can be seen for Black individuals for the following groups: all cancers, prostate cancer, lung and bronchus cancer, colorectal cancer, and liver and bile duct cancer.

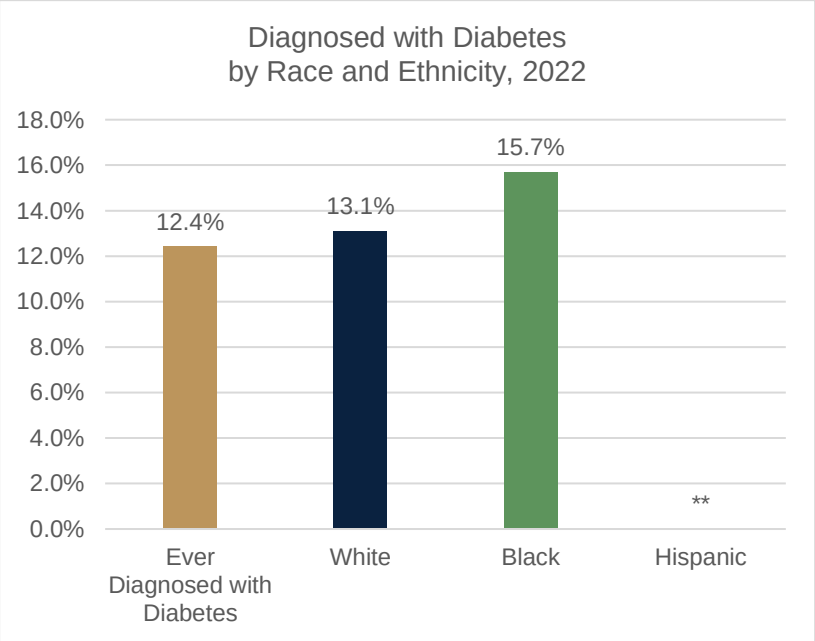


Late-stage cancer incidence was also shown for selected cancers. This data was reported to the National Institutes for Health (NIH) by the Iowa SEER cancer registry, and analyzed by the NIH, who also released it publicly. As with invasive cancer incidence, disparities can be seen for Black individuals for lung and bronchus cancer as well as colorectal cancer. While breast cancer (female) is more likely to be diagnosed among white women, it is more likely to be diagnosed at a later stage in Black women. Other cancers could not be disaggregated due to low counts.

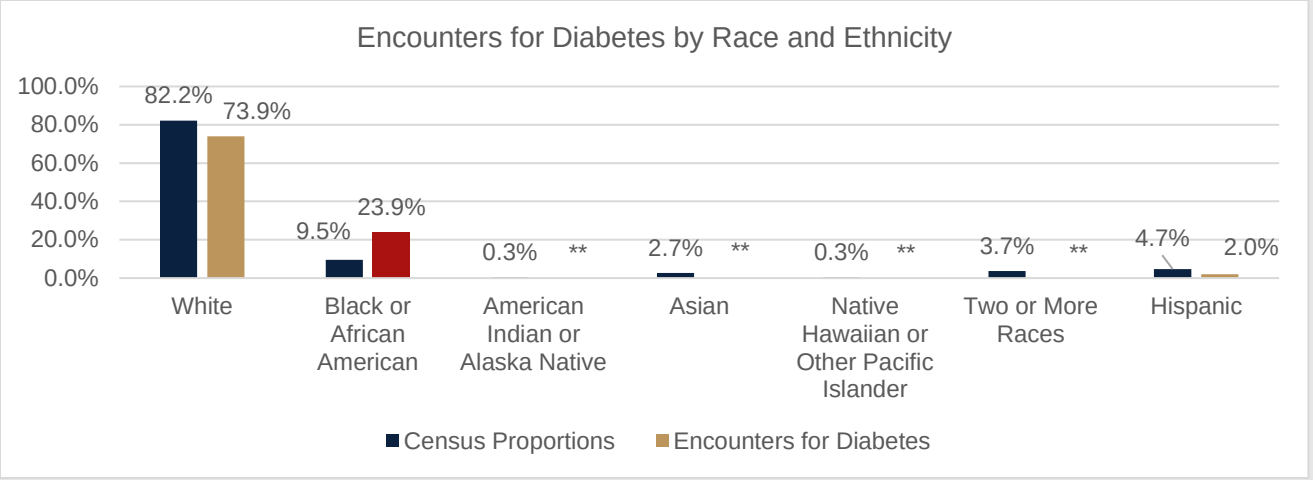


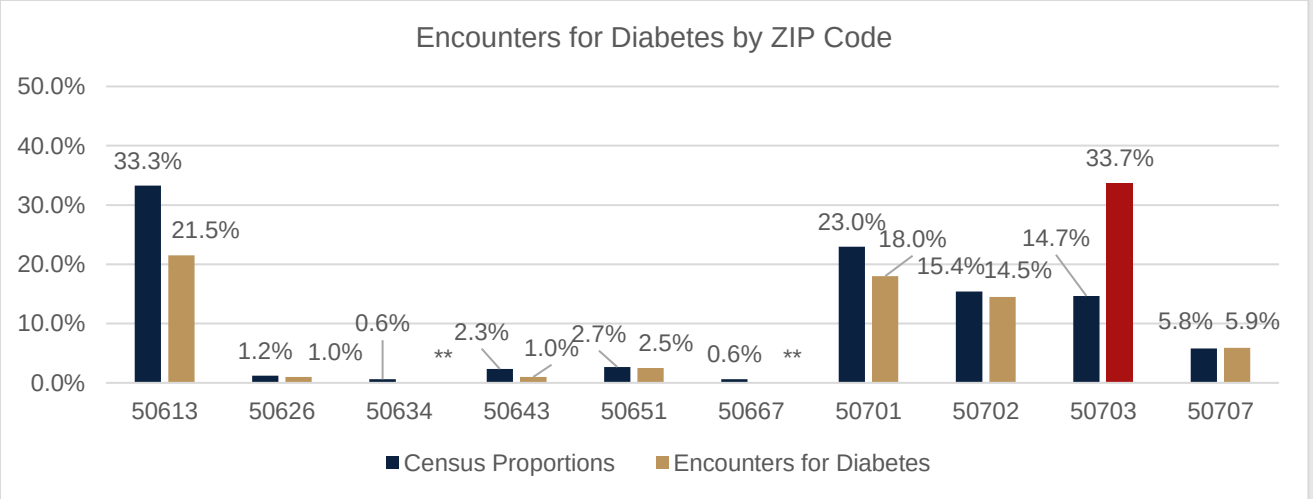
The graph above shows the top 6 cancer mortality rates disaggregated by race. Disparities for Black individuals compared to White individuals and All Races are seen for all cancers shown.



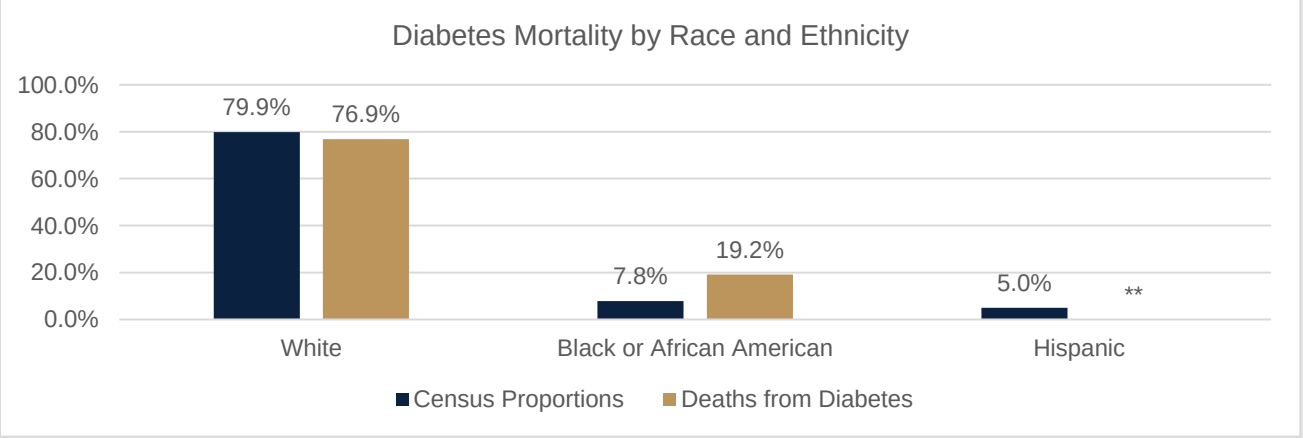


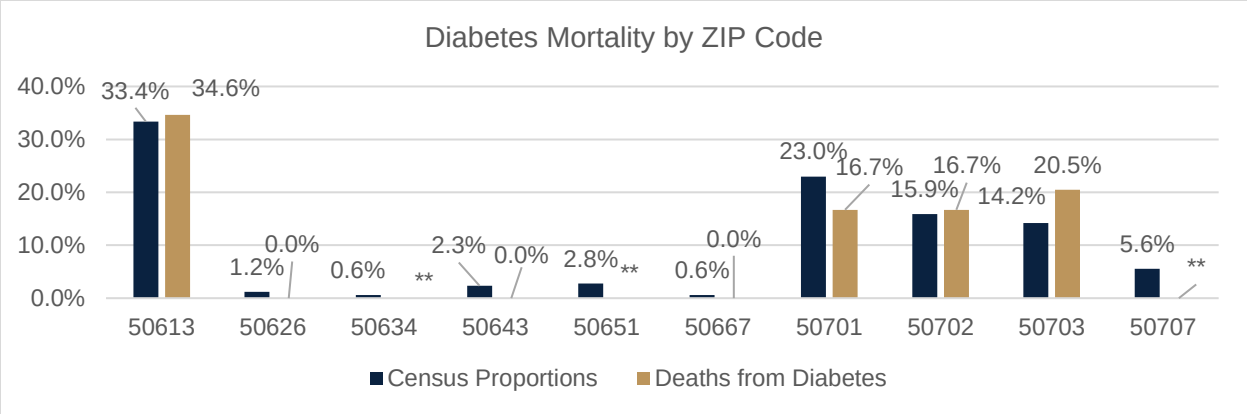
More BRFSS respondents reported having been diagnosed with diabetes from 2021 to 2022. Diabetes diagnoses were also disaggregated by race and ethnicity, as diabetes came up as a chronic disease concern in the community survey for Black or African American respondents as well as a few other groups. The graph above on the right shows that Black individuals were more likely to report having been diagnosed with diabetes. This BRFSS data highlights the concern identified in the community survey.



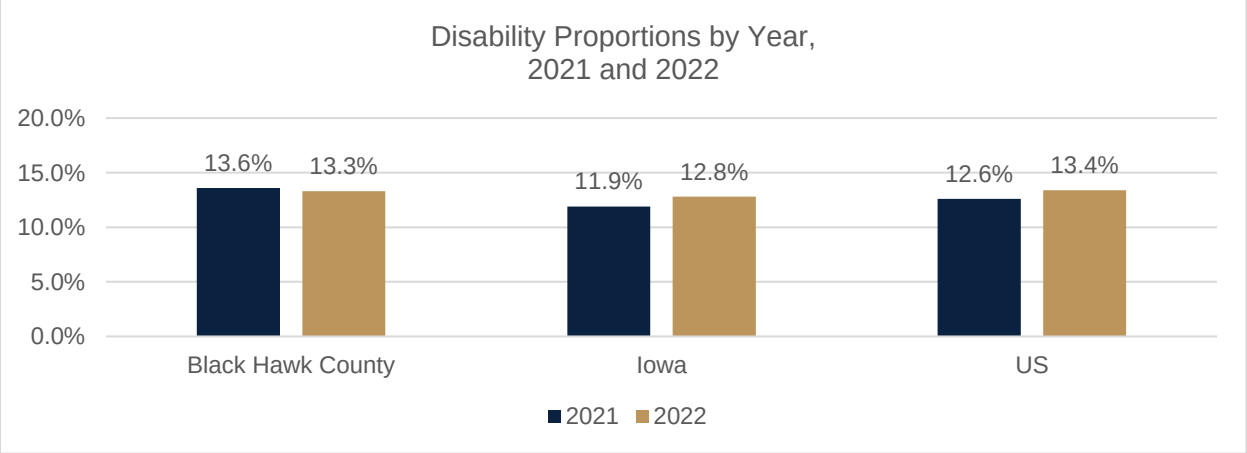


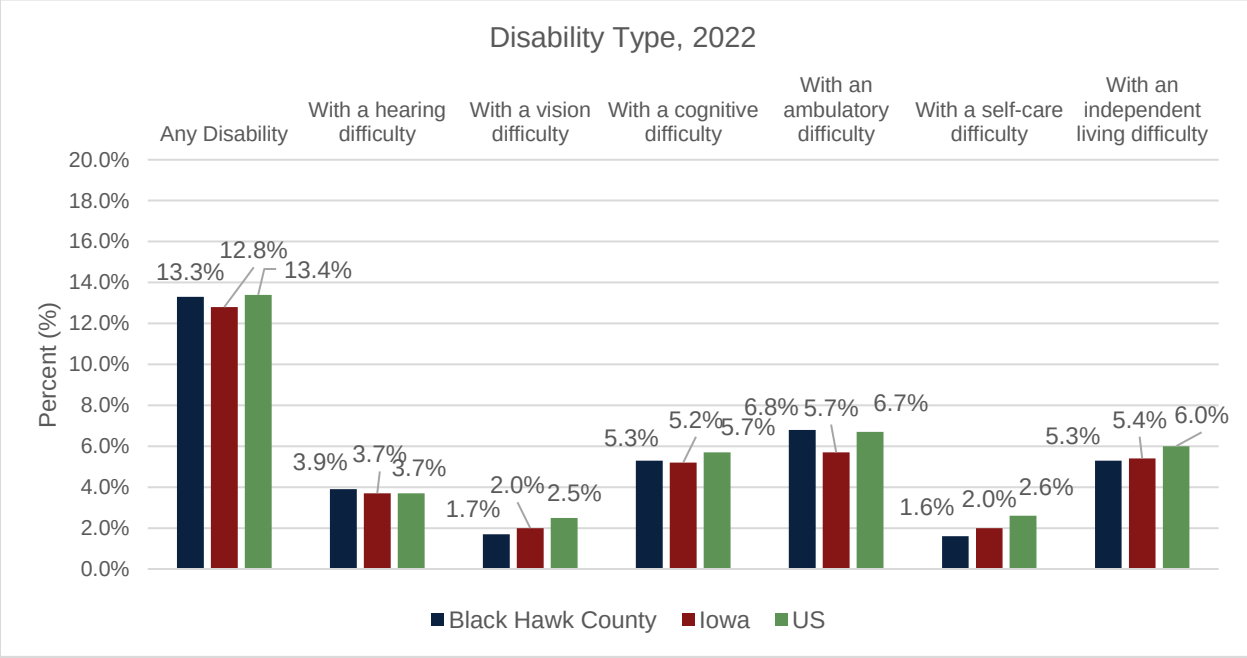
Type 2 Diabetes (ICD-10 Code E11) was also a diagnosis assessed in the IHA inpatient data, as it made up the largest proportion of all diabetes diagnoses. Data was disaggregated by race and ethnicity as well as ZIP code. Proportions for Black or African American individuals as well as those from ZIP code 50703 were larger than Census proportions, highlighting an impact on these groups.

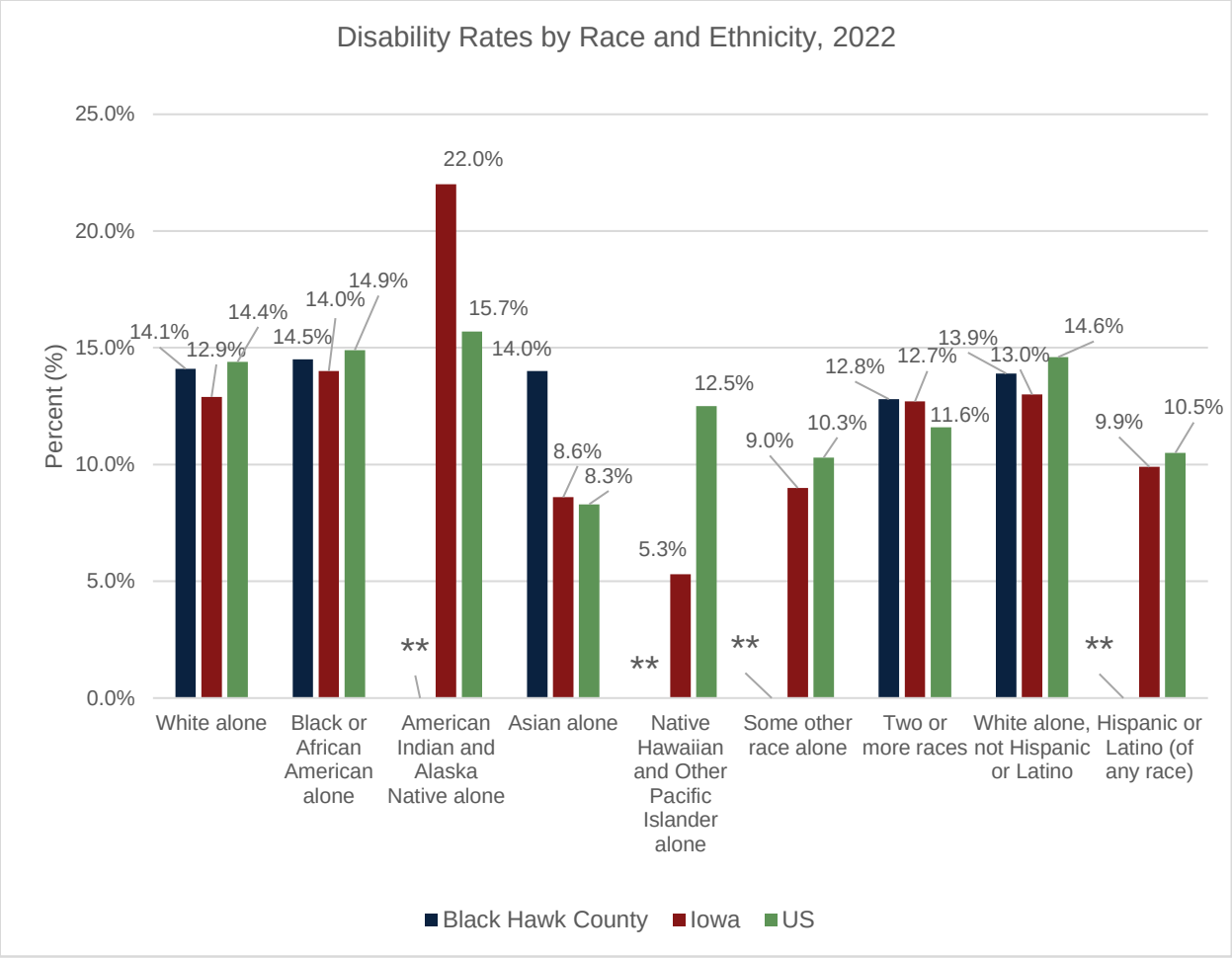




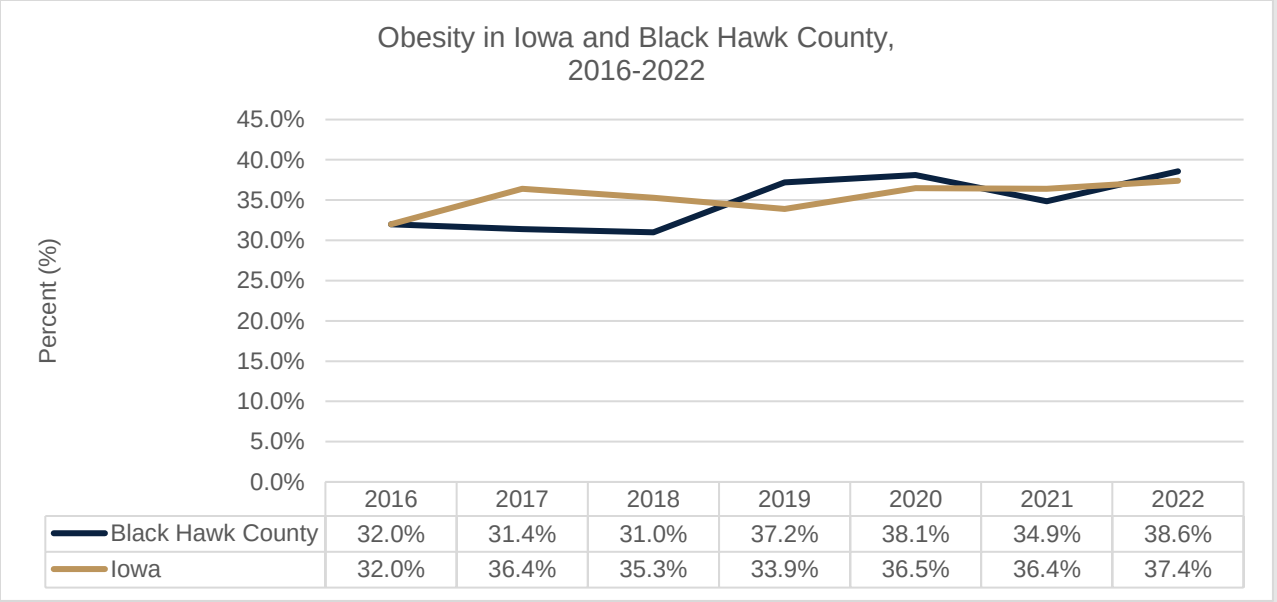
Diabetes mortality from the Vital Records- Mortality data (ICD-10 Codes E08-14) by race and ethnicity and ZIP code is shown above. Trends can be seen for both Black or African American individuals and those from 50703. These trends are similar to the IHA inpatient data.

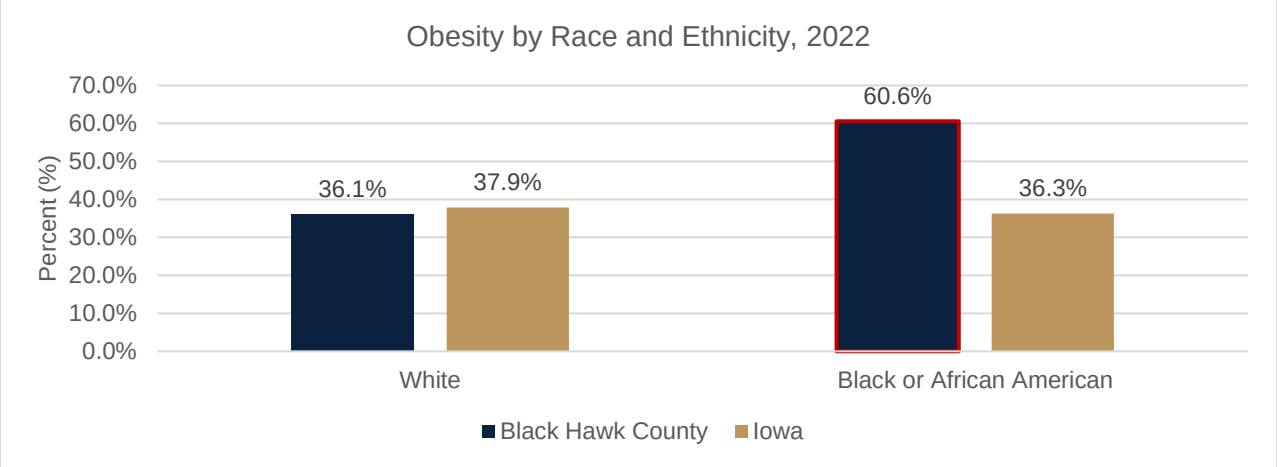






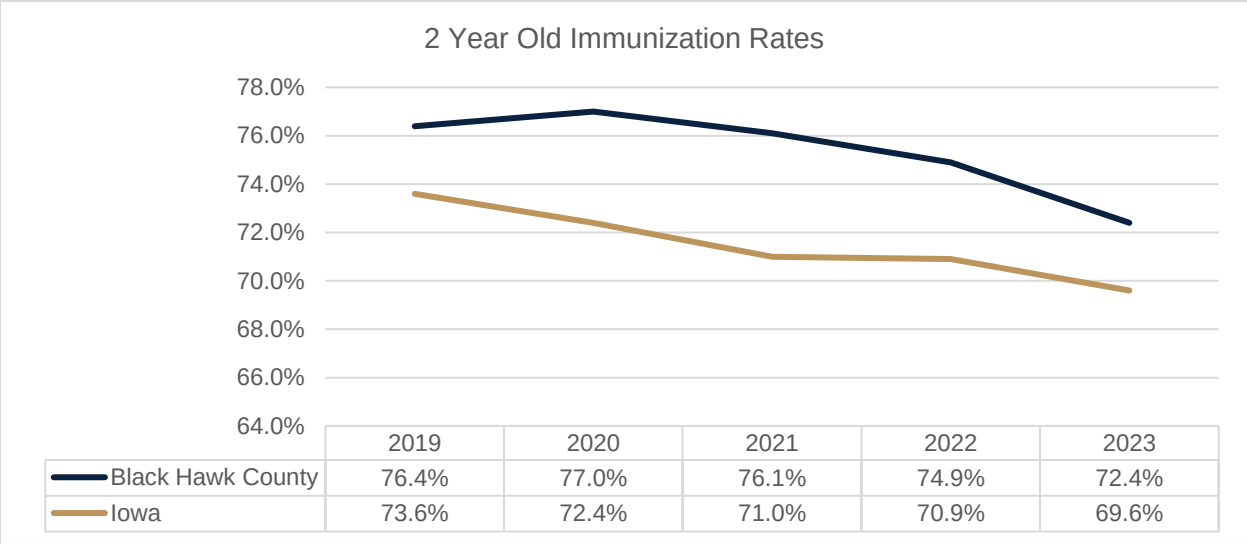
Disability rates for BHC, Iowa, and the US were similar between 2021 and 2022. However, in 2021, the BHC proportion was higher than both the Iowa and US proportions, while in 2022 it was similar to the US proportion. When disaggregated by disability type, the most common disabilities in BHC were cognitive difficulties, ambulatory difficulties, and independent living difficulties. When disaggregated by race and ethnicity, proportions for BHC were more like the US level in most cases, with the Iowa level being lower. For Asian individuals, the proportion was higher than both the US and Iowa levels. For Two or More Races, the BHC level was more like the Iowa level, with the US level being lower.



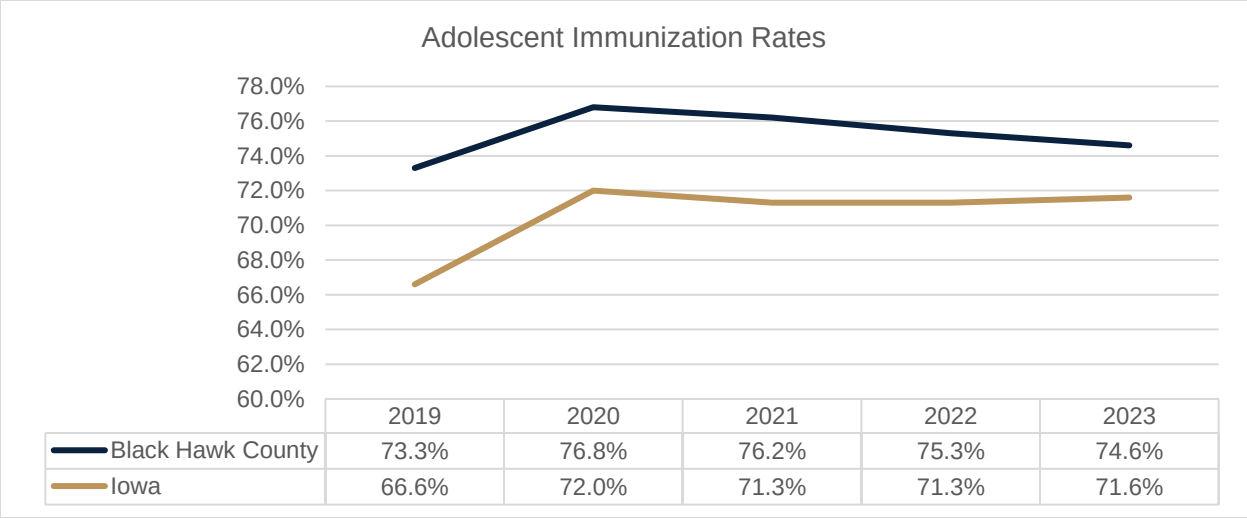


BRFSS respondents were asked questions about their height and weight, and from this information, Body Mass Index (BMI) was calculated to find obesity proportions. BHC data was calculated using BRFSS respondent data, and Iowa data was collected from the Iowa HHS Public Health Tracking Portal. From 2016 to 2022, obesity proportions in both BHC and Iowa increased at similar rates, with the proportions in 2022 being the highest. Additionally, when disaggregated by race, the proportion of Black respondents who were obese was higher than the proportion of white respondents who were obese for BHC. For Iowa, however, the proportions were similar between Black or African American and white respondents who were obese.

Infectious Disease

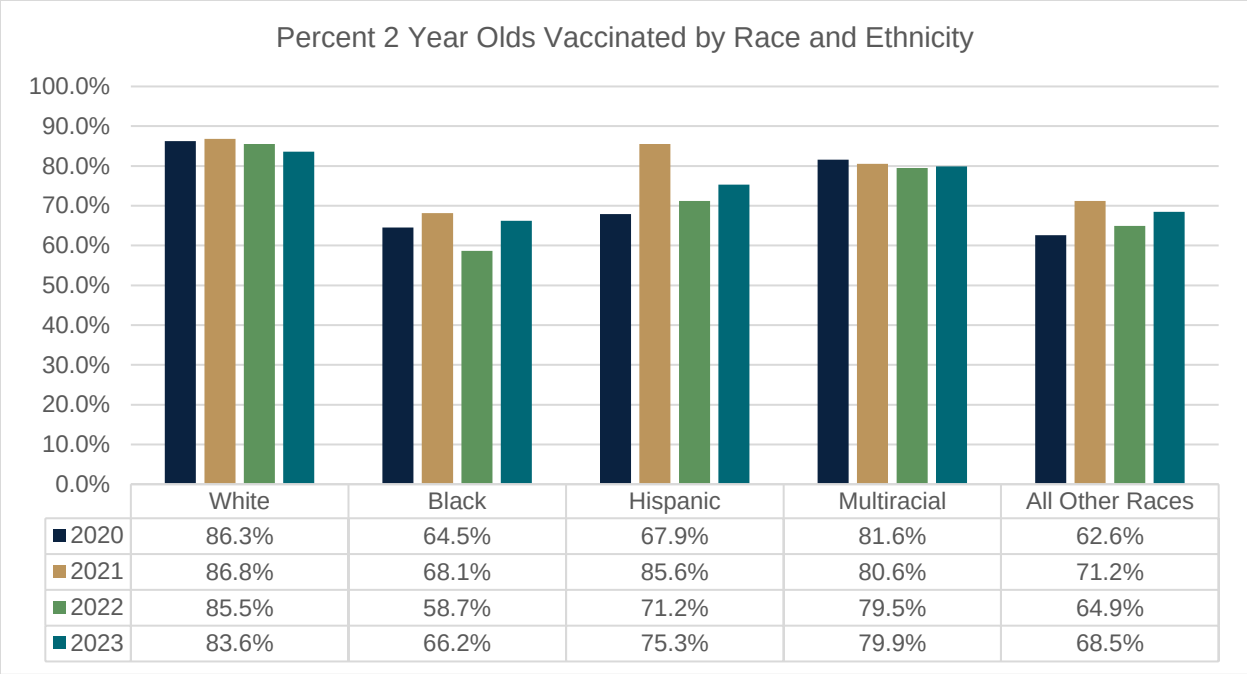


	2019	2020	2021	2022	2023
Black Hawk County	76.4%	77.0%	76.1%	74.9%	72.4%
Iowa	73.6%	72.4%	71.0%	70.9%	69.6%

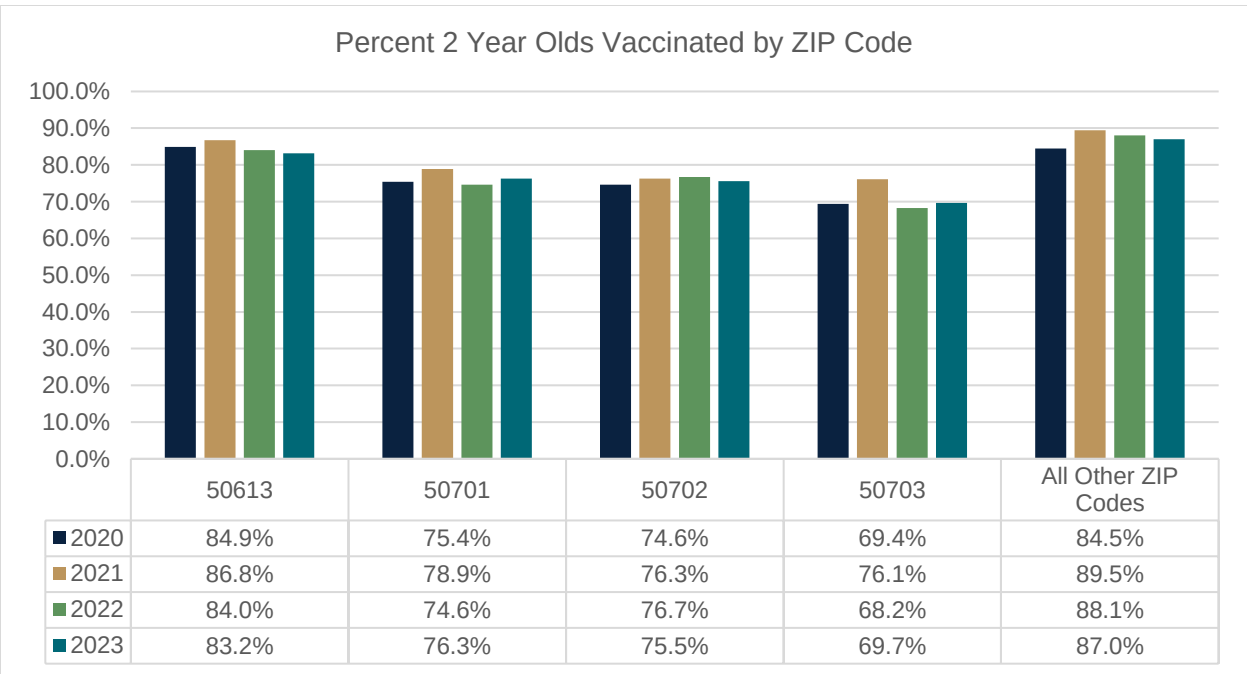


	2019	2020	2021	2022	2023
Black Hawk County	73.3%	76.8%	76.2%	75.3%	74.6%
Iowa	66.6%	72.0%	71.3%	71.3%	71.6%

Immunization rates for BHC and Iowa were retrieved from the Iowa Public Health Tracking Portal. Two age groups, 2-year-olds and adolescents, are typically assessed to see if they have received the full vaccine series for their age group. For two-year-olds, they are expected to have 4 DTaP, 3 Polio, 4 Pneumococcal, 3 Hib, 3 Hepatitis B, 1 MMR, and 1 varicella. If all these are present, they are considered to have a completed vaccine series. Adolescents are defined as individuals aged 13 to 15 and are expected to have 1 Tdap, 3 Hep B, 1 meningococcal, 2 MMR, and 2 varicella. The trend for two-year-olds shows that the vaccination rate has been declining over the last several years, for both Iowa and BHC. However, the vaccination rate in BHC remains a little higher than the state of Iowa. The trend for adolescents shows a slight decrease overall from 2020 to 2023; however, the rates in 2019 for both BHC and Iowa were lower than the rates in 2023. Again, the rates for BHC remain higher than Iowa's.

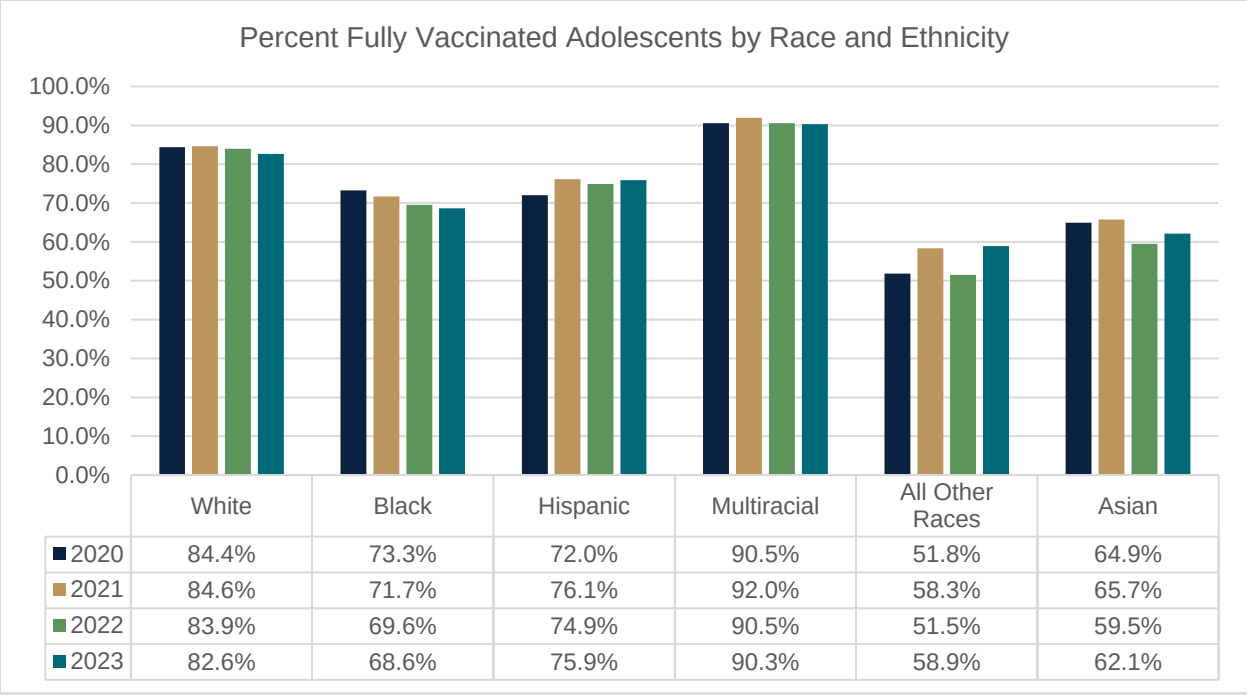


	White	Black	Hispanic	Multiracial	All Other Races
2020	86.3%	64.5%	67.9%	81.6%	62.6%
2021	86.8%	68.1%	85.6%	80.6%	71.2%
2022	85.5%	58.7%	71.2%	79.5%	64.9%
2023	83.6%	66.2%	75.3%	79.9%	68.5%

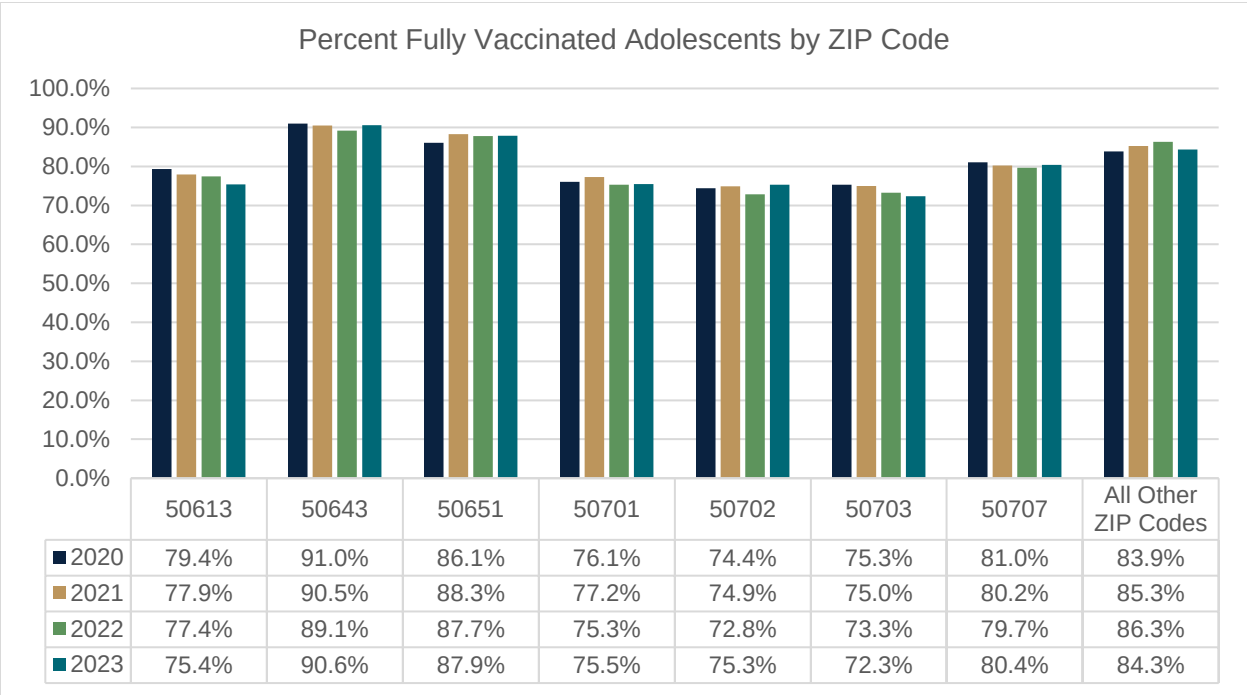


	50613	50701	50702	50703	All Other ZIP Codes
2020	84.9%	75.4%	74.6%	69.4%	84.5%
2021	86.8%	78.9%	76.3%	76.1%	89.5%
2022	84.0%	74.6%	76.7%	68.2%	88.1%
2023	83.2%	76.3%	75.5%	69.7%	87.0%

Data for immunizations of two-year-olds was pulled from Immunization Registry Information System (IRIS). Disaggregation was performed by race and ethnicity and ZIP code. Population groups for races that had less than 100 total individuals (American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Asian, and Other Race) were combined into the All Other Races category. A similar method was used for ZIP codes. The groups that consistently had the lowest proportions for race and ethnicity were Black and All Other Races. There were fewer disparities across ZIP codes than by race and ethnicity, but generally children from rural ZIP codes were vaccinated at slightly higher proportions than urban ZIP codes. The proportion of children vaccinated in ZIP code 50703 was slightly lower than for other ZIP codes.

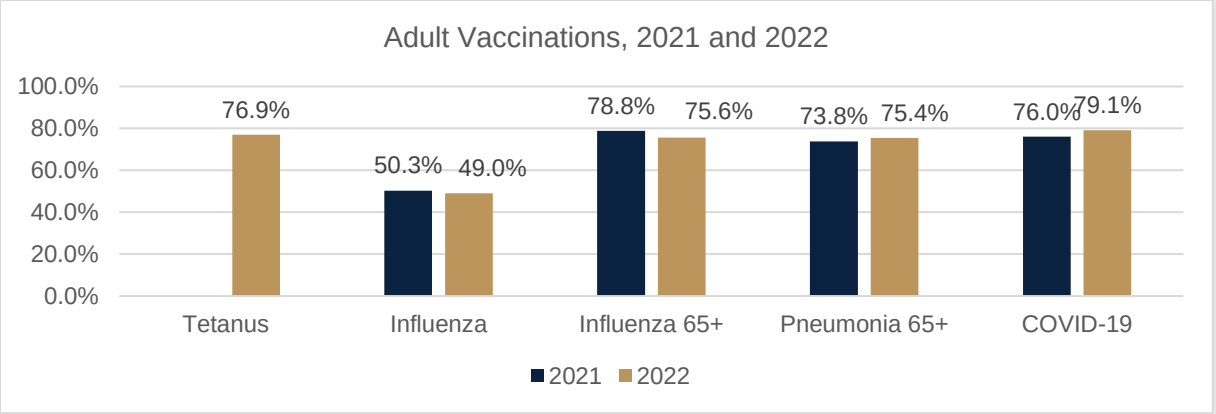


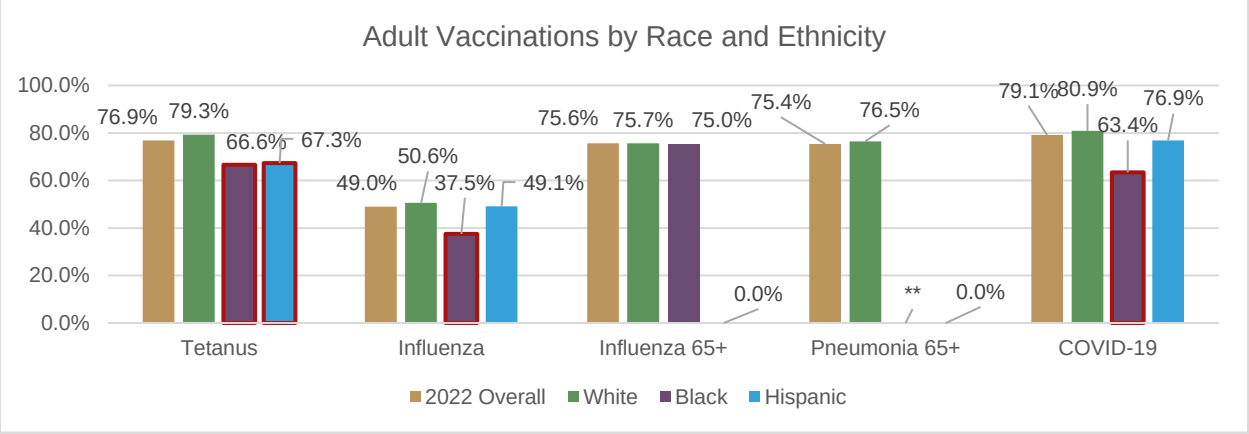
	White	Black	Hispanic	Multiracial	All Other Races	Asian
2020	84.4%	73.3%	72.0%	90.5%	51.8%	64.9%
2021	84.6%	71.7%	76.1%	92.0%	58.3%	65.7%
2022	83.9%	69.6%	74.9%	90.5%	51.5%	59.5%
2023	82.6%	68.6%	75.9%	90.3%	58.9%	62.1%



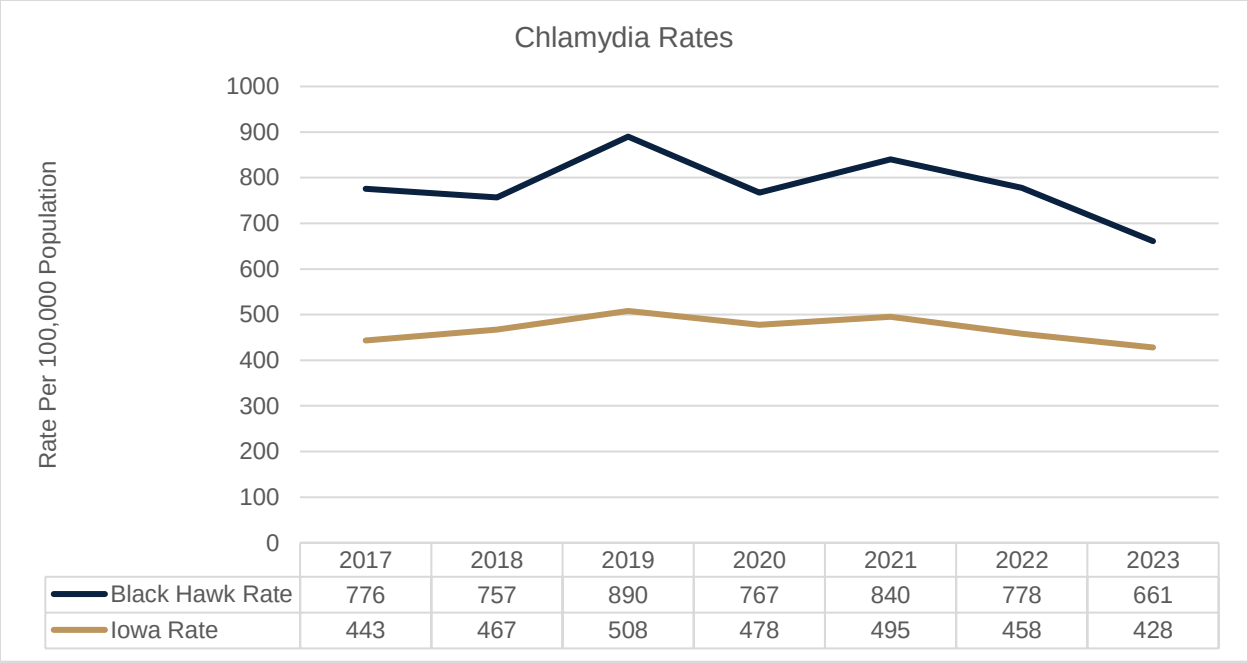
	50613	50643	50651	50701	50702	50703	50707	All Other ZIP Codes
2020	79.4%	91.0%	86.1%	76.1%	74.4%	75.3%	81.0%	83.9%
2021	77.9%	90.5%	88.3%	77.2%	74.9%	75.0%	80.2%	85.3%
2022	77.4%	89.1%	87.7%	75.3%	72.8%	73.3%	79.7%	86.3%
2023	75.4%	90.6%	87.9%	75.5%	75.3%	72.3%	80.4%	84.3%

Data for the adolescent age group was similar to the two-year-olds, with the exception that the All Other Races category does not include Asian individuals, as there were more than 100 total in this group. Some smaller ZIP codes (50643, 50651, and 50707) also had more than 100 individuals and were included in the graph. The race and ethnicity groups that had the lowest vaccination proportions were All Other Races and Asian. For ZIP codes, the trend was similar to the two-year-olds: there were less disparities across ZIP codes, and those from rural ZIP codes were vaccinated at higher proportions compared to urban ZIP codes.

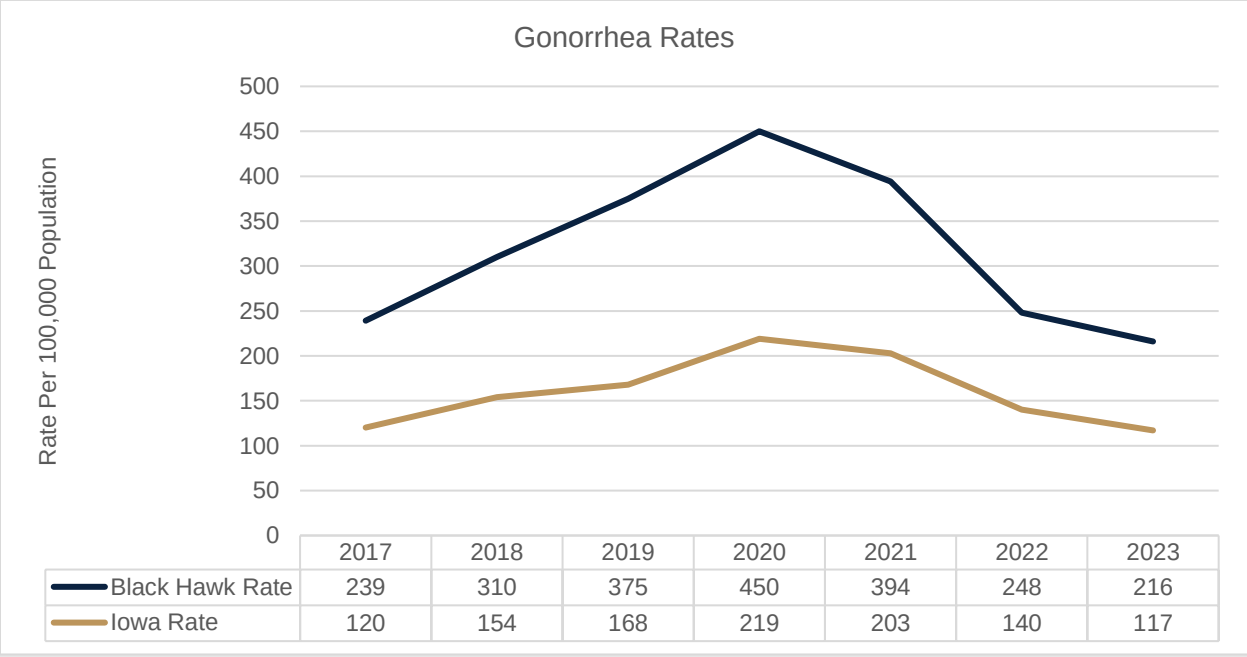




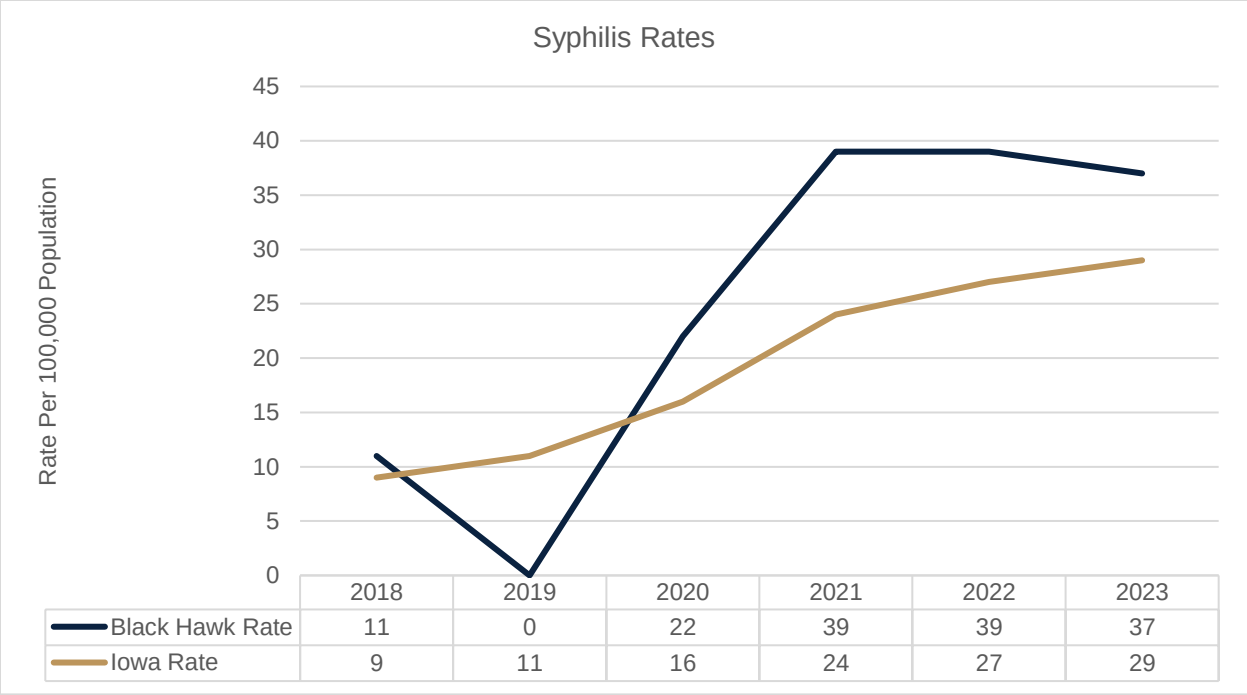
BRFSS respondents were asked about immunizations they had received as an adult including influenza, pneumonia, and COVID-19 in 2021 and 2022. Questions about tetanus vaccines were only asked in 2022. Influenza vaccines were assessed for adults 18 and older and 65 and older, while pneumonia shots were only assessed for adults 65 and older. Proportions of those vaccinated were similar from 2021 to 2022. When disaggregated by race and ethnicity, Black or African American respondents were less likely to be immunized for tetanus, COVID-19, and influenza 18+. Hispanic individuals were less likely to have received a tetanus shot.



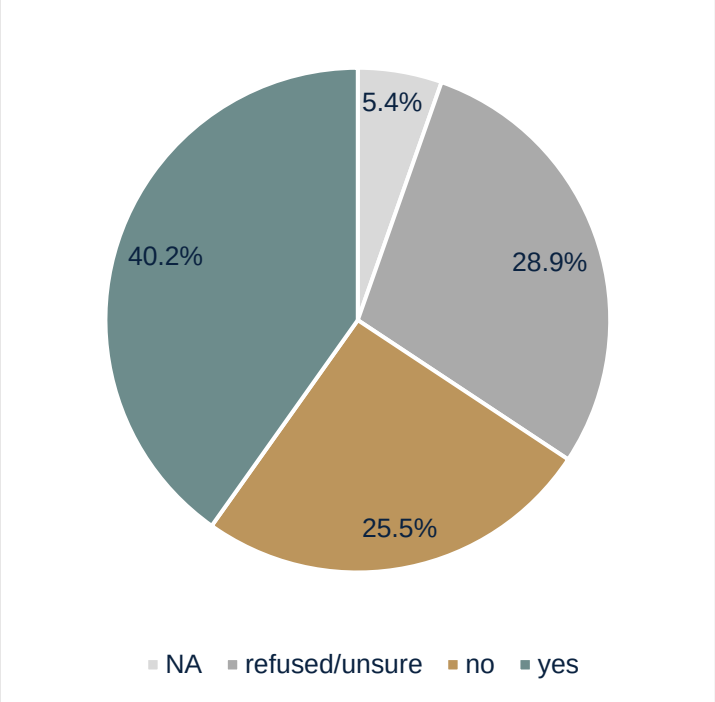
Iowa Public Health Tracking Portal data on chlamydia shows rates for Iowa and BHC from 2017 to 2023. The trend appears to be decreasing for both BHC and Iowa since 2021; however, BHC still has a higher rate compared to Iowa. The most recent year of data shows a difference of 661 per 100,000 in BHC and 428 per 100,000 in Iowa.



Iowa Public Health Tracking Portal data on gonorrhea shows rates for Iowa and BHC from 2017 to 2023. The trend for both Iowa and BHC has increased from 2017 to 2020, and decreased from 2020 to 2023. The rate in BHC in 2023 was 216 per 100,000 compared to Iowa with 117 per 100,000.

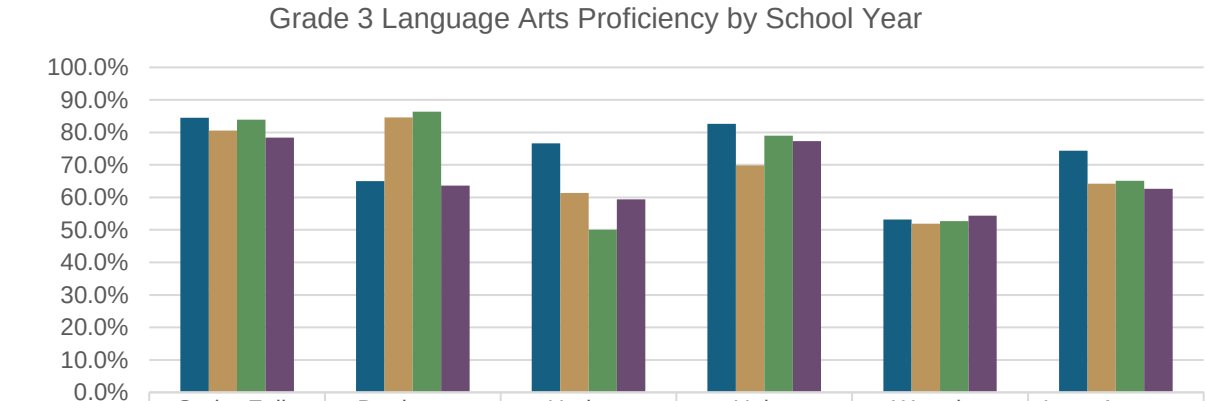


Iowa Public Health Tracking Portal data on syphilis shows rates for Iowa and BHC from 2018 to 2023. The syphilis rate has been increasing for the past several years at the state level. Although the BHC rate is higher than Iowa's, the case rates from 2021 to 2023 have been steady while the Iowa rate is increasing.



Due to increased rates of congenital syphilis, the CDC recommends that all women who are pregnant be tested for syphilis at multiple points during pregnancy if they live in a county where the primary and secondary syphilis rate among women ages 15-44 is 4.6 per 100,000 population or higher (see References). In 2022, the Barriers to Prenatal Care survey asked mothers if they were tested for syphilis during their pregnancy. 40.2% said they were. It should be noted that this is a new recommendation implemented in 2024, and BHCPH plans to monitor this metric to see if more mothers indicate they were tested during pregnancy.

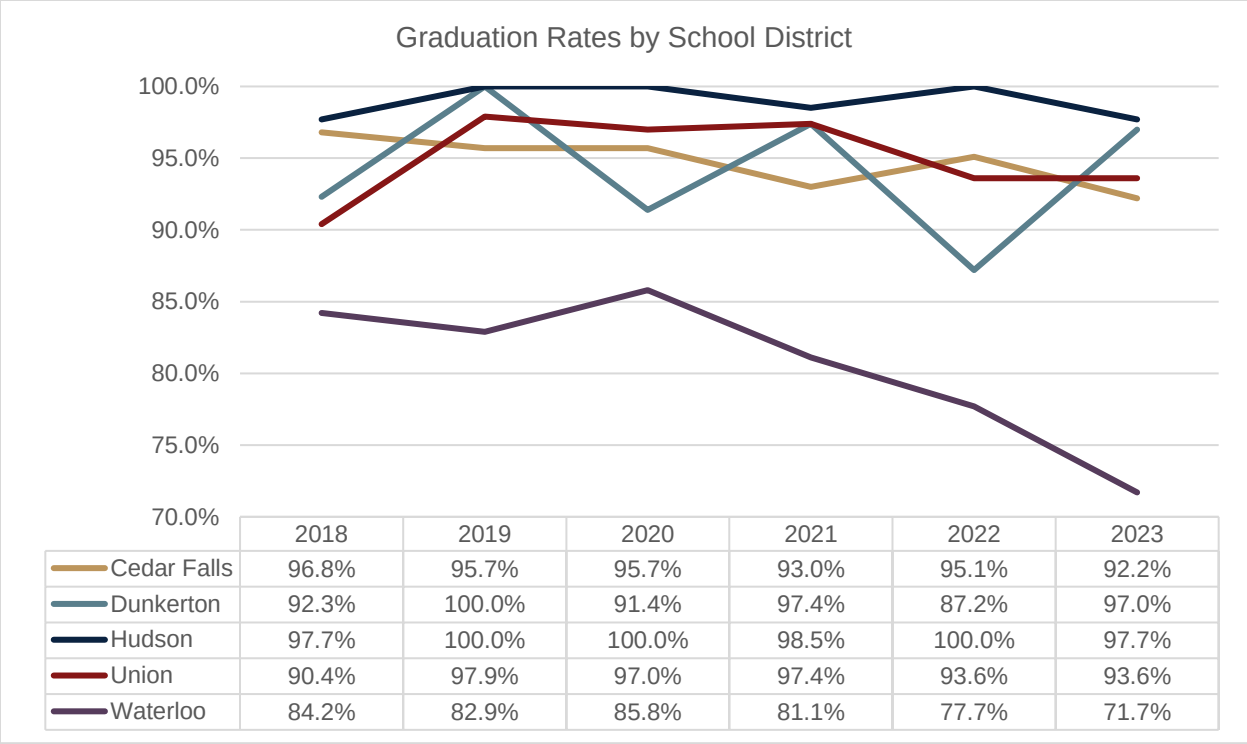
Cultural and Linguistic Inclusivity



	Cedar Falls	Dunkerton	Hudson	Union	Waterloo	Iowa Average
2017-2018	84.5%	65.0%	76.6%	82.6%	53.2%	74.4%
2021-2022	80.6%	84.6%	61.4%	69.8%	51.9%	64.2%
2022-2023	83.9%	86.4%	50.0%	79.0%	52.7%	65.1%
2023-2024	78.4%	63.6%	59.4%	77.3%	54.4%	62.6%

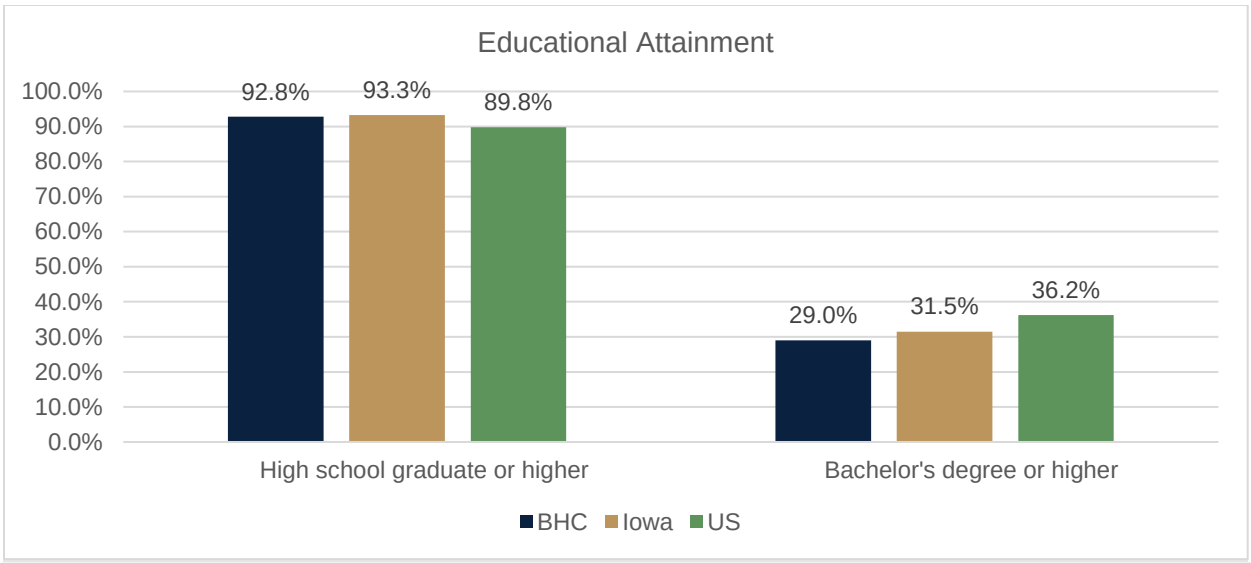
The Iowa Department of Education gathers data on grade 3 language arts proficiency for each public school. There are disparities by race and ethnicity and program, but all groups reflect the district disparity with Waterloo schools having consistently lower proficiency and Cedar Falls having higher proportions. Dunkerton and Union schools vary, but have a similar average to Iowa or above. Another observation is that Hudson schools proficiency has dropped in recent years. Note: no data was released for 2018-2019, 2019-2020, and 2020-2021 school years.

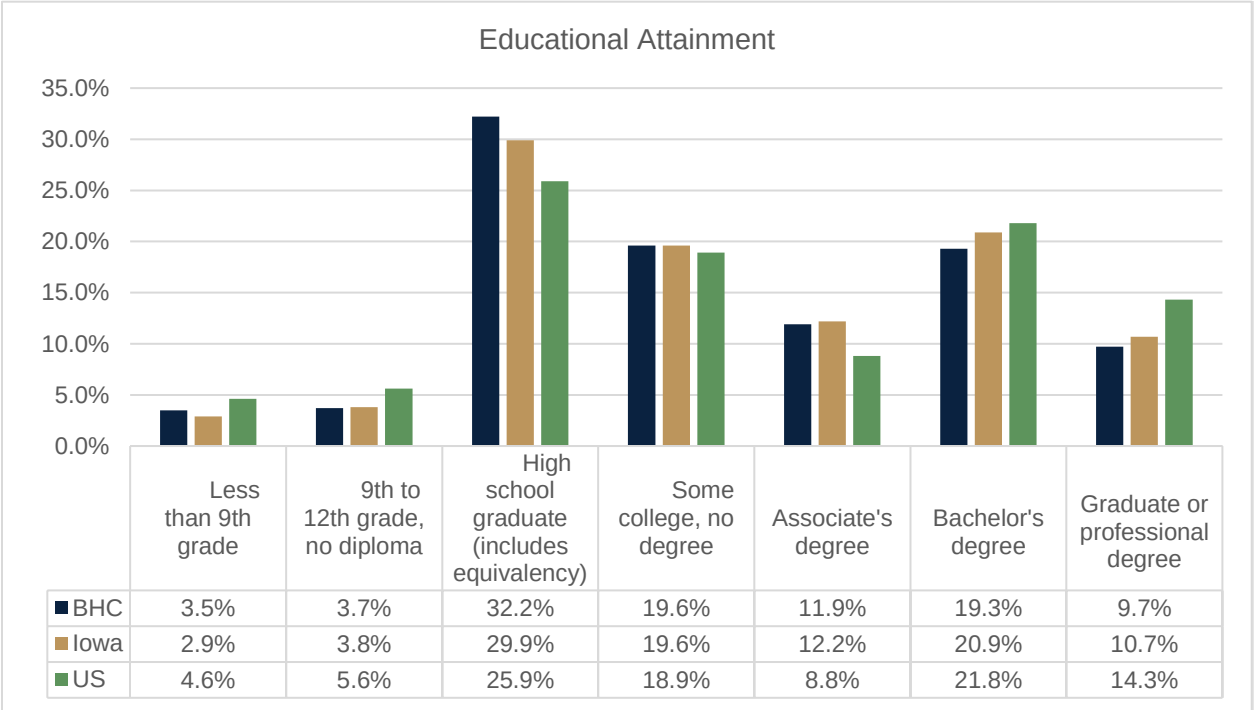
The Iowa Department of Education collects data on ELL in public schools. The word cloud above shows languages spoken by ELL students across Iowa. Locally, many languages are spoken by ELL students including Bosnian, Burmese, Creole-Haitian, French, Karen languages, Marshallese, and Spanish.



	2018	2019	2020	2021	2022	2023
Cedar Falls	96.8%	95.7%	95.7%	93.0%	95.1%	92.2%
Dunkerton	92.3%	100.0%	91.4%	97.4%	87.2%	97.0%
Hudson	97.7%	100.0%	100.0%	98.5%	100.0%	97.7%
Union	90.4%	97.9%	97.0%	97.4%	93.6%	93.6%
Waterloo	84.2%	82.9%	85.8%	81.1%	77.7%	71.7%

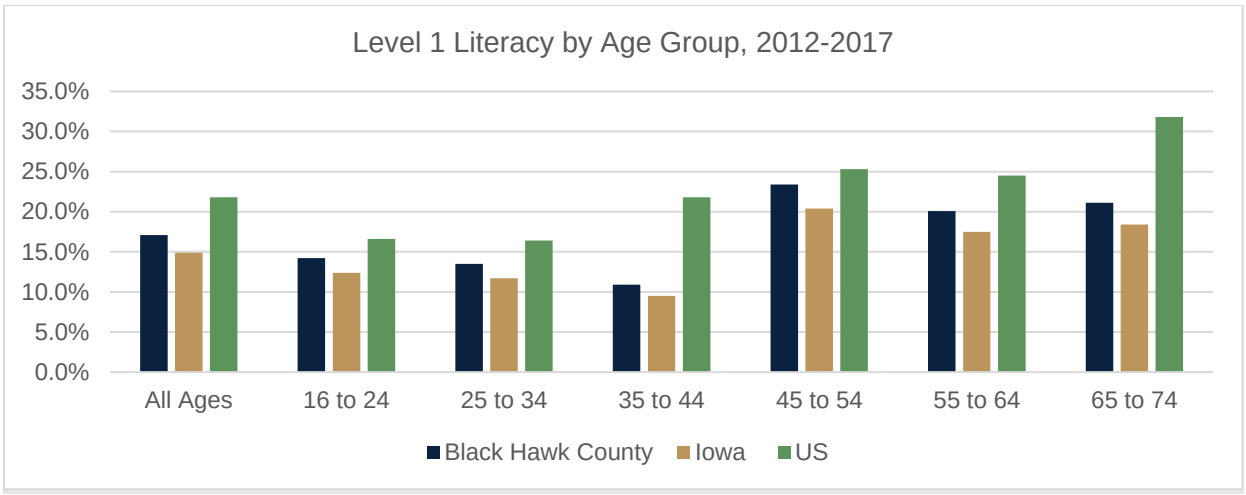
The Iowa Department of Education collects data on graduation rates. Data on the public-school districts from 2018 to 2023 show that graduation rates vary across years. However, there is a disparity between the rates of the other school districts and Waterloo. Waterloo schools averaged 80.6% graduation rate between 2018 and 2023 while other public-school districts averaged at or above 94.2%. Most graduation rates decreased from 2022 to 2023.

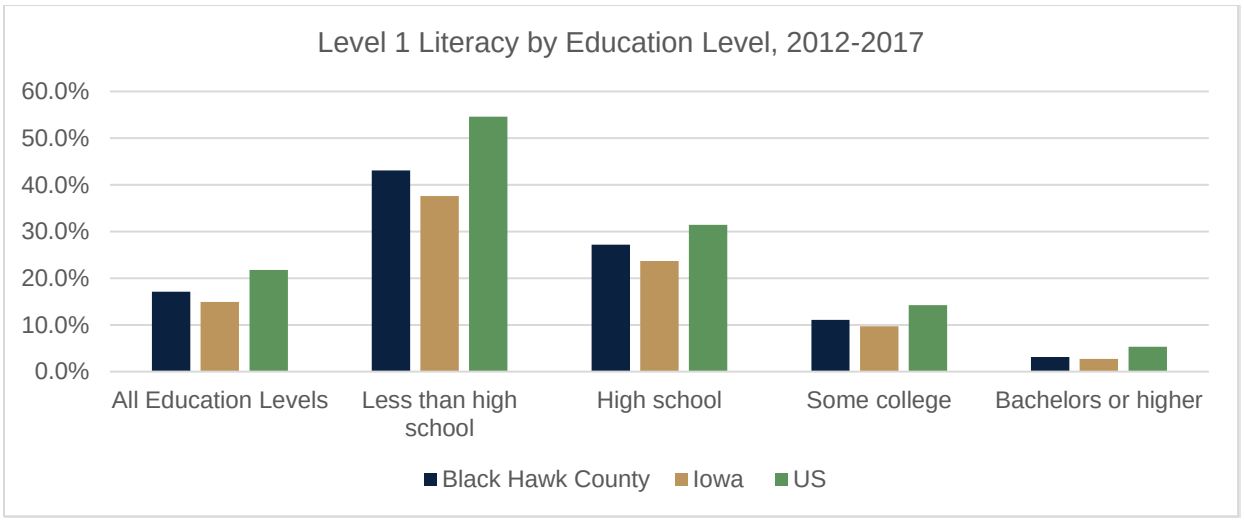




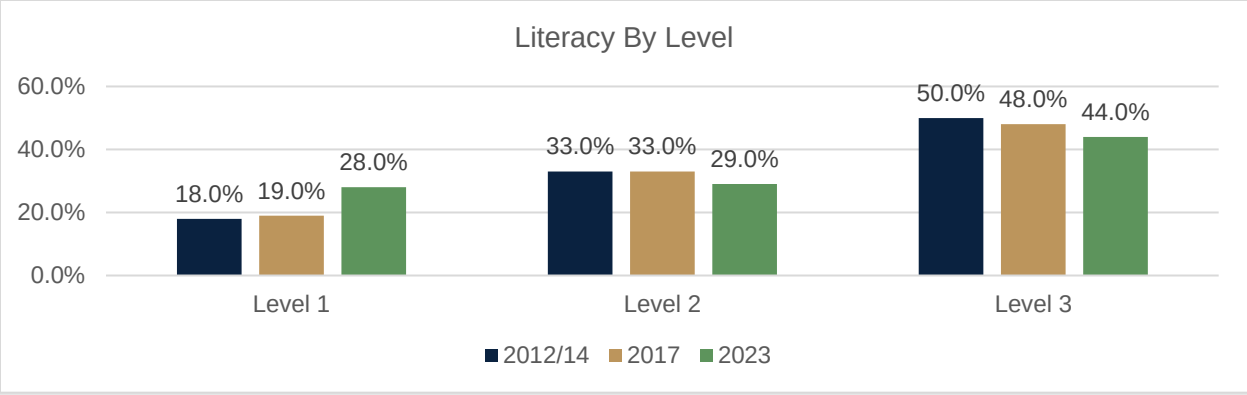
	Less than 9th grade	9th to 12th grade, no diploma	High school graduate (includes equivalency)	Some college, no degree	Associate's degree	Bachelor's degree	Graduate or professional degree
BHC	3.5%	3.7%	32.2%	19.6%	11.9%	19.3%	9.7%
Iowa	2.9%	3.8%	29.9%	19.6%	12.2%	20.9%	10.7%
US	4.6%	5.6%	25.9%	18.9%	8.8%	21.8%	14.3%

Census data on educational attainment shows that while HS graduate proportions are higher in BHC, the proportion of those with a Bachelor's degree or higher is lower in BHC than in Iowa and the US.

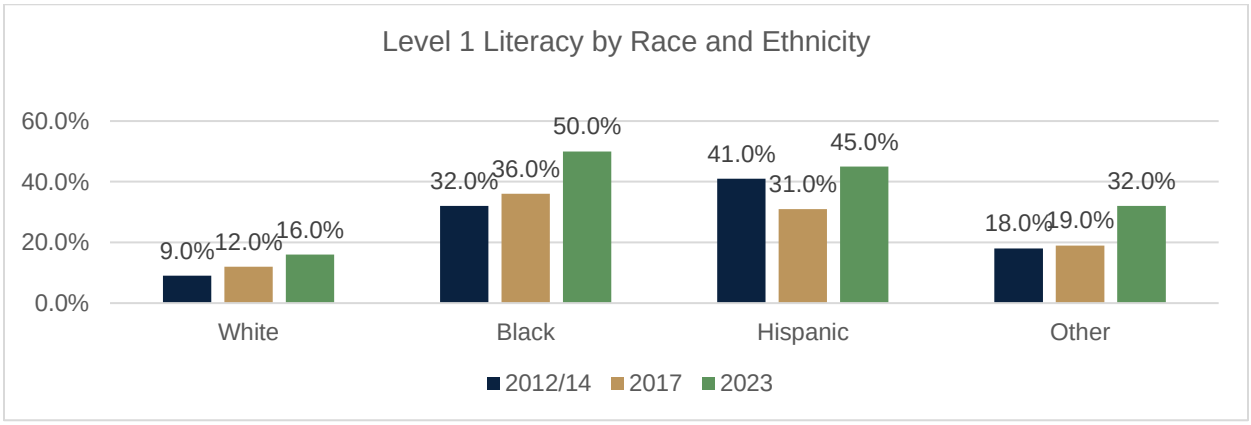


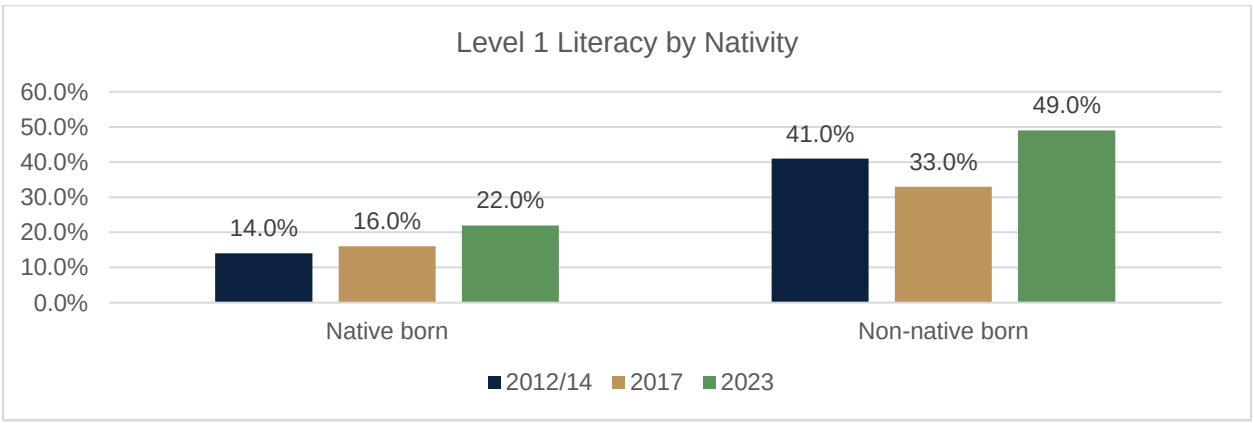


The Program for the International Assessment of Adult Competencies (PIAAC) is a test administered about every 5 years to assess proficiency in different areas including adult literacy. Results from 2012/14 (results from these two specific years are always combined to form one group) and 2017 were combined in a model to produce small-area estimates at the state and county levels. In the PIAAC framework, there are levels 0 through 5, with 0 being the lowest level and 5 being the highest. Level 1 represents adults that can read short, clearly organized texts or web pages with few distractions, easily spot obvious details like a key word or link, and finish simple one-step tasks. Proportions of those at or below level 1 literacy levels are shown by age group and educational attainment, and demonstrate that older age groups (45 and older) and lower educational attainment (less than high school education and high school education) are more impacted than others.



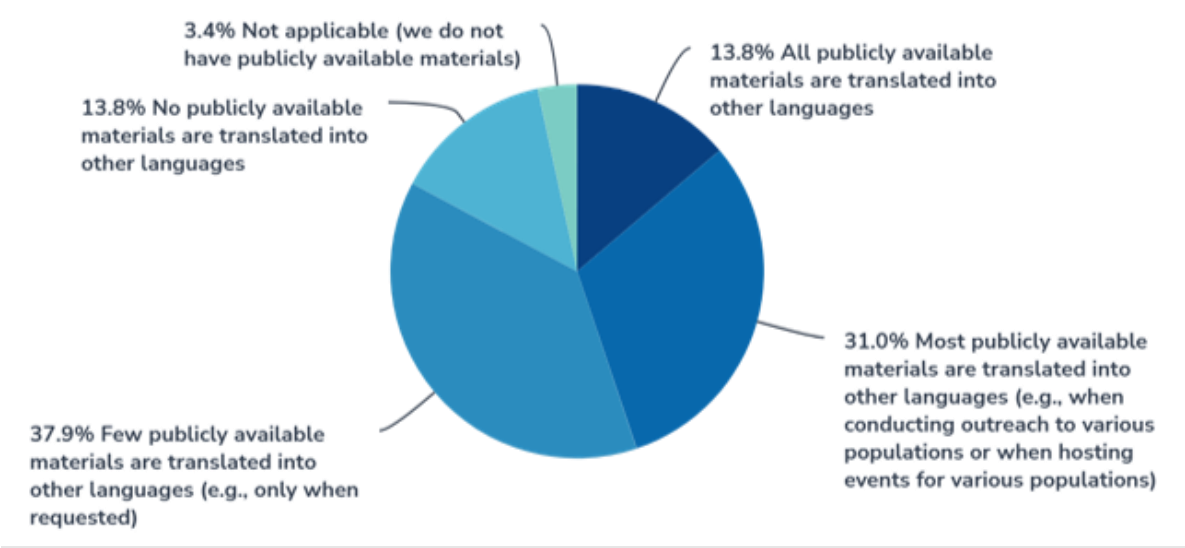
PIAAC literacy national results are shown by level and year. Proportions of adults testing at level 1 has been increasing from 2012/14 (combined to form one group) to 2023, and proportions of adults testing at level 3 is decreasing during the same time period.

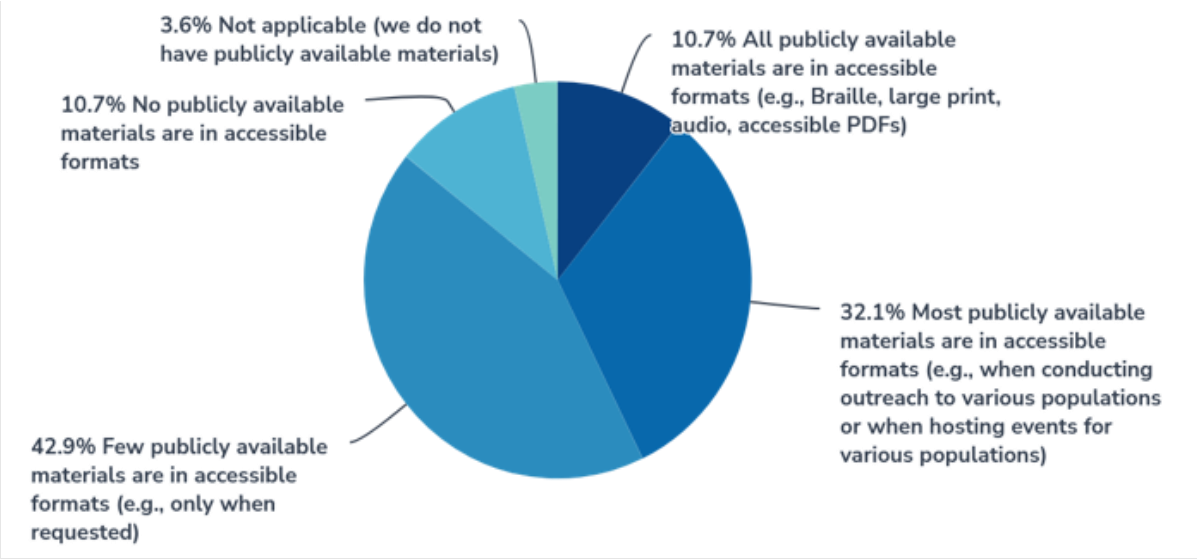




National PIAAC results were also disaggregated by race and ethnicity and nativity status. Those who identify as Black, Hispanic, or Other Race are more likely to be at or below level 1 than those who identify as white. All racial and ethnic groups were more likely to test at or below level 1 in 2023 than in previous years. The same trend is seen for nativity status. Foreign born respondents were more likely to test at or below level 1 than native born respondents. Both groups were more likely to test at or below level 1 than in previous years.

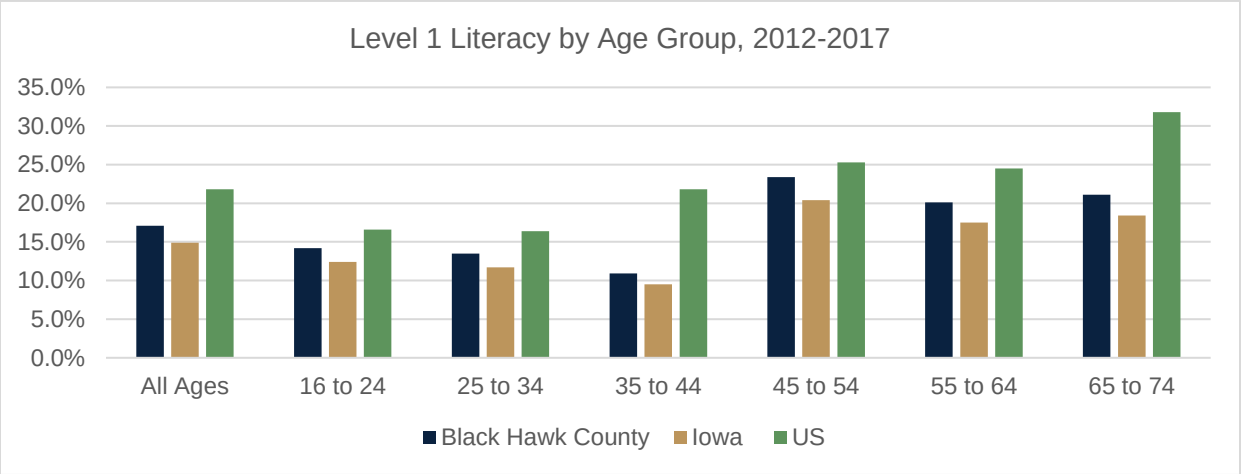
In the community survey, 2.8% of respondents said that they did not receive mental health services due to a lack of providers that speak the same language or share the same culture. Also, 10.5% of respondents said they did not receive services due to being unable to find a provider that they connect with. *no image

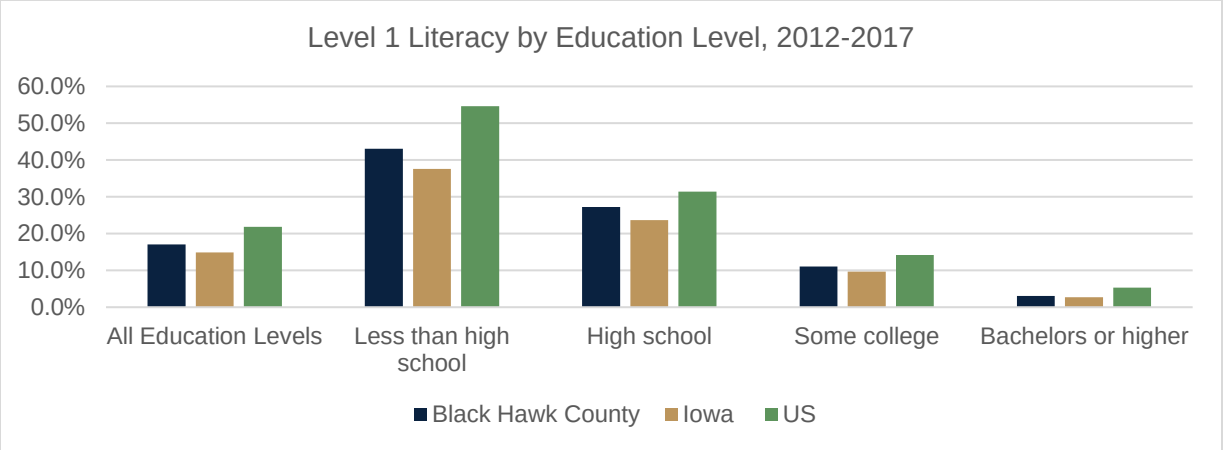




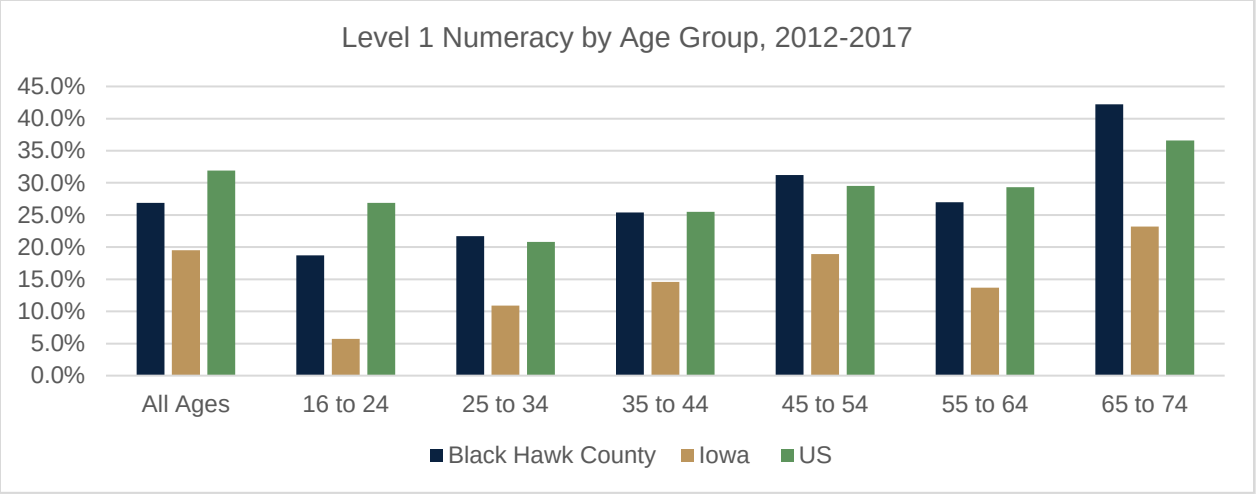
The Community Partner Assessment (CPA) survey contained several questions about culturally and linguistically accessible materials and methods. This included accessibility, availability, and translations. A little under half of respondents indicated that all or most publicly available materials were translated into other languages. A little over half answered few or none. Similar results were noted for materials available in accessible formats. While not every agency experienced barriers when providing these services, a few challenges were cost/funding, resources, time, and training. There were impacts to both language services and accessibility, although agencies were more likely to be able to access language services than have accessible materials. The full results can be found in the CPA full report.

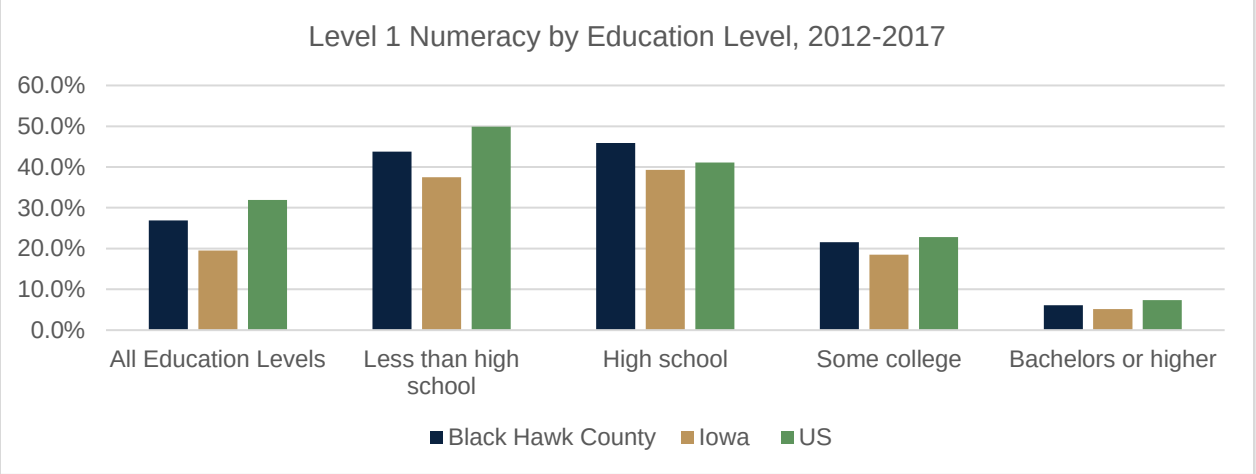
Health Literacy



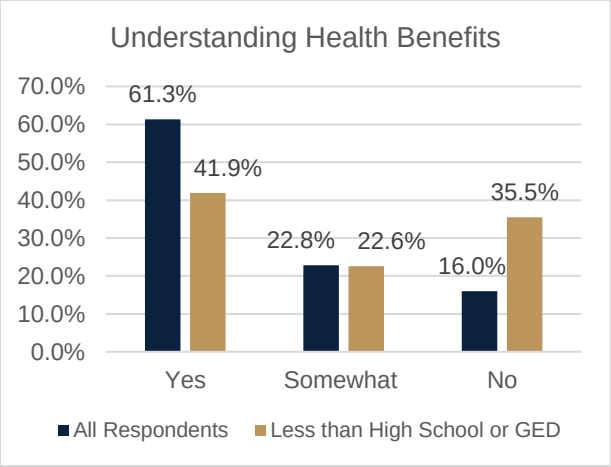


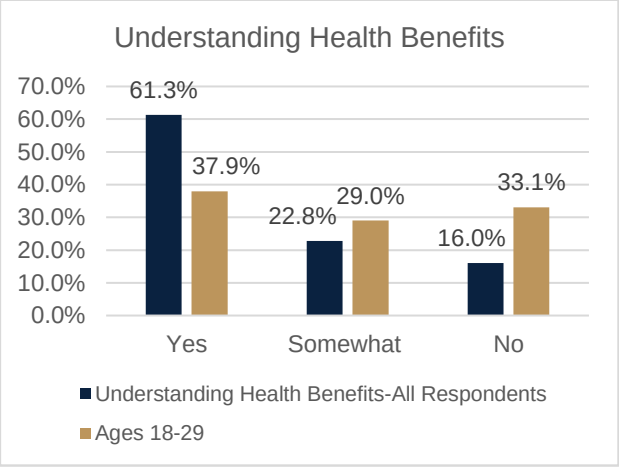
Data from PIAAC for at or below level 1 literacy results from 2012/14 (combined to form one group) and 2017 were combined to produce small-area estimates at both the state and county levels. The data, broken down by age group and education, shows that individuals aged 45 and older and those with a high school diploma or less are more likely to fall at or below level 1 literacy.



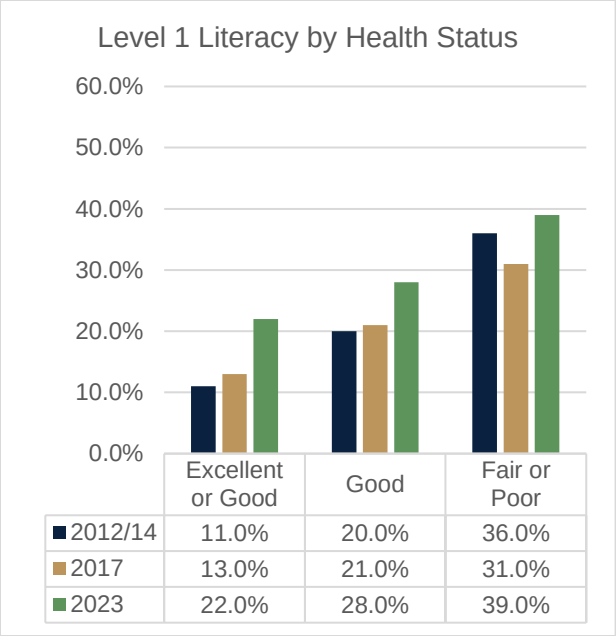


Numeracy, which is the ability to understand and make decisions based on numeric information, is also measured by PIAAC. Similar small-area estimates for 2012/14 and 2017 indicate that older adults, 45 and older, and those with lower levels of education, less than high school or only a high school diploma, are more likely to score at or below level 1 numeracy.

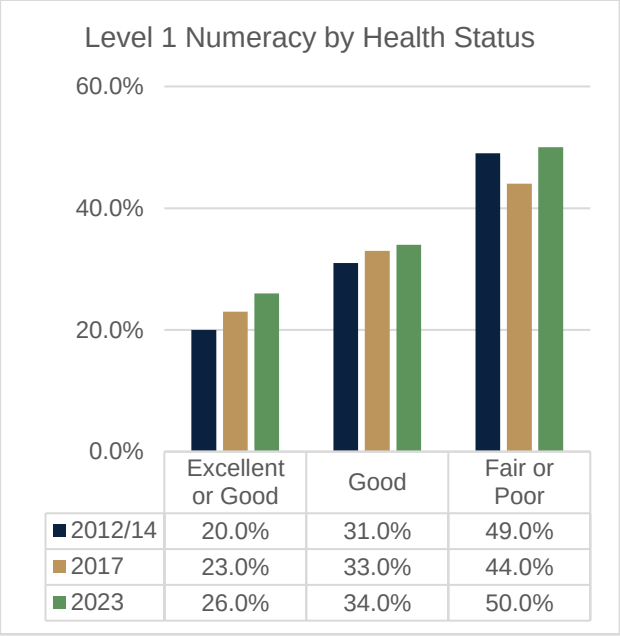




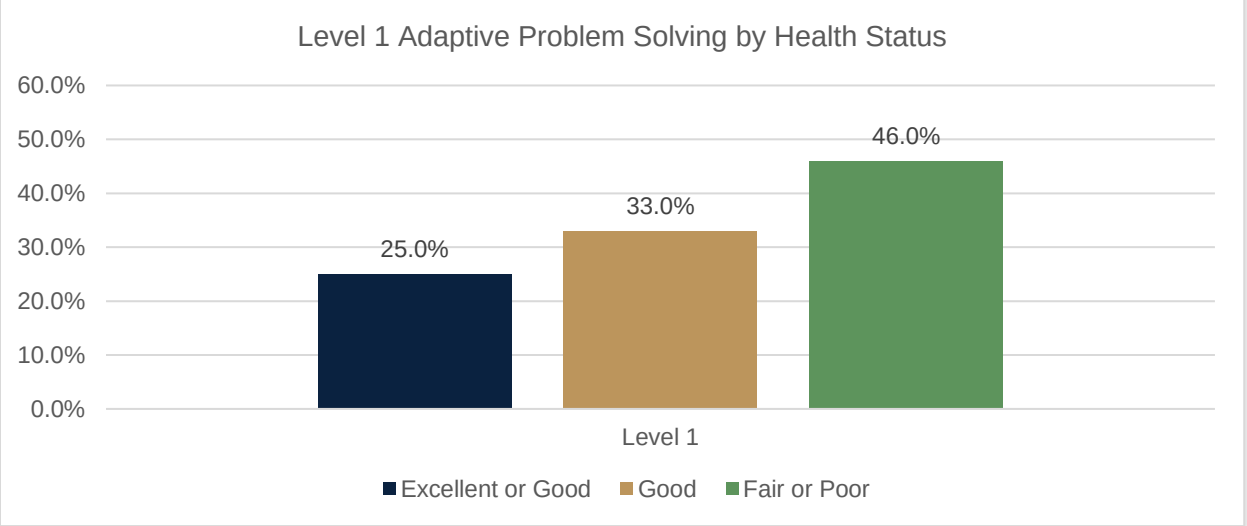
Data from the community survey showed that 61.3% of respondents reported understanding their health benefits. An answer was considered they understood their benefits by answering either a 4 or 5 on a 5-point Likert scale, an answer of 1 or 2 indicated they didn't understand their health benefits, and 3 was somewhat understand their health benefits. Among those with less than a high school education, only 41.9% felt they understood their benefits. A similar pattern emerges for individuals aged 18–29, with 37.9% indicating they understood their health benefits.



	Excellent or Good	Good	Fair or Poor
2012/14	11.0%	20.0%	36.0%
2017	13.0%	21.0%	31.0%
2023	22.0%	28.0%	39.0%



	Excellent or Good	Good	Fair or Poor
2012/14	20.0%	31.0%	49.0%
2017	23.0%	33.0%	44.0%
2023	26.0%	34.0%	50.0%



National PIAAC results are also separated by health status. Individuals in fair or poor health are more likely to test at or below level 1 literacy, numeracy, and adaptive problem solving compared to previous years. Adaptive problem solving was first included in 2023, and the data suggests that all demographic groups are more prone to test at or below level 1 for literacy and numeracy than in previous assessment cycles.

References

Barriers to Prenatal Care: A survey administered to individuals who have given birth at hospitals in the state of Iowa. Questions are related to prenatal care and pregnancy/pre-pregnancy risk factors. https://hhs.iowa.gov/programs/programs-and-services/family-health/maternal-health/data-reports

Behavioral Risk Factor Surveillance System: A phone survey administered at the state level to adults 18 and over to learn about health conditions and risk factors experienced. https://hhs.iowa.gov/performance-and-reports/brfss

CDC Social Vulnerability Index: This is a metric designed to enhance preparedness and response and includes several factors that would affect a community's ability to respond to disasters. The four categories included are socioeconomic status, household characteristics, racial and ethnic minority status, and housing type and transportation. https://data.cdc.gov/Health-Statistics/CDC-Social-Vulnerability-Index-SVI-/u6k2-rtt3/about_data

CDC Vital Signs: Missed Opportunities for Preventing Congenital Syphilis — United States, 2022. A *Morbidity and Mortality Weekly Report* (MMWR) discussing recommendations relating to increasing rates of congenital syphilis in the US. Released November 17, 2023. https://www.cdc.gov/mmwr/volumes/72/wr/mm7246e1.htm?s_cid=mm7246e1_w

Feeding America: Feeding America produces data related to food insecurity. Data is publicly available at the state, national, and county level. https://map.feedingamerica.org/

Iowa Drug Control Strategy & Drug Use Profile Annual Report, 2021: A report released from the Governor's Office of Drug Control Policy that includes data on substances used by Iowa residents as well as several goals for that include reducing substance use and increasing service utilization.

Iowa HHS Vital Records: Data from all Iowa birth and death records. https://hhs.iowa.gov/vital-records

Iowa Hospital Association Inpatient Outpatient Data: Data from hospital system inpatient and outpatient visits. This report includes data for residents of Black Hawk County. https://www.legis.iowa.gov/law/iowaCode/sections?codeChapter=135

Iowa's Immunization Registry Information System (IRIS): Database for all immunizations given to Iowans. https://hhs.iowa.gov/immunization/immunization-registry-information-system-iris

Iowa Public Health Tracking Portal: Publicly available health data for the state of Iowa. https://hhs.iowa.gov/data

Iowa School Performance Profiles: Data from the Iowa Department of Education for the state, school districts and individuals schools on graduation rates, performance metrics, and related topics. https://www.iaschoolperformance.gov/ECP/Home/Index

Iowa SEER Cancer Registry: Registry for all cancers reported in the state of Iowa. https://www.cancer-rates.info/ia/

Languages Spoken in Iowa: A report released from the Iowa State Extension Office that shows the languages spoken by English Language Learners in Iowa. https://indicators.extension.iastate.edu/DHR/languages.html#

NACCHO MAPP 2.0 Handbook, 2023: Guidebook for the MAPP 2.0 process.

New Americans in Iowa: A report released by the American Immigration Council that summarizes data available about immigrants in Iowa. https://map.americanimmigrationcouncil.org/locations/iowa/

NIH National Cancer Institute: Reports data on cancers nationwide, with state and county level data available. https://statecancerprofiles.cancer.gov/incidencerates/index.php?stateFIPS=19&areatype=county&cancer=001&race=00&sex=2&age=001&type=incd&sortVariableName=rate&sortOrder=default&output=0#results

Northeast Iowa Food Bank: Local food bank in Black Hawk County that has a 16-county service area. https://www.neifb.org/

Program for the International Assessment of Adult Competencies: An objective assessment of adult literacy, numeracy, and adaptive problem solving administered approximately every 5 years. Results are available at the national level. https://nces.ed.gov/surveys/piaac/2023/national_results.asp

US Census Bureau: Produces the decennial census data and 1 and 5 year American Community Survey (ACS) results on a variety of topics. https://data.census.gov/

US PIAAC: U.S. Skills Map: State and County Indicators of Adult Literacy and Numeracy: A model based on the national results to produce estimates for states and counties. https://nces.ed.gov/surveys/piaac/skillsmap/

Waterloo MET Transit Plan: Waterloo, Iowa's public transportation plan for the MET transit bus routes. https://mettransit.org/sites/default/files/PM%20Banner%20Page%201.pdf

Black Hawk County Public Health

Black Hawk County Community Context Assessment

March 2025

Table of Contents

Introduction

Framework

MAPP (Mobilizing for Action through Planning and Partnerships) is a method for community health improvement planning which encourages collaboration with community partners to increase the likelihood of long-lasting change. The community health assessment portion of MAPP 2.0 consists of 3 assessments. The Community Context Assessment (CCA) is a qualitative tool to assess and collect data. The CCA explores the strengths, assets, lived experiences, and forces of change. It is designed to answer the following questions:

- *What strengths and resources does the community have that support health and well-being?*
- *What current and historical forces of change locally, regionally, and globally shape political, economic, and social conditions for community members?*
- *What physical and cultural assets are in the built environment? How do these vary by neighborhood?*
- *What is the community doing to improve health outcomes? What solutions has the community identified to improve community health?*

Purpose

The CCA was conducted to provide a comprehensive understanding of the overall health landscape of Black Hawk County, Iowa. Its findings will be integrated with the results of the other two CHA assessments to identify priority health needs for the county. These insights will guide the development of the Community Health Improvement Plan (CHIP) for FY26-28.

Process and Timeline

The assessment took place between June 11 and July 2, 2024. The work was led by the Community Health Improvement (CHI) core team. This team consisted of a public health planner and two epidemiologists, working in collaboration with key area healthcare institutions: MercyOne, UnityPoint Health, and the Federally Qualified Health Center (FQHC) Peoples Community Health Clinic. Additional guidance was provided by a broader steering committee and an assessment design team. A student intern from the University of Northern Iowa also contributed to the CCA's implementation.

Methods

The CCA focused on ZIP Code 50703, an area identified through the Community Status Assessment as having the most significant health disparities, along with higher rates of poverty, food insecurity, and unemployment. Many of these neighborhoods also have historical ties to redlining, which has long-term effects on economic opportunities and chronic disease prevalence.

The initial phase of the assessment involved mapping community assets within ZIP Code 50703. This process identified key locations such as public transportation routes, educational institutions, healthcare facilities, non-profits, and government agencies. Data sources included United Way's 211 resource list and local resource lists compiled by Black Hawk County General Assistance, The Salvation Army, Cedar Valley United Way, and the Community Partnership for Protecting Children. Assets were analyzed for accessibility via current and upcoming public

transit routes, with additional insight gained from proposed September 2024 Metropolitan Transit Authority route updates.

This data was used to define four regions for further study:

- Region A consists of the area surrounding the Northeast Iowa Food Bank, Operation Threshold, and Waterloo Women's Center for Change.
- Region B consists of the Black Hawk County Pinecrest Building
- Region C consists of the area surrounding the Black Hawk County Courthouse and Black Hawk County Sheriff's Office
- Region D consists of the area between the Salvation Army, Boy's and Girl's Club, and People's Community Health Clinic

From that point, the core team proceeded with two primary data collection methods to assess the built environment and forces of change within ZIP Code 50703:

1. **Key Informant Interviews:** Conducted with representatives from local government, transportation authorities, and service organizations to gain insights into community needs, accessibility challenges, and historical influences on the built environment.
2. **Walking/Windshield Surveys:** Conducted to observe transportation infrastructure, sidewalk conditions, and accessibility in four defined regions within ZIP Code 50703.

Key Informant Interviews

Key informant interviews were conducted to provide deeper insights into community needs and barriers. Interviews were held with representatives from the city of Waterloo, Iowa Northland Regional Council of Governments (INRCOG), Black Hawk County agencies, the Salvation Army, and the Northeast Iowa Food Bank.

The interview questions explored how community members access services, barriers related to the built environment, existing resources to mitigate these barriers, and opportunities for community-led solutions. Additionally, participants were asked to reflect on trends that may impact community health in the future, as well as historical factors that shape present-day conditions and disparities. INRCOG provided key reports, including the *Pedestrian Masterplan, 2050 Long Range Transportation Plan*, and the *2024 Downtown Walking Audit*. The city of Waterloo provided a document about sidewalk construction, inspections, and repairs showing the requirements for sidewalk repairs. They also provided a map of the sidewalk inspection zones showing the regions they inspect and what the next inspection year for that zone will be.

Walking/Windshield Survey

A walking/windshield survey was conducted on July 1, 2024, to observe built environment conditions, transportation access, and overall neighborhood infrastructure. A survey checklist was developed to systematically assess sidewalks, road conditions, and pedestrian accessibility across the four regions.

Findings

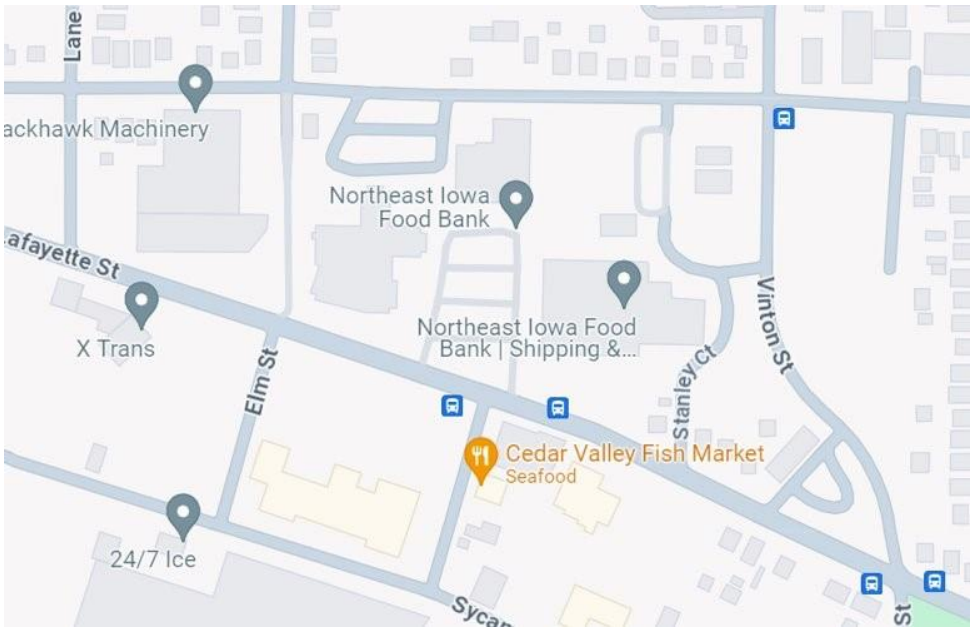
The following pages show the results of the key informant interviews and walking/windshield survey for each of the four regions.

Region A

Region A consists of the environs surrounding the Northeast Iowa Food Bank, Operation Threshold, and Waterloo Women's Center for Change.

Summarized Findings:

- Primary transportation mode: Personal vehicles or carpooling.
- Sidewalk conditions: Generally well-maintained but absent along Vinton Street.
- Environmental observations: Well-maintained buildings side by side with deteriorating industrial structures.
- Accessibility challenges: Inconsistent signage for some service locations.

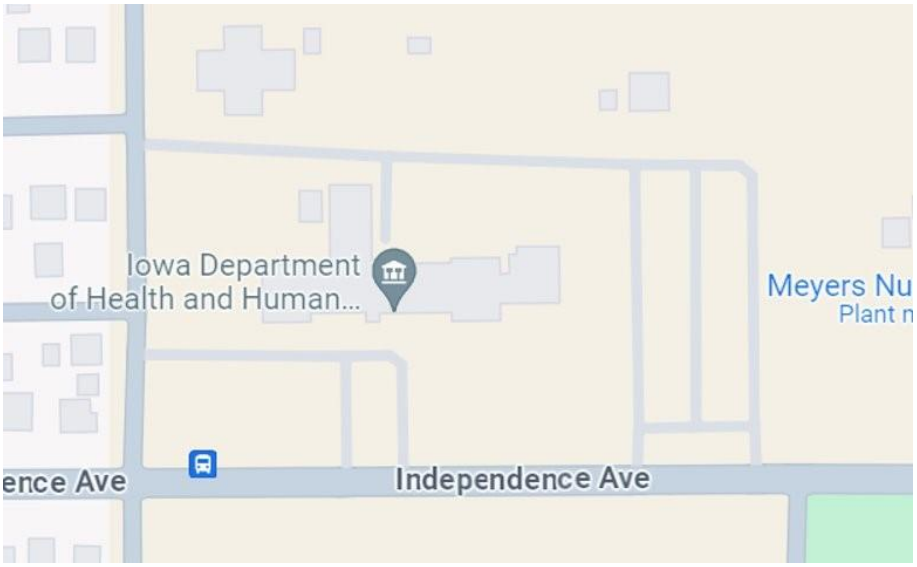


Region B

Region B consists of the Black Hawk County Pinecrest Building (1407 Independence Avenue)

Summarized Findings:

- Well-maintained building and parking facilities with clear signage.
- Sidewalk access along Independence Avenue is fair but becomes limited past Century Avenue.
- Public transit access includes a sheltered bus stop.
- Walkability limitations due to distance from key community resources.

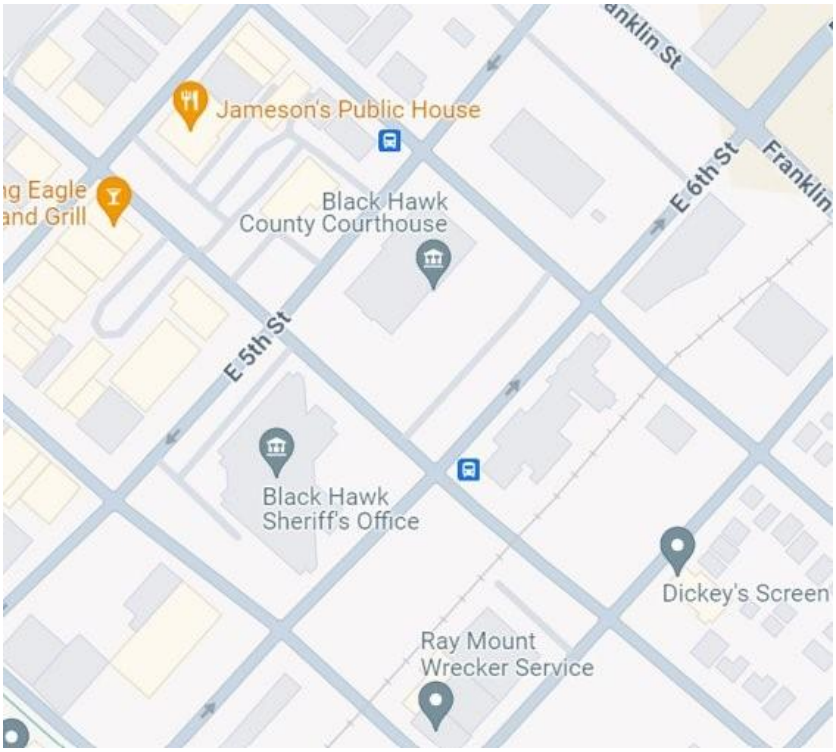


Region C

Region C consists of the area surrounding the Black Hawk County Courthouse and Black Hawk County Sheriff's Office.

Summarized Findings:

- High walkability score (75/100) due to wide sidewalks, pedestrian crossings, and street lighting.
- Some curbs in disrepair, posing challenges for individuals with mobility devices.
- Mixed visibility of building signage, with the Sheriff's Office sign appearing faded.

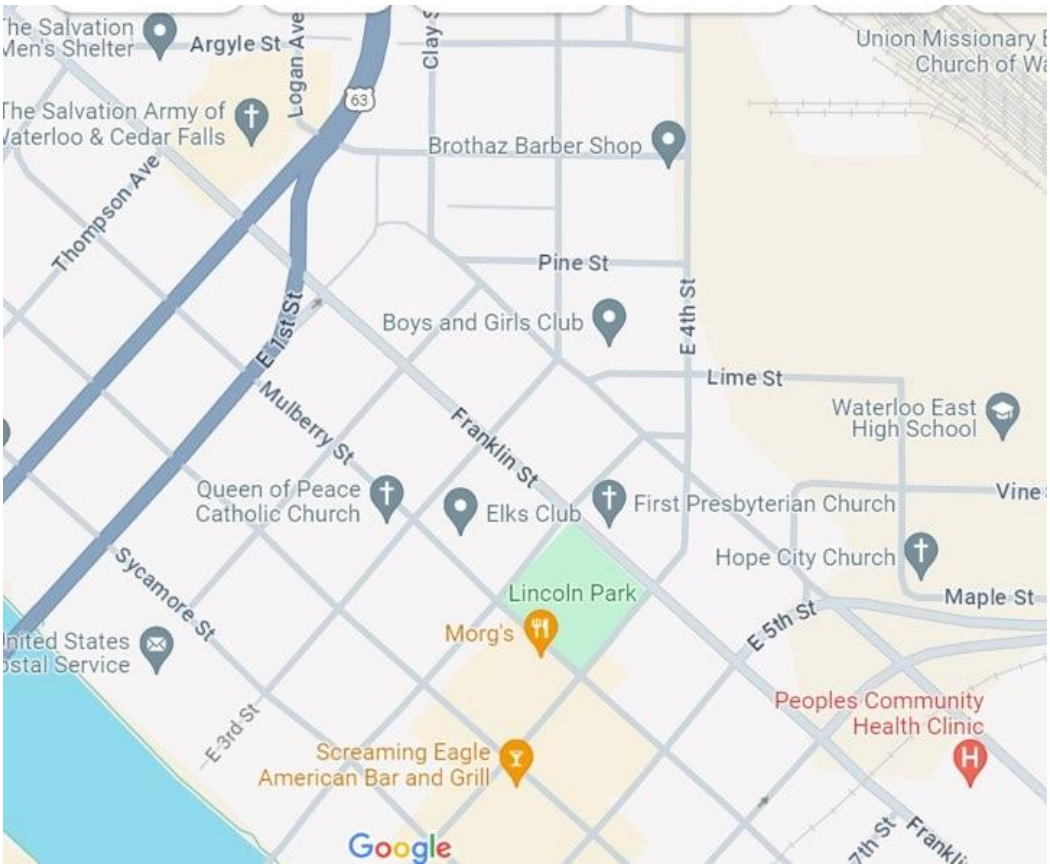


Region D

Region D consists of the area including and between the Salvation Army, Boy's and Girl's Club, and Peoples Community Health Clinic.

Summarized Findings:

- High-traffic intersections and diagonal roads create navigation challenges for pedestrians and cyclists.
- Documented safety concerns related to speeding and traffic signal adherence.
- The Salvation Army has improved pedestrian access with direct sidewalks from bus stops and bulk bus pass purchases for unhoused individuals.
- Planned road reconstruction (2026–2035) aims to enhance pedestrian and bicycle accessibility.



Conclusion

The findings from this CCA highlight key strengths, challenges, and opportunities within ZIP Code 50703. While the region has valuable community assets, there are still barriers related to transportation, walkability, and historical disinvestment. Key informant interviews and survey observations reinforced the need for improved sidewalk connectivity, pedestrian safety measures, and enhanced public transit accessibility. Organizations within the community are actively working to address these challenges, but broader systemic changes and investments will be required to create sustainable improvements. Key themes included:

- Transportation access remains a significant barrier, with many residents relying on public transit or carpooling.
- Sidewalk infrastructure varies, with some areas lacking connectivity or presenting safety concerns.
- Organizations are working to address mobility challenges by providing bus passes or adjusting service locations.
- Historical patterns of disinvestment continue to shape health disparities and economic conditions in ZIP Code 50703.

The insights from this assessment will be integrated with data from the other two MAPP 2.0 assessments to inform the development of the Community Health Improvement Plan (CHIP) for FY26-28. Moving forward, collaborative efforts among local agencies, policymakers, and community stakeholders will be essential to addressing these challenges and promoting equitable health outcomes for all residents in Black Hawk County.

Limitations of this study included the timing with the transition between bus routes. It was not always clear if the qualitative data collected was in reference to the existing bus routes or proposed routes. In addition, the assessment did not include the collection of data for rural Black Hawk County, the city of Cedar Falls, or the west side of Waterloo.

References

Waterloo MET Transit Plan: Waterloo, Iowa's public transportation plan for the MET transit bus routes. https://mettransit.org/sites/default/files/PM%20Banner%20Page%201.pdf

United Way 211. 211 Iowa is a free, comprehensive information and referral system. https://ia211.c211.io/

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The Nations Health, "More programs offering low-cost reliable transportation for healthcare visits", June 2024 https://www.thenationshealth.org/content/54/4/1.2

Nykiforuk CI, Vallianatos H, Nieuwendyk LM. Photovoice as a Method for Revealing Community Perceptions of the Built and Social Environment. Int J Qual Methods. 2011 Jan 1;10(2):103-124. doi: 10.1177/160940691101000201. PMID: 27390573; PMCID: PMC4933584.

Pedestrian Masterplan (INRCOG)

2050 Long Range Transportation Plan (INRCOG)

2024 Downtown Walking Audit (INRCOG)

Black Hawk County Public Health

Black Hawk County Community Partner Assessment

March 2025

Table of Contents

Introduction

Framework

MAPP (Mobilizing for Action through Planning and Partnerships) is a method for community health improvement (CHI) planning which encourages collaboration with community partners to increase the likelihood of long-lasting change. The community health assessment portion of MAPP version 2.0 consists of 3 assessments. The Community Partner Assessment (CPA) allows partners involved in community health improvement to look critically at their individual systems, processes, and capacities and look at the collective capacity as a network of community partners to address health inequities. The CPA has five goals:

- *Describe why community partnerships are critical to CHI and how to build or strengthen relationships with community partners and organizations.*
- *Name the specific roles of each community partner to support the local public health system and engage communities experiencing inequities produced by systems.*
- *Assess each CHI partner's capacity, skills, and strengths to improve community health, health equity, and advance CHI goals.*
- *Document the landscape of CHI community partners to summarize collective strengths and opportunities for improvement.*
- *Identify whom else to involve in CHI work and ways to improve community partnerships, engagement, and power building.*

Purpose

The CPA was conducted to provide a comprehensive understanding of the overall health landscape of Black Hawk County, Iowa. Its findings will be integrated with the results of the other two CHA assessments to identify priority health needs for the county. These insights will guide the development of the Community Health Improvement Plan (CHIP) for FY26-28.

Process and Timeline

The assessment took place between October 3 through December 2, 2024. The work was led by the Community Health Improvement (CHI) core team. This team consisted of a public health planner and two epidemiologists, working in collaboration with key area healthcare institutions: MercyOne, UnityPoint Health, and the Federally Qualified Health Center (FQHC) Peoples Community Health Clinic. Additional guidance was provided by a broader steering committee and an assessment design team.

Methods

Community Partner Survey

The CPA replaces the MAPP 1.0 Local Public Health Systems Assessment (LPHSA). Black Hawk County completed a modified version of the LPHSA in 2019. The results were reviewed in order to incorporate lessons learned and inform the development of the 2024 CPA. Using the MAPP 2.0 handbook as a guide, the CHI core team developed an initial draft CPA focused on *Diversity, Access, and Community Engagement* as well as *Data Collection and Sharing* topics from the recommended CPA topics. The CHI steering committee and the assessment design team conducted a review of the updated survey to ensure its relevance and alignment with

community needs. The survey was then uploaded to Alchemer, a HIPAA-compliant survey platform.

The survey was sent out by email to 52 organizations associated with Advancing Equity in the Cedar Valley multi-sector coalition. This approach was chosen based on the coalition's focus on removing barriers, mobilizing and connecting people and organizations, and supporting organizations and communities to develop equitable practices. Survey results would then be shared with the coalition to inform their strategic planning.

Facilitated Discussion

The initial survey results were shared with the Advancing Equity steering committee in October 2024 through a presentation followed by a facilitated discussion around the following topics:

- Next steps to increase participation in the CPA
- Initial discussion on how the CPA data could be used to inform the Advancing Equity workplan

The final CPA survey results were then shared with the CHI steering committee in December 2024 for any additional feedback.

Findings

Community Partner Survey

A total of 30 responses were received. The organizations who responded are listed below.

- Black Hawk County (overall and multiple departments)
- Black Hawk Grundy Mental Health
- Catholic Charities
- Cedar Valley United Way
- Childcare Resource and Referral Agency
- Community Foundation of Northeast Iowa
- City of Cedar Falls (overall and Housing Authority)
- Grow Cedar Valley
- Hawkeye Community College
- House of Hope
- Iowa Northland Regional Council of Governments
- Iowa Heartland Habitat for Humanity
- Lutheran Services of Iowa
- Northeast Iowa Food Bank
- ONE Cedar Valley
- Operation Threshold
- Pathways Behavioral Services, Inc.
- Peoples Community Health Clinic
- University of Northern Iowa (overall, Student Health Clinic, Center for Energy and Environmental Education)
- UnityPoint Health
- Veridian Credit Union
- World Grace Project
- Waterloo Public Library

Diversity, Access, and Community Engagement

The results of the CPA survey demonstrate that most organizations who are part of the Advancing Equity coalition have already taken steps to move toward ensuring that their publicly available materials are accessible as well as culturally and linguistically adapted. Some organizations were just beginning to explore translation with most survey respondents reporting that at least some of their materials are translated into Spanish. Other common responses for languages translated included French, Marshallese, Bosnian, and Burmese/Karen/Karenni. Spanish, French, and Bosnian were reported to be the most common languages spoken by staff employed at responding organizations. Only 13.8% reported that they have not translated publicly available materials into any other languages and 10% indicated that their materials were not accessible.

Challenges to increasing the accessibility as well as culturally and linguistically adapting materials included:

- Cost/funding was a major limitation for expanding capacity
- Resources for translation/interpretation
- Time
- Training

Survey results also indicated that language and interpretation needs were present throughout the community and that the need for these services was higher than most organizations' ability to provide accessibility, translation, and interpretation services.

Data Collection and Sharing

Most organizations were already sharing or open to discussing sharing data with the coalition. The most common types of data collected were:

- Quality improvement, performance management, evaluation
- Demographics of clients served
- Access and utilization of services by clients

See **Appendix A** for a copy of the survey tool and **Appendix B** for the complete survey results.

Facilitated Discussion

Initial CPA survey results were shared with the Advancing Equity in the Cedar Valley steering committee in October 2024 by the CHI core team for the purposes of obtaining feedback on increasing survey engagement and a discussion on how the CPA data could be used to inform the Advancing Equity workplan.

Most of the organizations at the meeting already completed the survey and the participants indicated that 28 responses out of 45 organizations who were sent the survey gave meaningful data to proceed. Based on limited feedback from other local public health agencies that had already conducted the CPA survey, the core team noted that the 63% rate of return was high

compared to rates of return experienced by other agencies. Two additional responses were recorded when the survey closed on December 2, 2024, for a total response rate of 67%.

The CPA data was used to inform the coalition's activities related to mobilizing and connecting organizations and supporting them to develop equitable practices. The discussion was focused on how the steps the coalition could take to reduce the barriers related to accessibility, culture, and language. The participants discussed in greater detail the resources they currently use for translation and interpretation services. In addition, they discussed the potential to use artificial intelligence to reduce the cost barriers either for written translations or inexpensive headsets that allow participants to engage in a real-time conversation. It was noted by coalition members from immigrant and refugee communities that best practice should be to have a person familiar with the culture and language review the translation or be present for the conversation. Examples were given where words were translated that did not mean the same for specific communities or not even used even if there was a word that translated.

Items identified for action by the committee based on the CPA results and facilitated discussion included:

- Look for projects that could be piloted and replicated for greater impact.
- Build metrics related to each activity and the need for greater data sharing through the development of a data hub.
- Create forums designed to educate and increase engagement between the Cedar Valley's multicultural communities and organizations/employers. Leaders from immigrant and refugee communities noted that people in their communities are getting hired but get stuck when they have to complete all the human resource forms and aren't receiving culturally/linguistically focused orientations to their work.
- Develop a mentorship program to build leadership in the multicultural community. Existing staff and small non-profits are very active in this work but cannot meet all the needs.

Conclusion

This assessment helped quantify how organizations in the Cedar Valley are approaching accessibility, language, and culture of both publicly available materials and the current state of languages spoken by organizations. Steps are already underway by the Advancing Equity in the Cedar Valley coalition that were informed by the CPA. In addition, the survey results related to data sharing, type of data collected, and resources available will be used by the CHI assessment design team as they work to create a community data hub. These steps will be a starting point for the development of targeted, inclusive strategies that support the health and well-being of all community members.

References

Languages Spoken in Iowa: A report released from the Iowa State Extension Office that shows the languages spoken by English Language Learners in Iowa. https://indicators.extension.iastate.edu/DHR/languages.html#

NACCHO MAPP 2.0 Handbook, 2023: Guidebook for the MAPP 2.0 process.

New Americans in Iowa: A report released by the American Immigration Council that summarizes data available about immigrants in Iowa. https://map.americanimmigrationcouncil.org/locations/iowa/

Healthy Johnson County, Iowa 2022 Community Partner Assessment https://www.johnsoncountyiowa.gov/sites/default/files/2022-07/2022_Community_Partners_Assessment_Report.pdf

Healthy Teton County Community Health Needs Assessment https://www.tetoncountywy.gov/1750/Healthy-Teton-County

Appendix A

Community Partner Assessment

This survey helps to identify capacities and skills of organizations participating in the "Advancing Equity in the Cedar Valley" collaborative. Survey results will help us understand the strengths as a community and opportunities for greater impact. Results will be reported as summary statistics and de-identified comments only.*

Organization Details

1. **What is the full name of your organization? (Please complete only 1 survey per organization)**

2. **Why is your organization interested in the "Advancing Equity in the Cedar Valley" collaborative?**
    a. Access to data
    b. Connections to communities with lived experience
    c. Connections to other organizations
    d. Connections to decision-makers
    e. Connections to potential funders
    f. Positive publicity (e.g., our organization supports community health)
    g. Improving conditions for community members/constituents
    h. Other:

Diversity, Access, and Community Engagement

3. **Who are your priority or target populations?**

4. **What do you do to reach/engage/work with your clientele or community? (check all that apply)**
    a. We hire staff from specific racial/ethnic groups that mirror our target populations
We aim to provide facilities and services that are accessible to persons with disabilities
    b. We hire staff/interpreters who speak the language/s of our target populations
    c. We have access to translation and interpretation services (Propio, Language Line, etc.)
    d. We support leadership development in our target populations
    e. Our organization is physically located in neighborhood/s of our target populations
    f. We work closely with community organizations from our target populations
    g. Other:

5. **Which of the following methods of community engagement does your organization use? (check all that apply):**
    a. Billboards
    b. Video creation
    c. Focus groups
    d. Community forums/events
    e. Surveys (Customer/patient satisfaction surveys, community input, etc.)

f. Advocacy/Lobbying
g. Memorandums of understanding (MOUs) with community-based organizations
h. Citizen advisory committees
i. Social media
j. Other:

6. **When you host community meetings, do you offer: (select one option per row)**

	Always	**Frequently**	**Sometime**	**Rarely**	**Never**
Stipends or gift cards for participation					
Interpretation/translation to other languages including sign language					
Food/snacks					
Transportation vouchers if needed					
Childcare if needed					
Accessible materials for low literacy populations					
Virtual ways to participate					
Not applicable					
Other:					

7. **What languages do staff at your organization speak? (check all that apply)**
   a. English
   b. Spanish
   c. Marshallese
   d. Languages of Burma refugee community (Burmese, Karen, Karenni, etc.)
   e. Bosnian
   f. Pohnpeian
   g. Chinese (Mandarin, Cantonese, Hokkien, etc.)
   h. Vietnamese
   i. French
   j. French Creole
   k. Arabic
   l. Sign language
   m. Other:

8. **How do you aim to make your publicly available materials linguistically accessible?**
   a. All publicly available materials are translated into other languages
   b. Most publicly available materials are translated into other languages (e.g., when conducting outreach to various populations or when hosting events for various populations)
   c. Few publicly available materials are translated into other languages (e.g., only when requested)
   d. No publicly available materials are translated into other languages
   e. Not applicable (we do not have publicly available materials)

9. **Which languages do you typically translate your available materials into?**

10. **How do you aim to make your publicly available materials accessible to all?**
    a. All publicly available materials are in accessible formats (e.g., Braille, large print, audio, accessible PDFs)
    b. Most publicly available materials are in accessible formats (e.g., when conducting outreach to various populations or when hosting events for various populations)
    c. Few publicly available materials are in accessible formats (e.g., only when requested)
    d. No publicly available materials are in accessible formats
    e. Not applicable (we do not have publicly available materials)

What methods do you use to make your publicly available materials linguistically and accessible to all, if applicable?
Provide alt text for pictures
Staff are available to assist patients/customers
Closed captioning for videos
Large print options
Audio readers
Assess readability for grade level
Accessible PDFs
Cultural respect
None of the above
Other:

Do you experience any barriers in translating materials or making accessible materials? Please explain.

Organizational Capacity

11. **Does your organization have an advisory board of community members, stakeholders, youth, or others who are impacted by your organization?**
    a. No
    b. Yes, please write 1 or 2 sentences describing the advisory board

12. **Does your organization have sufficient capacity to meet the needs of your clients/ members? For example, do you have enough staff/funding/support to do your work?**
    a. Yes
    b. No
    c. Unsure

13. **Please provide any additional comments about your organizational capacity.**

Data Collection and Sharing

14. **What data does your organization collect? (check all that apply)**
    a. Demographic information about clients or members
    b. Access and utilization data about services provided and to whom
    c. Evaluation, performance management, or quality improvement information about services and programs offered
    d. Data about health status
    e. Data about health behaviors
    f. Data about conditions and social determinants of health (e.g., housing, education, or other conditions)
    g. Data about systems of power, privilege, and oppression
    h. We don't collect data
    i. Other:

15. **Can you share any of that data with the Advancing Equity collaborative?**
    a. Yes, already being shared
    b. Yes, can share
    c. Yes, willing to discuss sharing
    d. No
    e.
16. **What data skills does your organization have? (check all that apply)**
    a. Survey design and analysis
    b. Secondary data analysis
    c. Needs assessment
    d. Focus group facilitation
    e. Interviewing
    f. Participatory research
    g. Facilitators of community or town hall meetings
    h. Asset mapping
    i. Mapping/visualization skills
    j. Other quantitative or qualitative methods:

* Community: Our community includes all people who are connected to Black Hawk County, whether they live, work, play, worship, learn, or visit. Community can also mean people connected by common interests, values, cultural heritage, or area

Thank you for completing the survey. Results will be shared as summary statistics and de-identified comments only and will be incorporated into the Community Health Assessment conducted by Black Hawk County Public Health, MercyOne, Peoples Community Health Clinic, and UnityPoint Health.

Appendix B

Question 2: Why is your organization interested in the "Advancing Equity in the Cedar Valley" collaborative. (check all that apply)

Value	Percent	Responses
Access to data	66.7%	24
Connections to communities with lived experience	80.6%	29
Connections to other organizations	86.1%	31
Connections to decision-makers	72.2%	26
Connections to potential funders	52.8%	19
Positive publicity (e.g., our organization supports community health)	72.2%	26
Improving conditions for community members/constituents	94.4%	34
Other (click to view)	8.3%	3

Question 3: Who are your priority or target populations?

Responses generally fit into these categories:

- Underserved populations
- Immigrant and Refugees
- People living in poverty/low income
- Mental health or substance use disorder
- All who live, work, visit Black Hawk County
- All people in the region
- Homeless
- Families looking for childcare

Question 4: What do you do to reach/engage/work with your clientele or community? (check all that apply)

Value	Percent
We hire staff from specific racial/ethnic groups that mirror our target populations	57.1%
We aim to provide facilities and services that are accessible to persons with disabilities	78.6%
We hire staff/interpreters who speak the language/s of our target populations	46.4%
We have access to translation and interpretation services (Propio, Language Line, etc.)	67.9%
We support leadership development in our target populations	57.1%
Our organization is physically located in neighborhood/s of our target populations	50.0%
We work closely with community organizations from our target populations	96.4%
Other (click to view)	10.7%

Question 5: Which of the following methods of community engagement does your organization use? (check all that apply)

Value	Percent
Social media	89.3%
Community forums/events	85.7%
Surveys (customer/patient satisfaction surveys, community input, etc.)	71.4%
Video creation	64.3%
Memorandums of understanding (MOUs) with community-based organizations	60.7%
Advocacy/Lobbying	46.4%
Citizen advisory committees	42.9%
Focus groups	35.7%
Billboards	21.4%
Other (click to view)	21.4%

Question 6: When you host community meetings, do you offer:

Multiple options with a Likert scale for each option

- Most common response virtual meetings (always or frequently)
- Food and snacks (frequently or sometimes)
- Interpretation or translation was evenly split between always, sometimes, and rarely
- 59% rarely or never offer stipends or gift cards for participation

Question 7: What languages do staff at your organization speak? check all that apply)

Value	Percent
English	100.0%
Spanish	71.4%
French	28.6%
Bosnian	25.0%
Other (click to view)	21.4%
Marshallese	14.3%
Languages of Burma refugee community (Burmese, Karen, Karenni, etc.)	14.3%
American Sign Language	14.3%
French Creole	10.7%
Chinese (Mandarin, Cantonese, Hokkien, etc.)	3.6%
Vietnamese	3.6%

Other response included: Bulgarian, Haitian Creole, Portuguese, Lingala, Swahili, Hindi, Italian, Dari and Pashto

Question 8: How do you aim to make your publicly available materials linguistically accessible?

Value	Percent
All publicly available materials are translated into other languages	13.8%
Most publicly available materials are translated into other languages (e.g., when conducting outreach to various populations or when hosting events for various populations)	31.0%
Few publicly available materials are translated into other languages (e.g., only when requested)	37.9%
No publicly available materials are translated into other languages	13.8%
Not applicable (we do not have publicly available materials)	3.4%

Question 9: Which languages do you typically translate your available materials into?

- Nearly every response included Spanish
- Other common responses
- French
- Marshallese
- Bosnian
- Burmese (also Karenni and Karen)
- Selected additional languages
- Haitian Creole
- Swahili
- Somalian
- Dari/Pashto
- Some variability based on community needs and grant requirements

Question 10: What methods do you use to make your publicly available materials culturally and linguistically accessible appropriate and accessible to all?

Value	Percent
All publicly available materials are translated into other languages	13.8%
Most publicly available materials are translated into other languages (e.g., when conducting outreach to various populations or when hosting events for various populations)	31.0%
Few publicly available materials are translated into other languages (e.g., only when requested)	37.9%
No publicly available materials are translated into other languages	13.8%
Not applicable (we do not have publicly available materials)	3.4%

Question 11: What methods do you use to make your publicly available materials culturally and linguistically accessible appropriate and accessible to all?

Value	Percent
Staff are available to assist patients/customers	78.6%
Cultural respect	57.1%
Closed captioning for videos	46.4%
Accessible PDFs	42.9%
Provide alt text for pictures	28.6%
Assess readability for grade level	28.6%
Other (click to view)	28.6%
Large print options	21.4%
Audio readers	7.1%

Other responses: Google translate, graphics, accessibility application on website

Question 12: Do you experience any barriers in translating materials or making accessible materials? Please explain.

- Range of responses
- Some organizations are just beginning to explore translation
- Some have translated documents and staff who speak languages other than English
- Others rely on partner organizations for assistance
- Challenges
- Cost/funding
- Resources for translation/interpretation
- Time
- Training
- Impacts to both language services and accessibility, although organizations are more likely to be able to access language services than have accessible materials

Notes

- Not everyone experiences barriers and not every organization has a need to translate their materials
- Receiving funding to support staff, price per document, Language Line
- Who or what organizations to send translations to, no ability to print materials in Braille
- Time to receive translations or find an interpreter
- Training staff to use accessible materials – difficult with current staffing

Question 13: Does your organization have an advisory board of community members, stakeholders, youth or others who are impacted by your organization?

Value	Percent
No	28.6%
Yes	71.4%

Question 13.1: Please write 1-2 sentences describing the advisory board.

Variety of responses

Leaders/representatives from the communities served/target populations

Diverse community leaders

Question 14: Does your organization have sufficient capacity to meet the needs of your clients/members?

Value	Percent
Yes	35.7%
No	42.9%
Unsure	21.4%

Question 15: Please provide any additional comments about your organizational capacity.

- Funding was a major limitation for expanding capacity
- Language and interpretation needs throughout the community
- Workforce shortages in some professions
- Need for services is higher than the organization's ability to provide

Question 16: What data does your organization collect? (check all that apply)

Value	Percent
Demographic information about clients or members	81.5%
Access and utilization data about services provided and to whom	70.4%
Evaluation, performance management, or quality improvement information about services and programs offered	85.2%
Data about health status	33.3%
Data about health behaviors	37.0%
Data about conditions and social determinants of health (e.g., housing, education, or other conditions)	51.9%
We don't collect data	3.7%
Other (click to view)	14.8%

Question 17: Can you share any of the data with the Advancing Equity Collaborative?

Value	Percent
Yes, already being shared	11.1%
Yes, can share	18.5%
Yes, willing to discuss sharing	59.3%
No	11.1%

Question 18: What data skills does your organization have? (check all that apply)

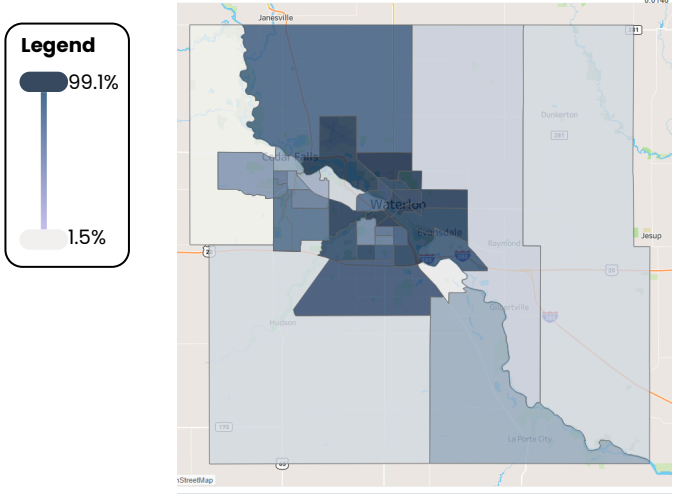
Value	Percent
Survey design and analysis	52.2%
Secondary data analysis	26.1%
Needs assessment	56.5%
Focus group facilitation	30.4%
Interviewing	47.8%
Participatory research	34.8%
Facilitators of community or town hall meetings	39.1%
Asset mapping	30.4%
Mapping/visualization skills	26.1%
Other quantitative or qualitative methods: (click to view)	13.0%

Appendix B: Community Health Assessment Prioritization Fact Sheets

Economic Stability

Economic instability disproportionately affects residents in the top five Social Vulnerability Index census tracts, particularly in ZIP code 50703, including Black/African American, Hispanic, and young adults aged 18-24. Contributing factors such as low wages, lack of worker protections, limited childcare, and unreliable transportation make it difficult for many households to meet basic needs, increasing their vulnerability during emergencies and exacerbating health disparities.

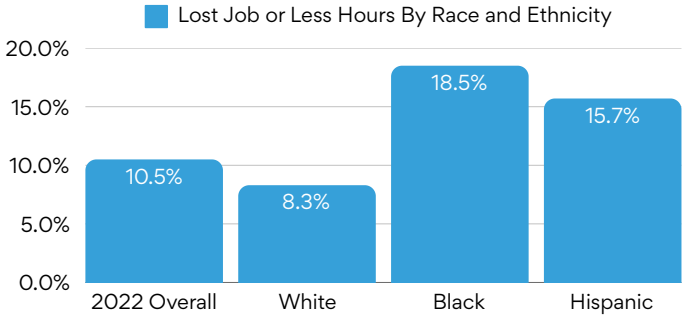
Social Vulnerability Index (SVI)



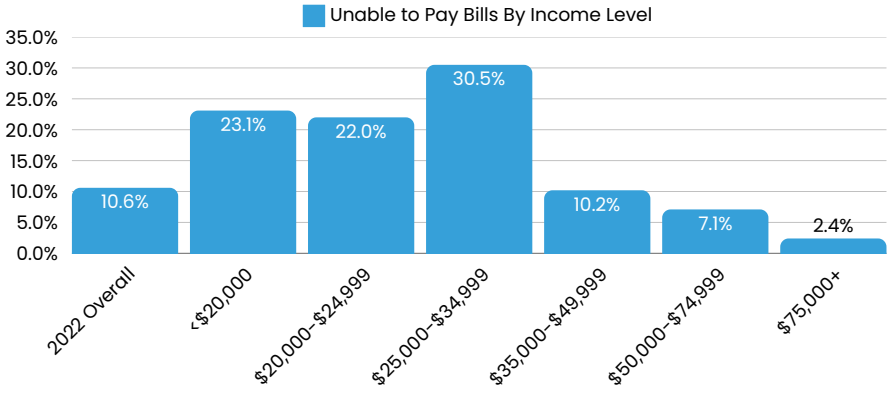
The SVI was created to enhance preparedness and response by understanding social factors that would affect a community's ability to respond to disasters. It combines several factors in four categories: socioeconomic status, household characteristics, racial and ethnic minority status, and housing type and transportation. The map shows census tracts in Black Hawk County ranked against other counties in Iowa. Census tracts with darker blue have a higher SVI than other census tracts.

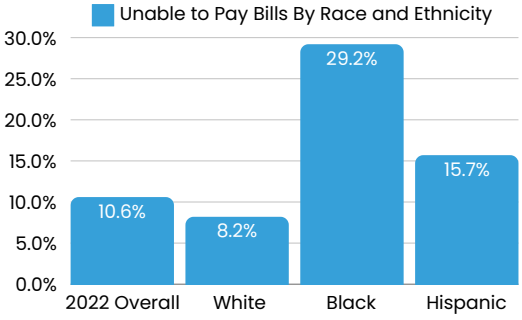
Lost Job or Less Hours

In 2022, Behavioral Risk Factor Surveillance Survey (BRFSS) participants were asked if they had lost their jobs or had hours reduced in the last 12 months. Participants identifying as Black or Hispanic were more likely to say yes to that question. Others impacted were individuals ages 18-24 (20.2%) and households earning less than $49,999 (18%), with households earning $25,000 to $34,999 impacted the most (22.6%).



Unable to Pay Bills or Utilities Shut Off



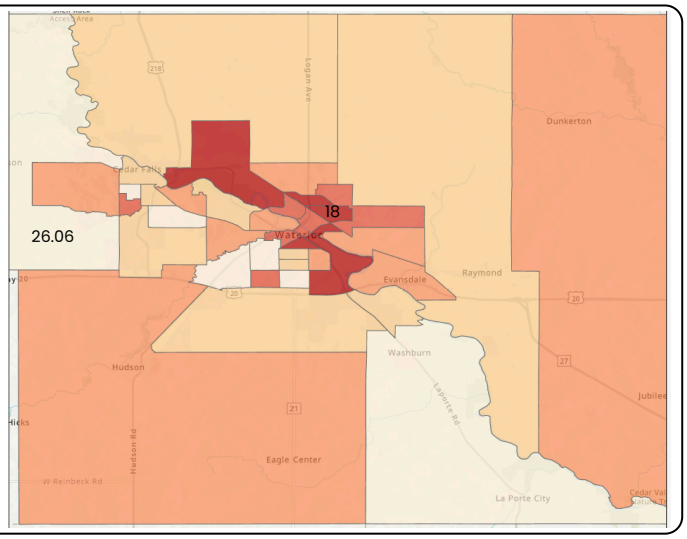


BRFSS participants were asked if they were unable to pay their mortgage, rent, or utility bills in the last 12 months. Individuals identifying as Black were the most likely to say yes to that question, followed by Hispanic individuals, as were households earning less than $34,999. They were also asked if utility companies threatened to shut off services in the last 12 months, and the same groups were affected at similar rates. However, households earning less than $35,000 (15.4%) were more likely to say yes compared to an overall average of 6.5%.

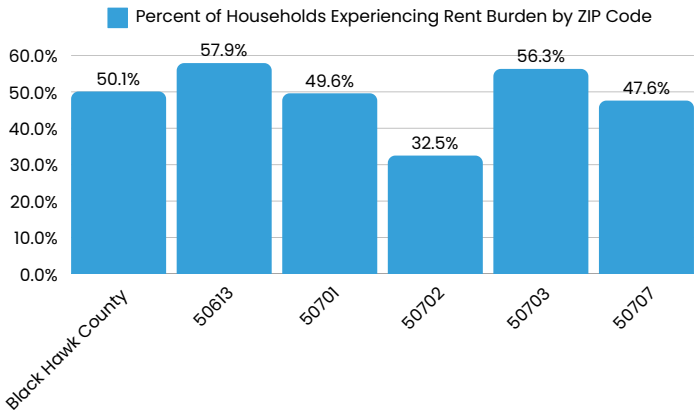
Economic Stability

Unemployment

The map shows Black Hawk County's unemployment rates for individuals aged 16 and older in the civilian labor force. Areas shown in dark red represent higher unemployment proportions, such as 21% in Census Tract 18 (east Waterloo), while lighter areas indicate lower unemployment, such as 0.1% in Census Tract 26.06 (northwest corner of map). This variation highlights distinct economic disparities within the county.

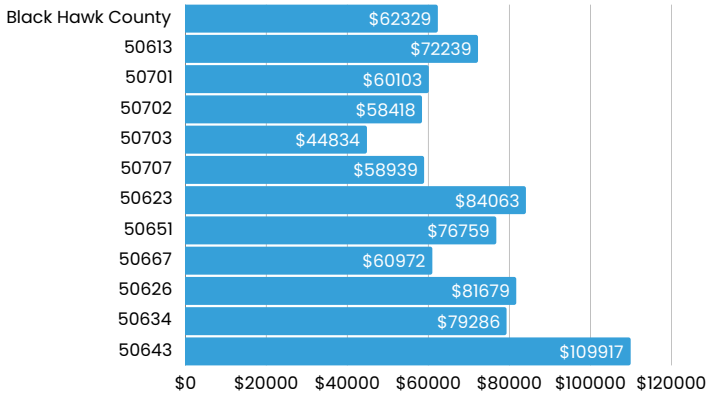


Rent Burden



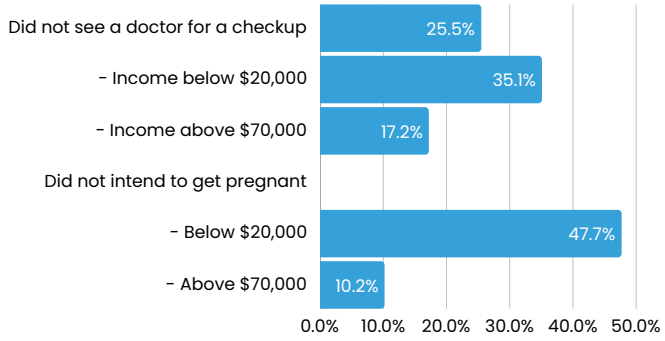
Rent burden is when people spend 30% or more of household income on rent.

Median Household Income



Waterloo ZIP Code 50703 had the lowest median household income in 2022.

Iowa Prenatal Care Survey



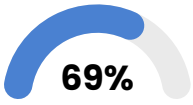
Nearly 1 in 4 women did not have a doctor's check-up in the year before pregnancy, with the highest rates among those earning under $20,000, potentially highlighting disparities in healthcare access compared to higher-income women.

Further, mothers earning under $20,000 reported the highest rates of stressors during pregnancy, followed by those earning $20,000–$70,000, while mothers with incomes above $70,000 experienced the fewest stressors.

Community Survey

#3

Overall Rank



Needs Improvement

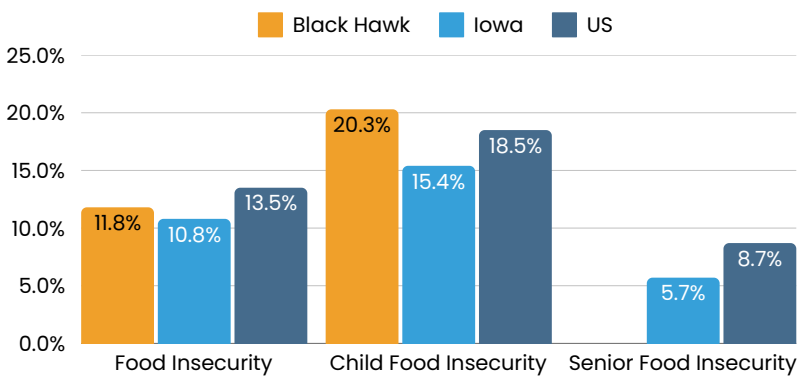
69% of respondents said that jobs and a healthy economy needs improvement

Jobs and a healthy economy was ranked **3rd** overall as top 3 important factors for a healthy community

Inequitable Food Access

Inequitable food access affects residents in ZIP code 50703 and census tracts, including tract 1, within 50703, characterized by high food insecurity, a vast food desert, and a lack of healthy food options.
These community members face a triple burden: struggling to afford enough food, no grocery stores, and the food that is readily available is often of poor nutritional quality.

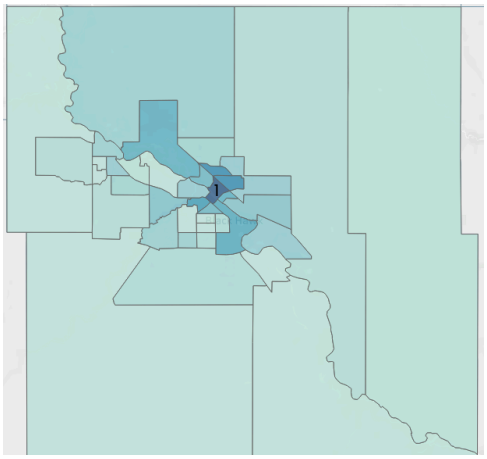
Food Insecurity, 2022



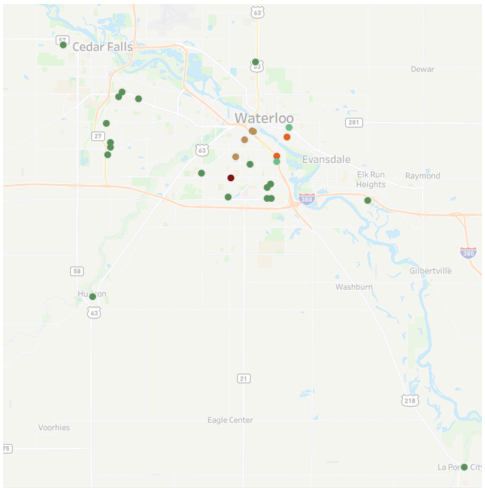
In 2022, food insecurity in Black Hawk County was 12%, slightly higher than Iowa at 11%, but lower than the U.S. average of 14%. Child food insecurity in Black Hawk County was higher at 20%, compared to 15% in Iowa and 19% nationally. Senior food insecurity data for Black Hawk County was suppressed, but Iowa's rate was 6%, lower than the U.S. average of 9%.

Food Insecurity by Census Tract, 2020

This map highlights food insecurity levels across Black Hawk County census tracts, ranging from 6% to 42%. Created using data modeled by Feeding America and the Northeast Iowa Food Bank, it identifies areas where access to sufficient, nutritious food is most limited. The analysis considers factors like unemployment, poverty, income, homeownership, disability, and demographics to pinpoint areas with the greatest need. Census tract 1 had the highest rates of food insecurity in the county.



NEMs Food Desert

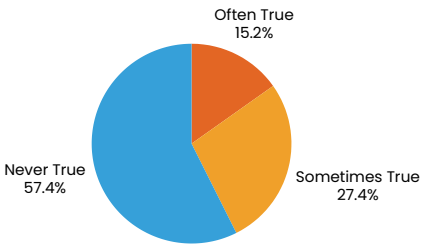


Locations of supermarkets and grocery stores in Black Hawk County. Two grocery stores closed in ZIP Code 50703 since the NEMS survey was performed.

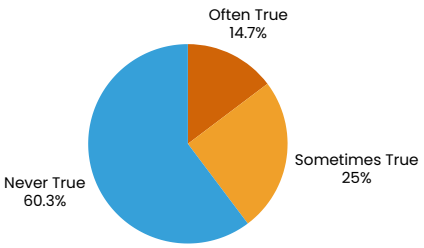
Community Survey

Many community respondents answered “sometime true” or “often true” to questions indicating that in the past year, they were concerned that food would run out (42.6%) or it did run out, and they didn’t have money to buy more (39.8%).

Concerned food would run out



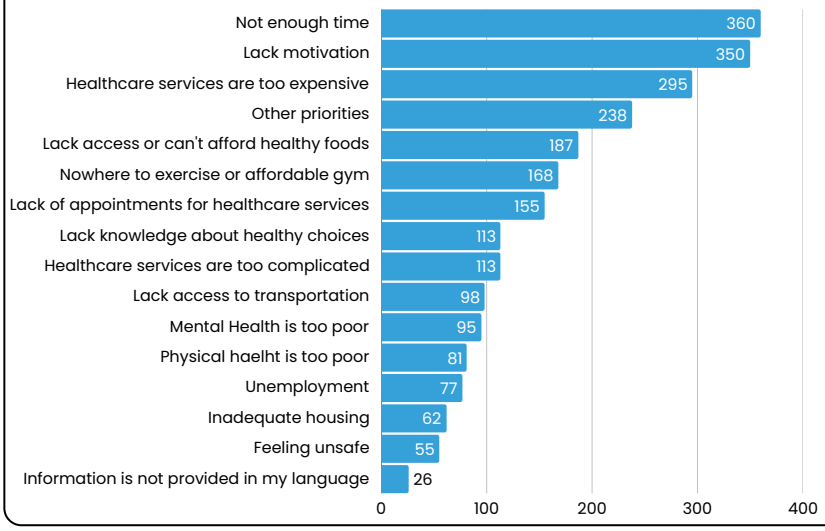
Food ran out, could not get more



Transportation Challenges

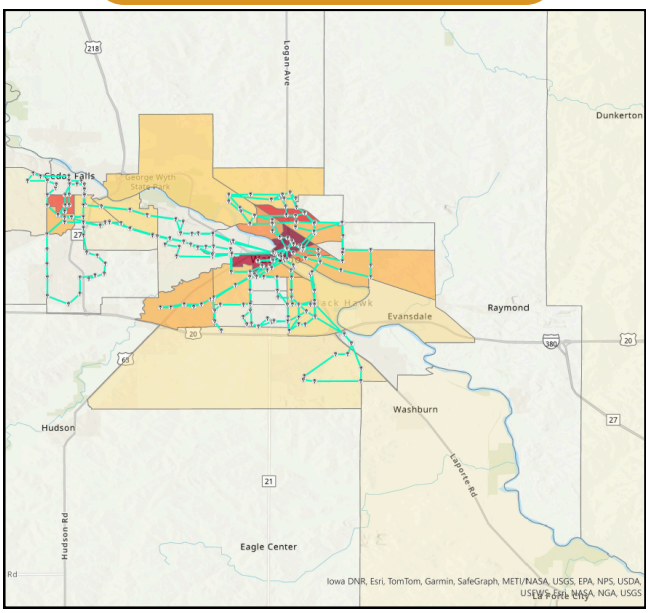
Limited access to reliable transportation disproportionately affects Black/African American community members, immigrant and refugee communities, and individuals with median incomes less than $20,000 in downtown Waterloo. This issue arises due to a transportation system primarily designed for car owners, compounded by a newly revised public transit system, limited ride-sharing availability, and a lack of education on available routes and infrastructure, all of which create barriers to essential services for these communities.

Community Survey



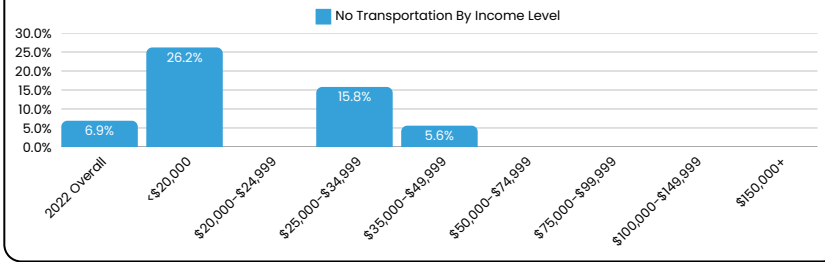
Transportation was ranked 10 out of 16 overall for factors that respondents said prevented them from being healthier and was not a major barrier noted in other questions. However, it was one of the top barriers for individuals with an income less than $15,000. Transportation was also the top reason why individuals who made less than $15,000 did not seek mental health services when they needed them. Additionally, Marshallese and Burmese respondents said it was the most needed improvement.

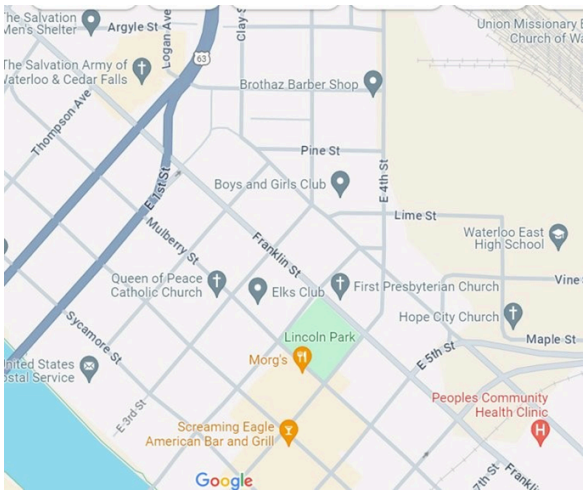
Low Income and Bus Routes



BRFSS, 2022

Low income prevented some BRFSS respondents from getting to appointments, work, and daily activities.





Diagonal roads and high-speed traffic on Mullen and Franklin Streets create pedestrian safety concerns

Salvation Army is enhancing accessibility with a new parking lot entrance and a sidewalk from the bus stop

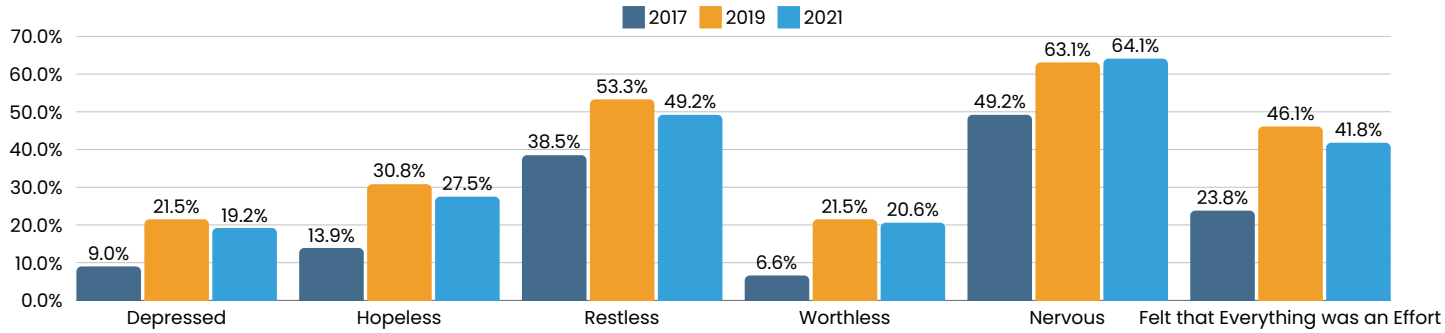
Franklin Street is undergoing construction to improve conditions, with a plan for pedestrian and bike-friendly upgrades.

Window Survey

Behavioral Health: Treatment, Prevention, and Recovery

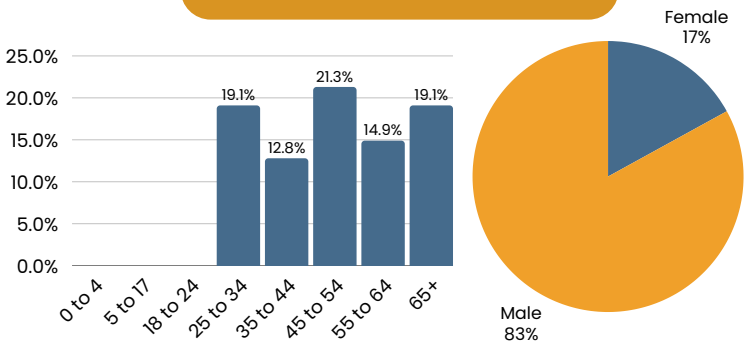
Behavioral health challenges disproportionately affect Black/African Americans, individuals aged 18-24 and 45-54, and those with lower incomes, with contributing factors including high ACE scores, male SUD, and anxiety disorders among younger age groups. 18-24-year-old females report the highest percentage of days that their mental health was not good, while alcohol, marijuana, and methamphetamine use pose significant challenges as they, directly or indirectly, impact many people.

Behavioral Risk Factor Survey



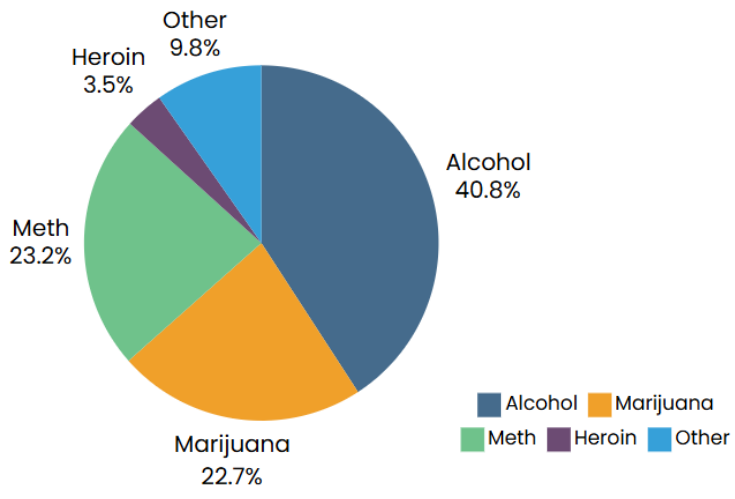
BRFSS participants in 2017, 2019, and 2021 have been asked if they had certain mental health symptoms in the past 30 days. There was an increase for each symptom from 2017 to 2019. In 2021, there was a slight decrease for all symptoms, except nervousness, but overall, they remain more similar to 2019 levels than returning to 2017 levels.

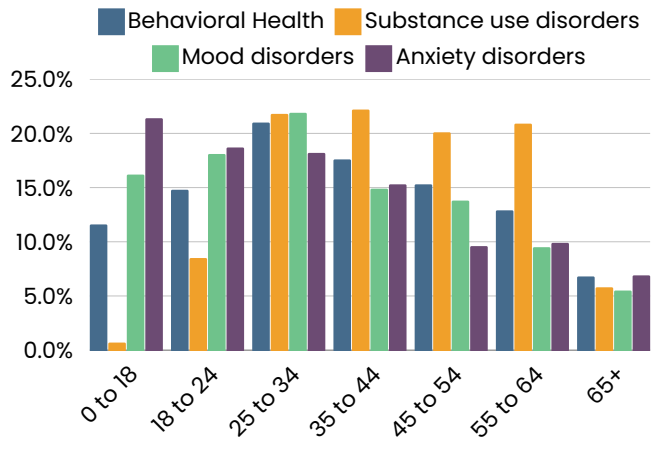
Vital Records

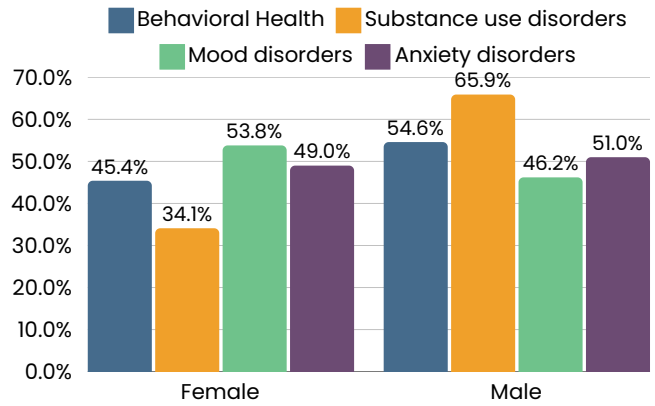


Individuals who died by suicide were more likely to be male, but no age group stands out as being more affected than others.

Substance Use Disorder Treatment







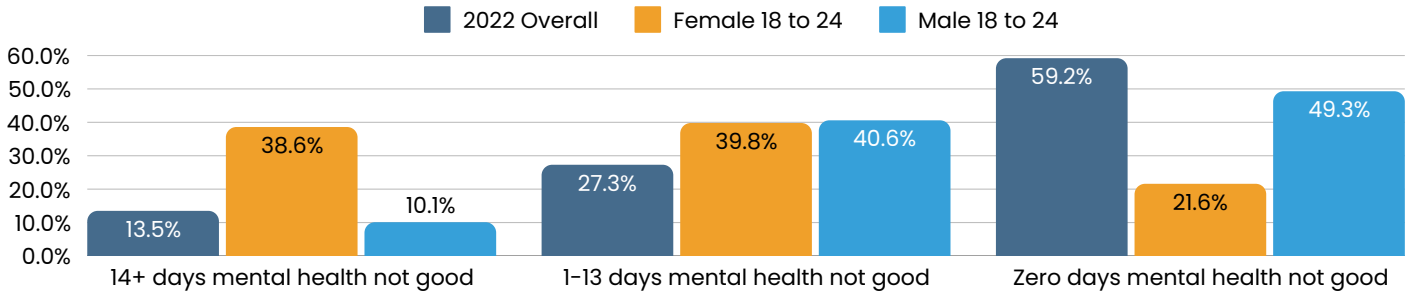
Anxiety disorders affected younger age groups, while substance use disorders affected men and older age groups.

Behavioral Health Diagnosis

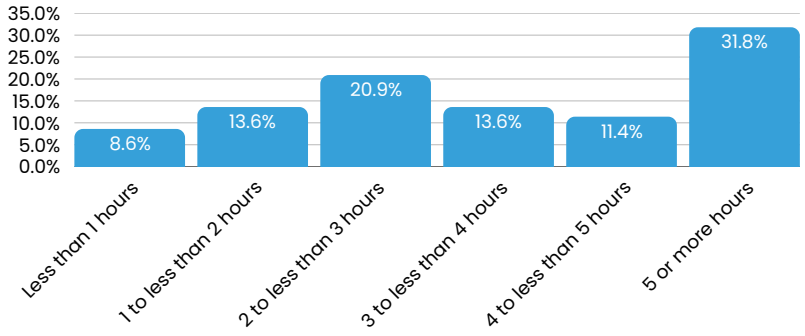
Behavioral Health: Treatment, Prevention, and Recovery

Mental Health Not Good, 2022

BRFSS participants were asked how many days out of the last 30 days was their mental health overall not good. In 2021, 16.1% individuals said that their mental health was not good 14-30 days. This decreased to 13.5% in 2022. However, women were more likely than men to be affected in 2022 (16.7% compared to 9.5%). 18-24 year olds were also more likely to be affected than other age groups (26.1%). The most affected group was 18-24 year old women, with 38.6% saying they had 14-30 days that their mental heath was not good.

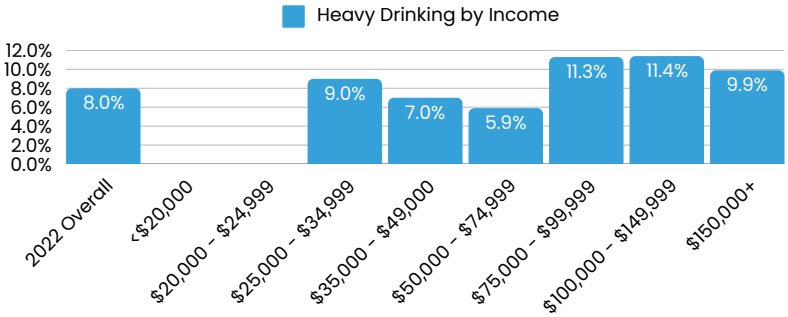


Screen Time, 2021

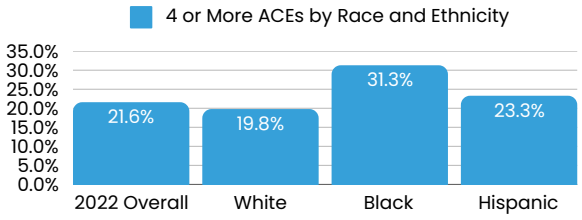


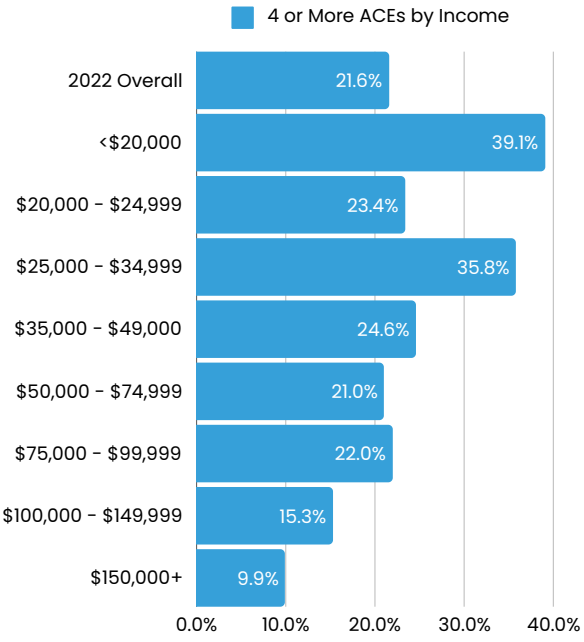
BRFSS participants were asked how many hours were they using screens or devices when they were not at work.

Heavy Drinking Alcohol, 2022



Heavy drinking is defined as more than 14 drinks per week for men and more than 7 drinks per week for women. Higher income levels, having a less than high school education, identifying as male, and people ages 25-34 were groups more likely to be affected.





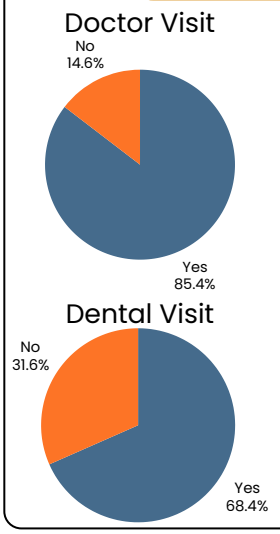
People reporting 4+ ACEs increased in 2022 (21.6%) compared to 2021 (18.6%). Age groups were normally distributed, but those who were under the age of 55 were more likely to report 4+ ACEs than those older than 55.

4+ ACEs, 2022

Access to Healthcare

Healthcare access disproportionately affect Black/African American, Hispanic, immigrant and refugee communities (Marshallese and Burmese communities), and low-income populations across the county, with many unable to access care due to cost, insurance issues, scheduling conflicts, lack of transportation or language support. These barriers reduce those receiving timely preventive care, leading to increased Emergency Department visits, delayed diagnoses, and poorer health outcomes.

Community Survey

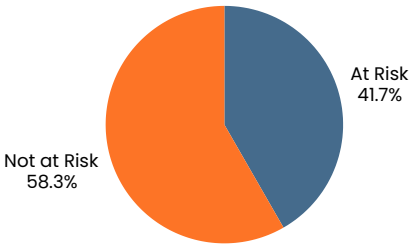


Younger age groups and lower income groups were less likely to visit the doctor or the dentist, as were some foreign-born population groups (Burma, Marshall Islands).

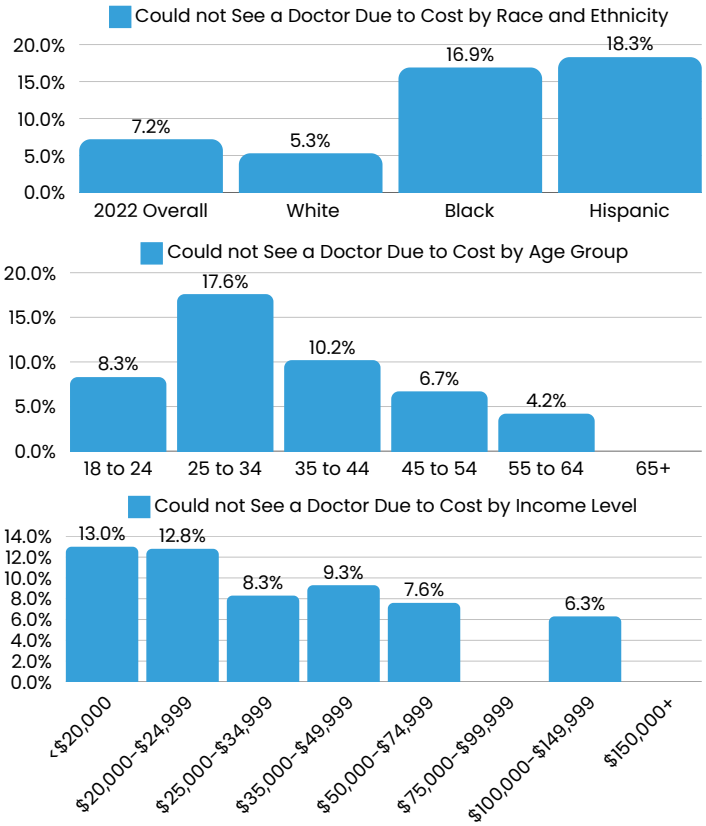
Top reasons included cost and inability to get an appointment time that works for them.

Dental insurance was also a barrier for dental care.

Oral Healthcare

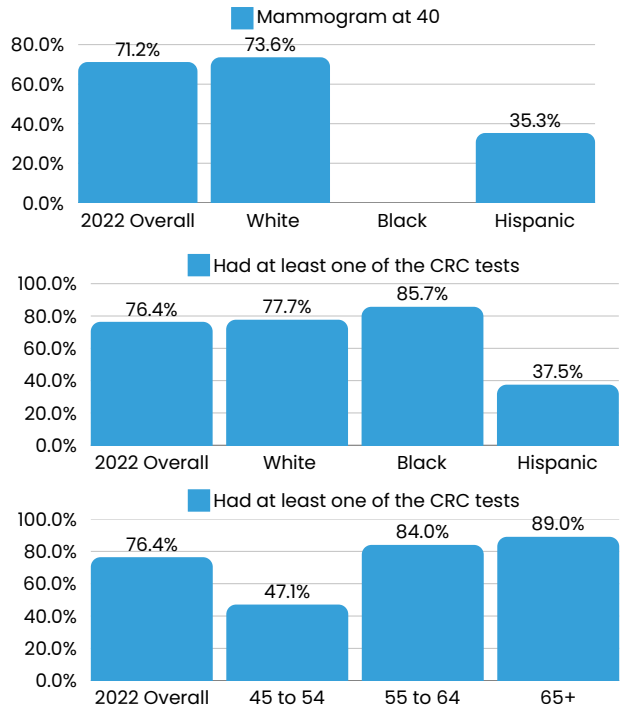


BRFSS participants were asked if they had lost any teeth to decay or gum disease. Those who had lost one or more for those reasons are considered to be "at risk". Individuals with a less than high school education (56.7%) and individuals earning less than $25,000 (63.8%) were the most affected.



BRFSS participants were asked if they could not see doctor due to cost in the last 12 months. There was a slight increase from 2016 to 2020, but the level has been similar from 2020 to 2022. The most impacted groups are shown above.

Cancer Screening



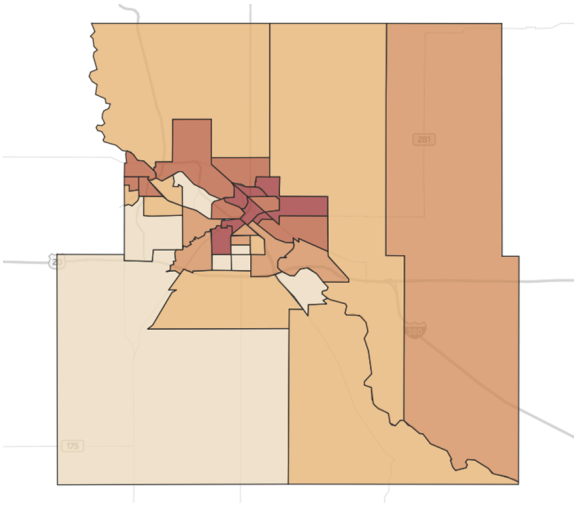
BRFSS participants were asked how long it had been since they had their last cancer screenings. While over 70% of participants were able to get a recommended cancer screening test, Hispanic individuals were less likely to get either a mammogram or colorectal cancer screening. Individuals ages 45 to 54 were also less likely to get a colorectal cancer screening test.

Cost of Healthcare

Housing Stability

Housing instability and lead exposure affect residents in east and central west Waterloo, particularly in ZIP codes 50703 and 50613, where rent burden is high, and older homes increase lead exposure risks. Rising housing costs, economic challenges, limited transitional housing, and zoning policies contribute to these issues, which mirror broader national and state trends.

Lead Exposure Risk Map, 2021



This map, created by IHHS, shows areas of risk for lead exposure based on the age of housing and childhood poverty. Darker red areas indicate higher risk. Parts of Waterloo have the highest risk zones, parts of Cedar Falls have moderate risk with fewer older homes and lower poverty, and rural areas generally show lower risk, though the eastern part of the county remain a concern.

Community Survey

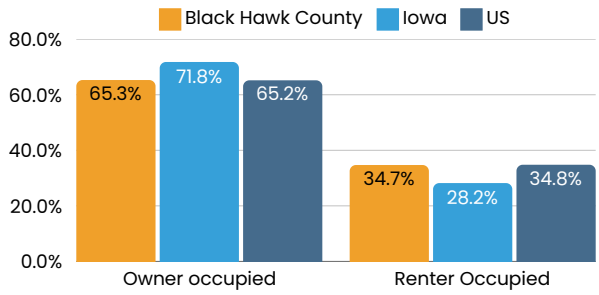
#2

Overall Rank

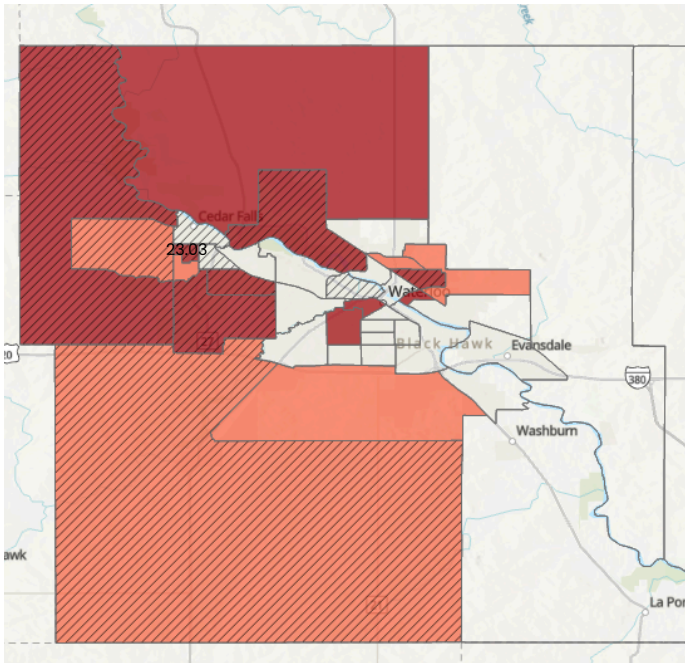
Needs Improvement

Affordable safe housing ranked #2 as a top factor for a healthy community, with 77% of respondents identifying it as the area most in need of improvement.

Homeownership



Black Hawk County has a lower owner-occupied housing rate than Iowa but is similar to the U.S. average. Census tracts 23.03 (home to UNI) and 1 have the lowest homeownership rates, ranging from 12.5% to 14.5%.



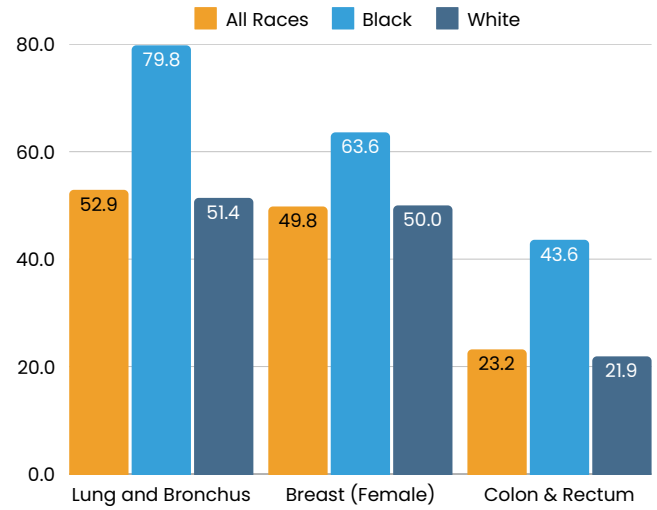
This map highlights areas in Black Hawk County where households face a high rent burden in red, meaning they spend more than 35% of their income on rent. While some neighborhoods with high rent burden also have higher-than-average rents (over $1,000 per month shown with hatched lines), the map shows that rent burden is significant even in areas with lower median rents.

Rent Burden

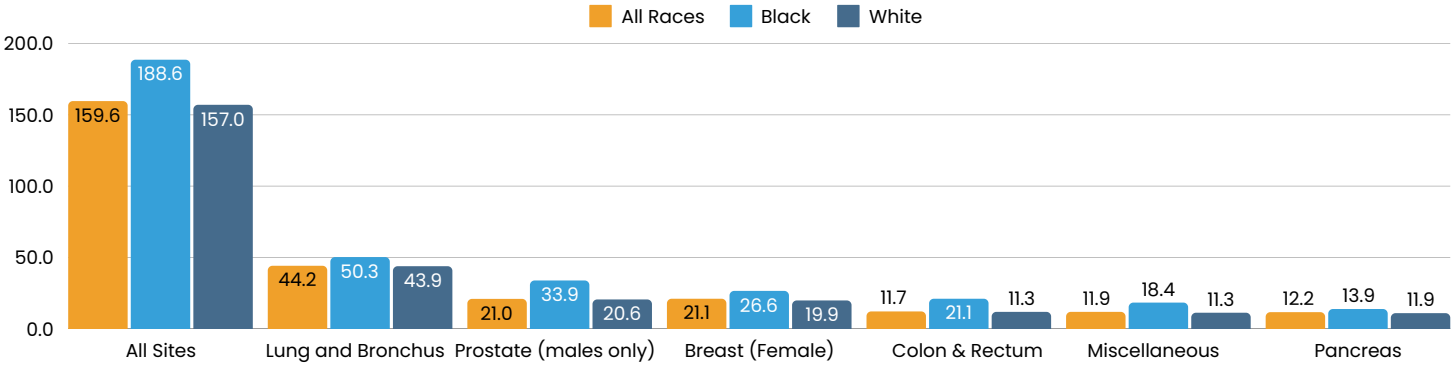
Chronic Disease

Chronic diseases such as cancer, diabetes, and obesity disproportionately affect Black/African American residents in ZIP code 50703, with obesity rates particularly high and cancer rates exceeding national levels. Contributing factors include complex interactions of lifestyle, genetics, concentrated poverty, and limited access to healthcare, creating significant health disparities in this community.

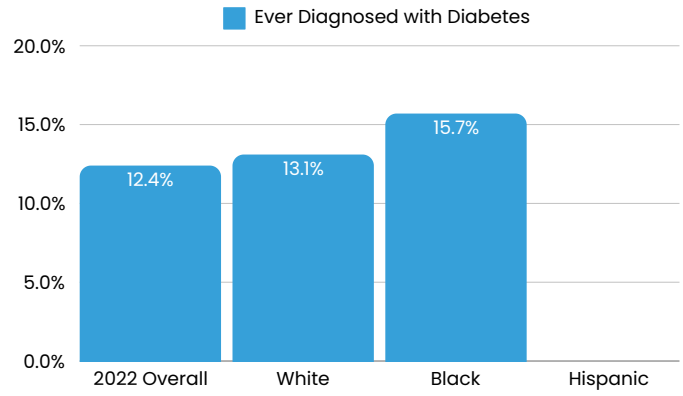
Cancer

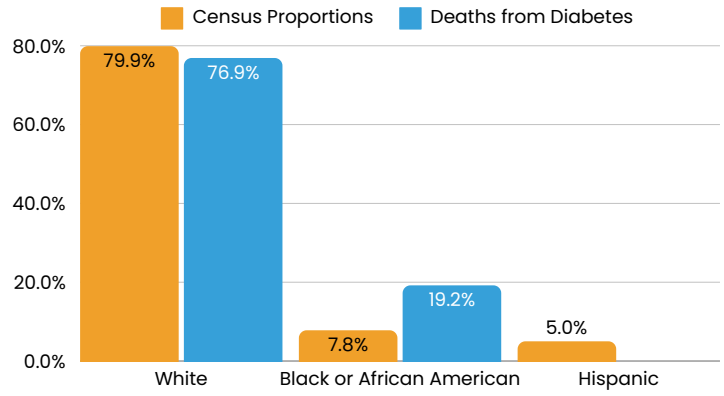


Invasive cancer incidence (defined as stages 1-4) has been increasing between 2010 and 2019 for Black Hawk County. Black or African American individuals are more likely to be diagnosed with some of the top cancers (prostate, lung and bronchus, colorectal, and liver cancer), in addition to having an overall higher cancer diagnosis rate. The first graph shows late-stage cancer rates for lung, breast, and colon cancers. Black residents have higher rates than White residents and the overall population. The second graph shows cancer mortality by race, which shows that Black or African American individuals are more likely to die of the cancers listed.



Diabetes

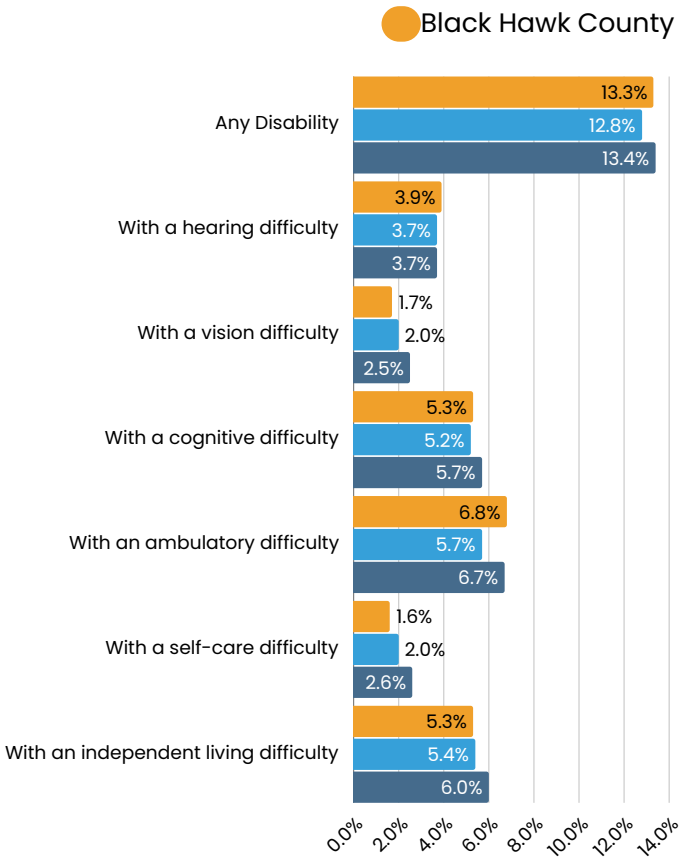


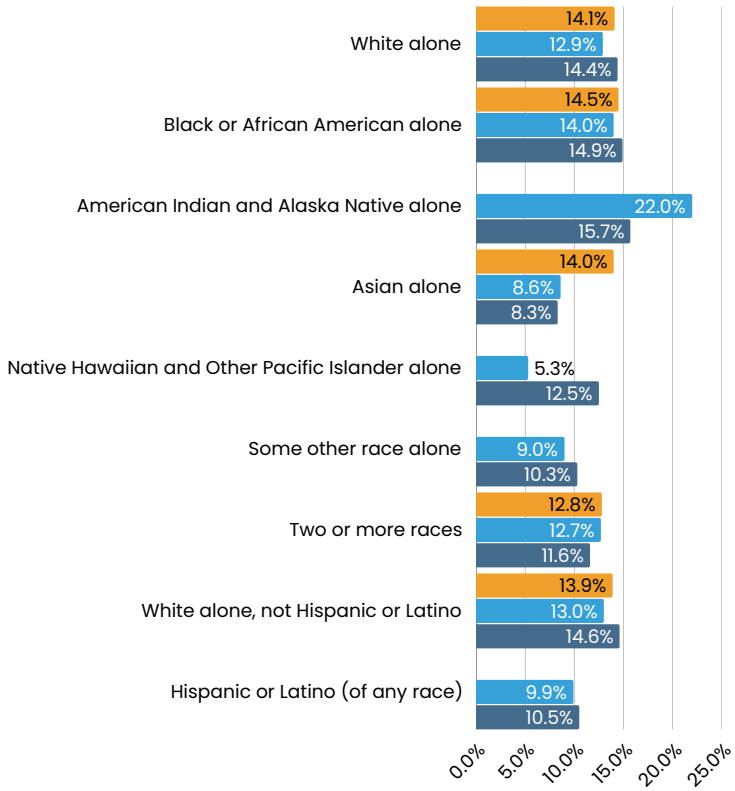


Black or African American individuals are more likely to identify as having diabetes or to die from diabetes compared to Census proportions. Individuals from Waterloo ZIP code 50703 are also more likely to go to the hospital or die from diabetes compared to Census proportions.

Chronic Disease

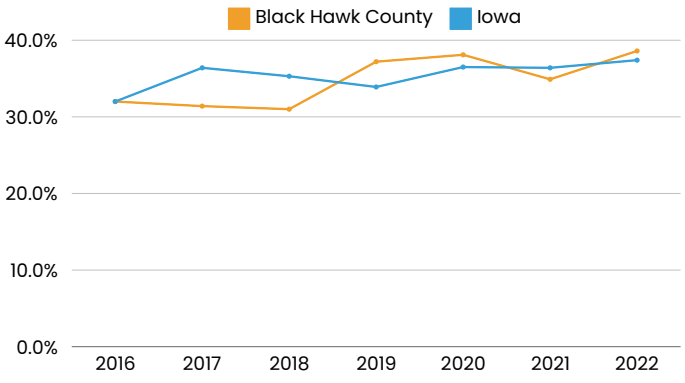
Disability

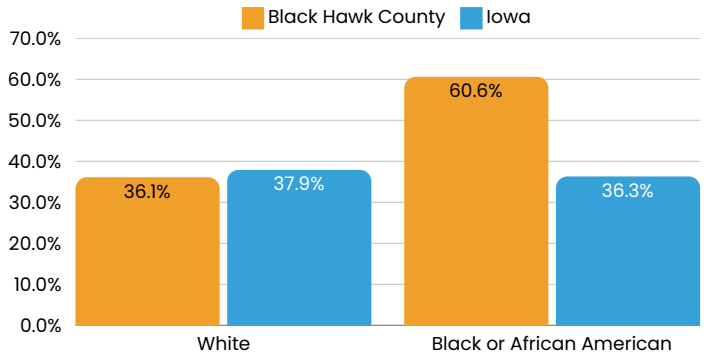




Proportions of individuals with disabilities in Black Hawk County were more likely to reflect US levels than Iowa levels. The most common disabilities were cognitive, ambulatory, and independent living disabilities. Racial and ethnic groups in Black Hawk County were more likely to identify as having a disability than the Iowa average, but less likely than the US average, with the exception of people identifying as Asian or Two or more races.

Obesity



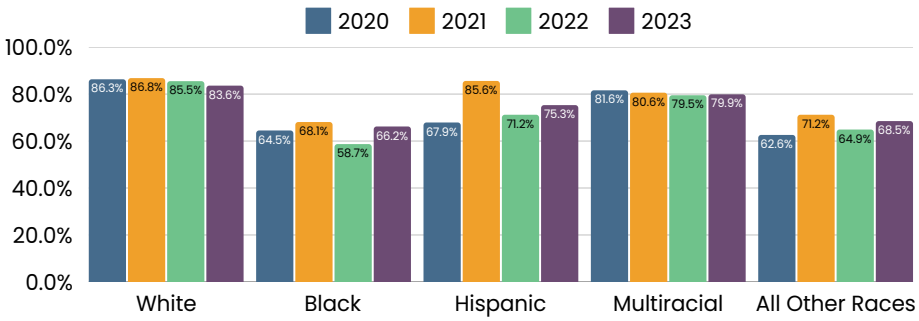


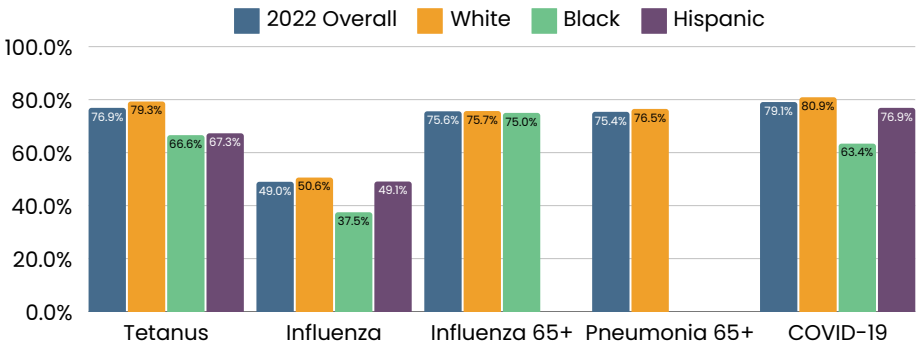
Obesity has been increasing in Black Hawk County and Iowa from 2016 to 2022. Rates for White individuals are lower in Black Hawk County than Iowa, while rates for Black or African American individuals are much higher.

Infectious Disease

Lower influenza and COVID-19 vaccination rates among Black/African American adults and children, combined with a rise in syphilis and congenital syphilis cases, highlight growing infectious disease risks in the county. Contributing factors include declining childhood immunization rates and insufficient maternal syphilis testing, increasing the likelihood of outbreaks and severe health outcomes.

Immunizations

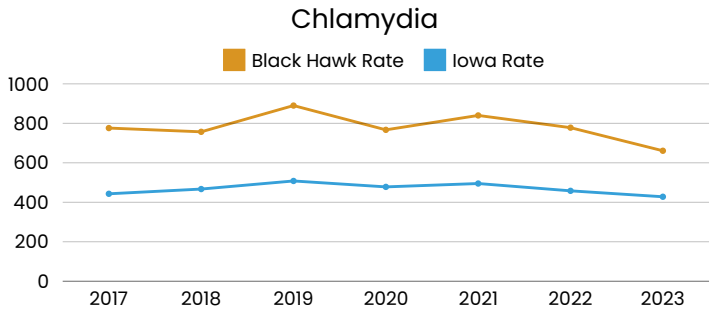


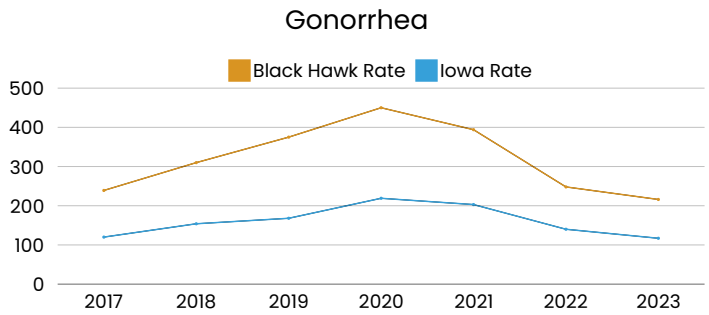


Immunization rates for children completing their recommended vaccines by age 2 have been steadily declining, while adolescent vaccinations are experiencing a slower, more gradual drop.

For adults, overall vaccination rates for tetanus, influenza (65+), pneumonia (65+), and COVID-19 hover around 75-79%, but significant disparities exist. Black and Hispanic adults have lower rates of tetanus vaccination, with Black adults having the lowest vaccination rates across all listed vaccines.

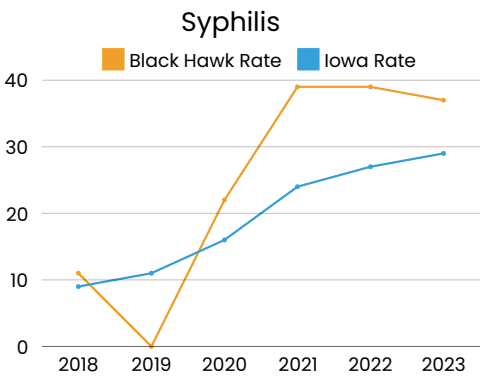
STI - Gonorrhea and Chlamydia

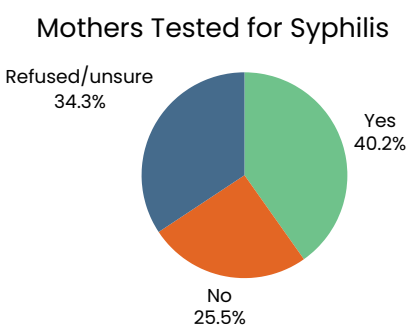




Chlamydia and gonorrhea rates have been steadily decreasing in recent years, but rates in Black Hawk County remain higher than both the Iowa and U.S. averages.

Syphilis



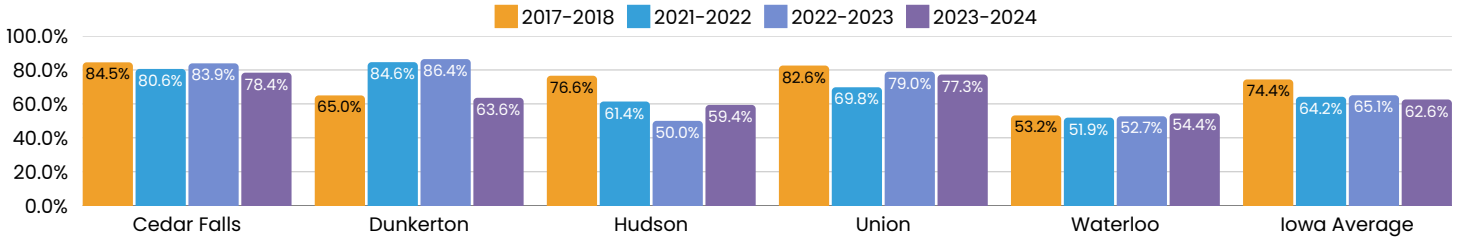


Local syphilis rates remain higher than Iowa but have stayed consistent in recent years. Only about 40% of mothers reported being tested for syphilis during pregnancy. New recommendations from the CDC are for all pregnant women to be tested multiple times due to rising rates of congenital syphilis.

Cultural and Linguistic Inclusivity

Cultural and linguistic inclusivity challenges impact education and community services with disparities in grade 3 reading proficiency, graduation rates, and support for diverse language needs. Contributing factors include increasing linguistic diversity, limited translation services beyond Spanish, and systemic gaps in fostering inclusivity, exacerbating disparities in education and access to resources.

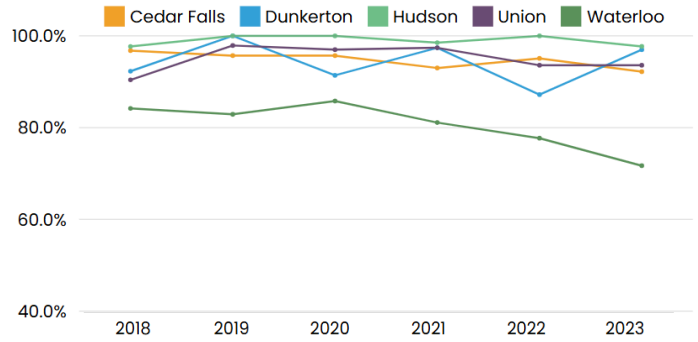
3rd Grade Reading Level



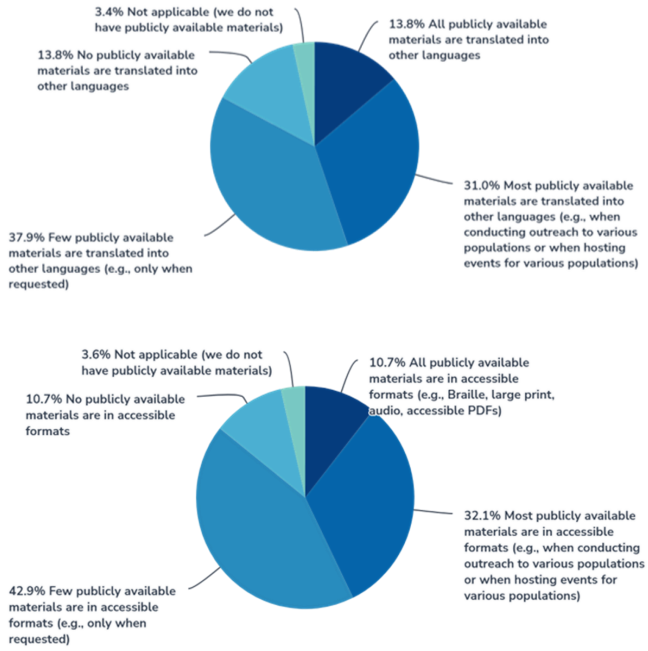
Grade 3 language arts proficiency is monitored annually at the state and school district levels. There are disparities across school districts which have been consistent from the 2017-2018 school year to the 2023-2024 school year. Disparities are seen across racial and ethnic groups and programs, but all groups reflect the district disparity.

Languages for ELL in Public Schools

Graduation Rates



Waterloo has consistently had the lowest graduation rates compared to local public schools and the Iowa average, dropping from 84.2% in 2018 to 71.7% in 2023. In contrast, Hudson has maintained the highest graduation rate, consistently above 97%.



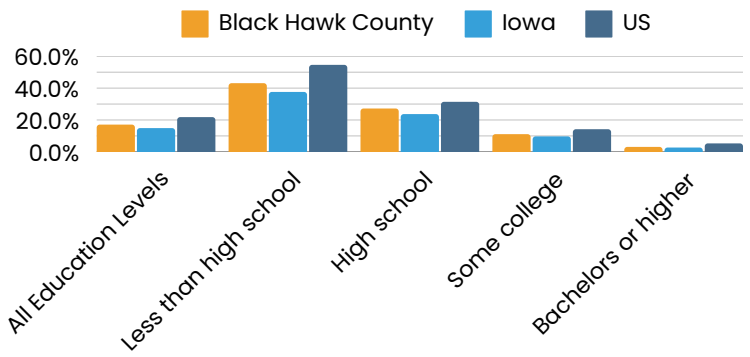
Staff at local organizations had staff that spoke Spanish, French, Bosnian, Marshallese, and languages of the Burma refugee community, among others, and were more likely to translate into these languages. However, many organizations still face barriers with translations and accessibility. Local organizations reported that most publicly available materials are only occasionally translated into other languages or provided in accessible formats, with less than 14% translating all materials and fewer than 11% offering all materials in accessible formats like Braille or audio.

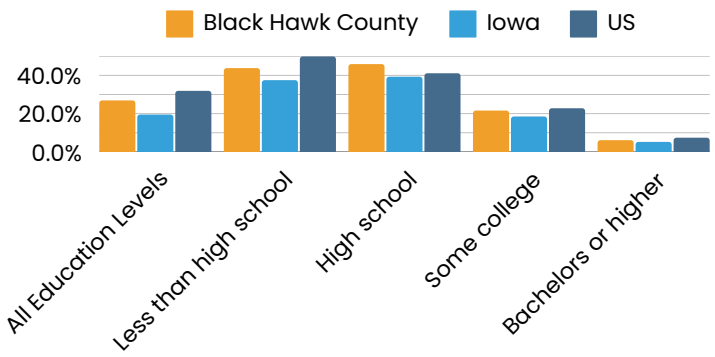
Community Partner Survey

Health Literacy

Health literacy challenges disproportionately affect individuals with lower education levels, young adults (18-29), Black/African American and Hispanic populations, and those in fair or poor health, with worsening trends over time nationally, statewide, and in the county. Declining literacy and numeracy skills impact self-advocacy and contribute to poorer health outcomes, particularly for older adults and those with lower education levels.

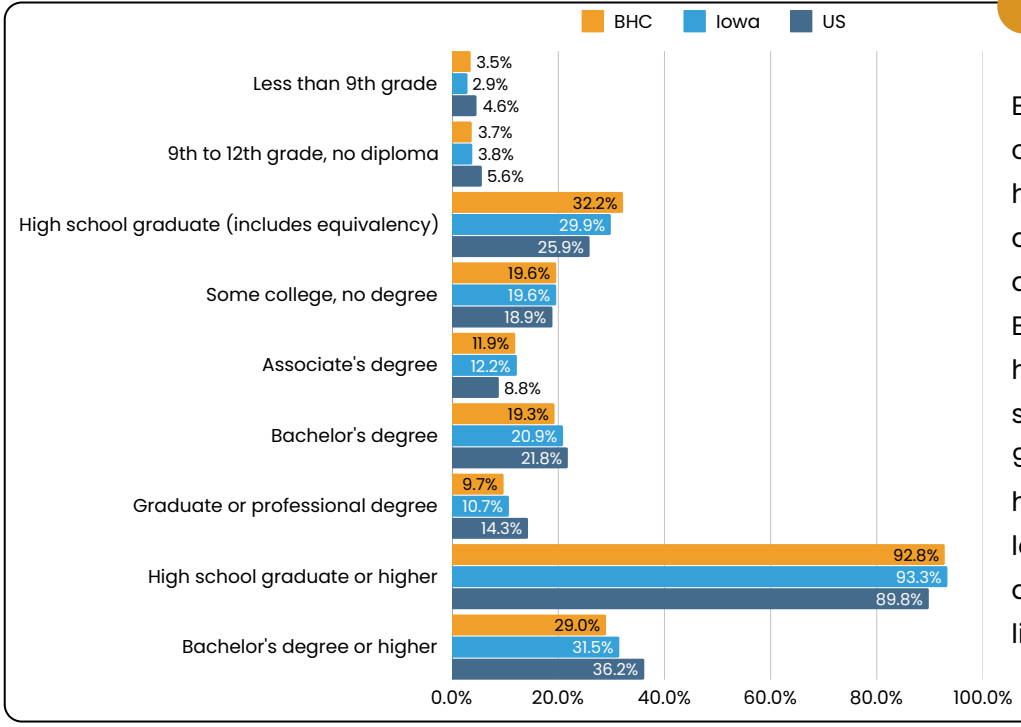
Literacy Estimates





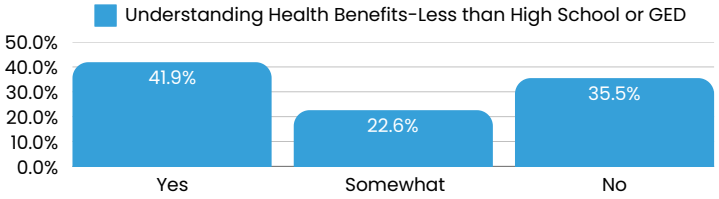
Health literacy is the ability to understand and make decisions about health information. Literacy and numeracy (ability to understand numbers) are important factors that impact health literacy levels. In Black Hawk County, people were more likely to be below level 1 literacy and numeracy levels than the Iowa average. Also, those with a less than high school education and those who were above the age of 45 were more likely to be impacted than other groups for both literacy and numeracy.

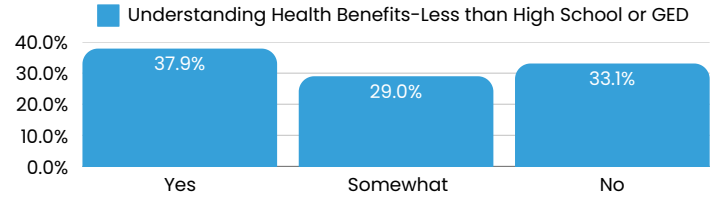
Educational Attainment



Educational attainment plays a critical role in health literacy, with higher education levels often associated with better understanding and navigation of health benefits. In Black Hawk County, 92.8% of residents have at least a high school diploma, slightly below the Iowa average of 93.3%. However, only 29% of residents have a bachelor's degree or higher, lagging behind both the state (31.5%) average, potentially impacting health literacy in the community.

Community Survey





Respondents with less than an 8th-grade education or a GED, as well as those aged 18-29, reported higher rates of not understanding health benefits compared to the overall average.

UnityPoint Health

2022 Community Health Needs Assessment

2023-2025 EVALUATION OF PAST ACTIVITIES

UNITYPOINT HEALTH – ALLEN HOSPITAL

Community Benefit Evaluation of Impact

UnityPoint Health – Allen Hospital completed its most recent Community Health Needs Assessment (CHNA) in 2022, identifying key health priorities for the community. Based on these findings—and considering available resources, alignment with the hospital's mission, and strategic goals—the Board approved a focused approach to address the following areas:

- Access to Healthcare
- Health Literacy
- Behavioral Health

Through the CHNA and the subsequent Community Health Improvement Plan (CHIP), UnityPoint Health – Allen Hospital has made measurable progress in advancing community health and well-being. This progress reflects a collaborative effort to align local partnerships, resources, and strategies with the most pressing health needs identified in the assessment.

The following report provides an evaluation of the impact of the priorities established in the 2022 CHNA and outlines actions taken as part of the 2023–2025 CHIP.

Priority One – Access to Healthcare

- Established UnityPoint Clinic Orthopedics service line to expand specialty care.
- Broke ground on UnityPoint Clinic Family Medicine Conrad Clinic to increase rural primary care access.
- Partnered with Family and Children's Council to integrate child abuse prevention and family-strengthening education through the Allen Child Protection Center.
- Added Magnetic Resonance Imaging (MRI) capabilities at United Medical Park to enhance diagnostics services.
- Approved and completed a third cardiac catheterization lab, improving cardiovascular care capacity.
- Allen Hospital 2 East Medical Unit was converted to become a procedural center for increased access to care.

Priority Two – Health Literacy

- Increased public awareness and fundraising through the Allen Foundation Mental Health Awareness Breakfast, attended by over 750 community members, supporting Black Hawk Grundy Mental Health initiatives.
- Implemented pharmacy automation compliance packaging and home delivery services to improve medication adherence and patient safety.

Priority Three – Behavioral Health

- Secured a Substance Abuse and Mental Health Administration (SAMHSA) grant to expand social determinants of health screenings and mental health access.
- Advocated successfully for legislation requiring the Suicide Hotline (988) to be printed on all Iowa student identification cards, in collaboration with the Waterloo Mayor's City Youth Council.
- Expanded on-site mental health evaluations and medication management for Medicare beneficiaries at Pillar of the Cedar Valley.
- Increased school-based mental health services through additional funding from Waterloo Community School District and Cedar Falls Community School Districts.