COMMUNITY HEALTH IMPROVEMENT ROADMAP

2026 - 2028

ADVANCING TOGETHER

A CEDAR VALLEY WHERE EVERYONE CAN THRIVE

Black Hawk County Public Health

(319) 291-2413
www.bhcpublichealth.com
publichealth@blackhawkcounty.iowa.gov

December 2025

UnityPoint Health

MERCYONE

PEOPLES Community Health Clinic

BLACK HAWK COUNTY PUBLIC HEALTH

Contents

Introduction

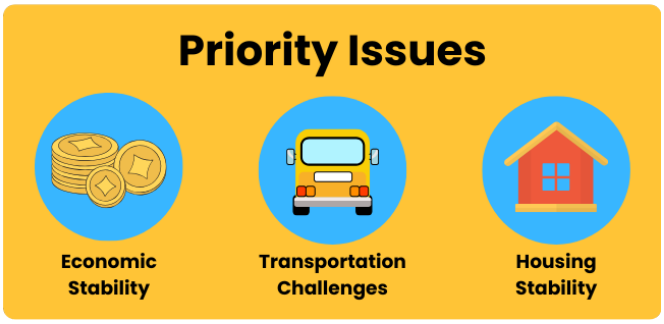
Over the past several years, the Cedar Valley has been working together to improve community well-being and promote belonging. The origins of this work trace back to 2019, following a national report naming Waterloo–Cedar Falls as the worst place for Black Americans to live. In response, community members 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



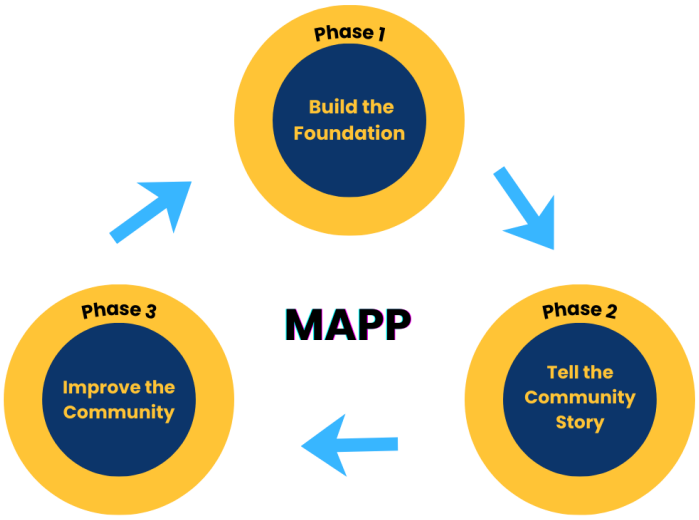
Both Advancing Equity and the Community Health Improvement Steering Committee shared a commitment to reducing barriers and expanding opportunity. In 2025, these efforts merged to form Advancing Together in the Cedar Valley, a unified coalition grounded in a shared vision: to create a place where all 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.

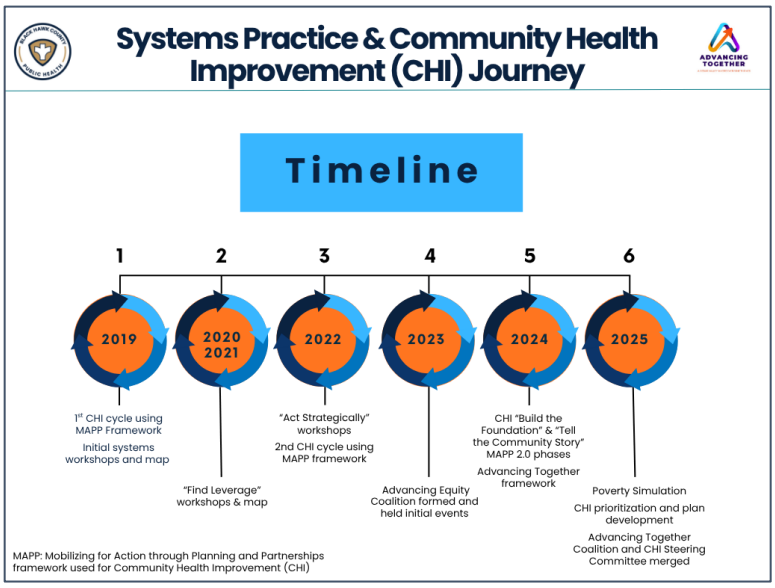
Phase 1: Build the Foundation

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:

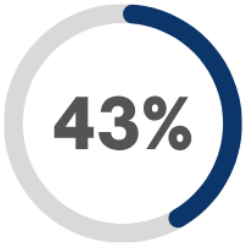
- Excessive screen time and social media use
- Bullying
- Limited access to mental health services

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.

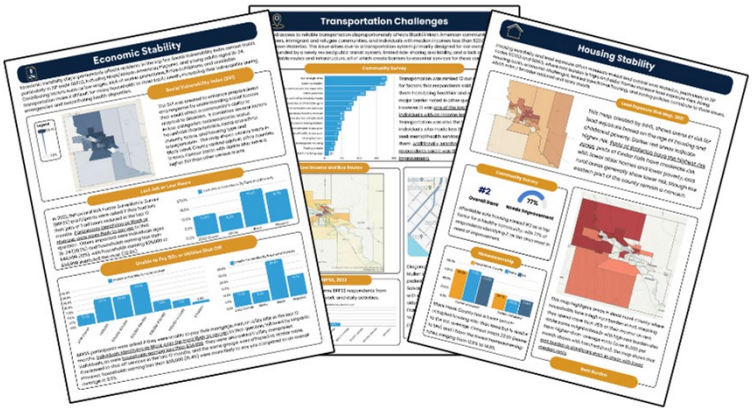
Community Engagement and Prioritization

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

Sources*

24/7 Wall Street. (2018, November 9). *The worst cities for Black Americans*. Retrieved from https://247wallst.com/special-report/2018/11/09/the-worst-cities-for-black-americans-4/4/

Black Hawk County Public Health. (2019). *Systems mapping presentation and interactive map*. Retrieved from https://bhcph.kumu.io/black-hawk-county

Bronfenbrenner, U. (1977). Experimental toward an ecology of human development. *American Psychologist*, *32*, 513–531.

Iowa Department of Health and Human Services. (n.d.). *Healthy Iowans, Iowa's state health assessment, improvement plan, and partners in action: Health improvement strategies throughout Iowa*. Retrieved from https://hhs.iowa.gov/about/data-reports/performance-reports/healthy-iowans

National Association of County and City Health Officials. (n.d.). *MAPP 2.0 handbook*. Retrieved from https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

The Omidyar Group. (2017). *Systems practice workbook*. Retrieved from https://docs.kumu.io/disciplines/systems-practice

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). *Healthy People 2030*. Retrieved from https://odphp.health.gov/healthypeople

*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

Appendices are available through separate links on the Black Hawk County Public Health website: https://www.bhcpublichealth.org/our-approach/community-health-improvement