Black Hawk County Public Health

Black Hawk County Community Status Assessment

March 2025

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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

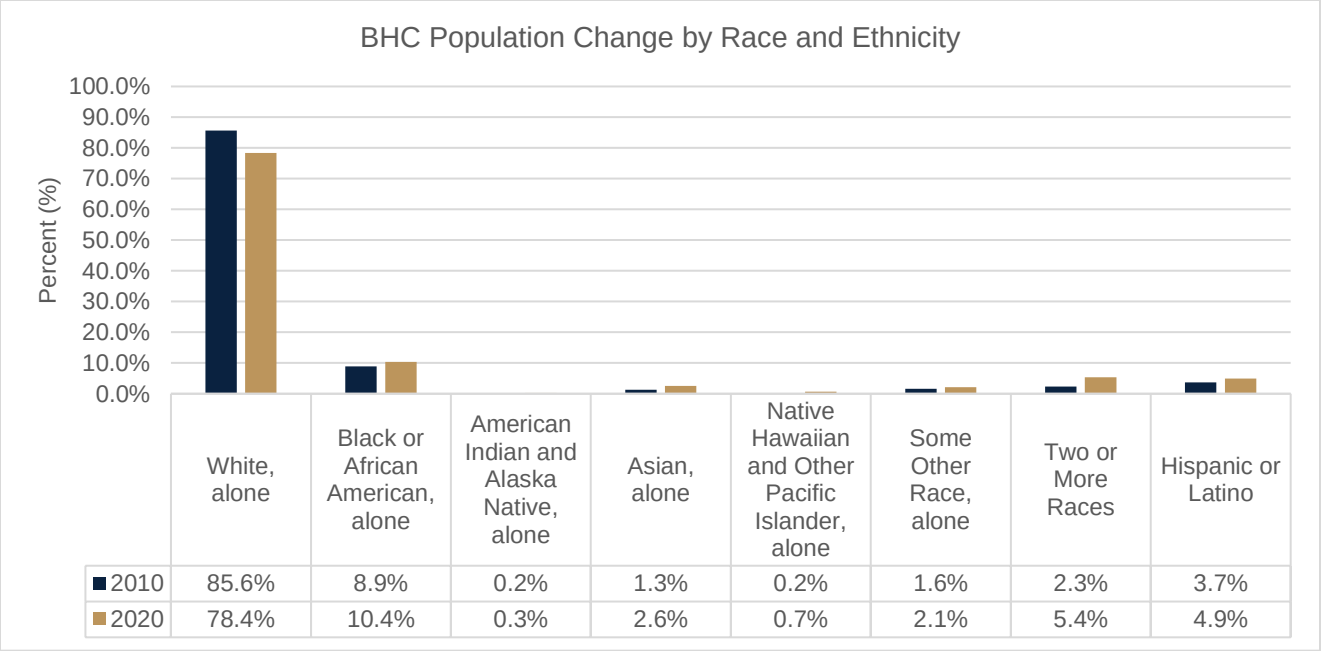
The CSA was performed to answer the previous questions to assess the overall health of Black Hawk County, Iowa. Results were intended to be used alongside the results of the other two assessments to identify the highest priority health needs for Black Hawk County, Iowa, and inform the development of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

Process and Timeline

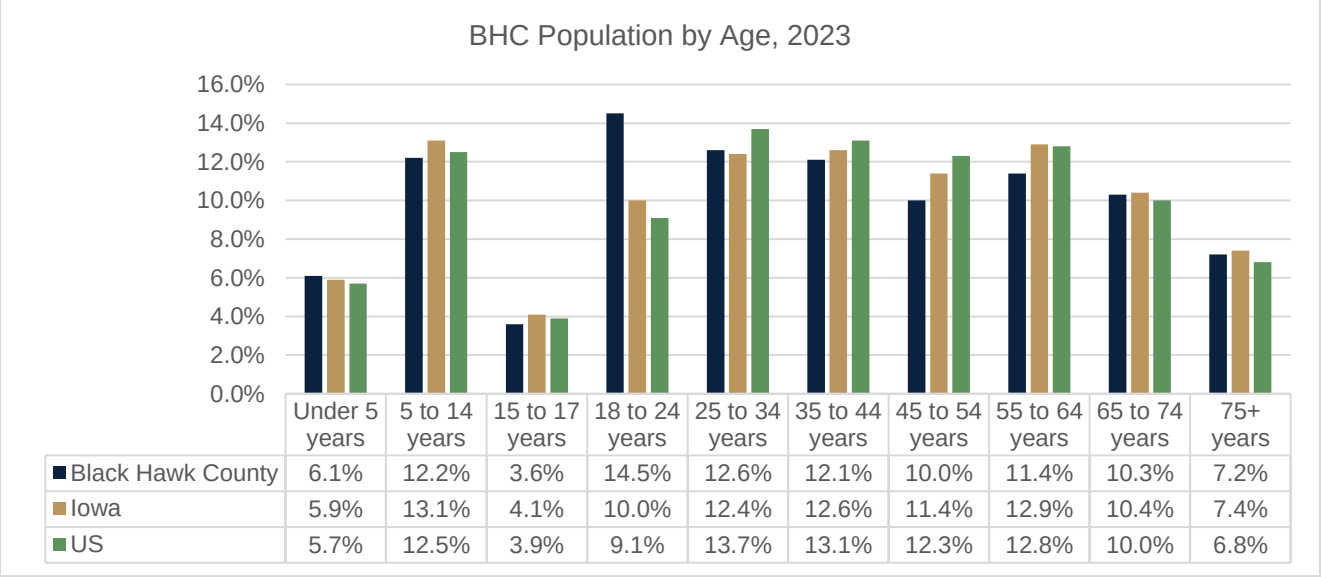
This CSA was conducted from February 2024 to December 2024. The work was led by the Community Health Improvement (CHI) core team, which includes a public health planner and two epidemiologists, in collaboration with area hospital systems, MercyOne and UnityPoint Health, and the Federally Qualified Health 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.

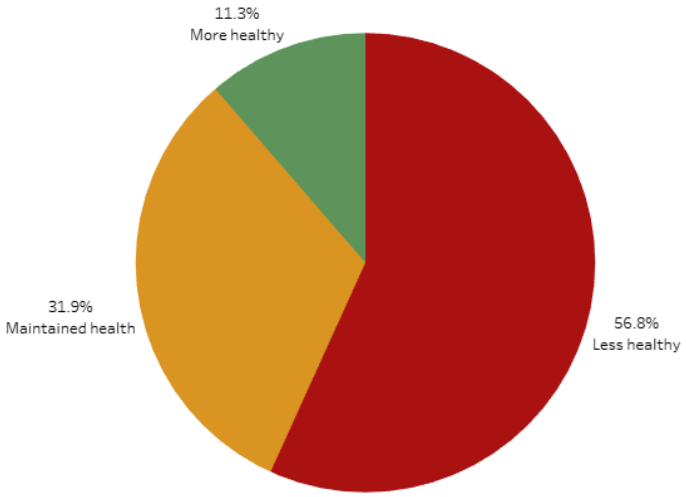
While these findings highlight urgent areas for improvement, there are some limitations. The amount of available data was large, so two epidemiologists selected what they believed to be the most important information based on selection criteria. Other analysts might have chosen different data. Whenever 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.

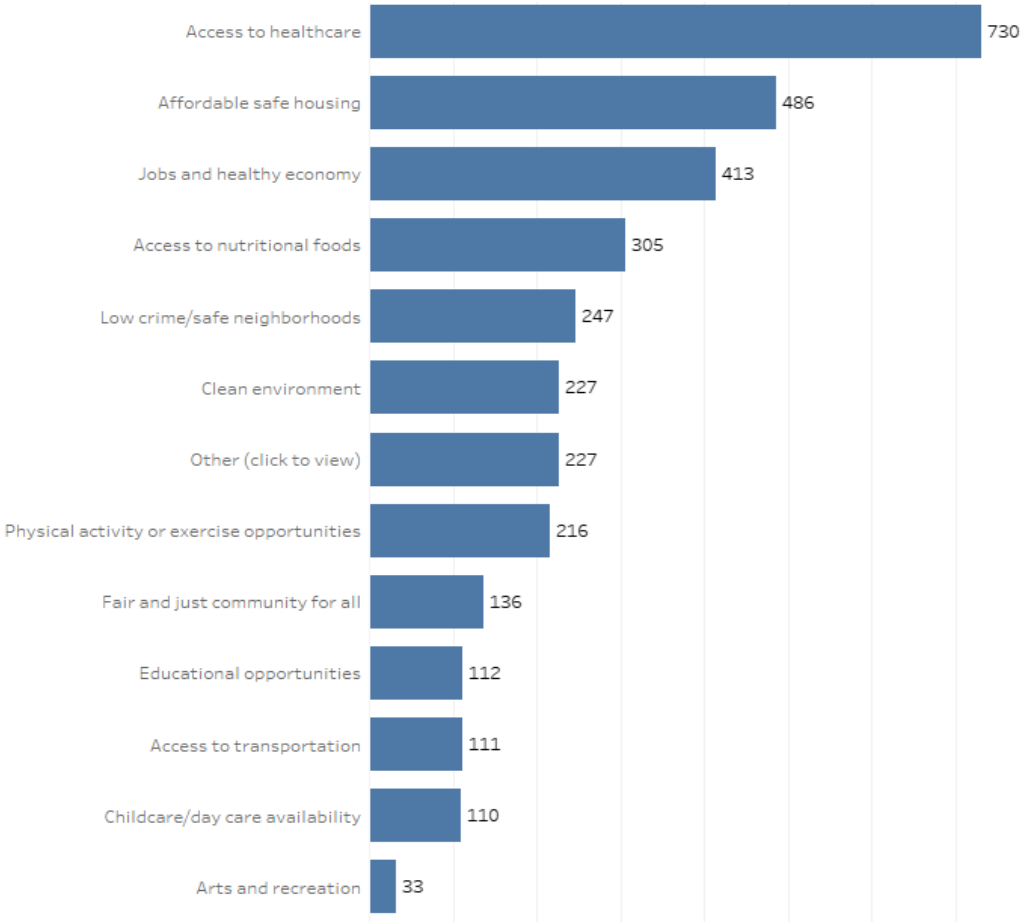
By understanding these ten issues and their impact on different groups, we hope this information guides efforts toward targeted, inclusive strategies that support the health and well-being of all community members.

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%

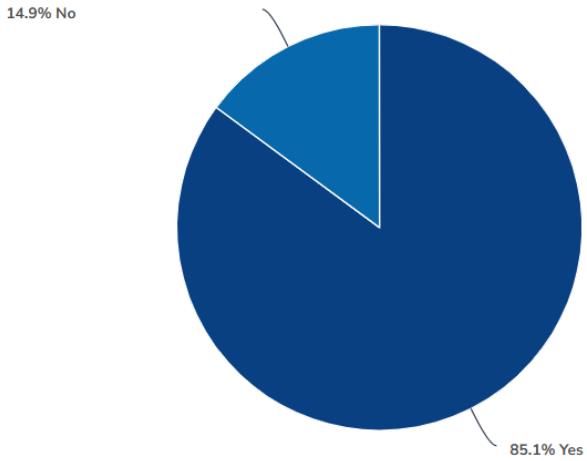
4. What do you feel are the top three (3) health problems for adults in the community? (Select up to three (3) boxes below)

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%	

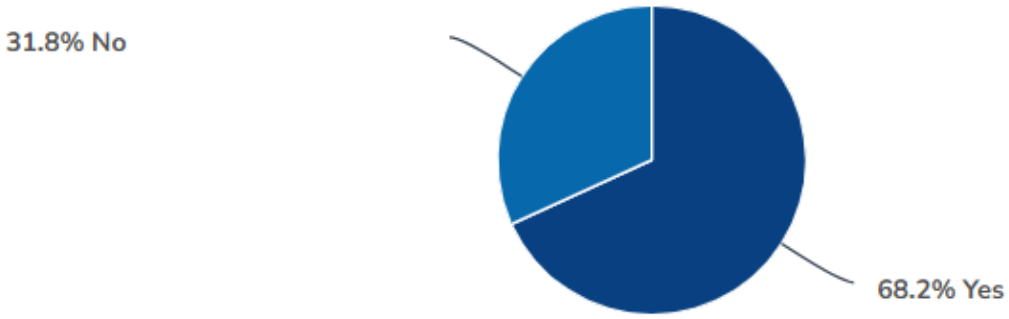
6. Do you receive an annual health exam (check-up/physical)?



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%	

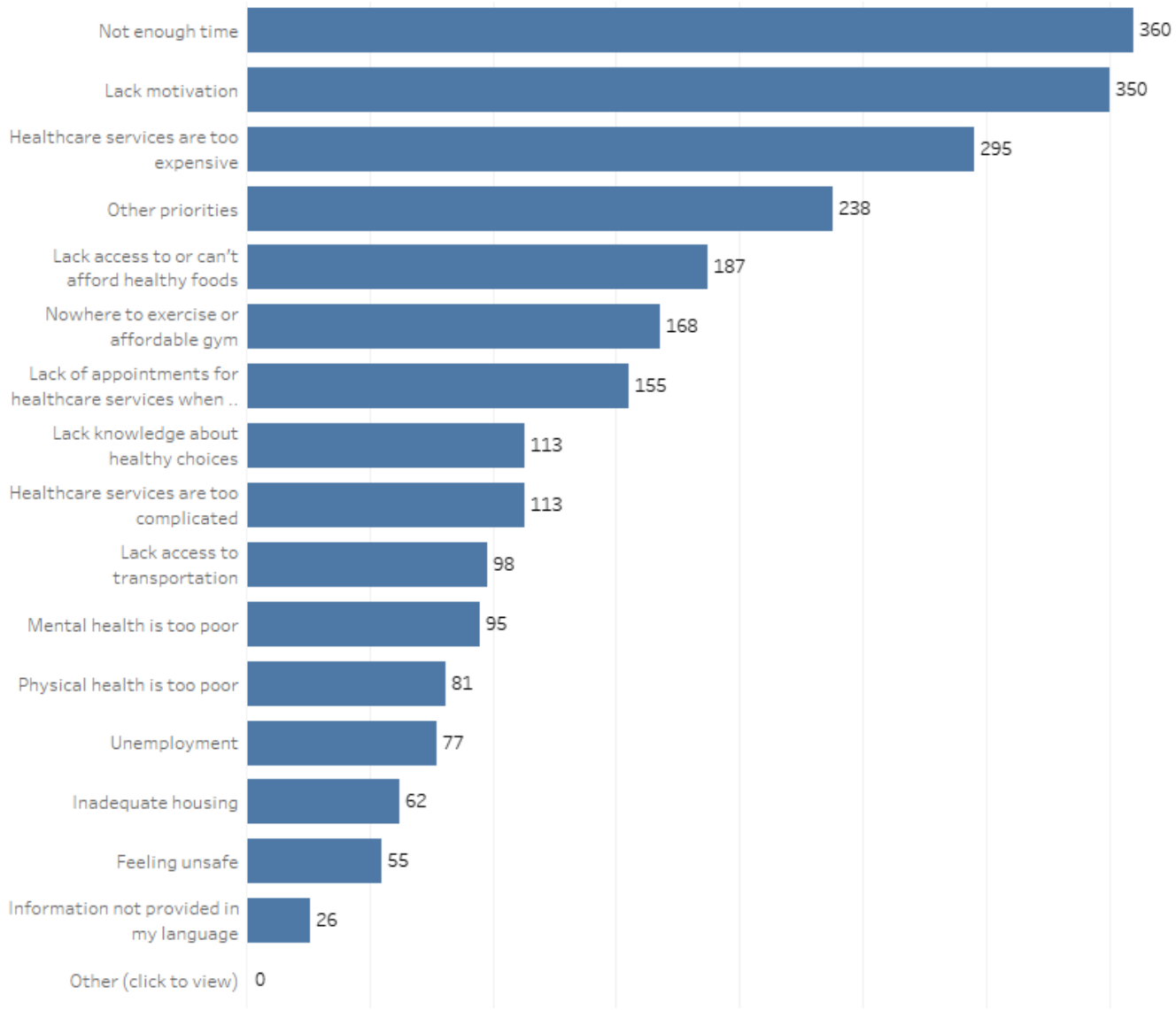
8. Do you visit the dentist regularly (1-2 times per year)?



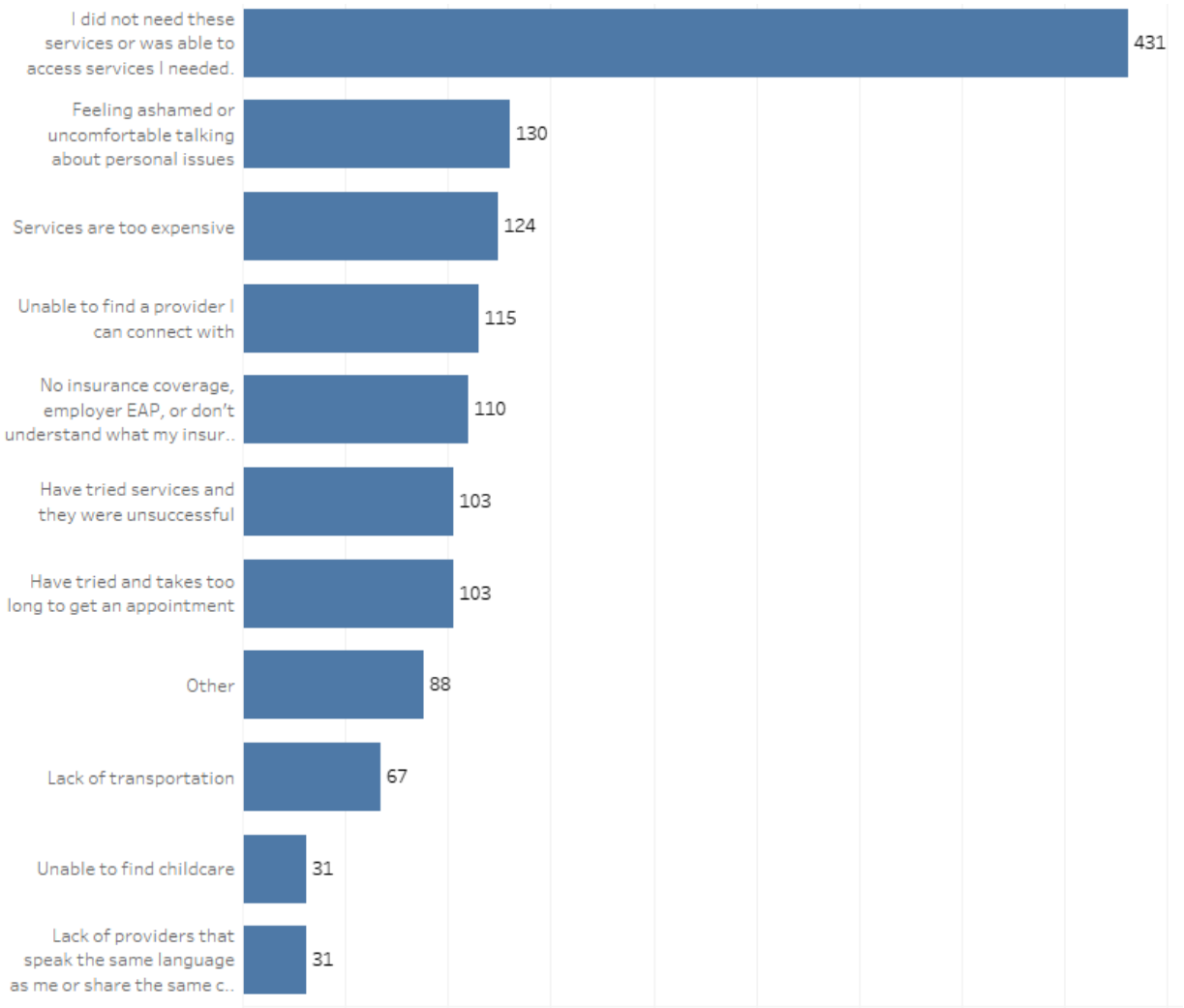
9. If no, why? (Select all that apply)

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%	

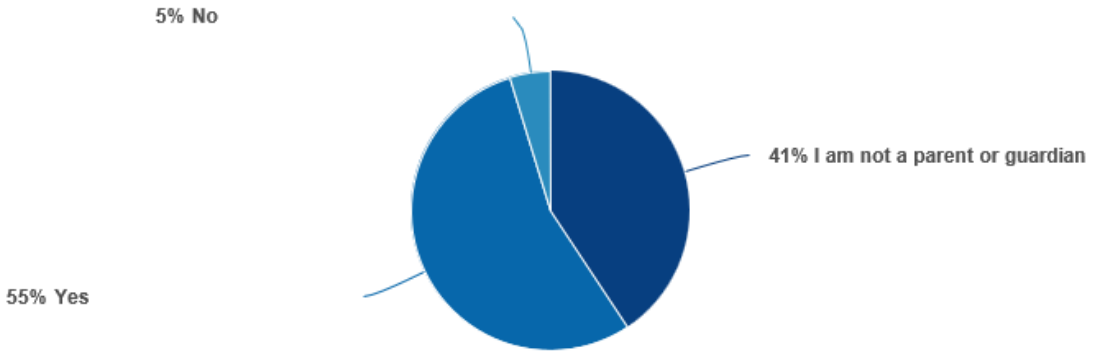
10. What prevents you from being healthier? (Select all that apply)



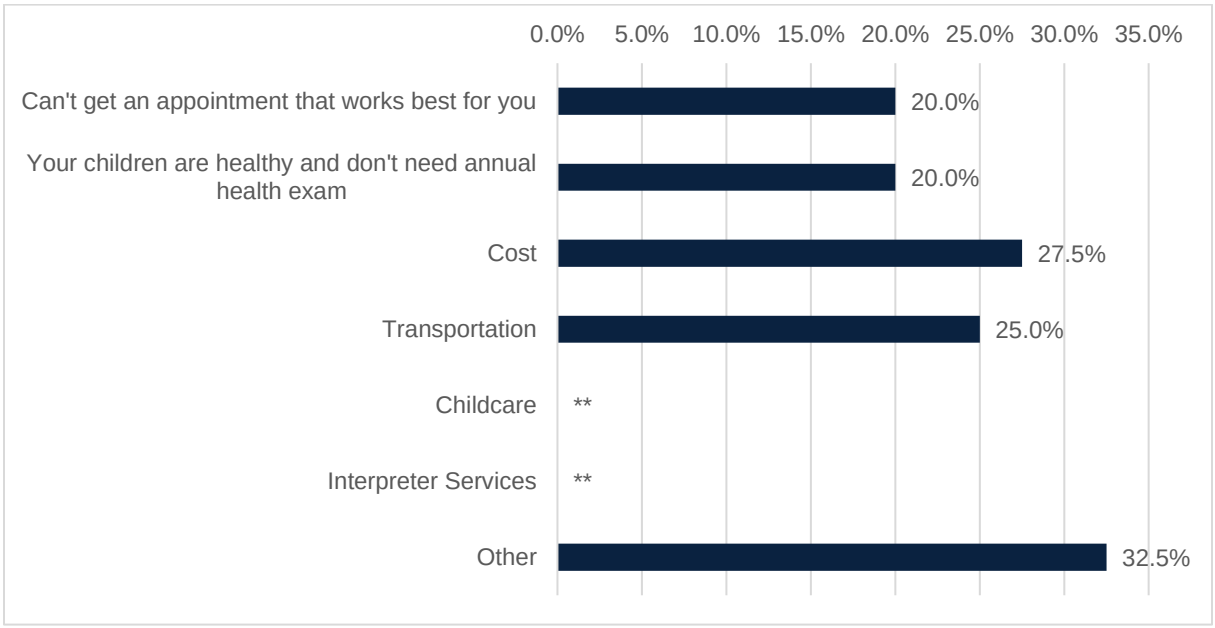
11. If you feel you could benefit from mental health or substance use disorder services but are not currently receiving them, please select your reason(s) for not accessing those services.



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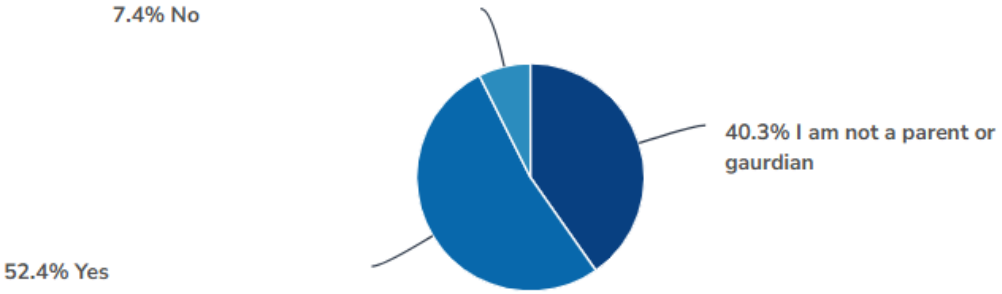
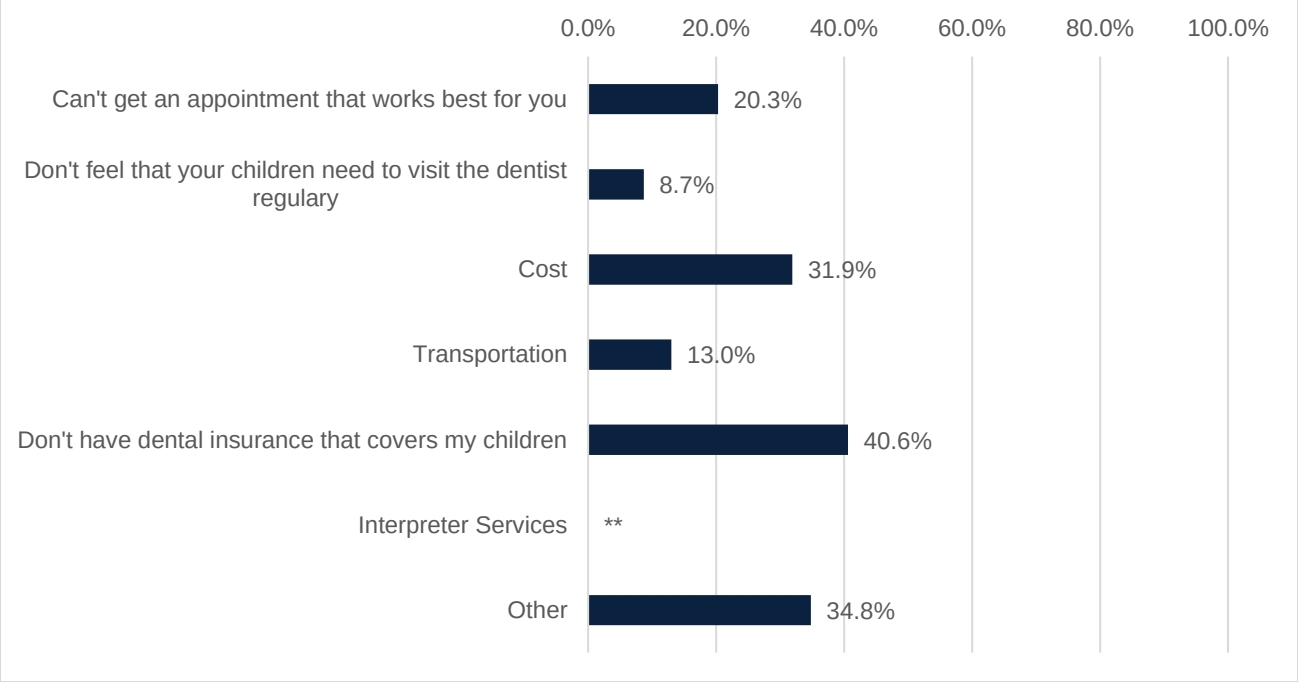
14. If you are a parent or guardian, do your children visit the dentist regularly (1-2 times per year)?



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



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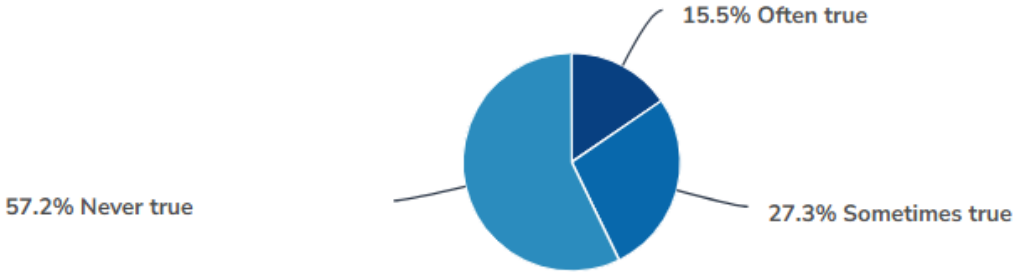
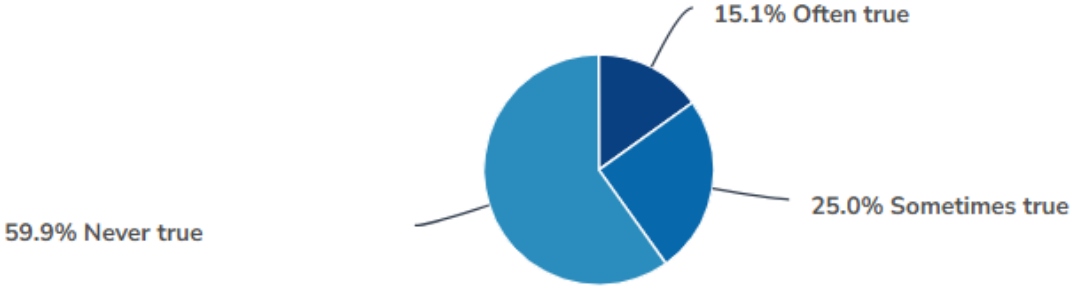
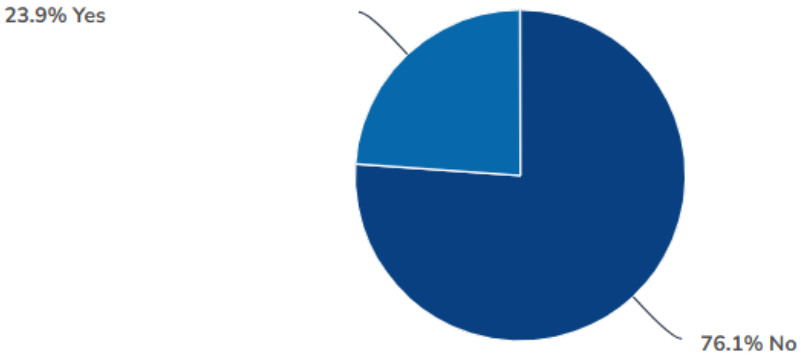
16. Within the past 12 months, you worried that your food would run out before you got money to buy more.



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%	

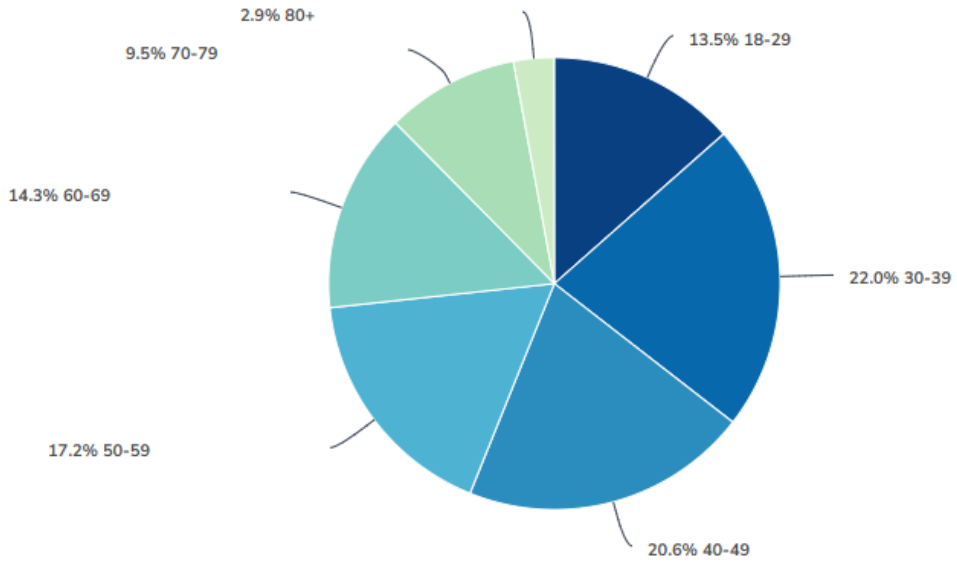
21. Who do you trust for health information? (Select all that apply)

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%	

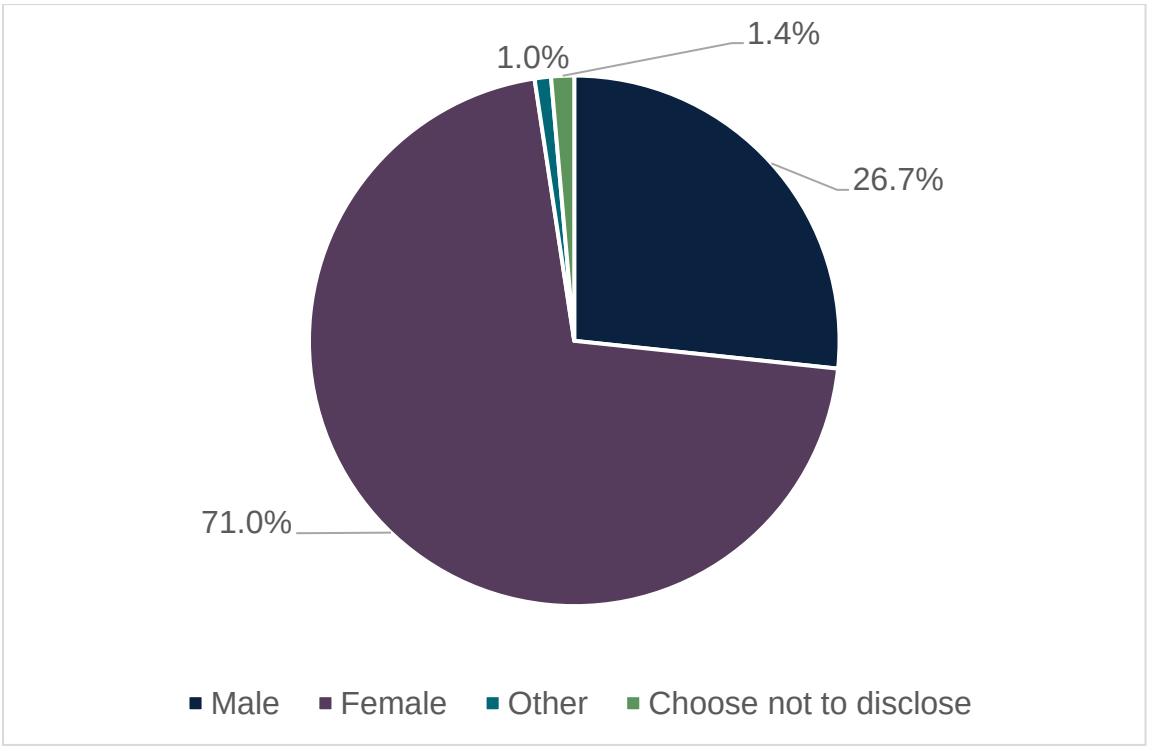
22. Which of the following emergency preparedness statements are true for you/your family? (Select all that apply)

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%	

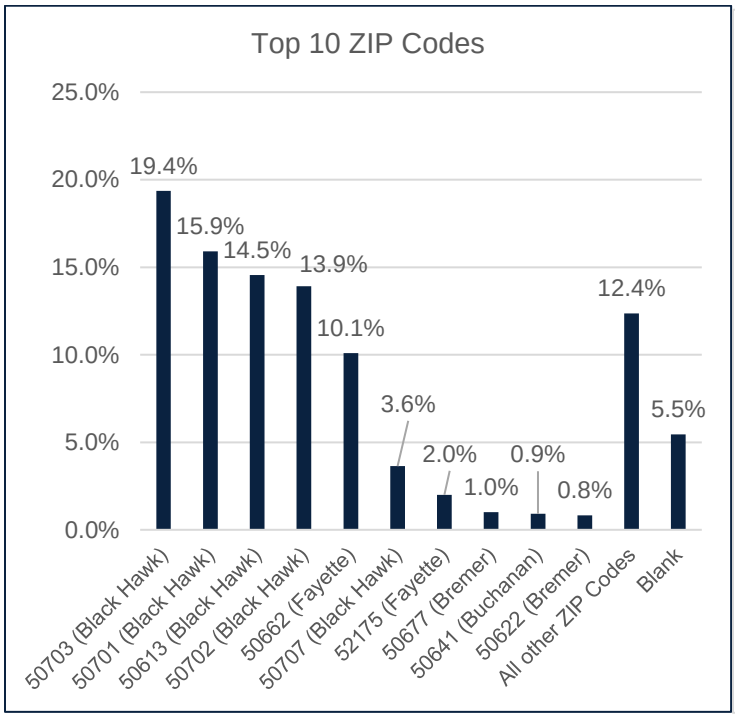
23. Age

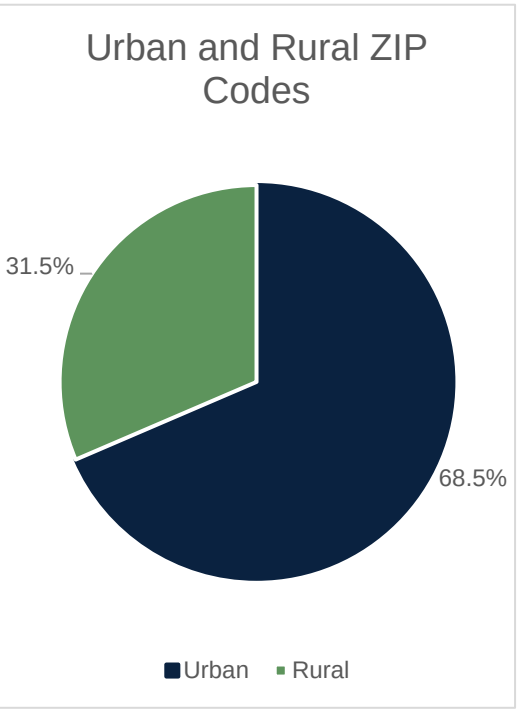


24. Gender (note: Other includes transgender male, transgender female, gender variant/nonconforming, and other – please specify to maintain confidentiality)

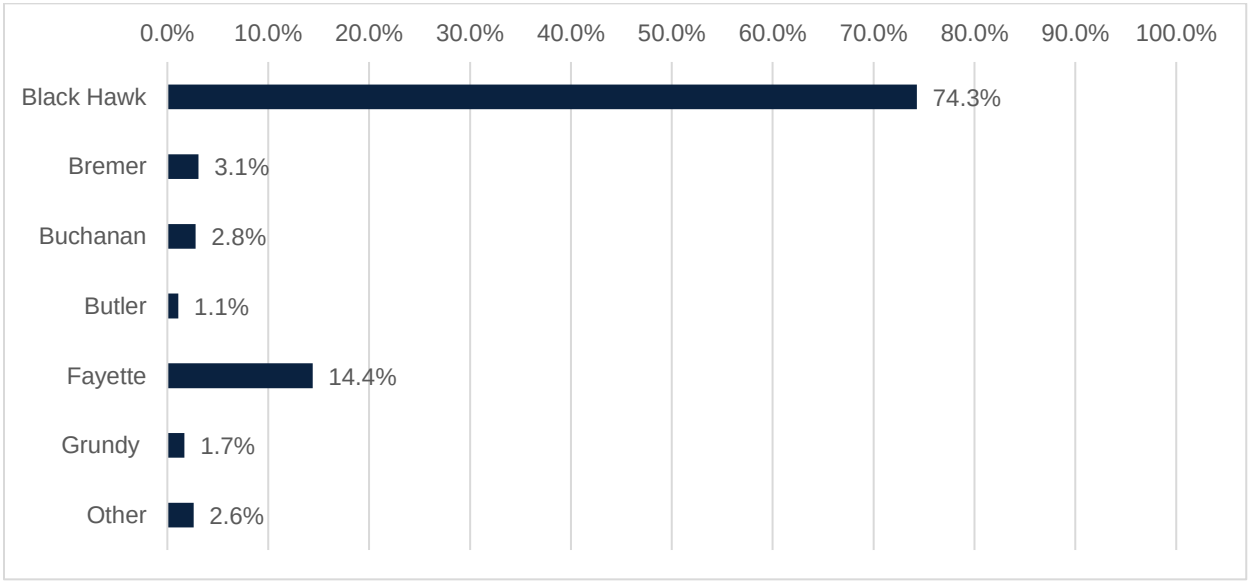


25. ZIP Code





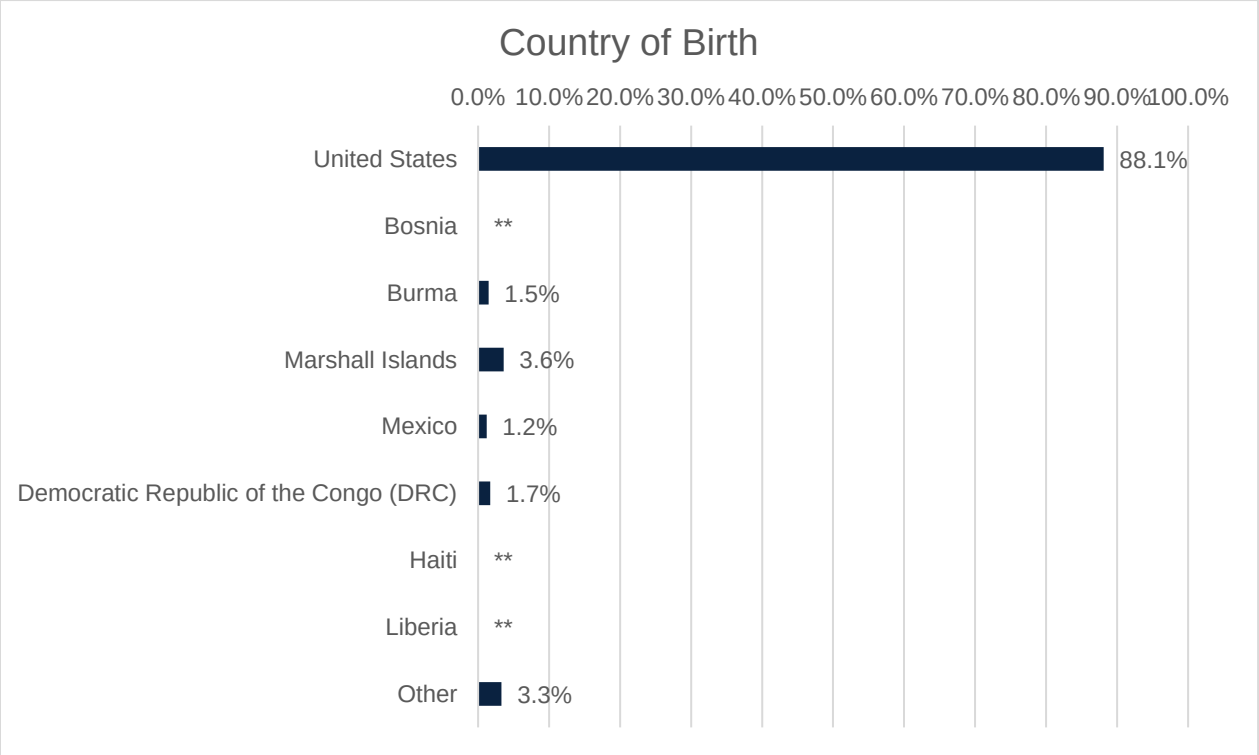
26. County of Residence



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%	

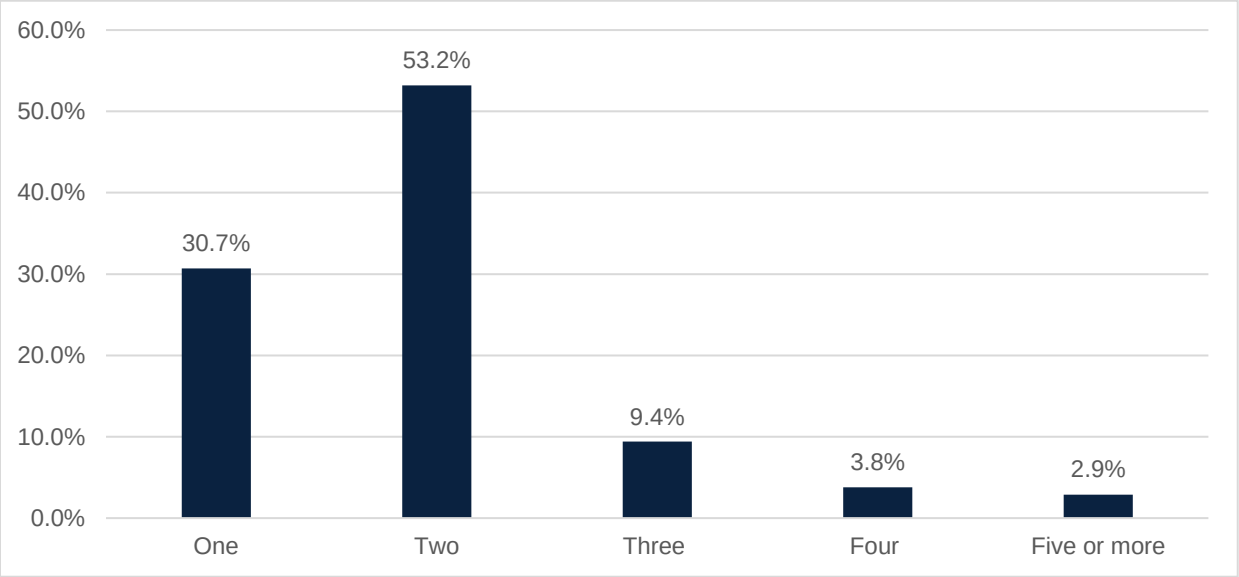
30. Health insurance status (select all that apply)

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%	

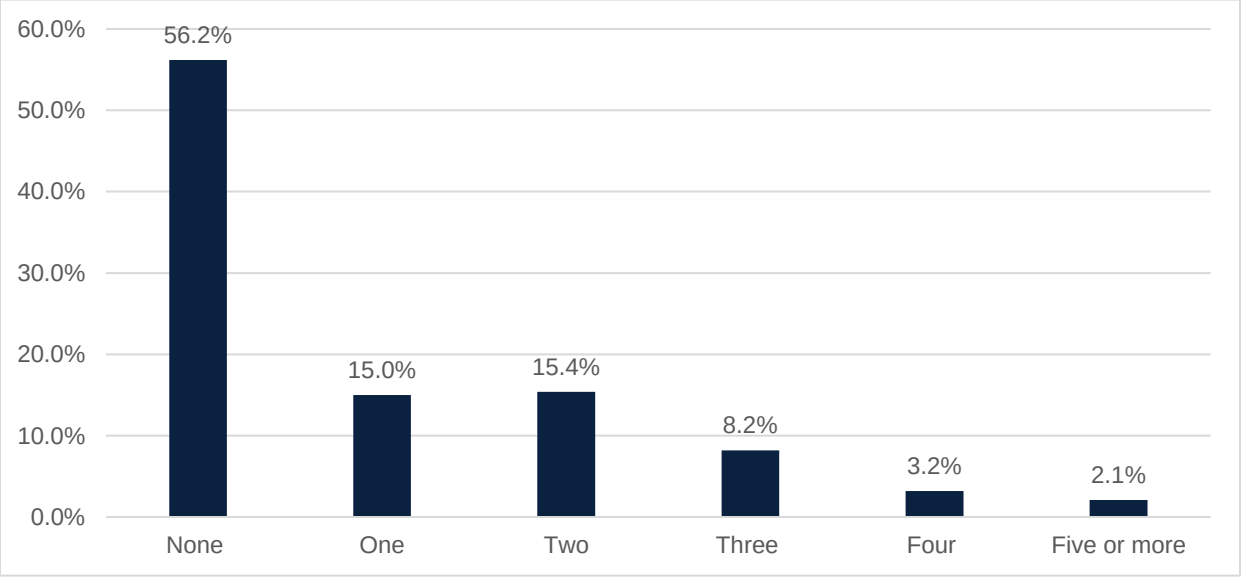
31. How well do you understand the benefits offered under your health insurance plan?

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



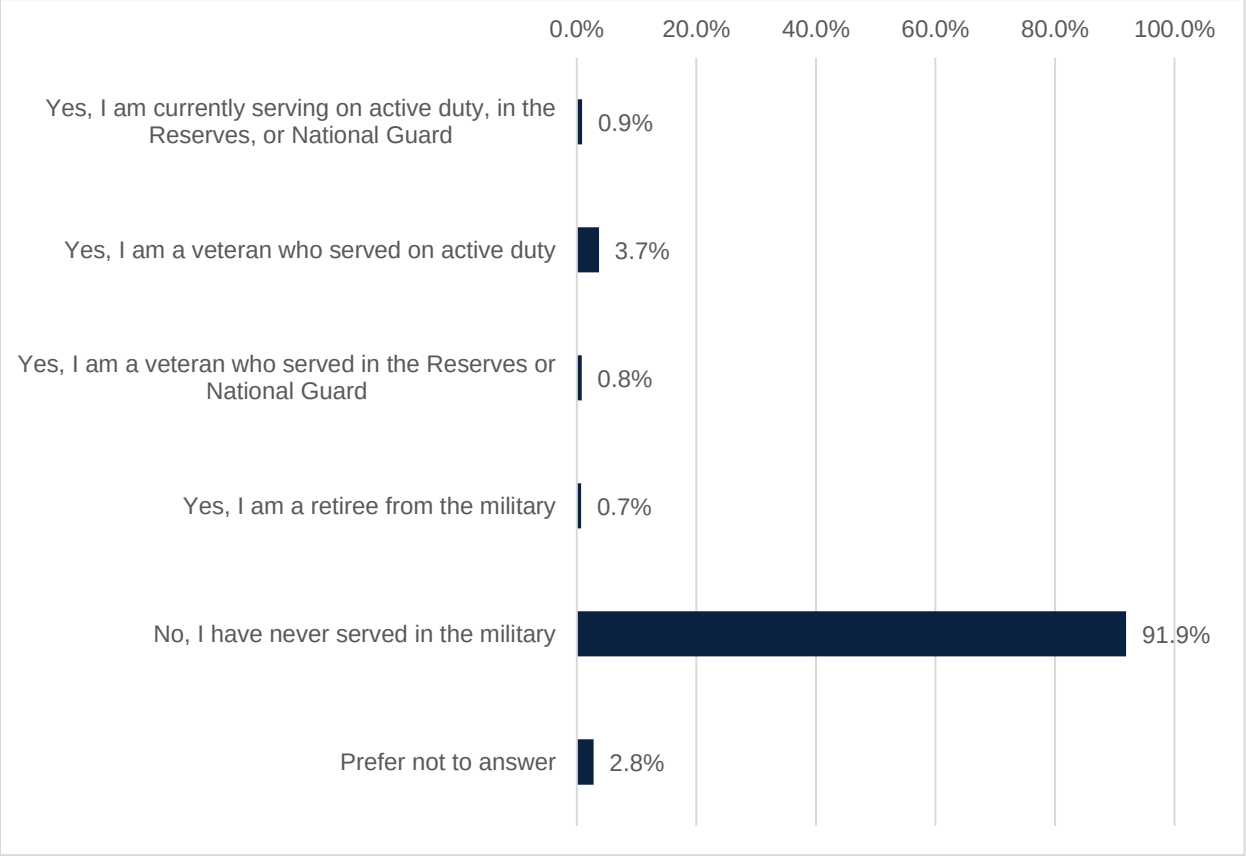
33. Number of children in home



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

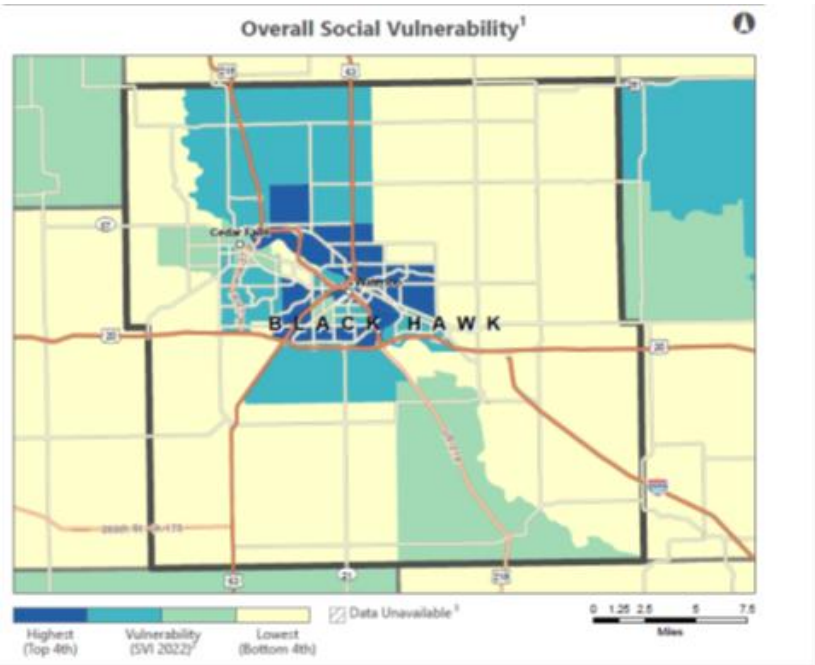
Under $15,000	17.6%
Between $15,000 and $29,999	12.4%
Between $30,000 and $49,999	16.1%
Between $50,000 and $74,999	16.2%
Between $75,000 and $99,999	13.0%
Between $100,000 and $149,000	15.2%
More than $150,000	9.5%

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)

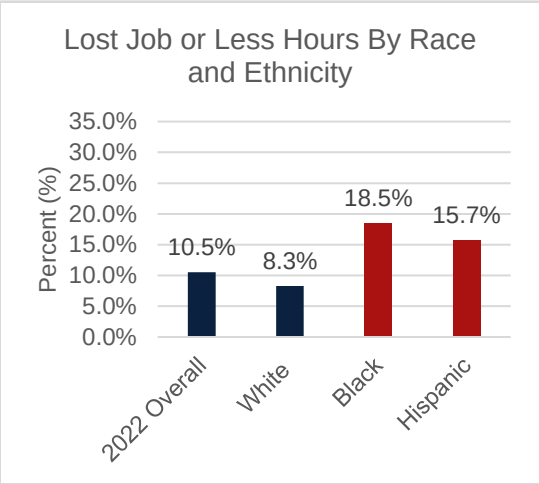


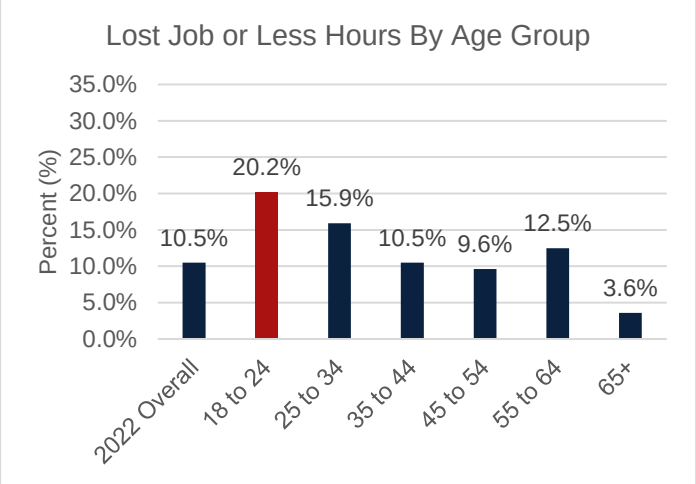
Appendix B

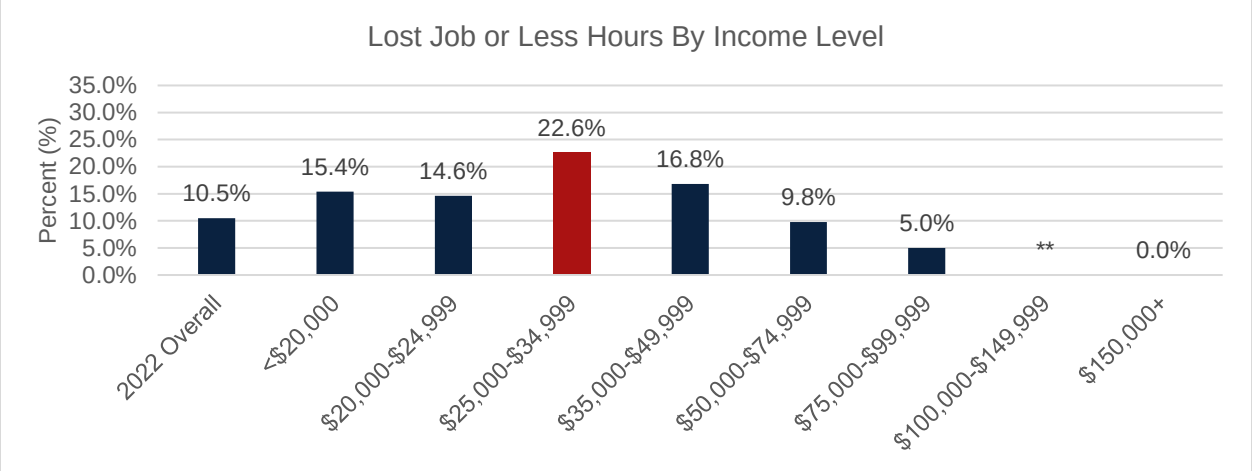
Economic Stability



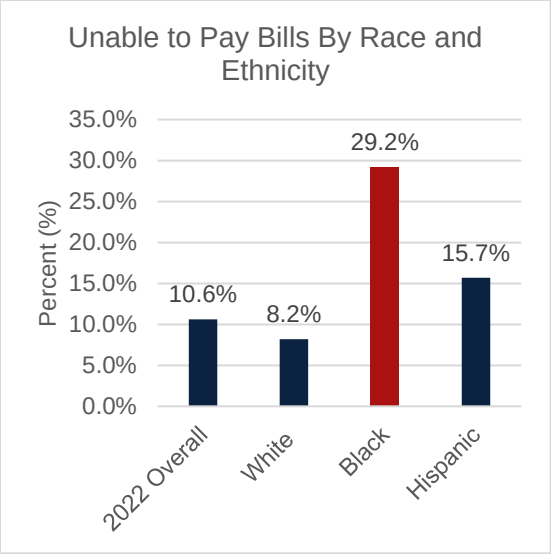
The Social Vulnerability Index measures how well communities can prepare for and respond to disasters and considers factors that affect a community's ability to recover. It focuses on four categories: socioeconomic status, household characteristics, racial and ethnic minority status, and housing type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

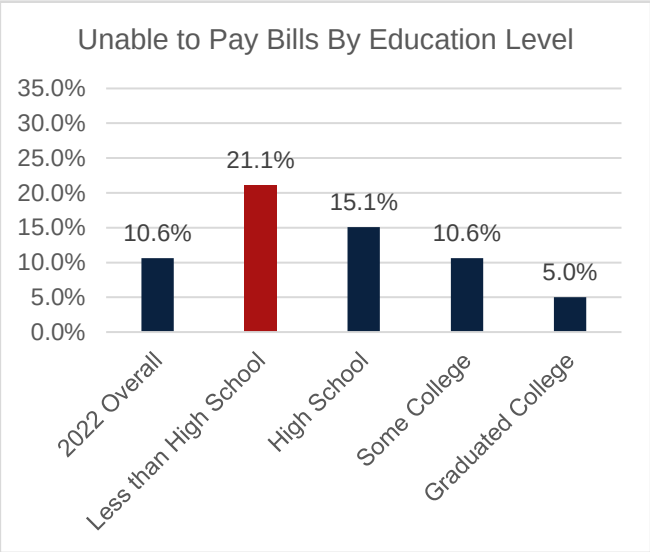


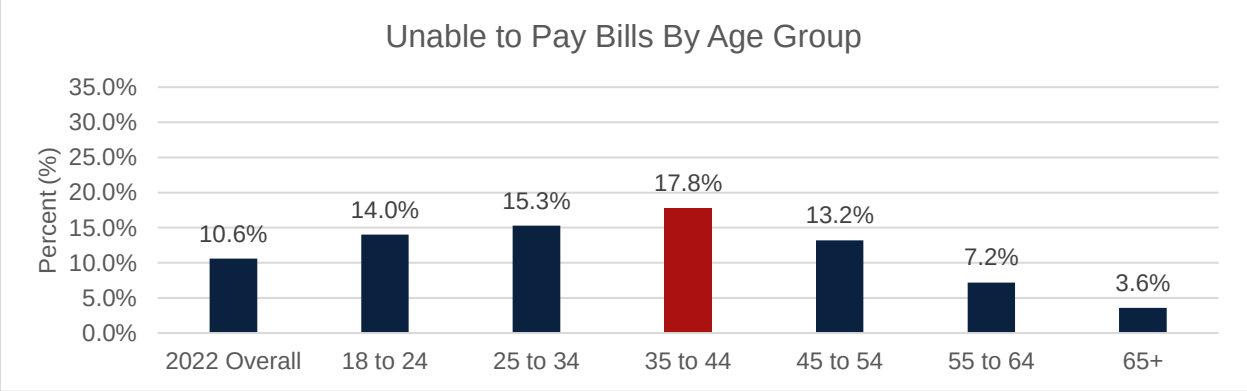


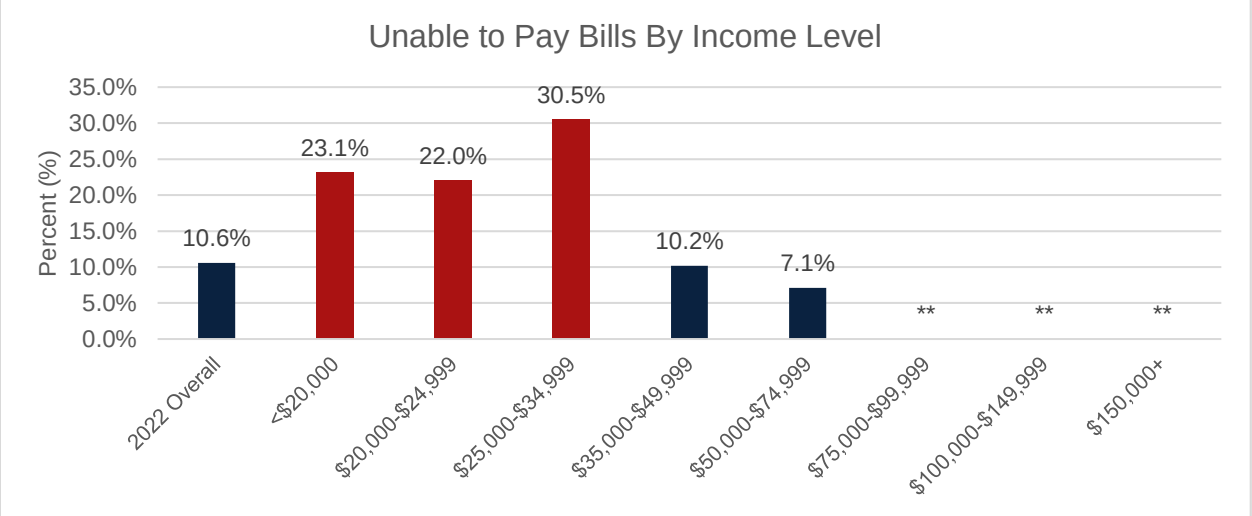


Data from the Behavioral Risk Factor Surveillance System (BRFSS) is shown above for a question about job loss or reduced work hours in the past 12 months. The figures shown reflect those who answered “Yes” and are broken down by race/ethnicity, age group, and income level. The results highlight disparities 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%.

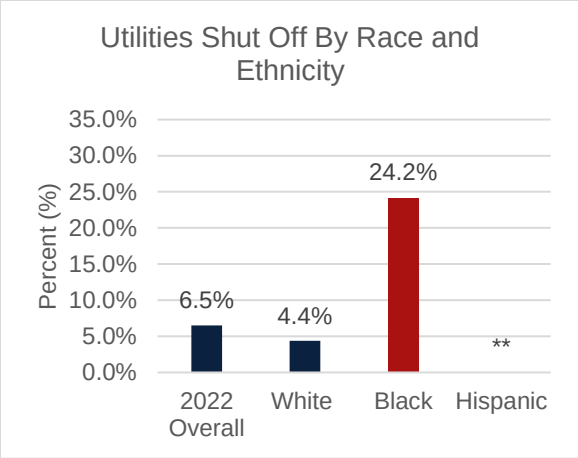


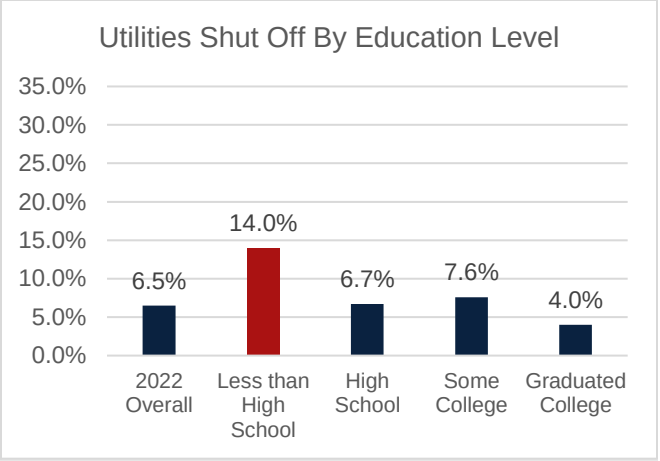


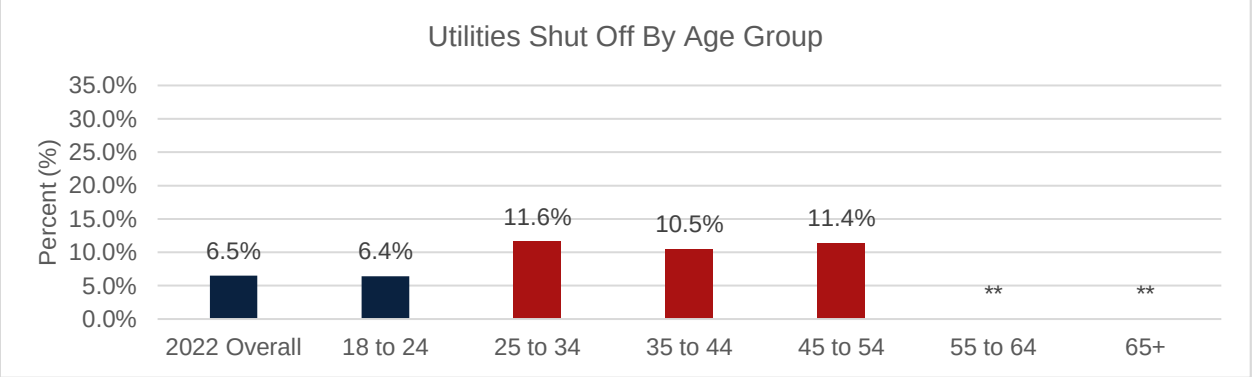


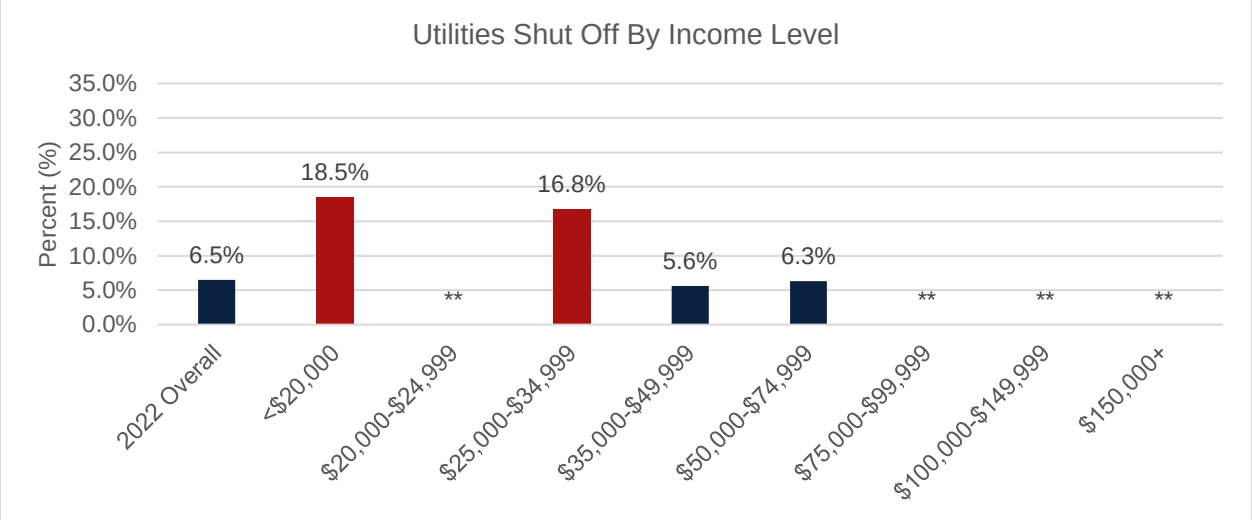


BRFSS respondents were asked if they were unable to pay their bills in the last 12 months. Results are shown for individuals who answered “Yes” to that question. Data was disaggregated by race and ethnicity, age group, income level, and education for each question. Black or African American individuals, 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.



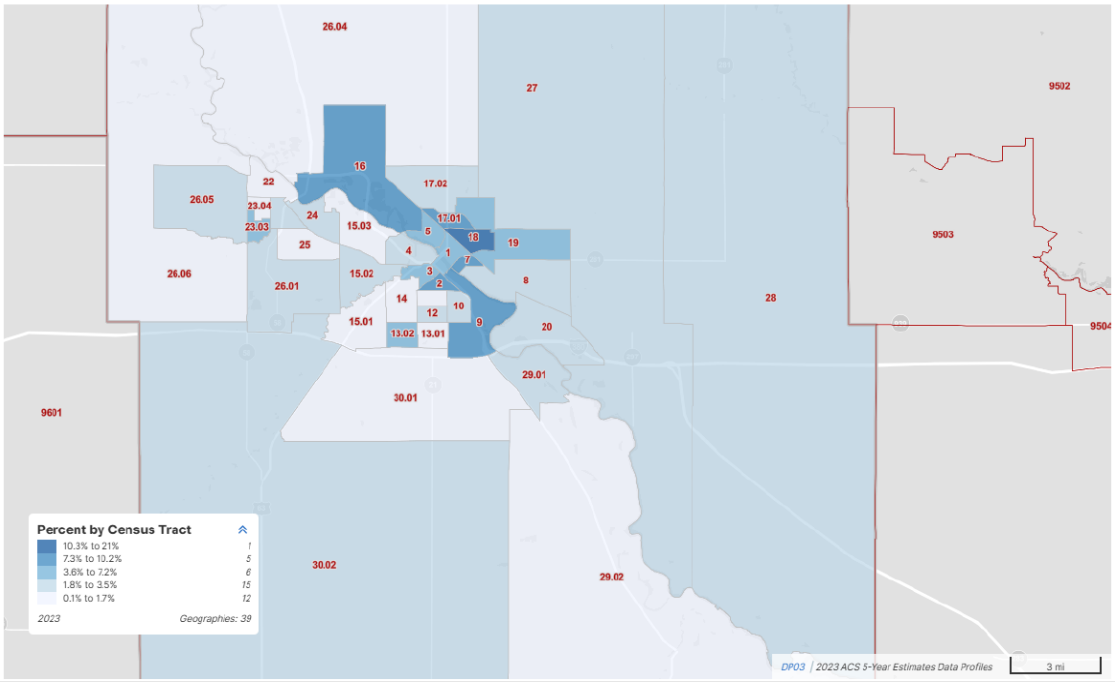




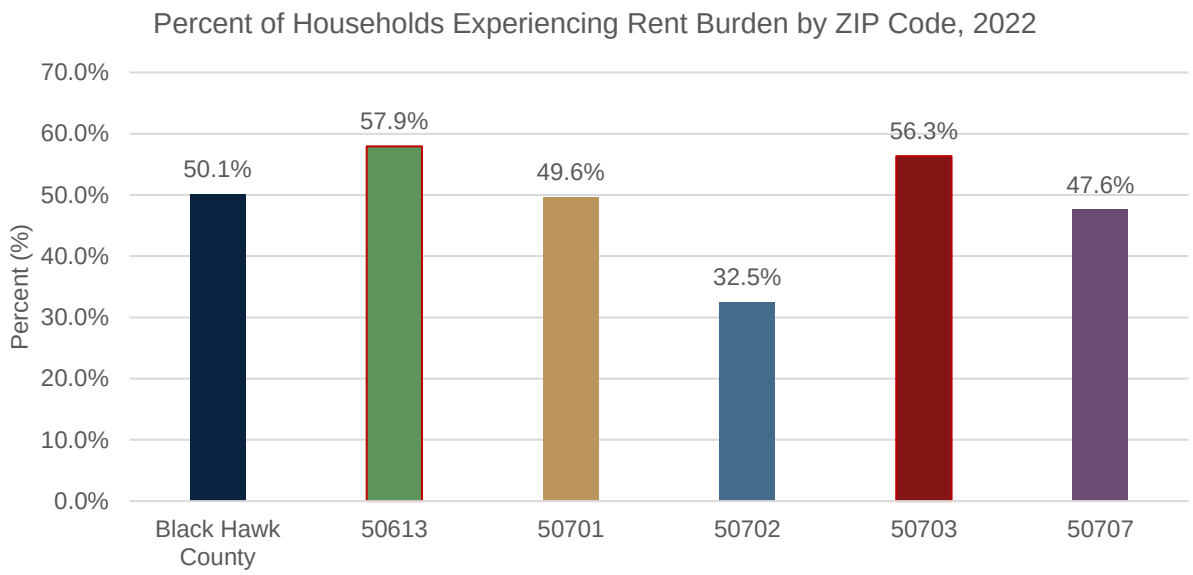


BRFSS respondents were also asked if their utilities were shut off in the last 12 months. Results are shown for individuals who answered “Yes” to that question. Data was disaggregated by the same groups as the question regarding being unable to pay the bills. The results were similar to those from the 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.

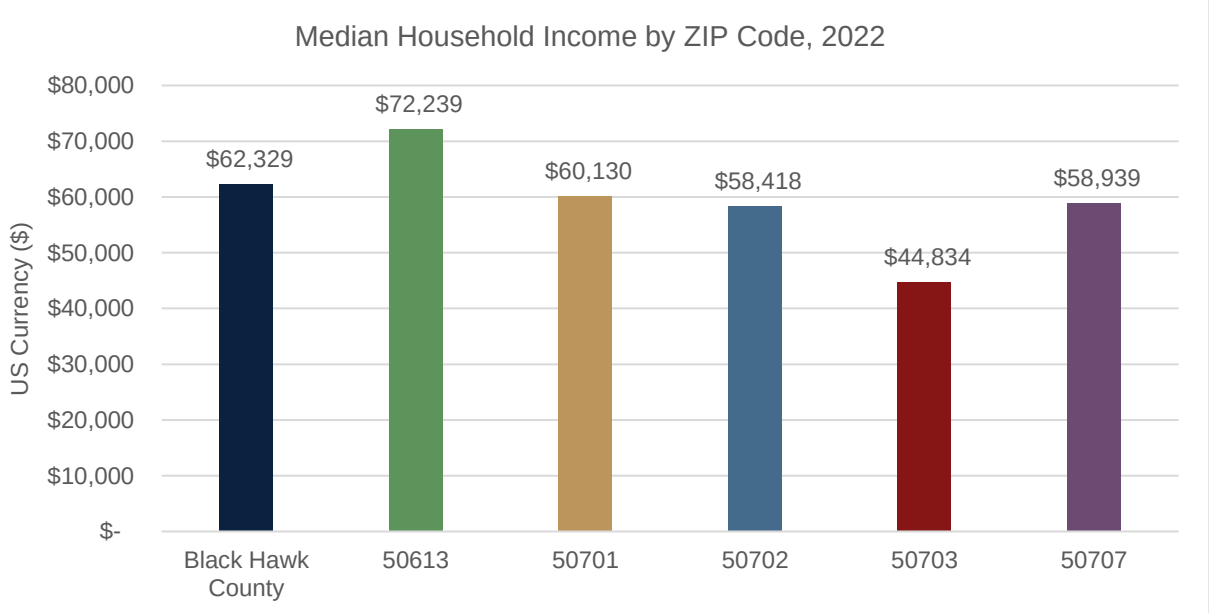
Unemployed - Civilian labor force | In labor force | Population 16 years and over | EMPLOYMENT STATUS



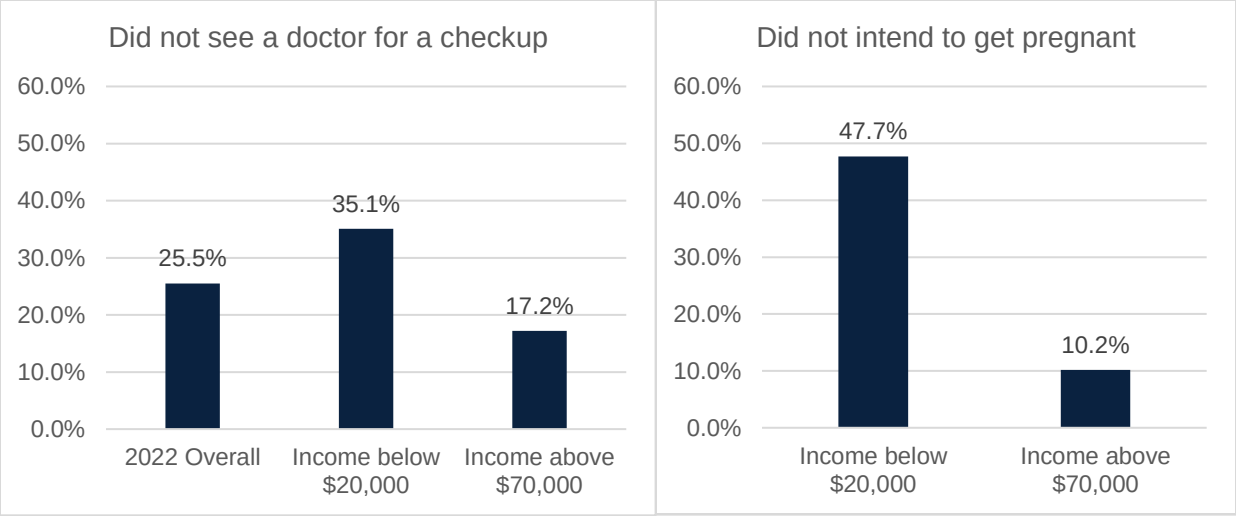
The map above displays Census data for individuals who are unemployed within the labor force, organized by census tract. Tracts 18 (21%), 9 (10.2%), 16 (9.9%), 17.01 (9.3%), 2 (9.2%), and 7 (9.2%) show the highest unemployment levels. Most of these tracts are in eastern, southern, and northern Waterloo.



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.

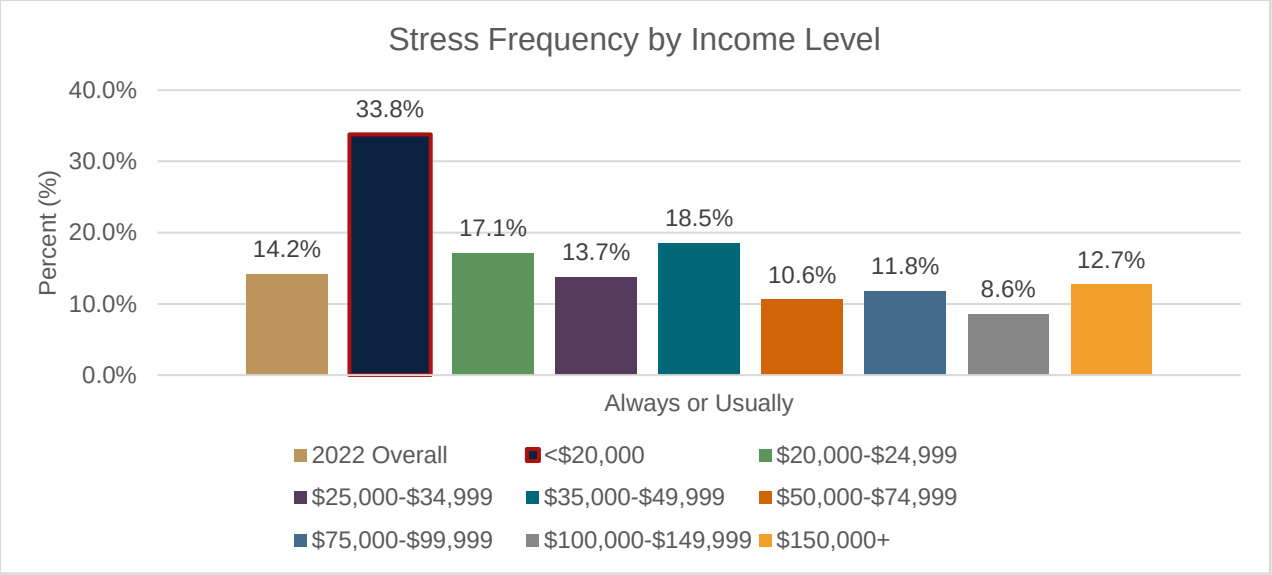


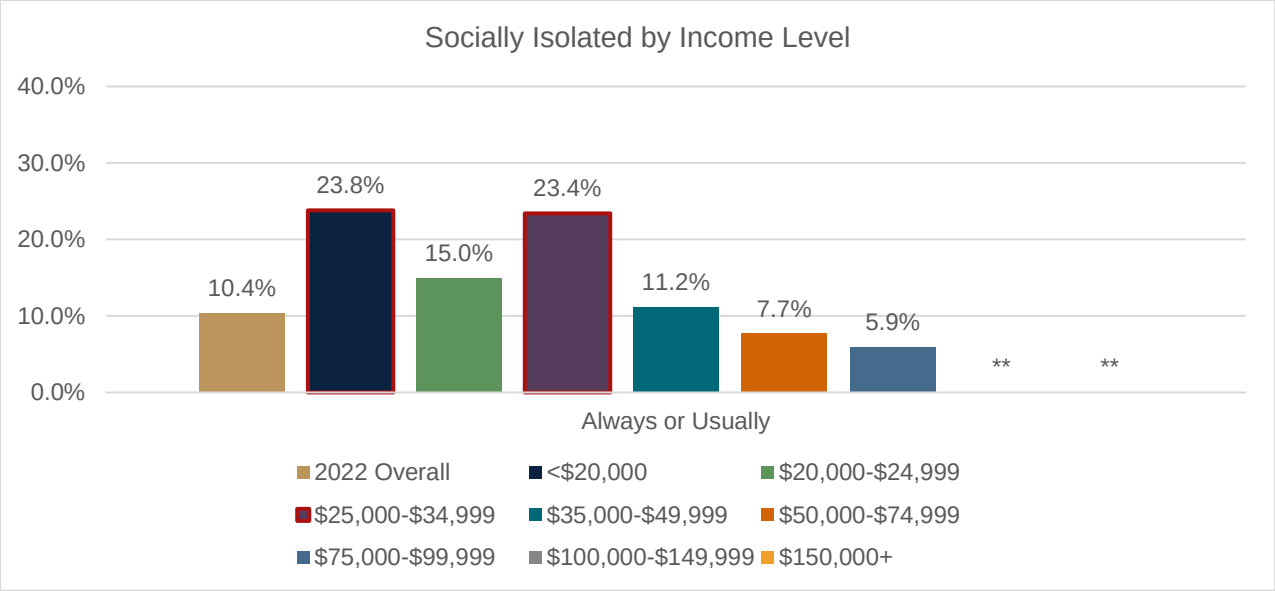
Median household income is also tracked by the Census. BHC has a lower median household income than the Iowa and U.S. averages. In BHC, median household income has risen across all ZIP codes from 2021 to 2022. However, ZIP code 50703 consistently had the lowest median household income.



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

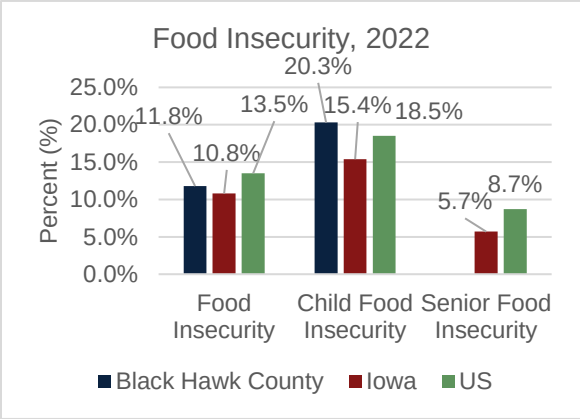


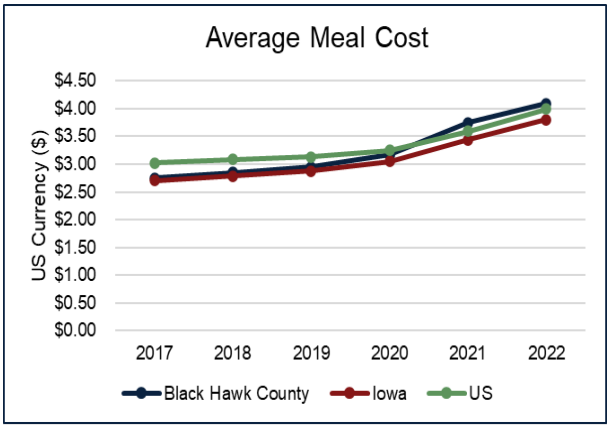


The BRFSS has four questions related to stress and social determinants of health. The graphs above focus on two of the questions: stress frequency in the past 30 days and perceived social isolation. Both were measured using five-point scales ranging from “Never” to “Always”. Responses of “Always” and “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.

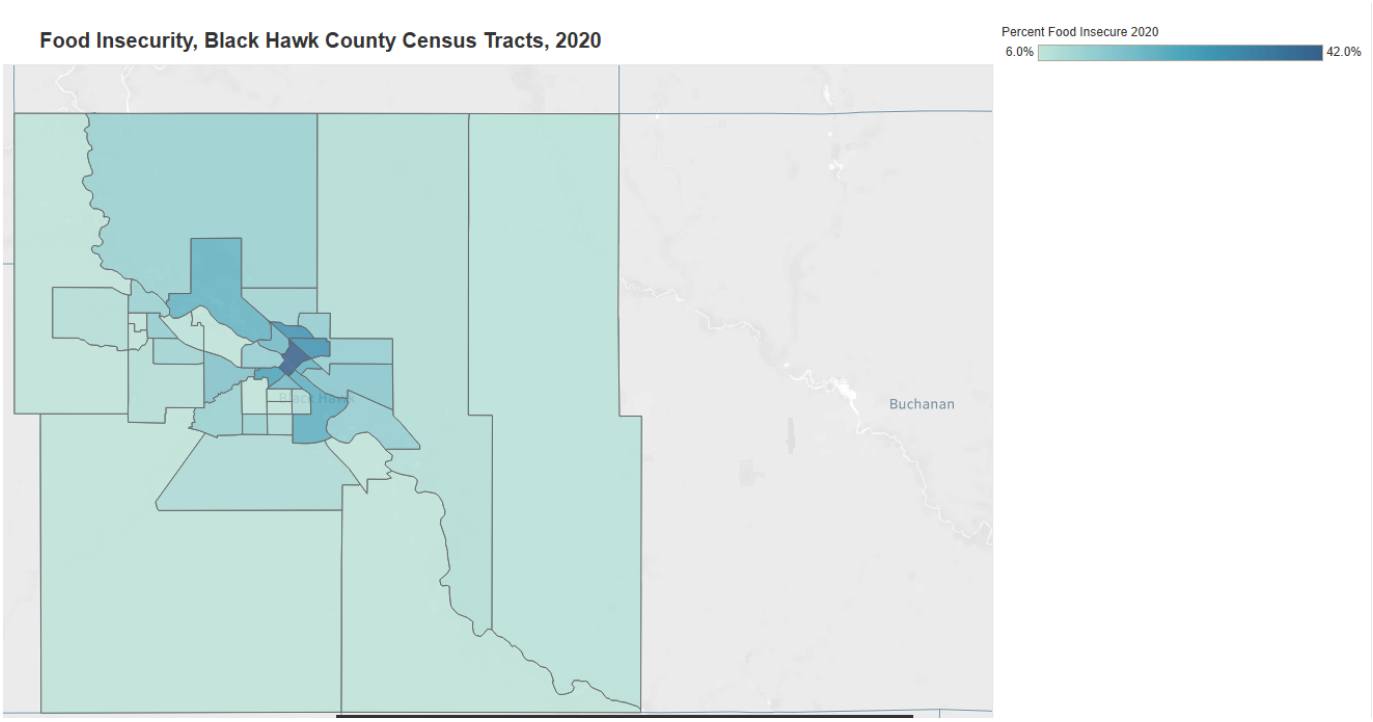
Community survey data shows that 69.1% of respondents believe that jobs and a healthy economy require improvement, ranking it third among the most important factors for a healthy community. *no image

Inequitable Food Access

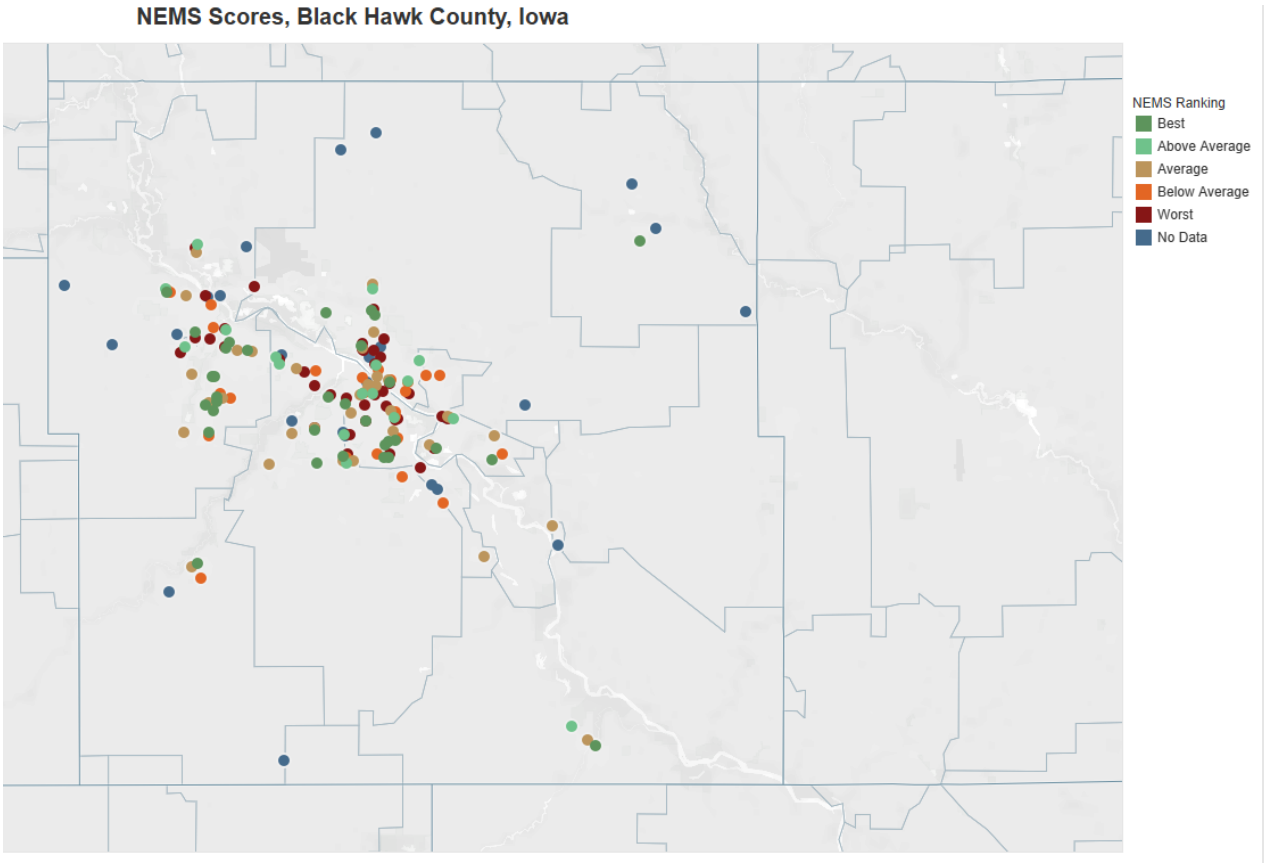


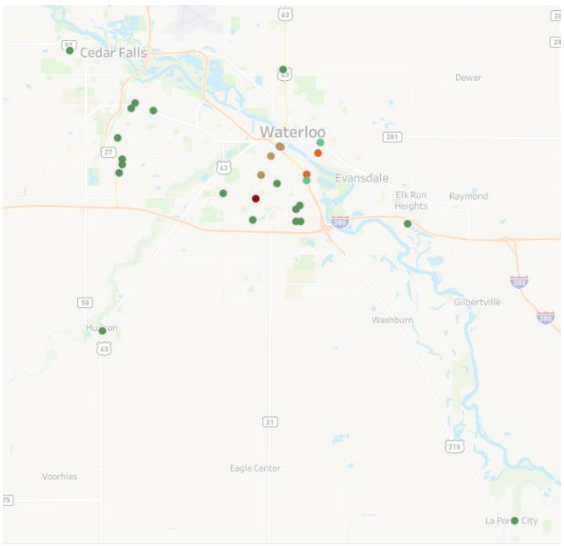


Data on food insecurity for BHC by age group and average meal cost was retrieved from Feeding America's Map the Meal Gap webpage. The average meal cost has been increasing over time since 2017, but even more since 2020. In 2022, BHC food insecurity data for children and all ages were higher than the 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.



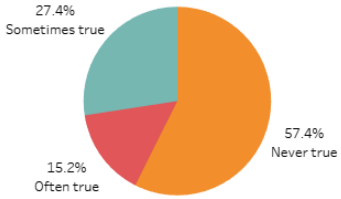
Food insecurity was also shown by census tract from data by Feeding America in partnership with NEIFB. Food insecurity in BHC census tracts ranged from 6% to 42%. The census tract with the highest impact is census tract 1 (42%), which is in east Waterloo.





NEMS 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.

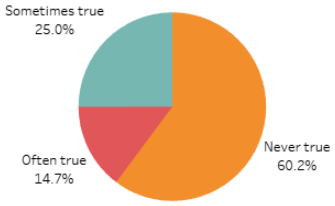
Food Would Run Out



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%

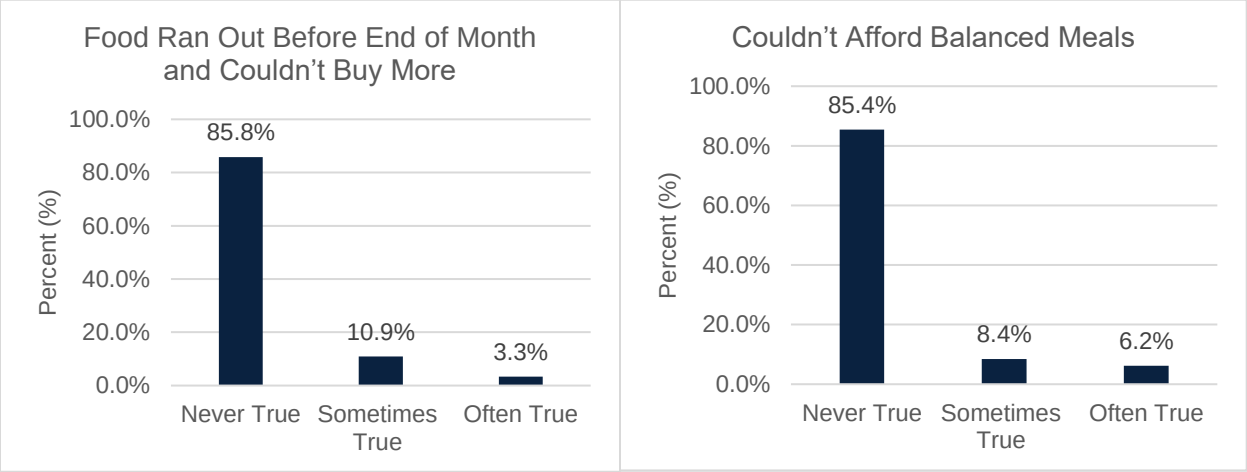
Food Didn't Last



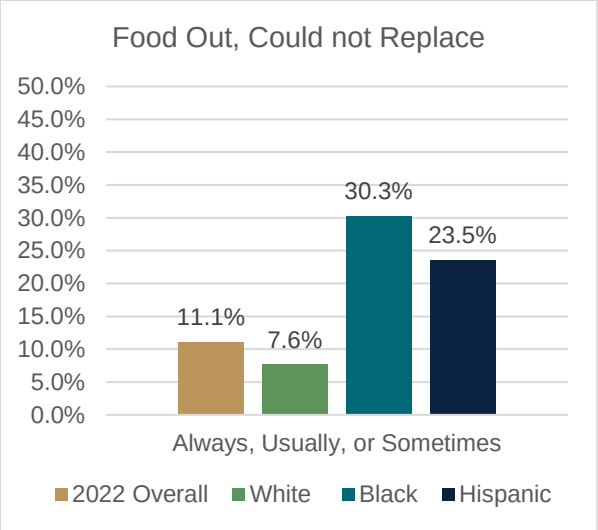
Food did run out, and I didn't have money to buy more (Sometimes or Often True)

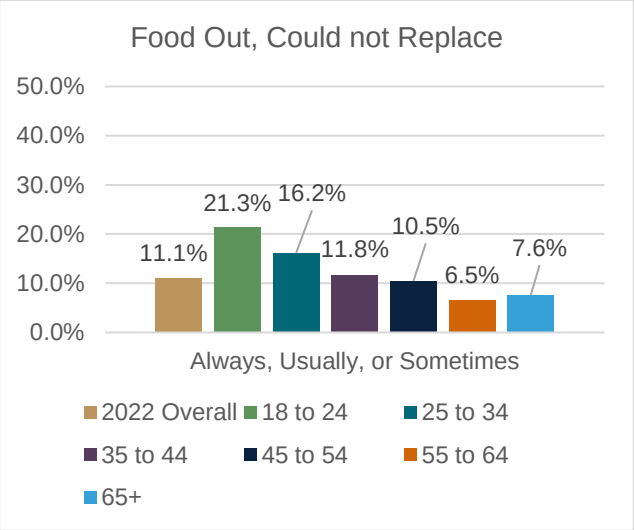
- Ages 18 to 29: 50.7%
- Black: 59%
- Burma: 73.3%
- DRC: 62.5%
- Marshall Islands: 90.3%
- Income under $15k: 80.8%
- Receiving local services: 74.2%

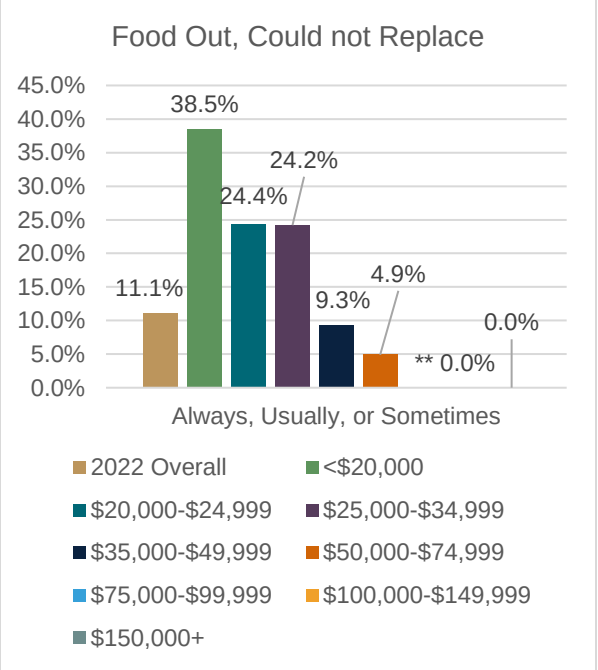
Food insecurity was assessed in the community survey through two questions, and each question was disaggregated by age, race and ethnicity, country of birth, and income level. Results shown are for individuals who answered "Sometimes True" or "Often True" for either question.

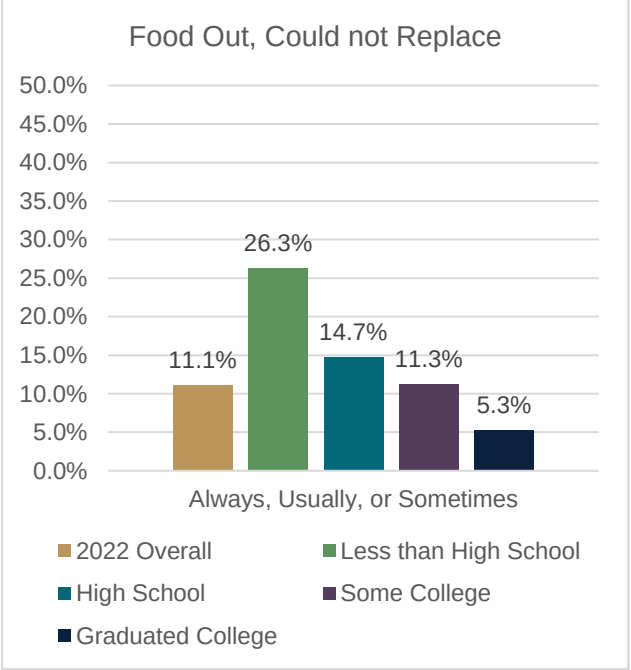


BRFSS respondents were asked similar questions in 2021 and 2022. In 2021, 14.2% answered "Sometimes True" or "Often True" to a question asking the if their food ran out before then end of the month and they couldn't buy more. Additionally, 14.6% of respondents said that it was "Sometimes True" or "Often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

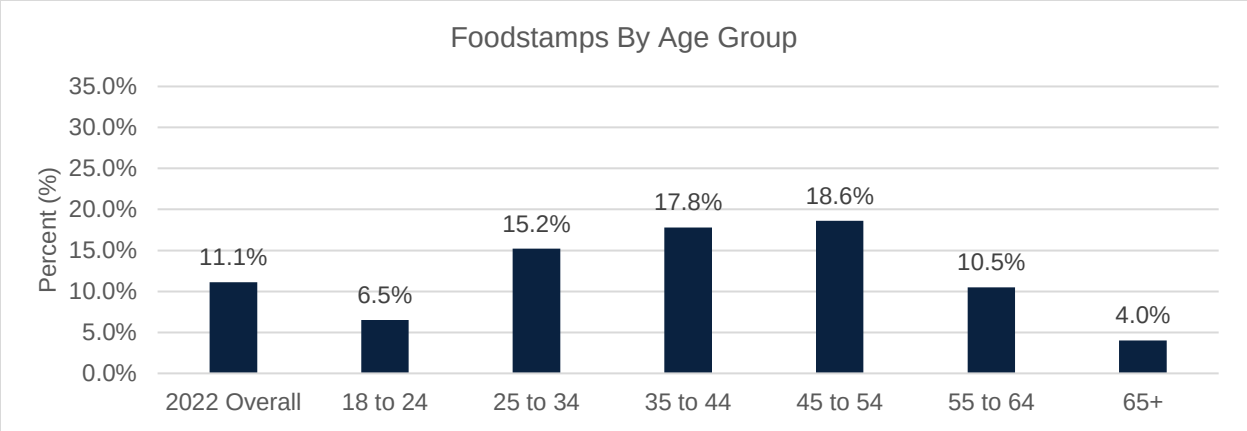


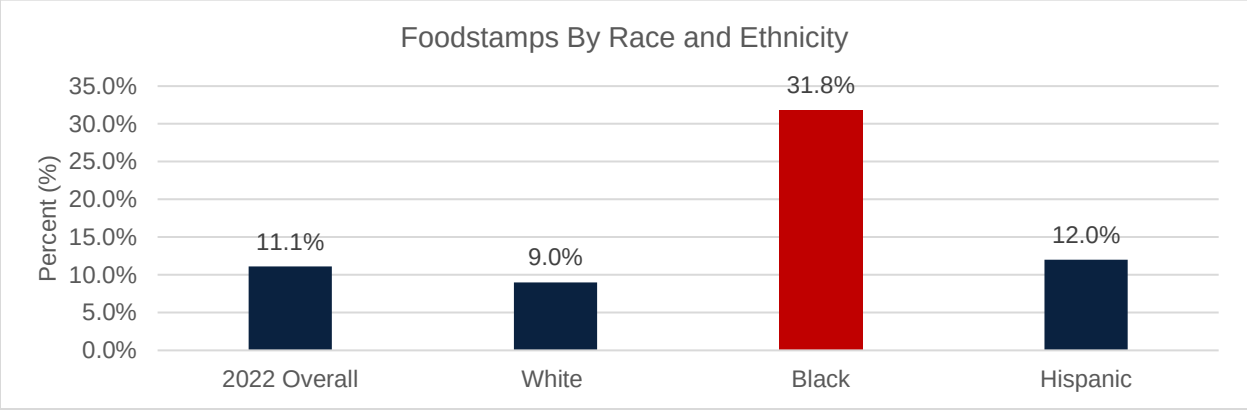


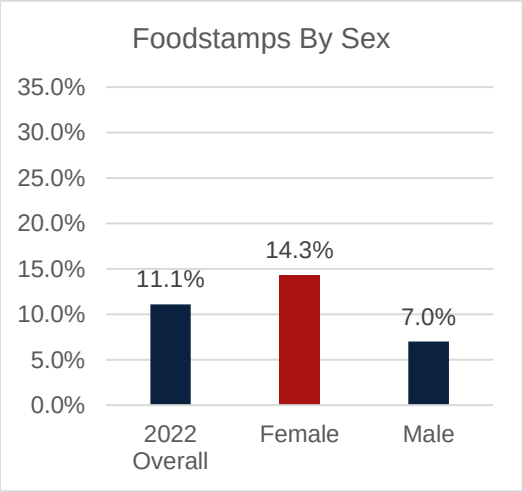


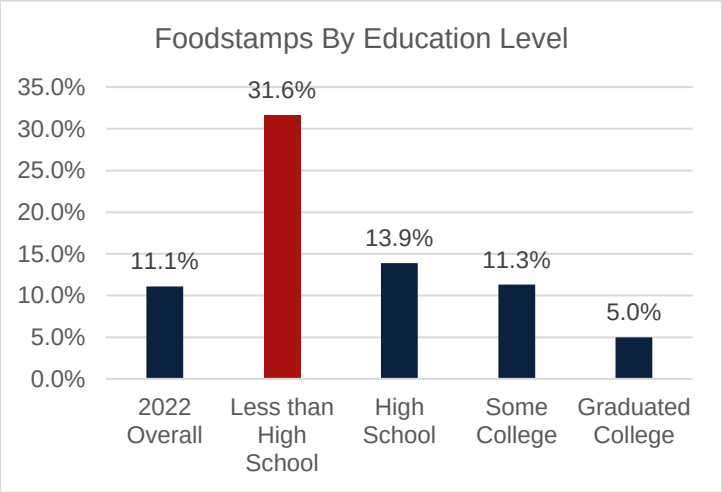


In 2022, participants were just asked if food ran out during the last 12 months, and they could not afford to buy more. Response options were a 5-point Likert scale. Those who answered Always, Usually, or Sometimes were more likely to be Black or African American, Hispanic, ages 18-24, have a lower income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

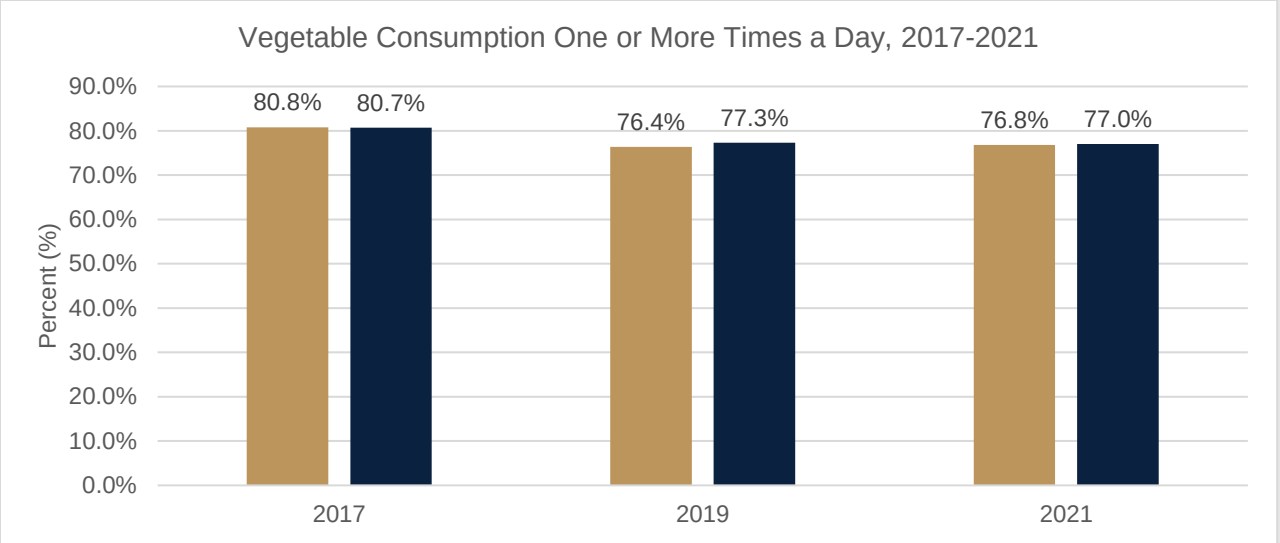


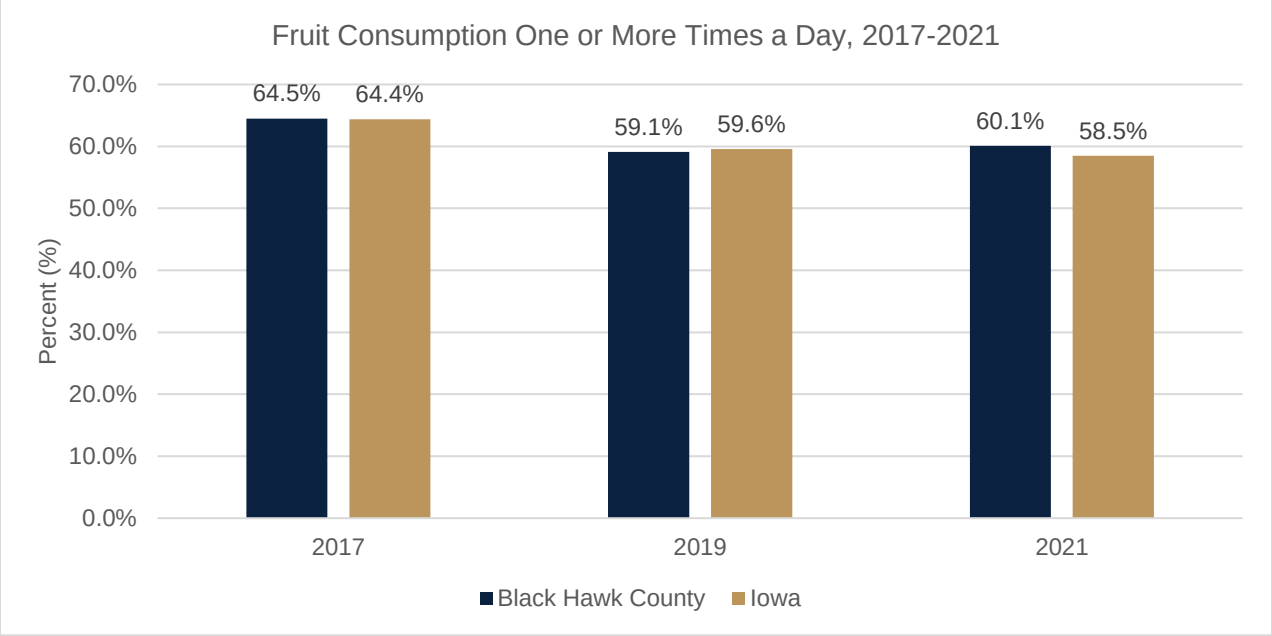






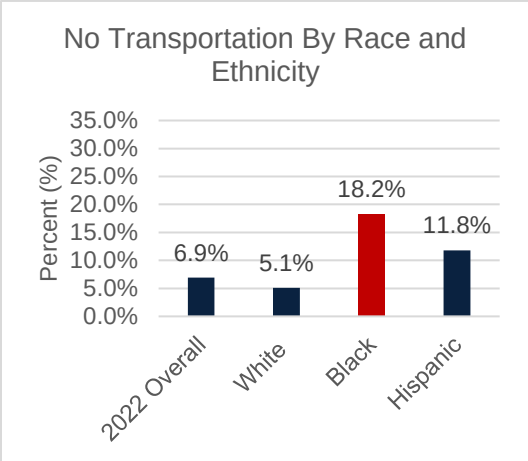
BRFSS participants were also asked if they had received any food stamps in the last 12 months. Proportions shown are the individuals who answered “yes” to that question. They were more likely to receive food stamps, if they were Black or African American, ages 25 to 54, female, or had a less than high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

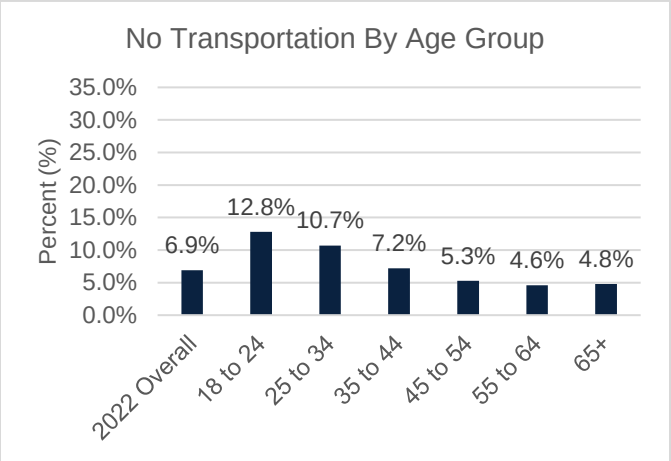


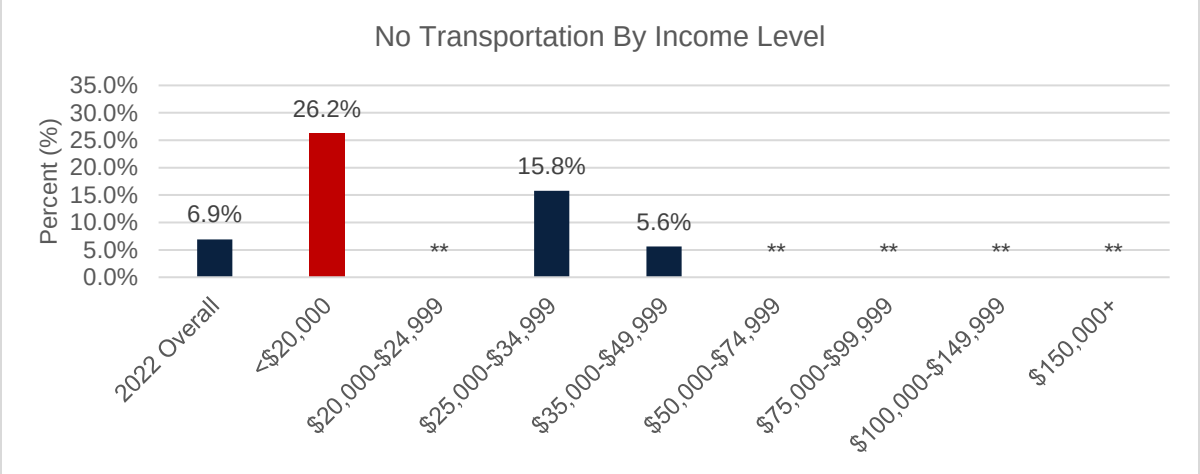


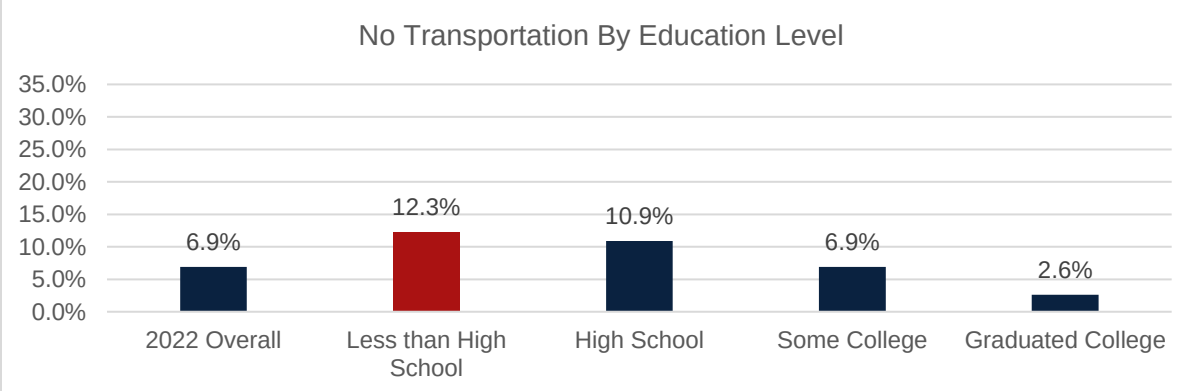
BRFSS participants were also asked how many servings of fruits and vegetables they ate daily. Data is shown for 2017, 2019, and 2021, but is not able to be disaggregated due to lower counts for each of these years. Overall, year-to-year responses for BHC and Iowa have not changed much. However, people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

Transportation Challenges

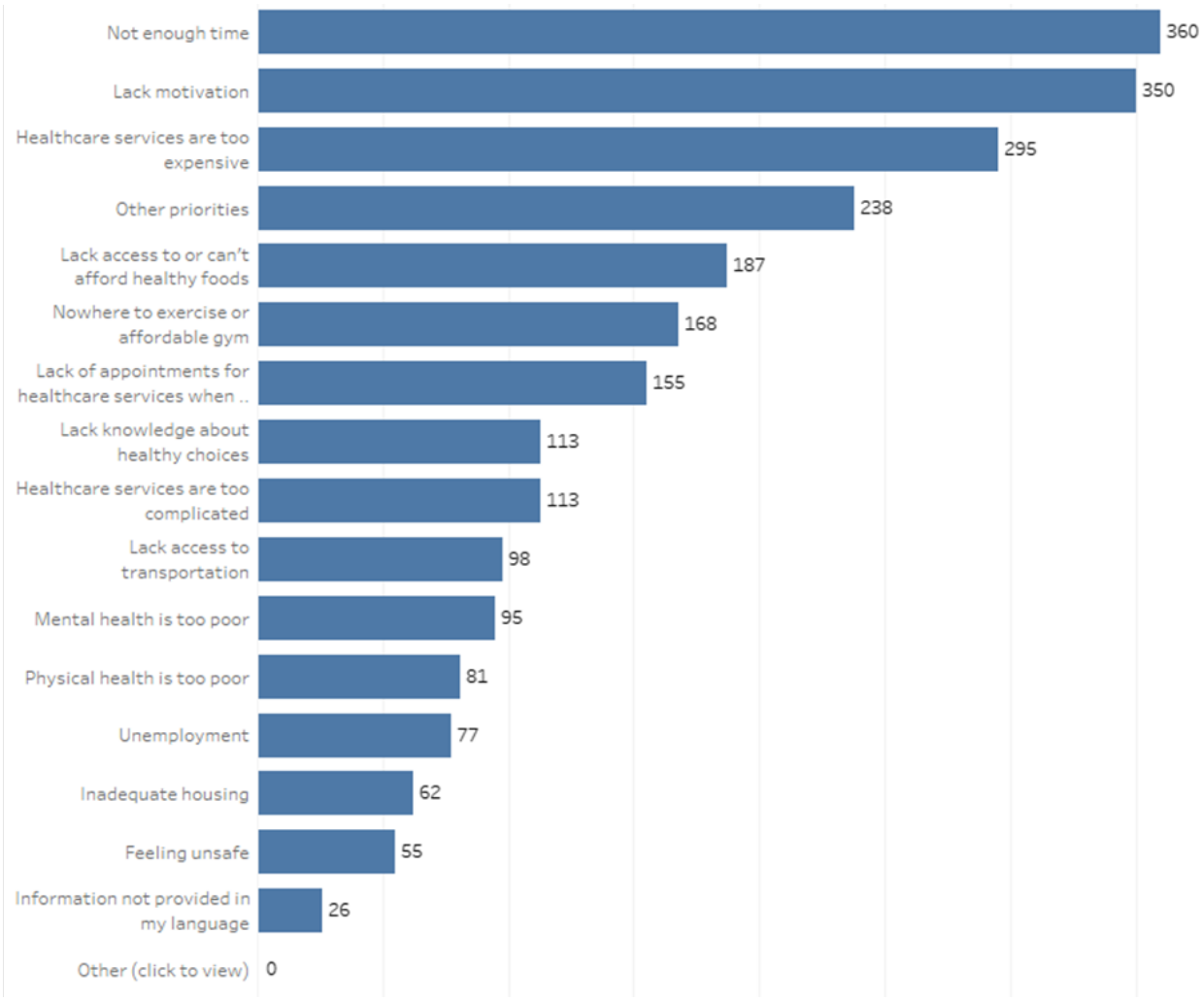




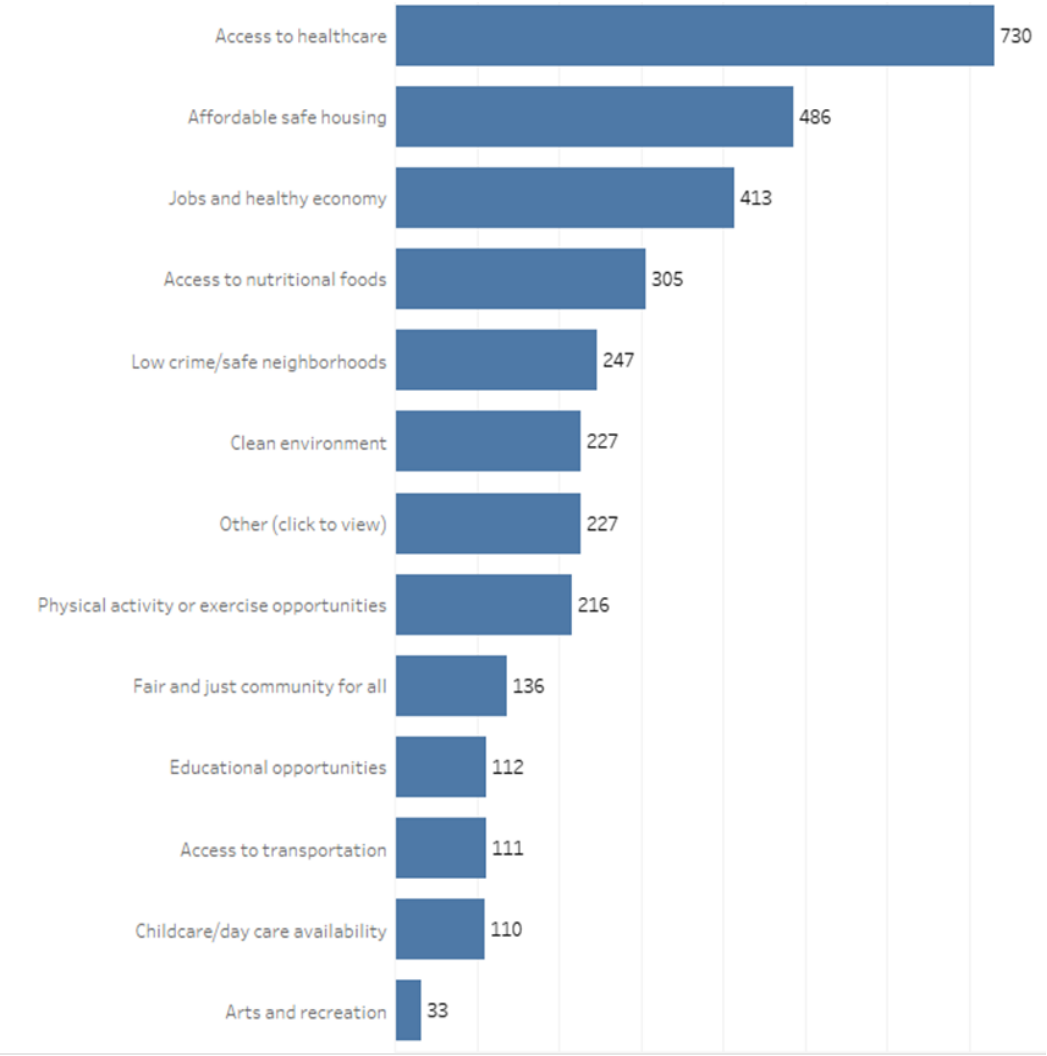




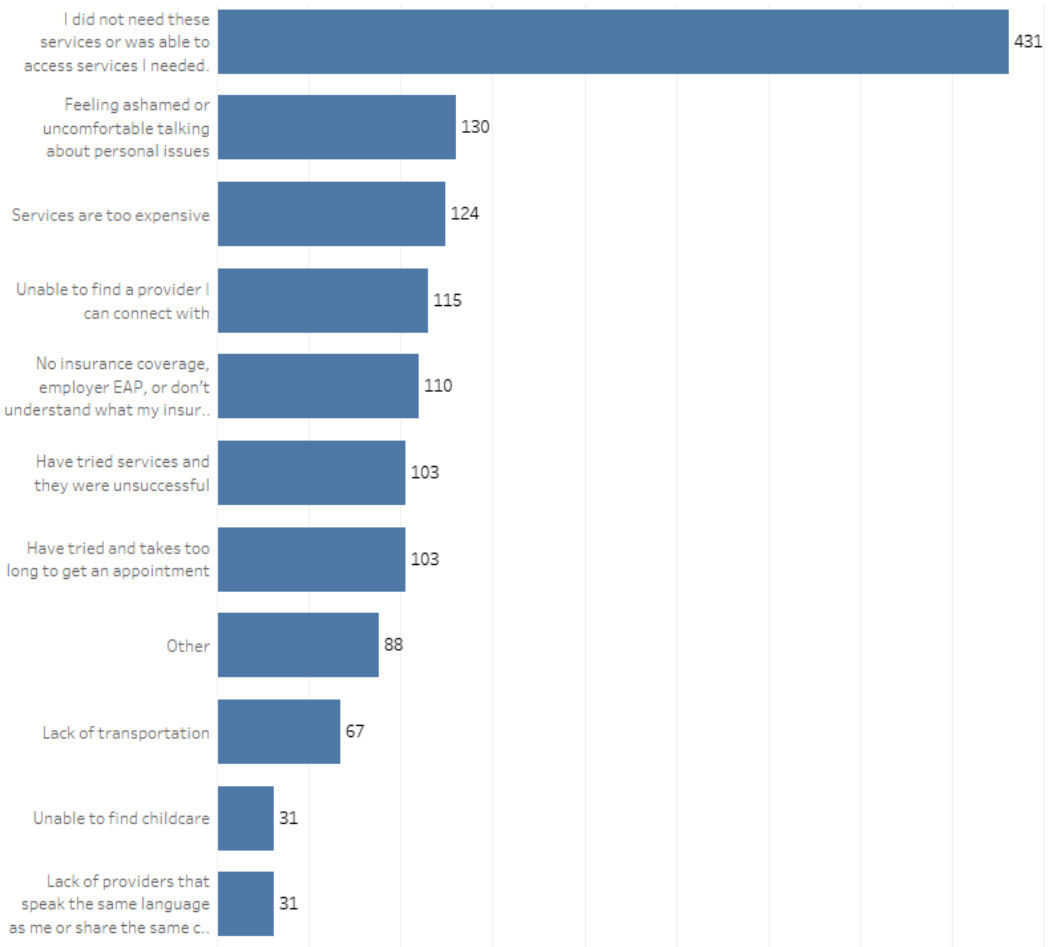
BRFSS respondents were asked if they had any problems accessing transportation in the past year for work, appointments, and any activities needed for daily living. Results shown individuals who answered “Yes” to that question. Data was disaggregated by race and ethnicity, age group, income level, and 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.



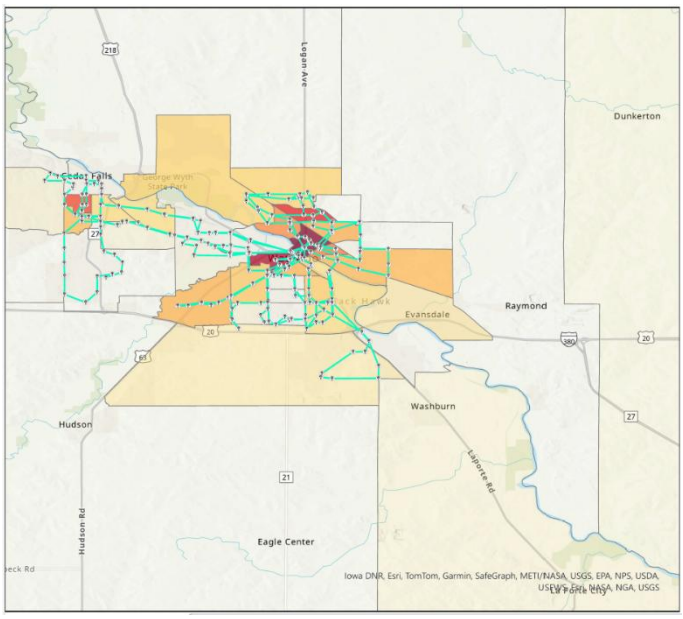
In the community survey, respondents were asked if there was anything that prevented them from being healthier. While transportation was ranked 10 of 16 in the overall results, it was the second most important factor for those with an income under $15,000.



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.



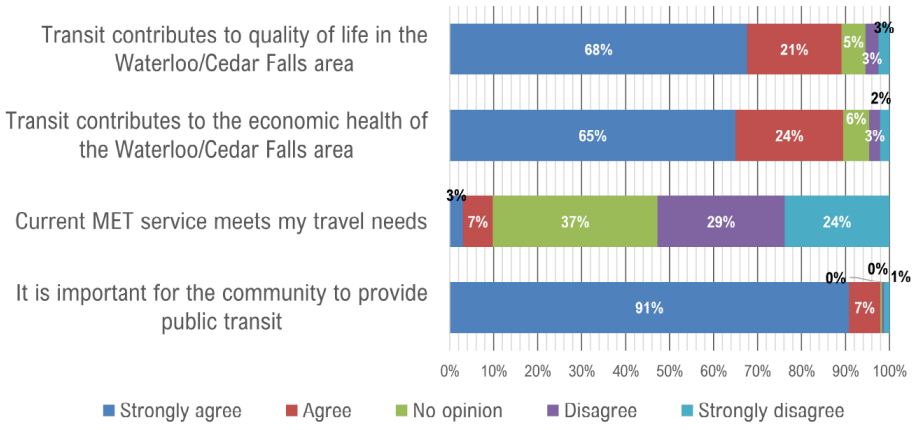
Respondents were also asked in the community survey reasons why they didn't access needed mental health services. Transportation was ranked #9 in the overall results, but it was the top reason for those with an income less than $15,000.



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.

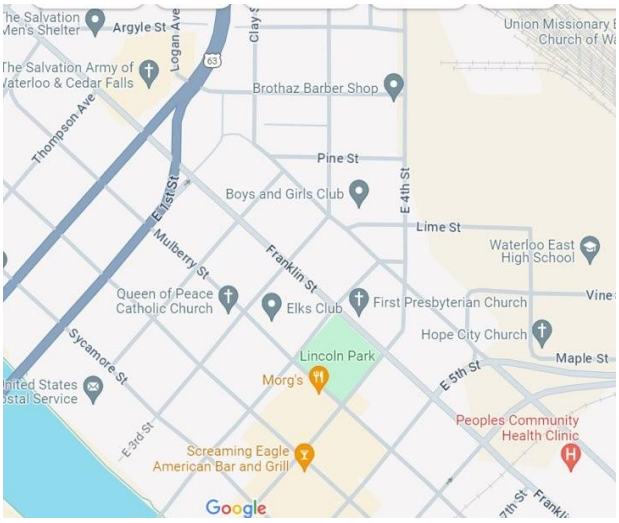
TRANSIT IS IMPORTANT TO THE COMMUNITY

Responses from March 2023 Community Survey

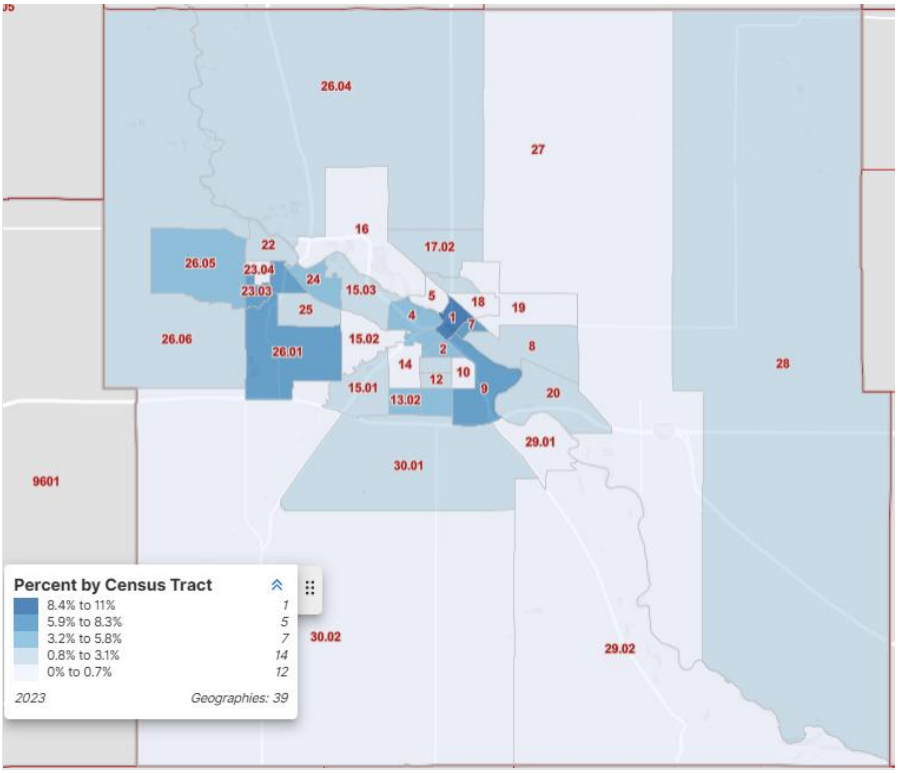


Gaps/Conflict:

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

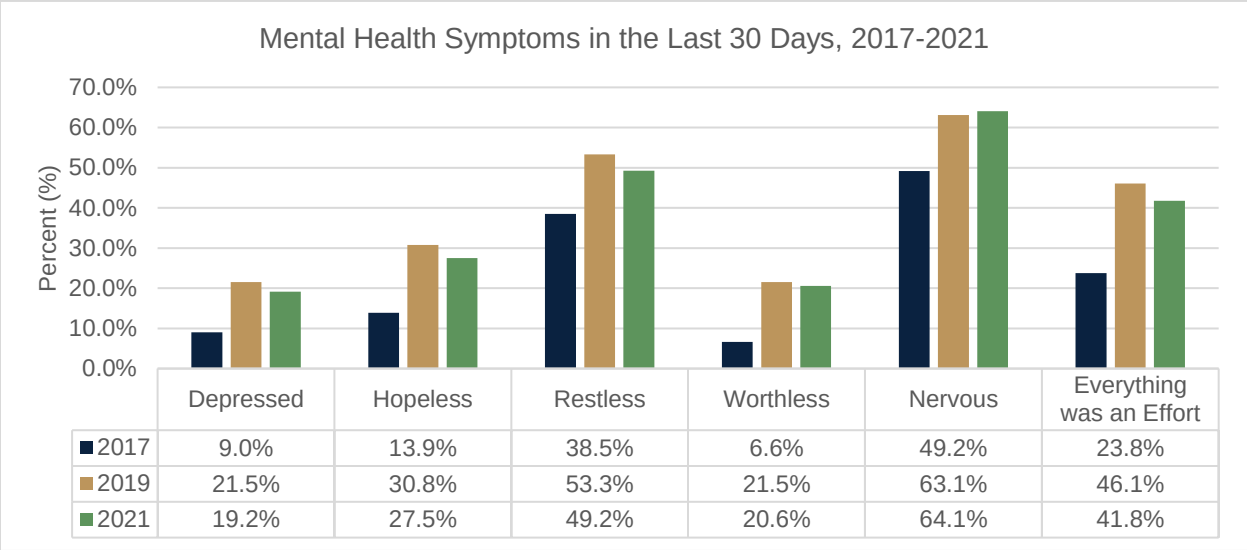


For the Community Context Assessment, pedestrian access to different frequently accessed resources in east Waterloo was assessed. Full results can be found in the Community Context Assessment Summary. It was noted that due to high-speed traffic at a busy intersection (Franklin Street and Mullen Ave), 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.



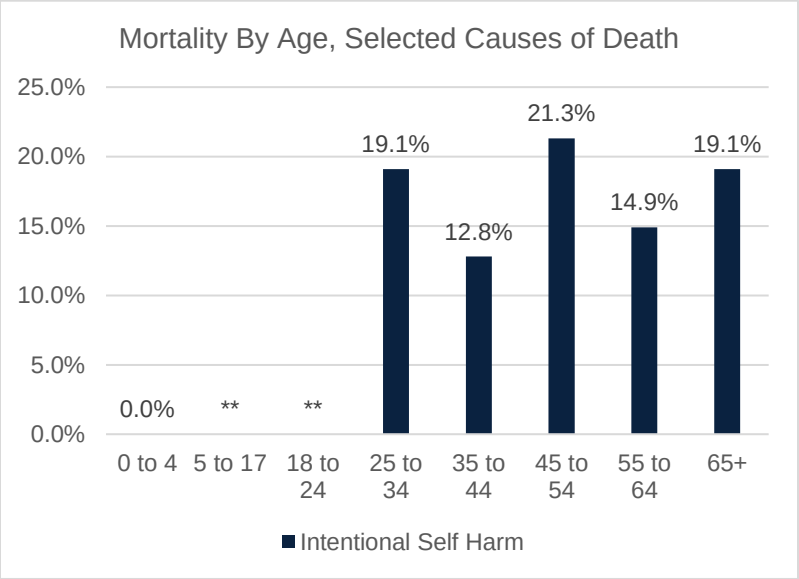
The map shows Census tracts where individuals have no vehicle available. The darker the blue, the higher the likelihood individuals had no vehicle available to them. Census tracts ranged from 0% to 11% with no vehicles available. Census tract 1 in Waterloo had the highest proportion (11%).

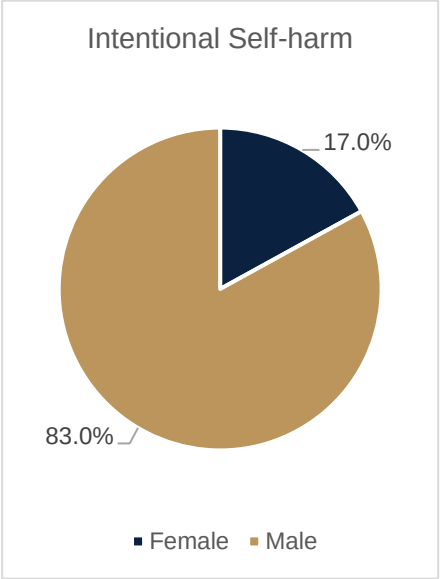
Behavioral Health: Treatment, Prevention, and Recovery



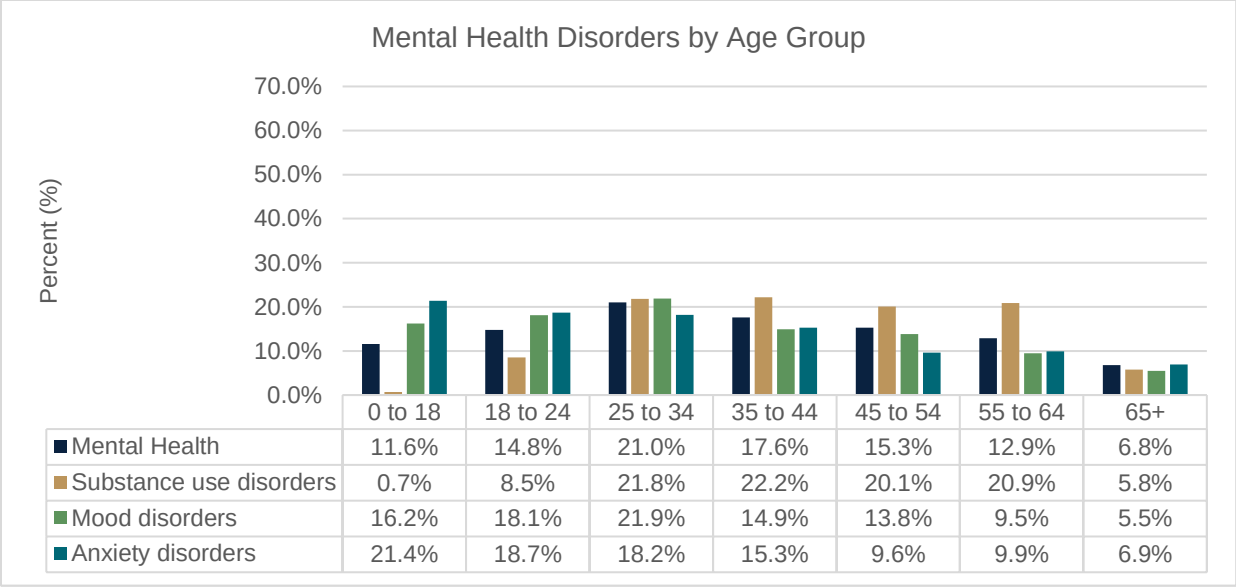
	Depressed	Hopeless	Restless	Worthless	Nervous	Everything was an Effort
2017	9.0%	13.9%	38.5%	6.6%	49.2%	23.8%
2019	21.5%	30.8%	53.3%	21.5%	63.1%	46.1%
2021	19.2%	27.5%	49.2%	20.6%	64.1%	41.8%

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.

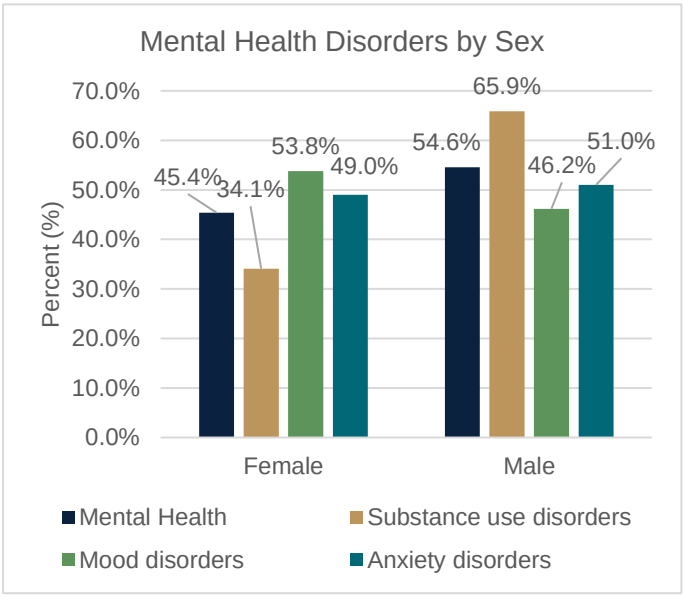




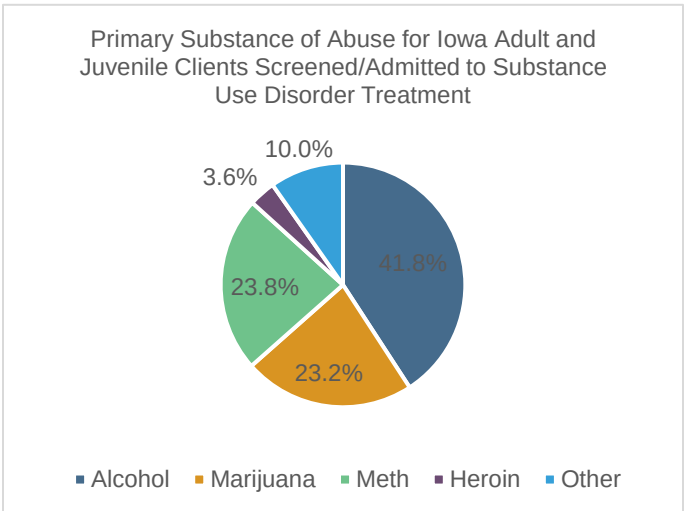
The Iowa Vital Records mortality data was broken down by the top 15 causes of death by ICD-10 code, and shown here are the results for intentional self-harm (suicide), using ICD-10 codes X60 to X84. The data showed that 83% were men. When broken down by age, there was limited data for those younger than 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.



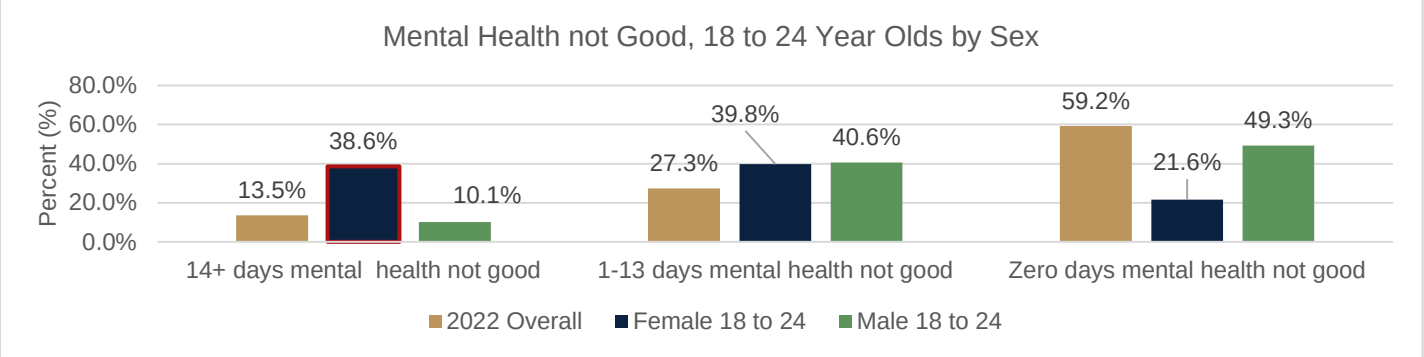
	0 to 18	18 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65+
Mental Health	11.6%	14.8%	21.0%	17.6%	15.3%	12.9%	6.8%
Substance use disorders	0.7%	8.5%	21.8%	22.2%	20.1%	20.9%	5.8%
Mood disorders	16.2%	18.1%	21.9%	14.9%	13.8%	9.5%	5.5%
Anxiety disorders	21.4%	18.7%	18.2%	15.3%	9.6%	9.9%	6.9%

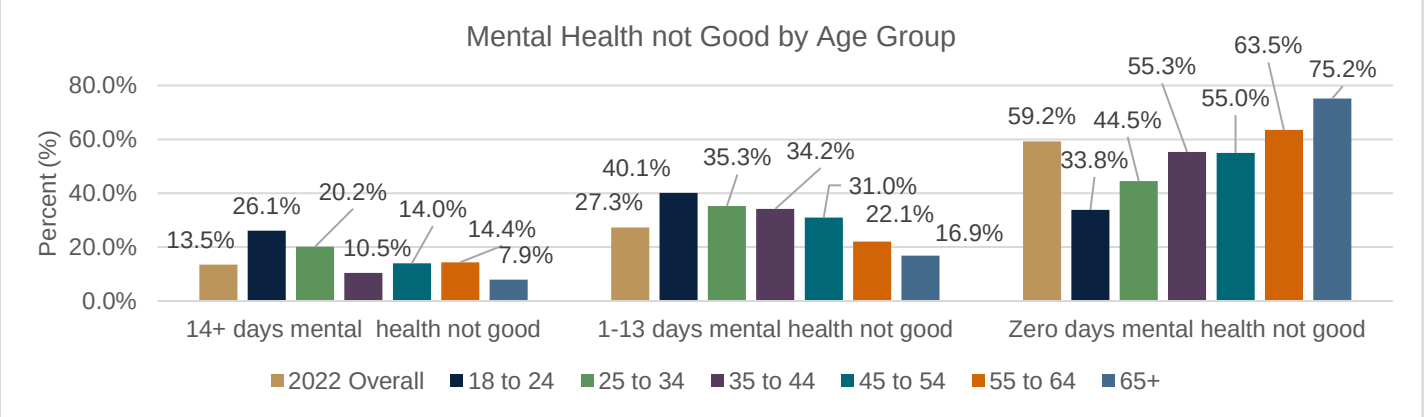


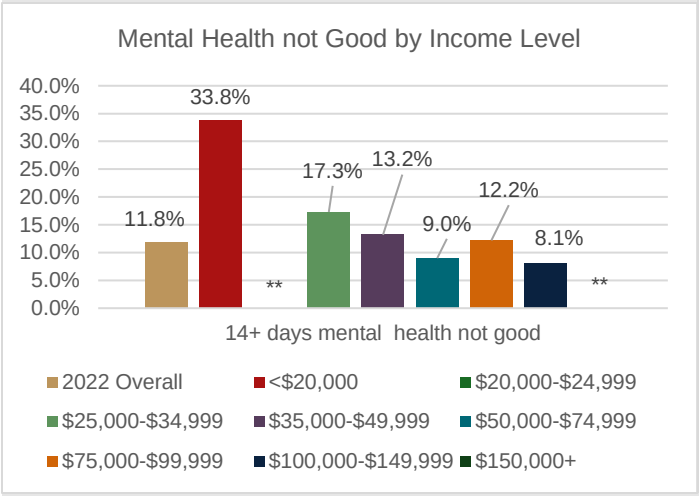
The IHA is a network of hospitals in Iowa that report data to the state based on reporting requirements. We reviewed ICD-10 codes for mental health disorders and broke them down by age and sex. For anxiety disorders (codes starting with F4), patients aged 0 to 18 made up the largest proportion. Mood 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.

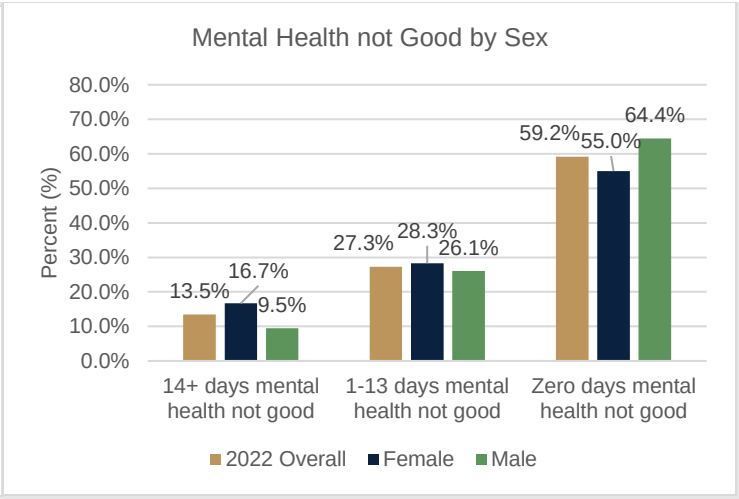


Data from the Iowa Drug Control Strategy and Drug Use Profile showed the primary substance of abuse for Iowa adult and juvenile clients screened or admitted to substance use disorder treatments. The highest proportion was alcohol at 41.8%, followed by meth at 23.8%, and marijuana at 23.2%. Heroin accounted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

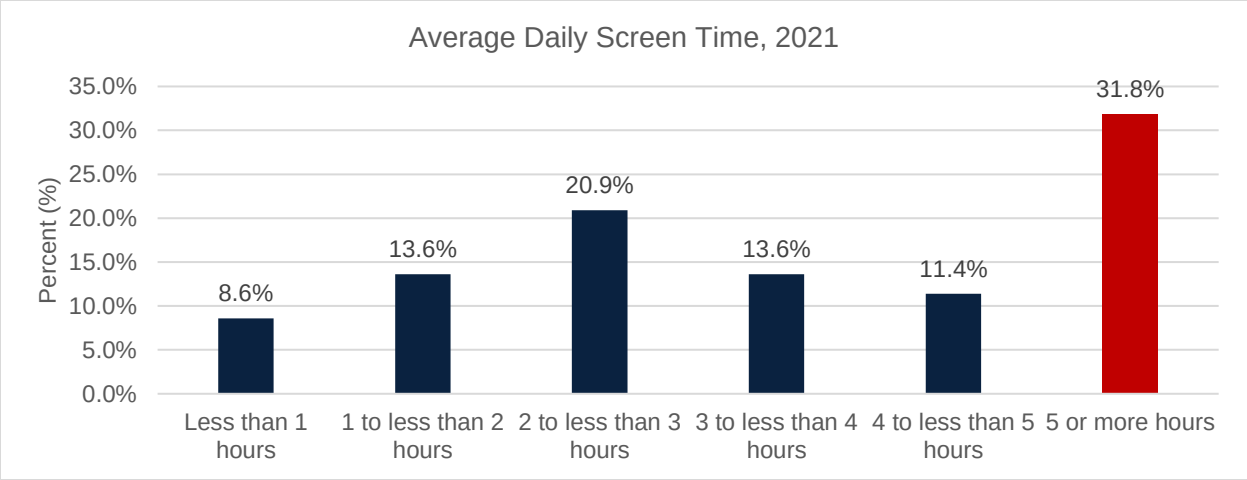




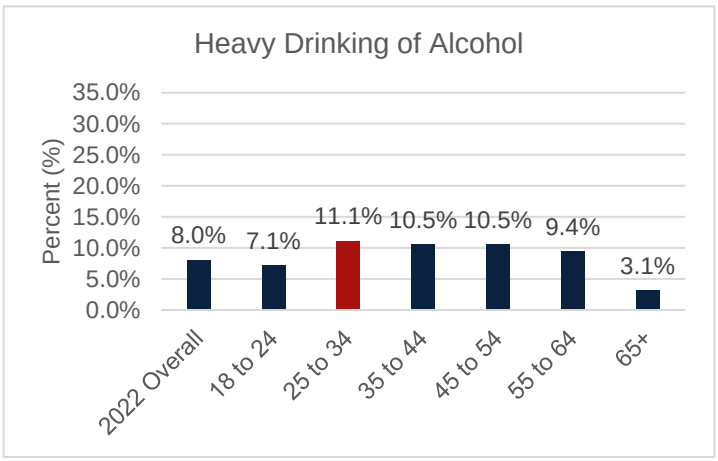


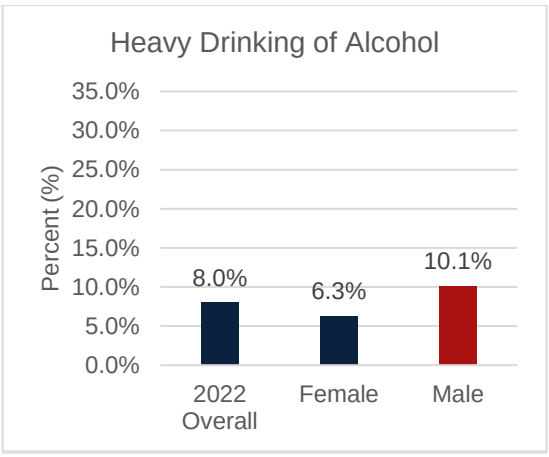


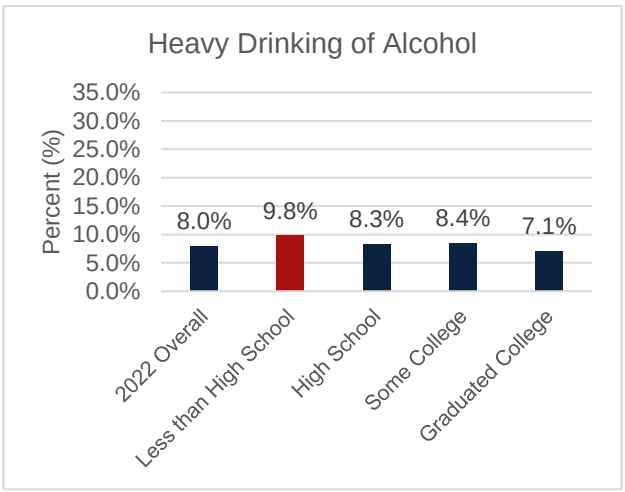
BRFSS respondents were asked if their mental health was not good, and for how many days if it was not good in the last month. Most respondents report that they had 0 days their mental health was not good. Women had more days where mental health was not good compared to men, and the same was seen for 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%).



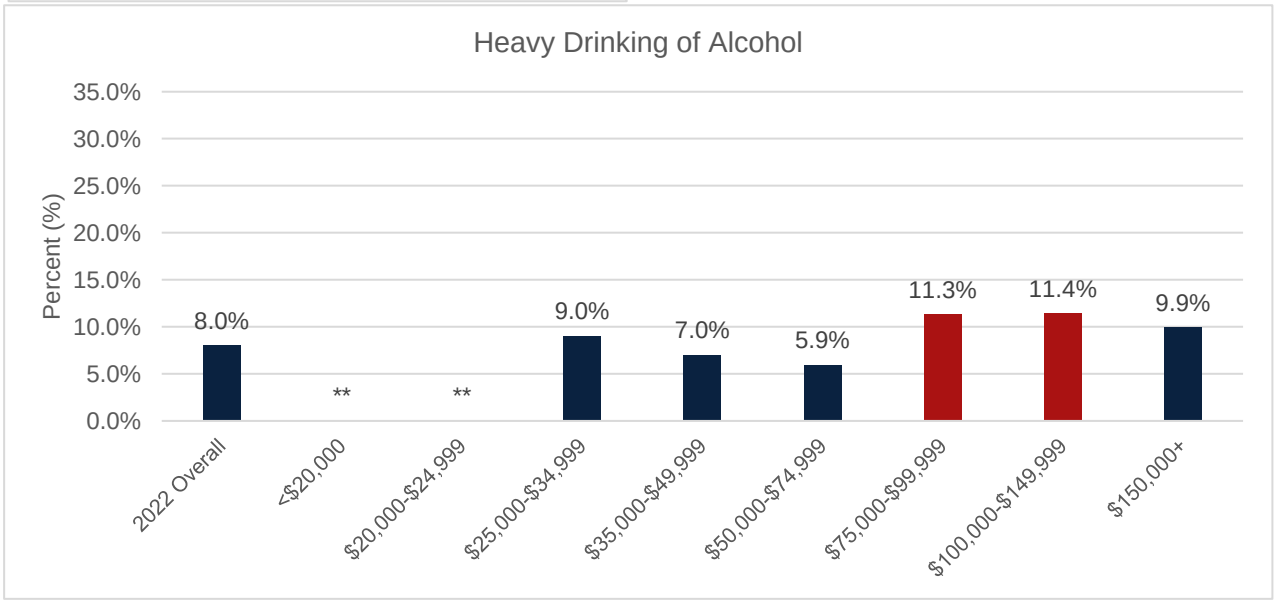
BRFSS respondents were asked about their average daily screentime (TV, phone, computer, etc.). The highest proportion is 5 or more hours (not including work time). This concern also came up in the community survey for the top health factor for children.

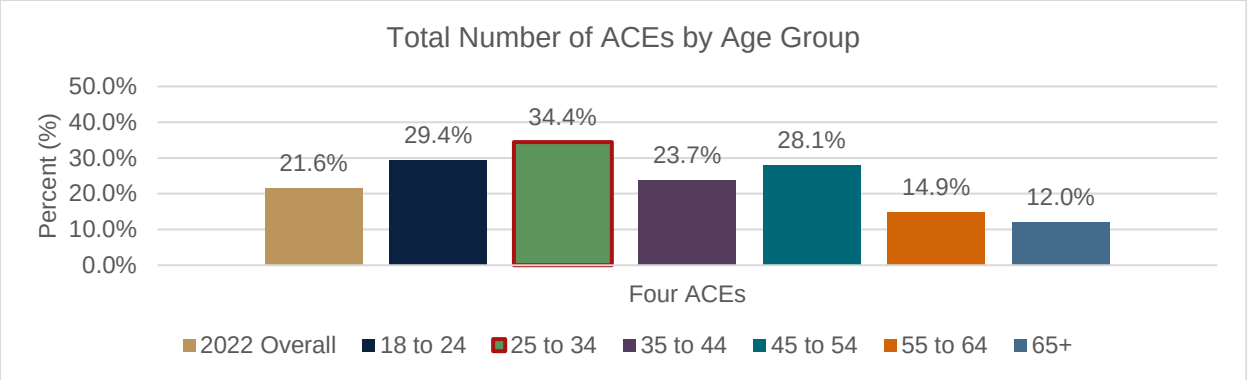


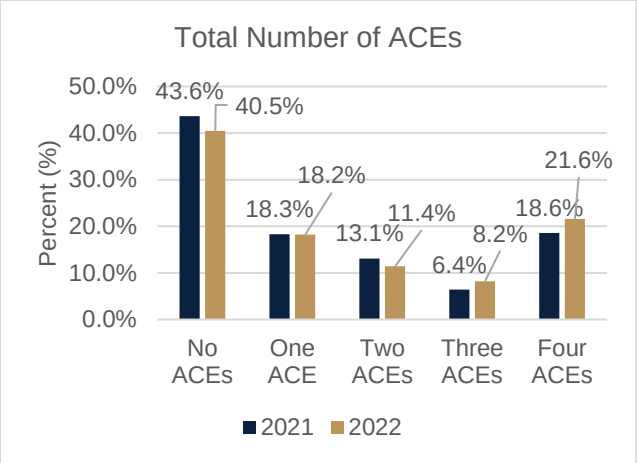


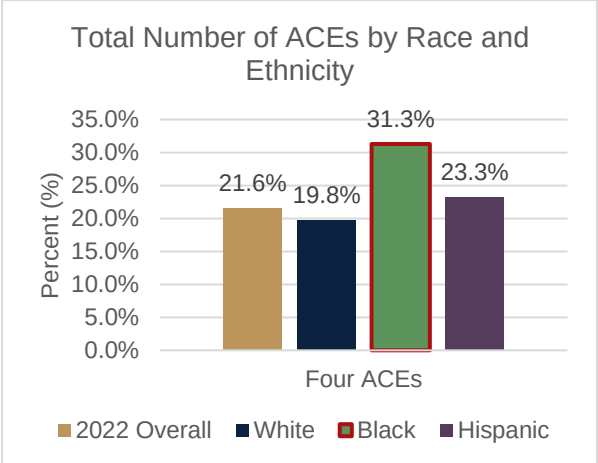


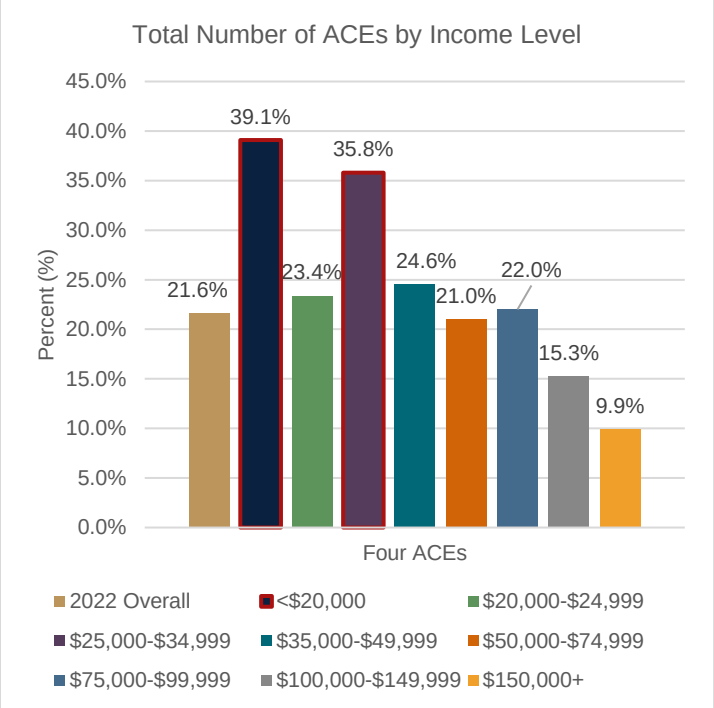
BRFSS respondents were asked about their alcohol consumption, and data displayed is for heavy drinking. The definition of heavy drinking (per BRFSS) for men is having more than 14 drinks per week, and women having more than 7 drinks per week. Additionally, women having 1 or more drinks per day and men 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.



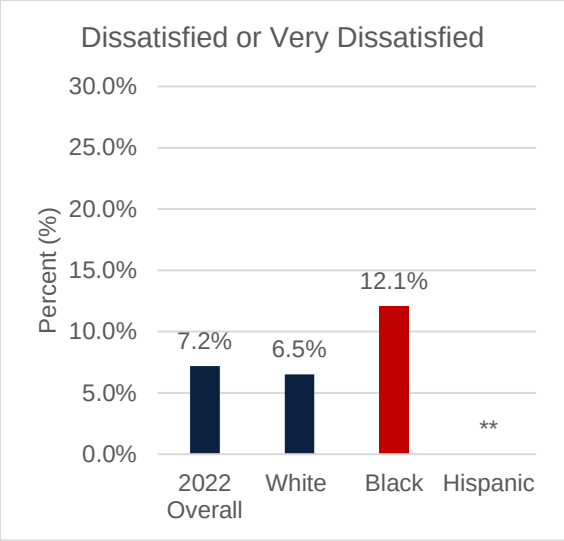


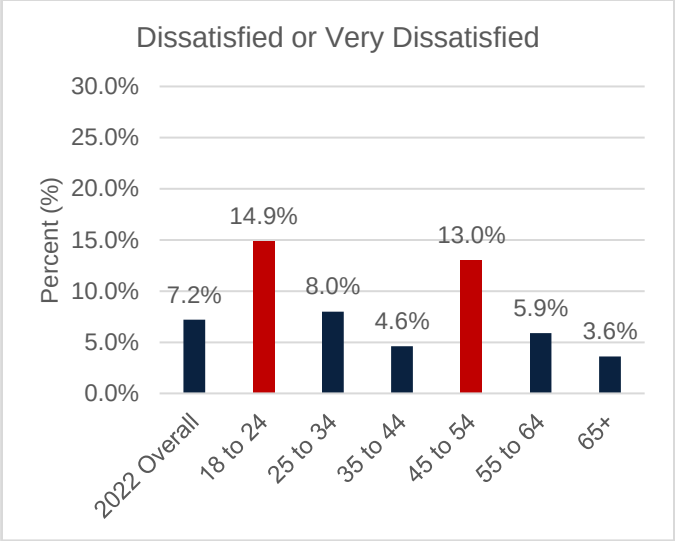


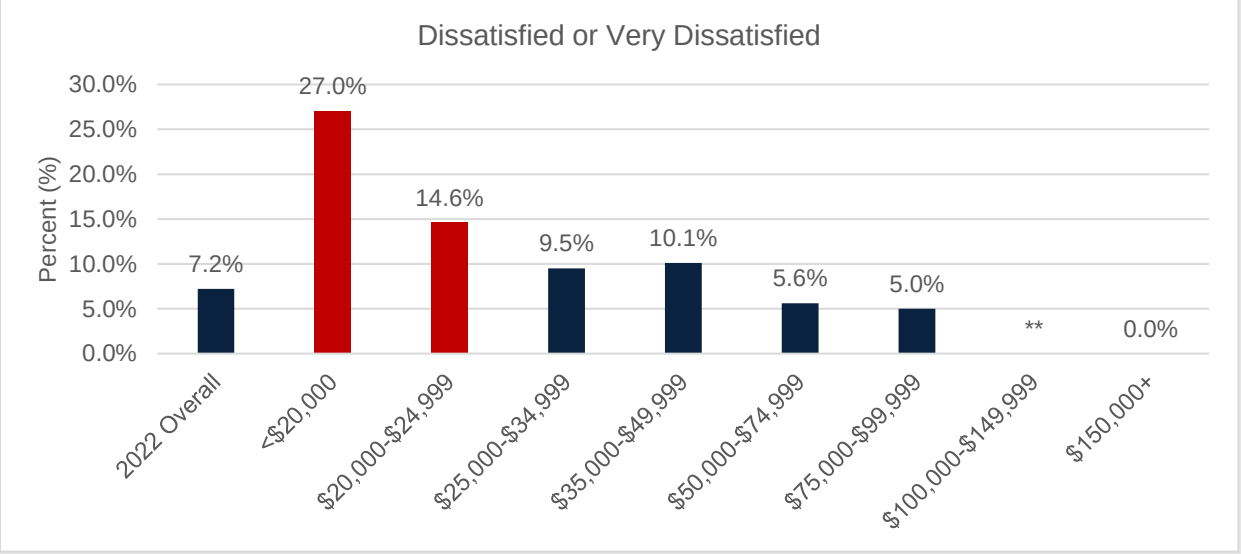




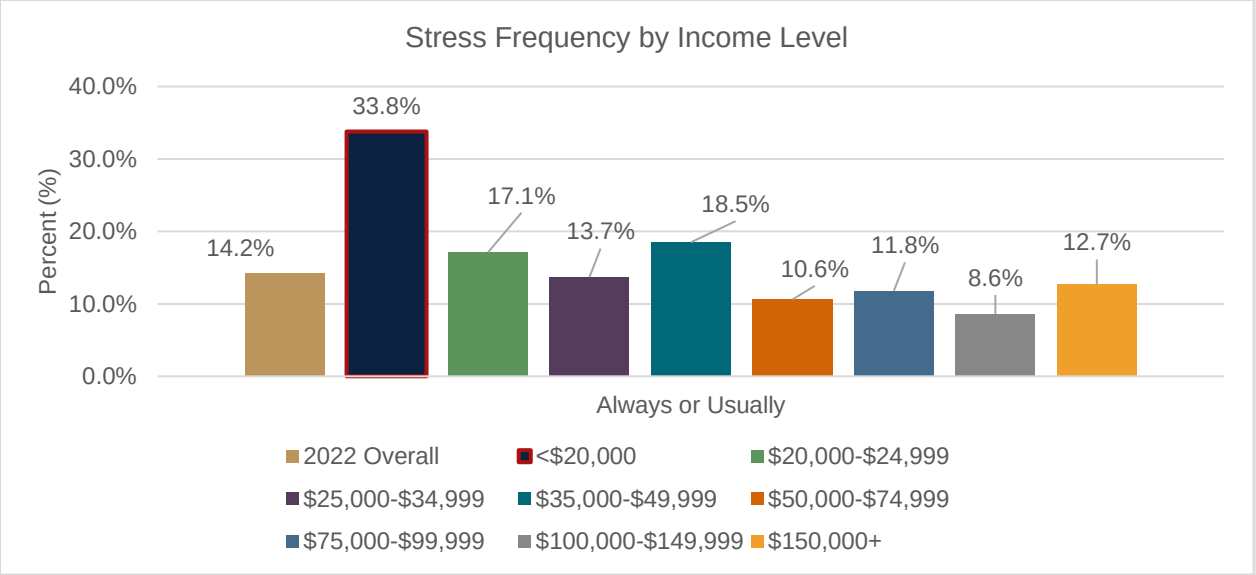
BRFSS participants were asked if they had experienced one or more adverse childhood experiences (ACEs). Those who have experienced 4+ ACEs are more at risk for adverse health outcomes. 2022 ACEs data was disaggregated by race and ethnicity, age group, and income level. Those most affected were those 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.

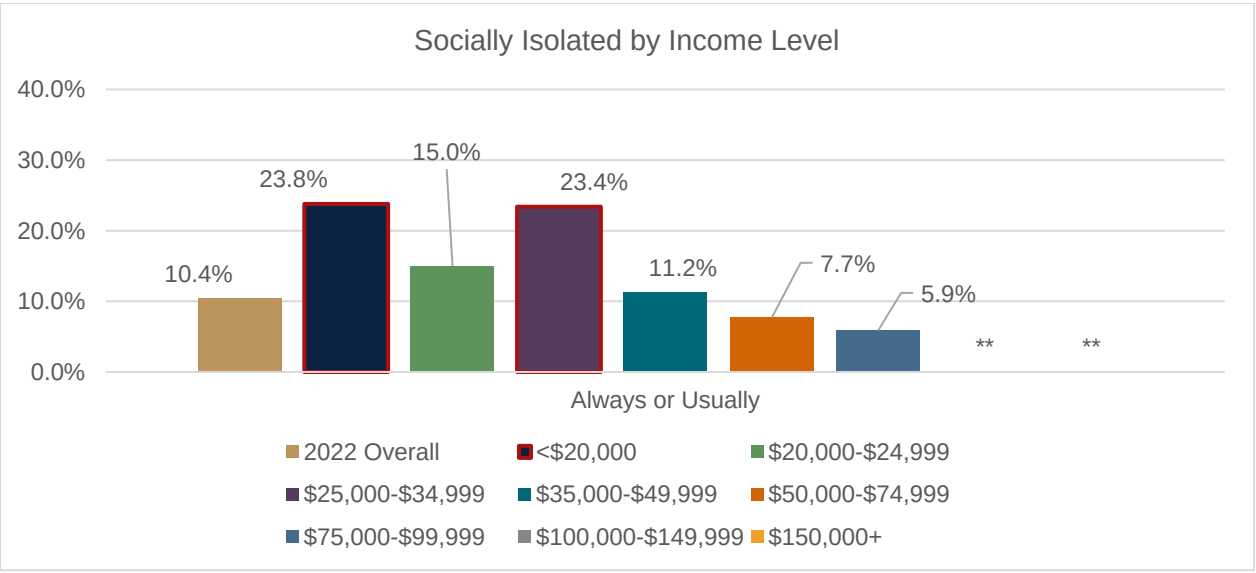






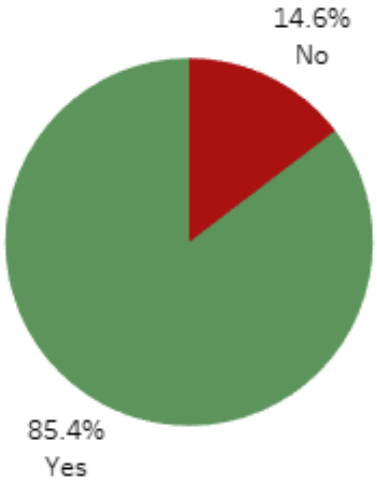
BRFSS respondents were asked if they were satisfied with their life, and response options were on a 4-point Likert scale. What is shown is the proportion of those who said that their life was dissatisfying or very dissatisfying. Those who were most affected included those who identified as Black, who 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.



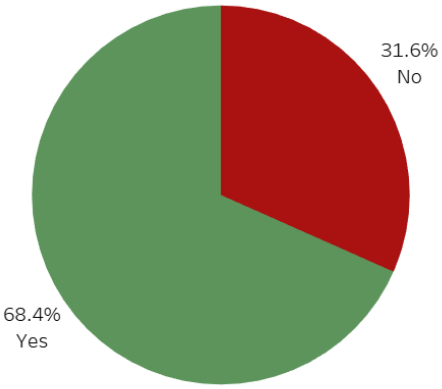


BRFSS has 4 questions related to stress and social determinants of health. The two questions shown are stress frequency within the last 30 days and how often the person felt socially isolated, both of which were represented by 5-point Likert scales. The responses representing Always and Usually were 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.

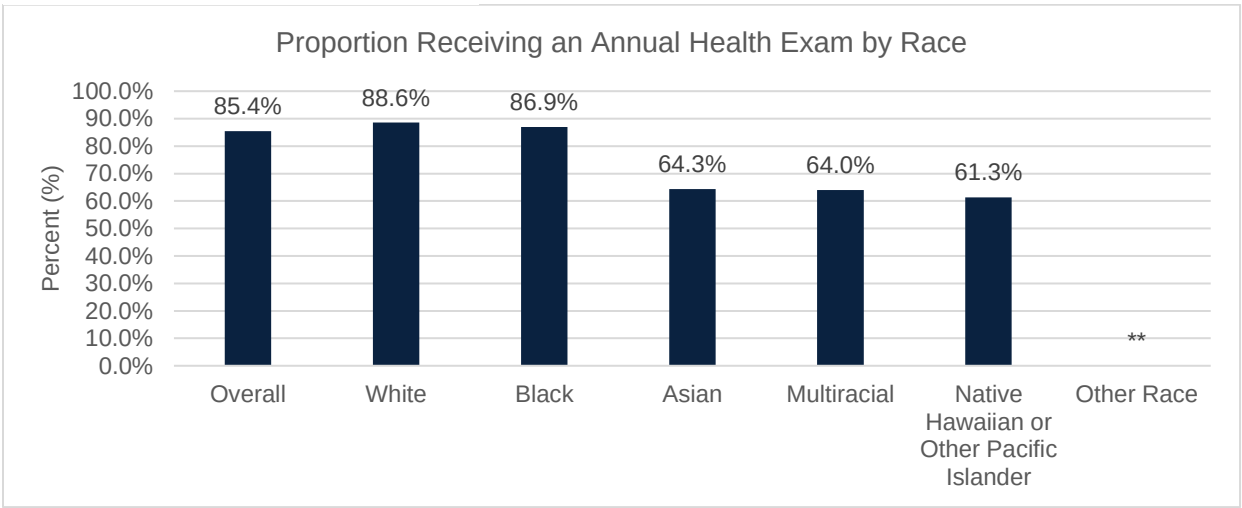
Access to Healthcare

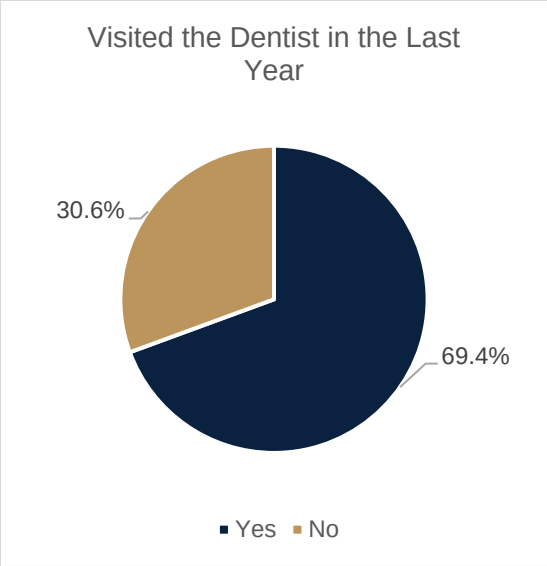


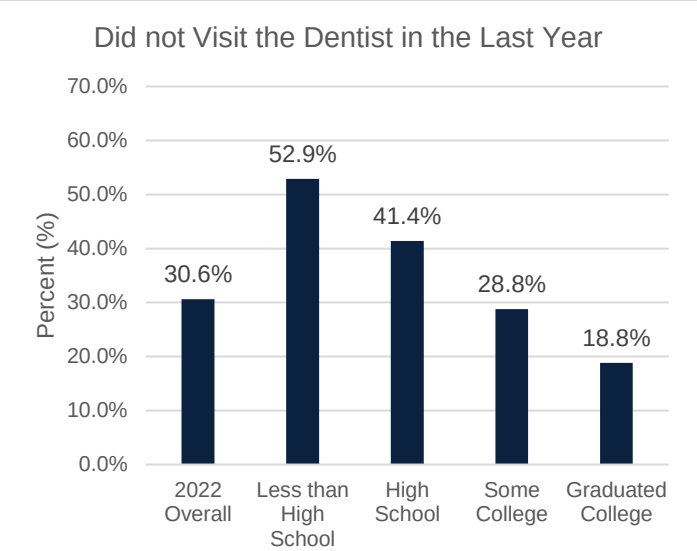
Respondents to the community survey were asked if they receive an annual health exam. If they were unable to, they had an additional question to understand their barriers. Younger age groups and people with lower income levels were less likely to visit a doctor, as well as respondents born in Burma and 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.

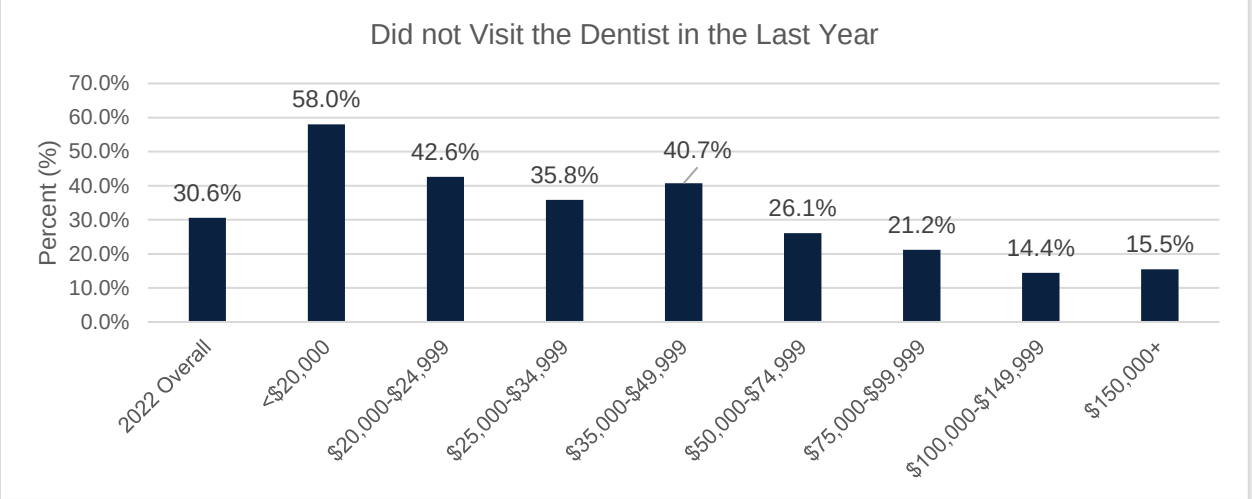


Community survey participants were also asked if they visited the dentist regularly (1-2 times a year) and what the barriers were if they had not. The groups affected the most were the same as those who were less likely to visit a doctor. The top barriers were cost, not having dental insurance, and not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

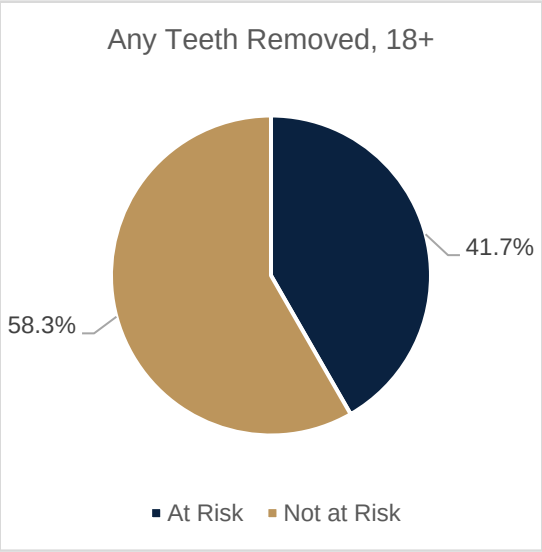


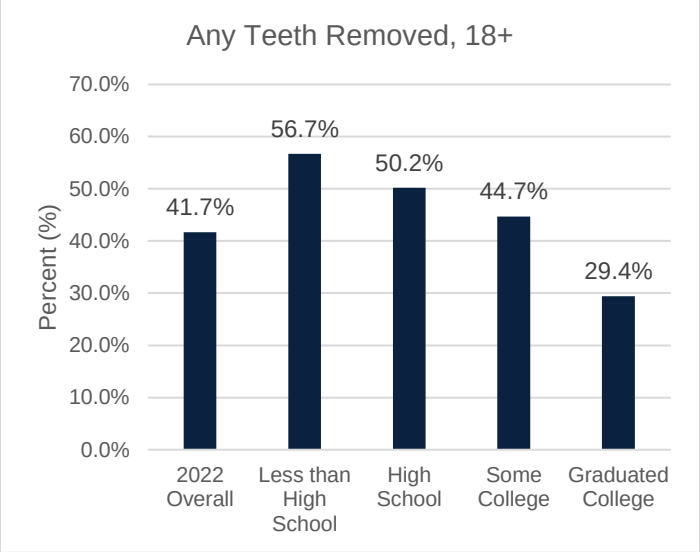


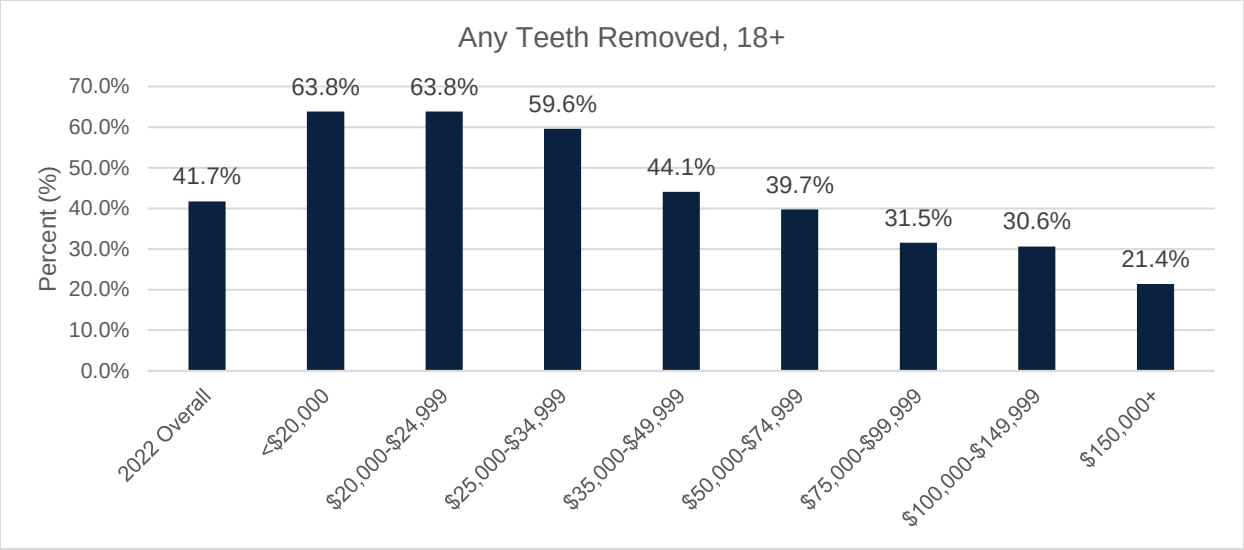




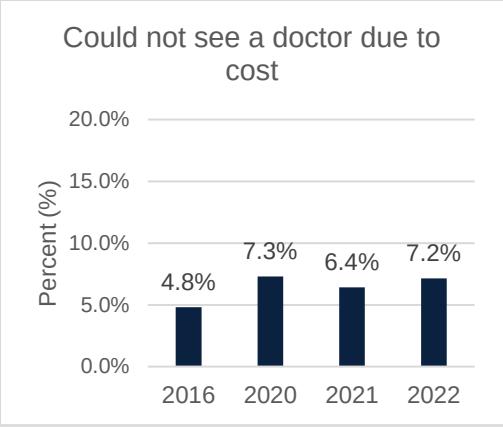
A similar question was asked in BRFSS if participants had been able to visit the dentist in the past year, with nearly the same proportion saying no. When disaggregated, the groups most affected were lower income levels and lower levels of educational attainment. Other populations that were impacted 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%).

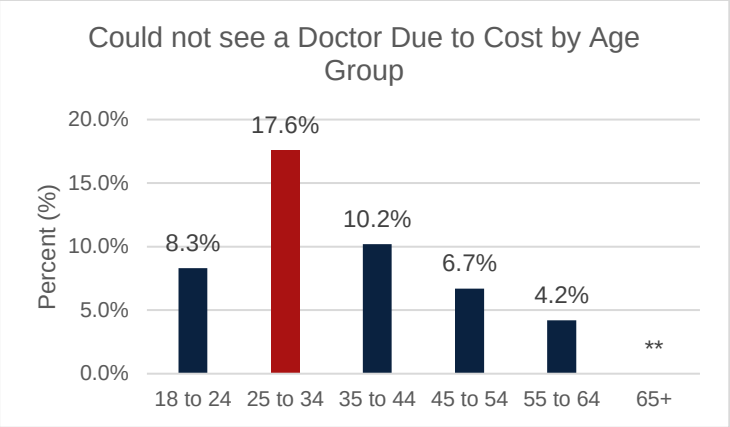


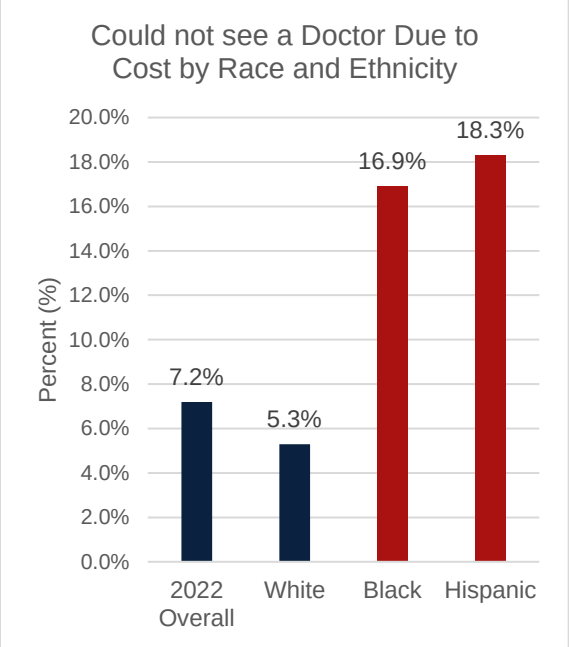


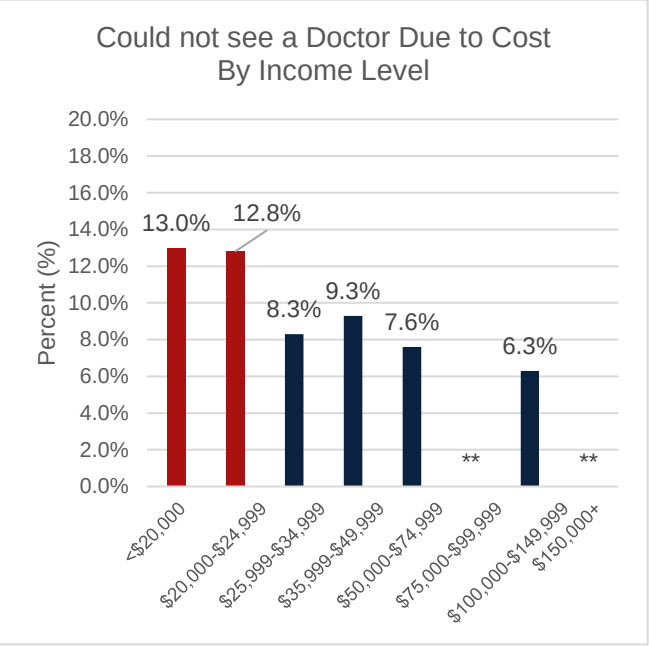


BRFSS respondents were asked if they ever had any teeth removed due to decay or gum disease (orthodontics and other causes were excluded). Those who had teeth removed for those reasons were “at risk.” Those who had less than a high school education and an income below $25,000 were the most likely to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

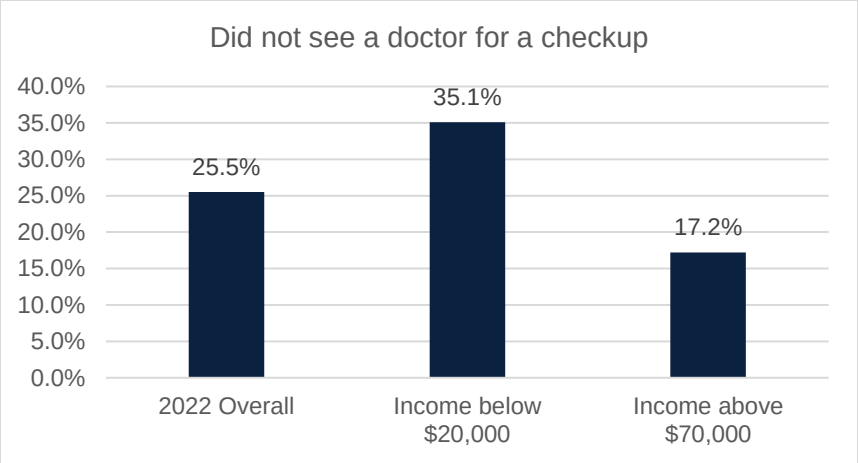




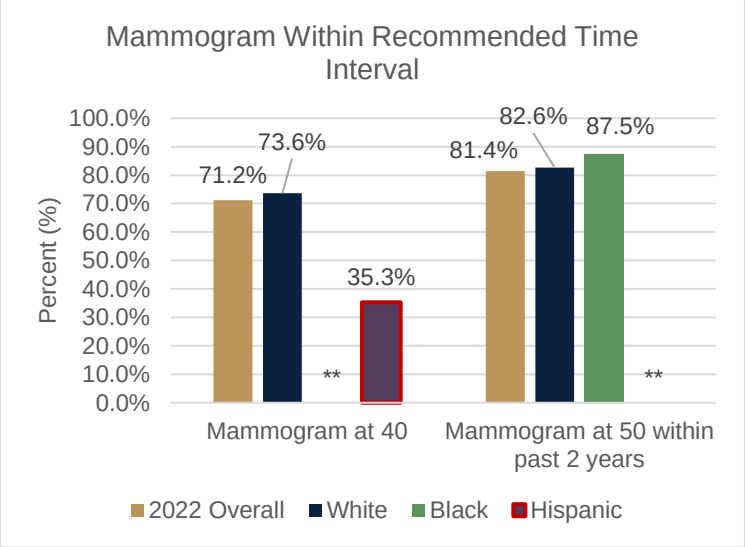


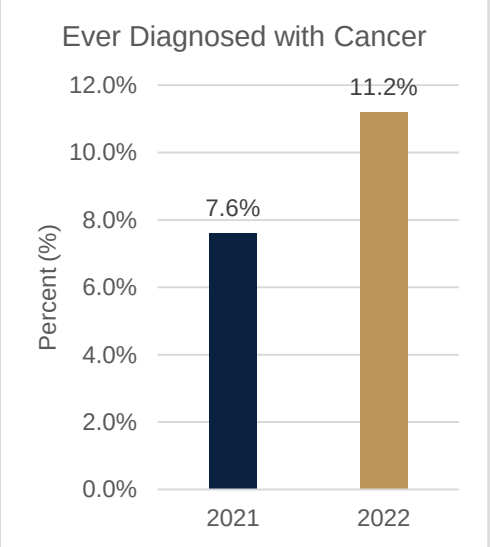


BRFSS respondents were asked if they could not see a doctor due to cost in the last year. The largest disparities were by race and ethnicity (Black or African American and Hispanic), age group (25-34), and income level (less than $25,000).

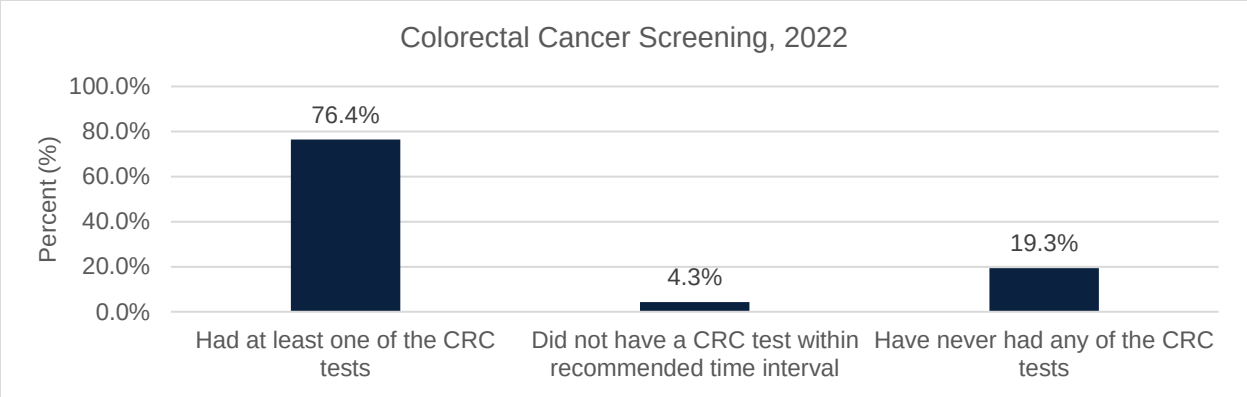


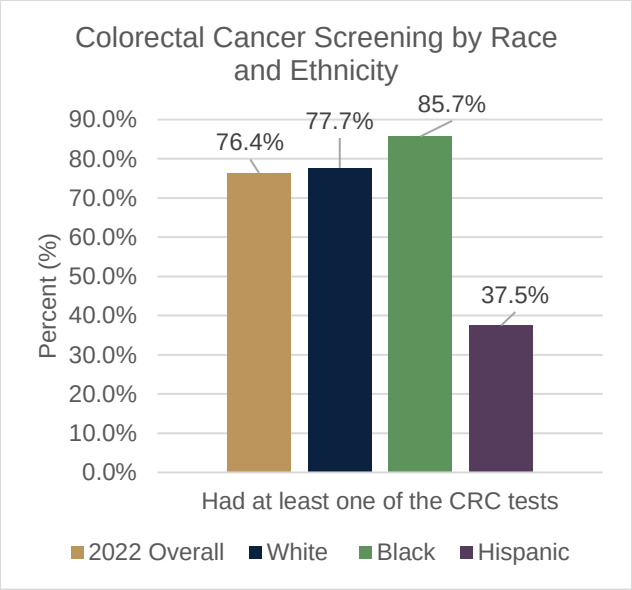
In the Barriers survey, participants were asked if they were able to see a doctor 12 months before pregnancy. On average, 25.5% were not able to see a doctor. When disaggregated by income, 35.1% of those with an income below $20,000 did not see a doctor 12 months before pregnancy compared to 17.2% for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

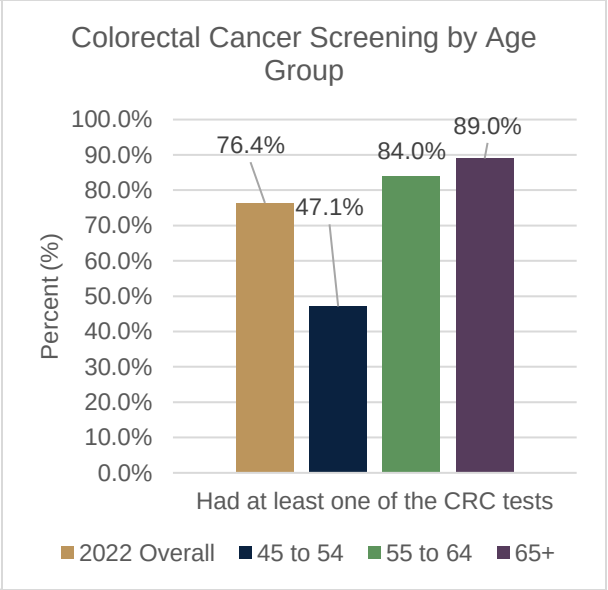




There was an increase in the proportion of BRFSS respondents diagnosed with cancer from 2021 to 2022. Respondents identifying as female were asked in 2022 if they had a breast cancer screening at ages 40 and 50 within the past 2 years. When disaggregated by race and ethnicity, Hispanic individuals were 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.



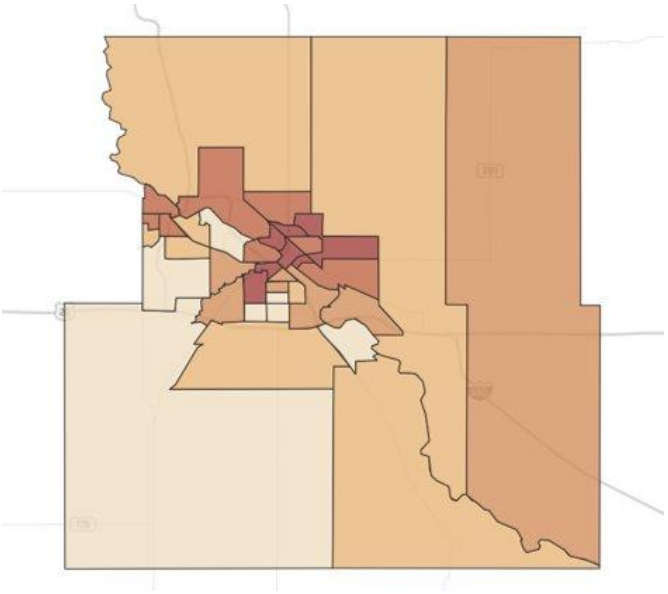




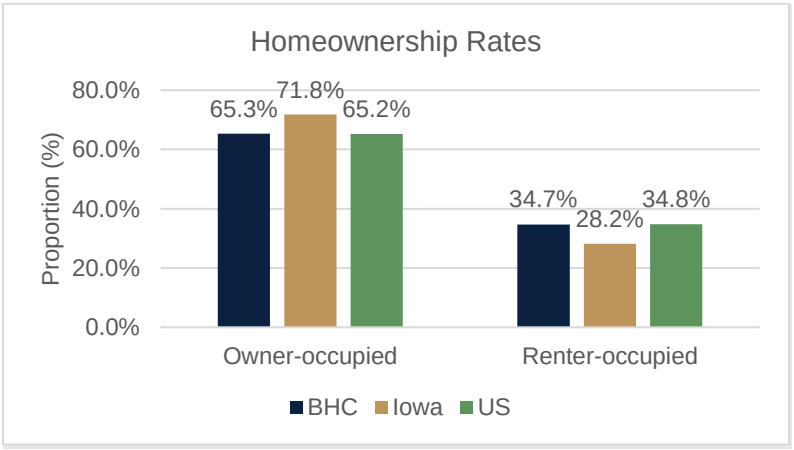
BRFSS participants were asked if they had any colorectal cancer screening in 2022. 76.4% of individuals had at least 1 test within the recommended time interval. Hispanic individuals and those aged 45-54 were the least likely to have had at least 1 screening within the recommended time interval, 37.5% 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

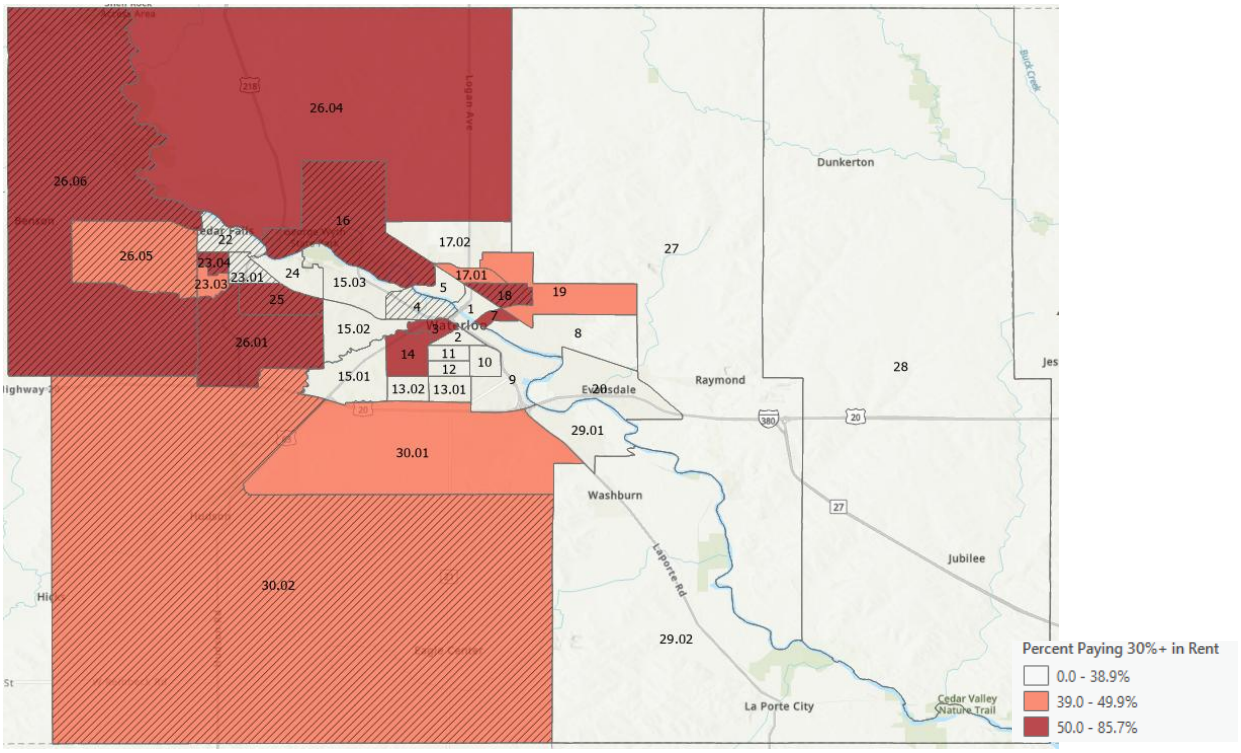
According to the community survey, safe and affordable housing ranked second among areas most in need of improvement, with 77% of respondents identifying it as a priority.



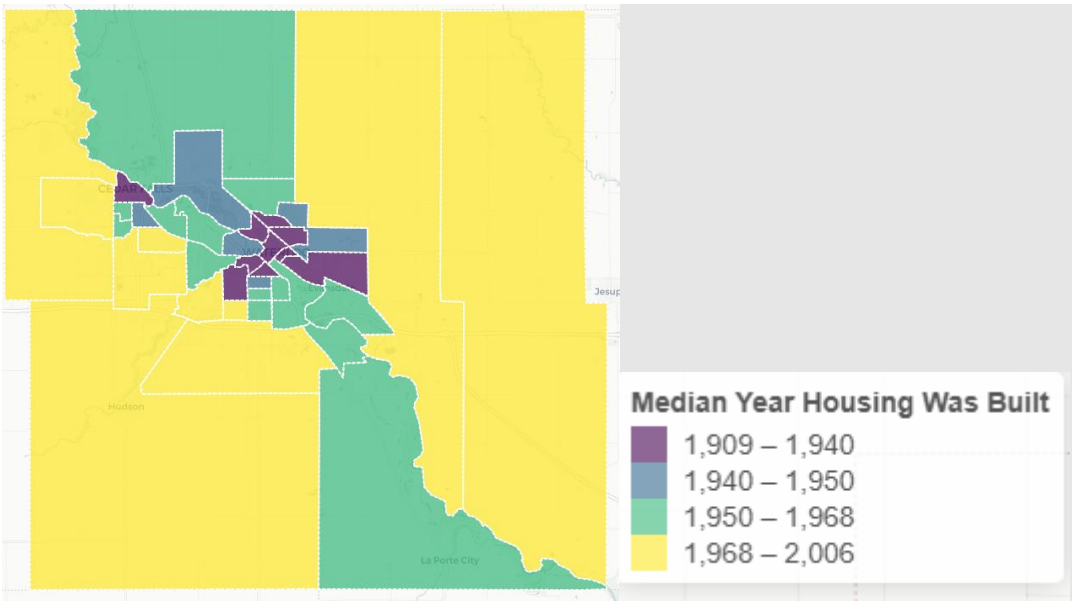
Iowa HHS created a map depicting lead exposure risk. This map highlights areas at higher risk based on age of housing (houses built before 1949) and childhood poverty. Parts of Waterloo show the highest risk. Cedar Falls has regions with moderate risk. Rural regions generally exhibit lower risk, except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

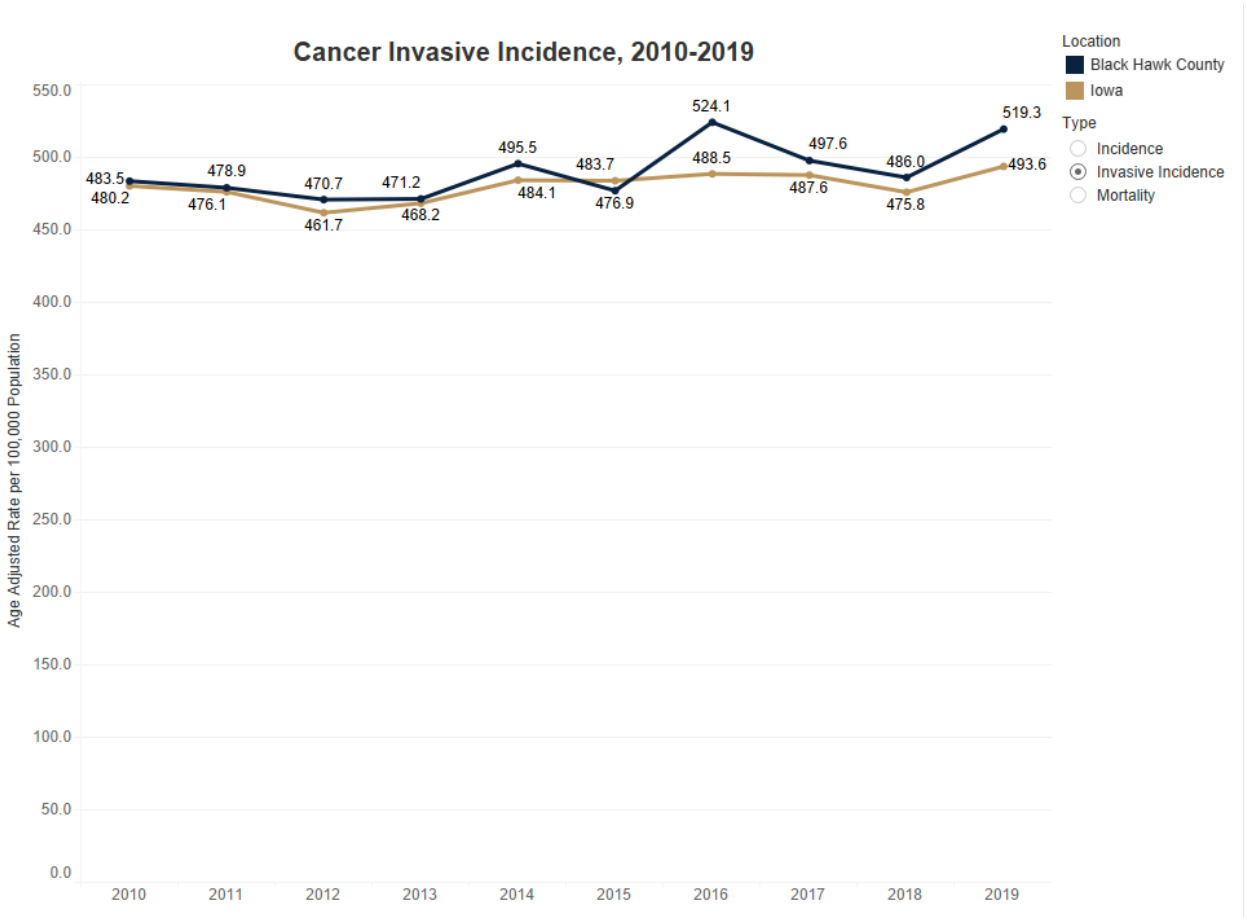


Rent burden, defined as spending over 30% of household income on rent, is prevalent in central and northwestern parts of the county. On the map, dark colors signify a higher proportion of rent burden, and census tracts with diagonal lines are tracts where rent is $1000 or higher for median rent. When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

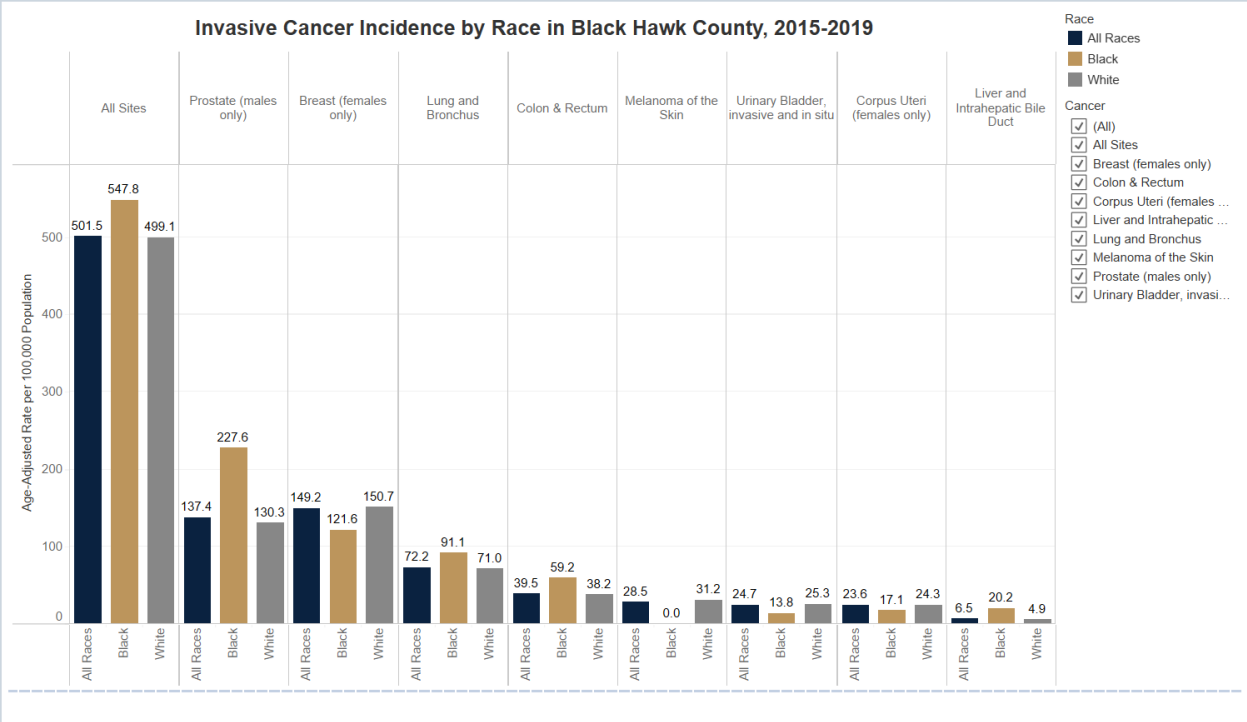


Data from the BHC assessor's office shows the median construction year of residential properties in each census tract. Housing in Waterloo tends to be older, aligning with the higher risk for lead exposure map created by Iowa HHS.

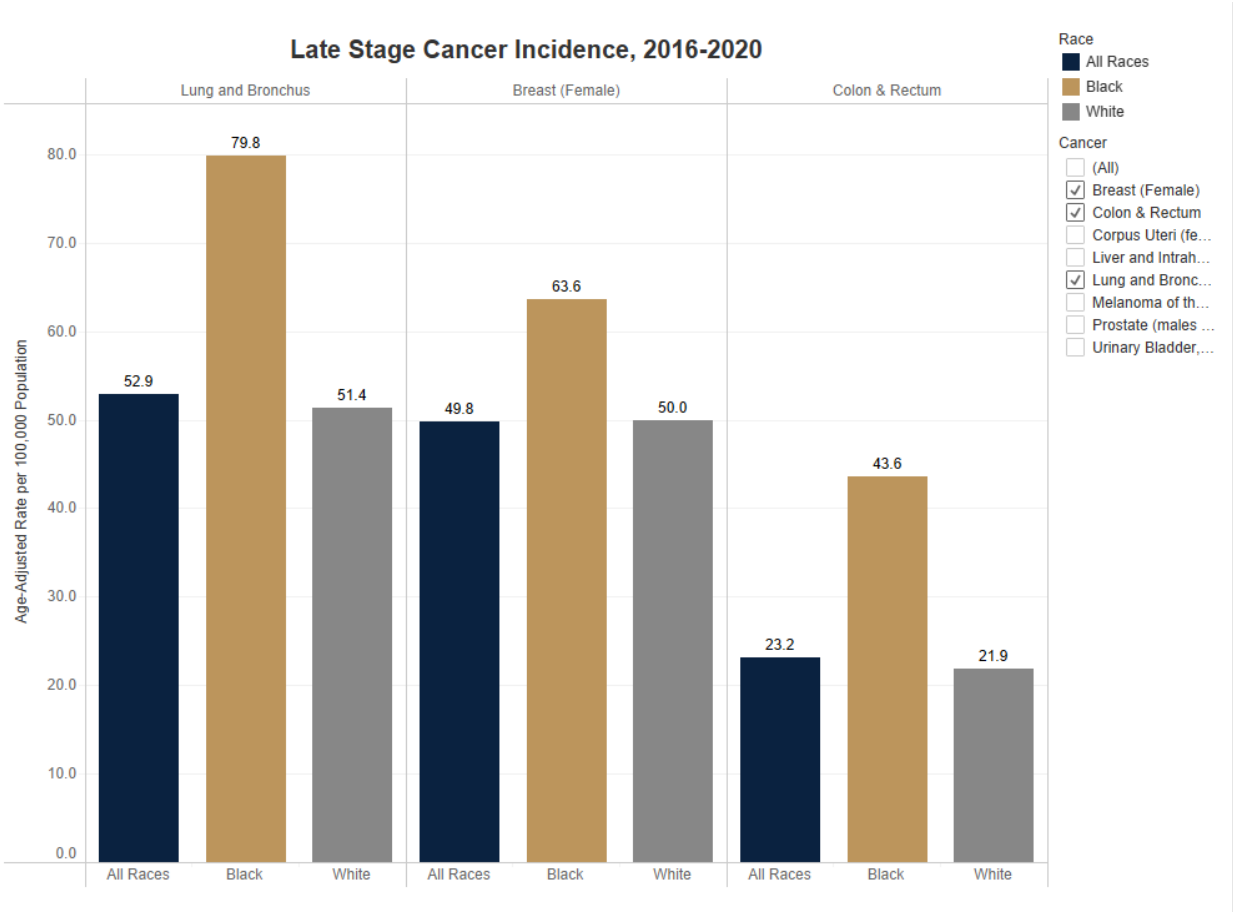
Chronic Disease



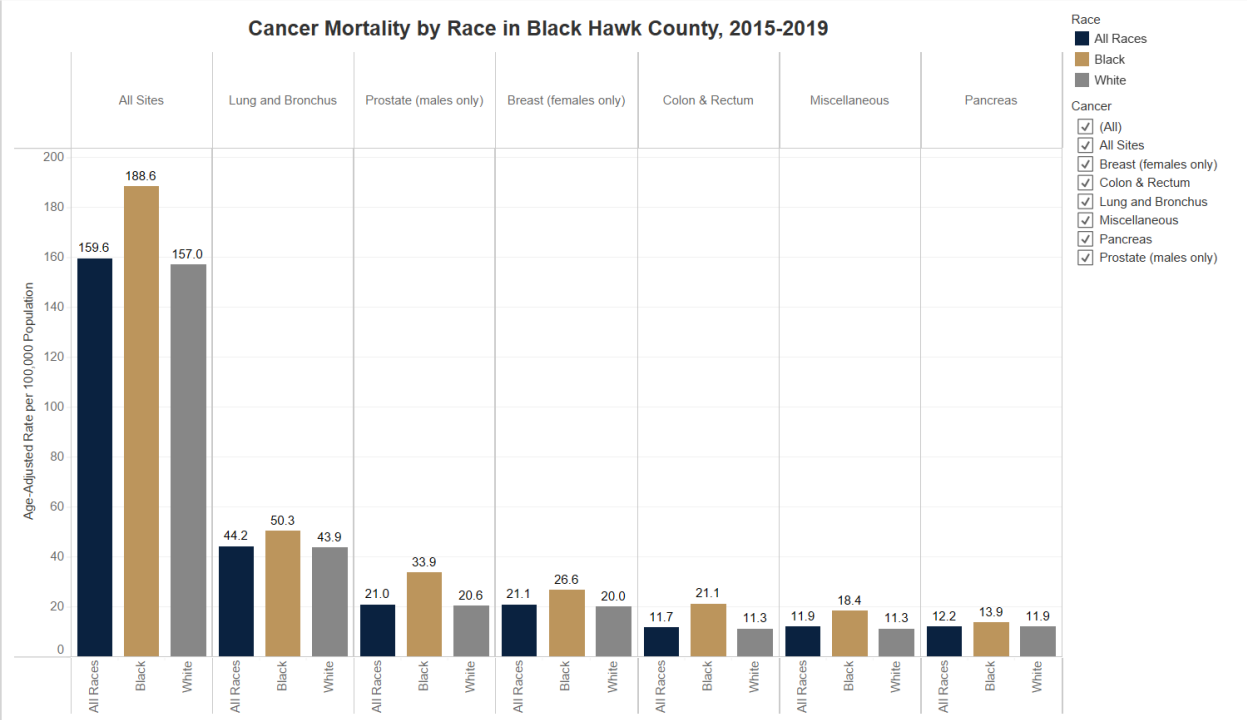
The Iowa Surveillance, Epidemiology, and End Results (SEER) Cancer Registry is a database with information on cancers diagnosed in Iowa. The data available was analyzed by the SEER Cancer Registry and released publicly. The graph above shows invasive cancer incidence (cancers diagnosed at stages 1-4)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



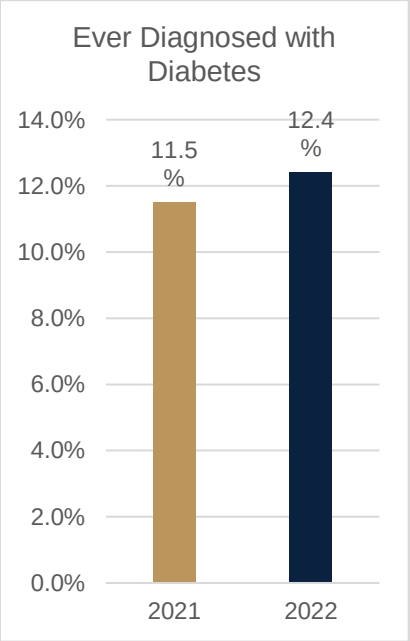
The top 6 invasive cancer rates for each race are shown above. Disparities can be seen for Black individuals for the following groups: all cancers, prostate cancer, lung and bronchus cancer, colorectal cancer, and liver and bile duct cancer.

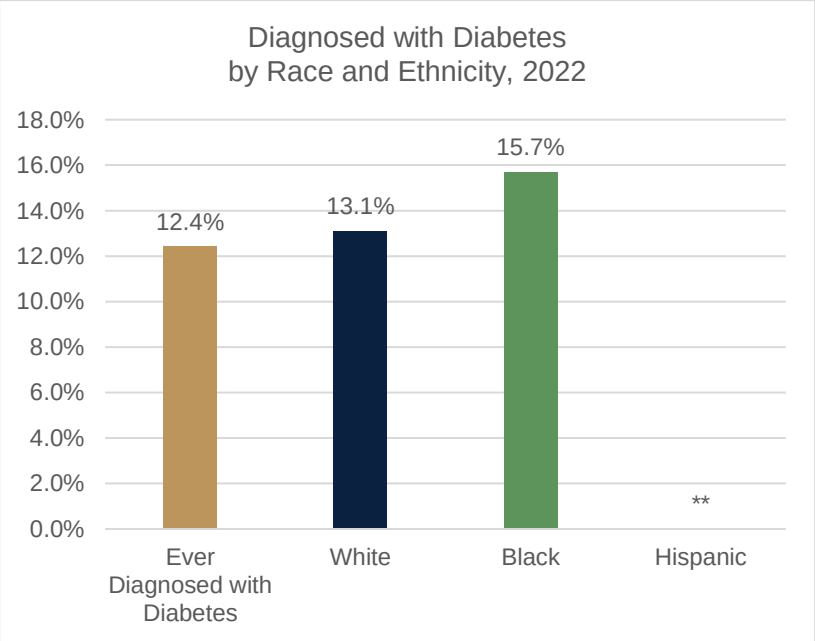


Late-stage cancer incidence was also shown for selected cancers. This data was reported to the National Institutes for Health (NIH) by the Iowa SEER cancer registry, and analyzed by the NIH, who also released it publicly. As with invasive cancer incidence, disparities can be seen for Black individuals 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.

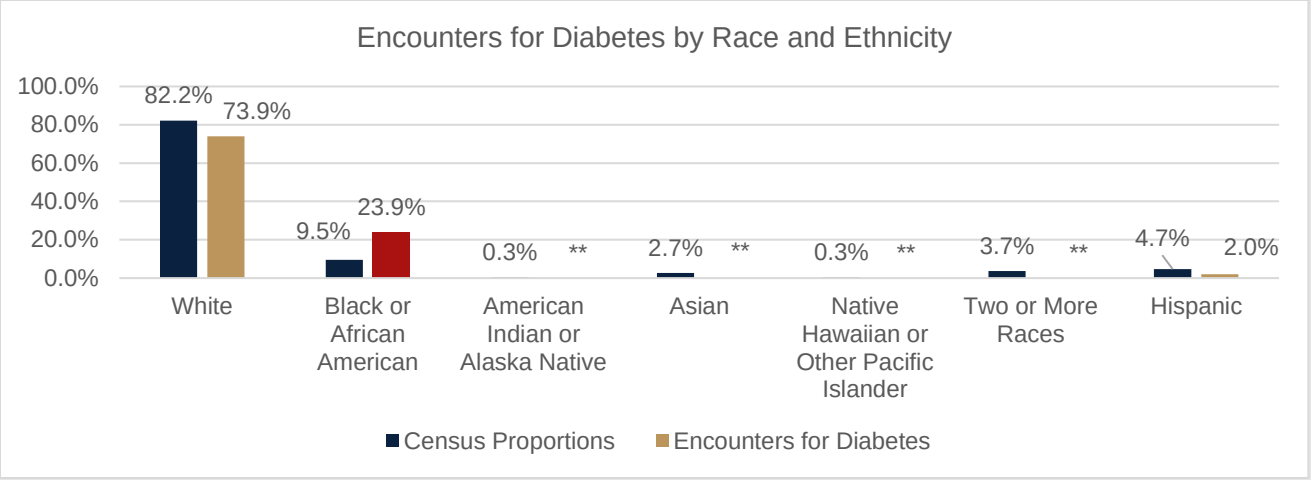


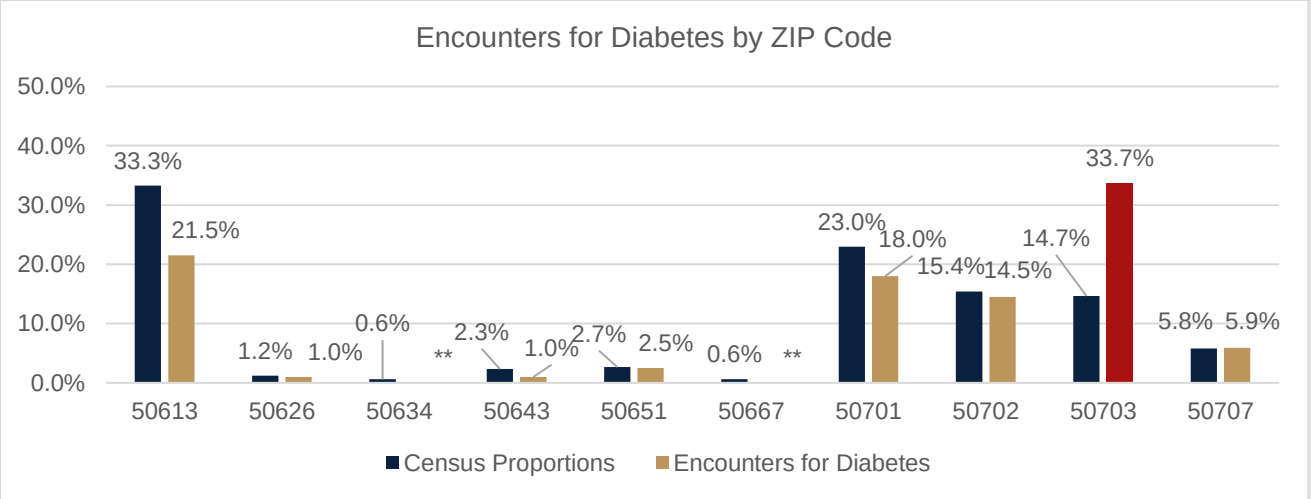
The graph above shows the top 6 cancer mortality rates disaggregated by race. Disparities for Black individuals compared to White individuals and All Races are seen for all cancers shown.



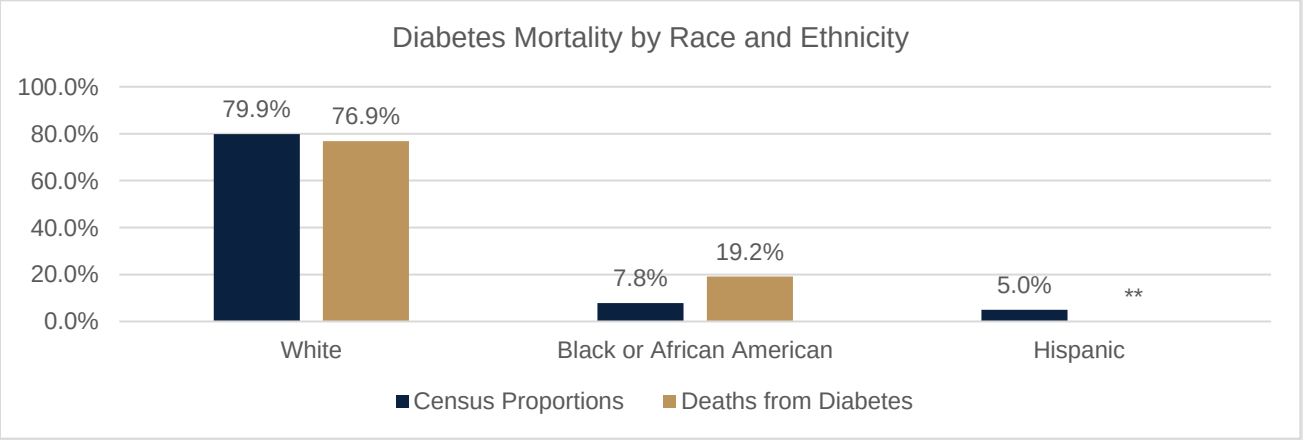


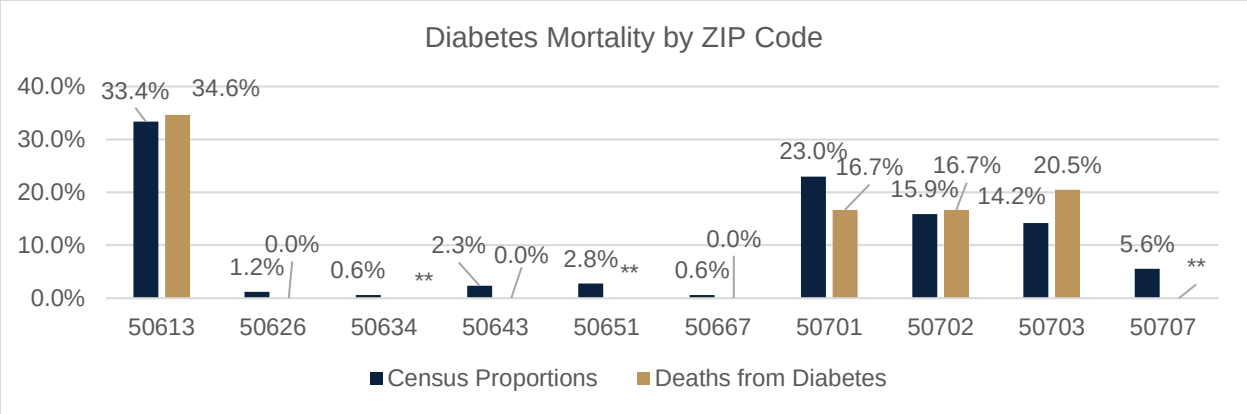
More BRFSS respondents reported having been diagnosed with diabetes from 2021 to 2022. Diabetes diagnoses were also disaggregated by race and ethnicity, as diabetes came up as a chronic disease concern in the community survey for Black or African American respondents as well as a few other groups. The 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.



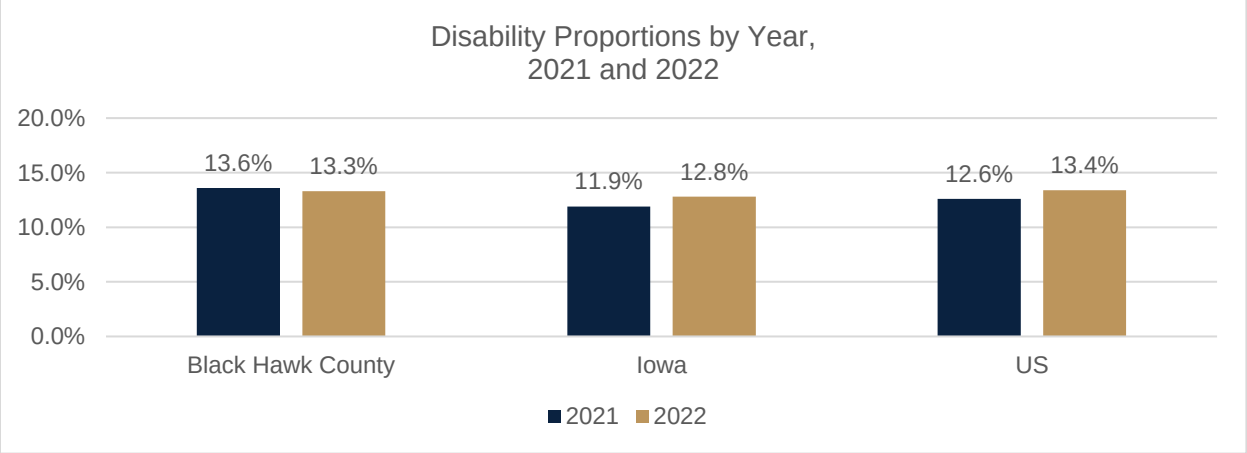


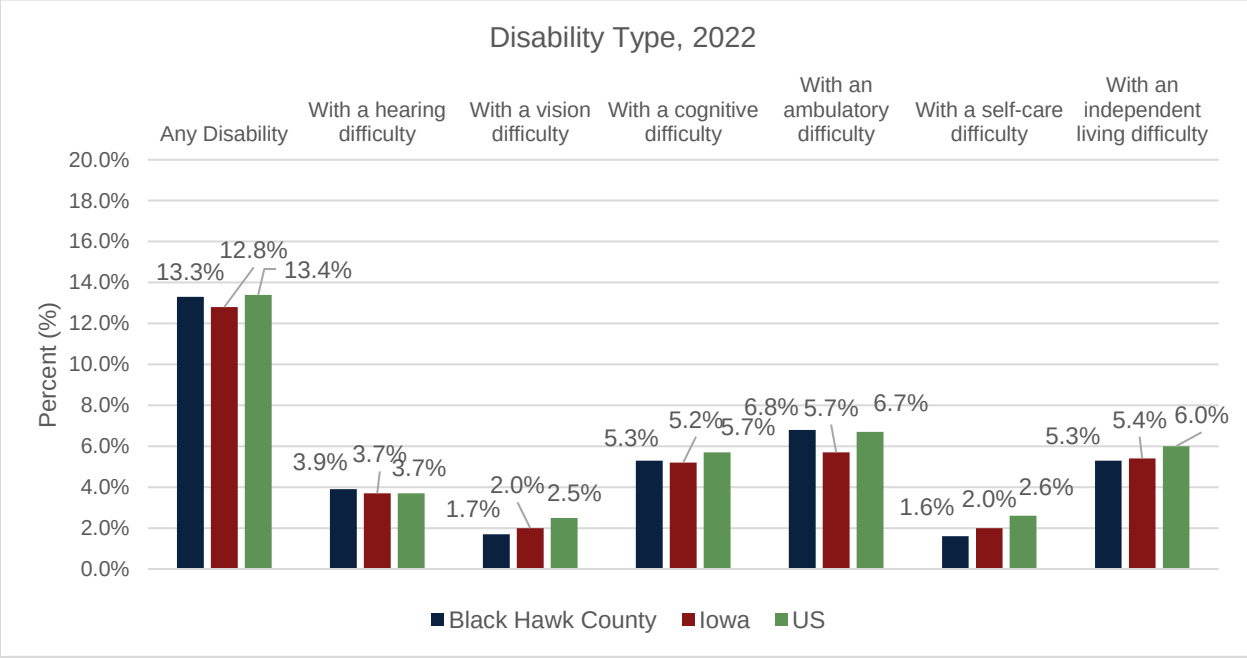
Type 2 Diabetes (ICD-10 Code E11) was also a diagnosis assessed in the IHA inpatient data, as it made up the largest proportion of all diabetes diagnoses. Data was disaggregated by race and ethnicity as well as ZIP code. Proportions for Black or African American individuals as well as those from ZIP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

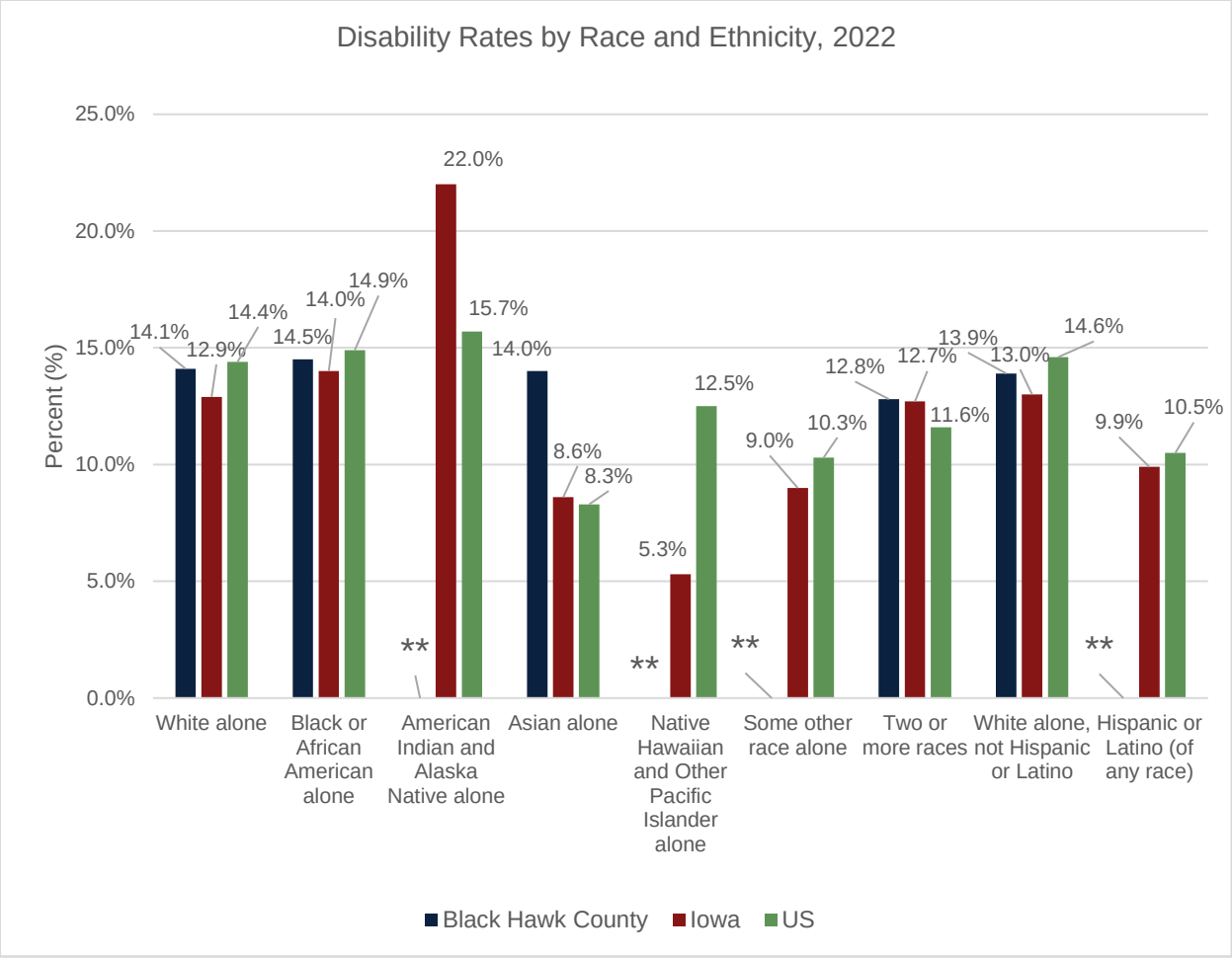




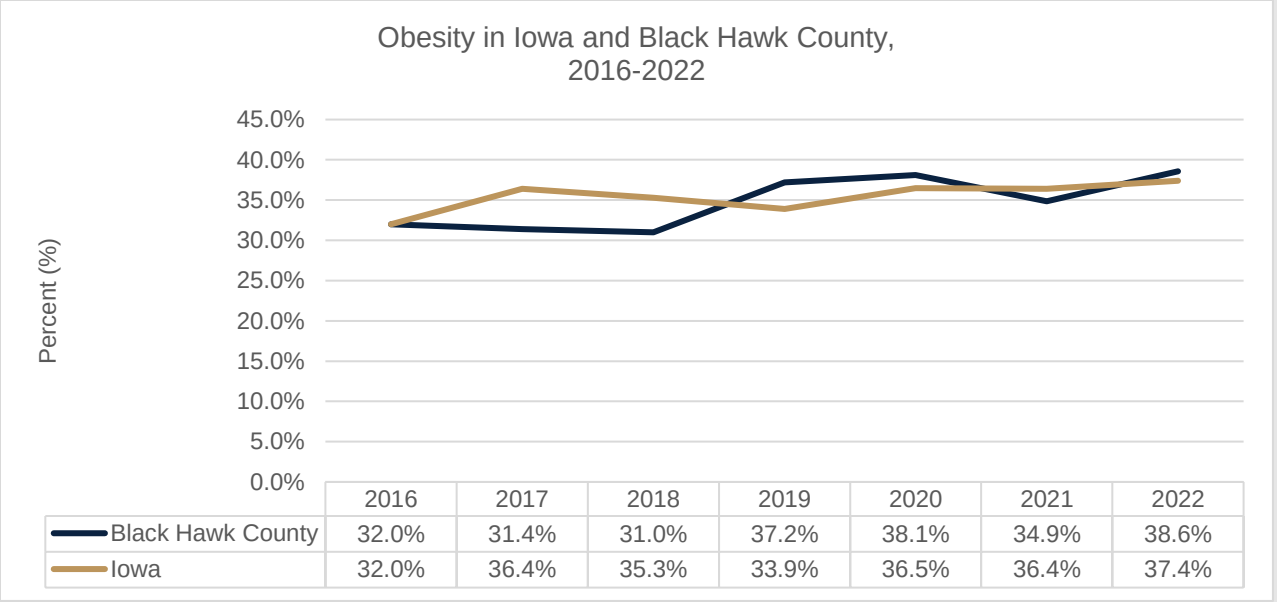
Diabetes mortality from the Vital Records- Mortality data (ICD-10 Codes E08-14) by race and ethnicity and ZIP code is shown above. Trends can be seen for both Black or African American individuals and those from 50703. These trends are similar to the IHA inpatient data.

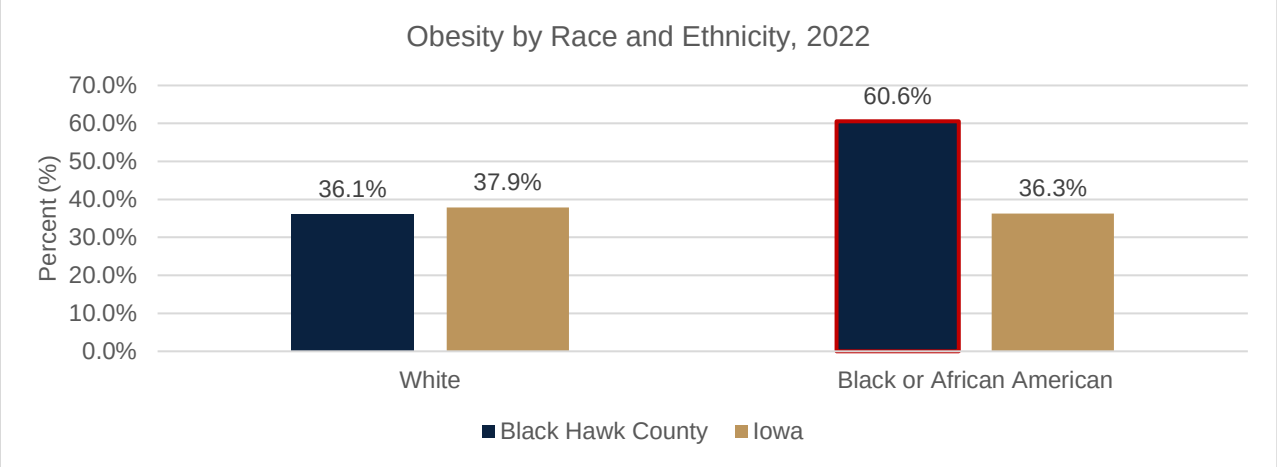






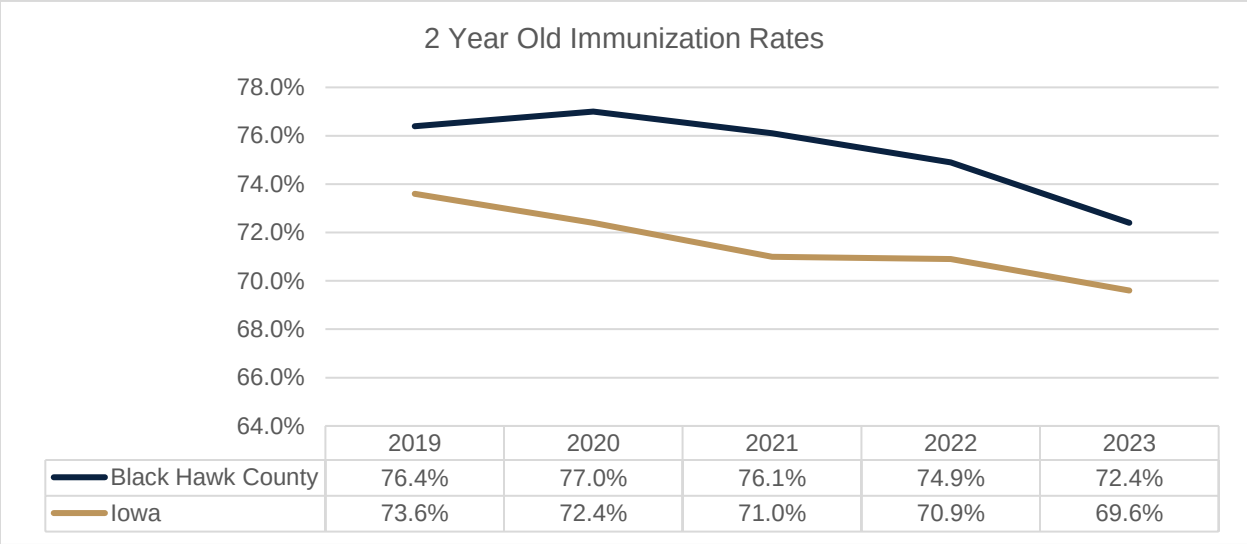
Disability rates for BHC, Iowa, and the US were similar between 2021 and 2022. However, in 2021, the BHC proportion was higher than both the Iowa and US proportions, while in 2022 it was similar to the US proportion. When disaggregated by disability type, the most common disabilities in BHC were cognitive 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.



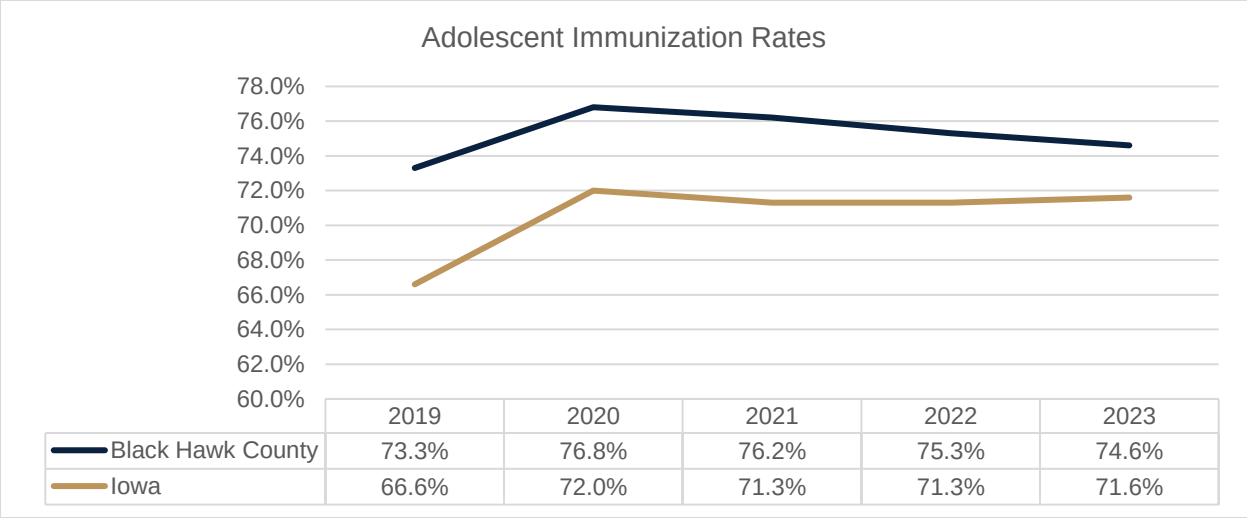


BRFSS respondents were asked questions about their height and weight, and from this information, Body Mass Index (BMI) was calculated to find obesity proportions. BHC data was calculated using BRFSS respondent data, and Iowa data was collected from the Iowa HHS Public Health Tracking Portal. From 2016 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

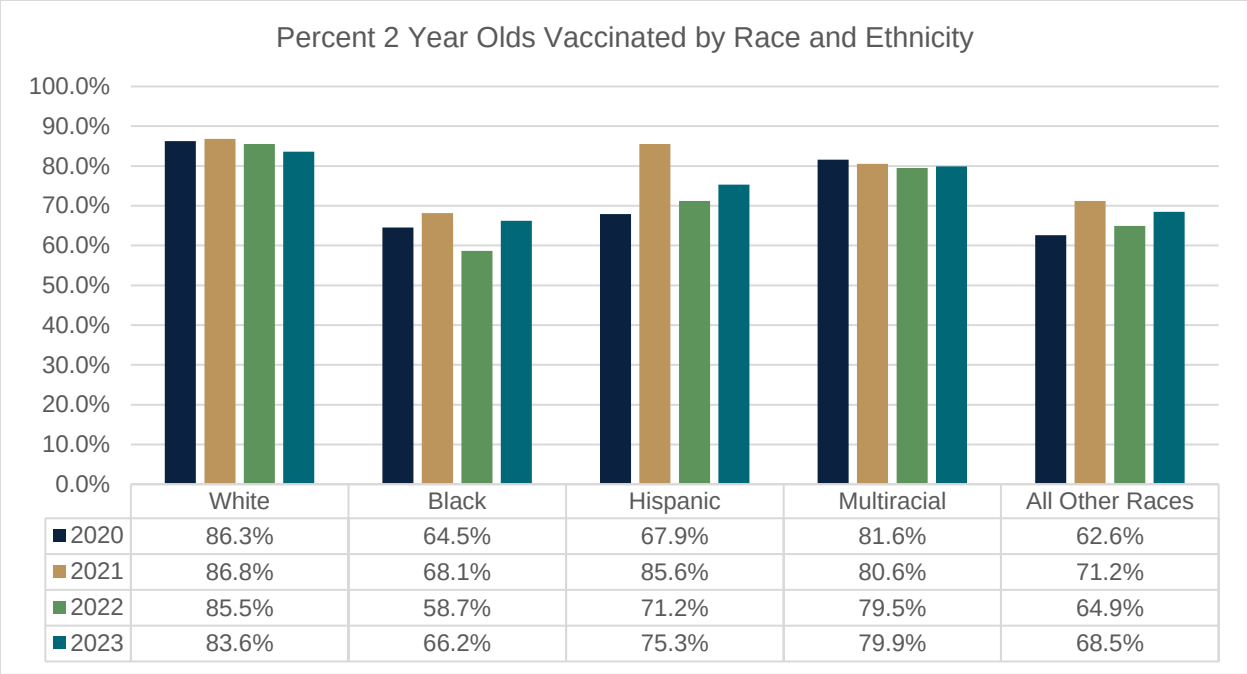


	2019	2020	2021	2022	2023
Black Hawk County	76.4%	77.0%	76.1%	74.9%	72.4%
Iowa	73.6%	72.4%	71.0%	70.9%	69.6%

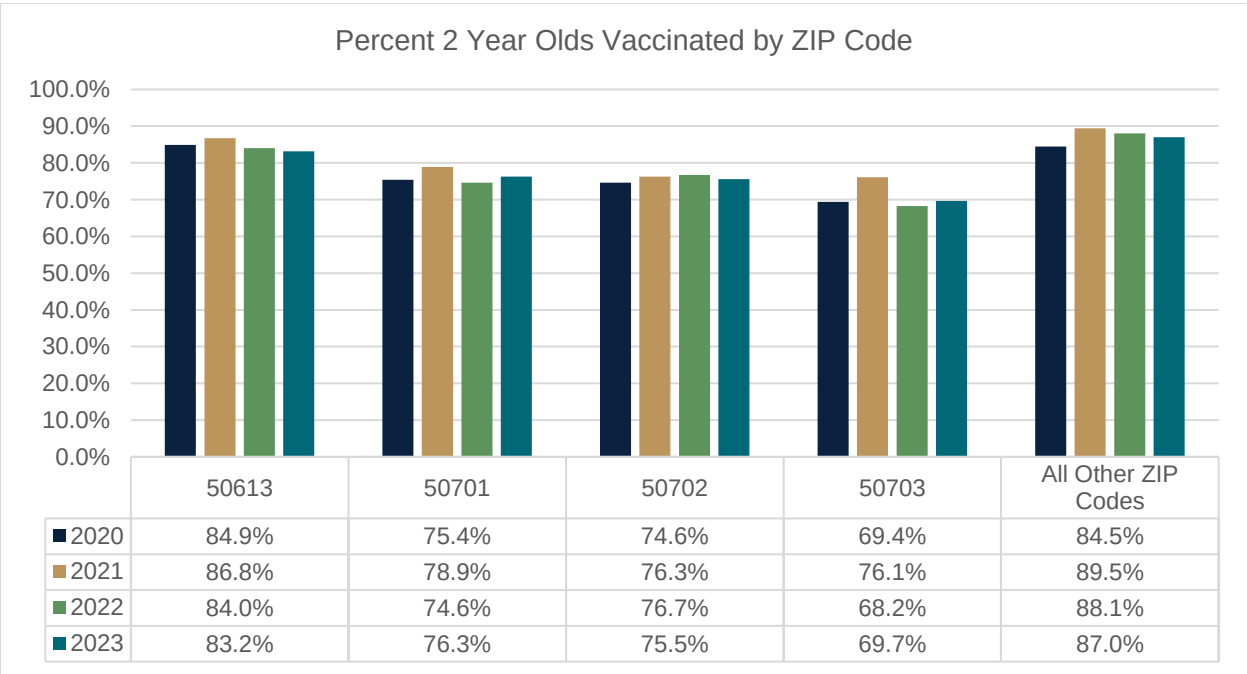


	2019	2020	2021	2022	2023
Black Hawk County	73.3%	76.8%	76.2%	75.3%	74.6%
Iowa	66.6%	72.0%	71.3%	71.3%	71.6%

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.

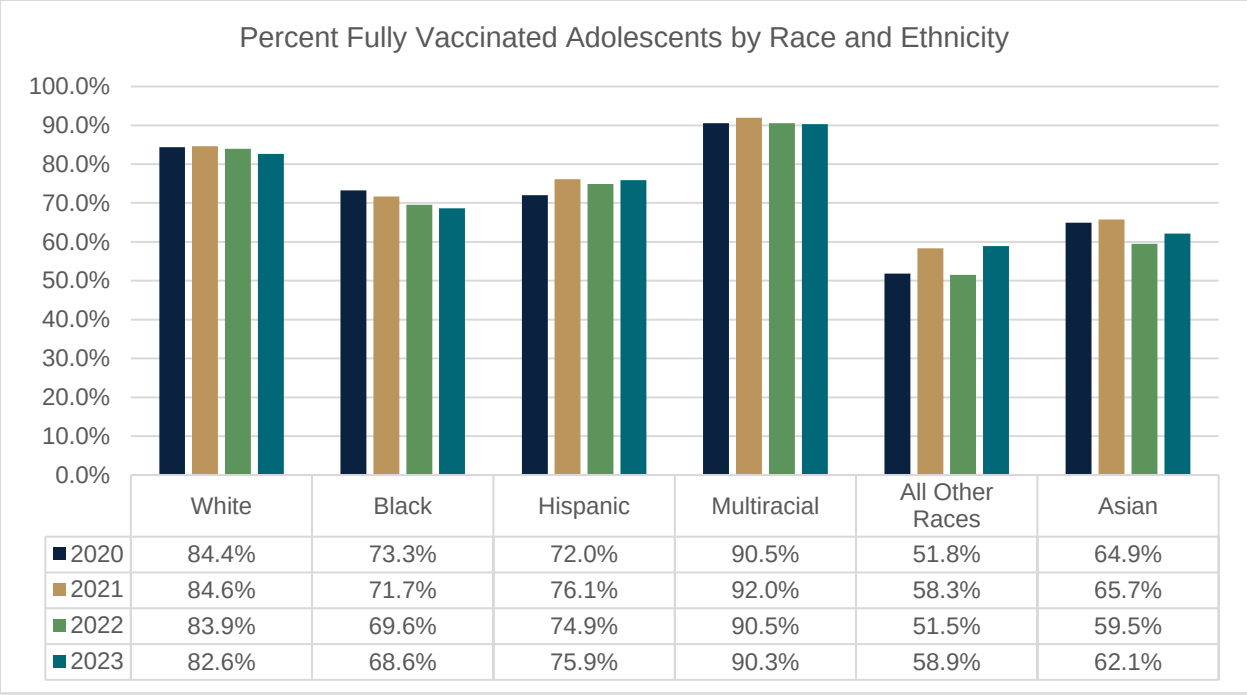


	White	Black	Hispanic	Multiracial	All Other Races
2020	86.3%	64.5%	67.9%	81.6%	62.6%
2021	86.8%	68.1%	85.6%	80.6%	71.2%
2022	85.5%	58.7%	71.2%	79.5%	64.9%
2023	83.6%	66.2%	75.3%	79.9%	68.5%

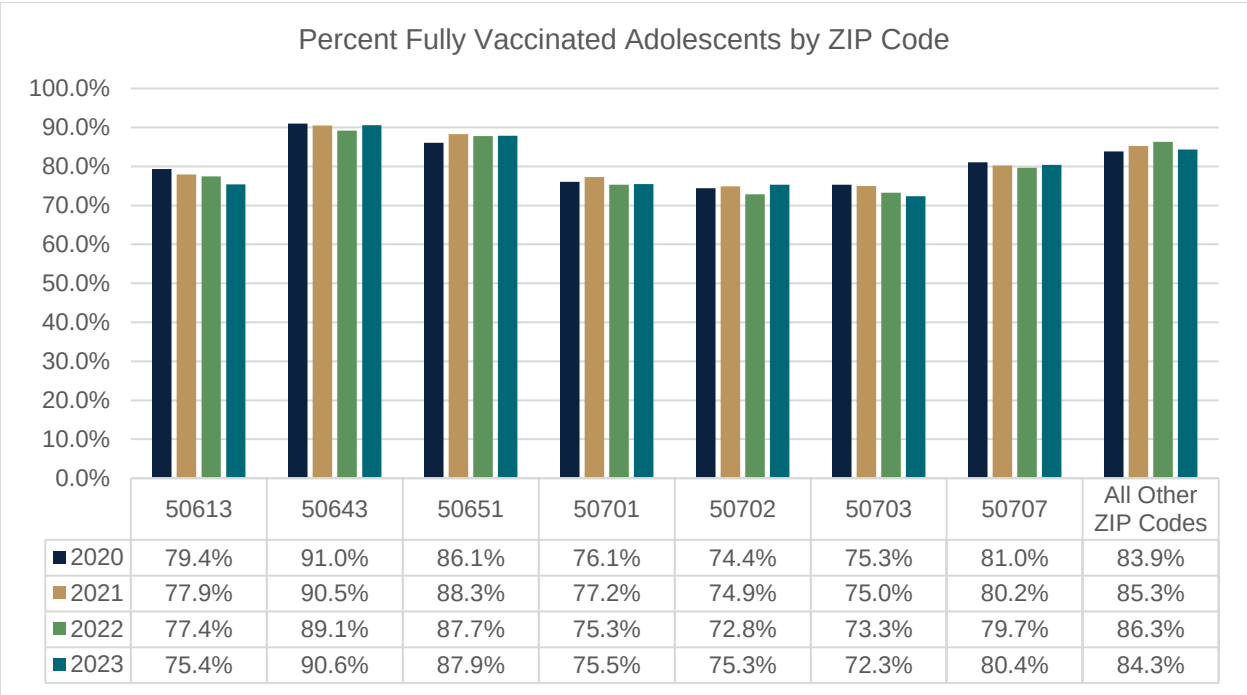


	50613	50701	50702	50703	All Other ZIP Codes
2020	84.9%	75.4%	74.6%	69.4%	84.5%
2021	86.8%	78.9%	76.3%	76.1%	89.5%
2022	84.0%	74.6%	76.7%	68.2%	88.1%
2023	83.2%	76.3%	75.5%	69.7%	87.0%

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.

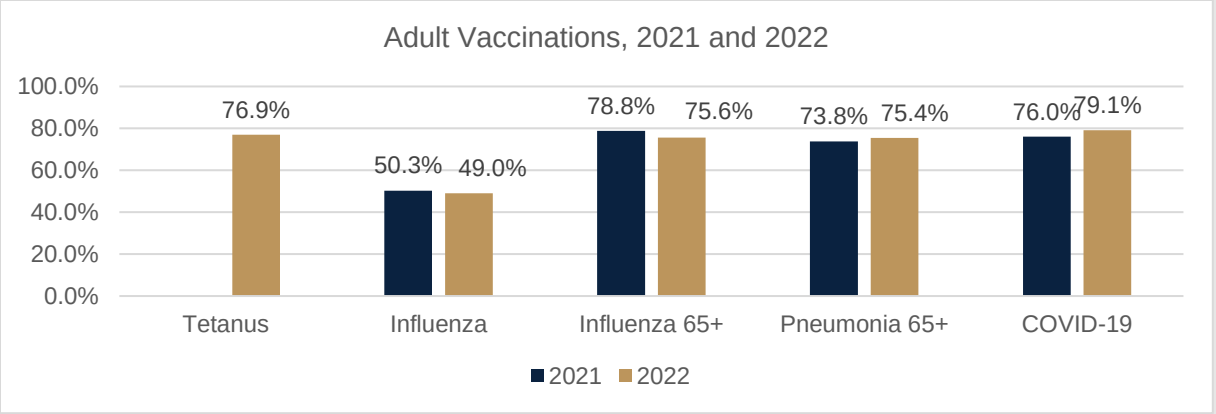


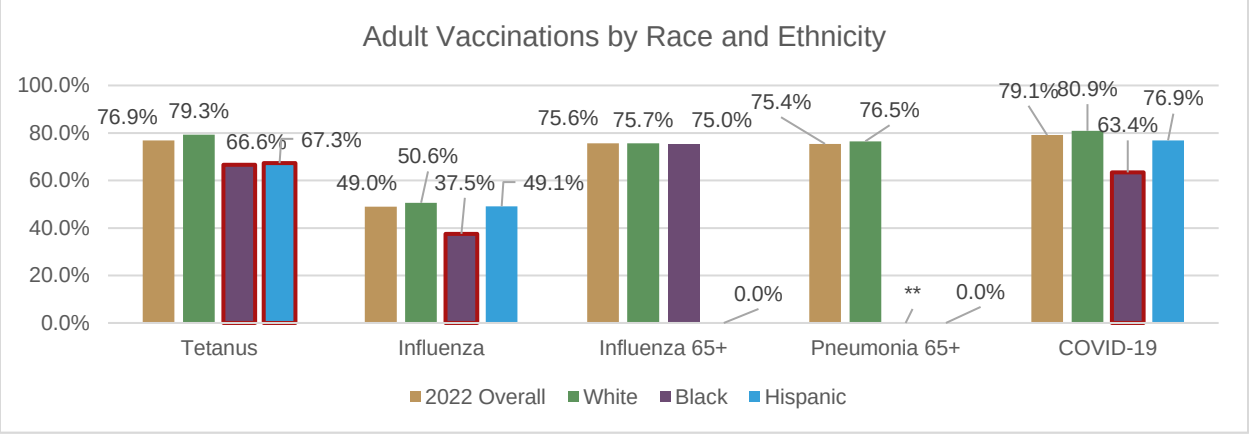
	White	Black	Hispanic	Multiracial	All Other Races	Asian
2020	84.4%	73.3%	72.0%	90.5%	51.8%	64.9%
2021	84.6%	71.7%	76.1%	92.0%	58.3%	65.7%
2022	83.9%	69.6%	74.9%	90.5%	51.5%	59.5%
2023	82.6%	68.6%	75.9%	90.3%	58.9%	62.1%



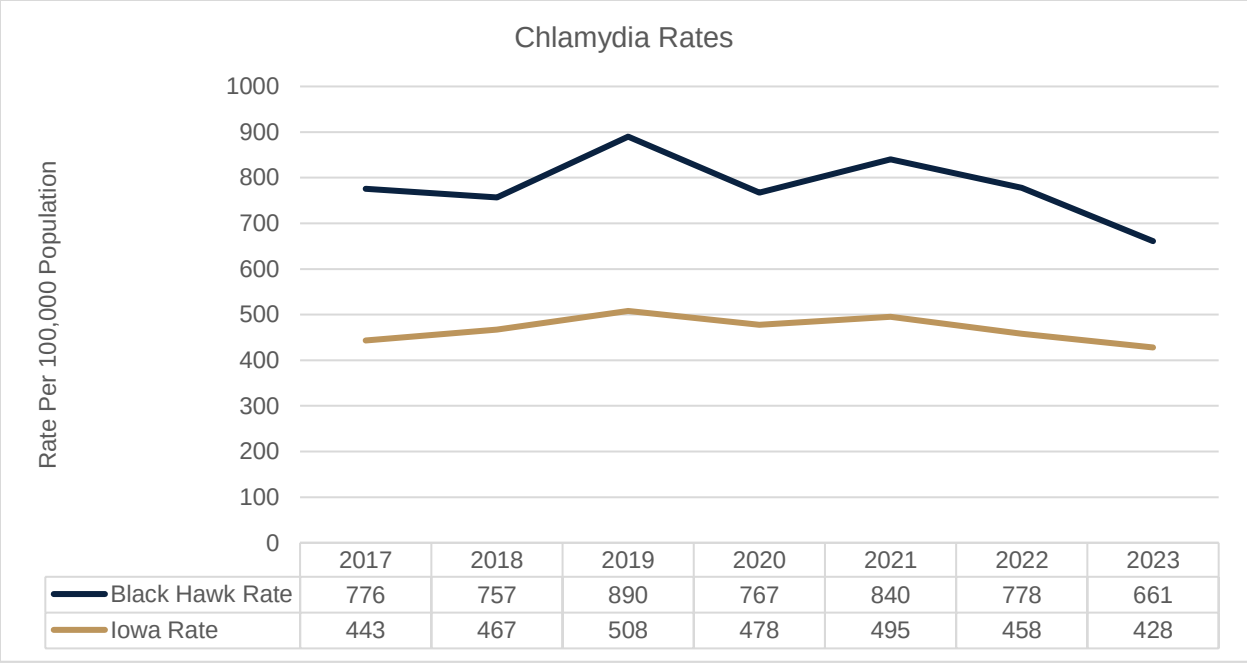
	50613	50643	50651	50701	50702	50703	50707	All Other ZIP Codes
2020	79.4%	91.0%	86.1%	76.1%	74.4%	75.3%	81.0%	83.9%
2021	77.9%	90.5%	88.3%	77.2%	74.9%	75.0%	80.2%	85.3%
2022	77.4%	89.1%	87.7%	75.3%	72.8%	73.3%	79.7%	86.3%
2023	75.4%	90.6%	87.9%	75.5%	75.3%	72.3%	80.4%	84.3%

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.



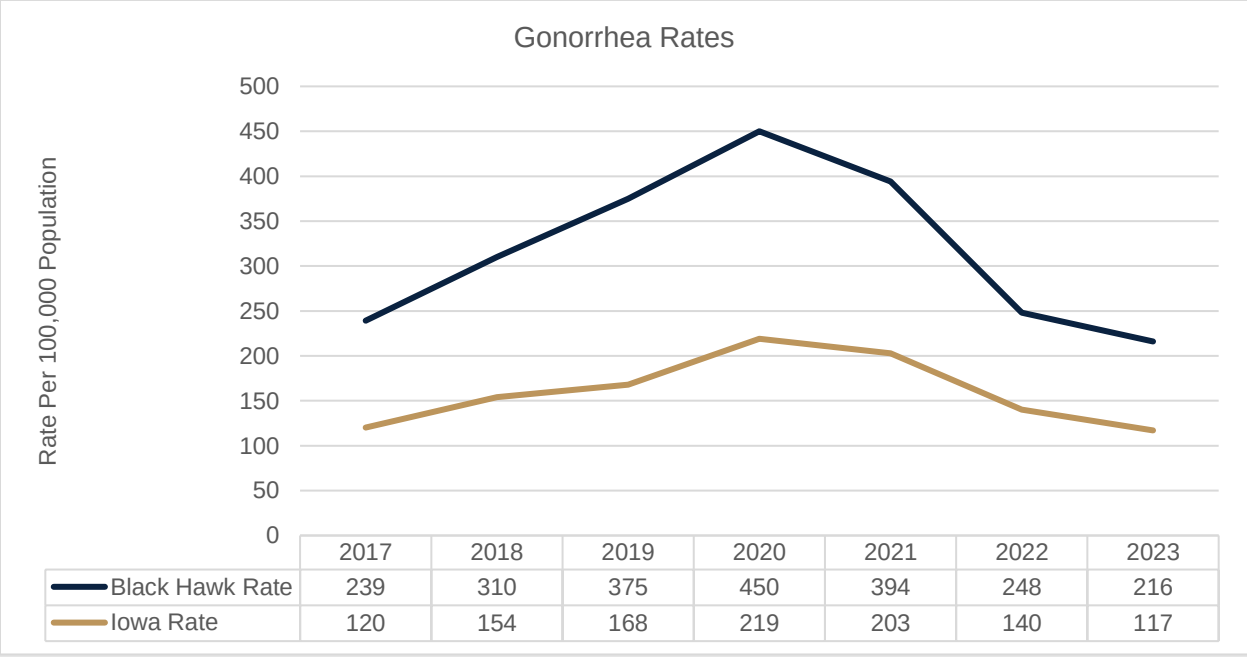


BRFSS respondents were asked about immunizations they had received as an adult including influenza, pneumonia, and COVID-19 in 2021 and 2022. Questions about tetanus vaccines were only asked in 2022. Influenza vaccines were assessed for adults 18 and older and 65 and older, while pneumonia shots were 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.



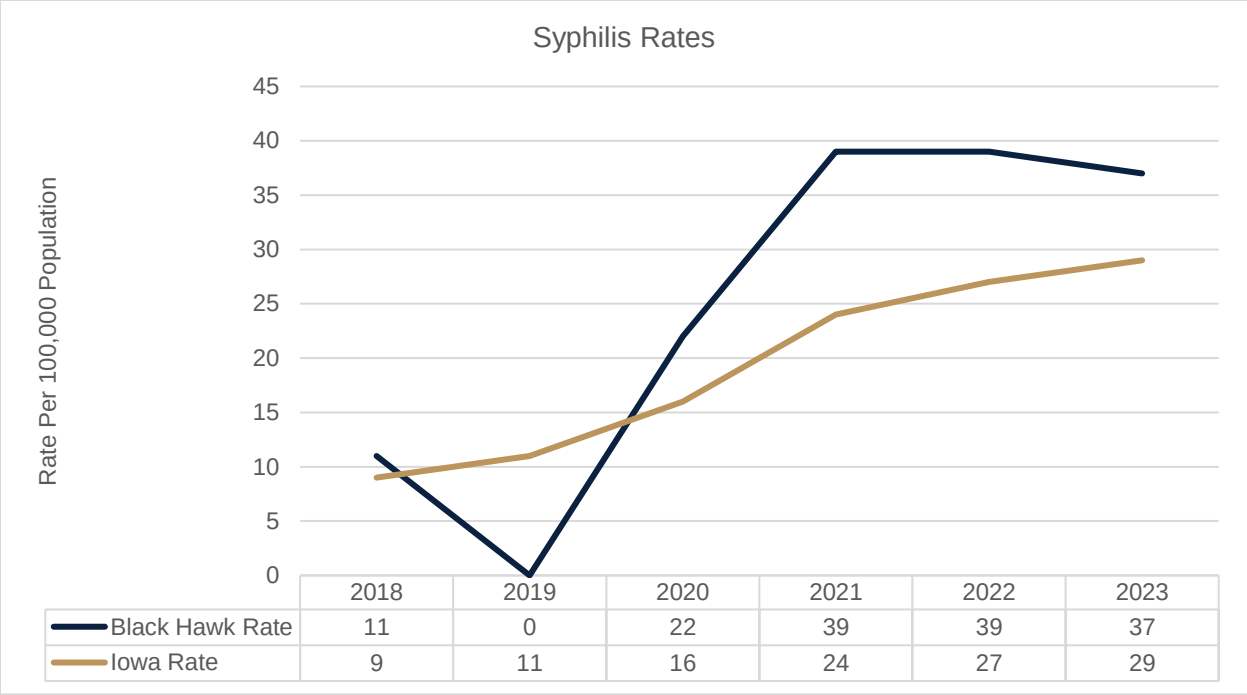
	2017	2018	2019	2020	2021	2022	2023
Black Hawk Rate	776	757	890	767	840	778	661
Iowa Rate	443	467	508	478	495	458	428

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.

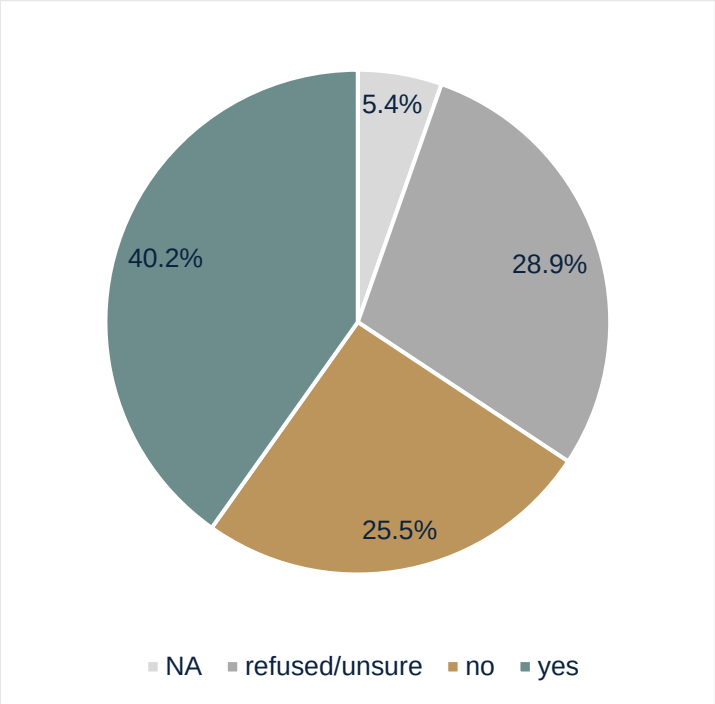


	2017	2018	2019	2020	2021	2022	2023
Black Hawk Rate	239	310	375	450	394	248	216
Iowa Rate	120	154	168	219	203	140	117

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.

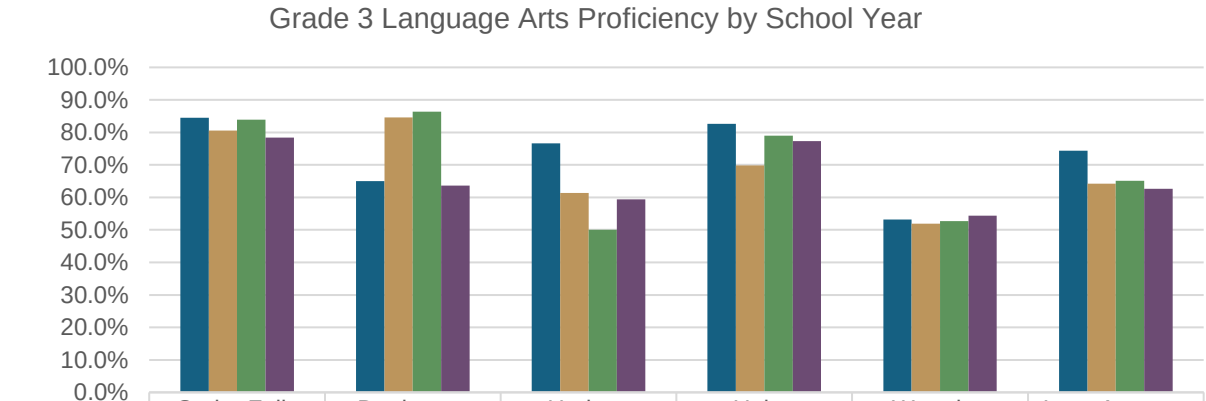


Iowa Public Health Tracking Portal data on syphilis shows rates for Iowa and BHC from 2018 to 2023. The syphilis rate has been increasing for the past several years at the state level. Although the BHC rate is higher than Iowa's, the case rates from 2021 to 2023 have been steady while the Iowa rate is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

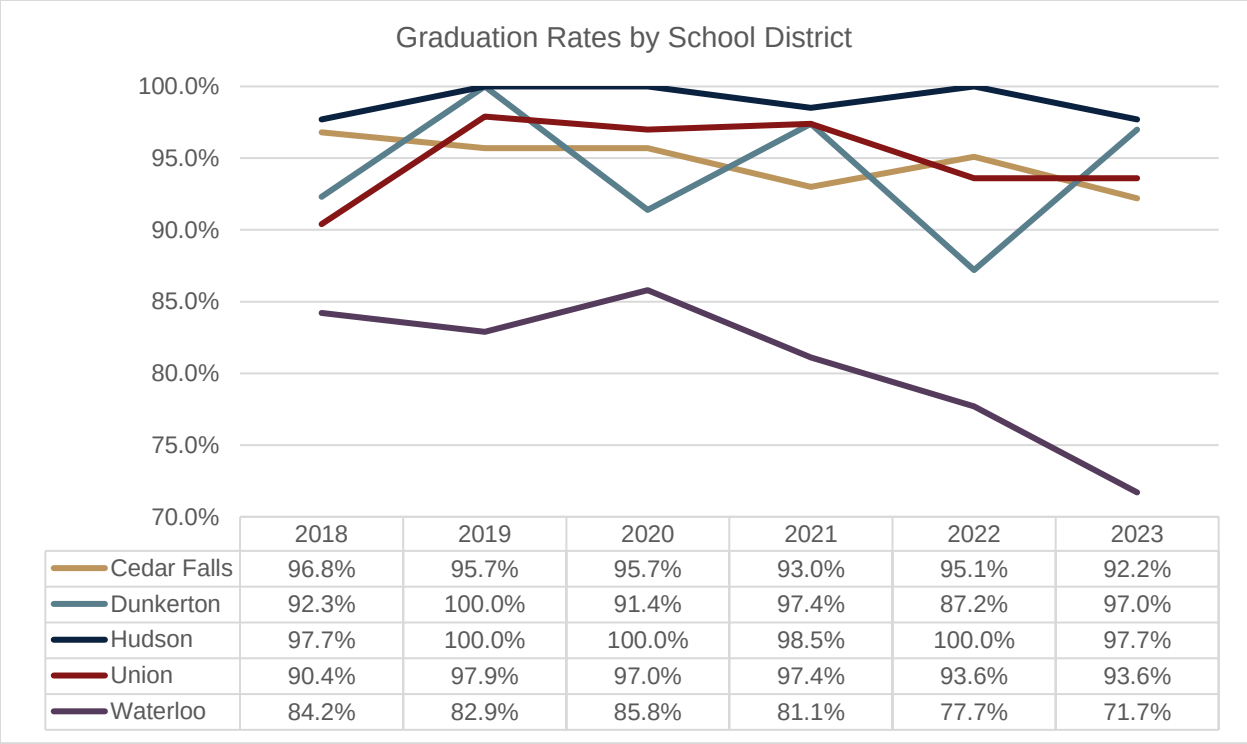
Cultural and Linguistic Inclusivity



	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%

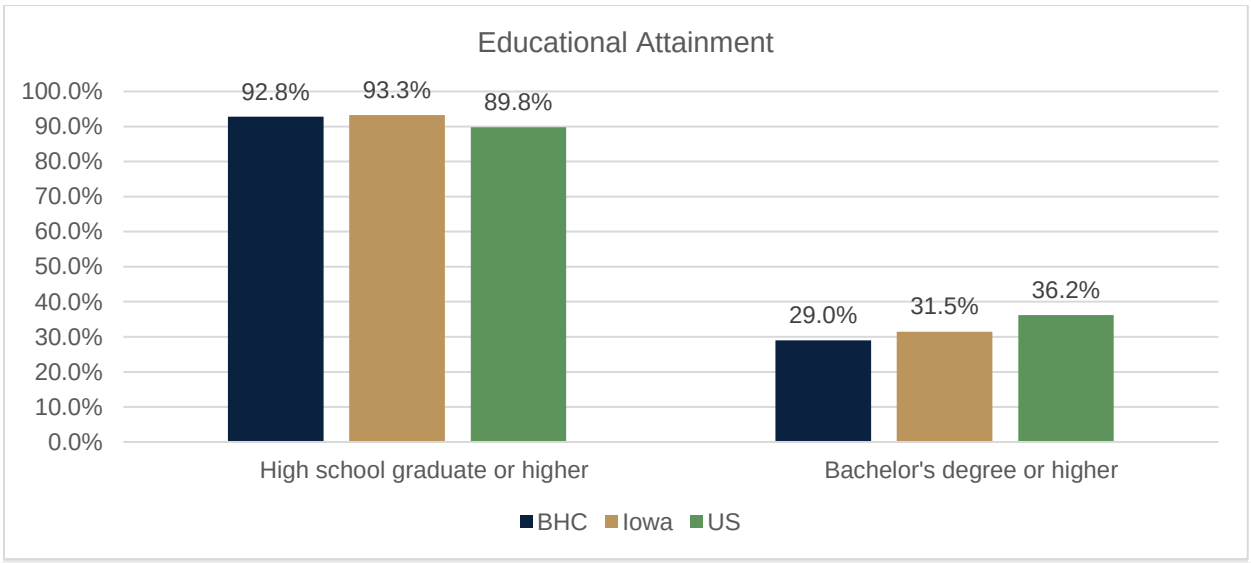
The Iowa Department of Education gathers data on grade 3 language arts proficiency for each public school. There are disparities by race and ethnicity and program, but all groups reflect the district disparity with Waterloo schools having consistently lower proficiency and Cedar Falls having higher proportions. 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.

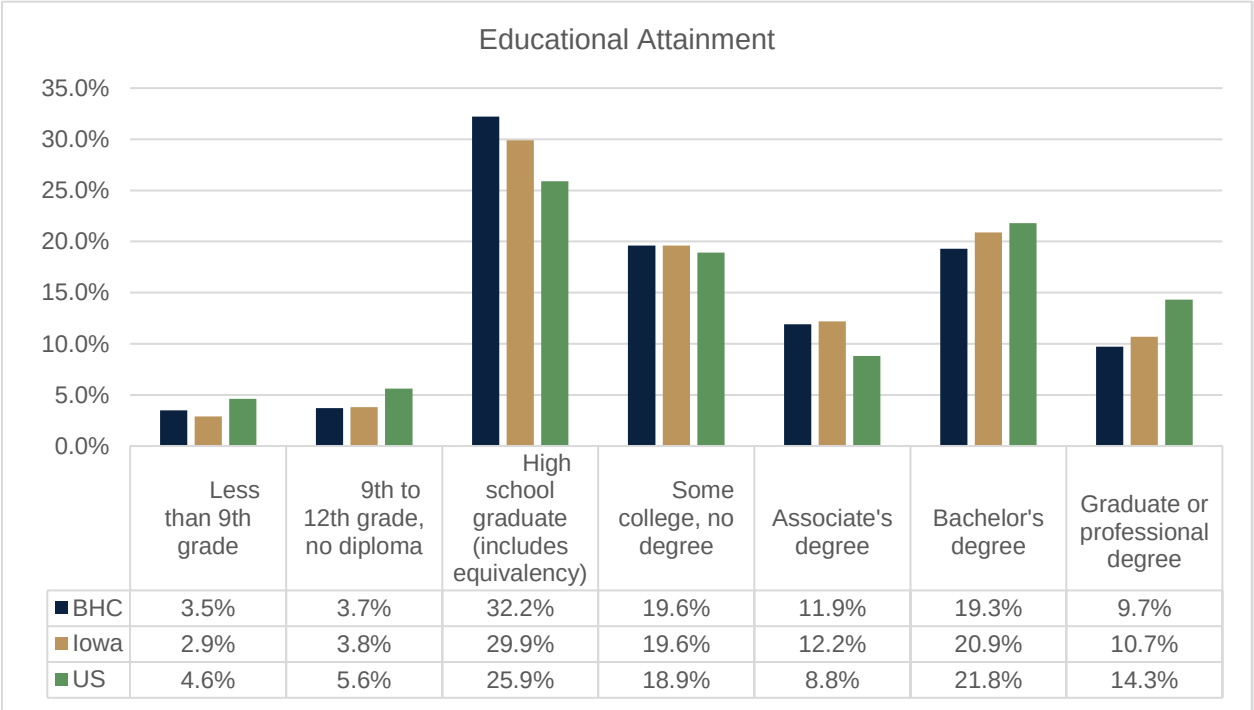
The Iowa Department of Education collects data on ELL in public schools. The word cloud above shows languages spoken by ELL students across Iowa. Locally, many languages are spoken by ELL students including Bosnian, Burmese, Creole-Haitian, French, Karen languages, Marshallese, and Spanish.



	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%

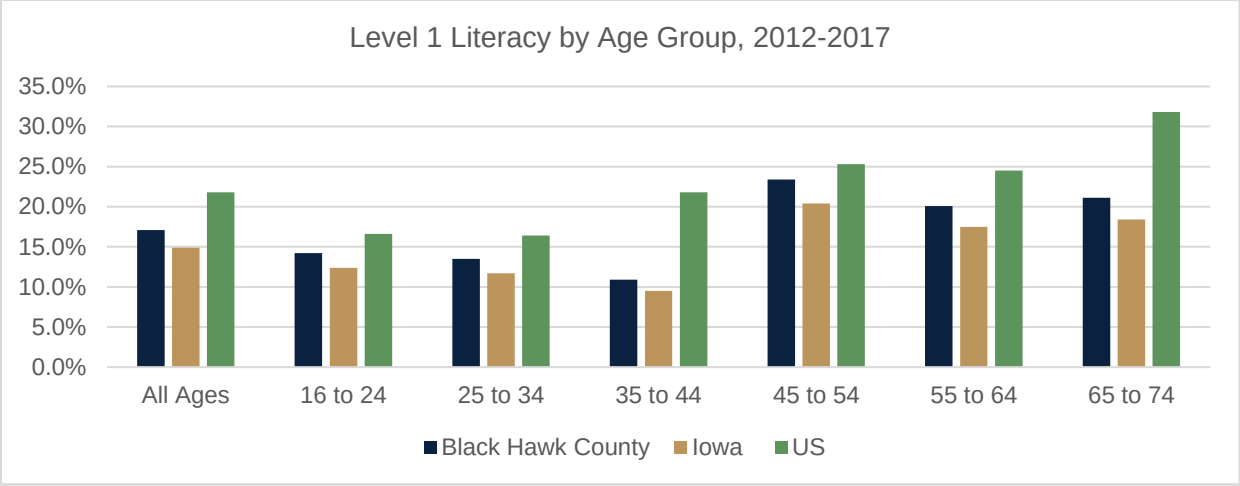
The Iowa Department of Education collects data on graduation rates. Data on the public-school districts from 2018 to 2023 show that graduation rates vary across years. However, there is a disparity between the rates of the other school districts and Waterloo. Waterloo schools averaged 80.6% graduation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

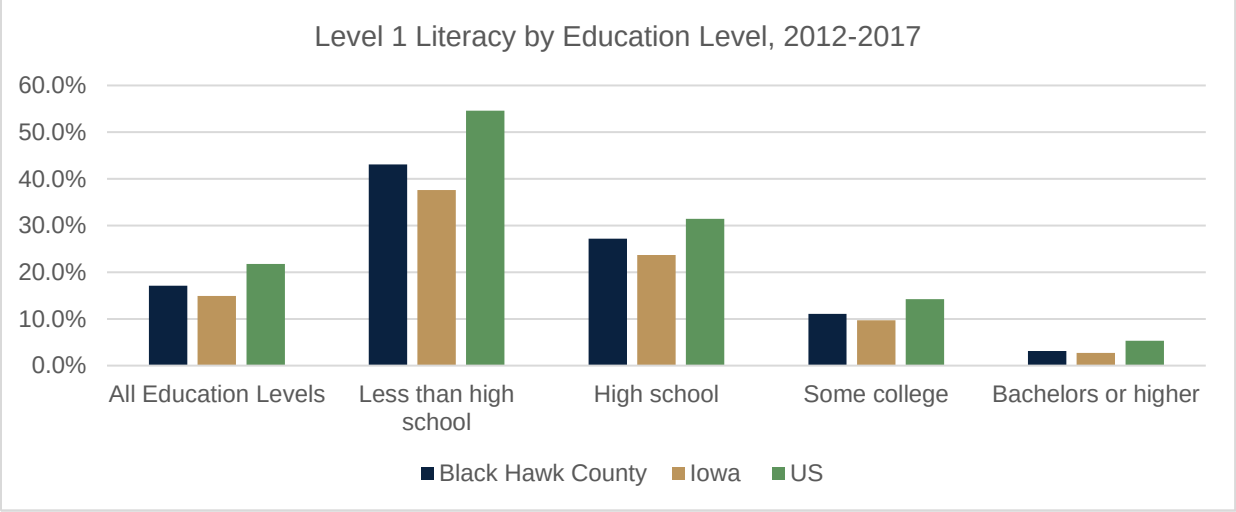




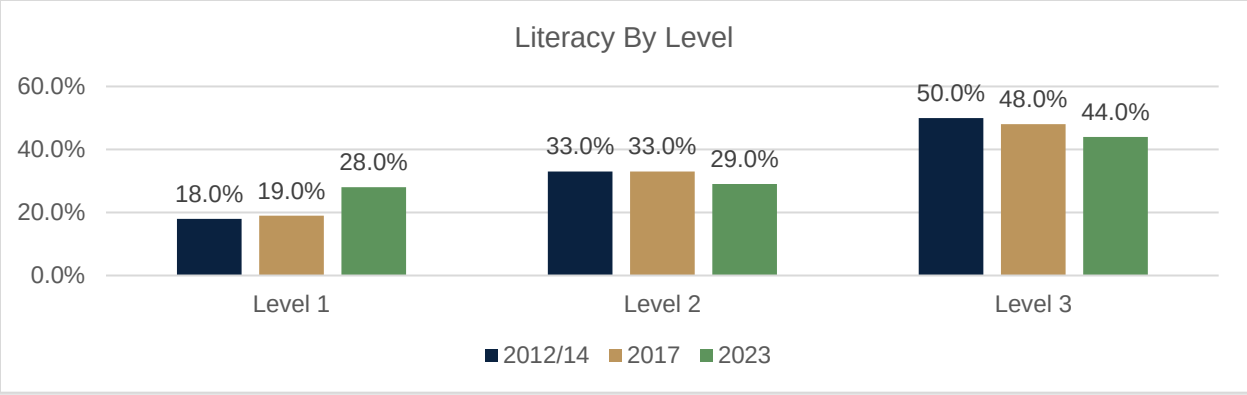
	Less than 9th grade	9th to 12th grade, no diploma	High school graduate (includes equivalency)	Some college, no degree	Associate's degree	Bachelor's degree	Graduate or professional degree
BHC	3.5%	3.7%	32.2%	19.6%	11.9%	19.3%	9.7%
Iowa	2.9%	3.8%	29.9%	19.6%	12.2%	20.9%	10.7%
US	4.6%	5.6%	25.9%	18.9%	8.8%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

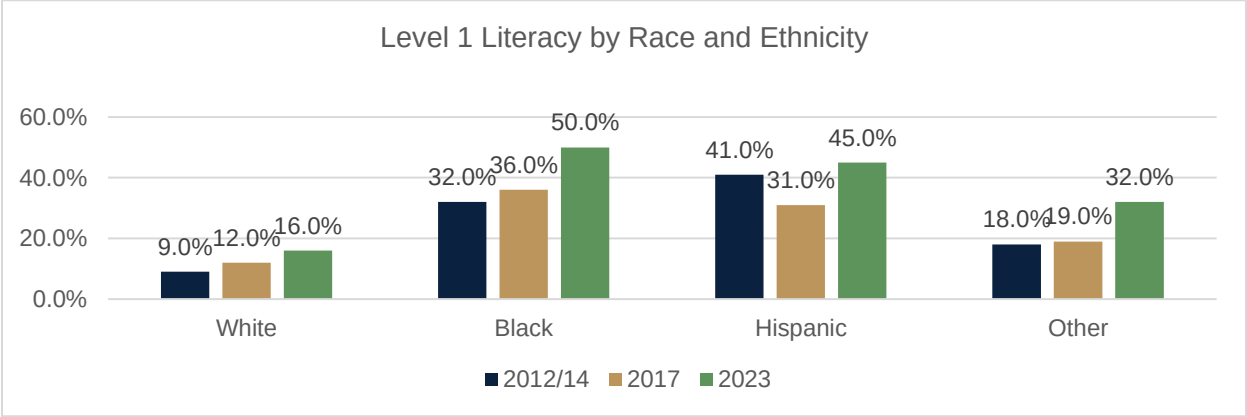


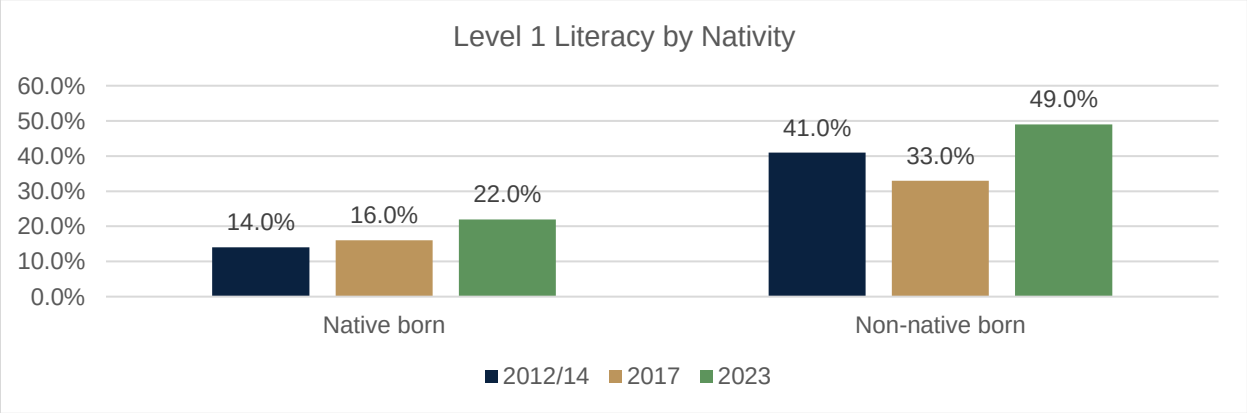


The Program for the International Assessment of Adult Competencies (PIAAC) is a test administered about every 5 years to assess proficiency in different areas including adult literacy. Results from 2012/14 (results from these two specific years are always combined to form one group) and 2017 were combined 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.



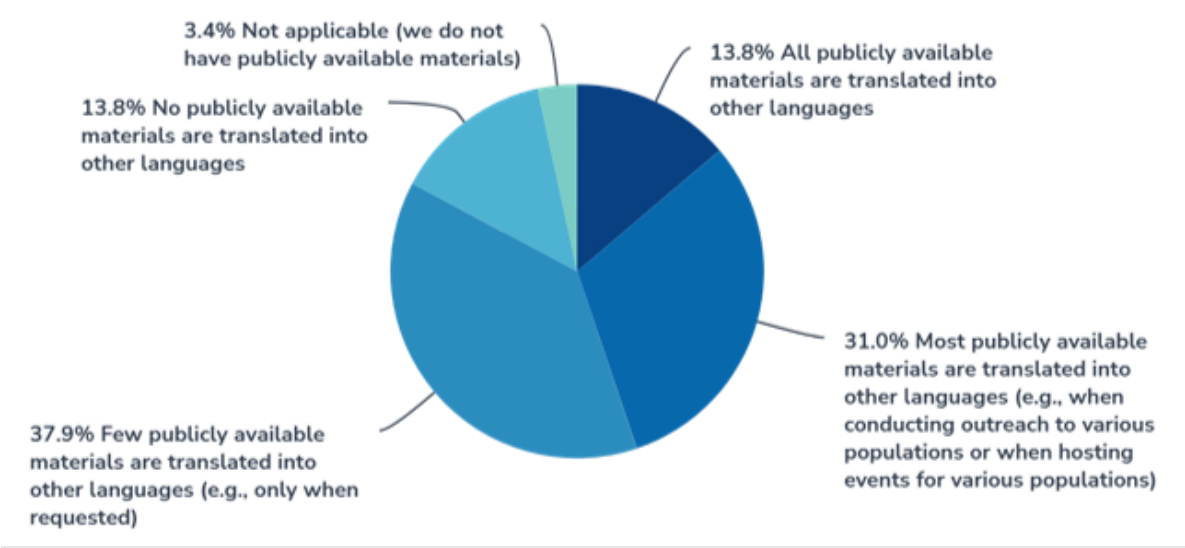
PIAAC literacy national results are shown by level and year. Proportions of adults testing at level 1 has been increasing from 2012/14 (combined to form one group) to 2023, and proportions of adults testing at level 3 is decreasing during the same time period.

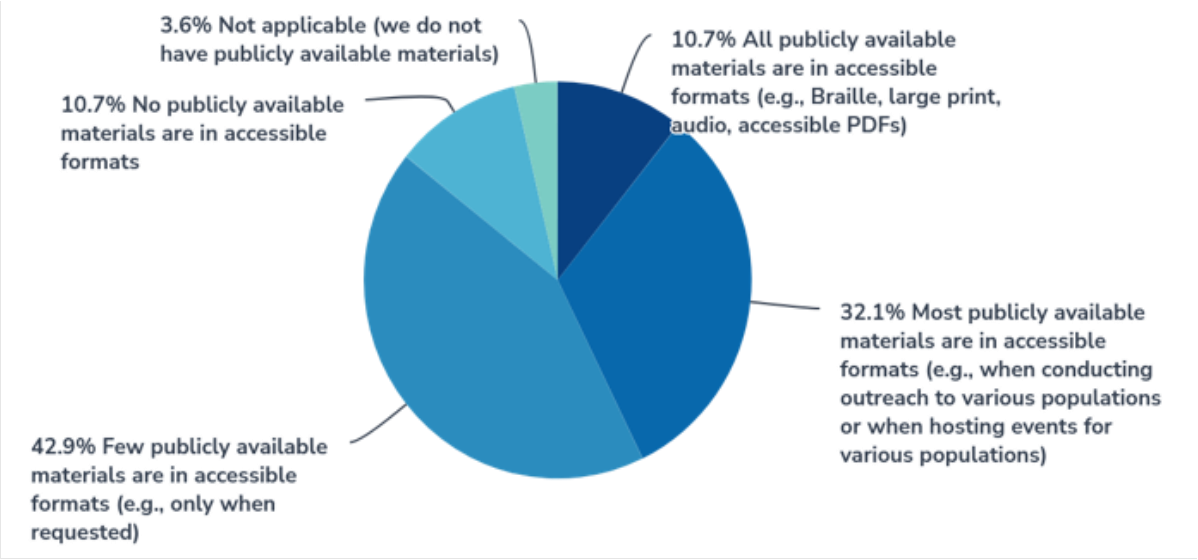




National PIAAC results were also disaggregated by race and ethnicity and nativity status. Those who identify as Black, Hispanic, or Other Race are more likely to be at or below level 1 than those who identify as white. All racial and ethnic groups were more likely to test at or below level 1 in 2023 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.

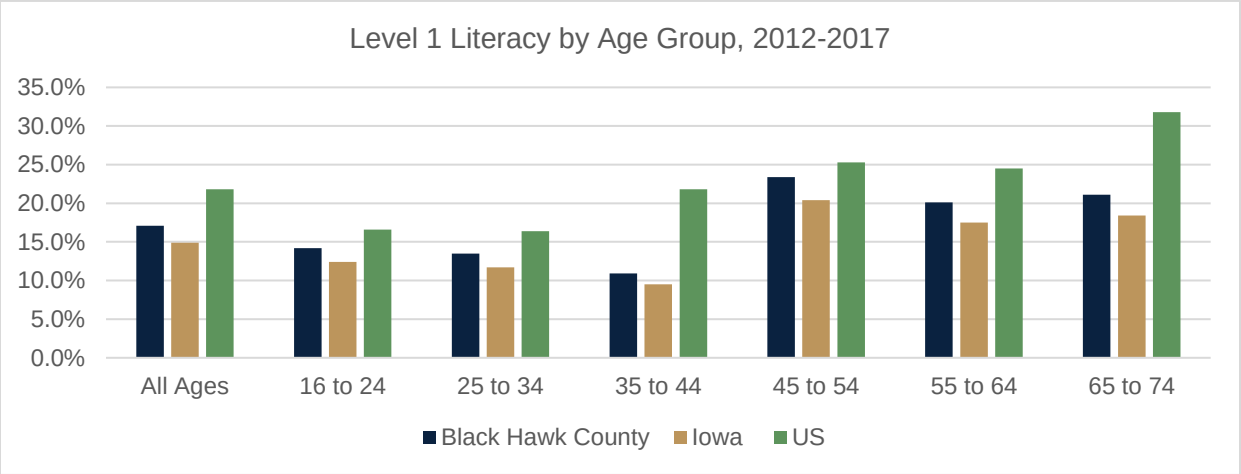
In the community survey, 2.8% of respondents said that they did not receive mental health services due to a lack of providers that speak the same language or share the same culture. Also, 10.5% of respondents said they did not receive services due to being unable to find a provider that they connect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

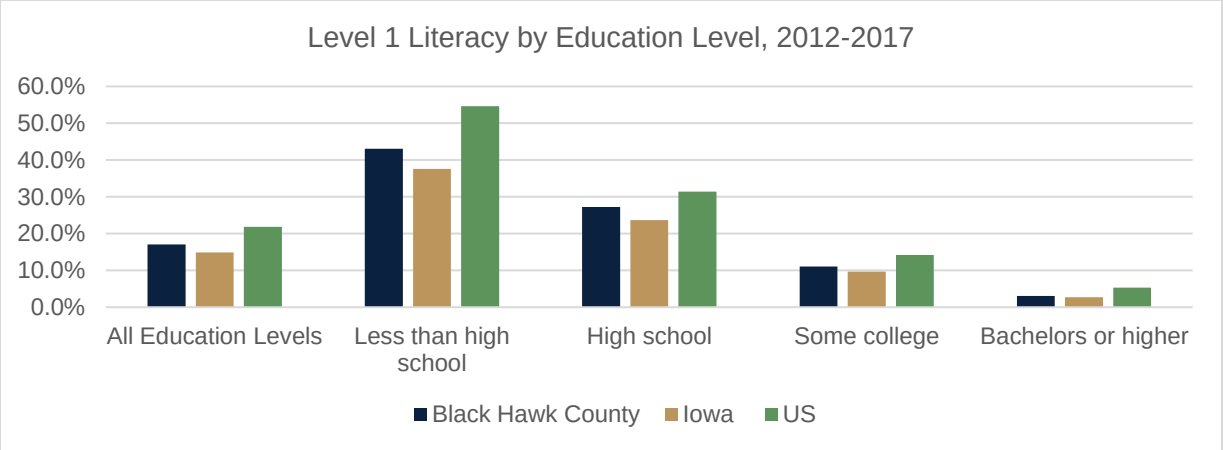




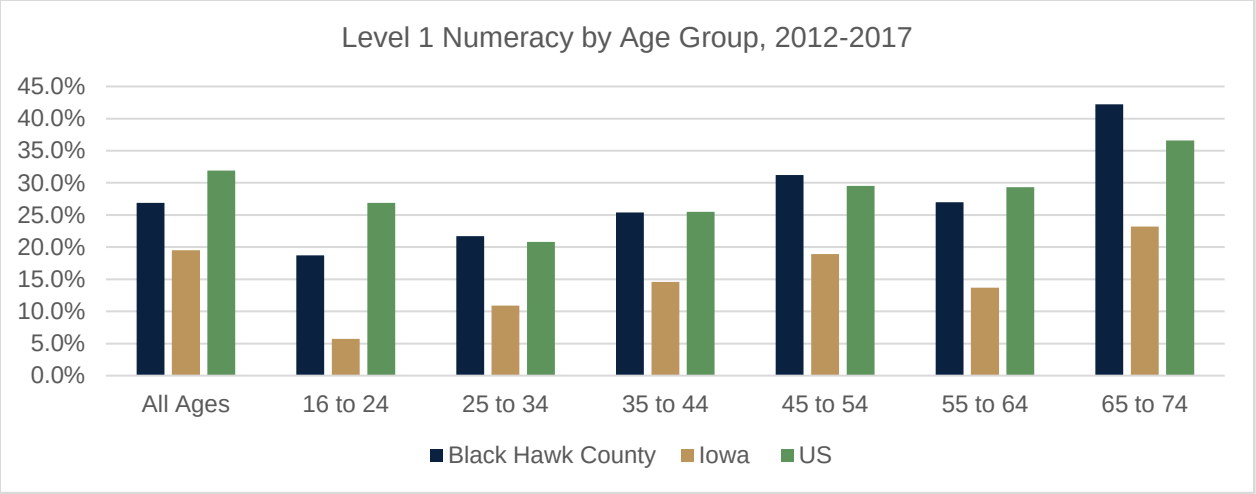
The Community Partner Assessment (CPA) survey contained several questions about culturally and linguistically accessible materials and methods. This included accessibility, availability, and translations. A little under half of respondents indicated that all or most publicly available materials were 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.

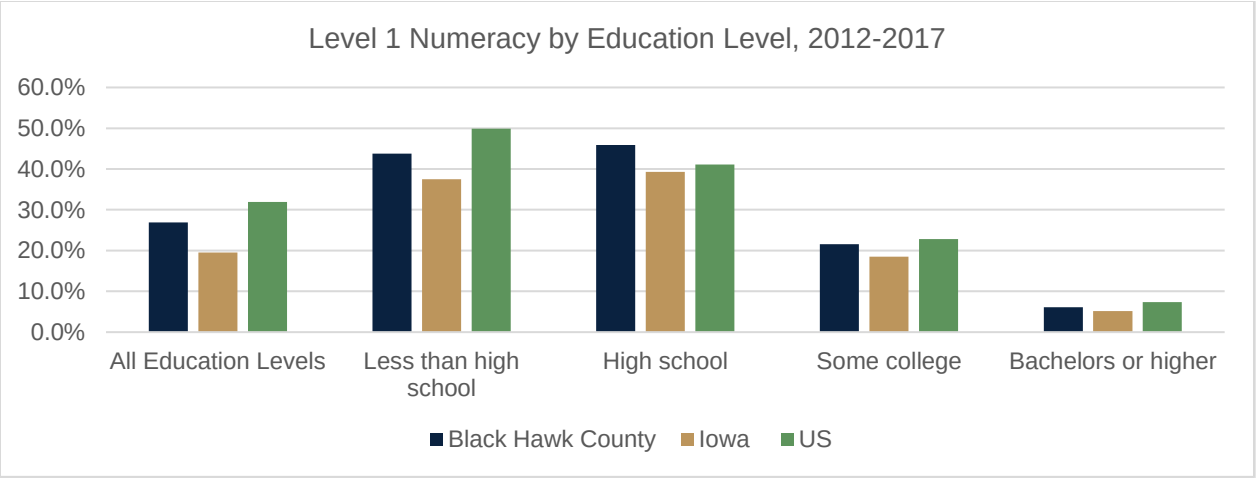
Health Literacy



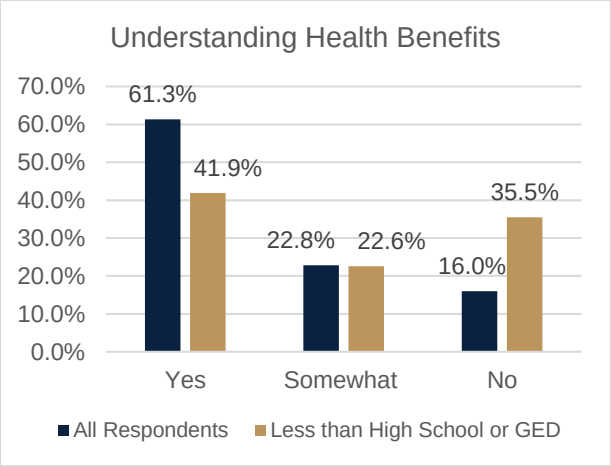


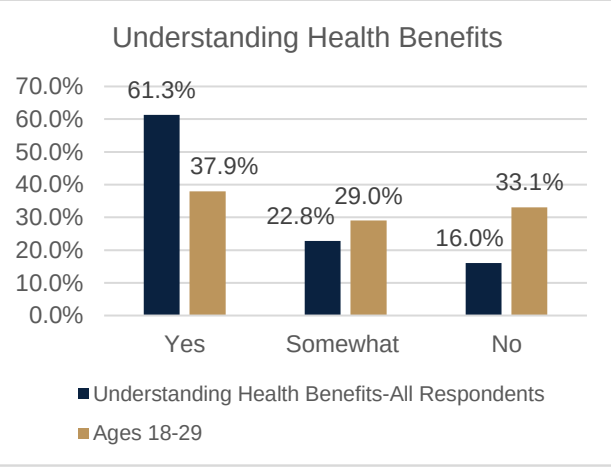
Data from PIAAC for at or below level 1 literacy results from 2012/14 (combined to form one group) and 2017 were combined to produce small-area estimates at both the state and county levels. The data, broken down by age group and education, shows that individuals aged 45 and older and those with a high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



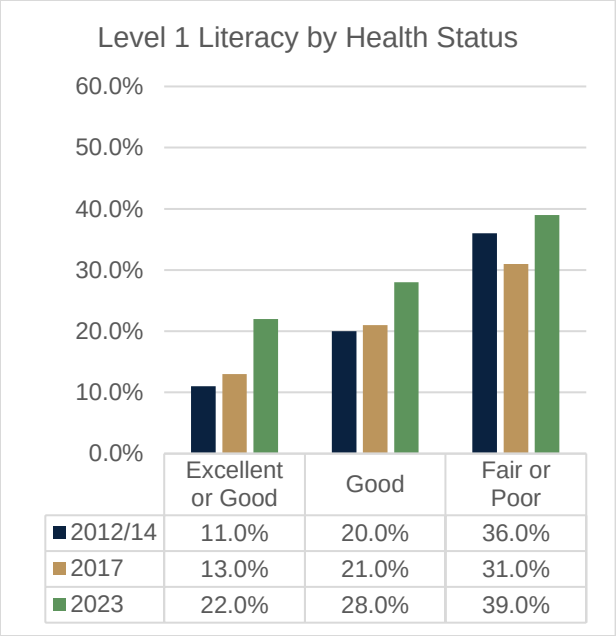


Numeracy, which is the ability to understand and make decisions based on numeric information, is also measured by PIAAC. Similar small-area estimates for 2012/14 and 2017 indicate that older adults, 45 and older, and those with lower levels of education, less than high school or only a high school diploma,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

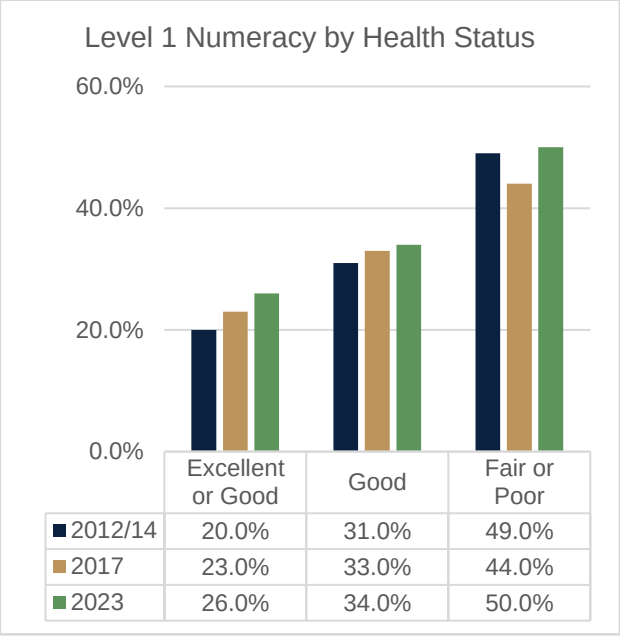




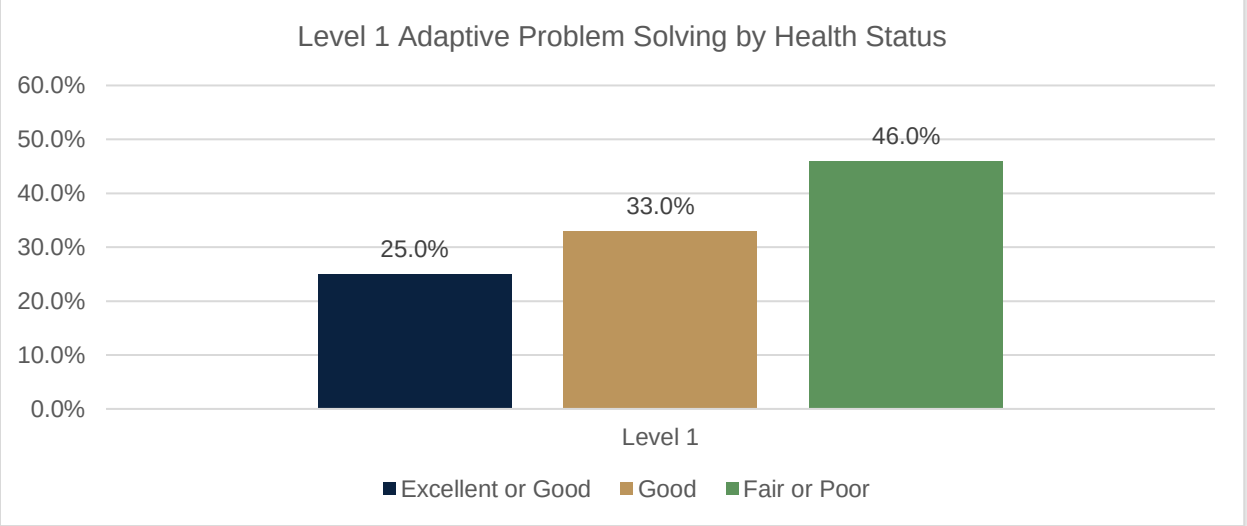
Data from the community survey showed that 61.3% of respondents reported understanding their health benefits. An answer was considered they understood their benefits by answering either a 4 or 5 on a 5-point Likert scale, an answer of 1 or 2 indicated they didn't understand their health benefits, and 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

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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

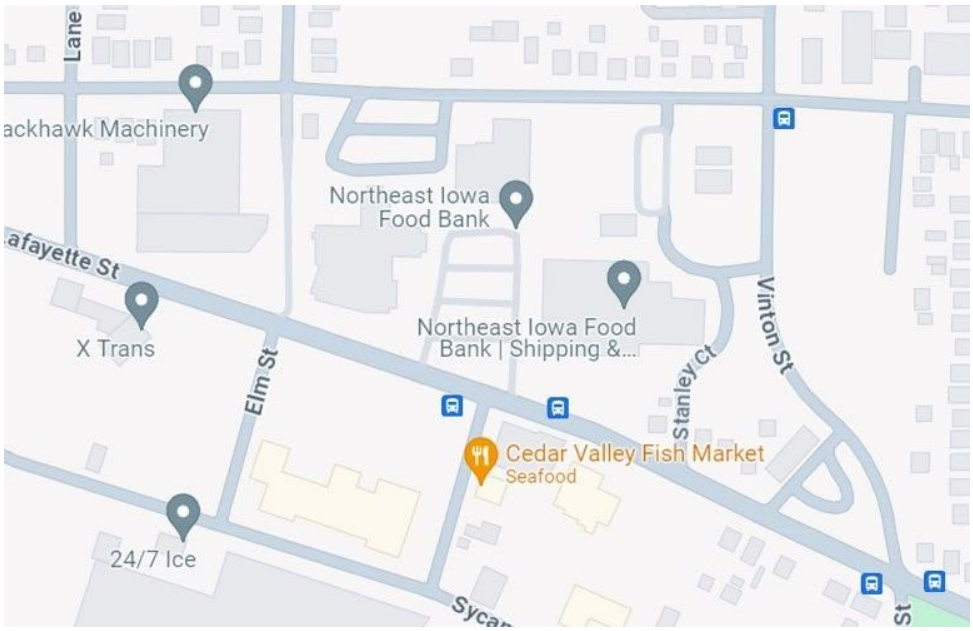
The following pages show the results of the key informant interviews and walking/windshield survey for each of the four regions.

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.

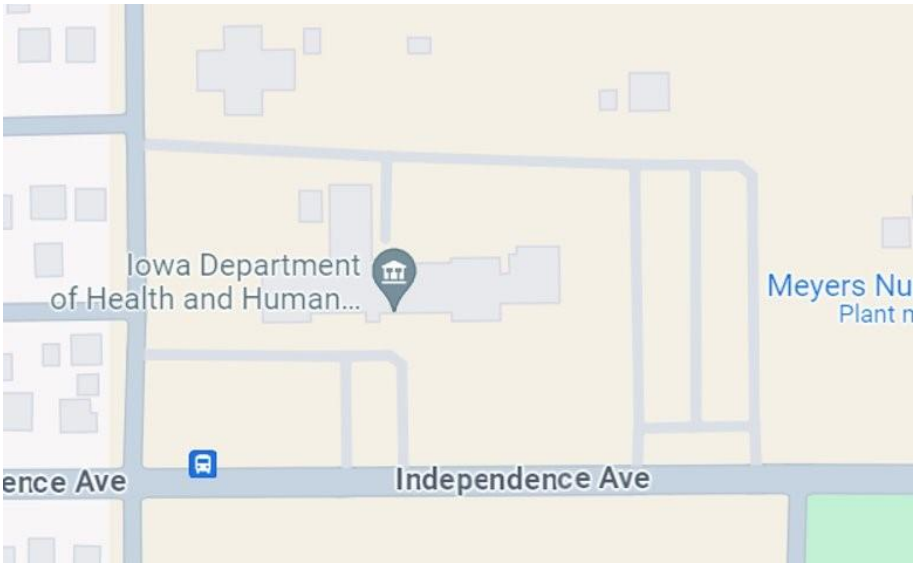


Region B

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.

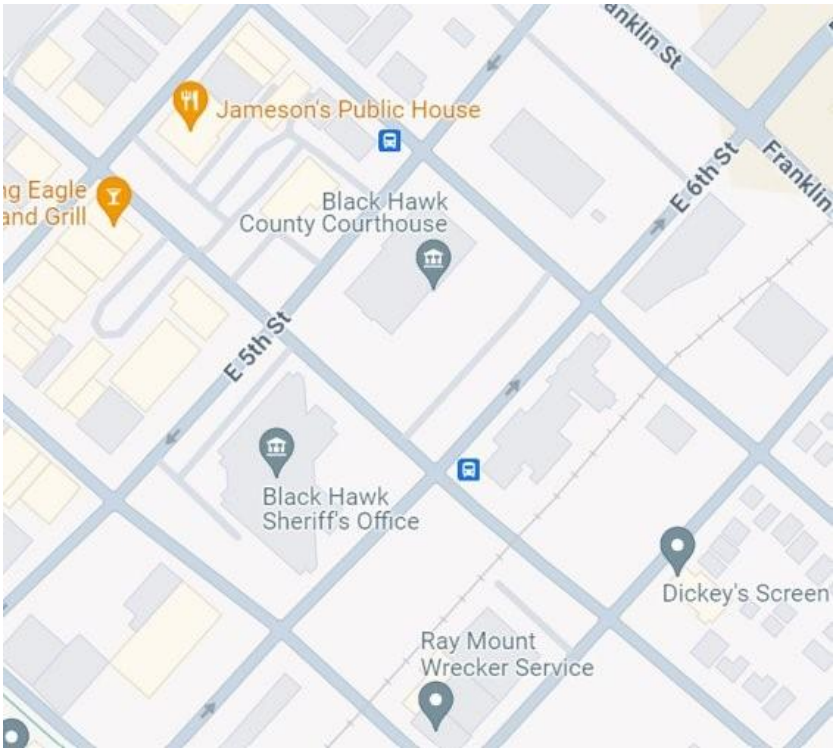


Region C

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.

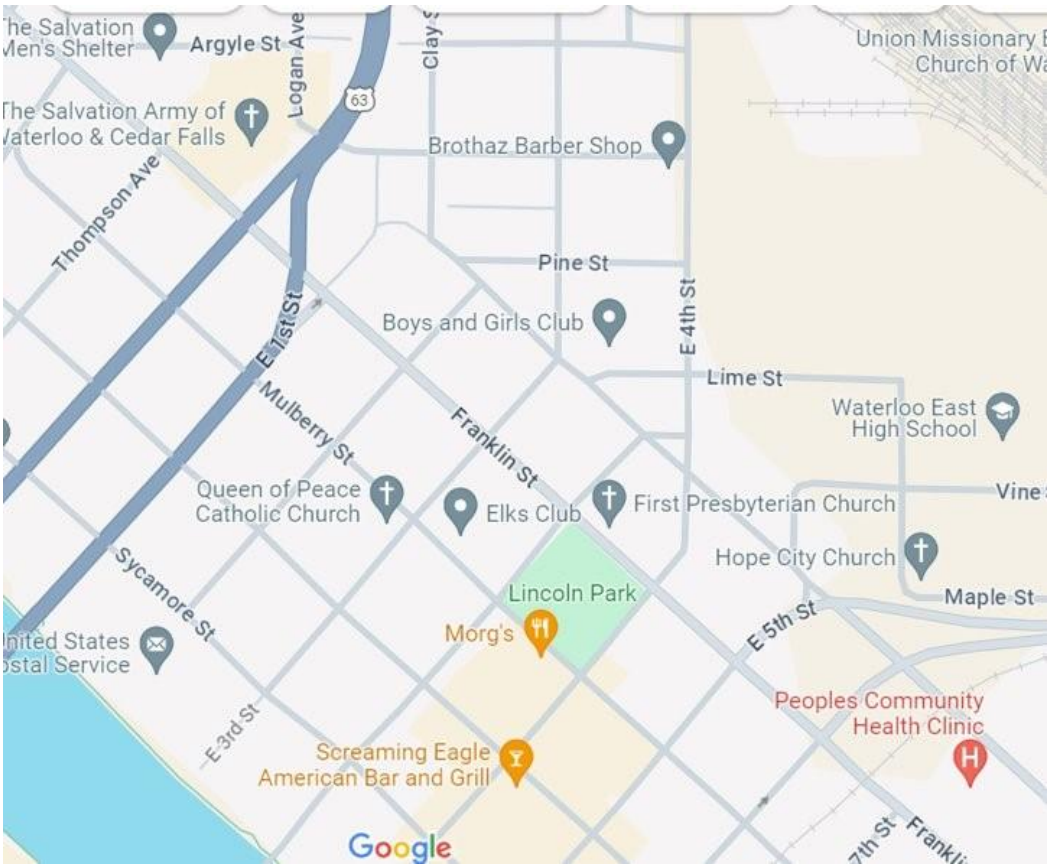


Region D

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/

Seguin RA, Morgan EH, Connor LM, Garner JA, King AC, Sheats JL, et al. Rural Food and Physical Activity Assessment Using an Electronic Tablet-Based Application, New York, 2013–2014. Prev Chronic Dis 2015;12:150147. DOI: http://dx.doi.org/10.5888/pcd12.150147

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%