District 2 Disability Access Points (DAPs) District Assessment

December 2025

CICS
Supporting Individuals. Strengthening Communities.

info@cicsmhds.org

Phone: 515-513-6870

ADRC
Iowa Aging and Disability Resource Center
Iowa HHS

Table of Contents

About Us

Collaborative Individual and Community Supports (CICS) is a public intergovernmental entity formed through a 28E agreement among Iowa counties to ensure individuals and communities receive coordinated health and human services. Guided by a vision of a world where everyone has the means and freedom to live purposefully and abundantly, CICS works to build supportive social, economic, and environmental systems where people can thrive. As a designated Disability Access Point (DAP), CICS serves as a “no wrong door” entry for individuals and caregivers seeking information, options, and access to long-term supports, integrating with Iowa’s Aging and Disability Resource Center (ADRC) network to promote consistent and equitable access statewide. With a focus on respect, dignity, strength, and community, CICS delivers services that include information and assistance, options counseling, short-term services and supports, and coordination of long-term care access — ensuring that every Iowan it serves can live with dignity, purpose, and inclusion.

Introduction

In May 2024, House File 2673 was signed into Iowa law that made changes to how non-Medicaid disability services were managed in the state. The coordination of disability services moved from the Mental Health and Disability Services (MHDS) Regions to Disability Access Points (DAPs). There were four agencies designated to serve as DAPs across the seven disability services districts in Iowa. These agencies are part of the state’s Aging and Disability Resource Center (ADRC) Network.

In order to understand the needs of each of the districts; the DAPs, with support from the Iowa Department of Health and Humans Services (Iowa HHS), conducted a district assessment. A district assessment is a systematic process that uses data to assess a district’s ability to meet tactics for disability services such as service navigation, service coordination, short-term services, and caregiver services. The district assessment is an opportunity to identify district strengths, gaps, and resources to help create a district plan for the next 18 months.

The purpose of this assessment is to identify and prioritize the needs of entities that serve individuals with disabilities across their lifespan within the populations served by the Iowa HHS system. The assessment aims to engage key partners including providers, community-based organizations, and local system partners to gather insights and ensure that activities, services, and interventions meet the specific needs of district partners. The assessment process includes gathering and analyzing both quantitative and qualitative data to better understand services across the disability services system, identifying needs across age groups from early childhood through older adulthood, and highlighting gaps within each district. The assessment also documents existing assets and strengths that can support improved outcomes, as well as challenges and barriers that limit equitable access to disability services and supports. The findings will be used to prioritize district needs based on data, partner input, and best practices. District-specific summaries will be developed to provide recommendations that guide planning, investment, and coordinated action.

Approach

The development of the district assessment included the collection and analysis of both quantitative data and qualitative information. Quantitative data was collected from the U.S. Census Bureau, Behavioral Risk Surveillance Survey (BRFSS), and the National Child Health Survey (NCHS). These data were compiled into district profiles for DAPs to be used alongside qualitative findings to identify gaps and prioritize needs within each district.

Qualitative information was collected using a questionnaire with key partners around strengths, resources, challenges, and barriers as they relate to three Disability Services System result statements. The statements being evaluated were:

- People of all ages, served by Iowa HHS' Aging and Disability Services System, have choices and access to high quality, equitable, and person-centered programs and services to maximize independence, community integration, and self-sufficiency.
- People of all ages, served by Iowa HHS' Aging and Disability Services System, are empowered to utilize or access programs that improve their health and wellness.
- People of all ages, served by Iowa HHS' Aging and Disability Services System, are supported by family members and friends of their choice, and have social connections within their communities.

To complement the quantitative data, CICS conducted a structured qualitative assessment to gather local perspectives on the current system’s strengths, challenges, and unmet needs. Qualitative information was collected through a combination of semi-structured interviews and standardized questionnaires designed by Iowa HHS for the Disability Access Point (DAP) process.

Between September 23 and October 10, 2025, CICS gathered qualitative input from 17 community agencies and service providers across District 2. These participants represented a cross-section of the local disability services network, including:

Behavioral Health and Clinical Providers: Plains Area Mental Health, UnityPoint Health Berryhill Center, UnityPoint Health Trinity Regional Medical Center

Community-Based and Employment Services: Hope Haven, LifeWorks Community Services, CIR (Central Iowa Recovery), and Thrive

Public Health and Social Services: Webster County Public Health, Palo Alto County Health System – Community Health Department, and County General Assistance Offices (Calhoun, Humboldt, Winnebago, and Emmet), Elderbridge Area Agency on Aging

Housing and Resource Providers: Northwest Iowa Regional Housing Authority and Region XII Council of Governments

Education and Community Partners: West Hancock Community Schools

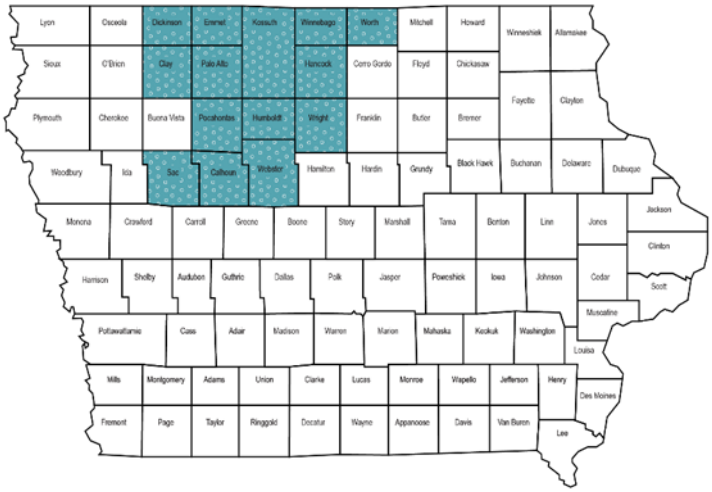
Each interview and questionnaire followed a consistent format aligned with the three statewide result statements. Respondents were asked to describe their organization's strengths, resources needed, challenges, and barriers related to serving individuals with disabilities. Responses were reviewed and analyzed thematically to identify trends, shared priorities, and key system gaps across agencies and counties.

The qualitative findings were then synthesized with quantitative indicators from the District Disability Services Profile (October 2025) to create a comprehensive view of system performance, community strengths, and unmet needs. Together, these data sources provide a balanced understanding of both the measurable outcomes and lived experiences shaping disability services across the District.

District 2 Profile

District 2 encompasses 14 counties across North Central and Northwest Iowa. The Disability Access Point (DAP) serving District 2 is Collaborative Individual and Community Supports.

Counties
Dickinson, Emmet, Kossuth, Winnebago, Worth, Clay, Palo Alto, Hancock, Pocahontas, Humboldt, Wright, Sac, Calhoun, Webster



Demographics

According to the US Census Bureau, District 2 had a total population of 180,822 in 2024. Of this population, 22% (39,358) were children aged 0-17, 19% (35,122) were adults ages 18-34, 35% (63,139) were adults ages 35-64, and 24% (43,203) were adults 65 years of age and older.

Demographics for Individuals with a Disability – District 2 (2019-2023)

Living with Disability, by Type	% of Population
Any disability	14.4%
With an ambulatory difficulty	6.7%
With a cognitive difficulty	5.3%
With a hearing difficulty	4.9%
With an independent living difficulty	4.6%
With a self-care difficulty	2.4%
With a vision difficulty	2.2%

Source: US Census Bureau, American Community Survey

Living with Disability, by Age	% of Population
0 to 17 years	4.6%
18 to 34	9.1%
35 to 64	13.3%
65 years and over	65.3%

Source: US Census Bureau, American Community Survey

Children with Special Health Care Needs (CSHCN)
Percent of children aged 0-17 - 24.3%
Estimated number of children ages 0-17 in Iowa – 175,995
Source: 2022-2023 National Survey of Children's Health

Assessment Findings

Interviews with multiple agencies and organizations across District 2 provided valuable insights into the strengths, challenges, and opportunities within the disability services system. Providers represented a diverse range of services, including health and mental health care, supported community living, housing assistance, financial supports, public health, and social connection programs. Their feedback highlights the system's commitment to person-centered care while also underscoring persistent gaps that limit access, equity, and independence for people with disabilities.

Result Statement #1 – Choice and Access to Person-Centered Programs
Agencies identified their greatest strengths as offering person-centered planning, individualized service delivery, and strong community partnerships. Many reported success in helping people remain in their homes and communities, tailoring supports to promote independence and integration. However, consistent gaps were reported in funding, workforce capacity, and transportation, which limit the ability to expand or sustain services. The most significant challenges include staffing shortages, rural provider scarcity, and complex client needs. Barriers most often cited were structural issues with Medicaid and waiver systems, rate inadequacies, and systemic funding limitations, which agencies emphasized cannot be resolved locally and require higher-level intervention.

Result Statement #2 – Empowerment to Access Health and Wellness
Strengths were found in education, prevention, and wellness programming, such as day programs promoting healthy routines, nurse care management addressing chronic conditions, and partnerships with community organizations. Many agencies described themselves as recovery-oriented and client-driven, ensuring health and wellness opportunities align with individual goals. The largest gaps were again transportation, sustainable funding, and staffing shortages, followed by limited wellness opportunities in rural areas. Challenges also included limited motivation or follow-through among clients, requiring significant staff oversight. Barriers identified at the system level included fragmented coordination between mental and physical health providers, insufficient funding streams, and workforce shortages, all of which restrict continuity and accessibility of care.

Result Statement #3 – Support from Family, Friends, and Social Connections
Providers emphasized strengths in leveraging partnerships, peer support, and person-centered approaches that involve families, friends, and natural supports at the client's request. Many also highlighted their success in fostering social connections through group programming, resource navigation, and community collaborations. The most significant gaps

were transportation limitations, inadequate funding for community programs, and lack of affordable and accessible social opportunities. Challenges included social stigma, strained family relationships, and provider capacity constraints. At the barrier level, agencies pointed to systemic underfunding, weak coordination across agencies, and stigma at the community level as issues that require broader solutions beyond local resources.

Cross-Cutting Themes

Across all three Result Statements, providers consistently cited person-centered care, strong community partnerships, and flexible service models as their primary strengths. The most significant and recurring gaps were transportation, funding limitations, and workforce shortages, followed closely by provider scarcity in rural areas. Barriers most often reflected structural and systemic issues such as Medicaid and waiver program challenges, lack of coordinated systems of care, and community-level stigma. These findings suggest that while agencies are committed and resourceful in delivering individualized supports, higher-level policy, funding, and infrastructure changes are essential to close gaps and reduce barriers across the disability services system.

District Gaps

The gap analysis process for District 2 combined both quantitative data from the *District 2 Disability Services Profile (October 2025)* and qualitative information gathered from key community partners to identify where current resources and services fall short of meeting the needs of individuals with disabilities. Quantitative data provided a measurable view of population characteristics, health outcomes, and system performance, while qualitative feedback from interviews and questionnaires offered local insight into lived experiences, operational challenges, and community barriers. Together, these data sources allowed CICS to align district-level trends with provider perspectives to pinpoint the most significant gaps in access, capacity, and coordination across the district. The following analysis summarizes each identified gap, showing how both data sources — statistical indicators and stakeholder input — converge to define District 2's primary areas of need and opportunity for system improvement.

The following were identified as gaps:

District 2 gaps:

1. Transportation barriers across rural counties

- Source: District 2 Disability Services (DS) Profile pp. 5-6 — Adults 18–59 with disabilities have lower employment (69.4%) and higher loneliness (64.3%) than peers without disabilities, indicating mobility and access constraints.
- Qualitative support: Cited by CIR, Region XII COG, Thrive, Calhoun GA, Humboldt GA, Hope Haven, and Northwest Iowa Regional Housing Authority — all reported lack of rural transit and non-medical transportation options.
  → GAP = Need for reliable, affordable transportation to reach jobs, appointments, and community activities.

2. Workforce shortages and staff turnover

- Source: District 2 Profile p. 4 & 6 — High rates of chronic conditions (86.8% for adults 18–59; 95.8% for 60+) imply heavy service demand and strain on providers.
- Qualitative support: Plains Area Mental Health, UPH Berryhill, CIR, and Thrive all reported difficulty recruiting and retaining qualified direct-care and clinical staff.
  → GAP = Insufficient workforce capacity to maintain consistent, high-quality services.

3. Limited affordable and supportive housing

- Source: District 2 Profile p. 7 — Homeownership among adults 60+ with disabilities (87.1%) trails non-disabled peers (92.1%); adults 18–59 have even lower rates and greater economic instability.
- Qualitative support: Humboldt GA, Calhoun GA, and the Northwest Iowa Regional Housing Authority identified few safe units, waitlists, and landlord barriers.
  → GAP = Shortage of accessible and affordable housing with supports.

4. Fragmented system navigation and coordination

- Source: District 2 Profile p. 8 — Multiple systems and eligibility streams noted; no district-level integration data available.
- Qualitative support: Humboldt GA (“no wrong door”), Winnebago GA, Thrive, and Calhoun GA described confusing referral paths and agency silos.
  → GAP = Need for coordinated, user-friendly navigation and shared referral system.

5. Behavioral-health and specialty-service shortages

- Source: District 2 Profile p. 4 & 6 — Lower self-rated health (only 22–25% “very good or excellent”) among people with disabilities indicates limited access to appropriate care.
- Qualitative support: Plains Area Mental Health, UPH Trinity, and Humboldt GA reported waitlists, short inpatient stays, and scarce providers.
  → GAP = Insufficient mental health and specialty service capacity throughout District 2.

6. Funding and rate limitations

- Source: District 2 Profile pp. 3-4 & 6 — Economic-stability data show higher poverty and food insecurity among households with disabilities (44.4% unable to afford nutritious meals).
- Qualitative support: CIR, UPH Berryhill, Hope Haven, and Humboldt GA noted that reimbursement rates and short-term funding restrict program growth.
  → GAP = Need for sustainable, flexible funding to support long-term stability.

7. Social isolation and community stigma

- Source: District 2 Profile p. 5 & 7 — 64.3% of adults 18–59 and 34.8% of adults 60+ with disabilities report loneliness—double non-disabled rates.

- Qualitative support: Hope Haven, Plains Area Mental Health, Region XII COG, and West Hancock Schools described limited social opportunities and stigma within small communities.
  → GAP = Need for inclusive community programs to reduce stigma and promote social connection.

8. Economic instability and basic needs insecurity

- Source: District 2 Profile pp. 3-4 — Households with children with special health care needs face higher housing instability (20.1%) and food insecurity (44.4%).
- Qualitative support: General-assistance offices (Humboldt, Calhoun, Winnebago) and public-health partners reported growing financial strain and limited support funds.
  → GAP = Economic vulnerability limiting independence and community participation.

Identified Priorities

The following priorities were identified through a stakeholder prioritization meeting held by CICS on October 11, 2025, using the Impact–Momentum Matrix framework. During this session, community partners, providers, and local leaders reviewed the eight system gaps identified in the District 2 assessment and evaluated each one based on its potential impact on individuals with disabilities and the current momentum or readiness for implementation within the district. Through group discussion, consensus-building, and review of existing efforts, participants identified five areas that represent both high-impact opportunities and strong potential for coordinated action. These priorities reflect the collective vision of stakeholders across District 2 to strengthen access, collaboration, and quality within the disability services system.

Final District 2 Priorities

1. **Transportation Access and Coordination**
   Strengthen and expand rural and regional transportation options through partnerships with local transit providers and taxi services. Improve access to medical, behavioral-health, and community services for residents across all counties.

2. **Affordable and Supportive Housing Development**
   Increase affordable, accessible housing through landlord engagement, development incentives (e.g., LIHTC projects), and collaboration with local and state partners to expand housing subsidies and reduce waitlists.

3. **System Navigation and Resource Coordination**
   Develop or enhance a *"No Wrong Door"* approach that connects agencies across systems. Create a centralized resource directory and referral network to streamline access for individuals and families.

4. **Legislative and Funding Advocacy**
   Coordinate local and district-level advocacy with legislators to address low reimbursement rates, funding restrictions, and eligibility barriers. Increase awareness by inviting policymakers to see local programs and their impact.

5. **Community Education and Engagement**
   Promote education and awareness about available resources and strengthen natural supports through partnerships with community organizations, schools, and peer networks.

Following the stakeholder Impact–Momentum Matrix meeting, CICS and community partners identified five initial priorities: transportation, housing, system navigation, legislative and funding advocacy, and community education and engagement. As planning progressed, these focus areas were analyzed for overlap and interdependence. Transportation and housing were combined into a single priority, *Access and Mobility*, reflecting their shared goal of improving community access and independence. System navigation and advocacy were merged into *Coordination and Navigation*, recognizing that effective system alignment and funding advocacy are inseparable parts of improving service pathways. Community education and engagement were maintained as a standalone priority, emphasizing the importance of awareness, inclusion, and social connection. This refinement resulted in three comprehensive priorities—*Access and Mobility, Coordination and Navigation,* and *Education and Community Engagement*—that encompass the district's key needs while aligning with the scope and functions of the Disability Access Point.

These priorities will serve as the foundation for ongoing planning and collaboration across District 2. They represent the most critical opportunities to strengthen access, equity, and person-centered service delivery for individuals with disabilities. CICS and its community partners will use these priorities to guide the development of actionable strategies, identify potential funding sources, and coordinate with Iowa HHS to advance system improvements. By focusing collective efforts on these key areas, District 2 aims to create a more integrated,

responsive, and sustainable network of supports that enhances independence, inclusion, and quality of life for all residents.

Next Steps

District 2 – Alignment of Priorities, Needs, Activities, and Collaborators with Result Statements

Narrative Overview
Each priority in District 2's plan directly supports the statewide Result Statements that guide the Aging and Disability Services System. The priorities—Access and Mobility, Coordination and Navigation, and Education and Community Engagement—were developed through analysis of quantitative data from the District 2 Disability Services Profile and qualitative input from local partners. Together, they form an integrated approach that addresses infrastructure, coordination, and inclusion across the lifespan.

Collaborators were intentionally selected for their influence, expertise, and established community presence. These partners include local governments, housing and transportation authorities, health and behavioral health providers, educational systems, and community organizations. Each brings a unique role to ensure that the activities are operationally feasible, person-centered, and sustainable within the existing service landscape.

Result Statement 1: Access and Independence
People of all ages, served by Iowa HHS' Aging and Disability Services System, have choices and access to high-quality, equitable, and person-centered programs and services to maximize independence, community integration, and self-sufficiency.

Aligned Priority: Access and Mobility
The Access and Mobility priority advances this result statement by targeting the foundational barriers to independence—specifically, limited transportation and affordable housing. When reliable transportation or safe, stable housing is unavailable, individuals face reduced access to employment, education, health care, and community participation. To address these structural challenges, District 2 will establish the Disability Services Network (NETWORK) to coordinate planning, create shared referral processes, and align resource development across partners.

Needs Addressed:

- Fragmented coordination between housing and transit systems.
- Limited affordable and accessible housing options.
- Inconsistent access to short-term, flexible supports.

Key Activities:

1. Establish the NETWORK to coordinate housing and transportation planning.
2. Conduct a districtwide inventory of transportation and housing resources to identify gaps.
3. Develop a pilot collaboration between housing and transportation providers to test shared referral processes.
4. Use Short-Term Services and Supports (STSS) to meet urgent housing and transit needs while long-term solutions are developed.

Collaborators:

CICS; Councils of Governments; Regional Housing Authorities; County General Assistance Offices; Local Public Health Departments; Community Action Agencies; Regional Transit Agencies (RIDES, MIDAS); Local Planning and Zoning Commissions; City Housing Offices; Faith-based and civic volunteer driver programs; Emergency management coordinators and shelters.

Connection to the Result Statement:

Through these activities, District 2 will create an equitable, person-centered infrastructure that maximizes independence and community integration. The combination of strategic planning, flexible supports, and coordinated partnerships ensures that individuals have meaningful choices about where and how they live. The collaborators—representing both local government and community-based organizations—were selected because they directly influence the housing, transportation, and emergency systems that determine access and stability for people with disabilities.

Result Statement 2: Empowerment and Wellness

People of all ages, served by Iowa HHS' Aging and Disability Services System, are empowered to utilize or access programs that improve their health and wellness.

Aligned Priority: Coordination and Navigation
The Coordination and Navigation priority fulfills this result statement by building a cohesive system that empowers residents to locate and use services that meet their individual needs. The needs identified stem from fragmented referral systems, unclear entry points, and inconsistent follow-up across providers. By developing a centralized resource directory, shared referral protocols, and consistent warm-handoff procedures, District 2 will create a “No Wrong Door” environment that simplifies access for every resident.

Needs Addressed:

- Fragmented and inconsistent navigation systems.
- Lack of unified referral and follow-up processes.
- Gaps in communication between service sectors.

Key Activities:

1. Create a centralized District 2 resource directory and shared referral protocol.
2. Conduct provider training on “No Wrong Door” navigation and warm handoffs.
3. Convene biannual cross-sector coordination meetings to align funding and eligibility processes.
4. Evaluate navigation improvements annually using feedback and performance metrics.

Collaborators:
CICS; Elderbridge Area Agency on Aging; Behavioral health and healthcare providers (Plains Area Mental Health), UPH Berryhill, UPH Trinity); Housing and employment agencies; 211 Iowa; Managed Care Organizations (MCOs); IowaWORKS; Iowa Vocational Rehabilitation Service (IVRS); Public libraries; Hospitals and primary care providers; Law enforcement; Schools; County Veterans Affairs; Faith-based organizations; University or community college partners.

Connection to the Result Statement:
This coordinated approach creates a unified, client-focused system that empowers people to access programs promoting health and wellness. Collaborators were selected based on their roles as key access points in the service system—providers, navigators, and advocates who can streamline entry into care. By connecting public, private, and community-based partners, District 2 ensures that individuals can locate, understand, and engage with the full range of services available to them, strengthening both wellness and self-sufficiency.

Result Statement 3: Connection and Support
People of all ages, served by Iowa HHS’ Aging and Disability Services System, are supported by family members and friends of their choice, and have social connections within their communities.

Aligned Priority: Education and Community Engagement
The Education and Community Engagement priority aligns with this result statement by addressing social isolation and stigma—key barriers to community inclusion. The needs identified include low awareness of available resources, stigma toward people with disabilities, and limited natural-support networks. District 2 will promote inclusion and social connection through awareness campaigns, community education events, and partnerships that strengthen peer and family support systems.

Needs Addressed:

- Limited awareness of disability services and supports.
- Stigma and misconceptions about disabilities.
- Weak natural-support and peer networks.

Key Activities:

1. Develop a districtwide disability-awareness and inclusion campaign.
2. Partner with schools, employers, and civic organizations to build peer and natural-support networks.
3. Host annual community education events in each county to promote inclusion and awareness.
4. Collect and analyze community feedback to evaluate impact and refine outreach strategies.

Collaborators:
CICS; Elderbridge Area Agency on Aging; Schools; Employers; Civic organizations; Public health departments; Local media outlets; Community colleges; The Arc; NAMI; Chambers of commerce; Parks and recreation departments; Workforce development boards; Faith-based organizations; Senior centers; YMCA; County Extension offices; Community action agencies; Family councils; Peer advisory groups.

Connection to the Result Statement:
These efforts strengthen community inclusion and reduce isolation by fostering awareness and collaboration. Collaborators were chosen to represent trusted community institutions that already serve as social connectors. By uniting schools, employers, advocacy groups, and local organizations, District 2 will create opportunities for individuals with disabilities to participate fully in community life, build natural supports, and maintain meaningful relationships.

Overall Integration
Each activity and partnership in the District 2 plan is strategically tied to a result statement, forming a continuous thread from identified needs to measurable outcomes.

Access and Mobility builds the physical and logistical foundation for independence.

Coordination and Navigation provides the systemic infrastructure for empowerment and wellness.

Education and Community Engagement fosters the social environment necessary for inclusion and connection.

Collaborators were intentionally selected to represent the full continuum of care—public health, social services, education, housing, and transportation—ensuring that efforts are comprehensive, inclusive, and sustainable across the district.

Appendix

District Plan

Following the completion of the district assessment, Disability Access Points (DAPs) developed Disability Services District Plans to guide efforts for the time frame of January 1, 2026, through June 30, 2027. These plans aim to address both infrastructure and system-building needs, as well as the specific needs of population groups across the lifespan.

Using prioritized needs from the assessments, DAPs were asked to identify which needs fit within the following categories: infrastructure/system building, all ages, ages 0–20, ages 21–59, and ages 60+. DAPs then outlined:

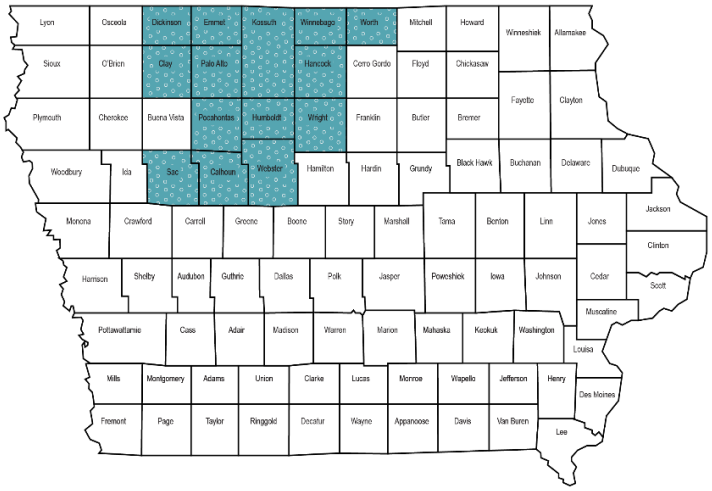
- **Identified Needs:** Key challenges and service gaps within their districts.
- **Activities:** Targeted tasks designed to address the identified needs.
- **Collaborators:** Partners and stakeholders engaged in implementing activities.
- **Deliverables:** Tangible and intangible outcomes resulting from the activities.
- **Milestones:** Projected completion dates for each activity.

District plans are dynamic, working documents that will be updated as needed through ongoing collaboration between the Iowa Health and Human Services and the DAPs.

Infrastructure and System Building: Result Statement	**Need** The infrastructure or system building need identified in your district assessment	**Activities** The tasks you will complete to help meet the identified need	**Collaborators** The partners or people who will assist with the completion of the activity	**Deliverable** The tangible or intangible output that results from the completion of the activity	**Milestone** The date the activity will be completed (DD/MM/YY format)
People of all ages, served by HHS' Aging and Disability Services System, have choices and access to high quality, equitable, and person-centered programs and services to maximize independence, community integration, and self-sufficiency.	Improve coordination of transportation and housing resources to increase independence and community integration.	1. Establish the District 2 Disability Services Network (Network) to coordinate housing and transportation planning.	CICS, COGs, Regional Housing Authorities, county GA offices, local public health.	Network membership roster and meeting schedule approved.	3/31/2026
People of all ages, served by HHS' Aging and Disability Services System, have choices and access to high quality, equitable, and person-centered programs and services to maximize independence, community integration, and self-sufficiency. (2)	Improve coordination of transportation and housing resources to increase independence and community integration. (2)	2. Conduct a districtwide inventory of transportation and housing resources to identify service gaps.	Network members, local governments, community partners.	Completed resource inventory report shared with all Network members.	6/30/2026
People of all ages, served by HHS' Aging and Disability Services System, have choices and access to high quality, equitable, and person-centered programs and services to maximize independence, community integration, and self-sufficiency. (3)	Improve coordination of transportation and housing resources to increase independence and community integration. (3)	3. Develop a pilot collaboration between housing and transportation providers to test shared referral or subsidy processes.	Network workgroup, housing and transit providers.	Pilot partnership implemented and summary report.	12/31/2026
People of all ages, served by HHS' Aging and Disability Services System, have choices and access to high quality, equitable, and person-centered programs and services to maximize independence, community integration, and self-sufficiency. (4)	Improve coordination of transportation and housing resources to increase independence and community integration. (4)	4. Use STSS flexibly to assist clients with urgent short-term housing or transportation needs identified through navigation.	CICS and Network navigation leads.	Quarterly STSS utilization summaries and outcomes report.	Ongoing – first report 03/31/2026, final 06/30/2027
People of all ages, served by HHS' Aging and Disability Services System, are empowered to utilize or access programs that improve their health and wellness.	Strengthen system navigation and develop shared tools to improve access and reduce duplication.	1. Create a centralized District 2 resource directory and shared referral protocol.	CICS, Elderbridge AAA, behavioral-health providers, housing and employment agencies.	Completed directory and referral guide accessible to NetworkDSN partners.	6/30/2026
People of all ages, served by HHS' Aging and Disability Services System, are empowered to utilize or access programs that improve their health and wellness. (2)	Strengthen system navigation and develop shared tools to improve access and reduce duplication. (2)	2. Conduct training sessions for Network members and providers on “No Wrong Door” navigation and warm handoffs.	CICS, Network partners, public health agencies.	Training materials, attendance logs, and evaluation summary.	9/30/2026
People of all ages, served by HHS' Aging and Disability Services System, are empowered to utilize or access programs that improve their health and wellness. (3)	Strengthen system navigation and develop shared tools to improve access and reduce duplication. (3)	3. Convene twice-yearly cross-sector coordination meetings to align funding and eligibility processes.	CICS (facilitator), Network agencies, HHS regional liaisons.	Meeting agendas, minutes, and action plan summaries.	First meeting 06/30/2026; second 12/31/2026; third 06/30/2027
People of all ages, served by HHS' Aging and Disability Services System, are empowered to utilize or access programs that improve their health and wellness. (4)	Strengthen system navigation and develop shared tools to improve access and reduce duplication. (4)	4. Evaluate navigation improvements through feedback and performance metrics.	CICS evaluation team, NetworkDSN agencies.	Annual evaluation report with recommendations.	Final report 06/30/2027
People of all ages, served by HHS' Aging and Disability Services System, are supported by family members and friends of their choice, and have social connections within their communities.	Reduce social isolation and stigma by building awareness and promoting inclusive community engagement.	1. Develop districtwide disability-awareness and inclusion campaign materials.	CICS, Elderbridge AAA, local schools, and public health departments.	Campaign toolkit with consistent branding and messages.	3/31/2026
People of all ages, served by HHS' Aging and Disability Services System, are supported by family members and friends of their choice, and have social connections within their communities. (2)	Reduce social isolation and stigma by building awareness and promoting inclusive community engagement. (2)	2. Partner with schools, employers, and civic organizations to promote peer and natural-support networks.	CICS, Network members, schools, community organizations.	Memoranda of understanding (MOUs) or partner participation agreements.	9/30/2026
People of all ages, served by HHS' Aging and Disability Services System, are supported by family members and friends of their choice, and have social connections within their communities. (3)	Reduce social isolation and stigma by building awareness and promoting inclusive community engagement. (3)	3. Host one community-education event per county each year focused on inclusion and resource awareness.	CICS, Network partners, peer-support and advocacy organizations.	Event summaries, attendance data, and media coverage.	First round 12/31/2026; second round 06/30/2027
People of all ages, served by HHS' Aging and Disability Services System, are supported by family members and friends of their choice, and have social connections within their communities. (4)	Reduce social isolation and stigma by building awareness and promoting inclusive community engagement. (4)	4. Collect and analyze community feedback and event outcomes to refine outreach efforts.	CICS data team, public health partners.	Survey results and updated outreach strategy for next cycle.	3/31/2027

Disability Services District 2 Profile

Disability Access Points (DAPs) work with Iowa Health and Human Services to provide services to Iowa's living with a disability. To help inform plans for future work through Iowa's Disability Services System, DAPs must understand the needs of their district. The following profile provides information regarding the health and social needs of children, adults aged 18-59, and older adults (60 years of age and older) living with a disability in District 2.



District 2 encompasses 14 counties across North Central and Northwest Iowa. The Disability Access Point (DAP) serving District 2 is Collaborative Individual and Community Supports.

Demographics

According to the US Census Bureau, District 2 had a total population of 180,822 in 2024. Of this population, 22% (39,358) were children aged 0-17, 19% (35,122) were adults ages 18-34, 35% (63,139) were adults ages 35-64, and 24% (43,203) were adults 65 years of age and older.

Demographics for Individuals with a Disability – District 2 (2019-2023)

Living with Disability, by Type	% of Population
Any disability	14.4%
With an ambulatory difficulty	6.7%
With a cognitive difficulty	5.3%
With a hearing difficulty	4.9%
With an independent living difficulty	4.6%
With a self-care difficulty	2.4%
With a vision difficulty	2.2%

Source: US Census Bureau, American Community Survey

Living with Disability, by Age	% of Population
0 to 17 years	4.6%
18 to 34	9.1%
35 to 64	13.3%
65 years and over	65.3%

Source: US Census Bureau, American Community Survey

Children with Special Health Care Needs (CSHCN)

Percent of children aged 0-17 - 24.3%

Estimated number of children ages 0-17 in Iowa – 175,995

Source: 2022-2023 National Survey of Children's Health

Children

The data in this section reflects state level data taken from the 2022-2023 (two-years combined) National Survey of Children's Health (NSCH); district level data was not available for this section. The NSCH survey process includes randomly selected households with one or more children under the age of 18. Adults who are familiar with the child's health and health care are asked to participate in the survey. The following information represents responses for children ages 0 – 17.

Overall Health Status

Children with Special Health Care Needs (CSHCN) have or are at an increased risk of having chronic physical, developmental, behavioral, or emotional conditions. They have conditions such as asthma, sickle cell disease, epilepsy, anxiety, autism, and learning disorders. They may require more specialized health and educational services to thrive, even though each child's needs may vary.

80.5% of Iowans children who have special health care needs reported excellent or very good overall health status.

95.8% of Iowans children without special health care needs reported excellent or very good overall health status.

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood. The NSCH tracks data for children with two or more ACEs. Adverse childhood experiences can include, but are not limited to, experiencing violence, abuse, or neglect; experiencing homelessness or unstable housing; and being treated unfairly because of a health condition or disability. To learn more about ACEs, please visit https://www.cdc.gov/aces/about/index.html.

Iowa ranks **47th** for children who have special health care needs that reported they were treated unfairly because of a health condition or disability

- **35.1%** of children who have special health care needs reported they experienced ACEs more than children without special health care needs (13.4%).
- **13%** of children who have special health care needs reported being treated unfairly because of a health condition or disability.

Medical Home

A medical home serves as a consistent, non-emergency source of care and where children have a personal doctor or nurse and access to family-centered care, referrals when needed, and effective care coordination. Children with a medical home receive coordinated, ongoing and comprehensive care. A medical home is crucial for a child's health and wellbeing.

In Iowa, **57.1%** of children who have special health care needs responded that they did not have a medical home compared to **45.3%** of children without special health care needs.

Developmental Screening

Developmental screenings provide a structured way to assess a child's growth in various areas, including motor skills, language, cognitive abilities, and social-emotional development. Among Iowan children ages 9-35 months, **76.1%** of parents of children who have special health care needs did not complete standardized developmental screening, compared to **65.9%** of parents of children without a special health care need.

Economic Stability

Economic stability means families' ability to meet basic needs (housing, food, healthcare, transportation), maintain steady income or employment, and handle unexpected expenses without falling into crisis.

20.1% of children who have a special health care need between the ages of 0-11 experienced housing instability in the last year (Children without a special health care need = 13.0%).

44.4% of households with children who have special health care needs reported they couldn't always afford to eat nutritious meals (Children without a special health care need = 30.1%)

Physical Activity

The physical activity guidelines recommend that children engage in at least 60 minutes of activity every day. Parents reported that **78.8%** of children aged 6-17 who have special health care needs were less likely to meet the guidelines, compared to children without special health care needs (74.8%).

Adults Ages 18-59

The data in this section provides state and district level data taken from 2023 Iowa Behavioral Risk Factor Surveillance System (BRFSS) for adults aged 18-59 years old. Please note, the district level data for adults are unweighted.

For BRFSS, disability is defined as responding "yes" to one of the corresponding six questions:

1) Are you deaf or do you have serious difficulty hearing?
2) Are you blind or do you have serious difficulty seeing, even when wearing glasses?
3) Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
4) Do you have serious difficulty walking or climbing stairs?
5) Do you have difficulty dressing or bathing?
6) Because of physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

The prevalence of disability refers to the total number or percentage of people in a population who have a disability. The percentage of people aged 18-59 who have a disability in District 2 (19.1%) **is similar to** the state percentage (21.8%).

Overall Health Status

Health status is a measure of how people perceive their health. It refers to the overall condition of an individual's physical, mental, and social well-being at a given point in time. Health status is influenced by various factors such as education, lifestyle choices, medical conditions, and economic stability. Living with a disability can also influence overall health status. Through the BRFSS survey, Iowans were asked to rate their health status as excellent, very good, good, fair, or poor.

Within the district, **22.4%** of individuals with a disability age 18-59 reported their overall health status as very good or excellent

25.3% - Iowa
(living with a disability)

Within the district, **53.1%** of individuals without a disability age 18-59 reported their overall health status as very good or excellent.

55.3% - Iowa
(living without a disability)

Chronic Conditions

Chronic conditions are defined as conditions that last one or more years and require ongoing medical attention or limit activities of daily living or both.

86.8%
of individuals living with a disability in District 2 have **at least one chronic condition**

67.3%
of individuals living with a disability in District 2 have **two or more chronic conditions**

Overall, Iowans 18-59 years of age living with a disability have **a significantly higher prevalence** of having any chronic condition (85.9%) than Iowans of the same age without a disability (66.6%). The higher prevalence among people with disabilities highlights their disproportionate health burdens and emphasizes the need for accessible, coordinated healthcare services.

Loneliness

Elevated rates of loneliness among people with disabilities point to barriers to social inclusion and highlight the need to expand opportunities for connection and belonging. For District 2, **64.3%** of Iowans aged 18-59 with a disability reported feeling lonely compared to **60.3%** statewide; **23%** of people aged 18-59 **living without a disability** in District 2 reported feeling lonely. In addition, Iowans aged 18-59 with a disability are almost two times more likely to feel lonely as compared to Iowans aged 60+ who live with a disability (60.3% compared to 32.6%).

Social Emotional Support

Social and emotional support plays a critical role in a person's health by strengthening mental well-being, reducing stress, and contributing to better physical outcomes, including longer life expectancy and protection against chronic disease. District level data for social and emotional support was not available for District 2. Statewide, **59.3%** of adults aged 18–59 with a disability reported receiving social and emotional support. These findings point to gaps in natural and community-based networks of care for people with disabilities.

Economic Stability

Economic stability refers to having a steady, livable income that covers housing, transportation, healthcare, food, and other basic needs. It is essential for maintaining both physical and mental health.

District level data for homeownership was not available for District 2. In Iowa, home ownership is **lower** (48.9%) among Iowans 18-59 years of age with a disability than Iowans 18-59 years of age without a disability (71.1%). Disability status can influence homeownership, often making it more difficult for people with disabilities to become or remain homeowners.

69.4% of persons living with a disability, in District 2, are employed. Iowans aged 18-59 that have a disability have **significantly lower rates** of being employed (12 in 20) than those Iowans of the same age that do not have a disability (16 in 20).

Iowans with a disability have a higher rate of having lost employment or having their hours reduced than do those that do not have a disability. Access to work and job stability remains a challenge for individuals with a disability, emphasizing the need for stronger workforce support and protections.

Physical Activity

Participation in physical activity is essential for maintaining overall health and well-being. The criteria for meeting aerobic physical activity are defined as participation in 150 minutes or more of aerobic physical activity per week. The criteria for strength physical activity are defined as participation in muscle strengthening exercise two or more times per week.

50%

of 18–59-year-olds living with a disability in District 2 reported they met the criteria for aerobic physical activity

49.5% - Iowa

43.8%

of 18–59-year-olds living with a disability in District 2 reported they met the criteria for strength physical activity

33.9% - Iowa

Adults Ages 60+

The data in this section provides state and district level data taken from 2023 Iowa Behavioral Risk Factor Surveillance System (BRFSS) for adults 60 years of age and older. Please note, the district level data for adults are unweighted.

For BRFSS, disability is defined as responding "yes" to one of the corresponding six questions:

1) Are you deaf or do you have serious difficulty hearing?
2) Are you blind or do you have serious difficulty seeing, even when wearing glasses?
3) Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
4) Do you have serious difficulty walking or climbing stairs?
5) Do you have difficulty dressing or bathing?
6) Because of physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

The prevalence of disability refers to the total number or percentage of people in a population who have a disability. The percentage of people 60+ who have a disability in District 2 (40.1%) **is similar to** the state percentage (39.2%).

Overall Health Status

Health status is a measure of how people perceive their health. It refers to the overall condition of an individual's physical, mental, and social well-being at a given point in time. Health status is influenced by various factors such as education, lifestyle choices, medical conditions, and economic stability. Living with a disability can also influence overall health status. Through the BRFSS survey, Iowans were asked to rate their health status as excellent, very good, good, fair, or poor.

Within the district, **25%** of individuals with a disability age 60+ reported their overall health status as very good or excellent

23.9% - Iowa
(living with a disability)

Within the district, **54%** of individuals without a disability age 60+ reported their overall health status as very good or excellent

53.1% - Iowa
(living without a disability)

Chronic Conditions

Chronic conditions are defined as conditions that last one or more years and require ongoing medical attention or limit activities of daily living or both.

95.8%
of individuals 60 years of age or older living with a disability in District 2 have **at least one chronic condition**

87.2%
of individuals 60 years of age or older living with a disability in District 2 have **two or more chronic conditions**

Overall, Iowans 60 years of age or older living with a disability have **a significantly higher prevalence** of having any chronic condition (96.1%) than Iowans of the same age without a disability (89.6%). The higher prevalence among people with disabilities highlights their disproportionate health burdens and emphasizes the need for accessible, coordinated healthcare services.

Loneliness

Elevated rates of loneliness among people with disabilities point to barriers to social inclusion and highlight the need to expand opportunities for connection and belonging. For District 2, **34.8%** of individuals 60 years of age or older with a disability reported feeling lonely compared to **32.6%** statewide; **18.9%** of Iowans 60+ **living without a disability** in District 2 reported feeling lonely.

Social Emotional Support

Social and emotional support plays a critical role in a person's health by strengthening mental well-being, reducing stress, and contributing to better physical outcomes, including longer life expectancy and protection against chronic disease. In District 2, the percentage of Iowans 60+ with a disability who report receiving social and emotional support **is lower than** the state percentage (68.5% compared to 72.8%). These findings point to gaps in natural and community-based networks of care for people with disabilities.

Economic Stability

Economic stability refers to having a steady, livable income that covers housing, transportation, healthcare, food, and other basic needs. It is essential for maintaining both physical and mental health.

In District 2, **87.1%** of persons aged 60+ living with a disability own their own home, compared to **92.1%** of persons aged 60+ without a disability. Disability status can influence homeownership, often making it more difficult for people with disabilities to become or remain homeowners.

Iowans that have a disability who are 60 years of age or older **have a significantly higher rate** (17 in 20) of owning their own homes than Iowans with a disability aged 18-59 (10 in 20).

In District 2, persons aged 60+ with a disability are **less likely to be employed** (14%) than those without a disability (35.1%). Persons 60 years of age and older with a disability in District 2 also have a lower rate of being employed as compared to the state rate (19.4%).

Overall, Iowans with a disability have a **higher rate of having lost employment** (4.7%) or **having their hours reduced** than do those that do not have a disability (3.5%). Access to work and job stability remains a challenge for individuals with a disability, emphasizing the need for stronger workforce support and protections.

Physical Activity

Participation in physical activity is essential for maintaining overall health and well-being. The criteria for meeting aerobic physical activity are defined as participation in 150 minutes or more of aerobic physical activity per week. The criteria for strength physical activity are defined as participation in muscle strengthening exercise two or more times per week.

43.2%

of persons 60+ living with a disability in District 2 reported they met the criteria for aerobic physical activity

41.8% - Iowa

32.3%

of persons 60+ living with a disability in District 2 reported they met the criteria for strength physical activity

29.6% - Iowa

Caregivers Living with a Disability

Iowans with disabilities aged 18-59 have a **significantly higher rate of current caregiving responsibilities** than peers without disabilities (24.9% compared to 13.1%). Older Iowans with disabilities (aged 60+) report **similar** current caregiving responsibilities as people without disabilities (18.9% compared to 19.2%). Statewide,**13.9%** of Iowans aged 18-59 and **14.7%** aged 60+ living with a disability reported that they expected to be in a caregiving role within the next two years. These percentages were similar to people in the same age ranges without disabilities.*

Patterns of caregiving show that **people with disabilities are often both care recipients and caregivers**, illustrating the dual roles they play and the importance of supporting them in both capacities.

* District level data for caregiving was not available.