DUBUQUE COUNTY, IOWA

COMMUNITY HEALTH ASSESSMENT & HEALTH IMPROVEMENT PLAN

NOVEMBER 2023

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APPENDICES

Executive Summary

Approximately every five years, local boards of health lead a community-wide process to identify the most important factors affecting health in their communities and what must be done to address those needs. Similarly, every three years, not-for-profit hospitals are required by the Patient Protection and Affordable Care Act (ACA) to conduct a needs assessment and adopt implementation strategies to meet the needs identified by the assessment. The development of this joint assessment included the formation of a Community Health Assessment and Community Health Improvement Plan Steering Committee including representatives from the Dubuque County Public Health Department, the City of Dubuque Health Services Department, the Dubuque Visiting Nurse Association, MercyOne Dubuque/Dyersville Medical Centers, UnityPoint Dubuque Hospital, and Crescent Community Health Center. This document, Dubuque County's Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP), is the result of the process. Qualitative and quantitative data were collected through the compiling of statistics from various secondary data sources, as well as distributing and evaluating a community-wide survey. The committee also incorporated findings from the Community Equity Profile conducted by Community Foundation of Greater Dubuque. The statistical data and community input shaped the community health improvement plan by identifying health concerns and needs in the community, which were then prioritized by the Steering Committee by reviewing qualitative and quantitative data from a variety of sources, including the community survey, as well as needs experienced through public health work in the Dubuque area. The community health improvement plan will serve as a foundation for community health improvement efforts over the next three years.

Community Health Assessment and Health Improvement Plans yield the following community benefits:

1. Increases awareness of community health needs and resources.
2. Creates a common understanding of the community's health needs.
3. Enhances relationships between and among stakeholders.
4. Provides a basis upon which community stakeholders can make informed decisions about how they can contribute to improving the health of the community.
5. Provides a rationale for current and potential funders to support efforts to improve the health of the community.
6. Creates opportunities for collaboration in delivering services to the community.
7. Provides guidance to the hospitals and health departments for how they can align their services and community benefit programs to best meet needs.

COMMUNITY HEALTH ASSESSMENT

Data Sources

The Steering Committee gathered primary data from a community-wide survey to elicit feedback from residents regarding health opportunities in the community. The survey data and data from a Community Equity Profile conducted by the Community Foundation of Greater Dubuque was analyzed and compared with that which resulted from a comprehensive examination of available health data from secondary sources.

COMMUNITY SURVEY

The Steering Committee created a survey to gather community-based input on health needs and health priorities in the community. The City of Dubuque's Office of Shared Prosperity and Neighborhood Support (OSPNS) assisted with the process of assessing community health needs and sought to promote equity throughout this process. The ONSPS encouraged the committee to translate surveys into Spanish and Marshallese to increase accessibility and participation within Hispanic, Latino, and Marshallese communities. The department partnered with the City of Dubuque's Office of Equity and Human rights to directly assist with the Spanish translation.

The survey was promoted by making paper copies available at frequently visited municipalities and medical offices and posting fliers at high traffic metro and rural locations throughout the area that contained a QR code linked directly to the survey. The OSPNS promoted the survey flier within the business community through relationships with John Deere Dubuque Works, the Dubuque Chamber of Commerce, and the Greater Dubuque Development Corporation and encouraged survey participation through the network of Neighborhood Association and minority groups and communities. The survey was also available on the Dubuque County Public Health Department website, the City of Dubuque Health Services Department webpage, Crescent Community Health Center, and social media pages. In addition, the OSPNS engaged with local school systems by leveraging relationships with the Dubuque Community School District, Western Dubuque Community School District, and the Holy Family School System. The OSPNS additionally encouraged survey participation through the network of Neighborhood Associations which the department directly supports. The office also worked with a handful of groups, including the Black and Brown Small Business Network and the Dubuque Black Men Coalition to promote the survey within minority communities, and sent personal email to leaders within the Marshallese community. Finally, the OSPNS advertised the survey during Community Conversation sessions dedicated to health and wellness while helping to create the Community Equity Profile.

A total of 711 people responded to the survey. The top three community health problems identified were obesity (48.5%), brain health (46.7%), and substance misuse (42.8%). The top two health services that

respondents reported barriers to accessing were brain health care (12.7%) and dental health care (11.1%). Community survey responses are further depicted in Appendix A.

COMMUNITY EQUITY PROFILE

The Community Equity Profile was conducted by the Community Foundation of Greater Dubuque. It provides information on how all people in the community are affected by various systems, such as housing, education, and health care. It can be used to inform leaders, community members and policymakers and serve as a guide for creating an action plan that supports Dubuque's growth as an equitable and inclusive community.

SECONDARY HEALTH DATA SOURCES

LOCAL	Community Survey County Health Rankings Community Equity Profile
STATE	Iowa Public Health Tracking Portal Iowa State University Indicators Program Vital Statistics of Iowa Annual Report Iowa Health Fact book Iowa State University Data for Decision Makers Document Iowa HHS website State Cancer Profiles
NATIONAL	Centers for Disease Control US Census and American Community Survey National Health and Nutrition Examination Survey (NHANES) Community Commons Behavioral Risk Factor Surveillance System (BRFSS) Youth Risk Behavior Surveillance System (YRBSS) Centers for Medicare and Medicaid Services Feeding America

Figure 1. Health Data Sources

Community Profile

DEMOGRAPHICS

Dubuque County is in northeastern Iowa, bordered by the Mississippi River and is comprised of twenty-one unincorporated communities and their surrounding rural areas. The county is home to the City of Dubuque, Iowa's oldest city and the core of a metropolitan service area. Spanning 608 square miles, the County is known for its unique blend of rural and metropolitan characteristics. As of the 2020 census, the population was 99,266 making it the eighth most populated county in Iowa [4].

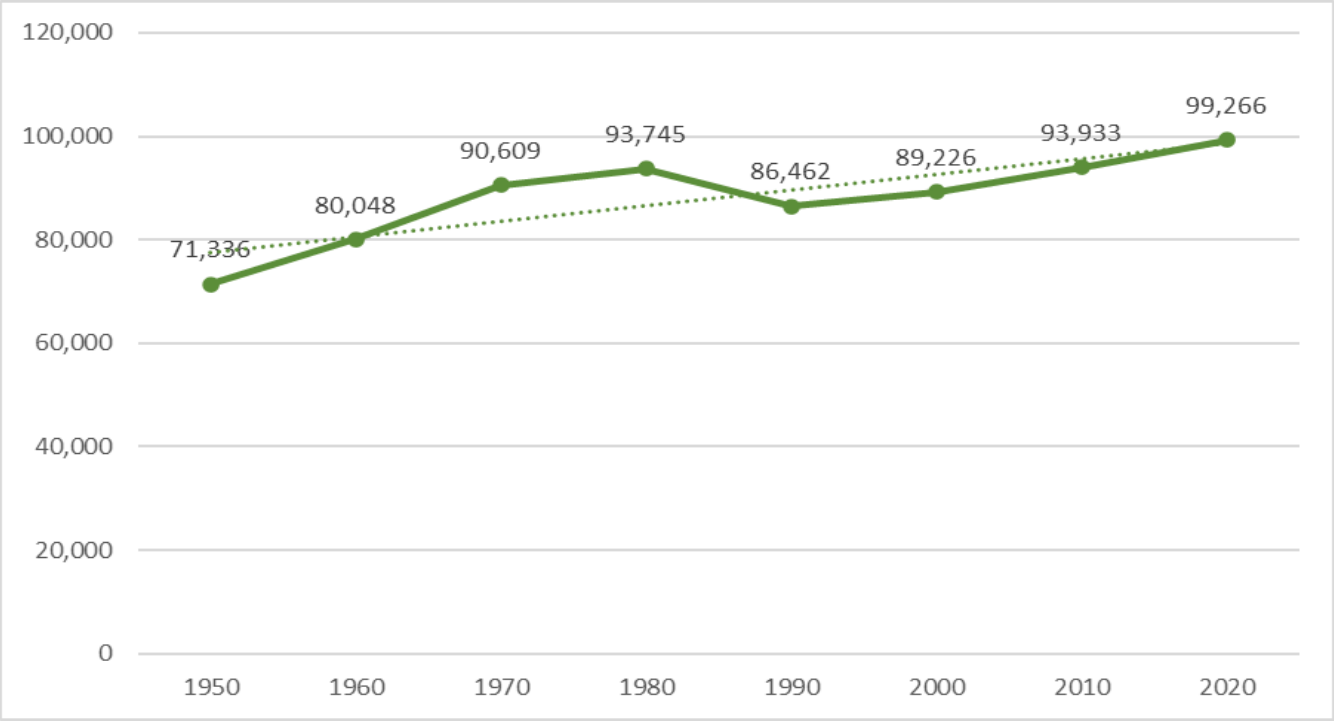


Figure 2. Population in Dubuque County, Iowa

MEDIAN AGE

The median age of Dubuque County residents is 39.5 years, which is slightly above the state and national median ages of approximately 38 years. The share of the Dubuque County population that is 65 and older increased from 15.3% in 2010 to 18.7% in 2021, representing an aging population [4].

BIRTHS

The birth rate in Dubuque County has remained consistent around 11.1 (2022 Iowa HHS live births per 1,000 population, which mirrors that of the state and national averages.

RACE & ETHNICITY

According to the US Census Bureau population estimates as of 2022, Dubuque County's population was predominately White (91.9%) though there has been a slow increase in the diversity of the population since 2000 [4]. The Dubuque community has experienced an increase in the Pacific Islander population in recent years.

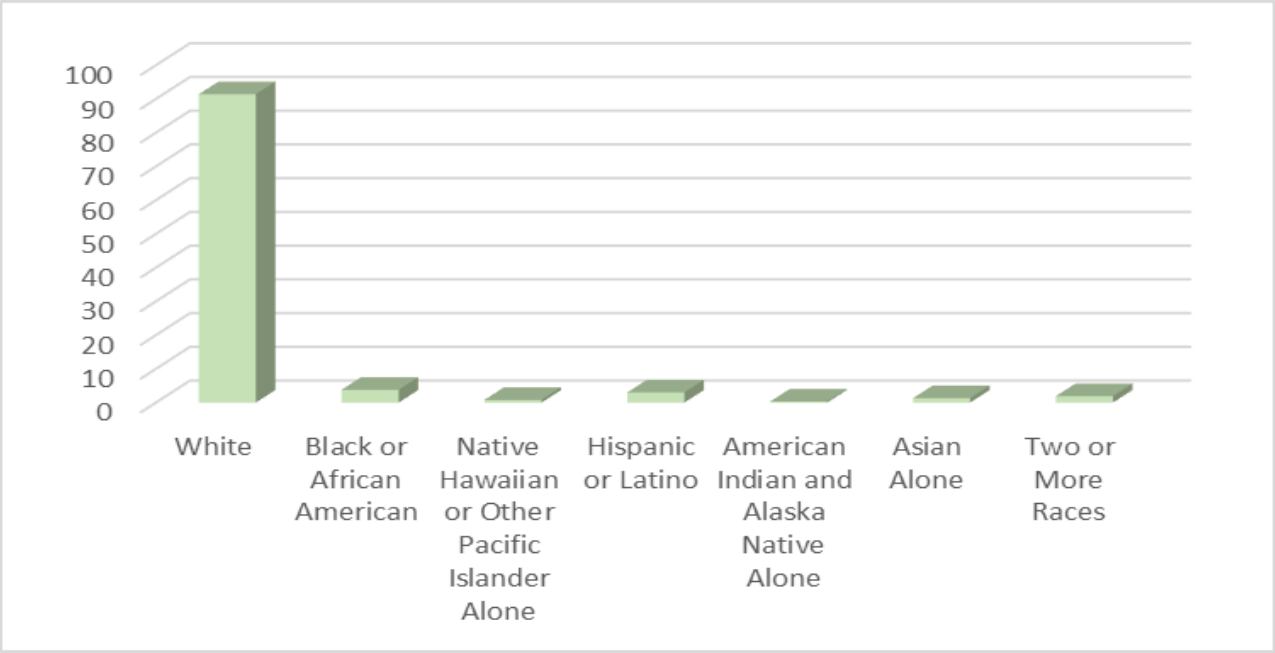


Figure 3. Race and Ethnicity in Dubuque County, Iowa

Year	Native Hawaiian and Pacific Islander Population	Dubuque County Total Population	Native Hawaiian and Pacific Islander Percentage
2016	338	96,359	0.351%
2017	357	96,571	0.370%
2018	394	96,802	0.407%
2019	509	96,982	0.525%
2020	577	97,193	0.594%
2021	639	98,687	0.648%

Figure 4. Native Hawaiian and Pacific Islander Population Growth in Dubuque County, IA

LEADING CAUSE OF DEATH AND LIFE EXPECTANCY

The leading causes of death in Dubuque County in 2022 were diseases of the heart, which includes a variety of conditions such as heart failure, myocardial infarction, ischemic heart disease, and atherosclerotic heart disease [22]. At 17.3 deaths per 10,000 and Malignant neoplasms (Cancer) at 17.4 deaths per 10,000. The average life expectancy for Dubuque County residents rose in 2023 to 80.1 years while national average life expectancy in 2023 declined to the shortest it's been in nearly two decades [25].

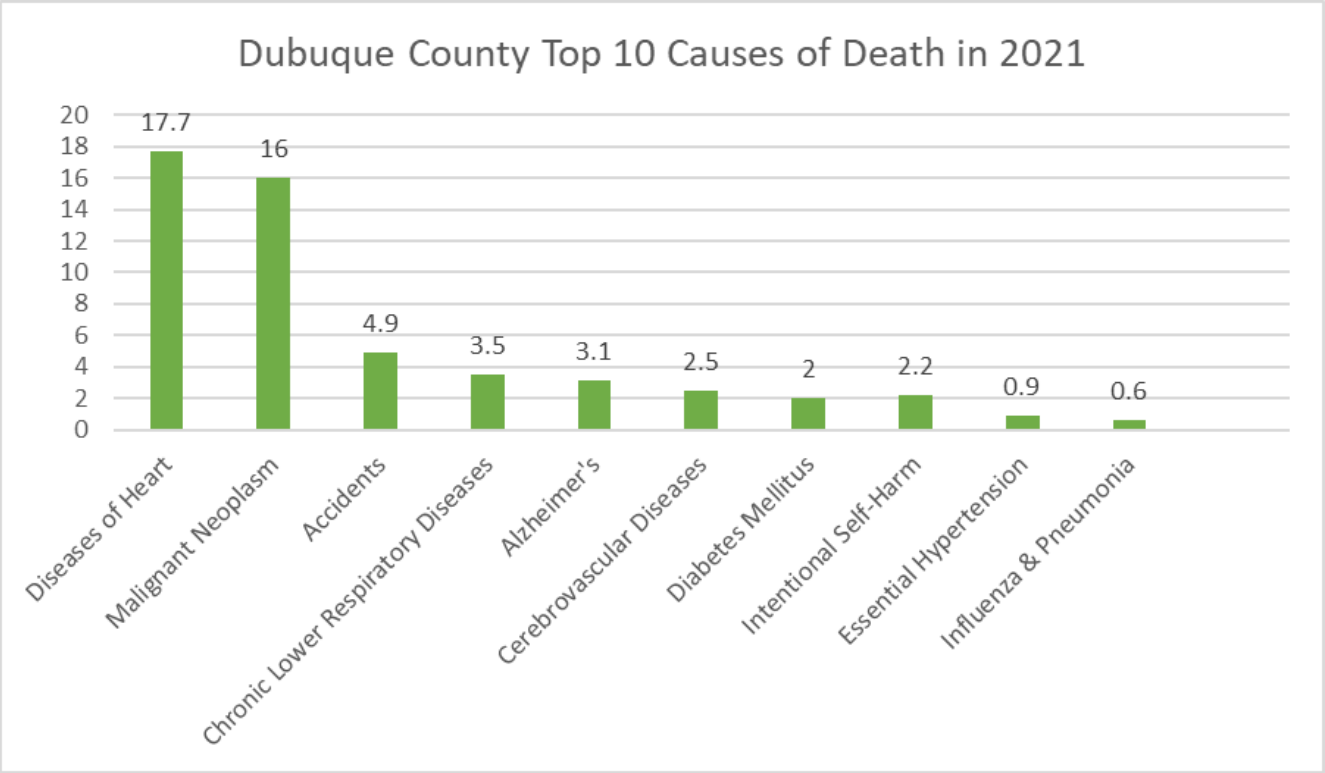


Figure 5. Dubuque County, IA Causes of Death per 10k people [22].

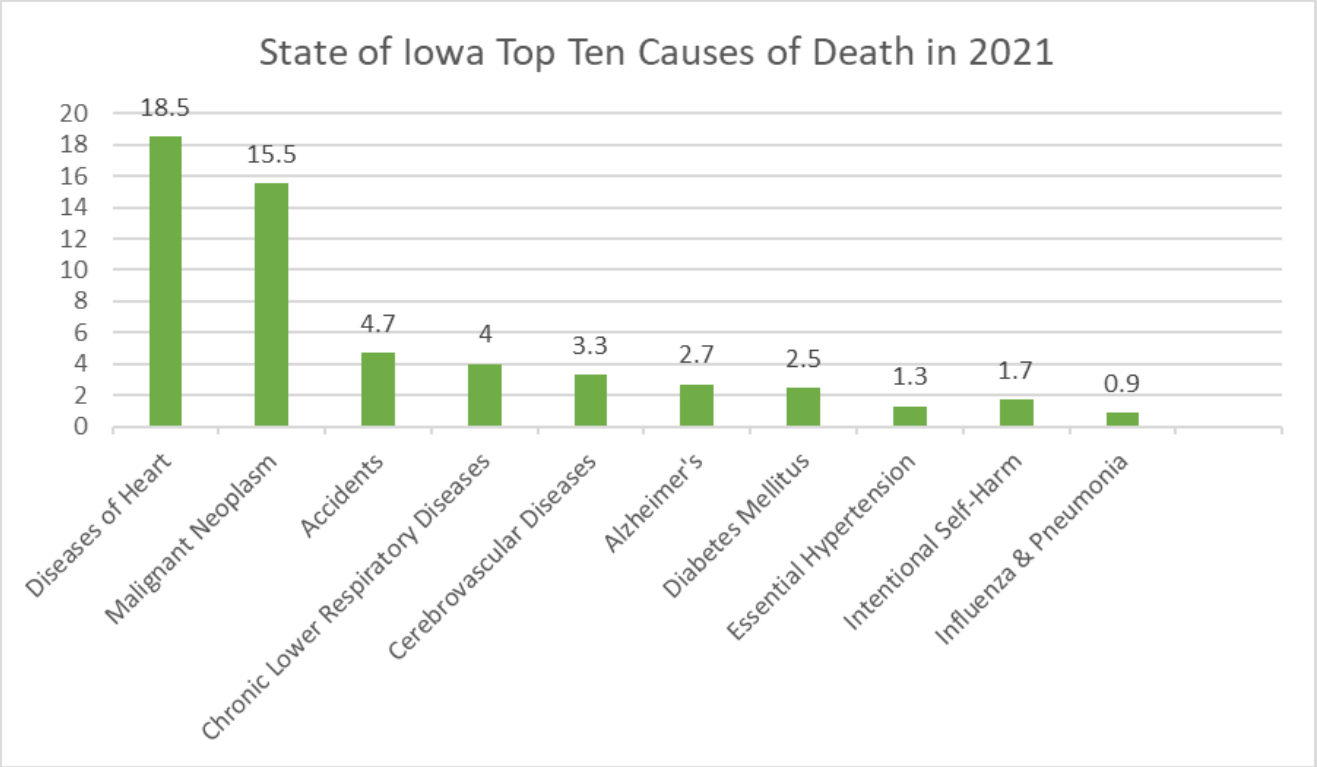


Figure 6. Iowa Causes of Death per 10k people [22].

ECONOMIC STABILITY

Economic stability means that people have the resources essential to a healthy life such as healthy foods, healthcare, and housing. In Dubuque County, approximately 1 in 11 people live in poverty with those who identify as Black/African American disproportionately affected. People with steady employment are less likely to live in poverty and more likely to be healthy.

According to Iowa Workforce Development, Dubuque County's unemployment rates have been consistently decreasing since 2010. Major employers include local school districts, John Deere Dubuque Works, MercyOne Medical Center, Cottingham & Butler, and Medical Associates.

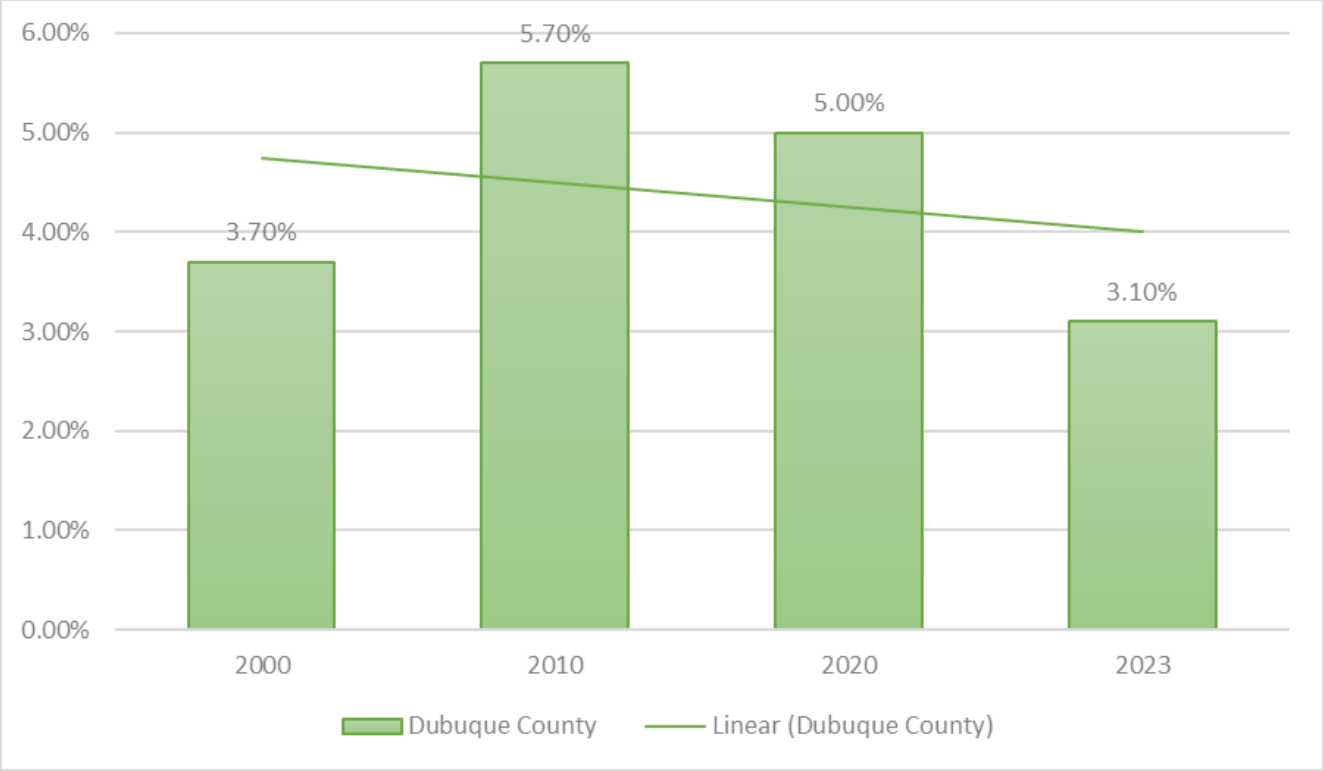


Figure 7. Unemployment Rate for Dubuque County, Iowa

One indicator of economic stability is median household income. The median household income for Dubuque County is $68,198, which is higher than the state median household income of $65,429 and lower than the national median household income of $69,021.

HOUSING

Safe and reliable housing is essential to people's well-being and is generally the largest necessary expense to account for. Housing affordability can be assessed using different metrics including housing market, housing conditions and affordability, and public policies towards affordable housing. Nearly 74% of Dubuque County residents reside in a housing unit that they own and 26.4% of units are renter occupied. Of households with Black/African American residents, only 15.3% own their home, while

76.6% of Whites own their home, making White residents five times more likely to own the home they are living in than their Black/African American counterparts. This disparity is also much more pronounced in Dubuque County than it is nationally, which has a national average of 42.7% home ownerships in Black/African American residents. It is important to note that the population of Black/African American residents in Dubuque County is small (3,042), which may have exacerbated these statistics. **

EDUCATION ACCESS AND QUALITY

People with higher levels of education are more likely to be healthier and live longer. Dubuque County accommodates two public K-12 school districts. The Dubuque Community School District serves approximately 10,000 students across twenty buildings, 28.6% of whom are eligible to participate in the federal free and reduced-price meal program. The Western Dubuque Community School District serves 3,701 students in eight schools, 19.9% of whom are eligible to participate in the federal free and reduced-price meal program. Holy Family Catholic schools and other Catholic and private elementary and high schools are located throughout the county. Nearly 94% of students in Dubuque County successfully complete high school. Dubuque is a college town with five higher learning institutions and 32.1% of the Dubuque County population 25 and older holds a bachelor's degree or higher.

HEALTHCARE ACCESS AND QUALITY

Access to comprehensive, high-quality health care services are important for promoting and maintaining health, preventing, and managing disease, and achieving health equity. Sometimes people don't get the health care they need because they cannot afford it, they don't have a primary medical provider, or they lack reliable transportation. In Dubuque County, 5% of people under the age of 65 do not have health insurance - half that of the national uninsured rate. Dubuque County accommodates one primary care physician per 1,270 people. 79% of community survey respondents reported getting a yearly health exam at a Medical Provider/Doctor's Office/Clinic.

NEIGBORHOOD AND BUILT ENVIRONMENT

Where people live can have a major impact on their health and well-being [4]. Components such as air quality, ambient noise, climate, land use and development patterns, physical activity, public spaces, and transportation contribute to a built environment. According to the Community Equity profile, 75% of survey respondents agreed or strongly agreed that they feel safe when traveling to other neighborhoods in Dubuque, and 79% of workers living in Dubuque commute to work alone by car, truck, or van. Several respondents reported challenges to finding parking in the downtown Dubuque area.

SOCIAL AND COMMUNITY CONTEXT

Social support at home, at work, and in the community can help reduce the negative impact of stressors that people cannot control. Social support networks have been identified as powerful predictors of health behaviors, suggesting people with a strong social network are less likely to make healthy lifestyle choices than people with a strong network. According to County Health Rankings, there are 107 social

associations in Dubuque County. Associations include membership organizations such as civic, sports, religious, political, labor, business, and professional organizations. They also include centers that offer physical activities such as fitness centers, golf clubs, and bowling leagues. According to the County Health Rankings, 5% of youth reported disconnection [25]. According to the Community Equity Profile, 85% of survey respondents agreed or strongly agreed that there are opportunities to attend art events in Dubuque.

COMMUNITY HEALTH DISPARITIES

In 2023, Dubuque County ranked 21 out of 99 Iowa counties with respect to health outcomes (how healthy a county is) and 48 out of 99 in health factors (things that can be modified to improve the length and quality of life for residents) according to the County Health Rankings [23]. Of those that responded to the community survey, the majority felt that the community was less healthy in 2023 than in the previous five years. Approximately 11% of Dubuque County residents reported fair or poor health, which is slightly lower than the state and national averages, both of which are 12% [23].

The data subcommittee collected secondary data indicators and calculated a differential for each data indicator, comparing quantitative data indicators from Dubuque County to the state of Iowa and the United States. The need differential was calculated using the following formula: Need Differential= (current rate- benchmark rate)/ current rate) x 100. In the table below, data indicators that were worse than both the state and the nation are coded in red. Data indicators that are similar to or fall in between the state and nation are coded in yellow. Data indicators coded as green are areas of strength.

Secondary Data		Dubuque County	Iowa	United States	Year
Access to Care					
Primary care providers per 100,000 population[21]		86.64	109.33	109.34	2023
Mental health providers per 100,000 population[21]		119.88	122.15	155.76	2023
Addiction/substance use providers per 100,000 population[21]		18.13	20.94	24.88	2023
Dentists per 100,000 population[1]		83	70	72.4	2021
Recent Primary Care Visit within past one year (Age adjusted)[7]		73.00%	73.39%	71.80%	2021
Uninsured Population[2]		3.42%	4.86%	8.77	2017-21
Health Outcomes					
Preventable hospitalizations per 100,000 Medicare beneficiaries[21]		5542	2289	2752	2021
30-Day hospital readmissions (Medicare beneficiaries)[21]		18.10%	15.20%	18.10%	2020
Asthma hospitalizations per 10,000 population (Age-adjusted)[26]		2.3	1.66		2022
Asthma emergency department visits per 10,000 population (Age adjusted)[26]		32.17	26.94		2022
Current Asthma Age 18+ (Age adjusted)[7]		9.30%	9.40%	9.70%	2021
Oral health emergency department visits per 10,000 population (Age adjusted)[26]		36.74	28.71		2022

Heart attack hospitalizations per 10,000 population (Age adjusted)[26]		27.02	25.66		2022
Heat related illness Emergency Department visits per 100,000 (Age adjusted)[26]		44.92	31.95		2022
Diabetes Prevalence (Age adjusted)[7]		8.20%	8.57%	9.90%	2021
Cancer Incidence All Sites per 100,000 population[28]		475.3	486.8	442.3	2016-20
Colon and Rectum Cancer Incidence per 100,000 population[28]		37.2	40.7	36.5	2016-20
Breast Cancer incidence per 100,000 population[28]		135.2	134.7	127	2016-20
Lyme Disease per 100,000 population[26]		51.2	11.3		2021
Alzheimer's Disease Prevalence (Medicare beneficiaries)[21]		8.40%	9.60%	10.80%	2018
Heart Disease Prevalence (Medicare beneficiaries)[21]		17.90%	24.00%	26.80%	2018
Chronic Obstructive Pulmonary Disease (COPD) Prevalence (Age adjusted)[7]		5.80%	5.98%	5.70%	2021
High Blood Pressure Prevalence Age 18+ (Age Adjusted)[7]		25.20%	27.90%	29.60%	2021
Low Birth Weight (less than 2,500 grams)[20]		6.00%	6.80%	8.20%	2014-20
Low Birth Weight (less than 2,500 grams) Non-Hispanic White[20]		6.00%	6.00%	6.90%	2014-20
Low Birth Weight (less than 2,500 grams) Non-Hispanic Black/African American[20]		12.00%	12.00%	13.60%	2014-20
Low Birth Weight (less than 2,500 grams) Hispanic or Latino[20]		5.00%	7.00%	7.40%	2014-20
Health Behaviors and Risk Factors					
Obesity (Adult) (Age adjusted)[7]		32.30%	36.64%	33.00%	2021
Obesity (9th-12th graders)[13,11]			15.80%	16.30%	2021
Overweight (9th-12th graders)[13,11]			16.00%	16.00%	2021
Access to exercise opportunities[20]		83%	79%	84%	2020 & 2022
Current smokers[7]		15.60%	16.53%	13.80%	2021
Excessive drinking (Age adjusted)[20]		27%	25%	19%	2020
Binge drinking (Age adjusted)[7]		22.20%	21.33%	16.70%	2021
Gonorrhea cases per 100,000 population[26]		175	140		2022
Syphilis cases per 100,000 population[26]		30	27		2022
Chlamydia cases per 100,000 population[26]		479	458		2022
HIV Prevalence[10]		91.8	111.1	379.7	2020
Child immunization (2-year-olds)[26]		65.50%	70.10%		2022
Teen birth rate (births per 1,000)[8]		6.5	6.2		2022
Breastfeeding initiation rate[26]		81.60%	85.30%		2022
Social Influencers of Health					
Food insecurity rate[17]		7.20%	7.62%	10.28%	2021
Food insecurity (children)[17]		8.60%	9.70%	13.30%	2021
Food insecure children ineligible for assistance[17]		31.00%	27.12%	26.64%	2021
Poverty- Population below 200% Federal Poverty Level (FPL)[5]		22.93%	27.34%	29.21%	2017-21
Preschool Enrollment (Children Aged 3-4)[5]		45.78%	43.49%	45.93%	2017-21
Housing cost burdened[5]		23.84%	22.73%	30.34%	2017-21

Unemployment Rate[29]		3.10%	3.30%	4.00%	2023
Rate of Homelessness Among Public School Districts[30]		1.80%	1.54%	2.77%	2019-20
Median Household Income[5]		$68,198	$65,429	$69,021	2017-21
Students Eligible for Free or Reduced Price Lunch[14]		35.70%	40.10%	51.70%	2020-21
Percent Households Receiving SNAP Benefits[5]		8.62%	9.58%	11.37%	2017-21
Population Age 25+ with bachelor's degree or Higher[2]		32.10%	29.17%	33.67%	2017-21
Population Age 25+ with No High School Diploma[2]		6.25%	7.19%	11.13%	2017-21
Students Scoring "Not Proficient" or Worse in Reading (4th grade)[30]		36.80%	34.50%	60.10%	2020-21
Incarceration Rate[27]		0.70%	0.70%	1.30%	2018
Violent Crime Rate per 100,000 population[16]		209	283	416	2015-17
Physical Environment					
Driving alone to work[13]		81%	79%	73%	2017-21
Air pollution (Particulate matter micrograms per cubic meter)[13,12]		9.1	7.4	7.4	2019
Population who live within a 10-min walk from a park[15]		45.46	45.28	43.57	2020
Recreation and Fitness Facilities per 100,000 population[3]		16.12	12.13	11.94	2020
Fast Food Restaurants per 100,000 population[3]		73.54	64.82	75.89	2020
Percent Low Income Population with Low Food Access[18]		21.95	19.53	19.41	2019
Occupied Housing Units with One or More Substandard Conditions**[5]		24.49%	23.10%	31.49%	2017-21
Brain Health					
Suicide Mortality per 100,000 population[9]		13.8	16	13.8	2020
Male Suicide Mortality per 100,000 population[9]		26.3	26.1	22.2	2020
Female Suicide Mortality per 100,000 population[9]		suppressed	6	6	2020
Poor Mental Health (14 or more poor mental health days during the past 30)[7]		14.80%	15.12%	14.70%	2021
Depressive Disorder Age 18+ (Age adjusted)[7]		17.80%	18.80%	19.80%	2021

* Low Birth Weight (less than 2,500 grams) in non-Hispanic Black/African Americans, although similar to state and national rates for non-Hispanic Black/African Americans, was still coded as red since it is higher than the all-race overall rate of 6%.

**1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%.

TABLE 1. Community Health Disparities

COMMUNITY HEALTH ASSESSMENT FINDINGS

It is important to note that some health needs are state and/or nationwide issues and were not detected during the need differential analysis. Therefore, annual trends were also analyzed. This list was cross-referenced to the CHA community survey results as well as the qualitative and quantitative responses from the Health & Wellness Community Equity Profile, which consisted of a survey and community discussion conducted by the Community Foundation of Greater Dubuque.

After aggregating all data sources, the following needs were determined to be most pertinent in the Dubuque Community and the Steering Committee selected items 1, 2, and 3 for inclusion in the CHIP.

1. Brain/Mental Health (including alcohol and drug misuse)
2. Obesity (including physical activity and nutrition)
3. Access to dental care
4. Access to care
5. STIs & Sexual Health/Behavior
6. Food Insecurity
7. Lyme Disease
8. Alzheimer's Disease
9. Asthma

PRIORITY 1A: BRAIN HEALTH

COMMUNITY EQUITY PROFILE

According to the Dubuque Community Equity Profile, concerns regarding brain (mental) health treatment were significant. The data indicated that 58.33% of respondents strongly agreed and 30.56% agreed that there is a need for improved brain health treatment. Participants expressed frustration with long waiting times to secure appointments and a shortage of brain health providers. When asked whether it was easy to access brain (mental) health services, 59.38% either disagreed or strongly disagreed. The CHA Survey also found that brain health was a major concern among Dubuque County residents, consistently ranking as a top response.

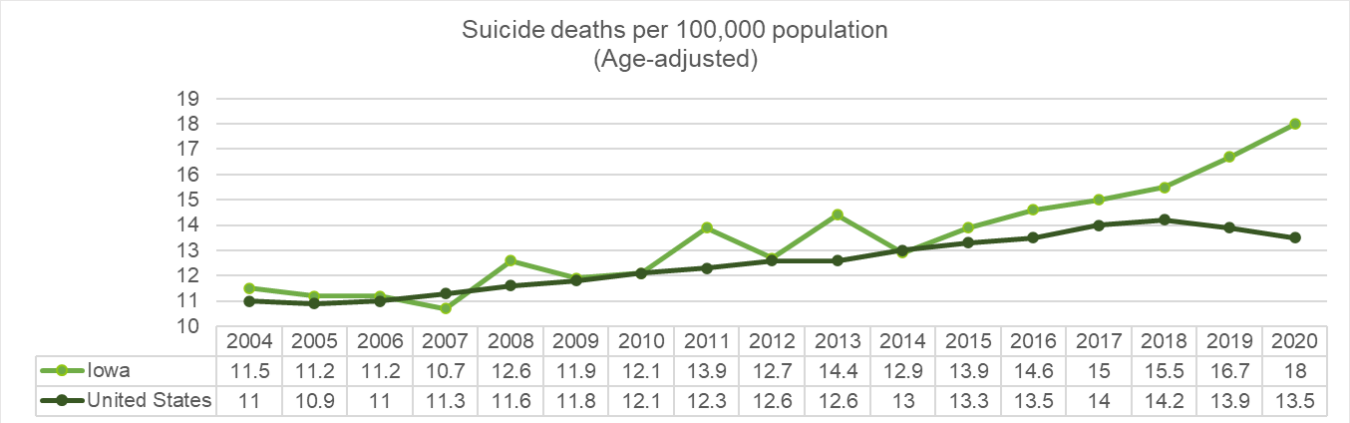
COMMUNITY SURVEY

- "Brain/Mental health" was the #1 response (12.7%) to the question "Do you currently have trouble accessing any of the following?"
- "Access to brain/mental health services" was the #1 response (39%) to the question "What do you feel are the top three (3) health concerns for CHILDREN (0-17 years old) in your community?"
- "Help with access to brain/mental health services" was the #1 top response (34.2%) to the question "What are the top three (3) public health services you would like to see in your community?"
- "Brain/Mental health" was the 2nd top response (46.7%) to the question "What do you feel are the top three (3) health problems in your community?"
- "Decrease stress" was the #2 top response (47.4%) to the question "What three (3) healthy behaviors would you like to start or improve?"
- "Access to brain/mental health services" was the #3 top response (36.3%) to the question "What do you feel are the top three (3) most important factors in a healthy community?"

- 58.5% of respondents reported having ever had a mental/brain health diagnosis, such as depression, bipolar disorder, or anxiety.

SECONDARY DATA

- The male suicide rate for Dubuque County is 26.3 per 100,000, which is higher than both the state and national rates.
- 14.8% of adults aged 18+ report having poor mental health. (BRFSS, 2021)
- 17.8% adults 18 and older reported having depressive disorder (BRFSS, 2021)
- There are 23% fewer mental health care providers in Dubuque County per 100,000 population than the total United States. (Centers for Medicare and Medicaid Services, 2023.)
- Suicide mortality rates in Iowa have been increasing for over the past decade.



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Iowa	11.5	11.2	11.2	10.7	12.6	11.9	12.1	13.9	12.7	14.4	12.9	13.9	14.6	15	15.5	16.7	18
United States	11	10.9	11	11.3	11.6	11.8	12.1	12.3	12.6	12.6	13	13.3	13.5	14	14.2	13.9	13.5

Figure 8. The graph above shows age-adjusted death rates due to intentional self-harm (suicide).

PRIORITY 1B: SUBSTANCE MISUSE

COMMUNITY EQUITY PROFILE

Participants of the Dubuque Community Equity Profile expressed desire for better access to substance use disorder care and services and recognized the importance of these services in promoting a healthy community. The data indicated that 50% of respondents strongly agreed and 38.89% agreed that there is a concern regarding the use of other substances. Access to substance abuse treatment was also a concern, with 47.22% of respondents strongly agreeing and 33.33% agreeing.

Qualitative comments provided by community members regarding substance misuse resources:

- "We need a substance abuse treatment facility. We also need better mental health care, what happened to discussions about a mental health court, similar to the drug court, to help those untreated, chronic individuals who end up in jail or back to the Mission."
- "Additional brain health providers are also needed in Dubuque."

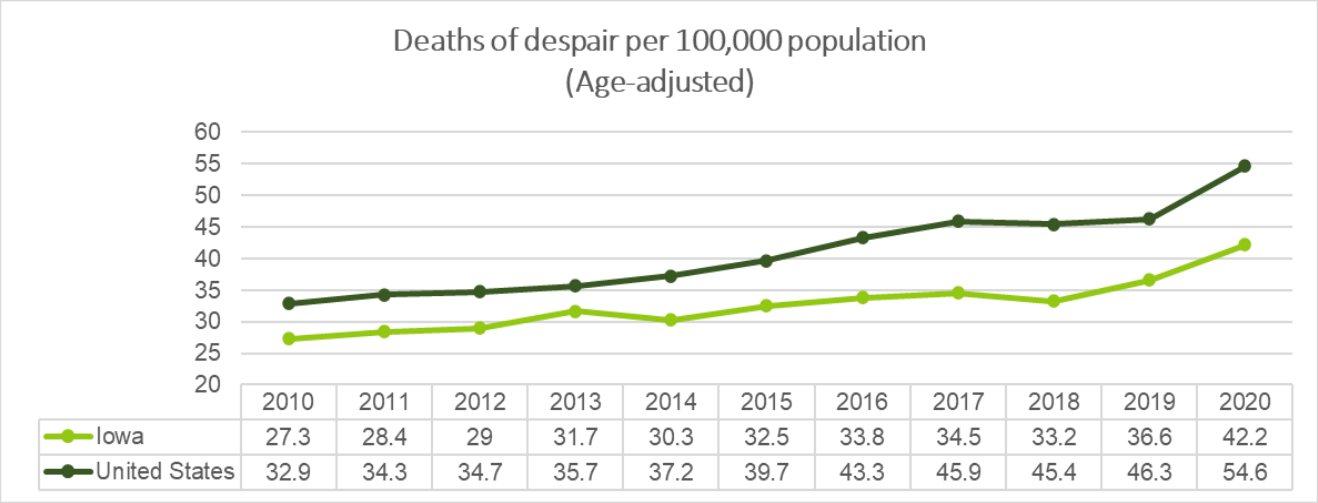
- "Dubuque really needs an in-patient substance use disorder treatment center! What ever happened to the 6 'access centers' that Governor Reynolds was going to open? We need what Cedar Rapids has!"

COMMUNITY SURVEY

- "Substance misuse" was identified as the #3 top health problem in the community (42.8%)
- "Alcohol misuse" was the #1 top response for adult high-risk behaviors.
- "Illegal drug misuse" was the 4th top response for adult high-risk behaviors.

SECONDARY DATA

- There are 18.13 addiction/substance use providers per 100,000 population in Dubuque County, which is lower than the state (20.94) and national (24.88) rates.
- 22.20% of adults report binge drinking (age adjusted), which is higher than the state (21.33%) and national (16.70%) rates.
- Although Dubuque had fewer alcohol-impaired driving deaths in comparison to Iowa and the USA (19%, 27% and 27% respectively), Dubuque County ranked first for excessive drinking – with 27% of adults reporting they binge drink or drink heavily.
- Deaths of despair which include deaths due to intentional self-harm (suicide), alcohol-related disease, and drug overdoses have been on the rise in the state of Iowa and nationally over the past decade.
- Deaths due to alcohol and psychostimulants (e.g. methamphetamine, cocaine, bath salts) have been on the rise in the past decade in Iowa



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Iowa	27.3	28.4	29	31.7	30.3	32.5	33.8	34.5	33.2	36.6	42.2
United States	32.9	34.3	34.7	35.7	37.2	39.7	43.3	45.9	45.4	46.3	54.6

Figure 9. The graph above shows age-adjusted death rates due to intentional self-harm (suicide), alcohol-related disease, and drug overdoses, also known as "deaths of despair," per 100,000 population over time.

- Deaths due to alcohol and psychostimulants (e.g. methamphetamine, cocaine, bath salts) have been on the rise in the past decade in Iowa

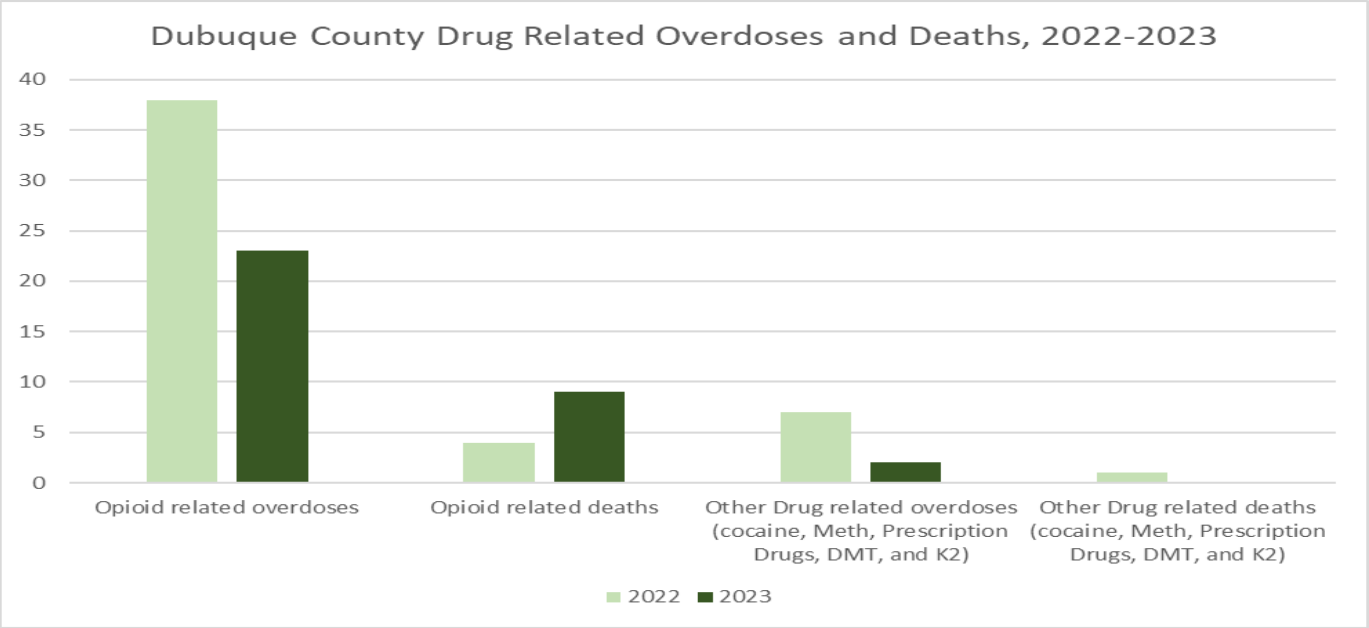


Figure 10. Opioid related overdoses and deaths in Dubuque County in 2022 and 2023 compared to overdoses and deaths related to all other drugs such as cocaine, Meth, Prescription Drugs, DMT, and K2.

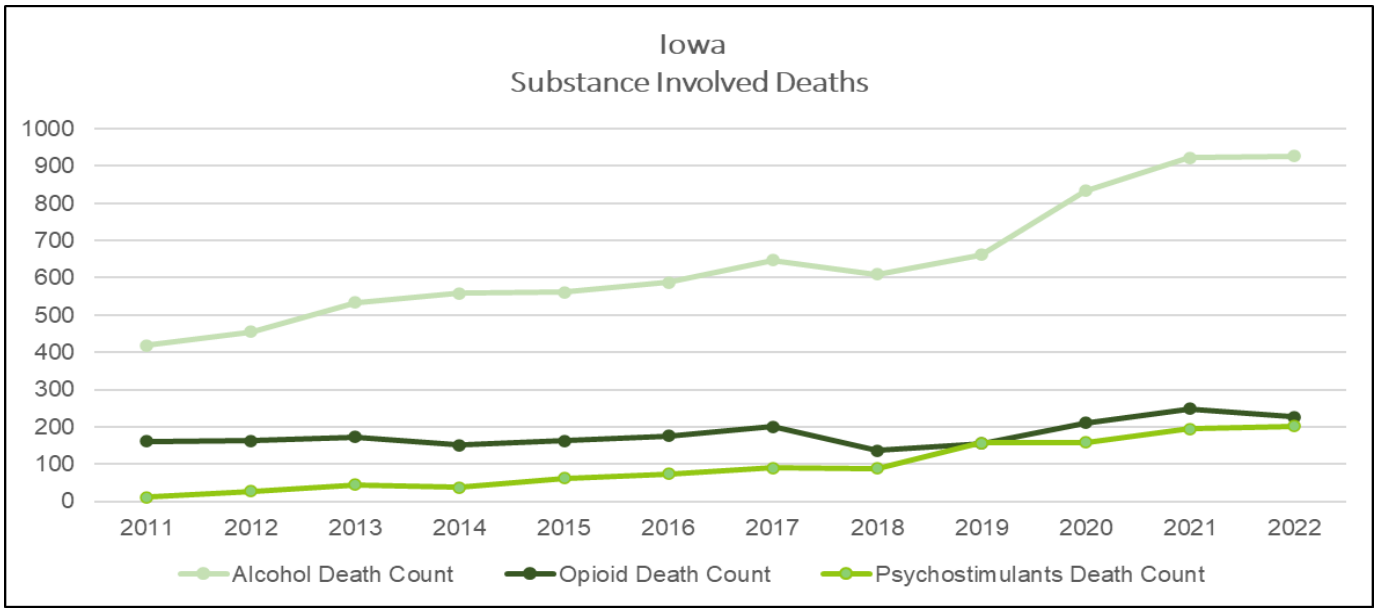


Figure 11. Deaths caused by substance-involved poisoning include the number of people who died because they were exposed to drugs such as opioids, alcohol, and methamphetamines.

PRIORITY 2: IMPROVED ACCESS TO DENTAL CARE

COMMUNITY EQUITY PROFILE

Comments from participants related to dental care access included:

- "Clinics for ob-gyn, dental, and mental health are limited depending on insurance coverage. Title 19 recipients are severely impacted from having a choice of providers."
- "I can get no Dental at all."

COMMUNITY SURVEY

- "Dentist" was the second top response (11.1%) to the question "Do you currently have trouble accessing any of the following?" Of those who were currently uninsured, 18.75% reported having trouble.
- Dental inaccessibility is most experienced by those with low incomes.
- Despite the ratio of dental providers to population being a strength of Dubuque County, there is a shortage of dentists who accept Medicaid and Iowa Wellness Delta Dental Insurance. 51.8% of survey respondents on Medicaid reported having trouble accessing a dentist.

SECONDARY DATA

- Dubuque County oral health emergency department visits were 36.74 per 10,000 population (Age adjusted) which is higher than the state's average of 28.71.
- Current capacity of Crescent

PRIORITY 3: PHYSICAL ACTIVITY, NUTRITION, AND OBESITY

In 2023, 33.7% of Dubuque County was reported to have a BMI greater than 30 which classifies as being obese and 42% have a BMI greater than 25 classifying them as overweight. From 2021 to 2023 the obesity rate in Dubuque County dropped 3.6% from 37.3% to 33.7%. Dubuque County's prevalence of obesity was lower than the state average (36.4%) and the national average (39.6%). People classified as overweight and/or obese are at greater risk for heart disease, stroke, type II diabetes, musculoskeletal disorders, and certain cancers. Access to exercise opportunities in Dubuque County was slightly below the national average, 83% of the Dubuque County population has adequate access to locations for physical activity compared to the national average of 84%. The CHA survey identified obesity as the number one health problem in the community, with 48.5% of respondents reporting it as one of their top three concerns. Physical activity (43.5%) and poor diet (36.7%) were identified as the second and third top adult high-risk behaviors in the community. Of the top three healthy behaviors respondents said they would like to start or improve, "Get more physical activity" (59.1%) and "Eat more fruits and vegetables" (42.1%) were the first and third most popular answers.

Iowa ranks 11th in the nation for adult obesity

- In 2023, Iowa's rate for adult obesity was 36.4%
- 31.8% of Iowan highschoolers are overweight or obese (YBRSS)

- Over the past decade, the proportion of adult Iowans with a normal body mass index (BMI) has declined, while the proportion of obese Iowans has increased.

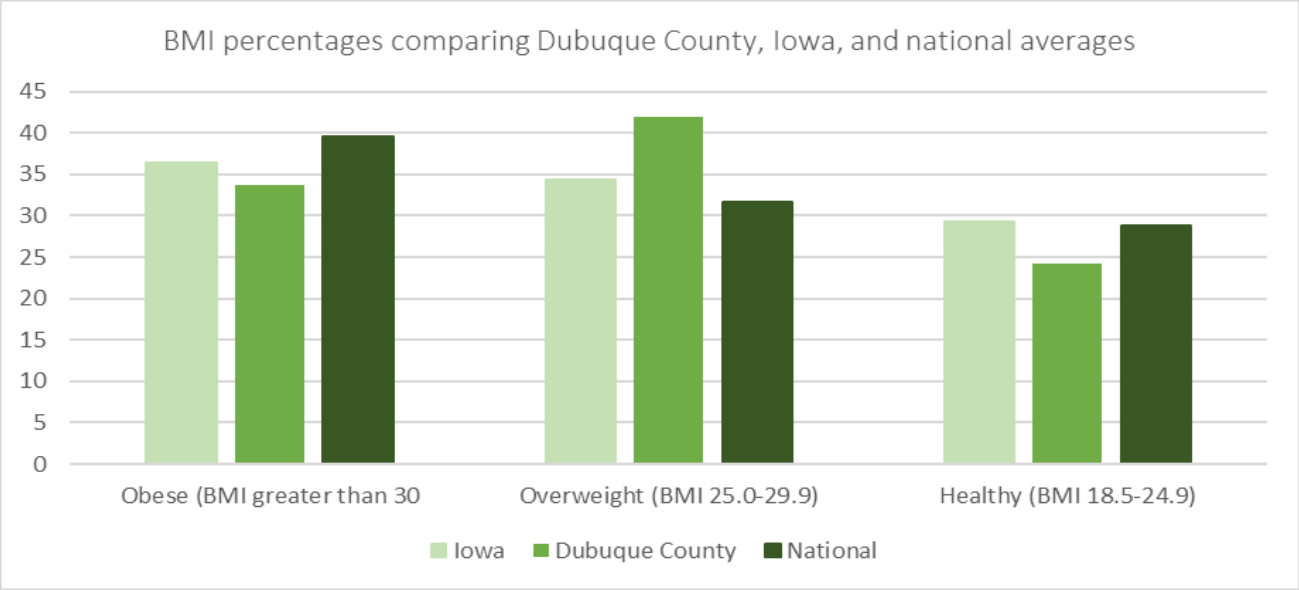


Figure 12. Weight Classification by Body Mass Index (BMI) comparing Dubuque Counties average to the state and national average.

COMMUNITY HEALTH IMPROVEMENT PLAN

The goals, objectives, and strategies to address each of the selected health priorities are outlined below.

PRIORITY 1: BRAIN HEALTH (INCLUDING SUBSTANCE MISUSE)

Goal: Improve brain health and reduce substance misuse among Dubuque County residents.		
CHNA Impact Measures	**2024 Baseline**	**2027 Target**
Service providers will update 211, Findhelp, and AccessMeCare when prompted. 45% in year one, 50% in year two, and 55% in year three.	0	55%
Improve one or more policies related to tobacco or alcohol.	0	≥1
125 people will participate in Mental Health First Aid training. (25 in year one, 50 in year two, and 50 in year three.)	0	125

Strategy	Timeline	Hospitals and Committed Partners	Focus Populations (in Dubuque County)
Create a workflow for service providers to update 211, findhelp.org, and AccessMeCare online directories regularly and otherwise improve navigation of the system for help seekers.	Years 1-3	• MercyOne Dubuque Medical Center • Hillcrest • United Way	Service Providers
Review local policies on tobacco and alcohol sales; explore and promote model policies that assure age appropriate and safe tobacco and alcohol purchases.	Years 1-3	• Area Substance Abuse Council • City of Dubuque Health Department • Dubuque County Health Department • Police Department • Sherriff Department	Dubuque County Residents
Recruit community leaders to participate in Mental Health First Aid training.	Years 1-3	• MercyOne Dubuque Medical Center • Certified Mental First Aid Educators • Community Foundation • John Deere • City of Dubuque	Religious leaders, Business Leader Equity Cohort, Employer Inclusion Council
Active participation in the committee responsible for planning the use of the Opioid Settlement funds.	Years 1-3	• MercyOne Dubuque Medical Center • Dubuque County Public Health • City of Dubuque	Dubuque County Residents

PRIORITY 2: IMPROVED ACCESS TO DENTAL CARE

Strategy 1: Implement Oral Health Advisory Board

Objective	Action Plans
Oral Health Advisory Board (OHAB) to meet quarterly beginning March 2024.	1. By January 2024, I Smile Coordinator will work with local dentists to identify Dental Health Champion. 2. Dental Health Champion and I Smile Coordinator will set up structure and meeting schedule to begin March 2024 3. Invite representatives from vulnerable populations, community partners, schools, and medical providers.
Develop tools and information to highlight resources available to advocate for increased oral health care by September 2025.	1. OHAB will develop partnership with NICC Dental clinic to increase dental care by September 2025. 2. Through September 2025 I Smile Coordinator will train additional pediatric medical offices to screen and promote oral health care. 3. Through September 2025 OHAB will work to increase maternal health education and clinical appointments including post pregnancy. 4. Through September 2025 I Smile Coordinator and Crescent will talk with legislatures about Medicaid reimbursement rates and the number of providers accepting Medicaid 5. By September 2025 DBQ Co will increase partnerships with University of Iowa to explore additional outreach clinics.
I Smile Coordinator will disseminate quarterly PSA's throughout DBQ County Beginning June 2024 and OHAB will work to identify organizations and community partners to develop consistent messaging for oral health education and promotion.	1. By December 2024 I Smile Coordinator will develop 1st birthday messaging for families and distribute throughout the community targeting child care centers and pediatricians. 2. By December 2024 I Smile Coordinator will develop oral health messaging for adults attending annual wellness exams. 3. By December 2025 OHAB will develop an oral health tool kit for well child exams. 4. Through June 2025 Tobacco Prevention and Control Coordinator will incorporate oral health focus when conduction school education. 5. Through December 2025 OHAB will investigate opportunities for oral health and nutrition education and outreach in grocery stores and gas stations. 6. Through September 2025 I Smile Coordinator will train additional medical offices to screen and promote oral health care. 7. Through December 2025 I Smile Coordinator will investigate grant opportunities to increase the purchase of toothbrushes.

Timeline and Tasks

Strategy	Timeline	Community Partners	Community Resources	Focus Populations
Implement Oral Health Advisory Board	Year 1	• NICC • Crescent Community Health Center • Visiting Nurses Association (VNA) • Dental Providers • Medical Providers	• Medical Offices • Dental Offices • VNA • Crescent • Community Meeting Space	• Medicaid • Uninsured • All residents
Increase Access to Oral Health Providers	Year 2-3	• NICC • University of Iowa • Crescent Community Health Center • I Smile/ VNA • Pediatricians • Local Legislatures • Dental Providers	• Crescent Dental Mobile Unit • NICC Dental Clinic • Local Dental Staff • Local Medical Staff • Students • Dental Offices	• Medicaid • Uninsured • All residents
Increase Oral Health Education and Awareness	Year 1-3	• I Smile/ VNA • Tobacco Control and Prevention Staff • WIC • Medical Providers • Grocery Stores • Gas Stations	• Child Care • Schools • Medical offices • Dental Offices • I Smile/ VNA • Crescent • Board of Health • Dubuque Co. Early Childhood • Food Pantries • Shelters • WIC • DBQ. Co. Wellness • Legislatures	• Medicaid • Uninsured • All Residents

PRIORITY 3: PHYSICAL ACTIVITY, NUTRITION, AND OBESITY

Strategy 1: Promoting Physical Activity and Nutritional Resources in Dubuque County

Objective	Action Plans
Develop a webpage including all of the physical activity and nutrition resources in Dubuque County.	1. Develop a comprehensive list of all physical activity and resources available in Dubuque County including walking paths and trails, golf courses, pools, available courts and fields, disc golf courses, playgrounds, gyms, hiking areas, Etc. 2. Create a tab within the webpage for local physical activity and nutrition groups and clubs 3. Create a tab within the webpage that promotes and supports local food initiatives such as the Dubuque Farmer's Market, Local Gardens, Etc.
Map all physical activity and nutritional resources available to residents of Dubuque County.	1. Work with the Dubuque County GIS team to develop a map that is easily accessible to Dubuque residents in order to promote physical fitness and nutrition opportunities. 2. Update the map each month to include an up-to-date list of physical activity resources that takes into account seasonal availability.
Identify gaps that prohibit sufficient exercise and nutrition for Dubuque County residents.	1. Reduce barriers to affordable, nutritious food for all people in Dubuque County, Iowa. 2. Increasing engagement in active living through a variety of mediums for all Dubuque County residents.

Contact Information

The Community Health Assessment and Community Health Improvement Plan Steering Committee invites your feedback regarding this document. If you would like to share your feedback with us, please contact any of the Steering Committee members listed below.

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Accessibility

The Community Health Assessment and Community Health Improvement Plan will be posted to the Dubuque County Public Health Department website: https://dubuquecountyiowa.gov/223/Health-Department. Paper copies of the document are available upon request by visiting the Dubuque County Public Health Department. You can also write or call the office of the Executive Director to request a copy of the document.

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Next Community Health Assessment

The next Community Health Assessment will be scheduled for completion by November 2028.

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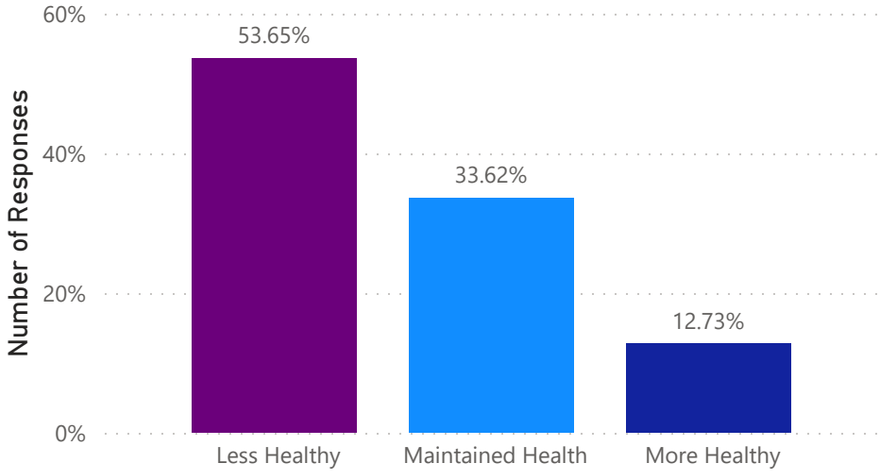
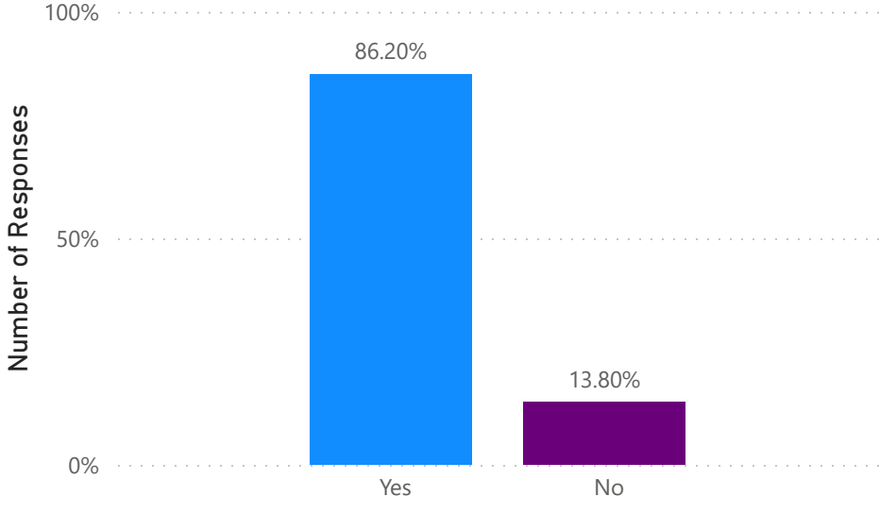
Community Health Survey: Demographic Breakdown

1: Introduction and Demographics

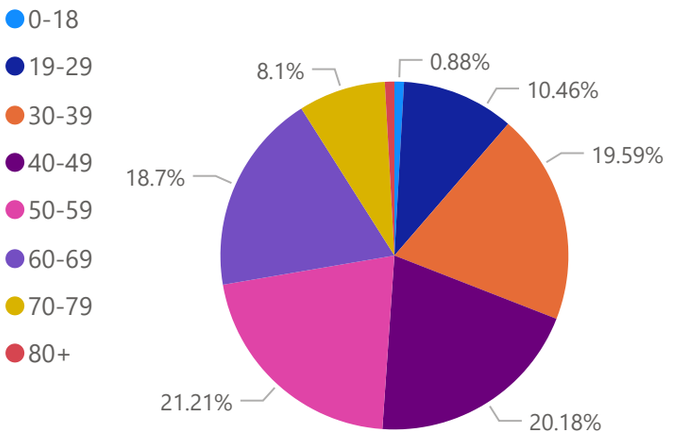
1a: Do you feel people in this community are healthier, less healthy, or have maintained health over the last five (5) years?



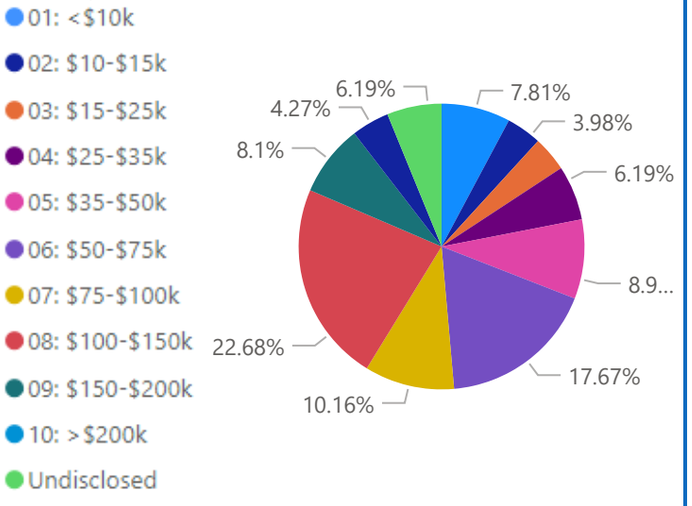
1b. Do you get a yearly health exam?



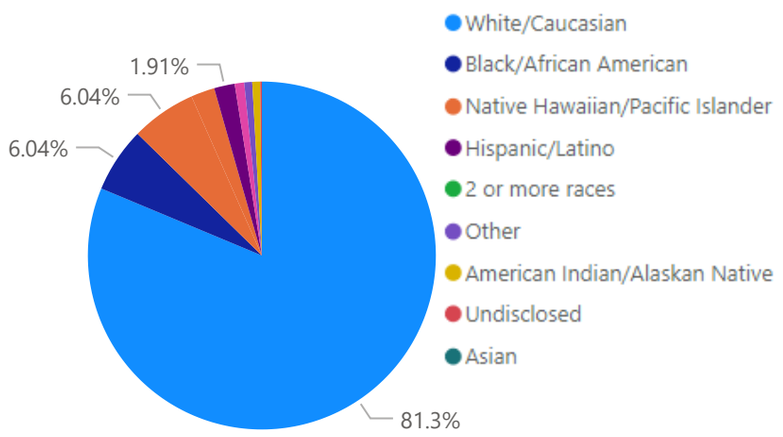
1c. Responses by Age



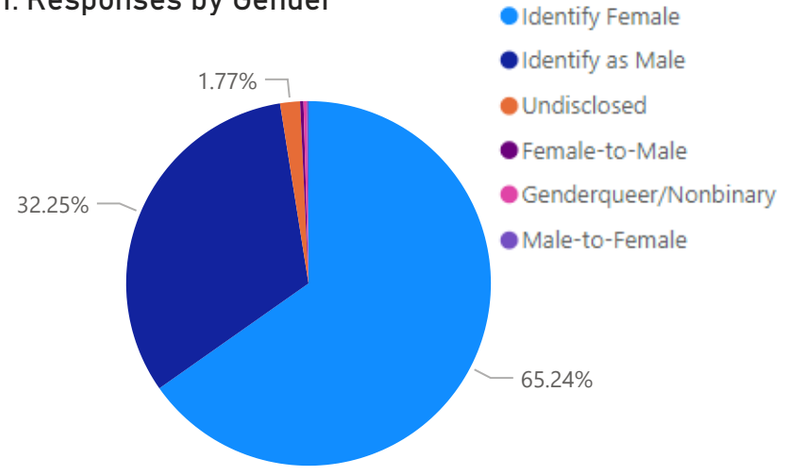
1d. Responses by Annual Family Income



1e. Responses by Race/Ethnicity



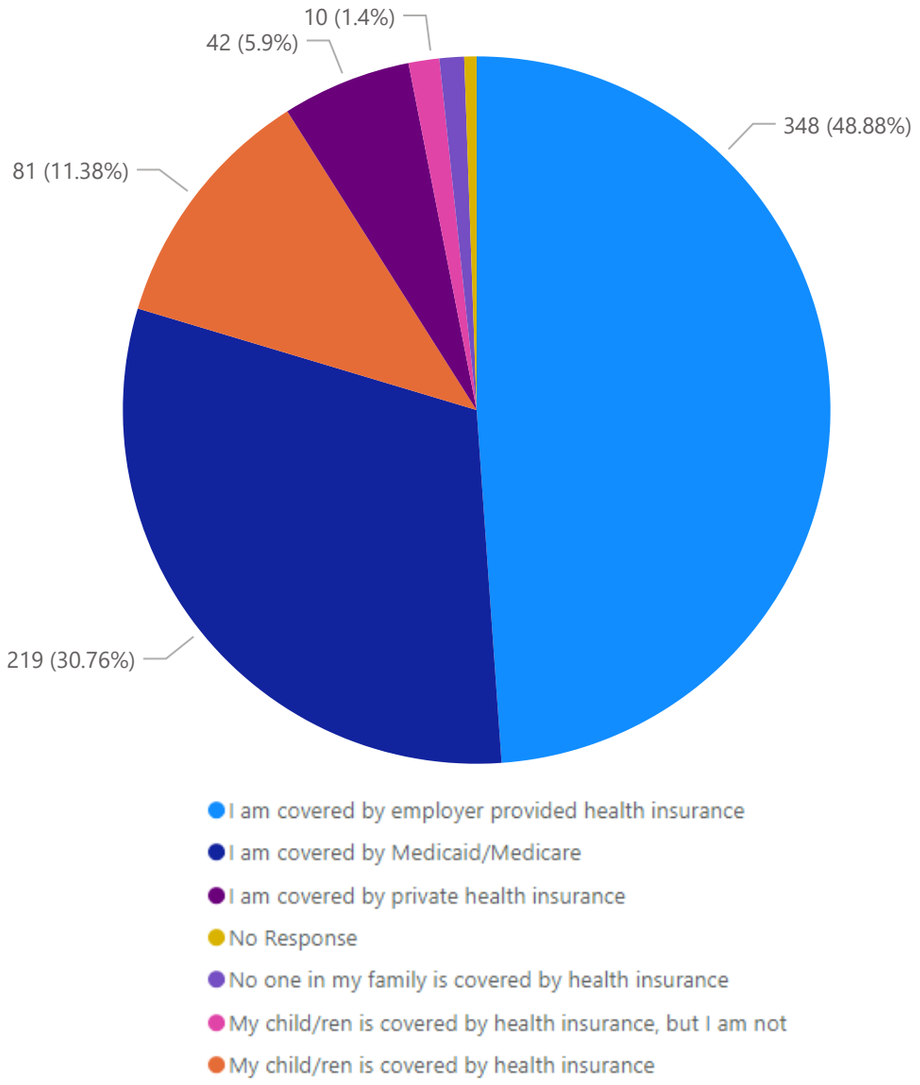
1f. Responses by Gender



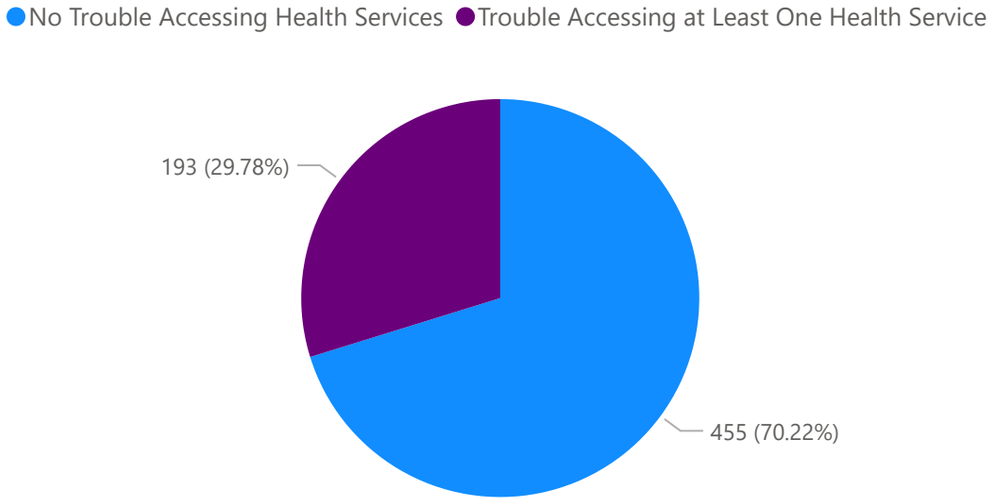
Preface: This report is based on a Community Health Survey. These charts reflect respondents' opinions and feedback about their community, provided on a volunteer basis. The information provided here is not based on medical data.

2: Insurance Status

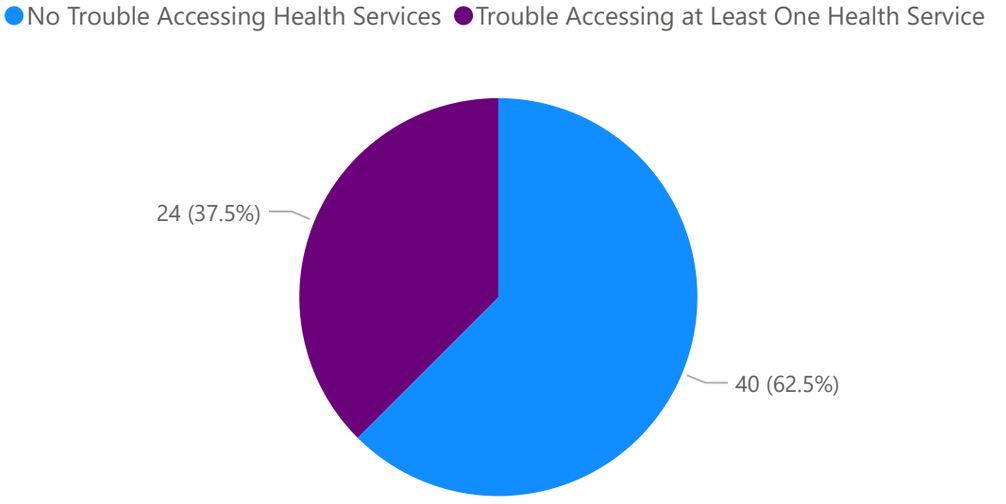
2a. Insurance Status of Survey Respondents



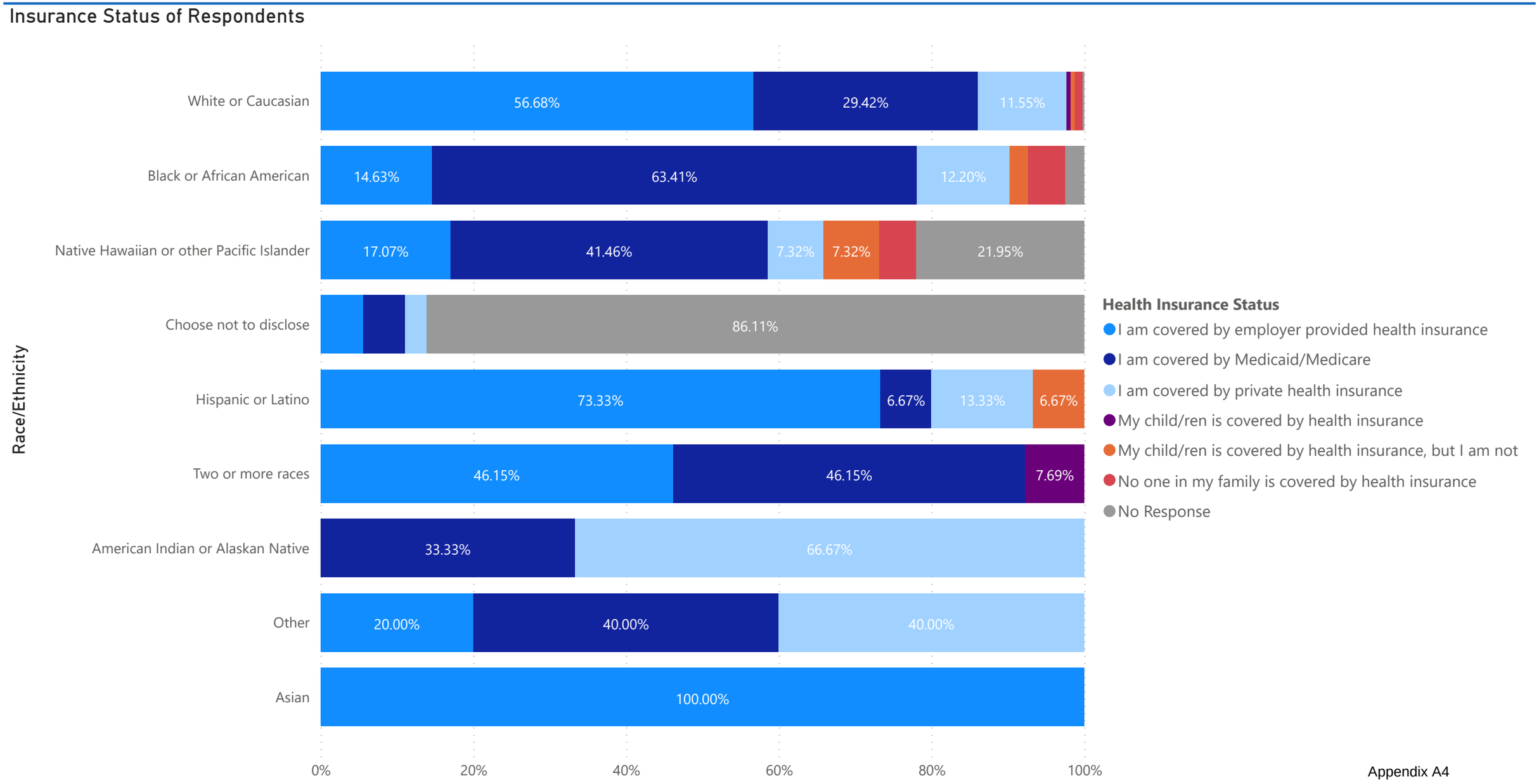
2b. Inaccessibility for Insured Respondents



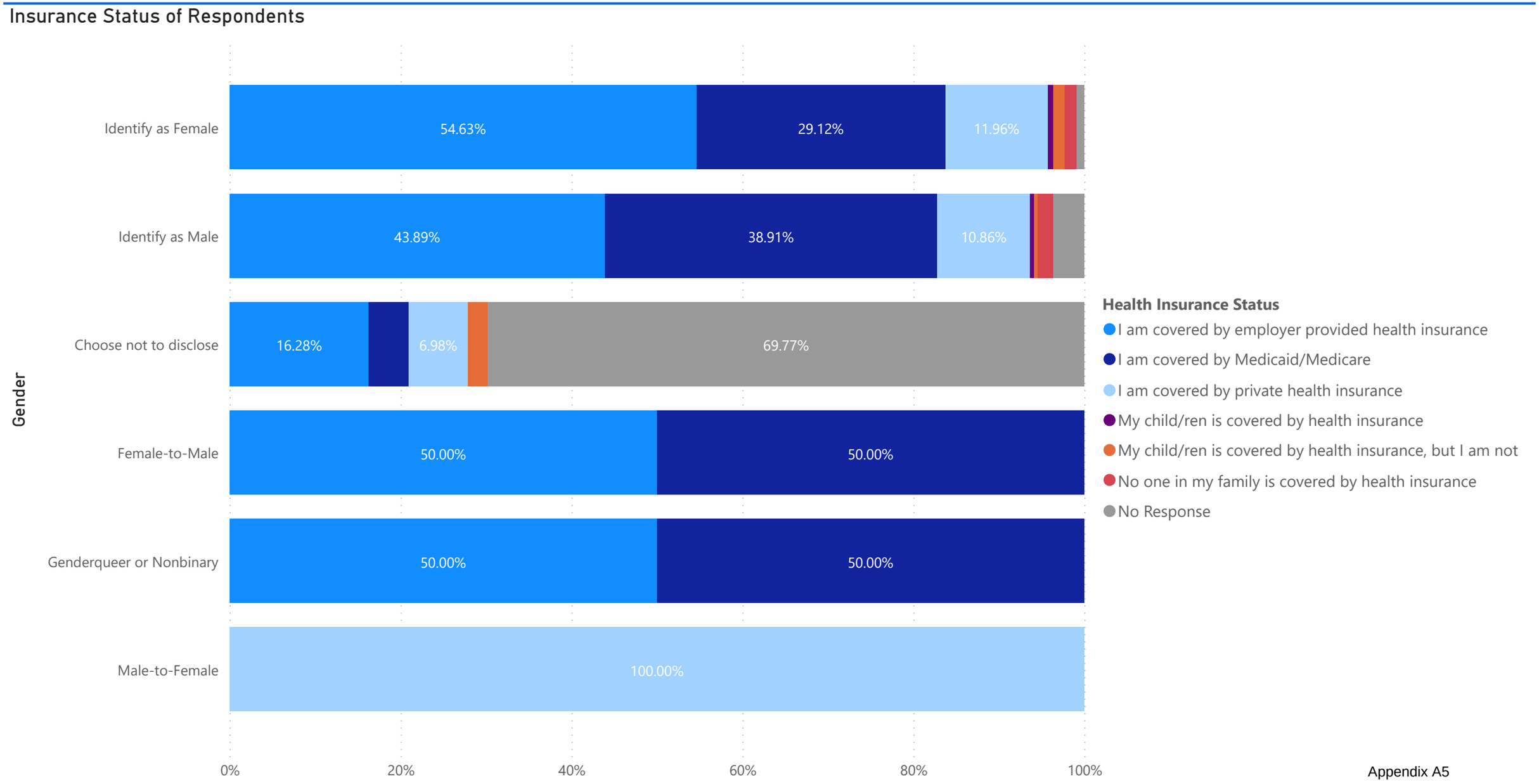
2c. Inaccessibility for Uninsured Respondents



3: Insurance Status by Race/Ethnicity

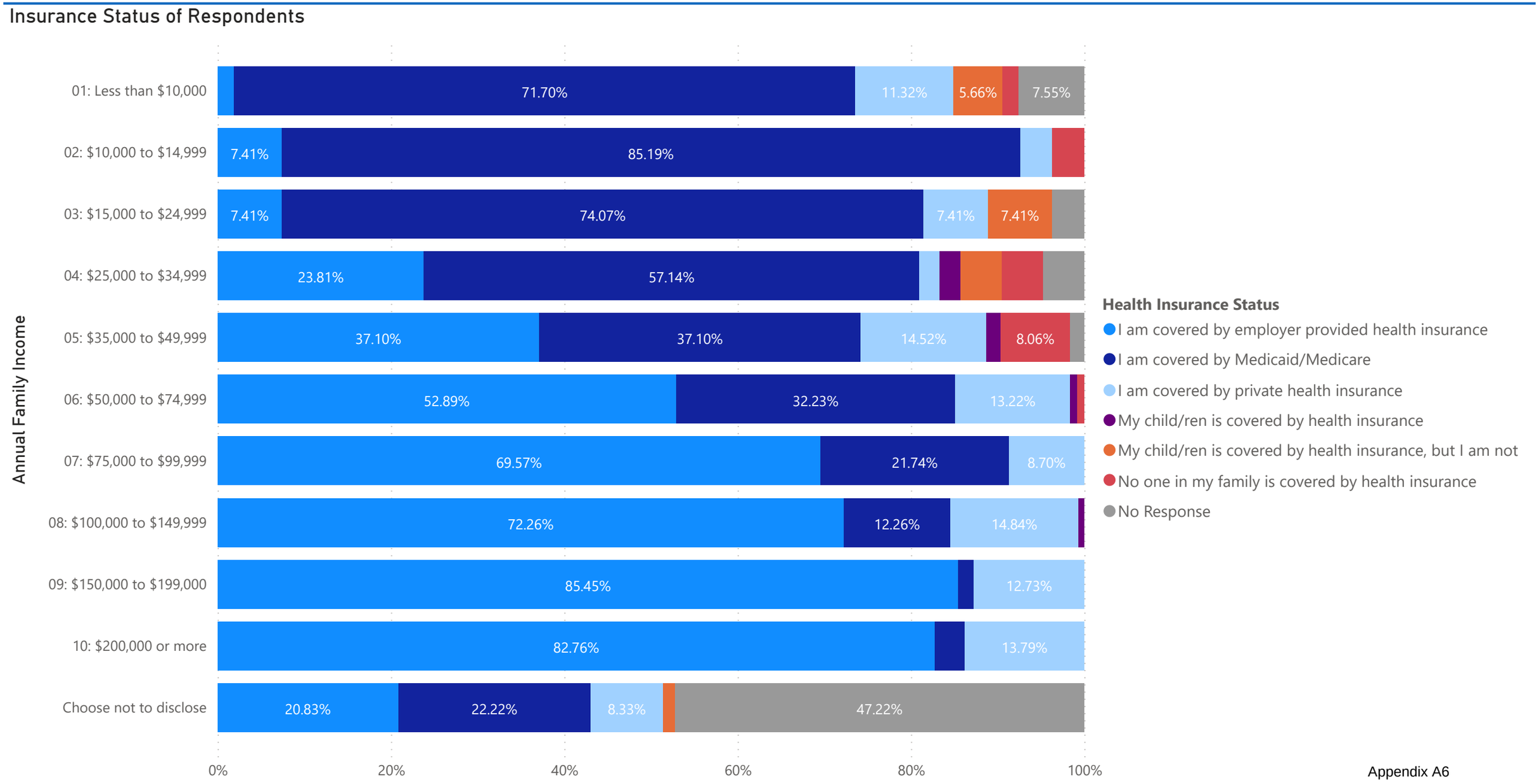


4: Insurance Status by Gender



Appendix A5

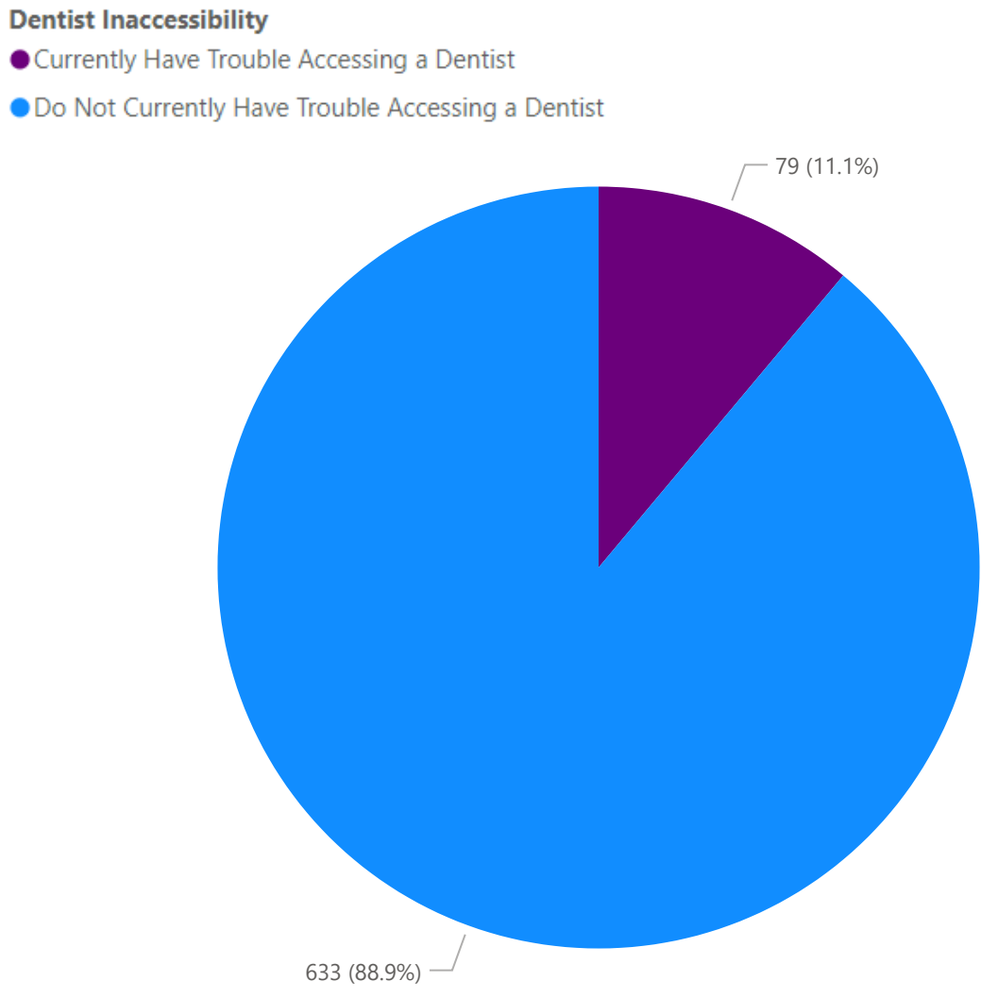
5: Insurance Status by Annual Family Income



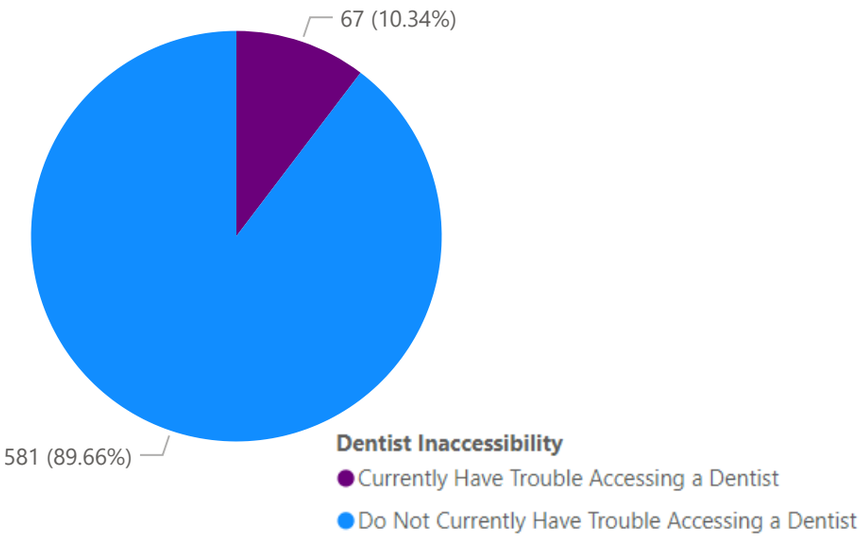
Appendix A6

6: Dental Inaccessibility

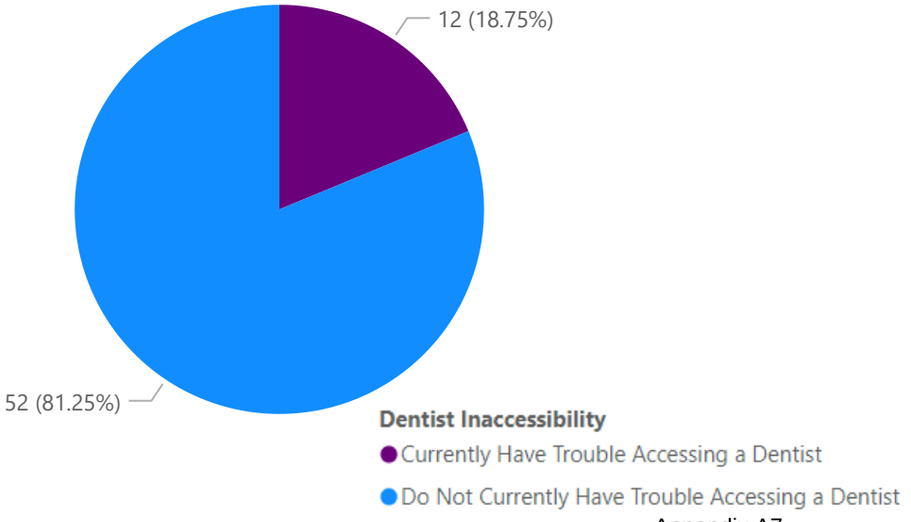
Dental Inaccessibility Across All Respondents



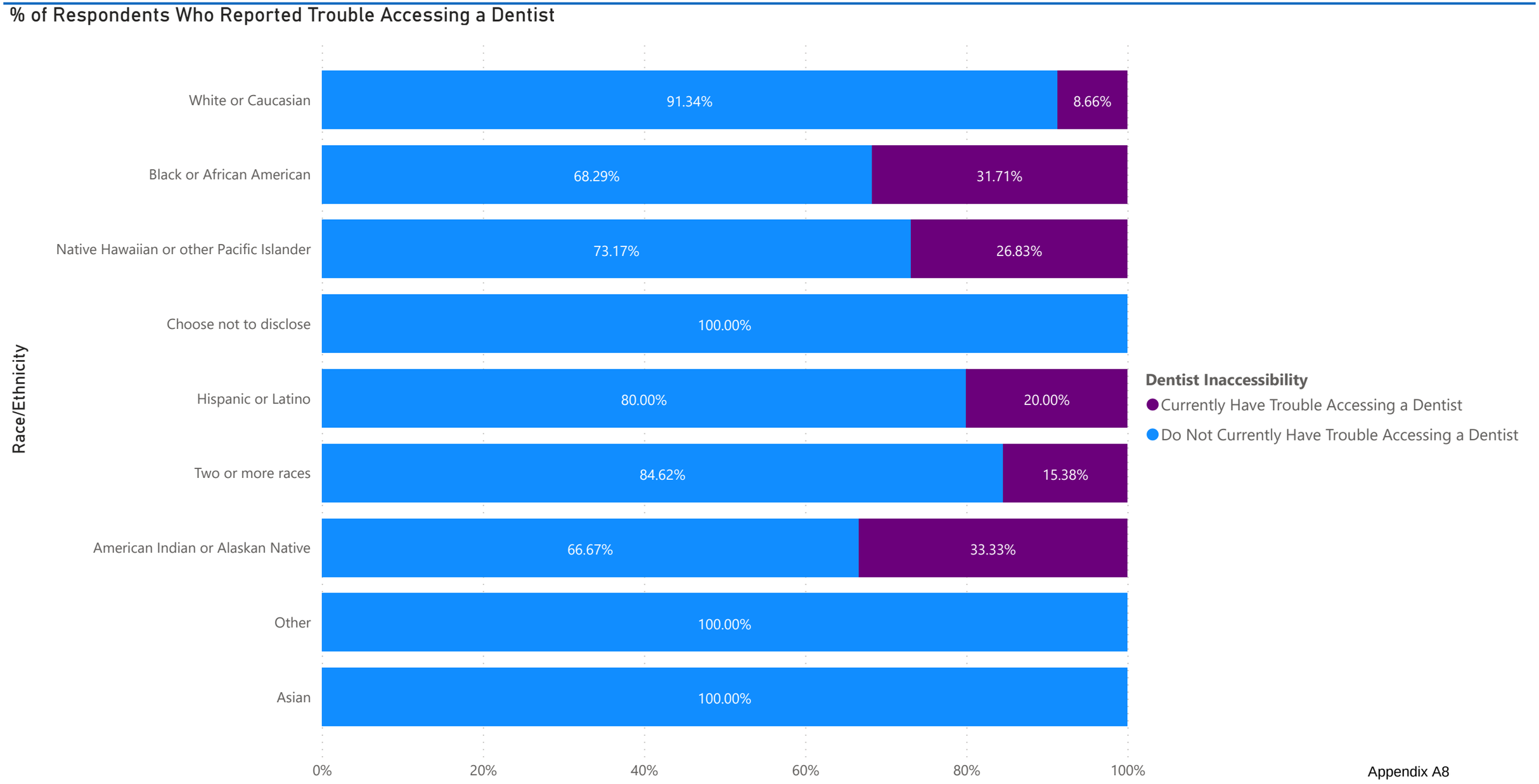
Dental Inaccessibility for Insured Respondents



Dental Inaccessibility for Uninsured Respondents

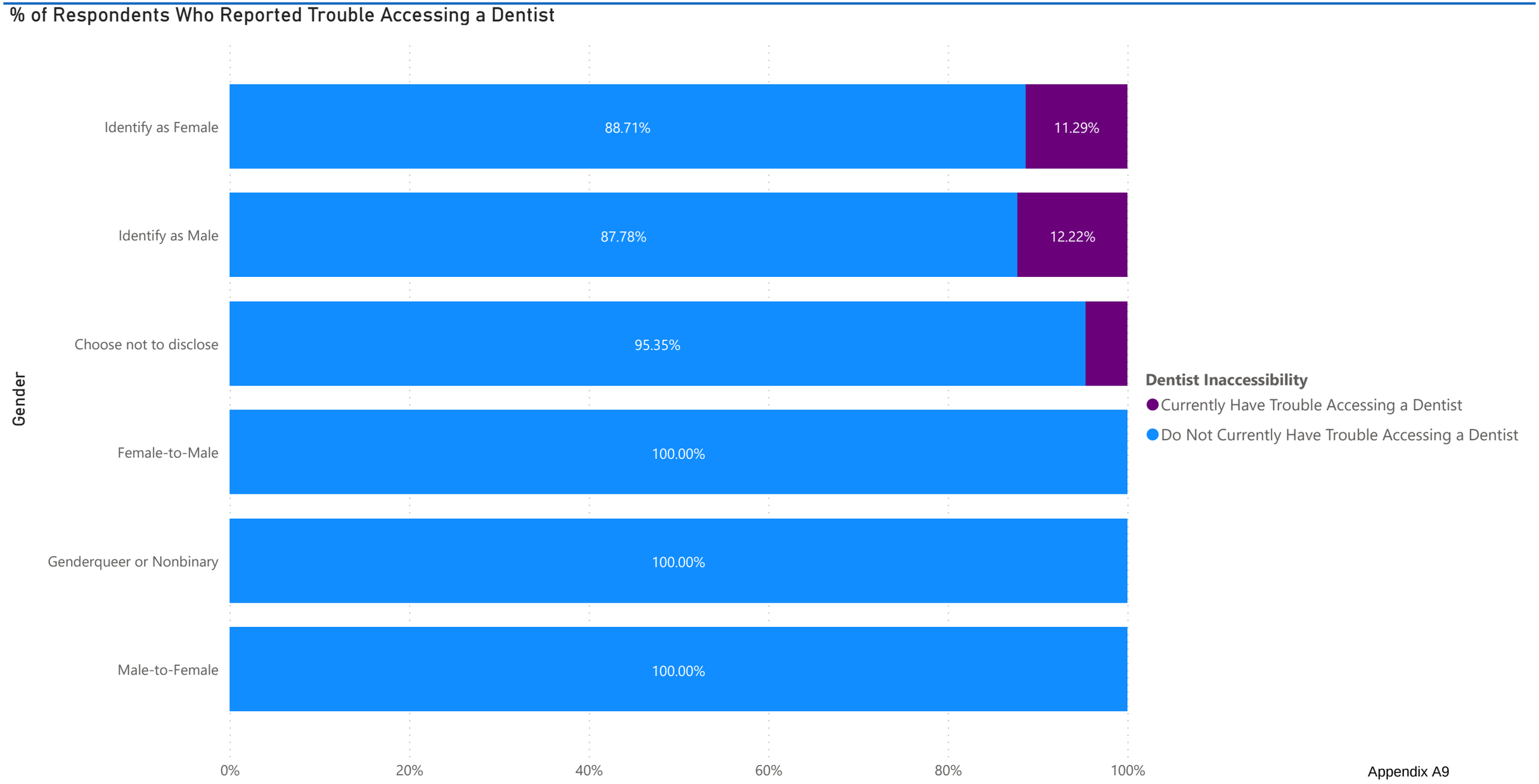


7: Dental Inaccessibility by Race/Ethnicity



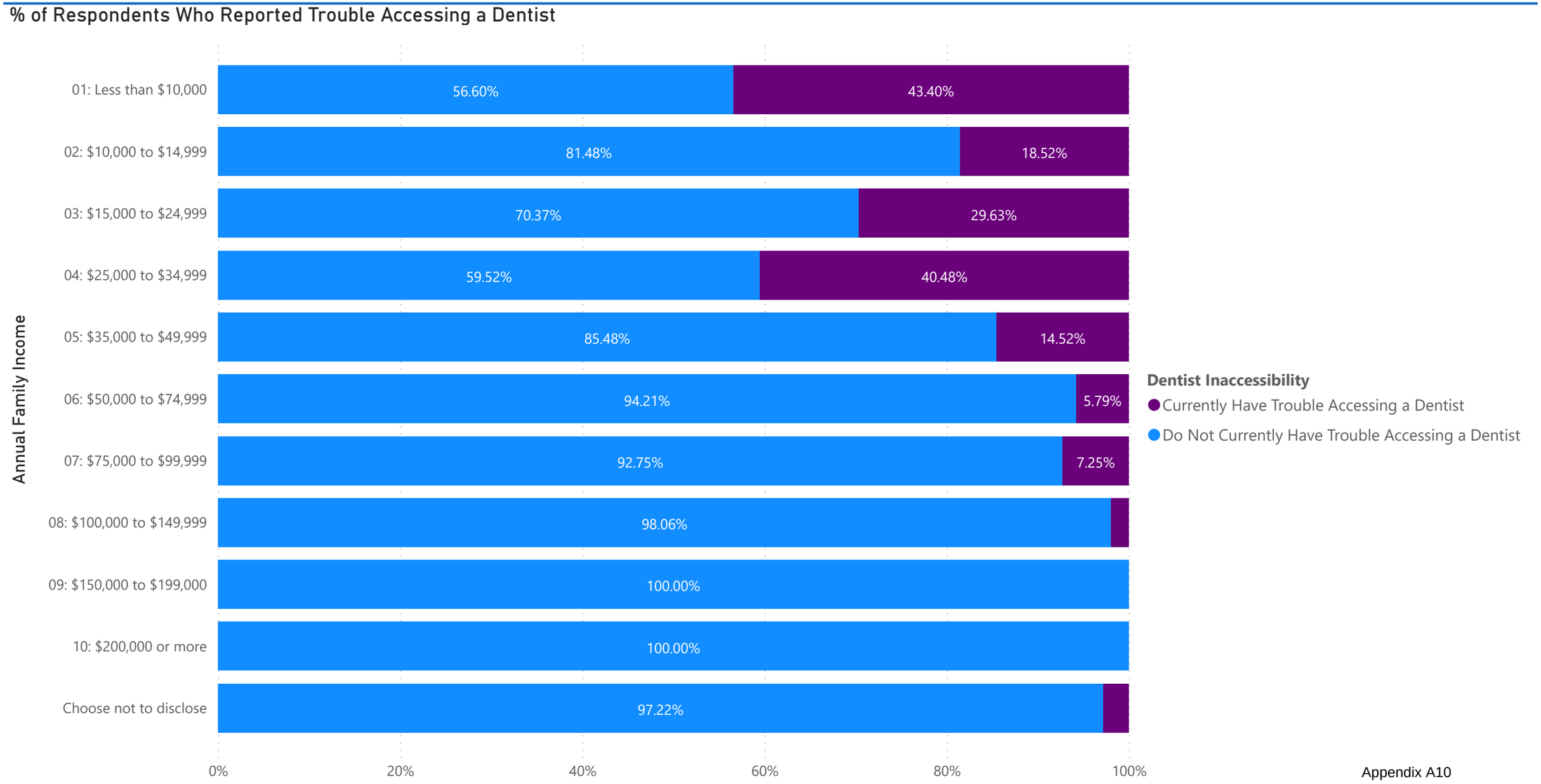
Appendix A8

8: Dental Inaccessibility by Gender



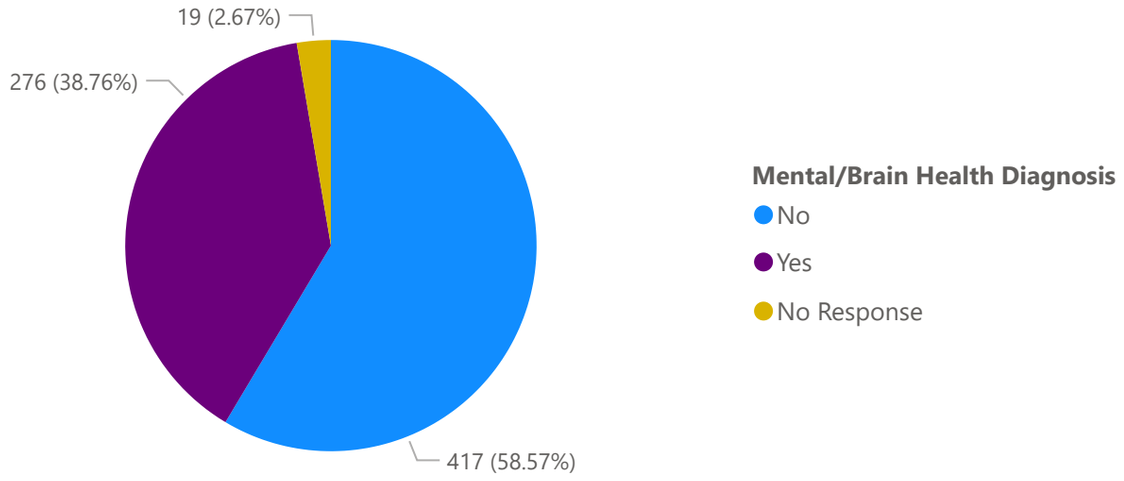
Appendix A9

9: Dental Inaccessibility by Annual Family Income

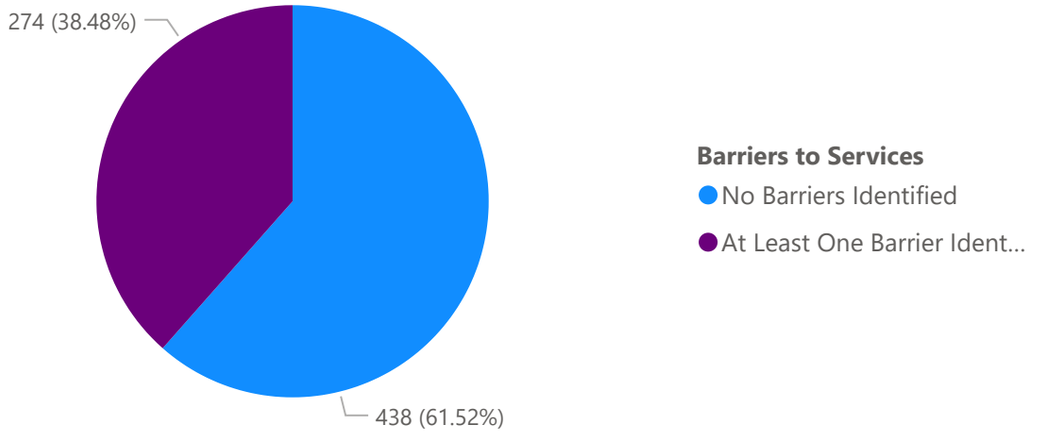


10: Brain/Mental Health Diagnosis and Barriers to Services

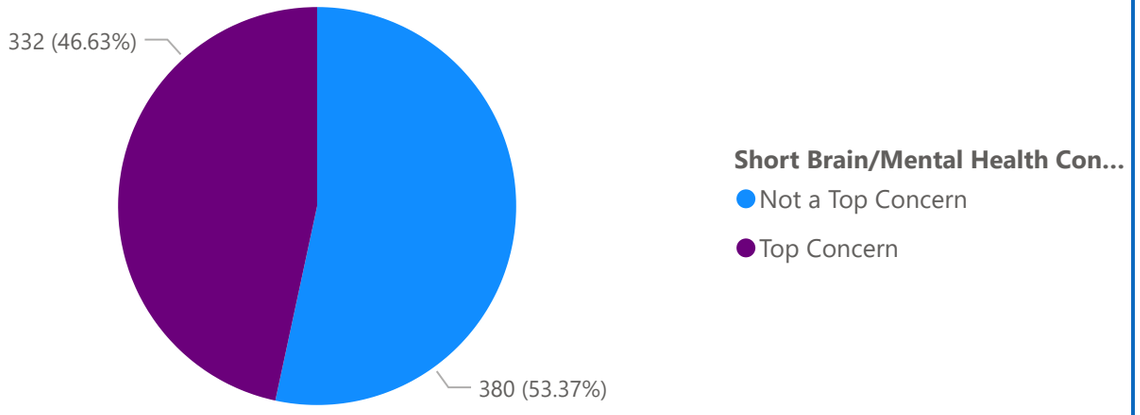
10a. % of Respondents Who Reported Having Had a Mental/Brain Health Diagnosis



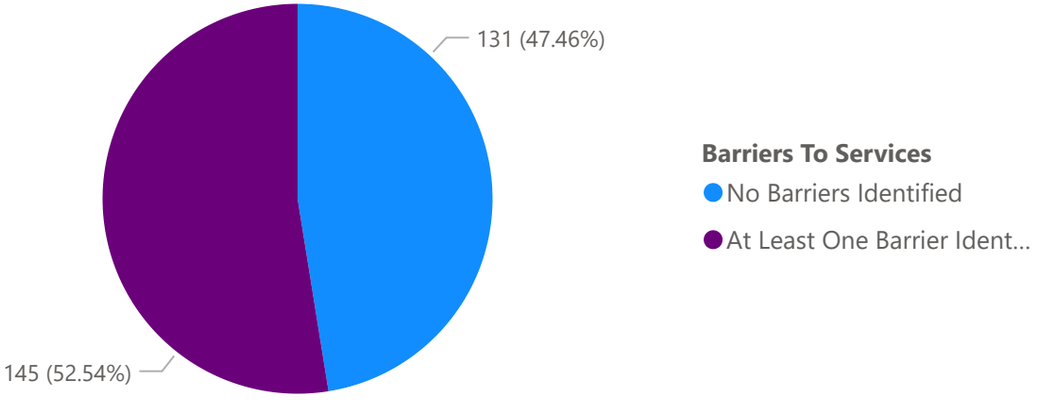
10c. % of Respondents Who Identified at Least One Barrier to Receiving Brain/Mental Health Services



10b. % of Respondents Who Identified Brain/Mental Health as One of the Top Three Health Problems in Their Community

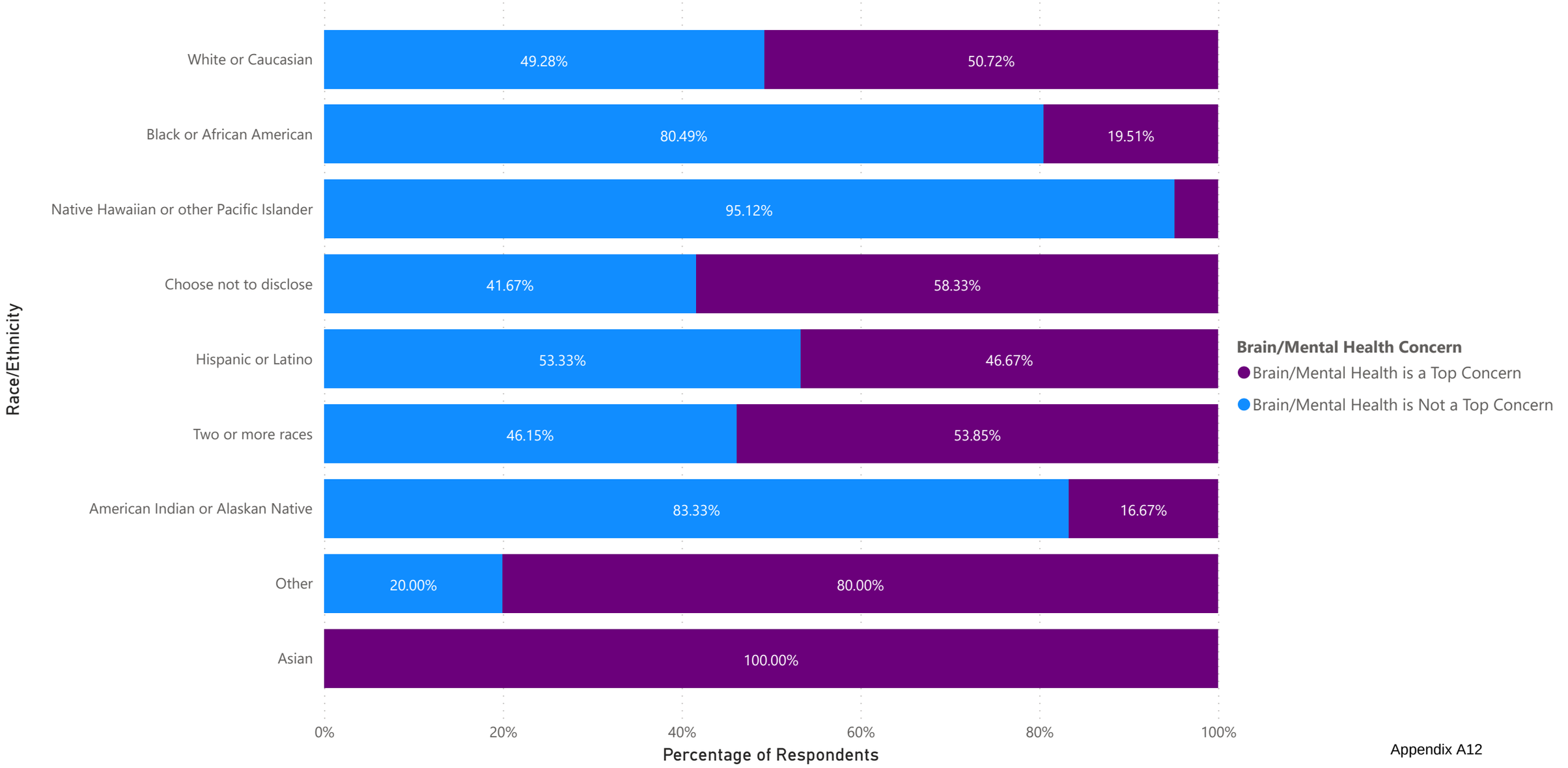


10d. % of Respondents With a Mental/Brain Health Diagnosis Who Identified at Least One Barrier to Receiving Brain/Mental Health Services



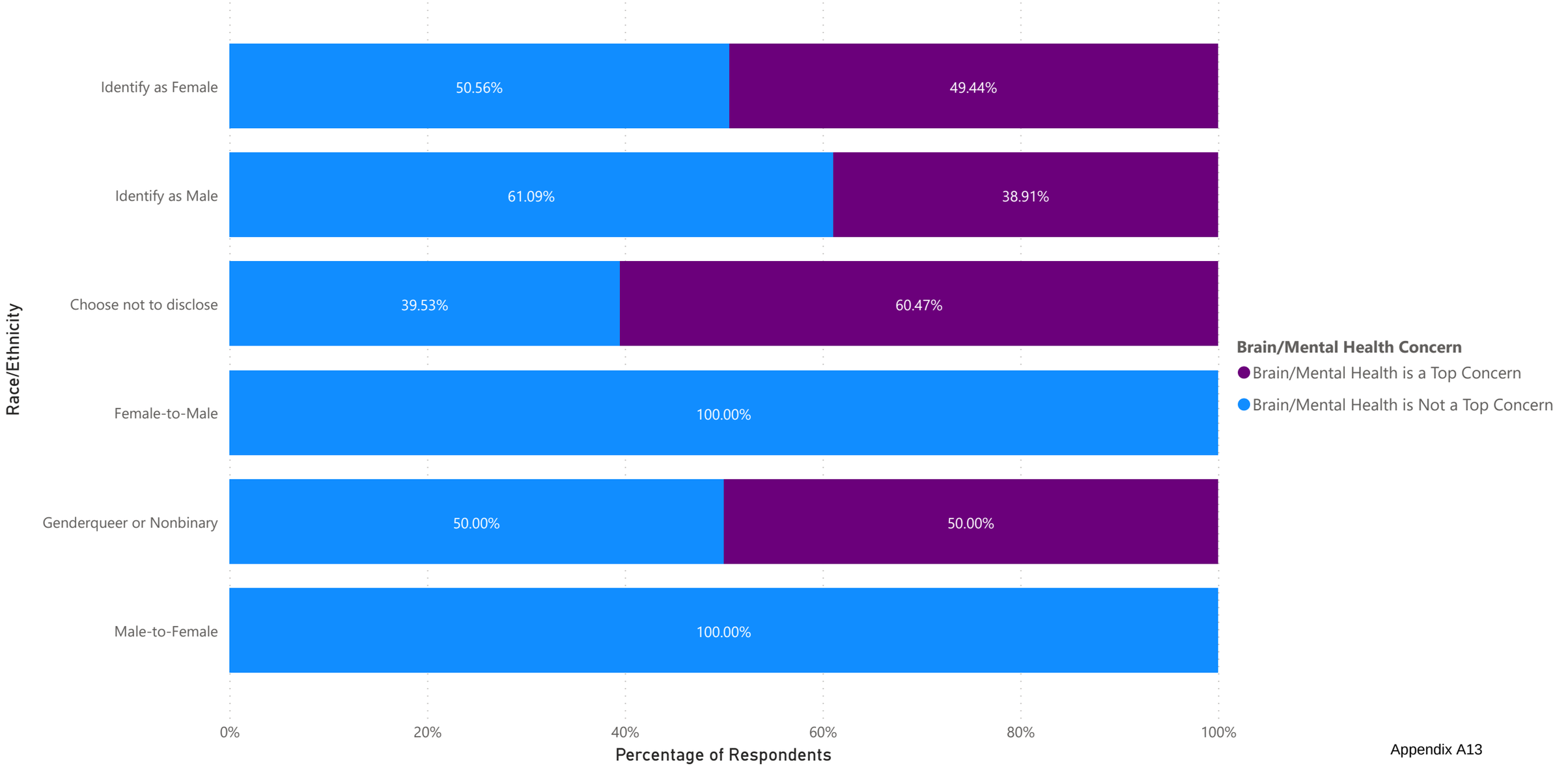
11: Brain/Mental Health Concern by Race/Ethnicity

% of Respondents Who Identified Brain/Mental Health as One of the Top Three Health Problems in Their Community



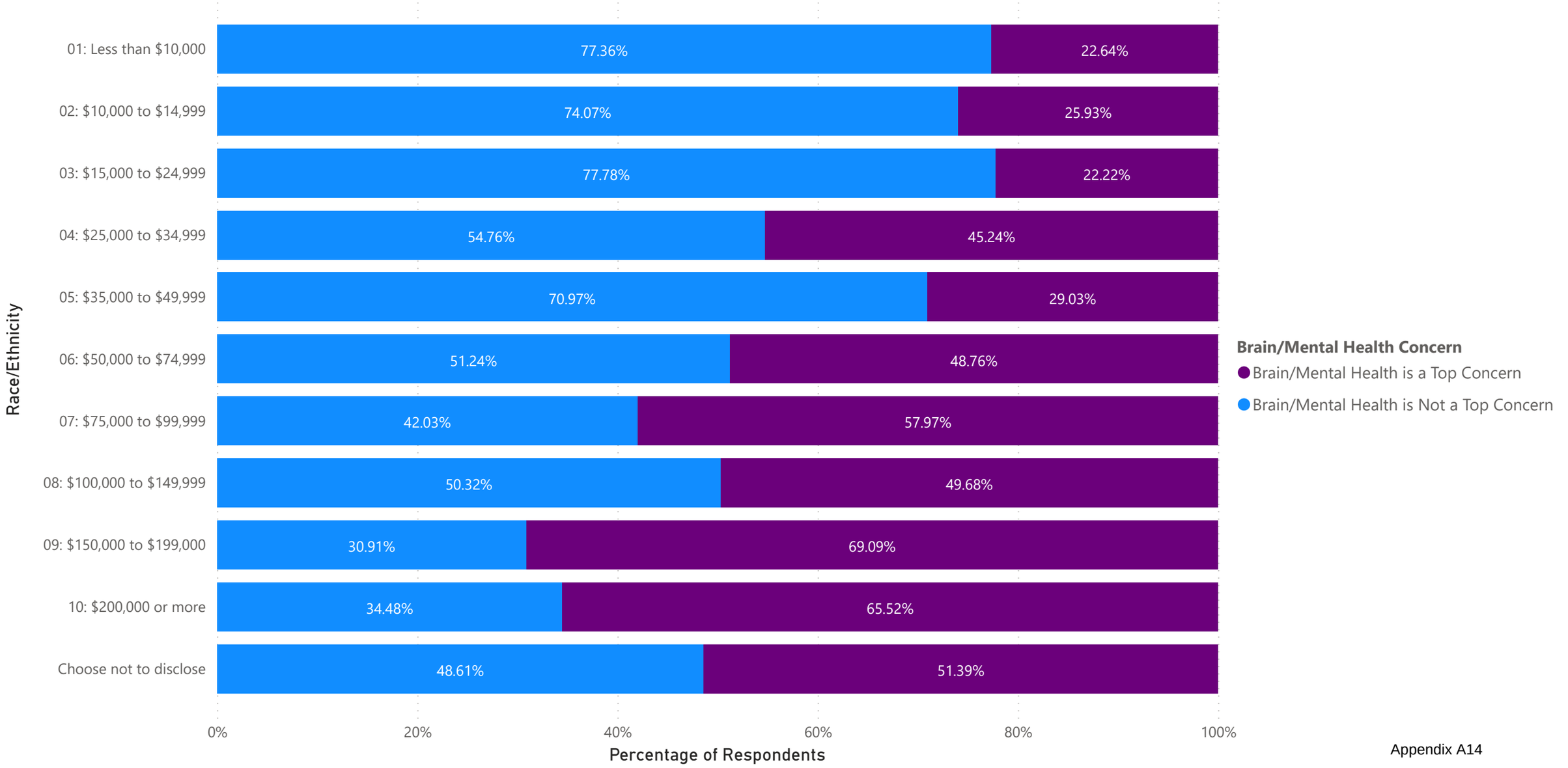
12: Brain/Mental Health Concern by Gender

% of Respondents Who Identified Brain/Mental Health as One of the Top Three Health Problems in Their Community



13: Brain/Mental Health Concern by Annual Family Income

% of Respondents Who Identified Brain/Mental Health as One of the Top Three Health Problems in Their Community

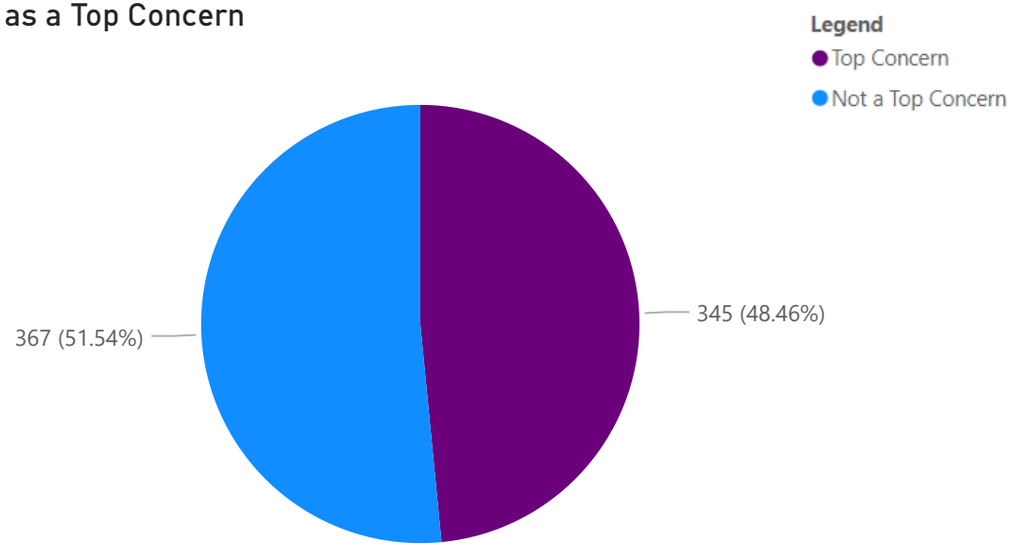


14: Healthy Behaviors

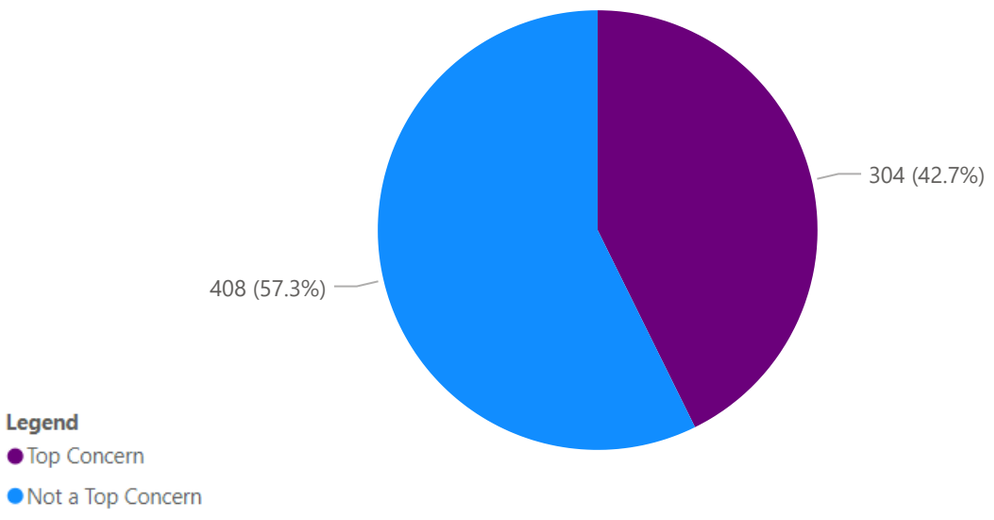
Top Concerns:

What do you feel are the top three (3) health problems in your community?

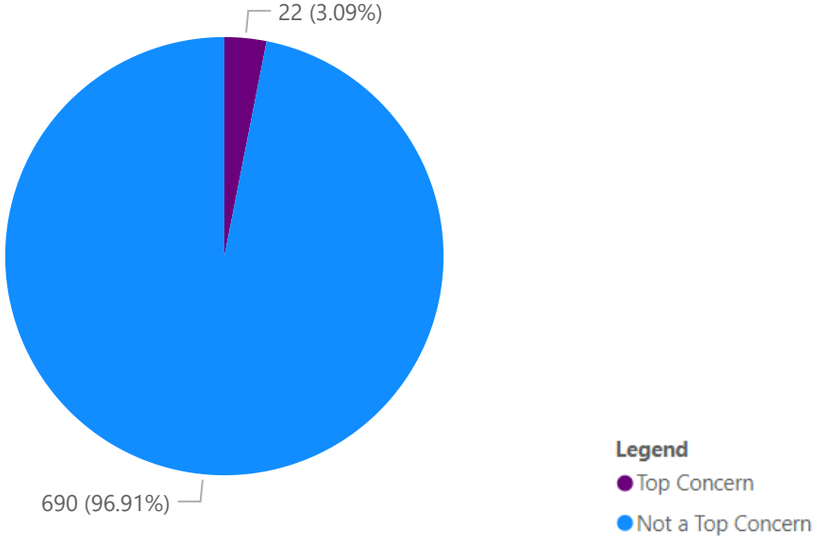
14b. Obesity as a Top Concern



14a. Substance Misuse as a Top Concern



14c. STDs as a Top Concern

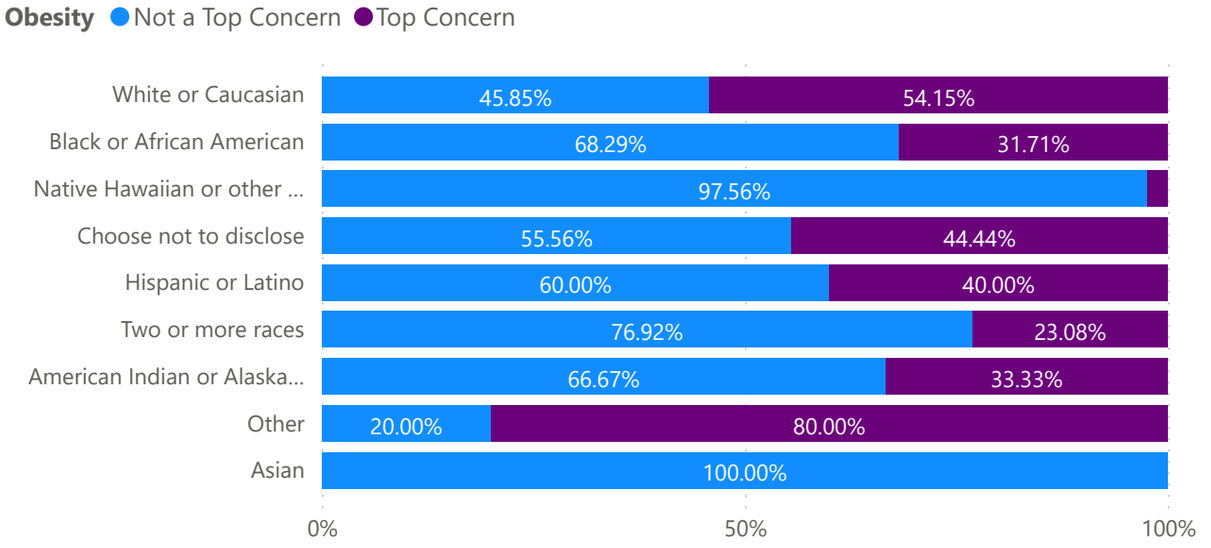


15: Healthy Behaviors by Race/Ethnicity

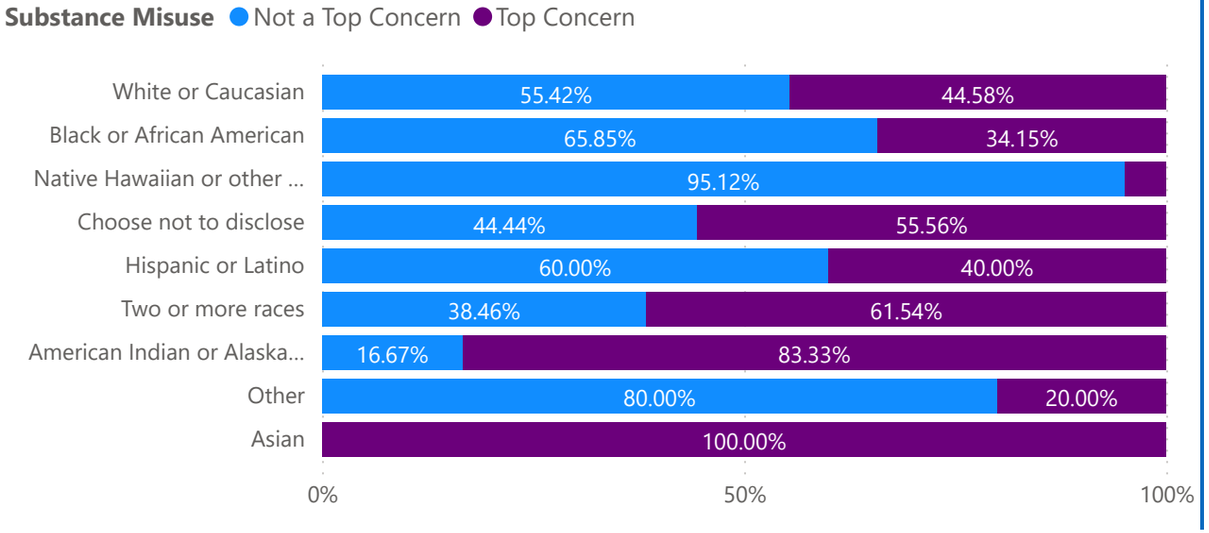
Top Concerns:

What do you feel are the top three (3) health problems in your community?

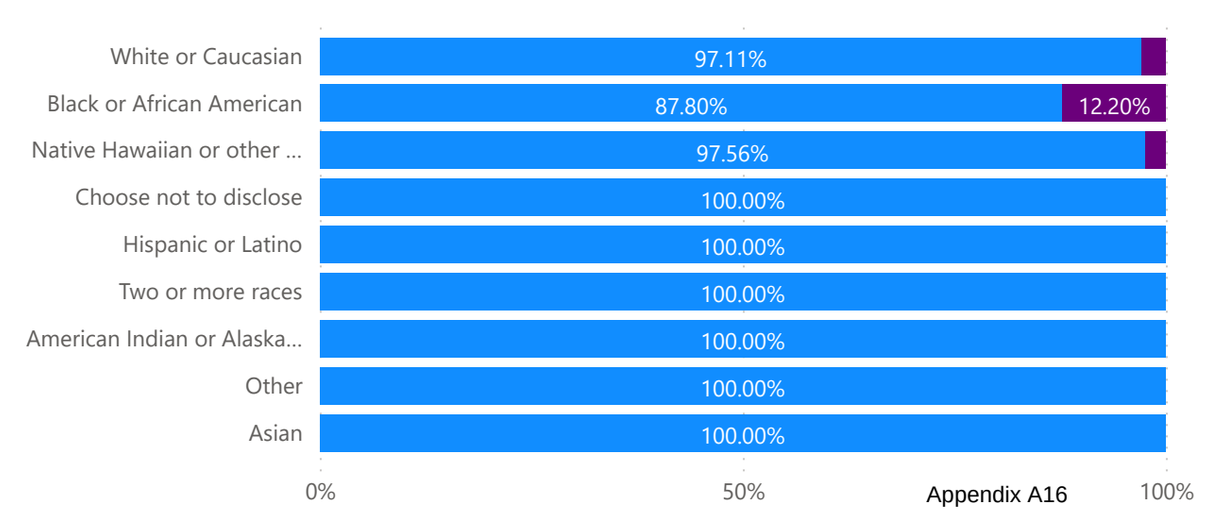
15b. % of Respondents by Race/Ethnicity Who Consider Obesity a Top Concern



15a. % of Respondents by Race/Ethnicity Who Consider Substance Misuse a Top Concern



15c. % of Respondents by Race/Ethnicity Who Consider STDs a Top Concern

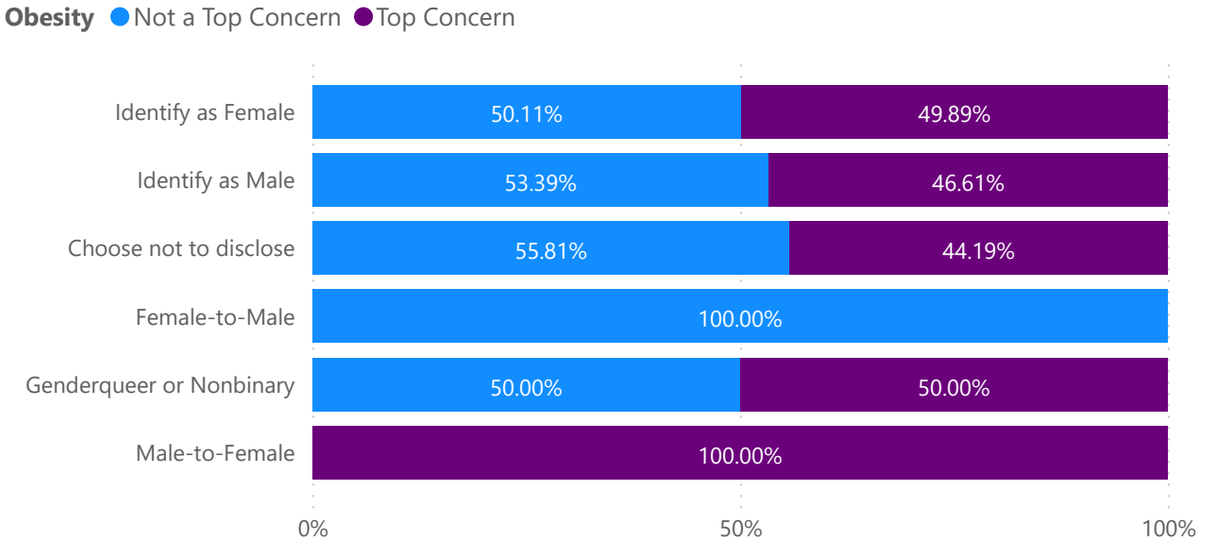


16: Healthy Behaviors by Gender

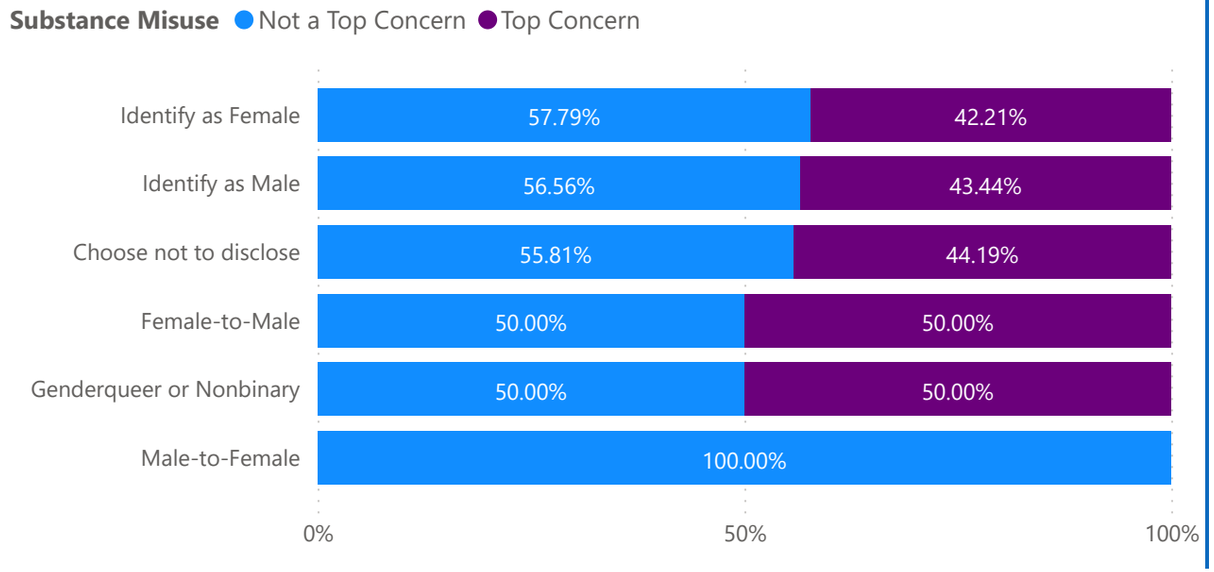
Top Concerns:

What do you feel are the top three (3) health problems in your community?

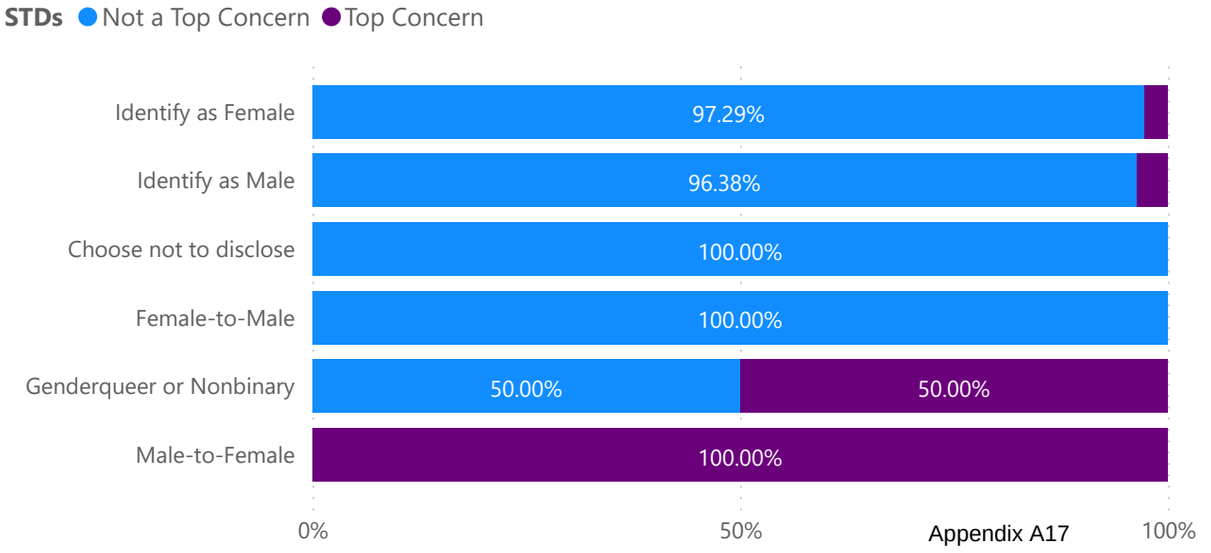
16b. % of Respondents by Gender Who Consider Obesity a Top Concern



16a. % of Respondents by Gender Who Consider Substance Misuse a Top Concern



16c. % of Respondents by Gender Who Consider STDs a Top Concern

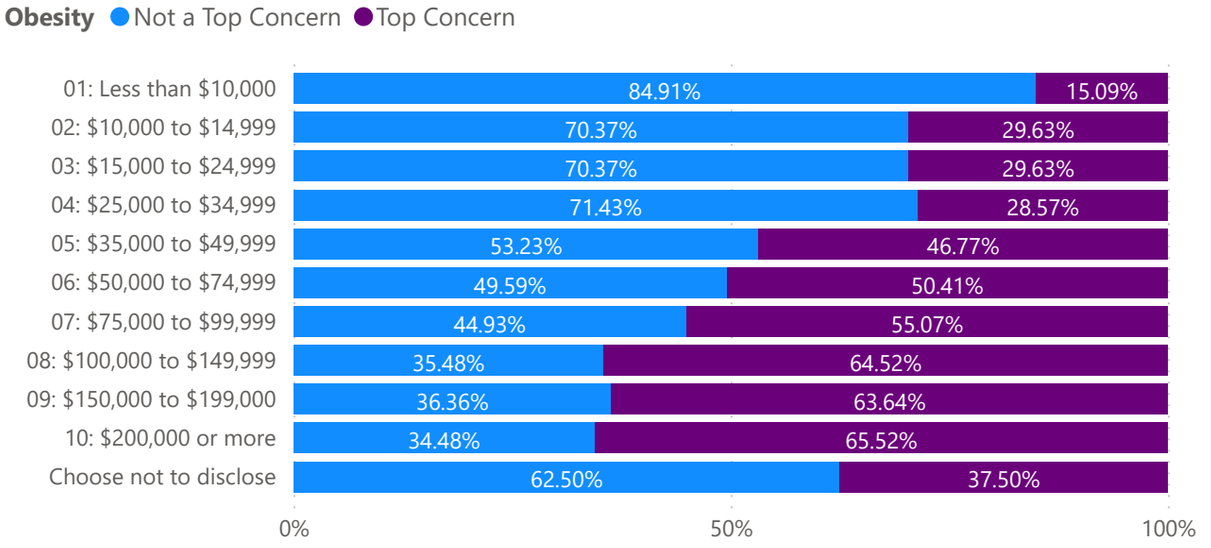


17: Healthy Behaviors by Annual Family Income

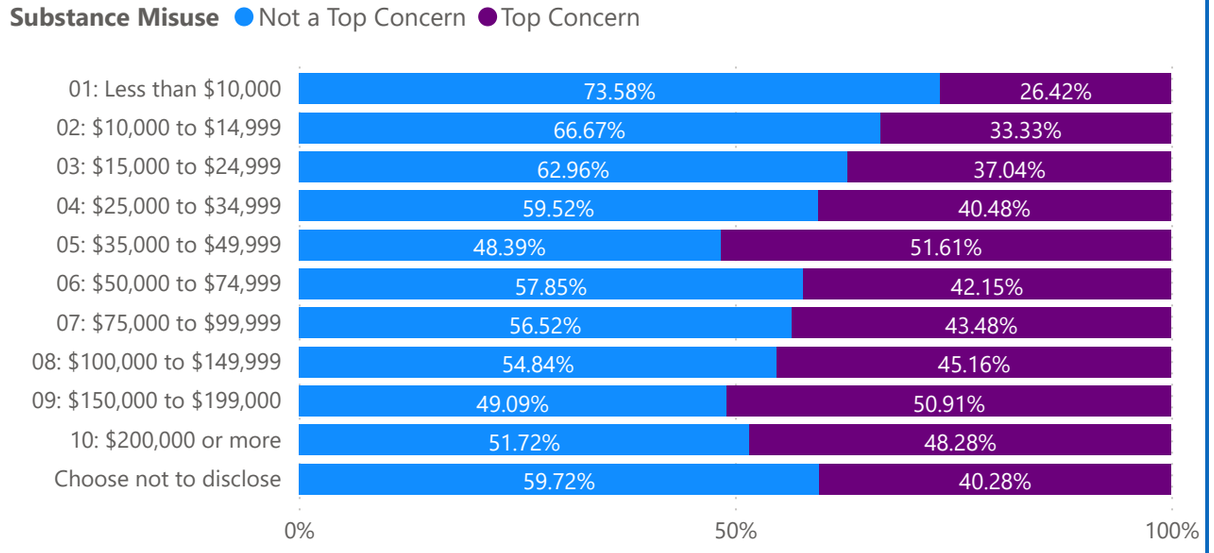
Top Concerns:

What do you feel are the top three (3) health problems in your community?

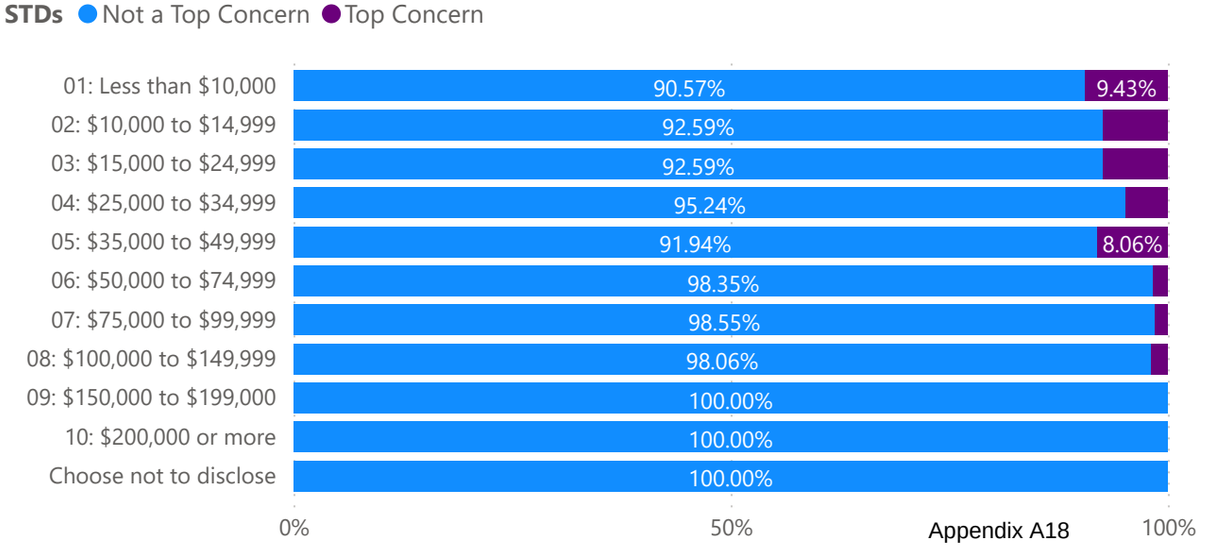
17b. % of Respondents by Income Who Consider Obesity a Top Concern



17a. % of Respondents by Income Who Consider Substance Misuse a Top Concern



17c. % of Respondents by Income Who Consider STDs a Top Concern

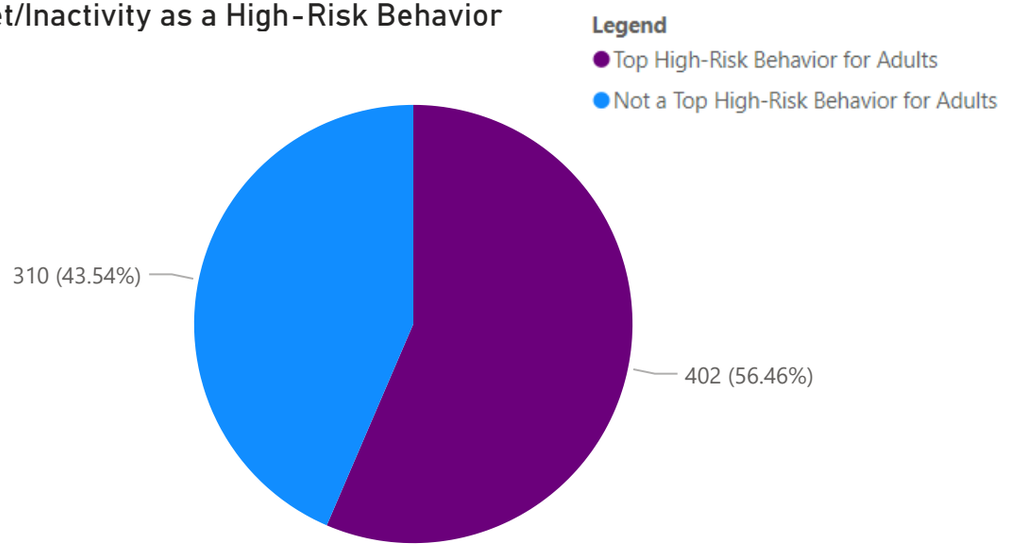


18: High Risk Behaviors

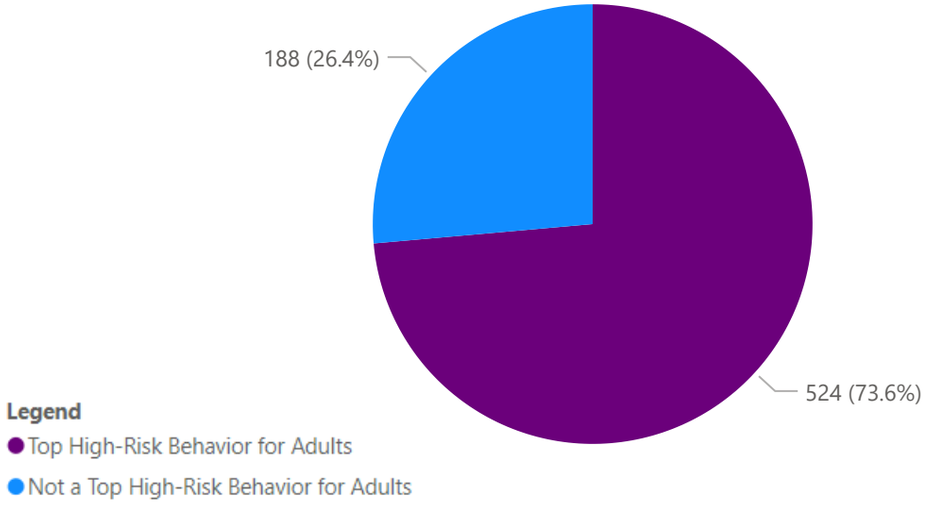
Top High-Risk Behaviors:

What do you feel are the top three (3) ADULT high-risk behaviors in your community?

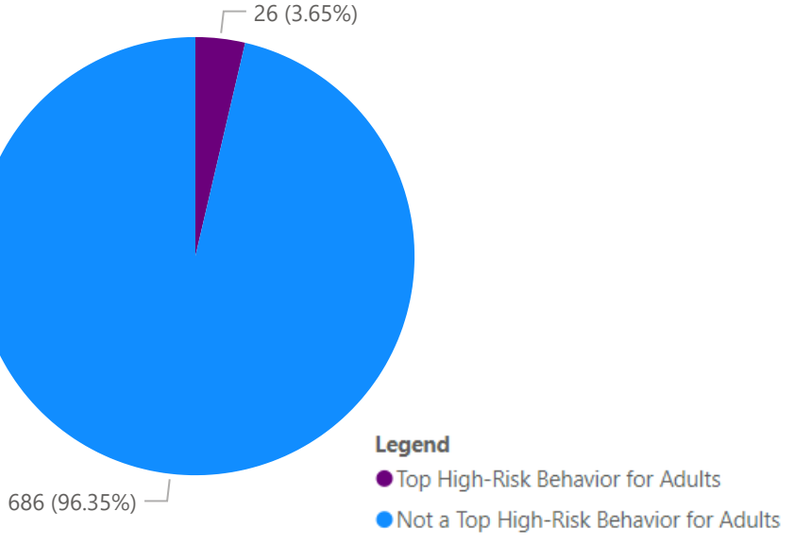
18b. Poor Diet/Inactivity as a High-Risk Behavior



18a. Substance Misuse as a High-Risk Behavior



18c. Unprotected Sex as a High-Risk Behavior

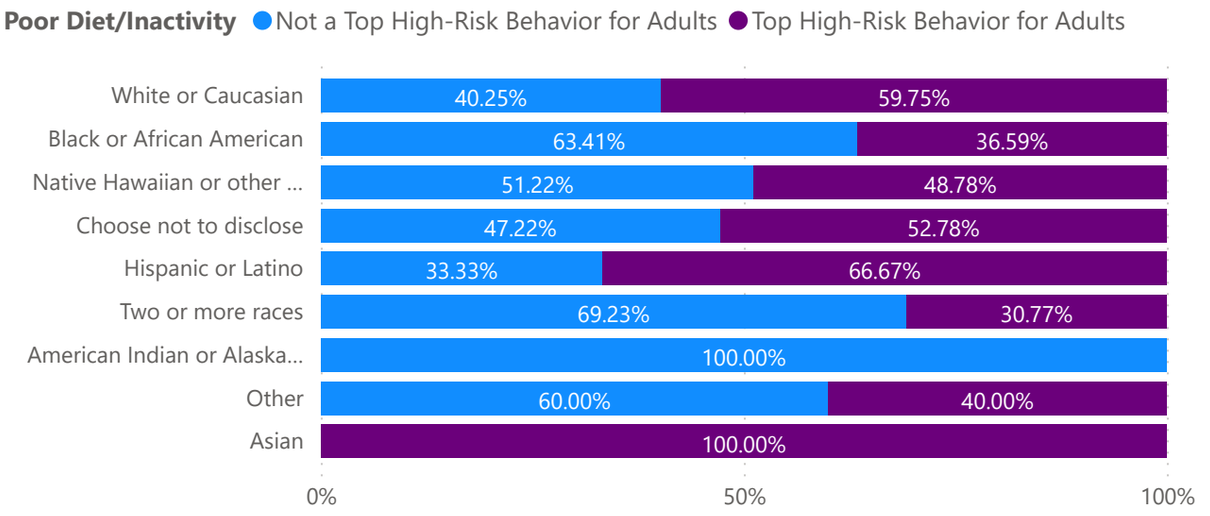


19: High-Risk Behaviors by Race/Ethnicity

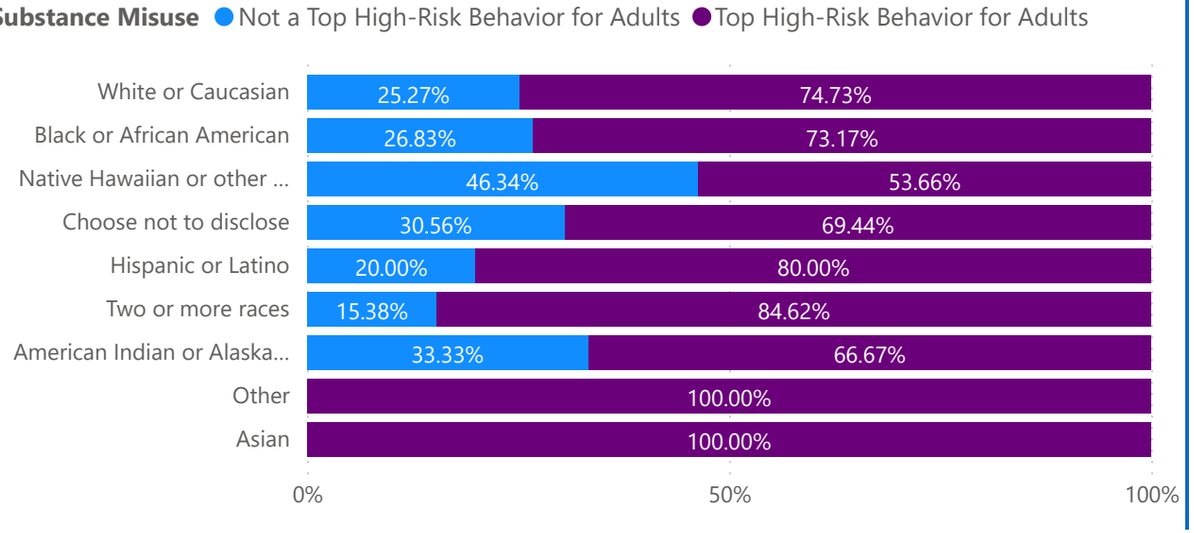
Top High-Risk Behaviors:

What do you feel are the top three (3) ADULT high-risk behaviors in your community?

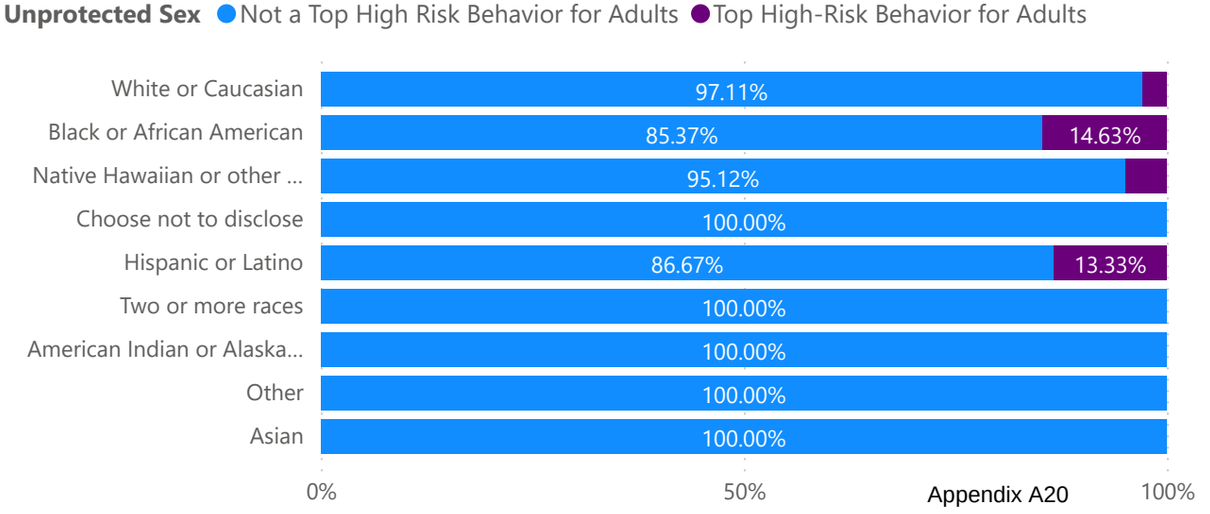
19b. % of Respondents by Race/Ethnicity Who Consider Poor Diet/Inactivity a Top High-Risk Behavior



19a. % of Respondents by Race/Ethnicity Who Consider Substance Misuse a Top High-Risk Behavior



19c. % of Respondents by Race/Ethnicity Who Consider Unprotected Sex a Top High-Risk Behavior

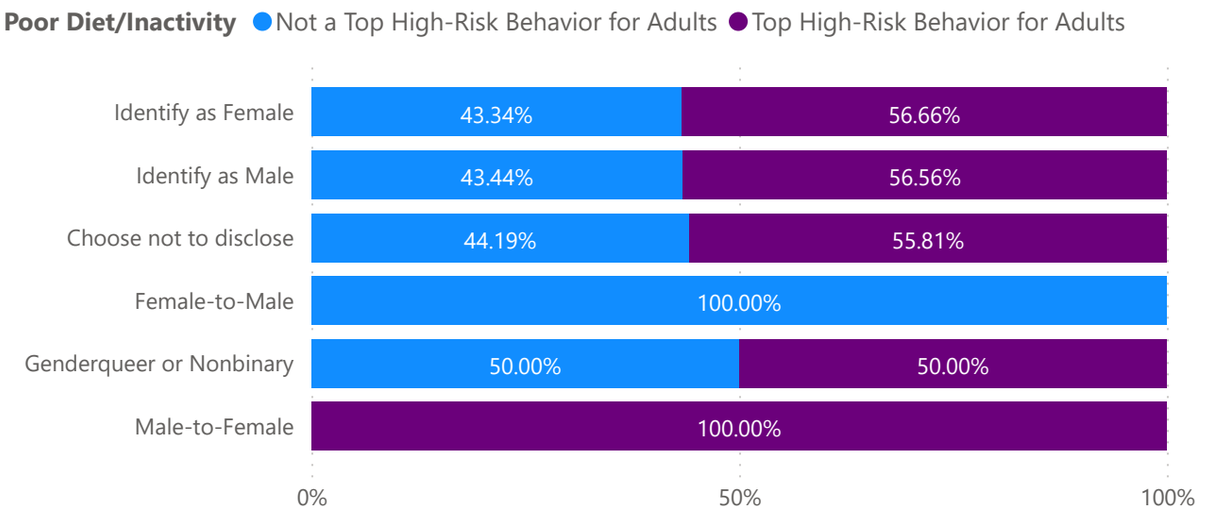


20: High-Risk Behaviors by Gender

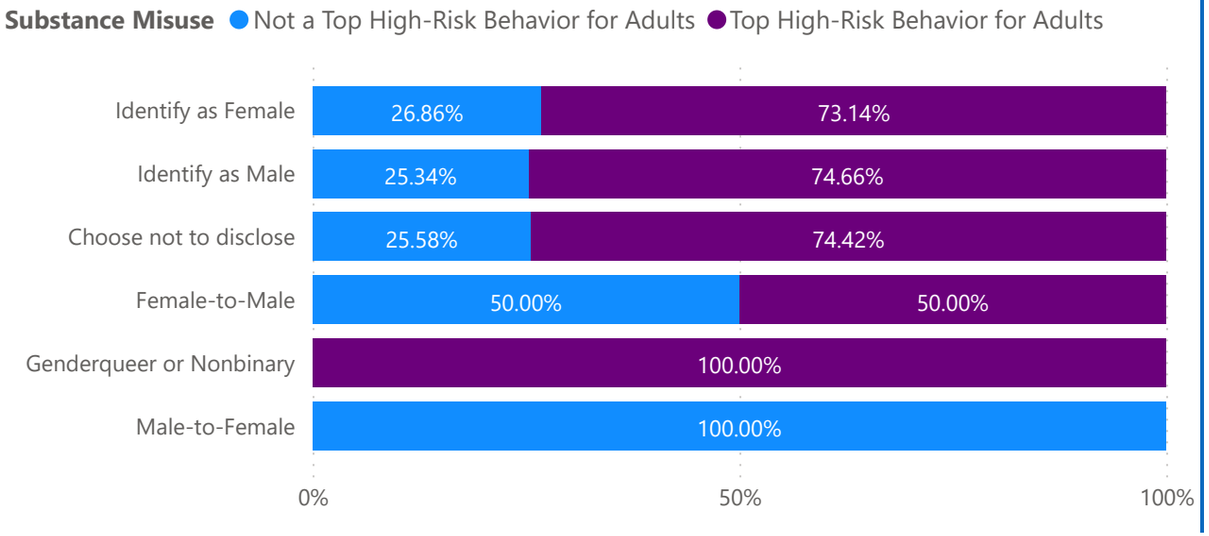
Top High-Risk Behaviors:

What do you feel are the top three (3) ADULT high-risk behaviors in your community?

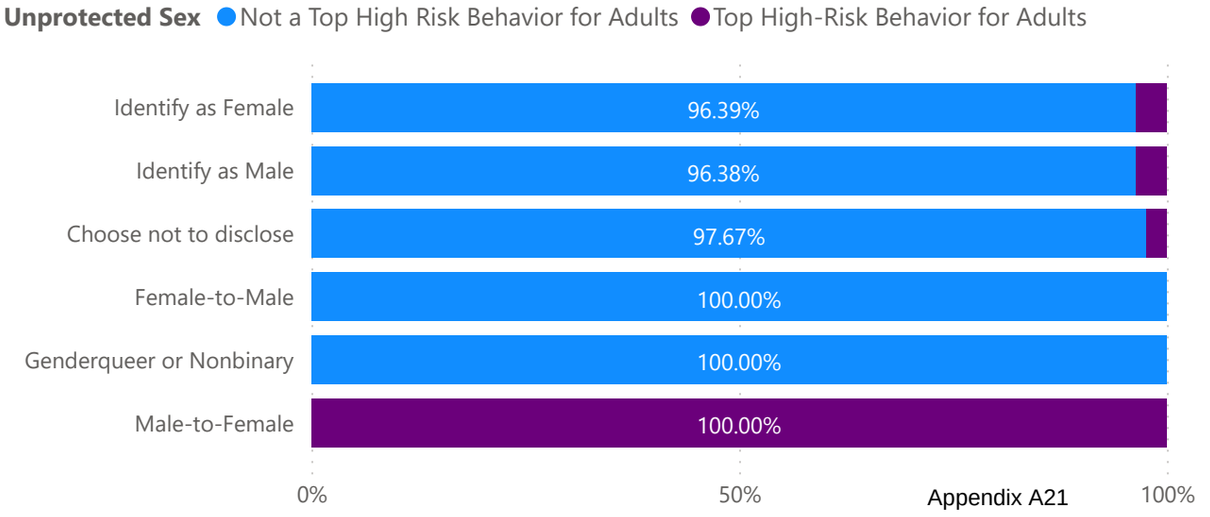
20b. % of Respondents by Gender Who Consider Poor Diet/Inactivity a Top High-Risk Behavior



20a. % of Respondents by Gender Who Consider Substance Misuse a Top High-Risk Behavior



20c. % of Respondents by Gender Who Consider Unprotected Sex a Top High-Risk Behavior

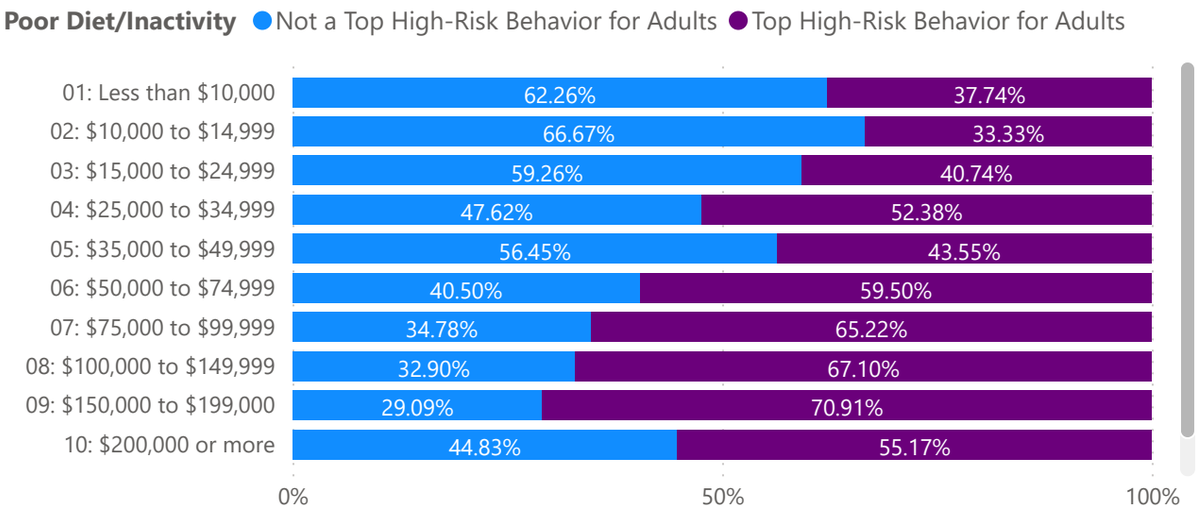


21: High-Risk Behaviors by Annual Family Income

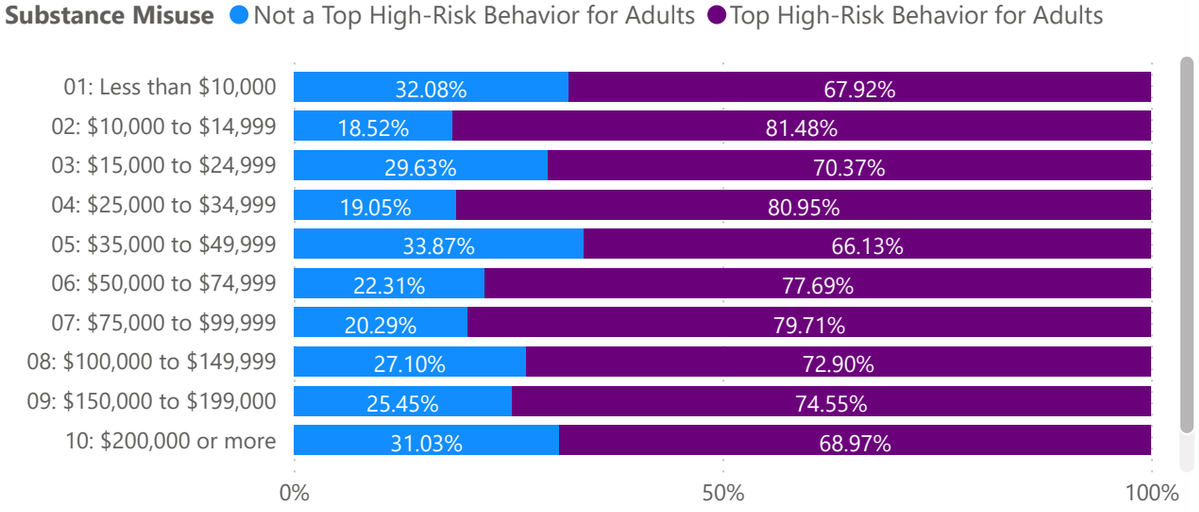
Top High-Risk Behaviors:

What do you feel are the top three (3) ADULT high-risk behaviors in your community?

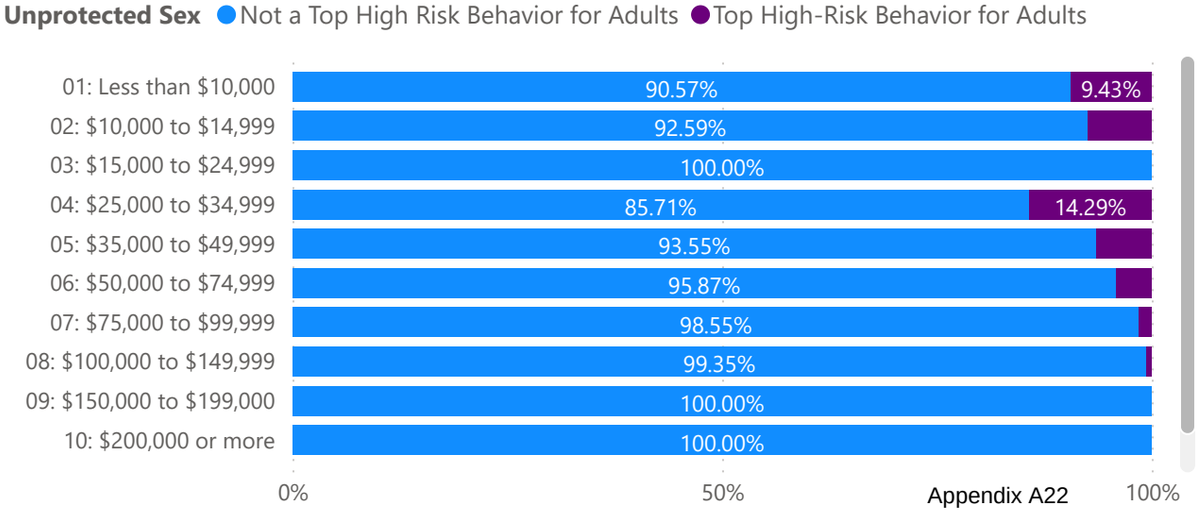
21b. % of Respondents by Income Who Consider Poor Diet/Inactivity a Top High-Risk Behavior



21a. % of Respondents by Income Who Consider Substance Misuse a Top High-Risk Behavior



21c. % of Respondents by Income Who Consider Unprotected Sex a Top High-Risk Behavior



Community Health Survey: Demographic Breakdown

Chart Explanations, Interpretations, and Image Descriptions

Preface: This report is based on a Community Health Survey. These charts and statistics reflect respondents' opinions and feedback about their community provided on a volunteer basis. The information provided here is not based on medical data.

1a: Figure 1a shows the breakdown of responses to the question "Do you feel people in this community are healthier, less healthy, or have maintained health over the last five (5) years?". Over half of all respondents felt that community health declined over the five-year period, while one third believed community health was consistent and an eighth believed their community was healthier than five years prior.

1b: Figure 1b shows that 86% of respondents reported getting a yearly health exam while 13% reported not receiving such an exam.

1c: Figures 1c through 1f demonstrate the demographic information of all survey respondents by age, annual family income, race/ethnicity, and gender respectively. Figure 1c shows a roughly equal make-up of ages 30 to 69, with each decade within that range accounting for around 20% of our respondents. We received fewer respondents from the 19-29 and 70-79 age groups with each accounting for around 10% of respondents. The 0-18 and 80+ demographics each account for less than one percent of our total responses. Due to the small number of respondents among certain groups, this survey should not be used to make broad generalizations about people above the age of 80 or below the age of 18.

1d: Figure 1d shows a somewhat even distribution of annual family incomes among our survey respondents. The income brackets from which we received the most respondents were $100,000 to $149,999 and $50,000 to $74,999 which accounted for just under 23% and 18% of our respondents respectively. We

received the fewest responses from the $10,000 to $14,999, $15,000 to $24,999, and greater than $200,000 brackets which each accounted for about 4% of our responses.

1e: Figure 1e demonstrates the racial and ethnic demographics of our responses which represent slightly greater diversity than the county's population, likely as a result of conscious efforts to increase response rates among minority communities. 81% of our respondents identified themselves as White or Caucasian while 91.9% of people in Dubuque County identified themselves as White alone according to US Census Bureau data for 2022. The Asian population was underrepresented, accounting for 0.15% of our respondents and 1.3% of the county population. The Hispanic or Latino population was also slightly underrepresented, accounting for 2.2% of respondents and 3% of the county population. The Black or African American were slightly overrepresented, accounting for 6% of respondents and 3.8% of the county population. The American Indian or Alaskan Native population was also slightly overrepresented accounting for 0.9% of our respondents and 0.3% of the County population. The Native Hawaiian or other Pacific Islander population was significantly overrepresented, accounting for 6.04% of our respondents and 0.8% of the population. The population who identified with 2 or more options accounted for 1.9% of our respondents as well as 1.9% of the county population. Less than 1% of respondents declined to disclose their race/ethnicity. Due to the small number of respondents among certain groups, this survey should be used to make broad generalizations about the Asian, American Indian or Alaskan Native, Hispanic or Latino, or two or more race communities. Because this survey had only one respondent who identified their race/ethnicity as Asian, this report will not state any generalizations about the Asian community in general.

1f: Figure 1f demonstrates the gendered demographics of our survey responses. Respondents identifying as female accounted for 65% of our responses and 50.4% of the county population. Male identifying respondents accounted for 32% of our respondents. 1.8% of our respondents declined to disclose their gender and a small percentage of respondents identified as Female-to-Male, Male-to-Female, or Genderqueer or Nonbinary. Due to the small number of respondents among certain groups, this survey should not be used to make broad generalizations

about the Female-to-Male, Male-to-Female, or Genderqueer or Nonbinary communities.

2a: Figure 2a displays the health insurance status of survey respondents. 48.8% of respondents report being covered by employer provided health insurance, 30.8% report being covered by Medicare or Medicaid and 11.4% report being covered by private health insurance. 5.9% of respondents did not respond to this question. 1.4% of respondents reported that no one in their family is covered by health insurance. 1.1% of respondents report their child/ren being covered by health insurance while they are not. Another 0.6% of respondents reported that their child/ren are covered by health insurance but did not specify their own insurance status.

2b: Figure 2b shows that29.8% of respondents who are insured through their employer, Medicare, Medicaid, or private means, report having trouble accessing at least one health service. (General doctors, Dentists, Brain/Mental Health/Spiritual Support/Prescriptions/Food/Health Insurance/etc.)

2c: Figure 2c shows that 37.5% of respondents who are not insured report having trouble accessing at least one health service. (General doctors, Dentists, Brain/Mental Health/Spiritual Support/Prescriptions/Food/Health Insurance/etc.)

3-5: Figures 3-5 demonstrate health insurance status broken down by race/ethnicity, gender, and annual family income respectively. Shades of blue indicate different ways in which respondents are covered by health insurance, while shades of red/orange denote respondents who are not covered themselves. Purple respondents marked that their children are covered but did not specify whether they themselves were.

3: Figure 3 shows that respondents who identify as Black or African American, two or more races. or Native Hawaiian or other Pacific Islander, are the most likely to be covered by either Medicare or Medicaid. Respondents who identify as Hispanic or Latino, or White or Caucasian are the most likely to be covered by employer provided health insurance. Respondents who identify as Native Hawaiian or other Pacific Islander, Black or African American, two or more races, or Hispanic or Latino are the most likely to be uninsured.

4: Figure 4 shows that respondents who identify as female are more likely to be covered by employer provided health insurance and less likely to be covered by Medicare or Medicaid, when compared to respondents who identify as male. Respondents who identify as female are also slightly more likely to be uninsured than male identifying respondents.

5: Figure 5 shows that respondents with lower incomes are significantly more likely to be covered by Medicare or Medicaid, and less likely to be covered by employer provided health insurance than respondents with higher incomes. Respondents with lower incomes are also more likely to be uninsured than higher incomes. However, respondents with incomes between $25,000 and $49,999 were more likely to be uninsured than respondents with incomes below $25,000. This is likely due to the "Cliff Effect" which describes the situation when a person's income exceeds the threshold for social programs like Medicaid, but is not enough to afford private or employer provided health insurance plans. Zero respondents who reported an annual family income above $75,000 report being uninsured.

6a: Figure 6a shows that 11.1% of all respondents reported that they were currently having trouble accessing a dentist.

6b: Figure 6b shows that 10.34% of all respondents who are insured by their employer, Medicare, Medicaid, or private insurance reported that they were currently having trouble accessing a dentist.

6c: Figure 6c shows that 18.75% of all respondents who do not have health insurance report that they are currently having trouble accessing a dentist.

7-9: Figures 7 through 9 highlight dental inaccessibility broken down by race/ethnicity, gender, and annual family income respectively.

7: Figure 7 shows that trouble accessing a dentist is most common among respondents who identify as American Indian or Alaskan Native, 33.33% of whom experience inaccessibility. Black or African American respondents report slightly lower rates of inaccessibility at 31.71%, followed by Native Hawaiian or other Pacific Islander (26.83%), Hispanic or Latino (20%), two or more races (15.38%), and White or Caucasian (8.66%).

8: Figure 8 shows that 12.22% of male identifying respondents reported trouble accessing a dentist. Female identifying respondents reported inaccessibility at a slightly lower rate of 11.29%.

9: Figure 9 shows that dental inaccessibility predominantly affects low-income respondents. Those with an annual family income below $10,000 had the highest rates of dental inaccessibility as 43.4% reported that they are currently having trouble accessing a dentist. Respondents with an income between $25,000 and $34,999 experienced greater inaccessibility than those with incomes between $10,000 and $24,999. Once again, this is likely due to the "Cliff Effect" as people whose income barely exceeds the thresholds for Medicaid or food or housing subsidies may be less able to afford dental care than people with slightly lower incomes. Only eight respondents with incomes above $75,000 reported having trouble accessing a dentist.

10a: Figure 10a shows 38.76% of respondents reported having had a mental/brain health diagnosis like Depression, Bi-Polar, or Anxiety at some point in their life. 58.57% reported not having had such a diagnosis, and 2.37% declined to respond.

10b: Figure 10b shows that 46.63% of all survey respondents identified brain/mental health as one of the top three health problems in their community.

10c: Figure 10c shows that 38.48% of all respondents reported that at least one barrier exists which may prevent them from receiving brain/mental health services. Examples of such barriers include access to appointments, costs, lack of transportation, lack of insurance, and social stigma.

10d: Figure 10d shows that, of the group of respondents who reported having had a mental/brain health diagnosis, 52.54% reported that at least one barrier exists which may prevent them from receiving brain/mental health services. Examples of such barriers include access to appointments, costs, lack of transportation, lack of insurance, and social stigma.

11-13: Figures 11 through 13 display the percentage of respondents who identified brain/mental health as one of the top three health problems in their community, broken down by race/ethnicity, gender, and annual family income respectively.

11: Figure 11 shows that 53.85% of respondents who identified as two or more races, identified brain/mental health as one of the top three problems in their community. 50.72% of White or Caucasian respondents identified brain/mental health as a top concern, followed by Hispanic or Latino (46.67%), Black or African American (19.51%), American Indian or Alaskan Native (16.67%) and Native Hawaiian or other Pacific Islander respondents (4.88%).

12: Figure 12 shows that 49.44% of female identifying respondents identified brain/mental health as one of the top three health problems in their community. Male identifying respondents did so at a lower rate of 38.91%.

13: Figure 13 shows that respondents with higher incomes were most likely to identify brain/mental health as one of the top three health problems in their community. Respondents with an annual family income between $150,000 and $199,000 were the most likely to identify brain/mental health as a top concern at a rate of 69.09%. Respondents with an income between $15,000 and $24,999 and those with an income below $10,000were least likely to identify brain/mental health as a top concern at a rate of 22.22% and 22.64% respectively.

14a-14c: Figures 14a through 14c show what percentage of respondents identified issues related to each of the three focuses dealing with health behaviors (Substance Misuse, Nutrition/Inactivity/Obesity, STDs respectively), as being among the top three health problems in their community.

14a: Figure 14a shows that 42.7% of respondents identified substance misuse (tobacco, alcohol, drugs) as one of the top three health problems in their community.

14b: Figure 14b shows that 48.46% of respondents identified obesity as one of the top three health problems in their community.

14c: Figure 14c shows that 3.09% of respondents identified STDs as one of the top three health problems in their community.

15a-15c: Figures 15a through 15c show what percentage of respondents identified certain issues related to each of the three focuses of the task force on healthy behaviors (Substance Misuse, Nutrition/ Inactivity/Obesity, and STD/Unprotected Sex respectively), as being among the top three health problems in their community, broken down by race and ethnicity.

15a: Figure 15a demonstrates that American Indian or Alaskan Native respondents were the most likely to identify substance misuse as one of the top three health problems in their community at a rate of 83.33%, followed by respondents who identify as two or more races (61.54%), White or Caucasian (44.58%), Hispanic or Latino (40%), Black or African American (34.15%) and Native Hawaiian or other Pacific Islander (4.88%).

15b: Figure 15b demonstrates that White or Caucasian respondents were the most likely to identify obesity as one of the top three health problems in their community at a rate of 54.15%, followed by respondents who identify as Hispanic or Latino (40%), American Indian or Alaskan Native (33.33%), Black or African American (31.71%), two or more races (23.08%) and Native Hawaiian or Pacific Islander (2.44%).

15c: Figure 15c demonstrates that Black or African American respondents were the most likely to identify STDs as one of the top three health problems in their community at a rate of 54.15%, followed by respondents who identify as White or Caucasian (2.89%), and Native Hawaiian or other Pacific Islander (2.44%). All respondents of all other racial and ethnic demographics did not identify STDs as one of the top three health problems in their community.

16a-16c: Figures 16a through 16c show what percentage of respondents identified certain issues related to each of the three focuses of the task force on healthy behaviors (Substance Misuse, Nutrition/ Inactivity/Obesity, and STD/Unprotected Sex respectively), as being among the top three health problems in their community, broken down by gender.

16a: Figure 16a shows that male identifying respondents identified substance misuse as one of the top three health problems in their community at a rate of 43.44%, while female identifying respondents did so at a slightly lower rate of 42.21%.

16a: Figure 16a shows that male identifying respondents identified substance misuse as one of the top three health problems in their community at a rate of 43.44%, while female identifying respondents did so at a slightly lower rate of 42.21%.

16b: Figure 16b shows that female identifying respondents identified obesity as one of the top three health problems in their community at a rate of 49.89%, while male identifying respondents did so at a lower rate of 46.61%.

16c: Figure 16c shows that male identifying respondents identified STDs as one of the top three health problems in their community at a rate of 3.42%, while female identifying respondents did so at a slightly lower rate of 2.71%.

17a-17c: Figures 17a through 17c show what percentage of respondents identified certain issues related to each of the three focuses of the task force on healthy behaviors (Substance Misuse, Nutrition/ Inactivity/Obesity, and STD/Unprotected Sex respectively), as being among the top three health problems in their community, broken down by annual family income.

17a: Figure 17a shows that respondents with higher annual family incomes were more likely to identify substance misuse as one of the top three health problems in their community than those with lower annual family incomes. Respondents with incomes between $35,000 and $49,999 were the most likely to identify substance misuse as a top concern at a rate of 51.61%, followed by those with incomes between $150,000 and $199,999 at a rate of 50.91%. Respondents with incomes less than $10,000 were the least likely to identify substance misuse as a top concern at a rate of 26.42%, followed by those with incomes between $10,000 and $24,999 at a rate of 33.33%.

17b: Figure 17b shows that respondents with higher annual family incomes were more likely to identify obesity as one of the top three health problems in their community than those with lower annual family incomes. Respondents with incomes above $200,000 were the most likely to identify obesity as a top concern at a rate of 65.52%, followed by those with incomes between $100,000 and $149,999 at a rate of 64.52%. Respondents with incomes less than $10,000 were the least likely to identify obesity as a top concern at a rate of 15.09%, followed by those with incomes between $25,000 and $34,999 at a rate of 28.57%.

17c: Figure 17c shows that respondents with lower annual family incomes were more likely to identify STDs as one of the top three health problems in their community than those with higher annual family incomes. Respondents with incomes below $10,000 were the most likely to identify STDs as a top concern at a rate of 9.43%, followed by those with incomes between $35,000 and $49,999 at a

rate of 8.06%. Zero respondents with annual family incomes above $150,000 identified STDs as a top concern.

18a-18c: Figures 18a to 18c show what percentage of respondents identified certain high-risk behaviors related to each of the three focuses of the task force on healthy behaviors (Substance Misuse, Nutrition/ Inactivity/Obesity, and STD/Unprotected Sex respectively), as being among the top three high-risk behaviors among adults in their community.

18a: Figure 18a shows that 73.6% of respondents identified substance misuse (Alcohol, Illegal Drugs, Prescription Drugs, Tobacco or Vaping) as one of the top three high-risk behaviors among adults in their community.

18b: Figure 18b shows that 56.46% of respondents identified poor diets or physical inactivity as one of the top three high-risk behaviors among adults in their community.

18c: Figure 18c shows that 3.65% of respondents identified unprotected sex as one of the top three high-risk behaviors among adults in their community.

19a-19c: Figures 19a to 19c show what percentage of respondents identified certain high-risk behaviors related to each of the three focuses of the task force on healthy behaviors (Substance Misuse, Nutrition/ Inactivity/Obesity, and STD/Unprotected Sex respectively), as being among the top three high-risk behaviors among adults in their community, broken down by race and ethnicity.

19a: Figure 19a shows that respondents who identify as two or more races were the most likely to identify substance misuse behaviors as being among the top three high-risk behaviors among adults in their community at a rate of 84.62%, followed by respondents who identify as Hispanic or Latino (80%), White or Caucasian (74.73%), Black or African American (73.17%), American Indian or Alaskan Native (66.67%), and Native Hawaiian or other Pacific Islander (53.66%).

19b: Figure 19b shows that respondents who identify as Hispanic or Latino were the most likely to identify poor diets or physical inactivity as being among the top three high-risk behaviors among adults in their community at a rate of 66.67%, followed by respondents who identify as White or Caucasian (59.75%), Native Hawaiian or other Pacific Islander (48.78%), Black or African American (36.59%), two or more races (30.77%) and American Indian or Alaska Native (0%).

19c: Figure 19c shows that respondents who identify Black or African American were the most likely to identify unprotected sex as one of the top three high-risk behaviors among adults in their community at a rate of 14.63%, followed by respondents who identify as Hispanic or Latino (13.33%), Native Hawaiian or other Pacific Islander (4.88%), and White or Caucasian (2.89%). Zero respondents who identify as American Indian or Alaskan Native or two or more races identified unprotected sex as one of the top three high-risk behaviors among adults in their community.

20a-20c: Figures 20a to 20c show what percentage of respondents identified certain high-risk behaviors related to each of the three focuses of the task force on healthy behaviors (Substance Misuse, Nutrition/ Inactivity/Obesity, and STD/Unprotected Sex respectively), as being among the top three high-risk behaviors among adults in their community, broken down by gender.

20a: Figure 20a shows that male identifying respondents are most likely to identify substance misuse behaviors as being among the top three high-risk behaviors among adults in their community at a rate of 74.66%. Female identifying did so at a slightly lower rate of 73.14%.

20b: Figure 20b shows that female identifying respondents are most likely to identify poor diets or physical inactivity as being among the top three high-risk behaviors among adults in their community at a rate of 56.66%%. Male identifying did so at a slightly lower rate of 55.56%.

20c: Figure 20c shows that male identifying respondents are most likely to identify unprotected sex as one of the top three high-risk behaviors among adults in their community at a rate of 3.42%. Female identifying did so at a slightly lower rate of 3.41%.

21a-21c: Figures 21a to 21c show what percentage of respondents identified certain high-risk behaviors related to each of the three focuses of the task force on healthy behaviors (Substance Misuse, Nutrition/ Inactivity/Obesity, and STD/Unprotected Sex respectively), as being among the top three high-risk behaviors among adults in their community, broken down by annual family income.

21a: Figure 21a shows that respondents with higher annual family incomes and those with lower annual family incomes were generally just as likely to identify substance misuse behaviors as being among the top three high-risk behaviors among adults in their community than respondents with lower annual family incomes. Respondents with incomes between $10,000 and $14,999 were the most likely to identify substance misuse behaviors as top high-risk behaviors at a rate of 81.48%, followed by those with incomes between $25,000 and $34,999 at a rate of 80.95%. Respondents with incomes between $35,000 and $49,999 were the least likely to identify substance misuse behaviors as top high-risk behaviors at a rate of 66.13%, followed by those with incomes below $10,000 at a rate of 67.92%

21b: Figure 21b shows that respondents with higher annual family incomes were more likely to identify poor diets or physical inactivity as being among the top three high-risk behaviors among adults in their community than respondents with lower annual family incomes. Respondents with incomes between $150,000 and $199,999 were the most likely to identify poor diets or physical inactivity as top high-risk behaviors at a rate of 70.91%, followed by those with incomes between $100,000 and $149,999 were the least likely to identify poor diets or physical inactivity as top high-risk behaviors at a rate of 67.1%. Respondents with incomes between $10,000 and $14,999 were the least likely to identify poor diets or physical inactivity as top high-risk behaviors at a rate of 33.33%, followed by those with incomes below $10,000 at a rate of 37.74%.

21c: Figure 21c shows that respondents with lower annual family incomes were more likely to identify unprotected sex as one of the top three high-risk behaviors among adults in their community than respondents with higher annual family incomes. Respondents with incomes between $25,000 and $34,999 were the most likely to identify unprotected sex as a top high-risk behavior at a rate of 14.29%, followed by those with incomes below $10,000 at a rate of 9.43%. Zero respondents with incomes between $15,000 and $24,999, or above $150,000, identified unprotected sex as a top high-risk behavior.

Dubuque County Demographics

The steering committee looked at several socio-economic demographic indicators associated with poor health. Utilizing data collected from the American Community Survey (ACS) and the City of Dubuque Geographic Information System (GIS), areas with elevated health risk were found at the Census Tract level.

Health Risk Indicators

The following indicators were identified by the Steering Committee as contributing to higher health risk levels. The ACS data table ID is included in parentheses

- Population 65+ Years of Age (B11007)
- Population Under 6 Years of Age (S0101)
- School Age Children Ages, 6-17 (S0101)
- Disability Status (S1810)
- Educational Attainment (B15003)
- Local Unemployment (DP03)
- SNAP Recipients (B22010)
- Median Household Income (B19013)
- Racial Minority (B02001)
- Black or African American (B02001)
- Native Hawaiian or Pacific Islander (B02001)
- Hispanic/Latino (B03002)
- Overcrowded Housing Units (B25014)
- Poverty Status by Age (B17017)
- No Health Insurance (S2701)
- No Vehicle Access (S2504)

Information on these indicators was collected at the Census Tract level using American Community Survey 2021 5-year estimates data found at the US Census website, downloaded in an Excel table, imported into ArcGIS Pro, and mapped to the tract geographies. https://data.census.gov/

American Community Survey 2021 5-Year Estimates

The American Community Survey (ACS) is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data every year. Like the Decennial Census, the ACS provides detailed data on demographic, social, economic, and housing characteristics throughout the US.

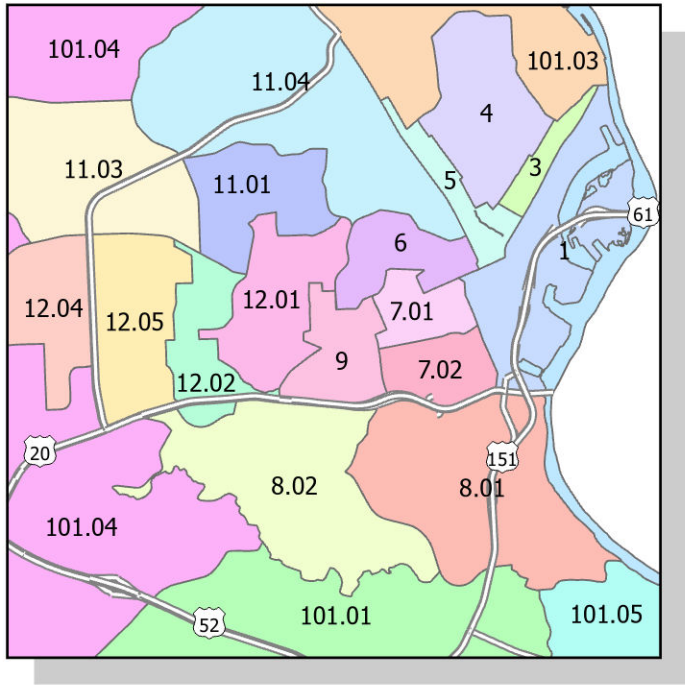
The ACS differs from the Decennial Census by only surveying a sample of persons within a neighborhood or community, whereas the Decennial Census surveys every household in the country. https://www.census.gov/programs-surveys/acs

Indicator Maps

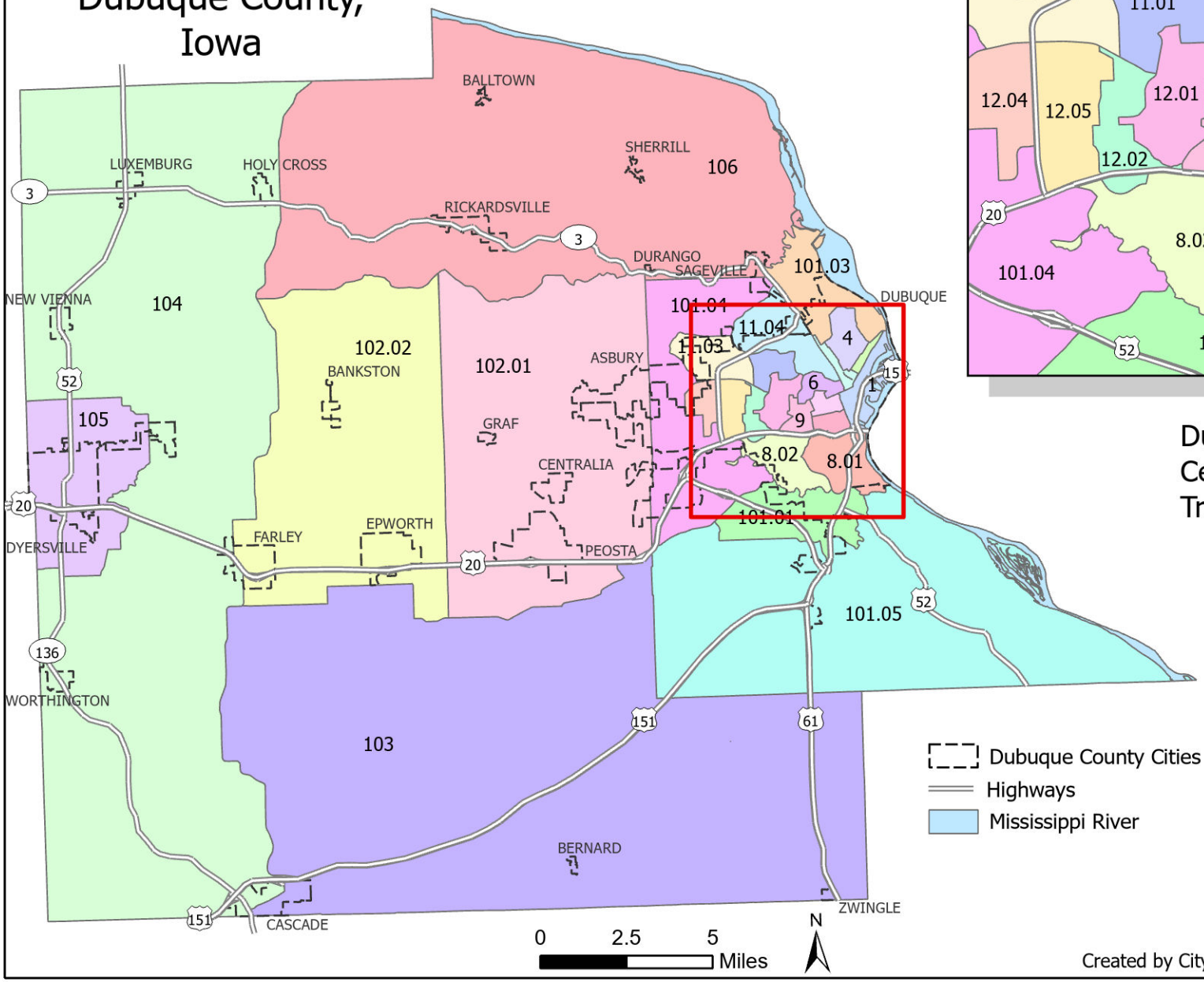
The following map series shows each indicator by tract. Each indicator was broken down into a range of values, given an index value, and symbolized by a color range. The last map, titled “Combined Health Risk Indicator” shows the sum of the index values from all 16 of the preceding maps for each tract. Darker areas depict block groups with overall elevated health risk.

Census Tracts

Dubuque County, Iowa

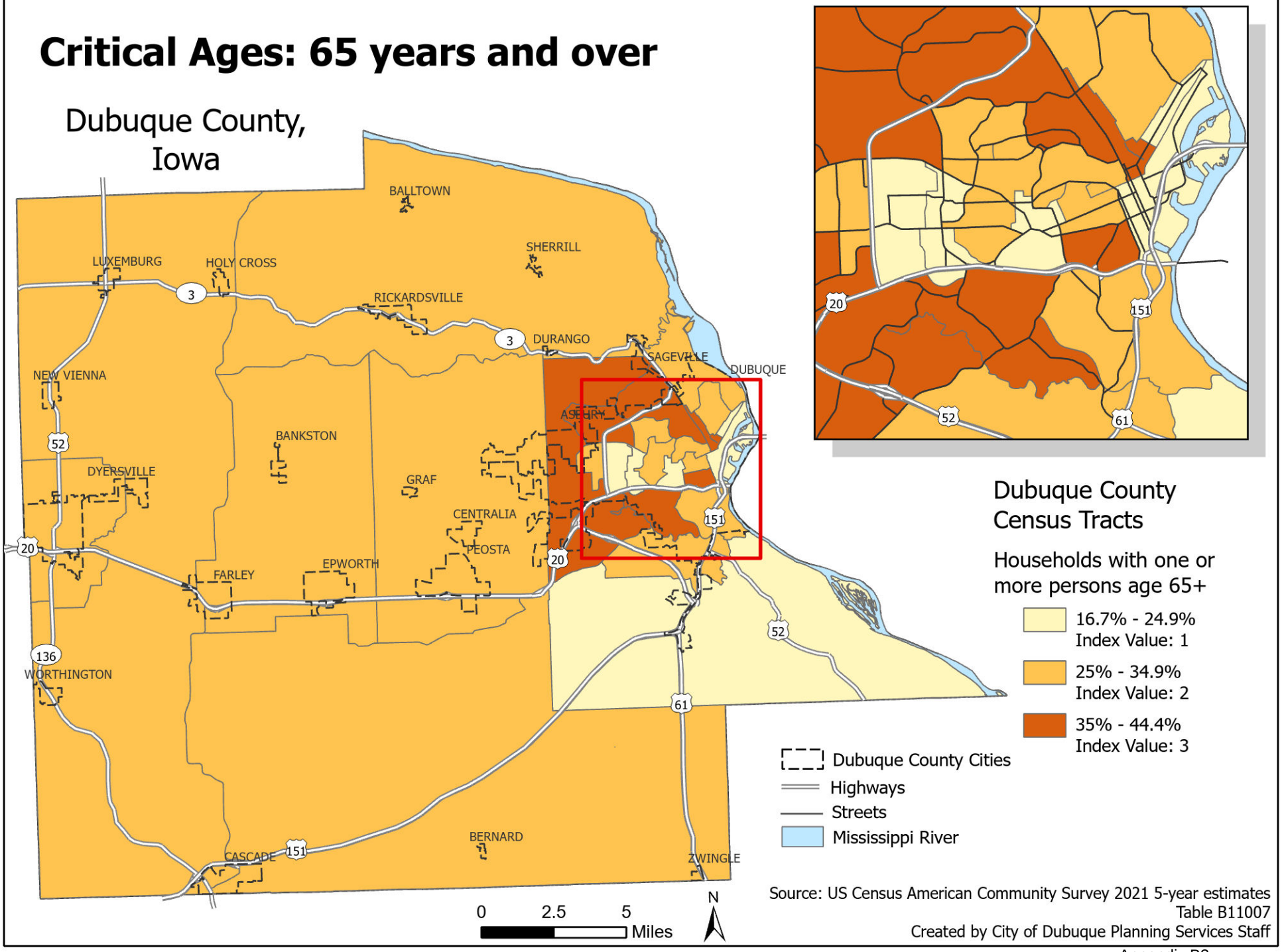


Dubuque County Census Tracts with Tract Numbers



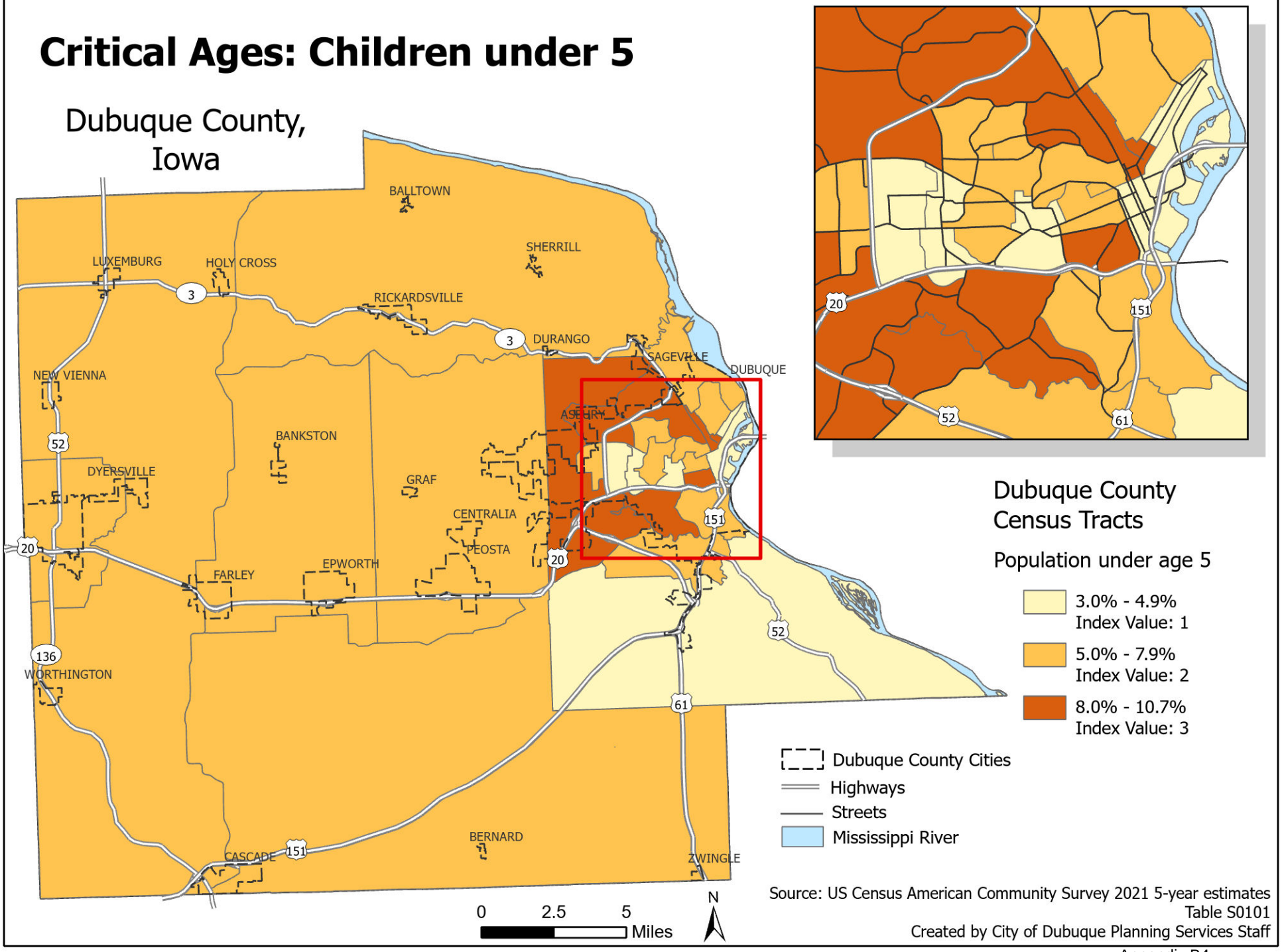
Source: US Census
Created by City of Dubuque Planning Services Staff

Critical Ages: 65 years and over



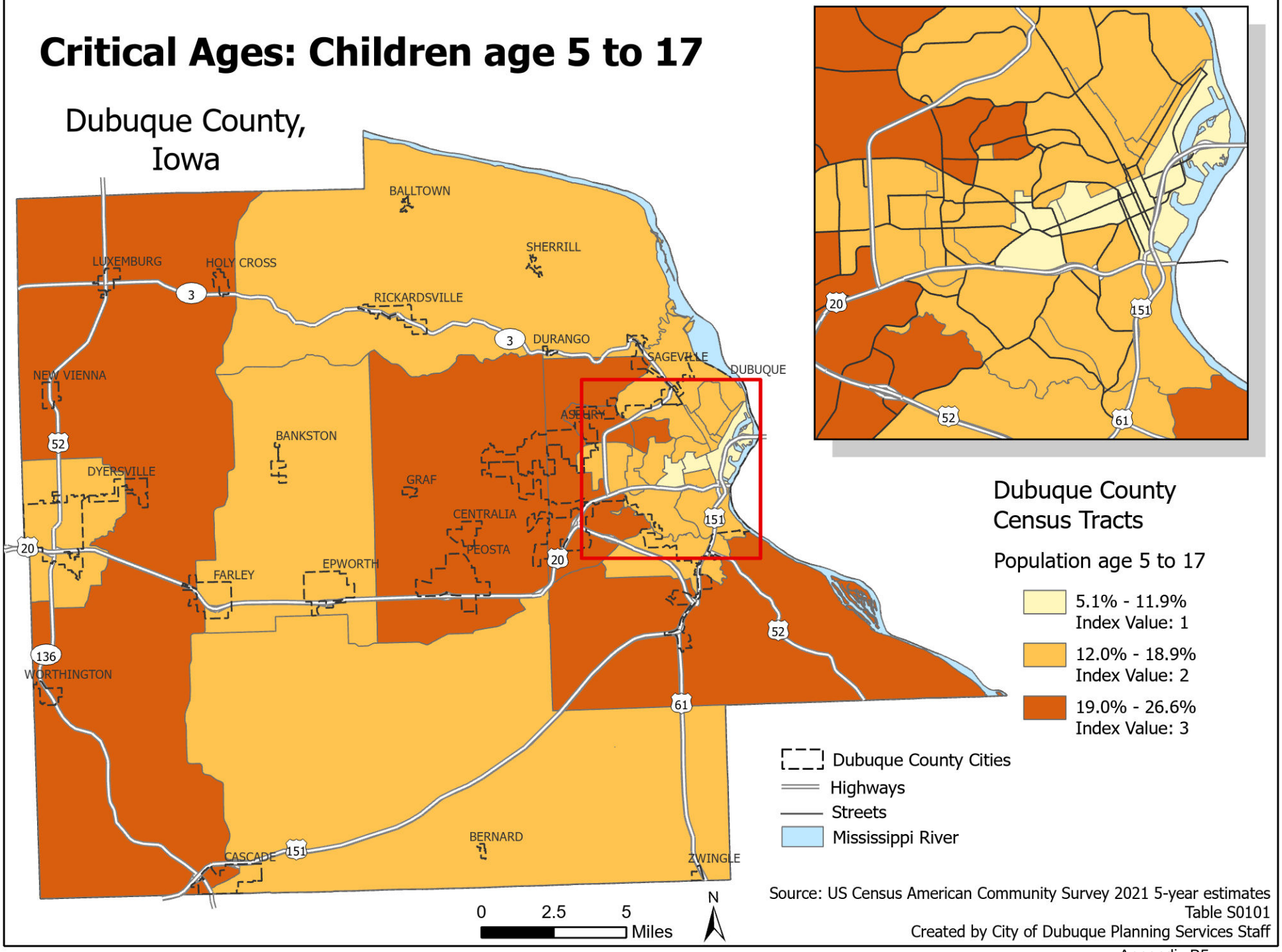
Source: US Census American Community Survey 2021 5-year estimates
Table B11007
Created by City of Dubuque Planning Services Staff

Critical Ages: Children under 5



Source: US Census American Community Survey 2021 5-year estimates
Table S0101
Created by City of Dubuque Planning Services Staff

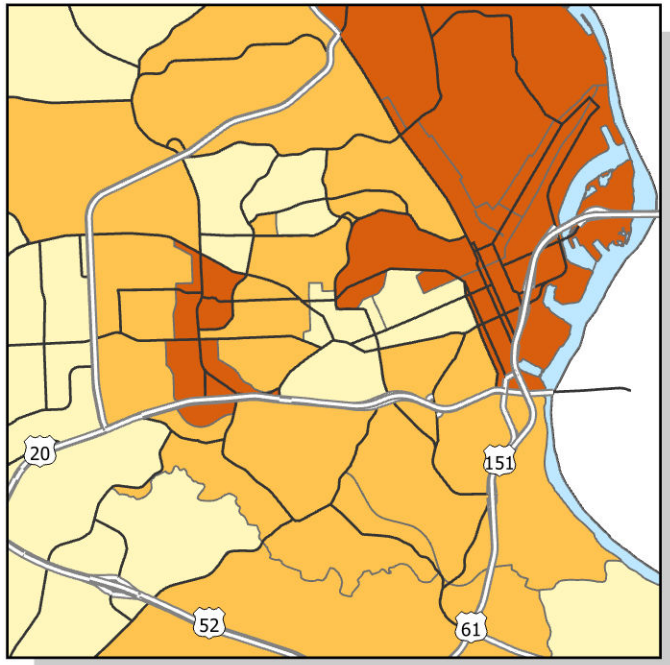
Critical Ages: Children age 5 to 17



Source: US Census American Community Survey 2021 5-year estimates
Table S0101
Created by City of Dubuque Planning Services Staff

Disability Status

Dubuque County, Iowa



BALLTOWN
SHERRILL
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RICKARDSVILLE
DURANGO
SAGEVILLE
DUBUQUE
NEW VIENNA
ASBURY
BANKSTON
DYERSVILLE
GRAF
CENTRALIA
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FARLEY
WORTHINGTON
BERNARD
CASCADE
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0 2.5 5 Miles

N

Dubuque County Census Tracts

Civilian noninstitutionalized population with a disability

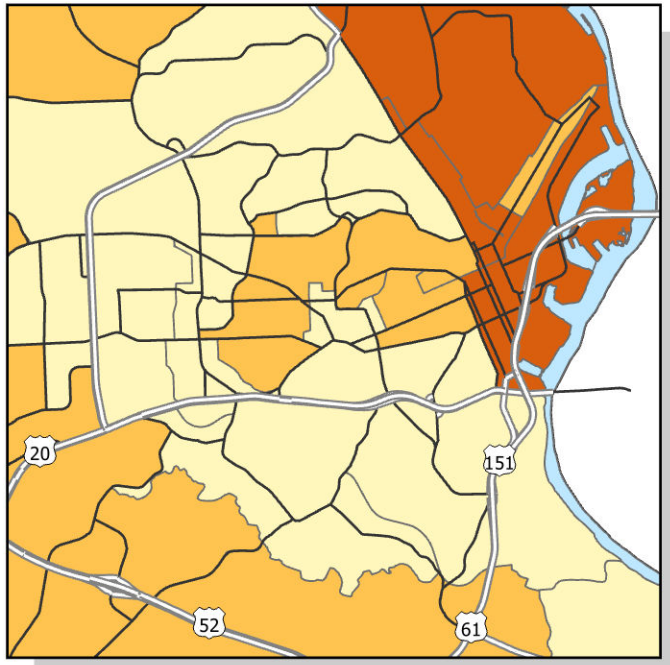
- 4.7% - 9.9% Index Value: 1
- 10.0% - 14.9% Index Value: 2
- 15.0% - 23.7% Index Value: 3

Dubuque County Cities
Highways
Streets
Mississippi River

Source: US Census American Community Survey 2021 5-year estimates Table S1810
Created by City of Dubuque Planning Services Staff

Educational Attainment

Dubuque County, Iowa



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ZWINGLE

0 2.5 5 Miles

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Dubuque County Census Tracts

Population age 25 and over not having a diploma or GED

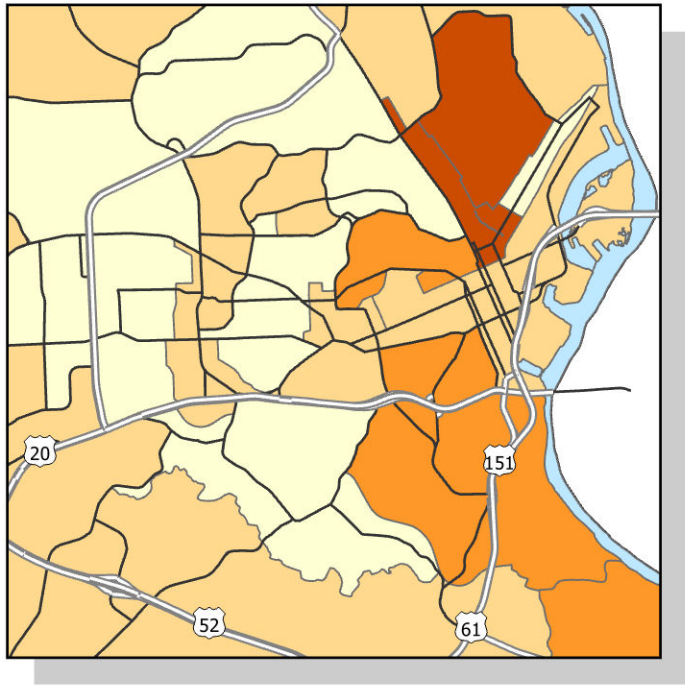
- 0.8% - 4.9% Index Value: 1
- 5.0% - 9.9% Index Value: 2
- 10.0% - 23.3% Index Value: 3

Dubuque County Cities
Highways
Streets
Mississippi River

Source: US Census American Community Survey 2021 5-year estimates Table B15003
Created by City of Dubuque Planning Services Staff

Unemployment

Dubuque County, Iowa



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Miles

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Dubuque County Census Tracts

Percent of workforce unemployed

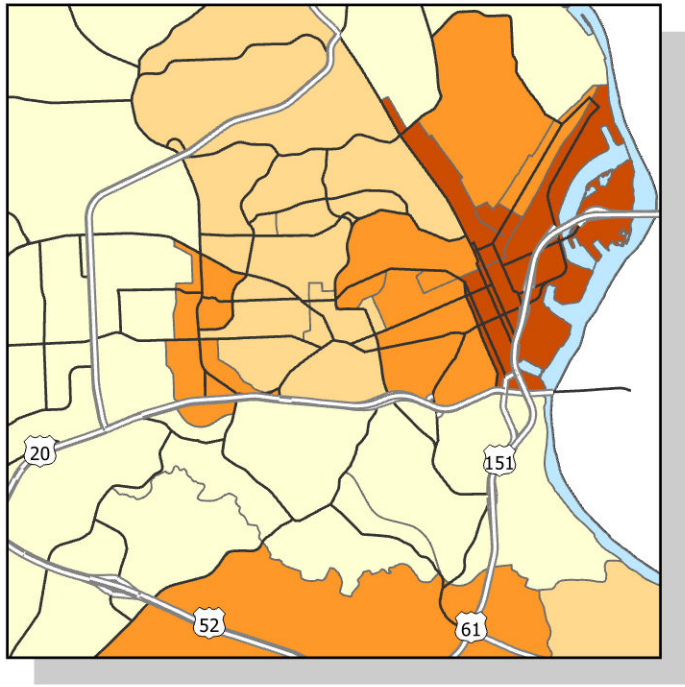
- 0.3% - 1.4% Index Value: 1
- 1.5% - 2.9% Index Value: 2
- 3% - 4.9% Index Value: 3
- 5% - 17.3% Index Value: 4

- Dubuque County Cities
- Highways
- Streets
- Mississippi River

Source: US Census American Community Survey 2021 5-year estimates Table DP03
Created by City of Dubuque Planning Services Staff

Food Stamps/SNAP

Dubuque County, Iowa



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0 2.5 5 Miles

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Dubuque County Census Tracts

Household received Food Stamps/SNAP in the past 12 months

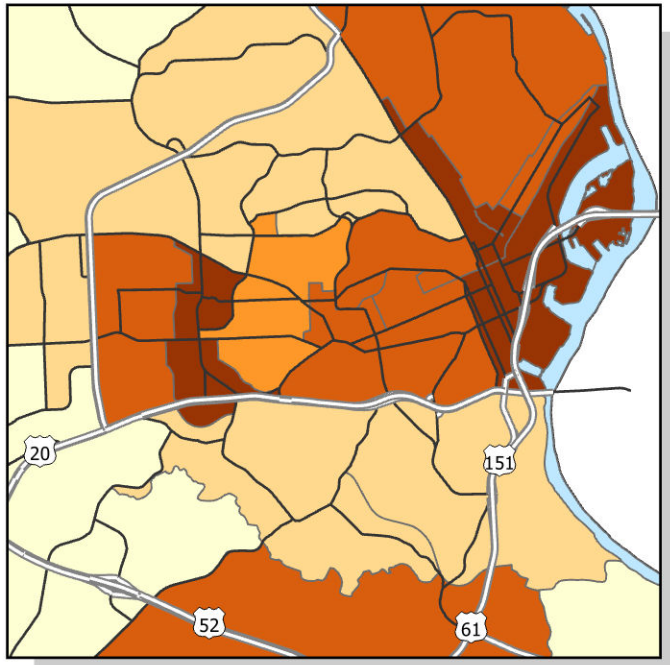
- 0.0% - 4.9% Index Value: 1
- 5.0% - 9.9% Index Value: 2
- 10.0% - 19.9% Index Value: 3
- 20.0% - 35.7% Index Value: 4

Dubuque County Cities
Highways
Streets
Mississippi River

Source: US Census American Community Survey 2021 5-year estimates Table B22010
Created by City of Dubuque Planning Services Staff

Median Household Income

Dubuque County, Iowa



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CASCADE
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ZWINGLE

0 2.5 5 Miles

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Dubuque County Census Tracts

Median Household Income (Dubuque County Median Household Income: $68,198)

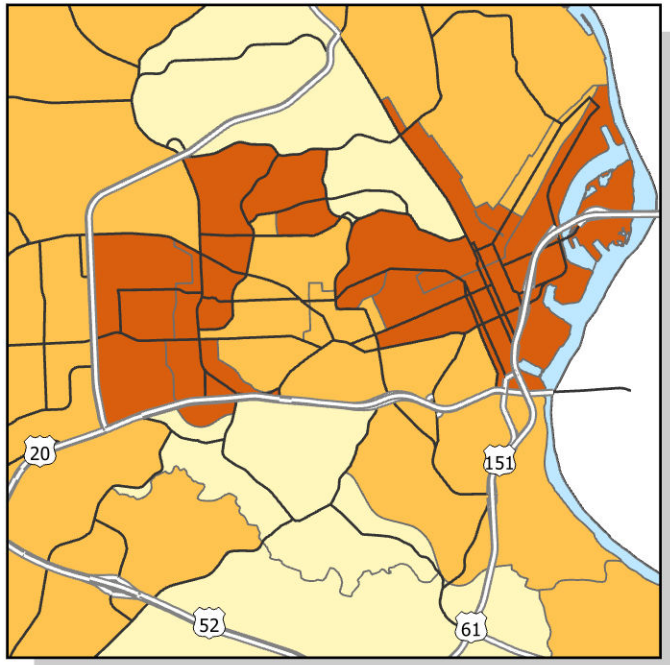
- $35,679 - $44,999 Index Value: 5
- $45,000 - $59,999 Index Value: 4
- $60,000 - $74,999 Index Value: 3
- $75,000 - $89,999 Index Value: 2
- $90,000 - $117,361 Index Value: 1

Dubuque County Cities
Highways
Streets
Mississippi River

Source: US Census American Community Survey 2021 5-year estimates Table B19013
Created by City of Dubuque Planning Services Staff

Racial Minority

Dubuque County, Iowa



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0 2.5 5
Miles

N

Dubuque County Census Tracts

Population whose race is not "White alone"

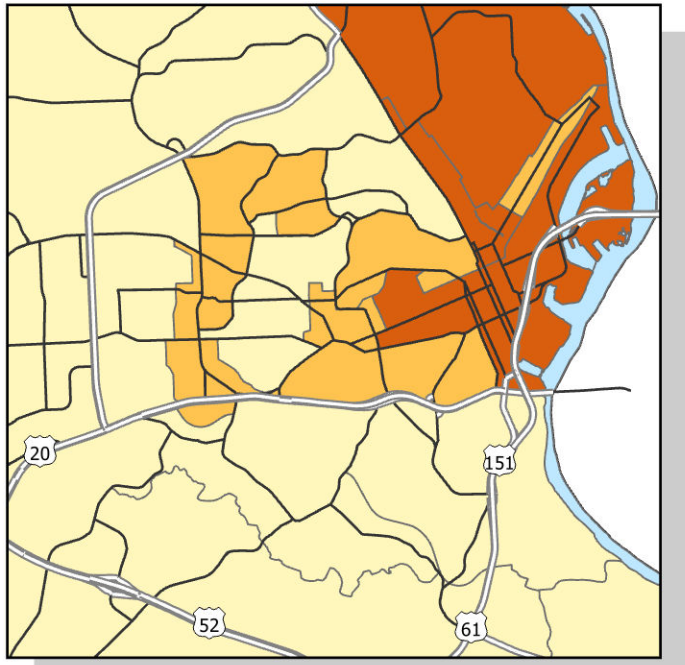
- 0.6% - 4.9% Index Value: 1
- 5.0% - 11.9% Index Value: 2
- 12.0% - 28.3% Index Value: 3

Dubuque County Cities
Highways
Streets
Mississippi River

Source: US Census American Community Survey 2021 5-year estimates Table B02001
Created by City of Dubuque Planning Services Staff

Black or African American

Dubuque County, Iowa



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0 2.5 5 Miles

N

Dubuque County Census Tracts

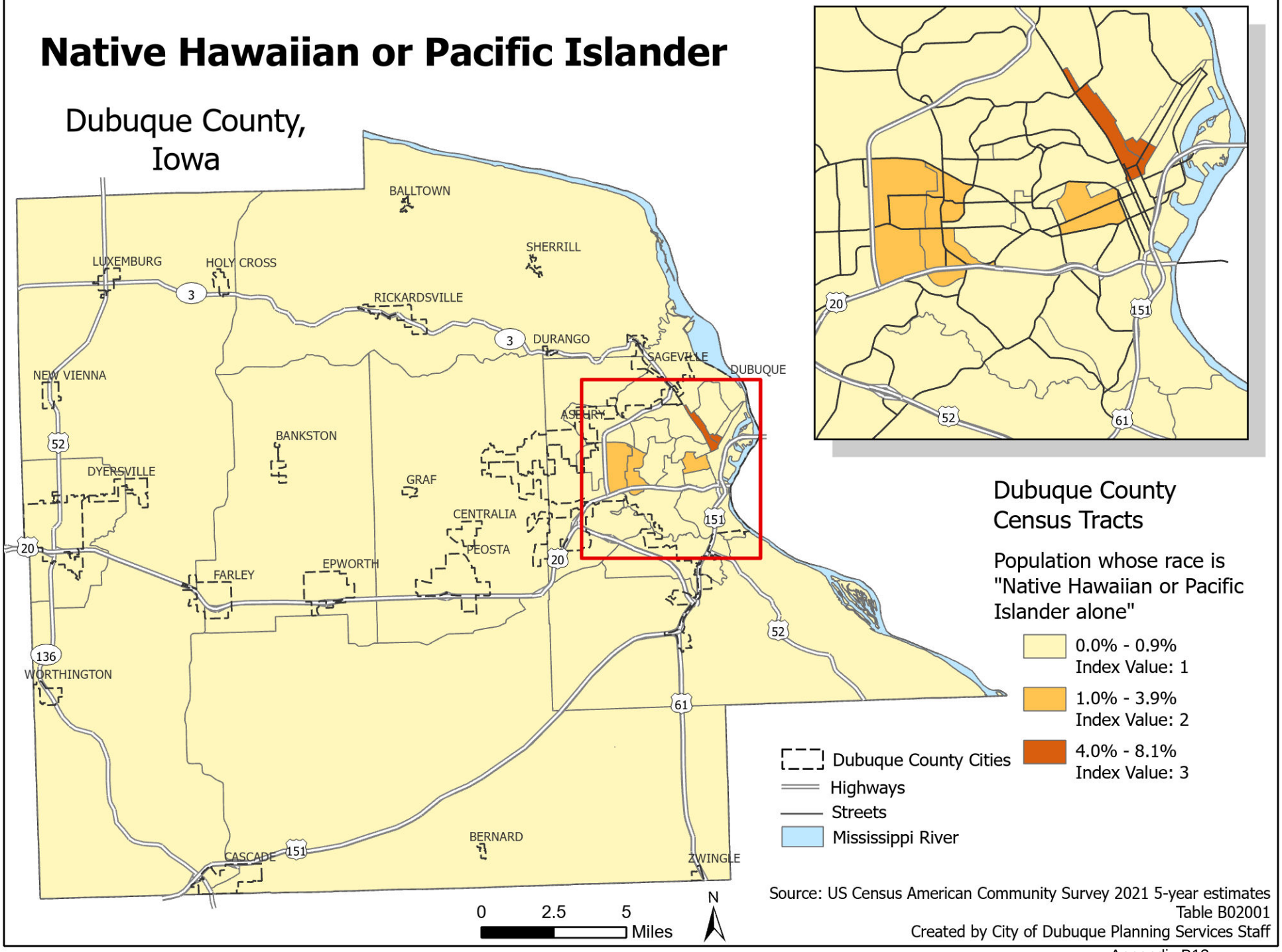
Population whose race is "Black or African American alone"

- 0.0% - 1.9% Index Value: 1
- 2.0% - 6.9% Index Value: 2
- 7.0% - 11.3% Index Value: 3

Dubuque County Cities
Highways
Streets
Mississippi River

Source: US Census American Community Survey 2021 5-year estimates Table B02001
Created by City of Dubuque Planning Services Staff

Native Hawaiian or Pacific Islander



Dubuque County Census Tracts

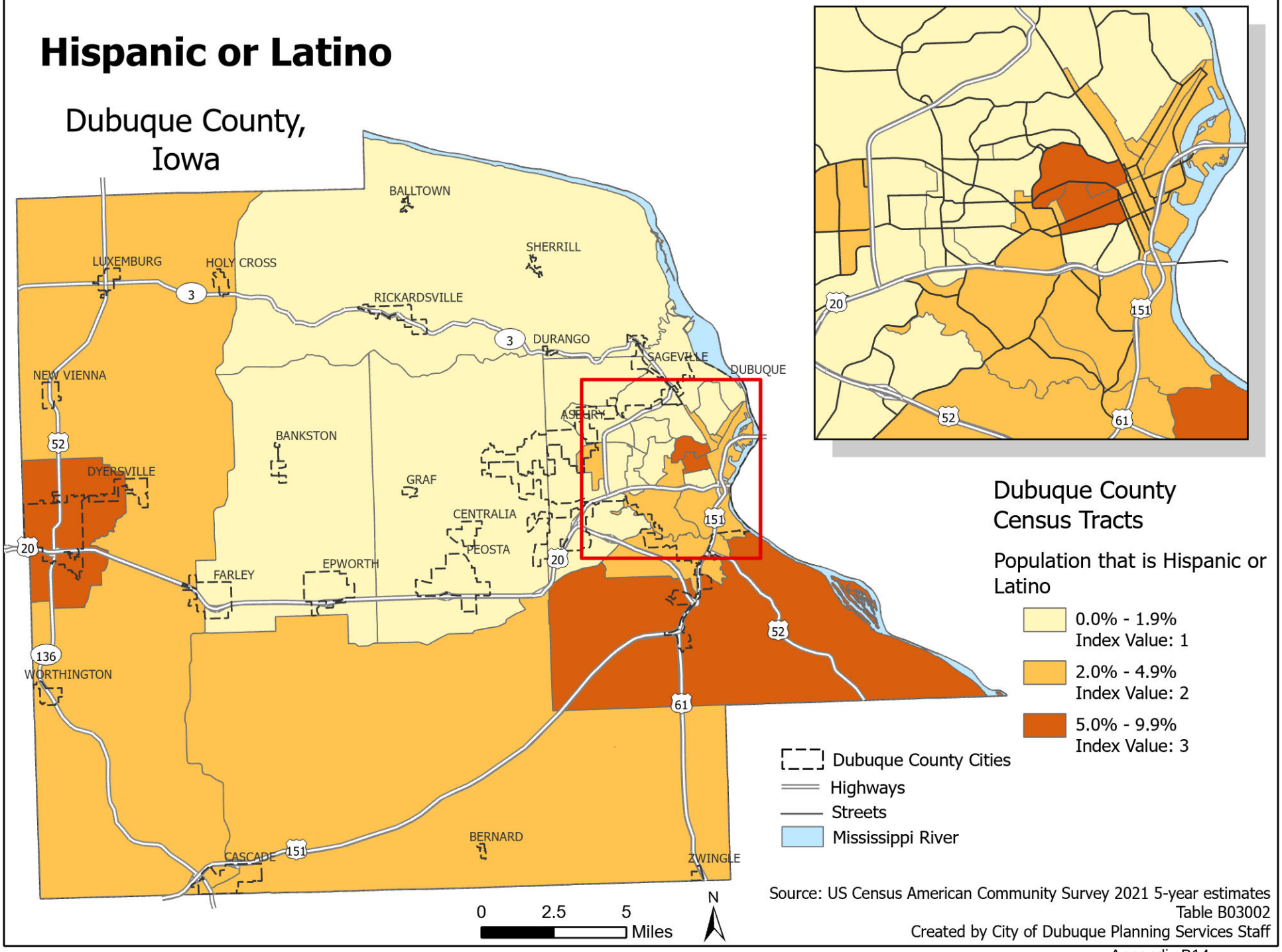
Population whose race is "Native Hawaiian or Pacific Islander alone"

- 0.0% - 0.9% Index Value: 1
- 1.0% - 3.9% Index Value: 2
- 4.0% - 8.1% Index Value: 3

Source: US Census American Community Survey 2021 5-year estimates Table B02001

Created by City of Dubuque Planning Services Staff

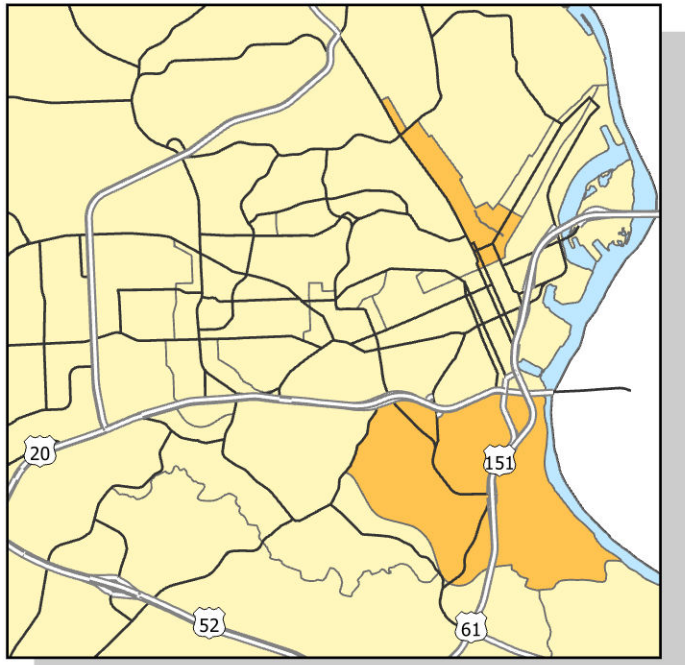
Hispanic or Latino

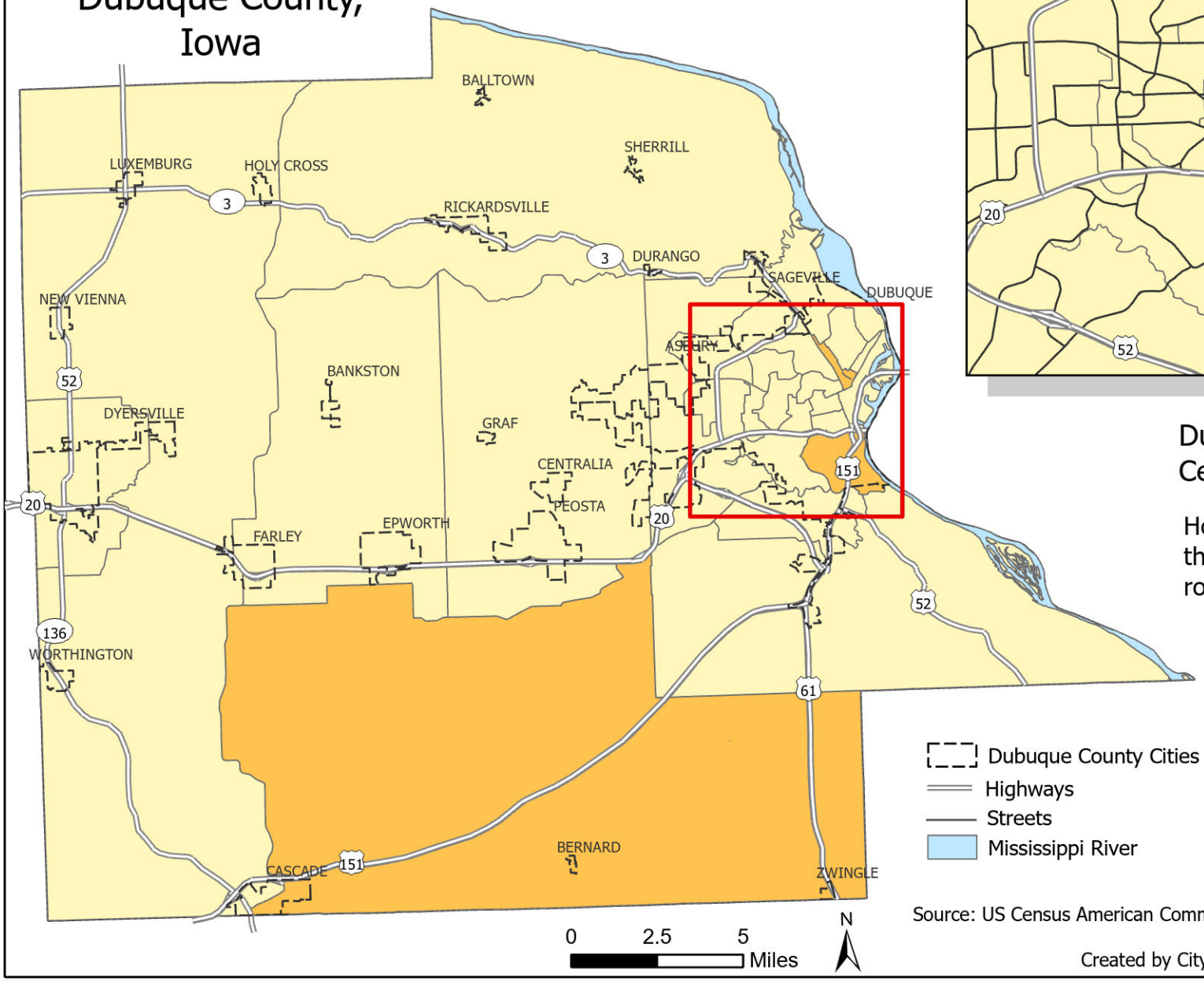


Source: US Census American Community Survey 2021 5-year estimates
Table B03002
Created by City of Dubuque Planning Services Staff

Overcrowded Housing

Dubuque County, Iowa





Dubuque County Census Tracts

Housing units with more than 1.5 occupants per room

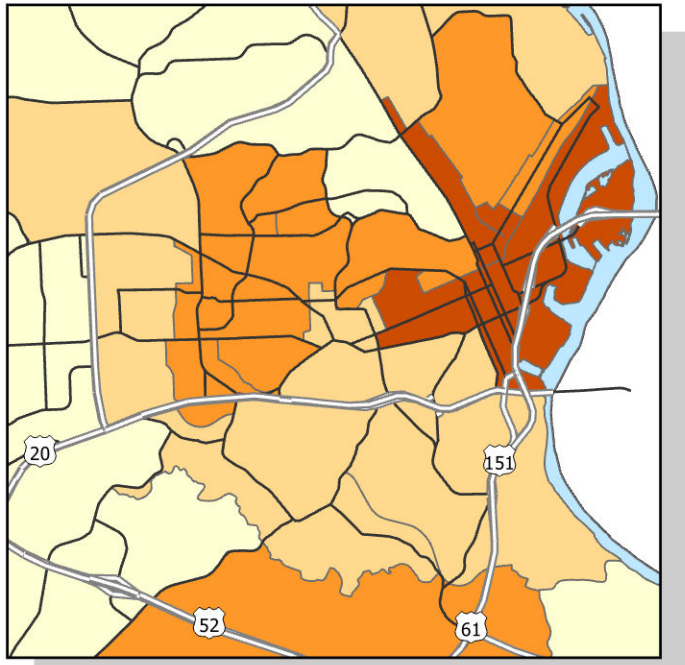
- 0% - 0.9% Index Value: 1
- 1% - 2.1% Index Value: 2

- Dubuque County Cities
- Highways
- Streets
- Mississippi River

Source: US Census American Community Survey 2021 5-year estimates Table B25014
Created by City of Dubuque Planning Services Staff

Household Poverty Status

Dubuque County, Iowa



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0 2.5 5 Miles

N

Dubuque County Census Tracts

Households with Income in the past 12 months below the Poverty Level

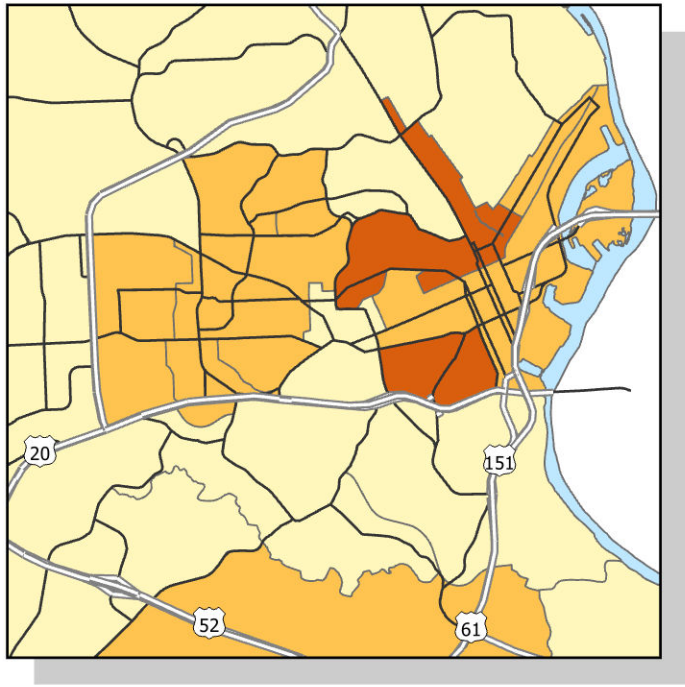
- 3.1% - 4.9% Index Value: 1
- 5.0% - 9.9% Index Value: 2
- 10.0% - 19.9% Index Value: 3
- 20.0% - 27.3% Index Value: 4

Dubuque County Cities
Highways
Streets
Mississippi River

Source: US Census American Community Survey 2021 5-year estimates Table B17017
Created by City of Dubuque Planning Services Staff

No Health Insurance

Dubuque County, Iowa



BALLTOWN
SHERRILL
LUXEMBURG
HOLY CROSS
3
RICKARDSVILLE
3
DURANGO
SAGEVILLE
DUBUQUE
NEW VIENNA
ASBURY
BANKSTON
52
DYERSVILLE
GRAF
151
CENTRALIA
PEOSTA
20
EPWORTH
FARLEY
20
52
136
WORTHINGTON
61
BERNARD
CASCADE
151
ZWINGLE

0 2.5 5 Miles

N

Dubuque County Census Tracts

Percent Uninsured of civilian noninstitutionalized population

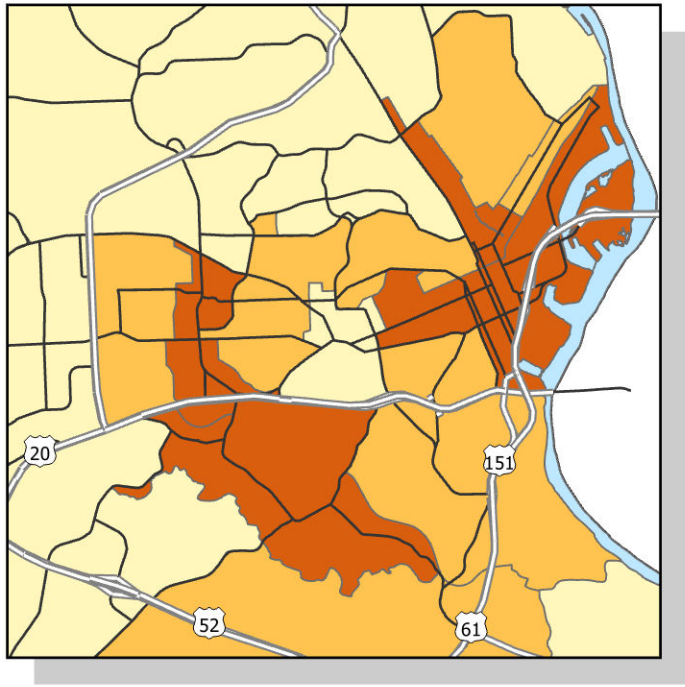
- 0.2% - 2.9% Index Value: 1
- 3.0% - 5.9% Index Value: 2
- 6.0% - 10.9% Index Value: 3

Dubuque County Cities
Highways
Streets
Mississippi River

Source: US Census American Community Survey 2021 5-year estimates Table S2701
Created by City of Dubuque Planning Services Staff

No Vehicle Access

Dubuque County, Iowa



BALLTOWN
SHERRILL
LUXEMBURG
HOLY CROSS
3
RICKARDSVILLE
DURANGO
SAGEVILLE
DUBUQUE
NEW VIENNA
ASBURY
52
BANKSTON
DYERSVILLE
GRAF
CENTRALIA
151
PEOSTA
20
EPWORTH
FARLEY
52
136
WORTHINGTON
61
BERNARD
CASCADE
151
ZWINGLE

0 2.5 5 Miles

N

Dubuque County Census Tracts

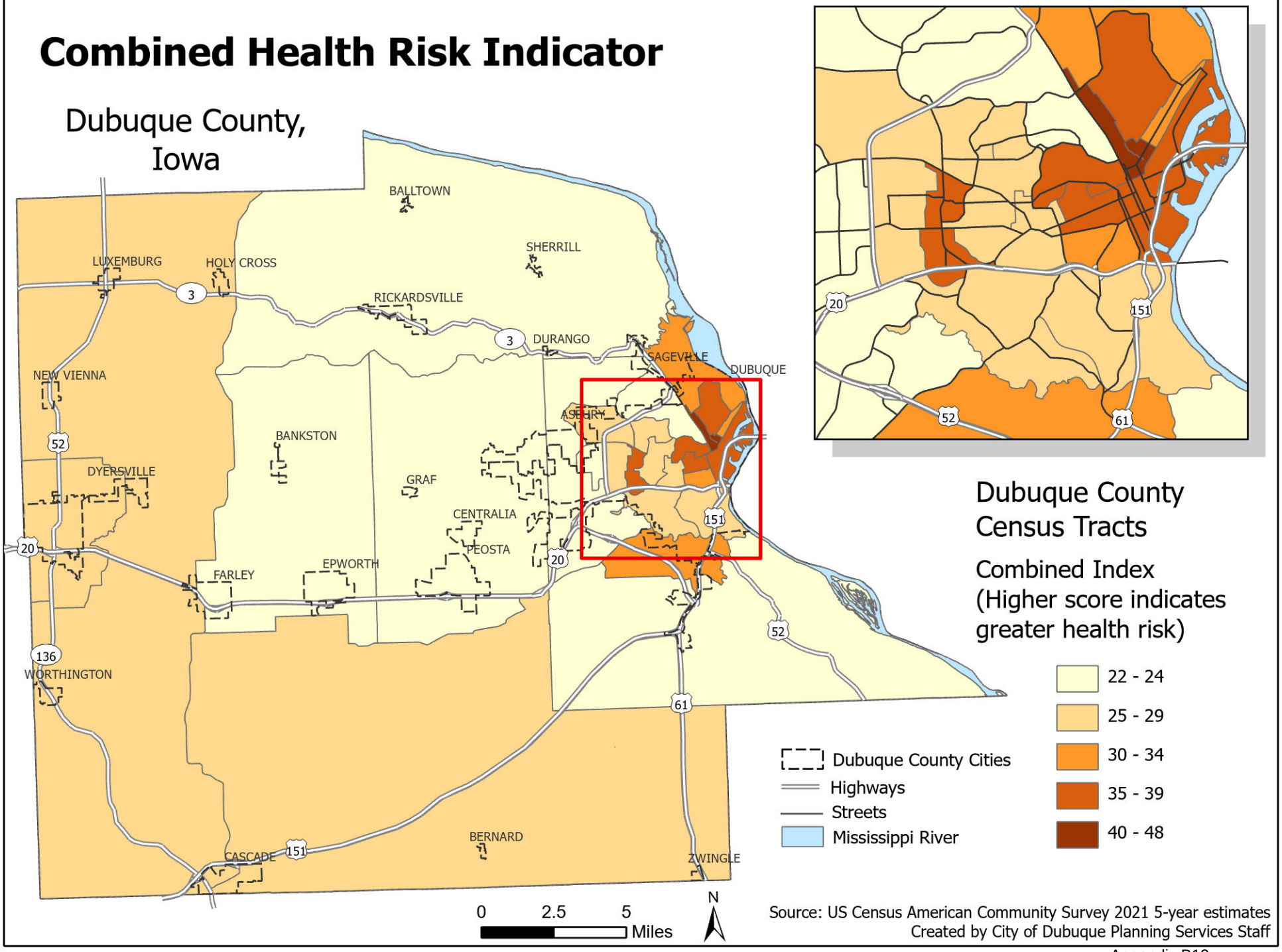
Occupied housing units with no vehicle available

- 0.7% - 4.9% Index Value: 1
- 5.0% - 9.9% Index Value: 2
- 10.0% - 25.2% Index Value: 3

- Dubuque County Cities
- Highways
- Streets
- Mississippi River

Source: US Census American Community Survey 2021 5-year estimates Table S2504
Created by City of Dubuque Planning Services Staff

Combined Health Risk Indicator



Source: US Census American Community Survey 2021 5-year estimates
Created by City of Dubuque Planning Services Staff