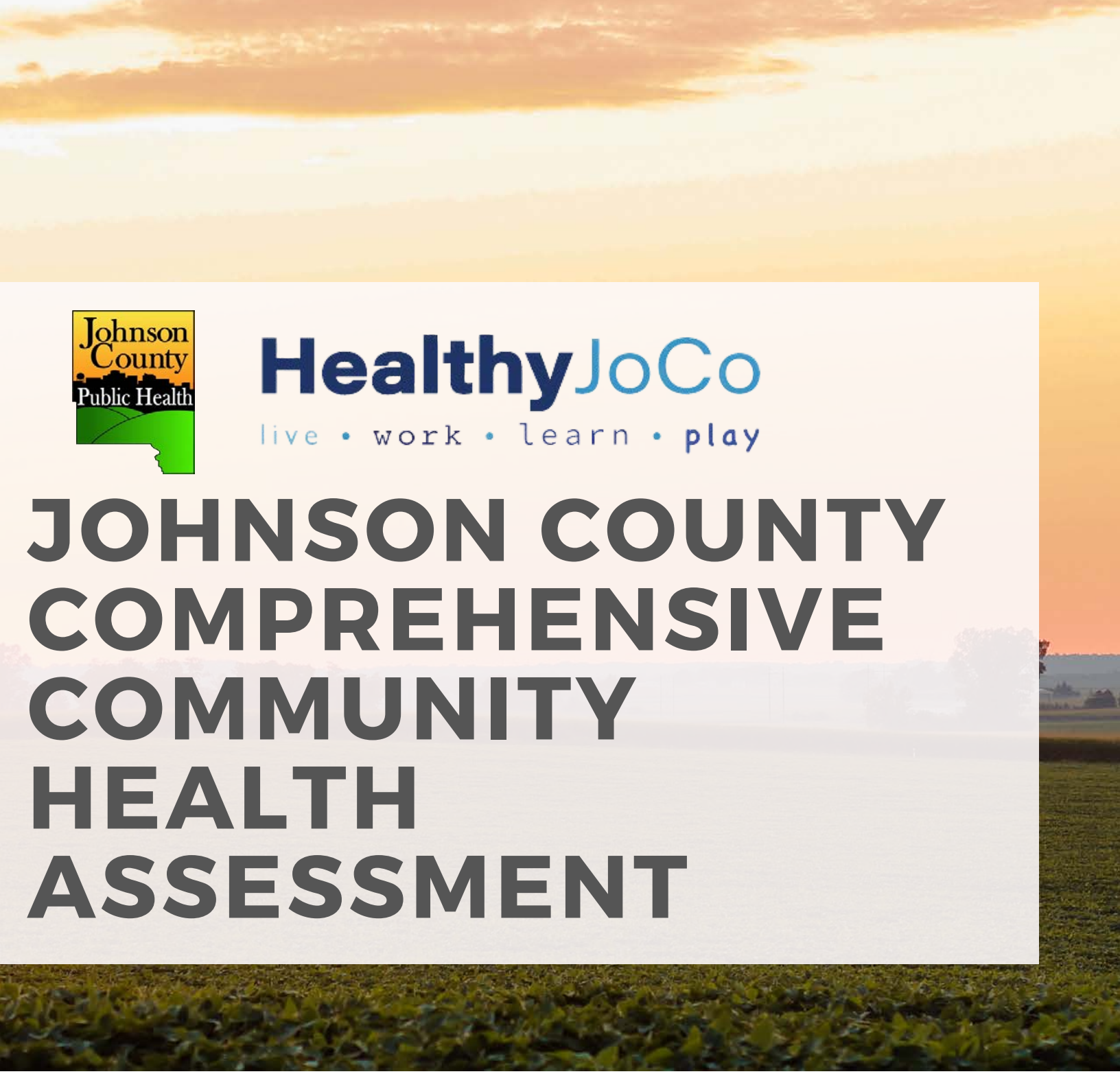

HealthyJoCo

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JOHNSON COUNTY COMPREHENSIVE COMMUNITY HEALTH ASSESSMENT

DECEMBER 2023

Johnson County Public Health

855 S. Dubuque St.
STE 113
Iowa City, Iowa 52240

Table of Contents

ACKNOWLEDGEMENTS

Thank you to all of our partners and community members who participated in these assessments. Your input and feedback is incredibly valuable in this work.

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Special thanks to all who provided comments in Focus Groups and Key Informant Interviews for this Community Context Assessment. Selected participants who elected to publish their names in this report are listed below.

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CSA COMMUNITY PARTNER SUPPORT

Center for Worker Justice
CommUnity Crisis Services and Food Bank
Iowa City Free Medical Clinic
North Liberty Public Library
University of Iowa College of Public Health, Community Strike Force Team

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ABOUT HEALTHYJOCO

HealthyJoCo is a community health assessment (CHA) and community health improvement plan (CHIP) effort in Johnson County and is largely supported by Johnson County Public Health and members of the Core Committee.

HealthyJoCo follows the National Association for County and City Health Officials (NACCHO)'s Mobilizing for Action through Planning and Partnerships (MAPP 2.0) framework. MAPP 2.0 is a community-driven strategic planning process for improving community health.

The MAPP 2.0 process includes an assessment phase of telling the community story by conducting the three following assessments: Community Partners Assessment (CPA), Community Status Assessment (CSA), and Community Context Assessment (CCA).

After all three assessments are completed, HealthyJoCo will prioritize top health issues and focuses to complete a Community Health Improvement Plan (CHIP). The CHIP is part of MAPP 2.0 Phase 3, which aims to continuously improve the community.

PARTNER ENGAGEMENT AND REPORT NAVIGATION

CORE COMMITTEE AND PARTNER ENGAGEMENT

Over the course of the last five years, the Johnson County Public Health's initiative, known as HealthyJoCo, has been steadfast in its commitment to conducting the Community Health Assessment (CHA) and orchestrating the Community Health Improvement Plan (CHIP). Guided by the esteemed framework of Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 as prescribed by the National Association of County and City Health Officials (NACCHO), this endeavor has undergone a reinvigoration in the wake of the pandemic. The renewed focus on the CHA involved the integration of new members into the Core Committee, a selection meticulously made in 2021 through a comprehensive power mapping exercise conducted by JCPH staff.

These selected individuals, although not necessarily occupying positions of traditional power, were identified as embodying true leadership and expertise within the community. Many of the Core Committee members represent the voices of underserved and marginalized sectors of our community, each contributing their unique expertise in areas such as planning and development, healthcare, mental health, diversity, equity, and inclusion, public health, and youth and family services and education.

Beyond the Core Committee, other community partners and community members are consistently engaged in each assessment. JCPH staff places an emphasis on gathering input from the community before, during, and after each assessment to ensure comprehensive community involvement.

We encourage anyone interested in participating in HealthyJoCo efforts contact us at healthyjoco@johnsoncountyiowa.gov.

REPORT NAVIGATION & BACKGROUND

The following report is a consolidation of the 3 MAPP 2.0 community health assessments conducted from 2022 - 2023. The reports are listed chronologically, with the Community Partner Assessment (CPA) first, followed by the Community Status Assessment (CSA) and the Community Context Assessment (CCA).
The end of the report lists all health issue profiles identified from the collected data, as well as the top health priorities selected by the community and methods for prioritizing health issues.

VISION

HealthyJoCo strives for Johnson County to be a diverse community where all have the resources, access, and opportunity to thrive in a resilient, safe, and inclusive community. We also strive to be a community where institutions and community members actively work together to deconstruct silos and address health inequities through partnerships, collaboration, and power-sharing.

MISSION

To evaluate, promote, and improve the health and well-being of those who live, work, learn, and play in Johnson County.

VALUES

01 Inclusive
02 Collaborative
03 Transparent
04 Progressive
05 Genuine

Johnson County Public Health

HealthyJoCo

live • work • learn • play

COMMUNITY PARTNERS ASSESSMENT REPORT

RELSEASED JULY 2022

COMMUNITY PARTNERS ASSESSMENT BACKGROUND

The Community Partners Assessment allows partners to "look critically within their own systems and processes, reflect on their role in the community's health and well-being, and understand the degree to which they are addressing or perpetuating health inequities across a spectrum of action ranging from the individual to systemic and structural levels" (Clayton, 2020). The domains embedded in this assessment are Health Equity Capacity, Community Engagement, Resources, Community Linkages, Leadership, as well as Data Access and Systems. The domains are described below.

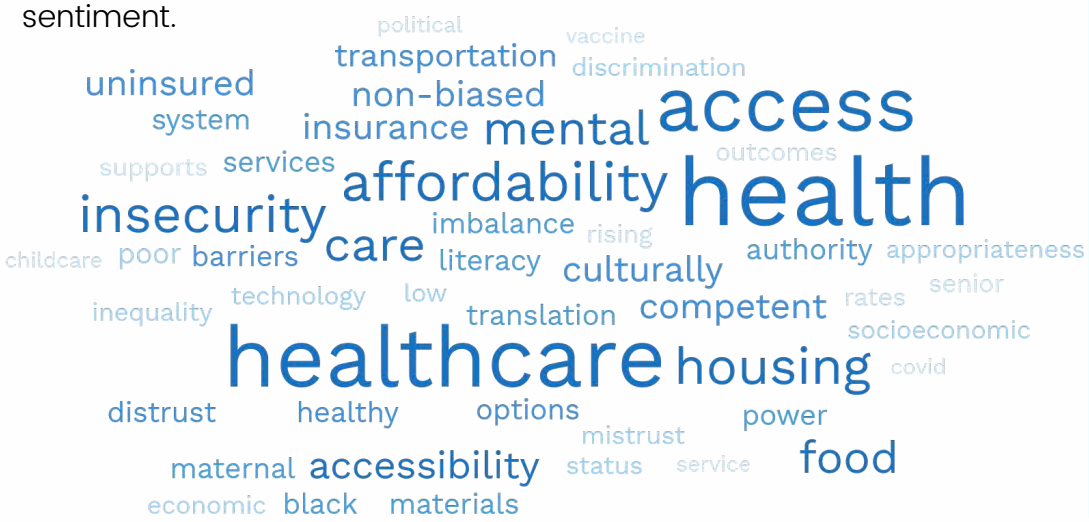
- **Health Equity Capacity:** Assesses each partner's understanding and commitment to health equity and related concepts, their role in addressing health inequities and their perception of the public health system addressing health inequities in Johnson County.
- **Community Engagement:** Assesses each partner's relationship with the community and how they engage the community to participate in shaping programs, services, or other activities designed to help them.
- **Resources**: Assesses partner resources to meet community needs.
- **Community Linkages:** Assesses capacity to coordinate and align with other partners and stakeholders within the community system to improve quality, efficiency, and effectiveness of programs, services, and interventions to address inequities.
- **Leadership:** Assesses each partner's leadership support around achieving equity as it relates to their mission and willingness to participate in the **Healthy**JoCo process.
- **Data Access and Systems:** Inventories available assessments and data across partners that may inform and contribute to the larger community health assessment; explores opportunities for data sharing and transparency across the community; and assesses data infrastructure.

Clayton, A., Verma, P., Weller Pegna, S. (2020). MAPP Evolution Blueprint: Executive Summary. National Association of County and City Health Officials, 21 - 22.

METHODOLOGY

As part of the Community Partners Assessment, the Partnership Assessment Tool for Health (PATH), was identified and amended. The original PATH tool was developed by Partnership for Healthy Outcomes, a collaboration of Center for Health Care Strategies (CHCS), Nonprofit Finance Fund, and Alliance for Strong Families and Communities. The PATH tool was amended by utilizing additional questions from the Bay Area Regional Health Inequities Initiative (BARHII) Local Health Department Self-Assessment Toolkit, specifically the Partners Assessment tool. Detailed survey tool changes can be found at the end of this report.

We reached out to 31 community-based organizations, non profits, health care agencies and already established community partners. In order to have a representative sample, participants were selected based on the work they do in the community and specific subpopulations served. From April 25, 2022 to May 20, 2022, we conducted 15 interviews using the tool described above and in the appendix below. Interviews lasted around 1 hour and were held by either our Public Health Systems Analysis, our Public Health Associate, our Community Health manager or a combination of the above. Interviewees were prompted with questions regarding their mission and who they serve, but did not see the rest of the questions until the interview took place. After each section of questions, the interviewee was asked a benchmark statement to rate 1-5 to assess the current status of our partnership and note areas for opportunities and growth. Notes were taken during each interview and then responses were qualitatively analyzed according to question by theme and sentiment.



ASSESSMENT TOOL NAVIGATION

The Community Partners Assessment tool is separated by the sections outlined below. Each section contains a benchmark statement where each participant is asked to give a rating on a scale from 1 (Needs development) to 5 (Well-Developed) on behalf of their organization or group.

Section A. General Demographics

In this section, organizations or groups select specific subpopulations in which they provide services, products, programs, and/or activities for.

Section B. Health Equity Capacity

This section is comprised of 6 questions asking participants perspectives on health issues in the Johnson County community, as well as attitudes and beliefs of their organizational goals.
Benchmark | My organization/group has a deep understanding of our role in addressing health inequities in Johnson County.

Section C. Internal and External Relationships

A core element of effective partnership is having strong relationships among partners and with other stakeholders, like the community. This subsection focuses on the progress of the partnership towards shared goals.

Subsection CA. Shared Goals

This subsection contains 3 questions asking participants what their current organizational goals are, as well as ways HealthyJoCo could work with their organization to address community issues and needs.
Benchmark | My partner and I want to share an understanding of the goals our partnership seeks to achieve.

Subsection CB. Community and External Engagement

This subsection contains 3 questions regarding involvement of the community to shape programs designed to help them, as well as engagement with other organizations providing a variety of services in the community.
Benchmark | Both organizations in the partnership engage the community and external organizations/groups in the community to advance our partnership's goals.

Subsection CC. Maximizing Partner Value

This subsection contains 3 questions regarding the value each partner contributes to the partnership, opportunities that exist for collaboration, and additional resources and skills needed to achieve partnership goals.
Benchmark | Both organizations in the partnership engage the community and external organizations/groups in the community to advance our partnership's goals.

Subsection CD. Internal Buy-in

This subsection contains 3 questions regarding support on addressing health inequities in the Johnson County community.
Benchmark | Leadership and key staff at each partner organization understand the importance of collaborating with other organizations to address health inequities in our community.

Section D. Data Collection

This section contains 4 questions regarding organizational data collection efforts, systems, and opportunities for data collaboration and sharing.
Benchmark | Our partnership will strive to collect accurate data that measures progress of shared goals.

Section F. Open Reflection

The participant reflects on anything that may have been left out of the conversation.

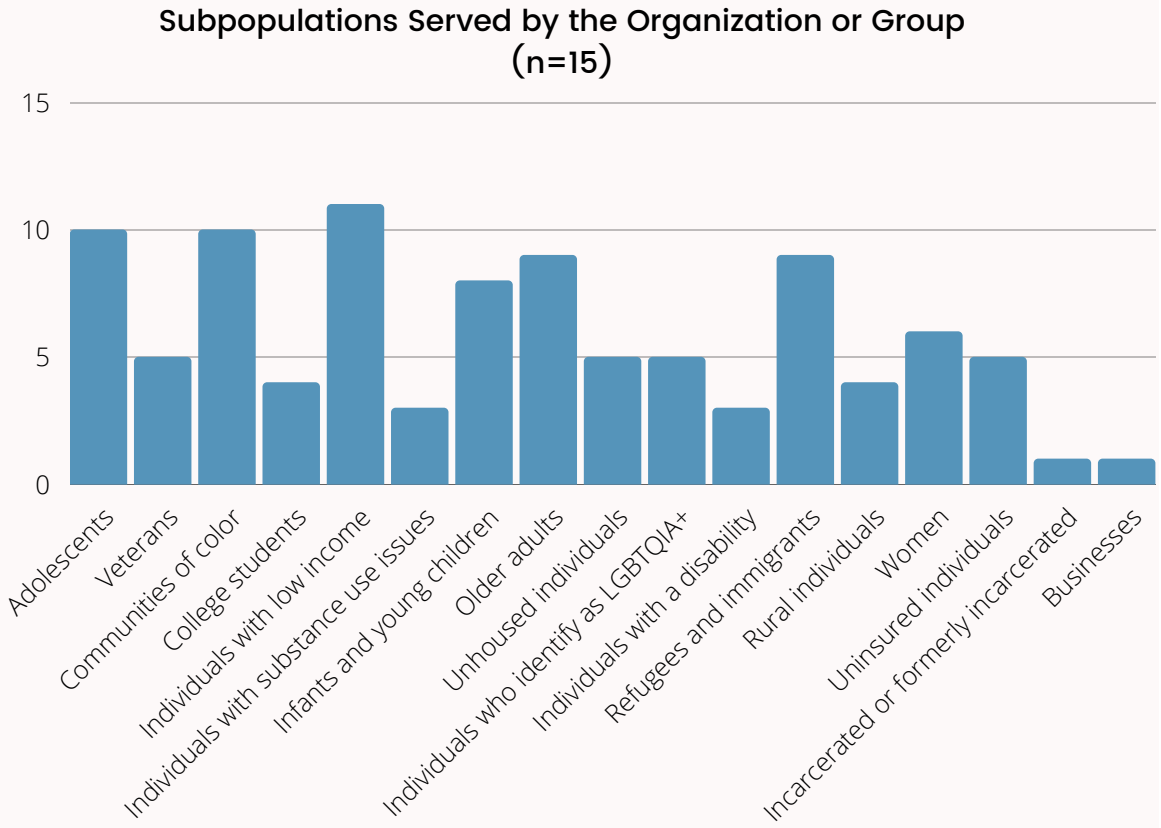
PARTICIPANT DETAILS

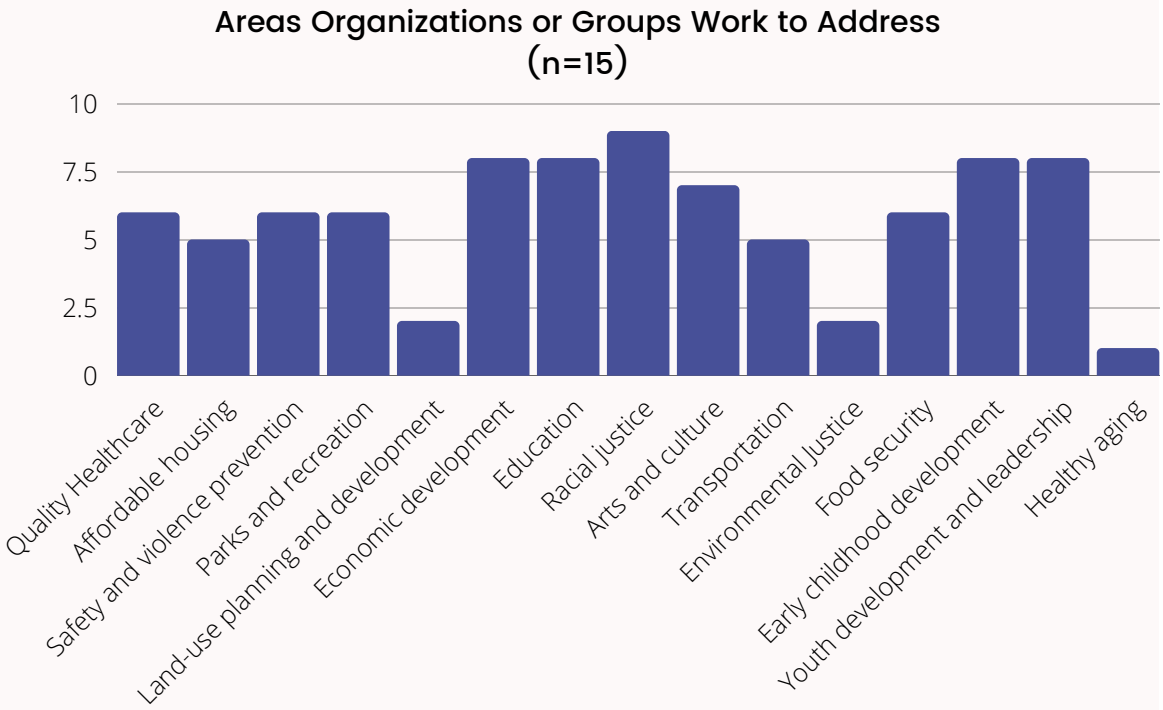
Organizations and Groups Contacted

A total of 31 organizations and/or groups in Johnson County were identified based on the work they do and the subpopulations they serve. Below is a list of the organizations/groups that were contacted and asked to participate in one-on-one discussions. Approximately 48% (15) of those contacted completed a discussion.

Organization/Group Name	Completed Discussion	Organization/Group Name	Completed Discussion
Swisher Library	X	Black Voices Project	
Resurrection Assembly of God	X	Heritage Area Agency on Aging	
Affordable Housing Coalition	X	Iowa City Human Rights Commission	
Project Better Together	X	Johnson County Ambulance	
Neighborhood Centers of Johnson County	X	Johnson County Interfaith Coalition	
Inside Out Reentry	X	Rural Health and Safety	
CommUnity	X	Shelter House	
Center for Worker Justice	X	Solon Library	
Coralville Public Library	X	Towncrest Pharmacy	
City of North Liberty	X	Guidelink Center	
Horizons	X	Iowa City School District Student and Family Advocates	
Proteus Inc	X	Path of Hope	
North Liberty Public Library	X	Four Oaks	
Iowa 4Cs	X	Bur Oak Land Trust	
Johnson County Sheriffs Office			
Coralville Parks and Recreation			

PARTICIPANT DETAILS
(CONTINUED)





HEALTH EQUITY CAPACITY

The Health Equity Capacity section assesses each partner's understanding and commitment to health equity and related concepts, as well as their role in addressing health inequities in the Johnson County community.

B1. In this community, what are the top 5 unevenly and unfairly distributed health issues? (n=15)

Figure 1 below shows the the overall categories discussed by participants for this question.

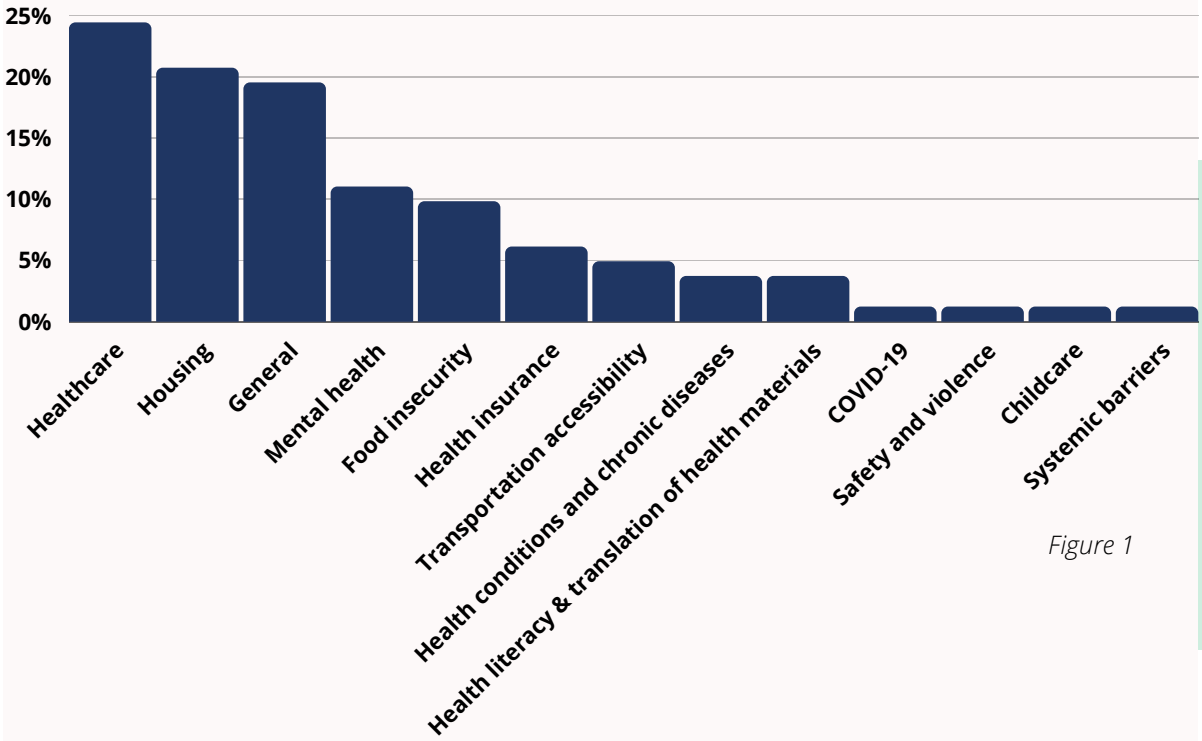


Figure 1

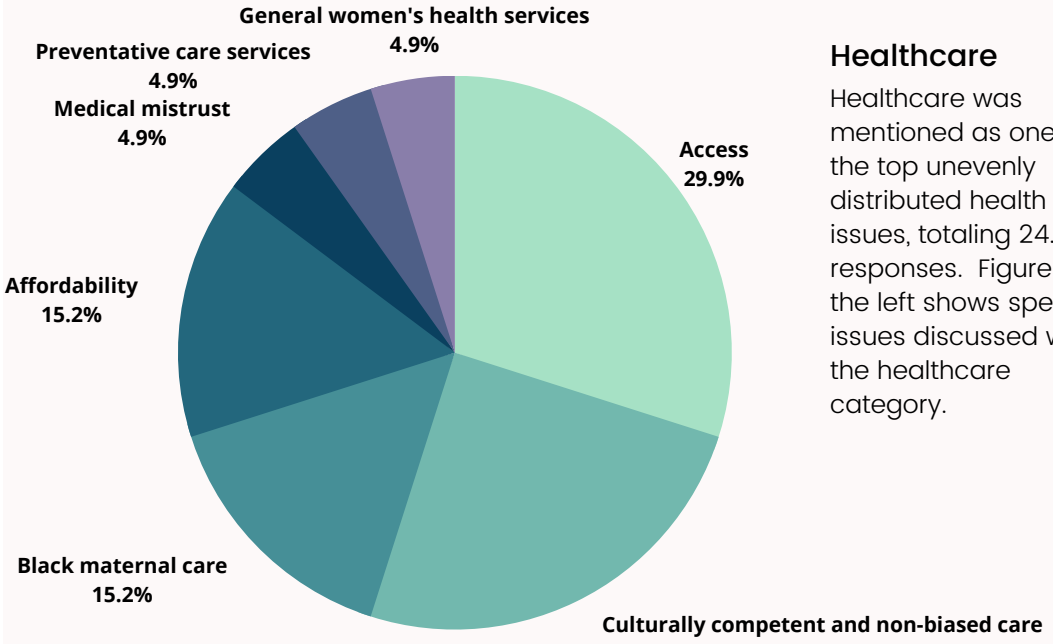


Figure 2

Healthcare

Healthcare was mentioned as one of the top unevenly distributed health issues, totaling 24.4% of responses. Figure 2 on the left shows specific issues discussed within the healthcare category.

HEALTH EQUITY CAPACITY (CONTINUED)

Housing

Housing was mentioned as one of the top unevenly distributed health issues, totaling 20.7% of responses. Figure 3 on the right shows specific issues discussed within the housing category.

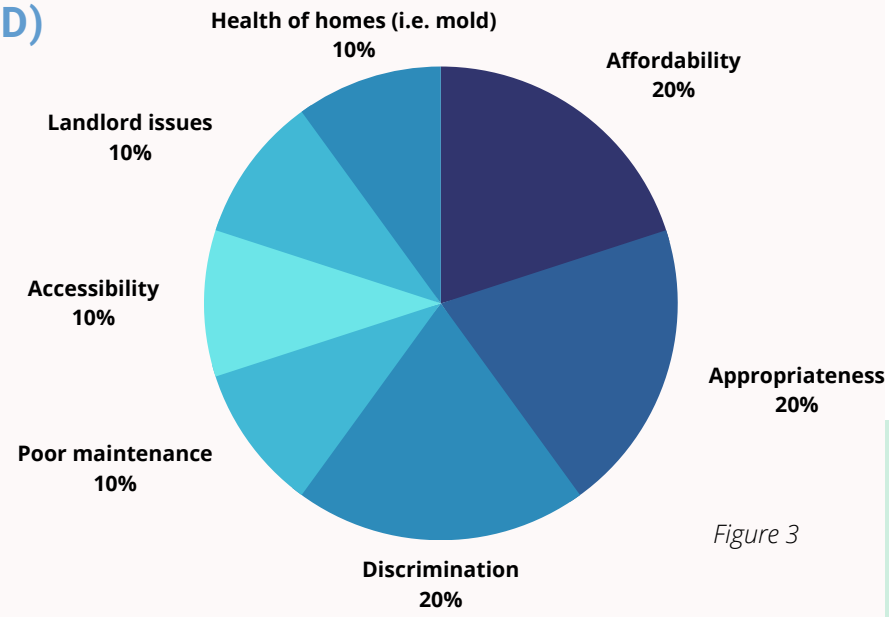


Figure 3

Affordability

Housing is considered "affordable" if a household spends no more than 30% of their income to live there.

Appropriateness

Appropriate housing means housing that meets the different needs of different households (i.e. enough space for all who reside there, etc.)

Discrimination

Under Iowa and federal law, a landlord may not discriminate against a person on the basis of race, color, creed, sex, religion, national origin, disability or family status. However, some participants noted discriminatory practices still happening today.

Poor maintenance

Participants noted poor maintenance of housing leading to poor health outcomes. In example, a non-working shower leads to poor personal hygiene, which puts individuals at a higher risk of hygiene-related diseases and infections.
Source: Centers for Disease Control and Prevention

Accessibility

Accessible housing refers to housing that enables independent living for persons with disabilities, as well as aging individuals.

Landlord Issues

Landlord issues were referenced under terms of fear of retaliation specifically from immigrant and refugee families, serving as barriers for overall self-advocacy in housing issues.

General and Miscellaneous Topics

Figure 4 to the right shows various general topics that do not fit under a specific category.

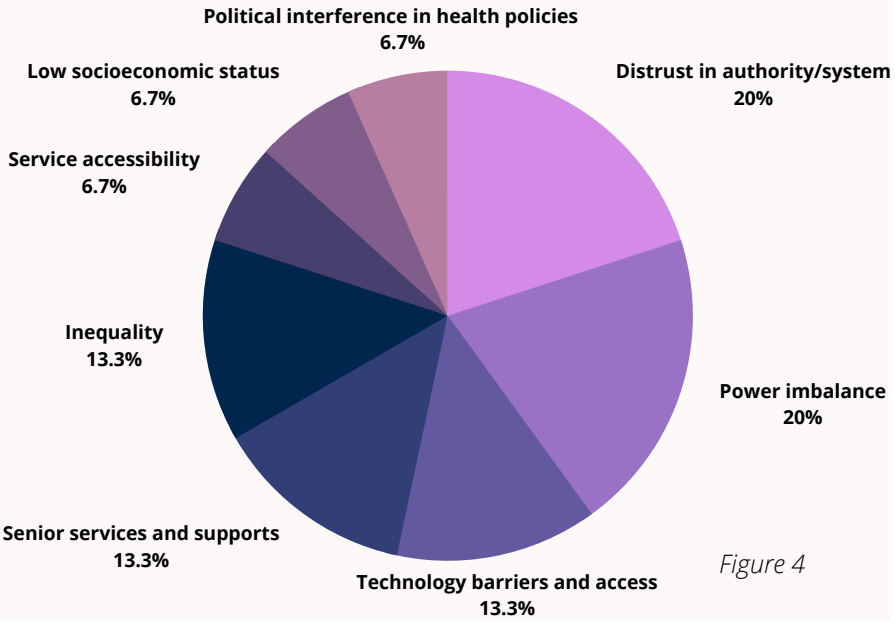


Figure 4

HEALTH EQUITY CAPACITY
(CONTINUED)

Mental Health

Mental Health was mentioned as one of the top unevenly distributed health issues, totaling 11% of responses.
Figure 5 below shows the split between the two specific issues discussed within the mental health category.

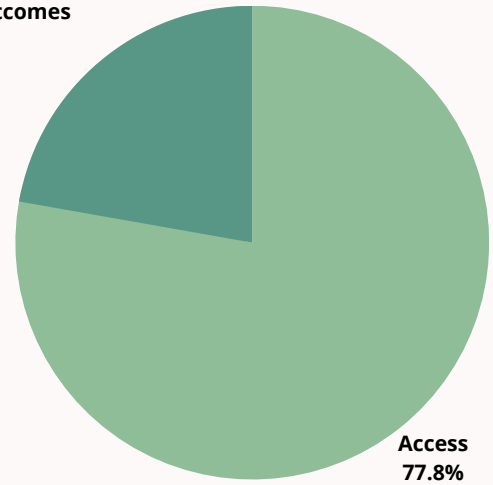


Figure 5

Access

Mental health access was referred to in terms of provider availability. Affordability was also mentioned within access. One participant noted the lack of diverse and culturally adept mental health providers in Johnson County.

Rising rates of poor outcomes

Many participants noted the general feeling of worsening mental health status in the general population in the last few years. Some pointed to a stigma around mental health care. Others noted the compounding of mental health burdens among populations with intersecting identities.

Food Insecurity

Figure 6 below shows the split between the two mentioned issues within food insecurity.

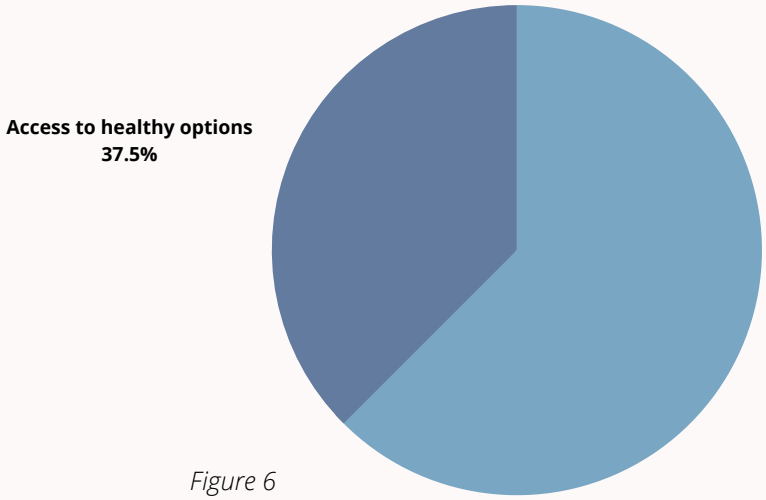


Figure 6

Affordability

Participants discussed the lack of affordable, healthy foods. Often times, when faced with many expenses and a low income, a household may have to choose between paying the rent and buying healthy foods, or any food in general.

Access to healthy options

Many noted the lack of healthy food options like fresh produce in proximity to certain neighborhoods, leaving residents needing transportation. Some residents may not have reliable means of transportation in these cases.

HEALTH EQUITY CAPACITY
(CONTINUED)

B2. What would you describe as the leading environmental, social, and economic conditions that impact the health issues you identified previously? (n=15)

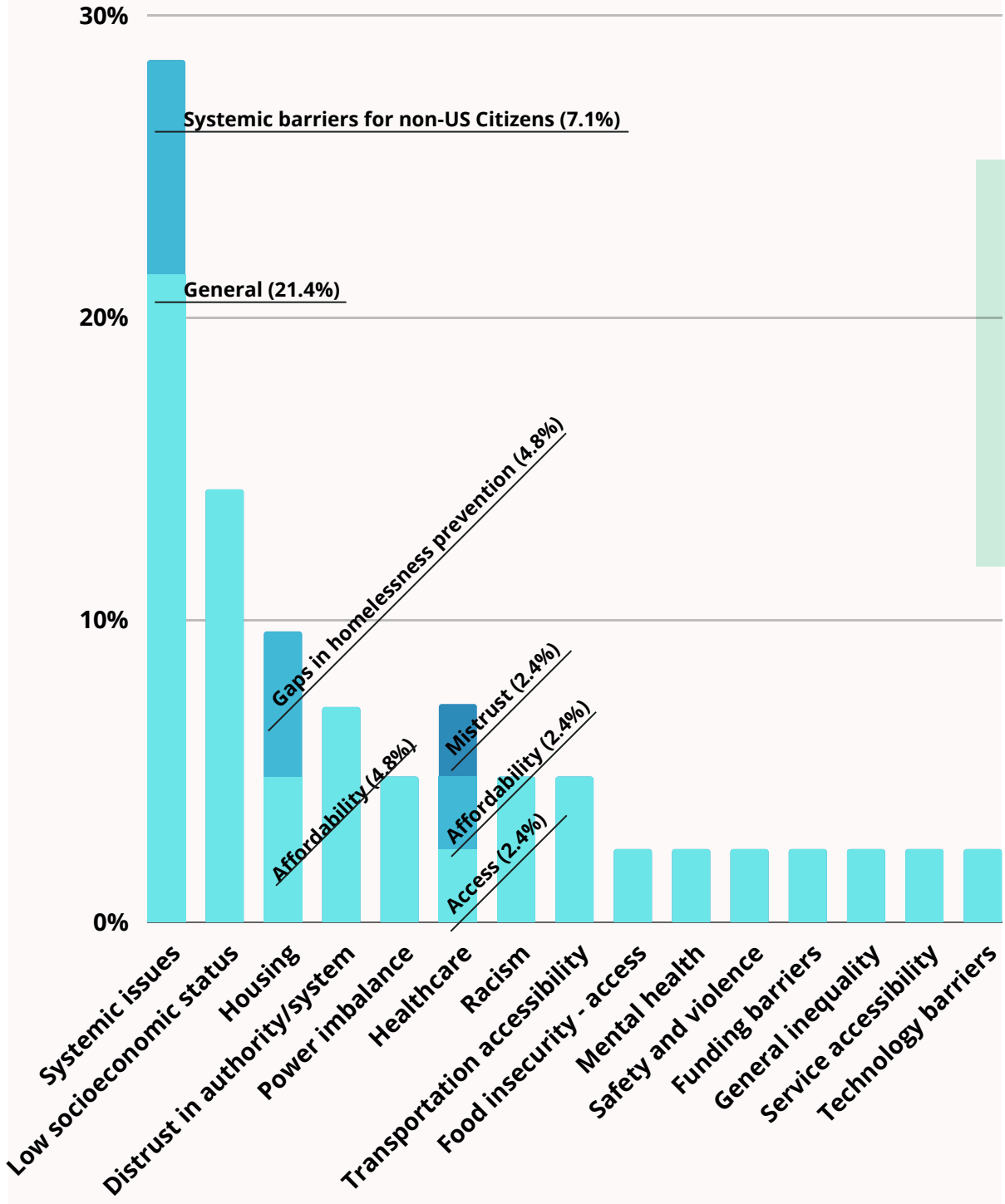


Figure 7

HEALTH EQUITY CAPACITY
(CONTINUED)

B3. My organization's work addresses the environmental, social, and economic conditions that impact health in some way. (n=15)

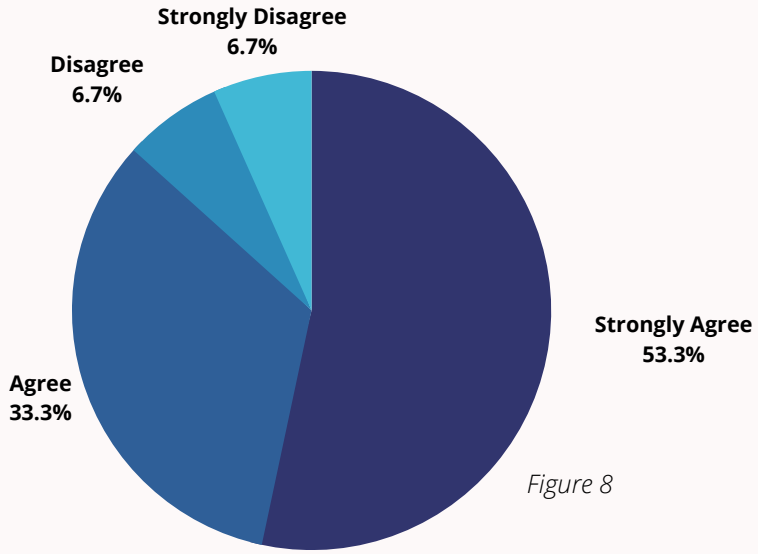


Figure 8

Approximately 86.6% (13) of participants agree in some way their organizations work addresses the environmental, social, and economic conditions that impact health in some way.

B4. I think there is a general awareness of the environmental, social, and economic conditions that impact health among organizations like mine in Johnson County. (n=15)

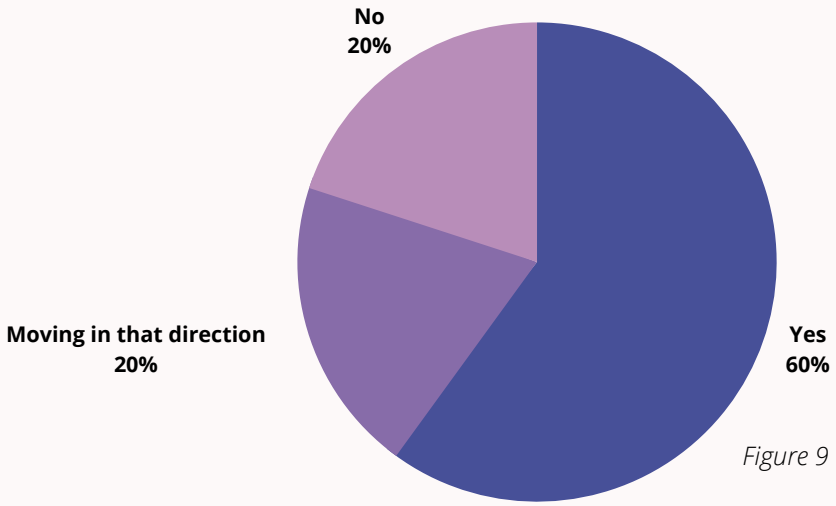


Figure 9

Approximately 80% (12) of participants think there is a general awareness, in some capacity, of the environmental, social, and economic conditions that impact health among organizations like theirs in Johnson County.

HEALTH EQUITY CAPACITY
(CONTINUED)

B5. Addressing the environmental, social, and economic conditions that impact health in the Johnson County community is a high priority among organizations like mine. (n=15)

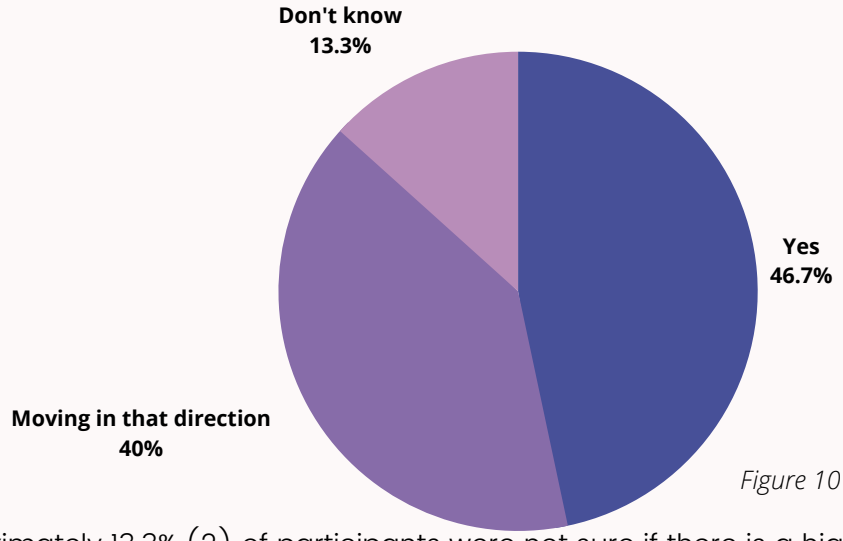


Figure 10

Approximately 13.3% (2) of participants were not sure if there is a high priority to address the environmental, social, and economic conditions that impact health amongst other organizations like theirs in Johnson County. Many felt that they needed more information about what others were doing in order to answer this question.

B6. Where are the areas where innovation is most needed when it comes to addressing health inequities in our community?

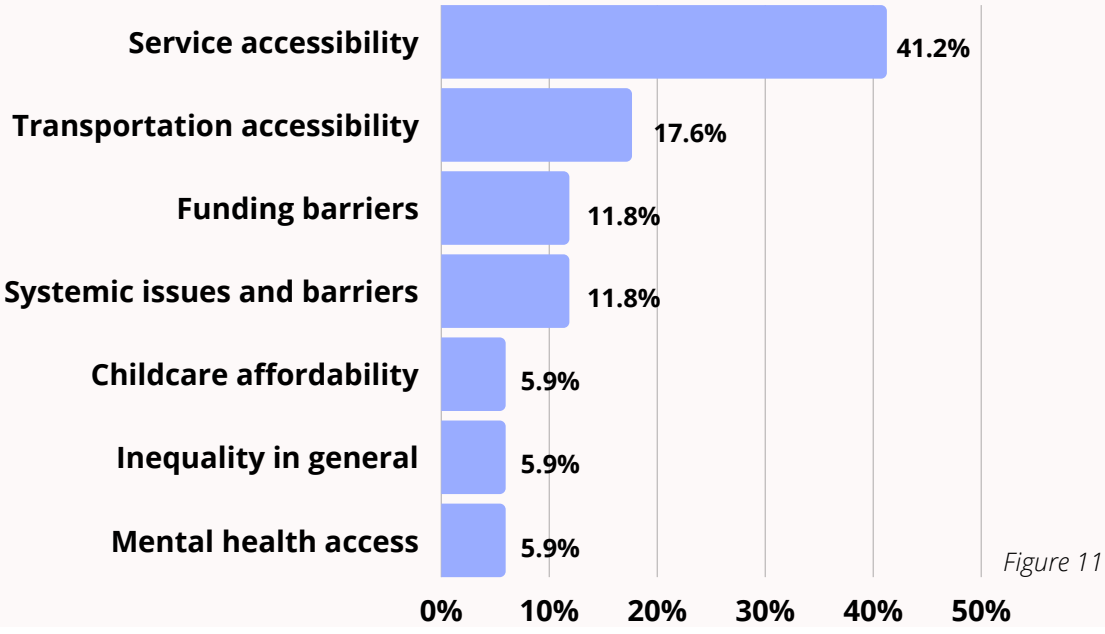


Figure 11

HEALTH EQUITY CAPACITY
(CONTINUED)

Uncategorized participant responses

- Access to healthcare, particularly for seniors is an issue in Northern Johnson County. Some residents receive care in Linn County, but face barriers with transportation to medical appointments there due to lack of options. Johnson County SEATS will not take folks to appointments across county lines.
- Private security presence of guards in low income housing areas lead to increased stress of residents and fear of physical violence on residents.
- Poor maintenance of housing by certain landlords is a huge health issue. (For example, one participant described experience of a resident with a hole in their roof. Other examples include apartments with rotting wood and door frames, mold, and ongoing infestation of bed bugs.)
- Lack of access to affordable and quality childcare is an issue. Often, young children are left in dangerous situations with abusive people, or are left alone, or are taken care of by siblings that are too young to provide supervision.
- There is a deep-rooted mistrust with the University of Iowa and the University of Iowa Hospitals and Clinics amongst certain populations in Johnson County due to the perception that the University is affiliated with luxury student housing that drives up the cost of rent for others not affiliated with the University.
- There is general mistrust amongst the immigrant and refugee population of anyone in authority (government, landlords, etc.) for fear of retaliation and deportation.
- With homelessness, often times there is a gap for folks who are almost going to be homeless. Services often do not help them until they are homeless.
- It is difficult for families experiencing homelessness to stay together, as it is difficult for children to reside at Shelter House with parents and guardians.
- Housing affordability is a large issue in Johnson County. If making minimum wage, one would have to work 3 full time jobs to afford average housing prices.
- If housing is not affordable, people cannot maintain stability in their lives as they would likely have to move out. Many end up moving out of Johnson County due to this reason.
- Evictions disproportionately affect single Black women-represented households at a ratio of 20 to 1.

HEALTH EQUITY CAPACITY
(CONTINUED)

Uncategorized participant responses

- Housing accessibility is especially difficult for those with low credit scores or no credit, individuals who do not speak English as their first language, and those returning from incarceration.
- Housing either needs to cost less or people need to be able, or have the opportunity, to make more money.
- Services need to shift and meet people where they are.
- If people do not have health insurance, they are not going in for check ups until absolutely necessary (i.e. emergency situations where it may be too late to intervene).
- Immigrant and refugee individuals, or individuals where English is not their first language, have a hard time navigating the system and finding necessary services.
- Access to reliable transportation is an issue, especially when it comes to healthcare appointments. If people miss a healthcare appointment, it could set them back and have a negative impact on their health.
- A lot of community programs focus on children, however, we have a large aging population and need more services for them.
- Maternal mortality is an issue, especially among women of color.
- Many people don't have access to technology, which serves as a huge barrier to finding services. More in person services would help.
- We need to focus on Black maternal health equity. Many Black mothers are often disproportionately affected and die.
- Aging populations that already were disproportionately affected by other issues now have are experiencing increasing health conditions that comes with aging.
- Implicit bias in healthcare is an issue that perpetuates racism. There is no mandatory training for healthcare workers and this can disproportionately affect the health of patients.
- Diabetes, hypertension, hyperlipidemia, hyperthyroidism and musculoskeletal issues are typical problems amongst agricultural workers.
- Amongst agricultural workers, nutritional education is needed as portioning is unknown. There is a lot of unlearning what they've always eaten.
- There is a high cost of living in the Iowa City area compared to other areas in the state where migrant agricultural workers live. Here in Iowa City, people at the Proteus clinic typically ask about any additional governmental or non-profit assistance they would qualify for. Living expenses are constantly more than what these folks are typically bringing in.

SHARED GOALS

1. What goals do you currently have for your work at your organization?

Approximately 70% of responses to this question entailed providing education and resources to clients and the community. Figure 13 below shows the breakdown of specific education and resources.

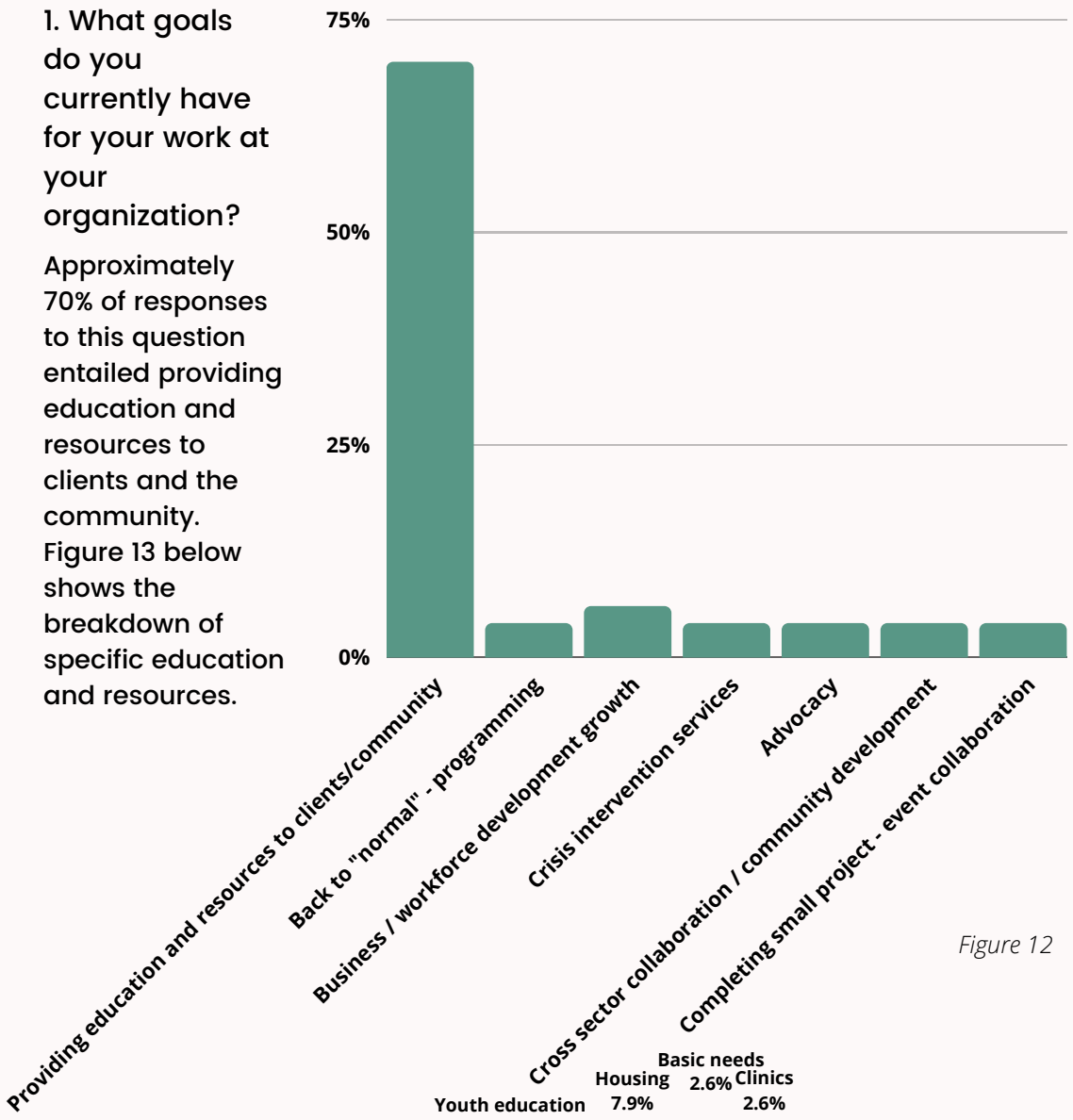


Figure 12

Education and Resources (Expanded)

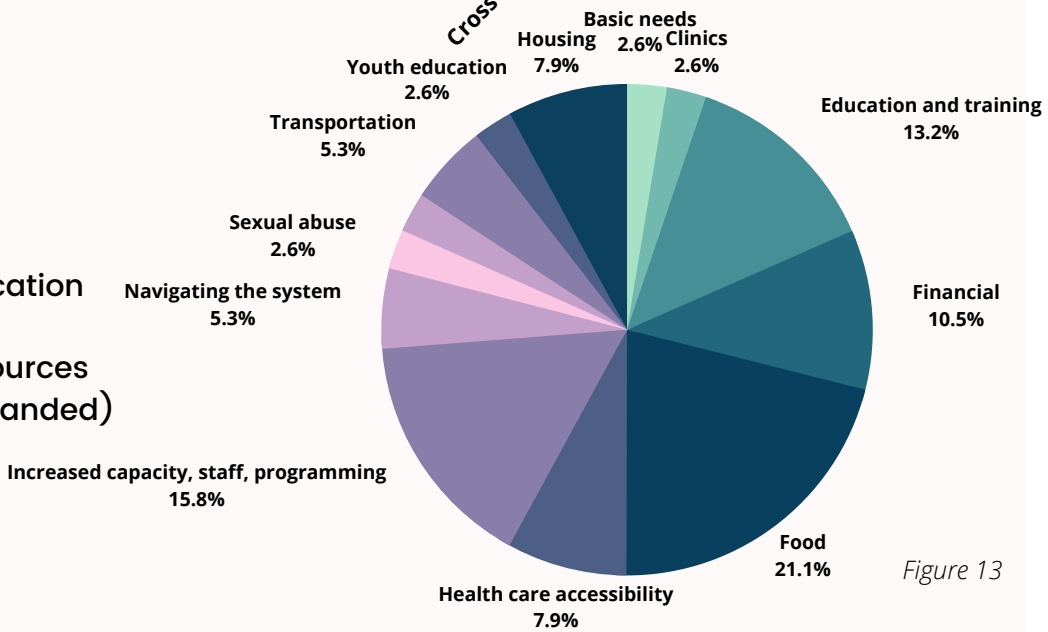


Figure 13

SHARED GOALS
(CONTINUED)

2. What would a partnership mean to you? What need and specific population could our partnership be designed to address?

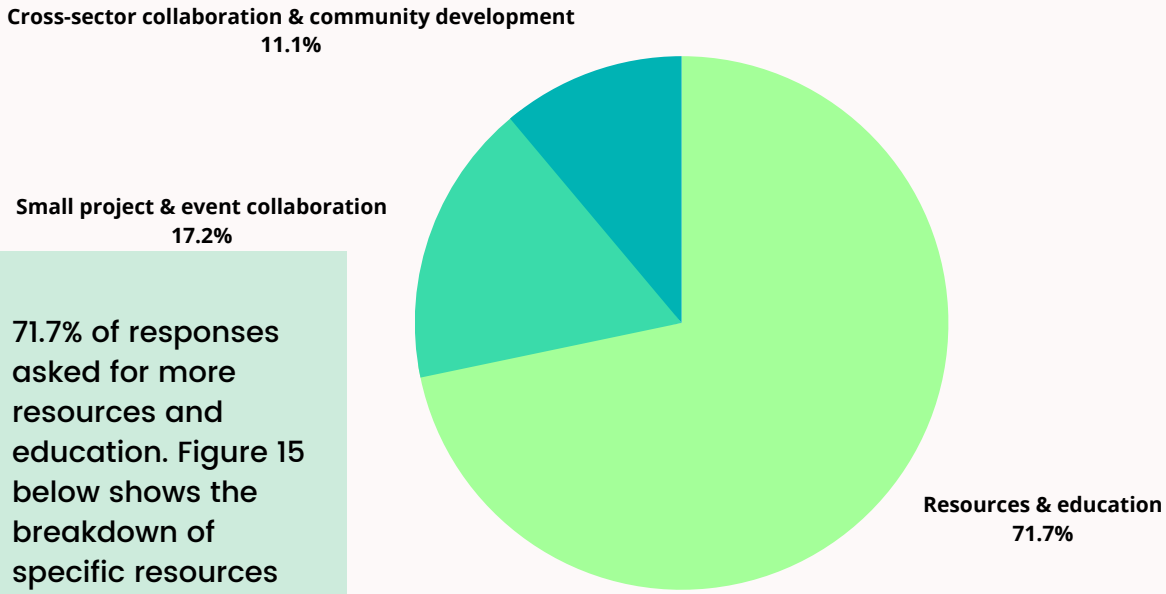


Figure 14

71.7% of responses asked for more resources and education. Figure 15 below shows the breakdown of specific resources and education asked for.

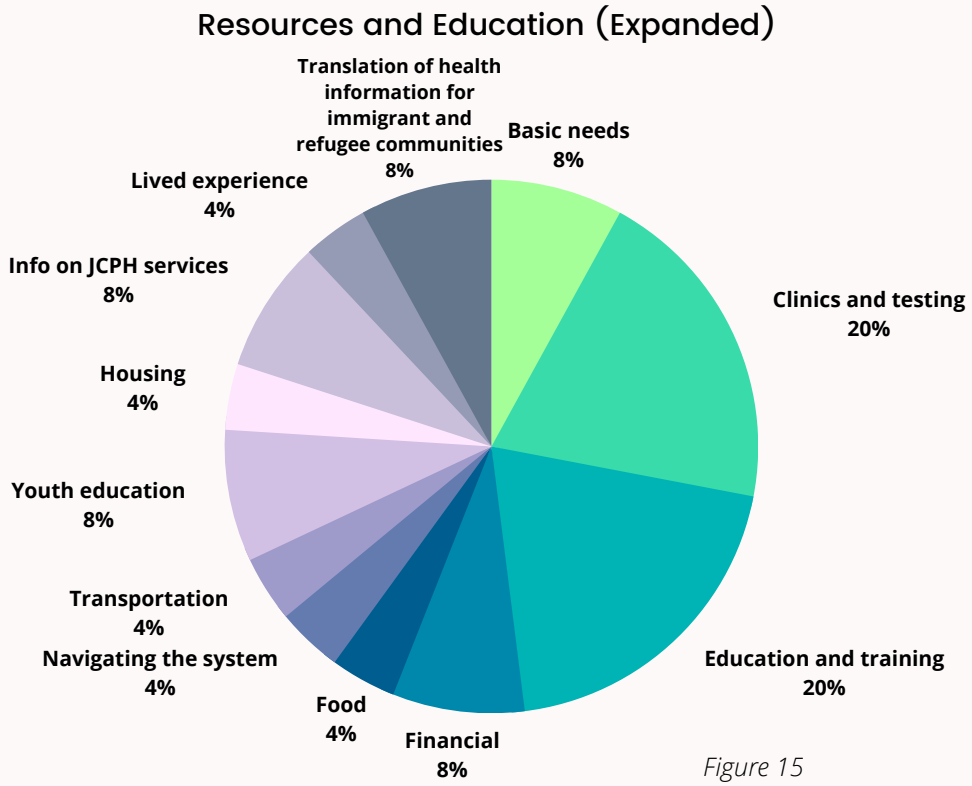


Figure 15

COMMUNITY AND EXTERNAL ENGAGEMENT

What are some ways your organization involves the community in shaping programs, services, or other activities designed to help them?

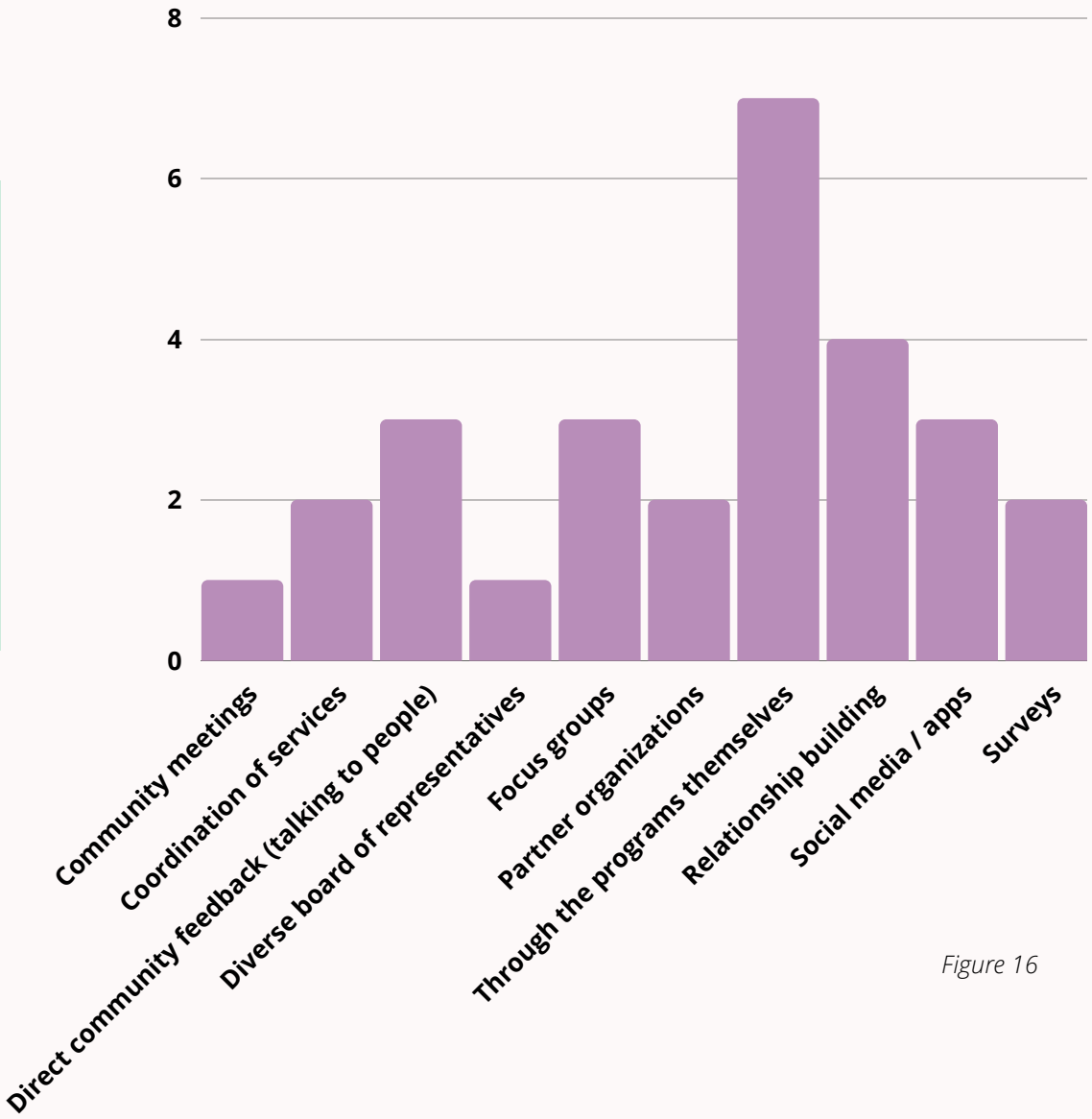


Figure 16

Partners detailed a variety of ways they engage the community with the most common answer being through the programs themselves, meaning direct feedback from the participants of the programs.

MAXIMIZING PARTNER VALUE

1. What value - including skills and expertise - do you see each partner contributing to the partnership?

An overwhelming majority of responses indicated our partners being experts in relationship building and connecting to people, while JCPH has knowledge of community data and access to data analysis tools, as well as connections to expertise and resources with other partners.

"No one organization can do it all. It is important to understand the bigger picture and where we all fit" - Participant

2. What opportunities exist to deepen our partnership? What resources do we need to achieve our goals?

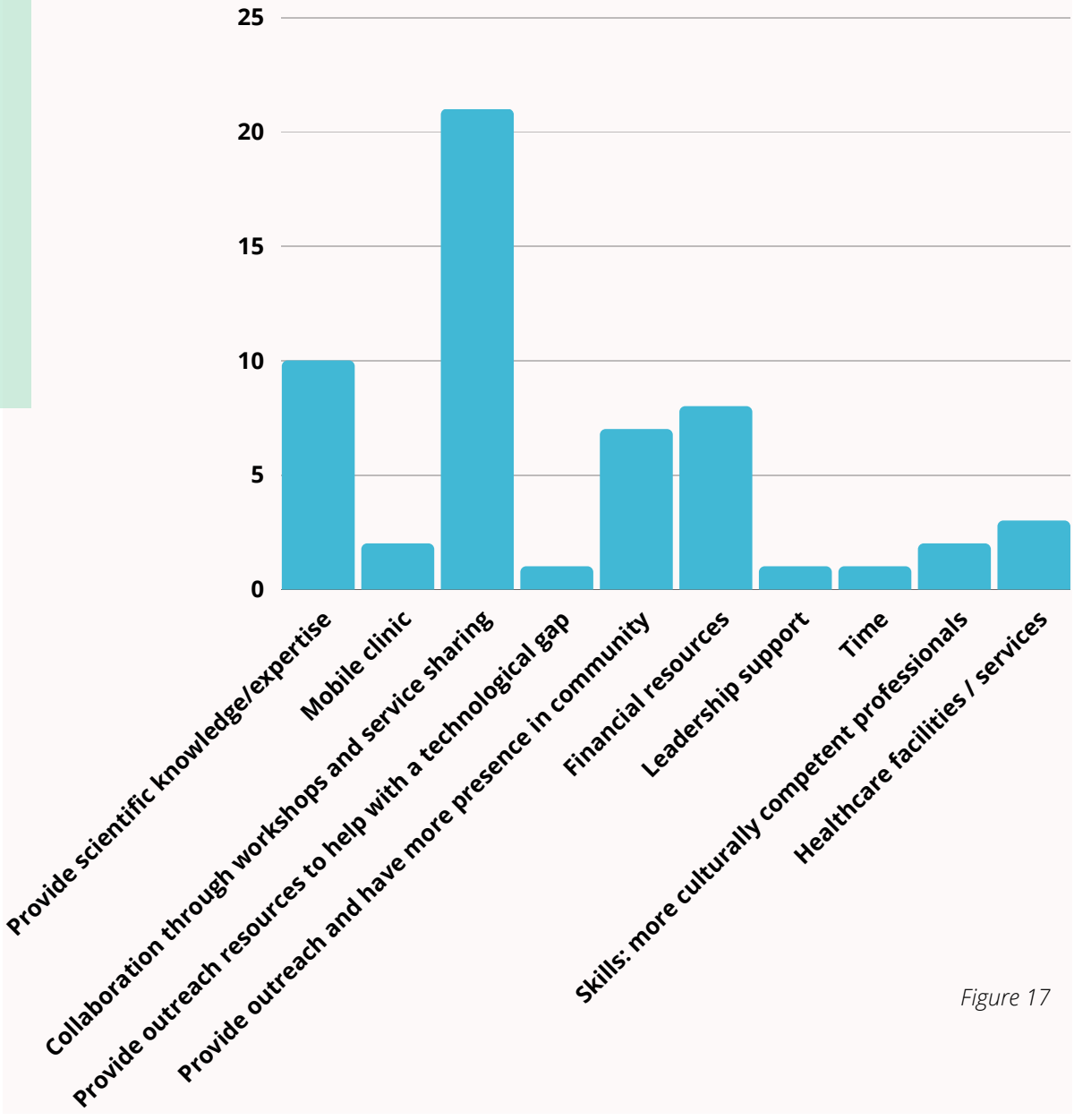


Figure 17

INTERNAL BUY IN

1. Leadership at my organization are supportive of collaborations between programs and sectors to address health inequities. (n=15)

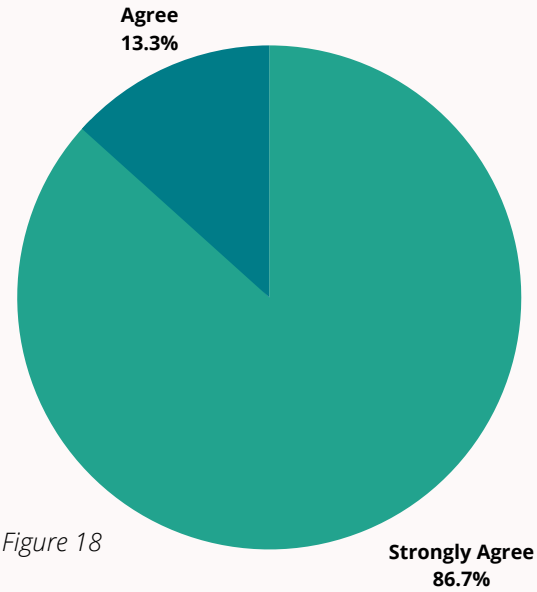


Figure 18

All 15 participants agree in some way that leadership at their organizations are supportive of collaborations between programs and sectors to address health inequities.

2. Would leaders at your organization support a partnership to address health inequities and issues in our community? (n=15)

14 participants said there would be support in a partnership to address health inequities and issues in the community. Only one participant said there may be some uncertain support and additional questions leadership would ask. A majority of the participants were part of their organizations leadership in some capacity.

DATA COLLECTION

1. What data does your organization collect to understand your social or community impact? Is this data sufficient? (i.e. population health outcomes and indicators collected)

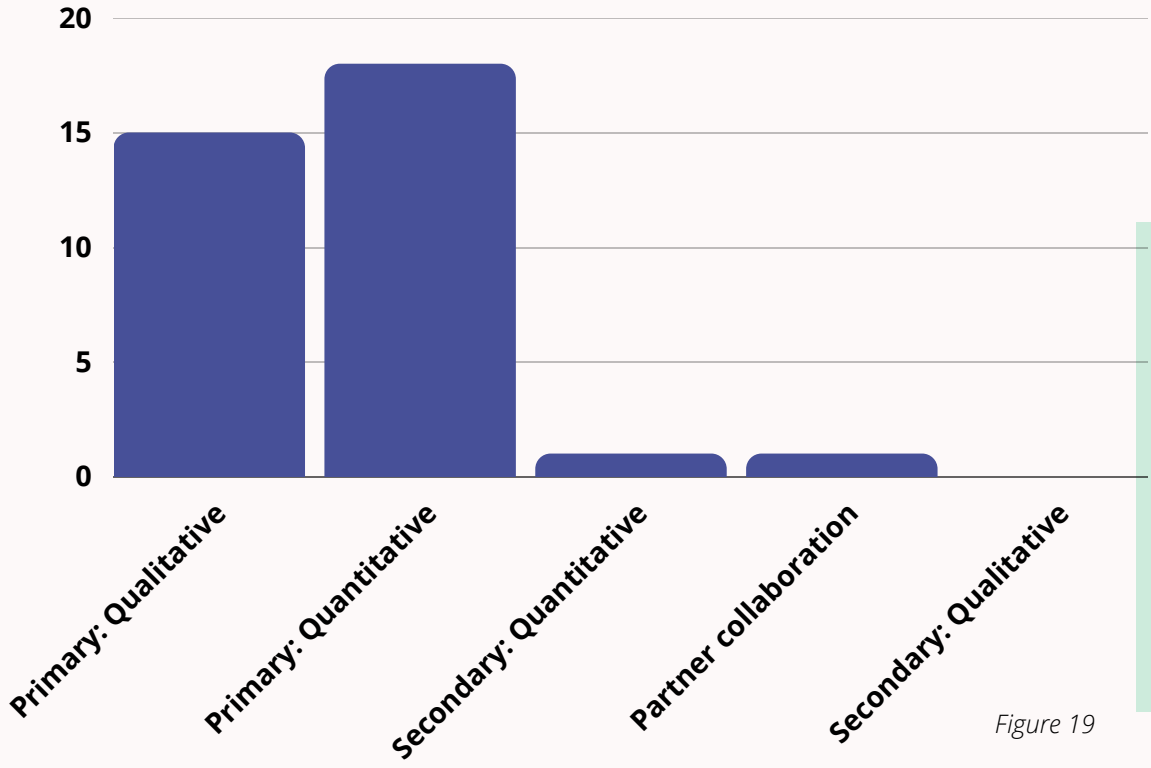


Figure 19

Types of primary qualitative data collected

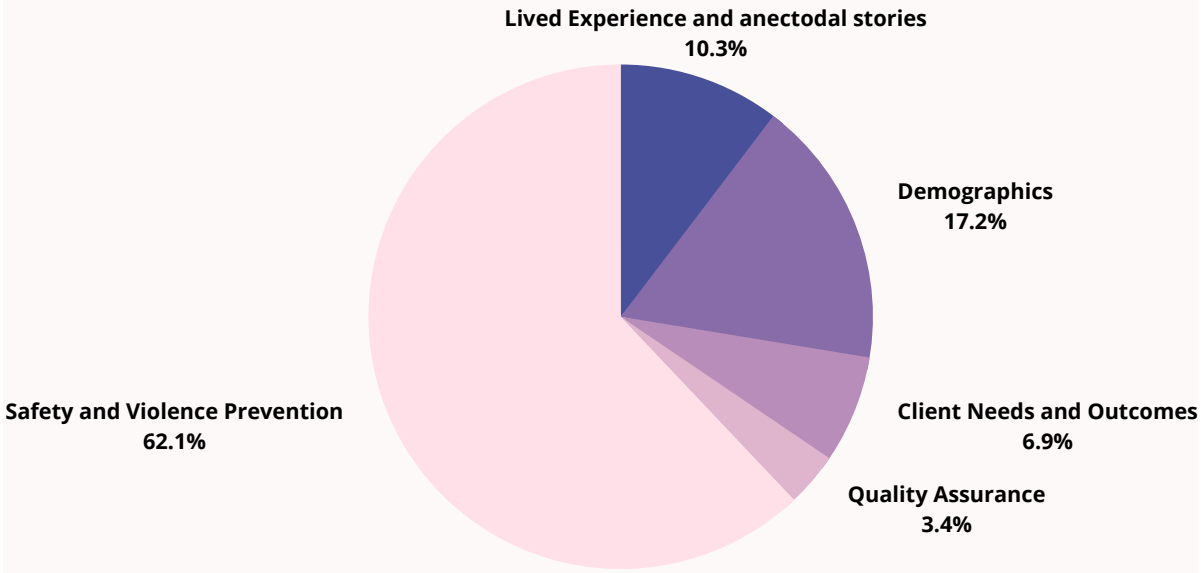


Figure 20

DATA COLLECTION
(CONTINUED)

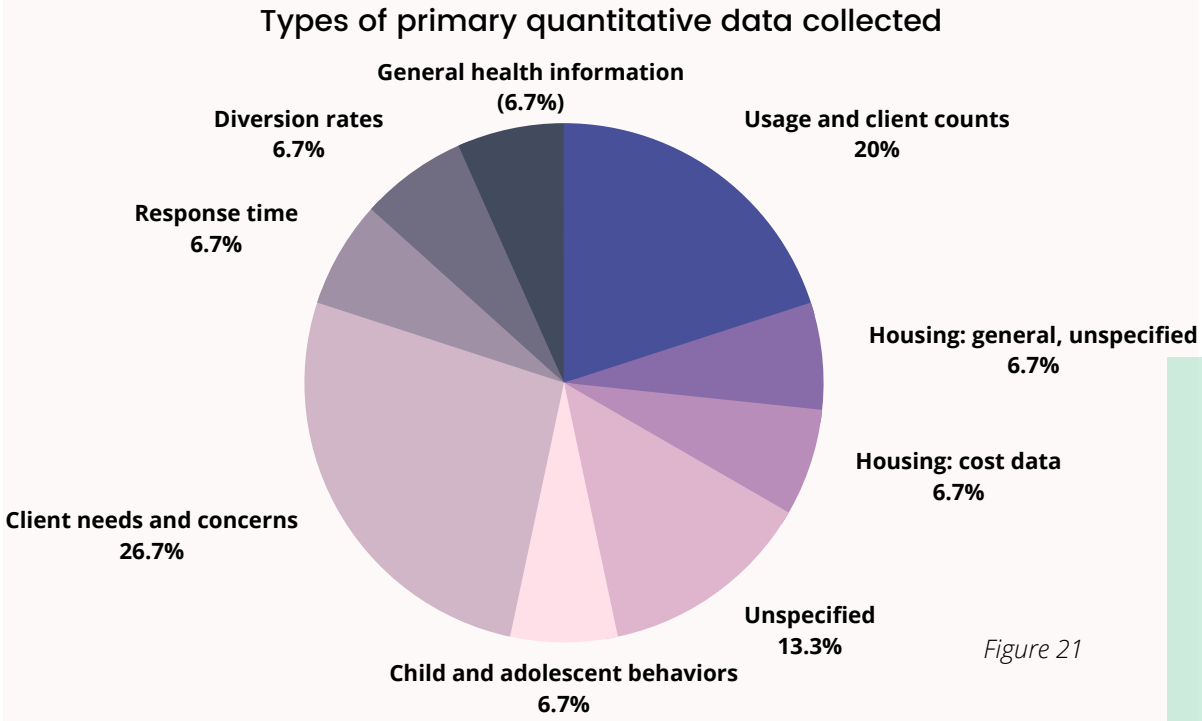


Figure 21

2.What systems and people do you have in place to support data collection and sharing? (i.e. staffing support, funding, timing of data collection, grant requirements)

Several organizations have primary qualitative and quantitative data collection systems in place. Data collection barriers include survey fatigue leading to incomplete or inaccurate responses. One organization felt collaborating with partners would give them more comprehensive data, while one organization lacks the infrastructure to collect data and needs overall assistance with these processes. One organization expressed the desire for resources to modernize their current data collection systems.

Many participants noted only collecting data required of them for grants. Many felt it was burdensome to collect client data, as many clients did not want their data to be collected for various reasons. One participant noted only wanting to collect lived-experience, anecdotal stories with non-identifiable information.

DATA COLLECTION
(CONTINUED)

3. How could our partnership with data deepen our understanding of and impact on the community?

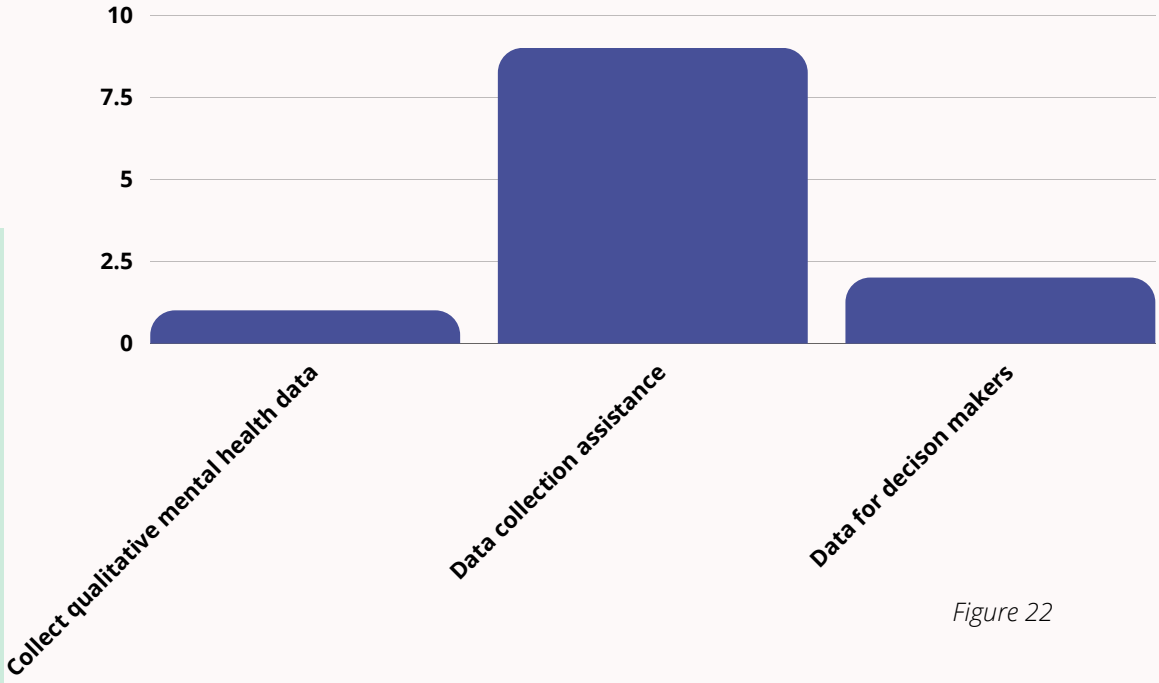


Figure 22

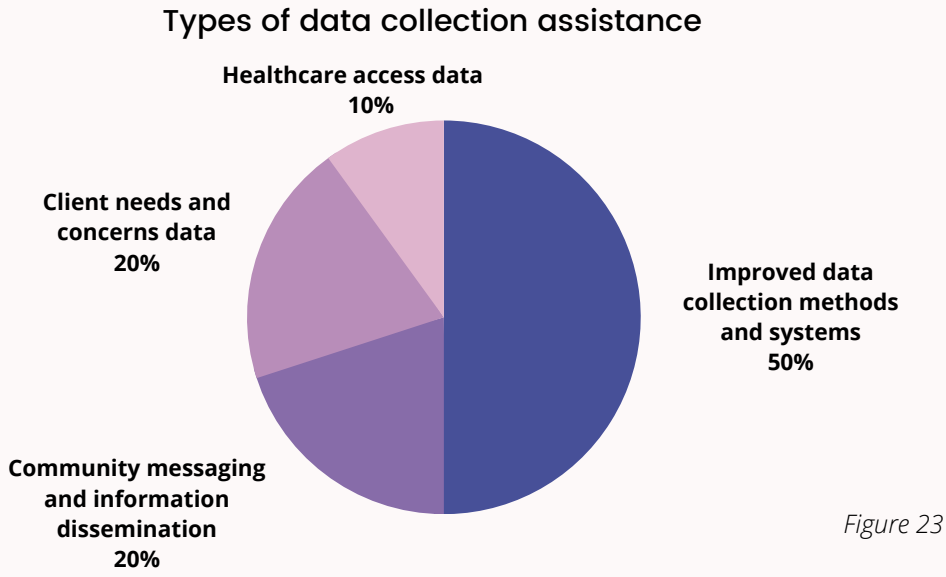
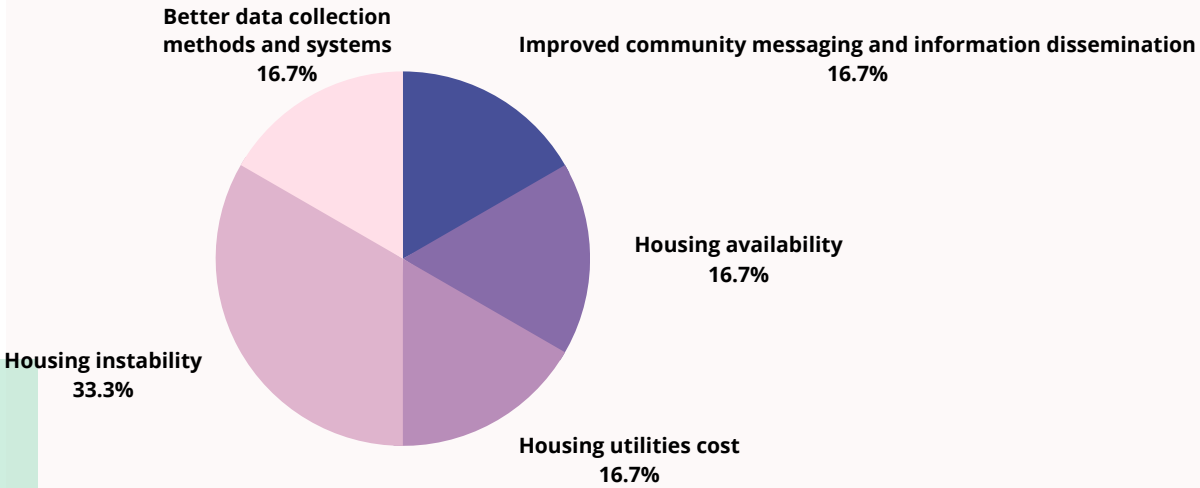


Figure 23

DATA COLLECTION
(CONTINUED)

What could we learn from the data our partnership collects?



Assistance through our partnership would lead to better data collection methods and systems aimed at identifying community needs and gaps. For example, a map of current areas with low access to healthy foods and a map noting areas with low access to transportation. Partners expressed an emphasis on needing resources in order to meet people where they are physically.

Specific data questions from participants

- Do we have enough available, quality, affordable housing for people? How many places are available for $400 per month, $500 per month, etc.?
- How much do utilities cost, on average, for each rental place?
- What is the typical length of stay in housing; and if people leave, what was the reason for leaving?
- For the direct cash payments going on right now, can we look into data collection on any preventive support that could have taken place (for example, for those not able to pay rent before it was late)?
- What do our community members still feel is lacking and what are their perceptions?
- How many people feel like they are not food secure?
- How many people are suicidal in the community right now and how can we connect with them before they hit that point?
- How do people feel about law enforcement in the community?
- What do community members not have access to but need access to? What are the barriers to getting access? How frequent do they see these barriers?

OPEN REFLECTION

Below are comments participants made at the end of each one-on-one discussion.

- Develop and provide more aging resources
- Deeper community understanding of drug/substance abuse and impact on children
- Trust building
- How housing connects to all aspects of health
- Provide more resources for previously incarcerated folks and make it less difficult to navigate the system after incarceration
- How to navigate the American System
- County needs to hire more diverse staff
- Better understanding of racial differences in mortality data
- Reduce stigma around those receiving government assistance
- The County should do something about educating people to learn English. County should support ESL classes as well as job scenario classes. The are very helpful, especially when tailored to the job they are working at.
- Curious to know if there's a way to score community wellness via community profiles.
- Would be helpful to have a map of the areas where food deserts are and where lack of transportation is. Would be helpful to identify where to provide services and tackle K – 6 food insecurity.

Johnson County Public Health

HealthyJoCo

live • work • learn • play

COMMUNITY STATUS ASSESSMENT REPORT

RELEASED JANUARY 2023

METHODS

HealthyJoCo's 2022 Johnson County Community Status Assessment aims to describe the community in a quantitative way by measuring demographics, health status, the social determinants of health, and identify existing inequities.

SURVEY DESIGN

HealthyJoCo's 2022 Johnson County Community Status Assessment (CSA) was designed to take a deep dive into typical secondary data sources, such as data from the Behavioral Risk Factor Surveillance System (BRFSS). Secondary data sources are useful but do not always tell the full picture of a community's health, especially in identifying barriers to optimal health. HealthyJoCo's CSA questions were established by viewing secondary data from Johnson County BRFSS through a data sharing agreement with Iowa Department of Health and Human Services. Trends from the baseline year of 2015 up until 2020 were identified. Concerning trends from that data led to original BRFSS questions being used in the final CSA. Follow up questions were often added in the event a respondent chose a specific answer where additional context would be useful knowing.

This assessment was also designed with input from community partners in Johnson County by utilizing partner questions in the 2022 Community Partner Assessment. For example, one partner asked how the community feels about the police. Questions structured around food security, law enforcement, and housing were all incorporated into this assessment from partner input as well. The HealthyJoCo team worked with the Affordable Housing Coalition in Johnson County for questions surrounding housing and eviction.

Some assessment questions on the 2022 CSA were derived from the national report of Personal Experiences of U.S. Racial/Ethnic Minorities in Today's Difficult Times, conducted in the spring of 2022 by the Robert Wood Johnson Foundation, NPR, and the Harvard T.H. Chan School of Public Health[1]. The questions specifically regarding finances and safety were utilized.

All survey questions were compiled into an online survey platform, Qualtrics. The survey launched on September 22, 2022 and closed on November 19, 2022.
Tickets from survey responses were configured if respondents indicated they would like to be followed up with. These tickets alerted the HealthyJoCo team, and an email was sent to correspond with respondents and link them to community resource information.

[1] Robert Wood Johnson Foundation, et al. "Personal Experiences of U.S. Racial/Ethnic Minorities in Today's Difficult Times." Npr.org, Aug. 2022, https://legacy.npr.org/assets/pdf/2022/08/NPR-RWJF-Harvard-Poll.pdf.

SURVEY DISTRIBUTION

Many avenues of distribution were used for the assessment. Emails with an anonymous, online link to the survey were sent to numerous community partners and individuals within the local public health system, asking them to forward it on via email or newsletter to populations with which they work. Posters with QR codes were posted in many community locations, such as libraries, salons, recreation centers, food pantries, ethnic grocery stores, places of worship, and many more. Posters also included information for participants to receive a SMS text link to the online survey by texting @HEALTHYJOCO to a toll-free number. Personalized links were sent via Qualtrics' XM Directory, where only consenting contacts received those links. A link to the survey was posted online at healthyjoco.com as well.

Social media was utilized to advertise the health assessment. Two regular posts per week via Facebook, Instagram, and Twitter were scheduled throughout the duration of time when the survey was active. Meta ads were also utilized to advertise the survey. One ad was targeted to all Facebook and Instagram users that live in Johnson County ages 18 years and older. Later on, another ad was utilized to target only males living in Johnson County due to large amounts of female participants taking the survey. One last video advertisement was utilized via Instagram only in order to target those ages 18 - 34 living in Johnson County as those ages were underrepresented in the survey data at that time. To assist with eliciting more responses from the student population in Johnson County, a post was submitted on the University of Iowa Class of 2024, 2025, and 2026 Facebook page. Outside of Instagram, Facebook and Twitter, a community Reddit page called r/iowacity was posted in by Johnson County Public Health staff.

Johnson County Public Health released a press release at the time the survey was launched. That press release was picked up by the Daily Iowan, and an article showcasing the assessment, along with the University Of Iowa College Of Public Health's Strike Force, was published on October 5, 2022 by news editor Kate Perez.

Partner sites played a large role in survey distribution. Johnson County Public Health reached out to many area partners prior to survey launch in order to enter into a Memorandum of Understanding (MOU) agreement to survey at their locations with electronic tablets. Four partner sites agreed to participate: North Liberty Public Library, Iowa City Free Medical Clinic, CommUnity Crisis Services and Food Bank, and Center for Worker Justice. Three survey locations were given

help from the University of Iowa College of Public Health Strike Force team, a team of college students looking to help the community to gain public health experience. Each partner site was supplied with 2 tablets with access to the online survey, as well as postcards with QR codes and text-to-receive information. The survey was live at these locations for one month after the survey first launched in September of 2022. Each partner location received their own dashboard of anonymous client information after helping with this effort.

Johnson County Public Health Staff went on site to other community locations with tablets and postcards in November of 2022. Staff connected with community members at the Iowa City Mosque, Kirkwood Community College (Iowa City Campus), Iowa City's Mercer Aquatic Center, Solon's Community Library, Veterans Liberty Center, and the North Liberty Recreation Center.

ANALYSIS

All data collected from the 2022 Johnson County Community Status Assessment was compiled into a live, interactive dashboard via Qualtrics. Each new survey response updated the dashboard in real-time as it was submitted. This dashboard was outfitted with filters for age, sex, race, and ethnicity in order to easily disaggregate data and find disparities. Access to the dashboard is not public, however. This report includes many snapshots from the dashboard, as well as tables of disaggregated values. Many tables show values disaggregated by race and ethnicity, education level, income, age, and gender. Disaggregated values less than 6 have been suppressed to protect privacy and confidentiality. Values less than 6 also raise statistical issues concerning accuracy and data may not be useful.

Survey responses with equal to or less than 18% of reported progress were excluded from analysis. These responses were excluded as they only covered demographic questions and did not advance on to any next sections discussing health. Responses were also sifted through for accuracy, and some responses were omitted based on inaccurate responses. For example, a response that indicated 30 days of poor mental and physical health in the last 30 days but an overall excellent health ranking, as well as other inaccuracies in the record was omitted from analysis.

In total, 726 respondents completed the assessment. For the Johnson County population of approximately 154,000, 726 respondents in our sample at a confidence interval level of 95% yields a 4% margin of error. It is notable that certain questions had less respondents in our assessment, which leads to a slightly higher margin of error in those questions.

IMPORTANT DEFINITIONS

Listed in this section are important definitions of terms used in this report.

Demographic Analysis: An analysis that examines and measures the dimensions and dynamics of populations and particular groups defined by criteria such as education, nationality, religion, and ethnicity.

Dis-aggregated data: Information that has been collected from various sources using multiple measures, variables, and/or populations that has been summarized and broken down into component parts based on demographic information in order to reveal trends, patterns, and insights that are hidden in aggregated data.

Health Disparities: This term describes the differences in health and health care between communities that are derived from broader inequities leading to a higher burden of illness, injury, disability, mortality, or to experiencing more barriers to accessing quality health care. Health disparities refer to a type of health difference that is closely adjoined with social, economic, and/or environmental disadvantages that have a negative impact on groups of people who have systemically experienced great obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics that are historically connected to discrimination or exclusions[1].

Health Inequities: These types of inequities are systemic differences in the health status within various populations. These inequities have significant impact on social and economic costs to both individuals and communities[2].

Social Determinants of Health (SDH): This term defines the non-medical factors the influence health outcomes. They are conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems[3].

IMPORTANT DEFINITIONS

Ethnicity: Belonging to a population group or subgroup made up of people who share a common cultural background or descent.

Race: Classification of individuals largely based on physical and genetic traits shared between people of the same ancestry, common history, nationality, or geographic distribution.

Gender: This refers to an individual's identity surrounding social and cultural differences rather than biological differences between sexes, and, more broadly, to denote a spectrum of identities that are not cohesive with the traditional idea of "male" or "female".

Gender Non-Conforming: Refers to a person whose behavior, appearance, or identity does not conform to gender-focused cultural and social expectations.

Intersex: Broadly describes a wide range of natural biological variations of male/female characteristics.

Sex: Biological classification of an individual based on reproductive organs and structure.

[1]"Disparities." Disparities | Healthy People 2020, wayback.archive-it.org/5774/20220414003754/www.healthypeople.gov/2020/about/foundation-health-measures/Disparities.

[2] World Health Organization. (2018, February 22). Health inequities and their causes. World Health Organization. Retrieved January 6, 2023, from https://www.who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes

[3]"Social Determinants of Health." World Health Organization, World Health Organization, www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

DEMOGRAPHICS

A total of 726 responses were utilized for this report. Among respondents who provided their home zip codes (682), the majority were in the Iowa City, Coralville, and North Liberty areas. Twenty-three respondents reported home zip codes outside of Johnson County, the majority of which were located in Linn County (not shown). The distribution of responses by reported zip code throughout Johnson County is shown in Figure D.1 (below).

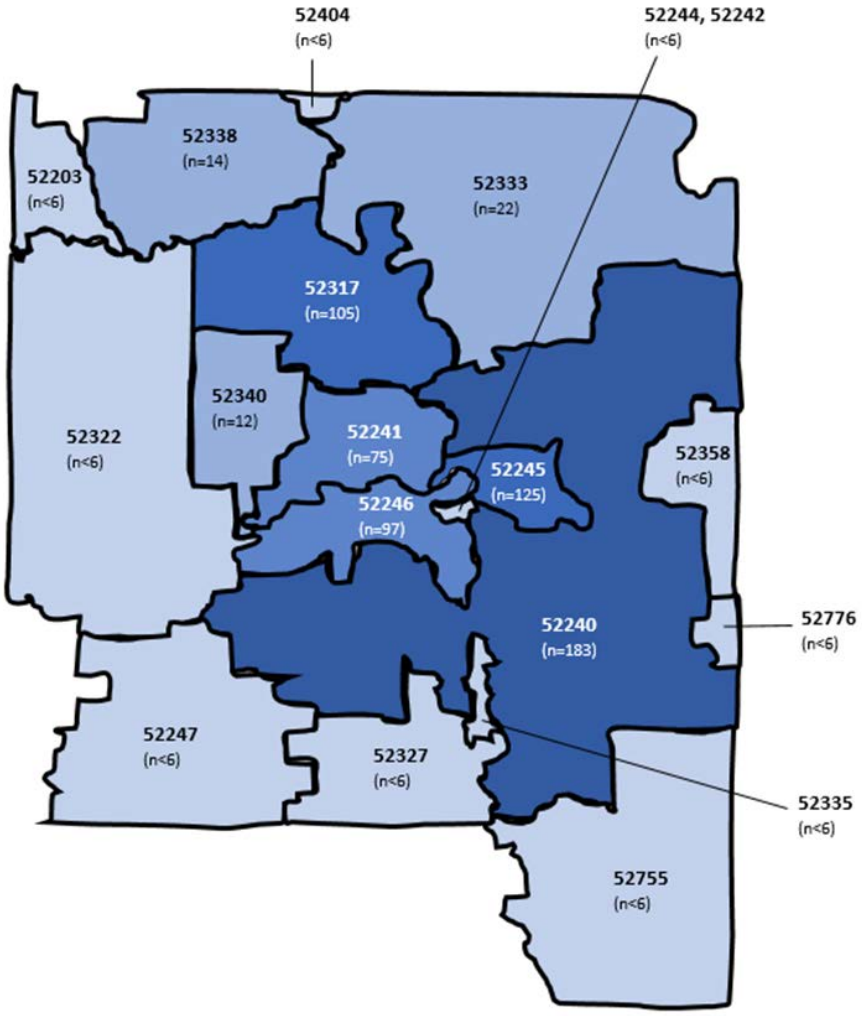


Figure D.1. Number of survey responses gathered from each zip code in Johnson County, as reported by respondents (n=682).

DEMOGRAPHICS

The demographic distribution of the 726 survey respondents is compared to that of Johnson County overall in Table D.1. Survey respondents were predominantly female, with a higher median age than the overall Johnson County population.

Table D.1. Sample Demographics of Community Status Assessment (CSA) vs. Population Demographics of Johnson County, IA

	CSA Sample	Johnson County Population[1]
Race		
White	82.8%	82.3%
Black or African American	7.5%	8.2%
Middle Eastern or North African	1.5%	*
Asian	2.2%	6.4%
Native Hawaiian or other Pacific Islander	0.0%	0.1%
American Indian or Alaska Native	1.0%	0.4%
Other	5.0%	*
Ethnicity		
Hispanic / Latino/a/x	12.6%	6.0%
Sex		
Male	23.9%	49.7%
Female	76.1%	50.3%
Intersex	0.1%	*
Age		
Median Age	45-49 years	30.4 years
Population over age 65	20.3%	12.9%
Education Level *(age 25+)*		
High School Graduate or Higher	93.5%	96.2%
Bachelor's Degree or Higher	64.71%	54.1%
Economic Status		
Median Household Income	$60,000-$69,999	$67,414
Below Federal Poverty Level (FPL)	15.2%	14.7%

*Data not available from U.S. Census

[1] United States Census Bureau. Johnson County, Iowa. 2017-2022.

DEMOGRAPHICS

RACE

A total of 671 (92%) of respondents reported their race as one or more of the following: white, Black or African American, Middle Eastern or North African, Asian, American Indian or Alaska Native, or other.

Figure D.2 shows respondents' reported race. Figure D.3 shows the specific races of respondents within the Asian race category.

FIGURE D.2. RACE
671 Responses

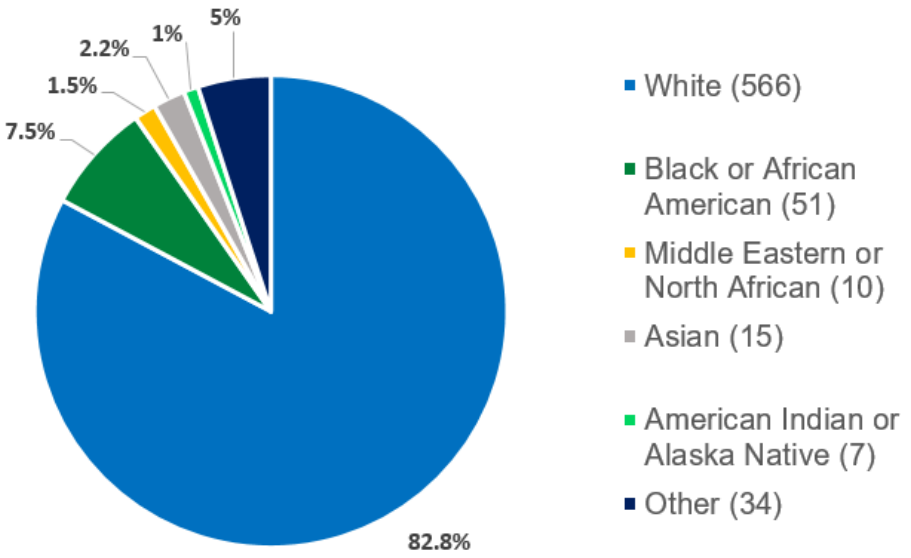


FIGURE D.3. ASIAN RACE

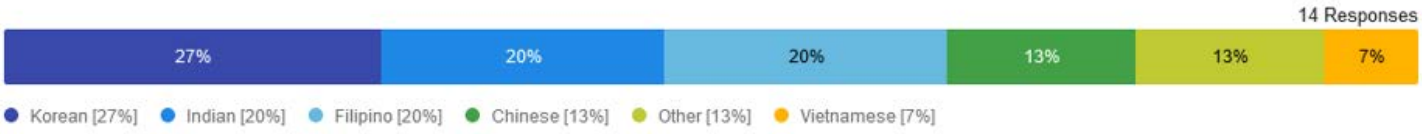


Table D.2 to the right shows open, written responses for other race specifications.

Table D.2. Other Race Specifications, Open Response (n=13)

Response	Count
Centroamerica	1
Indígena Maya	1
Latina/Latino	2
Hondureña	1
Hispano	1
Mixed	2
American	1
Puerto Rican	1
Taino (Native Indian from PR)	1
Northern European	1
Caucasian	1

1 United States Census Bureau. Johnson County, Iowa. 2017-2022.

DEMOGRAPHICS

ETHNICITY

Ethnicity (Hispanic or Latino/a/x vs. non-Hispanic or Latino/a/x) was reported by 681 respondents (94%). Among the 87 respondents who reported their ethnicity as Hispanic or Latino/a/x, 64 also reported their race separately. The most common reported races among Hispanic or Latino/a/x respondents were white (60%) and "other" (33%); all written responses specifying other races are presented in Table D.2 on the previous page.

FIGURE D.4. ETHNICITY OVERALL

681 Responses

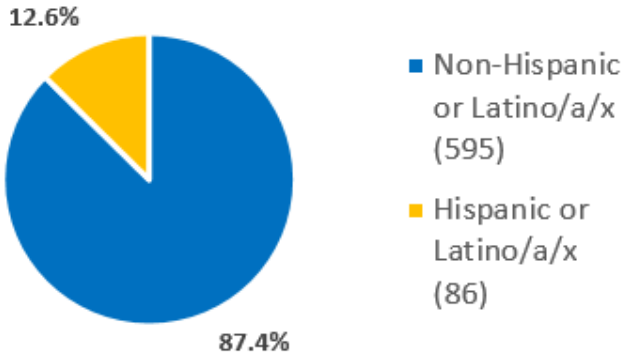


FIGURE D.5. HISPANIC, LATINO/A/X, OR OTHER SPANISH ETHNICITY

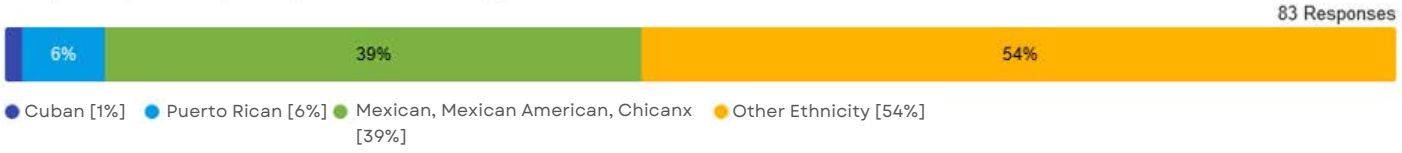
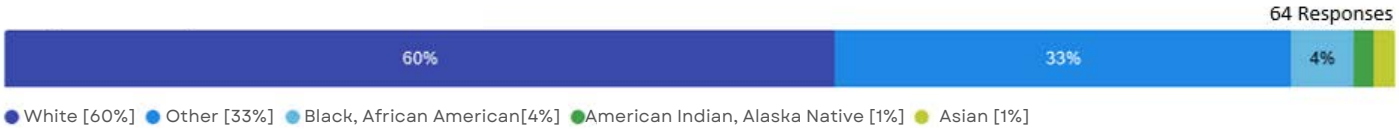


FIGURE D.6. HISPANIC OR LATINO/A/X RESPONDENTS' REPORTED RACE



DEMOGRAPHICS

GENDER

Out of 708 respondents who reported their gender, 73% were women, 24% were men, and 4% were non-binary, transgender, and/or gender-nonconforming. 533 respondents were assigned female at birth, 167 were assigned male at birth, and fewer than six respondents self-reported as intersex. More respondents provided their biological sex than their gender identity; this may be related to survey design as the question "What was your assigned sex at birth?" directly preceded "Which of the following best represents your gender?"

FIGURE D.7. GENDER

701 Responses

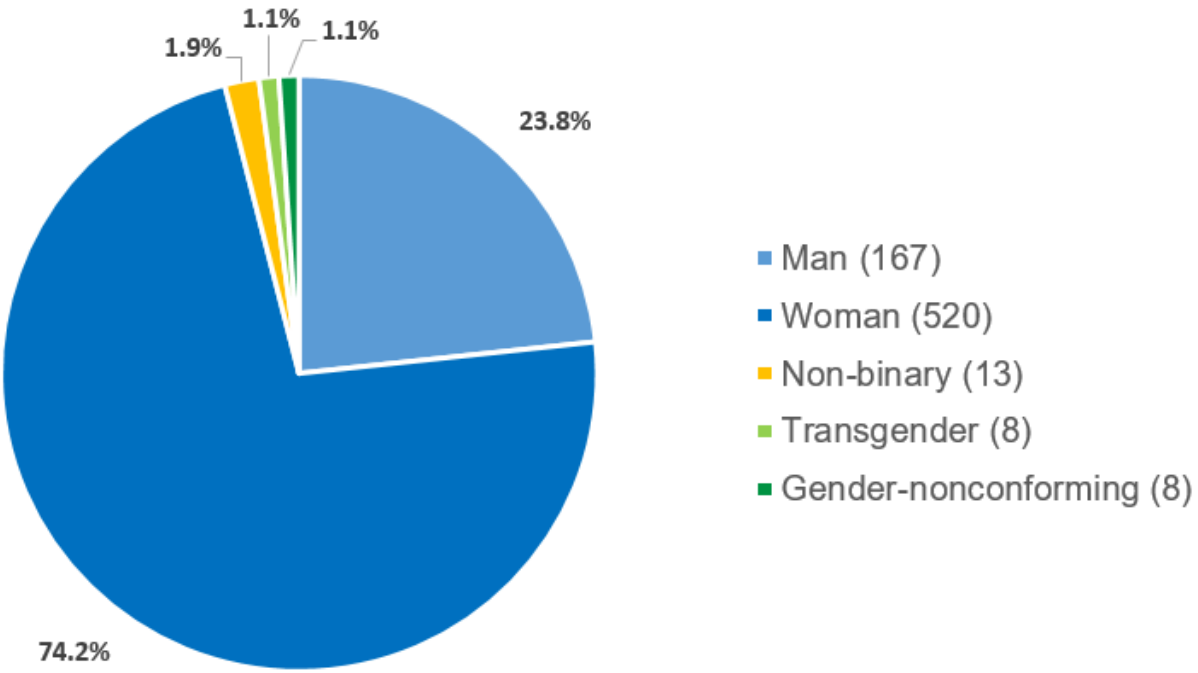


FIGURE D.8. GENDER OF RESPONDENTS WHO SELECTED MALE AT BIRTH

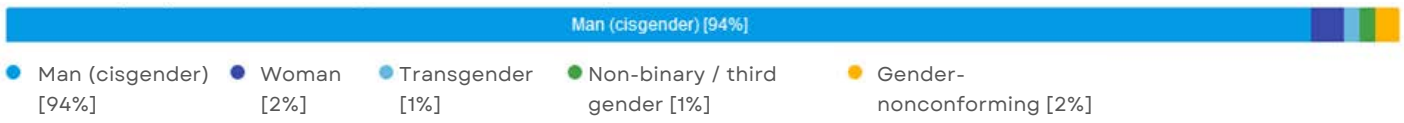
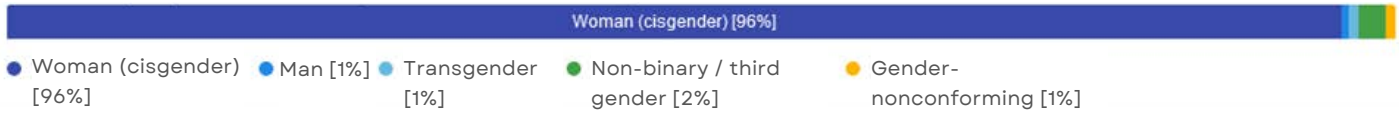


FIGURE D.9. GENDER OF RESPONDENTS WHO SELECTED FEMALE AT BIRTH



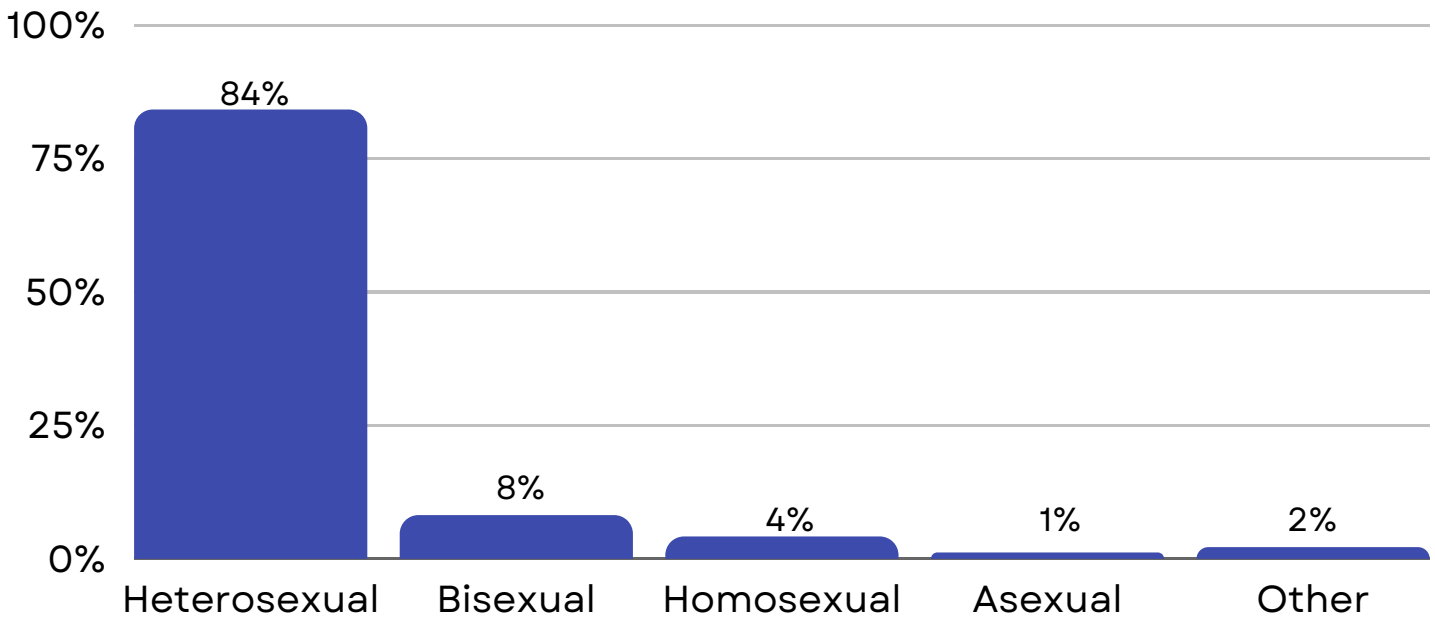
DEMOGRAPHICS

SEXUAL ORIENTATION

The majority of respondents (80%) identified as heterosexual, while 8% identified as bisexual and 4% identified as homosexual. However, 78 respondents omitted their sexual orientation or selected "prefer not to respond," which may have incurred a response bias to this question.

FIGURE D.10. SEXUAL ORIENTATION

642 Responses



SEXUAL ORIENTATION, BY AGE

Respondent sexual orientation did not show noticeable variation when disaggregated by race (not shown); variation by age group is shown in Table D.3.

Table D.3. Sexual Orientation by Age Group

	Heterosexual	Bisexual	Homosexual	Asexual	Other
Age <25	77%	18%	2%	0%	3%
Age 25-39	77%	13%	4%	3%	3%
Age 40-54	90%	4%	3%	1%	2%
Age 55-69	84%	7%	8%	1%	0%
Age 70+	95%	0%	3%	1%	1%

DEMOGRAPHICS

AGE

The average respondent was between 45-49 years of age. Respondents who identified as LGBTQ+ tended to be younger on average compared to non-LGBTQ+ respondents, and those who identified as Hispanic or Latino/a/x also tended to be younger than non-Hispanic respondents. Trends in respondent age were very similar between cisgender men and women (not shown).

FIGURE D.11. RESPONDENT AGES

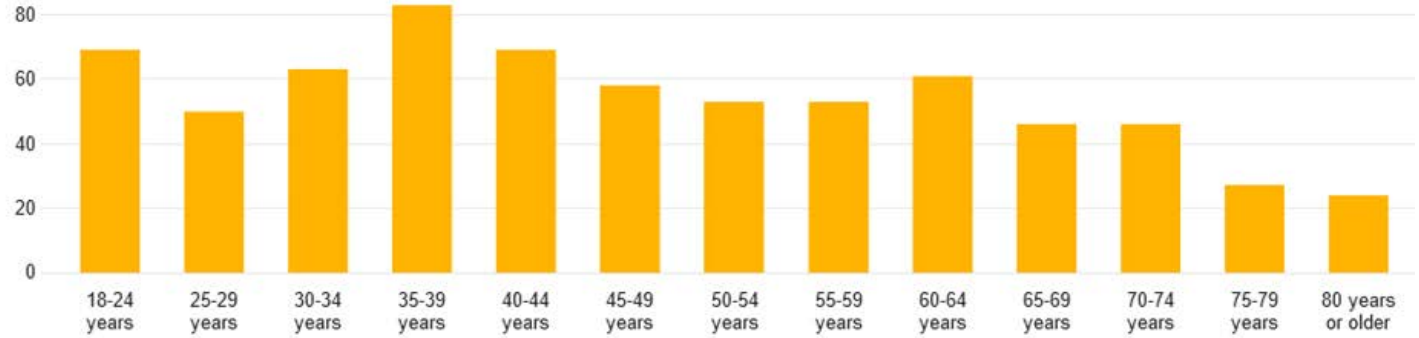


FIGURE D.12. RESPONDENT AGES BY LGBTQ+ STATUS

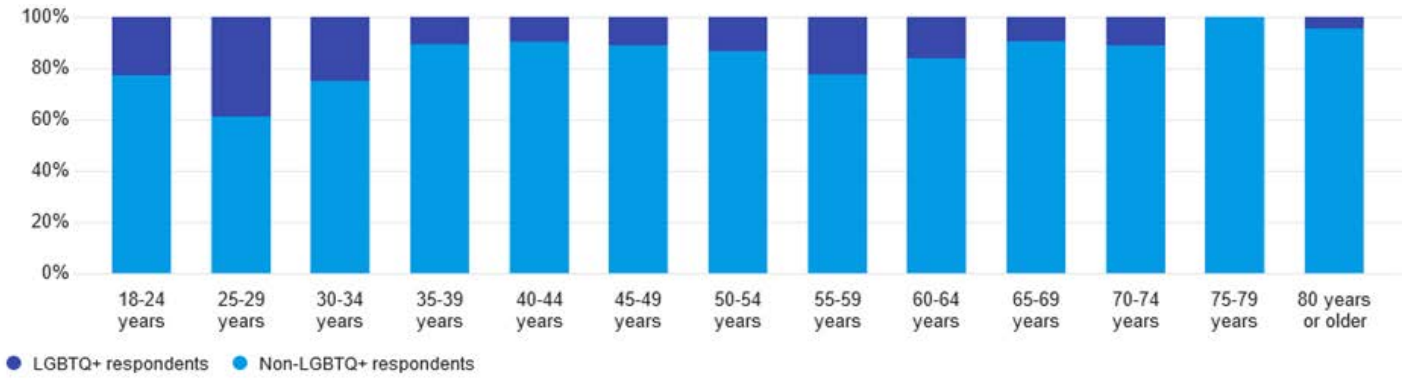
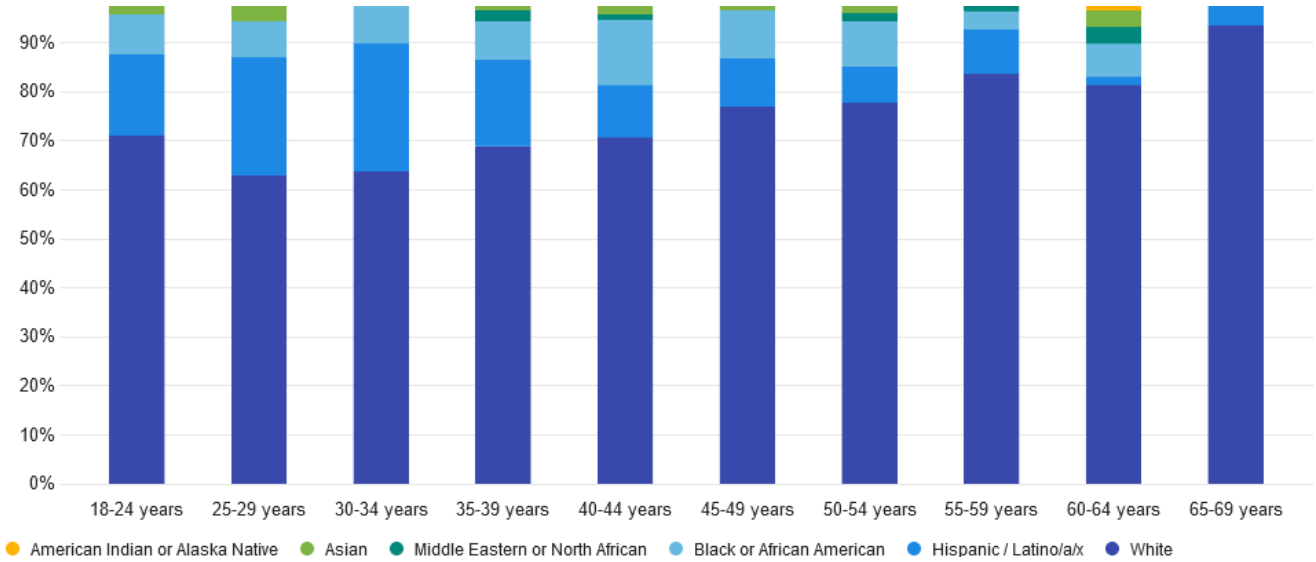


FIGURE D.13. Respondent Ages by Race / Ethnicity



DEMOGRAPHICS

SOCIOECONOMIC STATUS

Of the 591 participants who provided their employment status, the majority of respondents (78%) were either currently employed for wages or retired. The top three reported employment industries were Health Care and Social Assistance (31%), Educational Services (16%), and Other Services (16%).

FIGURE D.14. Employment Status

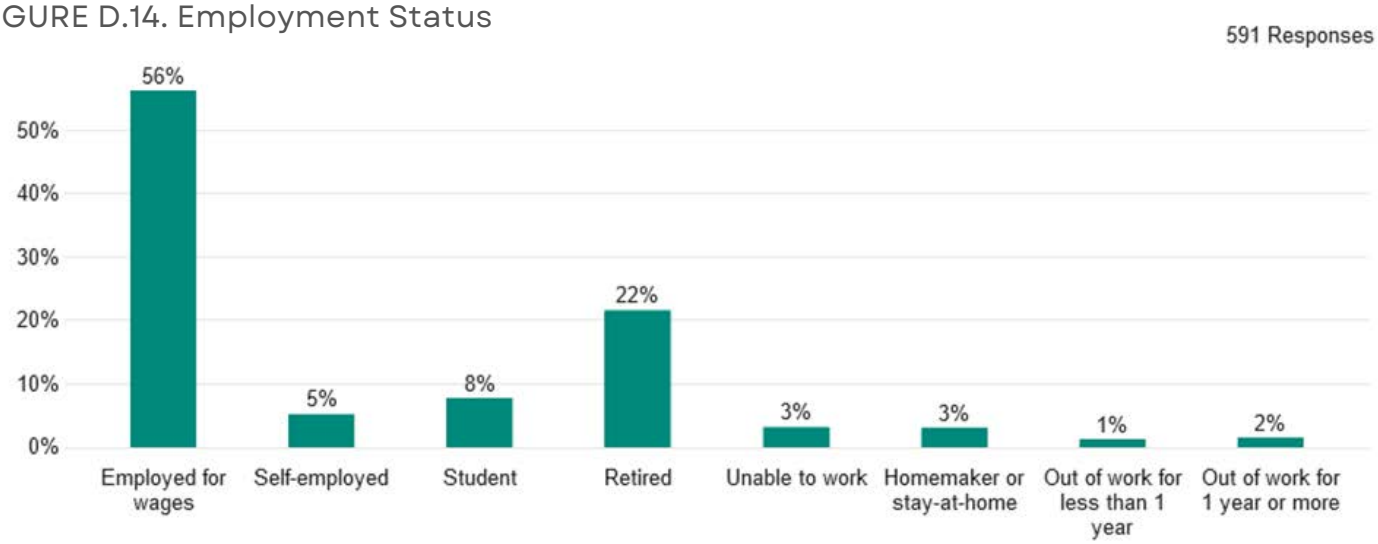
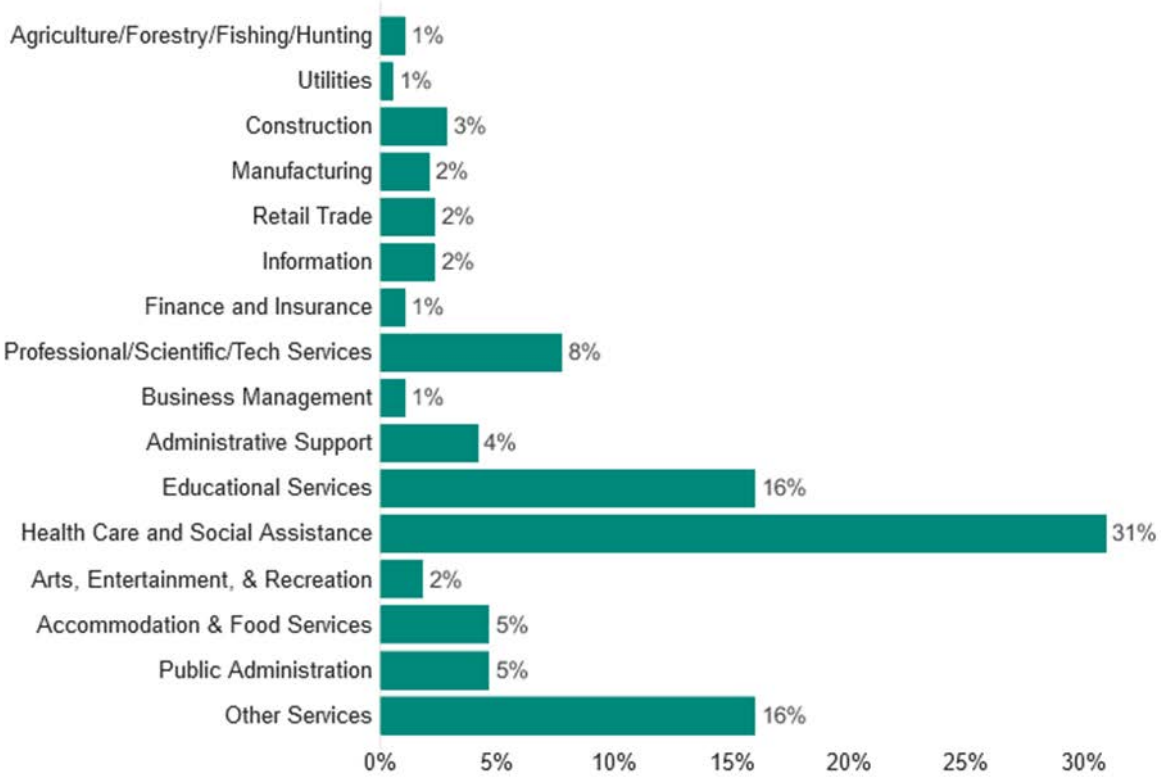


FIGURE D.15. TYPE OF BUSINESS OR INDUSTRY RESPONDENT WORKS IN



DEMOGRAPHICS

615 respondents provided their annual household income, revealing an unequal distribution of income among the CSA sample. Approximately one-third of respondents (30%) had household incomes below $29,999 per year, while the top third (33%) reported $100,000 per year or more, leaving a range of $30,000 to $99,999 for the remaining (37%) of respondents. This disparity in household income was more apparent in certain areas of Johnson County when results were separated by zip code.

FIGURE D.16. RESPONDENT ANNUAL HOUSEHOLD INCOME

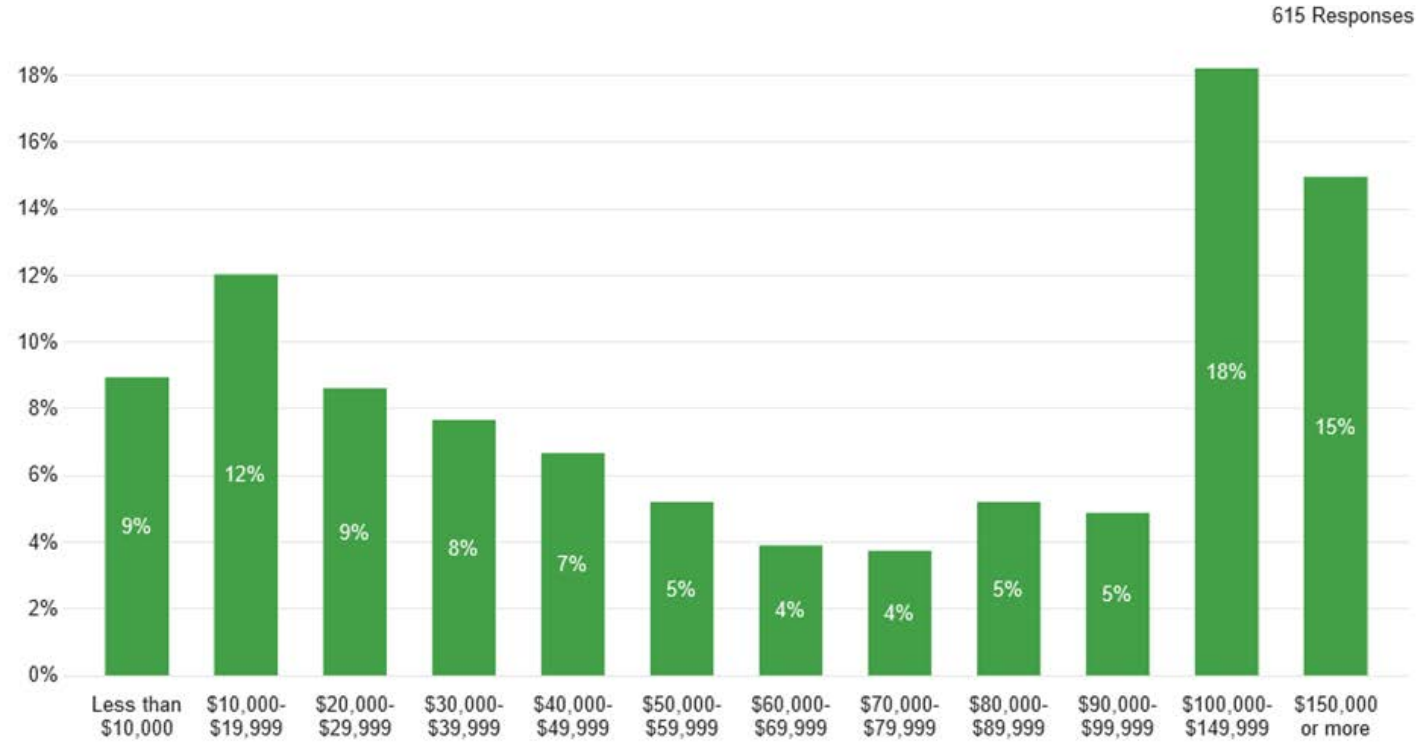
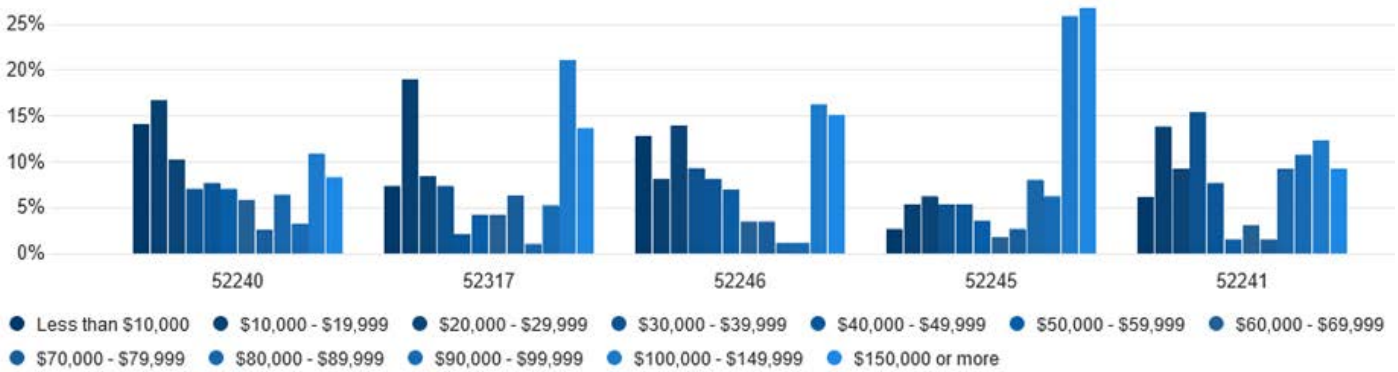


FIGURE D.17. HOUSEHOLD INCOME BY ZIP CODE



DEMOGRAPHICS

FIGURE D.18. ANNUAL HOUSEHOLD INCOME BY RACE/ETHNICITY

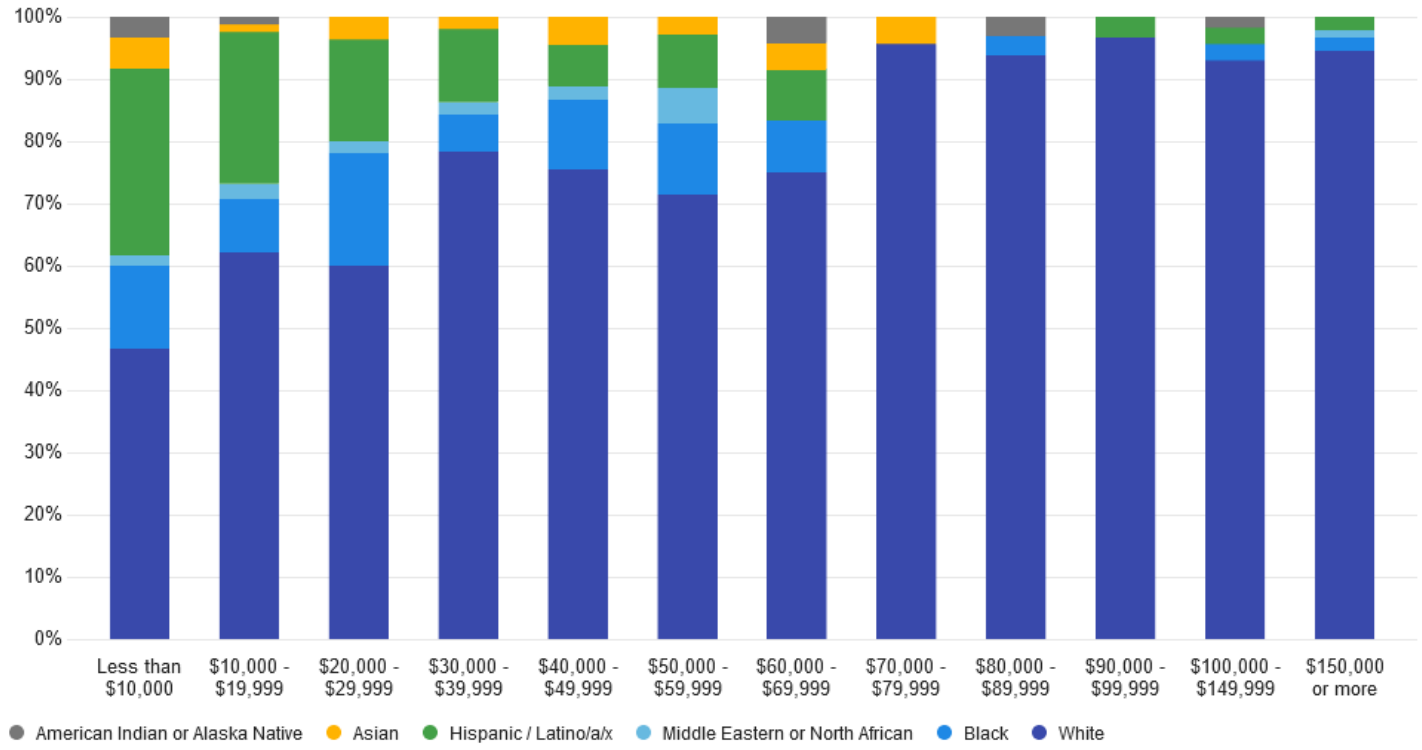
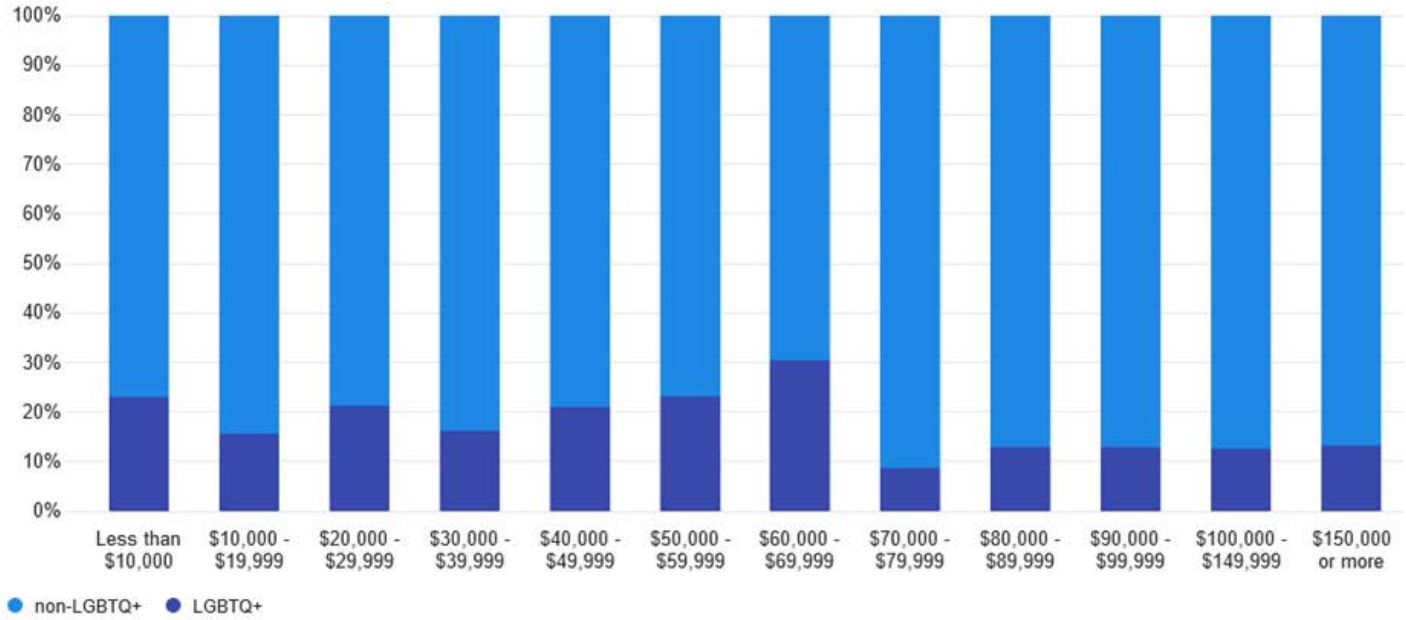
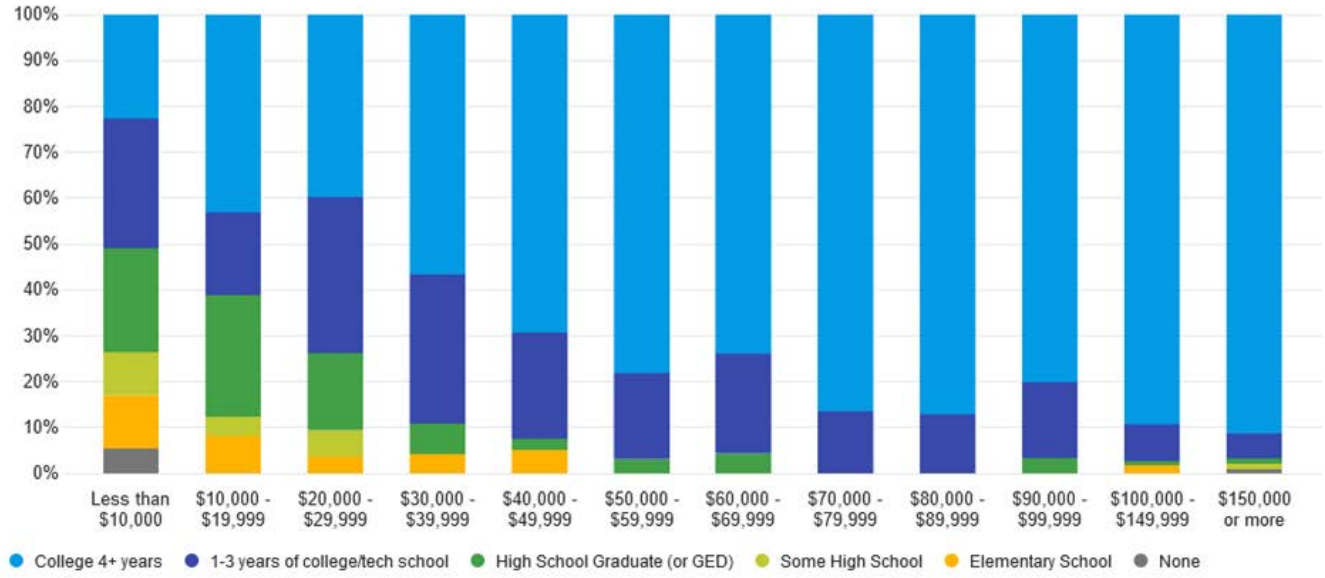


FIGURE D.19. ANNUAL HOUSEHOLD INCOME BY LGBTQ+ STATUS



DEMOGRAPHICS

FIGURE D.20. ANNUAL HOUSEHOLD INCOME BY EDUCATION LEVEL



EDUCATION

The majority of respondents (85%) had some post-secondary education. Respondents' education level did not noticeably differ by LGBTQ+ status, but there was variation by race and ethnicity, as shown in Table D.4.

FIGURE D.21. HIGHEST GRADE OR YEAR OF SCHOOL COMPLETED

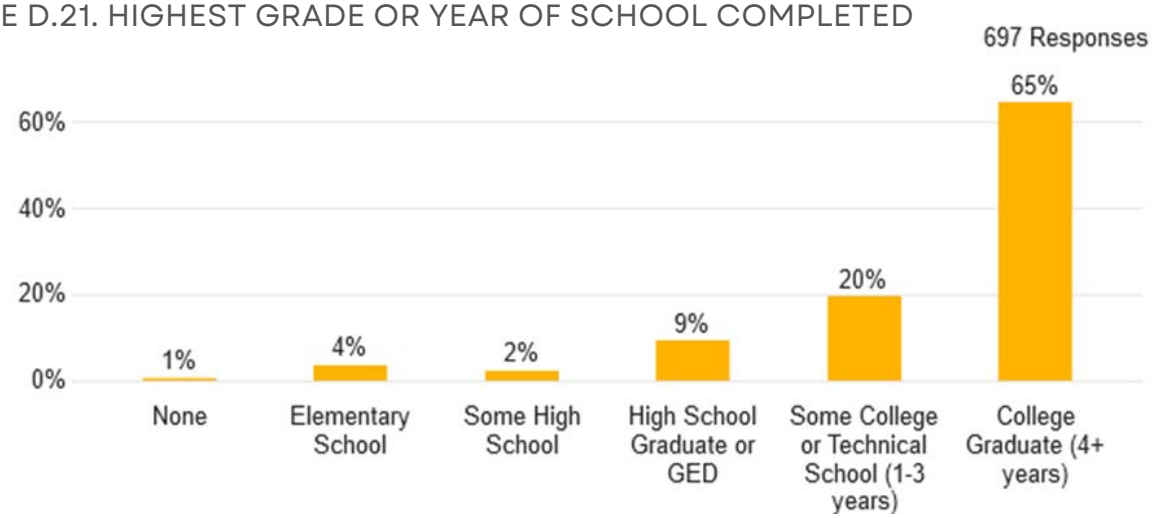


Table D.4. Education Level, by Race/Ethnicity

	< High School	High School Graduate or GED	Some College or Technical School (1-3 years)	College Graduate (4+ years)
White	2%	7%	20%	71%
Black or African American	12%	21%	23%	44%
Hispanic / Latino/a/x	35%	25%	15%	25%
Asian	0%	0%	27%	73%
Middle Eastern or North African	10%	10%	20%	60%
Native American	0%	17%	33%	50%

Table D.5. Education Level, LGBTQ+

	Non-LGBTQ+	LGBTQ+
< High School	4%	4%
High School Graduate or GED	7%	10%
Some College or Technical School (1-3 years)	20%	17%
College Graduate (4+ years)	68%	69%

HEALTH STATUS

SELF-REPORTED HEALTH STATUS

FIGURE HS.1. SELF-REPORTED HEALTH STATUS

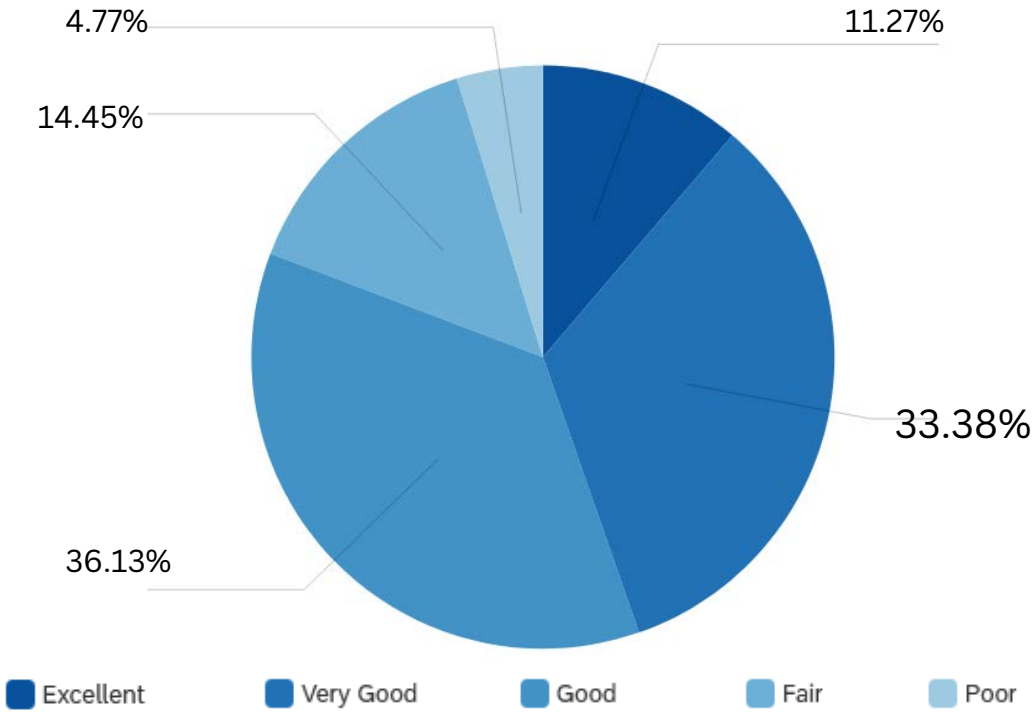


Figure HC.1 shows percentages of 692 survey respondents rating their general health as excellent, very good, good, fair, or poor.

Table HS.1 describes the count and percentages of individuals rating their general health as excellent, very good, good, fair, or poor by race and ethnicity.

TABLE HS.1. SELF-REPORTED HEALTH STATUS BY RACE AND ETHNICITY

	Black or African American		Middle Eastern or North African		Asian		White		Hispanic / Latino/a/x		Total*
Excellent	13.63%	6	--	--	--	--	10.06%	51	18.18%	8	68
Very Good	25.00%	11	--		28.57%	4	37.87%	192	11.36%	5	**213**
Good	43.18%	19	62.50%	5	42.86%	6	34.91%	177	14.91%	18	**225**
Fair	13.64%	6	--	--	--	--	14.00%	71	13.64%	6	**85**
Poor	--	--	--	--	--	--	--	--	15.91%	7	**26**
Total*		**44**		**8**		**14**		**507**		44	

*Total included other race categories that are not shown due to too small sample size

HEALTH STATUS

MENTAL AND PHYSICAL HEALTH

> 14 DAYS OF POOR PHYSICAL HEALTH (N=659)

FIGURE HS.2. REPORTED POOR PHYSICAL HEALTH DAYS >14

> 14 DAYS OF POOR MENTAL HEALTH (N=654)

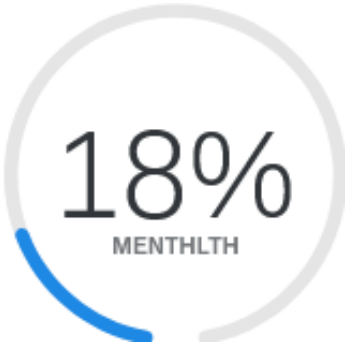


FIGURE HS.3. REPORTED POOR MENTAL HEALTH DAYS >14

> 14 DAYS PHYSICAL OR MENTAL HEALTH PREVENTED ACTIVITES (N=653)

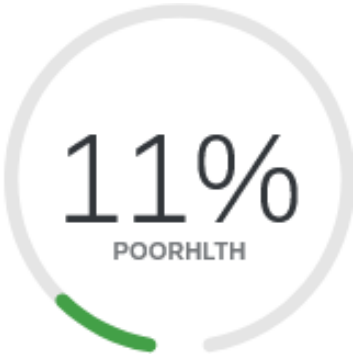


FIGURE HS.4. REPORTED PREVENTED ACTIVITY DAY >14

AVERAGE POOR PHYSICAL HEALTH DAYS

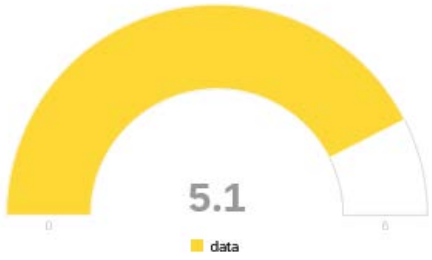


FIGURE HS.5. AVERAGE POOR PHSYCIAL HEALTH DAYS

AVERAGE POOR MENTAL HEALTH DAYS

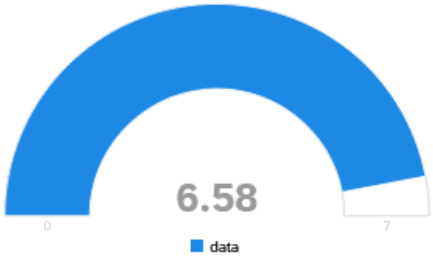


FIGURE HS.6. AVERAGE POOR MENTAL HEALTH DAYS

AVERAGE DAYS OF PREVENTED ACTIVITES

FIGURE HS.7. AVERAGE DAYS OF PREVENTED ACTIVITES

COUNTY HEALTH RANKINGS & ROADMAPS, QUALITY OF LIFE WITHIN JOHNSON COUNTY[1]

TABLE HS.2. COUNTY HEALTH RANKINGS & ROADMAPS, QUALITY OF LIFE 2019

Quality of Life	Iowa	United States
Poor or Fair Health	14%	17%
Poor Physical Health Days	3.1	3.9
Poor Mental Health Days	4.1	4.5

[1] "Iowa." County Health Rankings & Roadmaps, www.countyhealthrankings.org/.

HEALTH STATUS

ALCOHOL USE

ABOUT EXCESSIVE DRINKING
Excessive Drinking includes heavy and/or binge drinkers:

HEAVY DRINKERS : men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drinks per day

BINGE DRINKERS: men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion

ALCOHOL CONSUMPTION

Of the 456 survey respondents that answered that they consume alcohol, 39% (265) drink 0-1 days per week, 16% (111) drink 2-3 times per week, 6% (38) drink 4-5 times per week, and 6% (42) drink 6-7 days per week.

FIGURE HS.8. ALCOHOL CONSUMPTION BY DAYS PER WEEK

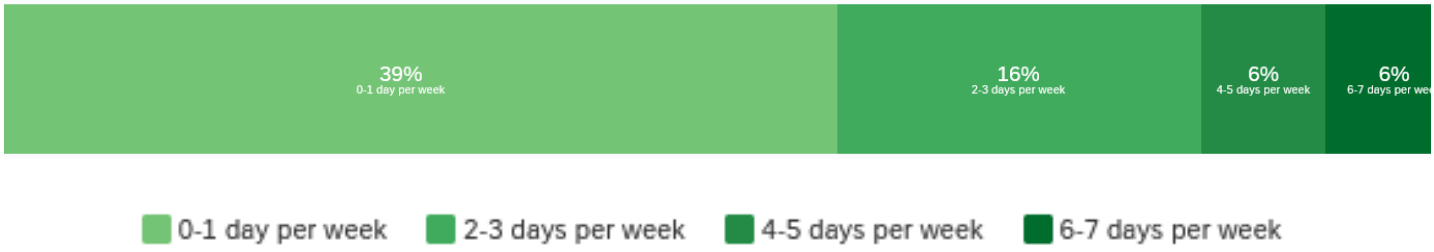


TABLE HS.3. ALCOHOL COMSUMPTION DAYS PER WEEK BY SEX ASSISGNED AT BIRTH

	Male		Female		Total
0-1 day per week	20.23%	53	79.77%	209	**262**
2-3 days per week	17.27%	19	82.73%	91	**110**
4-5 days per week	29.73%	11	70.27%	26	**37**
6-7 days per week	30.95%	13	69.05%	29	**42**
Total		**96**		**355**	

HEALTH STATUS

ALCOHOL USE CONT.

Of the 465 survey respondents that indicated how many days a week they drank, 394 reported how many drinks they had on said days. Figure HS.9 demonstrates this data by sex assigned at birth below.

FIGURE HS.9. NUMBER OF DRINKS BY SEX ASSIGNED AT BIRTH

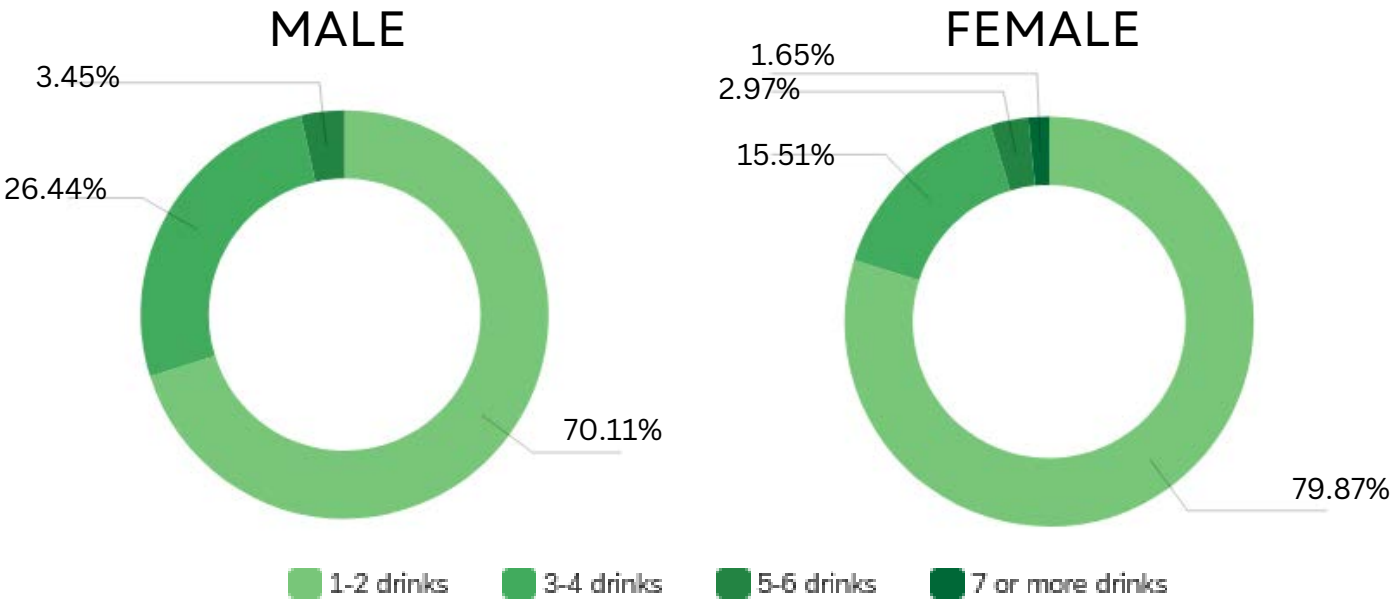


Table HS.4 displays the count and percentage of number of alcohol drinks consumed by sex assigned at birth.

TABLE HS.4. NUMBER OF DRINKS BY SEX ASSIGNED AT BIRTH, COUNT AND PERCENTAGES

	Male		Female		Total
1-2 drinks	**70.11%**	**61**	**79.87%**	**242**	**303**
3-4 drinks	**26.44%**	**23**	**15.51%**	**47**	**70**
5-6 drinks	--	--	**2.97%**	**9**	**12**
7+ drinks	**--**	--	**--**	**--**	**--**
Total		**87**		**303**	

HEALTH STATUS

ALCOHOL USE CONT.

394 respondents, indicated the number of alcoholic drinks they consumed each week. When this data was disaggregated by age there was no significant difference across ages.

FIGURE HS.10. ALCOHOL CONSUPTION DAYS PER WEEK BY AGE

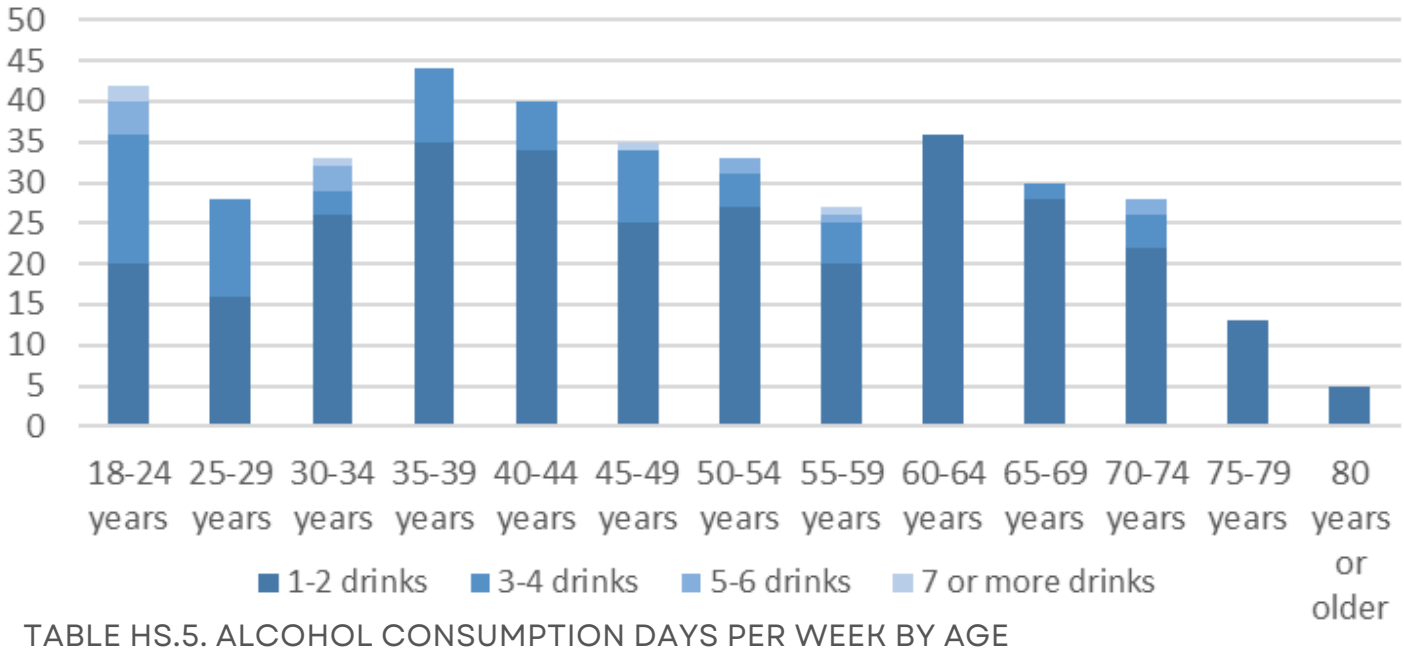


TABLE HS.5. ALCOHOL CONSUMPTION DAYS PER WEEK BY AGE

	Minimum	Maximum	Mean	Std Deviation	Variance	Count
18-24 years	0	12	5.15	2.67	7.15	41
25-29 years	0	10	4.07	2.49	6.2	29
30-34 years	0	15	4.03	3.77	14.24	37
35-39 years	0	8	2.65	2	3.98	49
40-44 years	0	10	2.95	2.16	4.68	41
45-49 years	0	15	3.2	2.91	8.45	41
50-54 years	0	20	2.86	3.29	10.82	37
55-59 years	0	12	2.75	2.8	7.81	32
60-64 years	0	6	1.95	1.33	1.77	44
65-69 years	0	8	2.23	1.73	2.98	35
70-74 years	0	30	2.8	4.93	24.33	35
75-79 years	0	3	1.11	0.97	0.94	19
80 years or older	0	2	0.78	0.63	0.4	9

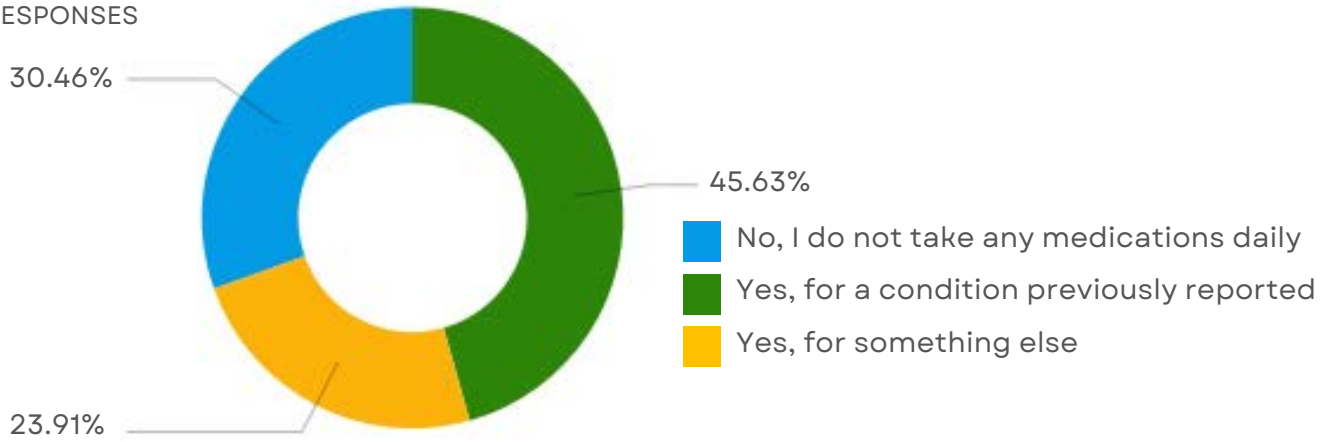
HEALTH STATUS

MEDICATION USE

Figure HS.11 shows reported daily prescription medication usage. Approximately 30.5%, or 203 of 665 respondents, report no daily prescription medication use.

FIGURE HS.11. DAILY PRESCRIPTION MEDICATION USE

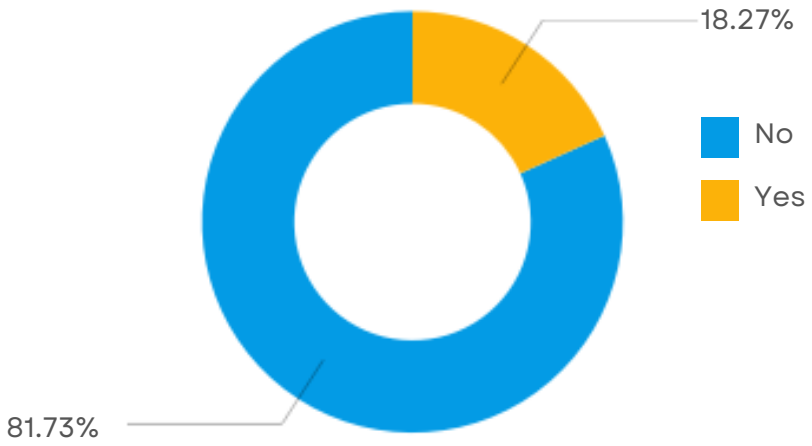
665 RESPONSES



Of the 427 respondents taking prescription medication daily, approximately 51.52% (220) take 1 to 2 per day, 32.55% (139) take 3 to 5 per day, and 15.93% (68) take 6 or more per day. As age increases, we see an increase in amount of prescription medication used as well.

FIGURE HS.12. MEDICATION DELAY DUE TO COST

427 RESPONSES



Approximately 56% (14 of 25) respondents who do not have health insurance of any kind experienced a delay in medication due to cost. Of those who do have health insurance, approximately 15.67% (60 of 383) experienced a delay due to medication cost.

HEALTH STATUS

CHRONIC HEALTH CONDITIONS & BMI

Figure HS.13 shows individuals' chronic health conditions diagnosed by a doctor, nurse, or other health professional. Of the 491 survey respondents, the top three diagnosed conditions are (1) anxiety disorder (40.9%, 201), (2) high blood pressure (40.1%, 197), and (3) depressive disorder (35.2%, 173). Table HS. shows body mass index (BMI). For adults 20 years or older, a BMI of 18.5 to 24.9 is considered healthy.

FIGURE HS.13. CHRONIC HEALTH CONDITIONS

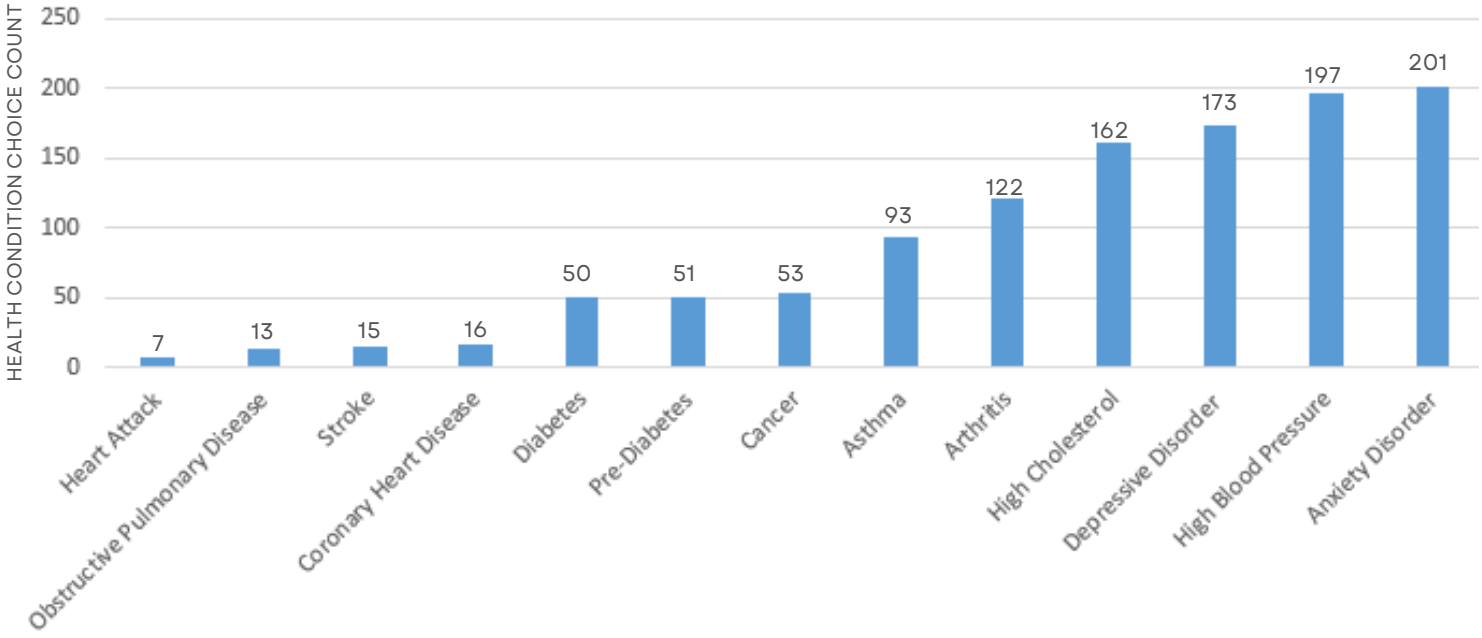


TABLE HS.6. AVERAGE BODY MASS INDEX, BY AGE

	18 - 24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
Female	25	28	30	29	29	30	30	31	27	29	28	28	24
Male	25	30	27	28	25	32	32	28	33	27	26	24	24

PHYSICAL HEALTH

ABOUT PHYSICAL HEALTH [2]

The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

KEY GUIDELINES FOR ADULTS [3]

For substantial health benefits, adults should do at least 150 minutes to 300 minutes a week of moderate-intensity, or 75 minutes to 150 minutes a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic activity.

[2] "Physical Activity." Physical Activity - Healthy People 2030, health.gov/healthypeople/objectives-and-data/browse-objectives/physical-activity.

[3] Piercy KL;Troiano RP;Ballard RM;Carlson SA;Fulton JE;Galuska DA;George SM;Olson RD; "The Physical Activity Guidelines for Americans." JAMA, U.S. National Library of Medicine, pubmed.ncbi.nlm.nih.gov/30418471/.

HEALTH STATUS

PHYSICAL ACTIVITY MINUTES, BY AGE

FIGURE HS.14 PARTICIPATED IN ANY PHYSICAL ACTIVITIES IN THE LAST 30 DAYS

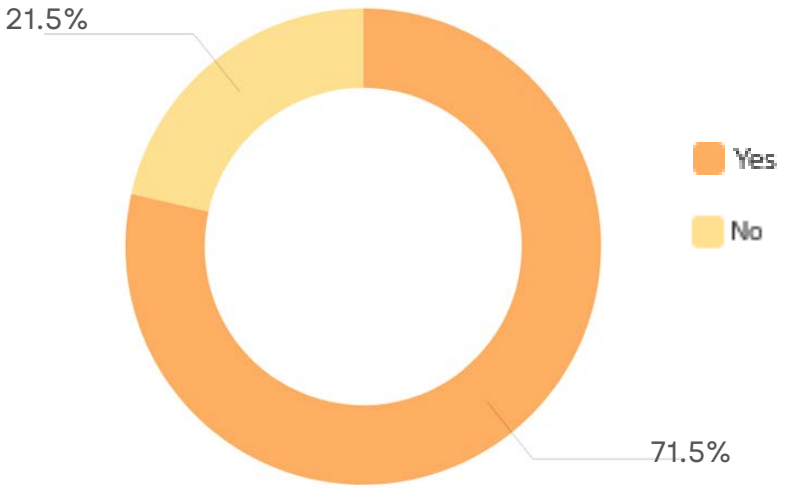


Figure HS.14 demonstrates that approximately 71.5% of respondents participated in any physical activity in the last 30 days.

TABLE HS.7 shows average number of exercise or physical activity minutes each age group participated in per week, all ages averaging above the recommended guidelines.

TABLE HS.7. PHYSICAL ACTIVITY MINUTES PER WEEK, BY AGE

Age	Mean	Responses
18-24	153.65	46
25-29	167	35
30-34	163	37
35-39	167.65	49
40-44	161.29	42
45-49	178.61	36
50-54	176.05	38
55-59	162.03	36
60-64	197.63	48
65-69	251.9	31
70-74	205.91	33
75-79	223.28	18
80+	271.67	9

HEALTH STATUS

SLEEP

Figure HS.15 demonstrates average hours of sleep per night. Of the 639 survey respondents, 7 hours of sleep was most commonly reported by 216 individuals followed by 8 hours of sleep reported by 183 individuals and 6 hours of sleep being the third most reported by 144 individuals.

FIGURE HS.15. HOURS OF SLEEP PER NIGHT

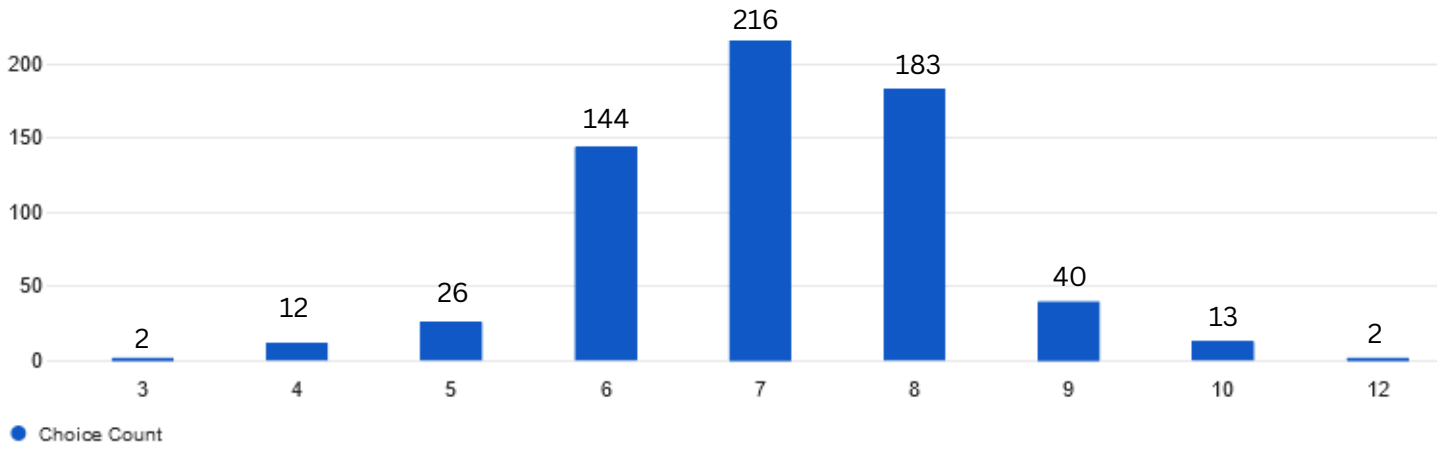
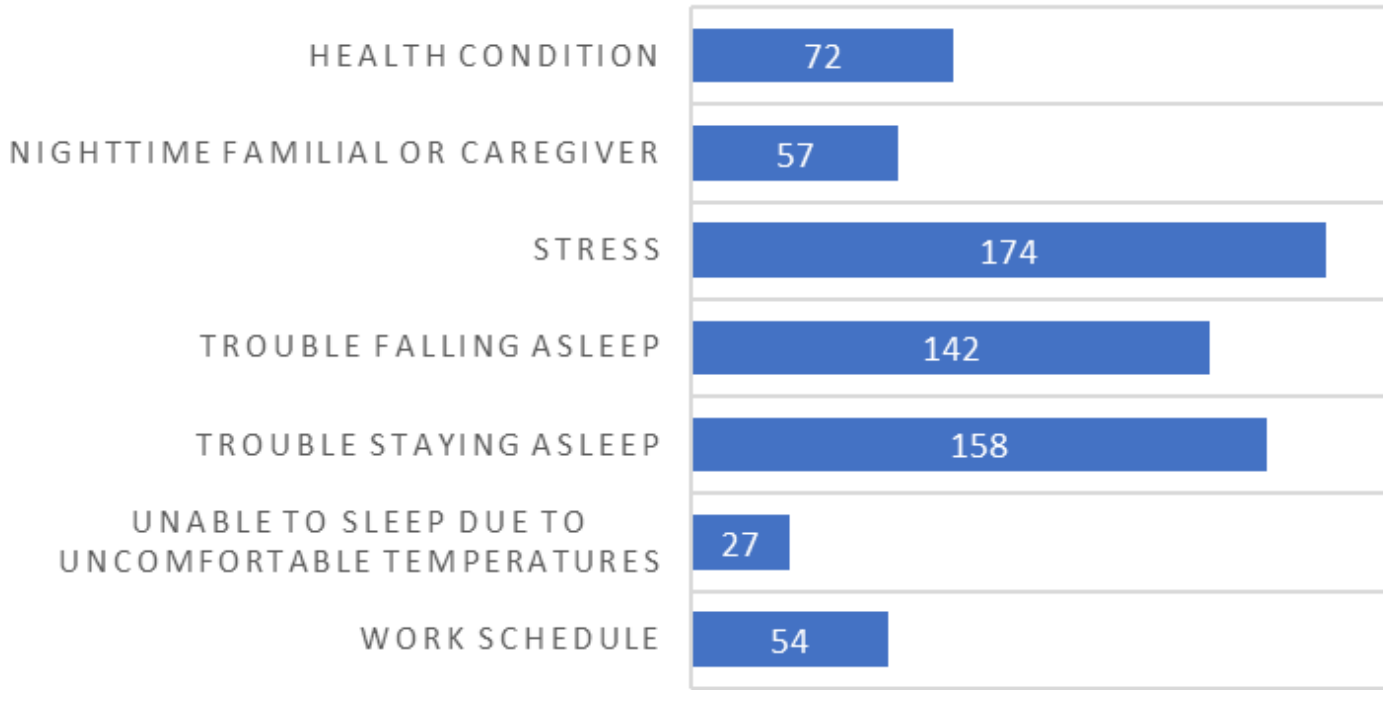


Figure HS.16 displays the factors that 735 survey respondents indicated were affecting their current sleep. Respondents' three most selected factors are (1) stress, (2) trouble staying asleep, and (3) trouble falling asleep.

FIGURE HS.16. REASONS AFFECTING SLEEP



HEALTHCARE ACCESS

HEALTH CARE COVERAGE

559 (87.76%) of respondents answered 'yes' to having any kind of health care coverage. Of those that answered yes, 145 (27.05%) selected Medicare as their provider and 84 (15.25%) selected Medicaid as shown in Figures HC.1-3 below. Tables HC.1-3 disaggregate these findings further by race and ethnicity.

FIGURE HC.1. HEALTH INSURANCE

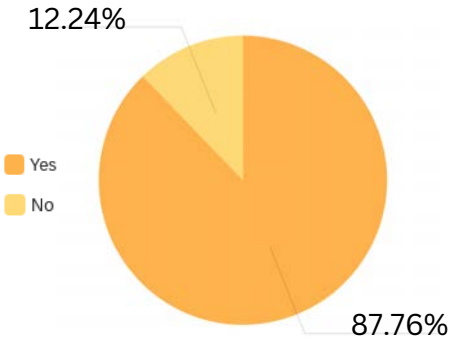


FIGURE HC.2. MEDICARE

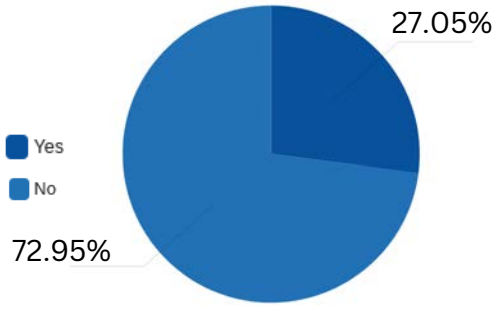
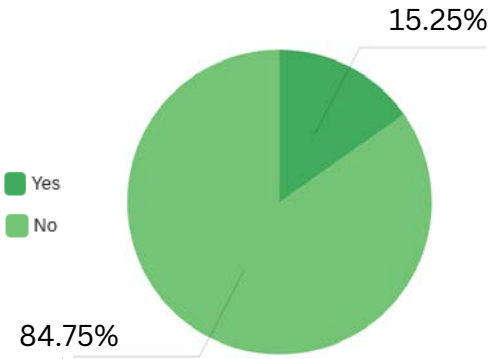


FIGURE HC.3. MEDICAID



TABLEHC.1. HEALTH INSURANCE BY RACE AND ETHNICITY

	Black or African American		Middle Eastern or North African		Asian		White		Hispanic / Latino/a/x		Total*
Yes	81.08%	30	--	--	75.00%	9	98.10%	465	44.07%	26	535
No	18.92%	7	--	--	--	--	1.90%	9	61.11%	33	54
Total		**37**		**7**		**12**		**474**		**59**	

*Total included other race categories that are not shown due to too small sample size

TABLE HC.2. MEDICARE COVERAGE BY RACE AND ETHNICTY

	Black of African American		Middle Eastern or North African		Asian		White		Hispanic / Latinx		Total
Yes	20.69%	6	--	--	--	--	26.97%	123	--	--	136
No	79.31%	23	--	--	88.89%	8	70.83%	323	84.62%	22	380
Total		**29**		**6**		**9**		**456**		**26**	

*Total included other race categories that are not shown due to too small sample size

TABLE HC.3. MEDICAID COVERAGE BY RACE AND ETHNICTY

	Black or African American		Asian		White		Hispanic / Latino/a/x		Total*
Yes	55.17%	16	--	--	11.28%	52	26.92%	7	79
No	44.83%	13	66.67%	6	88.72%	409	73.08%	19	447
Total		**29**		**9**		**461**		**26**	

*Total included other race categories that are not shown due to too small sample size

HEALTHCARE ACCESS

PRIMARY CARE PROVIDER(S)

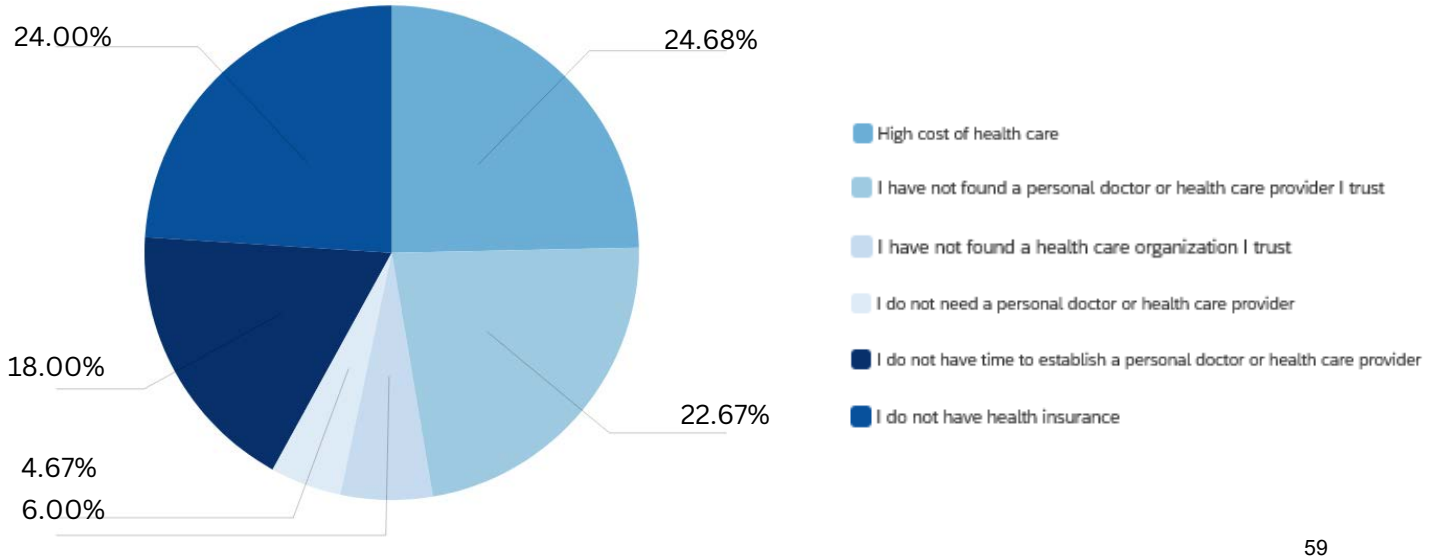
Figure HC.4 shows that 64% (394) of respondents have at least one person they consider their primary care provider, 13% (82) have more than one, and 23% (143) indicated they do not have one. This information is broken down and displayed by race and ethnicity in Table HC.4 below. Figure HC.5 indicates that the top three reasonings selected for those who do not have a provider are: (1) high cost of care, (2) not having health care coverage, and (3) not finding a provider they trust.

FIGURE HC.4. PRIMARY CARE PROVIDER(S)

TABLE HC.4. PRIMARY CARE PROVIDERS BY RACE AND ETHNICTY

	Black or African American		Middle Eastern or North African		Asian		White		Hispanic / Latino/a/x		Total*
Yes, one	55.56%	20	--	--	54.55%	6	70.63%	327	37.50%	18	**374**
Yes, more than one	--	--	--	--	--	--	15.98%	74	--	--	**79**
No	41.67%	15	--	--	--	--	13.90%	62	58.33%	28	**113**
Total		**36**		**8**		**11**		**463**		**48**	

FIGURE HC.5. REASONS FOR NOT HAVING PRIMARY CARE PROVIDER(S)

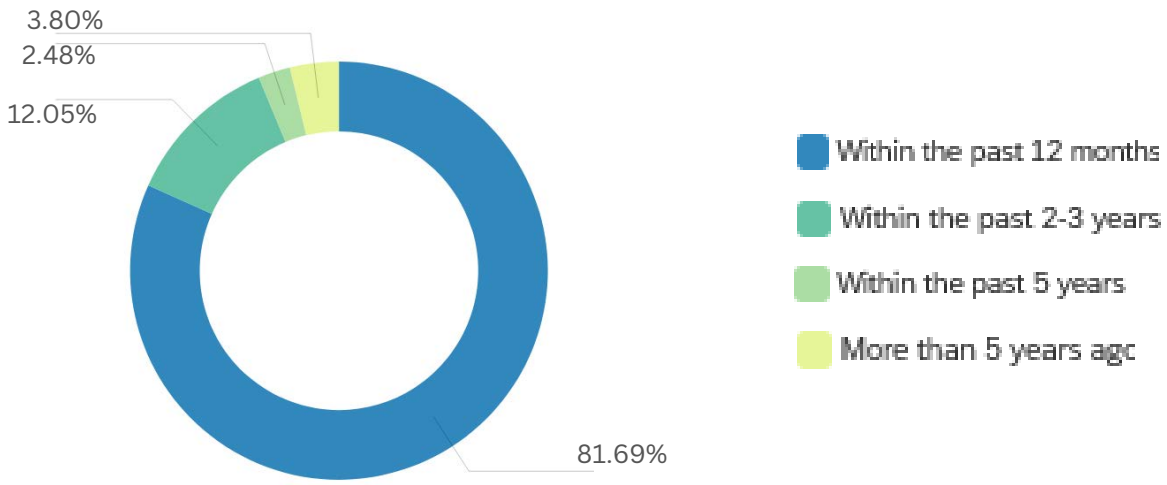


HEALTHCARE ACCESS

PHYSICAL OR ROUTINE CHECKUP

Figure HC.6 shows that of 606 respondents, 81.68% (495) individuals have completed their routine checkup within the last 12 months.

FIGURE HC.6. LAST PHYSICAL OR ROUTINE CHECKUP



DENTAL CHECKUP

Figure HC.7 shows the percentages of 618 survey respondents that answered when they were last seen by a dentist. Figure HC.8 shows the top three reasoning for not seeing a dentist being (1) not have dental insurance, (2) concerns that it will be too expensive, and (3) not have any presenting issues with their teeth.

FIGURE HC.7. LAST DENTAL CHECKUP

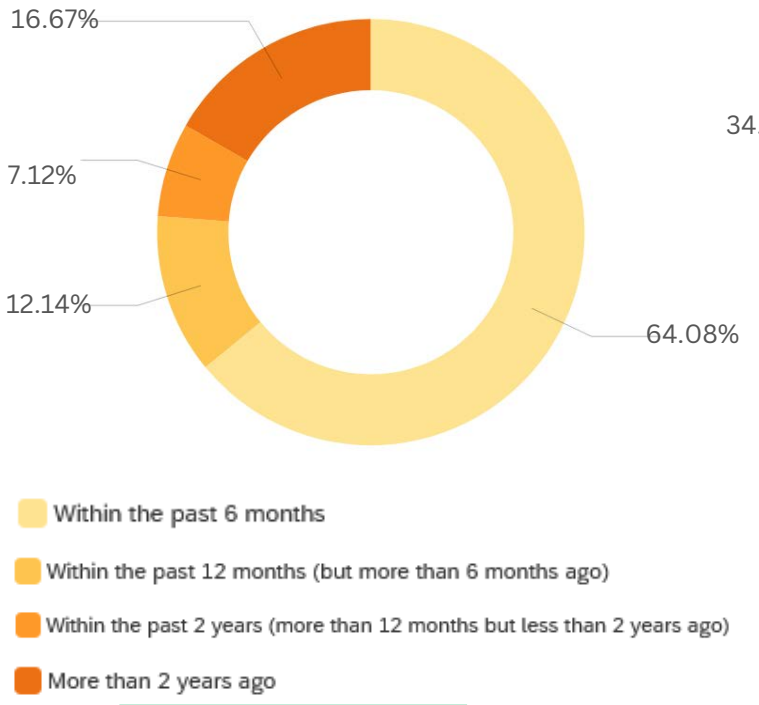
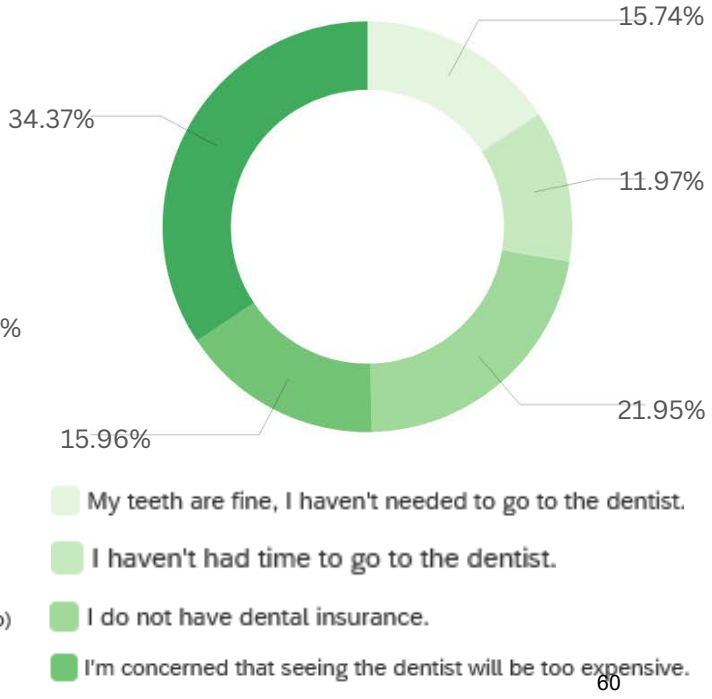


FIGURE HC.8. REASONINGS FOR NOT SEEING DENTIST



HEALTHCARE ACCESS

HEALTH CARE COST BARRIER

Figure HC.9 below shows that 15.78% (98 of 621) of respondents did not see a doctor due to cost in the past 12 months. Of these respondents, approximately 11.75% or 73 report not having health insurance.
Of the 73 respondents without health insurance, 56.16% or 41 respondents report not seeing a doctor due to cost in the past 12 months.

FIGURE HC.9. COULD NOT SEE A DOCTOR DUE TO COST IN PAST 12 MONTHS

621 RESPONSES

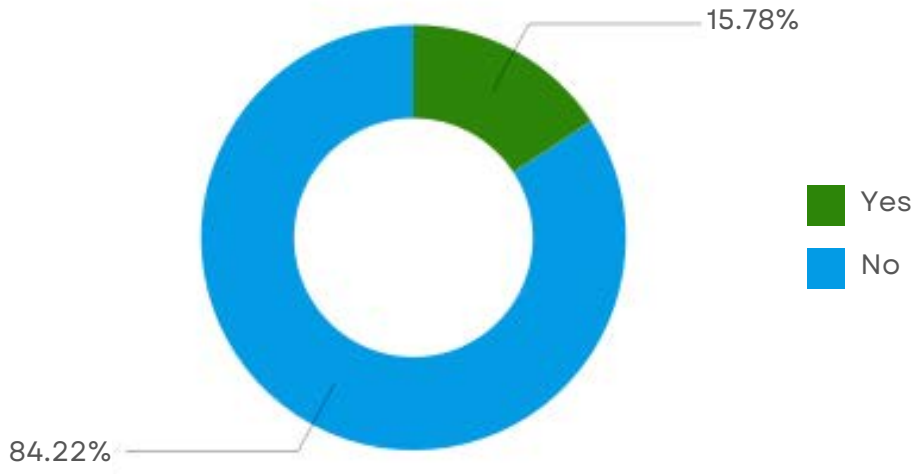
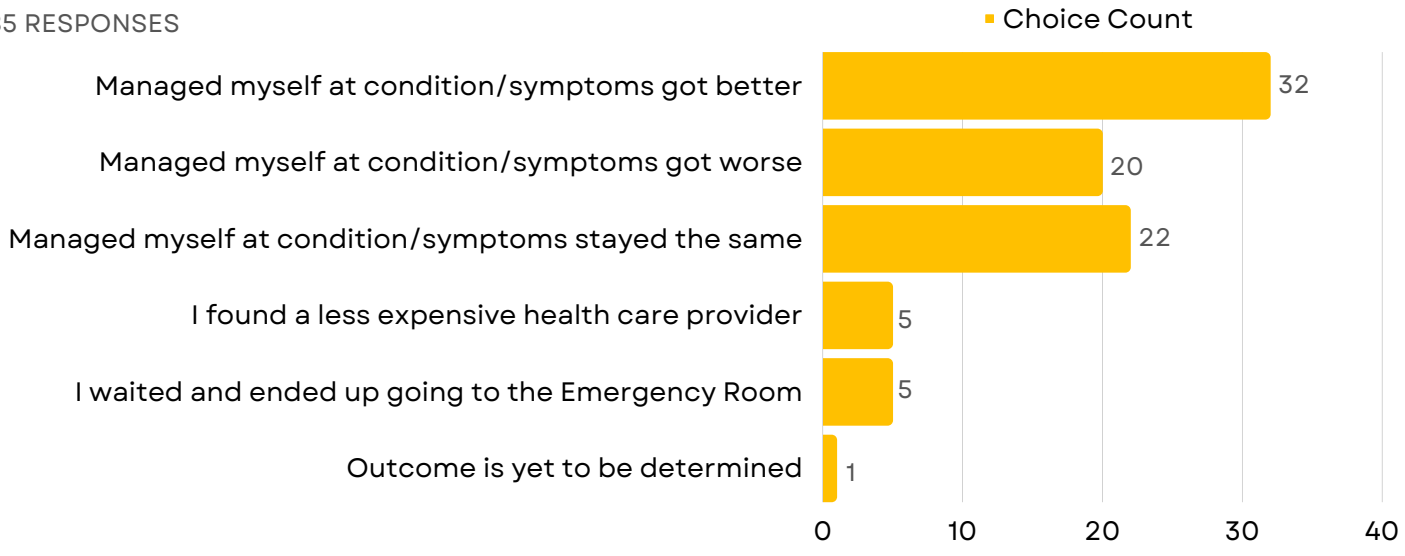


Figure HC.10 below details the outcome of not seeing a doctor or health care provider due to cost in the past 12 months. 23.53% or 20 respondents reported their condition worsened and 5.88% or 5 respondents waited and ended up going to the Emergency Room.

FIGURE HC.10. OUTCOME OF NOT SEEING HEALTH CARE PROVIDER DUE TO COST

85 RESPONSES



HEALTHCARE ACCESS

SCREENINGS

Figure HC.11 displays the percentage of the 358 survey respondents answering if they have received a colorectal cancer screening. Figure HC.12 displays the count for the 250 survey respondents answering when they had this screening completed. Figure HC.8 excludes "prefer not to answer" and "not sure" responses.

FIGURE HC.11. COLRECTAL CANCER SCREENING

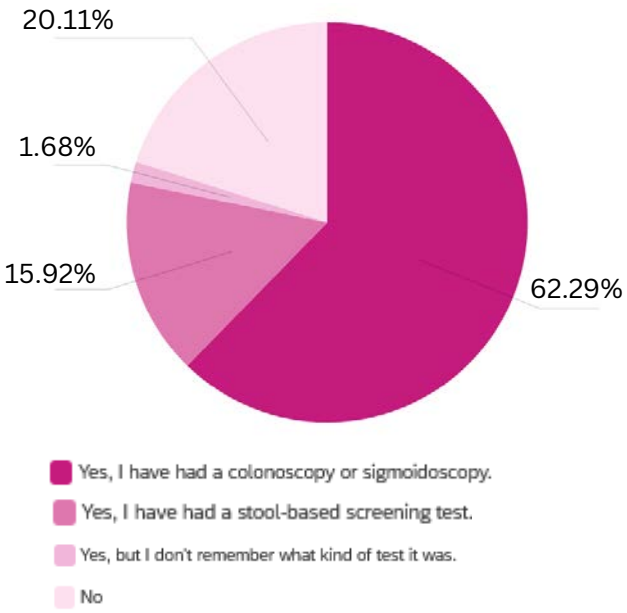


FIGURE HC.12. COLORECTAL CANCER SCREENING COMPLETED

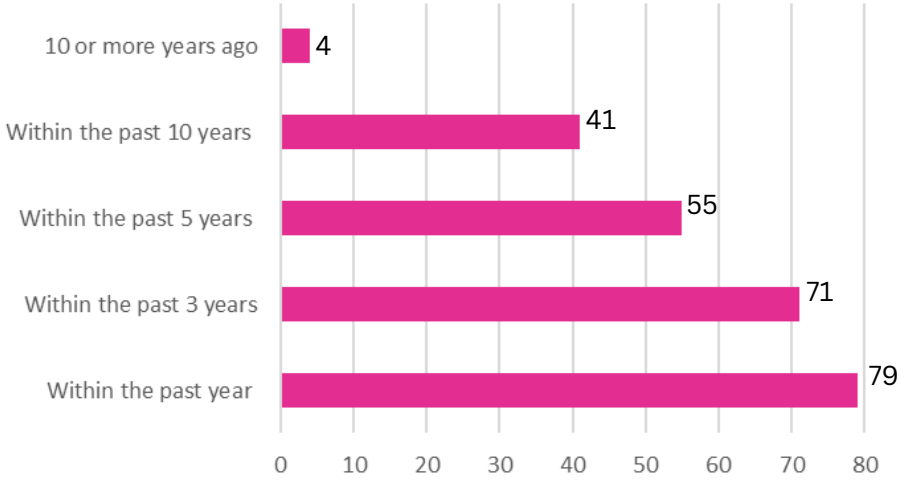


Figure HC.13 displays the percentages of the 467 survey respondents answering if they have received a cervical cancer screening (pap test). Figure HC.14 displays the count for the 402 survey respondents answering when they has this screening completed. Figure HC.14 excludes "prefer not to answer" and "not sure" responses.

FIGURE HC.13. CERVICAL CANCER SCREENING (PAP TEST)

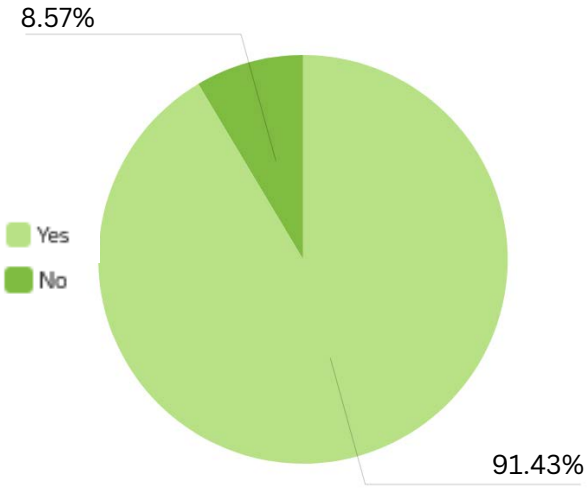
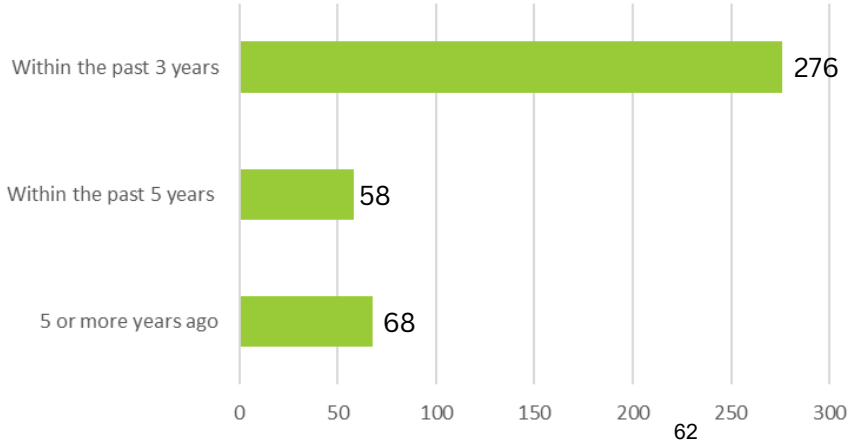


FIGURE HC.14. CERVICAL CANCER SCREENING (PAP TEST) COMPLETED



HEALTHCARE ACCESS

SCREENINGS

Figure HC.15 displays the percentage of the 301 survey respondents answering if they have received a breast cancer screening (mammogram). Figure HC.16 displays the count for the 273 survey respondents answering when they had this screening completed. Figure HC.16 excludes "prefer not to answer" and "not sure" responses.

FIGURE HC.15. BREAST CANCER SCREENING (MAMMOGRAM)

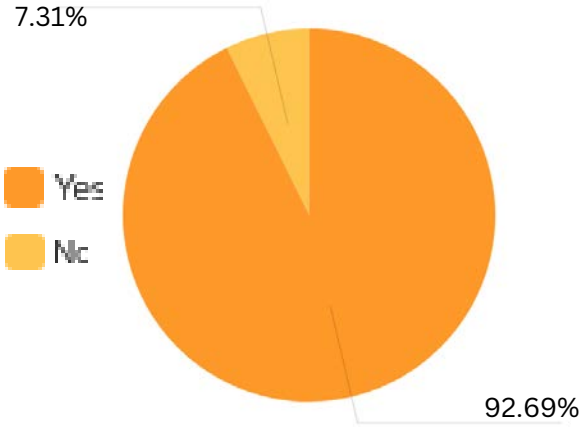


FIGURE HC.16. BREAST CANCER SCREENING (MAMMOGRAM) COMPLETED

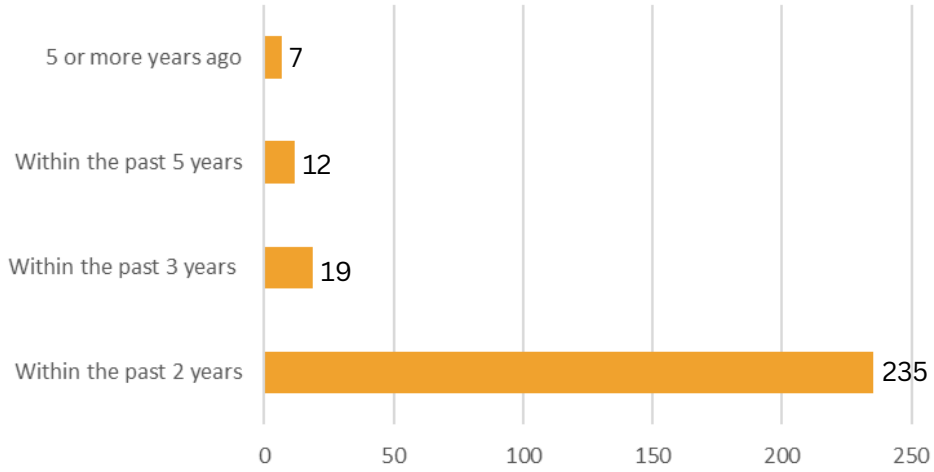


Figure HC.17 displays the percentage of the 593 survey respondents answering if they have had their cholesterol levels checked. Figure HC.18 displays the count for the 457 survey respondents answering when they had this exam completed. Figure HC.18 excludes "prefer not to answer" and "not sure" responses.

FIGURE HC.17. CHOLESTEROL LEVELS CHECKED

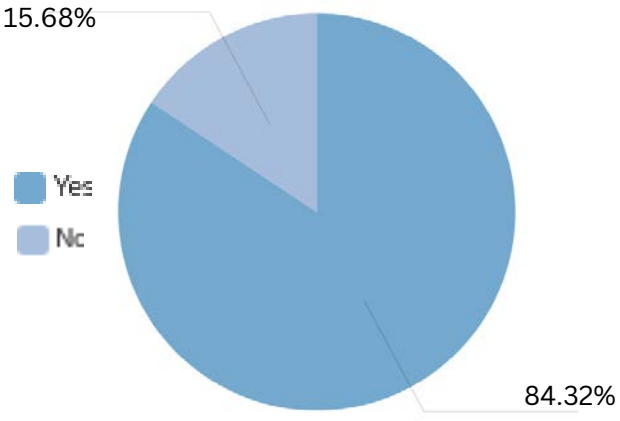
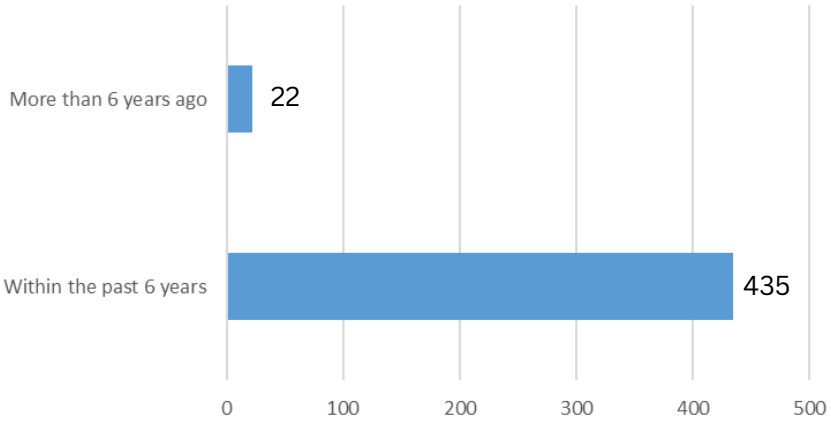


FIGURE HC.18. CHOLESTEROL LEVELS



HEALTHCARE ACCESS

SCREENINGS

Figure HC.19 displays the percentage of the 305 survey respondents answering if they have received a blood sugar (diabetes) test. Figure HC.20 displays the count for the 191 survey respondents answering when they had this test completed. Figure HC.20 excludes "prefer not to answer" and "not sure" responses.

FIGURE HC.19. BLOOD SUGAR (DIABETES) TEST

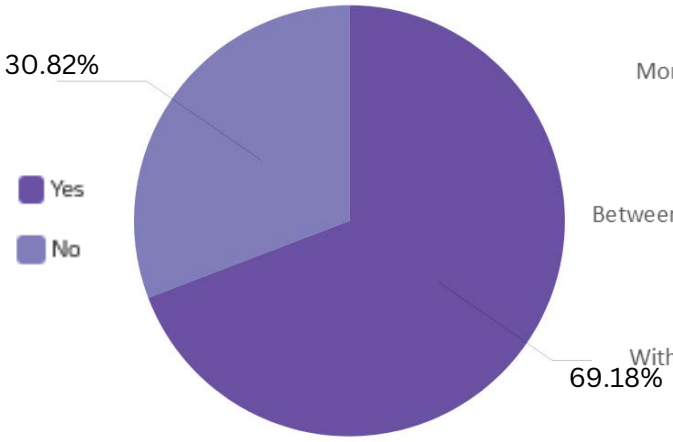


FIGURE HC.20. BLOOD SUGAR (DIABETES) TEST COMPLETED

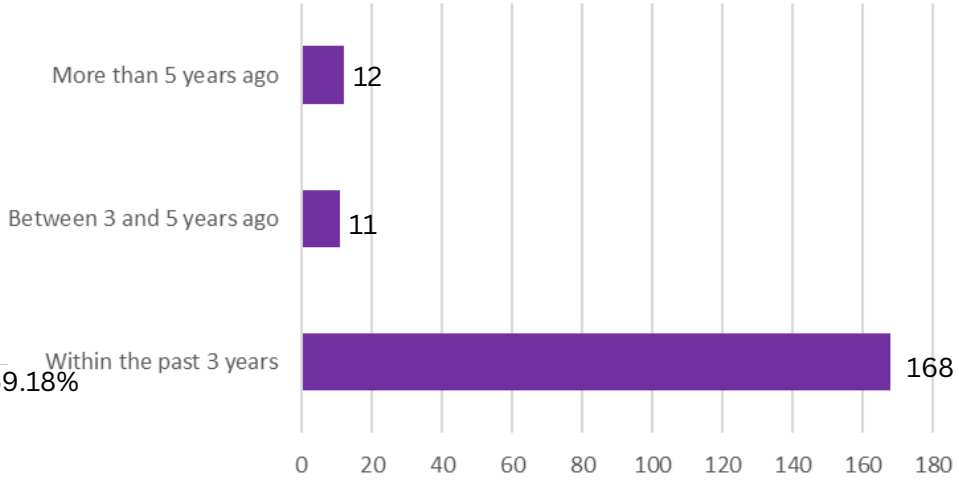


Figure HC.21 displays the percentage of the 571 survey respondents answering if they have been tested for HIV. Figure HC.22 displays the count for the 457 survey respondents answering when they had this exam completed. Figure HC.22 demonstrates 68.42% (N=13) of survey respondents answered yes to being tested for HIV and are identified at higher risk

FIGURE HC.21. HIV TESTING

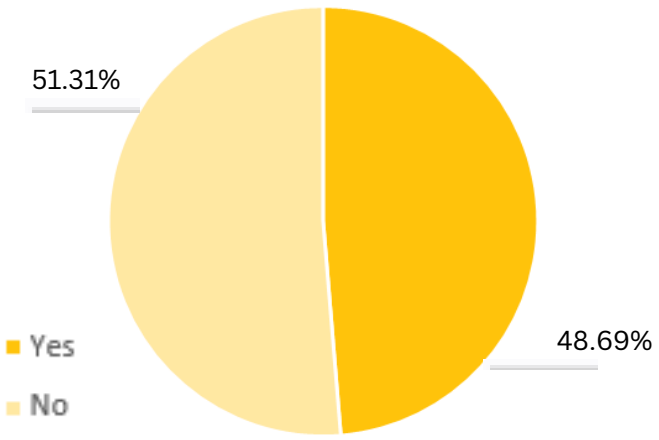
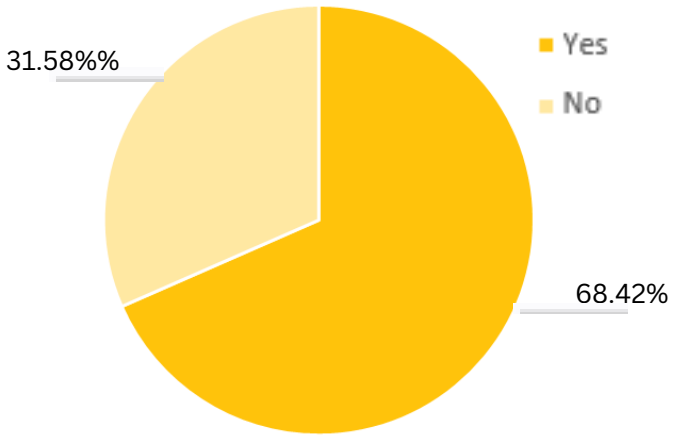


FIGURE HC.22. RESPONSES OF HIGHER RISK POPULATION AND HIV TESTING



FOOD SECURITY

This section of the assessment provides information on specific populations currently struggling with food security. Food security is defined as “having, at all times, both physical and economic access to sufficient food to meet dietary needs for a productive and healthy lifestyle” [1]. According to Feeding America, 1 in 14 people in Iowa face hunger[2]. Food insecurity can influence poor health outcomes. One study states that chronic diseases are higher among food insecure individuals [3]. HealthyJoCo asks questions regarding the frequency of individuals cutting or skipping meals, utilization of local food banks, food supply and access to nutritional meals. While conducting the survey some limitations emerged in regards to the wording of the questions; it was observed that some respondents received aid through the Supplemental Nutrition Assistance Program (SNAP) and therefore did not answer experiencing food insecurity. Numbers of food insecure people are likely larger than we represented in the survey.

MAIN FINDINGS

Disparities by income - The median household income in Johnson County is $67, 134 [4]. Our data reflects Johnson County residents who made more than the median income are less likely to report food insecurity in all areas measured by the assessment (skipping meals, whole days without food, utilization of emergency food, sustainability of food and balanced meals).

Disparities by race and ethnicity- More Black or African Americans and Hispanic or Latino/a/x respondents struggled with food insecurity compared to White respondents in all areas measured by the assessment.

Disparities by education levels- Overall trends in the assessment show respondents with lower education had higher rates of food insecurity than those with higher education in all areas of the assessment.

Difficulties affording a balanced meal-Johnson County respondents that identify as LGBTQ+ are less likely to experience difficulties affording balanced meals (32%) compared to the state prevalence of LGBTQ+ Iowans (36.2%) [5].

[1] USAID. (2022, February 03). Agriculture and Food Security. https://www.usaid.gov
[2] Hunger in Iowa. Feeding America. (n.d.) https://www.feedingamerica.org
[3] Gregory, C. A., & Coleman-Jensen , A. (2017, July). Food insecurity, chronic disease, and health among working-age ... - USDA. Economic Research Service. Retrieved December 19, 2022, from https://www.ers.usda.gov
[4] U.S. Census Bureau. (2021). American Community Survey 1 Year Estimates Subject Tables (S1901INCOME IN THE PAST 12 MONTHS (IN 2021 INFLATION-ADJUSTED DOLLARS) [Data set]. U.S. Census Bureau. Retrieved December 12, 2022, from https://data.census.gov
[5] Iowa Department if Health and Human Services, Division of Public Health, Bureau of Public Health Performance. Iowa BRFSS Brief:2021 Survey Findings. Des Moines: Iowa Dept. of Health and Human Services. Published October 2022. Web. https://www.idph.iowa.gov/brfss

FOOD SECURITY

CUTTING OR SKIPPING MEALS DUE TO COST

Figure FS.1, below, shows the percentage of survey respondents that indicated they cut or skipped meals because there wasn't enough money for food (N=620). The total number of respondents was 620. 19.03% responded yes meanwhile 80.97% of respondents did not experience cutting or skipping meal size.

FIGURE FS.1: TOTAL RESPONSES OF CUT OR SKIPPED MEAL SIZE (PERCENT)

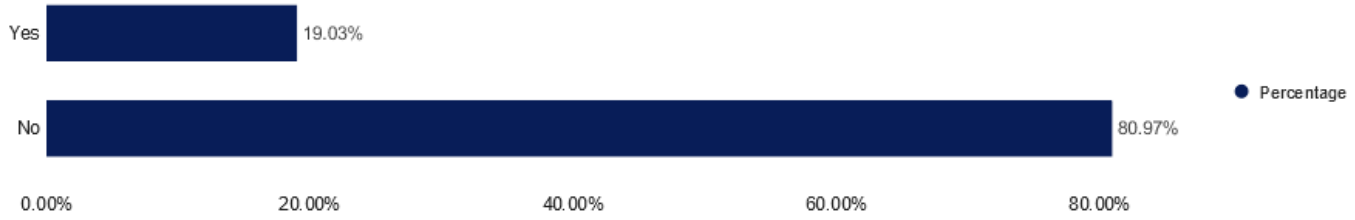
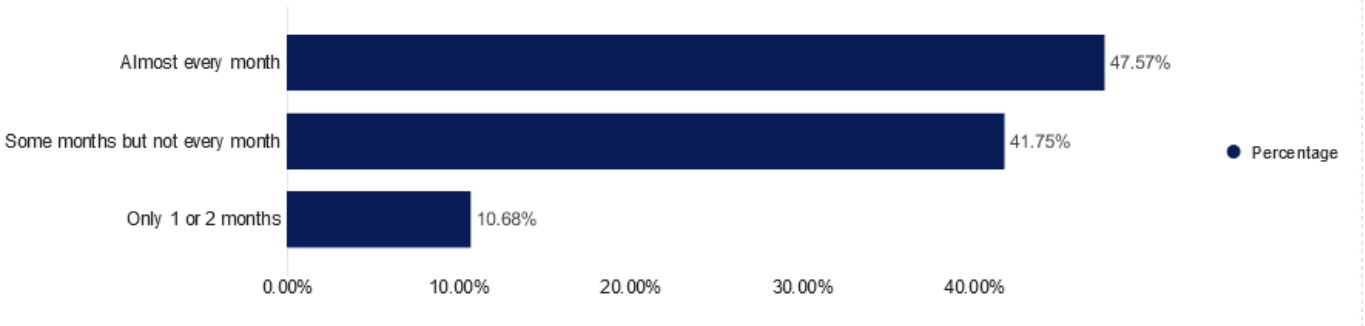


Figure FS.2, below, shows the frequency of survey respondents that indicated they did cut or skipped meals because there wasn't enough money for food in percentages. Many respondents stated that it occurred almost every month (47.57%) or some months but not every month (41.75%).

FIGURE FS.2: FREQUENCY OF RESPONSES THAT CUT OR SKIPPED MEAL SIZE (PERCENT)



FOOD SECURITY

CUTTING OR SKIPPING MEALS DUE TO COST

Table FS.1, below, describes the dis-aggregated data by race and ethnicity. Among the respondents that said yes to cutting or skipping meals Black or African Americans (51.43%) and Hispanic or Latino/a/x (49.09%) had higher percentages than other racial groups.

TABLE FS.1: RESPONSES OF CUT OR SKIPPED MEAL SIZE BY RACE AND ETHNICITY (PERCENT)

Question		Total*	Black or African American		Middle Eastern or North African		Asian		White		Hispanic or Latino/a/x	
Yes		100	51.43%	18	-	-	-	-	10.75%	50	49.09%	27
No		477	.49%	17	.86%	6	.75%	9	89.25%	415	50.91%	28
	Total		Total	35	Total	7	Total	12	Total	465	Total	55

*Table combines categories that are not shown due to too small sample size.

Figure FS.3, below, shows the percentage of survey respondents that indicated they cut or skipped meals because there wasn't enough money for food by income levels. Overall, individuals that had higher income were more likely to not experience cutting or skipping meals due to cost.

FIGURE FS3: RESPONSES OF CUT OR SKIPPED MEAL SIZE BY INCOME (PERCENT)

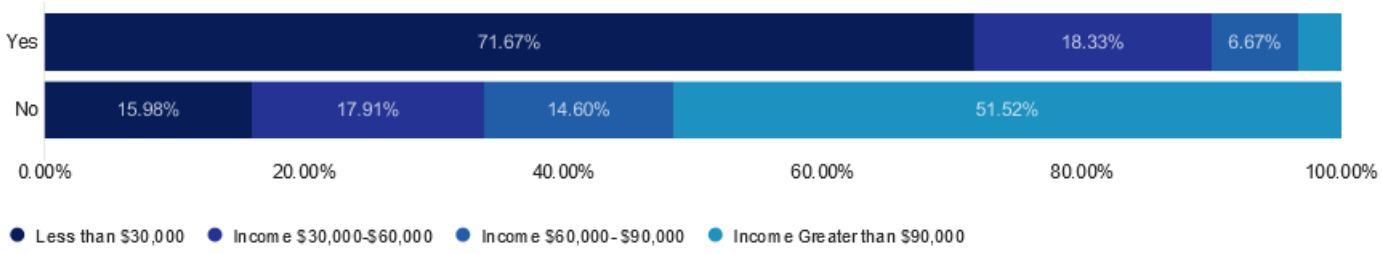


*Figure combines categories that are not shown due to too small sample size.

FOOD SECURITY

CUTTING OR SKIPPING MEALS DUE TO COST

Figure FS.4 below describes the percentage of respondents that indicated they cut or skipped meals because there wasn't enough money for food by their education level. Some categories were combined in order to have a significant sample size. As shown, individuals with higher education were less likely to experience cutting or skipping meals due to cost.

FIGURE FS.4: RESPONSES OF CUT OR SKIPPED MEAL SIZE BY EDUCATION LEVEL (PERCENT)

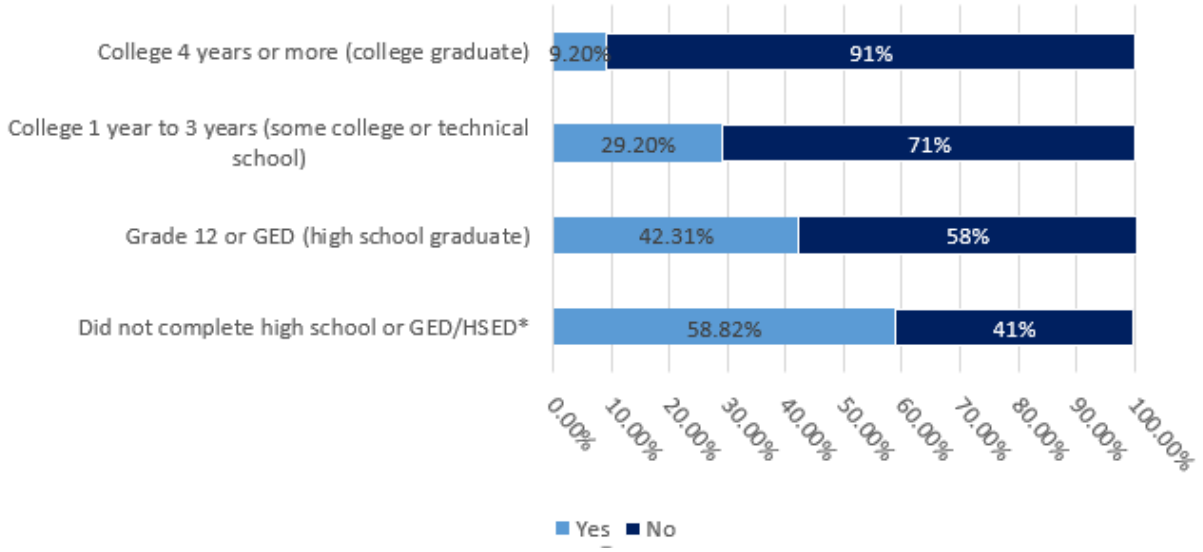
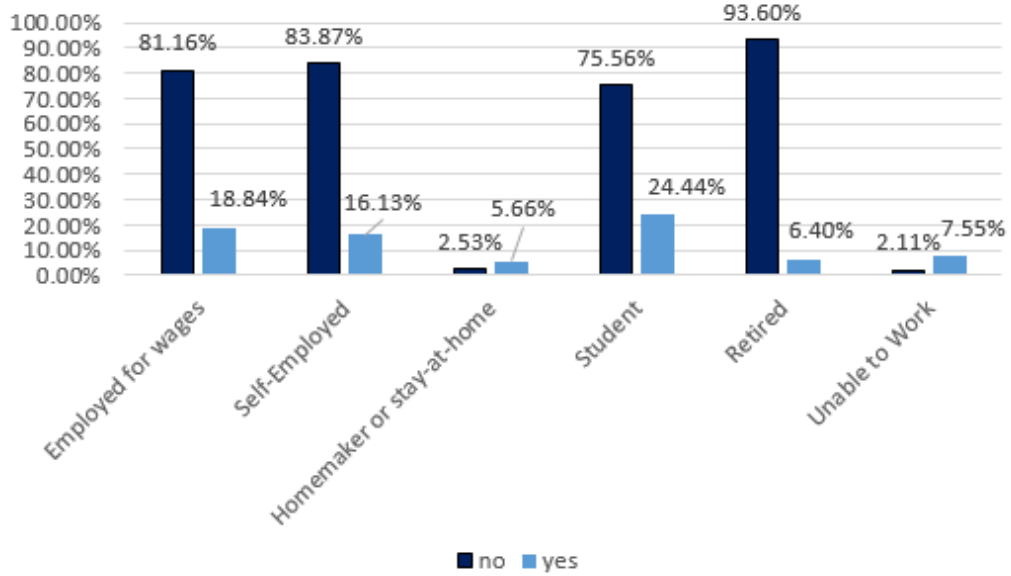


Figure FS.5 below describes the percentage of respondents that indicated they cut or skipped meals because there wasn't enough money for food by their employment type. Specific populations that stand out in skipping or cutting meals are students, individuals unable to work, employed for wages and self-employed.

FIGURE FS.5: RESPONSES OF CUT OR SKIPPED MEAL SIZE BY INCOME (PERCENT)



FOOD SECURITY

WHOLE DAY(S) WITHOUT FOOD

Figure FS. 6, below, describes the percentage of respondents that indicated not eating for a whole day because there wasn't enough money for food in the last 12 months (N=606). 8.42% of survey respondents answered yes meanwhile 91.58% answered no.

FIGURE FS.6 TOTAL RESPONSES OF WHOLE DAY(S) WITHOUT FOOD (PERCENT)

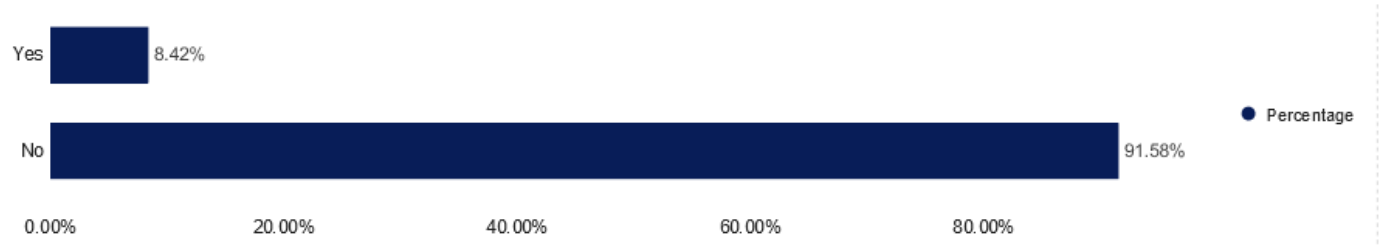


Figure FS. 7, below, describes the frequency of respondents that indicated not eating for a whole day because there wasn't enough money for food in the last 12 months. 47.83% had experienced whole day(s) without food almost every month. 41.30% experienced it some months, but not every month and 10.87% only 1 or 2 months.

FIGURE FS.7: FREQUENCY OF WHOLE DAY(S) WITHOUT FOOD (PERCENT)

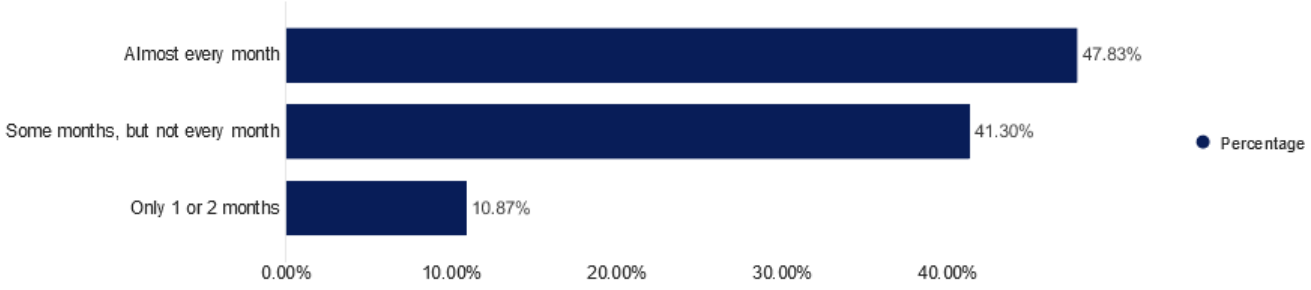


Table FS. 2, below, describes the count and percentage of respondents that indicated not eating for a whole day because there wasn't enough money for food in the last 12 months disaggregated by race and ethnicity. Among the racial and ethnic groups represented, Black or African American (32.35%) and Hispanic or Latino/a/x had a higher percentage of whole day(s) without food (White 3.97%).

TABLE FS.2: RESPONSES OF WHOLE DAY(S) WITHOUT FOOD BY RACE AND ETHNICITY

Whole Day(s) without food	Total*		Black or African American		Middle Eastern or North African		Asian		White		Hispanic or Latino/a/x	
Yes		43	32.35%	11	-	-	-	-	3.87%	18	49.09%	12
No		547	.68%	23	.86 %	6	.90%	9	95.27%	443	84.62%	66
	Total		Total	34	Total	7	Total	10	Total	461	Total	78

FOOD SECURITY

WHOLE DAY(S) WITHOUT FOOD

Figure FS. 8, below, describes the percentage of respondents that indicated not eating for a whole day because there wasn't enough money for food in the last 12 months dis-aggregated by income. Overall, respondents that had an income less than $30,000 (78%) and income between $30,000-$60,000 (13%) were more likely to experience whole day(s) without food as compared to respondents with income between $60,000- $90,000 (4%) and income greater than $90,000 (4%).

FIGURE FS.8 RESPONSES OF WHOLE DAY(S) WITHOUT FOOD BY INCOME (PERCENT)

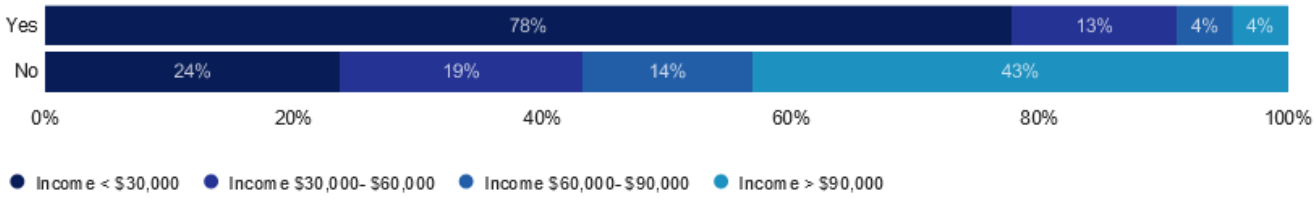
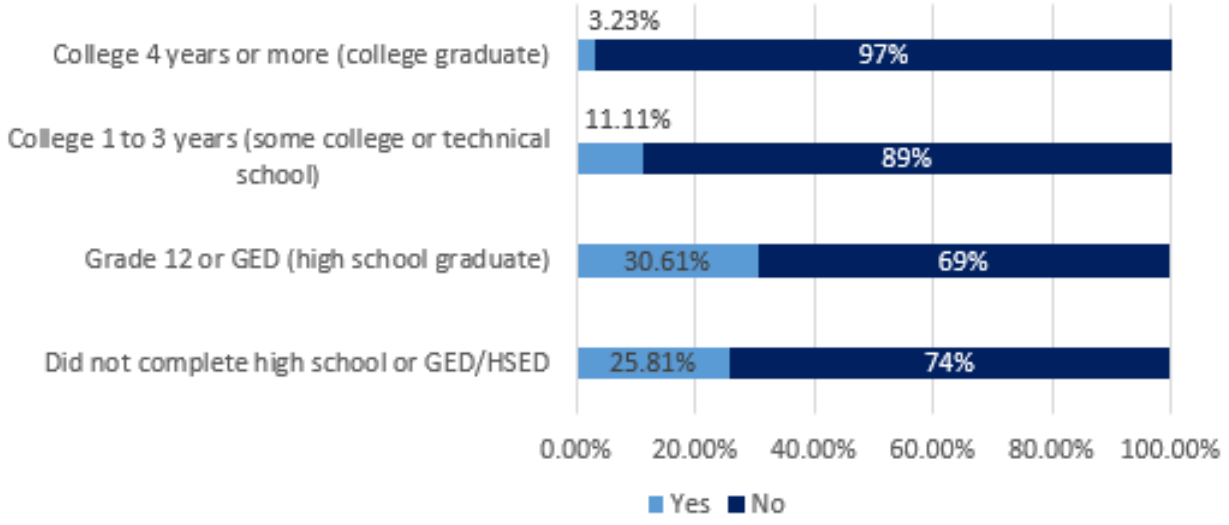


Figure FS. 9, below, describes the percentage of respondents that indicated not eating for a whole day because there wasn't enough money for food in the last 12 months dis-aggregated by education level. Noticeable trends seen are that as education levels increase, the percentages of respondents who've experienced whole day(s) without food decreases.

FIGURE FS.9: RESPONSES OF WHOLE DAY(S) WITHOUT FOOD BY EDUCATION LEVEL (PERCENT)



FOOD SECURITY

EMERGENCY FOOD UTILIZATION

Figure FS.10, below, describes the percentage of respondents that accessed emergency food from a church, a food pantry, or a food bank or eat in a soup kitchen in the last 12 months (N=114). Approximately 54.38% of respondents indicated they do access emergency food services. 45.61% described not using these services.

FIGURE FS.10: RESPONSES OF EMERGENCY FOOD UTILIZATION (PERCENT)

Table FS.3,below, describes the count and percentage of respondents that accessed emergency food from a church, a food pantry, or a food bank or eat in a soup kitchen in the last 12 months dis-aggregated by race and ethnicity.

TABLE FS.3: RESPONSES OF EMERGENCY FOOD UTILIZATION BY RACE AND ETHNICITY

		Total*	Black or African American		White		Hispanic or Latino/a/x	
Yes		48	61.11%	11	35.42%	17	76.92%	20
No		44	.39%	7	64.58%	31	23.08%	6
	Total		Total	18	Total	48	Total	26

FOOD SECURITY

EMERGENCY FOOD UTILIZATION

Figure FS.11, below, describes the percentage of respondents that accessed emergency food from a church, a food pantry, or a food bank or eat in a soup kitchen in the last 12 months dis-aggregated by income.

FIGURE FS.11: RESPONSES OF EMERGENCY FOOD UTILIZATION BY INCOME (PERCENT)

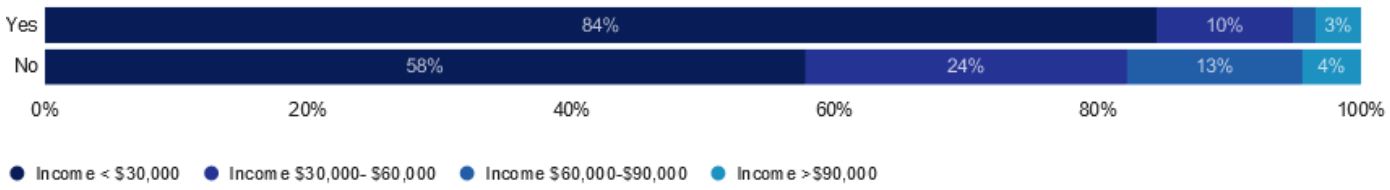
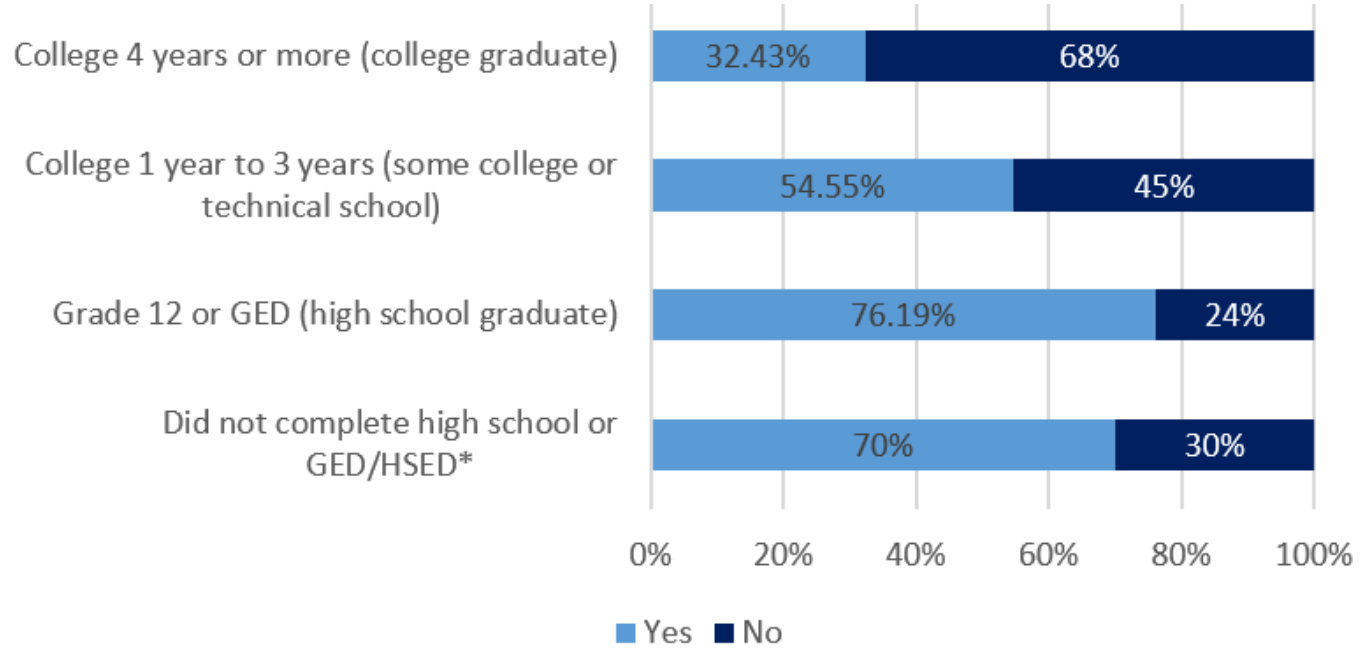


Figure FS.12, below, describes the percentage of respondents that accessed emergency food from a church, a food pantry, or a food bank or eat in a soup kitchen in the last 12 months dis-aggregated by education level.

FIGURE FS.12: RESPONSES OF EMERGENCY FOOD UTILIZATION BY EDUCATION LEVEL (PERCENT)



FOOD SECURITY

FOOD SUSTAINABILITY

Figure FS.13, below, describes the responses of the statement, "the food that I bought just didn't last, and I didn't have money to get more" (N=598). Food sustainability amongst respondents was 7.19% indicated often true. 13.05% sometimes true and 79.77% never true.

FIGURE FS.13: FOOD SUSTAINABILITY (PERCENT)

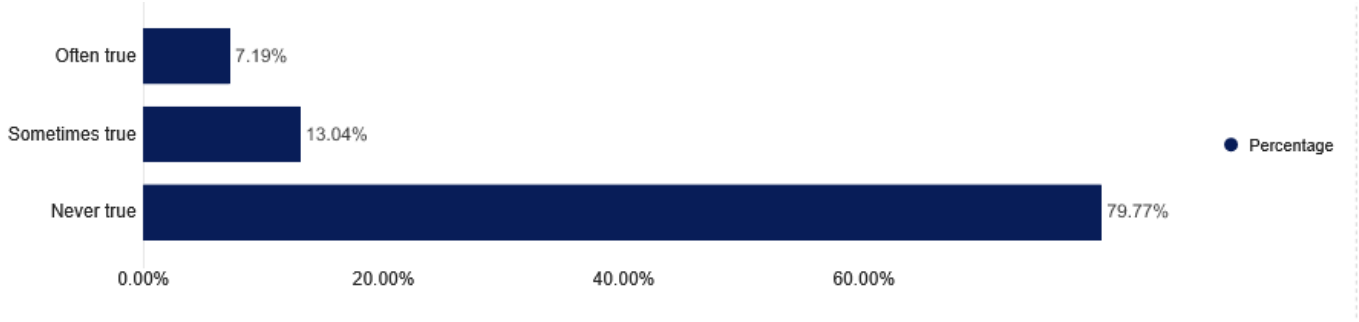


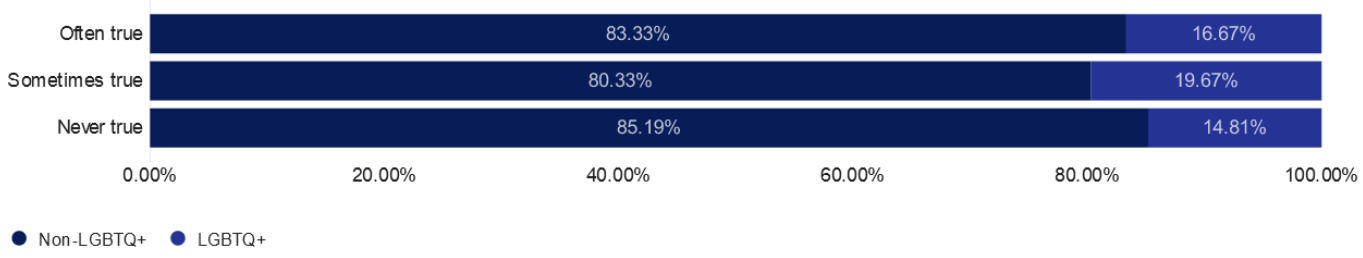
Table FS.4, below, describes the count and percentage of the statement disaggregated by race and ethnicity. Among the respondents that answered often true (7.19%), 15.15% were Black or African American, 3.95% White and 23.53% Hispanic or Latino/a/x.

TABLE FS.4: FOOD SUSTAINABILITY BY RACE AND ETHNICITY

Question	Total*		Black or African American		White		Hispanic or Latino/a/x	
Often true		36	15.15%%	-	3.95%%	18	23.53%	12
Sometimes true		62	.36%	12	6.80%	31	33.33%	17
Never true		450	.48%%	16	89.25%	407	43.14%	22
	Total		Total	33	Total	456	Total	51

Figure FS.14, below, describes percentage of the statement dis-aggregated by sexual orientation. Among respondents that identify as LGBTQ+, 16.67% related often true, 19.67% sometimes true and 14.81% never true.

FIGURE FS.14: FOOD SUSTAINABILITY BY SEXUAL ORIENTATION (PERCENT)



FOOD SECURITY

FOOD SUSTAINABILITY

Figure FS.15, below, describes the percentage of responses that had difficulties with food sustainability dis-aggregated by income. Respondents with income levels greater than $60,00 were less likely to relate to the statement of "the food that I bought just didn't last, and I didn't have money to get more."

FIGURE FS.15: FOOD SUSTAINABILITY BY INCOME (PERCENT)

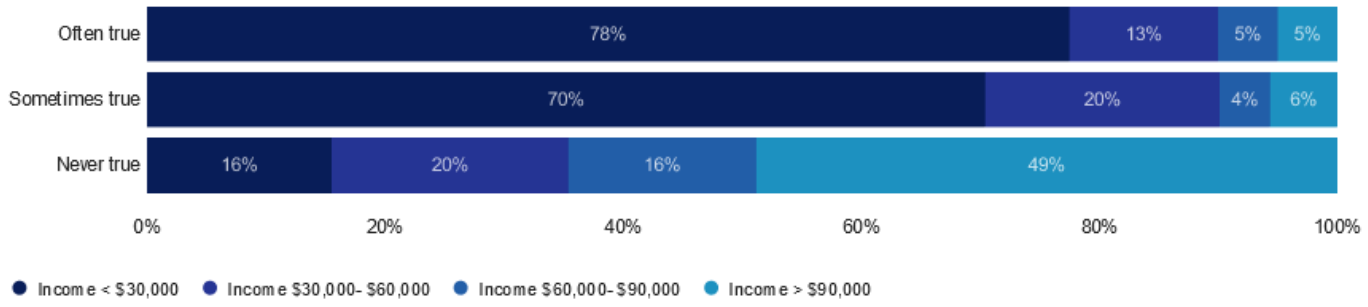
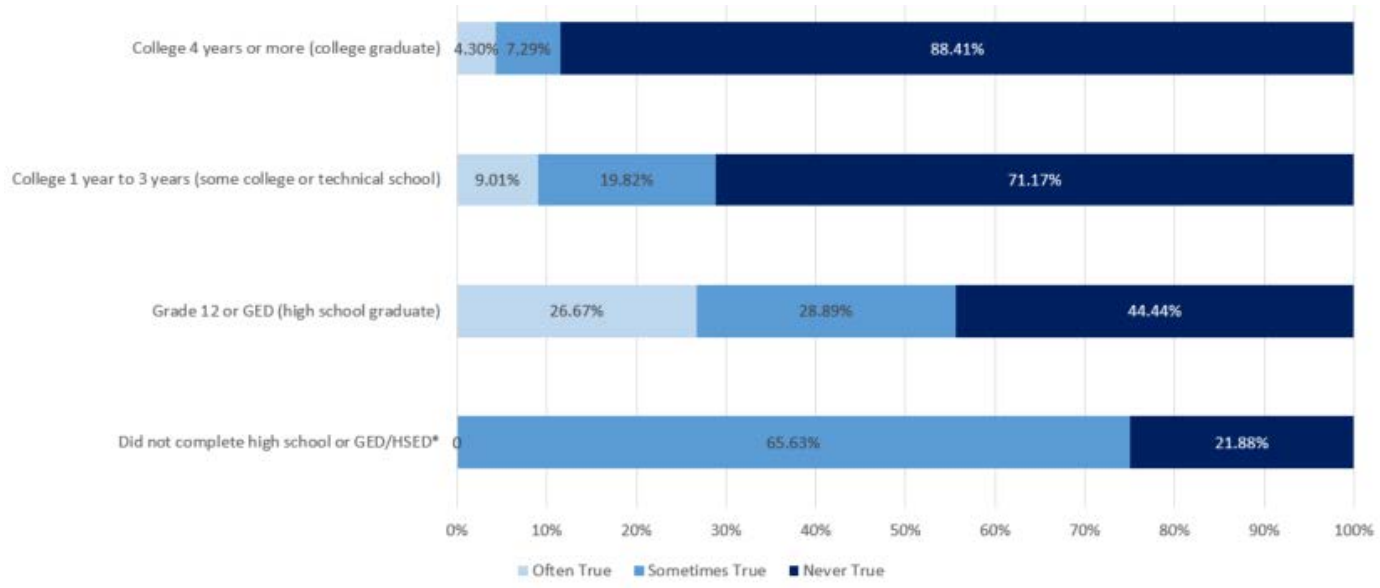


Figure FS.16, below, describes the percentage of respondents that that had difficulties with food sustainability dis-aggregated by education level. The statement was most often never true with respondents that had higher education (88.41%).

FIGURE FS.16: FOOD SUSTAINABILITY BY EDUCATION LEVEL (PERCENT)



FOOD SECURITY

BALANCED MEALS

Figure FS.17, below, shows the total responses to the statement, "I couldn't afford to eat balanced meals" (N=598). Approximately, 9.03% of respondents describe difficulties affording balanced meals as often true, 17.89% sometimes true and 73.08% never true.

FIGURE FS.17: TOTAL RESPONSES OF BALANCED MEALS (PERCENT)

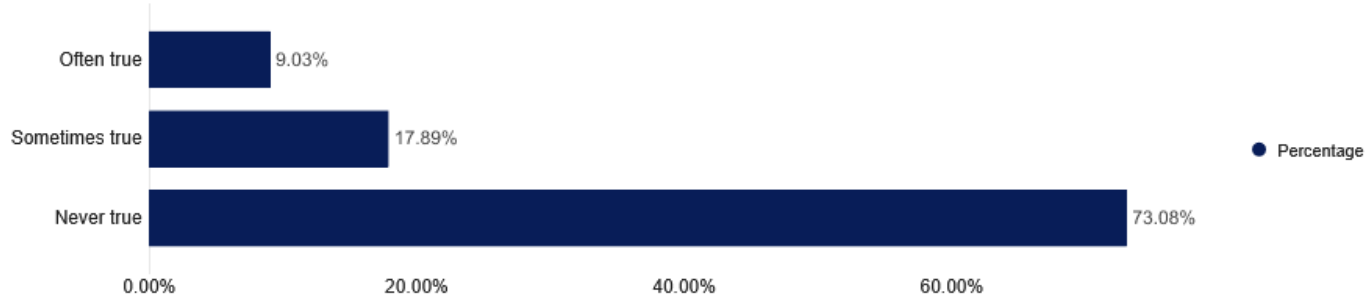


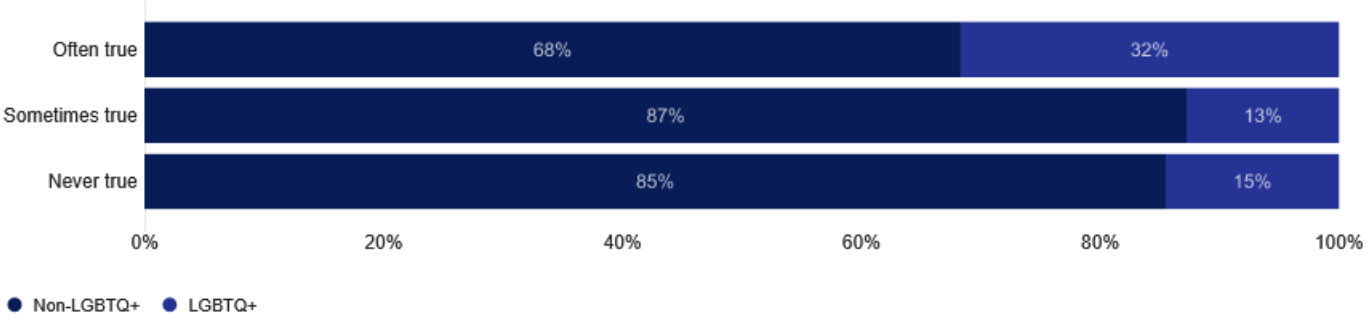
Table FS.5, below, describes the count and percentage of responses that had difficulties affording balanced meals dis-aggregated by race and ethnicity.

TABLE FS.5: RESPONSES OF BALANCED MEALS BY RACE AND ETHNICITY

	Total*		Black or African American		Asian		White		Hispanic or Latino/a/x	
Often True		50	21.21%	7		-	6.28%	29	20.41%	10
Sometimes True		97	39.39%	13		-	12.55%	58	42.86%	21
Never True		415	39.39%	13	60.00%	6	81.17%	375	36.73%	18
Total			Total	33	Total	10	Total	462	Total	49

Figure FS.18, below, describes the percentage of respondents that that had difficulties affording balanced meals dis-aggregated by sexual orientation Among the respondents that identified as LGBTQ+, 32% stated often true, 13% sometimes true and 15% never true to not affording to eat balanced meals.

FIGURE FS.18: FOOD SUSTAINABILITY BY SEXUAL ORIENTATION (PERCENT)



FOOD SECURITY

BALANCED MEALS

Figure FS.19, below, shows the percentages of responses having difficulties affording balanced meals by income. Respondents with income less than $30,000 (78%) and income between $30,000-$60,000 (14%) also described the statement as often true.

FIGURE FS.19: RESPONSES OF BALANCED MEALS BY INCOME (PERCENT)

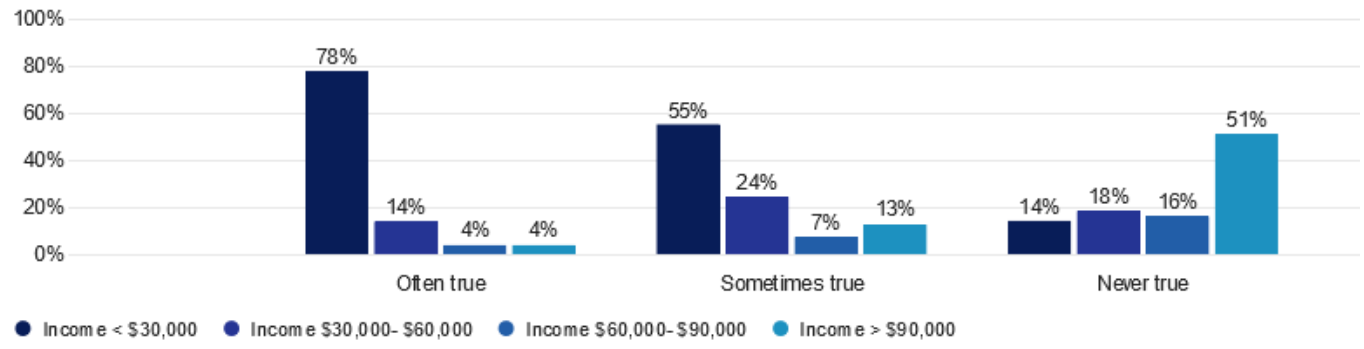
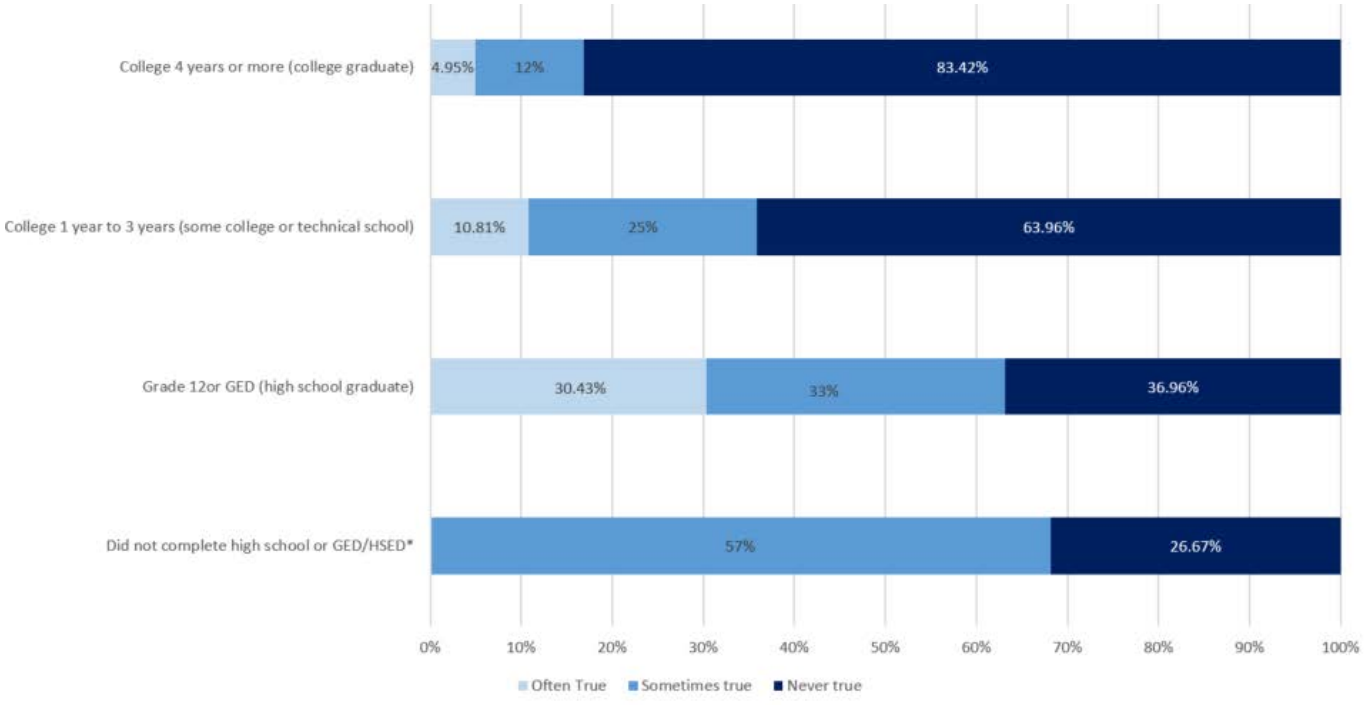


Figure FS.20, below, describes the percentage of respondents that that had difficulties affording balanced meals dis-aggregated by education levels. Among the respondents with higher education, the statement was often, "never true".

FIGURE FS.20: FOOD SUSTAINABILITY BY EDUCATION LEVELS (PERCENT)



HOUSING

Most survey respondents who provided their housing information (n=691) were homeowners (61%), while 33% rented and 4% reported another living arrangement.

FIGURE H.1. HOUSING STATUS

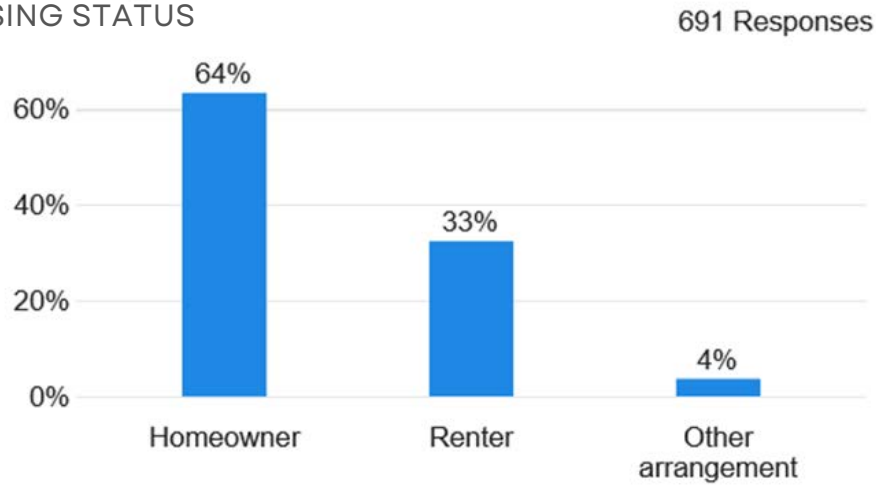


FIGURE H.2. HOUSING STATUS, BY AGE

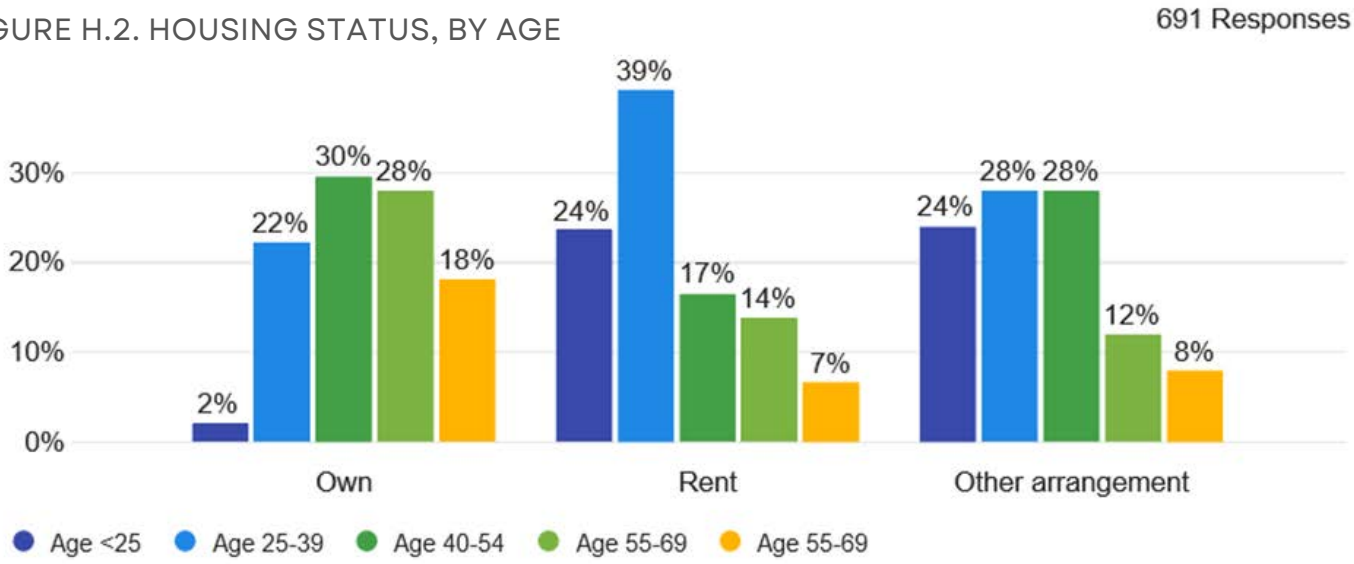


TABLE H.1. HOUSING CHARACTERISTICS IN COMMUNITY STATUS ASSESSMENT (CSA) SAMPLE VS. POPULATION OF JOHNSON COUNTY, IA

	CSA Sample	Johnson County Population[1]
Owner-occupied housing rate	63.7%	59.4%
Median monthly gross rent	$753	$1031
Median monthly owned housing cost	$1200	-
With a mortgage payment	-	$1763
Without a mortgage payment	-	$599
Persons per household	2.7	2.4

[1] United States Census Bureau. Johnson County, Iowa. 2017-2022.

HOUSING

The average reported monthly cost of rent in Johnson County was $792, while the average monthly housing payment for homeowners was $1,330. The rate of homeownership in CSA respondents was higher than that of Johnson County according to the U.S. Census, and the median reported monthly rent cost was lower (Table H.1). However, there are several known limitations in the representativeness and consistency of these responses due to the wording of the survey questions. Respondents may have entered either their portion of monthly rent or the total rent that their household pays, for example; or someone who lives in a mobile home may have reported the cost of their lot rent, while they may or may not describe themselves as a homeowner.

FIGURE H.3. RENT INCREASE IN PAST 2 YEARS, BY ANNUAL HOUSEHOLD INCOME

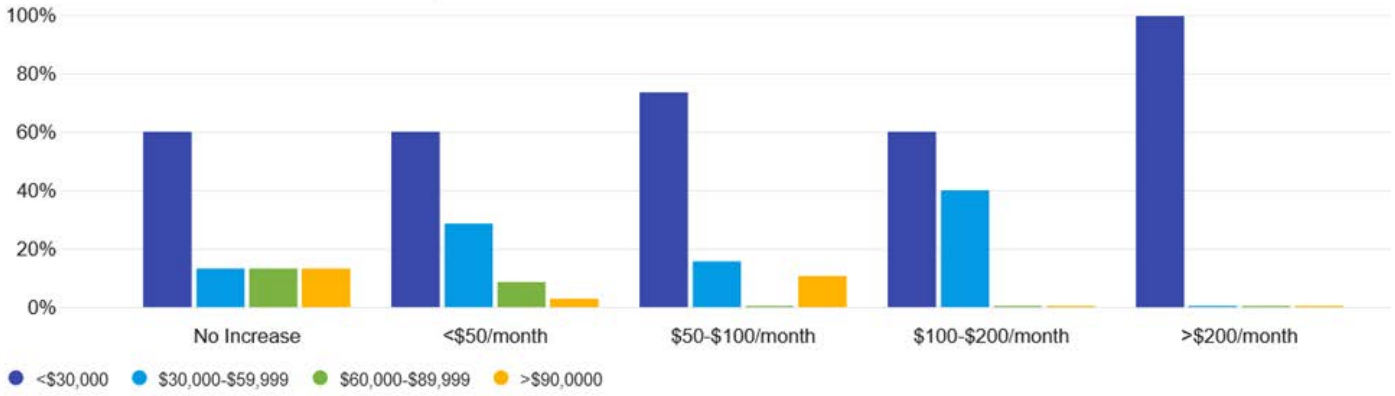
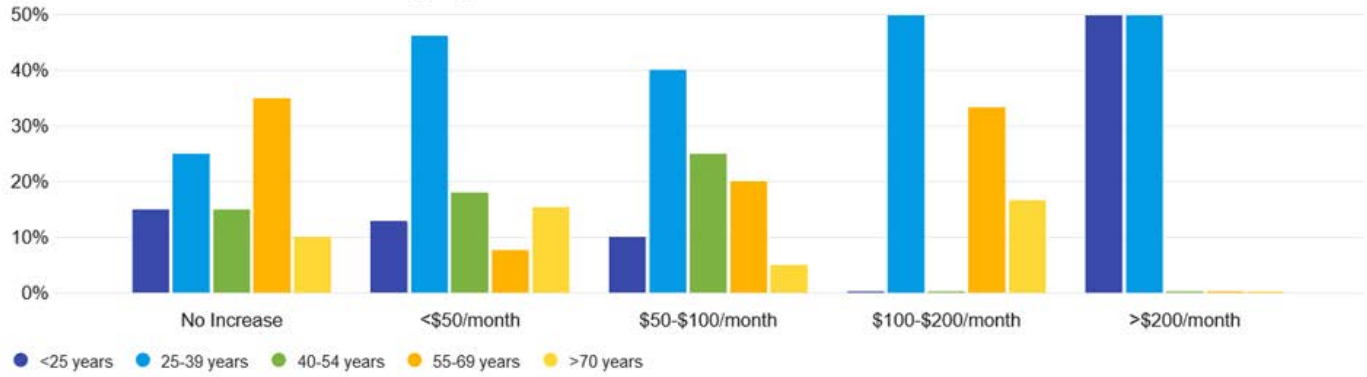


FIGURE H.4. RENT INCREASE IN THE PAST 2 YEARS, BY AGE

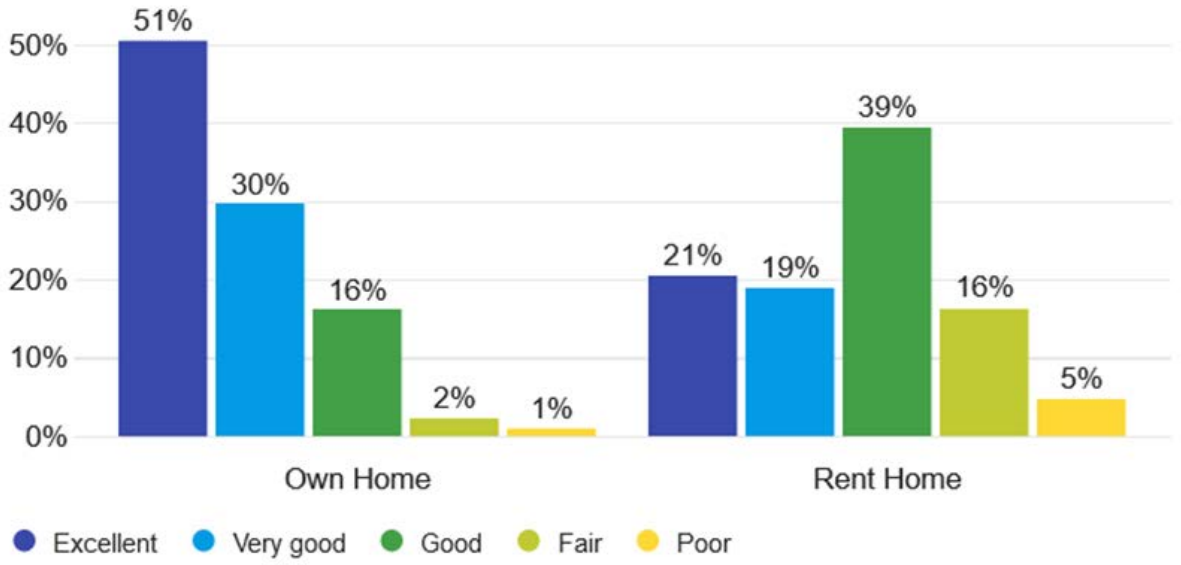


Rent costs have increased an average of 17% in the state of Iowa in 2022,[2] which would be about $128 according to the average rental price recorded from this CSA data. Most survey respondents reported that their rent had increased less than $50 per month; however, younger renters and renters with lower incomes were more likely to report higher increases in their monthly rent.

[2]Apartment List Rent Estimates: Iowa. 2022. Apartmentlist.com.

HOUSING

FIGURE H.5. REPORTED QUALITY OF HOUSING BY HOUSING STATUS



Respondents' reported quality of housing showed associations with several demographic variables. Respondents who owned their homes were most likely to rate their housing quality as "excellent," while renters were most likely to rate their housing quality as "good." Housing quality showed a consistent trend of improving as household income increased, while the likelihood of having moved within the past two years generally decreased as household income increased. Housing quality also highlighted disparities by race and ethnicity: respondents who rated their housing quality as "poor" were predominantly or Hispanic or Latinx ethnicity, and all non-white racial groups (Black or African American, Middle Eastern or North African, Asian, and American Indian or Alaska Native) as well as Hispanic or Latino/a/x ethnicity were disproportionately represented in the lower ratings of housing quality.

FIGURE H.6. REPORTED QUALITY OF HOUSING BY ANNUAL HOUSEHOLD INCOME

HOUSING

FIGURE H.7. REPORTED QUALITY OF HOUSING, BY RACE

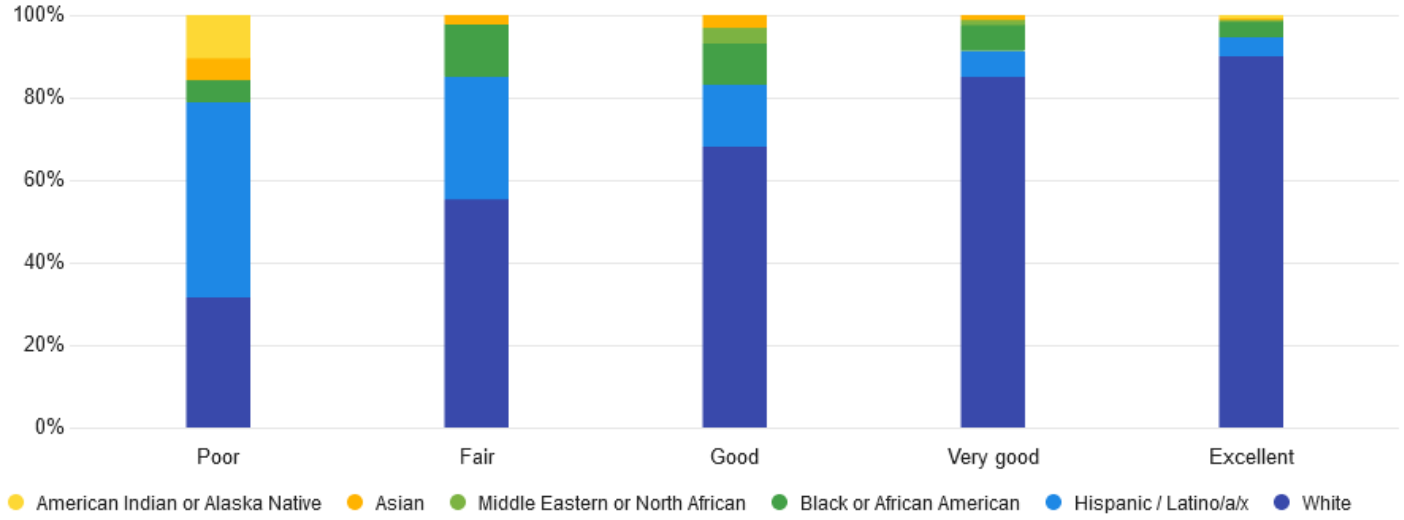


Figure H.8 (below) shows the percentage of respondents who have moved within the past 2 years by household income level. The highest percentage of respondents who indicated moving in the past 2 years reported making less than $10,000 per year.

FIGURE H.8. MOVED WITHIN THE PAST 2 YEARS, BY ANNUAL HOUSEHOLD INCOME

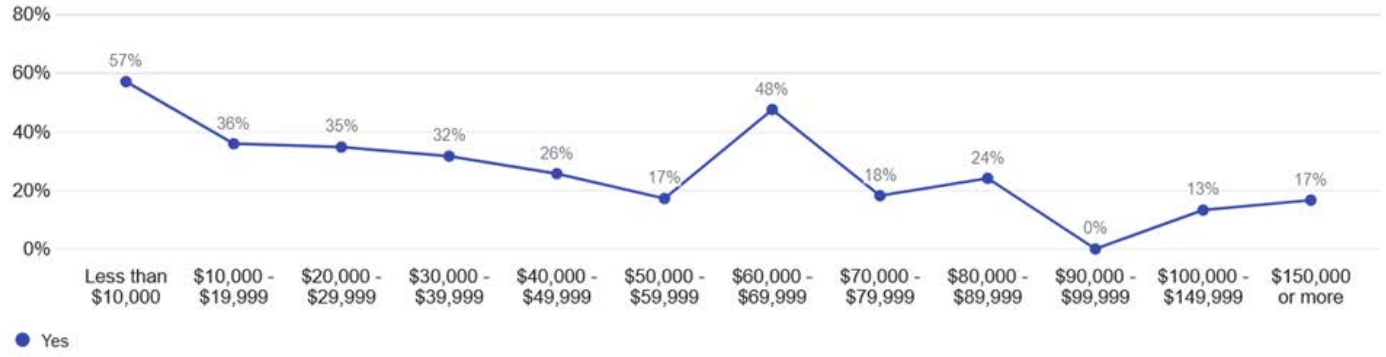
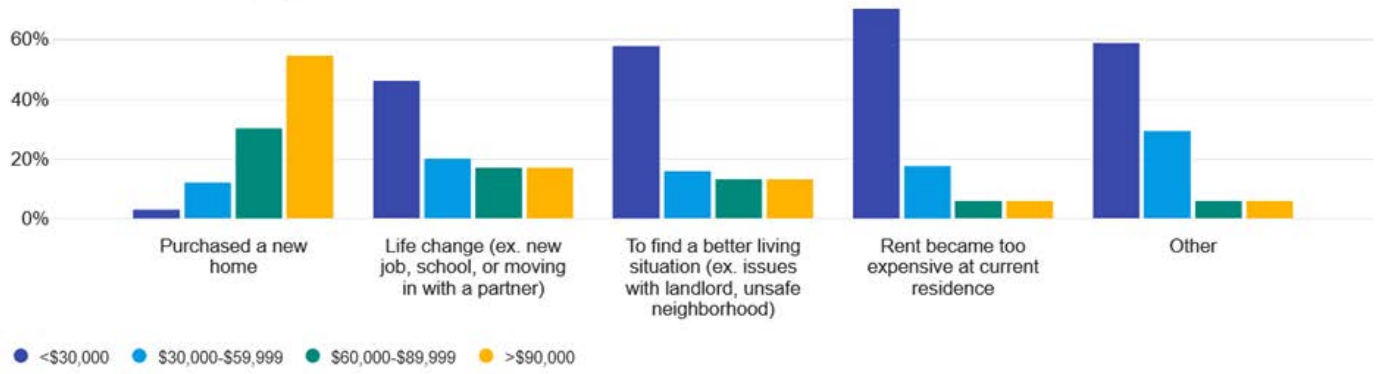


FIGURE H.9. REASONS FOR MOVING BY ANNUAL HOUSEHOLD INCOME



HOUSING

UTILITIES

Out of 104 respondents who answered the question about utility shutoffs (having responded “yes” to a previous question about difficulty affording housing expenses), 50 reported that they have experienced a water shutoff, electricity shutoff, or both while living in Johnson County. Rates of difficulty affording housing expenses and of experiencing a utility shutoff were very similar across each race and ethnicity represented (data not shown).

FIGURE H.10. UTILITY SHUT OFF EXPERIENCED
104 Responses

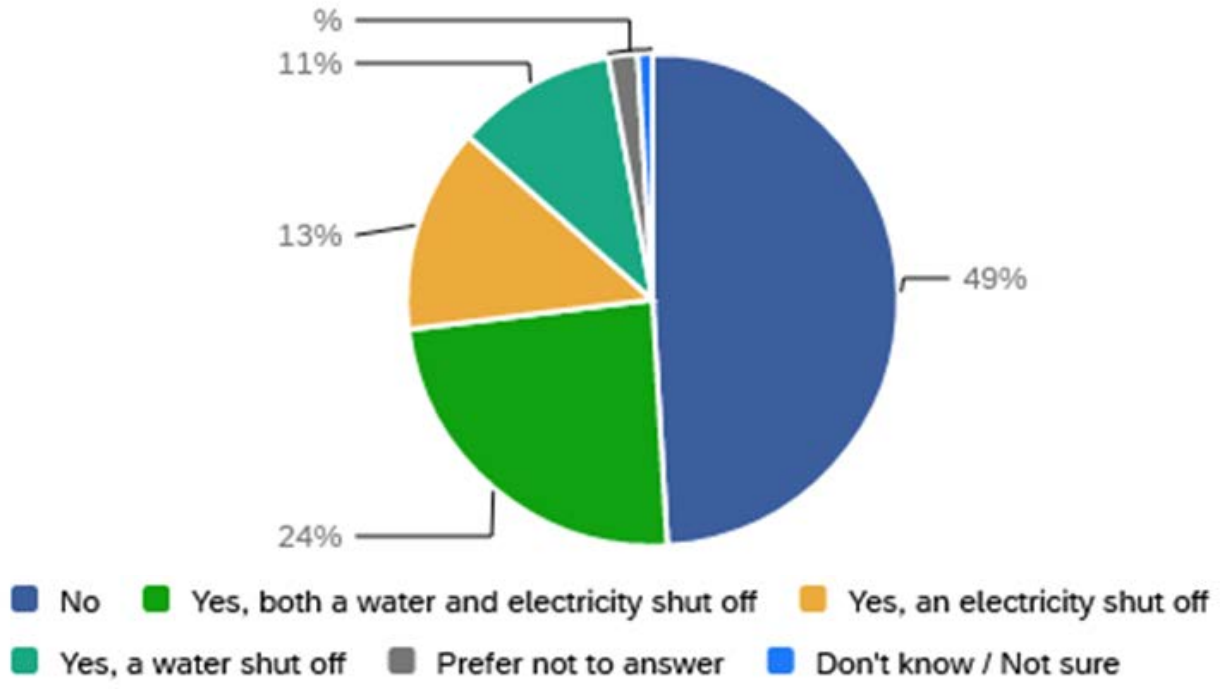


TABLE H.2. REPORTED TIME AND COST TO HAVE UTILITIES TURNED BACK ON (N=35)

	Average	Minimum	Maximum
Number of days until water or electricity was turned back on	15 days	0 days	1 year
Amount paid for water or electricity to be turned back on	$221	$0	$1000

HOUSING

EVICTION

A total of fifteen respondents (2.1%) reported that they had experienced an eviction in Johnson County in which they were forced to leave their home. While the small sample size limits the generalizability of these results, this data points to a sizeable racial disparity in evictions. 13% of respondents who identified as Black or African American had been evicted and forced to leave their home, compared to 2% of white respondents, 3% of Hispanic or Latino/a/x respondents, and 4% of respondents of other races.

FIGURE H.11. REPORTED EVICTION RATES AMONG SURVEY RESPONDENTS IN JOHNSON COUNTY, BY RACE/ETHNICITY

18 Responses

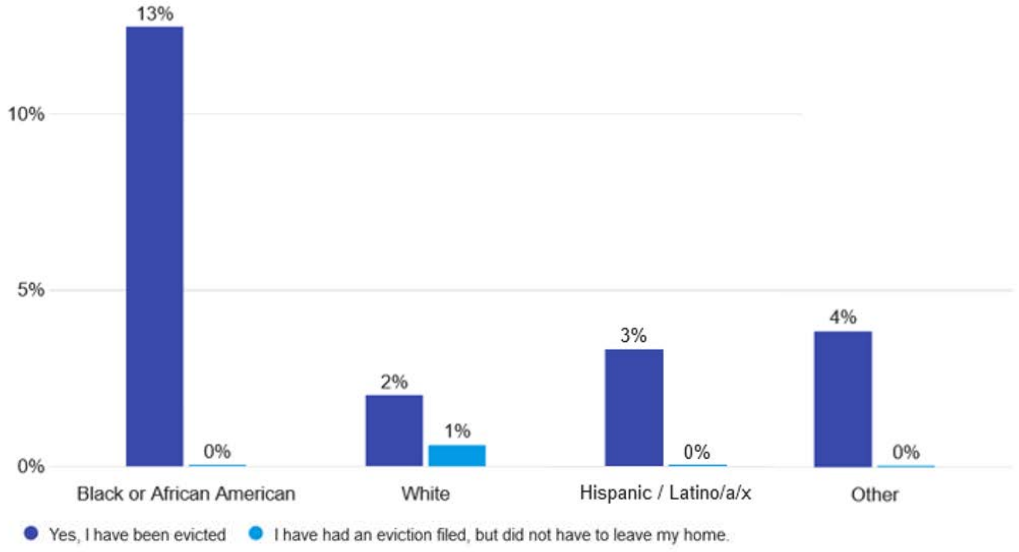
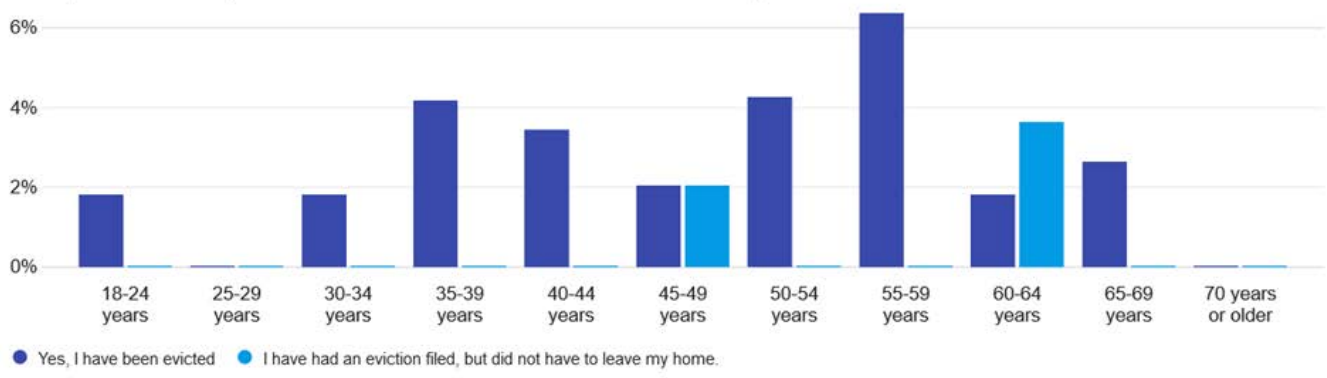


FIGURE H.12. REPORTED EVICTION RATES AMONG SURVEY RESPONDENTS IN JOHNSON COUNTY, BY AGE GROUP

18 Responses

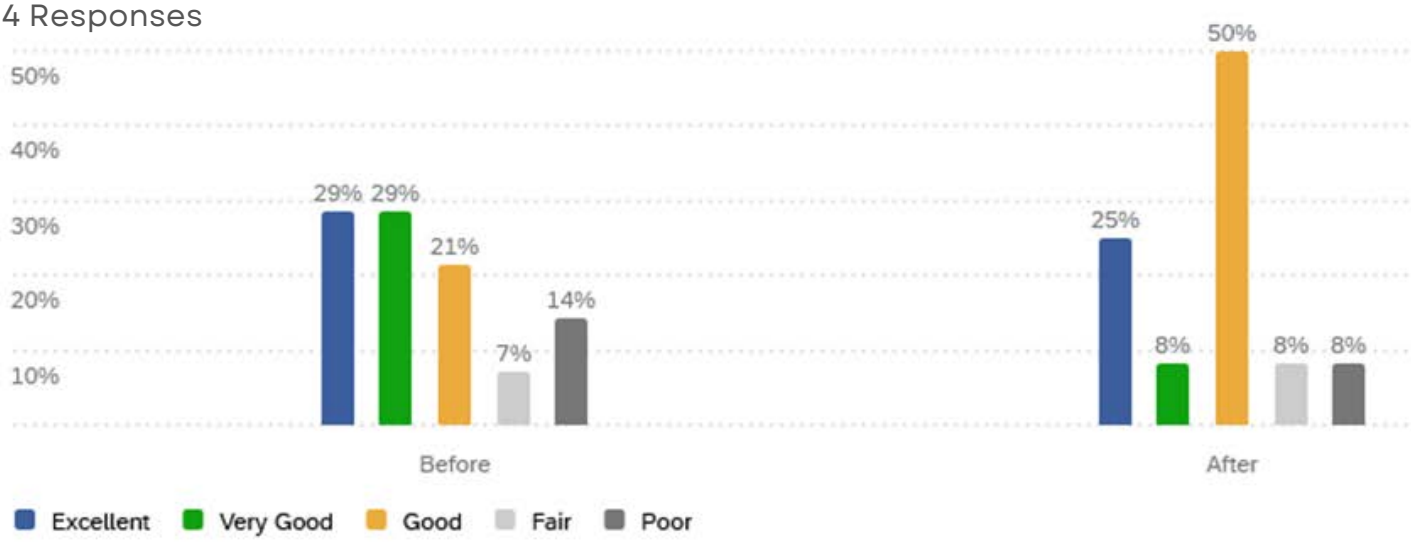


HOUSING

Out of respondents who reported experiencing an eviction in Johnson County, 12 also reported that they did not have a permanent home lined up immediately after they were evicted. More than half of these respondents reported that it took over a month to find a new permanent home; they stayed in an emergency shelter, with friends or family, in their car, or did not have a place to stay at all following their eviction.

FIGURE H.13. QUALITY OF HOUSING BEFORE AND AFTER EVICTION

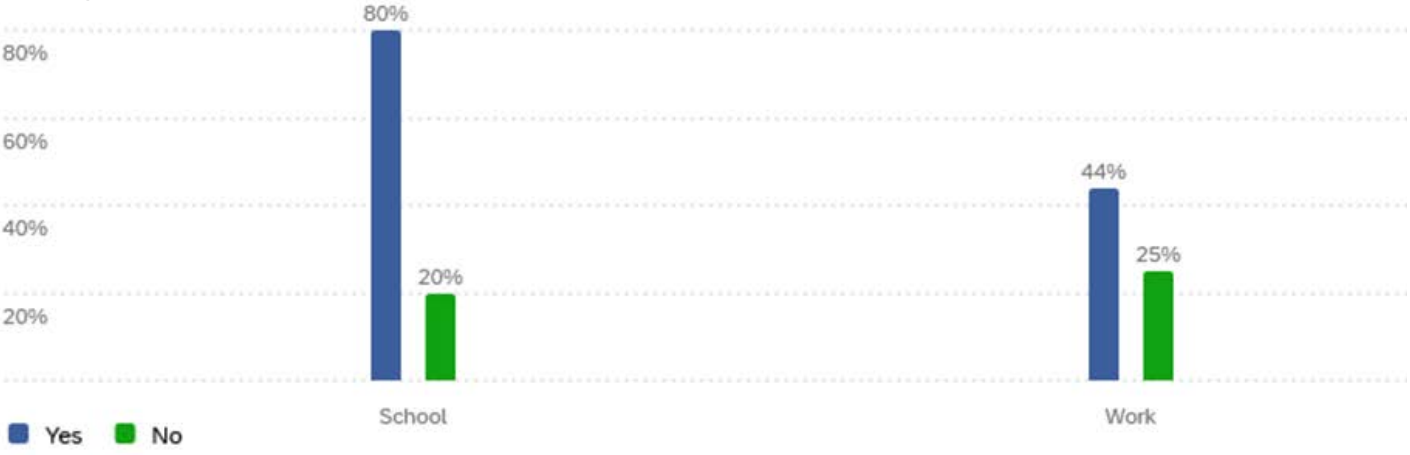
14 Responses



Despite the average reported quality of housing decreasing after an eviction, the majority of respondents who had experience eviction (83%) also reported that the cost of their new housing increased compared to what they were paying before. Most respondents also reported that their eviction had a negative impact on their children's ability to go to school, and/or their own ability to go to work.

FIGURE H.14. EVICTION NEGATIVELY IMPACTED SCHOOL AND WORK

16 Responses



HOUSING

HOUSING COST BURDEN

Housing cost burden has been generally accepted as being 30% or more of income spent on housing. Extreme housing cost burden is approximately 50% or more of income spent on housing. While overall housing cost burden averages and percentages are helpful, in this section we provide housing cost burden information between homeowners and renters broken down by household type, age, and zip code. Additional context is helpful when determining areas of housing cost burden in Johnson County.

OVERALL HOUSING COST BURDEN

Table H.3 below shows housing cost burden for homeowners and renters who pay 30% or more and 50% or more of their monthly household income on housing, respectively. The sample (n) takes into account all homeowners or renters. Approximately 3.4% of homeowners report spending 30% or more of their monthly household income on housing. For renters, the percentage is much larger as 58% of renters report spending 30% or more of their monthly household income on housing. Approximately 34.4% of renters report spending 50% or more of their income on housing, resulting in severe housing cost burden.

TABLE H.3. HOUSING COST BURDEN FOR HOMEOWNERS AND RENTERS

	Homeowners (n=321)		Renters (n=157)	
	Count	Percent	Count	Percent
30% + Income Spent on Housing	43	13.4%	91	58.0%
50% + Income Spent on Housing	17	5.3%	54	34.4%

HOUSING COST BURDEN BY HOUSEHOLD TYPE, HOMEOWNERS

Housing cost burden is complex, and household size is important to consider when calculating housing cost burden. Table H.4 above shows average and median percentages of household income spent on housing per month for homeowners by household type.

TABLE H.4. HOMEOWNER HOUSING COST BURDEN BY HOUSEHOLD TYPE

Household Type	Average	Median	Count
1 Adult, No Children	8.6%	9.1%	41
1 Adult, 1 or More Children	15.8%	15.8%	8
2 Adults, No Children	19.3%	16.4%	97
2 Adults, 1 Child	20.0%	17.3%	27
2 Adults, 2 Children	8.0%	8.7%	33
2 Adults, 3 + Children	6.1%	5.8%	15

HOUSING

HOUSING COST BURDEN BY HOUSEHOLD TYPE, RENTERS

Table H.5 to the right shows average and median percentages of household income spent on housing per month for all renters by household type. Some averages and medians vary due to potential outliers. Overall, we see renters spending more of their household income on housing in almost every household type category compared to respondents who own their homes.

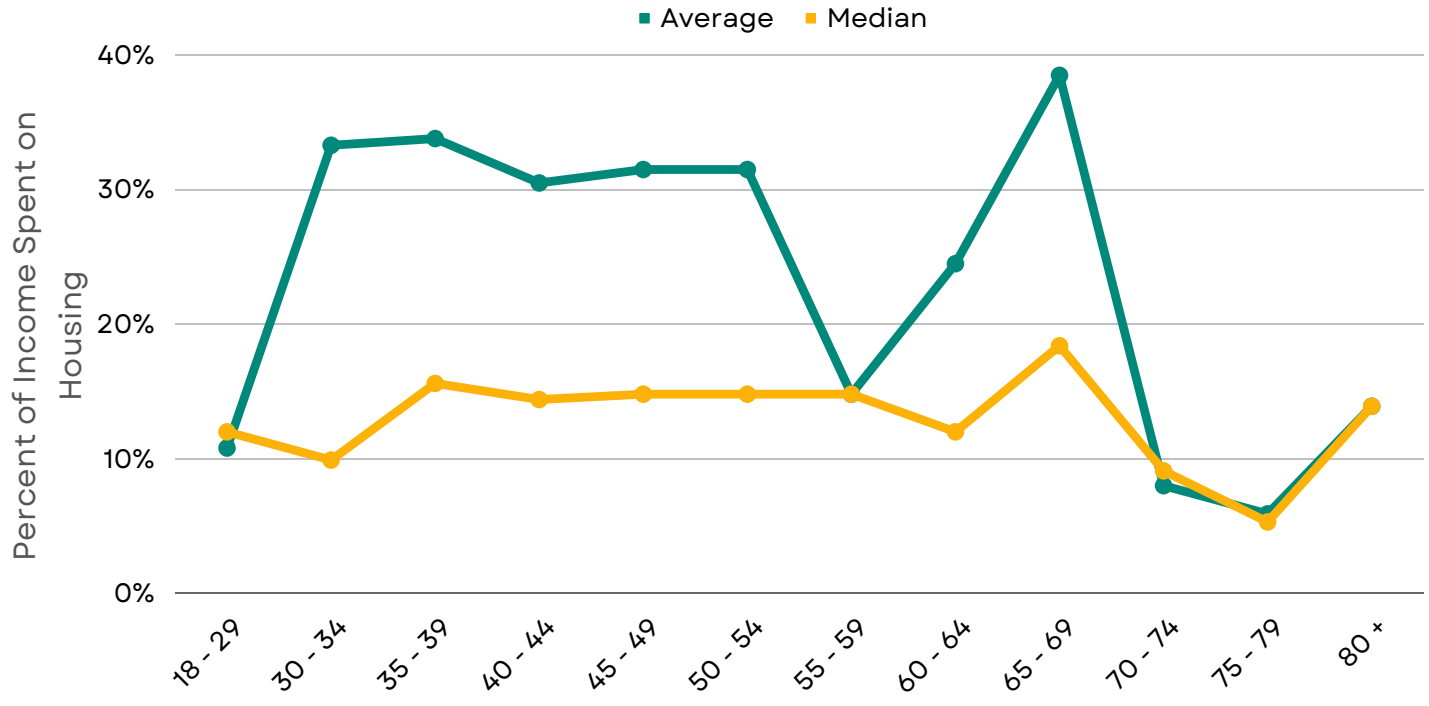
TABLE H.5. RENTER HOUSING COST BURDEN, BY HOUSEHOLD TYPE

Household Type	Average	Median	Count
1 Adult, No Children	54.2%	26.5%	47
1 Adult, 1 or More Children	69.8%	33.8%	12
2 Adults, No Children	62.3%	32.0%	35
2 Adults, 1 Child	30.7%	26.9%	6
2 Adults, 2 Children	34.2%	34.7%	14
2 Adults, 3 + Children	89.7%	54.1%	10

HOUSING COST BURDEN BY AGE, HOMEOWNERS

Figure H.15 below shows average and median percentages of household income spent on housing per month for homeowners. Homeowners ages 65 - 69 are spending, on average, around 38.5% of their monthly income on housing. The sample size for the below figure is 276.

FIGURE H.15. HOUSING COST BURDEN BY AGE, HOMEOWNERS

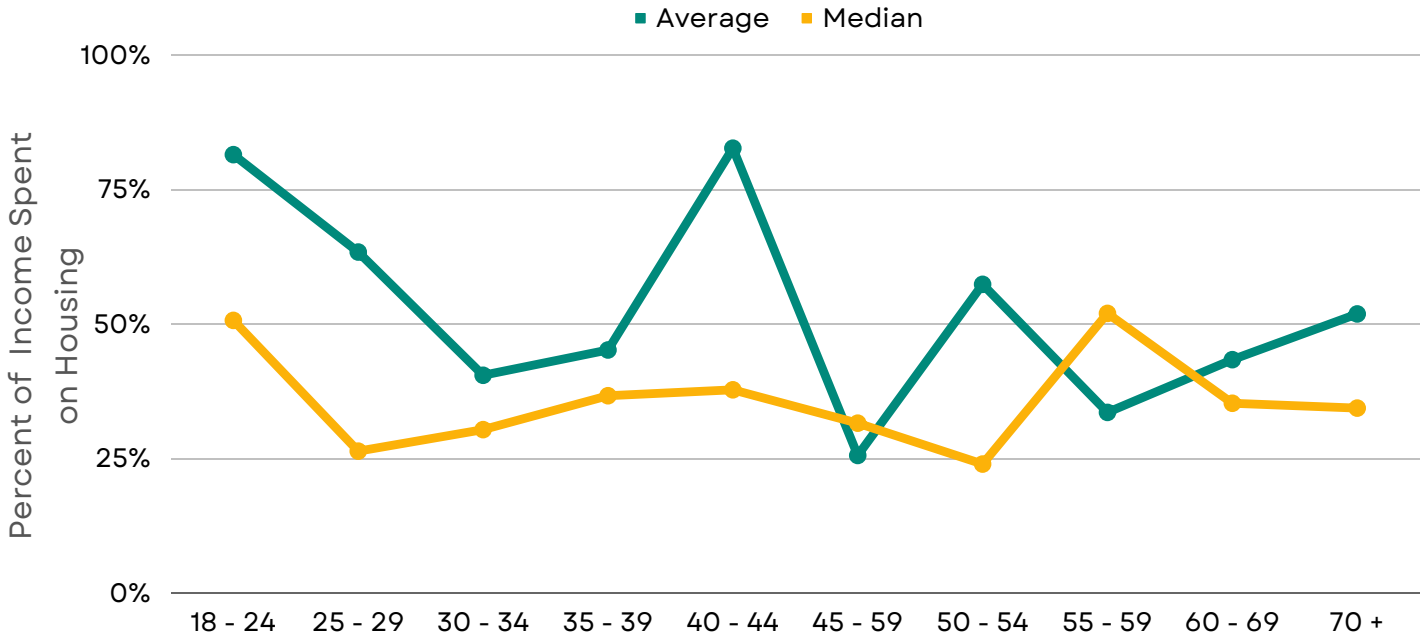


HOUSING

HOUSING COST BURDEN BY AGE, RENTERS

Figure H.16 below shows average and median percentages of household income spent on housing per month for renters. The sample size for the below figure is 155. Renters ages 18 - 24 and 40 - 44 report, on average, spending 81.5% and 82.7%, respectively, of monthly income on housing.

FIGURE H.16. HOUSING COST BURDEN BY AGE, RENTERS



HOUSING COST BURDEN BY ZIP CODE

Tables H.6 and H.7 below show average and median percentages of income spent on housing per month, by zip code.

TABLE H.6. HOMEOWNER HOUSING COSTS

Zip Code	Average	Median	Count
52240	31.1%	18.4%	70
52241	28.5%	9.9%	26
52245	17.8%	16.8%	51
52246	12.0%	11.8%	24
52317	18.6%	17.9%	40
52333	16.1%	16.0%	13
52338	15.8%	15.8%	10
52340	19.9%	19.2%	7

TABLE H.7. RENTER HOUSING COSTS

Zip Code	Average	Median	Count
52240	68.4%	46.3%	38
52241	35.8%	28.8%	21
52245	56.9%	37.6%	14
52246	55.5%	32.4%	38
52317	80.5%	34.1%	23

MOBILITY

The intersection between health and built environment can be seen through transportation and safety in neighborhoods. This section of the assessment describes household vehicles and difficulties with transportation.

MAIN FINDINGS

Disparities by Owner V.S. Renter households- percentage of households with no vehicles is higher among people that rent (15.11%) as compared to those who own their homes (2.27%). This is a similar trend, which can be seen based on the U.S. Census American Community Survey data, with the rest of Johnson County and state of Iowa.

Disparities among race and ethnicity- can be seen in vehicle ownership. Among the 8.51% of respondents that answered no to owning a vehicle, 20.59% were Black or African American and 26.92% were Hispanic or Latino/a/x. (White: 5.29%)

Disparities among race and ethnicity- can be seen in transportation. Among the respondents that stated, “difficulty getting to work or school” (22%), 41% of them were Black or African American and 30.43% were Hispanic or Latino/a/x. (White: 15.89%)

MOBILITY

HOUSEHOLD VEHICLES

Most survey respondents that provided information on household vehicles (N=599) reported owing at least one vehicle (91.48%).

FIGURE M.1 HOUSEHOLDS WITH ACCESS TO VEHICLES (PERCENT)

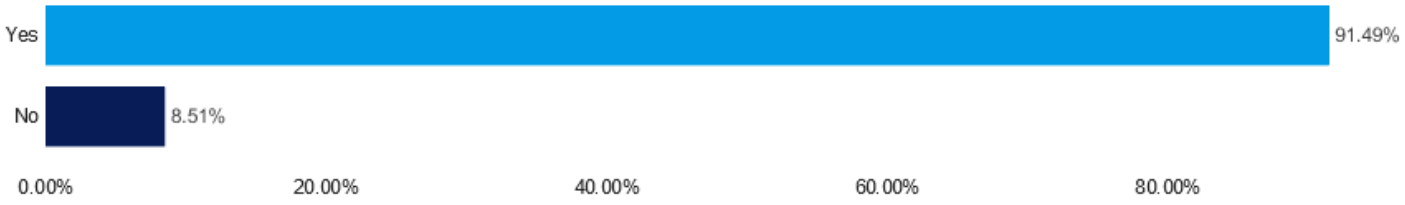
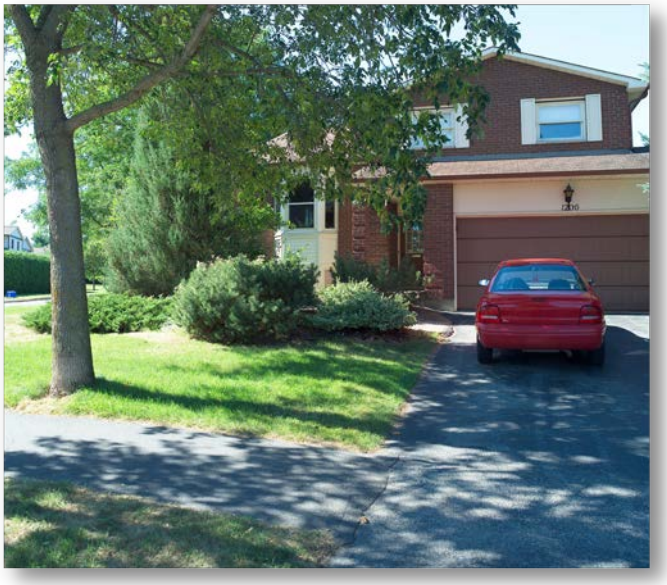


Table M.1 describes the count and percentage of households with access to vehicles dis-aggregated by race and ethnicity.

TABLE M.1 HOUSEHOLD ACCESS TO VEHICLES BY RACE AND ETHNICITY

	Total*		Black or African American		Middle Eastern or North African		Asian		White		Hispanic or Latino/a/x	
Yes		511	79.41176	27	100%	8	80%	8	94.71%	430	73.08%	38
No		47	20.58824	7	-		-		5.29%	24	26.92308	14
Total			Total	34	Total		Total	10	Total	454	Total	52



[1]U.S. Census Bureau (2021). *S2504: Physical Housing Characteristics for Occupied Housing Units.* [Data file] Retrieved from https://data.census.gov/

MOBILITY

HOUSEHOLD VEHICLES

Based on the U.S. Census American Community Survey, 7.58% of Johnson County households have no vehicles compared to 5.55% in Iowa and 8.04% in the United States [1]. Table M.2, below, reports the number and percentage of households with no vehicle.

TABLE M.2 HOUSEHOLD ACCESS WITH NO VEHICLES

	Total households	Households No vehicle	% of households with no motor vehicle
Johnson County	61,301	4,647	7.58%
Iowa	1,300,467	72,234	5.55%
United States	127,544,730	10,263,494	8.04%

HOUSEHOLDS WITH NO VEHICLES BY HOUSING TYPE

Table M.3, below, describes the Community Status Assessment (CSA) sample number of occupied-owner households with no vehicle and occupied-renter households with no vehicles as compared to the rest of Johnson County, Iowa and the United States. There is significant difference in households with no vehicle by whether they own or rent.

TABLE M.3 OWNER AND RENTER OCCUPIED HOUSEHOLDS WITH NO VEHICLES

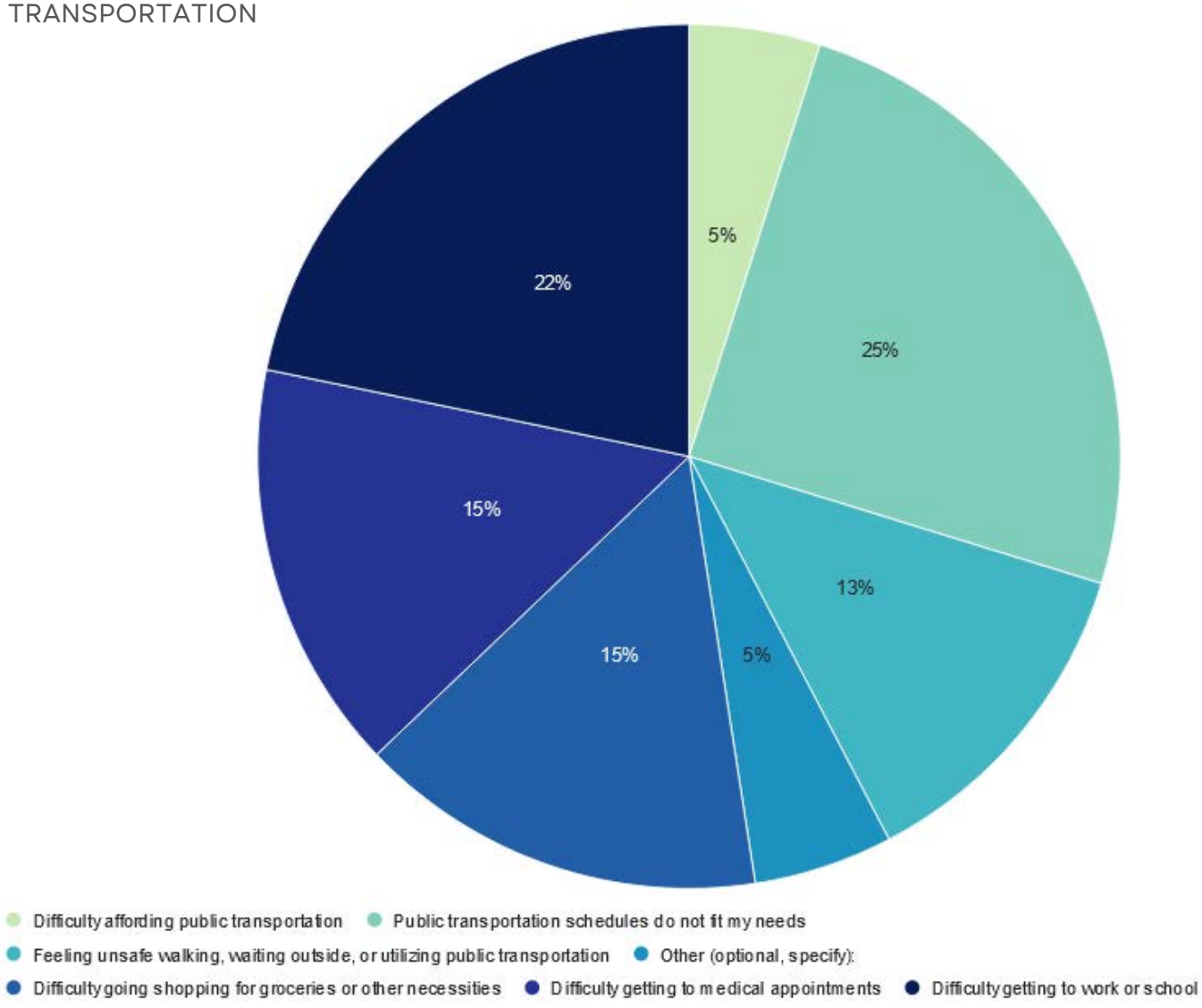
	Owner-occupied households with no vehicle	Number of owner-occupied households	Percent of owner occupied households with no vehicle	Renter-occupied households with no vehicle	Total renter occupied	Percentage of renter-occupied households with no vehicle
CSA Sample	10	440	2.27%	34	225	15.11%
Johnson County	942	36,297	2.59%	3705	25004	14.81%
Iowa	19,955	935,111	2.13%	52,279	365,356	14.30%
United States	2,645,057	83,396,988	3.17%	7,618,437	44,147,742	17.25%

[1]U.S. Census Bureau (2021). *S2504: Physical Housing Characteristics for Occupied Housing Units.* [Data file] Retrieved from https://data.census.gov/table?q=Johnson+County,+Iowa,+iowa,+united+states&tid=ACSST1Y2021.S2504

MOBILITY
TRANSPORTATION

Transportation can become a barrier for individuals to access healthcare, commute to work or access groceries. Johnson County provides several resources for individuals to make the best decision on their transportation needs like having a mobility coordinator, public transportation, rideshare and transportation assistance to appointments [1]. Transportation can become a barrier for individuals to complete daily tasks. Although plentiful services and resources in Johnson County the CSA reveals that, 25% of respondents describe public transportation schedules not fitting their needs, 22% difficulty getting to work or school and 15% difficulty getting to medical appointments due to inadequate transportation. (N=326)

FIGURE M.2 PERCENTAGE OF DIFFICULTY IN FOLLOWING AREA DUE TO INADEQUATE TRANSPORTATION



[[1] Johnson County. (2022, December 29). Mobility/Transportation Coordinator. https://www.johnsoncountyiowa.gov/mobility

MOBILITY

TRANSPORTATION

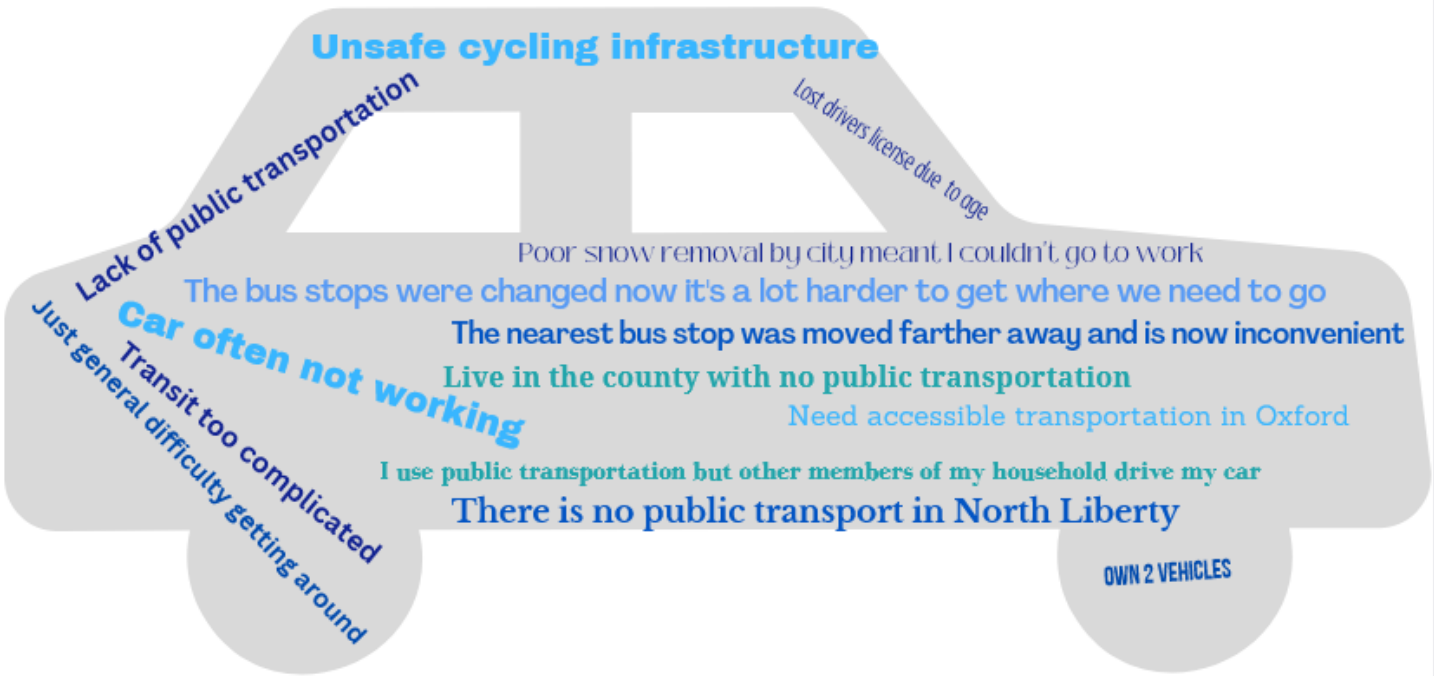
TABLE M.4 DIFFICULTY IN FOLLOWING AREA DUE TO INADEQUATE TRANSPORTATION BY RACE AND ETHNICITY

	Total*	Black or African American		White		Hispanic or Latino/a/x	
Difficulty getting to work or school	69	41.18%	14	15.89%	34	30.43%	14
Difficulty getting to medical appointments	50	-		13.08%	28	30.43%	14
Difficulty going shopping for groceries or other necessities	48	17.65%	6	14.02%	30	19.57%	9
Feeling unsafe walking, waiting outside, or utilizing public transportation	39		-	14.95%	32		-
Public transportation schedules do not fit my needs	77		-	30.84%	66		-
Difficulty affording public transportation	16		-	5.61%	12		-
Other (optional, specify)	14		-	5.61%	12		-
Total			34		214		46

*Total includes other race categories that are not shown due to too small sample size.

Additionally, other comments (N=14) suggested that there are unsafe cycling infrastructure, complications with public transportation; changed routes and limited to certain cities within Johnson County and as seen on the word cloud.

FIGURE M. 3 WORD CLOUD OF OTHER COMMENTS



SAFETY

This section of the assessment provides information on the confidence of respondents being treated fairly by police in their neighborhood. This question is posted to collect information on serious problems regarding neighborhood conditions that racial/ethnic minorities might face. It is sampled from the *Personal Experiences of U.S. Racial/Ethnic Minorities in Today's Difficult Times*, the poll assess current events like the economy, COVID-19, and political conflict in the nation and how it is affecting African American/Black, Hispanic/Latino, Asian, and Native American/American Indian/Alaska Native populations [1].

MAIN FINDINGS

Disparities among race and ethnicity can be seen in the confidence of respondents being treated fairly by police. Among the total responses of individuals reporting that they do not feel too confident (9.27%) in being treated fairly by police, 20.69% were Black or African American and 19.51% were Hispanic or Latino/a/x.

Disparities by sexual orientation- respondents that identify as LGBTQ+ were 19% not too confident that they would be treated fairly by police as compared to the 7% of Non-LGBTQ+.

[1] Harvard University T.H. Chan School of Public Health. (2022, August 1). Personal Experiences of U.S. Racial/Ethnic Groups in Today's Difficult Times. NPR/Robert Wood Johnson Foundation/Harvard School of Public Health. https://www.hsph.harvard.edu/horp/npr-harvard/

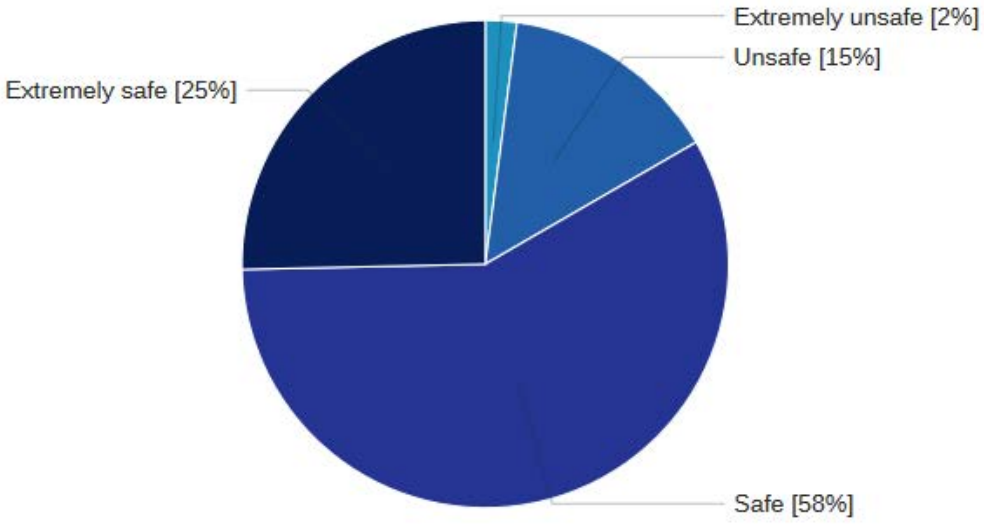
SAFETY

Neighborhoods can influence the health of individuals through physical, social and service aspects [1]. This section of the assessment describes personal safety in neighborhoods of individuals living in Johnson County.

SAFETY WALKING AT NIGHT

Figure S.1, below, describes the safety of respondents walking at night in their neighborhood (N=576). Most respondents felt safe (52%) or extremely safe (40%).

FIGURE S. 1 SAFETY AT NIGHT



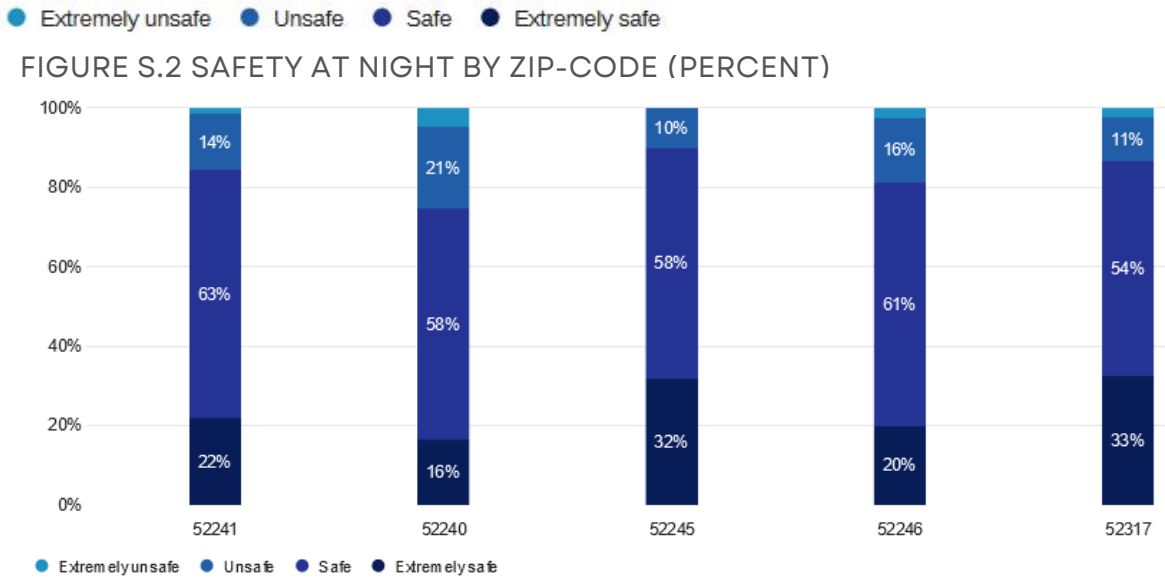


FIGURE S.2 SAFETY AT NIGHT BY ZIP-CODE (PERCENT)

Dis-aggregated by Zip-code, Figure S.2, on the left, shows significant difference between extremely safe and safe based on location.

[1]Braveman, P., Cubbin, C., Egerter, S., & Pedregon, V. (2011). Where We Live Matters for Our Health: Neighborhoods and Health. Robert Wood Johnson Foundation Exploring the Social Determinants of Health Series #8.

SAFETY

SAFETY WALKING AT NIGHT

Table S.1, below, shows the count and percentages of responses by extremely safe, safe, unsafe and extremely unsafe, dis-aggregated by race and ethnicity. Among the racial and ethnic groups represented, 64.52% Black or African Americans, 57.01% White and 70.59% Hispanic or Latino/a/x responded feeling safe walking at night.

TABLE S.1 SAFETY AT NIGHT BY RACE AND ETHNICITY

	Total*	Black or African American		White		Hispanic or Latino/a/x	
Extremely safe	132		-	26.24%	116	11.76%	6
Safe	318	64.52%	20	57.01%	252	70.59%	36
Unsafe	82		-	14.93%	66	17.65%	9
Extremely unsafe	11		-	1.81%	8		-
Total			31	442		51	

*Total includes other race categories that are not shown due to too small sample size.

Furthermore, there is a distinction among safety walking home at night in their neighborhood by respondents that identify as LGBTQ+. Table S.2, below, describes respondents that identify as LGBTQ+ and their safety levels walking at night.

TABLE S.2 SAFETY AT NIGHT BY LGBTQ+

	Total*	LGBTQ+		Non-LGBTQ+	
Extremely safe	127	17.95%	14	28.11%	113
Safe	273	62.82%	49	55.72%	224
Unsafe	68	17.95%	14	14.93%	54
Extremely unsafe	12		-	2.74%	11
Total	480		78	402	

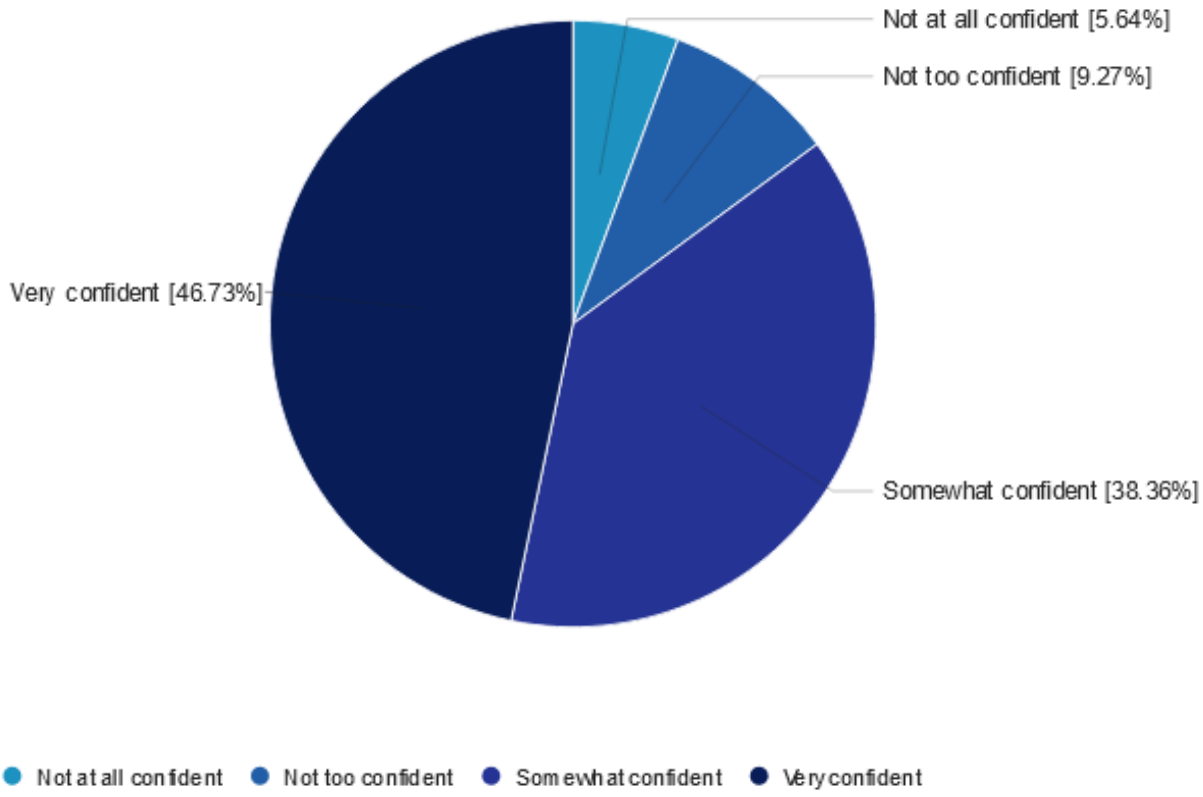
*Total includes LGBTQ+ responses not shown due to too small sample size.

SAFETY

INTERACTIONS WITH THE POLICE

Figure S. 3, below, describes total respondents being very confident (46.73%) and somewhat confident (38.36%) with fair treatment by police in their neighborhood. (N=550)

FIGURE S. 3 CONFIDENCE IN FAIR TREATMENT BY POLICE, PERCENTAGE



SAFETY

INTERACTIONS WITH THE POLICE

Figure S. 4, below, describes the confidence in fair treatment by police dis-aggregated by Zip-codes

FIGURE S. 4 CONFIDENCE IN FAIR TREATMENT BY POLICE BY ZIP-CODE

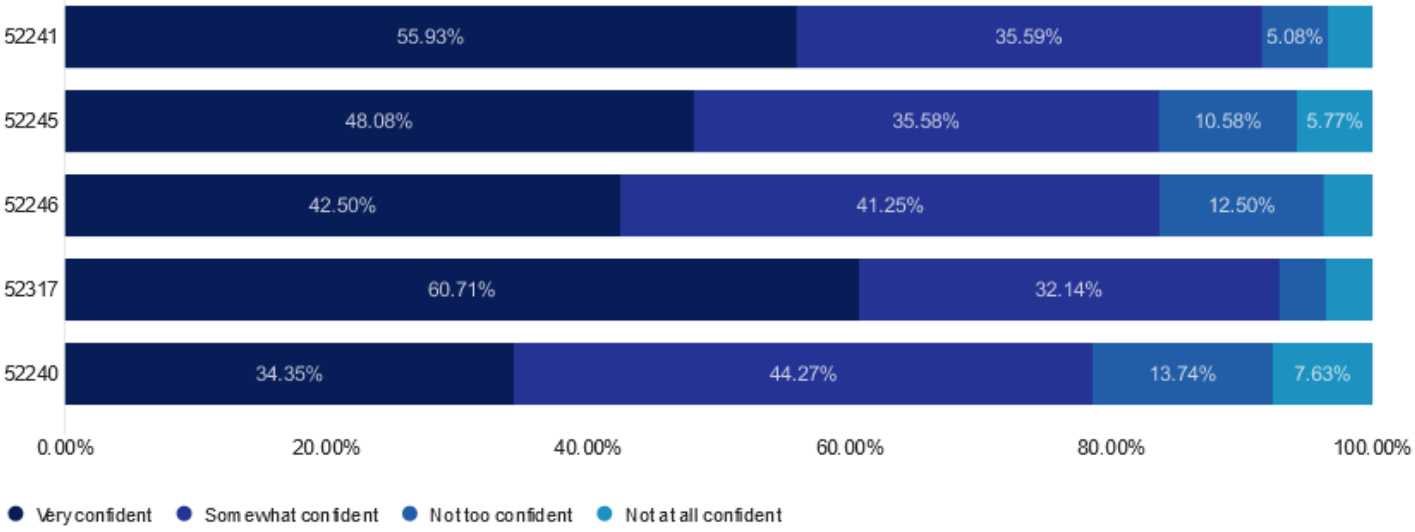


Table S.3, below, describes the count and percentages of respondent's level of confidence in fair treatment by police by race and ethnicity. Among the respondents that stated "not too confident", 20.69% were Black or African American, 19.51% were Hispanic or Latino/a/x and 7.73% were White.

TABLE S. 3 CONFIDENCE IN FAIR TREATMENT BY POLICE BY RACE AND ETHNICITY

	Total	Black or African American		White		Hispanic or Latino/a/x	
Very confident	237	27.59%	8	49.09%	216	31.71%	13
Somewhat confident	199	37.93%	11	38.64%	170	43.90%	18
Not too confident	48	20.69%	6	7.73%	34	19.51%	8
Not at all confident	26	-	4	4.55%	20		-
Total			29		440		41

*Total includes other race categories that are not shown due to too small sample size.

Table S. 4, below, describes the count and percentages of respondents that identify as LGBTQ+ and their level of confidence in fair treatment by police.

TABLE S. 4 PERCENTAGE OF CONFIDENCE IN FAIR TREATMENT BY POLICE

	Total	LGBTQ+		Non-LGBTQ+	
Very confident	251	26%	22	52%	229
Somewhat confident	200	42%	36	37%	164
Not too confident	45	19%	16	7%	29
Not at all confident	30	14%	12	4%	18
Total	526		86		440

FINANCE

This section of the assessment provides information on specific populations currently struggling with serious financial problems. Financial wellness impacts overall health in many ways. For example, serious financial problems can lead to stress that can manifest in physical ways like anxiety, loss of sleep, digestive problems, and high blood pressure to name a few.

This section has been disaggregated by race and ethnicity, as well as highest educational level attained. In particular, high proportions of individuals who are Black or African American report facing serious financial problems in paying rent or mortgage, affording medical care or prescriptions, affording food, and paying credit cards and other loans in comparison to individuals who are white.

MAIN FINDINGS

Serious Financial Problems - Disparities by race and ethnicity – Approximately 29.4% of respondents overall indicated experiencing any serious financial problems. Disaggregated by race, approximately 64.3% of Black or African American, 57.1% Middle Eastern or North African, 40% Asian, and 35.7% Hispanic/Latino respondents say they are experiencing serious financial problems (White: 15.3%).

Serious Financial Problems – Credit cards bills, loans, or other – When comparing all 4 areas of financial problems (rent/mortgage, medical care/prescriptions, food, and credit cards bills/loans/other), approximately 20% of respondents indicated having serious financial problems due to credit card bills, loans, or other serious financial problems. While the category of "other" can be left to interpretation, it is notable that this category was higher. According to the Federal Reserve Bank of New York, the national non-housing debt topped at a record $4.51 trillion in Q1 of 2022.[1]

Serious Financial Problems – Disparities by educational status – In almost every area of serious financial problems measured by this assessment, respondents reported less serious financial problems as educational level increased.

Serious Financial Problems and Mental Health – Our data suggests individuals struggling with other serious financial problems, like paying credit card bills, loans, or other serious financial problems have approximately 5 more days of poor mental health, on average, compared to those who do not struggle with other serious financial problems.

[1] Federal Reserve Bank of New York. "Quarterly Report on Household Debt and Credit." Federal Reserve Bank of New York, Nov. 2022, www.newyorkfed.org

FINANCE

Currently having serious problems paying rent or mortgage

FIGURE F.1. RENT OR MORTGAGE PROBLEMS

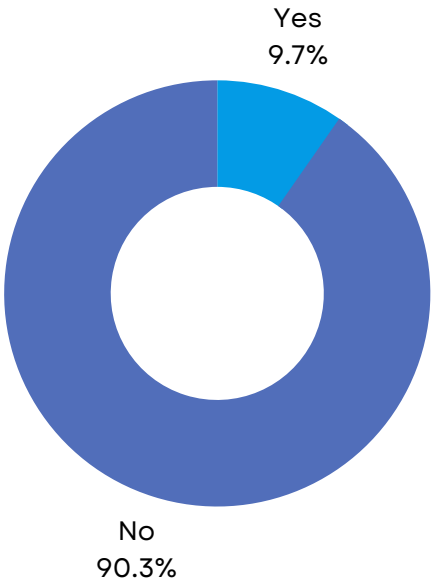


Figure F.1 to the left shows percentages of individuals overall who indicate currently having serious problems paying rent or mortgage (9.7%, 55).

Table F.1 shows responses of yes and no, disaggregated by race and ethnicity. 35.6% of Hispanic or Latino/a/x and 24.1% of Black or African American individuals report having current problems paying rent or mortgage. Approximately 4.7% of white respondents report having current problems paying rent or mortgage.

TABLE F.1. PROBLEMS PAYING RENT OR MORTGAGE, BY RACE AND ETHNICITY

	Total*		Black or African American		Asian		White		Hispanic or Latino/a/x	
Yes	9.65%	55	24.14%	7	-	-	4.73%	21	34.55%	19
No	90.35%	515	75.86%	22	90%	9	95.27%	423	64.45%	36
	Total		Total	29	Total	10	Total	474	Total	55

*Total includes other race categories that are not shown due to too small sample size.

Table F.2 shows responses disaggregated by education. As education increases from not completing high school to college graduate, the percentage of respondents reporting current problems paying rent or mortgage decreases.

TABLE F.2. PROBLEMS PAYING RENT OR MORTGAGE, BY EDUCATION

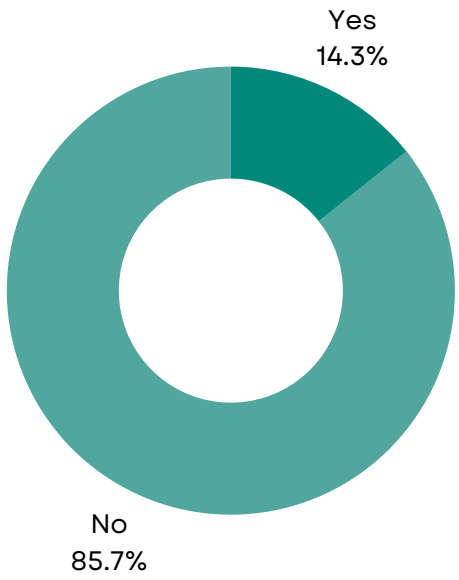
	Did not complete high school or GED/HSED		Grade 12 or GED		College 1 year to 3 years (some college or technical school)		College, 4 years or more (college graduate)	
Yes	44%	11	30.23%	13	9.35%	10	4.65%	18
No	56%	14	69.77%	30	90.65%	97	95.35%	369
	Total	25	Total	43	Total	107	Total	387

FINANCE

Currently having serious problems affording medical care or prescriptions

Figure F.2 shows responses to the question, "Are you currently having serious problems affording medical care or prescriptions?" Approximately 85.7% of respondents overall indicated they were not currently having serious problems affording medical care or prescriptions. 8.3% of respondents who have health insurance report still having problems affording medical care or prescription medications.

FIGURE F.2. PROBLEMS AFFORDING MEDICAL CARE OR PRESCRIPTIONS



In Table F.3, 45.8% of Hispanic or Latino/a/x and 38.7% of Black or African American respondents report currently having problems affording medical care or prescriptions. 7.7% of White respondents report having problems affording medical care or prescriptions.

TABLE F.3. PROBLEMS AFFORDING MEDICAL CARE OR PRESCRIPTIONS, BY RACE AND ETHNICITY

	Total*		Black or African American		Asian		White		Hispanic or Latino/a/x	
Yes	14.31%	84	38.71%	12	-	-	7.73%	35	45.76%	27
No	85.69%	503	61.29%	19	90%	9	92.27%	418	54.24%	32
	Total	587	Total	31	Total	10	Total	489	Total	59

*Total includes other race categories that are not shown due to too small sample size.

TABLE F.4. PROBLEMS AFFORDING MEDICAL CARE OR PRESCRIPTIONS, BY EDUCATION

	Did not complete high school or GED/HSED		Grade 12 or GED (high school graduate)		College 1 year to 3 years (some college or technical school)		College, 4 years or more (college graduate)	
Yes	54.84%	17	34.04%	16	14.29%	16	8.16%	32
No	45.16%	14	65.96%	31	85.71%	96	91.84%	360
	Total	31	Total	47	Total	112	Total	392

FINANCE

Currently having serious problems affording food

FIGURE F.3. PROBLEMS AFFORDING FOOD

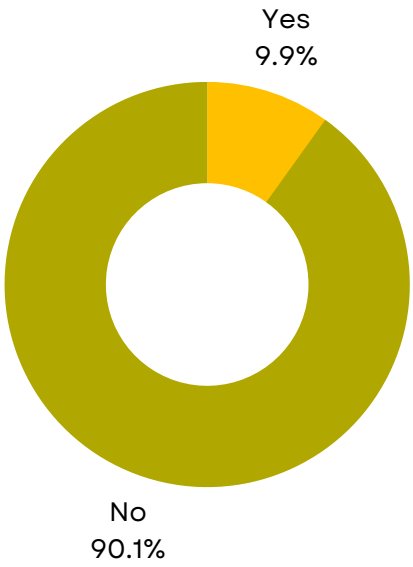


Figure F.3 to the left shows responses to the question, "Are you currently having serious problems affording food?" Approximately 90.1% of respondents overall indicated they were not currently having serious problems affording food.

Table F.5 shows disaggregated values by race and ethnicity. Approximately 33.3% of Black or African American and 30.4% of Hispanic or Latino/a/x respondents report currently having problems affording food. Only approximately 5.5% of white respondents report having problems affording food.

TABLE F.5. PROBLEMS AFFORDING FOOD, BY RACE AND ETHNICITY

	Total*		Black or African American		Middle Eastern or North African		Asian		White		Hispanic or Latino/a/x	
Yes	9.88%	56	33.33%	10	-	-	-	-	5.49%	24	30.36%	17
No	90.12%	511	66.67%	20	85.71%	6	90%	9	94.51%	413	69.64%	39
	Total	567	Total	30	Total	7	Total	10	Total	437	Total	56

*Total includes other race categories that are not shown due to too small sample size.

Table F.6 shows as education level increases, the percentage of respondents currently having problems affording food decreases.

TABLE F.6. PROBLEMS AFFORDING FOOD, BY EDUCATION

Question	Did not complete high school or GED/HSED		Grade 12 or GED (high school graduate)		College 1 year to 3 years (some college or technical school)		College 4 years or more (college graduate)	
Yes	40%	10	26.09%	12	10.89%	11	5.68%	22
No	60%	15	73.91%	34	89.11%	90	94.32%	365
	Total	25	Total	46	Total	101	Total	387

FINANCE

Currently having other serious financial problems, like paying credit card bills, loans, or other serious financial problems.

FIGURE F.4. CURRENT OTHER SERIOUS FINANCIAL PROBLEMS

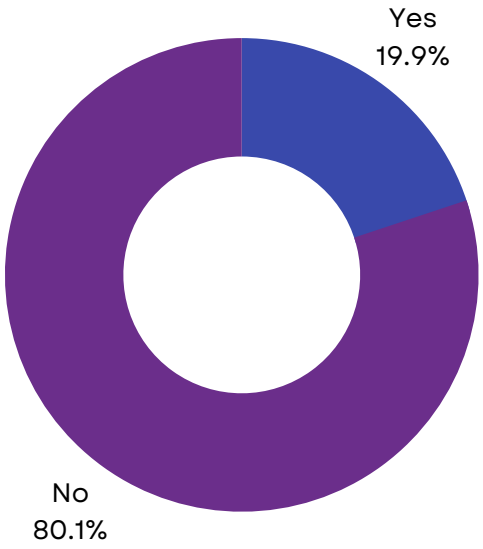


Figure F.4 to the right shows responses to the question, "Are you currently having other serious financial problems, like paying credit card bills, loans, or other serious financial problems?" Approximately 19.9% of respondents overall indicated they were currently having other serious financial problems.

Table F.7 below shows values by race and ethnicity. 56.7% of Black or African American and 44.6% of Hispanic or Latino/a/x respondents report currently having other serious financial problems. 14.5% of White respondents report experiencing these issues as well.

TABLE F.7. OTHER SERIOUS FINANCIAL PROBLEMS, BY RACE AND ETHNICITY

	Total*		Black or African American		Asian		White		Hispanic or Latino/a/x	
Yes	19.86%	114	56.67%	17	-	-	14.45%	64	44.64%	25
No	80.14%	460	43.33%	13	87.5%%	7	85.55%	379	55.36%	31
	Total	574	Total	30	Total	8	Total	480	Total	56

*Total includes other race categories that are not shown due to too small sample size.

TABLE F.8. OTHER SERIOUS FINANCIAL PROBLEMS, BY EDUCATION

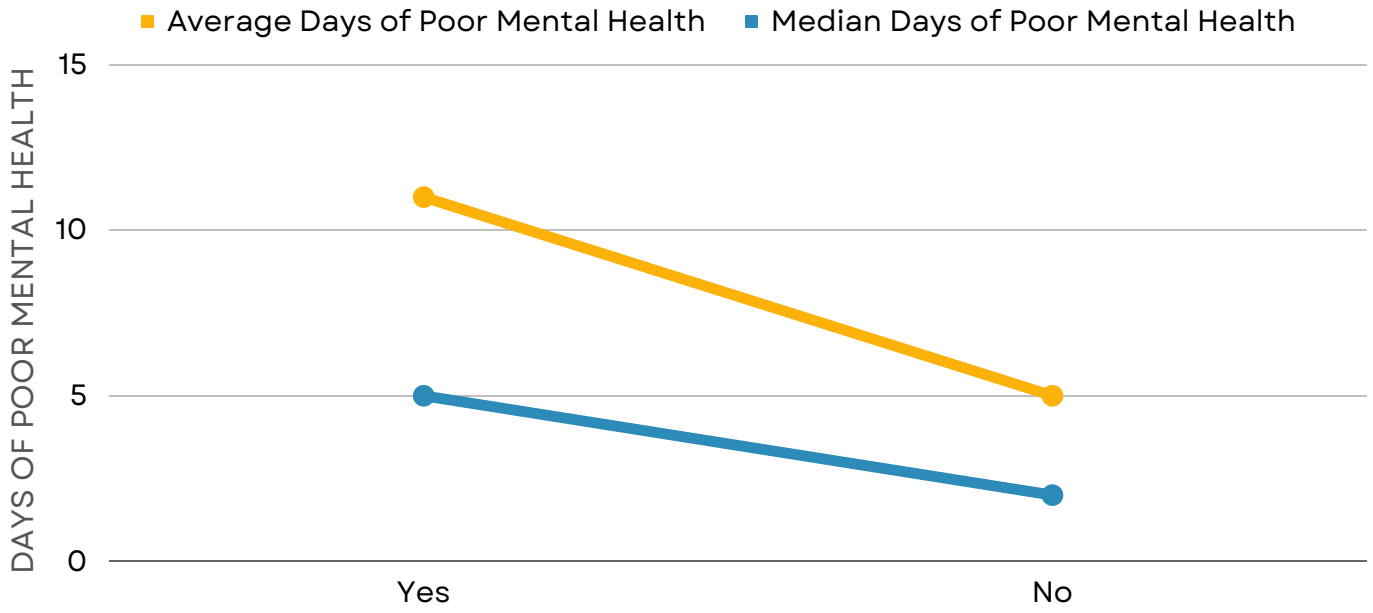
	Did not complete high school or GED/HSED		Grade 12 or GED (high school graduate)		College 1 year to 3 years (some college or technical school)		College 4 years or more (college graduate)	
Yes	34.78%	8	38.30%	18	24.55%	27	15.25%	59
No	65.22%	15	61.70%	29	75.45%	83	84.75%	328
	Total	23	Total	47	Total	110	Total	387

FINANCE

Finances and Mental Health

The data suggests individuals struggling with other serious financial problems, like paying credit card bills, loans, or other serious financial problems have approximately 5 more days of poor mental health, on average, compared to those who do not struggle with other serious financial problems. Figure F.5 shows average and median days of poor mental health for individuals who answered yes or no to the question, "Are you currently having other serious financial problems, like paying credit card bills, loans, or other serious financial problems?"

FIGURE F.5. DAYS OF POOR MENTAL HEALTH AND OTHER FINANCIAL ISSUES



Finances and Health Rating

The data also suggests respondents who answer yes to struggling with serious financial problems are more likely to rate their overall health lower compared to respondents who answer no to struggling with serious financial problems. On Table F.9 below, green indicates the cells with clear, high statistical significance values than typical, and red indicates cells with clear, low statistical significance values than typical.

TABLE F.9. OTHER FINANCIAL ISSUES AND HEALTH RATING

Other Financial Issues (Col %)	Excellent	Very Good	Good	Fair	Poor
Yes	13%	11.7%	17.2%	34.2%	55.6%
No	87%	88.3%	82.8%	65.8%	44.4%

FINANCE

Serious Financial Problems Combo Table

Based on Total

TABLE F.10. SERIOUS FINANCIAL PROBLEMS, BY RACE AND ETHNICITY

	Total*	Black or African American	Middle Eastern or North African	Asian	White	Hispanic or Latino/a/x
Had any financial issues (Net)	29.4%	64.3%	57.1%	40%	15.3%	35.7%
Paying rent or mortgage	9.6%	24.1%	16.7%	10%	4.7%	34.6%
Affording medical care or prescriptions	14.3%	38.7%	50%	10%	7.7%	45.8%
Affording food	9.9%	33.3%	14.29%	10%	5.5%	30.4%
Other serious Financial problems	19.9%	56.7%	28.6%%	12.5%	14.5%	44.6%
Did not have any financial issues (Net)	70.6%	35.7 %	42.9%	60%	84.7%	64.3%
Count	587	28	7	10	444	56

*Total includes other race categories that are not shown due to too small sample size.

Table F.10 above, in the row labeled, "Had any financial issues (Net)" shows net percentages of responses for having **any** financial issues (answering "yes" to any one or more of the following: problems paying rent or mortgage, affording medical care or prescriptions, affording food, other serious financial problems) in each race or ethnicity category.

FINANCE

End of month financial situation

Figure below indicates approximately 15.5% of respondents (89 of 576) do not have enough money to make ends meet at the end of the month. Approximately 30.4% have just enough money to make ends meet by the end of the month. Figure F.7 below disaggregates values by race and ethnicity. Table F.11 on the next page disaggregates values by education status.

FIGURE F.6. END OF MONTH FINANCES

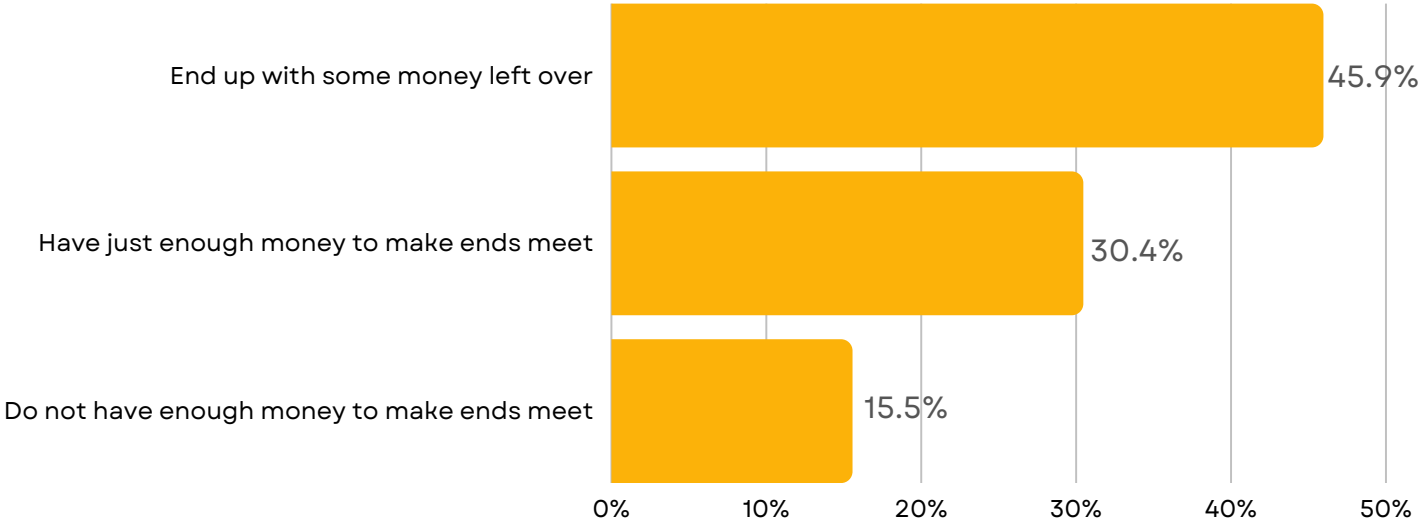
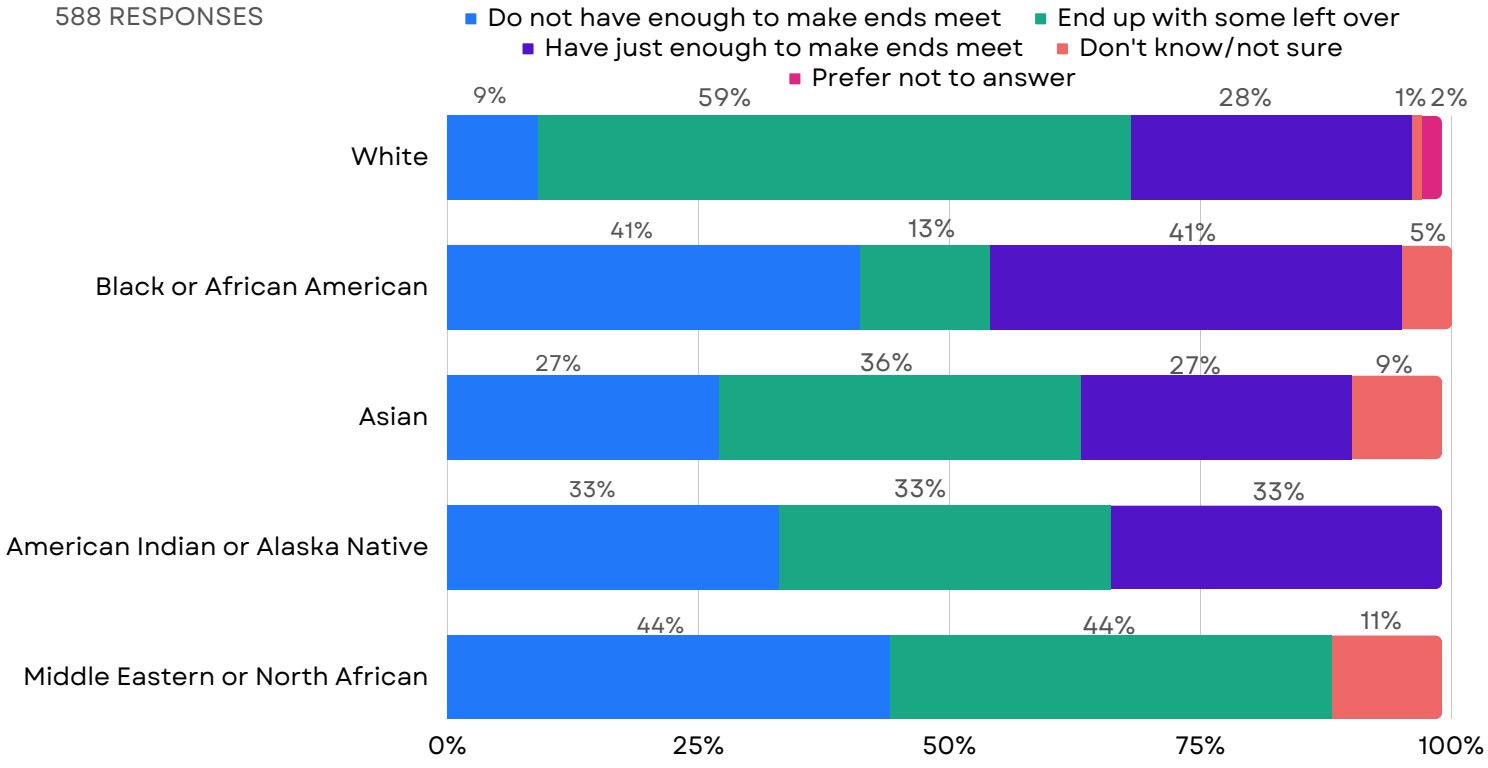


FIGURE F.7. END OF MONTH FINANCES, BY RACE AND ETHNICITY

588 RESPONSES



FINANCE

End of month financial situation (Continued)

TABLE F.11. END OF MONTH FINANCES, BY EDUCATION

	Did not complete high school or GED/HSED		Grade 12 or GED (high school graduate)		College 1 year to 3 years (some college or technical school)		College 4 years or more (college graduate)	
Do not have enough money to make ends meet	50%	14	37.78%	17	15.45%	17	10.08%	39
Have just enough money to make ends meet	28.57%	8	35.56%	16	39.09%	43	27.91%	108
End up with some money left over	21.43%	6	26.67%	12	45.45%	50	62.02%	240
		28		45		110		387

Table F.12 shows values disaggregated by current employment status. Of those employed for wages, approximately 46.6% have not enough (14.6%) or just enough (32%) money to make ends meet by the end of the month.

TABLE F.12. END OF MONTH FINANCES, BY EMPLOYMENT STATUS

	Employed for wages		Self-employed		Out of work		Student		Retired	
End up with some money left over	53.35%	175	44.83%	13	-	-	47.62%	20	71.54%	88
Have just enough money to make ends meet	32.01%	105	41.38%	12	-	-	38.10%	16	23.58%	29
Do not have enough money to make ends meet	14.63%	48	-	-	66.67%	9	14.29%	6	4.88%	6
		328		29		14		42		123

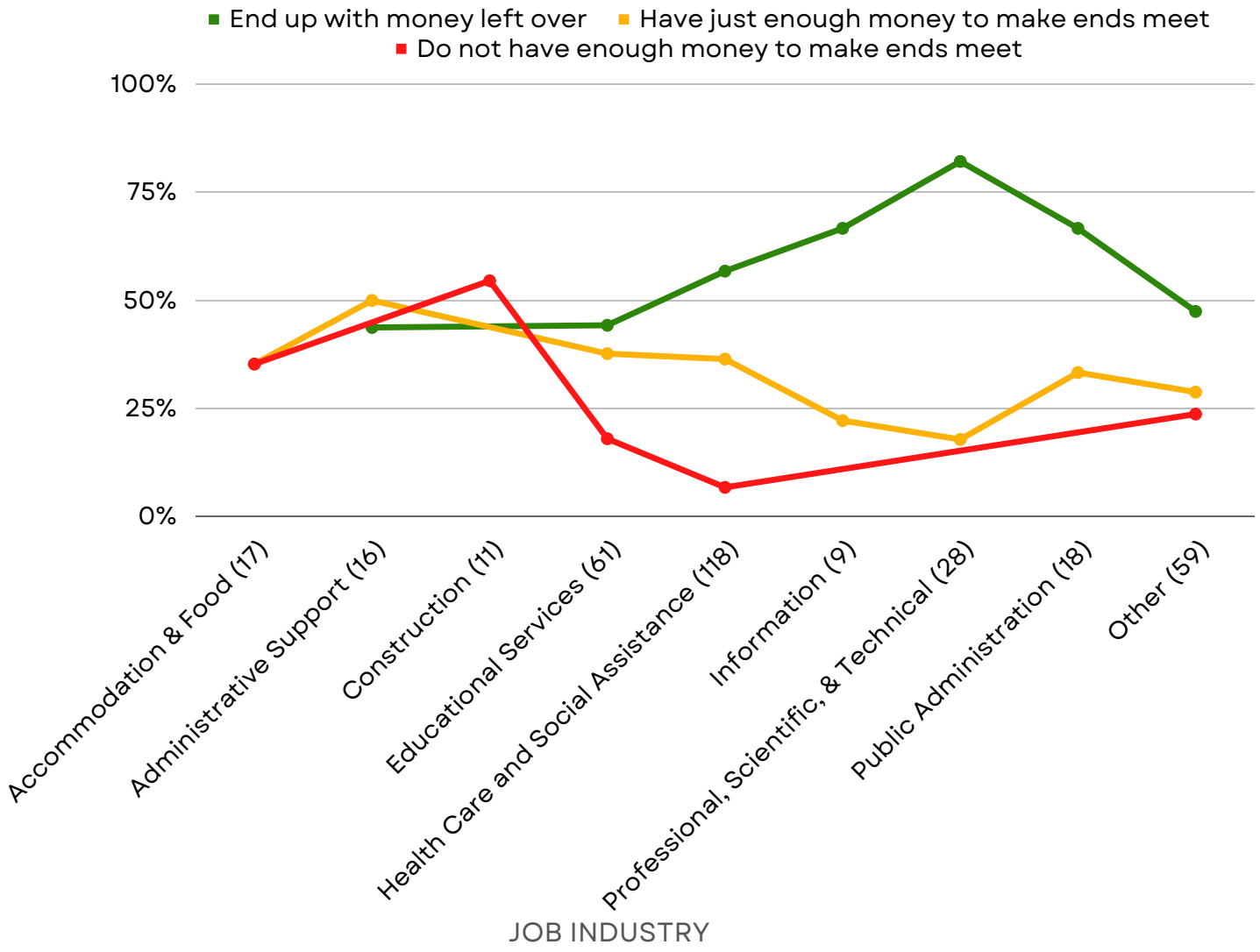
For many, having just enough money to make ends meet by the end of the month makes it difficult to save for future investments, like owning a home or paying for college. It also makes it difficult to plan for future emergencies, like vehicle maintenance or other unforeseen bills.

FINANCE

End of month financial situation, by job industry

Figure F.8 below shows end of the month financial situation by job industry. The job industry reporting the most money left over by the end of the month is professional, scientific, and technical services. The job industry reporting the highest percentage in not having enough money left to make ends meet by the end of the month is construction. Some data points are suppressed due to too low sample size. Counts of each category are indicated by the number next to the category.

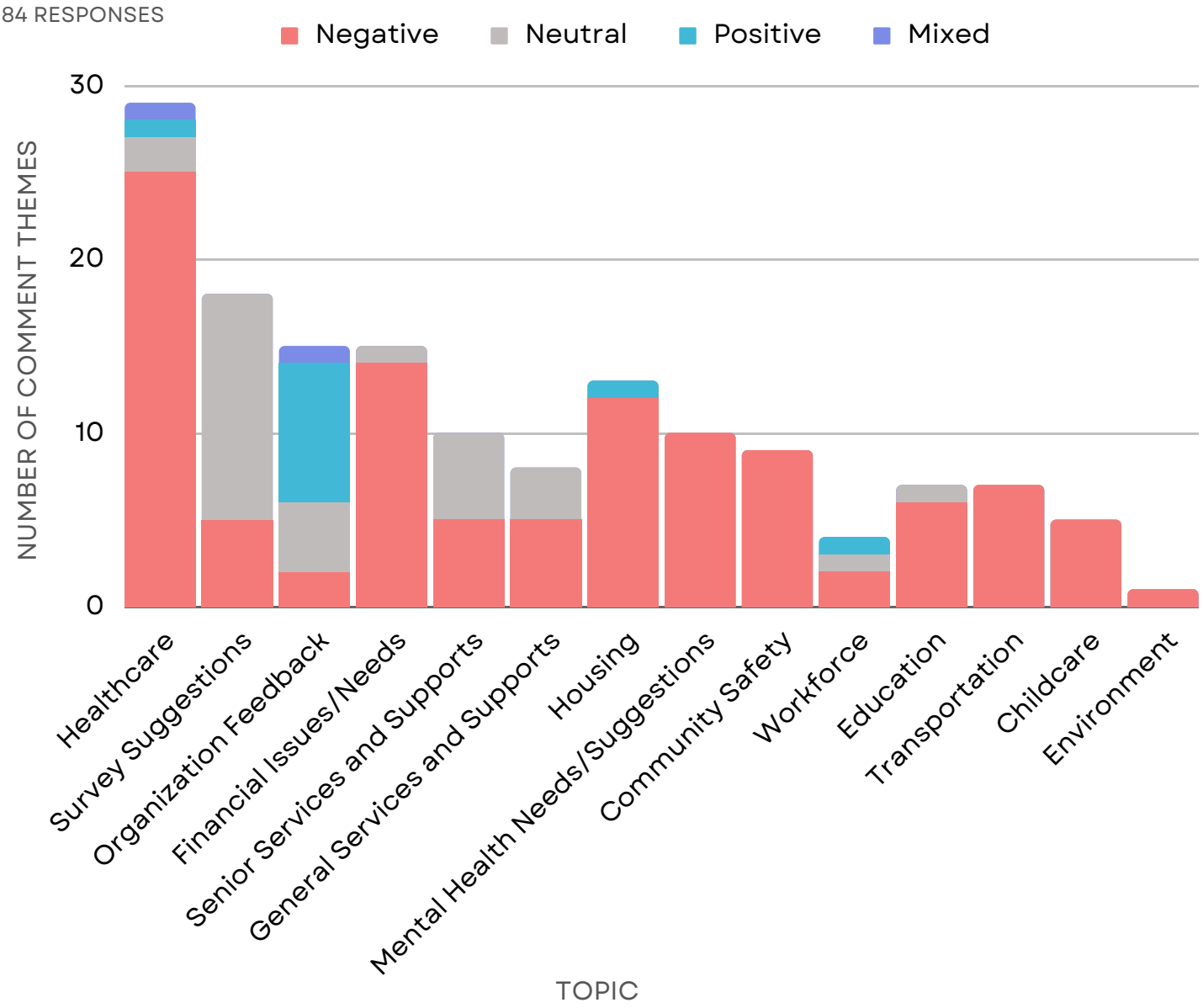
FIGURE F.8. END OF MONTH FINANCES, BY JOB INDUSTRY



OPEN RESPONSE

At the end of the Community Status Assessment, respondents were asked to provide any additional comments or note anything they were unable to do so in the survey. Approximately 146 comments were made in response to this statement. 84 responses were qualitatively coded according to the main theme of the comment. Other comments were not coded due to lack of content (i.e. many comments stated "none"). 15 parent topics were created for overall theme of the comment. Below, Figure O.1 shows each parent topic and counts of comment themes associated. Comments were coded for sentiment level, from negative to positive. Many comments that stated a need were coded with a negative sentiment.

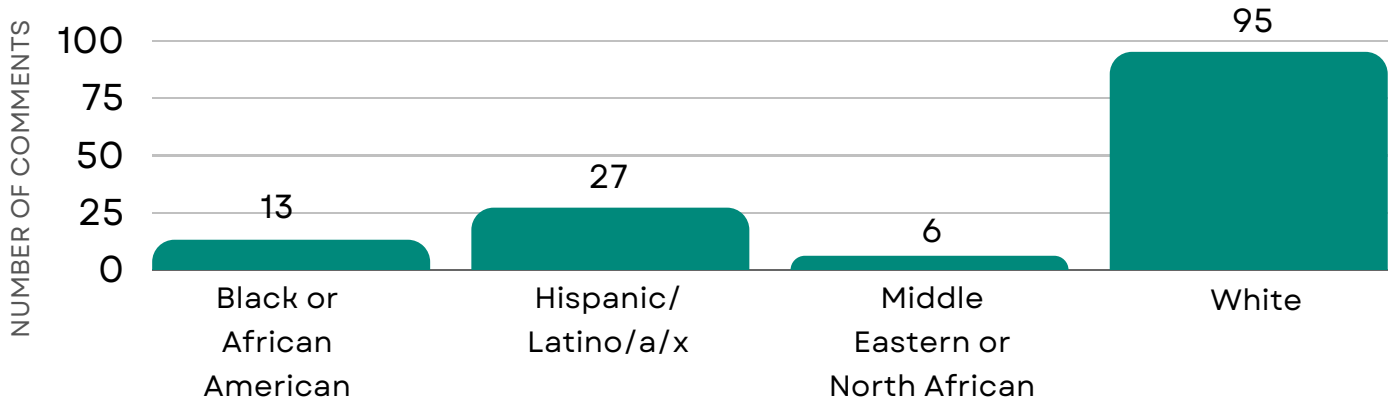
FIGURE O.1. OPEN COMMENT THEMES AND SENTIMENTS



OPEN RESPONSE

Number of Comments, by Race and Ethnicity

FIGURE O.2. OPEN COMMENT BY RACE AND ETHNICITY



All Comments

All open comments are listed below. Any potentially identifying information was redacted. All "no" responses were also removed.

- Need more services available in Small towns
- Are the HPV shots recommended for peoople in their 60s?
- Thanks for doing what you do. I think Public Health and Public Education should get the budget currently going to police and the carceral state.
- Informed Choices Medical Clinic provides free medical care in Iowa City. You should include them on your (biased) survey.
- Level of County services is good. Do not need to add any additional services.
- Godspeed
- Need help assembling things like shelves
- No option for zero alcoholic drinks
- we are an elderly couple dealing with my husbands [redacted].
- Husband was active duty during [redacted] I was not in the military. Might ask about tax help being needed. People to go with those who are having problems to help with doctor financial Medicare Medicaid and other things which is hard for some people to understand Telephone scams and TV ads which make it sound like people should call insurance agents
- Food
- Thank you for putting this together I hope you get some good data and are able to help the community in a good and meaningful way
- Electrical gas and water bills need to be addressed as human needs these are more important than paying the Iowa Hawkeyes
- Inflation
- thank you public heath people
- Serious need for better mental health care
- Serious unmet mental health needs in this county Those with serious mental health issues should be sent for care NOT to jail Police and sheriffs abuse mentally ill people and aggravate illness Mentally ill people in jail are not getting proper care Mentally ill people should not have to be housed in ER for days while awaiting inpatient bed Those attempting suicide belong in mental health care NOT jail
- public transportation isinadequate in western Coralville

OPEN RESPONSE

All Comments

- I am applying for longterm disability due to [redacted] which means a drastic cut in my income and because UIHC MD's will not help with this I must pay literally thousands of dollars OUT OF POCKET for function medicine MD's and the supplements they prescribe none of which are covered by insurance
- Guidelink does not seem able to do what it is intended to do Those will serious mental health illnesses should be sent for treatment NOT arrested Our police and sheriffs do not treat mentall ill adequately or with respect
- No but I work for [redacted] so thank you for including us in the survey
- Downtown IC feels unsafe after dark
- ICCSD needs to pay living wage to paras and this area needs to stop putting those who seek care for psychiatric diseases in jail where illness gets worse and they become traumatized by cops and jail staff
- Insurance premiums take of a huge percent of my income Legislators do not care about this or education for the young
- Covid response of public health
- Thanks for your efforts
- I guess my income is not accurate as I receive parental financial assistance
- Why does the survey not accept punctuation here This is poorly designed More needs to be done to ensure bicyclists' safety on the roads I've had too many close calls with automobiles I'd like to see better protected bike lanes in cities and more awareness of bicycle rights by drivers on county roads
- Alternative medicine Tx and coverage
- The only dentists that take the Medicaid dental plans that are taking new patients are the UI Dental College and the UIHC Dental Clinic Its difficult to access dental care if you have one of the dental plans
- Covid information that you provide is very helpful Thank you for trying to keep our community safe
- We need more inpatient beds for mental health services for kids and adults
- Medicaid can only see a student at the ui college dentistry which leads to little or no dental care with too many people from across the state to be seen
- We are lucky we can afford our medical bills but we spend hundreds each month even with insurance I still have reservations about some medical appointments and procedures bc I worry how much out of pocket we will have to pay
- Si respecto a mi salud
- It would not take some of my answers
- Check out [redacted] and how it is run
- Need to differentiate between county and city residents It is important as county folks do not have access to wrap around support services such as public transportation
- You did not ask my race key factor
- My rent has increased six percent a year for the last three years
- Heath insurance is extremely difficult to afford
- I live in Davenport
- CITY bus routes too far from my home
- I lost my job
- Access to services to help seniors stay in their own homes is lacking
- yes childcare is the source of our financial difficulties

OPEN RESPONSE

All Comments

- Correct answer for me not always available on this survey
- Finding adequate mental health services for children and adults even in this community where we have lots of services can be difficult I think it is an area that we could pursue and maybe lead the state in figuring out ways to provide these necessary resources
- Thank you for doing this important work
- Johnson Co is a pretty nice place to live
- Thanks for doing this
- the community will respond better when there is more equity. JCPH needs to hire more diverse employees to better serve the growing diverse population of the county especially Black and brown individuals
- Cant afford fresh fruit and veg Need inpatient care for mental illness rather than jail Need to pay paraeducators what they deserve Need police that arent bullies and brutes Need fair judicial and correctional systems Need ACT to stop laying off those close to retirement Need affordable and sufficient care for those with schizophrenia and those with dementia Need to examine healthfulness of rewards given to BD students in our schools Need to have healthier school entrees Provide help for caregivers
- Paper survey would be good for those who do not get online Lots of seniors do not use the computer much
- Do not forget about homebound people
- I know that I am extremely lucky and privileged. No one should have food insecurities, be unable to access medical care, or live in an unsafe environment due finances!
- Should ask about Senior Center. Important link for my demographic.
- Home is paid for-no mortgage
- Survey is too long. I am an English teacher and it was too much.
- You asked if people are taking prescription medications in the question but the answer just says medications. People could take a daily OTC medication.
- Services for children and young adults with disabilities.
- It can be very hard to find affordable quality housing especially in Tiffin and North Liberty, even parts of Coralville. This creates communities that lack diversity, and a population that can not relate to the needs of people with lower incomes or limited incomes or disabilities. It creates pockets of unsafe low quality housing within the county.
- Are students considered in this survey?
- I work two jobs part time [redacted] and full time [redacted]. I think you are missing that option along with capturing people who are full or part time students. Why wouldn't you ask about covid vaccinated and positive cases?
- Retired RN aware resources in the community
- Thank you for the work you all are doing. I know it can be tedious and frustrating to get results, but it is important!
- Very odd that you specifically mention Emma Goldman clinic but not Planned Parenthood. Planned parenthood actually offers more services than Emma Goldman .
- I have type [redacted] that is managed. I also drank a lot on one occasion because [redacted] and I don't want to screw the numbers for your survey
- I am a college student and have great support from my parents.
- I was not asked about not getting a job and what are the reasons
- I have not had trouble paying for food or housing, but inflation is impacting my choices at the moment. I also have student loans. And some local control over prescription costs would be amazing.

OPEN RESPONSE

All Comments

- Dental and vision medicaid need to reconsidered. Amounts and availability are not satisfactory.
- If there is an affordable dental clinic that is not going to cost me a leg and an arm after treating my teeth.
- After an inept at best, and authoritarian at worst, public health response to the COVID-19 pandemic, confidence in public health is rightly at an all-time low. As long as public health institutions continue to treat people as automatons that just need more money and more information to become healthy we will continue to see poor outcomes. Disregard the "whole person," as lockdown policies did, at your own peril.
- Fighting diseases on an exponential level. Grapes, eggs.
- Could local governments to provide the opportunity for residents who are not employees to be on those government's healthcare plans rather than having them use the public exchanges (with crazy deductibles/out of pocket costs)? If enough governments in Johnson County banded together and offered those plans, it may lead to more affordable care for everyone, including low income people who can use the ACA subsidies to help pay those costs.
- There was not a question about ability to drive -important for elderly citizens.
- I've relied heavily on dvip and their emotional support services. Most of the safety issues in my life are a direct result of my past abuser still being at large even though he has arrest warrants out.
- Even though I have access to primary care, it is difficult to get appointments in a reasonable time.Our secondary and tertiary care is better than primary in Johnson County
- Affordable senior housing
- Return the old bus routes and stops!
- Childcare -huge issue. It's super expensive and very hard to find.
- They need more help for single moms with disable children
- Me quitaron la ayuda de snap y por esta razÃ³n estoy preocupada por los alimentos de mis hijos
- The water quality is terrible, and this needs addressing
- I have a son and two daughters; we are all [redacted] students; it is very difficult for us to pay all the bills. We have applied for a state house, but we haven't have any feedback yet, we really need assistance, especially for the house (3 rooms at least).
- To keep my identification information confidential
- I truly hope this school has morals and does not try and push any gender or racial agendas on my kid there is only girls and boys and racism only exists if you continue to tech it
- Mascotas, problemas y alto costo administraciÃ³n de terrenos de vivienda, idioma adtual. Gracias

Johnson County Public Health

HealthyJoCo

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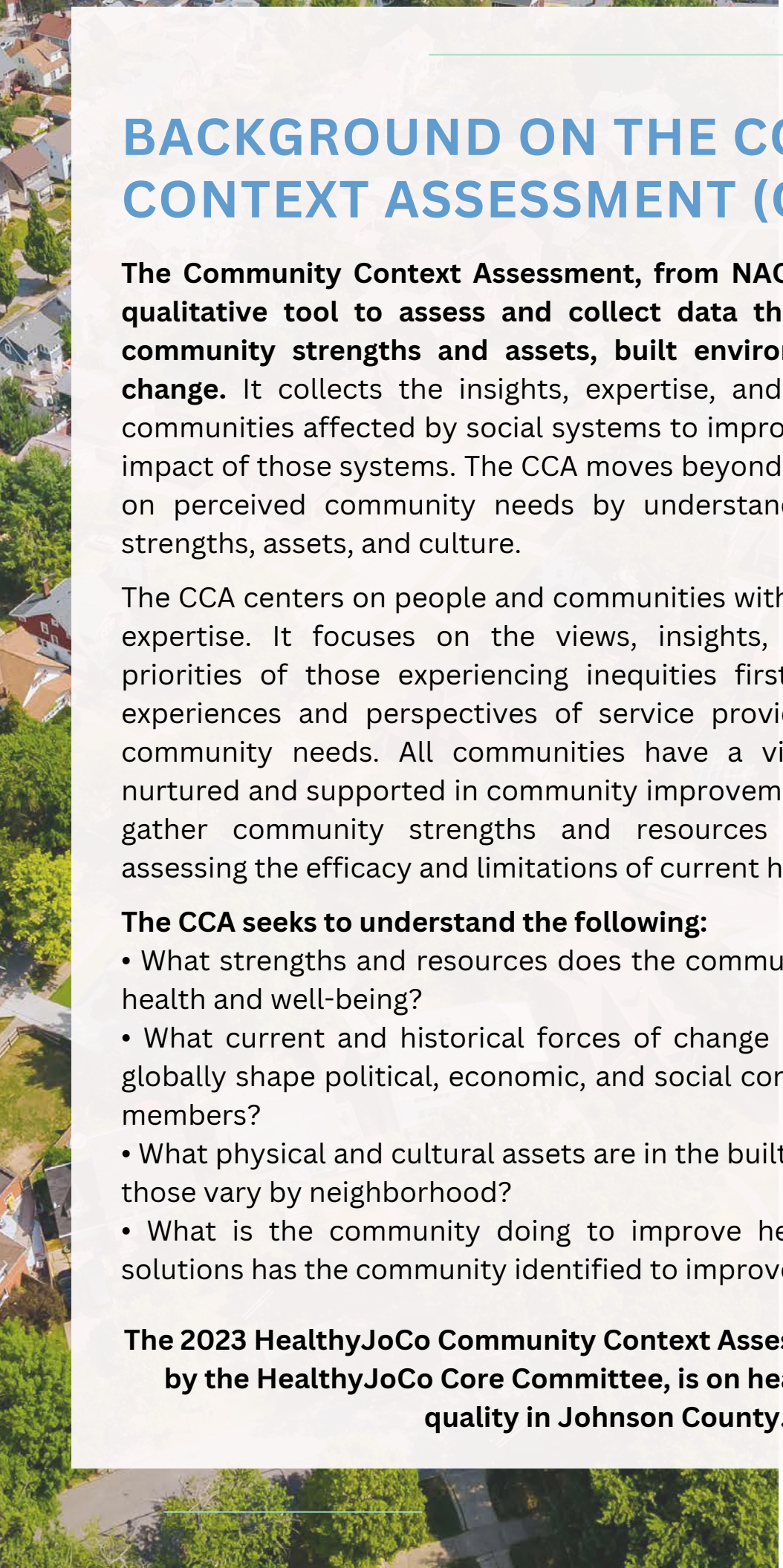
COMMUNITY CONTEXT ASSESSMENT REPORT

RELEASED AUGUST 2023



BACKGROUND ON THE COMMUNITY CONTEXT ASSESSMENT (CCA)

The Community Context Assessment, from NACCHO's MAPP 2.0, is a qualitative tool to assess and collect data through three domains: community strengths and assets, built environment, and forces of change. It collects the insights, expertise, and views of people and communities affected by social systems to improve the functioning and impact of those systems. The CCA moves beyond interventions that rely on perceived community needs by understanding the community's strengths, assets, and culture.

The CCA centers on people and communities with lived experiences and expertise. It focuses on the views, insights, values, cultures, and priorities of those experiencing inequities firsthand, as well as the experiences and perspectives of service providers working to meet community needs. All communities have a vibrancy that must be nurtured and supported in community improvement, so it is essential to gather community strengths and resources while simultaneously assessing the efficacy and limitations of current health systems.

The CCA seeks to understand the following:

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

The 2023 HealthyJoCo Community Context Assessment's focus, guided by the HealthyJoCo Core Committee, is on healthcare access and quality in Johnson County.

METHODS

The HealthyJoCo (HJC) Community Context Assessment (CCA) consists of two components: the creation of a Johnson County Healthcare Access Map, and the facilitation of virtual focus groups to gather input from healthcare providers and community partners. These components together provide an in-depth depiction of the landscape of healthcare services offered in Johnson County as well as the accessibility and quality of those services.

Healthcare Access Mapping

The goal of the HealthyJoCo Healthcare Access map, also referred to as an asset map, was to visualize the locations and services of clinics in Johnson County for community members to easily access through an ArcGIS interactive online map.

The initial planning phase for the asset map began in January of 2023. Johnson County Public Health already had an established data set of healthcare facilities, which was utilized and expanded upon for this project. HJC staff created a survey (Appendix A) seeking information on healthcare access, including types of health insurance accepted and services provided by each facility. Survey questions were modeled from the healthcare access section of the previous Community Status Assessment. The final question of the survey asked healthcare providers if they would like to engage in a conversation with Johnson County Public Health regarding healthcare access and quality, and many participants for the focus groups and interviews were recruited through outreach conducted by the asset map.

In March of 2023, Johnson County Public Health staff and a student intern called 188 healthcare facilities to find points of contact and updated contact information. Many contacts were added into a directory that will be used for future projects and emergency preparedness activities. Between April-June of 2023, Johnson County Public Health staff collaborated with Johnson County's IT Department to input values from healthcare facilities' survey responses into ArcGIS Experience Builder for the map design.

The values displayed in the map include the facility name, address, website, and approximate number of community members living within a 0.75 mile radius. Facilities on the map are categorized by healthcare service type, such as hospitals; medical, dental, eye, mental health, and physical therapy clinics; pharmacies; and blood banks. Staff also collaborated with Johnson County Planning, Development, and Sustainability for assistance on mapping transportation. This asset map will continue as an ongoing JCPH project as staff update and input additional healthcare facility information to benefit community knowledge.

Focus Group Facilitation

The HealthyJoCo team also scheduled and facilitated focus groups with healthcare providers and community partners in order to gather information on healthcare access and quality in Johnson County. If only one participant was able to join at a particular scheduled time, the meeting would still be conducted utilizing the same questions; these meetings will be referred to as a key informant interview (KII) in this report. Discussions within these focus groups and KIIs elicited providers' and community partners' perspectives on the healthcare system and service delivery within the county, as well as participants' personal experiences and anecdotes from their patients or clients. These insights allowed for more in-depth exploration into the two main areas of emphasis identified from the 2022 Community Status Assessment: healthcare access and quality.

Focus groups and KIIs were held from March-May 2023, with one additional KII held in July 2023. All focus groups and KIIs were scheduled and facilitated by HJC staff, held virtually through Zoom, and recorded with participants' consent (obtained via Qualtrics, Appendix B). All focus group and KII participants' consent to their comments' presentation in the final report was given prior to publication in September 2023.

Many participants in the focus groups and KIIs were recruited through outreach conducted during the asset mapping component of the CCA. HJC conducted outreach to public and private healthcare facilities as well as nonprofit organizations and other community partners. To invite perspectives across different sectors, outreach was divided into four categories: general health; women's, maternal and reproductive health; dental health; and mental health (including crisis services and law enforcement, as these professionals often encounter and refer clients in need of mental healthcare).

A total of 46 providers, staff, and other community partners were contacted by email, phone, or both (if HJC staff could access contact information); 28 of those contacted responded to these invitations, and 23 participants completed a focus group or KII with HJC staff for an overall 37% success rate in outreach leading to an interview. All outreach efforts are documented in Table 1.

Focus group and KII participants were provided with the list of questions they would be asked one week prior to the focus group or interview via email (Appendices C-F), along with a link to the Qualtrics form through which they could give consent for JCPH to record the focus group or interview session. Consent to publish participants' names in association with their comments was optional; participants who did not consent to their names being published will be referred to as health professionals and acknowledged without name recognition in this report.

Focus group/KII questions included five general questions that were asked to every provider and community partner:

1. Please describe your work in Johnson County (e.g. How long have you worked in Johnson County, what is your job title, what services does your organization provide?)
2. Who is your patient/client population, and how do patients/clients find you or your services?
3. What does healthcare access mean to you? What are some ways you ensure access at your facility or in your practice?
4. What does healthcare quality mean to you? What are some ways you ensure or measure quality at your facility or in your practice?
5. How do you ensure cultural competency at your facility or in your practice?

These questions were asked in order to ascertain a baseline understanding of each participant's role within their organization, the scope of services that they provide, the patients or clients they serve, and their current perspectives on healthcare access and quality (including cultural competency and services such as language interpretation).

Following these five general questions, specific questions were asked of each healthcare sector (Appendices C-F) to gain deeper insight into the resources, strengths, barriers, and nuances of healthcare access and quality from the perspective of each organization or practice. The final interview questions, "Can you think of a way Johnson County Public Health can assist [your organization/sector] with improving health equity in Johnson County?" and "Is there anything else that you would like us to know?" were asked of all sectors as well. Questions were designed and selected to highlight the three MAPP 2.0 CCA Domains: Community Strengths, Built Environment, and Forces of Change.

After completion of each focus group or KII, HJC staff reviewed and edited the transcription of each recording. Responses to each question were then entered into an Excel spreadsheet as direct quotes. These quotes were coded according to the overall main concept(s) described in each statement, and comments were organized into categories based on the NACCHO Themes of Community Strengths; Organizational Capacity; Systems of Power, Privilege, and Oppression; Social Determinants of Health; and Health Behaviors and Outcomes. The percentages of comments related to each theme are presented by sector in the Results section of this report, along with specific quotes chosen by HJC staff to highlight important or recurring topics that emerged from focus groups and KIIs.

Table 1.) Outreach and contact efforts to healthcare providers and community partners for HJC focus groups/KIIs, by healthcare sector.

Organization Name	Date(s)	Outreach/Contact		Response	Focus Group or KII		Notes
		Email	Phone		Meeting Scheduled	Interview Completed	
General Health							
UIHC Interpretation and Translation Services	03/2/23	X		Yes	Yes: 03/21/23	Yes: 03/24/23	
UIHC Family Medicine	03/2/23 03/14/23	X		No	No	No	
UI Stead Family Children's Hospital Chairperson	03/14/23 03/21/23	X		No	No	No	
UI Stead Family Children's Hospital, Center for Disabilities and Development	03/14/23	X		Yes	No	No	
UIHC Patient Experience Advisory Board	03/14/23 03/21/23	X		No	No	No	
Linn County Public Health's Healthy Linn Efforts	03/01/23	X		Yes	No	No	We cancelled meeting when focus group was switched to KII
Iowa City Free Medical and Dental Clinic		X		Yes	Yes; March	04/03/23	
Iowa City Veterans Affairs		X		Yes	Yes; March	04/21/23	
Mercy Family Medicine Clinic	03/08/23; 03/13/23		X	No	No	No	
Summary		**% of orgs contacted by email**	**% of orgs contacted by phone**	**% of orgs contacted replied back**	**% of orgs contacted scheduled an interview**	**% of orgs contacted completed an interview**	
		88.9%	11.1%	55.6%	33.3%	33.3%	
Women's, Maternal & Reproductive Health							
Organization Name	**Date(s)**	**Outreach/Contact**		**Response**	**Focus Group or KII**		**Notes**
		Email	**Phone**		**Meeting Scheduled**	**Interview Completed**	
Corridor OB-GYN	03/22/23 05/05/23 05/10/23		X	No	No	No	
Margaret A. Smollen: Obstetrics and Gynecology	05/08/23 05/10/23	X		No	No	No	In the process of moving practices
Emma Goldman Clinic	03/27/23 5/03/23 05/05/23	X		No	No	No	
Planned Parenthood	03/27/23 05/03/23 05/05/23	X		No	No	No	
RVAP	03/14/23	X		Yes	Yes	Yes	
University of Iowa Hospitals and Clinics Family Medicine Clinic	07/21/23	X		Yes	Yes	Yes 7/27/23	
University of Iowa Hospitals and Clinics OB-GYN Midwife Clinic	07/21/23 07/27/23	X		No	No	No	
University of Iowa Hospitals and Clinics OB-GYN	03/20/23 07/21/23	X		Yes	No	No	Scheduling difficulty
Summary		**% of orgs contacted by email**	**% of orgs contacted by phone**	**% of orgs contacted replied back**	**% of orgs contacted scheduled an interview**	**% of orgs contacted completed an interview**	
		87.5%	12.5%	37.5%	25%	25%	

Mental Health							
Healthcare and Counseling Service Providers							
Organization Name	Outreach/Contact				Focus Group or KII		Notes
	Date(s)	Email	Phone	Response	Meeting Scheduled	Interview Completed	
Acceptance Recovery Counseling	3/14/23; 3/27/23; 4/5/23	X	X	Yes	Yes: 4/13/2023	Yes	
Guidelink Center	3/22/23; 3/27/23	X	X	Yes	Yes: 4/13/2023	Yes	
AbbeCenter for Community Mental Health	3/21/23; 3/27/23	X	X	Yes	Yes: 4/26/2023;5/5/2023	Yes	
Community and Family Resources	3/14/23	X		Yes	Yes: 4/26/2023;5/17/2023	No	Make-up focus group scheduled; accepted meeting invitations but did not attend
CommUnity Crisis Services	3/14/23; 3/21/23	X		Yes	Yes: 4/26/2023	Yes	
Iowa Refugee Counseling Center (Iowa City Compassion)	3/20/23	X		Yes	Yes: 4/13/2023;5/17/2023	No	Make-up focus group scheduled; accepted meeting invitations but did not attend
Alli Center	3/20/23	X	X	Yes	Yes: 4/13/2023	Yes	
UIHC Psychiatry- Mental Health	3/21/23; 3/27/23	X		Yes	Yes: 4/13/2023;5/5/2023	Yes	
UIHC Emergency Dept	3/21/23	X		Yes	Yes: 4/13/2023; 5/17/2023	No	Make-up focus group scheduled; accepted meeting invitations but did not attend
VA Mental Health Services	3/14/23; 3/20/23; 3/21/23	X	X	No	No	No	
Meadowlark Psychiatric Services	3/27/23	X		Yes	Yes: 4/13/2023	Yes	
Mercy Behavioral Health Clinic	3/20/23; 3/27/23	X	X	No	No	No	
Ward Counseling Services	3/20/23	X	X	No	No	No	
Psychiatric Associates	3/27/23	X	X	No	No	No	
Summary							
		% of orgs contacted by email	% of orgs contacted by phone	% of orgs contacted replied back	% of orgs contacted scheduled an interview	% of orgs contacted completed an interview	
		100%	57.1%	71.4%	71.4%	50%	

Mental Health - Community Partners and Advocates							
Shelter House	3/21/23; 3/27/23	X		Yes	Yes: 4/13/2023	Yes	
Iowa Mental Health Advocacy	3/21/23	X		Yes	Yes: 4/13/2023	Yes	
American Association for Community Psychiatry	3/22/23	X		Yes	Yes: 4/13/2023;5/17/2023	No	Make-up focus group scheduled; accepted meeting invitations but did not attend
Johnson County Jail & Sheriff's Office	3/21/23; 3/27/23	X		Yes	Yes: 4/11/2023	Yes	
Iowa City Police	4/5/23	X		Yes	No	No	
NAMI Johnson County	3/27/23; 4/5/23	X	X	Yes	No	No	Emailed via "contact us" webpage

Summary

	% of orgs contacted by email	% of orgs contacted by phone	% of orgs contacted replied back	% of orgs contacted scheduled an interview	% of orgs contacted completed an interview	
	100%	16.7%	100%	66.7%	50%	

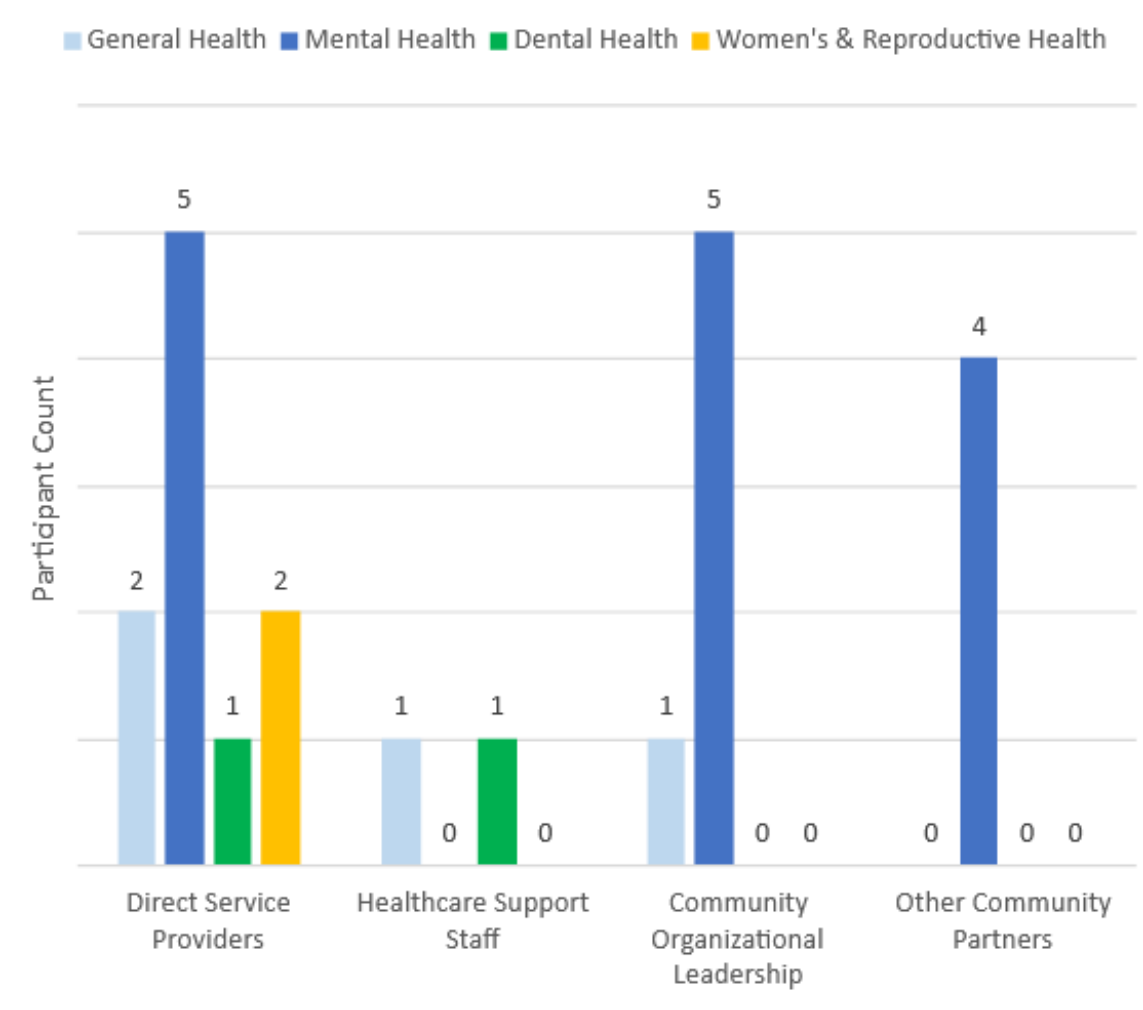
Dental Health							
Organization Name		**Outreach/Contact**			**Focus Group or KII**		**Notes**
	Date(s)	**Email**	**Phone**	**Response**	**Meeting Scheduled**	**Interview Completed**	
Croco Orthodontics	3/14/23; 3/22/23; 4/4/23	X	X	Yes	Yes: 4/11/2023	Yes	
Iowa City Orthodontics	3/14/23; 3/22/23	X		No	No	No	
North Liberty Oral Surgery & Dental Implants	3/14/23; 3/22/23	X		No	No	No	
The Family Dental Center	3/14/23; 3/22/23	X		No	No	No	
The Children's Dental Center	3/14/23; 3/22/23	X	X	No	No	No	
Iowa City Dental Health	5/1/23		X	Yes	No	No	
Corridor Kids	5/1/23	X	X	Yes	Yes: 5/12/2023	No	Interview was scheduled for 5/12/2023 but cancelled by provider
Michael Kanellis	03/13/23	X	X	Yes	Yes: 03/13/23	Yes 05/02/23	
Midwest Dental	03/28/23	X	X	No	No	No	

Summary

	% of orgs contacted by email	% of orgs contacted by phone	% of orgs contacted replied back	% of orgs contacted scheduled an interview	% of orgs contacted completed an interview	
	88.9%	66.6%	44.4%	33.3%	22.2%	

Figure 1 below details the sectors of focus group and KII participants who were interviewed, based on the type of work they specialize in. Direct service providers saw the highest participant counts overall, compared to other categories of healthcare support staff, community organizational leadership, and other community partners.

Figure 1.) Focus Group and KII Participants, by Sector and Type of Work



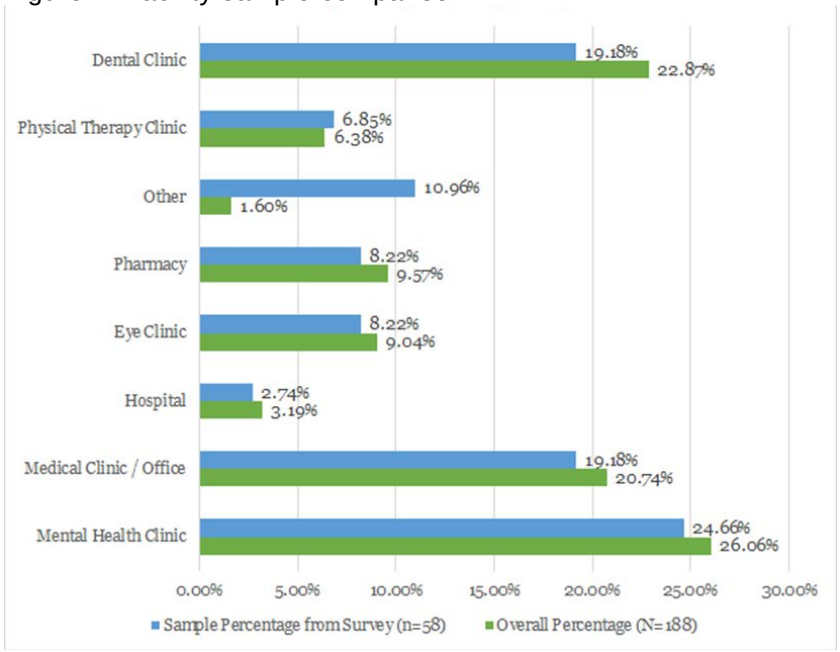
HEATHCARE ACCESS MAP

HEALTHCARE ACCESS MAP

Asset Map Survey Results

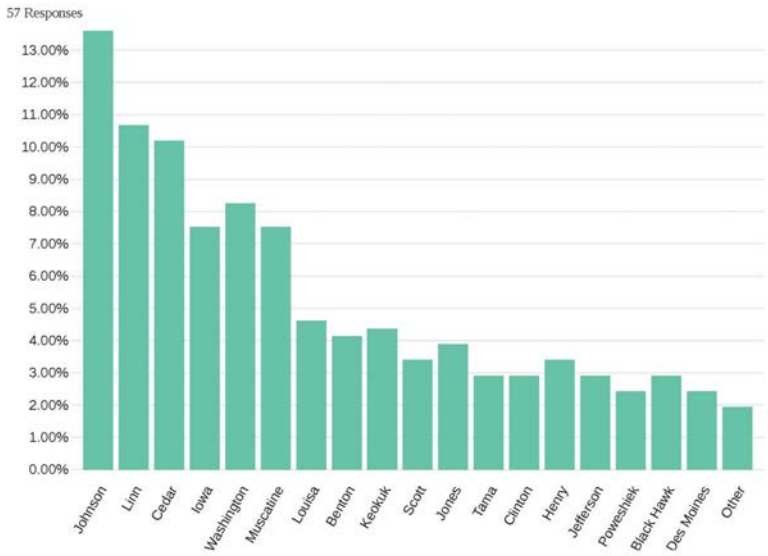
Approximately 58 of the 188 overall health care facility respondents completed the survey used to populate the healthcare access asset map in March of 2023. Of the 58 respondents, 17% reported having more than one facility or clinic in Johnson County. Mental Health Clinics accounted for the highest percentage of respondents in the survey, at almost 25%. Figure 2 shows the distribution of all types of places Johnson County Public Health staff reached out to compared to the responses received back on the survey sample.

Figure 2. Facility sample comparison



Many health facilities service individuals from Johnson County, as well as other counties. Figure 2 shows the overall service area distribution amongst counties nearest to Johnson County. Johnson and Linn are the resident counties of those most commonly served at health facilities in Johnson County.

Figure 3. Health Facility Service Area



Health Insurance Accepted

Figures 4 – 7 show types of insurance accepted by health facility type.

Figure 4. Facility acceptance of **Medicaid health insurance**

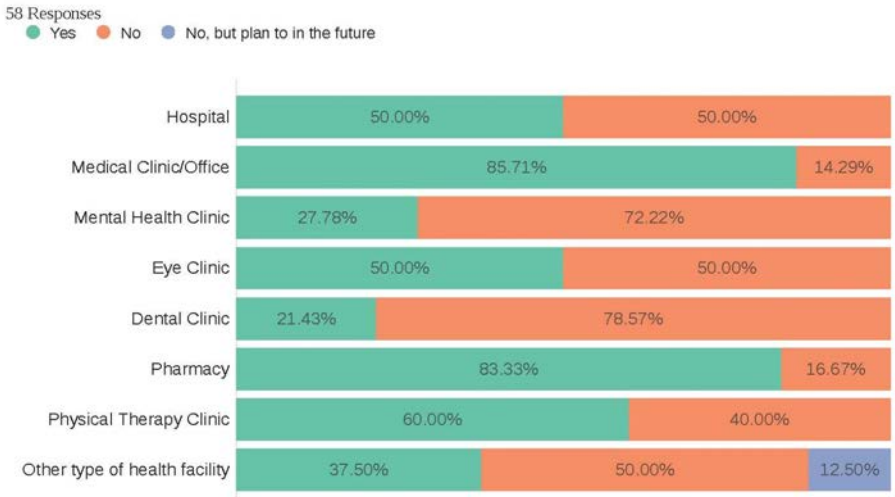


Figure 5. Facility acceptance of **Medicare health insurance**

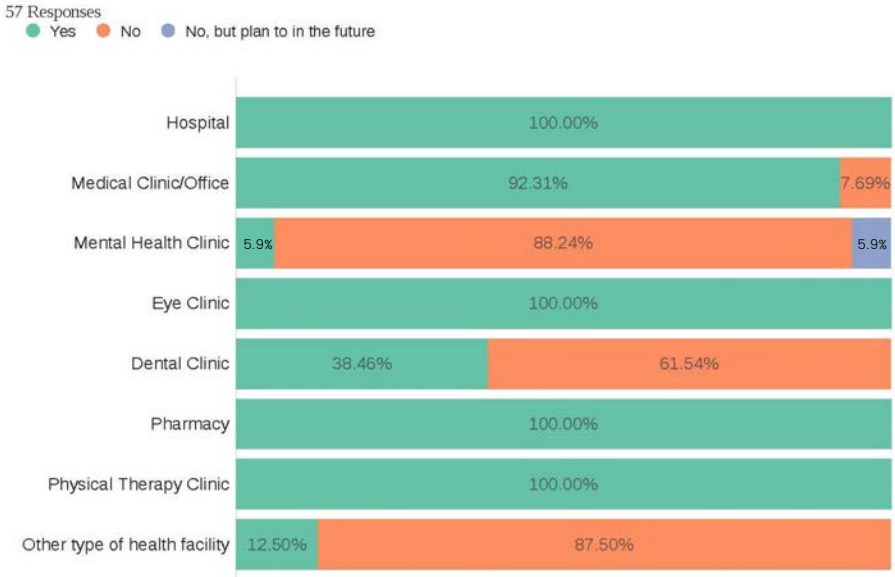


Figure 6. Facility acceptance of **private health insurance**

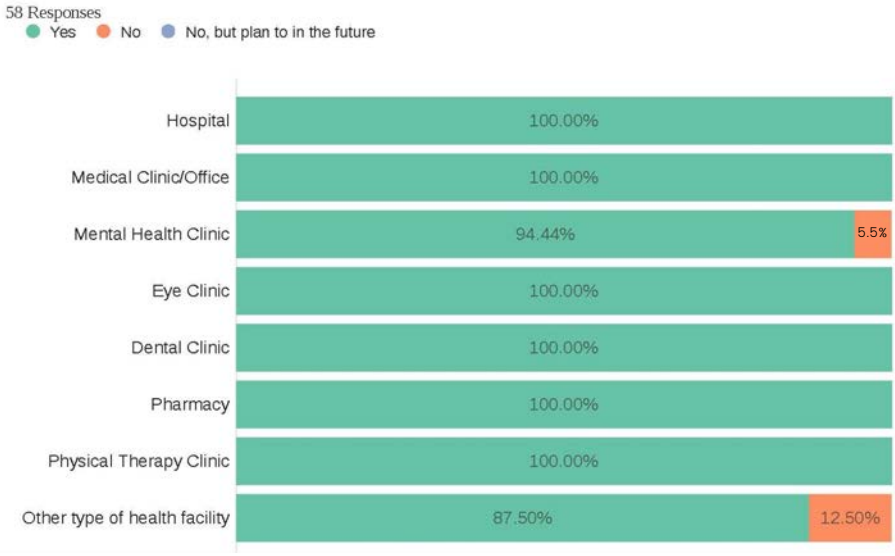
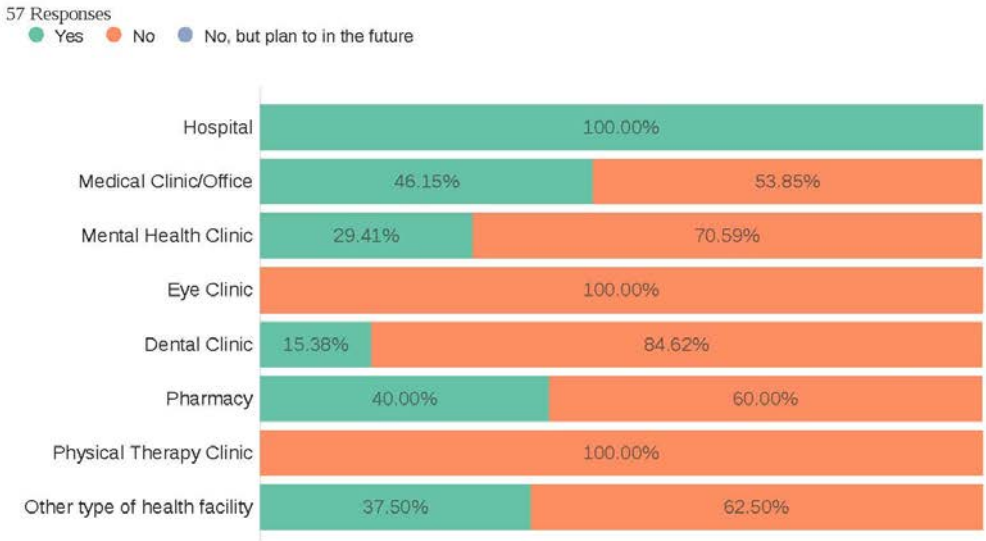


Figure 7. Facility offering **sliding-scale discount program or cost assistance** for patients who cannot afford care



Health Facility and Clinic Attributes

Figures 8 – 16 show other attributes of each health facility, such as the capability of on-site language interpretation or telehealth visits.

Figure 8. Facility providing **on-site, in person language interpreters or translators**

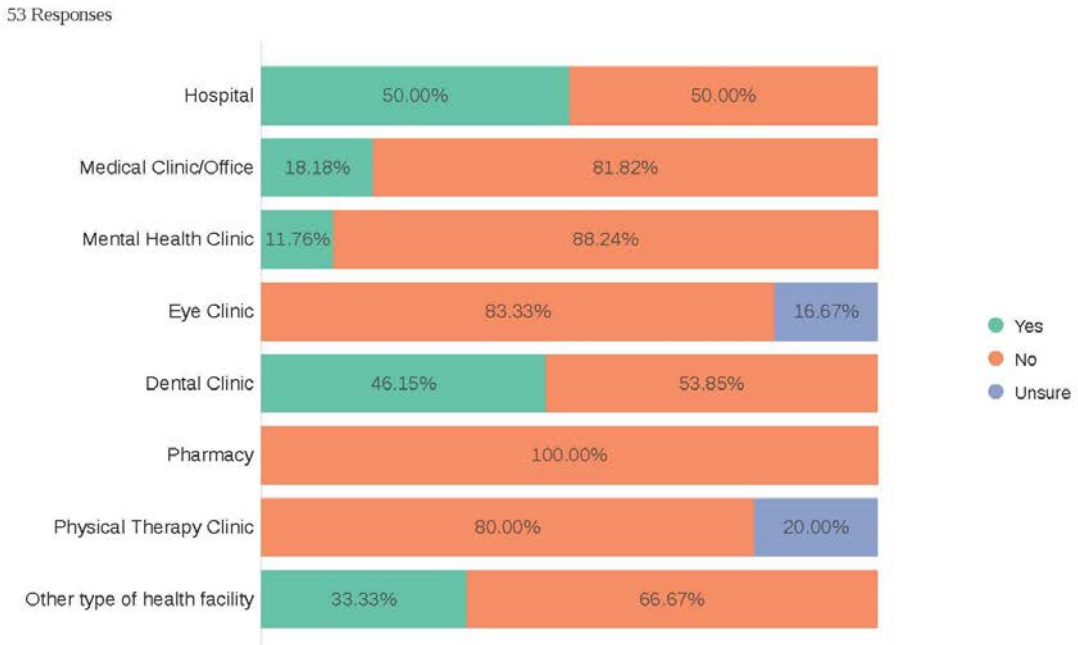


Figure 9. Facility providing **language interpretation or translation services via digital devices,** such as tablets or telephones.

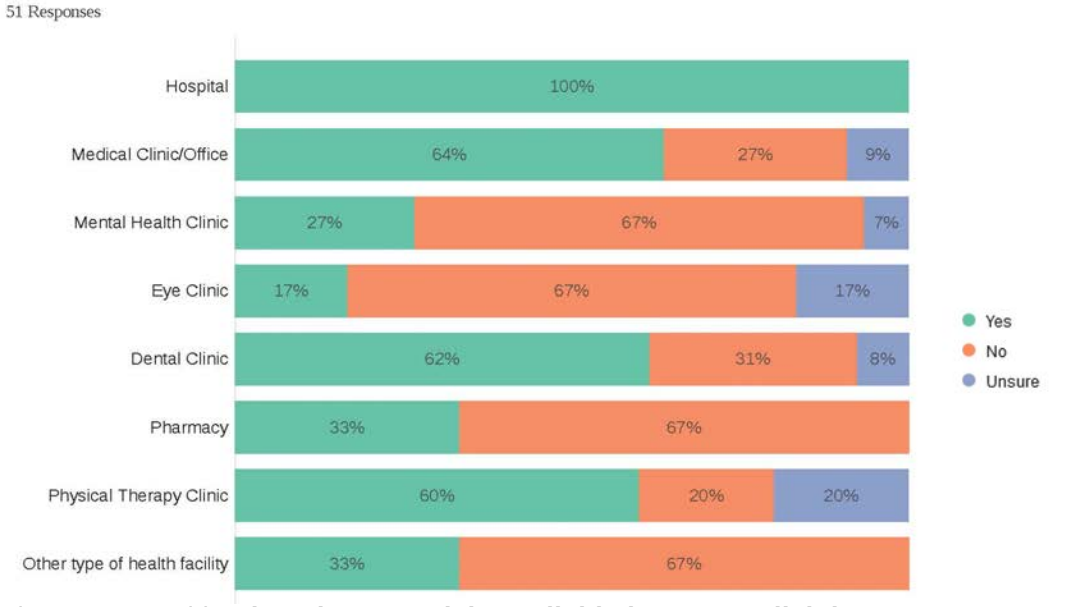


Figure 10. Health **education materials available in non-English languages.**

Figure 11. Facility identifies as **LGBTQ-inclusive**

Figure 12. Facility offers **transportation assistance** to patients

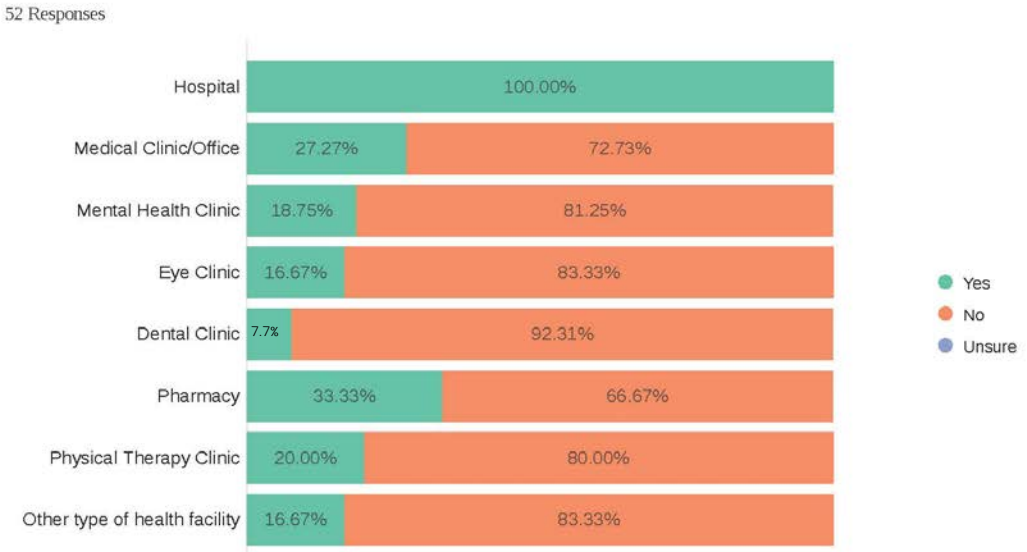


Figure 13. Facility offers **telehealth appointments via phone or video**

Figure 14. Service **prices** at the facility are **publicly available**

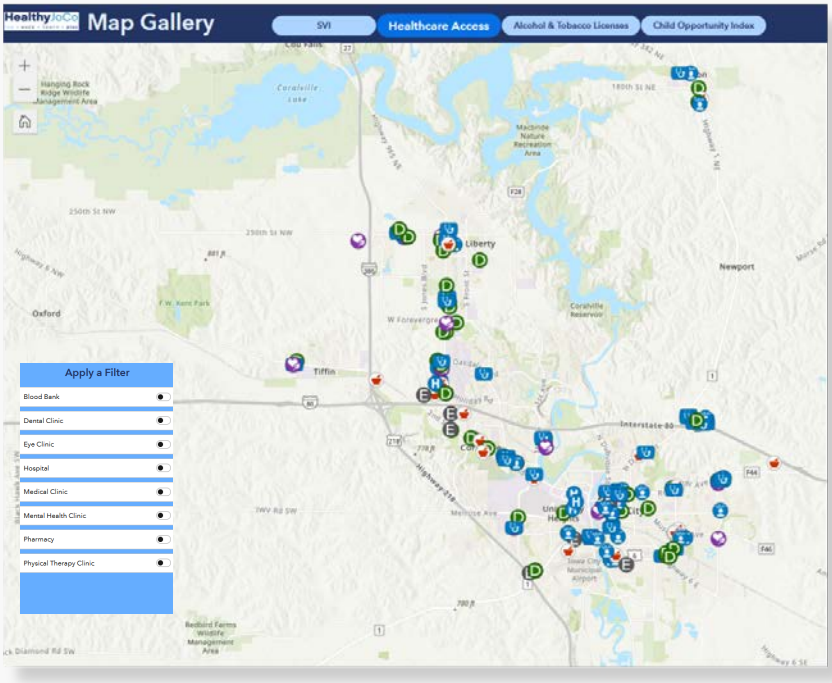
Figure 15. Staff required to participate in **Diversity, Equity, and Inclusion (DEI) training**

Figure 16. Facility **recruits and maintains diverse staff**

HEALTHCARE ACCESS ASSET MAP

Asset Map Preview

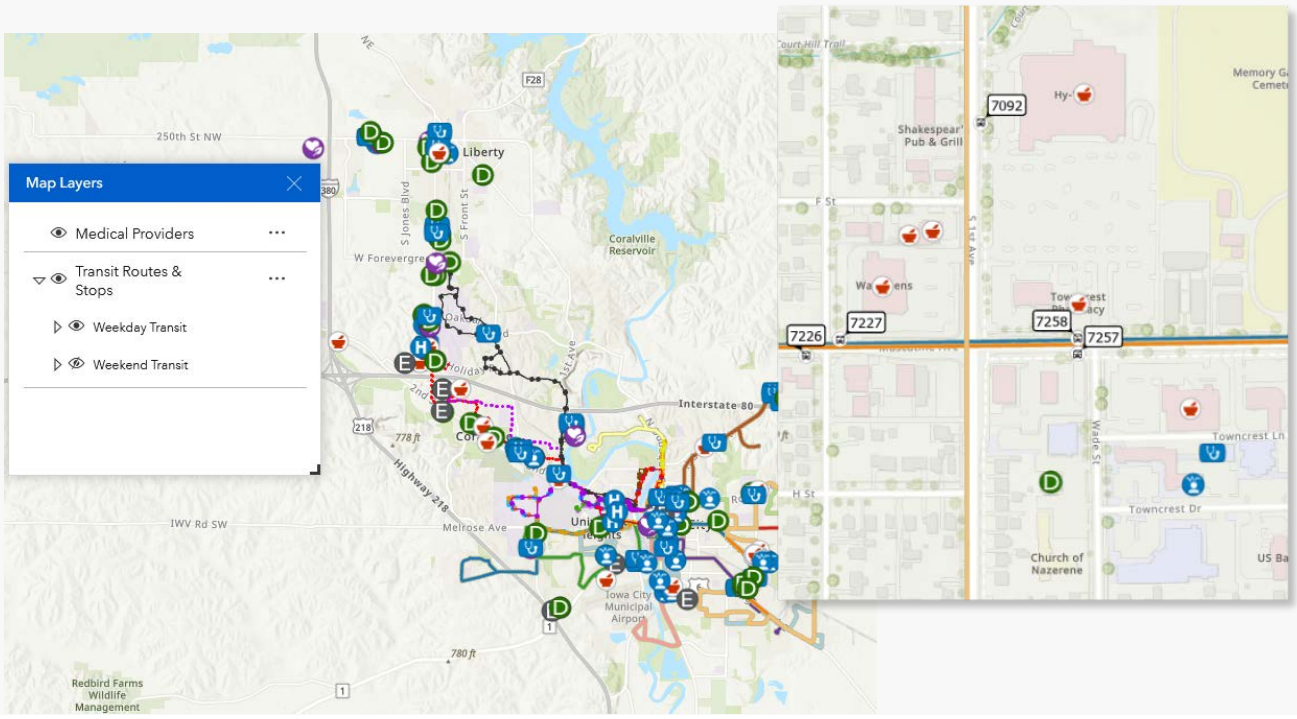
The image on the right is a snapshot of the HealthyJoCo Healthcare Access Asset Map. Each icon represents a health facility of some kind, which users are able to toggle on and off using the filters.



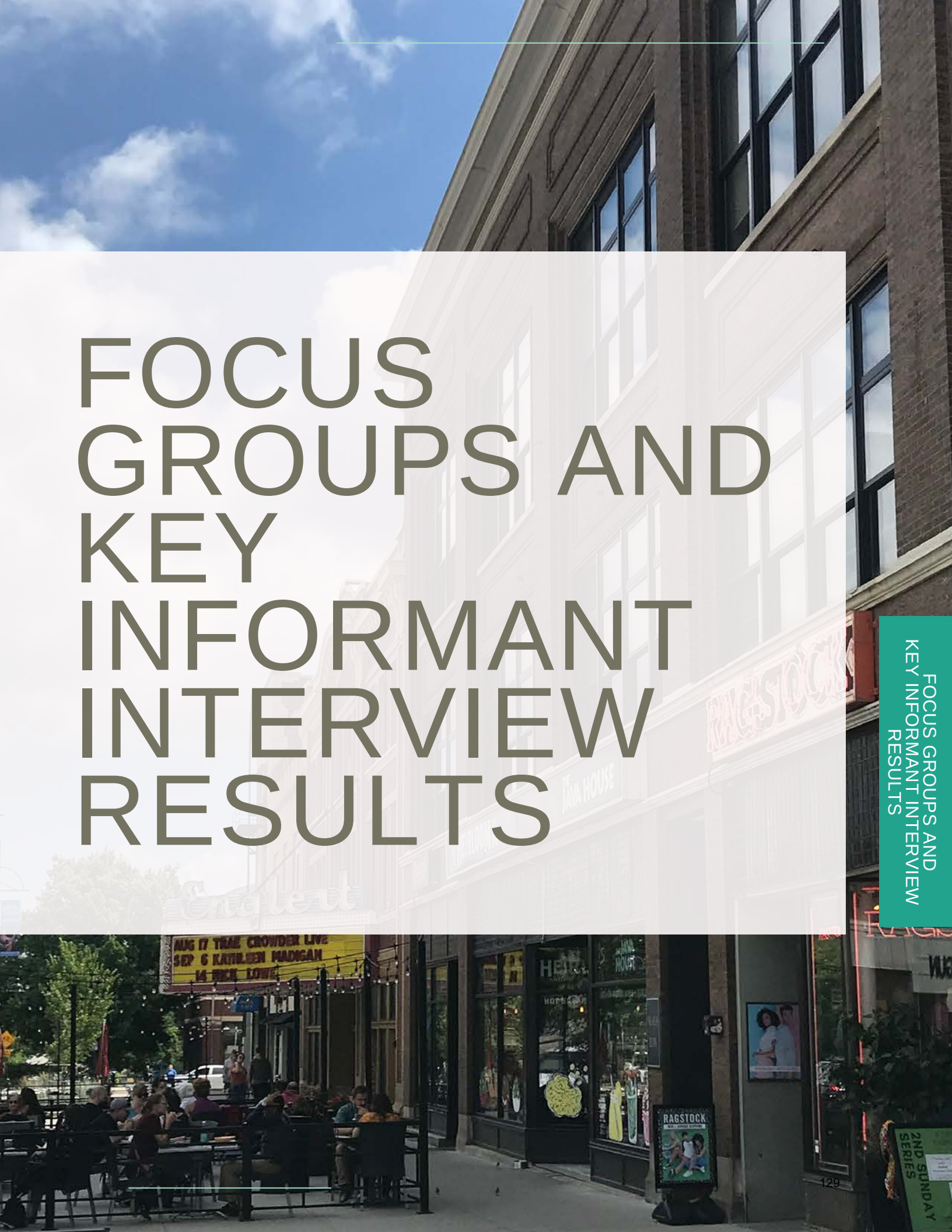
Once an icon is clicked on, users will see the address of the location, a link to their website as well as Google Maps link, and information about how many individuals live within 0.75 miles of the facility (which is considered walking distance).

Access the full map at gis.johnsoncountyiowa.gov/hjc

The image below is another snapshot of the HealthyJoCo Healthcare Access Asset Map that includes health facilities as well as transit routes and stops. Users are able to visualize the bus stop number nearest each facility.



FOCUS GROUPS AND KEY INFORMANT INTERVIEW RESULTS



MAPP 2.0 THEMES

Results in this section have been coded and organized in relation to the five overarching MAPP 2.0 Themes. For additional context, all are described below using definitions from the NACCHO MAPP 2.0 Handbook.

Systems of Power, Privilege, and Oppression

According to NACCHO, systems of power, privilege, and oppression represent the root causes, or structural drivers, of inequity. Privilege operates on personal, interpersonal, cultural, and institutional levels and gives advantages, favors, and benefits to members of dominant groups at the expense of members of target groups. Oppression embodies the combination of prejudice and institutional power, which creates a system that discriminates against some groups (often called "target groups") and benefits other groups, including those groups mentioned earlier who experience privilege (often called "dominant groups"). Examples of these systems are racism, sexism, heterosexism, ableism, classism, ageism, and antisemitism.

Social Determinants of Health (SDOH)

SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The five main SDOH areas include: economic stability; education access and quality; healthcare access and quality; neighborhood and built environment; and social and community context.

Health Behaviors and Outcomes

Health behaviors are actions people take that affect their health. These can lead to improved health, such as eating well and being physically active; or increase one's risk of disease, such as smoking, excessive alcohol intake, and risky sexual behavior. *Health outcomes* represent how healthy a community is right now. They reflect the physical and mental well-being of residents within a community through measures representing length and quality of life.

Community Strengths and Organizational Capacity

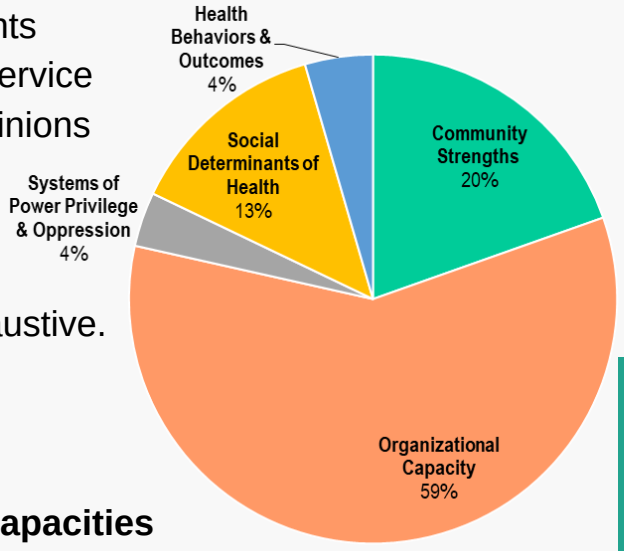
Data contributing to these two themes were often combined into one section. These themes include information on how partner organizations' capacity and activities align with the 10 Essential Public Health Services and on community organizing and resiliency.

GENERAL HEALTH

METHODS

In addition to having a set list of contacts from the asset map, HealthyJoCo staff members contacted via email and phone call a variety of providers within Johnson County and neighboring counties to gain a holistic perspective on available resources, better understanding of clients being served, and areas of improvement between public health and community organizations.

We understand these interviews are the thoughts and opinions of healthcare professionals and service providers, and may not reflect thoughts and opinions of all healthcare professionals in the areas of general, dental, mental, or reproductive health. We also understand issues and solutions offered in this report may not be exhaustive.



RESULTS

Community Strengths and Organizational Capacities

The frequency of comments made by general health providers for the MAPP theme of community strength was 19.64%. Participants described transparency of understanding care, availability, and resource expansion and knowledge as important themes in ensuring access to healthcare. All participants emphasize the significance of having their patients understand their care plans and options. One participant stated, **“Our ethics teams have been really working to clarify and create a knowledge base around decisional capacity versus competency and how we can support people in a lot of different ways and allow them [clients] to try as many options as possible”**. Another participant describes how healthcare access should be available to everyone. They describe access as the following: **“So regardless of their background or their resources or lack thereof. That’s what it means to me just that if you’re sick or need help that you should be able to get that help and so some ways that we try to do that here.”**

GENERAL HEALTH

Community Strengths and Organizational Capacities (cont.)

The highest frequency of comments made by general health providers was 58.93% regarding organizational capacity. Interviewees shared a plethora of resources each of their organizations have to offer, how they're getting this information to patients, and strategies to overcome barriers they face. In efforts to understand how organizations continuously improve the quality-of-care they offer, a participant states, **"The patient advocate tracking data and that's the data that the complaints or compliments, questions, whatever that we get in our patient advocates office, we log"** . Another interviewee describes quality of care as the following: **"...our mission as an institution is providing world class medicine and changing people's lives. Right. And so, I think if we're able to do that again, regardless of your background, your language, your socioeconomic status, your education, your understanding of healthcare as a whole, if we're able to make your health better, your children's health better, improve healthcare outcomes, that's what healthcare quality means to me".**

Systems of Power, Privilege, and Oppression

The fewest number of comments were made regarding systems of power, privilege, and oppression with 3.57%. While interviewees shined light on their resources and organization's capabilities, they addressed some adversities faced as well. One participant mentions, **"not every veteran qualifies for every service, which is a little bit of a challenge too...we do have priority groups when we're looking at more limited resources"**. Insurance literacy and access are additional barriers seen across all interviewed organizations. An interviewee says the **"type of insurance eligibility is certainly a barrier. A lot of our patients that are undocumented, for example, aren't eligible for most insurance plans and if you need to have a big surgery, you're going to incur a huge cost without insurance, right? So, the insurance are barriers, the language is a barrier, transportation is another big barrier for a lot of our families".**

GENERAL HEALTH

Social Determinants of Health

The frequency of comments made by general health providers was 13.39%, addressing social determinants of health. An interviewee goes into detail about their internal assessment and how they are utilizing this tool to enhance their understanding of client needs. This individual shares, **“We’ve got a comprehensive social work assessment that will be completed....for identified patients. We have what’s called CAN [Care Assessment Needs] scores. ...our comprehensive assessment or our triage assessment identifies what social determinants of health [clients fall under] and assessing for that”**. In gaining a comprehensive assessment of client needs, an interviewee highlights the importance of clients’ choosing their healthcare action plans. An interviewee says, **“...we want to make sure that we are attending to theirs [needs] and getting them the access and healthcare in the area where they want to be served”.**

Health Behaviors and Outcomes

Providers’ comments made regarding health behaviors and outcomes were 4.46%. During our interviews we learn about clients’ expressing the difficulties maintaining a variety of health behaviors. Whether that is consistently taking their medication, completing certain steps for a surgery, changing their nutritional intake, etc. In efforts to help clients improve their health behaviors, an interviewee shares how they go above and beyond: **“...we have one patient who’s on a number of pills three times a day and he comes in every month. Any my nurse, my care manager sits. She punches out all his pills and she fills the Monday, Tuesday, Wednesday. You know, four weeks' worth of boxes. Because that’s what it takes for him to be able to comply with his medicine regime... that’s quality care”.**

GENERAL HEALTH

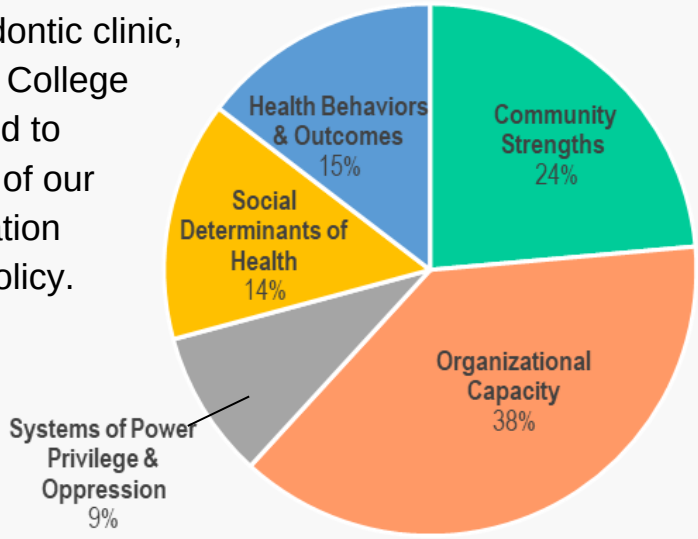
Health Behaviors and Outcomes (cont.)

In an effort for organizations to meet people where they are, clinic hours are expanded. One interviewee shares, **“Wednesday nights, they have what they call international clinic. So, they can see patients that speak Swahili, that have preferred languages of Swahili, French, Spanish, and Arabic. And so, families that identify as preferred language for those have that as an option. It's later in the evening, it's like 6:00 to 8:00 or 6:00 to 9:00 PM because a lot of our patients that are non-English speaking have end up working jobs that are first or second shift and so they're not necessarily available during business hours to come to appointments”.**

DENTAL HEALTH

METHODS

Staff began recruitment by speaking with the Public Health Dental Hygienist within Johnson County Public Health. With her guidance, we then proceeded to call and email several general and pediatric dental clinics with information about the MAPP 2.0 framework and the goal of collecting their experience on patient barriers to access dental care in the county. Additionally, the asset map survey provided us with dental providers who were interested in hearing more about the project. Despite multiple attempts to connect with these providers, only one orthodontic clinic confirmed participation in the assessment. In addition to the orthodontic clinic, a provider at the University of Iowa's College of Dentistry and Dental Clinics agreed to participate after connecting with one of our staff during an online Zoom presentation about Dental Health and Medicaid Policy.



RESULTS

Community Strengths and Organizational Capacities

Overall, participants in the dental health key informant interviews (KII) provided a total of 20 comments or a frequency of 30% addressing the MAPP theme of community strength. Some clinics have a unique opportunity to support the health and wellbeing of the community like trying to fill patient needs, a practitioner participant describes, **"we employ, and have for some time—I think we were the first dental school in the country to do this—a full-time social worker to help arrange for transportation needs for the patients. We do accept all insurances, which is rare. We do utilize a language translation service, but I think we can do more. Our clinics are so busy right now that we don't do a lot of outreach to increase the number of patients seeking care here. But we do try to make sure that it is acceptable and appropriate care when they come."**

DENTAL HEALTH

Community Strengths and Organizational Capacities (cont.)

Participants described customer service, transparency and affordability of care as important themes in healthcare access. Another participant notes that their employer avoids pushing patients into unnecessary treatments, **“One of the reasons he is the best orthodontist is he never tries to encourage anyone to get braces if it’s not worth it. We also don't want to put people in a financial struggle so there is no pressure at our consults.”** They also shared examples of how their clinic is supporting dental access by being flexible with payment options. One participant shares, **“We want to work with [patient's] budget, and when patients get behind on their accounts, we don't just immediately send them to collections”**. The dental clinic builds a plan tailored to the patient's financial situation. Another participant states, **“this 2011 fund, or patient assistance fund, is used for patients who are already in the door. They're already in our clinics that need the treatment but can't afford it.”** Being unaware of payment plan options, adjustments and available resources certain practices offer can delay care, making it more expensive when care is received, or prevent someone from receiving care all together.

Receiving quality healthcare is another crucial element to accessing healthcare. If a patient has a negative experience while trying to access care or while getting care that did not result in a satisfactory health outcome, this can deter them from seeking care from a facility at a different time and sharing their experience with their community. A participant notes that, **“Health care quality, to me means having a healthy mouth, no active disease, good function, and acceptable aesthetics—so that you can speak and chew and interact with the public with confidence.... Health care access means that members of the community have the ability to receive the dental care they need in a timely fashion. And that would include the ability to afford the care as well as to physically access the care, and have that care patient-centered, culturally competent, etcetera.”** If dental health care access is unavailable for those who cannot afford care, we have a chunk of the population not getting routine screenings and preventative cleanings, putting them at a higher risk for developing costly and painful oral disease.

DENTAL HEALTH

Community Strengths and Organizational Capacities (cont.)

According to the Community Status Assessment, 34.37% of survey respondent's reasonings for not seeing a dentist was because of fear that it'll be too expensive (1). Although our sample of dental providers is small, it is important to acknowledge the flexibility of clinics as a resource to access dental services that are available at some dental clinics. The frequency of organizational capacity comments made by dental providers during their interviews was 35.71%. Both participants described having administrative services or support in order to provide the best quality of care for their patients. A private practice staff member mentions having updated practice management software that alerts staff with a patient's pronouns and greeting name to ensure their patients feel comfortable and respected. Another provider states, **"...because we're a dental school, we actually have a curriculum that hits pretty heavily on cultural competency during the first two years of dental school. And then during the third and fourth year, they have the opportunity to work with a very diverse patient population to put that training into action. I think it's during that final two years of patient care where they're spending more than 80% of their time with patients that really brings everything together for them. It really reinforces the concepts that we've tried to instill in them during the first two years of a didactic curriculum."** Other comments made in organizational capacity include quality measurement at their facilities. The changes to administrative services that the clinics have improved and expanded their ability to provide quality dental healthcare.

1. Johnson County Public Health. (2023). Community Status Assessment Report.

DENTAL HEALTH

Systems of Power, Privilege, and Oppression

The frequency of the MAPP theme, systems of power, privilege and oppression, made by participants during the KII was 17.14%. Participants shared frustration with Medicaid policies in Iowa. One provider states, **“it seems like the number one problem with Dental Medicaid in Iowa is that the fees have not been increased in the last 20-plus years.”** Another participant echoes the sentiment, **“I mean, what did Medicaid pay? Like $3,200. And we charge close to [double as much]”** Private practices that accept patients with Medicaid are few and far between in Johnson County, as it is in much of Iowa, largely due to the low Medicaid coverage for dental services. The lack of funding and reimbursements to the program has caused some dental providers in the county to not accept Medicaid patients. The same participant stated, **“we did accept Medicaid for many, many years. Once Medicaid switched over in July of [2021] that's kind of when we tapped out.... One [reason for leaving Medicaid] it's difficult to get a claim processed. Number 2, we're kind --- we're almost losing money.”** This participant notes that their clinic is losing money due to the cost/ payment discrepancy. The decreasing payout from Medicaid to providers has made it a burden to accept patients with Medicaid insurance. They continue to say, **“We want to help people we do, but if we accepted all of the Medicaid patients [that call the clinic] we wouldn't survive as a practice.”** Private dental practitioners are then stuck with the difficult decision to help one patient or keep their practice open. This has increased pressure for clinics that do not turn away Medicaid patients, like the College of Dentistry and Dental Clinics, **“...Because of the decrease in the number of dentists accepting new Medicaid patients statewide, we’ve kind of become a safety net for the state more than we have been in the past... Now when the marketing committee meets and we talk about what we should be doing, we've had very, very little request to market for increased patient volume because we just can't handle it.”**

DENTAL HEALTH

Social Determinants of Health

The frequency of social determinants of health (SDoH) comments made by participants during their KII was 17.14%. When providers were asked to describe the rate of needs of community members being served on a scale from one to ten, one being not at all and ten being above and beyond, one participant describes, ***"...dental disease is such a disease of disparities that for lower socio-economic status patients, I think the rate of needs being served would be relatively low, like maybe a three or a four...If you have the means to afford dental care in Iowa City, you're in great shape because there are some great dentists in this area. But if you're low-income and poorly educated, I don't think we're doing very well."*** The participant goes into more detail surrounding the impact that socioeconomic status (SES) has on dental healthcare access, **"...especially with kids. With kids, the dental disease is cavities, it's tooth decay, and 80% of it is found in 20% of the kids and that 20% is almost all low income, so just this huge disparity based on SES**." Dental health inequities between those with polarized socioeconomic statuses are gaping and largely complicated by Medicaid policies in Iowa. One participant mentions, **"They're also talking about adding assets to the determination eligibility for Medicaid like they used to, which might end up cutting 100-40,000 people out of the Medicaid program. So, you'll have more patients who are low-income but not covered by Medicaid."**

DENTAL HEALTH

Social Determinants of Health (cont.)

Though the inequities in dental care access are daunting, there are promising ways to begin bridging this gap. The participant explains **"I think that to try to engage private practitioners would be a really important first step because what I've seen in--let's pick a community like Burlington. Burlington had private practicing dentists who accepted Medicaid. And then all of a sudden, the state opened up a federally qualified community health center there and that gave dentists in that community the opportunity to say, 'Oh, well, then that's where Medicaid patients need to go' and they no longer felt an obligation to see those patients. And I know that from speaking to dentists. We don't have a federally qualified health center in Iowa City, but I think there are states that are experimenting with programs where they try to get every dentist in the community to be willing to take, let's say six Medicaid patients a year, new patients or six referrals a year. I don't know what that program would look like for Iowa City or for Johnson County, but I do think it's worth pursuing. We've got really great people and great dentists in the community that aren't taking cold-call new patients on Medicaid. If they knew they wouldn't be overrun and there was somebody helping monitor the no-shows and the cancellations, I think that people would want to help."** The suggestion from this practitioner has been replicated in state dental coalitions like the Oregon Oral Health Coalition. One of the priorities in the strategic plan is to strengthen the dental infrastructure by incentivizing providers that serve Medicaid clients (2). By adopting a similar model, community members with Medicaid will have a variety of dental practitioners to seek care from and it'll not overwhelm current infrastructure.

2. Oregon Oral Health Coalition. (2016). Strategic Plan for Oral Health in Oregon.

DENTAL HEALTH

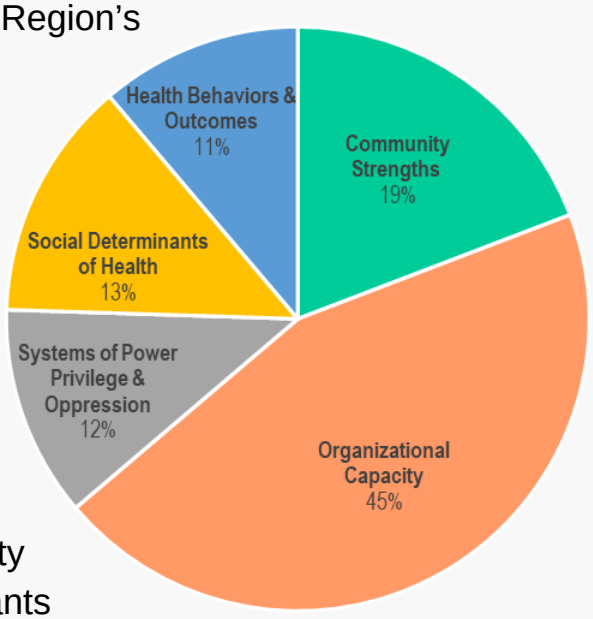
Social Determinants of Health (cont.)

Another SDoH-centered barrier to receiving care is language. A participant expands that, **"I think where we run into the most risk is at the initial contact. If somebody isn't comfortable with English, or if it's not their first language, who can make that phone call? And how at that point can we guarantee that someone on the other end of the line will be able to help them? Because we can't utilize the Delta Dental language line until they're physically in the building. I do think that the initial contact is rough. We do better with Spanish, of course, than with other languages. But my gosh, there are so many different languages and dialects and sometimes it's their fifth-grade child that's calling to make the appointment for the adult because the fifth-grade child knows how to speak English better...once we're in the building, I think we do a great job, but I worry that sometimes about those patients who don't have the comfort and confidence to make that initial contact."** Although, this facility has the capability to provide translation services for patients during their appointment, the challenge arises prior to stepping foot into the clinic. The timeline for beginning care starts with a phone call and if the patients are unable to communicate for an initial screening, they fall through the inequitable gaps in our healthcare system. This provider acknowledges that the clinics have identified this as an issue and a crucial moment on the timeline to accessing care where there is heightened possibility of community members falling through the inequitable gaps in our healthcare system.

MENTAL HEALTH

METHODS

HealthyJoCo staff consulted with Johnson County's Mental Health and Disability Services regarding outreach to mental healthcare providers and community partners in order to capture a broad range of perspectives on the mental healthcare system through work with a variety of clients and specific healthcare needs. Many providers and community partners were reached via Iowa Mental Health/Disability Services of the East Central Region's Johnson County System of Care meetings. A total of 20 providers and partner organizations were contacted, and 14 respondents participated in a focus group.



RESULTS

Community Strengths

The frequency of comments made by participants on the MAPP theme of Community Strengths was 19.15%. Focus group participants identified low barrier facilities for mental health and thorough follow-up care, including wrap-around services addressing social determinants of health, as important resources that support health and wellbeing in our community. Three of these key service providers/access points specifically identified and represented in the focus groups were CommUnity Crisis Services' Mobile Crisis Response; GuideLink Center; and Shelter House.

One partner from CommUnity Crisis Services explained that, "**Mobile Crisis [Response], by design, addresses some of those [common challenges]... We are free, we will come to you, and we are available within typically 15 minutes in Johnson County."** Mobile Crisis Response represents a community strength because it is a free and fast service that is available to anyone who is experiencing a mental health crisis. Community members are greeted by a mental health counselor who stabilizes the crisis and then conducts follow-up care. **"Our**

MENTAL HEALTH

Community Strengths (cont.)

robust follow-up is... just as important as the crisis counseling that we provide to people because they know we're not going to leave and walk away and never talk to them again. Like, people know that... once our counselors leave, in 24 hours they're going to get a phone call and, you know, that we're going to keep following up as long as they need."

Johnson County's GuideLink Center is **"a community-initiated collaborative led by the Johnson County Board of Supervisors. It is designed to offer a welcoming space where experienced staff can deliver 24/7 services, including rapid assessment, triage, stabilization, and follow-up resources."**(3) A participant from GuideLink stated**, "our door is open so [we'll] see anybody that comes in."** Regarding healthcare quality, **"This is what we say: you [should] feel comfortable bringing your own loved one [here for care]... and if you hesitate at all... then we're doing something wrong. So it has to be that level of quality, those types of standards."**

Another resource that supports health and wellbeing in our community is Shelter House, an organization that serves community members experiencing homelessness with the motto of "More Than a Roof and a Bed." Thinking about mental healthcare access and quality, one focus group participant from Shelter House emphasized the importance of wrap-around services in particular. **"I think about the amount of effort for those who I think struggle to integrate into healthcare services the most, how much more support they need than, kind of, one person calling them and telling/reminding them for an appointment... it's a lot of work to go see your doctor, let alone then all of the, like, tasks that need to happen after you have seen that doctor."**

A major strength in Johnson County is also the community emphasis on a collaborative approach to providing mental healthcare and related services, as many patients and clients present with complex and multifaceted concerns. Johnson County providers and community organizations regularly refer patients and clients to each other in an effort to provide that continuum of care and ensure that patients and clients are able to access all of the services they need.

3. GuideLink Center. (2023). *24/7 Services.*

MENTAL HEALTH

Community Strengths (cont.)

One community partner from Shelter House explained this as the importance of **“creating that [mental healthcare] access and building those relationships with some targeted partners within the... psychiatric world to be able to come to our agency and be able to provide services to the individuals in the space that they are living in currently."**

CommUnity Crisis Services, for example, also conducts outreach to organizations serving vulnerable populations in the county. **“Another example is the recent kind of collaboration with Open Heartland on support for their community. So... relying on their expertise and relying on their kind of own narratives about what their community needs... and what the services might look like that might best meet their needs.”** Addressing the needs of Johnson County requires communication and collaboration between all of these different organizations and agencies so that we can maximize the impact of our numerous strengths, assets, and resources to best serve our communities.

Organizational Capacities

The total comments made by focus group participants were 63, or a frequency of 33.51%, in regards to the MAPP theme of Organizational Capacity. The main comments were surrounding topics of facility capabilities and quality measurements. Focus group participants were asked how they measured and ensured accessibility and quality of care (and/or any other services) that they provide. Providers and community partners agreed that care should be affordable; available at the time it is needed; and appropriate, meaning that treatment or services fit the patient or client’s needs and are administered by staff who are appropriately educated and trained to provide that care.

Community organizations in Johnson County make great efforts to increase the accessibility of mental healthcare, particularly for populations who are often underserved. For example, one partner shared that their facility ensured healthcare access by **“…bringing the service to the person rather than always, you know, kind of creating that box and then they have to fit inside of it.”**

MENTAL HEALTH

Organizational Capacities (cont.)

However, ensuring that mental healthcare in Johnson County meets these goals of affordability, timeliness, and appropriateness in practice is often easier said than done. Organizational capacity to provide services for patients in Johnson County, especially at higher levels of care, is currently not enough to serve the number of folks in need in a timely and effective manner. Lack of an adequate number of facilities and providers, as well as challenges in referring patients with specific and complex needs, were both recurring themes in our focus group comments.

Although some facilities are adapting to the needs of the community, several participants noted a lack of care for young adults and a lack of longer-term facilities to treat patients with the highest needs. During the focus groups, participants identified the lack of facilities and providers as a barrier to the health of the community, and specifically the lack of mental health services for youth. One provider stated, **"we don't have enough mental health groups for adolescents or children. I think there's a huge gap in care of that tween age kid."** Another community partner mentioned, **"[a barrier is the lack of] youth crisis stabilization. Like, every time we are responding to a young person who could really, really benefit from three to five days in a youth crisis stabilization bed with time, with a therapist to talk about strategies and [be seen and treated] by a med provider."** Another provider's quote supports this sentiment: "**My adolescent clients who end up in UIHC Psych, they're not getting a lot of really high quality treatment during that stay. There's some maybe planning for afterward, but really it's not a huge transition when you go from the emergency room to the site floor."**

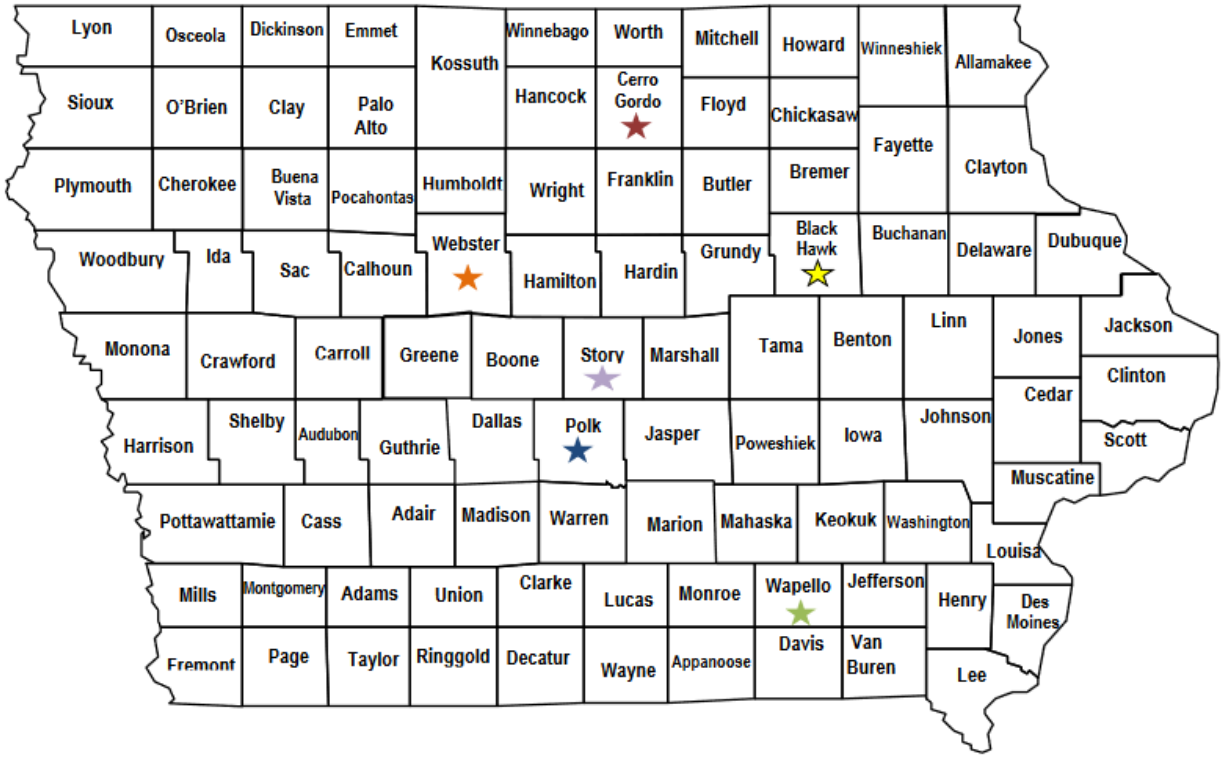
Crisis stabilization units are short term inpatient facilities with a more secure and less restrictive environment than a hospital, with the goal of stabilizing and providing resources to the patient before they return home. (4) Johnson County has Iowa City's GuideLink Center for adult crisis stabilization residential services; however, the county does not have these facilities for patients under 18 years of age (5). Figure 4 on the next page maps out the locations of Iowa's six child crisis stabilization units, with the closest facilities in Wapello and Black Hawk counties.

4. National Alliance on Mental Illness. (n.d). *Getting Treatment During a Crisis.*
5. Crisis Stabilization Residential Services- Child. (n.d). Iowa Department of Health and Human Services.

MENTAL HEALTH

Organizational Capacities (cont.)

Figure 4. Youth Crisis Stabilization Residential Services in Iowa



	Children's Crisis Stabilization Residential Services Provider	Location	Contact Information
★	Youth Shelter Care of North Central Iowa, Inc. (Ages 12-18)	Fort Dodge/Webster County	515-955-4222
★	YSS Francis Lauer (Ages 12-18)	Mason City/Cerro Gordo	641-423-7362
★	YSS Rosedale (Ages 12-18)	Ames/Story County	515-233-2330
★	American Home Finding Association	Ottumwa/Wapello County	641-937-5272
★	Easterseals Iowa	Des Moines/Polk County	515-288-0818
☆	North Iowa Regional Services	Waterloo/Black Hawk County	319-229-2240

5. Crisis Stabilization Residential Services- Child. Iowa Department of Health and Human Services.

MENTAL HEALTH

Organizational Capacities (cont.)

Further investigation into these facilities by a staff member revealed the number of inpatient beds ranged from two to eight. Additionally, American Home Finding Association, the child crisis stabilization unit closest to Johnson County, reported that they are currently not operating because of staffing issues. On this issue, one provider from our focus groups noted, **“The number of psychiatric inpatient beds has dwindled exponentially in our lifetimes. And that that is causing a pretty significant mental health crisis, especially for teens and their families. The average time that a teenager waits in an emergency room for a psychiatric hospital bed is four to seven days. Without leaving the Emergency Room.”** While patients can be referred for treatment outside of Johnson County, this is not a sufficient solution, especially for youth. **“The greatest predictor of success post hospitalization is the involvement of a parent figure while you were in the hospital. And if it's 7 1/2 hours away...”** that makes it incredibly difficult for a parent figure to be involved in treatment.

Additionally, the issue of wait times for mental healthcare is not limited to inpatient treatment. Even at the “lower” levels of care, just being able to get scheduled for outpatient mental health services such as weekly therapy sessions can be a challenge. There are **“lots of wait lists... whether that's at UIHC or in private practice."** Focus group participants noted wait times of 2-4 months for clients to obtain an appointment for substance abuse evaluation and counseling, and up to 6-month long wait lists for outpatient therapy sessions in general, particularly for patients who do not have private insurance and have more limited options as to where they can go for mental healthcare (for example, limiting access to facilities that accept Medicaid).

Another barrier to mental healthcare access that participants identified was the lack of residential facilities for patients with co-occurring disorders. A participant states, **“we don't have enough residential care for people with co-occurring disorders and we really don't have enough actual treatment for people with co-occurring disorders in the residential setting, where they're treating those two issues simultaneously and effectively and integratively.”**

MENTAL HEALTH

Organizational Capacities (cont.)

Another participant shares, **“they're decreasing certain levels of care based on funding, so specifically those higher levels of care, which are then kind of flooding these lower levels of care.”** Consequently, individuals with serious mental illness are seeking care at hospitals even though the hospitals might not be the best place to treat them. **“It impacts... even those who are not marginalized. I mean, there are people in our community who are having suicidal ideation and making attempts... and they're going into the hospital. And because they have a home that they can go back to, they're there for a very short amount of time and then they're being discharged back to that environment. With not a whole lot of like aftercare, other than following up with your provider, when really, maybe those hospitalizations need to be a little bit longer, but the hospital can't manage the number of people... And it's just because there's a lack of variety of options.”**

This lack in variety of mental healthcare options was brought up in several different ways throughout our focus groups, particularly for patients who have specific needs and who would be referred to as complex cases. **“For people with the highest needs, the most vulnerable, the ones that we might even consider the most expensive to the healthcare system, there's lack of access...”** participants told us, with one specific barrier as **“facilities being unwilling to take challenging persons due to their history."** One focus group participant from Johnson County law enforcement stated, **“I think there is a missing resource for certain people with serious mental illness[es] that have tried and failed several of these things and end up still here in the criminal justice system because they've either burned all their bridges... or they become more dangerous and there's nowhere for them to go.”** So while the resources and referral networks we do have in Johnson County already are certainly a community strength, there is still work to be done in order to ensure healthcare access and quality for “challenging” patients.

MENTAL HEALTH

Organizational Capacities: Workforce

During the focus groups, many participants identified challenges in changes to the mental health workforce. We categorized this as a subset of Organizational Capacity, comprising 11.17% of the total focus group comments. Workforce represents a significant local force of change, as participants frequently referenced the **“dearth of mental health providers”** in Iowa as **“nowhere enough to meet the demand.”**

Provider burnout and state-level policies that increase the challenges of providing mental health and substance abuse services in Iowa contribute to difficulties keeping providers in the state. Policy implications to the mental health workforce are discussed further in *Systems of Power, Privilege, and Oppression* (p. 43).

One participant mentions staff needing to “gap fill” for clients when their needs aren’t being met. **“I see our counselors just kind of constantly gap filling and I absolutely know that we are not the only ones doing this... sometimes that's just the nature of the work that we do and it's, you know, kind of the nature of nonprofit work as well.”** We are expecting mental health and social service providers to go above and beyond to serve their clients when the workforce is stretched thin. **“[Another] barrier is staffing at agencies that serve the highest need individuals. So by that I mean Shelter House, low barrier shelters, GuideLink.”** Organizations that serve high-need populations in the community are already frequently over-burdened with demand—we must support the mental health workforce to continue their work as well.

This can lead to increased burnout in mental health professionals, as one provider mentions as barrier to mental healthcare availability. **“Access is [also] making sure that the team that you work with and that are providing the care are healthy and appropriately compensated and are themselves understanding their own value within this system... Burnout among medical and mental health care professionals is a real and problematic thing, and a single healthcare provider who's experiencing burnout can affect hundreds of clients and families.”**

MENTAL HEALTH

Organizational Capacities: Workforce (cont.)

Our focus group participants also expressed that it is difficult enough keeping mental healthcare providers in Iowa, let alone maintaining enough diversity in providers to reflect patient populations. We asked participants how they ensured cultural competency at their facility, and several participants mentioned that their organizations provide DEI trainings. However, one major implication of this general lack of provider diversity is the persistence of language barriers in access to mental healthcare.

Some participants mentioned having translations services (phones or apps) but no in-house translations, while others described having bilingual staff to assist with patients. One participant explained, **"we do have a translation service that we can call and have on speakerphone to do translation for us, but we don't have any in-house translation otherwise and we have extremely limited sign language availability."** Another provider described the difficulties of hiring staff who speak another language. **"We currently have one Spanish speaking provider who's seeing a number of Spanish speak[ing patients]. And we've engaged in, with translation from time to time, but only occasionally and we have had the occasional French speaking practicum student, with some limited use there. But we make a lot of efforts to try to have somebody who speaks the language... it's hard."** The health of the community improves when there are providers who can communicate with patients in their preferred language, improving accessibility and quality of healthcare (6). The providers we spoke with understand the importance of this, but continue to face challenges hiring and retaining multilingual providers and staff at their organizations.

6. González, H. M., Vega, W. A., & Tarraf, W. (2010). Health care quality perceptions among foreign-born Latinos and the importance of speaking the same language. The Journal of the American Board of Family Medicine, 23(6), 745-752.

MENTAL HEALTH

Systems of Power, Privilege, and Oppression

Overall, participants of our mental health focus groups provided a total of 22 comments, or a frequency of 11.7%, addressing the MAPP theme of Systems of Power, Privilege, and Oppression. Out of these 22 comments, 10 were from mental healthcare providers, 7 were from community partners, and 5 were from law enforcement. Many of these comments were focused on barriers to mental healthcare access and quality in two overarching topics: insurance coverage and state level policies.

Focus group participants noted that insurance coverage was a significant barrier in access to mental healthcare for many of their clients. One provider stated, **"I think there are gaps in... just the number of people [i.e. providers] who take Medicaid."** Other providers elaborated on this, explaining, "**Medicaid has different reimbursement rates in individual states. If someone crosses the Missouri River, the same appointment that we give an Iowa nets twice the money in Nebraska for a Medicaid patient than it does in Iowa. If you head into Minnesota, it's 1.8 times more... Our patients that sometimes go on Medicaid and then come back, we see them for free in the interim because it's cheaper than it is to bill them, so we don't... And we'll see people with a secondary Medicaid and just take what we can get from the primary insurance and then write off the remainder. But we are hearing horror stories from our colleagues that do take Medicaid and... Iowa Total Care, for example, is 6 months behind in paying clinicians for their work. I don't understand how that's possible."**

Another provider described their challenges in accepting patients with Medicaid . **"Medicaid is about 25, 28% of our revenue and it's a lot of work and it scales, but it only scales up slightly. So if you're, you know, a five- or fewer provider place, it's really hard. And the overhead, regardless of the size of the organization, is really high and there's a strong disincentive to have any involvement with it."**

MENTAL HEALTH

Systems of Power, Privilege, and Oppression (cont.)

The administration cost of contracting and working/accepting payment through myriad insurance policies were also cited by providers as a barrier to providing care for patients. One provider from a small independent practice explained, **"...even taking Medicaid, I take calls every week [from] people that I can't accept because it's just not feasible for me to take, you know, all the insurance. Like, it's just not really realistic for me to have all those different contracts."** Other providers echoed these sentiments. **"It's very difficult for me to contract with Medicaid and Wellmark and then also do Aetna and United and Medicare and...," "and the VA," "and UMR..."**

Additionally, in many cases the types of healthcare services that are accessible to patients are dictated by finances—patients are limited to the services that their insurance is willing to cover. One focus group participant described what has been a common occurrence in their experience: that patients in need of high levels of care and extended inpatient stays are made to end their primary treatment earlier than would have otherwise been recommended for their condition and transition to less intensive levels of care that do not meet their needs—because their insurance will not cover the level of care that they do need.

For mental health—and particularly substance abuse—therapy or counseling services, participants noted that state level policies likely worsen both access to and quality of care. **"Iowa has this unusual set of laws that puts up a firewall between substance abuse treatment and mental health treatment. For example, we have two people in our office that are Certified Substance Abuse Counselors. But we are not allowed to provide those services because the Department of Human Services will not certify us as a Substance Abuse Location. And there are parallel legal pieces in the Iowa code that separate mental health and substance abuse from each other. And even though our understanding both in the therapy world and in the medical science world is that, you know, rarely do you have one without the other. It is in some ways like saying, okay, we're going to treat vertebrae number 4, 5 and 6; but 1, 2 and 3 have to be treated by a different professional."**

MENTAL HEALTH

Systems of Power, Privilege, and Oppression (cont.)

State policy requirements for Substance Abuse Locations not only create difficulties for providers pursuing the designation, but add barriers to quality of care and can perpetuate systems of oppressions for patients as well. **"...That designation that I have as a substance use treatment facility. There's a whole lot of information that I'm required by IDPH to collect about my substance use clients. And that is certainly problematic... IDPH is having me ask about sexuality and gender and income and veteran status and stuff that's really invasive. And I am required to report that back to IDPH... The other piece of that is a lot of those people are required by the courts to do that appointment, right, so they have no choice... Once you get an OWI, you are required by the State of Iowa to disclose your sexuality."**

Additionally, cultural attitudes and perceptions of patients who are receiving mental healthcare services can contribute to systemic oppression. For example, one participant mentioned that, in their experience as an advocate, feedback from patient experience evaluations from those receiving mental healthcare services did not appear to be elicited or recognized to the same degree as feedback from patients receiving other services in the same hospital. **"...I think the guideline is pretty unique in doing the surveys of people that have mental illness. The University [UIHC] doesn't because they consider information coming in from a psychiatric patient to be unreliable."** Perceptions like this contribute to distrust in the healthcare system from patients, and contribute additional stress to the already difficult process of navigating and accessing mental health treatment. This also feeds into a systemic challenge that comes with using surveys as a common quality measurement tool, which is the likelihood of response bias. **"I think surveys are really hard also though, because it's all kind of dependent on the individuals who are willing and able to fill those out and their ability to understand, like, the question(s). And then also, how are the agencies then implementing any feedback or changes... based on that feedback they're receiving?"**

MENTAL HEALTH

Systems of Power, Privilege, and Oppression (cont.)

The health implications of policies that do not directly address hospitals or healthcare need to be considered as well. One community partner mentioned the effects of recent legislation, particularly in school settings: **"State policies limiting trans students' abilities to access affirmation and safety in their school environments is already and going to continue to be a barrier around mental health for that population."** Not only do these policies directly impede access to the healthcare that meets these students' needs, but additional policies like "bathroom bills" contribute more potential stressors, triggers, and physical safety concerns that increase distress and exacerbate mental health issues. It is essential to consider a Health in All Policies approach when assessing any dimension of health and wellbeing, but this was particularly highlighted in our conversations with mental healthcare professionals and community partners.

Social Determinants of Health

Participants provided a total of 25 coded comments (13.3%) from the focus group discussions related to the MAPP theme of Social Determinants of Health (SDOH). Immediately upon being asked about mental healthcare access and quality, one community partner stated, **"Mental healthcare is not just about coming to an office and talking about how you're doing."** While every aspect of our health is affected by SDOH, mental healthcare particularly exemplifies the connection between a person's wellbeing and the environment that they live in—and how these factors both influence each other. It is important for both healthcare and social service providers to understand this connection, especially given the nuances in symptom presentation of mental health conditions.

For example, one participant explained that in many cases it is an environmental factor or physical need that a person will initially bring up to a service organization or access center, rather than a co-occurring mental health concern. **"[The information] from a lot of our folks is narrative... they may not say 'I struggle with my mental illness,' but they're going to tell you they need a cell phone and they need housing and... you know, their foot hurts."**

MENTAL HEALTH

Social Determinants of Health

It is often up to providers and community partners to identify both environmental and medical needs by working with their patients or clients, and to find a way to provide those services or refer to another organization. **"The people that I serve and work with don't always have the ability to communicate those aspects of their life to their providers in a way that a provider maybe can understand."** This is a challenge that, while not unique to mental healthcare, is definitely highlighted in mental healthcare settings because the nature of the care relies so heavily upon patients' ability to communicate their experiences to a provider.

Three aspects of SDOH in relation to mental healthcare stood out among these focus groups: finances, housing, and transportation. The cost of mental healthcare is a widely acknowledged barrier; even for patients who have health insurance, there are often still copays and deductibles to meet that can be too much to afford. **"It's stopping them from getting mental health or substance use care because they can't prioritize it in their life because of other things, you know, that they need to take care of... and so people are deciding between 'can I pay the electric bill or can I send my kid [or myself] to therapy?'"**

The cost of housing, specifically, can be a major burden—whether it compounds existing mental health stressors with additional financial stress, precludes potential patients from being able to afford care, or even leads to patients lacking permanent housing altogether. **"A healthy community needs to have a variety of housing options and access to different types of care,"** one community partner commented. **"We just see [in our work] that intersection between both houseless[ness] or housing insecurity or lack of quality housing, and mental health symptoms kind of being pushed into crisis."**

Comments regarding social determinants of health also highlighted the role of built environment in healthcare access. Transportation to and from appointments was mentioned several times as a barrier that providers have witnessed making access to care difficult for their clients, and the existing services to combat these problems, in their experience, have still left gaps.

MENTAL HEALTH

Social Determinants of Health (cont.)

One provider stated, **“The MCO* says that they provide transportation to their, you know, patient and so they can call a few days in advance to make sure that they're going to go to their appointment. I can't count anymore how many patients, that same day, they're told, ‘I'm sorry we don't have a driver, so you can't go.’”** Another provider added, “**At one point there was a bus that would go to North Liberty from Iowa City and would go once in the morning and once in the afternoon. And so if a patient came to an appointment in the morning, they would stay with us ‘till the afternoon... I can’t tell you how many people we fed in our waiting room because they had a six hour wait. They were there for the day. And Uber to some extent has been helpful with that, but not everyone can afford an Uber from Southside Iowa City to North Liberty.”**

While telehealth appointments have been helpful in reducing this barrier, there is still the financial aspect of having access to a computer or a cell phone. And even then, there are still challenges with provider availability; after all, **“telehealth doesn’t make more hours in the day.”**

Patients experiencing poverty or homelessness also face the constant systemic barrier of trying to physically access care and keep track of appointments without a stable income or place to stay. One community partner described the struggles they witnessed their clients have in accessing mental healthcare. **“There's consequences for missing... appointments. So if you miss an appointment, depending on the clinic, then the provider might move you to a wait list only option. And how do you get on your wait list? Only option if there's a cancellation; you have to have a cell phone. And if you have severe and persistent mental illness and you're experiencing homelessness and your stuff gets stolen or you lose your stuff, it's really hard for anyone to get ahold of you or find you.”**

*"*Managed Care Organizations [MCOs] are integrated entities in the healthcare system, which endeavor to reduce healthcare expenditures costs. Since the 1970s, managed care organizations have shaped healthcare delivery in the United States through preventative medicine strategies, financial provisioning, and treatment guidelines."* NIH National Library of Medicine, 2023.

There are currently three MCOs in Iowa: Iowa Total Care, Amerigroup, and Molina Healthcare. These entities contract with Iowa Medicaid to provide services for most Medicaid and Hawki members.

MENTAL HEALTH

Social Determinants of Health (cont.)

Overall, it was clear from these focus groups that we cannot overstate the importance of addressing social determinants of health in any care setting, but this is especially true when it comes to mental health care. Providers and staff who work in crisis centers, access centers, and social service organizations are acutely aware of this. **“Until some of those—not only mental health and substance use care, but a lot of just plain old social determinants of health—are seen [as] important, or equate to healthcare in general, like medical, healthcare. I don't think our work is done ‘till we get closer to that."**

Health Behaviors and Outcomes

The frequency of comments made by participants that reflect the MAPP theme of Health Behaviors and Outcomes was 12.57%. During the focus groups, participants shared anecdotes of their clients no longer seeking care because of poor experiences with providers.

One provider explained, **“What I see with many of my patients is that they have very bad experiences in the past accessing care whether it was inpatient or whether it was outpatient. And so they are reluctant to go, not necessarily because they don't want to go, but they're afraid to go--that they're going to have another bad experience.”** Another participant, a mental health advocate, mentioned, **“the big barriers are for the people with the most serious illnesses. Especially those that do not know they're sick. And so the docs get tired of having to repeatedly admit them... they get cherry picked out. There are a lot of patients in our community that no longer can see many of the providers in town.”** Individuals are not only responsible for seeking out their care but, also often shoulder the burden of self-advocating to ensure that their providers are treating them fairly. A poor experience with a provider can discourage them from continuing to seek care.

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METHODS

Staff began outreach by cold-calling and emailing several OB/GYN providers, midwives, family medicine providers, and other reproductive health care providers using contact information that was collected for the Asset Map. Staff provided information on the MAPP 2.0 framework and expressed our goal to collect their experience on patient barriers to access reproductive and maternal care in the county. Though some clinics expressed interest in participating in the interview process, no OB/GYN practitioners were able to schedule an interview due to various reasons. Clinics that provide abortion services, STI testing, gender affirming care, and birth control declined to interview. JCPH staff made many attempts to contact additional individuals for input but were unsuccessful.

One certified childbirth educator, full-spectrum Douala, employed by one of the organizations in Johnson County that provides services and resources to those impacted by sexual assault and violence, agreed to an interview. Their scope of practice specializes in working with survivors of medical violence and sexual assault—particularly survivors who identify as LBGTQ+--by supporting them after they have become pregnant after a rape, connecting survivors to resources and funds for necessary services, accompany people to their reproductive health appointments, transition care appointments, and providing them with medical and legal advocacy throughout these processes.

One family medicine provider that is trained in OB care agreed to interview as well. Their practice extends across a broad spectrum in terms of patients and locations in which they work. They have experience working at a large hospital, a free medical clinic, as well as nursing homes and rural clinics. This provider has experience working with almost every type of patient, given their role as a family medicine provider, but has specific experience working with immigrant and refugee populations and antepartum and postpartum patients.

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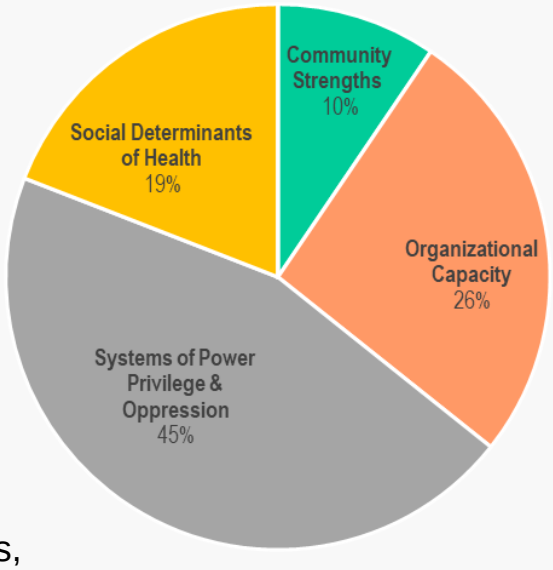
RESULTS

Systems of Power, Privilege, and Oppression



The frequency of comments made by the maternal/reproductive health interviewees for the MAPP theme of Systems of Power, Privilege & Oppression was 26.43%. One participant described upcoming red-tape or additional hurdles based on policy changes and excessive regulation in providing healthcare services to survivors of assault. Participant states, **"...if you don't want to allow abortions, you should at the very least fund emergency contraceptives, which they've also stopped doing...Brenna Bird, our attorney general, decided that she doesn't want to fund emergency contraceptive pills for survivors. If you don't fund that, then that's how you get the abortion problem".**

One participant mentioned institutions, such as hospitals themselves, may make it slightly more difficult for patients without insurance or with Medicaid to find available appointment times, compared to patients with private insurance that reimburses at a higher rate. The participant noted a time where a patient they referred to a different area in the hospital had a difficult time finding an appointment. The participant called the area they referred their patient to and recalled, **"the staff made the mistake of saying "oh OK, I see they've got this insurance, not this insurance…".** The participant continued, **"They work kind of like the airlines. So, the insurance that pays better, there's more slots available. So, as it pays less and less then there are less slots. And once they're filled, then even though there are slots open, they're not available to those people."**

JCPH staff reviewed a meta-analysis on this topic that alluded to this issue being found in many institutions across the nation. The analysis concluded that

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Systems of Power, Privilege, and Oppression

"Medicaid patients have reduced access to appointments compared with their privately insured counterparts."(8)

A participant referenced the economic system playing a part in delaying needed care to all patients, stating, **"A lot of this reflects back on sort of the whole economic system. If the hospital stays full then it's more profitable because then it's more appropriately staffed. But then what that means is a lot of time you don't have beds. So, people sit in the emergency department. They (the hospital) haven't been willing to take economic cost of putting more beds and hiring more staff to meet the true needs."**

Finding practitioners that are competent in providing quality of care for LGBTQ+ survivors was also noted as a problem in Johnson County. **"A lot of the clients I see are trying to find an LGBT-friendly provider and can't. Even at the University, sure a lot of them have taken the Safe Zone Training, but that doesn't mean they're LGBT-friendly, it means they've started the path to getting there. I'm always trying to identify which providers are going to accept them as their whole selves and are not going to assault them. ... I try to keep lists of providers of whom I don't have any reports of medical violence, or I can include providers on there and say there maybe was an incident of medical violence. Here's the caveat. It involves just this specific group of people. If you're not a part of that specific group of people, you may be spared from that".**

Lack of confidence in a provider, especially after an assault, is a barrier to accessing healthcare for many people, specifically if they are a part of the Queer community. Fear of being mistreated and violated by practitioners is a fear of marginalized communities, like the LGBTQ+ community. This makes the importance of having an advocate and/or doula present necessary, as the interviewee clarifies that, **"having a support person is actually really crucial to them because if they are doing a surgical procedure, they are going to be sticking instruments inside someone's vagina and causing them very significant pain that very much mimics the pain from sexual assault. ...I've**

(8) Hsiang, W. R., Lukasiewicz, A., Gentry, M., Kim, C. Y., Leslie, M. P., Pelker, R., Forman, H. P., & Wiznia, D. H. (2019). Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance Patients: A Meta-Analysis. Inquiry : a journal of medical care organization, provision and financing, 56, 46958019838118. https://doi.org/10.1177/0046958019838118

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had clients say things to me before like, 'they treated me like I was a cow ... they just shuffled me from one place to the other. They wouldn't tell me why they took this blood test or urine test. They just said they need it'".

When talking about barriers to accessing health care in general, one provider mentioned lack of flexibility of employers to allow employees to get care. The participant stated, **"I would say that inflexibility of employers, you know, so like people working at Tyson and West Liberty Foods, you take time off even if you've asked for it, you get points. And if you get so many points, then they can fire you. And then they have this thing, 'OK, if you're off for three days then it's OK. You don't get points.' But if I want to go to the doctor, I'm not going to take off 3 days."**

A participant also highlighted the importance of trauma-informed, patient-driven, evidence-based care. **"I think healthcare quality means that you must fight to have the power playing field level in some way. And so that means that you're giving people all the information, including options that you don't think are necessarily the best ones for that person. ...The trauma-informed model's incredibly important and trauma-informed care is also a part of evidence-based care. With evidence-based care, that would mean not structuring policies around things like liability, but rather structuring it based on the science that we have available. ...you have to center consent in every interaction that you have with somebody and that's one of the biggest components of trauma-informed care. They all link up to trauma-informed care. But that's something that I don't really see a lot of practice in healthcare, especially here in our county. It's not consent driven"**. They mention a concern for this problem within abortion clinics around the county, **"A lot of the abortion clinics around the area have started operating from the security-based scarcity mindset and it's hurting people. They have foregone trauma-informed care so that they can ensure the security of the building because I think they think it's going to cause harm if you let just anybody into the clinic".**

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Systems of Power, Privilege, and Oppression

Recently proposed and passed Iowa legislation has left marginalized groups and many women feeling targeted and confused about how law makers decisions will impact their bodies in the near future. **“Here's the deal with the abortion policies that are going on in reproductive care- as well as the outright assault on Trans-care in Iowa...I've been following the bill trackers on several different nonprofit orgs, and I find that if I don't check it every single day at least twice a day, then I don't know what's going on. Thankfully the legislative session has finally stopped so I can rest. Abortion specifically, more than likely, this is what I hear from a lot of my colleagues in the reproductive health movement, we’re probably going to lose the right to abortion in Iowa”.**

This upheaval leaves organizations like the one the interviewee is employed at in a tough position. Having had previously worked with survivors as young as 11 dealing with an unwanted pregnancy due to a rape, a participant notes that even if the state allows abortions for those who experienced rape, that exception will not necessarily allow for an abortion to be performed unless the rape is reported within six weeks and four days. This means a sexual assault victim will be required to report and be subject to police questioning. If the survivor’s abuser is from their own family, it may make it more difficult to access this form of reproductive healthcare.

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Systems of Power, Privilege, and Oppression

Lack of sexual education was also identified as a problem. **“They [children/young adults] take away the message that abstinence-only is the way to go, but then they don’t really concern themselves with the matter of contraceptives. And then, of course, they end up having issues like and unwanted pregnancy”.** Comprehensive sexuality education (CSE) is an important element in protecting and educating children and teens. It enables them to think about what is right, healthy, and safe for them, while also learning how to avoid coercion, STIs, as well as unwanted and unintended pregnancies. When this is missing from early education surrounding sex and puberty, it warrants a young person to make decisions without being aware of all the facts, options, and safety precautions. Furthermore, it leaves space for confusion about dangerous and unwanted sexual contact/abuse from predators they might be exposed to at home, church, school events, or other spaces with adults (9).

Organizational Capacity

The frequency of the MAPP theme Organizational Capacity comments made by the interviewees was 30.71%. A few sub-themes that come up around organizational capacity are barriers to providers working together across departments within an institution, barriers to training staff in OB care, hospital policies limiting reproductive healthcare options, and the capacity of healthcare institutions to meet people where they are for care.

(9) Comprehensive sexuality education: For healthy, informed and empowered learners. UNESCO.org. (n.d.). https://www.unesco.org/en/health-education/cse

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Organizational Capacity

One participant emphasizes the frustration that comes with their position and policies that are in place at clinics and hospitals that contribute to the barriers in accessing reproductive health care. **"...the Mercy One network recently banned doing tubal ligations on their patients. They will not tie your tubes and they won't do hysterectomies unless you have cancer. And those are the major hospital networks in a lot of Iowa, up in Waterloo especially. If you can't get sterilized and you can't get contraception and you can't get comprehensive sex education-- that's pleasure-centered as well, not just risk averse-centered, you have a problem".** Another participant discusses institutional limitations at hospitals when trying to collaborate with different departments and specialties, saying, **"even at the University, the internal financial structure is limiting. So, if somebody in OB helps me to take care of a more complex patient as outpatient, that doesn't help their (OBs) economic bottom line unless they see the patient, so the CEO doesn't really want them to do that. But on the other hand, it could make the system better / more efficient."**

A participant also noted if OB and Family Medicine departments were able to more easily work together and even learn from each other, newer family medicine residents could be trained in OB care, further expanding healthcare access for women in Johnson County and Iowa, if those residents chose to stay past graduation. The participant explained, **"our residents don't get enough experience to feel confident. I think it's improved because now that they're going up to Cedar Rapids for a month, they're getting more deliveries than they did. But it's still not enough. When I when I was an intern, I was 24 hours on, 24 hours off for two months. And during that time, I had 300 deliveries... That's a lot different than doing 30 deliveries in terms of what your level of comfort is after doing that. I do think it's important OB and family medicine work together because the bedrock of rural health is always going to be family medicine."** The participant goes on to say, **"I think you need to have collaborative relationships because you're not going to have enough OBs to take care of all those patients."**

WOMEN'S, MATERNAL & REPRODUCTIVE HEALTH

Social Determinants of Health

The frequency of the MAPP theme Social Determinants of Health comments made by the interviewees was 14.29%. Not having the financial stability to seek out healthcare and receive it in a timely manner is a major barrier in accessing reproductive and maternal health services that often impacts many areas of an individual's life. Especially for those who have the added barrier of past experiences of medical violence being inflicted on them. The participate states that, **"...for the clients that I have that are impoverished, it's just being able to get any form of care, even if it is violent in the first place. Even if people have insurance, it often does not cover anywhere near enough of what they need it to cover".**

Transportation was noted as a barrier in terms of access to care for appointments. One participant noted, for patients in and around Iowa City, **"it [the bus] doesn't come frequently enough so it's inconvenient to use. Then you're leaving an hour and a half early as opposed to going straight there at your appointment time."** The participant said, to help with this issue, it is important to have **"clinics in areas where there are the people that need them, so like rural areas."** The participant also noted if families only have one car and it is being used by another household member for work, it is hard for patients to get to daytime appointments. To get around this issue, the participant suggested evening and weekend hours may be helpful. Telehealth was also mentioned as a tool to utilize when in person visits are hard for patients to get to.

Maternal and reproductive health care doesn't stop at providing and connecting people to direct health care service, but rather working towards creating or pulling together an environment that an individual can holistically thrive and be supported in. The participant states that, **"When it comes to things like poverty, [my organization] will provide emergency financial assistance to clients. Of course, we connect them with community resources like food banks and social service programs, etcetera. But often those programs are really not enough to meet their needs. And you can't qualify for services as quickly as you may need them".**

WOMEN'S, MATERNAL & REPRODUCTIVE HEALTH

Health Behaviors and Outcomes

Another area often referenced by an interviewee that impacts health behavior relates to the affordability of care. If individuals are not able to afford care due to being uninsured or under-insured, or having a large copay, they often will not seek care even if they need it, which leads to poor health outcomes. The participant said, **“In terms of improving access, I think there's good evidence in terms of primary care that if you reduce co-pays and things like that, then people are more likely to start treatment earlier, which actually saves money.”**

In order to get around affordability and help access, a participant said, **“I'm always willing to work with patients. An example would be somebody needs follow up for like a blood pressure or because we think they have preeclampsia. But since they don't have insurance, I'm always willing to have them come to my clinic and just do the blood pressure and not put it as a charged visit. Unfortunately, that only has a minimal impact on the access problem and sometimes feels like second class care.”**

Community Strengths

The frequency of the MAPP theme Community Strengths comments made by the interviewees was 7.86%. It is impossible to capture all the community strengths in this area of women’s, maternal and reproductive health with only two interviews. However, many strengths came out in what was shared in both interviews. A commonality between both interviews relates to the interviewees themselves, as their passion for helping people is apparent. It is a great strength to have such dedicated professionals serving individuals in and around Johnson County.

WOMEN'S, MATERNAL & REPRODUCTIVE HEALTH

Community Strengths

A participant identified resource and knowledge sharing, as well as community support as a community strength while they were giving context to what their position entails, **“Or giving people instructions on what to do if something goes wrong. Let’s say you start hemorrhaging and you're terrified that they're somehow going to know that you have an abortion, which spoiler alert, they can't tell because they can't distinguish it from a miscarriage.... It might, also involve things like sitting with people during it and being able to answer questions”.**

The passionate and dedicated staff at organizations that provide advocacy and information on topics like sexual and reproductive health are imperative to maternal and reproductive health improvement. A participant states, **“I frequently will go along to people's reproductive health appointments, and transition-related care appointments as well. I help them navigate those situations and try to help foster a good relationship with their healthcare providers and make sure they feel listened to and that they're getting their medical needs met.”** Having this support allows accessing healthcare to feel safer and less emotionally exhausting for many. The participant's organization also strives to offer as many inclusive services and resources possible, **“I have access to a lot of different resources through [my organization] as well. If someone needs interpreter services, we have a paid interpreter service, we don't just do like the hospital does where they use those computers and type back and forth because that doesn't provide a good dialogue. We have actual certified human interpreters that we can call upon when we need to. I also do a lot of work to make sure that the practice that I do, my mode of thinking, is as inclusive as possible."**

WOMEN'S, MATERNAL & REPRODUCTIVE HEALTH

Maternal and Reproductive Health Recommendations for Practitioners

Many solutions and recommendations were offered throughout the two interviews. The following is not exhaustive of all solutions in the area of women's, maternal, and reproductive health.

Both participants emphasized the need for practitioners to include and empower their patients with information and options by including evidence-based and trauma-informed care. **"Listen to patients. If they listen to patients and they listen to what they want, they engage in evidence-based care. They engage in trauma-informed care, but most importantly, if they listen to patients, they will cover most of their bases. But they need to look inward and focus on providing inclusive care as well. Because a lot of the training that you would get to provide better care to marginalized communities will also cover things like how to provide better evidence-based care, how to check your own biases, and how to do trauma-informed care. Because you can't provide better care to marginalized people without providing trauma-informed care. It's all connected, and you can't really separate it".**

One participant offered, **"What I try to do is remain non-judgmental and open to my patients, and I try to truly hear what they want, what they're saying so that I address their perceived needs, as well as what I see are their healthcare needs. You have to create a system that allows for that. I think if we switched to a system where you took care of a panel of patients and as opposed to billing for each visit, then you could be more innovative in terms of how do I do the best job."**

Communication and collaboration between providers across specialties and departments, as mentioned earlier, was recommended often in one interview. The interviewee specifically mentions collaborations between Family Medicine and OB, especially in training new Family Medicine Residents. **"I think you need to have collaborative relationships because you're not going to have enough OBs to take care of all those patients."**

WOMEN'S, MATERNAL & REPRODUCTIVE HEALTH

Maternal and Reproductive Health Recommendations for Practitioners

Collaboration and communication with public health and healthcare providers was also mentioned as an area that could use improvement, both locally and at the state level. **“The pandemic certainly showed us that we were hurting. For example: shortly after the pandemic started, I had a patient that I wanted to get tested for Zika. Previously, public health, through the state hygienic lab, had done those tests. So, I tried to get it set up and they said, 'Oh no, we're no longer doing that anymore.' Zika hasn't gone away, it just wasn’t en vogue. I understand, organizations need to make financial decisions and you we were able to get it done privately. But still... it points out that there is rationing in public health and health care which disproportionately effects the poor and those without adequate insurance.”**

An interviewee also noted that marginalized groups, particularly women who are Black, have a higher maternal mortality rate than other demographics, and that this inequity can be prevented by those providing maternal care**. “Providers should work on getting the Black maternal mortality rate down. It is high, not because Black people's bodies are different, but because of provider bias. And that doesn't mean that if you just attend a building course at the university or some sort of seminar on How to Provide Better Care, that's actually going to make you a better provider”.** Providing quality care to all communities is a lifelong process and should be ongoing throughout the practitioner's career. **“To be a better provider, it takes years’ worth of work and a deep commitment to bettering yourself and developing a better lens of how you treat patients and view them as well. I think just note that a one-time ‘How to Do Inclusive Care’ seminar isn't going to do the things for you that you think it's going to do”.**

“Within [my organization] we do a lot of racial justice work, so I am always looking for new ways to try and challenge myself about ideas, race, disability, or gender. Ultimately, a lot of that self-reflection and education is what helps create inclusion and access because you have to start first from within and then the rest of it falls into place naturally because you develop the ability to think from an inclusive mindset”.

RECOMMENDATIONS

FROM HEALTHCARE PROVIDERS AND COMMUNITY PARTNERS

RECOMMENDATIONS

We understand data from these interviews and focus groups reflect the thoughts and opinions of the sample of individuals involved and may not reflect thoughts and opinions of all healthcare professionals in Johnson County. We also understand issues and solutions offered in this report may not be exhaustive. Johnson County Public Health welcomes additional thoughts and opinions of professionals working in healthcare in Johnson County. Following the completion of this report, JCPH will be prioritizing health areas to focus on in health improvement planning.

The following Figures 5-8 include recommendations given by healthcare providers and community partners for improving healthcare access and quality in Johnson County. Recommendations are categorized by healthcare sector. Displayed are summaries of recommendations as well as direct quotes from focus group and KII participants.

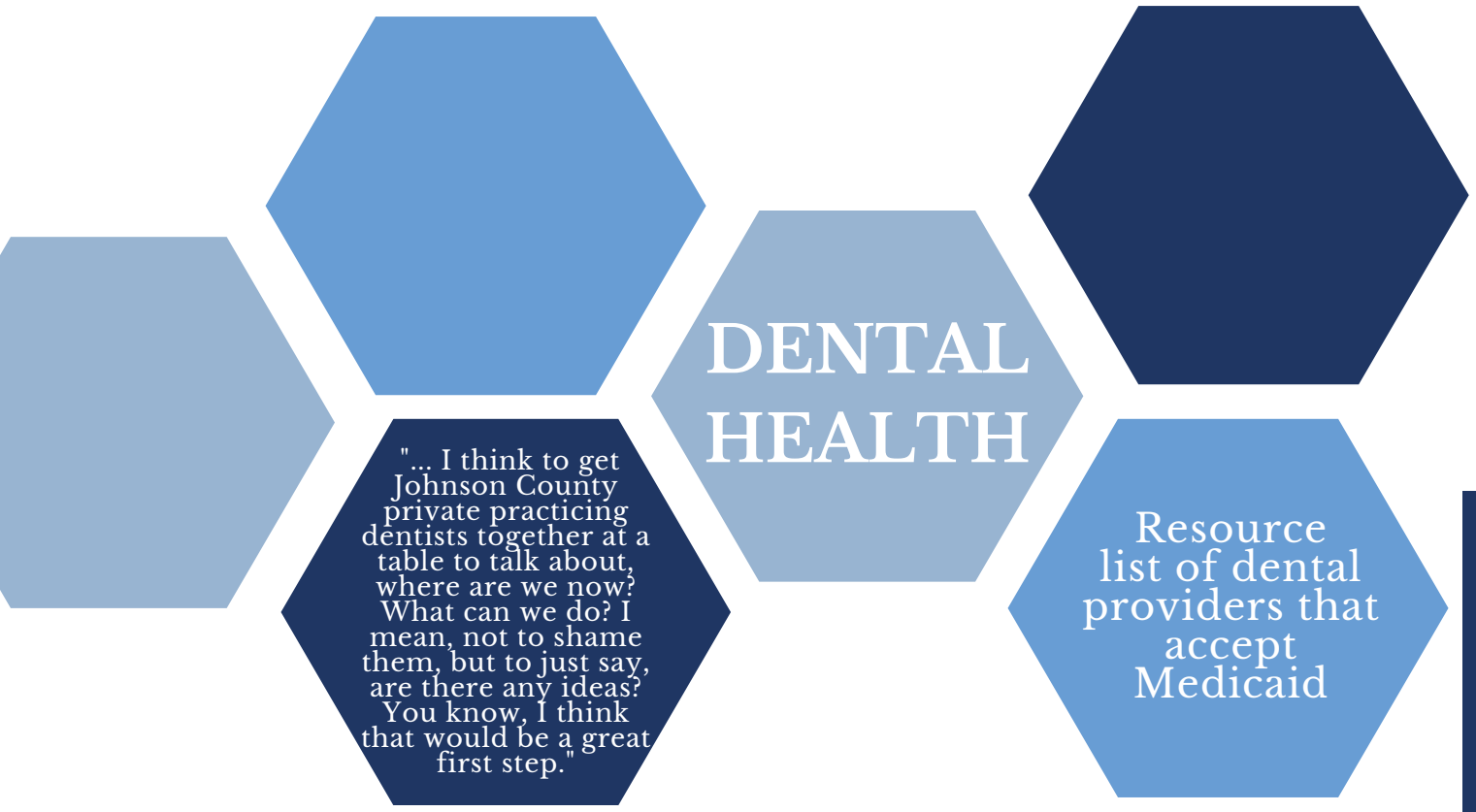

FIGURE 5

RECOMMENDATIONS

FIGURE 6

RECOMMENDATIONS

FIGURE 7

RECOMMENDATIONS

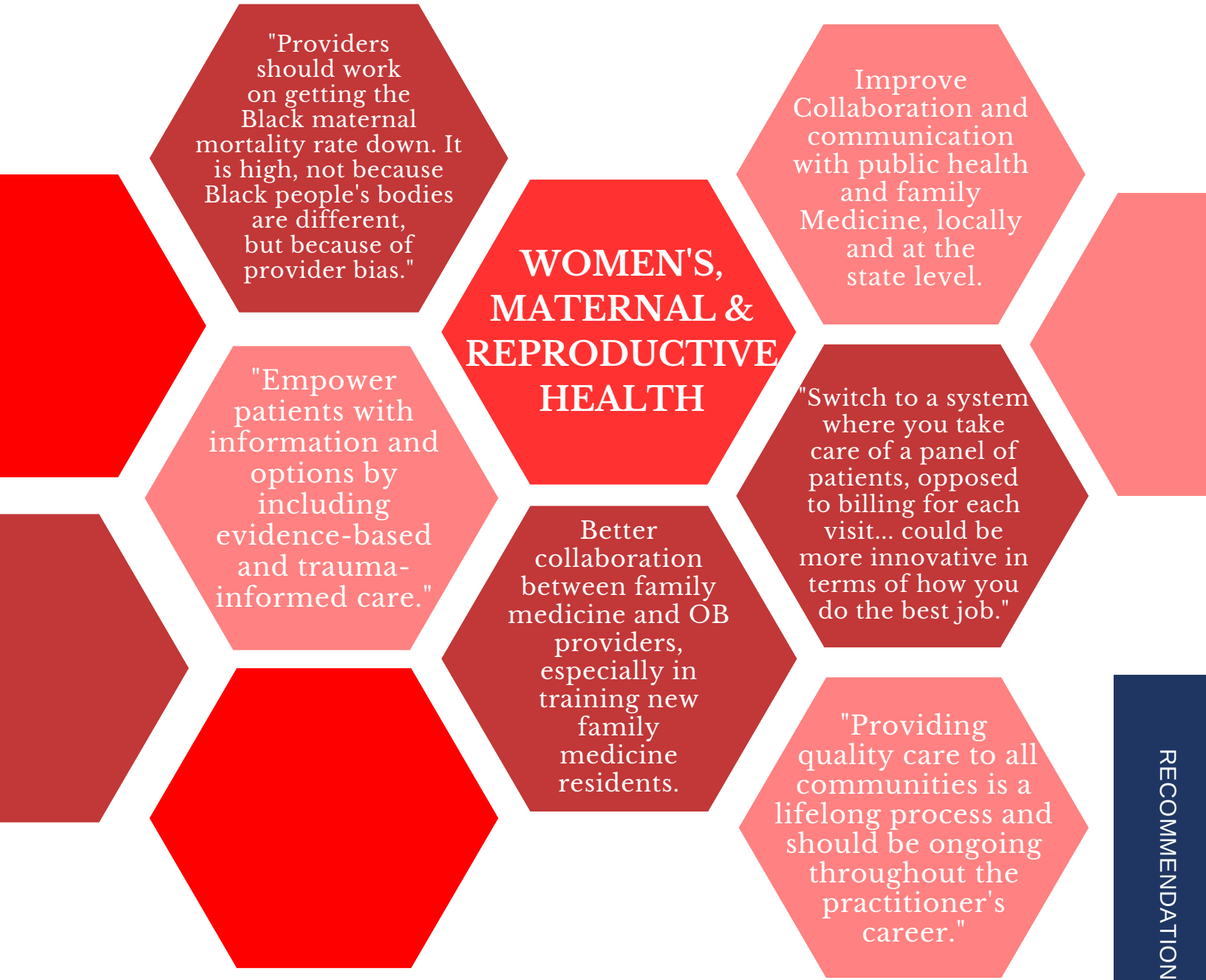

FIGURE 8

CCA REFLECTIONS AND NEXT STEPS

COMMUNITY CONTEXT ASSESSMENT REFLECTIONS & NEXT STEPS

The following are reflections of ours, JCPH staff facilitators, on focus groups and key informant interviews. To start, A diverse array of voices ultimately participated in this assessment. We feel as though each participant provided great feedback and perspective in terms of their roles in healthcare and opinions of quality and access in Johnson County. It was especially valuable to have a focus group with participants, as focus groups led to more in-depth conversations around each topic area. Key informant interviews, however, allowed for a more intimate environment where each participant had ample space to talk with us on their opinions. Both modes of discussion were beneficial in different ways, and we feel it is a strength to have both in this assessment.

Regarding participant recruitment, we found it helpful to find groups in each area of healthcare that meet regularly already, such as the Johnson County Systems of Care group, and attend their next meeting to advertise our community assessment and the need for their voices to be part of it. After attending one meeting, JCPH staff were invited to continue attending to allow for future collaborations elsewhere outside of the assessment. These connections are paramount to much of the work we do. Not only did we appreciate the connection and conversation, but feedback from participants was largely positive. We hope to maintain these relationships in the years to come.

We believe the questions we asked in focus groups and key informant interviews were well formed and led to interesting conversations with all participants involved. These questions also related well to each MAPP 2.0 theme, as previously described in this report.

With any project and assessment, we recognize there is room for improvement. We would allow for more time to do outreach if we were to undergo another similar assessment. At the time we started outreach, many individuals may have been on spring break or out of the office. Emails are easily missed during this time period. We had a particularly hard time reaching out to staff from Mercy Iowa City. That may have been due to the pending acquisition of the hospital, which became public news in August of 2023. We recognize also that burnout of healthcare staff may have contributed to the lack of response from individuals.

While a written report can house substantial amounts of information, it would be advantageous to utilize another mode of storytelling for this assessment. In the future we may explore use of other media, such as audio and video, to communicate the results of this assessment to the community.

We as JCPH's HealthyJoCo team recognize potential bias in the compilation of this report, and even in the interviews and focus groups themselves. Everyone involved in this assessment was asked to recount their own thoughts and opinions of healthcare access and quality, among other things, in each interview or focus group. The goal was to understand their perspectives, which are inherently biased. It is important to also note potential bias in the coding process by our own staff. We feel that bias was minimized, however, by reviewing all data together as a team after the coding process was completed and by sending the report to individuals involved in the focus groups or interviews for their feedback.

Next Steps

The Community Context Assessment is the last of the three assessments HealthyJoCo conducted under the MAPP 2.0 framework. The team will be compiling and triangulating data from all 3 assessments to identify themes. Partners and community members will be able to participate in theme identification as well through an online survey that will be available in public locations via tablets. Once themes are identified, issue statements will be crafted again through a public facing survey. Finally, another public facing survey will be launched asking individuals to prioritize the issues. Once health priorities are chosen, HealthyJoCo will recruit individuals interested in joining a subcommittee of each priority area to begin health improvement planning.

Johnson County Public Health

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COMMUNITY HEALTH ISSUE PRIORITIZATION

METHODS OF PRIORITIZATION

A crucial part of collecting all health assessment data is prioritizing issues and forming health improvement plans and actions to address priorities. The following is a detailed summary of steps Johnson County Public Health (JCPH) staff took to prioritize health issues.

THEME MATCHING

On September 6, 2023, HealthyJoCo (HJC) staff invited individuals from Johnson County Public Health (JCPH), Johnson County Board of Supervisors Office, Social Services, and MHDS to take part in a theme matching day, where data collected from the 2022 – 2023 community health assessments were matched to sub-themes created by participants. Themes are overarching public health topics that are represented in two to four words. Each sub-theme was matched to a broader theme category of either: Health Behaviors and Outcomes, Social Determinants of Health, Systems of Power, Privilege, and Oppression, and Community Strengths and Organization. Figure 1 outlines all themes created during the matching exercise.

Table 1. Theme and Sub-theme Categories

Health Behaviors & Outcomes	Systems of Power, Privilege & Oppression	Social Determinants of Health	Community Strengths & Organizational Capacity
Preventative Care	Access to Care	Safe & Affordable Housing	Inclusion Efforts
Mental Health	Language Barriers	Food Security	Community Organization Data Needs
Physical Activity	Health Inequities	Economic Status and Finances	Community Organization Resources and Education Needs
Healthcare Affordability	Legislative/ Policy Barriers	Cultural & Language Barriers	Financial System Limitations
Trauma Informed Care	Discrimination/ Community Perceptions of Discrimination	Transportation	Mental Health Support
Food Access and Affordability	Community Perceptions of Safety	Education	
		Employment	

THEME SURVEY

A community-facing survey was live September 11, 2023 until September 21, 2023. The survey asked community members to match data that was leftover and uncategorized after the theme matching day to sub-themes. Survey participants were given a list of all sub-themes created from theme day matching participants. Participants were also able to create their own sub-theme.

45 respondents overall interacted with the theme survey in some way, from only opening the survey to answering all questions. Ultimately, 29 responses were incomplete at 15% or lower progress due to survey abandonment and were excluded from analysis. Respondents with 15% progress only answered the readiness question but did not advance on to any questions asking respondents to match data to an overall health theme. 16 respondents completed the assessment at 23% to 100% progress. Those with 23% progress matched at least one theme to the respective data point associated.

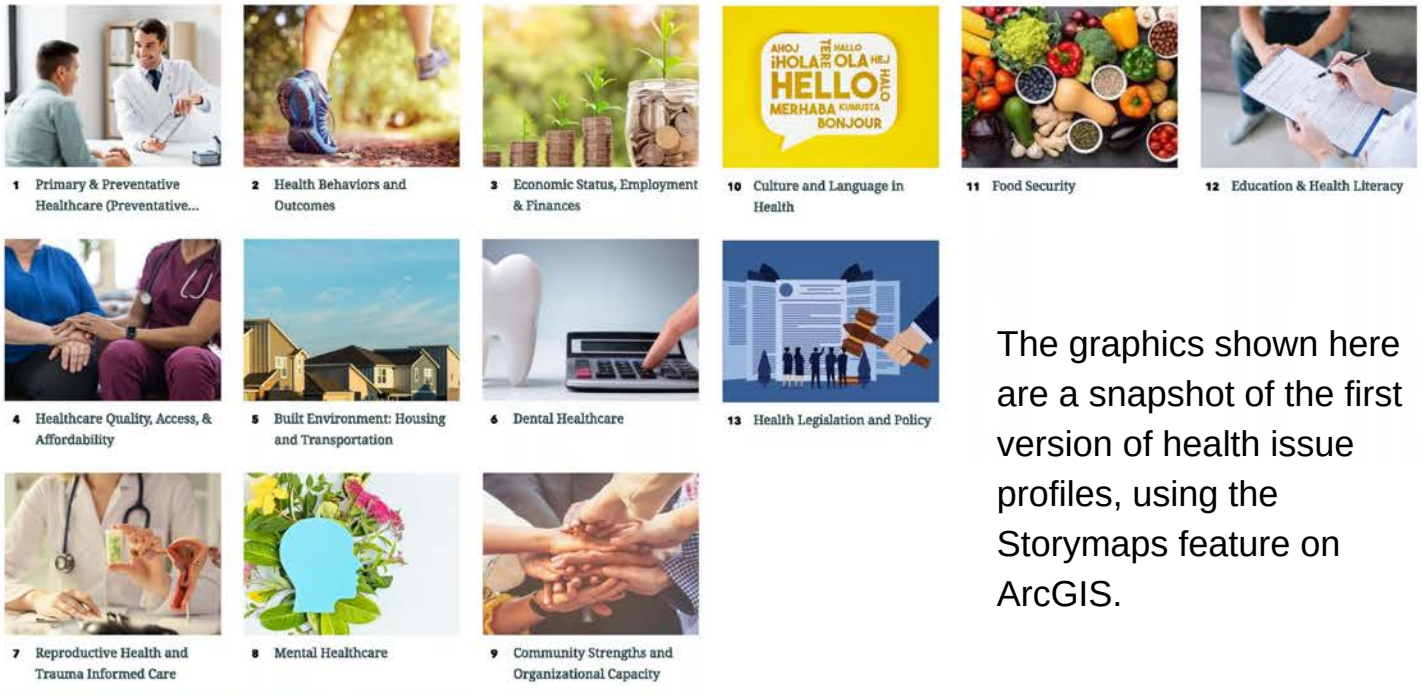
Only 9 respondents provided demographic information. Age ranged from 18 – 69 years. All 9 respondents that provided demographic information identified as white, non-Hispanic women. Most respondents that provided demographic information have a college education of 4 years or more.

Survey responses with a clear top theme chosen from the multiple-choice answers were incorporated into selecting the overall theme the data is categorized under. Write-in responses were also taken into consideration when selecting the final theme. Staff met to discuss survey results and decided on the final theme each metric would be categorized under.

ISSUE STATEMENTS AND PROFILE FORMING

The HealthyJoCo team formed 13 issue profiles based on data from all 3 MAPP 2.0 assessments, as well as relevant secondary data. Listed below are the titles of each health issue profile. Issue profiles also consisted of the following categories: definition and summary, issue statements, prevalence and trends, equity, contributing factors, and community input and thoughts.

1. Primary and Preventative Healthcare
2. Health Behaviors and Outcomes
3. Economic Status, Employment & Finances
4. Healthcare Quality, Access, & Affordability
5. Built Environment: Housing and Transportation
6. Dental Healthcare
7. Reproductive Health and Trauma Informed Care
8. Mental Healthcare
9. Community Strengths and Organizational Capacity
10. Culture and Language in Health
11. Food Security
12. Education and Health Literacy
13. Health Legislation and Policy



The graphics shown here are a snapshot of the first version of health issue profiles, using the Storymaps feature on ArcGIS.

NOMINAL GROUP TECHNIQUE

Nominal group technique (NGT) is a process by which 6 – 20 individuals representing the community are involved to take part in brainstorming and voting on priority issues. This technique was selected as a precursor to launching a community-wide health priority survey. The top 10 issues selected from the NGT meeting will be the 10 issues Johnson County community members will have the opportunity to rank on the prioritization survey. NGT was selected as a method for facilitating prioritization due to its ability to balance the influence of individuals involved in limiting the power and distributing it evenly amongst participants. NGT is a democratic process and can bring about a greater sense of closure than a regular discussion may bring. [1]

During the week of September 25, 2023, staff reviewed a list of 49 individuals to invite to the group meeting where staff will facilitate using nominal group technique. The list was composed of community partners who were previously involved in the 2022 – 2023 assessment process, as well as additional partners that were not previously involved in the assessment process. The list was organized by sector type based on the organization the individual represented. Each of the 6 staff members were assigned 20 points, which were distributed amongst each of the individuals to invite to be an NGT participant. 20 potential participants were selected, and outreach was done via email inviting them to the NGT.

The Nominal Group Technique meeting 1 was held on October 24th in person. 20 individuals were invited, and 11 individuals attended. Participants were guided through 7 of the 13 issue profiles. After each issue profile was presented by Johnson County Public Health staff members, participants were asked to reflect on the questions: (1) what stood out to you, and (2) what is missing. Due to great discussion and feedback on the issue profiles, 6 of the 13 health issue profiles were not discussed. A second meeting was necessary to continue the feedback and discussion. Table 2 outlines participants from the NGT Meeting 1.

Table 2. Nominal Group Technique Meeting 1 Participants

Name	Organization	Area of Work
James Mims	Neighborhood Centers of Johnson County	Social Services/Supports
Cassidy Bremmer	Johnson County Food Policy Council	Food Security
Ashely Salinas	Guidelink Center	Mental Health
Paola Jaramillo Guayara	Johnson County Board of Supervisors	Diversity, Equity, Inclusion
Emily Sinnwell	Catholic Worker House	Refugee and Immigrant Services, Healthcare
Sunday Goshit	Iowa City Compassion	Refugee and Immigrant Services, Disability Services
Jessica Lang	Johnson County Attorney's Office	Community Safety and Violence Prevention
Anjali Deshpande	University of Iowa College of Public Health	Public Health
Becky Soglin	Johnson County PDS	Planning and Development
Kelly Schneider	Johnson County Social Services	Social Services/Supports
Jon Green	Johnson County Board of Supervisors	Elected Official

NOMINAL GROUP TECHNIQUE MEETING 2

The second Nominal Group Technique meeting took place on November 7, 2023. 8 participants, not including the 6 JCPH staff members, were led through the remaining 6 issue profiles. Again, participants were asked to reflect on the questions: (1) what stood out to you, and (2) what is missing.

Following the second NGT meeting, the JCPH team worked through the input from participants to consolidate the issues into better-to-understand profiles and include potential objectives should the profiles be chosen. Table 3 below shows the changes made.

Table 3. Health Issue Profile Re-Organization

Original Priority	Final Priority
Primary and Preventative Healthcare	**Primary and Preventative Healthcare (Preventative Screenings)**
Health Behaviors and Outcomes	**Chronic Disease and Physical Health & Activity**
Economic Status, Employment & Finances	**Financial Wellness**
Healthcare Quality, Access, & Affordability	**Healthcare Quality, Access, & Affordability**
Built Environment: Housing and Transportation	**Built Environment: Housing**
Built Environment: Housing and Transportation	**Built Environment: Transportation**
Dental Healthcare	**Dental Healthcare**
Reproductive Health and Trauma Informed Care	**Reproductive Health and Trauma Informed Care**
Mental Healthcare	**Mental Healthcare**
Community Strengths and Organizational Capacity	No longer, is part of education
Culture and Language in Health	No longer, but is part of Community Health Resources, Health Education & Literacy As well as Healthcare Access, quality, Affordability
Food Security	**Food Security**
Education and Health Literacy	**Community Health Resources, Health Education & Literacy**
Health Legislation and Policy	No longer, but is incorporated throughout

The above table was sent to NGT participants along with an online Qualtrics survey. Participants were asked to vote for their top 4 health priorities. The NGT prioritization survey assigned a score to the top 4 priorities, with the top priority being assigned 4 points, the second-most important priority being 3 points, the third-most important priority being 2 points, and the fourth-most important priority being 1 point.

Details of the issue profiles can be found at this link: arcg.is/14vLyP1 . A snapshot of the home page is shown below.

COMMUNITY PRIORITIZATION SURVEY

On November 13, 2023, a community prioritization survey was launched. The survey included details of the 11 health issue profiles. After survey respondents read about each health issue, they were prompted to vote for their top four health priorities. Demographic information such as zip code, gender, race, ethnicity, and age were collected to better understand the reach of the survey.

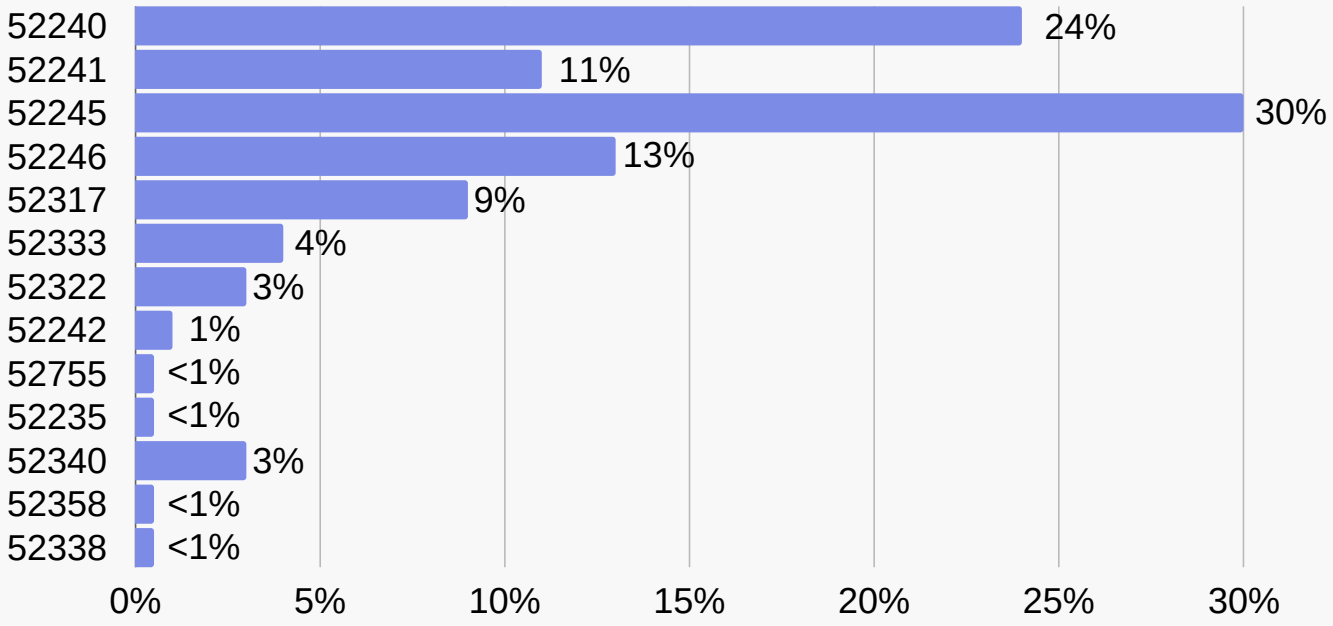
Outreach was conducted on site with tablets pre-loaded with the survey at the Iowa City Public Library, Catholic Worker House, and North Liberty Public Library. Some respondents received gift cards for completing the survey on site. Outreach was also conducted in the form of posting flyers and handing out cards with QR codes and bit.ly links to the survey. The following is a list of all locations JCPH staff conducted outreach to for distributing flyers and cards: Coralville Food Pantry, CommUnity Food Pantry, North Liberty Food Pantry, Big Brothers Big Sisters, Public Space One, South of 6 Business District, local Hy-Vees, Walmart, Aldi, Target, Prairie Lights Café, Raygun, Center for Worker Justice, Monsoon, Guidelink, Neighborhood Centers of Johnson County, IC Compassion, Iowa City Free Medical and Dental Clinic, Iowa City Senior Center, Iowa City Towncrest Pharmacy, University of Iowa Hospitals and Clinics, Iowa City School District, Clear Creek Amana School District, Solon School District, and Lone Tree School District.

The survey was promoted on both the Johnson County Public Health (JCPH) Facebook and Instagram platforms, with consistent weekly announcements, until its closure. Additionally, it was prominently featured on the official healthyjoco.com website. The survey officially concluded on December 4, 2023, with a total of 286 respondents providing their input. However, 55 respondents dropped out of the survey before voting for priorities. Therefore, 231 Johnson County respondents fully completed the survey. Based on a confidence interval of 95%, the margin of error is calculated to be ±6.4%. Table 4 shows results of both the NGT and community prioritization survey.

PRIORITIZATION SURVEY DEMOGRAPHICS

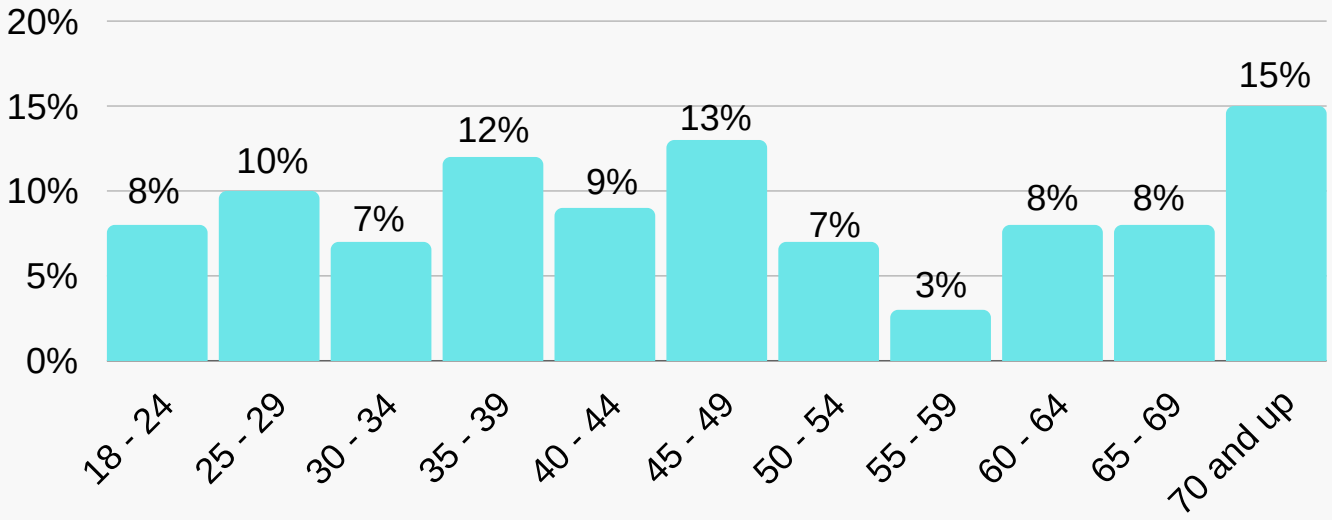
Zip code distribution of those who completed the survey is shown in the graph below. Many respondents (67%) were from Iowa City area codes of 52245, 52240, and 52246. Followed by 11% from 52241 (Coralville), 9% from 52317 (North Liberty), and 4% from 52333 (Solon). The remaining approximate 7% of responses were from other rural Johnson County areas such as Oxford, Tiffin, Swisher, and Shueyville.

Zip Code (231)



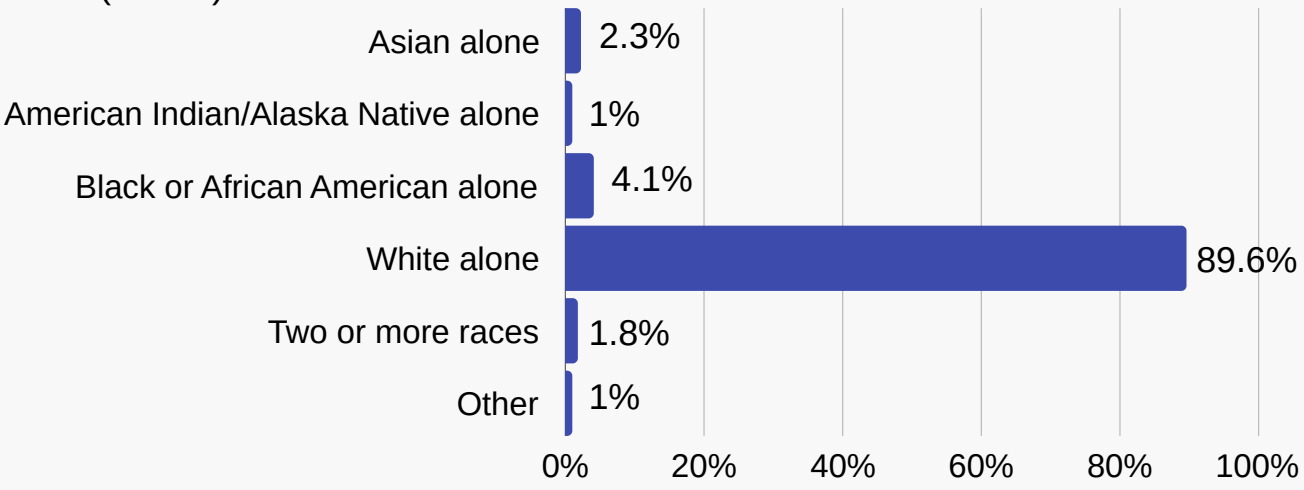
Respondents of all ages participated in the survey. The median age range was 45 – 49 years. The graph below shows the distribution of respondent age ranges.

Age (231)



PRIORITIZATION SURVEY DEMOGRAPHICS

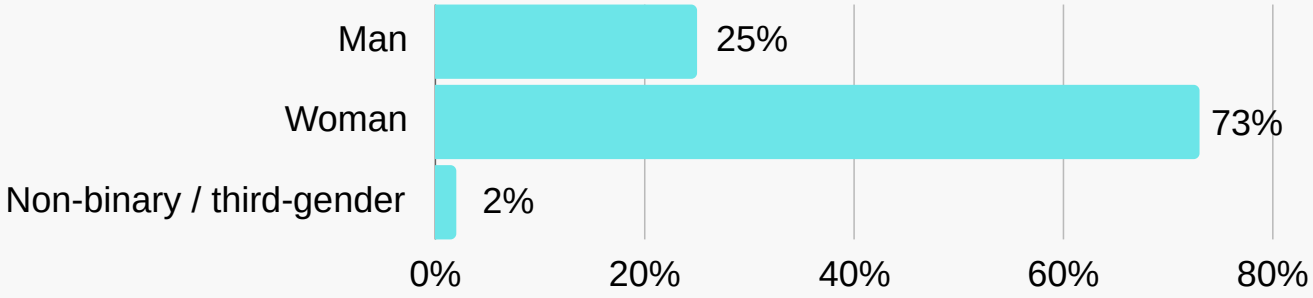
Race (n=222)



Ethnicity

Approximately 4% (9) of respondents reported being of Hispanic, Latino, or Spanish origin.

Gender (n=225)



PRIORITIZATION RESULTS

Results of the prioritization surveys were discussed with participants of the NGT on December 5, 2023. Table 4 with all survey results, as well as the weighted score, can be seen below. The weighted metric was calculated by dividing 11 NGT respondents by 231 and multiplying by 100 to get a percentage. Each NGT score was then multiplied by 4.76 and added to the community score, resulting in the weighted score (rounded to the nearest whole number).

Table 4. Health Priority Combined Ranking

Health Priority	NGT Score	NGT Rank	Community Score	Community Rank	Total Weighted Score	Total Weighted Rank
Healthcare Quality, Access, & Affordability	17	1,2	510	1	591	1
Community Health Resources, Health Education & Literacy	17	1,2	150	7	231	6
Mental Healthcare	14	3	500	2	567	2
Built Environment: Housing	10	4,5	350	3	398	3
Primary & Preventive Healthcare (e.g. screenings)	10	4,5	210	5	238	5
Dental Healthcare	9	6	40	10	69	10
Financial Wellness	7	7	120	8	143	8
Reproductive Health & Trauma Informed Care	6	8	20	11	39	11
Built Environment: Transportation	5	9	50	9	74	9
Chronic Disease and Physical Health & Activity	3	10	180	6	194	7
Food Security	2	11	240	4	250	4

Overall, individuals in the meeting to discuss prioritization made the decision to have an overarching priority of Community Health Resources, Health Education & Literacy. Community Health Resources, Health Education & Literacy will be incorporated into each of the 4 priorities. The following 4 community health priorities were officially selected:

For more information about goals and objectives surrounding these priorities, please visit www.healthyjoco.com.