HEALTH DEPARTMENT
DALLAS COUNTY, IOWA

HEALTH NAVIGATION

SUPPORTING THE HEALTH & WELL-BEING OF DALLAS COUNTY RESIDENTS SINCE 2010

HEALTHY & THRIVING PEOPLE

Our Mission

Dallas County Health Department strives to give all Dallas County residents an equal opportunity to make healthy choices. We do this by empowering people to overcome financial, emotional, environmental, occupational, social, and physical roadblocks to health through Health Navigation services.

Health Navigation began in 2010 when a needs assessment identified access to healthcare as an issue in Dallas County. Since its beginning, Health Navigation has evolved to help residents connect with resources for many other needs. The program currently employs a licensed social worker, and community health workers to address the diverse needs in Dallas County.

In 2017, Dallas County's Health Navigation Program was recognized as a Model Practice by the National Association of County and City Health Officials (NACCHO).

LIFE STYLE

MENTAL HEALTH

FOOD & SHELTER & EMPLOYMENT

Basic Needs are Essential to Health

We want all Dallas County residents to be able to thrive!

Our Health Navigation program helps people address basic needs to create a firm foundation from which they can securely make healthy choices.

Anyone that lives in Dallas County can use the Health Navigation Program.

HEALTH NAVIGATION SERVES DALLAS COUNTY

No Income Requirements

There are no income requirements to participate in the Health Navigation program. These resource referral services are available to any resident.

No Age Restrictions

The Health Navigation team works with people of all ages. We work with many families, connecting them with resources for both the adults and children. Minors can meet with a navigator after parental consent has been received.

You just need to live here

If you are currently living in Dallas County, our Health Navigation team will serve you. Whether that is in your permanent home or temporary living situation, we will visit with you and connect you with available resources to meet your goals.

In FY23, Health Navigation served people living in every Dallas County community as well as those living in rural areas.

HOW HEALTH NAVIGATION WORKS TO SERVE YOU

We receive a referral

There is no wrong door when trying to access the Health Navigation program. Referrals come from partners that are also serving the community, family and friends, and from people seeking assistance for themselves.

Anyone can make a referral to the Health Navigation program by calling the office or completing our online referral form.

A Health Navigator schedules a visit

A Health Navigator will reach out to a client within 48 hours to schedule a visit. These visits are often done at the clients home to remove any access barriers. During this visit a Health Navigator will learn about what the client is wanting to work on, ask some basic demographic and screening questions , and talk about how they can work together to achieve the clients goals.

The Client and Health Navigator work on goals

During the initial visit, the Health Navigator will ask questions to explore all the areas in which they may be able to assist a client, however, the client drives which goals they want to work on. The Health Navigator will help them to find resources to meet their identified needs.

The Client is discharged, but welcome back

Once a client is connected with the resources they need to meet their needs they are discharged from the program. Client will never receive a bill from the Dallas County Health Department for this service and are welcome to call back if they need assistance in the future.

We collaborate with our team...

Each member of our Health Navigation team brings a unique skill set that allows us to support each other.

The team gathers three times a week to assign case loads and brainstorm strategies to help our clients achieve their goals.

with community partners...

When a referral is made to the Health Navigation program, our team makes sure to keep that partner informed and a part of the team.

Health Navigators are able to connect clients with resource to achieve goals they may have set with a different community partner.

and with our clients.

Working with a Health Navigator is a collaborative experience. Our clients drive the interaction, decide what goals they want to achieve, and lead the team in taking action. The Health Navigator supports the client offering resources and assistance as needed.

HEALTH NAVIGATION IS A TEAM EFFORT

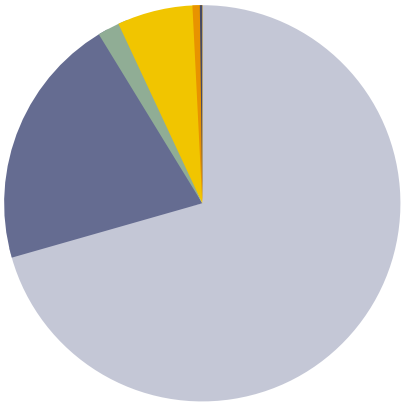
HEALTH NAVIGATION SEEKS EQUITABLE OUTCOMES

Dallas County is wonderfully diverse, but health outcomes shouldn't be.

The Health Navigation team connects people with the resources that are needed to allow everyone the opportunity to live a healthy and thriving life.

In FY23, 30% of clients identified as non-white.

Many identified as multiple racial categories.



In FY23, two out of ten clients identified as Hispanic.

Language can be a barrier to healthcare access

Research has shown that those who speak English less than "very well" have consistently received lower quality care, often due to communication barriers but also cultural differences, biases, and ineffective systems.

In FY23, 16% of clients did not speak English and 25% of clients preferred to speak a language other than English.

Residents living in poverty are at increased risk for poor health outcomes & reduced lifespan.

In Dallas County, 14% or about 15,000 people are supported by an income that is considered "very low" or less than 185% of the federal poverty level. Young children and older adults experience poverty at higher rates than other age groups. 14% of children under the age of 5 are living in poverty.

In contrast, **50% of Health Navigation clients are experiencing extremely low poverty** (<100% FPL), and an additional 36% are living in very low poverty (<185% FPL).

The Health Navigation team connects residents with resources to reduce financial stress and improve access to care so families can thrive.

Education positively influences health

Education typically leads to jobs that offer higher salaries and better benefits, including health insurance which improves a persons access to health care.

In FY23, 76% of clients reporting education attainment had a high school diploma or less than a high school diploma.

Health Equity Defined

Health equity means that all people have a fair and just opportunity to be as healthy as possible.

Older residents often experience additional barriers

From limited fixed incomes amid increasing cost of living, to finding health insurance or providers that are covered, the Health Navigation team helps older adults find resources to help them thrive as they age.

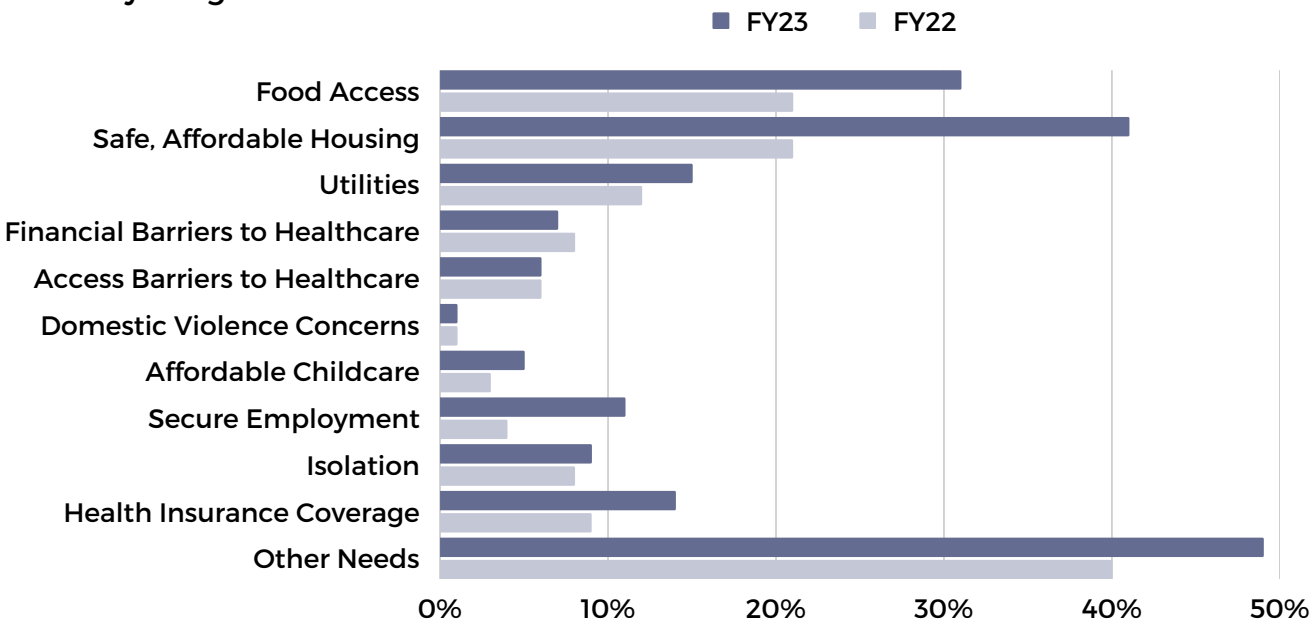
In FY23, we served several minor children, 281 adults (ages 18-64), and 205 older adults (65+).

HEALTH NAVIGATION IDENTIFIES NEEDS IN THE COMMUNITY

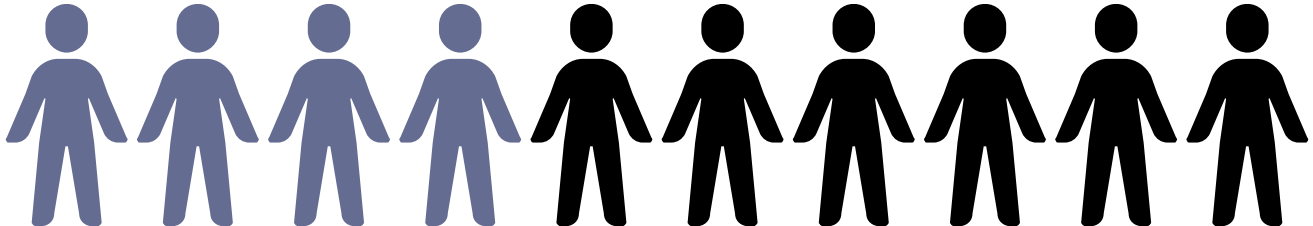
Every client is screened for 11 basic needs.

Between July 1, 2022 and June 30, 2023, our Health Navigators completed 557 screenings. These screenings included 11 basic yes/no questions to better understand the basic foundational needs that were present or missing.

The top needs identified were housing-related (41% of clients) and food-related (31% of clients). "Other needs" often were very specific requests that the client didn't feel fit into one of the 10 categories or clients that were accessing specific programs (like Senior Farmer's Market Nutrition Program) and didn't want help with anything else.



4 out of every 10 clients wanted help improving their housing situation.



HEALTH NAVIGATION CONNECTS PEOPLE WITH RESOURCES

We connected 500+ people with 1000+ resources!

In fiscal year 2023, our Health Navigators served 504 clients, helping connect them with resources to reach 1071 individual goals. **Clients were able to successfully connect with resources to meet their specific needs 89% of the time**.

Resource connections fall into one of 10 categories:

*Resource connections are guided by what the clients want to work on and may not include ALL identified needs. Additional needs may arise over time as the Health Navigator and client develop a more trusting relationship.

30%

Food

Includes resources for: food pantries, community meal sites, SNAP (food assistance), home-delivered meals, seasonal meal programs, and WIC. **172 connections + 151 SFMNP sign-ups; 323 total connections**

23%

Health

Includes resources for: adult and child health insurance, specialty healthcare, mental health care, dental care, free clinics, in-home care, primary care, prescription assistance, medical equipment, skilled care, and wellness programs. **245 connections**

20%

Housing & Utilities

Includes resources for: financial assistance for housing-related & energy costs, emergency shelter, & home repairs. **218 connections**

<10%

285 connections were made across the following categories:

Financial (cash assistance programs, unemployment benefits)

Education (childcare & preschool enrollment, childcare assistance, ESL, secondary education, parenting programs)

Transportation (Medicaid, private, & public transit services)

Commodities (clothing & basic household goods)

Legal (immigration & general legal advice)

Employment (job placement services & job training)

SENIOR FARMER'S MARKET NUTRITION PROGRAM (SFMNP) PARTNERSHIP

Health Navigators connected clients with over $7500 in fresh produce

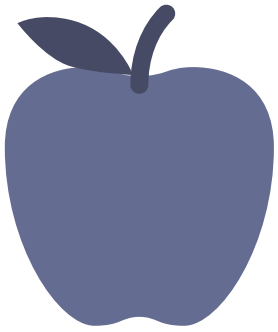
The Senior Farmer's Market Nutrition Program connects older adults with financial assistance to purchase fresh, local produce at farmer's markets, farms, and farm stands throughout the summer. The goal of this program is to improve access to healthy fruits and vegetables for better nutritional outcomes.

SFMNP is a USDA program administered locally by Aging Resources of Central Iowa. The Health Navigation team assists Dallas County residents in registering for the program each year. **In FY23, the Health Navigation team enrolled and distributed checks to 151 applicants.**

Screenings show more than just food needs

Each person that the Health Navigation team enrolls into SFMNP is also screened for additional needs that the team can assist with. **41% of residents enrolled in the SFMNP screened positive for additional needs during FY23.**

Top needs among SFMNP participants were food-related, housing-related, and access to health care services.



NEW IN 2023!

Welcome to our Newest Team Member!

Christina Schalk joined the Health Navigation team and has been connecting Dallas County residents with resources to meet their goals since March 2023. Christina has served Dallas County families for many years through her work in the Head Start program. We are excited to have her join our team!

Referring to Health Navigation Just Got Easier!

Health Navigation has gone semi-paperless! With our online referral tool, partners can make a referral to the Health Navigation program with just a few clicks. Simply type in the referral details and we will receive them by secure email. Access the online referral tool by scanning the QR code or visiting www.DallasCountyIowa.gov/PublicHealth

Of course, still accept referrals via paper, phone, fax, or email too!

Bring Health Navigation Information to Your Team!

We have new rack cards! These cards are easy to hand out to member of the public or staff on your team. They include basic details about the program as well as the QR code & phone number to make a referral. Cards are available in English & Spanish. **Contact us to request rack cards for your office!**

Interested in learning more? **Request a Health Navigation training for your team.** We can offer a 30 minute overview of the program & discussion on how we can work together to serve the residents of Dallas County.

THANK YOU TO OUR TEAM,

Health Navigators

Vivian Aldridge
Ann Cochran, LMSW
Christina Schalk

Program Support & Management

Abigail Chihak, MSW, MPH
Suzanne Hegarty
Rose Seibert

OUR COMMUNITY PARTNERS,

Adel Mental Health, ADM Community School District, Aging Resources of Central Iowa, Children's Minnesota Hospital & Clinics, Crisis Intervention & Advocacy Center, Dallas County EMS, Dallas County Hospitals & Clinics, Dallas County Sheriff's Department, Early Head Start, Every Step, Heart of Iowa Community Services, Heartland AEA, HIRTA, Iowa Department of Health and Human Services, MercyOne Adel, Monsoon Asians and Pacific Islanders in Solidarity, Mt. Olivet Lutheran Church, New Hope Church, New Opportunities, Optum United Healthcare, Perry Community School District, Plymouth Church, Safe Harbor, Zion Integrated and Behavioral Health Services, SAIL-DC, Short Years, South West Iowa Mental Health Center, Sunrise Valley Trail Apartments, Tyson Foods, Unity Point Kettlestone, Unity Point Methodist Hospital, Waukee Area Christian Services, Waukee Fire Department, Waukee Community School District, WIC.

AND OUR FUNDERS.

DALLAS COUNTY, IOWA

United Way
United Way of Central Iowa