Dallas County Health Navigation

Building Strong Foundations in Dallas County since 2010

FY2024 Annual Report

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).

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.

Our Team

Ann Cochran, LMSW
Health Navigator

Abigail Chihak, MSW, MPH
Program Manager

Vivian Aldridge
Health Navigator

Suzanne Hegarty
Agency Director

Christina Schalk
Health Navigator

Our Sponsors

DALLAS COUNTY IOWA

United Way
United Way of Central Iowa

Access to Care

Access to care issues was the reason that the Health Navigation program was founded and remains a top area of need among clients. The top reasons Navigators connected clients with access to care resources was for **insurance, dental care, and transportation** to medical appointments.

436	262	202
# Access to care needs addressed	# Clients served with access to care needs	# Client that screened positive

FY24 saw an increase in **access to care needs** among Health Navigation clients, including resource connections for both healthcare (+86%) and transportation (+91%) compared to FY23.

Three screening questions are asked about access to care.

- **6%** of clients served in FY24 said yes when asked **"In the past year, was there a time when you needed to see a doctor but could not because of the cost?"**
- **5%** of clients said yes when asked **"In the past year, have you ever had to go without health care because you didn't have a way to get there?"**
- 10% of clients said yes when asked **"Are there members of your household that do not have health insurance?"**

Health Navigators were able to connect clients with resources to successfully meet their health-related needs **89%** of the time and transportation needs **87%** of the time.

Transportation Collaboration Projects with HIRTA

The Health Navigation team assisted HIRTA Public Transit in registering Perry residents for the Flex Route project. Riders received free bus passes for completing a social determinants of health survey. The team also helped test the Health Connector project to alleviate burdens faced when scheduling transportation for medical appointments.

Food Security

Health Navigators helped Dallas County residents connect with a variety of resources related to food in FY24. The top categories of food related needs included the **Senior Farmers Market Nutrition Program, food pantries, & SNAP**.

405	**322**	**175**
# Food related needs addressed	# Clients served with food related needs	# Clients that screened positive for food needs

Food related needs have been among the top three needs the last three fiscal years and **have a slight upward trend in prevalence** among Health Navigation clients; +32% from FY23.

15% of clients served in FY24 said yes when asked **"In the past year, did you ever eat less than you felt you should because there wasn't enough money for food?"**

Health Navigators were able to connect clients with resources to successfully meet their food-related needs **93%** of the time.

Senior Farmers Market Nutrition Program Outreach

The Health Navigation team assisted in registration for the SFMNP to help connect income-eligible, older adults with vouchers to purchase fresh fruits, vegetables, and herbs in Dallas County.

142	**$7,100**
Older adults registered	SFMNP benefits distributed

Housing Costs

One in three Health Navigation clients received help with some form of housing need. The top housing related resources Navigators provided clients included **rental assistance, affordable housing, and utility assistance**.

337	**202**	**254**
# Housing related needs addressed	# Clients served with housing related needs	# Clients that screened positive

Housing related needs have been increasing over the last three years. Among Health Navigation clients, there was a 143% increase in housing needs and 39% increase in utility needs compared to FY22 .

Two screening questions relate to housing:

- **19%** of clients served in FY24 said yes when asked **"Do you have concerns about your current living situation, like housing conditions, safety, and costs?"**
- 8% of clients said yes when asked **"Do you have trouble paying your utility bills? (gas, water, electric, phone)**

It is becoming more difficult to connect clients with resources to successfully meet their housing-related needs. Resource connection success rates of **79%** for housing needs and **76%** for utility needs are down 1% and 16% respectively.

What does homelessness look like in Dallas County?

Families uprooted to stay in a shelter

Neighbors living in their car or camper

People staying with family or friends

Residents limited to substandard housing

Demographics

Our Health Navigation team seeks equitable outcomes for everyone living in Dallas County. **In FY24, health navigators served 580 unique individuals**.

Health navigators serve the entire family unit, with one parent or adult often acting as the primary client. Including all household members, **the Health Navigation program impacted 1374 Dallas County residents in FY24** (1.3% of the total Dallas County population!).

The only eligibility criteria to participate in the Health Navigation program is residence in Dallas County, IA. The program serves clients of all income levels and backgrounds. **Navigators assisted clients speaking 8 different languages in FY24** using in-person or phone services.

Notes:

- Quantities less than 5 are suppressed and notated with an *
- The HN program served many youth, however it is more frequently in the context of the family unit with the parent as the primary client.
- Missing data was removed for the purposes of calculation. Therefore raw numbers will not add up to 580.
- Poverty Level is calculated from income and household number and then compared to the Federal Poverty Line (FPL). Those in the 'Low' and 'Very Low' category, while above the FPL, are often considered ALICE families (Asset Limited, Income Constrained, Employed).

Age Group	# Served	% of Total Served
Youth & Adolescents (0-17)	*	<1%
Young Adults (18-34)	135	25%
Middle Age Adults (35-64)	222	41%
Older Adults (65+)	187	34%

Ethnicity	# Served	% of Total Served
Hispanic/ Latino	124	22%
Non-Hispanic/ Non-Latino	437	78%

Educational Attainment	# Served	% of Total Served
Less than a High School Diploma	109	24%
High School Diploma or Equivalent	252	55%
Some College or Associate Degree	57	12%
Bachelor Degree or Higher	42	9%

Poverty Level	# Served	% of Total Served
Extremely Low (<100% FPL)	273	50%
Very Low (<185% FPL)	204	37%
Low (<250% FPL)	39	7%
Self Sufficient (>250% FPL)	31	6%

FY24 Screens

A series of 11 social determinants of health screening questions were asked of each Health Navigation client. In FY24, 581 screenings (+4% from FY23) were completed identifying 1246 presenting needs (+31% from FY23)

Screening Question	# Positive Screens	% of Total Presenting Needs	% Change from FY23
In the past year, did you ever eat less than you felt you should because there wasn't enough money for food?	175	14%	13%
Do you have concerns about your current living situation, like housing conditions, safety, and costs?	220	18%	7%
Do you have trouble paying your utility bills? (gas, water, electric, phone)	98	8%	27%
In the past year, was there a time when you needed to see a doctor but could not because of the cost?	69	6%	92%
In the past year, have you ever had to go without health care because you didn't have a way to get there?	59	5%	90%
Are you afraid that you might be hurt by someone in your home?	12	1%	71%
Do problems getting child care make it difficult for you to work or study?	38	3%	41%
During the last four weeks, have you been actively looking for work?	84	7%	58%
Do you often feel lonely or isolated from those around you?	84	7%	83%
Are there members of your household that do not have Health Insurance?	118	9%	64%
Do you have any other needs that you would like help with?	289	23%	18%

Notes:

- Other needs included mainly participation in specific programs & additional financial concerns.
- Screening needs are considered presenting needs but are not always addressed by the Health Navigator if the client does not wish to do so.
- Screenings are completed at every intake, including for returning clients. This data represents 494 unique individuals.
- Percent change is a way to measure how much a value has changed over time as a percentage of its original value. In this report, it looks at the size of the increase or decrease in number compared to FY23.

FY24 Needs

In FY24, Health Navigators assisted Dallas County residents to resolve 1547 needs with a success rate of 87%. More needs were identified overall (+44% more than FY23), with increases in every need category.

Need Category	# Needs Identified	% of Total Needs	% Resolved Successfully	% Change from FY23
Adult Education	23	1%	87%	77%
Behavioral Health	81	5%	78%	29%
Child-Related	133	9%	90%	77%
Commodities	48	3%	98%	50%
Employment	46	3%	89%	77%
Financial	97	6%	86%	20%
Food	369	24%	93%	14%
Health	339	22%	89%	86%
Housing	226	15%	79%	59%
Legal	39	3%	77%	50%
Transportation	61	4%	87%	91%
Utilities	85	5%	76%	12%

Notes:

- Food needs are inclusive of Senior Farmers Market Nutrition Program Outreach which accounts for just over one third of the needs identified.
- Increases in Adult Education, Employment, Health, and Housing were in part due to outreach among workers laid off from the Tyson plant.
- Increases in Transportation were in part due to increased outreach for the Flex Route project which connected residents with free bus passes in exchange for social determinants of health survey participation.
- FY23 produced a resource connection success rate of 89% indicating reduced success in finding resources to meet clients needs in FY24 (-2%). The need categories with the largest drop in resource connection success rate were adult education (-13%) and utilities (-16%). The top reasons for an unsuccessful connection are a lack of resources available and the client no longer wanted to work on the need because it was solved elsewhere or is no longer a priority.