United Way of East Central Iowa
Health Report Card

COMMUNITY GOAL

By 2020, improve social connectedness & mental health functioning of low-income adults by 10%.

KEY STRATEGIES

- Grow prevention efforts by providing access to preventative screenings and education.
  - Increase the number of targeted school dental clinics to assess dental health needs.
  - Engage youth and businesses in community education around substance abuse prevention to healthy youth and community.
  - Increase access to care through strategic women's health partnerships by providing prescription assistance, co-pay assistance, medical supplies, and vision and dental care.
- Support families' well-being where they live and work by preventing, mitigating, and treating adverse childhood experiences that impact long-term health.
  - Build resiliency through expanding mental health assessment and services to keep individuals healthy.
  - Improve outcomes and function at home, work, and school for participants involved in mental and behavioral health programs.
- Improve conditions for older adults and persons living with disabilities by supporting home-based services that increase well-being and independence.

THE NEED

The conditions in which we are born, grow, live, work, and age influence our lifelong health.

Factors that contribute to or detract from healthy individuals and communities including, but not limited to healthy behaviors (alcohol, drug, and tobacco use; sexual activity; and diet and exercise), clinical care (access to and quality of care), social and economic factors (family and social support, community safety, income, and employment), and environmental factors (air and water quality, housing, and transit). 70% of health outcomes attribute to socioeconomic factors and health behaviors that determine length and quality of life.[1]

Our community continues to learn from and support individuals who have experienced Adverse Childhood Experiences (ACEs), which can include household dysfunction, neglect, and abuse. ACEs are common across socioeconomic and culture/ethnicity lines. They are interrelated; multiple ACEs have a powerful impact on mental, physical, and behavioral health throughout the life course. Additionally, we are learning how to enhance and build trauma-informed responses to those impacted by ACEs in order to improve health and community outcomes, as well as systems of care.[2]

With proper knowledge and access to services and supportive systems, we can reduce health barriers and promote well-being, healthy behaviors, and healthy aging across all life stages, especially for those who are at greater risk for health disparities.

- In 2013, 29% of adult residents reported having one or more days of poor mental health. Among those adults, 16% reported between one and five days of poor mental health in the past 30 days. [3]
  - Among female respondents, mothers are at an increased risk for experiencing poor mental health; 47% experienced poor mental health for 11 or more days per month.[3]
- Doctors diagnosed 24% of Iowa women with some form of depression; this is a 3% increase since 2011. For women, as income decreases, poor mental health increases.[3]

Sources:

[1] Adapted from the World Health Organization; Marmot, 2005; McGinnis, Williams-Russo, & Knickman, 2002

[2] Adapted from ACE Interface - Building self-healing communities

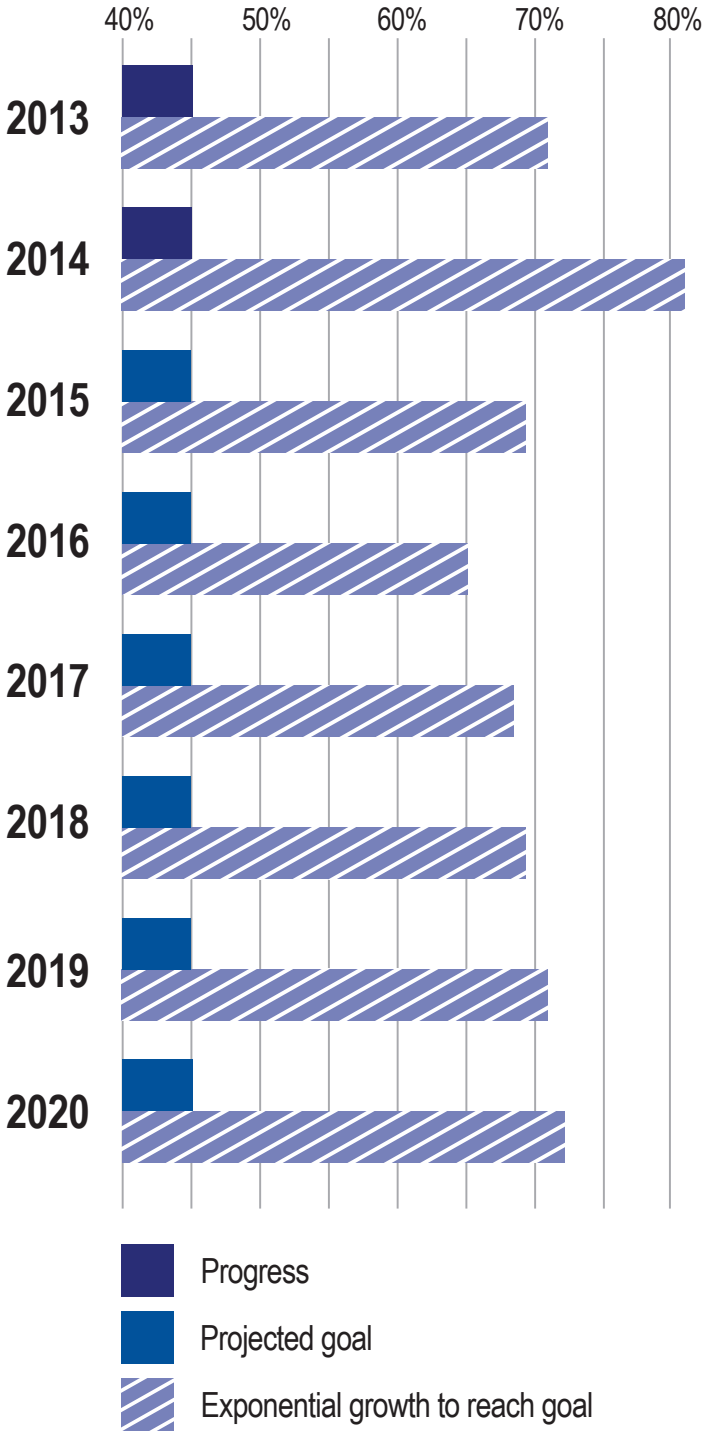
[3] Community Health Improvement Plan, Linn County Public Health

[4] Behavioral Risk Factor Surveillance System - Iowa (BRFSS)

THE NEED, CONTINUED

- The Iowa 2014 Mental Health National Outcome Measures (NOMs) report captures client perceptions on the services they receive from SAMHSA Block Grant funded mental health providers. Percentage reporting improved functioning from services in 2012 was 43.3% to 44.2% in 2014 (.9% increase).
  - Locally, in 2015, United Way of East Central Iowa's partners reported 67.9% of reporting clients improved functioning (MHSIP Consumer Survey).
  - The financial implications of mental health issues are significant for our community. Nationally, health care costs for those with one of the 10 most common chronic health illnesses were, on average, 65% higher for those who also had a diagnosis of depression, and 77% higher for people with anxiety.[3]
  - In addition, nearly one in five adults with mental illness also had a substance abuse disorder.[4] Not only is the cost of care higher, but people with serious mental illnesses die 25 years earlier, on average, than the rest of the population.[5]
- In partnership with the FamilyWize Prescription Savings Card program, we support reducing high prescription costs. Between July 2014 - June 2015; 461 of 1889 (24%) claims were highest for mental health medications making up 28% of total claim expenses ($16,493 of total $59,842).
- Economic factors as a contributing factor to health is reflected in the additional stress of female-headed households with one or more children under the age of 18 which is nearly 5,250 households in Linn County.[7]
  - This has adirect impact on addressing how families grow, live, and work in meeting basic needs (food, clothing, and transportation), obtaining and maintaining safe housing, accessing and navigating health care, and gaining education resources for herself and her child.
- And in focusing on healthy aging for those 65 and older in our five-county UWECI service area with an estimated 43,094 individuals with 68% living in Linn County[8]:
  - 52% of two person households live below 250% of the Federal Poverty Level, with income less than $40,000.
  - Nearly one in three individuals live with a disability, which impacts quality of life[7] as well as increases the need for access to social and service supports that help improve independence and ability to live and function within the community.

Low-Income Individuals Reporting Improved Functioning from Services



Sources:

[3] Steve Melek and Doug Norris, "Chronic Conditions and Comorbid Psychological Disorder," Milliman Research Report (July 2008)

[4] Substance Abuse and Mental Health Services Administration, "Substance Use and Mental Health Estimates, " 5-6.)

[5] National Association of State Mental Health Program Directors, Measurement of Health Status for People With Serious Mental Illness (Alexandria, VA:2008)

[6] Medicaid, 2015, http://Medicaid-chip-program-information/by-population/pregnant-women/pregnant-women.html

[7] American Fact Finder- female headed household with no husband present and one or more children under age 18

[8] American Fact Finder- Sex by Age by Disability Status

Health Stability Report Card

UNITED WAY OF EAST CENTRAL IOWA
WOMEN'S LEADERSHIP INITIATIVE
women helping women

BREAKTHROUGH STRATEGY: Women's Leadership Initiative

Increase the well-being of low-income women (250% of FPL) age 18–54 by increasing affordability, reducing barriers to access, improving utilization of health care systems, and improving mental health.

PARTNERS: Eastern Iowa Health Center, Community Health Free Clinic, and Linn County Public Health

Performance measures	Number impacted								
	FY2011 (baseline)	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Women who received prescription assistance	1,380	1,479	1,964	1,515	1,340	669			
Women who received dental care	125	103	432	530	328	489			
Women who received medical co-pay and preventative screenings	704	321	853	700	796	374			
Women who received eye exams and glasses	155	225	136	85	57	77			
Women who received medical supplies or diabetic testing supplies	109	197	248	148	106	50			
Women who received care coordination	NEW INDICATORS FY2015					166			
Women who received medical supplies or diabetic testing supplies						954			

INTERMEDIATE OUTCOME 1: Preventative Health

Increase factors contributing to long-term health by increasing education, screening, early detection, and reducing health care barriers.

PARTNERS: Area Substance Abuse Council (ASAC) and St. Luke's Dental Health Center

Performance measures	Number impacted								
	FY2011 (baseline)	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Individuals referred for additional services based on screening/assessments	2,741	3,161	3,165	2,861	4,829	7,970			
Individuals referred for severe/urgent care	1,882	735*	858	359*	117*	128			
Individuals with increased knowledge of risky behaviors	735	938	1,437	440	259	280			

*Denotes a change in data compilation from previous year.

*In this document, due to changing strategies and changes data collection, some values do not exist and are noted by an * in a gray box.*

As FY15 is a new reporting cycle, many agencies have changed which indicators to report, have added new ones, and have dropped others. Therefore, use caution when comparing FY2014 to FY2015

INTERMEDIATE OUTCOME 2: Reducing Adverse Childhood Experiences (ACES)

Prevent, mitigate, and treat main contributors of adverse childhood experiences for families with children to build resiliency.

PARTNERS: Area Substance Abuse Council (ASAC), Abbe Center, Foundation 2, Horizons, Mississippi Valley Child Protection Center, and Mississippi Valley Child Protection Center, and St. Luke's Child Protection Center

Performance measures	Number impacted								
	FY2011 (baseline)	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Individuals with reduced levels of crisis, depression, anxiety, and/or stress	15,013	14,587	12,615	10,379	11,460	18,897			
Individuals screened for ACEs, behavioral health problems, and/or trauma	NEW INDICATORS FY2015				11,828	17,711			
Individuals who received care based on follow-up appointments					441	747			
Individuals with increased feelings of social connectedness					957	1,318			
Individuals with improved/maintained functioning at school, work, and/or home	515	1,969*	1,526	1,714	1,522	1,766			
Individuals who completed treatment with goals met	1,046	1,055	1,016	1,088	938	1,021			

INTERMEDIATE OUTCOME 3: Community Living

Support home-based services that increase well-being and independence for older adults and persons living with disabilities.

PARTNERS: Aging Services Inc., The Arc of East Central Iowa, Horizons, HACAP, Rural Employment Alternatives, Inc., Benton County Volunteer Services, and Southeast Linn Community Center

Performance measures	Number impacted								
	FY2011 (baseline)	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
Individuals with increased feelings of social connectedness	NEW INDICATORS FY2015				5,951	5,537			
Individuals with improved/maintained daily functioning					3,738	4,284			
Caregivers with reduced levels of stress	62	192*	175*	111	187	226			
Individuals with increased access to nutritious, low-cost food	N/A	945	971	1,185	3,346	2,025			
Individuals with decreased sense of isolation and loneliness	924	3,344	3,887	3,909	2,469	1,096			
Individuals with increased knowledge of how to improve/maintain their health and wellness	1,362	1,208	1,027	1,054	2,101	511			

*Denotes a change in data compilation from previous year.

As FY2015 is a new 3 year reporting cycle, many agencies have changed, added or dropped the indicators they report, and there have been changes to the agencies funded, use caution when comparing FY2014 to FY2015.