HealthyNTexas.org

Platform Features

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Director of Client Services
Healthy Communities Institute
Agenda

1. Welcome and Introductions
2. HCI Background
3. System Configuration
4. Indicators and Data
5. Platform Features and Tools
6. Questions
7. Appendices
Background and Overview
Healthy Communities Institute

**Mission**
Improve the health, vitality and environmental sustainability of communities, counties and states

**Headquarters**
Berkeley, California

**Problem**
Health data is too decentralized

**Approach**
Centralize data, make understandable, lead to informed action
Our Reach

• Work in 38 States, 140 active engagements, over 500 partner organizations

• Markets: health departments, hospitals/healthcare delivery, health collaboratives, and any organization assuming risk of populations

• National Knowledge Base and Peer-Learning Network of Population Health Solutions
Healthy North Texas is a web-based source of community health and population data. We invite planners, policy makers, and community members to use the site as a tool for community assessment, strategic planning, identifying best practice for improvement, collaboration and advocacy.
Your Platform Includes

Technology and support to help you drive and monitor community health improvement

- Support from dedicated Account Manager
- Analytic tools for indicator comparison across geographies and sub-populations
- Data exports
- Targets to track progress towards meeting state and national goals
- Customizable web pages to highlight priorities
- Promising Practices database of best and evidence-based programs
- Regularly updated Funding Opportunities
- SocioNeeds Index to identify areas of greater socioeconomic need
- CHNA Guide to assist you with determining the health needs of your community
- Data Scoring Tool to view data across multiple comparisons
Additional Benefits

More then just a platform

• Ongoing Account Manager training and support
• Access to on demand and live webinars
• Subscription to client email communications
• Access to online client Help Center
• Invitations to national or regional client meetings
• Opportunities to network with other HCI clients
System Configuration
System Configuration

Geography: Counties in Texas: Collin, Cooke, Dallas, Denton, Ellis, Erath, Hunt, Johnson, Kaufman, Parker, Rockwall, Tarrant, Wise plus zip codes and census tracts when available from the data source

Website URL: www.HealthyNTexas.org

Local Administrator: Sushma Sharma, DFWHCF

Demographics: US Census Bureau QuickFacts
Indicators and Data
Health and quality of life indicators are selected by HCI and used to construct your community dashboard

Selection criteria:

- Data is publicly available from state or national source
- Data reported at county level (region or census tract in some cases)
- Validity of data and data source (appropriate methodology, adequate sample size)
- High likelihood that indicator will be replicated in the future
- Consistency of data availability across counties
- Aligns with national goals for health improvement (Healthy People 2020 objectives)
QuickFacts Demographics Data

- Approximately 70 demographic elements viewable at the county and state level
- Includes population, housing, economy, business, and geography data
- Data provided by US Census Bureau
Platform Features and Tools
Dashboard Homepage

Community Health Dashboards

Learn about your community's health and wellness. Compare indicators for your community against state averages, county values, and target goals. Discover areas of excellence and improvement in your community.

Search by Keyword

Find an indicator OR Find a Location

All Data
This dashboard contains data for all indicators at all locations

Disparities Dashboard
View all indicators that include breakout data by topics such as race/ethnicity, age and gender

Healthy People 2020 Progress Tracker

Indicator List by Location
View a list of all indicators and see at what location data is available
Community Dashboard

100-200 Health and Quality of Life Indicators used by communities to identify areas for improvement
Indicator Detail Page (County View)
Indicator Detail Page (ZIP Code View)
Indicators – Export Ability

Allows you to learn more and save indicators
SocioNeeds Index

The 2017 SocioNeeds Index, created by Healthy Communities Institute, is a measure of socioeconomic need that is correlated with poor health outcomes.

All zip codes, counties, and county equivalents in the United States are given an Index Value from 0 (low need) to 100 (high need). To help you find the areas of highest need in your community, the selected locations are ranked from 1 (low need) to 5 (high need) based on their Index Value.

Learn More
Promising Practices

The Promising Practices database informs professionals and community members about documented approaches to improving community health and quality of life. The ultimate goal is to support the systematic adoption, implementation, and evaluation of successful programs, practices, and policy changes. The database provides carefully reviewed, documented, and ranked practices that range from good ideas to evidence-based practices. Learn more about the ranking methodology.

Submit a Promising Practice

A Matter of Balance
Filed under: Evidence-Based Practice, Health / Older Adults & Aging, Fall ery
GOAL: The Matter of Balance/Volunteer Lay Leader (MOB/VLL) program is designed to reduce the fear of falling, stop the fear of falling cycle, and improve the activity levels among community-dwelling older adults. The goal of the program is to use volunteer lay leaders as facilitators, in order to make the program affordable to offer in the community setting.
IMPACT: When following up one year after the program, participants reported significant gains in fall management and there was a trend to increased exercise level as well. In addition, participants sustained a reduction in monthly falls.

A Text Message-Based Intervention for Weight Loss (San Diego County, CA)
Filed under: Evidence-Based Practice, Health / Exercise, Nutrition & Weight, Adults
GOAL: To reduce weight in overweight and obese patients using mobile-based text and multimedia messaging.

Accelerated Benefits (AB) Demonstration (USA)
Filed under: Evidence-Based Practice, Health / Disabilities, Adults
GOAL: The program's goal was to eliminate the waiting period for access to health care benefits for newly entitled SSDI beneficiaries, and see if this investment has long-term benefits.

Across Ages
Filed under: Evidence-Based Practice, Health / Children's Health, Children, Teens
GOAL: The goal of this program is to enhance the resiliency of children in order to promote positive development.
Resource Library

The Resource Library allows you to locate resources that help make your community a healthier place. If you have a resource you think should be included, please submit it here.

Explore Our Collections

- **Readmissions in North Texas: A Comprehensive Overview of Statistics, Demographics and Charges to Identify Disparities**
  - Author: Dr. Sushma Sharma, DFWHC Foundation
  - Published: August 7, 2015
  - Filed Under: Health, Health / Diabetes, Reports

- **Diabetes Associated Disparities**
  - Author: Sushma Sharma
  - Published: 2015
  - Filed Under: Health / Diabetes, Reports

- **Resources for Diabetes Prevention and Management**
  - Author: North Texas Community Health Collaborative
  - Published: 2015
  - Filed Under: Health / Diabetes, Reports

- **Free training opportunities for Tarrant County coalitions**
  - Author: Linda Fulmer
  - Published: September 26, 2014
  - Filed Under: Education / Vocational & Adult Education, 211 Resources

- **Tarrant County Coalition Training Opps**
  - Author: Linda Fulmer
  - Published: September 26, 2014
  - Filed Under: Education / Vocational & Adult Education, 211 Resources

Search Filters

- **Keyword Search**

- **Grouping**
  - No Grouping (default)

- **Sorting**
  - Resource Date (default)

- **Resource Type**
  - 211 Resources
  - Dashboard Reports
  - Data Resources
  - Funding Opportunities
  - Reports
CHNA Guide

Community Health Needs Assessment Guide

Use this guide to help you conduct your community health needs assessment and develop an implementation strategy. Within each section you will find valuable tools as well as hand-selected resources to help your efforts.

Choose one of the steps below to learn more:

- Assess
- Prioritize
- Design

Conducting a Community Health Needs Assessment for the IRS? Use our IRS Checklist
Data Scoring Tool

Comparisons
- Quantitatively score all possible comparisons

Indicators
- Summarize comparison scores for each indicator

Topics
- Summarize indicator scores by topic area

Indicator Score
Topic Score
# Data Scoring

## Health Topic

<table>
<thead>
<tr>
<th>Health Topic</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Chronic Diseases</td>
<td>2.54</td>
</tr>
<tr>
<td>Mental Health &amp; Mental Disorders</td>
<td>2.26</td>
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<tr>
<td>Older Adults &amp; Aging</td>
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<tr>
<td>Heart Disease &amp; Stroke</td>
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<tr>
<td>Children's Health</td>
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<tr>
<td>Diabetes</td>
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<td>Other Conditions</td>
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<td>Women's Health</td>
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<tr>
<td>Exercise, Nutrition, &amp; Weight</td>
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<tr>
<td>Maternal, Fetal &amp; Infant Health</td>
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<tr>
<td>Respiratory Diseases</td>
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<td>Cancer</td>
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<tr>
<td>Immunizations &amp; Infectious Diseases</td>
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<td>Access to Health Services</td>
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<td>Men's Health</td>
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<tr>
<td>Substance Abuse</td>
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<tr>
<td>Wellness &amp; Lifestyle</td>
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<tr>
<td>Prevention &amp; Safety</td>
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## Quality of Life Topic

<table>
<thead>
<tr>
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<tr>
<td>Transportation</td>
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<td>Social Environment</td>
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<td>Economy</td>
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<tr>
<td>Environment</td>
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<tr>
<td>Education</td>
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</tbody>
</table>

Score range:  

- **Good** (0-1)  
- **2**  
- **3** (Bad)
Topic Centers

Health Topic Center

Indicators

- Adults who have had a Routine Checkup
- Adults who Visited a Dentist
- Adults with Health Insurance
- Adults without Health Insurance
- Children with Health Insurance
- Dentist Rate

View all 8 items in this topic...
Questions?

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Appendices
Appendix A: Core Indicator List Methodology

- The framework for indicator selection within the Health category is based on the Health and Human Services’ (HHS) Healthy People initiative. Healthy People establishes science-based national objectives for improving the health of the nation. The initiative establishes benchmarks every ten years and tracks progress toward these achievable goals. This framework encourages collaboration across sectors and allows communities to track important health and quality of life indicators focusing on general health status, health-related quality of life and well-being, determinants of health and disparities.

- The Health subcategories are based on the Healthy People framework, and multiple indicators across the health sub-topics that correspond with Healthy People targets have been chosen (based on data availability, reliability and validity from the source).

- Hospital utilization indicators are based on the Agency for Healthcare Research and Quality (AHRQ)’s Prevention Quality Indicators (PQIs), which are a set of definitions for preventable causes of admission. These measures can be used with hospital inpatient discharge data to identify quality of care for “ambulatory care sensitive conditions.” These indicators are important for communities to identify where prevention needs to be focused and can help lead to evidence-based community benefit planning. Ambulatory care sensitive conditions are also tracked by Healthy People.

- Indicators in the other categories were selected according to national consensus and feedback from a wide set of advisors, public health officials, health departments, and local stakeholders from various sectors in the community. For example, the education indicators are based on the National Center for Health Research and Statistics and United Way of America, and the standards and goals they set forth to help track educational attainment in the U.S. Economic indicators were selected in conjunction with economic development and chamber of commerce input. All of the selected indicators have gone through a vetting process where CHS’s advisory board, as well as stakeholders in communities who have implemented CHS products, provide feedback to refine the core indicators in order to best reflect local priorities.

- The indicator selection process evolves over time with changing health priorities, new research models and national benchmarks. CHS continues to incorporate models and standards from nationally recognized institutions such HHS’s Healthy People, AHRQ’s PQI’s, EPA Air Quality standards, National Center for Education Research and Statistics’ priorities, United Way, and United States Department of Agriculture’s Food Atlas, among many others.
Indicator Comparisons

- CA Counties
- CA Value (81.2%)
- US Value (86.9% in 2015)
- Prior Value (89.2%)
- Trend
- HP 2020 Target (100.0%)
Legend

Can be viewed by clicking on the “See the Legend” tab.

The gauge represents the distribution of communities reporting the data, and tells you how you compare to other communities. Keep in mind that in some cases, high values are “good” and sometimes high values are “bad.”

- Green represents the “best” 50th percentile.
- Yellow represents the 50th to 25th quartile.
- Red represents the “worst” quartile.

Our icons are color-coded. Green 🟢 is good, Red 🟥 is bad. Blue ⚫ is neither.

The circle represents a comparison to a target value.

- 🟢 The current value has met, or is better than the target value.
- ☢️ The current value not met the target value.

The diamond represents a comparison to a single value.

- 🟢 The current value is lower than the comparison value.
- 🟠 The current value is higher than the comparison value.
- ☢️ The current value is not statistically different from the comparison value.

The square represents the measured trend.

- ⬆️ There has been a non-significant increase over time.
- ▼️ There has been a non-significant decrease over time.
- ▲️ There has been a significant increase over time.
- ▼️ There has been a significant decrease over time.
- ☢️ There has been neither a statistically significant increase nor decrease over time.

The triangle represents a comparison to a prior value.

- ▲️ The current value is higher than the previously measured value.
- ▼️ The current value is lower than the previously measured value.
- ▼️ The current value is not statistically different from the previously measured value.
Calculating Compare to Distribution
Percent of People Living Below Poverty
California counties, 2008-2012
Calculating Compare to Distribution

Percent of People Living Below Poverty
California counties, 2008-2012
Calculating Compare to Distribution
Percent of People Living Below Poverty
California counties, 2008-2012

50th percentile
Calculating Compare to Distribution

Percent of People Living Below Poverty
California counties, 2008-2012

50th percentile
Calculating Compare to Distribution
Percent of People Living Below Poverty
California counties, 2008-2012

50th percentile

75th percentile
Calculating Compare to Distribution
Percent of People Living Below Poverty
California counties, 2008-2012

50th percentile
75th percentile
Calculating Compare to Distribution

Percent of People Living Below Poverty

California counties, 2008-2012