HealthyNTexas.org

Platform Features

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Agenda

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

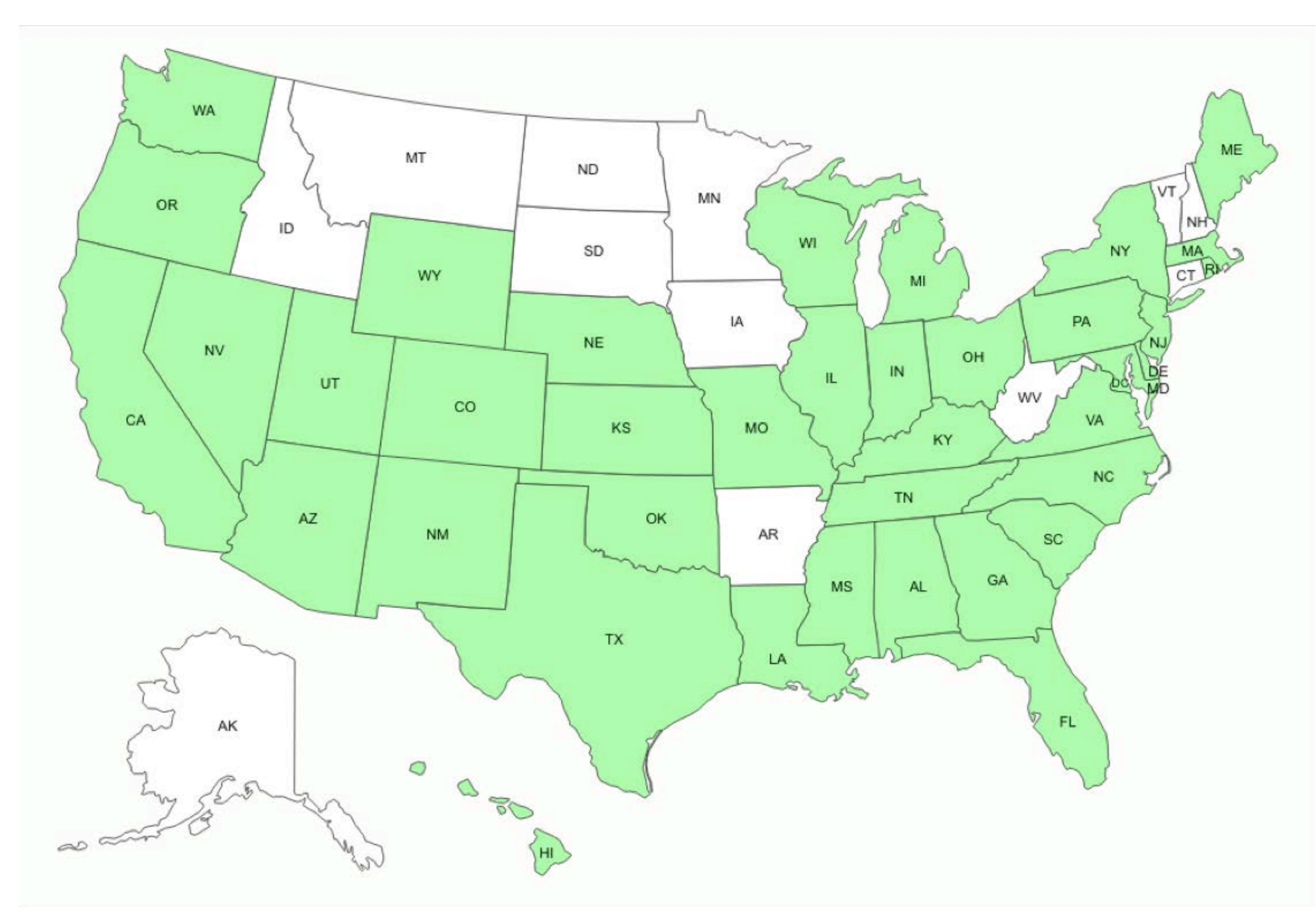
Background and Overview

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



HealthyNTexas.org

DFWHC FOUNDATION

HEALTHY NORTH TEXAS

HOME | EXPLORE DATA | SEE HOW WE COMPARE | LOCATE RESOURCES & FUNDING | LEARN MORE

- View Community Indicators
- Generate a Report
- Learn More about Community Health Collaborative
- Use the CHNA Guide

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.

Indicator Data by County
* please select *

Demographic Data by County
* please select *

Topic Centers
* please select *

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

Indicators

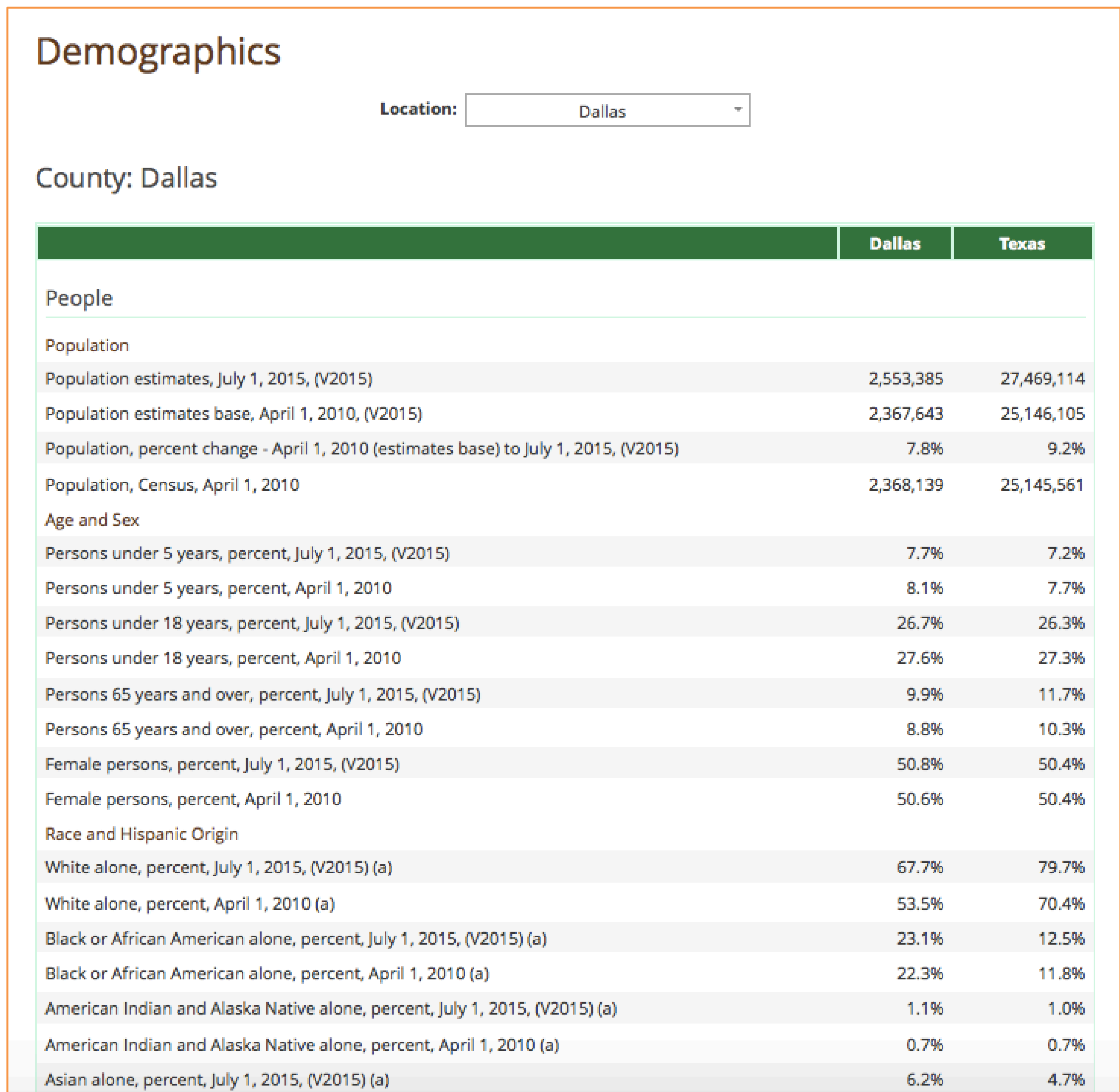
Health and quality of life indicators are selected by HCI and used to construct your community dashboard

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



Demographics

Location: Dallas

County: Dallas

	Dallas	Texas
People		
Population		
Population estimates, July 1, 2015, (V2015)	2,553,385	27,469,114
Population estimates base, April 1, 2010, (V2015)	2,367,643	25,146,105
Population, percent change - April 1, 2010 (estimates base) to July 1, 2015, (V2015)	7.8%	9.2%
Population, Census, April 1, 2010	2,368,139	25,145,561
Age and Sex		
Persons under 5 years, percent, July 1, 2015, (V2015)	7.7%	7.2%
Persons under 5 years, percent, April 1, 2010	8.1%	7.7%
Persons under 18 years, percent, July 1, 2015, (V2015)	26.7%	26.3%
Persons under 18 years, percent, April 1, 2010	27.6%	27.3%
Persons 65 years and over, percent, July 1, 2015, (V2015)	9.9%	11.7%
Persons 65 years and over, percent, April 1, 2010	8.8%	10.3%
Female persons, percent, July 1, 2015, (V2015)	50.8%	50.4%
Female persons, percent, April 1, 2010	50.6%	50.4%
Race and Hispanic Origin		
White alone, percent, July 1, 2015, (V2015) (a)	67.7%	79.7%
White alone, percent, April 1, 2010 (a)	53.5%	70.4%
Black or African American alone, percent, July 1, 2015, (V2015) (a)	23.1%	12.5%
Black or African American alone, percent, April 1, 2010 (a)	22.3%	11.8%
American Indian and Alaska Native alone, percent, July 1, 2015, (V2015) (a)	1.1%	1.0%
American Indian and Alaska Native alone, percent, April 1, 2010 (a)	0.7%	0.7%
Asian alone, percent, July 1, 2015, (V2015) (a)	6.2%	4.7%

Platform Features and Tools

Dashboard Homepage

Community Health Dashboards

Build a Custom Dashboard

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

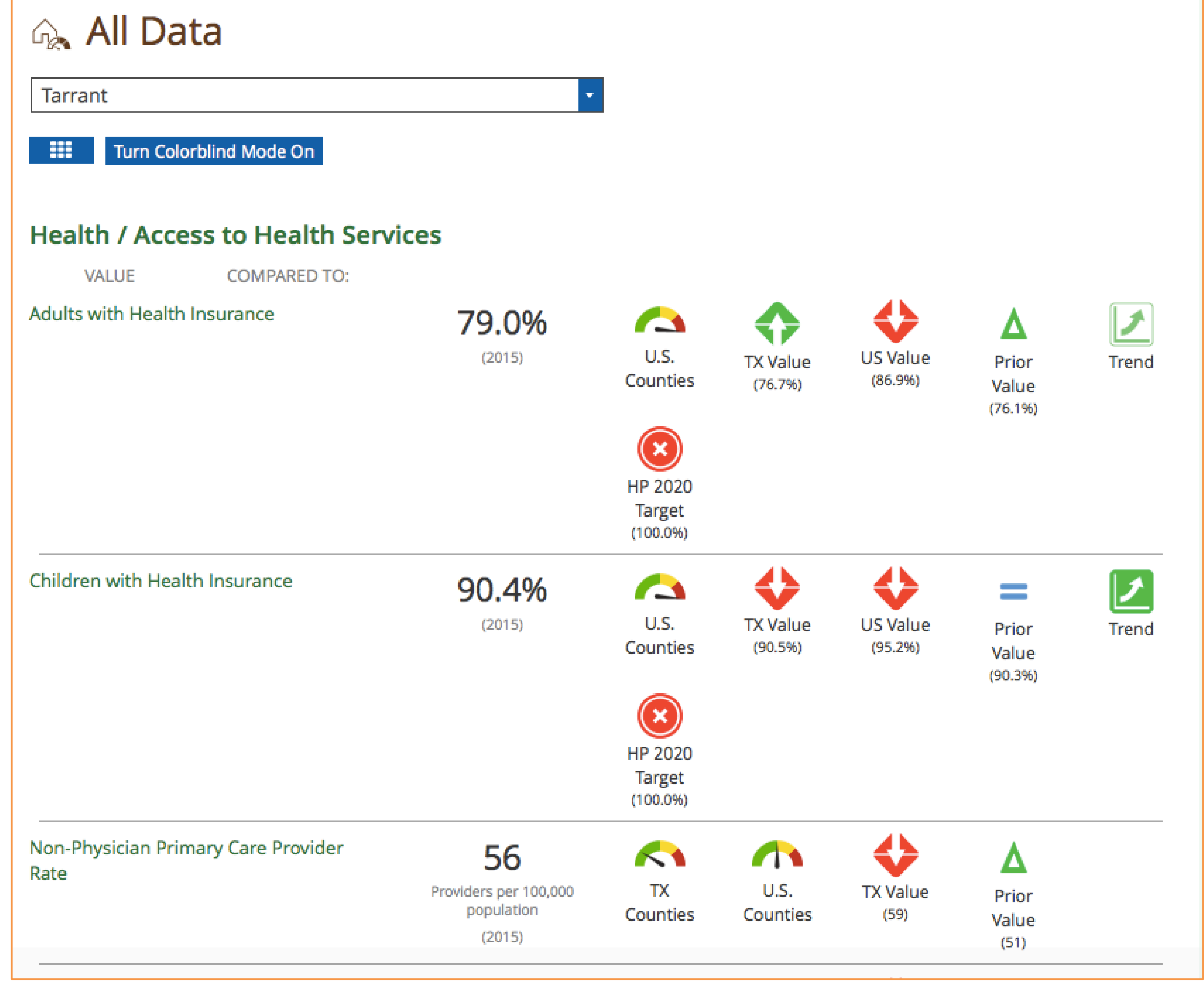
View all indicators that include breakout data by topics such as race/ethnicity, age and gender

Healthy People 2020 Progress Tracker

Indicator List by Location

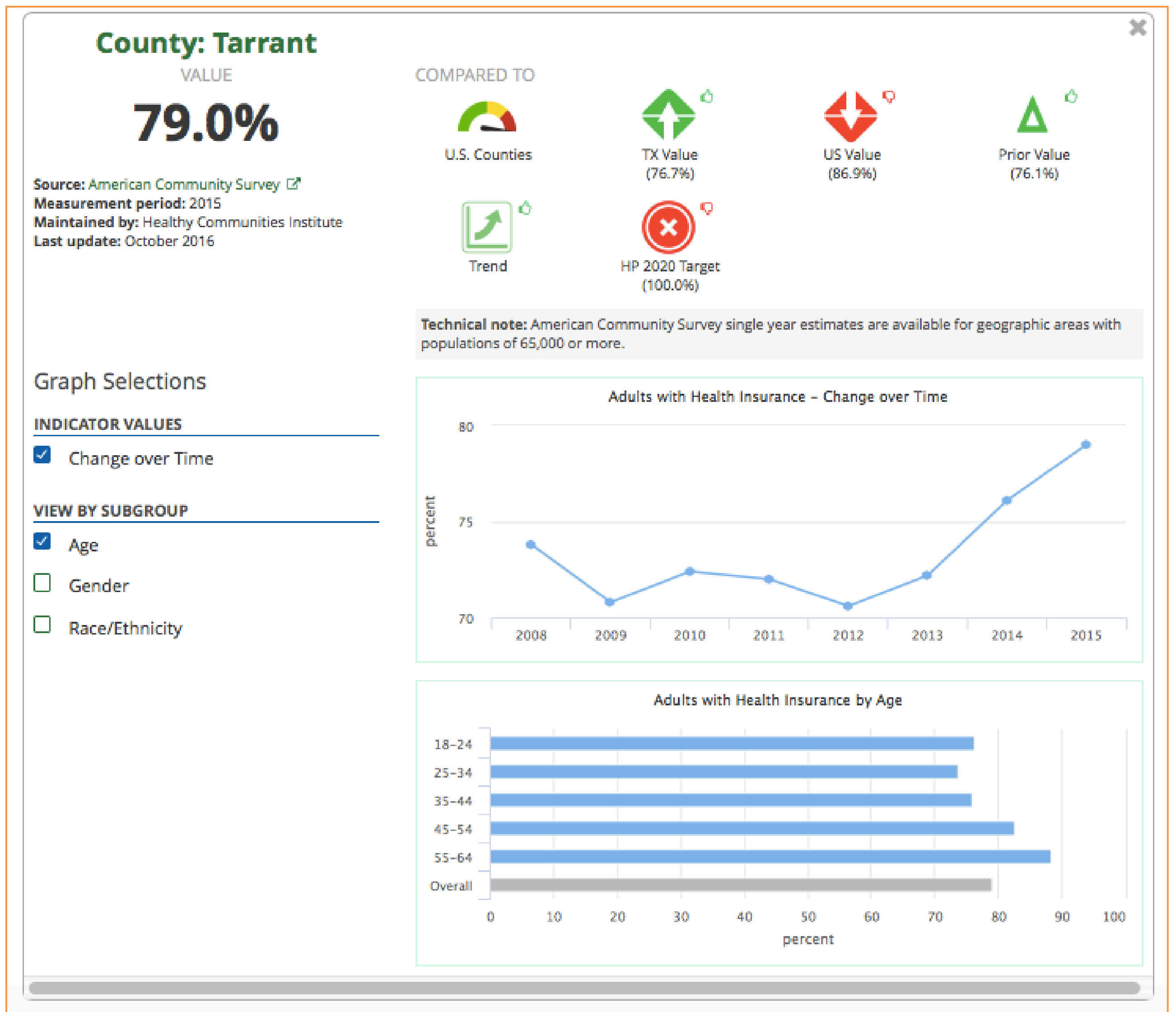
View a list of all indicators and see at what location data is available

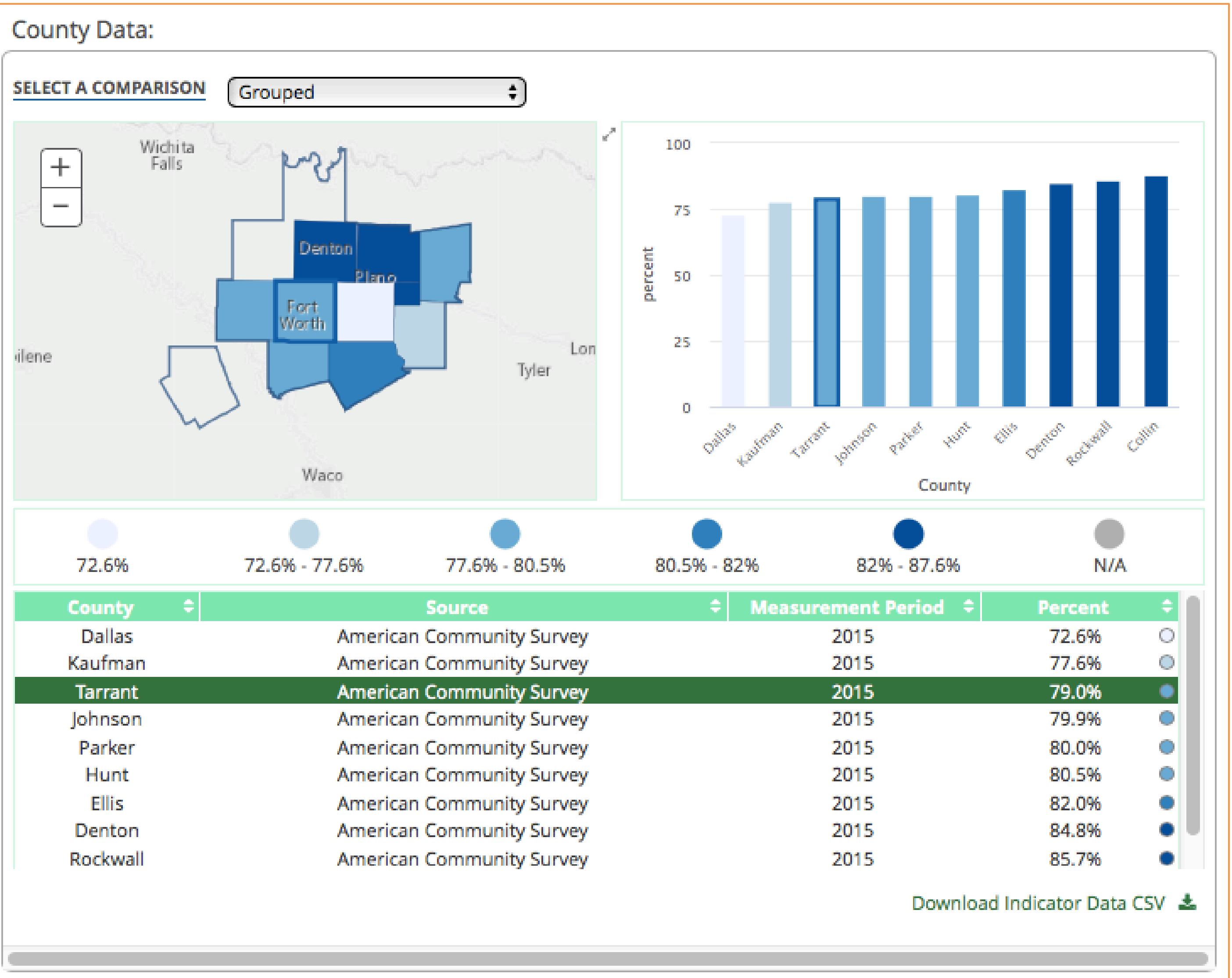
Community Dashboard



100-200 Health and Quality of Life Indicators used by communities to identify areas for improvement

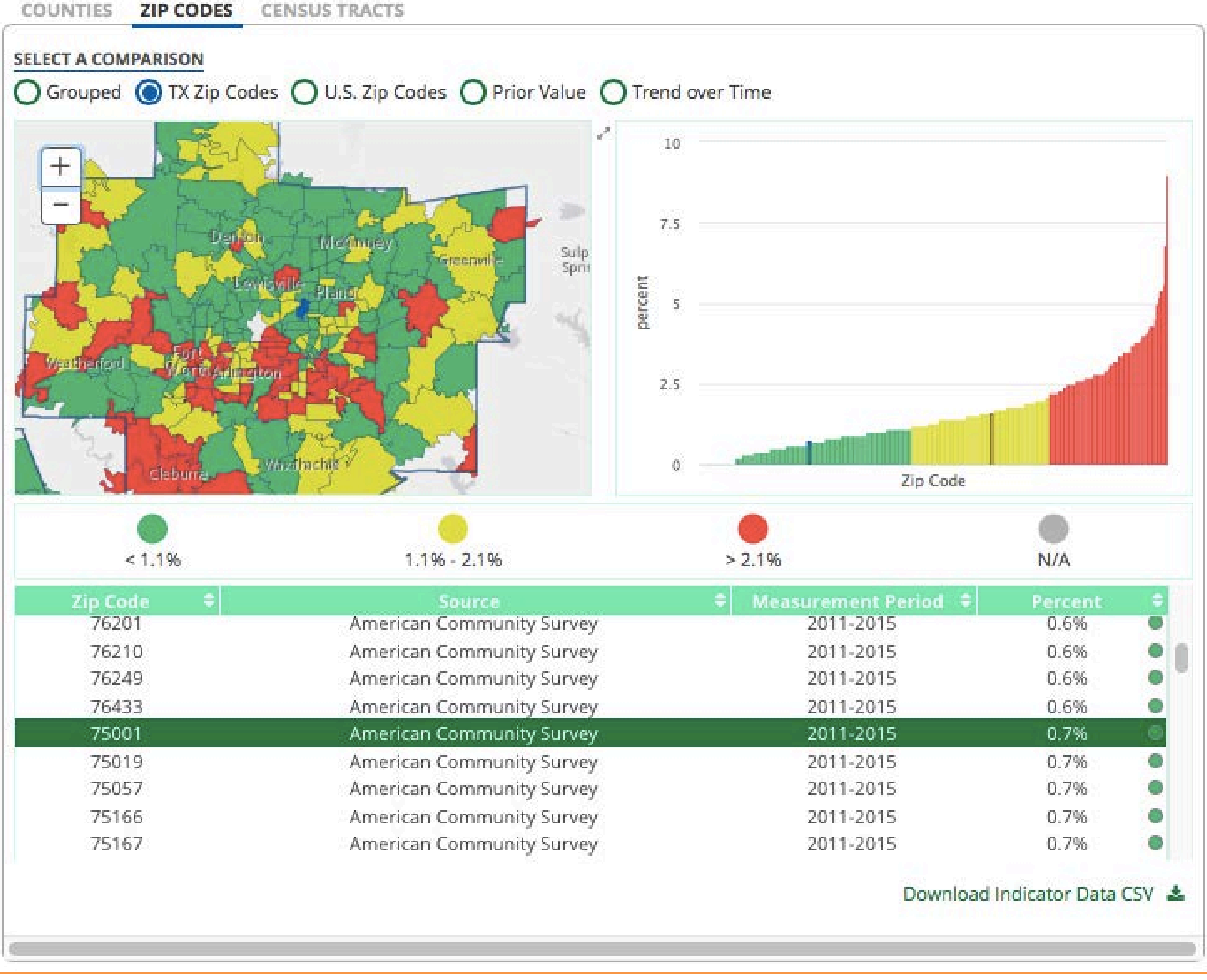
Indicator Detail Page (County View)





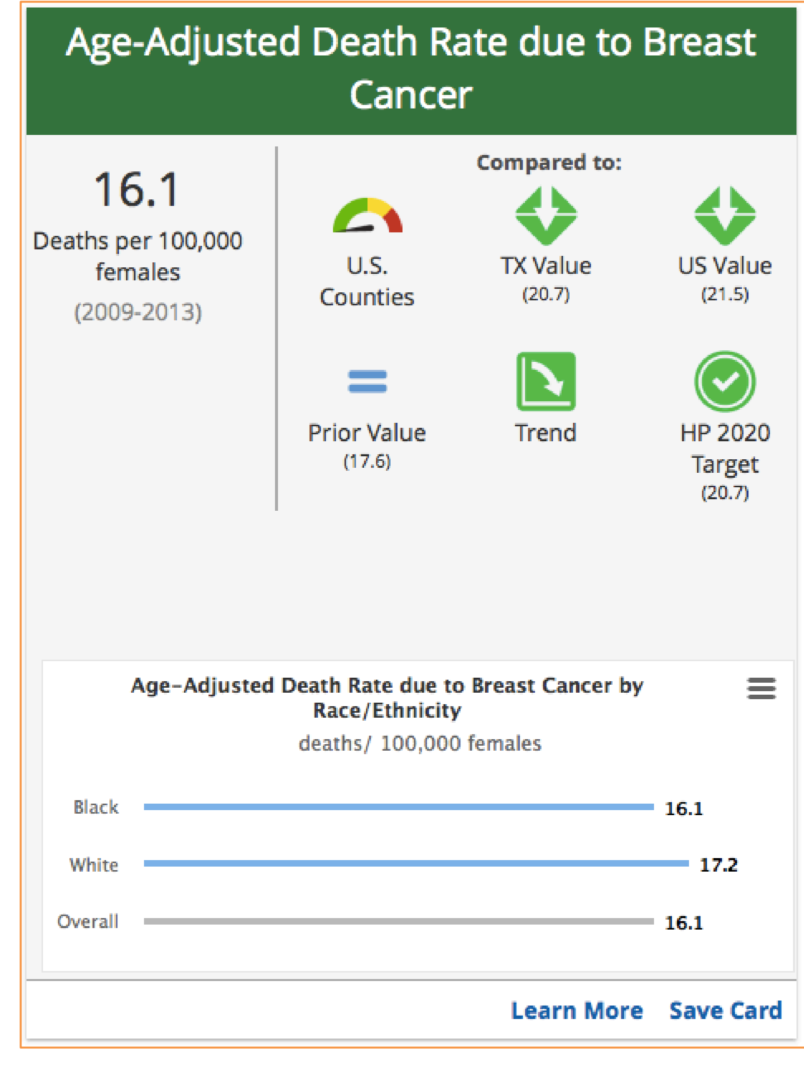
County	Source	Measurement Period	Percent
Dallas	American Community Survey	2015	72.6%
Kaufman	American Community Survey	2015	77.6%
Tarrant	American Community Survey	2015	79.0%
Johnson	American Community Survey	2015	79.9%
Parker	American Community Survey	2015	80.0%
Hunt	American Community Survey	2015	80.5%
Ellis	American Community Survey	2015	82.0%
Denton	American Community Survey	2015	84.8%
Rockwall	American Community Survey	2015	85.7%

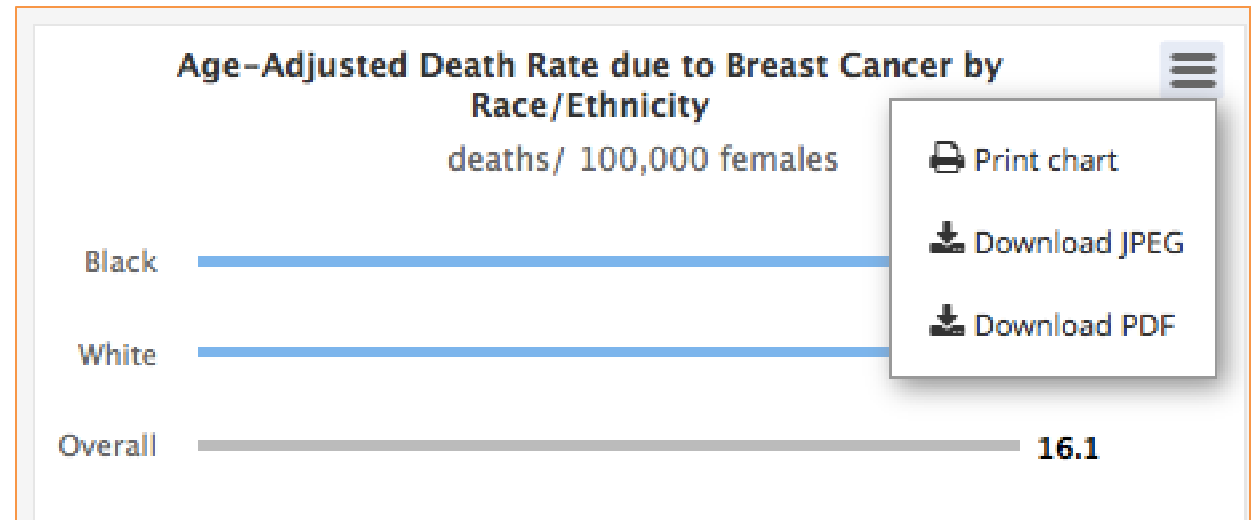
Indicator Detail Page (ZIP Code View)



Indicators – Export Ability

Allows you to learn more and save indicators





SocioNeeds Index

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.

HOW DOES IT WORK?

Learn More

Wichita Falls
Denison
Paris
Denton
McKinney
Greenville
Sulphur Springs
Graham
Lewisville
Plano
Weatherford
Fort Worth
Arlington
Abilene
Longview
Cleburne
Waxahachie
Tyler
Stephenville
Corsicana

MAP LEGEND

greater need →

1 2 3 4 5

Powered by Healthy Communities Institute

Promising Practices

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, Elderly

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

Search Filters (2210 results) Clear all

Keyword Search

Search

Sorting

Sort by relevance

Ranking

- Evidence-Based Practice
- Effective Practice
- Good Idea

Featured

- Local
- CDC Community Guide
- Spotlight

Resource Library

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

2-1-1
Free training opportunities for Tarrant County coalitions
Author: Linda Fulmer
Published: September 26, 2014
Filed Under: Education / Vocational & Adult Education, 211 Resources

2-1-1
Tarrant County Coallition Training Opps
Author: Linda Fulmer
Published: September 26, 2014
Filed Under: Education / Vocational & Adult Education, 211 Resources

Search Filters Clear all
(71 results)

Keyword Search

Search

Grouping
No Grouping (default)

Sorting
Resource Date (default)

Resource Type
- 211 Resources
- Dashboard Reports
- Data Resources
- Funding Opportunities
- Reports

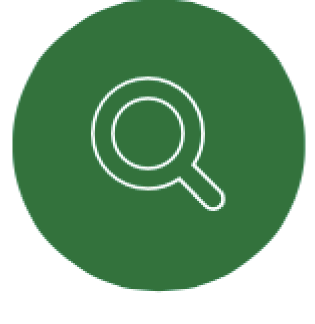
Topics and Sub-topics

CHNA Guide

Community Health Needs Assessment Guide

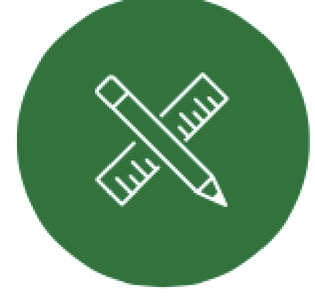
Use this guide to help you conduct your community health needs assessment and develop an implementation strategy. Within each section you will find valuable tools as well as hand-selected resources to help your efforts.

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

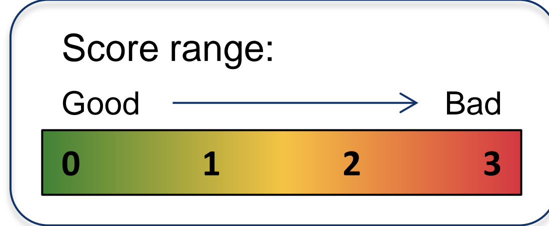
Indicator Score

Topic Score

Data Scoring

Health Topic	Score
Other Chronic Diseases	2.54
Mental Health & Mental Disorders	2.26
Older Adults & Aging	1.99
Heart Disease & Stroke	1.66
Children's Health	1.65
Diabetes	1.59
Other Conditions	1.58
Women's Health	1.56
Exercise, Nutrition, & Weight	1.54
Maternal, Fetal & Infant Health	1.52
Respiratory Diseases	1.51
Cancer	1.50
Immunizations & Infectious Diseases	1.49
Access to Health Services	1.49
Oral Health	1.49
Men's Health	1.36
Substance Abuse	1.29
Wellness & Lifestyle	1.26
Prevention & Safety	1.13

Quality of Life Topic	Score
Transportation	1.83
Social Environment	1.55
Economy	1.51
Environment	1.50
Education	1.39



Topic Centers

Health Topic Center

Health / Access to Health Services

X

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

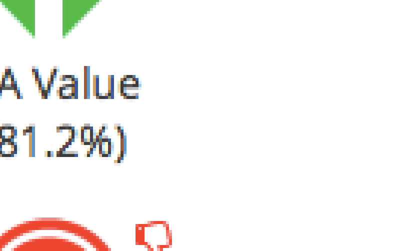
Appendix A: Core Indicator List Methodology

- 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

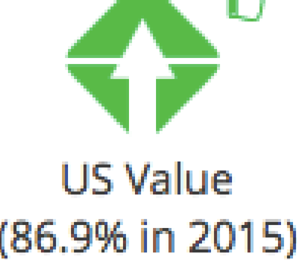
Indicator Comparisons

COMPARED TO

CA Counties

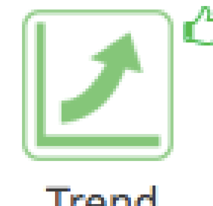


CA Value
(81.2%)



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

30
25
20
15
10
5
0

Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo, Yuba

Calculating Compare to Distribution

Percent of People Living Below Poverty

California counties, 2008-2012

30
25
20
15
10
5
0

San Mateo, Marin, El Dorado, Placer, Mono, Santa Clara, Napa, Contra Costa, Ventura, Calaveras, Amador, Inyo, Sonoma, Nevada, Orange, Solano, Alameda, San Benito, Tuolumne, San Francisco, Alpine, San Luis Obispo, Plumas, San Diego, Santa Cruz, Mariposa, Colusa, Santa Barbara, Lassen, Riverside, Monterey, Sacramento, Sierra, Sutter, Los Angeles, San Joaquin, San Bernardino, Shasta, Trinity, Yolo, Stanislaus, Mendocino, Glenn, Siskiyou, Humboldt, Modoc, Tehama, Butte, Yuba, Kings, Madera, Del Norte, Kern, Imperial, Lake, Merced, Fresno, Tulare

Calculating Compare to Distribution

Percent of People Living Below Poverty

California counties, 2008-2012

30
25
20
15
10
5
0

50th percentile

San Mateo
Marin
El Dorado
Placer
Mono
Santa Clara
Napa
Contra Costa
Ventura
Calaveras
Amador
Inyo
Sonoma
Nevada
Orange
Solano
Alameda
San Benito
Tuolumne
San Francisco
Alpine
San Luis Obispo
Plumas
San Diego
Santa Cruz
Mariposa
Colusa
Santa Barbara
Lassen
Riverside
Monterey
Sacramento
Sierra
Sutter
Los Angeles
San Joaquin
San Bernardino
Shasta
Trinity
Yolo
Stanislaus
Mendocino
Glenn
Siskiyou
Humboldt
Modoc
Tehama
Butte
Yuba
Kings
Madera
Del Norte
Kern
Imperial
Lake
Merced
Fresno
Tulare

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

Calculating Compare to Distribution

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

75th percentile

50th percentile

30
25
20
15
10
5
0

San Mateo, Marin, El Dorado, Placer, Mono, Santa Clara, Napa, Contra Costa, Ventura, Calaveras, Amador, Inyo, Sonoma, Nevada, Orange, Solano, Alameda, San Benito, Tuolumne, San Francisco, Alpine, San Luis Obispo, Plumas, San Diego, Santa Cruz, Mariposa, Colusa, Santa Barbara, Lassen, Riverside, Monterey, Sacramento, Sierra, Sutter, Los Angeles, San Joaquin, San Bernardino, Shasta, Trinity, Yolo, Stanislaus, Mendocino, Glenn, Siskiyou, Humboldt, Modoc, Tehama, Butte, Yuba, Kings, Madera, Del Norte, Kern, Imperial, Lake, Merced, Fresno, Tulare

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