



Resource Compendium September 2010

Data sets

Data platforms

Data utility



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Produced for the Public Health Institute by Valerie Stull, MPH, Tyler Norris and Mélange Matthews

NOTE: *Much of the text in this Resource Compendium has been drawn from organizational web sites and interviews. While every effort has been made to ensure accuracy, the Resource Compendium contains qualitative and feature claims reflecting representations made by the purveyor organizations and agencies themselves, not all of which have been independently verified.*

*Comments, corrections and enhancements are invited.
Send to: lstauber@phi.org*



August 20, 2010

At no time in history, have our communities and nation been better equipped to apply quality data to informing evidence-based policy, systems, and environmental change. At the same time, many practitioners find themselves swimming in data, and seeking to discern which of the myriad platforms and tools now available are most appropriate for them.

We are often asked: What are some of the most important data sets and metrics available? Which can best serve our purposes? Who are their purveyors? How can we best access and apply these? Is there a collaborative resource out there that is current now, and being updated over time, that can help us choose?

To these ends, the Public Health Institute is pleased to release the 2010 Data Utility Resource Compendium.

The purpose of the compendium is to establish a curated list of public health-related data sets and platforms that provide population-based health information for the broad purposes of creating healthier people in healthier places

Our goal in compiling the compendium is to make an immediate connection between those who collect and compile public health data with those who are actively engaged in promoting and protecting the public's health—be they public health officials or practitioners, grant makers and social investors research scientists or analysts, policymakers or legislators, community leaders or advocates, private sector innovators or patients and consumers.

The data sets and platforms described in the compendium are the products of local, state and federal governmental agencies; academic institutions; nonprofit organizations; and private-public partnerships. Though each data set or platform is uniquely constituted as to content, the common thread running between them is that each one has something important to offer those who are interested in turning data into useful insights, applications, products and services and thereby improving the public's health. This represents information available as of August 2010 and is accurate to the best of our knowledge. Some items will undoubtedly change, but we hope this resource stimulates dialogue and strengthens our shared learning about these important data tools.

We look forward to hearing how you use this Compendium, and any ideas for future enhancement.

Mary A. Pittman, DrPH
President & CEO

Part I: Data Sets

MATCH – Mobilizing Action Toward Community Health

In January 2009, the University of Wisconsin Population Health Institute (the Institute) began a three-year national project entitled *Mobilizing Action Toward Community Health* (MATCH).

Mission:

This project, supported by a grant from the Robert Wood Johnson Foundation, is designed to:

- Increase awareness of the many factors—health care access and quality, health-promoting behaviors, socio-economic factors, and the physical environment—that contribute to the health of communities
- Foster engagement among public and private decision makers to improve community health
- Develop incentives to encourage coordination across sectors for community health improvement, and
- Create innovative approaches to sharing the results of community health improvement efforts.

Description:

The *County Health Rankings* are a key component of the MATCH project. The *County Health Rankings* show that where people live matters to their health. This first-of-its-kind collection of 50 reports – one per state – helps community leaders see that where people live, learn, work, and play influences how healthy they are and how long they live. The Robert Wood Johnson Foundation is collaborating with the University of Wisconsin Population Health Institute to develop these reports that rank the health of counties in each state.

The *Rankings* are based on a [model of population health](#) (Fig. 1) that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play. Building on the work of *America's Health Rankings*, the University of Wisconsin Population Health Institute has used this model to rank the health of Wisconsin's counties every year since 2003.

The *Rankings* are a “call to action” for state and local health departments to work with others in their community to develop broad-based solutions so all residents can be healthy. The *Rankings* team works closely with state teams to help health departments take advantage of the discussions and opportunities that will arise from the release of the *Rankings*. Efforts are also being made to mobilize community leaders outside the public health sector to take action and invest in programs and policy changes that address barriers to good health and help residents lead healthier lives.

Release Date:

The *Rankings* will be released annually. The first *County Health Rankings (2010)* were released on February 17, 2010.

Purveyor and Partners:

The Robert Wood Johnson Foundation is collaborating with the University of Wisconsin Population Health Institute to develop the *Rankings*.

How to Access:

See: www.countyhealthrankings.org

The *County Health Rankings* web site provides access to the 50 state reports, ranking each county within the 50 states according to its health outcomes and the multiple health factors that determine a county's health. Each county receives a summary rank for its health outcomes and health factors and also for the four different types of health factors: health behaviors, clinical care, social and economic factors, and the physical environment. Each county can also drill down to see specific county-level data (as well as state benchmarks) for the measures upon which the *Rankings* are based.

This web site serves as a corner stone of the project, a place where people from all sectors can find *Rankings* data, as well as a [model for action](#) (Fig. 2) describing action steps for various stakeholders, and the latest news about the multiple factors that determine health.

Metrics:

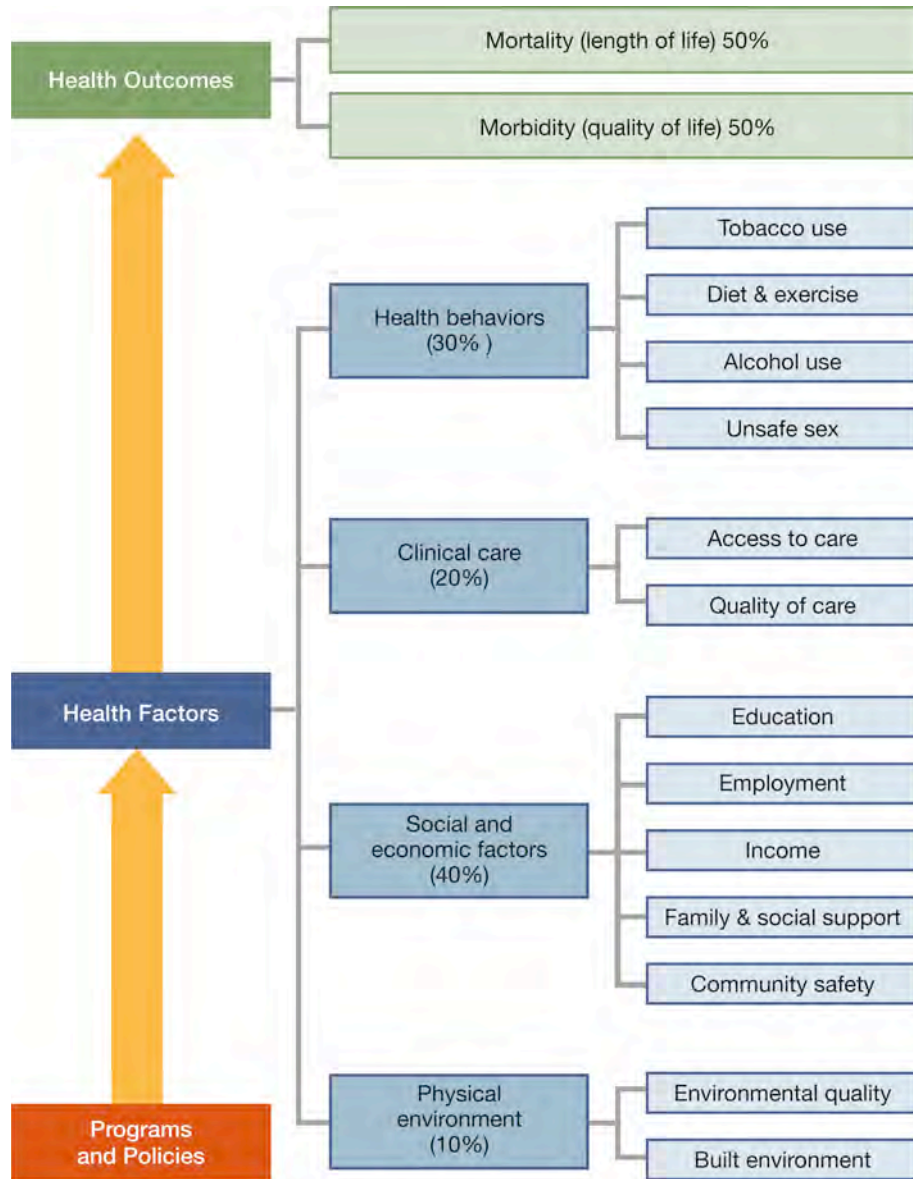
The *County Health Rankings* are based on data for nearly every county in all 50 states on health outcomes and measures known to affect health in four key categories (health factors):

- Health outcomes include measures of premature mortality and health-related quality of life (self-reported health status).
- Health factors include measures of:
 - Health Behaviors: Tobacco Use, Diet and Exercise, Unsafe Sex, Alcohol Use
 - Clinical Care: Access to Care, Quality of Care
 - Social and Economic Factors: Education, Employment, Income, Family and Social Support, Community Safety
 - Physical Environment: Environmental Quality, Built Environment

The measures are obtained from a number of data sources, including:

- Centers for Disease Control and Prevention (CDC): Behavioral Risk Factor Surveillance System (BRFSS), National Center for Health Statistics, National Center for Chronic Disease Prevention and Health Promotion (Division of Diabetes Translation), National Center for Hepatitis, HIV, STD, and TB Prevention
- CDC-Environmental Protection Agency (EPA) Collaboration
- Health Resources and Services Administration (Area Resource File)
- Decennial Census and American Community Survey, Census/Current Population Survey: Small Area Health Insurance Estimates and Income and Poverty Estimates, and Census County and Zip Code Business Patterns
- Federal Bureau of Investigation (Uniform Crime Reporting)
- Medicare claims/The Dartmouth Institute
- National Center for Education Statistics

Model of Population Health (Fig. 1)



County Health Rankings model ©2010 UWPHI

Model for Action (Fig. 2)



CHIS - California Health Interview Survey

CHIS is the nation's largest state health survey. It is conducted every two years on a wide range of health topics using a random-dial telephone survey methodology. CHIS data gives a detailed picture of the health and health care needs of California's large and diverse population.

Mission:

To Provide:

- Statewide information on the overall population, including many racial and ethnic groups.
- Local-level information on most counties for health planning and important comparison purposes.

Description:

CHIS is used by legislators, policy makers, local health departments, state agencies, community organizations, advocacy groups, foundations, researchers, and many others as a data source for a wide range of purposes related to improving public health.

Release Date:

CHIS is currently in use.

Purveyor and Partners:

CHIS is conducted by the UCLA Center for Health Policy Research in collaboration with the California Department of Public Health, the Department of Health Care Services and the Public Health Institute. Its Principal Investigator is Dr. E. Richard Brown, director of The UCLA Center for Health Policy Research and a noted authority on health policy issues.

How to access:

For quick statistics:

AskCHIS, <http://www.chis.ucla.edu/main/default.asp>, is a quick and easy-to-use online tool that enables anyone to produce customized health statistics on hundreds of health and health related indicators by county, region or across California. *AskCHIS* is free following a quick, one-time registration. See example steps 1 and 2 of the *AskCHIS* process below.

AskCHIS Step #1 (Fig. 1)

The screenshot shows the AskCHIS website home page. At the top left is the CHIS logo with the text "california health interview survey". To the right is the tagline "Making California's voices heard on health." and a search bar labeled "SEARCH the CHIS SITE:" with a "GO" button. A navigation menu includes links for Home, AskCHIS, About CHIS, Newsroom, Design & Methods, Get CHIS Data, Publications, and Join Our Newsletter. Below the navigation is a large banner image of three healthcare professionals. A "GET CHIS DATA" button is overlaid on the banner. On the left is a sidebar menu with categories: Get Data, Overview, AskCHIS, Public Use Data Files, Confidential Data, Current CHIS Data Projects, and Frequently Asked Questions. The main content area features the AskCHIS logo and the heading "AskCHIS gives you the answers." followed by a description of the tool and a list of features: Easy to use and Quick. On the right is a login box with fields for Username and Password, a SUBMIT button, and a link for "Forgot Your Password?". Below the login box is a "Not registered? Register Now for Free!" link.

AskCHIS Step #2 (Fig. 2)

The screenshot shows the AskCHIS search results selection screen. At the top is the AskCHIS logo and navigation links: CHIS home, Question about AskCHIS?, CLEAR RESULTS AND START NEW, VIEW SAVED RESULTS, ACCOUNT SETTINGS, and LOGOUT. Below the navigation are four selection buttons: GEOGRAPHIC AREA, MAIN TOPIC, COMPARE BY, and POPULATION, followed by a "GET YOUR RESULTS" button. The "GEOGRAPHIC AREA" button is highlighted. Below the buttons is the heading "Select the Geographic Area for your results" with a "HELP" link. A list of options is provided, each with a "SELECT" button: Entire State of California, Specific large regions (i.e., groups of counties) in California, Specific counties in California, Los Angeles County Service Plan Areas (SPA), and San Diego County Health Regions. At the bottom is a footer with links for Privacy Policy, Legal Notice, and Data Privacy & Advisory, and a copyright notice: © 2008 The Regents of the University of California. All Rights Reserved. The CHIS logo is in the bottom right corner.

For in-depth data:

Public Use Data Files: See: <http://www.chis.ucla.edu/main/default.asp?page=puf>
These files allow individuals to conduct research using statewide CHIS data files on a variety of topics. The files are available in SAS, SPSS and STATA data formats.

Sensitive Data: See: <http://www.chis.ucla.edu/main/default.asp?page=dac>
Researchers can apply to study sensitive or confidential CHIS variables (sexual orientation, gun ownership, etc.) through the CHIS Data Access Center (DAC). A research application and review process and stringent adherence to the CHIS Privacy Policy are criteria for use of such data. There are costs associated with data access through the DAC.

Geo-Coded Data: See: <http://www.chis.ucla.edu/main/default.asp?page=dac>
Researchers can also apply to use geography-specific or geo-coded CHIS data via the CHIS Data Access Center (DAC).

Current CHIS Data Projects: See: <http://www.chis.ucla.edu/rc/>
This free listing of current CHIS data projects provides information on what other researchers are doing with CHIS data. Researchers can list projects or network with others and promote work.

Metrics:

In 2009, CHIS covered 19 topic areas.

See: http://www.chis.ucla.edu/pdf/respondent_topics_2009.pdf for a complete list. The general categories include:

- Health Status
- Health Conditions
- Mental Health
- Health Behaviors
- Women's Health
- Cancer History and Prevention
- Dental Health
- Food Environment
- Neighborhood and Housing
- Emergency Preparedness
- Access to and Use of Health Care
- Health Insurance
- Public Program Eligibility
- Interpersonal Violence
- Parental Involvement/Adult Supervision
- Childcare
- Employment
- Income
- Detailed Respondent Demographic Characteristics

Healthy People 2020

Healthy People 2020 offers science-based, 10-year national objectives for promoting health and preventing disease. Healthy People objectives inform public health planning, measure the impact of health promotion and disease prevention activities, encourage collaboration across sectors, and guide individuals toward making informed health decisions.

Each decade since 1979, the U.S. Department of Health and Human Services (HHS) has leveraged scientific insights and lessons learned from the past decade, along with new knowledge of current data, trends, and innovations, to set and monitor objectives. The next iteration of Healthy People objectives, Healthy People 2020, will be released in late 2010. Healthy People 2020 reflects assessments of major risks to health and wellness, changing public health priorities, and emerging issues. It offers leadership to achieve a society in which all people live long, healthy lives.

Framework:

The vision, mission, and overarching goals of Healthy People 2020 provide structure and guidance for achieving the objectives. While general in nature, they offer specific, important areas of emphasis where action must be taken if the United States is to achieve better health by the year 2020.

Vision:

A society in which all people live long, healthy lives.

Mission:

Healthy People 2020 strives to:

- Identify nationwide health improvement priorities;
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress;
- Provide measurable objectives and goals that are applicable at the national, state, and local levels;
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge;
- Identify critical research, evaluation and data collection needs.

Overarching Goals:

- Attain high quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development and healthy behaviors across all life stages.

Description:

The Healthy People 2020 initiative is grounded in science, guided by public input, and designed to measure progress. Healthy People 2020 objectives use valid, reliable, nationally representative data and data systems. Each objective includes: 1) an identified data source or potential data source, 2) baseline data and 3) assurance that there will be at least one additional data point over the decade.

Healthy People 2020 will make objectives available through a Web-based, interactive resource that will expand the initiative's reach and usability. This dynamic system will accommodate changing needs and priorities over the coming decade. Health determinants will be integrated across multiple areas of the initiative in order to support a "Health in All Policies" approach.



Developed under the leadership of a Federal Interagency Workgroup, Healthy People 2020 is the product of an extensive process of collaboration among HHS and other Federal agencies, public stakeholders, and the Secretary's Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020—a fully public advisory group of public health experts. This inclusive process was designed to maximize transparency, public input, and stakeholder dialogue, and to ensure the initiative's relevance to current issues in public health.

Federal stakeholders participated in the development of Healthy People 2020 through their involvement in the Federal Interagency Workgroup that included representatives from federal agencies within and outside of HHS. Thousands of citizens were engaged in shaping the initiative through public meetings, online opportunities for public comment, and other venues. In addition, the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020 provided strategic guidance and feedback to shape the development of Healthy People 2020 and address the risk factors, health determinants, diseases, and disorders that affect communities.

Release Date:

Healthy People 2020 is being released in phases. The initiative's framework, (the vision, mission, and overarching goals) and draft topic areas and draft objectives were released in 2009. The Healthy People 2020 final objectives will be released late in 2010, and guidance for achieving the new 10-year targets, including leading health indicators and evidence-based resources, will be released during 2011.

Purveyor and Partners:

The Office of Disease Prevention and Health Promotion (ODPHP), Office of Public Health and Science, Office of the Secretary, HHS, oversees and manages the development of Healthy People 2020 through its leadership of the Federal Interagency Workgroup. Using input from the Secretary's Advisory Committee on National Health Promotion and Disease Prevention

Objectives for 2020 and other Healthy People stakeholders, ODPHP has led of the development of Healthy People 2020, which embraces a “social determinants of health” approach to health improvement and promotes an integrated approach to policies that impact health.

How to Access:

At the time that this document was being prepared, the Healthy People 2020 objectives were still being finalized. Once it is released, Healthy People 2020 will be accessible through the Healthy People Web site: <http://www.healthypeople.gov>. Until the updated objectives become available, there are several ways to access data provided by *Healthy People 2010*.

Online database:

DATA2010, <http://wonder.cdc.gov/data2010/>, an interactive database system developed by staff of the Health Promotion Statistics Branch of the National Center for Health Statistics, contains the most recent monitoring data for the Healthy People 2010 objectives. Data are provided when available for all the objectives and populations groups tracked by the U.S. Census. DATA2010 currently contains national-level data and State data for selected objectives when available.

DATA2010 is updated quarterly (the data contained in the November 2000 edition of the Healthy People publications are as of June 2000). DATA2010 is the only authoritative source for Healthy People 2010 data. DATA2010 is hosted on the Centers for Disease Control and Prevention's Wonder data system.

Primary Publications:

- *Healthy People in Healthy Communities: A Community Planning Guide Using Healthy People 2010* A guide for building community coalitions, creating a vision, measuring results, and creating partnerships dedicated to improving the health of a community. Includes "Strategies for Success" to help in starting community activities.
- *Healthy People 2010: Understanding and Improving Health*
- *Healthy People 2010: Objectives for the Nation*
- *Healthy People 2010: Tracking Healthy People 2010*

Metrics:

1. Access to Health Services
2. Adolescent Health
3. Arthritis, Osteoporosis, and Chronic Back Conditions
4. Blood Disorders and Blood Safety
5. Cancer
6. Chronic Kidney Diseases
7. Dementias, Including Alzheimer's Disease
8. Diabetes
9. Disability and Health
10. Early and Middle Childhood
11. Educational and Community-Based Programs
12. Environmental Health

13. Family Planning
 15. Genomics
 17. Health Communication and Health IT
 19. Hearing and Other Sensory or
Communication Disorders (Ear, Nose
Throat - Voice, Speech, and Language)
 21. HIV
 23. Injury and Violence Prevention
 25. Medical Product Safety
 27. Nutrition and Weight Status
 29. Older Adults
 31. Physical Activity
 33. Public Health Infrastructure
 35. Quality of Life and Well Being
 37. Sexually Transmitted Diseases

 39. Substance Abuse
 41. Vision
14. Food Safety
 16. Global Health
 18. Healthcare-Associated Infections
 20. Heart Disease and Stroke

 22. Immunization and Infectious Diseases
 24. Maternal, Infant and Child Health
 26. Mental Health and Mental Disorders
 28. Occupational Safety and Health
 30. Oral Health
 32. Preparedness
 34. Public Health Infrastructure
 36. Respiratory Diseases
 38. Social Determinants of Health
(measures are under development)
 40. Tobacco Use

The State of the USA / Institute of Medicine Health Measures

The State of the USA, Inc. (SUSA), a new nonprofit, will offer a website – as a public service – where every American can get the best available facts drawn from the country’s most respected sources. The site will be easy-to-use and available around the clock, so that people can find credible, relevant data in minutes or hours. SUSA assembles high-quality measures and data that can be used to assess the progress of the United States; SUSA will serve nongovernmental organizations, the media, policy makers, business leaders, foundations, scientists, educators and citizens by providing valuable information so all Americans can educate themselves about the progress of the United States.

Mission:

To help all Americans assess national progress for themselves, with the best quality measures and data on the most important issues facing the nation.

SUSA’s mission is to unite nonprofits, the media, government decision makers, business leaders, scientists, educators, and citizens around a single goal: to deepen knowledge and understanding of the country’s most pressing issues. SUSA will offer Americans a new tool to help them assess where the nation is moving forward and where it has stalled.

Description:

Overview and Purpose:

SUSA is creating a free website to provide every American with a single place to track progress across a range of national concerns, as determined by independent polling and research. To do this, SUSA has designed a scientifically credible and participatory process to frame issues using relevant national indicators, or measures, and reliable supporting data sources. The upcoming site is being designed to be easy to use and to provide tools that will enable Americans to discover, understand, and share information across the Web through distributed publishing and social networking.

SUSA will seek to address the void between online searches and professional-quality research. Search engines offer rapid access to relevant sources, but cannot yet guide users effectively past the first results. First-class research can produce high-quality answers to sophisticated questions; but it can take weeks, months or years to complete. SUSA’s website will provide the best available information to help its users answer their questions in minutes or hours—and at no cost.

SUSA will focus on displaying reliable, objective data to measure conditions in the United States; and it will seek to support, rather than compete with, existing information providers. SUSA will provide health data by partnering with the Institute of Medicine (IOM) at the National Academies to release a set of health measurements determined by experts to be key indicators of the nation’s health and health care. SUSA will address relevant issues, but not set goals. It will assemble information, not collect it. It will display data, but not interpret them.

And it will concentrate on quantitative information, with supporting explanations and context that will make the measures easy to use and understand.

SUSA's website will also work to ensure the quality of the indicators and data on its website and will provide user-friendly, credible commentary about those indicators. This information will include sources of the data, details about how the data were collected, definitions of key concepts, tips on data use or misuse and any known limitations of the data. In this way, SUSA will educate website users about the quality and objectivity of its measures so the public can become more informed consumers of data.

The SUSA Work

Relying on scientific expertise and quality assurance from the National Academy of Sciences, the statistical community, the scientific community and individual, nationally recognized subject-matter experts, SUSA is assembling the highest quality quantitative measures and related data and developing Web presentations designed to make it easy for interested citizens to assess whether progress is being made, where it is being made, by whom and compared to what.

World and national events have made the need for unbiased factual information more urgent, but such a resource will take time to build. With recommendations from the Institute of Medicine, SUSA has begun its work by focusing on key national health measures, data sets and contextual content that can be used to assess the nation's health and health systems. SUSA is now replicating its model of choosing key measures – an anticipated several hundred – in more than a dozen [topic areas](#), including education, the economy, energy, the environment, crime and justice, safety and security, housing, governance, infrastructure, civic and cultural life and demographics. These choices were based on polling data and research into the issues garnering high levels of concern by the American people.

Collaborative Approach

SUSA seeks to address relevant issues, but not to set goals. It will display and explain data, but avoid interpreting them. And it will concentrate on quantitative information, with enough qualitative explanation and context that will make the data easy to use and understand.

SUSA employs a collaborative approach that crosses sectors and issue areas. Its [leadership](#) includes recognized thought leaders and experts and its team represents a wide array of talents -- including digital expertise, scientific analysis, statistical review, editorial content development, communications strategies and marketing approaches. SUSA's skill base crosses a variety of sectors -- education, business, media, government and the nonprofit community. The organization is designed to capture the geographic and demographic diversity and the breadth of professional expertise and political philosophies required to create and lead a national institution.

The organization seeks to reaffirm the principle behind the centuries-old tradition of the State of the Union address, but complement it with a steady dose of 21st century information-age reality on the state of the American dream.

SUSA seeks user input – about the issues that matter to most, features and functions that users would find useful and a common journey toward transparency and accountability.

Release Date:

Although the first public version of the website was originally scheduled for release in 2009, a “beta,” or initial State of the USA website, is expected to be developed and launched for audience testing during 2010.

Purveyor and Partners:

SUSA work is supported by a board of directors, a group of executive officers, a product advisory group, and a national advisory group. Additionally, vital strategic ideas, relationships, and start-up funding to launch the first public version of SUSA’s indicators website in 2009 are being provided by the following foundations:

- The William and Flora Hewlett Foundation
- The Rockefeller Foundation
- The John D. and Catherine T. MacArthur Foundation
- The Carnegie Corporation of New York
- The F.B. Heron Foundation
- The Charles H. Revson Foundation
- The Peter G. Peterson Foundation
- The Bill & Melinda Gates Foundation
- Private Donors : Jerilyn Asher, Vincent Barabba, Jack Connors, Christopher Hoenig, Clay Johnson, III, Thomas C. Jorling, Ruben King-Shaw, Bernard Korman, Peter Lynch, Janet L. Norwood, Stephen Pagliuca, Kenneth Prewitt, Arthur D. Ullian

How to Access:

See: <http://www.stateoftheusa.org/> or www.stateoftheusa.org/index.asp

SUSA will offer the public a web-based information source that presents key national indicators. It will make these measures of the nation's progress easy to access for potentially vast numbers of users. The site will be powerful and highly interactive; it will contain data that support the indicators along with explanations of the data, educational features and sophisticated analytical tools for users to interact with those data. Key indicators for the economy, education, the environment and other national concerns will be delivered in a way that enables exploration and surfaces connections across categories.

When SUSA's website is fully developed, anyone with Internet access will be able to enjoy the same quality of information as policy makers, journalists, scientists and the private sector simply by visiting the site. It will be designed to stimulate exchanges among users and encourage users' suggestions, critiques and ideas so that SUSA can be responsive to them.

Metrics:

SUSA developed its set of topics and key national indicators through rigorous and open review. This process included broad and deep input from hundreds of stakeholders – from business, the private sector, education, government, nonprofit groups, advocacy groups and the general public – as well as from experts in data collection, management and dissemination.

After an initial set of topics, indicators and data sets are selected through its participatory process, SUSA will continue to update and re-evaluate the issues, indicators, data sets, explanations and usability of its website through extensive consultation with diverse audience groups and substantive experts.

To help orient discussion and ground it in fact, the nonprofit, nonpartisan SUSA and the Institute of Medicine (IOM) at the National Academies are releasing a set of health measurements determined by experts to be key indicators of the nation's health and health care (see: <http://www.iom.edu/Reports/2008/State-of-the-USA-Health-Indicators-Letter-Report.aspx>). The list was commissioned by SUSA in the spring of 2008. That led to the formation of an IOM committee, which set about culling a myriad of publicly available health indicators to a manageable set of 20 considered crucial for understanding the state of the nation's health.

Ultimately, the 20 IOM indicators will be part of a new Web site that provides other accessible measures – along with equally vetted data – across a range of topics. Key indicators for the economy, education, the environment and other national concerns will be delivered in a way that enables exploration and highlights connections across categories.

The IOM committee took this into account in developing its selection criteria. Its report emphasizes that one's physical environment, such as air and water quality and housing, and the social environment in which people live, work and play, are fundamental determinants of health. However, such measures were not included in its list of health indicators because they are expected to be captured in the development of other issue areas for the upcoming State of the USA Web service.

The committee's report also underscored the importance of identifying socioeconomic, race, and ethnicity disparities across a variety of issue areas, calling them "crucial to a better understanding of the determinants of health and health outcomes."

With criteria in place, the committee organized its selections in three categories: health outcomes, health-related behaviors and health systems. The resulting recommended health and health care indicators are:

Health Outcomes

- Life Expectancy at Birth
- Infant Mortality
- Life Expectancy at Age 65
- Injury–Related Mortality
- Self-Reported Health Status
- Unhealthy Days, Physical and Mental

- Chronic Disease Prevalence
- Serious Psychological Distress

Health-Related Behaviors

- Smoking
- Physical Activity
- Excessive Drinking
- Nutrition
- Obesity
- Condom Use

Health Systems

- Health Care Expenditures
- Insurance Coverage
- Unmet Medical, Dental, and Prescription Drug Needs
- Preventive Services
- Preventable Hospitalizations
- Childhood Immunization

Gallup-Healthways Well-Being Index™

The Gallup-Healthways Well-Being Index™ has been developed to *provide the official measure for health and wellbeing among American adults. It's the most ambitious effort ever undertaken to measure what people believe constitutes a good life.*

Over the next 25 years, the Well-Being Index will collect and measure the daily pulse of the nation's wellbeing and provide best-in-class solutions for a healthier world. By helping Americans understand how work impacts life and health and conversely how life affects work and health, Americans can work together to improve wellbeing for a better way of life.

Mission:

The Well-Being Index is today's "voice of the people" and the most ambitious effort ever undertaken to measure what it is that people believe constitutes a good life, who is feeling good about life, and who is in need of a helping hand. The goal of the Well-Being Index is to provide the world's most up-to-date measure of individual and collective health and wellbeing, the Gallup-Healthways Well-Being Index tracks the wellbeing of U.S. residents 350 days out of the year interviewing no fewer than 1,000 U.S. adults nationwide each day.

The Well-Being Index also aligns with Healthways' care and support solutions to help people maintain and improve their health. With measures that reflect Americans' evaluations of their day-to-day lives as well as their daily emotional and physical experiences both at work and at home, Gallup and Healthways are now able to provide an unprecedented view and understanding of public wellbeing in the United States.

Description:

On January 2, 2008, Gallup and Healthways formed a 25-year partnership merging decades of clinical research and development expertise, health leadership and behavioral economics, to understand the key factors that drive wellbeing. The Gallup-Healthways Well-Being Index is the result of both companies' commitment to transform healthcare by advancing the world's understanding of wellbeing and its impact on lives.

Through this historic effort to create the official statistic for measuring Americans' wellbeing, the Gallup-Healthways Well-Being Index will allow governments, employers, health plans, organizations and community leaders to understand the wellbeing of their constituents and make more informed decisions to improve health programs and benefits, work environment, leadership culture and business performance.

Release Date:

A Monthly Well-Being report is created and published on the second Thursday of every month. It highlights the most recent month's wellbeing composite score and the scores for each of the six domains: Life Evaluation, Emotional Health, Physical Health, Healthy Behavior, Work

Environment and Basic Access and analyzes the changes seen since the previous month. The first report was published in February of 2009.

Purveyor and Partners:

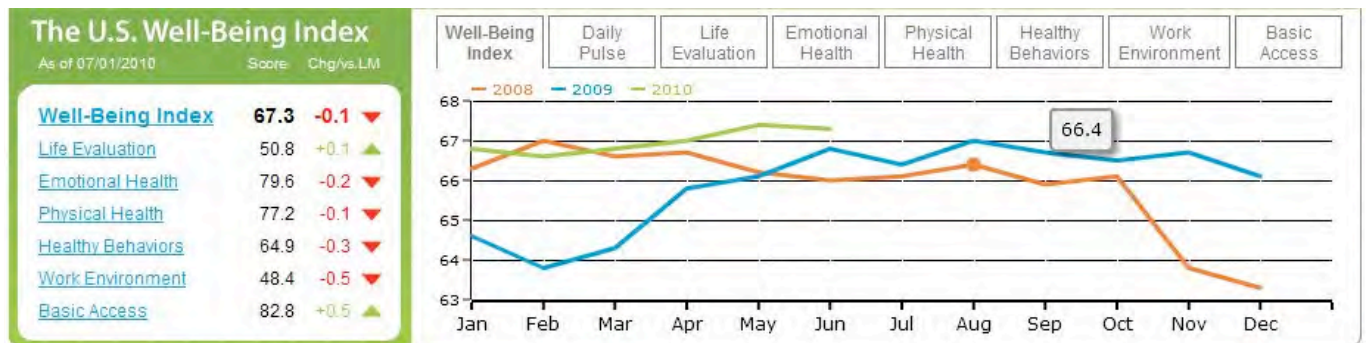
This project is made possible through a partnership between Gallup and Healthways. Additionally, the Gallup-Healthways Well-Being Index collaboration draws on the diverse backgrounds and achievements of the four published researchers and scientists to find the combinations of questions, results, and impacts that have the most positive effects on individuals, communities, states and the nation.

How to Access:

See: www.well-beingindex.com

Gallup and Healthways produce an annual report on the wellbeing of each of the 435 congressional districts in the U.S. and bi-annually on each of the 50 states and their respective cities. The massive scope of the Well-Being Index's 1,000 interviews completed a night was intentionally designed to support this level of reporting and insight. There are specific challenges that are unique to even adjoining areas, and a simplistic national solution will not have the impact that is required to stave off the looming healthcare crisis. Using the Gallup-Healthways Well-Being Index as the barometer of wellbeing will expand the benchmark for conversations about healthcare nationwide.

U.S. Well-Being Index (Fig. 1)



Metrics:

Gallup-Healthways Well-Being Index tracked the wellbeing of U.S. residents 350 days a year interviewing no fewer than 1,000 U.S. adults nationwide each day during 2008, with the exception of major holidays. Survey respondents were asked an in-depth series of questions associated with health and wellbeing. The Gallup-Healthways Well-Being Index segments the data for respondents in both adverse and optimum situations according to household income,

location demographics (based on zip code), and personal health status. The results are reported in continuous daily, weekly, and monthly averages.

Domains Measured:

See: www.well-beingindex.com/methodology.asp

For geographic regions of the United States, the Well-Being Index currently measures six domains. Each one is determined based on scientific study of responses to the survey questions and includes:

Life Evaluation:

The Well-Being Index asks Americans to evaluate their lives today as well as their lives five years from now by imagining a "ladder" with steps numbered from 0 to 10, where "0" represents the worst possible life and "10" represents the best possible life. Thriving Americans say they presently stand on steps 7 or higher of the ladder and that they expect to stand on steps 8 or higher five years from now. These people have their basic needs (such as food and shelter) met, and they have higher incomes, are less burdened by disease, report fewer sick days and have better work environments. The Life Evaluation Index is composed of two items:

- Evaluation of present life situation
- Anticipated life situation five years from now

States are ranked on this domain according to the percentage of thriving respondents minus the percentage of suffering respondents.

Emotional Health:

The Emotional Health Index is a composite of respondents' daily experiences. It includes one item that probes for prior history of diagnosed depression. In the remaining items, respondents are asked to think about yesterday, from the morning until the end of the day, and whom they were with, what they did, and how they felt.

Physical Health:

The Physical Health Index is comprised of questions related to:

- Estimates of Body Mass Index
- Disease burden
- Sick days
- Physical pain
- Daily energy
- History of disease
- Daily health experiences

Healthy Behavior:

The Healthy Behavior Index includes items measuring lifestyle habits with established relationships to health outcomes. The index is based on key items related to smoking, a healthy diet and exercise.

Work Environment: The Well-Being Index surveys people on several factors to gauge their feelings and perceptions about their work environment. Prior large-scale meta-analyses have shown important linkages between worker engagement and several organizational performance outcomes, such as attendance, retention, productivity, profitability, safety and customer ratings.

Positive work environments are characterized as those where workers express satisfaction with their work, report using their strengths in their area of work, and work in a culture of trust and partnership. Conversely, negative work environments lack satisfying work and are characterized by poor supervision.

Basic Access: The Basic Access Index is based on items that measure people's access to food, shelter, healthcare and a safe and satisfying place to live.

National Quality Forum

The National Quality Forum (NQF) is a nonprofit organization that aims to improve the quality of healthcare for all Americans.

Mission:

NQF operates under a three-part mission to improve the quality of American healthcare:

- Setting national priorities and goals for performance improvement;
- Endorsing national consensus standards for measuring and publicly reporting on performance; and
- Promoting the attainment of national goals through education and outreach programs.

NQF's vision is:

- To be the convener of key public and private sector leaders to establish national priorities and goals to achieve healthcare that is safe, effective, patient-centered, timely, efficient, and equitable;
- That NQF-endorsed standards will be the primary standards used to measure and report on the quality and efficiency of healthcare in the United States; and
- To be a major driving force for and facilitator of continuous quality improvement of American healthcare quality.

Release Date:

Population Health Measures, TBA

Purveyor and Partners:

NQF was created in 1999 by a coalition of public- and private-sector leaders in response to the recommendation of the *Advisory Commission on Consumer Protection and Quality in the Health Care Industry*. In its final report, published in 1998, the commission concluded that an organization like NQF was needed to promote and ensure patient protections and healthcare quality through measurement and public reporting.

Today, NQF receives funding from both public and private sources, including grants from foundations, corporations, and the federal government. In recent years, the Robert Wood Johnson Foundation and the Centers for Medicare & Medicaid Services have provided generous support for NQF. Other funders have included the Agency for Healthcare Research and Quality, the Bristol-Myers Squibb Foundation, the Cardinal Health Foundation, Pfizer Inc., Sanofi-Aventis, and the Texas Medical Institute of Technology. Thirty-four percent of the organization's total funding comes directly from membership dues. In 2009, the U.S. Department of Health and Human Services (DHHS) awarded a contract to NQF to help establish a portfolio of quality and efficiency measures that will allow the federal government to more clearly see how and whether healthcare spending is achieving the best results for patients and taxpayers. The contract is part of a provision in the *Medicare Improvements for Patients and Providers Act of*

2008 that directs the Secretary of Health and Human Services “to contract with a consensus-based entity, such as the National Quality Forum.”

The contract provides \$10 million for fiscal 2009 with the option for renewal each year through 2012, and is being administrated through DHHS’ Centers for Medicare & Medicaid Services and the Assistant Secretary for Planning and Evaluation.

How to Access:

See: www.qualityforum.org

Metrics:

NQF uses its formal Consensus Development Process (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The Consensus Development Process is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry.

Because NQF uses this formal Consensus Development Process, it is recognized as a voluntary consensus standards-setting organization as defined by the National Technology Transfer and Advancement Act of 1995 and Office of Management and Budget Circular A-119.

Over the past 10 years, the procedures that form NQF’s Consensus Development Process and its implementation have evolved to ensure that evaluation of candidate consensus standards continues to follow best practices in performance measurement and standards-setting. NQF is currently using version 1.8 of the CDP.

NQF’s Consensus Development Process involves nine principal steps. Each contains several sub-steps and is associated with specific actions. The steps are:

1. Call for Intent to Submit Candidate Standards
2. Call for Nominations
3. Call for Candidate Standards
4. Candidate Consensus Standard Review
5. Public and Member Comment
6. Member Voting
7. CSAC Decision
8. Board Ratification
9. Appeals

As an endorsing body, NQF is responsible for ensuring that performance measures it endorses are reevaluated every three years to ensure they meet measure evaluation criteria terms.

There are several steps in the ongoing cycle of measure maintenance:

- Annual Report from Measure Steward
- Notification of Endorsement Status
- Completion of Measure Resubmission Form by Measure Steward
- Member and Public Comment Periods
- Evaluation of Measure
- Ongoing Feedback on NQF-endorsed Measures

BRFSS - The Behavioral Risk Factor Surveillance System (& YRBSS)



The Behavioral Risk Factor Surveillance System (BRFSS) is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. Currently, data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.

Mission:

BRFSS information collected is used to improve health care for citizens on a national and statewide basis. More specifically, BRFSS data are used to:

- Determine priority health issues, and develop strategic plans.
- Monitor the effectiveness of intervention measures.
- Examine the achievement of prevention program goals.
- Support appropriate public health policy.
- Educate the public, the health community, and policy makers about disease prevention through the creation of reports, fact sheets, press releases, and other publications.

BRFSS is about people and how to improve and maintain their health. In order to accomplish that goal, valid and reliable data are needed by policy-makers, legislators, researchers, professional organizations, and community-based organizations to create policies, target prevention activities, and establish programs to assist persons in developing healthier lifestyles.

Description:

BRFSS is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. For many states, the BRFSS is the only available source of timely, accurate data on health-related behaviors.

BRFSS was established in 1984 by the Centers for Disease Control and Prevention; currently data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. More than 350,000 adults are interviewed each year, making the BRFSS the largest telephone health survey in the world. States use BRFSS data to identify emerging health problems, establish and track health objectives, and develop and evaluate public health policies and programs. Many states also use BRFSS data to support health-related legislative efforts.

The Youth Risk Behavior Surveillance System (YRBSS) is a subset of BRFSS, also sponsored by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. The national

survey is administered in schools and has several components all of which are administered among samples of 9th through 12th grade students.

Release Date:

BRFSS survey results are continually updated.

Purveyor and Partners:

The Centers for Disease Control and Prevention and state health agencies work together to conduct BRFSS surveys.

How to Access:

Survey data and comprehensive documentation for a given year can be found in the Technical Information and Data section of this website. Data files, codebooks, design documents, methodology, and more information can be found on the BRFSS Technical Documents and Survey Data section page for any given survey year. For data, methodology, and other documentation specific to Selected Metropolitan/Micropolitan Area Risk Trends (SMART), please see the SMART Technical Documents and Survey Data section.

See: www.cdc.gov/brfss/index.htm

Access for survey data and documentation is available for any BRFSS survey year. The documentation provides technical and statistical information regarding the BRFSS, such as comparability, sample information, and more. For the corresponding annual questionnaires, see the [Questionnaires](#) section of this site. For other data sets, see the [SMART](#) and [BRFSS Maps \(GIS\)](#) sections of this site.

There are 432,607 records for 2009. More information on participation is available in the [states conducting surveillance, by year](#) table. The data files are provided in ASCII and SAS Transport formats.

BRFSS Datasets:

Survey Data and Documentation
Chronic Disease and the Environment
Summary Data Quality Reports
Numbered Memos
BRFSS Operational and User's Guide

BRFSS Data Sets and Available Resources:

- **Survey Data and Documentation**
A collection of documents and survey data providing technical and statistical information regarding the BRFSS, such as comparability, sample information, and more.
- **Chronic Disease and the Environment**
The 2001-2006 BRFSS data are compared with 2001-2006 Air Quality System (AQS)

database measurements to calculate annual summary statistics in select metropolitan areas.

- **Summary Data Quality Reports**

These reports measure statistical indicators to monitor quality of data collection for a specific year.

- **Numbered Memos**

The numbered memos are documents describing policies and procedures related to conducting the Behavioral Risk Factor Surveillance System.

- **BRFSS Operational and User's Guide**

The User's Guide is a manual covering all aspects of BRFSS survey operations, including roles and responsibilities, sampling methods, quality assurance, data management and utilization, and much more.

- **BRFSS Forms**

These forms assist states with assessing and improving the quality of their survey operations. Printable Self-Certification, callback verification, and interviewer monitoring forms are available.

Metrics:

BRFSS interviewers ask questions related to behaviors that are associated with preventable chronic diseases, injuries, and infectious diseases. States use standard procedures to collect data through monthly telephone interviews.

Core metrics covered on surveys:

Health Status

Health Care Access

Exercise

Oral Health

Asthma

Tobacco Use

Alcohol Consumption

Falls

Drinking and Driving

Prostate Cancer Screening

HIV/AIDS

Health Status

Healthy Days—Health-Rated Quality of Life

Sleep

Diabetes

Cardiovascular Disease Prevalence

Disability

Demographics

Immunizations

Seatbelt Use

Women's Health

Colorectal Cancer Screening

Emotional Support and Life Satisfaction

American Community Survey

The American Community Survey (ACS) is a nationwide survey designed to provide communities a fresh look at how they are changing. It is a critical element in the Census Bureau's reengineered decennial census program. The ACS collects and produces population and housing information every year instead of every ten years.

Mission:

Up-to-date information from the ACS is needed to better understand community issues, respond to needs, and allocate programs and resources. Data are used by local governments (for budgeting, evaluating programs, and planning community development projects), improving community programs, and evaluating and improving transportation projects.

Description:

The ACS is conducted by the U.S. Census Bureau in every county, American Indian and Alaska Native Area, and Hawaiian Home Land. Puerto Rico is also included in ACS data, using the Puerto Rico Community Survey. The ACS provides critical economic, social, demographic, and housing information to this country's communities every year. Communities report that the ACS helps them make informed decisions and is a key to their future.

The ACS is a separate part of the 2010 Census program. Some households and group quarters (such as college residence halls, skilled nursing facilities, group homes, barracks, and correctional facilities) will receive both the ACS and the 2010 Census this year. Response to both is required by law.

In their own way, the ACS and the 2010 Census provide important pictures of America. They show not only the number of people who live here, but how people live as a Nation—including education, housing, jobs, and more. The information collected in each helps community leaders decide where schools, highways, hospitals, and other services are needed.

Release Date:

Census 2008 survey results are available. ACS 2010 surveying is now underway.

Purveyor and Partners:

U.S. Department of Commerce Economics and Statistics Administration
US Census Bureau

How to Access:

Results of the survey are published on the Census Bureau's American FactFinder® website. See: <http://factfinder.census.gov>. The data are provided in several formats for everyone from beginners (who may just want to look at the data) to experienced researchers.

American FactFinder® includes tables that:

- Provide an overview of the data quickly,
- Compare data for different places, and
- Provide more extensive data for more detailed research.

Two easy steps to ACS data:

1. Go to the ACS page on the American FactFinder website:
<http://factfinder.census.gov/servlet/DatasetMainPageServlet>
2. Select any of the data products on the lower right of the Webpage.

Metrics:

The American Community Survey provides summarized data for social, economic, housing, and demographic estimates. Many of these estimates are cross tabulated by various characteristics. The summarized data products are designed to provide statistics with a level of subject and geographic detail that are sufficient for most data users. These products include tabular and

narrative profiles, year-to-year comparison profiles, selected population profiles, detailed summary tables, subject tables, ranking tables by state, and geographic comparison tables.

The primary metrics include:

- Administrative
- Basic Demographics
- Social (Population)
- Financial (Housing)
- Physical (Housing)
- Economic (Population and Housing)

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U.S. DEPARTMENT OF COMMERCE
Economic and Statistics Administration
U.S. CENSUS BUREAU

THE American Community Survey

This booklet shows the content of the American Community Survey questionnaire.

Please complete this form and return it as soon as possible after receiving it in the mail.

This form asks for information about the people who are living or staying at the address on the mailing label and about the house, apartment, or mobile home located at the address on the mailing label.

If you need help or have questions about completing this form, please call 1-800-354-7271. The telephone call is free.

Telephone Device for the Deaf (TDD): Call 1-800-582-8330. The telephone call is free.

¿NECESITA AYUDA? Si usted habla español y necesita ayuda para completar su cuestionario, llame sin cargo alguno al 1-877-533-5626. Usted también puede pedir un cuestionario en español o completar su entrevista por teléfono con un entrevistador que habla español.

For more information about the American Community Survey, visit our web site at: <http://www.census.gov/acs/www/>

Start Here

➔ Please print today's date.
Month Day Year

➔ Please print the name and telephone number of the person who is filling out this form. We may contact you if there is a question.
Last Name
First Name MI
Area Code + Number

➔ How many people are living or staying at this address?
• INCLUDE everyone who is living or staying here for more than 2 months.
• INCLUDE yourself if you are living here for more than 2 months.
• INCLUDE anyone else staying here who does not have another place to stay, even if they are here for 2 months or less.
• DO NOT INCLUDE anyone who is living somewhere else for more than 2 months, such as a college student living away or someone in the Armed Forces on deployment.
Number of people

➔ Fill out pages 2, 3, and 4 for everyone, including yourself, who is living or staying at this address for more than 2 months. Then complete the rest of the form.

U.S. CENSUS BUREAU

FORM ACS-1(INFO)(2010)KFI
08-14 2009

OMB No. 0607-0810

Example of American Community Survey (Fig. 1)

OLM- Optimal Lifestyle Measures

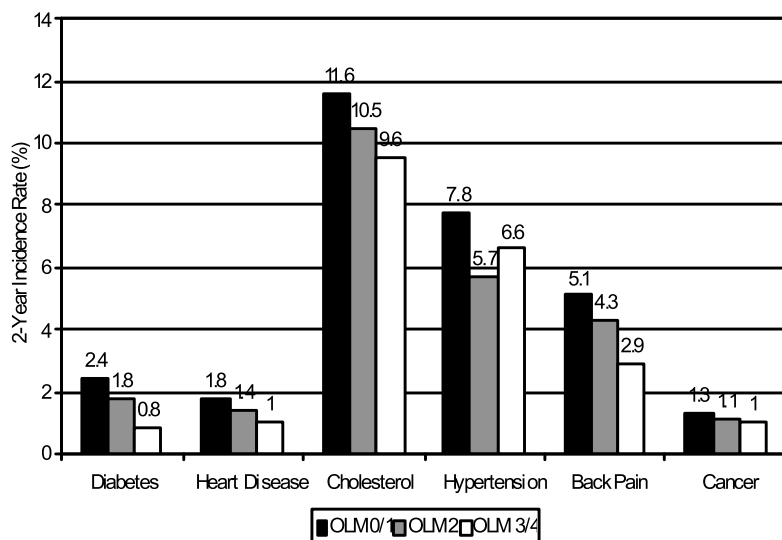
Description:

Optimal Lifestyle Measures (OLM) explore four key areas and refer to the simultaneous adherence to:

1. Abstinence from smoking
2. Adequate physical activity
3. Eating five servings of fruits and vegetables each day
4. Consuming limited or no amount of alcohol

“Optimal lifestyle,” comprised of abstinence from smoking, adequate physical activity, eating five servings of fruits and vegetables each day, and consuming limited or no alcohol, is associated with low risk of chronic disease when unselected populations are observed for long periods of time. Adherence to optimal lifestyle, in particular adequate physical activity, is also associated with lower near-term risk of developing several chronic conditions. Furthermore, adherence to optimal lifestyle is associated with significantly more positive emotional health states as measured by feeling depressed, risk for high stress, and impact of emotional health on daily life.

Unadjusted 2-year incidence rates by OLM adherence rates (Fig. 1)



Unfortunately, adherence to all four optimal lifestyle components might be considered remarkably low across the population. Analyzing National Health and Nutrition Examination Survey III (NHANES III) data collected between 1988 and 1994, adherence to exercise (vigorous and moderate level of physical activity), abstinence from tobacco, consumption of five

servings of fruits and vegetables each day, and no or moderate alcohol consumption was 6%. More recently, NHANES III and NHANES 2001-2006 data for adults aged 40-74 years showed that adherence to the four behavioral factors and a BMI criterion was 8%.

Purveyor and Partners:

Nico Pronk, Ph.D.
Vice President and Health Science Officer, JourneyWell
HealthPartners
Minneapolis, Minnesota.

Data Elements and Sources:

See: <http://www.aboutjourneywell.com/howItWorks/publishedResearch.html>

1. Pronk, N.P., Goodman, M.J., O'Connor, P.J., & Martinson, B.C. Short-term cost to health plans of obesity, smoking status, and physical activity. *Journal of the American Medical Association (JAMA)*, 1999, 282(23), 2235-2239.
2. Babor, T.F., Sciamanna, C.N., & Pronk, N.P. Assessing multiple risk behaviors in primary care: Screening issues and related concepts. *American Journal of Preventive Medicine*, 2004, 27(2S):42-53.
3. Pronk, N.P., Goldstein, M.G., & Peek, C.J. Addressing multiple health risk behaviors in primary care: A synthesis of current knowledge and stakeholder dialogue sessions. *American Journal of Preventive Medicine*, 2004, 27(2S):4-17.
<http://linkinghub.elsevier.com/retrieve/pii/S0749379704001023>
4. Pronk NP, Lowry M, Kottke TE, Austin E, Gallagher J, Katz A. The association between optimal lifestyle adherence and short-term incidence of chronic conditions among employees. *Population Health Management*, in press.
5. Pronk, NP, Katz AS, Gallagher J, Austin E, Mullen D, Lowry M, Kottke TE. Adherence to optimal lifestyle behaviors is related to emotional health indicators among employees. *Population Health Management*, in press.

The above four OLM measures are sometimes combined with:

The single question of self perceived health (“*In general, would you say your health is...*” with a 5-category Likert response scale of “*Excellent, Very Good, Good, Fair, Poor*”)

PHQ2 (Patient health questionnaire (2 items) related to mental health/depression.)

Could ideally be examined against data sets such as the Mobilizing Action Toward Community Health (MATCH).

Kindig DA, Booske BC, Remington PL. Mobilizing Action Toward Community Health (MATCH): Metrics, Incentives, and Partnerships for Population Health. *Prev Chronic Dis* 2010;7(4). http://www.cdc.gov/pcd/issues/2010/jul/10_0019.htm. Accessed June, 2010.

Part II: Data Platforms

Healthy City Description:

Healthy City is an information + action resource that unites community voices, rigorous research and innovative technologies to solve the root causes of social inequity. The team consists of authorities in public policy, research, technology, and data analysis. HC provides actionable information such as data, maps, and service referrals through an easy-to-use online platform. Healthy City also partners directly with organizations to develop targeted strategies that fuel social change.

Healthy City is a project of Advancement Project, (AP), an innovative civil rights law, policy, and communications “action tank” that advances universal opportunity and a just democracy for those left behind in America. AP believes that sustainable progress can be made when multiple tools—law, policy analysis, strategic communications, technology, and research—are coordinated with grassroots movements.

Healthy City Website Homepage (Fig. 1)



Partners/Sponsors:

Governing partners include a few of the founding partners that helped bring Healthy City to fruition.

Advancement Project
211 LA County
Children's Hospital Los Angeles
United Ways of California
USC School of Social Work

Statewide Partners share Healthy City's goal of fueling social change. They support efforts to provide services throughout California.

CPEHN (California Pan-Ethnic Health Network)
Ella Baker Center for Human Rights
Prevention Institute
Legal Services of Northern California
Children Now
California Rural Legal Assistance
United Ways of California
Insight Center for Community Economic Development

Regional Partners support the establishment of Healthy City as a resource within their region. Regional Partners may play one or more of the following roles in their region: Technology & Mapping Support, Outreach & Community Engagement, Community Research & Public Policy, and Data Provider. Regional Partners participate in ongoing regional meetings and help support the establishment of Healthy City as a resource within their region.

211 Partners provide the social service data that is displayed on HealthyCity.org. These partners are fundamental to the information and referral capacity of the website.

See complete list at: www.HealthyCity.org

Healthy City Strategies:

Healthy City partners with organizations across California to develop technology and strategic solutions that fuel social change. Healthy City has three core areas of work:

Data & Technology:

On HealthyCity.org users can search for community services and research demographics and information on health and economics to support policy and planning.

Technical Assistance:

Tell Healthy City the policy goals of an organization. Healthy City works with organizations to develop targeted research strategies and customized web tools to help achieve their community's goals.

Capacity Building:

Healthy City offers a specialized program called the Community Research Lab (CRL) which engages, trains, and provides tools for community organizations to lead and sustain research. The CRL offers organizations the opportunity to experiment with multiple research and technology tools and apply new skills to their organizational strategy.

System Features:

See: <http://healthycity.org>

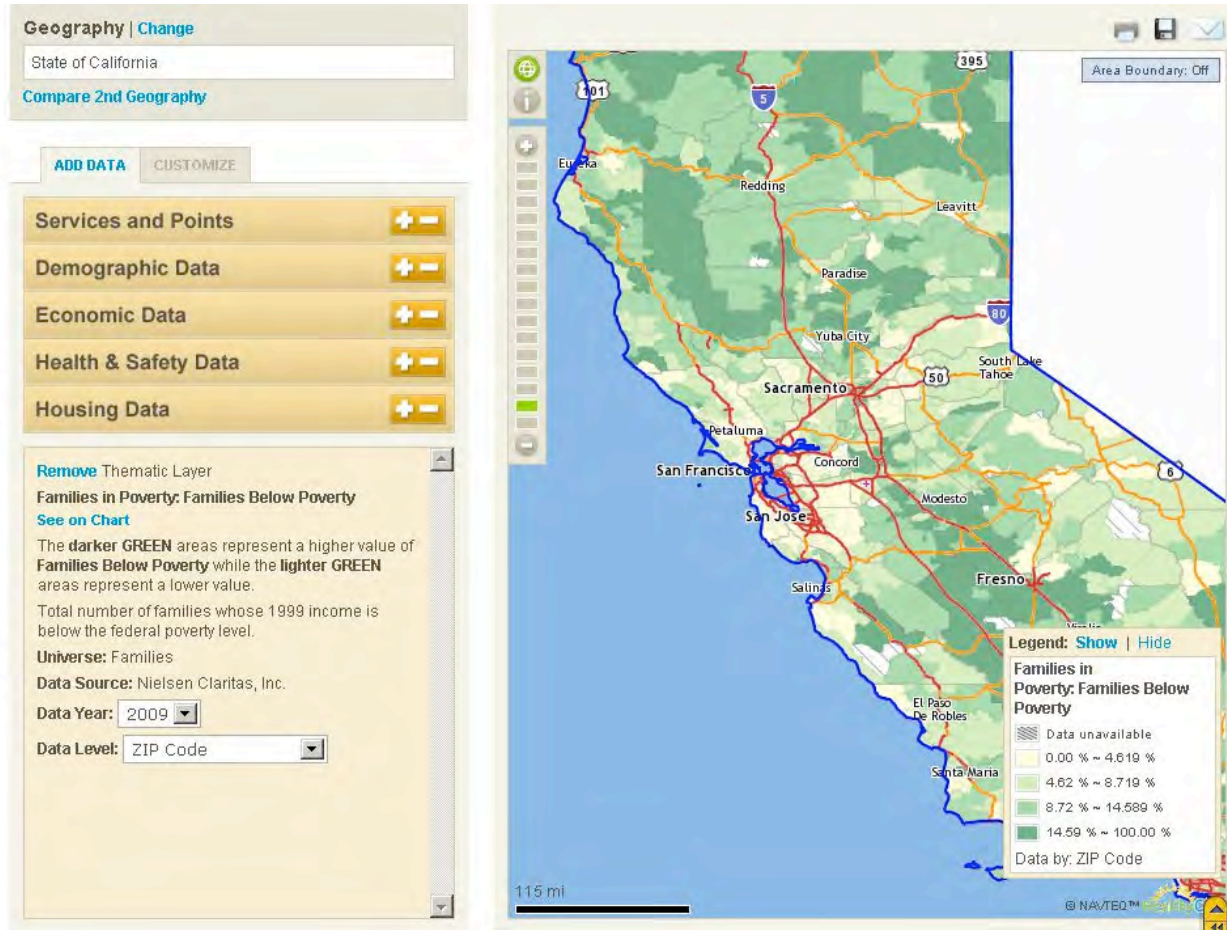
Organizations across California use HealthyCity.org's state-of-the-art mapping capabilities to improve their communities. HealthyCity.org also allows organizations to search for local services and connect with their communities. Beyond providing free access to the largest database of community services and localized data variables, HealthyCity.org offers the ability for users to "tell their own story" by uploading their own data or multimedia to the system.

Healthy City has been recognized as a national model for using online GIS mapping to strengthen regional social service sectors and to advocate for policy that benefits high-need communities. Since its first launch in October 2003, the site has made a significant impact on public policy making and resource planning in Los Angeles County, and now serves an expanding user base across California with a growing set of tools.

Some note-worthy statistics about HealthyCity.org:

- Over 50,000 resource points
- 2,500 thematic variables (including demographic, economic, health & safety, and housing data)
- Over 10,000 visits per month in 2010

Website Data Available (Fig. 2)



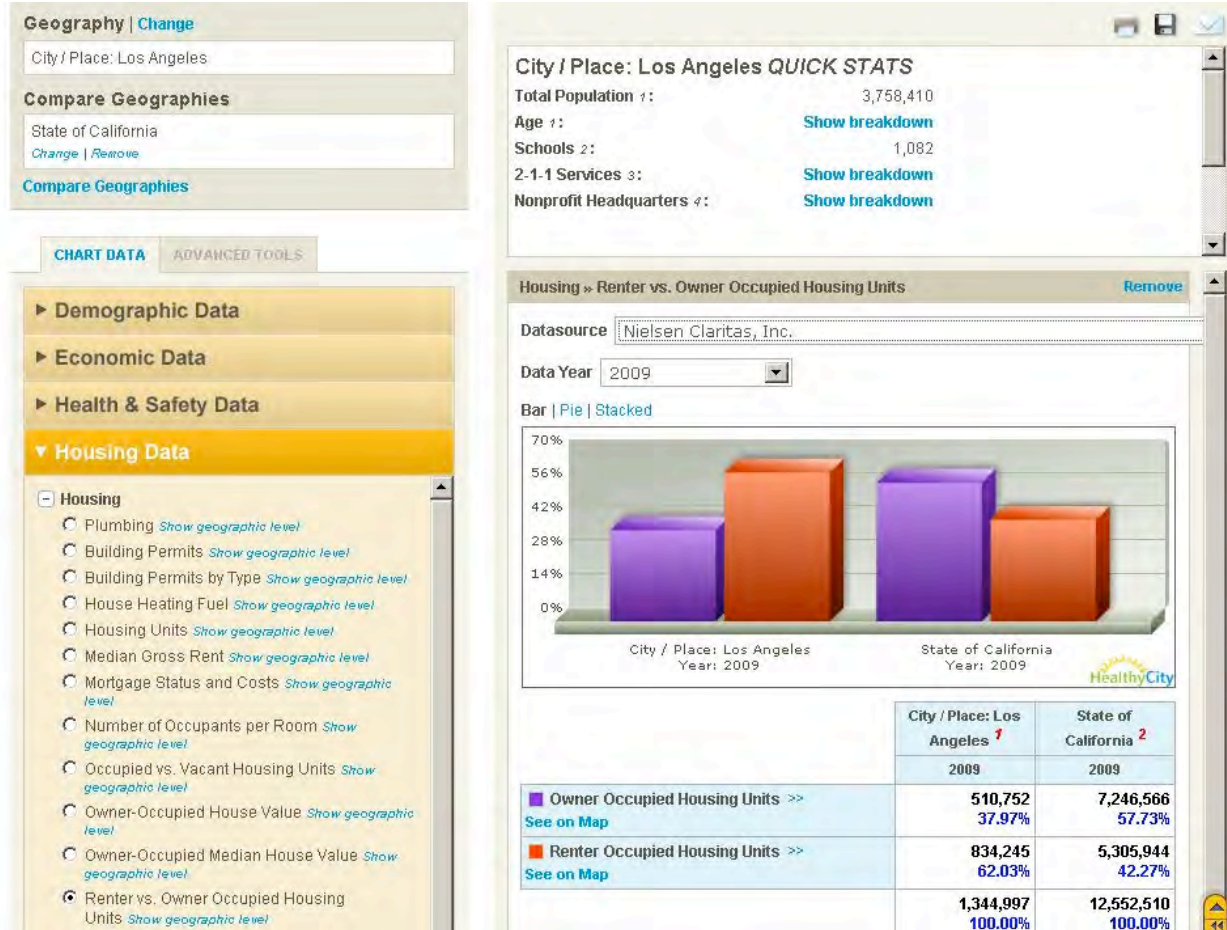
Data Elements and Sources:

Primary indicators:

- Demographic
- Civic Participation
- Child Welfare
- Child Care & Early Education
- Income & Poverty
- Employment
- Nonprofit Infrastructure
- Environment & Land Use
- Health – Birth, Prenatal & Child
- Health - Conditions, Disease & Injury
- Health – Deaths
- Health - Insurance & access
- Health – Physical Activity & Nutrition

Neighborhood & Community
 Crime & Public Safety
 Housing

Example Search, Housing Data, California (Fig.3)



Healthy City for all of California:

The new statewide system was built using the cutting-edge design and technology of HealthyCity.org to meet a wide array of public sector and community research needs. As HC has become trusted for service providers, foundations, governments, researchers, and advocacy organizations in LA, it is hoped that the statewide expansion will prove beneficial in supporting statewide and regional analysis of critical issues.

Healthy Communities Institute

The Healthy Communities Institute has developed a web based information system for use by states, counties, regions, hospitals, foundations, community coalitions and others. The information system is called the Healthy Communities Network (HCN). The HCN provides an easy to understand presentation layer of health, environmental, and other quality of life indicators for stakeholders and community members. Geographic and sub-population indicator disparities are highlighted within the system. For each indicator, users view a rich selection of related content, included promising practices, news, reports, local services, collaboration tools and other resources. The system also provides tracking and evaluation tools that measure progress towards national benchmarks (HP2010) or local target. By providing an understanding and focus to public health data, the system helps communities identify problems, priorities, and inform evidence-based action.

Mission:

The Healthy Communities Institute's mission is to help public and private community stakeholders in counties, regions, and states, improve the health and environmental sustainability of their communities through the use of the Healthy Communities Network.

Description:

The Healthy Communities Institute:

The Healthy Communities Institute is a multi-disciplinary team comprised of scientists, researchers, technologists, community development experts and business people who are committed to providing technology to support community health development. The company is rooted in work started in 2002 in conjunction with the Healthy Cities movement and the University of California at Berkeley. The management team hails from Harvard, Cornell University, and the University of California, Berkeley with expertise in informatics, public health, urban sustainability, community planning and high volume Internet sites.

The Healthy Communities Network:

The Healthy Communities Network web platform was developed in order to provide high-quality data and a decision support information system to improve indicator tracking, best practice sharing, and community development. The primary problem the HCN was designed to solve is health, as environmental, economic and other sectors collect a wide range of data, and yet it has remained a great challenge for the variety of stakeholders in communities to understand the data and be able to take concrete action to improve areas of target interest. The HCN is a living community needs assessment that tracks over 100 health and quality of life indicators, contains over 1,200 best practices, and offers multiple supporting features such as reporting, collaboration, and integration of local content and resources. The promising practices library provides easy access to practical and evidence-based learning from hundreds of successful community interventions from around the country to help users work with government and non-government groups to effect change.

Communities use the HCN in multiple ways, including guiding strategic planning, meeting Public Health Accreditation Board (PHAB) requirements, tracking Healthy People 2010 targets, and soon, 2020, assisting with MAPP planning, helping meet Health Reform Legislation and IRS 990 requirements, and building community report cards. In essence, the HCN allows communities to identify priority areas and increases the efficiency of implementing tried and true programs to address target problems. The HCN can be embedded in an existing website or it can be created as a new destination website and focus for collaboration on improving the health status of the community.

Partners/Sponsors, the Healthy Communities Institute Team:

Management Team, see: http://www.healthycommunitiesinstitute.com/about_management.html

Board of Directors, see: http://www.healthycommunitiesinstitute.com/about_bod.html

Advisory Board, see: http://www.healthycommunitiesinstitute.com/about_advisory.html

System Tools:

Provides solutions for:

- State and community-level and strategic planning
- Community needs assessments
- Meeting various regulatory requirements at city, county, state and federal levels
- Outcomes evaluation
- Local data and program dissemination
- Information & referral search
- Custom community report cards and portals

System Features:

See: <http://www.healthycommunitiesinstitute.com/index.html>

1. A fully configured and hosted website tailored to any sized region or community
2. A local view of a “core set of content” that is readily customized by local communities
 - **Indicator Dashboard for Health and Quality of Life (100-150):** Color-coded gauges that provide a visual representation of health and quality of life indicators in a community. Indicators cover a broad range of topic areas including Health (chronic diseases, health risk factors, mental health, obesity, substance abuse), Economy (unemployment, poverty), Education (high school drop-out rate), Natural Environment (air quality, beach water quality), Transportation (vehicle-bicycle collision rate), Public Safety (violent crime rate), and Social Environment (voter registration rate).
 - **Healthy People 2010 Tracker:** Automated progress tracker for key Healthy People 2010 national health targets. This feature allows communities to assess their health status and track progress toward national benchmarks.
 - **Promising Practices (1,200+):** A database of successful interventions and policy changes that have been implemented across the nation. This database provides

communities with information about how a problem was addressed, what were the benefits, and who to contact (e.g. designs to reduce neighborhood traffic, increase physical activity, and advocate for healthy food policies).

- **Local Resources and Content:** Integration of local resource databases, reports, needs assessments, and events, creating a rich blend of local and centrally provided content.
- **News.** A health-related news feed consisting of RSS news stories that are hand selected from numerous news sources. The stories are contextually linked to indicators, best practices, and other website content.
- **Customized Homepage:** Allows communities to highlight key local “content,” including local concerns, emergency alerts, new programs and events.
- **Report Center:** A central repository for local reports, community needs assessments, community profiles, and other local documents.
- **Report Assistant:** A report writing tool which pulls together related content into one document. This tool can be used to pull together source material for creating a variety of reports and can assist in grant writing, community assessment reports, and community benefit planning.
- **Web Surveys:** Create questions to query community opinions from general users or a targeted group.
- **Community Needs Assessment Tools:** Content and structure to support a community needs assessment.
- **Integration of GIS Maps:** The platform seamlessly allows the integration of static or dynamic GIS maps.
- **Administrative Tools:** Allows non-technical system administrators to add and edit indicators and local content.

Example Website Hosted By HCI (Fig. 1)

Data Elements and Sources:

The Healthy Communities Network provides a core set of 100-150 indicators from key national, state, and local agencies. The data is reviewed and processed by trained epidemiologists with peer review and training in data quality. The centrally provided core data is complimented by the unlimited addition of local data. The indicators cover eight primary topic areas: Health, Economy, Education, Natural Environment, Transportation, Public Safety, Social Environment, and Government and Politics.

Data sources include:

- Centers for Disease Control and Prevention
- National Cancer Institute
- Environmental Protection Agency
- Census (American Community Survey, Economic and Business Census)
- AIRNow
- U.S. Department of Agriculture

- American Lung Association
- Bureau of Labor Statistics
- State and local Departments of Public Health
- State Departments of Education
- And many other datasets

For each indicator, the community value is provided at the smallest geographic level for which it is available (county, school district or zipcode) and statistically stable. Data is presented in several views:

- Comparison to other counties in the state or nation
- Comparison to the last measurement period
- Comparison to a national or local target

In addition to the quantitative display of indicators, HCN provides text describing the indicator, its significance, technical notes, and web links back to the data source.

Featured Community Sites:

San Francisco (<http://www.healthmattersinsf.org/>),
 Marin County (<http://www.healthymarin.org/>),
 Sonoma County (<http://www.healthysonoma.org/>),
 San Bernardino County (<http://www.healthysanbernardinocounty.org/>),
 Whatcom County (<http://www.whatcomcounts.org/whatcom/index.php>)
 State of Hawaii (<http://www.hawaiihealthmatters.org/>),
 State of Arizona (<http://www.arizonahealthmatters.org/>)
 Miami-Dade County (<http://www.miamidadematters.org/>)
 Kern County (<http://www.healthykern.org/>)

Community Issues Management

Community Issues Management (CIM) is a web-based system designed to help local, regional and statewide organizations frame, manage and take action on complex issues.

Mission:

To improve community decision making using facilitation technologies that engage people in ways that promote understanding, strategic collaborations and the wise use of resources.

Description:

The Purpose of CIM is to better align community resources with people and place at all levels of the community. The CIM framework uses a patchwork quilt approach to link and organize data within an Internet based geographic information system (GIS). The CIM system serves as the engine to engage organizations in a transparent and collaborative space. CIM's existing framework utilizes the place-based knowledge of these organizations to inform policy makers and stakeholders about local issues, assets and resources available to address their needs. Public users have free access to CIM by registering on the homepage (www.cim-network.org).

Partners/Sponsors:

The primary sponsor and site host for CIM is the Center for Applied Research and Environmental Systems (CARES) at the University of Missouri. See: <http://cares.missouri.edu> CARES integrates the social, physical, and biological sciences to better understand human, natural resource, and environmental issues and problems. Since founding in 1992, CARES goal has been to aid interested public and private parties in learning about and managing resources, utilizing the latest technologies in geographic information systems, satellite imagery, environmental modeling, and the internet to compile, analyze and distribute information about the world.

CIM has partners across the United States, including:

United Way of Tucson and Southern Arizona, AZ
United Way of Massachusetts and Bay and Merrimack Valley, MA
United Way of Central Maryland, MD
United Way for Southeastern Michigan, MI
United Way of Greater Chattanooga, TN
United Way of the Mid-South, TN
Columbia/Boone Co. Public Health Dept., MO
University of Missouri Extension, MO
Lehigh Valley Health Network, PA
Trident United Way, SC
Mississippi Institute for the Improvement of Geographic Minority Health, MS
Center for Applied Research and Environmental Systems (CARES), USA
Rural Policy Research Institute, RUPRI, USA

System Tools:

See: <http://www.cim-network.org/>

A very useful overview can be found at: www.cim-network.org/aboutCIM.pdf

CIM is a web-based system designed for local and regional organizations to frame, manage and take action on complex issues. CIM can be employed as a tool for use within organizations and as a tool for community engagement to foster participation in transparent, data-informed and collaborative decision making. The foundation of this system is a process for framing issues through a wealth of GIS data, and mapping and reporting tools custom built for organizations to better understand how issues impact people and place. The CIM system allows users to access these defined issues through the CIM Library, to learn how organizations in their region and across the U.S. are confronting issues.

Unique to CIM is a streamlined process to integrate and overlay local mapping data with state and national mapping data that resides in CIM's Data Warehouse. Data can be organized around specific issues that CIM organizations or other user groups have identified. At its core, CIM makes public data publicly accessible in a more meaningful context for decision support.

Informed community decision making is realized through the use of CIM's unique tools and facilitation support. CIM helps organizations and other user groups tell sophisticated stories about key issues such as gaps and overlap in service provision for vulnerable populations, health inequities, workforce retention, and emergency preparedness. Using CIM ensures that the stories told – about people, place and the impact of organizations – are more complete and more accurate. Stories developed with CIM's tools enable policy makers to better align resources with needs.

System Features:

Each CIM Partner Organization has its own customizable web portal to effectively engage regional stakeholders and the public. Partners can take advantage of these unique capabilities in one system. For more information about joining the collaborative as a CIM Partner contact info@cim-network.org.

A. Content Management System

Issue notebooks: Issue Notebooks help organizations frame and manage the issues they have identified in their regions. An organization begins by creating a new Issue Notebook that can be edited or updated to track the development and progress made in addressing the issue.

Notebooks include the following tab sections: *Overview, Maps, Reports, Documents, Multimedia, Other Resources*, and *Take Action* (the amount of content generated, uploaded or hyperlinked varies depending on the issue).

CIM library: The library is a space for viewing Issue Notebooks. A user can search the library by CIM Partner to find out what issues are being addressed in a given region. A user can also search by Keyword (e.g. Health, Education, Childhood Obesity) to seek out information of interest.

Security: CIM Partner Organizations have great flexibility in assigning access roles to users and security levels for each Issue Notebook, map, report or other content that is uploaded or hyperlinked to CIM. Setting security levels for content enables organizations to work internally or engage the public around issues addressing their community.

B. Data Integration

CIM Partner Organizations can build on the wealth of national data already available in CIM by dynamically integrating their local and regional data into the system. All integrated data is assigned to user-defined security levels. CIM Partners can: (1) Dynamically upload GIS data layers (Shapefiles) to add to the CIM mapping engine; (2) Dynamically upload tabular data (Excel, dBase or CSV) to create maps and add to mapping engine; and (3) Manually add points, lines and polygons using the “YouAdd” tool. These features are dynamically converted to GIS layers and added to the CIM mapping engine.

C. Maps and Reports

Interactive maps: CIM’s Interactive mapping tool enables users to visualize and overlay 500+ national GIS data layers (e.g., socio-economic, demographic, health, education). Additional local data is provided by CIM Partners. Users can visualize data for their area of concern, and use Geographic Information System (GIS) tools to analyze and illuminate priority issues in their region. CIM Partners have additional functionality to dynamically add new data (points, lines and polygons) through an easy to use mapping interface and save mapping sessions to the Library for issues framing.

Dynamic reports: CIM’s reporting tool enables the public to generate dynamic reports about specific social, economic, demographic and health characteristics for predefined geographic areas such as counties, cities and zip codes. These reports contain maps, tables and charts, depicting the selected geography. CIM Partner Organizations have additional functionality to generate dynamic reports comparing up to three areas with integrated local data and user-defined report areas. Additionally, CIM Partner Organizations can save reports to the Library for issues framing.

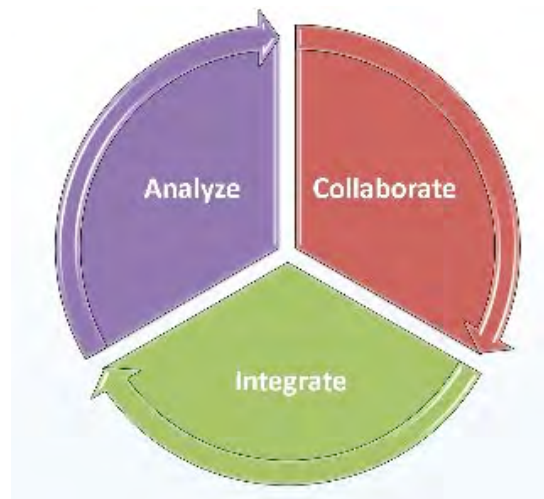
D. Collaborative Working Groups

Often community issues require the engagement/involvement of multiple organizations. A CIM Partner Organization can readily create secure Intranet Web Portals or “Collaborative Working Groups” where multiple organizations can work together, create Issue Notebooks, share data, ideas and perspectives around issues in a region. An advantage of creating separate Working Group portals is to prevent outside organizations from having access to the CIM Organization Portal where internal data or sensitive Issue Notebooks are located for organizational planning purposes.

For example, a CIM Partner Organization (e.g., a United Way) may engage other regional organizations (e.g., YMCA, local school districts, local government, public health, foundations and non-profit organizations) in a “Collaborative Working Group” around childhood obesity. Individuals from these organizations become Working Group Members, collaborating to address the childhood obesity epidemic. The secure Intranet portal enables these organizations to build trust relationships around data sharing and content exchange, and to co-create Issue notebooks

that help the community get a broader, more grounded understanding of childhood obesity in their region.

CIM Features (Fig. 1)



Data Elements and Sources:

A robust group of public data sets are accessible via CIM – over 500 data layers from wide array of sources, with a large array of all the vendors considered. To see data access: www.cim-network.org/tools/reports/reportData.aspx

National data available including: Administrative Areas, Children and Youth, Civic Engagement, Demographics, Economic/Income, Education, Environment, Health, Housing, Neighborhood Characteristics, Poverty, Rural and Urban Designations, and Transportation

Featured Community Sites:

See: www.cim-network.org/partners.aspx, CIM links to 11 community sites:

- United Way of Tucson and Southern Arizona, AZ
- United Way of Massachusetts and Bay and Merrimack Valley, MA
- United Way of Central Maryland, MD
- United Way for Southeastern Michigan, MI
- United Way of Greater Chattanooga, TN
- United Way of the Mid-South, TN
- Columbia/Boone Co. Public Health Dept., MO
- University of Missouri Extension, MO
- Lehigh Valley Health Network, PA
- Trident United Way, SC
- Mississippi Institute for the Improvement of Geographic Minority Health, MS

Health Landscape

HealthLandscape is an interactive web atlas that allows health professionals, policy makers, academic researchers and planners to combine, analyze and display information in ways that promote understanding and improvement of health and healthcare.

Mission:

This interactive site is intended to let its users combine, analyze and display information in maps to better understand health and health care and to advocate for primary care.

Description:

HealthLandscape uses Geographic Information Systems (GIS), a powerful tool for displaying health-related data in a manner comprehensible to policymakers and advocates, novices and experts alike. To date, widespread use of GIS by doctors has been limited due to the time, costs, and expertise required to use the software.

HealthLandscape now makes this powerful tool available to physicians and other health providers, policy makers, advocates, researchers, planners and industry professionals.

Partners/Sponsors

- Health Foundation of Greater Cincinnati (financier), see: www.healthfoundation.org/ [501(c)(4) social welfare organization dedicated to improving community health. The foundation awards grants to non-profit and governmental organizations for programs and activities that improve health in Cincinnati and 20 surrounding counties in Indiana, Kentucky, and Ohio.]
- The Robert Graham Center (incubator), see: www.graham-center.org [Founded by American Academy of Family Physicians to improve individual and population health by enhancing the delivery of primary care. The Center aims to achieve this mission through the generation or synthesis of evidence that brings a family medicine and primary care perspective to health policy deliberations from the local to international levels.]
- American Academy of Family Physicians (see: www.aafp.org) [One of the largest national medical organizations, representing 95K+ family physicians, family medicine residents and medical students nationwide. Founded 1947. Vision is to transform health care to achieve optimal health for everyone. Mission is to improve the health of patients, families and communities by serving the needs of members with professionalism and creativity.]

System Tools:

See: <http://www.healthlandscape.org/>

HealthLandscape is a user friendly mapping tool, and does not require advanced computer skills. HL has an interactive web atlas that allows health professionals, policy makers, academic researchers and planners to combine, analyze and display information in ways that promote understanding and improvement of health and healthcare.

HealthLandscape allows users to create and display maps and tables based on a growing array of data relevant to health and primary care. Users can combine, analyze and display information spatially in order to promote understanding and improvement of health and health care. Additionally, it offers select users the unique capacity to upload, geocode, and map their own data. Once converted, this data may be shared with the HealthLandscape community or securely stored for limited user access. This online instrument appeals to U.S. health professionals, policymakers, advocates, academic researchers, planners and industry professionals interested in the visual and spatial relationships among health information.

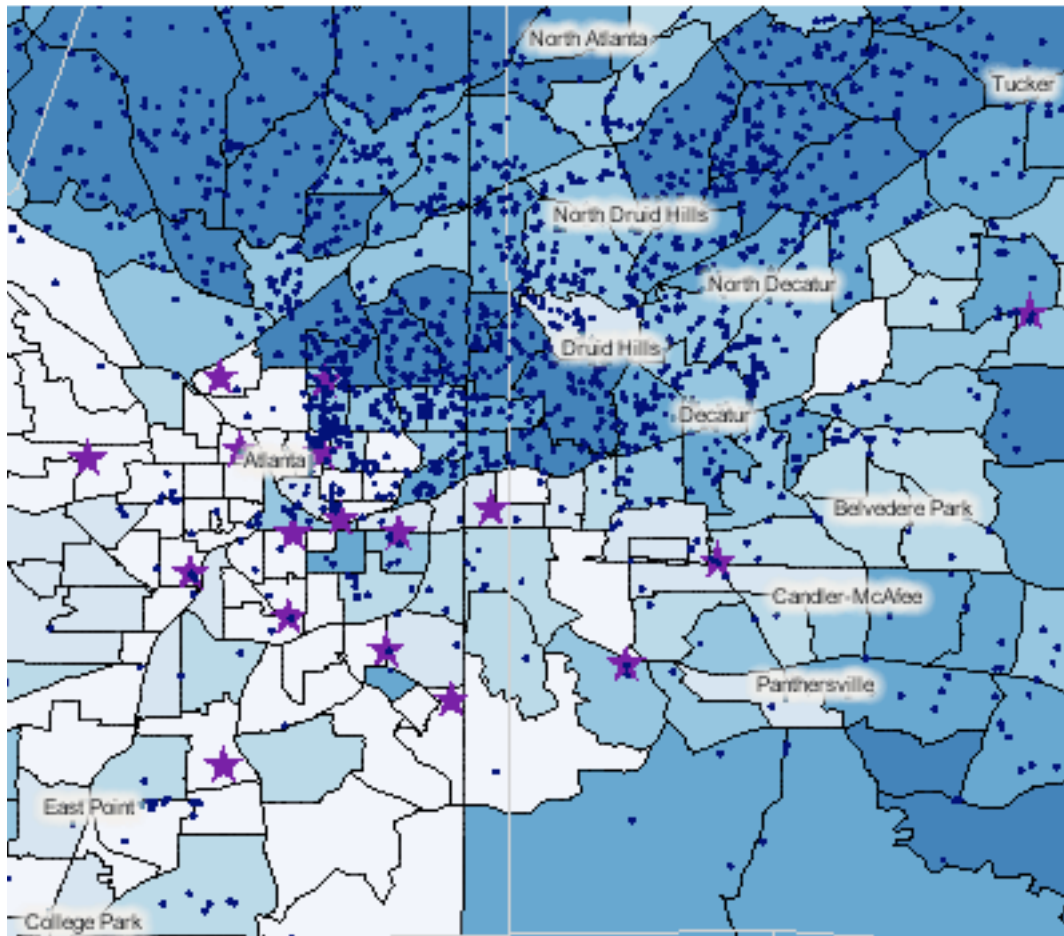
System Features:

- Community HealthView: A home for data relevant to health in communities, where public users can upload and geocode their information and share it with others to depict populations at risk, health outcomes and the distribution of health services.
- Primary Care Atlas: A place to explore the relationship between primary care, the physician workforce, and the populations and places that providers serve.
- Health Center Mapping Tool: A HIPAA-compliant, secure home for uploading, geocoding and mapping clinical data and other secure information, and a place to understand the patient distribution, service areas, market penetration, and relationships to local and regional populations.
- My HealthLandscape: This section provides a secure environment for users to upload and geocode their own health-relevant data; display information with key population, demographic, and economic indicators; and collaborate with others in their organization to create a myriad of informative visual displays.

The Health Center Mapping Tool turns Community Health Center or clinic data into maps of the patients served, the core neighborhoods that comprise a service area, and areas with the densest concentrations of patients. Also, the tool maps U.S. Census data to find populations of interest.

Sample Map (Fig. 1)

 My HealthLandscape



Data Elements and Sources:

The site makes available a wide array of population data related to health, a series of health workforce datasets (some proprietary and restricted to specific user groups), and allows users to upload, geocode and visualize their own HIPAA-sensitive clinical data from clinical care settings (clinic, ER, hospital) - in combination with the other layers.

KP HealthConnect

KP HealthConnect® is Kaiser Permanente's comprehensive health information system that includes one of the most advanced electronic medical records available. It securely connects 8.6 million people to their health care teams, their personal information, and the latest medical knowledge, leveraging the integrated approaches to health care available only at Kaiser Permanente.

KP HealthConnect facilitates communication between members and Kaiser Permanente professionals to help make getting well and staying healthy even more convenient.

Mission:

To Provide: Quality Patients Can Trust, Personal Service, Convenient Service, and Affordable Health Care. HealthConnect seeks to:

- Reduce the cost of care and improve visit experiences.
- Eliminate waste associated with paper medical records and missing medical records.
- Eliminate costly in-person services unless medically necessary or desired by the patient.
- Streamlines IT and administrative processes and costs.

Description:

KP HealthConnect represents a multi-billion dollar strategic investment for Kaiser Permanente. The project has already improved the quality of care and service to members where implemented, and KP believes that trend will continue. It ensures patient safety and quality care by providing access to comprehensive patient information and the latest best practice research in one place. KP HealthConnect also coordinates patient care between the physician's office, the hospital, radiology, the laboratory, and the pharmacy — and it helps to eliminate the pitfalls of incomplete, missing, or unreadable charts. The fully-implemented system has enabled us to streamline and retire many outdated systems. KP HealthConnect directly or indirectly supports the majority of hospital and health plan operations nationwide.

System Tools:

KP HealthConnect is an innovative tool that enables Kaiser Permanente to deliver high-quality, safe and efficient care in new and unique ways. The system supports the organization's commitment to preventive medicine by giving clinicians access to the latest treatments and protocols to make sure its members receive the right care at the right time.

With secure e-mail messaging through My Health Manager, patients can communicate with their doctors at any time, from anywhere. Demonstrating the growing consumer interest in online health management, 80,000 members sign onto My Health Manager each month and patients send more than 500,000 secure e-mail messages each month to doctors and care teams. In his [August 2008 report on personal health records](#), California Insurance Commissioner Steve Poizner noted that Kaiser Permanente has more than four times the percentage of members using electronic health records — 22.1 percent — than the state average.

System Features:

Though [Epic Systems](#) is KP's primary vendor in the deployment of KP HealthConnect, the system integrates a number of different applications, beyond Epic's product offerings, including applications provided by IBM, Vignette, Right Fax, Ingenix, and PerSe.

Data Elements and Sources:

All 8.6 million Kaiser members have the benefit of a complete or partial KP HealthConnect record. Additionally, as of April 2008 all outpatient medical offices were live with outpatient KP HealthConnect. As of Dec. 31, 2009, 33 hospitals deployed end-to-end with complete KP HealthConnect suite. All KP adult members are eligible to activate their My Health Manager personal health record (PHR).

American Human Development Index

The American Human Development Index is a composite measure of well-being comprised of indicators of health, education, and income. It is calculated every two years and published in *The Measure of America: American Human Development Report*, the first-ever human development report for a wealthy, developed country. Of particular interest to the public health community are the Project's calculations of life expectancy for congressional districts and other population groups.

Mission:

Based at the Social Science Research Council, the **American Human Development Project** is a nonpartisan, non-profit initiative established to introduce to the United States a well-honed international approach and tool for measuring human well-being: the human development approach and the human development index.

The project stimulates fact-based public debate about and political attention to human development issues in the United States and empowers people with an instrument to hold elected officials accountable for progress on issues everyone cares about: health, education, and income.

In addition to the biennial *Measure of America*, the Project produces state-level human development reports, research briefs on human development issues in the United States, and rich online data analysis and visualization tools.

Description:

Human development is defined as the process of enlarging people's freedoms and opportunities and improving their well-being. Human development is about the real freedom ordinary people have to decide who to be, what to do, and how to live. Each human development index is comprised of three areas recognized the world over as instrumental to a life of choice and value: a long and healthy life, access to knowledge, and a decent standard of living. Indicators for these dimensions are combined into a single number that can be used to evaluate change over time and disparities between states, congressional districts, metropolitan areas, men and women, and racial and ethnic groups. American HD Index values can also be compared to other social indicators, which the American Human Development Project enables through tools on its [website](#). The Index rankings of the 50 states and 436 congressional districts reveal huge disparities in the health, education, and living standards of different groups.

Partners/Sponsors:

The American Human Development Project benefits from the guidance of an engaged group of leading thinkers and practitioners from a variety of sectors – policy-makers, academics, business and religious leaders, and providers of social services who, acting in their personal capacities, provide invaluable feedback at every stage of the project. The list of current advisors is available on the Project [website](#).

The American Human Development Project is currently made possible by support from:

- [Conrad N. Hilton Foundation](#)

- [The Lincy Foundation](#)
- [Social Science Research Council](#)

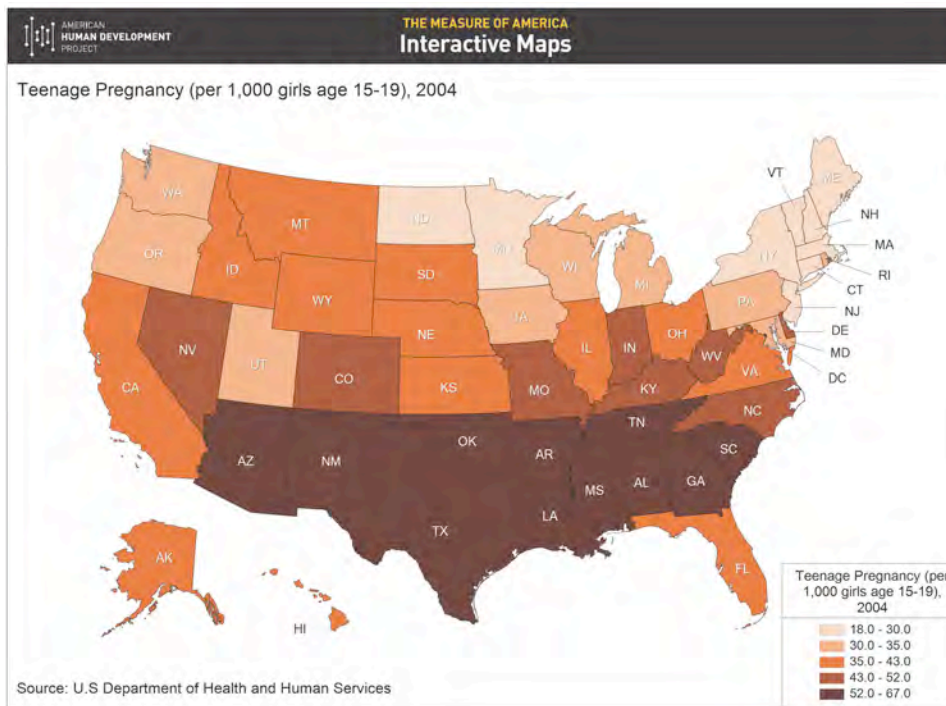
Supporters of and partners in state-level and issue-based work include: [Oxfam America](#), [United Way](#), [Mississippi State Conference NAACP](#), [Foundation for the Mid South](#), [Louisiana Disaster Recovery Foundation](#), [California Endowment](#), the [San Francisco Foundation](#), and many others.

System Tools:

See: www.measureofamerica.org/

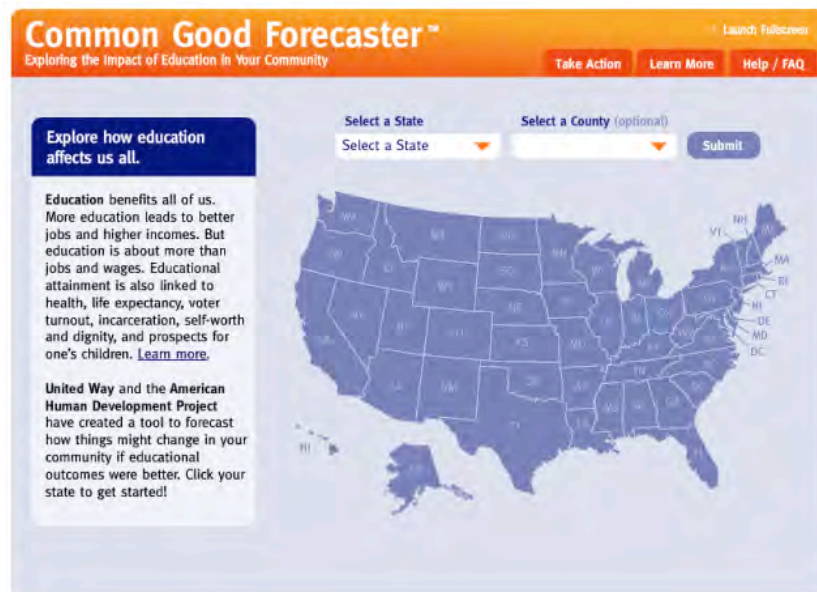
Interactive Maps: Visitors to the Project website can visualize the American Human Development Index and its components on interactive maps of the United States. Users can make comparisons between different regions of the country and examine correlations between Index scores and a set of over 60 other social indicators in areas of health, education, income, demographics, environment, housing and transportation, and security.

The Measure of America Interactive Map (Fig. 1)



Common Good Forecaster™: a tool created in collaboration with the United Way to explore the impact of education on American communities. Users can select their location and observe graphically how improvements in education are associated with gains to their community in numerous other dimensions.

The Common Good Forecaster (Fig. 2)



[The Well-O-Meter™](#): Perhaps individuals have seen where their state and congressional district stack up in the American HD Index rankings, but what about themselves? The formula used to calculate the American HD Index for large population groups cannot be used for individuals. However, individuals can get a general sense of their own human development level by using The Well-O-Meter™, a fun, interactive online tool.

[Philanthropy In/Sight™](#): an interactive mapping tool developed by The Foundation Center to map grants and grant recipients by location, and it now includes demographic data provided by the American Human Development Project. By comparing grant recipients against the American HD Index scores of their geographic areas and a host of other social indicators, funds can be matched to need.

[Data Tables from The Measure of America](#): The website also provides data tables drawn from *The Measure of America* and ancillary reports for research, presentation, advocacy, and other purposes. Data from American Human Development Index and a wide range of additional social indicators are available for states, congressional districts, men and women, racial and ethnic groups, and select countries. All data are standardized in order to ensure comparability between groups and over time.

Example Data Table (Fig. 3)

THE MEASURE OF AMERICA													
AMERICAN HUMAN DEVELOPMENT REPORT 2008-2009													
AMERICAN HUMAN DEVELOPMENT INDEX													
by State													
Rank	State	HD Index	Life Expectancy at Birth (years)	Less Than High School (%)	At Least High School Diploma (%)	At Least Bachelor's Degree (%)	Graduate Degree (%)	Educational Attainment Score	School Enrollment (%)	Median Earnings (2005 dollars)	Health Index	Education Index	Income Index
1	Connecticut	6.37	80.1	12.1	87.9	34.9	15.0	1.378	91.4	35,387	5.9	6.3	6.9
2	Massachusetts	6.27	79.8	12.0	88.0	36.9	15.7	1.406	92.4	33,544	5.7	6.5	6.6
3	District of Columbia	6.14	73.8	16.4	83.6	45.3	25.2	1.540	99.8	36,948	3.2	7.9	7.2
4	New Jersey	6.14	79.2	13.7	86.3	34.2	12.5	1.330	90.5	35,468	5.5	6.0	7.0
5	Maryland	5.99	78.0	13.0	87.0	34.5	15.2	1.368	89.9	35,144	5.0	6.1	6.9
6	Hawaii	5.82	81.7	11.9	88.1	27.9	9.1	1.251	87.5	29,897	6.6	5.3	5.8
7	New York	5.81	79.6	15.7	84.3	31.3	13.4	1.290	90.1	30,983	5.7	5.8	8.0
8	New Hampshire	5.80	79.5	10.1	89.9	31.8	11.7	1.334	88.0	31,054	5.6	5.7	6.0
9	Minnesota	5.72	80.5	9.1	90.9	30.7	9.7	1.314	86.1	29,687	6.0	5.4	5.7
10	Rhode Island	5.72	79.2	16.5	83.5	29.3	11.5	1.243	91.6	30,742	5.5	5.7	6.0
11	California	5.62	79.7	19.9	80.1	29.5	10.6	1.202	90.2	30,018	5.7	5.4	5.8
12	Colorado	5.59	79.1	11.3	88.7	35.5	12.3	1.365	86.0	29,438	5.5	5.6	5.7
13	Virginia	5.56	78.1	14.6	85.4	33.2	13.4	1.320	87.5	31,108	5.0	5.6	6.1
14	Illinois	5.42	78.1	14.3	85.7	29.2	10.9	1.259	89.3	29,696	5.0	5.5	5.7
15	Vermont	5.42	79.6	10.5	89.5	32.5	12.3	1.343	87.9	26,280	5.7	5.7	4.9
16	Washington	5.41	79.4	11.2	88.8	30.1	10.5	1.294	83.9	29,052	5.6	5.1	5.6
17	Alaska	5.35	78.5	9.0	91.0	27.3	10.1	1.284	83.1	30,388	5.2	4.9	5.9
18	Delaware	5.22	77.4	14.4	85.6	27.6	11.1	1.243	84.8	30,702	4.8	5.0	6.0
19	Wisconsin	5.20	79.0	11.2	88.8	28.0	8.1	1.218	86.6	27,387	5.4	5.0	5.2
20	Michigan	5.13	77.7	13.0	87.0	24.7	9.5	1.212	89.5	27,466	4.9	5.3	5.2
21	Iowa	5.03	79.3	10.4	89.6	23.8	7.3	1.207	87.3	25,818	5.6	4.9	4.7
22	Pennsylvania	5.03	77.7	13.3	86.7	25.7	9.8	1.221	86.7	27,395	4.9	5.1	5.2
23	Nebraska	5.00	79.2	10.5	89.5	27.3	8.5	1.253	85.1	24,865	5.5	5.0	4.5
24	Florida	4.96	78.5	15.4	84.6	25.1	8.8	1.185	86.7	25,951	5.2	4.9	4.8
25	Kansas	4.93	78.0	11.3	88.7	28.2	9.6	1.285	86.6	25,038	5.0	5.2	4.5
26	Arizona	4.90	78.2	16.2	83.8	25.6	9.3	1.187	83.9	26,764	5.1	4.6	5.0
27	North Dakota	4.90	79.8	11.8	88.2	25.5	6.7	1.204	84.6	23,789	5.8	4.8	4.2
28	Oregon	4.90	78.7	12.5	87.5	27.7	10.0	1.251	84.3	24,825	5.3	4.9	4.5
29	Maine	4.86	78.1	11.0	89.0	25.6	8.6	1.232	86.3	24,944	5.0	5.1	4.5
30	Utah	4.86	79.5	9.9	90.1	27.9	8.7	1.267	83.8	23,144	5.6	5.0	4.0

System Features:

Along with a versatile set of data tools, the American Human Development Project provides detailed analysis of why disparities exist and what can be done to alleviate them. In addition to *The Measure of America*, which can be purchased through Amazon.com, the following reports are available for download:

[A Portrait of Mississippi: Mississippi Human Development Report 2009](#): the first human development report for the state of Mississippi, this analysis drills down to the level of counties to uncover what's driving disparities in human well-being in the state that ranked at the bottom of the Index in 2008.

[A Portrait of Louisiana: Louisiana Human Development Report 2009](#): the first report to use post-Hurricane Katrina data, this county-level analysis explores the gulfs that separate human well-being along the Gulf today.

[A Portrait of California: California Human Development Report 2011](#) (forthcoming)

[Goals for the Common Good](#): a companion to the [Common Good Forecaster™](#), this report demonstrates how access to knowledge is a catalyst for progress in other dimensions of human development.

[Health Care Shouldn't Have to Cost an Arm and a Leg: 29 Reasons for Optimism](#): that 29 countries spend less on health care but live longer lives than Americans indicates that health care reform holds great promise.

[A Century Apart: New Measures of Well-being for U.S. Racial and Ethnic Groups](#): a national conversation about race tends to take place in black and white, but this report reveals

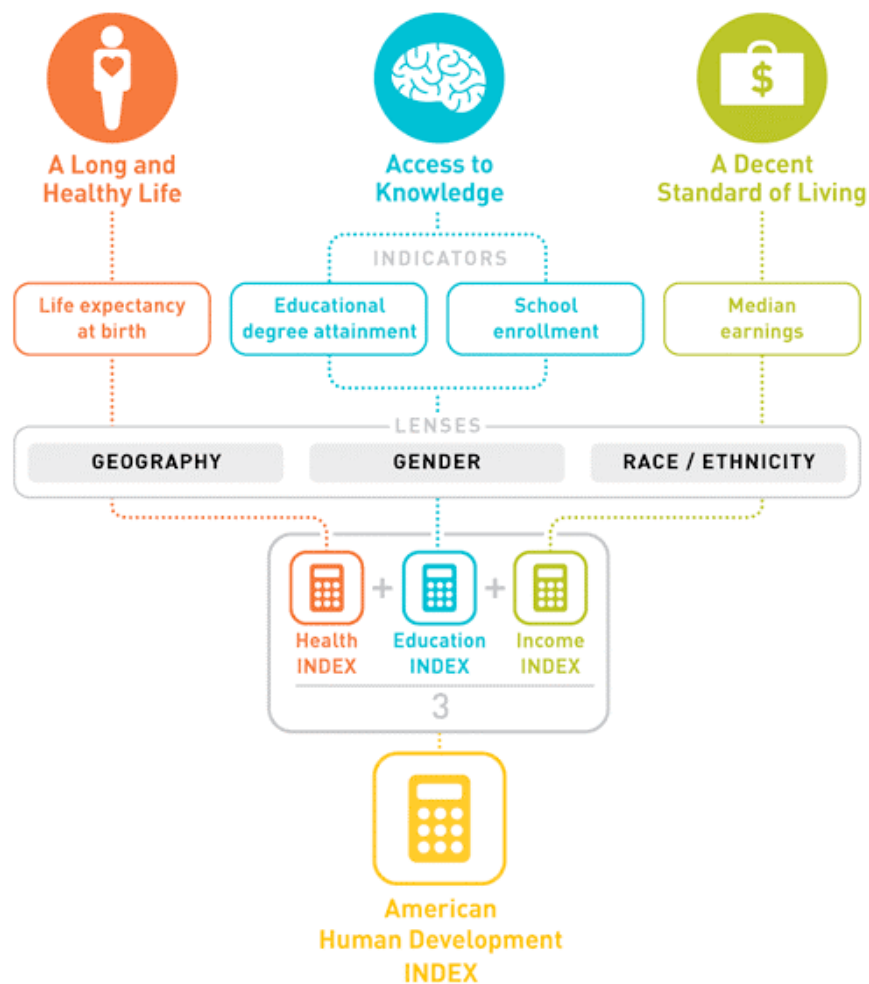
that the greatest disparities in the United States actually separate Native Americans in one state and Asian Americans in another (includes American HD Index rankings of racial and ethnic groups by state).

Teacher’s Guide to *The Measure of America*: Lesson plans for high school teachers to use *The Measure of America* for teaching topics in U.S. government, civics, history, and Census data (includes worksheets, full-color maps, assessment rubrics, and more).

Data Elements and Sources:

The American HD Index measures the same three basic dimensions as the global human development index (HDI), but it uses different indicators to better reflect the U.S. context and to maximize use of available data. For example, while the standard index measures access to knowledge in part using adult literacy data, educational attainment has been chosen to be used instead, a more demanding indicator.

The American Human Development Index (Fig. 4)



While data are plentiful on the extremes of affluence and deprivation in the United States, the American Human Development Index provides a single measure of well-being for all Americans, disaggregated by state and congressional district, as well as by gender, race, and ethnicity. All data used in the index come from official U.S. government sources—the American Community Survey of the U.S. Census Bureau and the Centers for Disease Control and Prevention. Of note, the Project is the only entity that calculates and publishes life expectancy by congressional district.

Self Perceived Health in the European Union

Description:

One of the ways EU governments and the European Commission assess the aspects of health is regularly surveying their population's self-perceived health status. Subjective or self-reported health status is not a substitute for more objective indicators – but rather complements them: “reports of self-perceived health introduce a consumer perspective into population health monitoring and reveal aspects of health that may not become apparent with more traditional measures.”

The self-perceived health is measured by means of health interview surveys using a representative population sample, using the (WHO recommended) question "How is your health in general? Is it: very good / good / fair / bad / very bad?"

Partners/Sponsors:

Self-perceived health is one of the ECHI indicators (European Community Health Indicators). The ECHI (European Community Health Indicators) project was carried out in the framework of the Health Monitoring Program and the Community Public Health Program 2003-2008. The result is a list of 'indicators' for the public health field arranged according to a conceptual view on health and health determinants.

In 2002 a framework at EU level – named the European Health Survey System (EHSS) – was set up for a regular collection of harmonized data by means of surveys (or survey modules) on health.

The aim of the EHSS is to bring together under a single framework, the different health and health related surveys taking place at the EU level for different purposes and by a variety of actors. It should anticipate health information needs from the Member States as well as from the EU and coordinate the efforts on Health Interview Surveys (HIS).

System Features:

The EHSS consists of three parts of which the first one is of particular interest for the self-perceived health: the European Core Health Interview Survey (ECHIS), a complementary set of special surveys such as the future European Health Examination Survey (EHES) and a methodology database on health surveys (HIS and HES) carried out in EU countries and some others such as US and Canada.

The ECHIS contains an annual Minimum European Health Module (MEHM) composed of questions on self-perceived health, longstanding illness, activity limitation due to health problems and unmet health care needs. This module is included in the annual European social survey on Statistics on Income and Living Conditions (SILC) which began in 2004.

The ECHIS also consists of the European Health Interview Survey (EHIS) to be held every five years in the 27 Member States. This survey aims at measuring on a harmonized basis and with a high degree of comparability among EU Member States the health status, life style (health determinants) and health care services use of the EU citizens. The first wave of the EHIS was carried out for 21 Member States in the period 2005-2010. The wave 2 covering all Member States is planned for 2014.

How to Access:

Multidimensional tables on self-perceived health according different breakdowns (sex, age, educational level, activity status, and income quintile) are available on Eurostat's website. See the data collection "Health status: indicators from surveys (SILC, HIS, LFS)" in: http://epp.eurostat.ec.europa.eu/portal/page/portal/health/public_health/database

Data Elements and Sources:

The European social survey on Statistics on Income and Living Conditions (EU-SILC) is a European statistical System instrument aiming at collecting timely and comparable cross-sectional and longitudinal multidimensional micro data on income, poverty, social exclusion and living conditions. EU-SILC contains the question on self-perceived health through the inclusion of the Minimum European Health Module (MEHM).

For more information, see: <http://circa.europa.eu/Public/irc/dsis/eusilc/library>

Featured Community Sites:

Policy information on public health and ECHI:
http://ec.europa.eu/health/indicators/echi/index_en.htm

Documentation sheets on the ECHI indicators:
http://www.echim.org/docs/documentation_sheets.pdf

Part III: Indicator Set from a Leading Foundation

The California Endowment: Building Healthy Communities-10 Outcomes

The California Endowment, a private, statewide health foundation, was founded in 1996 by Blue Cross of California as a result of its conversion from a nonprofit to for-profit corporation. Since its inception, The Endowment has awarded more than 9,000 grants totaling nearly \$1.7 billion to organizations in California.

Mission:

To expand access to affordable, quality health care for underserved individuals and communities, and to promote fundamental improvements in the health status of all Californians.

Description:

The California Endowment strongly believes that to fulfill its mission of creating a healthier California, everyone must become more effective leaders and catalysts for change, including the Board and Staff of The California Endowment, community residents, policymakers and grant makers.

Another important factor in the California Endowment's work as a change agent is "grassroots-to-treetops" advocacy and mobilization. The Endowment actively promotes and supports an array of grassroots coalitions (which are deeply rooted in communities and know best the conditions that need to change), as well as statewide and, in some cases, national organizations. Together, these individuals, organizations and coalitions act to influence health decision makers and shape policies and systems at all levels so that they reflect ideas that emerge from the grassroots and work for everyone.

The California Endowment remains committed to its mission to improve the health of Californians. But the lessons from its first decade as a foundation made it clear that it could enhance the impact of its work by adopting a more tightly focused direction. Beginning in 2010, the Endowment work will be focused in pursuit of a single vision: *Building Healthy Communities in the state of California*.

The California Endowment will:

Focus on Places: Understanding that where one lives has a direct impact on one's health, The Endowment will target a limited number of communities impacted by poverty with 10-year partnership funding to build healthy communities where all children and youth have the opportunity to be healthy, safe and ready to learn.

Focus on Children and Youth: Children and youth will serve as the primary (although not exclusive) focus of The Endowment's work and the measure of success.

Focus on Systems: The California Endowment will provide the resources and support the leadership necessary to influence a range of local and state-level changes in policies and systems that influence the health of children and youth.

Focus on Impact and Results: The California Endowment's work will be guided by specific state-level policy outcomes and local-level health outcomes and policies that advance a comprehensive movement for building healthy communities in California.

Release Date:

The research and data-gathering phase of the selection process is under way.

Purveyor and Partners:

The California Endowment is governed by a 17-member Board of Directors from California's leading nonprofits, health organizations, educational institutions, businesses and industries. The Endowment recently identified 14 communities throughout California that it would like to partner with to achieve the goals outlined in the 10-year strategic initiative, *Building Healthy Communities* -- places where kids and youth are healthy, safe and ready to learn.

How to Access:

See: www.calendow.org/healthycommunities/ or www.calendow.org/Collection_Publications.aspx

The California Endowment provides a publications library. The Endowment commissions and funds reports that reflect the work of grantees in three program goal areas: Access to Health, Community Health and the Elimination of Disparities and Culturally Competent Health Systems. All publications in this section are free to download (Adobe PDF) and those with an "Order Publication" button next to the title are available in hard copy.

Metrics:

The primary program areas include:

Access: Children's Coverage, Uninsured, Mental Health, General

Disparities: Agricultural Worker/Border and Rural Health, Obesity and diabetes, Asthma, Oral Health, General

Culturally Competent Health Systems: Language Access, Health Care Interpreter, Training Materials, Special Populations, Workforce Diversity, General

The Endowment will demonstrate the long term success of Building Healthy Communities: by assessing progress toward achieving Four Big Results:

Big Result #1: Provide a health home for all children

Big Result #2: Reverse the childhood obesity epidemic

Big Result #3: Increase school attendance

Big Result #4: Reduce youth violence

To measure progress toward The Four Big Results, The Endowment established 10 Outcomes.

The 10 Outcomes as a whole represent The California Endowment's view of the complex characteristics required to create a healthy community. They provide the basis for measurement of The California Endowment's overall success.

1. All children have health coverage.
2. Families have improved access to a healthy home that supports healthy behaviors.
3. Health and family-focused human services shift resources toward prevention.
4. Residents live in communities with health-promoting land use, transportation and community development.
5. Children and their families are safe from violence in their homes and neighborhoods.
6. Communities support healthy youth development.
7. Neighborhood and school environments support improved health and healthy behaviors.
8. Community health improvements are linked to economic development.
9. Health gaps for young men and boys of color are narrowed.
10. Strategic use of media elevates local experience to help influence policy and systems change at all levels.

Part IV: Other Groups and Projects

Community Health Data Initiative (HHS & CDC)

Description:

The Community Health Data Initiative is a collaborative effort among government and non-government partners to establish a network of suppliers and demanders of community health data, indicators, and interventions. Its purpose is to help Americans understand health and health care system performance in their communities, thereby sparking and facilitating action to improve performance and value.

The HHS Health Indicators Warehouse that is currently under development will serve as the data hub for the initiative. Health indicators are measurable characteristics that describe the health of a population (such as life expectancy, mortality, disease incidence or prevalence, or other health states); determinants of health (such as health behaviors, health risk factors, physical environments, and socioeconomic environments); and health care access, cost, quality, and use.

Depending on the measure, a health indicator may be defined for a specific population, place, political jurisdiction, or geographic area. NCHS is working with data, content, and application experts to develop this interactive system that will represent a major infusion of free, easily accessible HHS data. While the warehouse is under development, several resources are available.

Below are links to downloadable data sets which form the basis for the content anticipated to be available through the Indicator Warehouse and which will further the success of the Community Health Data Initiative. A [draft set of indicators \[PDF - 122 KB\]](#) that may be included is available for review and comment. Please send all questions and suggestions to:

IndicatorsWarehouse@cdc.gov.

How to Access:

See: http://www.cdc.gov/nchs/data_access/chdi.htm

Downloadable Data Sets:

[Community Health Status Indicators \(CHSI\)](#) - A web-based tool providing local public health agencies access to county health status profiles for improving community health by identifying resources and setting priorities. Visit the [CHSI home page](#) to read about the data sources, definitions, and notes, and then explore the [CHSI dataset file \[ZIP - 5 MB\]](#).

[County Health Rankings](#) - An interactive website providing access to 50 state reports with rankings of each county within each state according to its health outcomes and health determinants. The County Health Rankings are a key component of the Mobilizing Action Toward Community Health (MATCH) project. MATCH is a collaboration between the [Robert Wood Johnson Foundation](#) and the [University of Wisconsin Population Health Institute](#). Read [about the project](#) and then examine the [MATCH State Data file \[XLS - 3 MB\] \[ZIP - 3.4 MB\]](#).

[DATA2010](#) - An interactive database system containing the most recent monitoring data for the Healthy People 2010 objectives.

[Centers for Medicare & Medicaid Services](#) - Provides a wealth of downloadable data, such as [Hospital Quality Compare](#) and [Nursing Home Compare](#), for health policy researchers, the media, and others interested in Medicare ([Medicare's database download resource page](#)).

[USDA Economic Research Service](#) - Provides the [US Food Environment Atlas](#), a spatial overview of a community's ability to access healthy food and its success in doing so. The Atlas assembles statistics on three broad categories of food environment factors: Food Choices; Health and Well-Being; and Community Characteristics.

[Agency for Healthcare Research and Quality](#) - Produces the [National Healthcare Quality and Disparities Reports](#) measuring the trends in effectiveness of care, patient safety, timeliness of care, patient centeredness, and efficiency of care. [Static tables](#) are available in addition to an interactive tool for generating [customized tables](#). A data table containing [all measures by all states](#) is also available.

[The State of the USA](#) - An organization assembling high-quality measures and data that will increase the understanding and progress of the US across many areas, including health. SUSA is currently developing a set of health indicators that will be available in the near future.

Select Indicator Reports and Initiatives:

[America's Children: Key national indicators of well-being, 2009](#)

A compendium of indicators illustrating both the promises and the difficulties confronting the Nation's young people.

[Chronic Disease Indicators](#)

A set of 90 cross-cutting, important, uniform, and available indicators developed by consensus and drawn from many data sources.

[Health, United States, 2009](#)

A chart book and 150 detailed tables providing an annual picture of the health of the entire United States.

[Healthy People](#)

Healthy People 2010 contains 467 objectives in 28 focus areas designed to serve as a framework for improving the health of all people in the United States. Healthy People 2020 is currently under development.

[Older Americans 2008](#)

A report of the Federal Interagency Forum on Aging-Related Statistics, providing data on 38 key indicators that portray aspects of the lives of older Americans and their families.

Purveyors and Partners:

- [Department of Health and Human Services, Office of the Secretary \(HHS\)](#)
- [Centers for Medicare & Medicaid Services \(CMS\)](#)
- [Health Resources and Services Administration \(HRSA\)](#)
- [Office of the Assistant Secretary for Planning and Evaluation \(ASPE\)](#)
- [Office of Disease Prevention and Health Promotion \(ODPHP\)](#)
- [Office of Minority Health \(OMH\)](#)
- [Substance Abuse & Mental Health Services Administration \(SAMHSA\)](#)

Community Indicators Consortium

The Community Indicators Consortium (CIC) is an active learning network and community of practice among persons and organizations interested or engaged in the field of community indicators and their application.

Mission:

The mission of CIC is to:

- Advance the art and science of indicators;
- Facilitate the exchange of knowledge about the effective use of indicators;
- Encourage development of effective indicators;
- Foster informed civic and media discourse about local, regional, national, and global priorities.

Description:

CIC was organized in the belief that information sharing, collaboration and open dialogue -- across geography and disciplines -- are key to the advancement of people, the quality of community life and the sustainability of a shared environment. To that end, CIC seeks bridges that span the gap between community indicators use and performance measurement, providing ways for community groups and governments to coordinate efforts and jointly enhance knowledge about the use of indicators to leverage positive change.

Through these activities, CIC has become a major node in the expanding field of community measurement. The CIC website offers a place where community-based practitioners, academic experts, engaged community residents, public officials, students, civic leaders, planners, media professionals and other stakeholders can learn from one another and participate in an active global learning community.

Partners/Sponsors:

CIC is led by a [Board of Directors](#) elected each year by the membership. Individual and organizational members also play an important role in the organization.

CIC is proud to list the following as active partners working to improve the use of indicators and information in making better decisions and better communities:

- [Measuring the Progress of Societies Project](#)
- [Organization for Economic Co-operation and Development \(OECD\)](#)
- [Public Performance Measurement and Reporting Network](#)
- [State of the USA](#)

Strategic Goals & Action Plan:

In July 2007, the CIC Board adopted five strategic goals for CIC and an [Action Plan](#) for 2007-2010. This Action Plan was built upon the following five strategic goals for CIC:

1. Advance the use of indicators for community awareness and change;
2. Create a global community of practice (COP);
3. Strengthen CIC's international perspective and relevance;
4. Promote connectivity between indicators and performance measurement;
5. Build and sustain the organization.

System Tools:

CIC's website is a resource for individuals and organizations working to improve the use of indicators for better planning, decision-making and communities' quality of life. See the [Indicator Projects](#) list for information about and links to community indicator projects around the world.

The [Community Indicator-Performance Measures Integration Project](#) section offers information on what community indicators-performance measures (CI-PM) integration means, why it is important, and where it is being done. The work related to this project is being supported by a grant from the [Alfred P. Sloan Foundation](#) and countless hours by volunteers and subject matter experts.

The [Events](#) page lists upcoming conferences, webinars, workshops and other events that may be of interest to practitioners.

See [Resources](#) for community indicator-related information such as blogs, newsletters, publications, websites and organizations, including an archive of past CIC conference proceedings, newsletters, and webinars.

The CIC [Members' Corner](#) allows members-only access to sections of the site such as social networking tools and information about upcoming Webinars.

CIC is a member-run, member-supported organization. Please check out the [benefits of membership](#) and [join](#) the international community of practice.

System Features:

See: <http://www.communityindicators.net/> or <http://www.communityindicators.net/efforts>

Community Indicator Projects

Listed on the Community Indicator Projects page is a small selection of indicator efforts. CIC does not claim involvement or endorse any projects, but finds those listed interesting and informative. In addition to these indicator projects, CIC also hosts a Working Group on

Integrating Community Indicators and Performance Measures. See the [CI-PM](#) section of the CIC website for more information about the project and examples of places where Community Indicator Projects are being integrated with Performance Measures to improve the use of information in collaborative community decision-making.

Additionally, CIC has assembled a list of web sites and other resources that have in-depth information on various topics related to indicators. See the CIC [Indicator Projects listing](#) for more details about individual geographic or topic-focused projects. CIC accepts suggestions for additions to the list, using the [contact](#) function on the webpage.

The Community Health Data Forum

The Community Health Data Forum was a standalone public health workshop. On June 2, 2010, the Institute of Medicine (IOM) and the Department of Health and Human Services (HHS) held a public forum, *The Community Health Data Forum: Harnessing the Power of Information to Improve Health* (the Forum). The purpose of the Forum was to further ongoing efforts of innovators using community-level health data to empower individuals and communities to make informed choices about their health.

In March, the IOM and HHS hosted a small gathering of leaders from the White House, federal agencies, academia, social sectors, public health communities, information technology firms, major businesses, and health care delivery systems to catalyze the formation of the new Community Health Data Initiative (the Initiative). The Initiative is a public-private collaboration that is encouraging innovators to utilize community health data to develop applications that help raise awareness of community health performance and spark action to improve health.

Community Health Data Initiative

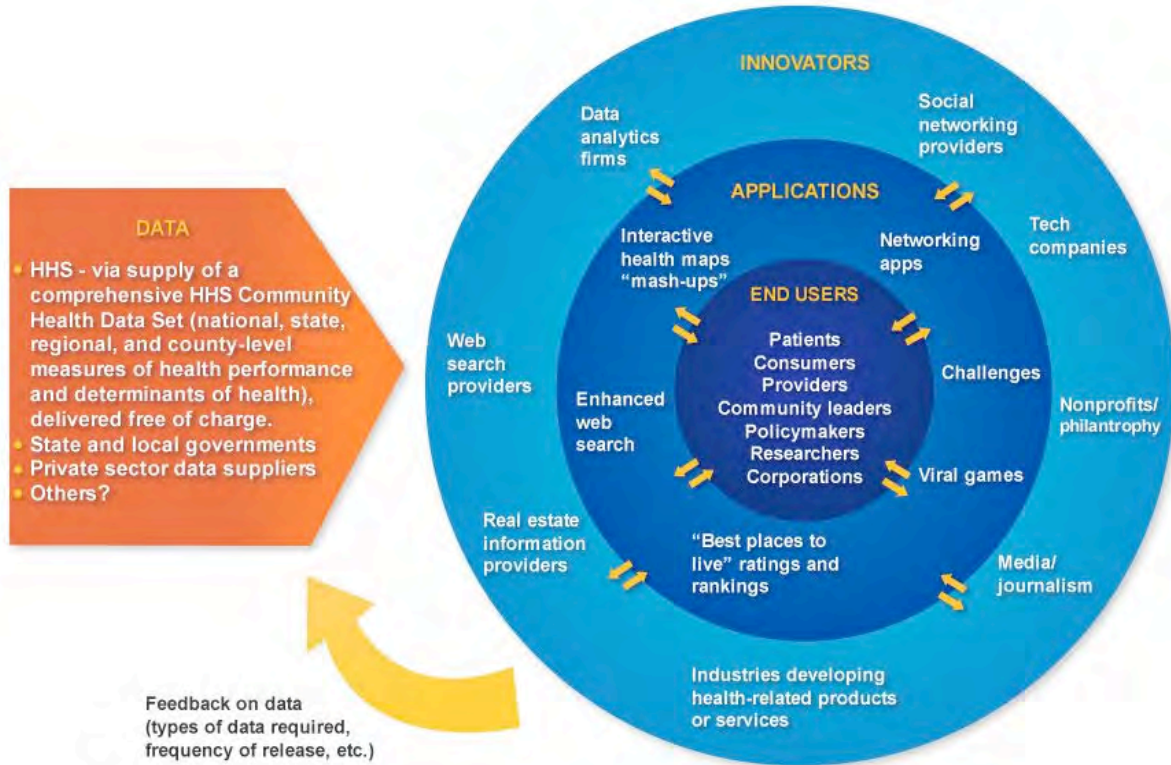
The Community Health Data Initiative was launched in a [Forum](#) at the Institute of Medicine in Washington, D.C., on June 2, 2010. Opening speakers were IOM President Harvey Fineberg, HHS Secretary [Kathleen Sebelius](#) and HHS Deputy Secretary [Bill Corr](#). About 15 new applications were demonstrated, making health data available in new formats. Press releases were issued by [HHS](#) and the [IOM](#).

HHS and the Institute of Medicine have launched a national initiative to help consumers and communities get more value out of the Nation's wealth of health data. Under the Community Health Data Initiative:

- HHS will release greater amounts of health data in more usable formats
- Software developers will use the data to create new applications that will make health information increasingly useful for individuals and communities
- With improved data and creative new applications, communities and consumers will initiate effective new efforts in disease prevention, health promotion and measurement of health care quality and performance.

See: <http://www.hhs.gov/open/datasets/communityhealthdata.html>

The Community Health Data Initiative (Fig. 1)



Selected Projects with Descriptions

Below, please find a sample of other important data groups and projects with brief descriptions.

Analyze the USA

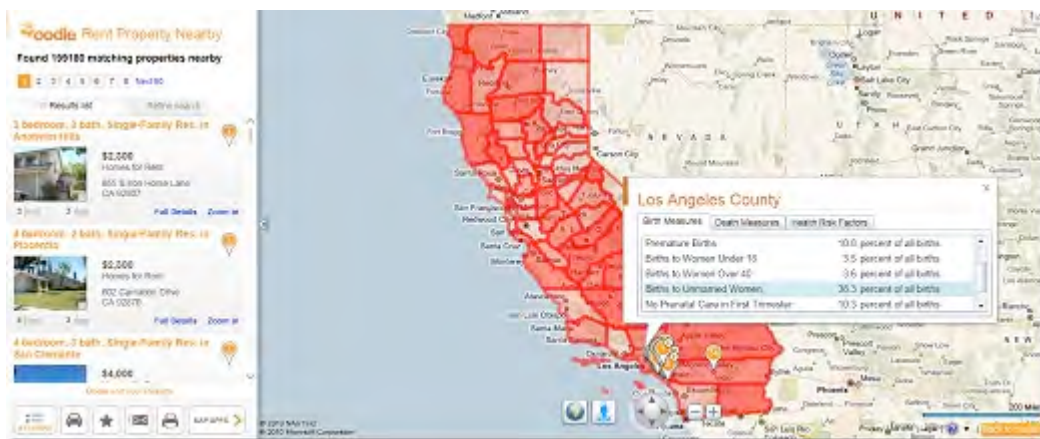
AnalyzeThe.US allows anyone to use Palantir to explore vast amounts of data only recently released into the public domain, including key datasets from www.data.gov. Information about key individuals, organizations, and activities exists in many places, and conducting meaningful analysis first requires the ability to integrate data seamlessly and completely. AnalyzeThe.US brings critical knowledge together on a single stage, while providing rich analytical applications that enable anyone to develop an intuitive picture of the complex flow of resources, money, and influence that affect how the government functions. Ultimately, by allowing citizens to analyze democracy, AnalyzeThe.US democratizes analysis.

See: <https://www.analyzethe.us/>

Bing Map App: Bing Health Maps

Composed of data from the Department of Health and Human Services, Bing Released the [Bing Map App](#) dubbed [Bing Health Maps](#) during the summer of 2010. The Bing Health Map App allows viewers to quickly see the different counties around the U.S. The new Map App provides statistical information for the entire United States by county to visualize healthy (and not-so-healthy) parts of the country to help viewers make healthier decisions.

Sample Bing Health Map (Fig. 1)



Bing Health Maps is very straightforward to use - (1) Select a state and, (2) Select a Community Health Indicator. The map will re-center on the respective state and color-code the counties

within that state based on unit-based reporting. Health indicators, such as Birth Indicators (low birth weight, premature births, births to women under 18, etc.); Death Measures (homicide, lung cancer, stroke, etc.) or Health Risk Factors (obesity, smokers, high blood pressure, etc.) can be selected. Once the map is loaded with the respective counties shaded you can click on any county to get all of the factors listed under the Community Health Indicator list all in one popup for that county.

See: <http://www.bing.com/maps/explore/>

Community Health Status Indicators (CHSI)

The Community Health Status Indicators (CHSI) Project was initially launched in 2000 and archived in 2004 when the data became outdated. In 2006, the project was re-launched by a new partnership that included the Centers for Disease Control and Prevention (including NCHS and ATSDR), the National Institutes of Health/National Library of Medicine, the Health Resources Services Administration, the Public Health Foundation, the Association of State and Territorial Health Officials (ASTHO), National Association of County and City Health Officials (NACCHO), National Association of Local Boards of Health (NALBOH), and Johns Hopkins University School of Public Health.

The re-launch of CHSI includes 3,141 county health status profiles representing each county in the United States excluding territories. CHSI now includes updated data, select mapping capabilities of health indicators, and a website where the public can access and download the data and information. While some relatively minor modifications have been made to the reports, no new indicators were added.

The goal of CHSI is to provide an overview of key health indicators for local communities and to encourage dialogue about actions that can be taken to improve a community's health. The CHSI report was designed not only for public health professionals but also for members of the community who are interested in the health of their community. The CHSI report contains over 200 measures for each of the 3,141 United States counties. Although CHSI presents indicators like deaths due to heart disease and cancer, it is imperative to understand that behavioral factors such as tobacco use, diet, physical activity, alcohol and drug use, sexual behavior and others substantially contribute to these deaths (see chart).

In addition to the web pages, community profiles can be displayed on maps or downloaded in a brochure format. The CHSI mapping capability allows users to visually compare similar counties (termed peer counties) as well as adjacent counties with their county. The downloaded CHSI report allows broad dissemination of information to audiences that may not have access to the internet.

The CHSI report provides a tool for community advocates to see, react, and act upon creating a healthy community. The report can serve as a starting point for community assessment of needs, quantification of vulnerable populations, and measurement of preventable diseases, disabilities,

and deaths. The CHSI report is accompanied by a companion document entitled [Data Sources, Definitions, and Notes](#) (PDF - 433KB). This document gives detailed descriptions on data estimations, definitions, caveats, methodology, and sources.

See: <http://www.communityhealth.hhs.gov/>

Network of Care

Network of Care is a highly interactive, single information place where consumers, community-based organizations and municipal government workers all can go to easily access a wide variety of important information. The resources in this "virtual community" include a fast, comprehensive Service Directory; links to pertinent Web sites from across the nation; a comprehensive, easy-to-use Library; a political advocacy tool; community message boards; and many others.

Network of Care eLearning is an online education resource for government agencies as well as the general public. States and counties can manage their employee training and development process of both online and classroom courses, while the general public may access an extensive catalog of online courses.

See: <http://networkofcare.org/home.cfm>

Partners in Information Access for the Public Health Workforce

Partners in Information Access for the Public Health Workforce (Partners) is a collaboration of U.S. government agencies, public health organizations, and health sciences libraries which provides timely, convenient access to selected public health resources on the Internet.

The mission of Partners is to help the public health workforce find and use information effectively to improve and protect the public's health. The goals of the organization are as follows:

- Organize and deliver public health resources so they are easier to find and use.
- Identify and develop collaborative projects to meet the information needs of the public health workforce.
- Increase the visibility of the partnership with librarians and the public health workforce.
- Increase the information literacy of the public health workforce.
- Strengthen the collaboration among the Partners.

Project activities include: developing tools and other resources for the public health workforce in information access and management, grant writing, needs assessment, and training; sponsoring meetings, workshops, and satellite broadcasts geared toward improving content of and access to information needed by public health professionals and the information professionals who work

with them; developing distance learning materials and fostering partnerships for distance learning initiatives; providing ongoing information on funding opportunities and training available to public health professionals; exhibiting at national meetings of public health professionals; and funding projects to train and provide outreach to public health professionals. A list of the Partners can be found here: <http://www.nlm.nih.gov/nno/partners.html>

The Partners Web site provides links to information in 10 main categories:

Health Promotion and Health Education	Literature and Guidelines
Health Data Tools and Statistics	Grants and Funding
Education and Training	Legislation
Conferences and Meetings	Finding People
Discussion and E-mail Lists	Jobs and Careers

Partners also provides a list of National Public Health Data Sets. See:

http://phpartners.org/health_stats.html#National%20Public%20Health%20Data%20Sets

In addition, it provides public health topic pages and news as well as links to several Partners-supported initiatives such as the Healthy People 2010 Information Access Project, the Public Health Information and Data: Training Manual and online tutorial, and the Resource Guide for Public Health Preparedness.

See: <http://PHPartners.org>

Whole Measures

To help broaden the view of success and how it is measured, and to catalyze stronger collaborative efforts, Center for Whole Communities is developing Whole Measures – an ethically-based, community-oriented standard on why and for whom land is restored and conserved. Whole Measures offers a means of describing and measuring the healthy relationships between land and people. It offers the beginning foundations for a highly integrated, whole systems approach that effectively embraces a wide variety of practical issues including biodiversity, social equity, human rights, civic engagement and landscape-scale conservation.

Whole Measures is not intended to measure each and every aspect of a healthy, whole community. Nor does it presume that it will replace the measurement tools already being used by the many partners in a whole community building effort. Whole Measures does intend, however, to:

- Make it possible for organizations to be more intentional about their decisions and use of resources in ways that contribute to healthy, whole communities.
- Elevate and inform discussions – both within and across organizations – of the relationship between healthy lands, healthy people and healthy communities.
- Create the foundation for more effective collaborative relationships, based upon a shared vision of success and common measures.

- Improve understanding and provide language to describe the relationships between land, environment and people that are valued most and yet are difficult to measure adequately.
- Help organizations and communities answer the question, “In what ways – positive or negative – do we affect the creation of whole communities? How can we measure those effects?”
- Guide more intentional and strategic choices about the kind of land that is protected, and for whom.

Whole Measures – informed by a set of [guiding principles](#) – expresses a clear vision of [big picture values](#) that link environmental and social goals, and sets out a [collection of value-based practices](#) that conservation and community organizations need to adopt in order to reach those values. Its simple, practical evaluation process invites users into a conversation about vision, values and practice. It celebrates success as well as helping organizations to be more self-aware about unintended consequences. It helps us see and nurture the connections between cities and wilderness and between biological and cultural diversity.

In short, Whole Measures will help people and organizations working for positive community transformation to articulate a new story about the role of land in a just and fair society.

A [printable version of Whole Measures](#) as an Adobe PDF can be downloaded on the [Additional Resources page](#).

See: <http://www.measuresofhealth.net/index.shtml>

Example Community and Project Sites

This list is included as a reflective snapshot of many different tools, resources and examples of the intersection of health and data.

- Baltimore Neighborhood Indicators Alliance: www.ubalt.edu/bnia/about/index.html
- Boston Indicators Project: www.bostonindicators.org/Indicators2008
- HealthyKids GIS : <http://healthykidsgis.org/>
- Jacksonville Quality of Life Indicators: www.jcci.org
- Long Island Index: <http://longislandindex.org>
- Maryland Smart Growth Indicators: www.indicatorproject.com
- National Neighborhood Indicators Partnership (NNIP): www2.urban.org/nnip
- Open Indicators Consortium: <http://openindicators.org>
- Open Layers/A Map for Change: <http://openlayers.org/> or <http://civic.mit.edu/blog/alyssa/a-map-for-change>
- PolicyMap: <http://www.policymap.com/>
- Regional Equity Atlas: Metropolitan Portland's Geography of Opportunity: www.equityatlas.org/about.html
- Rhiza Labs & Pittsburgh 3RC: www.rhizalabs.com/solutions/3rc
- Sustainable Seattle: www.sustainableseattle.org & Be Sustainable Seattle: www.b-sustainable.org

