NLC University – Healthy Cities: Advancing City Health through Innovative Policies, Data and Partnerships Strategies

Speakers:

Julie Willems Van Dijk
Associate Scientist and Director - County Health Rankings & Roadmaps Program

Kathryn Pettit
Senior Research Associate in the Metropolitan Housing and Communities Policy Center - Urban Institute

John Chesser
Enterprise Management Analyst - Mecklenburg County; Charlotte, NC

Dr. Janet A. Phoenix
Assistant Research Professor - George Washington University
Milken Institute School of Public Health

Karen Seaver Hill
Director - Children’s Hospital Association
Mayors and city leaders play a pivotal role in the overall health and well-being of the cities and towns they serve. Across the county, city leaders are taking action to address the underlying factors that influence health and improve the environments where their residents live, learn, work and play. This seminar is designed to build capacity of city leaders to work across city agencies and engage multi-sector partners to adopt an integrated approach to governing that is data-driven and more comprehensively focuses on health. Additionally, participants will be exposed to partnership strategies that cities can leverage to support, finance and/or sustain their efforts to build healthier communities.

9:00 – 9:10 Welcome and Overview: What You Can Expect Today  
Sue Pechilio Polis, Director of Health & Wellness, National League of Cities’ Institute for Youth, Education, and Families (NLC)

9:10 – 9:15 Culture of Health Video: Missouri’s 24:1 Community  
More than half a decade ago, city leaders in Missouri rose above their individual municipal identities and city charters, embracing an “all-for-one” approach. Calling themselves “24:1,” they came together in the midst of the nationwide mortgage foreclosure crisis that threatened the health of individuals, families, neighborhoods, and entire communities. Today, the 24:1 municipalities strive to realize a unified vision: strong communities, engaged families, and successful children. (Note: Panelist Chris Krehmeyer is here to represent this initiative.)

9:15 – 10:00 Assessing Your City’s Health & Well-Being  
**Speaker/Facilitator:** Julie Willems Van Dijk, Associate Scientist and the Co-Director of the County Health Rankings and Roadmaps

Understanding the underlying factors that influence health is critical to planning city health improvement efforts. Working with a facilitator, participants will complete an assessment to better understand their city’s data as it relates to health outcomes and other related measures that indicate long-term health and well-being. This assessment will expose participants to tools that they can use to better identify health disparities within their cities.

10:00 – 10:30 Data-Driven Partnerships and Policymaking  
**Speaker/Moderator:** Kathryn Pettit, Senior Researcher and Director of National Neighborhood Indicators Partnership (NNIP), Urban Institute
How Local Level Data Initiatives are Informing City Policy & Practice: Participants will hear examples on how cities are using data to tailor and target initiatives in partnership with key sectors to improving health outcomes.

**Panelists:**
- John Chesser, Enterprise Management Analyst, Mecklenburg County Manager’s Office, Office of Management and Budget
- Laura McKieran, DrPH, Director, Community Information Now, San Antonio, TX

10:30—11:00  **Operationalizing Data to Improve Health Outcomes in Your Community**  
**Facilitator:** Kathryn Pettit

Based on the morning exercise, participants will consider how their assessment data applies and could further inform a current city effort or initiative. Additionally, participants will explore how cross-sector partnerships with the health system, public health, non-profits and county leaders can strengthen their efforts. Participants will work together at their tables to co-inform their findings and exchange ideas.

**Table Facilitators:** Kathy Pettit, John Chesser, Laura McKieran, Julie Willems Van Dijk

**Table Topics:** City-County Connections; Non-Profit Organizations; Health System Partnerships; Public Health Partnerships

11:00-11:10  **BREAK**

11:10 – 11:55  **Innovative Approaches to Partnership Efforts that Improve Resident Health & Well-Being**  
**Moderator:** Katie Horton, RN, MPH, JD, Research Professor, Department of Health Policy & Management, George Washington University (GWU)

A key element of successful and sustainable efforts and initiatives is ensuring robust partnerships. In this portion of our session, participants will get acquainted with how they can think about augmenting their existing efforts by better engaging health and health system and community development stakeholders.

**Panelists:**
- Janet Phoenix, MD, MPH, Manager, Asthma and Health Education Services, BreatheDC
- Chris Krehmeyer, President/CEO, Beyond Housing
- Karen Seaver Hill, Director, Community and Child Health, Children’s Hospital Association

11:55 – 12:00  **Closing & Next Steps:**  
Alyia Gaskins, Senior Associate, National League of Cities’ Institute for Youth, Education, and Families (NLC)
**Vision Statement**

Explain your product in one phrase or sentence.

By establishing and supporting a culture of data-driven action, we will improve the quality of life for people in our region.

<table>
<thead>
<tr>
<th>Target Group</th>
<th>Needs</th>
<th>Product</th>
<th>Value</th>
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</thead>
</table>
| Citizen leaders and other members of the general public | Wide access to relevant, quality and unbiased, timely data, sustainably provided  
- Connected across sectors  
- With common data definitions and standards  
- Visualized and communicated effectively  
- With transparency of data source, limitations, and how it has been transformed or analyzed  
- With appropriate protections and permissions | Central repository of shared public data available online freely and publicly  
Central access point for shared protected data available as appropriate  
Platform for sharing analysis and presentations with internal and external colleagues | Inform decisions about resource allocation and implementation strategies  
Monitor program and policy implementation and outcomes  
Improve the effectiveness and efficiency of policies and programs  
Improve the efficiency of working with data  
Enable coordination and collaboration so that:  
- all parties can access the same data at the same time  
- organizations and unaffiliated individuals can collaborate across disciplines  
Analyze risk and identify opportunities  
Encourage mutual accountability through the transparent use of data for decision making and action |
| Public and private sector policy and decision makers and their advisors  
Other data consumers and communicators, including PR, communications, and advocacy  
Researchers and analysts | Target groups understand and value the use of data for decision making.  
Analysis services and tools for users without analysis capacity or interest  
Training and technical assistance (e.g., coaching and consultation) to help target groups understand and use data and analysis effectively  
Infrastructure and process for ongoing local data capacity building | Data analysis services provided directly and/or via facilitated connections with researchers/analysts  
Training, coaching, and consultation for target groups on understanding, using, and valuing data, including building internal capacity and strategy for data-driven decision making | |

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Communicate, Participate, Shape, Drive... Get Involved!

The Alamo Regional Data Alliance is a community-based initiative to build a vibrant network of local data analysts, data users, and data consumers.

The Data Alliance believes that by establishing and supporting a culture of data-driven action, we will improve the quality of life for people in our region. This is our vision.

To realize our vision, we need everyone to... Get Involved!

Click on the chart to learn more about each opportunity and who we are.

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**SHAPE**
*Let Us Know Your Ideas*
- Have an idea? [Add an item to our “to-do list” by submitting a user story to our backlog](#)
- [Host or attend a demonstration of work just completed](#)

**PARTICIPATE**
*Join In the Effort*
- Attend planning meetings and events
- Give us feedback by submitting a comment online

**DRIVE**
*Commit to Leading*
- Apply to be a Steering Committee member
- Join a technical or non-technical workgroup
- Join other groups and committees

**COMMUNICATE**
*Stay Updated & Let Others Know What We Are Doing*
- [Sign-up for the newsletter](#)
- Host or attend a presentation about the Data Alliance

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**Alamo Regional Data Alliance**

- **CI:Now** (staffing entity)
  - Agile Process

- **Steering Committee**
  - Non-Technical Workgroups
  - Technical Workgroups
  - Other Groups/Committees
Who we are

CI:Now provides tools to turn data into information that Texas communities can use to improve our common well-being. We find, collect, link and analyze, and visually communicate the data that our neighbors need to improve neighborhood and regional conditions. We work to expand people’s access to data that is understandable, trustworthy, neutral, and timely.

CI:Now serves Bexar (San Antonio) and 11 surrounding counties (Atascosa, Bandera, Comal, Frio, Gillespie, Guadalupe, Karnes, Kendall, Kerr, Medina, and Wilson) in south-central Texas, near the U.S.-Mexico border. While covering the full 12-county area with county- and zip-code level data, CI:Now works to make small-area (e.g., block group or parcel-level) data accessible wherever those data are available.

CI:Now supports both general and focused community information needs. On one track, CI:Now gathers, processes, and engages the broader community around data and stories of perennial and general interest, such as poverty and child immunization rates. On a parallel track, CI:Now responds to the specific information needs of targeted change-oriented initiatives or topical focus areas.

CI:Now, formerly called the Alamo Area Community Information System (AACIS), has by design been unincorporated to ensure broad community ownership. The United Way of San Antonio and Bexar County has served as fiscal agent since CI:Now’s founding in the late 1990s. All staffing is by partnership and contract with the San Antonio Regional Campus of the University of Texas School of Public Health, our physical and institutional “home” since 2008. Learn more about our governance and staffing at http://www.CINow.info/governance-and-staff/.

In 2010 CI:Now became the 35th local partner in the National Neighborhood Indicators Partnership (NNIP). Staffed by The Urban Institute, NNIP is working to democratize information, promoting the use of neighborhood-level information to create better policy and build stronger communities. Check out CI:Now’s NNIP Partner Profile at http://www.neighborhoodindicators.org/partner/139.
How we can help

CI:Now is a local data intermediary that provides several different kinds of data support to organizations and collaboratives in Bexar and 11 surrounding counties. We work across all issue areas, with particular expertise in health, education, and demographics, and we look at all geographic levels from region all the way down to parcel. Here are a few of the ways we can support your use of data to improve the well-being of communities, neighborhoods, families, and individuals:

- Collection and analysis of secondary/existing data to assist in neighborhood and community planning or change monitoring
- Integration of administrative datasets to link the records of individuals or households across service sectors
- Data visualization through maps, charts, scatterplots, and other formats
- Evaluation of intervention effects on community-wide systems
- Development of automated dashboards or other data visualizations
- Assisting many different audiences in understanding and using data
- Consultation on the development of outcomes/results and indicators and selection of data sources

You can find more information about our current partnerships and projects by visiting http://cinow.info/current-work/. Here are some of the projects we’re working on right now:

- Data to support EastPoint PaCT neighborhood transformation
- The CommunityViewer integrated data system that links records across human service agencies and systems
- Hyperlocal data for the Bexar County community health needs assessment
- Measuring integrated care outcomes for safety net “high utilizers” who are living with serious mental illness
- Evaluating interventions to prevent hospital readmission
- SA2020 Community Dashboard and Children’s Issue Council Dashboard
- Mapping kinder-readiness

Please feel free to email us at CINow@CINow.info to tell us about your needs. We’re happy to let you know whether and how we can help. And please visit http://cinow.info/newsletter-signup/ to sign up for our newsletter!

You’re doing the hard work of changing our community for the better.

How can we help you?
USING THE RANKINGS DATA

The Using the Rankings Tool (http://www.countyhealthrankings.org/using-the-rankings-data) helps you navigate the information in your county’s snapshot and identify key areas where you may wish to look for additional data. It also directs you to additional national and state data sources.

Directions
• Find your county’s snapshot at www.countyhealthrankings.org.¹
• Use your snapshot and the Using the Rankings Tool to review your county’s data.
• Record your notes and additional questions here.

EXPLORING THE DATA

We provide a variety of ways of exploring, comparing, and visualizing the Rankings and all of the underlying data. Take a moment to get acquainted with the types of data included in your snapshot. We’ve included short descriptions here, but you can read more detail in the Exploring the Data section of Using the Rankings Data.

• Trends: We’ve included trend graphs for 12 measures (click on the graph in the Trend column of your county’s snapshot). Most of the charts are based on multiple-year rolling averages for the county, state and nation. The color on the line in the icon shows the direction of the measures in your county.
• Top U.S. Performers: This is the point at which only 10% of counties in the nation do better. (It is NOT the U.S. average.)
• Error Margins: Each measure has a confidence interval or error margin surrounding it—if a measure is above the state average AND the state average is beyond the error margin for your county, then further investigation is recommended. Likewise, if a measure is below the state average AND the state average is below the error margin for your county, this is a measure of strength in your community.
• Data and Measures: If you click on a measure’s name in a county snapshot, you can see more information about that measure.
• Areas to Explore: Highlight potential challenges your community may want to examine more closely.
• Compare Counties: You can compare ranks and measures for multiple counties within a state.

¹ To find your snapshot, go to www.countyhealthrankings.org and select your state and then your county. You will see the county’s “data snapshot.”
MAKING USE OF YOUR SNAPSHOT

Health Outcomes

How does your county rank?

How do these measures compare to state averages?  
To Top U.S. Performers?

<table>
<thead>
<tr>
<th>Measure</th>
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<tbody>
<tr>
<td>Premature Death</td>
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<tr>
<td>Poor or fair health</td>
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<tr>
<td>Poor physical health days</td>
</tr>
<tr>
<td>Poor mental health days</td>
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<tr>
<td>Low birthweight</td>
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</tbody>
</table>

Where is your county doing well?  
How might this differ for your city?

Where might your county need to improve?  
How might this differ for your city?

Health Factors

Explore each of the four health factors. Begin with looking at the overall rank of this health factor and then look at specific measures.  How do these measures compare to state averages?  To Top U.S. Performers?

Health Factor 1:  Social and Economic Factors (40% weight)

How does your county rank in this health factor? __________

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<thead>
<tr>
<th>Measure</th>
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<td>Measure 1:</td>
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<td>Measure 2:</td>
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<td>Measure 3:</td>
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<td>Measure 4:</td>
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<td>Measure 5:</td>
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<td>Measure 6:</td>
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</table>
Health Factor 2: Health Behaviors (30% weight)

How does your county rank in this health factor? __________

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<tr>
<th>Measure 1:</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Measure 2:</td>
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<td>Measure 3:</td>
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<td>Measure 4:</td>
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<td>Measure 5:</td>
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<td>Measure 6:</td>
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Note: Some health factors have fewer than six measures, so you may not need to fill in all measures spaces.

Where is your county doing well? How might this differ for your city?

Where might your county need to improve? How might this differ for your city?

Turn on the Areas to Explore. How do the highlighted measures compare with your findings?
DIGGING DEEPER

What other information would help you further understand health in your community?

What other groups might you categorize data by? What measures are available for those groups?

BROADEN YOUR VIEW

Consider what you learned from your county’s snapshot. What other questions might you want to ask to better understand your community’s health factors?

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<tr>
<th>Health Behaviors</th>
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<th>Clinical Care</th>
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<table>
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<tr>
<th>Social &amp; Economic Factors</th>
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<tr>
<th>Physical Environment</th>
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VISUALIZE THE DATA

Explore one mapping tool that relates to your county’s data. What did you find?

FINDING MORE DATA

Where might you start to find more data? Which state or national data sources might be most helpful?

<table>
<thead>
<tr>
<th>National Data Sources</th>
<th>State Data Sources</th>
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</table>

What data might you need to collect locally? (e.g., via surveys, interviews, etc.)
Congressional City Conference

Healthy Cities:
Advancing City Health through Innovative Policies, Data and Partnership Strategies

March 11, 2017
Washington, DC
National League of Cities University Training Seminar

#NLCDC
Welcome and Overview: What You Can Expect Today

Sue Polis, Director, Health & Wellness, National League of Cities (NLC)
NLC: Advancing a Culture of Health in Cities...
Healthy Cities: Advancing Health through Innovative Policies, Data and Partnerships Strategies

WASHINGTON, D.C.
Short Distances to Large Gaps in Health

- 84 yrs
  Montgomery County
- 78 yrs
  District of Columbia
- 86 yrs
  Fairfax County
- 86 yrs
  Arlington County
- 78 yrs
  Prince George's County

Life expectancy at birth (years)
- Shorter
- Longer

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Healthy Cities: Advancing Health through Innovative Policies, Data and Partnerships Strategies

Framing Question: Collaboration is key to advancing a Culture of Health – through cross-sector partnerships and working across city agencies. What factors are critical to the success of fostering strong, collaborative relationships?
RWJF Culture of Health Prize Winner

Missouri’s 24:1 Community Comes Together for Health: A Deeper Look
Today’s Outline

What do we mean by health and well-being?

Why is assessment important?

What tools are available through County Health Rankings & Roadmaps that could be helpful to my city?

Let’s dig in and practice!!
www.countyhealthrankings.org
Health Equity

Health equity means creating a vibrant community where all people, especially those most affected by poor health outcomes, are heard and have the power to create and implement solutions.
Work Together

Evaluate Actions

Assess Needs & Resources

Act on What's Important

Focus on What's Important

Choose Effective Policies & Programs

Communicate

Community Members

Public Health

Business

Educators

Philanthropy & Investors

Nonprofits

Community Development

Government

Healthcare
Action Center

Each step on the Action Cycle is a critical piece of making communities healthier. There is a guide for each step that describes key activities within each step and provides suggested tools, resources, and additional reading. You can start at Assess or enter the cycle at any step. Work Together and Communicate sit outside because they are needed throughout the Cycle. At the core of the Action Cycle are people from all walks of life because we know we can make our communities healthier if we all get involved.

Roadmaps to Health Coaching is available to provide local leaders with direct support in using Action Center tools and guidance to advance health.

Select an Action Step or community member to learn more.
What Works for Health

Find effective programs and policies at [www.countyhealthrankings.org/what-works-for-health](www.countyhealthrankings.org/what-works-for-health)
Community land trusts (CLTs) are private, non-profit organizations that purchase land to lease to low and middle income residents for housing use. CLTs separate ownership of the home and the land it occupies; the land is leased to homeowners as part of a long-term ground lease, typically for 99 years (Skobba 2014). Homeowners on CLT-owned land are required to sell the home back to the CLT or to another low income resident at an affordable price (NCLTN). CLTs may also purchase and hold land to support community development, open space efforts, community gardens, and similar initiatives (Miller 2013a, Lowe 2015). CLTs often include stewardship activities such as teaching expectant and new homeowners about finances, alerting them to high risk loans, and assisting potentially delinquent homeowners (Thaden 2010).

**Expected Beneficial Outcomes (Rated)**

- Increased housing stability

**Other Potential Beneficial Outcomes**

- Increased access to affordable housing
- Improved neighborhood quality

**Evidence of Effectiveness**

There is some evidence that community land trusts (CLTs) decrease rates of foreclosure and payment delinquency for CLT homeowners, increasing housing stability (Thaden 2011, Temkin 2011, Thaden 2010). CLTs are a suggested strategy to minimize the displacement of low income residents that can follow neighborhood improvements such as new affordable housing options (Damewood 2011). Additional evidence is needed to confirm effects.
Community policing

**Evidence Rating**

Scientifically Supported

**Health Factors**

Community Safety

**Decision Makers**

Government
Community Members
Non-Profit Leader

**Community in Action**

Police and community members work together in Everett, MA

Community policing is a policing philosophy based on community partnership, organizational transformation, and problem solving techniques. This approach requires partnerships between local law enforcement and community members to proactively address immediate public safety issues. Law enforcement uses a team approach rather than special units and officers have long-term assignments to specific geographic areas (US DOJ-COPS 2014). Community policing includes various types of interventions such as neighborhood newsletters, bike and foot patrols, police-sponsored recreational activities, beat policing, and neighborhood watches set up with police assistance (CEBCP).

**Expected Beneficial Outcomes (Rated)**

- Increased satisfaction with law enforcement

**Other Potential Beneficial Outcomes**

- Improved neighborhood safety
- Reduced crime
- Increased problem solving skills

**Evidence of Effectiveness**

There is strong evidence that community policing increases residents’ satisfaction with police (Campbell-Mazerolle 2013, Gill 2014). However, additional research is needed to confirm effects on other outcomes, especially crime rates (Campbell-Mazerolle 2013, Gill 2014, Braga 2015).
Streetscape design

Streetscape design improvements (e.g., Complete Streets) accommodate the needs of all users and enable pedestrians, bicyclists, transit riders, and motorists to share and use the street. Improvements to streetscape design can include increased street lighting, enhanced street landscaping, increased sidewalk coverage and connectivity of pedestrian walkways, bicycling infrastructure, street crossing safety features, and traffic calming measures. Streetscape design improvement projects typically include elements from more than one of these categories; these projects can be implemented incrementally or comprehensively (SGA-Complete streets).

Expected Beneficial Outcomes (Rated)

- Increased physical activity
- Increased pedestrian and cyclist safety

Other Potential Beneficial Outcomes

- Increased active transportation
- Reduced obesity rates
- Improved sense of community
- Improved neighborhood safety
- Reduced stress
- Reduced vehicle miles traveled
Using the Rankings Data

The County Health Rankings provide a snapshot of a community’s health and a starting point for investigating and discussing ways to improve health. This guide will help you find and understand the data in this site and beyond as you begin to assess your needs and resources and focus on what’s important. The guide includes seven sections:

- Communities Using the Rankings Data -- introduces the many ways communities are using the Rankings.
- Exploring the Data -- helps you get the most out of the Rankings and the wealth of underlying data.
- Making Use of Your Snapshot -- helps you navigate the information in your county’s snapshot and identify key areas where you may wish to look for additional data.
- Digging Deeper -- helps you think through what other information would help you further understand the health of your community.
- Broaden Your View -- helps you widen your focus beyond the specific measures included in the Rankings.
- Visualize the Data -- provides links to resources to help you visualize where the assets and weaknesses are in your community.
- Finding More Data -- directs you to additional national and state data sources.

Learn more about data in this site and beyond at www.countyhealthrankings.org/using-the-rankings-data
Find out how healthy your county is and explore factors that drive your health.
### Lauderdale (LU)

#### County Demographics

<table>
<thead>
<tr>
<th>Rank</th>
<th>County</th>
<th>Lauderdale County</th>
<th>Trend</th>
<th>Error Margin</th>
<th>Top U.S. Performers</th>
<th>Alabama</th>
<th>Rank (of 67)</th>
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<tbody>
<tr>
<td>12</td>
<td>Lauderdale (LU)</td>
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</tbody>
</table>

#### Health Outcomes

**Length of Life**
- Premature death: 8,900, 8,200-9,600, 5,200, 9,500

**Quality of Life**
- Poor or fair health: 19%
- Poor physical health days: 4.5, 4.3-4.6, 2.9, 4.6
- Poor mental health days: 4.6, 4.4-4.7, 2.8, 4.7
- Low birthweight: 10%, 9-11%, 6%, 10%
## Lauderdale (LU)

### County Demographics

<table>
<thead>
<tr>
<th></th>
<th>County</th>
<th>State</th>
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<tbody>
<tr>
<td>Population</td>
<td>93,096</td>
<td>4,849,377</td>
</tr>
<tr>
<td>% below 18 years of age</td>
<td>20.5%</td>
<td>22.8%</td>
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<tr>
<td>% 65 and older</td>
<td>18.2%</td>
<td>15.3%</td>
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<tr>
<td>% Non-Hispanic African American</td>
<td>10.3%</td>
<td>26.4%</td>
</tr>
<tr>
<td>% American Indian and Alaskan Native</td>
<td>0.5%</td>
<td>0.7%</td>
</tr>
<tr>
<td>% Asian</td>
<td>0.9%</td>
<td>1.3%</td>
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<tr>
<td>% Native Hawaiian/Other Pacific Islander</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>% Hispanic</td>
<td>2.4%</td>
<td>4.1%</td>
</tr>
<tr>
<td>% Non-Hispanic white</td>
<td>84.7%</td>
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<tr>
<td>% not proficient in English</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>% Females</td>
<td>52.1%</td>
<td>51.5%</td>
</tr>
<tr>
<td>% Rural</td>
<td>49.3%</td>
<td>41.0%</td>
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</table>
**Lauderdale (LU)**

**County Demographics**

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<th>Rank</th>
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</tr>
<tr>
<td>6</td>
<td>Coffee (CF)</td>
<td></td>
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</tr>
<tr>
<td>7</td>
<td>Limestone (Li)</td>
<td></td>
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</tr>
<tr>
<td>8</td>
<td>Blount (BL)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>9</td>
<td>Dale (DA)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>10</td>
<td>Autauga (AU)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>11</td>
<td>Houston (HO)</td>
<td></td>
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</tr>
</tbody>
</table>

**Health Outcomes**

**Length of Life**

- Premature death: 8,900
- Top U.S. Performers: 8,200-9,600
- Alabama: 5,200
- Rank: 12

**Quality of Life**

- Poor or fair health: 19%
- Poor physical health days: 4.5
- Poor mental health days: 4.6
- Low birthweight: 10%

**Additional Health Outcomes**

- (not included in overall ranking)
### Health Factors

<table>
<thead>
<tr>
<th>Health Behaviors</th>
<th>Lauderdale County</th>
<th>Trend</th>
<th>Error Margin</th>
<th>Top U.S. Performers</th>
<th>Alabama</th>
<th>Rank (of 67)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult smoking</td>
<td>19%</td>
<td>18-20%</td>
<td>14%</td>
<td>21%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult obesity</td>
<td>32%</td>
<td>28-36%</td>
<td>25%</td>
<td>34%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food environment index</td>
<td>7.2</td>
<td></td>
<td>8.3</td>
<td>6.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical inactivity</td>
<td>30%</td>
<td>26-33%</td>
<td>20%</td>
<td>29%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to exercise opportunities</td>
<td>63%</td>
<td>91%</td>
<td>63%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive drinking</td>
<td>14%</td>
<td>13-14%</td>
<td>12%</td>
<td>13%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol-Impaired driving deaths</td>
<td>28%</td>
<td>22-34%</td>
<td>14%</td>
<td>30%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexually transmitted Infections</td>
<td>382.5</td>
<td>134.1</td>
<td>611.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teen births</td>
<td>32</td>
<td>30-34</td>
<td>19</td>
<td>44</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Additional Health Behaviors (not included in overall ranking)

### Clinical Care

<table>
<thead>
<tr>
<th>Clinical Care</th>
<th>Lauderdale County</th>
<th>Trend</th>
<th>Error Margin</th>
<th>Top U.S. Performers</th>
<th>Alabama</th>
<th>Rank (of 67)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
<td>15%</td>
<td>13-17%</td>
<td>11%</td>
<td>16%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care physicians</td>
<td>2,020:1</td>
<td></td>
<td>1,040:1</td>
<td>1,570:1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentists</td>
<td>2,070:1</td>
<td></td>
<td>1,340:1</td>
<td>2,200:1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health providers</td>
<td>820:1</td>
<td></td>
<td>370:1</td>
<td>1,200:1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventable hospital stays</td>
<td>61</td>
<td>57-65</td>
<td>38</td>
<td>65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic monitoring</td>
<td>87%</td>
<td>83-91%</td>
<td>90%</td>
<td>85%</td>
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</tr>
</tbody>
</table>
The 500 Cities project is a collaboration between CDC, the Robert Wood Johnson Foundation, and the CDC Foundation. The purpose of the 500 Cities Project is to provide city- and census tract-level small area estimates for chronic disease risk factors, health outcomes, and clinical preventive service use for the largest 500 cities in the United States. These small area estimates will allow cities and local health departments to better understand the burden and geographic distribution of health-related variables in their jurisdictions, and assist them in planning public health interventions. Learn more about the 500 Cities Project.
Questions?

Contact us!

Julie Willems Van Dijk
Director
County Health Rankings & Roadmaps
match-info@match.wisc.edu
608-265-8240
@CHRankings

Please fill out this session’s evaluation on the NLC Events app!
Mini Assessment:
Informing Efforts
Back Home
Why invest in neighborhood data?

- Understand the variation among your neighborhoods
- Identify the right strategies for the right places
- Uncover the connections between health and crime, housing, education, etc.
- Catalyze and guide cross-sector partnerships
Getting started

• Start with low-hanging fruit
• Identify available tools and expertise to help with collection, analysis, visualization
• Listen to those on the ground to validate the findings and place them in context
• Raise your expectations for good data - work on gaps and long-term capacity
Congressional City Conference

Community Information Now
Local data that’s trustworthy, neutral, and timely

March 11, 2017
Washington, DC
Laura McKieran, DrPH
Executive Director
Community Information Now

#NLCDC
How we help local public and private organizations and collaboratives

Assess and monitor community conditions

Open up access to timely, relevant, neutral data

Assist in understanding and using data

Consult on the development of outcomes/results and indicators and selection of data sources

Build capacity to use data to improve quality of life
Questions?

Please fill out this session’s evaluation on the NLC Events app!

Contact us!

Laura McKieran
Executive Director
CI:Now
Laura.C.McKieran@uth.tmc.edu
@CINow
Data-Driven Partnerships and Policymaking: Quality of Life Explorer
City of Charlotte
Mecklenburg County
UNC Charlotte

March 11, 2017
Washington, DC
John Chesser
Enterprise Management Analyst
Mecklenburg County, NC
A neighborhood indicator project that covers all of Charlotte and Mecklenburg County

The Quality of Life Explorer is an interactive online tool to help neighborhoods, government leaders and staff, businesses, community organizations, new residents and others learn more about our county and the diverse neighborhoods within it.

The Explorer features over 80 variables in 9 dimensions that reflect you, the places you live and work, and collectively, our community. Check out the Explorer online to learn more about what’s happening, see trends over time, and connect to resources to take action on the issues that matter to you.

Get Started! [mcmap.org/qol]
Quality of Life Timeline

1992 – Project begun

- Focus on distressed neighborhoods within central Charlotte
  - Impact of funding / where resources should be allocated

Soon joined by UNC Charlotte

- Data collaborator
  - Published biannual reports
  - Expanded to all of Charlotte
Quality of Life Timeline

2012 – Mecklenburg County and other municipalities joined the project

- Realigned neighborhoods
  - Added more variables

Created an online dashboard

- City, County and towns contribute local data
- University compiles local data and adds national datasets / align all data to neighborhood geography
- County created and hosts dashboard
Quality of Life Timeline

2012 – Mecklenburg County and other municipalities joined the project

- Realigned neighborhoods
  - Added more variables

Created an online dashboard

- City, County and towns contribute local data
- University compiles local data and adds national datasets / align all data to neighborhood geography
- County created and hosts dashboard
Resource

Now, it is possible to better:

- Understand the community
- Analyze the differences within the area
- Target areas by need
- See the relationships between all these variables
  - All with detailed explanations of the data that gives both technical and non-technical users a better understanding of the data’s importance
Data for Community Vision

Quality of Live ⇔ Livable Meck

- Livable Meck, a community visioning and planning project is using Quality of Life for many of the measures for baseline and trend data.
Join our collaboration

Development version is open source

- Available on Github
  - Go to: https://github.com/tobinbradley/Mecklenburg-County-Quality-of-Life-Dashboard
Questions?

Please fill out this session’s evaluation on the NLC Events app!

Contact us!

John Chesser
Enterprise Management Analyst,
Mecklenburg County Manager’s Office
John.Chesser@mecklenburgcountync.gov
Panel: Data-Driven Partnerships and Policymaking

Kathryn Pettit, Senior Researcher and Director, National Neighborhood Indicators Partnership (NNIP)

Laura McKieran, DrPH, Director, Community Information Now (CI:Now)

John Chesser, Enterprise Management Analyst, Mecklenburg County Manager’s Office, Office of Management and Budget
**Table Facilitations: Operationalizing Data to Improve Health Outcomes in Your Community**

Based on the issues you identified in the previous session, please consider the following questions:

A) Is your city already collecting data to support this issue(s)?
B) If so, what are the source(s)? Who’s collecting it?
C) How would data from hospitals, public health, or other county or nonprofit agencies augment your current efforts?
D) Who else needs to be at the table?
10 Minute Break

We Will Resume at 11:10 AM
Panel: Innovative Approaches to Partnership Efforts that Improve Resident Health & Well-Being

Katie Horton, RN, MPH, JD, Research Professor, George Washington University (GWU)

Chris Krehmeyer, President/CEO, Beyond Housing

Janet Phoenix, MD, MPH, Manager, Asthma and Health Education Services, BreatheDC

Karen Seaver Hill, Director, Community and Child Health, Children’s Hospital Association
Closing Remarks and Next Steps

Alyia Gaskins, Senior Associate, Health & Wellness, National League of Cities (NLC)
NLC Contact Information

SUE PECHILO POLIS  
**Director, Health & Wellness**  
polis@nlc.org

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**Senior Associate, Health & Wellness**  
gaskins@nlc.org

NICK WALLACE  
**Associate, Health & Wellness**  
nwallace@nlc.org

*To learn more about our work, check out*  
http://www.nlc.org/culture-of-health

*Please fill out this session’s evaluation on the NLC Events app!*
Key Take-Aways
NLC University – Healthy Cities: Advancing City Health through Innovative Policies, Data and Partnerships Strategies

March 11, 2017
9:00 a.m. – 12:00 noon

Presenters: Sue Pechilio Polis, Julie Willems Van Dijk, Kathryn Pettit, John Chesser, Laura McKieran, Katie Horton, Janet Phoenix, Chris Krehmeyer, Karen Seaver Hill, Alyia Gaskins

• Assessing Your City’s Health & Well-Being

Working with a facilitator, participants will complete an assessment to better understand their city’s data as it relates to health outcomes and other related measures that indicate long-term health and well-being. This assessment will expose participants to tools that they can use to better identify health disparities within their cities, including County Health Rankings and Roadmaps.

• Data-Driven Partnerships and Policymaking

Participants will hear examples on how cities are using data to tailor and target initiatives in partnership with key sectors to improving health outcomes.

• Innovative Approaches to Partnership Efforts that Improve Resident Health & Well-Being

A key element of successful and sustainable efforts and initiatives is ensuring robust partnerships. Participants will get acquainted with how they can augment existing efforts by better engaging health, health systems, and community development stakeholders.