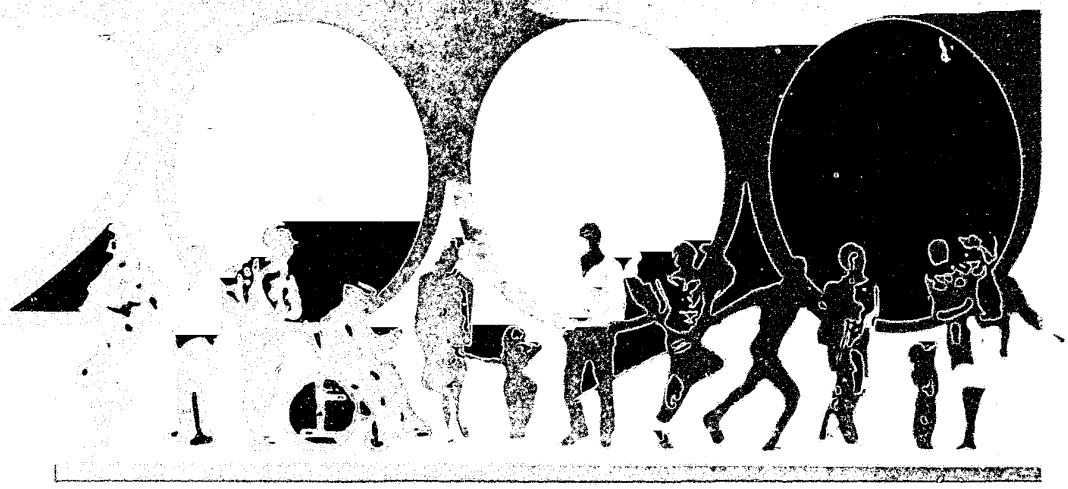
# HEALTHY PEOPLE





# *State Action*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

Dear Colleague:

I am pleased to present the *Healthy People 2000 Action Series* for your use and information. During the year and a half since release of *Healthy People 2000*, the one question I am asked most frequently is "what exactly are you doing to achieve the national objectives?" The *Action Series* is the beginning of an answer to that question. It describes the breadth of current action to achieve the Nation's health goals and objectives for the year 2000.

The Public Health Service is committed to achieving the three overarching goals and 300 specific objectives of *Healthy People 2000*. The three year, nationwide process used to set the goals and objectives determined what we needed to accomplish in the decade of the 1990s. We have accepted that challenge. Our task now is to determine how to achieve these national goals, then to achieve them.

The *Action Series* is the second step in the process, in that it is a critical resource for determining how to achieve goals and objectives. The Series lays out a baseline of current actions to accomplish the objectives being taken by the Public Health Service, the States, and national membership organizations of the Healthy People 2000 Consortium.

An impressive array of activities is described in the Series. *Public Health Service Action* describes nearly a thousand activities, ranging from low-cost information services to one hundred million dollar health services programs. *State Action* contains profiles from all 50 States and the District of Columbia, describing their objectives-related actions, their plans for achieving their objectives, and noting who has been involved in their efforts. *Consortium Action* describes some of the private sector actions that support our national health goals and objectives.

Nonetheless, the Series is not intended merely to impress. It is an information resource, connecting people who need to know what is going on to the people who can tell them. It is a baseline against which we can measure our efforts to expand activities. Finally, it is an integral element of strategic planning for the Public Health Service. We will use the Series to determine gaps, untapped opportunities, and unnecessary overlap and use this information to adjust our plans for achieving the objectives.

I commend the Series to you. I am counting on you to use this wealth of information to contribute to efforts to achieve *Healthy People 2000*.

Sincerely yours,

James O. Mason

James O. Mason, M.D., Dr.P.H.
Assistant Secretary for Health

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# HEALTHY PEOPLE 2000

# *State Action*



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Public Health Service

## Acknowledgements

The *Healthy People 2000 Action Series* was made possible through the work and dedication of a number of people. Preparation of the Series was sponsored by the U.S. Public Health Service (PHS) and coordinated by the Deputy Assistant Secretary for Health (Disease Prevention and Health Promotion). Development of the Series was facilitated by the PHS Healthy People 2000 Steering Committee, the Healthy People 2000 Consortium, and the coordinators and members of the 22 PHS Healthy People 2000 priority area work groups. Principal staff and editorial responsibilities were carried out by James A. Harrell, Ashley Files, Katherine Julian, and David Baker. Other staff from the Office of Disease Prevention and Health Promotion who helped develop and produce the Series were Delores Flenoury, Diane Rittenhouse, Annette Vangele, and Sandra Wong. *State Action* was produced under a contract from the U.S. Public Health Service to the Public Health Foundation. The Assistant Secretary for Health's Office of Health Planning and Evaluation supervised the contract, Paul Johnson served as Project Officer, and Valerie Welsh provided additional review.

# Foreword

In 1980, publication of *Promoting Health/Preventing Disease: Objectives for the Nation*, established for the first time, measurable objectives for preventing disease and improving the health status of the U.S. population. This ground-breaking report also encouraged States to set their own objectives to meet statewide health needs and those of specific population groups. As the 1980s progressed, States increasingly embraced the concept of establishing clear health objectives to guide health agency planning and to mobilize public and professional commitment to improving health status.

The release of *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* in 1990 provided the impetus for States to advance their objective-setting efforts into the next decade. Today, most States have at least begun the process of establishing their own State health objectives for the year 2000 and some have completed the task. This report presents a comprehensive overview of States' initial efforts to establish state-specific health objectives. We hope that *State Action* will stimulate continued activity at the State level and provide the framework for future action.

We are indebted to the many State health department officials who voluntarily provided data for this report and who continue to make health promotion and disease prevention the cornerstone of their work.

We invite comments on this report. Please address communications to the Public Health Foundation, 1220 L Street NW., Washington, DC 20005.

George Degnon
Executive Vice President
Association of State and Territorial Health Officials

James T. Dimas
Executive Director
Public Health Foundation

# Contents

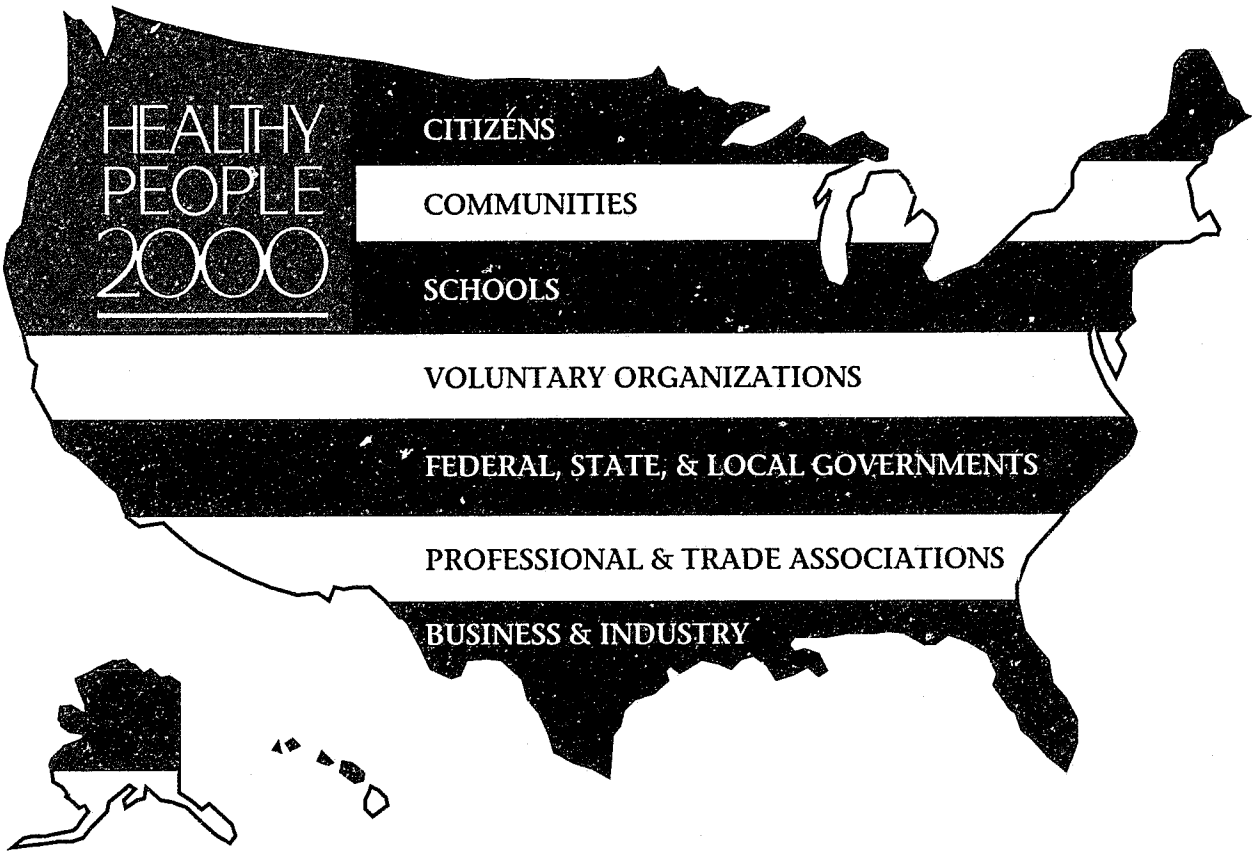
## Part II
## State Profiles—*Continued*



## Tables

# Part I

# Introduction




# *Meeting the Healthy People 2000 Challenge*

# Introduction

In September 1990, the Public Health Service (PHS) issued *Healthy People 2000: National Health Promotion and Disease Prevention Objectives,* a national strategy for significantly improving the health of the Nation by the year 2000. The objectives were developed over a three-year period, during which PHS solicited input from hundreds of people in the public, private, and voluntary sectors. PHS made a concerted effort to involve a broad spectrum of organizations and individuals in the process to help ensure their participation in the national effort to achieve the objectives.

State health agency input was essential in the development of the *Healthy People 2000* objectives (see Appendix). In fact, the inaugural public hearing in the objective-setting process was held in conjunction with the 1987 annual meeting of the Association of State and Territorial Health Officials, during which State health officers commented on the proposed process. Based on their experience in developing the 1990 prevention objectives, the State health officers strongly recommended that individuals from all sectors be encouraged to take "ownership" of the objectives. They stated that resources from all levels of government, as well as from the private sector, were needed to achieve the objectives. The State health officers also emphasized the importance of being able to measure progress toward achieving the objectives.

State involvement, however, was not intended to be limited to participation in the national hearings. Instead, PHS officials stressed that achieving the year 2000 objectives depended upon the commitment of every State and local health department.[1] Indeed, during the 1980s States exhibited an increasing acceptance of the 1990 National Health Objectives. The Intergovernmental Health Policy Project at George Washington University reported that, as of 1985, eighteen States had developed their own objectives and many had placed new emphasis on health promotion and disease prevention in programs and legislation.[2] By 1988, the Public Health Foundation reported that forty-six of the fifty-six States and Territories had developed objectives and eight additional States had begun the process of establishing objectives.[3]

Today, many States have developed, or are in the process of developing, specific health objectives for their populations using *Healthy People 2000* as a guide. *State Action*, which describes these objectives-setting activities, is one publication in the *Healthy People 2000 Action Series*, a set of three reports that includes *State Action*, *Consortium Action*, and *Public Health Service Action.* The *Action Series* demonstrates that achieving *Healthy People 2000* is a responsibility shared by the Federal Government, State governments, and private organizations. *State Action* is a comprehensive overview of States' objective-setting activities, with particular attention to the use of coalitions and partnerships, and efforts to include citizens and nongovernmental groups in health promotion. *State Action* can also be used as a directory to State programs and resources.

*Consortium Action* describes support for the national health objectives arising from the more than 325 national membership organizations of the Healthy People 2000 Consortium. This report begins the process of documenting activities in the private and nonprofit sectors that will help the Nation achieve its health objectives.

*Public Health Service Action* describes the programs and activities of the U.S. Public Health Service (PHS), listing the activities of the eight PHS agencies and noting resource levels for Healthy People 2000 activities in Fiscal Year 1991. *Public Health Service Action* also includes discussion of the strategies the PHS agencies have for accomplishing the objectives for which the Assistant Secretary for Health has given them lead responsibility. The document serves both as a comprehensive listing of supporting activities and as a directory to agencies and resources.

# Objectives and Methodology

## Objectives

This report provides an overview of States' efforts to establish statewide health objectives, including the process States are using to set objectives and to develop plans for achieving them. The report reflects the diversity of ways in which States have used the *Healthy People 2000* objectives as a guide for developing state-specific health objectives. It is intended to serve as a catalyst for the exchange of ideas and encourage States' future commitment to the achievement of their objectives.

The report is presented in two sections. In the first section, information on States' objective-setting activities is summarized. In the second section, individual profiles describe the objective-setting process in each State. These profiles provide detailed information concerning the level and diversity of activities within the States. This information may serve as a reference for guiding States' future objective-setting activities.

## Methodology

To obtain information about each State's objective-setting process, the Public Health Foundation (PHF) and the Association of State and Territorial Health Officials (ASTHO) asked each State health officer to describe activities undertaken in the State to:

- Set statewide health objectives;
- Implement programs to achieve the objectives; and
- Monitor State progress toward achieving the objectives.

Fifty State health agencies and the District of Columbia (hereafter referred to as 51 States) submitted information about their States' objective-setting activities. When necessary, PHF staff edited responses to fit a uniform format and contacted State representatives for additional information when responses were unclear or incomplete.

PHF incorporated the information provided by each State into three tables. Because most States' priorities are similar to the *Healthy People 2000* priorities, PHF used the national priority areas as its priority area categories. Although the names of the State priority areas often differed from the general categories, they were included in the most appropriate category. For example, a "teenage pregnancy" State priority was included in the Family Planning priority area and "occupational and environmental hazards" was included in both the Occupational Safety and Health and the Environmental Health priority areas. To ensure the accuracy of the information, PHF asked representatives from each State to verify all the information in the tables.

# Overview of States' Objective-Setting Activities

A majority of States are committed to developing and achieving state-specific health promotion and disease prevention objectives. As of December 1, 1991, forty-seven States had developed or were in the process of developing state-specific health objectives (Table 1). Of the forty-seven States, twenty-one had finalized their State health objectives and twenty-six were in the process of developing objectives. Altogether, forty-two States project that they will have completed development of the objectives by the end of 1992.

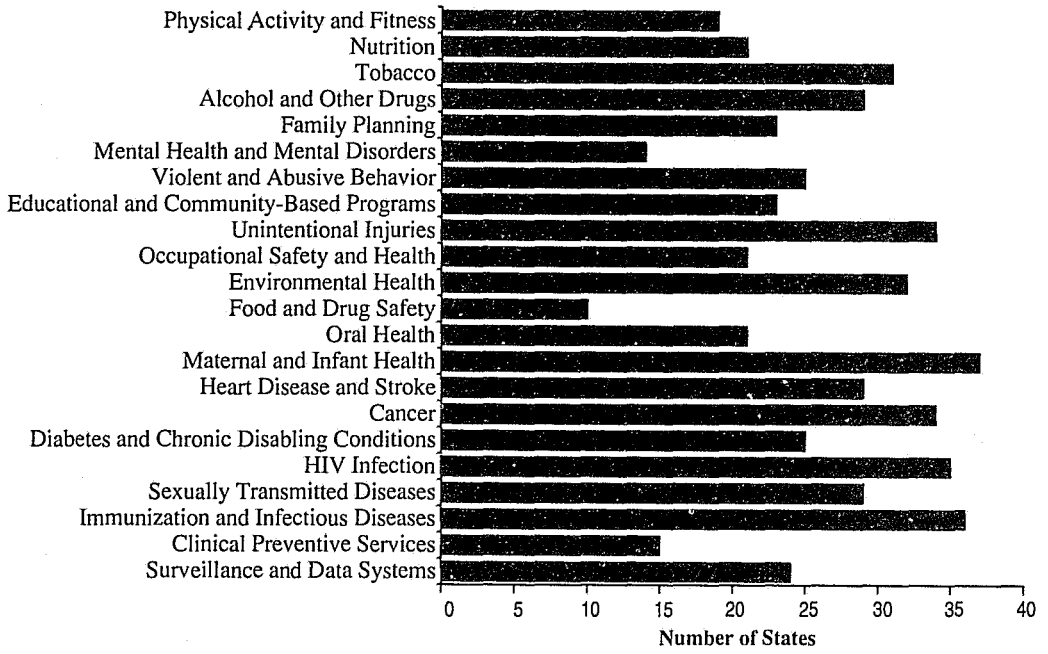
Officials in four States (Colorado, Georgia, Massachusetts, and Ohio) indicated that, although objective-setting activities have not been initiated, plans for developing statewide objectives are currently under discussion.

Generally, States specified the year 2000 as the target date for achieving objectives (Table 1). Several States explained the benefits of establishing a year 2000 target. Kentucky, for example, indicated that the year 2000 target provides the State with long-range, unchanging, quantified objectives. Unlike annual objectives, the targets will not constantly shift as the State tries to focus on them.[4] Louisiana and Virginia have set 1996 as the target date for achieving their objectives. In Utah, the target dates for achieving specific objectives vary depending upon when each objective was developed and the State's perceived ability to achieve each objective.

## Priority Areas in State Objectives

Thirty-seven States have completed or nearly completed developing priority areas (Table 2). Of these thirty-seven States, twenty-one States have completed the development process, while sixteen are still finalizing their objectives. States' priority areas closely parallel the twenty-two national priority areas outlined in *Healthy People 2000*. These similarities reflect States' use of

## States' Priority Areas*




* Includes all States that had determined priority areas as of December 1, 1991

the *Healthy People 2000* objectives as a guide for developing state-specific health promotion and disease prevention objectives. Generally, States reported that they modified the *Healthy People 2000* objectives based on their populations' most pressing health problems, the availability of state-level data, and their States' financial and programmatic resources.

All 37 States identified maternal and infant health as a priority, although the States did not always call the priority area maternal and infant health. In addition, a majority of States established priority areas covering immunizations and infectious diseases (36 States), HIV infection (35 States), the prevention of unintentional injuries (34 States), cancer (34 States), environmental health (32 States), and the reduction of tobacco-caused diseases (31 States).

Slightly more than half of the thirty-seven States reported that they had established priority areas covering physical activity and fitness (19 States), nutrition (21 States), occupational safety and health (21 States), and oral health (21 States). Fewer States identified food and drug safety (10 States), mental health and mental disorders (14 States), and clinical preventive services (15 States) as priority areas.

The omission of a priority area generally did not mean that a State had not established objectives for this priority area. In fact, most States' objectives directly or indirectly addressed most of the priority areas identified by PHS. Oregon, for example, did not include nutrition as a priority area, but nutritional objectives were addressed within its maternal and infant health, environmental health, cancer, and cardiovascular disease priority areas. To emphasize the fact that many objectives are integrated, several States cross referenced objectives when it was not readily apparent that the objectives related to other priority areas.

Like the *Healthy People 2000* objectives, States often addressed the health care needs of different age groups and special populations, such as children, adolescents, older adults, and minority groups. Several States emphasized the needs of special populations by establishing separate age-related priority areas. Fourteen States established a separate priority area for adolescent and young adult health, and 13 established a separate priority area that addressed the health of their older populations. In addition, eighteen States included improving access to care as a distinct priority area, even though this was not a separate priority area in the *Healthy People 2000* objectives.

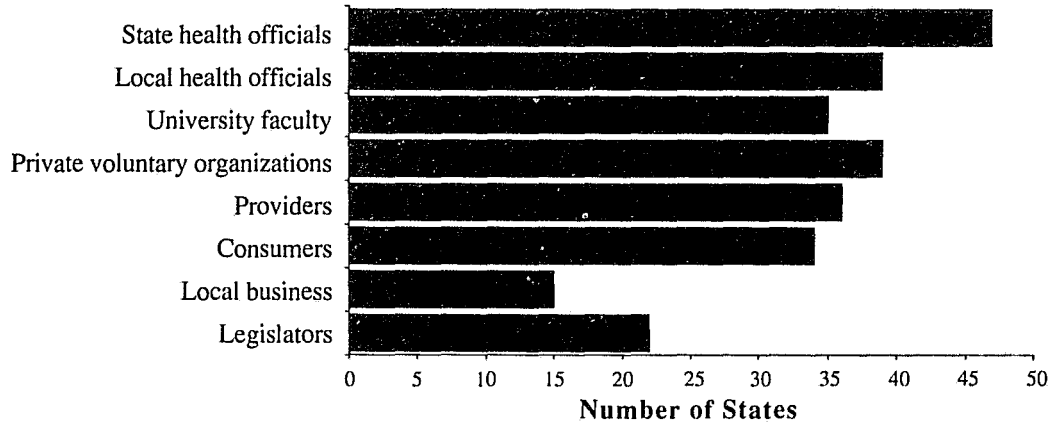
Many States developed additional priority areas that were not included in the *Healthy People 2000* objectives. These included broad health issues, such as the improvement of the public health infrastructure and the health care delivery system, and targeted issues, such as emergency medical services. Development of these additional priority areas reflected States' intent to address their populations' most pressing health problems.

## Developing the Objectives

The method which approximately one-half of the States used or will use to develop state-specific health objectives is similar to the process used by the PHS to develop the *Healthy People 2000* objectives. In most cases, a wide range of individuals and organizations participated in developing States' objectives (Table 3). Generally, participants included representatives from State and local health departments, other State and local government agencies, university faculty, private and voluntary organizations, providers, consumer and citizen groups, local businesses, and State legislatures. Many State representatives said that the participation of a wide variety of groups and individuals in the planning process was important because it promoted a sense of ownership among the organizations whose actions are essential for achieving the objectives.

States incorporated input into the planning process in different ways. In many States, work groups or task forces, with members from the public and private sectors, were convened to develop their States' health promotion and disease prevention objectives. Texas, for example, organized 300 individuals from public, private, and voluntary organizations into twenty-one work groups to

## Participants in Objective-Setting Processes*




*Includes all States that had set or were in the process of setting objectives as of December 1, 1991

develop objectives for each of the national priority areas. Texas' draft objectives were reviewed by more than 1,000 individuals from health and human services organizations, community groups, a variety of health care professions, and academic institutions. In Oregon, a 20-member "Health Team 2000," with representatives from State agencies, academic institutions, and nonprofit organizations, was organized to develop the State objectives. The composition of the team reflected Oregon's ethnic populations, organizational diversity, and service availability. Professional facilitators led the team's strategic planning process.

In other States, such as New Jersey and Kentucky, State health department representatives initially identified their States' most pressing health problems and developed state-specific health promotion and disease prevention objectives to address those problem areas. Public input then was sought through such mechanisms as focus groups, public hearings, draft review periods and, in New Jersey, a public opinion telephone survey. Input from these forums was used to confirm and augment the States' priority areas. In Kentucky, public input resulted in the addition of an entire chapter in the State's year 2000 document related to the role of academic health science centers in public health.

Taking a different approach, South Carolina convened a Healthy People South Carolina 2000 Coalition, which served as the facilitating organization for promoting local involvement in improving the health of the population and achieving South Carolina's equivalent of the *Healthy People 2000* objectives. A coalition development subcommittee helps communities establish local health promotion coalitions that are made up of public agencies and private organizations.

In many States, objectives are being developed through a variety of mechanisms. Washington's objectives, for example, are not being developed through a single, unified process. Instead, objectives are being set through the development of a State health report, individual program plans, and grant applications. In addition, Washington will develop some objectives through a newly initiated strategic planning process and also through the use of the Assessment Protocol for Excellence in Public Health developed by the National Association of County Health Officials, in cooperation with other national public health organizations.

In other States, the objective-setting process was incorporated into the yearly program planning process. In Idaho, for example, each program manager, under the guidance of the administrator and bureau chiefs within the Division of Health, incorporated the *Healthy People 2000* objectives that were applicable to specific program goals into their annual program plans. This process ensured that Idaho's health promotion and disease prevention objectives were consistent with national efforts.

## Plans for Implementation

Most States indicated that their States' objectives will serve as a guide for health department activities, although few States have developed detailed implementation plans. Generally, States indicated that objectives will guide program development, data collection activities, grant activities, legislative action, and budget-setting processes within the health agency.

Like Healthy People 2000, several States stressed that achieving State health objectives depends upon the commitment and cooperation of many different organizations, including State and local agencies, private and voluntary organizations, universities, and businesses. Several States will incorporate input from various organizations into the development of action strategies. Pennsylvania, for example, is developing a State consortium for public health to assist in achieving its objectives. Toward this end, organizations that participated in developing the objectives and other health-related agencies in the State have been encouraged to adopt Pennsylvania's objectives. In addition, Pennsylvania will host a conference to discuss how various organizations can work together to achieve the objectives. Similarly, Nebraska will conduct six public forums throughout the State to gain input on how to achieve its objectives through public and private sector collaboration.

Several States have already outlined specific action steps and identified organizations whose participation is essential for achieving the objectives. Oregon, for example, recommended general or specific actions which will lead to progress toward meeting the *Healthy People 2000* objectives. For each recommendation, public or private groups are named which might play a lead role in implementing the recommendation. Wisconsin identified key organizations that are responsible for carrying out each action step and a target year by which the organizations should have completed the action.

## Tracking the Objectives

States' objectives generally are quantifiable; that is, they are usually stated in terms of rates, numbers of cases, or the existence or lack of implementation. Of the States that have completed their objectives, most identified baseline data and set quantifiable goals for the year 2000. Several States, such as Oregon and Texas, also estimated, where possible, what the year 2000 rates would be in their States if no new action was taken.

Most of the States with completed objectives identified the data sources used to determine the baseline and future progress toward achieving each objective. Data sources included State sources, such as vital records, Behavioral Risk Factor Surveillance System surveys, Youth Risk Behavioral Surveillance System surveys, and other State agency data. When State data were unavailable, data were often obtained from national surveys or *Healthy People 2000*.

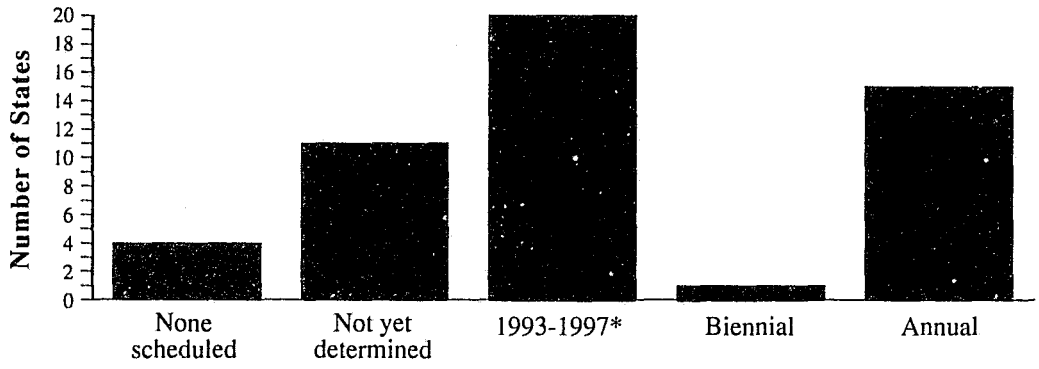
Many States with completed objectives included a data needs section within each priority area which contained specific recommendations regarding data collection and analysis efforts that will be needed to establish baselines or measure progress toward achieving objectives. For example, within its physically fit children priority area, Oregon identified two specific data needs: an assessment of health-related fitness in school children and an assessment of the proportion of children in grades K-12 who receive daily physical education. These data sources will enable Oregon to measure its objectives for increasing the proportion of all children who meet health-related fitness standards and the proportion who participate regularly in a physical education and fitness program. In some cases, the development of baseline data is itself an objective. Wisconsin, for example, established objectives that focus on developing data systems for tracking communicable and chronic diseases.

Several States identified data needs throughout their year 2000 plans, but also included separate sections describing the States' general data needs. Arkansas identified the need for a Hospital Discharge Data System and Behavioral Risk Factor Surveillance System in a general data needs

assessment. More specific data needs were identified throughout Arkansas' individual priority areas. Texas also identified data needs throughout its priority areas, while a Surveillance and Data Systems priority area addressed broader data issues, such as creating a data review advisory group, expanding existing data bases to include local level information, and creating a system for the rapid transfer of health data among Federal, State, and community agencies.

Of the States that have developed or are in the process of developing objectives, fifteen have plans for a mid-course review (Table 1). Other States will evaluate progress toward attaining objectives more frequently: twice during the decade (4 States), biennially (1 State), and annually (15 States). Several States said that dates for reviewing the status of objectives had not yet been decided.

## State Scheduling of Progress Reviews




*Progress reviews scheduled within 1993-1997

## For More Information...

For ordering information on *Healthy People 2000* or other volumes of the *Healthy People 2000 Action Series*, contact ODPHP National Health Information Center: P.O. Box 1133, Washington, DC 20013-1133.

## Notes

[1]Institute of Medicine, *Healthy People 2000: Citizens Chart the Course*, Washington, DC: National Academy Press, 1990.

[2]The Intergovernmental Health Policy Project at The George Washington University, *A Review of State Activities Related to the Surgeon General's Health Promotion and Disease Prevention Objectives for the Nation*, Washington, DC: November 1985.

[3]Public Health Foundation, *Status Report: State Progress on 1990 Health Objectives for the Nation*, Washington, DC: May 1988.

[4]Department for Health Services, *Healthy Kentuckians 2000: Kentucky's Public Health Objectives for the Year 2000*, Frankfurt, KY: September 1991, p. 1.

## Table 1. Status of State Objectives, As of December 1, 1991

| State | Status of objectives | Expected completion date | Target date for achieving objectives | Progress reviews scheduled |
|---|---|---|---|---|
| Alabama | C | — | 2000 | Annual |
| Alaska | I | Winter 1992 | 2000 | Annual |
| Arizona | I | December 1992 | 2000 | 1995 |
| Arkansas | C | — | 2000 | 1996 |
| California | I | Ongoing | 2000 | Annual |
| Colorado | N | — | — | — |
| Connecticut | I | September 1992 | 2000 | Annual |
| Delaware | I | Spring 1993 | 2000 | Undetermined |
| District of Columbia | I | Summer 1992 | 2000 | Annual |
| Florida | C | — | 2000 | 1996 |
| Georgia | N | — | — | — |
| Hawaii | I | September 1992 | 2000 | 1995 |
| Idaho | C | — | Annually until year 2000 | Annual |
| Illinois | I | December 1991 | 2000 | 1996 |
| Indiana | C | — | 2000 | 1996 |
| Iowa | I | July 1992 | 2000 | 1995 |
| Kansas | I | Fall 1992 | 2000 | Annual |
| Kentucky | C | — | 2000 | 1995 |
| Louisiana | C | — | 1996 | Annual |
| Maine | I | Spring 1992 | 2000 | 1995 |
| Maryland | I | January 1992 | 2000 | 1994, 1997 |
| Massachusetts | N | — | — | — |
| Michigan | I | Late 1992 | 2000 | Undetermined |
| Minnesota | C | — | 2000 | Biennial |
| Mississippi | I | Undetermined | 2000 | Undetermined |
| Missouri | C | — | 2000 | 1995 |
| Montana | I | Undetermined | 2000 | Undetermined |
| Nebraska | C | — | 2000 | 1995 |
| Nevada | I | Early 1992 | 2000 | Undetermined |
| New Hampshire | I | Early 1992 | 2000 | 1995 |
| New Jersey | C | — | 2000 | 1993, 1997 |
| New Mexico | C | — | 2000 | Annual |
| New York | C | — | 2000 | Annual |
| North Carolina | I | September 1992 | 2000 | Undetermined |
| North Dakota | I | Fall 1992 | 2000 | Undetermined |
| Ohio | N | — | — | — |
| Oklahoma | I | January 1992 | 2000 | Undetermined |
| Oregon | C | — | 2000 | 1995 |
| Pennsylvania | C | — | 2000 | 1993, 1997 |
| Rhode Island | I | December 1992 | 2000 | Annual |
| South Carolina | C | — | 2000 | 1995 |
| South Dakota | C | — | 2000 | Annual |
| Tennessee | I | December 1991 | 2000 | Undetermined |

C=Completed; I=In process; N=No objective-setting activities underway

## Table 1. Status of State Objectives, As of December 1, 1991—*Continued*

| State | Status of objectives | Expected completion date | Target date for achieving objectives | Progress reviews scheduled |
|---|---|---|---|---|
| Texas | C | — | 2000 | 1993, 1997 |
| Utah | I | Mid 1992 | Varies by objective | Annual |
| Vermont | I | August 1992 | 2000 | Undetermined |
| Virginia | C | — | 1996 | Annual |
| Washington | I | Undetermined | 2000 | Undetermined |
| West Virginia | C | — | 2000 | Periodic |
| Wisconsin | C | — | 2000 | 1995 |
| Wyoming | I | Early 1992 | 2000 | Annual |

C=Completed; I=In process; N=No objective-setting activities underway

## Table 2. States' Priority Areas, As of December 1, 1991

| State[1] | Physical Activty and Fitness | Nutrition | Tobacco | Alcohol and Other Drugs | Family Planning | Mental Health and Mental Disorders | Violent and Abusive Behavior | Educational and Community-Based Programs | Unintentional Injuries | Occupational Safety and Health | Environmental Health | Food and Drug Safety | Oral Health | Maternal and Infant Health | Heart Disease and Stroke | Cancer | Diabetes and Chronic Disabling Conditions | HIV Infection | Sexually Transmitted Diseases | Immunization and Infectious Diseases | Clinical Preventive Services | Surveillance and Data Systems | Access | Adolescents and Young Adults | Older People | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alabama | X | X | X | X | X | X | X | X | X | X | X | | X | X | X | X | X | X | X | X | X | | | | X | X[2] |
| Arkansas | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | | | | | |
| California | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | |
| Connecticut | X | X | X | | | | | X | X | X | X | | | X | X | X | | X | X | X | | X | | | | |
| District of Columbia | | X | | X | | | | X | | | | | | X | X | X | X | X | X | X | | X | X | X | | X[3] |
| Florida | | | | | | | | | X | | X | | X | X | | X | X | X | X | X | | X | X | X | | X[4] |
| Hawaii | X | X | X | X | | | X | X | X | X | | | X | X | X | X | X | X | X | X | X | X | X | X | X | |
| Idaho | | X | X | | X | | | X | | | X | X | X | X | X | X | | X | X | X | | X | X | X | X | |
| Indiana | X | X | | X | | X | X | | X | | X | | X | X | | X | X | X | X | X | | X | | X | X | X[5] |
| Iowa | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | | | | |
| Kentucky | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X[6] |
| Louisiana | | | X | X | X | | | | X | | X | X | | X | | X | | X | X | X | | | X | X | | |
| Maine | | | X | X | | X | | | X | X | X | | X | X | | X | X | X | | X | | | | X | | |
| Maryland | X | | X | X | X | X | X | | X | | X | | X | X | X | X | X | X | X | X | | X | | | | |
| Michigan | X | X | X | X | X | | X | X | X | | X | | | X | X | X | X | X | | X | | X | X | | | |
| Minnesota | X | | X | X | | | X | | X | X | X | | | X | | X | X | X | X | X | | X | X | | X | X[7] |
| Mississippi | X | X | X | X | X | | X | X | X | X | X | | | X | X | X | | X | X | X | | | | | | |
| Missouri | | | X | | | | | X | X | X | X | | | X | X | X | | X | X | X | | | X | X | X | X[8] |
| Nebraska | | X | X | X | X | X | X | X | X | X | X | | | X | X | X | | X | | X | | | X | X | X | X[9] |

See notes at end of table.

## Table 2. States' Priority Areas, As of December 1, 1991—*Continued*

| State[1] | Physical Activity and Fitness | Nutrition | Tobacco | Alcohol and Other Drugs | Family Planning | Mental Health and Mental Disorders | Violent and Abusive Behavior | Educational and Community-Based Programs | Unintentional Injuries | Occupational Safety and Health | Environmental Health | Food and Drug Safety | Oral Health | Maternal and Infant Health | Heart Disease and Stroke | Cancer | Diabetes and Chronic Disabling Conditions | HIV Infection | Sexually Transmitted Diseases | Immunization and Infectious Diseases | Clinical Preventive Services | Surveillance and Data Systems | Access | Adolescents and Young Adults | Older People | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nevada | | | X | X | X | X | X | | X | | X | | | X | X | X | | X | | X | | X | | | | |
| New Jersey | | | X | X | X | | X | | X | X | X | | | X | X | X | X | X | X | X | | X | X | | | |
| New Mexico | | X | X | X | X | | X | | X | | | | X | X | X | X | X | X | X | X | X | X | X | X | | X[10] |
| New York | X | X | X | X | X | | X | X | X | X | X | | X | X | X | X | X | X | X | X | | X | X | | | |
| North Dakota | X | X | X | | X | X | | | X | X | | | X | X | X | X | X | X | X | X | | X | | X | | |
| Oklahoma | X | X | X | X | | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | | | | | | |
| Oregon | X | | X | X | | | X | | X | | X | | | X | X | X | | X | X | X | X | X | | | | |
| Pennsylvania | | | X | X | | | X | X | X | | | | | X | | | | X | | | | | | | | |
| South Carolina | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | | | | |
| South Dakota | | | X | | | | | X | X | X | X | | | X | X | X | | X | X | X | X | X | | | X | |
| Tennessee | | | | | | | | | X | | X | | | X | | | X | | | X | | | | | | X[11] |
| Texas | X | X | X | X | X | X | X | X | X | X | X | | X | X | X | X | X | X | X | X | | X | | | X | X[12] |
| Utah | | | X | X | X | | X | | X | | X | | | X | X | X | | X | | X | | X | X | | X | X[13] |
| Virginia | | | | | X | | | X | | | X | | X | X | | | | | | X | X | | X | | X | X[14] |
| Washington | | | X | X | | | | | X | | X | | | X | X | X | | X | X | X | X | | X | | | |
| West Virginia | X | X | X | X | X | | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | | | | |
| Wisconsin | | X | X | X | X | | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | | | X | | |
| Wyoming | | | | X | X | X | | X | X | | X | | | X | X | X | X | X | X | X | X | X | X | | | |
| **Total of States** | 19 | 21 | 31 | 29 | 23 | 14 | 25 | 23 | 34 | 21 | 32 | 10 | 21 | 37 | 29 | 34 | 25 | 35 | 29 | 36 | 15 | 24 | 18 | 14 | 13 | 13 |

See notes at end of table.

## Table 2. States' Priority Areas, As of December 1, 1991—*Continued*

1. Includes all States that have determined priority areas as of December 1, 1991
2. Health promotion
3. Minority health; health care reform; infrastructure
4. Health care delivery system
5. Minority health; rural health; women's health; health of disadvantaged populations, including homeless, migrant, medically indigent; support services; local public health departments
6. Emergency medical services; cost containment; radiation; academic health science centers in public health
7. Minority health
8. Public health research; health communications systems
9. Minority health; rural health
10. Emergency medical services; child care and development
11. Health promotion; health systems support, management support
12. Health education and preventive services
13. Minority health; rural health; public health delivery system/infrastructure, environmental risk assessment; preventive and primary care for infants and children; early identification and intervention for handicapped infants and children
14. Manpower; health systems support; management support

## Table 3. Participants in Objective-Setting Activities

| State[1] | State health officials | Local health officials | University faculty | Private/ voluntary organizations | Providers | Consumers | Local businesses | Legislators |
|---|---|---|---|---|---|---|---|---|
| Alabama | X | X | X | X | | X | | |
| Alaska | X | X | X | X | X | X | X | X |
| Arizona | X | X | | | | | | |
| Arkansas | X | | X | X | X | | | X |
| California | X | X | X | X | X | X | | X |
| Connecticut | X | X | X | | | | | |
| Delaware | X | X | X | X | X | X | | X |
| District of Columbia | X | N/A | X | X | X | X | | |
| Florida | X | X | X | X | X | X | | |
| Hawaii | X | X | X | X | X | X | X | X |
| Idaho | X | X | | | | | | |
| Illinois | X | X | X | X | X | | | X |
| Indiana | X | X | X | X | X | X | X | X |
| Iowa | X | X | X | X | X | X | X | X |
| Kansas | X | X | X | X | X | X | | X |
| Kentucky | X | X | X | X | X | X | | |
| Louisiana | X | X | X | | | | | |
| Maine | X | X | | X | X | X | | X |
| Maryland | X | X | X | X | X | X | X | X |
| Michigan | X | X | X | X | X | X | X | |
| Minnesota | X | X | | | | | | |
| Mississippi | X | X | X | X | X | X | X | X |
| Missouri | X | X | X | X | X | X | X | X |
| Montana | X | X | | X | X | X | | |
| Nebraska | X | X | X | X | X | X | X | X |
| Nevada | X | X | X | | | X | X | X |
| New Hampshire | X | | | | | | | |
| New Jersey | X | X | X | X | X | X | | X |
| New Mexico | X | X | X | X | X | X | | |
| New York | X | X | | | | | | |
| North Carolina | X | X | X | X | X | X | | |
| North Dakota | X | X | | X | | | | |
| Oklahoma | X | | X | X | | | | |
| Oregon | X | X | X | X | X | X | | |
| Pennsylvania | X | X | X | X | X | X | | |
| Rhode Island | X | N/A | X | X | X | X | X | |
| South Carolina | X | X | X | X | X | X | | X |
| South Dakota | X | | | X | X | | | |
| Tennessee | X | | | X | X | X | | |
| Texas | X | X | X | X | X | X | X | X[2] |
| Utah | X | X | X | X | X | X | X | X |
| Vermont | X | N/A | X | X | X | X | X | X |
| Virginia | X | X | | X | X | X | | |
| Washington | X | X | | X | | X | | |
| West Virginia | X | X | X | X | X | X | X | |
| Wisconsin | X | X | X | X | X | | | X |
| Wyoming | X | X | X | X | X | X | X | X |

1. Includes all States that have set or are in the process of setting objectives
2. Legislative aide

# Part II

# State Profiles

# Alabama

## Summary of State Objectives

*Healthy Alabama 2000*, the document that contains Alabama's health objectives for the year 2000, was published and released in October 1991. The goals of *Healthy Alabama 2000* are to:

- Increase the years of healthy, productive life for all Alabamians;
- Provide measurable health promotion and disease prevention objectives for Alabama;
- Facilitate a common statewide base for improved health planning and resource allocations at Federal, State, and local levels; and
- Highlight the need for development of data collection systems in selected health areas.

Within the document, sixty objectives representing nearly all twenty-two national priority areas are organized into four broad priority health areas:

| *Priority Area* | *# of Objectives* |
|---|---|
| Chronic Diseases | 21 |
| Communicable Diseases | 12 |
| Maternal, Reproductive, and Child Health | 14 |
| Environmental Health, Injury Control, and Occupational Safety and Health | 13 |
| | 60 |

Objectives were organized under the four broad health categories to facilitate communication of the objectives to the media and the public. A brief narrative "sets the stage" for each of the four categories by highlighting recent health trends and priority needs. Both health status and risk reduction objectives are included in each of the priority health areas. In addition, services and protection objectives are included for Chronic Diseases and Maternal, Reproductive, and Child Health.

One criterion for the final selection of objectives included in the document was the availability of statewide baseline data and data sources so that progress can be monitored throughout the next decade. However, a selected number of objectives were included even though statewide data are not currently available because they were determined to be highly important in improving the health and well-being of selected groups.

## Developing the Objectives

In strong support of *Healthy People 2000*, the Alabama Department of Public Health initiated the following process in the fall of 1990 to develop a set of health promotion and disease prevention objectives for the State based upon the deliberation of a broad consortium of individuals, agencies, and organizations. The Alabama Department of Public Health:

- Formed a planning team in the fall of 1990 to discuss and formulate a project outline for developing Alabama's health objectives for the year 2000.
- Held seven public meetings in public health areas throughout the State during January and February 1991 to which a range of community groups and professional organizations, as well as the public were invited.
- Compiled position statements, comments, and testimony of more than 2,000 individuals and organizations who participated in the public hearings and used this information as a guide in the selection of priority areas for Alabama's health objectives.

- In April 1991, convened a statewide conference, co-sponsored by more than sixty organizations and attended by more than 700 individuals, to further define and highlight the needs and concerns of the public and various interest groups.
- Identified representatives to make recommendations for the final selection of objectives for statewide consensus and publication; convened the Task Force for Alabama's Health Objectives for the Year 2000 and formed work groups that met from May to August to refine and revise objectives.
- Prepared a final draft of the objectives in September 1991 that was mailed to the co-sponsoring agencies and organizations and other participants in the Healthy Alabama 2000 project for final review.
- Published and disseminated *Healthy Alabama 2000* in October 1991 and held a statewide press conference to publicly announce release of the document.

## Plans for Implementation

Implementation of *Healthy Alabama 2000* was "kicked-off" with a conference sponsored by the University of Alabama at Birmingham (UAB), entitled Alabama's Health Objectives for the Year 2000: Getting From Here to There. The aim of the conference, which was held October 28-30, 1991, in Birmingham, was to begin to identify and undertake strategies for achieving *Healthy Alabama 2000.* Participants included more than 350 decision-makers of programs and projects throughout the State that have the potential to play key roles in achieving *Healthy Alabama 2000,* such as professional association leaders, administrators of voluntary agencies and corporations, local and State public health and other government officials, and academicians. The Alabama Department of Public Health was highly supportive of this conference and participated in the planning since early spring 1991.

With the statewide and UAB conferences serving as catalysts, the Alabama Department of Public Health will continue to encourage and support the endeavors of the more than sixty agencies that have been contributing or co-sponsors in the Healthy Alabama 2000 project aimed at achieving *Healthy Alabama 2000.* The health department also plans to continue existing, successful programs and initiate new activities aimed at *Healthy Alabama 2000.* For example, the 5th Alabama AIDS Symposium was held October 2-4, 1991. As in the past, more than 700 individuals and organizations participated in this conference. A new conference entitled, Looking to the Year 2000: Alabama's Conference on Nutrition for Health Promotion and Disease Prevention is planned for June 1992. The purpose of this conference will be to convene more than 250 people representing nutrition and nutrition-related professional and voluntary associations, local and State government agencies, trade organizations, worksites, schools, and communities to expand awareness of *Healthy Alabama 2000,* especially the nutrition and nutrition-related objectives; and to identify, explore, and encourage innovative approaches for reaching Alabama's nutrition targets statewide. In short, the Alabama Department of Public Health plans to serve as a leader, facilitator, and supporter of efforts throughout the State to achieve *Healthy Alabama 2000.*

## Tracking the Objectives

With statewide baseline data and sources established for nearly all of the objectives, progress will be tracked through existing data collection systems. Development of data collection systems is underway for those objectives for which statewide baseline data was not available. Annually, highlights of progress will be disseminated through existing Alabama Department of Public Health publications and media sources, as well as through the agencies and organizations that have been sponsors or participants in the Healthy Alabama 2000 project. A mid-course report and statewide conference are planned for 1996.

## For More Information . . .

To obtain a copy of *Healthy Alabama 2000*, contact:

James J. McVay, DR.P.A.
Director
Bureau of Health Promotion and Information
Alabama Department of Public Health
434 Monroe Street
Montgomery, AL 36130-1701
(205) 242-5095

# Alaska

## Summary of State Objectives

The Alaska Department of Health and Social Services is beginning the process of establishing State health objectives for the year 2000. The division has completed a data inventory to identify its population's health needs.

## Developing the Objectives

Alaska is developing the process it will use to determine priority health areas. The five divisions of the Department of Health and Social Services, including Mental Health and Developmental Disabilities, Alcohol and Substance Abuse, Medicaid and Public Health, Family and Youth, and Public Assistance divisions, will develop objectives for the year 2000 internally. The Department of Health and Social Services will organize these objectives, in addition to objectives developed by the Department of Sanitation and the Environment, into a statewide plan.

In April 1992, the Department of Health and Social Services and the Alaska Public Health Association will sponsor a State health summit. The Department plans to use this forum to present its year 2000 objectives to the public and also to obtain public input regarding the objectives. Objectives will be finalized in the fall of 1992.

## Plans for Implementation

Alaska has not yet established implementation plans for achieving its objectives.

## Tracking the Objectives

To track progress toward achieving objectives, the Alaska Department of Health and Social Services plans to use vital statistics, results from epidemiological studies, and the department's medical management information system as data sources. Quarterly reviews of data are expected.

## For More Information . . .

Dwayne Peeples
Division of Public Health
P.O. Box H-06
Juneau, AK 99811-0610
(907) 465-3090

# Arizona

## Summary of State Objectives

Arizona does not have a separate, stand alone, publication on State health objectives. However, several efforts have been completed and others are underway that demonstrate Arizona's commitment to establishing State health objectives that are consistent with *Healthy People 2000*. Briefly, these activities are:

- A completed analysis of the 300 *Healthy People 2000* objectives to determine which ones were either solely or primarily within the purview of the Arizona Department of Health Services (ADHS). We concluded that 258 are in ADHS' domain; the remainder are the responsibility of other agencies.
- A special section in our 1980-1989 Health Status and Vital Statistics report that compared Arizona's mortality and morbidity indicators to the objectives for both the year 2000 and the year 1990. This detailed examination showed that Arizona must collect additional health status indicators and that we have many areas to improve if we are to achieve the year 2000 objectives. The theme of the annual report is "how did we do in the 1980s and where should we be going in the 1990s to improve health?"
- A completed draft position paper on Arizona's public health challenge. The paper has several thrusts including a detailed presentation of health problems in seven age groups and a proposed set of programs grouped in six functional categories. The entire document is based upon programmatic development that is consistent with year the 2000 objectives.
- Three major programs, Maternal and Child Health, Dental Health, and Nutrition, have worked for more than a year to establish State objectives that tie directly to *Healthy People 2000*. This work is expanding to include other ADHS programs in Health Education, Chronic Diseases, Infectious Diseases, the State Laboratory, and AIDS/HIV.
- ADHS Division of Behavioral Health staff have followed Federal and State mandates to develop several plans for serving seriously mentally ill adults and children, as well as providing mental health, domestic violence, and substance abuse services. Again, *Healthy People 2000* served as a guide.

These efforts will lead Arizona to its own year 2000 State Health Objectives by the end of 1992. In the meantime ADHS, is fully focused on the *Healthy People 2000* objectives.

## Developing the Objectives

Much of the above work has been done over an eighteen-month time frame, primarily by ADHS staff. Public comments were received from county health departments, State social service and medical agencies, university faculty, health constituency groups, and two private health agencies. All of the behavioral health activities are extensively reviewed and guided by public advocacy groups.

## Plans for Implementation

The Arizona Department of Health Services has a planning and budgeting process that complies with guidance from a newly established Governor's Office of Strategic Planning and Budgeting. By the spring of 1992, the Department will have a strategic plan that covers a three-year time frame and continues to be driven by critical statements of ADHS mission, goals, and program objectives. It is anticipated that wherever appropriate the objectives will encompass State adapted year 2000 objectives. This has already occurred in several programs and more will follow with each annual update of the Department's Strategic Plan. A major constraint, however, is State

funding. The Governor has already directed that State agencies should not expect any increases in discretionary funding for the next three years.

## Tracking the Objectives

The overall tracking of indicators will be done through the annual compilation of the Health Status and Vital Statistics Report. Of course, ADHS program chiefs will be tracking programs as they prepare updates for their annual plan.

## For More Information . . .

To obtain a report on Arizona's status with respect to year 2000 objectives, contact:

Joanne Gersten, Ph.D.
Office of Planning and Health Status Monitoring
Arizona Department of Health Services
1740 West Adams, Room 312
Phoenix, AZ
(602) 542-1216

# Arkansas

## Summary of State Objectives

Published in September 1991, Arkansas' health promotion and disease prevention objectives for the year 2000 are divided into twenty-one health priority areas. For each priority area, the State plan, *Healthy Arkansans 2000*, contains:

- Information on the significance of the priority area;
- A discussion of recent trends in the area based on Arkansas data when available;
- Specific objectives to be accomplished by the year 2000;
- Recommended actions and organizations that might play a lead role in implementing the recommendations; and
- An identification of major data needs.

The State plan includes priority areas for: Physical Activity and Fitness, Nutrition, Tobacco, Alcohol and Other Drugs, Family Planning, Mental Health, Violent and Abusive Behavior, Educational and Community-Based Programs, Unintentional Injuries, Occupational Safety and Health, Environmental Health, Food and Drug Safety, Oral Health, Maternal and Infant Health, Heart Disease and Stroke, Cancer, Diabetes and Chronic Disabling Conditions, HIV Infection, Sexually Transmitted Diseases, Immunization and Infectious Diseases, and Clinical Preventive Services.

## Developing the Objectives

*Healthy Arkansans 2000* was developed over a fifteen-month period. The Arkansas Department of Health formed nineteen work groups to review the national plan, examine health data, develop State objectives, and make recommendations for the accomplishment of the objectives. Work groups developed a total of 116 objectives believed to address the issues of greatest priority in Arkansas. Participants on the work groups represented 85 Arkansas organizations.

The initial draft of the objectives was widely distributed during a six-week public review period. The final report was released at a meeting in Little Rock on September 6, 1991.

## Plans for Implementation

Regional meetings in the State will be conducted to publicize *Healthy Arkansans 2000* and to promote community-based health promotion and disease prevention initiatives. The Arkansas Department of Health will coordinate the development of an operational plan for the years 1992 through 1995.

## Tracking the Objectives

For every objective in the State plan, the most recent available data are identified. Where data are unavailable, the plan identifies a method for obtaining the data. A mid-course report will be prepared in 1996.

## For More Information . . .

To obtain a copy of *Healthy Arkansans 2000*, contact:

Arkansas Department of Health
Director's Office
4815 West Markham Street
Little Rock, AR 72205-3867
(501) 661-2765

# California

## Summary of State Objectives

While California-specific objectives for all the categories of the *Healthy People 2000* document are in various stages of development, several programs have developed objectives for their program areas. For example, the Maternal and Child Health (MCH) Branch initiated an elaborate system to ensure broad professional and community input into the development of their planning document in response to the requirements of the Federal Title V Block Grant. Title V now requires that priority populations and services highlighted in *Healthy People 2000* be addressed.

A multi-ethnic health promotion conference sponsored by the Health Promotion Section's Preventive Medical Services Division had as a planned outcome the presentation of four ethnic-specific papers outlining the priorities for health promotion/disease prevention based on the *Healthy People 2000* objectives and California-specific data where they exist. The four papers outline objectives and recommendations for the State's African American, American Indian, Asian and Pacific Islander, and Hispanic populations. The final papers will be ready for distribution in early 1992.

The Emergency Preparedness and Injury Control Section participated in the setting of objectives, as violence and abusive behavior and unintentional injuries are areas of primary concern for some groups. Development of local oral health objectives consistent with the *Healthy People 2000* Oral Health objectives was the focus of the Dental Health Section's annual conference for contractors in the Children's Dental Disease Prevention Program. For nutrition, emphasis is on achieving objectives for dietary change in the general public and in major population subgroups. The channels used are: government, mass media, the food industry, and professional associations. Other organizational units in the department are beginning to analyze the objectives for relevance to the programs and populations they serve.

## Developing the Objectives

The Maternal and Child Health (MCH) Branch used a thorough and broad-based approach to develop its plan. The Branch developed a survey questionnaire to solicit input from approximately 300 individuals involved in MCH activities throughout the State that proved useful in drafting the plan. Meetings were held at three California Schools of Public Health and the proceedings were incorporated into the plan. Regional meetings were held in both northern and southern parts of the State to provide forums for discussions of maternal and child health priorities and to continue consensus building.

The Health Promotion Section convened committees to review the objectives in ten health promotion and disease prevention areas. Northern and Southern California groups were convened to review relevant data, establish priorities, and make recommendations. Members of committees represented community leaders interested in health, leaders from community agencies, providers, county health departments, universities, and schools of public health. The majority of each committee was representative of its ethnic community. Drafts of each committee's papers were distributed at the conference and participants were given the opportunity to provide input and approve or amend the recommendations. Some groups progressed to the point of discussing implementation plans for meeting their objectives.

Three other sections in the Preventive Medical Services Division--Emergency Preparedness and Injury Control, Tobacco Control, and Epidemiology and Disease Prevention--have joined the Health Promotion Section to monitor progress in their specific areas.

Participants in the Dental Health Section's annual conference used the *Healthy People 2000* Oral Health objectives as part of their reference materials in developing a set of priority objectives for State and local dental public health programs in California.

In 1990, an interagency work group developed dietary guidance policy for the State. The *California Daily Food Guide: A Technical Report for Professionals* (CDFG) and its companion consumer education information contain clear, consistent messages about foods needed to promote good health and lower chronic disease risk. The State Departments of health services, education, and aging all participated with assistance from the University of California Cooperative Extension.

## Plans for Implementation

The MCH Branch is finishing its plan which will include implementation strategies. In addition, the Dental Health Section is preparing a Request for Proposal for funding to implement activities to help meet the objectives developed at its annual conference.

The Health Promotion Section has prepared a Request For Proposals for funding to implement specific objectives. The Steering Committee and task forces will remain in action to help identify additional resources for implementation and for providing input and testimony for implementing policy recommendations.

The California Daily Food Guide (CDFG) is being used in all nutrition activities of the three State departments, such as the 5 a Day for Better Health program, Project LEAN, the School Nutrition: Shaping Healthy Choices initiative, and guidelines for congregate meals for older people. The Guide has been disseminated to local governments, the major health professional associations, and all voluntary heath agencies; endorsed by the State's major nutrition organizations; and promoted by the State medical society, the health-care and hospital association, and several agriculture marketing boards. The Department is working with the legislature to maintain and expand programs to help the public implement the CDFG's recommendations. A three-year strategic plan is being finalized.

## Tracking the Objectives

The Department has had an active interest in monitoring the health status of California compared to both the 1990 objectives and the *Healthy People 2000* objectives. The Department published two reports, in 1984 and 1987, outlining California's status on the 1990 objectives. These reports helped identify areas where California had met 1990 objectives and areas where additional data or services were needed to meet the goals.

With the release of the first draft of *Healthy People 2000*, the Department began collecting and analyzing pertinent data for California's progress in meeting these objectives. The Department's Health Data and Statistics Branch is releasing a series of documents assessing California's progress in specific objectives. The first report was released in May 1991 and addressed the ten objectives for Maternal and Child Health. Progress in meeting the Maternal and Child Health objectives will begin to appear in the vital statistics records of the State for low-birth-weight babies, teenage pregnancies, birth defects, and other data sources. In addition, a major report that assessed California's progress in meeting the *Healthy People 2000* objectives is currently being prepared by the Data Retrieval and Analysis Section.

Implementation and tracking progress are integral to the California Daily Food Guide strategic plan. Evaluation measures for process, policy, and population endpoints are included in the strategic plan. In 1993 and beyond, the Department hopes to repeat statewide dietary surveys first conducted in 1989 and 1991, to obtain trend information, and continue to inform intervention programs.

The Department of Health Services is also making much of its data available to other State agencies that are using *Healthy People 2000* as a policy tool for addressing disparities in the programs and activities that they administer. The Department's data are available to local health departments and other agencies interested in using data to address local public health issues and the *Healthy People 2000* objectives.

The MCH Branch has identified funds from the MCH Services Block Grant that will be used to conduct the first statewide oral health needs assessment for children in California. This assessment will include the collection of baseline data related to a number of children's oral health objectives, including caries and periodontal disease prevalence, and the use of sealants.

## For More Information . . .

Contact people for specific information:

Data reports:

Anthony Oreglia
Health Data and Statistics Branch
(916) 657-3057

MCH Title V Plan:

Dr. Terrance Smith
MCH Branch
(916) 657-1363

Health Promotion and Disease Prevention:

Dr. Donald O. Lyman
Preventive Medical Services Division
(916) 445-1102

# Colorado

## Summary of State Objectives

At present, Colorado has not set specific objectives for all the priority areas in *Healthy People 2000*. Divisions in the Department of Health, however, have incorporated the *Healthy People 2000* objectives into their annual program plans. *Healthy People 2000* priority areas that have been incorporated into program plans include:

- Cancer;
- Heart Disease and Stroke;
- Diabetes and Chronic Disabling Conditions;
- Unintentional Injuries;
- Nutrition; and
- Physical Activity and Fitness.

## Developing the Objectives

To develop their annual program plans, divisions solicit input from community advisory groups. Currently, Colorado is evaluating the *Healthy People 2000* objectives as they relate to Colorado to initiate the development of a statewide year 2000 plan. A recently hired staff member will coordinate development of the process Colorado will use to determine its priorities. The process for developing State objectives will be similar to the process currently used by divisions in the Department of Health. Community advisory groups and Department staff will aggregate information concerning objectives that the State currently is pursuing and identify areas where objectives must be set.

## Implementing the Plans

By June 1992, the State expects to have between two-thirds and three-fourths of its year 2000 objectives organized into individual program plans. Colorado has implemented an injury prevention plan and is in the process of implementing cardiovascular disease prevention, diabetes, and physical fitness plans.

## Tracking the Objectives

Colorado maintains various data sources that it will use to track progress toward its objectives. The State also will develop mechanisms for tracking objectives for which data does not exist.

## For More Information . . .

To obtain further information regarding Colorado's objective-setting process, contact:

Snip Young
Division of Prevention Programs
Colorado Department of Health
4210 East 11th Avenue
Denver, CO 80220
(303) 331-8301

# Connecticut

## Summary of State Objectives

Connecticut faces many of the severe health and health-care access problems that plague northeastern States including: high incidence of AIDS among urban intravenous drug users and their sexual partners; high rates of pediatric AIDS cases; significant rates of infant mortality and morbidity, especially in the urban areas; substantial percentage of the population who are medically uninsured or under-insured; high incidence of cancer and other chronic diseases; increasing levels of infectious disease, especially STDs and TB; and a significant radon problem, among others. The Connecticut Department of Health Services has been addressing these and other pressing health issues through its various public health programs, interagency initiatives, and its participation in special legislative commissions like the Blue Ribbon Commission on State Health Insurance and the Health Care Access Commission.

A new administration took office in January 1991. Two of Governor Lowell P. Weicker, Jr.'s key policy goals are:

- Increase access to health care, particularly for children; and
- Emphasize preventive health care for children and other at-risk populations to improve their health and to reduce future health-care costs.

In this policy context, the new Commissioner of Health, Susan Addiss, has outlined the Connecticut Department of Health Services' top four health priorities. They are:

- Maternal and Child Health;
- AIDS: Prevention, Counseling, Testing, and Health Services;
- Drinking Water; and
- Health Data and Surveillance Systems.

In addition to the priorities set by the Commissioner, certain bureaus in the Department of Health Services have already targeted specific priority areas. The Bureau of Health Promotion has targeted Occupational Safety, Sexually Transmitted Diseases, and Immunizations and Infectious Diseases. The Bureau of Community Health has targeted Nutrition and Maternal and Child Health. The Office of Chronic Disease has targeted Physical Activity and Fitness, Tobacco, Educational and Community-Based Programs, Unintentional Injuries, Heart Disease, Stroke, and Cancer.

## Developing the Objectives

The Department of Health Services is conducting an internal review of its programs and subprograms to determine priorities among the programs, keeping in mind Department of Health Services priorities, pressing health problems, severe budget constraints, and legislative mandates.

In addition, the Department is evaluating how its programs and priorities connect with the *Healthy People 2000* objectives. This process is expected to take several months to complete.

## Plans for Implementation

Divisions in the Department have used the *Healthy People 2000* objectives to develop annual workplans. For example, eleven of the priority areas dealing with chronic diseases are incorporated into the planning of chronic disease activities for 1991-92.

## Tracking the Objectives

Connecticut participated in the Behavioral Risk Factor Surveillance System in 1985, and in 1988 through the present time. This telephone survey of adults is coordinated and funded by the U.S.

Centers for Disease Control. In addition to the core questions asked by all States, Connecticut has added questions each year to specifically address the *Healthy People 2000* objectives. These have included cervical cancer screening practices, mammography use, smoke detector use, levels of radon knowledge and testing, and dietary factors. Reports of survey results are issued each year; the report of 1990 data will incorporate both achievement of 1990 objectives and progress toward meeting the *Healthy People 2000* objectives.

The Department also collects data on youth in grades four through twelve through implementation of its Connecticut Health Check, a computerized health risk appraisal. Although random sampling is not employed, between 7,000 and 10,000 young people participate each year. Our experience suggests that these data provide a reasonably accurate representation of the level of behavioral health risks in the adolescent and preteen population in the State that can be used to track objectives.

The State of Connecticut recently applied to the Robert Wood Johnson Foundation for a grant to enhance and centralize its health data system for health policy development and program evaluation purposes.

## For More Information . . .

For further information about Connecticut's health objectives and the strategies for meeting them, please contact:

Marie V. Roberto, Dr. P.H.
Chief
Center for Health Policy Development
Connecticut Department of Health Services
150 Washington Street
Hartford, CT 06106
(230) 566-1060

# Delaware

## Summary of State Objectives

The Delaware Department of Health and Social Services' Division of Public Health (DPH) has taken the lead in developing plans and State objectives related to *Healthy People 2000*. DPH coordinates several important grants that affect the year 2000 goals: the Preventive Health and Health Services Block Grant, the Maternal and Child Health Block Grant, and the Women, Infants, and Children (WIC) grant. These grants allowed DPH to address the year 2000 goals in the following manner:

- Assess the health needs of the population and the significance of the problem(s);
- Rank the health needs of these specific populations; and
- Develop specific State objectives that correspond to the *Healthy People 2000* goals and objectives.

Throughout the course of the current year, these goals will be monitored by project/grant coordinators and reported on in the next application cycle for these grants. Information gathered will be channeled to the DPH Support Section where the Director of Strategic Planning and Budget Coordination will use the information for further development of year 2000 objectives.

## Developing the Objectives

To date, DPH has confined year 2000 planning to specific grants. During the course of 1992, this process will change. DPH will be initiating a comprehensive, statewide, multi-agency planning process to develop a *Healthy Delaware 2000* plan. Our goals and objectives will be based on *Healthy People 2000* and will reflect the needs of Delaware's citizens.

## Plans for Implementation

A detailed implementation plan will not be developed until the final *Healthy Delaware 2000* plan has been completed. It is anticipated that multiple agencies will be involved in developing action plans to implement specific objectives from the plan to attain Delaware's goals.

## Tracking the Objectives

Grant managers are currently tracking those objectives related to WIC, Maternal and Child Health, and the Preventive Health and Health Services Block Grant.

## For More Information . . .

Terrance Zimmerman, Ph.D.
Director of Strategic Planning and Budget Coordination
Division of Public Health
Delaware Department of Health and Social Services
P.O. Box 637
Dover, DE 19903
302-739-3034

# District of Columbia

## Summary of State Objectives

Because of the administrative structure of the District of Columbia Government, the city, and in particular, the Commission of Public Health, has various health plans to meet the needs of its clients as mandated by law or determined by need assessment. The Commission of Public Health is part of the Department of Human Services. The Commission has standing plans in the priority areas of Maternal and Child Health, Nutrition, Alcohol and Drug Abuse, and Acquired Immune Deficiency Syndrome (AIDS). Currently, the District of Columbia Commission of Public Health's objectives for the year 2000 are divided into priority areas and each priority area has a minimum of five measurable objectives. The priority areas are:

- Nutrition;
- Alcohol and Drug Abuse;
- Educational and Community-Based Programs;
- Maternal and Infant Health;
- Heart Disease and Stroke;
- Cancer;
- Diabetes and Chronic Disabling Conditions;
- HIV Infection;
- Sexually Transmitted Diseases;
- Immunization and Infectious Diseases;
- Adolescents and Young Adults;
- Minority Health;
- Health Care Reform; and
- Surveillance and Data Systems.

Efforts are underway to develop a strategic plan that addresses the specific priority areas with an emphasis on their relationship to the *Healthy People 2000* objectives.

In addition to updating the existing independent plans to reflect the year 2000 health objectives in the select priority areas, the Commission of Public Health will seize the opportunities presented in grant applications to emphasize its efforts and the need for attaining the *Healthy People 2000* objectives.

Development of the plans and objectives is usually a collaborative effort between the Commission, consumers, and providers. Each of the priority areas is reflected in the administrative structure of the Commission of Public Health, either in the responsible program administrations or offices. Each administration or office is supported by an Advisory Council or Task Force composed of consumers and providers. This ensures broad involvement in decision making. When the need arises, public meetings or hearings are held to elicit citizens' input.

## Developing the Objectives

The various programs in the D.C. Commission of Public Health generate a great amount of data. The commission, through its District of Columbia Initiative, is pursuing efforts to refine and redesign its data collecting system. The system will be centralized, consistent with program indicators under the purview of the Commission, and more compatible with national standards for better access and comparable analysis. This effort is being accomplished with technical assistance from the U.S. Centers for Disease Control and the U.S. National Center for Health Statistics.

## Plans for Implementation

The Commissions's plans or programs delineate action plans on a year-to-year basis. These action plans are translated into implementation plans for the various priority areas.

## Tracking the Objectives

The Monitoring and Evaluation Division of the Commission develops standards based on program indicators. The various programs are monitored and measured against the standards.

## For More Information . . .

To obtain information on the District of Columbia's efforts to attain the *Healthy People 2000* objectives, you may contact:

Carlessia A. Hussein, Dr.P.H.
Chief
Office of Health Planning and Development
DC Commission of Public Health
1660 L Street NW.
Suite 1117
Washington, DC 20036
(202) 673-7481

# Florida

The State Health Office, in the Department of Health and Rehabilitative Services (HRS), developed the *Florida State Health Plan* in 1989. This plan is based on health outcome indicators, many that are linked to the goals and objectives eventually published in *Healthy People 2000*. *Healthy People 2000* has been valuable to us in presenting our initiatives to the Governor's Office and the legislature. It provides justification and a comparison for our objectives.

## Summary of State Objectives

The *Florida State Health Plan* is divided into seven health areas:

- Maternal and Child Health;
- Sexually Transmitted Diseases, AIDS, Other Communicable Diseases;
- Chronic Diseases;
- Environmental Health;
- Dental Health;
- Injuries and Accidents; and
- the Delivery System.

Each area lists the area goal and an issue description presenting current conditions. In addition, each area contains strategies, milestones, and measurable objectives. In addition, Florida is committed to improving the health of adolescents and young adults, improving access to care, and developing surveillance and data systems.

The Florida Department of Health and Rehabilitative Services has also adopted a new agency functional plan entitled the *Strategic Plan for Results in the 90s*. The health section of this plan is similar in many respects to the *Florida State Health Plan*. Both are built around measurable outcome indicators. The health section of the agency function plan is broken into four major parts: a Healthy Start for Children, a Chance to Succeed in School; a Wellness Strategy; and Access to Health Care. Maternal and child health activities are assigned the highest priorities.

## Developing the Objectives

Objectives for the *Florida State Health Plan* were developed between October and December 1988. During this process, regional forums were held involving Department State Health Office staff, Department District staff, and county public health unit staff. Also having input were representatives of approximately forty State and private nonprofit organizations including the American Cancer Society, the Association of Voluntary Hospitals, the Florida Health Care Association, the March of Dimes, and three major State universities. The draft *Healthy People 2000* document was the model for our efforts. Our goals were selected to either meet or exceed the national goals. The plan is reviewed and updated biannually through a public process involving representatives similar in composition to the original forums.

## Plans for Implementation

Strategies for each objective in the plan present the broad action steps necessary to meet milestones and objectives. The strategies set forth specific actions and time frames and, in most cases, are themselves quantifiable. The strategies are comprehensive and include activities such as developing needed information systems, education efforts, and linkages with non-HRS providers in addition to merely expanding programs and increasing the number of clients served.

## Tracking the Objectives

Progress towards strategies is tracked quarterly. In addition, the State Health Office is developing a comprehensive reporting and tracking system for all objectives. We anticipate this will be in place in approximately six months. The State Health Officer reviews progress on strategies and objectives and provides leadership and direction.

## For More Information . . .

For further information or a copy of the *Florida State Health Plan* contact:

C. Meade Grigg
Health Services and Facilities Consultant Supervisor
Department of Health and Rehabilitative Services
1323 Winewood Boulevard, Room 113
Tallahassee, FL 32301

# Georgia

## Summary of State Objectives

Although not finalized, Georgia plans to address the twenty-two *Healthy People 2000* priority areas into a statewide plan for enhancing the health of its population. Georgia is in the process of establishing the method that will used to rank the priority of its objectives.

Due to the appointment of a new public health director and budget cuts, the State of Georgia will not finalize its plan before spring 1992.

## Developing the Objectives

The Division of Public Health is approaching the development of Georgia's objectives from the viewpoint of local adaptation and shared responsibility. Each of the *Healthy People 2000* objectives will be evaluated regarding its relevance for Georgia and translated into goals for each of the State's nineteen health districts. For example, in 1987, the Georgia Center for Health Statistics developed a methodology for translating the 1990 infant mortality objective into an operational process in the State. The purpose of the methodology was to distribute the reduction of infant deaths among the State's health districts so that a shared proportional contribution toward the 1990 State objective was achieved.

State health officials, with the approval of district health officials, will develop the statewide goals. District health officials will be expected to solicit the input of local constituents when appropriate.

## Plans for Implementation

Implementation plans will be developed by State and district health directors. Implementation of these plans will be the responsibility of district health officials and local agencies.

## Tracking the Objectives

Georgia plans to use vital statistics as a tool for measuring the success of particular objectives. To fulfill its data needs, Georgia also hopes to cooperate with the U.S. National Center for Health Statistics.

## For More Information . . .

To obtain additional information regarding Georgia's objective-setting process, contact:

Tom Wade
Director, Administrative Services
Division of Public Health
878 Peachtree Street, NE.
Atlanta, GA 30309
(404) 894-6475

# Hawaii

## Summary of State Objectives

Published in October 1990, *Hawaii's Health* summarized the 1990 health objectives and described data for 93 of the 202 Hawaii 1990 objectives. It was reasonably likely that twenty-six of the objectives would be met and that twenty-nine would not be met by the end of 1990.

Task Forces are currently reviewing the objectives and identifying priorities and special problem areas, particularly the objectives not previously met. The Task Forces will develop annual implementation plans and several will serve as a community advisory group to divisions in the Department of Health.

## Developing the Objectives

The Hawaii health objectives were developed over a period of five years through the participation of fifteen Task Forces. The Task Forces were comprised of public, private, professional and voluntary agencies, private business sector, academic institutions, and the military.

The Task Force chairs received training in parliamentary procedure, group facilitation and decision-making, and the health objectives. Three statewide conferences were held to discuss progress toward attaining the objectives. The 1988 conference reviewed progress and revised objectives in fifteen priority areas. Three statistical reports have been published that track Hawaii's current status on the objectives.

A Transition Team was convened to facilitate transition from the 1990 health objectives to the year 2000 health objectives by making specific recommendations to the Director of Health in several specific areas:

- Strategic Plan Review - review the current strategic Plan and recommend any changes;
- Organizational Infrastructure - define the organizational elements and the roles and responsibilities of each of these units;
- Membership and Training - define the criteria and qualifications for community board appointees and recommend a list of nominees; and
- Identify "Cluster of Needs" - review the twenty-two priority areas of *Healthy People 2000* and recommend a "clustering" of these areas to eliminate the overlap and duplication of effort experienced in implementing the 1990 objectives.

## Plans for Implementation

All divisions in the Department of Health are incorporating the year 2000 objectives into their program plans with detailed implementation strategies to measure progress and attainment of the goals. Strategies include collection of appropriate data, linking with other databases, developing targeted programs, and introduction of legislative initiatives.

A Community Board, comprised of 50 percent health-care representatives and 50 percent community membership, will be formed. The purpose of the Community Board is to:

- Recommend community priorities and direction of year 2000 activities;
- Advise the Director of Health on issues and strategies related to attaining the year 2000 health objectives; and
- Develop linkages, partnerships, and initiatives with agencies, organizations, and community groups.

The Project staff will provide the necessary and vital data and information required for the Task Forces to discuss issues, create alternatives, and make decisions. Another strategy is to give the general public information about the year 2000 objectives through regular media releases that

highlight Hawaii's Health Risk Behavior data information and how Hawaii residents are progressing toward the achievement of a healthy lifestyle. The activities of the health objectives in Hawaii are coordinated by three public health educators in the Health Promotion and Education Branch. The Project is funded under the Prevention Block Grant and is called Healthy Hawaii 2000.

## Tracking the Objectives

The Project staff is working closely with the Office of Minority Health Status Monitoring to develop new databases needed to identify the critical data elements, and to coordinate information from current data sources. Emphasis is being placed on ethnic specific data to address the needs of Hawaii's many Asian and Pacific Islander groups. A mid-course report will be prepared in 1995.

## For More Information . . .

For further information about Hawaii's health objectives, contact:

Paul Davis
Healthy Hawaii 2000
Health Promotion and Education Branch
Hawaii Department of Health
1250 Punchbowl Street
Honolulu, HI 96813
(808) 586-4661

# Idaho

## Summary of State Objectives

During the annual planning process for fiscal year 1992, program managers in the Division of Health reviewed the health objectives from *Healthy People 2000* that relate to their programs. National health objectives that are measurable in the State of Idaho (i.e., data is available to track progress) were integrated into program plans, thus ensuring that Idaho's health promotion and prevention activities are congruent with national efforts.

The *Public Health Plan, FY 1992* incorporated selected national objectives from the following priority areas: Nutrition, Tobacco, Family Planning, Food and Drug Safety, Educational and Community-Based Programs, Environmental Health, Oral Health, Maternal and Infant Health, Heart Disease and Stroke, Cancer, HIV Infection, Sexually Transmitted Diseases, Immunization and Infectious Diseases, Surveillance and Data Systems, Access, and Adolescents and Young Adults.

## Developing the Objectives

Each year, program managers in the Division of Health complete a formal planning process that serves as a management tool for Division staff. The plan development process involves each program manager analyzing and developing the following components for the various program plans:

- Service description of current program activities;
- Service need documenting statewide health-care needs that are germane to the program;
- Goals stating what is to be accomplished during a three-year time frame;
- National objectives that are applicable to the program goal;
- State objectives that identify a quantifiable, measurable target to be achieved during the upcoming year in progressing toward the stated goal;
- Indicators that identify specific data and/or the system that will be used to track progress toward the State objective; and
- Management strategies that establish the action steps necessary to achieve the program objective.

Program objectives are developed annually over a three-month period at the request of the Administrator of the Division of Health. The objectives respond to community need and are outcome oriented, achievable, quantifiable, and measurable. Program managers establish the objectives with guidance and supervision from the Administrator and Bureau Chiefs in the Division of Health. *Healthy People 2000* objectives were integrated into the following program plans:

- Child Health Improvement;
- Children's Special Health;
- Dental Health;
- Environmental Health;
- Epidemiological Services;
- Family Planning;
- Food Protection;
- Genetic Service;
- Health Promotion and Disease Prevention;
- Improved Pregnancy;

- Nutrition;
- Sexually Transmitted Disease; and
- WIC.

## Plans for Implementation

The *Public Health Plan* contains management strategies that program managers are responsible for completing during the stated time frame. These action steps are intended to lead to the achievement of the goals and objectives.

## Tracking the Objectives

Evaluation is the final step in the Division's formal planning process. By analyzing the appropriate indicators, program progress is measured and compared to the desired outcome stated in the objectives. This allows program managers to identify strengths and weaknesses of program activities and to revise future program plans accordingly. Although program activities are continuously monitored, a formal evaluation is completed at the end of the year and published in the *Annual Program Report.*

Indicators detailed in the *Public Health Plan* identify the data or mechanism that will be used to track progress. With most objectives, current data is available to quantify the existing statewide status and a mechanism is in place to track the degree of progress toward the objective.

## For More Information . . .

To obtain a copy of the *Public Health Plan, Fiscal Year 1992,* contact:

Office of Health Policy and Resource Development
Division of Health
Idaho Department of Health and Welfare
450 West State Street, 4th Floor
Boise, ID 83720
(208) 334-5992

# Illinois

## Summary of State Objectives

As part of Project Health, an extensive statewide effort that began in the mid-1980s, the Illinois Department of Public Health (IDPH) is scheduled to finalize its year 2000 plan by early 1992. The plan will include priority objectives for Illinois. The scheduled release of the plan accommodates the drafting of new local program standards consistent with *Healthy People 2000* and the scheduling of a statewide conference focusing on local needs assessment in support of targeting State and local priority objectives for the year 2000.

## Developing the Objectives

In March 1990, a statewide task force issued its final report, *The Road to Better Health for All of Illinois*. The report is viewed as Illinois' companion document to the Institute of Medicine's report, *The Future of Public Health*. The Illinois report compares the optimal with the existing public health system and makes recommendations for change. It explores the statutory and regulatory framework in Illinois, the organizational structure, service delivery, and funding. More than 300 colleagues participated in the preparation of this document, including a mid-project conference to develop a consensus on a public health charter. The charter contains a broad mission statement for public health, identifies three major roles of government, and provides a common vision of where we want to go.

The task force presented twenty-nine recommendations that constitute a plan to address seven major categories of activities necessary for achieving the public health mission. The categories are marketing public health, statutory authority, organizational characteristics, accountability, financing, educating public health professionals, and basic public health services. Project Health is establishing a framework for the protection and improvement of the public's health into the next century. Illinois's system will be consistent with *Healthy People 2000*, *Healthy Communities 2000: Model Standards*, APEX/*PH* (Assessment Protocol for Excellence in Public Health), and other Federal initiatives. The process emphasizes those objectives of highest priority in Illinois to achieve the *Healthy People 2000* objectives.

## Plans for Implementation

Currently, more than 170 public health professionals are working to implement each of the twenty-nine recommendations, and finalizing the strategy for assessing local and State needs, the focus of the upcoming conference. The newly revised requirements for program and personnel standards will be responsive to the needs assessment results and will complement *Healthy People 2000* and *Healthy Communities 2000: Model Standards*.

IDPH has provided leadership in organizing public and private groups to be partners in State plan implementation. In addition to involving them in the restructuring of the State system, IDPH has coordinated their participation in helping to shape *Healthy People 2000*. In June 1991, IDPH organized a Governor's Conference on *Healthy People 2000*. As follow-up to that conference, IDPH is helping other State agencies with responsibilities in health-related areas to organize resources in support of the year 2000 plan. These agencies include the Departments of Mental Health and Developmental Disabilities, Alcoholism and Substance Abuse, and Rehabilitation Services.

## Tracking the Objectives

Project Health is finalizing a set of health indicators to serve as the minimal elements for local and State needs assessments. The set contains a series of indicators (along with the relevant data source) for each of the following: demographic and socioeconomic characteristics; general health and access to care; maternal and child health; chronic diseases; communicable diseases; and

environmental health, occupational health, and injury control. State and local responsibilities for obtaining and analyzing the indicators, as they are used in tracking the health objectives, are being identified.

## For More Information . . .

To obtain a copy of the documents referenced in this summary, including Illinois' health plan when it is published, contact:

Office of the Deputy Director
Illinois Department of Public Health
535 West Jefferson
Springfield, IL 62761
(217) 782-2180

# Indiana

## Summary of State Objectives

The *Indiana Plan for Health, Sixth Edition, 1991-1996*, was approved by the Executive Board of the Indiana State Board of Health in November 1990. The Plan was forwarded to the Governor for consideration and distributed to primary implementers of the Plan, local health departments, universities, State agencies, and other interested parties.

*Healthy People 2000* objectives are included in the plan in the areas in which the State has data to track progress towards the objective or had a commitment to collect data to measure progress. The Plan has 34 goal areas, 110 objectives, and about 300 recommended actions. Each Plan component contains a brief discussion of the issues and trends, the Indiana 1988 baseline, the 1996 target for Indiana, and the year 2000 target. Recommended actions include expected impact, primary implementers, and resource requirements.

The *Indiana Plan for Health* includes the *Healthy People 2000* objectives (or portions of the objectives) relevant to Indiana. The following Plan components contain objectives relating to: infants, adolescents and young adults, cancer, respiratory health, dental health, vision and hearing programs, mental health (mental and behavioral disorders and alcohol and other drug problems), syndrome of violence, unintentional injuries, health of minorities, health of the rural population, health of older people, nutrition, physical fitness and exercise, environmental health, HIV, sexually transmitted diseases, immunizations and infectious diseases, and surveillance and data systems. The Plan contains a list of high priorities for the State of Indiana.

## Developing the Objectives

*The Indiana Plan for Health, Sixth Edition*, was developed over a one-year time span. Drafts of each of the thirty-four goal areas with objectives and recommended actions were developed in cooperation with experts in the field, a review of national and State data, plans, projects, and programs, and consultation with State and local officials. Each Plan component was reviewed by an external review group (ERG). The ERGs were composed of people from the public and private sector, academic institutions, voluntary health organizations, State and local agencies, and health and health-related agencies. The ERG members represented a geographic distribution across the State. More than 110 agencies or organizations were involved in this review process. Approximately 350 people reviewed one or more components of the Plan. Five public meetings were held throughout the State. The Plan was also reviewed by staff from the Governor's office and the Executive Board of the Indiana State Board of Health.

## Plans for Implementation

The Plan includes one or more primary implementers for each recommended action. Each action relates to an objective under a priority area that, if implemented, would help achieve the health status or health systems level desired in the State. Primary implementers, (i.e., agencies and organizations in the public and private sectors) were involved in the external review process and in the initial development of the Plan component. Written commitments to implement their component of the Plan were obtained.

The Plan, while developed under legislative mandate, relies upon voluntary efforts for implementation.

## Tracking the Objectives

Each of the 300 recommended actions have a primary implementer committed to either tracking or implementing that Plan component. About 130 agencies and organizations serve as primary implementers of the Plan. The Indiana State Board of Health annually prepares a monitoring and

implementation report. Each primary implementer is contacted to ascertain progress or lack of progress towards implementing the action that they were committed to implement.

A mid-course correction will be made by the development of a document titled *The State of Indiana's Health, Fifth Edition.* This document will contain an analysis of statewide health needs. In addition to *The State of Indiana's Health*, Indiana will update a document entitled *The State of Indiana's Health and The 1990 Objectives for the Nation* to include the *Healthy People 2000* objectives for the Nation.

## For More Information . . .

The Plan is developed in three documents: an Executive Summary, a Summary, and the complete Plan. To obtain a copy of the Plan, contact:

Indiana State Board of Health
Public Health Research Division, Room 332 West
1330 West Michigan Street
Indianapolis, IN 46206-1964
(317) 633-8534

# Iowa

## Summary of State Objectives

Iowa is currently developing year 2000 goals and action steps for health promotion and disease prevention under the direction of the Healthy Iowans 2000 Task Force, a Governor-appointed, nineteen-member group. Since its first meeting in March 1991, the task force has adopted a mission statement, a work plan, and procedures for setting measurable goals and action steps; reviewed and revised the environmental health section of the plan; and discussed proposed sections in the plan for the priority areas Food and Drug Safety, Immunization and Infectious Diseases, Sexually Transmitted Diseases, and HIV Infection. By early 1992, the task force will complete the review and approval process for Iowa's year 2000 plan. Public hearings in each congressional district will follow. An adopted plan with implementation strategies at the State and local levels is targeted for completion by July 1992.

## Developing the Objectives

A Department of Public Health work group has assumed responsibility for coordinating tasks in the department, across other State departments, and with groups outside State government. Each work group member also is responsible for convening an interagency committee to review the various national priority area objectives and propose relevant State goals and actions. For example, staff from the Departments of Public Health and Natural Resources presented background information and proposed goals and action steps at a task force meeting and then revised their plan on the basis of task force input. As a result, both agencies will work in tandem over the next decade on public and private water supplies, waste water, surface water, solid waste, childhood lead poisoning, indoor air quality, ambient air quality, hazardous waste, and surveillance. The environmental health plan will provide a focus for greater coordination of staff resources and programs.

A strategic planning process includes these elements for each priority area:

- A brief description of the problem in Iowa with supporting data;
- A measurable and realistic year 2000 goal statement with baseline data;
- Rationale for the goal statement;
- An action plan with action steps supported by a rationale and discussion of feasibility;
- An appendix listing agencies sharing responsibilities for specific health programs; and
- An appendix relating the Iowa goals and action steps to the national objectives in *Healthy People 2000.*

The task force responsible for overseeing Iowa's Healthy People 2000 plan is gender and political party balanced. Members represent key departments of State government, health professional associations, voluntary associations, academic institutions, consumers, and the State board of health. The Governor appointed the task force chair, Dr. Richard Remington, Director of the Institute of Health, Behavior, and Environmental Policy at the University of Iowa. Dr. Remington chaired the Institute of Medicine's seminal study, *The Future of Public Health.*

A consortium of professional and voluntary organizations will further broaden participation in Iowa's plan. Thus far, more than 60 groups have accepted invitations to become involved in the planning and implementation process. In addition, a *Healthy Iowans 2000* newsletter will link local health initiatives to State plans, and thus build upon Iowa's well-developed county health planning program.

## Plans for Implementation

The strategic planning process has included implementation plans. Each action step in the plan will contain a discussion of what agencies or groups are responsible for assuring that actions are taken and what changes must occur in reallocating staff resources, legislation and administrative rules, and increased funding levels.

## Tracking the Objectives

Iowa has taken immediate steps to integrate its basic set of eighteen health status indicators into its Vital Records Bureau reports. In other areas not covered by these indicators, Iowa will coordinate State data reporting systems and develop tracking where data are limited. Following adoption of the plan, the task force will appoint working groups to ensure monitoring and implementation for each goal and action step. Using *Healthy Communities 2000: Model Standards*, counties will fit their health planning initiatives into the State plan and annually report on their progress to the Department of Public Health.

A mid-course review with possible goal and action step changes is scheduled for 1995-1996.

## For More Information . . .

For further information, contact:

Louise Lex, Ph.D.
State Health Planner
Division of Health Policy and Planning
Iowa Department of Public Health
Lucas State Office Building
Des Moines, IA 50319-0075
(515) 281-4066

# Kansas

## Summary of State Objectives

The Kansas Department of Health and Environment has recently begun a planning process to develop and implement year 2000 health objectives specific to Kansas and responsive to the *Healthy People 2000* objectives. The process is an organized, decade-long effort to achieve the objectives. The campaign is called Healthy Kansans 2000 and parallels the national Healthy People 2000 campaign. The objectives that will be adopted for *Healthy Kansans 2000* will reflect the consensus of public health agencies, voluntary health organizations, private health foundations, health provider trade and professionals organizations, private industry, and others.

## Developing the Objectives

The Kansas process began with establishment of a policy committee appointed by the Department Secretary. The committee is composed of representatives of the Department's four Divisions: Health, Environment, Information Systems, and Laboratories and the Secretary's Office. Their task is to authorize and coordinate the Department's activities related to the year 2000 planning process.

The decision-making process uses a consortium that is broadly representative of Kansas society. The consortium will provide a foundation for both the planning and implementation activities of Healthy Kansans 2000. Organizations will be invited by the Secretary to participate. A steering committee of the consortium will be appointed by the Secretary and have primary responsibility for selecting the priority areas to be addressed. Priority areas will be selected based on the perceived biggest public health challenges in Kansas. The objectives for each priority area will be outcome oriented, preventive in nature, achievable, and measurable. After the priority areas are identified, work groups will be formed to identify indicators and objectives for each priority area. Consortium members will be invited to select the priority area work groups in which they wish to participate.

## Plans for Implementation

In addition to developing indicators and objectives for each priority area, the work groups will recommend activities to be pursued and recommend key organizations to become involved in implementation. The consortium steering committee, in conjunction with the Department policy committee, will coordinate implementation plans.

## Tracking the Objectives

Existing data sources will be used in measuring progress towards meeting the objectives. It is anticipated that data will not be available for every indicator, therefore, provisions for collecting data for these indicators will be addressed in the plan.

## For More Information . . .

For more information regarding *Healthy Kansans 2000*, inquiries should be directed to:

Dick Morrissey
Deputy Director
Division of Health
900 Southwest Jackson, Room 1051
Topeka, KS 66612-1290
(913) 296-1086

# Kentucky

## Summary of State Objectives

*Healthy Kentuckians 2000--Kentucky's Public Health Objectives for the Year 2000* was released in November 1991. Kentucky's Year 2000 project was undertaken after issuance of the national objectives to maximize the correlation between State and national objectives. As a result, most of Kentucky's 179 objectives relate to equivalent national objectives, and many are exactly parallel.

- For the most part, *Healthy Kentuckians 2000* is organized parallel to *Healthy People 2000*, but with a few important differences. Like the national objectives, Kentucky's topical chapters are mostly categorized under sections on Health Promotion, Health Protection, and Preventive Services. Most chapter headings are the same as the *Healthy People 2000* priority areas; chapters on Emergency Medical Services and Radiation have been added. Chapters on Environmental Health and Food Safety are more comprehensive than their national equivalents.
- A section on Delivery System and Infrastructure contains Kentucky's equivalent to the *Healthy People 2000* Clinical Preventive Services priority area. The latter has been expanded to address broad public health policy issues that are generally absent from the national objectives, including the interrelationships between medical indigence, primary care, prevention, and health-care cost containment.
- A chapter on Academic Health Science Centers in Public Health is included in the infrastructure section. This chapter reflects the major and growing involvement of academic institutions in public health concerns such as rural health, production and distribution of primary care professionals, and related health policy issues.

## Developing the Objectives

Kentucky's public health objectives were developed over ten months at the direction of the State health commissioner, mostly by the Department for Health Services (State departments for Mental Health, Environmental Protection, and Social Services also contributed). The ground rules were simple: examine the *Healthy People 2000* objectives to identify those most applicable to Kentucky, substituting Kentucky-specific quantification in the objective targets and baselines. There was no requirement to include all national objectives and drafters were encouraged to write new objectives where a Kentucky health need was not addressed by any national objective.

A three-month public review was conducted during the spring and early summer of 1991. Approximately eighty State associations and organizations--public, private, and academic--with interest in public health, medical care, and health policy were invited to review and comment on the draft document. The resulting responses produced many helpful ideas that were incorporated into the final document, including one entire new chapter. Broad exposure to the objectives during this public review permitted early involvement and a degree of ownership by the many organizations whose actions are essential for achieving them, as well as acquainting their members with Kentucky's objectives.

## Plans for Implementation

*Healthy Kentuckians 2000* addresses a combination of approaches to ensure action toward achieving the objectives. Each objective (or in some cases groups of objectives) is followed by an "Implementation Strategy" and "Action Steps." The strategy lays out the broad scope of efforts to be pursued, in many cases naming a "lead" or "responsible" implementing agency as well as others that should collaborate or provide support. This is followed by brief descriptions of specific actions that could be taken to carry out the strategy.

These items are of course not exhaustive, and many may be revised or expanded as agencies and organizations confront the actual mechanics of implementation. Nonetheless, they provide a firm basis for planning and acting, and will likely affect determination of future priorities for public funds for health programs in Kentucky.

More broadly, the document also places great emphasis on cooperative efforts among the many public and private actors whose involvement is necessary to achieve the objectives. With the State Department for Health Services maintaining a permanent lead and initiating role, it is anticipated that academic and private-sector organizations also will take initiative actions toward various objectives during the decade. Particular emphasis is placed on front-line efforts by local agencies.

## Tracking the Objectives

A comprehensive mid-course progress assessment is being planned for 1995 (most objectives cite a 1989 or 1990 baseline). Other partial or ad hoc assessments will no doubt be conducted in response to requests by national health organizations, Federal funding requirements, and similar stimuli.

## For More Information . . .

C. Hernandez, M.D., M.P.H.
Commissioner, Department for Health Services
275 East Main Street
Frankfort, KY 40621
(502) 564-3970

# Louisiana

## Summary of State Objectives

Louisiana's Office of Public Health had incorporated the 1990 National Health Objectives into its planning, evaluation, and priority setting activities over the past decade. *Healthy People 2000* is now being incorporated into tactical and strategic planning for the coming years. It is the State's goal to achieve high priority objectives by 1996.

Each year, the Office of Public Health publishes its *Public Health Plan.* This document contains and tracks the *Healthy Communities 2000: Model Standards* and the *Healthy People 2000* objectives determined to be a priority in Louisiana. It contains objectives for the current year, future years, and the year 2000. The format of the *Public Health Plan* provides an evaluation mechanism to determine progress based on the achievement of measurable objectives. Funding and specific indicator activities are included for each program for current, past, and future years.

Priority areas at this time are Maternal and Infant Health, Tobacco-Caused Diseases, HIV/AIDS, Unintentional Injuries, Access to Health Care, Sexually Transmitted Diseases, Teen Pregnancy, Environmental Health, Alcohol and Other Drugs, Food and Drug Safety, Cancer, Immunizations and Infectious Diseases, and Adolescents and Young Adults.

Pursuant to APEX/PH (Assessment Protocol for Excellence in Public Health), the agency is in the process of developing community health advocacy/advisory committees at the parish level. Begun in 1989, this initiative provides local health units with parish specific data, training, and support in the development of viable programmatic planning at the local level. It is anticipated that parish community health advisory committees will provide major input into pursuit of the objectives at the local level.

## Developing the Objectives

Input into the planning process is provided by all program management staff based on needs and problems identified by staff at the parish, regional, and State levels. For many years, program planning has been fully integrated with budget planning thereby assuring undivided agency initiative. Because of this planning process, there was no need for special actions or a committee to incorporate year 2000 initiatives.

## Plans for Implementation

Louisiana's Public Health Plan contains action steps for implementation. The plan is revised and updated annually. Program management staff, with the assistance of programmatic and local health advisory committees, are responsible for implementation of the strategies.

## Tracking the Objectives

Senior executive staff of the agency, through its Policy, Planning, and Evaluation Section, are responsible for evaluation of progress toward meeting objectives. Louisiana's *Public Health Plan* provides for six month and twelve month evaluations of progress.

## For More Information . . .

To obtain a copy of Louisiana's *Public Health Plan*, contact:

Office of Public Health
Policy, Planning and Evaluation Section
P.O. Box 60630
New Orleans, LA 70160
(504) 568-2952

# Maine

## Summary of State Objectives

Publication of Maine's objectives for the year 2000 is expected by early 1992. Current plans include a conference to highlight release of the objectives and two separate documents, an executive summary, and a larger document with chapters for each priority area. There are expected to be thirteen priority areas, and each priority area will contain up to six quantifiable objectives. For each priority area, the report will contain:

- A statement of the overall goal of the priority area;
- Specific objectives for the year 2000;
- A discussion of the current status of each priority area based on available Maine data, with comparisons to national data where appropriate;
- Strategies that could be used to reach the objectives; and
- A discussion of benefits that could be realized if the proposed year 2000 goals are reached (lives saved, disabilities prevented, cost savings realized).

Our priority areas include: Maternal and Child Health, Injury Prevention, Prevention of Tobacco-Related Diseases, Infectious Disease Control, HIV Infection Control, Oral Health, Environmental Health, Chronic Disease Control, Cancer Prevention and Control, Teen and Young Adult Health, Occupational Health, Mental Health, and Substance Abuse.

## Developing the Objectives

Maine has been at work developing year 2000 goals and objectives since November 1989, when public health staff, private providers, and community agencies responded jointly to a draft of *Healthy People 2000*. The Commissioner of Human Services has strongly supported the development of health objectives and statewide involvement in that process.

Maine had the first full evaluation of its own draft year 2000 objectives in October of 1990. Since then, the Maine Legislative session and the budget crisis have slowed progress. However, we expect to release the Maine year 2000 objectives by early 1992. The Maine Bureau of Health is collaborating with three other State agencies, the Department of Mental Health and Mental Retardation, the Department of Education, and the Office of Substance Abuse, to develop the year 2000 objectives, along with a wide array of health-care providers, volunteer groups, and Maine citizens.

## Plans for Implementation

The proposed reports will contain identified implementation strategies that, if carried out, are expected to lead to achievement of the goals. The strategies include, for example, recommending that specific data be collected, developing specific programs, recommending legislative actions, expanding health education efforts, and improving access to health maintenance-oriented screening and treatment services. Each priority area is accompanied by a listing of public and private groups that might be expected to have a key role in initiating or carrying out the strategies to reach the objectives. It is expected that the year 2000 goals and objectives will serve to guide resource allocation in this last decade of the 20th century.

## Tracking the Objectives

Every objective has been analyzed to determine what data may be needed to adequately track progress. If such data are not available, strategies include the need to establish such data sources. Wherever quoted, the data source is identified. In addition, a mid-course evaluation of progress is planned for 1995.

## For More Information . . .

To obtain a copy of the Maine year 2000 objectives, when published, contact:

Maine Bureau of Health
Department of Human Services
State House Station # 11
Augusta, ME 04333
(207) 289-3201

# Maryland

## Summary of State Objectives

Scheduled for early 1992 publication, Maryland's report will address objectives in sixteen of the twenty-two priority areas of *Healthy People 2000*. For *Healthy People 2000*'s 22nd priority area on Data and Surveillance Systems, the report will meet that priority area's reporting objective (objective 22.5). The five areas that will not be addressed at this time are: Nutrition, Educational and Community-Based Programs, Occupational Safety and Health, Food and Drug Safety, and Clinical Preventive Services.

For each of our priority areas, the report will include:

- Summaries of the most significant implications for Maryland;
- Graphic depictions of these implications, with quantitative tables;
- Related trend data, when available; and
- Brief narrative discussions of the principal findings in terms of their significance for the health of Maryland residents and related services.

Data needs will be indicated and discussed in a separate section of the report.

An accompanying appendix (to be made available upon request) will provide detailed information on every objective assessed in each priority area addressed. Currently, we have collected information to assess Maryland's status in relation to 165 of the objectives. Information in this section will include:

- Each *Healthy People 2000* objective addressed;
- Maryland's current status in comparison to the targets specified in the *Healthy People 2000* objectives; and
- A brief discussion of the significance of the findings for each objective assessed in terms of health impact, indications for program development, and needed remedial actions.

## Developing the Objectives

Maryland is currently using the targets in *Healthy People 2000* without any adjustments. After the initial report is completed and published, subsequent reports may adjust the targets to provide a more realistic basis for assessment of Maryland's health status and available resources. To the extent that additional information is available, data may be assembled to allow objective setting at the local level. These follow-up analyses at the local level will be separate from the initial statewide surveillance and reporting effort.

The Maryland Health Resources Planning Commission has been designated by the Secretary of the Maryland Department of Health and Mental Hygiene as the agency with lead responsibility in responding to the reporting requirement of the Healthy People 2000 initiative. The Commission plans to execute this task in collaboration with other relevant State agencies. A Department of Health and Mental Hygiene Advisory Council is being formed of representatives from the principal public health programs responsible for delivery of health services related to the priority areas of interest in *Healthy People 2000*. The Commission is also encouraging participation in its efforts by all Maryland Health Officers. Through consultation with these and other health-care advocates, the Commission's outreach efforts are being structured to address the interests of the business, consumer, and professional communities.

The initial and subsequent reports will be widely distributed throughout the State's public and private sectors and will be made available to the Public Health Service and other States as well. The format used for the initial report may be changed in subsequent reports to adjust to recommendations made by participating agencies and other users of the report.

## Plans for Implementation

Development of plans for implementation will be a separate activity beyond the development of the State report. However, it is anticipated that the State report will serve as a catalyst for the development of implementation strategies. The initial and subsequent reports generated will be the result of a broad-based, interagency, collaborative effort. These collaborators, such as the members of the Advisory Council and the local health officers, are the principal entities that should be involved in formulation of remedial recommendations and actions. The Commission, as the State agency with statutory responsibility for production of the State Health Plan to support the development of an effective health-care system in Maryland, is prepared to assist in this process.

## Tracking the Objectives

The 1991 State report will contain the most current data available to address each objective of interest. The report will list all sources of the data reported as well as indicate areas of data inadequacies. Current plans call for updates of an initial 1991 report in 1994, 1997, and 2000.

## For More Information . . .

To obtain a copy of the report, *Healthy People 2000: A Maryland Assessment*, contact:

Maryland Health Resources Planning Commission
4201 Patterson Avenue
P.O. Box 2679
Baltimore, MD 21215-2299
(301) 764-3255

# Massachusetts

## Summary of State Objectives

Division and program directors meet regularly with senior staff to plan each bureau's objectives. As of yet, Massachusetts has not developed one centralized set of objectives for the State. Some bureaus may use the Healthy People 2000 model to guide the objective-setting process.

## Developing the Objectives

Under jurisdiction of the Executive Office of Health and Human Services and the Public Health council (whose members are appointed by the Governor), the Massachusetts Department of Public Health has organized itself for planning purposes into four "clusters" of related bureaus and divisions. Division and program directors in these groupings meet regularly with senior staff, including the Public Health Commissioner, to develop integrated sets of objectives and to plan, coordinate, and evaluate activities aimed at achieving them. In addition, each bureau has involved relevant advisory bodies, outside agencies, organizations, and associations in the planning process. In this planning context, the Department's bureaus have been developing goals and objectives, and means of monitoring and evaluating outcomes, and conveying these to the outside groups that will be affected or whose involvement will be relevant. While the bureau objectives are being carefully coordinated through the "cluster" system, they have yet to be fashioned into a single State health plan.

## Plans for Implementation

Objectives are implemented by individual bureaus, although implementation of a particular program often requires coordination by several related bureaus.

## Tracking the Objectives

The Department's bureaus develop the specific mechanisms necessary for evaluating their progress toward each objective. This information, although tracked in each individual bureau, is shared between all bureaus and divisions in the State. In addition, relevant results often are made available to outside groups.

## For More Information . . .

Additional information regarding Massachusetts' objective-setting process may be obtained by contacting:

Massachusetts Department of Public Health
Division of Policy and Planning
150 Tremont Street, 10th Floor
Boston, MA 02111
(617) 727-2692

# Michigan

## Summary of State Objectives

Completion of the State objectives and plans related to *Healthy People 2000* is anticipated for 1992. High priority objectives of the Michigan Department of Public Health (MDPH) include:

- Reduction of preventable morbidity and mortality from the leading causes of death where Michigan exceeds the national averages;
- Reduction of the gap between black and white populations in terms of infant mortality and in other areas of excess deaths in minority populations, including violence;
- Making the most of support and resources for Michigan's local public health network, the key frontline delivery point for public health services in the State; and
- Streamlining regulatory policies and processes to create a more efficient and effective health system.

These objectives will be met in the general framework of goals determined by the Michigan Health Planning Council, an advisory group developing the statutorily required State Health Plan. The proposed plan focuses on the *Healthy People 2000* goals--to increase the span of healthy life, reduce health disparities, and achieve access to preventive services for all. The plan also emphasizes the goal of achieving a cost-effective health-care system that delivers high quality services to all.

Specific plans related to the *Healthy People 2000* objectives will be developed by the Michigan Department of Public Health (MDPH) Office of Policy, Planning, and Evaluation (OPPE). This recently organized office will begin operations in October 1991, with the "Michiganizing" of the *Healthy People 2000* objectives as one of its first projects. Through the Michigan Public Health Institute (MPHI), funding has been sought from the W. K. Kellogg Foundation to support this project and some of the necessary local data-gathering efforts.

## Developing the Objectives

The process of developing the year 2000 objectives and plans will include convening a group representing the MDPH, local public health, Michigan's major research universities, health-care providers, and others. Objectives must be achievable in the relevant time period and must be measurable.

## Plans for Implementation

Detailed implementation plans will not be developed until the objectives are finalized in 1992. It is expected that many entities will be involved in the implementation of the objectives.

## Tracking the Objectives

Michigan will track progress toward achieving the year 2000 objectives by means of:

- Existing data systems and data system additions and modifications created and supported by the MDPH Office of Policy, Planning, and Evaluation;
- The anticipated MPHI Health Profiles Project that will provide health status and health systems profiles for all 50 local public health jurisdictions in Michigan; and
- The anticipated MDPH Michigan Health Statistics Improvement Project, a response to the Robert Wood Johnson Foundation's Information for State Health Policy initiative.

## For More Information . . .

If you wish to obtain further information, please contact:

Vernice Davis Anthony, M.P.H.
Director
Michigan Department of Health
3423 North Logan/Martin Luther King Jr. Boulevard
P.O. Box 30195
Lansing, MI 48909

# Minnesota

## Summary of State Objectives

Minnesota's goals and objectives for the year 2000 were approved by the Commissioner of Health in October 1991 and are contained in the document *Charting the Course: Minnesota Health Goals and Objectives for the Year 2000.* Priority areas target:

- Diseases or conditions influenced by lifestyle choices and cultural norms;
- Vaccine-preventable disease;
- HIV infection and sexually transmitted diseases;
- Chronic disease;
- Environmentally induced and occupationally induced disease;
- Injury, including injury resulting from abuse and neglect;
- Health status of minority communities;
- Health status of women of child-bearing age and their children, including violence against women;
- Health status of older people;
- Health care reform; and
- Public health infrastructure.

Minnesota's goals and objectives have been patterned after those in *Healthy People 2000.* Where appropriate, Minnesota's objectives have been amended to reflect differences between State and national baseline data.

## Developing the Objectives

The development of Minnesota's health objectives began at the program level in early 1990. Using the draft report *Year 2000 Objectives for the Nation* as a reference, sections in each of the eight Divisions of the Minnesota Department of Health identified goals and objectives for the next decade. These were reviewed and discussed at individual division retreats, and each division produced an outline of goals and objectives that applied to their division's mission. Division goals and objectives were presented and discussed at a departmental retreat attended by all upper level management. Following the retreat, the Commissioner and her assistants reviewed the goals and objectives and identified those deserving priority attention.

A work group, consisting of representatives from all divisions in the Health Department, was formed to finalize the objectives. This group worked for five months refining the goals and objectives. Community Health Boards (49 in the State) were also involved in the process. The work group agreed that the final document should be brief and readable.

## Plans for Implementation

The year 2000 objectives will provide direction for public health and strategic planning in the State of Minnesota. The objectives are being incorporated into program plans in divisions of the Minnesota Department of Health. The objectives are also being distributed as guidelines for planning in local health departments.

## Tracking the Objectives

Baseline data and a tracking mechanism exist for nearly all of the objectives. Baseline data, as well as target data, are included in the document.

## For More Information . . .

A copy of *Charting the Course: Minnesota Health Goals and Objectives for the Year 2000* can be obtained by writing or calling:

Elisabeth Emerson
Assistant Director of Policy and Special Projects
Minnesota Department of Health
P.O. Box 9441
717 Southeast Delaware Street
Minneapolis, MN 55440-9441
(612) 623-5759

# Mississippi

## Summary of State Objectives

Using the *Healthy People 2000* objectives, Mississippi is building community awareness and public support. The State Department of Health began working with a representative group of people to develop a planning process for Mississippi. One of the first steps has been to examine what the initial planning committee considered to be the highest priority areas for Mississippi. Preliminary information from surveys indicate that the following priority areas are most important:

- Family Planning;
- Maternal and Infant Health;
- Alcohol and Other Drugs;
- Tobacco;
- Immunization and Infectious Diseases;
- HIV Infection
- Sexually Transmitted Diseases;
- Heart Disease and Stroke;
- Cancer;
- Physical Activity and Fitness;
- Nutrition;
- Violent and Abusive Behavior;
- Educational and Community-Based Programs;
- Unintentional Injuries;
- Occupational Safety and Health;
- Environmental Health;
- Oral Health;
- Diabetes and Chronic Disabling Conditions; and
- Surveillance and Data Systems.

## Developing the Objectives

Based upon surveys and comments from participants, the next step will be to form work groups to begin establishing objectives for Mississippi for the year 2000. These objectives will become the State's targets upon which the agency's operational plan and grant applications will be based. The purpose of using this process is to have the objectives reflect a broad representation from the State.

The State Department of Health intends to incorporate *Healthy People 2000* and *Healthy Communities 2000: Model Standards* into the agency's existing planning process and to use this initiative along with APEX/PH (Assessment Protocol for Excellence in Public Health) to encourage more local level planning and community involvement. The agency also has been working on an integrated quality assurance model that will be incorporated into this process.

APEX/PH is an excellent model for working with communities to assess health needs and set priorities. It provides a blueprint for developing a plan of action based upon these priorities. The revised model standards in *Healthy Communities 2000: Model Standards* will be quite helpful in setting local area objectives. Because they are closely tied to the *Healthy People 2000* objectives, the standards will be useful in Mississippi's planning process. The agency stresses linkages between local and State objectives.

## Plans for Implementation

Technical assistance, including training in the use of the standard guidance documents, will be provided to local areas to encourage the development of local plans for the year 2000 using these documents and State objectives. This planning may be conducted at the district, county, or city level based upon local needs.

## Tracking the Objectives

Our quality assurance model includes five major components: effectiveness of programs and service outcome; acceptability of services to clients; accessibility and availability of services needed at the community level and congruence with overall State and national health-related goals; efficiency and appropriateness of services provided; and continuity in program and service provision. These components will be addressed using a multi-dimensional, multidisciplinary, coordinated approach. Mississippi's year 2000 objectives will form the basis for the development of the plan.

Community involvement in the district planning effort will address acceptability and appropriateness of the plan for the area served. Evaluation of this component will be one area of our overall quality management program and will include both outcome and process measures. The service delivery components, including both observational data as well as retrospective chart review, will address client opinion of services received, staff opinion of services provided, availability and accessibility of services, and efficiency in rendering the services.

A clinical review tool, that will be used by both the local staff and the State staff, has been developed and piloted in several counties in Mississippi. The multidisciplinary test team includes a physician, a social worker, a nutritionist, a nurse, and a medical records staff member. The process is now being documented for local use by early 1992. As with the planning process, the real value expected from these joint reviews lies in the process of communicating expected levels of performance related to the agency's overall mission and plan. For a State like Mississippi where the public health needs are sometimes overwhelming, the use of the *Healthy People 2000* objectives in conjunction with the component documents previously described, can provide a useful framework for carrying out assessment, assurance, and policy development roles. The *Healthy People 2000* objectives also allow the connection of these roles for the Federal, State, and local levels and provide a sense of ownership and common vision, involving related agencies and organizations as well as communities. The State's primary intent is to integrate these documents into the basic management activities of the agency in planning, budgeting, quality assurance, and evaluation and consequently to strengthen the public health infrastructure of the State.

## For More Information . . .

For additional information on the use of the *Healthy People 2000* objectives, contact:

Therese Hanna, Director
Office of Policy and Planning
Mississippi State Department of Health
P.O. Box 1700
Jackson, MS 39215-1700
(601) 960-7951

# Missouri

## Summary of State Objectives

Published in January 1987, Missouri's objectives for the year 2000 are divided into thirteen priority areas with each priority area containing a goal statement and up to six objectives. For the most part, these objectives are quantifiable; however, where an area was felt to be important and data did not exist, an objective was still set in hopes that a new data base would be developed. The year 2000 objectives as written in 1987 were not intended to be a summary of everything that the Department does, but rather a statement of the most important goals to achieve in the next thirteen years. Priority areas included in this plan are:

- Partnership for Public Health Services;
- Health Insurance for All;
- Maternal and Child Health;
- Adolescent Health;
- Healthy Older Adults;
- Tobacco;
- Communicable Diseases;
- Major Chronic Diseases;
- Environmental and Occupational Health;
- Injury Control;
- Comprehensive School Health Education;
- Public Health Education and Research; and
- Health Communication Systems.

The entire document was limited to fourteen pages to encourage policy makers in both the executive and legislative branches to read the document. The plan was developed primarily with input from the Department of Health. Then, in an initial draft form, it was submitted to local health departments and other State health departments for their review and comment. The document was finalized based on that review. With the recent release of *Healthy People 2000, Healthy Communities 2000: Model Standards*, and APEX/PH (Assessment Protocol for Excellence in Public Health), the Department of Health is currently engaged in developing a much more detailed and up to date year 2000 plan. Work on this new plan began in the spring of 1991 and should be completed by the spring of 1992.

## Developing the Objectives

We began by modifying APEX/PH, which was designed for use by State and local health departments. Information from our review identified certain problems that will be addressed in our year 2000 plan. At the same time, staff were asked to reevaluate progress on Missouri's 1987 year 2000 plan to determine areas that needed to be expanded/changed. These and subsequent year 2000 planning activities are being directed by the Department of Health Year 2000 Planning Committee, co-chaired by the director and deputy director. Other members of the committee include each division director and a representative from the Department of Health/Local Health Department "Partnership Council" that represents local health department directors throughout the State.

We decided to use *Healthy Communities 2000: Model Standards* as the basis for our plan since it not only contains all of the objectives from *Healthy People 2000*, but also provides much broader coverage of all the areas overseen by public health. As a next step, we will create a Model Standards work groups to:

- Screen each objective in Model Standards for its relevance to our Department of Health mission;
- Review whether or not we have (or should try to gather) data to measure progress for each objective and determine which objectives Missouri should adopt; and
- Identify additional resources or changes in legislation necessary to achieve the objectives.

Each of these Model Standards work groups will consist of Department of Health employees, local health department staff, and other parties identified as being interested in a particular content area.

## Plans for Implementation

Once the Model Standards work groups have made decisions on which of the *Healthy People 2000* objectives and model standards to adopt and have set specific targets, the lead division for each goal will be assigned key responsibility for developing and monitoring implementation strategies for that goal. In addition, division requests for budget increases will be analyzed for their adherence to the year 2000 plan, as will requests for new or amended legislation.

## Tracking the Objectives

A "report card" will be published at regular intervals to provide updates on progress made toward achieving each of the objectives. A mid-course report will be prepared based on 1995 data.

## For More Information . . .

To obtain a copy of Missouri's 1987 *Strategic Plan for the Year 2000* or more information about their current process to update the plan, contact:

Linda Hillemann
Office of the Director
Missouri Department of Health
P.O. Box 570
Jefferson City, MO 65102
(314) 751-6005

# Montana

## Summary of State Objectives

The State of Montana has begun the process of developing goals and objectives for the year 2000. *Healthy People 2000* will be used as a guide for the process. All goals and objectives are expected to be finalized in the first half of 1992.

## Developing the Objectives

Division administrators, bureau chiefs, and program managers, in consultation with local health departments and other nonprofit health organizations, will be involved in setting State objectives. Each of these staff members will participate in developing short- and long-term goals, objectives, and mission statements for areas that are relevant to the health priorities of Montana's citizens.

## Plans for Implementation

Implementation will be based on a plan developed in cooperation with local health departments and other nonprofit health organizations. Long-range objectives will require the combined efforts of State and local government policy makers and public health agencies.

## Tracking the Objectives

Tracking the objectives will be the responsibility of division administrators, bureau chiefs, and program managers. Each program's director must be able to quantify his or her program's success before Montana's State department of health, State legislature, and Federal funding agencies.

## For More Information . . .

Additional information regarding Montana's year 2000 objectives may be obtained by contacting:

Director's Office
Montana Department of Health and
Environmental Sciences
Cogswell Building
Helena, MT 59620
(406) 444-2544

# Nebraska

## Summary of State Objectives

Published in September 1990, *Nebraska Objectives for the Year 2000* are divided into eight priority areas with each priority area containing up to seven quantified objectives. For each priority area, the Nebraska year 2000 health objectives contain:

- A goal statement addressing the priority area;
- Current status and trends using indicators consistent with those used in *Healthy People 2000*;
- A comparison of current national and State rates;
- A comparison of national and State objectives;
- Risk factor prevalence;
- Rationale for reducing the risk factors; and
- References and data sources used in the data analysis.

Priority areas included in the plan are Infant Mortality, Low Birth Weight, Cancer, Tobacco-Caused Diseases, Cardiovascular Disease, Intentional Injuries, Unintentional Injuries, Motor Vehicle Injuries, and AIDS/HIV Infections. A supplement to the plan is being prepared to include Immunization, Teen Pregnancy, Environmental Health, Alcohol and Drug Abuse, Mental Health, Education and Community-Based Programs, Occupational Health, and Nutrition. This supplement was released in fall 1991.

## Developing the Objectives

The Nebraska health objectives were developed in 1990 at the request of the Director of Health. The task of developing the objectives was assigned to the Division of Health Policy and Planning with support from the Division of Health Data Support. The objectives were to be derived through an in-depth analysis of available data with reference to the draft *Year 2000 Health Objectives for the Nation*. As each priority area was developed, draft copies were reviewed by department professional staff experienced in the programs and services applicable to the area. This professional judgment proved valuable in terms of determining the feasibility of achieving the prescribed objectives, the selection of risk factors, and the rationale for setting the objectives. The result of this staff effort produced a document that was subsequently approved by the Director of Health for release for public review and comment.

## Plans for Implementation

Recommendations for implementation strategies are to be gained by conducting at least six public forums throughout the State. The locations of these forums will coincide with the communities where the regional offices of the Nebraska State Health Department are located. These will be open forums in which participants will be invited to present oral or written testimony. The main focus will be on how to achieve the objectives through both the public and private sectors.

At each forum, staff will provide a brief slide presentation that will be followed by a response from a panel of local experts. After the panel discussion, comments will be encouraged from the audience. Staff will also solicit comments and recommendations from other health organizations including local health departments, community service agencies, voluntary health associations, and professional associations.

Once the recommendations have been collected, a special task force of the State Board of Health will review the material and prepare a report to the Board of Health on plans for achieving the *Nebraska Year 2000 Health Objectives*.

## Tracking the Objectives

Every indicator in the plan is applied using available data that permits an annual update on a provisional basis. We plan to prepare an in-depth mid-course review in 1995.

## For More Information . . .

For more information, contact:

David Palm, Director of Bureau of Health
Planning and Data Management
Nebraska Department of Health
Division of Health Policy and Planning
P.O. Box 95007
Lincoln, NE 68509
(402) 471-2337

# Nevada

## Summary of State Objectives

Nevada has identified priority areas and objectives for the year 2000. The priorities identified will be the foundation of a State plan to be developed in late 1991 and early 1992. One priority area that has been identified is Surveillance and Data Systems to enhance Nevada's present data collection capabilities. The Health Division has compiled preliminary baseline information and target objectives in a document entitled *Nevada's Progress in Meeting the National Health Objectives for the Year 2000*, produced by the Bureau of Health Information and Data Management of the Health Division. In addition, the Health Promotion program of the Health Division produced the theme and logo of "Healthy Nevadans 2000" for use on all Division publications to heighten identity and provide focus for activities.

As the Healthy Nevadans project continues and the State plan is developed, a report with information on Nevada trends, objectives, and priority areas will be produced by the State Health Division. It is anticipated that this document will be available in early 1992.

## Developing the Objectives

Nevada's activities centering on *Healthy People 2000* started in the fall of 1990 with the formation of a work group involving the Nevada State Health Division, Clark County District Health Department, and Washoe County District Health Department. Key programs in the State Health Division concurrently identified data sources and gaps.

On July 1, 1991, the Nevada State Health Division was reorganized as a result of legislative action. This reorganization moved the health planning entity in the State to the Health Division. The Bureau of Health Planning provides a focus for planning activities in the Health Division. It is the State Health Coordinating Council's Prevention/Health Status Task Group, staffed by Health Planning, that will identify Nevada's priority health concerns. This group of statewide representatives of health organizations and interested individuals has formed a statewide core group using the Planned Approach to Community Health (PATCH) to identify needs.

The Prevention Task Group used health trends information for Nevada and data from the Behavioral Risk Factor Survey, conducted in the spring of 1991, to identify priority health problems. This examination was completed in the fall of 1991. In addition to the PATCH activities of the Prevention Task Group, Clark, and Washoe Counties also have been involved in developing priorities through PATCH activities.

## Plans for Implementation

With the identification of priority health concerns, Nevada will turn its attention to the integration of measurably defined objectives into program planning. Nevada's activities will center on the priorities established by the Prevention Task Group. A State plan will be developed from these priority areas that will address intervention strategies for Nevada's most pressing health concerns.

## Tracking the Objectives

Nevada's finalized State plan also will include details of surveillance strategies for measuring outcomes of proposed interventions.

## For More Information . . .

To obtain more information on Healthy Nevadans 2000 and PATCH activities in Nevada, contact:

Office of the Administrator
Nevada State Health Division
505 East King Street
Room 201
Carson City, NV 89710
(702) 687-4740

# New Hampshire

## Summary of State Objectives

The year 2000 plan for the New Hampshire Division of Public Health Services is being developed for release early in 1992. The Division has been working on its plan since the release of *Healthy People 2000* but, because of budget issues, has been forced to delay the release of the year 2000 plan for New Hampshire.

The plan will present a limited number of quantifiable objectives in the priority areas that the Division believes have a reasonable probability of being achieved or that reflect high priority health needs that should be pursued, even if they cannot be measured, or that should be the target of enhanced capacities in the Division. The plan will be structured to reflect the work that the staff of the Division has put into its development over the past eighteen months. The discussion on each priority area will contain:

- A statement of the overall goal;
- The specific objectives identified by the Division, with an indication of which operating units will be directly involved;
- A presentation of the State's status in reaching each of the objectives;
- A discussion of actions and interventions that are needed to realize each objective;
- Recommendations for other actions and interventions that would require authority or funding not presently available to the Division and that would hasten realization of the objectives; and
- A description of the data analysis to be undertaken to track progress on each objective, or the steps that must be taken to capture the data needed to perform the analysis.

In addition, the plan will present a framework for incorporating the abilities of communities and organizations throughout the State that may participate with the Division in meeting the objectives. Finally, the recently released *Healthy Communities 2000: Model Standards* will be reviewed to identify objectives appropriate for the Division and for community-based groups that do not have the ability to identify outcome objectives.

## Developing the Objectives

The Division of Public Health Services began, with the release of the draft *Healthy People 2000*, to identify the State's status in meeting each of the objectives. The Division then began an extensive staff effort to identify objectives that should be pursued by the Division and, after considering the extent of the Division's capacities and funds, the senior management of the Division selected those objectives that are compatible with its present and potential capabilities. A number of objectives were selected that should be pursued because of their importance to the health of the State. These will be the target of grant activities and legislative requests to improve the current capacities of the Division.

## Plans for Implementation

Release of the New Hampshire year 2000 plan will be prior to the development of the next State operating budget. Our intention is to present that budget showing how the expenditure of funds can lead to specific health improvements in the communities of the State. The Division expects the plan to be dynamic, reflecting changes in abilities or the needs of the State's communities, and that it will be used to judge the Division's accomplishment of its mission and legislative mandates.

## Tracking the Objectives

The Division will, for all objectives that can be measured using currently available data, prepare a brief annual assessment of its progress and, in 1995-96, prepare and release a mid-course report. The annual assessment and mid-course report will include, using national indicators now under development, those measures intended to present a general overview of the State's health status.

## For More Information . . .

To receive further information, contact:

John D. Bonds
Assistant Director for Planning
Division of Public Health Services
6 Hazen Drive
Concord, NH 03301
(603) 271-4617
FAX 271-3745

# New Jersey

## Summary of State Objectives

*Healthy New Jersey 2000: A Public Health Agenda for the 1990s* was published in June 1991. It contains thirteen sections. The first two sections provide statewide demographic information and an accounting of the leading causes of death by age group. The remaining sections are devoted to the eleven issues identified as the top priority health concerns of the people of the State of New Jersey. The nine priority areas recommended by the Association of State and Territorial Health Officials were adopted as the basis of New Jersey's response. Two additional goals were added to address the central issues of access to basic health services and addiction to tobacco, alcohol, and drugs. The eleven goals of *Healthy New Jersey 2000* are:

- Increase access to preventive and primary care;
- Improve infant and child health and maternal outcomes;
- Reduce the incidence of adolescent pregnancy;
- Prevent, detect, and control cancer;
- Prevent, detect, and control cardiovascular and other vascular diseases;
- Prevent and control AIDS and HIV infection;
- Prevent and control sexually transmitted diseases;
- Prevent and control vaccine-preventable and other infectious diseases;
- Reduce and control injuries;
- Reduce occupational and environmental hazards; and
- Reduce the rates of mortality and morbidity due to use and abuse of tobacco, alcohol, and other drugs.

Each health priority area section contains:

- A goal statement.
- Objectives - Three to ten quantifiable objectives are presented with baseline data (usually 1988) and targets for the year 2000. The criteria used to select the objectives included effect on the population, effectiveness of preventive interventions, availability of data, and validation of the importance of the objective through the public input process. The target levels for the year 2000 for each objective were set by the Department of Health using baseline data, trend data, and clinical judgment.
- Current Status - This section defines the central health problems associated with the goal. Disparities between population groups are noted and comparisons of New Jersey to the Nation are presented.
- Associated Health Issues - The risk factors and health effects associated with the disease or health problem are noted. Also contained in this section are any relationships to other health priority areas, as well as economic and social impacts.
- Current Strategies - The status of the current efforts to reach these goals, in both the public and private sectors, is reviewed. When possible, there is a statement about the relative success of the strategies and a discussion of the major obstacles to implementation.
- Recommended Actions - This section recommends both general and specific actions that are needed to achieve the year 2000 objectives.
- Data Needs - For each goal, additional information will be helpful in measuring progress in the years ahead. This section makes recommendations for future data collection and analysis needed to track our progress.

- Sources - The reader is referred to additional reports and publications; these are sources that were used as reference materials in creating the document.

## Developing the Objectives

State Commissioner of Health, Frances J. Dunston, M.D., M.P.H., directed her staff to respond to *Healthy People 2000* by identifying quantifiable health objectives that reflect the specific needs of the residents of this State. During the first half of 1991, the Department of Health assembled a core team to prepare New Jersey's health promotion and disease prevention goals for this decade and develop objectives to be used to measure our progress toward achieving those goals throughout the coming years. Every division in the Department of Health participated in this effort. Assistance was also offered by other agencies in New Jersey State government, notably the Department of Labor, the Department of Law and Public Safety, the Department of Education, and the Department of Human Services.

Public input was sought in three ways. First, six regional focus groups were held across the State. These meetings provided a rare opportunity for community leaders, health and social service providers, consumers, and advocates to come together, present their views and discuss their differences and common concerns. The expressed views of New Jerseyans were remarkably consistent across the State. The eleven goals identified by the Department of Health were affirmed as priority concerns. Abuse of alcohol and drugs, because of its inextricable connection with so many of the other pressing health problems, was generally viewed as a central issue. Infant mortality was another universal concern. Special emphasis was given to the need to address barriers to access to primary and preventive care. The needs of special populations such as older people were raised as well. Across focus groups, a unified message was heard: "Invest more resources in community-based primary and preventive care."

Next, a formal public hearing was held to broaden the scope of public input. Twenty-eight people testified or contributed written testimony. The testimony supported the views expressed in the focus groups. In addition, policy makers called for access to timely health data on which to base decisions. Finally, a public opinion telephone survey was conducted by Eagleton Institute of Politics. Eight hundred people throughout the State were asked to rate health issues. More than two-thirds of the people interviewed rated the eleven priority areas as either "extremely" or "very" important.

## Plans for Implementation

*Healthy New Jersey 2000* will be used as the public health needs assessment of the State Health Plan, which is anticipated to be published in 1992. A recent omnibus health-care reform law passed by the State legislature called for a State Health Plan that will identify unmet health-care needs by service and location and shall serve as the basis for approval of all certificates of need. The State Health Plan shall be adopted pursuant to our Administrative Procedure Act that requires action by the State Health Care Administration Board, publication in the *New Jersey Register*, and a public comment and response process. It shall have the full force and effect of State law, and shall be updated annually.

## Tracking the Objectives

Every indicator has a data source available for tracking progress over the course of the decade. Two interim progress reports are planned.

## For More Information . . .

To obtain a copy of *Healthy New Jersey 2000: A Public Health Agenda for the 1990s*, contact:

Office of Health Policy and Research
New Jersey Department of Health
CN 360
Trenton, NJ 08625-0360
(609) 984-2151

# New Mexico

## Summary of State Objectives

For the past four years, the Public Health Division of the Department of Health has had a program planning process that included a central planning team of key division staff from all bureaus and districts that set broad guidelines for the program plan organized by health problem areas with detailed objectives and strategies defined by local office staff and program staff. Key players outside the division in local communities and for specific health problems were included in the planning process. The current plan was developed in June 1990 and goes through June 1992. Priorities in this plan were motor vehicle crashes, chronic diseases (heart disease and cancer), and perinatal problems with an emphasis on tobacco, substance abuse, diet, and self esteem as key determinants to these health problems. A community-based approach using local coalitions to tackle local health problems was emphasized.

## Developing the Objectives

The Public Health Division is now in the process of developing the next program plan incorporating the year 2000 objectives. In late spring of this year, work groups made up of staff from all levels of the division were named for each of the sections in *Healthy People 2000.* These groups were to identify key players outside the division to work with them to determine priority objectives for New Mexico. Each group recommended to the central planning team those *Healthy People 2000* objectives that were most relevant to New Mexico with an emphasis on the objectives that could be measured and would give the best indication of health status for our State. By early 1992, the planning team will define the format for the next planning document with the selected *Healthy People 2000* objectives. Work groups in each community will then define short term objectives and strategies in the defined format.

## Plans for Implementation

Once the new State plan is completed, it will be the basis for public health activities in local health offices as well as central office programs in coordination with the defined community groups, other health organizations and agencies, and advocates. The plan will be presented to the newly formed New Mexico Health Policy Commission, a Governor-appointed advisory group to make recommendations to the Governor and the Legislature.

## Tracking the Objectives

The plan will identify data sources. Where new data are needed or where data will need to be formatted differently, the office of Vital Records and Health Statistics will work with the appropriate work group to get the data. Reports on progress will be made at least annually.

## For More Information . . .

To obtain a copy of the current program plan or a copy of the new plan when it is completed, contact:

Pat Cleaveland, Director
Public Health Division
Department of Health
P.O. Box 26110
1190 St. Francis Drive
Santa Fe, NM 87502
(505) 827-2389

# New York

## Summary of State Objectives

One of the most significant routes for the promotion and achievement of the *Healthy People 2000* objectives in New York State is the provision of local assistance to counties and municipalities for local public health services. Under this program, referred to as Article Six, New York's 56 local health units are required to prepare municipal public health service plans every two years. The plans are required by statute to include, at a minimum, the following:

- An estimate and description of the immediate and long-term needs for public health services in the municipality, particularly those services that are needed to promote public health and prevent illness;
- A statement and description of the public health objectives that the municipality intends to achieve, including how public health services funds will maintain and improve accessibility and quality of health care, and assist in containing the costs of the health-care system;
- A description of the program for achieving those goals; and
- A projected plan of expenditures including staff, revenue, etc., for the implementation of these programs.

## Developing the Objectives

Article Six services include the following: community health assessment; family health (including dental health, primary care and preventive health care, lead poisoning prevention, infant mortality, and prenatal care, family planning, nutrition, and injury control and prevention); disease control (including sexually transmitted diseases, tuberculosis, communicable disease, immunization, chronic disease, and HIV); health education; and, environmental health (including public water supply protection, environmental radiation protection, community sanitation and food protection, realty subdivisions, individual water and sewage systems, nuisances, chemical emergencies, and environmental health assessment).

Working in conjunction with the New York State Association of County Health Officials, the State health department, through its central and regional offices, promotes the application of selected State and national public health objectives that are relevant to high priority issues. These seven priorities are improved pregnancy outcomes; reduced morbidity and mortality among children; early detection and treatment of breast and cervical cancer; promotion of health lifestyle behaviors such as nonsmoking, exercise, healthy eating habits, and freedom from substance abuse; reduction of syphilis, tuberculosis and measles; and reduction of HIV infection including HIV-related diseases in children and adults.

## Plans for Implementation

Implementation of the local municipal public health service plans is monitored by the New York State Department of Health through program reviews, staff site visits and the collection of activity reports and descriptions of the results.

## Tracking the Objectives

An annual report is prepared for the State legislature. The report displays outcome indicators by county that are used in the process of determining progress toward meeting prescribed public health objectives, expenditure information that includes almost $630 million in combined State and local financing of local public health services, and performance based on the satisfaction of established public health standards.

## For More Information . . .

More information regarding the delivery of local public health services in New York State may be obtained by contacting:

Joann Dawson
Director of Preventive Health Services
New York State Department of Health
Empire State Plaza
Corning Tower Building
Room 612
Albany, NY 12237
(518) 473-4223

# North Carolina

## Summary of State Objectives

North Carolina will create a blueprint for action for North Carolinians that will use health objective outcomes suitable for local, as well as State initiatives. The goals of this health plan are:

- Increase the span of healthy life;
- Reduce health disparities among the disadvantaged; and
- Emphasize preventive health services.

The objectives outlined in the plan will have several characteristics. First, they will be measurable. Unless there are data that can establish a base from which to measure direction of these objectives, they will not be included. Second, these objectives will show special benefit to the disadvantaged of our society. Third, the objectives will be show a benefit-to-cost advantage. Fourth, these objectives will be realistic, and while some may have their genesis in idealism, the objectives will describe realistic outcomes. Fifth, they will emphasize opportunities for intervention at the community level. Health plans, including this plan, if developed and implemented at the State level, will have limited impact. On the other hand, if local groups develop their own plans tailored to suit the characteristics of their own communities, the likelihood of successful outcomes increases significantly. Finally, these objectives will be selected so as to be especially relevant to the citizens of North Carolina.

## Developing the Objectives

For the North Carolina plan to be successful, ownership in its creation must be widespread. It will require involvement by broad-based leadership, including legislative representation, if it is to enjoy the sustaining support necessary over the next decade to ensure success. Therefore, a multidisciplinary Blue Ribbon Task Force will be created. Its members will be limited to twenty-five people with representation from seventeen different organizations in the State. It will be appointed by the Governor, thus adding the prestige and visibility of his office, as well as emphasizing the importance of this plan to the citizens of the State.

Staff support and technical assistance will be provided by the Department of Environment, Health, and Natural Resources, the Department of Human Resources, the University of North Carolina School of Public Health, the North Carolina Hospital Association, the North Carolina Medical Society, and a number of other agencies.

The task force will meet no less than bimonthly and will complete the development of this plan by September 1, 1992. It will be directed to develop no fewer than 10, nor more than 25 specific objectives. It is believed that this will offer a manageable number of objectives and yet provide sufficient options for communities to choose from.

## Plans for Implementation

The task force recommendations will afford the maximum opportunity for implementation at the local level. It is envisioned that the list of objectives will allow communities to select several objectives that are viewed as meaningful and relevant to their needs. Experience indicates that health promotion solutions tend to be more acceptable when developed and implemented at local levels. Of special importance to the success of this venture will be the creation of a model local plan for communities to emulate. It is expected that such a model plan will emphasize the use of local task forces and coalitions consisting of health-care providers, business, industry, and lay and political leadership.

It is anticipated that community volunteers will be used extensively. Many health promotion activities can be operated by trained lay volunteers. Numerous examples exist in the area of injury

prevention, and these models can be replicated in addressing other health concerns. This, of course, leverages the cost/benefit ratio of the outcome as well.

## Tracking the Objectives

The ultimate test of the success of this proposal will be in the reduction of unnecessary death and illness. Evidence of this outcome will occur beyond the requested funding period. However, the task force will design a monitoring process for assessing progress throughout the State, and will identify appropriate agencies to carry out this responsibility. It will also be the responsibility of the task force to develop the details of the evaluation process for the ensuing decade.

## For More Information . . .

Additional information regarding North Carolina's objective-setting process can be obtained by contacting:

North Carolina Department of Environment, Health
and Natural Resources
512 North Salisbury Street
Raleigh, NC 27611
(919) 733-4984

# North Dakota

## Summary of State Objectives

The North Dakota State Department of Health and Consolidated Laboratories uses objectives from *Healthy People 2000* for a variety of preventive health activities. The following programs use the *Healthy People 2000* objectives in their grants and activities:

- Native American Programs;
- Injury Prevention;
- Dental Health;
- Maternal and Child Health;
- Family Planning;
- WIC;
- HIV Prevention and Control;
- STD Programs;
- Agricultural and Occupational Injury;
- Diabetes;
- Immunizations;
- Tobacco Prevention and Control;
- Behavioral Risk Factor Survey;
- Cancer Prevention and Control;
- Comprehensive School Health; and
- Environmental Laboratory and Regulatory Programs.

Many of the programs have coalitions or advisory bodies that use the *Healthy People 2000* objectives in priority setting and planning.

## Developing the Objectives

North Dakota has convened a planning group to look at all of the *Healthy People 2000* objectives in relation to State data. *Healthy People 2000* objectives will be matched with the Department priority list to establish a rank order list of objectives. Existing data will be analyzed to determine gaps between objectives and surveillance.

## For More Information . . .

Steven L. McDonough, M.D.
Chief, Preventive Health Section
North Dakota State Department of Health
600 East Boulevard Avenue
Bismarck, ND 58505
(701) 224-2493

# Ohio

## Summary of State Objectives

The Ohio Healthy People 2000 objectives related to Maternal and Child Health have been completed and will undergo revision each year through the next decade. This document was submitted as the Maternal and Child Health Services Block Grant application for fiscal year 1992 and was completed in compliance with the Title V MCH Block Grant statute.

## Developing the Objectives

The Department is carefully reviewing the other objectives contained in *Healthy People 2000* and will finalize its plans on these objectives over the next six months. A major component in working to finalize these objectives is the establishment of a partnership with the 151 county and local health departments in Ohio. Without a synergistic relationship existing between these separately functioning entities and the State health department, achievement of the *Healthy People 2000* objectives will not be possible.

The objectives will be met in the general framework of goals as determined by the Director of Health and his ongoing relationships with the local health departments. Ultimately, the proposed objectives will increase the span of healthy life, reduce disparities in health between racial groups, and expand the scope and content of preventive service activities for the entire State population.

## Plans for Implementation

Those activities specifically defined in the Maternal and Child Health Services Block Grant Title V and the Preventive Health and Health Services Block Grant will follow closely the already established objectives for those two programs. The Governor for Ohio has established the reduction of infant mortality as one of his administration's three major objectives. Advancing the Health Department's "Opportunities for Change" program, that established an aggressive effort to ensure access to health care for all Ohioans is also a major objective. It is anticipated that an internal departmental Healthy People 2000 planning committee and an external, statewide Healthy People 2000 planning committee will both be formed during early 1992.

## Tracking the Objectives

An activities chart with tracking on a quarterly basis is being developed via the Maternal and Child Health Services Block Grant and Preventive Health and Health Services Block Grant. Objectives are both process and outcome oriented.

## For More Information . . .

Additional information regarding Ohio's Healthy People 2000 objectives may be obtained by contacting:

Director of Health
Ohio Department of Health
246 North High Street
Columbus, OH 43266
(614) 466-3543

# Oklahoma

## Summary of State Objectives

Publication of *Healthy Oklahomans 2000* is expected in early 1992. We have twenty priority areas with specific quantifiable, measurable objectives that are realistic and achievable with existing resources. Also included is an introduction for each priority area that includes information on the extent and implications of the problems involved.

The State plan includes priority areas for: Physical Activity, Tobacco, Educational and Community-Based Programs, Nutrition, Heart Disease and Stroke, Cancer, Diabetes and Chronic Disabling Conditions, Alcohol and Other Drugs, Mental Health and Mental Disorders, Violent and Abusive Behavior, Maternal and Child Health, Unintentional Injuries, HIV, Sexually Transmitted Diseases, Immunization and Infectious Diseases, Occupational Safety, Environmental Health, Food and Drug Safety, and Oral Health.

## Developing the Objectives

Development of the objectives has been an eighteen-month process. The framers of the objectives have used *Healthy People 2000* as a guide. The development was coordinated by the State health department's Chief of Program Development using teams made up of program staff in the Oklahoma State Department of Health, Education Department, Department of Mental Health and Department of Human Services. Voluntary health organizations and other agencies were involved, as well as the University of Oklahoma College of Public Health.

## Plans for Implementation

An implementation conference will be held in November in conjunction with the College of Public Health and at least thirty other organizations that are involved statewide for planning and implementation of the objectives in *Healthy Oklahomans 2000. Healthy Communities 2000: Model Standards* will be used a tool for implementation and the objectives will serve as a guide for the Oklahoma State Department of Health over the next ten years. In addition, there will be coordination with numerous other groups in the State to achieve these goals.

## Tracking the Objectives

Baseline data has been established where available. Where it is not available, surveillance systems will be developed for data collection improvement. Specific divisions in Oklahoma State Department of Health will be responsible for tracking progress of the objectives.

## For More Information . . .

To obtain a copy of *Health Objectives for the Year 2000: Report of the Oklahoma Health 2000 Project*, contact:

Alan S. Grubb, Ph.D.
Chief, Program Development
Oklahoma State Department of Health
1000 Northeast 10th Street
Oklahoma City, OK 73117-1299
(405) 271-4218

# Oregon

## Summary of State Objectives

Published in September 1988, Oregon's objectives for the year 2000 are divided into thirteen priority areas, and each priority area contains up to six quantifiable objectives. The priority area on Environmentally-Caused Diseases is the only priority area in which specific objectives are not identified. For each priority area the State plan, *Health Objectives for the Year 2000: Report of the Oregon Health 2000 Project,* contains:

- A statement of the overall goal in the priority area;
- Specific objectives for the year 2000 that represent the Oregon Health 2000 Project Team's consensus opinion of a realistic goal, assuming that action is taken on the Team's recommendations;
- A discussion of recent trends in the area based on Oregon data when available;
- Information about the significance and health impact of the priority area;
- Recommended actions and public or private groups that might logically play a lead role in implementing the recommendations; and
- Major data needs that the Team believes must be filled.

The State plan includes priority areas for: Healthy Babies, Physically Fit Children, Unintentional Injuries; Intentional Injuries, Drug and Alcohol Abuse; Sexually Transmitted Diseases, HIV Infections, Cardiovascular Diseases, Tobacco-Caused Diseases, Disease Prevented Through Immunization and Chemoprophylaxis, Environmentally-Caused Diseases, and Independent Living Among Dependent Populations.

## Developing the Objectives

The Oregon health objectives were developed over a ten-month period at the request of the Administrator of the Oregon Health Division. The objectives were to be based on the perceived biggest public health challenges, to be outcome oriented, preventive in nature, and achievable.

The task force assembled to develop the objectives, called "Health Team 2000," was made up of representatives from several State agencies, academic institutions, and nonprofit public health organizations. An attempt was made to strike a balance that would reflect the diverse population in Oregon's ethnic populations, organizational diversity, and service availability. An assistant Administrator of the Health Division coordinated the task force's activities.

A strategic planning process was used for developing the objectives and professional facilitators were hired to lead the process. At the outset, it was decided that the final report on the team's recommendations would be a "non-government-looking," brief report that could be used by any participating organization. The report would not be a health division document; it would be attributed to the groups involved in creating it.

The initial draft of the objectives was widely distributed and input was sought both from the groups represented on the team and others who were seen to have particular expertise in one or more of the objective areas. The final report was released during a press conference and kick-off event.

## Plans for Implementation

The State plan contains detailed implementation strategies that, if carried out, are expected to lead to achievement of the goals. The strategies include, for example, recommending that specific data be collected, developing specific programs, recommending legislative actions, expanding health education efforts, and establishing economic incentives for healthful behaviors. Each

implementation strategy is accompanied by a listing of public and private groups that might be expected to have a key role in carrying out the recommendation.

The Health Division appointed a senior staff member to begin the process of implementing the objectives, and the State's Public Health Advisory Board (PHAB) serves as a monitor. The PHAB is a Governor-appointed, volunteer board representing health-care providers and consumers.

The Health Team 2000 initially identified 82 key organizations who would be asked to assume leadership roles in implementing the objectives. In addition, public meetings have been held to obtain input on how to best achieve the objectives. During the meetings, specific activities, community leaders, and timelines have been determined.

## Tracking the Objectives

Nearly every indicator included in the State plan contains data on the most recent available statewide rate. The plan lists the source of the data. Where data is unavailable, the plan calls for the data to be collected. In addition, a mid-course report will be prepared in 1995.

## For More Information . . .

To obtain a copy of *Health Objectives for the Year 2000: Report of the Oregon Health 2000 Project,* contact:

Office of the Administrator
Oregon Health Division
P.O. Box 231
Portland, OR 97207-0231
(503) 229-5032

# Pennsylvania

## Summary of State Objectives

*Healthy Pennsylvania 2000: Priorities for Pennsylvania*, identifies seven priority areas, including:

- Tobacco;
- Alcohol and Other Drugs;
- Violent and Abusive Behavior;
- Educational and Community-Based Programs;
- Unintentional Injuries;
- Maternal and Infant Health; and
- HIV Infection.

In addition, the report identified five "over-arching" considerations relevant to any public health issue priority-setting process. The first of these is the Committee's conviction that public health policy must be shaped and based on scientific knowledge and proven public health methods. Public health actions must be based on accurate knowledge of the cause of the health problem, its distribution, and the known effectiveness of intervention. Public health decisions should be based on sound public health practice and should not be shaped by public opinion, public relations, or political expedience.

Secondly, the Steering Committee affirmed the importance of the relationship of health and the social environment. Evidence continues to mount that ill health is linked closely with physical, social, economic, and family environments. Public health must look beyond the traditional boundaries. A primary concern of the Steering Committee was the inequity of health status of certain populations. Although tremendous strides have been made in improving the health of certain subgroups, disparity in key health indicators are persistent. Public health must lessen the disparities in health status.

Finally, the Committee found important connections between health problems, objectives, and program activities. Many health risks are concurrent, correlated, and synergistic, as are many efforts to reduce them. The health of an individual is dynamic and effected by various social, environmental, psychological, biological, and behavioral factors. No single cause can be identified for a single health concern. Health is multidimensional and the risks to good health are interrelated. Therefore, the health issues that are identified as priorities for Pennsylvania cannot be viewed as singular issues addressed individually and detached from the other priorities. Additionally, they cannot be viewed as totally disconnected from the issues not identified as particular priorities.

## Developing the Objectives

In the fall of 1990, the Pennsylvania Department of Health's Office of Policy, Planning, and Evaluation proposed the formation of a statewide Healthy Pennsylvania 2000 Steering Committee. The Committee's sole charge was the development of a short list of topic areas and objectives and the reasons they are priorities for Pennsylvania. The topic areas were chosen from the twenty-two priority areas of *Healthy People 2000*. Additionally, the Committee designated objectives in the priority areas as the most important ones to be achieved in Pennsylvania. The Secretary of Health invited representatives of public health groups to be members of the Pennsylvania Year 2000 Steering Committee. The Committee members represent public health in general--single or special interest groups are not represented. In developing the list of individuals to be invited, however, care was taken to include Committee members with expertise in all of the twenty-two priority areas. The Steering Committee worked through a deliberate, comprehensive, and thoughtful process. They were provided staff support by the Health Department's Office of

Policy, Planning, and Evaluation. The Health Data Center provided vital statistic data support. The work plan developed by the Office of Policy, Planning, and Evaluation estimated that the Committee should be able to complete its charge in four meetings.

At their first meeting, held in December 1990, the Steering Committee was provided two documents for use in their discussions and considerations of the topic areas. The first was a presentation of results of a survey conducted by the Office of Policy, Planning, and Evaluation. The purpose of the survey was to obtain input from the special areas of public health. Since the members of the Steering Committee are general public health representatives, it was felt that the input of special interest groups, consumer groups, providers, and academic institutions was needed. A survey was broadly distributed to gather recommendations and opinions on the importance of various issues specific to Pennsylvania. The results of the survey were provided graphically in a booklet for the Committee's consideration and use.

The second document contained a review of Pennsylvania's status compared to the *Healthy People 2000* objectives, particularly the flagship objectives, developed using vital statistics and program data. This information was also presented graphically and included a description of the data's significance. The Committee discussed at length the importance of the implementation of the objectives and shared views on the significance of particular issues to Pennsylvania and its citizens. Through discussion and votes, the Committee developed a list of six initial priority topics. The Committee agreed to carefully review and amend this list at their second meeting.

The Committee adopted a set of fourteen uniform criteria that was applied against the issue topics for the final determination of priorities. The criteria addressed issues such as the priority area's contribution to morbidity and mortality, its relative effect on the most vulnerable citizens of the State, and the urgency of lessening the problem. The Committee then reviewed its preliminary list of priority topics and discussed each one. The Committee identified specific reasons that the seven topics are seen as the most critical issues for Pennsylvania. The Committee considered issues such as the degree to which the health problem is amenable to prevention (particularly primary prevention), disproportionately affects disadvantaged populations, affects the Commonwealth's children, and is linked with other health problems or their causes.

Between the second and third meetings, the Committee members individually completed a form ranking the importance of the objectives in each of the seven chapters. They adopted a set of objectives as priorities for action. These objectives are designated as priorities for the purpose of providing guidance on the most important problems in Pennsylvania, and promoting coalitions and cooperation of individuals and groups around the same targeted efforts.

## Plans for Implementation

The intent of the Healthy Pennsylvania 2000 Steering Committee is to use the report as a vehicle around which a statewide consortium for public health can be developed. This consortium would be dedicated to the achievement of the *Healthy People 2000* objectives, particularly Pennsylvania's priority objectives. The consensus on priority areas for Pennsylvania provides guidance for special concentration, coordination, and decision making. The seven Pennsylvania priorities cut across the single interests of public health groups. They provide a focus for public health organizations in the development of a consortium. The Healthy Pennsylvania 2000 Steering Committee does not propose the replacement of any existing organization or the delay of actions. The Committee proposes using the report as a mechanism to organize current efforts into a coalition of groups and individuals, all working together to achieve the *Healthy People 2000* objectives and to provide a public health organized constituency.

The Committee has begun several concurrent efforts toward this end. The first is to ask all of the members of the Committee to present the report for adoption by organizations they represent. To date, the Pennsylvania Public Health Association and the Pennsylvania Medical Society have adopted the report. A second implementation step is the distribution of the report. The Educational and Scientific Trust of the Pennsylvania Medical Society is working with the

Department of Health's Office of Policy, Planning, and Evaluation to develop an abbreviated version of the report. The Trust will underwrite the printing and wide distribution of this summary and the limited distribution of the entire report. Upon the availability of a printed report, members of the Steering Committee will request to meet with key members of the State administration and agency heads. The State's health-related agencies will be asked to adopt the report and join the coalition for public health. In addition, members of the Committee will present the report to various statewide and local organizations and ask for their support and involvement in a public health consortium.

There are also plans for the Educational and Scientific Trust and the Steering Committee to jointly host a conference of business, government, and public health leaders to discuss how groups can work together to achieve the objectives. Based on the results of the conference, private continuation funding will be sought.

Healthy Pennsylvania 2000 has developed into a statewide public health coalition. The ownership of the Committee's findings and the report is equally shared by all of the members of the Steering Committee and the organizations that adopt or endorse it. The Committee is continuing its efforts to expand and develop a statewide consortium and public health constituency. Cooperative efforts of all segments of the public health community are needed to address the difficult and growing public health problems facing us.

## Tracking the Objectives

Tentative plans have been made to track Pennsylvania's progress toward meeting its year 2000 objectives. Reviews will occur in approximately 1993 and 1997. To monitor Pennsylvania's progress, the health department statistics branch will analyze vital records and other data sources that provide State-level data.

## For More Information . . .

Additional information regarding Healthy Pennsylvania 2000 can be obtained by contacting:

Robin Wilcox
Director, Office of Policy, Planning
and Evaluation
Pennsylvania Department of Health
P.O. Box 90
Harrisburg, PA 17120
(717) 787-3488

# Rhode Island

## Summary of State Objectives

Rhode Island is in the process of making a major commitment to the *Healthy People 2000* objectives. Rhode Island intends to make the year 2000 health objectives process a centerpiece of its public health activities over the next ten years.

## Developing the Objectives

In October 1990, the Rhode Island Department of Health sponsored a major conference attended by 300 people entitled, Year 2000 National Health Objectives: The Decade Ahead. The purpose of this conference was to introduce the *Healthy People 2000* objectives to a wide range of health professionals in Rhode Island. The featured speakers at this conference included J. Michael McGinnis, M.D., Deputy Assistant Secretary for Health and Director, Office of Disease Prevention and Health Promotion (U.S. Department and Human Services), C. William Keck, M.D., M.P.H., President, American Public Health Association and Director of Health, Akron, Ohio, and H. Denman Scott, M.D., former Director of Health, Rhode Island Department of Health.

The Governor of Rhode Island has issued an Executive Order designating the Department of Health as the lead State agency for the pursuit of the year 2000 health objectives in Rhode Island. By the same Executive Order, the Governor created a Year 2000 Health Objectives Task Force. This Task Force, which is broadly representative of health and related interests in Rhode Island, will work closely with the Department of Health to set priorities, initiate action plans, and attain objectives.

The 1992-1993 Rhode Island Department of Health Plan completed in June 1991 includes a comprehensive identification of the specific *Healthy People 2000* objective that each Office in the Department of Health intends to pursue over the decade ahead. This represents the beginning of our attempt to internalize the year 2000 health objectives in the Department of Health.

## Plans for Implementation

In the months and years ahead, Rhode Island intends to implement a complete planning process for the *Healthy People 2000* objectives, including: the development of an explicit year 2000 Health Plan incorporating goals, objectives, priorities, and action recommendations; a full range of plan implementation activities, such as education, legislation, and program development; and evaluation of the structure, process, and outcome of the entire Healthy People 2000 initiative. The Department of Health is convinced that this commitment to the year 2000 health objectives process will result in better public health assessment, policy development, and assurance in Rhode Island.

## Tracking the Objectives

The Rhode Island Department of Health is in the process of finishing a baseline statistical study comparing the current United States rate, the current Rhode Island rate, and the *Healthy People 2000* target for each of the forty six national health objectives. This comparative analysis will enable Rhode Island to select its own year 2000 health objectives.

## For More Information . . .

Contact:

William J. Waters Jr., Ph.D.
Associate Director, Management and Policy
Rhode Island Department of Health
Three Capitol Hill
Providence, RI 02908

# South Carolina

## Summary of State Objectives

In September 1990, following Dr. Sullivan's issuance of *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, the State Health Commissioner convened a meeting of more than fifty public and private organizations to develop South Carolina's response to Dr. Sullivan's call for action. This group agreed that a Healthy People South Carolina 2000 Coalition should be established to serve as a focal point for efforts to achieve the *Healthy People 2000* objectives, and that the coalition's first activity should be to host a statewide conference on the objectives. A Steering Committee for these activities was formed.

## Developing the Objectives

The Healthy People South Carolina 2000 Conference was held in April 1991. The goals of the conference were to inform the attendees about the *Healthy People 2000* objectives, to identify how South Carolina stands in relation to each of the national objectives for which we have state-specific data, and to set an agenda for action that will move South Carolina toward the national objectives.

More than 365 individuals, representing public agencies, private organizations, professional associations, and private citizens, attended the conference. The outcome of the conference will be publication of the conference proceedings and the formal organization of the Healthy People South Carolina 2000 Coalition. Specific recommendations for action were developed at the conference and will serve as the agenda for the Coalition. The steering committee chose to make the conference and the Coalition as broadly representative as possible and, therefore, did not set State-specific priorities. The overall goal of the Coalition is to move the State toward achieving the *Healthy People 2000* objectives in areas where the State is deficient.

Members of the Healthy People South Carolina 2000 Coalition have not yet developed a formal document regarding the State's year 2000 objectives, as the development of formal statewide priorities might prove too general to adequately address communities' health needs. Instead, the Coalition will serve as a facilitating organization to promote local involvement in improving the health of the population.

## Plans for Implementation

Within the Department of Health and Environmental Control (DHEC), the *Healthy People 2000* objectives have been built into the Long Range Plans for our major deputy and program areas. DHEC will also function as the "organizational home" for the Coalition. Future activities of the Coalition will include special focus conferences and a mid-course conference to review the State's progress. In November 1991, the Coalition met to establish its by-laws. These by-laws will provide for the establishment of the following five committees:

- Data and Health Needs Assessment;
- Nominating;
- Public Policy;
- Coalition Development; and
- Communications.

The Coalition Development committee will help establish coalitions at the local level and facilitate the exchange of information among State and local coalitions. Local coalitions, composed of public agencies and private organizations, will be responsible for implementing State objectives. The Public Policy and Communications committees will be responsible for promoting health issues at the State level. The Data and Health Needs Assessment committee will provide

local coalitions with the appropriate quantitative information for setting objectives and measuring progress.

## Tracking the Objectives

The Healthy People South Carolina 2000 Coalition's Data and Health Needs Assessment committee will be responsible for identifying data needs and distributing the information to the necessary sub-coalitions.

## For More Information . . .

For further information about our efforts, please contact:

Tom Brown
Director
Office of Planning and Policy Development
South Carolina Department of Health and
Environmental Control
2600 Bull Street
Columbia, SC 29201
(803) 734-4930

# South Dakota

## Summary of State Objectives

"Health 2000" is a special project initiated by the South Dakota Department of Health during May 1989. The primary goal of the project was to improve the health of the State residents during the next decade by identifying and working toward specific health objectives that were set for the year 2000.

The project was developed to satisfy a number of principal aims:

- Address South Dakota's major public health problems in a focused manner--especially those that were not currently being addressed comprehensively;
- Promote prevention strategies to avert health problems rather than exhausting resources trying to bring health problems under control;
- Put into place disease reduction strategies that unilaterally improve the health of all South Dakotans, yet put emphasis on specially targeted risk groups;
- Implement and emulate national health strategies that are contained in *Healthy People 2000*, the national health objectives;
- Develop resources and new capacities to support pertinent disease prevention efforts; and, most importantly,
- Construct partnerships with other governmental, health-related, and special interest groups and individuals to mutually address health problems in a multidisciplinary, community-based fashion.

## Developing the Objectives

The original Health 2000 was the product of a three-year sequential planning effort undertaken by the department. The result of that process was the identification of seven priority areas that the Department of Health addresses with primary prevention initiatives:

- Infant Mortality;
- Breast Cancer;
- Heart and Cerebrovascular Disease;
- Child and Adolescent Vehicle Accident Deaths and Injuries;
- Respiratory Cancer;
- Pneumonia and Influenza Deaths; and
- Sexually Transmitted Diseases.

However, subsequent department-level planning activities that transpired during 1990 provided further opportunity for Health 2000 to evolve and broaden in scope. Conformance with Governor Michelson's statewide, five-year strategic planning initiative added new priority areas that made Health 2000 even more comprehensive. Examples of other priority areas that are presently contained in the plan are: Improvement of Primary Care Services, Elderly Health Care, Farm Occupational Health and Safety, Environmental Health, Adult and Child Immunization Services, Community Wellness, Surveillance and Data Systems Improvement, Injury Prevention, AIDS/HIV Prevention and Control, Tobacco Use Reduction and Prevention, School Health Education, and Tuberculosis Eradication.

Initial objectives were developed using the assistance of outside professional facilitators. The most noteworthy facilitation was provided by the U.S. Centers for Disease Control, using the "Health Analysis for Planning Prevention Services" (HAPPS) model. Subsequent modifications and enhancements to the plan have been self-administered by the department using an internal,

multi-disciplinary management team consisting of senior-level, program, and technical staff members. Comprehensive reviews and updates are conducted at least annually.

## Plans for Implementation

The strategic plan itself is a detailed document containing goal statements, related objectives, mid-term strategies, and short-term (annual) action plans. Action plans are specifically stated, assign general accountability, and are time phased.

Primary accountability for carrying out action plans for each priority areas (i.e., infant mortality) has been assigned to a specific individual in the department who is referred to as a coordinator. Coordinators have designated work groups consisting of departmental and interagency representatives who carry out action plans and continue to improve and enhance the plan itself.

A strategic plan leadership team was designated by Secretary of Health Barbara Smith to oversee implementation and review progress on a continuous basis. The leadership team is charged with overall quality control and standardization of Health 2000-related operations, assisting assigned work groups to overcome obstacles, and reporting progress to senior management staff and the Office of the Governor.

Most recently, the department took deliberate steps to implement the plan. Recognizing the need to focus limited resources, one of the first steps toward implementation was a general review and ranking of the activities contained in Health 2000. This sorting process lead to categorization of the various priority areas that were subsequently grouped into 5 general classes for purposes of scheduling implementation. These categories, in order of decreasing emphasis are: mandatory, urgent, essential, important, and future.

Availability of resources remains the major factor limiting implementation. As a result, resource development remains an ongoing supporting activity. Because Health 2000 links directly with the Governor's five-year strategic planning initiative for State government, it enjoys full visibility in the budget planning process. Many of the priority areas contained in the plan have subsequently been assumed as gubernatorial priorities.

## Tracking the Objectives

Almost every objective included in Health 2000 contains baseline information indicating current status of the health issue and problem concerned. Data collection systems are being established to collect tracking information for those objectives for which data are currently lacking. A centralized strategic planning data base is being developed to track progress on a continuous basis and to provide "real time" management information to state-based health planners and policy makers.

Priority area coordinators provide monthly progress reports to the Leadership Team and senior management staff. Annual progress reports and trend analysis will be prepared.

## For More Information . . .

To obtain additional information regarding South Dakota Health 2000, contact:

Brian K. Williams, Director
Center for Health Policy and Statistics
South Dakota Department of Health
523 East Capitol
Pierre, SD 57501-3182
(605) 773-3693

# Tennessee

## Summary of State Objectives

The Tennessee Department of Health's plan for the year 2000 is currently being developed and is scheduled for completion by the end of the calendar year. In its present form, the draft contains three components. One volume will present baseline statistical information about health status indicators, health systems resources, and various demographic information by individual county, region, and State. The second volume will articulate our year 2000 objectives in five priority areas. The third volume will provide specific resource allocation guidance to be used in conducting the State's certificate of need (CON) program. For the purpose of this summary, volume two will be highlighted.

The State plan includes priority areas for Environmental Health, Health Status, Health Systems Development, Health-Care Regulation, and Departmental Management. A majority of the *Healthy People 2000* objectives are addressed in the health status priorities section of our plan. In the present draft, approximately forty objectives target:

- Maternal and Child Health;
- Communicable Disease Prevention and control;
- Injury Prevention;
- Chronic Disease Prevention and Control; and
- Health Promotion.

Each quantified objective is accompanied by baseline data, when available, and up to five specific actions necessary to meet the objective. The actions are intended to guide the Department of Health's activities, but in some instances may identify roles for other public or private groups.

## Developing the Objectives

The Tennessee health status objectives have been developed largely by the Bureau of Medicaid, Health Services Administration, Health Systems Development, and Manpower and Facilities in the Department of Health. However, leadership in developing the three component plans has been provided by a legislatively established Health Planning Commission. This interdepartmental group is chaired by the Chief Medical Officer of the Department of Health. The goals, objectives, and actions, along with the data volume and the CON standards and criteria have been developed in stages over the past year. Public hearings will be held by early 1992 to enable health-care professionals, associations and community members to participate in development of the health plan.

## Plans for Implementation

Actions called for in the plan assume the current level of funding at a minimum, and often identify the need for additional resources to meet stated objectives. The priority areas identified through the plan will guide resource allocation as the State weathers its current fiscal crisis.

## Tracking the Objectives

Each Bureau in the Department of Health will be monitoring progress toward those objectives in its area of responsibility. For most of the health status objectives, that responsibility rests with the Bureau of Health Services Administration. Data are being collected and reviewed to track all quantified objectives against 1989-1990 baseline information.

## For More Information . . .

Copies of the health plan are available from:

Office of the Chief Medical Officer
Tennessee Department of Health
344 Cordell Hull Building
Nashville, TN 37247-0101
(615) 741-3111

# Texas

## Summary of State Objectives

*Healthy Texans 2000* offer a vision of a new century. It is the product of a statewide effort involving more that 1,000 Texans from the public, private, and voluntary sectors. This document is modeled after *Healthy People 2000*, a national strategy for improving the health of the Nation during this decade. It addresses the prevention of major chronic illnesses, injuries, and infectious diseases. The purpose of the Texas Year 2000 Health Objectives project is to make a commitment to three broad goals:

- Increase the span of healthy life for Texans;
- Reduce health disparities among Texans; and
- Achieve access to preventive services for all Texans.

Work groups addressed twenty-one priority areas using the following descriptive information:

- A broad statement of intent;
- Indicators to track progress;
- Description of trends that affect the problem;
- Summary of the effect on the health-care system;
- Recommended strategies for achieving the objectives; and
- Identification of needed data systems.

## Developing the Objectives

During the fall of 1990, twenty-one work groups met to begin developing the Texas Year 2000 Health Objectives. These objectives were based upon the Texas 1990 and the national *Healthy People 2000* objectives. Officials at the Texas Department of Health (TDH) selected a process of developing the year 2000 health objectives that allowed for broad-based participation. Facilitators for each of the twenty-one groups were selected. More than 300 individuals representing public, private, and voluntary sector groups participated during the year-long process. The draft Texas Year 2000 Objectives were reviewed by more than 1,000 individuals from health and human service organizations, community groups, health-care professions, and academic institutions. TDH coordinators were pleased with the cross-section of input. Revisions were completed in November 1990 and the document was then given to the staff editing team. The editors consisted of the TDH Year 2000 facilitators, health promotion specialists, health statisticians, and a public information specialist. Texas modeled the final product after *Health Objectives for the Year 2000: Report of the Oregon Health 2000 Project* and published a relatively brief document (74 pages) that can be quickly read and understood by the broadest possible audience. A more detailed set of short background papers was also developed for some of the topic areas. The background papers specifically respond to issues that the work group members felt were particularly relevant to the health problem being addressed.

The 1991-92 Texas State Health Plan was published in February 1991, and incorporates many points from our 1990 and year 2000 State health objectives. This legislatively mandated plan represents a cooperative effort to provide direction for implementing essential health services for Texas. *Model Standards for Community Preventive Health Services* was a useful tool for us in implementing the 1990 health objectives. TDH incorporated these standards into the year 2000 project. The department is working with local and regional health departments to analyze performance-based objectives. Five program areas were selected for initial analysis. They included consumer protection, HIV, chronic diseases, maternal and child health, and immunizations. Additional program areas will be added during future fiscal years. Our major objective is to tie *Healthy People 2000, Texas Year 2000 Objectives,* and *Healthy Communities*

*2000: Model Standards* into performance-based contracts and other statewide planning activities for delivery of services in the community.

## Plans for Implementation

The Texas Department of Health Public Health Promotion Division coordinates activities related to the year 2000. Division staff have developed many different approaches to increasing awareness and dissemination of State health objectives information to the public. A set of three colorful posters were developed to stimulate interest in Texas communities, with the ultimate goal of building community coalitions to tackle year 2000 issues. A toll-free number is provided for individuals to obtain information on the year 2000 project. In addition, a newsletter will be published twice yearly beginning in the fall of 1991. The newsletter will address specific issues concerning implementation, highlight innovative activities, and review monitoring of *Healthy Texans 2000*. To date, community-based year 2000 projects have been initiated in Houston, Dallas, Fort Worth, Galveston, El Paso, and Austin.

## Tracking the Objectives

Ninety-five indicators (data sources) were chosen to track progress towards the objectives. Three pieces of information were given for each indicator:

- The most recent statewide rate;
- The year 2000 projected rate; and
- The year 2000 goal.

Major gaps exist in monitoring progress. Sometimes the indicators we are using are poor substitutes for the data actually needed to monitor progress. A section entitled Data Needs was developed to focus attention on developing needed data systems. Progress reports will be developed throughout the ten-year period.

## For More Information . . .

To obtain a copy of *Healthy Texans 2000* (stock No. 4-156), please contact:

Texas Department of Health
Materials Acquisition and Management Division
1000 West 49th Street
Austin, TX 78756-3199
(512) 458-7744

For additional information on the Healthy Texans 2000 project, please contact:

Texas Department of Health
Public Health Promotion Division
(512) 458-7405

# Utah

## Summary of State Objectives

In early 1990, the Utah Department of Health initiated a strategic planning process to identify and address new and emerging, as well as continuing, public health problems that we believe demand priority and strategic consideration. After updating the Department mission statement to ensure a comprehensive vision for public health in the State, Department senior leadership identified nineteen broad issues as the most pressing public health concerns facing Utah over the next decade. These include:

- Access to Maternal and Infant Care;
- Waste Generation and Management;
- HIV Infection and AIDS;
- Adolescent Tobacco Use;
- Preventable Injuries;
- Public Health Delivery Systems;
- Health Care Cost Containment;
- Health Care Access for the Uninsured;
- Preventive and Primary Health Care for Infants and Children;
- Toxics Management;
- Cancer;
- Heart Disease;
- Substance Abuse;
- Air Pollution;
- Senior Health Care;
- Health Data Collection;
- Access to Rural Health Care;
- Water Contamination; and
- Early Identification and Intervention for Handicapped Infants and Children.

Work groups consisting of a broad range of community leaders, health professionals, and government representatives are selected to perform in-depth analysis of each issue, to prepare State objectives that are in consonance with and supportive of the *Healthy People 2000* national health objectives, and to recommend strategies and alternatives for the Department or other agencies for achieving the long-range objectives. To date, six strategic planning work groups are at various stages of completing their tasks and three more are currently being formed. An annual reevaluation of the relevance of priority issues will be conducted. In 1991/92 we are considering adding an issue related to minority health and special populations. Further, because of the separation of environmental health responsibilities into a new State Department of Environmental Quality, we are considering collapsing the four environmental issues into one issue that focuses on human health risk assessment and local environmental services.

## Developing the Objectives

The Division of Family Health Services has included specific *Healthy People 2000* objectives where appropriate as performance measures in their Maternal and Child Health Block Grant application. By adopting a large portion of the *Healthy People 2000* objectives relating to Utah families, the State will develop valid indicators of progress in overcoming adverse health conditions affecting Utah families.

## Plans for Implementation

The Division of Community Health Services (CHS) is using the *Healthy People 2000* objectives as a reference and guide in evaluating and setting health objectives relevant to Utah-specific problems. As part of this process, an assessment of the Division's capacity to measure and track its accomplishment of national and Utah year 2000 objectives has been conducted. The assessment included CHS bureaus' capacity to: define measures or indicators for objectives that may be developed to address priority health problems or conditions; determine risk factors, and contributing factors; and collect, analyze, and report relevant data. Adequacy of systems, staffing levels, and staff skills to support such activities were also evaluated as directed by the APEX/PH (Assessment Protocol for Excellence in Public Health). CHS has also been working with local health departments to assess community needs and set local priorities for the programs of Community Health Services. Long-range planning and objective setting are being integrated into this priority-setting process.

## Tracking the Objectives

The Department formed an internal committee to analyze each of the *Healthy People 2000* objectives to determine which agencies in the State (government or private) are the most appropriate to promote and monitor the objective, which agencies currently have programs addressing the conditions described in the objectives, and whether collection of data for tracking each objective is being or can be reasonably accomplished. The initial inventory is being completed. Objectives determined to fall within the responsibility of Department of Health programs are being confirmed with program managers. A number of the objectives fall within areas of responsibility of local health departments, and other State government agencies, such as Mental Health and Education. Also, it seems appropriate for private and private nonprofit agencies (such as the American Heart Association or American Cancer Society) to take the lead for tracking and accomplishing these objectives.

Over the next year, the Department will coordinate with local health departments, private agencies, and other government agencies to obtain their commitment to promoting and tracking specific year 2000 objectives in Utah where they are best qualified and willing to do so. The State Department of Health plans to coordinate existing information systems and develop necessary new systems as needed to collect data for tracking Utah's progress in addressing conditions targeted by the Utah or national *Healthy People 2000* objectives.

## For More Information . . .

To obtain further information or copies of the Utah Department of Health Strategic Planning documents, contact:

Laverne Snow
Director
Bureau of Organizational Development and Evaluation
Utah Department of Health
P.O. Box 16700
Salt Lake City, UT 84116
(801) 538-6172

# Vermont

## Summary of State Objectives

Vermont is developing year 2000 goals and objectives through an advisory committee appointed by the Commissioner of Health. The advisory committee, composed of health department and non-health department members, is charged with identifying twelve key priority areas from among the twenty-two *Healthy People 2000* priority areas. The twelve priority areas are to reflect the public health needs and priorities specific to Vermont. Working groups involving a wide range of participants will be set up for each priority area. The working groups will be charged with identifying three to five specific objectives for each priority area. The objectives will be adapted from *Healthy People 2000*. By August 1992, a working document *Healthy Vermonters 2000*, will have been developed. In the fall of 1992, a conference involving a broad representation of health and health-related professionals, policy makers, advocacy groups, and others will be held for the purpose of identifying key roles and developing recommendations for strategies needed to meet Vermont's year 2000 goals and objectives.

## Developing the Objectives

The Healthy Vermonters 2000 Advisory Committee consists of members from the Departments of Health, Mental Health, Social Welfare, Education, the Office of Alcohol and Drug Abuse, the Agency of Natural Resources, the University of Vermont (Health Promotion), key legislators, and others representing employers and health-care consumers. The committee is reviewing national and Vermont-specific data for each of the twenty-two priority areas in *Healthy People 2000*. Factors being considered in the review include size and severity of the problem, costs associated with the problem, available intervention strategies, and inter-State comparisons. The committee is scheduled to reach consensus by early 1992.

A working group will be convened for each priority area. Participation in the working groups will be expanded beyond the membership of the advisory committee to include individuals and organizations with specific interest and expertise in the priority area. Each working group is to identify three to five objectives for the specific priority area and report back to the advisory committee. The advisory committee will compile a final comprehensive set of twelve goals and approximately fifty objectives to recommend to the Commissioner of Health in the form of the *Healthy Vermonters 2000* document.

## Plans for Implementation

A statewide conference is planned for the fall of 1992. The purpose of the conference will be to:

- Inform interested parties about the year 2000 process;
- Identify lead organizations for each priority area;
- Develop strategies for reaching the objectives; and
- Set up a plan for monitoring performance.

## Tracking the Objectives

The Department of Health will be involved in identifying available data and how they are being collected and analyzed with respect to the year 2000 objectives. Where data for specific objectives are not available, it will be necessary to set up new systems for data collection and analysis.

## For More Information . . .

Burton Wilcke, Chair
Healthy Vermonters 2000 Committee
Department of Health
195 Colchester Avenue
P.O. Box 70
Burlington, VT 05402
(802) 863-7335

# Virginia

## Summary of State Objectives

The Virginia Department of Health has extended its *Six Year Plan* through fiscal year 1996. This plan is a statement of the agency's direction, identifying health goals and objectives that the agency will pursue in the Commonwealth. Managers will base their biennium budgets on the plan, direct agency programs toward the attainment of objectives in the plan, and measure their progress against the objective targets in the plan. This statewide plan represents the objectives of the Department of Health and each district's contribution to their attainment.

The *Six Year Plan* employs ten general categories of activities that contribute to the prevention of illness, the promotion of health, the protection of health, or the administration of the Department's service. These categories include the following:

- Maternal and Child Health;
- Oral Health;
- Family Planning;
- Long Term Care;
- Infectious Disease;
- Health Promotion and Education;
- Primary Care;
- Health Systems Support;
- Environmental Health; and
- Management Support.

Approximately 75 percent of the Virginia Department of Health's direct service *Six Year Plan* objectives are based on draft objectives from *Healthy People 2000.*

## Developing the Objectives

Deputy Commissioners named field and central office program representatives to review the previous planning process and recommend specific actions to enhance both the plan and the planning process. Based on those recommendations the Executive Management Team directed the structure of an organizational matrix into which all services of the department fit. The Executive Management Team named task forces, composed of central office program staff and field representatives from each of the regions, for each of ten activity areas. These task forces drafted goals and objectives based on draft objectives from *Healthy People 2000.* These drafts were circulated throughout the agency for comment. The Minority Task Force participated to ensure that the process identified and targeted health status disparities experienced by minority population groups. The result was a consensus on initial statewide goals and objectives to be used by all planning process participants in developing their *Six Year Plans.*

Community involvement and public and private initiatives were considered crucial to developing the local community public health plans. In developing the local plan, local health directors consulted with community advisors. Approaches included advisory group meetings, interviews with key community leaders, surveys of community leaders or members, public hearings, governmental meetings, and professional group meetings. Similar methods were used to obtain community views on health needs.

The health districts set targets that were then reviewed by Virginia Department of Health management, planning staff, program directors, and Deputy Commissioners. Discussions among these individuals led to some adjustments in district targets. The final district targets upon which there was consensus were compiled to form the State targets for each objective.

## Plans for Implementation

Local districts and programs have developed implementation strategies as well as additional objectives that are specific to their areas. These are documented in the districts' and programs' individual plans. Copies are maintained in a clearinghouse by the Division of Health Planning.

Local districts continue the community participation initiated during the plan development process as they implement the strategies in the plan. All districts have established local advisory committees that will be focusing initially on primary care availability and access.

## Tracking the Objectives

To integrate the Department's fiscal and management responsibilities, the plan will be employed in the budget process and will complement the *Program for Excellence*, the evaluation system for the Virginia Department of Health. The program includes a self evaluation tool that measures the agency's progress toward meeting its statewide objectives.

Development of data as part of the planning process will drive the management and budgeting processes. Methodologies are continuously under development to employ health data and statistics for service/program development and evaluation. Consistent and comprehensive data collection is essential to measure progress toward local and statewide targets. The *Program for Excellence* contains evaluation components that correspond with the language and the specific targets in the objectives.

## For More Information . . .

To obtain a copy of the *Virginia Department of Health 1991-1996 Six Year Plan*, please contact:

The Division of Health Planning
Virginia Department of Health
1500 East Main Street, Suite 105
Post Office Box 2448
Richmond, VA 23219
(804) 786-4891

# Washington

## Summary of State Objectives

Washington State has no single process for setting quantitative, measurable State health objectives related to *Healthy People 2000*. Rather, goals and objectives are being set through a variety of processes including development of the State Health Report, development of individual program plans and grant applications, a Department of Health strategic planning process, use of APEX/PH (Assessment Protocol for Excellence in Public Health), and activities of the State's Health Care Commission.

## Developing the Objectives

The Washington State Board of Health established seven broad non-quantitative goals with action strategies in the biennial Washington State Health Report published in 1990. These goals relate to:

- Infant Morbidity and Mortality;
- Infectious Disease;
- Environmental Hazards;
- Tobacco Use;
- Alcohol and Other Drug Use;
- Unintentional Injury; and
- Access to Health and Illness Care Services and Resources.

The State Health Report contains no specific quantitative objectives related to these goals.

The Board of Health reviewed the draft *Healthy People 2000* while developing an initial list of priority health goals for Washington State. The board sought the advice of numerous individuals representing State agencies, professional and civic groups, voluntary agencies, and the general public. Health forums were organized by local health departments and community groups throughout the State to gather input directly from citizens and professionals. The result was further refinement of and support for six initial goals, and addition of a seventh goal on Access to Services and Resources. For each goal in the State Health Plan there are action strategies for promoting information, education, service, regulation, and system change. The report further identifies action partners recommended to join in coordinated Federal, State, county, and private sector efforts to achieve the goals.

Some individual programs in the Washington Department of Health have set or are setting objectives as part of the development of State plans and Federal grant applications.

- Washington Cancer Control Plan: The Washington Cancer Control Plan, developed with the assistance of a U.S. National Cancer Institute grant and published by the Department of Health in February 1991, contains time-specific quantitative objectives regarding breast, cervical, and smoking-related cancers. Several of these objectives are identical in wording to those in *Healthy People 2000*. All relate to the broad goals of reducing cancer risk, detecting and treating cancer early, or increasing knowledge of cancer problems and solutions. The planning process involved a Cancer Advisory Committee with members representing business, health professionals, cancer organizations, the Legislature, and State, Federal, and local government. For each objective in the plan, there are action strategies, lists of responsible agencies, and methods of evaluating progress toward the objective.
- HIV/AIDS: With assistance from the Washington Department of Health, the State's six AIDS Regional Networks (AIDSNETs) are setting regional objectives related to HIV/AIDS. When this process is completed, by January 1992, the AIDSNETs and the

Department of Health will work cooperatively to develop state-specific quantitative objectives in *Healthy People 2000*. Others will go beyond those and deal with treatment.

- Maternal and Child Health: In late 1991, the Department of Health's Parent-Child Health Services program (PCHS) will initiate a process to identify State-specific objectives and indicators. PCHS will identify existing indicators such as the *Healthy People 2000* objectives, national family planning indicators, national WIC indicators, and the State Board of Health goals and strategies. An advisory committee will be formed with representatives from local health departments, other local agencies, universities, and other institutions. This process is expected to take one to two years.
- Immunization: The Department of Health's Immunization program has developed state-specific quantitative objectives as part of the process of writing the application for the Maternal and Child Health Block Grant. The objectives relate directly to those in *Healthy People 2000*. The grant application development process included many opportunities for review by service agencies, contractors, and the general public. Other state-specific immunization objectives were developed as part of the process of writing the State's application for a Federal categorical immunization grant.
- Cardiovascular Disease: As part of the process of applying for the Preventive Health and Health Services Block Grant, the Department of Health has developed state-specific quantitative objectives for cardiovascular disease. These are related directly to objectives in *Healthy People 2000*. The grant application development process included community forums throughout the State and review by a panel of experts.
- Sexually Transmitted Disease (STD): The STD program has set state-specific objectives in conjunction with its application for the Federal categorical grant related to sexually transmitted diseases.

## Plans for Implementation

The Department of Health has begun a strategic planning process that will include some setting of health objectives related to the *Healthy People 2000* objectives. Washington State is also the implementation site for a nationally significant application of the APEX/PH (Assessment Protocol for Excellence in Public Health), that will include objective-setting. The Washington Department of Health will use Part I of APEX/PH for evaluating its own organizational capacity. The Washington State Health Care Commission is now developing recommendations on a broad range of health issues. It is expected that one recommendation will be for full implementation of the *Healthy People 2000* objectives on Clinical Preventive Services.

## Tracking the Objectives

Washington has developed a sophisticated prototype microcomputer system for tracking and reporting on health indicators and objectives. Department of Health staff presented the system at the 1991 Public Health Conference on Records and Statistics in Washington, D.C., and have distributed sample diskettes and documentation to numerous State and Federal agencies. The department is interested in collaborating on future development of this system or other tools for tracking health objectives.

## For More Information . . .

Office of Health Policy Support
Washington State Department of Health, LL-12
Olympia, WA 98504
(206) 753-2246

# West Virginia

## Summary of State Objectives

To be published by early 1992, *West Virginia Healthy People 2000* contains health objectives for the year 2000 that are divided into twenty-one priority areas, with each priority area containing up to four objectives. All except one of the priority areas addressed in *Healthy People 2000* were addressed in West Virginia. For each priority area, *West Virginia Healthy People 2000* contains:

- A background narrative providing a brief overview of the topical area being addressed, including a discussion of possible health impacts;
- A section providing historical data and pertinent statistics to provide an understanding of the issue being addressed and its status in West Virginia;
- Information concerning existing methods of preventing, treating, or otherwise addressing each particular objective topic in a section entitled "Prevailing Strategies;"
- Up to four specific objectives for the year 2000 that represent the culmination of a particular working group's efforts to develop a consensus opinion on appropriate objectives and realistic impact targets for the year 2000;
- A listing of the working group participants; and
- A listing of resources and bibliographical information.

In all, more than sixty objectives were developed across the twenty-one priority areas addressed in *West Virginia Healthy People 2000*. Out of this set of objectives, approximately twenty "flagship" objectives were selected by a committee chaired by the Commissioner of the Bureau of Public Health. The flagship objectives were selected based on the criteria that each objective should address a particularly significant, potentially preventable, or readily addressed health priority. The principal purpose in identifying flagship objectives was to place special focus on priority issues.

## Developing the Objectives

*West Virginia Healthy People 2000* was developed over an eighteen-month period at the request of the Commissioner of the West Virginia Bureau of Public Health. West Virginia objectives were to be based on the prevalence, level of severity, and nature of the health problem(s) associated with the specific topics addressed by working groups. It was understood by all project participants that emphasis was to be placed on developing objectives that were (or would become) measurable, outcome oriented, and achievable.

The process of developing West Virginia objectives entailed establishing twenty-one working groups, with each group coordinated by a chairperson to facilitate the development of the group's objectives and written report. Members of these working groups were generally comprised of representatives of State agencies, nonprofit corporations, academic institutions, and a wide variety of organizations. A planner in the Bureau of Public Health was dedicated part-time to coordinating resources and communications concomitant with the working group process.

A structured outline was established and used to set parameters in terms of design, style, and general content for each section of the document. The document was then independently developed by the respective working groups. The surveillance and data systems working group provided oversight to working groups on issues involving data quality, objective measurability, and the comparability of data sets.

## Plans for Implementation

The release of *West Virginia Healthy People 2000* will mark the end of phase one, establishment of the objectives, and the beginning of phase two, the development of implementation strategies. At the outset of Healthy People 2000 planning in West Virginia, it was determined that initially a

document containing objectives should be developed and disseminated. Next, expanded working groups would set about the task of developing specific interventions for the objectives concentrating specifically on the flagship objectives. This would permit input from a wider spectrum of groups and individuals in the process of developing focused and primarily community-based interventions and preventive programs, as well as modifications and amendments to existing service delivery mechanisms. Further, it will permit better timing in our State by coordinating the development of our Healthy People 2000 implementation strategies to coincide and mesh with the State wellness plan. This plan is being developed by the Healthy West Virginia Coalition, composed of the West Virginia Bureau of Public Health, the West Virginia School Health Committee, the State Health Education Council, the West Virginia State Medical Association, and the Wellness Council of West Virginia.

Implementation strategies are being developed for release during the spring of 1992. It is anticipated that these strategies will focus heavily on programs, policies, and public awareness initiatives that:

- Create an environment where health enhancing behaviors can be developed and maintained;
- Focus on measures that confer protection on community populations; and
- Focus on corporate, community, and individual responsibilities for wellness and lifestyle choices.

To facilitate implementation of the Healthy People 2000 process in communities throughout West Virginia, the Bureau of Public Health is establishing a network of regional health educators in the eight public health management districts throughout the State. Working through local health departments, these regional health educators will communicate directly with community groups to assess health problems in the community and to plan and implement various interventions to address the health problems identified. They will also assist local health departments in executing internal assessments and capacity strengthening initiatives using APEX/PH (Assessment Protocol for Excellence in Public Health) and other resources.

Specific interventions may necessitate developing new data tracking mechanisms, increasing training and information dissemination, developing new funding sources, and updating State statutes and/or legislative rules affecting public health policy and service delivery. The establishment of new links and public private partnerships are already underway through initiatives such as the Healthy West Virginia Coalition, the West Virginia Tobacco Control Coalition, West Virginia Community Nutrition Coalition, and West Virginia Diabetes Control Advisory Committee.

## Tracking the Objectives

Whenever baseline data are available, this information is provided along with the statewide rate and the objective including a reduction target for the year 2000. In some instances data sets have not yet been established and in these cases target dates are generally cited for establishing baselines. In rare instances, objectives were included for important topics about which neither baselines, nor tracking mechanisms were presently available, with the intent that planning for tracking mechanisms for these objectives would be hastened.

## For More Information . . .

To obtain a copy upon publication of *West Virginia Healthy People 2000*, please contact:

Office of the Commissioner
c/o Local Health Unit
Healthy People 2000 Project
West Virginia Bureau of Public Health
1411 Virginia Street, East
Charleston, WV 25301
(304) 348-8870

# Wisconsin

## Summary of Objectives

Published in April 1990, *Healthier People in Wisconsin: A Public Health Agenda for the Year 2000*, contains more than 200 measurable goals and objectives in 40 priority areas. For each priority area, a chapter was written and includes:

- Background information discussing the problems, morbidity and mortality trends, risk factors and potential for prevention;
- Overall goals for improving health status;
- Measurable outcome objectives and measurement indicators; and
- Implementation steps that state what needs to be done, by whom, and by when, to accomplish the objectives.

The Public Health Agenda includes objectives in the following areas:

- Communicable Diseases (sexually transmitted diseases, AIDS/HIV, vaccine preventable diseases, viral hepatitis, and enteric diseases);
- Chronic Diseases (cancer, cardiovascular diseases, chronic diseases of aging, nutrition, alcohol, oral diseases, tobacco use);
- Injury Prevention (transportation, intentional injuries, falls, burns, occupational injuries, drowning, and aquatic injuries);
- Environmental Diseases (environmental hazards, emergency response, radiation protection, environmental disease, sanitation); and
- Reproductive and Perinatal Health (reproductive health promotion, infant mortality/low birth weight, prevention of birth defects).

## Developing the Objectives

The Public Health Agenda was developed over a fifteen-month period. The genesis of the document was interest from the public health community and an inquiry in late 1987 from the State Assembly's Subcommittee on Maternal and Child Health (MCH) about the Department of Health and Social Services' (DHSS) long-range plan for the MCH block grant dollars. In response, community, industry, and health leaders from throughout the State, with support and participation from the DHSS, undertook the development of a plan to identify and address the most significant public health issues.

In doing so, a decision was made to parallel a similar nationwide exercise and develop objectives for Wisconsin to meet by the year 2000. A fourteen-member Public Health Plan Steering Committee was appointed that determined: a definition of public health; the purpose of the public health plan; and the format of the plan. In 1988, a 23 member Community Health Plan Committee and a thirty-three-member Maternal and Child Health Committee were appointed. Committee members represented the public and private communities.

The charge to the committees was to create a plan with measurable goals and objectives that identifies the State's public health needs for the decade beginning in 1990. The first meeting of these committees was held in January 1989. More than fifty technical advisors from throughout the State and sixty DHSS staff were called upon for expertise in specific topics discussed by the committees.

The document created by these committees contains seven sections:

- Environmental Health;
- Chronic Disease;

- Communicable Disease;
- Injury Prevention;
- Reproductive and Perinatal Health;
- Infant and Child Health; and
- Adolescent Health.

On April 9, 1990, the completed 200-page document and executive summary were presented to Governor Tommy Thompson.

## Plans for Implementation

In June 1990, an invitational leadership conference was held with delegates from many State organizations to begin the implementation process. For two days, these representatives met in small groups to discuss how the objectives could be implemented by their respective organizations. Each organizational delegate completed a pledge form that committed their organization to specific objectives and implementation steps. Many organizations have adopted these objectives and are moving forward to play their part in implementation.

## Tracking the Objectives

Most of the objectives have measurement indicators that are part of the health data collection and analysis system in Wisconsin. For some objectives, new data measurements are required. A data plan and budget estimate for these data has been prepared and is awaiting funding through a legislative proposal to increase the cigarette tax. A mid-course review is planned for 1995.

## For More Information . . .

To obtain a copy of *Healthier People in Wisconsin: A Public Health Agenda for the Year 2000* or the Executive Summary, please contact:

Wisconsin Division of Health, BCHP
Attention: Ruth Okey
P.O. Box 309
Madison, WI 53701
(608) 266-1251

# Wyoming

## Summary of State Objectives

The mission of the Department of Health is "the promotion and protection of the health of the people; the prevention of disease, injury, and disabilities where possible; the treatment of disease, injury, and disabilities when needed; and, rehabilitation from the effects of the disease, injury, and disabilities whenever possible."

## Developing the Objectives

With these objectives and with this mission statement in mind, the Division of Health and Medical Services put together a committee to set health objectives for the State of Wyoming for the year 2000. Many of the objectives the committee developed paralleled the *Healthy People 2000* objectives. The following committees were formed:

- Access to care;
- Chronic disease;
- Communicable disease;
- Environmental health;
- Independent living;
- Injury control;
- Maternal and child health; and
- Substance abuse and mental health.

These committees met over an eighteen month period from 1989 to early 1991. The committees were made up of public and private citizens who represented many of the health organizations in the State of Wyoming. These objectives are presently being compiled, and will be presented to the new Department of Health, that was reorganized during the 1990 and 1991 fiscal years.

## Plans for Implementation

The State is presently implementing the new reorganization plan and the new division administrators were appointed in May 1991. The reorganization plan was presented to the citizens of the State through a series of sixteen public hearings around the State. Now that the State reorganization plan has been approved and is being implemented, an implementation plan and tracking system for meeting the Wyoming health objectives will be addressed.

## Tracking the Objectives

The Department of Health is putting into place a new data system to collect, compile, and evaluate data in regards to meeting the health objectives for Wyoming. The system is presently being developed and implemented.

## For More Information . . .

Further information about the health objectives in the State can be obtained, by contacting:

Department of Health
Hathaway Building
Cheyenne, WY 82002

When the document outlining the objectives is completed, it will be made public (early in 1992).

# Appendix

# *Healthy People 2000* Objectives

# *Healthy People 2000* Objectives

Duplicate objectives, which appear in two or more priority areas, are marked with an asterisk (*).

Except as otherwise noted, all rates in the following objectives are annual. Where the baseline rate is age adjusted, it is age adjusted to the 1940 U.S. population, and the target is age adjusted also.

## 1. Physical Activity And Fitness

### Health Status Objectives

1.1* Reduce coronary heart disease deaths to no more than 100 per 100,000 people. (Age-adjusted baseline: 135 per 100,000 in 1987)

| | | *Special Population Target* | |
|---|---|---|---|
| | *Coronary Deaths (per 100,000)* | *1987 Baseline* | *2000 Target* |
| 1.1a | Blacks | 163 | 115 |

1.2* Reduce overweight to a prevalence of no more than 20 percent among people aged 20 and older and no more than 15 percent among adolescents aged 12 through 19. (Baseline: 26 percent for people aged 20 through 74 in 1976-80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12 through 19 in 1976-80)

| | | *Special Population Targets* | |
|---|---|---|---|
| | *Overweight Prevalence* | *1976-80 Baseline*[†] | *2000 Target* |
| 1.2a | Low-income women aged 20 and older | 37% | 25% |
| 1.2b | Black women aged 20 and older | 44% | 30% |
| 1.2c | Hispanic women aged 20 and older | | 25% |
| | Mexican-American women | 39%[‡] | |
| | Cuban women | 34%[‡] | |
| | Puerto Rican women | 37%[‡] | |
| 1.2d | American Indians/Alaska Natives | 29-75%[§] | 30% |
| 1.2e | People with disabilities | 36%[+] | 25% |
| 1.2f | Women with high blood pressure | 50% | 41% |
| 1.2g | Men with high blood pressure | 39% | 35% |

[†] *Baseline for people aged 20-74* [‡] *1982-84 baseline for Hispanics aged 20-74*

[§] *1984-88 estimates for different tribes* [+] *1985 baseline for people aged 20-74 who report any limitation in activity due to chronic conditions*

*Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12 through 14, 24.3 for males aged 15 through 17, 25.8 for males aged 18 through 19, 23.4 for females aged 12 through 14, 24.8 for females aged 15 through 17, and 25.7 for females aged 18 through 19. The values for adolescents are the age- and gender-specific 85th percentile values of the 1976-80 National Health and Nutrition Examination Survey (NHANES II), corrected for sample variation. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.*

### Risk Reduction Objectives

1.3* Increase to at least 30 percent the proportion of people aged 6 and older who engage regularly, preferably daily, in light to moderate physical activity for at least 30 minutes per day. (Baseline: 22 percent of people aged 18 and older were active for at least 30 minutes 5 or more times per week and 12 percent were active 7 or more times per week in 1985)

*Note: Light to moderate physical activity requires sustained, rhythmic muscular movements, is at least equivalent to sustained walking, and is performed at less than 60 percent of maximum heart rate for age. Maximum heart rate equals roughly 220 beats per minute minus age. Examples may include walking, swimming, cycling, dancing, gardening and yardwork, various domestic and occupational activities, and games and other childhood pursuits.*

1.4 Increase to at least 20 percent the proportion of people aged 18 and older and to at least 75 percent the proportion of children and adolescents aged 6 through 17 who engage in vigorous physical activity that promotes the development and maintenance of cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion. (Baseline: 12 percent for people aged 18 and older in 1985; 66 percent for youth aged 10 through 17 in 1984)

| | | *Special Population Target* | |
|---|---|---|---|
| | *Vigorous Physical Activity* | *1985 Baseline* | *2000 Target* |
| 1.4a | Lower-income people aged 18 and older (annual family income <$20,000) | 7% | 12% |

*Note: Vigorous physical activities are rhythmic, repetitive physical activities that use large muscle groups at 60 percent or more of maximum heart rate for age. An exercise heart rate of 60 percent of maximum heart rate for age is about 50 percent of maximal cardiorespiratory capacity and is sufficient for cardiorespiratory conditioning. Maximum heart rate equals roughly 220 beats per minute minus age.*

1.5 Reduce to no more than 15 percent the proportion of people aged 6 and older who engage in no leisure-time physical activity. (Baseline: 24 percent for people aged 18 and older in 1985)

| | | *Special Population Targets* | |
|---|---|---|---|
| | *No Leisure-Time Physical Activity* | *1985 Baseline* | *2000 Target* |
| 1.5a | People aged 65 and older | 43% | 22% |
| 1.5b | People with disabilities | 35%† | 20% |
| 1.5c | Lower-income people (annual family income <$20,000) | 32%† | 17% |

†*Baseline for people aged 18 and older*

*Note: For this objective, people with disabilities are people who report any limitation in activity due to chronic conditions.*

1.6 Increase to at least 40 percent the proportion of people aged 6 and older who regularly perform physical activities that enhance and maintain muscular strength, muscular endurance, and flexibility. (Baseline data available in 1991)

1.7* Increase to at least 50 percent the proportion of overweight people aged 12 and older who have adopted sound dietary practices combined with regular physical activity to attain an appropriate body weight. (Baseline: 30 percent of overweight women and 25 percent of overweight men for people aged 18 and older in 1985)

## Services and Protection Objectives

1.8 Increase to at least 50 percent the proportion of children and adolescents in 1st through 12th grade who participate in daily school physical education. (Baseline: 36 percent in 1984-86)

1.9 Increase to at least 50 percent the proportion of school physical education class time that students spend being physically active, preferably engaged in lifetime physical activities. (Baseline: Students spent an estimated 27 percent of class time being physically active in 1983)

*Note: Lifetime activities are activities that may be readily carried into adulthood because they generally need only one or two people. Examples include swimming, bicycling, jogging, and racquet sports. Also counted as lifetime activities are vigorous social activities such as dancing. Competitive group sports and activities typically played only by young children such as group games are excluded.*

1.10 Increase the proportion of worksites offering employer-sponsored physical activity and fitness programs as follows:

| *Worksite Size* | *1985 Baseline* | *2000 Target* |
|---|---|---|
| 50-99 employees | 14% | 20% |
| 100-249 employees | 23% | 35% |
| 250-749 employees | 32% | 50% |
| ≥750 employees | 54% | 80% |

1.11 Increase community availability and accessibility of physical activity and fitness facilities as follows:

| *Facility* | *1986 Baseline* | *2000 Target* |
|---|---|---|
| Hiking, biking, and fitness trail miles | 1 per 71,000 people | 1 per 10,000 people |
| Public swimming pools | 1 per 53,000 people | 1 per 25,000 people |
| Acres of park and recreation open space | 1.8 per 1,000 people (553 people per managed acre) | 4 per 1,000 people (250 people per managed acre) |

1.12 Increase to at least 50 percent the proportion of primary care providers who routinely assess and counsel their patients regarding the frequency, duration, type, and intensity of each patient's physical activity practices. (Baseline: Physicians provided exercise counseling for about 30 percent of sedentary patients in 1988)

# 2. Nutrition

## Health Status Objectives

2.1* Reduce coronary heart disease deaths to no more than 100 per 100,000 people. (Age-adjusted baseline: 135 per 100,000 in 1987)

| | | Special Population Target | |
|---|---|---|---|
| | *Coronary Deaths (per 100,000)* | *1987 Baseline* | *2000 Target* |
| 2.1a | Blacks | 163 | 115 |

2.2* Reverse the rise in cancer deaths to achieve a rate of no more than 130 per 100,000 people. (Age-adjusted baseline: 133 per 100,000 in 1987)

*Note: In its publications, the National Cancer Institute age adjusts cancer death rates to the 1970 U.S. population. Using the 1970 standard, the equivalent baseline and target values for this objective would be 171 and 175 per 100,000, respectively.*

2.3* Reduce overweight to a prevalence of no more than 20 percent among people aged 20 and older and no more than 15 percent among adolescents aged 12 through 19. (Baseline: 26 percent for people aged 20 through 74 in 1976-80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12 through 19 in 1976-80)

| | | Special Population Targets | |
|---|---|---|---|
| | *Overweight Prevalence* | *1976-80 Baseline*[†] | *2000 Target* |
| 2.3a | Low-income women aged 20 and older | 37% | 25% |
| 2.3b | Black women aged 20 and older | 44% | 30% |
| 2.3c | Hispanic women aged 20 and older | | 25% |
| | Mexican-American women | 39%[‡] | |
| | Cuban women | 34%[‡] | |
| | Puerto Rican women | 37%[‡] | |
| 2.3d | American Indians/Alaska Natives | 29-75%[§] | 30% |
| 2.3e | People with disabilities | 36%[+] | 25% |
| 2.3f | Women with high blood pressure | 50% | 41% |
| 2.3g | Men with high blood pressure | 39% | 35% |

[†]*Baseline for people aged 20-74* [‡]*1982-84 baseline for Hispanics aged 20-74*

[§]*1984-88 estimates for different tribes* [+]*1985 baseline for people aged 20-74 who report any limitation in activity due to chronic conditions*

*Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12 through 14, 24.3 for males aged 15 through 17, 25.8 for males aged 18 through 19, 23.4 for females aged 12 through 14, 24.8 for females aged 15 through 17, and 25.7 for females aged 18 through 19. The values for adolescents are the age- and gender-specific 85th percentile values of the 1976-80 National Health and Nutrition Examination Survey (NHANES II), corrected for sample variation. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.*

2.4 Reduce growth retardation among low-income children aged 5 and younger to less than 10 percent. (Baseline: Up to 16 percent among low-income children in 1988, depending on age and race/ethnicity)

| | | Special Population Targets | |
|---|---|---|---|
| | *Prevalence of Short Stature* | *1988 Baseline* | *2000 Target* |
| 2.4a | Low-income black children <age 1 | 15% | 10% |
| 2.4b | Low-income Hispanic children <age 1 | 13% | 10% |
| 2.4c | Low-income Hispanic children aged 1 | 16% | 10% |
| 2.4d | Low-income Asian/Pacific Islander children aged 1 | 14% | 10% |
| 2.4e | Low-income Asian/Pacific Islander children aged 2-4 | 16% | 10% |

*Note: Growth retardation is defined as height-for-age below the fifth percentile of children in the National Center for Health Statistics' reference population.*

## Risk Reduction Objectives

2.5* Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat intake to less than 10 percent of calories among people aged 2 and older. (Baseline: 36 percent of calories from total fat and 13 percent from saturated fat for people aged 20 through 74 in 1976-80; 36 percent and 13 percent for women aged 19 through 50 in 1985)

2.6* Increase complex carbohydrate and fiber-containing foods in the diets of adults to 5 or more daily servings for vegetables (including legumes) and fruits, and to 6 or more daily servings for grain products. (Baseline: 2½ servings of vegetables and fruits and 3 servings of grain products for women aged 19 through 50 in 1985)

2.7* Increase to at least 50 percent the proportion of overweight people aged 12 and older who have adopted sound dietary practices combined with regular physical activity to attain an appropriate body weight. (Baseline: 30 percent of overweight women and 25 percent of overweight men for people aged 18 and older in 1985)

2.8 Increase calcium intake so at least 50 percent of youth aged 12 through 24 and 50 percent of pregnant and lactating women consume 3 or more servings daily of foods rich in calcium, and at least 50 percent of people aged 25 and older consume 2 or more servings daily. (Baseline: 7 percent of women and 14 percent of men aged 19 though 24 and 24 percent of pregnant and lactating women consumed 3 or more servings, and 15 percent of women and 23 percent of men aged 25 through 50 consumed 2 or more servings in 1985-86)

*Note: The number of servings of foods rich in calcium is based on milk and milk products. A serving is considered to be 1 cup of skim milk or its equivalent in calcium (302 mg). The number of servings in this objective will generally provide approximately three-fourths of the 1989 Recommended Dietary Allowance (RDA) of calcium. The RDA is 1200 mg for people aged 12 through 24, 800 mg for people aged 25 and older, and 1200 mg for pregnant and lactating women.*

2.9 Decrease salt and sodium intake so at least 65 percent of home meal preparers prepare foods without adding salt, at least 80 percent of people avoid using salt at the table, and at least 40 percent of adults regularly purchase foods modified or lower in sodium. (Baseline: 54 percent of women aged 19 through 50 who served as the main meal preparer did not use salt in food preparation, and 68 percent of women aged 19 through 50 did not use salt at the table in 1985; 20 percent of all people aged 18 and older regularly purchased foods with reduced salt and sodium content in 1988)

2.10 Reduce iron deficiency to less than 3 percent among children aged 1 through 4 and among women of childbearing age. (Baseline: 9 percent for children aged 1 through 2, 4 percent for children aged 3 through 4, and 5 percent for women aged 20 through 44 in 1976-80)

*Special Population Targets*

| | *Iron Deficiency Prevalence* | *1976-80 Baseline* | *2000 Target* |
|---|---|---|---|
| 2.10a | Low-income children aged 1-2 | 21% | 10% |
| 2.10b | Low-income children aged 3-4 | 10% | 5% |
| 2.10c | Low-income women of childbearing age | 8%† | 4% |
| | *Anemia Prevalence* | *1983-85 Baseline* | *2000 Target* |
| 2.10d | Alaska Native children aged 1-5 | 22-28% | 10% |
| 2.10e | Black, low-income pregnant women (third trimester) | 41%‡ | 20% |

†*Baseline for women aged 20-44* ‡*1988 baseline for women aged 15-44*

*Note: Iron deficiency is defined as having abnormal results for 2 or more of the following tests: mean corpuscular volume, erythrocyte protoporphyrin, and transferrin saturation. Anemia is used as an index of iron deficiency. Anemia among Alaska Native children was defined as hemoglobin <11 gm/dL or hematocrit <34 percent. For pregnant women in the third trimester, anemia was defined according to CDC criteria. The above prevalences of iron deficiency and anemia may be due to inadequate dietary iron intakes or to inflammatory conditions and infections. For anemia, genetics may also be a factor.*

2.11* Increase to at least 75 percent the proportion of mothers who breastfeed their babies in the early postpartum period and to at least 50 percent the proportion who continue breastfeeding until their babies are 5 to 6 months old. (Baseline: 54 percent at discharge from birth site and 21 percent at 5 to 6 months in 1988)

*Special Population Targets*

| | *Mothers Breastfeeding Their Babies:* | *1988 Baseline* | *2000 Target* |
|---|---|---|---|
| | *During Early Postpartum Period—* | | |
| 2.11a | Low-income mothers | 32% | 75% |
| 2.11b | Black mothers | 25% | 75% |
| 2.11c | Hispanic mothers | 51% | 75% |
| 2.11d | American Indian/Alaska Native mothers | 47% | 75% |
| | *At Age 5-6 Months—* | | |
| 2.11a | Low-income mothers | 9% | 50% |
| 2.11b | Black mothers | 8% | 50% |
| 2.11c | Hispanic mothers | 16% | 50% |
| 2.11d | American Indian/Alaska Native mothers | 28% | 50% |

2.12* Increase to at least 75 percent the proportion of parents and caregivers who use feeding practices that prevent baby bottle tooth decay. (Baseline data available in 1991)

*Special Population Targets*

| | *Appropriate Feeding Practices* | *Baseline* | *2000 Target* |
|---|---|---|---|
| 2.12a | Parents and caregivers with less than high school education | — | 65% |
| 2.12b | American Indian/Alaska Native parents and caregivers | — | 65% |

2.13 Increase to at least 85 percent the proportion of people aged 18 and older who use food labels to make nutritious food selections. (Baseline: 74 percent used labels to make food selections in 1988)

## Services and Protection Objectives

2.14 Achieve useful and informative nutrition labeling for virtually all processed foods and at least 40 percent of fresh meats, poultry, fish, fruits, vegetables, baked goods, and ready-to-eat carry-away foods. (Baseline: 60 percent of sales of processed foods regulated by FDA had nutrition labeling in 1988; baseline data on fresh and carry-away foods unavailable)

2.15 Increase to at least 5,000 brand items the availability of processed food products that are reduced in fat and saturated fat. (Baseline: 2,500 items reduced in fat in 1986)

*Note: A brand item is defined as a particular flavor and/or size of a specific brand and is typically the consumer unit of purchase.*

2.16 Increase to at least 90 percent the proportion of restaurants and institutional food service operations that offer identifiable low-fat, low-calorie food choices, consistent with the *Dietary Guidelines for Americans.* (Baseline: About 70 percent of fast food and family restaurant chains with 350 or more units had at least one low-fat, low-calorie item on their menu in 1989)

2.17 Increase to at least 90 percent the proportion of school lunch and breakfast services and child care food services with menus that are consistent with the nutrition principles in the *Dietary Guidelines for Americans.* (Baseline data available in 1993)

2.18 Increase to at least 80 percent the receipt of home food services by people aged 65 and older who have difficulty in preparing their own meals or are otherwise in need of home-delivered meals. (Baseline data available in 1991)

2.19 Increase to at least 75 percent the proportion of the Nation's schools that provide nutrition education from preschool through 12th grade, preferably as part of quality school health education. (Baseline data available in 1991)

2.20 Increase to at least 50 percent the proportion of worksites with 50 or more employees that offer nutrition education and/or weight management programs for employees. (Baseline: 17 percent offered nutrition education activities and 15 percent offered weight control activities in 1985)

2.21 Increase to at least 75 percent the proportion of primary care providers who provide nutrition assessment and counseling and/or referral to qualified nutritionists or dietitians. (Baseline: Physicians provided diet counseling for an estimated 40 to 50 percent of patients in 1988)

# 3. Tobacco

## Health Status Objectives

3.1* Reduce coronary heart disease deaths to no more than 100 per 100,000 people. (Age-adjusted baseline: 135 per 100,000 in 1987)

| | | *Special Population Target* | |
|---|---|---|---|
| | *Coronary Deaths (per 100,000)* | *1987 Baseline* | *2000 Target* |
| 3.1a | Blacks | 163 | 115 |

3.2* Slow the rise in lung cancer deaths to achieve a rate of no more than 42 per 100,000 people. (Age-adjusted baseline: 37.9 per 100,000 in 1987)

*Note: In its publications, the National Cancer Institute age adjusts cancer death rates to the 1970 U.S. population. Using the 1970 standard, the equivalent baseline and target values for this objective would be 47.9 and 53 per 100,000, respectively.*

3.3 Slow the rise in deaths from chronic obstructive pulmonary disease to achieve a rate of no more than 25 per 100,000 people. (Age-adjusted baseline: 18.7 per 100,000 in 1987)

*Note: Deaths from chronic obstructive pulmonary disease include deaths due to chronic bronchitis, emphysema, asthma, and other chronic obstructive pulmonary diseases and allied conditions.*

## Risk Reduction Objectives

3.4* Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 20 and older. (Baseline: 29 percent in 1987, 32 percent for men and 27 percent for women)

| | | *Special Population Targets* | |
|---|---|---|---|
| | *Cigarette Smoking Prevalence* | *1987 Baseline* | *2000 Target* |
| 3.4a | People with a high school education or less aged 20 and older | 34% | 20% |
| 3.4b | Blue-collar workers aged 20 and older | 36% | 20% |
| 3.4c | Military personnel | 42%† | 20% |
| 3.4d | Blacks aged 20 and older | 34% | 18% |
| 3.4e | Hispanics aged 20 and older | 33%‡ | 18% |
| 3.4f | American Indians/Alaska Natives | 42-70%§ | 20% |
| 3.4g | Southeast Asian men | 55%+ | 20% |
| 3.4h | Women of reproductive age | 29%†† | 12% |
| 3.4i | Pregnant women | 25%‡‡ | 10% |
| 3.4j | Women who use oral contraceptives | 36%§§ | 10% |

†*1988 baseline* ‡*1982-84 baseline for Hispanics aged 20-74* §*1979-87 estimates for different tribes*
+*1984-88 baseline* ††*Baseline for women aged 18-44* ‡‡*1985 baseline* §§*1983 baseline*

*Note: A cigarette smoker is a person who has smoked at least 100 cigarettes and currently smokes cigarettes.*

3.5 Reduce the initiation of cigarette smoking by children and youth so that no more than 15 percent have become regular cigarette smokers by age 20. (Baseline: 30 percent of youth had become regular cigarette smokers by ages 20 through 24 in 1987)

*Special Population Target*

| | *Initiation of Smoking* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 3.5a | Lower socioeconomic status youth† | 40% | 18% |

†*As measured by people aged 20-24 with a high school education or less*

3.6 Increase to at least 50 percent the proportion of cigarette smokers aged 18 and older who stopped smoking cigarettes for at least one day during the preceding year. (Baseline: In 1986, 34 percent of people who smoked in the preceding year stopped for at least one day during that year)

3.7 Increase smoking cessation during pregnancy so that at least 60 percent of women who are cigarette smokers at the time they become pregnant quit smoking early in pregnancy and maintain abstinence for the remainder of their pregnancy. (Baseline: 39 percent of white women aged 20 through 44 quit at any time during pregnancy in 1985)

*Special Population Target*

| | *Cessation and Abstinence During Pregnancy* | *1985 Baseline* | *2000 Target* |
|---|---|---|---|
| 3.7a | Women with less than a high school education | 28%† | 45% |

†*Baseline for white women aged 20-44*

3.8 Reduce to no more than 20 percent the proportion of children aged 6 and younger who are regularly exposed to tobacco smoke at home. (Baseline: More than 39 percent in 1986, as 39 percent of households with one or more children aged 6 or younger had a cigarette smoker in the household)

*Note: Regular exposure to tobacco smoke at home is defined as the occurrence of tobacco smoking anywhere in the home on more than 3 days each week.*

3.9 Reduce smokeless tobacco use by males aged 12 through 24 to a prevalence of no more than 4 percent. (Baseline: 6.6 percent among males aged 12 through 17 in 1988; 8.9 percent among males aged 18 through 24 in 1987)

*Special Population Target*

| | *Smokeless Tobacco Use* | *1986-87 Baseline* | *2000 Target* |
|---|---|---|---|
| 3.9a | American Indian/Alaska Native youth | 18-64% | 10% |

*Note: For males aged 12 through 17, a smokeless tobacco user is someone who has used snuff or chewing tobacco in the preceding month. For males aged 18 through 24, a smokeless tobacco user is someone who has used either snuff or chewing tobacco at least 20 times and who currently uses snuff or chewing tobacco.*

## Services and Protection Objectives

3.10 Establish tobacco-free environments and include tobacco use prevention in the curricula of all elementary, middle, and secondary schools, preferably as part of quality school health education. (Baseline: 17 percent of school districts totally banned smoking on school premises or at school functions in 1988; antismoking education was provided by 78 percent of school districts at the high school level, 81 percent at the middle school level, and 75 percent at the elementary school level in 1988)

3.11 Increase to at least 75 percent the proportion of worksites with a formal smoking policy that prohibits or severely restricts smoking at the workplace. (Baseline: 27 percent of worksites with 50 or more employees in 1985; 54 percent of medium and large companies in 1987)

3.12 Enact in 50 States comprehensive laws on clean indoor air that prohibit or strictly limit smoking in the workplace and enclosed public places (including health care facilities, schools, and public transportation). (Baseline: 42 States and the District of Columbia had laws restricting smoking in public places; 31 States restricted smoking in public workplaces; but only 13 States had comprehensive laws regulating smoking in private as well as public worksites and at least 4 public places, including restaurants, as of 1988)

3.13 Enact and enforce in 50 States laws prohibiting the sale and distribution of tobacco products to youth younger than age 19. (Baseline: 44 States and the District of Columbia had, but rarely enforced, laws regulating the sale and/or distribution of cigarettes or tobacco products to minors in 1990; only 3 set the age of majority at 19 and only 6 prohibited cigarette vending machines accessible to minors)

*Note: Model legislation proposed by DHHS recommends licensure of tobacco vendors, civil money penalties and license suspension or revocation for violations, and a ban on cigarette vending machines.*

3.14 Increase to 50 the number of States with plans to reduce tobacco use, especially among youth. (Baseline: 12 States in 1989)

3.15 Eliminate or severely restrict all forms of tobacco product advertising and promotion to which youth younger than age 18 are likely to be exposed. (Baseline: Radio and television advertising of tobacco products were prohibited, but other restrictions on advertising and promotion to which youth may be exposed were minimal in 1990)

3.16 Increase to at least 75 percent the proportion of primary care and oral health care providers who routinely advise cessation and provide assistance and followup for all of their tobacco-using patients. (Baseline: About 52 percent of internists reported counseling more than 75 percent of their smoking patients about smoking cessation in 1986; about 35 percent of dentists reported counseling at least 75 percent of their smoking patients about smoking in 1986)

# 4. Alcohol and Other Drugs

## Health Status Objectives

4.1 Reduce deaths caused by alcohol-related motor vehicle crashes to no more than 8.5 per 100,000 people. (Age-adjusted baseline: 9.8 per 100,000 in 1987)

*Special Population Targets*

| | *Alcohol-Related Motor Vehicle Crash Deaths (per 100,000)* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 4.1a | American Indian/Alaska Native men | 52.2 | 44.8 |
| 4.1b | People aged 15-24 | 21.5 | 18 |

4.2 Reduce cirrhosis deaths to no more than 6 per 100,000 people. (Age-adjusted baseline: 9.1 per 100,000 in 1987)

*Special Population Targets*

| | *Cirrhosis Deaths (per 100,000)* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 4.2a | Black men | 22 | 12 |
| 4.2b | American Indians/Alaska Natives | 25.9 | 13 |

4.3 Reduce drug-related deaths to no more than 3 per 100,000 people. (Age-adjusted baseline: 3.8 per 100,000 in 1987)

4.4 Reduce drug abuse-related hospital emergency department visits by at least 20 percent. (Baseline data available in 1991)

## Risk Reduction Objectives

4.5 Increase by at least 1 year the average age of first use of cigarettes, alcohol, and marijuana by adolescents aged 12 through 17. (Baseline: Age 11.6 for cigarettes, age 13.1 for alcohol, and age 13.4 for marijuana in 1988)

4.6 Reduce the proportion of young people who have used alcohol, marijuana, and cocaine in the past month, as follows:

| *Substance/Age* | *1988 Baseline* | *2000 Target* |
|---|---|---|
| Alcohol/aged 12-17 | 25.2% | 12.6% |
| Alcohol/aged 18-20 | 57.9% | 29% |
| Marijuana/aged 12-17 | 6.4% | 3.2% |
| Marijuana/aged 18-25 | 15.5% | 7.8% |
| Cocaine/aged 12-17 | 1.1% | 0.6% |
| Cocaine/aged 18-25 | 4.5% | 2.3% |

*Note: The targets of this objective are consistent with the goals established by the Office of National Drug Control Policy, Executive Office of the President.*

4.7 Reduce the proportion of high school seniors and college students engaging in recent occasions of heavy drinking of alcoholic beverages to no more than 28 percent of high school seniors and 32 percent of college students. (Baseline: 33 percent of high school seniors and 41.7 percent of college students in 1989)

*Note: Recent heavy drinking is defined as having 5 or more drinks on one occasion in the previous 2-week period as monitored by self-reports.*

4.8 Reduce alcohol consumption by people aged 14 and older to an annual average of no more than 2 gallons of ethanol per person. (Baseline: 2.54 gallons of ethanol in 1987)

4.9 Increase the proportion of high school seniors who perceive social disapproval associated with the heavy use of alcohol, occasional use of marijuana, and experimentation with cocaine, as follows:

| *Behavior* | *1989 Baseline* | *2000 Target* |
|---|---|---|
| Heavy use of alcohol | 56.4% | 70% |
| Occasional use of marijuana | 71.1% | 85% |
| Trying cocaine once or twice | 88.9% | 95% |

*Note: Heavy drinking is defined as having 5 or more drinks once or twice each weekend.*

4.10 Increase the proportion of high school seniors who associate risk of physical or psychological harm with the heavy use of alcohol, regular use of marijuana, and experimentation with cocaine, as follows:

| *Behavior* | *1989 Baseline* | *2000 Target* |
|---|---|---|
| Heavy use of alcohol | 44% | 70% |
| Regular use of marijuana | 77.5% | 90% |
| Trying cocaine once or twice | 54.9% | 80% |

*Note: Heavy drinking is defined as having 5 or more drinks once or twice each weekend.*

4.11 Reduce to no more than 3 percent the proportion of male high school seniors who use anabolic steroids. (Baseline: 4.7 percent in 1989)

## Services and Protection Objectives

4.12 Establish and monitor in 50 States comprehensive plans to ensure access to alcohol and drug treatment programs for traditionally underserved people. (Baseline data available in 1991)

4.13 Provide to children in all school districts and private schools primary and secondary school educational programs on alcohol and other drugs, preferably as part of quality school health education. (Baseline: 63 percent provided some instruction, 39 percent provided counseling, and 23 percent referred students for clinical assessments in 1987)

4.14 Extend adoption of alcohol and drug policies for the work environment to at least 60 percent of worksites with 50 or more employees. (Baseline data available in 1991)

4.15 Extend to 50 States administrative driver's license suspension/revocation laws or programs of equal effectiveness for people determined to have been driving under the influence of intoxicants. (Baseline: 28 States and the District of Columbia in 1990)

4.16 Increase to 50 the number of States that have enacted and enforce policies, beyond those in existence in 1989, to reduce access to alcoholic beverages by minors.

*Note: Policies to reduce access to alcoholic beverages by minors may include those that address restriction of the sale of alcoholic beverages at recreational and entertainment events at which youth make up a majority of participants/consumers, product pricing, penalties and license-revocation for sale of alcoholic beverages to minors, and other approaches designed to discourage and restrict purchase of alcoholic beverages by minors.*

4.17 Increase to at least 20 the number of States that have enacted statutes to restrict promotion of alcoholic beverages that is focused principally on young audiences. (Baseline data available in 1992)

4.18 Extend to 50 States legal blood alcohol concentration tolerance levels of .04 percent for motor vehicle drivers aged 21 and older and .00 percent for those younger than age 21. (Baseline: 0 States in 1990)

4.19 Increase to at least 75 percent the proportion of primary care providers who screen for alcohol and other drug use problems and provide counseling and referral as needed. (Baseline data available in 1992)

# 5. Family Planning

## Health Status Objectives

5.1 Reduce pregnancies among girls aged 17 and younger to no more than 50 per 1,000 adolescents. (Baseline: 71.1 pregnancies per 1,000 girls aged 15 through 17 in 1985)

| | | *Special Population Targets* | |
|---|---|---|---|
| | *Pregnancies (per 1,000)* | *1985 Baseline* | *2000 Target* |
| 5.1a | Black adolescent girls aged 15-19 | 186† | 120 |
| 5.1b | Hispanic adolescent girls aged 15-19 | 158 | 105 |

†*Non-white adolescents*

*Note: For black and Hispanic adolescent girls, baseline data are unavailable for those aged 15 through 17. The targets for these two populations are based on data for women aged 15 through 19. If more complete data become available, a 35-percent reduction from baseline figures should be used as the target.*

5.2 Reduce to no more than 30 percent the proportion of all pregnancies that are unintended. (Baseline: 56 percent of pregnancies in the previous 5 years were unintended, either unwanted or earlier than desired, in 1988)

| | | *Special Population Target* | |
|---|---|---|---|
| | *Unintended Pregnancies* | *1988 Baseline* | *2000 Target* |
| 5.2a | Black women | 78% | 40% |

5.3 Reduce the prevalence of infertility to no more than 6.5 percent. (Baseline: 7.9 percent of married couples with wives aged 15 through 44 in 1988)

| | | *Special Population Targets* | |
|---|---|---|---|
| | *Prevalence of Infertility* | *1988 Baseline* | *2000 Target* |
| 5.3a | Black couples | 12.1% | 9% |
| 5.3b | Hispanic couples | 12.4% | 9% |

*Note: Infertility is the failure of couples to conceive after 12 months of intercourse without contraception.*

## Risk Reduction Objectives

5.4* Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17. (Baseline: 27 percent of girls and 33 percent of boys by age 15; 50 percent of girls and 66 percent of boys by age 17; reported in 1988)

5.5 Increase to at least 40 percent the proportion of ever sexually active adolescents aged 17 and younger who have abstained from sexual activity for the previous 3 months. (Baseline: 26 percent of sexually active girls aged 15 through 17 in 1988)

5.6 Increase to at least 90 percent the proportion of sexually active, unmarried people aged 19 and younger who use contraception, especially combined method contraception that both effectively prevents pregnancy and provides barrier protection against disease. (Baseline: 78 percent at most recent intercourse and 63 percent at first intercourse; 2 percent used oral contraceptives and the condom at most recent intercourse; among young women aged 15 through 19 reporting in 1988)

*Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens who are not yet sexually active.*

5.7 Increase the effectiveness with which family planning methods are used, as measured by a decrease to no more than 5 percent in the proportion of couples experiencing pregnancy despite use of a contraceptive method. (Baseline: Approximately 10 percent of women using reversible contraceptive methods experienced an unintended pregnancy in 1982)

### Services and Protection Objectives

5.8 Increase to at least 85 percent the proportion of people aged 10 through 18 who have discussed human sexuality, including values surrounding sexuality, with their parents and/or have received information through another parentally endorsed source, such as youth, school, or religious programs. (Baseline: 66 percent of people aged 13 through 18 have discussed sexuality with their parents; reported in 1986)

*Note: This objective, which supports family communication on a range of vital personal health issues, will be tracked using the National Health Interview Survey, a continuing, voluntary, national sample survey of adults who report on household characteristics including such items as illnesses, injuries, use of health services, and demographic characteristics.*

5.9 Increase to at least 90 percent the proportion of pregnancy counselors who offer positive, accurate information about adoption to their unmarried patients with unintended pregnancies. (Baseline: 60 percent of pregnancy counselors in 1984)

*Note: Pregnancy counselors are any providers of health or social services who discuss the management or outcome of pregnancy with a woman after she has received a diagnosis of pregnancy.*

5.10* Increase to at least 60 percent the proportion of primary care providers who provide age-appropriate preconception care and counseling. (Baseline data available in 1992)

5.11* Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that screen, diagnose, treat, counsel, and provide (or refer for) partner notification services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia). (Baseline: 40 percent of family planning clinics for bacterial sexually transmitted diseases in 1989)

## 6. Mental Health and Mental Disorders

### Health Status Objectives

6.1* Reduce suicides to no more than 10.5 per 100,000 people. (Age-adjusted baseline: 11.7 per 100,000 in 1987)

*Special Population Targets*

| | *Suicides (per 100,000)* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 6.1a | Youth aged 15-19 | 10.3 | 8.2 |
| 6.1b | Men aged 20-34 | 25.2 | 21.4 |
| 6.1c | White men aged 65 and older | 46.1 | 39.2 |
| 6.1d | American Indian/Alaska Native men in Reservation States | 15 | 12.8 |

6.2* Reduce by 15 percent the incidence of injurious suicide attempts among adolescents aged 14 through 17. (Baseline data available in 1991)

6.3 Reduce to less than 10 percent the prevalence of mental disorders among children and adolescents. (Baseline: An estimated 12 percent among youth younger than age 18 in 1989)

6.4 Reduce the prevalence of mental disorders (exclusive of substance abuse) among adults living in the community to less than 10.7 percent. (Baseline: One-month point prevalence of 12.6 percent in 1984)

6.5 Reduce to less than 35 percent the proportion of people aged 18 and older who experienced adverse health effects from stress within the past year. (Baseline: 42.6 percent in 1985)

*Special Population Target*

| | | *1985 Baseline* | *2000 Target* |
|---|---|---|---|
| 6.5a | People with disabilities | 53.5% | 40% |

*Note: For this objective, people with disabilities are people who report any limitation in activity due to chronic conditions.*

### Risk Reduction Objectives

6.6 Increase to at least 30 percent the proportion of people aged 18 and older with severe, persistent mental disorders who use community support programs. (Baseline: 15 percent in 1986)

6.7 Increase to at least 45 percent the proportion of people with major depressive disorders who obtain treatment. (Baseline: 31 percent in 1982)

6.8 Increase to at least 20 percent the proportion of people aged 18 and older who seek help in coping with personal and emotional problems. (Baseline: 11.1 percent in 1985)

*Special Population Target*

| | | *1985 Baseline* | *2000 Target* |
|---|---|---|---|
| 6.8a | People with disabilities | 14.7% | 30% |

6.9 Decrease to no more than 5 percent the proportion of people aged 18 and older who report experiencing significant levels of stress who do not take steps to reduce or control their stress. (Baseline: 21 percent in 1985)

### Services and Protection Objectives

6.10* Increase to 50 the number of States with officially established protocols that engage mental health, alcohol and drug, and public health authorities with corrections authorities to facilitate identification and appropriate intervention to prevent suicide by jail inmates. (Baseline data available in 1992)

6.11 Increase to at least 40 percent the proportion of worksites employing 50 or more people that provide programs to reduce employee stress. (Baseline: 26.6 percent in 1985)

6.12 Establish mutual help clearinghouses in at least 25 States. (Baseline: 9 States in 1989)

6.13 Increase to at least 50 percent the proportion of primary care providers who routinely review with patients their patients' cognitive, emotional, and behavioral functioning and the resources available to deal with any problems that are identified. (Baseline data available in 1992)

6.14 Increase to at least 75 percent the proportion of providers of primary care for children who include assessment of cognitive, emotional, and parent-child functioning, with appropriate counseling, referral, and followup, in their clinical practices. (Baseline data available in 1992)

## 7. Violent and Abusive Behavior

### Health Status Objectives

7.1 Reduce homicides to no more than 7.2 per 100,000 people. (Age-adjusted baseline: 8.5 per 100,000 in 1987)

*Special Population Targets*

| | *Homicide Rate (per 100,000)* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 7.1a | Children aged 3 and younger | 3.9 | 3.1 |
| 7.1b | Spouses aged 15-34 | 1.7 | 1.4 |
| 7.1c | Black men aged 15-34 | 90.5 | 72.4 |
| 7.1d | Hispanic men aged 15-34 | 53.1 | 42.5 |
| 7.1e | Black women aged 15-34 | 20.0 | 16.0 |
| 7.1f | American Indians/Alaska Natives in Reservation States | 14.1 | 11.3 |

7.2* Reduce suicides to no more than 10.5 per 100,000 people. (Age-adjusted baseline: 11.7 per 100,000 in 1987)

*Special Population Targets*

| | *Suicides (per 100,000)* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 7.2a | Youth aged 15-19 | 10.3 | 8.2 |
| 7.2b | Men aged 20-34 | 25.2 | 21.4 |
| 7.2c | White men aged 65 and older | 46.1 | 39.2 |
| 7.2d | American Indian/Alaska Native men in Reservation States | 15 | 12.8 |

7.3 Reduce weapon-related violent deaths to no more than 12.6 per 100,000 people from major causes. (Age-adjusted baseline: 12.9 per 100,000 by firearms, 1.9 per 100,000 by knives, in 1987)

7.4 Reverse to less than 25.2 per 1,000 children the rising incidence of maltreatment of children younger than age 18. (Baseline: 25.2 per 1,000 in 1986)

*Type-Specific Targets*

| | *Incidence of Types of Maltreatment (per 1,000)* | *1986 Baseline* | *2000 Target* |
|---|---|---|---|
| 7.4a | Physical abuse | 5.7 | <5.7 |
| 7.4b | Sexual abuse | 2.5 | <2.5 |
| 7.4c | Emotional abuse | 3.4 | <3.4 |
| 7.4d | Neglect | 15.9 | <15.9 |

7.5 Reduce physical abuse directed at women by male partners to no more than 27 per 1,000 couples. (Baseline: 30 per 1,000 in 1985)

7.6 Reduce assault injuries among people aged 12 and older to no more than 10 per 1,000 people. (Baseline: 11.1 per 1,000 in 1986)

7.7 Reduce rape and attempted rape of women aged 12 and older to no more than 108 per 100,000 women. (Baseline: 120 per 100,000 in 1986)

| | | *Special Population Target* | |
|---|---|---|---|
| | *Incidence of Rape and Attempted Rape (per 100,000)* | *1986 Baseline* | *2000 Target* |
| 7.7a | Women aged 12-34 | 250 | 225 |

7.8* Reduce by 15 percent the incidence of injurious suicide attempts among adolescents aged 14 through 17. (Baseline data available in 1991)

### Risk Reduction Objectives

7.9 Reduce by 20 percent the incidence of physical fighting among adolescents aged 14 through 17. (Baseline data available in 1991)

7.10 Reduce by 20 percent the incidence of weapon-carrying by adolescents aged 14 through 17. (Baseline data available in 1991)

7.11 Reduce by 20 percent the proportion of people who possess weapons that are inappropriately stored and therefore dangerously available. (Baseline data available in 1992)

### Services and Protection Objectives

7.12 Extend protocols for routinely identifying, treating, and properly referring suicide attempters, victims of sexual assault, and victims of spouse, elder, and child abuse to at least 90 percent of hospital emergency departments. (Baseline data available in 1992)

7.13 Extend to at least 45 States implementation of unexplained child death review systems. (Baseline data available in 1991)

7.14 Increase to at least 30 the number of States in which at least 50 percent of children identified as neglected or physically or sexually abused receive physical and mental evaluation with appropriate followup as a means of breaking the intergenerational cycle of abuse. (Baseline data available in 1993)

7.15 Reduce to less than 10 percent the proportion of battered women and their children turned away from emergency housing due to lack of space. (Baseline: 40 percent in 1987)

7.16 Increase to at least 50 percent the proportion of elementary and secondary schools that teach nonviolent conflict resolution skills, preferably as a part of quality school health education. (Baseline data available in 1991)

7.17 Extend coordinated, comprehensive violence prevention programs to at least 80 percent of local jurisdictions with populations over 100,000. (Baseline data available in 1993)

7.18* Increase to 50 the number of States with officially established protocols that engage mental health, alcohol and drug, and public health authorities with corrections authorities to facilitate identification and appropriate intervention to prevent suicide by jail inmates. (Baseline data available in 1992)

## 8. Educational and Community-Based Programs

### Health Status Objective

8.1* Increase years of healthy life to at least 65 years. (Baseline: An estimated 62 years in 1980)

| | | *Special Population Targets* | |
|---|---|---|---|
| | *Years of Healthy Life* | *1980 Baseline* | *2000 Target* |
| 8.1a | Blacks | 56 | 60 |
| 8.1b | Hispanics | 62 | 65 |
| 8.1c | People aged 65 and older | 12† | 14† |

†*Years of healthy life remaining at age 65*

*Note: Years of healthy life (also referred to as quality-adjusted life years) is a summary measure of health that combines mortality (quantity of life) and morbidity and disability (quality of life) into a single measure. For people aged 65 and older, active life-expectancy, a related summary measure, also will be tracked.*

### Risk Reduction Objective

8.2 Increase the high school graduation rate to at least 90 percent, thereby reducing risks for multiple problem behaviors and poor mental and physical health. (Baseline: 79 percent of people aged 20 through 21 had graduated from high school with a regular diploma in 1989)

*Note: This objective and its target are consistent with the National Education Goal to increase high school graduation rates. The baseline estimate is a proxy. When a measure is chosen to monitor the National Education Goal, the same measure and data source will be used to track this objective.*

## Services and Protection Objectives

8.3 Achieve for all disadvantaged children and children with disabilities access to high quality and developmentally appropriate preschool programs that help prepare children for school, thereby improving their prospects with regard to school performance, problem behaviors, and mental and physical health. (Baseline: 47 percent of eligible children aged 4 were afforded the opportunity to enroll in Head Start in 1990)

*Note: This objective and its target are consistent with the National Education Goal to increase school readiness and its objective to increase access to preschool programs for disadvantaged and disabled children. The baseline estimate is an available, but partial, proxy. When a measure is chosen to monitor this National Education Objective, the same measure and data source will be used to track this objective.*

8.4 Increase to at least 75 percent the proportion of the Nation's elementary and secondary schools that provide planned and sequential kindergarten through 12th grade quality school health education. (Baseline data available in 1991)

8.5 Increase to at least 50 percent the proportion of postsecondary institutions with institutionwide health promotion programs for students, faculty, and staff. (Baseline: At least 20 percent of higher education institutions offered health promotion activities for students in 1989-90)

8.6 Increase to at least 85 percent the proportion of workplaces with 50 or more employees that offer health promotion activities for their employees, preferably as part of a comprehensive employee health promotion program. (Baseline: 65 percent of worksites with 50 or more employees offered at least one health promotion activity in 1985; 63 percent of medium and large companies had a wellness program in 1987)

8.7 Increase to at least 20 percent the proportion of hourly workers who participate regularly in employer-sponsored health promotion activities. (Baseline data available in 1992)

8.8 Increase to at least 90 percent the proportion of people aged 65 and older who had the opportunity to participate during the preceding year in at least one organized health promotion program through a senior center, lifecare facility, or other community-based setting that serves older adults. (Baseline data available in 1992)

8.9 Increase to at least 75 percent the proportion of people aged 10 and older who have discussed issues related to nutrition, physical activity, sexual behavior, tobacco, alcohol, other drugs, or safety with family members on at least one occasion during the preceding month. (Baseline data available in 1991)

*Note: This objective, which supports family communication on a range of vital personal health issues, will be tracked using the National Health Interview Survey, a continuing, voluntary, national sample survey of adults who report on household characteristics including such items as illnesses, injuries, use of health services, and demographic characteristics.*

8.10 Establish community health promotion programs that separately or together address at least three of the Healthy People 2000 priorities and reach at least 40 percent of each State's population. (Baseline data available in 1992)

8.11 Increase to at least 50 percent the proportion of counties that have established culturally and linguistically appropriate community health promotion programs for racial and ethnic minority populations. (Baseline data available in 1992)

*Note: This objective will be tracked in counties in which a racial or ethnic group constitutes more than 10 percent of the population.*

8.12 Increase to at least 90 percent the proportion of hospitals, health maintenance organizations, and large group practices that provide patient education programs, and to at least 90 percent the proportion of community hospitals that offer community health promotion programs addressing the priority health needs of their communities. (Baseline: 66 percent of 6,821 registered hospitals provided patient education services in 1987; 60 percent of 5,677 community hospitals offered community health promotion programs in 1987)

8.13 Increase to at least 75 percent the proportion of local television network affiliates in the top 20 television markets that have become partners with one or more community organizations around one of the health problems addressed by the Healthy People 2000 objectives. (Baseline data available in 1991)

8.14 Increase to at least 90 percent the proportion of people who are served by a local health department that is effectively carrying out the core functions of public health. (Baseline data available in 1992)

*Note: The core functions of public health have been defined as assessment, policy development, and assurance. Local health department refers to any local component of the public health system, defined as an administrative and service unit of local or State government concerned with health and carrying some responsibility for the health of a jurisdiction smaller than a State.*

# 9. Unintentional Injuries

## Health Status Objectives

9.1 Reduce deaths caused by unintentional injuries to no more than 29.3 per 100,000 people. (Age-adjusted baseline: 34.5 per 100,000 in 1987)

*Special Population Targets*

| | *Deaths Caused By Unintential Injuries (per 100,000)* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 9.1a | American Indians/Alaska Natives | 82.6 | 66.1 |
| 9.1b | Black males | 64.9 | 51.9 |
| 9.1c | White males | 53.6 | 42.9 |

9.2 Reduce nonfatal unintentional injuries so that hospitalizations for this condition are no more than 754 per 100,000 people. (Baseline: 887 per 100,000 in 1988)

9.3 Reduce deaths caused by motor vehicle crashes to no more than 1.9 per 100 million vehicle miles traveled and 16.8 per 100,000 people. (Baseline: 2.4 per 100 million vehicle miles traveled (VMT) and 18.8 per 100,000 people (age adjusted) in 1987)

*Special Population Targets*

| | *Deaths Caused By Motor Vehicle Crashes (per 100,000)* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 9.3a | Children aged 14 and younger | 6.2 | 5.5 |
| 9.3b | Youth aged 15-24 | 36.9 | 33 |
| 9.3c | People aged 70 and older | 22.6 | 20 |
| 9.3d | American Indians/Alaska Natives | 46.8 | 39.2 |

*Type-Specific Targets*

| | *Deaths Caused By Motor Vehicle Crashes* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 9.3e | Motorcyclists | 40.9/100 million VMT & 1.7/100,000 | 33/100 million VMT & 1.5/100,000 |
| 9.3f | Pedestrians | 3.1/100,000 | 2.7/100,000 |

9.4 Reduce deaths from falls and fall-related injuries to no more than 2.3 per 100,000 people. (Age-adjusted baseline: 2.7 per 100,000 in 1987)

*Special Population Targets*

| | *Deaths From Falls and Fall-Related Injuries (per 100,000)* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 9.4a | People aged 65-84 | 18 | 14.4 |
| 9.4b | People aged 85 and older | 131.2 | 105.0 |
| 9.4c | Black men aged 30-69 | 8 | 5.6 |

9.5 Reduce drowning deaths to no more than 1.3 per 100,000 people. (Age-adjusted baseline: 2.1 per 100,000 in 1987)

*Special Population Targets*

| | *Drowning Deaths (per 100,000)* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 9.5a | Children aged 4 and younger | 4.2 | 2.3 |
| 9.5b | Men aged 15-34 | 4.5 | 2.5 |
| 9.5c | Black males | 6.6 | 3.6 |

9.6 Reduce residential fire deaths to no more than 1.2 per 100,000 people. (Age-adjusted baseline: 1.5 per 100,000 in 1987)

*Special Population Targets*

| | *Residential Fire Deaths (per 100,000)* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 9.6a | Children aged 4 and younger | 4.4 | 3.3 |
| 9.6b | People aged 65 and older | 4.4 | 3.3 |
| 9.6c | Black males | 5.7 | 4.3 |
| 9.6d | Black females | 3.4 | 2.6 |

*Type-Specific Target*

| | | *1983 Baseline* | *2000 Target* |
|---|---|---|---|
| 9.6e | Residential fire deaths caused by smoking | 17% | 5% |

9.7 Reduce hip fractures among people aged 65 and older so that hospitalizations for this condition are no more than 607 per 100,000. (Baseline: 714 per 100,000 in 1988)

*Special Population Target*

| | *Hip Fractures (per 100,000)* | *1988 Baseline* | *2000 Target* |
|---|---|---|---|
| 9.7a | White women aged 85 and older | 2,721 | 2,177 |

9.8 Reduce nonfatal poisoning to no more than 88 emergency department treatments per 100,000 people. (Baseline: 103 per 100,000 in 1986)

| | | Special Population Target | |
|---|---|---|---|
| | *Nonfatal Poisoning (per 100,000)* | *1986 Baseline* | *2000 Target* |
| 9.8a | Among children aged 4 and younger | 650 | 520 |

9.9 Reduce nonfatal head injuries so that hospitalizations for this condition are no more than 106 per 100,000 people. (Baseline: 125 per 100,000 in 1988)

9.10 Reduce nonfatal spinal cord injuries so that hospitalizations for this condition are no more than 5 per 100,000 people. (Baseline: 5.9 per 100,000 in 1988)

| | | Special Population Target | |
|---|---|---|---|
| | *Nonfatal Spinal Cord Injuries (per 100,000)* | *1988 Baseline* | *2000 Target* |
| 9.10a | Males | 8.9 | 7.1 |

9.11 Reduce the incidence of secondary disabilities associated with injuries of the head and spinal cord to no more than 16 and 2.6 per 100,000 people, respectively. (Baseline: 20 per 100,000 for serious head injuries and 3.2 per 100,000 for spinal cord injuries in 1986)

*Note: Secondary disabilities are defined as those medical conditions secondary to traumatic head or spinal cord injury that impair independent and productive lifestyles.*

### Risk Reduction Objectives

9.12 Increase use of occupant protection systems, such as safety belts, inflatable safety restraints, and child safety seats, to at least 85 percent of motor vehicle occupants. (Baseline: 42 percent in 1988)

| | | Special Population Target | |
|---|---|---|---|
| | *Use of Occupant Protection Systems* | *1988 Baseline* | *2000 Target* |
| 9.12a | Children aged 4 and younger | 84% | 95% |

9.13 Increase use of helmets to at least 80 percent of motorcyclists and at least 50 percent of bicyclists. (Baseline: 60 percent of motorcyclists in 1988 and an estimated 8 percent of bicyclists in 1984)

### Services and Protection Objectives

9.14 Extend to 50 States laws requiring safety belt and motorcycle helmet use for all ages. (Baseline: 33 States and the District of Columbia in 1989 for automobiles; 22 States, the District of Columbia, and Puerto Rico for motorcycles)

9.15 Enact in 50 States laws requiring that new handguns be designed to minimize the likelihood of discharge by children. (Baseline: 0 States in 1989)

9.16 Extend to 2,000 local jurisdictions the number whose codes address the installation of fire suppression sprinkler systems in those residences at highest risk for fires. (Baseline data available in 1991)

9.17 Increase the presence of functional smoke detectors to at least one on each habitable floor of all inhabited residential dwellings. (Baseline: 81 percent of residential dwellings in 1989)

9.18 Provide academic instruction on injury prevention and control, preferably as part of quality school health education, in at least 50 percent of public school systems (grades K through 12). (Baseline data available in 1991)

9.19* Extend requirement of the use of effective head, face, eye, and mouth protection to all organizations, agencies, and institutions sponsoring sporting and recreation events that pose risks of injury. (Baseline: Only National Collegiate Athletic Association football, hockey, and lacrosse; high school football; amateur boxing; and amateur ice hockey in 1988)

9.20 Increase to at least 30 the number of States that have design standards for signs, signals, markings, lighting, and other characteristics of the roadway environment to improve the visual stimuli and protect the safety of older drivers and pedestrians. (Baseline data available in 1992)

9.21 Increase to at least 50 percent the proportion of primary care providers who routinely provide age-appropriate counseling on safety precautions to prevent unintentional injury. (Baseline data available in 1992)

9.22 Extend to 50 States emergency medical services and trauma systems linking prehospital, hospital, and rehabilitation services in order to prevent trauma deaths and long-term disability. (Baseline: 2 States in 1987)

## 10. Occupational Safety and Health

### Health Status Objectives

10.1 Reduce deaths from work-related injuries to no more than 4 per 100,000 full-time workers. (Baseline: Average of 6 per 100,000 during 1983-87)

| | | Special Population Targets | |
|---|---|---|---|
| | *Work-Related Deaths (per 100,000)* | *1983-87 Average* | *2000 Target* |
| 10.1a | Mine workers | 30.3 | 21 |
| 10.1b | Construction workers | 25.0 | 17 |
| 10.1c | Transportation workers | 15.2 | 10 |
| 10.1d | Farm workers | 14.0 | 9.5 |

10.2 Reduce work-related injuries resulting in medical treatment, lost time from work, or restricted work activity to no more than 6 cases per 100 full-time workers. (Baseline: 7.7 per 100 in 1987)

| | | Special Population Targets | |
|---|---|---|---|
| | *Work-Related Injuries (per 100)* | *1983-87 Average* | *2000 Target* |
| 10.2a | Construction workers | 14.9 | 10 |
| 10.2b | Nursing and personal care workers | 12.7 | 9 |
| 10.2c | Farm workers | 12.4 | 8 |
| 10.2d | Transportation workers | 8.3 | 6 |
| 10.2e | Mine workers | 8.3 | 6 |

10.3 Reduce cumulative trauma disorders to an incidence of no more than 60 cases per 100,000 full-time workers. (Baseline: 100 per 100,000 in 1987)

| | | Special Population Targets | |
|---|---|---|---|
| | *Cumulative Trauma Disorders (per 100,000)* | *1987 Baseline* | *2000 Target* |
| 10.3a | Manufacturing industry workers | 355 | 150 |
| 10.3b | Meat product workers | 3,920 | 2,000 |

10.4 Reduce occupational skin disorders or diseases to an incidence of no more than 55 per 100,000 full-time workers. (Baseline: Average of 64 per 100,000 during 1983-87)

10.5* Reduce hepatitis B infections among occupationally exposed workers to an incidence of no more than 1,250 cases. (Baseline: An estimated 6,200 cases in 1987)

### Risk Reduction Objectives

10.6 Increase to at least 75 percent the proportion of worksites with 50 or more employees that mandate employee use of occupant protection systems, such as seatbelts, during all work-related motor vehicle travel. (Baseline data available in 1991)

10.7 Reduce to no more than 15 percent the proportion of workers exposed to average daily noise levels that exceed 85 dBA. (Baseline data available in 1992)

10.8 Eliminate exposures which result in workers having blood lead concentrations greater than 25 µg/dL of whole blood. (Baseline: 4,804 workers with blood lead levels above 25 µg/dL in 7 States in 1988)

10.9* Increase hepatitis B immunization levels to 90 percent among occupationally exposed workers. (Baseline data available in 1991)

### Services and Protection Objectives

10.10 Implement occupational safety and health plans in 50 States for the identification, management, and prevention of leading work-related diseases and injuries within the State. (Baseline: 10 States in 1989)

10.11 Establish in 50 States exposure standards adequate to prevent the major occupational lung diseases to which their worker populations are exposed (byssinosis, asbestosis, coal workers' pneumoconiosis, and silicosis). (Baseline data available in 1991)

10.12 Increase to at least 70 percent the proportion of worksites with 50 or more employees that have implemented programs on worker health and safety. (Baseline data available in 1991)

10.13 Increase to at least 50 percent the proportion of worksites with 50 or more employees that offer back injury prevention and rehabilitation programs. (Baseline: 28.6 percent offered back care activities in 1985)

10.14 Establish in 50 States either public health or labor department programs that provide consultation and assistance to small businesses to implement safety and health programs for their employees. (Baseline data available in 1991)

10.15 Increase to at least 75 percent the proportion of primary care providers who routinely elicit occupational health exposures as a part of patient history and provide relevant counseling. (Baseline data available in 1992)

## 11. Environmental Health

### Health Status Objectives

11.1 Reduce asthma morbidity, as measured by a reduction in asthma hospitalizations to no more than 160 per 100,000 people. (Baseline: 188 per 100,000 in 1987)

| | | Special Population Targets | |
|---|---|---|---|
| | *Asthma Hospitalizations (per 100,000)* | *1987 Baseline* | *2000 Target* |
| 11.1a | Blacks and other nonwhites | 334 | 265 |
| 11.1b | Children | 284† | 225 |

†*Children aged 14 and younger*

11.2* Reduce the prevalence of serious mental retardation among school-aged children to no more than 2 per 1,000 children. (Baseline: 2.7 per 1,000 children aged 10 in 1985-88)

11.3 Reduce outbreaks of waterborne disease from infectious agents and chemical poisoning to no more than 11 per year. (Baseline: Average of 31 outbreaks per year during 1981-88)

*Type-Specific Target*

| | *Average Annual Number of Waterborne Disease Outbreaks* | *1981-88 Baseline* | *2000 Target* |
|---|---|---|---|
| 11.3a | People served by community water systems | 13 | 6 |

*Note: Community water systems are public or investor-owned water systems that serve large or small communities, subdivisions, or trailer parks with at least 15 service connections or 25 year-round residents.*

11.4 Reduce the prevalence of blood lead levels exceeding 15 µg/dL and 25 µg/dL among children aged 6 months through 5 years to no more than 500,000 and zero, respectively. (Baseline: An estimated 3 million children had levels exceeding 15 µg/dL, and 234,000 had levels exceeding 25 µg/dL, in 1984)

*Special Population Target*

| | *Prevalence of Blood Lead Levels Exceeding 15 µg/dL & 25 µg/dL* | *1984 Baseline* | *2000 Target* |
|---|---|---|---|
| 11.4a | Inner-city low-income black children (annual family income <$6,000 in 1984 dollars) | 234,900 & 36,700 | 75,000 & 0 |

## Risk Reduction Objectives

11.5 Reduce human exposure to criteria air pollutants, as measured by an increase to at least 85 percent in the proportion of people who live in counties that have not exceeded any Environmental Protection Agency standard for air quality in the previous 12 months. (Baseline: 49.7 percent in 1988)

*Proportion Living in Counties That Have Not Exceeded Criteria Air Pollutant Standards in 1988 for:*

| | |
|---|---|
| Ozone | 53.6% |
| Carbon monoxide | 87.8% |
| Nitrogen dioxide | 96.6% |
| Sulfur dioxide | 99.3% |
| Particulates | 89.4% |
| Lead | 99.3% |
| Total (any of above pollutants) | 49.7% |

*Note: An individual living in a county that exceeds an air quality standard may not actually be exposed to unhealthy air. Of all criteria air pollutants, ozone is the most likely to have fairly uniform concentrations throughout an area. Exposure is to criteria air pollutants in ambient air. Due to weather fluctuations, multi-year averages may be the most appropriate way to monitor progress toward this objective.*

11.6 Increase to at least 40 percent the proportion of homes in which homeowners/occupants have tested for radon concentrations and that have either been found to pose minimal risk or have been modified to reduce risk to health. (Baseline: Less than 5 percent of homes had been tested in 1989)

*Special Population Targets*

| | *Testing and Modification As Necessary* | *Baseline* | *2000 Target* |
|---|---|---|---|
| 11.6a | Homes with smokers and former smokers | — | 50% |
| 11.6b | Homes with children | — | 50% |

11.7 Reduce human exposure to toxic agents by confining total pounds of toxic agents released into the air, water, and soil each year to no more than:

0.24 billion pounds of those toxic agents included on the Department of Health and Human Services list of carcinogens. (Baseline: 0.32 billion pounds in 1988)

2.6 billion pounds of those toxic agents included on the Agency for Toxic Substances and Disease Registry list of the most toxic chemicals. (Baseline: 2.62 billion pounds in 1988)

11.8 Reduce human exposure to solid waste-related water, air, and soil contamination, as measured by a reduction in average pounds of municipal solid waste produced per person each day to no more than 3.6 pounds. (Baseline: 4.0 pounds per person each day in 1988)

11.9 Increase to at least 85 percent the proportion of people who receive a supply of drinking water that meets the safe drinking water standards established by the Environmental Protection Agency. (Baseline: 74 percent of 58,099 community water systems serving approximately 80 percent of the population in 1988)

*Note: Safe drinking water standards are measured using Maximum Contaminant Level (MCL) standards set by the Environmental Protection Agency which define acceptable levels of contaminants. See Objective 11.3 for definition of community water systems.*

11.10 Reduce potential risks to human health from surface water, as measured by a decrease to no more than 15 percent in the proportion of assessed rivers, lakes, and estuaries that do not support beneficial uses, such as fishing and swimming. (Baseline: An estimated 25 percent of assessed rivers, lakes, and estuaries did not support designated beneficial uses in 1988)

*Note: Designated beneficial uses, such as aquatic life support, contact recreation (swimming), and water supply, are designated by each State and approved by the Environmental Protection Agency. Support of beneficial use is a proxy measure of risk to human health, as many pollutants causing impaired water uses do not have human health effects (e.g., siltation, impaired fish habitat).*

### Services and Protection Objectives

11.11 Perform testing for lead-based paint in at least 50 percent of homes built before 1950. (Baseline data available in 1991)

11.12 Expand to at least 35 the number of States in which at least 75 percent of local jurisdictions have adopted construction standards and techniques that minimize elevated indoor radon levels in those new building areas locally determined to have elevated radon levels. (Baseline: 1 State in 1989)

*Note: Since construction codes are frequently adopted by local jurisdictions rather than States, progress toward this objective also may be tracked using the proportion of cities and counties that have adopted such construction standards.*

11.13 Increase to at least 30 the number of States requiring that prospective buyers be informed of the presence of lead-based paint and radon concentrations in all buildings offered for sale. (Baseline: 2 States required disclosure of lead-based paint in 1989; 1 State required disclosure of radon concentrations in 1989; 2 additional States required disclosure that radon has been found in the State and that testing is desirable in 1989)

11.14 Eliminate significant health risks from National Priority List hazardous waste sites, as measured by performance of clean-up at these sites sufficient to eliminate immediate and significant health threats as specified in health assessments completed at all sites. (Baseline: 1,082 sites were on the list in March of 1990; of these, health assessments have been conducted for approximately 1,000)

*Note: The Comprehensive Environmental Response, Compensation, and Liability Act of 1980 required the Environmental Protection Agency to develop criteria for determining priorities among hazardous waste sites and to develop and maintain a list of these priority sites. The resulting list is called the National Priorities List (NPL).*

11.15 Establish programs for recyclable materials and household hazardous waste in at least 75 percent of counties. (Baseline: Approximately 850 programs in 41 States collected household toxic waste in 1987; extent of recycling collections unknown)

11.16 Establish and monitor in at least 35 States plans to define and track sentinel environmental diseases. (Baseline: 0 States in 1990)

*Note: Sentinel environmental diseases include lead poisoning, other heavy metal poisoning (e.g., cadmium, arsenic, and mercury), pesticide poisoning, carbon monoxide poisoning, heatstroke, hypothermia, acute chemical poisoning, methemoglobinemia, and respiratory diseases triggered by environmental factors (e.g., asthma).*

## 12. Food and Drug Safety

### Health Status Objectives

12.1 Reduce infections caused by key foodborne pathogens to incidences of no more than:

| *Disease (per 100,000)* | *1987 Baseline* | *2000 Target* |
|---|---|---|
| Salmonella species | 18 | 16 |
| Campylobacter jejuni | 50 | 25 |
| Escherichia coli 0157:H7 | 8 | 4 |
| Listeria monocytogenes | 0.7 | 0.5 |

12.2 Reduce outbreaks of infections due to *Salmonella enteritidis* to fewer than 25 outbreaks yearly. (Baseline: 77 outbreaks in 1989)

### Risk Reduction Objective

12.3 Increase to at least 75 percent the proportion of households in which principal food preparers routinely refrain from leaving perishable food out of the refrigerator for over 2 hours and wash cutting boards and utensils with soap after contact with raw meat and poultry. (Baseline: For refrigeration of perishable foods, 70 percent; for washing cutting boards with soap, 66 percent; and for washing utensils with soap, 55 percent, in 1988)

### Services and Protection Objectives

12.4 Extend to at least 70 percent the proportion of States and territories that have implemented model food codes for institutional food operations and to at least 70 percent the proportion that have adopted the new uniform food protection code ("Unicode") that sets recommended standards for regulation of all food operations. (Baseline: For institutional food operations currently using FDA's recommended model codes, 20 percent; for the new Unicode to be released in 1991, 0 percent, in 1990)

12.5 Increase to at least 75 percent the proportion of pharmacies and other dispensers of prescription medications that use linked systems to provide alerts to potential adverse drug reactions among medications dispensed by different sources to individual patients. (Baseline data available in 1993)

12.6 Increase to at least 75 percent the proportion of primary care providers who routinely review with their patients aged 65 and older all prescribed and over-the-counter medicines taken by their patients each time a new medication is prescribed. (Baseline data available in 1992)

# 13. Oral Health

## Health Status Objectives

13.1 Reduce dental caries (cavities) so that the proportion of children with one or more caries (in permanent or primary teeth) is no more than 35 percent among children aged 6 through 8 and no more than 60 percent among adolescents aged 15. (Baseline: 53 percent of children aged 6 through 8 in 1986-87; 78 percent of adolescents aged 15 in 1986-87)

*Special Population Targets*

| | *Dental Caries Prevalence* | *1986-87 Baseline* | *2000 Target* |
|---|---|---|---|
| 13.1a | Children aged 6-8 whose parents have less than high school education | 70% | 45% |
| 13.1b | American Indian/Alaska Native children aged 6-8 | 92%† | 45% |
| | | 52%‡ | |
| 13.1c | Black children aged 6-8 | 61% | 40% |
| 13.1d | American Indian/Alaska Native adolescents aged 15 | 93%‡ | 70% |

†*In primary teeth in 1983-84* ‡*In permanent teeth in 1983-84*

13.2 Reduce untreated dental caries so that the proportion of children with untreated caries (in permanent or primary teeth) is no more than 20 percent among children aged 6 through 8 and no more than 15 percent among adolescents aged 15. (Baseline: 27 percent of children aged 6 through 8 in 1986; 23 percent of adolescents aged 15 in 1986-87)

*Special Population Targets*

| | *Untreated Dental Caries:* | *1986-87 Baseline* | *2000 Target* |
|---|---|---|---|
| | *Among Children—* | | |
| 13.2a | Children aged 6-8 whose parents have less than high school education | 43% | 30% |
| 13.2b | American Indian/Alaska Native children aged 6-8 | 64%† | 35% |
| 13.2c | Black children aged 6-8 | 38% | 25% |
| 13.2d | Hispanic children aged 6-8 | 36%‡ | 25% |
| | *Among Adolescents—* | | |
| 13.2a | Adolescents aged 15 whose parents have less than a high school education | 41% | 25% |
| 13.2b | American Indian/Alaska Native adolescents aged 15 | 84%† | 40% |
| 13.2c | Black adolescents aged 15 | 38% | 20% |
| 13.2d | Hispanic adolescents aged 15 | 31-47%‡ | 25% |

†*1983-84 baseline* ‡*1982-84 baseline*

13.3 Increase to at least 45 percent the proportion of people aged 35 through 44 who have never lost a permanent tooth due to dental caries or periodontal diseases. (Baseline: 31 percent of employed adults had never lost a permanent tooth for any reason in 1985-86)

*Note: Never lost a permanent tooth is having 28 natural teeth exclusive of third molars.*

13.4 Reduce to no more than 20 percent the proportion of people aged 65 and older who have lost all of their natural teeth. (Baseline: 36 percent in 1986)

*Special Population Target*

| | *Complete Tooth Loss Prevalence* | *1986 Baseline* | *2000 Target* |
|---|---|---|---|
| 13.4a | Low-income people (annual family income <$15,000) | 46% | 25% |

13.5 Reduce the prevalence of gingivitis among people aged 35 through 44 to no more than 30 percent. (Baseline: 42 percent in 1985-86)

*Special Population Targets*

| | *Gingivitis Prevalence* | *1985 Baseline* | *2000 Target* |
|---|---|---|---|
| 13.5a | Low-income people (annual family income <$12,500) | 50% | 35% |
| 13.5b | American Indians/Alaska Natives | 95%† | 50% |
| 13.5c | Hispanics | | 50% |
| | Mexican Americans | 74%‡ | |
| | Cubans | 79%‡ | |
| | Puerto Ricans | 82%‡ | |

†*1983-84 baseline* ‡*1982-84 baseline*

13.6 Reduce destructive periodontal diseases to a prevalence of no more than 15 percent among people aged 35 through 44. (Baseline: 24 percent in 1985-86)

*Note: Destructive periodontal disease is one or more sites with 4 millimeters or greater loss of tooth attachment.*

13.7 Reduce deaths due to cancer of the oral cavity and pharynx to no more than 10.5 per 100,000 men aged 45 through 74 and 4.1 per 100,000 women aged 45 through 74. (Baseline: 12.1 per 100,000 men and 4.1 per 100,000 women in 1987)

## Risk Reduction Objectives

13.8 Increase to at least 50 percent the proportion of children who have received protective sealants on the occlusal (chewing) surfaces of permanent molar teeth. (Baseline: 11 percent of children aged 8 and 8 percent of adolescents aged 14 in 1986-87)

*Note: Progress toward this objective will be monitored based on prevalence of sealants in children at age 8 and at age 14, when the majority of first and second molars, respectively, are erupted.*

13.9 Increase to at least 75 percent the proportion of people served by community water systems providing optimal levels of fluoride. (Baseline: 62 percent in 1989)

*Note: Optimal levels of fluoride are determined by the mean maximum daily air temperature over a 5-year period and range between 0.7 and 1.2 parts of fluoride per one million parts of water (ppm).*

13.10 Increase use of professionally or self-administered topical or systemic (dietary) fluorides to at least 85 percent of people not receiving optimally fluoridated public water. (Baseline: An estimated 50 percent in 1989)

13.11* Increase to at least 75 percent the proportion of parents and caregivers who use feeding practices that prevent baby bottle tooth decay. (Baseline data available in 1991)

*Special Population Targets*

| *Appropriate Feeding Practices* | *Baseline* | *2000 Target* |
|---|---|---|
| 13.11a Parents and caregivers with less than high school education | — | 65% |
| 13.11b American Indian/Alaska Native parents and caregivers | — | 65% |

## Services and Protection Objectives

13.12 Increase to at least 90 percent the proportion of all children entering school programs for the first time who have received an oral health screening, referral, and followup for necessary diagnostic, preventive, and treatment services. (Baseline: 66 percent of children aged 5 visited a dentist during the previous year in 1986)

*Note: School programs include Head Start, prekindergarten, kindergarten, and 1st grade.*

13.13 Extend to all long-term institutional facilities the requirement that oral examinations and services be provided no later than 90 days after entry into these facilities. (Baseline: Nursing facilities receiving Medicaid or Medicare reimbursement will be required to provide for oral examinations within 90 days of patient entry beginning in 1990; baseline data unavailable for other institutions)

*Note: Long-term institutional facilities include nursing homes, prisons, juvenile homes, and detention facilities.*

13.14 Increase to at least 70 percent the proportion of people aged 35 and older using the oral health care system during each year. (Baseline: 54 percent in 1986)

*Special Population Targets*

| *Proportion Using Oral Health Care System During Each Year* | *1986 Baseline* | *2000 Target* |
|---|---|---|
| 13.14a Edentulous people | 11% | 50% |
| 13.14b People aged 65 and older | 42% | 60% |

13.15 Increase to at least 40 the number of States that have an effective system for recording and referring infants with cleft lips and/or palates to craniofacial anomaly teams. (Baseline: In 1988, approximately 25 States had a central recording mechanism for cleft lip and/or palate and approximately 25 States had an organized referral system to craniofacial anomaly teams)

13.16* Extend requirement of the use of effective head, face, eye, and mouth protection to all organizations, agencies, and institutions sponsoring sporting and recreation events that pose risks of injury. (Baseline: Only National Collegiate Athletic Association football, hockey, and lacrosse; high school football; amateur boxing; and amateur ice hockey in 1988)

# 14. Maternal and Infant Health

## Health Status Objectives

14.1 Reduce the infant mortality rate to no more than 7 per 1,000 live births. (Baseline: 10.1 per 1,000 live births in 1987)

*Special Population Targets*

| | *Infant Mortality (per 1,000 live births)* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 14.1a | Blacks | 17.9 | 11 |
| 14.1b | American Indians/Alaska Natives | 12.5† | 8.5 |
| 14.1c | Puerto Ricans | 12.9† | 8 |

*Type-Specific Targets*

| | *Neonatal and Postneonatal Mortality (per 1,000 live births)* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 14.1d | Neonatal mortality | 6.5 | 4.5 |
| 14.1e | Neonatal mortality among blacks | 11.7 | 7 |
| 14.1f | Neonatal mortality among Puerto Ricans | 8.6† | 5.2 |
| 14.1g | Postneonatal mortality | 3.6 | 2.5 |
| 14.1h | Postneonatal mortality among blacks | 6.1 | 4 |
| 14.1i | Postneonatal mortality among American Indians/Alaska Natives | 6.5† | 4 |
| 14.1j | Postneonatal mortality among Puerto Ricans | 4.3† | 2.8 |

† *1984 baseline*

*Note: Infant mortality is deaths of infants under 1 year; neonatal mortality is deaths of infants under 28 days; and postneonatal mortality is deaths of infants aged 28 days up to 1 year.*

14.2 Reduce the fetal death rate (20 or more weeks of gestation) to no more than 5 per 1,000 live births plus fetal deaths. (Baseline: 7.6 per 1,000 live births plus fetal deaths in 1987)

*Special Population Target*

| | *Fetal Deaths* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 14.2a | Blacks | 12.8† | 7.5† |

† *Per 1,000 live births plus fetal deaths*

14.3 Reduce the maternal mortality rate to no more than 3.3 per 100,000 live births. (Baseline: 6.6 per 100,000 in 1987)

*Special Population Target*

| | *Maternal Mortality* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 14.3a | Blacks | 14.2† | 5† |

† *Per 100,000 live births*

*Note: The objective uses the maternal mortality rate as defined by the National Center for Health Statistics. However, if other sources of maternal mortality data are used, a 50-percent reduction in maternal mortality is the intended target.*

14.4 Reduce the incidence of fetal alcohol syndrome to no more than 0.12 per 1,000 live births. (Baseline: 0.22 per 1,000 live births in 1987)

*Special Population Targets*

| | *Fetal Alcohol Syndrome (per 1,000 live births)* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 14.4a | American Indians/Alaska Natives | 4 | 2 |
| 14.4b | Blacks | 0.8 | 0.4 |

## Risk Reduction Objectives

14.5 Reduce low birth weight to an incidence of no more than 5 percent of live births and very low birth weight to no more than 1 percent of live births. (Baseline: 6.9 and 1.2 percent, respectively, in 1987)

*Special Population Target*

| | | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| | *Low Birth Weight* | | |
| 14.5a | Blacks | 12.7% | 9% |
| | *Very Low Birth Weight* | | |
| | Blacks | 2.7% | 2% |

*Note: Low birth weight is weight at birth of less than 2,500 grams; very low birth weight is weight at birth of less than 1,500 grams.*

14.6 Increase to at least 85 percent the proportion of mothers who achieve the minimum recommended weight gain during their pregnancies. (Baseline: 67 percent of married women in 1980)

*Note: Recommended weight gain is pregnancy weight gain recommended in the 1990 National Academy of Science's report,* Nutrition During Pregnancy.

14.7 Reduce severe complications of pregnancy to no more than 15 per 100 deliveries. (Baseline: 22 hospitalizations (prior to delivery) per 100 deliveries in 1987)

*Note: Severe complications of pregnancy will be measured using hospitalizations due to pregnancy-related complications.*

14.8 Reduce the cesarean delivery rate to no more than 15 per 100 deliveries. (Baseline: 24.4 per 100 deliveries in 1987)

*Type-Specific Targets*

| | *Cesarean Delivery (per 100 deliveries)* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 14.8a | Primary (first time) cesarean delivery | 17.4 | 12 |
| 14.8b | Repeat cesarean deliveries | 91.2† | 65† |

†*Among women who had a previous cesarean delivery*

14.9* Increase to at least 75 percent the proportion of mothers who breastfeed their babies in the early postpartum period and to at least 50 percent the proportion who continue breastfeeding until their babies are 5 to 6 months old. (Baseline: 54 percent at discharge from birth site and 21 percent at 5 to 6 months in 1988)

*Special Population Targets*

| | *Mothers Breastfeeding Their Babies:* | *1988 Baseline* | *2000 Target* |
|---|---|---|---|
| | *During Early Postpartum Period—* | | |
| 14.9a | Low-income mothers | 32% | 75% |
| 14.9b | Black mothers | 25% | 75% |
| 14.9c | Hispanic mothers | 51% | 75% |
| 14.9d | American Indian/Alaska Native mothers | 47% | 75% |
| | *At Age 5-6 Months—* | | |
| 14.9a | Low-income mothers | 9% | 50% |
| 14.9b | Black mothers | 8% | 50% |
| 14.9c | Hispanic mothers | 16% | 50% |
| 14.9d | American Indian/Alaska Native mothers | 28% | 50% |

14.10 Increase abstinence from tobacco use by pregnant women to at least 90 percent and increase abstinence from alcohol, cocaine, and marijuana by pregnant women by at least 20 percent. (Baseline: 75 percent of pregnant women abstained from tobacco use in 1985)

*Note: Data for alcohol, cocaine, and marijuana use by pregnant women will be available from the National Maternal and Infant Health Survey, CDC, in 1991.*

## Services and Protection Objectives

14.11 Increase to at least 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy. (Baseline: 76 percent of live births in 1987)

*Special Population Targets*

| | *Proportion of Pregnant Women Receiving Early Prenatal Care* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 14.11a | Black women | 61.1† | 90† |
| 14.11b | American Indian/Alaska Native women | 60.2† | 90† |
| 14.11c | Hispanic women | 61.0† | 90† |

† *Percent of live births*

14.12* Increase to at least 60 percent the proportion of primary care providers who provide age-appropriate preconception care and counseling. (Baseline data available in 1992)

14.13 Increase to at least 90 percent the proportion of women enrolled in prenatal care who are offered screening and counseling on prenatal detection of fetal abnormalities. (Baseline data available in 1991)

*Note: This objective will be measured by tracking use of maternal serum alpha-fetoprotein screening tests.*

14.14 Increase to at least 90 percent the proportion of pregnant women and infants who receive risk-appropriate care. (Baseline data available in 1991)

*Note: This objective will be measured by tracking the proportion of very low birth weight infants (less than 1,500 grams) born in facilities covered by a neonatologist 24 hours a day.*

14.15 Increase to at least 95 percent the proportion of newborns screened by State-sponsored programs for genetic disorders and other disabling conditions and to 90 percent the proportion of newborns testing positive for disease who receive appropriate treatment. (Baseline: For sickle cell anemia, with 20 States reporting, approximately 33 percent of live births screened (57 percent of black infants); for galactosemia, with 38 States reporting, approximately 70 percent of live births screened)

*Note: As measured by the proportion of infants served by programs for sickle cell anemia and galactosemia. Screening programs should be appropriate for State demographic characteristics.*

14.16 Increase to at least 90 percent the proportion of babies aged 18 months and younger who receive recommended primary care services at the appropriate intervals. (Baseline data available in 1992)

# 15. Heart Disease and Stroke

## Health Status Objectives

15.1* Reduce coronary heart disease deaths to no more than 100 per 100,000 people. (Age-adjusted baseline: 135 per 100,000 in 1987)

| | | *Special Population Target* | |
|---|---|---|---|
| | *Coronary Deaths (per 100,000)* | *1987 Baseline* | *2000 Target* |
| 15.1a | Blacks | 163 | 115 |

15.2 Reduce stroke deaths to no more than 20 per 100,000 people. (Age-adjusted baseline: 30.3 per 100,000 in 1987)

| | | *Special Population Target* | |
|---|---|---|---|
| | *Stroke Deaths (per 100,000)* | *1987 Baseline* | *2000 Target* |
| 15.2a | Blacks | 51.2 | 27 |

15.3 Reverse the increase in end-stage renal disease (requiring maintenance dialysis or transplantation) to attain an incidence of no more than 13 per 100,000. (Baseline: 13.9 per 100,000 in 1987)

| | | *Special Population Target* | |
|---|---|---|---|
| | *ESRD Incidence (per 100,000)* | *1987 Baseline* | *2000 Target* |
| 15.3a | Blacks | 32.4 | 30 |

## Risk Reduction Objectives

15.4 Increase to at least 50 percent the proportion of people with high blood pressure whose blood pressure is under control. (Baseline: 11 percent controlled among people aged 18 through 74 in 1976-80; an estimated 24 percent for people aged 18 and older in 1982-84)

| | | *Special Population Target* | | |
|---|---|---|---|---|
| | *High Blood Pressure Control* | *1976-80 Baseline* | *1982-84 Baseline* | *2000 Target* |
| 15.4a | Men with high blood pressure | 6% | 16% | 40% |

*Note: People with high blood pressure have blood pressure equal to or greater than 140 mm Hg systolic and/or 90 mm Hg diastolic and/or take antihypertensive medication. Blood pressure control is defined as maintaining a blood pressure less than 140 mm Hg systolic and 90 mm Hg diastolic. In NHANES II and the Seven States Study, control of hypertension did not include nonpharmacologic treatment. In NHANES III, those controlling their high blood pressure without medication (e.g., through weight loss, low sodium diets, or restriction of alcohol) will be included.*

15.5 Increase to at least 90 percent the proportion of people with high blood pressure who are taking action to help control their blood pressure. (Baseline: 79 percent of aware hypertensives aged 18 and older were taking action to control their blood pressure in 1985)

| | | *Special Population Targets* | |
|---|---|---|---|
| | *Taking Action to Control Blood Pressure* | *1985 Baseline* | *2000 Target* |
| 15.5a | White hypertensive men aged 18-34 | 51%† | 80% |
| 15.5b | Black hypertensive men aged 18-34 | 63%† | 80% |

†*Baseline for aware hypertensive men*

*Note: High blood pressure is defined as blood pressure equal to or greater than 140 mm Hg systolic and/or 90 mm Hg diastolic and/or taking antihypertensive medication. Actions to control blood pressure include taking medication, dieting to lose weight, cutting down on salt, and exercising.*

15.6 Reduce the mean serum cholesterol level among adults to no more than 200 mg/dL. (Baseline: 213 mg/dL among people aged 20 through 74 in 1976-80, 211 mg/dL for men and 215 mg/dL for women)

15.7 Reduce the prevalence of blood cholesterol levels of 240 mg/dL or greater to no more than 20 percent among adults. (Baseline: 27 percent for people aged 20 through 74 in 1976-80, 29 percent for women and 25 percent for men)

15.8 Increase to at least 60 percent the proportion of adults with high blood cholesterol who are aware of their condition and are taking action to reduce their blood cholesterol to recommended levels. (Baseline: 11 percent of all people aged 18 and older, and thus an estimated 30 percent of people with high blood cholesterol, were aware that their blood cholesterol level was high in 1988)

*Note: "High blood cholesterol" means a level that requires diet and, if necessary, drug treatment. Actions to control high blood cholesterol include keeping medical appointments, making recommended dietary changes (e.g., reducing saturated fat, total fat, and dietary cholesterol), and, if necessary, taking prescribed medication.*

15.9* Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat intake to less than 10 percent of calories among people aged 2 and older. (Baseline: 36 percent of calories from total fat and 13 percent from saturated fat for people aged 20 through 74 in 1976-80; 36 percent and 13 percent for women aged 19 through 50 in 1985)

15.10* Reduce overweight to a prevalence of no more than 20 percent among people aged 20 and older and no more than 15 percent among adolescents aged 12 through 19. (Baseline: 26 percent for people aged 20 through 74 in 1976-80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12 through 19 in 1976-80)

*Special Population Targets*

| *Overweight Prevalence* | *1976-80 Baseline*[†] | *2000 Target* |
|---|---|---|
| 15.10a Low-income women aged 20 and older | 37% | 25% |
| 15.10b Black women aged 20 and older | 44% | 30% |
| 15.10c Hispanic women aged 20 and older | | 25% |
| Mexican-American women | 39%[‡] | |
| Cuban women | 34%[‡] | |
| Puerto Rican women | 37%[‡] | |
| 15.10d American Indians/Alaska Natives | 29-75%[§] | 30% |
| 15.10e People with disabilities | 36%[+] | 25% |
| 15.10f Women with high blood pressure | 50% | 41% |
| 15.10g Men with high blood pressure | 39% | 35% |

[†]*Baseline for people aged 20-74* [‡]*1982-84 baseline for Hispanics aged 20-74*

[§]*1984-88 estimates for different tribes*

[+]*1985 baseline for people aged 20-74 who report any limitation in activity due to chronic conditions*

*Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12 through 14, 24.3 for males aged 15 through 17, 25.8 for males aged 18 through 19, 23.4 for females aged 12 through 14, 24.8 for females aged 15 through 17, and 25.7 for females aged 18 through 19. The values for adolescents are the age- and gender-specific 85th percentile values of the 1976-80 National Health and Nutrition Examination Survey (NHANES II), corrected for sample variation. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.*

15.11* Increase to at least 30 percent the proportion of people aged 6 and older who engage regularly, preferably daily, in light to moderate physical activity for at least 30 minutes per day. (Baseline: 22 percent of people aged 18 and older were active for at least 30 minutes 5 or more times per week and 12 percent were active 7 or more times per week in 1985)

*Note: Light to moderate physical activity requires sustained, rhythmic muscular movements, is at least equivalent to sustained walking, and is performed at less than 60 percent of maximum heart rate for age. Maximum heart rate equals roughly 220 beats per minute minus age. Examples may include walking, swimming, cycling, dancing, gardening and yardwork, various domestic and occupational activities, and games and other childhood pursuits.*

15.12* Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 20 and older. (Baseline: 29 percent in 1987, 32 percent for men and 27 percent for women)

*Special Population Targets*

| *Cigarette Smoking Prevalence* | *1987 Baseline* | *2000 Target* |
|---|---|---|
| 15.12a People with a high school education or less aged 20 and older | 34% | 20% |
| 15.12b Blue-collar workers aged 20 and older | 36% | 20% |
| 15.12c Military personnel | 42%[†] | 20% |
| 15.12d Blacks aged 20 and older | 34% | 18% |
| 15.12e Hispanics aged 20 and older | 33%[‡] | 18% |
| 15.12f American Indians/Alaska Natives | 42-70%[§] | 20% |
| 15.12g Southeast Asian men | 55%[+] | 20% |
| 15.12h Women of reproductive age | 29%[††] | 12% |
| 15.12i Pregnant women | 25%[‡‡] | 10% |
| 15.12j Women who use oral contraceptives | 36%[§§] | 10% |

[†]*1988 baseline* [‡]*1982-84 baseline for Hispanics aged 20-74* [§]*1979-87 estimates for different tribes*

[+]*1984-88 baseline* [††]*Baseline for women aged 18-44* [‡‡]*1985 baseline* [§§]*1983 baseline*

*Note: A cigarette smoker is a person who has smoked at least 100 cigarettes and currently smokes cigarettes.*

## Services and Protection Objectives

15.13 Increase to at least 90 percent the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high. (Baseline: 61 percent of people aged 18 and older had their blood pressure measured within the preceding 2 years and were given the systolic and diastolic values in 1985)

*Note: A blood pressure measurement within the preceding 2 years refers to a measurement by a health professional or other trained observer.*

15.14 Increase to at least 75 percent the proportion of adults who have had their blood cholesterol checked within the preceding 5 years. (Baseline: 59 percent of people aged 18 and older had "ever" had their cholesterol checked in 1988; 52 percent were checked "within the preceding 2 years" in 1988)

15.15 Increase to at least 75 percent the proportion of primary care providers who initiate diet and, if necessary, drug therapy at levels of blood cholesterol consistent with current management guidelines for patients with high blood cholesterol. (Baseline data available in 1991)

*Note: Current treatment recommendations are outlined in detail in the Report of the Expert Panel on the Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults, released by the National Cholesterol Education Program in 1987. Guidelines appropriate for children are currently being established. Treatment recommendations are likely to be refined over time. Thus, for the year 2000, "current" means whatever recommendations are then in effect.*

15.16 Increase to at least 50 percent the proportion of worksites with 50 or more employees that offer high blood pressure and/or cholesterol education and control activities to their employees. (Baseline: 16.5 percent offered high blood pressure activities and 16.8 percent offered nutrition education activities in 1985)

15.17 Increase to at least 90 percent the proportion of clinical laboratories that meet the recommended accuracy standard for cholesterol measurement. (Baseline: 53 percent in 1985)

# 16. Cancer

## Health Status Objectives

16.1* Reverse the rise in cancer deaths to achieve a rate of no more than 130 per 100,000 people. (Age-adjusted baseline: 133 per 100,000 in 1987)

*Note: In its publications, the National Cancer Institute age adjusts cancer death rates to the 1970 U.S. population. Using the 1970 standard, the equivalent baseline and target values for this objective would be 171 and 175 per 100,000, respectively.*

16.2* Slow the rise in lung cancer deaths to achieve a rate of no more than 42 per 100,000 people. (Age-adjusted baseline: 37.9 per 100,000 in 1987)

*Note: In its publications, the National Cancer Institute age adjusts cancer death rates to the 1970 U.S. population. Using the 1970 standard, the equivalent baseline and target values for this objective would be 47.9 and 53 per 100,000, respectively.*

16.3 Reduce breast cancer deaths to no more than 20.6 per 100,000 women. (Age-adjusted baseline: 22.9 per 100,000 in 1987)

*Note: In its publications, the National Cancer Institute age adjusts cancer death rates to the 1970 U.S. population. Using the 1970 standard, the equivalent baseline and target values for this objective would be 27.2 and 25.2 per 100,000, respectively.*

16.4 Reduce deaths from cancer of the uterine cervix to no more than 1.3 per 100,000 women. (Age-adjusted baseline: 2.8 per 100,000 in 1987)

*Note: In its publications, the National Cancer Institute age adjusts cancer death rates to the 1970 U.S. population. Using the 1970 standard, the equivalent baseline and target values for this objective would be 3.2 and 1.5 per 100,000, respectively.*

16.5 Reduce colorectal cancer deaths to no more than 13.2 per 100,000 people. (Age-adjusted baseline: 14.4 per 100,000 in 1987)

*Note: In its publications, the National Cancer Institute age adjusts cancer death rates to the 1970 U.S. population. Using the 1970 standard, the equivalent baseline and target values for this objective would be 20.1 and 18.7 per 100,000, respectively.*

## Risk Reduction Objectives

16.6* Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 20 and older. (Baseline: 29 percent in 1987, 32 percent for men and 27 percent for women)

*Special Population Targets*

| | *Cigarette Smoking Prevalence* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 16.6a | People with a high school education or less aged 20 and older | 34% | 20% |
| 16.6b | Blue-collar workers aged 20 and older | 36% | 20% |
| 16.6c | Military personnel | 42%† | 20% |
| 16.6d | Blacks aged 20 and older | 34% | 18% |
| 16.6e | Hispanics aged 20 and older | 33%‡ | 18% |
| 16.6f | American Indians/Alaska Natives | 42-70%§ | 20% |
| 16.6g | Southeast Asian men | 55%+ | 20% |
| 16.6h | Women of reproductive age | 29%†† | 12% |
| 16.6i | Pregnant women | 25%‡‡ | 10% |
| 16.6j | Women who use oral contraceptives | 36%§§ | 10% |

†*1988 baseline* ‡*1982-84 baseline for Hispanics aged 20-74* §*1979-87 estimates for different tribes*
+*1984-88 baseline* ††*Baseline for women aged 18-44* ‡‡*1985 baseline* §§*1983 baseline*

*Note: A cigarette smoker is a person who has smoked at least 100 cigarettes and currently smokes cigarettes.*

16.7* Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat intake to less than 10 percent of calories among people aged 2 and older. (Baseline: 36 percent of calories from total fat and 13 percent from saturated fat for people aged 20 through 74 in 1976-80; 36 percent and 13 percent for women aged 19 through 50 in 1985)

*Note: The inclusion of a saturated fat target in this objective should not be interpreted as evidence that reducing only saturated fat will reduce cancer risk. Epidemiologic and experimental animal studies suggest that the amount of fat consumed rather than the specific type of fat can influence the risk of some cancers.*

16.8* Increase complex carbohydrate and fiber-containing foods in the diets of adults to 5 or more daily servings for vegetables (including legumes) and fruits, and to 6 or more daily servings for grain products. (Baseline: 2½ servings of fruits and vegetables and 3 servings of grain products for women aged 19 through 50 in 1985)

16.9 Increase to at least 60 percent the proportion of people of all ages who limit sun exposure, use sunscreens and protective clothing when exposed to sunlight, and avoid artificial sources of ultraviolet light (e.g., sun lamps, tanning booths). (Baseline data available in 1992)

## Services and Protection Objectives

16.10 Increase to at least 75 percent the proportion of primary care providers who routinely counsel patients about tobacco use cessation, diet modification, and cancer screening recommendations. (Baseline: About 52 percent of internists reported counseling more than 75 percent of their smoking patients about smoking cessation in 1986)

16.11 Increase to at least 80 percent the proportion of women aged 40 and older who have ever received a clinical breast examination and a mammogram, and to at least 60 percent those aged 50 and older who have received them within the preceding 1 to 2 years. (Baseline: 36 percent of women aged 40 and older "ever" in 1987; 25 percent of women aged 50 and older "within the preceding 2 years" in 1987)

*Special Population Targets*

| *Clinical Breast Exam & Mammogram:* | *1987 Baseline* | *2000 Target* |
|---|---|---|
| *Ever Received—* | | |
| 16.11a Hispanic women aged 40 and older | 20% | 80% |
| 16.11b Low-income women aged 40 and older (annual family income <$10,000) | 22% | 80% |
| 16.11c Women aged 40 and older with less than high school education | 23% | 80% |
| 16.11d Women aged 70 and older | 25% | 80% |
| 16.11e Black women aged 40 and older | 28% | 80% |
| *Received Within Preceding 2 Years—* | | |
| 16.11a Hispanic women aged 50 and older | 18% | 60% |
| 16.11b Low-income women aged 50 and older (annual family income <$10,000) | 15% | 60% |
| 16.11c Women aged 50 and older with less than high school education | 16% | 60% |
| 16.11d Women aged 70 and older | 18% | 60% |
| 16.11e Black women aged 50 and older | 19% | 60% |

16.12 Increase to at least 95 percent the proportion of women aged 18 and older with uterine cervix who have ever received a Pap test, and to at least 85 percent those who received a Pap test within the preceding 1 to 3 years. (Baseline: 88 percent "ever" and 75 percent "within the preceding 3 years" in 1987)

*Special Population Targets*

| *Pap Test:* | *1987 Baseline* | *2000 Target* |
|---|---|---|
| *Ever Received—* | | |
| 16.12a Hispanic women aged 18 and older | 75% | 95% |
| 16.12b Women aged 70 and older | 76% | 95% |
| 16.12c Women aged 18 and older with less than high school education | 79% | 95% |
| 16.12d Low-income women aged 18 and older (annual family income <$10,000) | 80% | 95% |
| *Received Within Preceding 3 Years—* | | |
| 16.12a Hispanic women aged 18 and older | 66% | 80% |
| 16.12b Women aged 70 and older | 44% | 70% |
| 16.12c Women aged 18 and older with less than high school education | 58% | 75% |
| 16.12d Low-income women aged 18 and older (annual family income <$10,000) | 64% | 80% |

16.13 Increase to at least 50 percent the proportion of people aged 50 and older who have received fecal occult blood testing within the preceding 1 to 2 years, and to at least 40 percent those who have ever received proctosigmoidoscopy. (Baseline: 27 percent received fecal occult blood testing during the preceding 2 years in 1987; 25 percent had ever received proctosigmoidoscopy in 1987)

16.14 Increase to at least 40 percent the proportion of people aged 50 and older visiting a primary care provider in the preceding year who have received oral, skin, and digital rectal examinations during one such visit. (Baseline: An estimated 27 percent received a digital rectal exam during a physician visit within the preceding year in 1987)

16.15 Ensure that Pap tests meet quality standards by monitoring and certifying all cytology laboratories. (Baseline data available in 1991)

16.16 Ensure that mammograms meet quality standards by monitoring and certifying at least 80 percent of mammography facilities. (Baseline: An estimated 18 to 21 percent certified by the American College of Radiology as of June 1990)

# 17. Diabetes and Chronic Disabling Conditions

## Health Status Objectives

### Chronic Disabling Conditions

17.1* Increase years of healthy life to at least 65 years. (Baseline: An estimated 62 years in 1980)

*Special Population Targets*

| | *Years of Healthy Life* | *1980 Baseline* | *2000 Target* |
|---|---|---|---|
| 17.1a | Blacks | 56 | 60 |
| 17.1b | Hispanics | 62 | 65 |
| 17.1c | People aged 65 and older | 12† | 14† |

†*Years of healthy life remaining at age 65*

*Note: Years of healthy life (also referred to as quality-adjusted life years) is a summary measure of health that combines mortality (quantity of life) and morbidity and disability (quality of life) into a single measure. For people aged 65 and older, active life-expectancy, a related summary measure, also will be tracked.*

17.2 Reduce to no more than 8 percent the proportion of people who experience a limitation in major activity due to chronic conditions. (Baseline: 9.4 percent in 1988)

*Special Population Targets*

| | *Prevalence of Disability* | *1988 Baseline* | *2000 Target* |
|---|---|---|---|
| 17.2a | Low-income people (annual family income <$10,000 in 1988) | 18.9% | 15% |
| 17.2b | American Indians/Alaska Natives | 13.4%† | 11% |
| 17.2c | Blacks | 11.2% | 9% |

†*1983-85 baseline*

*Note: Major activity refers to the usual activity for one's age-gender group whether it is working, keeping house, going to school, or living independently. Chronic conditions are defined as conditions that either (1) were first noticed 3 or more months ago, or (2) belong to a group of conditions such as heart disease and diabetes, which are considered chronic regardless of when they began.*

17.3 Reduce to no more than 90 per 1,000 people the proportion of all people aged 65 and older who have difficulty in performing two or more personal care activities, thereby preserving independence. (Baseline: 111 per 1,000 in 1984-85)

*Special Population Target*

| | *Difficulty Performing Self-Care Activities (per 1,000)* | *1984-85 Baseline* | *2000 Target* |
|---|---|---|---|
| 17.3a | People aged 85 and older | 371 | 325 |

*Note: Personal care activities are bathing, dressing, using the toilet, getting in and out of bed or chair, and eating.*

17.4 Reduce to no more than 10 percent the proportion of people with asthma who experience activity limitation. (Baseline: Average of 19.4 percent during 1986-88)

*Note: Activity limitation refers to any self-reported limitation in activity attributed to asthma.*

17.5 Reduce activity limitation due to chronic back conditions to a prevalence of no more than 19 per 1,000 people. (Baseline: Average of 21.9 per 1,000 during 1986-88)

*Note: Chronic back conditions include intervertebral disk disorders, curvature of the back or spine, and other self-reported chronic back impairments such as permanent stiffness or deformity of the back or repeated trouble with the back. Activity limitation refers to any self-reported limitation in activity attributed to a chronic back condition.*

17.6 Reduce significant hearing impairment to a prevalence of no more than 82 per 1,000 people. (Baseline: Average of 88.9 per 1,000 during 1986-88)

*Special Population Target*

| | *Hearing Impairment (per 1,000)* | *1986-88 Baseline* | *2000 Target* |
|---|---|---|---|
| 17.6a | People aged 45 and older | 203 | 180 |

*Note: Hearing impairment covers the range of hearing deficits from mild loss in one ear to profound loss in both ears. Generally, inability to hear sounds at levels softer (less intense) than 20 decibels (dB) constitutes abnormal hearing. Significant hearing impairment is defined as having hearing thresholds for speech poorer than 25 dB. However, for this objective, self-reported hearing impairment (i.e., deafness in one or both ears or any trouble hearing in one or both ears) will be used as a proxy measure for significant hearing impairment.*

17.7 Reduce significant visual impairment to a prevalence of no more than 30 per 1,000 people. (Baseline: Average of 34.5 per 1,000 during 1986-88)

*Special Population Target*

| | *Visual Impairment (per 1,000)* | *1986-88 Baseline* | *2000 Target* |
|---|---|---|---|
| 17.7a | People aged 65 and older | 87.7 | 70 |

*Note: Significant visual impairment is generally defined as a permanent reduction in visual acuity and/or field of vision which is not correctable with eyeglasses or contact lenses. Severe visual impairment is defined as inability to read ordinary newsprint even with corrective lenses. For this objective, self-reported blindness in one or both eyes and other self-reported visual impairments (i.e., any trouble seeing with one or both eyes even when wearing glasses or colorblindness) will be used as a proxy measure for significant visual impairment.*

17.8* Reduce the prevalence of serious mental retardation in school-aged children to no more than 2 per 1,000 children. (Baseline: 2.7 per 1,000 children aged 10 in 1985-88)

*Note: Serious mental retardation is defined as an Intelligence Quotient (I.Q.) less than 50. This includes individuals defined by the American Association of Mental Retardation as profoundly retarded (I.Q. of 20 or less), severely retarded (I.Q. of 21-35), and moderately retarded (I.Q. of 36-50).*

### Diabetes

17.9 Reduce diabetes-related deaths to no more than 34 per 100,000 people. (Age-adjusted baseline: 38 per 100,000 in 1986)

*Special Population Targets*

| *Diabetes-Related Deaths (per 100,000)* | *1986 Baseline* | *2000 Target* |
|---|---|---|
| 17.9a Blacks | 65 | 58 |
| 17.9b American Indians/Alaska Natives | 54 | 48 |

*Note: Diabetes-related deaths refer to deaths from diabetes as an underlying or contributing cause.*

17.10 Reduce the most severe complications of diabetes as follows:

| *Complications Among People With Diabetes* | *1988 Baseline* | *2000 Target* |
|---|---|---|
| End-stage renal disease | 1.5/1,000† | 1.4/1,000 |
| Blindness | 2.2/1,000 | 1.4/1,000 |
| Lower extremity amputation | 8.2/1,000† | 4.9/1,000 |
| Perinatal mortality‡ | 5% | 2% |
| Major congenital malformations‡ | 8% | 4% |

†*1987 baseline* ‡*Among infants of women with established diabetes*

*Special Population Targets for ESRD*

| *ESRD Due to Diabetes (per 1,000)* | *1983-86 Baseline* | *2000 Target* |
|---|---|---|
| 17.10a Blacks with diabetes | 2.2 | 2 |
| 17.10b American Indians/Alaska Natives with diabetes | 2.1 | 1.9 |

*Special Population Target for Amputations*

| *Lower Extremity Amputations Due to Diabetes (per 1,000)* | *1984-87 Baseline* | *2000 Target* |
|---|---|---|
| 17.10c Blacks with diabetes | 10.2 | 6.1 |

*Note: End-stage renal disease (ESRD) is defined as requiring maintenance dialysis or transplantation and is limited to ESRD due to diabetes. Blindness refers to blindness due to diabetic eye disease.*

17.11 Reduce diabetes to an incidence of no more than 2.5 per 1,000 people and a prevalence of no more than 25 per 1,000 people. (Baselines: 2.9 per 1,000 in 1987; 28 per 1,000 in 1987)

*Special Population Targets*

| *Prevalence of Diabetes (per 1,000)* | *1982-84 Baseline*† | *2000 Target* |
|---|---|---|
| 17.11a American Indians/Alaska Natives | 69‡ | 62 |
| 17.11b Puerto Ricans | 55 | 49 |
| 17.11c Mexican Americans | 54 | 49 |
| 17.11d Cuban Americans | 36 | 32 |
| 17.11e Blacks | 36§ | 32 |

†*1982-84 baseline for people aged 20-74*

‡*1987 baseline for American Indians/Alaska Natives aged 15 and older*

§*1987 baseline for blacks of all ages*

## Risk Reduction Objectives

17.12* Reduce overweight to a prevalence of no more than 20 percent among people aged 20 and older and no more than 15 percent among adolescents aged 12 through 19. (Baseline: 26 percent for people aged 20 through 74 in 1976-80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12 through 19 in 1976-80)

*Special Population Targets*

| *Overweight Prevalence* | *1976-80 Baseline*[†] | *2000 Target* |
|---|---|---|
| 17.12a Low-income women aged 20 and older | 37% | 25% |
| 17.12b Black women aged 20 and older | 44% | 30% |
| 17.12c Hispanic women aged 20 and older | | 25% |
| Mexican-American women | 39%[‡] | |
| Cuban women | 34%[‡] | |
| Puerto Rican women | 37%[‡] | |
| 17.12d American Indians/Alaska Natives | 29-75%[§] | 30% |
| 17.12e People with disabilities | 36%[+] | 25% |
| 17.12f Women with high blood pressure | 50% | 41% |
| 17.12g Men with high blood pressure | 39% | 35% |

[†] *1976-80 baseline for people aged 20-74* [‡] *1982-84 baseline for Hispanics aged 20-74*

[§] *1984-88 estimates for different tribes*

[+] *1985 baseline for people aged 20-74 who report any limitation in activity due to chronic conditions*

*Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12 through 14, 24.3 for males aged 15 through 17, 25.8 for males aged 18 through 19, 23.4 for females aged 12 through 14, 24.8 for females aged 15 through 17, and 25.7 for females aged 18 through 19. The values for adolescents are the age- and gender-specific 85th percentile values of the 1976-80 National Health and Nutrition Examination Survey (NHANES II), corrected for sample variation. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.*

17.13* Increase to at least 30 percent the proportion of people aged 6 and older who engage regularly, preferably daily, in light to moderate physical activity for at least 30 minutes per day. (Baseline: 22 percent of people aged 18 and older were active for at least 30 minutes 5 or more times per week and 12 percent were active 7 or more times per week in 1985)

*Note: Light to moderate physical activity requires sustained, rhythmic muscular movements, is at least equivalent to sustained walking, and is performed at less than 60 percent of maximum heart rate for age. Maximum heart rate equals roughly 220 beats per minute minus age. Examples may include walking, swimming, cycling, dancing, gardening and yardwork, various domestic and occupational activities, and games and other childhood pursuits.*

## Services and Protection Objectives

17.14 Increase to at least 40 percent the proportion of people with chronic and disabling conditions who receive formal patient education including information about community and self-help resources as an integral part of the management of their condition. (Baseline data available in 1991)

*Type-Specific Targets*

| *Patient Education* | *1983-84 Baseline* | *2000 Target* |
|---|---|---|
| 17.14a People with diabetes | 32% (classes)<br>68% (counseling) | 75% |
| 17.14b People with asthma | — | 50% |

17.15 Increase to at least 80 percent the proportion of providers of primary care for children who routinely refer or screen infants and children for impairments of vision, hearing, speech and language, and assess other developmental milestones as part of well-child care. (Baseline data available in 1992)

17.16 Reduce the average age at which children with significant hearing impairment are identified to no more than 12 months. (Baseline: Estimated as 24 to 30 months in 1988)

17.17 Increase to at least 60 percent the proportion of providers of primary care for older adults who routinely evaluate people aged 65 and older for urinary incontinence and impairments of vision, hearing, cognition, and functional status. (Baseline data available in 1992)

17.18 Increase to at least 90 percent the proportion of perimenopausal women who have been counseled about the benefits and risks of estrogen replacement therapy (combined with progestin, when appropriate) for prevention of osteoporosis. (Baseline data available in 1991)

17.19 Increase to at least 75 percent the proportion of worksites with 50 or more employees that have a voluntarily established policy or program for the hiring of people with disabilities. (Baseline: 37 percent of medium and large companies in 1986)

*Note: Voluntarily established policies and programs for the hiring of people with disabilities are encouraged for worksites of all sizes. This objective is limited to worksites with 50 or more employees for tracking purposes.*

17.20 Increase to 50 the number of States that have service systems for children with or at risk of chronic and disabling conditions, as required by Public Law 101-239. (Baseline data available in 1991)

*Note: Children with or at risk of chronic and disabling conditions, often referred to as children with special health care needs, include children with psychosocial as well as physical problems. This population encompasses children with a wide variety of actual or potential disabling conditions, including children with or at risk for cerebral palsy, mental retardation, sensory deprivation, developmental disabilities, spina bifida, hemophilia, other genetic disorders, and health-related educational and behavioral problems. Service systems for such children are organized networks of comprehensive, community-based, coordinated, and family-centered services.*

# 18. HIV Infection

## Health Status Objectives

18.1 Confine annual incidence of diagnosed AIDS cases to no more than 98,000 cases. (Baseline: An estimated 44,000 to 50,000 diagnosed cases in 1989)

*Special Population Targets*

| | *Diagnosed AIDS Cases* | *1989 Baseline* | *2000 Target* |
|---|---|---|---|
| 18.1a | Gay and bisexual men | 26,000-28,000 | 48,000 |
| 18.1b | Blacks | 14,000-15,000 | 37,000 |
| 18.1c | Hispanics | 7,000-8,000 | 18,000 |

*Note: Targets for this objective are equal to upper bound estimates of the incidence of diagnosed AIDS cases projected for 1993.*

18.2 Confine the prevalence of HIV infection to no more than 800 per 100,000 people. (Baseline: An estimated 400 per 100,000 in 1989)

*Special Population Targets*

| | *Estimated Prevalence of HIV Infection (per 100,000)* | *1989 Baseline* | *2000 Target* |
|---|---|---|---|
| 18.2a | Homosexual men | 2,000-42,000† | 20,000 |
| 18.2b | Intravenous drug abusers | 30,000-40,000‡ | 40,000 |
| 18.2c | Women giving birth to live-born infants | 150 | 100 |

†*Per 100,000 homosexual men aged 15 through 24 based on men tested in selected sexually transmitted disease clinics in unlinked surveys; most studies find HIV prevalence of between 2,000 and 21,000 per 100,000*

‡*Per 100,000 intravenous drug abusers aged 15 through 24 in the New York city vicinity; in areas other than major metropolitan centers, infection rates in people entering selected drug treatment programs tested in unlinked surveys are often under 500 per 100,000*

## Risk Reduction Objectives

18.3* Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17. (Baseline: 27 percent of girls and 33 percent of boys by age 15; 50 percent of girls and 66 percent of boys by age 17; reported in 1988)

18.4* Increase to at least 50 percent the proportion of sexually active, unmarried people who used a condom at last sexual intercourse. (Baseline: 19 percent of sexually active, unmarried women aged 15 through 44 reported that their partners used a condom at last sexual intercourse in 1988)

*Special Population Targets*

| | *Use of Condoms* | *1988 Baseline* | *2000 Target* |
|---|---|---|---|
| 18.4a | Sexually active young women aged 15-19 (by their partners) | 26% | 60% |
| 18.4b | Sexually active young men aged 15-19 | 57% | 75% |
| 18.4c | Intravenous drug abusers | — | 60% |

*Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens who are not yet sexually active.*

18.5 Increase to at least 50 percent the estimated proportion of all intravenous drug abusers who are in drug abuse treatment programs. (Baseline: An estimated 11 percent of opiate abusers were in treatment in 1989)

18.6 Increase to at least 50 percent the estimated proportion of intravenous drug abusers not in treatment who use only uncontaminated drug paraphernalia ("works"). (Baseline: 25 to 35 percent of opiate abusers in 1989)

18.7 Reduce to no more than 1 per 250,000 units of blood and blood components the risk of transfusion-transmitted HIV infection. (Baseline: 1 per 40,000 to 150,000 units in 1989)

## Services and Protection Objectives

18.8 Increase to at least 80 percent the proportion of HIV-infected people who have been tested for HIV infection. (Baseline: An estimated 15 percent of approximately 1,000,000 HIV-infected people had been tested at publicly funded clinics, in 1989)

18.9* Increase to at least 75 percent the proportion of primary care and mental health care providers who provide age-appropriate counseling on the prevention of HIV and other sexually transmitted diseases. (Baseline: 10 percent of physicians reported that they regularly assessed the sexual behaviors of their patients in 1987)

*Special Population Target*

| | *Counseling on HIV and STD Prevention* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 18.9a | Providers practicing in high incidence areas | — | 90% |

*Note: Primary care providers include physicians, nurses, nurse practitioners, and physician assistants. Areas of high AIDS and sexually transmitted disease incidence are cities and States with incidence rates of AIDS cases, HIV seroprevalence, gonorrhea, or syphilis that are at least 25 percent above the national average.*

18.10 Increase to at least 95 percent the proportion of schools that have age-appropriate HIV education curricula for students in 4th through 12th grade, preferably as part of quality school health education. (Baseline: 66 percent of school districts required HIV education but only 5 percent required HIV education in each year for 7th through 12th grade in 1989)

*Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens who are not yet sexually active.*

18.11 Provide HIV education for students and staff in at least 90 percent of colleges and universities. (Baseline data available in 1995)

18.12 Increase to at least 90 percent the proportion of cities with populations over 100,000 that have outreach programs to contact drug abusers (particularly intravenous drug abusers) to deliver HIV risk reduction messages. (Baseline data available in 1995)

*Note: HIV risk reduction messages include messages about reducing or eliminating drug use, entering drug treatment, disinfection of injection equipment if still injecting drugs, and safer sex practices.*

18.13* Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that screen, diagnose, treat, counsel, and provide (or refer for) partner notification services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia). (Baseline: 40 percent of family planning clinics for bacterial sexually transmitted diseases in 1989)

18.14 Extend to all facilities where workers are at risk for occupational transmission of HIV regulations to protect workers from exposure to bloodborne infections, including HIV infection. (Baseline data available in 1992)

*Note: The Occupational Safety and Health Administration (OSHA) is expected to issue regulations requiring worker protection from exposure to bloodborne infections, including HIV, during 1991. Implementation of the OSHA regulations would satisfy this objective.*

# 19. Sexually Transmitted Diseases

## Health Status Objectives

19.1 Reduce gonorrhea to an incidence of no more than 225 cases per 100,000 people. (Baseline: 300 per 100,000 in 1989)

*Special Population Targets*

| | *Gonorrhea Incidence (per 100,000)* | *1989 Baseline* | *2000 Target* |
|---|---|---|---|
| 19.1a | Blacks | 1,990 | 1,300 |
| 19.1b | Adolescents aged 15-19 | 1,123 | 750 |
| 19.1c | Women aged 15-44 | 501 | 290 |

19.2 Reduce *Chlamydia trachomatis* infections, as measured by a decrease in the incidence of nongonococcal urethritis to no more than 170 cases per 100,000 people. (Baseline: 215 per 100,000 in 1988)

19.3 Reduce primary and secondary syphilis to an incidence of no more than 10 cases per 100,000 people. (Baseline: 18.1 per 100,000 in 1989)

*Special Population Target*

| | *Primary and Secondary Syphilis Incidence (per 100,000)* | *1989 Baseline* | *2000 Target* |
|---|---|---|---|
| 19.3a | Blacks | 118 | 65 |

19.4 Reduce congenital syphilis to an incidence of no more than 50 cases per 100,000 live births. (Baseline: 100 per 100,000 live births in 1989)

19.5 Reduce genital herpes and genital warts, as measured by a reduction to 142,000 and 385,000, respectively, in the annual number of first-time consultations with a physician for the conditions. (Baseline: 167,000 and 451,000 in 1988)

19.6 Reduce the incidence of pelvic inflammatory disease, as measured by a reduction in hospitalizations for pelvic inflammatory disease to no more than 250 per 100,000 women aged 15 through 44. (Baseline: 311 per 100,000 in 1988)

19.7* Reduce sexually transmitted hepatitis B infection to no more than 30,500 cases. (Baseline: 58,300 cases in 1988)

19.8 Reduce the rate of repeat gonorrhea infection to no more than 15 percent within the previous year. (Baseline: 20 percent in 1988)

*Note: As measured by a reduction in the proportion of gonorrhea patients who, within the previous year, were treated for a separate case of gonorrhea.*

### Risk Reduction Objectives

19.9* Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17. (Baseline: 27 percent of girls and 33 percent of boys by age 15; 50 percent of girls and 66 percent of boys by age 17; reported in 1988)

19.10* Increase to at least 50 percent the proportion of sexually active, unmarried people who used a condom at last sexual intercourse. (Baseline: 19 percent of sexually active, unmarried women aged 15 through 44 reported that their partners used a condom at last sexual intercourse in 1988)

*Special Population Targets*

| *Use of Condoms* | *1988 Baseline* | *2000 Target* |
|---|---|---|
| 19.10a Sexually active young women aged 15-19 (by their partners) | 25% | 60% |
| 19.10b Sexually active young men aged 15-19 | 57% | 75% |
| 19.10c Intravenous drug abusers | — | 60% |

*Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens who are not yet sexually active.*

### Services and Protection Objectives

19.11* Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that screen, diagnose, treat, counsel, and provide (or refer for) partner notification services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia). (Baseline: 40 percent of family planning clinics for bacterial sexually transmitted diseases in 1989)

19.12 Include instruction in sexually transmitted disease transmission prevention in the curricula of all middle and secondary schools, preferably as part of quality school health education. (Baseline: 95 percent of schools reported offering at least one class on sexually transmitted diseases as part of their standard curricula in 1988)

*Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens who are not yet sexually active.*

19.13 Increase to at least 90 percent the proportion of primary care providers treating patients with sexually transmitted diseases who correctly manage cases, as measured by their use of appropriate types and amounts of therapy. (Baseline: 70 percent in 1988)

19.14* Increase to at least 75 percent the proportion of primary care and mental health care providers who provide age-appropriate counseling on the prevention of HIV and other sexually transmitted diseases. (Baseline: 10 percent of physicians reported that they regularly assessed the sexual behaviors of their patients in 1987)

*Special Population Target*

| *Counseling on HIV and STD Prevention* | *1987 Baseline* | *2000 Target* |
|---|---|---|
| 19.14a Providers practicing in high incidence areas | — | 90% |

*Note: Primary care providers include physicians, nurses, nurse practitioners, and physician assistants. Areas of high AIDS and sexually transmitted disease incidence are cities and States with incidence rates of AIDS cases, HIV seroprevalence, gonorrhea, or syphilis that are at least 25 percent above the national average.*

19.15 Increase to at least 50 percent the proportion of all patients with bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia) who are offered provider referral services. (Baseline: 20 percent of those treated in sexually transmitted disease clinics in 1988)

*Note: Provider referral (previously called contact tracing) is the process whereby health department personnel directly notify the sexual partners of infected individuals of their exposure to an infected individual.*

## 20. Immunization and Infectious Diseases

### Health Status Objectives

20.1 Reduce indigenous cases of vaccine-preventable diseases as follows:

| *Disease* | *1988 Baseline* | *2000 Target* |
|---|---|---|
| Diphtheria among people aged 25 and younger | 1 | 0 |
| Tetanus among people aged 25 and younger | 3 | 0 |
| Polio (wild-type virus) | 0 | 0 |
| Measles | 3,058 | 0 |
| Rubella | 225 | 0 |
| Congenital Rubella Syndrome | 6 | 0 |
| Mumps | 4,866 | 500 |
| Pertussis | 3,450 | 1,000 |

20.2 Reduce epidemic-related pneumonia and influenza deaths among people aged 65 and older to no more than 7.3 per 100,000. (Baseline: Average of 9.1 per 100,000 during 1980 through 1987)

*Note: Epidemic-related pneumonia and influenza deaths are those that occur above and beyond the normal yearly fluctuations of mortality. Because of the extreme variability in epidemic-related deaths from year to year, the target is a 3-year average.*

20.3* Reduce viral hepatitis as follows:

| *(Per 100,000)* | *1987 Baseline* | *2000 Target* |
|---|---|---|
| Hepatitis B (HBV) | 63.5 | 40 |
| Hepatitis A | 31 | 23 |
| Hepatitis C | 18.3 | 13.7 |

*Special Population Targets for HBV*

| | *HBV Cases* | *1987 Estimated Baseline* | *2000 Target* |
|---|---|---|---|
| 20.3a | Intravenous drug abusers | 30,000 | 22,500 |
| 20.3b | Heterosexually active people | 33,000 | 22,000 |
| 20.3c | Homosexual men | 25,300 | 8,500 |
| 20.3d | Children of Asians/Pacific Islanders | 8,900 | 1,800 |
| 20.3e | Occupationally exposed workers | 6,200 | 1,250 |
| 20.3f | Infants | 3,500 | 550 new carriers |
| 20.3g | Alaska Natives | 15 | 1 |

20.4 Reduce tuberculosis to an incidence of no more than 3.5 cases per 100,000 people. (Baseline: 9.1 per 100,000 in 1988)

*Special Population Targets*

| | *Tuberculosis Cases (per 100,000)* | *1988 Baseline* | *2000 Target* |
|---|---|---|---|
| 20.4a | Asians/Pacific Islanders | 36.3 | 15 |
| 20.4b | Blacks | 28.3 | 10 |
| 20.4c | Hispanics | 18.3 | 5 |
| 20.4d | American Indians/Alaska Natives | 18.1 | 5 |

20.5 Reduce by at least 10 percent the incidence of surgical wound infections and nosocomial infections in intensive care patients. (Baseline data available in late 1990)

20.6 Reduce selected illness among international travelers as follows:

| *Incidence* | *1987 Baseline* | *2000 Target* |
|---|---|---|
| Typhoid fever | 280 | 140 |
| Hepatitis A | 1,280 | 640 |
| Malaria | 2,000 | 1,000 |

20.7 Reduce bacterial meningitis to no more than 4.7 cases per 100,000 people. (Baseline: 6.3 per 100,000 in 1986)

*Special Population Target*

| | *Bacterial Meningitis Cases (per 100,000)* | *1987 Baseline* | *2000 Target* |
|---|---|---|---|
| 20.7a | Alaska Natives | 33 | 8 |

20.8 Reduce infectious diarrhea by at least 25 percent among children in licensed child care centers and children in programs that provide an Individualized Education Program (IEP) or Individualized Health Plan (IHP). (Baseline data available in 1992)

20.9 Reduce acute middle ear infections among children aged 4 and younger, as measured by days of restricted activity or school absenteeism, to no more than 105 days per 100 children. (Baseline: 131 days per 100 children in 1987)

20.10 Reduce pneumonia-related days of restricted activity as follows:

| | *1987 Baseline* | *2000 Target* |
|---|---|---|
| People aged 65 and older (per 100 people) | 48 days | 38 days |
| Children aged 4 and younger (per 100 children) | 27 days | 24 days |

## Risk Reduction Objectives

20.11 Increase immunization levels as follows:

Basic immunization series among children under age 2: at least 90 percent. (Baseline: 70-80 percent estimated in 1989)

Basic immunization series among children in licensed child care facilities and kindergarten through post-secondary education institutions: at least 95 percent. (Baseline: For licensed child care, 94 percent; 97 percent for children entering school for the 1987-1988 school year; and for post-secondary institutions, baseline data available in 1992)

Pneumococcal pneumonia and influenza immunization among institutionalized chronically ill or older people: at least 80 percent. (Baseline data available in 1992)

Pneumococcal pneumonia and influenza immunization among noninstitutionalized, high-risk populations, as defined by the Immunization Practices Advisory Committee: at least 60 percent. (Baseline: 10 percent estimated for pneumococcal vaccine and 20 percent for influenza vaccine in 1985)

Hepatitis B immunization among high-risk populations, including infants of surface antigen-positive mothers to at least 90 percent; occupationally exposed workers to at least 90 percent; IV-drug users in drug treatment programs to at least 50 percent; and homosexual men to at least 50 percent. (Baseline data available in 1992)

20.12 Reduce postexposure rabies treatments to no more than 9,000 per year. (Baseline: 18,000 estimated treatments in 1987)

### Services and Protection Objectives

20.13 Expand immunization laws for schools, preschools, and day care settings to all States for all antigens. (Baseline: 9 States and the District of Columbia in 1990)

20.14 Increase to at least 90 percent the proportion of primary care providers who provide information and counseling about immunizations and offer immunizations as appropriate for their patients. (Baseline data available in 1992)

20.15 Improve the financing and delivery of immunizations for children and adults so that virtually no American has a financial barrier to receiving recommended immunizations. (Baseline: Financial coverage for immunizations was included in 45 percent of employment-based insurance plans with conventional insurance plans; 62 percent with Preferred Provider Organization plans; and 98 percent with Health Maintenance Organization plans in 1989; Medicaid covered basic immunizations for eligible children and Medicare covered pneumococcal immunization for eligible older adults in 1990)

20.16 Increase to at least 90 percent the proportion of public health departments that provide adult immunization for influenza, pneumococcal disease, hepatitis B, tetanus, and diphtheria. (Baseline data available in 1991)

20.17 Increase to at least 90 percent the proportion of local health departments that have ongoing programs for actively identifying cases of tuberculosis and latent infection in populations at high risk for tuberculosis. (Baseline data available in 1991)

*Note: Local health department refers to any local component of the public health system, defined as an administrative and service unit of local or State government concerned with health and carrying some responsibility for the health of a jurisdiction smaller than a State.*

20.18 Increase to at least 85 percent the proportion of people found to have tuberculosis infection who completed courses of preventive therapy. (Baseline: 89 health departments reported that 66.3 percent of 95,201 persons placed on preventive therapy completed their treatment in 1987)

20.19 Increase to at least 85 percent the proportion of tertiary care hospital laboratories and to at least 50 percent the proportion of secondary care hospital and health maintenance organization laboratories possessing technologies for rapid viral diagnosis of influenza. (Baseline data available in 1992)

## 21. Clinical Preventive Services

### Health Status Objective

21.1* Increase years of healthy life to at least 65 years. (Baseline: An estimated 62 years in 1980)

| | | *Special Population Targets* | |
|---|---|---|---|
| | *Years of Healthy Life* | *1980 Baseline* | *2000 Target* |
| 21.1a | Blacks | 56 | 60 |
| 21.1b | Hispanics | 62 | 65 |
| 21.1c | People aged 65 and older | 12† | 14† |

†*Years of healthy life remaining at age 65*

*Note: Years of healthy life (also referred to as quality-adjusted life years) is a summary measure of health that combines mortality (quantity of life) and morbidity and disability (quality of life) into a single measure. For people aged 65 and older, active life-expectancy, a related summary measure, also will be tracked.*

### Risk Reduction Objective

21.2 Increase to at least 50 percent the proportion of people who have received, as a minimum within the appropriate interval, all of the screening and immunization services and at least one of the counseling services appropriate for their age and gender as recommended by the U.S. Preventive Services Task Force. (Baseline data available in 1991)

| | | *Special Population Targets* | |
|---|---|---|---|
| | *Receipt of Recommended Services* | *Baseline* | *2000 Target* |
| 21.2a | Infants up to 24 months | — | 90% |
| 21.2b | Children aged 2-12 | — | 80% |
| 21.2c | Adolescents aged 13-18 | — | 50% |
| 21.2d | Adults aged 19-39 | — | 40% |
| 21.2e | Adults aged 40-64 | — | 40% |
| 21.2f | Adults aged 65 and older | — | 40% |
| 21.2g | Low-income people | — | 50% |
| 21.2h | Blacks | — | 50% |
| 21.2i | Hispanics | — | 50% |
| 21.2j | Asians/Pacific Islanders | — | 50% |
| 21.2k | American Indians/Alaska Natives | — | 70% |
| 21.2l | People with disabilities | — | 80% |

### Services and Protection Objectives

21.3 Increase to at least 95 percent the proportion of people who have a specific source of ongoing primary care for coordination of their preventive and episodic health care. (Baseline: Less than 82 percent in 1986, as 18 percent reported having no physician, clinic, or hospital as a regular source of care)

*Special Population Targets*

| | *Percentage With Source of Care* | *1986 Baseline* | *2000 Target* |
|---|---|---|---|
| 21.3a | Hispanics | 70% | 95% |
| 21.3b | Blacks | 80% | 95% |
| 21.3c | Low-income people | 80% | 95% |

21.4 Improve financing and delivery of clinical preventive services so that virtually no American has a financial barrier to receiving, at a minimum, the screening, counseling, and immunization services recommended by the U.S. Preventive Services Task Force. (Baseline data available in 1992)

21.5 Assure that at least 90 percent of people for whom primary care services are provided directly by publicly funded programs are offered, at a minimum, the screening, counseling, and immunization services recommended by the U.S. Preventive Services Task Force. (Baseline data available in 1992)

*Note: Publicly funded programs that provide primary care services directly include federally funded programs such as the Maternal and Child Health Program, Community and Migrant Health Centers, and the Indian Health Service as well as primary care service settings funded by State and local governments. This objective does not include services covered indirectly through the Medicare and Medicaid programs.*

21.6 Increase to at least 50 percent the proportion of primary care providers who provide their patients with the screening, counseling, and immunization services recommended by the U.S. Preventive Services Task Force. (Baseline data available in 1992)

21.7 Increase to at least 90 percent the proportion of people who are served by a local health department that assesses and assures access to essential clinical preventive services. (Baseline data available in 1992)

*Note: Local health department refers to any local component of the public health system, defined as an administrative and service unit of local or State government concerned with health and carrying some responsibility for the health of a jurisdiction smaller than a State.*

21.8 Increase the proportion of all degrees in the health professions and allied and associated health profession fields awarded to members of underrepresented racial and ethnic minority groups as follows:

| *Degrees Awarded To:* | *1985-86 Baseline* | *2000 Target* |
|---|---|---|
| Blacks | 5% | 8% |
| Hispanics | 3% | 6.4% |
| American Indians/Alaska Natives | 0.3% | 0.6% |

*Note: Underrepresented minorities are those groups consistently below parity in most health profession schools—blacks, Hispanics, and American Indians and Alaska Natives.*

## 22. Surveillance and Data Systems

### Objectives

22.1 Develop a set of health status indicators appropriate for Federal, State, and local health agencies and establish use of the set in at least 40 States. (Baseline: No such set exists in 1990)

22.2 Identify, and create where necessary, national data sources to measure progress toward each of the year 2000 national health objectives. (Baseline: 77 percent of the objectives have baseline data in 1990)

*Type-Specific Target*

| | | *1989 Baseline* | *2000 Target* |
|---|---|---|---|
| 22.2a | State level data for at least two-thirds of the objectives | 23 States† | 35 States |

†*Measured using the 1989 Draft Year 2000 National Health Objectives*

22.3 Develop and disseminate among Federal, State, and local agencies procedures for collecting comparable data for each of the year 2000 national health objectives and incorporate these into Public Health Service data collection systems. (Baseline: Although such surveys as the National Health Interview Survey may serve as a model, widely accepted procedures do not exist in 1990)

22.4 Develop and implement a national process to identify significant gaps in the Nation's disease prevention and health promotion data, including data for racial and ethnic minorities, people with low incomes, and people with disabilities, and establish mechanisms to meet these needs. (Baseline: No such process exists in 1990)

*Note: Disease prevention and health promotion data includes disease status, risk factors, and services receipt data. Public health problems include such issue areas as HIV infection, domestic violence, mental health, environmental health, occupational health, and disabling conditions.*

22.5 Implement in all States periodic analysis and publication of data needed to measure progress toward objectives for at least 10 of the priority areas of the national health objectives. (Baseline: 20 States reported that they disseminate the analyses they use to assess State progress toward the health objectives to the public and to health professionals in 1989)

*Type-Specific Target*

| | *1989 Baseline* | *2000 Target* |
|---|---|---|
| 22.5a Periodic analysis and publication of State progress toward the national objectives for each racial or ethnic group that makes up at least 10 percent of the State population | — | 25 States |

*Note: Periodic is at least once every 3 years. Objectives include, at a minimum, one from each objectives category: health status, risk reduction, and services and protection.*

22.6 Expand in all States systems for the transfer of health information related to the national health objectives among Federal, State, and local agencies. (Baseline: 30 States reported that they have some capability for transfer of health data, tables, graphs, and maps to Federal, State, and local agencies that collect and analyze data in 1989)

*Note: Information related to the national health objectives includes State and national level baseline data, disease prevention/health promotion evaluation results, and data generated to measure progress.*

22.7 Achieve timely release of national surveillance and survey data needed by health professionals and agencies to measure progress toward the national health objectives. (Baseline data available in 1993)

*Note: Timely release (publication of provisional or final data or public use data tapes) should be based on the use of the data, but is at least within one year of the end of data collection.*

## Age-Related Objectives

*Reduce the death rate for children by 15 percent to no more than 28 per 100,000 children aged 1 through 14, and for infants by approximately 30 percent to no more than 7 per 1,000 live births. (Baseline: 33 per 100,000 for children in 1987 and 10.1 per 1,000 live births for infants in 1987)

Reduce the death rate for adolescents and young adults by 15 percent to no more than 85 per 100,000 people aged 15 through 24. (Baseline: 99.4 per 100,000 in 1987)

Reduce the death rate for adults by 20 percent to no more than 340 per 100,000 people aged 25 through 64. (Baseline: 423 per 100,000 in 1987)

*Reduce to no more than 90 per 1,000 people the proportion of all people aged 65 and older who have difficulty in performing two or more personal care activities (a reduction of about 19 percent), thereby preserving independence. (Baseline: 111 per 1,000 in 1984-85)



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