Developing Objectives for HEALTHY PEOPLE 2010

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Disease Prevention and Health Promotion
September 1997

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About This Guide

You are invited to participate in the process of developing Healthy People 2010, the third set of national health promotion and disease prevention objectives. This guide includes background on the Healthy People initiative, who is involved, a calendar of major events, and ways the public can help develop objectives.

This guide is a resource for individuals and groups to use in reviewing and modifying year 2000 objectives, as well as developing new objectives. Proposed objectives and comments on the proposed structure may be submitted through December 15, 1997. In the fall of 1998, a draft of Healthy People 2010 objectives will be circulated for public review and comment. We encourage everyone to participate in these and other Healthy People 2010 development activities to ensure that this initiative reflects the broad scope of public health in the United States.

This guide is intended for use by private and voluntary organizations; local and State public health, mental health, substance abuse, and environmental agencies; Federal government agencies; and any individual interested in improving public health. Because Healthy People is national in scope, everyone is encouraged to participate in developing the objectives that will guide prevention efforts into the next millennium.

What Is "Healthy People"?

For two decades, the U.S. Public Health Service (PHS) has used health promotion and disease prevention objectives to improve the health of the American people. The first set of national health targets was published in 1979 in *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. This set of five challenging goals, to reduce mortality among four different age groups—infants, children, adolescents and young adults, and adults—and increase independence among older adults, was supported by objectives with 1990 targets that were designed to drive action. Through the combined efforts of the Nation's public health agencies, the 1990 targets set for infants, children, and adults were achieved. Adolescent mortality did not decline sufficiently to reach the 1990 target, and data systems could not adequately track the older adults' target.

HEALTHY PEOPLE 2000

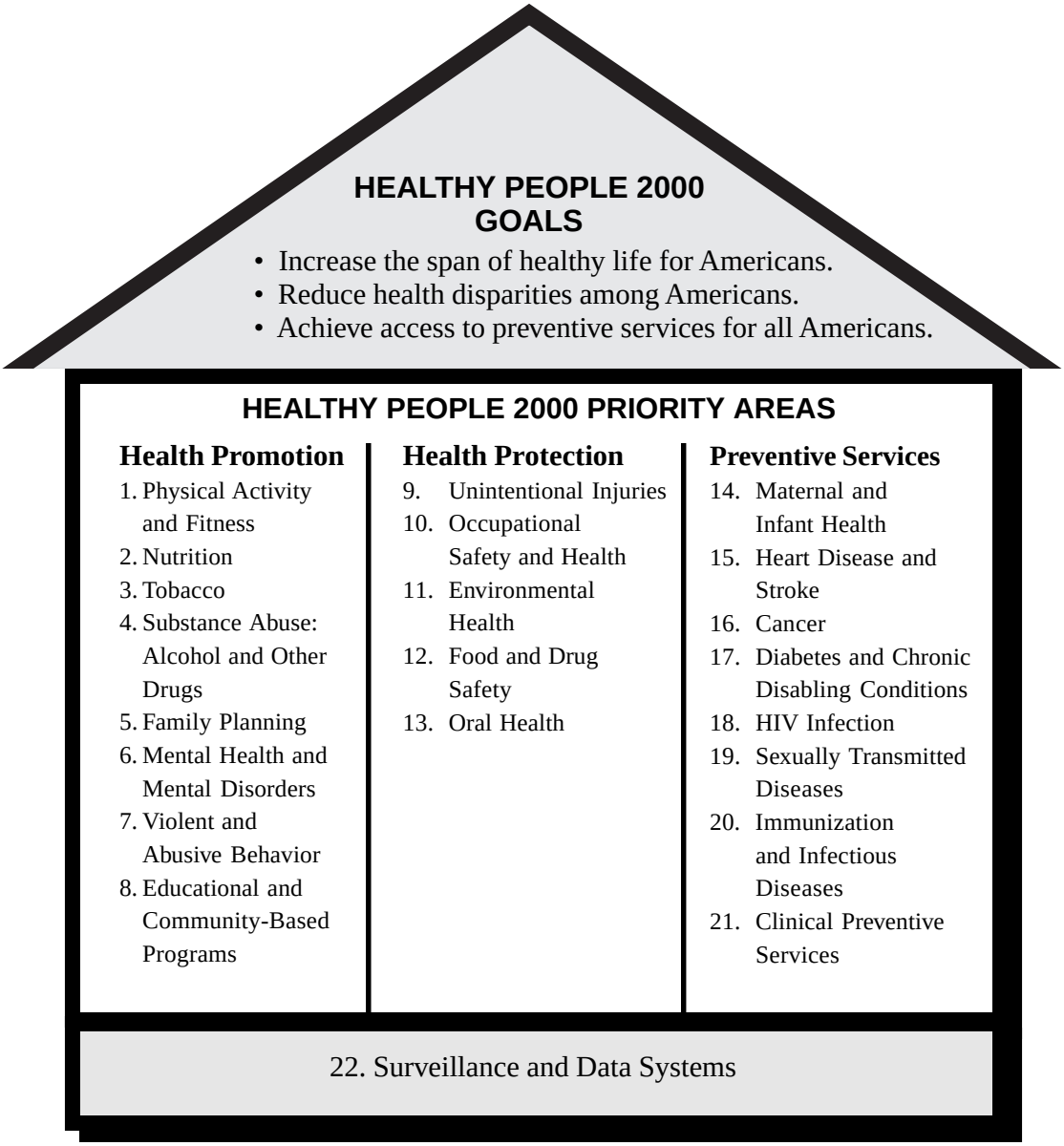
Healthy People 2000 built upon the lessons of the first Surgeon General's report and is the product of unprecedented collaboration among government, voluntary, and professional organizations; businesses; and individuals. Several themes distinguished Healthy People 2000 from past efforts, reflecting the progress and experience of 10 years, as well as an expanded science base for developing health promotion and disease prevention objectives. Many of the year 2000 objectives specify improving the health of groups of people bearing a disproportionate burden of poor health compared to the total population.

The framework of Healthy People 2000 consists of three broad goals:

1) Increase the span of healthy life for Americans,
2) Reduce health disparities among Americans, and
3) Achieve access to preventive services for all Americans.

Organized under the broad approaches of health promotion, health protection, and preventive services, the more than 300 national objectives are organized into 22 priority areas. A summary list of objectives is provided in Appendix B. This framework provides direction for individuals to change personal behaviors and for organizations and communities to support good health through health promotion policies. This framework can be envisioned as a house with a foundation of surveillance and data systems, rooms with Healthy People 2000 priority areas, and a roof that encompasses the three goals (see Figure 1).

Figure 1: Healthy People 2000 Framework



YEAR 2010 OBJECTIVES

The context in which Healthy People 2010 is being developed differs from that in which Healthy People 2000 was framed—and will continue to evolve throughout the decade. Advances in preventive therapies, vaccines and pharmaceuticals, assistive technologies, and computerized systems will all change the face of medicine and how it is practiced. New relationships will be defined between public health departments and health care delivery organizations. Meanwhile, demographic changes in the United States—reflecting an older and more racially diverse population—will create new demands on public health and the overall health care system. Global forces—including food supplies, emerging infectious diseases, and environmental interdependence—will present new public health challenges.

Development of the year 2010 objectives has already begun with the users of the current objectives. At the November 1996 meeting of the Healthy People 2000 Consortium in New York City, the theme was "Building the Prevention Agenda for 2010: Lessons Learned." This meeting was complemented by focus group sessions where Consortium members discussed the current framework, goals, and objectives to assess the improvements needed to make the 2010 agenda relevant to the first decade of the 21st century. A report on the focus group findings can be found on the Healthy People 2000 Homepage at **http://odphp.osophs.dhhs.gov/pubs/hp2000.**

This next set of national objectives will be distinguished from Healthy People 2000 by the broadened prevention science base; improved surveillance and data systems; a heightened awareness and demand for preventive health services and quality health care; and changes in demographics, science, technology, and disease spread that will affect the public's health into the 21st century. The widespread use of the year 2000 objectives by States, localities, and the private sector also provides a base of experience upon which to build. While the Federal Government will take the lead in developing the initial draft objectives, this process is designed to be very participatory.

Healthy People 2010 is the United States' contribution to the World Health Organization's (WHO) "Health for All" strategy. The U.S. effort will be characterized by intersectoral collaboration and community participation. Through national objectives, the United States can provide models for world policy and strategies for population health improvement.

How Can Organizations And Individuals Contribute To Healthy People?

Healthy People is a national initiative. Everyone is encouraged to participate. The following describes opportunities for collaboration.

1. ***Participate in Shaping the Healthy People 2010 Framework*** - The Healthy People Steering Committee, the Healthy People Work Group Coordinators, and the Secretary's Council on Health Promotion and Disease Prevention Objectives for 2010 already have been working to develop a suggested framework for Healthy People 2010. A call for comments on the proposed framework and recommendations for alternative approaches will be announced in the *Federal Register* in the fall of 1997. The call for comments on the framework is located on page 21 of this guide. Please feel free to use any part of the notice in organizational newsletters to spread the word about the comment period on the proposed Healthy People 2010 framework. Any group or person may provide comments.

2. ***Help Develop Objectives*** - A call for objectives will also be announced in the *Federal Register* in the fall of 1997 (see page 21). Any group or person may develop and submit objectives for Healthy People 2010. All suggestions will be reviewed and considered for inclusion. Criteria for new or modified objectives are included in this guide on page 19. Because many of the objectives will build on Healthy People 2000, a summary list of objectives with updated baselines is included in Appendix B. This is the most current set of objectives. It includes all revisions and newly established baselines and other corrections made since the 1995 midcourse review of Healthy People 2000.

3. ***Assist the Lead Agencies*** - The Assistant Secretary for Health has designated lead agencies within the PHS to convene work groups for each of the 22 Healthy People 2000 priority areas. Development of 2010 objectives will take place in these lead agency work groups. In addition, new work groups are being established to focus on some new areas—public health infrastructure, people with disabilities, children, adolescents, and racial/ethnic groups. Individuals may volunteer to join a work group hosted by the PHS lead agencies. These groups will examine data, prevention science, and other information to draft objectives for inclusion in the 2010 document. Contact information for the work group coordinators is on pages 29 to 38. Please contact these coordinators directly if you or your organization would like to participate in specific work groups.

4. ***Comment on Proposed Objectives*** - HHS will offer a comment period on the draft Healthy People 2010 objectives document in the fall of 1998. An announcement of that comment period will appear in the *Federal Register*. We anticipate holding regional meetings during this comment period, subject to funding.

5. ***Integrate Healthy People 2000 and 2010 Objectives into Current Programs, Special Events, Publications, and Meetings*** - The framework for the initiative is in the public domain and can be used by any organization to measure health improvements. Integrating Healthy People objectives (year 2000 and year 2010) into programs, special events, publications, and meetings will enable organizations to guide health improvements and monitor their results.

6. ***Incorporate Healthy People into Healthy Community Initiatives*** - Use Healthy People as a framework to promote healthy cities and communities. Businesses can use the framework to guide worksite and health promotion activities as well as for community-wide initiatives. Schools and colleges can undertake activities to further the health of children, adolescents and young adults. By selecting among the national objectives, any individual or organization can build an agenda for community health improvement.

7. ***Utilize Healthy People 2000 and 2010 in Planning*** - National membership organizations, as well as State and territorial agencies, can and have used Healthy People objectives to set their own benchmarks for systems and operational planning. Healthy People measures can also be used for evaluating programs and setting a research agenda.

8. ***Use Healthy People Objectives in Performance Measurement Activities*** - Healthy People objectives are linked to numerous performance measurement efforts. For example, the National Committee on Quality Assurance incorporated many Healthy People objectives into its Health Plan Employer Data and Information Set (HEDIS) 3.0, a set of standardized measures for health care purchasers and consumers to use in assessing performance of managed care organizations in the areas of immunizations, mammography screening, and other clinical preventive services. The May 1997 *Prevention Report* describes ways in which Healthy People objectives can be used in performance measurement activities by State and local health organizations.

9. ***Join the Consortium*** - The only criterion for membership is that the group be a national membership organization. As an enrollment benefit, you will receive a quarterly *Prevention Report*, which includes *Consortium Exchange*, a newsletter highlighting Consortium member programs, publications, and activities. Progress Review Reports on the Healthy People 2000 priority areas and special population groups are also included in *Prevention Report*. Consortium members also are invited to the annual Consortium meeting.

What Is The Healthy People Consortium And Who Are Its Members?

The Healthy People Consortium is an alliance of organizations committed to making Americans healthier by supporting the goals of Healthy People—the nation's prevention agenda. It consists of State and territorial public health, mental health, substance abuse, and environmental agencies; and national membership organizations representing professional, voluntary, and business sectors.

The Consortium was convened in 1987 when, at the request of the Public Health Service, the Institute of Medicine of the National Academy of Sciences invited national membership organizations representing professional, voluntary, and corporate sectors, as well as State and territorial public health agencies, to join the Healthy People 2000 Consortium. The members assisted in developing the Healthy People 2000 objectives and have played an important role throughout the decade in implementing, monitoring, and reporting on the Nation's successes and challenges.

The role of the Consortium has broadened since its inception. Many members have developed health promotion and disease prevention programs using Healthy People objectives. Some organizations have adopted Healthy People objectives as part of their missions. Many of these organizations assisted in the *Healthy People 2000 Midcourse Review and 1995 Revisions*, and several have participated in progress reviews chaired by the Assistant Secretary for Health.

Healthy People is being used throughout the States and territories. As of July 1997, 44 States, the District of Columbia, and Guam have published their own Healthy People plans. A 1993 National Association of County and City Health Officials survey showed that 70 percent of local health departments use Healthy People 2000 objectives.

The Consortium has grown in size as well as influence over the last decade. The number of national membership organizations has more than doubled since 1987, and in 1995, State mental health, substance abuse, and environmental agencies joined the effort (See Appendix A). This broadening membership has enriched the expertise and experience of the Consortium. During the next decade, it is envisioned that membership will expand beyond the traditional public health community and voluntary health associations to include a range of business, labor, and other organizations which will take the message of Healthy People into every community and workplace.

Consortium members receive a quarterly newsletter on their activities and convene annually at the Healthy People Consortium meeting, where information is shared, opportunities for collaboration are created, and commitments are renewed.

Participants at the 1994 Consortium meeting worked on revising and adding to the year 2000 objectives. In 1995, the meeting focused on action at the community level. *The Healthy People 2000 Midcourse Review and 1995 Revisions* was released by the Assistant Secretary for Health, Dr. Philip R. Lee, at that meeting. In 1996, the meeting addressed the broad determinants of health. In 1997, the meeting (to be held November 7 in Indianapolis, Indiana) will focus on health disparities, and the participants will work on drafting 2010 objectives. The 1998 meeting in Washington, DC, will provide an opportunity for Consortium members to comment on the draft 2010 document. A 1999 meeting may focus on implementation strategies in anticipation of the release of the 2010 document in January of 2000. Consortium members and Federal officials will continue to collaborate at the yearly meetings.

CONSORTIUM MEETINGS

Themes of annual Consortium meetings:

1990 Release of Healthy People 2000
1991 Implementation Using Public/Private Partnerships
1992 Healthy People Resource Lists
1993 Turning Commitment to Action
1994 Review the Progress: Renew Our Mission
1995 Healthy People in Healthy Communities
1996 Building the Prevention Agenda for 2010: Lessons Learned
1997 Decreasing Health Disparities: How Far Have We Come?

Proposed
1998 Building Toward 2010: Comments on the Healthy People 2010 Draft
1999 Preparing for the Future: Discussion of 2010 Implementation
2000 Release of Healthy People 2010

Schedule Of Healthy People 2010 Development

(Public events are in bold letters)

♦ 1996

Secretary's Council on National Disease Prevention and Health Promotion Objectives for 2010 Established	September 5, 1996
Healthy People Consortium Member Focus Groups	**October 1996-February 1997**
Healthy People Consortium Meeting "Building the Prevention Agenda for 2010: Lessons Learned"	**November 15, 1996**

♦ 1997

Secretary's Briefing on 2010 Objectives	January 22, 1997
Secretary's Council Meets on 2010 Objectives	**April 21, 1997**
Focus Group Report on Utility of Healthy People 2000	July 1997
***Federal Register* Notice of a Call for Comments on the 2010 Framework and Call for Objectives**	**September 1997**
Healthy People 2000 Consortium Meeting "Reducing Health Disparities: How Far Have We Come?"	**November 7, 1997 Indianapolis, Indiana**
Deadline for Public Submission of Comments on the 2010 Framework and on Draft Objectives	**December 15, 1997**
Work Groups Meet to Develop Objectives	**1997-1998**

♦ **1998**

Draft of 2010 Objectives Ready for Internal Review	March 1998
Secretary's Council Meeting	**April 1998**
Publication of Healthy People 2010 Draft	**October 1998**
***Federal Register* Notice of a Call for Public Comment on 2010 Draft**	**October 1998**
Public Comment Period/Proposed Regional Meetings	**October-December 1998**
Healthy People 2000 Consortium Meeting	**November 13, 1998 Washington, DC**

♦ **1999**

Secretary's Council Meeting	**April 1999**
Proposed Consortium Meeting	**June 1999**
Finalize 2010 Objectives	Throughout 1999
Develop Companion Documents	Throughout 1999

♦ **2000**

Release of Healthy People 2010	**January 2000**

How Should Healthy People 2010 Be Structured?

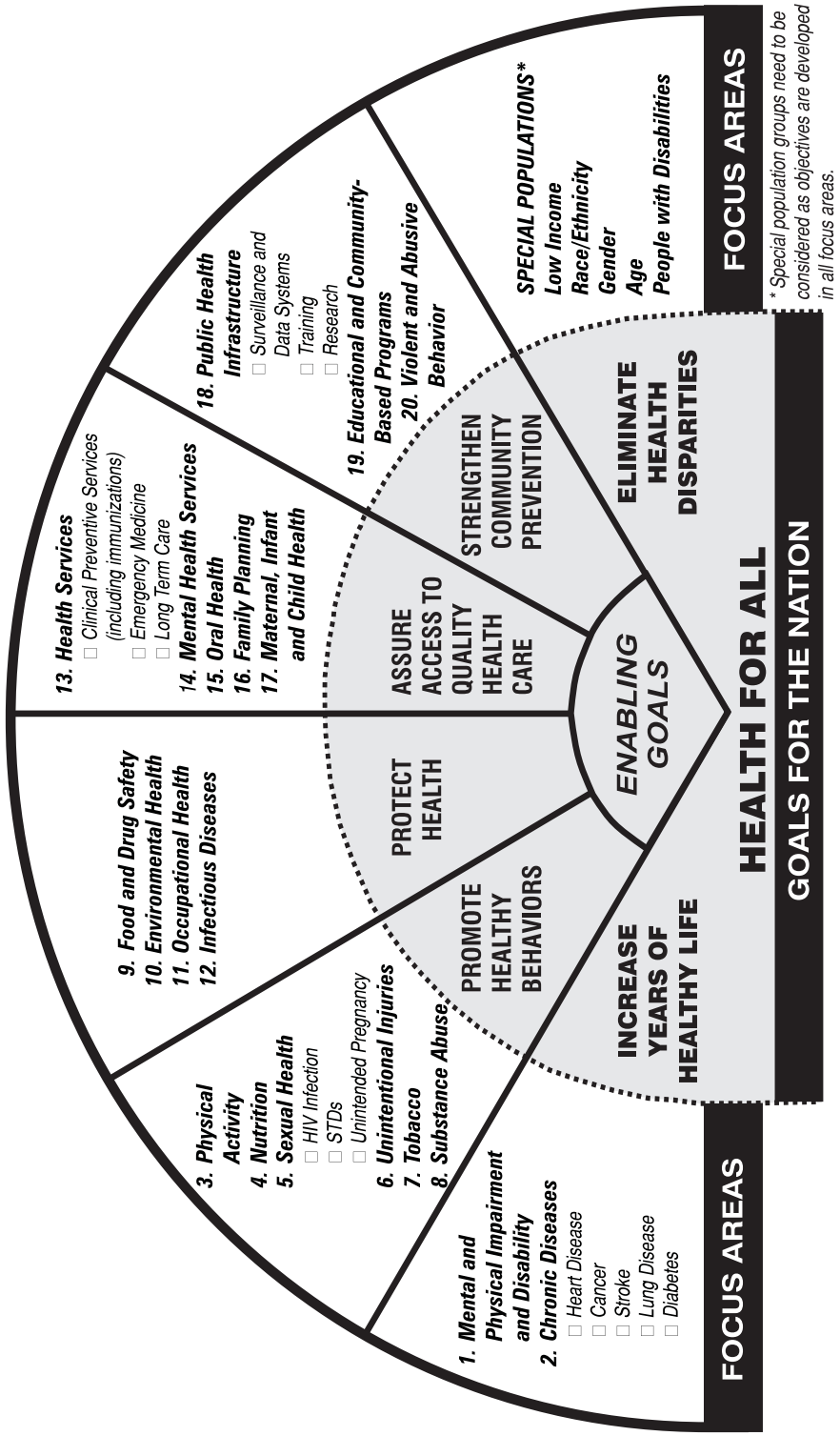
The process of envisioning how to structure Healthy People 2010 began in the fall of 1996. Members of the Healthy People Consortium participated in focus groups to discuss the usefulness of the Healthy People 2000 framework and consider alternatives. A number of recommendations for improvement were made, but the basic features of the current structure were provisionally retained. The report on these focus groups is available on the Healthy People Homepage, http://odphp.osophs.dhhs.gov/pubs/hp2000. The draft framework that follows reflects the cumulative advice received in these and other consultations. It represents our starting point for the design of Healthy People 2010 and is still very much a draft.

Now, we need your help.

Over the next four months, public comment from organizations and individuals is being actively solicited on the proposed framework for 2010. A formal call for comments will appear in the *Federal Register* on or about September 15, 1997. The entire draft framework will be reconsidered and revised in light of the advice received during the public consultation period.

When reading the descriptions of the different portions of the framework, please consider whether this framework would be useful to you in your work. Review the overall structure of the framework as well as its individual components. If you feel the entire framework or a piece of it does not work, let us know. For example, you could consider the number, arrangement, relationships, and utility of the goals and focus areas. Suggestions for new wording of the vision statement, goals, and focus areas are welcomed. Proposals for entirely new frameworks are also welcome.

Figure 2: Proposed Healthy People Framework



Proposed Framework for Healthy People 2010

The proposed **vision** for Healthy People 2010 is Healthy People in Healthy Communities. This statement recognizes that health improvement begins at home with what we do—individually, in families, and in communities to promote mental and physical health. Schools, worksites, community programs, religious institutions, voluntary organizations, senior centers, and other sites can deliver preventive health messages. The vision incorporates the World Health Organization's "Health for All" strategy.

The 2010 framework proposes two **overarching goals** for the Nation: 1) increase years of healthy life, and 2) eliminate health disparities. The first goal continues the year 2000 goal with an emphasis on increasing quality life years, not just life expectancy. The second goal strengthens the Healthy People 2000 goal of reducing health disparities by calling for the elimination of health disparities. In order to reach the second goal, the year 2010 targets will be identical for all population groups. These goals are aspirational, and their achievement will result in increased health for all people living in the United States and equity of health status. **Are these goals appropriate? Are there others? Is this a useful approach?**

Four proposed **enabling goals** accompany the overarching ones. Their purpose is to provide strategies to achieve the overarching goals: 1) promote healthy behaviors, 2) protect health, 3) assure access to quality health care, and 4) strengthen community prevention. These basic public health concepts have been integral to the categories of prevention—health promotion, health protection, and clinical preventive services—in Healthy People 2000. Using these parameters throughout the 1990's has sharpened the focus on ways to achieve the overarching goals. The third enabling goal has been broadened from "clinical preventive services" to "total health care." The emphasis is on "quality" as well as availability of a range of health services—preventive, emergency, and treatment service, as well as long-term care. The new enabling goal on community prevention recognizes the value of population-based activities that promote health. **Are these goals appropriate? Are there others? Is this a useful approach?**

The proposed **focus areas** are analogous to, and for the most part use the same names, as Healthy People 2000 priority areas. These are now called focus areas to move away from an implied prioritization. New focus areas have been added in response to changes in health care and public health during the last 10 years. These include impairment and disability and public health infrastructure. Discussions are ongoing about how best to address the disparities of special population groups. **Are these focus areas appropriate? Are there others? Is this a useful approach? Should there be special population group focus areas?**

The proposed focus areas are arranged under specific overarching or enabling goals to show the connections between the different goals and focus areas. As in Healthy People 2000, a set of objectives will be arranged under each focus area. Development of these objectives will be coordinated by focus area work groups with input from the public comments received during the fall of 1997 and fall of 1998. It is expected that

special population groups will be considered as objectives are developed in all focus areas. See page 17 for a detailed discussion of objectives.

Is the graphic presentation appropriate? Are there others that would be more useful?

Because different users of Healthy People 2010 will have changing needs, it is anticipated that available technology will be used to allow the users to customize a list of objectives for their purposes. For example, the set of objectives may be available on CD-ROM or the Internet. Search engines, based on key words, will be incorporated into the listing of objectives, allowing a person to compile all objectives that are relevant to any group, disease, or prevention strategy. For example, someone interested in compiling objectives relevant to adolescents could obtain all those objectives related to that age cohort regardless of where in the framework those objectives are located.

Again we emphasize that the proposed Healthy People 2010 framework is a *work in progress*. We need your input before December 15, 1997, to ensure that the structure of Healthy People 2010 that is published in the fall of 1998 uses a framework that is useful to you.

Types Of Objectives

The current proposal for Healthy People 2010 calls for two broad types of objectives—measurable and developmental objectives. Recommendations for both types of objectives will be taken in the fall 1997. It has been proposed that in order to reach the second overall goal—eliminate health disparities—the year 2010 targets will be identical for all population groups.

Measurable objectives provide direction for action. They have baselines that use valid and reliable data derived from currently established, nationally representative data systems. These baseline data provide the point from which a 2010 target can be set. Whenever possible, objectives should be measured with national systems that either build on or are comparable with State and local data systems. However, State data are not a prerequisite to developing an objective. Proxy data may be used when national data are not available or where regional data may provide better measurability. When providing an idea for a measurable objective, please include the data source.

> **Example:** Reduce the infant mortality rate by xx percent to no more than xx per 1,000 live births.
> (Baseline: 10.1 per 1,000 live births in 1987)
> (Data Source: National Vital Statistics)

Developmental objectives provide a vision for a desired outcome or health status. Current surveillance systems do not provide data on these objectives. The purpose of developmental objectives is to identify areas that are important and to drive the development of data systems to measure them.

> **Example:** Increase to at least 90 percent the proportion of pregnant women and infants who receive risk-appropriate care.
> (Baseline data unavailable)

Is this a useful approach? Should there be a limit on the number of objectives in each focus area?

Criteria For Objectives Development

The 2010 objectives should be useful to national, State and local agencies as well as to the private sector and the general public. In order to be used in the Healthy People 2010 framework, the objectives must have certain attributes:

- The result to be achieved should be **important and understandable** to a broad audience and relate to the Healthy People 2010 goals and focus areas.

- Objectives should be **prevention oriented** and should address health improvements that can be achieved through population-based and health-service interventions.

- Objectives should **drive action** and suggest a set of interim steps that will achieve the proposed targets within the specified timeframe.

- Objectives should be **useful and relevant**. States, localities, and the private sector should be able to use them to target efforts in schools, communities, work sites, health practices, and other settings.

- Objectives should be **measurable** and include a range of measures—health outcomes, behavioral and health service interventions, and community capacity— directed toward improving health outcomes and quality of life. They should count assets and achievements and look to the positive.

- **Continuity and comparability** are important. Whenever possible, objectives should build upon Healthy People 2000 and those goals and performance measures already adopted.

- There must be sound **scientific evidence** to support the objectives.

Call for Comments

An announcement will appear
in the *FEDERAL REGISTER*
on or about September 15, 1997

- **CALL FOR COMMENTS ON THE PROPOSED 2010 FRAMEWORK**
  Modifications recommended on:
  1) **Entire framework**
  2) **Vision statement**
  3) **Overarching goals**
  4) **Enabling goals**
  5) **Focus areas**
  6) **Arrangement of focus areas**
  7) **New proposals**

- **CALL FOR HEALTHY PEOPLE 2010 OBJECTIVES**
  A) Deletion of year 2000 objectives
  B) Modification of year 2000 objectives
  C) Ideas for new objectives
  1) **Measurable—must include data source**
  2) **Developmental**

Comment and Submission period:

September 15 through December 15, 1997

Submit comments and objectives after September 15 to:

Office of Disease Prevention and Health Promotion
Attention: Healthy People 2010 Objectives
738-G Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

For more information, check the
Healthy People Homepage:
http://odphp.osophs.dhhs.gov/pubs/hp2000

To submit comments: http://web.health.gov/healthypeople

The Secretary's Council On National Health Promotion And Disease Prevention Objectives For 2010

Approved September 5, 1996, and announced in the *Federal Register* on October 21, 1996, the Secretary's Council on National Health Promotion and Disease Prevention Objectives for 2010 oversees the development of Healthy People 2010. The Secretary of the Department of Health and Human Services (HHS) chairs this Council with the Assistant Secretary for Health sitting as vice chair. Members include all former Assistant Secretaries and all current heads of operating divisions in HHS.

The Council meets yearly to guide the development policies of Healthy People 2010.

PARTICIPANTS AT THE INAUGURAL MEETING APRIL 21, 1997

Chair
Donna E. Shalala, Ph.D.
Secretary

Kevin Thurm, J.D.
Deputy Secretary

Vice Chair
Jo Ivey Boufford, M.D., M.P.H.
Acting Assistant Secretary for Health

Former Assistant Secretaries for Health
Merlin K. DuVal, M.D.
Philip R. Lee, M.D.
Julius B. Richmond, M.D.
Robert E. Windom, M.D.

HHS Operating Division Heads

Administration for Children and Families	Olivia Golden, Ph.D. (Acting)
Administration on Aging	William F. Benson (Acting)
Agency for Health Care Policy and Research	John Eisenberg, M.D.
Centers for Disease Control and Prevention	David Satcher, M.D.
Food and Drug Administration	Michael Friedman, M.D. (Acting)
Health Care Financing Administration	Sally Richardson (Representing Bruce Vladeck, M.D.)
Health Resources and Services Administration	Claude Earl Fox, M.D., M.P.H. (Acting)
Indian Health Service	Craig Vanderwagen, M.D. (Representing Michael Trujillo, M.D.)
National Institutes of Health	William Harlan, M.D. (Representing Harold Varmus, M.D.)
Substance Abuse and Mental Health Services Administration	Paul Schwab (Representing Nelba Chavez, Ph.D.)

Other Members not in attendance:

Former Assistant Secretary for Health	Edward N. Brandt, Jr., M.D., Ph.D.
Former Assistant Secretary for Health	Charles C. Edwards, M.D.
Former Assistant Secretary for Health	James O. Mason, M.D., Dr.P.H.

The Healthy People Steering Committee

The Healthy People 2000 Steering Committee is an internal committee of HHS. This Committee coordinates work on the Healthy People initiative for the Assistant Secretary for Health. Originally composed of representatives designated by the heads of PHS agencies, it was expanded in 1995 by Secretary Shalala to encompass the Administration for Children and Families, the Administration on Aging, and the Health Care Financing Administration. Also represented are staff offices of the Office of Public Health and Science—the Office of Minority Health, the Office of Women's Health, the President's Council on Physical Fitness and Sports, and the Office of Population Affairs. The Office of the Assistant Secretary for Planning and Evaluation joined the Committee in 1997. The Office of Disease Prevention and Health Promotion has been designated by the Assistant Secretary for Health as the overall coordinator of this initiative. The Deputy Assistant Secretary for Health (Disease Prevention and Health Promotion) chairs the committee. At its quarterly meetings, the Steering Committee addresses policy issues and provides overall guidance to the departmental Healthy People 2000 activities. This Committee guided the 1995 midcourse revisions for the year 2000 objectives. It will continue its role for Healthy People 2010.

HEALTHY PEOPLE 2000 STEERING COMMITTEE

Chair

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Healthy People 2000 Homepage:
http://odphp.osophs.dhhs.gov/pubs/hp2000

To submit comments for Healthy People 2010:
http://web.health.gov/healthypeople

Healthy People Work Group Coordinators

The Assistant Secretary for Health has designated lead agencies in the PHS to be accountable for the achievement of the Healthy People 2000 targets. Lead agencies are assigned for each of the 22 Healthy People priority areas. The lead agency is responsible for monitoring, tracking, and reporting the Nation's progress on the objectives in its priority area. For some priority areas, there are two agencies acting as co-leads. PHS agency heads in turn have designated work group coordinators to assume the day-to-day responsibility for the objectives.

The work group coordinators participate in the quarterly Healthy People 2000 Steering Committee meetings and the annual Consortium meeting. They convene work groups to plan for briefings of the Assistant Secretary for Health and review documents, such as the annual statistical abstract, *Healthy People 2000 Review*, produced by the Centers for Disease Control and Prevention National Center for Health Statistics. Work group coordinators also participate in the planning and preparation of cross-cutting briefings on special population groups, including women, adolescents, people with disabilities, and racial and ethnic groups. Through the collaboration of work group coordinators, the Healthy People 2000 process is strengthened among HHS agencies. The following list of names is provided so that you may contact those people who will be leading the effort to develop the 2010 objectives.

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Co-Lead Agencies

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Co-Lead Agencies

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Lead Agencies

Co-Lead Agencies

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APPENDIX A

Consortium Members

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(Listed alphabetically by organization)

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State Mental Health Officials
State Substance Abuse Officials
State Environmental Officials
(Listed alphabetically by State and includes the name of the State Official)

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Washington, DC 20004-2037
Voice: 202-783-2242
Fax: 202-783-2255

American Association of Occupational Health Nurses
50 Lenox Pointe
Atlanta, GA 30324-3176
Voice: 404-262-1162
Fax: 404-262-1165

American Association of Pathologists' Assistants
803 Old Cedar Avenue South, Suite 225
Bloomington, MN 55425
Voice: 800-532-2272
Fax: 612-854-1402

American Association of Public Health Dentistry
10619 Jousting Lane
Richmond, VA 23235-3838
Voice: 804-272-8344
Fax: 804-272-0802

American Association of Public Health Physicians
515 North State Street
Chicago, IL 60610
Voice: 312-464-5000

American Association of Retired Persons
601 E Street, NW.
Washington, DC 20049
Voice: 202-434-2277
Fax: 202-434-2320

American Association of School Administrators
1801 North Moore Street
Arlington, VA 22209-9988
Voice: 703-875-0700
Fax: 703-528-2146

American Association of Suicidology
4201 Connecticut Avenue, NW., #310
Washington, DC 20008
Voice: 202-237-2280
Fax: 202-237-2282

American Association of University Affiliated Programs
8630 Fenton Street, Suite 410
Silver Spring, MD 20910
Voice: 301-588-8252
Fax: 301-588-2842

American Association on Mental Retardation
444 North Capitol Street, NW., Suite 846
Washington, DC 20001
Voice: 202-387-1968
Fax: 202-387-2193

American Cancer Society, Inc.
1599 Clifton Road, NE.
Atlanta, GA 30329
Voice: 404-329-7602
Fax: 404-329-7530

American College Health Association
P.O. Box 28937
Baltimore, MD 21240-8937
Voice: 410-859-1500
Fax: 410-859-1510

American College of Acupuncture
1021 Park Avenue
New York, NY 10028
Voice: 212-998-9922
Fax: 212-995-4081

American College of Cardiology
9111 Old Georgetown Road
Bethesda, MD 20814
Voice: 301-897-2691
Fax: 301-897-9745

American College of Clinical Pharmacy
3101 Broadway, Suite 380
Kansas City, MO 64111
Voice: 816-531-2177
Fax: 816-531-4990

American College of Emergency Physicians
P.O. Box 61911
Dallas, TX 75261-9911
Voice: 972-550-0911
Fax: 972-580-2816

American College of Gastroenterology
4900-B South 31th Street
Arlington, VA 22206-1656
Voice: 703-820-7400
Fax: 703-931-4520

American College of Health Care Administrators
325 South Patrick Street
Alexandria, VA 22314-3571
Voice: 703-739-7900
Fax: 703-739-7901

American College of Health Care Executives
One North Franklin, Suite 1700
Chicago, IL 60606-3491
Voice: 312-424-2800
Fax: 312-424-0023

American College of Nurse-Midwives
818 Connecticut Avenue, NW., Suite 900
Washington, DC 20006
Voice: 202-728-9860
Fax: 202-728-9897

American College of Nutrition
c/o Hospital for Joint Diseases
301 East 17th Street
New York, NY 10003
Voice: 313-777-1037
Fax: 313-777-1103

American College of Obstetricians and Gynecologists
409 12th Street, SW.
Washington, DC 20024
Voice: 202-863-2525
Fax: 202-863-1643

American College of Occupational and Environmental Medicine
55 West Seegers Road
Arlington Heights, IL 60005
Voice: 847-228-6850
Fax: 847-228-1856

American College of Physicians
Independence Mall West
Sixth Street at Race
Philadelphia, PA 19106-1572
Voice: 215-351-2800
Fax: 215-351-2829

American College of Preventive Medicine
1660 L Street, NW., Suite 206
Washington, DC 20036-5603
Voice: 202-466-2044
Fax: 202-466-2662

American College of Radiology
1891 Preston White Drive
Reston, VA 22091
Voice: 703-648-8900
Fax: 703-648-9176

American College of Sports Medicine
401 West Michigan Street
P.O. Box 1440
Indianapolis, IN 46206-1440
Voice: 317-637-9200
Fax: 317-634-7817

American Correctional Health Services Association
P.O. Box 2307
Dayton, OH 45401-2307
Voice: 937-586-3708
Fax: 937-586-3699

American Council on Alcoholism, Inc.
2522 St. Paul Street
Baltimore, MD 21218
Voice: 410-889-0100
Fax: 410-889-0297

American Council on Exercise
5820 Oberlin Drive, Suite 102
San Diego, CA 92121-3787
Voice: 619-535-8227
Fax: 619-535-1778

American Counseling Association
5999 Stevenson Avenue
Alexandria, VA 22304
Voice: 703-823-9800
Fax: 703-823-0252

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
Voice: 312-440-2500

American Dental Hygienists' Association
444 North Michigan Avenue, #3400
Chicago, IL 60611
Voice: 312-440-8900
Fax: 312-440-8929

American Diabetes Association
1660 Duke Street
Alexandria, VA 22314
Voice: 703-299-2067
Fax: 703-683-1839

American Dietetic Association
216 West Jackson Boulevard, Suite 800
Chicago, IL 60606-6995
Voice: 312-899-0040
Fax: 312-899-1758

American Federation of Teachers
555 New Jersey Avenue, NW.
Washington, DC 20001
Voice: 202-879-4440
Fax: 202-879-4545

American Geriatrics Society
770 Lexington Avenue, Suite 300
New York, NY 10021
Voice: 212-308-1414
Fax: 212-832-8646

American Heart Association
7272 Greenville Avenue
Dallas, TX 75231
Voice: 214-373-6300

American Highway Users Alliance
1776 Massachusetts Avenue, NW., Suite 500
Washington, DC 20036
Voice: 202-857-1200
Fax: 202-857-1220

American Hospital Association
One North Franklin
Chicago, IL 60606
Voice: 312-422-3000
Fax: 312-422-4576

American Indian Health Care Association
7050 West 120th Avenue, Suite 206A
Broomfield, CO 80020
Voice: 303-460-7420

American Institute for Preventive Medicine
30445 Northwestern Highway, Suite 350
Farmington Hills, MI 48334-3102
Voice: 810-539-1800
Fax: 810-539-1808

American Kinesitherapy Association
c/o The American Academy of PM&R
One IBM Plaza, Suite 2500
Chicago, IL 60611-3604
Voice: 800-296-AKTA
Fax: 312-464-0227

American Liver Foundation
1425 Pompton Avenue
Cedar Grove, NJ 07009
Voice: 201-256-2550
Fax: 201-256-3214

American Lung Association
1740 Broadway, 14th Floor
New York, NY 10019-4374
Voice: 212-315-8700
Fax: 212-315-8872

American Meat Institute
1700 North Moore Street, #1600
Arlington, VA 22209
Voice: 703-841-2400
Fax: 703-527-0938

American Medical Association
515 North State Street
Chicago, IL 60610
Voice: 312-464-5000

American Medical Student Association
1902 Association Drive
Reston, VA 20191
Voice: 703-620-6600
Fax: 703-620-5873

American Nurses Association
600 Maryland Avenue, SW., #100W
Washington, DC 20024-2571
Voice: 202-651-7000
Fax: 202-651-7001

American Occupational Therapy Association
4720 Montgomery Lane
Bethesda, MD 20824
Voice: 301-652-2682
Fax: 301-652-7711

American Optometric Association
1505 Prince Street, Suite 300
Alexandria, VA 22314
Voice: 703-739-9200
Fax: 703-739-9497

American Orthopaedic Society for Sports Medicine
6300 North River Road, Suite 200
Rosemont, IL 60018
Voice: 847-292-4900
Fax: 847-292-4905

American Osteopathic Academy of Sports Medicine
7611 Elmwood Avenue, Suite 201
Middleton, WI 53562
Voice: 608-831-4400
Fax: 608-831-5122

American Osteopathic Association
142 East Ontario Street
Chicago, IL 60611
Voice: 312-280-5800
Fax: 312-280-3860

American Osteopathic Healthcare Association
5550 Friendship Boulevard, Suite 300
Chevy Chase, MD 20815-7201
Voice: 301-968-2642
Fax: 301-968-4195

American Pharmaceutical Association
2215 Constitution Avenue, NW.
Washington, DC 20037
Voice: 202-628-4410
Fax: 202-783-2351

American Physical Therapy Association
1111 North Fairfax Street
Alexandria, VA 22314
Voice: 703-706-3252
Fax: 703-684-8519

American Podiatric Medical Association
9312 Old Georgetown Road
Bethesda, MD 20814-1698
Voice: 301-571-9200
Fax: 301-530-2752

American Psychiatric Association
1400 K Street, NW.
Washington, DC 20005
Voice: 202-682-6083
Fax: 202-682-6353

American Psychiatric Nurses Association
1200 19th Street, NW., Suite 300
Washington, DC 20036
Voice: 202-857-1133
Fax: 202-223-4579

American Psychological Association
750 First Street, NE.
Washington, DC 20002-4242
Voice: 202-336-5935
Fax: 202-336-6063

American Public Health Association
1015 15th Street, NW., Suite 300
Washington, DC 20005
Voice: 202-789-5600
Fax: 202-789-5661

American Red Cross
8111 Gatehouse Road
Falls Church, VA 22042-1203
Voice: 202-737-8300
Fax: 202-347-4486

American Rehabilitation Association
1910 Association Drive, Suite 200
Reston, VA 20191-1502
Voice: 703-648-9300
Fax: 703-648-0346

American Rehabilitation Counseling Association
5999 Stevenson Avenue
Alexandria, VA 22304
Voice: 703-823-9800
Fax: 703-823-0252

American Running and Fitness Association
4405 East-West Highway, Suite 405
Bethesda, MD 20814
Voice: 301-913-9517
Fax: 301-913-9520

American School Food Service Association
1600 Duke Street, 7th Floor
Alexandria, VA 22314
Voice: 703-739-3900
Fax: 703-739-3915

American School Health Association
National Office
7263 State Route 43
P.O. Box 708
Kent, OH 44240
Voice: 330-678-1601
Fax: 330-678-4526

American Social Health Association
P.O. Box 13827
Research Triangle Park, NC 27709
Voice: 919-361-8400
Fax: 919-361-8425

American Society for Clinical Nutrition
9650 Rockville Pike
Bethesda, MD 20814-3998
Voice: 301-571-7110
Fax: 301-571-1863

American Society for Gastrointestinal Endoscopy
13 Elm Street
Manchester, MA 01944
Voice: 508-526-8330
Fax: 508-526-4018

American Society for Microbiology
1325 Massachusetts Avenue, NW.
Washington, DC 20005
Voice: 202-737-3600
Fax: 202-942-9335

American Society for Nutritional Sciences
9650 Rockville Pike
Bethesda, MD 20814
Voice: 301-530-7050
Fax: 301-571-1892

American Society for Parenteral and Enteral Nutrition
8630 Fenton Street, Suite 412
Silver Spring, MD 20910
Voice: 301-587-6315
Fax: 301-587-2365

American Society for Pharmacology and Experimental Therapeutics
9650 Rockville Pike
Bethesda, MD 20814-3995
Voice: 301-530-7060
Fax: 301-530-7061

American Society of Addiction Medicine
4601 North Park Avenue, Suite 101
Chevy Chase, MD 20815
Voice: 301-656-3920
Fax: 301-656-3815

American Society of Health System Pharmacists
7272 Wisconsin Avenue
Bethesda, MD 20814
Voice: 301-657-3000
Fax: 301-657-1615

American Society of Human Genetics
9650 Rockville Pike
Bethesda, MD 20814-3998
Voice: 301-571-1825
Fax: 301-530-7079

American Society of Ocularists
493 Eighth Avenue
San Francisco, CA 94118
Voice: 415-221-5765

American Speech-Language-Hearing Association
10801 Rockville Pike
Rockville, MD 20852
Voice: 301-897-5700
Fax: 301-571-0457

American Spinal Injury Association
1333 Moursund Avenue
Houston, TX 77030
Voice: 713-797-5252
Fax: 713-797-5904

American Statistical Association
1429 Duke Street
Alexandria, VA 22314
Voice: 703-684-1221
Fax: 703-684-2037

American Thoracic Society
1740 Broadway
New York, NY 10019
Voice: 212-315-8700
Fax: 212-265-5642

American Trauma Society
8903 Presidential Parkway, #512
Upper Marlboro, MD 20772-2656
Voice: 800-556-7890
Fax: 301-420-0617

American Veterinary Medical Association
1931 North Meacham Road, Suite 100
Schaumburg, IL 60173-4360
Voice: 847-925-8070
Fax: 847-925-1329

Aquatic Exercise Association
820 Albee Road, Suite 9
Nokemis, FL 34275
Voice: 941-486-8600
Fax: 941-486-8820

Arthritis Foundation
1330 West Peachtree Street
Atlanta, GA 30309
Voice: 404-872-7100
Fax: 404-872-9559

Asian and Pacific Islander American Health Forum
116 New Montgomery, Suite 531
San Francisco, CA 94105
Voice: 415-541-0866
Fax: 415-541-0748

Asociacion Nacional Pro Personas Mayores
3325 Wilshire Boulevard, Suite 800
Los Angeles, CA 90010-1724
Voice: 213-487-1922
Fax: 213-385-3014

ASPO/Lamaze Association
1200 19th Street, NW., Suite 300
Washington, DC 20036-2422
Voice: 202-857-1128
Fax: 202-223-4579

Association for Applied Psychophysiology and Biofeedback
10200 West 44th Avenue, #304
Wheat Ridge, CO 80033
Voice: 303-422-8436
Fax: 303-422-8894

Association for Hospital Medical Education
1200 19th Street, NW., Suite 300
Washington, DC 20036-2422
Voice: 202-857-1196
Fax: 202-223-4579

Association for Professionals in Infection Control and Epidemiology
1016 16th Street, NW., 6th Floor
Washington, DC 20036-5703
Voice: 202-296-2742
Fax: 202-296-5645

Association for the Advancement of Automotive Medicine
2340 Des Plaines Avenue
Suite 106
Des Plaines, IL 60018
Voice: 847-390-8927
Fax: 847-390-9962

Association for the Care of Children
7910 Woodmont Avenue, Suite 300
Bethesda, MD 20814-3015
Voice: 301-654-6549
Fax: 301-986-4553

Association for Worksite Health Promotion
60 Revere Drive, #500
Northbrook, IL 60062
Voice: 847-480-9574
Fax: 847-480-9282

Association of Academic Health Centers
1400 16th Street, NW., Suite 720
Washington, DC 20036
Voice: 202-265-9600
Fax: 202-265-7514

Association of American Indian Physicians
1235 Sovereign Row, Suite C-7
Oklahoma City, OK 73108
Voice: 405-946-7072
Fax: 405-946-7651

Association of American Medical Colleges
2450 N Street, NW.
Washington, DC 20037
Voice: 202-828-0400
Fax: 202-828-1125

Association of Community Health Nurse Educators
4700 West Lake Avenue
Glenview, IL 60025-1485
Voice: 847-375-4717
Fax: 847-375-4777

Association of Food and Drug Officials
P.O. Box 3425
York, PA 17402
Voice: 717-757-2888
Fax: 717-755-8087

Association of Maternal and Child Health Programs
1350 Connecticut Avenue, NW., Suite 803
Washington, DC 20036
Voice: 202-775-0436
Fax: 202-775-0061

Association of Occupational and Environmental Clinics
1010 Vermont Avenue, NW., Suite 513
Washington, DC 20005
Voice: 202-347-4976
Fax: 202-347-4950

Association of Pediatric Oncology Nurses
4700 West Lake Avenue
Gleenview, IL 60025
Voice: 847-375-4724

Association of Rehabilitation Nurses
4700 West Lake Avenue
Glenview, IL 60025-1485
Voice: 847-375-4710
Fax: 847-375-4777

Association of Schools of Allied Health Professions
1730 M Street, NW., Suite 500
Washington, DC 20036
Voice: 202-293-4848
Fax: 202-293-4852

Association of Schools of Public Health
1660 L Street, NW., Suite 204
Washington, DC 20036-5603
Voice: 202-296-1099
Fax: 202-296-1252

Association of State and Territorial Chronic Disease Program Directors
1275 K Street, NW., Suite 800
Washington, DC 20005
Voice: 202-371-9090
Fax: 202-371-9797

Association of State and Territorial Dental Directors
Bureau of Dental Health
Missouri Department of Health
P.O. Box 570
Jefferson, MO 65102
Voice: 573-751-6247
Fax: 573-526-2753

Association of State and Territorial Directors of Health Promotion and Public Health Education
1015 15th Street, NW.
Washington, DC 20005
Voice: 202-289-6639
Fax: 202-408-9815

Association of State and Territorial Directors of Nursing
Kansas Department of Health and Environment
900 SW Jackson, Room 665
Topeka, KS 66611
Voice: 913-296-7100
Fax: 913-296-1231

Association of State and Territorial Health Officials
1275 K Street, NW., Suite 800
Washington, DC 20005
Voice: 202-371-9090
Fax: 202-371-9797

Association of State and Territorial Public Health Laboratory Directors
1211 Connecticut Avenue, NW., Suite 608
Washington, DC 20036
Voice: 802-863-7335
Fax: 802-863-7632

Association of State and Territorial Public Health Nutrition Directors
1275 K Street, NW., Suite 800
Washington, DC 20005
Voice: 202-789-1067
Fax: 202-789-1068

Association of State and Territorial Public Health Social Workers
Florida Department of Health
Division of Family Health
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Voice: 904-488-2834
Fax: 904-488-2341

Association of Teachers of Preventive Medicine
1660 L Street, NW., Suite 208
Washington, DC 20036
Voice: 202-463-0550
Fax: 202-463-0555

Association of Technical Personnel in Ophthalmology
2801 Lincoln Drive
Clarksville, IN 47129
Voice: 812-948-8897

Association of Women's Health, Obstetric, and Neonatal Nurses
700 14th Street, NW., Suite 600
Washington, DC 20005
Voice: 202-662-1600
Fax: 202-737-0575

Asthma and Allergy Foundation of America
1125 15th Street, NW., Suite 502
Washington, DC 20005
Voice: 202-466-7643
Fax: 202-466-8940

Black Congress on Health, Law, and Economics
1025 Vermont Avenue, NW., Suite 910
Washington, DC 20005
Voice: 202-347-2800

Blue Cross and Blue Shield Association
676 North Saint Clair Street
Chicago, IL 60611
Voice: 312-440-6012
Fax: 312-440-6120

Boy Scouts of America
1325 West Walnut Hill Lane
P.O. Box 152079
Irving, TX 75015-2079
Voice: 972-580-2000
Fax: 972-580-2502

Brain Injury Association, Inc.
1776 Massachusetts Avenue, N.W., #100
Washington, DC 20036
Voice: 202-296-6443
Fax: 202-296-8850

Business Roundtable
1615 L Street, NW., Suite 1100
Washington, DC 20036
Voice: 202-872-1260
Fax: 202-466-3509

Camp Fire
4601 Madison Avenue
Kansas City, MO 64112
Voice: 816-756-1950
Fax: 816-756-0258

Cardiovascular Credentialing International
4456 Corporation Lane, Suite 120
Virginia Beach, VA 23462
Voice: 804-497-3380
Fax: 804-497-3491

Catholic Health Association of the United States
4455 Woodson Road
St. Louis, MO 63134-3797
Voice: 314-427-2500
Fax: 314-427-0029

Center to Prevent Handgun Violence
1225 I Street, NW., Suite 1100
Washington, DC 20005
Voice: 202-289-7319
Fax: 202-898-0059

Chamber of Commerce of the United States of America
1615 H Street, NW.
Washington, DC 20062
Voice: 202-463-5300
Fax: 202-463-5327

Coalition for Consumer Health and Safety
1424 16th Street, NW., Suite 604
Washington, DC 20036
Voice: 202-387-6121
Fax: 202-265-7989

College of American Pathologists
325 Waukegan Road
Northfield, IL 60093-2750
Voice: 800-323-4040
Fax: 708-446-9182

Consortium of Social Science Associations
1522 K Street, NW., #836
Washington, DC 20005
Voice: 202-842-3525
Fax: 202-842-2788

Council for Responsible Nutrition
1300 19th Street, NW., Suite 310
Washington, DC 20036-1609
Voice: 202-872-1488
Fax: 202-872-9594

Council of Medical Specialty Societies
51 Sherwood Terrace, Suite Y
Lake Bluff, IL 60044-2232
Voice: 708-295-3456
Fax: 708-295-3759

Emergency Nurses Association
216 Higgins Road
Park Ridge, IL 60068
Voice: 847-698-9400
Fax: 847-698-9406

Employee Assistance Professionals Association
2101 Wilson Boulevard
Arlington, VA 22201
Voice: 703-522-6272
Fax: 703-522-4585

Environmental Council of the States
444 North Capitol Street, NW., Suite 517
Washington, DC 20001
Voice: 202-624-3660
Fax: 202-624-3666

Eye Bank Association of America
1001 Connecticut Avenue, NW., Suite 601
Washington, DC 20036-5504
Voice: 202-775-4999
Fax: 202-429-6036

Federation of American Societies for Experimental Biology
9650 Rockville Pike
Bethesda, MD 20814
Voice: 301-530-7000
Fax: 301-530-7191

Federation of Behavioral, Psychological, and Cognitive Sciences
750 First Street, NE., Suite 5004
Washington, DC 20002-4242
Voice: 202-336-5920
Fax: 202-336-5953

Food Marketing Institute
800 Connecticut Avenue, NW.
Washington, DC 20006
Voice: 202-452-8444
Fax: 202-429-4519

Future Homemakers of America
1910 Association Drive
Reston, VA 20191-1584
Voice: 703-476-4900
Fax: 703-860-2713

General Federation of Women's Clubs
1734 N Street, NW.
Washington, DC 20036-2990
Voice: 202-347-3168
Fax: 202-835-0246

Gerontological Society of America
1275 K Street, NW., #350
Washington, DC 20005-4006
Voice: 202-842-1275
Fax: 202-842-1150

Girl Scouts of the United States of America
420 Fifth Avenue, 15th Floor
New York, NY 10018-2798
Voice: 212-852-8000
Fax: 212-852-6515

Grocery Manufacturers of America
1010 Wisconsin Avenue, NW., #900
Washington, DC 20007
Voice: 202-337-9400
Fax: 202-337-4508

Health Industry Manufacturers Association
1200 G Street, NW., Suite 400
Washington, DC 20005
Voice: 202-783-8700
Fax: 202-783-8750

Health Insurance Association of America
555 13th Street, NW., Suite 600 E
Washington, DC 20004
Voice: 202-824-1600

Health Ministries Association
P.O. Box 7853
Huntington Beach, CA 92646
Voice: 800-852-5613
Fax: 216-742-2510

Health Sciences Communications Association
One Wedgewood Drive, Suite 28
Jewett City, CT 06351-2428
Voice: 860-376-5915
Fax: 860-376-6621

Healthier People Network
1549 Clairmont Road, #205
Decatur, GA 30033
Voice: 404-636-3127
Fax: 404-636-0105

Healthy Mothers, Healthy Babies
409 12th Street, SW.
Washington, DC 20024-2188
Voice: 202-863-2458
Fax: 202-554-4346

Institute for Child Health Policy
5700 SW. 34th Street, Suite 323
Gainesville, FL 32608-5367
Voice: 352-392-5904
Fax: 352-392-8822

Institute of Food Technologists
221 North LaSalle Street, #300
Chicago, IL 60601-1291
Voice: 312-782-8424
Fax: 312-782-8348

International Hearing Society
20361 Middlebelt Road
Livonia, MI 48152
Voice: 810-478-2610
Fax: 810-478-4520

International Lactation Consultant Association
4101 Lake Boone Trail, Suite 201
Raleigh, NC 27607
Voice: 919-787-5181
Fax: 919-787-4916

International Life Sciences Institute
1126 16th Street, NW., Suite 300
Washington, DC 20036
Voice: 202-659-0074
Fax: 202-659-3859

La Leche League International
1400 Meacham Road
P.O. Box 4079
Schaumburg, IL 60168-4079
Voice: 847-519-7730
Fax: 847-519-0035

Learning Disabilities Association of America
4156 Library Road
Pittsburgh, PA 15234
Voice: 412-341-1515
Fax: 412-344-0224

March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
Voice: 914-428-7100
Fax: 914-428-8203

Maternity Center Association
48 East 92nd Street
New York, NY 10128
Voice: 212-777-5000
Fax: 212-777-9320

Midwives Alliance of North America
P.O. Box 175
Newton, KS 67114-0175
Voice: 316-283-4543

Migrant Clinicians Network
P.O. Box 164285
Austin, TX 78716
Voice: 512-327-2017
Fax: 512-327-0719

Mothers Against Drunk Driving
511 East John Carpenter Freeway, #700
Irving, TX 75062
Voice: 972-744-6233
Fax: 972-869-2206

National 4H Council
7100 Connecticut Avenue
Chevy Chase, MD 20815
Voice: 301-961-2800
Fax: 301-961-2894

National AIDS Fund
1400 I Street, NW., Suite 1220
Washington, DC 20005
Voice: 202-408-4848
Fax: 202-408-1818

National PTA
2000 L Street, NW., Suite 600
Washington, DC 20036
Voice: 202-331-1380
Fax: 202-331-1406

National Alliance for the Mentally Ill
200 North Glebe Road, Suite 1015
Arlington, VA 22203-3754
Voice: 703-524-7600
Fax: 703-524-9094

National Alliance of Black School Educators
2816 Georgia Avenue, NW.
Washington, DC 20001
Voice: 202-483-1549
Fax: 202-483-8323

National Alliance of Nurse Practitioners
325 Pennsylvania Avenue, SE.
Washington, DC 20003
Voice: 202-675-6350

National Alliance of Senior Citizens
1744 Riggs Place, NW., 3rd Floor
Washington, DC 20009
Voice: 202-986-0117
Fax: 202-986-2974

National Asian Pacific American Families Against Substance Abuse
116 North San Pedro Street
Los Angeles, CA 90012-3805
Voice: 213-625-5795
Fax: 213-625-5796

National Association for Family and Community Education
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National Association for Home Care
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National Association for Human Development
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Voice: 202-328-2191
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National Association for Music Therapy
8455 Colesville Road, Suite 1000
Silver Spring, MD 20910-3319
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National Association for Public Health Statistics and Information Systems
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Kansas State Department of Health and Environment
900 SW Jackson, Room 152
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National Association for Public Worksite Health Promotion
c/o Maryland Department of Budget and Management
Office of Human Resources
301 West Preston Street, Suite 607
Baltimore, MD 21201
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National Association for Sport and Physical Education
1900 Association Drive
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National Association of Biology Teachers
11250 Roger Bacon Drive, #19
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Fax: 703-435-5582

National Association of Childbearing Centers
3121 Gottschall Road
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Fax: 215-234-8829

National Association of Children's Hospitals and Related Institutions
401 Wythe Street
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National Association of Community Health Centers
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National Association of Counties
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National Association of County and City Health Officials
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National Association of Elementary School Principals
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National Association of Governor's Councils on Physical Fitness and Sports
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National Association of Neighborhoods
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National Association of Neonatal Nurses
1304 South Point Boulevard, Suite 280
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National Association of Optometrists and Opticians, Inc.
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8650 Governor's Hill Drive
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National Association of Pediatric Nurse Associates and Practitioners
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National Association of RSVP Directors
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National Association of State School Nurse Consultants
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National Athletic Trainers' Association
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National Coalition Against Sexual Assault
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National Coalition of Hispanic Health and Human Services Organizations
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National League for Nursing
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National Minority Health Association
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Fax: 919-787-4916

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Fax: 202-785-8576

National Organization on Adolescent Pregnancy, Parenting and Prevention
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Washington, DC 20004
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Fax: (202) 783-5775

National Osteoporosis Foundation
1150 17th Street, NW., Suite 500
Washington, DC 20036-4603
Voice: 202-223-2226
Fax: 202-223-2237

National Pediculosis Association
P.O. Box 149
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Voice: 617-449-6487
Fax: 617-449-8129

National Pest Control Association
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Dunn Loring, VA 22027
Voice: 703-573-8330
Fax: 703-573-4116

National Recreation and Park Association
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Fax: 703-671-6772

National Restaurant Association
1200 17th Street, NW.
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Voice: 202-331-5900
Fax: 202-331-2429

National SAFE KIDS Campaign
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National Safety Council
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Fax: 630-285-9113

National School Boards Association
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National Strength and Conditioning Association
530 Communication Circle, Suite 204
Colorado Springs, CO 80905
Voice: 719-632-6722
Fax: 719-632-6367

National Stroke Association
96 Inverness Drive East, Suite I
Englewood, CO 80112-5112
Voice: 303-649-9299
Fax: 303-649-1328

National Wellness Institute, Inc.
1300 College Court
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Fax: 715-342-2979

National Women's Health Network
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Voice: 202-347-1140
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Network of Employers for Traffic Safety
1900 L Street, NW., Suite 705
Washington, DC 20036
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Fax: 202-223-7012

Nursing Network on Violence Against Women
Trauma Program UHN 66
Oregon Health Sciences University
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Portland, OR 97201
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Oncology Nursing Society
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Opticians Association of America
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Partnership for Prevention
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People's Medical Society
462 Walnut Street
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Fax: 610-770-0607

Pharmaceutical Researchers and Manufacturers of America
1100 15th Street, NW., Suite 900
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Physicians for a Violence-Free Society
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Planned Parenthood Federation of America
810 Seventh Avenue
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Poison Prevention Week Council
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Population Association of America
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Prevent Blindness America
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Produce for Better Health Foundation
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Produce Marketing Association
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Road Runners Club of America
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Salt Institute
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Sexuality Information and Education Council of the U.S.
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Society for Academic Emergency Medicine
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Fax: 517-485-0801

Society for Adolescent Medicine
1916 NW Copper Oaks Circle
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Society for Healthcare Strategy and Market Development
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Society for Hospital Epidemiology of America
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Society for Nutrition Education
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Society for Public Health Education
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Society of Behavioral Medicine
201 East Jefferson, Suite 205
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Society of General Internal Medicine
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Society of Prospective Medicine
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Society of State Directors of Health, Physical Education and Recreation
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The International Health, Racquet and Sportsclub Association
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The Sugar Association, Inc
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The United States Conference of Mayors
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Fax: 202-293-2352

Think First Foundation
22 South Washington Street
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Unitarian Universalist Seventh Principle Project
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1300 Evans Street
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United States Eye Injury Registry
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Visiting Nurse Association of America
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Voluntary Hospitals of America, Inc.
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Women's Sports Foundation
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Wound, Ostomy, and Continence Nurses Society
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APPENDIX B

Summary List Of Year 2000 Objectives

This listing of objectives reflects the 1995 Midcourse Revisions which added 19 new objectives and 111 special population targets. The language of many objectives was also revised in 1995 to make them measurable and more understandable. The year 2000 targets of some objectives that had already been met were made more challenging. Because new baseline data have become available or baselines have been modified, this summary list is current as of June 1997. *Current tracking data are available in Healthy People Review,* available from CDC/National Center for Health Statistics (see Appendix C for more information).

* Duplicate objectives which appear in two or more priority areas are marked with an asterisk alongside the objective number.

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	168	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 12–19. (Baseline: 26 percent for people aged 20–74 in 1976–80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12–19 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%
1.2h	Mexican-American men	30%‡	25%

†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 derived from self-reported height and weight

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 12–14, 24.3 for males aged 15–17, 25.8 for males aged 18–19, 23.4 for females aged 12–14, 24.8 for females aged 15–17, and 25.7 for females aged 18–19. The values for adults are the gender-specific 85th percentile values of the 1976–80 National Health and Nutrition Examination Survey (NHANES II), reference population 20–29 years of age. For adolescents, overweight was defined using BMI cutoffs based on modified age- and gender-specific 85th percentile values of the NHANES II. 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 16 percent were active 7 or more times per week in 1985)

Special Population Target

	Moderate Physical Activity	*1991 Baseline*	*2000 Target*
1.3a	Hispanics aged 18 and older 5 or more times per week	20%	25%

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 6–17 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 10–17 in 1984)

Special Population Targets

	Vigorous Physical Activity	*1985 Baseline*	*2000 Target*
1.4a	Lower-income people aged 18 and older (annual family income <$20,000)	7%	12%
		1991 Baseline	*2000 Target*
1.4b	Blacks aged 18 and older	12.8%	17%
1.4c	Hispanics aged 18 years	13.6%	17%

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%
		1991 Baseline	*2000 Target*
1.5d	Blacks aged 18 and older	28%	20%
1.5e	Hispanics aged 18 and older	34%	25%
1.5f	American Indians/Alaska Natives	29%	21%

†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 unavailable)

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)

Special Population Targets

	Adoption of Weight-Loss Practices	*1991 Baseline*	*2000 Target*
1.7a	Overweight Hispanic males aged 18 and older	15%	24%
1.7b	Overweight Hispanic females aged 18 and older	13%	22%

Services and Protection Objectives

1.8 Increase to at least 50 percent the proportion of children and adolescents in 1st–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)

1995 Addition

Health Status Objective

1.13* 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 Targets

	Difficulty Performing Self Care (per 1,000)	*1984–85 Baseline*	*2000 Target*
1.13a	People aged 85 and older	371	325
1.13b	Blacks aged 65 and older	132	98

Note: Personal care activities are bathing, dressing, using the toilet, getting in and out of bed or chair, and eating.

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	168	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: 134 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 health status objective differ from those presented here.

		Special Population Target	
	Cancer Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
2.2a	Blacks	182	175

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 12–19. (Baseline: 26 percent for people aged 20–74 in 1976–80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12–19 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%
2.3h	Mexican-American men	30%‡	25%

†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 derived from self-reported height and weight

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 12–14, 24.3 for males aged 15–17, 25.8 for males aged 18–19, 23.4 for females aged 12–14, 24.8 for females aged 15–17, and 25.7 for females aged 18–19.

The values for adults are the gender-specific 85th percentile values of the 1976–80 National Health and Nutrition Examination Survey (NHANES II), reference population 20–29 years of age. For adolescents, overweight was defined using BMI cutoffs based on modified age- and gender-specific 85th percentile values of the NHANES II. 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: 11 percent among low-income children aged 5 and younger in 1988.)

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 derived from the 1971–74 NHANES.

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: for people aged 2 and older: 36 percent of calories from total fat and 13 percent of calories from saturated fat based on 1-day dietary data from the 1976–80 NHANES II; 34 percent of calories from total fat and 12 percent from saturated fat based on 1-day dietary data from the 1989–91 Continuing Survey of Food Intakes by Individuals [CSFII]). In addition, increase to at least 50 percent the proportion of people aged 2 and older who meet the *Dietary Guidelines*' average daily goal of no more than 30 percent of calories from fat, and increase to at least 50 percent the proportion of people aged 2 and older who meet the average daily goal of less than 10 percent of calories from saturated fat. (Baseline for people aged 2 and older: 27 percent met the goal for fat and 29 percent met the goal for saturated fat based on 2-day dietary data from the 1988–94 NHANES; 22 percent met the goal for fat and 21 percent met the goal for saturated fat based on the 3-day dietary data from 1989–91 CSFII)

2.6* Increase complex carbohydrate and fiber-containing foods in the diets of people aged 2 and older to an average of 5 or more daily servings for vegetables (including legumes) and fruits, and to an average of 6 or more daily servings for grain products. (Baseline: 4.1 servings of vegetables and fruits and 5.8 servings of grain products for people aged 2 and older based on 3-day dietary data from the 1989–91 CSFII). In addition, increase to at least 50 percent the proportion of people aged 2

and older who meet the *Dietary Guidelines*' average daily goal of 5 or more servings of vegetables/fruits, and increase to at least 50 percent the proportion who meet the goal of 6 or more servings of grain products. (Baseline: 29 percent met the goal for fruits and vegetables, and 40 percent met the goal for grain products for people aged 2 and older based on 3-day dietary data in the 1989–91 CSFII)

Note: The definition of vegetables, fruits, and grain products and serving size designations are derived from The Food Guide Pyramid. *Vegetable, fruit, and grain ingredients from mixtures are included in the total, and fractions of servings are counted.*

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)

Special Population Targets

	Adoption of Weight-Loss Practices	*1991 Baseline*	*2000 Target*
2.7a	Overweight Hispanic males aged 18 and older	15%	24%
2.7b	Overweight Hispanic females aged 18 and older	13%	22%

2.8 Increase calcium intake so at least 50 percent of people aged 11–24 and 50 percent of pregnant and lactating women consume an average of 3 or more daily servings of foods rich in calcium, and at least 75 percent of children aged 2–10 and 50 percent of people aged 25 and older consume an average of 2 or more servings daily. (Baseline: 20 percent of people 11–24; 22 percent of pregnant and lactating women consumed an average of 3 or more servings; 48 percent of children aged 2–10 and 21 percent of people aged 25 and older who were not pregnant or lactating consumed an average of 2 or more servings based on 3-day dietary data from the 1989–91 CSFII)

Special Population Target

	Percent Meeting Goal	*1989–91 Baseline*	*2000 Target*
2.8a	Females aged 11–24	13%	50%

Note: Calcium-rich foods are defined for this purpose as milk and milk products, and the recommended number of servings and the age groupings are based on The Food Guide Pyramid *and on the National Research Council's Recommended Dietary Allowance (RDA) for calcium, respectively. Milk and milk product ingredients in mixtures are included, and fractions of servings are counted.*

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: 43 percent of main meal preparers did not use salt in food preparation based on the 1989–90 CSFII, and 60 percent of individuals never or rarely used salt at the table based on the 1989–91 CSFII; 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 1–4 and among women of childbearing age. (Baseline: 9 percent for children aged 1–2, 4 percent for children aged 3–4, and 5 percent for women aged 20–44 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 5–6 months old. (Baseline: 54 percent during early postpartum and 20 percent who are still breastfeeding at 5–6 months in 1988)

Special Population Targets

	Mothers Breastfeeding Their Babies During Early Postpartum Period:	*1988 Baseline*	*2000 Target*
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:	*1988 Baseline*	*2000 Target*
2.11a	Low-income mothers	9%	50%
2.11b	Black mothers	7%	50%
2.11c	Hispanic mothers	14%	50%
2.11d	American Indian/ Alaska Native mothers	28%	50%

Note: The definition used for breastfeeding includes exclusive use of human milk or the use of human milk with a supplemental bottle of formula or cow's milk.

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: 55 percent for parents and caregivers of children 6–23 months in 1991)

Special Population Targets

	Appropriate Feeding Practices	*1991 Baseline*	*2000 Target*
2.12a	Parents and caregivers with less than high school education	36%	65%
2.12b	American Indian/Alaska Native parents and caregivers	74%§	65%
2.12c	Black parents and caregivers	48%	65%
2.12d	Hispanic parents and caregivers	39%	65%

§1985–89 data in four IHS Service Areas in a pilot project

* *Note: Percentage of parents and caregivers of children 6–23 months. Appropriate feeding practices are that the child no longer uses a bottle, or if the child still uses a bottle that no bottle was given at bedtime, excluding bottles with plain water, during the past 2 weeks.*

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 of people aged 18 and older 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 ready-to-eat carry-away foods. Achieve compliance by at least 90 percent of retailers with the voluntary labeling of fresh meats, poultry, seafood, fruits, and vegetables. (Baseline: 60 percent of sales of processed foods regulated by FDA had nutrition labeling in 1988; less than 1 percent and 0 percent compliance by retailers for fresh produce and fresh seafood respectively based on the 1991 FDA Survey on Labeling of Raw Produce and Raw Fish; 67 percent for fresh meat and poultry in 1995; baseline data on carry-away foods are 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: 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: 1 percent of schools offered lunches that provided an average of 30 percent or less of calories from total fat, and less than 1 percent offered lunches that provided an average of less than 10 percent of calories from saturated fat based on the 1992 School Nutrition Dietary Assessment Study. Of the schools participating in the USDA school breakfast program, 44 percent offered breakfasts that provided an average of 30 percent or less of calories from total fat, and 4 percent offered breakfasts that provided an average of less than 10 percent of calories from saturated fat in 1992)

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: 7 percent in 1991)

2.19 Increase to at least 75 percent the proportion of the Nation's schools that provide nutrition education from preschool–12th grade, preferably as part of comprehensive school health education. (Baseline: 60 percent in 1990)

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)

1995 Additions

Health Status Objectives

2.22* Reduce stroke deaths to no more than 20 per 100,000 people. (Age-adjusted baseline: 30.4 per 100,000 in 1987)

		Special Population Target	
	Stroke Deaths (per 100,000)	*1987 Baseline*	*2000 Target*
2.22a	Blacks	52.5	27

2.23* Reduce colorectal cancer deaths to no more than 13.2 per 100,000 people. (Age-adjusted baseline 14.7 per 100,000 in 1987)

		Special Population Target	
		1990 Baseline	*2000 Target*
2.23a	Blacks	18.1	16.5

2.24* 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 1986–88; 28 per 1,000 in 1986–88)

Special Population Targets

	Prevalence of Diabetes (per 1,000)	*1982–84 Baseline*[†]	*2000 Target*
2.24a	American Indians/Alaska Natives	69[‡]	62
2.24b	Puerto Ricans	55	49
2.24c	Mexican Americans	54	49
2.24d	Cuban Americans	36	32
2.24e	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

2.25[*] 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 20–74 in 1976–80, 29 percent for women and 25 percent for men)

2.26[*] 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 18–74 in 1976–80)

Special Population Targets

	High Blood Pressure Control	*1976–80 Baseline*	*2000 Target*
2.26a	Men with high blood pressure	6%	40%
		1988–91 Baseline	*2000 Target*
2.26b	Mexican Americans with high blood pressure	14%	50%
2.26c	Women aged 70 and older	19%	50%

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. Control of hypertension does not include nonpharmacologic treatment.

2.27[*] Reduce the mean serum cholesterol level among adults to no more than 200 mg/dL. (Baseline: 213 mg/dL among people aged 20–74 in 1976–80, 211 mg/dL for men and 215 mg/dL for women)

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	168	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: 38.5 per 100,000 in 1987)

Special Population Targets

	Lung Cancer Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
3.2a	Females	25.6	27
3.2b	Black males	86.1	91

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 health status objective differ from those presented here.

3.3 Slow the rise in deaths for the total population from chronic obstructive pulmonary disease to achieve a rate of no more than 25 per 100,000 people. (Age-adjusted baseline: 18.9 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.

3.4* Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 18 and older. (Baseline: 29 percent in 1987, 31 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 18 and older	41%	20%
3.4c	Military personnel	42%†	20%
3.4d	Blacks aged 18 and older	33%	18%
3.4e	Hispanics aged 18 and older	24%	15%
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 ‡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. Since 1992, estimates include some-day (intermittent) smokers.

Risk Reduction Objectives

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 20–24 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 1 day during the preceding year. (Baseline: In 1986, 34 percent of people who smoked in the preceding year stopped for at least 1 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 20–44 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 12–24 to a prevalence of no more than 4 percent. (Baseline: 6.6 percent among males aged 12–17 in 1988; 8.9 percent among males aged 18–24 in 1987)

Special Population Target

	Smokeless Tobacco Use	*1986–87 Baseline*	*2000 Target*
3.9a	American Indian/Alaska Natives aged 18–24	18–64%	10%

Note: For males aged 12–17, a smokeless tobacco user is someone who has used snuff or chewing tobacco in the preceding month. For males aged 18–24, 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 comprehensive school health education. (Baseline: 17 percent of school districts totally banned smoking on school premises or at school functions in 1988; anti-smoking 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 100 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 and the District of Columbia comprehensive laws on clean indoor air that prohibit smoking or limit it to separately ventilated areas in the work-place and enclosed public places. (Baseline: 1 State regulated private workplaces; 9 States regulated public workplaces, including those that banned smoking through Executive Orders; 2 States regulated restaurants; 16 States and the District of Columbia regulated public transportation; 8 States regulated hospitals; 21 States regulated day care centers; and 4 States regulated grocery stores with comprehensive laws as of January 1995)

3.13 Enact in 50 States and the District of Columbia laws prohibiting the sale and distribution of tobacco products to youth younger than age 18. Enforce these laws so that the buy rate in compliance checks conducted in all 50 States and the District of Columbia is no higher than 20 percent. (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. Baseline and followup data on enforcement will be provided in State reports to the Substance Abuse and Mental Health Services Administration as a part of compliance with the Synar amendment.)

Note: In July 1992, the President signed Public Law 102-321, the reorganization of the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act, which included the "Synar Amendment." The new law requires all 50 States and the District of Columbia to ban the sale and distribution of tobacco products to everyone under the age of 18. It also required States to enforce their law "in a manner that can be reasonably be expected to reduce the extent to which tobacco products are available to underage youths" or risk the loss of a percentage of Federal Substance Abuse Prevention and Treatment Block Grants.

Although all States have enacted youth access laws, enforcement is variable. Therefore, this objective will separately report on the enactment and enforcement of youth access laws. Enforcement will be measured based on HHS regulations implementing the amendment.

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

3.14 Establish in 50 States and the District of Columbia 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 and 63 percent of primary care providers 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)

1995 Additions

Health Status Objectives

3.17* Reduce deaths due to cancer of the oral cavity and pharynx to no more than 10.5 per 100,000 men aged 45–74 and 4.1 per 100,000 women aged 45–74. (Baseline: 13.6 per 100,000 men and 4.8 per 100,000 women in 1987)

		Special Population Target	
		1990 Baseline	*2000 Target*
3.17a	Black males aged 45-74	29.4	26.0
3.17b	Black females aged 45-74	6.9	6.9

3.18* Reduce stroke deaths to no more than 20 per 100,000 people (Age-adjusted baseline: 30.4 per 100,000 in 1987)

		Special Population Target	
	Stroke Deaths (per 100,000)	*1987 Baseline*	*2000 Target*
3.18a	Blacks	52.5	27.0

Risk Reduction Objectives

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

3.20* Reduce the proportion of young people who have used alcohol, marijuana, cocaine, or cigarettes 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%	29.0%
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%

Use in past month	*1991 Baseline*	*2000 Target*
Alcohol		
Hispanic 12–17 years	22.5%	12.0%
Cocaine		
Hispanic 12–17 years	1.3%	0.6%
Hispanic 18–25 years	2.7%	1.0%
Cigarettes		
12–17 years	10.8%	6.0%

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.

3.21* Increase the proportion of high school seniors who perceive social disapproval of heavy use of alcohol, occasional use of marijuana, experimentation with cocaine, or regular use of tobacco, 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 five or more drinks once or twice each weekend.

Behavior	*1987 Baseline*	*2000 Target*
Smoking one or more pack of cigarettes per day	74.2%	95%

Note: The Monitoring the Future Survey defines regular use of cigarettes as smoking one or more packs daily.

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

Behavior	*1989 Baseline*	*2000 Target*
Heavy use of alcohol	44.0%	70%
Regular use of marijuana	77.5%	90%
Trying cocaine once or twice	54.9%	80%

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

Behavior	*1987 Baseline*	*2000 Target*
Smoking one or more packs of cigarettes per day	68.6%	95%
Using smokeless tobacco regularly	37.4%	95%

Note: The Monitoring the Future Survey defines regular use of cigarettes as smoking one or more packs daily.

Services and Protection Objectives

3.23 Increase the average (State and Federal combined) tobacco excise tax to at least 50 percent of the average retail price of all cigarettes and smokeless tobacco.

Tax as a Percent of Retail Price (State and Federal)	*1993 Baseline*	*2000 Target*
Cigarettes	31.4%	50%
Smokeless Tobacco	11.8%	50%

3.24 Increase to 100 percent the proportion of health plans that offer treatment of nicotine addiction (e.g., tobacco use cessation counseling by health care providers, tobacco use cessation classes, prescriptions for nicotine replacement therapies, and/or other cessation services). (Baseline: 11 percent of health plans cover treatment for nicotine addiction in 1985)

3.25* Reduce to zero the number of States that have clean indoor air laws preempting stronger clean indoor air laws on the local level. (Baseline: 17 States had preemptive clean indoor air laws as of January 1995)

3.26 Enact in 50 States and the District of Columbia laws banning cigarette vending machines except in places inaccessible to minors. (Baseline: 11 States and the District of Columbia as of January 1995)

Substance Abuse: Alcohol and Other Drugs

Health Status Objectives

4.1* Reduce deaths caused by alcohol-related motor vehicle crashes to no more than 5.5 per 100,000 people. (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	40.4	35.0
4.1b	People aged 15–24	21.5	12.5

4.2 Reduce cirrhosis deaths to no more than 6 per 100,000 people. (Age-adjusted baseline: 9.2 per 100,000 in 1987)

Special Population Targets

	Cirrhosis Deaths (per 100,000)	*1987 Baseline*	*2000 Target*
4.2a	Black men	22.6	12
4.2b	American Indians/Alaska Natives	20.5	10
		1990 Baseline	*2000 Target*
4.2c	Hispanics	14.2	10

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)

Special Population Targets

	Drug-Related Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
4.3a	Blacks	5.7	3
4.3b	Hispanics	4.3	3

4.4 Reduce drug abuse-related hospital emergency department visits by at least 20 percent. (Baseline: 175.8 per 100,000 people 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 12–17. (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, cocaine, or cigarettes 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%	29.0%
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%

Use in Past Month	*1991 Baseline*	*2000 Target*
Alcohol		
Hispanic 12–17 years	22.5%	12.0%
Cocaine		
Hispanic 12–17 years	1.3%	0.6%
Hispanic 18–25 years	2.7%	1.0%
Cigarettes		
12–17 years	10.8%	6.0%

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 five 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 of heavy use of alcohol, occasional use of marijuana, and experimentation with cocaine, or regular use of tobacco, 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 five or more drinks once or twice each weekend.

Behavior	*1987 Baseline*	*2000 Target*
Smoking one or more pack of cigarettes per day	74.2%	95%

Note: The Monitoring the Future Survey defines regular use of cigarettes as smoking one or more packs daily.

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

Behavior	*1989 Baseline*	*2000 Target*
Heavy use of alcohol	44.0%	70%
Regular use of marijuana	77.5%	90%
Trying cocaine once or twice	54.9%	80%

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

Behavior	*1987 Baseline*	*2000 Target*
Smoking one or more packs of cigarettes per day	68.6%	95%
Using smokeless tobacco regularly	30.0%	95%

Note: The Monitoring the Future Survey defines regular use of cigarettes as smoking one or more packs daily.

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 unavailable)

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 comprehensive 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: 88 percent of worksites had adopted alcohol policies; 89 percent of worksites had adopted drug policies in 1992)

4.15 Extend to 50 States and the District of Columbia 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. (Baseline data unavailable)

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 unavailable)

4.18 Extend to 50 States legal blood alcohol concentration tolerance levels of .08 percent for motor vehicle drivers aged 21 and older and zero tolerance (.02 percent and lower) for those younger than age 21. (Baseline: 7 States with .08 BAC laws and 9 States with zero tolerance laws in 1993)

Note: The legal blood alcohol concentration tolerance level for adults was revised to be consistent with the goals established by the National Highway Traffic Safety Administration.

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: 19–63 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing services to patients in 1992)

1995 Addition

Services and Protection Objective

4.20 Increase to 30 the number of States with Hospitality Resource Panels (including representatives from State regulatory, public health, and highway safety agencies, law enforcement, insurance associations, alcohol retail and licensed beverage associations) to ensure a process of management and server training and define standards of responsible hospitality. (Baseline: 8 States in 1994)

Family Planning

Health Status Objectives

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

Special Population Targets

	Pregnancies (per 1,000)	*1985 Baseline*	*2000 Target*
5.1a	Black adolescent females aged 15–19	169	120
5.1b	Hispanic adolescent females aged 15–19	143	105

Note: For black and Hispanic adolescent females, baseline data are unavailable for those aged 15–17. The targets for these two populations are based on data for females aged 15–19. 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 Targets

	Unintended Pregnancies	*1988 Baseline*	*2000 Target*
5.2a	Black females	78.0%	40%
5.2b	Hispanic females	54.9%	30%

5.3 Reduce the prevalence of infertility to no more than 6.5 percent. (Baseline: 7.9 percent of married couples with wives aged 15–44 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 females and 33 percent of males by age 15; 50 percent of females and 66 percent of males by age 17; reported in 1988)

Special Population Targets

	Adolescents Engaged in Sexual Intercourse	*1988 Baseline*	*2000 Target*
5.4a	Black males aged 15	69%	15%
5.4b	Black males aged 17	90%	40%
5.4c	Black females aged 17	66%	40%

5.5* Increase to at least 40 percent the proportion of ever sexually active adolescents aged 17 and younger who have not had sexual intercourse during the previous 3 months. (Baseline: 23.6 percent of sexually active females aged 15–17 in 1988 and 33 percent of sexually active males aged 15–17 in 1988)

5.6 Increase to at least 90 percent the proportion of sexually active, unmarried people aged 15–24 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 15–19 in 1988)

5.7 Increase the effectiveness with which family planning methods are used, as measured by a decrease to no more than 7 percent in the proportion of women experiencing pregnancy despite use of a contraceptive method. (Baseline: Approximately 14 percent of women using reversible contraceptive methods experienced an unintended pregnancy in 1988)

Special Population Targets

	Percent of Users Who Became Pregnant In the Last Year	*1988 Baseline*	*2000 Target*
5.7a	Black females	17.6%	8%
5.7b	Hispanic females	16.4%	8%

Services and Protection Objectives

5.8 Increase to at least 85 percent the proportion of people aged 10–18 who have discussed human sexuality, including correct anatomical names, sexual abuse, and 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 13–18 have discussed sexuality with their parents; reported in 1986)

5.9 Increase to at least 90 percent the proportion of family planning counselors who offer accurate information about all options, including prenatal care and delivery, infant care, foster care, or adoption and pregnancy termination to their patients with unintended pregnancies. (Baseline: 60 percent in 1984)

5.10* Increase to at least 60 percent the proportion of primary care providers who provide age-appropriate preconception care and counseling. (Baseline: 18–65 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing services to patients 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 provide on site primary prevention and provide or refer for secondary prevention services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia) to high-risk individuals and their sex or needle-sharing partners. (Baseline: 40 percent of family planning clinics for bacterial sexually transmitted diseases in 1989)

1995 Addition

Risk Reduction Objective

5.12 Increase to at least 95 percent the proportion of all females aged 15–44 at risk of unintended pregnancy who use contraception. (Baseline: 88.2 percent of all females aged 15–44 in 1982)

		Special Population Targets		
	Percent Using Contraception Among Females Aged 15–44 at Risk of Unintended Pregnancy	*1982 Baseline*	*1988*	*2000 Target*
5.12a	Black females	78.9%	84.7%	95%
5.12b	Females with income less than 100 percent of poverty	79.6%	80.2%	95%
5.12c	Females aged 15–19 under 200 percent poverty	67.4%	74.9%	95%

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	10.2	8.2
6.1b	Men aged 20–34	25.2	21.4
6.1c	White men aged 65 and older	46.7	39.2
6.1d	American Indian/ Alaska Native men	20.1	17.0

6.2* Reduce to 1.8 percent the incidence of injurious suicide attempts among adolescents aged 14–17. (Baseline: 2.1 percent in 1990)

Special Population Target

	Injurious Suicide Attempts	*1991 Baseline*	*2000 Target*
6.2a	Female adolescents aged 14–17	2.5	2.0

Note: Data are limited to those suicide attempts that result in hospitalization and are based on self-reports.

6.3 Reduce to less than 17 percent the prevalence of mental disorders among children and adolescents. (Baseline: An estimated 20 percent among youth younger than age 18 in 1992)

Note: The baseline has been revised based on Bird, H.R., et al., Estimates of the Prevalence of Childhood Maladjustment in a Community Survey in Puerto Rico, 1988, and Costello, E.J., et al., "Psychiatric Disorders in Pediatric Primary Care: Prevalence Risk Factors," 1988; in Archives of General Psychiatry, *Vol. 45. The ongoing data source will be the Multi-site Study of Service, Use, Need, Outcomes and Costs for Child and Adolescent Populations (UNO-CAP), NIH. The baseline revision has resulted in a year 2000 target revision.*

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: 1-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 report adverse health effects from stress within the past year. (Baseline: 44.2 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 54 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: 24 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: 2 States 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 a network to facilitate access to mutual self-help activities, resources, and information by people and their family members who are experiencing emotional distress resulting from mental or physical illness. (Baseline: 2 Federal and 8 State clearinghouses in 1995)

6.13 Increase to at least 60 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: 7–40 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing services to patients 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: 24–62 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, and family physicians reported rountinely providing services to patients in 1992)

1995 Addition

Health Status Objective

6.15 Reduce the prevalence of depressive (affective) disorders among adults living in the community to less than 4.3 percent. (Baseline: 1 month prevalence of 5.1 percent in 1984)

		Special Population Target	
	Depressive Disorders	*1991 Baseline*	*2000 Target*
6.15a	Women	6.6%	5.5%

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	91.1	72.4
7.1d	Hispanic men aged 15–34	41.3	33.0
7.1e	Black women aged 15–34	20.2	16.0
7.1f	American Indians/Alaska Natives	11.2	9.0

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	10.2	8.2
7.2b	Men aged 20–34	25.2	21.4
7.2c	White men aged 65 and older	46.7	39.2
7.2d	American Indian/Alaska Native men	20.1	17.0

7.3 Reduce firearm-related deaths to no more than 11.6 per 100,000 people from major causes. (Baseline: 14.6 firearm-related deaths in 1990)

Special Population Target

	Firearm-Related Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
7.3a	Blacks	33.4	30.0

7.4 Reverse to less than 22.6 per 1,000 children the rising incidence of maltreatment of children younger than age 18. (Baseline: 22.6 per 1,000 in 1986)

Type-Specific Targets

	Incidence of Types of Maltreatment (per 1,000)	*1986 Baseline*	*2000 Target*
7.4a	Physical abuse	4.9	<4.9
7.4b	Sexual abuse	2.1	<2.1
7.4c	Emotional abuse	3.0	<3.0
7.4d	Neglect	14.6	<14.6

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 8.7 per 1,000 people. (Baseline: 9.7 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 to 1.8 percent the incidence of injurious suicide attempts among adolescents aged 14–17. (Baseline: 2.1 percent in 1991)

Special Population Target

	Injurious Suicide Attempts	*1986 Baseline*	*2000 Target*
7.8a	Female Adolescents aged 14–17	2.5%	2.0%

Note: Data are limited to those suicide attempts that result in hospitalization and are based on self-reports.

Risk Reduction Objectives

7.9 Reduce to 110 per 100 the incidence of physical fighting among adolescents aged 14–17. (Baseline: 137 incidents per 100 high school students per month in 1991)

Special Population Target

	Adolescent Physical Fighting (per 100)	*1991 Baseline*	*2000 Target*
7.9a	Black males	207	160

7.10 Reduce to 86 per 100 the incidence of weapon-carrying by adolescents aged 14–17. (Baseline: 107 incidents per 100 high school students per month in 1991)

Special Population Target

	Adolescent Weapon-Carrying (per 100)	*1991 Baseline*	*2000 Target*
7.10a	Blacks	134	105

7.11 Reduce by 20 percent the proportion of people who possess weapons that are inappropriately stored and therefore dangerously available. (Baseline: 20 percent in 1994)

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 unavailable)

7.13 Extend to at least 45 States implementation of unexplained child death review systems. (Baseline: 33 States 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: 58.3 percent in 1994)

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 comprehensive school health education. (Baseline: 58.3 percent in 1994)

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

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: 2 States in 1992)

1995 Addition

Services and Protection Objective

7.19* Enact in 50 States and the District of Columbia laws requiring that firearms be properly stored to minimize access and the likelihood of discharge by minors. (Baseline: 1 State in 1989)

Educational and Community-Based Programs

Health Status Objectives

8.1* Increase years of healthy life to at least 65 years. (Baseline: An estimated 64 years in 1990)

Special Population Targets

	Years of Healthy Life	*1990 Baseline*	*2000 Target*
8.1a	Blacks	56.0	60
8.1b	Hispanics	64.8	65
8.1c	People aged 65 and older	11.9†	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.

Risk Reduction Objectives

8.2 Increase the high school completion rate to at least 90 percent, thereby reducing risks for multiple problem behaviors and poor mental and physical health. (Baseline: 87 percent of adults aged 19–20 in 1992)

Note: This objective and its target are consistent with the National Education Goal to increase high school graduation rates. The National Education Goal, the same measure and data source, is used to track this objective.

Special Population Targets

	Completion of High School	*1992 Baseline*	*2000 Target*
8.2a	Hispanics	65%	90%
8.2b	Blacks	81%	90%

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.

8.4 Increase to at least 75 percent the proportion of the Nation's elementary and secondary schools that provide planned and sequential kindergarten–12th grade comprehensive school health education. (Baseline: 11 percent met five essential criteria; 2.3 percent met all eight criteria; 31-77 percent of schools met one criteria in 1994)

8.5 Increase to at least 50 percent the proportion of postsecondary institutions with institution-wide 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: 21 percent of blue collar workers participated in employer-sponsored health promotion activities in 1994)

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 unavailable)

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: 54 percent of 9th–12th graders engaging in family discussion of HIV/AIDS and 83 percent of people aged 10 and older in 1994)

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 unavailable)

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 unavailable)

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: 68 percent of registered hospitals provided patient education services in 1987; 60 percent of community hospitals offered community health promotion programs in 1989)

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: 100 percent of local television affiliates in 1995-6)

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: 22-92 percent of local health departments reporting health assessment, policy development, and health assurance activities in 1990)

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.

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: 34.7 per 100,000 in 1987)

Special Population Targets

	Deaths Caused By Unintentional Injuries (per 100,000)	*1987 Baseline*	*2000 Target*
9.1a	American Indians/Alaska Natives	66.0	53.0
9.1b	Black males	68.0	51.9
9.1c	White males	49.8	42.9
		1990 Baseline	*2000 Target*
9.1d	Mexican-American males	53.1	43.0

9.2 Reduce nonfatal unintentional injuries so that hospitalizations for this condition are no more than 754 per 100,000 people. (Baseline: 832 per 100,000 in 1988)

Special Population Target

	Nonfatal Injuries (per 100,000)	*1991 Baseline*	*2000 Target*
9.2a	Black males	1,007	856

9.3 Reduce deaths caused by motor vehicle crashes to no more than 1.5 per 100 million vehicle miles traveled (VMT) and 14.2 per 100,000 people. (Baseline: 2.4 per 100 million vehicle miles traveled and 19.2 per 100,000 people 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	4.4
9.3b	Youth aged 15–24	36.9	26.8
9.3c	People aged 70 and older	22.6	20.0
9.3d	American Indians/Alaska Natives	37.7	32.0
		1990 Baseline	*2000 Target*
9.3g	Mexican Americans	20.9	18.0

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	25.6/100 million VMT 0.9/100,000
9.3f	Pedestrians	2.8/100,000	2.0/100,000

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	18.1	14.4
9.4b	People aged 85 and older	133.0	105.0
9.4c	Black men aged 30–69	8.1	5.6
		1990 Baseline	*2000 Target*
9.4d	American Indians/Alaska Natives	3.2	2.8

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	4.3	2.3
9.5b	Men aged 15–34	4.5	2.5
9.5c	Black males	6.6	3.6
		1990 Baseline	*2000 Target*
9.5d	American Indians/Alaska Natives	4.3	2.0

9.6 Reduce residential fire deaths to no more than 1.2 per 100,000 people. (Age-adjusted baseline: 1.7 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	4.5	3.3
9.6b	People aged 65 and older	4.9	3.3
9.6c	Black males	6.4	4.3
9.6d	Black females	3.3	2.6
		1990 Baseline	*2000 Target*
9.6f	American Indians/Alaska Natives	2.1	1.4
9.6g	Puerto Ricans	1.8	2.0

Type-Specific Target

		1983 Baseline	*2000 Target*
9.6e	Residential fire deaths caused by smoking	26%	8%

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: 120 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	762	520

9.9 Reduce nonfatal head injuries so that hospitalizations for this condition are no more than 106 per 100,000 people. (Baseline: 118 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: 5.3 per 100,000 in 1988)

Special Population Target

	Nonfatal Spinal Cord Injuries (per 100,000)	*1988 Baseline*	*2000 Target*
9.10a	Males	9.6	7.1

Risk Reduction Objectives

9.11 Reduce by 20 percent the incidence of secondary conditions (i.e., pressure sores) associated with traumatic spinal cord injuries. (Baseline data unavailable)

Note: Secondary conditions are defined as conditions causally related to a disabling condition (i.e., occurring as a result of the primary disabling condition) and can be either a pathology, an impairment, a functional limitation, or a disability).

9.12 Increase use of safety belts and child safety seats to at least 85 percent of motor vehicle occupants. (Baseline: 42 percent in 1988)

Special Population Target

	Use of Child Restraint Systems Among Children Aged 4 and Younger Involved in Potentially Fatal Crashes	*1988 Baseline*	*2000 Target*
9.12a		48%	70%

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: 700 jurisdictions in 1989)

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 comprehensive school health education, in at least 50 percent of public school systems (grades K–12). (Baseline: 65.8 percent of middle and junior high schools and 66.5 percent of senior high schools in 1994)

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: 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 50 the number of States that have design standards for markings, signing, and other characteristics of the roadway environment to improve the visual stimuli and protect the safety of older drivers and pedestrians. (Baseline data unavailable)

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: percentage of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians providing this service to 81–100 percent of patients in 1992)

9.22 Extend to 20 States the capability to link emergency medical services, trauma systems, and hospital data. (Baseline: 7 States in 1993)

1995 Additions

Health Status Objective

9.23* Reduce deaths caused by alcohol-related motor vehicle crashes to no more than 5.5 per 100,000 people. (Baseline: 9.8 per 100,000 in 1987)

Special Population Targets

	Alcohol-Related Motor Vehicle Crash Deaths (per 100,000)	*1987 Baseline*	*2000 Target*
9.23a	American Indian/Alaska Native men	40.4	35.0
9.23b	People aged 15–24	21.5	12.5

Services and Protection Objectives

9.24 Extend to 50 States laws requiring helmets for bicycle riders (Baseline: 9 States in 1994)

9.25* Enact in 50 States laws requiring that firearms be properly stored to minimize access and the likelihood of discharge by minors. (Baseline: 1 State in 1989)

9.26 Increase to 35 the number of States having a graduated driver licensing system for novice drivers and riders under the age of 18. (Baseline: 16 States in 1993)

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	21.0
10.1b	Construction workers	25.0	17.0
10.1c	Transportation workers	15.2	10.0
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 1983–87)

Special Population Targets

	Work-Related Injuries (per 100)	*1983–87 Average*	*2000 Target*
10.2a	Construction workers	14.9	10.0
10.2b	Nursing and personal care workers	12.7	9.0
10.2c	Farm workers	12.4	8.0
10.2d	Transportation workers	8.3	6.0
10.2e	Mine workers	8.3	6.0
		1992 Baseline	*2000 Target*
10.2f	Adolescent workers	5.8	3.8

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)

Risk Reduction Objectives

10.5* Reduce hepatitis B among occupationally exposed workers to an incidence of no more than 623 clinical cases. (Baseline: An estimated 3,090 clinical cases in 1987)

10.6 Increase to at least 95 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: 82.4 percent of worksites in 1992)

10.7 Reduce to no more than 15 percent the proportion of workers exposed to average daily noise levels that exceed 85 dBA. (Baseline: 16 percent in 1989)

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: 37 percent 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: Federal standards have been established for occupational exposure to airborne asbestos fibers, cotton dust, coal mine dust, and silica dust which apply to all 50 States.)

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: 63.8 percent in 1992)

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: 26 States 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: 6–14 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing this service to patients in 1992)

1995 Additions

Health Status Objectives

10.16 Reduce deaths from work-related homicides to no more than 0.5 per 100,000 full-time workers (Baseline: Average of 0.7 per 100,000 during 1980–1989)

10.17 Reduce the overall age-adjusted mortality rate for four major preventable occupational lung diseases (byssinosis, asbestosis, coal workers' pneumoconiosis, and silicosis) to 7.7 per 1,000,000. (Baseline: 9.6 per 1,000,000 in 1990)

Note: Secondary conditions are defined as conditions causally related to a disabling condition (i.e., occurs as a result of the primary disabling condition) and that can be either a pathology, an impairment, a functional limitation or a disability).

Services and Protection Objectives

10.18* Increase to 100 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)

10.19* Enact in 50 States and the District of Columbia comprehensive laws on clean indoor air that prohibit smoking or limit it to separately ventilated areas in the workplace and enclosed public places (Baseline: 1 State regulated private workplaces; 9 States regulated public workplaces including those that banned smoking through Executive Orders; 2 States regulated restaurants; 16 States and the District of Columbia regulated public transportation; 8 States regulated hospitals; 21 States regulated day care centers, and 4 States regulated grocery stores with comprehensive laws as of January 1995)

10.20* Reduce to 0 the number of States that have clean indoor air laws preempting stronger clean indoor air laws on the local level. (Baseline: 17 States had preemptive clean indoor air laws as of January 1995)

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
		1988 Baseline	*2000 Target*
11.1c	Women	229	183

[†]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: 3.1 per 1,000 children aged 10 in 1985–87)

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).

11.3 Reduce outbreaks of waterborne disease from infectious agents and chemical poisoning to no more than 11 per year. (Baseline: 16 outbreaks in 1988)

		Type-Specific Target	
	Average Annual Number of Waterborne Disease Outbreaks	*1988 Baseline*	*2000 Target*
11.3a	People served by community water systems	4	2

Note: Includes only outbreaks from water intended for drinking. 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 mg/dL and 25 mg/dL among children aged 6 months – 5 years to no more than 300,000 and zero, respectively. (Baseline: An estimated 3 million children had levels exceeding 15 mg/dL, and 234,000 had levels exceeding 25 mg/dL, in 1984)

		Special Population Targets	
	Prevalence of Blood Lead Levels	*1984 Baseline*	*2000 Target*
11.4a	Inner-city low-income black children (annual family income <$6,000 in 1984 dollars)		
	exceeding 15 mg/dL	234,900	75,000
	exceeding 25 mg/dL	36,700	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	*1988 Baseline*	*2000 Target*
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%	85%

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, multiyear 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 decreasing the release of hazardous substances from industrial facilities: 65 percent decrease in the substances on the Department of Health and Human Services list of carcinogens, and a 50 percent reduction in the substances on the Agency for Toxic Substances and Disease Registry (ATSDR) priority list of the most toxic chemicals. (Baseline: 0.35 billion pounds on the Department of Health and Human Services list of carcinogens, and 2.15 billion pounds on the ATSDR list of the most toxic chemicals 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 4.3 pounds before recovery and 3.2 pounds after recovery. (Baseline: 4.0 pounds per person each day in 1988)

Exposure to Solid Waste-Contamination (Average Pounds Per Person Each Day)	*1988 Baseline*	*2000 Target*
Total population	4.0	4.3
After recovery (recycling & composting)	3.5	3.2

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: 73 percent of 58,099 community water systems serving approximately 80 percent of the population in 1988)

Note: Compliance with the Safe Drinking Water Act includes monitoring and reporting as well as providing water that meets the 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 an increase in the proportion of assessed rivers, lakes, and estuaries that support beneficial uses, such as consumable fish and recreational activities.

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).

Water Supporting Beneficial Use	*1992 Baseline*	*2000 Target*
Rivers supporting:		
Consumable fish	89%	94%
Recreational activities	71%	85%
Lakes supporting:		
Consumable fish	64%	82%
Recreational activities	77%	88%
Estuaries supporting:		
Consumable fish	94%	97%
Recreational activities	83%	91%

Services and Protection Objectives

11.11 Perform testing for lead-based paint in at least 50 percent of homes built before 1950. (Baseline: 5 percent 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: 1,079 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 curbside recycling programs that serve at least 50 percent of the U.S. population and continue to increase household hazardous waste collection programs.

Recyclable Materials and Household Hazardous Waste Programs	*1991 Baseline*	*2000 Target*
Percentage of population served by curbside recycling programs	26%	50%
Permanent and temporary household hazardous waste collection events		
Permanent	96	215
Temporary	706	1,314
Total	**802**	**1,529**

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).

1995 Addition

Risk Reduction Objective

11.17* 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.

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	18.0	16.0
Campylobacter jejuni	50.0	25.0
Escherichia coli O157:H7	8.0	4.0
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 *Food Code 1993* for institutional food operations and to at least 70 percent the proportion that have adopted the new uniform food protection code that sets recommended standards for regulation of all food operations. (Baseline: 2 percent in 1994)

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: 95 percent of pharmacies utilized computer systems in 1993)

12.6 Increase to at least 75 percent the proportion of primary care providers and other dispensers of medicine 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 or dispensed. (Baseline: percentage of clinicians who routinely provide maintenance of current medications list—nurse practitioners, 63 percent; obstetricians/ gynecologists, 64 percent; internists, 84 percent; and family physicians, 70 percent of patients in 1992; percent of clincians who routinely provide review of medications when prescribing medications for people 65 and over—nurse

practitioners, 55 percent; obstetricians/gynecologists, 60 percent; internists, 77 percent and family physicians, 63 percent in 1992)

1995 Additions

Services and Protection Objectives

12.7 Increase to at least 75 percent the proportion of the total number of adverse event reports voluntarily sent directly to FDA that are regarded as serious. (Baseline: 69 percent based on first 7 months in 1993)

12.8 Increase to at least 75 percent the proportion of people who receive useful information verbally and in writing for new prescriptions from prescribers or dispensers. (Baseline: for written information, 14 percent from prescribers and 32 percent from dispensers in 1992)

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 6–8 and no more than 60 percent among adolescents aged 15. (Baseline: 54 percent of children aged 6–8 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%† 52%‡	45%
13.1c	Black children aged 6–8	56%	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 6–8 and no more than 15 percent among adolescents aged 15. (Baseline: 28 percent of children aged 6–8 in 1986; 24 percent of adolescents aged 15 in 1986–87)

Special Population Targets

	Untreated Dental Caries Among:	*1986–87 Baseline*	*2000 Target*
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	36%	25%
13.2d	Hispanic children aged 6–8	36%‡	25%
	Among:		
13.2e	Adolescents aged 15 whose parents have less than a high school education	41%	25%
13.2f	American Indian/Alaska Native adolescents aged 15	84%†	40%
13.2g	Black adolescents aged 15	38%	20%
13.2h	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 35–44 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 Targets

	Complete Tooth Loss Prevalence	*1986 Baseline*	*2000 Target*
13.4a	Low-income people (annual family income <$15,000)	46%	25%
		1991 Baseline	*2000 Target*
13.4b	American Indians/Alaska Natives	42%	20%

13.5 Reduce the prevalence of gingivitis among people aged 35–44 to no more than 30 percent. (Baseline: 41 percent in 1985–86)

Special Population Targets

	Gingivitis Prevalence	*1985-86 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 35–44. (Baseline: 25 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 45–74 and 4.1 per 100,000 women aged 45–74. (Baseline: 13.6 per 100,000 men and 4.8 per 100,000 women in 1987)

Special Population Targets

	Oral Cancer Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
13.7a	Black males aged 45–74	29.4	26.0
13.7b	Black females aged 45–74	6.9	6.9

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.

Special Population Targets

	Dental Sealants	*1988-91 Baseline*	*2000 Target*
13.8a	Blacks aged 8	9%	50%
13.8b	Blacks aged 14	5%	50%
13.8c	Hispanics aged 8*	10%	50%
13.8d	Hispanics aged 14*	9%	50%

* Mexican Americans

13.9 Increase to at least 75 percent the proportion of people served by community water systems providing optimal levels of fluoride. (Baseline: 61 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: 55 percent of parents and caregivers of children 6–23 months of age in 1991)

Special Population Targets

	Appropriate Feeding Practices	*1991 Baseline*	*2000 Target*
13.11a	Parents and caregivers with less than high school education	36%*	65%
13.11b	American Indian/Alaska Native parents and caregivers	74%†	65%
13.11c	Black parents and caregivers	48%*	65%
13.11d	Hispanic parents and caregivers	39%*	65%

* Of children aged 6-23 months

† 1985–89 data in four IHS Service Areas in a pilot study

Note: Percentage of parents and caregivers of children 6–23 months of age. Appropriate feeding practices are that the child no longer uses a bottle during the past 2 weeks or if the child still uses a bottle that no bottle was given at bedtime, excluding bottles with plain water, during the past 2 weeks.

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)

Special Population Targets

	Percentage of Children Visiting a Dentist	*1991 Baseline*	*2000 Target*
13.12a	Blacks aged 5	51%	90%
13.12b	Hispanics aged 5	51%	90%

Note: School programs include Head Start, prekindergarten, kindergarten, and first 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 are 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%
		1991 Baseline	*2000 Target*
13.14c	Blacks aged 35 and older	43%	60%
13.14d	Mexican Americans aged 35 and older	38%	60%
13.14e	Puerto Ricans aged 35 and older	51%	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 20 States had an organized referral system to craniofacial anomaly teams)

	Identification and Referral of Infants With Clefts	*1989 Baseline*	*2000 Target*
	States with system to identify infants	25	40
	States with system to refer for care	20	40
	States with system to identify and refer to follow up care	16†	40

†1993 Illinois Department of Health Survey

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: National Collegiate Athletic Association football, hockey, and lacrosse; high school football; amateur boxing; and amateur ice hockey in 1988)

1995 Addition

Risk Reduction Objective

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

		Special Population Target	
	Smokeless Tobacco Use	*1986–87 Baseline*	*2000 Target*
13.17a	American Indian/Alaska Native youth	18–64%	10%

Note: For males aged 12–17, a smokeless tobacco user is someone who has used snuff or chewing tobacco in the preceding month. For males aged 18–24, 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.

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	18.8	11.0
14.1b	American Indians/Alaska Natives	13.4†	8.5
14.1c	Puerto Ricans	12.9†	8.0

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	12.3	7.0
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	6.4	4.0
14.1i	Postneonatal mortality among American Indians/Alaska Natives	7.0†	4.0
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	13.1‡	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 (Per 100,000 live births)	*1987 Baseline*	*2000 Target*
14.3a	Blacks	14.9	5.0

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	4.0	2.0
14.4b	Blacks	0.8	0.4

Risk Reduction Objectives

14.5 Reduce low birthweight to an incidence of no more than 5 percent of live births and very low birthweight to no more than 1 percent of live births. (Baseline: 6.9 and 1.2 percent, respectively, in 1987)

Special Population Targets

	Low Birthweight	*1987 Baseline*	*2000 Target*
14.5a	Blacks	13.0%	9%
	Very Low Birthweight		
14.5b	Blacks	2.8%	2%
	Low Birthweight	*1990 Baseline*	*2000 Target*
14.5c	Puerto Ricans	9.0%	6%
	Very Low Birthweight		
14.5d	Puerto Ricans	1.6%	1%

Note: Low birthweight is weight at birth of less than 2,500 grams; very low birthweight 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: 68 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 (due to pregnancy-related complications) per 100 deliveries in 1987)

Special Population Target

	Pregnancy Complications (per 100 deliveries)	*1991 Baseline*	*2000 Target*
14.7a	Blacks	28	16

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 during early postpartum and 20 percent who are still breastfeeding 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:		
14.9e	Low-income mothers	9%	50%
14.9f	Black mothers	7%	50%
14.9g	Hispanic mothers	14%	50%
14.9h	American Indian/Alaska Native mothers	28%	50%

Note: The definition used for breastfeeding includes exclusive use of human milk or the use of human milk with a supplemental bottle of formula or cow's milk.

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)

	1988 Baseline	*2000 Target*
Alcohol	79%	95%
Cocaine	99%	100%
Marijuana	98%	100%

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 (Percent of live births)	*1987 Baseline*	*2000 Target*
14.11a	Black women	60.8%	90%
14.11b	American Indian/Alaska Native women	57.6%	90%
14.11c	Hispanic women	61.0%	90%

14.12* Increase to at least 60 percent the proportion of primary care providers who provide age-appropriate preconception care and counseling. (Baseline: 18–65 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing services to patients 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: 29 percent in 1988)

14.14 Increase to at least 90 percent the proportion of pregnant women and infants who receive risk-appropriate care. (Baseline data unavailable)

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 unavailable)

1995 Addition

Health Status Objective

14.17 Reduce the incidence of spina bifida and other neural tube defects to 3 per 10,000 live births. (Baseline: 6 per 10,000 in 1990)

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	168	115

15.2* Reduce stroke deaths to no more than 20 per 100,000 people. (Age-adjusted baseline: 30.4 per 100,000 in 1987)

		Special Population Target	
	Stroke Deaths (per 100,000)	*1987 Baseline*	*2000 Target*
15.2a	Blacks	52.5	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: 14.4 per 100,000 in 1987)

		Special Population Target	
	ESRD Incidence (per 100,000)	*1987 Baseline*	*2000 Target*
15.3a	Blacks	34.0	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 18–74 in 1976–80)

		Special Population Target	
	High Blood Pressure Control	*1976–80 Baseline*	*2000 Target*
15.4a	Men with high blood pressure	6%	40%
		1988–91 Baseline	*2000 Target*
15.4b	Mexican Americans with high blood pressure	14%	50%
15.4c	Women 70 years and older with high blood pressure	19%	50%

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. Control of hypertension does not include nonpharmacologic treatment.

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: People with high blood pressure are defined in the National Health Interview Survey as those who are told on two or more occasions by a physician or other health professional that they had 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 20–74 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 20–74 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: 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: for people aged 2 and older: 36 percent of calories from total fat and 13 percent of calories from saturated fat based on 1-day dietary data from the 1976–80 NHANES II; 34 percent of calories from total fat and 12 percent from saturated fat based on 1-day dietary data from the 1989–91 Continuing Survey of Food Intakes by Individuals [CSFII]). In addition, increase to at least 50 percent the proportion of people aged 2 and older who meet the *Dietary Guidelines*' average daily goal of no more than 30 percent of calories from fat, and increase to at least 50 percent the proportion of people aged 2 and older who meet the average daily goal of less than 10 percent of calories from saturated fat. (Baseline for people aged 2 and older: 27 percent met the goal for fat and 29 percent met the goal for saturated fat

based on 2-day dietary data from the 1989–94 NHANES; 22 percent met the goal for fat and 21 percent met the goal for saturated fat based on the 3-day dietary data from 1989–91 CSFII)

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 12–19. (Baseline: 26 percent for people aged 20–74 in 1976–80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12–19 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%
15.10h	Mexican-American men	30%‡	25%

†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 derived from self-reported height and weight

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 12–14, 24.3 for males aged 15–17, 25.8 for males aged 18–19, 23.4 for females aged 12–14, 24.8 for females aged 15–17, and 25.7 for females aged 18–19. The values for adults are the gender-specific 85th percentile values of the 1976–80 National Health and Nutrition Examination Survey (NHANES II), reference population 20–29 years of age. For adolescents, overweight was defined using BMI cutoffs based on modified age- and gender-specific 85th percentile values of the NHANES II. 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 16 percent were active 7 or more times per week in 1985)

Special Population Target

	Moderate Physical Activity	*1991 Baseline*	*2000 Target*
15.11a	Hispanics 18 years and older 5 or more times per week	20%	25%

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 18 and older. (Baseline: 29 percent in 1987, 31 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 18 and older	41%	20%
15.12c	Military personnel	42%†	20%
15.12d	Blacks aged 18 and older	33%	18%
15.12e	Hispanics aged 18 and older	24%	15%
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 ‡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. Since 1992, estimates include some-day (intermittent) smokers.

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.

Special Population Target

	Blood Pressure Checked	*1991 Baseline*	*2000 Target*
15.13a	Mexican-American men	69%	90%

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: 66 percent of people aged 18 and older had their cholesterol checked within the preceeding 5 years in 1993; 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)

Special Population Targets

	Blood Cholesterol Checked	*1991 Baseline*	*2000 Target*
	Ever checked		
15.14a	Blacks	56%	75%
15.14b	Mexican Americans	42%	75%
15.14c	American Indians/Alaska Natives	46%	75%
	Past two years		
15.14d	Mexican Americans	33%	75%
15.14e	American Indians/Alaska Natives	38%	75%
15.14f	Asians/Pacific Islanders	45%	75%

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: Median cholesterol level, 240–259 mg/dL, when diet therapy is initiated; median cholesterol level, 300–319 mg/dL drug therapy is initiated.)

Note: Treatment recommendations at baseline 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. Current treatment recommendations are described in the* Second Report of the Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults *released in 1993. 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: 35 percent offered high blood pressure and/or cholesterol programs in 1992)

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)

Cancer

Health Status Objectives

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 the health status objectives differ from those presented here.

16.1* Reverse the rise in cancer deaths to achieve a rate of no more than 130 per 100,000 people. (Age-adjusted baseline: 134 per 100,000 in 1987)

Special Population Target

	Cancer Deaths (per age-adjusted 100,000)	*1990 Baseline*	*2000 Target*
16.1a	Blacks	182	175

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: 38.5 per 100,000 in 1987)

Special Population Targets

	Lung Cancer Deaths (per age-adjusted 100,000)	*1990 Baseline*	*2000 Target*
16.2a	Females	25.6	27
16.2b	Black males	86.1	91

16.3 Reduce breast cancer deaths to no more than 20.6 per 100,000 women. (Age-adjusted baseline: 23.0 per 100,000 in 1987)

Special Population Target

	Breast Cancer Deaths (per age- adjusted 100,000)	*1990 Baseline*	*2000 Target*
16.3a	Black females	27.5	25

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)

Special Population Targets

	Cervical Cancer Deaths (per age-adjusted 100,000)	*1990 Baseline*	*2000 Target*
16.4a	Black females	5.9	3
16.4b	Hispanic females	3.6†	2

†NIH, Surveillance, Epidemiology, and End Results (SEER) 1977–83, age-adjusted to 1940

16.5* Reduce colorectal cancer deaths to no more than 13.2 per 100,000 people. (Age-adjusted baseline: 14.7 per 100,000 in 1987)

Special Population Target

	Colorectal Cancer Deaths (per age-adjusted 100,000)	*1990 Baseline*	*2000 Target*
16.5a	Blacks	18.1	16.5

Risk Reduction Objectives

16.6* Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 18 and older. (Baseline: 29 percent in 1987, 31 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 18 and older	41%	20%
16.6c	Military personnel	42%†	20%
16.6d	Blacks aged 18 and older	33%	18%
16.6e	Hispanics aged 18 and older	24%	15%
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 ‡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. Since 1992, estimates include same-day (intermittent) smokers.

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: for people aged 2 and older: 36 percent of calories from total fat and 13 percent of calories from saturated fat based on 1-day dietary data from the 1976–80 NHANES II; 34 percent of calories from total fat and 12 percent from saturated fat based on 1-day dietary data from the 1989–91 Continuing Survey of Food Intakes by Individuals [(CSFII]). In addition, increase to at least 50 percent the proportion of people aged 2 and older who meet the *Dietary Guidelines*' average daily goal of no more than 30 percent of calories from fat, and increase to at least 50 percent the proportion of people aged 2 and older who meet the average daily goal of less than 10 percent of calories from saturated fat. (Baseline for people aged 2 and older: 27 percent met the goal for fat and 29 percent met the goal for saturated fat based on 2-day dietary data from the 1989–94 NHANES; 22 percent met the goal for fat and 21 percent met the goal for saturated fat based on the 3-day dietary data from 1989–91 CSFII)

16.8* Increase complex carbohydrate and fiber-containing foods in the diets of people aged 2 and older to an average of 5 or more daily servings for vegetables (including legumes) and fruits, and to an average of 6 or more daily servings for grain products. (Baseline: 4.1 servings of vegetables and fruits and 5.8 servings of grain

products for people aged 2 and older based on 3-day dietary data from the 1989–91 CSFII). In addition, increase to at least 50 percent the proportion of people aged 2 and older who meet the *Dietary Guidelines*' average daily goal of 5 or more servings of vegetables/fruits, and increase to at least 50 percent the proportion who meet the goal of 6 or more servings of grain products. (Baseline: 29 percent met the goal for fruits and vegetables and 40 percent met the goal for grain products for people aged 2 and older based on 3-day dietary data in the 1989–91 CSFII).

Note: The definition of vegetables, fruits, and grain products and serving size designations are derived from The Food Guide Pyramid. *Vegetable, fruit, and grain ingredients from mixtures are included in the total, and fractions of servings are counted.*

Services and Protection Objectives

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: 32 percent limited sun exposure, 29 percent used sunscreen, and 28 percent wore protective clothing in 1992)

16.10 Increase to at least 75 percent the proportion of primary care providers who routinely counsel patients about the following: tobacco use cessation, diet modification, and cancer screening recommendations, which includes providing information on the potential benefit or harm attributed to the various screening modalities and discussion of risk factors associated with breast, prostate, cervical, colorectal, and lung cancers. (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 60 percent those women aged 50 and older who have received a clinical breast examination and a mammogram within the preceding 1–2 years. (Baseline: 25 percent of women aged 50 and older within the preceding 2 years in 1987)

Special Population Targets

	Clinical Breast Exam & Mammogram Received Within Preceding 2 Years:	*1987 Baseline*	*2000 Target*
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 who have ever received a Pap test, and to at least 85 percent those who received a Pap test within the preceding 1–3 years. (Baseline: 88 percent "ever" and 75 percent "within the preceding 3 years" in 1987)

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 1–2 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: 100 percent in 1988-92)

16.16 Ensure that mammograms meet quality standards by inspecting and certifying 100 percent according to the requirements of the Mammography Quality Standards Act. (Baseline: An estimated 18–21 percent certified by the American College of Radiology as of June 1990)

1995 Addition

Health Status Objective

16.17* Reduce deaths due to cancer of the oral cavity and pharynx to no more than 10.5 per 100,000 men aged 45–74 and 4.1 per 100,000 women aged 45–74. (Baseline: 13.6 per 100,000 men and 4.8 per 100,000 women in 1987)

Special Population Targets

	Oral Cancer Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
16.17a	Black males aged 45–74	29.4	26.0
16.17b	Black females aged 45–74	6.9	6.9

Diabetes and Chronic Disabling Conditions

Health Status Objectives

17.1* Increase years of healthy life to at least 65 years. (Baseline: An estimated 64 years in 1990)

Special Population Targets

	Years of Healthy Life	*1990 Baseline*	*2000 Target*
17.1a	Blacks	56.0	60
17.1b	Hispanics	64.8	65
17.1c	People aged 65 and older	11.9†	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.

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

		1991 Baseline	*2000 Target*
17.2d	Puerto Ricans	11.7%	10%

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 Targets

	Difficulty Performing Self-care Activities (per 1,000)	*1984–85 Baseline*	*2000 Target*
17.3a	People aged 85 and older	371	325
17.3b	Blacks aged 65 and older	132	98

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)

Special Population Target

	Asthmatics with Activity Limitations	*1989–1991 Baseline*	*2000 Target*
17.4a	Blacks	30.5%	19%
17.4b	Puerto Ricans	51.5%	22%

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 among school-aged children to no more than 2 per 1,000 children. (Baseline: 3.1 per 1,000 children aged 10 in 1985–87)

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).

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	67.0	58
17.9b	American Indians/Alaska Natives	46.0	41
		1990 Baseline	*2000 Target*
17.9c	Mexican Americans	55.7	50
17.9d	Puerto Ricans	40.7	42

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	2.0
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)	*1987 Baseline*	*2000 Target*
17.10c	Blacks with diabetes	9.0	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 1986-88; 28 per 1,000 in 1986-88)

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 §1986-88 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 12–19. (Baseline: 26 percent for people aged 20–74 in 1976–80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12–19 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%
17.12h	Mexican-American men	30%‡	25%

†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 derived from self-reported height and weight

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 12–14, 24.3 for males aged 15–17, 25.8 for males aged 18–19, 23.4 for females aged 12–14, 24.8 for females aged 15–17, and 25.7 for females aged 18–19.

The values for adults are the gender-specific 85th percentile values of the 1976–80 National Health and Nutrition Examination Survey (NHANES II), reference population 20–29 years of age. For adolescents, overweight was defined using BMI cutoffs based on modified age- and gender-specific 85th percentile values of the NHANES II. 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 five or more times per week, and 16 percent were active seven or more times per week in 1985)

Special Population Target

	Moderate Physical Activity	*1991 Baseline*	*2000 Target*
17.13a	Hispanics 18 years and older five or more times per week	20%	25%

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 unavailable)

Type-Specific Targets

	Patient Education	*1983–84 Baseline*	*2000 Target*
17.14a	People with diabetes	32% (classes) 68% (counseling)	75%
		1991 Baseline	*2000 Target*
17.14b	People with asthma	9%	50%
17.14c	Blacks with diabetes	34% (classes)	75%
17.14d	Hispanics with diabetes	27% (classes)	75%

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: 19–72 percent of pediatricians, nurse practitioners, and family physicians reported routinely providing services to patients 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)

		Special Population Target	
	Hearing Impairment	*1991 Baseline*	*2000 Target*
17.16a	Blacks	36	12

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: 3–63 percent of nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing services to patients 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: Women aged 40-60, 80 percent; women aged 40-49, 76 percent, and women aged 50-60, 83 percent in 1994)

17.19 Increase to at least 75 percent the proportion of worksites with 50 or more employees that have a policy or program for the hiring of people with disabilities. (Baseline: 37 percent of medium and large companies in 1986)

Note: Mandated by the Americans with Disabilities Act.

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 unavailable)

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.

1995 Additions

Health Status Objectives

17.21 Reduce the prevalence of peptic ulcer disease to no more than 18 per 1,000 people aged 18 and older by preventing its recurrence. (Baseline: 19.9 per 1,000 in 1991)

17.22* 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 data unavailable)

Note: Disease prevention and health promotion data include 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.

Services and Protection Objective

17.23 Increase to 70 percent the proportion of people with diabetes who have an annual dilated eye exam. (Baseline: 49 percent for people aged 18 and older in 1989)

HIV Infection

Health Status Objectives

18.1 Confine annual incidence of diagnosed AIDS cases to no more than 43 per 100,000 population. (Baseline: 17.0 per 100,000 in 1989)

	Rates of AIDS Cases (per 100,000)	*1989 Baseline*	*2000 Target*
18.1a	Men who have sex with men (number of cases)	27,000	No more than 48,000
18.1b	Blacks	44.4	No more than 136 per 100,000
18.1c	Hispanics	34.9	No more than 76 per 100,000
18.1d	Women	3.5	No more than 13 per 100,000
18.1e	Injecting drug users (number of cases)	10,300	No more than 25,000

Note: Cases are by year of diagnosis and are corrected for delays in reporting and underreporting.

18.2 Confine the prevalence of HIV infection to no more than 400 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	Men who have sex with men	15,000-61,800[†]	20,000
18.2b	Injecting drug users	0-48,200[‡]	40,000
18.2c	Women giving birth to live infants	160	100

[†]Per 100,000 men who have sex with men aged 15–24 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 injecting drug users aged 15–24 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

Note: The year 2000 target has been revised to reflect new CDC estimates of the prevalence of HIV infection.

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 females and 33 percent of males by age 15; 50 percent of females and 66 percent of males by age 17; reported in 1988)

Special Population Targets

	Adolescents Engaged in Sexual Intercourse	*1988 Baseline*	*2000 Target*
18.3a	Black males aged 15	69%	15%
18.3b	Black males aged 17	90%	40%
18.3c	Black females aged 17	66%	40%

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 15–44 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	Injecting drug users	34%†	75%
18.4d	Black women aged 15–44	12.4%	75%

† 1992 Baseline

18.5 Increase to at least 50 percent the estimated proportion of all injecting drug users who are in drug abuse treatment programs. (Baseline: An estimated 11 percent of opiate abusers were in treatment in 1989)

Note: An injecting drug user is anyone who within the past 12 months has injected drugs not prescribed by a physician. The definition of "drug abuse treatment" must include more than contact for treatment and must be sustained to be effective. Therefore, contacts for treatment do not represent treatment.

18.6 Increase to at least 75 percent the proportion of active injecting drug users who use only new or properly decontaminated syringes, needles and other drug paraphernalia ("works"). (Baseline: 30.8 percent in 1991)

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 know their serostatus. (Baseline: 72.5 percent in 1990)

Note: This objective will be tracked by the percentage of positive tests at public counseling and testing sites to which people returned for posttest counseling.

18.9* Increase to at least 75 percent the proportion of primary care and mental health care providers who provide 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 Targets

	Counseling on HIV and STD Prevention	*1987 Baseline*	*2000 Target*
18.9a	Providers practicing in high-incidence areas	—	90%
		1992 Baseline	*2000 Target*
18.9b	Family Physicians	27%	75%
18.9c	Internists	30%	75%
18.9d	Nurse Practitioners	50%	75%
18.9e	Obstetricians/gynecologists	46%	75%
18.9f	Pediatricians	46%	75%
18.9g	Mental Health Care Providers	—	75%

† Appropriate counseling is defined as counseling that is client centered and sensitive to issues of age or developmental stage, gender, race, ethnicity, culture, language, and sexual orientation.

Note: Primary care providers include physicians, nurses, nurse practitioners, and physician assistants. Mental health care providers include psychiatrists, psychologists, social workers, psychiatric nurses, and mental health counselors. 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 provide appropriate† HIV and other STD education curricula for students in 4th–12th grade, preferably as part of comprehensive school health education, based upon scientific information that includes the way HIV and other STDs are prevented and transmitted. (Baseline: 95 percent of schools reported offering at least one class on sexually transmitted diseases as a part of their standard curricula in 1988)

† An appropriate curriculum is defined as one that is sensitive to issues of age or developmental stage, gender, race, ethnicity, culture, language, and sexual orientation.

Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens. HIV and STD education should include information about primary transmission routes and should increase students' skills in avoiding infection.

18.11* Increase to at least 90 percent the proportion of students who received HIV and other STD information, education, or counseling on their college or university campus. (Baseline data: Students given AIDS or HIV infection prevention information, 49.1 percent; given STD prevention information, 43.4 percent; or taught about AIDS or HIV in college class, 41.4 percent, 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 users (particularly injecting drug users) to deliver HIV risk reduction messages. (Baseline: 35 percent in 1991)

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 provide onsite primary prevention and provide or refer for secondary prevention services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia) to high-risk individuals and their sex or needle-sharing partners. (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: 100 percent in 1992)

1995 Additions

Risk Reduction Objective

18.15* Increase to at least 40 percent the proportion of ever sexually active adolescents aged 17 and younger who have not had sexual intercourse for the previous 3 months. (Baseline: 23.6 percent of sexually active females aged 15–17 and 33 percent of sexually active males aged 15–17 in 1988)

Services and Protection Objectives

18.16 Increase to at least 50 percent the proportion of large businesses and to 10 percent the proportion of small businesses that implemented a comprehensive HIV/AIDS workplace program. (Baseline: for large businesses 25 percent in 1995; small businesses 2 percent in 1995)

Comprehensive Programs	*1995 Baseline*	*2000 Target*
Federal Government departments and agencies	80%	100%

Note: An HIV/AIDS workplace program consists of (1) an HIV/AIDS written policy, (2) managerial training about the policy and its application and (3) HIV/AIDS employee education.

18.17 Increase to at least 40 percent the number of federally funded primary care clinics that have formal established linkages with substance abuse treatment programs and increase to at least 40 percent the number of federally funded substance abuse treatment programs that have formal established linkages with primary care clinics. (Baseline data unavailable)

Sexually Transmitted Diseases

Health Status Objectives

19.1 Reduce gonorrhea to an incidence of no more than 100 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	650
19.1b	Adolescents aged 15–19	1,123	375
19.1c	Women aged 15–44	501	175

19.2 Reduce the prevalence of *Chlamydia trachomatis* infections among young women (under the age of 25 years) to no more than 5 percent. (Baseline: 8.5 percent in women 20–24 and 12.2 percent in females 19 and younger in 1988)

Note: As measured by a decrease in the prevalence of chlamydia infection among family planning clients <25 years old at their initial visit.

19.3 Reduce primary and secondary syphilis to an incidence of no more than 4 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	30

19.4 Reduce congenital syphilis to an incidence of no more than 40 cases per 100,000 live births. (Baseline: 91.0 per 100,000 live births in 1990)

Special Population Targets

	Congenital syphilis (per 100,000)	*1992 Baseline*	*2000 Target*
19.4a	Blacks	417.8	175
19.4b	Hispanics	134.6	50

19.5 Reduce genital herpes and genital warts, as measured by a reduction to 138,500 and 246,500, respectively, in the annual number of first-time consultations with a physician for the conditions. (Baseline: 163,000 and 290,000 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 100 per 100,000 women aged 15–44 and a reduction in the number of initial visits to physicians for pelvic inflammatory disease to no more than 290,000. (Baseline: 311 per 100,000 in 1988 and 430,800 visits in 1988)

Special Population Targets

	Hospitalizations for PID (per 100,000)	*1988 Baseline*	*2000 Target*
19.6a	Blacks	655	150
19.6b	Adolescents (aged 15–19)	342	110

19.7 Reduce sexually transmitted hepatitis B infection to no more than 30,500 cases. (Baseline: 47,593 cases in 1987)

19.8 Reduce the rate of repeat gonorrhea infection to no more than 15 percent within the previous year. (Baseline: 20 percent in 1987)

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.

Special Population Target

	Repeat Gonorrhea	*1992 Baseline*	*2000 Target*
19.8a	Blacks[†]	21.3%	17%

[†]Proportion of male gonorrhea patients with one or more gonorrhea infections within the previous 12 months.

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 females and 33 percent of males by age 15; 50 percent of females and 66 percent of males by age 17 reported in 1988)

Special Population Targets

	Adolescents Engaged In Sexual Intercourse	*1988 Baseline*	*2000 Target*
19.9a	Black males aged 15	69%	15%
19.9b	Black males aged 17	90%	40%
19.9c	Black females aged 17	66%	40%

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 15–44 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)	26.0%	60%
19.10b	Sexually active young men aged 15–19	57.0%	75%
19.10c	Injecting drug users	34.0%[†]	75%
19.10d	Black women aged 15–44 (by their partners)	12.4%	75%

[†] 1992 Baseline

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 provide onsite primary and secondary prevention services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia) to high-risk individuals and their sex or needle-sharing partners. (Baseline: 40 percent of family planning clinics for bacterial sexually transmitted diseases in 1989)

19.12* Increase to at least 95 percent the proportion of schools that provide appropriate† HIV and other STD education curricula for students in 4th–12th grade, preferably as part of comprehensive school health education, based upon scientific information that includes the way HIV infection and other STDs are prevented and transmitted. (Baseline: 95 percent of schools reported offering at least one class on sexually transmitted diseases as part of their standard curricula in 1988)

† An appropriate curriculum is defined as one that is sensitive to issues of age or developmental stage, gender, race, ethnicity, culture, language, and sexual orientation.

Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens. HIV and STD education should include information about primary transmission routes and should increase students' skills in avoiding infection.

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 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 Targets

	Counseling on HIV and STD Prevention	*1987 Baseline*	*2000 Target*
19.14a	Providers practicing in high-incidence areas	—	90%
		1992 Baseline	*2000 Target*
19.14b	Family Physicians	27%	75%
19.14c	Internists	30%	75%
19.14d	Nurse Practitioners	50%	75%
19.14e	Obstetricians/gynecologists	46%	75%
19.14f	Pediatricians	46%	75%
19.14g	Mental Health Care Providers	—	75%

† Appropriate counseling is defined as counseling that is client centered and sensitive to issues of age or developmental stage, gender, race, ethnicity, culture, language, and sexual orientation.

Note: Primary care providers include physicians, nurses, nurse practitioners and physician assistants. Mental health care providers include psychiatrists, psychologists, social workers, psychiatric nurses, and mental health counselors. 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 for the purpose of education, counseling, and referral to health care services.

1995 Additions

Risk Reduction Objective

19.16* Increase to at least 40 percent the proportion of ever sexually active adolescents aged 17 and younger who have not had sexual intercourse for the previous 3 months. (Baseline: 23.6 percent of sexually active females aged 15–17 in 1988; 33 percent of sexually active males aged 15–17 in 1988)

Services and Protection Objective

19.17* Increase to at least 90 percent the proportion of students who received HIV and other STD information, education, or counseling on their college or university campus. (Baseline data: Students given AIDS or HIV infection prevention information, 49.1 percent; given STD prevention information, 43.4 percent; or taught about AIDS or HIV in college class, 41.4 percent, in 1995)

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	3,396	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 15.9 per 100,000. (Baseline: Average of 19.9 per 100,000 during 1979–1987. This represents the average of the eight seasons from the 1979–80 season through the 1986–87 season.)

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, it is measured using a 3-year average.

20.3 Reduce viral hepatitis as follows:

(Per 100,000)	*1987 Baseline*	*2000 Target*
Hepatitis B	63.5	40.0
Hepatitis A	33.0	16.1
Hepatitis C	18.3	13.7

Special Population Targets

	Hepatitis B (Number of Cases)	*1987 Baseline*	*2000 Target*
20.3a	Injecting drug users	44,348	7,932
20.3b	Heterosexually active people	33,995	22,663
20.3c	Homosexual men	13,598	4,568
20.3d	Children of Asians/Pacific Islanders	10,817	1,500
20.3e	Occupationally exposed workers	3,090	623
20.3f	Infants (chronic infections)	6,012	1,111
20.3g	Alaska Natives (number of new carriers)	15	1
		1992 Baseline	*2000 Target*
20.3h	Blacks (cases per 100,000)	52.8	40.0
	Hepatitis A (cases per 100,000)		
20.3i	Hispanics	53.8	26.9
20.3j	American Indians/Alaska Natives	256.0	128.0
	Hepatitis C (cases per 100,000)		
20.3k	Hispanics	17.2	13.7

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: Device-associated nosocomial infection rates (per 1,000 device days for bloodstream infections, urinary tract infections and pneumonia in medical/coronary ICUs, surgical/medical-surgical ICUs and pediatric ICUs in 1986–90 and surgical wound infection rates (per 100 operations), low-risk patients 1.1, medium low-risk patients 3.2, medium-high-risk patients 6.3, and high-risk patients 14.4 in 1986–90)

20.6 Reduce selected illness among international travelers as follows:

Number of Cases	*1987 Baseline*	*2000 Target*
Typhoid fever	280	140
Hepatitis A	4,475	1,119
Malaria	932	750

20.7 Reduce bacterial meningitis to no more than 4.7 cases per 100,000 people. (Baseline: 6.5 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: 32 percent in children aged 0 to 6 years and 38 percent in children aged 0 to 3 years in 1991)

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: 135.4 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)	19.1 days	15.1 days
Children aged 4 and younger (per 100 children)	29.4 days	24 days

Risk Reduction Objectives

20.11 Increase immunization levels as follows: Basic immunization series among children through age 2: at least 90 percent. (Baseline: revised to 54 to 64 percent in 1985)

Basic immunization series among children in licensed child care facilities and kindergarten through postsecondary education institutions: at least 95 percent. (Baseline: For licensed child care, 94–95 percent; 97–98 percent for children entering school for the 1987–1988 school year; and for postsecondary institutions, baseline data unavailable in 1992)

Hepatitis B immunization among high-risk populations, including infants of hepatitis B surface antigen-positive mothers to at least 90 percent; occupationally exposed workers to at least 90 percent; injecting drug users in drug treatment programs to at least 50 percent; and men who have sex with men to at least 50 percent. (Baseline: 40 percent of infants of surface antigen-positive mothers in 1991; 37 percent of occupationally exposed workers in 1989; 3 percent of men who have sex with men in 1992-3; and data are unavailable for injecting drug users)

Pneumococcal pneumonia and influenza immunization among institutionalized chronically ill or older people: at least 80 percent. (Baseline data unavailable)

Pneumococcal pneumonia and influenza immunization among noninstitutionalized, high-risk populations, as defined by the Immunization Practices Advisory Committee: at least 60 percent. (Baseline: 15 percent estimated for pneumococcal vaccine and 33 percent for influenza vaccine in 1989)

Special Population Targets

		Influenza Vaccines	*Pneumococcal Vaccines*	
	Percent Immunized	*1991 Baseline*	*1991 Baseline*	*2000 Target*
20.11a	Blacks 65 years and older	20%	6%	60%
20.11b	Hispanics 65 years and older	28%	11%	60%

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: 10–49 States and the District of Columbia depending on the antigen and setting in 1989)

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: 68–89 percent of pediatricians, nurse practitioners, and family physicians reported routinely providing immunization services to children; and 4–49 percent of nurse practitioners, obstetricians/gynecologists, internists and family physicians reported routinely providing immunization services to adult patients 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 1981 and influenza immunization in 1993)

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: 37 percent in 1990 and 77 percent in 1992-3)

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: 80 percent in 1992-3)

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: 52 percent of tertiary care hospitals; 45 percent of secondary care hospitals, and 68 percent of HMOs in 1993)

Clinical Preventive Services

Health Status Objective

21.1* Increase years of healthy life to at least 65 years. (Baseline: An estimated 64 years in 1990)

Special Population Targets

	Years of Healthy Life	*1990 Baseline*	*2000 Target*
21.1a	Blacks	56	60
21.1b	Hispanics	64.8	65
21.1c	People aged 65 and older	11.9†	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.

Risk Reduction Objective

21.2 Increase the proportion of people who have received selected clinical preventive 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.

Receipt of Selected Clinical Preventive and Counseling Services

Special and Type-Specific Targets

	1991 Baseline	*2000 Target*
Basic Immunization Series (4 DTP, 3 Polio, and 2 MMR)	55%‡	90%
Children 19–35 months:		
DTP (3 or more doses)	83%‡	
Polio (3 or more doses)	72%‡	
Measles/Mumps/Rubella (1 dose)	83%‡	
Haemophilus influenzae B (3 or more doses)	28%‡	
Hepatitis B (1 dose)	16%§	

Special Population Targets

	1991 Baseline	*2000 Target*
Routine check-up†	74%	91%
People 65 years and over	67%	
*Cholesterol checked in last 5 years**	60%§	75%
*Cholesterol ever checked**	63%	75%
Low-income people	46%	
Blacks*	56%	
Hispanics	51%	
American Indians/Alaska Natives*	46%	

	1991 Baseline	*2000 Target*
Cholesterol checked in last 2 years	50%	75%
Low-income people	37%	
Hispanics	42%	
Asians/Pacific Islanders	45%	
American Indians/Alaska Natives	38%	
Tetanus booster in last 10 years	52%	62%
People 65 years and over	29%	
Hispanics	45%	
Asians/Pacific Islanders	40%	
People with disabilities	47%	
Pneumococcal vaccine in lifetime (Aged 65 and over)	21%	60%
Low-income people	17%	
Blacks*	14%	
Hispanics*	12%	
Asians/Pacific Islanders	15%	
*Influenza vaccine in last year (Aged 65 and over)**	42%	60%
Low-income people	36%	
Blacks*	27%	
Hispanics*	34%	
Asians/Pacific Islanders	29%	
Pap test in last 3 years		
Women aged 18 and over	74%‡	85%
Women aged 65 and over	51%‡	
Asians/Pacific Islanders	62%‡	
American Indians/Alaska Natives	64%‡	
Women with disabilities	65%‡	
Breast exam and mammogram in past 2 years		
Women 50 years and over	51%‡	60%
Women aged 65 and over	43%‡	
Low-income women	30%‡	
Asians/Pacific Islanders	38%‡	
American Indians/Alaska Natives	31%‡	
Women with disabilities	44%‡	
Counseling services††	56%	
People aged 65 and over	42%	80%
Asians/Pacific Islanders	51%	

Note: Baselines and targets for total population (18 years and over); special populations have more than a 10 percent disparity with the total population.

†In the last 3 years for people aged 18–64 and in the last year for people aged 65 and older ‡1992 data §1993 data ††For people aged 18–64, counseling is defined as a screening question on at least one of the following: diet, physical activity, tobacco use, alcohol use, drug use, sexually transmitted

diseases, contraceptive use in the past 3 years. For people aged 65 and over, counseling on at least one of: diet, physical activity, tobacco use, alcohol use in the past year.

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: 80 percent in 1991)

Special Population Targets

	Percentage With Source of Care	*1991 Baseline*	*2000 Target*
21.3a	Hispanics	63%	95%
	Mexican Americans	57%	95%
21.3b	Blacks	78%	95%
21.3c	Low-income people	71%	95%
21.3d	American Indians/Alaska Natives	70%	95%
21.3e	Asians/Pacific Islanders	70%	95%

Note: Since 1991, the emergency room has not been counted as a regular source for primary care services. 21.3a breaks out only Mexican Americans since the rates for Puerto Ricans and Cubans are similar to the total population.

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: 15.7 percent of people aged 65 and under in 1989)

Special Population Targets

	Proportion of People Without Health Care Coverage (People Under 65 Years)	*1989 Baseline*	*2000 Target*
21.4a	American Indians/Alaska Natives	36.1%	0%
21.4b	Hispanics	31.3%	0%
	Mexican Americans	38.1%	0%
	Puerto Ricans	21.4%	0%
	Cubans	20.7%	0%
21.4c	Blacks	22.0%	0%

21.5 Ensure 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: 10–100 percent for screening recommendations; 40–100 percent or counseling recommendations; 10–96 percent for immunizations in 1991–92)

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: 4–96 percent of pediatricians, nurse practitioners, family physicians, internists, and obstetricians/gynecologists reported routinely providing recommended services to patients 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: proportion of local health departments that assess the extent to which clinical preventive services are provided in jurisdiction—76 percent; proportion of local health departments that collect data to document the number of providers of clinical preventive services—45 percent; proportion of local health departments that evaluate the availability of and need for clinical preventive services—57 percent; of these, the proportion that provide programs to fill gaps—83 percent 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%	8.0%
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.

21.8a Increase the proportion of individuals from underrepresented racial and ethnic minority groups enrolled in U.S. schools of nursing.

Proportion Enrolled in fall Academic Year[*]	*1991–92 Baseline*	*2000 Target*
Blacks	9.1%	10%
Hispanic	3.1%	4%
Asians/Pacific Islanders[†]	2.9%	5%
American Indians/Alaska Natives	0.7%	1%

[*]Enrollment figures have been shown to be statistically predictive of graduating rates.

[†]The Asians/Pacific Islanders special population target is important because at this time the majority of Asian/Pacific Islander nurses in the United States is foreign-educated. Since this subobjective refers to preparing nurses in this country, it is appropriate to consider these nurses as an underrepresented minority.

Surveillance and Data Systems

Health Status 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: Set developed in 1991)

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	
		1995 Baseline	*2000 Target*
22.2a	Identify, and create where necessary, State level data for at least two-thirds of the objectives in State year 2000 plans	42 States	50 States

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: 12 percent of objectives 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 data unavailable)

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	
		1992 Baseline	*2000 Target*
22.5a	Periodic analysis and publication of data needed to measure State progress toward the national or State-specific objectives for each racial or ethnic group that makes up at least 10 percent of the State population	19 States	25 States

Note: Periodic is at least once every 4 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: 65 percent of data released within 1 year of collection and 24 percent of data were released between 1 and 2 years of collection in 1994)

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 1 year of the end of data collection.

Age-Related Objectives

*Reduce the death rate for children by 15 percent to no more than 28.6 per 100,000 children aged 1–14, and for infants by approximately 30 percent to no more than 7 per 1,000 live births. (Baseline: 33.7 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 83.1 per 100,000 people aged 15–24. (Baseline: 97.8 per 100,000 in 1987)

Reduce the death rate for adults by 20 percent to no more than 341.5 per 100,000 people aged 25–64. (Baseline: 426.9 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)

APPENDIX C

Resource Publications List

The following publications may assist you in developing objectives.

SELECTED PUBLICATIONS AND ORDER FORM

Healthy People 2000 is a national initiative to improve the health of all Americans through prevention. It is driven by 319 specific national health promotion and disease prevention objectives targeted for achievement by the year 2000. Healthy People 2000's overall goals are to:

- Increase the span of healthy life.
- Reduce health disparities.
- Achieve access to preventive services for all Americans.

The objectives are organized into 22 priority areas:

1. Physical Activity and Fitness
2. Nutrition
3. Tobacco
4. Substance Abuse: Alcohol and Other Drugs
5. Family Planning
6. Mental Health and Mental Disorders
7. Violent and Abusive Behavior
8. Educational and Community-Based Programs
9. Unintentional Injuries
10. Occupational Safety and Health
11. Environmental Health
12. Food and Drug Safety
13. Oral Health
14. Maternal and Infant Health
15. Heart Disease and Stroke
16. Cancer
17. Diabetes and Chronic Disabling Conditions
18. HIV Infection
19. Sexually Transmitted Diseases
20. Immunization and Infectious Diseases
21. Clinical Preventive Services
22. Surveillance and Data Systems

U.S. Department of Health and Human Services
Office of Public Health and Science
Office of Disease Prevention and Health Promotion
738G Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201
(202)205-8611 Fax (202)205-9478
Homepage addresses:
http://odphp.osophs.dhhs.gov
http://odphp.osophs.dhhs.gov/pubs/hp2000/

*** Developing Objectives for Healthy People 2010** (B0058). (1997) Provides information on the process for developing the Nation's third set of disease prevention and health promotion objectives and includes a 1997 Summary List of Objectives. Describes how to get involved. 175 pages. $7 handling fee. Also available from GPO, $18 (Stock No. 017-001-00530-4).

*** Healthy People 2000: Midcourse Review and 1995 Revisions** (B0053). (1995) Reviews progress toward the three goals of Healthy People 2000 and shows more than two-thirds of objectives for which there are data moving toward the targets. Includes a chapter on State and Healthy People 2000 Consortium organization action. A Summary List of Objectives reflects 1995 revisions. Single copy available from **ODPHP Communication Support Center** (B0053). 292 pages. $11 handling fee. Also available from **GPO**, $19 (Stock No. 017-001-00-526-6).

Healthy People 2000: National Health Promotion and Disease Prevention Objectives. (1991) Sets national health objectives for the decade to increase the span of healthy life for Americans, reduce health disparities among Americans, and achieve access to preventive services for all Americans. The goals are supported by specific objectives in 22 priority areas. 696 pages. For sale by **GPO,** $31 handling fee. (Stock No. 017 001-00474-0).

*** Healthy People 2000 Fact Sheet** (B0034). (1995) Describes the Healthy People 2000 initiative and highlights key activities and publications. 4 pages. No handling fee.

*** Healthy People 2000 Progress Reviews** (R0127–0148). Reports of the status of Healthy People 2000 priority areas and special population groups. See order form for complete list.

Healthy People 2000: Turning Commitment Into Action (B0049). (1993) Provides activity ideas for embracing the Healthy People 2000 objectives. 12 pages. $2.50 handling fee.

Healthy Worksites: Fact Sheet (B0033). (1994) Lists Healthy People 2000 objectives and publications related to the promotion of healthy worksites. 4 pages. No handling fee.

Dietary Guidelines for Americans (U0003). (Fourth edition, 1995) Presents guidelines for improved food habits for Americans ages 2 years and older. 44 pages. $1 handling fee.

*** Office of Disease Prevention and Health Promotion Publications List** (D0002P). (1997) Includes publications in the categories of Healthy People 2000, Public Health Initiatives, Health Promotion in Communities, Nutrition, and Clinical Preventive Services. 8 pages. No handling fee.

Publications Available from Other Organizations

Healthy Children 2000: National Health Promotion and Disease Prevention Objectives Related to Mothers, Infants, Children, Adolescents and Youth. (1991) 242 pages. The National Maternal and Child Health Clearinghouse. Reproductions available from Educational Resources Information Center, 7420 Fullerton Road, Suite 110, Springfield, VA 22153-2852; (800)443-ERIC. $39.70 plus $4.50 handling. ERIC Document #345870.

Healthy Communities Resource Guide (1992), National Civic League, 1445 Market Street, Suite 300, Denver, CO 80202-1728; (800)223-6004. $20 plus $3.25 handling.

Healthy Communities 2000: Model Standards (Third edition, 1991), American Public Health Association, P.O. Box 753, Waldorf, MD 20604; (301)893-1894. $35 plus $7 handling.

Healthy People 2000 Review 1995/6, CDC, NCHS. Fourth in series tracking annual data for objectives and subobjectives in all priority areas. National Center for Health Statistics; (301)436-8500. Free.

Healthy People 2000: Citizens Chart the Course (1990), National Academy Press, 2101 Constitution Avenue, NW., Washington, DC 20055; (800)624-6242. 242-page reproduction. $42.25 plus $4 handling.

Healthy Students 2000: An Agenda for Continuous Improvement in America's Schools (G009) (1994), American School Health Association, P.O. Box 708, Kent, OH 44240: (330)678-1603. $21.25 (members) or $24.95 (nonmembers) plus handling.

"Healthy People 2000: National Health Promotion and Disease Prevention Objectives and Healthy Schools," **Journal of School Health**, September 1991, American School Health Association, P.O. Box 708, Kent, OH 44240; (330)678-1603. $8.50 (members); $10.50 (nonmembers) plus $5.00 handling.

Healthy Youth 2000: A Mid-Decade Review (1995), Department of Adolescent Health, American Medical Association, 515 North State Street, Chicago, IL 60610; (312)464-5570. (ISBN 0-89970-807-2) Single copy free; additional copies $2.50 each.

Many States and communities have Healthy People 2000 publications. Contact your State or local health department.

HEALTHY PEOPLE 2000 PUBLICATIONS ORDER FORM

☐ B0058	$7	Developing Objectives for Healthy People 2010
☐ B0053	$11	Healthy People 2000: Midcourse Review and 1995 Revisions
☐ B0034	N/C	Healthy People 2000 Fact Sheet
☐ B0049	$2.50	Healthy People 2000: Turning Commitment Into Action
☐ B0033	N/C	Healthy Worksites: Fact Sheet
☐ U0003	$1	Dietary Guidelines for Americans
☐ D0002P	N/C	Office of Disease Prevention and Health Promotion Publications List

Progress Review Reports (No Charge)

- ☐ Physical Activity and Fitness
- ☐ Nutrition
- ☐ Tobacco
- ☐ Substance Abuse: 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
- ☐ Adolescents and Young Adults
- ☐ American Indians and Alaska Natives
- ☐ Asian and Pacific Islander Americans
- ☐ Black Americans
- ☐ Hispanic Americans
- ☐ Older Adults
- ☐ People with Disabilities
- ☐ Women

To receive publications through the new fax-back system, call (301)468-3028.

Unless otherwise indicated, single copies of publications may be ordered from ODPHP Communication Support Center, P.O. Box 37366, Washington, DC 20013-7366. Please include a check or money order made out to Communications Support *to cover all shipping and handling fees for each item.* ***Please add an order processing fee of $2 to all orders of $4 or more or orders of 3 or more items.***

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If you prefer to pay by VISA or MasterCard, please supply the following information (charge on your bill will be listed as Social & Health Services, Ltd.):

Card Number _____ Expiration Date _____

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Name and Address of Credit Card Holder (if different from above):

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Homepage addresses: http://odphp.osophs.dhhs.gov
http://odphp.osophs.dhhs.gov/pubs/hp2000/

Healthy People 2010 Fact Sheet

All Americans have the opportunity to build the Nation's health agenda for the 21st Century. Developing the objectives for Healthy People 2010 offers individuals, private and voluntary organizations, businesses, and the public health community the opportunity to help define the critical measures the United States must undertake to promote healthy behaviors, achieve improved health outcomes, reduce risk factors, and assure access to preventive strategies and health services that can improve the health of all Americans.

The first set of national health targets was published in 1979 in *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. Healthy People 2000, the second and current national prevention initiative, is the product of unprecedented collaboration among government, voluntary and professional organizations, businesses, and individuals. Healthy People's national targets have served as the basis for monitoring and tracking health status, health risks, and use of preventive services. Many States and localities have used the same process to guide local public health policy and program development.

Development of Healthy People 2010 has begun with members of the Healthy People Consortium, an alliance of over 600 national membership organizations representing professional, voluntary, and business sectors, and State and territorial public health, mental health, substance abuse, and environmental agencies. Overall development of Healthy People 2010 is guided by the Secretary's Council on Health Promotion and Disease Prevention Objectives for 2010. Chaired by the Secretary of HHS with the Assistant Secretary for Health as Vice Chair and composed of former Assistant Secretaries for Health and all HHS Operating Division Heads, the Council meets annually.

Healthy People Homepage: More information about Healthy People 2010 developments and Healthy People 2000 activities are posted on the Internet at **http://odphp.osophs.dhhs.gov/pubs/hp2000**. Also at this website is the guide *Developing Objectives for Healthy People 2010*, which describes the who, what, when, and how of the 2010 development process. Included in this publication are the names of people in Federal and State agencies who coordinate Healthy People activities, as well as contact information for organizations that are members of the Healthy People Consortium.

Development of Objectives: There will be two separate public comment periods on Healthy People 2010. In the fall of 1997, a call for comments on the proposed framework of Healthy People 2010 will be announced in the *Federal Register*, as well as a call for objectives. Individuals may submit comments on current Healthy People objectives—proposing modifications and/or deletions—or submit new draft objectives before December 15, 1997. Comments will be accepted electronically at: **http://web.health.gov/healthypeople**. Once the comment period closes, HHS work groups will develop the 2010 draft.

A second public comment period on the draft Healthy People 2010 document is scheduled for the fall of 1998. Publication of *Healthy People 2010* is slated for early in 2000.

For more information about Healthy People 2010, contact the Office of Disease Prevention and Health Promotion, Room 738G, Hubert Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201 at (202) 205-8583.

To submit comments for
Healthy People 2010:

http://web.health.gov/healthypeople