PART A: GENERAL DATA ISSUES

This section covers issues that affect many of the Healthy People 2010 objectives. Covered here in detail from the source volume, *Tracking Healthy People 2010,* are Target-Setting Methods, Assessing Methods for Measurable Objectives, and Developmental Objectives. Also included are the minimum select population template, along with abbreviated sections on National, State, and Local Data and the Healthy People 2010 Database. Not included here are sections on Population Estimates, Age Adjustment, Mortality and Morbidity Classification, and Variability of Estimates. In all cases, the reader is encouraged to refer to the main volume, *Tracking Healthy People 2010,* for a full explanation of abbreviated sections and for data issues that are not covered in this publication.

Target Setting and Assessing Progress for Measurable Objectives

Target-Setting Methods

One of the three overarching goals for the Healthy People 2000 prevention initiative was to reduce health disparities among Americans. The framework of Healthy People 2010 has taken this a step further by proposing to "eliminate health disparities" as one of the two primary goals for the next decade.

To support this goal of eliminating health disparities, a single national target that is applicable to all select populations has been set for each measurable, population-based objective. Three guiding principles were used in setting targets for the measurable, population-based objectives:

- For objectives that address health services and protection (for example, access to prenatal care, health insurance coverage, etc.) the targets have been set so that there is an improvement for all racial/ethnic segments of the population (that is, the targets are set "better than the best" racial/ethnic subgroup shown for the objective). Data points for at least two population groups under the race and ethnicity category are needed to use "better than the best" as the target-setting method.
- For objectives that can be influenced in the short term by policy decisions, lifestyle choices, and behaviors (for example, physical activity, diet, sexual activity, etc.), the target setting method is also "better than the best" group.
- For objectives that are unlikely to achieve an equal health outcome in the next decade, regardless of the level of investment (for example, occupational exposure and resultant lung cancer), the target represents an improvement for a substantial proportion of the population and is regarded as a minimum acceptable level. Implicit in setting targets for these objectives is the recognition that population groups with baseline rates already better than the identified target should continue to improve.

Beyond this general guidance, the exact target levels were determined by the lead agency workgroups that developed the objectives. The workgroups used various methods for arriving at the target levels, including retention of the year 2000 target, computation of a statistical regression using current rates to project a target, knowledge of the programs currently in place and expected change, and expert judgment.

The following target-setting methods have been used:

- Better than the best.
- __ percent improvement.
- "Total coverage" or "Total elimination" (for targets like 100 percent, 0 percent, all States, etc.).
- Consistent with __________________(another national program, for example, national education goals).
- Retain year 2000 target (the Healthy People 2000 target has been retained).

The specific method for developing the target is described under each objective.

Assessing Progress

Most objectives are tracked by a single measure. For these objectives, progress will be assessed by the change from the baseline measure toward the target. Some objectives seek to increase positive behaviors or outcomes while others are stated in terms of decreasing negative behaviors or outcomes.

A number of objectives contain multiple measures. Progress will be assessed separately for each measure. For these objectives, therefore, the progress may be mixed if some measures are progressing toward the target and others are regressing. Whenever possible, assessment of progress should consider the standard errors associated with the data.

For some objectives, precise measures that match the objective are not available. In these cases, similar proxy measures may be used to track progress. The tracking data and methods for assessing progress will be reviewed during the midcourse review in 2005, and a determination will be made at that time whether any changes will be made.

Developmental Objectives

Developmental objectives are those that currently do not have national baseline data and, therefore, currently have no operational definitions. Some objectives that contain several measures may have parts that are developmental. Developmental objectives indicate areas that need to be placed on the national agenda for data collection. They address subjects of sufficient national importance that investments should be made over the next decade to measure their change.

A potential data source has been identified for all developmental objectives or subobjective measures. These sources, along with other information, will be discussed in the operational definitions under "Comments." As data are developed and become available for these objectives, operational definitions will be disseminated on the Internet and/or in Healthy People publications. No targets have been set for developmental objectives; targets will be proposed at the midcourse review for those developmental objectives that have baseline data.

Population Template

Minimum Template

During the review of the September 1998 *Healthy People 2010 Draft for Public Comment*, the need for greater consistency in tracking population groups became apparent. To address this issue, a minimum template for all Healthy People 2010 population-based objectives was adopted. Population-based objectives may show more detailed and additional breakouts if appropriate.

This minimum select population template applies to most currently measurable population-based objectives and will be applied to developmental population-based objectives when data become available. The template does not apply to non-population-based objectives such as those that measure schools, worksites, or States. Because of problems in interpreting risk, the template is also not shown for population-based measurable objectives that are tracked using counts of events rather than rates or percents.

The minimum template for all population-based objectives is:

Race:

American Indian or Alaska Native
Asian or Pacific Islander
  Asian
  Native Hawaiian or Other Pacific Islander
Black or African American
White
Hispanic origin and race:
  Hispanic or Latino
  Not Hispanic or Latino
    Black or African American
    White

Gender:

Female

Male

Socioeconomic status:

Family income level-	or	Education level-
Poor		Less than high school
Near poor		High school graduate
Middle/high income		At least some college

The groups listed under most headings (race, Hispanic origin, gender, and income) in the minimum template are comprehensive; that is, they are intended to sum to the population (excluding "unknowns") tracked by the objective. For example, the three groups under income equal the total population tracked by the objective. The exception is the education category, which is limited to people of a minimum age or, in some cases, a maximum age. The groups listed under the subheading "Not Hispanic or Latino" are not inclusive.

If data are not provided for a group, this is indicated by one of four statements: data have been collected but have not yet been analyzed (DNA), data are not collected by the data system used to track the objective (DNC), data are statistically unreliable (DSU), or the specific breakout is not applicable (NA). In cases where data for the entire template are not collected by the data system tracking the objective, a note to this effect will replace the template.

National Data

Data used to track the Healthy People 2010 objectives are based on events occurring in the 50 States and the District of Columbia, where available. Unless specifically noted, all objectives exclude data for U.S. territories. The data used to track most population-based Healthy People 2010 objectives are derived from either a national census of events (for

example, National Vital Statistics System, National Notifiable Disease Surveillance System) or from nationally representative sample surveys (for example, National Health Interview Survey, National Household Survey on Drug Abuse).

For some objectives, however, complete national data are not available and data for selected States and/or areas are used to monitor the objectives. In these cases, the coverage area is described with the data for the objective and in the operational definitions. Data for these objectives may not be representative of the United States as a whole. If during the decade national data become available, they will be used to track the objectives.

For some national data systems that cover the entire United States, such as the Behavioral Risk Factor Surveillance System and the National Vital Statistics System, data are not available for some variables for all States. This is either because data for a specific variable are not collected by some States or because the quality of data for some States is not sufficient to produce reliable estimates for some variables. This information is also shown in the operational definitions for selected objectives.

State and Local Data

The national Healthy People initiatives have served as a "menu" for identifying State and local priorities and selecting objectives that are most relevant to specific States, communities, settings, and health care delivery systems. By using the national Healthy People initiative as a common point of departure, agencies and organizations have tailored programs targeted toward their customers, yet retained a common basis for evaluating performance in relation to both the nation, other States, or populations. This focus on performance has prompted State and local health agencies to shift from their emphasis of primarily providing services to one that conducts needs assessment and quality assurance. This shift has required increased collection and analysis of data. Health care delivery organizations have also experienced this shift and have increased efforts to collect standardized data on patients, services, and outcomes. The increased emphasis on data collection and analysis for purposes of assessment and evaluation has increased the need to address the associated issues of data availability, validity/reliability, comparability, and utilization. Some key areas where these issues need to be examined at State and local levels are discussed below.

Objective Wording/Operational Definition

Many agencies and organizations have tailored the objectives to better focus on specific concerns of their constituents. These modifications reduce comparability when evaluating objective progress relative to the nation, other States, or localities.

Population Data/Race and Ethnicity Reporting

Many Healthy People objectives are population based and are expressed in terms of mortality or morbidity rates, where the denominator is a population estimate. These estimates are provided by gender, age, and race and ethnicity. However, the sizes of some racial groups are relatively small, even at the national level, and are distributed unevenly across State and local areas. This precludes many jurisdictions from producing reliable rates for objectives that focus on these populations.

"Rare" Events/Confidentiality

Some Healthy People objectives (for example, HIV deaths) address important, sensitive health issues that are relatively rare events. Reporting small numbers of HIV deaths in a county or municipality with a small population may produce unreliable, nonrepresentative rates and may jeopardize confidentiality.

Age Adjustment

In general, States and localities age-adjust mortality data to the same standard population used for the national data. However, because Healthy People 2010 is implementing the 2000 standard population ahead of the recommended schedule, there may be a period of time when the State mortality data do not match the Healthy People 2010 data.

Data Sources

The availability and comparability of data for national, State, and local monitoring of Healthy People objectives vary considerably. Some data, especially vital statistics, are readily available at national, State, county, and some municipal levels. However, vital statistics data provide only a limited perspective on health status, risk behaviors, and access to health care. Morbidity and risk factor data are required to monitor a very large proportion of the current and proposed Healthy People objectives. Data for these objectives come from a wide range of household surveys, environmental hazard data, and other sources. In general, it should be noted that both differences in the data collection methods (household interview versus telephone interview) and wording of questions used to monitor the same objectives can affect the comparability of the information collected.

Other national Healthy People objectives are monitored using composite data sources (for example, General Estimates System). The national data are aggregated from data collected at State or local levels. Unlike the vital statistics data (which include all births and deaths), several of these systems are samples of events that use somewhat different data collection and analysis methods between States or between communities. This affects the quality and comparability of national, State, and local data.

During the development of the Healthy People 2010 objectives, participants proposed that a set of Leading Health Indicators be selected to further improve national, State, and local agencies' abilities to measure and evaluate health status and programmatic activity. The availability of data for the Leading Health Indicators may be somewhat limited at the State level, and it represents a substantial challenge for measurement at the local level.

Healthy People 2010 Database

The Healthy People 2010 database, called "DATA2010," can be accessed through the CDC/WONDER system found on the Internet at http://wonder.cdc.gov/data2010 or through the NCHS Web site at http://www.cdc.gov/nchs. Through DATA2010 the user can create tables that contain the baseline and tracking data for each of the Healthy People 2010 objectives and the Leading Health Indicators.

Tables can be constructed by selecting an entire Healthy People 2010 focus area (with or without related objectives in other focus areas), by selecting an objective within a focus area, or by selecting an objective from a keyword search that will search for all objectives containing a specific word or phrase. Users can also select all data for population subgroups such as race, ethnicity, gender, socioeconomic status, etc. Once tables are generated they can be exported in either ASCII, comma-delimited, or HTML format for use in common software applications such as Lotus 1-2-3 and SAS.

These Web sites also allow users to obtain other Healthy People 2010 information, such as full text of the objectives, lead agency contacts for each focus area, and information on Healthy People 2010 progress reviews.

Database Description

DATA2010 is a SAS database that contains one record (or observation) for each objective and subpart found in the 28 focus areas. The database will also contain records for the measures used to track the goals and the Leading Health Indicators.

Future Plans

In the future, DATA2010 will contain additional population groups, and include options for chart and map generation. State data are expected in the database, and users will be able to select national and/or State data. Where available, standard errors of the estimates will be included in the database.