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HEALTHY PEOPLE 2000 Statistics and Surveillance

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Data Challenges and Successes with Healthy People

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Which came first: the Healthy People objective or the data source to track the objective? This ''chicken or egg'' question and the experience in measuring national health promotion and disease prevention objectives can be instructive for planning Healthy People 2010—the Nation's health agenda for the first decade of the 21st century. This paper examines the experience of the past 18 years in monitoring and reporting on the nation's health objectives. Among the principle findings is that there has been considerably more success in tracking the Healthy People 2000 objectives as compared to the 1990 objectives. The experience in monitoring the second decade of public health objectives has produced more new data on subjects not previously tracked and has offered considerably more insight into prevention issues.

Background

Eighteen years ago, the terms performance measurement, total quality management and continuous quality improvement were not in the lexicon of public managers. Instead the approach was known as management by objectives (MBO). This term, coined by Peter Drucker (1) in the 1950s and pioneered at General Motors, was widely used in the business sector. In 1979, the U.S. Public Health Service (PHS) explored the applicability of MBO in the public sector. By setting the first national health targets in *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* (2), the PHS became the pioneers of the MBO approach in public health.

There were five life-stage targets in the *Surgeon General's Report.* Four of the measures tracked premature mortality. The fifth was an indicator of quality of life for older adults. Tracking the United States progress in reducing infant deaths, child deaths, adolescent and young adult deaths, and adult deaths was relatively easy because of the uniformity and completeness of death records in the U.S. vital statistics system. These four measures could also be replicated and tracked at State and local levels.

As for the older adults target, various measures were used to track this goal. In the *Surgeon General's Report,* death rates for persons over the age of 65 years were complemented by subgoals of reducing influenza and pneumonia deaths and increasing the number of older adults who function independently. In *The 1990 Health Objectives for the Nation: A Midcourse*

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Review (3), the older adults life stage target was stated as 20 percent fewer sick days. In the final report, *Health, United States, 1991 and Prevention Profile* (4), two measures were used for persons 65 years and older—restricted activity days and bed disability days. These measures were the converse of independent functioning. Thus the decade of the 1980s ended without ever fulfilling the promise of developing a satisfactory summary measure of health and independence for the elderly life stage.

In 1980, 226 objectives were published with targets for 1990. Designed to measure disease rates and the preventive interventions and strategies that would support the attainment of the life stage goals, these indicators posed many data challenges. At the time of publication, 73 objectives (32 percent) had no baseline data. While periodic progress reports were published in *Morbidity and Mortality Weekly* on specific priority area topics, A *Midcourse Review* (5) provided the first comprehensive summary report on the status of the Nation's prevention objectives. Published in 1986, this mid-decade report on the 1990 objectives showed that data were lacking for 26 percent of the objectives. However at the end of the decade, 70 objectives were left unmeasured (4). The priority areas with the biggest data gaps were Toxic Agents (14 of 20 objectives); Nutrition (8 of 17 objectives); and Occupational Safety and Health (9 of 20 objectives). Essentially the data gaps at the beginning of the decade were not ever filled.

Healthy People 2000 Data Developments

The difficulties in establishing baseline data and monitoring progress in the 1980s led the framers of the year 2000 objectives to set measurability as one of the criteria for new objectives. Yet, at the time of the release of the first Healthy People 2000 (6) report in September 1990, 91 of the 300 objectives were lacking baseline data. So the second generation of national prevention objectives began at roughly the same starting point as the 1990 objectives—30.3 percent were not measured. But the decade of the nineties began with a heightened level of attention given to getting objectives measured. Commitments were made with lead agencies to invest the resources to develop new measurement systems for the objectives. And in the first two years of Healthy People implementation, the groundwork was laid for developing new data sources.

In the first round of progress reviews chaired by Dr. James Mason, the Assistant Secretary for Health, considerable attention was given to data issues. Dr. Mason required that the Director of the National Center for Health Statistics (NCHS) provide an update on every objective thereby bringing attention to the number of objectives without baselines or data updates.

NCHS also began an annual statistical abstract exclusively focused on the objectives. First published in 1992, the *Healthy People 2000 Review* (7) provides an annual summary report, as well as detailed information for each objective in all of the 22 priority areas. This series of reports shows that there has been significant progress in developing data to track the Nation's prevention objectives. As shown in Table A, there has been steady progress in securing new baseline data. Between 1990 and 1997, 80 baselines have been established.

Table A. Baselines needed for Healthy People 2000 Objectives

1990	91
1991–2	61
1993	28
1994	23
1995–6	19
1997	11

SOURCE: CDC/NCHS, *Healthy People 2000 Reviews*

The new information has come from new surveys as well as supplements to existing data collection mechanisms. Among the new data resources are the Primary Care Providers/Preventive Care Survey that collects information on the extent to which doctors and nurse practitioners inquire, counsel and deliver clinical preventive services. First administered in 1992 by five provider organizations, the survey was repeated in 1997–8 by the American College of Preventive Medicine. A second new survey that was developed to track Healthy People 2000 objectives is the School Health Program and Practices Survey. Conducted by the Centers for Disease Control and Prevention (CDC) to measure the scope of school health curricula, the survey has provided insights into the health-promoting practices of secondary-level schools. A third set of surveys have measured the worksite health promotion activities of employers with 50 or more employees. The first was conducted in 1985 and was expanded in 1992 by the Office of Disease Prevention and Health Promotion with guidance provided by a National Worksite Health Promotion Committee. The results showed that America's employers are increasingly offering their employees health promotion materials and interventions, such as blood pressure and cholesterol checks. In 1995, CDC repeated portions of this survey in the course of determining the extent to which businesses were responding to the HIV epidemic. Because there are 16 provider preventive-care objectives, 14 school health objectives, and 22 worksite health objectives, these new surveys have provided a fundamental understanding of the activities that are taking place in clinical settings, schools and worksites to promote health and prevent disease.

Supplements to the National Health Interview Survey (NHIS) have also provided data for tracking the Healthy People objectives that address health behaviors and use of preventive services. The first supplement was developed in 1991 and additional supplements were administered in 1992, 1993, 1994, and 1995. The 1998 NHIS supplement will provide the last tracking points for the year 2000 objectives and the baselines for the year 2010 objectives. Because of the cross-cutting nature of these supplements, the funding has been provided by multiple agencies in the Department of Health and Human Services.

Because some objectives have lost their data sources, it has also been necessary to establish new tracking

sources. Altogether more than 100 objectives have had a data source created through the Healthy People framework. Despite this success, there remain some 11 objectives without data. Among the subjects not yet tracked are well child care in the Maternal and Infant Health priority areas (objective #14.16). The extent to which there are culturally and linguistically appropriate community health promotion and disease prevention programs also remains to be tracked (objective #8.11).

Moving beyond the baseline has also been a challenge. Without a second data point, there is no way to determine whether progress has been made. While 107 of the objectives are tracked with annual data from a number of data systems, among them, the National Vital Statistics System, the core of the NHIS and environmental health data sources, and 17 objectives are tracked with the data from the biennial Youth Risk Behavior Survey, the other objectives use data that are collected periodically and in some instances episodically. Thus at the point of the 1995 mid-decade review some 21 percent of the objectives lacked an update.

Once the data have been collected, the timeliness of release becomes a consideration. As shown in Table B, about half of the data used in tracking Healthy People 2000 objectives is available within one year of data collection. However, throughout the history of tracking objectives, the timeliness of the information has remained about the same. When the life-stage targets were set in 1979, they were based on 1977 data. At the midcourse review in 1986, the tracking data were from 1984 and the end-of-the-decade report published in 1992 showed provisional 1990 death rates. The life-stage targets continue to be tracked with year 2000 targets. At the time of the *Healthy People 2000 Midcourse Review and 1995 Revisions* (8), data were from 1992 or three years behind the year of publication. In the most current *Healthy People 2000 Review*, 1997 (9), the vital events data are from 1995.

As shown in Table C, there has been considerable progress in providing a data update. *The Healthy People 2000 Reviews* show that while 94 objectives lacked a second data point in 1992, this number has been reduced to 44 in 1997. And there are plans to reduce this number even further. Thus, one of the primary accomplishments of the Healthy People framework has been to drive the development of new measurement systems and to compel the awareness and understanding of new subjects.

Table B. Timeliness of data: Percentage of Healthy People 2000 objectives with data released within 1 or 2 years of data collection

	1 year	*2 year*
1994	65%	24%
1995	67%	24%
1996	46%	16%
1997	49%	18%

SOURCE: CDC/NCHS, *Healthy People 2000 Reviews,* Objective 22.7

Table C. Healthy People 2000 objectives without updates

1991–2	92
1993	69
1994	64
1995–6	75*
1997	44

* As a result of the addition of new objectives in the *Healthy People 2000 Midcourse Review and 1995 Revisions.*

SOURCE: CDC/NCHS, *Healthy People 2000 Reviews*

Healthy People 2010 Plans

As the scope of the next generation of national health objectives is being discussed, plans call for two types of objectives. Measurable objectives have data for baselines against which year 2010 targets can be set. A second type of objectives called developmental objectives has been proposed to be quite explicit about the lack of data. This label will bring attention to the fact that action needs to be taken to define the appropriate measures and to collect the data on those subjects. Furthermore, the plans call for these subjects to be measured before the mid-decade review in the year 2005 so that a year 2010 target could be set.

Laying the groundwork for data development requires significant lead time. For national surveys there is a three to four year lead time to develop the survey instrument and field test it, as well as to construct a sampling frame with sufficient sample sizes to collect data on racial and ethnic population groups. Because of the considerable planning time, most of the surveys that will be used for the Healthy People 2010 developmental objectives are probably already under development. Another challenge to be faced in the next decade is making national data comparable with State-specific data and developing more State and local-level data.

Another aspect of the planning requires that the framers of 2010 objectives anticipate changes in the major data systems used in Healthy People. Because the release of Healthy People 2010 is planned for early in the year 2000, the collection of the year 2000 census data will only have just begun. Yet the population data collected in the census will have a substantial effect on calculating death rates and disease incidence, particularly for population subgroups. The age adjustments done by NCHS to the national mortality data will be updated from a population base of 1940 to 2000. The revisions to the International Classification of Diseases from ICD–9 to ICD–10 will have bearing on objectives that track hospitalization and mortality rates. The Office of Management and Budget's revision to OMB directive #15 that provides the basis for classifying race and ethnicity in federal data collection efforts will take effect on January 1, 2003 (10). As data systems are converted to enable people to identify themselves with multiple racial groups, the effect on tracking subgroups of the U.S. population remains to be calculated. Taken together these many data systems revisions will have a profound impact on tracking the Healthy People 2010 objectives. Because there will be considerable differences in the data sets used as baselines and the tracking data that will update progress, substantial midcourse revisions can be anticipated in both the language and targets of the year 2010 objectives.

Since 1995, most Healthy People publications have been posted on the

world wide web (see box). The Healthy People home page contains the *Midcourse Review and 1995 Revisions, Developing Objectives for 2010* (11), as well as the periodic progress review reports produced by the Office of Disease Prevention and Health Promotion. This web site receives some 8,000 users a month and is ''hot'' linked to the NCHS page that contains the *Healthy People 2000 Review.* In addition to this publication, NCHS posts State-specific data on birth and death events and the 18 Health Status Indicators contained in Healthy People 2000 (see ''Touring the States Through Cyberspace'' in this issue). Using these web sites to provide more frequent data should be possible.

Conclusion

The past 18 years in monitoring and reporting on the Healthy People objectives have provided a means for assessing improvements in national data systems. While the picture that emerges from the first decade shows that little data development occurred, the second generation of Healthy People objectives has impelled considerable new data collection. The creation of new surveys and supplements to existing national surveys have provided new insights into prevention. This track record leads to the explicit inclusion of developmental objectives in Healthy People 2010 to focus attention on important health topics that need to be measured on a national basis in the next decade. The third generation of national health objectives will help to further propel data development.

Healthy People 2000 References

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Schedule of Healthy People 2010 Development

April 1997

Launch of Development Process by Secretary's Council on National Disease Prevention & Health Promotion Objectives for 2010

September ⋈ December

Public Submission of Draft Objectives and Comments on Draft Framework

October ⋈ December 1998

Public Comment Period on Draft 2010 Objectives

January 2000

Release of Healthy People 2010

State and local input is important to Healthy People 2010. Keep in touch
http://web.health.gov/healthypeople
or
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200 Independence Avenue, SW
Washington, DC 20201

Touring the States Through Cyperspace

Several surveys conducted in the past couple years have indicated that as many as half of the county and local departments either do not have computers capable of accessing the Internet or do not have the expertise to utilize the Internet. This is a rapidly changing situation as more and more information is available on the Web and government workers are expected to provide information to the public.

Departments of Health in each of the 50 States and the District of Columbia have home pages on the Web. Table 1 lists the addresses. In virtually all cases, the Department makes information from recent publications available at the site. In some instances the publications are available through .pdf files. To access these files the user must have copies of the Adobe Acrobat program on their computer. (Acrobat is free and can be downloaded from the web at http://www.adobe.com)

In a few cases, the Departments have made interactive data analysis available at their web sites. In these instances, the user specifies the parameters of a request, sends the request by clicking on the appropriate button, and waits for the computer to calculate the results and return the answer to the user. For instance, Utah has data on hospital discharges available at the http://161.119.100.19/hda/hda.html site. CDC makes state- and county-level mortality available through the WONDER site which works as an interactive query system. The WONDER site can be found at the http://wonder.cdc.gov site. No special computer programs are needed beyond the Internet access capability to utilize these query sites.

Another way that data are made available is through downloadable files. These are available on what is known as the FTP server, i.e., the File Transfer Protocol server. To download these files, the user must have a copy of the programs which can use the FTP to read and translate the files. Once these files are on the user's computer, the user must have a copy of the program which can use the files. For instance, in order to access a LOTUS 1–2-3 file, the user must have a copy of that program on their computer. NCHS has state-based data available for downloading as LOTUS 1–2-3 files on the Health Status Indicators (HSIs), Priority Data Needs (PDNs), and mortality-related Healthy People Year 2000 objectives at the http://www.cdc.gov/nchswww/datawh/ftpserv/ftpserv.htm site.

HSIs are also becoming regularly available at the county- and metropolitan-level on a number of home pages of state departments of health. For instance, county and community profiles are available from Florida (http://www.state.fl.us/health/statistics/out96/), Hawaii (http://www.hawaii.gov/health/press/prdoh200.htm), Maine (http://www.state.me.us/dhs/h2k/hm2k001.htm), Massachusetts (http://www.magnet.state.ma.us/dph/hstatin.htm), Oregon (http://www.ohd.hr.state.or.us/cdpe/chs/hsi/or_hsi.htm), Utah (http://hlunix.ex.state.ut.us/action2000/hsind.html), and Washington (http://weber.u.washington.edu/~hserv/hsic/resource/wahealth/hstatus.html). Other states have HSIs, and data from the Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System available at the local level. These sites may be accessed through the CDC home page at the http://www.cdc.gov/other.htm site.

State Home Page Information

	REGISTRATION AREA	*DEPARTMENT OF HEALTH HOME PAGE ADDRESS*
1	ALABAMA	http://www.alapubhealth.org/index.htm
2	ALASKA	http://health.hss.state.ak.us/
3	ARIZONA	http://www.hs.state.az.us/
4	ARKANSAS	http://health.state.ar.us/
5	CALIFORNIA	http://www.dhs.cahwnet.gov/
6	COLORADO	http://www.state.co.us/gov_dir/cdphe_dir/hs/hsshom.html
7	CONNECTICUT	http://www.state.ct.us/dph/
8	DELAWARE	http://www.state.de.us/govern/agencies/dhss/irm/dhss.htm
9	DISTRICT OF COLUMBIA	http://www.ci.washington.dc.us/HEALTH/schs.htm
10	FLORIDA	http://www.state.fl.us/health/
11	GEORGIA	http://www.ph.dhr.state.ga.us/
12	HAWAII	http://www.hawaii.gov/health/sdohpg02.htm
13	IDAHO	http://www.state.id.us/dhw/hwgd_www/home.html
14	ILLINOIS	http://www.idph.state.il.us/
15	INDIANA	http://www.state.in.us/doh/index.html
16	IOWA	http://www.idph.state.ia.us/

State Home Page Information—Con.

	REGISTRATION AREA	DEPARTMENT OF HEALTH HOME PAGE ADDRESS
17	KANSAS	http://www.ink.org/public/kdhe
18	KENTUCKY	http://cfc-chs.chr.state.ky.us/chshome.htm
19	LOUSIANA	http://204.58.127.20/dhh/
20	MAINE	http://www.state.me.us/dhs/boh/
21	MARYLAND	http://www.charm.net/~epi9/index.html
22	MASSACHUSETTS	http://www.magnet.state.ma.us/dph/dphhome.htm
23	MICHIGAN	http://www.mdmh.state.mi.us/
24	MINNESOTA	http://www.health.state.mn.us/
25	MISSISSIPPI	http://www.msdh.state.ms.us/
26	MISSOURI	http://www.health.state.mo.us/
27	MONTANA	http://www.dphhs.mt.gov
28	NEBRASKA	http://www.hhs.state.ne.us/svc/svcindex.htm
29	NEVADA	http://www.state.nv.us/health/
30	NEW HAMPSHIRE	http://www.state.nh.us/dhhs
31	NEW JERSEY	http://www.state.nj.us/health/vital/vital.htm
32	NEW MEXICO	http://www.state.nm.us/state/doh.html
33	NEW YORK STATE	http://www.health.state.ny.us/
34	NEW YORK CITY	http://www.pubadvocate.nyc.gov/^advocate/greenbook/health/health.html
35	NORTH CAROLINA	http://www.dhr.state.nc.us/DHR/
36	NORTH DAKOTA	http://www.ehs.health.state.nd.us/ndhd/
37	OHIO	http://www.state.oh.us/doh/
38	OKLAHOMA	http://www.health.state.ok.us/
39	OREGON	http://www.ohd.hr.state.or.us/
40	PENNSYLVANIA	http://www.state.pa.us/Pa_Exec/Health/overview.html
41	RHODE ISLAND	http://www.state.ri.us/stdept/sd29.htm
42	SOUTH CAROLINA	http://www.state.sc.us/dhec/division.htm
43	SOUTH DAKOTA	http://www.state.sd.us/state/executive/doh/doh.html
44	TENNESSEE	http://www.state.tn.us/health/
45	TEXAS	http://www.hhsc.state.tx.us
46	UTAH	http://hlunix.hl.state.ut.us/
47	VERMONT	http://www.vtmednet.org/
48	VIRGINIA	http://www.vdh.state.va.us
49	WASHINGTON	http://www.doh.wa.gov/
50	WEST VIRGINIA	http://wvbph.marshall.edu
51	WISCONSIN	http://www.dhfs.state.wi.us/
52	WYOMING	http://wdhfs.state.wy.us/WDH/

Healthy People 2000 Senate Briefing

On December 8, 1997, the *Partnership for Prevention* sponsored a briefing for Senate staff on *Healthy People 2000*. The purpose of the briefing was to familiarize Senate staff with *Healthy People 2000*, the data used to track the objectives, and sources of health information that are available. The briefing included presentations of two State *Healthy People 2000* plans to illustrate its utility at the state and local levels.

Dr. Susanne Stoiber, Acting Deputy Assistant Secretary for Disease Prevention and Health Promotion, welcomed the attendees and discussed the value of *Healthy People 2000* as an agenda for promoting health and preventing disease. Dr. Edward Sondik, Director of the National Center for Health Statistics, emphasized data and its importance in tracking *Healthy People 2000* objectives by presenting data at the federal and State levels. His presentation included a demonstration of the health-related data available in a host of web sites on the Internet. State *Healthy People 2000* plans were highlighted by Christopher Atchison, Director of Public Health at the Iowa State Health Department and by Dr. Burt Wilcke, Director of Health Surveillance at the Vermont Health Department. Both speakers noted the flexibility and value of *Healthy People 2000* at the State and county levels, including examples of the impact of *Healthy People 2000* on health plans in their respective States. The briefing ended with an invitation for all participants to submit their comments and recommendations on the proposed structure of *Healthy People 2010*. A similar briefing is scheduled for the House of Representatives for January 20.

Community Health Risk Assessment

On December 3, 1997, the Columbus and Franklin Health Departments jointly released the final report of the 1995–1996 Commmunity Health Risk Assessment. Over 100 of the Departments' community partners attended the event and discussed how they plan to use the data. Participants represented funding agencies, hospitals, universities, health-related associations, elected officials, libraries, and local schools. Also present were members of the local television and radio news media. This document contains information on health behaviors specific to the community. Never before has such comprehensive local information been compilied. This is a result of a large-scale telephone survey, funded by the National Center for Health Statistics, CDC, and conducted by Information Transfer Systems, Inc. of Ann Arbor, MI. The Columbus and Franklin Health Departments jointly were one of six communities that participated in the survey. Other survey communities include Houston and Harris County, TX; Benton County and Washington County, OR; and Delaware/Morrow/Union Counties, OH. *The Columbus and Franklin County 1995–1996 Community Health Risk Assessment* is available at any of the Columbus Metropolitan libraries or by contacting the health departments as listed below. It will soon be available on either health department's web site. Questions regarding the survey instrument and methodology should be directed to Information Transfer Systems, Inc, 1250 North Main Street, Ann Arbor, MI 48104 or telephone 313–994-0003.

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Priority Data Needs

Issue No. 15 of *Statiscal Notes*, an NCHS periodical, addresses the Priority Data Needs (PDNs). As part of their mandate to identify a set of indicators of community health status which would be relevant to public health practice, the Committee 22.1 identified PDNs as indicators that would be important for evaluating the health of a population; however, data for these indicators were not necessarily available for all levels of government in 1991.

The Committee's recommendation that existing data collection systems be modified to accommodate the PDNs served as an impetus for the development of alternative collection mechanisms to measure the PDNs. The Note provides definitions, State-level data sources, and standardized core questions for PDNs. These details should help State, Tribal, and local health agencies collect and evaluate these data items and, thereby, adopt the measures in the assessment of their community's health status and program planning, development and evaluation. If you would like to receive the *Statisticcal Notes* publications regularly, please contact NCHS by calling 301–436-8500.

State Health Profiles

State Health Profiles is a series of annual publications produced by the Epidemiology Program Office of the CDC. Begun in 1987, *State Health Profiles* is comprised of 51 separate monographs: one for each State and one for the District of Columbia. Currently, *State Health Profiles* are based on the 18 Health Status Indicators (HSIs) recommended by Committee 22.1, a panel of members representing key public health associations and organizations (see *Consensus set of health status indicators for the general assessment of community health status - United States.* MMWR. 40(27): 449–51. 1991). The HSIs are considered a minimum set of community health status data intended to describe a profile of the status of health and to plan, implement, describe and evaluate public health policies and programs. In addition to HSIs, other programs and prevention efforts for specific health conditions are highlighted each year. A brief description of State's partnership activities with CDC and of CDC funds for State and local health departments is also included in the *Profiles*. *State Health Profiles* are produced in a limited quantity. In addition to the members of the Congress, *Profiles* are distributed to State health departments. In order to obtain copies, please contact your State department of health.

Assessment Initiative Cooperative Agreement

The second round of the Assessment Initiative Cooperative Agreement began on October 1, 1997 with the following six State health departments as new grantees: New York, Massachusetts, Oregon, Missouri, North Carolina and Minnesota. An article detailing program objectives and focus of each State program will be contributed by the new coordinator of the Assessment Initiative, Dr. Carol Friedman of the Epidemiology Program Office, CDC, and will appear in the upcoming issue of *Statistics and Surveillance*.

Published Issues of Healthy People 2000 Statistical Notes

Number	*Title*	*Date of Issue*
1	Health Status Indicators for the Year 2000	Fall 1991
2	Infant Mortality	Winter 1991
3	Health Status Indicators: Definitions and National Data	Spring 1992
4	Issues Related to Monitoring the Year 2000 Objectives	Summer 1993
5	Revisions to *Healthy People 2000* Baselines	July 1993
6	Direct Standardization (Age-Adjusted Death Rates)	March 1995
7	Years of Healthy Life	April 1995
8	Evaluating Public Health Data Systems: A Practical Approach	June 1995
9	Monitoring Air Quality in Healthy People 2000	September 1995
10	Health Status Indicators: Differentials by Race and Hispanic Origin	September 1995
11	Operational Definitions for Year 2000 Objectives: Priority Area 20, Immunization and Infectious Diseases	February 1997
12	Operational Definitions for Year 2000 Objectives: Priority Area 23, Oral Health May 1997	May 1997
13	*Health People 2000* Midcourse Revisions; A Compendium	August 1997
14	Operational Definitions for Year 2000 Objectives: Priority Area 13, Maternal and Child Health	December 1997
15	Priority Data Needs: Sources of National, State, and Local-Level Data and Data Collection Systems	December 1997
16	Operational Definitions for Year 2000 Objectives: Priority Area 6, Mental Health and Mental Disorders	February 1998

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