Section 2.
Overview by Focus Area

Access to Quality Health Services

1

Co-Lead Agencies:

Agency for Healthcare Research and Quality
Health Resources and Services Administration

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Goal: Improve access to comprehensive, high-quality health care services.

Introduction*

Access to quality health services encompasses access to primary care, preventive services, and other health care services on a continuum of care in the health care delivery system. These services provide indicators of quality in the delivery of selected services in four settings: clinical preventive care, primary care, emergency services, and long-term care and rehabilitative services.

Since the release of *Healthy People 2010*, progress has been made in identifying national-level data sources for nearly all the objectives in this focus area. With few exceptions, the objectives with a baseline and at least one additional data year are making progress toward their targets.

Access to quality health services underpins the two overarching goals of Healthy People 2010: increase quality and years of healthy life and eliminate health disparities.

Sufficient national-level data were lacking to assess health insurance coverage for clinical preventive services. However, data from public and private insurance plans indicated that, over the past few years, most health insurance plans (excluding many "catastrophic health plans") provided coverage for a basic package of clinical preventive services, screening, or preventive counseling services, such as for weight control or tobacco use.[1]

Access to regular and consistent medical care also is important to quality of life and life expectancy. Objectives related to this goal that moved toward their targets included increasing the proportion of persons with a usual primary care provider and reducing difficulties or delays in obtaining needed health care.

Pediatric care also is making advances. Decreasing hospitalization for pediatric asthma moved toward its target. Pediatric protocols for online medical direction and pediatric guidelines for emergency and critical care also showed progress toward their targets. Such guidelines and protocols are likely to improve health-related quality of life and life expectancy as health care providers gain access to, and use of, evidence-based prevention interventions and treatment.

The second overarching goal of Healthy People 2010—eliminating health disparities—is being advanced by several objectives. Between 1997 and 2003, the disparities gap between poor and middle/high-income persons with health insurance decreased by 10 to 49 percentage points. Nonetheless, the difference between these two groups remained high; poor persons were three times as likely to lack health insurance as were middle/high-income persons. Data for racial and ethnic representation in health professions also

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* Unless otherwise noted, data referenced in this focus area come from Healthy People 2010 and can be located at http://wonder.cdc.gov/data2010. See the section on DATA2010 in the Technical Appendix for more information.

showed overall progress toward the targets for increasing the numbers of persons from racial and ethnic populations graduating from schools of nursing and pharmacy. The majority of objectives showed improvement in reducing disparities over the first half of the decade.

Modifications to Objectives and Subobjectives

The following discussion highlights the modifications, including changes, additions, and deletions, to this focus area's objectives and subobjectives as a result of the midcourse review.

As stated in *Healthy People 2010*: "Most developmental objectives have a potential data source with a reasonable expectation of data points by the year 2004 to facilitate setting 2010 targets in the mid-decade review. Developmental objectives with no baseline at the midcourse will be dropped." Accordingly, at the midcourse review some developmental objectives and subobjectives were deleted due to lack of a data source. However, the U.S. Department of Health and Human Services (HHS) and the agencies that serve as the leads for the Healthy People 2010 initiative will consider ways to ensure that these public health issues retain prominence despite their current lack of data.

Health insurance coverage for clinical preventive services (1-2) was deleted because no national-level data source was available. Data sources for counseling about health behaviors (1-3) were identified for all but one of the developmental subobjectives—vehicle restraints and bicycle helmets (1-3e), which was deleted due to a lack of data source. The wording of developmental subobjective 1-3d was changed from "excessive alcohol consumption" to "risky drinking" to reflect the data source and use an established, approved definition for excessive drinking. The age range for management of menopause (1-3h) was adjusted from 46 to 56 years of age to 45 to 57 years of age to more accurately reflect the data source. Counseling about sexually transmitted diseases (1-3g) remained developmental.

Core competencies in health profession training (1-7) remained a developmental objective. Of the seven national health profession organizations supporting data collection, four had sufficient data sources for use: allopathic medicine, osteopathic medicine, baccalaureate nursing, and advanced practice nursing. The other three organizations are working to secure similar data for physician assistants, dentistry, and pharmacy.[2]

The wording of objective 1-7 was modified to more accurately capture the inclusion of sentinel core competencies in health profession training. Two sentinel core curriculum competencies—counseling for health promotion and disease prevention and cultural diversity—were selected, and eight subobjectives were created to track those competencies in the curricula for allopathic medicine, osteopathic medicine, baccalaureate nursing, and advanced practice nursing.

Delay or difficulty in getting emergency care (1-10) became measurable as data were obtained from questions added to the National Health Interview Survey.

Rapid-response prehospital emergency care (1-11) became measurable as a comprehensive data source was identified. Seven subobjectives were created to describe the components of rapid-response prehospital emergency medical services (EMS) as defined by the American Medical Association's Subcommittee on Trauma Care. Data were obtained from the National Assessment of State Trauma System Development and Disaster Readiness for Mass Casualty Events.

The data source for trauma systems (1-13) was replaced by the Federal Trauma–Emergency Medical Services System Program Survey, which is a more comprehensive Federal data source that measures the components of a State-level trauma care system. The wording of the objective was modified to reflect the measurement of system-level improvement as reflected in the new data source. Nine subobjectives were created to show the data for the selected components of a State trauma plan or system.

The wording of long-term care services (1-15) was modified from "increase the proportion of persons with long-term care needs who have access to the continuum of long-term care services" to "reduce the proportion of adults with long-term care needs who do not have access to the continuum of long-term care services." The wording of the objective was modified to accurately reflect the data source. Four subobjectives were created to identify the delivery sites for long-term care services: home health care, adult day care, assisted living, and nursing home care.

Progress Toward Healthy People 2010 Targets

The following discussion highlights objectives that met or exceeded their 2010 targets; moved toward the targets, demonstrated no change, or moved away from the targets; and those that lacked data to assess progress. Progress is illustrated in the Progress Quotient bar chart (see Figure 1-1), which displays the percent of targeted change achieved for objectives and subobjectives with sufficient data to assess progress.

Objectives that met or exceeded their targets. The objective for a single toll-free number for poison control centers (1-12) met its target in 2001. The Poison Control Center Enhancement and Awareness Act was enacted in 2000 to provide a source of supplemental support to poison control centers (PCCs). The Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), and the American Association of Poison Control Centers have worked to maintain a national toll-free number so that access to the information is ensured.

The targets for representation of the Asian or Pacific Islander population in all health professions (1-8b), medicine (1-8j), dentistry (1-8n), and pharmacy (1-8r) were exceeded at the 1996–97 baseline and continued to improve beyond the baseline.

Objectives that moved toward their targets. Many objectives and subobjectives progressed toward their targets. Data indicated forward progress for persons with sources of ongoing care (1-4); persons with a usual primary care provider (1-5); difficulties or delays in obtaining needed health care (1-6); representation in health professions of underrepresented racial and ethnic groups (1-8), with the exception of black non-Hispanic representation in medicine (1-8k) and representation in dentistry by the American Indian or Alaska Native population (1-8m), the black non-Hispanic population (1-8o), and the Hispanic population (1-8p); hospitalization for pediatric asthma (1-9a); and pediatric guidelines for online medical direction and emergency and critical care (1-14a and b).

HHS agencies support programs to measure and improve the quality of care for persons living with asthma and to prevent hospitalization for uncontrolled asthma. Examples include the Agency for Healthcare Research and Quality's annual *National Healthcare Quality Report*[3] and *National Healthcare Disparities Report*[4]; HRSA's Health Disparities Asthma Collaborative,[5] which uses the Chronic Care

Model[6] to improve the length and quality of life for patients with chronic diseases, including asthma, and to satisfy patient and caregiver needs; and CDC's *Steps to a HealthierUS*[7] community grant program to prevent and improve the quality of care for chronic diseases, including asthma.

Progress toward the targets for persons with sources of ongoing care (1-4), persons with a usual primary care provider (1-5), and difficulties or delays in obtaining needed health care (1-6) may in part be attributed to the expansion of HRSA's community health center program across the country. The program now serves approximately 14 million people.[8]

Objectives that demonstrated no change. The overall proportion of persons with health insurance (1-1) remained similar to the proportion of persons with health insurance in 1997 with minor fluctuations.

The proportion of the black non-Hispanic population represented in medicine (1-8k) did not change, nor did the percentage of the American Indian or Alaska Native population or the Hispanic population represented in dentistry (1-8m and 1-8p, respectively). Through the Indian Health Service (IHS) programs, HHS strives to increase the proportion of the American Indian or Alaska Native population represented in health professions. The IHS Division of Health Professions Support Service Center houses the Loan Repayment Program and the Scholarship Program.[9] These programs function collaboratively to provide repayment of health profession education loans for a 2-year service obligation and scholarships to American Indian or Alaska Native health professionals. In addition, HRSA programs are geared toward diversifying the health professions workforce, such as the Centers of Excellence, Scholarships for Disadvantaged Students, and the Health Careers Opportunity Program.[10]

Objectives that moved away from their targets. For racial and ethnic representation in health professions (1-8), the black non-Hispanic population moved away from the target for dentistry (1-8o). The percentage of black non-Hispanic persons graduating from dental schools fell from 5.1 percent in 1996–97 to 4.0 percent in 2001–02. However, the percentage of black non-Hispanic persons graduating from schools of nursing (1-8g) and pharmacy (1-8s) increased, achieving 61 percent and 26 percent of the targeted change for these subobjectives, respectively.

HHS agencies continue to support programs that increase the numbers of underrepresented racial and ethnic populations entering the health profession fields so that the health workforce more accurately reflects the populations served. Grant programs fund disadvantaged individuals to compete successfully for health profession training programs.[11] The agencies actively seek to inform youth about health profession careers and the critical decision points in a person's life when career choices are made.

Subobjectives 1-9b and 1-9c moved away from their targets, with increases seen in hospitalizations for uncontrolled diabetes in persons aged 18 to 64 years and for immunization-preventable pneumonia or influenza in persons aged 65 years and older. Self-reported reasons for not receiving the influenza vaccination included lack of awareness that the influenza vaccination is needed, concerns that vaccination might cause side effects, vaccine shortages, or unavailability. Further efforts are needed to educate older persons regarding the benefits of the influenza vaccination and to address concerns of vaccine safety.[12]

The HHS-sponsored Task Force on Community Preventive Services recommends these effective interventions to increase the use of recommended immunizations: reminder systems for health care providers, standing orders to allow health professionals who are not physicians (for example, nurses and

pharmacists) to administer immunizations without direct physician involvement, consumer reminder and recall systems, reduction of out-of-pocket costs, expanded access to immunizations in health care settings, and provider assessment plus feedback to improve efficiency in administering recommended immunizations.[13]

Objective 1-16 moved away from its target with an increase in pressure ulcers in nursing home residents. Functioning (walking, dressing, eating, and bathing) of nursing home residents decreased between 1977 and 1999. In particular, the proportion of residents able to walk independently decreased from 33 percent to 21 percent.[14] Poorer functioning at older ages may result in increases in the percentage of nursing home residents with pressure ulcers.

Objectives that could not be assessed. The following objectives had only baseline data and could not be assessed: counseling about health behaviors (1-3a through d, f, and h), delay or difficulty in getting emergency care (1-10), rapid prehospital emergency care (1-11), trauma systems (1-13), and long-term care services (1-15). Potential data sources were identified for counseling for sexually transmitted diseases (1-3g) and core competencies in health profession training (1-7a through h).

The Emergency Medical Treatment and Active Labor Act, enacted in 1986, ensures universal access to emergency care without regard to health care insurance coverage.[15] Still, barriers exist to accessing emergency care. The number of emergency departments (EDs) declined 12.3 percent over the past 10 years, but the number of annual visits increased 24 percent to 114 million.[16]

With limited resources, EDs are experiencing overcrowding, ambulance diversion, boarding of admitted patients in the department, increased waiting times, and on-call crises. The overcrowding has depleted the surge capacity needed to deal with a natural disaster or a terrorism event.[17]

Progress Toward Elimination of Health Disparities

The following discussion highlights progress toward the elimination of health disparities. The disparities are illustrated in the Disparities Table (see Figure 1-2), which displays information about disparities among select populations for which data were available for assessment.

Numerous disparities in access to health care were observed among select populations. Among racial and ethnic groups, the white non-Hispanic population had the best group rate for health insurance (1-1), counseled about smoking cessation (1-3c), a source of ongoing care (1-4a, b, and c), usual primary care provider (1-5), difficulties or delays in obtaining needed health care (1-6), and delay or difficulty in getting emergency care (1-10). The black non-Hispanic population had the best rate for two of the subobjectives: persons counseled about physical activity (1-3a) and diet and nutrition (1-3b).

Females had better rates than males for health insurance (1-1); counseled about physical activity (1-3a), diet and nutrition (1-3b), and smoking cessation (1-3c); a source of ongoing care (1-4a, b, and c); usual primary care provider (1-5); and hospitalization for pediatric asthma (1-9a), uncontrolled diabetes (1-9b), and immunization-preventable pneumonia or influenza (1-9c). Males had the better rate for difficulties or delays in obtaining needed health care (1-6). The disparity between males and females for this objective increased by about 35 percentage points between 1996 and 1999.

Persons with at least some college had the best rates for counseling about physical activity (1-3a) and management of menopause (1-3h), usual primary care provider (1-5), and delay or difficulty in getting emergency care (1-10). The disparity between high school graduates and persons with at least some college having a usual primary care provider increased by about 10 percentage points between 1996 and 1999. High school graduates had the best rate for counseling about smoking cessation (1-3c). The middle/high-income population had the best rates for health insurance (1-1); counseled about physical activity (1-3a), smoking cessation (1-3c), and management of menopause (1-3h); a source of ongoing care (1-4a, b, and c); difficulties or delays in obtaining needed health care (1-6); hospitalization for pediatric asthma (1-9a), uncontrolled diabetes (1-9b), and immunization-preventable pneumonia or influenza (1-9c); and delay or difficulty in getting emergency care (1-10).

Disparities were observed for a number of objectives and subobjectives. The percentages of the American Indian or Alaska Native population and the Hispanic population that did not have health insurance (1-1) in 2003 were more than twice that of the white non-Hispanic population. Similarly, despite a decline in disparity between the poor and middle/high-income populations, lack of health insurance coverage among the poor and near-poor populations was more than three times that of the middle/high-income population.

Disparities were noted in the proportion of persons having a source of ongoing care (1-4). The disparity between the Hispanic population and the white non-Hispanic population exceeded 100 percent for all age groups; the level of disparity has been increasing for all ages and for persons aged 18 years and older (1-4a and c). A similar level of disparity was observed among the Asian and black non-Hispanic populations for persons under 18 years of age (1-4b). Between 1998 and 2003, the disparity between the black non-Hispanic and white non-Hispanic populations increased by 65 percentage points. Disparities of over 50 percent were also observed for objective 1-4 between the best income group (middle/high income) and the poor and near-poor populations.

Disparities in excess of 100 percent among income groups were observed between the poor and middle/high-income groups for hospitalizations for pediatric asthma (1-9a), uncontrolled diabetes (1-9b), and immunization-preventable pneumonia or influenza (1-9c). Disparities between the near-poor and the middle/high-income groups ranged from 50 percent to 100 percent or more.

Persons of two or more races were three times as likely as white non-Hispanic persons to experience delay or difficulty in getting emergency care (1-10). Similarly, the poor and near-poor populations were about twice as likely as the middle/high-income population to have difficulty in obtaining emergency care. Persons with disabilities were three times as likely as those without disabilities to have difficulty in obtaining care.

Opportunities and Challenges

Opportunities and challenges continue to exist when examining the disparities in access to health care and the 45 million persons who are uninsured. The Institute of Medicine has estimated that 18,000 deaths per year are directly related to the lack of health care insurance.[18]

There is a continued need to focus efforts on geographic regions where persons have limited access to primary and preventive health care. These include, but are not restricted to, rural and border areas. *Rural Healthy People 2010* and *Healthy Border 2010*, companion documents to *Healthy People 2010*, recognize significant preventable threats to health and identify priority health needs for residents of these regions.[19, 20]

Recruitment, training, and continuing education of the Nation's health care workforce, focused on both sentinel components of disease prevention and chronic care management, will continue to be important as linguistically appropriate services are needed.

Challenges exist for meeting targets for long-term care (LTC) services of home health, adult day care, assisted living, and nursing home care. Few older and middle-aged adults purchase LTC insurance due to the general misconception that Medicare provides coverage for extended use of LTC services.[21] Consumers have difficulty comparing one LTC policy with another because of differences in the services covered (for example, nursing home care versus home- and community-based care), as well as the extent and nature of the coverage.[21, 22] Older adults prefer to receive LTC services at home or in the community, rather than give up their independence by moving to a nursing home.[23] These preferences result in a greater demand for home health care and more challenges in meeting the target.

Emerging Issues

Primary care and preventive health care services remain the central health promotion and disease prevention components of the American health care system.[24] The continuing work of the U.S. Preventive Services Task Force and its *Guide to Clinical Preventive Services*, the *Healthy People 2000* chapter on clinical preventive services, the Healthy People 2010 objectives on clinical preventive care, and national prevention initiatives strive to achieve a heightened public and health professional awareness of the importance of clinical preventive services. The Medicare Prescription Drug, Improvement, and Modernization Act (Medicare Modernization Act), enacted in 2003, has expanded Medicare's menu of preventive benefits by covering an initial preventive physical examination. The Medicare Modernization Act also provides coverage for cardiovascular screening blood tests and for diabetes screening tests.[25] Input from insured populations and corporate cost-management initiatives may also be contributing to a heightened focus on reimbursement for preventive services.

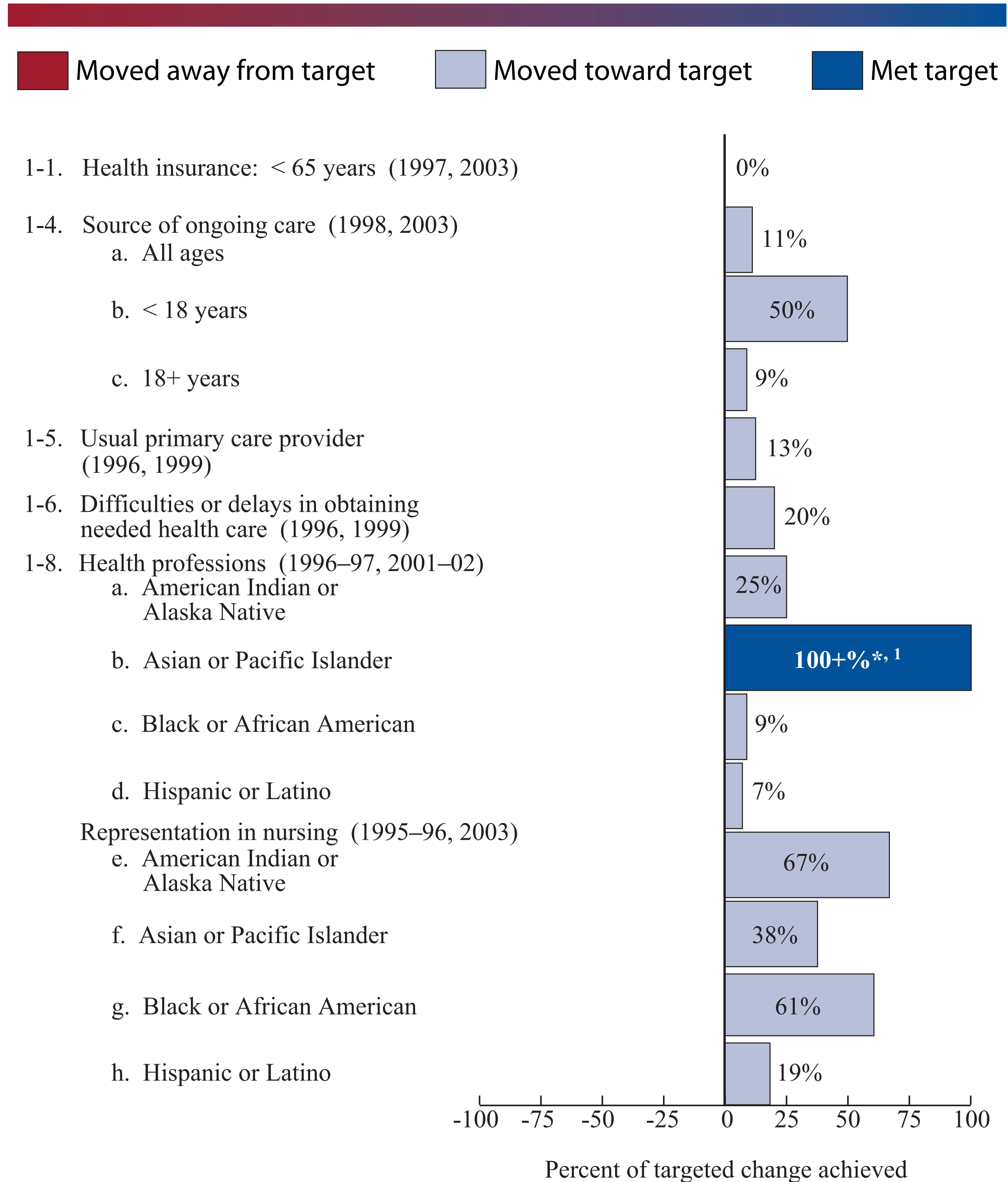
No national data regarding which preventive services are covered by health insurance exist. Initiating and sustaining collection of such information would be useful in assessing and increasing access to preventive care.

Timely access to the ED should be studied and tracked using measures that address health care disparities. Outcome measures could include EMS diversion times, patients leaving without being seen, patients in the ED longer than 6 hours, admitted patients who must wait for an inpatient bed more than 2 hours, antibiotics initiated for community-acquired pneumonia within 6 hours of ED arrival, and per-shift nurse-to-patient ratios (means and ranges) adjusted for triage acuity.

Emerging issues in LTC include topics of workforce, insurance, and consumer-directed services.[26] In addition, quality of care remains an enduring issue, but new approaches may have a positive impact. Because the older population has a higher rate for disability,[27] the aging of the baby boomers could result in increased demand for LTC services. This increase in demand will lead to a need for a LTC workforce. A major issue is how to attract, train, and retain a LTC workforce of health and social service providers.[28] Increasing effectiveness and use of chronic disease management may reduce disability and slow the increase in demand for LTC services. Education of older and middle-aged persons may increase the purchase of LTC insurance, especially if incentives are used. Recent illustrations of consumer direction of supportive services have shown promise in giving older persons and their families greater control over delivery of LTC services.[28] One consequence of consumer-directed services may be an even greater demand for LTC services, such as home health care and adult day care, that emphasize living independently in the community.[29]

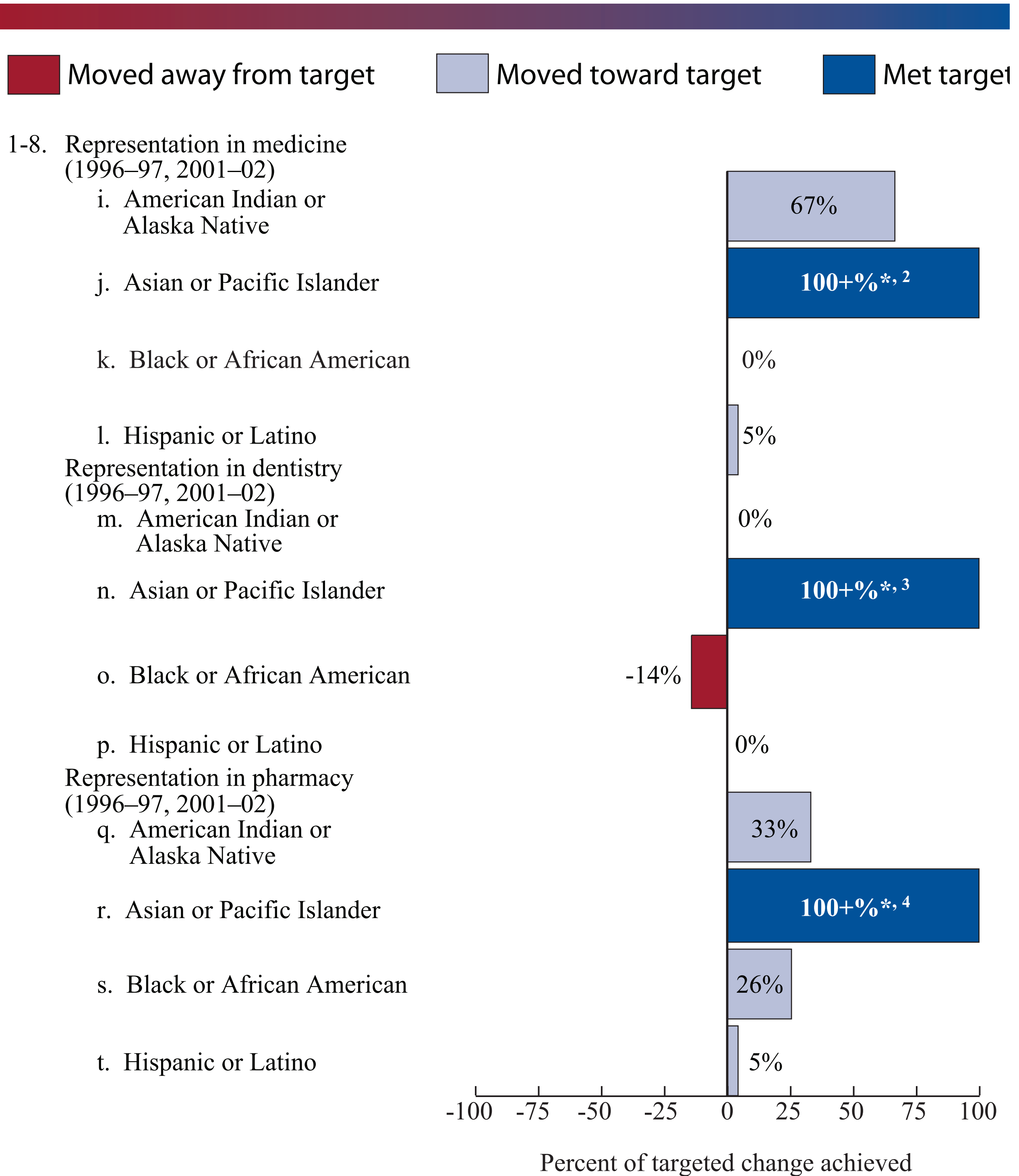
Recommendations of the Institute of Medicine Committee on Improving Quality in Long Term Care include, among others, efforts to help LTC providers redesign care processes consistent with best practices and improvements in quality of life.[30] Others have recommended more consumer-centered emphasis in quality of life domains.[30] How each of these issues evolves will have an impact on future demand for and access to specific types of LTC services.

Figure 1-1. Progress Quotient Chart for Focus Area 1: Access to Quality Health Services



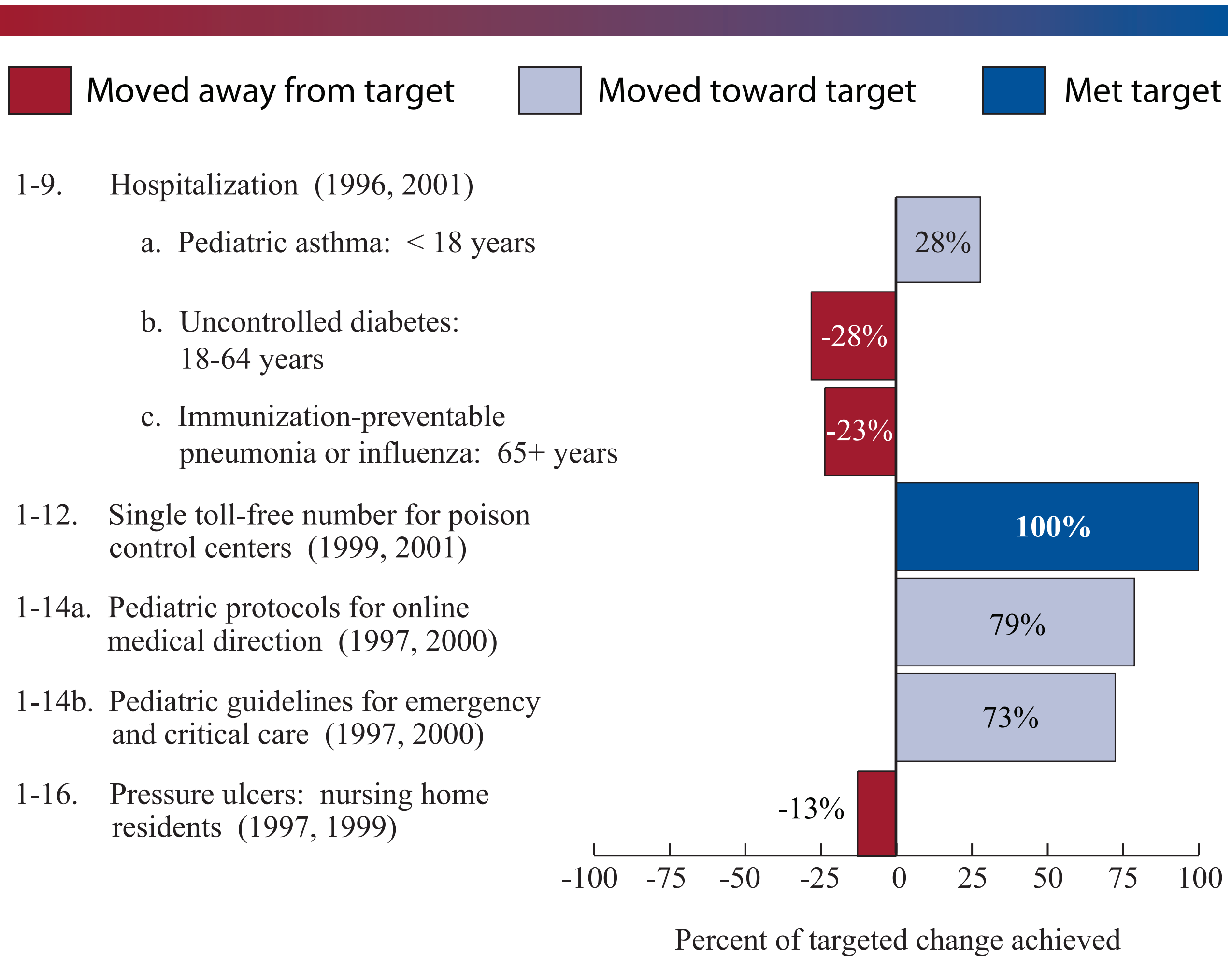
See notes at end of chart. *(continued)*

Figure 1-1. *(continued)*



See notes at end of chart. *(continued)*

Figure 1-1. *(continued)*



Notes: Tracking data for objectives 1-3a through d, f, g, and h, 1-7a through h, 1-10, 1-11a through g, 1-13a through i, and 1-15a through d are unavailable. Objectives 1-2 and 1-3e were deleted at the midcourse.

Years in parentheses represent the baseline data year and the most recent data year used to compute the percent of the Healthy People 2010 target achieved.

$$\text{Percent of targeted change achieved} = \left(\frac{\text{Most recent value} - \text{baseline value}}{\text{Year 2010 target} - \text{baseline value}}\right) \times 100$$

* Percent of target achieved cannot be calculated.

[1] The most recent value is 20.4%; the baseline value is 16.3%; the target value is 4.0%.

[2] The most recent value is 20.1%; the baseline value is 16.0%; the target value is 4.0%.

[3] The most recent value is 25.1%; the baseline value is 19.5%; the target value is 4.0%.

[4] The most recent value is 21.5%; the baseline value is 17.5%; the target value is 4.0%.

Figure 1-2. Disparities Table for Focus Area 1: Access to Quality Health Services

Disparities from the best group rate for each characteristic at the most recent data point and changes in disparity from the baseline to the most recent data point.

Population-based objectives	Characteristics: Race and ethnicity								Gender		Education				Income				Location		Disability	
	American Indian or Alaska Native	Asian	Native Hawaiian or other Pacific Islander	Two or more races	Hispanic or Latino	Black non-Hispanic	White non-Hispanic	**Summary index**	Female	Male	Less than high school	High school graduate	At least some college	**Summary index**	Poor	Near poor	Middle/high income	**Summary index**	Urban or metropolitan	Rural or nonmetropolitan	Persons with disabilities	Persons without disabilities
1-1. Health insurance: < 65 years (1997, 2003) * [1]							B		B						↓		B		B		B	
1-3a. Counseled about physical activity: 18+ years (2001) *						B			B				B				B		B		B	
1-3b. Counseled about diet and nutrition: 18+ years (2001) *						B			B		B				B				B		B	
1-3c. Counseled about smoking cessation: 18+ years (2001) *	b						B		B			B					B			B	B	
1-3d. Counseled about reduced alcohol consumption: 18+ years (2001) *						B				B	B				B					B	B	
1-3f. Counseled about unintended pregnancy: females 15-44 years (1995) †						B						B										
1-3h. Counseled about management of menopause: females 45-57 years (2001) *					B								B				B		B			B
1-4a. Source of ongoing care: all ages (1998, 2003) * [1]					↑		B		B								B			B	B	↑
1-4b. Source of ongoing care: < 18 years (1998, 2003) * [1]						↑↑	B		B								B					
1-4c. Source of ongoing care: 18+ years (1998, 2003) * [1]					↑		B		B								B			B	B	
1-5. Usual primary care provider (1996, 1999) *		2					B		B			↑	B							B	B	
1-6. Delays or difficulties in obtaining needed health care (1996, 1999) *	b	2				b	B		↑	B					3	3	B[3]	3	B			B
1-9a. Hospitalization for pediatric asthma: < 18 years (1996)†									B						4	4	B[4]	4				
1-9b. Hospitalization for uncontrolled diabetes: 18-64 years (1996)†									B						4	4	B[4]	4				
1-9c. Hospitalization for immunization-preventable pneumonia or influenza: 65+ years (1996)†									B						4	4	B[4]	4				
1-10. Delay or difficulty in getting emergency care (2001) *							B			B			B				B		B			B
1-15a. Access to home health care: 65+ years with long-term care needs (2001) *																						
1-15b. Access to adult day care: 65+ years with long-term care needs (2001) *																						
1-15c. Access to assisted living: 65+ years with long-term care needs (2001) *																						
1-15d. Access to nursing home care: 65+ years with long-term care needs (2001) *																						
1-16. Pressure ulcers: nursing home residents (1997, 1999) *																						

(continued)

Figure 1-2. *(continued)*

Notes: Data for objectives 1-3g, 1-7a through h, 1-8a through t, 1-11a through g, 1-12, 1-13a through i, and 1-14a and b are unavailable or not applicable. Objectives 1-2 and 1-3e were deleted at the midcourse.

Years in parentheses represent the baseline data year and the most recent data year (if available).

Disparity from the best group rate is defined as the percent difference between the best group rate and each of the other group rates for a characteristic (for example, race and ethnicity). The summary index is the average of these percent differences for a characteristic. Change in disparity is estimated by subtracting the disparity at baseline from the disparity at the most recent data point. Change in the summary index is estimated by subtracting the summary index at baseline from the summary index at the most recent data point. See Technical Appendix for more information.

The **best group rate** at the most recent data point.	B The group with the best rate for specified characteristic.	b Most favorable group rate for specified characteristic, but reliability criterion not met.		Best group rate reliability criterion not met.
	Percent difference from the best group rate			
Disparity from the best group rate at the most recent data point.	Less than 10 percent or not statistically significant	10-49 percent	50-99 percent	100 percent or more
Changes in disparity over time are shown when the change is greater than or equal to 10 percentage points and statistically significant, or when the change is greater than or equal to 10 percentage points and estimates of variability were not available.		**Increase** in disparity (percentage points)		
		↑ 10-49	↑↑ 50-99	↑↑↑ 100 or more
		Decrease in disparity (percentage points)		
		↓ 10-49	↓↓ 50-99	↓↓↓ 100 or more
Availability of data.	Data not available.		Characteristic not selected for this objective.	

* The variability of best group rates was assessed, and disparities of $\geq 10\%$ are statistically significant at the 0.05 level. Changes in disparity over time, noted with arrows, are statistically significant at the 0.05 level. See Technical Appendix.

† Measures of variability were not available. Thus, the variability of best group rates was not assessed, and the statistical significance of disparities and changes in disparity over time could not be tested. See Technical Appendix.

[1] Baseline data by race and ethnicity are for 1999.

[2] Data are for Asians or Pacific Islanders.

[3] Baseline data only.

[4] Median ZIP code income levels: $25,000 or less, $25,001-$35,000, and more than $35,000.

Objectives and Subobjectives for Focus Area 1: Access to Quality Health Services

Goal: Improve access to comprehensive, high-quality health care services.

As a result of the Healthy People 2010 Midcourse Review, changes were made to the Healthy People 2010 objectives and subobjectives. These changes are specific to the following situations:

- Changes in the wording of an objective to more accurately describe what is being measured.
- Changes to reflect a different data source or new science.
- Changes resulting from the establishment of a baseline and a target (that is, when a formerly developmental objective or subobjective became measurable).
- Deletion of an objective or subobjective that lacked a data source.
- Correction of errors and omissions in *Healthy People 2010.*

Revised baselines and targets for measurable objectives and subobjectives do not fall into any of the above categories and, thus, are not considered a midcourse review change.[1]

When changes were made to an objective, three sections are displayed:

1. In the Original Objective section, the objective as published in *Healthy People 2010* in 2000 is shown.
2. In the Objective With Revisions section, strikethrough indicates text deleted, and underlining is used to show new text.
3. In the Revised Objective section, the objective appears as revised as a result of the midcourse review.

Details of the objectives and subobjectives in this focus area, including any changes made at the midcourse, appear on the following pages.

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[1] See Technical Appendix for more information on baseline and target revisions.

Clinical Preventive Care

NO CHANGE IN OBJECTIVE

1-1. Increase the proportion of persons with health insurance.

Target: 100 percent.

Baseline: 83 percent of persons under age 65 years were covered by health insurance in 1997 (age adjusted to the year 2000 standard population).

Target setting method: Total coverage.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

OBJECTIVE DELETED

1-2. ***(Objective deleted due to lack of data source)*** **(Developmental) Increase the proportion of insured persons with coverage for clinical preventive services.**

ORIGINAL OBJECTIVE

1-3. Increase the proportion of persons appropriately counseled about health behaviors.

Target and baseline:

Objective	Increase in Counseling on Health Behaviors Among Persons at Risk With a Physician Visit in the Past Year	1995 Baseline	2010 Target
		Percent	
1-3a.	Physical activity or exercise (adults aged 18 years and older)	Developmental	
1-3b.	Diet and nutrition (adults aged 18 years and older)	Developmental	
1-3c.	Smoking cessation (adult smokers aged 18 years and older)	Developmental	
1-3d.	Reduced alcohol consumption (adults aged 18 years and older with excessive alcohol consumption)	Developmental	
1-3e.	Childhood injury prevention: vehicle restraints and bicycle helmets (children aged 17 years and under)	Developmental	
1-3f.	Unintended pregnancy (females aged 15 to 44 years)	19	50
1-3g.	Prevention of sexually transmitted diseases (males aged 15 to 49 years; females aged 15 to 44 years)	Developmental	

ORIGINAL OBJECTIVE *(continued)*

1-3h.	Management of menopause (females aged 46 to 56 years)	Developmental

Target setting method: Better than the best.

Data sources: National Survey on Family Growth (NSFG), CDC, NCHS; National Health Interview Survey (NHIS), CDC, NCHS.

OBJECTIVE WITH REVISIONS
(Including subobjective deleted)

1-3. Increase the proportion of persons appropriately counseled about health behaviors.

Target and baseline:

Objective*	Increase in Counseling on Health Behaviors Among Persons at Risk With a Physician Visit in the Past Year	~~1995~~2001 Baseline (unless noted)	2010 Target
		Percent	
1-3a.	Physical activity or exercise (adults aged 18 years and older)	~~Developmental~~45	54
1-3b.	Diet and nutrition (adults aged 18 years and older)	~~Developmental~~43	56
1-3c.	Smoking cessation (adult smokers aged 18 years and older)	66	72
1-3d.	~~Reduced alcohol consumption (adults aged 18 years and older with excessive alcohol consumption)~~ Risky drinking (adults aged 18 years and older)	~~Developmental~~11	17
~~**1-3e.**~~	*(Subobjective deleted due to lack of data source)** ~~Childhood injury prevention: vehicle restraints and bicycle helmets (children aged 17 years and under)~~	~~Developmental~~	
1-3f.	Unintended pregnancy (females aged 15 to 44 years)	19 (1995)	50
1-3g.	Prevention of sexually transmitted diseases (males aged 15 to 49 years; females aged 15 to 44 years)	Developmental	
1-3h.	Management of menopause (females aged 4~~6~~5 to 5~~6~~7 years)	~~Developmental~~40	42

OBJECTIVE WITH REVISIONS *(continued)*
(Including subobjective deleted)

* For data control purposes, subobjectives are not renumbered.

Target setting method: Better than the best.

Data sources: National Survey on Family Growth (NSFG), CDC, NCHS; National Health Interview Survey (NHIS), CDC, NCHS.

REVISED OBJECTIVE

1-3. Increase the proportion of persons appropriately counseled about health behaviors.

Target and baseline:

Objective*	Increase in Counseling on Health Behaviors Among Persons at Risk With a Physician Visit in the Past Year	2001 Baseline (unless noted)	2010 Target
		Percent	
1-3a.	Physical activity or exercise (adults aged 18 years and older)	45	54
1-3b.	Diet and nutrition (adults aged 18 years and older)	43	56
1-3c.	Smoking cessation (adult smokers aged 18 years and older)	66	72
1-3d.	Risky drinking (adults aged 18 years and older)	11	17
1-3f.	Unintended pregnancy (females aged 15 to 44 years)	19 (1995)	50
1-3g.	Prevention of sexually transmitted diseases (males aged 15 to 49 years; females aged 15 to 44 years)	Developmental	
1-3h.	Management of menopause (females aged 45 to 57 years)	40	42

* For data control purposes, subobjectives are not renumbered.

Target setting method: Better than the best.

Data sources: National Survey on Family Growth (NSFG), CDC, NCHS; National Health Interview Survey (NHIS), CDC, NCHS.

Primary Care

NO CHANGE IN OBJECTIVE

1-4. Increase the proportion of persons who have a specific source of ongoing care.

Target and baseline:

Objective	Increase in Persons With Specific Source of Ongoing Care	1998 Baseline*	2010 Target
		Percent	
1-4a.	All ages	87	96
1-4b.	Children and youth aged 17 years and under	93	97
1-4c.	Adults aged 18 years and older	85	96

* Age adjusted to the year 2000 standard population.

Target setting method: Better than the best.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

NO CHANGE IN OBJECTIVE

1-5. Increase the proportion of persons with a usual primary care provider.

Target: 85 percent.

Baseline: 77 percent of the population had a usual primary care provider in 1996.

Target setting method: Better than the best.

Data source: Medical Expenditure Panel Survey (MEPS), AHRQ.

NO CHANGE IN OBJECTIVE

1-6. Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members.

Target: 7 percent.

Baseline: 12 percent of families experienced difficulties or delays in obtaining health care or did not receive needed care in 1996.

Target setting method: Better than the best.

Data source: Medical Expenditure Panel Survey (MEPS), AHRQ.

ORIGINAL OBJECTIVE

1-7. (Developmental) Increase the proportion of schools of medicine, schools of nursing, and other health professional training schools whose basic curriculum for health care providers includes the core competencies in health promotion and disease prevention.

Potential data source: Adaptation of the Prevention Self-Assessment Analysis, Association of Teachers of Preventive Medicine (ATPM).

OBJECTIVE WITH REVISIONS

1-7. (Developmental) Increase ~~the proportion of schools of medicine, schools of nursing, and other health professional training schools whose basic curriculum for health care providers includes the~~ the inclusion of sentinel core competencies in health promotion and disease prevention in health profession training.

Target and baseline:

Objective	Increase in the Inclusion of Sentinel Core Competencies

Schools that include the competency in required courses

1-7a.	Allopathic medicine—counseling for health promotion and disease prevention	Developmental
1-7b.	Allopathic medicine—cultural diversity	Developmental

Students who receive training in the competency in required courses or clerkships

1-7c.	Osteopathic medicine—counseling for health promotion and disease prevention	Developmental
1-7d.	Osteopathic medicine—cultural diversity	Developmental

Schools that include the competency in required courses

1-7e.	Undergraduate nursing—counseling for health promotion and disease prevention	Developmental
1-7f.	Undergraduate nursing—cultural diversity	Developmental

Total clinical tracks that include the competency in the core curriculum

1-7g.	Advanced practice nursing—counseling for health promotion and disease prevention	Developmental
1-7h.	Advanced practice nursing—cultural diversity	Developmental

OBJECTIVE WITH REVISIONS *(continued)*

Potential data sources: ~~Adaptation of the Prevention Self-Assessment Analysis, Association of Teachers of Preventive Medicine (ATPM).~~ Liaison Committee on Medical Education (LCME) Annual Medical School Questionnaire, Association of American Medical Colleges (AAMC); Annual Report on Osteopathic Medical Education, American Association of Colleges of Osteopathic Medicine (AACOM); Women's Health in the Baccalaureate Nursing School Curriculum Survey, American Association of Colleges of Nursing (AACN); Collaborative Curriculum Survey, AACN and National Organization of Nurse Practitioner Faculties (NONPF).

REVISED OBJECTIVE

1-7. (Developmental) Increase the inclusion of sentinel core competencies in health promotion and disease prevention in health profession training.

Target and baseline:

Objective	Increase in the Inclusion of Sentinel Core Competencies	
	Schools that include the competency in required courses	
1-7a.	Allopathic medicine—counseling for health promotion and disease prevention	Developmental
1-7b.	Allopathic medicine—cultural diversity	Developmental
	Students who receive training in the competency in required courses or clerkships	
1-7c.	Osteopathic medicine—counseling for health promotion and disease prevention	Developmental
1-7d.	Osteopathic medicine—cultural diversity	Developmental
	Schools that include the competency in required courses	
1-7e.	Undergraduate nursing—counseling for health promotion and disease prevention	Developmental
1-7f.	Undergraduate nursing—cultural diversity	Developmental
	Total clinical tracks that include the competency in the core curriculum	
1-7g.	Advanced practice nursing—counseling for health promotion and disease prevention	Developmental
1-7h.	Advanced practice nursing—cultural diversity	Developmental

REVISED OBJECTIVE *(continued)*

Potential data sources: Liaison Committee on Medical Education (LCME) Annual Medical School Questionnaire, Association of American Medical Colleges (AAMC); Annual Report on Osteopathic Medical Education, American Association of Colleges of Osteopathic Medicine (AACOM); Women's Health in the Baccalaureate Nursing School Curriculum Survey, American Association of Colleges of Nursing (AACN); Collaborative Curriculum Survey, AACN and National Organization of Nurse Practitioner Faculties (NONPF).

NO CHANGE IN OBJECTIVE
(Data updated and footnoted)

1-8. In the health professions, allied and associated health profession fields, and the nursing field, increase the proportion of all degrees awarded to members of underrepresented racial and ethnic groups.

Target and baseline:

Objective	Increase in Degrees Awarded to Underrepresented Populations	1996–97 Baseline (unless noted)	2010 Target
		Percent	
	Health professions, allied and associated health profession fields (For the baselines, health professions include medicine, dentistry, pharmacy, and public health.)		
1-8a.	American Indian or Alaska Native	0.6	1.0
1-8b.	Asian or Pacific Islander	16.3[1]	4.0*
1-8c.	Black or African American	6.5[2]	13.0
1-8d.	Hispanic or Latino	5.2[3]	12.0
	Nursing		
1-8e.	American Indian or Alaska Native	0.7 (1995–96)	1.0
1-8f.	Asian or Pacific Islander	3.2 (1995–96)	4.0
1-8g.	Black or African American	6.9 (1995–96)	13.0
1-8h.	Hispanic or Latino	3.4 (1995–96)	12.0
	Medicine		
1-8i.	American Indian or Alaska Native	0.7[4]	1.0
1-8j.	Asian or Pacific Islander	16.0[5]	4.0*
1-8k.	Black or African American	7.0[6]	13.0
1-8l.	Hispanic or Latino	5.9[7]	12.0

NO CHANGE IN OBJECTIVE *(continued)*
(Data updated and footnoted)

	Dentistry		
1-8m.	American Indian or Alaska Native	0.5	1.0
1-8n.	Asian or Pacific Islander	19.5	4.0*
1-8o.	Black or African American	5.1	13.0
1-8p.	Hispanic or Latino	5.3[8]	12.0
	Pharmacy		
1-8q.	American Indian or Alaska Native	0.4	1.0
1-8r.	Asian or Pacific Islander	17.5	4.0
1-8s.	Black or African American	5.7	13.0
1-8t.	Hispanic or Latino	3.6[9]	12.0

* The Asian or Pacific Islander population group has exceeded its target, which represents the minimum target based on this group's estimated proportion of the population.

[1] Baseline revised from 16.2 after November 2000 publication.
[2] Baseline revised from 6.7 after November 2000 publication.
[3] Baseline revised from 4.0 after November 2000 publication.
[4] Baseline revised from 0.6 after November 2000 publication.
[5] Baseline revised from 15.9 after November 2000 publication.
[6] Baseline revised from 7.3 after November 2000 publication.
[7] Baseline revised from 4.6 after November 2000 publication.
[8] Baseline revised from 4.7 after November 2000 publication.
[9] Baseline revised from 2.8 after November 2000 publication.

Target setting method: Targets based on U.S. Bureau of the Census projections of the proportions of racial and ethnic groups in the population for the year 2000.

Data sources: Survey of Predoctoral Dental Educational Institutions, American Dental Association (ADA); Profile of Pharmacy Students, American Association of Colleges of Pharmacy (AACP); AAMC Data Book: Statistical Information Related to Medical Schools and Teaching Hospitals, Association of American Medical Colleges (AAMC); Annual Data Report, American Association of Schools of Public Health; Annual Survey of Registered Nurse Programs, National League for Nursing (NLN), Center for Research in Nursing Education and Community Health.

NO CHANGE IN OBJECTIVE

1-9. Reduce hospitalization rates for three ambulatory-care-sensitive conditions—pediatric asthma, uncontrolled diabetes, and immunization-preventable pneumonia and influenza.

Target and baseline:

Objective	Reduction in Hospitalizations for Ambulatory-Care-Sensitive Conditions	1996 Baseline	2010 Target
		Admissions per 10,000 Population	
1-9a.	Pediatric asthma—persons under age 18 years	23.0	17.3
1-9b.	Uncontrolled diabetes—persons aged 18 to 64 years	7.2	5.4
1-9c.	Immunization-preventable pneumonia or influenza—persons aged 65 years and older	10.6	8.0

Target setting method: 25 percent improvement.

Data source: Healthcare Cost and Utilization Project (HCUP), AHRQ.

Emergency Services

ORIGINAL OBJECTIVE

1-10. (Developmental) Reduce the proportion of persons who delay or have difficulty in getting emergency medical care.

Potential data source: National Health Interview Survey (NHIS), CDC, NCHS.

OBJECTIVE WITH REVISIONS

1-10. ~~(Developmental)~~ Reduce the proportion of persons who delay or have difficulty in getting emergency medical care.

Target: 1.5 percent.

Baseline: 2.4 percent of persons delayed or had difficulty in getting emergency medical care in 2001.

Target setting method: Better than the best.

~~Potential d~~Data source: National Health Interview Survey (NHIS), CDC, NCHS.

REVISED OBJECTIVE

1-10. Reduce the proportion of persons who delay or have difficulty in getting emergency medical care.

Target: 1.5 percent.

Baseline: 2.4 percent of persons delayed or had difficulty in getting emergency medical care in 2001.

Target setting method: Better than the best.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

ORIGINAL OBJECTIVE

1-11. (Developmental) Increase the proportion of persons who have access to rapidly responding prehospital emergency medical services.

Potential data source: Annual Survey of EMS Operations, International Association of Fire Fighters.

OBJECTIVE WITH REVISIONS

1-11. ~~(Developmental)~~ Increase the proportion of persons who have access to rapidly responding prehospital emergency medical services.

Target and baseline:

Objective	Increase in Access to Rapidly Responding Prehospital Emergency Medical Services	2002 Baseline*	2010 Target
		Percent	
1-11a.	Population covered by basic life support	91	100
1-11b.	Population covered by advanced life support	77	85
1-11c.	Population covered by helicopter	75	83
1-11d.	Population living in area with prehospital access to online medical control	78	86
1-11e.	Population covered by basic 911	74	81
1-11f.	Population covered by enhanced 911	72	79
1-11g.	Population living in area with two-way communication between hospitals	68	75

OBJECTIVE WITH REVISIONS *(continued)*

* Baseline is for 50 States, not including the District of Columbia or Territories, with the following exceptions:

1-11a. Data represent all States except Colorado, Illinois, and West Virginia.
1-11b. Data represent all States except Colorado, Illinois, New Hampshire, Ohio, and West Virginia.
1-11c. Data represent all States except Colorado and Georgia.
1-11d. Data represent all States except Colorado, Louisiana, New York, Ohio, Oregon, and Wisconsin.
1-11e. Data represent all States except Kentucky, Maine, and Virginia.
1-11f. Data represent all States except Kentucky, Maine, and Virginia.
1-11g. Data represent all States except Arkansas, Colorado, Idaho, Louisiana, Missouri, North Carolina, Ohio, Oklahoma, South Dakota, Tennessee, Texas, Washington, and Wyoming.

Target setting method: 10 percent improvement.

~~Potential d~~Data source: ~~Annual Survey of EMS Operations, International Association of Fire Fighters.~~ National Assessment of State Trauma System Development, Emergency Medical Services Resources, and Disaster Readiness for Mass Casualty Events, HRSA.

REVISED OBJECTIVE

1-11. Increase the proportion of persons who have access to rapidly responding prehospital emergency medical services.

Target and baseline:

Objective	Increase in Access to Rapidly Responding Prehospital Emergency Medical Services	2002 Baseline*	2010 Target
		Percent	
1-11a.	Population covered by basic life support	91	100
1-11b.	Population covered by advanced life support	77	85
1-11c.	Population covered by helicopter	75	83
1-11d.	Population living in area with prehospital access to online medical control	78	86
1-11e.	Population covered by basic 911	74	81
1-11f.	Population covered by enhanced 911	72	79
1-11g.	Population living in area with two-way communication between hospitals	68	75

REVISED OBJECTIVE *(continued)*

* Baseline is for 50 States, not including the District of Columbia or Territories, with the following exceptions:

1-11a. Data represent all States except Colorado, Illinois, and West Virginia.
1-11b. Data represent all States except Colorado, Illinois, New Hampshire, Ohio, and West Virginia.
1-11c. Data represent all States except Colorado and Georgia.
1-11d. Data represent all States except Colorado, Louisiana, New York, Ohio, Oregon, and Wisconsin.
1-11e. Data represent all States except Kentucky, Maine, and Virginia.
1-11f. Data represent all States except Kentucky, Maine, and Virginia.
1-11g. Data represent all States except Arkansas, Colorado, Idaho, Louisiana, Missouri, North Carolina, Ohio, Oklahoma, South Dakota, Tennessee, Texas, Washington, and Wyoming.

Target setting method: 10 percent improvement.

Data source: National Assessment of State Trauma System Development, Emergency Medical Services Resources, and Disaster Readiness for Mass Casualty Events, HRSA.

NO CHANGE IN OBJECTIVE

1-12. Establish a single toll-free telephone number for access to poison control centers on a 24-hour basis throughout the United States.

Target: 100 percent.

Baseline: 15 percent of poison control centers shared a single toll-free number in 1999.

Target setting method: Total coverage.

Data source: American Association of Poison Control Centers Survey, U.S. Poison Control Centers.

ORIGINAL OBJECTIVE

1-13. Increase the number of Tribes, States, and the District of Columbia with trauma care systems that maximize survival and functional outcomes of trauma patients and help prevent injuries from occurring.

Target: All Tribes, States, and the District of Columbia.

Baseline: 5 States had trauma care systems in 1998.

Target setting method: Total coverage. (Tribal trauma systems are measured differently because they frequently are regional and often are linked to a State EMS.)

ORIGINAL OBJECTIVE *(continued)*

Data sources: State EMS Directors Survey, National Association of State EMS Directors; IHS (Tribal data are developmental).

OBJECTIVE WITH REVISIONS

1-13. Increase the number of Tribes, States, and the District of Columbia with State-level trauma ~~care~~ system facilitation and coordination of statewide defined criteria~~systems that maximize survival and functional outcomes of trauma patients and help prevent injuries from occurring~~.

Target and baseline:

Objective	Increase in State-Level Trauma System Facilitation and Coordination of Statewide Defined Criteria	2002 Baseline	2010 Target
		Number of Tribes, States, and the District of Columbia*	
1-13a.	Presence of active multidisciplinary trauma advisory committee	29	51
1-13b.	Defined process for designing trauma centers	34	51
1-13c.	Use of American College of Surgeons standards for trauma center verification	34	51
1-13d.	Use of onsite survey teams for trauma center verification	36	51
1-13e.	Prehospital triage criteria allowing for the bypass of nondesignated hospitals	27	51
1-13f.	Standardized interhospital transfer protocols	23	51
1-13g.	Policies describing the types of patients who should be transferred	23	51
1-13h.	Process to monitor and evaluate trauma system outcomes	30	51
1-13i.	Trauma system plan	32	51

* Baseline data for Tribes are not available.

~~**Target:** All Tribes, States, and the District of Columbia.~~

~~**Baseline:** 5 States had trauma care systems in 1998.~~

OBJECTIVE WITH REVISIONS *(continued)*

Target setting method: Total coverage. ~~(Tribal trauma systems are measured differently because they frequently are regional and often are linked to a State EMS.)~~

Data sources: ~~State EMS Directors Survey, National Association of State EMS Directors; IHS (Tribal data are developmental).~~Federal Trauma-Emergency Medical Services System Program Survey, HRSA.

REVISED OBJECTIVE

1-13. Increase the number of Tribes, States, and the District of Columbia with State-level trauma system facilitation and coordination of statewide defined criteria.

Target and baseline:

Objective	Increase in State-Level Trauma System Facilitation and Coordination of Statewide Defined Criteria	2002 Baseline	2010 Target
		Number of Tribes, States, and the District of Columbia*	
1-13a.	Presence of active multidisciplinary trauma advisory committee	29	51
1-13b.	Defined process for designing trauma centers	34	51
1-13c.	Use of American College of Surgeons standards for trauma center verification	34	51
1-13d.	Use of onsite survey teams for trauma center verification	36	51
1-13e.	Prehospital triage criteria allowing for the bypass of nondesignated hospitals	27	51
1-13f.	Standardized interhospital transfer protocols	23	51
1-13g.	Policies describing the types of patients who should be transferred	23	51
1-13h.	Process to monitor and evaluate trauma system outcomes	30	51
1-13i.	Trauma system plan	32	51

* Baseline data for Tribes are not available.

Target setting method: Total coverage.

REVISED OBJECTIVE *(continued)*

Data source: Federal Trauma-Emergency Medical Services System Program Survey, HRSA.

NO CHANGE IN OBJECTIVE

1-14. Increase the number of States and the District of Columbia that have implemented guidelines for prehospital and hospital pediatric care.

1-14a. Increase the number of States and the District of Columbia that have implemented statewide pediatric protocols for online medical direction.

Target: All States and the District of Columbia.

Baseline: 18 States had implemented statewide pediatric protocols for online medical direction in 1997.

Target setting method: Total coverage.

Data source: Emergency Medical Services for Children Annual Grantees Survey, HRSA.

1-14b. Increase the number of States and the District of Columbia that have adopted and disseminated pediatric guidelines that categorize acute care facilities with the equipment, drugs, trained personnel, and other resources necessary to provide varying levels of pediatric emergency and critical care.

Target: All States and the District of Columbia.

Baseline: 11 States had adopted and disseminated pediatric guidelines that categorize acute care facilities with the equipment, drugs, trained personnel, and other resources necessary to provide varying levels of pediatric emergency and critical care in 1997.

Target setting method: Total coverage.

Data source: Emergency Medical Services for Children Annual Grantees Survey, HRSA.

Long-Term Care and Rehabilitative Services

ORIGINAL OBJECTIVE

1-15. (Developmental) Increase the proportion of persons with long-term care needs who have access to the continuum of long-term care services.

Potential data sources: National Long-Term Care Survey, Medicare Current Beneficiary Survey, HCFA; National Health Interview Survey (NHIS), CDC, NCHS; Medical Expenditure Panel Survey (MEPS), AHRQ.

OBJECTIVE WITH REVISIONS

1-15. ~~(Developmental)~~ ~~Increase~~ Reduce the proportion of ~~persons~~ adults with long-term care needs who do not have access to the continuum of long-term care services.

Target and baseline:

Objective	Reduction in Proportion of Adults Aged 65 Years and Older With Long-Term Care Needs Who Do Not Have Access to the Continuum of Long-Term Care Services	2001 Baseline	2010 Target
		Percent	
1-15a.	Home health care	9.6	7.7
1-15b.	Adult day care	2.9	2.3
1-15c.	Assisted living	3.3	1.8
1-15d.	Nursing home care	1.1	0.8

Target setting method: Better than the best.

~~Potential d~~Data sources: ~~National Long-Term Care Survey, Medicare Current Beneficiary Survey, HCFA;~~ National Health Interview Survey (NHIS), CDC, NCHS~~;~~ ~~Medical Expenditure Panel Survey (MEPS), AHRQ~~.

REVISED OBJECTIVE

1-15. Reduce the proportion of adults with long-term care needs who do not have access to the continuum of long-term care services.

Target and baseline:

Objective	Reduction in Proportion of Adults Aged 65 Years and Older With Long-Term Care Needs Who Do Not Have Access to the Continuum of Long-Term Care Services	2001 Baseline	2010 Target

REVISED OBJECTIVE *(continued)*

		Percent	
1-15a.	Home health care	9.6	7.7
1-15b.	Adult day care	2.9	2.3
1-15c.	Assisted living	3.3	1.8
1-15d.	Nursing home care	1.1	0.8

Target setting method: Better than the best.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

NO CHANGE IN OBJECTIVE

1-16. Reduce the proportion of nursing home residents with a current diagnosis of pressure ulcers.

Target: 8 diagnoses per 1,000 residents.

Baseline: 16 diagnoses of pressure ulcers per 1,000 nursing home residents were made in 1997.

Target setting method: Better than the best.

Data source: National Nursing Home Survey (NNHS), CDC, NCHS.

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Related Objectives From Other Focus Areas

2. Arthritis, Osteoporosis, and Chronic Back Conditions

2-2. Activity limitations due to arthritis
2-3. Personal care limitations
2-6. Racial differences in total knee replacement
2-7. Seeing a health care provider
2-11. Activity limitations due to chronic back conditions

3. Cancer

3-10. Provider counseling about cancer prevention
3-11. Pap tests
3-12. Colorectal cancer screening
3-13. Mammograms

5. Diabetes

5-1. Diabetes education
5-4. Diagnosis of diabetes
5-11. Annual urinary microalbumin measurement
5-12. Annual glycosylated hemoglobin measurement
5-13. Annual dilated eye examinations
5-14. Annual foot examinations
5-16. Aspirin therapy

6. Disability and Secondary Conditions

6-7. Congregate care of children and adults with disabilities
6-10. Accessibility of health and wellness programs

7. Educational and Community-Based Programs

7-2. School health education
7-3. Health-risk behavior information for college and university students
7-5. Worksite health promotion programs
7-12. Older adult participation in community health promotion activities

9. Family Planning

9-1. Intended pregnancy
9-2. Birth spacing
9-3. Contraceptive use
9-5. Emergency contraception
9-6. Male involvement in pregnancy prevention
9-10. Pregnancy prevention and sexually transmitted disease (STD) protection
9-11. Reproductive health education
9-13. Insurance coverage for contraceptive supplies and services

11. Health Communication

11-2. Health literacy

11-6. Satisfaction with health care providers' communication skills

12. Heart Disease and Stroke

12-1. Coronary heart disease (CHD) deaths

12-15. Blood cholesterol screening

13. HIV

13-6. Condom use

13-8. HIV counseling and education for persons in substance abuse treatment

14. Immunization and Infectious Diseases

14-5. Invasive pneumococcal infections

14-22. Universally recommended vaccination of children aged 19 to 35 months

14-23. Vaccination coverage for children in day care and kindergarten

14-24. Fully immunized young children and adolescents

14-25. Providers who measure childhood vaccination coverage levels

14-26. Children participating in population-based immunization registries

14-27. Vaccination coverage among adolescents

14-28. Hepatitis B vaccination among high-risk groups

14-29. Influenza and pneumococcal vaccination of high-risk adults

15. Injury and Violence Prevention

15-7. Nonfatal poisonings

15-8. Deaths from poisoning

15-10. Emergency department surveillance systems

15-12. Emergency department visits

15-19. Safety belts

15-20. Child restraints

15-21. Motorcycle helmet use

15-23. Bicycle helmet use

15-24. Bicycle helmet laws

16. Maternal, Infant, and Child Health

16-1. Fetal and infant deaths

16-2. Child deaths

16-3. Adolescent and young adult deaths

16-17. Prenatal substance exposure

16-18. Fetal alcohol syndrome

16-20. Newborn bloodspot screening

16-22. Medical homes for children with special health care needs

16-23. Service systems for children with special health care needs

17. Medical Product Safety

17-5. Receipt of oral counseling about medications from prescribers and dispensers

18. Mental Health and Mental Disorders

18-6. Primary care facilities providing treatment
18-7. Treatment for children with mental health problems
18-8. Juvenile justice facility screening
18-9. Treatment for adults with mental disorders
18-10. Treatment for co-occurring disorders
18-11. Adult jail diversion programs or mental health courts
18-12. State tracking of consumer satisfaction
18-13. State plans addressing cultural competence
18-14. State plans addressing elderly persons

19. Nutrition and Overweight

19-1. Healthy weight in adults
19-2. Obesity in adults
19-3. Overweight or obesity in children and adolescents
19-4. Growth retardation in children
19-17. Nutrition counseling for medical conditions
19-18. Food security

21. Oral Health

21-7. Annual examinations for oral and pharyngeal cancers
21-10. Use of oral health care system
21-11. Use of oral health care system by residents in long-term care facilities
21-13. School-based health centers with oral health component
21-14. Health centers with oral health service components
21-15. Referral for cleft lip or palate
21-16. Oral and craniofacial State-based surveillance system
21-17. Health agency dental programs

22. Physical Activity and Fitness

22-12. School physical activity facilities
22-13. Worksite physical activity and fitness
22-14. Community walking
22-15. Community bicycling

23. Public Health Infrastructure

23-2. Public access to information and surveillance data
23-3. Use of geocoding in health data systems
23-8. Competencies for public health workers
23-9. Training in essential public health services
23-10. Continuing education for public health personnel
23-12. Health improvement plans
23-13. Access to public health laboratory services
23-14. Access to epidemiology services

24. Respiratory Diseases

24-6. Patient education
24-7. Appropriate asthma care
24-11. Medical evaluation and followup

25. Sexually Transmitted Diseases

25-11. Responsible adolescent sexual behavior
25-13. Hepatitis B vaccine services in STD clinics
25-16. Annual screening for genital chlamydia

26. Substance Abuse

26-18. Treatment for alcohol or illicit drugs
26-20. Treatment of injection drug use
26-21. Treatment for alcohol abuse
26-22. Hospital emergency department referrals

27. Tobacco Use

27-5. Smoking cessation by adults
27-7. Smoking cessation by adolescents
27-8. Insurance coverage of cessation treatment

28. Vision and Hearing

28-1. Dilated eye examinations
28-2. Vision screening for children
28-10. Vision rehabilitation services and devices
28-11. Newborn hearing screening, evaluation, and intervention
28-13. Hearing aids, assistive listening devices, and cochlear implants
28-14. Hearing examination