Midcourse Review

HEALTHY PEOPLE 2010

Educational and Community-Based Programs

7

Co-Lead Agencies:

Centers for Disease Control and Prevention
Health Resources and Services Administration

Contents

Goal: Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life.

Introduction*

Educational and community-based programs continue to play an integral role in the success of Healthy People objectives. The programs also contribute to the improvement of health outcomes in the United States. Developed to reach people outside traditional health care settings, these programs are fundamental to health promotion and quality of life. The programs emphasize education, policy, and environmental strategies in schools, worksites, health care sites, and the community, and they provide guidance for intervention development and implementation.[1]

Healthy People 2010's two overarching goals to increase quality and years of healthy life and eliminate health disparities are supported and advanced by the objectives for educational and community-based programs. Knowledge is important in making healthy behavioral and lifestyle decisions, and the mission of these programs is to foster and develop this knowledge. By being local and community-based, these programs reduce disparities by increasing the proportion of the population that has access to health information and disease prevention programs.

At the time of this midcourse review, the most successful location for progress in education and community health programs was within the school setting. High school completion by persons aged 18 to 24 years and the school nurse-to-student ratio for middle/junior and senior high schools progressed toward the 2010 targets. School health education for middle/junior and senior high schools demonstrated a mixed picture, depending on the subject.

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.

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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.

No midcourse review changes were made to the wording of the objectives or subobjectives. No new objectives or subobjectives were added. Three objectives were deleted due to lack of data sources: patient and family education in the health care setting (7-7), patient satisfaction with education received in a health care setting (7-8), and health care organization sponsorship of community health promotion activities (7-9). Twelve subobjectives within the objective for culturally appropriate and linguistically competent community health programs (7-11) were deleted due to a lack of data sources: access to quality health services (7-11a); arthritis, osteoporosis, and chronic back conditions (7-11b); chronic kidney disease (7-11d); diabetes (7-11e); disability and secondary conditions (7-11f); food safety (7-11j); medical product safety (7-11k); health communication (7-11l); injury and violence prevention (7-11p); public health infrastructure (7-11w); respiratory diseases (7-11x); and vision and hearing (7-11bb).

The school nurse-to-student ratio (at least 1:750) for elementary schools (7-4d) became measurable. In 2000, 53 percent of elementary schools had a nurse-to-student ratio of greater than 1 to 750, and the target was set at 60 percent.[1] The data source for this objective, the School Health Policies and Programs Study, is anticipated to collect another data point by the end of the decade.

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 7-1), which displays the percent of targeted change achieved for objectives and subobjectives with sufficient data to assess progress.

A review of progress toward meeting targets for Educational and Community-Based Programs provides a limited picture. Four objectives and their subobjectives had data available for review (7-1, 7-2a through j, 7-4, and 7-6).

Two subobjectives for schools with a nurse-to-student ratio of at least 1 to 750 (7-4) met their targets: middle/junior and senior high schools (7-4a) and middle and junior high schools (7-4c).

Progress was made for six objectives and subobjectives: high school completion (7-1); school health education for unintentional injury (7-2b), violence (7-2c), suicide (7-2d), and tobacco use and addiction (7-2e); and the proportion of senior high schools with a nurse-to-student ratio of at least 1 to 750 (7-4b).

School health education for unhealthy dietary patterns (7-2h) and environmental health (7-2j) demonstrated no change since the beginning of the decade.

Five objectives and subobjectives moved away from their targets: school health education for all priority areas (7-2a), alcohol and other drug use (7-2f), unintended pregnancy, HIV/AIDS, and sexually transmitted disease (STD) infection (7-2g), and inadequate physical activity (7-2i), as well as participation in employer-sponsored health promotion programs (7-6). Data to assess trends for the remaining five objectives were unavailable.

Objectives that met or exceeded their targets. The proportion of all middle/junior and senior high schools with a nurse-to-student ratio of at least 1 to 750 (7-4a) increased from 28 percent to 53 percent, achieving 114 percent of the targeted change. The proportion of middle and junior high schools with a nurse-to-student ratio of 1 to 750 (7-4c) also surpassed its target, increasing from

32 percent to 57 percent, achieving 139 percent of the targeted change. These increases are attributable in part to HHS's work through the Centers for Disease Control and Prevention (CDC) in collaboration with organizations such as the American Nurses Foundation[2] and the National Association of School Nurses,[3] as well as the inclusion of health services as a component of CDC's Coordinated School Health Program (CSHP).[4]

Objectives that moved toward their targets. High school completion for persons aged 18 to 24 years (7-1) increased from 85 percent in 1998 to 87 percent in 2001, achieving 40 percent of the targeted change and moving toward the target of 90 percent. School health education for violence prevention (7-2c) achieved 68 percent of the targeted change. School health prevention education for unintentional injury (7-2b), suicide (7-2d), and tobacco use and addiction (7-2e) also made progress. These increases may be attributable in part to the CSHP model, which includes health education as a key component. Another contributor is the increased availability of curriculum materials and resources to address these topics. For example, in 2004 the Health Resources and Services Administration (HRSA) developed the "Take a Stand. Lend a Hand. Stop Bullying Now!" campaign.[5] Resources for young persons, parents, educators, and other adults interested in bullying prevention are available at the HRSA website.[6] The proportion of senior high schools with a nurse-to-student ratio of at least 1 to 750 (7-4b) increased from 26 percent to 44 percent, achieving 75 percent of its targeted change.

Objectives that demonstrated no change. Two measurable subobjectives for which data were reported showed no movement toward or away from their targets: school health education for unhealthy dietary patterns (7-2h) and for environmental health (7-2j).

While CSHP aims to make progress on school health education objectives, it is supported in only 23 States. To assist schools in the implementation of quality school health programs, HHS through CDC recently developed tools such as the Physical Education Curriculum Analysis Tool (PECAT).[7] Tools like PECAT provide curricular guidance to local school districts to improve the quality of components in a coordinated school health program. The guidance provided by these tools allows districts to meet local needs and interests and increase the likelihood of improving students' knowledge, skills, and health behaviors.

Objectives that moved away from their targets. One objective and four subobjectives moved away from their targets. School health education declined in all priority areas (7-2a), as well as in specific health topics, including alcohol and other drug use (7-2f), unintended pregnancy, HIV/AIDS, and STD infection (7-2g), and inadequate physical activity (7-2i). Participation in employer-sponsored health promotion programs (7-6) also decreased.

Objectives that could not be assessed. Progress toward the targets could not be assessed for health-risk behavior information for college and university students (7-3), school nurse-to-student ratio in elementary schools (7-4d), worksite health programs (7-5a through f), community health promotion programs (7-10), culturally appropriate and linguistically competent community health programs (7-11c, g, h, i, m, n, o, q through v, y, z, and aa), and older adult participation in community health promotion activities (7-12).

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 7-2), which displays information about disparities among select populations for which data were available for assessment.

Best group rates for objectives based on race and ethnicity showed a mixed distribution. The white non-Hispanic population had the best rate for high school completion of persons aged 18 to 24 years (7-1) with an overall high school completion rate of 91 percent in 2001. The Hispanic population had the largest disparity, with only 66 percent of the population aged 18 to 24 years old achieving high school completion. The disparity between the black non-Hispanic population and white non-Hispanic population decreased between 1998 to 2001. The Asian or Pacific Islander population had the best rate of persons aged 65 years or older participating in community health promotion activities (7-12). The Hispanic, black non-Hispanic, and white non-Hispanic populations demonstrated disparities of 10 percent to 49 percent.

Compared with males, females had a better rate for high school completion (7-1). Gender differences for the remaining objectives were less than 10 percent or not statistically significant.

Disparities also existed between populations of varying education levels. Persons with at least some college had the best rates for participation in employer-sponsored health promotion activities (7-6) and older adult participation in community health promotion activities (7-12).

Opportunities and Challenges

Several educational and community-based initiatives that demonstrate a commitment to increasing life quality and eliminating health disparities have been under way since the beginning of the decade. These include broad efforts, as well as more specific initiatives aimed at schools and workplaces.

The HHS *Steps to a HealthierUS* initiative, a component of the *HealthierUS* plan, uses the strategies and methodologies of the Educational and Community-Based Programs focus area to help Americans live longer and healthier lives. States and communities participating in the *Steps* initiative work to address diabetes, obesity, and asthma, as well as risk factors like poor nutrition, physical inactivity, and tobacco use.[8]

Colleges and universities provide a setting for educational and community-based programs. One resource designed to facilitate disease prevention and health promotion planning in colleges and universities is *Healthy Campus 2010: Making It Happen*.[9] The manual helps local health workers assess campus and community health needs in their area.[9]

A resource designed to increase disease prevention and health promotion activities in the workplace is *Healthy Workforce 2010: An Essential Health Promotion Sourcebook for Employers, Large and Small*.[10] This publication educates employers on how health promotion helps businesses function more effectively and efficiently. In addition, it provides strategies for developing and maintaining worksite health promotion programs and activities.[10]

In addition, community health efforts like the CDC-based initiative REACH 2010 (Racial and Ethnic Approaches to Community Health) provide valuable opportunities for communities to learn from each other. A report in a special issue of *Ethnicity and Disease* was published in the summer of 2004 to describe REACH 2010's early successes.[11]

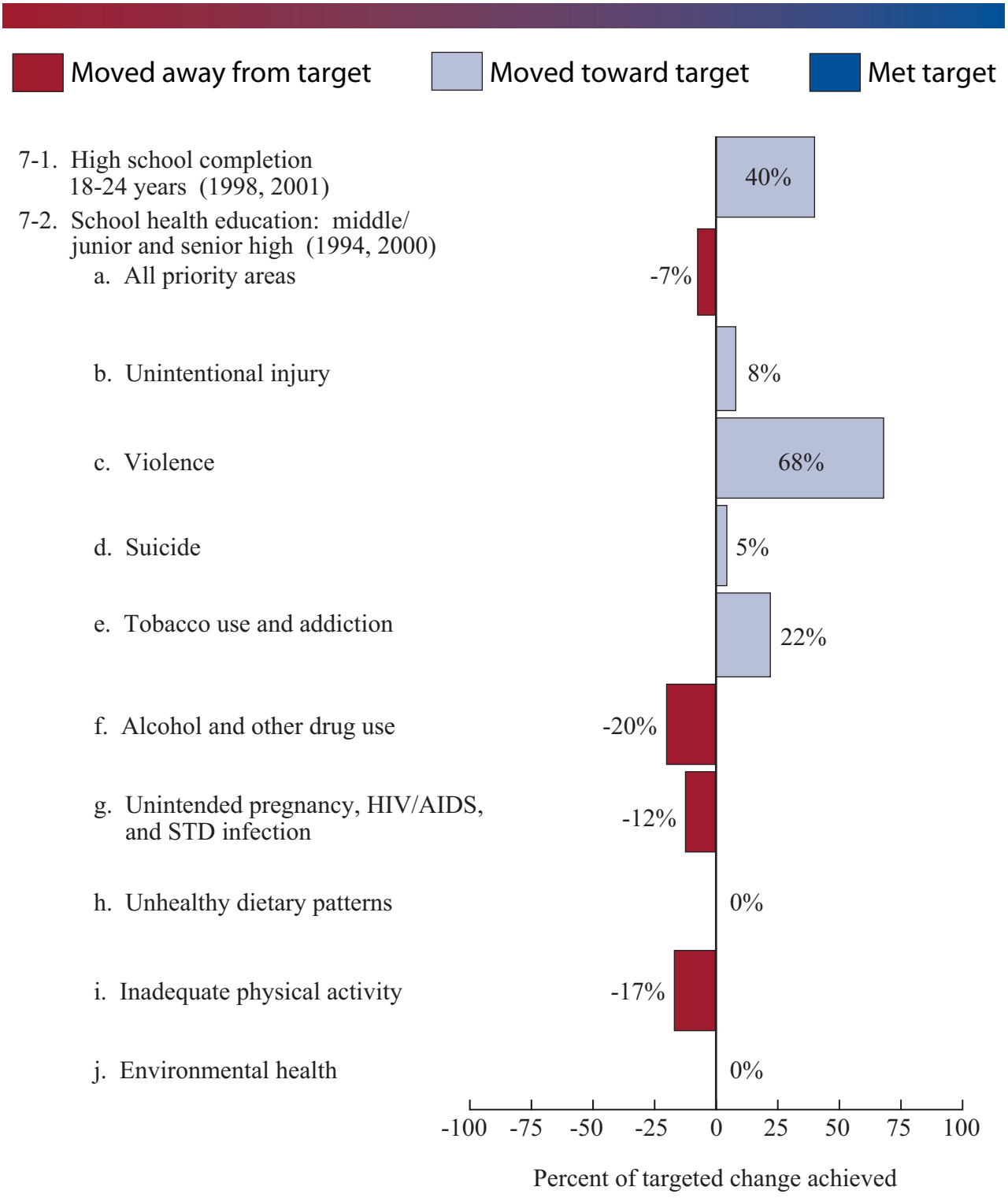
During the past decade, interest has increased in policy and environmental interventions as effective tools for health promotion and disease prevention. The Institute of Medicine's *The Future of the Public's Health in the 21st Century*[12] identifies the need to enhance practitioners' health promotion and education skills.

To provide guidance for designing and implementing policy and environmental change interventions that affect large segments of the population, the Directors of Health Promotion and Education (DHPE), with support from HHS through CDC, has developed *Policy and Environmental Change, New Directions for Public Health.*[13] Another report from DHPE, *State Health Promotion Capacity*,[14] describes the perceived health promotion capacities of those carrying out programs in State health agencies, priority needs for professional development, and actions that might be undertaken to strengthen health promotion activities and programs conducted by State and local public health agencies.

Emerging Issues

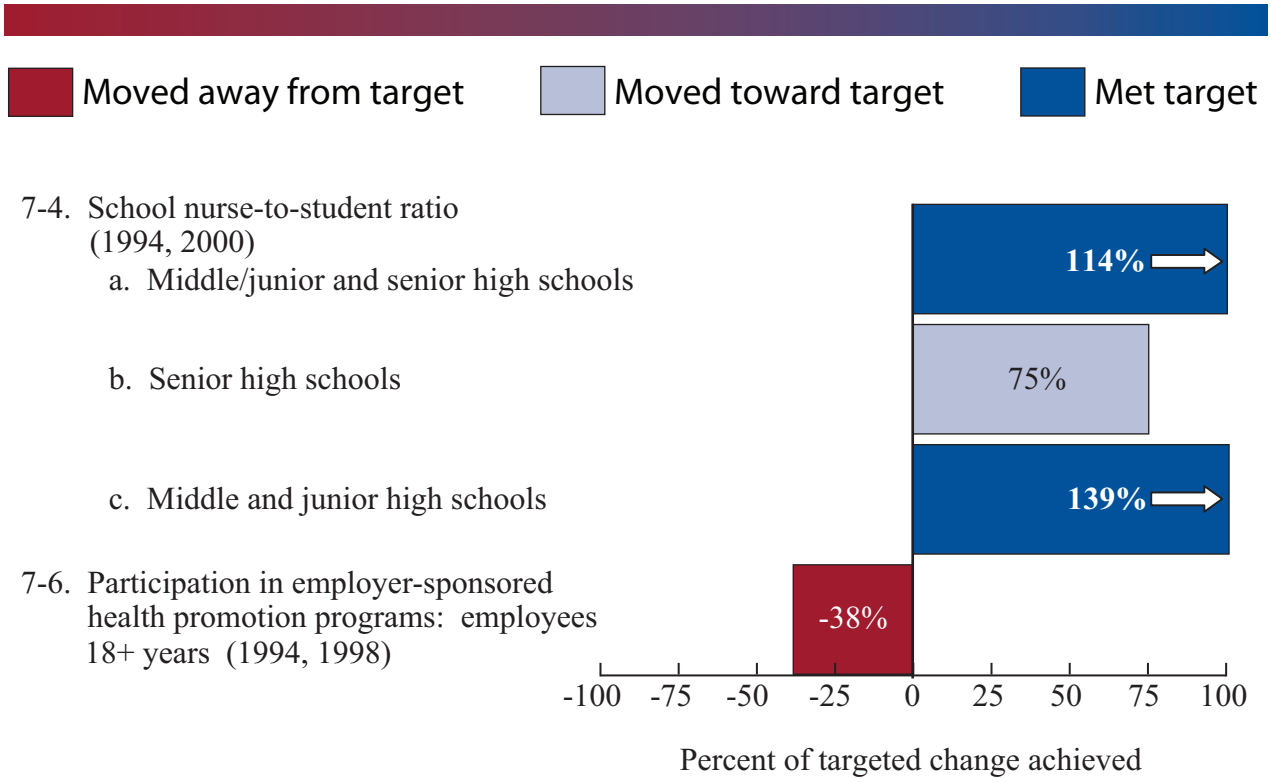
Several emerging issues exist within the Educational and Community-Based Programs focus area. Research on preventing health disparities contains multiple gaps. Important areas needing further study are the dissemination of effective programs, new technologies, relationships between settings, and approaches to disadvantaged populations and populations with unique needs. Micro-grant programs should be used more since these programs engage communities and populations and can have a ripple effect in bringing beneficial changes. Promotion of commonality and synergy among the fields of educational and community-based programs, health communication, and health literacy should also be encouraged. Finally, the identification of better ways to characterize the reach, coverage, and influence of educational and community-based programs by geographic region is important, so that features of the most successful programs can be emulated and spread across a larger proportion of the Nation.

Figure 7-1. Progress Quotient Chart for Focus Area 7: Educational and Community-Based Programs



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

Figure 7-1. *(continued)*



Notes: Tracking data for objectives 7-3, 7-4d, 7-5a through f, 7-10, 7-11c, g, h, i, m, n, o, q through v, y, z, and aa, and 7-12 are unavailable. Objectives 7-7 through 7-9 and 7-11a, b, d, e, f, j, k, l, p, w, x, and bb 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.

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

Figure 7-2. Disparities Table for Focus Area 7: Educational and Community-Based Programs

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: 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**	Gender: Female	Male	Education: Less than high school	High school graduate	At least some college	**Summary index**	Income: Poor	Near poor	Middle/high income	**Summary index**	Location: Urban or metropolitan	Rural or nonmetropolitan	Disability: Persons with disabilities	Persons without disabilities
7-1.	High school completion: 18-24 years (1998, 2001) *		b[1]				↓	B		B													
7-3.	Health-risk behavior information for college and university students (1995) †						B			B	B												
7-6.	Employer-sponsored health promotion activities: employees 18+ years (1994, 1998) *		b[2]			B					B			B		b		B			B		
7-12.	Participation in community health promotion activities: 65+ years (1998) * [3]		B[2]							B				B				B					B

Notes: Data for objectives 7-2a through j, 7-4a through d, 7-5a through f, 7-10, and 7-11c, g, h, i, m, n, o, q through v, y, z, and aa are unavailable or not applicable. Objectives 7-7 through 7-9, and 7-11a, b, d, e, f, j, k, l, p, w, x, and bb 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.

Disparity from the best group rate at the most recent data point.

Percent difference from the best group rate

- 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 ≥ 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] Data are for non-Hispanic Asians or Pacific Islanders.

[2] Data are for Asians or Pacific Islanders.

[3] Persons reported only one race or reported more than one race and identified one race as best representing their race.

Objectives and Subobjectives for Focus Area 7: Educational and Community-Based Programs

Goal: Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life.

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.

School Setting

NO CHANGE IN OBJECTIVE

7-1. Increase high school completion.

Target: 90 percent.

Baseline: 85 percent of persons aged 18 to 24 years had completed high school in 1998.

Target setting method: Consistent with National Education Goals Panel—Goals 2000.

Data source: Current Population Survey, U.S. Department of Commerce, Bureau of the Census.

NO CHANGE IN OBJECTIVE

7-2. Increase the proportion of middle, junior high, and senior high schools that provide school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health.

Target and baseline:

Objective	Middle, Junior High, and Senior High Schools Providing School Health Education in Priority Areas	1994 Baseline	2010 Target
		Percent	
7-2a.	All components	28	70
	Individual components to prevent health problems in the following areas:		
7-2b.	Unintentional injury	66	90
7-2c.	Violence	58	80
7-2d.	Suicide	58	80
7-2e.	Tobacco use and addiction	86	95
7-2f.	Alcohol and other drug use	90	95
7-2g.	Unintended pregnancy, HIV/AIDS, and STD infection	65	90
7-2h.	Unhealthy dietary patterns	84	95
7-2i.	Inadequate physical activity	78	90
7-2j.	Environmental health	60	80

NO CHANGE IN OBJECTIVE *(continued)*

Target setting method: 150 percent improvement for 7-2a; percentage improvement varies for individual components 7-2b through 7-2j.

Data source: School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

NO CHANGE IN OBJECTIVE

7-3. Increase the proportion of college and university students who receive information from their institution on each of the six priority health-risk behavior areas.

Target: 25 percent.

Baseline: 6 percent of undergraduate students received information from their college or university on all six topics in 1995: injuries (intentional and unintentional), tobacco use, alcohol and illicit drug use, sexual behaviors that cause unintended pregnancies and sexually transmitted diseases, dietary patterns that cause disease, and inadequate physical activity.

Target setting method: Better than the best.

Data source: National College Health Risk Behavior Survey, CDC, NCCDPHP.

ORIGINAL OBJECTIVE

7-4. Increase the proportion of the Nation's elementary, middle, junior high, and senior high schools that have a nurse-to-student ratio of at least 1:750.

Target and baseline:

Objective	Increase in Schools With Nurse-to-Student Ratio of at Least 1:750	1994 Baseline	2010 Target
		Percent	
7-4a.	All middle, junior high, and senior high schools	28	50
7-4b.	Senior high schools	26	50
7-4c.	Middle and junior high schools	32	50
7-4d.	Elementary schools	Developmental	

Target setting method: 79 percent improvement for 7-4a (all schools combined); percentage improvement varies for individual components 7-4b and 7-4c.

ORIGINAL OBJECTIVE *(continued)*

Data source: School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP. Data for elementary schools are developmental.

OBJECTIVE WITH REVISIONS

7-4. Increase the proportion of the Nation's elementary, middle, junior high, and senior high schools that have a nurse-to-student ratio of at least 1:750.

Target and baseline:

Objective	Increase in Schools With Nurse-to-Student Ratio of at Least 1:750	1994 Baseline (unless noted)	2010 Target
		Percent	
7-4a.	All middle, junior high, and senior high schools	28	50
7-4b.	Senior high schools	26	50
7-4c.	Middle and junior high schools	32	50
7-4d.	Elementary schools	53 (2000) ~~Developmental~~	60

Target setting method: 79 percent improvement for 7-4a; 92 percent improvement for 7-4b; 56 percent improvement for 7-4c; 13 percent improvement for 7-4d.~~79 percent improvement for 7-4a (all schools combined); percentage improvement varies for individual components 7-4b and 7-4c.~~

Data source: School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP. ~~Data for elementary schools are developmental.~~

REVISED OBJECTIVE

7-4. Increase the proportion of the Nation's elementary, middle, junior high, and senior high schools that have a nurse-to-student ratio of at least 1:750.

Target and baseline:

Objective	Increase in Schools With Nurse-to-Student Ratio of at Least 1:750	1994 Baseline (unless noted)	2010 Target
		Percent	
7-4a.	All middle, junior high, and senior high schools	28	50
7-4b.	Senior high schools	26	50
7-4c.	Middle and junior high schools	32	50
7-4d.	Elementary schools	53 (2000)	60

REVISED OBJECTIVE *(continued)*

Target setting method: 79 percent improvement for 7-4a; 92 percent improvement for 7-4b; 56 percent improvement for 7-4c; 13 percent improvement for 7-4d.

Data source: School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

Worksite Setting

NO CHANGE IN OBJECTIVE

7-5. Increase the proportion of worksites that offer a comprehensive employee health promotion program to their employees.

Target and baseline:

Objective	Increase in Worksites Offering a Comprehensive Employer-Sponsored Health Promotion Program	1999 Baseline	2010 Target
		Percent	
7-5a.	Worksites with fewer than 50 employees	Developmental	
7-5b.	Worksites with 50 or more employees	34	75
7-5c.	Worksites with 50 to 99 employees	33	75
7-5d.	Worksites with 100 to 249 employees	33	75
7-5e.	Worksites with 250 to 749 employees	38	75
7-5f.	Worksites with 750 or more employees	50	75

Target setting method: Better than the best.

Data source: National Worksite Health Promotion Survey (NWHPS), Association for Worksite Health Promotion (AWHP) and OPHS, ODPHP.

NO CHANGE IN OBJECTIVE
(Data updated and footnoted)

7-6. Increase the proportion of employees who participate in employer-sponsored health promotion activities.

Target: 88[1] percent.

Baseline: 67[2] percent of employees aged 18 years and older participated in employer-sponsored health promotion activities in 1994 (age adjusted to the year 2000 standard population).

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

Target setting method: Better than the best.

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

[1] Target revised from 75 because of baseline revision after November 2000 publication.
[2] Baseline revised from 61 after November 2000 publication.

Health Care Setting

OBJECTIVE DELETED

7-7. ***(Objective deleted due to lack of data source)*** **(Developmental) Increase the proportion of health care organizations that provide patient and family education.**

OBJECTIVE DELETED

7-8. ***(Objective deleted due to lack of data source)*** **(Developmental) Increase the proportion of patients who report that they are satisfied with the patient education they receive from their health care organization.**

OBJECTIVE DELETED

7-9. ***(Objective deleted due to lack of data source)*** **(Developmental) Increase the proportion of hospitals and managed care organizations that provide community disease prevention and health promotion activities that address the priority health needs identified by their community.**

Community Setting and Select Populations

ORIGINAL OBJECTIVE

7-10. **(Developmental) Increase the proportion of Tribal and local health service areas or jurisdictions that have established a community health promotion program that addresses multiple Healthy People 2010 focus areas.**

Potential data source: Special Survey, Association of State and Territorial Directors of Health Promotion and Public Health Education (ASTDHPPHE).

OBJECTIVE WITH REVISIONS

7-10. (Developmental) Increase the proportion of Tribal and local health service areas or jurisdictions that have established a community health promotion program that addresses multiple Healthy People 2010 focus areas.

Potential data source: ~~Special Survey,~~Directors of Health Promotion and Education (DHPE) [formerly Association of State and Territorial Directors of Health Promotion and Public Health Education (ASTDHPPHE)].

REVISED OBJECTIVE

7-10. (Developmental) Increase the proportion of Tribal and local health service areas or jurisdictions that have established a community health promotion program that addresses multiple Healthy People 2010 focus areas.

Potential data source: Directors of Health Promotion and Education (DHPE) (formerly Association of State and Territorial Directors of Health Promotion and Public Health Education [ASTDHPPHE]).

ORIGINAL OBJECTIVE

7-11. Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs.

Target and baseline:

Objective	Increase in Local Health Department Community Health Promotion and Disease Prevention Programs That Are Culturally Appropriate and Linguistically Competent	1996–97 Baseline	2010 Target
		Percent	
7-11a.	Access to quality health services	Developmental	
	Clinical preventive services	35	*
7-11b.	Arthritis, osteoporosis, and chronic back conditions	Developmental	
7-11c.	Cancer	30	50
	Diabetes and chronic disabling conditions	26	*
7-11d.	Chronic kidney disease	Developmental	
7-11e.	Diabetes	Developmental	
7-11f.	Disability and secondary conditions	Developmental	
7-11g.	Educational and community-based programs	33	50

ORIGINAL OBJECTIVE *(continued)*

7-11h.	Environmental health	22	50
7-11i.	Family planning	42	50
	Food and drug safety	18	*
7-11j.	Food safety	Developmental	
7-11k.	Medical product safety	Developmental	
7-11l.	Health communication	Developmental	
7-11m.	Heart disease and stroke	28	50
7-11n.	HIV	45	50
7-11o.	Immunization and infectious diseases	48	50
7-11p.	Injury and violence prevention	Developmental	
	Unintentional injuries	19	*
	Violent and abusive behavior	25	*
7-11q.	Maternal, infant (and child) health	47	50
7-11r.	Mental health (and mental disorders)	18	50
7-11s.	Nutrition and overweight	44	50
7-11t.	Occupational safety and health	13	50
7-11u.	Oral health	25	50
7-11v.	Physical activity and fitness	21	50
7-11w.	Public health infrastructure	Developmental	
	Surveillance and data systems	14	*
7-11x.	Respiratory diseases	Developmental	
7-11y.	Sexually transmitted diseases	41	50
7-11z.	Substance abuse (alcohol and other drugs)	26	50
7-11aa.	Tobacco use	24	50
7-11bb.	Vision and hearing	Developmental	

* These are Healthy People 2000 priority areas that are not applicable to Healthy People 2010.

Target setting method: Percentage improvement varies by program.

Data source: National Profile of Local Health Departments, National Association of County and City Health Officials (NACCHO).

OBJECTIVE WITH REVISIONS
(Including subobjectives deleted)

7-11. Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs.

Target and baseline:

Objective*	Increase in Local Health Department Community Health Promotion and Disease Prevention Programs That Are Culturally Appropriate and Linguistically Competent	1996–97 Baseline	2010 Target
		Percent	
~~**7-11a.**~~	*(Subobjective deleted due to lack of data source)** ~~Access to quality health services Developmental~~	~~Developmental~~	
	~~Clinical preventive services~~	~~35~~	*
~~**7-11b.**~~	*(Subobjective deleted due to lack of data source)** ~~Arthritis, osteoporosis, and chronic back conditions~~	~~Developmental~~	
7-11c.	Cancer	30	50
	~~Diabetes and chronic disabling conditions~~	~~26~~	*
~~**7-11d.**~~	*Subobjective deleted due to lack of data source)** ~~Chronic kidney disease~~	~~Developmental~~	
~~**7-11e.**~~	*(Subobjective deleted due to lack of data source)** ~~Diabetes~~	~~Developmental~~	
~~**7-11f.**~~	*(Subobjective deleted due to lack of data source)** ~~Disability and secondary conditions~~	~~Developmental~~	
7-11g.	Educational and community-based programs	33	50
7-11h.	Environmental health	22	50
7-11i.	Family planning	42	50
	~~Food and drug safety~~	~~18~~	*
~~**7-11j.**~~	*(Subobjective deleted due to lack of data source)** ~~*Food safety*~~	~~Developmental~~	
~~**7-11k.**~~	*(Subobjective deleted due to lack of data source)** ~~Medical product safety~~	~~Developmental~~	

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

~~**7-11l.**~~	*(Subobjective deleted due to lack of data source)** ~~Health communication~~	~~Developmental~~	
7-11m.	Heart disease and stroke	28	50
7-11n.	HIV	45	50
7-11o.	Immunization and infectious diseases	48	50
~~**7-11p.**~~	*(Subobjective deleted due to lack of data source)** ~~Injury and violence prevention~~	~~Developmental~~	
	~~Unintentional injuries~~	~~19~~	*
	~~Violent and abusive behavior~~	~~25~~	*
7-11q.	Maternal, infant (and child) health	47	50
7-11r.	Mental health (and mental disorders)	18	50
7-11s.	Nutrition and overweight	44	50
7-11t.	Occupational safety and health	13	50
7-11u.	Oral health	25	50
7-11v.	Physical activity and fitness	21	50
~~**7-11w.**~~	*(Subobjective deleted due to lack of data source)** ~~Public health infrastructure~~	~~Developmental~~	
	~~Surveillance and data systems~~	~~14~~	*
~~**7-11x.**~~	*(Subobjective deleted due to lack of data source)** ~~Respiratory diseases~~	~~Developmental~~	
7-11y.	Sexually transmitted diseases	41	50
7-11z.	Substance abuse (alcohol and other drugs)	26	50
7-11aa.	Tobacco use	24	50
~~**7-11bb.**~~	*(Subobjective deleted due to lack of data source)** ~~Vision and hearing~~	~~Developmental~~	

* For data control purposes, subobjectives are not renumbered.

Target setting method: Percentage improvement varies by program.

Data source: National Profile of Local Health Departments, National Association of County and City Health Officials (NACCHO).

REVISED OBJECTIVE

7-11. Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs.

Target and baseline:

Objective*	Increase in Local Health Department Community Health Promotion and Disease Prevention Programs That Are Culturally Appropriate and Linguistically Competent	1996–97 Baseline	2010 Target
		Percent	
7-11c.	Cancer	30	50
7-11g.	Educational and community-based programs	33	50
7-11h.	Environmental health	22	50
7-11i.	Family planning	42	50
7-11m.	Heart disease and stroke	28	50
7-11n.	HIV	45	50
7-11o.	Immunization and infectious diseases	48	50
7-11q.	Maternal, infant (and child) health	47	50
7-11r.	Mental health (and mental disorders)	18	50
7-11s.	Nutrition and overweight	44	50
7-11t.	Occupational safety and health	13	50
7-11u.	Oral health	25	50
7-11v.	Physical activity and fitness	21	50
7-11y.	Sexually transmitted diseases	41	50
7-11z.	Substance abuse (alcohol and other drugs)	26	50
7-11aa.	Tobacco use	24	50

* For data control purposes, subobjectives are not renumbered.

Target setting method: Percentage improvement varies by program.

Data source: National Profile of Local Health Departments, National Association of County and City Health Officials (NACCHO).

NO CHANGE IN OBJECTIVE

7-12. Increase the proportion of older adults who have participated during the preceding year in at least one organized health promotion activity.

Target: 90 percent.

Baseline: 12 percent of adults aged 65 years and older participated during the preceding year in at least one organized health promotion activity in 1998 (age adjusted to the year 2000 standard population).

Target setting method: Better than the best.

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

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Related Objectives From Other Focus Areas

1. Access to Quality Health Services
1-3. Counseling about health behaviors

2. Arthritis, Osteoporosis, and Chronic Back Conditions
2-8. Arthritis education

3. Cancer
3-10. Provider counseling about cancer prevention

5. Diabetes
5-1. Diabetes education

6. Disability and Secondary Conditions
6-9. Inclusion of children and youth with disabilities in regular education programs
6-13. Surveillance and health promotion programs

9. Family Planning
9-11. Reproductive health education

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

16. Maternal, Infant, and Child Health
16-7. Childbirth classes

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

18. Mental Health and Mental Disorders
18-12. State tracking of consumer satisfaction

19. Nutrition and Overweight
19-16. Worksite promotion of nutrition education and weight management
19-17. Nutrition counseling for medical conditions

20. Occupational Safety and Health
20-9. Worksite stress reduction programs

22. Physical Activity and Fitness
22-8. Physical education requirement in schools
22-9. Daily physical education in schools
22-10. Physical activity in physical education class
22-12. School physical activity facilities
22-13. Worksite physical activity and fitness

24. Respiratory Diseases

24-6. Patient education

26. Substance Abuse

26-23. Community partnerships and coalitions

27. Tobacco Use

27-11. Smoke-free and tobacco-free schools

27-12. Worksite smoking policies