Midcourse Review

HEALTHY PEOPLE 2010

# Disability and Secondary Conditions

6

## Co-Lead Agencies:

Centers for Disease Control and Prevention
National Institute on Disability and Rehabilitation Research,
U.S. Department of Education

## Contents

# Goal: Promote the health of people with disabilities, prevent secondary conditions, and eliminate disparities between people with and without disabilities in the U.S. population.

## Introduction*

The Disability and Secondary Conditions focus area contributes to increased quality and years of healthy life and the elimination of disparities through objectives that aim to increase participation and inclusion of people with disabilities in public health efforts as well as in everyday aspects of life. The objectives for disability and secondary conditions address the elimination of disparities in two ways: by seeking to eliminate disparities between people with and without disabilities, and by addressing health disparities among select populations of people with disabilities.

The midcourse review provides some of the first U.S. data comparing populations within the disability community that address quality of life and disparities. Disparities are noted between people with and without disabilities, as well as among populations within the disability community based on education, income, gender, and race and ethnicity. This focus area shows improvements in including people with disabilities in national and State health surveillance, including children with disabilities in regular classrooms and reducing their rates for sadness, and reducing the numbers of adults with disabilities in congregate care (large, out-of-home) facilities. The reasons for this progress cannot be ascribed to any particular program activity. However, the availability of technology, accessible features in homes and modes of transportation, and policy shifts toward inclusion are likely contributing factors to this progress.

## 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.

For six of the objectives, the data source or wording was modified to clarify the measurements. For social participation among adults with disabilities (6-4), the question in the National Health Interview Survey (NHIS) was reworded to more accurately reflect the stated objective: absolute participation instead of difficulty with participating. This modification produced new baseline and target measurements. For both emotional support (6-5) and life satisfaction (6-6), the original data source—the 1998–2000 Behavioral Risk Factor Surveillance System (BRFSS), which reflected data from eight States—was changed to NHIS to permit national data collection. For employment parity (6-8), the data source was changed from the U.S. Survey on Income and Program Participation to NHIS to improve the frequency and availability of data.[1]

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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.

The wording for the objective regarding the accessibility of health and wellness programs and facilities (6-10) was revised to reflect a population-based measurement. The objective was modified to "increase the proportion of people with disabilities who report having access to health and wellness programs and facilities."

Objective 6-13, to increase the number of States and Tribes that have public health surveillance programs and health promotion programs for people with disabilities and caregivers, was a developmental objective with two subobjectives. This objective was revised and divided into eight subobjectives. For both States and Tribes, the subobjectives were modified to track surveillance for people with disabilities (6-13a and b), health promotion programs for people with disabilities (6-13c and d), surveillance for caregivers (6-13e and f), and health promotion programs for caregivers (6-13g and h).

## 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 6-1), which displays the percent of targeted change achieved for objectives and subobjectives with sufficient data to assess progress. Overall, data at the midpoint of the decade reflected progress toward the inclusion of people with disabilities in public health efforts and everyday aspects of life.

**Objectives that met or exceeded their targets.** The objective for increasing the number of States (14 in 1999) with ongoing disability surveillance (6-13a) met its target of 50 States and the District of Columbia in 2004. Guam, Puerto Rico, and the Virgin Islands also have ongoing disability surveillance. This objective was achieved by adding questions that identify people with disabilities directly into the core questions of the BRFSS.

**Objectives that moved toward their targets.** Five objectives and subobjectives moved toward their 2010 targets: standard identification of people with disabilities in data sets (6-1), unhappy feelings and depression among children with disabilities (6-2), congregate care of adults with disabilities (6-7a), inclusion of children and youth with disabilities in regular education programs (6-9), and State-based health promotion programs for people with disabilities (6-13c).

Standard identification of people with disabilities (6-1) achieved 33 percent of the targeted change. At the baseline year of 1999, none of the major population-based Healthy People 2010 surveillance instruments had a standard set of questions to identify people with disabilities.[2] By 2004, however, some of the surveillance instruments included the questions, representing movement toward the target of 100 percent.

The proportion of children with disabilities who reported being sad, unhappy, or depressed (6-2) decreased from 31 percent in 1997 to 29 percent in 2003, achieving 14 percent of the targeted change. However, this change was not statistically significant. The target of 17 percent is based on the proportion of children without disabilities who reported being sad, unhappy, or depressed.

The number of adults aged 22 years and older with disabilities living in congregate care settings (6-7a) achieved 45 percent of the targeted change. Specifically, the number of adults in congregate care[3] decreased from 93,362 in 1997 to 72,474 in 2003, working toward the target of 46,681 persons.

This target is based on a 50 percent reduction from the baseline. Absolute numbers of adults in congregate care have been steadily declining since the 1980s due to increased availability and choice of community-based services for persons with disabilities.[4]

The proportion of children with disabilities who spend at least 80 percent of their time in regular education programs (6-9) increased from 45 percent in 1995–96 to 50 percent in 2003–04, achieving 33 percent of the targeted change. This increase may be due in part to the use of advanced technology in classrooms, teacher training, and specialized staffing.[5, 6]

The number of States with health promotion programs for persons with disabilities (6-13c) increased from 14 in 1999 to 17 in 2004, achieving 8 percent of the targeted change. The target is for all 50 States and the District of Columbia to have health promotion programs for persons with disabilities. An example of health promotion programs is Living Well With a Disability.[7]

**Objectives that demonstrated no change.** Data for surveillance for caregivers (6-13e) and health promotion programs for caregivers (6-13g) were unavailable in 2003. The target for each of these subobjectives is for programs to exist in all 50 States and the District of Columbia. Specifically, the number of States with surveillance for caregivers (6-13e) increased to 23 States in 2000, fell to 14 States in 2001, increased again to 24 States in 2002, and fell back to zero States in 2003 due to the lack of questions in the BRFSS core identifying caregiving.[8] The number of States with health promotion programs for caregivers (6-13g) was zero in both 1999 and 2004, with data unavailable in between.

**Objectives that moved away from their targets.** Two objectives moved away from their targets: feelings and depression interfering with activities among adults with disabilities (6-3) and employment parity for adults with disabilities (6-8). The target for both of these objectives is to achieve parity with adults without disabilities.

The proportion of adults with disabilities whose negative feelings interfere with activities (6-3) increased from 28 percent in 1997 to 32 percent in 2003, moving away from the target of 7 percent.

The proportion of adults with disabilities who were employed (6-8) decreased from 43 percent in 1997 to 41 percent in 2003. This data shift represents a move away from the target of 80 percent. Although employment rates for adults with and without disabilities were in decline, people with disabilities were not recovering from the 2001 recession as quickly as those without disabilities.[9] One reason might be that when individuals with disabilities lose their jobs in a recession, they enter the Supplemental Security Income program rather than the time-limited unemployment insurance program and are less likely to reenter employment.[9]

**Objectives that could not be assessed.** While single data points were available at the midcourse for several objectives and subobjectives, progress could not be assessed because two data points are needed to assess a trend.

The proportion of adults with disabilities who participate in social activities (6-4) was 61 percent in the 2001 baseline year. The target is 79 percent.

Some baseline data on quality of life were available for people with disabilities. The proportion of adults with disabilities reporting sufficient emotional support (6-5) was 71 percent in 2001, the baseline year. The target is 84 percent to achieve parity with adults without disabilities.

Eighty percent of adults with disabilities reported satisfaction with life (6-6) in 2001, the baseline year. The target for this objective is 96 percent to achieve parity with adults without disabilities.

The number of persons aged 21 years and under with disabilities in congregate care (6-7b) was 24,300 in 1997, the baseline year. The target is zero, consistent with permanency planning.[10]

The objective for accessibility of health and wellness programs (6-10) became measurable. In 2002, 48 percent of persons aged 18 years and older with disabilities reported having access to health and wellness programs. The target is 63 percent.

The objective for assistive devices and technology (6-11) also became measurable in 2002 when 10 percent of persons aged 18 years and older with disabilities reported not having needed devices or technology. The 2010 target is 7 percent.

Baseline data were established for the objective regarding environmental barriers (6-12), and this objective became measurable. In 2002, among adults with disabilities, 11 percent reported barriers in the community (6-12d), 10 percent reported barriers in the home (6-12a), 7.7 percent reported barriers in the workplace (6-12c), and 6.1 percent reported barriers in schools (6-12b).

Surveillance and health promotion programs (6-13) retained developmental subobjectives for Tribes pertaining to surveillance for people with disabilities (6-13b), health promotion programs for people with disabilities (6-13d), surveillance for caregivers (6-13f), and health promotion programs for caregivers (6-13h).

In 2002, baseline data for three objectives (accessibility of health and wellness programs [6-10], assistive devices and technology [6-11], and environmental barriers affecting participation in activities [6-12]) became available through NHIS. Progress will be measured after more data points are collected.

## 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 6-2), which displays information about disparities among select populations for which data were available for assessment.

Disparities exist between select populations (for example, race and ethnicity, gender, education, income, and location) within the total population of people with disabilities. Figure 6-2 shows that the white non-Hispanic population had the best rates for several objectives and subobjectives with significant racial and ethnic differences, compared with other racial and ethnic populations. The observed racial and ethnic disparities among people with disabilities were less than 50 percent, with one exception: Persons of two or more races experienced environmental barriers to community activities at a rate more than twice that of the white non-Hispanic population.

Males had better rates than females for four of the five objectives with significant gender disparities. All of the disparities were less than 50 percent. Persons with at least some college had the best rates for six of the seven objectives with significant education disparities. High school graduates had the lowest rate for negative feelings (6-3). The middle/high-income population had the best rates for all six objectives with significant income disparities. Persons living in rural or nonmetropolitan areas had a significantly lower rate for negative feelings, compared with urban or metropolitan dwellers.

These observations are largely consistent with typically reported trends in disparities for select populations, including race and ethnicity, and low education and low income populations. They are also consistent with differences observed between men and women in general. For example, men with disabilities are more likely to report having the emotional support they need and less likely to report negative feelings. Women with disabilities, on the other hand, are more likely to report social participation and life satisfaction.

## Opportunities and Challenges

Several challenges exist in the focus area and represent opportunities for research and program development across all agencies. For instance, the demand for personal care assistance and caregivers exceeds the supply of care services available nationwide, and the pay is often low. Possible strategies to increase the caregiver labor pool and job competence include making this employment sector more attractive through credentialing and career or social standing, higher pay, and job benefits for caregivers.[11] Personal care assistance and caregivers are critical to health and well-being, community-based living, and societal participation, including education and employment.[12]

Health disparities among people with and without disabilities are observed in several of the Healthy People 2010 focus areas. For example, data from the Healthy People 2010 cancer objectives (Focus Area 3) reveal that the proportion of women with disabilities who received mammograms in the past 2 years (objective 3-13) increased from 64 percent in 1998 to 65 percent in 2003. However, the proportion of women with disabilities who received Pap tests within the past 3 years (objective 3-11b) decreased from 79 percent in 1998 to 75 percent in 2003.[13] Such data highlight public health issues that exist beyond the condition-specific needs of individuals with disabilities.[14] The challenge lies in identifying and implementing evidenced-based health promotion practices that include people with disabilities.

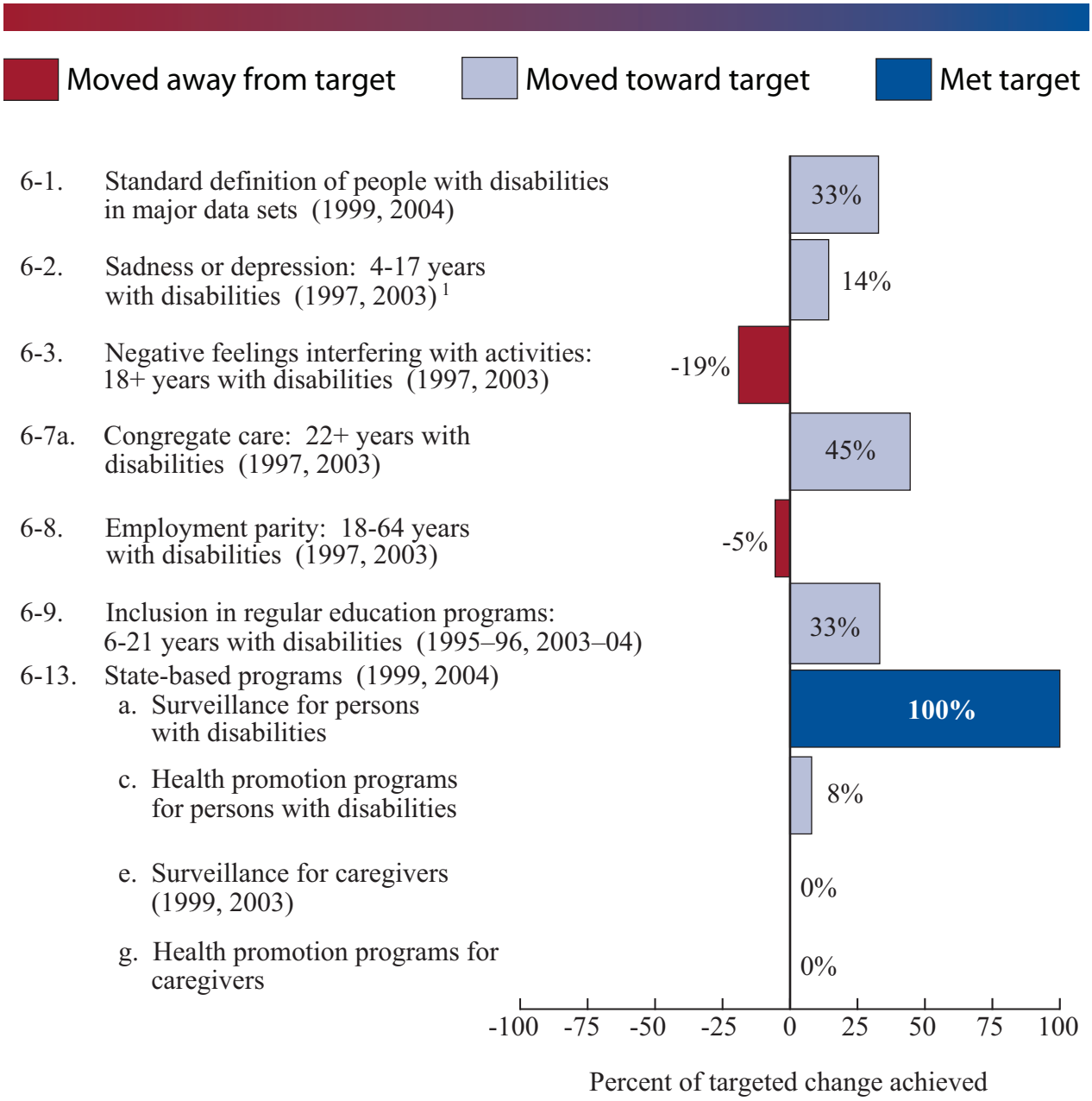
More effective health promotion for persons with disabilities, including prevention of secondary health conditions and elimination of disparities between persons with and without disabilities, will improve participation in education, employment, and community activities among this population.

## Emerging Issues

The U.S. Department of Health and Human Services (HHS), the U.S. Department of Education, the U.S. Department of Labor, and the National Council on Disability work to improve programs, policies, education, and employment among various populations of people with disabilities in an ongoing effort to enhance the daily lives of Americans with disabilities. For example, the Office on Disability (OD) within HHS, created in 2002, strives to improve the overall health and wellness of persons with disabilities through the development and implementation of *The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities*[15] and a comprehensive disability-based database that improves policy planning and impact, among other initiatives.

Along with ongoing issues in disability science, disaster preparation that includes evacuation, shelter, and recovery is an emergent issue for the 49.7 million persons with disabilities living in the United States.[16] In 2004, an executive order addressed the support, safety, and security of persons with disabilities in the event of natural and manmade disasters.[17] Notable issues include insufficient inclusion of persons with disabilities in disaster management processes, training for first responders, county-level data to locate and evacuate persons with disabilities, and resources to meet disability needs during a disaster.[18]

## Figure 6-1. Progress Quotient Chart for Focus Area 6: Disability and Secondary Conditions




**Notes:** Tracking data for objectives 6-4, 6-5, 6-6, 6-7b, 6-10, 6-11, 6-12a through d, and 6-13b, d, f, and h are unavailable.

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.

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

[1]Baseline data are for ages 4-11.

## Figure 6-2. Disparities Table for Focus Area 6: Disability and Secondary Conditions

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 | |
| | 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 |
| 6-2. Sadness or depression: 4-17 years with disabilities (1997, 2003) * [1, 2] | | | | | b | | B | | | | | | | | | | B | | | |
| 6-3. Negative feelings interfering with activities: 18+ years with disabilities (1997, 2003) * [2] | | | | | | | B | | | B | | B | | | | | B | | | B |
| 6-4. Social participation: 18+ years with disabilities (2001) * | b | | | | | | B | | B | | | | B | | | | B | | | B |
| 6-5. Sufficient emotional support: 18+ years with disabilities (2001) * | | | | | | | B | | | B | | | B | | | | | | | |
| 6-6. Satisfaction with life: 18+ years with disabilities (2001) * | b | | | | | | B | | B | | | | B | | | | | | | |
| 6-8. Employment parity: 18-64 with disabilities (1997, 2003) * [2] | | | | | | | B | | | B | | | B | | | | | | | |
| 6-10. Access to health and wellness programs: 18+ years with disabilities (2002) * | | | | | | | B | | | B | | | B | | | | B | | B | |
| 6-11. No assistive devices and technology: 18+ years with disabilities (2002) * | | | | | | b | B | | | B | | | B | | | | B | | | |
| 6-12a. Environmental barriers at home: 18+ years with disabilities (2002) * | | | | | | | B | | | B | | b | B | | | | B | | | |
| 6-12b. Environmental barriers at school: 18+ years with disabilities (2002) * | | | | | | | | | | | | | | | | | | | | |
| 6-12c. Environmental barriers at work: 18+ years with disabilities (2002) * | | | | | | | | | | | | | | | | | | | | |
| 6-12d. Environmental barriers to community activities: 18+ years with disabilities (2002) * | | | | | b | | B | | | B | | B | | | | | B | | | |

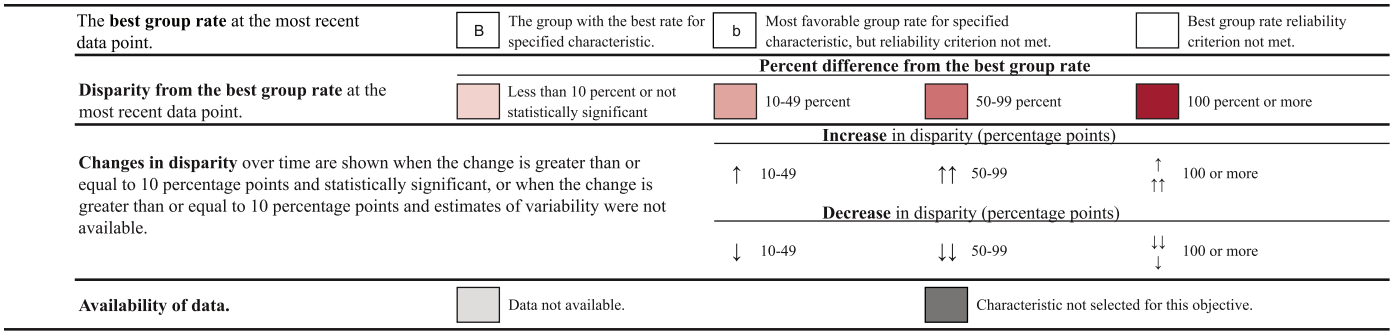
**Notes:** Data for objectives 6-1, 6-7a and b, 6-9, and 6-13a through h are unavailable or not applicable.

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.

*(continued)*

## Figure 6-2. *(continued)*




* 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.

[1] Baseline data are for ages 4-11 years.

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

# Objectives and Subobjectives for Focus Area 6: Disability and Secondary Conditions

**Goal:** Promote the health of people with disabilities, prevent secondary conditions, and eliminate disparities between people with and without disabilities in the U.S. population.

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.

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

**NO CHANGE IN OBJECTIVE**

**6-1. Include in the core of all relevant Healthy People 2010 surveillance instruments a standardized set of questions that identify "people with disabilities."**

**Target:** 100 percent.

**Baseline:** No Healthy People 2010 surveillance instruments include a standard set of questions that identify people with disabilities in 1999.

**Target setting method:** Total coverage.

**Data source:** CDC, NCBDD.

**NO CHANGE IN OBJECTIVE**

**6-2. Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed.**

**Target:** 17 percent.

**Baseline:** 31 percent of children and adolescents aged 4 to 11 years with disabilities were reported to be sad, unhappy, or depressed in 1997.

**Target setting method:** 45 percent improvement (parity with children and adolescents without disabilities in 1997).

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

**NO CHANGE IN OBJECTIVE**

**6-3. Reduce the proportion of adults with disabilities who report feelings such as sadness, unhappiness, or depression that prevent them from being active.**

**Target:** 7 percent.

**Baseline:** 28 percent of adults aged 18 years and older with disabilities reported feelings that prevented them from being active in 1997 (age adjusted to the year 2000 standard population).

**Target setting method:** 75 percent improvement (parity with adults aged 18 years and older without disabilities in 1997).

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

## ORIGINAL OBJECTIVE

**6-4. Increase the proportion of adults with disabilities who participate in social activities.**

**Target:** 100 percent.

**Baseline:** 95.4 percent of adults aged 18 years and older with disabilities participated in social activities in 1997 (age adjusted to the year 2000 standard population).

**Target setting method:** Total participation (parity with adults aged 18 years and older without disabilities in 1997).

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

## OBJECTIVE WITH REVISIONS

**6-4. Increase the proportion of adults with disabilities who participate in social activities.**

**Target:** ~~100~~79 percent.

**Baseline:** ~~95.4~~61 percent of adults aged 18 years and older with disabilities participated in social activities such as getting together with friends and family, telephoning friends and family, or going to worship or group events in 2001~~in 1997~~ (age adjusted to the year 2000 standard population).

**Target setting method:** ~~Total participation~~30 percent improvement (parity with adults aged 18 years and older without disabilities in ~~1997~~2001).

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

## REVISED OBJECTIVE

**6-4. Increase the proportion of adults with disabilities who participate in social activities.**

**Target:** 79 percent.

**Baseline:** 61 percent of adults aged 18 years and older with disabilities participated in social activities such as getting together with friends and family, telephoning friends and family, or going to worship or group events in 2001 (age adjusted to the year 2000 standard population).

**Target setting method:** 30 percent improvement (parity with adults aged 18 years and older without disabilities in 2001).

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

## ORIGINAL OBJECTIVE

**6-5. Increase the proportion of adults with disabilities reporting sufficient emotional support.**

**Target:** 79 percent.

**Baseline:** 71 percent of adults aged 18 years and older with disabilities reported sufficient emotional support in 1998 (data from 11 States and the District of Columbia; age adjusted to the year 2000 standard population).

**Target setting method:** 11 percent improvement (parity with adults aged 18 years and older without disabilities in 1998).

**Data source:** Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

## OBJECTIVE WITH REVISIONS

**6-5. Increase the proportion of adults with disabilities reporting sufficient emotional support.**

**Target:** ~~79~~84 percent.

**Baseline:** 71 percent of adults aged 18 years and older with disabilities reported sufficient emotional support in 2001~~1998 (data from 11 States and the District of Columbia;~~ (age adjusted to the year 2000 standard population).

**Target setting method:** 1~~1~~8 percent improvement (parity with adults aged 18 years and older without disabilities in ~~1998~~2001).

**Data source:** ~~Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP~~National Health Interview Survey (NHIS), CDC, NCHS.

## REVISED OBJECTIVE

**6-5. Increase the proportion of adults with disabilities reporting sufficient emotional support.**

**Target:** 84 percent.

**Baseline:** 71 percent of adults aged 18 years and older with disabilities reported sufficient emotional support in 2001 (age adjusted to the year 2000 standard population).

**Target setting method:** 18 percent improvement (parity with adults aged 18 years and older without disabilities in 2001).

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

## ORIGINAL OBJECTIVE

**6-6. Increase the proportion of adults with disabilities reporting satisfaction with life.**

**Target:** 96 percent.

**Baseline:** 87 percent of adults aged 18 years and older with disabilities reported satisfaction with life in 1998 (data from 11 States and the District of Columbia; age adjusted to the year 2000 standard population).

**Target setting method:** 10 percent improvement (parity with adults without disabilities in 1998).

**Data source:** Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

## OBJECTIVE WITH REVISIONS

**6-6. Increase the proportion of adults with disabilities reporting satisfaction with life.**

**Target:** 96 percent.

**Baseline:** ~~87 percent of adults aged 18 years and older with disabilities reported satisfaction with life in 1998 (data from 11 States and the District of Columbia; age adjusted to the year 2000 standard population)~~ 80 percent of adults aged 18 years and older with disabilities reported satisfaction with life in 2001 (age adjusted to the year 2000 standard population).

**Target setting method:** ~~10 percent improvement (parity with adults without disabilities in 1998)~~ 20 percent improvement (parity with adults without disabilities in 2001).

**Data source:** ~~Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP~~ National Health Interview Survey (NHIS), CDC, NCHS.

## REVISED OBJECTIVE

**6-6. Increase the proportion of adults with disabilities reporting satisfaction with life.**

**Target:** 96 percent.

**Baseline:** 80 percent of adults aged 18 years and older with disabilities reported satisfaction with life in 2001 (age adjusted to the year 2000 standard population).

**Target setting method:** 20 percent improvement (parity with adults without disabilities in 2001).

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

## NO CHANGE IN OBJECTIVE

**6-7. Reduce the number of people with disabilities in congregate care facilities, consistent with permanency planning principles.**

**Target and baseline:**

| Objective | Reduction in People With Disabilities in Congregate Care Facilities | 1997 Baseline | 2010 Target |
|---|---|---|---|
| | | *Number of Persons* | |
| **6-7a.** | Persons aged 22 years and older in 16 or more bed congregate facilities | 93,362 | 46,681 |
| **6-7b.** | Persons aged 21 years and under in congregate care facilities | 24,300 | 0 |

**Target setting method:** 50 percent improvement for 6-7a; total elimination for 6-7b.

**Data source:** Survey of State Developmental Disabilities Directors, University of Minnesota.

## ORIGINAL OBJECTIVE

**6-8. Eliminate disparities in employment rates between working-aged adults with and without disabilities.**

**Target:** 82 percent.

**Baseline:** 52 percent of adults aged 21 through 64 years with disabilities were employed in 1994–95.

**Target setting method:** 58 percent improvement (parity with adults without disabilities in 1994–97).

**Data source:** Survey of Income and Program Participation (SIPP), U.S. Department of Commerce, Bureau of the Census.

## OBJECTIVE WITH REVISIONS

**6-8. Eliminate disparities in employment rates between working-aged adults with and without disabilities.**

**Target:** ~~82 percent~~ 80 percent.

**Baseline:** ~~52 percent of adults aged 21 through 64 years with disabilities were employed in 1994-95~~ 43 percent of adults aged 18 through 64 years with disabilities were employed in 1997.

## OBJECTIVE WITH REVISIONS *(continued)*

**Target setting method:** ~~58 percent improvement (parity with adults without disabilities in 1994-97~~ 86 percent improvement (parity with adults without disabilities in 1997).

**Data source:** ~~Survey of Income and Program Participation (SIPP), U.S. Department of Commerce, Bureau of the Census~~ National Health Interview Survey (NHIS), CDC, NCHS.

## REVISED OBJECTIVE

**6-8. Eliminate disparities in employment rates between working-aged adults with and without disabilities.**

**Target:** 80 percent.

**Baseline:** 43 percent of adults aged 18 through 64 years with disabilities were employed in 1997.

**Target setting method:** 86 percent improvement (parity with adults without disabilities in 1997).

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

## NO CHANGE IN OBJECTIVE

**6-9. Increase the proportion of children and youth with disabilities who spend at least 80 percent of their time in regular education programs.**

**Target:** 60 percent.

**Baseline:** 45 percent of children and youth aged 6 to 21 years with disabilities spent at least 80 percent of their time in regular education programs in the 1995–96 school year.

**Target setting method:** 33 percent improvement. (Better than the best will be used when data are available.)

**Data source:** Data Analysis System (DANS), U.S. Department of Education, Office of Special Education.

## ORIGINAL OBJECTIVE

**6-10. (Developmental) Increase the proportion of health and wellness and treatment programs and facilities that provide full access for people with disabilities.**

**Potential data source:** National Independent Living Centers Network.

## OBJECTIVE WITH REVISIONS

**6-10. ~~(Developmental)~~ Increase the proportion of people with disabilities who report having access to health and wellness ~~and treatment~~ programs ~~and facilities that provide full access for people with disabilities.~~**

**Target:** 63 percent.

**Baseline:** 48 percent of people aged 18 years and older with disabilities reported having access to a health and wellness program in 2002.

**Target setting method:** 31 percent improvement (parity between adults aged 18 years and older with and without disabilities).

**~~Potential d~~Data source:** National ~~Independent Living Centers Network~~Health Interview Survey (NHIS), CDC, NCHS.

## REVISED OBJECTIVE

**6-10. Increase the proportion of people with disabilities who report having access to health and wellness programs.**

**Target:** 63 percent.

**Baseline:** 48 percent of people aged 18 years and older with disabilities reported having access to a health and wellness program in 2002.

**Target setting method:** 31 percent improvement (parity between adults aged 18 years and older with and without disabilities).

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

## ORIGINAL OBJECTIVE

**6-11. (Developmental) Reduce the proportion of people with disabilities who report not having the assistive devices and technology needed.**

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

## OBJECTIVE WITH REVISIONS

**6-11. ~~(Developmental)~~ Reduce the proportion of people with disabilities who report not having the assistive devices and technology needed.**

**Target:** 7 percent.

**Baseline:** 10 percent of people aged 18 years and older with disabilities reported not having assistive devices in 2002.

**Target setting method:** Better than the best.

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

## REVISED OBJECTIVE

**6-11. Reduce the proportion of people with disabilities who report not having the assistive devices and technology needed.**

**Target:** 7 percent.

**Baseline:** 10 percent of people aged 18 years and older with disabilities reported not having assistive devices in 2002.

**Target setting method:** Better than the best

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

## ORIGINAL OBJECTIVE

**6-12. (Developmental) Reduce the proportion of people with disabilities reporting environmental barriers to participation in home, school, work, or community activities.**

**Potential data source:** Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.

## OBJECTIVE WITH REVISIONS

**6-12. ~~(Developmental)~~ Reduce the proportion of people with disabilities reporting environmental barriers to participation in home, school, work, or community activities.**

**Target and baseline:**

| Objective | Reduction in People Aged 18 Years and Older With Disabilities Who Report Encountering Barriers to Participation in Activities | 2002 Baseline | 2010 Target |
|---|---|---|---|

## OBJECTIVE WITH REVISIONS *(continued)*

| | | *Percent* | |
|---|---|---|---|
| **6-12a.** | At home | 10 | 9 |
| **6-12b.** | At school | 6.1 | 5.7 |
| **6-12c.** | In workplace | 7.7 | 7.0 |
| **6-12d.** | In community | 11 | 7 |

**Target setting method:** Better than the best.

**~~Potential d~~Data source:** ~~Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP~~National Health Interview Survey (NHIS), CDC, NCHS.

## REVISED OBJECTIVE

**6-12. Reduce the proportion of people with disabilities reporting environmental barriers to participation in home, school, work, or community activities.**

**Target and baseline:**

| Objective | Reduction in People Aged 18 Years and Older With Disabilities Who Report Encountering Barriers to Participation in Activities | 2002 Baseline | 2010 Target |
|---|---|---|---|
| | | *Percent* | |
| **6-12a.** | At home | 10 | 9 |
| **6-12b.** | At school | 6.1 | 5.7 |
| **6-12c.** | In workplace | 7.7 | 7.0 |
| **6-12d.** | In community | 11 | 7 |

**Target setting method:** Better than the best.

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

## ORIGINAL OBJECTIVE

**6-13. Increase the number of Tribes, States, and the District of Columbia that have public health surveillance and health promotion programs for people with disabilities and caregivers.**

**Target and baseline:**

| Objective | Increase in Public Health Surveillance and Health Promotion Programs for People With Disabilities and Caregivers | 1999 Baseline | 2010 Target |
|---|---|---|---|

## ORIGINAL OBJECTIVE *(continued)*

| | | | |
|---|---|---|---|
| | | *Number* | |
| **6-13a.** | States and the District of Columbia | 14 | 51 |
| **6-13b.** | Tribes | Developmental | |

**Target setting method:** Total coverage.

**Data sources:** Tribal, State, and District of Columbia reports; Office on Disability and Health, CDC.

## OBJECTIVE WITH REVISIONS

**6-13. Increase the number of Tribes, States, and the District of Columbia that have public health surveillance and health promotion programs for people with disabilities and caregivers.**

**Target and baseline:**

| Objective | Increase in Public Health Surveillance and Health Promotion Programs for People With Disabilities and Caregivers | 1999 Baseline | 2010 Target |
|---|---|---|---|
| | | *Number* | |
| **6-13a.** | States and the District of Columbia—Surveillance for people with disabilities | 14 | 50 States and DC |
| **6-13b.** | Tribes—Surveillance for people with disabilities | Developmental | |
| **6-13c.** | States and the District of Columbia—Health promotion programs for people with disabilities | 14 | 50 States and DC |
| **6-13d.** | Tribes—Health promotion programs for people with disabilities | Developmental | |
| **6-13e.** | States and the District of Columbia—Surveillance for caregivers | 0 | 50 States and DC |
| **6-13f.** | Tribes—Surveillance for caregivers | Developmental | |
| **6-13g.** | States and the District of Columbia—Health promotion programs for caregivers | 0 | 50 States and DC |
| **6-13h.** | Tribes—Health promotion programs for caregivers | Developmental | |

**Target setting method:** Total coverage.

**Data sources:** Tribal, State, and District of Columbia reports; CDC, Office on Disability and Health, ~~CDC~~.

## REVISED OBJECTIVE

**6-13. Increase the number of Tribes, States, and the District of Columbia that have public health surveillance and health promotion programs for people with disabilities and caregivers.**

**Target and baseline:**

| Objective | Increase in Public Health Surveillance and Health Promotion Programs for People With Disabilities and Caregivers | 1999 Baseline | 2010 Target |
|---|---|---|---|
| | | *Number* | |
| 6-13a. | States and the District of Columbia—Surveillance for people with disabilities | 14 | 50 States and DC |
| 6-13b. | Tribes—Surveillance for people with disabilities | Developmental | |
| 6-13c. | States and the District of Columbia—Health promotion programs for people with disabilities | 14 | 50 States and DC |
| 6-13d. | Tribes—Health promotion programs for people with disabilities | Developmental | |
| 6-13e. | States and the District of Columbia—Surveillance for caregivers | 0 | 50 States and DC |
| 6-13f. | Tribes—Surveillance for caregivers | Developmental | |
| 6-13g. | States and the District of Columbia—Health promotion programs for caregivers | 0 | 50 States and DC |
| 6-13h. | Tribes—Health promotion programs for caregivers | Developmental | |

**Target setting method:** Total coverage.

**Data sources:** Tribal, State, and District of Columbia reports; CDC, Office on Disability and Health.

# References


[1] The Behavioral Risk Factor Surveillance System (BRFSS) and the U.S. Survey on Income and Program Participation are still currently available data sources.

[2] For more information regarding the questions to identify people with disabilities, see U.S. Department of Health and Human Services (HHS). *Tracking Healthy People 2010*. Washington, DC: U.S. Government Printing Office, November 2000.

[3] For the purposes of objective 6-7, congregate care is defined as an out-of-home facility in which rotating staff members provide care. These facilities contain 16 or more beds for adults and any number of beds for children.

[4] Prouty, R., et al. Progress toward a national objective of Healthy People 2010: Reduce to zero the number of children 17 years and younger living in congregate care. *American Association of Mental Retardation* 43(6):456–460, 2005.

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[7] More information available at www.livingwellweb.com; accessed October 31, 2006.

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[10] Permanency planning is defined as a process undertaken by public and private agencies on behalf of a child with developmental disabilities and their families with the explicit goal of securing a permanent living arrangement that enhances the child's growth and development. Singer, G., and Irvin, L. *Support for Caregiving Families: Enabling Positive Adaptation to Disability*. Baltimore, MD: Paul H. Brooks Publishing Company, 1989, 44.

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[17] Executive Order 13347, *Federal Register* 07/26/04. More information available at http://a257.g.akamaitech.net/7/257/2422/06jun20041800/edocket.access.gpo.gov/2004/pdf/04-17150.pdf; accessed October 31, 2006.

[18] White, G.W., et al. *Assessing the Impact of Hurricane Katrina on Persons with Disabilities.* Lawrence, KS: University of Kansas, 2006. More information available at www.rtcil.org/products/NIDRRInterimKatrinaReport.pdf; accessed October 31, 2006.

## Related Objectives From Other Focus Areas

### 1. Access to Quality Health Services

1-1. Persons with health insurance
1-4. Source of ongoing care
1-5. Usual primary care provider
1-6. Difficulties or delays in obtaining needed health care
1-16. Pressure ulcers among nursing home residents

### 2. Arthritis, Osteoporosis, and Chronic Back Conditions

2-3. Personal care limitations
2-5. Impact on employment
2-8. Arthritis education
2-11. Activity limitations due to chronic back conditions

### 3. Cancer

3-9. Sun exposure and skin cancer
3-11. Pap tests
3-12. Colorectal cancer screening
3-13. Mammograms

### 4. Chronic Kidney Disease

4-2. Cardiovascular disease deaths in persons with chronic kidney disease
4-7. Kidney failure due to diabetes

### 5. Diabetes

5-1. Diabetes education
5-2. New cases of diabetes
5-3. Overall cases of diagnosed diabetes
5-4. Diagnosis of diabetes
5-10. Lower extremity amputations

### 7. Educational and Community-Based Programs

7-1. High school completion
7-3. Health-risk behavior information for college and university students
7-6. Participation in employer-sponsored health promotion activities
7-11. Culturally appropriate and linguistically competent community health promotion programs
7-12. Older adult participation in community health promotion activities

### 9. Family Planning

9-2. Birth spacing
9-4. Contraceptive failure
9-7. Adolescent pregnancy

## 12. Heart Disease and Stroke

12-1. Coronary heart disease (CHD) deaths
12-7. Stroke deaths
12-9. High blood pressure
12-10. High blood pressure control
12-11. Action to help control blood pressure
12-12. Blood pressure monitoring
12-13. Mean total blood cholesterol levels
12-14. High blood cholesterol levels
12-15. Blood cholesterol screening

## 14. Immunization and Infectious Diseases

14-22. Universally recommended vaccination of children aged 19 to 35 months
14-24. Fully immunized young children and adolescents
14-26. Children participating in population-based immunization registries
14-29. Influenza and pneumococcal vaccination of high-risk adults

## 16. Maternal, Infant, and Child Health

16-1. Fetal and infant deaths
16-2. Child deaths
16-3. Adolescent and young adult deaths
16-4. Maternal deaths
16-6. Prenatal care
16-9. Cesarean births
16-10. Low birth weight and very low birth weight
16-11. Preterm births
16-13. Infants put to sleep on their backs
16-16. Optimum folic acid levels
16-17. Prenatal substance exposure
16-19. Breastfeeding
16-21. Hospitalization among children with sickle cell disease
16-22. Medical homes for children with special health care needs
16-23. Service systems for children with special health care needs

## 18. Mental Health and Mental Disorders

18-4. Employment of persons with serious mental illness
18-9. Treatment for adults with mental disorders

## 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
19-5. Fruit intake
19-6. Vegetable intake
19-7. Grain product intake
19-8. Saturated fat intake
19-9. Total fat intake

19-10. Sodium intake
19-11. Calcium intake
19-12. Iron deficiency in young children and in females of childbearing age
19-13. Anemia in low-income pregnant females
19-17. Nutrition counseling for medical conditions
19-18. Food security

## 20. Occupational Safety and Health

20-1. Work-related injury deaths

## 21. Oral Health

21-1. Dental caries experience
21-2. Untreated dental decay
21-3. No permanent tooth loss
21-4. Complete tooth loss
21-5. Periodontal disease
21-6. Early detection of oral and pharyngeal cancers
21-8. Dental sealants
21-10. Use of oral health care system
21-15. Referral for cleft lip or palate
21-16. Oral and craniofacial State-based surveillance system

## 22. Physical Activity and Fitness

22-1. No leisure-time physical activity
22-2. Moderate physical activity
22-3. Vigorous physical activity
22-4. Muscular strength and endurance
22-5. Flexibility

## 23. Public Health Infrastructure

23-4. Data for all population groups
23-6. National tracking of Healthy People 2010 objectives

## 24. Respiratory Diseases

24-1. Deaths from asthma
24-2. Hospitalizations for asthma
24-3. Hospital emergency department visits for asthma
24-4. Activity limitations
24-5. School or work days lost
24-6. Patient education
24-7. Appropriate asthma care
24-8. Surveillance systems
24-9. Activity limitations due to chronic lung and breathing problems
24-10. Deaths from COPD

## 27. Tobacco Use

27-1. Adult tobacco use
27-5. Smoking cessation by adults
27-6. Smoking cessation during pregnancy

## 28. Vision and Hearing

28-4. Impairment in children and adolescents
28-10. Vision rehabilitation services and devices
28-12. Otitis media
28-13. Hearing aids, assistive listening devices, and cochlear implants