Evaluation Planning Guidelines for Grant Applicants

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Introduction

The Government Performance and Results Act of 1993 (GPRA) requires that Federal programs provide information about program goals, performance relative to program goals, and results regarding program effectiveness and cost efficiency in the spending of Federal funds. In order to support the ability of the Office of Minority Health (OMH), U.S. Department of Health and Human Services (HHS) to comply with GPRA and to demonstrate "returns on the investment" for its grant programs, all grantees must be able to produce documented results that demonstrate whether and how the strategies, practices, and interventions funded contribute to improvements in the health of racial and ethnic minorities, reductions in health disparities that place a greater burden of preventable disease or disability and premature death on such populations, and/or improvements in systems approaches for addressing these problems. To this end, OMH requires the inclusion of evaluation plans in all new grant applications and the implementation of such plans by grant awardees so that the results of OMH-funded grant efforts can be better identified.

The steps outlined in this document are intended to provide guidance to OMH grant applicants on the development of an evaluation plan and the key components for identifying how proposed projects and activities will be evaluated to determine if intended results have been achieved (see **Appendix 1** for a brief glossary of terms). Following these steps will help promote more systematic and consistent processes for grantee evaluations of efforts that are linked to OMH's overall approach to its mission. This approach is presented in the document entitled *A Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities* (the Framework), developed by OMH (and available online at: http://minorityhealth.hhs.gov/npa/templates/content.aspx?ID=78&lvl=1&lvlID=13

The Strategic Framework

In January 2008, OMH released a strategic framework for guiding and organizing the systematic planning, implementation, and evaluation of efforts to improve racial and ethnic minority health, reduce racial and ethnic health disparities, and effect systems approaches to such problems. Through a review and synthesis of current science and knowledge, the *Framework* provides the rationale for

- Examining the long-term problems that OMH is trying to address
- Focusing on the major factors known to contribute to or cause the long-term problems
- Identifying promising, best, and/or evidence-based strategies and practices known to impact the causal or contributing factors

- Presenting the kinds of outcomes and impacts that might be expected from the strategies and practices, and focusing attention on how such outcomes and impacts are being or should be measured
- Assessing the extent to which the long-term objectives and goals toward which OMH's and other efforts contribute are being achieved

In this way, the *Framework* can help OMH, its grantees, and other partners strengthen planning and evaluation efforts in line with established objectives and goals; promote strategies and practices that are more evidence-based and that use available resources effectively and efficiently; and assess whether funded efforts are really making a difference and producing meaningful results. Achieving results that improve the health of racial and ethnic minorities, reduce racial and ethnic health disparities, and promote systems approaches toward these ends supports the overarching goals of *Healthy People*, the set of disease prevention and health promotion objectives for the Nation developed each decade.[1] In *Healthy People 2010* (*HP2010*), the two principal goals have been to increase the quality and years of healthy life, and to eliminate health disparities. (For additional information, see http://www.healthypeople.gov.)

Evaluation Planning Steps

Guided by the *Framework*, the seven steps below present a systematic process for identifying the problem (or problems) to be addressed and the key contributing or causal factors; matching proposed project strategies, practices, and interventions to these problem (or problems) and factors; identifying related outcomes and impacts for the proposed efforts; selecting performance measures to assess the outcomes and impacts; and implementing evaluation and data analysis methodologies that provide the highest level of rigor possible. OMH grant applicants/awardees and others engaged in minority health-/ health disparities-related programmatic efforts should address each of these steps in their evaluation plans.

Step 1: Identify and define the problem and factors contributing or causing the problem that will be addressed by the proposed project and interventions

- Identify the problem.--Grant applicants should specify the particular problem(s) that they are proposing to address (e.g., diabetes, heart disease and stroke, HIV/AIDS, motor vehicle accidents, methamphetamine abuse, lack of access to health care, lack of infrastructure, language barriers).

[1] As of this revision of OMH's *Evaluation Planning Guidelines*, OMH continues to use the long-term objectives and goals presented in *Healthy People 2010* for the first decade of the 21st century. After *Healthy People 2020* is released, OMH will use the new overarching goals and set of disease prevention and health promotion objectives for the second decade of this century to guide long-term directions by OMH, its grantees, and other partners.

- Review and use available data about the problem.—As much as possible, review and use data to support knowledge and understanding about the particular health condition(s), racial/ethnic minority or other target population(s), health disparities problem(s), and/or systems issue(s) to be addressed. In some cases, the problem that the proposed strategy, practice, or intervention may be aiming to address is a gap or weakness in data to inform program and policy decision-making (e.g., lack of data on health care access and utilization by members of a particular Tribal community to ensure adequate and appropriate diagnosis and treatment of chronic health conditions). The point here is to provide objective evidence of the nature and extent of the problem. Some examples of potential data sources that may be useful in describing racial/ethnic minority health or systems problems, and factors contributing to such problems, are provided in **Appendix 2**.
- Focus on priority issues.--Using available data, describe the importance of the particular problems to be addressed and why the problems are priority issues for the State, region, Tribal area, or community within which the proposed funded effort will take place. The extent to which addressing the particular priority issues will contribute to the objectives of the grant program, the OMH-wide objectives of the *National Partnership for Action to End Racial and Ethnic Health Disparities*, and *Healthy People 2010* (*HP2010*) – or, after official release, *Healthy People 2020* (*HP2020*) -- objectives for priority racial/ethnic minority health and systems issues should also be described. (For reference, see the items below).
    - The OMH-wide objectives for the *National Partnership for Action to End Racial and Ethnic Health Disparities* and the program-specific objectives are listed in the grant program announcements and guidelines.
    - All *Healthy People 2010* objectives and proposed *Healthy People 2020* objectives, including those that are population-based, are identified by focus or topic area on the *Healthy People* website (see http://www.healthypeople.gov). *HP2010* objectives and indicators can also currently be accessed at http://wonder.cdc.gov/data2010. Grant applicants are strongly encouraged to take special note of those *Healthy People* objectives and sub-objectives that are not making progress with respect to the particular racial/ethnic minority group(s) being targeted (see **Appendix 3** for a list of these objectives/sub-objectives).
- Identify contributing or causal factors to be addressed.–To the extent known by available data, identify the factors contributing or causing the long-term problems that are being addressed in the proposed project or activities. For e.g., factors contributing or causing diabetes may include, but are not limited to: lack of awareness and knowledge about the connections between diet, exercise, obesity, and diabetes; lack of healthy food choices in local grocery markets and restaurants, or lack of safe venues in the neighborhood to engage in physical activity, sports, and recreation; or the lack of language assistance services in health care settings to minimize systems barriers to access and utilization for limited-English-proficient individuals at risk for diabetes.

Step 2: Specify "best" or "evidence-based" strategies and practices being used in proposed project interventions in relation to the problem and factor(s) to be addressed

- Specify proposed project activities to be conducted or implemented.–Based on the priority health or systems issues–and factors causing or contributing to these issues–identified above, specify the project activities and/or interventions that will be conducted to influence or impact the factors and, ultimately, to resolve the issue(s).
- Draw from existing science or knowledge about "what works".–As much as possible, proposed activities and/or interventions should build upon existing science and knowledge about "promising," "best," or "evidence-based" practices (or "what works"). The questions that grant applicants should answer are: What is the basis for believing that the project and proposed interventions are likely to be effective in addressing the priority problem(s) and contributing/causal factors identified? What evidence exists from expert consensus panels, peer-reviewed scientific journals, findings from research or evaluation studies to suggest that the proposed strategy or practice has promise or may/will yield a meaningful result? For example, the recommendations of the U.S. Preventive Services Task Force, at http://www.ahrq.gov/clinic/uspstfix.htm#Recommendations, and those of the Task Force on Community Preventive Services, at http://www.thecommunityguide.org, are drawn from existing scientific evidence of effective clinical and community-based prevention practice. Other sources of "evidence-based" programs and "best" practices include, but are not limited to: the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-Based Programs and Practices, a database of interventions for the prevention and treatment of mental and substance use disorders, at http://nrepp.samhsa.gov), and the "Community Toolbox" at the University of Kansas on community health and development practices, at http://ctb.ku.edu.
- Organize proposed project activities and interventions.–Organize selected project activities and interventions to facilitate a clear link between the activities, the contributing/causal factors and priority problems being addressed by the activities. This will help in addressing subsequent steps.

Step 3: Identify Outcomes, Impacts, and Performance Measures for the Proposed Interventions

Specify expected outcomes or impacts for project activities and interventions (i.e., the results).–As grant applicants consider and plan their proposed activities and interventions, they need to identify the *outcomes and/or impacts* (i.e., the results) that might be expected to take place following implementation of their projects and such activities and interventions. The outcomes/impacts identified will guide the design and selection of methods for evaluating the effectiveness of project activities and interventions.

Once expected outcomes/impacts are identified, it is then necessary to determine how "success" in achieving these outcomes and impacts will be measured. The questions to consider include: how project managers or staffs will know if their intended outcomes or impacts have been achieved; what will be counted; and what will be the 'indicators' or measures of the change or progress that occurred as a result of project efforts. In evaluation, typical measures reflect inputs, outputs, processes, outcomes, and impacts (see definitions below).

- Input Measure: a measure of what an agency or manager has available (e.g., funding, staff, facilities or equipment, supplies, etc.) to carry out the program or intervention to produce an output or outcome
- Output Measure: a measure of a product, service, or result of a particular intervention (e.g., number of people vaccinated with the influenza vaccine, number of personnel trained; number of phone calls processed by the OMH Resource Center); this type of measure provides information about the activity or intervention, not the success in achieving the objectives and goals of the program/project
- Process Measure: a measure of the procedures, tasks, or processes involved in *implementing* program or project interventions and activities to produce an output or outcome (e.g., availability of trained medical interpreters at the time of a doctor's visit by a patient with limited-English-proficiency)
- Outcome Measure: a measure of an event, occurrence, condition, or result of a program or project that indicates achievement of objectives and goal(s); this type of measure is used to measure the success of a program, project, or system (e.g., the percentage of people who do not get influenza); typically, an outcome measure reflects short- and intermediate-term results (as compared to impact measures)
- Impact Measure: a measure of the direct or indirect long-term effects or consequences of the outcomes (in terms of overall effectiveness or efficiency), resulting from achieving program or project objectives and goals (e.g., reduction in the rate of diabetes in the general population)

The type(s) of measures identified will inform the evaluation plan and data collection procedures in support of evaluation.

In order to ensure that performance results from OMH-funded projects are linked and contribute to program-wide, OMH-wide, and *Healthy People* objectives and goals, all OMH grantees must include performance measures that are clearly linked to the set of measures or indicators used by OMH for its own performance monitoring and reporting purposes. This set of measures is provided at **Appendix 4**. All grantees are required to use performance measures that are clearly linked to the first 8 performance measures as well as at least 2 of the next 3 core measures identified in the Appendix. Grantees are also strongly encouraged to select additional measures or indicators from the list towards which the expected outputs, processes, and outcomes of their project efforts contribute. Depending upon the nature of the funded activities and other desired results, OMH grant applicants may develop and include additional measures.

Step 4: Tie Outcomes/Impacts and Measures to Long-Term Objectives and Goals

Effectively addressing racial and ethnic minority health problems and systems approaches to such problems supports the overarching goals of *Healthy People*. For the first decade of the 21st century, the two principal goals of *HP2010* are: (1) to increase the quality and years of healthy life, and (2) to eliminate health disparities. The overarching goals proposed for *HP2020* are similar but broader and are: (1) to attain high quality, longer lives free of preventable disease, disability, injury, and premature death, (2) to achieve health equity, eliminate disparities, and improve the health of all groups, (3) to crease social and physical environments that promote good health for all, and (4) to promote quality of life, healthy development, and health behaviors across all life stages. See http://www.healthypeople.gov for more detailed information and the final version of *HP2020* after official release. The results of OMH-funded projects and activities must, therefore, contribute to relevant grant program-specific, OMH-wide, and *HP2010* (or *HP2020* after release) objectives and priorities–which, in turn, contribute to the long-term *HP2010* (or *HP2020*) goals. Consistent with information provided in Step 1 to show the relationship between proposed project activities with grant program, OMH, and *Healthy People* objectives and priorities, grant applicants should identify and describe how the outcomes, impacts, and performance measures for their proposed efforts will contribute to relevant program, OMH, and *Healthy People* objectives and goals.

Step 5: Develop a Logic Model for the Proposed Project and Activities

A logic model is simply a tool, often used by program planners and evaluators, to help identify planned activities for the program, and how such activities relate to the problem being addressed and the anticipated results. Logic models can be very useful in clarifying the "logic" behind what is being done and how programs should work. The University of Wisconsin-Extension web site at http://www1.uwex.edu/ces/lmcourse is an excellent resource for more information on logic models. Other logic model planning resources and guidance are also available at:

- http://www.uidaho.edu/extension/LogicModel.pdf
- http://www.wkkf.org/knowledge-center/resources/2010/Logic-Model-Development-Guide.aspx
- http://www.cdc.gov/eval/resources.htm#logic%20model

In order to ensure a rational approach to OMH-funded grant efforts that will clearly link grant activities to broader program- and OMH-wide objectives and goals, each grant applicant is expected to develop and submit a logic model for the proposed project and activities. Such a logic model should be able to guide subsequent plans for collecting data on and evaluating the project and activities to determine whether expected outcomes and impacts have, in fact, been achieved. Examples of a logic model template, logic model worksheet, and a completed logic model for broad-based diabetes activities are provided for this purpose (see **Appendices 5, 6, and 7**).

Step 6: Obtain Appropriate Evaluation Expertise and Determine Evaluation Types and Methods

- Involve individuals who know about evaluation, the community, and the project.–Grant applicants should include individuals on their project teams with expertise to identify and select the evaluation methods and design needed to determine whether expected results have been achieved. Good evaluators will also be able to help with:
  - the development of the logic models themselves,
  - identification and selection of evaluation methods and design,
  - data collection methods appropriate for the evaluation,
  - design of data collection procedures and forms, and
  - analysis and reporting of the results.

  Some grant applicants may wish to enlist external evaluators for this purpose. Local colleges and universities with faculty, staff, and graduate students who are engaged in academic research are often good sources for such expertise. However, it is critical for such individuals and/or other members of the project team to also have knowledge and experience with the populations and health issues being addressed. In addition to trained evaluators or researchers, involvement of project participants and practitioners will help ensure that the evaluation is informed by those who have first-hand knowledge about the project and its participants as well as a stake in the project and its outcome. If interviews or surveys will be conducted, persons who understand the culture and who speak the language of the target population may also need to be included. The purpose of the evaluation expertise is to help grantees, the project team as a whole, and, ultimately, OMH, produce meaningful results of the project(s) and program(s) being funded.
- Identify evaluation types and methods.–Different types of evaluation and methods are available for assessing the effectiveness of parts and/or all of the proposed project or program. There are benefits and drawbacks to each type of evaluation and method. Working with individuals who have the needed expertise, grant applicants should identify the proposed evaluation type and methods for determining the effectiveness of the strategies, interventions, and activities to be funded. A list of the types of evaluations generally used is provided in **Appendix 8**.

Step 7: Develop Data Collection Plan, Protocols, and Forms Needed to Implement the Evaluation

- Develop Data Collection Plan.--Once the evaluation design, methods, and measures for assessing program or project results (outcomes and impacts) are clear, the kinds of data to be collected and analyzed–and a plan for such collection and analysis–can be determined. A data collection plan specifies in precise, clear, and unambiguous terms the data that must be collected, the frequency of collection, the instruments for collection, the sources of the data, the location of the data, and who will be responsible for collecting the data. This plan should assist in organizing and coordinating the data collection process. The kind of data to be collected may differ considerably from activity to activity, and the data source(s) selected will depend on the kinds of measures selected and the relative feasibility of obtaining the needed data. Data can be obtained from a variety of sources (such as, state agencies, hospitals, community health centers, program or project staff, etc.), and through a variety of means, including surveys or instruments administered to patients, trainees, health care providers, and other populations targeted or participating in planning and implementation of project activities. In the diabetes example, one of the measures is the "number/percent of individuals with increased awareness and knowledge," for which an appropriate source of this information may be the participants themselves who received an educational or training intervention. (See **Appendix 9** for a sample data collection plan template and a completed plan based on an actual example selected by OMH's Evaluation Technical Assistance Center from one of the FY 2009 grantees.)

  Grant awardees will be expected to implement their evaluation and data collection plans at the beginning of their projects, in order to capture and document activities and actions contributing to relevant project outcomes/impacts.

- Develop Data Collection Procedures and Forms.–Standard forms, questionnaires, other instruments, and databases–as well as standard procedures for using such tools, and staff training on these procedures–will facilitate the systematic data collection needed to effectively implement the data collection plan and conduct the requisite evaluation of program or project activities. These tools may include, but are not limited to:
  - *Activity records or tracking forms*. These forms document the activities conducted and provide the basis for assessing connections between the program or project and its outcomes/impacts. The recording and tracking of basic process data is often necessary in order to evaluate all activities.
  - *Outcome/impact data collection procedures and forms*. Based on the selected outcomes/impacts and performance measures to be used, forms need to be developed and a database (e.g., Microsoft ACCESS) established for recording and storing performance- or results-oriented data. Relevant forms may include, for example, surveys or questionnaires used to assess knowledge and attitudes before and after a program/project intervention, or forms that record changes in organizational linkages or services provided as a result of a community coalition.

Appendix 10 includes some examples of data collection forms for recording processes and outcomes of a few sample activities. In the diabetes example, the types of data that might be collected include: educational sessions conducted, number of people trained, evidence of change in awareness or knowledge, records of strategic planning documents and other products produced by community-based task forces, etc.

Conclusion

Upon award, additional steps will be needed by grantees to implement the evaluation plan, including training program/project staff to follow data collection protocols, enter data, analyze data, prepare reports, and submit data and disseminate reports to OMH and others, as appropriate. Grantees need not include information about these steps in the evaluation plan at this time. However, by following the steps outlined above, OMH grant applicants and other users will be guided through a careful evaluation planning process designed to increase the ability of OMH-funded activities to produce meaningful results in return for the public's investment in OMH's grant programs and other efforts. The ultimate goal is to improve the health and well-being of racial and ethnic minorities in the U.S.; reduce and, ultimately, eliminate the disparate burden of preventable disease, disability and premature death on such populations; and facilitate systems approaches to addressing these problems.

Appendix 1:
Glossary of Terms

Glossary of Terms

For reference, the following is a brief glossary of terms.

Best Practices: Program models or activities for which effectiveness in achieving specified goals or objectives has been demonstrated or suggested through a number of evaluations

Cost-Benefit Analysis: A process of measuring the expected cost of an effort or action against the expected benefit in order to evaluate the desirability of the effort

Cost-Effectiveness Analysis: A comparison of the relative costs and benefits of two or more approaches to a problem

Evaluability Assessment: A systematic process used to determine the feasibility of a program evaluation. It also helps determine whether conducting a program evaluation will provide useful information that will help improve the management of a program and its overall performance.

Evidence-based: Based on scientific evidence or the best possible knowledge that is available

Experimental Design: Individuals in the target population are randomly assigned to an experimental group receiving the intervention (project activities) or a control group that does not receive the intervention, and data are collected from both groups throughout the project. The overwhelming benefit of experimental designs is the ability to attribute the cause of the observed changes in the experimental group to the intervention rather than to something else. Because of random assignment to the two groups, the two groups are assumed to be equal in all relevant characteristics except the presence of the intervention. This “randomized controlled trial” produces stronger evidence, but it can be expensive and potentially difficult to implement in a community setting.

Formative Evaluation: Typically conducted during the development (or formation) of a strategy, program, or product (including trained personnel) to assess (or ‘test’) their strengths and weaknesses before implementation. Such evaluations permit necessary revisions and improvements that enable planned efforts to be tailored to the target audience(s), as in the case of campaign strategies, products, or messages that are ‘pre-tested’ by a small group before they are implemented on a large scale. They can also be used for observing, monitoring, and providing feedback on student, staff, or trainee performance to improve skills. The basic purpose is to maximize the chance for program, project, or trainee success before full implementation of the activity starts. Unlike summative evaluations, formative evaluations are primarily prospective, shape program/project direction, and provide feedback towards improvement. Examples of formative evaluations are needs assessments, evaluability assessments, and process evaluations.

Goals: Broad statements (i.e., written in general terms) that convey a program's overall intent to change, reduce, or eliminate the problem described. Goals identify the program's intended short- and long-term results.

Impact Evaluation: Focuses on the long-range results of the program or project, and changes or improvements as a result (for e.g., long-term maintenance of desired behavior, reduced absenteeism from work, reduced morbidity and mortality). Because such evaluations are the most comprehensive and focus on long-term results of the program and changes or improvements in health status, they are the most desirable. However, impact evaluations are rarely possible because they are frequently costly and involve extended commitment. Also, the results often cannot be directly related to the effects of a program, project, or activity because of other (external) influences on the target audience, which occur over time.

Impact Measure: A measure of the direct or indirect long-term effects or consequences of the outcomes (in terms of overall effectiveness or efficiency), resulting from achieving program or project objectives and goals (e.g., reduction in the rate of diabetes in the general population)

Input Measure: A measure of what an agency or manager has available (e.g., funding, staff, facilities or equipment, supplies, etc.) to carry out the program or activity to produce an output or outcome

Logic Model: A tool for planning, implementing, and evaluating programmatic efforts, by mapping out the theory or rationale that supports what is being done. Logic models typically tie together: *long-term problem(s)* to be addressed; *factors* that must be addressed that contribute to the problem(s); *strategies and practices*, and supporting resources, that can be mobilized to address the factors and the problems; and *measurable impacts and outcomes* that can be expected to result from implementing the strategies and practices – as these relate to the long-term problem(s).

Meta-Analysis: A technique for summarizing and reviewing research on a topic

Needs Assessment: A method of collecting information on the needs, wants, and expectations of a community or other group of people to gain a picture of the strengths and weaknesses of the community or group for program planning and resource allocation purposes

Non-experimental Design: Only one group receiving the intervention is being observed or studied without the use of a comparison group to control for outside factors. Thus, such designs generally involve less data collection and are easier to plan and carry out. They typically involve observing and/or collecting all relevant data–including data on key performance measures–on participants at selected points in time during the project. Examples of such design include, but are not limited to, case studies, structured interviews, surveys, pre-/post-tests, ethnographic studies, and document reviews (e.g., medical records, intake and discharge forms). Because non-experimental designs have only one group, they are infrequently used to evaluate whether particular interventions are effective in producing specified outcomes, because causality (i.e., whether outcomes are the result of the intervention) cannot be established. However, if conducted properly, this type of design can be just as informative as the two previously discussed designs.

Objectives: Are derived from the program goals and explain how the program goals will be accomplished. Objectives are well-defined, specific, quantifiable statements of the program's desired results and they should include the target level of accomplishment, thereby further defining goals and providing the means to measure program performance.

Outcome Evaluation: Used to obtain descriptive data on a program or project and to document (typically) short- and intermediate-term results. Task-focused results are those that describe the output of the activity (e.g., the number of public inquiries received as a result of a public service announcement). Shorter-term results describe the immediate effects of the project on the target audience (e.g., percent of the target audience showing increased awareness of the subject). Information from such evaluation can show results such as knowledge and attitude changes, short-term or intermediate behavior shifts, and policies initiated or other institutional changes.

Outcome Measure: A measure of an event, occurrence, condition, or result of a program or project that indicates achievement of objectives and goal(s); this type of measure is used to measure the success of a program, project, or system (e.g., the percentage of people who do not get influenza).

Output Measure: A measure of a product, service, or result of a particular activity (e.g., number of people vaccinated with the influenza vaccine, number of personnel trained; number of phone calls processed by the OMH Resource Center); this type of measure provides information about the activity, not the success in achieving the objectives and goals of the program/project.

Performance Data System (PDS): OMH's current web-based system for collecting and reporting performance data across all OMH-funded programs and projects. The PDS, unlike the previous Uniform Data Set (UDS), is organized to reflect the logic depicted in the *Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities*, is more outcome- rather than activity-oriented, and emphasizes measures that are more clearly linked to OMH-wide outcomes and longer-term objectives and goals.

Performance Measures/Performance Indicators: Particular values used to measure program activities, impacts and outcomes. They represent the actual data/information that will be collected at the program level to measure the specific activities/impacts/outcomes a program is designed to achieve. Therefore, they must be developed for each program objective.

Process Evaluation: Examine the tasks and procedures involved in implementing a program or activities, including the administrative and organizational aspects of, and delivery procedures involved in, the efforts. Such evaluations enable monitoring to ensure feedback during the course of the program or project.

Process Measure: A measure of the procedures, tasks, or processes involved in implementing program or project activities to produce an output or outcome (e.g., availability of trained medical interpreters at the time of a doctor's visit by a patient with limited English proficiency)

Program: A group of individual (grantee) projects, unified by a set of goals, health issues of focus, recommended types of activities, eligible grant recipients, etc.

Project: An individual project (grantee), usually within an overall program, addressing one or more specific target populations or communities, and health issues

Quasi-experimental Design: Data are collected and compared over the course of the project between an experimental group receiving the intervention (project activities) and a similar population (control or comparison group) not receiving the intervention. This can help assess whether the intervention was responsible for impacts/outcomes, even though it will not be as rigorous as a randomized controlled trial. A quasi-experimental design is usually more feasible than the experimental approach, and is ideal when randomization is not possible or is not appropriate.

Statistical Significance: When the analysis of data results in statistical significance, it means that the result is not likely to have occurred by chance. It confirms a relationship or difference between variables.

Summative Evaluation: Look at a combination of measures and conclusions for larger patterns and trends in performance, to assess, in summary, whether the program or project overall did what it was designed to do. Compared to formative evaluations, summative evaluations are primarily retrospective, document evidence, and show results and achievement. Examples of summative evaluations include outcome and impact evaluations, cost-effectiveness and cost-benefit analyses, and meta-analyses (which integrate outcomes from multiple studies to determine an overall judgment or summary conclusion about a particular research or evaluation question).

Uniform Data Set (UDS): A standard set of activity-oriented data previously collected by OMH from selected grantees via an Internet-based system. The data were organized by types of activity and limited to program and project outputs and processes.

Appendix 2:
Examples of Types and Sources of Data to Guide Planning

Examples of Types and Sources of Data to Guide Planning

The following types and sources of data may be useful in describing racial and ethnic minority health or systems problems, and factors contributing to such problems:

Demographic data. These data can provide information on certain population characteristics within a State, Tribal area, or region, such as race, ethnicity, gender, age, geographic location, education, income, and primary language spoken at home (i.e., English versus another language). Demographic data can be obtained from the U.S. Census Bureau at http://www.census.gov/. *These data can help answer questions about the racial and ethnic minority populations in a particular State, region, or community.*

Population and community health data. Excellent Federal sources for national and, in some cases, State or local health data include the CDC "Wonder" system at http://wonder.cdc.gov/, the *Morbidity and Mortality Weekly Report* data at http://www.cdc.gov/mmwr/, and data from the National Center for Health Statistics at http://www.cdc.gov/nchs/. Racial and ethnic minority health data can be accessed from such sites as http://www.hhs-stat.net/omh/ or, by State, at Kaiser Family Foundation's http://www.statehealthfacts.org/, or from national minority health organizations. State health departments and State offices of minority health are also good sources for data about the populations in their jurisdictions. In addition, Inter-Tribal Council Epidemiology Centers are designed to provide access to health data for member Tribes. *These data can help answer questions about the key health problems and risk factors for the selected populations.*

Systems data. This category refers to information on the kinds of broad systems characteristics that might promote or inhibit the ability to address racial and ethnic minority health problems in a State, another geographic area, or an organization (e.g., whether infrastructure and staff are available to address identified problems; whether strategic plans have been developed to guide progress toward goals and objectives; whether task forces or other coordinating bodies exist to identify and pool resources, expertise, and other talent; whether data/information and communication systems support needed functions; whether services provided are client, patient, or user centered). These systems characteristics go beyond health care or public health systems alone. Such information may be found through the Web sites of State health departments and other health-oriented task forces or organizations (e.g., the California Wellness Foundation). The Association of State and Territorial Health Officials has links for health departments in every State at http://www.astho.org/index.php?template=regional_links.php. The Kaiser Family Foundation has a set of State government links, including links to health departments, at http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile. *These data may help answer questions about key systems issues that make an impact on the health of selected populations.*

Health care coverage, access, and utilization data. One Federal source for such data is the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project Databases, at http://www.ahrq.gov/data/hcup/. This particular site includes State-level data, though such data vary in terms of what is reported. The Centers for Medicare & Medicaid Services is another Federal source of data, particularly on enrollees in Medicare, Medicaid, and the State Children's Health Insurance Programs, at http://www.cms.hhs.gov/home/rsds.asp. State departments of public health may also have data on health insurance coverage within the State. In addition, the Commonwealth Fund at http://www.cmwf.org/ tracks trends in health coverage, access, and quality and provides data on State health policy and underserved populations. *These data can help answer questions about the nature and extent of health care access and usage for a selected population (or populations).*

Appendix 3:
Healthy People 2010 Racial/Ethnic Minority-Specific Objectives and Subobjectives Going in the Wrong Direction or Making No Progress

Healthy People 2010 Racial/Ethnic Minority-Specific Objectives and Subobjectives Going in the Wrong Direction or Making No Progress

Number	*Objective*	*R/E*	*Baseline Year*	*Baseline*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*Target 2010*	*Progress Quotient*
01-01	**Persons with health insurance (aged under 65 years)**	Asian only	1997	81.00%	82%	84.00%	82%	83%	83%	82%	83%	100%	-12.50
01-01	**Persons with health insurance (aged under 65 years)**	Hispanic or Latino	1997	66%	66%	66%	64%	65%	66%	65%	66%	100%	-2.94
01-04c	**Source of ongoing care - Adults (age adjusted, aged 18 years and over)**	Black or African American not Hispanic	1998	85%	BSL	83%	84%	87%	85%	85%	84%	96%	0.00
01-04c	**Source of ongoing care - Adults (age adjusted, aged 18 years and over)**	Hispanic or Latino	1998	76%	BSL	75%	73%	74%	74%	75%	72%	96%	0.00
01-05	**Persons with a usual primary care provider**	American Indian or Alaska Native	1996	79%	ND	75%	80%	76%	73%	79%	ND	85%	-66.67
01-05	**Persons with a usual primary care provider**	Black or African American not Hispanic	1996	74%	ND	76%	74%	76%	75%	73%	ND	85%	-9.09
01-05	**Persons with a usual primary care provider**	Asian or Pacific Islander	1996	71%	ND	68%	73%	75%	DNC	DNC	ND	85%	-21.43
01-06	**Difficulties or delays in obtaining needed health care**	Black or African American not Hispanic	1996	10%	ND	8%	10%	11%	ND	ND	ND	7%	-33.33
01-08b	**Racial and ethnic representation in health professions - Asian or Pacific Islander**	Asian or Pacific Islander	1996-97	16.3%	18.0%	18.6%	18.8%	20.3%	20.4%	20.6%	20.3%	4.0%	-33.33
01-08f	**Racial and ethnic representation in Nursing - Asian or Pacific Islander**	Asian or Pacific Islander	1995-96	3.2%	ND	ND	ND	3.3%	3.2%	3.5%	ND	4.0%	0.00
01-08i	**Racial and ethnic representation in Medicine - American Indian or Alaska Native**	American Indian or Alaska Native	1996-97	0.7%	0.8%	0.8%	0.9%	0.9%	0.9%	0.7%	0.6%	1.0%	0.00
01-08j	**Racial and ethnic representation in Medicine - Asian or Pacific Islander**	Asian or Pacific Islander	1996-97	16.0%	17.7%	18.7%	18.1%	19.8%	20.0%	20.7%	20.0%	4.0%	-33.33
01-08m	**Racial and ethnic representation in Dentistry - American Indian or Alaska Nativ**	American Indian or Alaska Native	1996-97	0.5%	0.4%	0.7%	0.5%	0.6%	0.5%	0.5%	0.3%	1.0%	0.00
01-08n	**Racial and ethnic representation in Dentistry - Asian or Pacific Islander**	Asian or Pacific Islander	1996-97	19.5%	22.0%	24.4%	25.3%	26.5%	25.1%	24.6%	24.7%	4.0%	-36.13
01-08o	**Racial and ethnic representation in Dentistry - Black or African American**	Black or African American not Hispanic	1996-97	5.1%	4.9%	4.2%	4.5%	4.9%	4.0%	4.4%	4.5%	13.0%	-13.92
01-08p	**Racial and ethnic representation in Dentistry - Hispanic or Latino**	Hispanic or Latino	1996-97	5.3%	4.9%	5.0%	5.5%	4.9%	5.3%	6.1%	6.3%	12.0%	0.00
01-08r	**Racial and ethnic representation in Pharmacy - Asian or Pacific Islander**	Asian or Pacific Islander	1996-97	17.5%	19.0%	18.6%	20.7%	20.8%	21.5%	22.6%	22.8%	4.0%	-29.63
02-01	**Mean level of joint pain among adults with arthritis (age adjusted, aged 18 years and over)**	Black or African American not Hispanic	2002	6.3	NA	NA	NA	NA	BSL	6.6	ND	5.3	-30.00

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02-01	**Mean level of joint pain among adults with arthritis (age adjusted, aged 18 years and over)**	Hispanic or Latino	2002	6.3	NA	NA	NA	NA	BSL	6.5	ND	5.3	-20.00
02-02	**Activity limitations due to arthritis (age adjusted, aged 18 years and over)**	Hispanic or Latino	2002	40%	NA	NA	NA	NA	BSL	41%	47%	33%	-14.29
02-03	**Personal care limitations - Adults with arthritis (age adjusted, aged 18 years and over)**	Black or African American not Hispanic	2002	3.7%	NA	NA	NA	NA	BSL	5.1%	3.1%	1.5%	-63.64
02-05a	**Unemployment rate among adults with arthritis (age adjusted, aged 18 to 64 years) [New]**	Black or African American not Hispanic	2002	46%	NA	NA	NA	NA	BSL	48%	ND	27%	-10.53
02-05a	**Unemployment rate among adults with arthritis (age adjusted, aged 18 to 64 years) [New]**	Hispanic or Latino	2002	38%	NA	NA	NA	NA	BSL	40%	ND	27%	-18.18
02-07	**Seeing a health care provider among adults with chronic joint symptoms (age adjusted, aged 18 years and over)**	Asian only	2002	57%	NA	NA	NA	NA	BSL	53%	50%	61%	-100.00
02-08	**Arthritis education among adults with arthritis (age adjusted, aged 18 years and over)**	Black or African American not Hispanic	2002	12%	NA	NA	NA	NA	BSL	10%	ND	13%	-200.00
03-01	**Overall cancer deaths (age adjusted per 100,000 standard population)**	Asian or Pacific Islander	1999	123.0	NA	BSL	121.9	119.5	113.6	113.5	ND	158.6	-26.40
03-02	**Lung cancer deaths (age adjusted per 100,000 standard population)**	Asian or Pacific Islander	1999	27.9	NA	BSL	28.1	28.2	25.6	26.9	ND	43.3	-14.94
03-07	**Prostate cancer deaths (age adjusted per 100,000 standard population)**	Asian or Pacific Islander	1999	13.9	NA	BSL	12.5	11.6	10.2	10.9	ND	28.2	-25.87
03-08	**Melanoma deaths (age adjusted per 100,000 standard population)**	Black or African American not Hispanic	1999	0.4	NA	BSL	0.6	0.4	0.4	0.5	ND	2.3	0.00
03-08	**Melanoma deaths (age adjusted per 100,000 standard population)**	Asian or Pacific Islander	1999	0.4	NA	BSL	0.4	0.3	0.4	0.4	ND	2.3	0.00
03-09b	**Sun exposure and skin cancer - Adults who use protective measures (age adjusted, aged 18 years and over)**	Asian only	2000	63%	NA	NA	BSL	ND	ND	61%	ND	85%	-9.09
03-09b	**Sun exposure and skin cancer - Adults who use protective measures (age adjusted, aged 18 years and over)**	Hispanic or Latino	2000	59%	NA	NA	BSL	ND	ND	57%	ND	85%	-7.69
03-11a	**Pap tests - Ever received (age adjusted, aged 18 years and over)**	Black or African American not Hispanic	1998	94%	BSL	94%	95%	ND	ND	93%	ND	97%	-33.33
03-11a	**Pap tests - Ever received (age adjusted, aged 18 years and over)**	American Indian or Alaska Native	1998	88%	BSL	97%	95%	ND	ND	93%	ND	97%	Wrong
03-11b	**Pap tests - Received within past 3 years (age adjusted, aged 18 years and over)**	American Indian or Alaska Native	1998	72%	BSL	89%	76%	DNC	DNC	84%	ND	90%	-500.00

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03-11b	**Pap tests - Received within past 3 years (age adjusted, aged 18 years and over)**	Black or African American not Hispanic	1998	83%	BSL	84%	84%	DNC	DNC	83%	ND	90%	0.00
03-11b	**Pap tests - Received within past 3 years (age adjusted, aged 18 years and over)**	Hispanic or Latino	1998	74%	BSL	76%	77%	DNC	DNC	75%	ND	90%	-7.14
03-12a	**Colorectal cancer screening - Adults receiving a fecal occult blood test (FOBT) within past 2 years (age adjusted, aged 50 years and over)**	Asian only	2000	24%	NA	NA	BSL	ND	ND	18%	ND	33%	-66.67
03-13	**Mammograms - Adults receiving within past 2 years (age adjusted, aged 40 years and over)**	Hispanic or Latino	1998	60%	BSL	66%	62%	DNC	DNC	65%	ND	70%	-25.00
04-01	**End-stage renal disease - New cases (per million population - adjusted for age, gender, and race - where applicable)**	Black or African American not Hispanic	1997	938	984	984	995	962	982	ND	ND	221	-6.14
04-01	**End-stage renal disease - New cases (per million population - adjusted for age, gender, and race - where applicable)**	Hispanic or Latino	1997	408	454	446	454	484	481	ND	ND	221	-39.04
04-02	**Cardiovascular disease deaths in persons with chronic kidney failure (per 1,000 patient years at risk)**	Black or African American not Hispanic	1997	76.9	77.0	77.5	74.0	80.5	78.6	ND	ND	62.1	-11.49
04-02	**Cardiovascular disease deaths in persons with chronic kidney failure (per 1,000 patient years at risk)**	Hispanic or Latino	1997	71.6	73.3	74.5	71.7	76.9	74.6	ND	ND	62.1	-31.58
04-05	**Registration for kidney transplantation - Dialysis patients (aged under 70 year**	American Indian or Alaska Native	1998	14%	BSL	13%	13%	10%	11%	ND	ND	30.0%	-18.75
04-05	**Registration for kidney transplantation - Dialysis patients (aged under 70 years)**	Black or African American not Hispanic	1998	13.70%	BSL	13.7%	13.6%	10.8%	11.2%	ND	ND	30.0%	-15.34
04-05	**Registration for kidney transplantation - Dialysis patients (aged under 70 years)**	Asian or Pacific Islander	1998	27.70%	BSL	29.40%	31.20%	27.90%	27.60%	ND	ND	30.0%	-4.35
04-05	**Registration for kidney transplantation - Dialysis patients (aged under 70 years)**	Hispanic or Latino	1998	17%	BSL	16%	16%	14%	15%	ND	ND	30.0%	-15.38
04-06	**Waiting time for kidney transplantation - Cumulative percent of persons receivi**	American Indian or Alaska Native	1992-94	18%	12%	11%	14%	13%	11%	ND	ND	30.5%	-56.00
04-06	**Waiting time for kidney transplantation - Cumulative percent of persons receiving a kidney transplant within 3 years of the date of renal failure (aged under 70 years)**	Black or African American not Hispanic	1992-94	13.00%	12.50%	11.60%	9.80%	9.80%	9.60%	ND	ND	30.5%	-19.43
04-06	**Waiting time for kidney transplantation - Cumulative percent of persons receiving a kidney transplant within 3 years of the date of renal failure (aged under 70 years)**	Asian or Pacific Islander	1992-94	24.90%	21.60%	22.30%	20.30%	20.20%	19.40%	ND	ND	30.5%	-98.21
04-07	**End-Stage renal disease due to diabetes - new cases (per million population - adjusted for age, gender, and race - where applicable)**	Black or African American not Hispanic	1997	403	432	424	424	429	434	ND	ND	90	-9.90

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04-07	**End-Stage renal disease due to diabetes - new cases (per million population - adjusted for age, gender, and race - where applicable)**	Hispanic or Latino	1997	262	283	285	289	304	300	ND	ND	90	-22.09
05-01	**Diabetes education (age adjusted, aged 18 years and over)**	Black or African American not Hispanic	1998	48%	BSL	48%	ND	ND	ND	ND	ND	60%	0.00
05-02	**New cases of diabetes - 3-year average (age adjusted per 1,000 standard population, aged 18 to 84 years)**	Asian only	1997-99	7.3	NA	BSL	DSU	7.8	8.1	8.9	10.1	3.8	-22.86
05-02	**New cases of diabetes - 3-year average (age adjusted per 1,000 standard population, aged 18 to 84 years)**	Black or African American not Hispanic	1997-99	9.6	NA	BSL	9.3	9.6	10.0	10.1	10.5	3.8	-6.90
05-02	**New cases of diabetes - 3-year average (age adjusted per 1,000 standard population, aged 18 to 84 years)**	Hispanic or Latino	1997-99	7.9	NA	BSL	8.6	9.8	9.7	9.9	9.4	3.8	-43.90
05-03	**Prevalence of diabetes (age adjusted per 1,000 standard population)**	American Indian or Alaska Native	1997	84	83	DSU	95	106	114	88	108	25	-6.78
05-03	**Prevalence of diabetes (age adjusted per 1,000 standard population)**	Asian only	1997	32	44	34	34	38	45	50	56	25	-177.78
05-03	**Prevalence of diabetes (age adjusted per 1,000 standard population)**	Black or African American not Hispanic	1997	74	67	69	76	78	74	75	83	25	0.00
05-03	**Prevalence of diabetes (age adjusted per 1,000 standard population)**	Asian or Pacific Islander	1997	36	46	DNC	DNC	DNC	DNC	DNC	DNC	25	-90.91
05-03	**Prevalence of diabetes (age adjusted per 1,000 standard population)**	Hispanic or Latino	1997	61	66	65	65	69	69	65	76	25	-11.11
05-05	**Diabetes-related deaths (age adjusted per 100,000 standard population)**	Black or African American not Hispanic	1999	136	NA	BSL	137	137	138	138	ND	46	-2.22
05-07	**Cardiovascular disease deaths among persons with diabetes (age adjusted per 100,000 standard population)**	Black or African American not Hispanic	1999	349	NA	BSL	330	315	350	332	ND	299	-2.00
05-12	**A1C Test-at least two times a year - Persons with diabetes (age adjusted, aged 18 years and over)**	Asian or Pacific Islander	2000	62.00%	NA	NA	BSL	66%	66%	52%	73%	65%	-333.33
05-14	**Annual foot examinations - Persons with diabetes (age adjusted, aged 18 years and over)**	Hispanic or Latino	1998	68%	BSL	54%	54%	55%	62%	59%	62%	91%	-39.13
05-15	**Annual dental examinations - Persons with diabetes (age adjusted, aged 2 years and over)**	Black or African American not Hispanic	1997	53%	34%	57%	52%	55%	46%	49%	53%	71%	-22.22
05-15	**Annual dental examinations - Persons with diabetes (age adjusted, aged 2 years and over)**	Hispanic or Latino	1997	40%	52%	60%	53%	49%	45%	41%	47%	71%	-172.73
05-17	**Self-blood-glucose-monitoring - Persons with diabetes - At least once daily (age adjusted, aged 18 years and over)**	Asian or Pacific Islander	1998	30%	BSL	DSU	60%	57%	38%	30%	44%	61%	0.00

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06-03	**Negative feelings interfering with activities among adults with disabilities (a**	American Indian or Alaska Native	1997	22%	DSU	DSU	46%	50%	DSU	39%	DSU	7%	-113.33
06-03	**Negative feelings interfering with activities among adults with disabilities (age adjusted, aged 18 years and over)**	Asian only	1997	DSU	DSU	26%	33%	34%	28%	34%	32%	7%	-42.11
06-03	**Negative feelings interfering with activities among adults with disabilities (age adjusted, aged 18 years and over)**	Black or African American not Hispanic	1997	31%	31%	24%	25%	28%	31%	31%	30%	7%	0.00
06-03	**Negative feelings interfering with activities among adults with disabilities (age adjusted, aged 18 years and over)**	Hispanic or Latino	1997	40%	41%	27%	29%	35%	35%	36%	36%	7%	-45.00
06-08	**Employment parity - Adults with disabilities (aged 18 to 64 years)**	Black or African American not Hispanic	1997	31%	35%	26%	32%	26%	30%	25%	28%	80%	-12.24
06-08	**Employment parity - Adults with disabilities (aged 18 to 64 years)**	Hispanic or Latino	1997	29%	34%	38%	40%	34%	33%	38%	30%	80%	0.00
07-01	**High school completion (aged 18 to 24 years)**	Asian or Pacific Islander	1998	94%	BSL	94%	95%	96%	ND	ND	ND	90%	-50.00
07-06	**Participation in employer-sponsored health promotion activities (age adjusted, aged 18 years and over)**	Black or African American not Hispanic	1994	61%	60%	ND	ND	ND	ND	ND	ND	88%	-3.70
07-06	**Participation in employer-sponsored health promotion activities (age adjusted, aged 18 years and over)**	Hispanic or Latino	1994	73%	64%	ND	ND	ND	ND	ND	ND	88%	-60.00
08-01a	**Harmful air pollutants - Persons exposed to ozone**	Asian or Pacific Islander	1997	69%	69%	69%	69%	69%	69%	66%	66%	0%	0.00
08-01a	**Harmful air pollutants - Persons exposed to ozone**	Native Hawaiian or Other Pacific Islander	1997	39%	39%	39%	39%	39%	39%	35%	35%	0%	0.00
08-01a	**Harmful air pollutants - Persons exposed to ozone**	Hispanic or Latino	1997	61%	61%	61%	61%	61%	61%	59%	59%	0%	0.00
08-01b	**Harmful air pollutants - Persons exposed to particulate matter (<=10 um in diameter)**	Hispanic or Latino	1997	30%	30%	30%	30%	30%	28%	28%	28%	0%	0.00
08-01e	**Harmful air pollutants - Persons exposed to sulfur dioxide**	American Indian or Alaska Native	1997	1%	1%	1%	1%	1%	1%	1%	1%	0%	0.00
08-01e	**Harmful air pollutants - Persons exposed to sulfur dioxide**	Asian only	1997	1%	1%	1%	1%	1%	1%	1%	1%	0%	0.00
08-01e	**Harmful air pollutants - Persons exposed to sulfur dioxide**	Black or African American not Hispanic	1997	2%	2%	2%	2%	2%	2%	2%	1%	0%	0.00
08-01e	**Harmful air pollutants - Persons exposed to sulfur dioxide**	Asian or Pacific Islander	1997	1%	1%	1%	1%	1%	1%	1%	1%	0%	0.00
08-01e	**Harmful air pollutants - Persons exposed to sulfur dioxide**	Native Hawaiian or Other Pacific Islander	1997	3%	3%	3%	3%	3%	3%	3%	3%	0%	0.00

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08-01e	**Harmful air pollutants - Persons exposed to sulfur dioxide**	Hispanic or Latino	1997	1%	1%	1%	1%	1%	1%	1%	1%	0%	0.00
08-01g	**Harmful air pollutants - Persons exposed to any (thousands)**	Black or African American not Hispanic	1997	17,191	17,187	16,627	16,572	16,159	16,012	15,375	14,959	0	0.02
09-02	**Birth spacing - Births occurring within 24 months of a previous birth (females aged 15 to 44 years)**	Black or African American not Hispanic	1995	14%	ND	ND	ND	ND	19%	ND	ND	6%	-62.50
09-02	**Birth spacing - Births occurring within 24 months of a previous birth (females aged 15 to 44 years)**	Hispanic or Latino	1995	14%	ND	ND	ND	ND	17%	ND	ND	6%	-37.50
09-03	**Contraceptive use - Females at risk of unintended pregnancy (aged 15 to 44 years)**	Black or African American not Hispanic	1995	90%	ND	ND	ND	ND	85%	ND	ND	100%	-50.00
09-03	**Contraceptive use - Females at risk of unintended pregnancy (aged 15 to 44 years)**	Hispanic or Latino	1995	91%	ND	ND	ND	ND	88%	ND	ND	100%	-33.33
09-10c	**Pregnancy prevention and sexually transmitted disease (STD) protection - Condom & hormonal method use at first intercourse (unmarried females aged 15 to 17 years)**	Black or African American, not Hispanic/Latino	1995	9%	ND	ND	ND	ND	19%	ND	ND	9%	Worsening
09-12	**Problems in becoming pregnant and maintaining a pregnancy - Wives of married couples (aged 15 to 44 years) [New]**	Hispanic or Latino	1995	13%	ND	ND	ND	ND	14%	ND	ND	10%	-33.33
11-06a	**Patients reporting that doctors or other health providers always listen carefully to them [New]**	Asian or Pacific Islander	2000	55%	NA	NA	BSL	43%	DNC	DNC	ND	64%	-133.33
11-06b	**Patients reporting that doctors or other health providers always explain things so they can understand [New]**	Black or African American not Hispanic	2000	64%	NA	NA	BSL	63%	64%	65%	ND	65%	-100.00
11-06b	**Patients reporting that doctors or other health providers always explain things so they can understand [New]**	Asian or Pacific Islander	2000	52%	NA	NA	BSL	44%	DNC	DNC	ND	65%	-61.54
11-06c	**Patients reporting that doctors or other health providers always show respect for what they have to say [New]**	Asian or Pacific Islander	2000	51%	NA	NA	BSL	48%	DNC	DNC	ND	65%	-21.43
11-06d	**Patients reporting that doctors or other health providers always spend enough time**	American Indian or Alaska Native	2000	43%	NA	NA	BSL	39%	49%	54%	ND	52%	-44.44
11-06d	**Patients reporting that doctors or other health providers always spend enough time with them [New]**	Black or African American not Hispanic	2000	51%	NA	NA	BSL	50%	53%	55%	ND	52%	-100.00
11-06d	**Patients reporting that doctors or other health providers always spend enough time with them [New]**	Asian or Pacific Islander	2000	40%	NA	NA	BSL	30%	DNC	DNC	ND	52%	-83.33
12-01	**Coronary heart disease (CHD) deaths (age adjusted per 100,000 standard population)**	Asian or Pacific Islander	1999	124	NA	BSL	116	109	105	99	ND	162	-50.00

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12-06b	**Heart failure hospitalizations (per 1,000 population, aged 75 to 84 years)**	Black or African American not Hispanic	1997	21.4	25.2	22.3	ND	ND	ND	ND	ND	13.5	-11.39
12-09	**High blood pressure (age adjusted, aged 20 years and over)**	Black or African American not Hispanic	1988-94	38%	ND	ND	ND	ND	43%	ND	ND	14%	-20.83
12-09	**High blood pressure (age adjusted, aged 20 years and over)**	Mexican American	1988-94	26%	ND	ND	ND	ND	27%	ND	ND	14%	-8.33
12-12	**Blood pressure monitoring - Persons who know whether their blood pressure is high**	American Indian or Alaska Native	1998	89%	BSL	ND	ND	ND	ND	89%	ND	95%	0.00
12-12	**Blood pressure monitoring - Persons who know whether their blood pressure is high or low (age adjusted, aged 18 years and over)**	Black or African American not Hispanic	1998	92%	BSL	ND	ND	ND	ND	92%	ND	95%	0.00
12-12	**Blood pressure monitoring - Persons who know whether their blood pressure is high or low (age adjusted, aged 18 years and over)**	Hispanic or Latino	1998	84%	BSL	ND	ND	ND	ND	83%	ND	95%	-9.09
13-01	**New AIDS cases (per 100,000 population, aged 13 years and over)**	American Indian or Alaska Native	1998	9.4	BSL	10.9	10.4	9.8	10.5	10.3	ND	1.0	-10.71
13-01	**New AIDS cases (per 100,000 population, aged 13 years and over)**	Asian or Pacific Islander	1998	4.3	BSL	4.8	3.9	4.0	4.4	4.7	ND	1.0	-12.12
13-14	**HIV-infection deaths (age adjusted per 100,000 standard population)**	Asian or Pacific Islander	1999	0.8	NA	BSL	0.6	0.7	0.8	0.7	ND	0.7	0.00
13-16	**HIV infected persons surviving more than 3 years after a diagnosis of AIDS**	Asian or Pacific Islander	1998	87%	BSL	87%	ND	ND	ND	ND	ND	88%	0.00
14-05d	**Invasive pneumoccoccal infections - Penicillin-resistant - Adults (new cases per 100,000 population, aged 65 years and over)**	Black or African American not Hispanic	1997	9	12	9	7	6	11	ND	ND	7	-100.00
14-22a	**Universally recommended vaccination of children aged 19 to 35 months - 4 doses diphtheria-tetanus-acellular pertussis (DtaP) vaccine**	Asian or Pacific Islander	1998	87%	BSL	87%	DNC	DNC	DNC	DNC	ND	90%	0.00
14-22b	**Universally recommended vaccination of children aged 19 to 35 months - 3 doses Haemophilus influenzae type b (Hib) vaccine**	Asian only	1998	DNC	BSL	DNC	91%	92%	95%	91%	ND	90%	0.00
14-22d	**Universally recommended vaccination of children aged 19 to 35 months - 1 dose measles-mumps-rubella (MMR) vaccine**	Asian or Pacific Islander	1998	93%	BSL	93%	DNC	DNC	DNC	DNC	ND	90%	0.00
14-22d	**Universally recommended vaccination of children aged 19 to 35 months - 1 dose measles-mumps-rubella (MMR) vaccine**	Asian only	1998	DNC	BSL	DNC	90%	91%	94%	96%	ND	90%	Wrong
14-22f	**Universally recommended vaccination of children aged 19 to 35 months - 1 dose varicella vaccine**	Native Hawaiian or Other Pacific Islander	1998	DNC	BSL	DNC	74%	80%	DSU	73%	ND	90%	-6.30

Number	*Objective*	*R/E*	*Baseline Year*	*Baseline*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*Target 2010*	*Progress Quotient*
14-24a	**Fully immunized young children and adolescents - Children aged 19 to 35 months**	American Indian or Alaska Native	1998	65%	BSL	DNA	67%	73%	62%	ND	ND	80%	-20.00
14-24a	**Fully immunized young children and adolescents - Children aged 19 to 35 months**	Asian or Pacific Islander	1998	73%	BSL	73%	DNC	DNC	DNC	DNC	ND	80%	0.00
14-27c	**Vaccination coverage among adolescents - 1 or more doses of tetanus-diptheria booster (aged 13 to 15 years)**	Asian or Pacific Islander	1997	92%	96%	DNC	DNC	DNC	DNC	DNC	ND	90%	-200.00
14-27c	**Vaccination coverage among adolescents - 1 or more doses of tetanus-diptheria booster (aged 13 to 15 years)**	Asian only	1997	90%	DSU	DSU	86%	DSU	86%	DSU	ND	90%	Wrong
14-29a	**Influenza and pneumococcal vaccination of high-risk adults - Noninstitutionalized adults - Influenza vaccine in the past 12 months (age adjusted, aged 65 years and over)**	Asian only	1998	67%	BSL	73%	58%	58%	58%	63%	58%	90%	-58.82
14-29a	**Influenza and pneumococcal vaccination of high-risk adults - Noninstitutionalized adults - Influenza vaccine in the past 12 months (age adjusted, aged 65 years and over)**	Hispanic or Latino	1998	51%	BSL	56%	56%	52%	49%	47%	55%	90%	-26.47
14-29b	**Influenza and pneumococcal vaccination of high-risk adults - Noninstitutionalized adults - Pneumococcal vaccine ever received (age adjusted, aged 65 years and over)**	Asian only	1998	36%	BSL	41%	42%	28%	32%	35%	35%	90%	-12.24
14-29c	**Influenza and pneumococcal vaccination of high-risk adults - Noninstitutionalized high-risk adults - Influenza vaccine in the past 12 months (age adjusted, aged 18 to 64 years)**	Hispanic or Latino	1998	24%	BSL	27%	25%	20%	24%	23%	25%	60%	-12.12
15-03	**Firearm-related deaths (age adjusted per 100,000 standard population)**	Black or African American not Hispanic	1999	19.0	NA	BSL	18.9	18.9	19.8	19.7	ND	3.6	-5.19
15-07	**Nonfatal poisonings (age adjusted per 100,000 standard population)**	Black or African American not Hispanic	1997	464.4	506.2	798.4	537.6	566.8	614.4	585.9	668.4	292.0	-87.01
15-08	**Deaths from poisoning (age adjusted per 100,000 standard population)**	American Indian or Alaska Native	1999	7.5	NA	BSL	6.6	7.2	8.7	10.3	ND	1.5	-20.00
15-08	**Deaths from poisoning (age adjusted per 100,000 standard population)**	Black or African American not Hispanic	1999	8.2	NA	BSL	7.9	8.3	8.9	8.9	ND	1.5	-10.45
15-08	**Deaths from poisoning (age adjusted per 100,000 standard population)**	Asian or Pacific Islander	1999	1.6	NA	BSL	1.4	1.7	1.8	1.9	ND	1.5	-200.00
15-12	**Emergency department visits - Injury related (age adjusted per 1,000 standard population)**	Black or African American not Hispanic	1997	182	187	193	197	192	207	210	221	126	-44.64
15-13	**Deaths from unintentional injuries - (age adjusted per 100,000 standard population)**	Asian or Pacific Islander	1999	17.2	NA	BSL	17.9	17.4	17.9	18.0	ND	17.1	-700.00

Number	*Objective*	*R/E*	*Baseline Year*	*Baseline*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*Target 2010*	*Progress Quotient*
15-13	**Deaths from unintentional injuries - (age adjusted per 100,000 standard population)**	Hispanic or Latino	1999	30.6	NA	BSL	30.1	30.7	30.7	30.6	ND	17.1	-0.74
15-15a	**Deaths from motor vehicle crashes - (age adjusted per 100,000 standard population**	American Indian or Alaska Native	1999	26.9	NA	BSL	26.2	25.0	28.1	27.1	ND	8.0	-6.35
15-15a	**Deaths from motor vehicle crashes - (age adjusted per 100,000 standard population)**	Asian or Pacific Islander	1999	8.1	NA	BSL	8.4	8.0	8.2	8.3	ND	8.0	-100.00
15-15a	**Deaths from motor vehicle crashes - (age adjusted per 100,000 standard population)**	Hispanic or Latino	1999	13.9	NA	BSL	14.3	14.7	14.9	14.8	ND	8.0	-16.95
15-25	**Residential fire deaths (age adjusted per 100,000 standard population)**	American Indian or Alaska Native	1999	2.1	NA	BSL	1.3	1.8	2.1	1.2	ND	0.2	0.00
15-25	**Residential fire deaths (age adjusted per 100,000 standard population)**	Asian or Pacific Islander	1999	0.3	NA	BSL	0.4	0.3	0.4	0.3	ND	0.2	-100.00
15-25	**Residential fire deaths (age adjusted per 100,000 standard population)**	Hispanic or Latino	1999	0.7	NA	BSL	0.7	0.6	0.8	0.6	ND	0.2	-20.00
15-27	**Deaths from falls (age adjusted per 100,000 standard population)**	American Indian or Alaska Native	1999	5.2	NA	BSL	4.7	5.3	5.4	6.4	ND	3.3	-10.53
15-27	**Deaths from falls (age adjusted per 100,000 standard population)**	Asian or Pacific Islander	1999	3.5	NA	BSL	3.6	3.7	3.9	4.2	ND	3.3	-200.00
15-27	**Deaths from falls (age adjusted per 100,000 standard population)**	Hispanic or Latino	1999	4.1	NA	BSL	4.2	4.1	4.3	4.2	ND	3.3	-25.00
15-29	**Drownings (age adjusted per 100,000 standard population)**	Asian or Pacific Islander	1999	1.1	NA	BSL	1.2	1.2	1.2	1.2	ND	0.7	-25.00
15-29	**Drownings (age adjusted per 100,000 standard population)**	Hispanic or Latino	1999	1.2	NA	BSL	1.2	1.1	1.2	1.1	ND	0.7	0.00
15-32	**Homicides (age adjusted per 100,000 standard population)**	Black or African American not Hispanic	1999	20.7	NA	BSL	21.1	21.7	21.6	21.7	ND	2.8	-5.03
15-39	**Weapon carrying by adolescents on school property (grades 9 through 12)**	Black or African American not Hispanic	1999	5.0%	NA	BSL	ND	6.3%	ND	6.9%	ND	4.9%	-1900.00
16-01a	**Fetal deaths at 20 or more weeks of gestation (per 1,000 live births plus fetal deaths)**	Black or African American not Hispanic	1997	11.3	11.2	12.1	11.9	11.6	11.4	ND	ND	4.1	-1.39
16-01a	**Fetal deaths at 20 or more weeks of gestation (per 1,000 live births plus fetal deaths)**	Asian or Pacific Islander	1997	4.8	5.1	5.4	5.2	5.2	5.0	ND	ND	4.1	-28.57
16-01a	**Fetal deaths at 20 or more weeks of gestation (per 1,000 live births plus fetal deaths)**	Native Hawaiian or Other Pacific Islander	1997	6.2	6.3	6.5	6.5	5.8	7.4	ND	ND	4.1	-57.00
16-01b	**Perinatal mortality rate (28 weeks or more gestation to less than 7 days after birth) (per 1,000 live births plus fetal deaths)**	Asian only	1997	4.5	4.9	4.6	4.7	4.1	4.5	ND	ND	4.4	0.00

Number	*Objective*	*R/E*	*Baseline Year*	*Baseline*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*Target 2010*	*Progress Quotient*
16-01b	**Perinatal mortality rate (28 weeks or more gestation to less than 7 days after birth) (per 1,000 live births plus fetal deaths)**	Asian or Pacific Islander	1997	5.1	5.5	5.5	5.5	5.2	5.3	ND	ND	4.4	-28.57
16-01b	**Perinatal mortality rate (28 weeks or more gestation to less than 7 days after birth) (per 1,000 live births plus fetal deaths)**	Native Hawaiian or Other Pacific Islander	1997	7.1	7.7	6.5	7.5	5.5	8.9	ND	ND	4.4	-67.00
16-01c	**All Infant deaths (within 1 year) (per 1,000 live births)**	Black or African American not Hispanic	1998	13.9	BSL	14.1	13.6	13.5	13.9	13.6	ND	4.5	0.00
16-01e	**Postneonatal deaths (between 28 days and 1 year) (per 1,000 live births)**	Black or African American not Hispanic	1998	4.5	BSL	4.6	4.4	4.5	4.6	4.3	ND	1.2	-3.03
16-01e	**Postneonatal deaths (between 28 days and 1 year) (per 1,000 live births)**	Native Hawaiian or Other Pacific Islander	1998	3.3	BSL	2.6	2.4	4.0	4.3	DNC	ND	1.2	-48.00
16-01f	**All Infant deaths (within 1 year) from birth defects (per 1,000 live births)**	American Indian or Alaska Native	1999	1.8	NA	BSL	1.5	1.5	1.9	1.9	ND	0.7	-9.09
16-01f	**All Infant deaths (within 1 year) from birth defects (per 1,000 live births)**	Asian only	1999	1.0	NA	BSL	1.1	1.0	1.0	DNC	ND	0.7	0.00
16-01f	**All Infant deaths (within 1 year) from birth defects (per 1,000 live births)**	Black or African American not Hispanic	1999	1.7	NA	BSL	1.7	1.6	1.7	1.7	ND	0.7	0.00
16-01f	**All Infant deaths (within 1 year) from birth defects (per 1,000 live births)**	Asian or Pacific Islander	1999	1.1	NA	BSL	1.2	1.1	1.1	1.2	ND	0.7	0.00
16-01f	**All Infant deaths (within 1 year) from birth defects (per 1,000 live births)**	Hispanic or Latino	1999	1.4	NA	BSL	1.4	1.5	1.5	1.4	ND	0.7	-14.29
16-01g	**All Infant deaths (within 1 year) from congenital heart defects (per 1,000 live births)**	Asian only	1999	0.32	NA	BSL	0.38	0.35	0.37	DNC	ND	0.23	-55.56
16-01g	**All Infant deaths (within 1 year) from congenital heart defects (per 1,000 live births)**	Black or African American not Hispanic	1999	0.57	NA	BSL	0.55	0.55	0.58	0.48	ND	0.23	-2.94
16-01g	**All Infant deaths (within 1 year) from congenital heart defects (per 1,000 live births)**	Asian or Pacific Islander	1999	0.28	NA	BSL	0.35	0.37	0.37	0.34	ND	0.23	-180.00
16-01g	**All Infant deaths (within 1 year) from congenital heart defects (per 1,000 live births)**	Hispanic or Latino	1999	0.45	NA	BSL	0.45	0.46	0.45	0.40	ND	0.23	0.00
16-02a	**Child deaths - 1 to 4 years (per 100,000 population)**	Asian or Pacific Islander	1998	20.1	BSL	24.9	21.6	22.3	23.4	22.5	ND	20.0	-3300.00
16-02a	**Child deaths - 1 to 4 years (per 100,000 population)**	Hispanic or Latino	1998	29.4	BSL	30.9	29.6	30.6	29.8	30.2	ND	20.0	-4.26
16-02b	**Child deaths - 5 to 9 years (per 100,000 population)**	American Indian or Alaska Native	1998	17.3	BSL	16.4	17.0	15.5	17.3	20.1	ND	13.0	0.00
16-03a	**Adolescent deaths - 10 to 14 years (per 100,000 population)**	American Indian or Alaska Native	1998	23.8	BSL	20.0	21.0	28.0	25.5	26.9	ND	16.5	-23.29

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16-03b	**Young adult deaths - 15 to 19 years (per 100,000 population)**	American Indian or Alaska Native	1998	79.7	BSL	90.3	88.5	94.5	91.2	96.9	ND	38.0	-27.58
16-03b	**Young adult deaths - 15 to 19 years (per 100,000 population)**	Hispanic or Latino	1998	62.1	BSL	61.0	61.6	63.1	65.2	67.2	ND	38.0	-12.86
16-03c	**Young adult deaths - 20 to 24 years (per 100,000 population)**	Asian or Pacific Islander	1998	41.6	BSL	39.9	41.7	47.6	45.2	46.6	ND	41.5	-3600.00
16-03c	**Young adult deaths - 20 to 24 years (per 100,000 population)**	Hispanic or Latino	1998	84.4	BSL	81.1	83.3	86.9	87.9	85.7	ND	41.5	-8.16
16-05a	**Maternal illness and complications due to pregnancy - Maternal complications during hospitalized labor and delivery (per 100 deliveries)**	Black or African American not Hispanic	1998	37.7	BSL	35.4	39.1	39.0	40.8	ND	ND	24.0	-22.63
16-06b	**Prenatal care - Early and adequate**	Asian only	1998	76%	BSL	76%	75%	75%	75%	DNC	ND	90%	-7.14
16-06b	**Prenatal care - Early and adequate**	Asian or Pacific Islander	1998	74%	BSL	74%	74%	74%	74%	75%	ND	90%	0.00
16-06b	**Prenatal care - Early and adequate**	Native Hawaiian or Other Pacific Islander	1998	67%	BSL	68%	68%	67%	66%	DNC	ND	90%	-4.30
16-09a	**Cesarean births - Women giving birth for the first time**	American Indian or Alaska Native	1998	16%	BSL	16%	17%	18%	20%	20%	ND	15%	-400.00
16-09a	**Cesarean births - Women giving birth for the first time**	Asian only	1998	19%	BSL	20%	20%	22%	23%	DNC	ND	15%	-100.00
16-09a	**Cesarean births - Women giving birth for the first time**	Black or African American not Hispanic	1998	21%	BSL	21%	22%	24%	25%	27%	ND	15%	-66.67
16-09a	**Cesarean births - Women giving birth for the first time**	Asian or Pacific Islander	1998	18%	BSL	19%	19%	21%	23%	24%	ND	15%	-166.67
16-09a	**Cesarean births - Women giving birth for the first time**	Native Hawaiian or Other Pacific Islander	1998	17%	BSL	15%	14%	19%	19%	DNC	ND	15%	-100.00
16-09a	**Cesarean births - Women giving birth for the first time**	Hispanic or Latino	1998	18%	BSL	18%	19%	20%	21%	22%	ND	15%	-100.00
16-09b	**Cesarean births - Prior cesarean birth**	American Indian or Alaska Native	1998	68%	BSL	69%	73%	79%	82%	85%	ND	63%	-280.00
16-09b	**Cesarean births - Prior cesarean birth**	Asian only	1998	72%	BSL	75%	77%	83%	86%	DNC	ND	63%	-155.56
16-09b	**Cesarean births - Prior cesarean birth**	Black or African American not Hispanic	1998	73%	BSL	76%	78%	82%	86%	88%	ND	63%	-130.00
16-09b	**Cesarean births - Prior cesarean birth**	Asian or Pacific Islander	1998	70%	BSL	73%	76%	81%	85%	87%	ND	63%	-214.29
16-09b	**Cesarean births - Prior cesarean birth**	Native Hawaiian or Other Pacific Islander	1998	65%	BSL	68%	73%	81%	84%	DNC	ND	63%	-950.00
16-09b	**Cesarean births - Prior cesarean birth**	Hispanic or Latino	1998	76%	BSL	78%	80%	84%	88%	90%	ND	63%	-92.31

Number	*Objective*	*R/E*	*Baseline Year*	*Baseline*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*Target 2010*	*Progress Quotient*
16-10a	**Low birth weight (LBW), infants (less than 2,500 grams)**	American Indian or Alaska Native	1998	6.8%	BSL	7.1%	6.8%	7.3%	7.2%	7.4%	ND	5.0%	-22.22
16-10a	**Low birth weight (LBW), infants (less than 2,500 grams)**	Asian only	1998	7.3%	BSL	7.2%	7.1%	7.2%	7.5%	DNC	ND	5.0%	-8.70
16-10a	**Low birth weight (LBW), infants (less than 2,500 grams)**	Black or African American not Hispanic	1998	13.2%	BSL	13.2%	13.1%	13.1%	13.4%	13.6%	ND	5.0%	-2.44
16-10a	**Low birth weight (LBW), infants (less than 2,500 grams)**	Asian or Pacific Islander	1998	7.4%	BSL	7.4%	7.3%	7.5%	7.8%	7.8%	ND	5.0%	-16.67
16-10a	**Low birth weight (LBW), infants (less than 2,500 grams)**	Native Hawaiian or Other Pacific Islander	1998	6.6%	BSL	7.1%	6.6%	7.3%	7.3%	DNC	ND	5.0%	-44.00
16-10a	**Low birth weight (LBW), infants (less than 2,500 grams)**	Hispanic or Latino	1998	6.4%	BSL	6.4%	6.4%	6.5%	6.5%	6.7%	ND	5.0%	-7.14
16-10b	**Very low birth weight (VLBW), infants (less than 1,500 grams)**	American Indian or Alaska Native	1998	1.2%	BSL	1.3%	1.2%	1.3%	1.3%	1.3%	ND	0.9%	-33.33
16-10b	**Very low birth weight (VLBW), infants (less than 1,500 grams)**	Black or African American not Hispanic	1998	3.1%	BSL	3.2%	3.1%	3.1%	3.1%	3.1%	ND	0.9%	0.00
16-10b	**Very low birth weight (VLBW), infants (less than 1,500 grams)**	Asian or Pacific Islander	1998	1.1%	BSL	1.1%	1.0%	1.0%	1.1%	1.1%	ND	0.9%	0.00
16-10b	**Very low birth weight (VLBW), infants (less than 1,500 grams)**	Native Hawaiian or Other Pacific Islander	1998	1.4%	BSL	1.3%	1.3%	1.4%	1.4%	DNC	ND	0.9%	0.00
16-10b	**Very low birth weight (VLBW), infants (less than 1,500 grams)**	Hispanic or Latino	1998	1.1%	BSL	1.1%	1.1%	1.1%	1.2%	1.2%	ND	0.9%	-50.00
16-11a	**Total preterm births (less than 37 weeks gestation)**	American Indian or Alaska Native	1998	12.2%	BSL	12.9%	12.7%	13.2%	13.1%	13.5%	ND	7.6%	-19.57
16-11a	**Total preterm births (less than 37 weeks gestation)**	Asian only	1998	9.7%	BSL	9.8%	9.3%	9.7%	9.9%	DNC	ND	7.6%	-9.52
16-11a	**Total preterm births (less than 37 weeks gestation)**	Black or African American not Hispanic	1998	17.6%	BSL	17.6%	17.4%	17.6%	17.7%	17.8%	ND	7.6%	-1.00
16-11a	**Total preterm births (less than 37 weeks gestation)**	Asian or Pacific Islander	1998	10.4%	BSL	10.4%	9.9%	10.3%	10.4%	10.5%	ND	7.6%	0.00
16-11a	**Total preterm births (less than 37 weeks gestation)**	Native Hawaiian or Other Pacific Islander	1998	11.9%	BSL	12.3%	11.7%	13.5%	13.3%	DNC	ND	7.6%	-33.00
16-11a	**Total preterm births (less than 37 weeks gestation)**	Hispanic or Latino	1998	11.4%	BSL	11.4%	11.2%	11.4%	11.6%	11.9%	ND	7.6%	-5.26
16-11b	**Preterm births - Live births at 32 to 36 weeks of gestation**	American Indian or Alaska Native	1998	10.2%	BSL	10.8%	10.7%	11.1%	11.0%	11.3%	ND	6.4%	-21.05
16-11b	**Preterm births - Live births at 32 to 36 weeks of gestation**	Asian only	1998	8.4%	BSL	8.5%	8.1%	8.5%	8.6%	DNC	ND	6.4%	-10.00

Number	*Objective*	*R/E*	*Baseline Year*	*Baseline*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*Target 2010*	*Progress Quotient*
16-11b	**Preterm births - Live births at 32 to 36 weeks of gestation**	Black or African American not Hispanic	1998	13.5%	BSL	13.5%	13.3%	13.6%	13.6%	13.8%	ND	6.4%	-1.41
16-11b	**Preterm births - Live births at 32 to 36 weeks of gestation**	Asian or Pacific Islander	1998	8.9%	BSL	9.0%	8.5%	9.0%	9.0%	9.1%	ND	6.4%	-4.00
16-11b	**Preterm births - Live births at 32 to 36 weeks of gestation**	Native Hawaiian or Other Pacific Islander	1998	9.7%	BSL	10.2%	9.9%	11.2%	11.1%	DNC	ND	6.4%	-42.00
16-11b	**Preterm births - Live births at 32 to 36 weeks of gestation**	Hispanic or Latino	1998	9.7%	BSL	9.7%	9.5%	9.8%	9.9%	10.1%	ND	6.4%	-6.06
16-11c	**Preterm births - Live births at less than 32 weeks of gestation**	American Indian or Alaska Native	1998	2.0%	BSL	2.1%	2.0%	2.1%	2.1%	2.2%	ND	1.1%	-11.11
16-11c	**Preterm births - Live births at less than 32 weeks of gestation**	Asian or Pacific Islander	1998	1.4%	BSL	1.5%	1.4%	1.4%	1.5%	1.4%	ND	1.1%	-33.33
16-11c	**Preterm births - Live births at less than 32 weeks of gestation**	Native Hawaiian or Other Pacific Islander	1998	2.2%	BSL	2.1%	1.8%	2.2%	2.2%	DNC	ND	1.1%	0.00
16-11c	**Preterm births - Live births at less than 32 weeks of gestation**	Hispanic or Latino	1998	1.7%	BSL	1.7%	1.7%	1.7%	1.7%	1.7%	ND	1.1%	0.00
16-14a	**Mental retardation - Children with IQ's less than or equal to 70 - Metropolitan Atlanta, GA (per 10,000 population, age 8 years)**	Black or African American not Hispanic	1991-94	210.1	278.5	ND	ND	ND	ND	ND	ND	124.5	-79.91
16-14b	**Cerebral palsy in children - Metropolitan Atlanta, GA (per 10,000 population, age 8 years)**	Black or African American not Hispanic	1991-94	38.5	49.7	ND	ND	ND	ND	ND	ND	31.6	-162.32
16-17c	**Women abstaining from cigarette smoking during pregnancy (Reporting states and D.**	American Indian or Alaska Native	1998	80%	BSL	80%	80%	80%	80%	82%	ND	99%	0.00
16-17c	**Women abstaining from cigarette smoking during pregnancy (Reporting states and D.C., and New York City)**	Asian or Pacific Islander	1998	97%	BSL	97%	97%	97%	97%	98%	ND	99%	0.00
16-19a	**Breastfeeding - In early postpartum period**	Asian only	1998	77%	BSL	80%	81%	82%	80%	74%	ND	75%	-150.00
16-19b	**Breastfeeding - At 6 months**	Black or African American not Hispanic	1998	19%	BSL	20%	21%	22%	19%	20%	ND	50%	0.00
16-19c	**Breastfeeding - At 1 year**	Hispanic or Latino	1998	19%	BSL	DNA	18%	DNA	19%	20%	ND	25%	0.00
17-06	**Blood donations (age adjusted, aged 18 years and over)**	Asian only	1998	DSU	BSL	3%	3%	2%	3%	3%	3%	8%	0.00
17-06	**Blood donations (age adjusted, aged 18 years and over)**	Hispanic or Latino	1998	3%	BSL	3%	3%	3%	3%	3%	3%	8%	0.00
18-01	**Suicide (age adjusted per 100,000 standard population)**	American Indian or Alaska Native	1999	10.1	NA	BSL	9.8	10.5	10.2	10.0	ND	4.8	-1.89

Number	*Objective*	*R/E*	*Baseline Year*	*Baseline*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*Target 2010*	*Progress Quotient*
18-02	**Suicide attempts requiring medical attention (grades 9 through 12)**	Black or African American not Hispanic	1999	2.9%	NA	BSL	ND	3.4%	ND	3.7%	ND	1.0%	-42.11
18-02	**Suicide attempts requiring medical attention (grades 9 through 12)**	Hispanic or Latino	1999	3.0%	NA	BSL	ND	3.4%	ND	5.0%	ND	1.0%	-100.00
18-05	**Adolescents engaging in disordered eating (grades 9 through 12)**	Black or African American not Hispanic	2001	17%	NA	NA	NA	BSL	ND	17%	ND	16%	0.00
19-01	**Healthy weight in adults (age adjusted, aged 20 years and over)**	Black or African American not Hispanic	1988-94	34%	ND	ND	ND	ND	28%	ND	ND	60%	-23.08
19-01	**Healthy weight in adults (age adjusted, aged 20 years and over)**	Mexican American	1988-94	30%	ND	ND	ND	ND	26%	ND	ND	60%	-13.33
19-02	**Obesity in adults (age adjusted, aged 20 years and over)**	Black or African American not Hispanic	1988-94	30%	ND	ND	ND	ND	39%	ND	ND	15%	-60.00
19-02	**Obesity in adults (age adjusted, aged 20 years and over)**	Mexican American	1988-94	29%	ND	ND	ND	ND	31%	ND	ND	15%	-14.29
19-03a	**Overweight or obesity in children (aged 6 to 11 years)**	Black or African American not Hispanic	1988-94	15%	ND	ND	ND	ND	20%	ND	ND	5%	-50.00
19-03a	**Overweight or obesity in children (aged 6 to 11 years)**	Mexican American	1988-94	17%	ND	ND	ND	ND	22%	ND	ND	5%	-41.67
19-03b	**Overweight or obesity in adolescents (aged 12 to 19 years)**	Black or African American not Hispanic	1988-94	13%	ND	ND	ND	ND	21%	ND	ND	5%	-100.00
19-03b	**Overweight or obesity in adolescents (aged 12 to 19 years)**	Mexican American	1988-94	14%	ND	ND	ND	ND	23%	ND	ND	5%	-100.00
19-03c	**Overweight or obesity in children and adolescents (aged 6 to 19 years)**	Black or African American not Hispanic	1988-94	14%	ND	ND	ND	ND	21%	ND	ND	5%	-77.78
19-03c	**Overweight or obesity in children and adolescents (aged 6 to 19 years)**	Mexican American	1988-94	15%	ND	ND	ND	ND	22%	ND	ND	5%	-70.00
19-04	**Growth retardation in low-income children (aged under 5 years)**	American Indian or Alaska Native	1997	5%	5%	5%	5%	6%	5%	5%	ND	4%	0.00
19-04	**Growth retardation in low-income children (aged under 5 years)**	Black or African American not Hispanic	1997	7%	7%	7%	7%	7%	7%	7%	ND	4%	0.00
19-04	**Growth retardation in low-income children (aged under 5 years)**	Hispanic or Latino	1997	5%	5%	5%	5%	6%	6%	6%	ND	4%	-100.00
19-12b	**Iron deficiency in young children (aged 3 to 4 years)**	Mexican American	1988-94	6%	ND	ND	8%	ND	ND	ND	ND	1%	-40.00

Number	*Objective*	*R/E*	*Baseline Year*	*Baseline*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*Target 2010*	*Progress Quotient*
19-12c	**Iron deficiency in nonpregnant females (aged 12 to 49 years)**	Black or African American not Hispanic	1988-94	15%	ND	ND	19%	ND	ND	ND	ND	7%	-50.00
19-12c	**Iron deficiency in nonpregnant females (aged 12 to 49 years)**	Mexican American	1988-94	19%	ND	ND	22%	ND	ND	ND	ND	7%	-25.00
19-13	**Anemia in low-income pregnant females - In third trimester**	Black or African American not Hispanic	1996	44%	46%	46%	46%	46%	45%	44%	ND	20%	0.00
19-13	**Anemia in low-income pregnant females - In third trimester**	Hispanic or Latino	1996	25%	30%	29%	29%	30%	26%	25%	ND	20%	0.00
19-17	**Physician office visits that include diet/nutrition counseling for medical conditions (age adjusted, aged 20 years and over)**	Black or African American not Hispanic	1997	46%	37%	45%	37%	ND	ND	ND	ND	75%	-31.03
19-18	**Food security among U.S. households**	American Indian or Alaska Native	1995-97	78%	DSU	DSU	DSU	79%	79%	78%	ND	94%	0.00
21-01a	**Dental caries experience - Primary teeth - Young children (aged 2 to 4 years)**	Black or African American not Hispanic	1988-94	24%	ND	ND	ND	ND	27%	ND	ND	11%	-23.08
21-01a	**Dental caries experience - Primary teeth - Young children (aged 2 to 4 years)**	Mexican American	1988-94	34%	ND	ND	ND	ND	35%	ND	ND	11%	-4.35
21-01b	**Dental caries experience - Primary or permanent teeth - Children (aged 6 to 8 years)**	Black or African American not Hispanic	1988-94	49%	ND	ND	ND	ND	56%	ND	ND	42%	-100.00
21-01b	**Dental caries experience - Primary or permanent teeth - Children (aged 6 to 8 years)**	Mexican American	1988-94	64%	ND	ND	ND	ND	67%	ND	ND	42%	-13.64
21-02b	**Untreated dental decay - Primary or permanent teeth - Children (aged 6 to 8 years)**	Black or African American not Hispanic	1988-94	35%	ND	ND	ND	ND	37%	ND	ND	21%	-14.29
21-02c	**Untreated dental decay - Permanent teeth - Adolescents (aged 15 years)**	Black or African American not Hispanic	1988-94	27%	ND	ND	ND	ND	27%	ND	ND	15%	0.00
21-02d	**Untreated dental decay - Adults (aged 35 to 44 years)**	Mexican American	1988-94	34%	ND	ND	ND	ND	38%	ND	ND	15%	-21.05
21-06	**Early detection of oral and pharyngeal cancers**	American Indian or Alaska Native	1990-95	25%	ND	ND	24%	ND	ND	ND	ND	51%	-3.85
21-06	**Early detection of oral and pharyngeal cancers**	Black or African American not Hispanic	1990-95	22%	ND	ND	21%	ND	ND	ND	ND	51%	-3.45
21-10	**Annual dental visits (aged 2 years and over)**	American Indian or Alaska Native	1996	35%	ND	ND	ND	ND	31%	ND	ND	56%	-19.05
21-10	**Annual dental visits (aged 2 years and over)**	Hispanic or Latino	1996	30%	ND	ND	ND	ND	27%	ND	ND	56%	-11.54
22-01	**No leisure-time physical activity (age adjusted, aged 18 years and over)**	American Indian or Alaska Native	1997	46%	48%	46%	51%	50%	45%	53%	43%	20%	-26.92

Number	*Objective*	*R/E*	*Baseline Year*	*Baseline*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*Target 2010*	*Progress Quotient*
22-02	**Regular physical activity - Moderate or Vigorous (age adjusted, aged 18 years an**	American Indian or Alaska Native	1997	27%	32%	26%	23%	29%	25%	25%	22%	50%	-8.70
22-02	**Regular physical activity - Moderate or Vigorous (age adjusted, aged 18 years and over)**	Asian or Pacific Islander	1997	27%	25%	DNC	DNC	DNC	DNC	DNC	DNC	50%	-8.70
22-03	**Regular physical activity - Vigorous (age adjusted, aged 18 years and over)**	American Indian or Alaska Native	1997	20%	21%	15%	19%	23%	18%	18%	14%	30%	-20.00
22-04	**Muscular strength and endurance (age adjusted, aged 18 years and over)**	American Indian or Alaska Native	1998	18%	BSL	12%	13%	17%	21%	15%	14%	30%	-25.00
22-05	**Flexibility (age adjusted, aged 18 years and over)**	Hispanic or Latino	1998	22%	BSL	ND	ND	21%	ND	ND	ND	43%	-4.76
22-07	**Vigorous physical activity in adolescents (students in grades 9 through 12)**	Black or African American not Hispanic	1999	56%	NA	BSL	ND	60%	ND	55%	ND	85%	-3.45
22-07	**Vigorous physical activity in adolescents (students in grades 9 through 12)**	Hispanic or Latino	1999	61%	NA	BSL	ND	60%	ND	59%	ND	85%	-8.33
22-09	**Participation in daily physical education in schools (students in grades 9 through 12)**	Hispanic or Latino	1999	40%	NA	BSL	ND	39%	ND	37%	ND	50%	-30.00
22-10	**Physical activity in physical education class (students in grades 9 through 12)**	Hispanic or Latino	1999	41%	NA	BSL	ND	43%	ND	41%	ND	50%	0.00
24-01b	**Deaths from asthma - Children and youth (per million population, aged 5 to 14 years)**	Black or African American not Hispanic	1999	10.1	NA	BSL	10.6	7.9	10.7	9.2	ND	0.9	-6.52
24-01d	**Deaths from asthma - Adults (per million population, aged 35 to 64 years)**	Black or African American not Hispanic	1999	45.8	NA	BSL	47.2	45.1	46.4	40.8	ND	8.0	-1.59
24-02a	**Hospitalizations for asthma - Children (per 10,000 population, aged under 5 years)**	Black or African American not Hispanic	1998	82.4	BSL	103.0	114.4	103.4	111.4	ND	ND	25.0	-50.52
24-02b	**Hospitalizations for asthma - Children and adults (age adjusted per 10,000 standard population, aged 5 to 64 years)**	Black or African American not Hispanic	1998	28.4	BSL	27.9	23.6	25.0	28.5	ND	ND	7.7	-0.48
24-02c	**Hospitalizations for asthma - Adults (age adjusted per 10,000 standard population, aged 65 years and over)**	Black or African American not Hispanic	1998	27.3	BSL	45.6	32.1	25.1	38.1	ND	ND	11.0	-66.26
24-04	**Activity limitations - Among persons with asthma (age adjusted)**	Hispanic or Latino	1997	10%	8%	7%	9%	6%	6%	8%	5%	6%	-100.00
24-06	**Patient education - Among persons with asthma (age adjusted, aged 18 years and over)**	Black or African American not Hispanic	1998	11.3%	BSL	17.5%	ND	ND	ND	10.8%	ND	30.0%	-2.67
24-06	**Patient education - Among persons with asthma (age adjusted, aged 18 years and over)**	Hispanic or Latino	1998	7.8%	BSL	15.8%	ND	ND	ND	12.4%	ND	30.0%	-23.94

Number	*Objective*	*R/E*	*Baseline Year*	*Baseline*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*Target 2010*	*Progress Quotient*
24-07a	**Appropriate asthma care - Receiving written asthma plans from health care provider (age adjusted)**	Black or African American not Hispanic	2002	37%	NA	NA	NA	NA	BSL	33%	ND	38%	-400.00
24-07a	**Appropriate asthma care - Receiving written asthma plans from health care provider (age adjusted)**	Hispanic or Latino	2002	34%	NA	NA	NA	NA	BSL	32%	ND	38%	-50.00
24-09	**Activity limitations due to chronic lung and breathing problems (age adjusted, aged 45 years and over)**	Black or African American not Hispanic	1997	2.4%	2.3%	2.6%	2.4%	2.9%	2.5%	2.9%	2.1%	1.9%	-100.00
24-09	**Activity limitations due to chronic lung and breathing problems (age adjusted, aged 45 years and over)**	Hispanic or Latino	1997	2.1%	1.5%	1.4%	1.5%	1.6%	1.4%	1.3%	1.3%	1.9%	-20.00
24-10	**Deaths from chronic obstructive pulmonary disease (COPD, excluding asthma) - Adults (age adjusted per 100,000 standard population, aged 45 years and over)**	Asian or Pacific Islander	1999	47.6	NA	BSL	45.9	44.1	39.8	40.3	ND	62.3	-53.06
24-12	**Motor vehicle crash deaths caused by excessive sleepiness - All ages (percent of**	American Indian or Alaska Native	2000	3.6%	NA	NA	BSL	3.8%	DSU	DSU	DSU	1.7%	-10.53
24-12	**Motor vehicle crash deaths caused by excessive sleepiness - All ages (percent of all motor vehicle crash deaths)**	Black or African American not Hispanic	2000	1.8%	NA	NA	BSL	1.9%	1.6%	1.9%	2.1%	1.7%	-300.00
25-01a	**Chlamydia infections among females attending family planning clinics (aged 15 to 24 years)**	Asian only	1997	DNC	DNC	3.3%	7.0%	6.5%	6.5%	6.8%	ND	3.0%	-1166.67
25-01a	**Chlamydia infections among females attending family planning clinics (aged 15 to 24 years)**	Black or African American not Hispanic	1997	11.1%	13.0%	11.8%	12.8%	12.2%	12.0%	12.1%	ND	3.0%	-12.35
25-01a	**Chlamydia infections among females attending family planning clinics (aged 15 to 24 years)**	Asian or Pacific Islander	1997	4.9%	6.5%	DNC	DNC	DNC	DNC	DNC	ND	3.0%	-84.21
25-01a	**Chlamydia infections among females attending family planning clinics (aged 15 to 24 years)**	Hispanic or Latino	1997	5.2%	5.6%	6.0%	5.8%	5.7%	5.6%	6.0%	ND	3.0%	-36.36
25-01b	**Chlamydia infections among females attending STD clinics (aged 15 to 24 years)**	Asian only	1997	DNC	DNC	8.1%	15.4%	13.3%	13.8%	13.7%	ND	3.0%	-109.80
25-01b	**Chlamydia infections among females attending STD clinics (aged 15 to 24 years)**	Black or African American not Hispanic	1997	15.2%	16.4%	15.6%	16.4%	15.5%	15.9%	16.1%	ND	3.0%	-7.38
25-01b	**Chlamydia infections among females attending STD clinics (aged 15 to 24 years)**	Asian or Pacific Islander	1997	12.1%	15.9%	DNC	DNC	DNC	DNC	DNC	ND	3.0%	-41.76
25-01b	**Chlamydia infections among females attending STD clinics (aged 15 to 24 years)**	Native Hawaiian or Other Pacific Islander	1997	DNC	DNC	13.8%	12.5%	13.9%	13.4%	16.4%	ND	3.0%	-24.00
25-01c	**Chlamydia infections among males attending STD clinics (aged 15 to 24 years)**	American Indian or Alaska Native	1997	9.4%	19.1%	21.1%	14.8%	13.9%	15.5%	14.4%	ND	3.0%	-78.13
25-01c	**Chlamydia infections among males attending STD clinics (aged 15 to 24 years)**	Asian only	1997	DNC	DNC	11.4%	24.1%	19.6%	19.6%	16.1%	ND	3.0%	-55.95

Number	*Objective*	*R/E*	*Baseline Year*	*Baseline*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*Target 2010*	*Progress Quotient*
25-01c	**Chlamydia infections among males attending STD clinics (aged 15 to 24 years)**	Black or African American not Hispanic	1997	18.1%	19.4%	19.2%	18.0%	20.0%	21.3%	23.6%	ND	3.0%	-36.42
25-01d	**Chlamydia infections among females enrolled in National Job Training Program (ag**	American Indian or Alaska Native	2002	12.3%	NA	NA	NA	NA	BSL	12.5%	ND	6.8%	-3.64
25-02a	**Gonorrhea - New cases (per 100,000 population)**	American Indian or Alaska Native	1997	97	107	98	98	102	112	103	ND	19	-7.69
25-02a	**Gonorrhea - New cases (per 100,000 population)**	Hispanic or Latino	1997	65	65	65	69	70	69	72	ND	19	-15.22
25-02b	**Gonorrhea - Females aged 15 to 44 years (per 100,000 population) [New]**	Asian or Pacific Islander	2002	43	NA	NA	NA	NA	BSL	49	ND	42	-600.00
25-02b	**Gonorrhea - Females aged 15 to 44 years (per 100,000 population) [New]**	Hispanic or Latino	2002	144	NA	NA	NA	NA	BSL	154	ND	42	-9.80
25-03	**Primary and secondary syphilis - Domestic transmission (per 100,000 population)**	American Indian or Alaska Native	1997	2.0	2.6	2.4	2.2	3.8	2.2	2.8	ND	0.2	-44.44
25-03	**Primary and secondary syphilis - Domestic transmission (per 100,000 population)**	Asian or Pacific Islander	1997	0.3	0.3	0.4	0.3	0.5	0.8	1.0	ND	0.2	-700.00
25-03	**Primary and secondary syphilis - Domestic transmission (per 100,000 population)**	Hispanic or Latino	1997	1.6	1.4	1.6	1.6	2.0	2.5	3.0	ND	0.2	-100.00
25-04	**Genital herpes infection - Adults (aged 20 to 29 years)**	Black or African American not Hispanic	1988-94	33%	ND	ND	ND	ND	37%	ND	ND	14%	-21.05
25-09	**Congenital syphilis (per 100,000 live births)**	Asian or Pacific Islander	1997	8	5	8	11	5	9	11	ND	1	-42.86
25-11c	**Responsible adolescent sexual behavior - Students who used condoms at last intercourse (grades 9 through 12) [New]**	Black or African American not Hispanic	1999	70%	NA	BSL	ND	67%	ND	73%	ND	65%	-60.00
26-03	**Drug-induced deaths (age adjusted per 100,000 standard population)**	American Indian or Alaska Native	1999	6.1	NA	BSL	5.6	6.6	7.8	9.9	ND	1.2	-34.69
26-03	**Drug-induced deaths (age adjusted per 100,000 standard population)**	Black or African American not Hispanic	1999	9.4	NA	BSL	9.1	9.3	10.0	10.1	ND	1.2	-8.54
26-03	**Drug-induced deaths (age adjusted per 100,000 standard population)**	Asian or Pacific Islander	1999	1.4	NA	BSL	1.1	1.3	1.6	1.6	ND	1.2	-100.00
26-09a	**Average age at first use of alcohol among lifetime users of alcohol who initiated use in the U.S. - Adolescents (aged 12 to 17 years)**	Asian only	2002	13.6	NA	NA	NA	NA	BSL	13.1	ND	16.1	-20.00
26-09a	**Average age at first use of alcohol among lifetime users of alcohol who initiated use in the U.S. - Adolescents (aged 12 to 17 years)**	Asian or Pacific Islander	2002	13.6	NA	NA	NA	NA	BSL	13.2	ND	16.1	-16.00
26-09a	**Average age at first use of alcohol among lifetime users of alcohol who initiated use in the U.S. - Adolescents (aged 12 to 17 years)**	Native Hawaiian or Other Pacific Islander	2002	14.0	NA	NA	NA	NA	BSL	13.9	ND	16.1	-4.80

Number	*Objective*	*R/E*	*Baseline Year*	*Baseline*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*Target 2010*	*Progress Quotient*
26-09a	**Average age at first use of alcohol among lifetime users of alcohol who initiated use in the U.S. - Adolescents (aged 12 to 17 years)**	Hispanic or Latino	2002	13.1	NA	NA	NA	NA	BSL	13.1	ND	16.1	0.00
26-09b	**Average age at first use of marijuana - Adolescents (aged 12 to 17 years)**	Native Hawaiian or Other Pacific Islander	2002	12.6	NA	NA	NA	NA	BSL	12.0	ND	17.4	-12.00
26-10a	**Adolescents not using alcohol or illicit drugs in past 30 days (aged 12 to 17 years)**	Asian only	2002	90%	NA	NA	NA	NA	BSL	88%	ND	91%	-200.00
26-10a	**Adolescents not using alcohol or illicit drugs in past 30 days (aged 12 to 17 years)**	Black or African American not Hispanic	2002	84%	NA	NA	NA	NA	BSL	84%	ND	91%	0.00
26-10a	**Adolescents not using alcohol or illicit drugs in past 30 days (aged 12 to 17 years)**	Asian or Pacific Islander	2002	89%	NA	NA	NA	NA	BSL	88%	ND	91%	-50.00
26-10a	**Adolescents not using alcohol or illicit drugs in past 30 days (aged 12 to 17 years)**	Hispanic or Latino	2002	79%	NA	NA	NA	NA	BSL	78%	ND	91%	-8.33
26-10b	**Adolescents using marijuana in past 30 days (aged 12 to 17 years)**	Asian only	2002	1.5%	NA	NA	NA	NA	BSL	3.0%	ND	0.7%	-187.50
26-10b	**Adolescents using marijuana in past 30 days (aged 12 to 17 years)**	Asian or Pacific Islander	2002	1.8%	NA	NA	NA	NA	BSL	3.6%	ND	0.7%	-163.64
26-10b	**Adolescents using marijuana in past 30 days (aged 12 to 17 years)**	Hispanic or Latino	2002	6.8%	NA	NA	NA	NA	BSL	6.8%	ND	0.7%	0.00
26-10c	**Adults using illicit drugs in past 30 days (aged 18 years and over)**	American Indian or Alaska Native	2002	8.7%	NA	NA	NA	NA	BSL	8.8%	ND	3.2%	-1.82
26-10c	**Adults using illicit drugs in past 30 days (aged 18 years and over)**	Asian only	2002	3.3%	NA	NA	NA	NA	BSL	3.5%	ND	3.2%	-200.00
26-10c	**Adults using illicit drugs in past 30 days (aged 18 years and over)**	Asian or Pacific Islander	2002	3.7%	NA	NA	NA	NA	BSL	3.8%	ND	3.2%	-20.00
26-10c	**Adults using illicit drugs in past 30 days (aged 18 years and over)**	Native Hawaiian or Other Pacific Islander	2002	7.6%	NA	NA	NA	NA	BSL	10.3%	ND	3.2%	-61.00
26-10c	**Adults using illicit drugs in past 30 days (aged 18 years and over)**	Hispanic or Latino	2002	6.6%	NA	NA	NA	NA	BSL	7.5%	ND	3.2%	-26.47
26-11c	**Binge drinking - Adults (aged 18 years and over)**	American Indian or Alaska Native	2002	29.6%	NA	NA	NA	NA	BSL	30.0%	ND	13.4%	-2.47
26-11c	**Binge drinking - Adults (aged 18 years and over)**	Native Hawaiian or Other Pacific Islander	2002	25.8%	NA	NA	NA	NA	BSL	33.1%	ND	13.4%	-59.00
26-11d	**Binge drinking - Adolescents (aged 12 to 17 years)**	Asian only	2002	3.2%	NA	NA	NA	NA	BSL	3.4%	ND	3.1%	-200.00
26-11d	**Binge drinking - Adolescents (aged 12 to 17 years)**	Asian or Pacific Islander	2002	3.5%	NA	NA	NA	NA	BSL	4.0%	ND	3.1%	-125.00
26-14a	**Steroid use among adolescents - 8th graders**	Black or African American not Hispanic	1998	0.7%	BSL	0.8%	0.7%	0.7%	1.2%	1.2%	0.9%	0.4%	-66.67

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26-14a	**Steroid use among adolescents - 8th graders**	Hispanic or Latino	1998	1.4%	BSL	1.8%	1.8%	1.8%	1.5%	1.7%	1.7%	0.4%	-30.00
26-14b	**Steroid use among adolescents - 10th graders**	Black or African American not Hispanic	1998	0.5%	BSL	0.7%	1.2%	1.6%	1.2%	0.8%	0.7%	0.4%	-200.00
26-14b	**Steroid use among adolescents - 10th graders**	Hispanic or Latino	1998	1.2%	BSL	1.5%	1.8%	2.1%	2.1%	1.8%	1.6%	0.4%	-50.00
26-14c	**Steroid use among adolescents - 12th graders**	Black or African American not Hispanic	1998	0.9%	BSL	0.7%	1.0%	1.2%	1.0%	1.1%	1.3%	0.4%	-80.00
26-14c	**Steroid use among adolescents - 12th graders**	Hispanic or Latino	1998	2.4%	BSL	2.9%	2.4%	2.1%	2.2%	1.8%	2.4%	0.4%	0.00
26-15	**Inhalant use among adolescents (aged 12 to 17 years)**	Asian only	2002	2.5%	NA	NA	NA	NA	BSL	3.3%	ND	2.2%	-266.67
26-15	**Inhalant use among adolescents (aged 12 to 17 years)**	Black or African American not Hispanic	2002	2.3%	NA	NA	NA	NA	BSL	2.3%	ND	2.2%	0.00
26-15	**Inhalant use among adolescents (aged 12 to 17 years)**	Asian or Pacific Islander	2002	3.1%	NA	NA	NA	NA	BSL	3.7%	ND	2.2%	-66.67
26-15	**Inhalant use among adolescents (aged 12 to 17 years)**	Hispanic or Latino	2002	4.1%	NA	NA	NA	NA	BSL	4.2%	ND	2.2%	-5.26
26-16a	**Disapproval of 1-2 drinks a day of alcohol - 8th graders**	Black or African American not Hispanic	1998	80%	BSL	78%	76%	79%	81%	78%	75%	83%	-166.67
26-16b	**Disapproval of 1-2 drinks a day of alcohol - 10th graders**	Black or African American not Hispanic	1998	80%	BSL	80%	80%	79%	79%	78%	78%	83%	-66.67
26-16b	**Disapproval of 1-2 drinks a day of alcohol - 10th graders**	Hispanic or Latino	1998	75%	BSL	75%	74%	74%	74%	72%	74%	83%	-12.50
26-16c	**Disapproval of 1-2 drinks a day of alcohol - 12th graders**	Hispanic or Latino	1998	77%	BSL	78%	77%	81%	77%	74%	74%	83%	-50.00
26-16d	**Disapproval of trying marijuana or hashish once or twice - 8th graders**	Black or African American not Hispanic	1998	71%	BSL	70%	69%	71%	73%	72%	70%	72%	-100.00
26-16e	**Disapproval of trying marijuana or hashish once or twice - 10th graders**	Black or African American not Hispanic	1998	61%	BSL	62%	63%	61%	61%	60%	60%	72%	-9.09
26-17a	**Perception of risk associated with consuming 5+ alcoholic drinks once or twice a**	American Indian or Alaska Native	2002	37%	NA	NA	NA	NA	BSL	37%	ND	50%	0.00
26-17a	**Perception of risk associated with consuming 5+ alcoholic drinks once or twice a week - Adolescents (aged 12 to 17 years)**	Hispanic or Latino	2002	41%	NA	NA	NA	NA	BSL	39%	ND	50%	-22.22
26-17b	**Perception of risk associated with smoking marijuana once per month - Adolescents**	American Indian or Alaska Native	2002	31%	NA	NA	NA	NA	BSL	30%	ND	36%	-20.00
26-17c	**Perception of risk associated with using cocaine once per month - Adolescents (ag**	American Indian or Alaska Native	2002	44%	NA	NA	NA	NA	BSL	42%	ND	57%	-15.38

Number	*Objective*	*R/E*	*Baseline Year*	*Baseline*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*Target 2010*	*Progress Quotient*
26-17c	**Perception of risk associated with using cocaine once per month - Adolescents (aged 12 to 17 years)**	Asian only	2002	44%	NA	NA	NA	NA	BSL	43%	ND	57%	-7.69
26-17c	**Perception of risk associated with using cocaine once per month - Adolescents (aged 12 to 17 years)**	Asian or Pacific Islander	2002	43%	NA	NA	NA	NA	BSL	43%	ND	57%	0.00
26-18a	**Treatment for illicit drugs (aged 12 years and older) [New]**	Black or African American not Hispanic	2002	23%	NA	NA	NA	NA	BSL	21%	ND	24%	-200.00
26-18a	**Treatment for illicit drugs (aged 12 years and older) [New]**	Hispanic or Latino	2002	15%	NA	NA	NA	NA	BSL	8%	ND	24%	-77.78
26-18b	**Treatment for alcohol and/or drugs (aged 12 years and older) [New]**	Black or African American not Hispanic	2002	15%	NA	NA	NA	NA	BSL	13%	ND	16%	-200.00
26-18b	**Treatment for alcohol and/or drugs (aged 12 years and older) [New]**	Hispanic or Latino	2002	7%	NA	NA	NA	NA	BSL	6%	ND	16%	-11.11
27-01b	**Spit tobacco use - Adults (age adjusted, aged 18 years and over)**	Black or African American not Hispanic	1998	1.1%	BSL	ND	1.5%	ND	ND	ND	ND	0.4%	-57.14
27-01c	**Cigar smoking - Adults (age adjusted, aged 18 years and over)**	Black or African American not Hispanic	1998	1.9%	BSL	ND	1.9%	ND	ND	ND	ND	1.2%	0.00
27-01c	**Cigar smoking - Adults (age adjusted, aged 18 years and over)**	Hispanic or Latino	1998	1.3%	BSL	ND	1.6%	ND	ND	ND	ND	1.2%	-300.00
27-02c	**Adolescent use of spit tobacco in past month - Students (grades 9 through 12)**	Hispanic or Latino	1999	4%	NA	BSL	ND	4%	ND	5%	ND	1%	-33.33
27-02d	**Adolescent use of cigars in past month - Students (grades 9 through 12)**	Black or African American not Hispanic	1999	14%	NA	BSL	ND	12%	ND	15%	ND	8%	-16.67
27-02e	**Adolescent use of bidis in past month - Students (grades 9 through 12) [New]**	Asian only	2000	3%	NA	NA	BSL	ND	3%	ND	ND	2%	0.00
27-02e	**Adolescent use of bidis in past month - Students (grades 9 through 12) [New]**	Native Hawaiian or Other Pacific Islander	2000	10%	NA	NA	BSL	ND	10%	ND	ND	2%	0.00
27-05	**Smoking cessation attempts by adults (age adjusted, aged 18 years and over)**	American Indian or Alaska Native	1998	42%	BSL	50%	46%	39%	34%	34%	42%	75%	-24.24
27-07	**Smoking cessation attempts by adolescents - Students (grades 9 through 12)**	Hispanic or Latino	2001	53%	NA	NA	NA	BSL	ND	53%	ND	64%	0.00
27-12	**Indoor worksite policies that prohibit smoking**	Black or African American not Hispanic	1998-99	69%	NA	BSL	ND	ND	69%	ND	ND	100%	0.00
27-16a	**Exposure to tobacco advertising and promotions - Adolescents and young adults - I**	American Indian or Alaska Native	2000	33%	NA	NA	BSL	ND	45%	ND	ND	25%	-150.00

Number	*Objective*	*R/E*	*Baseline Year*	*Baseline*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*Target 2010*	*Progress Quotient*
27-16a	**Exposure to tobacco advertising and promotions - Adolescents and young adults - Internet (grades 6-12) [New]**	Asian only	2000	28%	NA	NA	BSL	ND	38%	ND	ND	25%	-333.33
27-16a	**Exposure to tobacco advertising and promotions - Adolescents and young adults - Internet (grades 6-12) [New]**	Black or African American not Hispanic	2000	31%	NA	NA	BSL	ND	39%	ND	ND	25%	-133.33
27-16a	**Exposure to tobacco advertising and promotions - Adolescents and young adults - Internet (grades 6-12) [New]**	Native Hawaiian or Other Pacific Islander	2000	38%	NA	NA	BSL	ND	47%	ND	ND	25%	-69.00
27-16a	**Exposure to tobacco advertising and promotions - Adolescents and young adults - Internet (grades 6-12) [New]**	Hispanic or Latino	2000	32%	NA	NA	BSL	ND	41%	ND	ND	25%	-128.57
27-16b	**Exposure to tobacco advertising and promotions - Adolescents and young adults - Magazines and newspapers (grades 6-12) [New]**	Black or African American not Hispanic	2000	68%	NA	NA	BSL	ND	68%	ND	ND	67%	0.00
27-16b	**Exposure to tobacco advertising and promotions - Adolescents and young adults - Magazines and newspapers (grades 6-12) [New]**	Hispanic or Latino	2000	71%	NA	NA	BSL	ND	71%	ND	ND	67%	0.00
27-17a	**Adolescent disapproval of smoking - 8th graders**	Black or African American not Hispanic	1998	82%	BSL	82%	80%	80%	83%	82%	ND	95%	0.00
27-17b	**Adolescent disapproval of smoking - 10th graders**	Hispanic or Latino	1998	81%	BSL	82%	79%	78%	79%	80%	ND	95%	-7.14
27-17c	**Adolescent disapproval of smoking - 12th graders**	Black or African American not Hispanic	1998	82%	BSL	80%	78%	82%	83%	81%	ND	95%	-7.69
28-04	**Blindness and visual impairment in children and adolescents (per 1,000 standard population, aged 17 years and under)**	Black or African American not Hispanic	1997	27	37	35	24	27	26	27	26	18	0.00
28-04	**Blindness and visual impairment in children and adolescents (per 1,000 standard population, aged 17 years and under)**	Hispanic or Latino	1997	21	25	21	19	26	36	21	19	18	0.00
28-14a	**Hearing examination in last 5 years - Adults (age adjusted, aged 20 to 69 years) [New]**	Mexican American	1999-00	30%	NA	NA	BSL	ND	26%	ND	ND	34%	-100.00

Appendix 4:
OMH Performance Measures for Grantees

OMH Performance Measures/ Indicators for Grantees

Once grantees identify the outputs, processes, outcomes, and other results expected from the strategies, practices, or interventions to be conducted as part of their OMH-funded projects, they will then need to determine what measures to use as indicators of progress towards--and achievement of–such results. OMH recognizes that some desired results (such as long-term progress towards *Healthy People* objectives and goals) will have fairly straightforward performance measures or indicators (e.g., the number of *Healthy People* objectives towards which a grant-funded program or project contributes). Other intended outcomes (such as increased coordination and collaboration for greater effectiveness and efficiency) currently lack precise methods or means for measuring progress and, thus, may require greater flexibility and/or be tailored to specific grant activities (e.g., the number of formal written agreements established between organizational partners, or the number of links and cross-references among a network of organizations identified on web pages or in resource or referral guides).

It is critical, however, for OMH grantees to keep in mind that their OMH-funded projects must use performance measures or indicators that are linked and contribute to grant program-wide, OMH-wide, and *Healthy People* objectives and goals[2].

Grantees are required to identify performance measures or indicators clearly linked to the following OMH or HHS-wide performance measures.

- Number of measurable, population-specific *Healthy People* objectives towards which OMH-funded project and programmatic efforts contribute (see *Healthy People* website at http://www.healthypeople.gov/Default.htm
- Number of measurable, racial/ethnic minority-specific *Healthy People* subobjectives that have not made progress towards – or are moving away from – their targets with which OMH-funded project and programmatic efforts are linked (see OMH list)
- Number of OMH-funded projects, programs, and initiatives that contribute towards each of the objectives of OMH's *National Partnership for Action to End Health Disparities*
- Number of grantee and partnering organizations with strategic plans and/or formal strategic planning processes to guide and monitor progress towards organizational goals and objectives, including those specific to racial/ethnic minority health improvement- and/or health disparities-reduction, towards which OMH-funded efforts contribute
- Number of full-time equivalents (FTEs) on grant project staff supported with OMH funding

[2] As of Summer 2010, the set of objectives used by OMH are those for *Healthy People 2010*. Upon the release of *Healthy People 2020* later in 2010, OMH-funded project and programmatic efforts should be linked to the long-term sub-objectives, objectives, and goals for the upcoming decade.

- Number of partnerships facilitated and/or established to enhance coordination and collaboration of efforts to address racial/ethnic minority health/health disparities problems
- Amount of funding, staffing, and other resources 'leveraged' through partnerships to more efficiently and effectively address racial/ethnic minority health/health disparities problems of mutual interest
    - At the grantee organization level
    - At the grant project level
- Number of individuals (unduplicated) participating in OMH-funded project and programmatic interventions and other efforts as strategies, practices, and interventions are being implemented or conducted
    - Total (unduplicated) participants
    - Participants by race, gender, and age

Grantees are required to identify performance measures or indicators clearly linked to at least two of the following OMH-wide performance measures.

- Number of OMH-funded strategies/practices or interventions addressing individual-level factors (e.g., individual awareness/knowledge, attitudes/perceptions, satisfaction, skills, behaviors)
- Number of OMH-funded strategies/practices or interventions addressing community- or environmental-level factors (e.g., air and water pollution, sanitation, crime and violence, safe parks and playgrounds, community awareness/knowledge, community norms and values, access to and availability of goods and services in the community (including health care), social capital and community support groups, policies supportive of community health and well-being)
- Number of OMH-funded strategies/practices or interventions addressing systems-level factors (e.g., infrastructure, resources, and capacity; leadership, commitment, and sustainability; coordination and collaboration; user-centered design such as culturally and linguistically appropriate services or enhanced workforce diversity; improved data collection, analysis, and use for planning and decision-making; dissemination and use of research and evaluation results)

Grantees are encouraged to identify performance measures or indicators that clearly link the expected outputs, processes, and outcomes of their project activities to the following OMH performance measures.

- Number of individuals (unduplicated) who participated in OMH-supported one-on-one education, training, technical assistance, mentoring, counseling, consultation, or case management sessions conducted
  - For patients, clients, customers, their families, or other individuals
  - For health care providers, other service providers, or other professionals
- Number of individuals who participated in OMH-supported group education, training, TA, mentoring, counseling, consultation, or case-management sessions conducted
  - For patients, clients, customers, their families, or other individuals
  - For health care providers, other service providers, or other professionals
- Number of individuals who received OMH-funded language interpretation and/or other verbal language assistance in clinical and/or other service encounters
- Number of individuals who received OMH-funded printed/written instructional or educational materials, forms, and other documents translated into languages other than English
- Number of individuals who received OMH-funded, English-language instructional or educational documents or other print materials to address health needs for themselves, their families, or, in the case of service providers, their patients or clients
- Number of individuals who received health referrals based on the results of OMH-funded community-based health screenings
- Number of individuals who participated in OMH-funded community-based health fairs, expositions, and other similar public events
- Number of individuals who participated in OMH-funded conferences or other large-scale meetings (e.g., town hall meetings, community listening sessions)
- Number of unique visitors (not hits) to grantee organizational websites and OMH-funded project-specific web pages
- Number of unique visitors and total interactions using social media forums, applications, and outlets (e.g., blogs, message boards) in support or as a result of OMH-funded projects or programs
- Number of texts, manuscripts, or other articles about OMH-funded projects published in peer-reviewed journals or other venues
- Estimated audience reach (in thousands of individuals) by a particular broadcast (e.g., radio, television) or print (e.g., newspaper, magazine) media outlet (as documented by that outlet) for informational and educational interventions conducted as part of OMH-funded project and program efforts

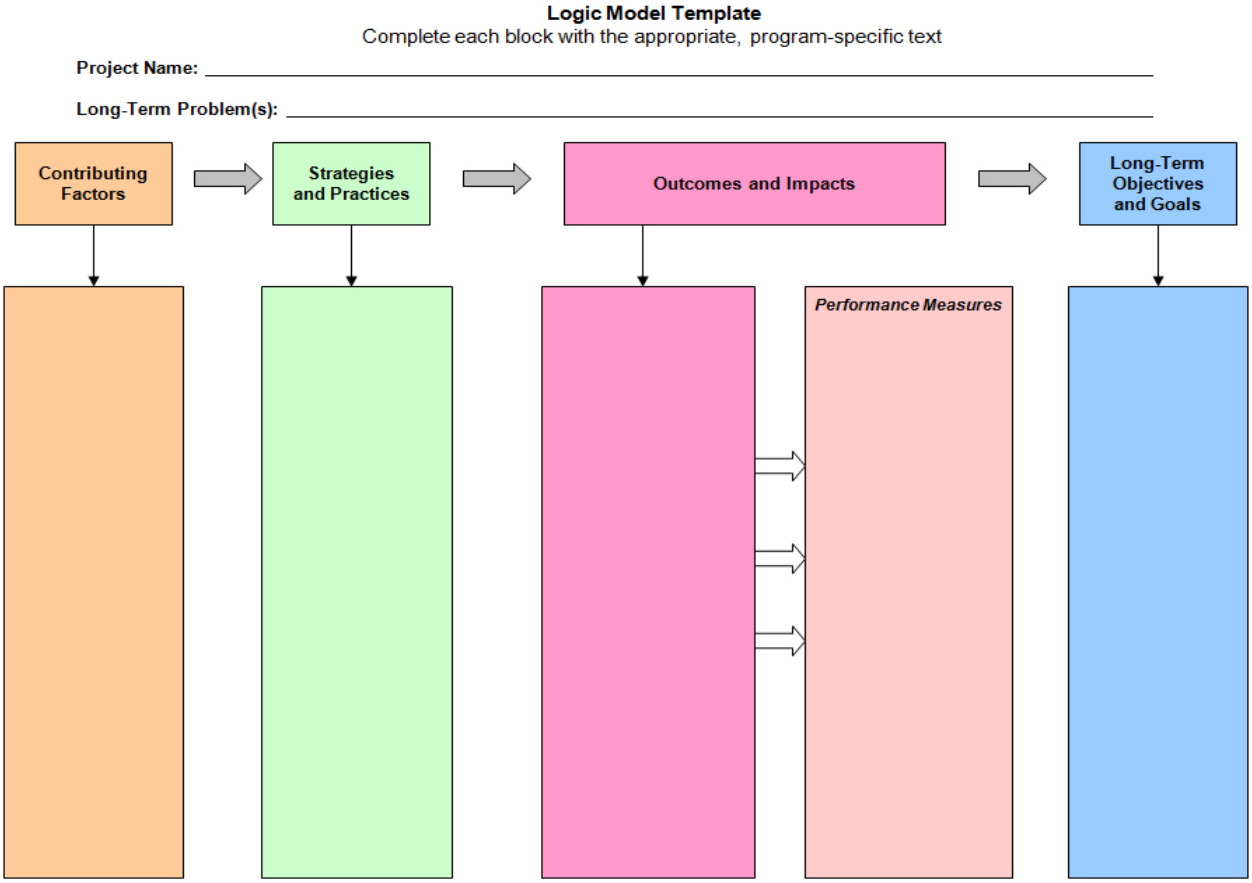
- Number and percent of individuals with increased awareness and knowledge of racial/ethnic minority health problems and how to address such problems as a result of OMH-funded project participation
- Number and percent of individuals with positive changes in attitudes/ perceptions that will improve racial/ethnic minority health and reduce health disparities
- Number and percent of individuals with improved skills that will contribute to improved racial/ethnic minority health and reduced health disparities
- Number and percent of individuals with increased satisfaction as a result of strategies/practices and interventions provided
- Number and percent of persons who seek and obtain more timely follow-up care as a result of OMH-funded health screening referrals
- Number and percent of limited-English proficient individuals who, as a result of OMH-funded strategies/practices or interventions, are offered improved language assistance through their usual source of health care
- Number and percent of racial/ethnic minority individuals seeking or obtaining clinical or hospital services who have improved communications with doctors and other staff and/or improved experiences of care as a result of OMH-funded activities
- Number and percent of doctors, nurses, and other clinical or hospital staff who have improved communications with -- and/or improved experiences providing care to -- racial/ethnic minority individuals seeking or obtaining health services as a result of OMH-funded activities
- Number and percent of persons with increased participation in OMH-supported “pipeline” programs that promote racial/ethnic diversity in the public health, health care, and/or research workforce
- Number and percent of persons who demonstrate positive changes in behaviors and/or lifestyles for greater health and well-being
- Number of public policies (e.g., laws, regulations, budget priorities, formal guidelines or standards of practice) developed, adopted, implemented, enforced, or changed with regard to racial and ethnic minority health and health disparities issues as a result of OMH-funded projects, programs, and initiatives
- Number of OMH-funded interventions and other programmatic efforts evaluated for effectiveness in achieving desired outcomes and subsequently identified as “best” or “evidence-based”

OMH grantees may develop and include additional measures depending upon the nature of the funded interventions/activities and desired results.

Appendix 5:
Logic Model Template

Logic Model Template

This template is based on the *Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities* developed by OMH. The template depicts four of the five steps in the *Framework*, aligned in a row from left to right, with each step identified in a logical progression necessary to effectively address the long-term racial/ethnic minority health problems identified.



Contributing factors are factors contributing to or causing long-term problems that are being addressed in the proposed project or activities. It is recommended that grantees identify the factors at the individual level, environmental-/community-level, and systems-level, as appropriate for their projects. Individual-level factors include knowledge, attitudes, skills, behaviors, and biological and genetic risks. Community- or environmental-level factors are related to the physical environment, the social environment, or economic barriers, with the social environment subdivided into community values, community assets, or community involvement. Systems-level factors include the kinds of systems that a community, State, tribal entity, region, or nation might have (or not have), and the approaches used (or not used) for identifying the problems or needs in their respective jurisdictions and for directing resources to address the problems or needs. They are organized into five major categories: components and resources; coordination and collaboration; leadership and commitment; user-centered design; and science and knowledge.

Strategies and practices are those specific intervention activities, including processes, tools, events, technology, and actions, that are an intentional part of the program implementation. They are used to bring about the intended program changes or results. Approaches that address individual-level factors include efforts to increase knowledge, promote attitudes, and improve skills that affect decisions about health-related behavior. Strategies for addressing community-or environmental-level factors extend beyond individuals and include efforts to promote a healthy physical or social environment and to address economic barriers. Systems-level strategies include efforts that seek to increase and strengthen system components and resources; promote coordination, collaboration, and partnerships; foster and ensure leadership and commitment; promote user-centered design to address racial/ethnic minority needs; and improve science and knowledge about successful strategies and practices.

Outcomes and impacts refer to specific changes occurring in individuals, groups, organizations, communities, or systems, and are often specified as short-, intermediate-, and long-term outcomes. Short-term outcomes are immediate effects of the program and usually include changes in program participants' knowledge and skills. Intermediate outcomes and long-term outcomes or impacts involve behavioral, normative, and system changes in the individuals, communities and systems. Individual-level outcomes and impacts include increased awareness and knowledge about health issues, increased skills for racial/ethnic minorities to adopt healthy lifestyle behaviors, increased patient adherence to prescribed treatment regimens, etc. Community- or environmental-level outcomes and impacts include decreased exposure to health risks in the community, increased health care access and appropriate utilization, increased health-conducive changes in community attitudes, values and norms, etc. Systems-level outcomes and impacts include increased formal partnerships and collaboration leading to coordination or leveraging of resources for greater efficiency and effectiveness of individual and collective efforts, increased strategic planning and implementation of plans, increased knowledge development and science base about successful strategies and practices for improving racial/ethnic minority health and reducing health disparities, etc.

Performance measures are specific and measurable indicators used for tracking and documenting the progress of the program towards achieving program objectives. There are different types of performance measures, including input measures, output measures, process measures, outcome measures, and impact measures (see Step 3 in the *Evaluation Planning Guidelines* for details). The grantee needs to align performance measures with OMH required and optional performance measures (see Appendix 4 for details).

Long-term objectives and goals are the long-term results that include those in *Healthy People 2010* (or, after release, *Healthy People 2020*). These objectives can be set, if desired, for the individual, community and/or systems level (s). At the individual level, the goals include increased quality and years of healthy life for racial/ethnic minority individuals; at the community level, the goals include reduced, and ultimately, eliminated racial/ethnic health disparities; and at the systems level, the goals include systems approaches to racial/ethnic minority health improvement and health disparity reduction.

Appendix 6:
Logic Model Worksheet and Example (for Diabetes) of Completed Worksheet

Logic Model Worksheet

The logic model should lay out the logical relationship between the factors causing or contributing to the long-term problem or problems the program is attempting to address, the strategies and practices being employed, and the outcomes and impacts to be achieved that will contribute towards longer-term objectives and goals for OMH and the Nation as a whole. It is a description of what the program will do and how the program will work to improve racial/ethnic minority health and eliminate racial/ethnic minority health disparities.

Project Name: _____

Long-Term Problem(s) to be Addressed: _____

Long-Term Objectives and Goals to be Achieved: _____

Contributing Factors	Strategies and Practices	Outcomes and Impacts	Performance Measures for All Grantees	Optional Measures

Logic Model Worksheet: Diabetes Project

The logic model should lay out the logical relationship between the long-term problem being addressed, the factors that cause or contribute to the long-term problem, the strategies and practices to be employed to affect the factors, the outcomes and impacts to be achieved if the strategies and practices are effective, and the longer term objectives and goals towards which the shorter term outcomes contribute. It is a description of what the program will do and how the program will work to improve racial/ethnic minority health and eliminate racial/ethnic minority health disparities.

Project Name: **Community Programs to Improve Minority Health**
Long-Term Problem to be Addressed: **High rate of preventable morbidity and premature mortality in relation to diabetes**
Long-Term Objectives and Goals to be Achieved: **Reduce prevalence of diabetes in minorities**

Contributing Factors	Strategies and Practices	Outcomes and Impacts	Performance Measures for All Grantees	Optional Measures
Lack of awareness and knowledge about the connections between diet, exercise, obesity, and diabetes Lack of public awareness about risk factors related to diabetes Lack of community assets, such as healthy food choices in local grocery stores and restaurants Lack of safe venues to engage in physical activity, sports and recreation Lack of strategic planning to guide leadership action and assess progress towards established diabetes prevention and management objectives and goals Lack of language assistance services in health care settings to minimize systems barriers to access and utilization for limited-English-proficient individuals at risk for diabetes	Provision of individually-oriented health education through tailored channels (e.g., health providers or faith-based organizations) Conduct of community-based health education or communication campaigns through local media channels, schools, and community organizations Partnerships among local leaders in the restaurant, grocery, and exercise/fitness industries, local health and city officials, and representatives of communities at risk for diabetes Development and implementation of a strategic plan that identifies diabetes prevention and management as a priority, and sets benchmarks and targets to guide action towards established objectives and goals that can strengthen leadership effectiveness Introduction of linguistically appropriate services, such as properly translated written materials and medical interpreters during clinical encounters to promote health care access and utilization for limited English proficient patients who may be at risk for or have diabetes and to provide user-centered care	Increased awareness/knowledge about the link between diet, exercise, obesity, and diabetes Increased healthcare provider skills in educating and counseling their patients about diabetes prevention, treatment, and management Increased patient adherence to prescribed diet, exercise, and treatment regimens for diabetes Increased public awareness about diabetes and related risk factors Increased plans and policies that promote healthier dietary choices and safe places for exercise and sports in the community Increased system design characteristics to minimize barriers for racial/ethnic minority users, such as the provision of trained medical interpreters or bilingual health care providers to facilitate health care access and use by limited-English-proficient patients with diabetes	Number of diabetes-related *Healthy People* objectives addressed, e.g. proportion of adults with diabetes whose condition has been diagnosed, proportion of adults with diabetes who have an annual dilated eye examination, proportion of adults with diabetes who have at least an annual foot examination Number of diabetes-related *Healthy People* objectives addressed that are not making progress, e.g. proportion of persons with diabetes who receive formal diabetes education, promotion of adults with diabetes who perform self-blood-glucose monitoring at least once daily Number of individuals (unduplicated) participating in OMH-funded diabetes activities per year Number/percent of individuals with increased awareness and knowledge of diabetes and how to address it as a result of OMH-funded program participation Number of strategic planning documents developed Number of partnerships to enhance coordination and collaboration on diabetes treatment and control	Number of training and TA events Number of evidence-based practices on diabetes treatment and control identified to inform planning and evaluation of minority health/health disparities efforts and systems approaches

Appendix 7:
Example of Completed Logic Model (for Diabetes)

Logic Model Example – Diabetes

This image shows an example of a completed Logic Model Template. The information provided for each step is as follows.

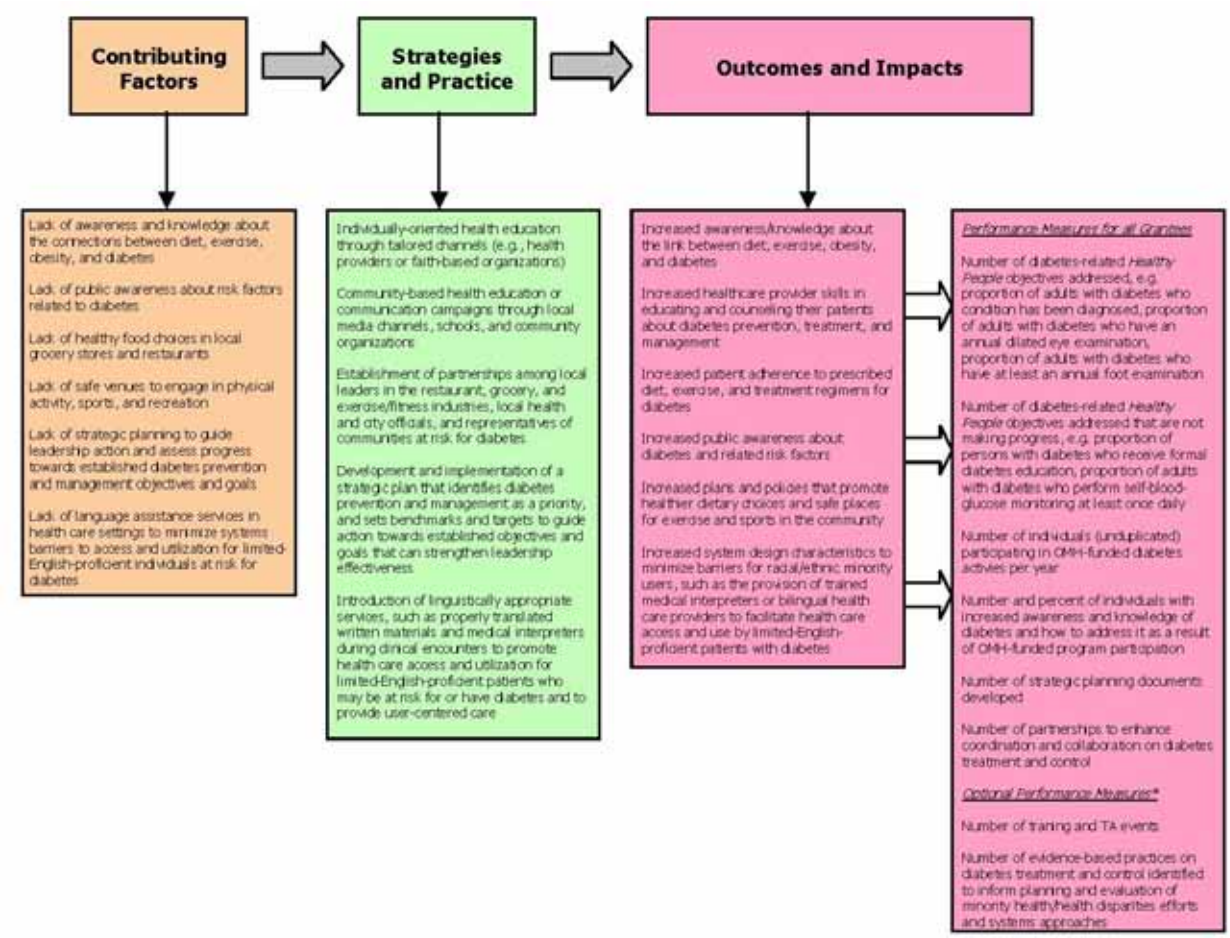
- Contributing Factors
  - Lack of awareness and knowledge about the connections between diet, exercise, obesity, and diabetes
  - Lack of public awareness about risk factors related to diabetes
  - Lack of healthy food choices in local grocery stores and restaurants
  - Lack of safe venues to engage in physical activity, sports, and recreation
  - Lack of strategic planning to guide leadership action and assess progress towards established diabetes prevention and management objectives and goals
  - Lack of language assistance services in health care settings to minimize systems barriers to access and utilization for limited English proficient individuals at risk for diabetes
- Strategies and Practices
  - Individually-oriented health education through tailored channels (e.g., health providers or faith-based organizations)
  - Community-based health education or communication campaigns through local media channels, schools, and community organizations
  - Establishment of partnerships among local leaders in the restaurant, grocery, and exercise/fitness industries, local health and city officials, and representatives of communities at risk for diabetes
  - Development and implementation of a strategic plan that identifies diabetes prevention and management as a priority, and sets benchmarks and targets to guide action towards established objectives and goals that can strengthen leadership effectiveness
  - Introduction of linguistically appropriate services, such as properly translated written materials and medical interpreters during clinical encounters to promote health care access and utilization for limited English proficient patients who may be at risk for or have diabetes and to provide user-centered care
- Outcomes and Impacts
  - Increased awareness/knowledge about the link between diet, exercise, obesity, and diabetes
  - Increased healthcare provider skills in educating and counseling their patients about diabetes prevention, treatment, and management
  - Increased patient adherence to prescribed diet, exercise, and treatment regimens for diabetes
  - Increased public awareness about diabetes and related risk factors

- Increased plans and policies that promote healthier dietary choices and safe places for exercise and sports in the community
- Increased system design characteristics to minimize barriers for racial/ethnic minority users, such as the provision of trained medical interpreters or bilingual health care providers to facilitate health care access and use by limited-English-proficient patients with diabetes

- Performance Measures
  - Performance Measures for All Grantees (measures that meet the requirement to clearly link expected grantee-specific outputs, processes, and outcomes to OMH and HHS-wide performance measures)
    - Number of diabetes-related *Healthy People* objectives addressed, e.g. proportion of adults with diabetes whose condition has been diagnosed, proportion of adults with diabetes who have an annual dilated eye examination, proportion of adults with diabetes who have at least an annual foot examination
    - Number of diabetes-related *Healthy People* objectives addressed that are not making progress, e.g. proportion of persons with diabetes who receive formal diabetes education, proportion of adults with diabetes who perform self-blood-glucose monitoring at least once daily
    - Number of individuals (unduplicated) participating in OMH-funded diabetes activities per year
    - Number/percent of individuals with increased awareness and knowledge of diabetes and how to address it as a result of OMH-funded program participation
    - Number of strategic planning documents developed
    - Number of partnerships to enhance coordination and collaboration on diabetes treatment and control
  - Optional Performance Measures (additional, selected measures that clearly link expected grantee outputs, processes, and outcomes to OMH performance measures)
    - Number of training and TA events
    - Number of evidence-based practices on diabetes treatment and control identified to inform planning and evaluation of minority health/health disparities efforts and systems approaches

Logic Model Examples – Diabetes

Project Name: Community Programs to Improve Minority Health
Long-Term Problem: High rate of preventable morbidity and premature mortality in relation to diabetes
Long-Term Objectives & Goals: Reduce prevalence of diabetes in minorities



*Grantees are encouraged to identify additional performance measures or indicators that clearly link the expected outputs, processes, and outcomes of their funded-efforts to other OMH performance measures

Appendix 8:
Types of Evaluations

Types of Evaluations

Generally, the types of evaluations used to provide information to program or project managers, staffs, funders, and other stakeholders about the results of their efforts are categorized as formative or summative evaluations, which may also be process, outcome, or impact evaluations – described briefly below:

- **Formative evaluations** are typically conducted during the development (or formation) of a strategy, program, or product (including trained personnel) to assess (or 'test') their strengths and weaknesses before implementation. Such evaluations permit necessary revisions and improvements that enable planned efforts to be tailored to the target audience(s), as in the case of campaign strategies, products, or messages that are 'pre-tested' by a small group before they are implemented on a large scale. They can also be used for observing, monitoring, and providing feedback on student, staff, or trainee performance to improve skills. The basic purpose is to maximize the chance for program, project, or trainee success before full implementation of the activity starts. Unlike summative evaluations, formative evaluations are primarily prospective, shape program/project direction, and provide feedback towards improvement. Examples of formative evaluations are needs assessments, evaluability assessments, and process evaluations.
- **Process evaluations** examine the tasks and procedures involved in implementing a program or activities, including the administrative and organizational aspects of, and delivery procedures involved in, the efforts. Such evaluations enable monitoring to ensure feedback during the course of the program or project.
- **Summative evaluations** look at a combination of measures and conclusions for larger patterns and trends in performance, to assess, in summary, whether the program or project overall did what it was designed to do. Compared to formative evaluations, summative evaluations are primarily retrospective, document evidence, and show results and achievement. Examples of summative evaluations include outcome and impact evaluations, cost-effectiveness and cost-benefit analyses, and meta-analyses (which integrate outcomes from multiple studies to determine an overall judgment or summary conclusion about a particular research or evaluation question).
- **Outcome evaluations** are used to obtain descriptive data on a program or project and to document (typically) short- and intermediate-term results. Task-focused results are those that describe the output of the activity (e.g., the number of public inquiries received as a result of a public service announcement). Shorter-term results describe the immediate effects of the project on the target audience (e.g., percent of the target audience showing increased awareness of the subject). Information from such evaluation can show results such as knowledge and attitude changes, short-term or intermediate behavior shifts, and policies initiated or other institutional changes.

- **Impact evaluations** focus on the long-range results of the program or project, and changes or improvements as a result (e.g., long-term maintenance of desired behavior, reduced absenteeism from work, reduced morbidity and mortality). Because such evaluations are the most comprehensive and focus on long-term results of the program and changes or improvements in health status, they are the most desirable. However, impact evaluations are rarely possible because they are frequently costly and involve extended commitment. Also, the results often cannot be directly related to the effects of a program, project, or activity because of other (external) influences on the target audience, which occur over time.

Appendix 9:
Data Collection Plan Template and Example of Completed Plan

Data Collection Plan

OMH Grant Program: _____

Grantee Name: _____

Grant Project Name: _____

Measures for All OMH Grantees Linked to OMH Measures	Instrument/Data Source	Location of Data	Frequency of Collection	Person Responsible for Collection

Optional Measures for All OMH Grantees Linked to OMH Measures	Instrument/Data Source	Location of Data	Frequency of Collection	Person Responsible for Collection

Additional Measures Used by OMH Grantee	Instrument/Data Source	Location of Data	Frequency of Collection	Person Responsible for Collection

Data Collection Plan – Actual Example of Completed Plan
(an OMH Evaluation Planning "Best Practice")[3]

OMH Grant Program: Curbing HIV/AIDS Transmission (CHAT) Program

Grantee Name: Alternatives for Girls

Grant Project Name: Community and Online Female Youth Peer Education and Outreach Initiative

Measures for All OMH Grantees	Instrument/Data Source	Location of Data	Frequency of Collection	Person Responsible for Collection
Number of HP2010 objectives for priority OMH issues addressed: 1) Increase the proportion of HIV-infected adolescents (aged 13 years and older) and adults who receive testing, treatment, and prophylasix consistent with current Public Health Service treatment guidelines.	State of Michigan required Counseling, Testing, Referral (CTR) Service Delivery Forms; State of Michigan HIV Event System (HES) log	Horizons Project (HP) will maintain all CTR and HES forms at their east Detroit facility in their state-approved filling system and will compete reports based on forms for AFG and DDHWP as needed	During community outreach activities, approximately once per month; CTR data is reported to the State of Michigan every 14 days	HP outreach worker
Number of HP2010 objectives addressed that are not making progress: 25-11c Responsible adolescent sexual behavior-students who used condoms at last intercourse (grades 9-12)-Black or African American not Hispanic.	Online screening form and demographic forms from community outreach	HP will maintain all demographic and evalaution data from internet and community outreach activities; AFG will have software for data review and analysis	Internet outreach will occur multiple times a week once in implementation phase	AFG Peer Outreach Coordinator, HP outreach worker, and HP evaluator
Number of individuals participating in OMH-funded, grant program activities per year	Sign in sheets and various internet tracking device	Project records	Monthly	Project/evaluation director

[3] The required versus optional measures in this example from an FY 2009 grantee may differ slightly from those identified for FY 2010 or subsequent grantees.

Measures for All OMH Grantees	Instrument/Data Source	Location of Data	Frequency of Collection	Person Responsible for Collection
Number/percent of individuals with increased awareness and knowledge	Online surveys, session evaluations, and pre and post tests	Project records	As occurs	Training staff
Number of strategic planning documents developed	Post tests at community outreach activities targeting staff of high-risk minority youth	Project records	Outcome data will be collected after each scheduled outreach activity and be reviewed quarterly by team	AFG Peer Educator Outreach Coordinator, HP outreach worker, HP evaluator
Number of partnerships	Signed Memorandums of Agreement	AFG will maintain hard copies of all MOAs	As new partnership develop	AGF case planner

Optional Measures for All OMH Grantees	Instrument/Data Source	Location of Data	Frequency of Collection	Responsible for Collection
Number of full-time equivalents (FTEs) on program/project staff supported with OMH funding	Employment and payroll records at AFG, HP and DDHWP	At respective sites, but with AFG receiving monthly billing from HP and DDHWP stating the number of FTEs to bill	Monthly	AFG OES director
Number of OMH-supported training and technical assistance events	Sign-in sheets	AFG will maintain hard copy forms of sign-in sheets and print-outs as available of online tracking devices	Gathered after each scheduled outreach activity and summarized monthly	AFG Peer Educator Outreach Coordinator and HP outreach worker

Additional Measures [4]	Instrument/Data Source	Location of Data	Frequency of Collection	Responsible for Collection
Process Measures Number of training hours provided, number of attendees at trainings, and number of completed pre and post tests	Sign-in sheets, agendas and pre and post tests.	AFG will maintain hard copy forms of sign-in sheets and agendas	After each scheduled outreach activity with hours and attendees summarized monthly and pre and post test data reviewed quarterly	AFG Peer Educator Outreach Coordinator, HP outreach worker, HP evaluator
Outcome measures Number of staff who indicate increase of skills and knowledge demonstrated between pre and post test	Pre and post tests		Data to be collected during every scheduled outreach activity	AGF Peer Educator Outreach Coordinator, HP outreach worker, and HP evaluator
Impact measures Enhanced infrastructure of alternative education/residential facilities to address HIV/AIDS among minority and high-risk youth	Pre and post tests		Data to be collected during every scheduled outreach activity	AGF Peer Educator Outreach Coordinator, HP outreach worker, and HP evaluator

[4] Additional measures refer to performance measures developed to address evaluation questions, in addition to OMH measures. Due to the page limit, additional measures included in this example only represent part of the performance measures submitted by the grantee.

Appendix 10:
Sample Data Collection Forms

Technical Assistance (To Individuals) Activity Record

Date	Recipient	Race	Ethnicity	Gender	Age	TA Type	Comment

Technical Assistance (To Organizations) Activity Record

Date	Organization	Type of Organization	New or Existing	TA Type	Comment

Linkage-Building Activity Record

Organization	Type of Organization	Type of Agreement	New/Existing Agreement	Role in Grant Activity	Number of Meetings/Activities	Comments

Appendix 11:
Frequently Asked Questions

Frequently Asked Questions on Evaluation Planning

1. What is evaluation?

Evaluation is a way of assessing how well a program, project, or some other activity is achieving or has achieved its objectives.

2. Why is evaluation important?

Good evaluation enables program and project managers and staffs, program administrators, funders, policymakers, and others to know whether their efforts are effectively accomplishing desired or expected results. With such knowledge, program and project activities can be adjusted and improved to better serve clients and communities, scarce resources can be used more effectively and efficiently, and results of challenges and accomplishments can be shared with others so that everyone can learn about and from their experiences. Without evaluation, it cannot be determined in a meaningful way whether a program, project, or activity is succeeding or failing and why.

3. Why is OMH requiring evaluation?

First of all, OMH is committed to evaluations that will demonstrate the effectiveness of the strategies, practices, and interventions that are supported by OMH funds, and that will 'grow the science' regarding 'what works' in improving the health and well-being of racial and ethnic minorities. Secondly, the Government Performance and Results Act of 1993 (GPRA) requires that Federal programs provide information about program goals, performance relative to program goals, and results regarding program effectiveness and cost efficiency in the spending of Federal funds. When OMH grantees are able to produce documented results showing how strategies and activities being funded contribute to OMH's objectives and goals, they support OMH's ability to comply with GPRA and demonstrate "returns on the investment" in the Office's grant programs. This further enables OMH to justify continued support for its grant programs and grantee efforts.

4. Are the steps and components outlined in OMH's evaluation planning guidelines required?

OMH's evaluation planning guidelines consist of very basic evaluation steps for developing an effective evaluation plan. The guidelines were developed to help grant applicants improve the evaluation plans submitted as part of their grant applications. The fact that review of these plans is a part of the grant award decision-making process – and comprises 25% of the total score – reflects the importance of evaluation planning and implementation to OMH.

5. What is Healthy People 2010 and Healthy People 2020?

Healthy People 2010 (HP2010) is a set of health objectives for the Nation to achieve over the first decade of this century (2001-2010). It can be used by many different people, States, communities, professional organizations, and others to help them develop programs to improve health. Like its predecessors, *Healthy People 2000* and the disease prevention/health promotion objectives laid out in the 1979 Surgeon General's Report, *HP2010* was developed through a broad consultation process, built on the best scientific knowledge, and designed to measure programs over time. More information about *HP2010* is available at http://www.healthypeople.gov. *Healthy People 2020* (*HP2020*) is a similar set of national health objectives for the Nation to achieve over the second decade of this century (2011-2020). You can read about the *HP2020* framework and planned objectives at http://www.healthypeople/hp2020/Objectives/framework.aspx.

The goals, objectives, and priorities established by OMH are intended to support the goals and objectives of the current set of *Healthy People* objectives and, therefore, where possible, efforts funded by OMH need to demonstrate their link to the relevant *Healthy People* goals and objectives.

Lastly, the U.S. Department of Health and Human Services (HHS) also maintains a website, DATA2010, where you can locate data for specific objectives nationally, by state, and by gender and racial/ethnic group (http://wonder.cdc.gov/data2010/).

6. What is the National Partnership for Action to End Health Disparities?

The *National Partnership for Action to End Health Disparities* (NPA) is an OMH-led initiative to mobilize a broad network of organizations and individuals to address the persistent health disparities that place a greater burden of preventable disease and premature death on racial/ethnic minorities in the U.S. The NPA has five main objectives:

- To increase awareness of health disparities
- To strengthen leadership at all levels for addressing health disparities
- To improve health and health care outcomes
- To improve cultural and linguistic competency
- To improve coordination and utilization of research and evaluation outcomes

Prospective and current OMH grantees are considered to be part of this network of partners, and are expected to support selected NPA objectives as appropriate.

7. If objectives are supposed to be measurable, does that mean that they have to be quantitative (such as numbers of people served, numerical scores on questionnaires, or changes in health statistics)?

No. Being "measurable" simply means being able to show, through the collection of data or information, that something is different from something else or how it has changed over time. A project objective is measurable if changes from the conditions described in baseline data can be shown in a convincing way. Some objectives describe things that can be counted (or that are quantitative), such as numbers of people receiving training; numbers of people receiving or providing particular kinds of services; numerical scores on questionnaires about people's knowledge, attitudes, or behavior; or, the numbers of people giving similar responses in interviews. Sometimes, however, measuring change is simply showing that something has been created that did not exist before, such as a new policy, a new organization, a new source of funding, a new training program, or a new building.

8. What are baseline data?

Baseline data are basic information or data that are available or can be collected before a program, project, or activity begins. Such data are used to provide a starting point against which to compare data collected later in the program, project, or activity in order to determine if there has been a change in specific conditions over time.

9. What is the difference between an outcome and an impact?

In evaluation, an outcome is generally used to describe a *short- or intermediate-term* result of an activity, such as changes in knowledge or attitudes, behavioral change, or policy changes. An impact is generally a *long-range* result of an activity and can be a direct or an indirect consequence of an activity. In evaluation, impacts are more desirable than shorter-term outcomes because they are more likely to show changes or improvements in health status.

10. What is a performance measure?

A performance measure is a particular value used to measure program activities, impacts and outcomes. A measure should represent the actual data or information that will be collected at the program or project level to measure the specific activities, outcomes, or impacts that the program/project is designed to achieve. Therefore, performance measures are generally developed for each program or project objective.

11. What is a logic model?

A logic model is a tool that describes how a program or project should work, presents the planned activities for the program or project, and focuses on anticipated outcomes. They are called "logic" models because they are very useful in helping program or project planners and evaluators to identify and clarify the "logic" or rationale behind what is being done and how programs or projects should work. Logic models typically tie together: *long-term problem(s)* to be addressed; *factors* that must be addressed that contribute to the problem(s); *strategies and practices* and supporting resources that can be mobilized to address the factors and the problems; and *measurable outcomes and impacts* that can be expected to result from implementing the strategies and practices – as these relate to the long-term problem(s).

12. What are the different types of evaluations that should be used?

Generally, there are five major types of evaluations used: (1) *process evaluation* which examines the tasks and procedures involved in implementing a program, project, or activities, including the administrative and organizational aspects of, and delivery procedures involved in, the efforts; (2) *outcome evaluation* which is used to obtain descriptive data on a program or project and to document (typically) short- and intermediate-term results; (3) *impact evaluation* which focuses on the long-range results of the program or project, and changes or improvements as a result (for e.g., long-term maintenance of desired behavior, reduced absenteeism from work, reduced morbidity and mortality); (4) *formative evaluation* which is typically conducted during the development (or formation) of a strategy, program, or product (including trained personnel) to assess (or 'test') their strengths and weaknesses before implementation; and (5) *summative evaluation* which looks at a combination of measures and conclusions for larger patterns and trends in performance, to assess, in summary, whether the program or project overall did what it was designed to do. A good evaluator can help grant applicants identify and select the types of evaluations and related methods needed to determine whether expected results have been achieved.

13. Although pre- and post-activity assessments have been used in past or current evaluation efforts, it is often difficult to see evidence of achievement. Are there better ways to use such assessments for evaluation purposes?

Many times when responding to a pre-activity questionnaire or test instrument, people try to present the best possible image of themselves. As a consequence, the post-activity test instrument may show very little change. Such results are fairly common in evaluations of activities seeking changes in behavior. To be able to measure changes with less bias, an alternative approach may be to use the pre-activity survey retrospectively. That is, the pre-activity survey is not given until *after* the activity, and people are asked to *recall* their opinions or behavior before the activity. Then, the post-activity test instrument is administered. With this technique, the ability to identify and measure change may be improved.

14. What is the difference between a best practice and an evidence-based practice or strategy?

A *best practice* is a program, process, method, technique, or other activity for which effectiveness in achieving specified outcomes/impacts or objectives/goals has been demonstrated or suggested across a number of implementations and evaluations. A best practice may also refer to a way of accomplishing a task that has been determined to be most efficient (least effort or expenditure for result desired) or most effective (best result), based on *repeated use of the practice* for large numbers of people over time. An *evidence-based practice or strategy* is one in which the best *scientific or research evidence* of what is effective for a desired result has been integrated into the effort.

15. Obtaining evaluation expertise to prepare the grant application may be difficult. Is it really necessary?

Yes. Grant applications are more likely to be successful if proposals demonstrate that adequate and appropriate expertise will be available to the project to ensure that expected results can be identified, measured, and achieved. External evaluators are not required, but may be useful in the preparation of evaluation plans. Local colleges and universities with faculty, staff, and graduate students who are engaged in academic research are often good sources for such expertise. However, it is important for such individuals to also have knowledge and experience with the populations and health issues being addressed. Depending upon the culture or the primary language spoken by the target population(s) involved in the project, it may be necessary for the evaluators to also understand that culture and speak the language of the population(s) in question. Grant applicants should note that evaluation training and targeted technical assistance on evaluation are provided to new grantees by OMH contractors shortly after award.

16. Do evaluation results need to be submitted to OMH? If so, how are such results submitted?

All OMH grantees are required to submit program/project data and results via OMH's Performance Data System (PDS) and through requested reports. The PDS is OMH's web-based system for collecting and reporting performance data across all OMH-funded programs and projects. It is organized to reflect the logic depicted in the Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities, and emphasizes outcome-oriented measures that are more clearly linked to OMH-wide outcomes and longer-term objectives and goals. Further details and training on the PDS and OMH reporting requirements will be provided to all new grantees at a time specified by OMH following grant awards.

17. Are there other resources that OMH would recommend to guide the development of our evaluation plan?

OMH's evaluation planning guidelines suggest several resources for more information on logic models. These include, but are not limited to:

- The University of Wisconsin-Extension web site at http://www1.uwex.edu/ces/lmcourse
- http://www.uidaho.edu/extension/LogicModel.pdf
- http://www.wkkf.org/knowledge-center/resources/2010/Logic-Model-Development-Guide.aspx

In addition, the Centers for Disease Control and Prevention provides a set of evaluation resources in a variety of topical areas, available at: http://www.cdc.gov/eval/resources.htm.