

# **An Evaluation Protocol**

For Systematically Evaluating Efforts to Improve Racial and Ethnic  
Minority Health, Reduce Health Disparities, and Effect Systems  
Approaches

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# **THE OMH EVALUATION PROTOCOL**

## ***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 and activities funded contribute to improvements in the health of racial and ethnic minorities, reductions in health disparities that place a greater burden of preventable disease/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 and strongly encourages such plans and their implementation in minority health-/health disparities-related efforts funded or otherwise supported by the office, its partners, and other stakeholders.

This document provides guidance—using a nine-step *Evaluation Protocol* (the *Protocol*)—for OMH grant applicants/awardees, contractors, other funded partners, and other stakeholders on the development and implementation of such an evaluation plan that clearly articulates how proposed projects and activities will be evaluated to determine if intended results have been achieved (see Attachment 1 for a brief glossary of terms). Using this *Protocol* is intended to promote more systematic and consistent processes for evaluations of efforts that are linked to OMH’s overall approach to its mission. This approach is outlined in *A Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities* (the *Framework*), developed by OMH.

## ***THE STRATEGIC FRAMEWORK***

The *Framework* (see Attachment 2) is a document 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/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 two principal goals of *Healthy People 2010 (HP2010)*: 1) to increase the quality and years of healthy life, and 2) to eliminate health disparities. (For additional information, see <http://www.healthypeople.gov>.)

## ***THE EVALUATION PROTOCOL***

The *Framework* serves as the basic guide for identifying nine steps that OMH grant applicants/awardees, other OMH-funded partners, and other stakeholders need to consider and incorporate into their plans for evaluating projects and activities funded or otherwise supported to address minority health/health disparities problems. These steps help answer the following questions:

- What problem is (or problems are) the proposed project or activity (activities) addressing?
- What are the key factors (from those outlined in the *Framework*) contributing to or causing the problem (or problems)?
- What data are available to shed light on the problem (or problems) and contributing/causal factors?
- What factors in the *Framework* do the project and activity (and activities) address?
- What activities make sense to conduct with respect to the factors that are being addressed? Are these activities best or evidence-based practices (that is, is there evidence from previous research or evaluation to indicate that these activities may/will work)?
- What are the expected outcomes and/or impacts, and can they be measured? Have outcomes/impacts from the *Framework* as well as organization-, agency-, and/or program-oriented performance measures been utilized?
- How will activities be tracked, what performance data will be collected, and how will the project be evaluated to determine whether the expected outcomes and impacts have been achieved?

## ***A Step-by-Step Evaluation Process***

Guided by the *Framework*, the nine 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 activities to these problem (or problems) and factors; identifying related outcomes and impacts for the proposed activities; 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 nine steps in their evaluation plans and implementation of such plans.

### **Step 1**

#### **Identify and Define the Problem (or Problems) and Factors to Be Addressed by the Proposed Project and Activity (or Activities)**

**1(a). Identify the particular racial and ethnic minority health or systems problem** (or problems) to be addressed in the proposed State, region, Tribal area, or community. In the *Framework*, two categories of racial and ethnic minority health problems are identified: 1) the presence of preventable disease/disability and/or premature death among racial and ethnic minority populations (i.e., poor health status) and 2) racial and ethnic health disparities in which a greater burden of morbidity and/or mortality exists among racial and ethnic minorities compared to that of the rest of the population. The *Framework* also identifies systems issues that inhibit or promote the ability to effectively impact racial and ethnic minority health problems. Within these broad *Framework* categories of long-term problems, grant applicants/awardees and others developing their evaluation plans should specify the particular problem (or problems) that they are proposing to address (e.g., diabetes, motor vehicle accidents, methamphetamine abuse, lack of access to health care, lack of infrastructure, language barriers).

**1(b). Review and use available data**—where available and appropriate—to support the definition and description of the problem (or problems) to be addressed. Data to support knowledge and understanding about the particular health condition (or conditions), racial and ethnic minority or other target population (or populations), health disparities problem (or problems), and/or systems issue (or issues) to be addressed should be provided as much as possible. In some cases, the problem that the proposed activity 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 and ethnic minority health or systems problems, and factors contributing to such problems, are provided in Attachment 3.

**1(c). 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 effort to be funded by OMH or others will take place. The extent to which addressing the particular priority issues will contribute to the objectives of a particular grant program (e.g., OMH's American Indian/Alaska Native Health Disparities Grant Program), if applicable, a particular office or agency (e.g., OMH), a particular initiative (e.g., the OMH-led *National Partnership for Action to End Racial and Ethnic Health Disparities*), and the *HP2010* objectives for priority racial and ethnic minority health and systems issues should also be described (for reference, see the items below).

- For OMH's grant programs, program-specific objectives are listed in relevant grant program announcements and program guidelines. Most of these are available on the OMH Resource Center Web site at <http://www.omhrc.gov>.
- OMH-wide objectives and priorities related to the *National Partnership for Action to End Racial and Ethnic Health Disparities* are also identified in OMH's grant program guidelines as well as on the OMH Resource Center Web site at <http://www.omhrc.gov>.
- All *HP2010* objectives, including those that are population-based, are identified by focus area on the *Healthy People* Web site at <http://www.healthypeople.gov>. *HP2010* objectives and indicators can also be accessed at <http://wonder.cdc.gov/data2010>. Grant applicants/awardees and others engaged in policy and programmatic efforts to address minority health/health disparities problems are strongly encouraged to take special note of those *HP2010* objectives identified in Attachment 4 for priority health and systems focus areas of particular relevance to racial and ethnic minority health, and those objectives and subobjectives that are not making progress with respect to the particular racial and ethnic minority group (or groups) being targeted (see Attachment 5 for a list of these objectives/subobjectives).

**1(d). Identify contributing or causal factors to be addressed.** In the *Framework*, factors contributing to the long-term problems are divided into three basic categories: 1) individual-level factors (such as knowledge or behavior), 2) community-level factors (such as physical surroundings or community values), and 3) systems-level factors (such as coordination, leadership, or health care access). In developing evaluation plans, grant applicants and others planning their minority health-/health disparities-related efforts should specify the particular factors—in terms of these three basic categories—that are causing or contributing to the priority health or systems issues to be addressed, and provide supporting data to the extent possible.

For example, if the priority issue is diabetes, contributing factors might include the following:

- ***Individual Level.*** Lack of awareness and knowledge about the connections between diet, exercise, obesity, and diabetes. This factor may have been/could be identified through national, State, Tribal, or local surveys of populations susceptible to this disease.
- ***Community Level.*** Lack of public awareness about risk factors related to diabetes, lack of community assets, such as 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. This may have been/could be determined through a community-based needs assessment conducted by the local health department, a task force, or a nonprofit organization.

- **Systems Level.** Lack of coordination between governmental and nongovernmental stakeholders (e.g., health plans, voluntary health agencies, academic institutions) and at-risk communities to ensure appropriate community involvement and to leverage resources, expertise, and other assets to address the priority issue at hand; the lack of strategic planning to guide leadership action and assess progress toward established diabetes prevention and management objectives and goals; 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. Data from recent community consultations, task force reports, the U.S. Census, and the like could be used to inform knowledge and understanding about such systems factors.

## Step 2

### **Specify ‘Best’ or ‘Evidence Based’ Strategies and Practices Being Employed in Proposed Project Activities in Relation to the Causal or Contributing Factor (or Factors) in the Framework to Be Addressed**

**2(a). 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 (or issues).

**2(b). Draw from existing science or knowledge about ‘promising,’ ‘best,’ or ‘evidence based’ strategies and practices (i.e., ‘what works’).** As much as possible, proposed activities and/or interventions should build upon existing science and knowledge about “what works.” The questions that grant applicants/awardees and others planning their programmatic efforts should answer are the following: What is the basis for believing that the project and activities proposed are likely to be *effective* in addressing the priority problem (or problems) and contributing/causal factors identified? What evidence exists from expert consensus panels, peer-reviewed scientific journals, research findings, or evaluation studies to suggest that the proposed strategy or practice has promise or may/will yield a meaningful result? The *Framework* itself was developed after extensive reviews of the literature to identify what is/is not known about how to address racial and ethnic minority health problems. For example, the recommendations of the AHRQ-based U.S. Preventive Services Task Force, at <http://www.ahrq.gov/clinic/uspstfix.htm#Recommendations>, and those of CDC’s 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 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>).

**2(c). Organize proposed project activities.** Organize selected project activities to facilitate a clear link between the activities, the contributing/causal factors and priority problems being addressed by the activities, and the three basic *Framework* categories (i.e., individual level, community level, and systems level) in which the factors fall. This will help later in fulfilling subsequent steps in this *Protocol*.

In the diabetes example, using the *Framework* categories for the contributing factors identified earlier, examples of how different kinds of activities might be organized are provided below:

- ***Individual Level.*** Individually oriented health education through tailored channels (e.g., health care providers or faith-based organizations) is a well-established strategy for addressing the *lack of individual awareness and knowledge* about healthy lifestyle behaviors, such as diet, exercise, and weight control, and their importance in preventing or managing diseases such as diabetes.
- ***Community Level.*** Providing community-based health education or communication campaigns through local media channels, schools, and community organizations has been proven to be effective in *increasing public awareness* about health risk factors, such as those associated with diabetes. Establishing 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 can promote the *provision of community assets*, such as healthier food choices and safe venues for sports and recreation that will encourage more nutritious diets and increased exercise and fitness among community residents, and be beneficial to all stakeholders.
- ***Systems Level.*** The development and implementation of a strategic plan that, in this instance, identifies diabetes prevention and management as a priority, and sets benchmarks and targets to guide action toward established objectives and goals can strengthen *leadership effectiveness* on this issue. Through the establishment of a task force or coalition that brings together key State, Tribal, and community officials and leaders, *coordination and collaboration* on diabetes prevention, care, and management can be achieved for greater effectiveness and resource efficiency in the various jurisdictions involved. The introduction of linguistically appropriate services, such as properly translated written materials and medical interpreters during clinical encounters, is one way 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*” for one particular subset of health care system users.

### Step 3

#### Identify Outcomes/Impacts and Performance Measures for the Proposed Activities

**(3a). Specify expected outcomes/impacts for project activities.** As grant applicants/awardees and others consider and plan their proposed activities, they also need to identify the *outcomes/impacts* (i.e., the results) that might be expected to take place following implementation of their projects and activities. The *Framework* identifies and organizes a broad range of outcomes/impacts that might be expected, with reference to broad strategies and practices and the factors and problems being addressed by such efforts. The evaluation plan should articulate project- and/or activity-specific outcomes/impacts that address one or more of the factors and problems in the *Framework* and that are organized, again, into the three categories or levels (individual, community, or systems) also identified in the *Framework*. For example, increased awareness and knowledge of diabetes and related risk factors is consistent with the broader outcome of “increased awareness/knowledge about disease prevention, risk reduction, and treatment and management for racial and ethnic minorities” in the *Framework* and addresses knowledge (or lack thereof) as a factor at the individual level that may contribute to (or inhibit) good health. The outcomes/impacts identified will guide the design and selection of methods for evaluating the effectiveness of project activities.

**(3b). Identify measures or indicators of expected outcomes/impacts.** 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 be contemplated here 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 activities. 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) to carry out the program or activity to produce an output or outcome.
- ***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.
- ***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).

- **Outcome Measure.** a measure of an event, occurrence, condition, or result of a program or project that indicates achievement of objectives and goal (or goals); 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 with 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 (or types) of measures identified will inform the data collection plan and procedures in support of evaluation. For example, increased individual awareness and knowledge of diabetes and related risk factors may require outcome measurement, via scores on pretests and posttests, of knowledge levels before and after one-on-one or group-oriented education or training sessions.

The specific measures identified and selected by a particular office, agency, or organization will differ depending upon the nature of its mission; how it functions to carry out its mission; the kinds and range of outcomes or impacts that can be realistically expected based on how it functions; the purpose and scope of the policy, program, or research effort (or efforts) being undertaken; the long-term goals and objectives toward which the outcomes and impacts contribute; and the resources, assets, and time available to support the effort (or efforts) and produce desired results. However, while the measures may differ from one entity to another, there should be some common bases for ensuring that individual efforts are connected for cumulative effect and collective impacts, both within and across offices, agencies, and organizations.

***The OMH Example: Developing ‘Core’ and Grantee-Specific Performance Measures.***—Thus, as an example, in OMH’s efforts to identify an initial set of office-wide “core” performance measures, particular consideration was given to

1. OMH’s particular role and functions of leadership, communication, and policy, program, and research coordination
2. The *HP2010* priority and “no progress” objectives for racial/ethnic minorities—discussed in Step 1(c) above and presented in Appendices E–4 and E–5—that provide the national context, priorities, and associated agendas for OMH, its HHS and other Federal partners, and other stakeholders
3. The five overarching objectives of the OMH-led *National Partnership for Action to End Health Disparities* (NPA) initiative, as follows:
  - Increased awareness of health disparities (in the general public and particular groups) through strategic, coordinated, and consistent communications
  - Strengthened leadership and increased leadership engagement for addressing health disparities at all levels
  - Improved patient-provider interactions

- Improved cultural and linguistic competency in health care
  - Improved coordination and utilization of research and outcome evaluations that identify and advance community solutions
4. How OMH-wide “core” measures would, then, provide the broader context for grant program- and grantee project-specific measures

***OMH-Wide ‘Core’ (Recommended and Developmental) Measures.***—This resulted in the following initial set of “core” recommended or developmental performance measures for OMH:

### **Healthy People**

- Number and percentage of racial/ethnic minority-specific *HP2010* objectives and subobjectives not making progress toward—or moving away from—targets that are being addressed by OMH grantees and other partners (data source: National Center for Health Statistics [NCHS])
- Number and percentage of *HP2010* objectives and recommended practices for priority racial/ethnic minority health and systems issues that are being addressed by OMH grantees and other partners (data source: OMH Uniform Data Set)

### **Community and Individual Awareness and Knowledge**

- Percent of persons in the general public with awareness or understanding of racial/ethnic minority health and health disparities problems (data source: Survey of Public Awareness by the National Opinion Research Center)
- Number and percent of individuals at the program or project level with increased awareness and knowledge about racial/ethnic minority health/health disparities problems, the need for a systems approach to such problems, and how to more effectively identify and effect solutions (data source: OMH Uniform Data Set)

### **Leadership and Coordination**

- Number of States, OMH grantee organizations, and other OMH partners with health disparities-related strategic plans (data source: OMH Uniform Data Set or a survey by the Association of State and Territorial Health Officials [ASTHO])
- Number of partnerships with a focus on racial/ethnic minority health, health disparities, and/or systems approaches to these problems (data source: OMH Uniform Data Set or ASTHO Survey or NPA Partnership Review Process/NPA Web site)
- Number of HHS-supported partnerships to strengthen research, demonstrations, and evaluation (RD&E) specifically focused on racial/ethnic

minority health, health disparities, and systems approaches to such problems (data source: to be determined)

### **Patient-Provider Interactions**

- Percent of adult patients who had a negative experience of care (data source: Medical Expenditure Panel Survey [MEPS])
- Percent of hospital patients who did not have good communications with doctors or nurses (data source: Consumer Assessment of Health Plans Survey)

### **Cultural and Linguistic Competency in Health Care**

- Percent of limited-English-proficient individuals with and without usual source of care that offers language assistance (data source: MEPS)
- Number of persons who participated in HHS-supported ‘pipeline’ programs to increase racial/ethnic minority representation in the public health, health care, and research workforce (data source: to be determined)

### **Research and Outcome Evaluations**

- Proportion of population-based *HP2010* objectives for which national data are available for all racial/ethnic minority population groups identified for the objective (Centers for Disease Control and Prevention/NCHS Data 2010 for *HP2010* Objective 23.4)
- Number of HHS-supported RD&E and special studies to improve racial/ethnic data and develop new knowledge about minority health/health disparities problems and solutions, and systems approaches to such problems and solutions (data source: to be determined; HHS Policy Information Center Database?)
- Number of coordinated, HHS-supported RD&E initiatives/programs (data source: to be determined)
- Number of reports from coordinated, HHS-supported RD&E initiatives/programs that strengthen knowledge and understanding of racial/ethnic minority health-/ health disparities-related problems, solutions, and systems approaches to such problems and solutions (data source: to be determined)
- Number of “best” or “evidence based” strategies and practices identified to inform planning and evaluation of minority health/health disparities efforts and systems approaches to such efforts (data source: to be determined)

The above set of “core” OMH-wide measures is being further developed and refined as better measures and data sources are identified or established. In the interim, the “core” OMH-wide measures have been used to inform the establishment of an initial set of required and optional measures at the OMH grantee level, so that the grantee measures link and contribute to the

OMH-wide measures. The grantee measures identified and presented below were included in OMH's *Evaluation Planning Guidelines for Grant Applicants*, which was issued, for the first time, as part of the new grant program announcements in June 2007. Such measures are identified below:

### **Selected Measures for All OMH Grantees**

- Number of *Healthy People 2010* objectives for priority racial/ethnic minority health and systems issues (as specified by OMH) that are being addressed by the OMH grantee (see Attachment 4)
- Number of measurable, racial/ethnic minority-specific *Healthy People 2010* objectives and subobjectives that have not made progress toward—or are moving away from—their targets that are being addressed by the OMH grantee (see Attachment 5)
- 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 program participation
- Number of racial/ethnic minority health improvement- and/or health disparities-related strategic plans developed to facilitate leadership and organizational effectiveness
- Number of partnerships facilitated and/or established to enhance coordination and collaboration on racial/ethnic minority health/health disparities problems

### **Selected Optional Measures for OMH Grantees**

- Change in number of limited-English-proficient individuals with usual source of health care that offers language assistance as a result of OMH-funded activities
- Percent of racial/ethnic minority adult patients with improved experiences of care as a result of OMH-funded activities
- Percent of racial/ethnic minority hospital patients who have good communications with doctors or nurses as a result of OMH-funded activities
- Number of persons who participated in OMH grantee-facilitated or -supported “pipeline” programs to increase racial/ethnic minority representation in the public health, health care, and/or research workforce
- Number of “best” or “evidence based” strategies and practices identified as a result of OMH-funded efforts

These two lists of grantee measures are illustrative of how such measures have been selected and designed to link to broader OMH-wide “core” measures for *HP2010* priority and “no progress” objectives and the NPA objectives. Other measures of efficiency and of capacity building (through staff hiring, training, and technical assistance) are not included here. In addition to the common measures to be used by all OMH grantees, at least two measures from the optional list must be chosen by each grantee based on the nature of the funded project activities. OMH

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

***A Diabetes Example.***—As further guidance for this step in the evaluation plan, the following example for diabetes illustrates possible outcomes/impacts, mandatory performance measures, and optional performance measures for each level identified in the *Framework*.

### **Individual Level**

#### ***Outcomes/Impact (or 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

#### ***Mandatory Measure (or Measures):***

- Number/percent of individuals with increased awareness and knowledge

#### ***Optional Measure (or Measures):***

- Number and type of training events on the impact of diabetes in racial and ethnic minority communities, disease prevention, risk reduction, treatment, and management
- Number of people trained at these training events

### **Community Level**

#### ***Outcomes/Impact (or Impacts):***

- 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

***Mandatory Measure (or Measures):***

- Number of grantee-initiated partnerships that promote coordination and strengthening of community assets, such as healthy restaurant choices and exercise/fitness facilities, for diabetes prevention and control

***Optional Measure (or Measures):***

- Proportion of adults with diabetes whose condition has been diagnosed as a result of initial screening and referral from community-based health events
- Number of adults with Type 2 diabetes who receive diabetes self-management education in community gathering places

**Systems Level**

***Outcomes/Impact (or Impacts):***

- Increased partnerships and collaborations for greater community involvement and to identify and leverage resources, expertise, and other talent that could be directed toward diabetes prevention and management
- Increased strategic planning with goals, objectives, and benchmarks for diabetes prevention and reduction in the community
- Increased system design characteristics to minimize for racial and 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

***Mandatory Measure (or Measures):***

- Number of grantees addressing two or more of the *HP2010* objectives related to the diabetes priority issue area
- Number of grantees addressing two or more of the *HP2010* diabetes-related objectives that are not making progress
- Number of partnerships facilitated and/or established by the grantee organization to enhance coordination and collaboration to address the health care needs of community residents with diabetes

- Number of strategic planning documents, with established goals, objectives, and benchmarks developed to promote and monitor improvements in priority health issues, such as diabetes prevention and control
- Number of projects implemented to increase availability of, access to, and use of data and information on American Indian/Alaska Native (AI/AN) individuals with diabetes in Tribal communities, in order to guide policy and program decision-making by Tribal leaders, managers, and staff concerning prevention and control of this priority health condition

**Optional Measure (or Measures):**

- Percent of limited-English-proficient individuals with diabetes who have a source of health care that offers language assistance
- Number of reports that identify diabetes-related issues/needs and/or effective strategies and practices to address this priority health concern in AI/AN communities

**Step 4**

**Tie Outcomes/Impacts and Measures to Long-Term Objectives and Goals**

4(a). Link the outcomes/impacts and performance measures specified for the proposed activities to grant program, OMH, and *Healthy People 2010* objectives and goals. As was stated earlier, effectively addressing racial and ethnic minority health problems and systems approaches to such problems supports the broader objectives and goals in *HP2010* (<http://www.healthypeople.gov>) to improve health status and eliminate health disparities for the U.S. population as a whole. The results of OMH-funded efforts, including, but not limited to, its grant programs and projects, as well as those efforts by OMH’s partners and other stakeholders, must, therefore, contribute to relevant program-specific, office-/agency-/organization-wide, and *HP2010* objectives and priorities—which, in turn, contribute to the long-term *HP2010* goals. Consistent with information provided in Step 1(c), in order to show the relationship between proposed project activities with program, OMH, and *HP2010* objectives and priorities, grant applicants/awardees and others should identify and describe how the outcomes/impacts and performance measures for their proposed efforts will contribute to relevant program, office-/agency-/organization-wide, and *HP2010* objectives and goals.

In the diabetes example, the outcomes/impacts and measures identified in Step 3 above could contribute to progress on such priority *HP2010* objectives as

- **Objective 5.1.** Increase the proportion of persons with diabetes who receive formal diabetes education

- **Objective 5.12.** Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement at least once a year, an annual dilated eye examination, and an annual foot examination
- **Objective 5.17.** Increase the proportion of adults with diabetes who perform self-blood-glucose-monitoring at least once daily
- **Objective 19.17.** Increase the proportion of physician office visits made by patients with a diagnosis of cardiovascular disease, diabetes, or hyperlipidemia that include counseling or education related to diet and nutrition
- **Objective 22.1.** Reduce the proportion of adults who engage in no leisure-time physical activity
- **Objective 23.12.** Increase the proportion of Tribal, State, and local health agencies that have implemented a health improvement plan and increase the proportion of local health jurisdictions that have implemented a health improvement plan linked with their State plan

**(NOTE: ALL OF THESE OBJECTIVES, WITH THE EXCEPTION OF 23.12, ARE NOT MAKING PROGRESS TOWARD THE TARGET FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.)**

## Step 5

### **Develop a Logic Model or Diagram, Guided by the Framework and Program Objectives, for the Proposed Project and Activities**

Logic models originate from the evaluation field and are simply a kind of tool often used by program planners and evaluators to present the theory or rationale (i.e., the logic) behind the actions or activities being proposed or done, and how such efforts relate to the problem being addressed and the anticipated results. Just as the steps carried out in the development of the *Framework* (see Attachment 2), using a “logic model approach,” laid out the logic behind what needs to be done to address racial and ethnic minority health problems and systems approaches to these problems, 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, but are by no means limited to

- <http://www.uidaho.edu/extension/LogicModel.pdf>
- <http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf>
- <http://www.cdc.gov/eval/resources.htm#logic%20model>

In order to ensure a rational approach to programmatic efforts aimed at racial/ethnic minority health problems and systems approaches to these problems, the development and submission of logic models or diagrams that clearly link activities to broader program- and OMH-wide

objectives and goals are now required or, at least, strongly encouraged, in grant applications and proposals for projects and activities to be funded by OMH. Such models or diagrams should help to guide subsequent plans for collecting data on and evaluating the project and activities to determine whether expected outcomes/impacts have, in fact, been achieved. Incorporate or promotion of logic models or diagrams in efforts funded or otherwise supported by OMH's partners and other stakeholders would contribute to more systematic planning and evaluation of individual and collective policy, program, and research actions and activities related to minority health and health disparities. Examples of a logic model worksheet and logic model template are provided for this purpose (see Attachments 6 and 7).

For the diabetes example, the contributing factors, activities aimed at these factors, and expected outcomes/impacts of these activities would be similarly incorporated into a logic model or diagram (see Attachment 8).

## **Step 6**

### **Obtain Appropriate Evaluation Expertise and Determine Evaluation Methods and Research Design**

#### **6(a). Involve individuals who know about evaluation, the community, and the project.**

Once logic models are developed, individual (or individuals) should be identified who have expertise to plan, design, and implement the evaluation of project or program activities 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.

Enlisting external evaluators for this purpose can be useful if individuals with adequate and appropriate evaluation expertise are not readily available within the office or organization planning to carry out the program or project. 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 firsthand 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, other relevant program managers and administrators, and funding organizations such as OMH produce the strongest possible evidence of outcomes/impacts or other meaningful results of the project (or projects) and program (or programs) being funded or otherwise supported.

**6(b). Identify Evaluation Methods.** Multiple evaluation methods may be used to determine the effectiveness of parts and/or all of the total project or program. Generally, the types of evaluation methods used to provide information to program/ project managers, staffs, funding agencies, and other stakeholders about the results of their efforts are categorized as process, outcome, or impact evaluations and formative or summative evaluations—described briefly below (also see the glossary of terms in Attachment 1):

- ***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.
- ***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.
- ***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 (or audiences), as in the case of campaign strategies, products, or messages that are ‘pretested’ 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 toward improvement. Examples of formative evaluations are needs assessments, evaluability assessments, and process evaluations.

- **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).

**6(c). Select a Research/Evaluation Design.** The ability to identify the effectiveness of strategies, interventions, and activities—and to determine ‘best’ practices—is dependent on the strength or rigor of the evaluation design. The greater the rigor, the greater the ability to produce strong evidence that the particular approach, intervention, or activity itself was responsible for a specified outcome or impact documented through the data collected. More rigorous evaluation designs will use control groups (i.e., people who do not get the intervention) for comparison with those who do get the intervention (i.e., experimental groups). In the most rigorous designs, people will also be randomly assigned to either the intervention or control group. Generally, research designs can be categorized as experimental designs, quasi-experimental designs, and nonexperimental designs—from the more rigorous to the less rigorous—as follows:

- **Experimental design (the “gold standard”)**—in which 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.
- **Quasi-experimental design**—in which 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 outcomes/impacts, 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.

- ***Nonexperimental design***—in which 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, pretests/posttests, ethnographic studies, and document reviews (e.g., medical records, intake and discharge forms). Because nonexperimental 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.

Although there are benefits and drawbacks to each type of design (e.g., cost, expertise to measure impacts, availability of participants for particular studies, and time required to observe outcomes), a range of methodological designs and approaches are clearly available for evaluation. Depending on the evaluation needs, multiple designs and methods may also be used. Most grantee organizations at the community level do not have the resources or expertise available to implement the most rigorous designs. However, choosing the highest level of rigor that can be feasibly carried out with the available resources is encouraged.

Referring to the earlier diabetes example, a nonexperimental design could be used to measure the effects of individually or group-oriented patient education/counseling on diabetes management by administering a pretest/posttest, with a 6-month follow-up administered to those patients who received the intervention. At the community level, a survey could be conducted of low-income neighborhood restaurants or grocers to assess changes in the availability of healthier food/menu choices following a community-based partnership and campaign to promote such options for its residents. At the systems level, a process evaluation could be employed with site visits or interviews to analyze the nature and extent of efforts to promote strategic planning or coordination focused on diabetes prevention and control.

## Step 7

### Develop Data Collection Plan, Protocols, and Forms/Implement the Evaluation

**7(a). Develop Data Collection Plan.** Once the evaluation design, methods, and measures for assessing program/project results (outcomes/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 (or sources) 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) 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 Attachment 9 for a sample data collection plan template and a completed plan based on the diabetes example.)

Evaluation and data collection plans should be implemented at the beginning of a program or project, in order to capture and document activities and actions contributing to relevant outcomes and impacts.

**7(b). 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, the following:

- ***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/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.

Attachment 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, and so forth.

**7(c). Implement Evaluation and Fulfill OMH and/or Other Reporting Requirements.** Once the data collection plan and procedures are developed, it is necessary to train program/project staff, as applicable, to follow data collection protocols, enter data, and prepare reports. Evaluation personnel on the project team may be able to assist with such training depending on the nature and extent of their involvement in the development of the data collection plan and

related procedures; otherwise, they will need to be included in the training as well. OMH and numerous other HHS offices and agencies have Web-based data systems in place or under development to facilitate the collection, management, and reporting of activity- and performance-related information at the grantee, program, and/or funding entity levels. All OMH grantees are required to submit data to OMH via the Uniform Data Set (UDS), a cross-program, uniform data reporting system that was developed to support OMH's efforts to monitor progress for its funded efforts. The UDS is currently organized around a set of data categories based primarily on the types of activities being implemented. However, data requirements—and the UDS—are under review and will evolve in order to ensure that data collected by OMH's grantees and other funded partners are appropriately outcome and performance oriented. Further details and training on the UDS and OMH reporting requirements is usually provided to all new grantees at a time specified by OMH following grant awards.

## **Step 8**

### **Analyze the Data and Assess the Significance of the Evaluation Results**

With the assistance of the individual (or individuals) on the project team who have evaluation and data analysis expertise, appropriate analytical techniques will need to be used to review and analyze the data that are collected throughout and at the completion of program or project activities. Determining the meaning and importance of evaluation results depends both on the design and data collected as well as the analysis of the data. The degree to which results of an entire grant program, project, and/or particular project activities contributed to program objectives and goals, as well as to broader OMH objectives and goals as outlined in the *Framework*, will determine the *significance* of the funded effort. Issues to consider include the following:

- What relevance and importance do the results of the evaluation have on current knowledge and science about how to improve racial and ethnic minority health, reduce racial and ethnic health disparities, or improve systems approaches to these issues? Were the results of the program or project statistically significant (i.e., how likely or unlikely were the results to have occurred by chance)? How did the results of the program or project demonstrate its success in achieving the intended outcomes/impacts?
- What evidence is available to determine whether the funded effort was cost efficient or cost effective?
- What implications do the project's results (outcomes and impacts) have for researchers, practitioners, policymakers, and other stakeholders working toward health improvements for racial and ethnic minorities and the general public?
- How did the evaluation validate the effectiveness of an already proven program model, a component of an already proven program model, an adaptation of such a model, or a new model?
- What were the "lessons learned?" Were there particular lessons learned about the health issues themselves, about the population (or populations) involved,

about the program's or project's approach to the issue or population, or about the methods used to evaluate effectiveness?

## **Step 9**

### **Prepare a Final Report and Disseminate Findings**

Results of the evaluation will need to be summarized and submitted to OMH or other appropriate entities via a final report and/or other required reports. It is also very important to report and disseminate evaluation data and other project findings to practitioners, researchers, and community stakeholders whose work can be strengthened by the results. The data generated are the “tools” that programs or projects have to document what has been achieved. This is a critical element in expanding the knowledge base, especially in the realm of racial and ethnic minority health improvement and health disparities reduction, because others can then build on what has been done, in a continual process of learning and improvement. Therefore, the evaluation plan should include an initial dissemination plan that identifies potential recipients or users of program or project findings, as well as appropriate methods for disseminating such information and reports to these audiences.

## ***CONCLUSION***

The *Evaluation Protocol* is based on the *Framework* developed by OMH to facilitate more systematic planning, testing, documentation, and use of evidence-based strategies and practices that really work. By following this *Protocol*, OMH grant applicants/awardees and others engaged in efforts to address racial/ethnic minority health and health disparities problems will be guided through a careful evaluation planning process designed to increase the ability of OMH- and other funded activities to produce meaningful results in return for the investment in such efforts. The ultimate goal is to improve the health and well-being of racial and ethnic minorities in the United States; 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.

**Attachment 1**  
**Glossary of Terms**

## **GLOSSARY OF TERMS**

***For reference, the following is a brief glossary of terms used in the Evaluation Protocol.***

*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 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 systematic data reporting system developed for all OMH-funded activities that organizes data collection and reporting by type of activity conducted. The UDS is an Internet-based system.

## **Attachment 2**

# ***A Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Disparities (the Framework)***

# **A STRATEGIC FRAMEWORK FOR IMPROVING RACIAL/ETHNIC MINORITY HEALTH AND ELIMINATING RACIAL/ETHNIC HEALTH DISPARITIES**

Office of Minority Health  
U.S. Department of Health and Human Services  
Rockville, Maryland  
January 2008

## ***Suggested Citation:***

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## ***Preface***

Although the health of all Americans has continued to improve over the more than two decades since the 1985 *Task Force Report on Black and Minority Health* was issued, racial and ethnic health disparities persist and, in some cases, are increasing. The persistence of such disparities suggests that current approaches and strategies are not producing the kinds of results needed to ensure that all Americans are able to achieve the same quality and years of healthy life, regardless of race/ethnicity, gender, and other variables (as reflected in the two overarching goals of *Healthy People 2010*).

The mission of the HHS Office of Minority Health (OMH) is to improve the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate disparities. OMH has a unique leadership and coordination role to play within the Department and across the Nation relative to this mission. However, such a mission cannot be accomplished by OMH alone. We need the active engagement and sustained efforts over time of all stakeholders working together with us and each other to effect the necessary changes at every level and across all sectors. These stakeholders include racial and ethnic minority communities and those who serve them, other HHS and Federal entities, academic and research institutions, State and Tribal governments, faith- and community-based organizations, private industry, philanthropies, and many others. We also need to examine what we are doing, identify what must be done differently, and determine how best to work together – within and across our respective disciplines, areas of interest, organizational/institutional or geographic boundaries, and spheres of influence – to enhance our individual and collective effectiveness and impacts.

The *Strategic Framework for Improving Racial and Ethnic Minority Health and Eliminating Racial and Ethnic Health Disparities (Framework)* presented here is intended to help guide, organize, and coordinate the systematic planning, implementation, and evaluation of efforts within OMH, HHS, and across the Nation to achieve better results relative to minority health improvements and health disparities reductions. The *Framework* is reflective of current knowledge and understanding of the nature and extent of health disparities, their causes or contributing factors, effective solutions, and desired outcomes and impacts. As such, it reinforces the importance of having and using existing science and knowledge as the basis for planning and implementing our program-, research-, or policy-oriented actions and activities. The *Framework* also suggests the need to adequately evaluate our efforts so that new knowledge gained can be used for continuous improvement. In addition, the *Framework* infers the need to fund our efforts accordingly, and to explore ways to enhance efficient use of programmatic and research funds as well as other resources and assets at our disposal.

Several aspects of this framework are worth highlighting:

- 1) By using a logic model approach which builds upon current science and expert consensus about racial/ethnic minority health/health disparities and systems problems, contributing or causal factors, and strategies that work, **the *Framework* provides the rationale for efforts funded and conducted as well as for the kinds of outcomes and impacts needed.** This approach can be used as a guide to better move us in the same general direction towards a common set of objectives and goals.
- 2) In addition to identifying the usual determinants of health, **the *Framework* emphasizes the role that “systems-level factors” play in promoting or inhibiting the effectiveness of strategies and practices aimed at improving racial and ethnic minority health or reducing racial and ethnic health disparities.** These systems factors include: the nature and extent of available resources and how they are used; coordination and collaboration through partnerships and communication; leadership and commitment through strategic visioning and sustained attention; user-centered design in which the products and services of the system are conceived with the needs of their users in mind; and the use of science and knowledge to inform programs and policies.
- 3) Ultimately, **the *Framework* presents a vision—and provides the basis—for a “systems approach” to addressing racial/ethnic minority health problems within and outside of HHS.** A systems approach implies that all parties engaged, in this case, in racial/ethnic minority health improvement and health disparities reduction are, themselves, part of a ‘system’ or ‘nested’ systems. As such, each party considers the causal or contributing factors and problems it is most likely to be able to impact with its particular strengths and talents. Resources and assets can then be coordinated and leveraged in

more systematic and strategic ways, to achieve a range of outcomes and impacts needed so that, together, all parties can more effectively and efficiently contribute to and achieve long-term objectives and goals. This focus on systems applies as well to how various fields of research work together for greater effectiveness and efficiency to address weaknesses and gaps in scientific knowledge. A systems approach to working across diverse research disciplines may be better able to illuminate our understanding about the nature and extent of minority health and health disparities problems, especially for small population groups; the relative importance of and interrelationships between causal or contributing factors; more effective ways to break the causal chain that produces greater burdens of preventable disease and premature death among racial and ethnic minorities; and the means for measuring desired outcomes and assessing progress.

We believe that the structure and approach outlined in the *Framework* offers a rational and systematic, yet broad and flexible, way of viewing and informing our efforts to achieve the OMH and, in reality, the national mission. We hope that the *Framework* will provide context for the actions needed by OMH and its partners across HHS and the Nation to better leverage resources, establish priorities for ensuring effectiveness of programs and activities funded and conducted, enable identification and promotion of best practices and concrete solutions at all levels, and serve as the foundation for a national results-oriented culture on racial and ethnic minority health improvement and the elimination of racial and ethnic health disparities.

# ***A STRATEGIC FRAMEWORK FOR IMPROVING RACIAL/ETHNIC MINORITY HEALTH AND ELIMINATING RACIAL/ETHNIC HEALTH DISPARITIES***

## **I. INTRODUCTION**

**The Challenge.**—The United States is a diverse Nation. According to 2000 Census data (U.S. Census Bureau, 2000), the population of the United States grew by 13 percent over the last decade, and has increased in diversity at an even greater rate. Racial and ethnic minorities are among the fastest growing of all communities in the country, and today comprise approximately 34 percent of the total U.S. population (U.S. Census Bureau, 2006a, 2). It is projected that, by 2030, 40 percent of the population will be non-White (U.S. Census Bureau, 2004).

Data on health status point to the fact that there is significant evidence of poor health outcomes among racial/ethnic minority populations with respect to premature death and preventable disease. These poor health outcomes for racial/ethnic minorities are reflected in the pervasiveness of health disparities<sup>1</sup> that exist. For example:

- The prevalence of high blood pressure—a major risk factor for coronary heart disease, stroke, kidney disease, and heart failure—is nearly 40 percent greater in African Americans than in Whites (an estimated 6.4 million African Americans have hypertension); and cardiovascular and renal disease damage are more frequent and severe (HHS, 2000a, G-2). In addition, African Americans continue to experience a higher rate of stroke, have more severe strokes, and continue to be twice as likely to die from a stroke as White Americans (HHS, 2000a, G-11).
- Racial and ethnic minority groups, especially the elderly, are disproportionately affected by diabetes. On average, African Americans are 2.1 times as likely as Whites to have diabetes (NCHS, 2006a, Table 55). African Americans with diabetes are also more likely than Whites to experience complications of diabetes, such as amputations of lower extremities (CDC, 2006a) and end-stage renal disease (CDC, 2006b). On average, American Indians/Alaska Natives are 2.3 times as likely as non-Hispanic Whites of similar age to have diabetes (Barnes et al, 2005). Hispanics are 1.7 times as likely to have diabetes as Whites (Lethbridge-Cejku et al, 2006), with Mexican Americans—the largest Hispanic subgroup – more than twice as likely (NCHS, 2006a, Table 55).

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<sup>1</sup>This paper will often use the term “health disparities” to refer to the more precise but longer term “disparities in health care and health status.”

- African Americans are 21 percent more likely to die from all types of cancer than Whites, adjusting for age (NCHS, 2006a, Table 29). African American men are more than 50 percent likelier to die from prostate cancer than are Whites (Ries et al, 2006, Tables I-23 and I-24). In addition, while breast cancer is diagnosed 10 percent less frequently in African American women than in White women (Ries et al, 2006, Tables I-20 and I-21), African American women are 36 percent more likely to die from the disease (Ries et al, 2006, Tables I-23 and I-24). In other minority communities, cancer also takes a disproportionate toll. Among Hispanics, women are 2.2 times more likely to be diagnosed with cervical cancer than non-Hispanic White women (NCHS, 2006b, Table 53). Asian/Pacific Islander women are 2.7 times as likely to fall ill from stomach cancer as non-Hispanic White women (NCHS, 2006b, Table 53), and Asian American men suffer from stomach cancer 93 percent more often than do non-Hispanic White men (Ries et al, 2006, Tables I-20 and I-21).
- Mexican American and African American mothers are more than 2.5 times as likely as non-Hispanic White mothers to begin prenatal care in the third trimester, or not receive prenatal care at all (NCHS, 2006b, Table 7).
- Among adults ages 18 to 64, nearly half of Hispanics (49 percent) and more than one of four African Americans (28 percent) were uninsured during 2006, compared with 21 percent of Whites and 18 percent of Asian Americans ((Beal et al, 2007). African Americans and Hispanics also experience differential access to a regular doctor or source of care, with approximately 43 percent of Hispanics and 21 percent of African Americans reporting that they do not have a regular doctor or source of care, compared with 15 percent of Whites and 16 percent of Asian Americans (Beal et al, 2007).

These health issues have been key public health concerns at the Federal level since the *1985 Secretary's Task Force Report on Black and Minority Health* (HHS, 1985) under then Secretary of Health and Human Services Margaret Heckler. However, data demonstrate that these disparities remain formidable challenges today. Reports of progress on the "reducing health disparities" goal of *Healthy People 2000* (HHS, 1990) showed that, in many respects, racial/ethnic minority populations have remained in relatively poor health, and continue to be underserved by the health care system. In many cases, the health gaps identified in the 1985 *Task Force Report* have grown (NCHS, 2001, 8). The need to address racial and ethnic minority health status and health disparities was reinforced in the two overarching goals of *Healthy People 2010*: to increase the quality and years of healthy life for *all* U.S. populations, and to eliminate health disparities, including those that affect racial and ethnic minorities (HHS, 2000a). The challenge for the U.S. is to adequately address poor racial/ethnic minority health status and persistent racial/ethnic health disparities at a time of rapidly increasing racial

and ethnic diversity. Successfully meeting this challenge will promote the continued strength and vitality of the Nation.

**OMH’s Role and Responsibilities.**—The Office of Minority Health (OMH) resides within the Office of Public Health and Science (OPHS), in the Office of the Secretary of the U.S. Department of Health and Human Services (HHS). Its creation was one of the most significant outcomes of the 1985 *Task Force Report* (HHS, 1985). OMH is a key player in the Federal effort to improve racial/ethnic minority health and to reduce and, ultimately, eliminate racial/ethnic disparities in health care and health status. The OMH mission is “to improve the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate disparities”<sup>2</sup>. This mission statement points to the two key action areas—policies and programs—through which OMH serves as the focal point within HHS for efforts to improve racial/ethnic minority health and eliminate racial/ethnic health disparities.

While OMH is the focal point within HHS for racial/ethnic minority health and health disparities efforts, it is not the only Federal agency involved in efforts to address racial/ethnic minority health and health disparities. Within HHS, a number of agencies and operating divisions engage in extensive activities to improve racial/ethnic minority health and reduce racial/ethnic health disparities. They fund a range of racial/ethnic minority health- and health disparities-related efforts, including health services to underserved (often racial/ethnic minority) communities; community-based health education and health communication campaigns and programs; biomedical, behavioral, and social science research; and health services and community-based prevention research. Such efforts also extend outside of HHS to other public- and private-sector organizations that have a stake in improving the health of racial/ethnic minorities and addressing racial and ethnic health disparities. In spite of these efforts, there is still much room for improvement.

## ***II. BACKGROUND ON THE FRAMEWORK***

**Purpose of the Strategic Framework.**—The purpose of this strategic framework is to guide and organize the systematic planning, implementation, and evaluation of OMH and other efforts aimed at improving racial/ethnic minority health—and reducing and, ultimately, eliminating racial/ethnic health disparities. Efforts include those aimed directly at racial/ethnic minority health problems, but also those that support a “systems approach” to addressing such problems across the country. This systems approach has not been previously available in efforts targeted to racial/ethnic minority health and health disparities issues.

OMH, through the application of a strategic framework, can sharpen the focus, coordination, and dissemination of its work, as well as that of its partners inside and

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<sup>2</sup>Racial and ethnic minorities encompassed in OMH’s mission include Black or African Americans; Asians; Native Hawaiians or Other Pacific Islanders; American Indians and Alaska Natives; and Hispanics who may be of any race.

outside of HHS. The ultimate goal, for all stakeholders, is that individual and collective efforts on behalf of racial/ethnic minority health will be more evidence-based and will use available resources effectively and efficiently. The strategic framework provides:

- **Rationale for efforts conducted and supported:** The *Framework* can provide a rational basis for identifying and developing effective strategies, practices, and other efforts that are conducted and supported by OMH, its partners, and other stakeholders across the country. The *Framework* does this by drawing on existing science and knowledge about the nature and extent of the long-term problems that OMH must address; the factors that contribute to those problems; and the effectiveness of various strategies and practices in addressing those problems.
- **Support for increased quantity and enhanced quality of evaluations of the effectiveness of efforts:** The *Framework* will strengthen OMH's evaluation efforts with its grantees and other partners. Increased quantity and quality of evaluations will help OMH assess whether racial and ethnic minority health improvement and health disparity reduction efforts (funded or supported by OMH and others) are really making a difference and are producing meaningful results.
- **Basis for enhancing effectiveness and efficiency:** The *Framework* can promote the effectiveness and efficiency of efforts by OMH and others to improve racial/ethnic minority health and reduce health disparities through more coordinated and systematic actions.

**Approach to Developing the Strategic Framework.**—To maximize clarity, a logic model approach is employed for developing the strategic framework. Logic models originate from the evaluation field as a way to plan, implement, and evaluate programmatic efforts, and to provide the theory or rationale undergirding what is being done (HHS, 1999; Taylor-Powell, Jones, and Henert, 2002). Similarly, the *Framework* presents the rational basis for efforts related to racial/ethnic minority health and health disparities by tying together the following components typically found in logic models<sup>3</sup>:

- long-term problem(s) to be addressed;
- factors that must be addressed, which contribute to the problem(s);

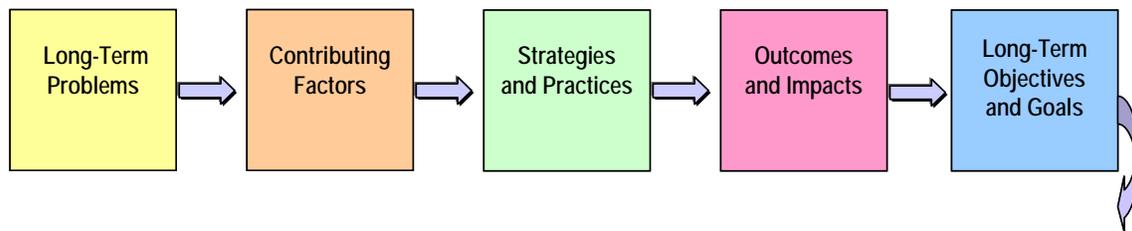
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<sup>3</sup> Numerous sources exist for information on the use of logic models to enhance program performance. Examples include, but are not limited to, the following sources identified in OMH's evaluation planning guidelines: The Centers for Disease Control and Prevention at <http://www.cdc.gov/eval/resources.htm#logic%20model>; the University of Wisconsin Cooperative Extension at <http://www1.uwex.edu/ces/lmcourse>; and the W.K. Kellogg Foundation at <http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf>.

- strategies and practices, and supporting resources, which can be mobilized to address the factors and the problems;
- measurable outcomes and impacts that can be expected to result from implementing the strategies and practices; and
- long-term objectives and goals that can be achieved by effectively producing impacts on the factors and the problems.

Figure 1 is a graphic depiction of the general structure of the strategic framework, which builds upon each of these five components.

**Figure 1. General Structure of the Strategic Framework**



Developing a strategic framework using a logic model development process emphasizes five steps which correspond to each of the components in Figure 1: (1) examination of the *long-term problems* that OMH and others are trying to address; (2) review of the *major factors known to contribute to or cause the long-term problems*; (3) identification of promising, best, and/or evidence-based *strategies and practices* known to impact the causal or contributing factors; (4) presentation of measurable *outcomes and impacts* that might be expected from the strategies and practices; and (5) assessment of the extent to which *long-term objectives and goals* have been achieved.

As the components of the *Framework*—using this five-step logic model approach—were developed, extensive literature reviews and environmental scans were conducted to identify what is known—and not known—about the long-term problems, contributing or causal factors, effective strategies and practices to address the factors, and identification and measurement of expected outcomes and impacts. As necessary, targeted reviews of the literature from fields other than public health and medicine (e.g., systems research) were also carried out to inform OMH’s understanding of the content needed in the *Framework*. In this way, the components and subcomponents of the *Framework* build on existing science and knowledge.

**Considerations and Limitations in Developing the *Framework*.**—The five-step process outlined above results in a strategic framework for addressing racial and ethnic minority health improvements and reducing and, ultimately, eliminating racial and ethnic health disparities. However, several points must be made regarding the task of identifying “best” or evidence-based strategies and practices:

- First, many strategies and practices address multiple contributing factors and may contribute to multiple outcomes and impacts. There is not a one-to-one correspondence or a strictly linear relationship between contributing factors, strategies and practices, and outcomes/impacts.
- Second, there is not adequate scientific evidence to demonstrate the effectiveness of all the strategies and practices that are considered effective. Thus, for some strategies or practices, it will be necessary to rely on expert opinion regarding what might be effective, and to continue to stress the importance of sound and systematic evaluation to determine the effectiveness of particular approaches, interventions, or activities in producing desired results.

Given these limitations and the certainty that any framework will be used within a complex, public policy and decision-making environment, this framework should be viewed as a dynamic, evolving document that provides *guidelines for action* rather than as a linear, predictable model for problem-solving and decision-making.

In addition, the utility of this framework does not end with the achievement of some objectives and goals. Rather, results can and should be used to inform OMH and its partners on their level of success in improving racial/ethnic minority health and tackling health disparities. Thus, any knowledge gained can be incorporated into the continuing efforts of all stakeholders. This process will help OMH, its grantees, and other partners consistently monitor and adjust program and policy efforts in ways that will result in greater effectiveness, efficiency, and success. The logic model approach used in the *Framework* and its general structure can, thus, also serve as a guide for action in a number of ways, and for a variety of public and private entities.

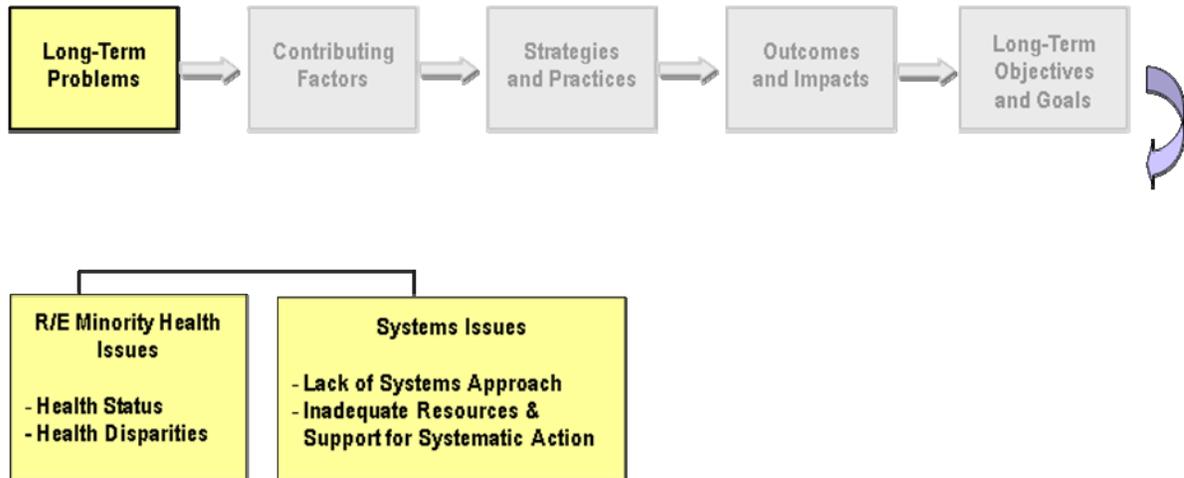
### ***III. THE STRATEGIC FRAMEWORK***

The *Framework* is presented in five sections, organized sequentially into the components presented in the graphic depiction of its general structure shown in Figure 1. Each component of the *Framework*, and the corresponding step toward its development, is discussed separately. The major elements within each of these sections are drawn from the literature, and briefly outlined and discussed below.

#### **► STEP 1: BEGIN WITH LONG-TERM PROBLEMS**

There are two sets of long-term problems that OMH and its partners must continue to address: (1) racial and ethnic minority health problems; and (2) systems issues that inhibit the ability to effectively impact racial/ethnic minority health problems. These long-term problems are depicted graphically in Figure 2.

**Figure 2. Long-Term Problems**



- **Racial and ethnic minority health problems** fall into two categories: racial/ethnic minority health status and, related to that, racial/ethnic health disparities. Racial/ethnic minority health status problems encompass preventable morbidity and premature mortality experienced by racial and ethnic minority individuals and groups without reference to others. Racial and ethnic health disparities entail differences in health status and health care that often reflect a greater burden of morbidity and mortality on racial and ethnic minorities as compared to the majority population.
- **Systems issues** encompass a wide variety of conceptual, organizational, structural, and process-related variables that influence the ability to adequately and effectively address complex problems—and that can exacerbate these problems, or constitute problems in their own right. These variables include the availability of adequate resources to support the systems and the strategies and practices aimed at the problems and contributing factors; the extent to which systems support strategies and practices that are evidence-based as well as systematic planning and evaluation of actions undertaken; the extent to which the systems (and the strategies/practices) are well-coordinated and strategically directed; and the extent to which existing stakeholder groups are willing to work together as parts of an interconnected system. This need for a ‘systems approach’ and systematic actions applies broadly across all efforts conducted for the purpose of improving minority health and reducing health disparities. It also applies specifically to research and evaluation efforts to address gaps and weaknesses in science and knowledge about the nature and extent of racial and ethnic minority health problems and effective solutions to such problems.

The two racial/ethnic minority health issues—health status and health disparities—parallel and link to the two principal goals of *Healthy People 2010*. (HHS, 2000b) Thus, success in addressing racial/ethnic minority health issues will contribute to the achievement of the two central goals of *Healthy People 2010*.

## ► STEP 2: ADDRESS CONTRIBUTING FACTORS

Since the factors contributing to poor racial/ethnic minority health—and to racial/ethnic health disparities—are many and complex, they have been organized into three categories or levels: individual-level factors, environmental-/community-level factors, and systems-level factors.

- ***Individual-level factors*** include the knowledge and attitudes that individuals have about health risks, disease prevention, and treatment; the skills that individuals have to put knowledge into practice; the individual behaviors that have an impact on one's own health or the health of others; and the genetic factors that may enhance or reduce individual susceptibility to particular health conditions. In the graphic representation of the contributing factors component of the *Framework* (see Figure 3), individual-level factors are identified as knowledge, attitudes, skills, behaviors, and biological or genetic risks.
- ***Environmental- and community-level factors*** include the physical environment (both natural and built); social and cultural characteristics of a community; and other economic, political, and organizational/institutional conditions that are not generally within the control of specific individuals but provide the context of their lives. These factors may be either protective of, or pose risks to, health. Such factors include, but are not necessarily limited to: natural and physical hazards or biochemical risks; crime and violence; cultural values and norms that influence individual behavior and can protect or hinder the health and well-being of residents within communities; bias and discrimination; housing conditions and residential segregation; access to and quality of health care as well as schools, parks and recreational sites, nutritious food sources, transportation, and other goods and services; communication networks and infrastructure; family and social networks or other supports for diverse segments of the community; low-income and poverty; unemployment; and the lack of health insurance. For purposes of framework development, environmental- and community-level factors are divided into those related to the physical environment, the social environment, or economic barriers, with the social environment subdivided into

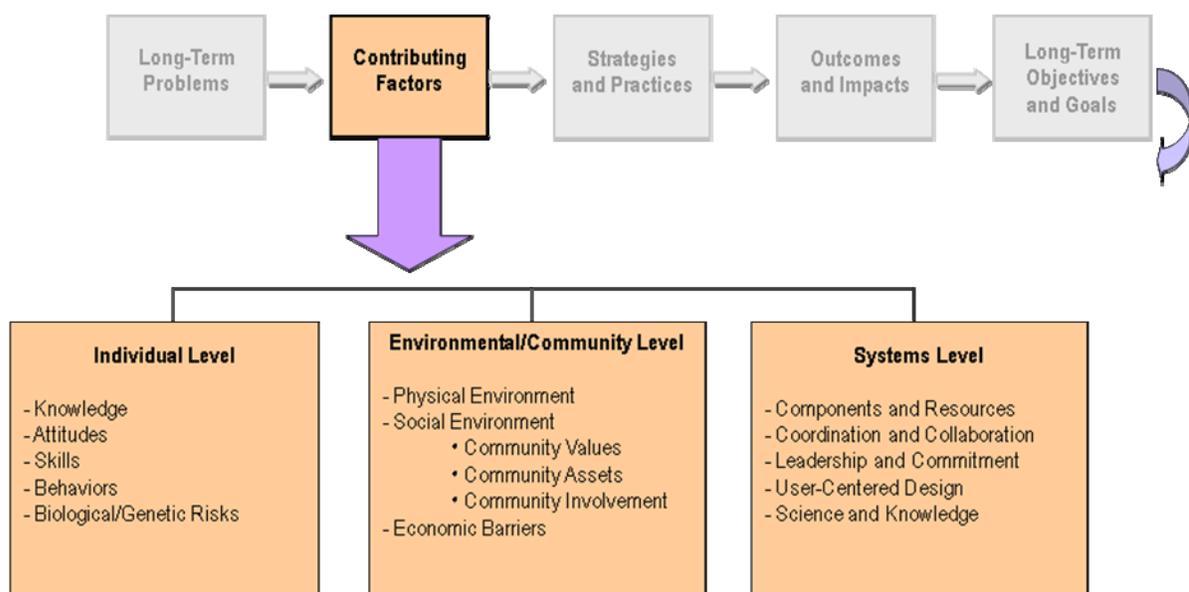
community values, community assets, or community involvement (see Figure 3)<sup>4</sup>.

- ***Systems-level factors*** include the kinds of systems that a community, State, region, or nation might have (or not have), and approaches used (or not used), for identifying the problems or needs—health-related or otherwise—in their respective jurisdictions and for directing resources to address the problems or needs. Whether such systems and approaches (including public health and health care systems and approaches) *effectively* address such problems or needs depends upon the presence or absence of certain factors that are characteristic, or key components, of systems-oriented, systematic, and strategic thinking and actions. These systems-level factors include, but are not limited to: the adequacy, appropriateness, and mix of components, resources, and assets; the effectiveness of efforts to configure, coordinate, and leverage such components, resources, and assets; the extent to which leadership and commitment are provided to direct and sustain the components and the use of resources and assets, especially as guided by a vision and a strategic plan; the nature and extent of information- and knowledge-sharing and supportive infrastructure; the extent to which systems—and the products or services provided by such systems—are designed, implemented, and evaluated with the needs of their users and beneficiaries in mind; and the continued, coordinated, and effective production of research and evaluation results that are widely shared and adopted for continuous improvement. As depicted in Figure 3, in the strategic framework, systems-level factors are organized into five major categories: components and resources; coordination and collaboration; leadership and commitment; user-centered design; and science and knowledge.

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<sup>4</sup> Because these factors are so complex and interrelated, many public health and social science researchers investigate and discuss such factors in combination, rather than as the discrete categories that are shown in this particular framework. The literature (see, for example, Kawachi, Kennedy, and Wilkinson, 1999) is replete with examples of the associations between socioeconomic status (SES) and morbidity/mortality—and the significant implications of SES for health. While problems related to low SES also affect White populations, the greatest impact is on racial/ethnic minorities who are overrepresented in the lower socioeconomic categories.

**Figure 3. Contributing Factors**



These three levels, or sets, of factors interact to form the context for considering health outcomes in general (see Evans and Stoddart, 1990; Green and Kreuter, 1999; Green, Potvin, and Richard, 1996), including those specific to racial/ethnic minority health improvement and health disparities reduction. A good example of an interacting factors model that is organized into levels or categories is the Determinants of Health Model in *Healthy People 2010* (HHS, 2000c). In this model, key categories or factors include biology, behavior, social environment, physical environment, policies and interventions, and access to quality health care. The determinants, or factors, approach to health is used herein to synthesize some of what the literature, research, and expert opinion have identified as the key factors that contribute to racial/ethnic minority health problems and disparities in health status and health care.<sup>5</sup>

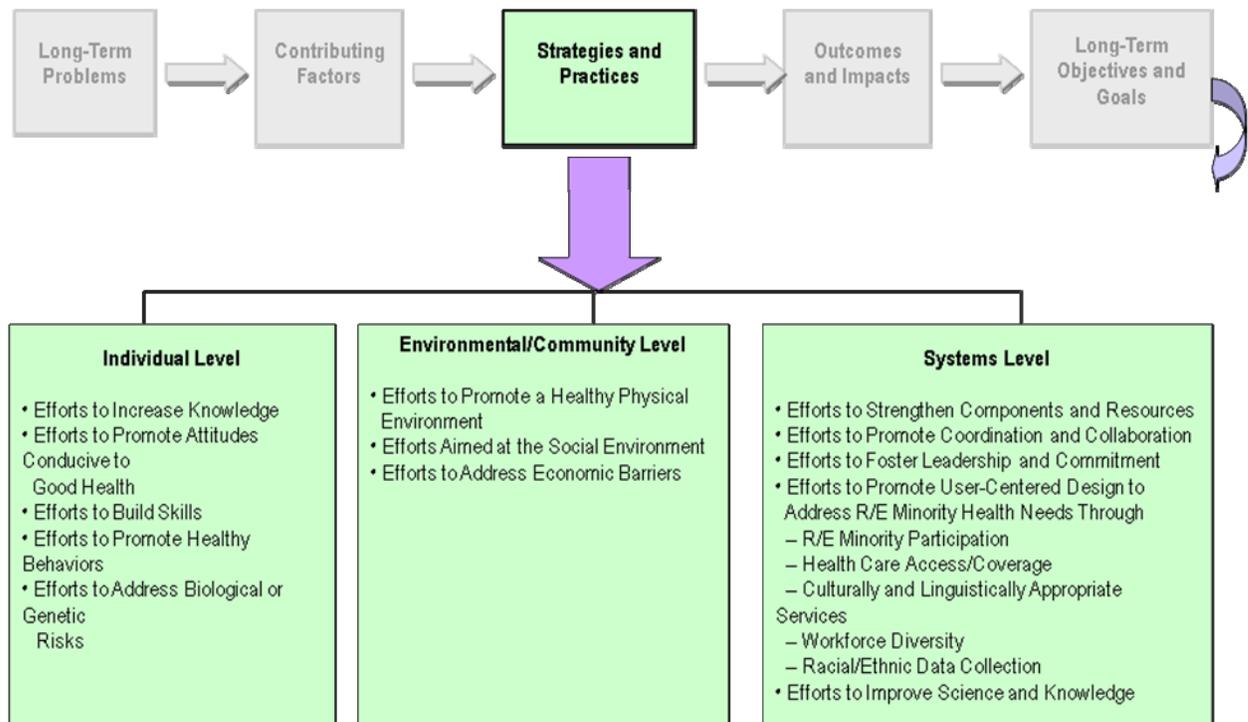
### ► STEP 3: SUPPORT EFFECTIVE STRATEGIES AND PRACTICES

The contributing factors identified above form the basis for the targets to be addressed by a range of strategies and practices employed by OMH and its partners. The strategies and practices discussed in this document represent what current evidence and expert consensus suggest to be successful in impacting contributing factors. Those strategies and practices that address the contributing factors and fit into OMH’s mission are emphasized. It is important to note that many of the strategies and practices may address

<sup>5</sup>Approaches to population health that describe relationships and interactions between multiple determinants of health at the individual and environmental/community levels and how they affect health or illness are sometimes referred to as “ecological models” of health.

several factors at the same time or in sequence, rather than only one factor. A number of strategies and practices are also often effectively combined with others, in more comprehensive approaches. In a number of cases, new strategies or practices need to be developed and tested, as guided by available science and practice. Figure 4 is a graphic depiction of the necessary relationship between the strategies and practices supported and the individual-, environmental-/community-, and/or systems-level factor(s) that cause or contribute to the problem(s) to be solved.

**Figure 4. Strategies and Practices**



- **Strategies and Practices to Address Individual-Level Factors.**— Approaches that address individual-level factors include efforts to increase knowledge, promote positive attitudes, and improve skills that affect decisions about health-related behavior. A broad range of informational/educational methods and materials, dissemination channels, and venues may be used (e.g., written materials, including popular and professional publications; radio and television broadcasts; computer- and web-based technologies; mass media campaigns; and one-on-one or group-oriented education, counseling, and training in schools, clinics, worksites, and community settings). With respect to biological and genetic risks, individual-level efforts include informational, screening, and counseling strategies and practices. Strategies and practices may be aimed at a variety of individuals and groups of individuals, including, but not limited to, those who are racial/ethnic minorities themselves, those meeting some other

***Strategies and Practices to Address Environmental- and Community-Level Factors.***—The strategies and practices included in this category are aimed at those factors that extend beyond individuals, and shape the broader communities and environments within which people live, work, and play. Examples of such efforts are: (1) promotion of a healthy physical environment through the development of policies that promote public health and safety; (2) fostering of a positive social environment by nurturing community values and norms conducive to good health; strengthening community capacity and “assets” for general well-being; and/or increasing community involvement, supports, and networks (i.e., “social capital”) via opportunities for civic engagement and positive social interaction that promote self-reliance, buffer stress, and otherwise protect the health and well-being of diverse members in the community; and (3) provision of health care financing and other initiatives that provide support to poor, low-income, and underserved populations (e.g., children’s health insurance for low-income families, implementation of prescription drug coverage for Medicare beneficiaries). Many other program efforts have tried to link multiple community-based strategies and practices together to address the interactive nature of all of the environmental- and community-level factors influencing health.

- ***Strategies and Practices to Address Systems-Level Factors.***—A review of systems literature and a research synthesis of “effective” public health and health care systems found that effective systems aimed at complex problems have certain characteristics in common. The systems-level strategies and practices recommended in the *Framework* include efforts to:
  - **Establish, increase, and strengthen system components and resources**, such as infrastructure, staffing, and funding to ensure specific attention to racial/ethnic minority health and health disparities. This often involves obtaining resources from mixed funding streams in order to leverage assets and expand the resource base.

- **Promote coordination, collaboration, and partnerships** to build relationships and trust; allow for pooling and leveraging of resources, expertise, and talent; and foster synergies that benefit all involved parties. Such coordination and collaboration requires strong information and communications systems and infrastructure.
- **Foster and ensure leadership and commitment**, including the development and implementation of strategic plans that provide vision and direction, set priorities, and coordinate and target resources. Ideally, strategic plans for addressing minority health and health disparities should draw on existing data on minority groups; incorporate input and feedback from community partners; build upon the best of existing and emerging evidence of successful strategies and practices; structure activities around expected outcomes and impacts tied to goal-setting processes (e.g., *Healthy People 2010*) at the State and Federal levels; and employ performance assessment and evaluation results for continuous improvement. Legislative or regulatory initiatives, executive orders, and other administrative mandates comprise another important set of strategies for ensuring sustained attention and commitment to minority health and health disparities issues.
- **Promote user-centered design to address racial/ethnic minority needs.** Racial/ethnic minorities may be disproportionately impacted by such experiences as lack of access to the public goods and services that are important for health and well-being; limited health care coverage or the inability to pay for health services; lack of trustworthiness on the part of health care and research institutions; racial/ethnic bias or discrimination; cultural and linguistic barriers; and lack of respect because of racial, ethnic, cultural or linguistic differences. Recommended strategies and practices to address these concerns include efforts that: increase participation of racial/ethnic minorities in planning, implementation, monitoring, and evaluation of programs and initiatives intended to meet their needs (i.e., community-based participation); increase health care access and coverage; increase availability of culturally and linguistically appropriate services (CLAS); increase workforce diversity; and improve the collection, analysis, and use of racial and ethnic data for performance monitoring and quality improvement purposes.
- **Improve science and knowledge about successful strategies and practices** through increased and enhanced research,

demonstrations, and evaluation (RD&E). This includes RD&E efforts that strengthen knowledge and understanding about: the nature and extent of minority health/health disparities problems, especially for small or hard-to-reach populations for which data continue to be lacking; the mechanisms by, and extent to, which systems factors inhibit the ability to address minority health and health disparities; the relative importance of the various factors that cause or contribute to the long-term problems and how interactions between these factors promote or inhibit health; effective interventions that not only improve racial/ethnic minority health, but actually reduce racial/ethnic health gaps among populations; effective systems and evidence-based systems approaches to addressing minority health/health disparities problems; and effective methods for disseminating results of research, “translating research into practice and policy,” and “putting practice into research” (making research results “practitioner-centered”). Transdisciplinary approaches to research which can inform more multi-faceted solutions to the long-term problems at hand are also emphasized.

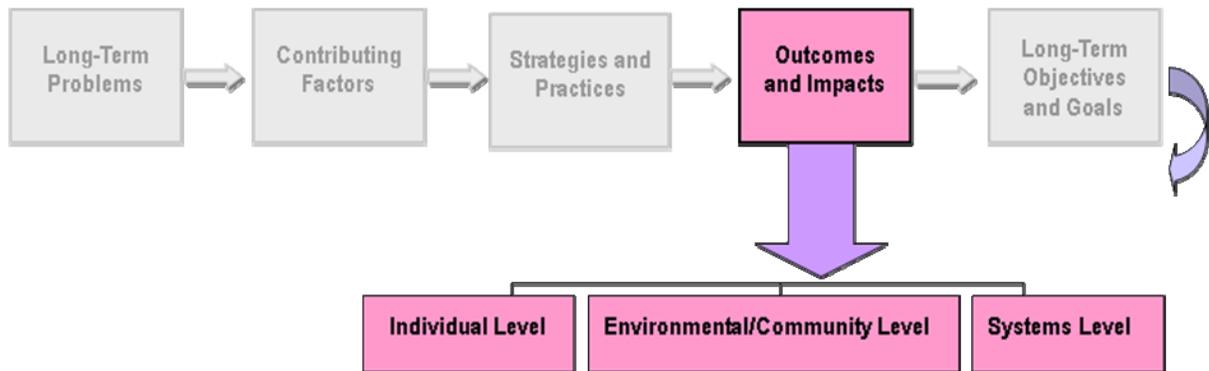
#### ► **STEP 4: MEASURE INTERMEDIATE OUTCOMES AND LONG-TERM IMPACTS**

This step identifies measurable **outcomes and impacts** that might be expected to take place following implementation of the indicated strategies and practices. Such outcomes and impacts relate to the contributing factors. Generally, outcomes refer to short-term results (e.g., increased awareness and knowledge about disease prevention or risk reduction) and impacts refer to long-term results (e.g., reduced morbidity or mortality). The outcomes and impacts include those for which there is actual research evidence as well as those based on expert judgment.

In many current efforts to address racial/ethnic minority health and health disparities problems, the strategies and practices have not been clearly tied to desired or intended outcomes and impacts. Nor have adequate and appropriate evaluations been performed to determine if, indeed, the strategies and practices produce meaningful results. This is a major shortcoming. It is necessary to structure future minority health and health disparity efforts so that they will be more health outcome- and impact-oriented. It is also important to determine the outcomes and impacts of systems-oriented strategies and practices on efforts to effect health outcomes and impacts. Identifying the outcomes and impacts expected from programmatic and policy-oriented minority health/health disparities efforts—as well as systems approaches to addressing minority health/health disparities issues—will inform, and be informed by, future research and evaluations. The *Framework* identifies and organizes a range of outcomes and impacts that might be expected, with reference to the contributing factors and the strategies and practices

already discussed. These outcomes and impacts are organized into three categories, or levels, as depicted in Figure 5.

**Figure 5. Outcomes and Impacts**



A wide range of short-term, intermediate, and longer-term outcomes and impacts are possible and desirable at the individual, environmental/community, and systems levels to move OMH and other stakeholders towards long-term objectives and goals. The desired or expected results are dependent upon the kinds of strategies and practices being planned and implemented, the factors and problems to be affected, the populations being targeted, and the settings in which interventions are taking place. Some examples of the general kinds of outcomes and impacts that might be produced by the strategies and practices are outlined below.

### **Individual-Level Outcomes and Impacts**

- Increased awareness/knowledge about disease prevention, risk reduction, and treatment and management for racial/ethnic minorities
- Improved attitudes/beliefs conducive to health and health-seeking behaviors among racial/ethnic minorities
- Improved attitudes/beliefs among health care/human service providers and researchers conducive to meeting the needs of racial/ethnic minorities
- Increased skills for racial/ethnic minorities to adopt healthy lifestyle behaviors
- Increased skills for public health/health care providers and other service professionals to provide culturally and linguistically appropriate services (CLAS)
- Increased patient satisfaction with patient-provider communications and interactions.
- Increased patient adherence to prescribed treatment regimens

- Increased engagement in/adoption of healthy lifestyle and appropriate health-seeking behaviors; reduced engagement in/adoption of risky behaviors
- Reduced morbidity and mortality

### **Environmental- and Community-Level Outcomes and Impacts**

- Decreased exposure to risks in the physical environment
- Increased awareness/knowledge about racial/ethnic minority health problems and racial/ethnic health disparities among racial/ethnic minorities, among public health/health care providers and service professionals, and in the general public
- Increased health-conducive changes in community attitudes, values, and norms
- Increased community assets that are protective of the health and well-being of its residents (e.g., health centers in underserved communities, neighborhood restaurants and grocers with healthy food options, faith-based organizations, gathering places)
- Increased number of active organizations and family or social networks that meet the social needs and promote the general health and well-being of racial/ethnic minority populations in the community (e.g., church groups, social clubs, recreational and after-school programs)
- Increased health care access and appropriate utilization
- Increased number of plans and policies that promote and protect health and well-being at the community, State, and national levels, in general, and for racial/ethnic minorities, in particular
- Increased engagement in/adoption of healthy lifestyle and appropriate health-seeking behaviors; reduced engagement in/adoption of risky behaviors
- Reduced morbidity and mortality

### **Systems-Level Outcomes and Impacts**

- Increased inputs, assets, and other resources allocated for racial/ethnic minority health and health disparities—in general and for specific priorities
- Increased dedicated assets and other resources for minority health/health disparities (including, but not limited to, State offices of minority health) and related priorities (as reflected in administrative, legislative, budgetary, and other mandates)

- Increased formal partnerships and collaboration leading to coordination/leveraging of resources for greater efficiency, and enhanced effectiveness of minority health/health disparities initiatives
- Increased strategic planning and implementation of plans, with clearly articulated goals and objectives, for racial/ethnic minority health improvement and health disparities reduction
- Increased integration of evaluation, performance measurement and monitoring, and continuous improvement in planning and implementation of racial/ethnic minority health and health disparities efforts
- Increased collection, dissemination, and use of racial/ethnic data for planning, quality assurance, and performance monitoring/improvement purposes (e.g., to assess whether clinical care guidelines for specific diseases are being employed consistently and appropriately; to address health care disparities)
- Improved system design characteristics that are directed to specific racial/ethnic minority health needs, such as the need to address cultural and linguistic differences, promote trust and trustworthiness, etc. (with measures that focus on, for example, increased involvement/participation of racial/ethnic minorities or representatives in health care quality and research initiatives; increased adoption of CLAS standards by health plans; and/or increased diversity in the public health/health care workforce)
- Increased knowledge development/science base about successful strategies and practices for improving racial/ethnic minority health and reducing health disparities
- Increased dissemination and diffusion of evidence-based strategies and practice to improve racial/ethnic minority health and reduce health disparities
- Increased formal partnerships and collaboration across research disciplines leading to coordination/leveraging of research dollars and more multi-faceted approaches to impacting factors that contribute to poor racial/ethnic minority health outcomes and health disparities
- Increased and improved outcomes and impacts at the individual and environmental/ community levels

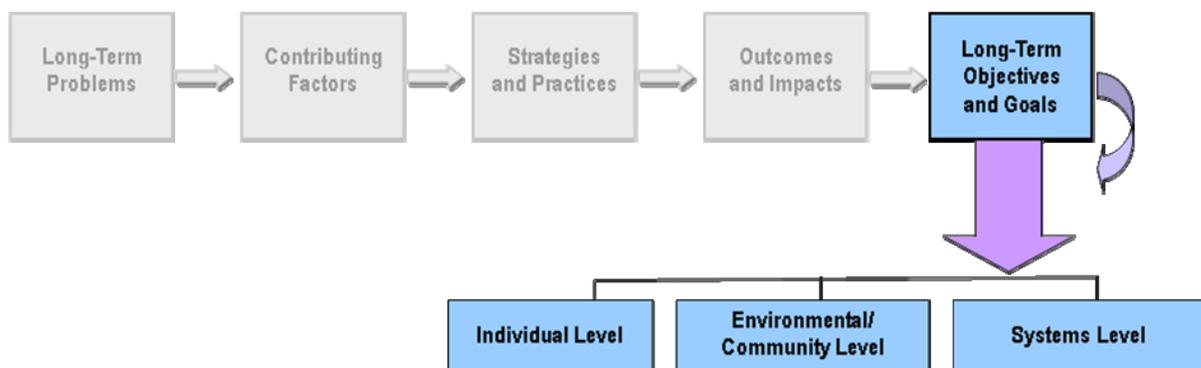
The identification of expected outcomes and impacts is an important part of the planning, implementation, and evaluation processes needed in minority health- and health disparities-related efforts conducted or supported by OMH and its partners. Once desired or expected outcomes and impacts are identified, the process of determining performance measures or indicators of progress in achieving such outcomes and impacts can occur. With the identification and selection of performance measures or indicators of the expected outcomes or impacts, the effectiveness of the strategies and practices in producing the desired results can then be evaluated. Hence, the identification of outcomes and impacts within the strategic framework becomes the basis for identifying and developing performance measures as well as the kind of evaluation needed to

promote an outcome or results orientation in the efforts being funded or otherwise supported by OMH and other stakeholders.

## ► STEP 5: ACHIEVE LONG-TERM OBJECTIVES AND GOALS

An important part of the strategic framework is its focus on long-term objectives and goals, including those in *Healthy People 2010*<sup>6</sup>. OMH, States, communities, and other stakeholders can use this framework to guide the selection of problems, factors, and strategies/practices that can be linked to short-term, intermediate-, and long-term objectives and goals, based on identified outcomes and impacts. And, as shown in Figure 6, these objectives and goals can be set, if desired, for the individual, environment/community, and/or systems level(s). With the collection of the appropriate output, outcome, and impact data, stakeholder organizations can evaluate the extent to which the objectives and goals have been attained.

**Figure 6. Long-Term Objectives and Goals**



To the extent that strategies and practices result directly or indirectly in impacts on the determinants of health, and achieve health outcomes, more progress will be made toward the long-term goals of improving racial/ethnic minority health and eliminating racial/ethnic health disparities. Such efforts will necessitate a systems approach—and a concerted effort to build and deploy evidence-based practice—to promote continuous improvement based on coordinated and strategic application of the most current science and knowledge, and to mobilize the resources and talents of all stakeholders.

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<sup>6</sup>OMH encourages and supports efforts that contribute to the long-term objectives and goals specified in *Healthy People 2010*, especially those that are of particular relevance to racial/ethnic minority populations and systems-related priorities.

#### ***IV. NEXT STEPS: USING THE FRAMEWORK TO SUPPORT EVALUATION AND EVIDENCE-BASED PRACTICES***

The *Framework* clearly identifies five steps that must be taken to ensure that strategies and practices aimed at improving racial/ethnic minority health and reducing racial/ethnic health disparities are effective. The five steps include: (1) identify the long-term problems; (2) identify the key factors that contribute to those long-term problems; (3) identify or develop strategies and practices that effectively address the contributing factors and the long-term problems; (4) identify expected outcomes and impacts and determine appropriate measures or indicators of such results; and (5) document progress in achieving agreed-upon objectives and goals. The *Framework* highlights many of the relationships between and among these five steps, and suggests a variety of ways in which the *Framework* can be used at a national, State, Tribal, regional, or local level.

While health status is the ultimate measure of health disparities, the intermediate outcomes—representing key steps along the path toward greater equity in health care and health status—must be based on the kind of rationale and model presented in this document. This is a model that explicitly encompasses the full range of multiple and complex factors that contribute to poor health for many racial/ethnic minorities and high levels of racial/ethnic health disparities. This model is unique in that it includes the need for a “systems approach” to addressing racial/ethnic minority health problems (i.e., working together as an interconnected system) and the lack of systematic planning, implementation, and evaluation of current efforts as a separate set of long-term problems that can have profound and persistent impacts on racial/ethnic minority health status and health disparities. Given their great importance, these systems issues must be addressed as problems in their own right, with attendant strategies and practices that are already proven or that need to be developed and rigorously evaluated. Improvements in systems that have population-wide scope can accelerate progress.

The strategic framework is simply structured, and its structure permits flexibility in its application by various stakeholders to different situations and for different purposes. First and foremost, the *Framework* can be used by OMH, other HHS entities, and HHS partners to focus programmatic and policy-oriented actions that are based on existing science and knowledge about the problems and contributing factors to be addressed and about strategies and practices known to be effective in producing desired outcomes and impacts. Secondly, the *Framework* can also provide the basis for a protocol to systematically evaluate OMH-funded and other activities in a way that produces more consistent information on what grantees and others are actually doing to improve racial/ethnic minority health status and reduce racial/ethnic health disparities.<sup>7</sup>

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<sup>7</sup>As part of its Spring 2007 grant cycle, OMH issued its new *Evaluation Planning Guidelines for Grant Applicants* to strengthen evaluation within its grant programs. These guidelines were informed by the strategic framework and serve as the preliminary version of OMH’s evaluation protocol for its State-based and other funded efforts.

In addition, through more systematic and rigorous research and evaluation, the *Framework* can facilitate more targeted and efficient methods for identifying and developing best or evidence-based practices, and can strengthen the justification for directing resources toward such efforts. Any effort to identify best practices, however, requires a set of criteria by which to make that judgment. The work of established, respected, scientific expert bodies within and outside of HHS—such as, the U.S. Preventive Services Task Force, the Task Force on Community Preventive Services, and the British-based Cochrane Collaboration—can inform this process. Both the *Guide to Clinical Preventive Services* (U.S. Preventive Services Task Force) and the *Guide to Community Preventive Services* (Task Force on Community Preventive Services) provide examples of how expert opinion—used as the basis for some strategies and practices where scientific evidence of their effectiveness is not adequate—and empirical evidence can be reconciled.

Thus, the *Framework* can promote use of existing science and knowledge while concurrently fostering the development of new evidence of effective strategies and practices for continuous improvement.

## **V. CONCLUSIONS**

The *Framework* presented in this document is intended to help OMH, its partners, and other stakeholders to use a more systems-oriented and strategic approach, based on existing science and knowledge, to attack the problems related to racial/ethnic minority health and health disparities. In the short run, this framework is being used by OMH to guide the development of a protocol for the evaluation of activities being funded in the States and elsewhere to improve racial/ethnic minority health and reduce racial/ethnic health disparities. In the longer run, this strategic framework can help in multiple ways:

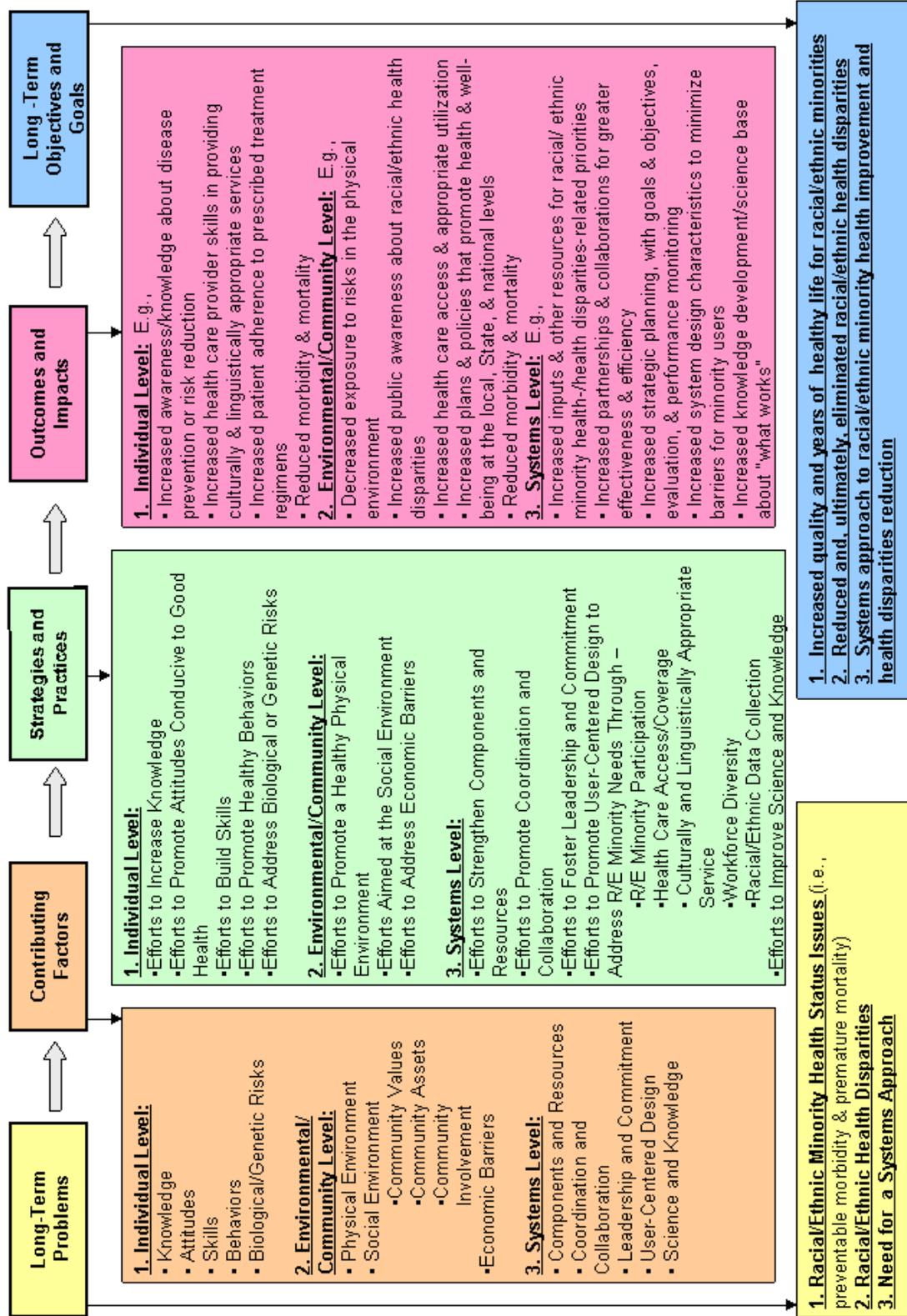
- First, the *Framework* can help enhance the understanding of policymakers, policy analysts, researchers, practitioners, and others about the key strategic components that must be addressed in developing policies or programs that affect racial and ethnic minority populations. These components are identified as the major categories and subcategories in the strategic framework.
- Second, the *Framework* can help deepen understanding about the many ways in which the components relate to one another. These relationships are multiple and complex, but the strategic framework has been designed to make it easier to articulate these multiple and complex relationships, as they play out in concrete situations within communities, States, Tribes, and the Nation.
- Third, the *Framework* will make it easier to identify areas and issues that need more input—whether by improved research, data systems, coordination in the use of research results, provision of services, or training of practitioners—if progress is to be made in improving

racial/ethnic minority health and reducing or eliminating racial/ ethnic health disparities.

- Fourth, the *Framework* can evolve and improve, both in its structure and in its details, through the full participation of interested parties at the national, State, Tribal, and local levels, and in both the public and the private sectors.
- Finally, the *Framework* can give rise to more systematic planning, testing, documentation, and use of evidence-based strategies and practices that really work. Because of its flexibility, the *Framework* makes it clear that progress in developing and using evidence-based strategies and practices can arise from any number of sources. The *Framework* can provide users with a better understanding of the exact problems and factors to be addressed; the kinds of components of strategies and practices that may best contribute to effectiveness; the measures of outcomes and impacts that are appropriate and feasible; and the kinds of goals and objectives that are realistic and achievable.

Improving the health of racial and ethnic minorities and reducing and, ultimately, eliminating the burden of health disparities will require a multi-faceted process sustained over many years. This process must be guided by systems-oriented, strategic, and systematic approaches.

**A STRATEGIC FRAMEWORK FOR IMPROVING RACIAL/ETHNIC (R/E) MINORITY HEALTH & ELIMINATING R/E HEALTH DISPARITIES**



(Source: Office of Minority Health, U.S. Department of Health and Human Services, January 2008.)

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## **Attachment 3**

# **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 (reported from States) at <http://www.cdc.gov/nchs/data>. 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](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).*

## **Attachment 4**

# **Selected Healthy People 2010 Objectives of Particular Relevance to Racial/Ethnic Minority Health and Systems-Related Priorities**

## **Selected *Healthy People 2010* Objectives**

### ***Objectives of Particular Relevance to Racial and Ethnic Minority Health and Systems-Related Priorities***

**[NOTE: THESE OBJECTIVES INCLUDE REVISIONS BASED ON THE HP2010 MIDCOURSE REVIEW.]**

#### ***Focus Area: Access to Quality Health Services***

- Increase the proportion of persons with health insurance (1.1) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Increase in counseling on health behaviors among persons at risk with a physician visit in the past year — physical activity or exercise (adults aged 18 years and older), diet and nutrition (adults aged 18 years and older), smoking cessation (adult smokers aged 18 years and older), risky drinking (adults aged 18 years and older), unintended pregnancy (females aged 15 to 44 years), prevention of sexually transmitted diseases (males aged 15 to 49 years; females aged 15 to 44 years), and management of menopause (females aged 45 to 57 years) (1.3a-d, f-h)
- Increase the proportion of persons who have a specific source of ongoing care (1.4) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Increase the proportion of persons with a usual primary care provider (1.5) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members (1.6) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- In the health professions, allied and associated health profession fields, and the nursing field, increase the proportion of all degrees awarded to members of under-represented racial and ethnic groups (1.8) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Reduce hospitalization rates for three ambulatory-care-sensitive conditions —pediatric asthma, uncontrolled diabetes, and immunization-preventable pneumonia and influenza (1.9)

#### ***Focus Area: Cancer***

**NOTE: MORE INFORMATION ON THESE OBJECTIVES IS AVAILABLE AT [WWW.HEALTHYPEOPLE.GOV](http://WWW.HEALTHYPEOPLE.GOV).**

- Increase the proportion of physicians and dentists who counsel their at-risk patients about tobacco use cessation, physical activity, and cancer screening — internists who counsel about smoking cessation, family physicians who counsel about smoking cessation, dentists who counsel about smoking cessation, primary care providers who counsel about blood stool tests, primary care providers who counsel about proctoscopic examinations, primary care providers who counsel about mammograms, primary care providers who counsel about Pap tests, and primary care providers who counsel about physical activity (3.10a-h)
- Increase the proportion of women (aged 18 years and older) who receive a Pap test within the preceding 3 years (3.11b) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Increase the proportion of adults who receive a colorectal cancer screening examination (3.12) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Increase the proportion of women aged 40 years and older who have received a mammogram within the preceding 2 years (3.13) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**

### ***Focus Area: Diabetes***

- Increase the proportion of persons with diabetes who receive formal diabetes education (5.1) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Increase the proportion of adults with diabetes whose condition has been diagnosed (5.4)
- Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement at least once a year (5.12) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Increase the proportion of adults with diabetes who have an annual dilated eye examination (5.13)
- Increase the proportion of adults with diabetes who have at least an annual foot examination (5.14) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Increase the proportion of adults with diabetes who perform self-blood-glucose monitoring at least once daily (5.17) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**

### ***Focus Area: Educational and Community-Based Programs***

- Increase the proportion of middle, junior high, and senior high schools that provide school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health (7.2)
- Increase the proportion of college and university students who receive information from their institution on each of the six priority health-risk behavior areas (7.3)
- Increase the proportion of worksites that offer a comprehensive employee health promotion program to their employees (7.5)
- Increase the proportion of employees who participate in employer-sponsored health promotion activities (7.6) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**

### ***Focus Area: Environmental Health***

- Reduce the proportion of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health-based standards for harmful air pollutants (8.1) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Eliminate elevated blood lead levels in children (8.11)

### ***Focus Area: Heart Disease and Stroke***

- Increase the proportion of eligible persons with witnessed out-of-hospital cardiac arrest who receive their first therapeutic electrical shock within 6 minutes after collapse recognition (12.5)
- Increase the proportion of adults with high blood pressure who are taking action (for example, losing weight, increasing physical activity, or reducing sodium intake) to help control their blood pressure (12.11)
- Increase the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high (12-12) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**

### ***Focus Area: HIV***

- Increase the proportion of substance abuse treatment facilities that offer HIV/AIDS education, counseling, and support (13.8)
- Increase the proportion of HIV-infected adolescents (aged 13 years and older) and adults who receive testing, treatment, and prophylaxis consistent with current Public Health Service treatment guidelines (13.13)

### ***Focus Area: Immunizations***

- Increase the proportion of all tuberculosis patients who complete curative therapy within 12 months (14.12)
- Increase the proportion of persons with latent tuberculosis infection who complete a course of treatment (14.13)
- Increase the proportion of all tuberculosis patients who complete curative therapy within 12 months (14.22) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Increase the proportion of adults who are vaccinated annually against influenza (14.29) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Increase the proportion of adults who are ever vaccinated against pneumococcal disease (14.29) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**

### ***Focus Area: Injury and Violence Prevention***

- Increase use of safety belts. (15.19)
- Increase the percentage of motor vehicle occupants aged 4 years and under who used child restraints (15.20)

### ***Focus Area: Maternal, Infant, and Child Health***

- Increase the proportion of pregnant women who receive early and adequate prenatal care (16.6a) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Increase the percentage of healthy full-term infants who are put down to sleep on their backs (16.13)

- Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women (16.17) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**

### ***Focus Area: Mental Health***

- Increase the proportion of adults with mental disorders who receive treatment — serious mental illness, recognized depression, schizophrenia, and generalized anxiety disorder (18.9)

### ***Focus Area: Nutrition and Overweight***

- Increase the proportion of persons aged 2 years and older who consume at least two daily servings of fruit (19.5)
- Increase the proportion of persons aged 2 years and older who consume at least three daily servings of vegetables, with at least one-third being dark green or orange vegetables (19.6)
- Increase the proportion of persons aged 2 years and older who consume less than 10 percent of calories from saturated fat (19.8)
- Increase the proportion of persons aged 2 years and older who consume no more than 30 percent of calories from total fat (19.9)
- Increase the proportion of worksites that offer nutrition or weight management classes or counseling (19.16)
- Increase the proportion of physician office visits made by patients with a diagnosis of cardiovascular disease, diabetes, or hyperlipidemia that include counseling or education related to diet and nutrition (19.17) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**

### ***Focus Area: Physical Activity and Fitness***

- Reduce the proportion of adults who engage in no leisure-time physical activity (22.1) **[Note: This objective is not making progress for one or more racial or ethnic minority group or groups.]**
- Increase the proportion of adults who engage in moderate physical activity for at least 30 minutes per day 5 or more days per week or vigorous physical activity for at least 20 minutes per day 3 or more days per week (22.2) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**

- Increase the proportion of adults who engage in vigorous physical activity that promotes the development and maintenance of cardiorespiratory fitness for at least 20 minutes per day 3 or more days per week (22.3) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Increase the proportion of adolescents who engage in moderate physical activity for at least 30 minutes per day on 5 or more days per week. (22.6)
- Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion (22.7) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Increase the proportion of the Nation’s public and private schools that require daily physical education for all students (22.8)
- Increase the proportion of adolescents who view television 2 or fewer hours on a school day (22.11)
- Increase the proportion of worksites offering employer-sponsored physical activity and fitness programs (22.13)

### ***Focus Area: Public Health Infrastructure***

- Increase the proportion of population-based *Healthy People 2010* objectives for which national data are available for all population groups identified for the objective. (23.4)
- Increase the proportion of Tribal, State (includes the District of Columbia), and local health agencies that have implemented a health improvement plan and increase the proportion of local health jurisdictions that have implemented a health improvement plan linked with their State plan (23.12)

### ***Focus Area: Respiratory Diseases (Asthma Only)***

- Increase the proportion of persons with asthma who receive formal patient education, including information about community and self-help resources, as an essential part of the management of their condition (24.6) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Increase the proportion of persons with asthma who receive appropriate asthma care according to the NAEPP Guidelines (24.7) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**

## ***Focus Area: Tobacco Use***

- Reduce tobacco use by adults — tobacco products, cigarettes, and spit tobacco (27.1a-c) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Reduce tobacco use by adolescents — tobacco products, cigarettes, spit tobacco, cigars, and bidis (27.2) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Reduce the proportion of nonsmokers exposed to environmental tobacco smoke (27.10)
- Increase smoke-free and tobacco-free environments in schools, including all school facilities, property, vehicles, and school events (27.11)
- Increase the proportion of persons covered by indoor worksite policies that prohibit smoking (27.12) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Establish laws on smoke-free indoor air that prohibit smoking in public places and worksites (27.13)
- Reduce the illegal sales rate to minors through enforcement of laws prohibiting the sale of tobacco products to minors (27.14)
- Reduce the proportion of adolescents and young adults who are exposed to tobacco advertising and promotion (27.16) **[NOTE: THIS OBJECTIVE IS NOT MAKING PROGRESS FOR ONE OR MORE RACIAL OR ETHNIC MINORITY GROUP OR GROUPS.]**
- Increase the number of States and the District of Columbia, Territories, and Tribes with sustainable and comprehensive evidence-based tobacco control programs. (27.18)

## **Attachment 5**

# **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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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 pneumococcal 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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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-diphtheria 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-diphtheria 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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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

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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

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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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

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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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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

<i>Number</i>	<i>Objective</i>	<i>R/E</i>	<i>Baseline Year</i>	<i>Baseline</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>Target 2010</i>	<i>Progress Quotient</i>
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

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

## **Attachment 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 program’s objectives, activities, impacts and outcomes. 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: \_\_\_\_\_

Overall Health Problem(s) to be addressed: \_\_\_\_\_

Long-Term Problem(s): \_\_\_\_\_

Long-Term Objectives and Goals: \_\_\_\_\_

Contributing Factors	Activities	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 program’s objectives, activities, impacts and outcomes. 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 \_\_\_\_\_

Overall Health Problem(s) to be addressed: \_\_\_\_\_ Diabetes \_\_\_\_\_

Long-Term Problem(s): \_\_\_\_\_ High rate of preventable morbidity and premature mortality in relation to diabetes \_\_\_\_\_

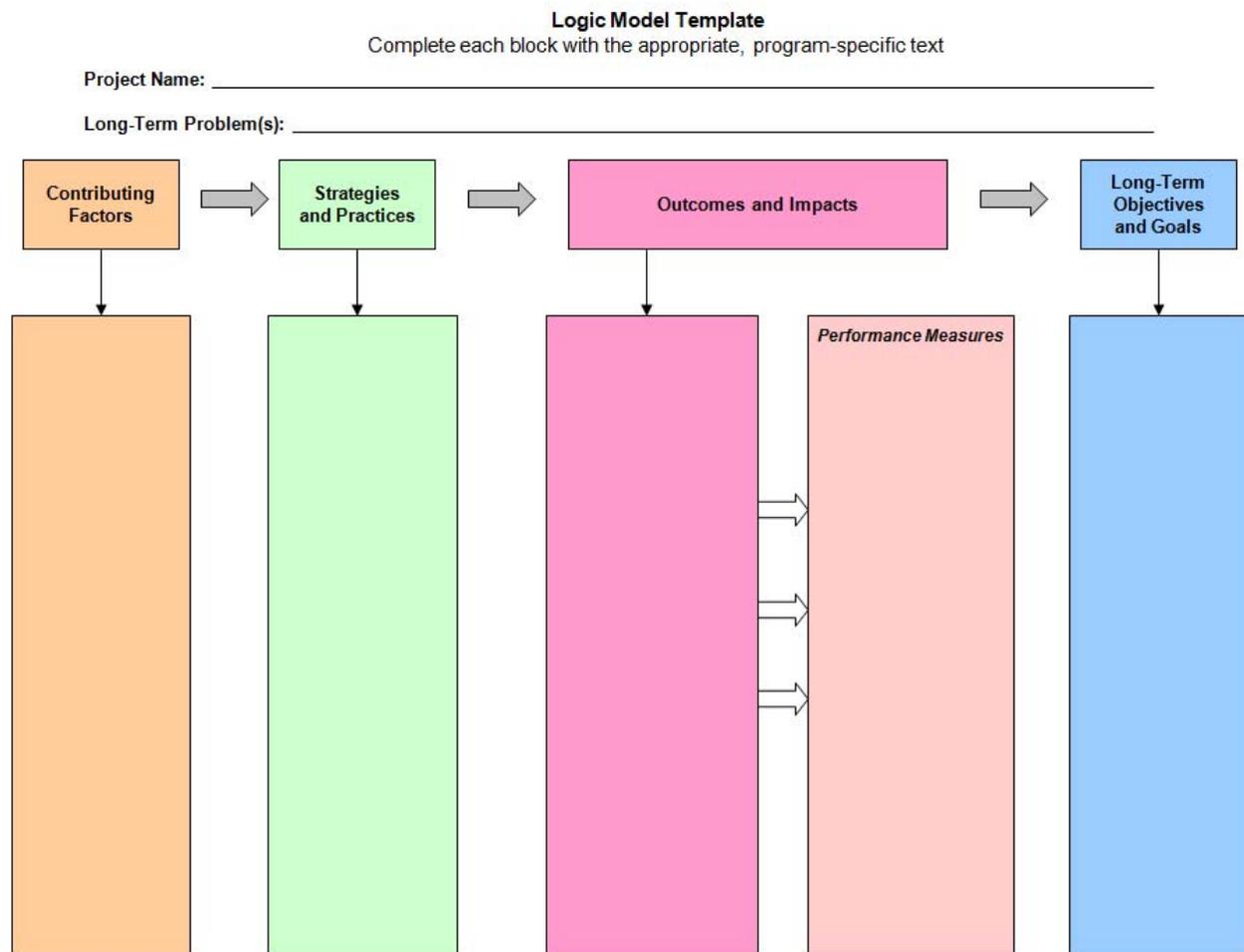
Long-Term Objectives and Goals: \_\_\_\_\_ Reduce prevalence of diabetes in minorities \_\_\_\_\_

Contributing Factors	Activities	Outcomes and Impacts	Performance Measures for All Grantees	Optional Measures
<p>Lack of awareness and knowledge about the connections between diet, exercise, obesity, and diabetes</p> <p>Lack of public awareness about risk factors related to diabetes</p> <p>Lack of community assets, such as healthy food choices in local grocery stores and restaurants</p> <p>Lack of safe venues to engage in physical activity, sports and recreation</p> <p>Lack of strategic planning to guide leadership action and assess progress towards established diabetes prevention and management objectives and goals</p> <p>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</p>	<p>Providing individually-oriented health education through tailored channels (e.g., health providers or faith-based organizations)</p> <p>Providing community-based health education or communication campaigns through local media channels, schools, and community organizations</p> <p>Establishing 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</p> <p>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</p> <p>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</p>	<p>Increased awareness/knowledge about the link between diet, exercise, obesity, and diabetes</p> <p>Increased healthcare provider skills in educating and counseling their patients about diabetes prevention, treatment, and management</p> <p>Increased patient adherence to prescribed diet, exercise, and treatment regimens for diabetes</p> <p>Increased public awareness about diabetes and related risk factors</p> <p>Increased plans and policies that promote healthier dietary choices and safe places for exercise and sports in the community</p> <p>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</p>	<p>Number of diabetes-related HP2010 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</p> <p>Number of diabetes-related HP2010 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</p> <p>Number of individuals (unduplicated) participating in OMH-funded diabetes activities per year</p> <p>Number/percent of individuals with increased awareness and knowledge of diabetes and how to address it as a result of OMH-funded program participation</p> <p>Number of strategic planning documents developed</p> <p>Number of partnerships to enhance coordination and collaboration on diabetes treatment and control</p>	<p>Number of training and TA events</p> <p>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</p>

**Attachment 7**  
**Logic Model Template**

# Logic Model Template

This template is based on the "Strategic Framework for Improving Racial/Ethnic Minority Health & Eliminating Racial/Ethnic Health Disparities." 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 racial/ethnic minority health problems. The first step depicted is entitled "Contributing Factors." This is where you should list the factors known to contribute to the long-term problem(s) that your project will address. The second step in this template is called "Strategies and Practices." This is where you should list the strategies and practices that will be used to address the contributing factors. The third step is entitled "Outcomes and Impacts," which is where you should describe the results intended from the strategies and practices. Another space is provided for you to list the indicators you will use to measure the results of your activities. The last step, "Long-Term Objectives and Goals," is where you should list the longer-term results that can be expected by producing the outcomes and impacts indicated in the previous step.



## **Attachment 8**

# **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
    - Number of diabetes-related HP2010 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 HP2010 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

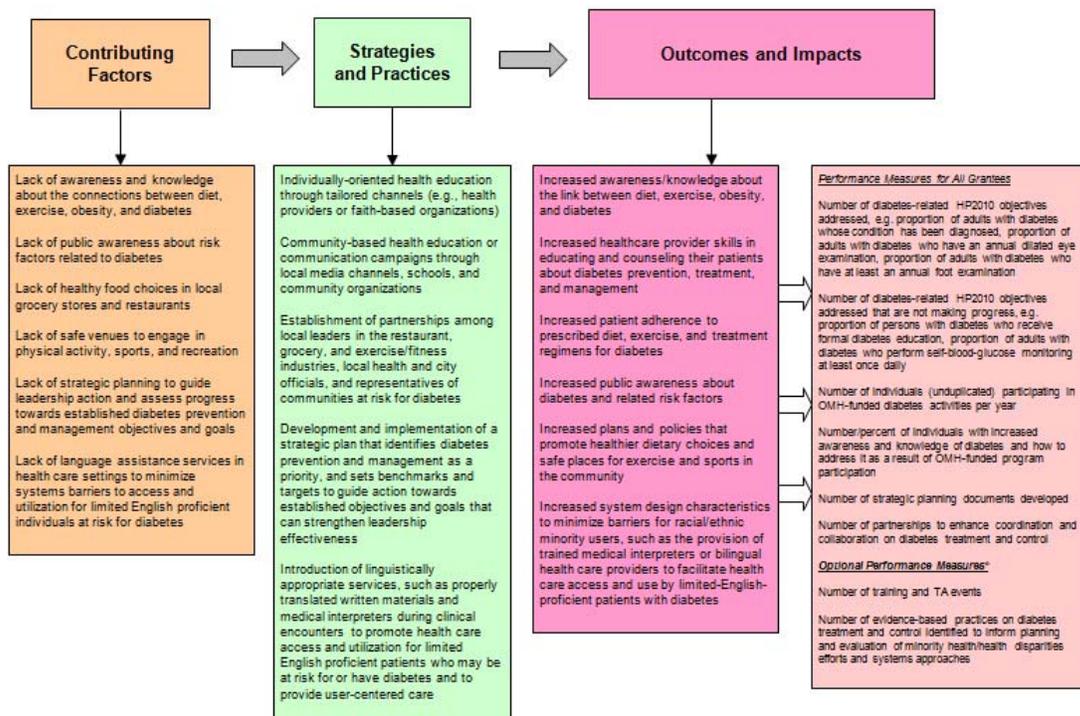
- Number of individuals (unduplicated) participating in OMH-funded diabetes activities per year
- Number/percent of individuals with increased awareness and knowledge of diabetes and how to address it as a result of OMH-funded program participation
- Number of strategic planning documents developed
- Number of partnerships to enhance coordination and collaboration on diabetes treatment and control
- Optional Performance Measures (Grantees need to select at least 2 optional OMH measures that apply to their activities and objectives.)
  - 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 Example – 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 and Goals: Reduce prevalence of diabetes in minorities



\*Grantees need to select at least 2 optional OMH measures that apply to their activities and objectives.

## **Attachment 9**

# **Data Collection Plan Template and Example of Completed Plan (for Diabetes)**

# Data Collection Plan

Grantee Name: \_\_\_\_\_

<b>Measures for All OMH Grantees</b>	<b>Instrument/Data Source</b>	<b>Location of Data</b>	<b>Frequency of Collection</b>	<b>Responsible for Collection</b>

<b>Optional Measures for All OMH Grantees</b>	<b>Instrument/Data Source</b>	<b>Location of Data</b>	<b>Frequency of Collection</b>	<b>Responsible for Collection</b>

<b>Additional Measures for All OMH Grantees</b>	<b>Instrument/Data Source</b>	<b>Location of Data</b>	<b>Frequency of Collection</b>	<b>Responsible for Collection</b>

## Data Collection Plan - Example

Grantee Name: \_\_\_\_\_Diabetes Project\_\_\_\_\_

<b>Measures for All OMH Grantees</b>	<b>Instrument/Data Source</b>	<b>Location of Data</b>	<b>Frequency of Collection</b>	<b>Responsible for Collection</b>
Number of HP2010 objectives for priority OMH issues addressed	Project files	Project records	Annually	Project/evaluation director
Number of HP2010 objectives addressed that are not making progress	Project files	Project records	Annually	Project/evaluation director
Number of individuals participating in OMH-funded, grant program activities per year	Project files	Project records	Monthly	Project/evaluation director
Number/percent of individuals with increased awareness and knowledge	Pre-post tests at training sessions	Project records	As occurs	Training staff
Number of strategic planning documents developed	Project files	Project records	As occurs	Project/evaluation director
Number of partnerships	Project files	Project records	As occurs	Project/evaluation director

<b>Optional Measures for All OMH Grantees</b>	<b>Instrument/Data Source</b>	<b>Location of Data</b>	<b>Frequency of Collection</b>	<b>Responsible for Collection</b>
Number of training and TA events	Project files	Project records	As occurs	Training staff
Number of evidence-based practices identified	Project files	Project records	As occurs	Project/evaluation director

<b>Additional Measures for All OMH Grantees</b>	<b>Instrument/Data Source</b>	<b>Location of Data</b>	<b>Frequency of Collection</b>	<b>Responsible for Collection</b>

**Attachment 10**  
**Sample Data Collection Forms**







