An Evaluation Protocol for Systematically Evaluating Efforts to Improve Racial and Ethnic Minority Health, Reduce Health Disparities, and Effect Systems Approaches to Racial and Ethnic Minority Health Problems

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The OMH Evaluation Protocol

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Introduction

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

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 an evaluation plan that clearly articulates how proposed projects and activities will be evaluated to determine if intended results have been achieved (see Appendix 1 for a brief glossary of terms). Using this *Protocol* is intended to promote more systematic and consistent processes for evaluations of efforts that are consistent with OMH's overall approach to its mission. This approach is outlined in a strategic framework which is discussed in the following section.

The Strategic Framework

In January 2008, OMH released *A Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities* (the *Framework*), provided at Appendix 2 and also available via OMH's website at http://www.minorityhealth.hhs.gov/npa/images/78/PrintFramework.html). The purpose of the *Framework* is to promote a rational way of thinking about – and guiding the systematic conduct of – 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; and
- Assessing the extent to which the long-term objectives and goals toward which OMH's and other efforts contribute are being achieved.

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

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 the strategies, practices, and interventions being funded or otherwise supported to address racial and ethnic minority health/health disparities problems. These steps help answer the following questions:

- What problem is the proposed project or effort and its strategies, practices, and interventions addressing?
- What are the key factors (from those outlined in the *Framework*) contributing to or causing the problem?
- What data are available to shed light on the problem and contributing or causal factors?
- What strategies, practices, and interventions are being proposed to address the problem and contributing or causal factors? What evidence exists from previous research or evaluation to indicate that these strategies, practices, and interventions may or will work?
- What are the expected outcomes and impacts to be achieved at the end of the project or effort?

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

- Can the desired outcomes and impacts of the program or project be measured and, if so, how will they be measured?
- Have the outcomes, impacts, and performance measures or indicators for the program or project been linked to broader outcomes, impacts, and performance measures of the organization or agency, the types of outcomes and impacts presented in the *Framework*, and to *Healthy People* objectives and goals?
- How will the strategies, practices, and interventions being conducted or employed throughout the course of the project be tracked, and what performance data will be collected?
- How will the project be evaluated to determine whether the expected outcomes and impacts have been achieved?
- How will data collected and results from evaluation be analyzed, reported, and disseminated?

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 strategies, practices, and interventions to the problem (or problems) and factors; identifying related outcomes and impacts for the proposed efforts; selecting performance measures to assess the outcomes and impacts; and implementing evaluation and data analysis methodologies that provide the highest level of rigor possible. OMH grant applicants/awardees and others engaged in minority health-/health disparities-related programmatic efforts should address each of these nine steps in their evaluation plans and implementation of such plans.

Step 1: Identify and Define the Problem and Factors Contributing to or Causing the Problem to Be Addressed by the Proposed Project and Interventions

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 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 strategy, practice, or intervention may be aiming to address is a gap or weakness in data to inform program and policy decision-making (e.g., lack of data on health care access and utilization by members of a particular Tribal community to ensure adequate and appropriate diagnosis and treatment of chronic health conditions). The point here is to provide objective evidence of the nature and extent of the problem. Some examples of potential data sources that may be useful in describing racial and ethnic minority health or systems problems, and factors contributing to such problems, are provided in Appendix 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 *Healthy People 2010* (*HP2010*) – or, after official release, *Healthy People 2020* (*HP2020*) -- 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.minorityhealth.hhs.gov.
- OMH-wide objectives and priorities related to the *National Partnership for Action to End Racial and Ethnic Health Disparities* (NPA) are also identified in OMH's grant program guidelines as well as on the NPA web pages of the OMH web site at http://www.minorityhealth.hhs.gov (also see Appendix 4).
- 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 and subobjectives that are not making progress with respect to the particular racial and ethnic minority group (or groups) being targeted (see Appendix 5 for a list of these objectives/subobjectives).

1(d). Identify contributing or causal factors to be addressed. In the *Framework*, factors contributing to or causing the long-term problems are divided into three basic categories: 1) individual-level factors (such as knowledge, attitudes, or behavior), 2) environmental- and community-level factors (such as physical hazards or biochemical risks, community values and norms, housing conditions, access to health care, employment status, or family cohesion and social networks), and 3) systems-level factors (such as infrastructure and resources, coordination, leadership, and user-centered design). 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 or could be identified through national, State, Tribal, or local surveys of populations susceptible to this disease.
- ***Environmental or 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 or 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 strategies, practices, 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 Agency for Healthcare Research and Quality (AHRQ)-based U.S. Preventive Services Task Force, at http://www.ahrq.gov/clinic/uspstfix.htm#Recommendations, and those of the Centers for Disease Control and Prevention's (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 (SAMHSA's) National Registry of Evidence-Based Programs and Practices, a database of interventions for the prevention and treatment of mental and substance use disorders (at http://nrepp.samhsa.gov), and the "Community Toolbox" at the University of Kansas on community health and development practices (at http://ctb.ku.edu).

2(c). Organize proposed project strategies, practices, and interventions. Organize selected project strategies, practices, and interventions to facilitate a clear link between these efforts, the contributing or causal factors and priority problems being addressed by such efforts, and the three basic *Framework* categories (i.e., individual level, environmental/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 or causal factors identified earlier, examples of how different kinds of strategies, practices, and interventions 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.
- ***Environment/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 Interventions

(3a). Specify expected outcomes/impacts (i.e., results) for project strategies, practices, and interventions. As grant applicants/awardees and others consider and plan their proposed strategies, practices, and interventions, they also need to identify the *outcomes and impacts* (i.e., the results) that might be expected to take place following implementation of their projects and its strategies, practices, and interventions. The *Framework* identifies and organizes a broad range of outcomes and 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 intervention-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, environment/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 and impacts identified will guide the design and selection of methods for evaluating the effectiveness of project interventions.

(3b). Identify measures or indicators of expected outcomes/impacts. Once expected outcomes and 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 efforts. In evaluation, typical measures reflect inputs, outputs, processes, outcomes, and impacts (see definitions below).

- ***Input Measure.*** A *Evaluation Protocol* measure of what an agency or manager has available (e.g., funding, staff, facilities or equipment, supplies) to carry out the program, activity, or intervention to produce an output or outcome.
- ***Process Measure.*** A measure of the procedures, tasks, or processes involved in *implementing* program or project activities or interventions 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.

See Appendix 6 for a more detailed discussion about identifying, developing, and selecting performance measures. As part of this appendix, OMH describes its own processes for selecting its initial set of OMH-wide "core" performance measures and subsequently developing specific performance measures for its grantees and cooperative agreement partners. Appendix 6 also includes descriptions of OMH's efforts to develop a searchable performance measures database that other partners and stakeholders will be able to use to support their evaluation and performance reporting needs. Furthermore, the appendix provides a list of other available databases that can be used for planning and evaluation purposes as well as other resources that can inform performance measures development and selection for outcomes and impacts in which gaps and weaknesses exist.

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 strategies, practices, or interventions to the broader objectives and goals of the program, office, agency, or organization in which the project is located as well as to outcomes held in common with partners and other stakeholders, such as the objectives and goals of the *National Partnership for Action to End Health Disparities* (Appendix 4) and/or *Healthy People* (at http://www.healthypeople.gov). 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 *Healthy People*. For the first decade of the 21st century, the two principal goals of *HP2010* are: (1) to improve the quality and years of healthy life, and (2) to eliminate health disparities. The overarching goals proposed for *HP2020* are similar but broader and are: (1) to attain high quality, longer lives free of preventable disease, disability, injury, and premature death, (2) to achieve health equity, eliminate disparities, and improve the health of all groups, (3) to crease social and physical environments that promote good health for all, and (4) to promote quality of life, healthy development, and health behaviors across all life stages. See the *Healthy People* website for more detailed information and the final version of *HP2020* after official release.

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 *Healthy People* objectives and priorities–which, in turn, contribute to the long-term *Healthy People* goals. Consistent with information provided in Step 1(c), in order to show the relationship between proposed project efforts with program, OMH or other agency, and *Healthy People* 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 *Healthy People* objectives and goals. In this way, individual and collective efforts by OMH, its grantees and other partners, and other stakeholders will be aiming towards and contributing to the disease prevention and health promotion directions presented in *Healthy People* for all Americans, including racial and ethnic minorities.

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

Thus, project measures of individual levels of knowledge and awareness about risk factors associated with diabetes might link to organizational objectives to increase community awareness of such risk factors which, in turn, contribute to State-wide goals to reduce diabetes incidence as well as to measurable objectives in the diabetes focus area chapter of *Healthy People 2010*.

(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 Interventions

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 Appendix 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 project interventions 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 interventions to determine whether expected outcomes/impacts have, in fact, been achieved. Incorporation 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 template and a logic model worksheet are provided for this purpose (see Appendices 7 and 8, respectively). For the diabetes example, a completed logic model worksheet and a completed logic model diagram are also provided, to show how the contributing factors, strategies/practices aimed at these factors, expected outcomes/impacts, and performance measures have been incorporated (see Appendices 9 and 10, respectively). In addition, two examples of actual project logic models, selected by OMH's Evaluation Technical Assistance Center (ETAC) team members, from grantees of OMH's Curbing HIV/AIDS Transmission (CHAT) Program and Youth Empowerment Program, respectively, are presented at Appendix 11.

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, an 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 Appendix 1):

- ***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.

- ***Process evaluations*** examine the tasks and procedures involved in implementing a program or activities, including the administrative and organizational aspects of, and delivery procedures involved in, the efforts. Such evaluations enable monitoring to ensure feedback during the course of the program or project.
- ***Summative evaluations*** look at a combination of measures and conclusions for larger patterns and trends in performance, to assess, in summary, whether the program or project overall did what it was designed to do. Compared to formative evaluations, summative evaluations are primarily retrospective, document evidence, and show results and achievement. Examples of summative evaluations include outcome and impact evaluations, cost effectiveness and cost–benefit analyses, and meta-analyses (which integrate outcomes from multiple studies to determine an overall judgment or summary conclusion about a particular research or evaluation question).
- ***Outcome evaluations*** are used to obtain descriptive data on a program or project and to document (typically) short- and intermediate-term results. Task-focused results are those that describe the output of the activity (e.g., the number of public inquiries received as a result of a public service announcement). Shorter-term results describe the immediate effects of the project on the target audience (e.g., percent of the target audience showing increased awareness of the subject). Information from such evaluation can show results such as knowledge and attitude changes, short-term or intermediate behavior shifts, and policies initiated or other institutional changes.
- ***Impact evaluations*** focus on the long-range results of the program or project and changes or improvements as a result (e.g., long-term maintenance of desired behavior, reduced absenteeism from work, reduced morbidity and mortality). Because such evaluations are the most comprehensive and focus on long-term results of the program and changes or improvements in health status, they are the most desirable. However, impact evaluations are rarely possible because they are frequently costly and involve extended commitment. Also, the results often cannot be directly related to the effects of a program, project, or activity because of other (external) influences on the target audience, which occur over time.

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 Appendix 12 for a sample data collection plan template as well as Appendix 13 for an example of a completed data collection plan – selected by OMH's Evaluation Technical Assistance Center team -- from Alternatives for Girls, one of OMH's *Curbing HIV/AIDS Transmission* (CHAT) Program grantees.

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 interventions and other efforts. 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.

Appendix 14 includes some generic 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 and cooperative agreement partners are required to submit standard data via OMH's Performance Data System (PDS), a web-based, password-protected system for systematically collecting performance information to support OMH's efforts to identify and monitor progress for its funded efforts (see Appendix 15 for selected screenshots of selected web pages in the PDS). Web-based training sessions, technical assistance (via a telephone- and e-mail-based PDS Helpdesk), and an online PDS User's Guide are available to all new and ongoing OMH grantees and cooperative agreement partners to support their efforts to plan for and submit performance reports. In addition, web-based training sessions are provided to all OMH grantees and cooperative agreement partners on OMH's *Evaluation Planning Guidelines* and ongoing evaluation technical assistance is also provided – through OMH's Evaluation Technical Assistance Center (ETAC) – to guide evaluation planning and implementation efforts and ensure that results of intervention effectiveness can be identified upon project completion. Like OMH's *Evaluation Protocol*, the *Evaluation Planning Guidelines* (an abbreviated version of the *Protocol* specifically geared to OMH grantees and cooperative agreement partners) and the Performance Data System are designed to reflect the logical approach presented in the *Framework*.

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 efforts. The data that are collected for the purpose of evaluating intervention effectiveness for funded projects as a whole may be broader than that collected for specific performance data reporting needs (as with OMH's PDS requirements). 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 efforts 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.

For more information on the Evaluation Protocol, responses to a list of frequently asked questions about evaluation planning are provided at Appendix 16.

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.

Appendix 1:
Glossary of Terms

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 2:
A Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities

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

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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[1] 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).
- 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

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[1] 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."

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"[2]. 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.

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[2] 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.

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 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.

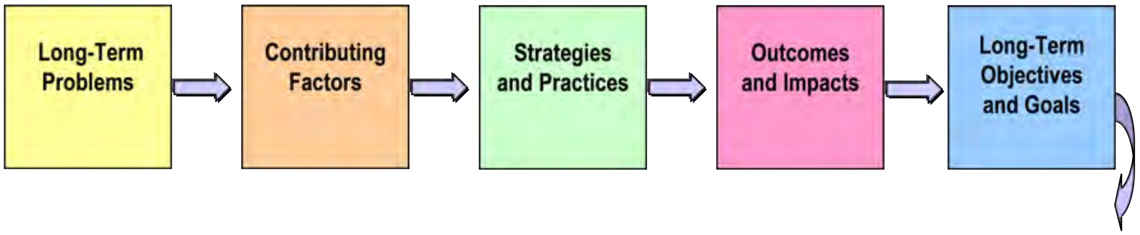
- **Basis for enhancing effectiveness and efficiency**: The *Framework* can promote the effectiveness and efficiency of efforts by OMH and others to improve racial/ethnic minority health and reduce health disparities through more coordinated and systematic actions.

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[3]:

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

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[3] 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 Extention at http://www1.uwex.edu/ces/lmcourse; and the W.K. Kellogg Foundation at http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf.

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.

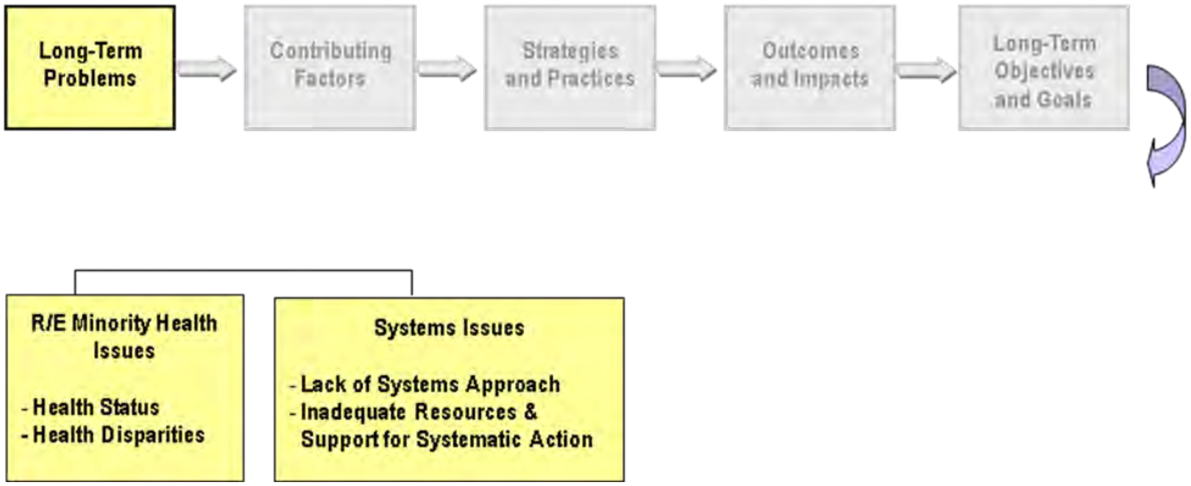
Step 1: Begin with Long-Term Problems

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.

- ***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*.

Figure 2. Long-Term Problems



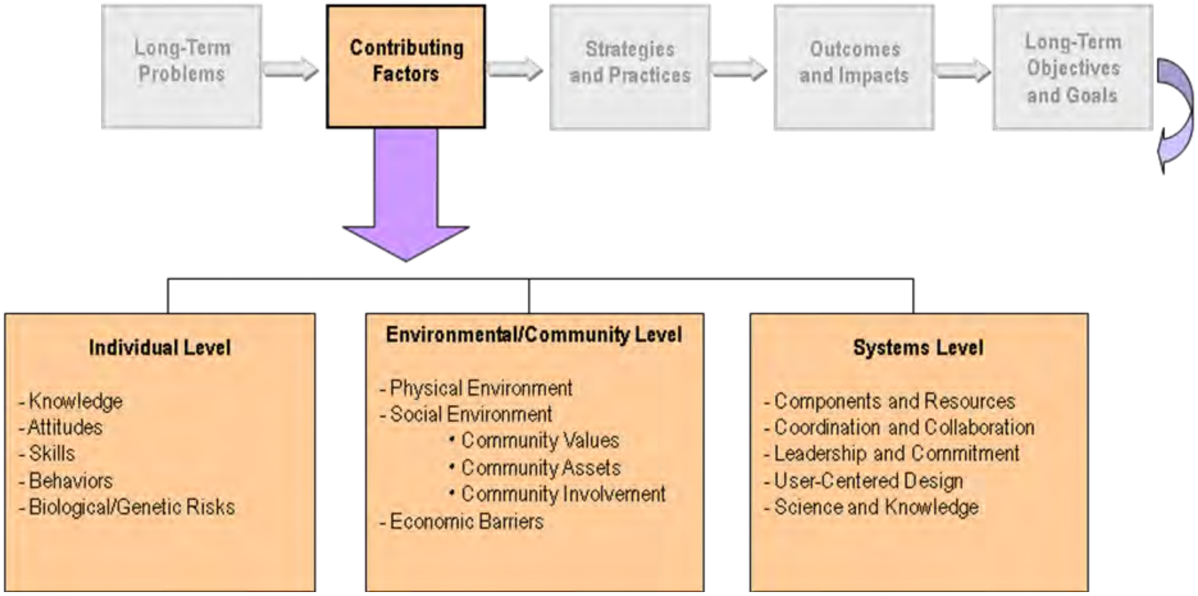
Step 2: Address Contributing Factors

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)[4].

Figure 3. Contributing Factors



- ***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

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[4] 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.

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.

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.[5]

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 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.

- ***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 particular characteristic (e.g., age range,

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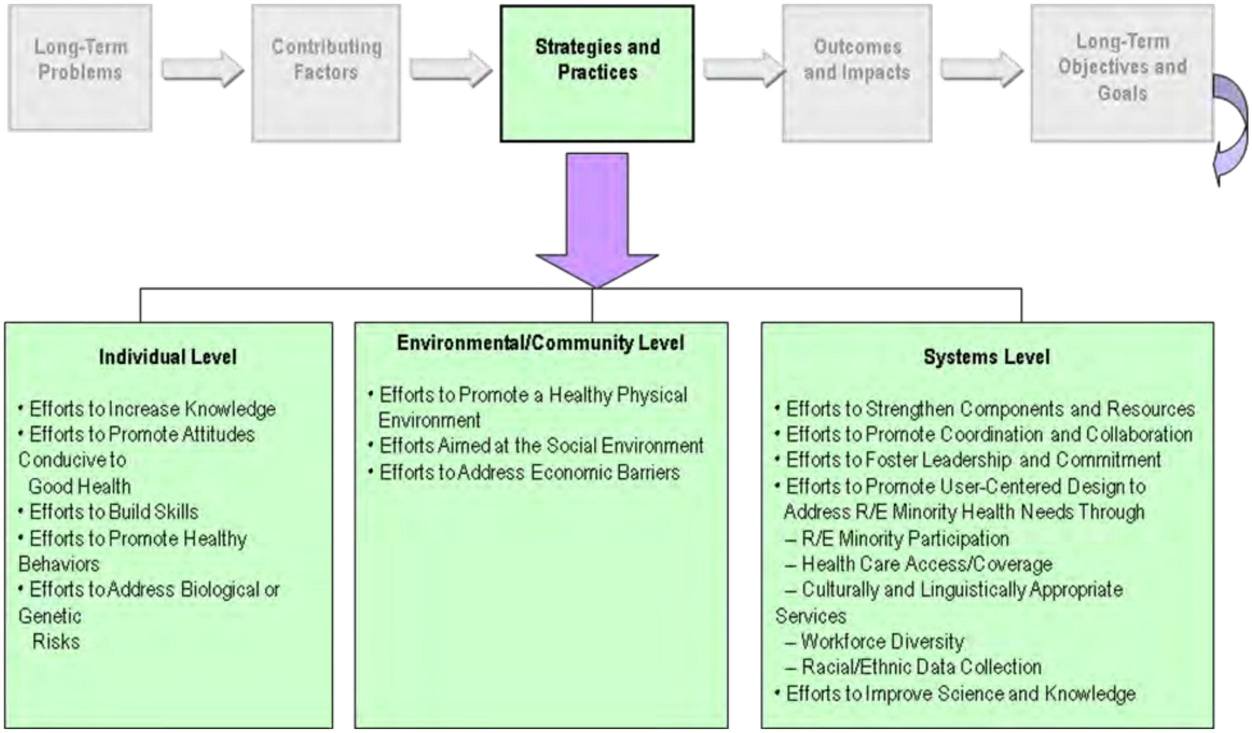
[5] Approaches to population health that describe relationships and interactions between multiple determinants of health at the individual and environmental/community levels and how they affect health or illness are sometimes referred to as "ecological models" of health.

gender, health literacy level) and those who interact with or serve minorities (e.g., health care providers). Effective efforts tend to reflect integrated approaches that address a combination of individual-level factors as well as their interactions with environmental factors that inhibit or support desired behaviors. In addition, health messages are more readily accepted if they do not conflict with existing cultural beliefs and practices, and take into account unique historical and cultural experiences of target audiences, including racial and ethnic minorities.

Figure 4. Strategies and Practices



- ***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

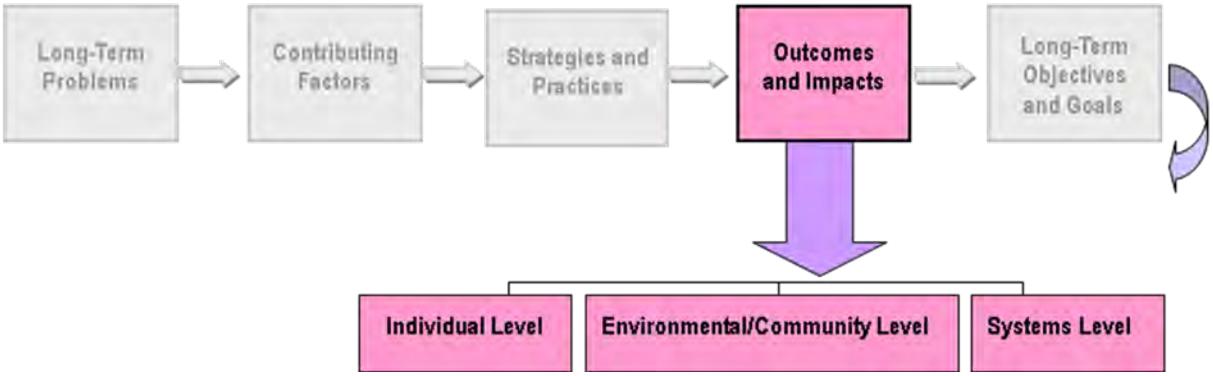
includes RD&E efforts that strengthen knowledge and understanding about: the nature and extent of minority health/health disparities problems, especially for small or hard-to-reach populations for which data continue to be lacking; the mechanisms by, and extent to, which systems factors inhibit the ability 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*[6]. 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.

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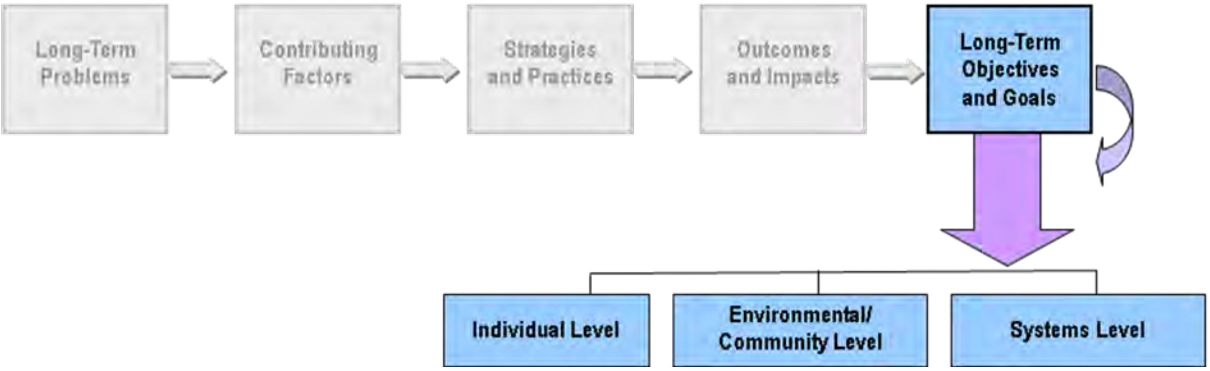
[6] OMH encourages and supports efforts that contribute to the long-term objectives and goals specified in *Healthy People 2010*, especially those that are of particular relevance to racial/ethnic minority populations and systems-related priorities.

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.

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.[7]

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:

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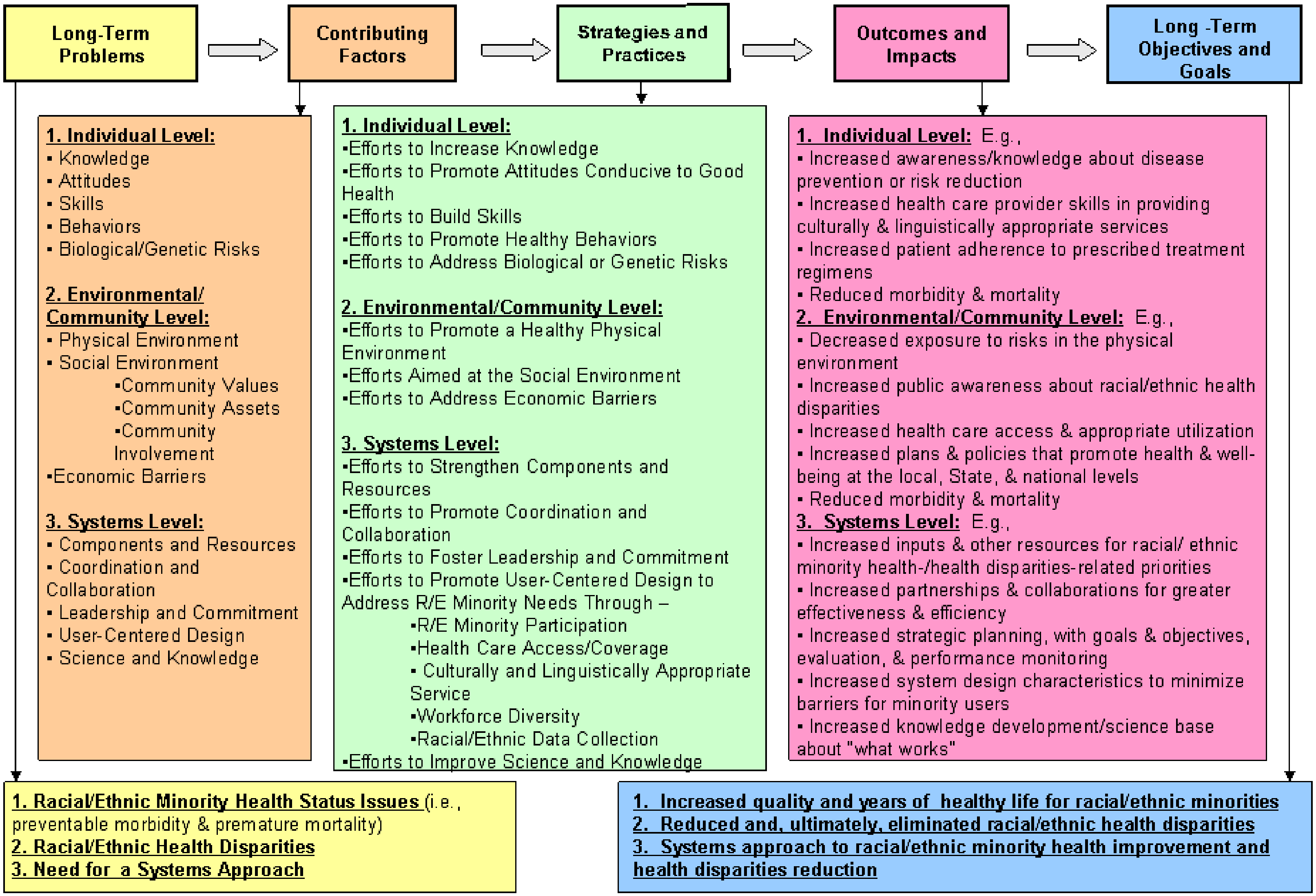
[7] As part of its Spring 2007 grant cycle, OMH issued its new *Evaluation Planning Guidelines for Grant Applicants* to strengthen evaluation within its grant programs. These guidelines were informed by the strategic framework and serve as the preliminary version of OMH's evaluation protocol for its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

- 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



Long-Term Problems

Contributing Factors

Strategies and Practices

Outcomes and Impacts

Long -Term Objectives and Goals

1. Individual Level:
- Knowledge
- Attitudes
- Skills
- Behaviors
- Biological/Genetic Risks

2. Environmental/ Community Level:
- Physical Environment
- Social Environment
  - Community Values
  - Community Assets
  - Community Involvement
- Economic Barriers

3. Systems Level:
- Components and Resources
- Coordination and Collaboration
- Leadership and Commitment
- User-Centered Design
- Science and Knowledge

1. Individual Level:
- Efforts to Increase Knowledge
- Efforts to Promote Attitudes Conducive to Good Health
- Efforts to Build Skills
- Efforts to Promote Healthy Behaviors
- Efforts to Address Biological or Genetic Risks

2. Environmental/Community Level:
- Efforts to Promote a Healthy Physical Environment
- Efforts Aimed at the Social Environment
- Efforts to Address Economic Barriers

3. Systems Level:
- Efforts to Strengthen Components and Resources
- Efforts to Promote Coordination and Collaboration
- Efforts to Foster Leadership and Commitment
- Efforts to Promote User-Centered Design to Address R/E Minority Needs Through –
  - R/E Minority Participation
  - Health Care Access/Coverage
  - Culturally and Linguistically Appropriate Service
  - Workforce Diversity
  - Racial/Ethnic Data Collection
- Efforts to Improve Science and Knowledge

1. Individual Level: E.g.,
- Increased awareness/knowledge about disease prevention or risk reduction
- Increased health care provider skills in providing culturally & linguistically appropriate services
- Increased patient adherence to prescribed treatment regimens
- Reduced morbidity & mortality

2. Environmental/Community Level: E.g.,
- Decreased exposure to risks in the physical environment
- Increased public awareness about racial/ethnic health disparities
- Increased health care access & appropriate utilization
- Increased plans & policies that promote health & well-being at the local, State, & national levels
- Reduced morbidity & mortality

3. Systems Level: E.g.,
- Increased inputs & other resources for racial/ ethnic minority health-/health disparities-related priorities
- Increased partnerships & collaborations for greater effectiveness & efficiency
- Increased strategic planning, with goals & objectives, evaluation, & performance monitoring
- Increased system design characteristics to minimize barriers for minority users
- Increased knowledge development/science base about "what works"

1. Racial/Ethnic Minority Health Status Issues (i.e., preventable morbidity & premature mortality)
2. Racial/Ethnic Health Disparities
3. Need for a Systems Approach

1. Increased quality and years of healthy life for racial/ethnic minorities
2. Reduced and, ultimately, eliminated racial/ethnic health disparities
3. Systems approach to racial/ethnic minority health improvement and health disparities reduction

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

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Appendix 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 at http://www.cdc.gov/nchs/. Racial and ethnic minority health data can be accessed from such sites as http://www.hhs-stat.net/omh/ or, by State, at Kaiser Family Foundation's http://www.statehealthfacts.org/, or from national minority health organizations. State health departments and State offices of minority health are also good sources for data about the populations in their jurisdictions. In addition, Inter-Tribal Council Epidemiology Centers are designed to provide access to health data for member Tribes. *These data can help answer questions about the key health problems and risk factors for the selected populations.*

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

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

Appendix 4:
Goals of OMH's National Partnership for Action to End Health Disparities

Goals of OMH's National Partnership for Action to End Health Disparities

NATIONAL PARTNERSHIP FOR ACTION
to End Health Disparities

NPA Goals

- **Awareness** - Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and other disparities populations.
- **Leadership** - Strengthen and broaden leadership for addressing health disparities at all levels.
- **Health System and Life Experience** – Improve health and healthcare outcomes for racial and ethnic minorities and for underserved populations and communities.
- **Cultural and Linguistic Competency** – Improve cultural and linguistic competency and the diversity of the health-related workforce.
- **Data, Research, and Evaluation** – Improve data availability and coordination, utilization, and diffusion of research and evaluation outcomes.

U.S. Department of Health & Human Services

Appendix 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

Number	Objective	R/E	Baseline Year	Baseline	1998	1999	2000	2001	2002	2003	2004	Target 2010	Progress Quotient
01-01	**Persons with health insurance (aged under 65 years)**	Asian only	1997	81.00%	82%	84.00%	82%	83%	83%	82%	83%	100%	-12.50
01-01	**Persons with health insurance (aged under 65 years)**	Hispanic or Latino	1997	66%	66%	66%	64%	65%	66%	65%	66%	100%	-2.94
01-04c	**Source of ongoing care - Adults (age adjusted, aged 18 years and over)**	Black or African American not Hispanic	1998	85%	BSL	83%	84%	87%	85%	85%	84%	96%	0.00
01-04c	**Source of ongoing care - Adults (age adjusted, aged 18 years and over)**	Hispanic or Latino	1998	76%	BSL	75%	73%	74%	74%	75%	72%	96%	0.00
01-05	**Persons with a usual primary care provider**	American Indian or Alaska Native	1996	79%	ND	75%	80%	76%	73%	79%	ND	85%	-66.67
01-05	**Persons with a usual primary care provider**	Black or African American not Hispanic	1996	74%	ND	76%	74%	76%	75%	73%	ND	85%	-9.09
01-05	**Persons with a usual primary care provider**	Asian or Pacific Islander	1996	71%	ND	68%	73%	75%	DNC	DNC	ND	85%	-21.43
01-06	**Difficulties or delays in obtaining needed health care**	Black or African American not Hispanic	1996	10%	ND	8%	10%	11%	ND	ND	ND	7%	-33.33
01-08b	**Racial and ethnic representation in health professions - Asian or Pacific Islander**	Asian or Pacific Islander	1996-97	16.3%	18.0%	18.6%	18.8%	20.3%	20.4%	20.6%	20.3%	4.0%	-33.33
01-08f	**Racial and ethnic representation in Nursing - Asian or Pacific Islander**	Asian or Pacific Islander	1995-96	3.2%	ND	ND	ND	3.3%	3.2%	3.5%	ND	4.0%	0.00
01-08i	**Racial and ethnic representation in Medicine - American Indian or Alaska Native**	American Indian or Alaska Native	1996-97	0.7%	0.8%	0.8%	0.9%	0.9%	0.9%	0.7%	0.6%	1.0%	0.00
01-08j	**Racial and ethnic representation in Medicine - Asian or Pacific Islander**	Asian or Pacific Islander	1996-97	16.0%	17.7%	18.7%	18.1%	19.8%	20.0%	20.7%	20.0%	4.0%	-33.33
01-08m	**Racial and ethnic representation in Dentistry - American Indian or Alaska Native**	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
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

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

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

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

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

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

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

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

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

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

Number	Objective	R/E	Baseline Year	Baseline	1998	1999	2000	2001	2002	2003	2004	Target 2010	Progress Quotient
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
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
18-02	**Suicide attempts requiring medical attention (grades 9 through 12)**	Black or African American not Hispanic	1999	2.9%	NA	BSL	ND	3.4%	ND	3.7%	ND	1.0%	-42.11
18-02	**Suicide attempts requiring medical attention (grades 9 through 12)**	Hispanic or Latino	1999	3.0%	NA	BSL	ND	3.4%	ND	5.0%	ND	1.0%	-100.00

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

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

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

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

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

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

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

Appendix 6:
Identifying and Selecting Performance Measures

Identifying, Developing, and Selecting Performance Measures for Racial/Ethnic Minority Health- and Health Disparities-Related Outcomes

Reviews, analyses, and syntheses conducted by the Office of Minority Health (OMH), U.S. Department of Health and Human Services (HHS), of performance elements and measures in existing health performance documents and data sources have revealed that not everything that may be important for health and systems outcomes is currently being measured in a systematic way. As Albert Einstein said, "Not everything that counts can be counted; not everything that can be counted counts." In many instances, while current science or knowledge may be clear about certain factors that influence racial and ethnic minority health, health disparities, and systems problems, or about certain strategies, practices, or interventions that are important to address these problems, the science, knowledge, and literature are not necessarily clear about how to measure the outcomes and impacts of efforts targeted to these factors.

Significant weaknesses and gaps exist in the availability of well-conceived and scientifically tested measures that can be used to evaluate the effectiveness of the range of strategies, practices, and interventions outlined in the *Strategic Framework*. For instance, many available health-related performance elements and measures, like existing performance measurement sources, are clinically-oriented rather than community- or population-based, and focus on health *care* rather than health *status* and well-being. Also, most of the identified performance elements and measures are at the individual level and are more likely to address short-term (proximal) results – such as changes in knowledge, attitudes, satisfaction, and skills – rather than long-term changes in behavior. Relatively few measures deal with the environmental-/community-level outcomes identified in the *Framework* (e.g., changes in community assets or "social capital") and even fewer enable assessment of systems-level outcomes (such as effective coordination and leveraging of resources, leadership effectiveness, the provision of culturally and linguistically appropriate services, or 'translation' of research into practice and vice versa).

These findings and observations highlight a need – and present a challenge to the research community – for the development and testing of new measures, especially at the environmental/community and systems levels, measures that go beyond clinical results, and measures for more distal rather than proximal outcomes.

That said, the discussion below presents, by way of example, an initial set of OMH-wide "core" performance measures, the considerations made in its development, proposed data sources for each measure, the relationship between OMH's 'core' measures and broader NPA and *Healthy People* objectives and goals as well as Office of Management and Budget (OMB) requirements for performance measurement, and a set of required and optional performance measures for OMH's grantees and cooperative agreement partners which were informed by the 'core' measures. For the identification, selection, and development of performance measures that can be used by other OMH partners and stakeholders for planning and evaluation purposes, further discussion is provided about OMH's efforts to develop a searchable performance measures 'inventory' and database, other available searchable performance data/measurement sources, and other related resources that may be used to inform performance measurement for outcomes and levels in the *Framework* for which gaps and weaknesses remain.

I. The OS/OMH Example: Development of ‘Core’ Measures and Subsequent Grantee-Specific Performance Measures Guided by the Core Measures

In the development of the *Framework*, the kinds of outcomes and impacts identified at the individual, environmental/community, and systems levels established a basis for identifying unique and common performance measures that can be used – or that may need to be developed and tested – to support evaluation of intervention effectiveness by OMH, its grantees, and other partners and stakeholders. By way of example, OMH’s process for identifying broad HHS- or OMH-wide and grantee-specific performance measures is outlined below.

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 and program coordination across HHS and the country;
2. The three levels (individual, environment/community, and systems) and components (long-term problems, contributing and causal factors, etc.), outlined in the *Strategic Framework*, that comprise the logic model approach for accomplishing OMH’s – and the Nation’s – mission relative to racial and ethnic minority health improvements and health disparities reductions;
3. The five overarching goals of the OMH-led *National Partnership for Action to End Health Disparities* (NPA) initiative, as follows:
    - Increased awareness of health disparities, their significance and impact on the nation, and the actions necessary to improve health outcomes for racial and ethnic minority and other underserved populations through strategic, coordinated, and consistent communications
    - Strengthened and broadened leadership for addressing health disparities at all levels
    - Improved health and healthcare outcomes for racial and ethnic minorities and other underserved populations
    - Improved cultural and linguistic competency and diversity of the health-related workforce
    - Improved data availability, and coordination, utilization, and diffusion of research and evaluation outcomes
4. Measures used by the Office of the Assistant Secretary for Health (OASH) for GPRA reporting purposes towards which OMH contributes;
5. Measures of long-term and annual outcomes and efficiency negotiated with the Office of Management and Budget (OMB) subsequent to its 2005 program assessment of OMH;

6. Measurable, racial/ethnic minority-specific objectives and sub-objectives presented in *Healthy People 2010* (*HP2010*) or *Healthy People 2020* (*HP2020*), including those for which “no progress” towards the target is being made;
7. The ability of the OMH-wide “core” measures to provide context and guide development of grant program- and grantee project-specific measures.

This resulted in an initial set of “core” recommended or developmental performance measures for OMH as a whole which are listed in Appendix 6-A.

The initial set of “core” OMH-wide measures, depicted graphically in Appendix 6-B, will continue to be improved and refined as better measures and data sources are identified or established. In the interim, this set of “core” OMH-wide measures have been used to inform the establishment and improvement of a 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 are also evolving and being improved, with revisions included with each iteration of OMH’s *Evaluation Planning Guidelines for Grant Applicants* – issued for the first time as part of the new OMH FY 2007 grant program announcements in June 2007 and most recently revised in June 2010 for the new OMH FY 2010 grant program announcements. The most recent set of OMH grantee-specific measures are identified in Appendix 6-C.

As further guidance in selecting performance measures for expected outcomes and impacts, Appendix 6-D presents an example for diabetes which illustrates possible outcomes and impacts, mandatory performance measures, and optional performance measures for each level identified in the *Framework.*

II. Identification, Selection, and Development of Performance Measures by Other OMH Partners and Stakeholders

The specific performance measures identified and selected for a particular project or program will differ depending upon the nature of the mission of the office, agency, or organization in which the project or program is located; how the organizational entity functions to carry out its mission; the kinds and range of outcomes or impacts that can be realistically expected based on how the entity 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. For example, different performance measures will be used as the basis for evaluation of intervention effectiveness by a community health center that delivers clinical services in underserved communities, a philanthropic enterprise that funds policy and research initiatives, a biomedical research institute or corporation that issues research grants to investigate the underlying causes of or cures for genetic- and biologically-based health conditions, or a Federal agency or entity whose purpose is to build program infrastructure and capacity at the State and county level to address particular health and social issues.

Appendices 6-E and 6-F describe OMH’s efforts to develop and provide an initial, searchable “inventory’ and database of performance measures that could be used to support evaluation of the effectiveness of interventions in achieving desired results. Appendix 6-G identifies a number of other existing and planned searchable databases currently or soon-to-be available to OMH's partners and stakeholders to facilitate identification and selection of performance measures for planning and evaluation purposes. However, as stated above, there continue to be gaps and weaknesses in available, credible, and tested performance measures for a number of the kinds of outcomes and levels outlined in the *Framework*. Appendix 6-H, therefore, presents a set of resources gleaned through a series of OMH-conducted environmental scans that may be used to inform development, identification, and selection of measures for such outcomes and levels in the *Framework* for which performance measurement gaps and weaknesses remain.

While performance measures may differ from one project, program, or 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 projects, programs, offices, agencies, and organizations. To this end, it is recommended that, to the extent possible, OMH's partners and other stakeholders incorporate relevant measures outlined in the *National Partnership for Action to End Health Disparities* (NPA) and/or *Healthy People* in their measures sets. More information on these efforts can be found on the NPA web pages of the OMH web site at http://www.minorityhealth.hhs.gov and the *Healthy People* web site at http://www.healthypeople.gov or *Data 2010* website at http://wonder.cdc.gov/data2010, respectively.

Appendix 6-A:
OMH Core Measure

OMH Core Measures

OMH-Wide 'Core' (Recommended and Developmental) Measures

Healthy People

- Number and percent of measurable, population-specific *HP2010* (or *HP2020*) objectives towards which OMH-funded programmatic efforts contribute [data sources: National Center for Health Statistics (NCHS) and the OMH Performance Data System (PDS)]
- Number and percentage of racial/ethnic minority-specific *HP2010* sub-objectives that have not made progress towards – or are moving away from – their targets being addressed by OMH-funded project and programmatic efforts (data sources: NCHS and OMH PDS)

National Partnership for Action to End Health Disparities

- Number of OMH-funded projects, programs, and initiatives that contribute towards each of the objectives of OMH's *National Partnership for Action to End Health Disparities* (NPA) [data source: OMH PDS]

Leadership

- Number of grantee and partnering organizations with strategic plans and/or formal strategic planning processes to guide and monitor progress towards organizational goals and objectives, including those specific to racial/ethnic minority health improvements and/or health disparities reductions [data sources: Quarterly GPRA reports from Regional Minority Health Consultants and OMH PDS]

Coordination and Collaboration

- Number of partnerships facilitated and/or established to enhance coordination and collaboration of efforts to address racial/ethnic minority health, health disparities, and/or systems approaches to these problems as reflected in a current written agreement that includes at a minimum:
  - Names of all parties involved in the partnership
  - Purpose of the partnership
  - Roles and responsibilities of each partner
  - Evidence of coordination and regular communication practices

  - Time frame for the partnership
  - Expected results of the partnership
  - Evidence of progress in achieving results

[data sources: Quarterly OMH GPRA reports from Division of Program Operations and Office of the Director, and OMH PDS]

Community and Individual Awareness and Knowledge/Education and Outreach

- Percent of persons in the general public with awareness or understanding of racial/ethnic minority health and health disparities problems [data source: OMH/NORC Surveys of Public Awareness; conducted in 2009 and 2010, and every 2-3 years thereafter]
- Number and percent of individuals at the OMH 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 PDS]

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 (CAHPS)]

Cultural and Linguistic Competency in Health Care/User-Centered Design

- Percent of limited-English-proficient individuals with and without usual source of care that offers language assistance [data source: MEPS]
- Number of persons who participate in OMH-supported ‘pipeline’ programs to increase racial/ethnic minority representation in the public health, health care, and research workforce [data source: OMH PDS]

Research and Outcome Evaluations/Science and Knowledge

- Proportion of population-based *HP2010* objectives for which national data are available for all racial/ethnic minority population groups identified for the objective [data source: CDC/NCHS Data 2010 for *HP2010* Objective 23.4 or equivalent in *HP2020*]

- Number of HHS-supported RD&E and special studies to improve racial/ethnic data and develop science/knowledge about MH/HD problems, solutions, and systems approaches to such problems and solutions [potential data sources: reports from the HHS Data Council or HHS Health Disparities Council; HHS/ASPE Policy Information Center Database]
- Number of *coordinated*, trans-disciplinary HHS-supported minority health-/health disparities-related RD&E initiatives and programs [potential data source: reports from the HHS Health Disparities Council and/or the Federal Collaboration on Health Disparities Research (FCHDR)]
- Number of reports from, and publications in professional journals about, 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 [potential data sources: reports from the HHS Health Disparities Council and/or the FCHDR]
- 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 sources: OMH PDS and OMH Evaluation TA Center]

Efficiency

- Number of individuals participating in OMH-funded project and programmatic strategies, practices, and interventions that are being implemented or conducted [data source: OMH PDS]
  - Total participants
  - Total participants by race, gender, and age

Appendix 6-B:
Graphic Depiction of OMH Core Measures Relative to NPA & Healthy People Objectives & Goals, and OMB Performance Measurement Requirements

Updated October 2010

Relationship Between OMH “Core” Measures, *Healthy People 2010*, OMB/PART Requirements, the *National Partnership for Action* Goals & OMH-funded Efforts

PART-Related; NPA-Related; Program-Related

Healthy People 2010 Goals & Objectives

Community Awareness & Knowledge

(4) Public/community awareness & knowledge of r/e minority health/health disparities (MH/HD) problems, the need for a system approach to such problems, & how to more effectively identify and effect solutions (PART-related)

(5) Individual awareness/ knowledge about r/e MH/HD problems, the need for a systems approach to such problems, & how to more effectively identify and effect solutions (PART & NPA goal-related)

***Healthy People 2010 (HP2010)* Objective-Related Outcomes & Impacts**

(1) Measurable, population-specific objectives towards which programmatic efforts of OMH grantees and other partners contribute

(2) Racial/ethnic (r/e) minority-specific objectives & subobjectives not making progress towards– or moving away from–their targets that are being addressed by OMH grantees & other partners (PART-related)

Cost-Efficiency

(3) Persons participating in OMH-funded grant programs/annual specified dollar amount of grant support (PART-related)

Leadership

(6) Grantee & partnering organizations with **strategic plans &/or formal strategic planning processes** to guide & monitor progress towards organizational goals & objectives, including MH/HD-related efforts (NPA goal-related)

Science & Knowledge

(9) Population-based *HP2010* objectives for which national **data are available for all r/e minority groups** identified (NPA goal-related)

(10) HHS-supported **RD&E & special studies** to improve r/e data & develop science/ knowledge about MH/HD problems, solutions, & systems approaches to same (NPA goal-related)

(11) *Coordinated* HHS-supported MH/HD-related RD&E initiatives & programs (NPA goal-related)

(12) Reports from such coordinated, HHS supported MH/HD-related RD&E efforts (NPA goal-related)

(13) “Best” or “evidence-based” practices identified from such MH/HD-related RD&E efforts (NPA goal-related)

Coordination & Collaboration

(7) Partnerships facilitated &/or established to strengthen focus on r/e MH/HD problems, effect systems approaches to such problems, & leverage resources & other assets aimed at results & solutions (NPA goal-related)

(8) HHS-supported partnerships to strengthen r/e MH/HD-related research, demos, & evaluation (RD&E) (NPA goal-related)

Cultural & Linguistically Appropriate Services & Patient-Provider Communications

(14) Limited English-proficient individuals with a usual source of care that offers **language assistance** (NPA goal-related)

(15) Adult patients w/ a negative **experience of care** (NPA goal-related)

(16) Hospital patients who did not have **good communications** with doctors or nurses (NPA goal-related)

CLAS

(17) Persons in HHS-supported **‘pipeline’ programs** to increase r/e diversity in the public health, health care, & research workforce (NPA goal-related)

OMH Demonstration Grant Programs (e.g., State Partnership, Community Partnership, AIAN Health Disparities)

- core measures
- other measures

OMH National Umbrella Cooperative Agreements

- core measures
- other measures

Other Major OMH-funded Programmatic Efforts (e.g., CCLCHC, OMH-RC)

- core measures
- other measures

Other OMH Initiatives (e.g., WH minority initiatives, HHS Disparities Council)

- core measures
- other measures

OMH Divisions, Managers, & Staffs

- specific OMH core & other measures to which each Division and staff contribute

Appendix 6-C:
OMH Performance Measures/Indicators for Grantees

OMH Performance Measures/Indicators for Grantees

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

It is critical, however, for OMH grantees to keep in mind that their OMH-funded projects must use performance measures or indicators that are linked and contribute to grant program-wide, OMH-wide, and *Healthy People* objectives and goals[1].

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

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

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

- Number of partnerships facilitated and/or established to enhance coordination and collaboration of efforts to address racial/ethnic minority health/health disparities problems
- Amount of funding, staffing, and other resources ‘leveraged’ through partnerships to more efficiently and effectively address racial/ethnic minority health/health disparities problems of mutual interest
  - At the grantee organization level
  - At the grant project level

- Number of individuals (unduplicated) participating in OMH-funded project and programmatic interventions and other efforts as strategies, practices, and interventions are being implemented or conducted
  - Total (unduplicated) participants
  - Participants by race, gender, and age

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

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

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

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

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

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

Appendix 6-D:
Example of Diabetes-Related Measures

Example of Diabetes-Related Measures

As further guidance for Step 3 in the evaluation protocol, 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

Appendix 6-E:
Initial Data Sets for an OMH Searchable Performance Measures Database

OMH'S Systematic Process for Identifying Performance Measure Sources as the Basis For Development of a Searchable Performance Measures Inventory and Database

Although the *Strategic Framework* developed by OMH includes a range of the types of outcomes and impacts that might be expected in planning, implementing, and evaluating efforts to improve racial and ethnic minority health and address racial and ethnic health disparities, recommendations regarding the particular performance measures or indicators to use in assessing progress towards such outcomes and impacts were not provided. Performance measures or indicators for OMH-funded grant programs and other programmatic efforts will be different from those needed by other OMH partners and stakeholders, depending upon the kinds of outcomes or impacts to be achieved, at what levels of the *Framework* (individual, environment/community, and/or systems) interventions are aimed, and whether adequate and tested measures actually exist for the kinds of results expected.

In FY 2006, OMH began the process of developing an initial set of performance measures that are aligned, to the extent possible, with the various levels and outcomes outlined in the *Framework*. To accomplish this task, OMH identified and analyzed a number of key sources for potential measures of outcomes and impacts presented in the *Framework*, isolated recommended measures from the selected sources, and created a combined "inventory" of these measures[1] which would, when completed, form the basis for a searchable performance measures database that could be used to broadly support evaluation planning and implementation needs. In order to be selected as one of the key sources for potential measures that would comprise this initial combined inventory, the source had to meet the following criteria:

In FY 2006, OMH began the process of developing an initial set of performance measures that are aligned, to the extent possible, with the various levels and outcomes outlined in the Framework. To accomplish this task, OMH identified and analyzed a number of key sources for potential measures of outcomes and impacts presented in the Framework, isolated recommended measures from the selected sources, and created a combined "inventory" of these measures[1] which would, when completed, form the basis for a searchable performance measures database that could be used to broadly support evaluation planning and implementation needs. In order to be selected as one of the key sources for potential measures that would comprise this initial combined inventory, the source had to meet the following criteria:

- Be produced by established, well-known, and credible organizations in health care, health promotion, or public health;
- Be produced and/or used by HHS;
- Be produced through rigorous and systematic scientific literature review and peer review; and,

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[1] Office of Minority Health (April 2008) *"Identifying and Developing Performance Measures for Improving Racial and Ethnic Minority Health, Reducing Racial and Ethnic Health Disparities, and Effecting a Systems Approach to Such Issues."*

- Contain measures and recommendations of relevance to the work of OMH and its partners.

Dozens of health-related documents and databases of possible measures were identified and assessed against the selection criteria. After a comprehensive review of potential collections, OMH selected the following eight measure sources for inclusion in its initial combined inventory of performance measures:

- ***Healthy People 2010***

  Each decade, the U.S. Department of Health and Human Services (HHS) releases a set of health objectives for the nation to achieve by the end of the decade, known as *Healthy People*. The most recent iteration, *Healthy People 2010* (*HP2010*, available at http://www.healthypeople.gov/ and http://wonder.cdc.gov/data2010/) was released in 2000 and was developed through a broad consultation process, built on the best scientific knowledge, and designed to measure progress of disease prevention and health promotion programs and related efforts over time. *HP2010* is comprised of 28 focus areas that organize its 467 objectives and numerous sub-objectives. Each objective and sub-objective is presented with a baseline and target for the population as a whole and for each race/ethnicity identified, as well as the data source and sponsoring organization collecting the information for that measure. Any objective without a data source was categorized as developmental, and was dropped at the Mid-Course Review (completed in 2006) if a national baseline data source still did not exist.

- **Recommendations of the *U. S. Preventive Services Task Force***

  The U. S. Preventive Services Task Force (USPSTF) is an independent panel, composed of experts in primary and preventive care. First convened by the U.S. Public Health Service in 1984, the Agency for Healthcare Research and Quality has sponsored the USPSTF since 1988. This Task Force assesses the availability and strength of scientific evidence in order to grade clinical preventive services and develops recommendations for physicians and health care organizations, available at http://www.uspreventiveservicestaskforce.org/. These recommendations are published in the form of "Recommendation Statements." Grades A and B both indicate that the Task Force recommends a service, with Grade A signifying a strongly recommended service. In the event that the Task Force does not recommend for or against a service, the item receives a Grade C. The USPSTF designates a service as Grade D when recommending against implementation of the intervention. Finally, a Grade I indicates that there is insufficient evidence for the USPSTF to make a recommendation for or against the service.

- **Partnership for Prevention's *Priorities for America's Health***

  Partnership for Prevention (PFP) conducted a study to rank the health impact and cost effectiveness of 25 of the clinical preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) and Advisory Committee on Immunization Practices (ACIP). These rankings were initially conducted in 2001, and are available at http://www.prevent.org/National-Commission-on-Prevention-Priorities/Rankings-of-Preventive-Services-for-the-US-Population.aspx. The PFP rankings have been updated by the National Commission on Prevention Priorities (NCPP), a 24-member panel of decision-makers from health insurance plans, an employer group, academia, clinical practices, and governmental health agencies. The organization uses two measures – Clinically Preventable Burden (CPB) and Cost Effectiveness (CE) – to rank the measures. The NCPP defined CPB as the "disease, injury and premature death that would be prevented if the service were delivered at recommended intervals" and CE as the "average net cost per quality adjusted life years gained", scoring each through a quantitative ranking of 1-5.

- **Centers for Medicare & Medicaid Services' *Hospital Quality Measures***

  The Centers for Medicare & Medicaid Services (CMS) and members of the Hospital Quality Alliance (HQA) created *Hospital Compare* http://www.hospitalcompare.hhs.gov, a web-based tool providing information on how well hospitals care for their patients. Within the tool, hospitals are evaluated using performance measures derived from three areas: process of care, outcome of care, and patient satisfaction. Process of Care measures note how often a hospital provides recommended treatments for certain conditions or procedures, using data that are derived from hospital patient records. Outcome of Care measures reflect the 30-day risk-adjusted mortality measures for heart attack, heart failure, and pneumonia, produced from Medicare claims and enrollment data. Patient Satisfaction measures were derived from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), a national, standardized survey of hospital patients.

- **Agency for Healthcare Research and Quality's *National Healthcare Quality Report and National Healthcare Disparities Report***

  The National Health Quality Report (NHQR) and the National Health Disparities Report (NHDR) are companion documents released annually by the Agency for Healthcare Research and Quality (AHRQ) on behalf of HHS, available at http://www.ahrq.gov/qual/measurix.htm#quality. Using different perspectives, both reports measure health care quality and track changes over time. The NHQR focuses on health care quality and the opportunities for improvement for all Americans as a whole, organizing measures according to four dimensions (quality-effectiveness, patient safety, timeliness, and patient centeredness) and covering four stages of care (staying healthy, getting better, living with illness or disability, and coping with the end of life). The NHDR addresses the distribution of improvements in health care quality and access across the populations that make up America. The NHDR tracks disparities among populations across the same measures addressed in the NHQR, as well as an access to care dimension. The 2007 NHQR consists of 41 core measures, of which 33 are focused on the effectiveness of care, 4 on patient safety, 2 on timeliness, and 2 on patient centeredness. The 2007 NHDR includes almost all of the NHQR measures, as well as 6 additional measures pertaining to access of care.

- **Commonwealth Fund's (CF's)** *State Scorecard on Health System Performance*, available at http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Jun/Aiming-Higher--Results-from-a-State-Scorecard-on-Health-System-Performance.aspx, assesses state performance across measures of their healthcare systems. The document evaluates state performance relative to what is achievable, based on benchmarks drawn from the range of state health system performance. The measure collection consists of 32 measures, ranking each state's performance within each measure to compare across the states and tracking performance over time. The measures fall into key performance domains: access; quality; potentially avoidable use of hospitals and costs of care; equity; and healthy lives. Whenever possible, indicators of health system performance were selected to be equivalent to those used in the National Scorecard on U.S. Health System Performance. However, comparable state-level data were not available for some topics, in particular, chronic disease management and patient safety. State Scorecard first ranks states from best to worst on each of the 32 performance indicators. Then, the rankings are averaged within each of the five dimensions. Finally, an average of dimension rankings provides overall ranking.

- **Recommendations of the *Task Force on Community Preventive Services***

  The Task Force on Community Preventive Services (TFCPS) is an independent panel of public health and prevention expert volunteers, appointed by the Director of the Centers for Disease Control and Prevention (CDC). Established in 1996, the Department of Health and Human Services (DHHS) charged the Task Force with developing recommendations for community-based interventions that promote health and prevent disease in addition to identifying areas that need additional research. In 2005, the TFCPS released the first edition of "The Guide to Community Preventive Services". Although the Task Force continually updates recommendations and findings on its web-based resource, located at the URL http://www.thecommunityguide.org, to date, the Task Force has not released a second paper-based edition of the Guide.

It is important to note that, in the review and analyses of the performance information in the above source documents, one of the key issues that was identified was the need to resolve performance versus measurement language. While all source documents present performance information, the contents were not uniformly presented in measurement language. For example, *Healthy People 2010* contains "objectives," while the *Guide to Community Preventive Services* contains recommended clinical practices. Therefore, over the next two years, OMH undertook a process to "convert" and integrate, as necessary, such information into measures language to ensure consistency with actual measures language in other source documents, such as the AHRQ annual health care quality and health care disparities reports. The original wording and intent of all performance-oriented objectives, recommended or suggested practices, and other related data were preserved as much as possible from the source documents. For example, *Healthy People 2010* objective 5.1 is to "increase the proportion of persons with diabetes who receive formal education," while the converted measure is, "proportion of persons with diabetes who receive formal education."

Thus, while each of the eight selected data sets can be individually accessed and searched for the kinds of performance elements contained therein, the process that OMH has been using to convert all performance elements into measures language and subsequently integrate all such elements into a ‘combined inventory’ – currently in the form of an Excel spreadsheet – may provide a more efficient means for identifying and selecting measures relevant to the kinds of outcomes, impacts, and other results expected from interventions conducted. The current status of the Excel-based inventory and database development is discussed in more detail in Appendix 6-F.

Appendix 6-F:
OMH Excel Sheet Spreadsheet/Database of Performance Measures

Development of an Initial OMH Performance Measures "Inventory" and Searchable Database for General Use

Building upon the performance elements or measures gleaned from each of the initial eight data sources identified in Appendix 6-E, in FY 2009, OMH contracted with the National Opinion Research Center (NORC) to begin development of an integrated, searchable database that could serve as a "one-stop shop" for identifying and selecting performance measures related to the various types of outcomes and impacts outlined in the *Framework*. The combined inventory of these measures was the first step towards building such a database. OMH's intention was to facilitate identification and selection of performance measures, more strongly support and encourage evaluation of the effectiveness of interventions conducted, and, hence, 'grow the science' regarding 'what works' relative to racial/ethnic minority health improvements and health disparities reductions.[1]

Quality Review Process for Initial Inventory Development:

A careful, systematic, and extensive quality review process was first undertaken to ensure the accuracy, consistency, completeness, and currency[2] of all of the measures from each of the eight initial data sources. The quality assurance process included identifying errors, tracking the cause and breadth of systematic errors, establishing and following a cohesive process of remediation, and applying those fixes identified to other similarly affected measures. Furthermore, the process included development and implementation of a second round of quality assurance which included the development of a series of rules for such actions as noting all deletions and insertions to text, identifying statistical notations, modifying text, providing supplemental information, etc. Measures were also examined across different sources so that, to the extent possible, duplications or overlaps between measures could be removed. Then, the more than 1100 performance elements or measures from these initial data sets were organized and compiled into a 'combined inventory – in the form of an Excel spreadsheet[3] – in a manner that would enable searches for measures according to measure source (including multiple sources for the

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[1] A detailed description of the process undertaken by OMH to review, analyze, and glean information from the initial eight data sets for inclusion as performance elements or measures in this inventory is available in the OMH Final Report, *Identifying and Developing Performance Measures for Improving Racial and Ethnic Minority Health, Reducing Racial and Ethnic Health Disparities, and Effecting a Systems Approach to Such Issues*, Office of Minority Health, U.S. Department of Health and Human Services, April 2008.

[2] The most recent iteration of online reports or data available from the initial eight data sets as of the end of 2008 have been incorporated into the current Excel-based performance measures inventory.

[3] Microsoft Excel is a widely distributed spreadsheet application that features basic data manipulation functionalities, such as sorting and filtering which are potentially valuable features for users of the datafile. Users can employ the Find features of Microsoft Excel by clicking the Find and Select button, entering the text or numbers being searched and clicking "Find All," which lists every occurrence of the item being searched and allows the user to make a cell active by selecting a specific occurrence. This allows a user interested in a particular item in the measure categories, or a particular word across any measure entry (e.g., "cancer" or "access") to have a ready-made list of all instances of that word or phrase. In addition, users can sort data in one or more columns by text, numbers, or according to their personally-created list to organize the inventory contents according to their specifications and ease usage. Additionally, users can filter the data, telling Microsoft Excel to display only the rows that meet specified criteria and to hide any other rows. Filters are additive, so that each additional filter is based on the current filter and further reduces the subset of data. This could allow a user to, for example, display only those measures from *Healthy People 2010* whose data was collected in 2001 and is moving in the wrong direction.

same measure), health or system issue identifiers, measure descriptions, baseline year, data source for tracking progress, race/ethnicity identifiers, and variables related to OMH performance measurement requirements (e.g., is the measure a ‘core’ measure, including a *Healthy People* racial/ethnic minority-specific objective for which no progress is being made towards the target or that is moving away from the target). Furthermore, OMH followed a systematic analytical and review process to align and link the performance measures from these initial data sets, to the extent possible, to individual-, environmental-/community-, and/or systems-level outcomes and impacts outlined in the *Framework*. Hence, all of the selected measure sources address at least some of the levels, factors, and outcomes/impacts in the *Framework* as well as at parts of the continuum of care, ranging across clinical prevention, community prevention, risk reduction, treatment, and patient management.

Description of the OMH Performance Measures Inventory (Excel Spreadsheet) To Date

The present version of the Excel Spreadsheet that comprises the electronic version of the OMH Performance Measures Inventory includes a set of rows and columns that can be reduced or expanded as new measures or requisite fields for defining, describing, organizing, or selecting the measures are revised or refined. The inventory currently consists of a collection of 1,138 distinct performance measures, with each measure listed in its own row in the spreadsheet. Measures are initially grouped according to measure source. Within each measure source, the measures are organized alphabetically using the corresponding priority health or systems issues category. For instance, the first measure which addresses the “number of interventions aimed at improving adolescent health that implement person-to-person interventions to improve caregivers’ parenting skills’ (from the Task Force on Community Preventive Services) is associated with the “adolescent health” priority health issue. This is consistent for all measure sources with the exception of Healthy People 2010. For this source, measures are organized according to their objective number. For example, Healthy People 2010 measures begin with objective number 1-1 (proportion of persons aged under 65 years with health insurance) and end with objective 28-18 (Number of adults who have elevated hearing thresholds, or audiometric notches, in high frequencies (3,4, or 6 kHz) in both ears, signifying noise-induced hearing loss (per 1,000 population aged 20 to 69 years).
The Spreadsheet also includes a total of 81 columns that represent descriptors or attributes for each measure that can be searched or sorted (such as its data source, related priority health or systems issue, *HP2010* objective number, whether it is a *HP2010* ‘wrong-way’ objective, whether it has data for each particular OMB-recommended racial/ethnic categories, whether it is an OMH ‘core’ measure, etc.). Below is a more detailed description of the content included within the spreadsheet’s/inventory’s columns:

1. *Columns A through H (Measure Source)* - Identifies from which of the eight measure sources the measure was obtained. Each column represents a measure source. Measure sources include: *Healthy People 2010*, the recommendations of the U.S. Preventive Services Task Force and Task Force for Community Preventive Services, the Partnership for Prevention, the Centers for Medicare and Medicaid Services, AHRQ’s National Healthcare Quality Report (NHQR) and National Healthcare Disparities Report (NHDR), and the

Commonwealth Fund's State Scorecards. In instances where there are multiple data sources for one measure, all relevant measure sources are identified. For example, for the measure "Proportion of pregnant women who receive early and adequate prenatal care," there is an 'X' in the columns for AHRQ's NHDR, NHQR, and *HP2010*.

2. *Column I (OMH Core)* - Identifies those measures that OMH has selected to support the objectives and goals of *Healthy People* and the *National Partnership for Action to End Health Disparities*, incorporate OMB-approved measures, and guide the development of selected measures that will link the contributions of its own grantees and cooperative agreement partners to OMH-wide performance. Only those measures marked with an "X" are considered OMH core measures.

3. *Column J (Priority Health Issue)* – Provides a short title for each measure based on the health area or condition it addresses (e.g., cancer, obesity, etc.). The titles were taken directly from the measure source and are included to assist users in identifying measures of interest via the keyword search.

4. *Column K (Description of Measure)* – Provides a qualitative description of the measure that specifically identifies what should be counted and reported, and establishes the parameters for the count. This column, in addition to column J, provides most of the content for the keyword searches.

5. *Column L (Objective Number HP2010)* – Identifies the measure by its Healthy People 2010 objective number which ranges from 1-1 to 28-18.

6. *Column M (Baseline Year)* – Provides the baseline year or range of years for which there is baseline data available.

7. *Columns N-BR (Baseline Data/Racial and Ethnic Group)* – Represents a race/ethnicity combination as identified by the data collection procedures in HP2010.[4] For those measures with available baseline data, a percentage or number is included based on what is being measured. For instance, for measures that quantify a proportion, there is a percentage (i.e., proportion of adults with diabetes who obtain an annual urinary microalbumin measurement). For measures with a count, there is a number (i.e., number of health promotion programs in the States and District of Columbia for people with disabilities).

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[4] Measure Baseline Data: Baseline Year for American Indian or Alaska Native; Baseline Year for Asian Only; Baseline Year for Native Hawaiian or Other Pacific Islander only; "Baseline: All Races/Ethnicities "; All R/E Wrong Way; All R/E No Progress; "Baseline: American Indian or Alaska Native"; AI/AN Wrong Way; AI/AN No Progress; "Baseline: Asian r Pacific Islander"; A/PI Wrong Way; A/PI No Progress; Baseline: Asian; Asian Wrong Way; Asian No Progress; "Baseline: Native Hawaiian and other Pacific Islander"; NH/oPI Wrong Way; NH/oPI No Progress; "Baseline: Black or African American"; B/AA Wrong Way; B/AA No Progress; "Baseline: White"; W Wrong Way; W No Progress; "Baseline: Two or More Races"; 2+ Wrong Way; 2+ No Progress; "Baseline:; American Indian or Alaska Native & White"; AI/AN&W Wrong Way; AI/AN&W No Progress; "Baseline: Black or African American & White"; B/AA&W Wrong Way; B/AA&W No Progress; "Baseline: Hispanic or Latino"; H/L Wrong Way; H/L No Progress; "Baseline: Cuban"; H/L-C Wrong Way; H/L-C No Progress; "Baseline: Mexican American"; H/L-MA Wrong Way; H/L-MA No Progress; "Baseline: Puerto Rican"; H/L-PR Wrong Way; H/L-PR No Progress; "Baseline: Other Hispanic"; H/L-o Wrong Way; H/L-o No Progress; "Baseline: Non Hispanic or Latino"; Non-H/L Wrong Way; Non-H/L No Progress; "Baseline: Not Hispanic- Black or African American"; Non-H/L-B/AA Wrong Way; Non-H/L-B/AA No Progress; "Baseline: Not Hispanic- White"

7a. Columns *N-BR (Objective Moving Away From the Target)* – Indicates whether the measure is a *Healthy People 2010* objective that is moving away from the established target; indicator follows each racial and ethnic group baseline column.

7b. Columns *N-BR (Objective Making No Progress Toward the Target)* –Indicates if the measure is a *Healthy People 2010* objective for which no progress is being made towards the established target; indicator follows each racial and ethnic group baseline column and the previous "moving away from the target" column.

7c. Columns *BS (Healthy People 2010 Target)* –Identifies the target towards which the population should be heading (for population-based objectives).

8. *Column BT (2007 Measure Number/NHQR/NHDR)* – Indicates the reference number assigned to the measure by the Agency for Health Care Research and Quality (AHRQ) as noted in AHRQ's National Healthcare Quality Report (NHQR) and National Healthcare Disparities Report.

9. *Column BU (Baseline Group – NHQR/NHDR)* - Identifies whether there was data available at the time of publication which could be used for comparison purposes, i.e., measures use the national average at the baseline year as a denominator to identify progress over time.

10. *Column BV (Clinically Preventable Burden)* - Includes a scale score developed by the National Commission on Prevention Priorities (NCPP). Clinically Preventable Burden (CPB) is defined by the NCPP as the "disease, injury and premature death that would be prevented if the service were delivered at recommended intervals." Services that produce the most health benefits received the highest CPB score of 5.

11. *Column BW (Cost Effectiveness)* - Includes a scale score developed by the NCPP. Cost Effectiveness (CE) is defined by the NCPP as the "average net cost per quality adjusted life years gained", scoring each through a quantitative ranking of 1-5. Services that are most cost effective received the highest CE score of 5.

12. *Column BX (Total Ranking)* - Includes a scale score developed by the NCPP. Scores for CPB and CE were added to give each service a possible total score between 2 and 10.

13. *Column BY (USPSTF Full Recommendation)* - Includes the "clinical considerations" provided by the U.S. Preventive Services Task Force (USPSTF) as additional details supporting its recommendation. The information provided includes content such as the types of patients for which the recommendation is applicable, treatment options for those applicable patients, risks and morbidity rates for the population as a whole and for particular at-risk demographic groups, and other details.

14. *Column BZ (TFCPS Summary Recommendation)* - Includes the additional details provided by the Task Force on Community Preventive Services (TFCPS) to contextualize its recommendations. The content includes background information on the topic, descriptions of interventions, results from systematic reviews, and other details.

15. *Column CA (Data Source)* - Identifies the survey, administrative data, or professional organization that collected or developed the data.

16. *Column CB (Sponsoring Organization for the Data Collection)* – Identifies the agency or organization responsible for the data collection effort.

17. *Column CC (Comments)* – Includes any appropriate details regarding the measure or measure data not included in the measures description that may be of interest to some users, e.g., the letter of the recommendation for USPSTF measures that indicates whether it was recommended, strongly recommended, or recommended against.

To further illustrate the kinds of measures that are in the current OMH Excel Spreadsheet/ Performance Measures Inventory, three examples of measures and the kinds of easily identifiable information that are available in this tool are provided below.

Example Measure #1

COLUMN HEADING	COLUMN LETTER	DATA
Measure Source	E	Commonwealth Fund
Priority Health or Systems Issue	J	Quality
Description of Measure	K	Percent of adults age 50 and older receiving recommended screening and preventive care
Baseline Year	M	2004
Baseline: All Races/Ethnicities	Q	39.7%
Data Source	CA	Behavioral Risk Factor Surveillance System (BRFSS)
Sponsoring Organization	CB	Centers for Disease Control and Prevention (CDC)-- National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)
Comments	CC	Percent of adults age 50 and older who have received: sigmoidoscopy or colonoscopy in the last ten years or a fecal occult blood test in the last two years; a mammogram in the last two years (women only); a pap smear in the last three years (women only); and a flu shot in the past year and a pneumonia vaccine ever (age 65 and older only). Baseline = All States Median

Example Measure #2

COLUMN HEADING	COLUMN LETTER	DATA
Measure Source	H	Healthy People 2010
OMH CORE Measure	I	X
Priority Health or Systems Issue	J	Access to Quality Health Services
Description of Measure	K	Proportion of persons aged 18 and older appropriately counseled about physical activity or exercise
Objective Number - HP2010	L	Objective 1-3a
Baseline Year	M	2001
Baseline: All Races/Ethnicities	Q	45%
Baseline: American Indian or Alaska Native	T	38%
Baseline: Asian/Pacific Islander	W	DNC
Baseline: Asian	Z	42%
Baseline: Native Hawaiian and other Pacific Islander	AC	DSU
Baseline: Black or African American	AF	53%
Baseline: White	AI	44%
Baseline: Two or More Races	AL	47%
Baseline: American Indian or Alaska Native & White	AO	43%
Baseline: Black or African American & White	AR	DSU
Baseline: Hispanic or Latino	AU	48%
Baseline: Non Hispanic or Latino	BJ	45%
Baseline: Not Hispanic- Black or African American	BM	53%
Baseline: Not Hispanic- White	BP	44%
Healthy People 2010 Target	BS	54%
Data Source	CA	National Health Interview Survey (NHIS); National Survey of Family Growth (NSFG)
Sponsoring Organization	CB	Centers for Disease Control and Prevention (CDC)-- National Center for Health Statistics (NCHS)

Example #3

COLUMN HEADING	COLUMN LETTER	DATA
Measure Source	D	Task Force for Community Preventative Services
Priority Health or Systems Issue	J	Diabetes
Description of Measure	K	Number of interventions aimed at improving diabetes prevention and control in adults with type 2 diabetes that implement diabetes self-management education in community gathering places
Recommendation Summary-TFCPS	BZ	The Task Force on Community Preventive Services recommends that diabetes self-management education (DSME) interventions be implemented in community gathering places on the basis of sufficient evidence of effectiveness in improving glycemic control for adults with Type 2 diabetes. Diabetes self-management education (DSME) is the process of teaching people to manage their diabetes.
Data Source	CA	N/A - Recommendation for Data Collection
Sponsoring Org.	CB	N/A - Recommendation for Data Collection

Next Steps for the Performance Measures Inventory

As noted previously, this Excel Spreadsheet, and the initial Performance Measures Inventory contained therein, is intended to serve as the basis for developing a searchable, web-based performance measures database that can be used by OMH grantees, partners, and other stakeholders in their efforts to plan and evaluate the extent to which the strategies, practices, and interventions being funded, conducted, or otherwise supported are achieving expected results.

Currently, the existing tool – which, as a basic but expansive Excel Spreadsheet, is not reproducible in printed form – is awaiting conversion to a format that is compliant with Section 508 of the Rehabilitation Act so that it will be accessible to visually impaired individuals. OMH is also investigating whether a list of search terms and/or a users' guide should also be made available concurrently with the tool.

The tool, even if and when available, also has its limitations as an Excel Spreadsheet. By using Excel's native search functions, users will be able to perform limited sorting, filtering, and conducting of keyword searches. Users can employ the "find and select" function to search for measures that contain keywords of interest. This allows a user interested in a particular word such as a specific health condition (e.g., "cancer") to view a list of all measures where that word appears. In addition, users can sort data in one or more columns by text and numbers to organize the content according to their specifications. Additionally, users can filter data (i.e., users can choose to display only the rows that meet criteria specified and hide any other rows). Filters are also additive and, therefore, each additional filter is based on the current filter and further reduces the subset of data. This allow users to, for example, display only those measures from *Healthy People 2010* whose data was collected in 2001 and is moving in the wrong direction.

Developing a Searchable Performance Measures Database

While the type of Excel Spreadsheet/Performance Measures Inventory described above does have limited search and sort capabilities that can be useful for OMH's purpose, the tool itself is not particularly user-friendly, attractive, or capable of performing other functions that are available through actual searchable databases. In the spreadsheet, for example, there may be instances where keyword searches do not produce any measures due to existing gaps in the literature without offering users other alternatives or options for continuing their searches. In addition, a spreadsheet only retrieves measures that include keywords provided by users that exactly correspond with the terms included in the measure descriptions. A database has the flexibility to retrieve measures using an expanded list of search terms (i.e., applying the taxonomy) with which users are more likely to be familiar. As such, OMH is continuing to explore the potential for moving this tool to the next level of usability, i.e., a searchable database.

To date, with the assistance of a team of researchers and analysts working with OMH on the development of its Performance Improvement and Management System (PIMS), a careful step-by-step process to develop a taxonomy which will be used to tag measures based on categories that are intuitive to users has already been completed. The process began with a broad list of potential categories, with each category examined in terms of purpose, location, exclusivity, and operational definition. As development of the taxonomy evolved, decision-making criteria were also developed to enable consistent application of the taxonomy in the tagging of measures for database search purposes. The objectives of this process were to:

- Minimize the time and effort required of the end-users to maneuver from the landing page of the performance measures database to the search results;
- Ensure against any ambiguity between the tags that are used and the category in which a measure resides;
- Ensure that tags used are clearly understood by all potential end-users, not only to those who have public health or evaluation expertise;
- Ensure fidelity across the reviewers during the final tagging implementation phase; and
- Provide sufficient detail in the tags to limit search results while providing the end-user with measures relevant to their needs.

Using the guiding objectives above, tags were reconciled and merged into a structure that will form the blueprint for the initial performance measures database/website content. The tags are organized first into Principal Categories, which are the main categorizations within which end-users will search. These categories will not be mutually exclusive; rather, end users will be able to select across categories as well as to mark more than one tag within each category when searching for measures. After determining the draft Principal Categories, an environmental scan was conducted to establish operational definitions that could be used for internal purposes and also be provided to website users on the landing page to clarify and direct their searches. After establishing this preliminary draft of the taxonomy, tests of the taxonomy were conducted to simulate the end-user search process. After each round of testing, results were shared among the testers to share their experiences and discuss improvements that needed to be made.

At this stage of performance measures inventory and database development, OMH has been planning to complete the tagging of all measures using the taxonomy, and take steps necessary to ensure that the inventory, database, and other resource documents are Section 508 compliant. However, as the performance measures inventory has undergone the tagging process to prepare the tool as the basis for a searchable performance measures database, OMH has become aware of other federal and private-sector efforts (e.g., the NCHS Community Health Data Initiative) that may have already established or are currently taking steps to establish a similar, but broader, more comprehensive, and/or more integrated databases of performance measures or indicators that may be able to accomplish OMH's intended purpose in a more robust, cost-effective, and timely way (see Appendix 6-G). OMH is currently investigating the depth and breadth of these other efforts identified to determine if they will, indeed, meet the objectives of OMH's performance measures database before determining whether to proceed with its previous plans.

Lastly, in order to inform development, selection, and testing of performance measures or indicators where measurement gaps and weaknesses currently exist, OMH has also conducted a series of environmental scans and literature reviews to determine what is (and is not) reflected in the current science about how to develop and test measures to address such gaps and weaknesses. This is discussed further in Appendix 6-H.

Appendix 6-G:
Other Selected Performance Measures Documents and Databases

Other Selected Performance Measures Databases

Over the past two years, as OMH has attempted to develop an initial searchable performance measures inventory and database to support evaluation of intervention effectiveness related to minority health and health disparities, other initiatives and efforts by AHRQ, CDC, and other HHS and outside entities have been identified as either developed or under development which may better meet OMH's purpose. A selection of these Federal and non-Federal efforts are identified and briefly described below. OMH is in the process of investigating such efforts before proceeding further on development of its own searchable performance measures database.

Selected Federal Databases

AHRQ National Quality Measures Clearinghouse

The National Quality Measures Clearinghouse (NQMC) is an initiative the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. It is a public resource for evidence-based quality measures and measure sets. NQMC is both a database and a website on evidence-based health care quality measures and sets. The goal of NQMC is to provide the health care community and other interested individuals widespread access to quality measures in order to augment health care decisions. Measures related to health are classified as either health care delivery measures or population health measures. The NQMC builds on previous initiatives, including the Computerized Needs-Oriented Quality Measurement Evaluation System (CONQUEST), the Expansion of Quality of Care Measures (Q-SPAN) project, the Quality Measurement Network (QMNet) project, and the Performance Measures Inventory (PMI).
http://qualitymeasures.ahrq.gov/

CDC/NCHS Community Health Data Initiative

The purpose of the Community Health Data Initiative is to aid Americans in understanding health and health care system performance in their communities, in order to encourage and facilitate action to improve performance and value. The Health Indicators Warehouse is currently being developed. HIW will be the initiative's interactive, web-accessible database of pre-tabulated national, state and local health indicators, descriptive data and evidence-based interventions. Health indicators will include measureable characteristics that describe the health of a population, including life expectancy, mortality and disease prevalence; determinants of health, including health behaviors, health risk factors and socioeconomic environments; and health care access, cost, quality and use. Health measures will be defined according to a specific population, place, political jurisdiction, or geographic area.
http://www.cdc.gov/nchs/data_access/chdi.htm

CDC Healthy Schools, Healthy Youth! State and District-Level Report Cards

The School Health Policies and Practices Study (SHPPS) is the largest, most comprehensive assessment of school health policies and practices in the United States. It is a national survey that is periodically conducted by the CDC, with the most recent survey data from 2006. It is conducted at the state, district, school, and classroom levels nationwide. SHPPS assesses the characteristics of eight components of school health at the elementary, middle, and high school levels. Such characteristics include health education, physical education and activity, health services, mental health and social services, nutrition services, healthy and safe school environment, faculty and staff health promotion, and family and community involvement. The SHPPS's purpose is to find data related to the characteristics of each component of school health at the state, district, school, and classroom levels and across elementary, middle, and high schools, as well as determine if there are persons responsible for coordinating and delivering each component of school health, and what are their qualifications and educational backgrounds. The SHPPS also reveals what collaboration occurs among staff from each component of school health and with staff from outside agencies and organizations, and how key policies and practices have changed over time.
http://www.cdc.gov/HealthyYouth/shpps/index.htm

CMS Hospital Compare

The Hospital Compare website provides information to help users compare the quality of care provided in the hospitals that agree to submit data. This quality information not only helps users make good decisions about their health care, but also encourages hospitals to improve the quality of health care they provide. Hospital Compare tool displays rates for Process of Care measures that show whether or not hospitals provide some of the care that is recommended for patients being treated for a heart attack, heart failure, pneumonia, asthma (children only) or patients having surgery. The data include patients with Medicare, those enrolled in Medicare health plans, and those who do not have Medicare. This website also displays information on Hospital Outcome of Care Measures. The Hospital Outcome of Care Measures include the 30-day Risk Adjusted Death (Mortality) and Readmission Rates for patients with Medicare who were admitted to the hospital for heart attack, heart failure and pneumonia. Furthermore, Hospital Compare displays the Survey of Patients' Hospital Experiences, using data collected from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. The website also displays Medicare inpatient hospital payment information and the number of Medicare patients treated (volume) for certain illnesses or diagnoses Medicare Severity-Diagnosis Related Groups (MS-DRG).
http://www.hospitalcompare.hhs.gov/

CMS Nursing Home Compare

The Nursing Home Compare tool has detailed information about every Medicare and Medicaid-certified nursing home in the country. The tool allows users to find nursing homes in their local areas and compare the quality of the nursing homes they are considering, using the Five-Star Quality Ratings, health inspection results, nursing home staff data, quality measures, and fire safety inspection results. It also provides additional resources for those choosing a nursing home, such as the Nursing Home Checklist.
http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteriaNEW.asp?version=default&browser=IE%7C7%7CWinXP&language=English&defaultstatus=0&pagelist=Home&CookiesEnabledStatus=True

FDA Food Environment Atlas

The objectives of the USDA Food Atlas are to assemble statistics on food environment indicators to stimulate research on the determinants of food choices and diet quality, and, to provide a spatial overview of a community's ability to access healthy food and its success in doing so. The Atlas assembles statistics on three broad categories of food environment factors: (1) Food Choices – Indicators of the community's access to and acquisition of healthy, affordable food, such as: access and proximity to a grocery store; number of foodstores and restaurants; expenditures on fast foods; food and nutrition assistance program participation; quantities of foods eaten; food prices; food taxes; and availability of local foods; (2) Health and Well-Being –

Indicators of the community's success in maintaining healthy diets, such as: food insecurity; diabetes and obesity rates; and physical activity levels; and, (3) Community Characteristics –

Indicators of community characteristics that might influence the food environment, such as: demographic composition; income and poverty; population loss; metro-nonmetro status; natural amenities; and recreation and fitness centers. The Atlas currently includes 90 indicators of the food environment. Though levels of details vary, the most recent county-level data are used whenever possible.
http://maps.ers.usda.gov/FoodAtlas/

Federal Interagency Forum on Child and Family Statistics – America's Children: Key National Indicators of Well-Being

The Federal Interagency Forum on Child and Family Statistics was founded in 1994 and formally established under Executive Order No. 13045 in April 1997 to foster coordination and collaboration in the collection and reporting of Federal data on children and families. Since 1997, the Forum has published an annual report on the well-being of children and families which updates all 40 indicators on its website. The indicators and background measures presented are chosen because they are easy to understand, are based on substantial research connecting them to child well-being, cut across important areas of children's lives, are measured regularly so that they can be updated and show trends over time, and represent large segments of the population, rather than one particular group. These child well-being indicators span seven domains: *Family and Social Environment, Economic Circumstances, Health Care, Physical Environment and Safety, Behavior, Education,* and *Health.*
http://childstats.gov

HRSA Cultural Competency and Health Literacy Resources

The US Department of Health and Human Services, Health Resources and Services Administration (HRSA) created the Cultural Competency and Health Literacy Resources webpage to highlight approximately 40 HRSA-supported provide resources for assessment tools, culture/language, diseases/conditions, health professions education, research, rural populations, special populations, technical assistance, training curricula and web-based training. As a result of HRSA's increased focus on aiding health care providers to enhance their clinical and organizational skills in cultural competence, the quality of cultural and linguistically appropriate services that HRSA provides to its diverse constituents has improved.
http://www.hrsa.gov/culturalcompetence/

NCI: Cancer Control P.L.A.N.E.T.

The NCI, and numerous other sponsors, run a web portal called The Cancer Control P.L.A.N.E.T. The portal is a collaborative effort aimed at providing access to data and resources that can help cancer control planners, health educators, program staff, and researchers design, implement, and evaluate evidence-based cancer control programs. The Cancer Control P.L.A.N.E.T.'s goals are to reduce cancer incidence, reduce the number of deaths from cancer, and enhance quality of life for cancer survivors. While many of the public health professionals share the same goals, not all have easy access to resources that can facilitate the transfer of evidence-based research findings into practice. The Cancer Control P.L.A.N.E.T. portal provides access to data and resources that can help planners, program staff, and researchers to design, implement and evaluate evidence-based cancer control programs. The portal lists five steps to achieving these goals: 1) assess program priorities, 2) move from research to practice, 3) research reviews of different intervention approaches, 4) find research-tested intervention programs and products, and 5) plan and evaluate the program.
http://cancercontrolplanet.cancer.gov/

OWH Quick Health Data Online

The system provides state- and county-level data for all 50 states, the District of Columbia, and US territories and possessions. Data are available by gender, race and ethnicity and come from a variety of national and state sources. The database is organized into eleven topic areas: Codes and Status, Demographics, Mortality, Infectious and Chronic Diseases, Mental Health, Reproductive Health, Maternal Health, Violence and Abuse, Prevention, Access to Care, and Healthy People 2010. Within each main category, there are numerous subcategories. Data have been obtained at the lowest geographic level (preferably county) and for the most refined racial and age categories available. The system directs users to select their variable(s) of interest from the database, identify which categorical/demographic variable(s) of interest they wish to see the variable broken down by, select up to county-level geographies of interest, and generate reports in a chart, map or spreadsheet format.
http://www.healthstatus2010.com/owh/index.html

Selected Non-Federal Databases

Annie E. Casey Foundation - KIDS COUNT Data Center

The KIDS COUNT *Data Book* compiles data available on children and families in the U.S. and ranks every state on the well-being of its kids. The *KIDS COUNT Data Book* is intended to illuminate the status of America’s children and to assess trends in their well-being. By updating the assessment every year, KIDS COUNT provides ongoing benchmarks that can be used to see how states have advanced or regressed over time. Readers can also use KIDS COUNT to compare the status of children in their state with those in other states across several dimensions of child well-being. The data possess three important attributes: (1) they reflect a wide range of factors affecting the well-being of children, such as health, adequacy of income, and educational attainment; (2) they reflect experiences across a range of developmental stages—from birth through early adulthood; (3) they permit legitimate comparisons because they are consistent across states and over time.
http://datacenter.kidscount.org/

The Aspen Institute's Community Building Resource Exchange

The Aspen Institute Roundtable on Comprehensive Community Initiatives for Children and Families runs a project called the Community Building Resource Exchange, which provides a broad array of resources and information about innovative community building efforts to revitalize poor neighborhoods and improve the life circumstances of residents and their families. Hundreds of community-based development organizations, human service agencies, and state and local governments have initiated projects based on comprehensive, community building initiatives, and their experiences have produced a wealth of learning and documentation on the opportunities and challenges of a community building approach to neighborhood transformation. The resources included on the web site come from a variety of fields, including children and family services, community development, evaluation, and public policy. The website brings together these resources and organizes them in a way that highlights the broad range of issues associated with community building strategies and draws connections between them. http://www.commbuild.org/

Mobilizing Action Toward Community Health

County Health Rankings is the product of the Mobilizing Action Toward Community Health (MATCH) project. MATCH is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. They developed a report for every state documenting the county's health. Each county received a summary rank for its health outcomes, namely length and quality of life; and health factors, including health behaviors, clinical care, social and economic factors, and the physical environment. Data sources include the Behavioral Risk Factor Surveillance System, National Center for Health Statistics; the National Center for Chronic Disease Prevention and Health Promotion; the National Center for Hepatitis, HIV, STD, and TB Prevention; the CDC Environmental Protection Agency (EPA) Collaboration; the Health Resources and Services Administration (Area Resource File); the Decennial Census and American Community Survey; the Census/Current Population Survey; the Small Area Health Insurance Estimates; the Small Area Income and Poverty Estimates; the Census County and Zip Code Business Patterns; the Federal Bureau of Investigation (Uniform Crime Reporting); the Dartmouth Institute; and the National Center for Education Statistics. http://www.countyhealthrankings.org

NACCHO Mobilizing for Action through Planning and Partnerships (MAPP) Clearinghouse

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven strategic planning tool for improving community health. The MAPP framework was developed by the National Association of County and City Health Officials (NACCHO) in cooperation with the Centers for Disease Control and Prevention (CDC). The tool intends to help communities apply strategic thinking to prioritize public health issues and identify resources resulting in measureable improvement in the community's health and quality of life, increased visibility of public health within the community, the ability of community advocates to anticipate and manage change, and stronger public health infrastructure, partnerships and leadership. It is designed to be an interactive process to improve efficiency, effectiveness and the performance of local public health systems. The MAPP tool, resources and technical assistance are available through their website.
http://www.naccho.org/topics/infrastructure/mapp/framework/

RTI International and the National Human Genome Research Institute (NHGRI)

PhenX, Consensus Measures for Phenotypes and eXposures, is a three-year project led by RTI International and funded by the National Human Genome Research Institute (NHGRI), of the National Institutes of Health. The research will contribute to the integration of genetics and epidemiological research. PhenX has 21 research priorities related to complex diseases and environmental exposure. They are currently developing a set of high priority measures for use in Genome-wide Association Studies and other large-scale Genome research efforts. These measures will maximize benefits of future research by enabling cross-study comparisons and analysis. The PhenX toolkit presents the selected high priority measures, along with associated protocols, references and links to resources.
https://www.phenx.org/

RWJF Active Living Research Tools and Resources

Active Living Research is a national program of the Robert Wood Johnson Foundation. It was established in 2001 to support research to identify environmental factors and policies that influence physical activity. The research focuses on active living related to youth in low-income and high-risk communities. Findings from the research are used to help inform policy, design of the built environment, and other factors to promote active living. The research examines how environments and policies affect physical activity, and aims to identify promising approaches for preventing childhood obesity, specifically among ethnic minorities and children living in low-income communities. The primary objectives are to establish a strong research base, to build a multidisciplinary field and research and a diverse network of researchers, and to ensure that findings are effectively communicated to inform policy debates and guide the development of effective solutions.
http://www.activelivingresearch.org/resourcesearch/toolsandmeasures

San Francisco Department of Health – Healthy Development Measurement Tool

The San Francisco Department of Public Health's Healthy Development Measurement Tool (HDMT) is a comprehensive evaluation metric that houses data on the built environment and urban planning in order to monitor and address social determinants of health. The site was developed as a tool for bringing health issues into the decision-making process in neighborhood planning. The HDMT encompasses three core components: A Community Health Indicator System, with over 100 indicators of social, environmental and economic conditions that can be used to evaluate baseline conditions in a neighborhood, planning area or city, and to monitor those conditions prospectively; A "Healthy Development" checklist of development targets (associated with each indicator) that can be used to assess whether urban plans and projects help achieve community health objectives; and, A Menu of Policies and Design Strategies - A listing of potential actions that can be taken by project sponsors or policy-makers to achieve development targets in the checklist and advance community health objectives.
http://thehdmt.org

State of the USA – Key National Indicator System

The State of the USA (SUSA) is a non-profit institution that collaborates with the scientific and statistical communities, and individual subject-matter experts to identify key national measures for more than a dozen topic areas. SUSA intends to help Americans better assess the progress of the United States by providing scientifically selected measures, supporting statistical data and appropriate editorial context. SUSA utilizes scientific expertise and quality assurance from the National Academy of Sciences, the statistical community, the scientific community and individual, nationally recognized subject-matter experts. SUSA is planning to launch its version 1.0 website for beta use during 2010 to help Americans assess the progress of the U.S.
http://www.stateoftheusa.org/

The Urban Institute's National Neighborhood Indicators Partnership (NNIP)

The National Neighborhood Indicators Partnership (NNIP) is a collaborative effort by the Urban Institute and local partners to further the development and use of neighborhood-level information systems in local policymaking and community building. The local partners in the National Neighborhood Indicators Partnership (NNIP) have built information systems with recurrently updated data on various neighborhood conditions in their cities for community planning and action. The partnership keeps records for which local data sets our partners have for internal planning and to understand the national patterns in data availability. Major activities include cross-site action initiatives (using data to drive community change), tool building and dissemination, and direct technical assistance and training. All of the NNIP partners have recurrently updated neighborhood data systems covering a variety of topics. In some cities, communities use the data from the NNIP partners to develop comprehensive community indicator initiatives. In this approach, indicators are selected across topical domains to collectively track trends in community well-being and quality of life. A comprehensive indicators project offers the community an opportunity to discuss what is important to them, to systematically review whether things have been getting better or worse, and to establish priorities for policy response.
http://www2.urban.org/nnip/index.htm

Appendix 6-H:
Other Selected Resources to Guide Performance Measurement Where Weaknesses and Gaps Exist

Other Selected Resources to Guide Performance Measurement Where Weaknesses and Gaps Exist

As OMH attempted to identify performance measures for the various levels and range of outcomes and impacts presented in the *Strategic Framework*, a number of significant gaps and weaknesses in the nature and extent of available performance measures, especially at the environmental/community- and systems-levels, became apparent. Based on its findings, OMH conducted a literature review to determine how performance measurement for the kinds of outcomes and impacts in which there were weaknesses and gaps was being discussed and addressed. This resulted in the identification of selected articles and other resources that suggest lines of query and thinking about the development and use of performance measures where such measures are not yet available and/or tested. These resources and materials have been grouped by topics into "topic summaries," intended to parallel, as much as possible, the kinds of factors and outcomes presented in the *Framework.* Each of these topic summaries can be used to guide further thinking, development, and testing of performance measures for outcomes and impacts that do not yet have adequate means of measurement.

Topic summaries were developed for those subject areas for which there are scant or no scientifically tested measures, but for which there are concrete outputs such as instruments, frameworks, or recommendations for possible measurement of specific concepts. OMH developed a topic summary for each area of interest that has an implicit relevance for a concept or output a grantee or other stakeholder may want to quantify; is explicitly consistent with or complementary to the *Framework* levels and kinds of outcomes/impacts that need to be addressed, and provides actionable information and/or information not found in the performance measures inventory. Specifically, the topic summaries were developed to address the particular causal or contributing factors at the environmental/community and systems levels that were outlined in the *Framework* as follows:

Environmental/Community Level Topics

- Physical Environment
    - Physical Activity Resources
    - Violence and Crime
- Social Environment
    - Community Assets
    - Community Involvement
    - Social Health
- Economic Barriers

Systems Level Topics

- User-Centered Design
  - Access and Coverage
  - Culturally and Linguistically Appropriate Services
  - Minority Participation
  - Race and Ethnicity Data Collection
  - Social Health
  - Workforce Diversity
- Components and Resources
  - Capacity Building
- Coordination and Collaboration
- Leadership and Commitment
  - Sustainability
- Science and Knowledge
  - Dissemination

The print version of these topic summaries is provided below. Each topic summary contains links to specific journal articles of *PubMed* citations where the articles can be accessed, a brief summary or an abstract of the article and its main findings, and links to performance measures databases and other tools referenced in the articles. OMH anticipates having these summaries available shortly in a web-based format that meets Section 508 compliance requirements for accessibility. At that time, these summaries will be accessible via the performance/evaluation web pages of OMH's website at http://www.minorityhealth.hhs.gov/templates/browse.aspx?lvl=1&lvlID=44.

Topic: Access and Coverage

Description:

Federally funded programs such as Medicare and Medicaid are efforts to expand health insurance coverage to low-income, underage and elderly Americans. However, disparities in location, quantity, and quality of healthcare service utilization still exist between whites and racial/ethnic minorities. The 1985 Department of Health and Human Services *Secretary's Task Force Report* encouraged HHS "to increase flexibility of health care delivery", and to "facilitate access to services by minority populations."[1] Since then, a variety of federal and state government initiatives have been implemented to expand and strengthen the health care safety net, including federally-funded programs such as Medicare, Medicaid, and SCHIP.

The materials of interest identified below provide guidance to providers improve their accessibility to minority patients and research on potential causes for the disparities in access and coverage.

OMH Strategic Framework:

The OMH Strategic Framework includes User-Centered Design as one of the Systems-level contributing factors to minority health /health disparities. One of the components of user-centered design in the Strategic Framework is implementation of efforts to increase or improve healthcare access and coverage. The Strategic Framework notes findings indicating that "creating new and affordable health insurance options, strengthening and expanding the health care safety net … would help" racial/ethnic minorities "connect with the health care system."

Materials of Interest:

Washington DL, Bowles J, Saha S, Horowitz CR, Moody-Ayers S, Brown AF, Stone, VE Cooper LA. Transforming Clinical Practice to Eliminate Racial–Ethnic Disparities in Healthcare. J Gen Intern Med 23(5):685–91. http://www.rwjf.org/pr/product.jsp?id=30410

> This paper serves as a blueprint for translating principles for the elimination of racial–ethnic disparities in health care into specific actions that are relevant for individual clinical practices. The authors describe what is known about reducing racial–ethnic disparities in clinical practice and make recommendations for how clinician leaders can apply this evidence to transform their own practices.

- Recommendation 1: Enroll in programs that reimburse you for delivering covered services to low-income patients (e.g., "free" pap smear programs).
- Recommendation 2: Provide patients with referral information for pharmaceutical manufacturer assistance programs (e.g., the Together Rx Access Card), and prescribe lower cost, equivalently effective medications, when available.

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[1] Task Force on Black and Minority Health. Washington, DC: Department of Health and Human Services, 1985 Report of the Secretary's Task Force on Black and Minority Health. vol 1.

- Recommendation 3: Have referral information available for your patients for the social work department at your affiliated hospital(s).
- Recommendation 4: Incorporate sliding scale and/or flexible payment plans when possible.
- Recommendation 5: Hire clinical and office staff who are culturally and linguistically representative of the communities your practice serves.
- Recommendation 6: Market or advertise the diversity of office and clinical staff, emphasizing the presence of multilingual staff as a way to recruit diverse staff and inform patients.
- Recommendation 7: Explore the current organizational climate, culture, policies, and training related to diversity in your practice setting.
- Recommendation 8: Review the decor and substitute potentially offensive pieces with more culturally appropriate decor.
- Recommendation 9: Have available signage, language services, and printed patient information material that is appropriate for the cultures, languages, and literacy levels of patients in your practice.
- Recommendation 10: Provide training for providers in patient-centered communication skills that focus on increasing participatory decision-making
- Recommendation 11: Provide cultural competence training for providers and staff in your setting.
- Recommendation 12: Measure the quality of care delivered in your clinical setting stratified by patient race–ethnicity.
- Recommendation 13: Assess patient perceptions of care, e.g., using periodic self-administered surveys.
- Recommendation 14: Provide a "suggestions box" so that patients can provide immediate feedback at the time of their visit.

Trivedi AN, Ayanian JZ. Perceived discrimination and use of preventive health services. J Gen Intern Med. 2006 Jun;21(6):553-8. http://www.ncbi.nlm.nih.gov/pubmed/16808735

> Using 2001 California Health Interview Survey data, the authors attempted to determine the prevalence of perceived discrimination in health care, its association with use of preventive services, and the contribution of perceived discrimination to disparities in these services by race/ethnicity, gender, and insurance status. Approximately 5% of the cohort reported recent experiences with discrimination in health care, and among these respondents, the most commonly reported reasons were related to type of insurance (27.6%), race or ethnicity (13.7%), and income (6.7%). As they found that persons who reported discrimination were less likely to receive some preventive services but not others, the authors conclude that persons who report discrimination may be less likely to receive some preventive health services, however, perceived discrimination is unlikely to account for a large portion of observed disparities in receipt of preventive care.

Waidmann TA, Rajan S. Race and ethnic disparities in health care access and utilization: an examination of state variation. Med Care Res Rev. 2000;57 Suppl 1:55-84. http://mcr.sagepub.com/cgi/content/abstract/57/4_suppl/55

> This article examines disparities in access to high-quality health care. What these findings imply is that efforts to eliminate disparities in access to quality health care may need to be tailored to the specific needs of states and that the strategies for reducing disparities affecting African Americans are not necessarily the same ones that will be successful in reducing disparities for Latinos. The authors' findings confirm that reducing disparities in insurance coverage is a key pathway toward equalizing access to the health care system. The findings suggest that the three most important components in the insurance disparity between Latinos and whites are income, citizenship, and the residual component. The most important components between African-Americans and whites were income, family composition, and the residual component.

Reschovsky JD, O'Malley AS. Do Primary Care Physicians Treating Minority Patients Report Problems Delivering High-Quality Care? Health Affairs 26, no. 3 (2007): w222-w231. http://content.healthaffairs.org/cgi/content/abstract/27/3/w222

> Primary care physicians in high-minority practices rely more heavily on lower-paying Medicaid reimbursements, devote more time to uncompensated charity care, and earn lower incomes. Magnifying these resource disparities, geographic areas with more high minority practices tend to have lower Medicaid and private insurance reimbursements than those with fewer high-minority practices. Two of the quality indicators most affected by Medicaid payment levels, time spent per patient seen and difficulties getting timely reports from other providers, suggest the possibility that physicians may compensate for the lower revenue flows by increasing the volume of patients they see, reducing the time spent per patient seen, and perhaps devoting less time to coordinating and documenting care. This is despite the more complex psychosocial contexts and the language and cultural barriers that often complicate the treatment of lower-income and minority patients. The results of this study suggest that racial and ethnic disparities in quality primary health care are in part systemic in nature, and the lower resources flowing to physicians treating more minority patients are a contributing factor. State legislators and governors should not assume that physicians would be able to shift costs so that Medicaid patients receive care equivalent to care for other patients.

Topic: Capacity Building/Sustainability

Description:

Capacity building is broadly defined as processes that improve the ability of an organization or system to meet objectives or to perform better. Hawe et al describes capacity building three ways: as the ability to deliver a specific health program or service, the ability to continue delivering that service after resource support has ended, and the ability to build on program specific experiences to identity new problems and develop means to address them.[2] Capacity building efforts often have the aim of improved health practices that are in a system of providers than can be maintained over time. Therefore, they are integrally related to efforts aimed at sustainability, or program maintenance after cessation of limited term funding.

Materials of interests relating to capacity building and sustainability consist of conceptual as well as strategic planning checklists and toolkits that can be used to evaluate capacity building and sustainability efforts.

OMH Strategic Framework:

The OMH Strategic Framework identifies systems-level factors that contribute to poor racial/ethnic minority health and to racial/ethnic health disparities. Within the systems-level factors, the OMH Strategic Framework identifies capacity building as an important contributor to health outcomes and notes that organizational capacity can be “critical for adequate responses to natural disasters, disease pandemics, and biological or chemical attacks.”

Materials of Interest:

LaFond A, Brown L. A Guide to Monitoring and Evaluation of Capacity-Building Interventions in the Health Sector in Developing Countries. MEASURE Evaluation Manual Series, No. 7. Carolina Population Center, University of North Carolina at Chapel Hill. 2003. http://gametlibrary.worldbank.org/FILES/610_M&E%20of%20Capacity%20Building%20Interventions.pdf

> This guide has grown out of the collective experience of health and development organizations working to build health sector capacity in developing countries. The focus of the Guide is the measurement of capacity for the purpose of monitoring and evaluating capacity-building interventions. It responds to a demand among public health planners, evaluators, and practitioners for advice on assessing the many aspects of health programming that fall under the rubric of capacity building. The purpose of this guide is to assist health planners and evaluators to: gain a clear understanding of the concepts of capacity and capacity building; critically evaluate the strengths and limitations of current approaches to capacity measurement; design a capacity-building M&E plan that outlines a systematic approach to measuring capacity and assessing the results of capacity-building interventions in the health sector.

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[2] Hawe P., King L, Noort M, Jordens C, and Lloyd B. 2000. Indicators to Help with Capacity building in Health Promotion. Australian Center for Health Promotion.

Hawe P, King L, Noort M, Jordens C, and Lloyd B. Indicators to Help with Capacity Building in Health Promotion. Australian Center for Health Promotion, 2000. http://www.health.nsw.gov.au/pubs/2000/capbuild.html

> The project behind this report set out to clarify capacity building as a concept, and to develop indicators that could determine whether or not capacity building by health promotion workers was being done well. This report contains nine checklists, each with a number of indicators, developed for health promotion practitioners to assess the quality of their overall work practice.

Marguerite Casey Foundation. Marguerite Casey Foundation Capacity Assessment Tool. http://www.caseygrants.org/pages/resources/resources_downloadassessment.asp.

> The Marguerite Casey Foundation Organizational Capacity Assessment Tool is a self-assessment instrument that helps nonprofits identify capacity strengths and challenges and establish capacity building goals. It is primarily a diagnostic and learning tool. Results from the Assessment can also help grantmakers deepen their understanding of the current capacity of their grantees as well as track their growth in capacity over time.

Cooke J. A framework to evaluate research capacity building in health care. BMC Family Practice. 2005; 6:44. http://www.biomedcentral.com/1471-2296/6/44

> Background: Building research capacity in health services has been recognized internationally as important in order to produce a sound evidence base for decision-making in policy and practice. Activities to increase research capacity for, within, and by practice include initiatives to support individuals and teams, organizations and networks. Little has been discussed or concluded about how to measure the effectiveness of research capacity building (RCB) Discussion: This article attempts to develop the debate on measuring RCB. It highlights that traditional outcomes of publications in peer reviewed journals and successful grant applications may be important outcomes to measure, but they may not address all the relevant issues to highlight progress, especially amongst novice researchers. They do not capture factors that contribute to developing an environment to support capacity development, or on measuring the usefulness or the 'social impact' of research, or on professional outcomes. The paper suggests a framework for planning change and measuring progress, based on six principles of RCB, which have been generated through the analysis of the literature, policy documents, empirical studies, and the experience of one Research and Development Support Unit in the UK. These principles are that RCB should develop skills and confidence, support linkages and partnerships, ensure the research is 'close to practice', develop appropriate dissemination, invest in infrastructure, and build elements of sustainability and continuity. It is suggested that each principle operates at individual, team, organization and supra-organizational levels. Some criteria for measuring progress are also given. Summary: This paper highlights the need to identify ways of measuring RCB. It points out the limitations of current measurements that exist in the literature, and proposes a framework for measuring progress, which may form the basis of comparison of RCB activities. In this way, it could contribute to establishing the effectiveness of these interventions, and establishing a knowledge base to inform the science of RCB.

Nu'Man J, King W, Bhalakia A, Criss S. A Framework for Building Organizational Capacity Integrating Planning, Monitoring, and Evaluation. J Public Health Management Practice. 2007, January(Suppl); S24–S32. http://www.ncbi.nlm.nih.gov/pubmed/17159464

> Background: HIV prevention organizations are increasingly adopting more intensive and evidence-based strategies with the goal of protecting targeted populations from HIV infection or transmission. Thus, capacity building has moved to the forefront as a set of activities necessary to enable HIV prevention organizations to plan, implement, monitor, and evaluate prevention programs and services. Cost-effective approaches to the provision of capacity building assistance traditionally use strategies that compromise efficaciousness and more intensive approaches can be cost prohibitive. In addition, traditional approaches treat program planning and implementation and program monitoring and evaluation as two separate entities, even though they are interdependent aspects of an efficient and effective service delivery system. Objective: This article describes a framework for building sustainable organizational capacity that combines high- and low-intensity approaches; integrates program planning, monitoring, and evaluation; and focuses on building understanding of the value of appropriate organizational change. Methods: The described framework was used over a 3-year period with 52 community-based organizations funded by the Centers for Disease Control and Prevention (CDC) and organizations funded by CDC-funded health departments. Results and Conclusions: The article includes lessons learned, recommendations for building long-term sustainability, organizational change at various levels, and the need to develop standardized indicators to measure changes in organizational capacity.

Topic: Community Assets

Description:

A community's assets are the resources it has available to provide support for safety and health. These assets include, but are not limited to, health services and clinics, parks and recreation, educational institutions, transportation, police/fire response times, and stores. A number of authors have recognized the importance of communities understanding the resources they have available and have developed guidelines for assessing community assets and capacities. Such assessments have been identified as useful tools in supporting and mobilizing resources already at communities' disposal.

The materials of interest identified below provide guidance for assessing community assets. They identify what a community should consider when assessing their ability to create change, and provide information on pooling these assets.

OMH Strategic Framework:

The OMH Strategic Framework includes the Social Environment as an Environmental- and Community-level factor contributing to minority health /health disparities. Community Assets are one of the components of the Social Environment. The Strategic Framework notes, “An ‘asset-based approach’ to planning, development, and capacity building can improve the health and well-being of troubled communities.”

Materials of Interest:

Pan R, Littlefield D, Valladolid S, Tapping P, and West D. Building Healthier Communities for Children and Families: Applying Asset-Based Community Development to Community Pediatrics. Pediatrics. 2005;115:1185-1187. http://pediatrics.aappublications.org/cgi/content/full/115/4/S1/1185

> This article proposes the use of Asset-Based Community Development (ABCD) to influence a community’s social environment and improve its health. This method focuses on recognizing and mobilizing community assets, rather than identifying problems and then developing single dimensional solutions. The 5 key aspect areas are individuals’ skills and capacities, associational life, institutional assets, economic development potential, and physical assets. With this collaborative process, a lead group first assesses its own assets by identifying the knowledge and skills it possessed, and then completes the same assessment for the entire community. After creating an understanding of the assets employed by the community, the community can prioritize the issues to be addressed and match them with already existing assets.

Sharpe P, Greaney M, Lee P, and Royce S. Assets-Oriented Community Assessment. Public Health Reports. 2000; 115: 205-211. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1308712/

> This article presents a similar assets-oriented perspective as that of Pan et al, while also providing a number of techniques for assessing a community’s assets. Techniques include tours of communities, observational research, key informant interviews, focus and dialogue groups, inventories, and assets mapping.

Stokols D, Grzywacz J, McMahan S, and Phillips K. Increasing the Health Promotive Capacity of Human Environments. American Journal of Health Promotions. 2003; 18:4-13. http://www.ncbi.nlm.nih.gov/pubmed/13677958

> While this article does not use the same terminology to describe community assessment, it does integrate the physical and social environmental resources and proposes methods for promoting health by utilizing these resources. The article provides typologies for recognizing and organizing community capacities, and develops process guidelines for promoting health around these capacities.

Kilpatrick S, and Abbott-Chapman J. Community Efficacy and Social Capital. Centre for Sustainable Regional Communities, La Trobe University. 2005. http://www.latrobe.edu.au/csrc/fact2/refereed/kilpatrick_abbott-chapman.pdf

> This article presents a framework for measuring a community's capacity to "deliver favorable outcomes for its members." The authors developed a measurement matrix intended to measure "the processes and community resources that generate commonly measured outcomes" The matrix should enable community leaders to identify the facilitators of community efficiency as well as the factors restricting positive change. The matrix avoids a "one-size fits all approach" in an effort to adapt to the unique contexts within individual communities.

Goodman R, Speers M, Mcleroy K, Fawcett S, Kegler M, Parker E, Smith S, Sterling T, and Wallerstein N. Identifying and Defining the Dimensions of Community Capacity to Provide a Basis for Measurement. Health Education and Behavior. 1998; 23:258-278. http://www.ncbi.nlm.nih.gov/pubmed/9615238

> This article was developed from discussions of experts at a symposium sponsored by the CDC on community capacities. The article identifies ten key dimensions of community capacity, describing each of these dimensions and how they interact. The dimensions are: leadership, citizen participation, skills, resources, social and inter-organizational networks, sense of community, understanding of community history, community power, community values, and critical reflection. While the authors recognize that the list of dimensions is not exhaustive, they believe that it provides community leaders with a starting point to assess the capacity of the community to respond to public health needs.

Topic: Community Involvement and Community Values

Description:

Community Involvement, or Social Capital, is a concept used to describe the inherent value of social networks. There are a number of different definitions for Social Capital in the literature. The most common view of Social Capital refers to the nature and extent of one's involvement in various informal networks and formal civic organizations. Putnam uses this conceptual term to characterize the many and varied ways in which a given community's members interact. Some sociologists use the concept of Social Capital to refer to the resources (information, ideas, support) that individuals are able to procure by virtue of their relationships with other people. These resources are deemed 'social' because they are only accessible in and through relationships, as opposed to the more standard view of other types of capital (physical or human, for example), which are essentially the property of individuals.

Similarly, Community Values are attitudes or subjective views that are shared by a group of individuals. In certain cases, both Community Involvement and Community Values can have an impact on the health of the individuals that comprise that community. Addressing this situation may involve changing group and cultural norms, such as the attitudes and practices of faith-based groups, community leadership structures, community organizations, informal groups, and other social units within the community.

Materials of interest identified below describe conceptual frameworks that have been used to analyze the impact of social capital in various contexts; household surveys that have been used to measure Social Capital at the community, local and national levels; and information on the methods used to measure Community Values.

OMH Strategic Framework:

Within the OMH Strategic Framework, Community Involvement, or, Social Capital, is an Environmental- and Community-level factor that contributes to poor racial/ethnic minority health and to racial/ethnic health disparities. Specifically, Social Capital is a part of the Social Environment construct, defined as efforts aimed at the importance of organization supports, community-based services, and social networks that create connectedness and build relationships with others in the community who may share common needs, interests, experiences, and values. Community Values is also an Environmental- and Community-level factor within the OMH Strategic Framework.

Materials of Interest:

Franke S. Measurement of Social Capital: Reference Document for Public Policy Research, Development, and Evaluation. Government of Canada Public Research Initiative Project, September 2005. http://policyresearch.gc.ca/doclib/Measurement_E.pdf.

> This document is intended as a reference tool for measuring social capital for use by the public policy research community within the Government of Canada. It presents various methodological options for adopting a social capital approach in the context of developing and evaluating public policy and government programs. Taking into account the potential and limitations of current data and knowledge on social capital in Canada, it proposes avenues for examining this concept for public policy purposes.

Grootaert C, Narayan D, Jones VN, Woolcock M. Integrated Questionnaire for the Measurement of Social Capital (SC-IQ). The World Bank Social Capital Thematic Group, 23 June 2003. http://empresa.rediris.es/pub/nj_bscw.cgi/S4a65690f/d471605/Integrated%20Questionnaire%20for%20the%20Measurement%20of%20Social%20Capital%20(SC-IQ).doc

> This document describes the development and content of the Integrated Questionnaire for the Measurement of Social Capital (SC-IQ), a questionnaire used to measure social capital that is meant to be incorporated into a larger survey. The SC-IQ measures social capital at the household and individual level, not the country level, and contains the follow modules: Groups and Networks; Trust and Solidarity; Collective Action and Cooperation; Information and Communication; Social Cohesion and Inclusion; Empowerment and Political Action.

Putnam R. The Social Capital Community Benchmark Survey. Harvard University, 2000. http://www.cfsv.org/communitysurvey/index.html.

> The Social Capital Community Benchmark Survey was developed by the Saguaro Seminar at the John F. Kennedy School of Government with the involvement of a Scientific Advisory Group consisting of leading experts around the country on social capital measurement. It represents the largest scientific investigation of civic engagement in America.

Stone W. Measuring social capital: Towards a theoretically informed measurement framework for researching social capital in family and community life. Australian Institute of Family Studies, February 2001. http://www.aifs.gov.au/institute/pubs/RP24.html

> This paper sets forth a conceptual framework for the measurement of social capital, reviews existing measures in light of this framework, and presents a series of guidelines for the empirical investigation of social capital.

Kim D, Subramanian SV, Kawachi I. Bonding versus bridging social capital and their associations with self rated health: a multilevel analysis of 40 US communities. J Epidemiol Community Health 2006;60:116-122. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2566138/?tool=pubmed.

> The study uses data from the 2000 Social Capital Community Benchmark Survey to distinguish between the effects of different forms of social capital on health. The results suggest modest protective effects of community bonding and community bridging social capital on health. Interventions and policies that leverage community bonding and bridging social capital might serve as means of population health improvement.

Ubel PA. The Challenge of Measuring Community in Ways Appropriate for Setting Health Care Priorities. Kennedy Institute of Ethics Journal 1999; 9(3):263-284. http://muse.jhu.edu/login?uri=/journals/kennedy_institute_of_ethics_journal/v009/9.3ubel.html

> The move from a notion that community values ought to play a role in health care decision making to the creation of health care policies that in some way reflect such values is a challenging one. No single method will adequately measure community values in a way appropriate for setting health care priorities. Consequently, multiple methods to measure community values should be employed, thereby allowing the strengths and weaknesses of the various methods to complement each other. A preliminary research agenda to bring together empirical research on community values with more traditional research on health care ethics is outlined, with the goal of identifying and measuring acceptable community values that are relatively consistent across measurement methods and, ultimately, developing ways to incorporate these values into health care priority decision making.

Topic: Components and Resources

Description:

A health system's components and resources are believed to contribute directly to its performance and sustainability. Research on this topic examines the impact of components and resources on an organization or system's intended functions as well as their adequacy with respect to the organization or system's goals and outcomes. Much of the research on this topic attempts to address components and resources issues by examining the organization (i.e., local public health department) as a whole, developing ways to prioritize public health issues within that organization and identifying resources to address these issues. Other research examines the impact of public policy on system and organization components and resources.

Materials of interests relating to components and resources consist of conceptual as well as strategic planning tools, checklists, and toolkits that can be used to evaluate components and resources.

OMH Strategic Framework:

Within the OMH Strategic Framework, Components and Resources is a Systems-level factor that contributes to poor racial/ethnic minority health and to racial/ethnic health disparities. Specifically, Components and Resources refers to the adequacy, appropriateness, and mix of components, resources, and assets in a system. Resources and sufficient infrastructures are needed that ensure specific attention to minority health and health disparities as well as the public health and health care needs of the American population in general.

Materials of Interest:

Derose S, Schuster MA, Fielding JE, Asch SM. Public Health Quality Measurement: Concepts and Challenges. Annu Rev Public Health. 2002;23:1–21. http://arjournals.annualreviews.org/doi/abs/10.1146/annurev.publhealth.23.092601.095644?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dncbi.nlm.nih.gov

> Public health agencies increasingly are recognizing the need to formally and quantitatively assess and improve the quality of their programs, information, and policies. Measuring quality can help organizations monitor their progress toward public health goals and become more accountable to both the populations they serve and policy makers. Yet quality assessment is a complex task that involves precise determination and specification of useful measures. We discuss a well-established conceptual framework for organizing quality assessment in the context of planning and delivery of programs and services by local health departments, and consider the strengths and limitations of this approach for guiding quality improvement. We review several past and present quality measurement-related initiatives designed for public health department use, and discuss current and future challenges in this evolving area of public health practice.

National Association of County & City Health Officials (ACCHO). Mobilizing for Action through Planning and Partnerships (MAPP). MAPP Project. 2009.
http://www.naccho.org/topics/infrastructure/MAPP/index.cfm

> Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven strategic planning tool for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment tool; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems. MAPP includes four assessment tools: Community Themes and Strengths Assessment; Local Public Health System Assessment; Community Health Status Assessment; Forces of Change Assessment.

The Centers for Disease Control and Prevention (CDC). National Public Health Performance Standards Program, Local Public Health Performance Assessment. Version 2.0 OMB Control No. 0920–0555.
http://www.cdc.gov/od/ocphp/nphpsp/documents/07_110300%20Local%20Booklet.pdf

> The National Public Health Performance Standards Program (NPHPSP) assessments are intended to help users answer questions such as “What are the activities and capacities of our public health system?” and “How well are we providing the Essential Public Health Services in our jurisdiction?” The dialogue that occurs in answering these questions can help to identify strengths and weaknesses and determine opportunities for improvement. The NPHPSP assessment instruments guide state and local jurisdictions in evaluating their current performance against a set of optimal standards. The Local Public Health System Performance Assessment Instrument is organized into ten essential services: Monitor Health Status to Identify Community Health Problems; Diagnose and Investigate Health Problems and Health Hazards; Inform, Educate, and Empower People about Health Issues; Mobilize Community Partnerships to Identify and Solve Health Problems; Develop Policies and Plans that Support Individual and Community Health Efforts; Enforce Laws and Regulations that Protect Health and Ensure Safety; Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable; Assure a Competent Public and Personal Health Care Workforce; Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services; Research for New Insights and Innovative Solutions to Health Problems.

Ladenheim K, Groman R. State Legislative Activities Related to Elimination of Health Disparities. Journal of Health Politics, Policy and Law. February 2006; 31(1): 153-184.
http://jhppl.dukejournals.org/cgi/content/abstract/31/1/153

> How have state legislatures acted to address racial and ethnic disparities in health care? This article examines trends over time in state legislation related to disparities in care and access, proposed legislation during one biennial session, and contemporary legislative attitudes and awareness of the issue. The mix of strategies adopted across the states reflects the differing ways that states understand gaps in minority health and changing strategies over time. Historically, California, Florida, and Louisiana (all states with substantial minority

populations) have been the most active in dealing with minority health issues through statutes. In the eighteen months of the 2001–2002 legislative session that we studied, the most common bills called for studies of disparities and appropriations for identifiable minority health initiatives. Measures that successfully cleared the legislature include measures related to cultural competence and minority health awareness month. Finally, the article discusses issues and limitations in using legislative action to measure the level of state policy activity with regard to health disparities. To ground the description of trends in disparity legislation, the authors integrated comments by state legislators with a discussion of problems in interpreting legislative activity.

Trivedi AN, Gibbs B, Nsiah-Jefferson L, Ayanian JZ, Prothrow-Stith D. Creating A State Minority Health Policy Report Card. Health Affairs. March/April 2005; 24(2): 388-396. http://content.healthaffairs.org/cgi/content/abstract/24/2/388

A state minority health policy report card may provide an important tool for evaluating and promoting state policies to reduce health disparities. This study develops criteria that can form the basis of such a state report card and assesses the performance of all fifty states on these measures. The results indicate wide variation among states, with geographic region being a significant predictor of performance on all four measures. Future research should be conducted on other predictors of state variation in minority health policy and connections between state policy and health outcomes for minorities.

McDonough JE, Gibbs BK, Scott-Harris JL, Kronebusch K, Navarro AM, Taylor K. A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities. The Commonwealth Fund, Publication #746. June 2004. http://www.commonwealthfund.org/programs/minority/mcdonough_statepolicyagenda_746.pdf

This report provides state policymakers with a menu of policy interventions that have been implemented to address disparities in minority health and health care. The authors divide these state and local programs into those targeting infrastructure, management, and capacity, and those targeting specific health conditions. Based on their review, the authors identified eight key needs that state and national policymakers will need to consider: consistent racial/ethnic data collection; effective evaluation of disparities-reduction programs; minimum standards for culturally and linguistically competent health services; greater minority representation within the health care workforce; expanded health screening and access to services (e.g., through expanded insurance coverage); establishment or enhancement of state offices of minority health; involvement of all health system stakeholders in minority health improvement efforts; and creation of a national coordinating body to promote continuing state-based activities to eliminate racial and ethnic health disparities.

Topic: Coordination and Collaboration

Description:

Collaborative partnerships are a common method for carrying out efforts that seek to eliminate racial and ethnic health disparities. A number of different formal and informal studies have sought to measure the efficacy and impact of partnerships, as opposed to using simply a count of types of partnerships as a measurement tool. Many attempt to measure partnerships' impact by linking assessments of collaboration to outcomes achieved, while some analyze the internal workings of the collaborative partnership, such as the degree of coordination through network mapping analysis. In addition, collaborative partnerships sometimes employ community-based participatory research, which expands the partnerships strategy to include involvement of community members and local organizational representatives in all aspects of the research process.

The materials of interest included below include studies that have used a combination of quantitative and qualitative methods, including respondent interviews, meeting notes, surveys, and network mapping, to attempt to measure the effectiveness of coordination and collaboration in the form of partnerships and community-based participatory research. Other resources include a number of self-evaluation toolkits and measurement frameworks that have previously been used to aid in assessing the work of partnerships.

OMH Strategic Framework:

Within the OMH Strategic Framework, collaborative partnerships are a Systems-level contributing factor to racial/ethnic minority health and to racial/ethnic health disparities. The Strategic Framework notes that, "in effective systems, collaboration and partnerships are integral to planning, implementation, and performance." Specifically, efforts to promote coordination, collaboration, and partnerships contribute to greater effectiveness and efficiency, including strong information and communications systems and infrastructure.

Materials of Interest:

Borden LM, Perkins DF. Assessing Your Collaboration: A Self-Evaluation Tool. Journal of Extension. April 1999; 37(2). http://www.joe.org/joe/1999april/tt1.php

> This self-evaluation tool examines thirteen factors that can influence the collaborative process. The information gained from this tool can provide group members with an understanding of the strengths and challenges they face as they work to reach their goals.

Fetterman DM, Wandersman A, Kaftarian S. The Plan Quality Index: An Empowerment Evaluation Tool for Measuring and Improving the Quality of Plans. In Empowerment Evaluation: Knowledge and Tools for Self-Assessment and Accountability. Thousand Oaks, California: Sage Publications, 1996. http://www.worldcat.org/oclc/315836058

> This article describes how the Plan Quality Index (PQI) was developed and primarily used as a quantitative measure of plan quality and later became a qualitative tool to facilitate the improved functioning of coalitions. A survey was also administered to measure member satisfaction so that evaluators could compare the association between levels of plan quality, satisfaction with the plan and satisfaction with input into the plan.

Butterfoss FD, Goodman RM, Wandersman A. Community Coalitions for Prevention and Health Promotion: Factors Predicting Satisfaction, Participation and Planning. Health Educ Q. 1996 Feb;23(1):65-79. http://www.ncbi.nlm.nih.gov/pubmed/8822402.

> Coalitions currently are a popular tool for promoting community-based solutions to health problems, such as alcohol, tobacco, and other drug (ATOD) abuse. Private foundations, granting agencies, and other public health organizations assume that participation of community members in health promotion coalitions will increase the likelihood of program success. This article examines whether key characteristics of coalitions are related to effectiveness as measured by member satisfaction, commitment to the coalition, and the quality of planning efforts. Member survey data from the first year evaluation of an ATOD coalition were analyzed using factor analysis, chi-square, and multiple regression techniques at both the individual and group levels. The results suggest that community leadership, shared decision making, linkages with other organizations, and a positive organizational climate were key determinants of member satisfaction and participation. These same factors were not related to the quality of coalition plans. However, the significance of coalitions for community empowerment and health promotion is discussed.

Foss SK, Waters W. TGYS Collaboration Assessment Toolkit. Child Adolescent and School Health, Colorado Department of Public Health and Environment. 2007. http://74.125.113.132/search?q=cache:v5he0tk7TkUJ:www.cdphe.state.co.us/ps/tgys/TGYSCollaborationEvaluationToolkit.DOC+Bright,+R.,+%E2%80%9CCommunity+Organization+Assessment+Tool,%E2%80%9D+Family+Living+Programs,&cd=2&hl=en&ct=clnk&gl=us

> The Tony Grampsas Youth Services (TGYS) Grant administered through the Colorado Department of Public Health and Environment provides a tool to assess a collaboration. The Survey encompasses six factors that influence the collaboration success: Collaboration Membership, Collaboration Structure, Collaboration Leadership, Internal Collaboration, Collaboration Effectiveness, and Collaboration Sustainability (From the Tony Grampsas Youth Services Program). Additional information available at: http://www.cdphe.state.co.us/ps/tgys/index.html.*)*

Barr DA. A Research Protocol to Evaluate the Effectiveness of Public–Private Partnerships as a Means to Improve Health and Welfare Systems Worldwide. American Journal of Public Health, January 2007; 97(1): 19-25. http://www.ajph.org/cgi/content/abstract/97/1/19

> Public–private partnerships have become a common approach to health care problems worldwide. Many public–private partnerships were created during the late 1990s, but most were focused on specific diseases such as HIV/AIDS, tuberculosis, and malaria. Recently there has been enthusiasm for using public–private partnerships to improve the delivery of health and welfare services for a wider range of health problems, especially in developing countries. The success of public–private partnerships in this context appears to be mixed, and few data are available to evaluate their effectiveness. This analysis provides an overview of the history of health-related public–private partnerships during the past 20 years and describes a research protocol commissioned by the World Health Organization to evaluate the effectiveness of public–private partnerships in a research context.

Cook WK. Integrating research and action: a systematic review of community-based participatory research to address health disparities in environmental and occupational health in the USA. Journal of Epidemiology and Community Health. 2008 August; 62(8):668-676. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2772828/

> Introduction: Integrating research and action represents a goal and key principles of community-based participatory research (CBPR), but there has been little effort to synthesize the literature to evaluate whether such integration is occurring. Objectives: (1) To examine the extent to which CBPR integrates action to effect community-level change and (2) to ascertain factors that facilitate such integration. Methods: Original articles reporting on CBPR in environmental and occupational health in the USA were identified primarily through a MEDLINE search. Inceptions, processes, methods and outcomes of the projects were reviewed. Results: In 14 of the 20 studies reviewed, CBPR led to community-level action to improve the health and well-being of the community members. Observational studies that investigated problems posed by the affected community and that incorporated qualitative methods were more likely to lead to action. The collaboration among government scientists, university researchers and community partners emerged as a new model of CBPR partnerships that effectively integrates research and action. Conclusions: To help CBPR better integrate research and action, a shift towards community-initiated and action-oriented observational studies might be needed.

Lindamer LA, Lebowitz B, Hough RL, et al. Establishing an implementation network: lessons learned from community-based participatory research. Implementation Science. 2009 March; 4(17), http://implementationscience.com/content/4/1/17

> Implementation of evidence-based mental health assessment and intervention in community public health practice is a high priority for multiple stakeholders. Academic-community partnerships can assist in the implementation of efficacious treatments in community settings; yet, little is known about the processes by which these collaborations are developed. In this paper, we discuss our application of community-based participatory research (CBPR) approach to implementation, and we present six lessons we have learned from the establishment of an academic-community partnership.

Topic: Culturally and Linguistically Appropriate Services

Description:

Researchers hypothesize that major contributing factors to racial/ethnic health disparities include social/environmental determinants of health and patient-physician communication. Understanding factors affecting a patient's life external to health services may aid providers in delivering care, resulting in improved outcomes."'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups."[3] The Office of Minority Health defines culturally and linguistically appropriate services as those "health care services that are respectful of and responsive to cultural and linguistic needs."

The materials of interest identified below provide recommendations for provision of culturally and linguistically appropriate services by healthcare providers as well as resources for both providers and research to further understand the components of cultural competency.

OMH Strategic Framework:

The OMH Strategic Framework includes User-Centered Design as one of the Systems-level contributing factors to minority health /health disparities. Within the context of user-centered system design, the Strategic Framework notes that provision of culturally and linguistically competent care includes the "provision of language assistance services in the preferred languages of patients; patient-related materials and signage in languages commonly encountered in the service area; effective, understandable, and respectful care from health care staff in a manner compatible with the cultural health beliefs and practices of their patients; and strategies that promote diversity of staff and leadership that is representative of the demographic characteristics of the service area."

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[3] Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). Towards A Culturally Competent System of Care Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center

Materials of Interest:

In 2003, the W.K. Kellogg Foundation issued a grant to Duke University School of Medicine to plan and convene the Sullivan Commission on Diversity in the Healthcare Workforce. Composed of 16 health, education, legal, and business leaders and headed by former U.S. Health and Human Services Secretary Dr. Louis W. Sullivan, this Commission was given the task of identifying and understanding the barriers to achieving diversity in the health professions and then to finding solutions. http://www.aacn.nche.edu/media/pdf/sullivanreport.pdf

> Chapter 2: This chapter provides a historical context for the inequitable patterns of access to health care and careers in the health care professions for racial and ethnic minorities. The chapter also provides a basic overview of minority health care today, a brief discussion of the range of public and professional perceptions of health care disparity, and a basic framework for understanding the complexity of racism in today's health care delivery system and the implications for workforce diversity. Recommendations include the following:

- Recommendation 2.1: The complementary strategies of increasing diversity and ensuring cultural competence at all levels of the health workforce should be endorsed by all in our society, with leadership from the key stakeholders in the health care system.
- Recommendation 2.2: There should be increased recognition of underrepresented minority health professionals as a unique resource for the design, implementation, and evaluation of cultural competence programs, curriculums, and initiatives.
- Recommendation 2.3: Public and private funding entities, including U.S. Public Health Service agencies, foundations, and corporations, should increase funding for research about racial disparities in health care and health status, including, but not limited to: research on culturally competent care, how to measure and eliminate racial bias and stereotyping, and strategies for increasing positive health behaviors among racial and ethnic groups.
- Recommendation 2.4: Health systems should set measurable goals for having multilingual staff and should provide incentives for improving the language skills of all health care providers.
- Recommendation 2.5: Health professions schools should work to increase the number of multilingual students, and health care systems should provide language training to health professionals.
- Recommendation 2.6: Key stakeholders in the health system should promote training in diversity and cultural competence for health professions students, faculty, and providers.

Health Resources and Services Administration: Cultural Competence Resources for Health Care Providers. http://www.hrsa.gov/culturalcompetence/

> The Health Resources and Services Administration (HRSA) website on health literacy notes that "They [the poor and underserved] require culturally competent providers who speak their language in order to make informed health care choices." One of the resources provided by HRSA is a collection of materials titled: "Cultural Competence Resources for Health Care Providers." The page provides Assessment Tools, Culture/Language, Disease/Condition, Health Professions Education, Research, Rural, Special Populations, Technical Assistance, Training Curricula, and Web-based Training.

The University at Buffalo: the State University of New York. Health Sciences Library – Cultural Competence Resources.
http://libweb.lib.buffalo.edu/dokuwiki/hslwiki/doku.php?id=cultural_competence_resources

> The University of Buffalo has a publicly available web-based collection of resources on topics related to culturally and linguistically appropriate services. According to the website, "These wikis are authored and maintained by the librarians and graduate reference assistants of the Health Sciences Library at the University at Buffalo." The cultural competence resources page notes that, "The information presented here highlights resources that assist with independent learning to help nursing faculty and other interested professionals incorporate cultural competence skills into nursing curricula and practice."

Office of Minority Health. National Standards for Culturally and Linguistically Appropriate Services in Health Care. 2001. http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

> In 1997, the OMH undertook the development of national standards to provide a much-needed alternative to the current patchwork of independently developed definitions, practices, and requirements concerning CLAS. The OMH initiated a project to develop recommended national CLAS standards that would support a more consistent and comprehensive approach to cultural and linguistic competence in health care. Between January-April 2000, recommendations for national standards underwent the national public comment process in which the public reviewed and commented on the standards as well as the complete report. The CLAS standards were published in final form in the Federal Register on December 22, 2000, as recommended national standards for adoption or adaptation by stakeholder organizations and agencies. The standards can be found online here.

Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Normand J; Task Force on Community Preventive Services. Culturally competent healthcare systems. A systematic review. Am J Prev Med. 2003 Apr;24(3 Suppl):68-79.
http://linkinghub.elsevier.com/retrieve/pii/S0749379702006578

> The authors reviewed five interventions to improve cultural competence in healthcare systems-programs to recruit and retain staff members who reflect the cultural diversity of the community served, use of interpreter services or bilingual providers for clients with limited English proficiency, cultural competency training for healthcare providers, use of linguistically and culturally appropriate health education materials, and culturally specific healthcare settings.
>
> The effectiveness of five interventions to improve the cultural competence of healthcare systems could not be determined in this systematic review, because of a lack of both quantity and quality of available studies. The authors found no comparative studies evaluating (1) programs to recruit and retain staff members who reflect the cultural diversity of the community served or (2) the use of culturally specific healthcare settings; only one qualifying study each (with fair quality of execution) evaluating (1) use of interpreter services or bilingual providers for clients with limited English proficiency or (2) cultural competency training for healthcare providers; and only four qualifying studies (three with fair quality of execution) evaluating the use of linguistically and culturally appropriate health education materials.
>
> Additional research is needed to determine whether or not these interventions are effective in improving client satisfaction with care received, improving client health, and reducing inappropriate racial or ethnic differences in use of health services or in received or recommended treatment.

Topic: Dissemination of Science and Knowledge

Description:

While indicators of quality in healthcare are developed through careful research, the consequent guidelines for delivery are often not implemented in a timely, consistent manner. For example, one study reviewed the care received by people in different metropolitan areas and found that 45% were not receiving recommended care.[4] Researchers have estimated that, after researchers have developed evidence for care, it takes an average of 17 years for that knowledge to be implemented, and even then, that application is inconsistent.[5] The Institute of Medicine's *Crossing the Quality Chasm* notes that, even for those practices for "which there is strong

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[4] McGlynn EA, Asch SM, Adams J. The quality of health care delivered to adults in the United States. N Engl J Med. 2003;348: 2635-2645

[5] Balas E, Boren S. Managing Clinical Knowledge for Health Care Improvement. Yearbook of Medical Informatics, National Library of Medicine, Bethesda, MD: 65-70, 2000.

scientific evidence and a high degree of expert consensus about best practices" … "current dissemination efforts fail to reach many clinicians and patients."[6]

Materials of interest below include investigations into the limited implementation of science into clinical practices, frameworks of the cycle of translating knowledge into practice, and research into methods to improve dissemination of research.

OMH Strategic Framework:

The OMH Strategic Framework includes dissemination and translation of research within the science and knowledge category as one of the contributing factors to minority health /health disparities. It notes, "The current public health and health care systems do not effectively identify or disseminate evidence-based practices. Nor do such systems effectively enable prospective adopters to effectively receive and manage information about such practices; train the workforce in the application and use of such practices; or otherwise facilitate the 'translation' of science and knowledge into practice."

Materials of Interest:

Cabana MD, Rand CS, Powe NR, Wu AW, Wilson MH, Abboud PC, Rubin HR. Why Don't Physicians Follow Clinical Practice Guidelines?: A Framework for Improvement. JAMA. 1999;282(15):1458-1465. http://www.ncbi.nlm.nih.gov/pubmed/10535437

> Context: Despite wide promulgation, clinical practice guidelines have had limited effect on changing physician behavior. Little is known about the process and factors involved in changing physician practices in response to guidelines. Objective: To review barriers to physician adherence to clinical practice guidelines. Data Sources We searched the MEDLINE, Educational Resources Information Center (ERIC), and HealthSTAR databases (January 1966 to January 1998); bibliographies; textbooks on health behavior or public health; and references supplied by experts to find English-language article titles that describe barriers to guideline adherence. Study Selection: Of 5658 articles initially identified, we selected 76 published studies describing at least 1 barrier to adherence to clinical practice guidelines, practice parameters, clinical policies, or national consensus statements. One investigator screened titles to identify candidate articles, then 2 investigators independently reviewed the texts to exclude articles that did not match the criteria. Differences were resolved by consensus with a third investigator. Data Extraction: Two investigators organized barriers to adherence into a framework according to their effect on physician knowledge, attitudes, or behavior. This organization was validated by 3 additional investigators. Data Synthesis: The 76 articles included 120 different surveys investigating 293 potential barriers to physician guideline adherence, including awareness (n = 46), familiarity (n = 31), agreement (n = 33), self-efficacy (n = 19), outcome expectancy (n = 8), ability to overcome the inertia of previous practice (n = 14), and absence of external barriers to perform recommendations (n = 34). The majority of surveys (70 [58%] of 120) examined only 1 type of barrier. Conclusions: Studies on improving physician guideline adherence may not be generalizable, since barriers in one setting may not be present in another. Our review offers a

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[6] Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century, National Academy Press, Washington, D.C., 2001

differential diagnosis for why physicians do not follow practice guidelines, as well as a rational approach toward improving guideline adherence and a framework for future research.

Grol R, Grimshaw J. From Best Evidence to Best Practice: Effective Implementation of Change in Patients' Care. Lancet 2003 Oct 11;362(9391):1225-30. http://www.ncbi.nlm.nih.gov/pubmed/14568747

> Major difficulties arise when introducing evidence and clinical guidelines into routine daily practice. Data show that many patients do not receive appropriate care, or receive unnecessary or harmful care. Many approaches claim to offer solutions to this problem; which ones are as yet the most effective and efficient is unclear. We aim to provide an overview of present knowledge about initiatives to changing medical practice. Substantial evidence suggests that to change behavior is possible, but this change generally requires comprehensive approaches at different levels (doctor, team practice, hospital, wider environment), tailored to specific settings and target groups. Plans for change should be based on characteristics of the evidence or guideline itself and barriers and facilitators to change. In general, evidence shows that none of the approaches for transferring evidence to practice is superior to all changes in all situations.

Colditz GA, Emmons KM, Vishwanath K, and Kerner JF. Translating Science to Practice: Community and Academic Perspectives. J Public Health Manag Pract. 2008 Mar-Apr;14(2):144-9. http://www.ncbi.nlm.nih.gov/pubmed/18287920

> While evidence reviews inform practice and policy guidelines, the gap between guidelines and implementation may be growing. We place dissemination and implementation research in the context of other changes needed to drive research into practice. Multilevel approaches to research and dissemination are needed as are metrics to inform academic appointment and promotions. Moving beyond funding that stops and starts with grant cycles is a key issue from the community perspective to ensure continuity and improved health. Transdisciplinary approaches that cut across disciplinary boundaries to develop shared conceptual frameworks may help speed the integration of research with practice. Identifying and implementing structural changes to develop and support transdisciplinary teams may further facilitate this process. Changes in the approaches used to structure and implement scientific advances into practice will help achieve the enormous potential to advance the health of the population.

Timmermans S, Mauck A. The Promises and Pitfalls of Evidence-Based Medicine. Health Affairs, 24, no. 1 (2005): 18-28. http://content.healthaffairs.org/cgi/content/full/24/1/18

> Evidence-based medicine (EBM) aims to address the persistent problem of clinical practice variation with the help of various tools, including standardized practice guidelines. While advocates welcome the stronger scientific foundation of such guidelines, critics fear that they will lead to "cookbook medicine." Studies show, however, that few guidelines lead to consistent changes in provider behavior. The hopes, fears, and mixed record of EBM are rooted in the traditional professional perspective of the clinician as sole decision maker.

Multifaceted implementation strategies that take the collaborative nature of medical work into consideration promise more effective changes in clinical practice.

Graham ID, Tetroe J, KT Theories Research Group. Some Theoretical Underpinnings of Knowledge Translation. Acad Emerg Med. 2007 Nov;14(11):936-41. http://www.ncbi.nlm.nih.gov/pubmed/17967955

A careful analysis of the definition of knowledge translation highlights the importance of the judicious translation of research into practice and policy. There is, however, a considerable gap between research and practice. Closing the research-to-practice gap involves changing clinical practice, a complex and challenging endeavor. There is increasing recognition that efforts to change practice should be guided by conceptual models or frameworks to better understand the process of change. The authors conducted a focused literature search, developed inclusion criteria to identify planned action theories, and then extracted data from each theory to determine the origins, examine the meaning, judge the logical consistency, and define the degree of generalizability, parsimony, and testability. An analysis was conducted of the concepts found in each theory, and a set of action categories was developed that form the phases of planned action. Thirty-one planned action theories were identified that formed the basis of the analyses. An Access database was created, as well as a KT Theories User's Guide that synthesizes all the planned change models and theories, identifies common elements of each, and provides information on their use. There are many planned change models and frameworks with many common elements and action categories. Whenever any planned change model is used, change agents should consider documenting their experiences with the model so as to advance understanding of how useful the model is and to provide information to others who are attempting a similar project.

Tian H, Brimmer DJ, Lin JS, Tumpey AJ, Reeves WC. Web Usage Data as a Means of Evaluating Public Health Messaging and Outreach. J Med Internet Res 2009;11(4):e52. http://www.jmir.org/2009/4/e52/

Objective: The aim of the study was to examine the utilization of the chronic fatigue syndrome (CFS) website at the Centers for Disease Control and Prevention (CDC). We evaluated (1) CFS website utilization, (2) outcomes of a CDC CFS public awareness campaign, and (3) user behavior related to public awareness campaign materials and CFS continuing medical education courses. Methods: To describe and evaluate Web utilization, we collected Web usage data over an 18-month period and extracted page views, visits, referring domains, and geographic locations. We used page views as the primary measure for the CFS awareness outreach effort. We utilized market basket analysis and Markov chain model techniques to describe user behavior related to utilization of campaign materials and continuing medical education courses. Results: The CDC CFS website received 3,647,736 views from more than 50 countries over the 18-month period and was the 33rd most popular CDC website. States with formal CFS programs had higher visiting density, such as Washington, DC; Georgia; and New Jersey. Most visits (71%) were from Web search engines with 16% from non-search-engine sites and 12% from visitors who had bookmarked the site. The public awareness campaign was associated with a sharp increase and subsequent quick drop in Web traffic. Following the campaign, user interest shifted from information targeting consumer basic knowledge to information for health care professionals. The market basket analysis showed that visitors preferred the 60-second radio clip public service announcement over the 30-second one. Markov chain model results revealed that most visitors took the online continuing education courses in sequential order and were less likely to drop out after they reached the Introduction pages of the courses.

Topic: Leadership

Description:

Leadership includes all efforts aimed at fostering and ensuring leadership and commitment within an organization. Broadly, this includes all efforts to enlist the support and aid of available individuals and resources to complete a common task. Measurements of leadership can assess the effectiveness of strategic planning or the success of an individual and/or a group of individuals in directing the efforts of an organization as a whole.

Materials of interest below provide surveys and toolkits for assessing leadership effectiveness within varying types of organizations, some of which include methods and frameworks to consider in measuring leadership and strategic planning within an organization.

OMH Strategic Framework:

Within the OMH Strategic Framework, Leadership is a Systems-level factor that contributes to racial/ethnic minority health and to racial/ethnic health disparities. Elements of leadership noted in the Strategic Framework include strong commitment; clearly defined goals and objectives; reduction of barriers to performance; provision, collection, and responsiveness to feedback; and a systematic, strategic plan that is monitored and evaluated for improvement to set priorities and coordinate and target resources.

Materials of Interest:

Trott MC, Windsor K. Leadership Effectiveness: How Do You Measure Up? Nursing Economics. May-June 1999; 17(3): 127-130. http://www.ncbi.nlm.nih.gov/pubmed/10711151

> The purpose of this article is to provide leaders with a tool to collect accurate data of subordinate's perceptions. Leaders in the nursing profession must feel comfortable and be encouraged to seek the opinion of the staff they serve. Without actively seeking the feedback of subordinates, there is no opportunity for personal growth and insight. So, while asking for staff feedback can be a "daring adventure" for any leader, leading staff who do not want to follow will result in an organization of "nothing" in today's health care arena.

Pronovost PJ, Weast B, Holzmueller CG, Rosenstein BJ, Kidwellv RP, Haller KB, Feroli ER, Sexton JB, Rubin HR. Evaluation of the Culture of Safety: Survey of Clinicians and Managers in an Academic Medical Center. Qual Saf Health Care. 2003; 12:405-410. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1758025/pdf/v012p00405.pdf

> Despite the emphasis on patient safety in health care, few organizations have evaluated the extent to which safety is a strategic priority or their culture supports patient safety. In response to the Institute of Medicine's report and to an organizational commitment to patient safety, we conducted a systematic assessment of safety at the Johns Hopkins Hospital (JHH) and, from this, developed a strategic plan to improve safety. The specific aims of this study were to evaluate the extent to which the culture supports patient safety at JHH and the extent to which safety is a strategic priority. During July and August 2001, the authors implemented two surveys in disparate populations to assess patient safety. The Safety Climate Scale (SCS) was administered to a sample of physicians, nurses, pharmacists, and other ICU staff. SCS assesses perceptions of a strong and proactive organizational commitment to patient safety. The second survey instrument, called Strategies for Leadership (SLS), evaluated the extent to which safety was a strategic priority for the organization. This survey was administered to clinical and administrative leaders. The authors received 395 completed SCS surveys from 82% of the departments and 86% of the nursing units. Staff perceived that supervisors had a greater commitment to safety than senior leaders. Nurses had higher scores than physicians for perceptions of safety. The survey results suggest that strategic planning of patient safety needs enhancement. Several efforts to improve our culture of safety were initiated based on these results, which should lead to measurable improvements in patient safety.

Management and Leader Assessment Scale. In Kouzes, J.M., and Posner, B.Z. The Leadership Challenge. San Francisco: Jossey-Bass, 2002. http://www.worldcat.org/oclc/50055536

> This survey describes twenty practices commonly demonstrated by excellent managers and twenty more commonly demonstrated by effective leaders: 1) Gets tough when needed, 2) Speaks well to groups, 3) Established consistent, clear discipline line, 4) Motivates others with a clear message, 5) Provides environment conducive to a feeling of cohesiveness, 6) Communicates sense of being in charge, 7) Has full backing from those reporting to him or her, 8) Converts employees into followers, 9) Strives to win by allowing employees to also win, 10) Attracts others to join his or her group, 11) Providers important rewards to staff, 12) Utilizes sources or power in a sensitive, consistent manner, 13) Shows compassion, 14) Strong track record for making solid and decisive decisions, 15) Good listener, 16) Formalizes and "stages" communication announcements, 17) Expresses thoughts clearly, 18) Prudent risk taker, 19) Keeps employees fully informed, 20) Articulates an inspiring mission, 21) Highly ethical, 22) Generates a feeling of pride in followers, 23) Delegates effectively, 24) Ties short-term work goals to mission, 25) Shares large and small victories with staff, 26) Gets others caught up in his or her positive force, 27) Makes work enjoyable, 28) Creates active tempo, 29) Maintains positive, upbeat attitude, 30) Highly energetic, not "desk-bound", 31) Admits to mistakes, 32) Good negotiator; knows when to compromise, 33) Follows logical steps in making decisions, 34) If he or she resigned, others would consider following, 35) Consults with others when making decisions, 36) Builds commitment to his or

her cause, 37) Uses management role with sensitivity, 38) Stands firm on principle, 39) Respected by employees when authority is used, 40) Communicates a power image.

Mcdougal JA, Brooks CM, Albanese M. Achieving Consensus on Leadership Competencies and Outcomes Measures: The Pediatric Pulmonary Centers' Experience. Eval Health Prof 2005; 28; 428. http://ehp.sagepub.com/cgi/content/abstract/28/4/428

> Pediatric Pulmonary Centers (PPCs) are federally funded interdisciplinary leadership training programs aiming to improve the health of families and children. This article describes the process PPCs used to efficiently and effectively achieve consensus on leadership training competencies and outcome measures among a large and diverse group of health professionals. Phase 1 used a modified Delphi technique to develop an initial set of competencies and outcome measures. Phase 2 used the nominal group technique and modified focus group strategies to refine and prioritize the competencies and outcomes measures. Participants reported being highly satisfied with the process and outcomes. In Phase 3, a formal program evaluation instrument was implemented, designed to measure the competency and describe the career paths and leadership accomplishments of previous trainees. The consensus process adopted can serve as a model for academic and public health entities seeking to achieve consensus on program goals, strategies, methods, priorities, and outcomes.

Shipton H, Armstrong C, West M, Dawson J. The Impact of Leadership and Quality Climate on Hospital Performance. International Journal for Quality in Health Care 2008; 20(6):439-445. http://intqhc.oxfordjournals.org/cgi/reprint/20/6/439.pdf

> Objective: To explore the relationship between leadership effectiveness and health-care trust performance, taking into account external quality measures and the number of patient complaints; also, to examine the role of care quality climate as a mediator. Design: We developed scales for rating leadership effectiveness and care quality climate. We then drew upon UK national indices of health-care trust performance—Commission for Health Improvement star ratings, Clinical Governance Review ratings and the number of patient complaints per thousand. We conducted statistical analysis to examine any significant relationships between predictor and outcome variables. Setting: The study is based on 86 hospital trusts run by the National Health Service (NHS) in the UK. The data collection is part of an annual staff survey commissioned by the NHS to explore the quality of working life. Participants: A total of 17 949 employees were randomly surveyed (41% of the total sample). Results: Leadership effectiveness is associated with higher Clinical Governance Review ratings and Commission for Health Improvement star ratings for our sample ($\beta = 0.42$, $P < 0.05$; $\beta = 0.37$, $P < 0.05$, respectively), and lower patient complaints ($\beta = -0.57$, $P < 0.05$). In addition, 98% of the relationship between leadership and patient complaints is explained by care quality climate. Conclusions: Results offer insight into how non-clinical leadership may foster performance outcomes for health-care organizations. A frequently neglected area—patient complaints—may be a valid measure to consider when assessing leadership and quality in a health-care context.

Gibbs BK, Nsiah-Jefferson L, McHugh MD, Trivedi AN, Prothrow-Stith D. Reducing Racial and Ethnic Health Disparities: Exploring an Outcome-Oriented Agenda for Research and Policy. Journal of Health Politics, Policy and Law 2006; 31(1): 185-218.
http://jhppl.dukejournals.org/cgi/content/abstract/31/1/185

> Even though the elimination of racial and ethnic health disparities challenges the whole nation, individual states are on the front line of many initiatives and are often the focus of important policy efforts. In addition, it is important to focus on states because they are already responsible for much of the health and public health infrastructure, and several states have developed initiatives dating back to the release of Margaret Heckler's report on the gaps in health outcomes by race in 1985. This article makes the case for an outcome-oriented approach and provides a summary of lessons learned based upon preliminary investigations into constructing and applying two indices, the disparity reduction profile to measure effort and the disparity index to measure outcomes. Specifically, the authors quantified leadership by measuring political support -- they examined the inclusion of HIV/AIDS in the speeches of senior-level officials and policy and planning according to whether countries have a strategic plan.

Topic: Minority Participation in Research

Description:

In an attempt to ensure that research is done in a manner that provides information generalizable to the whole U.S. population, the National Institutes of Health (NIH) expanded their policies regarding women and minorities in research within the NIH Revitalization Act of 1993. The guidelines state "It is the policy of the NIH that women and members of minority groups and their subpopulations must be included in all NIH-supported biomedical and behavioral research", unless there are valid reasons not to do so.[7] Researchers have noted continuing barriers to minority recruitment in health research, which lead to lower enrollment rates. These include provider time constraints, lack of knowledge about and distrust of research, lack of confidentiality, fear of safety, schedule conflicts, poor access to medical care, and language and cultural differences[8,9]

Materials of interest below include investigations into the reasons for limited minority participation in research, case studies demonstrating strategies to reducing the disparities in participation, and recommendations for public health agencies, scientific organizations, professional associations, governing bodies, and academic institutions to undertake to remedy limited minority participation in research.

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[7] National Institutes of Health Office of Human Subjects Research. Sheet 11 – Inclusion of Women and Minorities in Study Populations: Guidance For IRBs and Principal Investigators. http://ohsr.od.nih.gov/info/sheet11

[8] UyBico SJ, Pavel S, Gross CP. Recruiting vulnerable populations into research: a systematic review of recruitment interventions. J Gen Intern Med. 2007 Jun;22(6):852-63

[9] Yancey AK, Ortega AN, Kumanyika SK. Effective Recruitment And Retention of Minority Research Participants. Annu. Rev. Public Health 2006. 27:1–28

OMH Strategic Framework:

The OMH Strategic Framework includes User-Centered Design as one of the Systems-level contributing factors to minority health /health disparities. One of the components of user-centered design in the Strategic Framework is racial/ethnic minority participation. According to the Strategic Framework, this includes involving racial/ethnic minority stakeholders at all stages of planning and implementation of the intervention, using Institutional Review Boards, ethics committees, funders, and stakeholders from the community.

Materials of Interest:

Horowitz CR, Brenner BL, Lachapelle S, Amara DA, Arniella G. Effective Recruitment of Minority Populations Through Community-Led Strategies. Am J Prev Med. 2009 Dec;37(6 Suppl 1):S195-200. http://rwjcsp.unc.edu/resources/articles/S195-S200.pdf

> Background: Traditional research approaches frequently fail to yield representative numbers of people of color in research. Community-based participatory research (CBPR) may be an important strategy for partnering with and reaching populations that bear a greater burden of illness but have been historically difficult to engage. The Community Action Board, consisting of 20 East Harlem residents, leaders, and advocates, used CBPR to compare the effectiveness of various strategies in recruiting and enrolling adults with prediabetes into a peer-led, diabetes prevention intervention. Methods: The board created five recruitment strategies: recruiting through clinicians; recruiting at large public events such as farmers markets; organizing special local recruitment events; recruiting at local organizations; and recruiting through a partner-led approach, in which community partners developed and managed the recruitment efforts at their sites. Results: In 3 months, 555 local adults were approached; 249 were appropriate candidates for further evaluation (overweight, nonpregnant, East Harlem residents without known diabetes); 179 consented and returned in a fasting state for 1/2 day of prediabetes testing; 99 had prediabetes and enrolled in a pilot randomized trial. The partner-led approach was highly successful, recruiting 68% of those enrolled. This strategy was also the most efficient; 34% of those approached through partners were ultimately enrolled, versus 0%–17% enrolled through the other four strategies. Participants were predominantly low-income, uninsured, undereducated, Spanish-speaking women. Conclusions: This CBPR approach highlights the value of partner-led recruitment to identify, reach out to, and motivate a vulnerable population into participation in research, using techniques that may be unfamiliar to researchers but are nevertheless rigorous and effective.

Shavers VL, Lynch CF, Burmeister LF. Why Are African Americans Under-Represented In Medical Research Studies? Impediments to Participation. Ethnicity & Health, 1997 Mar-Jun;2(1-2):31-45. http://www.ncbi.nlm.nih.gov/pubmed/9395587

> Objectives: In accordance with the NIH Revitalization Act of 1993, the National Institutes of Health and the Alcohol, Drug and Mental Health Administration require grant applicants and cooperative agreement participants to include minorities in human subject research. In an environment characterized by diminishing research dollars, this mandate has increased the pressure on investigators to determine factors that impede minority participation and to

> develop strategies to overcome these impediments. Methods: An extensive review of the literature was conducted to identify the factors possibly responsible for the low participation levels of African Americans in medical research studies and to highlight areas for further research. The items examined included the historical relationship between African Americans and medical researchers and the attitudes, perceptions and beliefs of potential participants and researchers as they relate to the low representation of African Americans in medical research. Results: The factors identified as possible impediments to African American participation included distrust of the medical/scientific community, poor access to primary medical care, the failure of researchers to recruit African Americans actively, the alienation of minority health professionals, and lack of knowledge about clinical trials, language and cultural barriers. Conclusions: Well-designed, relevant, ethical research in conjunction with an appreciation of the many barriers to participation are paramount to increasing African American presence in clinical research.

Yancey AK, Ortega AN, Kumanyika SK. Effective Recruitment and Retention of Minority Research Participants. Annu. Rev. Public Health 2006. 27:1–28.
http://www.toniyancey.com/is19/102406c.pdf

> "Confining our review to those minority groups federally defined as underrepresented (African Americans/blacks, Latinos/Hispanics, and Native Americans/American Indians), [the authors] identified 95 studies published between January 1999 and April 2005 describing methods of increasing minority enrollment and retention in research studies, more than three times the average annual output of scholarly work in this area during the prior 15-year period." The authors provide the following recommendations:

- Federal and state public health agencies should:
  - Support analytical or hypothesis-testing recruitment and retention research studies that are planned at the outset of studies of various designs. For example, supplements to NIH and CDC P01s and R01s may be created to fund nested projects to engage senior investigators with research interests in recruitment/retention in creating more rigorous study designs from study inception. Although current administrative supplements to NIH grants for mentoring minority investigators may be used in this way, a greater and more focused investment is needed to advance the science, especially because these supplements do not generally cover funding for increasing or diversifying samples.
  - Allow sufficient resources (time and funding) for the conduct of feasibility studies, which are part of any standard protocol for implementing large scientific investigations, because they are useful in determining the most practical and potentially efficacious approaches or strategies for recruiting and retaining sampled populations in an identified setting or context.
  - Establish the inclusion of sufficient numbers of at least one minority group for the conduct of subgroup analyses stratified by race/ethnicity as a formal review criterion for all federally funded research studies. Studies may be exempted if there is a strong scientific rationale, but serious deliberation and consideration in grant review committee discussions must be incentivized to accelerate the proportion of studies

  achieving substantive inclusiveness. This regulatory approach has been successful in the recent past, as reflected in the valuable information gained by Marquez and colleagues when the competitive renewal of their grant was contingent on their achieving more substantive minority engagement. Similarly, the National Cancer Institute program staff and review committee members spurred an increased black Adventist recruitment goal to approximately one third of the total sample of the Adventist Health Study-2 by communicating a high scientific priority for this inclusiveness in their comments and scoring.

  - Provide training to reviewers of grants to increase their expertise in recognizing adequate plans for minority recruitment and retention.
  - Invest more heavily in supporting “pipeline” programs to diversify the public health investigator pool.

- Public health scientific organizations, professional associations, and governing bodies should:
  - Establish journal standards for the reporting of sampling frame (population from which sample is drawn), sample composition, study recruitment, eligibility, and enrollment and retention statistics by race/ethnicity, including consistency in usage of terminology. Sociodemographic data should be provided, to the extent possible, on non-responder, drop-out, refuser, and/or ineligible subjects. Indeed, this is part of standard research practice. It must not be considered acceptable to assume a sample is European American white unless otherwise specified, much as it is no longer acceptable to assume a sample is male unless otherwise specified.
  - Organize interest groups to examine the challenges to minority recruitment and retention, and make recommendations for their redress.
- Public health academic institutions should:
  - Change the promotion and tenure process to reward the conduct of research in understudied ethnic groups and in settings in underserved communities, and to recognize the more time-consuming and, consequently, lower academic productivity rate for intervention research in lower SES and ethnic minority populations.
  - Link with local public health practice agencies, such as public health departments, which serve the needs of and may provide access to low-income ethnic minority populations: establishment of true collaborative relationships from research project inception may infuse different perspectives and expertise into the generation of hypotheses and research questions, as well as recruitment, implementation and evaluation approaches, that may have greater cultural relevance and resonance.

Topic: Physical Activity Resources

Description:

The literature has noted the availability of physical activity resources within a community as a relevant factor associated with the health and well-being of the community, specifically related to obesity and physical activity. For the purposes of this document, physical activity resources include resources such as recreational spaces (parks, trails, public beaches, etc.), sports facilities, fitness clubs, community centers, and dance studios, as well as the general walkability of the community.

The resources provided below provide information on community-level physical activity resources and methods of assessing the availability of these resources.

OMH Strategic Framework:

The OMH Strategic Framework identifies environmental- and community-level factors that contribute to poor racial/ethnic minority health and to racial/ethnic health disparities. Within the environmental- and community-level factors, the OMH Strategic Framework identifies the physical environment as an important contributor to health outcomes and notes "certain kinds of neighborhood characteristics (e.g., crime, lack of recreation space)—which are typically intertwined with socioeconomic status—can also be viewed as elements of an environment that contributes to health conditions such as obesity, violence, and substance use."

Materials of Interest:

The Robert Wood Johnson Foundation. "Active Living Research: Building the Evidence to Prevent Childhood Obesity and Support Active Communities." http://www.activelivingresearch.org/resourcesearch/toolsandmeasures

> Active Living Research, a national program of the Robert Wood Johnson Foundation, contributes to the prevention of childhood obesity in low-income and high-risk racial/ethnic communities by supporting research to examine how environments and policies influence active living for children and their families. The website provides an expansive list of tools to assess the walkability and availability of physical activity resources within a community.

Gordon-Larsen P, Nelson M, Page P, and Popkin B. Inequality in the Built Environment Underlies Key Health Disparities in Physical Activity and Obesity. Pediatrics. 2006; 117:417-424. http://pediatrics.aappublications.org/cgi/reprint/117/2/417

> Using a nationally representative cohort, the authors found that lower-SES and high-minority block groups had reduced access to facilities, which in turn was associated with decreased Physical Activity (PA) and increased overweight. Inequality in availability of PA facilities may contribute to ethnic and SES disparities in PA and overweight patterns. This nationally representative study of 20 000 adolescents and 19% of all US census-block groups provides the first empirical evidence to suggest that all major categories of PA-related resources are distributed inequitably, with high-minority, low-educated neighborhoods at a strong

disadvantage. In addition, this inequitable distribution is significantly associated with subsequent disparities in health-related behaviors and obesity measured at the individual level. Presence of a PA facility in a block group is associated with an increased likelihood of engaging in 5 bouts of MVPA per week and decreased relative odds of overweight. In addition, there is a significant beneficial effect linked with each additional PA facility.

Estabrooks P, Lee R, and Gyurcsik N. Resources for physical activity participation: Does availability and accessibility differ by neighborhood socioeconomic status? Annals of Behavioral Medicine. 2003; 25:100-104. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2708147/

> The purpose of this study was to determine whether the availability and accessibility of physical activity resources differed by neighborhood socioeconomic status (SES) in a small U.S. city (population = 133,046). U.S. census tracts (N = 32) were used to represent neighborhoods and categorized into high, medium, or low SES on the basis of the percentage of unemployed individuals, per capita income, and percentage of the population below the poverty threshold. We developed a geographic information system to generate a comprehensive list of physical activity resources available within each census tract in the city. Data suggest that individuals from lower SES neighborhoods may have limited ability to control their physical activity in the face of inaccessible environments. Community research and promotion efforts should include assessment and targeting of available and accessible physical activity resources.

Giles-Corti B, and Donovan R. The relative influence of individual, social and physical environment determinants of physical activity. Social Science & Medicine. 2002; 54:1793-1812. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448014/

> Environmental determinants of health are receiving growing attention in the literature, although there is little empirical research in this area. The Study on Environmental and Individual Determinants of Physical Activity (known as the SEID project) was a social ecological project that examined the relative influence of individual, social environmental and physical environmental determinants of recreational physical activity. The physical environment's directs the influence on exercising as recommended was found to be secondary to individual and social environmental determinants. Nevertheless, accessible facilities determined whether or not they were used and in this way, support and enhance the achievement of recommended levels of physical activity behaviour by providing opportunities. The results suggest that access to a supportive physical environment is necessary, but may be insufficient to increase recommended levels of physical activity in the community. Complementary strategies are required that aim to influence individual and social environmental factors. Given the popularity of walking in the community, it is recommended that greater emphasis be placed on creating streetscapes that enhance walking for recreation and transport.

Topic: Race and Ethnicity Data Collection

Description:

In 1997, the Office of Management and Budget (OMB) published Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity to address the need for more refined data on ethnicity than those mandated by OMB's 1977 Directive No. 15. The revised race categories established by the 1997 standards are: American Indian/Alaskan Native; Asian; Black/African-American; Native Hawaiian/Other Pacific Islander; and White. In addition, the 1997 standards established a minimum of two ethnic categories: (1) Hispanic or Latino; and (2) Not Hispanic or Latino.[10] While these requirements are currently applicable for federally funded surveys, historical and health system administrative data often do not meet these standards. Many health data systems are unable to report administrative data for all of the 1997 OMB race and ethnicity categories. In addition, while national surveys often have self-reported categories matching the 1997 OMB standards, because of smaller sample sizes and response rates, they typically cannot provide reliable estimates for smaller racial populations. Documenting racial and ethnic disparities and analyzing their causes are becoming increasingly complex, as the population becomes more diverse, greater focus is given to the heterogeneity of population subgroups, and rare populations are concentrated in particular states or communities.[11]

Materials of interest below include research on the rationale for collecting data on respondents' race and ethnicity as well as concrete recommendations to ensure the collection and reporting of that data at the individual organization, state and federal levels.

OMH Strategic Framework:

The OMH Strategic Framework includes User-Centered Design as one of the Systems-level contributing factors to minority health /health disparities. One of the components of user-centered design in the Strategic Framework is collecting data on race and ethnicity. According to the Strategic Framework, it is only through the collection and examination of racial and ethnic data that knowledge about the nature, extent, and persistence of racial/ethnic minority health problems and health disparities have become known.

Materials of Interest:

Perot RT and Youdelman M. The Commonwealth Fund. Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices, September 2001. http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2001/Sep/Racial--Ethnic--and-Primary-Language-Data-Collection-in-the-Health-Care-System--An-Assessment-of-Fed.aspx

> Using interviews conducted with administrators at federal health agencies, this report finds wide gaps between the goals of federal initiatives to eliminate racial and ethnic disparities in

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[10] Office of Management and Budget. Federal Register Notice October 30, 1997. Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. http://www.whitehouse.gov/omb/rewrite/fedreg/ombdir15.html

[11] Bilheimer LT and Sisk JE Collecting Adequate Data on Racial and Ethnic Disparities in Health: The Challenges Continue. Health Affairs 27, no. 2 (2008): 383–391

health care, such as Healthy People 2010, and the efforts of federal health agencies to collect and report data needed to help achieve these goals. The report provides the first comprehensive analysis of the policies and statutes governing the collection of health care data by race, ethnicity, and primary language.

The Department of Health and Human Services (HHS) should recommit to the national goal of eliminating racial and ethnic disparities in health. It should do so with a firm resolution expressed through written policy and sustained action to ensure the collection and reporting of data necessary to support and facilitate achievement of this goal throughout HHS. Specifically, HHS leadership should do the following:

- Recommendation 1: Ensure that Medicare data, as well as other data regarding individuals who are served by HHS programs or who participate in HHS research activities, are readily available and accurate by race, ethnicity, and primary language. Independent analysts have estimated that the Medicare beneficiary eligibility file compiled by the Social Security Administration is less than 60 percent accurate for all racial/ethnic classifications other than black or white.
- Recommendation 2: Enforce state collection and reporting of data by race, ethnicity, and primary language for enrollees in Medicaid and the State Children’s Health Insurance Program (SCHIP). Currently, data collection and reporting by states are often inconsistent and incomplete.
- Recommendation 3: Revise the standards for implementation of the Health Insurance Portability and Accountability Act (HIPAA) to designate the code set for race and ethnicity data as mandatory for both claims and enrollment standards. Racial and ethnic categories used under HIPAA must be compliant with OMB standards.
- Recommendation 4: Recommend that quality measurement and reporting tools such as the Health Plan Employer Data and Information Set (HEDIS) should collect and report health data by race, ethnicity, and primary language.
- Recommendation 5: Ensure access to quality health care for people with limited English proficiency by effective monitoring of adherence to guidelines and collection of requisite data.
- Recommendation 6: Include statutory conditions in new program initiatives, including block grants, stating that data must be collected and reported by race, ethnicity, and primary language, and that programs should allocate adequate resources to promote compliance, address technological difficulties, ensure privacy and confidentiality of data collected, and implement effective educational strategies.
- Recommendation 7: Encourage public and private agencies to participate in the development and implementation of approaches to improve data availability and promote data collection and reporting. In support of agencies, HHS should create a “tool kit” containing information on effective data-related techniques, technologies, and privacy safeguards currently in use; bolster its Data Council’s efforts to identify and document benefits of data collection and reporting; and support national policies to facilitate data-sharing among all federal and state agencies.

- Recommendation 8: Expand or create public and private educational programs to inform insurers, health plans, providers, agencies, and the general public that data collection and reporting by race, ethnicity, and primary language are legal and in many instances required by federal regulations; raise public awareness that the collection and reporting of these data are prerequisites for achieving Healthy People 2010 goals and essential to demonstrate compliance with the nondiscrimination requirements of Title VI; and make such compliance a condition for receiving government resources.
- Recommendation 9: Provide states and health care providers with greater access to aggregated and disaggregated racial, ethnic, and primary language data acquired at the federal level, subject to privacy and confidentiality regulations.
- Recommendation 10: Support research on existing best practices for data collection.

Hasnain-Wynia R, Baker DW. Obtaining Data on Patient Race, Ethnicity, and Primary Language in Health Care Organizations: Current Challenges and Proposed Solutions. Health Serv Res. 2006 Aug;41(4 Pt 1):1501-18. http://www.ncbi.nlm.nih.gov/pubmed/16899021

This article provides an overview of why health care organizations (HCOs) should collect race, ethnicity, and language data, review current practices, discuss the rationale for collecting this information directly from patients, and describe barriers and solutions.

The authors found that hospitals and HCOs with data from their own institutions may be more likely to look at disparities in care, design targeted programs to improve quality of care, and provide patient-centered care. Yet data collection is fragmented and incomplete within and across organizations. A major factor affecting the quality of data is the lack of understanding about how best to collect this information from patients.

They suggest that the elements of a uniform framework for collecting race, ethnicity, and language data in HCOs should include:

1. A rationale for why the patient is being asked to provide information about his/her race, ethnicity, and language.
2. A script for staff to use each time so that they ask questions in a uniform fashion.
3. A method for allowing patients to self-identify their race, ethnicity, and language using their own words rather than a pre-established set of categories.
4. A standardized approach for ‘‘rolling up’’ granular responses to the OMB categories for analytical and reporting purposes.
5. Assurances that the data will be held confidential and that a limited number of people will have access to the data, and a mechanism to guarantee this claim.

National Academy of Sciences. Panel on DHHS Collection of Race and Ethnic Data, Michele Ver Ploeg and Edward Perrin, Editors, National Research Council. Eliminating Health Disparities: Measurement and Data Needs. Washington, DC: National Academies Press, 2004. http://www.nap.edu/openbook.php?isbn=0309092310

> The panel was charged to review data collection or reporting systems required under the department's programs or activities relating to the collection of data on race, ethnicity, and socioeconomic position. The charge included examining data collection systems in other federal agencies with which the department interacts to collect relevant data on race and ethnicity…, as well as systems of the private health care sector. The panel developed the following conclusions and recommendations:

- CONCLUSION 3-1: Measures of race and ethnicity should be obtained in all health and health care data systems.
- CONCLUSION 3-2: Measures of socioeconomic position should, where feasible, be obtained along with data on race and ethnicity.
- CONCLUSION 3-3: Measures of acculturation and proxies such as language use, place of birth, and generation and time in the United States should, where feasible, be obtained.
- CONCLUSION 3-4: Health and health care data collection systems should return useful information to the institutions and local and state government units that provide the data.
- CONCLUSION 3-5: Linkages of data should be used whenever possible, with due regard to proper use and the protection of confidentiality in order to make the best use of existing data without the burden of new data collection.
- Recommendation 4-1: DHHS should begin immediately to implement the recommendations contained in the 1999 report entitled Improving the Collection and Use of Racial and Ethnic Data in Health and Human Services.
- Recommendation 4-2: DHHS should conduct the necessary methodological research and develop and implement a long-range plan for the national surveys to periodically conduct targeted surveys of racial and ethnic subgroups.
- Recommendation 4-3: The adequacy of sampling methods aimed at key racial and ethnic groups, as well as the quality of survey measurement obtained from them, should be carefully studied and shortcomings, where found, remedied for all major national DHHS surveys.
- Recommendation 4-4: DHHS should require the inclusion of race and ethnicity in its data systems in accordance with its Policy for Improving Race and Ethnicity Data.
- Recommendation 4-5: DHHS should routinely collect measures of socioeconomic position and, where feasible, measures of acculturation and language use.
- Recommendation 4-6: DHHS should develop a culture of sharing data both within the department and with other federal agencies, toward understanding and reducing disparities in health and health care.

- Recommendation 4-7: The Centers for Medicare and Medicaid Services should develop a program to collect racial, ethnic, and socioeconomic position data at the time of enrollment and for current enrollees in the Medicare program.
- Recommendation 4-8: The Centers for Medicare and Medicaid Services should seek from the Social Security Administration a summary of wage data on individuals enrolled in Medicare.
- Recommendation 4-9: DHHS should prepare and disseminate implementation guidelines for the Office of Management and Budget standards for collecting racial and ethnic data.
- Recommendation 4-10: DHHS should, in its reports on health and health care, tabulate data on race and ethnicity classified across different levels of socioeconomic position (SEP).
- Recommendation 5-1: States should require, at a minimum, the collection of data on race, ethnicity, socioeconomic position, and, where feasible, acculturation and language use.
- Recommendation 5-2: DHHS should provide guidance and technical assistance to states for the collection and use of data on race, ethnicity, socioeconomic position, and acculturation and language use.
- Recommendation 6-1: DHHS should require health insurers, hospitals, and private medical groups to collect data on race, ethnicity, socioeconomic position, and acculturation and language.
- Recommendation 6-2: DHHS should provide leadership in developing standards for collecting data on race, ethnicity, socioeconomic position, and acculturation and language use by health insurers, hospitals, and private medical groups.
- Recommendation 6-3: DHHS should establish a service that would geocode and link addresses of patients or health plan members to census data, with suitable protections of privacy, and make this service available to facilitate development of geographically linked analytic data sets.

National Academy of Sciences. Panel on DHHS Collection of Race and Ethnicity Data, Daniel Melnick and Edward Perrin, Editors. Committee on National Statistics. Improving Racial and Ethnic Data on Health: Report of a Workshop, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press, 2003.
http://www.nap.edu/catalog/10833.html

> Disparities in health outcomes and in health care access, utilization, and quality between people of different races and ethnic backgrounds are well documented in the literature (IOM, 2002a). Government and private sector parties have sought to better understand these disparities in order to formulate strategies to ensure better health and the highest quality of care for everyone.
>
> Efforts to understand disparities in health care access, utilization, and quality between people of different races and ethnic backgrounds have been hampered by the limited availability and inconsistent quality of data on race, ethnicity, and other characteristics of individuals.

Concerns about these data weaknesses led Congress to ask that the National Academies conduct a comprehensive study of the adequacy of the Department of Health and Human Services (DHHS) data collection systems in measuring race, ethnicity, and socioeconomic status to better understand disparities (PL 106-525, 2000).

The DHHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), with support from several other DHHS offices, asked the Committee on National Statistics (CNSTAT) of the National Academies to convene a panel of experts to review the Department's data systems. The Panel on DHHS Collection of Race and Ethnicity Data is reviewing DHHS' systems and practices for collecting racial, ethnic, socioeconomic, and language data as well as related practices in other federal agencies such as the Social Security Administration and in private providers and insurance companies. The following themes emerged from the workshop presentations and discussions:

1. Racial and ethnic data help providers, plans, and state and local officials measure and address disparities among racial and ethnic groups in health status and care. These data provide important information about variations in access to care, quality outcomes, and the underlying causes of the variations. The data are used to implement improvements and to promote informed health care decisions, including policy, consumerism, and value purchasing.
2. Some health care providers, insurance plans, and local officials erroneously believe that federal law prohibits collection of racial and ethnic data on individuals. One legal analysis presented at the workshop demonstrated that collecting race, ethnicity, and primary language data is legal under federal law and permitted under most circumstances by state law.
3. Differences in the definitions and procedures used to collect racial and ethnic data are a major barrier to their appropriate use. Lack of standardization inhibits the integration of this data collection in administrative records, surveys, and other health records. Representatives of health care providers and plans expressed the view that strong federal leadership was required to advance and improve the collection of racial and ethnic data and to work toward common standards for reporting. State government officials noted that much of the confusion about the appropriate racial and ethnic categories to use reflects federal agency stovepiping — i.e., uncoordinated decisions made by individual federal agencies that can result in contradictory guidance to local and state agencies. State agencies respond to different federal requirements, making it difficult for them to integrate their data at the state level (Perot and Youdelman, 2001).
4. State and local government agencies as well as private providers and health plans face problems implementing changes in their computer systems to collect consistent racial and ethnic data. Changes in management information systems (MIS) are expensive. Many workshop participants believe that until the standardization problems are addressed, it will not be possible to make substantial changes in their MIS systems.
5. Privacy is an important concern when collecting racial and ethnic data. A number of workshop participants agreed that the need for the data must be balanced against the need to protect individual privacy.
6. There are measurement issues as well as sampling problems in collecting racial and ethnic data. On one hand, respondents may have different definitions of their own

identity depending upon the circumstances, and this variability will make it difficult to construct reliable measures. On the other hand, even when reliable measures are available, survey estimates for some groups are difficult because of their small numbers. Administrative data, which provide a complete register of all persons receiving a service, could potentially provide estimates for these groups because these data sets are larger. However, the primary purpose of transaction-based records is to record health care interventions, not to collect standardized racial and ethnic data. Consequently, reliable data about racial or ethnic groups with small populations may be difficult to report.

7. The perceived costs of collecting racial and ethnic data are a major barrier to convincing private organizations to implement collection. Some workshop participants pointed out that the largest cost of collecting racial and ethnic information is the cost of modifying data collection forms, procedures, and information systems. They noted that a decision to collect racial and ethnic data on administrative records is directly related to available information technology. For example, they reported that many state government agencies use old systems, which are difficult to modify. Changes in private-sector systems are costly as well.
8. There is considerable confusion over the meaning and applicability of the Office of Management Budget (OMB) “Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.” These standards and their appropriate implementation need to be clearly described for both DHHS agencies and non-DHHS organizations. Furthermore, it should be made clear that these represent only minimal standards that may be incorporated in a more complete set as the need arises.

Topic: Science and Knowledge about Effective Strategies and Practices

Description:

Within the context of public health, HHS considers "research for new insights and innovative solutions to health problems"[12] as one of the ten essential public health services. The National Institutes of Health, Agency for Healthcare Research and Quality and Centers for Disease Control and Prevention lead the majority of such research demonstration efforts within the Federal government. In the private sector, funding and programmatic support from the health philanthropies, private industry, and academic institutions have also been invaluable.

Materials of interest below identify and develop key dimensions and conceptual models of interventions to reduce health care disparities, as well as analyze trends in existing research focused on reduction of minority health and health disparities.

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[12] "Public Health in America", Vision Statement of the Essential Public Health Services Work Group, Public Health Functions Steering Committee, U.S. Department of Health and Human Services, July 1995, http://www.health.gov/phfunctions/public.htm

OMH Strategic Framework:

The OMH Strategic Framework includes Science and Knowledge as one of the Systems-level contributing factors to minority health /health disparities. It notes that relatively little is known about particular strategies and practices that will improve health outcomes specifically for racial/ethnic minority populations, and that research must move beyond descriptive studies toward more outcome-oriented investigations.

Materials of Interest:

Jones RG, Trivedi AN, Ayanian JZ. Factors influencing the effectiveness of interventions to reduce racial and ethnic disparities in health care. Social Science & Medicine 70 (2010) 337–341. http://linkinghub.elsevier.com/retrieve/pii/S0277953609007205

> Reducing racial and ethnic disparities in health care has become an important policy goal in the United States and other countries, but evidence to inform interventions to address disparities is limited. The objective of this study was to identify important dimensions of interventions to reduce health care disparities. The authors used qualitative research methods to examine interventions aimed at improving diabetes and/or cardiovascular care for patients from racial and ethnic minority groups within five health care organizations. The authors interviewed 36 key informants and conducted a thematic analysis to identify important features of these interventions. Key elements of interventions included two contextual factors (external accountability and alignment of incentives to reduce disparities) and four factors related to the organization or intervention itself (organizational commitment, population health focus, use of data to inform solutions, and a comprehensive approach to quality). Consideration of these elements could improve the design, implementation, and evaluation of future interventions to address racial and ethnic disparities in health care.

Chin MH, Walters AE, Cook SC, and Huang ES. Interventions to Reduce Racial and Ethnic Disparities in Health Care. Med Care Res Rev 2007; 64; 7S. http://www.ncbi.nlm.nih.gov/pubmed/17881624

> In 2005, the Robert Wood Johnson Foundation created Finding Answers: Disparities Research for Change, a program to identify, evaluate, and disseminate interventions to reduce racial and ethnic disparities in the care and outcomes of patients with cardiovascular disease, depression, and diabetes. In this introductory paper, the authors present a conceptual model for interventions that aim to reduce disparities. With this model as a framework, the authors summarize the key findings from the six other papers in this supplement on cardiovascular disease, diabetes, depression, breast cancer, interventions using cultural leverage, and pay-for-performance and public reporting of performance measures. Based on these findings, the authors present global conclusions regarding the current state of health disparities interventions and make recommendations for future interventions to reduce disparities. Multifactorial, culturally tailored interventions that target different causes of disparities hold the most promise, but much more research is needed to investigate potential solutions and their implementation.

Fisher TL, Burnet DL, Huang ES, Chin MH, Cagney KA. Cultural Leverage: Interventions Using Culture to Narrow Racial Disparities in Health Care. Med Care Res Rev 2007; 64; 243S. http://www.ncbi.nlm.nih.gov/pubmed/17881628?dopt=Abstract

> The authors reviewed interventions using cultural leverage to narrow racial disparities in health care. Thirty-eight interventions of three types were identified: interventions that modified the health behaviors of individual patients of color, that increased the access of communities of color to the existing health care system, and that modified the health care system to better serve patients of color and their communities. Individual-level interventions typically tapped community members' expertise to shape programs. Access interventions largely involved screening programs, incorporating patient navigators and lay educators. Health care interventions focused on the roles of nurses, counselors, and community health workers to deliver culturally tailored health information. These interventions increased patients' knowledge for self-care, decreased barriers to access, and improved providers' cultural competence. The delivery of processes of care or intermediate health outcomes was significantly improved in 23 interventions. Interventions using cultural leverage show tremendous promise in reducing health disparities, but more research is needed to understand their health effects in combination with other interventions.

Schlotthauer AE, Badler A, Cook SC, Pérez DJ, Chin MH. Evaluating Interventions To Reduce Health Care Disparities: An RWJF Program. Health Aff (Millwood). 2008 Mar-Apr;27(2):568-73. http://www.ncbi.nlm.nih.gov/pubmed/18332515

> The Robert Wood Johnson Foundation's Finding Answers: Disparities Research for Change program funds evaluation of interventions to reduce racial and ethnic disparities in cardiovascular disease, depression, and diabetes. Of the 177 applications received in 2006, the most prevalent proposed interventions were patient or provider education (57 percent), community health workers (25 percent), case management (24 percent), integrated health care (24 percent), and cultural modification (24 percent). Policy interventions, including pay-for-performance (P4P) incentives, were lacking. The eleven grantees target patients, providers, patient-provider communication, health care organizations, and communities in innovative ways. We identify important future research questions.

Topic: Social Health

Description:

Social Health is a way to describe and measure the well-being of society at a National, State or Local level. Measures of Social Health most often appear in the form of indices and are generally broad in scope, often combining dozens of separate indicators. Indices of Social Health reflect the view that the well-being of society cannot be measured by any one issue, such as related measures currently collected like infant mortality. Rather, Social Health can only be measured by the combined effect of many issues acting on each other.

The materials of interest below describe recommended types of data to consider in quantifying a population's health. These materials also describe ways to combine different measures into an index in order to create a measure the health of a population at the local, state or national level.

OMH Strategic Framework:

Social Health includes aspects of both Systems-level and Environmental- and Community-level factors related to racial/ethnic minority health and health disparities. Specifically, Social Health includes efforts to address economic barriers, promote a healthy physical and social environment, as well as efforts to increase health care access and coverage and other Systems-level constructs.

Materials of Interest:

Miringoff M, Miringoff ML, Opdycke S. The Index of Social Health and The Social Health of the States 2008. Institute for Innovation in Social Policy. http://iisp.vassar.edu/ish.html

> The Index of Social Health, the centerpiece of the Institute's work, monitors the social well-being of American society. It has been released annually by the Institute (formerly the Fordham Institute for Innovation in Social Policy) since 1987. Like the Index of Leading Economic Indicators or the Gross Domestic Product, it is a composite measure that combines multiple indicators to produce a single number. The Index of Social Health is based on sixteen social indicators. These are: infant mortality, child poverty, child abuse, teenage suicide, teenage drug abuse, high school dropouts, unemployment, wages, health insurance coverage, poverty among the elderly, out-of-pocket health costs among the elderly, homicides, alcohol-related traffic fatalities, food stamp coverage, affordable housing, and income inequality.

Parnell H. State of the USA, Institute of Medicine Identify 20 Key Indicators of Health. The State of the USA. 2009. http://www.stateoftheusa.org/ourwork/iom_summary.asp.

> Policy makers, the media, academics, medical professionals, patients and their families across the country are debating the merits of health care reform. A variety of ideas are attracting attention, including proposals to expand access to insurance coverage, improve health information systems and invest more in prevention and public health. But compared to what? To help orient discussion and ground it in fact, the nonprofit, nonpartisan State of the USA and the Institute of Medicine at the National Academies are releasing a set of measurements determined by experts to be key indicators of the nation's health and health care. The list was commissioned by the State of the USA in the spring of 2008. That led to the formation of an IOM committee, which set about culling a myriad of publicly available health indicators to a manageable set of 20 considered crucial for understanding the state of the nation's health.

Meadows SO, Pearson RC, Land KC, Lamb V. The Social State of Connecticut 2008. Center for Population Health and Aging, Population Research Institute, Duke University. http://www.cga.ct.gov/coc/PDFs/socialstateofct/2008/2008_Social_Health_Index.pdf

> The Connecticut Index of Social Health provides an overview of the social performance of the State since 1970. Each indicator of the Index represents an important area of social well-being: health, employment, income, education, and security. The performance of each indicator also reflects the relative strength of the State's social institutions: its communities, schools, and families. Taken together, they tell us much about the quality of life in Connecticut.

Hillemeier M, Lynch J, Harper S, Casper M. Data Set Directory of Social Determinants of Health at the Local Level. Atlanta: Social Determinants of Health Work Group at the National Center for Chronic Disease Prevention and Health Promotion U.S. Department of Health and Human Services; 2004. http://www.cdc.gov/dhdsp/library/data_set_directory/pdfs/data_set_directory.pdf

> There is widespread interest in the role of local social determinants of health at the local level. Federal, state, and local government agencies, academic institutions, and community organizations are increasingly recognizing the need to understand and address the socioeconomic contexts within which people work and play in order to improve their health and welfare. There is renewed emphasis on implementing interventions aimed at improving socioenvironmental conditions. Such interventions have the potential to produce wide-ranging health benefits (see the April 2003 supplement of the American Journal of Preventive Medicine) and could reduce marked health disparities that remain a high-priority concern for public health (USDHHS 2000). It is critical that decisions regarding how to improve health and eliminate health disparities are integrated into the larger picture of community characteristics that promote or endanger health. A recent theme in the literature and in meetings of interested parties around the country is the need for improved conceptualization and availability of data on how the social environment impacts the health of populations (Pickett and Pearl 2001; Macintyre and Ellaway and Cummins 2002; Yen and Syme 1999; Kaplan and Lynch 1997, 2001; Diez Roux 2004; Berkman 2004; Krieger and Davey Smith 2004; Institute of Medicine 1997; M. Miringoff and M.L. Miringoff 1999; Howell et al. 2003). This Data Set Directory of Social Determinants of Health at the Local Level is a response to those needs. The directory contains an extensive list of existing data sets that can be used to address these determinants. The data sets are organized according to 12 dimensions, or broad categories, of the social environment. Each dimension is subdivided into various components.

Topic: Violence and Crime

Description:

Violence and crime have been noted to affect the health and well-being of both the directly affected individuals and the community at large. Violence is one of the leading causes of death worldwide for people 15 to 44 years old. [13] Violence affects both the physical and mental well-being of the individuals affected. There is some evidence that fear of crime is associated with a person's health and may explain some disparities geographic-based disparities in health.[14]

The information below covers the full purview of violence and crime's interplay with public health, and provides communities with insight on how to respond to and impact violence and crime.

OMH Strategic Framework:

The OMH Strategic Framework identifies environmental- and community-level factors that contribute to poor racial/ethnic minority health and to racial/ethnic health disparities. Within the environmental- and community-level factors, the OMH Strategic Framework identifies Violence and Crime as an important contributor to health outcomes and notes "The concentration, of poor schools, drug markets and their associated violence, and deteriorating conditions in urban neighborhoods of concentrated poverty multiplies the health risks for the largely minority populations who live there."

Materials of Interest:

Krug EG, Dahlberg LL, Mercy JA, Zwi AB and Lozano R, eds. World Report on Violence and Health. Geneva, World Health Organization, 2002.
http://www.who.int/violence_injury_prevention/violence/world_report/en/

> In 2002 the World Health Organization released the first World Report on Violence and Health. The report explores the different types of violence, and for each analyzes the magnitude of the health and social effects, the risk and protective factors, and the types of prevention efforts that have been initiated. After providing an expansive discussion of violence as a global public health problem, the report does individual analysis on youth violence, child abuse, violence by intimate partners, abuse of the elderly, sexual violence, self-directed violence, and collective violence. The analyses are particularly useful because they not only provide in-depth discussions on the extent and nature of violence, but they also include risk factors, interventions/actionable prevention steps, and recommendations for furthering the research.

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[13] The WORLD HEALTH REPORT 2002: Reducing Risks, Promoting Healthy Life World Health Reporting World Health Organization. Geneva, Switzerland.

[14] Chandola T. 2001. The fear of crime and area differences in health. Health Place 7(2):105-16.

Mercy J, Rosenberg M, Powell K, Broome C, and Roper W. Public Health Policy for Preventing Violence. Health Affairs. 1993; 7-29. http://content.healthaffairs.org/cgi/reprint/12/4/7

> This article provides extensive background on the interaction between violence and public health, recognizing that violence has physical and psychological impacts; with disproportionate impacts on specific subgroups. In providing suggestions for diminishing violence, the authors provide community focused interventions for breaking the cycle of violence, while presenting ideas for developing and evaluating approaches put in place.

Cohen L, and Swift S. A Public Health Approach to the Violence Epidemic in the United States. Environment and Urbanizations. 1993; 5: 50-66.
http://eau.sagepub.com/cgi/content/abstract/5/2/50

> Through profiling the Contra Costa County Prevention Program in northern California, this article provides a discussion of violence and crime as a health issue, and then focuses on the causes of this issue and provides a public health approach to changing the environment. Three root causes are identifying (economics, oppression, and mental health), along with six community risk factors (guns, media, alcohol and other drugs, incarceration, witnessing acts of violence, and community deterioration. These root causes and community risk factors are important to recognize, as these highlight the interplay of environmental- and community-level factors on health. The presented public health approach to change is focused on coalition building, community education, provider training, changing organizational practices, and influencing policy and legislation.

Topic: Workforce Diversity

Description:

Racial inequalities in health care may be partly attributable to racial, cultural, and communication barriers between minority patients and white health care providers. Health disparities may be partially a function of cultural or linguistic incongruity between patient and physician, lack of mutual trust, or racial discrimination. Research indicates that racial/ethnic minority physicians are more likely to provide services in minority and underserved communities, are more likely to treat poor and sicker patients,[15] and are more likely to have minority patients with higher levels of satisfaction with their clinical encounters.[16] Based on the lack of representation of under-represented minority groups, efforts are underway in medical schools to increase the racial diversity of their student population, and by researchers to understand the linkage between a race-concordant provider-patient relationship and patient health outcomes.

The materials of interest below provide measures of diversity, recommendations for educational and financial resource systems to support training of minorities in the healthcare and public health fields, recommendations to health organizations in developing a culture supportive of a

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[15] Ernest Moy, Barbara Bartman. Physician Race and Care of Minority and Medically Indigent Patients. JAMA, May 1995, 273(19):1515-1520

[16] Blanchard J, Nayar S, Lurie N . Patient-Provider and Patient-Staff Racial Concordance and Perceptions of Mistreatment in the Health Care Setting. J Gen Intern Med. 2007 Aug;22(8):1184-9. Epub 2007 May 8

diverse workforce, and research on perceptions of minority patients regarding discrimination from non-minority medical professionals.

OMH Strategic Framework:

The OMH Strategic Framework includes User-Centered Design as one of the Systems-level contributing factors to minority health /health disparities. One of the components of user-centered design in the Strategic Framework is implementation of efforts to increase the racial/ethnic diversity in the public health and healthcare workforce. Specifically, the framework focuses on efforts to reduce the gap between the representation of minorities in the healthcare workforce and the proportion of minorities in the general population. The Strategic Framework notes that, "such diversity affords more opportunities to obtain care and services from public health professionals, clinicians, and other service providers who are racially/ethnically, culturally and/or linguistically concordant."

Materials of Interest:

Sullivan, Louis W. (2004) Missing Persons: Minorities in the Health Professions, A Report of the Sullivan Commission on Diversity in the Healthcare Workforce. Retrieved from the American Association of Colleges of Nursing on 10/18/10 at: http://www.aacn.nche.edu/media/pdf/sullivanreport.pdf

> In 2003, the W.K. Kellogg Foundation issued a grant to Duke University School of Medicine to plan and convene the Sullivan Commission on Diversity in the Healthcare Workforce. Composed of 16 health, education, legal, and business leaders and headed by former U.S. Health and Human Services Secretary Dr. Louis W. Sullivan, this Commission was given the task of identifying and understanding the barriers to achieving diversity in the health professions and then to finding solutions.
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> Chapter 3: State of Diversity in Today's Health Professions Schools and Workforce. This section of the report presents a quantitative summation of the state of diversity in today's health professions schools and workforce. Diversity measures noted include the following:

- Total Physicians by Race/Ethnicity
- Number of Racial/Ethnic Minority and Non-Minority RNs
- Distribution of Registered Nurses by Race/Ethnic Background
- Distribution of Registered Nurses in Each Racial/Ethnic Group by Highest Educational Preparation
- U.S. Dentist to Population Ratio by Race/Ethnicity of the Dentist
- Underrepresented Minorities in Medical Schools, Total Enrollment
- Underrepresented Minority Graduates of U.S. Medical Schools
- Race/Ethnicity Characteristics of Baccalaureate Nursing Students
- Race/Ethnicity of Baccalaureate Degree Completions in Nursing (RN Training)
- Minority Status of Students with Master's Degrees in Nursing

- Minority Status of Doctoral Students in Nursing
- Total Pre-Doctoral Minority Enrollment in U.S. Dental Schools
- Comparison of Percentage of Minorities in the U.S. Population to the Percentage of Minorities Enrolled in Dental Schools
- Total Enrollments in Dental Schools by Race and Ethnicity
- Percent Minority Enrollment in Advanced Dental Education Programs/U.S. Dental Schools
- Minority Graduates of U.S. Dental Schools
- Distribution of U.S. Medical School Faculty by Race/Ethnicity
- Distribution of URM Medical School Faculty Total Number at Each School
- Distribution of U.S. Medical School Faculty by Race/Ethnicity and Rank
- Distribution of U.S. Medical School Deans and Department Chairs by Race and Ethnicity
- Minority Status of All Full-Time Nurse Faculty
- Minority Status of Deans
- Minority Status of All Full-Time Administrative Nurse Faculty

Chapter 4: The Pipeline to the Health Care Professions. This chapter provides a discussion of multiple obstructions found at three key segments of the pipeline: (1) primary and secondary education (K-12), (2) post-secondary education (the college years), and (3) health professions education. Sullivan Commission recommendations for the pipeline from primary to secondary to postsecondary education, and finally to professional training include the following:

- Recommendation 4.1: Health professions schools, hospitals, and other organizations should partner with businesses, communities, and public school systems to: a) provide students with classroom and other learning opportunities for academic enrichment in the sciences; and b) promote opportunities for parents and families to increase their participation in the education and learning experiences of their children.
- Recommendation 4.2: The U.S. Public Health Service, state health departments, colleges, and health professions schools should provide public awareness campaigns to encourage underrepresented minorities to pursue a career in one of the health professions. Such a campaign should have a significant budget comparable to other major public health campaigns.
- Recommendation 4.3: For underrepresented minorities who decide to pursue a health profession as a second career, health professions schools should provide opportunities through innovative programs.
- Recommendation 4.4: Baccalaureate colleges and health professions schools should provide and support “bridging programs” that enable graduates of two-year colleges to succeed in the transition to four-year colleges. Graduates of two-year community college nursing programs should be encouraged (and supported) to enroll in baccalaureate degree-granting nursing programs.

- Recommendation 4.5: Key stakeholders in the health system should work to increase leadership development opportunities in nursing in order to prepare minority nurses with graduate degrees for roles as scholars, faculty, and leaders in the profession.
- Recommendation 4.6: Key stakeholders in the health system should work to increase leadership training and opportunities for underrepresented minority physicians and dentists.
- Recommendation 4.7: Colleges, universities, and health professions schools should support socio-economically disadvantaged college students who express an interest in the health professions, and provide these students with an array of support services, including mentoring, test-taking skills, counseling on application procedures, and interviewing skills.
- Recommendation 4.8: The Association of American Medical Colleges, the American Association of Colleges of Nursing, the American Dental Education Association, and the Association of Academic Health Centers should promote the review and enhancement of health professions schools admissions policies and procedures to: a) enable more holistic, individualized screening processes; b) ensure a diverse student body with enhanced language competency and cultural competency for all students; and c) develop strategies to enhance and increase the pool of minority applicants.
- Recommendation 4.9: Dental and medical schools should reduce their dependence upon standardized tests in the admissions process. The Dental Admissions Test and the Medical College Admissions Test should be utilized, along with other criteria in the admissions process, as diagnostic tools to identify areas where qualified health professions applicants may need academic enrichment and support.
- Recommendation 4.10: Diversity should be a core value in the health professions. Health professions schools should ensure that their mission statements reflect a social contract with the community and a commitment to diversity among their students, faculty, staff, and administration.
- Recommendation 4.11: Health systems and health professions schools should use departmental evaluations as opportunities for measuring success in achieving diversity, including appropriate incentives.
- Recommendation 4.12: Health systems and health professions schools should have senior program managers who oversee: a) diversity policies and practices; b) assist in the design, implementation, and evaluation of recruitment, admissions, retention, and professional-development programs and initiatives; c) assess the institutional environment for diversity; and d) provide regular training for students, faculty, and staff on key principles of diversity and cultural competence.
- Recommendation 4.13: Health professions schools should increase the representation of minority faculty on major institutional committees, including governance boards, and advisory councils. Institutional leaders should regularly assess committee/board composition to ensure the participation of underrepresented minority professionals.

Chapter 5: Financing Education in the Health Professions. This chapter provides an overview of the costs of financing an education in the health professions and the attendant debt burden. Additionally, this chapter assesses the impact of high educational costs on academic persistence, career choices, and career planning. Finally, a review of financial assistance resources for undergraduate and health professions education is made, and a rationale is given for emphasizing scholarships, tuition reimbursement, and loan repayment over conventional loan instruments. Sullivan Commission recommendations include the following:

- Recommendation 5.1: Congress should substantially increase funding to support diversity programs within the National Health Service Corps, and Titles VII and VIII of the Public Health Service Act. Such funding should also provide for collection of data on diversity.
- Recommendation 5.2: To reduce the debt burden of underrepresented minority students, public and private funding organizations for health professions students should provide scholarships, loan forgiveness programs, and tuition reimbursement strategies to students and institutions, in preference to loans.
- Recommendation 5.3: Public and private entities should significantly increase their support to those health professions schools with a sustained commitment to educating and training underrepresented minority students.
- Recommendation 5.4: Businesses, foundations, and other private organizations should be encouraged to support health professions schools and programs to increase financial resources needed to implement the recommendations of the Sullivan Commission.
- Recommendation 5.5: The President and Congress should increase the funding for the National Institutes of Health’s National Center for Minority Health and Health Disparities Loan Repayment Programs, with a special emphasis on programs for underrepresented minority students. 5.6 The National Institutes of Health should develop a Centers of Excellence program for schools of nursing.

Mitchell DA, Lassiter SL. Addressing Health Care Disparities and Increasing Workforce Diversity: The Next Step for the Dental, Medical, and Public Health Professions. Am J Public Health. 2006 Dec;96(12):2093-7. Epub 2006 Oct 31. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1698162/

The authors reviewed literature concerning health care disparities and workforce diversity issues – particularly within the oral health field – and provide a synthesis of recommendations for Academic Dental Institution to implement in order to address healthcare provider workforce issues. The recommendations within the article include:

- Formal declaration of each institution’s commitment to diversity, cultural competency, and the elimination of oral health care disparities;
- Creation of a mediation process for the investigation of perceived threats to the institution’s commitment to diversity;
- Appointment of a dedicated individual to oversee diversity measures; and,

- Use of formal systems currently in place to monitor engagement in diversity-building initiatives.
- Recommendations for activities specific to academic institutions include:
  - Incorporate diversity and cultural competency training into the predoctoral curriculum;
  - Expose students to underserved populations early in their careers;
  - Provide ongoing cultural competency training to faculty and staff members; and,
  - Encourage interdisciplinary instruction.
- Efforts to reach students include:
  - Improving the identification and academic enrichment of potential underrepresented minority students at the K–12 and undergraduate stages of their education;
  - Developing campaigns that increase the visibility of health professions;
  - Recruiting underrepresented minorities who are taking nontraditional paths to careers in the health professions; and,
  - Providing underrepresented minority students with psychosocial and skill-building services that will improve their chances for success in dental school.

Grumbach K, Mendoza R. Disparities in Human Resources: Addressing the Lack of Diversity in the Health Professions. Health Aff (Millwood). 2008 Mar-Apr;27(2):413-22. http://www.ncbi.nlm.nih.gov/pubmed/18332497

This paper presents the case for why diversity in the health care workforce is a public policy imperative and describes the current status of underrepresented minorities in the health professions and health professions schools. It also explores some of the major reasons for lack of greater diversity and discusses interventions and policies that hold promise for increasing workforce diversity. The authors note that improving the diversity of the healthcare workforce requires significant changes in primary education for minority children. In the shorter-term, they cite the opportunity to intervene at the college stage, noting that the largest single funder for these types of activities has been the federal government - specifically, the Health Careers Opportunities Program and the Centers of Excellence Program.

The authors identify key elements of an institutional culture supportive of diversity:

- Grassroots activism among students, faculty, and staff;
- Commitment at the highest levels of institutional leadership;
- Reconsideration of admissions processes; and,
- Explicit mission statements, action plans, and institutional policies that embrace diversity as critical to institutional excellence.

Rumala BB, Cason FD Jr. Recruitment of Underrepresented Minority Students to Medical School: Minority Medical Student Organizations, an Untapped Resource. J Natl Med Assoc. 2007 Sep;99(9):1000-4, 1008-9. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2575864/

> Recruitment of more underrepresented minority students to increase racial diversity in the physician workforce is on the agenda for medical schools around the nation. Numerous recruitment strategies have been employed to increase the number of underrepresented minority students. However, formal collaboration with minority medical student organizations is an underutilized tool in the recruitment process. Many medical schools have informally used minority medical students and members of various minority organizations on campus in the recruitment process, but a formal collaboration that entails a strategic approach on using minority medical student organizations has yet to be included in the literature.
>
> This paper discusses the innovative collaboration between the University of Toledo College of Medicine (UTCOM) chapter of the Student National Medical Association (SNMA) and the college of medicine's admissions office to strategize a recruitment plan to increase the number of underrepresented minority students at the UTCOM. Phases of the recruitment strategy include (1) Identify obstacles, challenges and potential solutions for recruitment of URM students at the college of medicine, (2) Tracking of students from before the interview through matriculation, (3) Reach out to diversity committee on campus and community members, (4) Propose and implement second-look weekend, and (5) Retention initiative.

Blanchard J, Nayar S, Lurie N. Patient-Provider and Patient-Staff Racial Concordance and Perceptions of Mistreatment in the Health Care Setting. J Gen Intern Med. 2007 Aug;22(8):1184-9. Epub 2007 May 8. http://www.ncbi.nlm.nih.gov/pubmed/17486386

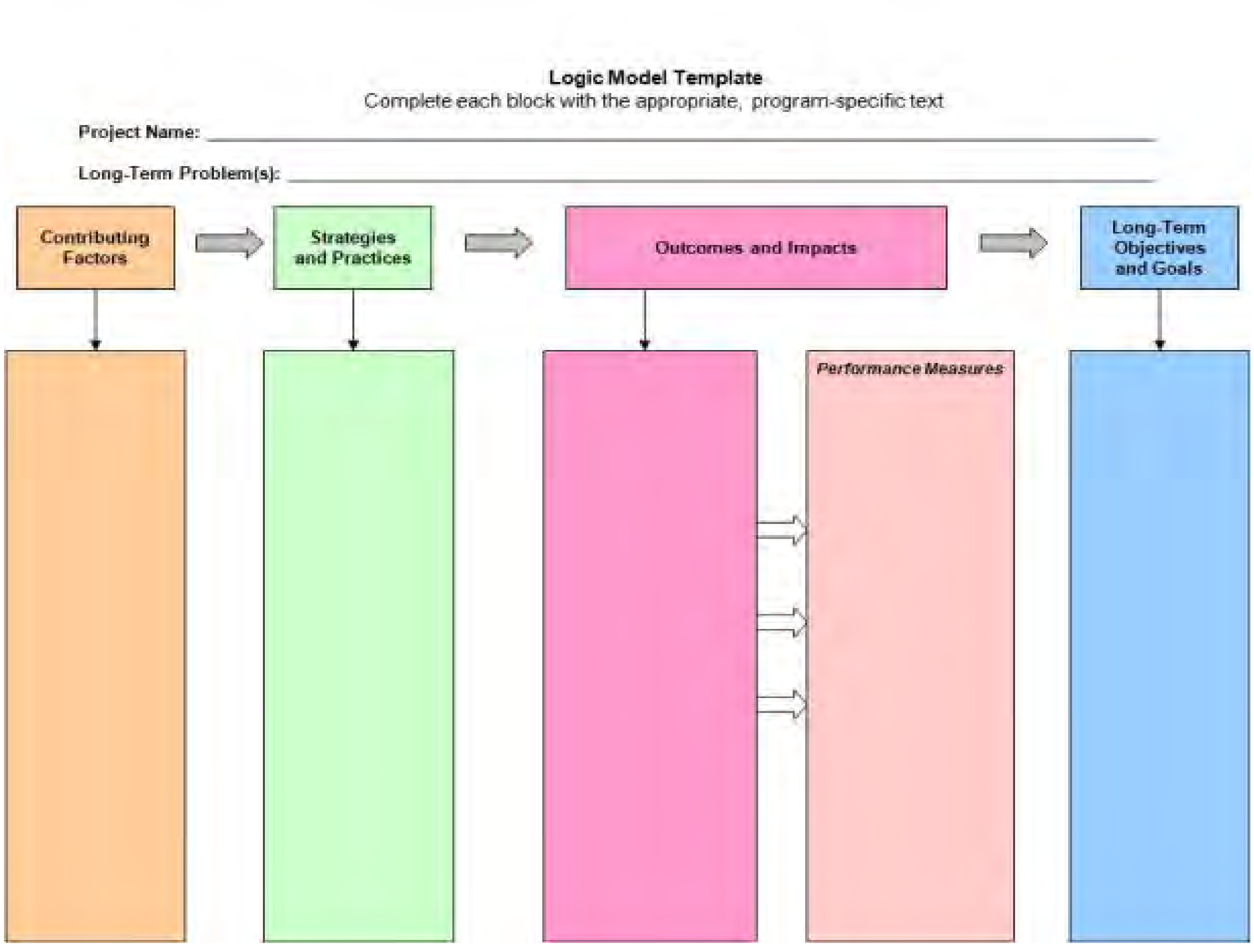
> The authors analyzed patients' responses about perceptions of disrespect, unfair treatment because of race and language, and the belief that he/she would have received better treatment if he/she belonged to a different race, comparing perceptions of mistreatment with provider and staff racial concordance. Their results led to their conclusion that recruiting minority staff to racially concordant practice settings and promoting grants and programs that train ancillary minority medical staff may be necessary to improve the experience for minority patients within the health care system.

The targeted literature reviews conducted to inform the development of potential indicators for addressing gaps in performance measures were limited in scope. More extensive reviews are needed, especially for environmental-/community- and systems-level outcomes and impacts, to ensure that proposed measures are reflective of the best available science and knowledge. The ability to lead, coordinate, and otherwise support research and evaluation initiatives to develop and test such measures will also be critical to OMH’s efforts to improve performance and ensure results on the minority health and health disparities fronts.

Appendix 7:
Logic Model Template

Logic Model Template

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



Logic Model Template

Complete each block with the appropriate, program-specific text

Project Name: ______________________

Long-Term Problem(s): ______________________

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

coordination and collaboration; leadership and commitment; user-centered design; and science and knowledge.

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

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

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

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

Appendix 8:
Logic Model Worksheet

Logic Model Worksheet

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

Project Name: ____

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

Long-Term Objectives and Goals to be Achieved: ______________________________

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

Appendix 9:
Example (for Diabetes) of
Completed Logic Model Worksheet

Example (for Diabetes) of Completed Logic Model Worksheet

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

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

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

Appendix 10:
Example (for Diabetes) of Completed Logic Model

Example (for Diabetes) of Completed Logic Model

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

Contributing Factors

- Lack of awareness and knowledge about the connections between diet, exercise, obesity, and diabetes
- Lack of public awareness about risk factors related to diabetes
- Lack of healthy food choices in local grocery stores and restaurants
- Lack of safe venues to engage in physical activity, sports, and recreation
- Lack of strategic planning to guide leadership action and assess progress towards established diabetes prevention and management objectives and goals
- Lack of language assistance services in health care settings to minimize systems barriers to access and utilization for limited English proficient individuals at risk for diabetes

Strategies and Practices

- Individually-oriented health education through tailored channels (e.g., health providers or faith-based organizations)
- Community-based health education or communication campaigns through local media channels, schools, and community organizations
- Establishment of partnerships among local leaders in the restaurant, grocery, and exercise/fitness industries, local health and city officials, and representatives of communities at risk for diabetes
- Development and implementation of a strategic plan that identifies diabetes prevention and management as a priority, and sets benchmarks and targets to guide action towards established objectives and goals that can strengthen leadership effectiveness
- Introduction of linguistically appropriate services, such as properly translated written materials and medical interpreters during clinical encounters to promote health care access and utilization for limited English proficient patients who may be at risk for or have diabetes and to provide user-centered care

Outcomes and Impacts

- Increased awareness/knowledge about the link between diet, exercise, obesity, and diabetes
- Increased healthcare provider skills in educating and counseling their patients about diabetes prevention, treatment, and management
- Increased patient adherence to prescribed diet, exercise, and treatment regimens for diabetes
- Increased public awareness about diabetes and related risk factors
- Increased plans and policies that promote healthier dietary choices and safe places for exercise and sports in the community
- Increased system design characteristics to minimize barriers for racial/ethnic minority users, such as the provision of trained medical interpreters or bilingual health care providers to facilitate health care access and use by limited-English-proficient patients with diabetes

Performance Measures

Performance Measures for All Grantees (measures that meet the requirement to clearly link expected grantee-specific outputs, processes, and outcomes to OMH and HHS-wide performance measures)

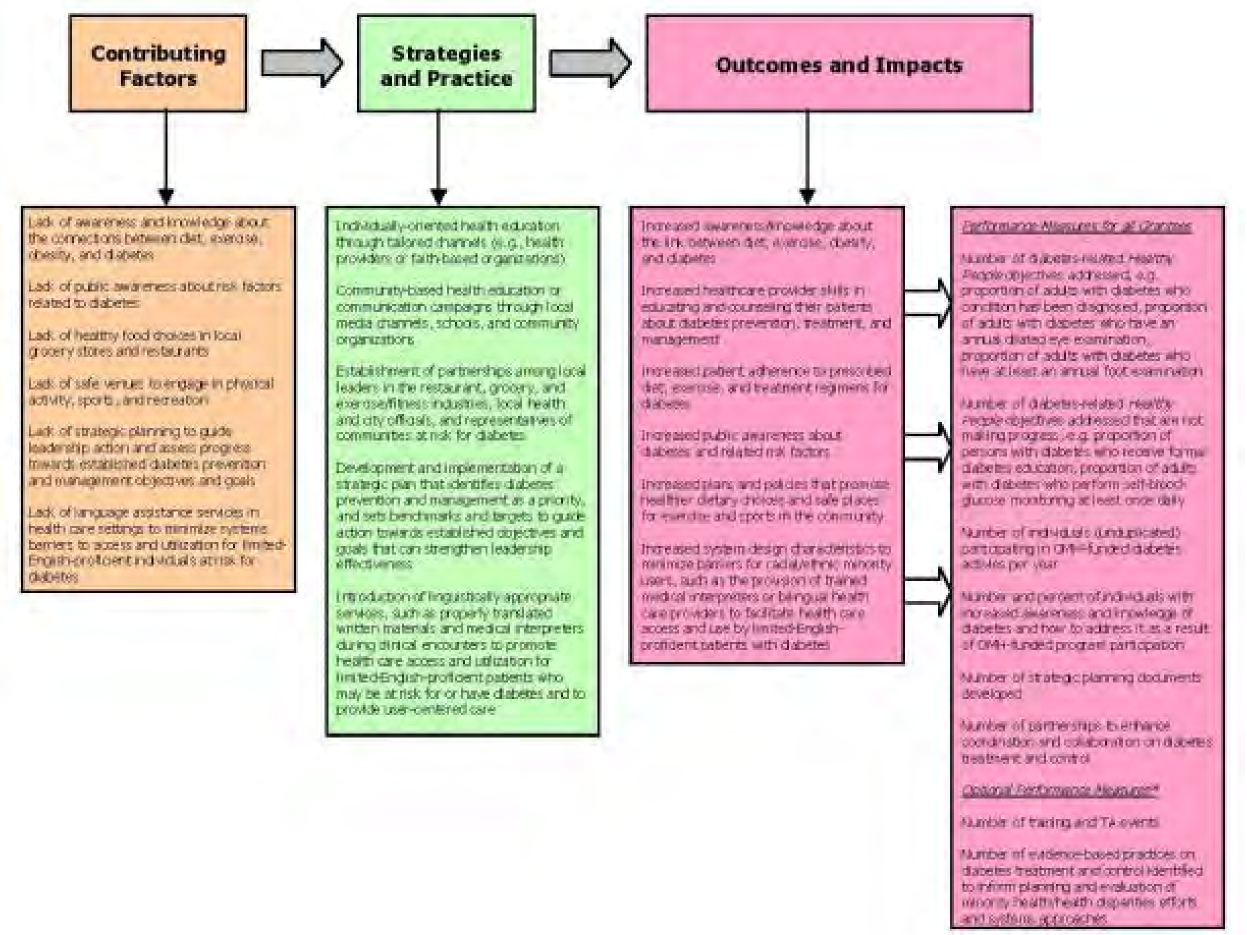
- Number of diabetes-related *Healthy People* objectives addressed, e.g. proportion of adults with diabetes whose condition has been diagnosed, proportion of adults with diabetes who have an annual dilated eye examination, proportion of adults with diabetes who have at least an annual foot examination
- Number of diabetes-related *Healthy People* objectives addressed that are not making progress, e.g. proportion of persons with diabetes who receive formal diabetes education, proportion of adults with diabetes who perform self-blood-glucose monitoring at least once daily
- Number of individuals (unduplicated) participating in OMH-funded diabetes activities per year
- Number/percent of individuals with increased awareness and knowledge of diabetes and how to address it as a result of OMH-funded program participation
- Number of strategic planning documents developed
- Number of partnerships to enhance coordination and collaboration on diabetes treatment and control

Optional Performance Measures (additional, selected measures that clearly link expected grantee outputs, processes, and outcomes to OMH performance measures)

- Number of training and TA events
- Number of evidence-based practices on diabetes treatment and control identified to inform planning and evaluation of minority health/health disparities efforts and systems approaches

Logic Model Examples – Diabetes

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



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 systemic barriers to access and utilization for limited-English-proficient individuals at risk for diabetes

Strategies and Practice

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

<u>Performance Measures for all Grantees</u>

Number of diabetes-related *Healthy People* objectives addressed, e.g. proportion of adults with diabetes whose condition has been diagnosed, proportion of adults with diabetes who have an annual dilated eye examination, proportion of adults with diabetes who have at least an annual foot examination

Number of diabetes-related *Healthy People* objectives addressed that are not making progress, e.g. proportion of persons with diabetes who receive formal diabetes education, proportion of adults with diabetes who perform self-blood glucose monitoring at least once daily

Number of individuals (unduplicated) participating in OMH-funded diabetes activities per year

Number and 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

<u>Optional Performance Measures</u>*

Number of training and TA events

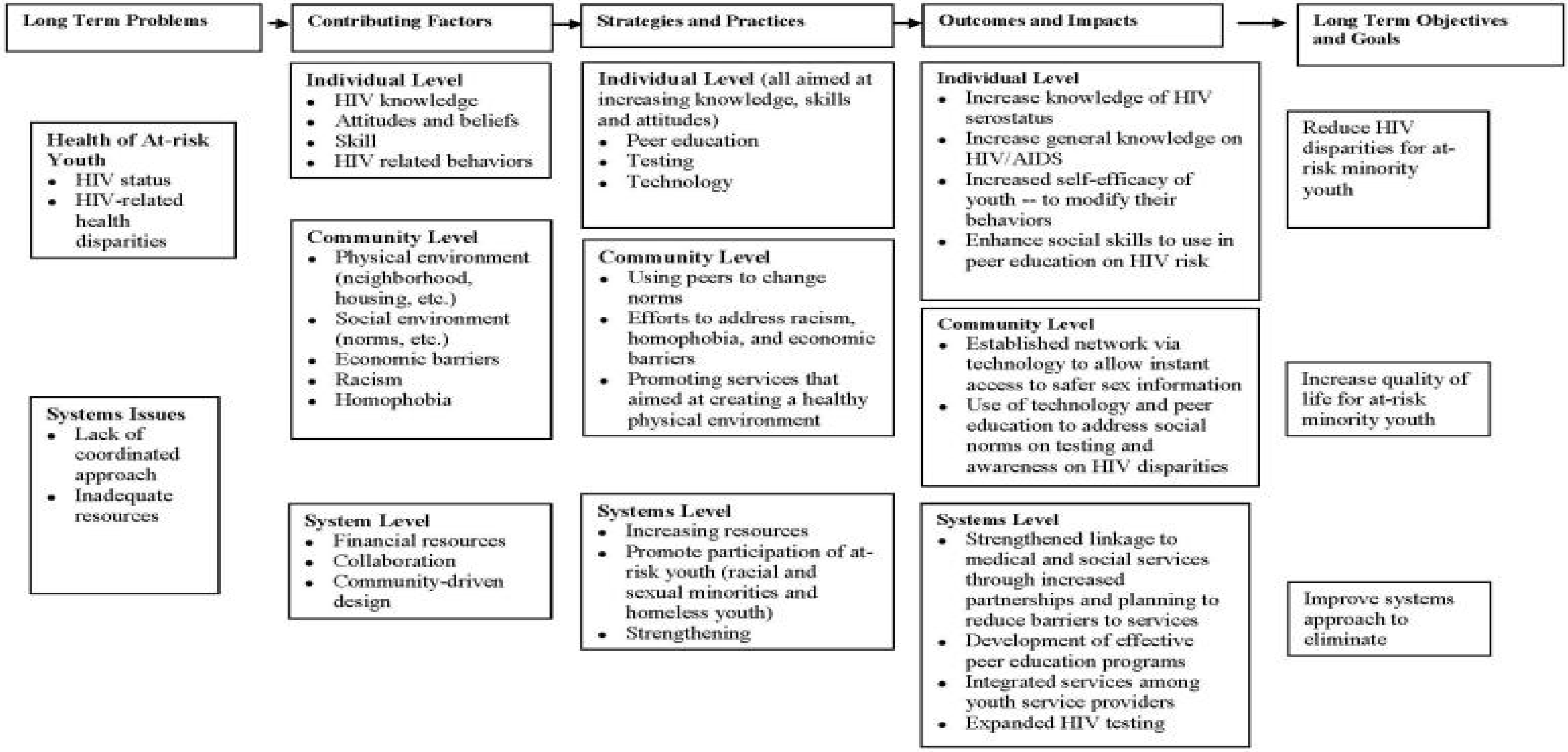
Number of evidence-based practices on diabetes treatment and control identified to inform planning and evaluation of minority health/health disparities efforts and systems approaches

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

Appendix 11:
Examples of Actual Logic Model Diagrams from Two OMH Grantees

Logic Model

Grant Program: CHAT
Grantee Name: Cascade AIDS Project
Project Name: CHAT PDX



Long Term Problems

Health of At-risk Youth
- HIV status
- HIV-related health disparities

Systems Issues
- Lack of coordinated approach
- Inadequate resources

Contributing Factors

Individual Level
- HIV knowledge
- Attitudes and beliefs
- Skill
- HIV related behaviors

Community Level
- Physical environment (neighborhood, housing, etc.)
- Social environment (norms, etc.)
- Economic barriers
- Racism
- Homophobia

System Level
- Financial resources
- Collaboration
- Community-driven design

Strategies and Practices

Individual Level (all aimed at increasing knowledge, skills and attitudes)
- Peer education
- Testing
- Technology

Community Level
- Using peers to change norms
- Efforts to address racism, homophobia, and economic barriers
- Promoting services that aimed at creating a healthy physical environment

Systems Level
- Increasing resources
- Promote participation of at-risk youth (racial and sexual minorities and homeless youth)
- Strengthening

Outcomes and Impacts

Individual Level
- Increase knowledge of HIV serostatus
- Increase general knowledge on HIV/AIDS
- Increased self-efficacy of youth -- to modify their behaviors
- Enhance social skills to use in peer education on HIV risk

Community Level
- Established network via technology to allow instant access to safer sex information
- Use of technology and peer education to address social norms on testing and awareness on HIV disparities

Systems Level
- Strengthened linkage to medical and social services through increased partnerships and planning to reduce barriers to services
- Development of effective peer education programs
- Integrated services among youth service providers
- Expanded HIV testing

Long Term Objectives and Goals

Reduce HIV disparities for at-risk minority youth

Increase quality of life for at-risk minority youth

Improve systems approach to eliminate

Logic Model

Grant Program: YEP
Grantee Name: Swarthmore College
Project Name: Blueprints (Phase II)
Project Name: SWARTHMORE COLLEGE'S BLUEPRINTS PROGRAM (PHASE II)

Long-Term Problem: Chester youth experience many of the community, family, school, and individual risk factors associated with substance abuse, teen pregnancy, interpersonal violence, and drop-out. There is a need to engage youth in programs that will build protective factors, which will help to insulate them from the potential negative impact of risk factors. Reducing their risk behaviors contributes to the OMH and PH2010 goal to eliminate health disparities in the U.S.
Long-Term Objectives and Goals: To increase protective factors and decrease risk taking behavior among 14-19 year old participants of Swarthmore College's Blueprints Program, in the urban community of Chester, PA through use of a positive youth development framework, thus reducing disparities in their health status.

Contributing Factors to be Addressed	Strategies, Practices & Output Measures	Outcomes & Impacts (Outcome & Impact Measures)	Performance Measures
• Antisocial beliefs and attitudes toward targeted risk taking behaviors related to interpersonal violence, sexual activity, and use of alcohol, tobacco and other drugs • Low levels of community participation /engagement • Poor academic performance, attendance & educational expectations • Low levels of school connectedness • Lack of connection to prosocial peers and adults _____________________ **Contributing Factors not Directly Addressed:** Availability of drugs, Community norms favorable to drugs and crime, Community & school district disorganization; Residential transitions and mobility, Extreme economic deprivation; Community norms against commitment to education	**Academic Enrichment** - Swarthmore students provide curriculum-based remediation in math and reading **Life Skills** - 1) Wellness Center trains participants to be peer educators (community service component); 2) Mentoring/Role Modeling-Provided by Swarthmore students; 3) Participants are held accountable to meet program standards and requirements; 4) College Access Center teaches skills to navigate career exploration and college access **Personal Development/Wellness**- 1) Participation offers positive use for time; 2) Participants learn risk-reduction lesson plans to be taught to younger students via community service component; 3) Youth take part in team building activities to promote bonding with other participants and staff; 4) Youth participate in recognition events and receive incentives for effort and achievement **Cultural Enrichment** – Participation in Saturday Cultural Institute presented by Swarthmore students **Career Development** – 1) College Access Center aids students in identifying careers of interest; 2) Wellness Center places students in job shadowing experiences **Key Output Measures**: # youth ever enrolled; # youth retained; # youth for whom each data collection activity has been completed, by activity, by due date; # hours of youth contacts, by type; # parent contact, by type. **Key Process Measures**: Please see Timeline, Appendices.	**Academic enrichment:** 1) Increased reading and math levels (% with increase of 2 or more levels) 2) Increased/sustained year-end promotion to next grade (% promoted) 3) Increased commitment to education (& with increased scores baseline vs. post-test) **Life Skills:** 4) Increased knowledge and skill required for peer educator role (% with increased assessment scores baseline vs. post-test) 5) Increased attainment of social and workforce skills (% with increased assessment scores baseline vs. post-test) 6) Increased knowledge of college application & financial aid process (% who complete college application checklist in full) **Personal Development/Wellness:** 7) Increased connection to prosocial peers and adults (% with increased scores baseline vs. post-test) 8) Increased commitment to community service /civics (% with increased scores baseline vs. post-test) 9) Enhanced view of one's value to the community (% who self-report enhanced view retrospectively) **Cultural Enrichment:** 10) Enhanced view of self as part of African-American community (% who self-report enhanced view retrospectively) **Career Development:** 11) Increased participant knowledge of career interests and completion of job shadowing (% who complete at least one shadowing experience in career of interest) **Risk Behaviors:** 12) Deceased participation in ATOD use, risky sexual behaviors, and interpersonal violence (% active in program for duration with decreased participation in at least one risk behavior previously reported)	**For All OMB Grantees:** 1) Number of HP2010 objectives for priority racial/ethnic minority health & systems issues that are being addressed by the OMH grantee 2) Number of measurable, racial/ethnic minority-specific HP2010 objectives/sub-objectives that have not made progress towards (or are moving away from) their targets that are being addressed by the OMH grantee 3) Number of unduplicated individuals participating in OMH-funded, grant program activities per year 4) Number and % 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 5) Number of racial/ethnic minority health improvement- and/or disparities-related strategic plans developed to facilitate leadership and organizational effectiveness 6) Number of partnerships facilitated and/or established to enhance coordination and collaboration on racial/ethnic/minority health/health disparities problems **Optional OMH Grantee Measures:** 7) Number of FTEs on program/project staff supported with OMH funding 8) Number and % of individuals trained through OMH-supported activities 9) Number of "best practices" or "evidence based strategies" identified as a result of OMH-funded efforts **Optional Additional OMH Grantee Measures are listed parenthetically to the left (Outcome & Impact Measures)**

Appendix 12:
Data Collection Plan Template

Data Collection Plan

OMH Grant Program: ____

Grantee Name: ____

Grant Project Name: ____

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

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

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

Appendix 13:
Example of a Completed Data Collection Plan (Alternatives for Girls, Curbing HIV/AIDS Transmission Program)

Data Collection Plan –
Actual Example of Completed Plan
(an OMH Evaluation Planning "Best Practice")[1]

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

Grantee Name: Alternatives for Girls

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

Measures	INSTRUMENT/ DATA SOURCE	LOCATION OF DATA	FREQUENCY OF COLLECTION	COLLECTION RESPONSIBILITY
Measures of All OMH Grantees				
Health Peoples 2010 objectives for priority racial/ethnic minority health and systems addressed: 1) 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)	State of Michigan required Counseling, Testing, Referral (CTR) service Delivery Forms; State of Michigan HIV Event System (HES) log	Horizons Project (HP) will maintain all CTR and HES forms at their east Detroit facility in their state-approved filing system and will complete reports based on forms for AFG and DDHWP as needed	During community outreach activities, approximately once per month; CTR data is reported to the State of Michigan every 14 days	HP Outreach Worker
Healthy People 2010 objectives not meeting progress being met: 1) 25-11c Responsible adolescent sexual behavior - Students who used condoms at last intercourse (grades 9 through 12) [New] - Black or African American not Hispanic. 2) 09-03 Contraceptive use - Females at risk of unintended pregnancy (aged 15 to 44 years) - Black or African American not Hispanic	Online screening form and demographic forms from community outreach	HP will maintain all demographic and evaluation data from Internet and community outreach activities; AFG will have software for data review and analysis	Internet outreach will occur multiple times a week once in implementation phase	AFG Peer Educator Outreach Coordinator, HP Outreach Worker, and HP Evaluator

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

Measures	INSTRUMENT/ DATA SOURCE	LOCATION OF DATA	FREQUENCY OF COLLECTION	COLLECTION RESPONSIBILITY
Number of individuals (unduplicated) participating in OMH-funded, grant program activities per year	Sign in sheets and various Internet tracking devices	AFG will maintain hard copy forms of sign-in sheets and print outs as available of online tracking devices	Gathered after each scheduled outreach activity and summarized monthly	AFG Peer Educator Outreach Coordinator and HP Outreach Worker
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	Online surveys, session evaluations, and pre and post tests	HP will maintain all demographic and evaluation data from Internet and community outreach activities; AFG will have software for data review and analysis	Outcome data will be collected after each scheduled outreach activity and be reviewed quarterly by team	AFG Peer Educator Outreach Coordinator, HP Outreach Worker, HP Evaluator
Number of racial/ethnic minority health improvement- and/or health disparities, related strategic plans developed to facilitate leadership and organizational effectiveness	Post tests at community outreach activities targeting staff of high-risk minority youth	*	Outcome data will be collected after each scheduled outreach activity and be reviewed quarterly by team	AFG Peer Educator Outreach Coordinator, HP Outreach Worker, HP Evaluator
Number of partnerships facilitated and/or established to enhance coordination	Signed Memorandums of Agreement (MOA)	AFG will maintain hard copies of all MOAs	As new partnerships develop	AFG Case Planner
Optional Measures (Two Chosen by Potential Grantee)				
Number of full-time equivalents (FTEs) on program/project staff supported with OMH funding	Employment and payroll records at AFG, HP, and DDHWP	At respective sites, but with AFG receiving monthly billing from HP and DDHWP stating number of FTEs to bill	Monthly	AFG OES Director
Number of OMH-supported training and technical assistance events	Sign-in sheets	AFG will maintain hard copy forms of sign-in sheets and print outs as available of online tracking devices	Gathered after each scheduled outreach activity and summarized monthly	AFG Peer Educator Outreach Coordinator and HP Outreach Worker

Measures	INSTRUMENT/ DATA SOURCE	LOCATION OF DATA	FREQUENCY OF COLLECTION	COLLECTION RESPONSIBILITY
Process Measures				
Development of recruitment materials, hours of training, case management hours, completion of initial and subsequent bi-annual assessment tools	Flyers, Peer Educator activity logs (time sheets), case notes, participant assessment intake forms and assessment tools	AFG will maintain all Peer Educator files	Flyers will occur as needed; activity logs are completed weekly; case management meetings happen monthly and as needed; and assessments are completed at intake and every 6 months	The AFG Peer Educator Outreach Coordinator will generate publicity materials and maintain activity logs, and the AFG Case Planner will complete and maintain participant files and assessments.
Number of 'hits' to a page (website), friends on a page (social networking site), responses to ad (Craigslist), number of followers (Twitter); number who complete screening tools; number who participate in online scheduled activities, number who participate in scheduled testing events	Online tracking tools (vary by site)	AFG will maintain hard copy forms of sign-in sheets and print outs as available of online tracking devices	Once implemented internet outreach will occur multiple times during the week and data will be collected with every separate event	AFG Peer Educator Outreach Coordinator and HP Outreach Worker
Number of training hours, number attendees at trainings, number of completed pre and post tests	Sign-in sheets agendas, and pre and post tests	AFG will maintain hard copy forms of sign-in sheets and agendas; HP will maintain a database for all evaluation data with AFG having software for shared analysis and review	Gathered after each scheduled outreach activity with hours and attendees summarized monthly and pre and post test data reviewed quarterly CTR data is reported to every 14 days	AFG Peer Educator Outreach Coordinator and HP Outreach Worker, HP Evaluator

Measures	INSTRUMENT/ DATA SOURCE	LOCATION OF DATA	FREQUENCY OF COLLECTION	COLLECTION RESPONSIBILITY
Number of training hours provided, number of attendees at trainings, completed session evaluations, completed follow-up services (such as getting HIV test results, accessing case management services, etc.), HIV CTR forms completed on site	Sign-in sheets, agendas, session evaluations, ES Forms, Referral Completed Forms	AFG will maintain hard copy forms of sign-in sheets and agendas; HP will maintain a database for all evaluation data with AFG having software for shared analysis and review; HP will maintain all CTR and HES forms as needed by the State of Michigan	Gathered after each scheduled outreach activity with hours and attendees summarized monthly and pre and post test data reviewed quarterly CTR data is reported to every 14 days	AFG Peer Educator Outreach Coordinator and HP Outreach Worker
Outcome Measures (short and Intermediate term)				
Number of training attendee quota reached, Percentage of Peer Educators are able to demonstrate skills and knowledge learned in training, goals completed, positive behavior modifications adopted, and identify skills learned as a peer educator	Sign in forms; skill and knowledge tests/ demonstrations; Goal forms; behavior assessments	AFG will maintain all Peer Educator files	Peer Educator training happens twice per year and as needed, goals are reviewed at monthly case meetings; assessments are completed at intake and bi-annually thereafter	AFG Peer Educator Coordinator and AFG Case Planner
Number youth who indicate HIV testing completed/report status; Number of youth who can tell one another testing resources in the community through discussion boards, wall posts, status updates/comments, and more; Number of youth access testing/case management services of partner agencies and site internet outreach as referral source	Online surveys; online monitoring tools; referral forms and specific-agency forms	HP will maintain all demographic and evaluation data from internet and community outreach activities; AFG will have software for data review and analysis	Data to be collected during every scheduled outreach activity	AFG Peer Educator Outreach Coordinator, HP Outreach Worker, HP Evaluator
Percent of staff who indicate increase of skills and knowledge demonstrated between pre and post tests	Pre and Post tests	**	Data to be collected during every scheduled outreach activity	AFG Peer Educator Outreach Coordinator, HP Outreach Worker, HP Evaluator

Measures	INSTRUMENT/ DATA SOURCE	LOCATION OF DATA	FREQUENCY OF COLLECTION	COLLECTION RESPONSIBILITY
Number of HIV test results discussion forms completed; Percentage of youth indicate one resource learned; Percentage of youth indicate intent to utilize skills learned; Number of youth access testing/case management services of partner agencies and site internet outreach as referral source	CTR forms and HES forms; session evaluation forms; referral forms	HP will maintain a database for all evaluation data with AFG having software for shared analysis and review; HP will maintain all CTR and HES forms as needed by the State of Michigan	Gathered after each scheduled outreach activity session evaluation data reviewed quarterly; CTR data is reported to the state every 14 days	AFG Peer Educator Outreach Coordinator, HP Outreach Worker, HP Evaluator
Impact Measure (long-term)				
Increase in perception of risk of HIV/AIDS transmission, increase In knowledge of HIV transmission, increase in use of safer sex practices	Assessment tools	AFG will maintain all Peer Educator files	Completed at intake and at 6-month intervals of participation	AFG Case Planner
Increase in access to youth knowing serostatus through counseling/testing resources	Online surveys and discussion monitoring tools	HP will maintain a database for all evaluation data with AFG having software for shared analysis and review	Gathered after each scheduled outreach activity session evaluation data reviewed quarterly	AFG Peer Educator Outreach Coordinator, HP Outreach Worker, HP Evaluator
Enhanced infrastructure of alternative education/ residential facilities to address HIV/ AIDS among minority and high-risk youth	Pre and post tests	**	Data to be collected during every scheduled outreach activity	AFG Peer Educator Outreach Coordinator, HP Outreach Worker, HP Evaluator
Increase of intent to modify behaviors to incorporate more risk reduction strategies; Increase access to HIV-counseling and testing services	Session evaluations; CTR and HES forms	HP will maintain a database for all evaluation data with AFG having software for shared analysis and review; HP will maintain all CTR and HES forms as needed by the State of Michigan	Gathered after each scheduled outreach activity session evaluation data reviewed quarterly; CTR data is reported to the state every 14 days	AFG Peer Educator Outreach Coordinator, HP Outreach Worker, HP Evaluator

Appendix 14:
Sample Data Collection Forms

Technical Assistance (To Individuals) Activity Record

Date	Recipient	Race	Ethnicity	Gender	Age	TA Type	Comment

Technical Assistance (To Organizations) Activity Record

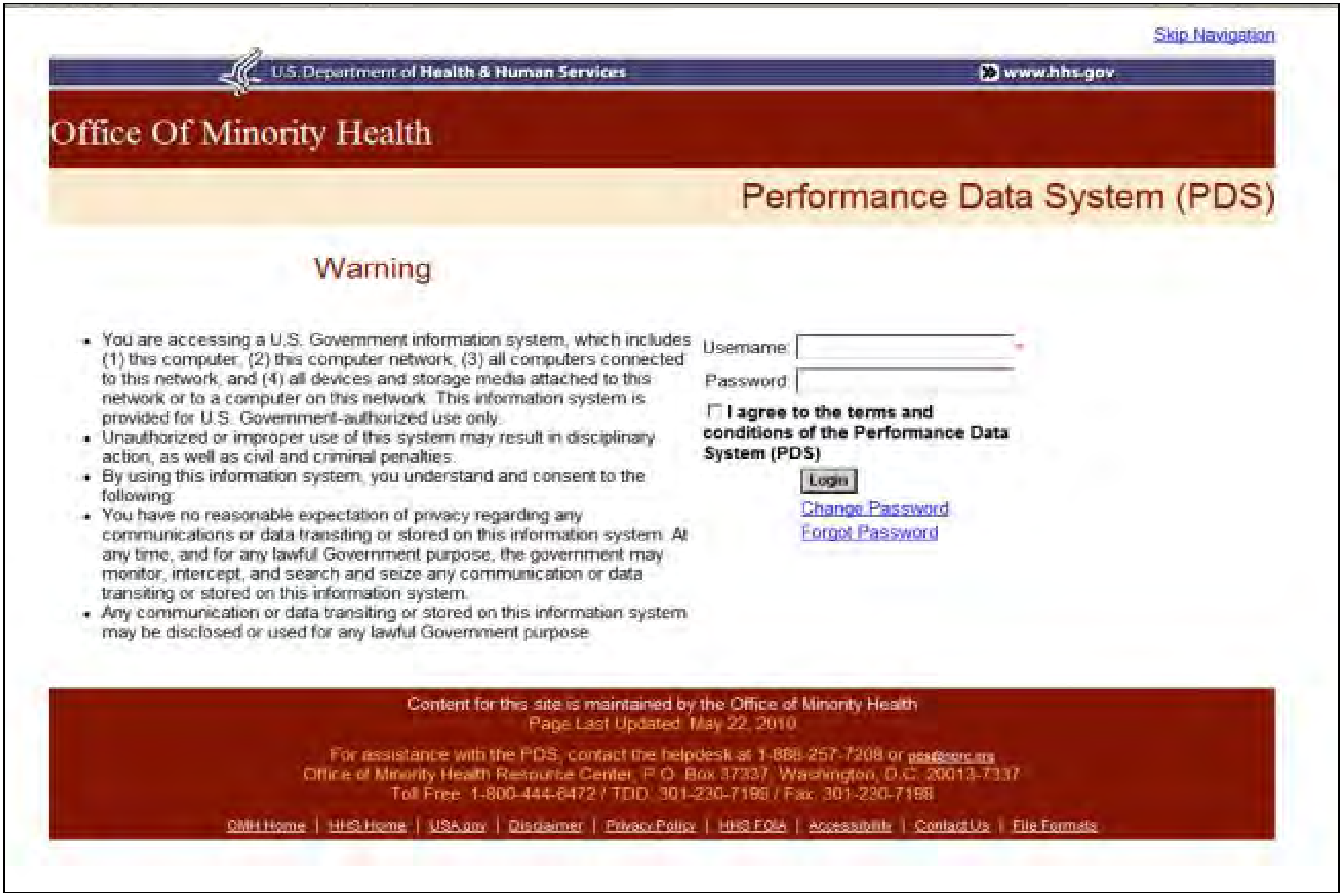
Date	Organization	Type of Organization	New or Existing	TA Type	Comment

Linkage-Building Activity Record

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

Appendix 15:
Screenshots of Selected Web Pages in OMH's Performance Data System

Screenshot of Log-in Page



Office Of Minority Health

Performance Data System (PDS)

Warning

- You are accessing a U.S. Government information system, which includes (1) this computer, (2) this computer network, (3) all computers connected to this network, and (4) all devices and storage media attached to this network or to a computer on this network. This information system is provided for U.S. Government-authorized use only.
- Unauthorized or improper use of this system may result in disciplinary action, as well as civil and criminal penalties.
- By using this information system, you understand and consent to the following:
- You have no reasonable expectation of privacy regarding any communications or data transiting or stored on this information system. At any time, and for any lawful Government purpose, the government may monitor, intercept, and search and seize any communication or data transiting or stored on this information system.
- Any communication or data transiting or stored on this information system may be disclosed or used for any lawful Government purpose.

Username:

Password:

☐ **I agree to the terms and conditions of the Performance Data System (PDS)**

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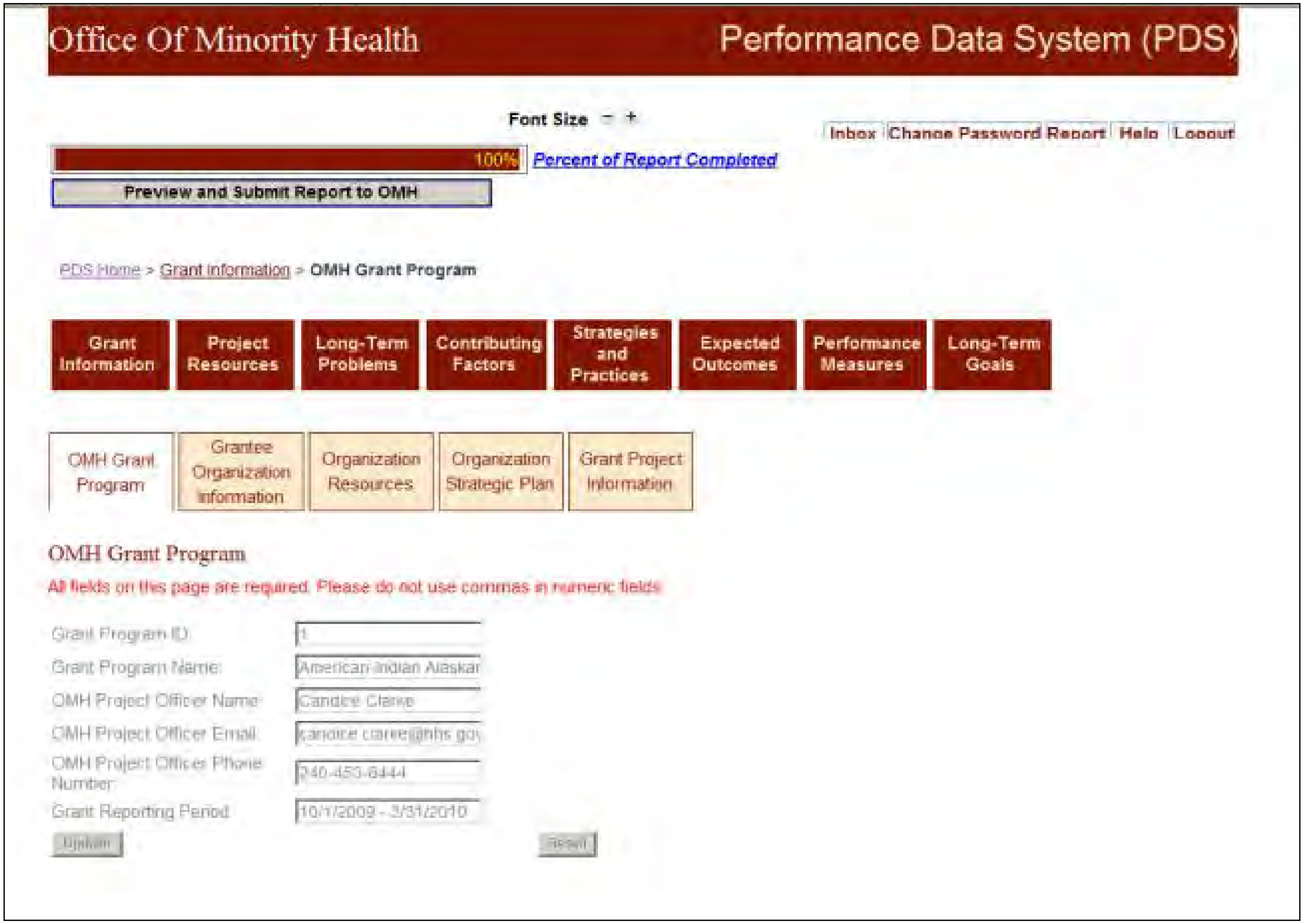
Page Last Updated: May 22, 2010

For assistance with the PDS, contact the helpdesk at 1-888-257-7208 or pds@omhrc.org
Office of Minority Health Resource Center, P.O. Box 37337, Washington, D.C. 20013-7337
Toll Free: 1-800-444-6472 / TDD: 301-230-7199 / Fax: 301-230-7198

Screenshot of Grant Program Page

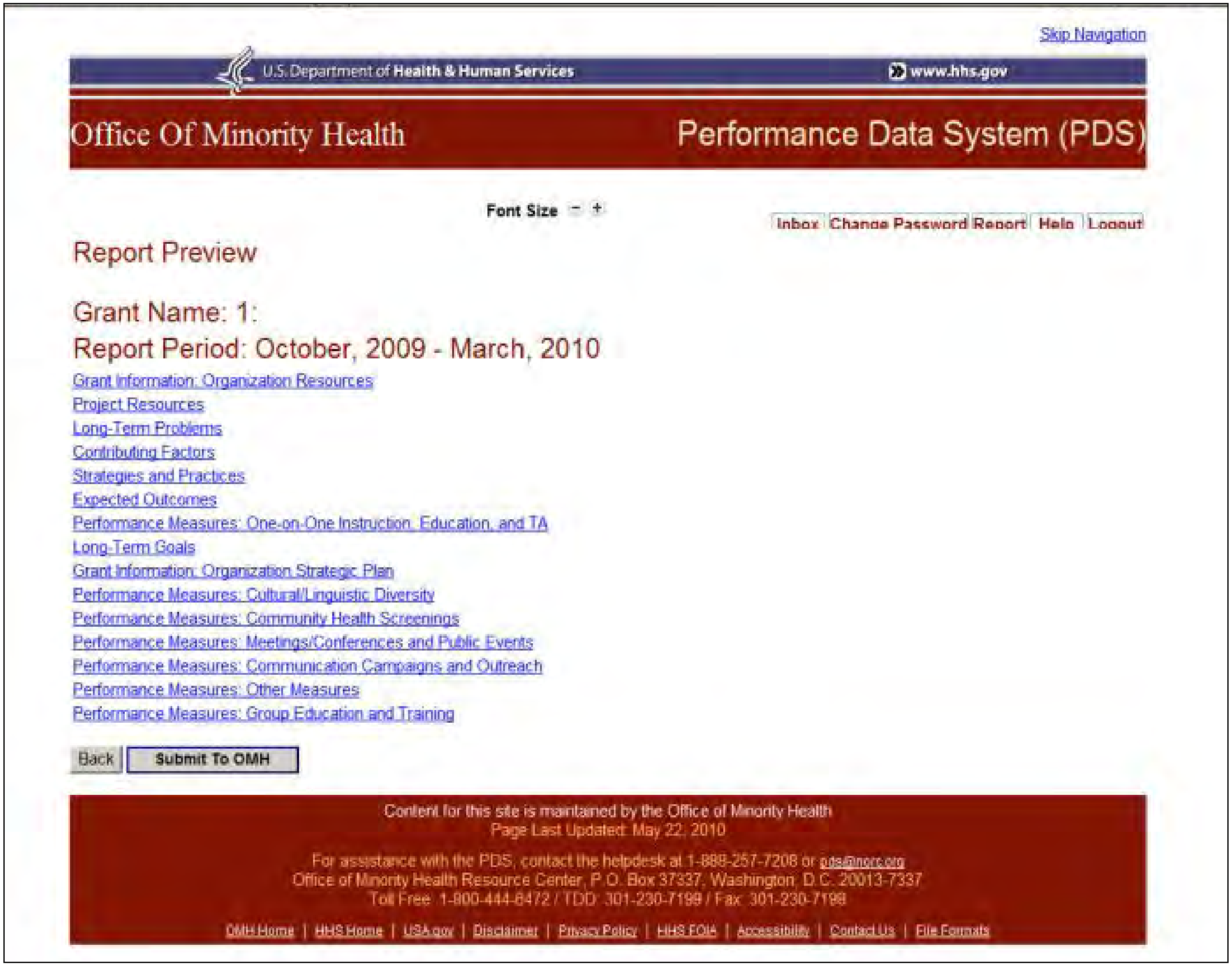


OMH Grant Program

All fields on this page are required. Please do not use commas in numeric fields.

Grant Program ID:	1
Grant Program Name:	American Indian Alaskar
OMH Project Officer Name:	Candice Clarke
OMH Project Officer Email:	candice.clarke@hhs.go
OMH Project Officer Phone Number:	240-453-8444
Grant Reporting Period:	10/1/2009 - 3/31/2010

Screenshot of Report Preview Page



Report Preview

Grant Name: 1:

Report Period: October, 2009 - March, 2010

Grant Information: Organization Resources
Project Resources
Long-Term Problems
Contributing Factors
Strategies and Practices
Expected Outcomes
Performance Measures: One-on-One Instruction, Education, and TA
Long-Term Goals
Grant Information: Organization Strategic Plan
Performance Measures: Cultural/Linguistic Diversity
Performance Measures: Community Health Screenings
Performance Measures: Meetings/Conferences and Public Events
Performance Measures: Communication Campaigns and Outreach
Performance Measures: Other Measures
Performance Measures: Group Education and Training

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Appendix 16:
Frequently Asked Questions

Frequently Asked Questions on Evaluation Planning

1. What is evaluation?

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

2. Why is evaluation important?

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

3. Why is OMH requiring evaluation?

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

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

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

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

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

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

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

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

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

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

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

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

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

8. What are baseline data?

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

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

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

10. What is a performance measure?

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

11. What is a logic model?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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