Access to Quality Health Services

CHAPTER 1

Co-Lead Agencies

Agency for Healthcare Research and Quality
Health Resources and Services Administration

Contents

GOAL:
Improve access to comprehensive, high-quality health care services.

Access to quality health services includes access to primary care, preventive services, and other health care services on a continuum of care in the health care delivery system. The objectives in this chapter monitor progress in four general areas:

- The first section monitors **clinical preventive care** and includes objectives that track health insurance coverage and counseling about health behaviors.
- Objectives in the second section are concerned with **primary care** and examine source of ongoing care, having a usual primary care provider, difficulties and delays obtaining needed health care, cultural diversity and racial and ethnic representation in health professions, and hospitalization for ambulatory-care-sensitive conditions.
- **Emergency services**, including delay or difficulty getting emergency care, rapid prehospital emergency care, trauma care systems, and special needs of children, are monitored in the third section.
- The final section tracks **long-term care and rehabilitative services,** including long-term care services and diagonsis of pressure ulcers among nursing home residents.

All Healthy People tracking data quoted in this chapter, along with technical information and Operational Definitions for each objective, can be found in the Healthy People 2010 database, DATA2010, available from http://wonder.cdc.gov/data2010/.

More information about this Focus Area can be found in the following publications:

- *Healthy People 2010: Understanding and Improving Health*, available from http://www.healthypeople.gov/2010/Document/tableofcontents.htm#under.
- *Healthy People 2010 Midcourse Review*, available from http://www.healthypeople.gov/2010/data/midcourse/html/default.htm#FocusAreas.

Highlights

- Substantial progress was achieved in meeting objectives for this Focus Area during the past decade [1]. Seventy-three percent of the Access to Quality Health Services objectives with data to measure progress moved toward or achieved their Healthy People 2010 targets (Figure 1-1). However, statistically significant health disparities of 10% or more were observed among racial and ethnic populations and income groups (Figure 1-2) [2].
- Rates of persons with health insurance (objective 1-1) did not change over the decade. As in 1997, the baseline year for this objective, 83% of the U.S. population under age 65 had health insurance coverage in 2008. Disparities were observed for a number of population groups, for example:
  - Among racial and ethnic groups, the non-Hispanic white population had the highest (best) rate of health insurance coverage, 88% in 2008, whereas the American Indian or Alaska Native population and the Hispanic or Latino population had rates of 72% and 67%, respectively. When expressed as persons *without* health insurance, the rate for the American Indian or Alaska Native population was more than twice that for the non-Hispanic white population) [2]. The rate of coverage for the Hispanic or Latino population was nearly three times the non-Hispanic white rate.
  - The American Indian or Alaska Native population had health insurance coverage rates of 62% in 1999 and 72% in 2008, whereas the non-Hispanic white population had rates of 88% in both 1999 and 2008. When rates are expressed in terms of persons *without* health insurance, the disparity between the American Indian or Alaska Native population and the non-Hispanic white population decreased 83 percentage points between 1999 and 2008 [2,3].

- Among income groups, the middle/high-income population had the highest (best) rate of health insurance coverage, 89% in 2008, whereas the poor and near-poor populations had rates of 71% and 69%, respectively. When expressed as persons *without* health insurance, the rate for the poor population was more than two and a half times that for the middle/high-income population [2]. The rate of non coverage for the near-poor population was almost three times the rate for the middle/high-income population.
- The poor population had health insurance coverage rates of 66% in 1997 and 71% in 2008, whereas the middle/high-income population had rates of 90% in 1997 and 89% in 2008. When rates are expressed in terms of persons *without* health insurance, the disparity between the poor population and the middle/high-income population decreased 76 percentage points between 1997 and 2008 [2,3].

› Health insurance coverage varied by state. Although no state had achieved the Healthy People 2010 target of total coverage, five states (Connecticut, Hawaii, Iowa, Massachusetts, and Minnesota) had rates of coverage over 88% in 2008. Texas, at 71%, had the lowest coverage rate (Figure 1-3).

› Statistically significant health disparities of 100% or more were observed for several other objectives, for example:

- Persons who had a specific source of ongoing care among all ages (objective 1-4a):
  - Among racial and ethnic groups, the non-Hispanic white population had the highest (best) rate, 89% in 2008, whereas the Hispanic or Latino population had a rate of 77%. When expressed as persons *without* a specific source of ongoing care, the rate for the Hispanic or Latino population was more than twice the non-Hispanic white rate [2].
  - Among income groups, the middle/high-income population had the highest (best) rate, 90% in 2008, whereas the poor and near-poor populations had rates of 78% and 80%, respectively. When expressed as persons *without* a specific source of ongoing care, the rates for the poor and near-poor populations were about twice the rate for the middle/high-income population [2].
- Persons who had a specific source of ongoing care among adults aged 18 and over (objective 1-4c):
  - Among racial and ethnic groups, the non-Hispanic white population had the highest (best) rate, 87% in 2008, whereas the Hispanic or Latino population had a rate of 69%. When expressed as persons *without* a specific source of ongoing care, the rate for the Hispanic or Latino population was almost two and a half times the non-Hispanic white rate [2].
  - Among income groups, the middle/high-income population had the best rate, 88% in 2008, whereas the near-poor and poor populations had rates of 76% and 71%, respectively. When expressed as persons *without* a specific source of ongoing care, the rate for the near-poor population was twice the rate, for the middle/high-income population, while the rate for the poor population was almost two and a half times the middle/high-income population rate [2].
- Persons who delayed or had difficulty in getting emergency medical care (objective 1-10):
  - Among racial and ethnic groups, the rate for persons of two or more races (6.7% in 2001) was about three times the best group rate, that for the non-Hispanic white population (2.2% in 2001).
  - Among income groups, the rate for the poor population (4.5% in 2001) was more than twice that of the best group rate, that for the middle/high-income population (2.0% in 2001).
  - The rate for persons with disabilities (5.7% in 2001) was more than three times that for persons without disabilities (1.8% in 2001).

Summary of Progress

› Figure 1-1 presents a quantitative assessment of progress in achieving the Healthy People 2010 objectives for Access to Quality Health Services [1]. Data to measure progress toward target attainment were available for 48 objectives. Of these:

- Eleven objectives (1-7a through d; 1-8b, f, j, n, and r; 1-9a; and 1-12) met or exceeded their Healthy People 2010 targets.
- Twenty-four objectives moved toward their targets. A statistically significant difference between the baseline and the final data points was observed for three of these objectives (1-3c, 1-6, and 1-9c). Data to test the significance of the difference were unavailable for 21 objectives (1-3f; 1-7e and g; 1-8a, d, e, g through i, l, p, q, s, and t; 1-13a, b, e, f, and i; and 1-14a and b).
- Six objectives (1-1; 1-4b; 1-7f and h; and 1-8m and o) showed no change.
- Seven objectives moved away from their targets. A statistically significant difference between the baseline and final data points was observed for three objectives (1-4a and c, and 1-9b). No significant differences were observed for two

objectives (1-5 and 1-16); and data to test the significance of the difference were unavailable for two objectives (1-8c and k).

- One objective (1-3g) remained developmental, and 20 objectives (1-3a, b, d, h; 1-10; 1-11a through g; 1-13c, d, g, and h; and 1-15a through d) had no follow-up data available to measure progress [4]. Two objectives (1-2 and 1-3e) were deleted at the Midcourse Review.

- Figure 1-2 displays health disparities in Access to Quality Health Services from the best group rate for each characteristic at the most recent data point [2]. It also displays changes in disparities from baseline to the most recent data point [3].

  - Of the 10 objectives with statistically significant health disparities of 10% or more by race and ethnicity, the non-Hispanic white population had the best rate for seven objectives (1-1, 1-3c, 1-4a and c, 1-5, 1-10, and 1-16). The non-Hispanic black population had the best rate for two objectives (1-3a and b), and the Hispanic or Latino population had the best rate for one objective (1-6).
  - Females had better rates than males for eight of the nine objectives with statistically significant health disparities of 10% or more by sex (objectives 1-1, 1-3c, 1-4a and c, 1-5, 1-9a and b, and 1-16). Males had a better rate than females for the remaining objective (1-6).
  - Persons with at least some college education had the best rate for the three objectives with statistically significant health disparities of 10% or more by education level (objectives 1-3h, 1-5, and 1-10).
  - Persons with middle/high incomes had the best rate for all six objectives with statistically significant health disparities of 10% or more by income (objectives 1-1, 1-3h, 1-4a and c, 1-6, and 1-10).
  - Persons living in rural or nonmetropolitan areas had better rates than persons living in urban or metropolitan areas for two of the three objectives with statistically significant health disparities of 10% or more by geographic location (objectives 1-4c and 1-5). Persons living in urban or metropolitan areas had a better rate for the third objective (1-1).
  - Persons with disabilities had better rates than persons without disabilities for 7 of the 10 objectives with statistically significant health disparities of 10% or more by disability status (objectives 1-1, 1-3a through c, 1-4a and c, and 1-5). Persons without disabilities had better rates for the remaining three objectives (1-3h, 1-6, and 1-10).
  - Health disparities of 100% or more were observed for four objectives: health insurance coverage (objective 1-1), source of ongoing care among all ages and among adults (objective 1-4a and c, respectively), and delay or difficulty in getting emergency care (objective 1-10). These disparities are discussed in the Highlights, above.
  - As indicated in the Highlights, increases in disparity over time between select population groups and income groups were observed for health insurance coverage.

Transition to Healthy People 2020

For Healthy People 2020, the Access to Health Services (AHS) Topic Area uses a new organizational approach based on two major components of health services delivery: access to health services and quality of health services. See HealthyPeople.gov for a complete list of Healthy People 2020 topics and objectives.

Objectives that appear in the Healthy People 2020 AHS Topic Area focus on the first component only, access to health services, whereas objectives that pertain to the second component, quality of health services, have been shifted into the appropriate disease- or condition-specific Topic Area and are, therefore, spread throughout Healthy People 2020.

The Healthy People 2010 Focus Area name was changed from "Access to Quality Health Services" to "Access to Health Services" for Healthy People 2020 to be consistent with the new organizational structure. To capture the objectives that are related to quality of health services, a crosswalk will be created, consisting of objectives found in the other Healthy People 2020 chapters (e.g., cancer screening rates and primary care counseling services) that are aligned with the annual National Health Quality Report (NHQR) [5].

The Healthy People 2020 AHS Topic Area objectives can be grouped into several sections:

- Coverage
- Workforce
- Utilization and Services
- Timeliness.

The differences between the Healthy People 2010 and Healthy People 2020 objectives are summarized below:

- The Healthy People 2020 AHS Topic Area has a total of 26 objectives, 16 of which are developmental, whereas the Healthy People 2010 Focus Area had 71 objectives [4]. In transitioning to Healthy People 2020, some objectives were deleted at the Midcourse Review or were removed during the Healthy People

2020 planning process. Many other objectives were archived due to the shift in Topic Area focus, as well as for data-related issues such as lack of viable data sources and successful attainment of 2010 targets [6].

- Four Healthy People 2010 objectives were retained "as is": health (medical) insurance (objective 1-1), specific source of ongoing care for all ages and for children and adolescents aged 17 and under (objectives 1-4a and b, respectively), and usual primary care provider (objective 1-5) [7].
- Two Healthy People 2010 objectives were modified [8]. The objective on source of ongoing care for adults aged 18 and over (objective 1-4c) was split into adults aged 18–64 and adults aged 65 and over; and the objective on difficulties or delays in receiving needed health care (objective 1-6) was modified to measure individuals instead of families and was split by type of care or service (all, medical care, dental care, and prescription medicines).
- Two Healthy People 2010 objectives, the population covered by basic and advanced life support (objectives 1-11a and b respectively), were reverted to developmental status in 2020 due to a lack of baseline data.
- One Healthy People 2010 objective on prevention of sexually transmitted diseases (objective 1-3g) that remained developmental was removed during the Healthy People 2020 planning process. Counseling about vehicle restraints and bicycle helmets (objective 1-3e) was deleted at the Midcourse Review. Health insurance coverage for clinical preventive services (objective 1-2) was deleted at the Midcourse Review but then retained as developmental for 2020.
- The remaining 60 Healthy People 2010 AHS objectives were archived or moved to other Healthy People 2020 Topic Areas, including new Topic Areas related to age groups: Early and Middle Childhood, Adolescent Health, and Older Adults. These objectives cover the following topics: counseling about health behaviors (objectives 1-3a through d, f, and h); health professions training on health promotion, disease prevention, and cultural diversity (objectives 1-7a through h); racial and ethnic representation in health professions (objectives 1-8a through t); hospitalization for specific conditions (objectives 1-9a through c); emergency care (objectives 1-10 and 1-11c through g); poison control (objectives 1-12); trauma care systems (objectives 1-13a through i); special needs of children (objectives 1-14a and b); and access to long-term care services (objectives 1-15a through d, and 1-16).
  - In many cases, objectives were dropped or moved to other Topic Areas due to the revised focus of the AHS Topic Area, while in other cases the target was met or objectives no longer had viable data sources.
  - For example, the objective that tracks physician counseling about physical activity (objective 1-3a) was moved into the Healthy People 2020 Physical Activity Topic Area and modified to include objectives on physician counseling and education related to exercise.
- Thirteen new objectives were added to the Healthy People 2020 AHS Topic Area:
  - The health insurance coverage objective was expanded from one to three objectives covering medical insurance (retained from Healthy People 2010), dental insurance (developmental), and prescription drug insurance (developmental).
  - Four new objectives related to the workforce were added. These developmental objectives will track practicing primary care providers in the following professions: medical doctor, doctor of osteopathy, physician assistant, and nurse practitioner.
  - One new developmental objective will track persons who receive appropriate evidence-based clinical services.
  - Six new developmental objectives track hospital emergency department visits for which wait time to see an emergency department clinician exceeds the recommended timeframe.

Appendix D, "A Crosswalk Between Objectives From Healthy People 2010 to Healthy People 2020," summarizes the changes between the two decades of objectives, reflecting new knowledge and direction for this area.

Data Considerations

Data on health professions, training on health promotion, disease prevention, and cultural diversity (objectives 1-7a through h) and racial and ethnic representation in health professions (objectives 1-8a through t) had definitional issues that resulted in difficulties in interpreting trends for certain objectives during the Healthy People 2010 tracking decade. For example, objectives 1-7e and f used a different survey in 2008 than for the 1999 baseline, which may result in data for those objectives not being comparable over time. The baseline survey data for objectives 1-7g and h did not include the D.N.P. degree as a response option, whereas the 2008 survey data did include that degree. Finally, objectives 1-8a through d, racial and ethnic representation for health professions, do not include data for dental professionals for the final year of data (2009) because those data were not available at the time of publication.

Education and income are the primary measures of socioeconomic status in Healthy People 2010. Most data systems used in Healthy People 2010 define income as a family's income before taxes. To facilitate comparisons among groups and over time, while adjusting for family size and for inflation, Healthy People 2010 categorizes income using the poverty thresholds developed by the Census Bureau. Thus, the three categories of family income that are primarily used are:

- Poor—below the Federal poverty level
- Near poor—100% to 199% of the Federal poverty level
- Middle/high income—200% or more of the Federal poverty level.

These categories may be overridden by considerations specific to the data system, in which case they are modified as appropriate. See *Healthy People 2010: General Data Issues*, referenced below.

In general, data on educational attainment are presented for persons aged 25 and over, consistent with guidance given by the Census Bureau. However, because of the requirements of the different data systems, the age groups used to calculate educational attainment for any specific objective may differ from the age groups used to report the data for other Healthy People 2010 objectives, as well as from select populations within the same objective. Therefore, the reader is urged to exercise caution in interpreting the data by educational attainment shown in the Health Disparities Table. See *Healthy People 2010: General Data Issues*, referenced below.

Figure 1-3 (Persons With Health Insurance) presents state-level data from the Behavioral Risk Factor Surveillance System (BRFSS). National data for these objectives come from the National Health Interview Survey (NHIS) and are the basis for setting the targets. BRFSS data may not be comparable with the national data from NHIS.

Additional information on data issues is available from the following sources:

- All Healthy People 2010 tracking data can be found in the Healthy People 2010 database, DATA2010, available from http://wonder.cdc.gov/data2010/.
- Detailed information about the data and data sources used to support these objectives can be found in the Operational Definitions on the DATA 2010 website, available from http://wonder.cdc.gov/data2010/focusod.htm.
- More information on statistical issues related to Healthy People tracking and measurement can be found in the Technical Appendix and in *Healthy People 2010: General Data Issues*, which is available in the General Data Issues section of the NCHS Healthy People website under Healthy People 2010; see http://www.cdc.gov/nchs/healthy_people/hp2010/hp2010_data_issues.htm.

References and Notes

1. Displayed in the Progress Chart (Figure 1-1), the percent of targeted change achieved expresses the difference between the baseline and the final value relative to the initial difference between the baseline and the Healthy People 2010 target. As such, it is a relative measure of progress toward attaining the Healthy People 2010 target. See the Reader's Guide for more information. When standard errors were available, the difference between the baseline and the final value was tested at the 0.05 level of significance. See the Figure 1-1 footnotes, as well as the Technical Appendix, for more detail.

2. Information about disparities among select populations is shown in the Health Disparities Table (Figure 1-2). Disparity from the best group rate is defined as the percent difference between the best group rate and each of the other group rates for a characteristic. For example, racial and ethnic health disparities are measured as the percent difference between the best racial and ethnic group rate and each of the other racial and ethnic group rates. Similarly, disparities by sex are measured as the percent difference between the better group rate (e.g., female) and the rate for the other group (e.g., male). Some objectives are expressed in terms of favorable events or conditions that are to be increased, while others are expressed in terms of adverse events or conditions that are to be reduced. To facilitate comparison of health disparities across different objectives, disparity is measured only in terms of adverse events or conditions. For comparability across objectives, objectives that are expressed in terms of favorable events or conditions are re-expressed using the adverse event or condition for the purpose of computing disparity, but they are not otherwise restated or changed. For example, objective 1-1, to increase the proportion of persons with health insurance (e.g., 72% of the American Indian or Alaska Native population under age 65 had some form of health insurance in 2008), is expressed in terms of the percentage of persons without health insurance (e.g., 100% – 72% = 28% of the American Indian or Alaska Native population under age 65 did not have any form of health insurance in 2008) when the disparity from the best group rate is calculated. See the Reader's Guide for more information. When standard errors were available, the difference between the best group rate and each of the other

group rates was tested at the 0.05 level of significance. See the Figure 1-2 footnotes, as well as the Technical Appendix, for more detail.

3. The change in disparity is estimated by subtracting the disparity at baseline from the disparity at the most recent data point and, therefore, is expressed in percentage points. See the Reader's Guide for more information. When standard errors were available, the change in disparity was tested at the 0.05 level of significance. See the Figure 1-2 footnotes, as well as the Technical Appendix, for more detail.

4. To be included in Healthy People 2010, an objective must have a national data source that provides a baseline and at least one additional data point for tracking progress. Some objectives lacked baseline data at the time of their development but had a potential data source and were considered of sufficient national importance to be included in Healthy People. These are called "developmental" objectives. When data become available, a developmental objective is moved to measurable status and a Healthy People target can be set.

5. Agency for Healthcare Research and Quality. National Healthcare Quality Report 2010 [online]. Washington, D.C.: Agency for Healthcare Research and Quality. 2010. (AHRQ publication no. 11–0004). Available from http://www.ahrq.gov/qual/qrdr10.htm.

6. Archived objectives had at least one data point in Healthy People 2010 but were not carried forward into Healthy People 2020.

7. As of the Healthy People 2020 launch, Healthy People 2020 objectives that were retained "as is" from Healthy People 2010 had no change in the numerator or denominator definitions, the data source(s), or the data collection methodology. These include objectives that were developmental in Healthy People 2010 and are developmental in Healthy People 2020, and for which no numerator information is available.

8. As of the Healthy People 2020 launch, objectives that were modified from Healthy People 2010 had some change in the numerator or denominator definitions, the data source(s), or the data collection methodology. These include objectives that went from developmental in Healthy People 2010 to measurable in Healthy People 2020, or vice versa.

Comprehensive Summary of Objectives: Access to Quality Health Services

Objective	Description	Data Source or Objective Status
1-1	Persons with health insurance (< 65 years)	National Health Interview Survey (NHIS), CDC, NCHS.
1-2	Health insurance coverage for clinical preventive services	Deleted at the Midcourse Review.
1-3a	Counseling about physical activity or exercise (age adjusted, 18+ years)	National Health Interview Survey (NHIS), CDC, NCHS.
1-3b	Counseling about diet and nutrition (age adjusted, 18+ years)	National Health Interview Survey (NHIS), CDC, NCHS.
1-3c	Counseling about smoking cessation (age adjusted, smokers 18+ years)	National Health Interview Survey (NHIS), CDC, NCHS.
1-3d	Counseling about risky drinking (age adjusted, 18+ years)	National Health Interview Survey (NHIS), CDC, NCHS.
1-3e	Counseling about childhood injury prevention (≤17 years)	Deleted at the Midcourse Review.
1-3f	Counseling about unintended pregnancy (females 15–44 years)	National Survey of Family Growth (NSFG), CDC, NCHS.
1-3g	Counseling about prevention of sexually transmitted diseases (15–44 years)	Developmental.
1-3h	Counseling about management of menopause (females 45–57 years)	National Health Interview Survey (NHIS), CDC, NCHS.
1-4a	Source of ongoing care—All ages	National Health Interview Survey (NHIS), CDC, NCHS.
1-4b	Source of ongoing care—Children and adolescents (<18 years)	National Health Interview Survey (NHIS), CDC, NCHS.

Comprehensive Summary of Objectives: Access to Quality Health Services (continued)

Objective	Description	Data Source or Objective Status
1-4c	Source of ongoing care—Adults (18+ years)	National Health Interview Survey (NHIS), CDC, NCHS.
1-5	Persons with a usual primary care provider	Medical Expenditure Panel Survey (MEPS), AHRQ.
1-6	Difficulties or delays in obtaining needed health care (families)	Medical Expenditure Panel Survey (MEPS), AHRQ.
1-7a	Medical doctor (M.D. degree)—Counseling for health promotion and disease prevention	Liaison Committee on Medical Education (LCME) Annual Medical School Questionnaire, Association of American Medical Colleges.
1-7b	Medical doctor (M.D. degree)—Cultural diversity	Liaison Committee on Medical Education (LCME) Annual Medical School Questionnaire, Association of American Medical Colleges.
1-7c	Osteopathic medical doctor (D.O. degree)—Counseling for health promotion and disease prevention	Annual Report on Osteopathic Medical Education, American Association of Colleges of Osteopathic Medicine.
1-7d	Osteopathic medical doctor (D.O. degree)—Cultural diversity	Annual Report on Osteopathic Medical Education, American Association of Colleges of Osteopathic Medicine.
1-7e	Baccalaureate-level nurse (B.S.N., B.A., or B.S. degree)—Counseling for health promotion and disease prevention	Special Healthy People Survey of Entry-Level Baccalaureate Nursing School Curriculum, formerly Survey on Women's Health in the Entry-Level Baccalaureate Nursing School Curriculum, American Association of Colleges of Nursing.
1-7f	Baccalaureate-level nurse (B.S.N., B.A., or B.S. degree)—Cultural diversity	Special Healthy People Survey of Entry-Level Baccalaureate Nursing School Curriculum, formerly Survey on Women's Health in the Entry-Level Baccalaureate Nursing School Curriculum, American Association of Colleges of Nursing.
1-7g	Nurse Practitioner (M.S., M.S.N., or D.N.P. degree)—Counseling for health promotion and disease prevention	Collaborative Curriculum Survey, American Association of Colleges of Nursing and National Organization of Nurse Practitioner Faculties.
1-7h	Nurse Practitioner (M.S., M.S.N., or D.N.P. degree)—Cultural diversity	Collaborative Curriculum Survey, American Association of Colleges of Nursing and National Organization of Nurse Practitioner Faculties.
1-8a	Racial and ethnic representation in health professions—American Indian or Alaska Native	Survey of Predoctoral Dental Educational Institutions, American Dental Association; Profile of Pharmacy Students, American Association of Colleges of Pharmacy; AAMC Data Book, Association of American Medical Colleges; Annual Data Report, Association of Schools of Public Health.
1-8b	Racial and ethnic representation in health professions—Asian or Pacific Islander	Survey of Predoctoral Dental Educational Institutions, American Dental Association; Profile of Pharmacy Students, American Association of Colleges of Pharmacy; AAMC Data Book, Association of American Medical Colleges; Annual Data Report, Association of Schools of Public Health.
1-8c	Racial and ethnic representation in health professions—Black or African American	Survey of Predoctoral Dental Educational Institutions, American Dental Association; Profile of Pharmacy Students, American Association of Colleges of Pharmacy; AAMC Data Book, Association of American Medical Colleges; Annual Data Report, Association of Schools of Public Health.
1-8d	Racial and ethnic representation in health professions—Hispanic or Latino	Survey of Predoctoral Dental Educational Institutions, American Dental Association; Profile of Pharmacy Students, American Association of Colleges of Pharmacy; AAMC Data Book, Association of American Medical Colleges; Annual Data Report, Association of Schools of Public Health.
1-8e	Racial and ethnic representation in Nursing—American Indian or Alaska Native	Annual Survey of RN (Registered Nurse) Programs, National League for Nursing, Center for Research in Nursing Education and Community Health.
1-8f	Racial and ethnic representation in Nursing—Asian or Pacific Islander	Annual Survey of RN (Registered Nurse) Programs, National League for Nursing, Center for Research in Nursing Education and Community Health.

Comprehensive Summary of Objectives: Access to Quality Health Services (continued)

Objective	Description	Data Source or Objective Status
1-8g	Racial and ethnic representation in Nursing—Black or African American	Annual Survey of RN (Registered Nurse) Programs, National League for Nursing, Center for Research in Nursing Education and Community Health.
1-8h	Racial and ethnic representation in Nursing—Hispanic or Latino	Annual Survey of RN (Registered Nurse) Programs, National League for Nursing, Center for Research in Nursing Education and Community Health.
1-8i	Racial and ethnic representation in Medicine—American Indian or Alaska Native	AAMC Data Book: Statistical Information Related to Medical Schools and Teaching Hospitals, Association of American Medical Colleges.
1-8j	Racial and ethnic representation in Medicine—Asian or Pacific Islander	AAMC Data Book: Statistical Information Related to Medical Schools and Teaching Hospitals, Association of American Medical Colleges.
1-8k	Racial and ethnic representation in Medicine—Black or African American	AAMC Data Book: Statistical Information Related to Medical Schools and Teaching Hospitals, Association of American Medical Colleges.
1-8l	Racial and ethnic representation in Medicine—Hispanic or Latino	AAMC Data Book: Statistical Information Related to Medical Schools and Teaching Hospitals, Association of American Medical Colleges.
1-8m	Racial and ethnic representation in Dentistry—American Indian or Alaska Native	Survey of Predoctoral Dental Educational Institutions, American Dental Association.
1-8n	Racial and ethnic representation in Dentistry—Asian or Pacific Islander	Survey of Predoctoral Dental Educational Institutions, American Dental Association.
1-8o	Racial and ethnic representation in Dentistry—Black or African American	Survey of Predoctoral Dental Educational Institutions, American Dental Association.
1-8p	Racial and ethnic representation in Dentistry—Hispanic or Latino	Survey of Predoctoral Dental Educational Institutions, American Dental Association.
1-8q	Racial and ethnic representation in Pharmacy—American Indian or Alaska Native	Profile of Pharmacy Students, American Association of Colleges of Pharmacy.
1-8r	Racial and ethnic representation in Pharmacy—Asian or Pacific Islander	Profile of Pharmacy Students, American Association of Colleges of Pharmacy.
1-8s	Racial and ethnic representation in Pharmacy—Black or African American	Profile of Pharmacy Students, American Association of Colleges of Pharmacy.
1-8t	Racial and ethnic representation in Pharmacy—Hispanic or Latino	Profile of Pharmacy Students, American Association of Colleges of Pharmacy.
1-9a	Hospitalization for pediatric asthma (admissions per 10,000 population, <18 years)	Healthcare Cost and Utilization Project (HCUP), AHRQ.
1-9b	Hospitalization for uncontrolled diabetes (admissions per 10,000 population, 18–64 years)	Healthcare Cost and Utilization Project (HCUP), AHRQ.
1-9c	Hospitalization for immunization—preventable pneumonia or influenza (admissions per 10,000 population, 65+ years)	Healthcare Cost and Utilization Project (HCUP), AHRQ.
1-10	Delay or difficulty in getting emergency care (age adjusted, 18+ years)	National Health Interview Survey (NHIS), CDC, NCHS.
1-11a	Rapid pre-hospital emergency care—Population covered by basic life support	National Assessment of State Trauma System Development, Emergency Medical Services Resources, Disaster Readiness for Mass Casualty Events, HRSA.
1-11b	Rapid pre-hospital emergency care—Population covered by advanced life support	National Assessment of State Trauma System Development, Emergency Medical Services Resources, Disaster Readiness for Mass Casualty Events, HRSA.

Comprehensive Summary of Objectives: Access to Quality Health Services (continued)

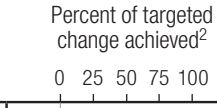
Objective	Description	Data Source or Objective Status
1-11c	Rapid pre-hospital emergency care—Population covered by helicopter	National Assessment of State Trauma System Development, Emergency Medical Services Resources, Disaster Readiness for Mass Casualty Events, HRSA.
1-11d	Rapid pre-hospital emergency care—Pre-hospital access to online medical control	National Assessment of State Trauma System Development, Emergency Medical Services Resources, Disaster Readiness for Mass Casualty Events, HRSA.
1-11e	Rapid pre-hospital emergency care—Population covered by basic 9-1-1	National Assessment of State Trauma System Development, Emergency Medical Services Resources, Disaster Readiness for Mass Casualty Events, HRSA.
1-11f	Rapid pre-hospital emergency care—Population covered by enhanced 9-1-1	National Assessment of State Trauma System Development, Emergency Medical Services Resources, Disaster Readiness for Mass Casualty Events, HRSA.
1-11g	Rapid pre-hospital emergency care—Population living in an area with two-way communication between hospitals	National Assessment of State Trauma System Development, Emergency Medical Services Resources, Disaster Readiness for Mass Casualty Events, HRSA.
1-12	Single toll-free number for poison control centers	American Association of Poison Control Centers Survey, U.S. Poison Control Centers.
1-13a	Trauma care systems (no. States and D.C.)—Presence of active multidisciplinary trauma advisory committee	Federal Trauma–EMS Systems Program Survey, HRSA.
1-13b	Trauma care systems (no. States and D.C.)—Defined process for designing trauma centers	Federal Trauma–EMS Systems Program Survey, HRSA.
1-13c	Trauma care systems (no. States and D.C.)—Use of ACS standards for trauma center verification	Federal Trauma–EMS Systems Program Survey, HRSA.
1-13d	Trauma care systems (no. States and D.C.)—Use of on-site survey teams for trauma center verification	Federal Trauma–EMS Systems Program Survey, HRSA.
1-13e	Trauma care systems (no. States and D.C.)—Pre-hospital triage criteria allowing for the bypass of non-designated hospitals	Federal Trauma–EMS Systems Program Survey, HRSA.
1-13f	Trauma care systems (no. States and D.C.)—Standardized inter-hospital transfer protocols	Federal Trauma–EMS Systems Program Survey, HRSA.
1-13g	Trauma care systems (no. States and D.C.)—Policies describing the types of patients who should be transferred	Federal Trauma–EMS Systems Program Survey, HRSA.
1-13h	Trauma care systems (no. States and D.C.)—Process to monitor and evaluate trauma system outcomes	Federal Trauma–EMS Systems Program Survey, HRSA.
1-13i	Trauma care systems (no. States and D.C.)—Trauma system plan	Federal Trauma–EMS Systems Program Survey, HRSA.
1-14a	Special needs of children (no. States and D.C.)—Pediatric protocols for online medical direction	Emergency Medical Services for Children Annual Grantees Survey, HRSA.
1-14b	Special needs of children (no. States and D.C.)—Pediatric guidelines for emergency and critical care	Emergency Medical Services for Children Annual Grantees Survey, HRSA.
1-15a	Lack of access to home health care among persons with long-term care needs (age adjusted, 65+ years)	National Health Interview Survey (NHIS), CDC, NCHS.
1-15b	Lack of access to adult day care among persons with long-term care needs (age adjusted, 65+ years)	National Health Interview Survey (NHIS), CDC, NCHS.
1-15c	Lack of access to assisted living among persons with long-term care needs (age adjusted, 65+ years)	National Health Interview Survey (NHIS), CDC, NCHS.
1-15d	Lack of access to nursing home care services among persons with long-term care needs (aged adjusted, 65+ years)	National Health Interview Survey (NHIS), CDC, NCHS.
1-16	Pressure ulcers among nursing home residents (current diagnoses per 1,000 residents)	National Nursing Home Survey (NNHS), CDC, NCHS.

Figure 1-1. Progress Toward Target Attainment for Focus Area 1: Access to Quality Health Services

LEGEND — Moved away from target[1] | Moved toward target | Met or exceeded target

Objective	Percent of targeted change achieved[2] (0 25 50 75 100)	2010 Target	Baseline (Year)	Final (Year)	Baseline vs. Final: Difference[3]	Statistically Significant[4]	Percent Change[5]
1-1. Persons with health insurance (<65 years)	0.0%	100%	83% (1997)	83% (2008)	0	No	0.0%
1-3c. Counseling about smoking cessation (age adjusted, smokers 18+ years)	30.8%	66%	53% (2000)	57% (2005)	4	Yes	7.5%
1-3f. Counseling about unintended pregnancy (females 15–44 years)	6.5%	50%	19% (1995)	21% (2006–08)	2	Not tested	10.5%
1-4. Source of ongoing care							
a. All ages		96%	87% (1998)	86% (2008)	-1	Yes	-1.1%
b. Children and adolescents (<18 years)	0.0%	97%	94% (1998)	94% (2008)	0	No	0.0%
c. Adults (18+ years)		96%	85% (1998)	84% (2008)	-1	Yes	-1.2%
1-5. Persons with a usual primary care provider		85%	77% (1996)	76% (2007)	-1	No	-1.3%
1-6. Difficulties or delays in obtaining needed health care (families)	25.0%	9%	21% (2002)	18% (2007)	-3	Yes	-14.3%
1-7. Medical doctor (M.D. degree)							
a. Counseling for health promotion and disease prevention	200.0%	87%	79% (2003–04)	95% (2007–08)	16	Not tested	20.3%
b. Cultural diversity	133.3%	96%	87% (1999–2000)	99% (2007–08)	12	Not tested	13.8%
Osteopathic medical doctor (D.O. degree)							
c. Counseling for health promotion and disease prevention	100.0%	100%	95% (2003–04)	100% (2009)	5	Not tested	5.3%
d. Cultural diversity	1,525.0%	39%	35% (2003–04)	96% (2009)	61	Not tested	174.3%
Baccalaureate-level nurse (B.S.N., B.A., or B.S. degree)							
e. Counseling for health promotion and disease prevention	88.9%	100%	91% (1999)	99% (2008)	8	Not tested	8.8%
f. Cultural diversity	0.0%	100%	98% (1999)	98% (2008)	0	Not tested	0.0%
Nurse Practitioner (M.S., M.S.N., or D.N.P. degree)							
g. Counseling for health promotion and disease prevention	33.3%	100%	94% (2000–01)	96% (2008)	2	Not tested	2.1%
h. Cultural diversity	0.0%	100%	97% (2000–01)	97% (2008)	0	Not tested	0.0%

Figure 1-1. Progress Toward Target Attainment for Focus Area 1: Access to Quality Health Services (continued)



Objective	2010 Target	Baseline (Year)	Final (Year)	Baseline vs. Final: Difference[3]	Baseline vs. Final: Statistically Significant[4]	Baseline vs. Final: Percent Change[5]
1-8. Racial and ethnic representation in health professions						
a. American Indian or Alaska Native	1.0%	0.6% (1996–97)	0.7% (2008–09)	0.1	Not tested	16.7%
b. Asian or Pacific Islander	4.0%	16.3% (1996–97)	21.2% (2008–09)	4.9	Not tested	30.1%
c. Black or African American	13.0%	6.5% (1996–97)	6.4% (2008–09)	-0.1	Not tested	-1.5%
d. Hispanic or Latino	12.0%	5.2% (1996–97)	5.8% (2008–09)	0.6	Not tested	11.5%
Racial and ethnic representation in Nursing						
e. American Indian or Alaska Native	1.0%	0.7% (1995–96)	0.9% (2006–07)	0.2	Not tested	28.6%
f. Asian or Pacific Islander	4.0%	3.2% (1995–96)	5.3% (2006–07)	2.1	Not tested	65.6%
g. Black or African American	13.0%	6.9% (1995–96)	10.9% (2006–07)	4.0	Not tested	58.0%
h. Hispanic or Latino	12.0%	3.4% (1995–96)	6.5% (2006–07)	3.1	Not tested	91.2%
Racial and ethnic representation in Medicine						
i. American Indian or Alaska Native	1.0%	0.7% (1996–97)	0.8% (2008–09)	0.1	Not tested	14.3%
j. Asian or Pacific Islander	4.0%	16.0% (1996–97)	21.1% (2008–09)	5.1	Not tested	31.9%
k. Black or African American	13.0%	7.0% (1996–97)	6.5% (2008–09)	-0.5	Not tested	-7.1%
l. Hispanic or Latino	12.0%	5.9% (1996–97)	6.9% (2008–09)	1.0	Not tested	16.9%
Racial and ethnic representation in Dentistry						
m. American Indian or Alaska Native	1.0%	0.5% (1996–97)	0.5% (2007–08)	0.0	Not tested	0.0%
n. Asian or Pacific Islander	4.0%	19.5% (1996–97)	23.4% (2007–08)	3.9	Not tested	20.0%
o. Black or African American	13.0%	5.1% (1996–97)	5.1% (2007–08)	0.0	Not tested	0.0%
p. Hispanic or Latino	12.0%	5.3% (1996–97)	6.1% (2007–08)	0.8	Not tested	15.1%

Figure 1-1. Progress Toward Target Attainment for Focus Area 1: Access to Quality Health Services (continued)

Objective	Percent of targeted change achieved[2] (0 25 50 75 100)	2010 Target	Baseline (Year)	Final (Year)	Baseline vs. Final: Difference[3]	Baseline vs. Final: Statistically Significant[4]	Baseline vs. Final: Percent Change[5]
Racial and ethnic representation in Pharmacy							
q. American Indian or Alaska Native	33.3%	1.0%	0.4% (1996–97)	0.6% (2008–09)	0.2	Not tested	50.0%
r. Asian or Pacific Islander	Target exceeded at baseline and final	4.0%	17.5% (1996–97)	21.2% (2008–09)	3.7	Not tested	21.1%
s. Black or African American	8.2%	13.0%	5.7% (1996–97)	6.3% (2008–09)	0.6	Not tested	10.5%
t. Hispanic or Latino	6.0%	12.0%	3.6% (1996–97)	4.1% (2008–09)	0.5	Not tested	13.9%
1-9a. Hospitalization for pediatric asthma (admissions per 10,000 population, <18 years)	142.1%	17.3	23.0 (1996)	14.9 (2008)	-8.1	Yes	-35.2%
1-9b. Hospitalization for uncontrolled diabetes (admissions per 10,000 population, 18–64 years)		5.4	7.2 (1996)	8.7 (2008)	1.5	Yes	20.8%
1-9c. Hospitalization for immunization-preventable pneumonia or influenza (admissions per 10,000 population, 65+ years)	61.5%	7.9	10.5 (1996)	8.9 (2008)	-1.6	Yes	-15.2%
1-12. Single toll-free number for poison control centers	100.0%	100%	15% (1999)	100% (2005)	85	Not tested	566.7%
1-13. Trauma care systems (no. States and D.C.)							
a. Presence of active multidisciplinary trauma advisory committee	77.3%	51	29 (2002)	46 (2005)	17	Not tested	58.6%
b. Defined process for designing trauma centers	29.4%	51	34 (2002)	39 (2005)	5	Not tested	14.7%
e. Pre-hospital triage criteria allowing for the bypass of non-designated hospitals	16.7%	51	27 (2002)	31 (2005)	4	Not tested	14.8%
f. Standardized inter-hospital transfer protocols	28.6%	51	23 (2002)	31 (2005)	8	Not tested	34.8%
i. Trauma system plan	78.9%	51	32 (2002)	47 (2005)	15	Not tested	46.9%
1-14. Special needs of children (no. States and D.C.)							
a. Pediatric protocols for online medical direction	78.8%	51	18 (1997)	44 (2002)	26	Not tested	144.4%
b. Pediatric guidelines for emergency and critical care	75.0%	51	11 (1997)	41 (2003)	30	Not tested	272.7%
1-16. Pressure ulcers among nursing home residents (current diagnoses per 1,000 residents)		8	16 (1997)	20 (2004)	4	No	25.0%

Figure 1-1. Progress Toward Target Attainment for Focus Area 1: Access to Quality Health Services (continued)

NOTES

See the Reader's Guide for more information on how to read this figure. See DATA2010 at http://wonder.cdc.gov/data2010 for all HealthyPeople 2010 tracking data. Tracking data are not available for objectives 1-3a, 1-3b, 1-3d, 1-3g, 1-3h, 1-10, 1-11a through g, 1-13c, 1-13d, 1-13g, 1-13h, and 1-15a through d. Objectives 1-2 and 1-3e were deleted at the Midcourse Review.

FOOTNOTES

[1] Movement away from target is not quantified using the percent of targeted change achieved. See Technical Appendix for more information.

[2] Percent of targeted change achieved = $\frac{\text{Final value} - \text{Baseline value}}{\text{Healthy People 2010 target} - \text{Baseline value}} \times 100$.

[3] Difference = Final value – Baseline value. Differences between percents (%) are measured in percentage points.

[4] When estimates of variability are available, the statistical significance of the difference between the final value and the baseline value is assessed at the 0.05 level. See Technical Appendix for more information.

[5] Percent change = $\frac{\text{Final value} - \text{Baseline value}}{\text{Baseline value}} \times 100$.

DATA SOURCES

1-1.	National Health Interview Survey (NHIS), CDC, NCHS.
1-3c.	National Health Interview Survey (NHIS), CDC, NCHS.
1-3f.	National Survey of Family Growth (NSFG), CDC, NCHS.
1-4a–c.	National Health Interview Survey (NHIS), CDC, NCHS.
1-5–1-6.	Medical Expenditure Panel Survey (MEPS), AHRQ.
1-7a–b.	Liaison Committee on Medical Education (LCME) Annual Medical School Questionnaire, Association of American Medical Colleges.
1-7c–d.	Annual Report on Osteopathic Medical Education, American Association of Colleges of Osteopathic Medicine.
1-7e–f.	Special Healthy People Survey of Entry-Level Baccalaureate Nursing School Curriculum, formerly Survey on Women's Health in the Entry-Level Baccalaureate Nursing School Curriculum, American Association of Colleges of Nursing.
1-7g–h.	Collaborative Curriculum Survey, American Association of Colleges of Nursing and National Organization of Nurse Practitioner Faculties.
1-8a–d.	Survey of Predoctoral Dental Educational Institutions, American Dental Association; Profile of Pharmacy Students, American Association of Colleges of Pharmacy; AAMC Data Book, Association of American Medical Colleges; Annual Data Report, Association of Schools of Public Health.
1-8e–h.	Annual Survey of RN (Registered Nurse) Programs, National League for Nursing, Center for Research in Nursing Education and Community Health.
1-8i–l.	AAMC Data Book: Statistical Information Related to Medical Schools and Teaching Hospitals, Association of American Medical Colleges.
1-8m–p.	Survey of Predoctoral Dental Educational Institutions, American Dental Association.
1-8q–t.	Profile of Pharmacy Students, American Association of Colleges of Pharmacy.
1-9a–c.	Healthcare Cost and Utilization Project (HCUP), AHRQ.
1-12.	American Association of Poison Control Centers Survey, U.S. Poison Control Centers.
1-13a–b.	Federal Trauma-EMS Systems Program Survey, HRSA.
1-13e–f.	Federal Trauma-EMS Systems Program Survey, HRSA.
1-13i.	Federal Trauma-EMS Systems Program Survey, HRSA.
1-14a–b.	Emergency Medical Services for Children Annual Grantees Survey, HRSA.
1-16.	National Nursing Home Survey (NNHS), CDC, NCHS.

Figure 1-2. Health Disparities Table for Focus Area 1: Access to Quality Health Services

Disparities from the best group rate for each characteristic at the most recent data point and changes in disparity from the baseline to the most recent data point.

Figure 1-2. Health Disparities Table for Focus Area 1: Access to Quality Health Services (continued)

NOTES

See DATA2010 at http://wonder.cdc.gov/data2010 for all Healthy People 2010 tracking data. Disparity data are either unavailable or not applicable for objectives 1-3g, 1-7a through h, 1-8a through t, 1-11a through g, 1-12, 1-13a through i, and 1-14a and b. Objectives 1-2 and 1-3e were deleted at Midcourse Review.

Years in parentheses represent the baseline and most recent data years (if available).

Disparity from the best group rate is defined as the percent difference between the best group rate and each of the other group rates for a characteristic (e.g., race and ethnicity). The summary index is the average of these percent differences for a characteristic. Change in disparity is estimated by subtracting the disparity at baseline from the disparity at the most recent data point. Change in the summary index is estimated by subtracting the summary index at baseline from the summary index at the most recent data point. See Technical Appendix for more information.

Measures of variability were available for all objectives in this table. Thus, the variability of best group rates was assessed, and statistical significance was tested. Disparities of 10% or more are displayed when the differences from the best group rate are statistically significant at the 0.05 level. Changes in disparities over time are indicated by arrows when the changes are greater than or equal to 10 percentage points and are statistically significant at the 0.05 level. See Technical Appendix.

LEGEND

The "best" group rate at the most recent data point.

- B — The group with the best rate for specified characteristic.
- b — Most favorable group rate for specified characteristic, but reliability criterion not met.
- Reliability criterion for best group rate not met, or data available for only one group.

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

Percent difference from the best group rate

- Less than 10%, or difference not statistically significant (when estimates of variability are available).
- 10%–49%
- 50%–99%
- 100% or more

Changes in disparity over time are shown when: (a) disparities data are available at both baseline and most recent time points; (b) data are not for the group(s) indicated by "B" or "b" at either time point; and (c) the change is greater than or equal to 10 percentage points and statistically significant, or when the change is greater than or equal to 10 percentage points and estimates of variability were not available. See Technical Appendix.

Increase in disparity (percentage points)

- ↑ 10–49 points
- ↑↑ 50–99 points
- ↑↑↑ 100 points or more

Decrease in disparity (percentage points)

- ↓ 10–49 points
- ↓↓ 50–99 points
- ↓↓↓ 100 points or more

Availability of Data

- Data not available.
- Characteristic not selected for this objective.

Figure 1-2. Health Disparities Table for Focus Area 1: Access to Quality Health Services (continued)

FOOTNOTES

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

[2] Baseline data by disability status are for 2006–08.

[3] Baseline data by race and ethnicity are for 2002.

[4] Baseline data by disability status are for 2004.

[i] The group with the best rate at the most recent data point is different from the group with the best rate at baseline. Both rates met the reliability criterion. See Technical Appendix.

[ii] Change in the summary index cannot be assessed. See Technical Appendix.

[iii] For this objective, only activity limitations are considered as disabilities.

[iv] Reliability criterion for best group rate not met, or data available for only one group, at baseline. Change in disparity cannot be assessed. See Technical Appendix.

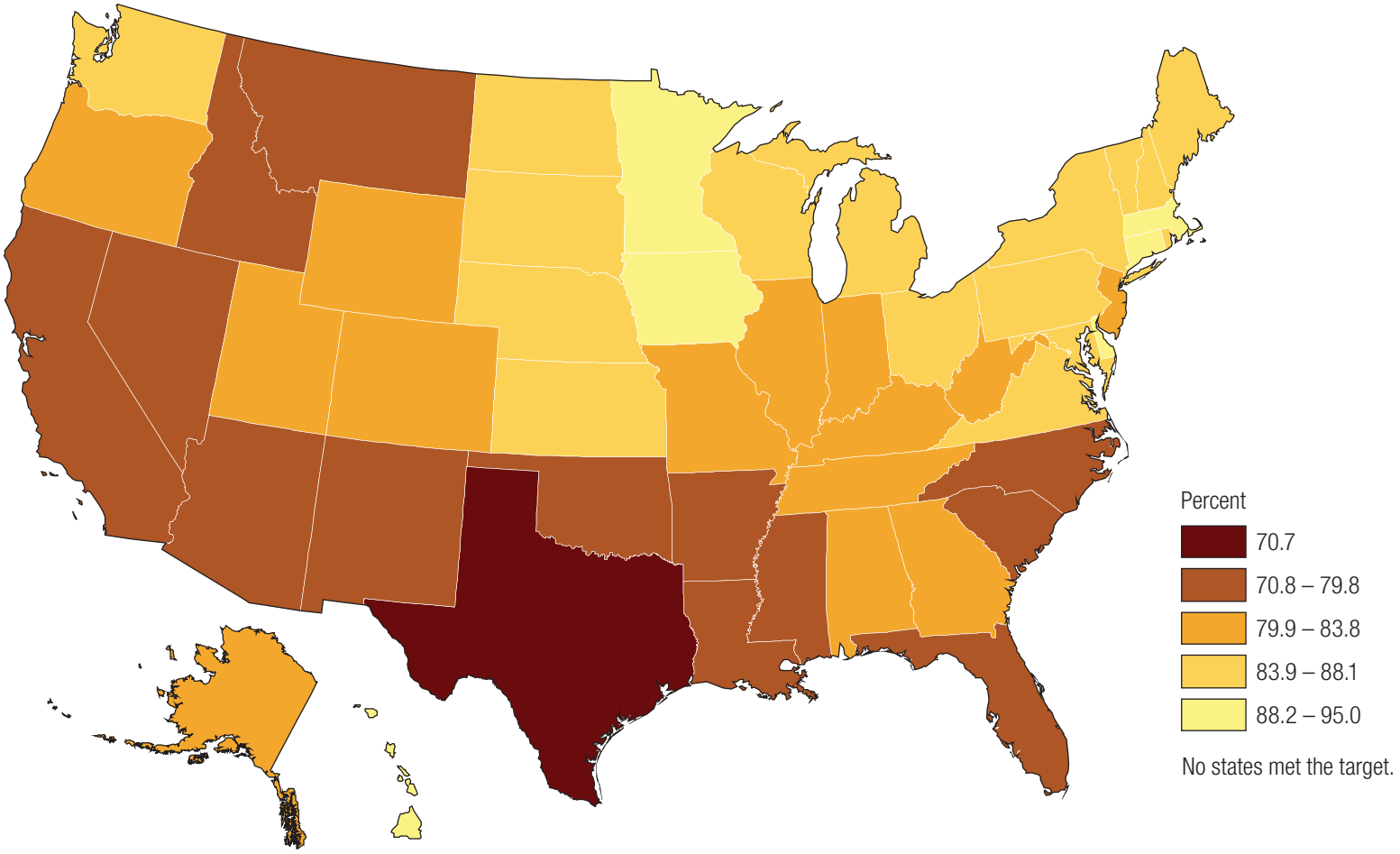
[v] For this objective, only severe disabilities are considered as disabilities.

DATA SOURCES

1-1. National Health Interview Survey (NHIS), CDC, NCHS.
1-3a–d. National Health Interview Survey (NHIS), CDC, NCHS.
1-3f. National Survey of Family Growth (NSFG), CDC, NCHS.
1-3h. National Health Interview Survey (NHIS), CDC, NCHS.
1-4a–c. National Health Interview Survey (NHIS), CDC, NCHS.
1-5–1-6. Medical Expenditure Panel Survey (MEPS), AHRQ.
1-9a–c. Healthcare Cost and Utilization Project (HCUP), AHRQ.
1-10. National Health Interview Survey (NHIS), CDC, NCHS.
1-15a–d. National Health Interview Survey (NHIS), CDC, NCHS.
1-16. National Nursing Home Survey (NNHS), CDC, NCHS.

Figure 1-3. Persons With Health Insurance (Age <65), 2008

Healthy People 2010 objective 1-1 • Target = 100 percent



NOTES: Data are age adjusted to the 2000 standard population. Rates are displayed by a Jenks classification for U.S. states. National data for the objective come from the National Health Interview Survey (NHIS) and are the basis for setting the target. State data from BRFSS may not be comparable with national data from NHIS. The U.S. rate in 2008 from NHIS was 83.3%. The rate for all states combined from BRFSS in 2008 was 82.0%.

SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP.