

10. ACCESS TO QUALITY HEALTH SERVICES

Clinical Preventive Services

Number	Objective
A.1	Uninsured children and adults
A.2	Insurance coverage
A.3	Routine screening about lifestyle risk factors
A.4	Reporting on service delivery
A.5	Training to address health disparities

Primary Care

Number	Objective
B.1	Source of ongoing primary care
B.2	Failure to obtain all needed health care
B.3	Lack of primary care visits
B.4	Access to primary care providers in underserved areas
B.5	Racial/ethnic minority representation in the health professions
B.6	Preventable hospitalization rates for chronic illness

Emergency Services

Number	Objective
C.1	Access to emergency medical services
C.2	Insurance coverage
C.3	Toll-free Poison Control Center number
C.4	Time-dependent care for cardiac symptoms
C.5	Special needs of children
C.6	Followup mental health services

Long-Term Care and Rehabilitative Services

Number	Objective
D.1	Functional assessments
D.2	Primary care evaluation
D.3	Access to the continuum of services
D.4	Pressure ulcers

Access to Quality Health Services

Goal

Improve access to comprehensive, high quality health care across a continuum of care.

Terminology

(A listing of all acronyms used in this publication appears on page 27 of the Introduction.)

Overview

The new Access to Quality Health Services chapter is an evolution and an expansion of the goals embodied in the Healthy People 2000 Clinical Preventive Services (CPS) Priority Area. The CPS objective priorities were organized around the goal of assuring access to a defined set of clinical preventive services.

The Healthy People 2000 objectives addressed issues such as increasing the delivery of preventive services, improving access to primary care, and reducing financial barriers to primary and preventive care. The Health Services Focus Area recognizes that access to other components of the health care system is also important to achieve the overarching Healthy People 2010 goals of eliminating health disparities and increasing years of healthy life. Many of the persisting disparities in health outcomes across population groups reflect problems of access within a continuum of care that includes preventive services, primary care, emergency services, and long-term and rehabilitative care. Additionally, these four elements of the health care system represent critical components of the interface between public health and clinical medicine.

Broader problems of access and quality are appropriately the concern of public health planners and policy makers because many problems are amenable to population-based, service-oriented interventions. Equally important, until these issues are addressed, the full benefits of prevention will never be realized. For example, reducing the burden of heart disease depends on more than successful efforts to screen for high blood pressure and high cholesterol. Success also will depend on whether effective interventions such as smoking cessation counseling are available and affordable, whether the primary care system effectively manages cardiac risk factors and appropriately refers patients with heart disease for necessary tertiary preventive care or procedures, whether emergency services effectively handle acute cardiac events, and whether recovering patients can avail themselves of needed long-term care and rehabilitative services.

Access has been defined by the Institute of Medicine as “**the timely use of personal health services to achieve the best possible health outcomes.**”¹ This definition requires considering both the use of services and the outcomes of services as indicators of access. The IOM has also developed a definition of **quality** as “**the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.**”²

The Health Services objectives, therefore, focus on services areas where significant disparities exist between access to quality health services available to the general population and to vulnerable populations and where access to care is likely to affect years of healthy life. The objectives are **prevention** oriented and achievable through population-based interventions. The measures go beyond the traditional measures of mortality and morbidity; they are crosscutting—they measure and seek to improve quality of life and to address aspects of health services that improve and maintain physical, mental, emotional, and social functioning. The health services settings addressed in the continuum of care include: clinical preventive care, primary care, emergency services, and long-term care and rehabilitative services. The initial focus of

1 these objectives was the interface between population-based interventions and clinical care. At the same
2 time, it is clear that interventions delivered by specialists and in hospital settings are also important to
3 achieving the overarching Healthy People 2010 goals of increasing years and quality of healthy life and
4 eliminating health disparities. We anticipate that additional objectives, addressing generic issues related to
5 the quality of tertiary services and specialty care, will be incorporated into Healthy People 2010 as the
6 science and available data improve.

7
8 Ensuring access to quality health care is one of four “enabling” goals proposed under Healthy People 2010
9 to further progress toward our overarching goals. Over the past two decades, major changes have occurred
10 in the structure of the American health care delivery system and in the roles of the Federal, State and local
11 governments in ensuring access to and quality of health care for all vulnerable and at-risk populations. The
12 planning for objectives under this priority area for Healthy People 2010 provides an opportunity to
13 establish consensus on long-term goals, as well as the outcomes and processes that can be used to monitor
14 our progress towards a health care delivery system that provides all members of our society with quality
15 prevention-focused health care.

16
17 The Healthy People 2000 Clinical Preventive Services Priority Area serves as the primary cornerstone for
18 the shift to services settings in a broader **continuum of care** in the Health Services Focus Area of Healthy
19 People 2010. Within the health services settings identified in the continuum, primary, secondary, and
20 tertiary preventive interventions are considered. The goal of access to primary care and the appropriate
21 preventive care services for all Americans continues hand-in-hand with assuring that all services provided
22 meet accepted standards of quality and are delivered in a high-quality, culturally competent setting by
23 culturally and linguistically competent health care providers.

24
25 Having adequate access to health care services can significantly influence patient use of the health care
26 system and, ultimately, improve health outcomes. Consequently, measures of access to care provide an
27 important mechanism for evaluating the quality of the Nation’s health care system. Limitations in access
28 to care extend beyond such simple causes as a shortage of health care providers or facilities in some areas.
29 Even where health care services are readily available, individuals may not have a usual source of care or
30 may experience multiple barriers to receiving services, such as financial (e.g., lack of insurance or being
31 underinsured), structural (e.g., lack of nearby facilities or necessary providers), and personal (e.g., cultural,
32 language, knowledge barriers, physical barriers for the handicapped.) In addition, populations with special
33 needs, such as the disabled, elderly, chronically ill, and HIV infected, require access to providers with the
34 requisite knowledge and skills to address their needs.^{2a}

35
36 One significant measure of the access problem is the proportion of people without health care coverage.
37 Since the development of the Healthy People 2000 objectives, the proportion of people without health care
38 coverage has increased. Those under 65 without health care coverage increased from 15.7 percent in 1989
39 to 17.4 percent in 1994. The Current Population Survey estimates that 41.7 million people had no health
40 insurance during all of 1996, up 1.1 million from the previous year.

41
42 Additionally, there are significant disparities among different racial and ethnic groups with regard to health
43 care coverage. Approximately 32.9 percent of Hispanics were without coverage, while 21.5 percent of
44 African Americans were without such coverage. On the other hand, the proportion of individuals with an
45 identified source of ongoing primary care (excluding the emergency room) rose during the past decade,
46 from a level of approximately 78 percent to 84 percent. A usual source of care is associated with improved
47 access to preventive services and followup care. Among low-income people, some 73 percent identified a
48 usual source of care.

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1 The issues of how to define, monitor, and assure health care quality have received extensive attention in
2 recent years. A wide variety of measures are currently being developed by sources at multiple levels,
3 including the national, State, local, and private sector levels. The National Committee on Quality
4 Assurance (NCQA) is a managed care accreditation group that is undertaking some of the most significant
5 work. They have led the effort to develop HEDIS (the Health Plan Employer Data and Information Set),
6 which is a widely used tool for evaluating health plan performance. The Health Care Financing
7 Administration (HCFA) has participated in the development of HEDIS measures, particularly those
8 measures designed for Medicare and Medicaid. HEDIS 3.0 includes Medicare and Medicaid measures.
9 The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) has developed
10 performance measures as well. In addition, the Agency for Health Care Policy and Research has
11 developed the Consumer Assessment of Health Plans Survey (CAHPS), which is an instrument that will be
12 used by a variety of organizations to assist in assessing consumer experiences with health plans.
13

14 In March 1997, the President appointed the Advisory Commission on Consumer Protection and Quality in
15 the Health Care Industry. The purpose of the Commission was to “advise the President on changes
16 occurring in the health care system and recommend measures as may be necessary to promote and assure
17 health care quality and value, and to protect consumers and workers in the health care system.”³ The
18 Commission focused its work in two areas. First, it established a Bill of Rights that describes what
19 consumers should expect from the health care system. The second phase of the Commission’s work
20 outlined the steps necessary to improve the quality of care delivered in this country. They recommended
21 improving quality measurement and reporting, facilitating the ability of consumers and purchasers to make
22 effective choices in the marketplace, and developing the tools and skills needed by the provider community
23 to improve the quality of care.
24

25 The Commission also recommended the creation of two national bodies to encourage and facilitate efforts
26 to improve quality. The first is a public sector Council on Health Care Quality, which would set national
27 aims for improvement and monitor our progress toward achieving those goals. The second is the Forum on
28 Quality Measurement and Reporting. It is to be organized in the private sector and is to establish a core set
29 of quality measures and effective reporting tools. Finally, to ensure that the Federal agencies with
30 responsibility for health care collaborate to improve care for Federal beneficiaries along the lines outlined
31 by the Commission, the President mandated the establishment of the Quality Interagency Coordinating
32 Task Force (QuIC). It has already begun work to establish a common set of measures and common
33 terminology to be used by Federal programs in describing and assessing the quality of care delivered.
34

35 The Clinical Preventive Services Priority Area of Healthy People 2000, written to address barriers to the
36 delivery of clinical preventive services, served as policy guidance for the development of national, State,
37 and local level strategies to achieve the third goal of *Healthy People 2000*: “Achieve access to preventive
38 services for all Americans.” The specific preventive services originally selected as the focus of the CPS
39 objectives and tracked by a variety of data methodologies refined and developed to measure the receipt of
40 those services were the preventive services recommended by the U.S. Preventive Services Task Force in its
41 1989 report: *Guide to Clinical Preventive Services: An Assessment of the Effectiveness of 169*
42 *Interventions*. The *Guide* was revised in 1995. The U.S. Preventive Services Task Force will be
43 reconvened in 1998 to update and expand recommendations for effective clinical preventive services.
44

45 Preceding the shift to services settings in a continuum of care, the Healthy People 2000 CPS objectives
46 took a multidimensional look at access to services for defined populations and subpopulations. Different
47 measures were selected for the provision of and the receipt of specifically recommended clinical preventive
48 services by defined populations and across clinical settings. One objective addressed access through the
49 proportion of the total population who reported having a specific source of ongoing primary care; another
50 objective approached access as the proportion of people with financial barriers to the receipt of specific,

1 recommended services—measured by proxy as the proportion of people without health care coverage or
2 insurance. Other measures of access included whether persons receiving health care services delivered by
3 a primary care provider are offered, at a minimum, the recommended CPS for their specific population and
4 risk group, the proportion of primary care providers who offer the recommended range of CPS to patients,
5 and the proportion of people eligible to receive services through publicly funded programs who are offered
6 the recommended CPS when seen in a publicly funded clinical setting.

7
8 Within the past decades, hand-in-hand with managed care strategies, there has been a significant increase
9 in national attention and emphasis on preventive services, health educational materials, and the role of the
10 client in adopting healthy behaviors. As the Nation approaches the end of the decade, dramatic changes in
11 the demographics of the population, the characteristics and numbers of higher risk populations, diminished
12 resources for publicly funded health care programs coupled with an increase in the demand for health care
13 services, and the emergence of managed care have made the implementation of a health care system built
14 on preventive services and the informed consumer an imperative. Within the evolving health care system
15 is the recognition that the health status outcome for the whole Nation will improve only as disparities in the
16 receipt of services between populations are reduced, then eliminated.

17
18 As the barriers to the delivery of CPS were better understood, PHS took an active role in driving the
19 changes necessary to diminish or eliminate barriers. HCFA worked to assign Current Procedural
20 Terminology (CPT) codes to selected preventive services so that providers were more adequately
21 reimbursed for services rendered; others developed ICD-9 Codes for preventive services previously
22 uncoded, to assure provider reimbursement. In every venue possible, tools were put into the hands of
23 primary care providers and their staffs to make it easier to determine the appropriate preventive service at
24 the recommended interval to be delivered to each patient.

25
26 Throughout the decade, however, Health Resources and Services Administration (HRSA) and the Centers
27 for Disease Control and Prevention (CDC), the co-lead agencies, have struggled with the need for better
28 national level data to track all of the CPS objectives. Where possible, existing surveys were expanded or
29 modified to include questions specific to tracking the objectives and, particularly, to provide data for the
30 receipt of services by special population groups—the most vulnerable and high-risk subpopulations. At
31 the 1995 Midcourse Review and Revision of Healthy People 2000, special population groups,
32 subpopulation groups, and special targets were routinely added where data were available and disparities
33 indicated. Objective 21.2 was expanded to show data for the receipt of individual vs. aggregated clinical
34 preventive services across population groups.

35
36 As the content of the Access to Quality Health Services Focus Area of Healthy People 2010 was
37 developed, the need to identify the most important medical and health care settings in which preventive
38 services can be and should be delivered came into clarity. As the changes under way in the American
39 health care system are better understood, and policy makers attempt to be proactive in planning for
40 projected changes, new objectives that address access to quality emergency services and to long-term care
41 and rehabilitative services are timely. The new objectives cover the following services settings in the
42 continuum of care.

43 44 ***Clinical Preventive Care***

45
46 Access to high-quality clinical preventive care is an integral component of quality health care, and it is
47 critical to achieving the goal of Healthy People 2010 of *eliminating disparities in health outcomes*.
48 Individual clinical preventive services, which include a range of immunizations, screening tests, and
49 counseling interventions, have been demonstrated to have a substantial impact on morbidity and mortality
50 from many of the leading causes of death. This discussion focuses on ensuring access to and quality of

1 those CPS that have been demonstrated to be effective in preventing disease (primary prevention) or
2 detecting asymptomatic disease or risk factors for disease at early, treatable stages (secondary prevention).
3 The recommendations of the U.S. Preventive Services Task Force,⁴ as in Healthy People 2000, serve as a
4 guide for services that should be included as a component of quality health care.

5
6 Improving access to appropriate preventive care requires addressing barriers that exist at multiple levels,
7 including those at the level of the patient, provider, and system of care.⁵ Important **patient barriers**
8 include lack of knowledge or skepticism about the importance of prevention, lack of a primary care
9 provider, and lack of financial resources to pay for preventive care. While patient awareness and
10 acceptance of some interventions such as mammography are high, other interventions (e.g., colorectal
11 cancer screening, STD screening, etc.) are less uniformly accepted. A small but important minority of
12 patients remain skeptical of even widely accepted preventive measures. Having health insurance, a higher
13 income, and a primary care provider are all strong predictors of receiving appropriate preventive care.
14 While reimbursement for common screening tests such as mammography and Pap smear are standard
15 under most insurance plans (and mandated by law in many States), reimbursement for effective counseling
16 interventions such as smoking cessation is less common.

17
18 Important **provider barriers** include lack of time, lack of training in prevention, lack of perceived
19 effectiveness, and practice environments that do not facilitate prevention. Although provider acceptance of
20 screening tests is generally high, there is greater skepticism about lifestyle counseling. A variety of
21 measures can serve as important “enabling” factors for providers in delivering necessary preventive care:
22 computerized or manual tracking systems, patient and clinician reminders, guidelines, patient information
23 materials, etc.⁶

24
25 Finally, **system barriers** can include lack of resources or attention devoted to prevention, lack of coverage
26 or inadequate reimbursement for services, and lack of systems to track performance in prevention.
27 Systems interventions that can increase delivery of CPS include offering CPS among standard covered
28 benefits, feedback on performance to providers and practices, incentives for improved performance, and
29 systems to identify and provide outreach to patients overdue for services.

30 *Primary Care*

31
32 As part of its study “Primary Care: America’s Health in a New Era,” the Institute of Medicine (IOM)
33 defined primary care as follows:

34
35
36 **Primary care is the provision of integrated, accessible health care services by clinicians who**
37 **are accountable for addressing a large majority of personal health care needs, developing a**
38 **sustained partnership with patients, and practicing in the context of family and**
39 **community.⁷**

40
41 The IOM report calls attention to several attributes of this definition:

- 42 • Integrated and accessible health care services;
- 43
- 44 • Clinicians are considered primary care providers based on the functions they perform rather than
45 strictly by virtue of discipline or specialty;
- 46
- 47 • Services provided by primary care clinicians—generally considered to be physicians, nurse
48 practitioners, and physician assistants—but involving a broader array of individuals in a primary care
49 team;

- Accountability of clinicians and systems for quality of care, patient satisfaction, efficient use of resources, and ethical behavior;
- The majority of personal health care needs, which include physical, mental, emotional, and social concerns;
- A sustained partnership between patients and clinicians; and primary care in the context of family and community.

Emergency Services

Emergency services are health care services that are needed or appear to be needed immediately because of injury or sudden illness that threatens serious impairment of any bodily function or serious dysfunction of any bodily organ or part.⁸ Prehospital emergency medical services (EMS), Poison Control Centers (PCCs), and hospital-based emergency departments (EDs) are the most commonly sought sources of emergency care. Each year, they provide prompt, first-contact care for millions of Americans regardless of their socioeconomic status, age, or special need. For many severely ill and injured persons, they are a crucial link in the chain of survival between symptom onset and definitive treatment in a hospital inpatient unit or operating room. For persons whose health problems are less pressing, but who believe they need urgent medical attention, they are an appropriate source of care and a gateway to additional health care services that may be needed.

What sets emergency services apart from other components of the health care delivery system are a unique scope of coverage and around-the-clock availability. The range of health problems addressed by emergency services includes not only obvious physical disease and injury but also undiagnosed conditions that often require rapid assessment and treatment. Most emergency services are provided in the EDs of acute care hospitals in conjunction with community-based, prehospital EMS. Within the current health care delivery system, EDs are the only institutional providers mandated by Federal law to evaluate anyone seeking care.⁹ They are expected at least to stabilize the most severely ill and injured patients, and they provide ambulatory care for vast numbers of people who face financial, attitudinal, or other barriers to receiving care elsewhere.

Although emergency services are widely available in the United States, they vary in accessibility and quality from region to region and, in many cases, from neighborhood to neighborhood.¹⁰ Financial pressures also threaten the viability of emergency services in some communities, which raises additional concerns about access to emergency care, particularly for medically underserved populations.¹¹ The objectives in this section focus on key opportunities to solve existing problems and maximize accessibility to high-quality emergency services. Because the promptness of emergency care determines many treatment outcomes, several objectives seek to assure a rapid response once an emergency condition is recognized. Other objectives seek to overcome technological, financial, or organizational barriers that can impede access to emergency services. Surmounting these barriers and optimizing emergency care accessibility and quality will require concerted effort by health care providers, health plans, and health care consumers as well as government agencies at all geopolitical levels.¹²

Long-Term Care and Rehabilitative Services

Objectives for long-term care and rehabilitative services cover persons with functional limitations regardless of age. Long-term care is health, personal care, and social services delivered over a sustained

1 period of time to persons who have lost or never acquired some degree of functional capability. People
2 who need long-term care have physical or mental conditions that limit their capacity for self care. The
3 population covers persons of all ages, from those who experienced physical or mental limitations at birth or
4 in their youth to those with diminishing functioning at older ages.¹³ About 40 percent are under age 65,¹⁴
5 and include members of the population who need the help or supervision of another person to perform
6 activities of daily living or instrumental activities of daily living. Activities of daily living are personal
7 care activities such as bathing, dressing, eating, toileting, transferring from bed to chair, and getting around
8 (with special equipment, if needed) inside the home. Instrumental activities for daily living are activities
9 that enable a person to live independently in the community such as preparing meals,
10 shopping, telephoning, taking medications, managing money, and performing light and heavy housework.
11

12 Long-term care services cover a continuum of health and social services delivered in institutions, the
13 community, and at home. The continuum includes **institutional services**, such as nursing homes,
14 rehabilitation hospitals, subacute care, hospice, and assisted living; **home-based services**, such as home
15 health and personal care, hospice, homemaker, and home delivered meals; and **community-based**
16 **services**, such as adult day care, social services, congregate meals, transportation and escort services, legal
17 protective services, and counseling for clients as well as their caregivers.¹⁵ The goals of services are either
18 to improve functioning through rehabilitative services, maintain existing functioning, or slow deterioration
19 in functioning, while delivering care in the least restrictive environment.
20

21 Rehabilitative services are defined as services to restore specific skills, including overall physical mobility
22 and functional abilities. The goal of rehabilitative services is to return individuals to their most optimal
23 level of functioning through various modes of therapeutic treatment.
24

25 **Progress Toward Year 2000 Objectives**

26
27 Of the eight Clinical Preventive Services objectives in Healthy People 2000, data are available for five of
28 the objectives to assess trends toward meeting the year 2000 targets. For two objectives (21.3 and 21.8),
29 data show progress toward achieving the year 2000 target, while trends are moving away from the targets
30 for two objectives (21.1 and 21.4). Trends are mixed for objective 21.2, a cross-population comparison of
31 the receipt of individual recommended CPS, including receipt by gender and age range where indicated,
32 rather than the receipt of an aggregated set of services. The comparative data effectively underlined the
33 extent of the disparity in the receipt of services between the total population and vulnerable, underserved
34 populations. As data for subpopulations were made available, the data points were added to the CPS data
35 tracking report.
36

37 For much of the decade, data beyond a baseline measure were not available for two objectives (21.5, 21.6),
38 and a third objective (21.7) was assigned a new baseline due to modifications in the survey. A summary of
39 the highlights of progress toward achieving the objectives follows:
40

- 41 • 21.1: Between 1990 and 1994, years of healthy life declined slightly, moving away from the target.
- 42
- 43 • 21.2: Trends were mixed for the receipt of individual services. The receipt of immunization services
44 increased across all immunizations, while the percentage of people 18 years and older getting a routine
45 checkup declined from 74 to 70 percent. All populations increased in receiving tetanus boosters and
46 influenza vaccine, as well as all but Asian/Pacific Islanders in receiving their pneumococcal vaccine.
47 Receipt of Pap tests increased across all populations, as did breast exam and mammograms. The
48 percentage of people being asked a screening question, however, remained steady or declined.
49

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- 1 • 21.3: The proportion of people with a specific source of ongoing primary care (excluding the
2 emergency room) increased for all populations reported, bringing several groups closer to the
3 populationwide target of 95 percent.
4
- 5 • 21.4: The proportion of people under age 65 without health care coverage increased by 2 percent, as
6 did the numbers of American Indians/Alaskan Natives, Hispanics, and Cubans reporting that they had
7 no health care coverage. Coverage increased slightly for Mexican-Americans, Puerto Ricans, and
8 African Americans.
9
- 10 • 21.5: Only baseline data are available for the delivery of CPS by publicly funded programs.
11
- 12 • 21.6: Only 1992 baseline data are available for provision of services by provider groups; a second,
13 revised survey from which data are not yet available was distributed in 1997.
14
- 15 • 21.7: A new baseline was established in 1992-93 for local health departments to track the delivery of
16 CPS in their jurisdictions and, where gaps exist, fill them. Trend data are not available at this time.
17
- 18 • 21.8: For graduates from health professions schools, the percentage of degrees awarded to African
19 Americans and American Indians/Alaska Natives increased; Hispanics declined slightly. Subobjective
20 21.8a shows the percentage of African Americans and Hispanics enrolling in nursing schools
21 decreased slightly, the percentage of American Asians/Pacific Islanders increased, and American
22 Indians/Alaskan Natives has held steady.
23

1 **Draft 2010 Objectives**

2
3 **A. Clinical Preventive Care**

4
5 *Goal: Assure Access to Appropriate Clinical Preventive Services*

6
7 **A.1 (Former 21.4) Reduce to 0 percent the proportion of children and adults under 65 without**
8 **health care coverage.** (Baseline: in first half of 1996, 19 percent of the general population under
9 age 65 lacked health care coverage*)

10

Select Populations	1996
African American	24.8%
American Indian/Alaska Native	Not available
Asian/Pacific Islander	Not available
Hispanic	35.1%
White	15.2%
Male	18.6%
Female	15.4%
Youth aged 0-17	15.4%
People aged 18-30	27-38%
People aged 30-65	15-19%
<100% poverty threshold	Not available
100-199% poverty threshold	Not available
≥200% poverty threshold	Not available
People with disabilities	Not available

11
12 * MEPS data from first half of 1996 for civilian noninstitutionalized population. Persons lacking
13 coverage by any type of private health insurance obtained through employment or purchased directly,
14 or health insurance provided through publicly funded programs, including Medicare, Medicaid,
15 CHAMPUS/CHAMPVA, or other public hospital/physician programs.

16
17 **Target Setting Method:** Retain year 2000 target.

18
19 **Data Sources:** Medical Expenditure Panel Survey (MEPS), AHCPR; NHIS, CDC, NCHS, for
20 special populations.

21
22 Lack of insurance remains a major determinant of access to necessary health services, including preventive
23 care,¹⁶ primary care, tertiary care, and emergency care.^{17,18} Uninsured patients are less than half as likely
24 to have a primary care provider, to have received appropriate preventive care such as recent mammograms
25 or Pap smears, or to have had any recent medical visits.¹⁹ Lack of insurance also affects access to care for
26 relatively serious medical conditions. There is evidence that lack of insurance over an extended period
27 significantly increases the risk of premature death and that mortality rates among hospitalized patients
28 without health insurance are significantly higher than among patients with insurance.²⁰ A recent study of
29 NHIS data has demonstrated that increases in the proportion of a State's population eligible for Medicaid
30 are associated with lower child mortality rates.²¹ The disparity in utilization of needed clinician services
31 between the insured and uninsured is particularly acute for those with chronic health problems.²²

1 **A.2 (Developmental) Increase the proportion of patients who have coverage for clinical**
2 **preventive services as part of their health insurance.**
3

Select Populations

African American	Not available
American Indian/Alaska Native	Not available
Asian/Pacific Islander	Not available
Hispanic	Not available
White	Not available
<100% of poverty threshold	Not available
100-199% of poverty threshold	Not available
≥200% of poverty threshold	Not available

4
5 **Note:** 1996 data in MEPS (due in 1998) will provide baseline data on coverage of selected
6 preventive services (well-child visits, immunizations, mammogram and cervical cancer screening,
7 adult physicals). MEPS data will be available annually on utilization of child immunizations,
8 mammograms, and cervical cancer. Data are collected every 5 years from policy booklets obtained
9 from participants and could be modified to collect information on a broader set of preventive
10 services. Recommended services to track would include childhood and adult immunizations;
11 recommended cancer screening (breast, cervix, and colon); smoking cessation counseling;
12 contraceptive services.

13
14 **Potential Data Source:** Medical Expenditure Panel Survey (MEPS), AHCPR.

15
16 **Alternate Sources:** OASPE (Foster-Higgins survey): 1997 employer survey of covered benefits
17 (11,000 small to large employers). Survey conducted annually, but preventive benefits component
18 would need specific funding to repeat it. AAHP survey of covered benefits in health plans (covers
19 roughly 80 percent of 160 million U.S. managed care patients).
20

21 Coverage for individual preventive services has improved over the last decade, but significant variations
22 exist in which services are covered, depending on plan and type of insurance. According to a 1988
23 national survey of employers, of all Americans with employer-sponsored health insurance, only 26 percent
24 were covered for adult physicals, 35 percent for well-child care (including immunizations), and 43 percent
25 for preventive screening tests. A 1996 national survey of over 1,000 mid- to large-size employers found
26 that 84 percent of employers offer coverage including well-baby care, 80 percent cover adult physicals, 78
27 percent cover gynecologic exams, and 52 percent cover cancer screening.²³ Including effective clinical
28 preventive services among the services routinely covered by insurance is an important way to further
29 increase the acceptance of clinical preventive services as an integral part of health care.²⁴ The Balanced
30 Budget Act of 1997 added colorectal cancer screening as a benefit under the Medicare program and
31 expanded Medicare coverage of mammography and cervical cancer screening. Although insurance
32 coverage is not by itself sufficient to eliminate existing gaps in delivery of preventive services,²⁵ it is an
33 important factor influencing who gets recommended services.²⁶ Selected clinical preventive services have
34 important impacts on health, and many are cost-effective in comparison to treatment of disease at later
35 stages.^{27,28} Reimbursement is especially problematic for counseling services, in part because of
36 uncertainty about the efficacy of some counseling interventions. The effectiveness of smoking cessation
37 counseling, however, is supported by strong evidence, and more intensive interventions have the greatest
38 impact and most favorable cost-effectiveness.²⁹ The U.S. Preventive Services Task Force will be
39 reconvened in 1998, and in conjunction with the work of AHCPR's Evidence-based Practice Centers
40 (EPCs), will provide additional evidence regarding the effectiveness of clinical preventive services.

1
2 **A.3.a (Former 21.2) Increase to 80 percent the proportion of patients who are routinely screened**
3 **about major lifestyle risk factors: diet, tobacco use, alcohol or drug use, exercise, sexual**
4 **practices/contraception.** (Baseline: in 1994, 56 percent reported being asked about any one of
5 these factors)
6

7 **A.3.b (Developmental) Increase the proportion of current smokers and problem drinkers who**
8 **report being counseled about smoking and alcohol use *at last visit* to their health care**
9 **provider.**
10

11 **Note:** This objective proposes modifying screening/counseling questions in NHIS HP Supplement
12 to distinguish general screening for risk factors among patients (old objective) and appropriate
13 *identification and counseling* of patients who have specific risk factors (smoking, hazardous
14 alcohol use). Proposed new questions (for persons reporting use of tobacco and alcohol): Has your
15 health care provider advised you to stop smoking? advised you to stop or reduce your use of
16 alcohol? Objective would track performance on each of the individual lifestyle screening questions
17 asked in NHIS (Current questions: During last checkup were you asked about: diet/eating habits;
18 physical activity/exercise; tobacco use; how much/how often use alcohol; drug use [under 65];
19 STDs [under 65]; contraceptive use [under 50]?).
20

21 **Target Setting Method:** Retain year 2000 target.
22

23 **Potential Data Source:** National Health Interview Survey (NHIS), CDC, NCHS.
24

25 Substantial gaps remain in the delivery of appropriate lifestyle screening and counseling services. NHIS
26 data and surveys of providers indicate that lifestyle interventions are delivered less frequently than other
27 screening interventions (e.g., cancer screening). Unhealthy diets, smoking, lack of physical activity, and
28 alcohol use account for a majority of preventable deaths in the U.S.,³⁰ and there is now good evidence that
29 brief clinician counseling interventions are effective for both smoking cessation³¹ and reducing problem
30 drinking.³² In addition, more intensive dietary counseling can lead to reductions in dietary fat, reductions
31 in cholesterol, and increased consumption of fruits and vegetables.³³ Effective interventions to increase
32 physical activity have been more difficult to identify. Although some objectives relating to provider
33 counseling behavior are included in other priority areas, this objective uses reports of patients to track the
34 overall attention to lifestyle issues using population-based data in NHIS.
35

1 *Goal: Assure Quality and Accountability in Delivery of Clinical Preventive Services*
2

3 **A.4 (Developmental/Former 21.7) Increase the collection and reporting of information on**
4 **delivery of recommended clinical preventive services, by provider group, health plan, health**
5 **system, and payer status.**
6

7 **Note:** Measuring objective with total population as numerator (e.g., proportion of patients cared
8 for within systems that report such data) would be difficult. Objective could track proportion of
9 individual organizations (e.g., health plans, community clinics) within each category that report
10 such data.
11

12 **Potential Data Sources**

Medicare (HMO)	HEDIS measures ³⁴
Medicare (FFS)	PRO quality initiatives, administrative data
Medicaid (child)	EPSTD
Medicaid (adult)	Medicaid Statistical Information Systems
Veterans Administration	Veteran's Health Survey
Military—TRICARE	Pending
Local Health Departments	National Profile of Local Health Departments, National Association of County and City Health Officials
Managed Care	HEDIS, Quality Compass (NCQA)
Fee-for-Service (non-Medicare)	No data source identified

13
14 Significant progress in the delivery of CPS is unlikely without appropriate data systems to allow providers
15 and administrators to identify those services and populations most in need of better delivery. Ideally,
16 information systems would allow both cross-sectional comparisons of performance by providers, plans,
17 systems and localities and longitudinal analysis of individuals to identify those overdue for necessary
18 services. A substantial body of evidence suggests that audit and feedback to individual providers and
19 groups can improve rates of immunization and screening tests, but this is a challenge outside of centralized
20 health systems with stable populations. Even in those systems, tracking of individuals has been employed
21 effectively for only a limited number of services, primarily immunizations and cancer screening.³⁵
22 Measuring how well preventive care is provided under different systems is an essential first step to
23 motivating those systems that are not performing well to develop the information, tools, and incentives to
24 improve care.
25

26 **A.5 (Developmental) Increase the proportion of physicians, physician assistants, nurses, and**
27 **other clinicians who receive appropriate training to address important health disparities:**
28 **disease prevention and health promotion, minority health, women's health, geriatrics.**
29

30 **Potential Data Sources:** Physicians: Association of American Medical Colleges Medical School
31 Graduation Questionnaire—annual survey of graduating medical students. (Baseline 1997: 77
32 percent rated time devoted to health promotion/ disease prevention at least “adequate”; 85 percent
33 rated time devoted to screening for disease “adequate” or better.) Nurses: No current data source
34 identified. Other surveys have assessed curricular content with respect to gender issues in health,
35 but appropriate data sources to assess adequacy of education and training in minority health and
36 geriatrics need to be identified.
37

38 Medical curricula have undergone substantial changes over the past decade, and further improvements
39 could equip clinicians to address more fully the goals of Healthy People 2010. Although provider
40 awareness of effective screening tests has increased over the past decade, attitudes and skills related to

1 preventive services continue to vary based on specialty, training, and practice setting. “Inadequate
2 training” continues to contribute to inadequate delivery of recommended services, particularly lifestyle
3 counseling by clinicians. “Perceived efficacy of counseling” is strongly correlated with the delivery of
4 health promotion messages about diet, exercise, and smoking—i.e., providers who do not regularly offer
5 lifestyle counseling commonly cite their belief that they cannot effectively counsel patients to change
6 behavior. Given the growing evidence that even brief clinician counseling can reduce major behavioral
7 risk factors such as smoking and problem drinking, clinicians (especially physicians) need better training
8 on how to incorporate lifestyle advice and prevention in general into routine practice.
9

10 **B. Primary Care**

11
12 *Goal: Assure Access to Primary Care Services*
13

14 **B.1 (Former 21.3) Increase to at least 95 percent the proportion of people who have a specific** 15 **source of ongoing primary care.** (Baseline: 84 percent of adults 18 years and over in 1994) 16

Select Populations	1994
African American	82%
American Indian/Alaska Native	81%
Asian/Pacific Islander	78%
Hispanic	71%
Mexican American	69%
White	Not available
Persons with low income	73%

17 18 **B.1.a Increase to at least 95 percent the proportion of children 18 years and under who have a** 19 **specific source of ongoing primary care (i.e., a medical/health home).** (Baseline: 91 percent 20 of persons 18 years and under in 1995) 21

Select Populations	1995
African American	88%
American Indian/Alaska Native	88%
Asian/Pacific Islander	89%
Hispanic	84%
White	Not available
Male	91%
Female	91%
At or above poverty threshold	93%
Below poverty threshold	86%
Limited in activity	86%
Not limited in activity	91%

22
23 **Data Sources:** National Health Interview Survey (NHIS), CDC, NCHS; Medical Expenditure
24 Panel Survey (MEPS), AHCPR, provides an additional data source.
25

26 Access to care depends in part on access to an ongoing source of primary care. Persons with a usual source
27 of health care have been shown to be more likely than those without a usual source of care to receive a
28 variety of preventive health care services.^{36,37}
29

1 Depending on the data source, 16 to 18 percent of the population does not have a usual source of care.
2 Thus, more than 40 million Americans had no particular doctor's office, clinic, health center, or other
3 place that they would usually go if they were to seek or needed advice about their health care. Emergency
4 rooms have not been counted as a usual source of care.

5
6 A new subobjective has been added to determine the proportion of children 18 years and under who have a
7 specific source of ongoing primary care. Given the passage and implementation of the State Children's
8 Health Insurance Program, there is particular interest in whether the proportion of children with an
9 ongoing source of care (i.e., a medical/health home) increases.

10
11 According to 1996 MEPS data, among those who did have a usual source of care, 88 percent had an office-
12 based provider and 11 percent had a hospital outpatient department or clinic as their usual source of care.³⁸

13
14 Americans' usual source of care can vary among groups with different demographic and health-related
15 characteristics, including age, race/ethnicity, perceived health status, health insurance coverage, and place
16 of residence:

- 17
18 • Age: Young children and elderly adults are more likely than adults aged 18 to 64 to have a usual
19 source of care. Young adults aged 18 to 24 were more likely than any other age group to lack a usual
20 source of care.
- 21
22 • Race/ethnicity: Among racial/ethnic groups, Hispanics were the least likely to have a usual source of
23 care. Almost 30 percent of Hispanics lacked a usual source of care, compared to 18 percent of African
24 Americans and 16 percent of the total population. Among those who had a usual source of care,
25 African Americans and Hispanics were more likely to have hospital-based providers (including
26 hospital clinics and outpatient departments) as their usual source of care.
- 27
28 • Health Insurance Coverage: Persons under age 65 who are uninsured are substantially more likely to
29 lack a usual source of care (38 percent) than those who had either public or private insurance. When
30 compared with their counterparts who had private health insurance, persons under age 65 who were
31 uninsured were 2.6 times more likely to lack a usual source of care.

32
33 **B.2 Reduce to no more than 7 percent the proportion of individuals/families who report that**
34 **they did not obtain all of the health care that they needed.** (Baseline: 11.6 percent in 1996)

35

Select Populations	1996
African American	9.9%
American Indian/Alaska Native	Not available
Asian/Pacific Islander	Not available
Hispanic	15.1%
White	11.4%
Any family member in fair or poor health	17.9%
All family members in excellent to good health	9.9%
All members private insurance	7.0%
All members public insurance	12.2%
All members uninsured	27.1%

36
37 **Data Source:** Medical Expenditure Panel Survey (MEPS), AHCPR; data are based on self-
38 reporting.
39

1 This presents a different approach to measuring access. This measure is based on respondents' perceptions
2 of whether they have been able to obtain all of the care they believe is necessary.³⁹ It also attempts to get
3 at underlying reasons why individuals did not receive the care they thought they needed. The 1996 MEPS
4 reported that 12.8 million families (11.6 percent of U.S. families) experienced difficulty or delay in
5 obtaining care or did not receive needed health care services for a variety of reasons. In addition to a lack
6 of insurance or underinsurance, barriers include lack of appropriate referrals; travel distance to provider;
7 lack of transportation; and availability of specialists. The target has been set at 7 percent to match the level
8 of families in which all members have private insurance. Among families that experienced barriers to care,
9 a variety of reasons were cited:

- 11 • 59.9 percent cited inability to afford health care.
- 12
- 13 • 19.5 percent cited insurance-related reasons as the main obstacle to receiving needed health care.
14 These reasons included their insurance company not approving, covering, or paying for care; having
15 preexisting conditions (for which insurance coverage is often restricted); referrals being required but
16 unobtainable; and clinicians refusing to accept the family's insurance plan.
- 17
- 18 • The remaining 20.7 percent of families experienced a variety of other problems receiving health care,
19 including transportation problems, physical barriers, communication problems, child care limitations,
20 lack of time or information, or refusal of services.⁴⁰

21

22 The 1994 National Access to Care Survey, sponsored by the Robert Wood Johnson (RWJ) Foundation,
23 suggests that some studies have missed substantial components of unmet need by failing to include specific
24 questions about supplementary health care services such as prescription drugs, eyeglasses, dental care, and
25 mental health care or counseling—services less likely to be covered by private insurance.⁴¹ When specific
26 questions were added about these services, the findings show that 16.1 percent of respondents
27 (approximately 41 million Americans) were unable to obtain at least one service they believe they needed.
28 The highest reported unmet need was for dental care. This problem can be partly attributed to insufficient
29 provider reimbursement leading to lack of participation in plans even when the service is covered—e.g.,
30 EPSDT.

1 **B.3 Reduce the proportion of persons who report being in fair or poor health but who have no**
2 **primary care visits during the previous year to no more than 8 percent.** (Baseline: 10
3 percent of adults 18 years and over in 1995)
4

Select Populations	1995
African American	12%
American Indian/Alaska Native	14%
Asian/Pacific Islander	9%
Hispanic	17%
Cuban	16%
Mexican American	20%
Puerto Rican	9%
White	Not available
At or above poverty threshold	9%
Below poverty threshold	12%

5
6 The 1994 RWJ survey had earlier estimated that 4.5 million people reported being in fair or poor
7 health, with no physician visit during the year.
8

9 **Data Source:** National Health Interview Survey (NHIS), CDC, NCHS.
10

11 This is a less frequently used measure of access. The potential objective focuses on groups that consider
12 themselves in fair or poor health, yet who still did not have a physician visit. It may represent a group that
13 definitely should have seen a physician, but for one reason or another did not have such a visit. The target
14 was set by reducing the proportion to a level slightly lower (8 percent) than the group with the lowest
15 proportion (9 percent) of persons in fair or poor health who do not have a primary care visit during the
16 previous year.
17

18 **B.4 Reduce by 50 percent the number of individuals lacking access to a primary care provider**
19 **in underserved areas.** (Baseline: estimated 43 million people lacked access to a primary care
20 provider in underserved areas in 1997)
21

Proportion in urban areas	51% (22 million)
Proportion in rural areas	46% (21 million)

22 **Data Source:** The Bureau of Primary Health Care Shortage Designation database provides
23 estimates of the number of people who lack access to a primary care provider in underserved areas;
24 HRSA.
25

26 Shortage designations are based on the evaluation of shortage/underservice criteria established by
27 regulation to qualify either geographic areas or population groups as having a shortage of primary care
28 providers. There are two types of shortage designations:
29

- 30 • Health Professional Shortage Area (HPSA) designation, which is a prerequisite to apply for National
31 Health Service Corps assistance.
32
- 33 • Medically underserved areas/populations (MUA/Ps) designation, which is a prerequisite to grant
34 awards to plan or operate a community health center.
35

1 Other Federal programs also use these shortage designations. The Health Care Financing Administration,
2 for example, gives a 10 percent bonus for Medicare-reimbursable physician services provided within
3 geographic HPSAs. The population in both HPSAs and MUAs (unduplicated count) totals 72 million.
4 Subtracting out the population served by existing primary care providers yields a remaining population of
5 43 million. This is because most underserved areas have some, but not enough, primary care providers. It
6 is currently estimated that the primary care programs of the Health Resources and Services Administration
7 serve 10.3 million of the 43 million who do not otherwise have access to a primary care provider, leaving a
8 balance of 33 million. The target would then be to reduce that 33 million by 50 percent, or 16.5 million,
9 through a variety of Federal, State and local efforts. Currently, the primary care physician-to-population
10 ratio is the major factor in designating primary medical care HPSAs. An area can be designated if it has a
11 ratio of 1 primary care physician for every 3,500 people. The ratio can be lowered to 1:3,000 in the
12 presence of high need, illustrated by factors such as poverty and infant mortality.

13
14 MUA/Ps are based on an index of four factors: Primary care physician-to-population ratio, proportion of
15 population under the Federal poverty level, proportion of population aged 65 years or over, and the infant
16 mortality rate. The factors are weighted relatively equally, and a score of 62 out of a possible 100 points is
17 required for designation.

18
19 **B.5 (Former 21.8) Increase the proportion of all degrees in the health professions and allied and**
20 **associated health professions fields awarded to members of underrepresented racial and**
21 **ethnic minority groups as follows:**
22

Degrees Awarded to	1993-94 Baseline	2010 Target
African Americans	5.9%	8.0%
American Indians/Alaska Natives	0.4%	0.6%
Hispanics	4.3%	6.4%

23
24 **Note:** Underrepresented minorities are those groups consistently below parity in most health
25 profession schools—African Americans, Hispanics, and American Indians and Alaska Natives.
26

27 **B.5.a (Former 21.8a) Increase the proportion of individuals from underrepresented racial and**
28 **ethnic minority groups enrolled in U.S. schools of nursing as follows:**
29

Proportion Enrolled in Fall Academic Year	1993-94 Baseline	2010 Target
African American	8.7%	10%
American Indian/Alaska Native	0.7%	1%
Asian/Pacific Islander	3.3%	5%
Hispanic	3.0%	4%

30
31 **Note:** Enrollment figures shown to be statistically predictive of graduating rates.
32

33 **Data Source:** Bureau of Health Professions, HRSA.
34

35 Minority and disadvantaged communities lag behind the U.S. population on virtually all health status
36 indicators. Furthermore, among the poor, minorities, and the uninsured, access to health care continues to
37 be a problem. Increasing the number of minority health professionals is viewed as a partial solution to
38 improving access to care.
39

40 Some 25 percent of the U.S. population is from underrepresented minorities, and this percentage is
41 expected to grow significantly over the next decade. Yet the proportion of underrepresented practitioners is

1 in the range of 10 percent. Several studies have shown that underrepresented minority health profession
2 graduates are more likely to enter primary care specialties and to voluntarily practice in or near designated
3 primary care health professions shortage areas.

4
5 Despite considerable efforts to increase the number of minorities in health professional and allied and
6 associated health professions schools, the percentage of minority entrants, enrollees, and graduates has not
7 advanced significantly and in some cases not at all. The targets set for Healthy People 2000 were not
8 achieved, and achieving them by 2010 will continue to present a significant challenge. Additional
9 attention will need to be given to such efforts as financial assistance for minority students to pursue health
10 care degrees; mentor relationships; early recruitment; and increasing minority faculty and administrative
11 staff in schools that train health care professionals.

12
13 *Goal: Improve Quality of Primary Care Delivery*

14
15 **B.6 Reduce preventable hospitalization rates by 25 percent for chronic illness for three**
16 **ambulatory care sensitive conditions—pediatric asthma, immunization-preventable**
17 **pneumonia and influenza in the elderly, and diabetes—by improving access to high-quality**
18 **primary care services.** (Baseline: Pediatric asthma, 23.9 admissions per 10,000 population under
19 age 18 years; Immunization-preventable pneumonia and influenza in the elderly, 11.2 admissions
20 per 10,000 population aged 65 years or older; Diabetes, 9.7 admissions per 10,000 population
21 aged 18 years or older)

22
23 **Note:** Ambulatory Care Sensitive Conditions

24 Pediatric asthma: denominator age <18 years, exclude newborns

25 Immunization-preventable pneumonia in the elderly: pneumococcal pneumonia and
26 influenza, denominator age >65

27 Diabetes: related to suboptimal glucose control (includes uncontrolled diabetes, diabetic
28 ketoacidosis, hyperosmolar coma), denominator age >18

29
30 **Data Source:** The Health Care Cost and Utilization Project (HCUP), managed by AHCPR,
31 contains a hospital inpatient discharge database that includes 100 percent of hospitals and 100
32 percent of discharges from 19 States. A nationally representative sample of hospitals has been
33 drawn from this that can be used to derive nationally representative estimates for the U.S.
34 population.

35
36 **Other Data Sources:** Approximately 40 States maintain hospital discharge databases.

37
38 Results from the analysis of 1995 HCUP-3 data are consistent with prior literature and show significant
39 variation in admission rates for all three indicators by geography, income, insurance status, and
40 race/ethnicity. For example, individuals with private insurance have admission rates (as defined above) of
41 15.5 for pediatric asthma and 4.2 for uncontrolled diabetes, 35 percent and 57 percent less than the overall
42 population, respectively. In California, African Americans have admission rates of 67.7 for pediatric
43 asthma and 19.0 for uncontrolled diabetes, while the admission rate for whites for pediatric asthma is 16.1
44 and for uncontrolled diabetes is 6.2. The elderly residing in zip codes with median annual household
45 incomes of \$25,000-35,000 have admission rates for preventable pneumonia of 22.3 compared to 5.1 for
46 the elderly residing in zip codes with a median income >\$45,000.

47
48 Comprehensive primary care services for chronic illness can reduce the morbidity associated with these
49 illnesses. Hospital admission for “ambulatory care sensitive conditions” serves as a marker for both
50 impaired access to primary care and suboptimal quality of primary care delivered. Disparities in admission

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1 rates for vulnerable population subgroups have been well documented. A study by the Institute of
2 Medicine found that residents of low-income zip codes had admission rates that were 5.8 times higher for
3 asthma and 4.1 times higher for short-term complications of diabetes than residents of high-income zip
4 codes. They concluded that ACS rates could be used to monitor national objectives in access to care and
5 recommended that States that do not have centralized discharge databases should develop them.
6

7 The three indicators selected here represent common problems encountered in primary care and allow
8 monitoring for children (asthma), the elderly (pneumonia and influenza), and the general population
9 (diabetes). These conditions were chosen because reduction in the burden of illness from these conditions
10 can best be obtained by coordination of community preventive services, public health interventions,
11 clinical preventive services and primary care. For each of these conditions there is evidence that
12 interventions can reduce hospitalization rates. For example, significant advances have been made in the
13 ambulatory management of asthma. Primary care interventions can reduce admission rates in vulnerable
14 populations. Preventable pneumonia and influenza are a cause of avoidable morbidity and mortality
15 among the elderly. Underuse of pneumococcal and influenza vaccines in this population has been well
16 documented. An individual with Type 2 diabetes may remain asymptomatic for many years, and many with
17 this disorder remain undiagnosed. Risk factor modification may delay the onset or prevent development of
18 Type 2 diabetes. Adequate primary care can prevent problems associated with poor control of diabetes and
19 retard the long-term complications of the condition.
20

21 While factors in addition to access and quality also influence admission rates (prevalence of disease,
22 comorbidities, physician practice style, psychosocial factors, hospital bed supply), it has been shown that
23 disparities in preventable hospitalization persist after controlling for prevalence of underlying conditions,
24 health care seeking behavior, and physician practice style. In addition, disparities exist even in States with
25 relatively low rates of admission for these conditions. The fact that sociodemographic characteristics also
26 influence admission rates indicates that integration of clinical and public health interventions will be
27 needed to reduce preventable hospitalizations in underserved populations.⁴²⁻⁴⁶
28

29 Interventions that improve both access to and quality of care in population groups at high risk for avoidable
30 hospitalizations and coordination of these efforts with community-based public health activities have the
31 potential to reduce the disparities identified here. The national target for a 25 percent reduction in
32 avoidable hospitalizations for these conditions was chosen based on current disparities based on income
33 status, and it is felt this reduction can be achieved through targeting these high-risk populations. Because
34 multiple factors in addition to access and quality contribute to the admission rates for ambulatory care
35 sensitive conditions, each State will need to examine its rates and interpret them in the context of
36 population, health system, and community characteristics and implement strategies that build on an
37 understanding of local factors. The objective is to reduce the need for admission, and therefore the
38 morbidity and costs associated with hospitalization, through improved primary care and preventive
39 services.
40

41 (Note: If this indicator is retained, national rates stratified by income and insurance status and overall rates
42 and rates stratified by race/ethnicity for the five States (CA, FL, NY, MO, SC) will be provided together
43 with guidelines for interpretation. National estimates for race/ethnicity cannot be derived as 20 percent of
44 States in HCUP-3 do not provide data on race.)
45

1 **C. Emergency Services**
2

3 *Goal: Assure Access to Timely Emergency Services*
4

5 **C.1 (Developmental) Increase to at least 90 percent the proportion of all individuals who have**
6 **access to rapidly responding prehospital emergency medical services (EMS). (Defined in**
7 **urban areas as a response time of less than 9 minutes between initiation of an emergency**
8 **call and arrival of EMS on the scene for 90 percent of such calls. Defined in rural areas as**
9 **availability of EMS within 40 miles of the place where an emergency call is initiated).**

10
11 The outcome of many medical emergencies depends on the prompt availability of appropriately trained and
12 properly equipped prehospital emergency medical care providers. While not every emergency call requires
13 this prompt response, the EMS system must be capable of delivering it when necessary. Assuring a
14 prompt response requires a well-coordinated system of care and involves a variety of organizations and
15 agencies, some of which are outside the traditional health care arena. The components of a rapidly
16 responding EMS system include public awareness of how and whom to call for emergency assistance and
17 public education concerning initial, lifesaving emergency care procedures to be followed until the arrival
18 of EMS providers; access via a 9-1-1 or enhanced 9-1-1 system, including, in rural areas, a uniform
19 addressing system that allows emergency responders to locate quickly the person requesting emergency
20 assistance; availability of well-trained and appropriately certified response personnel, who are frequently
21 law enforcement or fire services; transportation (ground, air, or water ambulance); medical direction and
22 oversight; and destination hospitals that are well-equipped and appropriately staffed.

23
24 Timeliness of responses or distances traveled are indicative of State and local EMS capacity, and standard-
25 setting bodies have established separate benchmarks for urban and rural areas.^{47,48} However, wide
26 variation in EMS record keeping practices limits the extent to which data describing response times and
27 distances can be compared to the established indicators. In an effort to foster more uniform EMS data, the
28 National Highway Traffic Safety Administration has developed a consensus data set that has been
29 incorporated into EMS databases in at least 19 States.^{49,50} Adoption of this data set by EMS agencies
30 throughout the United States would facilitate use of available benchmarks to monitor EMS responses.⁵¹
31

32 **C.2 (Developmental) Increase to ___ percent the proportion of patients whose access to**
33 **emergency services when and where they need them is unimpeded by their insurance status**
34 **or by their health plan's coverage or payment policies.**
35

36 As well as the barriers to the needed use of emergency services by individuals with no or inadequate health
37 insurance coverage, increasing numbers of individuals enrolled in managed care plans have found that
38 many health plans use coverage and payment policies to control their enrollees' access to hospital
39 emergency departments (EDs) and, in some instances, their use of prehospital emergency services.⁵²
40 Typically these health plans stipulate that unless an enrollee's condition is life threatening, the enrollee or
41 the ED must obtain authorization from a plan gatekeeper prior to an ED visit or risk a claims denial for
42 services provided. Some health plans also retroactively deny claims for ED visits that they deem medically
43 unnecessary. The rationale for these coverage and payment policies is clear: health plans seek to manage
44 care and contain costs. However, health plan gatekeeping requirements discourage some enrollees from
45 receiving emergency treatment when and where it is warranted.⁵³ Mounting concerns about access barriers
46 prompted the President's Advisory Commission on Consumer Protection and Quality in the Health Care
47 Industry to include access to emergency services in its November 1997 Consumer Bill of Rights and
48 Responsibilities.⁵⁴ The Advisory Commission recommended that health plans should provide payment
49 when their enrollees present to an ED with acute symptoms of sufficient severity—including severe pain—

1 such that a prudent layperson could reasonably expect the absence of medical attention to result in serious
2 jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

3
4 National uniform data sets and standardized methods for collecting and analyzing data are needed to
5 monitor ED access. Data collected on gatekeeping contacts between EDs and health plans as well as data
6 on the timeliness of care and patient outcomes could be aggregated centrally and used to track this
7 objective. Recommended data elements for ED record systems and health plan authorization systems are
8 available.^{55,56}

9
10 **C.3 Establish a single toll-free telephone number for access to Poison Control Centers on a 24-**
11 **hour basis throughout the United States.** (Baseline: as of early 1998, 12 of 74 Poison Control
12 Centers in the United States share a single toll-free telephone number: 1-800 POISON1)

13
14 **Data Source:** American Association of Poison Control Centers Survey of U.S. Poison Centers.

15
16 Poison Control Centers are staffed on a 24-hour basis by toxicologists and specialists in poison information
17 who respond to requests from the general public and health care professionals for immediate information
18 and treatment advice about poisonings and toxic exposures. The primary access to these services is
19 through a local or toll-free telephone call to a PCC hotline number, and each year more than 2 million
20 callers seek telephone assistance from PCCs throughout the United States.⁵⁷ When a caller reports a
21 poisoning or toxic exposure, a PCC toxicologist or specialist in poison information assesses the severity of
22 the incident, advises the caller about treatment, and makes referrals for further medical attention only when
23 necessary. PCCs manage most incidents by providing telephone advice to a caregiver at home, obviating
24 the need for more costly care at a hospital emergency department or another health care facility.

25
26 As valuable as PCCs are to the public's health, the viability of many PCCs is threatened by reduced
27 financial support from State and local governments and community hospitals.⁵⁸ Linking all PCCs in the
28 United States through a single toll-free telephone number can facilitate access to PCC services and foster
29 cost-effective consolidation of several key PCC functions.^{59,60} When PCCs are linked through a common
30 telephone number, callers can automatically be routed to the nearest PCC based on their area code,
31 telephone exchange number, and zip code. Awareness of how to access PCCs stands to increase as
32 educational efforts are focused on a single emergency number. As the new number becomes common
33 knowledge, callers will access PCCs more quickly, and fewer calls would be misdirected. Incorporating all
34 PCCs under the umbrella of a toll-free nationwide telephone number will help assure access to poison
35 control services when and where they are needed.

1 *Goal: Assure Appropriate, High-Quality Emergency Care*
2

3 **C.4 (Developmental) Assure access to time-sensitive care for individuals with symptoms and**
4 **signs of an acute myocardial infarction or who have a witnessed out-of-hospital cardiac**
5 **arrest.**
6

7 **C.4.a Increase to at least ___ percent the proportion of eligible patients with acute myocardial**
8 **infarction who receive clot-dissolving therapy within an hour of symptom onset.**
9

10 **Potential Data Source:** National Registry of Myocardial Infarction or the Health Care Financing
11 Administration's Cardiovascular Cooperative Project.
12

13 **C.4.b Increase to ___ percent the proportion of persons with witnessed, out-of-hospital cardiac**
14 **arrest who receive their first therapeutic electrical shock within 10 minutes of collapse**
15 **recognition.**
16

17 Early access to emergency health care services is a critical determinant of outcomes for victims of both
18 acute myocardial infarction (AMI) and out-of-hospital cardiac arrest. For AMI, a key factor is minimizing
19 the elapsed time from symptom onset to restoration of coronary artery blood flow, which is often
20 accomplished by administering a clot-dissolving medication (thrombolytic agent) to patients who meet the
21 eligibility criteria for receiving this treatment. The greatest reduction in death rates and heart muscle
22 damage from AMI occurs when patients are treated early with these medications, especially within an hour
23 of symptom onset.⁶¹ For witnessed out-of-hospital cardiac arrest, a key factor is minimizing the time from
24 collapse recognition to delivery of a short burst of electrical current (defibrillatory shock) aimed at
25 restoring a spontaneous and productive heart rhythm. Ventricular fibrillation is the chaotic and ineffective
26 heart rhythm found most frequently in survivors of out-of-hospital cardiac arrest, and early defibrillatory
27 shock is the intervention that is most responsible for their survival.⁶² Although bystander cardiopulmonary
28 resuscitation (CPR) is clearly beneficial, it is only temporizing and loses its value if defibrillation does not
29 rapidly follow.
30

31 Despite evidence that treatment effectiveness depends on rapid delivery times, only a minority of
32 individuals who can benefit from a thrombolytic agent or defibrillatory shock are treated early enough to
33 achieve maximal therapeutic effects.^{63,64} The public health challenge is to develop and maintain programs
34 that facilitate more rapid identification and treatment of individuals with AMI and out-of-hospital sudden
35 cardiac arrest.
36

37 *Goal: Increase Access to Emergency Care That Meets the Special Needs of Children in the Prehospital*
38 *and Hospital Settings*
39

40 **C.5.a. Increase to 50 the number of State EMS agencies that have pediatric protocols for both**
41 **online medical direction of emergency medical technicians (EMTs) and paramedics at the**
42 **scene of an emergency and overall medical direction in the development of written pediatric**
43 **protocols, medical policies, and guidelines. (Baseline: 11 States in 1997)**
44

44 **Data Source:** Emergency Medical Services for Children Annual Grantees Survey, HRSA.

45 **C.5.b Increase to 50 the number of States that have adopted and disseminated pediatric guidelines**
46 **that categorize acute care facilities with the equipment, drugs, trained personnel, and**
47 **facilities necessary to provide varying levels of pediatric emergency and critical care.**
48 **(Baseline: 18 States in 1997)**
49

49 **Data Source:** Emergency Medical Services for Children Annual Grantees Survey, HRSA.

1
2 Emergency care for life-threatening pediatric illness and injury requires specialized resources, medical
3 direction, equipment, drugs, trained personnel, and properly staffed and equipped hospitals.⁶⁵ Most EMS
4 systems operate independently of hospitals or other facilities and typically with few physicians to ensure
5 appropriateness of care. Stricter medical direction is needed in pediatric cases as compared to adult cases
6 owing to the much more limited experience and assessment skills that prehospital care providers have in
7 pediatrics. Medical direction operates in two ways: online direction involves direct communication (e.g.,
8 voice) with emergency medical technicians (EMTs) and paramedics to authorize and guide their care of
9 patients at the scene and during transport. Offline medical direction includes planning, training,
10 evaluation, and development of guidelines, protocols, procedures, and policies.⁶⁶

11
12 Hospitals vary in terms of their readiness to treat children's emergencies.⁶⁷ Children can frequently
13 receive the care that they need at local hospitals, if properly equipped and staffed, but some require the
14 more advanced care available only at regional specialty centers. Categorization is essentially an effort to
15 identify the readiness and capability of a hospital and its staff to provide optimal emergency care.⁶⁸
16 Compliance can be voluntary or assigned by official agencies.

17
18 *Goal: Assure Access to Followup Mental Health Services for Persons Treated in Emergency Departments*

19
20 **C.6 Increase to 75 percent the number of hospital emergency departments that provide or**
21 **arrange followup mental health services for persons treated for mental health problems,**
22 **including self-destructive behavior.** (Baseline: in 1995-1996, of persons seen in emergency
23 departments for self-destructive behavior or for mental illness (ICD-9-CM range 290-315), 35.6
24 percent were referred to another physician or clinic)

25
26 **Data Source:** National Hospital Ambulatory Medical Care Survey (NHAMCS), Emergency
27 Department Component, 1995-96, CDC, NCHS.

28
29 Psychiatric and behavioral emergencies are a growing concern, including psychoses and suicidal behavior.
30 Such emergencies place a special burden on the emergency response system. The overall mental health
31 resources are inadequate and linkages are often lacking. Thus, patients with acute behavioral emergencies
32 are often simply treated for physical problems and released, or at best kept in emergency departments and
33 acute care inpatient facilities that may be ill-prepared to care properly for them. Linkages need to be made
34 and, where they are missing, appropriate mental health services developed.

35 36 *D. Long-Term Care and Rehabilitative Services*

37
38 *Goal: Improve Quality of Assessment for Persons with Long-Term Care Needs*

39
40 **D.1 (Developmental) Increase the proportion of primary care providers who routinely provide a**
41 **functional assessment to potential long-term care patients or refer them for a functional**
42 **assessment.**

43
44 **Note:** A functional assessment is an assessment of activities of daily living, instrumental activities
45 of daily living, dementia, depression, other mental disorders, incontinence; the availability of
46 supports (including caregivers and special equipment); and the care preferences of the client and
47 the family. Based on the functional assessment, a plan of care is developed to maximize the
48 independence of the long-term care client.

49 **Potential Data Source:** Primary Care Providers Survey, ODPHP.

1
2 An assessment that covers all aspects of functioning is critical to the members of the long-term care
3 population.⁶⁹ Information from a multidimensional assessment of activities of daily living and
4 instrumental activities of daily living is necessary to achieve the goals of long-term care to improve,
5 maintain, or slow the deterioration in functioning. Such an assessment is essential to developing a plan of
6 care appropriate to the specific needs of the long-term care client,⁷⁰ a plan that integrates care from the
7 formal and informal care systems and provides care in the least restrictive environment.
8

9 **D.2 (Developmental) Increase the proportion of primary care providers who routinely evaluate,**
10 **treat, and, if appropriate, refer their long-term care patients to subacute rehabilitative and**
11 **other services, to address:**

- 12 • **Physical mobility**
- 13 • **Urinary incontinence**
- 14 • **Polypharmacy (taking multiple prescription and over-the-counter drugs that may have**
15 **adverse interactions)**
- 16 • **Communication and hearing disorders**
- 17 • **Depression**
- 18 • **Dementia**
- 19 • **Mental disorders, including alcoholism and substance abuse**

20
21 **Potential Data Source:** Primary Care Providers Survey, OPDHP. Household Component of
22 MEPS could be modified.
23

24 This developmental objective is based on Healthy People 2000 objective 17.17, which focused on the
25 delivery of care to the general population. This developmental objective differs from objective 17.17 in
26 that it focuses specifically on the long-term care population and on conditions and functional limitations
27 that are common to this population.⁷¹ For example, urinary incontinence is often a consequence of
28 limitations in the ability to transfer from bed to chair. Polypharmacy often occurs in the long-term care
29 population due to their treatments from multiple care providers who use drug therapy to address a
30 combinations of chronic physical and mental conditions.⁷²
31

32 *Goal: Assure Access to the Continuum of Long-term Care Services*
33

34 **D.3 (Developmental) Assure that every person with long-term care needs has access to the**
35 **continuum of long-term care services, especially:**
36

- 37 • **Nursing home care**
- 38 • **Home health care**
- 39 • **Adult day care**
- 40 • **Assisted living**

41
42 **Note:** Proportion of persons with long-term care needs (need help with two or more activities of
43 daily living) who report problems with access, defined as needing but not receiving the specified
44 long-term care services in the past 12 months.
45

46 **Potential Data Sources:** National Long-Term Care Survey, Medicare Current Beneficiary
47 Survey, HCFA; National Health Interview Survey (NHIS), CDC, NCHS; and Medical Expenditure
48 Panel Survey (MEPS), AHCPR.
49

1 Because of the diverse care needs of the long-term care population, a continuum of care from institutional
2 to home to community settings is essential. Long-term care crosses the boundaries among types of care—
3 from health to social—and among intensity of services—from round-the-clock subacute care to periodic
4 home health and homemaker visits. Access to the continuum of long-term care services continues to be a
5 problem because of financial barriers and the limited availability of specific services.^{73,74} While the long-
6 term care population and their caregivers prefer long-term care to be delivered in the least restrictive care
7 environment, limited access and limited knowledge about care options can result in a long-term care
8 population that is more dependent than necessary. The long-term care services along the continuum of care
9 were selected to cover key services in institutions, in the home, and in the community.

10
11 *Goal: Improve Quality of Long-Term Care Services*

12
13 **D.4 (Developmental) Reduce to no more than ___ per 1,000 the proportion of nursing home**
14 **residents with pressure ulcers at stage 2 or greater.**

15
16 **Potential Data Source:** Long-Term Care Minimum Data Set in all Medicare and Medicaid
17 certified nursing homes. These data are available at the State level. National Nursing Home
18 Survey (NNHS) and the Medical Expenditure Panel Survey-Nursing Home Component could be
19 modified.

20
21 Pressure ulcers have long been recognized as a serious quality of care problem in nursing homes.^{76,77}
22 Because the prevention of pressure ulcers depends on close observation and good nursing care, measuring
23 the incidence of pressure ulcers could serve as a proxy for the overall quality of care provided to nursing
24 home residents. The population at risk for pressure ulcers in nursing homes is significant. About 24
25 percent of the Nation's 1.4 million nursing home residents require the assistance of another person to
26 transfer from bed to chair (1995 data). Recently, there have been a number of guidelines on the prevention
27 and treatment of pressure ulcers. The Agency for Health Care Policy and Research developed guidelines⁷⁸
28 that were adapted for long-term care facilities by the American Medical Directors Association.

29
30 **Related Objectives From Other Focus Areas**

31
32 **Physical Activity and Fitness**

33 14 Clinician counseling about physical activity

34
35 **Nutrition**

36 18 Nutrition assessment and planning

37 19 Nutrition counseling

38
39 **Tobacco Use**

40 10 Advice to quit smoking

41 12 Providers advising smoking cessation

42 13 Physician inquiries about secondhand smoke

43
44 **Educational and Community-Based Programs**

45 3 Undergraduate health risk behavior information

46 7 Patient satisfaction with health care provider communication

47 8 Patient and family education

48 12 Elderly participation in community health promotion

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Environmental Health

26 Environmental and environmental health information systems

Injury/Violence Prevention

23 Hip fractures
28 Nonfatal poisoning
29 Deaths from unintentional poisoning
32 Injury prevention counseling

Oral Health

8 Stage I oropharyngeal cancer lesions
12 Screening/counseling for 2-year-olds
13 Screening, referral, treatment for first-time school program children
17 Exams and services for those in long-term care facilities
19 State-based surveillance system

Family Planning

1 Planned pregnancy
2 Repeat unintended births
3 Contraceptive use, females
6 Male involvement in family planning
11 Pregnancy prevention education

Maternal, Infant, and Child Health

9 Preconception counseling
11 Quality of prenatal care
12 Serious developmental disabilities
21 Alcohol use during pregnancy
22 Tobacco use during pregnancy
23 Drug use during pregnancy
24 Fetal alcohol syndrome
31 Newborn screening
33 Newborn hearing screening
34 Training in genetic testing
37 Primary care services for babies 18 months and younger
38 Screening for vision, hearing, speech, and language impairments
39 Service systems for children with chronic and disabling conditions

Medical Product Safety

6 Provider review of medications taken by patients
7 Complementary and alternative health care
8 Safety-related labeling changes

Public Health Infrastructure

2 Training in essential public health services
3 Continuing education and training by public health agencies
6 Access to public health information and surveillance data

- 1 **Health Communication**
2 2 Centers for excellence
3 4 Satisfaction with health information
4 7 Health communication/media technology curricula
5
6 **Arthritis, Osteoporosis, and Chronic Back Conditions**
7 3 Personal care limitations (arthritis)
8 7 Failure to see a doctor for arthritis
9 13 Counseling about prevention, 13 and over (osteoporosis)
10 14 Counseling about prevention, women 50 and over (osteoporosis)
11 15 Activity limitations (chronic back conditions)
12
13 **Cancer**
14 9 Provider counseling about preventive measures
15 10 Pap tests
16 11 Colorectal screening examination
17 12 Oral, skin, and digital rectal examinations
18 13 Breast examination and mammogram
19 14 Physician counseling of high-risk patients
20
21 **Diabetes**
22 3 Diagnosis of diabetes
23 18 Controlled blood pressure
24
25 **Heart Disease and Stroke**
26 1 Coronary heart disease deaths
27 4 Provider counseling about early warning symptoms of heart attack
28 6 High blood pressure
29 7 Controlled high blood pressure
30 9 Blood pressure monitoring
31 12 Blood cholesterol screening
32 15 Knowledge of early warning symptoms of stroke
33 16 Provider counseling about early warning symptoms of stroke
34
35 **HIV**
36 4 Screening for STDs and immunization for hepatitis B
37
38 **Immunization and Infectious Diseases**
39 1 Vaccine-preventable diseases
40 21 Immunization of children 19-35 months
41 22 States with 90 percent immunization coverage
42 23 Immunization coverage for children in day care, kindergarten, and first grade
43 24 Immunizations among adults
44 30 2-year-olds receiving vaccinations as part of primary care
45 31 Provider measurement of immunization coverage levels
46 32 Immunization registries
47

1 **Mental Health and Mental Disorders**

- 2 10 Provider training in screening for mental health problems in children
3 11 Provider training in addressing mental health problems in young children
4 12 Provider review of patients' cognitive, emotional, and behavioral functioning
5 13 Primary care provider assessment of mental health of children
6 15 Access to mental health services
7 16 Children's access to mental health services
8 17 Comparability of mental health and physical health care coverage
9 18 Children with mental health insurance

10
11 **Respiratory Diseases**

- 12 7 Continuing medical education (asthma)
13 9 Counseling on early signs of worsening asthma
14 16 Culturally competent care: Chronic Obstructive Pulmonary Disease (COPD)
15 17 Training in early signs of COPD

16
17 **Sexually Transmitted Diseases**

- 18 14 Reimbursement for treatment of partners of STD patients
19 17 Screening for genital chlamydia
20 18 Screening of pregnant women
21 19 Screening in youth detention facilities and jails
22 22 Reimbursement for counseling on reproductive health issues
23 23 Provider counseling during initial visits

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25 **Substance Abuse**

- 26 19 Screening and treatment of patients 60 and older
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28 **References**

- 29 1. Millman, M., ed. Institute of Medicine (IOM). *Access to Health Care in America*, Washington, D.C.,:
30 National Academy Press, 1993.
31 2. Lohr, K.N., ed. IOM. *Medicare: A Strategy for Quality Assurance*, Volume I. Washington, DC: National
32 Academy Press, 1990.
33 2a. Bierman, A.S. *Journal of Ambulatory Care Management* 21(3):17-26, 1998.
34 3. Advisory Commission on Consumer Protection and Quality in the Health Care Industry. *Consumer Bill of*
35 *Rights and Responsibilities - Report to the President*. Washington, DC: Advisory Commission, November
36 1997.
37 4. U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services, 2nd Edition*. Baltimore, MD:
38 Williams and Wilkins, 1996.
39 5. Thompson, R.S.; Taplin, S.H.; McAfee, T.A.; et al. Primary and secondary prevention services in clinical
40 practice. Twenty years' experience in development, implementation, and evaluation. *JAMA* 273:1130-1135,
41 1995.
42 6. Ibid.
43 7. Donaldson, M.; et al., eds. IOM. *Primary Care: America's Health in a New Era*. Washington, DC: National
44 Academy Press, 1996.
45 8. Advisory Commission, op. cit.
46 9. Josiah Macy, Jr. Foundation. The role of emergency medicine in the future of American medical care:
47 Summary of the conference. *Annals of Emergency Medicine* 25:230-233, 1995.
48 10. Ibid.
49 11. Tranquada, RE. Emergency medical care and the public purse. *JAMA* 276:945-946, 1996.
50 12. Advisory Commission, op. cit.
51 13. Kane, RA. and Kane, RL. *Principles, Programs, and Policies*. New York: Springer, 1987.

Healthy People 2010 Objectives: Draft for Public Comment

- 1 14. Wiener, J.; Illston, L.H.; Hanley, A.J. *Sharing the Burden*. Washington, DC: The Brookings Institution, 1994.
- 2 15. Kane and Kane, op. cit.
- 3 16. Centers for Disease Control and Prevention. Health insurance coverage and receipt of preventive health
4 services-United States, 1993. *MMWR* 44:219-225, 1995.
- 5 17. Weissman, J.S. and Epstein, A.M. The insurance gap: Does it make a difference? *Annual Review of Public*
6 *Health* 14:243-270, 1993.
- 7 18. U.S. General Accounting Office. *Health Insurance: Coverage Leads to Increased Health Care Access for*
8 *Children*. GAO/HEHS-98-14. Washington, DC: General Accounting Office, 1998.
- 9 19. Centers for Disease Control and Prevention, op. cit.
- 10 20. Reinhardt, U.E. Coverage and access in health care reform. *New England Journal of Medicine* 330:1452-1453,
11 1994.
- 12 21. Currie, J. and Gruber, J. Health insurance eligibility, utilization of medical care, and child health. *Quarterly*
13 *Journal of Economics*, May 1996.
- 14 22. Hafner-Eaton, C. Physician utilization disparities between the uninsured and insured: comparisons of the
15 chronically ill, acutely ill, and well nonelderly populations. *JAMA* 269:787-792, 1993.
- 16 23. Hay Group. *1996 Hay/Huggins Benefits Report*. Philadelphia, PA: Hay/Huggins, 1997.
- 17 24. Davis, K.; Bialek, R.; Parkinson, M.; Smith, J.; Vellozzi, C. Paying for preventive care: Moving the debate
18 forward. *American Journal of Preventive Medicine* 64 (suppl.):7-30, 1990.
- 19 25. Faust, H.S. Strategies for obtaining preventive services reimbursement. *American Journal of Preventive*
20 *Medicine* 64 (suppl.):1-5, 1990.
- 21 26. Hopkins, R.S. Insurance coverage and usage of preventive health services. *Journal of the Florida Medical*
22 *Association* 80:529-532, 1993.
- 23 27. U.S. Preventive Services Task Force, op. cit.
- 24 28. Tengs, T.O.; Adams, M.E.; Pliskin, J.S.; Safran, D.G.; Siegel, J.E.; Weinstein, M.C.; Graham, J.D.
25 Five-hundred life-saving interventions and their cost-effectiveness. *Risk Analysis* 15:369-390, 1995.
- 26 29. Cromwell, J.; Bartosch, W.J.; Fiore, M.C.; Hasselblad, V.; Baker, T. Cost-effectiveness of the clinical practice
27 recommendations in the AHCPR guideline for smoking cessation. *JAMA* 278:1759-1766, 1997.
- 28 30. McGinnis, J.M.; Foege, W.H. Actual causes of death in the United States. *JAMA* 270:2207-2212, 1993.
- 29 31. Fiore, M.C.; Bailey, W.C.; Cohen, S.J.; et al. *Smoking Cessation. Clinical Practice Guideline No. 18*. AHCPR
30 publication no. 96-0692. Rockville, MD: U.S. Department of Health and Human Services, Agency for Health
31 Care Policy and Research (AHCPR), 1996.
- 32 32. U.S. Preventive Services Task Force, op. cit.
- 33 33. Ibid.
- 34 34. National Committee for Quality Assurance (NCQA). Health Plan Employer Data and Information Set (HEDIS
35 3.0). Washington, DC: NCQA, 1997.
- 36 35. Thompson, et al., op. cit.
- 37 36. Ettner, S.L. The timing of preventive services for women and children: the effect of having a usual source of
38 care. *American Journal of Public Health* 86:1748-1754, 1996.
- 39 37. Moy, E.; Bartman, B.A.; Weir, M.R. Access to hypertensive care: effects of income, insurance, and source of
40 care. *Archives of Internal Medicine* 155(14):1497-1502, 1995.
- 41 38. Weinick, R.M.; Zuvekas, S.H.; Drilea, S.K. *Access to Health Care—Sources and Barriers, 1996*. MEPS
42 Research Findings No. 3. AHCPR publication no. 98-0001. Rockville, MD: Agency for Health Care Policy
43 and Research, 1997.
- 44 39. Berk, M.L. and Schur, C.L. Measuring access to care: Improving information for policymakers. *Health Affairs*
45 17(1): 180-186.
- 46 40. Weinick, Zuvekas, and Drilea, op cit.
- 47 41. Berk, M.L.; Schur, C.L.; Cantor, J.C. Ability to obtain health care: Recent estimates from the RWJF National
48 Access to Care Survey. *Health Affairs* 139-146, Fall 1995.
- 49 42. Billings, J.; Anderson, G.M.; Newman, L.S. Recent findings on preventable hospitalizations. *Health Affairs*
50 15(3), 239-249, 1996.
- 51 43. Billings, J.; Zeitel, L.; Lukomnik, J.; Carey, T.S.; Blank, A.E.; Newman, L. Impact of socioeconomic status on
52 hospital use in New York City. *Health Affairs* 12(1), 162-173, 1993.
- 53 44. Bindman, A.B.; Grumbach, K.; Osmond, D.; Komaromy, M.; Vranizan, K.; Lurie, N.; Billings, J.; Stewart, A.
54 Preventable hospitalizations and access to health care. *JAMA* 274(4), 305-311, 1995.
- 55 45. Millman, op. cit.

Healthy People 2010 Objectives: Draft for Public Comment

- 1 46. Weissman, J.S.; Gatsonis, C.; Epstein, A.M. Rates of avoidable hospitalization by insurance status in
2 Massachusetts and Maryland. *JAMA* 268(17), 2388-2394, 1992.
- 3 47. Commission on Accreditation of Ambulance Services (CAAS). *Standards for the Accreditation of Ambulance*
4 *Services*. Waukegan, IL: CAAS, 1993.
- 5 48. Health Care Financing Administration. 42 CFR, Parts 410 and 424:Medicare Program; Ambulance Services.
6 *Federal Register* 62:32715-32733, 1997.
- 7 49. National Highway Traffic Safety Administration (NHTSA). *Uniform Pre-Hospital Emergency Medical*
8 *Services Data Conference Final Report*. Springfield, VA: National Technical Information Service, 1994.
- 9 50. Desmond, J. Use of National Highway Traffic Safety Administration uniform out-of-hospital data elements in
10 Statewide EMS databases. *Academic Emergency Medicine* 4:419, 1997.
- 11 51. NHTSA. *EMS Agenda for the Future*. DOT HS 808 441. Washington, DC: NHTSA, 1996.
- 12 52. Young, C.J. Emergency! Says who?: Analysis of the legal issues concerning managed care and emergency
13 medical services. *Journal of Contemporary Health Law & Policy* 13:553-579, 1997.
- 14 53. Young, G.P. and Lowe, R.A. Adverse outcomes of managed care gatekeeping. *Academic Emergency Medicine*
15 4:1129-1136, 1997.
- 16 54. Advisory Commission, op. cit.
- 17 55. National Center for Injury Prevention and Control. Data Elements for Emergency Department Systems, Release
18 1.0. Atlanta, GA: Centers for Disease Control and Prevention, 1997.
- 19 56. Kongstvedt, P.R. Authorization systems. In: Kongstvedt, P.R. *The Managed Health Care Handbook, Third*
20 *Edition*. Gaithersburg, MD: Aspen Publishers, 1996. pp. 469-478.
- 21 57. Litovitz, T.L.; Smilkstein, M.; Felberg, L.; et al. 1996 annual report of the American Association of Poison
22 Control Centers: Toxic Exposure Surveillance System. *American Journal of Emergency Medicine* 15:447-500,
23 1997.
- 24 58. Kearney, T.E.; Olson, K.R.; Bero, L.A.; et al. Health care cost effects of a regional poison control center.
25 *Western Journal of Medicine* 165:499-504, 1995.
- 26 59. Zuvekas, A.; Nolan, L.S.; Azzouzi, A.; Tumaylle, C.; Ellis, J. *An Analysis of Potential Economies of Scale in*
27 *Poison Control Centers: Final Report*. Washington, DC: Center for Health Policy Research, Georgetown
28 University Center, 1997.
- 29 60. Poison Control Center Advisory Work Group. *Final Report*. Atlanta, GA and Rockville, MD: National Center
30 for Injury Prevention and Control, Centers for Disease Control and Prevention, and Maternal and Child Health
31 Bureau, Health Resources and Services Administration, 1997.
- 32 61. National Heart Attack Alert Program Coordinating Committee, 60 Minutes to Treatment Working Group.
33 Emergency department: Rapid identification and treatment of patients with acute myocardial infarction. *Annals*
34 *of Emergency Medicine* 23:311-329, 1994.
- 35 62. Cummins, R.O. Emergency medical services and sudden cardiac arrest: The "chain of survival" concept.
36 *Annual Review of Public Health* 14:313-333, 1993.
- 37 63. Advisory Commission, 1996, op. cit.
- 38 64. Josiah Macy, Jr. Foundation, op. cit.
- 39 65. Institute of Medicine, Committee on Pediatric Emergency Medical Services. Durch, J.S. and Lohr, K.N., eds.
40 *Emergency Medical Services for Children*. Washington, DC: National Academy Press, 1993
- 41 66. Ibid.
- 42 67. U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and
43 Child Health Bureau. *5 Year Plan: Emergency Medical Services for Children, 1995-2000*. Washington, DC:
44 Emergency Medical Services for Children National Resource Center, 1995.
- 45 68. American Academy of Pediatrics. Guidelines for pediatric emergency care facilities. *Pediatrics* 96:526-537,
46 1995.
- 47 69. Estes, C.L. and Swann, J.H. *The Long Term Care Crisis*. Newbury Park, CA: Sage, 1993.
- 48 70. Robert Wood Johnson Foundation. *Chronic Care in America: A 21st Century Challenge*. Princeton, NJ:
49 Robert Wood Johnson Foundation, 1996.
- 50 71. Kane, R.A. and Kane, R.L. *LTC: Principles, Programs and Policies* Springer, New York 1987
- 51 72. Havens, B. and Beland, F. eds. Long term care in five countries. *Canadian Journal on Aging* 15(suppl. 1),
52 1996.
- 53 73. Wiener, Illston, and Hanley, op. cit.
- 54 74. Estes and Swann, op. cit.
- 55 75. Spector, W. and Fortinsky, W. Pressure ulcer prevalence in Ohio nursing homes. *Journal of Aging and Health*

Healthy People 2010 Objectives: Draft for Public Comment

- 1 10(1):62-80, 1998.
2 76. Ibid.
3 77. Spector, W. Correlates of pressure sores in nursing homes: Evidence from the National Medical Expenditure
4 Survey. *Journal of Investigative Dermatology* 102(6):425-455, 1994.
5 78. The Pressure Ulcer Guideline Panel. *Treating Pressure Ulcers: Guideline Technical Report, No. 15, Volumes 1*
6 *and 2*. AHCPR publication no. 96-N014. Rockville, MD: AHCPR, 1996.