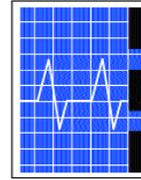


Southern Extension Health Institute

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Rural Health Institute

Goal

The Southern Region Health Institute is designed to provide Extension agents with a unique opportunity to be an active participant in an intensive state-of-the-art training program related to health. It is designed to provide participants with an increased understanding of:

- ❖ health systems,
- ❖ Extension's role in health, and
- ❖ tools and strategies for working with individuals, families and communities on health issues.

Who Are We?

- ❖ Introductions

What Is Health?

- ❖ WHO definition
- ❖ Whole people and quality of life issues

Who Is Involved?

- ❖ Health care providers
- ❖ Health care consumers
- ❖ Citizens and officials
- ❖ Community members/leaders/employers
- ❖ Individuals/families
- ❖ Third party payers

What Is a Health System?

- ❖ Healthcare delivery
- ❖ Private vs. public
- ❖ Federal, state, community
- ❖ Managed care
- ❖ Health education
- ❖ Disease prevention, early detection, diagnosis and treatment
- ❖ Social/Environmental support for healthy habits, mental health, healthy growth and development
- ❖ Community health determinants
- ❖ Healthcare reimbursement

Why Are We Here?

- ❖ What is community?
 - ◆ Activity: Gordian Knot

The Historical Perspective: How Did We Get to this Place in Time?

- ❖ Public health

- ❖ Sanitation
- ❖ Hill-Burton Act
- ❖ Medical discoveries/technology
- ❖ Health care financing

Cultural Perspectives

- ❖ Ways of knowing, believing, behaving
- ❖ Health communications
- ❖ Bad experiences/trust
- ❖ Traditional vs. modern vs. alternative/complementary medicine

Community Health Determinants

- ❖ Disparities within community
- ❖ Maintaining and developing the infrastructure
- ❖ Maintaining a healthy population (RWJ wording/logic)
- ❖ Video of women in health coalition (SALIC)
- ❖ National Initiatives for Health
- ❖ Extension Healthy People, Healthy Communities
- ❖ Healthy People 2010
- ❖ CYFAR National Network for Health
- ❖ Rural vs. Urban

Extension's Roles

There are provider-driven elements, individual health issues, official policies, and consumer-driven elements in the health system. Extension's role in community health is primarily that of facilitator to bring the elements together for a strategic process resulting in healthier people and communities:

- ❖ Balanced, non-biased information related to current community, state and national health issues and
- ❖ Research-based education and skills training for identified populations on individual health concerns.

National Health Status: Healthy People 2010

To completely understand the health status of a population, it is essential to monitor and evaluate the consequences of the determinants of health.

The health status of the United States is a description of the health of the total population using information that is representative of most people living in this country. For relatively small population groups, however, it may not be possible to draw accurate conclusions about their health using current data collection methods. The goal of eliminating health disparities will necessitate improved collection and use of standardized data to correctly identify disparities among select population groups.

Health status can be measured by birth and death rates, life expectancy, quality of life, morbidity from specific diseases, risk factors, use of ambulatory care and inpatient care, accessibility of health personnel and facilities, financing of health care, health insurance coverage, and many other factors. The information used to report health status comes from a variety of sources, including birth and death records, hospital discharge data, and health information collected from health care records, personal interviews, physical examinations and telephone surveys. These measures are monitored on an annual basis in the United States and are reported in a variety of publications, including *Health, United States and Healthy People Reviews*.

The leading causes of death are frequently used to describe the health status of the nation. The nation has seen a great deal of change over the past 100 years in the leading causes of death. At the beginning of the 1900s, infectious diseases ran rampant in the United States and worldwide and topped the leading causes of death. A century later, with the control of many infectious agents and the increasing age of the population, chronic diseases top the list.

A very different picture emerges when the leading causes of death are viewed for various subgroups. Unintentional injuries, mainly motor vehicle crashes, are the fifth leading cause of death for the total population, but they are the leading cause of death for people aged 1 to 44 years. Similarly, HIV/AIDS is the 14th leading cause of death for the total population but the leading cause of death for African American men aged 25 to 44 years.

The leading causes of death in the United States generally result from a mix of behaviors; injury, violence and other factors in the environment; and the unavailability or inaccessibility of quality health services. Understanding and monitoring behaviors, environmental factors and community health systems may prove more useful to monitoring the nation's true health, and in driving health improvement activities, than the death rates that reflect the cumulative impact of these factors. This approach has served as the basis for developing the Leading Health Indicators.

Healthy People 2010 Goals

Goal 1: Increase Quality and Years of Healthy Life

The first goal of Healthy People 2010 is to help individuals of all ages increase life expectancy and improve their quality of life.

Life Expectancy

Life expectancy is the average number of years people born in a given year are expected to live based on a set of age-specific death rates. At the beginning of the 20th century, life expectancy at birth was 47.3 years. Fortunately,

life expectancy has dramatically increased over the past 100 years. Today, the average life expectancy at birth is nearly 77 years.

Life expectancy for persons in every age group has also increased during the past century. Based on today's age-specific death rates, individuals aged 65 years can be expected to live an average of 18 more years, for a total of 83 years. Those aged 75 years can be expected to live an average of 11 more years, for a total of 86 years.

Differences in life expectancy between populations, however, suggest a substantial need and opportunity for improvement. At least 18 countries with populations of one million or more have life expectancies greater than the United States for both men and women.

There are substantial differences in life expectancy among different population groups within the United States. For example, women outlive men by an average of 6 years. White women currently have the greatest life expectancy in the United States. The life expectancy for African American women has risen to be higher today than that for white men. People from households with an annual income of at least \$25,000 live an average of 3 to 7 years longer, depending on gender and race, than people from households with annual incomes of less than \$10,000.

Quality of Life

Quality of life reflects a general sense of happiness and satisfaction with our lives and environment. General quality of life encompasses all aspects of life including health, recreation, culture, rights, values, beliefs, aspirations, and the conditions that support a life containing these elements. Health-related quality of life reflects a personal sense of physical and mental health and the ability to react to factors in the physical and social environments. Health-related quality of life is inherently more subjective than life expectancy and, therefore, can be more difficult to measure. Some tools, however, have been developed to measure health-related quality of life.

- ❖ Global assessments, in which a person rates his or her health as "poor," "fair," "good," "very good," or "excellent," can be reliable indicators of a person's perceived health. In 1996, 90 percent of people in the United States reported their health as good, very good or excellent.
- ❖ Healthy days is another measure of health-related quality of life that estimates the number of days of poor physical and mental health in the past 30 days. In 1998, 82 percent of adults reported having no days in the past month where poor physical or mental health impaired their usual activities. The proportions of days that are reported "unhealthy" are the

result more often of mentally unhealthy days for younger adults and physically unhealthy days for older adults.

- ❖ Years of healthy life is a combined measure developed for the Healthy People initiative. The difference between life expectancy and years of healthy life reflects the average amount of time spent in less than optimal health because of chronic or acute limitations. After decreasing in the early 1990s, years of healthy life increased to a level in 1996 that was only slightly above that at the beginning of the decade (64.0 years in 1990 to 64.2 years in 1996). During the same period, life expectancy increased a full year.
- ❖ As with life expectancy, various population groups can show dramatic differences in quality of life. For example, people in the lowest income households are five times more likely to report their health as fair or poor than people in the highest income households (see figure 3). A higher percentage of women report their health as fair or poor compared to men. Adults in rural areas are 36 percent more likely to report their health status as fair or poor than are adults in urban areas.

Achieving a Longer and Healthier Life - The Healthy People Perspective

Healthy People 2010 seeks to increase life expectancy and quality of life over the next 10 years by helping individuals gain the knowledge, motivation and opportunities they need to make informed decisions about their health. At the same time, Healthy People 2010 encourages local and state leaders to develop community and statewide efforts that promote healthy behaviors, create healthy environments, and increase access to high-quality health care. Given the fact that individual and community health are virtually inseparable, it is critical that both the individual and the community do their parts to increase life expectancy and improve quality of life.

Goal 2: Eliminate Health Disparities

The second goal of Healthy People 2010 is to eliminate health disparities among different segments of the population.

These include differences that occur by gender, race or ethnicity; education or income; disability; living in rural localities; or sexual orientation. This section highlights ways in which health disparities can occur among various demographic groups in the United States.

Gender

Whereas some differences in health between men and women are the result of biological differences, others are more complicated and require greater attention and scientific exploration. Some health differences are obviously gender specific, such as cervical and prostate cancers.

Overall, men have a life expectancy that is 6 years less than women and have higher death rates for each of the 10 leading causes of death. For example, men are two times more likely than women to die from unintentional injuries and four times more likely than women to die from firearm-related injuries. Although overall death rates for women may currently be lower than for men, women have shown increased death rates over the past decade in areas where men have experienced improvements, such as lung cancer. Women are also at greater risk for Alzheimer's disease than men and twice as likely as men to be affected by major depression.

Race and Ethnicity

Current information about the biologic and genetic characteristics of African Americans, Hispanics, American Indians, Alaska Natives, Asians, Native Hawaiians, and Pacific Islanders does not explain the health disparities experienced by these groups compared with the white, non-Hispanic population in the United States. These disparities are believed to be the result of the complex interaction among genetic variations, environmental factors and specific health behaviors.

Even though the nation's infant mortality rate is down, the infant death rate among African Americans is still more than double that of whites. Heart disease death rates are more than 40 percent higher for African Americans than for whites. The death rate for all cancers is 30 percent higher for African Americans than for whites; for prostate cancer, it is more than double that for whites. African American women have a higher death rate from breast cancer despite having a mammography screening rate that is higher than that for white women. The death rate from HIV/AIDS for African Americans is more than seven times that for whites; the rate of homicide is six times that for whites.

Hispanics living in the United States are almost twice as likely to die from diabetes than are non-Hispanic whites. Although constituting only 11 percent of the total population in 1996, Hispanics accounted for 20 percent of the new cases of tuberculosis. Hispanics also have higher rates of high blood pressure and obesity than non-Hispanic whites. There are differences among Hispanic populations as well. For example, whereas the rate of low-birth-weight infants is lower for the total Hispanic population compared with whites, Puerto Ricans have a low-birth-weight rate that is 50 percent higher than that for whites.

American Indians and Alaska Natives have an infant death rate almost double that for whites. The rate of diabetes for this population group is more than twice that for whites. The Pima of Arizona have one of the highest rates of diabetes in the world. American Indians and Alaska Natives also have disproportionately high death rates from unintentional injuries and suicide.

Asians and Pacific Islanders, on average, have indicators of being one of the healthiest population groups in the United States. However, there is great diversity within this population group, and health disparities for some specific groups are quite marked. Women of Vietnamese origin, for example, suffer from cervical cancer at nearly five times the rate for white women. New cases of hepatitis and tuberculosis are also higher in Asians and Pacific Islanders living in the United States than in whites.

Income and Education

Inequalities in income and education underlie many health disparities in the United States. Income and education are intrinsically related and often serve as proxy measures for each other. In general, population groups that suffer the worst health status are also those that have the highest poverty rates and least education. Disparities in income and education levels are associated with differences in the occurrence of illness and death, including heart disease, diabetes, obesity, elevated blood lead level, and low birth weight. Higher incomes permit increased access to medical care, enable one to afford better housing and live in safer neighborhoods, and increase the opportunity to engage in health-promoting behaviors.

Income inequality in the United States has increased over the past three decades. There are distinct demographic differences in poverty by race, ethnicity and household composition as well as geographical variations in poverty across the United States. Recent health gains for the U.S. population as a whole appear to reflect achievements among the higher socioeconomic groups; lower socioeconomic groups continue to lag behind.

Overall, those with higher incomes tend to fare better than those with lower incomes. For example, among white men aged 65 years, those in the highest income families could expect to live more than 3 years longer than those in the lowest income families. The percentage of people in the lowest income families reporting limitation in activity caused by chronic disease is three times that of people in the highest income families.

The average level of education in the U.S. population has steadily increased over the past several decades - an important achievement given that more years of education usually translate into more years of life. For women, the amount of education achieved is a key determinant of the welfare and survival of their children. Higher levels of education may also increase the likelihood of obtaining or understanding health-related information needed to develop health-promoting behaviors and beliefs in prevention.

But again, educational attainment differs by race and ethnicity. Among people aged 25 to 64 years in the United States, the overall death rate for those with less than 12 years of education is more than twice that for people with 13 or

more years of education. The infant mortality rate is almost double for infants of mothers with less than 12 years of education when compared with those with an education of 13 or more years.

Disability

People with disabilities are identified as persons having an activity limitation, who use assistance, or who perceive themselves as having a disability. In 1994, 54 million people in the United States, or roughly 21 percent of the population, had some level of disability. Although rates of disability are relatively stable or falling slightly for people aged 45 years and older, rates are on the rise among the younger population. People with disabilities tend to report more anxiety, pain, sleeplessness and days of depression and fewer days of vitality than do people without activity limitations. People with disabilities also have other disparities, including lower rates of physical activity and higher rates of obesity. Many people with disabilities lack access to health services and medical care.

Rural Localities

Twenty-five percent of Americans live in rural areas, that is, places with fewer than 2,500 residents. Injury-related death rates are 40 percent higher in rural populations than in urban populations. Heart disease, cancer and diabetes rates exceed those for urban areas. People living in rural areas are less likely to use preventive screening services, exercise regularly or wear seat belts. In 1996, 20 percent of the rural population was uninsured compared with 16 percent of the urban population. Timely access to emergency services and the availability of specialty care are other issues for this population group.

Sexual Orientation

America's gay and lesbian population comprises a diverse community with disparate health concerns. Major health issues for gay men are HIV/AIDS and other sexually transmitted diseases, substance abuse, depression, and suicide. Gay male adolescents are two to three times more likely than their peers to attempt suicide. Some evidence suggests lesbians have higher rates of smoking, obesity, alcohol abuse, and stress than heterosexual women. The issues surrounding personal, family and social acceptance of sexual orientation can place a significant burden on mental health and personal safety.

Achieving Equity - The Healthy People Perspective

Although the diversity of the American population may be one of our nation's greatest assets, diversity also presents a range of health improvement challenges - challenges that must be addressed by individuals, the community and state in which they live, and the nation as a whole.

Healthy People 2010 recognizes that communities, states and national organizations will need to take a multidisciplinary approach to achieving health equity

that involves improving health, education, housing, labor, justice, transportation, agriculture, and the environment. However, our greatest opportunities for reducing health disparities are in empowering individuals to make informed health care decisions and in promoting community-wide safety, education and access to health care.

Healthy People 2010 is firmly dedicated to the principle that regardless of age, gender, race, ethnicity, income, education, geographic location, disability and sexual orientation every person in every community across the nation deserves equal access to comprehensive, culturally competent, community-based health care systems that are committed to serving the needs of the individual and promoting community health.

Healthy People 2010 Objectives

The nation's progress in achieving the two goals of Healthy People 2010 will be monitored through 467 objectives in 28 focus areas and distributed as the publication, *Healthy People 2010: Objectives for Improving Health*. Many objectives focus on interventions designed to reduce or eliminate illness, disability and premature death among individuals and communities. Others focus on broader issues such as improving access to quality health care, strengthening public health services, and improving the availability and dissemination of health-related information. Each objective has a target for specific improvements to be achieved by the year 2010.

Together, these objectives reflect the depth of scientific knowledge as well as the breadth of diversity in the nation's communities. More importantly, they are designed to help the nation achieve its two overarching goals and realize the vision of healthy people living in healthy communities.

In addition, *Healthy People 2010: Objectives for Improving Health* provides an overview of the issues, trends and opportunities for action in each of the 28 focus areas. It also contains detailed language of each objective, the rationale behind its focus, the target for the year 2010, and national data tables of its measures.

Access to Health Care

Strong predictors of access to quality health care include having health insurance, a higher income level, and a regular primary care provider or other source of ongoing health care. Use of clinical preventive services, such as early prenatal care, can serve as indicators of access to quality health care services.

In 1997, 86 percent of all individuals had health insurance, and 86 percent had a usual source of health care. Also in that year, 83 percent of pregnant women received prenatal care in the first trimester of pregnancy.

Some examples of access objectives are listed below. These are only indicators and do not represent all the access to quality health care objectives in Healthy People 2010.

- ❖ 1-1. Increase the proportion of persons with health insurance.
- ❖ 1-4a. Increase the proportion of persons who have a specific source of ongoing care.
- ❖ 16-6a. Increase the proportion of pregnant women who begin prenatal care in the first trimester of pregnancy.

Health Insurance

Health insurance provides access to health care. Persons with health insurance are more likely to have a primary care provider and to have received appropriate preventive care such as a recent Pap test, immunization or early prenatal care. Adults with health insurance are twice as likely to receive a routine checkup as are adults without health insurance.

More than 44 million persons in the United States do not have health insurance, including 11 million uninsured children. Over the past decade, the proportion of persons aged 65 years and under with health insurance remained steady at about 85 percent. About one-third of adults 65 years and under who are below the poverty level were uninsured. For persons of Hispanic origin, approximately one in three was without health insurance coverage in 1997. Mexican Americans had one of the highest uninsured rates at 38 percent.

Ongoing Sources of Primary Care

More than 40 million Americans do not have a particular doctor's office, clinic, health center or other place where they usually go to seek health care or health-related advice. Even among privately insured persons, a significant number lacked a usual source of care or reported difficulty in accessing needed care due to financial constraints or insurance problems. People aged 18 to 24 years were the most likely to lack a usual source of ongoing primary care. Only 76 percent of individuals below the poverty level and 74 percent of Hispanics had a usual source of ongoing primary care.

Barriers to Access

Financial, structural and personal barriers can limit access to health care. Financial barriers include not having health insurance, not having enough health insurance to cover needed services, or not having the financial capacity to cover services outside a health plan or insurance program. Structural barriers include the lack of primary care providers, medical specialists, or other health care professionals to meet special needs or the lack of health care

facilities. Personal barriers include cultural or spiritual differences, language barriers, not knowing what to do or when to seek care, or concerns about confidentiality or discrimination.

Leading Health Indicators 2010

The Leading Health Indicators are a group of the most highly targeted issues and objectives of Healthy People 2010 and reflect the major public health concerns in the United States. They were chosen based on their ability to motivate action, the availability of data to measure their progress, and their relevance as broad public health issues.

The Leading Health Indicators illuminate individual behaviors, physical and social environmental factors, and important health system issues that greatly affect the health of individuals and communities. Underlying each of these indicators is the significant influence of income and education.

The process of selecting the Leading Health Indicators mirrored the collaborative and extensive efforts undertaken to develop Healthy People 2010. The process was led by an interagency workgroup within the U.S. Department of Health and Human Services. Individuals and organizations provided comments at national and regional meetings or via mail and the Internet. A report by the Institute of Medicine, National Academy of Sciences, provided several scientific models on which to support a set of indicators. Focus groups were used to ensure that the indicators are meaningful and motivating to the public.

For each of the Leading Health Indicators, specific objectives derived from Healthy People 2010 will be used to track progress. This small set of measures will provide a snapshot of the health of the nation. Tracking and communicating progress on the Leading Health Indicators through national and state-level report cards will spotlight achievements and challenges in the next decade. The Leading Health Indicators serve as a link to the 467 objectives in *Healthy People 2010: Objectives for Improving Health* and can become the basic building blocks for community health initiatives. A major challenge throughout the history of Healthy People has been to balance a comprehensive set of health objectives with a smaller set of health priorities.

The Leading Health Indicators are intended to help everyone more easily understand the importance of health promotion and disease prevention and to encourage wide participation in improving health in the next decade. Developing strategies and action plans to address one or more of these indicators can have a profound effect on increasing the quality of life and the years of healthy life and on eliminating health disparities - creating healthy people in healthy communities.

Determinants of Health - Healthy People 2010

The depth of topics covered by the objectives in Healthy People 2010 reflect the array of critical influences that determine the health of individuals and communities.

For example, individual behaviors and environmental factors are responsible for about 70 percent of all premature deaths in the United States. Developing and implementing policies and preventive interventions that effectively address these determinants of health can reduce the burden of illness, enhance quality of life, and increase longevity.

Individual biology and behaviors influence health through their interaction with each other and with the individual's social and physical environments. In addition, policies and interventions can improve health by targeting factors related to individuals and their environments, including access to quality health care.

Biology refers to the individual's genetic makeup (those factors with which he or she is born), family history (which may suggest risk for disease), and the physical and mental health problems acquired during life. Aging, diet, physical activity, smoking, stress, alcohol or illicit drug abuse, injury or violence, or an infectious or toxic agent may result in illness or disability and can produce a "new" biology for the individual. Behaviors are individual responses or reactions to internal stimuli and external conditions. Behaviors can have a reciprocal relationship to biology; in other words, each can react to the other. For example, smoking (behavior) can alter the cells in the lung and result in shortness of breath, emphysema or cancer (biology) that may then lead an individual to stop smoking (behavior). Similarly, a family history that includes heart disease (biology) may motivate an individual to develop good eating habits, avoid tobacco and maintain an active lifestyle (behaviors), which may prevent his or her own development of heart disease (biology).

Personal choices and the social and physical environments surrounding individuals can shape behaviors. The social and physical environments include all factors that affect the life of individuals, positively or negatively, many of which may not be under their immediate or direct control. The social environment includes interactions with family, friends, coworkers and others in the community. It also encompasses social institutions such as law enforcement, the workplace, places of worship, and schools. Housing, public transportation and the presence or absence of violence in the community are among other components of the social environment.

The social environment has a profound effect on individual health, as well as on the health of the larger community, and is unique because of cultural customs, language, and personal, religious or spiritual beliefs. At the same time, individuals and their behaviors contribute to the quality of the social environment.

The physical environment can be thought of as that which can be seen, touched, heard, smelled or tasted. However, the physical environment also contains less tangible elements such as radiation and ozone. The physical environment can harm individual and community health, especially when individuals and communities are exposed to toxic substances, irritants, infectious agents, and physical hazards in homes, schools and work sites. The physical environment can also promote good health, for example, by providing clean and safe places for people to work, exercise and play.

Policies and interventions can have a powerful and positive effect on the health of individuals and the community. Examples include health promotion campaigns to prevent smoking; policies mandating child restraints and seat belt use in automobiles; disease prevention services, such as immunization of children, adolescents and adults; and clinical services such as enhancing mental health care. Policies and interventions that promote individual and community health may be implemented by a variety of agencies such as transportation, education, energy, housing, labor, justice, and other venues or through places of worship, community-based organizations, civic groups, and businesses.

The health of individuals and communities also depends greatly on access to quality health care. Expanding access to quality health care is important to eliminate health disparities and to increase the quality and years of healthy life for all people living in the United States. Health care in the broadest sense not only includes services received through health care providers but also health information and services received through other venues in the community.

The determinants of health - individual biology and behavior, the physical and social environments, policies and interventions, and access to quality health care - have a profound effect on the health of individuals, communities and the nation. An evaluation of these determinants is an important part of developing any strategy to improve health.

Our understanding of these determinants and how they relate to one another, coupled with our understanding of how individual and community health determines the health of the nation, is perhaps the most important key to achieving our Healthy People 2010 goals of increasing the quality and years of life and of eliminating the nation's health disparities.

For more information on Healthy People 2010 objectives or on access to health care, visit <http://www.health.gov/healthypeople/> or call 1-800-336-4797.

Southern Region Health Goals, Objectives and Indicators

Goal 1: Improve the health and well-being of clientele through increased physical activity.

Objective 1 - At the end of eight weeks or more, program participants will walk an average of 10 miles per week.

Indicators

- ❖ Number of contracted participants
- ❖ Total number of miles walked
- ❖ Comparison of week one average mileage to week eight average mileage for all ages and all beginning activity levels

Goal 2: Improve clientele quality of life through community-based organizations that address health-related needs.

Objective 1 - Extension will facilitate/support the planning, development and maintenance of new health coalitions.

Indicators

- ❖ Number of Extension staff providing leadership to community health coalitions
- ❖ Number of participants completing skill training

Objective 2 - Local groups will promote desired community health outcomes.

Indicators

- ❖ Number of active health task forces/coalitions
- ❖ Number of community health action plans implemented annually

Objective 3 - Local coalitions will identify perceived and actual health needs in the community.

Indicators

- ❖ Surveys/evaluation projects completed
- ❖ Number of needs assessments conducted

Goal 3: Increase detection of early stage breast cancer in order to reduce the mortality, morbidity and negative economic impact of late stage breast cancer.

Objective 1 - Program participants will demonstrate positive attitudes toward and

increased knowledge of breast cancer early detection methods.

Indicators

- ❖ Number of program participants who identify three parts of a breast cancer early detection plan
- ❖ Number of program participants who report increased positive attitudes toward breast cancer treatment on post-tests

Objective 2 - Extension staff will provide training and support for breast cancer volunteers.

Indicators

- ❖ Numbers of volunteers trained annually
- ❖ Numbers of breast cancer materials distributed and breast cancer programs conducted

Objective 3 - Targeted clientele will follow recommendations for BSE, mammograms and clinical breast exams.

Indicators

- ❖ Number of targeted clientele who report following recommendations on modified behavioral risk factor surveillance survey
- ❖ Mammography utilization rates as measured by Medicare
- ❖ Numbers of clinical breast exam and mammography performed by CDC Breast and Cervical Cancer projects in targeted areas

Goal 4: Increase awareness of diabetes as a significant health problem in order to increase early detection.

Objective 1 - Program participants will demonstrate increased knowledge of diabetes.

Indicators

- ❖ People aged 18 to 24 years were the most likely to lack a usual source of ongoing primary care. Only 76 percent of individuals below the poverty level and 74 percent of Hispanics had a usual source of ongoing primary care.
- ❖ Number who participate in diabetes programs
- ❖ Number of program participants who correctly name three symptoms of diabetes
- ❖ Number of program participants who can identify three complications of diabetes
- ❖ Number of program participants who can define diabetes in terms of increased blood sugar

Objective 2 - Program participants will obtain diabetes screening tests.

Indicators

- ❖ Number of participants who obtain FBS
- ❖ Number of participants who report new diagnosis of DM 1
- ❖ Number of participants who report new diagnosis of DM 2

Goal 5: Prevent complications from poorly controlled diabetes in target clientele in order to reduce mortality and morbidity.

Objective 1 - Increase knowledge of diabetes control measures in targeted clientele with diabetes.

Indicators

- ❖ Number of program participants with diabetes who can identify four elements of blood sugar control - Monitoring Plan, Medication Plan, Special Occasion Plan, and Meal Plan - comparing program pre-test and post-test.
- ❖ Number of program participants who can name the two tests in a Diabetes Monitoring Plan: Hemoglobin A1c and Fasting Blood Sugar test.

Objective 2 - Increased number of people who adopt diabetes control measures to prevent complications of the disease.

Indicators

- ❖ Number of people who report diabetes control measures in program pre-test and post-program survey: taking prescribed medicines, following a prescribed meal plan, regular home blood sugar measurement, regular professional foot care, regular vision check-ups, regular HgA1c tests.