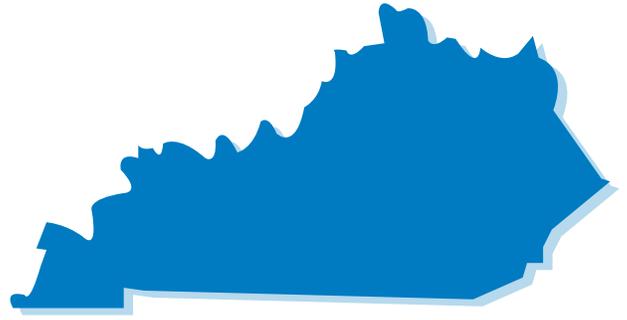


Healthy Kentuckians 2010



Mid-Decade Review Summary Report

**KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES**

Department for Public Health
William Hacker, M.D., F.A.A.P., C.P.E.
Commissioner



Healthy Kentuckians 2010

Mid-Decade Review Summary Report

Produced by

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Released

March 2006

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Introduction

In the spring of 2000, the Kentucky Department for Public Health released *Healthy Kentuckians 2010* (HK 2010). This document, which set the agenda for Kentucky's public health initiatives, was based on the U.S. Department of Health and Human Services' document *Healthy People 2010*. The two overarching goals for HK 2010 are extending years of healthy life and eliminating health disparities. HK 2010 has been used extensively in program planning, targeting prevention initiatives, grant preparation, and forming health policy.

Now it is time to determine how well Kentucky is meeting its objectives. This document, *Healthy Kentuckians 2010 Mid-Decade Review*, is a roadmap that shows how well Kentucky is making progress and where added emphasis is needed.

The Mid-Decade Review process began in the spring of 2005 with the development of a steering committee comprised of representatives from all divisions in the Kentucky Department for Public Health. The steering committee guided development of the document format and recommended coordinators for each chapter. These chapter coordinators worked with epidemiologists, team members, and other stakeholders to track each objective in HK 2010. While most objectives remained the same as in the original document, some were revised to reflect data from new or modified data sources. For example, an objective may rely on data from a certain survey question. If that survey question was changed, the objective was altered to reflect data obtained from the new survey question.

At the time that HK 2010 objectives and targets were set, most had data sources to track their progress. Other objectives were classified as "developmental" because no data source was available at the time to track the objectives. The developers of the objectives hoped that a data source would be available by mid-decade. Although many developmental objectives now have data sources to track their progress, some still do not. If a developmental objective would not have a data source by 2006, then in most cases it was deleted. Although these objectives are still considered important, they were removed from the document since no data would be available to track their progress.

Due to the changing emphasis on certain public health issues and the development of additional data sources, new objectives were added to certain chapters. In fact, an entire chapter on Public Health Preparedness was added to reflect the state's commitment to this issue. In the first five years of this decade, we have seen acts of bioterrorism, wide scale natural disasters, and the potential for disease pandemics—all of which underscore the need for states to be able to effectively respond to such catastrophes.

This document is a summary of the HK 2010 Mid-Decade Review. Each chapter includes the overall goal, overview of the chapter topic, and a summary of the progress for the objectives in the chapter. Each chapter also includes a summary table that lists each objective, the baseline, HK 2010 target, mid-decade status, and the data source. More extensive information on each objective, such as data trends and strategies to achieve each objective, may be found in the main HK 2010 document.

Healthy Kentuckians 2010 Mid-Decade Review reflects the objectives that Kentucky will be tracking for the next half of this decade (from FY 2006 through FY 2010). This updated document provides the framework for developing public health prevention initiatives geared to improving the health status of all Kentuckians. For questions on how to use this document in public health planning, please contact the Kentucky Department for Public Health, Division of Epidemiology and Health Planning at (502) 564-3418.

Executive Summary

Included below is a summary of the public health progress that Kentucky is making and the challenges the state is facing. A snapshot of leading health indicators will be included first. These are indicators which reflect areas of major public health importance as determined by the federal Department of Health and Human Services. The leading health indicators reflect individual behaviors, societal factors, and health system issues which affect the health of Kentuckians and Kentucky communities. After the leading health indicators, the progress of other notable objectives is included. Areas in which Kentucky is making progress will be noted by a ✓ symbol. Those areas in which added emphasis is needed will be listed without notation.

Snapshot of Progress in the Leading Health Indicators:

Overweight and Obesity

Obesity (BMI \geq 30) among adult Kentuckians ages 20 and older has increased from 23.5 percent in 2000 to 26.1 percent in 2004.

The percentage of adolescents in high school who are overweight has increased from 12.3 percent in 2001 to 14.6 percent in 2003.

Physical Activity

- ✓ The level of moderate physical activity among Kentucky adults increased from 28.9 percent in 2001 to 33.8 percent in 2003.

Tobacco Use

- ✓ The percentage of Kentucky adults who are current smokers declined from 30.8 percent in 1998 to 27.5 percent in 2004.
- ✓ Among Kentucky high school students, the percentage who smoked cigarettes in the past 30 days declined from 37 percent in 2000 to 28 percent in 2004.
- ✓ The proportion of young people in grades 9 through 12 who have never smoked increased from 26 percent in 2000 to 31 percent in 2002.

Substance Abuse

- ✓ The percentage of adolescents who report using alcohol or marijuana during the past 30 days has decreased from 49.3 percent in 1997 to 45 percent in 2003 for alcohol and from 28.4 percent in 1997 to 21 percent in 2003 for marijuana.

The percentage of adolescents who report having ever used cocaine, steroids, or other injectable substances has increased. Cocaine use increased from 8.3 percent in 1997 to 9.8 percent in 2003. Steroid use increased from 6.1 percent in 1997 to 7.1 percent in 2003. Injecting drug use increased from 2.6 percent in 1997 to 3.2 percent in 2003.

Among Kentucky adults, binge drinking increased from 8.7 percent in 2001 to 9.6 percent in 2004. However, Kentucky still has one of the lowest percentages of binge drinking in the nation.

Responsible Sexual Behavior

- ✓ Pregnancies among females ages 15-17 have decreased from 31.9 per 1,000 in 2000 to 25.8 per 1,000 in 2004.

Mental Health

- ✓ The percentage of Kentucky children with severe emotional disabilities who receive mental health services from Mental Health/ Mental Retardation (MH/MR) Boards or their subcontractors has increased from 22 percent to 39 percent. The target for this objective has been achieved.
- ✓ The percentage of adult Kentuckians with severe mental illness who receive mental health services from (MH/MR) Boards or their subcontractors has increased from 28 percent to 37 percent. The target for this objective has been achieved.

Injury and Violence

The death rate from motor vehicle crashes has increased from 16.5 deaths per 100,000 to 18.8 deaths per 100,000.

- ✓ The death rate from homicides has decreased slightly from 4.9 per 100,000 in 2000 to 4.6 per 100,000 in 2003.

Environmental Quality

- ✓ The proportion of manufacturing worksites that prohibit smoking indoors increased from 43 percent in 2000 to 49.3 percent in 2004.

Immunizations

- ✓ Kentucky has surpassed the national childhood immunization coverage rates for children 19-35 months of age for the vaccination series of DTaP, polio, MMR, Hib, hepatitis B, and varicella. The percentage of children in this age group adequately immunized has increased from 77 percent in 2000 to 81.2 percent in 2004.
- ✓ Kentucky has exceeded the 2010 immunization series coverage target of 95 percent of kindergarteners (with the exception of varicella which is 84.5 percent).
- ✓ The percentage of non-institutionalized Kentuckians 65 and older who have been immunized against influenza has increased from 60.9 percent in 2001 to 64.9 percent in 2004; the percentage immunized against pneumonia has increased from 55.1 percent in 2001 to 57.7 percent in 2004.

Access to Health Care

The proportion of adult Kentuckians without health care coverage has increased from 14.3 percent in 1998 to a high of 18.2 percent in 2002. The prevalence in 2004 was 14.9 percent.

The proportion of adults who have a specific source of ongoing primary care has decreased from 84.4 percent in 2001 to 82.9 percent in 2004.

Other Data of Note:

The percentage of adult Kentuckians who have been told by a doctor that they have diabetes increased from 5 percent in 1996-98 to 7.5 percent in 2004.

In Kentucky, the death rate from diabetes as a leading or contributing cause of death increased from 76 per 100,000 in 1999 to 78 per 100,000 in 2002.

The prevalence of asthma among Kentucky adults has increased from 7.8 percent in 2000 to 8.3 percent in 2004.

- ✓ The rate of Kentuckians dying from heart disease has decreased from 316 deaths per 100,000 in 1997 to 290 per 100,000 in 2002.
- ✓ The percentage of adult Kentuckians who have had their blood cholesterol checked in the preceding five years has increased from 66 percent in 1997 to 73.9 percent in 2003.
- ✓ The breast cancer death rate decreased from 28.1 per 100,000 women in 1997 to 27.6 per 100,000 women in 2002.
- ✓ The death rate from cancer of the uterine cervix declined from 4.3 per 100,000 women in 1997 to 2.4 deaths per 100,000 women in 2002. The target for this objective has been achieved.
- ✓ The incidence of tuberculosis is at an historic all time low in Kentucky—with only 3.1 cases per 100,000 in 2004.
- ✓ The infant mortality rate has decreased from 6.7 per 1,000 live births in 2000 to 6.5 per 1,000 live births in 2004.
- ✓ Neural tube defects have decreased from 8.7 per 10,000 births in 2000 to 5.3 per 10,000 births in 2004. The target for this objective has been achieved.
- ✓ The Kentucky All Schedule Prescription Electronic Reporting (KASPER) database has been implemented statewide. This electronic database was designed to capture information on prescriptions for controlled substances that are dispensed within Kentucky. This informational system facilitates targeting of individuals (prescribers, dispensers, and end users) who are in violation of Kentucky's Controlled Substances Act. The electronic information system also provides valuable information to prescribing health care professionals on other controlled substances that the patient may be using.

Health Disparities

One of the main overarching goals of *Healthy Kentuckians 2010* is to eliminate health disparities. Kentucky still faces many challenges in addressing this goal. Health disparities by race, gender, geographic region and socioeconomic status continue to exist throughout Kentucky. Of particular concern, are the many health disparities between the races that are included below:

Obesity: A racial disparity exists in the prevalence of adult obesity in Kentucky. From 2000-2004, the prevalence of obesity was considerably higher among African Americans. In 2004, 39.2 percent of African Americans were obese compared to 25.5 percent of whites.

Diabetes and Asthma: Many health conditions for which obesity is a risk factor, such as diabetes and asthma, also affect African Americans disproportionately. In 2004, 12.9 percent of adult African Americans had been told by a doctor that they had diabetes compared to 7.4 percent of whites. In 2002, diabetes as a primary cause of death was the fourth leading cause of death for African Americans (64.9 per 100,000), but it was the seventh leading cause of death for whites (29.4 per 100,000). From 2000-2004, the prevalence of asthma was consistently higher among African Americans, and in the past few years, the disparity has increased. In 2004, the prevalence of asthma was 14.8 percent among African American adults compared to 8.0 percent among white adults.

AIDS and Other STDs: Disparities also exist in the incidence of AIDS and other sexually transmitted diseases. In 2003, the incidence of AIDS was over seven times higher among African Americans (24.3 per 100,000) compared to whites (3.2 per 100,000). In 2003 among African American females age 15 and older, the combined rate of gonorrhea, chlamydia, and syphilis infections (1,975 per 100,000 females) was over eight times higher than the rate among white females age 15 and older (238 per 100,000 females).

Adolescent Pregnancy, Low Birth Weight, and Infant Mortality: The overall adolescent pregnancy rate for females age 15-17 declined 19 percent over the past five years. However, a disparity exists in the pregnancy rates for adolescent African Americans, 47.9 per 1,000 females, compared to adolescent whites, which was 24.7 per 1,000 females in 2004. Among African Americans, low birth weight was 13.1 percent compared to 8.0 percent among whites in 2004. Infant mortality is another area in which racial disparities exist. Over the past five years, the infant mortality rate for African Americans has been twice the rate for whites. In 2004, the infant mortality rate for African Americans was 11.9 per 1,000 live births compared to 5.5 per 1,000 live births for whites.

Leading Health Indicators - Summary Tables

The following pages include summary tables of the objectives included in the leading health indicators. Not all chapter objectives are included. Refer to each chapter for a complete listing of chapter objectives. Also included with the tables in this report are specific notations and abbreviations. Please refer below for their definitions.

DELETED	At the time that HK 2010 objectives and targets were set, most had data sources to track their progress. Other objectives were classified as “developmental” because no data source was available at the time to track the objectives. Although many developmental objectives now have data sources to track their progress, some still do not. If a developmental objective would not have a data source by 2006, then in most cases it was deleted. Although these objectives are still considered important, they were removed from the document since no data would be available to track their progress.
R for Revision	Most objectives are the same as in the original document; however, some were revised to reflect data from new or modified data sources. For example, an objective may rely on data from a certain survey question. If that survey question was changed, the objective was altered to reflect data obtained from the new survey question.
N for New Objective	A new objective has been added.
N/A	For these objectives only baseline data are available, and progress is not able to be determined at this time.
TBD	No reliable data currently exist for these objectives. Progress on these objectives will be tracked when a data source becomes available.

Progress toward Achieving HK 2010 Objectives

Summary of Objectives for Leading Health Indicators	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
Physical Activity					
1.2R. Increase to at least 35 percent the proportion of Kentuckians ages 18 and over who engage in moderate physical activity 5 or more days per week.	28.9% (2001)	≥35%	33.8% (2003)	Yes	BRFSS
1.4R. Increase to at least 24 percent the proportion of young people in grades K-12 who engage in moderate physical activity for at least 30 minutes on five or more of the previous seven days.	High School 20.3% (2001)	≥24%	21.3% (2003)	Yes	YRBSS
Overweight and Obesity					
2.1. Increase to at least 50 percent the prevalence of healthy weight (defined as a body mass index (BMI) greater than 19.0 and less than 25.0) among all people aged 20 and older.	35.6% (2000)	≥50.0%	32.6% (2004)	No	BRFSS
2.2. Reduce to less than 15 percent the prevalence of BMI at or above 30.0 among people aged 20 and older.	23.5% (2000)	<15.0%	26.1% (2004)	No	BRFSS
2.3. Reduce to 5 percent or less the prevalence of overweight and obesity (at or above the sex and age specific 95 th percentile of BMI from the revised NCHS/CDC growth charts) in children (aged 1-5 and 6-11) and adolescents (aged 12-19).					
Children <5 and on WIC	13.5% (2000)	≤5%	17.7% (2003)	No	PedNSS
Adolescents in High School	12.3% (2001)	≤5%	14.6% (2003)	No	YRBSS
Tobacco Use					
3.1. Reduce the proportion of adults (18 and older) who use tobacco products.	Cigarettes 30.8% (1998)	≤25%	27.5% (2004)	Yes	BRFSS
	Cigars 5.5% (1998)	≤4%	5.9% (2001)	No	
	Spit Tobacco 3% (1997)	≤2%	5% (2004)	No	

R = Revised objective

Progress toward Achieving HK 2010 Objectives

Summary of Objectives for Leading Health Indicators	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
3.6. Reduce the proportion of young people who have smoked cigarettes within the past 30 days.	High School 37% (2000)	≤27%	28% (2004)	Yes	YTS
	Middle School 22% (2000)	≤14%	15% (2004)	Yes	
3.8. Increase to 32 percent the proportion of young people in grades 9 to 12 who have never smoked.	26% (2000)	≥32%	31% (2002)	Yes	YTS
Substance Abuse					
26.11. Reduce past month use of alcohol among adolescents to no more than 30 percent.	49.3% (1997)	≤30%	45% (2003)	Yes	YRBSS
26.13. Reduce to no more than 10 percent the proportion of adolescents reporting marijuana use during the past 30 days.	28.4% (1997)	≤10%	21% (2003)	Yes	YRBSS
26.14. Reduce to no more than 4 percent the proportion of adolescents reporting use of illicit drugs other than marijuana at any time (lifetime use).	Cocaine 8.3% (1997)	≤4%	9.8% (2003)	No	YRBSS
	Inhalants 24.7% (1997)	≤4%	14.3% (2003)	Yes	
	Heroin 3.7% (2003)	≤4%	3.7% (2003)	Target Achieved	
	Meth 9.7% (2003)	≤4%	9.7% (2003)	N/A	
	Ecstasy 6.7% (2003)	≤4%	6.7% (2003)	N/A	
	Steroids 6.1% (1997)	≤4%	7.1% (2003)	No	
	Any Injections 2.6% (1997)	≤4%	3.2% (2003)	No	

N/A = Only baseline data are available. Not able to determine progress at this time.

Progress toward Achieving HK 2010 Objectives

Summary of Objectives for Leading Health Indicators	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
26.18R. Reduce by one-fourth the proportion of Kentuckians age 18 and older who report binge drinking within the past month.	8.7% (2001)	≤6.5%	9.6% (2004)	No	BRFSS
Responsible Sexual Behavior					
11.6R. Reduce births among females ages 15-17 to no more than 20 per 1,000 adolescents.	31.9/1,000 (2000)	≤20/1,000	25.8/1,000 (2003)	Yes	Vital Statistics
11.7. Increase by at least 10 percent the proportion of sexually active individuals, ages 15-19, who use barrier method contraception with or without hormonal contraception to prevent sexually transmitted disease and prevent pregnancy.	62.8% (2003)	≥69.1%	62.8% (2003)	N/A	YRBSS
21.4. (Developmental) Increase proportion of sexually active unmarried people age 18 and older who reported that a latex condom was used at last sexual intercourse.	TBD	TBD	TBD	TBD	BRFSS
Mental Health					
23.2. Increase the number of adults with severe mental illness (SMI) who receive mental health services from Regional MH/MR Boards or their sub-contractors to 30 percent.	28% (1999)	≥30%	37% (2004)	Target Achieved	DMHMRS Client Data Set
Injury and Violence					
7.10. Reduce deaths caused by motor vehicle crashes to no more than 12 per 100,000 and 1 per 100 million vehicle miles.	16.5/100,000 (2000)	≤12/100,000	18.8/100,000 (2003)	No	Vital Statistics
7.19R. Reduce homicides to less than 4.2 per 100,000 people.	4.9/100,000 (2000)	≤4.2/100,000	4.6/100,000 (2003)	Yes	Vital Statistics
Environmental Quality					
5.13. (Developmental) To reduce health effects of air pollution. (DELETED)					
3.16R. Increase to 50.3 percent the proportion of manufacturing worksites that prohibit smoking indoors.	43% (2000)	≥50.3%	49.3% (2004)	Yes	Workplace Policy Survey

R = Revised objective

N/A = Only baseline data are available. Not able to determine progress at this time.

TBD = To be determined. No reliable data currently exist.

Progress toward Achieving HK 2010 Objectives

Summary of Objectives for Leading Health Indicators	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
Immunization					
22.10. Achieve immunization coverage of at least 90 percent among children 19-35 months of age for the following: -4 DTapP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B -1 dose of varicella vaccine.	77.0% ±5.2% (2000)	≥90%	81.2% ±5.9% (2004)	Yes	National Immunization Survey
22.11. Achieve immunization coverage of 95 percent for children in licensed day care facilities and children in kindergarten for the following:	(2004)		(2004)	No	Annual School Survey
Licensed Day Care Facilities					
Diphtheria-tetanus-pertussis (4 doses, at least 1 on or after age 4)	91%	≥95%	91%	No	
Measles, mumps, rubella (2 doses for kindergarten, 1 dose for children over 16 months of age in day care)	93.9%	≥95%	93.9%	No	
<i>Haemophilus influenzae</i> type b (if under 5 years of age)	95.7%	≥95%	95.7%	Target Achieved	
Hepatitis B (3 doses)	94.6%	≥95%	94.6%	No	
Varicella	90.1%	≥95%	90.1%	No	
Polio (3 doses)	92.8%	≥95%	92.8%	No	
Kindergarten					
Diphtheria-tetanus-pertussis (4 doses, at least 1 on or after age 4)	96.3%	≥95%	96.3%	Target Achieved	
Measles, mumps, rubella (2 doses for kindergarten, 1 dose for children over 16 months of age in day care)	95.6%	≥95%	95.6%	Target Achieved	
<i>Haemophilus influenzae</i> type b (if under 5 years of age)	96.3%	≥95%	96.3%	Target Achieved	
Hepatitis B (3 doses)	95.8%	≥95%	95.8%	Target Achieved	
Varicella	84.5%	≥95%	84.5%	No	
Polio (3 doses)	96.3%	≥95%	96.3%	Target Achieved	

Progress toward Achieving HK 2010 Objectives

Summary of Objectives for Leading Health Indicators	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
22.12. Increase to the following targets the rate of immunization coverage among the following adult groups:					
<u>Non-institutionalized adults 65 years of age or older</u>					
Influenza Vaccine	60.9% (2001)	≥75%	64.9% (2004)	Yes	BRFSS
Pneumococcal Vaccine	55.1% (2001)	≥70%	57.7% (2004)	Yes	
<u>Institutionalized adults in long term care or nursing homes</u>					
Influenza Vaccine	84.1% (2004)	≥90%	84.1% (2004)	N/A	Special Surveys for Long Term Care
Pneumococcal Vaccine	74.6% (2004)	≥90%	74.6% (2004)	N/A	
Access to Health Care					
10.1. Reduce to zero the proportion of children and adults without health care coverage.	Adults 14.3% (1998)	0%	14.9% (2004)	No	BRFSS
10.6. Increase to at least 90 percent the proportion of people who have a specific source of ongoing primary care.	84.4% (2001)	≥90%	82.9% (2004)	No	BRFSS
12.9. Increase to at least 90 percent the proportion of all pregnant women who begin prenatal care in the first trimester of pregnancy.	85.7% (2000)	≥90%	86.2% (2004)	Yes	Vital Statistics

N/A = Only baseline data are available. Not able to determine progress at this time.

Healthy Kentuckians 2010 Mid Decade Review

Chapter Summaries

1

Physical Activity and Fitness

Goal

Improve the health, fitness, and quality of life of all Kentuckians through the adoption and maintenance of regular, daily physical activity.

Overview

The first Surgeon General's Report on Physical Activity and Health, released in 1996, concluded that regular sustained physical activity can substantially reduce the risk of developing or dying of heart disease, diabetes, colon cancer, and high blood pressure. Additionally, research by Blair, SN et al. (JAMA 262:2395-2401, 1989) and Paffenbarger, R.S. Jr., et al. (N Engl J Med 328:538-45, 1993) has shown that regular physical activity can reduce the risk of osteoporosis, promote weight loss and foster a sense of well being. According to the Behavioral Risk Factor Surveillance System (BRFSS) conducted by the Division of Epidemiology and Health Planning, Kentucky Department for Public Health (KDPH), Kentucky ranks second in the nation for physical inactivity.

With high physical inactivity rates, Kentuckians also have seen increasing rates of overweight and obesity. Kentucky BRFSS data reveal a clear trend of an increasing number of individuals being overweight. Kentucky ranked fifth highest in the nation for obesity in 2001 and tenth in 2002. Consistently, males tend to have a slightly higher prevalence of overweight than females, and blacks tend to have a higher prevalence than whites. The prevalence of overweight and obesity is a serious public health threat in Kentucky. The 1988 Surgeon General's Report on Nutrition and Health established that being overweight is associated with elevated serum cholesterol levels, elevated blood pressure and noninsulin-dependent diabetes, as well as being an independent risk factor for coronary heart disease.

Summary of Progress

Although some progress has been made in meeting the objectives for Healthy Kentuckians 2010 in regards to physical activity, recent data indicate that the proportion of Kentuckians who either overweight or obese has increased. Progress has been made in participating in any leisure time physical activity and in moderate physical activity. Nine objectives or sub-objectives were revised to meet current data collection efforts and definitions, and one objective was deleted for lack of data.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Physical Activity and Fitness	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
1.1aR. Reduce overweight to a prevalence of no more than 25 percent among Kentuckians 18 and older. (Overweight for this objective is defined as a Body Mass Index (BMI) greater than or equal to 25 and less than 30.)	38% (2000)	≤25%	37.6% (2004)	Yes	BRFSS
1.1bR. Reduce the percentage of Kentuckians 18 and over who are either overweight or obese. (The prevalence of overweight or obese for this objective is defined as a BMI greater than or equal to 25.)	61.0% (2000)	≤55%	63.4% (2004)	No	BRFSS
1.2R. Increase to at least 35 percent the proportion of Kentuckians ages 18 and over who engage in moderate physical activity 5 or more days per week.	28.9% (2001)	≥35%	33.8% (2003)	Yes	BRFSS
1.3R. Decrease the percentage of Kentuckians reporting no leisure time physical activity (by BMI category. i.e. normal weight, overweight, obese class I, obese class II, obese class III).	Normal weight 29.6% (2001)	≤25.5%	26.5% (2004)	Yes	BRFSS
	Overweight 30.7%	≤26.3%	27.3%	Yes	
	Obese Class I 38.7%	≤34.7%	35.7%	Yes	
	Obese Class II 45.6%	≤34.1%	35.1%	Yes	
	Obese Class III 46.8%	≤42.0%	43.0%	Yes	
1.4R. Increase to at least 24 percent the proportion of young people in grades K-12 who engage in moderate physical activity for at least 30 minutes on five or more of the previous seven days.	High school 20.3% (2001)	≥24%	21.3% (2003)	Yes	YRBSS

R = Revised objective

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Physical Activity and Fitness	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
1.5. (Developmental) Increase the proportion of the state’s public and private elementary, middle/junior high, and senior high schools that provide access to their physical activity spaces and facilities for young people and adults outside of normal school hours.	51% of middle and high schools allow access to students after hours (2003)	≥56%	51% (2003)	N/A	School Policy Survey
	31% of middle and high schools allow access to the general public after hours. (2003)	≥34%	31% (2003)	N/A	
1.6. (Developmental) Increase the proportion of Kentucky worksites with 50 or more employees offering employer-sponsored physical activity and fitness programs.	45% (2001)	≥50%	45% (2001)	N/A	Worksite Survey
1.7. (DELETED)					

N/A = Only baseline data are available. Not able to determine progress at this time.

2

Nutrition

Goal

To promote health and reduce chronic disease risk, disease progression, debilitation, and premature death associated with dietary factors and nutritional status among all people in Kentucky.

Overview

Nutrition is essential for growth, development, and maintenance of every individual. Diet has been linked to preventable illness and premature death in the United States and to the nation's economic burden. In Kentucky, dietary factors are associated with four of the ten leading causes of death: coronary heart disease, some types of cancer, strokes, and diabetes mellitus. Dietary factors are also linked to osteoporosis, which is the major underlying cause of bone fractures among the elderly and postmenopausal women in the United States. During the last five years, obesity rates have increased in children, adolescents, and adults in Kentucky. The effects of diets high in fats and sugars and the lack of physical activity contribute to the obesity "epidemic". The economic costs of adult obesity for Kentucky were estimated by Centers for Disease Control and Prevention (CDC) in 2003 to be \$1.163 billion.

Summary of Progress

Objectives 2.1 through 2.3 deal with pediatric and adult obesity which continue to be on the rise. Legislation, advocacy, and health programs have been activated during the last five years to address obesity, but progress is not expected to impact data for at least a generation. Growth retardation or underweight among low-income children has improved slightly over the last five years. Among participants of the Women, Infants and Children (WIC) food program, underweight has improved over the last five years showing a decrease from 6.2 percent in 2000 to 4.0 percent in 2004. Diet related problems such as iron deficiency and meals low in fruits and vegetables continue to be prevalent. The objective for consumption of five fruits and vegetables per day has not been attained during the last five years in Kentucky. Iron deficiency anemia in low income children under the age of five has remained stable at approximately 11 percent from 2000 to 2004.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Nutrition	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
2.1. Increase to at least 50 percent the prevalence of healthy weight (defined as a body mass index (BMI) greater than 19.0 and less than 25.0) among all people aged 20 and older.	35.6% (2000)	≥50%	32.6% (2004)	No	BRFSS
2.2. Reduce to less than 15 percent the prevalence of BMI at or above 30.0 among people aged 20 and older.	23.5% (2000)	<15%	26.1% (2004)	No	BRFSS
2.3. Reduce to 5 percent or less the prevalence of overweight and obesity (at or above the sex and age specific 95 th percentile of BMI from the revised NCHS/CDC growth charts) in children (aged 1-5 and 6-11) and adolescents (aged 12-19). Children <5 and on WIC	13.5% (2000)	≤5%	17.7% (2003)	No	PedNSS
Adolescents in High School	12.3% (2000)	≤5%	14.6% (2003)	No	YRBSS
2.4. Maintain reduced growth retardation among low-income children aged 5 and younger to 5 percent or less.	6.2% (2000)	≤5%	4.0% (2004)	Target Achieved	PedNSS
2.5. Increase to at least 40 percent the proportion of people age 2 and older who meet the Dietary Guidelines' minimum average daily goal of at least five servings of vegetables and fruits. Adolescents in High School	19.2% (2001)	≥40%	13.2% (2003)	No	YRBSS
Adults Age 18 and Older	22.7% (2000)	≥40%	18.2% (2003)	No	BRFSS
2.6R. Reduce iron deficiency to 7 percent or less among low-income children less than age 5.	11.2% (2000)	≤7%	11.8% (2004)	No	PedNSS

R = Revised objective

3

Tobacco Use

Goal

Reduce the burden of tobacco-related addiction, disease, and mortality, thereby improving the health and well being of adults and youth in Kentucky. This includes decreasing tobacco use among adults, pregnant women, youth, and disparate populations, eliminating exposure to secondhand smoke, and building capacity in communities for tobacco prevention and cessation.

Overview

Tobacco use is the number one public health threat in Kentucky. The state's adult and youth smoking rates, annual deaths related to smoking, and lung cancer death rates are among the highest in the country. Smoking accounts for approximately 30 percent of all cancer deaths, and 87 percent of lung cancer deaths. Smoking is known to cause an increased risk for cancers of the mouth, pharynx, larynx, esophagus, pancreas, cervix, kidney, and bladder. In addition, smoking is a major cause of heart disease, stroke, chronic bronchitis, and emphysema.

At current smoking rates, 87,902 Kentucky children who are 18 years or younger will die prematurely from smoking. According to the latest National Youth Tobacco Survey (YTS), 10 percent of middle school and 23 percent of high school students in the United States smoke cigarettes. Kentucky's youth far exceed the national average in current cigarette use. The Kentucky 2004 YTS revealed that 15 percent of middle school students surveyed and 28 percent of high school students surveyed smoke cigarettes.

Kentucky has the second highest percentage of pregnant smokers, 23.9 percent versus the national average of 11.4 percent. (Kentucky's figure is based on 2003 birth records.) This behavior places children of pregnant smokers at risk for low birth weight, Sudden Infant Death Syndrome (SIDS), respiratory problems, and various other health conditions.

In addition to the toll it takes in human lives lost, tobacco use also has substantial economic consequences for the Commonwealth. Health care costs attributable to smoking are estimated at \$1.2 billion annually, creating an extra tax burden for each household in the Commonwealth of \$567 in state and federal taxes. In addition to increased health care costs, it is estimated that Kentucky families experience a loss of an additional \$1.8 billion dollars in income from premature death of those who die of smoking related disease.

The Tobacco Prevention and Cessation Program provides leadership to achieve the four goals identified as best practice by the Centers for Disease Control and Prevention: preventing youth initiation, promoting quitting among adults and young people, eliminating exposure to secondhand smoke, and identifying and eliminating disparities among population groups disproportionately affected by tobacco use.

Funds are allocated to local health departments for evidence-based programs ranging from youth education programs to adult cessation. Local health department staff teach prevention education in schools, provide smoking cessation programs, conduct community assessments, offer technical assistance to schools and businesses, and develop coalitions to promote and provide community interventions related to tobacco use. Funds are maximized through collaboration with partners such as Regional Prevention Centers, Family Resource and Youth Services Centers (FRYSC's), Substance Abuse programs, the Kentucky Cancer Program, American Cancer Society, American Lung Association, and American Heart Association.

Summary of Progress

The *Healthy Kentuckians 2010 Mid-Decade Review* revealed that progress has been made in 24 of the 38 possible objectives or partial objectives. (Some objectives have multiple parts in which progress may have been made in one part but not the other.) Of those with progress, 21 percent have already reached the Healthy Kentuckians 2010 Target. Three objectives have been deleted due to absence of a data source with no prospective suitable data sources by 2006. Progress has not been made in eight objectives/partial objectives. One objective is using baseline data for the mid-decade status; therefore progress cannot be measured at this time. Finally, data is not expected until 2006 for one objective, causing it to remain in developmental status.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Tobacco Use	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
3.1. Reduce the proportion of adults (18 and older) who use tobacco products.	Cigarettes 30.8% (1998)	≤25%	27.5% (2004)	Yes	BRFSS
	Cigars 5.5% (1998)	≤4%	5.9% (2001)	No	
	Spit Tobacco 3% (1997)	≤2%	5% (2004)	No	
3.2R. Increase to 58 percent the proportion of cigarette smokers ages 18 and older who smoke every day and stop smoking for a day or more.	47.9% (1998)	≥58%	47.6% (2004)	No	BRFSS
3.3. (DELETED)					
3.4. Reduce cigarette smoking among pregnant women to a prevalence of no more than 17 percent.	24.7% (1997)	≤17%	23.9% (2003)	Yes	Vital Statistics
3.5R. (Developmental) Of new mothers who smoked in the first three months before becoming pregnant, increase the percentage who abstained from using tobacco during pregnancy.	TBD	TBD	TBD	TBD	Vital Statistics
3.6. Reduce the proportion of young people who have smoked cigarettes within the past 30 days.	High School 37% (2000)	≤27%	28% (2004)	Yes	YTS
	Middle School 22% (2000)	≤14%	15% (2004)	Yes	
3.7R. Reduce the proportion of high school youth who smoked a whole cigarette before age 13.	32.5% (1997)	≤22%	29.4% (2003)	Yes	YRBSS
3.8. Increase to 32 percent the proportion of young people in grades 9 to 12 who have never smoked.	26% (2000)	≥32%	31% (2002)	Yes	YTS
3.9R. Of the students in high school who smoke, increase to 62 percent the proportion who quit for at least a day or more.	60% (2000)	≥62%	55.2% (2004)	No	YTS

R = Revised objective

TBD = To be determined. No reliable data currently exist.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Tobacco Use	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
3.10R. Reduce the proportion of high school and middle school students who think smoking cigarettes makes young people look cool or fit in.	High School 11.5% (2000)	≤10.4%	11.8% (2002)	No	YTS
	Middle School 16.5% (2000)	≤11.1%	12.1% (2002)	Yes	
3.11R. Increase to 100 percent the proportion of high school students who think secondhand smoke is harmful.	91.5% (2000)	100%	92.2% (2002)	Yes	YTS
3.12. Increase the proportion of schools (middle and high) that provide research-based tobacco use prevention curricula.	73.8% (2003)	≥81.2%	73.8% (2003)	N/A	School Policy Survey
3.13R. Increase the proportion of stores that are compliant with youth tobacco access laws.	86% (1998)	≥96%	95% (2004)	Yes	KY ABC
3.14. (DELETED)					
3.15R. Increase the proportion of schools with tobacco-free environments (both indoors and outdoors) for students and staff, and at all school events.	Indoor for everyone 98.7% (2001)	100%	99% (2003)	Yes	School Policy Survey
	School grounds for students 96.8% (2001)	100%	96.6% (2003)	No	
	School grounds for teachers and staff 44.7% (2001)	≥49.2%	41.7% (2003)	No	
	Indoor school-related events 95.5% (2001)	100%	92.7% (2003)	No	
	Outdoor school-related events 41.4% (2001)	≥45.5%	43.6% (2003)	Yes	
3.16R. Increase to 50.3 percent the proportion of manufacturing worksites that prohibit smoking indoors.	43% (2000)	≥50.3%	49.3% (2004)	Yes	Workplace Policy Survey
3.17R. Increase to 51 percent the proportion of food service establishments that prohibit smoking.	32% (1999)	≥51%	44.5% (2003)	Yes	Food Service Estab. Survey
3.18. Increase to 95 percent the proportion of patients who receive advice to quit smoking from a health care provider.	73.3% (2003)	≥95%	70.8% (2004)	No	BRFSS

R = Revised objective. N/A = Only baseline data are available. Not able to determine progress at this time.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Tobacco Use	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
3.19. Increase the proportion of health plans that reimburse for nicotine addiction treatment.	Manufacturing: 26% (2000)	≥29%	36.9% (2004)	Target Achieved	Workplace Policy Survey
	LHDs: 7% (2000)	≥8%	23.7% (2004)	Target Achieved	
3.20a. Increase the proportion of health departments that have a tobacco-user identification system for patients.	83% (2000)	≥91.3%	94.6% (2004)	Target Achieved	LHD Survey
3.20b. Increase the proportion of health departments that dedicate staff to provide research-based smoking cessation treatment.	43.6% (2000)	≥48%	92.9% (2004)	Target Achieved	LHD Survey
3.20cR. Increase to 100 percent the proportion of health departments that provide annual training on smoking cessation programs for health care providers.	15.1% (2000)	100%	30.4% (2004)	Yes	LHD Survey
3.20d. (DELETED)					
3.20e. Increase to 48 percent manufacturing facilities that reimburse for smoking cessation services.	26% (2000)	≥48%	26.3% (2004)	Yes	Workplace Policy Survey
3.21R. Establish a comprehensive research-based tobacco control program in Kentucky, as characterized by the following: 1) The number of local health department (LHDs) that are funded for tobacco prevention and cessation. 2) The number of LHDs that offer Cooper Clayton Method to Stop Smoking Programs. 3) The number of full-time state-level tobacco control program staff. 4) The percentage of schools with research-based tobacco prevention curricula.	1) 10 (1999)	1) 56	1) 56 (2005)	Target Achieved	Plan/Budget Records
	2) 21 (1999)	2) 56	2) 52 (2004)	Yes	LHD Survey
	3) 4 (1999)	3) Staff to cover all CDC goals	3) 5 (2005)	Yes	Personnel Records
	4) 73% (2003)	4) 100%	4) 73% (2003)	N/A	School Policy Survey
3.22R. Increase the proportion of localities that adopt ordinances and/or policies to restrict tobacco use.	0 (2000)	≥5	2 (2004)	Yes	Local Ordinance Data

R = Revised objective

N/A = Only baseline data are available. Not able to determine progress at this time.

4

Educational and Community Based Programs

Goal

Increase the quality, availability and effectiveness of educational and community-based programs designed to prevent disease, prevent disability and premature death, and promote the health and quality of life of all Kentuckians (*Healthy People 2010*, 1998).

Overview

The health of our communities depends in large part on whether the physical and social aspects of the communities make it possible for people to live healthy lives. There is a dynamic and unavoidable interaction between individuals and their environment. While lifestyle choices are ultimately individual choices, these personal decisions are made in the midst of a complex mix of social and community relationships and environments that can actively support or obstruct personal change. Research has shown that behavior change is more likely to happen and be maintained when a person's environment is altered in a manner that supports the change.

This complex of interrelationships between people and their social and community networks is termed "the Socioecological Model". The different levels of the model include: Individual (personal behavior change), Interpersonal and Group (family or peer groups), Institutions and Organizations (such as schools, faith organizations or worksites), Community (local policy makers, planners and civic organizations), and Societal or Public Policy (state or national level policy or law). The most effective community promotion programs are those that take into account the different levels of the Socioecological Model, implementing multiple intervention strategies across multiple settings. For example, community promotion programs that involve educational, policy, and environmental strategies within schools, workplaces, and health care facilities within the community have a greater chance of succeeding. These settings serve as channels for reaching the "targeted" population and, at the same time, generate the possibility of intervening at the policy level to facilitate healthy choices (i.e., smoking cessation classes may lead to a decision for an agency to become "smoke-free").

The school, ranging from preschool through college, provides an important setting for reaching the entire population, over time. Schools have more influence on the lives of youth than any other social institution, except the family. Because healthy children learn better than children with health problems, to achieve their educational mission, schools and colleges must address the health and related social problems of youth. A focal point of their efforts, in this respect, must be to reduce health risks and improve the health status of youth.

The growing cost of health care coupled with the increasing problems of preventable acute and chronic illness have brought health education to the forefront of workplace concerns. Health promotion in the workplace is critical to the long-term maintenance of our nation's health. Increasing awareness, promoting healthy individual lifestyles, fostering health-related behavior changes and creating supportive work environments are core to workplace health promotion. This, in turn, is beneficial to managers, employees, and the community at large.

Summary of Progress

Progress has been made in several areas of educational and community based programs. The high school dropout rate has actually been reduced, which means that more Kentucky citizens are in a position to hold better jobs, earn a better income, and are more likely to have health insurance. Progress has been made in school health programs. The decrease in the ratio of students to school nurses, and the implementation of a coordinated school health program statewide will impact policies and programs in all Kentucky schools. In community health programming, local health departments are offering more and more programs to Kentucky citizens which address multiple *Healthy Kentuckians 2010* objectives. They are also offering culturally appropriate programming to meet the needs of different social and ethnic groups as well as serving more older citizens than ever before.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Educational and Community Based Programs	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
4.1. Increase to at least 90 percent the number of individuals, through age 24, who have completed high school.	74.7% (2000)	≥90%	74.7% (2000)	N/A	Census
4.2. Reduce the annual dropout rate for students enrolled in grades 9-12, to a rate of less than 5 percent.	5.2% (1997)	<5%	3.4% (2004)	Target Achieved	KY Dept. of Education
4.3. (DELETED)					
4.4R. Increase to or maintain at 95 percent the proportion of public middle and high schools that require instruction in the areas that contribute to the leading causes of morbidity and mortality among youth.	See Below (2002)	Increase to or Maintain at 95%	See Below (2002)		
<u>2002 Baseline Middle School</u>	%	%	%	N/A	SHEP
HIV Prevention	97.3	95	97.3		
Sexually Transmitted Diseases	94.7	95	94.7		
Human Sexuality	77.6	95	77.6		
Accident or Injury Prevention	93.4	95	93.4		
Alcohol or Other Drug Prevention	97.4	95	97.4		
Suicide Prevention	66.7	95	66.7		
Tobacco Use Prevention	98.7	95	98.7		
Violence Prevention	85.5	95	85.5		
Benefits of Healthy Eating	100	95	100		
Risks of Unhealthy Weight Control	96.0	95	96.0		
Accepting Body Size Differences	89.3	95	89.3		
Decreasing Sedentary Activity	89.2	95	89.2		

R = Revised objective

N/A = Only baseline data are available. Not able to determine progress at this time.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Educational and Community Based Programs	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
<u>2002 Baseline High School</u>	% (2002)	%	% (2002)	N/A	SHEP
HIV Prevention	98.2	95	98.2		
Sexually Transmitted Diseases	98.2	95	98.2		
Human Sexuality	92.0	95	92.0		
Accident or Injury Prevention	96.4	95	96.4		
Alcohol or Other Drug Prevention	98.2	95	98.2		
Suicide Prevention	83.6	95	83.6		
Tobacco Use Prevention	98.2	95	98.2		
Violence Prevention	90.1	95	90.1		
Benefits of Healthy Eating	98.2	95	98.2		
Risks of Unhealthy Weight Control	97.3	95	97.3		
Accepting Body Size Differences	95.5	95	95.5		
Decreasing Sedentary Activity	93.6	95	93.6		
4.5. - 4.6. (DELETED)					
4.7. Increase the nurse to student ratio to 1:750 among Kentucky's elementary, middle, and junior high schools.	1:1831.25 (1997-98)	1:750	1:1426 (2004-05)	Yes	Ky Dept. of Education
4.8. (Developmental) Increase to at least 50 percent of worksites in Kentucky that offer a health promotion activity, preferably as part of a comprehensive worksite health promotion program.	39% (2001)	≥50%	39% (2001)	N/A	CHWS
4.9. (Developmental) Increase to at least 37 percent the number of employees who participate in one or more "employer-sponsored" health promotion activities.	23% (2001)	≥37%	23% (2001)	N/A	CHWS

N/A = Only baseline data are available. Not able to determine progress at this time.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Educational and Community Based Programs	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
4.10.- 4.12. (DELETED)					
4.13. Maintain the annual operating standard of 100 percent of Local Health Departments that submit a community health promotion plan that addresses multiple <i>Healthy People 2010</i> focus areas.	100% (1999)	100%	100% (2005)	Target Achieved	Activity Plans of LHDs
4.14. (Developmental) Increase by 50 percent the proportion of Local Health Departments (LHDs) that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs for racial and ethnic minority populations.	5 LHDs reported providing 27 activities to 615 participants (FY 2002)	≥8 LHDs	6 LHDs reported providing 19 activities to 2,176 participants (FY 2003)	Yes	Activity Plans of LHDs
4.15. (Developmental) Increase by 25 percent the proportion of people age 65 and older that have participated during the preceding year in at least one organized health promotion program.	30,544 65 and older participants via LHD programs (FY 2003)-	≥38,180	49,872 65 and older participants via LHD programs (FY 2004)	Target Achieved	Community Based Planning Data Warehouse

5

Environmental Health

Goal

Health for all through a healthy environment.

Overview

According to the National Center for Environmental Health of the Centers for Disease Control and Prevention—*Environmental public health is the discipline that focuses on the interrelationships between people and their environment, promotes human health and well-being, and fosters a safe and healthful environment.*

As one can tell from the definition, environmental health is very broad and all encompassing. Just the portion of the definition associated with fostering a safe and healthful environment covers a wide range of issues from assuring safe drinking water to reducing beach and recreational water contamination, air pollution, lead exposure in our homes, and environmental exposures to mercury, hepatitis A, and other toxins and pathogens.

The Kentucky Department for Public Health and its partners have strived to protect and ensure a safe environment through policies, enforcement, inspections, and implementation of new processes for emerging environmental health problems and concerns. We will continue to work jointly to protect the health and safety of Kentuckians as well as the environment of Kentucky.

Summary of Progress

Kentucky, through its partnerships with the Poison Control Center, Department for Environmental Protection, Division of Conservation, Department of Fish and Wildlife, and Department for Public Health, has made considerable progress towards a healthier environment. Progress has been made toward reaching the targets of many of the HK 2010 objectives; however, efforts need to be refocused on other objectives to achieve their targets.

Some steps that have been taken include: continued surveillance of waterborne diseases (Kentucky had no outbreaks associated with drinking water as of 2005) and a continued focus on reducing the number of children who are poisoned each year. The baseline for receiving best management plans for agricultural water quality in 2000 was 5,500 plans. By midyear of 2005, 59,000 plans had been received, far exceeding the target. The Kentucky Lead Program has also experienced success. The Lead Program implemented an abatement permits and risk assessment/inspection review to ensure corrective action is taken on homes found to have lead. Progress has been made toward achieving targets in lead abatement activities pertaining to housing.

Other program areas which will be implementing new initiatives are the Consumer Products Section which will begin a partnership with the Department for Environmental Protection. The Consumer Products Section will establish a product safety database in 2006 to monitor and report on injuries and deaths to children from defective products. The database will enable the Department for Public Health to better monitor injuries and allow the Department to take timely action to avoid preventable deaths in children.

The ongoing relationship between the Departments for Environmental Protection and Public Health has facilitated the creation of more dynamic and robust objectives in the areas of health and environmental air quality. These new objectives will be benchmarked in 2005 and 2006. As a result of these new objectives, the impact of air toxins as a whole can be assessed and non-attainment areas for ozone and particulates can be identified. Consequently, Kentucky will be better able to assess the impact of air quality on Kentuckians with asthma, chronic obstructive pulmonary disease (COPD), and other respiratory illnesses. Kentucky will also be in a better position to monitor the impact of state initiatives on air quality and on our citizens' health.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Environmental Health	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
5.1. (Developmental) Ensure that there are no outbreaks of waterborne disease in water intended for drinking.	0 (2000)	0	0 (2005)	Target Achieved	KYEPHRS
5.2. - 5.3. (DELETED)					
5.4R. Increase the number of Best Management Plans set forth by Agriculture Water Quality Act by 80 percent.	5,500 (2000)	≥9,900	59,296 (2005)	Target Achieved	Best Management Plan Database
5.5.1R. Increase the number of abatement permits for lead housing projects to 115 per grant fiscal year.	7 (2000)	≥115	85 (2004)	Yes	Env. Lead Rep. System
5.5.2R. For lead in housing, increase the number of risk assessments/inspections reviewed to 400 reports.	7 (2000)	≥400	307 (2004)	Yes	Env. Lead Rep. System
5.6. (DELETED)					
5.7R. Reduce nonfatal poisonings of children (<19) from exposures to household chemicals by 1 percent.	8,400 (2000)	≤8,316	9,044 (2004)	No	TESS
5.8R. Increase the number of "short" radon test kits conducted.	2,042 (2000)	≥3000	2,801 (2003)	Yes	Public Protection and Safety Database
5.9. - 5.11. (DELETED)					
5.12. Reduce the number of injuries and deaths to children caused by defective consumer products.	Database to be developed in 2006	TBD	TBD	TBD	Product Safety Database
5.13. (DELETED)					
5.14N. Ensure areas of the state designated by U.S EPA, as not meeting an Ambient Air Quality Standard, are brought into compliance to provide healthy air quality for all citizens of the Commonwealth.	8 counties deemed non-attainment for 8 hour ozone (2004); 6 counties deemed non-attainment for fine particulate (2005)	All counties Re-designated to attainment	8 counties deemed non-attainment for 8 hour ozone (2005); 6 counties deemed non-attainment for fine particulate (2005)	No	Federal Air Quality Systems Database
5.15N. Reduce hazardous and toxic air pollutants to levels that protect Kentucky's citizens from excess cancer incidences and/or unacceptable risks.	TBD	TBD	TBD	TBD	

R = Revised objective, N = New objective
 TBD = To be determined. No reliable data currently exist.

6

Food Safety

Goal

Reduce the number of foodborne illnesses.

Overview

The Centers for Disease Control and Prevention (CDC) receive confirmed reports of thousands of foodborne illnesses each year. The number of foodborne illnesses increases significantly when unreported cases are taken into account: an estimated 76 million illnesses, 325,000 hospitalizations, and 5,000 deaths in the United States may be attributable to foodborne illnesses. While the number of foodborne illnesses reported annually in Kentucky is only in the hundreds, it is recognized that just a small percentage of cases are actually reported.

Many factors make foodborne illnesses a growing problem in Kentucky as well as the rest of the nation. The numbers of elderly and immuno-compromised are on the rise. Our food industry has a large number of employees. This creates a high turnover rate. In addition, the employees are increasingly diverse, which may create language barriers. Not all consumers are knowledgeable about safe food preparation practices in the home. Many foods found in our groceries and restaurants may have been produced in another country. We are also becoming cognizant of new and emerging pathogens which were previously not recognized as pathogens in food. Many of these new and emerging pathogens may be resistant to previously effective antibiotics. Another significant factor in increased reporting of pathogens is the database management and data reporting practices now available to capture information. Lastly, sensitivity to possible deliberate contamination of the food supply has increased reporting.

Summary of Progress

Solid progress has been made toward the 2010 objectives. Kentucky is on schedule for adopting the 2001 FDA Food Code this year which will be utilized in the regulation of food safety in all retail food establishments. Also in 2006, Kentucky plans to adopt a statewide food manager certification program. A field prototype program is underway. The Program will require that at least one certified manager will be on duty at all times that a retail food establishment is in operation.

Additionally, a foodborne illness surveillance investigation collection form and the Kentucky reportable disease forms are being utilized so that data may be collected for food related diseases stemming from bacteria and parasites. *Cryptosporidium* has been added to the Kentucky Reportable Disease Surveillance System.

There has been an increased effort to inform consumers of key food safety practices. The food safety curriculum for teaching students throughout Kentucky has been maintained, and both Spanish and Chinese FSAST (Food Safety Accreditation Student Training) videos are being developed.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Food Safety	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
6.1. (Developmental) Reduce the proportion of infections caused by bacteria, parasites and key foodborne pathogens. Reduce the yearly outbreaks for infections due to <i>Salmonella</i> serotype <i>Enteritidis</i> and <i>Escherichia coli</i> 0157:H7.	40 cases of <i>E Coli</i> 0157:H7 (2000)	≤38	31 cases of <i>E Coli</i> 0157:H7; Serotypes on <i>Salmonella</i> are not collected (2004)	Target Achieved	KYEPHRS
6.1a. (Developmental) Reduce foodborne infections caused by the parasitic pathogens <i>Cryptosporidium parvum</i> , <i>Cyclospora cayetanensis</i> , hepatitis A virus, and Norwalk virus.	<i>Cryptosporidium parvum</i> : 7 cases (2000)	≤6	47 (2004)	No	KYEPHRS
	Hepatitis A: 63 cases (2000)	≤60	31 (2004)	Target Achieved	
	<i>Cyclospora cayetanensis</i>	TBD	TBD	TBD	
	Norwalk virus	TBD	TBD	TBD	
6.1b. (DELETED)					
6.2. Reduce the annual incidence of infection from <i>Listeria monocytogenes</i> and <i>Vibrio vulnificus</i> .	<i>Listeria monocytogenes</i> : 4 cases (2000)	≤3	4 (2004)	No	KYEPHRS
	<i>Vibrio vulnificus</i> : 0 cases (2000)	≤1	1 (2004)	Target Achieved	
6.3R. Reduce foodborne infections caused by antimicrobial-resistant bacterial infections of the species <i>Salmonella</i> and <i>Campylobacter</i> .	<i>Salmonella</i> : 393 cases (2000)	≤373	361 (2004)	Target Achieved	KYEPHRS
	<i>Campylobacter</i> : 213 cases	≤202	273	No	

R = Revised objective.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Food Safety	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
6.4. Make food-induced anaphylaxis death a reportable condition. Because allergens are present in a variety of foods, and because even trace amounts of these allergens can induce anaphylaxis, education and clear ingredient information are critical to the management of food allergy.	Not a reportable disease	Make food-induced anaphylaxis death a reportable condition	Not a reportable disease	No	
6.5. (Developmental) Increase the proportion of consumers who practice each of the four key food handling practices.	TBD	TBD	TBD	TBD	
6.6. (Developmental) Reduce occurrences of improper holding temperatures, inadequate cooking, poor personal hygiene, contaminated equipment and foods from unsafe sources.	TBD	TBD	TBD	TBD	
6.7. (Developmental) Assess the changes in pesticide residue tolerances mandated by the Food Quality Protection Act.	TBD	TBD	TBD	TBD	
6.8. (Developmental) Increase to at least 75 percent the proportion of households in which principal food preparers routinely refrain from leaving perishable food out of the refrigerator for over 2 hours and clean and sanitize cutting boards and utensils after contact with raw meat and poultry.	TBD	TBD	TBD	TBD	
6.9. Maintain raw agricultural produce pesticide sampling and monitoring (approx. 200 samples annually).	Program has been maintained	Maintain program	Program has been maintained	Target Achieved	Dept. for Public Health Test Samples
6.10. (Developmental) Conduct fish tissue contaminant analysis (approx. 20 samples annually) for methyl mercury, PCB and chlordane on samples of edible fish species collected from Kentucky permitted commercial fish processing establishments and harvested from KY waterways open to commercial fishing.	28 (2000)	≥20	18 (2004)	No	Specific Lab form 504

TBD = To be determined. No reliable data currently exist.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Food Safety	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
6.11. Maintain inspection surveillance (approx. 1,000 inspections annually) and enforcement under the authority of KRS 217.005 to 217.285 for Kentucky's approximately 1400 food manufacturing and storage firms.	1,049 (2000)	≥1,000	1,180 (2004)	Target Achieved	Inspection Surveillance Reports

7

Injury/Violence Prevention

Goal

To reduce the incidence and severity of injuries from unintentional causes, as well as death and disabilities due to violence.

Overview

In 2000, there were 4,005 unintentional injury deaths in Kentucky with an unintentional injury death rate of 46 deaths per 100,000 population, the 14th highest rate in the nation (National Safety Council, 2004). This rate is 29 percent above the national unintentional injury death rate of 35.6 deaths per 100,000. Nonfatal occupational injury and illness incidence rates are also higher at 7.4 non-fatal injuries and illnesses per 100 full-time workers compared with the national rate of 5.7 injuries and illnesses per 100 full-time workers.

In Kentucky, the leading cause of unintentional death by injury is motor vehicle related incidents (21.1 deaths per 100,000 population), followed by poisoning (5.4 deaths per 100,000 population), falls (3.7 deaths per 100,000 population), choking (2.5 deaths per 100,000 population), and fire and burns (2.1 deaths per 100,000).

Summary of Progress

Significant progress has been made for a number of objectives: nonfatal spinal cord injury rates have decreased; safety belt and child restraint usage have increased; suffocations and unintentional drownings have decreased; fire-related and fall-related deaths have decreased; and homicide rates have declined. With regard to surveillance improvements, pilot collection of emergency department data for 10 Kentucky hospitals has started, and child fatality review teams cover about 50 percent of the state. Increased funding is needed to obtain statewide coverage.

Education, increased awareness, and targeted interventions are necessary for a number of 2010 objectives that are unlikely to be met. These include goals for reducing motor vehicle crash and pedestrian deaths, nonfatal motor vehicle crashes, nonfatal head injuries, nonfatal unintentional injuries, firearm-related deaths, and unintentional injury and poisoning deaths. Poisoning death rates have doubled as a consequence of the increase in illicit prescription drug use. A number of objectives related to violence need to be further addressed: child maltreatment, adult forcible rapes, and sexual assault.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Injury /Violence Prevention	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
7.1R. Reduce to 59 per 100,000 the rate of nonfatal head injuries that are hospitalized.	73.9/ 100,000 (2001)	≤59/ 100,000	70.6/ 100,000 (2003)	No	HOSP
7.2R. Reduce to 4 per 100,000 the rate of nonfatal spinal cord injuries.	6.4/ 100,000 (2001)	≤4/ 100,000	4.3/ 100,000 (2003)	Yes	HOSP
7.3R. Reduce firearm-related deaths to less than 11 per 100,000.	13/ 100,000 (2000)	<11/ 100,000	13.7/ 100,000 (2003)	No	Vital Statistics
7.4. (Developmental) Extend multi-agency, multidisciplinary case review of all unexpected child fatalities (Coroner's cases) among children less than 18 years to all 120 counties.	0 counties reviewed (2000)	120 counties	Approx. 60 counties (2005)	Yes	Vital Statistics and Coroner Report Forms
7.5R. Reduce deaths caused by poisoning to no more than 6.0 per 100,000.	7.1/ 100,000 (2000)	≤6.0/ 100,000	14/ 100,000 (2003)	No	Vital Statistics
7.6R. Reduce deaths caused by suffocation to 4.4 per 100,000.	5.8/ 100,000 (2000)	≤4.4/ 100,000	4.9/ 100,000 (2003)	Yes	Vital Statistics
7.7. (Developmental) Extend the collection of Uniform Hospital data to include emergency departments.	No coverage	Complete coverage	Pilot Testing	Yes	
7.8R. Reduce deaths caused by unintentional injuries to no more than 35 per 100,000 people.	40.9/ 100,000 (2000)	≤35/ 100,000	49.2/ 100,000 (2003)	No	Vital Statistics
7.9R. Reduce nonfatal unintentional injuries so that hospitalizations for this condition are no more than 317 per 100,000.	374.7/ 100,000 (2001)	≤317/ 100,000	387.7/ 100,000 (2003)	No	HOSP
7.10. Reduce deaths caused by motor vehicle crashes to no more than 12 per 100,000 and 1 per 100 million vehicle miles.	16.5/ 100,000 (2000)	≤12/ 100,000	18.8/ 100,000 (2003)	No	Vital Statistics
7.11. Reduce pedestrian deaths on public roads to no more than 1 per 100,000.	1.2/ 100,000 (2000)	≤1/ 100,000	1.3/ 100,000 (2003)	No	Vital Statistics.
7.12. Reduce hospitalizations for non-fatal injuries caused by motor vehicle crashes to 72 per 100,000.	85/ 100,000 (2001)	≤72/ 100,000	85.4/ 100,000 (2003)	No	HOSP
7.13R. Increase use of safety belts to 69 percent of motor vehicle occupants.	60% (2000)	≥69%	66% (2003)	Yes	KY Transportation Center
7.14R. Increase use of child restraints to 96 percent of motor vehicle occupants ages 4 years and younger.	87% (2000)	≥96%	95% (2003)	Yes	KY Transportation Center

R = Revised objective

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Injury /Violence Prevention	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
7.15R. Reduce fire-related deaths to no more than 1.9 per 100,000.	2.2/ 100,000 (2000)	≤1.2/ 100,000	1.8/ 100,000 (2003)	Yes	Vital Statistics
7.16. (DELETED)					
7.17R. Reduce deaths from falls to no more than 3.7 per 100,000.	4.3/ 100,000 (2000)	≤3.3/ 100,000	3.7/ 100,000 (2003)	Yes	Vital Statistics
7.18R. Reduce unintentional drownings to no more than .5 per 100,000.	1.3/ 100,000 (2000)	≤0.5/ 100,000	0.9/ 100,000 (2003)	Yes	Vital Statistics
7.19R. Reduce homicides to less than 4.2 per 100,000 people.	4.9/ 100,000 (2000)	<4.2/ 100,000	4.6/ 100,000 (2003)	Yes	Vital Statistics
7.20R. Reduce to less than 15.9 per 1,000 children the incidence of maltreatment of children younger than age 18.	18.7/ 100,000 (2000)	<15.9/ 100,000	18.3/ 100,000 (2003)	Yes	Child Maltreatment Report
7.21. (Developmental) Reduce to less than 7 per 1,000 the incidence of maltreatment of persons aged 60 and older.	Data not available	<7/1,000	Preliminary data now available	TBD	Dept. for Community Based Services
7.22. (Developmental) Reduce physical abuse by current or former intimate partners to less than 23 per 10,000.	Data not available	<23/ 10,000	Preliminary data now available	TBD	Dept. for Community Based Services
7.23R. Reduce the rate of forced sexual intercourse or attempted forced sexual intercourse of persons aged 18 and older to less than 9.4 per 10,000 persons.	11/ 10,000 (1995)	<9.4/ 10,000	11.9/ 10,000 (2004)	No	Uniform Crime Reports
7.24R. Reduce sexual assault other than rape to less than 0.43 per 1,000 people.	0.5/1,000 (1995)	<0.43/ 1,000	0.52/1,000 (2004)	No	Uniform Crime Reports

R = Revised objective

TBD = To be determined. No reliable data currently exist.

8

Occupational Safety and Health

Goal

Promote worker health and safety through prevention and early intervention.

Overview

Currently, Kentucky's occupational fatality rate is 7 deaths per 100,000 workers (Kentucky Fatality Assessment and Control Evaluation (FACE) program data, 2004), 72.5 percent above the national rate of 4 per 100,000 workers. The nonfatal worker injury rate is also greater in Kentucky at 6.4 injuries and illnesses per 100 workers compared to a total worker injury rate of 5 injuries and illnesses per 100 workers nationwide (Bureau of Labor Statistics [BLS], 2004). FACE data indicate that a total of 2,248 years of potential life were lost (YPLL) in 2003 due to work-related injuries. Lost future productivity attributable to these injuries is an estimated \$65.2 million dollars.

From 1994 through 2004, 1,445 Kentucky workers were killed on the job, averaging 131 per year (Kentucky FACE data). Kentucky's occupational fatality rates are twice as high as national rates in agriculture, forestry, fishing, transportation, and mining.

Summary of Progress

While interventions have been developed for the workplace, targeted prevention interventions are needed in the transportation and construction sectors. Kentucky's construction worker fatal injury rate has not improved since 1998.

Strides have been made in the agriculture, forestry, and fishing industry sectors for the prevention of occupational injuries. Tractor rollover protection structures (ROPS) continue to be promoted by disseminating prevention materials, FACE tractor report text analysis results, and a CD developed by the Community Partners for Healthy Farming project. These materials focus on reducing tractor fatalities by retrofitting tractors with a ROPS and encouraging safe tractor operation through public service announcements, exercises, simulations, motor vehicle crash prevention materials, and other similar materials. This information is designed to be used by local health educators and injury prevention coordinators.

Statewide nonfatal occupational injury and illness surveillance began in 2005 for a number of injuries and illnesses, including pneumoconiosis hospitalizations and mortality, occupational poisonings, blood lead levels, amputations, work-related burns, malignant mesothelioma incidence, and carpal tunnel syndrome, among others. This program will bring a consistent approach to the analysis of existing data sets through the use of uniform methods, results, and interpretation of findings within Kentucky and among states.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Occupational Safety and Health	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
8.1R. Reduce deaths from work-related injuries to no more than 3.6 per 100,000 full time workers.	6/100,000 (1998)	≤3.6/100,000	6.8/100,000 (2004)	No	FACE
8.2. Reduce deaths from work-related injuries among agriculture and forestry occupations to no more than 40 per 100,000 full time agriculture, forestry, and fishing workers.	79/100,000 (1998)	≤40/100,000	46/100,000 (2004)	Yes	FACE
8.3. Reduce deaths from work-related injuries among construction occupations to no more than 12.5 per 100,000 full-time construction workers.	25/100,000 (1998)	≤12.5/100,000	24/100,000 (2004)	Yes	FACE
8.4R. Reduce the number of pneumoconiosis deaths by 10 percent.	Data not yet available	Reduce by 10%	Data not yet available	TBD	

R = Revised objective

TBD = To be determined. Reliable data do not exist.

9

Oral Health

Goal

To improve the health and quality of life for individuals and communities by preventing and controlling oral disease and injuries, and to improve access to oral health care for all Kentuckians.

Overview

Oral disease is a major health problem for Kentuckians. Much of this problem can be prevented through primary prevention efforts, including community water fluoridation, the application of dental sealants and fluoride varnish, oral cancer screenings, and routine dental care as well as oral health education and health promotion.

In 1987, the Office of Oral Health conducted a statewide oral health survey (Kentucky Oral Health Survey - KOHS) consisting of an interview component and a clinical screening component. Findings from this survey were alarming.

Dental caries were a significant problem, with 26 percent of adult Kentuckians 18 to 64 years of age having untreated decay, compared to 6 percent on a national survey conducted by the National Institute of Dental Research in the same year. Additionally, KOHS found that 34 percent of Kentuckians had not visited a dentist within the past 12 months. This number became more disturbing when, nine years later, the 1996 Behavioral Risk Factor Surveillance System (BRFSS) reported that the measure had increased to 38 percent.

Children fared no better than adults with respect to oral health outcomes. In 1987, 30 percent of children aged 0-4 had caries. In the 5-9 age range, 58 percent of children had a decayed filled surface in a primary tooth (dfs) and 34 percent had a decayed filled surface in a permanent tooth (DFS). Twenty-eight percent of children aged 0-4 had untreated decay, while this number rose to 38 percent (dfs) and 27 percent (DFS) for the 5-9 aged children.

Kentucky adolescents proved to have even worse oral health. Eighty-four percent of 14-17 year olds had one or more caries (filled or unfilled), while 67 percent had untreated cavities in primary and permanent teeth.

This information was a catalyst for additional surveys specific to three populations: children, adults, and elders, to be implemented in the current decade. Details about these three surveys are provided, as is updated information about other projects undertaken by the Oral Health Program.

Summary of Progress

Ninety percent of Kentucky's 4.1 million residents receive optimally fluoridated water. The remaining 10 percent of Kentuckians have wells, cisterns, or springs as their source of water.

The KIDS SMILE Children's Oral Screening and Fluoride Varnish application program has increased the number of children (aged 0 to 5) who have received oral health screenings. The program has also provided over 27,000 topical applications of fluoride varnish. Additionally, Kentucky has begun a sealant program in partnership with local health departments to encourage front-line public health agencies and local dental professionals to work together to combat childhood decay in permanent molars.

The oral health status of adults has also improved since the inception of this document. Data from the BRFSS indicate that the proportion of edentulous Kentuckians decreased from 42.9 percent in 1996 to 38.1 percent in 2004. Additionally, the proportion of adults using the oral health care system increased from 62 percent in 1996 to nearly 70 percent in 2004. And the proportion of oral cancer lesions detected early (in situ and local), has improved from 47 percent in 2000 to 49 percent in 2003. While this is a modest increase, it does bring Kentucky closer to the 2010 goal of 57 percent.

To meet the needs for data acquisition and analysis in the area of oral health, two surveys have been completed during this period: the Kentucky Children's Oral Health Profiles 2001 (University of Kentucky College of Dentistry) and the Kentucky Adult Oral Health Survey 2002 (University of Louisville School of Dentistry). A third survey, the Elder Oral Health Survey, is currently near completion (University of Kentucky College of Dentistry) and results will be reported by the end of 2006.

To monitor the health status of children and adults throughout the state on a continuous basis, the Children's Oral Health Surveillance System (visual screening) and an adult surveillance program (using the BRFSS methodology) will be implemented in FY06.

Funding from the Health Resources and Services Administration and the Maternal and Child Health Bureau, has made possible the development of a statewide Oral Health Strategic Plan and a Dental Professional Workforce Study.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Oral Health	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
9.1. Reduce the proportion of children who have had one or more dental caries in the primary and permanent teeth (filled or unfilled). Children Ages 2-5	46.8% (2001)	≤15%	46.8% (2001)	N/A	COHSS
Children Ages 6 to 8	56.1%	≤40%	56.1%		
Children Age 12	56.1%	≤50%	56.1%		
Adolescents Age 15	No Data	≤55%	No Data		
9.2. Reduce the proportion of children with untreated cavities in the primary and permanent teeth (decayed teeth not filled). Children Ages 2 to 5	28.7% (2001)	≤12%	28.7% (2001)	N/A	COHSS
Children Ages 6 to 8	28.7%	≤22%	28.7%		
Children Age 12	28.7%	≤20%	28.7%		
Adolescents Age 15	No Data	≤15%	No Data		
9.3. (DELETED)					
9.4R. Reduce the proportion of Kentuckians 65+ who have lost all of their natural teeth (edentulous).	42.9% (1996)	≤20%	38.1% (2004)	Yes	BRFSS
9.5R. Increase the proportion of oral cancer lesions detected at Stage 0 and 1 (in situ and local).	47% (2000)	≥57%	49% (2003)	Yes	KCR
9.6. Increase the proportion of 8 year olds, 12 year olds and 15 year olds who have received protective sealants in permanent molar teeth.	29.1% of Kentucky 3rd & 6th graders have dental sealants. (2001)	≥50%	29.1% of Kentucky 3rd & 6th graders have dental sealants. (2001)	N/A	COHSS

R = Revised objective

N/A = Only baseline data are available. Not able to determine progress at this time.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Oral Health	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
9.7. Increase proportion of the population served by community water systems with optimally fluoridated water.	90% of Kentucky's population received optimally fluoridated water in 1996.	≥95%	90% (2004)	No	Fluoridation Database
9.8. (Developmental) Increase to at least 70 percent the proportion of children ages 6, 7, 12, and 15 who have participated in an oral health screening, including those who have been referred, and those who have received the appropriate follow-up.	TBD	≥70% of children Ages 6, 7, 12, and 15	TBD	TBD	COHSS
9.9. Increase the proportion of adults aged 18 and older using the oral health care system (those who have used the system each year)	62% of Kentuckians visited a dentist or dental clinic within the past 12 months. (1996)	≥70%	69.8% (2004)	Yes	BRFSS
9.10. (DELETED)					
9.11. (Developmental) Increase the proportion of local health departments that have an oral health education component focusing on adults and children from infancy through 5 years of age.	25% (1997)	100%	90% (2005)	Yes	Local Health Dept. Survey
9.12. (Developmental) Design, implement and fund on-going oral health surveillance systems to include components to measure youth, adult, and elder oral health.	No systems in 2000	Surveillance systems in place	Children, adult, and elder oral health surveys completed	Yes	COHSS; Adult Oral Health Survey
9.13R. Increase the proportion of long term care residents who use the oral health care system each year.	28.3% (2005)	≥50%	28.3% (2005)	N/A	Elder Oral Health Survey.
9.14. Insure that Kentucky has a viable system for recording and referring all infants and children up to age 5 with cleft lip, cleft palate and other craniofacial anomalies to craniofacial anomaly rehabilitative teams.	KBSR system in place	Referral system in operation	KBSR system in place	Yes	KBSR

R = Revised objective

N/A = Only baseline data are available. Not able to determine progress at this time.

TBD = To be determined. No reliable data currently exist.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Oral Health	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
9.15. (Developmental) Increase the proportion of children ages 2 through 5 who have received at least one annual fluoride varnish application and oral health screening, including adequate referral and follow-up as needed.				N/A	KIDS SMILE Database
Age 2	11% (2005)	≥50%	11% (2005)		
Age 3	9%	≥50%	9%		
Age 4	11%	≥50%	11%		
Age 5	7%	≥50%	7%		

N/A = Only baseline data are available. Not able to determine progress at this time.

10

Access to Quality Health Services

Goal

Improve access to a continuum of comprehensive, high quality health care using both the public and private sectors in Kentucky.

Overview

Healthy Kentuckians 2010 built on the *Healthy Kentuckians 2000* goals in the priority areas of Clinical Preventive Services and Health Services, which included both access and barrier issues in primary and preventive health care. *Healthy Kentuckians 2010* acknowledged those past efforts and looked at the many disparities remaining with the intent of eliminating as many of those disparities as possible in the arenas of Clinical Preventive Services, Primary Care, Emergency Medical Services, and Long-Term Care and Rehabilitative Services. The goals and objectives outlined focus on areas of large disparity where attention to prevention and quality can demonstrate improved health care delivery and outcomes. The Mid-Decade Review examines these goals for relevance and provides an update on progress.

Summary of Progress

Access to Quality Health Service objectives of Chapter 10 have seen mixed progress in the last five years. Much of the progress has been shaped by national events and initiatives not solely within the scope of control of a state agency. Other objectives are no longer under the purview of the state health agency, having been moved to agencies outside the Cabinet for Health and Family Services. Objectives previously associated with the Cabinet are not priorities for the reorganized agencies. Other objectives are still developmental and need constant and reliable data sources to be useful as tracking objectives.

Objectives 1 through 5 have seen an increase in uninsured over the period, despite hopeful signs of progress in reducing the degree of under or uninsured. Objectives 9 through 11 have seen some activity and recommendations are made to merge some of those objectives. The Emergency Medical Services (EMS) objectives (10.13, 10.14, and 10.17) were originally listed as developmental and are still that way. Progress has not been made toward institutionalizing these objectives. In fact, responsibility for the EMS program has been transferred out of the Cabinet for Health and Family Services to an independent body—the Kentucky Board of Emergency Medical Services (KBEAM). Over the next five years it is anticipated that the Cabinet would have an opportunity for input into EMS goals, objectives, and data needs. In the interim, however, the status of the EMS objectives remains undetermined.

Long Term Care (LTC) development goals (Objectives 20, 21) are all still valid but will be difficult to validate without a reliable data source. Additionally, responsibility for health policy has been transferred to the newly created Office of Health Policy in the Secretary's Office, Cabinet for Health and Family Services. Further discussion needs to be held to determine if and how these objectives can be met. What is clear is that the occupancy rate in LTC facilities continues to drop while the population of elderly increases. This means that citizens are entering later stages of life in better physical health, and/or that adult day care and home health are providing increasingly sophisticated services that allow individuals to stay at home. The role of assisted living facilities is also important to the decrease in LTC stays. For future reference a look at the increased use of LTC insurance would be helpful, because most policies have as a primary goal that of keeping people in their homes.

It is expected that over the next five years the new Office of Health Policy will have an opportunity to address some of the acute care and long term care objectives and data needs. In the interim, the status of Objectives 10.12, 10.16, and 10.18-10.23) remains undetermined.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Access to Quality Health Services	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
10.1. Reduce to zero the proportion of children and adults without health care coverage.	Adults: 14.3% (1998)	0%	14.9% (2004)	No	BRFSS
10.2. Increase the proportion of patients who have coverage for clinical preventive services as part of their health insurance.	TBD	Increase	TBD	TBD	
10.3. (Developmental) Increase the proportion of current smokers and problem drinkers who report being counseled about smoking and alcohol use at the last visit to their health care provider.	73.3% (2003) Current smokers only	≥75%	70.8% (2004)	No	BRFSS
10.4. Increase the collection and reporting of information on delivery of recommended clinical preventive services, by provider group, health plan, health system and payer status.	TBD	Increase	TBD	TBD	
10.5. Increase the proportion of physicians, PA's, nurses and other clinicians who receive appropriate training to address important health disparities: disease prevention and health promotion, minority health, women's health, geriatrics.	TBD	Increase	TBD	TBD	
10.6. Increase to at least 90 percent the proportion of people who have a specific source of ongoing primary care.	84.4% (2001)	≥90%	82.9% (2004)	No	BRFSS
10.7. (DELETED)					
10.8. Reduce to no more than 7 percent, the proportion of individuals/families who report that they did not obtain all of the health care that they needed.	13.8% (2000)	≤7%	17.9% (2003)	No	BRFSS
10.9. (DELETED)					
10.10. Reduce by 25 percent the number of individuals lacking access to a primary care provider in underserved areas.	987,322 (1997)	≤740,492	707,271 (2004)	Yes	HRSA

TBD = To be determined. No reliable data currently exist.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Access to Quality Health Services	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
10.11R. Increase the proportion of individuals from under represented racial and ethnic minority groups that have registered for licensure with the Board of Nursing.	<u>RN (2005)</u> Af. Am. 2.5% Asian Indian .05% Asian Oth. .55% Hispanic .28% Native Am. .36% Pac. Isl. .06% White/NH 95.84% <u>LPN (2005)</u> Af. Am. 8.5% Asian Indian .06% Asian Oth. .2% Hispanic .28% Native Am. .4% Pac. Isl. .03% White/NH 89.7%	Increase from under represented minority groups	<u>RN (2005)</u> Af. Am. 2.5% Asian Indian .05% Asian Oth. .55% Hispanic .28% Native Am. .36% Pac. Isl. .06% White/NH 95.84% <u>LPN (2005)</u> Af. Am. 8.5% Asian Indian .06% Asian Oth. .2% Hispanic .28% Native Am. .4% Pac. Isl. .03% White/NH 89.7%	N/A	KY Board of Nursing
10.12. Reduce preventable hospitalization rates by 25 percent for chronic illness for three ambulatory care sensitive conditions – pediatric asthma, immunization preventable pneumonia and influenza in the elderly, and diabetes – by improving access to high quality primary care services.	TBD	Reduce by 25%	TBD	TBD	
10.13. Increase the proportion of all individuals who have access to rapidly responding pre-hospital EMS.	TBD	Increase	TBD	TBD	
10.14.(Developmental) Increase the proportion of patients whose access to EMS when and where they need them is unimpeded by their health plan's coverage or payment policies.	TBD	TBD	TBD	TBD	
10.15. (DELETED)					
10.16. (Developmental) Assess the proportion of eligible patients with acute myocardial infarction (AMI) who currently receive clot-dissolving therapy within an hour of symptom onset, and establish a realistic plan for im-	TBD	TBD	TBD	TBD	

R = Revised objective

N/A = Only baseline data are available. Not able to determine progress at this time.

TBD = To be determined. No reliable data currently exist.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Access to Quality Health Services	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
10.17. (Developmental) Assess the proportion of persons with witnessed, out-of hospital cardiac arrest currently receiving their first therapeutic shock within 10 minutes of collapse recognition, and establish a realistic plan for improvement.	TBD	TBD	TBD	TBD	
10.18. (Developmental) Incorporate “model” pediatric ALS and BLS protocols into a comprehensive set of protocols for both adults and children. Facilitate implementation and use of comprehensive protocols through use	TBD	Incorporate standards	TBD	TBD	
10.19. (Developmental) Develop and implement a program to identify hospitals that are prepared and committed to provide emergency treatment for children. Disseminate information about such hospitals to ambulance	TBD	Program developed	TBD	TBD	
10.20. (Developmental) Increase the number of primary care providers who routinely provide or refer potential long-term care patients for a functional assessment.	TBD	Increase	TBD	TBD	
10.21. (Developmental) Increase the proportion of primary care providers who routinely evaluate, treat, and, if appropriate, refer their long-term care patients to subacute rehabilitative and other services to address: Physical mobility Urinary incontinence Polypharmacy Communicating and hearing disorders Depression Dementia Mental disorders, including alcoholism and substance abuse	TBD	Increase	TBD	TBD	

TBD = To be determined. No reliable data currently exist.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Access to Quality Health Services	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
10.22. (Developmental) Assure that every person with long-term care needs has access to the continuum of long-term care services, especially: Nursing home care Home health care Adult day care Assisted living	TBD	Assure access	TBD	TBD	
10.23. Reduce to no more than 6.0 per 1,000 the proportion of nursing home residents with pressure ulcers at stage 2 or greater.	TBD	Reduce to no more than 6.0 per 1,000	TBD	TBD	

TBD = To be determined No reliable data currently exist.

11

Family Planning

Goal

Make all pregnancies in Kentucky intended pregnancies.

Overview

The mission of the Kentucky statewide Family Planning Program remains that of providing the target population of low-income men and women at any age the information and the means to choose the number and the spacing of their children. Kentucky's priorities are identical to those of the federal Title X Program in fulfilling this mission. Reducing unintended pregnancies in Kentucky will have far-reaching effects in both medical and social settings. The social costs of unintended pregnancies include reduced educational achievement, reduced employment opportunities, increased welfare rolls, and increased potential for domestic violence and child abuse. Rising medical costs can create a barrier for individuals seeking family planning services. Limited availability of federally funded family planning services can be directly associated with the resultant number of low birth weight infants, Sudden Infant Death Syndrome (SIDS), neonatal mortality, miscarriages, and follow-up treatment for "babies having babies".

While most people obtain contraceptive care from a private physician, access can be problematic for those who cannot afford a private physician, for those who need confidential care, or who live in areas where few private physicians are available. Federally funded family planning programs assist in eliminating the disparity in access to preventive and reproductive healthcare. Federally funded family planning services allow individuals the availability and accessibility of contraceptive services and supplies while supporting their motivation to act on that information to protect themselves and their partners from unwanted outcomes.

Summary of Progress

Great strides have been made toward achieving the 2010 objectives. Progress has been made on objective 11.1 which relates to increasing planned pregnancies among women age 15-44. The target was 87 percent for this objective and the mid-decade status was 85.7 percent. Progress was made toward achieving Objective 11.5R. For this objective, the number of men who received services at family planning clinics increased by 21 percent. For objective 11.6R, the pregnancy rate among adolescents age 15 to 17 declined 19 percent. The Kentucky Family Planning Program plans to increase women's knowledge about the availability of highly effective contraception since progress was not made in reaching this objective. Only baseline data are available for the other objectives; however, strategies are in place to promote progress in attaining their 2010 targets.

The State Family Planning Program continually reinforces to its delegate agencies the need to increase community access and awareness of family planning services. Increasing the number of clinic days, expanding clinic hours, and broadening community outreach are all ways to eliminate current health disparities.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Family Planning	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
11.1R. (Developmental) Increase to at least 87 percent the proportion of all pregnancies among women age 15-44 that are planned.	85.1% (2000)	≥87%	85.7% (2003)	Yes	BRFSS
11.2. Decrease to no more than 7 percent the percentage of women age 15-44 experiencing pregnancy despite use of a reversible contraceptive method.	17.3% (2003)	≤7%	17.3% (2003)	N/A	BRFSS
11.3. Increase to at least 95 percent the proportion of all females aged 15-44 at risk of unintended pregnancy who use highly effective contraception.	67.9% (2000)	≥95%	53.9% (2002)	No	BRFSS
11.4. Increase to 100 percent the proportion of Title X family planning clinics that provide, either directly or through referral, postcoital hormonal contraception.	90% (2004)	100%	90% (2004)	N/A	PSRS
11.5R. Increase male involvement in pregnancy prevention and family planning as measured by the increase with which health providers provide outreach, education, or services to males.	610 (2000) Number of men receiving services at family planning clinics	≥915	738 (2004)	Yes	PSRS
11.6R. Reduce pregnancies among females ages 15-17 to no more than 20 per 1,000 adolescents.	31.9/1,000 (2000)	≤20/1,000	25.8/1,000 (2003)	Yes	Vital Statistics
11.7. Increase by at least 10 percent the proportion of sexually active individuals, ages 15-19, who use barrier method contraception with or without hormonal contraception to prevent sexually transmitted disease, and prevent pregnancy.	62.8% (2003)	≥69.1%	62.8% (2003)	N/A	YRBSS
11.8R. Increase by 10 percent the proportion of health education courses in public and private middle/junior and senior high schools that require instruction on human sexuality, pregnancy prevention, STD prevention, and HIV prevention.	(2002)		(2002)		SHEP
Middle School					
Pregnancy Prevention	82.9%	≥91.2%	82.9%	N/A	
HIV Prevention	97.3%	100.0%	97.3%	N/A	
STD Prevention	94.7%	100.0%	94.7%	N/A	

R = Revised objective

N/A = Only baseline data are available. Not able to determine progress at this time.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Family Planning	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
<u>Middle School</u>					
Human Sexuality	77.6%	≥85.4%	77.6%	N/A	
<u>High School</u>					
Pregnancy Prevention	96.4%	100.0%	96.4%	N/A	
HIV Prevention	98.2%	100.0%	98.2%	N/A	
STD Prevention	98.2%	100.0%	98.2%	N/A	
Human Sexuality	92.0%	100.0%	92.0%	N/A	

N/A = Only baseline data are available. Not able to determine progress at this time.

12

Maternal, Infant, and Child Health

Goal

Improve maternal health and pregnancy outcomes and reduce the rate of disability in infants, thereby improving the health and well being of women, infants, children, and families in the Commonwealth of Kentucky.

Overview

Improving the health of mothers and infants is a national as well as a state priority. Infant mortality is an important measure of a state's health and an indicator of health status and social well being. In addition, the disparity in infant mortality rates between whites and African Americans and other specific ethnic groups persists.

Infant mortality is not the only measure of the health of infants. This chapter addresses a range of indicators of maternal, infant, and child health, including those affecting women of childbearing age, pregnant, and post-partum women.

Summary of Progress

Great strides have been made toward achieving the 2010 Objectives. The target was surpassed for objective 12.16 which relates to decreasing neural tube defects to 12 per 10,000 births by increasing the proportion of women of childbearing age taking daily folic acid supplements. The mid-decade status of neural tube defects is 5.3 per 10,000 births (more than a 50 percent reduction below the 2010 Objective), while the proportion of women of childbearing age taking daily folic acid supplements is 45.6 percent (a 9.4 percent increase from 2000). The 2010 target was also surpassed by 34 percent for Objective 12.20 which relates to increasing the number of pregnant alcohol and drug abusers admitted to publicly funded substance abuse treatment programs. Progress has been made towards meeting the proportion of women who breastfeed their infants at hospital discharge from 54.2% to 56.5%, and a steady increase is being made in the WIC population who have breastfed from 26% in 2001 to 30.1% in 2004. Progress is also being made toward increasing the percent of newborns screened for hearing disorders before discharge, and in decreasing the death rate for children ages 5-14 in the state. The infant mortality rate has declined to 6.5 per 1,000 live births, down from 7.2 per 1,000 in 2002, and the perinatal mortality rate has declined considerably since 2001. Although the maternal mortality rate increased sharply in 2002, the rate has continued to decline since, and is currently at 7.7 per 100,000 live births. For areas in which targets are not being met, interventions and strategies have been put in place to improve the likelihood of achieving our 2010 Objectives.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Maternal, Infant, and Child Health	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
12.1. To reduce infant mortality to no more than 6/1,000 live births.	6.7/1,000 (2000)	≤6/1,000	6.5/1,000 (2004)	Yes	Vital Statistics
12.2. Reduce the infant mortality rate due to birth defects to 1.2 per 1,000 live births.	1.4/1,000 (2000)	≤1.2/1,000	1.1/1,000 (2004)	Target Achieved	Vital Statistics
12.3. Reduce the Sudden Infant Death Syndrome (SIDS) mortality rate to 0.3 per 1,000 live births.	0.6/1,000 (2000)	≤0.3/1,000	0.9/1,000 (2004)	No	Vital Statistics
12.4. Reduce the rate of child mortality a) to 20 per 100,000 children ages 1-4 and b) 17 per 100,000 children ages 5-14.	a)33.8/100,000 (2000)	≤20/100,000	33.9/100,000 (2004)	No	Vital Statistics
	b)17.5/100,000 (2000)	≤17/100,000	17/100,000 (2004)	Target Achieved	Vital Statistics
12.5. Reduce the fetal death rate to no more than 4 per 1,000 live births plus fetal deaths.	6.4/1,000 (2000)	≤4.0/1,000	5.7/1,000 (2004)	Yes	Vital Statistics
12.6. Reduce the perinatal mortality rate to no more than 4.5 per 1,000 live births plus fetal deaths.	9.1/1,000 (2000)	≤4.5/1,000	7.5/1,000 (2004)	Yes	Vital Statistics
12.7. Reduce the maternal mortality rate to no more than 3.3 per 100,000 live births.	3.6/100,000 (2000)	≤3.3/100,000	7.7/100,000 (2004)	No	Vital Statistics
12.8R. Increase to 25 percent the percentage of women of childbearing age who routinely receive preconception counseling in the local health department.	13.3% (2000)	≥25%	11.1% (2004)	No	PSRS
12.9. Increase to at least 90 percent the proportion of all pregnant women who begin prenatal care in the first trimester of pregnancy.	85.7% (2000)	≥90%	86.2% (2004)	Yes	Vital Statistics
12.10. Increase to at least 95 percent the proportion of all live born infants whose mothers received adequate prenatal care based on the Kotelchuck Index.	80.6% (2000)	≥95%	82% (2004)	Yes	Vital Statistics
12.11. (DELETED)					
12.12. Reduce the incidence of a) low birth weight to no more than 5 percent, b) very low birth weight to no more than 1 percent and c) reduce the incidence of premature birth to no more than 7.6 percent of all live births.	a)8.2% (2000)	≤5%	8.4% (2004)	No	Vital Statistics
	b)1.5% (2000)	≤1%	1.5% (2004)	No	Vital Statistics
	c)12.7% (2000)	≤7.6%	15.8% (2004)	No	Vital Statistics

R = Revised objective

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Maternal, Infant, and Child Health	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
12.13. Increase to at least 90 percent the proportion of very low birth weight infants (<1500 grams) born at facilities equipped for high-risk deliveries and neonates.	51.7% (2000)	≥90%	52% (2004)	Yes	Vital Statistics
12.14. (DELETED)					
12.15R. Increase to at least 75 percent the proportion of mothers who breastfeed their babies at hospital discharge; to at least 50 percent the proportion who continue breastfeeding until their babies are 6 months old; and increase among the WIC population to at least 50 percent the proportion of mothers who have ever breastfed their babies; to at least 25 percent the proportion who are currently breastfeeding their babies.					
<u>Kentucky</u> Hospital discharge	54.2% (2000)	≥75%	56.5% (2002)*	Yes	Ross Survey
6 months of age	23.9% (2000)	≥50%	25.3% (2002)*	Yes	Ross Survey
<u>WIC Population</u> Ever breastfed	26% (2001)	≥50%	30.1% (2004)	Yes	WIC
Currently breastfeed	8.8% (2001)	≥25%	12.7% (2004)	Yes	WIC
12.16. Reduce the incidence a) of Neural Tube Defects (Spina Bifida and Anencephaly) to 12/10,000 births b) by increasing to at least 50 percent the proportion of women of childbearing age who take a daily vitamin that contains 0.4mg of folic acid.	a)8.7/10,000 (2000)	≤12/10,000	5.3/10,000 (2004)	Target Achieved	KBSR
	b)41.7% (2000)	≥50%	45.6% (2004)	Yes	BRFSS
12.17R. Increase to at least 20 percent the proportion of pregnant smokers who abstain from tobacco use beginning in the first trimester of pregnancy and maintain abstinence for the remainder of their pregnancy.	11.7% (2004)	≥20%	11.7% (2004)	N/A	Vital Statistics

R = Revised objective N/A = Only baseline data are available. Not able to determine progress at this time.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Maternal, Infant, and Child Health	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
12.18.-12.19. (DELETED)					
12.20. Increase by 50 percent the number of pregnant alcohol and/or drug abusers who are admitted to publicly funded substance abuse treatment programs.	276 (2000)	≥414	630 (2004)	Target Achieved	MHMR
12.21R. Ensure that 96 percent of all newborns are tested for phenylketonuria (PKU), congenital hypothyroidism, galactosemia, and hemoglobinopathies.	94.5% (2001)	≥96%	93.2% (2003)	No	NBS & Vital Statistics
12.22. (DELETED)					
12.23R. Reduce the number of children with serious developmental disabilities such as Cerebral Palsy among children aged 0-5 years old and Hearing Impairment, Visual Impairment, and Developmental Delay among children aged 3-8 years.					
Cerebral Palsy	39 (2000)	≤21	22 (2002)	Yes	KBSR
Hearing Impairment	765 (2000)	≤671	706 (2004)	Yes	KDE
Visual Impairment	494 (2000)	≤437	460 (2004)	Yes	KDE
Developmental Delay	6,982 (2000)	≤6,633	9,808 (2004)	No	KDE
12.24R. Increase to 100 percent the number of newborns who are screened for hearing disorders	99.2% (2001)	100%	99.4% (2004)	Yes	UNHS

R = Revised objective

13

Medical Product Safety

Goal

Ensure the safest and most effective use of medical products.

Overview

Over the last two to three decades, several federal programs and initiatives have been developed to assure the safe and effective use of medical products. Many states including Kentucky have implemented programs designed to complement or enhance these federal initiatives. For example, in 1998, Kentucky implemented a Controlled Substances Act and promulgated corresponding regulations. In the last 5-6 years Kentucky has also developed a uniform electronic database which captures information on prescriptions for controlled substances. This database has proven to be a significant enhancement in assuring the safe use of controlled substances.

Misuse and abuse of controlled drugs is a serious problem in Kentucky. Over the last two years, articles have appeared in the *Lexington Herald Leader* concerning abuse of controlled substances by both Medicaid and non-Medicaid individuals particularly in the mountains of Eastern and Southeastern Kentucky. Abuse of controlled substances is harmful to individuals and families as well as to communities and the state at large. The individual, family, and society all bear the consequences of addiction. An electronic data system which captures prescriptions for controlled substances is essential in determining the extent of the problem and in creating solutions to curb continued abuse.

Summary of Progress

On July 1, 1999, the KASPER (Kentucky All Schedule Prescription Electronic Reporting) database was implemented statewide. This electronic database was designed to capture information on prescriptions for controlled substances that are dispensed within Kentucky. The database is quite comprehensive in that it captures information on all schedules of controlled substances for which there is a legitimate medical use-- Schedules II-V. Information on out of state dispensing to Kentucky residents (via mail order) is also captured, provided the patient does not visit the dispensing agent in person. This informational system facilitates targeting of individuals (prescribers, dispensers, and end users) who are in violation of Kentucky's Controlled Substances Act. The electronic information system also provides valuable information to prescribing health care professionals on other controlled substances that the patient may be using.

In 2002 duties associated with the Department for Public Health's Drug Control Branch including responsibility for the KASPER reporting system were transferred to the Office of the Inspector General, Cabinet for Health and Family Services. Through this transfer increased emphasis was placed on investigation, follow-up, and enforcement of regulations in situations involving controlled substance abuse. Because of the transfer to an investigational/enforcement unit, there are no plans at this time to pursue some of the preventive measures originally developed by Department for Public Health staff (Objectives 13.3-13.5).

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Medical Product Safety	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
13.1. Maintain an electronic database of 90% of all prescription controlled substances dispensed to citizens of the Commonwealth.	Database first implemented in FY 2000	≥90%	95% (2005)	Target Achieved	KASPER
13.2. Expand the electronic monitoring system described in Objective 13.1.	a) Lag time in reporting averaged 16 days	Decrease lag time in reporting	Lag-time of reporting not decreasing	No	KASPER
	b) Data not readily available to professionals	Expand availability	Expanded access to health professionals	Yes	
13.3. – 13.5. (DELETED)					

14

Public Health Infrastructure

Goal

Ensure that the public health infrastructure at the state and local levels has the capacity to provide essential public health services.

Overview

A strong and competent public health workforce is vital to protecting and promoting the health of Kentuckians as well as the health of our local communities. Kentucky's public health workforce provides essential services in the areas of disease surveillance and investigation; monitoring the safety and cleanliness of restaurants and other public establishments, protecting us against environmental hazards, educating the public in healthy lifestyles and disease prevention, and responding to disasters and other emergencies. Recent disasters (Hurricanes Katrina and Rita) have made it apparent that a well organized and well functioning public health workforce is essential in disaster planning and recovery.

Summary of Progress

Kentucky's public health workforce has entered the 21st century better equipped and better trained. State general funds appropriated by Kentucky's Legislature in the 2000-2002 Biennium provided training to local health departments to transition from clinical services to population-based services. A multi-disciplinary team of training coordinators implemented a competency-based curriculum using the core public health functions and essential services as a guide. The Department for Public Health partnered with four universities for needs assessments and curriculum development and implementation. Additionally, the funding provided a base of support for the Kentucky Public Health Leadership Institute (KPHLI) at the University of Kentucky. This Institute provides special training and mentoring for state and local public health workers.

During this time, Kentucky also applied for and received several grants relating to bioterrorism and other public health emergencies. These funds significantly bolstered the state's epidemiological expertise and ability to respond to a disaster or bioterrorism event. (Kentucky sent several teams of professionals to assist in the aftermath of Hurricanes Katrina and Rita.)

Kentucky is also well on its way in establishing the Kentucky Electronic Public Health Records System (KYEPHRS). Through KYEPHRS, an electronic record will be initiated on all babies born in Kentucky beginning in FY 2006. This electronic information system will give health care professionals improved additional information on the health status of Kentuckians, and as a result, facilitate better care. Any contact with a health care facility or provider will initiate an update on the child's electronic record. Through the availability of federal and state funds, Kentucky has been able to bring its public health information (IT) systems into the 21st century.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Public Health Infrastructure	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
14.1. (Developmental) Increase to 100% the number of local health departments (LHDs) that incorporate specific competencies for public health workers into the public health personnel system.	Not established	100%	TBD	TBD	Survey of LHDs in FY 2007
14.2. (Developmental) Increase the number of schools training public health workers that integrate specific training in the essential public health services into their curricula.	Four schools of public health include training; Of nursing schools surveyed, no training included (2005)	Higher than baseline	Same as baseline	N/A	Survey of Schools of Public Health and Nursing Schools
14.3. (Developmental) Increase by 10 percent the number of public health agencies that provide continuing education and training to 100 percent of their employees to improve performance of the essential public health services.	100% (2001-2002)	100%	TBD	TBD	Survey of Public Health Agencies
14.4. The state and all local health departments will provide onsite access to data via electronic systems and online information systems such as the Internet.	Few LHDs had onsite access (1999)	Access Provided	DPH and all LHDs have onsite access (2005)	Yes	Survey of LHDs and DPH
14.5R. To assure accessibility by the public to public health information and surveillance data via the internet while maintaining privacy, confidentiality, and security.	Limited KY public health data on internet (1999)	Assure accessibility to the public	All libraries have internet to public free of charge. CHFS now has an internet site that contains public health data	Yes	Review and maintenance of CHFS website
14.6. Increase to 100 percent the proportion of <i>Healthy Kentuckians 2010</i> objectives that can be tracked for select populations.	62.8% (2005)	100%	62.8% (2005)	Yes	HK 2010 Mid-Decade Review

R = Revised Objective

N/A = Only baseline data are available. Not able to determine progress at this time.

TBD = To be determined. No reliable data currently exist.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Public Health Infrastructure	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
14.7. Increase to 90 percent the proportion of <i>Healthy Kentuckians 2010</i> objectives that are tracked at a) least every three years, and b) to 60 percent the proportion of objectives that are tracked annually.	a)86.3% (2005)	a)90%	86.3% (2005)	Yes	HK 2010 Mid-Decade Review
	b)50%	60%	50%	Yes	
14.8. (Developmental) Increase the use of geocoding in all state health data systems to promote geographical information systems (GIS) as a tool for enhanced surveillance and data information.	In 2000 geocoding in KY health data systems was non-existent	Increase geocoding	In 2005 geocoding has been used in the Environmental Health Program and in the Epidemiology Division	Yes	Review of geocoding section of public health data systems
14.9. Ensure access to an essential set of accurate, reliable, and timely population-based public health and environmental health laboratory services primarily in support of the Department for Public Health, but also in support of the Department of Mental Health and Mental Retardation, the Justice Cabinet, and the Labor Cabinet.	In 2001, Div. of Lab Services provided full range of lab services as mandated by statute	Ensure access to lab services	In 2005, Div. of Lab Services provided full range of lab services as mandated by statute	Yes	Review of lab services
14.10. Increase to 100 percent the proportion of local health departments that provide comprehensive epidemiology services to support core public health activities.	90% (2005)	100%	90% (2005)	N/A	Division of Epidemiology and LHDs
14.11R. Increase the proportion of state and local public health agencies that make expenditure data readily available to the public.	Not established	Increase from baseline	TBD	TBD	Survey of LHDs
14.12. (Developmental) Facilitate greater collaboration and cooperation between public and private agencies for conducting population-based prevention research.	Not established	Greater collaboration	TBD	TBD	
14.13. (Developmental) Maintain at 100 percent the number of state and local health agencies that use summary measures of population health.	100%	100%	100%	Target Achieved	Review of LHDs

R = Revised objective

N/A = Only baseline data are available. Not able to determine progress at this time.

TBD = To be determined. No reliable data currently exist.

15

Health Communication

Chapter 15 “Health Communication” has been eliminated from Kentucky’s 2010 objectives and mid-decade review because of a lack of measurable data to assess the status of Chapter objectives. Additionally, information on health education/health communications is addressed to some degree under the “Strategies to Achieve Objective” sections of each HK 2010 Mid-Decade Review chapter. (Information on one of the “Health Communication” Chapter objectives, Objective 15.1 relative to public access to health information, is specifically addressed under Objective 14.5 of Chapter 14-Public Health Infrastructure.)

Goal

Reduce the impact of selective musculoskeletal conditions by lessening their occurrences, activity limitations, and disabilities.

Overview

An increasing number of Americans have focused attention on the prevention and treatment of certain disabling conditions, because they desire to increase the quality and longevity of their lives. Musculoskeletal conditions such as arthritis, osteoporosis, and chronic back pain are all relevant conditions of interest for the public health system.

Arthritis

Arthritis encompasses more than 100 diseases and related conditions. Osteoarthritis, gout, rheumatoid arthritis, and fibromyalgia are among the most common forms of arthritis. Rheumatoid arthritis and lupus are two forms of arthritis that can affect multiple organs and result in widespread symptoms with seriously disabling effects. Kentucky is known to have one of the highest arthritis prevalence rates in the nation. The 2003 Behavioral Risk Factor Surveillance System (BRFSS) data indicate 35 percent of Kentuckians have doctor-diagnosed arthritis and an additional 15 percent have chronic joint symptoms consistent with arthritis. Barriers to care, being overweight or obese, and lack of regular physical activity put many of Kentucky's residents at risk for the development and progression of this disease.

Early diagnosis, consistent medical management, weight control, appropriate levels of regular physical activity, and further education through evidence based self-management strategies are essential steps toward reducing the burden of arthritis. Evidence based self-management strategies to improve the functioning of people with arthritis include: Arthritis Foundation Self-Help Programs, Arthritis Foundation Exercise Programs, and Arthritis Foundation Aquatic Programs.

Osteoporosis

Osteoporosis is a disease in which bones become fragile and are more likely to break. If not prevented or if left untreated, osteoporosis can progress painlessly until a bone breaks. These fractures occur typically in the hip, spine, and wrist. Osteoporosis is the most important underlying cause of fractures in the elderly. Although osteoporosis can be defined as low bone mass leading to structural fragility, it is difficult to determine the extent of the condition described in these qualitative terms. Using the World Health Organization's quantitative definition based on bone density measurement, there are roughly 10 million Americans over age 50 with osteoporosis and an additional 34 million with low bone mass or osteopenia of the hip, which puts them at risk for osteoporosis, fractures, and their potential complications later in life (National Osteoporosis Foundation 2002).

Chronic Back Conditions

Chronic back conditions are common and often debilitating. Annually, back pain occurs in 15-45 percent of individuals, and 70 percent to 85 percent of people report back pain at some time in their lives. Back pain in the United States has been documented as the most frequent cause of activity limitation for persons under age 45 years, the second most common reason for physician visits, the fifth most common reason for hospitalization, and the third most common reason for surgical procedures (Healthy People 2010).

Summary of Progress

The HK 2010 objectives for arthritis, osteoporosis, and chronic back pain were originally written to mirror the national Healthy People 2010 draft objectives being circulated at the time. The national draft objectives largely relied on national data sets, in particular the National Health Interview Survey. Because there is no comparable surveillance system in Kentucky, it is not possible to measure progress toward many of the objectives for Kentucky. In addition, the arthritis related questions on the BRFSS, including the questions used to measure arthritis prevalence and chronic joint pain have changed since the year 2000, making comparisons across time invalid.

Because of these issues, the objectives for arthritis, osteoporosis and chronic back pain have been revised to align with the surveillance priorities established by the Centers for Disease Control and Prevention's (CDC) Arthritis Program. The new objectives rely on the BRFSS optional arthritis management module and the core arthritis and core quality of life questions.

The state arthritis program was first funded by the CDC in September of 1999. The program receives no state general funds. The state program works with local health departments and the Kentucky affiliate of The Arthritis Foundation to expand the reach of evidence based interventions to improve the ability of Kentuckians to live more comfortably and productively despite the presence of arthritis.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Arthritis, Osteoporosis, and Chronic Back Conditions	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
16.1R. Decrease the percentage of people with doctor diagnosed arthritis who report activity limitations because of their arthritis, from 50 percent to 48 percent.	50% (2003)	≤48%	50% (2003)	N/A	BRFSS
16.2. - 16.4. (DELETED)					
16.5R. Decrease the percentage of people with doctor diagnosed arthritis who report that arthritis impacts the ability, type, or amount of paid work they can perform, from 51 percent to 49.	51% (2003)	≤49%	51% (2003)	N/A	Optional Arthritis module on BRFSS
16.6. (DELETED)					
16.7R. Decrease the percentage of people reporting chronic joint pain who have not seen a doctor for diagnosis, from 52 percent to 50 percent.	52% (2003)	≤50%	52% (2003)	N/A	Optional Arthritis module on BRFSS
16.8.- 16.9. (DELETED)					
16.10R. Increase by 10 percent, the number of certified instructors for the evidence-based arthritis education programs: Arthritis Foundation Self Help (ASH) courses, Arthritis Foundation Exercise Programs (AFEP), and Arthritis Foundation Aquatics courses by 2010.	Aquatics: 77 (2005)	≥84	77 (2005)	N/A	As compiled by the KY Arthritis Foundation
	AFEP: 20	≥22	20	N/A	
	ASH : 21	≥23	21	N/A	
	Support Group: 20	≥22	20	N/A	
16.11R. Increase the percentage of adults with arthritis who meet or exceed the recommendations for moderate physical activity, from 28 percent to 30 percent .	28% (2003)	≥30%	28% (2003)	N/A	Optional Arthritis module on BRFSS
16.12. (DELETED)					
16.13R. Increase the percentage of middle and high schools in Kentucky that teach the importance of including calcium in the diet in their health education courses.	86.8% (2002)	≥90%	86.8% (2002)	N/A	SHEP

R = Revised objective

N/A = Only baseline data are available. Not able to determine progress at this time.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Arthritis, Osteoporosis, and Chronic Back Conditions	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
16.14.- 16.15. (DELETED)					
16.16N. Reduce the rate of hospitalization for vertebral fractures associated with osteoporosis (rate per 10,000 adults aged 65 and older).	12.8 per 10,000 (2001)	≤11.5 per 10,000	14.8 per 10,000 (2003)	No	HOSP
16.17N. Increase the number of practicing rheumatologists in Kentucky by 25 percent.	35 (2005)	≥44	35 (2005)	N/A	Survey of Medical Board of Licensure

N = New objective

N/A = Only baseline data are available. Not able to determine progress at this time.

Goal

Reduce the burden of cancer on the Kentucky population by decreasing cancer incidence, morbidity, and mortality rates.

Overview

Cancer is the second leading cause of death in Kentucky. The American Cancer Society (ACS) estimates over 570,000 Americans will die of cancer in 2005. Of these annual cancer deaths, 9,560 are expected in Kentucky. In 2005, 1,372,910 million new cases of cancer will be diagnosed nationally, including 23,020 new cases that are likely to be diagnosed in Kentucky.

Kentucky's health care community continues to meet challenges in determining the contributing factors for and addressing geographic and racial disparities in cancer mortality. African-American residents die from cancer at a higher rate than white residents. The age-adjusted mortality rate for cancers in Kentucky during 1998 through 2002 is higher for men than for women, slightly higher for rural Kentuckians than urban residents, and higher for Appalachian residents than for non-Appalachian Kentuckians.

In addition to the human toll of cancer, the financial costs of cancer are enormous. The National Cancer Institute (NCI) estimates that the overall costs for cancer in 2004 were \$189.8 billion, with \$69.4 billion for direct medical expenditures, \$16.9 billion for lost productivity due to illness, and \$103.5 billion for costs of lost productivity due to premature death.

The number of new cancer cases and deaths, as well as the costs of cancer morbidity and mortality, can be reduced in Kentucky through screening tests for breast, cervical, and colorectal cancers. Other essential public health activities include education of residents about cancer screening, tobacco avoidance and cessation, and other risk reduction practices, such as increasing physical activity, achieving a healthy weight, improving nutrition, and avoiding sun overexposure. Efforts to make cancer screening, information, and referral services available and accessible are essential for reducing the high rates of cancer and cancer deaths. These efforts must include approaches to reduce health care disparities among Appalachian and African-American residents.

Summary of Progress

For all cancers, the mortality rate in 2002 was 226.3 per 100,000, a decrease from the baseline of 229.9 per 100,000. As evidenced by Kentucky Cancer Registry (KCR) data through 2002, progress has been made toward achieving the majority of targets for HK 2010 goals related to cancer mortality. Targets were achieved for maintaining lung cancer deaths at or below 80.7 per 100,000 and reducing deaths from cancer of the uterine cervix to at or below 3.2 per 100,000. Additionally, Kentucky has met the 2010 targets to increase to at least 85 percent those women age 18 and older who received a Pap test within the preceding one to three years and to increase to at least 40 percent both men and women age 50 and older who have ever received a sigmoidoscopy or colonoscopy. Kentucky still faces challenges in improving the percentage of women age 50 and older who have received a mammogram and clinical breast exam in the past two years. The percentage declined from 73% in 1997 to 68.6% in 2004. Another concern is the decline in the percentage of persons age 50 and older who have received a fecal occult blood test within the past two years from 26 percent in 1997 to 24 percent in 2004. The number of cancer survivors who are living 5 years or longer after diagnosis also declined from 57.8 percent in 2000 to 56.2 percent in 2002.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Cancer	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
17.1. Reduce cancer deaths to a rate of no more than 220.7 per 100,000 people in Kentucky.	229.9/ 100,000 (1996)	≤220.7/ 100,000	226.3/ 100,000 (2002)	Yes	KCR
17.2. Maintain lung cancer deaths to a rate of no more than 80.7 per 100,000 people in Kentucky.	80.7/ 100,000 (1997)	≤80.7/ 100,000	79.8/ 100,000 (2002)	Target Achieved	KCR
17.3. Reduce breast cancer deaths to no more than 22.5 per 100,000 women in Kentucky.	28.1/ 100,000 (1997)	≤22.5/ 100,000	27.6/ 100,000 (2002)	Yes	KCR
17.4. Reduce deaths from cancer of the uterine cervix to no more than 3.2 per 100,000 women in Kentucky.	4.3/ 100,000 (1997)	≤3.2/ 100,000	2.4/ 100,000 (2002)	Target Achieved	KCR
17.5. Increase a) to at least 85 percent the proportion of women ages 40 and older who have ever received a Clinical Breast Exam (CBE) and mammogram, and b) to at least 85 percent those ages 50 and older who have received a CBE and mammogram within the preceding one to two years.	a)78% (1997)	≥85%	82.3% (2004)	Yes	BRFSS
	b) 73% (1997)	≥85%	68.6% (2004)	No	
17.6. Increase a) to at least 95 percent the proportion of women ages 18 and older who have ever received a Pap test, and b) to at least 85 percent those who received a Pap test within the preceding one to three years.	a)93% (1997)	≥95%	94.2% (2004)	Yes	BRFSS
	b)82%	≥85%	85%	Target Achieved	
17.7. Reduce colorectal cancer deaths to no more than 23.5 per 100,000 people in Kentucky.	25.3/ 100,000 (1996)	≤23.5/ 100,000	24.1/ 100,000 (20.4 for women; 30.0 for men) (2002)	Yes	KCR
17.8. Increase a) to at least 35 percent the proportion of people ages 50 and older who have received fecal occult blood testing within the preceding one to two years, and b) to at least 40 percent in those who have ever received a sigmoidoscopy or colonoscopy.	a)26% (1997)	≥35%	24% (2004)	No	BRFSS
	b)34% (1997)	≥40%	47.2% (2004)	Target Achieved	

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Cancer	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
17.9. (DELETED)					
17.10R. (Developmental) Increase the percentage of persons ages 50 and older a) who have received a digital rectal exam in the preceding year to at least 51 percent and b) have visited an oral health professional in the preceding year to at least 69 percent.	a)46% (2001)	≥51%	46.3% (2004)	Yes	BRFSS
	b)63% (2002)	≥69%	62.4% (2004)	No	
17.11. (DELETED)					
17.12. (Developmental) Increase the number of cancer survivors who are living 5 years or longer after diagnosis to at least 58.8 percent.	57.8% (1996 - 2000)	≥58.8%	56.2% (2002)	No	KCR

R = Revised objective

Goal

Reduce preventable disease and economic burden associated with diabetes and improve the quality of life for all persons who have, or are at risk for, diabetes.

Overview

Diabetes is a major public health problem in Kentucky. Diabetes was the fifth leading cause of death in 2004, affecting an estimated 7.5 percent of the adult population. Kentucky ranks seventh among the 50 states for the highest prevalence of diabetes (2003). The prevalence of diabetes has steadily risen since the mid-1990s. A portion of this increase may be related to increased efforts to diagnose previously unrecognized diabetes or changes in the diagnostic criteria for diabetes. Nevertheless, this upward trend is expected to continue into the near future because of population characteristics and the rising prevalence of certain lifestyle risk factors for the disease.

Prevalence of diabetes is highest among men, individuals of African American descent, those aged 65 and older, and those living in the Appalachian region of the state. Death rates due to diabetes are also higher among men and African Americans in Kentucky. In fact, the age-adjusted death rate due to diabetes for African Americans (147 per 100,000) in 2002 was almost twice the comparable rate for the white population (78 per 100,000).

The medical complications of diabetes create an additional burden on the health care system in Kentucky. Specific problems include diabetic ketoacidosis, non-traumatic lower extremity amputations, cardiovascular and cerebrovascular disease, and end-stage renal disease. During 2002, there were 96,320 diabetes-related hospitalizations in the state. Direct and indirect costs due to diabetes in the Commonwealth were estimated at \$2.9 billion in 2002. These costs and the impact of diabetes on the population can be reduced through modification of lifestyle risks, early diagnosis, appropriate health care, and informed self-care.

Summary of Progress

Progress is being made toward achieving the 2010 objectives. Considerable improvement in the rate of lower extremity amputations has been made, with a decline from the 2000 baseline of 6 per 1,000 to 4.4 per 1,000 in 2002. The percent of adults who have a glycosylated hemoglobin measurement at least once a year has increased from the 2000 baseline of 82.9 percent to 86.9 percent in 2004. Significant improvement has also been achieved in persons with diabetes who perform self-blood glucose monitoring daily, with an increase from 55.1 percent in 2000 to 61.7 percent in 2004. Behavioral Risk Factor Surveillance System (BRFSS) data indicate that persons with diabetes who take an aspirin a day or every other day has increased from 47.6 percent in 2000 to 55 percent in 2003. Progress was made in persons with diabetes who receive formal diabetes self-management training, increasing from 45.7 percent in 2000 to 48.8 percent in 2004. Reducing anomalies in infants of mothers with diabetes has improved from 266 per 1,000 in 1998 to 234 per 1,000 in 2002. In 2000 the percentage of persons with diabetes who had annual foot exams was 63 percent. This percentage declined slightly to 62 percent in 2004.

Progress has been slow, however, in decreasing the prevalence of diagnosed diabetes. The rate has increased from 6 percent in 1996-98 to 7.5 percent in 2004. The diabetes death rate has also climbed from 76 per 100,000 in 1999 to 78 per 100,000 in 2002. The incidence rate for diabetes-related end stage renal disease (ESRD) has also increased. In 1998, 11.9 per 100,000 persons with diabetes had ESRD. The 2002 rate increased to 14.8 per 100,000. The percentage of annual flu vaccinations in persons with diabetes has shown a slight improvement from 52 percent in 1997 to 54.9 percent in 2004. BRFSS data showed that 75.5 percent of persons with diabetes had an annual eye exam in 2000. However, the percentage decreased to 70.5 percent in 2004.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Diabetes	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
18.1. (DELETED)					
18.2. Decrease the rate at which the prevalence of diagnosed diabetes is climbing so that it reaches no more than 6 percent of the population 18 years and older.	5.0% (1996-98)	≤6%	7.5% (2004)	No	BRFSS
18.3. (DELETED)					
18.4R. Limit the upward trend in the diabetes death rate to the 1999 base-line of 76 per 100,000.	76/100,000 (1999)	≤76/ 100,000	78/100,000 (2002)	No	Vital Statistics
18.5. Slow the rise in deaths due to cardiovascular disease where diabetes is listed as either a supplemental cause of death or an existing condition to no more than 276 per 100,000 diabetic population.	283.3/ 100,000 (1997)	≤276/ 100,000	334.2/ 100,000 (2002)	No	Vital Statistics
18.6. (DELETED)					
18.7R. Reduce the frequency of anomalies in infants of mothers with diabetes to no more than 233.3 per 1,000 births.	265.9/ 1,000 (1998)	≤233.3/ 1,000	234.3/ 1,000 (2002)	Yes	Vital Statistics
18.8R. Maintain the frequency of foot sores lasting more than four weeks to no more than 13 percent among persons with diabetes.	Adults: 13% (2000)	≤13%	14% (2003)	No	BRFSS
18.9. Reduce the frequency of lower extremity amputation to 5.4 per 1,000 persons with diabetes.	6/ 1,000 (2000)	≤5.4/ 1,000	4.4/ 1,000 (2002)	Target Achieved	HOSP and BRFSS
18.10. (DELETED)					
18.11R. Decrease the incidence of diabetes related ESRD that requires dialysis or transplantation to no more than 11.3 per 100,000 population.	11.9/ 100,000 (1998)	≤11.3/ 100,000	14.8/ 100,000 (2002)	No	Tri-State Renal Network
18.12. (DELETED)					
18.13R. Increase to 90 percent the proportion of persons with diabetes who have a glycosylated hemoglobin measurement (A1C) at least once a year.	Adults: 82.9% (2000)	≥90%	86.9% (2004)	Yes	BRFSS
18.14. (DELETED)					
18.15. Increase to 80 percent the proportion of persons with diabetes who have an annual dilated eye exam.	Adults: 75.5% (2000)	≥80%	70.5% (2004)	No	BRFSS

R = Revised objective

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Diabetes	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
18.16. Increase to 70 percent the proportion of persons with diabetes who have at least an annual foot exam.	Adults: 63% (2000)	≥70%	62.1% (2004)	No	BRFSS
18.17R. Increase to 56 percent the proportion of persons with diabetes over 40 years of age that take aspirin daily or every other day.	47.6% (2000)	≥56%	55% (2003)	Yes	BRFSS
18.18R. Increase to 65 percent the proportion of persons with diabetes who perform self-blood glucose monitoring at least daily.	Adults: 55.1% (2000)	≥65%	61.7% (2004)	Yes	BRFSS
18.19R. Increase to 49.8 percent the proportion of persons with diabetes who have received formal diabetes self-management training.	Adults: 45.7% (2000)	≥49.8%	48.8% (2004)	Yes	BRFSS
18.20. Increase to 80 percent the proportion of persons with diabetes who receive an annual influenza vaccination.	Adults: 52% (1997)	≥80%	54.9% (2004)	Yes	BRFSS

R = Revised objective

Goal

Promote health and prevent secondary conditions among persons with disabilities, including eliminating disparities between persons with disabilities and the U.S. population.

Overview

Data from the 2000 Census indicate that 24 percent of Kentucky's citizens are living with a physical, mental or sensory disability. This is almost twice the rate of the entire United States (12.5 percent). Disability is generally defined as having limitations in activities because of an impairment or health condition with a duration of at least 12 months. Activities impacted include those that negatively influence participation in work, school, leisure, and family and community life, from simple to complex, including looking and listening, standing, walking, achieving mobility, performing personal care, communicating, learning, and engaging in related behaviors.

The state is well served, however, by such organizations as the Developmental Disabilities Network, consisting of the Kentucky Developmental Disabilities Council, the Division of Protection and Advocacy and the University of Kentucky Interdisciplinary Human Development Institute. Projects of these agencies have focused on areas including: increasing access to community supports that will enable persons with disabilities to exercise greater autonomy in deciding where to live and how to spend their free time; training medical, allied health and nursing students in practical aspects of working with persons with disabilities of all ages; increasing access to public transportation services for persons with mobility limitations; improving special education services through areas such as instructional climate, use of assistive technology, training of para-educators, and improving secondary transition services; and, increasing the opportunities for employment among persons with disabilities.

While the population of Kentuckians with disabilities includes those with disabilities that are not developmental in nature, the most proactive disability organizations and agencies in the state (as well as the best data sources) are those focusing on developmental disabilities. The focus is on these types of disabilities for several reasons: 1) a large proportion of disabilities in the state are developmental; 2) many efforts that affect services for persons with developmental disabilities will have either a direct or indirect effect on those with other disabilities (e.g. transportation, employment); and 3) there is a great overlap in the needs of persons with developmental and other disabilities.

In Kentucky, as well as throughout the nation, large gaps are known to exist between individuals with and without disabilities in the areas of quality of life, access to and satisfaction with health care services, education, employment, and transportation. This chapter addresses the extent to which progress has been made in reducing these gaps during the first half of this decade.

Summary of Progress

The HK 2010 objectives for disability and secondary conditions were originally written on the assumption that certain data sources would be developed to measure progress; however, these sources were not developed. Therefore, new objectives were developed based on data sources that address existing programs serving persons with disabilities. One original objective addressing the education of children with disabilities has been retained. Good improvement is shown for that objective, with 61 percent of students who have a disability spending 80 percent or more of their school day in a regular education environment, up from a 1997 baseline of 50 percent.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Disability and Secondary Conditions	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
19.1. - 19.2. (DELETED)					
19.3. Increase to 75 percent the proportion of children with disabilities included with appropriate supports in regular education programs.	50% (1997)	≥75%	61% (2004)	Yes	Special Education Data
19.4. (DELETED)					
19.5N. Ensure that 100 percent of persons with a developmental disability who receive services from the state receive a yearly physical examination.	85.3% (2000)	100%	89.5% (2004)	Yes	NCIS
19.6N. Ensure that 100 percent of women with a developmental disability who receive services from the state receive an annual gynecological examination.	53.3% (2000)	100%	61.2% (2004)	Yes	NCIS
19.7N. Ensure that 100 percent of persons with a developmental disability who receive services from the state receive a dental examination every six months.	61.2% (2000)	100%	45.3% (2004)	No	NCIS
19.8N. Ensure that 100 percent of persons with a developmental disability who receive services from the state report having access to adequate transportation.	81.6% (2000)	100%	81.7% (2004)	Yes	NCIS
19.9N. Ensure that 100 percent of persons with a developmental disability who receive services from the state report engaging in some form of exercise or sport.	72.1% (2000)	100%	74.5% (2004)	Yes	NCIS
19.10N. Increase the percentage of persons with a developmental disability that receive services from the state that report going to a club or community meeting.	30% (2002)	≥40%	25.9% (2004)	No	NCIS

N = New objective

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Disability and Secondary Conditions	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
19.11N. Increase to 25 percent the number of public transportation vehicles that are accessible to persons with mobility limitations.	16% (1999)	≥25%	No data available	TBD	Repeat Human Service Transportation Delivery Program Brokers Survey
19.12N. Decrease the employment gap between persons with and without disabilities by 50 percent.	29.6% (2000)	≤14.8%	29.6% (2000)	N/A	2010 Census
19.13N. Decrease the median earnings gap between persons with and without disabilities by 50 percent.	13.5% (2000)	≤6.8%	13.5% (2000)	N/A	2010 Census
19.14N. Assure that a minimum level of at least 2.24 percent (the national percentage minimum) of Kentucky children ages 0-3 are eligible for and receive Part C services from the First Steps Program.	2.37% (2003)	≥2.24%	2.37% (2003)	N/A	First Steps Report

N = New objective

N/A = Only baseline data are available. Not able to determine progress at this time.

TBD = To be determined. No reliable data currently exist.

Goal

Enhance the cardiovascular health and quality of life of all Kentuckians through improvement of medical management, prevention and control of risk factors, and promotion of healthy lifestyle behaviors.

Overview

Cardiovascular disease is the leading cause of death in Kentucky. In 2001, approximately 38 percent of all deaths occurred from cardiovascular disease (heart disease — 30 percent and cerebrovascular disease — 7 percent). Approximately 14,500 Kentuckians died from cardiovascular disease in 2001. Kentucky ranks fifth highest in the nation for heart disease mortality and twelfth in the nation for stroke mortality.

Research shows that specific risk factors increase the occurrence of cardiovascular disease. The major modifiable risk factors are high blood pressure, high blood cholesterol, cigarette smoking, lack of physical activity, poor dietary choices and obesity. Each of these risk factors have high rates of occurrence in Kentucky.

Summary of Progress

Progress is being made toward achieving the 2010 objectives. Significant improvement in the rate of deaths due to heart disease has been made, with a decline from the 1997 baseline of 316 deaths per 100,000 to 290 per 100,000 in 2003. The percent of adults who have had their blood cholesterol checked within the past 5 years has increased from the 1997 baseline of 66 percent to 74 percent in 2003.

Progress has been slow in the area of deaths due to stroke. The rate of death due to stroke has remained level, with a 1997 baseline of 65 per 100,000 as compared to 64 per 100,000 in 2002. The percent of adults who have been told that their blood pressure is too high has increased from the 1997 baseline of 27 percent to 30 percent in 2003.

Data from the 2003 Behavioral Risk Factor Surveillance System (BRFSS) show that 35 percent of adults are aware of all signs and symptoms of a heart attack and would react by calling 911. 2003 BRFSS data also show that 43 percent of adults know all signs of a stroke and would respond by call 911. (This is a new developmental objective.)

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Heart Disease and Stroke	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
20.1R. Reduce heart disease deaths to no more than 250 deaths per 100,000 people (age adjusted to the year 2000 standard).	316/ 100,000 (1997)	≤250/ 100,000	290/ 100,000 (2002)	Yes	Vital Statistics
20.2R. Reduce cerebrovascular deaths to no more than 59 deaths per 100,000 people.	65/ 100,000 (1997)	≤59/ 100,000	64/ 100,000 (2002)	Yes	Vital Statistics
20.3. Decrease to at least 20 percent the proportion of adult Kentuckians with high blood pressure.	27% (1997)	≤20%	29.8% (2003)	No	BRFSS
20.4. Increase to at least 85 percent the proportion of adults who have had their blood cholesterol checked within the preceding five years.	66% (1997)	≥85%	73.9% (2003)	Yes	BRFSS
20.5R. Increase the proportion of Kentucky adults, aged 18 years and over, who are aware of the early warning symptoms and signs of heart attack and importance of accessing rapid emergency care by calling 911.	35% (2002)	≥36%	35% (2002)	N/A	BRFSS
20.6. (DELETED)					
20.7N. Increase the proportion of Kentucky adults aged 18 years and over, who are aware of the early warning symptoms and signs of a stroke and importance of accessing rapid emergency care by calling 911.	43% (2002)	≥44%	43% (2002)	N/A	BRFSS

R = Revised objective

N = New objective

N/A = Only baseline data are available. Not able to determine progress at this time.

Goal

Prevent HIV transmission and associated morbidity and mortality by (1) ensuring that all persons at risk for HIV infection know their serostatus, (2) ensuring that those persons not infected with HIV remain uninfected, (3) ensuring that those persons infected with HIV do not transmit HIV to others, and (4) ensuring that those infected with HIV are accessing the most effective therapies possible.

Overview

At the start of the 21st century, HIV and AIDS continue to impact the health of Kentuckians. Since the first AIDS case was reported in 1982, there have been 4,119 Kentuckians reported with AIDS of whom 2,245 are still living. Males continue to represent a sizable majority (85 percent) of cumulative AIDS cases reported. Whites comprise the majority of cumulative AIDS cases at 67 percent. However, African Americans are affected far more disproportionately. In 2002, African Americans comprised 7 percent of Kentucky's total population yet 33 percent of AIDS cases diagnosed. This discrepancy has increased in recent years. Among all AIDS cases diagnosed in 2002, the majority of AIDS cases are reported in those ages 25-44. Kentucky has had very few AIDS cases reported resulting from perinatal transmission. Men who have sex with men (MSM) comprise the majority of Kentucky's AIDS cases. In 2002, the majority of all AIDS cases resided in two of Kentucky's largest districts at the time of diagnosis: the KIPDA District (46 percent), including the city of Louisville, and the Bluegrass District (19 percent), which includes the city of Lexington. Although the majority of AIDS cases reside in urban areas, AIDS is widely dispersed throughout the state. Cases have resided in 118 of 120 Kentucky counties at time of diagnosis.

HIV/AIDS continues to be a serious public health problem in Kentucky even though AIDS incidence and deaths have declined in Kentucky and throughout the nation. Prevention efforts targeting those at high risk for HIV infection must continue. These initiatives must be culturally sensitive and incorporate differences in economic status. Emphasis on early HIV testing is an important component of HIV prevention efforts. HIV testing counselors educate HIV positive clients about ways to prevent infecting others and educate HIV negative clients about ways to avoid infection in the future. One developmental *Healthy Kentuckians 2010* objective sets the goal to lengthen the time from HIV diagnosis to AIDS infection. Early HIV diagnosis and treatment are directly related to this goal. As more people are living with HIV and AIDS, we must continue to improve medical, financial, and other support services in order to extend quality years of life.

Summary of Progress

There are several objectives that have shown progress toward meeting the 2010 targets and one objective that has exceeded its target. Objective 21.1.a., which relates to confining the annual incidence of AIDS cases among adults and adolescents to 5.4 per 100,000 population, was met and exceeded; the annual incidence of AIDS cases was lower than the target at 5.0 per 100,000 population. Progress is being made on Objective 21.1.b., which states the annual number of AIDS cases diagnosed among adults and adolescents should be confined to no more than 184 cases. The mid-decade status shows a considerable drop in the AIDS cases reported annually, although the 2010 target has not yet been met. Objective 21.5 - to increase the percent of sexually active, unmarried high school-aged youth who used a latex condom at last sexual intercourse - has also shown progress. The mid-decade status shows a 4 percentage point increase from the 1997 baseline. Progress has also been demonstrated for Objective 21.9, to increase to 100 percent the number of school children who receive classroom education on HIV and STDs. The mid-decade status for this objective shows a 2 percent incremental increase from 88 percent in 1997 to 90 percent in 2003.

The progress on objectives pertaining to HIV incidence still remains undetermined due to a change in HIV reporting criteria. On July 13, 2004, Kentucky adopted a “Confidential Name Based” reporting system. Previously, HIV cases were reported using a unique identifier system containing the case’s initials. The Centers for Disease Control and Prevention (CDC) would not accept Kentucky’s data as part of the national total because of this unique identifier system. By using the “Confidential Named Based” reporting system, Kentucky will now be included in national totals and will be able to more accurately determine the incidence of HIV in the state. Until a formal evaluation of this new system is conducted; however, no data on HIV will be released.

The HIV/AIDS Branch is dedicated to establishing goals and objectives to prevent and/or reduce HIV infection throughout Kentucky. Health providers are educated and encouraged to report HIV/AIDS cases to the Branch in an efficient and timely manner, in order to help facilitate HIV prevention and care services. HIV Prevention Specialists throughout Kentucky are reaching out to Kentucky’s communities by providing HIV education and awareness to high risk groups. HIV care services are also offered for those persons living with HIV/AIDS through the Care Coordinator Program in centers throughout Kentucky along with HIV drug assistance programs and insurance assistance.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for HIV	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
21.1.a. Confine the annual incidence of diagnosed AIDS cases among adolescents and adults to no more than 5.4 per 100,000 population.	7.1/ 100,000 (1998)	≤5.4/ 100,000	5.0/ 100,000 (2003)	Target Achieved	HIVAIDS Surveillance System
21.1.b. Confine the annual number of diagnosed AIDS cases among adolescents and adults to no more than 184 cases.	231 (1998)	≤184	206 (2003)	Yes	HIVAIDS Surveillance System
21.2. (Developmental) Reduce the annual incidence of diagnosed HIV infection in adolescents and adults.	TBD	TBD	TBD	TBD	HIVAIDS Surveillance System
21.3. Reduce the annual incidence of perinatally acquired HIV infection to zero cases.	TBD	0	TBD	TBD	HIVAIDS Surveillance System
21.4. (Developmental) Increase proportion of sexually active unmarried people age 18 and older who reported that a latex condom was used at last sexual intercourse.	TBD	TBD	TBD	TBD	BRFSS
21.5. Increase to at least 68 percent the number of sexually active, unmarried high school-aged youth who used a latex condom at last sexual intercourse.	59% (1997)	≥68%	63% (2003)	Yes	YRBSS
21.6R. Increase the proportion of clients who are screened for common bacterial STDs (chlamydia, gonorrhea, and syphilis) and immunized against Hepatitis B in confidential federally funded HIV counseling and testing sites.	TBD	TBD	TBD	TBD	HIV Counseling and Testing; STD Surveillance
21.7. (Developmental) Increase the proportion of persons entering treatment for injecting drug use who are also offered HIV counseling and voluntary testing.	TBD	TBD	TBD	TBD	Dept. of Mental Health and Mental Retardation
21.8R. Increase to 20 percent the proportion of 25 to 44 year olds with reported tuberculosis who also have knowledge of their HIV serostatus.	12.5% (2000)	≥20%	12.5% (2004)	No	TIMS
21.9. Increase to 100 percent the proportion of school children who receive classroom education on HIV and STDs.	88% (1997)	100%	90% (2003)	Yes	YRBSS

R = Revised objective

TBD = To be determined No reliable data currently exist.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for HIV	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
21.10. (Developmental) Increase the percentage of HIV-infected adolescents and adults in care who receive treatment consistent with current Public Health Service treatment guidelines.	TBD	TBD	TBD	TBD	HIVAIDS Surveillance System Unmet Needs Database
21.11. Reduce mortality due to HIV infection (AIDS) to no more than 1.0 per 100,000 population, and then by ethnicity and gender.	2.0/ 100,000 (1998)	≤1.0	2.3/ 100,000 (2002)	No	HIVAIDS Surveillance System
21.12. (Developmental) Increase years of healthy life of all individuals with HIV by extending the interval between an initial diagnosis of HIV infection and AIDS diagnosis, and between AIDS diagnosis and death.	TBD	TBD	TBD	TBD	HIVAIDS Surveillance System
21.13R. Increase to 15 percent the proportion of individuals who engage in injecting drug use who are enrolled in drug abuse treatment programs.	9.6% (2000)	≥15%	11.6% (2004)	Yes	Dept. of Mental Health and Mental Retardation

R = Revised objective

TBD = To be determined No reliable data currently exist.

Goal

Prevent disease, disability, and death from infectious diseases, including vaccine-preventable diseases.

Overview

The incidence and threat of bioterrorism during the first half of the decade have greatly impacted infectious disease control in Kentucky and abroad. In response to the anthrax threat of 2001 and the smallpox threat of 2002-2003, the Department for Public Health has focused its attention on public health preparedness at the state and local levels, as well as improving disease surveillance and immunization service delivery. The development and expansion of regional Epidemiologic Rapid Response Teams is one of the benefits brought about by public health preparedness and response initiatives.

Another new development within the Department for Public Health is the development and implementation of an immunization registry. In 2006, the Cabinet for Health and Family Services will pilot test a statewide, population-based immunization registry. The registry is web-enabled and will eventually be made available to all public and private immunization providers. Use of the immunization registry will be a crucial addition to public health informatics, as it will promote the success of public health preparedness activities and enhance infectious disease outbreak investigations.

The purpose of public health is to assure conditions under which optimum quality of life may be realized for all people. The primary modalities are disease prevention, detection, and intervention, health protection, and health promotion. The state Tuberculosis (TB) Control Program seeks to accomplish this purpose through organized efforts that address the physical, mental and environmental health concerns of communities and populations at risk of disease. The primary program objective is to reduce Kentucky's TB rate of 3.5 per 100,000 people to 1 per 100,000 people by the year 2010.

Adult immunization has not received major federal or state funding support, but modest increases in coverage with influenza and pneumococcal vaccines have been made. Pandemic influenza planning has moved to the forefront of the public health agenda. With the emergence of Avian Influenza (H5N1) in Southeast Asia, planning efforts have increased in an attempt to contain the potential devastation caused by a pandemic. An indirect benefit from pandemic planning is the encouragement and recommendation for the eligible adult population to be vaccinated against influenza and pneumococcal diseases.

Summary of Progress

Considerable progress has been made in infectious disease control throughout the first half of the decade. By mid-year 2005, the Louisville Metro Health Department's immunization tracking system evolved into a population-based immunization registry that is expected to be deployed statewide early in 2006. The immunization registry is sponsored and maintained by the Department for Public Health, Cabinet for Health and Family Services. The TB rate for Kentucky continues to decrease. The state TB rate for 2004 was at an historic low of 3.1 cases per 100,000 population, compared to 3.4 in 2003. There were 127 cases reported in 2004, compared to 138 cases in 2003. *Haemophilus influenzae* type b (Hib) meningitis continues to surface sporadically in unvaccinated children. Pertussis outbreaks continue to occur in unvaccinated children, but occur mostly in children outside of the recommended ages for vaccination. With the licensing in 2005 of two

new “combined tetanus, diphtheria and pertussis” (Tdap) vaccines for older children and adults, (one vaccine for 10-18 years of age and another for 11-64 years of age), a decrease in pertussis is predicted among those adolescents and adults for whom previously there was no available licensed vaccine. There has been a decline in the incidence rate of hepatitis A since 2000, with the exception of 2001 (an outbreak), decreasing from 63 cases in 2000 to 31 cases in 2004. With the introduction of a regulation requiring hepatitis B immunizations for entry and attendance in 6th grade, a decrease in the hepatitis B incidence rate is anticipated throughout the decade.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Immunization and Infectious Diseases	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
22.1. Reduce indigenous cases of vaccine-preventable disease.					KYEPHRS
Congenital rubella syndrome	0 (2000)	0	0 (2004)	Target Achieved	
Diphtheria (people <35 years)	0	0	0	Target Achieved	
<i>Haemophilus influenzae</i> type b invasive disease (Includes unknown serotype)	7	0	0	Target Achieved	
Hepatitis B (people <18 years except perinatal infections)	4	0	0	Target Achieved	
Measles	0	0	0	Target Achieved	
Mumps	1	0	0	Target Achieved	
Pertussis (children <7 years)	50	≤46	16	Yes	
Polio (wild-type virus)	0	0	0	Target Achieved	
Rubella	0	0	0	Target Achieved	
Tetanus (people <35 years)	0	≤1	0	Target Achieved	
Varicella	TBD	TBD	TBD	TBD	
22.2. Reduce hepatitis A cases to an incidence of no more than 1.0 case per 100,000.	2/ 100,000 (1997)	≤1/ 100,000	0.8/ 100,000 (2004)	Target Achieved	KYEPHRS
22.3. Reduce to no more than 6 chronic hepatitis B virus infections in infants (perinatal infections).	48 (2000)	≤6	45 (2004)	Yes	KYEPHRS
22.4. Reduce the hepatitis B rate to zero cases per 100,000 in persons less than 18 years of age (except perinatal infections).	0.4/ 100,000 (1998)	0	0 (2004)	Target Achieved	KYEPHRS
22.5. Reduce hepatitis B cases per 100,000 in the following age groups:					
25-39 years	3.1/ 100,000 (1998)	3/ 100,000	0.9/ 100,000 (2004)	Target Achieved	KYEPHRS
>40 years	6/ 100,000 (1998)	1/ 100,000	0.9/ 100,000 (2004)	Target Achieved	KYEPHRS
22.6. (DELETED)					

TBD = To be determined. No reliable data currently exist.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Immunization and Infectious Diseases	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
22.7. Reduce tuberculosis to an incidence of no more than 1.0 per 100,000.	5.3/ 100,000 (1998)	≤1/ 100,000	3.1/ 100,000 (2004)	Yes	TIMS
22.8. Limit the hospitalizations due to invasive pneumococcal infections to 9.8 per 100,000 persons less than 5 years of age and to 81.7 per 100,000 persons aged 65 and older.					
<5	15.4/ 100,000 (2000)	≤9.8/ 100,000	10.8/ 100,000 (2004)	Yes	HOSP
65+	93.9/ 100,000 (2000)	≤81.7/ 100,000	82.7/ 100,000 (2004)	Yes	HOSP
22.9. Limit hospitalizations for peptic ulcer disease to 4.0 per 100,000 population.	5/ 100,000 (2000)	≤4.0/ 100,000	5.1/ 100,000 (2004)	No	HOSP
22.10. Achieve immunization coverage of at least 90 percent among children 19-35 months of age for the following: -4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B -1 dose of varicella vaccine.	77.0% +5.2% (2000)	≥90%	81.2% +5.9% (2004)	Yes	National Immunization Survey
22.11. Achieve immunization coverage of 95 percent for children in licensed day care facilities and children in kindergarten for the following:					Annual School Survey
Kindergarten Diphtheria-tetanus-pertussis (4 doses, at least 1 on or after age 4)	96.3% (2004)	≥95%	96.3% (2004)	Target Achieved	
Measles, mumps, rubella (2 doses for kindergarten, 1 dose for children over 16 months of age in day care)	95.6%	≥95%	95.6%	Target Achieved	
<i>Haemophilus influenzae</i> type b (if under 5 years of age)	96.3%	≥95%	96.3%	Target Achieved	
Hepatitis B (3 doses)	95.8%	≥95%	95.8%	Target Achieved	
Varicella	84.5%	≥95%	84.5%	No	
Polio (3 doses)	96.3%	≥95%	96.3%	Target Achieved	

N/A = Only baseline data are available. Not able to determine progress at this time.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Immunization and Infectious Diseases	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
Licensed Day Care Facilities Diphtheria-tetanus-pertussis (4 doses, at least 1 on or after age 4)	91% (2004)	≥95%	91% (2004)	No	
Measles, mumps, rubella (2 doses for kindergarten, 1 dose for children over 16 months of age in day care)	93.9%	≥95%	93.9%	No	
<i>Haemophilus influenzae</i> type b (if under 5 years of age)	95.7%	≥95%	95.7%	Target Achieved	
Hepatitis B (3 doses)	94.6%	≥95%	94.6%	No	
Varicella	90.1%	≥95%	90.1%	No	
Polio (3 doses)	92.8%	≥95%	92.8%	No	
22.12. Increase to the following targets the rate of immunization coverage among the following adult groups:					
Non-institutionalized adults 65 years of age or older					
Influenza Vaccine	60.9% (2001)	≥75%	64.9% (2004)	Yes	BRFSS
Pneumococcal Vaccine	55.1% (2001)	≥70%	57.7% (2004)	Yes	
Institutionalized adults in long term care or nursing homes					
Influenza Vaccine	84.1% (2004)	≥90%	84.1% (2004)	N/A	Special Surveys for Long Term Care
Pneumococcal Vaccine	74.6% (2004)	≥90%	74.6% (2004)	N/A	
22.13. Maintain at least 75 percent the proportion of all tuberculosis patients who complete curative therapy within 12 months.	92.7% (1999)	≥75%	93.8% (2003)	Target Achieved	TIMS
22.14. Increase to at least 75 percent the proportion of contacts, including other high-risk persons with tuberculosis infection (as defined by the Centers for Disease Control and Prevention), who complete courses of preventive therapy.	58.2% (2000)	≥75%	63.5% (2003)	Yes	TIMS

N/A = Only baseline data are available. Not able to determine progress at this time.
 TBD = To be determined. No reliable data currently exist.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Immunization and Infectious Diseases	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
22.15. (Developmental) Decrease to 50 the number of inappropriate rabies postexposure prophylaxis, as defined by current Advisory Committee on Immunization Practices (ACIP) guidelines.	111 (2000)	≤50	75 (2004)	Yes	KYEPHRS
22.16. (Developmental) Increase to 50 percent the number of immunization providers who have systematically measured the immunization coverage levels in their practice population.	Data not available	≥50%	Data not available	TBD	KYEPHRS
22.17. (Developmental) Increase to 90 percent the number of children enrolled in a fully functional population-based immunization registry (birth through age 5).	No registry (2000)	≥90%	Pilot to begin in 2006	No	
22.18. Maintain at zero the number of cases of vaccine-associated paralytic polio.	0 (2000)	0	0 (2004)	Target Achieved	KYEPHRS
22.19R. Increase to 75 percent the proportion of lab specimens on new tuberculosis cases that are confirmed in 48 hours or less.	50% in 48 hours (2000)	75% in 48 hours	72% in 48 hours (2005)	Yes	Laboratory Standard Operating Procedure Manual

R = Revised Objective

Goal

Improve the mental health of all Kentuckians by ensuring appropriate, high-quality services informed by scientific research to those with mental health needs.

Overview

Mental illness is a term used for a group of disorders causing severe disturbances in thinking, feeling, and relating. Untreated, these disorders result in a substantially diminished capacity for coping with ordinary demands of everyday life. Mental illness can affect persons of all ages and can occur in any family.

To assure that persons most in need of mental health care have access to services, the Department for Mental Health and Mental Retardation Services (DMHMRS) has identified specific groups of people, who, because of type or degree of disability, concomitant functional level, and financial need, are considered the most vulnerable and most in need of services. These people are also the most unlikely to be served by the private sector. The DMHMRS has committed financial and staff resources in order to assure priority program and fiscal responsiveness of the service system for adults with severe mental illness and children and youth with severe emotional problems.

Summary of Progress

The Kentucky General Assembly has passed important legislation in the past few years that has profoundly affected mental health, mental retardation, and substance abuse services. The Commission created by the legislation (HB 843) convened regular meetings throughout the Commonwealth since state fiscal year (SFY) 2001 and continued bringing together key stakeholders to monitor and upgrade plans for addressing service needs across the state.

House Bill 843 created the Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnosis. This legislation also created fourteen regional councils organized by Regional MHMR Boards. Members include representatives of major state agencies (e.g. justice, social services) as well as consumers and other stakeholders. A planning process that began at the regional level, and was carried out during SFY 2001, culminated with a plan submitted to the Governor and the General Assembly on June 21, 2001. This plan (and annual updates) laid the groundwork for a budget request submitted for the SFY 2005 and 2006 biennium. The Commission charged eleven separate workgroups to provide in-depth study on various issues. Annual progress reports are submitted to the Governor on October 1 of each year.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Mental Health	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
23.1. Increase the number of children with severe emotional disabilities (SED) who receive mental health services or coordinated interagency services from Regional MH/MR Boards or their subcontractors to 30 percent.	22% (1999)	≥30%	39%* (2004)	Target Achieved	DMHMRS Client Data Set
23.2. Increase the number of adults with severe mental illness (SMI) who receive mental health services from Regional MH/MR Boards or their subcontractors to 30 percent.	28% (1999)	≥30%	37%* (2004)	Target Achieved	DMHMRS Client Data Set
23.3. Increase by 5 percent the number of adults with severe mental illness (SMI) served by Regional MH/MR Boards (or their subcontractors) who are employed.	10% (1999)	≥15%	14%* (2004)	Yes	DMHMRS Client Data Set
23.4. Increase the number of referrals of adults with severe mental illness (SMI) from the justice system to Regional MH/MR Boards or their subcontractors to 12 percent.	4% (1999)	≥12%	6%* (2004)	Yes	DMHMRS Client Data Set
23.5. (Developmental) Increase the number of referrals of children with SED from the justice system to Regional MH/MR Boards or their subcontractors to 12 percent.	5% (1999)	≥12%	4%* (2004)	No	DMHMRS Client Data Set
23.6. (Developmental) Develop and implement a plan to improve the cultural competence of personnel within Kentucky's mental health delivery system. Increase to 90 percent the number of facility and DMHMRS central office staff and to 75 percent the number of regional MH/MR Board staff, who have received cultural competency training.	Facility: 60% (1999)	≥90%	75% (2004)	Yes	Training Logs
	Central Off: 50%	≥90%	90%	Target Achieved	
	Boards: Not Available	≥75%	Not Available	TBD	
23.7. By 2010, of families who have incomes less than 200 percent of the Federal Poverty Level (FPL), increase to 90 percent the number of children who are covered by mental health insurance.	77% (1999)	≥90%	89% (2003)	Yes	Dept. of Insurance
23.8. (Developmental) Form a consumer consortium of state consumer organizations for mutually beneficial activities.	No consortium (1999)	Create a consortium	No consortium (2005)	No	DMHMRS Recovery Services

*NOTE: Percentages for all fiscal years changed due to the use of the 2000 US Census. R = Revised objective, TBD = To be determined. No reliable data currently exist.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Mental Health	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
23.9. (Developmental) Develop a statewide consumer 5-year plan.	No 5-year plan (1999)	5-year plan	No 5-year plan (2005)	No	DMHMRS Recovery Services
23.10. Establish 13 regional consumer advocacy programs based on the prototype in Bowling Green, Kentucky.	1	14	0	No	DMHMRS Recovery Services
23.11. Increase the number of consumer and family self-help groups to 200 groups.	25 (1999)	≥200	158 (2005)	Yes	DMHMRS Recovery Services
23.12. Increase by 50 percent the number of regional parent coordinators.	20 (1999)	≥30	53 (2005)	Target Achieved	Office of Family Leadership
23.13R. Increase by 10 percent the provision of annual services to victims of rape/sexual assault in order to promote an effective recovery and alleviate the emotional trauma associated with rape and sexual abuse.	4,973 (2003)	≥5,470	4,635 (2004)	No	Div. of Child Abuse/ Domestic Violence Services
23.14R. Increase by 10 percent the provision of services to family members and friends of victims of rape and sexual abuse.	1,856 (2003)	≥2,042	1,826 (2004)	No	Div. of Child Abuse/ Domestic Violence Services
23.15R. Increase the number of persons educated within the Commonwealth regarding the incidence and dynamics of sexual assault in order to increase their understanding of this social problem and to prevent its occurrence.	153,034 (1999)	≥217,962	193,472 (2004)	Yes	Div. of Child Abuse/ Domestic Violence Services
23.16R. Provide a 50 percent increase in comprehensive and coordinated mental health services for victims of child sexual abuse and their families.	3,581 (1999)	5,372	5,203 (2004)	Yes	DMHMRS Client Data Set
23.17R. Provide a 75 percent increase in comprehensive and coordinated mental health services for victims of domestic violence and their children.	12,405 (1999)	21,709	21,146 (2004)	Yes	DMHMRS Client Data Set

R = Revised objective

Goal

Increase education and awareness in Kentucky about the signs and symptoms of lung diseases, specifically asthma, chronic lower respiratory disease (CLRD), and obstructive sleep apnea (OSA). Promote lung health through better detection, treatment, and management.

Overview

Asthma is one of the most common chronic diseases in the United States, affecting more than 20 million people. In Kentucky it affects 9.8 percent of the adult population, approximately 400,000 Kentuckians. Additionally, asthma affects nearly 10 percent of the population younger than 18 years of age. The exact cause or causes of asthma are not yet known; however, genetic and environmental factors can exacerbate symptoms and lead to an asthma episode or attack. Factors that can trigger an asthma attack include allergens (such as pet dander, dust mites, mold, pollen, and food allergies), secondhand tobacco smoke, exercise, strong odors, and cold weather.

The successful management and control of asthma leads to improved quality of life and decreased adverse outcomes, including asthma episodes and attacks, hospitalizations, emergency room visits, and missed school or work days. This reduction in adverse outcomes also translates into a reduction in the economic impact of asthma. The effective management of asthma includes reducing exposure to asthma triggers, adequately managing asthma with medicine, monitoring asthma using objective measures of lung function, and education of asthma patients to be responsible for their own care.

CLRD, also referred to as chronic obstructive pulmonary disease (COPD), continues to affect the health of Kentuckians. COPD was changed to chronic lower respiratory disease (CLRD) in 1999 with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports. CLRD is characterized by the presence of airflow obstruction due to chronic bronchitis and emphysema, two diseases that often coexist. Most people with CLRD are current or former smokers. There is no cure for CLRD. It is one of the most common respiratory conditions of adults and is the fourth leading cause of death in the United States. Obstructive sleep apnea (OSA) is an illness characterized by snoring, partial or complete cessation of breathing during sleep, reductions in blood oxygen levels, severe sleep fragmentation, and excessive daytime sleepiness. If left untreated, sleep apnea can increase the risk for high blood pressure, diabetes, a heart attack or stroke, work-related accidents, and driving accidents.

Summary of Progress

The burden of asthma in Kentucky remains as evidenced by the increase in adult asthma prevalence from 7.8% in 2000 to 8.3% in 2004. However, the target was achieved for objective 24.1, which measures asthma mortality. The age-adjusted asthma death rate declined from 20 per million in 1997 to 13 per million in 2003. Objective 24.3R requires that a statewide surveillance system be established for asthma, and data sources have been identified and utilized to develop several surveillance documents. The CLRD hospitalization rate, Objective 24.4R, is well below the 2010 target. The asthma hospitalization rate and asthma prevalence (Objective 24.2R) have both increased since this document was originally developed, but the Department for Public Health, the Kentucky Asthma Partnership, and other partner agencies are dedicated to securing re-

sources that will help support a reduction in these outcomes. Resources to address the remaining objectives are limited; however, strategies are provided that will move these objectives toward the 2010 targets. The Kentucky Asthma Partnership, its member agencies, and its partners continue to seek funding, educational and awareness materials, and other resources that will help reduce the burden of asthma in Kentucky.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Respiratory Diseases	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
24.1. Reduce the asthma death rate to no more than 14 per million population.	20/ million (1997)	≤14/ million	13/ million (2003)	Target Achieved	Vital Statistics
24.2.1R. Reduce the asthma hospitalization rate to 10 per 10,000 population.	15.5/ 10,000 (2000)	≤10/ 10,000	17.6/ 10,000 (2004)	No	HOSP
24.2.2R. (Developmental) Reduce the adult asthma prevalence to 6.8 percent.	7.8% (2000)	≤6.8%	8.3% (2004)	No	BRFSS
24.3R. (Developmental) Establish an asthma surveillance system for tracking asthma morbidity, hospitalizations, and mortality.	No system	System in place	Partial system in place	Yes	
24.4R. (Developmental) Reduce the Chronic Lower Respiratory Disease (CLRD) hospitalization rate to no more than 56 per 10,000 population.	57/ 10,000 (2000)	≤56/ 10,000	68.3/ 10,000 (2003)	No	HOSP
24.5R. (Developmental) Reduce the CLRD death rate for adults to no more than 55 per 100,000 population.	52.4/ 100,000 (2001)	≤51.4/ 100,000	58.9/ 100,000 (2002)	No	Vital Statistics
24.6. - 24.8. (DELETED)					

R = Revised objective

Goal

A society where healthy sexual relationships free of infection is the standard.

Overview

In 2004, sexually transmitted disease (STD), specifically chlamydia and gonorrhea, remained among the top ten most frequently reported communicable diseases in Kentucky. Also of significance was the number of persons diagnosed with AIDS/HIV disease and patients reported with infectious (primary or secondary) syphilis. Because of the frequency of asymptomatic disease, screening programs are of vital importance in controlling gonorrhea and chlamydia infections. Screening programs for gonorrhea using the culture method were begun in Kentucky in the late 1960s. Programs were expanded to include screening for chlamydia infection in the late 1980s via an improved testing modality known as nucleic acid probes which enabled testing for both infections from the same specimen. Further refinement in the nucleic acid probe technique has led to the development of amplified nucleic acid probe testing (a more sensitive screening test) which enables detection of chlamydia and gonorrhea from both urine specimens as well as from specimens collected from exposed sites.

The medical management of patients diagnosed with chlamydia, gonorrhea, and early syphilis (and their sexual partners) has been greatly enhanced by the use of single-dose regimens for treatment which have been in use since the early 1990s.

Sustained transmission of syphilis does not occur in most parts of Kentucky, but outbreaks continue to occur. Seventy one patients were diagnosed with early syphilis in Kentucky in calendar year 2004. The early syphilis cases were patients who had their infection less than one year and who potentially could have spread infection to their sexual partner(s). Only 14 (11.7 percent) of Kentucky's 120 counties reported early syphilis cases in 2004. Jefferson county residents accounted for 48 (67.6 percent) of the total, and residents of Fayette county were a distant second in reports with 7 cases (9.9 percent).

Summary of Progress

The incidence of chlamydia, gonorrhea and syphilis has decreased from 2000 to 2004. In 2004 based on a population of 4,145,922 and 6470 chlamydia case reports, the incidence rate was 157.1 per 100,000 population. In 2003 the rate was 216.6 per 100,000 (8756 cases were reported). In 2004, 2758 gonorrhea cases were reported among Kentuckians for a rate of 66.5 per 100,000 population. Use of the more sensitive amplified nucleic acid probe test for gonorrhea detection will likely result in an increased number of cases detected and an increased incidence rate for gonorrhea through 2008.

Based on 47 primary and secondary cases reported in 2004, the rate per 100,000 population was 1.8 compared with 0.82 in 2003 when 33 cases were reported. Sporadic outbreaks in sub-populations in urban areas will likely continue. One case of congenital syphilis in a neonate was reported in calendar year 2004 among 53,654 recorded live births for a rate of 1.8 per 100,000 live births.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Sexually Transmitted Diseases	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
25.1. Reduce the incidence of <i>Chlamydia trachomatis</i> infections to no more than 140 cases per 100,000 population.	197.8 per 100,000 (2000)	≤140 per 100,000	157 per 100,000 (2004)	Yes	KYEPHRS
25.2. Reduce the incidence of gonorrhea to no more than 55 per 100,000 population.	99.3 per 100,000 (2001)	≤55 per 100,000	66.5 per 100,000 (2004)	Yes	KYEPHRS
25.3. Reduce the incidence of primary and secondary syphilis to no more than 0.27 cases per 100,000 population.	2.1 per 100,000 (2000)	≤.27 per 100,000	1.8 per 100,000 (2004)	Yes	KYEPHRS
25.4. Reduce the incidence of congenital syphilis to a level not exceeding two (2) cases per 100,000 live births.	11.4 per 100,000 (1997)	≤2 per 100,000	1.8 per 100,000 (2004)	Target Achieved	KYEPHRS
25.5R. Reduce to 0 the incidence of a)chlamydial ophthalmia neonatorum and b)gonococcal ophthalmia neonatorum.	a) 1.8 per 100,000 live births (2000)	0	0 (2003)	Target Achieved	KYEPHRS
	b) 1.8/100,000 live births	0	0	Target Achieved	
25.6. - 25.11. (DELETED)					

R = Revised objective

Goal

To increase abstinence from substances while reducing experimentation, use and abuse, especially among Kentucky's youth, thereby reducing the consequences -- violence, crime, illness, death and disability -- that result from abuse of substances at great cost and harm to individuals and society.

Overview

The combined costs of health care, law enforcement, motor vehicle crashes, crime and lost productivity caused by substance abuse have been calculated at nearly \$1,000 annually for every man, woman and child in America. Applying this figure to Kentucky's population, the consequences of substance abuse cost a staggering \$4.1 billion each year in the Commonwealth.

A great variety of serious health and social problems as well as enormous dollar costs are associated with abuse of alcohol, drugs, and tobacco. Seventy-two conditions requiring hospitalizations are wholly or partially attributable to abuse of substances. Use of tobacco, alcohol, and illicit drugs all increase the risk of hypertension, stroke, and heart disease. Tobacco is involved in one-third of all cancer deaths. Heavy alcohol use increases the risk for cirrhosis and other liver disorders, which also may result from infection with hepatitis viruses. Use of cocaine and comparable drugs can produce cardiac irregularities and heart failure, convulsions and seizures. Cocaine use temporarily narrows blood vessels in the brain, contributing to the risk of strokes as well as to cognitive deficits and memory loss.

Some of the major consequences of long-term use of alcohol or drugs include chronic depression, sexual dysfunction, and psychosis. Most substance abusers initiated use of tobacco and alcohol during adolescence and progressed to nicotine addiction, alcohol abuse, and illicit drug use. Accordingly, Kentucky's substance prevention efforts place high priority on reducing substance use and promoting abstinence among adolescents, as well as reducing experimentation by young adolescents. Adolescent behaviors are especially influenced by policies and laws that limit youth access to tobacco, alcohol, and drugs, and by interventions that alter youths' susceptibility to peer pressure, and norms and attitudes tolerant of substance use.

Summary of Progress

Of the 51 HK 2010 objectives and sub-objectives, six have been met and 11 show progress, while the rest show no progress or progress is not able to be tracked at this time. The target was achieved for Objective 26.8 which was to increase at least by one year the average age of first alcohol use by adolescents. The average age increased from 12 in 1997 to 13 in 2003. There is improvement in objective 26.17 to reduce to no more than 20 percent the proportion of adolescents who report binge drinking within the past 30 days. The number of adolescents reporting binge drinking in the past 30 days in 2003 was 33 percent, down from a 1997 baseline of 37 percent.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Substance Abuse	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
26.1. (DELETED)					
26.2. Achieve participation, by communities representing at least 80 counties, in comprehensive, science-based strategic planning, programming and evaluation for substance prevention, employing techniques developed through the Kentucky Prevention Evaluation and Planning System (KPEPS) and the Governor's Kentucky Incentives for Prevention Project (KIP).	31 counties (1999)	80 counties	110 counties (2005)	Target Achieved	County Survey
26.3. Achieve passage of legislation mandating Administrative License Revocation (ALR) or a program of equal effectiveness for people determined to drive under the influence of intoxicants, and a maximum legal blood alcohol concentration (BAC) level of 0.08 percent for motor vehicle drivers aged 21 and older.	Legislation submitted	Passage	Legislation enacted	Target Achieved	Kentucky Revised Statutes
26.4R. Increase the proportion of 8th grade students who report strong disapproval for use of tobacco, alcohol and other drugs to: tobacco - 60 percent; alcohol - 65 percent; marijuana - 85 percent; other drugs - 98 percent.	Tobacco 50% (2004)	≥60%	50% (2004)	N/A	KIP
	Alcohol 55%	≥65%	55%	N/A	
	Marijuana 75%	≥85%	75%	N/A	
	Other Drugs 88%	≥98%	88%	N/A	
26.5R. Increase the proportion of 8th grade students who report that none of their friends use substances to: tobacco - 70 percent; alcohol - 70 percent; marijuana - 90 percent; other drugs - 95 percent.	Tobacco 58% (2004)	≥70%	58% (2004)	N/A	KIP
	Alcohol 59%	≥70%	59%	N/A	
	Marijuana 78%	≥90%	78%	N/A	
	Other Drugs 91%	≥95%	91%	N/A	

R = Revised objective

N/A = Only baseline data are available. Not able to determine progress at this time.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Substance Abuse	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
26.6R. Increase the proportion of 8th grade students who perceive great risk of personal harm and/or trouble associated with regular use of substances: tobacco - 50 percent; alcohol - 35 percent; and marijuana - 80 percent.	Tobacco 41% (2004)	≥50%	41% (2004)	N/A	KIP
	Alcohol 26%	≥35%	26%	N/A	
	Marijuana 69%	≥80%	69%	N/A	
26.7R. Increase the percentages of 8th grade students who report having never used tobacco, alcohol and other drugs to: tobacco - 65 percent; alcohol - 65 percent; marijuana - 90 percent; cocaine - 98 percent.	Tobacco 59% (2004)	≥65%	59% (2004)	N/A	KIP
	Alcohol 54%	≥65%	54%	N/A	
	Marijuana 85%	≥90%	85%	N/A	
	Cocaine 96%	≥98%	96%	N/A	
26.8. Increase by at least one year the average age of first use of alcohol by adolescents.	12 years old (1997)	13 years old	13 years old (2003)	Target Achieved	YRBSS
26.9. Increase by at least one year the average age of first use of marijuana by adolescents.	14 years old (1997)	15 years old	13 years old (2003)	No	YRBSS
26.10. (DELETED)					
26.11. Reduce past month's use of alcohol among adolescents to no more than 30 percent.	49.3% (1997)	≤30%	45% (2003)	Yes	YRBSS
26.12. Reduce alcohol consumption in Kentucky to an annual average of no more than 2 gallons of ethanol per person.	2.2 gallons (1994)	≤2 gallons	1.8 gallons (2002)	Target Achieved	National Institute on Alcohol Abuse and Alcoholism
26.13. Reduce to no more than 10 percent the proportion of adolescents reporting marijuana use during the past 30 days.	28.4% (1997)	≤10%	21% (2003)	Yes	YRBSS

R = Revised objective

N/A = Only baseline data are available. Not able to determine progress at this time.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Substance Abuse	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
26.14. Reduce to no more than 4 percent the proportion of adolescents reporting use of illicit drugs other than marijuana at any time (lifetime use).	Cocaine 8.3% (1997)	≤4%	9.8% (2003)	No	YRBSS
	Inhalants 24.7% (1997)	≤4%	14.3% (2003)	Yes	
	Heroin 3.7% (2003)	≤4%	3.7% (2003)	Target Achieved	
	Meth 9.7% (2003)	≤4%	9.7% (2003)	N/A	
	Ecstasy 6.7% (2003)	≤4%	6.7% (2003)	N/A	
	Steroids 6.1% (1997)	≤4%	7.1% (2003)	No	
	Any Injections 2.6% (1997)	≤4%	3.2% (2003)	No	
26.15R. Reduce to no more than 2 percent the proportion of adolescents reporting inhalant use during the past 30 days.	4% (2003)	≤2%	4% (2003)	N/A	YRBSS
26.16R. Reduce to no more than 3 percent the proportion of adolescents reporting ever using steroids without a prescription.	6.1% (1997)	≤3%	7% (2003)	No	YRBSS
26.17. Reduce to no more than 20 percent the proportion of adolescents who report binge drinking within the past month.	37.1% (1997)	≤20%	33% (2003)	Yes	YRBSS
26.18R. Reduce by one-fourth the proportion of Kentuckians age 18 and older who report binge drinking within the past month.	8.7% (2001)	≤6.5%	9.6% (2004)	No	BRFSS

R = Revised objective

N/A = Only baseline data are available. Not able to determine progress at this time.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Substance Abuse	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
26.19. (Developmental) Reduce by half the proportion of youth who report having driven a vehicle, or riding with a driver who had been drinking, during the past month.	16% driving after drinking (1997)	≤8%	11% (2003)	Yes	YRBSS
	36% riding with a driver after drinking	≤18%	25%	Yes	
26.20.- 26.22. (DELETED)					
26.23. Increase to 40 percent the percentage of persons who become and remain totally abstinent as a result of treatment for abuse of alcohol, drugs, or both in combination.	29.1% (1997)	≥40%	44.5% (2003)	Target Achieved	KTOS
26.24.– 26.26. (DELETED)					
26.27R. Reduce by half the proportion of Kentucky adolescents who report considering or attempting suicide during the past year.	Considered 22% (1997)	≤11%	18% (2003)	Yes	YRBSS
	Made plan 17%	≤8.5%	15%	Yes	
	Actual attempt: 8%	≤4%	10%	No	
	Treatment: by doctor as result of attempt 3%	≤1.5%	4%	No	
26.28. Reduce to the following levels the percentages of adolescents who report experiencing problems or trouble as a consequence of using alcohol or drugs.	Trouble w/ family 9% (2004)	≤8%	9% (2004)	N/A	KIP
	Trouble w/ friends 12%	≤11%	12%	N/A	
	Trouble w/ police 3%	≤2%	3%	N/A	
	Problems in school 8%	≤7%	8%	N/A	

R = Revised objective

N/A = Only baseline data are available. Not able to determine progress at this time.

Goal

Upgrade and improve state and local public health jurisdictions' preparedness response to bioterrorism, outbreaks of infectious disease, and other public health threats and emergencies.

Overview

Disaster and emergency planning is an essential public health service—one that has been given short shrift until the last few years. Recent events such as the statewide anthrax scare, September 11th, Hurricanes Katrina and Rita, and the possibility of an avian flu pandemic, have brought home the importance of adequate planning, preparedness, and appropriate response to disasters and emergencies. Specific objectives relating to the added emphasis on public health preparedness are included in this new chapter.

The Department for Public Health is charged with utilizing funds made available through the Centers for Disease Control and Prevention to upgrade both state and local public health jurisdictions and to prepare them for a timely and appropriate response to bioterrorism, outbreaks of infectious disease, and other public health threats and emergencies. Because such events (as bioterrorism) can occur both at state and local levels, response capacity must be assured so that all affected jurisdictions are readied to the maximum capacity and can respond in a reasonable length of time. Education of state and local public health agencies, key policy makers, partners and stakeholders and their recognition of the importance of adequate disaster and emergency planning are paramount in making Kentucky a proactive state—one that is prepared for any possible catastrophic event.

Summary of Progress

Since this is a new chapter with baselines set at mid-decade status, a summary of progress is not applicable.

Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Public Health Preparedness	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
27.1N. Increase to 100 percent the percentage of local health departments (LHDs) that distribute to key policy makers, partners, and stakeholders in their jurisdiction, a periodic newsletter regarding the nature and scope of public health surveillance, investigation, response, and control.	35% produce newsletters (2005)	100%	35% (2005)	N/A	Survey of LHDs
27.2N. Increase response capacity by 20 percent by adding appropriately trained staff, such as epidemiologists, to conduct surveillance activities and investigate outbreaks as well as other public health emergencies.	10 state epis 17 regional epis (2005)	12 state epis 20 regional epis	10 state epis 17 regional epis (2005)	N/A	Review number of epidemiologists on staff
27.3N. Develop and maintain a registry of all public health personnel, other health care personnel, and security staff needed to maintain public order; EMS staff needed to transport ill patients; and hospital staff, private physicians and their staff who could serve on health care response teams in the event of a local, state or national emergency.	Registry began in Sept. 2005	Registry 95% complete	Registry began in Sept. 2005	N/A	Registry of personnel
27.4N. Develop an integrated, automated system to link infectious zoonotic disease information identified at the state diagnostic labs with the surveillance, identification and tracking system of the Kentucky Electronic Public Health Records System (KYEPHRS)	Will begin system in 2006	85% of system complete	Will begin system in 2006	N/A	Integrated database flag system

N= New objective

N/A = Only baseline data are available. Not able to determine progress at this time.

Appendix

List of Abbreviations

Behavioral Risk Factor Surveillance System	BRFSS
Body Mass Index	BMI
Cardiovascular Health Worksite Survey	CHWS
Children’s Oral Health Surveillance System	COHSS
Clinical Assessment Software Application – for the Kentucky Immunization Program	CASA
Fatality Assessment and Control Evaluation	FACE
Kentucky All Schedule Prescription Electronic Reporting	KASPER
Kentucky Birth Surveillance Registry	KBSR
Kentucky Board of Emergency Medical Services	KBEAM
Kentucky Cancer Registry	KCR
Kentucky Department for Education	KDE
Kentucky Electronic Public Health Record System.....	KYEPHRS
Kentucky Incentives for Prevention Student Survey	KIP
Kentucky Substance Abuse Treatment Outcomes Survey	KTOS
Hospital Inpatient Discharge Database.....	HOSP
National Core Indicators Survey of Persons with Disabilities	NCIS
Minimum Data Sets used in determining the long term care resident’s acuity level for payment.....	MDS
Medical Standards/Delegated Practice Committee of the Kentucky EMS Council, Kentucky Board of Medical Licensure.....	MS/DPC
Pediatric Nutrition Surveillance System	PedNSS
Patient Services Reporting System	PSRS
School Health Education Profiles.....	SHEP
Toxic Exposure Surveillance System.....	TESS
Tuberculosis Information Management System.....	TIMS
Universal Newborn Hearing Screening Program	UNHS
Youth Risk Factor Surveillance System.....	YRBSS
Youth Tobacco Survey.....	YTS