Secretary's Advisory Committee on
National Health Promotion and Disease Prevention Objectives for 2030
9th Meeting: Monday, May 14, 2018, 1:00 p.m. – 4:00 p.m. ET, via webcast

Co-Chairs

- Dushanka V. Kleinman, DDS, MScD
- Nico Pronk, PhD, MA, FACSM, FAWHP

Chair Emeritus

- Jonathan Fielding, MD, MPH, MA, MBA

Members

- Susan F. Goekler, PhD, MCHES
- Glenda Wrenn Gordon, MD, MSHP, FAPA
- Paul K. Halverson, DrPH, MHSA, FACHE
- Mary A. Pittman, DrPH
- Therese S. Richmond, PhD, CRNP, FAAN
- Nirav R. Shah, MD, MPH
- Joel B. Teitelbaum, JD, LLM

Committee Recommendations Approved by Vote

The Committee unanimously voted to approve the following recommendations.

Recommendation 1: LHI Definition
LHIs are a selected set of measures of determinants and sentinel indicators of current and potential changes in population health and well-being.

Recommendation 2: Criteria for LHI Selection
Phase 1*:* All core objectives should be assessed across 4 criteria. The criteria include:

- **Public health burden**—the relative significance to the health and well-being of the nation
- Magnitude of the **health disparity** and the degree to which, if the target were met, **health equity** would be achieved
- The degree to which it is a **sentinel or bellwether**
- **Actionability**

Phase 2*:* The potential pool of LHIs that emerge from *Phase 1* would then be subjected to an **additional set of criteria** prior to the selection of the final LHIs for Healthy People 2030. These considerations include the assessment of the LHIs as a group.

- The LHIs represent a **balanced portfolio** or cohesive set of indicators of health and well-being across the lifespan
- The LHIs are balanced between common, **upstream root causes** of poor health and well-being and measures of **high-priority health states**
- The LHIs are **amenable to policy, systems, and program interventions** at the local, state, tribal, and national level
- The LHIs are **understandable and will resonate** with diverse stakeholders to drive action

Action Items

1. The Data Subcommittee will revise their recommendations on target-setting methodology and present them to the Committee for approval at the July 10, 2018, Committee meeting.

Welcome

1:00 p.m. – 1:02 p.m.
Ms. Carter Blakey thanked the Committee members and meeting attendees for joining the 9th meeting of the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. Ms. Blakey reviewed the agenda for the meeting, which included discussions regarding target-setting methods for Healthy People 2030 objectives and criteria for selecting the Leading Health Indicators (LHIs). She noted that the U.S. Department of Health and Human Services (HHS) has begun the process of developing Healthy People 2030 objectives and that Dr. Jennifer Villani, a member of the Healthy People Federal Interagency Workgroup (FIW), would present to the Committee the FIW's efforts to operationalize the Committee's recommendations, identify objectives for Healthy People 2030, share the anticipated timeline for public comment, and answer questions the Committee may have about the FIW's work.

Goals for the Meeting

1:03 p.m. – 1:05 p.m.
Dr. Dushanka Kleinman described the following goals for the meeting:

- Consider the recommendations from the Data Subcommittee
- Develop recommendations regarding target setting for Healthy People 2030 objectives
- Explore issues regarding the recommendations for selecting Leading Health Indicators
- Develop recommendations for selecting the LHIs

Healthy People Federal Interagency Workgroup (FIW) Update

1:06 p.m. – 1:33 p.m.
Dr. Kleinman introduced Dr. Villani, the National Institutes of Health (NIH) representative to the Healthy People FIW.

Dr. Villani described the recommendations previously received from the Committee. The FIW has adopted all aspects of the Committee's recommended Healthy People 2030 framework, including the Vision, Mission, Foundational Principles, Plan of Action, and Overarching Goals. Dr. Villani also provided an overview of the Committee's recommended step-wise process to identify topics and objectives for Healthy People 2030, namely:

1. Select topics that will be used to organize objectives and convene workgroups
2. Identify objectives using inclusion and quality control criteria, then set targets
3. Categorize the refined list of objectives and prioritize based on expected impact

The FIW incorporated many of the Committee's recommendations into their final objective selection process. To develop the objective selection process, the FIW Implementation subgroup formed 3 work streams in November 2017 on the following subjects:

1. Topic areas and organizing framework
2. Core, developmental, research objectives
3. Objective selection criteria

The topic areas work stream considered whether to begin the objective selection process by identifying topic areas first and selecting objectives second, or vice versa; the Implementation subgroup decided to begin by selecting objectives, and later organize the selected objectives into a framework of topic areas or themes.

The core, developmental, research objectives work stream operationalized the Committee's recommended definitions for each type of objective. Core objectives must meet the following criteria:

- Approved data source
- Baseline data no older than 2015
- At least 2 additional data points for the decade
- Supported by scientific evidence
- Of national importance
- Addresses health equity and disparities

Developmental objectives are high-priority issues that do not have reliable baseline data, but for which evidence-based interventions have been developed. Research objectives represent significant opportunities for advancement in areas with limited research, may/may not have reliable data, and do not yet have evidence-based interventions identified.

The objective selection criteria work stream developed a 2-step initial objective selection process for topic area workgroups to undertake. During the first round, each topic area workgroup applied the following 2 required criteria to their current Healthy People 2020 objectives:

- Must be measurable by the data cutoff for inclusion in Healthy People 2030, which is 2019
- Must have baseline data no older than 2015, and 2 additional data points during the Healthy People 2030 decade

Forty of Healthy People 2020's 42 topic area workgroups submitted a first-round assessment. Based on their submissions, the number of potential objectives to be proposed for Healthy People 2030 was reduced to 705.

All 42 topic area workgroups were asked to complete a second-round assessment, which prompted them to determine which objectives they plan to propose for Healthy People 2030. The FIW plans to review proposals for HP2030 core objectives during the summer and fall of 2018. Each proposed core objective must address the additional objective selection criteria:

- National importance
    - Direct impact or influence on health
    - Broad and comprehensive applicability
    - Substantial burden
    - National public health priority
- Evidence-based
- Health equity and disparities

The FIW will review each objective proposal and assign the objective a rating. A subgroup of the FIW will then determine the slate of Healthy People 2030 objectives by considering the ratings, criteria, and Healthy People 2030 framework. After the slate of Healthy People 2030 objectives is confirmed by the FIW, there will be a 60-day public comment period, tentatively planned for November 2018 through January 2019. Public comments can be submitted at HealthyPeople.gov.

Dr. Villani provided an overview of the timeline for developing Healthy People 2030 objectives, including work completed to date. Topic area workgroups are beginning to develop their objective proposals, and the FIW will begin reviewing those proposals in June or July 2018. The Objective Review Subgroup will convene in September and October 2018 to determine a slate of objectives, the FIW will review the proposed slate in October or November 2018, and public comment will take place from November 2018 through January 2019.

Dr. Kleinman thanked Dr. Villani for her presentation and asked how the FIW determined the baseline data cutoff of 2015. Dr. Villani replied that the FIW selected this date because they would like objectives to use data that are as current as possible, but noted that there may be some flexibility with this criterion.

Dr. Paul Halverson asked how the FIW plans to consider infrastructure-related objectives that may not satisfy the evidence-based criterion. The FIW has specifically considered how infrastructure objectives may not meet the evidence-based criterion and will assess these objectives primarily on their national importance.

Dr. Halverson also asked how the FIW plans to engage non-traditional health sectors (e.g., transportation, agriculture, education, etc.) in the selection of objectives and the development of Healthy People 2030. Many topic area workgroups include representatives from other non-HHS agencies (e.g., the Department of Veterans Affairs, the Department of Education, etc.), and the FIW includes representatives from every federal department. The FIW is also incorporating feedback from regional listening sessions into its work.

Dr. Nico Pronk asked how the FIW plans to operationalize the objective selection criteria related to health equity and disparities. The FIW is using the HHS Office of Minority Health (OMH)'s definition of health equity as, "*Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities*." OMH defines health disparities as, "*A particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion.*" Topic area workgroups will indicate how each proposed objective is addressing these areas, potentially by using data to show population group differences and measure disparities.

Dr. Susan Goekler is chairing the subcommittee writing the brief on Health Promotion, which includes discussion of healthy community measures that may draw on data sources beyond traditional health data. Dr. Goekler noted that the Robert Wood Johnson Foundation (RWJF) and the National Association

of County and City Health Officials (NACCHO) have identified datasets that may be useful in measuring healthy communities. Dr. Villani noted that the National Center for Health Statistics (NCHS) has developed a vetted list of federal high-quality nationally representative data sources that will be the foundation of Healthy People data, but that there is an opportunity to use datasets in Healthy People 2030 beyond the traditional datasets.

Data Subcommittee

1:34 p.m. – 2:07 p.m.
Dr. Nirav Shah reviewed the charge of the Data Subcommittee, which is to develop recommendations regarding the data core (data needs, data source standards, and progress reporting) and innovation related to data (changes in data sources, analysis, and reporting; community data; summary measures; and the future of health data).

Dr. Shah reviewed the history of target setting in the Healthy People program and outlined the purposes of target setting, which are to specify achievable gains in health and well-being and to encourage action and appropriate human and financial resource allocation on the part of public and private stakeholders.

He noted that setting measurable targets for objectives requires judgment and is not an exact science. A variety of information needs to be integrated into a realistic assessment of what can be accomplished, aided by methods of target setting.

The Data Subcommittee suggested the following 4 principles for target setting:

- Objectives should be science-based.
- Improving health equity is an important goal.
- A target-setting method may be augmented with a subjective or aspirational component.
- Supporting material for each objective must include at least 1 scenario that will achieve the target.

The subcommittee also recommended that target-setting methods be prioritized from 1 to 9, with 1 being the preferred target-setting method and 9 being the least preferred choice.

1. Modeling and/or projection/trend analysis
2. Adapting recommendations from national programs, regulations, policies, and laws
3. Specific percentage point improvement
4. Ten percent improvement
5. Minimal statistical significance
6. Retention of the previous Healthy People target
7. Total coverage/elimination
8. Better than the best
9. Maintain the baseline value as the target

Dr. Shah reviewed each of the target-setting methods and provided an illustrative example for each.

Target-Setting Method	Description	Example
1. Modeling and/or projection/trend analysis	Modeling and statistical analysis are used to identify possible future targets. Target selection based on health impact, achievability, feasible actions.	EH-3.2 Reduce the risk of adverse health effects caused by area sources of airborne toxins. This target was developed from an EPA emissions concentration forecast model that includes mobile sources, fires, area sources, and major sources in the modeling. **Baseline**: 1,300,000 tons (2005) **Target:** 1,700,000 tons
2. Adapting recommendations from national programs, regulations, policies, and laws	National programs may have targets suitable for Healthy People. Methods used to set the targets should be reviewed to assure consistency with current science. Level of target achievability and health impact depend on the supporting analysis.	IID-8 Increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and pneumococcal conjugate vaccine (PCV). **Baseline**: 68.4% in 2012 **Target**: 80.0%, consistent with CDC analysis
3. Specific percentage point improvement	Target selected by choosing a percentage improvement. Supporting the choice should be a systematic review of evidence and/or modeling/projection to assure target achievability. Strong target achievability assuming systematic review of evidence and projection of trends.	EMC-4.3.1 Increase the proportion of elementary schools that require cumulative instruction in health education that meet the U.S. National Health Education Standards for elementary, middle, and senior high schools. **Baseline**: 7.5% in 2006 **Target**: 11.5%, an increase of 4% (or a relative increase of 53%)
4. Ten percent improvement	Target selected to represent a 10% improvement. Supporting the choice should be a systematic review of evidence and/or modeling/projection to assure target achievability. Low outcome rates would mean small change; high rates would mean large change.	MHMD-1 Reduce the suicide rate. **Baseline**: 11.3 suicides per 100,000 population (2007) **Target**: 10.2 suicides per 100,000 population (10% improvement)
5. Minimal statistical significance	Chooses a target so the distance between the target and the baseline is the smallest distance to represent a statistically significant change.	RD-4 Reduce activity limitations among persons with current asthma. This rate represents the percentage of people with asthma who currently have activity limitations.

	The target should take into account key factors that will influence improvement. Could lead to a target consistent with little health impact.	**Baseline**: 12.7% (2008) **Target**: 10.3%
6. Retention of the previous Healthy People target	Reflects little progress made in the prior decade. New analysis is critical to assure achievability, determine importance of health problem, and encourage action. Key factors that will influence improvement should be identified.	TU-11.1 Reduce cigarette smoking by adults. **Baseline**: 20.6% (2008) **Target**: 12%
7. Total coverage/elimination	Total coverage or total elimination is sought and deemed achievable within the decade. Concern that these goals may not be realistic and/or achievable.	AHS-1.1 Increase the proportion of persons with medical insurance. **Baseline**: 83.2% (2008) **Target**: 100% **Interim data**: 89.7% (2016) IID-1.8 Maintain elimination of polio. **Baseline**: 0 cases (2008) **Target**: 0 cases **Interim data**: 0 cases (2015)
8. Better than the best	Chooses the "best" value of the measure across subgroups as an achievable target for other subgroups. Analysis should include identification of key subgroup-specific factors that enable progress.	(HP2010) 12-9 Reduce the proportion of adults with high blood pressure. **Baseline**: 25% (1998–94) **Target**: 14% **Note**: Mexican Americans had the "best" rate.
9. Maintain the baseline value as the target	For health problems that are in imminent danger of getting worse. Key factors that will achieve stability of the baseline need to be known. Should be used only in special cases of a concern for decreasing health status.	IVP-9.4 Prevent an increase in poisoning deaths caused by unintentional or undetermined intent among persons aged 35 to 54 years. **Baseline**: 21.6 deaths per 100,000 (2007) **Target**: 21.6 deaths per 100,000 **Interim data**: 34.2 (2016)

Dr. Shah noted that the majority of objectives for Healthy People 2030 used 10 percent improvement as the target-setting method. He added that the subcommittee recommended that addressing health disparities should be foundational to the objectives and targets, and, furthermore, regardless of which target-setting method is selected, it should take into account health equity.

Committee Discussion

Dr. Jonathan Fielding recommended that each objective target include a description of whether it is subjective or objective, so that it is clear if the target is achievable, based on trend analysis, or whether it is aspirational. He added that there are not many interventions that are proven to reduce inequities and recommended that the subcommittee revisit the prioritized list of target-setting methods, taking into account the likelihood of reducing inequities.

Dr. Glenda Wrenn Gordon supported Dr. Fielding's suggestion of incorporating progress toward achieving health equity in the prioritization of target-setting methods. She emphasized that targets that are clinically significant from a public health perspective should be prioritized over arbitrary numbers. Dr. Kleinman added that while the subcommittee emphasized the importance of modeling as the preferred method of target setting, they recognized that many times expert opinion is required to make subjective decisions; therefore, she supported Dr. Fielding's suggestion.

Dr. Pronk agreed and reminded the Committee of principle 4, that the "targets should be achievable under at least one possible scenario"; he further noted that while aspirational goals are good, they should have some relationship to what is achievable. He added that while modeling is a preferred method for target setting, it requires resources, so the prioritized list of target-setting methods provides flexibility in target-setting approaches and recognizes the limits on resources available.

The Committee discussed whether progress toward achieving targets on a small scale (e.g., County Health Rankings) could be generalized to a national level. Dr. Shah noted that the "better than the best" target-setting method could be applied to geographic sub-groups to set targets. Dr. Fielding recommended that the "better than the best" target-setting method should be ranked higher in the prioritized list, because if a sub-group has already met the target, it would be a better indicator of what is realistically achievable than a specific percentage point improvement. However, it is difficult to make a general prioritized list that fits all objectives and targets.

Dr. Shah supported the recommendations of noting the level of objectivity or subjectivity that went into setting a target and highlighting the objectives that have a potential to impact inequity. He recommended revising the list of the prioritized methods and noted that he would prefer if the majority of objectives did not rely on the 10 percent improvement method.

Dr. Kleinman noted that the subcommittee has reviewed the previous target-setting methods and the percentage of targets that have been met for each target-setting method. The subcommittee has learned that it is important to have specific documentation available about the approach for selecting the target-setting method, so that future decades of Healthy People can learn from past objectives and targets.

Dr. Fielding felt that the 10 percent improvement target is an easy way out and recommended setting a goal to restrict the number that use the 10 percent improvement method to no higher than 40 or 50 percent of objectives. Dr. Pronk agreed, but noted that it would be difficult to determine the percentage of objectives that should use that target-setting method. He recommended moving the "better than the best" method higher on the prioritized list to the fourth position and making the 10 percent improvement the final method of the prioritized list.

The Data Subcommittee will meet, revise the recommendations, and finalize the report to share with the Committee to vote on during the next meeting on July 10, 2018.

Leading Health Indicators Subcommittee

2:08 p.m. – 2:45 p.m.
Dr. Therese Richmond presented on behalf of the LHI Subcommittee. She noted that the subcommittee's charge is to provide advice regarding the selection of LHIs for Healthy People 2030. Furthermore, this guidance should include considerations related to:

- The definition of LHIs
- The use of LHIs (past, present, future) and how LHIs can help achieve the Healthy People 2030 mission, goals, and objectives
- The alignment of LHIs with the selection of Healthy People 2030 objectives/priority areas
- Criteria for LHI selection
- Use of the Healthy People 2030 Framework as a foundation for the criteria for selecting LHIs for the Healthy People 2030 initiative
- Consideration of the recommendations from other subcommittees (Prioritization, SDOH and Health Equity, Data, and Stakeholders) in recommending criteria for the selection of LHIs for Healthy People 2030

The LHI Subcommittee held 5 meetings with conversations focused around the LHI definition, the rationale for the proposed LHI definition, and the LHI selection criteria and approach. To inform its work, the subcommittee received presentations on the following topics to inform their recommendations:

- Development and Implementation of the Healthy People 2020 LHIs
- Who's Leading the Leading Health Indicators? Series
- Healthy People 2020 Leading Health Indicators: History and Current Status

Dr. Richmond presented the first recommendation to the Committee.

Recommendation 1: LHI Definition

- LHIs are a selected set of measures of determinants and sentinel indicators of current and potential changes in population health and well-being.

Dr. Richmond explained that the definition is designed to represent the key priorities to catalyze action and stimulate resources to improve health and well-being. The subcommittee had robust discussion debating whether the LHI emphasis should be on leading or on serving as a bellwether, as a predictor of change, and/or as an early warning of existing and potential threats to population health. The LHIs provide critical data and are an external facing portion of the Healthy People initiative.

Dr. Richmond presented the second recommendation to the Committee.

Recommendation 2: Criteria for LHI Selection

Phase 1*:* All core objectives should be assessed across 4 criteria.

<u>The criteria include</u>:

- **Public health burden**—the relative significance to the health and well-being of the nation
- Magnitude of the **health disparity** and the degree to which, if the target were met, **health equity** would be achieved

- The degree to which it is a **sentinel or bellwether**
- **Actionability**

Phase 2*:* The potential pool of LHIs that emerge from *Phase 1* would then be subjected to an **additional set of criteria** prior to the selection of the final LHIs for Healthy People 2030. These considerations include the assessment of the LHIs as a group.

- The LHIs represent a **balanced portfolio** or cohesive set of indicators of health and well-being across the lifespan
- The LHIs are balanced between common, **upstream root causes** of poor health and well-being and measures of **high-priority health states**
- The LHIs are **amenable to policy interventions** at the local, state, tribal, and national level
- The LHIs are **understandable and will resonate** with diverse stakeholders to drive action

Next, Dr. Richmond provided an overview of the process for application of the criteria. Key themes include:

- Rationale for the 2-phase process
- Recommended Phase 1 process for evaluating core objectives as potential LHIs
- Recommended Phase 2 process
- Importance of an iterative approach to selecting the final set of LHIs

Dr. Richmond shared that the rationale for the 2-phase process is a key component to the LHI selection process. Phase 1 will be applied to all Core objectives. A subset of objectives will be selected as a result of the Phase 1 process and move to Phase 2. The criteria for Phase 1 and 2 will be evaluated on a scale from 1 to 10. The cumulative score across the criteria would then be compared to each other. Phase 2 will allow the assessors to consider the remaining LHIs as a group and apply the Phase 2 criteria Dr. Richmond previously presented. This 2-phase process will hopefully result in a subset of the Core objectives rising to the top and be considered in the larger set of LHIs.

Dr. Richmond added that the LHI Subcommittee members tested out the recommended selection process by applying the criteria and 2-phase process to the HP2020 LHIs. The subcommittee found the process to be helpful and clear and to enable a select set of LHIs to emerge. The subcommittee agreed that the 2-phase process is an iterative approach to selecting the LHIs and will likely result in multiple rounds of back and forth between Phase 1 and Phase 2 before the final set of LHIs is selected.

Committee Discussion

Dr. Fielding shared that the set of recommendations designed by the subcommittee is a thorough set and adds to the work that has been completed thus far. Dr. Fielding suggested that the third bullet under the Phase 2 criteria, "The LHIs are amenable to policy interventions at the local, state, tribal, and national level," be revised to state, "The LHIs are amenable to policy, systems, and program interventions at the local, state, tribal, and national level." Dr. Fielding asked how many LHIs the subcommittee is looking to identify. Ms. Tiffani Kigenyi responded that the subcommittee's charge is to focus on the definition and criteria for the LHIs and not to identify the number of LHIs. Dr. Richmond added the subcommittee is in agreement that the number of LHIs should be parsimonious.

As chair of the Stakeholder Engagement and Communications Subcommittee, Dr. Halverson shared the recommendations successfully capture the intent of the Stakeholder Subcommittee, especially in terms of the actionability criteria.

Dr. Pronk called the Committee to a vote. The Committee **approved** all 3 recommendations by a unanimous vote.

Meeting Summary: Recommendations, Action Items, and Next Steps

2:46 p.m. – 2:49 p.m.
Dr. Pronk thanked Dr. Villani for her presentation on the work completed by the Healthy People FIW. He also thanked Dr. Shah and Dr. Richmond for their presentations and the Committee for their participation in the meeting. The next meeting of the Committee will be a webinar meeting on July 10, 2018, from 1:00 p.m. to 4:00 p.m., Eastern time. The focus of the Committee's July meeting will be the Committee's recommendations regarding target-setting methods for the HP2030 objectives and the Committee's consideration of the issue-specific briefs that its various subcommittees are developing on health and well-being, health promotion, health literacy, law and policy, systems science, summary measures, and health equity.

The next in-person meeting of the Committee will be held on September 6–7, 2018, in Washington, DC. During the Committee's September meeting, the Committee will receive updates and recommendations from its other subcommittees, including the Stakeholder Engagement and Communications Subcommittee and the Logic Model Subcommittee, and will take up its charge to develop recommendations for the implementation of Healthy People 2030 prior to launch, as it launches, and post launch.

Meeting Adjourned

2:50 p.m.