

**Secretary's Advisory Committee on
National Health Promotion and Disease Prevention Objectives for 2030**

20 F Street Conference Center
20 F Street NW, Washington, DC 20001

Fifth Meeting: September 6–7, 2017

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
- Cynthia A. Gómez, PhD
- Paul K. Halverson, DrPH, MHSA, FACHE
- Mary A. Pittman, DrPH
- Therese S. Richmond, PhD, CRNP, FAAN
- Nirav R. Shah, MD, MPH
- Edward J. Sondik, PhD
- Joel B. Teitelbaum, JD, LLM
- Glenda L. Wrenn Gordon, MD, MSHP, FAPA

Committee Recommendations Approved by Vote

Social Determinants of Health (SDOH) and Health Equity Subcommittee

- **Recommendation 1.1:** Include SDOH and health equity as cross-cutting themes in Healthy People 2030.
- **Recommendation 1.2:** Maintain SDOH as a distinct topic area.
- **Recommendation 2:** SDOH should be applied as a selection criterion for topic area objectives.

Data Subcommittee

- **Recommendation 1:** For Healthy People 2030 objectives, data should be made available as soon as possible and no longer than 1 year after the end of data collection.
- **Recommendation 3.B:** To establish reliable trends, data points may include those from a prior decade if comparable in outlining a trend.
- **Recommendation 4:** Current data syndication efforts should continue for Healthy People 2030 and, if possible, increase in number.

Prioritization and Objective Selection Criteria Subcommittee

- **Recommendation 2:** Healthy People 2030 should identify priorities and opportunities by applying a prioritization framework, generalizable to and usable by all target audiences. The initiative should offer context and background information on the overarching purpose of the initiative, inclusive of increasing health equity. Broad criteria:

- Overall health burden (both preventable and not yet preventable based on current opportunities)
- Preventable burden (i.e., amenable fraction/amount of health and well-being to be gained) from implementation of available effective interventions
- Health inequities/disparities reductions possible based on current opportunities
- Cost effectiveness and prevention effectiveness

Stakeholder Engagement and Communications

- **Recommendation 2:** Broad engagement should include more than structured public comment periods for testimony or written comment.

Next Steps

1. Subcommittees will revise their recommendations and reports based on the Committee discussion. Revised recommendations will be presented at a subsequent Committee meeting for approval.

Day 1: September 6, 2017

Welcome and Introduction

8:30 a.m. – 8:50 a.m.

Ms. Carter Blakey, Deputy Director of the Office of Disease Prevention and Health Promotion (ODPHP), welcomed attendees to the fifth meeting of the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030 (hereafter referred to as the Committee). She introduced Dr. Don Wright, Acting Assistant Secretary for Health and Director, ODPHP. Dr. Wright thanked the Committee members for their efforts. He summarized the agenda for the meeting, which included updates from each of the subcommittees, a stakeholder panel, and a discussion on the Healthy People 2030 logic graphic. He also explained the process for in-person public comment (on the proposed Healthy People 2030 framework), which was scheduled for the second day of the meeting. He noted that the public may also provide comments online (at healthypeople.gov) to respond to the Healthy People 2030 vision, mission, overarching goals, foundational principles, and plan for action. The public comment period will continue through September 29, 2017. He formally opened the Committee meeting by introducing the Committee co-chairs, Dr. Dushanka V. Kleinman and Dr. Nico Pronk. Dr. Kleinman and Dr. Pronk added their welcome to the Committee members and meeting attendees, and thanked Dr. Wright for his overview of the main objectives and goals of the meeting.

Social Determinants of Health (SDOH) and Health Equity Subcommittee and Recommendations Regarding the Role of SDOH and Health Equity in the Priorities and Scope of HP2030 and Inclusion of SDOH and Health Equity as Cross-Cutting Themes

8:50 a.m. – 9:40 a.m.

Dr. Glenda Wrenn Gordon introduced the charge of the Social Determinants of Health (SDOH) and Health Equity subcommittee, which is to: 1) Identify how the themes of SDOH and health equity can contribute to the organizing framework of the Committee's charge, and their relation to health disparities and law and policy; 2) Conduct a high-level discussion of the approach to integrate SDOH and health equity in Healthy People 2030; and 3) Consider how SDOH and health equity relate to health disparities and law and policy.

The subcommittee has met twice since the June 27, 2017, Committee meeting and worked to develop a report of recommendations regarding the role of SDOH and health equity in the priorities and scope of Healthy People 2030, as well as on the inclusion of the cross-cutting themes of SDOH and health equity throughout Healthy People 2030. In the future, the subcommittee will develop recommendations for how to represent these themes in Healthy People 2030, including how best to integrate measuring and reporting on SDOH into the objectives, as well as on the relationship between SDOH and health equity. The subcommittee began its work with an examination of the history of SDOH in Healthy People and the progress achieved in Healthy People 2020 for SDOH-related objectives. The subcommittee then discussed what approach should be used for SDOH in Healthy People 2030, and considered how adding the concept of health equity might inform that approach. This led to a study of whether current measurements and interventions are adequate to cover SDOH and health equity or if there are new strategies and measures that should be explored. The subcommittee utilized a broad conceptualization of SDOH and health equity to discuss and explore the adequacy of the current SDOH framework, advances and new conceptualizations of health equity, definitions and nomenclature, and the relationship between SDOH and health equity.

The subcommittee first sought to understand how Healthy People 2020 currently incorporates SDOH into the initiative's structure. SDOH is one of the 12 topics that organize the 26 Leading Health Indicators (LHIs). Created with Healthy People 2020, the SDOH topic area has 33 objectives, 8 of which are newly created and unique to the SDOH topic area.

Dr. Wrenn Gordon explained the evolution of reporting progress by race/ethnicity over time in Healthy People as an example informing the Committee's decisions regarding SDOH. Healthy People 2000 reported on race/ethnicity progress in the final report for the first time, and Healthy People 2010 integrated progress by race/ethnicity throughout all topic areas. Reporting on SDOH is new in Healthy People 2020, and Dr. Wrenn Gordon noted that many SDOH objectives are informational and do not have an explicit target as there may not be clearly identified and defined evidence-based interventions. She suggested that a baseline measure may need to be established before assigning a target.

Dr. Wrenn Gordon provided an overview of the subcommittee's recommendations. The subcommittee made the following recommendations regarding how the themes of SDOH and health equity can contribute to the organizing framework:

Recommendation 1.1: Include SDOH and health equity as cross-cutting themes in Healthy People 2030.

- **Rationale:**
 - Including SDOH and health equity as cross-cutting themes could encourage prioritization of SDOH and health equity within topic areas, and could also prompt Healthy People topic areas to assess opportunities to address SDOH when they might not otherwise do so.
- **Issues for Consideration:**
 - In the proposed HP2030 framework and approach, SDOH and health equity are addressed as cross-cutting themes.
 - There are opportunities to incorporate an understanding of the impact of SDOH and the goal of health equity into other aspects of Healthy People 2030, such as data, and to take SDOH and health equity into consideration in decisions about prioritizing Healthy People objectives.

Recommendation 1.2: Maintain SDOH as a distinct topic area.

- **Rationale:**
 - Maintaining a separate topic area for SDOH would ensure that it continues to be acknowledged as a significant and uniquely overarching public health issue, and that progress toward addressing SDOH (and achieving health equity) is readily assessed. Healthy People users will be able to select and view SDOH data separately, even if the data are embedded within other topic areas. This will make it easier for groups that are doing work to address SDOH to use Healthy People data.
 - The creation of the National Institute on Minority Health and Health Disparities (NIMHD) offers an example of maintaining a separate identity for an issue, even as its work is integrated into that of other, existing groups.
 - This remains a relatively new domain within Healthy People, and several objectives within the SDOH topic area lack targets.
 - While there have been important advances in the understanding of SDOH during the last decade, maintaining a separate topic area for SDOH would reflect the developmental status of public health approaches to addressing SDOH.
- **Issues for Consideration:**
 - SDOH measures may be based on data from non-health sectors, with limitations on how they are measured.
 - Due to the multi-sectoral nature of SDOH, a more integrated organizational approach could encourage advances in the measurement of SDOH, and the identification of emerging best practices for strategies to address SDOH.

The subcommittee made the following recommendation regarding how SDOH should be considered as an objective selection criterion within Healthy People 2030:

Recommendation 2: SDOH should be applied as a selection criterion for topic area objectives.

- **Rationale:**
 - As a topic area workgroup is reviewing objectives and determining what to include or exclude, this criterion could ensure that objectives related to SDOH are included in Healthy People 2030 where appropriate. For example, if a topic area workgroup wanted to eliminate the objective on high school graduation rates, which are a strong indicator for SDOH, this criterion would support its inclusion.
- **Issues for Consideration:**
 - This recommendation will be of value in developing objective ways to prioritize objectives.
 - Criteria for relevance of additional SDOH objectives may include factors such as whether:
 - A measure has been identified
 - A valid data source is available
 - An evidence base has been established for interventions that can result in significant progress on the objective or LHI

Additionally, the subcommittee reviewed, considered, and continues to discuss how SDOH and health equity relate to health disparities, law, and policy. Disparities are measured and monitored in an integrated manner throughout many relevant Healthy People 2020 objectives. Within a specific health area, disparities are driven by multiple health determinants such as biological and genetic risk, environmental factors, individual behaviors, and treatment availability. SDOH are widely understood to

be underlying drivers of health disparities, both because they are determinants of disparities that are observed in many of the health determinants, and because they are directly linked to many health disparities. Dr. Wrenn Gordon noted that the Robert Wood Johnson Foundation (RWJF) distinguishes between health equity and health disparities by suggesting that disparities are what is measured. She suggested that it is important to consider whether measures under the Healthy People 2030 framework should assess objectives related to social determinants, measures of disparities themselves, or a combination of both.

Given the evolving definition and understanding of health equity, the Committee will review and discuss the brief on health equity under development to explore the historical use of this concept in Healthy People, its evolving definition, and current views on the health equity construct as an achievable outcome. The subcommittee continues to contemplate the ways in which law functions as an SDOH, and how policymaking across a range of health-related social factors (e.g., housing, nutrition, transportation) affects health equity.

The subcommittee requested a briefing paper that describes:

- How law can create, perpetuate, and ameliorate health-harming social conditions
- Whether state and local efforts to implement “Health in All Policies” approaches may serve as a model for addressing SDOH and advancing health equity

Dr. Wrenn Gordon proposed the following next steps for the subcommittee:

- Continue to explore health equity through:
 - Discussion about the health equity brief under development
 - Exploring nomenclature and recent advances in definitions, and measuring and discussing health disparities
- Further discuss how SDOH and health equity relate to health disparities, law, and policy by:
 - Examining SDOH concepts, current science, and the role of SDOH and health equity
 - Continuing to contemplate how law functions as an SDOH, and how policymaking across a range of health-related social factors (e.g., housing, nutrition, transportation) affects health equity
 - Reviewing the law brief under development
- Develop additional recommendations in these areas.

Committee Discussion

The Committee discussed Recommendations 1.1 and 1.2, which are related to how the themes of SDOH and health equity can contribute to the organizing framework. Dr. Cynthia Gómez noted that the subcommittee has taken care to consider SDOH and health equity separately, particularly regarding conceptualization and measurement. Health equity can be considered a value, a principle, or as a goal or aspiration; the brief on health equity will speak to this to ensure that Committee members are operating from a common understanding of the concept.

Dr. Nirav Shah suggested that the SDOH objectives could look at variation across the country and the target would be the national average; this would allow users to focus on measures with the most unexplained variation. Dr. Edward Sondik suggested that a shift toward more complex objectives (e.g., measuring variance in poverty levels rather than only measuring poverty levels) would help Healthy People 2030 speak to SDOH and encode SDOH within objectives and within targets; Committee members agreed that Healthy People 2030 would benefit from embracing complexity.

Dr. Susan Goekler suggested that Healthy People 2030 could include data sources from a broader range of sectors. Dr. Therese Richmond noted that Healthy People 2020's assessment of health disparities is fairly 1-dimensional, and hoped that more complex intersections of disparities could be measured in Healthy People 2030; Dr. Wrenn Gordon replied that the initiative is limited to a more simplistic representation of disparities by its data sources. Dr. Jonathan Fielding suggested that valuable sectors may include transportation, housing, and criminal and juvenile justice; Dr. Paul Halverson added retail and information systems sectors.

Dr. Sondik noted that Healthy People 2030 could play a key role in stimulating data analysis and prompting use of multi-sectoral data by suggesting what research objectives should be undertaken in the future, and possibly identifying incentives and rewards for organizations that become involved. Recommendations 1.1 and 1.2 were **approved unanimously**.

Next, the subcommittee discussed Recommendation 2, regarding applying SDOH as selection criteria for topic area objectives. Dr. Halverson suggested that the Committee remain open to the idea of developmental objectives, particularly as the initiative finds ways to engage a variety of sectors. The Committee decided to wait to vote on Recommendation 2 until they have discussed the Prioritization and Objective Criteria Selection subcommittee's recommendations as well.

Dr. Fielding noted that policy takes many different forms, including both formal and informal laws and regulations. Dr. Fielding also commented that the term "Health in All Policies" suggests that health is important to all sectors, but suggested that other sectors are more likely to engage with health if they believe there is a distinct benefit of the collaboration. Mr. Joel Teitelbaum agreed with this assessment. Dr. Mary Pittman noted that the "Health in All Policies" framework has successfully encouraged many sectors to look at their decisions and policies from a different perspective.

Dr. Pittman suggested that the subcommittee study the variety of different ways that health equity is measured. Dr. Fielding asked where resilience fits into the subcommittee's discussion; Dr. Wrenn Gordon had removed text from the report about the conceptualization of SDOH as a health and well-being outcome because the subcommittee was not ready to produce a succinct recommendation regarding this topic, but the subcommittee will continue to discuss the subject in future meetings.

Data Subcommittee and Recommendations Regarding Increasing Data Timeliness and Dissemination and Developing a Data Logic Model

9:40 a.m. – 10:55 a.m.

Dr. Sondik, chair of the Data subcommittee, provided an overview of the subcommittee's work since the June 27, 2017, Committee meeting. The Data subcommittee has met twice since then. Key issues considered by the subcommittee include data timeliness, data quality, periodicity of the data, number of required data points, syndication of content to stimulate data use, data source standards, and the role of data in Healthy People.

Dr. Sondik spoke about the role of data in Healthy People. Data is key because it enables Healthy People to track objectives and measure progress over the decade. Healthy People relies on many diverse data systems, including national censuses of events (e.g., births and deaths), nationally representative sample surveys, and other data sources (e.g., air quality index). In total, 191 data sources are used in Healthy

People 2020. However, challenges exist. For example, the data sources are of varying quality and formats and about two-thirds of the data sources do not have annual data. The challenge for Healthy People 2030 is to balance data quality and timeliness. Timeliness can be impacted by how frequently the data is collected, but also, in terms of Healthy People objectives, by how long it takes for the analysis and updating of data to occur on the website. Additionally, there is the challenge of local needs for data in addition to national sources of data.

Dr. Sondik reviewed the recommendations from the Data subcommittee.

Timeliness of the Data

Recommendation 1.A: For LHIs, data should ideally be made available within 1 year of the end of data collection.

Recommendation 1.B: As a selection criterion for LHIs, include the requirement that data be available within 1 year of data collection.

Recommendation 1.C: For other Healthy People 2030 objectives, data should be made available no more than 2 years after data collection.

- **Rationale:**
 - Timely data enables earlier assessment of progress and earlier intervention to meet the objectives' targets.
- **Issues for Consideration:**
 - Timeliness depends on a combination of factors: quality control and processing after collection, the periodicity of data collection, and the data agency's capacity to manage the full set of objectives (now about 1,300) for editing and analysis.

Periodicity of the Data

Recommendation 2.A: Data collection should ideally occur annually for LHIs, or at least every 2 years for other objectives. Data sources that do not meet these standards are encouraged to increase their periodicity.

- **Rationale:**
 - The frequency of data release is important to ensure that sufficient information is available to support ongoing, constructive public health action.
- **Issues for Consideration:**
 - Healthy People data releases are subject to the schedules and statistical designs of data systems as well as the data processing resources data and HP staff.
 - Some data source designs require at least 2 years for an adequate sample (e.g., the National Health and Nutrition Examination Survey).

Number of Required Data Points

Recommendation 3.A: It is strongly recommended that LHIs have annual data points and other objectives have at least 3 data points within the decade.

Recommendation 3.B: To establish reliable trends, data points may include those from a prior decade if comparable in outlining a trend.

- **Rationale:**

- Currently, Healthy People 2020 objectives are required to have 2 data points. Having only 2 data points may lead to false conclusions about whether the objective's measure is increasing, decreasing, or remaining the same.
- **Issues for Consideration:**
 - Increasing the number of data points depends on increasing periodicity, and on having adequate resources.

Syndication of Content to Stimulate Data Use

Recommendation 4: Current data syndication efforts should continue for Healthy People 2030 and, if possible, increase in number.

- **Rationale:**
 - Disseminating data through content syndication has the potential to increase the audience for, and users of, Healthy People.
- **Issues for Consideration:**
 - Increasing syndication depends on sufficient staff resources; conceivably, third parties could be employed. The total number of objectives is also a factor.

New Data Sources and Data Source Standards

Recommendation 5: When objectives and data sources for Healthy People 2030 are being selected, the quality of the potential data sources should be considered.

- **Rationale:**
 - To date poor data quality has not been an issue, but as new data sources are explored their quality should be assessed.
- **Issues for Consideration:**
 - Data should be measured according to recognized data standards, such as the OMB federal data standards.

Dr. Sondik also noted areas the subcommittee will consider in the future, which include how progress is assessed (e.g., through updates, progress reviews, etc.); how to encourage data development at the state and local level; national data partnerships; summary measures of health and well-being; and innovation in data.

Committee Discussion

Dr. Fielding commented that it would also be important to address data about interventions and what actions are impacting the objectives. Dr. Sondik and Dr. Halverson agreed that data on interventions is important for effecting change.

Dr. Halverson noted there are often challenges with the tradeoffs of the timeliness, quality, and completeness of data. He shared an example from when he was a state health officer and the health department was trying to address infant mortality in the state. He noted that health officials were frustrated with the delay in data sharing, noting that often final birth and death data were delayed by years due to the need to confirm small numbers of births and deaths with other states. Ultimately, they determined a tradeoff was needed to allow the use of near-final but more recent data to look at infant mortality. The availability of data in a more timely manner spurred action to address the issue and had been a worthwhile tradeoff. Dr. Halverson suggested that allowing and encouraging the use of provisional data is important for progress. Dr. Sondik noted that the National Center for Health Statistics has recently focused on making data available and being willing to make corrections later if necessary.

Dr. Gómez noted that the Committee should be careful in how they word the criteria for data quality. There may be areas where national data is lacking but local data is very strong, so they want to promote the use of that data. Dr. Wrenn Gordon commented that there may also be an opportunity to use local data and aggregate it to the national level. Many federal grants require a link to Healthy People to receive funding, and there is an opportunity for Healthy People 2030 to speak about the need for collaboration. She added that there might also be opportunities to encourage states to collect data and facilitate interest in building data infrastructure. Dr. Sondik noted that aggregated data could be useful but it would be important to ensure that the data sources are high quality, since it would be detrimental to Healthy People if the data sources were not respected.

Dr. Wrenn Gordon asked for more information about the impact of requiring annual or biennial data collection. Dr. Sondik noted that 38% of Healthy People 2020 objectives would be affected, as well as 1 LHI, which is related to the percentage of sexually active females ages 15–44 receiving reproductive services. Data for that LHI comes from the National Survey of Family Growth, which has a long data collection period of approximately 4 years. Therefore, more frequent data collection is not possible, but it is a highly respected survey that gathers detailed information on this topic.

Mr. Teitelbaum asked if Recommendation 5 was stating that Healthy People 2030 should use the same standards for quality or whether it is proposing new standards for Healthy People 2030. Dr. Sondik noted that Healthy People 2020 does not have a quality measure for each data source or criteria for the data sources, so the Data subcommittee's suggestion is to judge data sources against a set of criteria, like the OMB federal data standards.

Dr. Shah commented that the name "Leading Health Indicators" implies that the data should be available on a frequent basis (e.g., weekly, monthly, etc.), not every 1 or 2 years. He noted it is difficult to act on annual or biennial data. It can be used to benchmark or prioritize, but it won't spur action in real time. This might require different data sources or approaches than currently exist. Dr. Richmond explained that the subcommittee has been considering data partnerships, which would be a mechanism for incorporating new data sources.

Dr. Goekler suggested that one challenge with these recommendations is that it is difficult to know what capabilities will be available throughout the next decade, particularly from new data sources like electronic medical records and other non-survey sources of data. Additionally, data sources outside of the health sector may need to be included if there will be measurement in areas related to SDOH. Dr. Fielding mentioned qualitative data as another source of data that could be important, particularly in regards to interventions that work.

The Committee discussed each of the recommendations in turn and determined whether to defer or vote on the recommendations. The Committee agreed to defer votes on Recommendations 1.A and 1.B because they reference LHIs and selection criteria, which will be discussed further by other subcommittees.

The Committee discussed Recommendation 1.C. Dr. Fielding suggested a revision to note that data should be available preferably within a few months, but no longer than 2 years. He was concerned about implying that 2 years is a good standard. Dr. Sondik noted that the subcommittee was trying to balance what was possible and reasonable; for example, it would be difficult to report data more frequently than

every 2 years for some non-federal data sources in Healthy People. Dr. Halverson raised concerns about promoting updates of data no later than 2 years, indicating that more timely data may prove to be more actionable for stakeholders and that the data that are 2 years old are not ideal. The Committee initially approved this recommendation but later elected to defer a vote on this recommendation as it was related to Recommendations 1.A and 1.B.

There was no discussion on Recommendations 2.A or 3.A as they also referenced LHIs. Recommendations 3.B. and 4 were **approved unanimously**.

The Committee discussed Recommendation 5. Dr. Wrenn Gordon was concerned this recommendation may be interpreted to only apply to new data sources or objectives. Dr. Sondik explained that any objectives proposed for Healthy People 2030 should include a review of the data source and data quality, whether new to Healthy People or already in Healthy People 2020. Dr. Halverson was concerned about inferring that only data sources of the highest quality can be included, given the discussion about tradeoffs and use of imperfect data to spur action. Mr. Teitelbaum noted that the language “should be considered” may need to be revised to be more precise. The Committee agreed that the recommendation should be revised to be more precise and clearer about data quality, and should clearly state that it applies to existing and new data sources. This recommendation will be revised by the subcommittee.

The Committee took a 10-minute recess.

Prioritization Subcommittee and Recommendations Regarding the Priorities and Scope of HP2030 and the Criteria for Selecting Objectives

11:05 a.m. – 12:30 p.m.

Dr. Fielding reviewed the charge of the subcommittee, which is to: 1) Identify criteria to be used in prioritizing and setting quantifiable objectives; and 2) Consider how to reduce the overall number of measurable objectives. The subcommittee has met twice since the June 27, 2017, Committee meeting. Dr. Fielding provided an overview of the recommendations of the subcommittee. The recommendations include:

1. Scope of Healthy People 2020

Recommendation:

Give priority attention to health inequities and opportunities to reduce them.

Recommendation:

Make economic and prevention effectiveness analyses for Healthy People objectives part of budget priorities for the government. Analyses should include preventable health burden and intervention cost effectiveness.

Recommendation:

The availability of an effective intervention is a critical consideration. Healthy People 2030 should drive action on issues for which there is a known, effective intervention. The core set of implementation objectives should only include those that have data on effective interventions. Particular attention

should be accorded to any objectives that were not included in Healthy People 2020 but that meet these inclusion criteria.

2. Criteria to Be Used in Prioritizing Quantifiable Objectives

Recommendation:

Healthy People 2030 should identify priorities and opportunities by applying a prioritization framework, generalizable to and usable by all target audiences. The initiative should offer context and background information on the overarching purpose of the initiative, inclusive of increasing health equity.

Broad criteria are listed below:

- Overall health burden (both preventable and not yet preventable based on current opportunities)
- Preventable burden (i.e., amenable fraction/amount of health and well-being to be gained) from implementation of available effective interventions
- Health inequities/disparities reductions possible based on current opportunities
- Cost effectiveness and prevention effectiveness

3. Criteria for Selecting Objectives for the Framework

Recommendation:

The following 8 criteria should be taken into consideration when commenting on the proposed objectives or suggesting additional ones.

The criteria are listed below in the Committee Discussion section.

4. Organizing Opportunities Within Healthy People 2030

Recommendation:

Healthy People 2030 should offer users the flexibility to array objectives according to different interests or dimensions. The organization of Healthy People 2030 could offer analysis by age group across the life course, and it could be organized by a number of different organizational approaches, such as: general domain (social environment, physical environment, behavior, clinical, etc.), intervention type (policy, education, clinical, system, etc.), risk factors, disease or injury, or target audience (business, schools, states, local government, federal government, clinical care system, etc.).

To illustrate how the approach to organizing objectives might shape analyses and content, the subcommittee offers preliminary ideas on how opportunities could be arrayed and analyzed by life course. Additional examples could be developed to provide guidance for the Federal Interagency Work Group (FIW).

5. Process for Developing Healthy People 2030 Objectives

Recommendation:

The U.S. Department of Health and Human Services (HHS) should use a blended, public-private approach to prioritizing and objective setting. For some topics, the preferred approach should involve leadership and coordination from FIW, but with meaningful involvement from relevant private organizations. For

others, it would be preferable to have private-sector organizations provide leadership and coordination, but with involvement of appropriate federal organizations. The subcommittee also recommends that HHS, working with FIW, develop guidelines for how to distribute responsibilities in a manner that builds on the strength of both the public and private sectors, and promotes efficiency and transparency.

6. Setting Targets for Healthy People 2030 Objectives, and Modifying These Based on New Evidence and Data During the Decade

Recommendation:

Healthy People 2030 objectives should include targets that employ best current knowledge to estimate what can be achieved, and how quickly, for systematically identified opportunities. The initiative should not make use of incremental targets or default to 10% improvement, as it did often in Healthy People 2020.

Recommendation:

Healthy People 2030 should not be a static document, but should be subject to revisions based on new knowledge and experience in efforts to achieve defined objectives.

7. Reducing the Overall Number of Objectives in Healthy People 2030

Recommendation:

Reduce the overall number of objectives included in Healthy People 2030 by eliminating objectives that have limited data available, except in certain circumstances (i.e., objectives that are important but have no baseline data, for which a data source could be developed and monitored). Developmental objectives should not be counted along with regular objectives but should be placed in a separate section. Developmental objectives that have not progressed by a particular date, e.g., mid-course review, could be moved to an appendix of research opportunities.

8. Developing and Organizing a Separate List of Research Priorities

Recommendation:

HHS, through its many agencies, needs to play an enhanced role in helping stakeholders meet the Healthy People objectives. It should prioritize financial and policy support for activities that, based on the best evidence, have a high likelihood of improving measurable outcomes. It should assure alignment of Healthy People 2030 objectives with the responsibilities and accountability of all its agencies and support the identified priority developmental and research needs. HHS should also explore whether the priorities and activities of other advisory bodies are consistent with this recommendation, if such an activity would be permissible under FACA regulations.

After summarizing each of these recommendations, Dr. Fielding discussed the rationale and important considerations related to the recommendations. He also noted recognized limitations, and that the process for developing objectives for Healthy People 2030 must balance empowering stakeholders and ensuring that high standards of quality, consistency, and credibility are maintained. Dr. Fielding described the subcommittee's next steps, which include developing a recommendation on the process for selecting LHIs, and guidance for developing the Healthy People 2030 objectives through a blended, public-private approach.

Committee Discussion

The Committee members discussed the recommendations from the Prioritization and Objective Selection Criteria subcommittee. There were a number of suggested revisions to the recommendations:

1. Scope of Healthy People 2030

The first recommendation states, “Give priority attention to health inequities and opportunities to reduce them.” One suggestion was to revise this language to a positive framing, for example, “Give priority attention to achieving health equity and addressing the social determinants of health.” Another suggestion was, “Give priority attention to the goal of health equity and opportunities to address the social determinants of health and reduce health disparities.” The third recommendation states, “The availability of an effective intervention is a critical consideration.” The Committee noted it should be clear that “intervention” includes policies, systems, and program-level interventions, in addition to medical and/or behavioral interventions.

The subcommittee decided the first section on the scope of Healthy People 2030 should serve as an introduction to and framing of the remaining recommendations. These recommendations should be transformed into a narrative that introduces the recommendations, as these 3 concepts align with the overall framework.

2. Criteria to Be Used in Prioritizing Quantifiable Objectives

The Committee members agreed with this recommendation and the broad criteria for prioritizing quantifiable objectives. Dr. Halverson requested that language for the broad criteria be inclusive of cross-cutting public health issues like public health infrastructure. Dr. Kleinman suggested including language in the introduction to both #2 and #3 that highlights the importance of infrastructure as a critical part of the foundation needed to operate. This recommendation was **approved unanimously**.

3. Criteria for Selecting Objectives for the Framework

Dr. Sondik asked whether the Committee should describe an algorithm for how these criteria would be used to prioritize objectives. Dr. Pronk asked whether selection of objectives would occur based on all or some of these criteria. The Committee needs to determine the minimum number of criteria an objective must meet to be included in Healthy People 2030. Similarly, he asked whether the criteria vary in terms of level of importance. Dr. Kleinman said the Committee could recommend a decision-making tool that could help with the selection process and describe how the criteria would be operationalized. Finally, Committee members asked whether there are any other criteria that should be included, in addition to these 8 criteria. The Committee discussed adding the criterion from the SDOH and Health Equity subcommittee.

The criteria for prioritizing quantifiable objectives are listed below. Suggestions for revisions by the Committee members are reflected:

- The result to be achieved should **reflect issues of national importance**, be useful and **understandable** to a broad audience, and **support the Healthy People 2030 goals**. Federal agencies, states, localities, non-governmental organizations, and the public and private sectors should be able to use objectives to target efforts in schools, communities, work sites, health practices, and other environments.

- Objectives should be **prevention and protection oriented** and **should address health improvements that can be achieved** through population-based public health infrastructure and individual actions, and systems-based, environmental, health-service, or policy interventions.
 - This revision was suggested to ensure infrastructure objectives are not excluded based on this criterion.
- Objectives should **drive actions** that will work toward the achievement of the proposed targets (defined as quantitative values to be achieved by the year 2030).
- Objectives **should be measurable** and **should address a range of issues**—such as behavior and health outcomes; availability of, access to, and content of behavioral and health service interventions; socio-environmental conditions; and community capacity—**directed toward improving health and well-being** across the life span. (Community capacity is defined as the ability of a community to plan, implement, and evaluate health strategies.)
 - This revision was suggested to reflect the language used in the Healthy People 2030 framework developed by the Approaches subcommittee.
- **Continuity and comparability** of measured phenomena from year to year **are important**, but continuity **should not be the sole basis** for maintaining or archiving an objective. Whether or not an objective has met its target in a previous Healthy People iteration also should not determine whether it is maintained or archived. If an objective meets all of the established criteria, avoiding arbitrary removal will support the integrity of the Healthy People system. Exceptions include when an objective is no longer relevant or is subsumed by another objective.
- The objectives should be **supported by the best available scientific evidence**. The objective selection and review processes should be flexible enough to allow revisions to objectives to reflect major updates or new knowledge. If an important objective **does not have any evidence of improvement** through an effective intervention, it should become a **prioritized research agenda item**.
- Objectives should **address health inequities** in defined populations. These include populations categorized by race/ethnicity, socioeconomic status, gender, disability status, sexual orientation, and geographic location. For particular health issues, additional special populations should be addressed, based on an examination of the available evidence on vulnerability, health status, and disparate care.
 - The Committee agreed that the population subgroups should be described as examples, not as an exhaustive list.
- Healthy People 2030, like past versions, is heavily data driven. **Valid, reliable, nationally representative data and data systems should be used** for Healthy People 2030 objectives. Each regular objective must have 1) a data source, or potential data source, identified; 2) baseline data; and 3) assurance of at least 1 additional data point throughout the decade. One additional data point (in addition to the 2 that are required) is recommended, but not required.
 - One Committee member expressed concern regarding “nationally representative data,” noting the importance of state and local data for some objectives.

4. Organizing Opportunities Within Healthy People 2030

The SDOH and Health Equity subcommittee has also discussed approaches for organizing objectives within Healthy People 2030. Committee members noted that more detail could be added to this recommendation. Dr. Sondik asked whether the organization of objectives will occur before or after applying the criteria to a set of objectives. For example, are objectives selected first and then organized? Or is the organizing framework established and then objectives are selected within that framework?

5. Process for Developing Healthy People 2030 Objectives

The Committee said this recommendation should be more inclusive of a wide range of stakeholders for all sectors, including governmental representatives. Dr. Halverson, chair of the Stakeholder Engagement and Communication subcommittee, expressed strong support that this recommendation align with the work and recommendations of his subcommittee.

6. Setting Targets for Healthy People 2030 Objectives, and Modifying These Based on New Evidence and Data During the decade

There was no discussion on this recommendation.

7. Reducing the Overall Number of Objectives in Healthy People 2030

The Committee discussed the recommendation to reduce the overall number of objectives included in Healthy People 2030 by eliminating objectives that have limited data available. Some Committee members were confused by this recommendation. The Committee members agreed that this recommendation was included within #3 (Criteria for Selecting Objectives for the Framework), and decided to remove this as a separate recommendation.

8. Developing and Organizing a Separate List of Research Priorities

Dr. Halverson said these research priorities should be emphasized, and he thought this recommendation was an innovative approach to reclassifying objectives without disenfranchising them.

The Committee determined additional discussion was required and planned to discuss the remaining recommendations on the second day of the meeting.

The Committee adjourned for lunch.

Stakeholder Panel

1:40 p.m. – 3:30 p.m.

Presentation from Paul K. Halverson, DrPH, MHSA, FACHE

Dr. Halverson presented information on how the Association of Schools and Programs of Public Health (ASPPH) has historically been involved with the Healthy People initiative. ASPPH is a member of the Healthy People Curriculum Task Force (HPCTF) where it represents academic public health. Academic public health has been significantly involved in the initiative; faculty at schools and programs of public health lead efforts to measure the effects of prevention activities, which is an important goal of the

Healthy People initiative. Faculty also address the Healthy People initiative within their courses, and ensure that all students of public health are aware of the initiative. Academic public health finds the initiative most useful for its user-friendly data.

Dr. Halverson provided suggestions for future involvement and ways to enhance engagement with Healthy People 2030:

- Require all governmental agencies, in public health as well as in other sectors, to collaborate on the Healthy People initiative.
- Support academe in co-building the evidence base for promising practices in reaching the objectives (including developmental objectives).
- Refine the objectives to a slim, high-priority set.
- Connect Healthy People 2030 objectives to Public Health Accreditation Board (PHAB) accreditation criteria (already, some health departments opt to demonstrate meeting PHAB criteria using Healthy People).

Dr. Halverson recommended the following to enhance academic public health engagement in Healthy People 2030:

- Support schools and programs of public health to create innovative learning products drawn from Healthy People priorities for wide dissemination.
- Support schools and programs of public health to collaborate with partners to develop inter-professional educational resources designed to improve health.

Dr. Halverson provided suggestions for a national partnership for activities to achieve the Healthy People 2030 targets:

- HHS convenes representatives from other federal agencies to develop joint plans aimed to achieve the Healthy People 2030 targets.
- National organizations representing inter-professional academic and practice partners collaborate to build an implementation plan.
- National, regional, and local conversations take place on promising practices in meeting the objectives.

Presentation from Edward Hunter, MA, President and CEO, de Beaumont Foundation

Mr. Edward Hunter introduced the de Beaumont Foundation, a private foundation focused on public health and helping governmental public health meet new challenges. The de Beaumont Foundation has 3 strategic priorities:

- Transform public health practice by strengthening it through fostering innovation in and for governmental public health agencies.
- Build cross-sector partnerships connecting public health agencies to key partners.
- Strengthen the voice of public health by creating new tools and approaches for communicating about public health, particularly to those in other spheres.

While the de Beaumont Foundation does not have a history of working with the Healthy People initiative, Dr. Hunter has a personal history with the initiative and is familiar with its structure, evolution, and implementation. Dr. Hunter considers the Healthy People initiative as a signal to the field indicating what aspects of public health are most important. The initiative's first iteration signaled a shift from focus on insurance and systems of care to health promotion and disease prevention. Currently, Healthy People captures the depth and breadth of public health and provides a framework for measuring and

evaluating progress. Healthy People 2020 and 2030's involvement with SDOH signals the importance of cross-sector collaboration to the public health world. The Healthy People initiative plays an important role in showing where public health currently is and where it is headed.

Dr. Hunter noted the importance of addressing workforce issues and infrastructure gaps, and commented that the de Beaumont Foundation conducts a workforce needs survey that could inform some Healthy People measures, suggesting that Healthy People could measure public health's engagement with other sectors. He also suggested that HHS could be a helpful facilitator in encouraging other federal partners to become involved in the Healthy People initiative.

Dr. Hunter also acknowledged that Healthy People data sources should be broadened to include new cross-sector, upstream, and social determinants factors, which could be combined with health outcome data to better understand how SDOH impact health and disparities. Dr. Hunter suggested that the Committee look into other data frameworks that have been developed to inform their work. Dr. Hunter noted that communities experience difficulty accessing federal data, and suggested that the Committee take care not to link to data sources that will be inaccessible to Healthy People users. Public health data access issues continue to persist, and Dr. Hunter commented that work needs to be undertaken to stabilize and expand national data systems.

Dr. Hunter discussed the de Beaumont Foundation's philanthropic undertakings, including work on tools and capacities important to advancing Healthy People. The de Beaumont Foundation collaborates with RWJF on the BUILD Health Challenge, which encourages multi-sector community partnerships to improve health. Dr. Hunter added that philanthropic funders may choose to support efforts toward certain Healthy People objectives regardless of whether they have a proven evidence-based intervention (i.e., even if they are developmental).

Dr. Hunter commented that it is particularly important in a challenging budget environment to frame Healthy People objectives as having a benefit for other federal agencies and businesses, as well as to reopen discussion of why public health is important.

Presentation from Ellen Kelsay, Chief Strategy Officer, National Business Group on Health

Ms. Ellen Kelsay introduced the National Business Group on Health (NBGH), a non-profit community of member companies who leverage their thought leadership and share best practices to:

- Manage health care costs and drive delivery transformation
- Link well-being to business performance and workforce strategy
- Address the health and productivity of the global workforce
- Accelerate the adoption of effective innovations

NBGH has 420 employer members, including industry partners, health plans, startups, IT data aggregators, and more. Ms. Kelsay presented some of the results from a recent NBGH-conducted survey of its members focused on health care strategies and plan designs. Health care costs remain a major concern for employers, both before and after plan design changes, and costs will likely continue to increase in future years.

NBGH tracks leading employer trends, including:

- Shift in focus from demand side to supply side
- Greater focus on behavioral health services

- Shift from broad-based to targeted, personalized communications
- Focus on improving consumer experience with the health care system
- Focus on employee holistic well-being as part of an overall workforce strategy

Regarding the shift from demand side to supply side, Ms. Kelsay noted that employers are frequently looking to alternative payment and delivery models; 21% of employers indicated that they are offering or will offer an ACO strategy by 2018, and over 50% of employers will implement or are considering implementing alternative delivery models by 2020. Ms. Kelsay also noted that the percentage of employers offering telehealth as an option to employees has been growing dramatically; only 7% of employers were offering telehealth in 2012, while 96% will offer it by 2018. Fifty-six percent of employers will offer tele-behavioral health in 2018, more than a 50% increase over 2017.

By 2020, 66% of employers will have 1 or more on-site (or near-site) health centers (an increase from 55% in 2018). Historically, occupational health has been the most common offering at on-site health centers, but they have begun to offer more holistic services (e.g., acute care, health improvement programs, primary care, chronic care management, etc.).

Ms. Kelsay noted that 80% of employers indicated concern about inappropriate use of opioids, and described what steps employers are taking to counter opioid abuse:

- Approving a limited supply of opioids
- Limiting coverage to a select network of pharmacies and/or providers
- Ensuring coverage of alternatives for pain management such as physical therapy
- Providing training in the workplace to increase awareness and recognition of symptoms
- Working through health plans to encourage physicians to communicate the dangers of opioids
- Encouraging physicians who are prescribing more frequently than expected to change prescribing patterns and consider alternatives

Ms. Kelsay described benefits that employers are reaping from shifting from broad-based communications to targeted, personalized communications:

- Intersection of data and technology
- Use of predictive analytics
- Engagement platforms integrating multiple-point solutions
- Going mobile with personalized, real-time messaging
- Using segmented and culturally and linguistically appropriate communications to promote health equity

Employers are interested in improving consumer experience with the health care system; Ms. Kelsay noted dramatic increases in navigation/decision support services being offered. Additionally, Ms. Kelsay described the benefits of shifting from a model of wellness to one of holistic well-being. Compared to employees with low well-being, those with high well-being:¹

- Have lower health care costs
- Are more productive
- Are more likely to stay with the company

¹ Sears LE, Shi Y, Coberley CR, Pope JE. Overall well-being as a predictor of health care, productivity, and retention outcomes in a large employer. *Popul Health Manag.* 2013;16:397–405.

- Have higher performance

Presentation from Donald F. Schwarz, MD, MPH, MBA, Vice President, Robert Wood Johnson Foundation

Dr. Schwarz described RWJF's longstanding relationship and contribution to Healthy People. RWJF has been involved with the development of Healthy People 2010 and Healthy People 2020, and has supported work on Healthy People 2020 objectives, particularly related to tobacco prevention and childhood obesity. RWJF also has a partnership with CDC Foundation and HHS to look at how law and policy impacts Healthy People objectives.

Dr. Schwarz suggested that the Healthy People 2030 objectives should be related back to health equity and SDOH. In terms of engagement, it will be important to think about education on SDOH. Other sectors are increasingly acknowledging the role health plays in their outcomes. He suggested that rather than health as an outcome of social determinants, the Committee could consider health as an input, which would improve the likelihood of engagement.

RWJF has significant experience with engagement with other sectors. Dr. Schwarz provided an illustrative example that considered how bankers would be interested in the importance of health. They might think about how health reduces investment risk and improves the bottom line by providing savings in health care costs. It is important to understand how other sectors might view health and engage them in outcomes of interest to them. Dr. Schwarz also noted the importance of partnerships with other federal departments like Education, HUD, Interior, and Treasury.

The frequency and timeliness of data is important for engagement. Timely data can help spur action at the local level and with partners. Dr. Schwarz also noted the importance of the ability to see the change in disparities over time. There is an urgency to see progress or lack of progress to facilitate engagement with partners. He noted that one thing missing from data in Healthy People 2020 is the ability to see changes in disparities over time.

Presentation from Nirav Shah, MD, MPH, Kaiser Permanente

Dr. Shah spoke about how Kaiser Permanente has used the Healthy People initiative. As a hospital, they have primarily used Healthy People as part of the community health needs assessment process. They identified priority areas and used local data to address issues in their area, such as cervical cancer incidence.

He spoke about CMS's Center for Medicare and Medicaid Innovation's 3-part framework for addressing SDOH: awareness, assistance, and alignment. Health systems should be conducting screening, intervening and connecting to community-based resources, and making community-level investments. Dr. Shah provided an example where screening showed that the number-one unmet need of their members was related to housing and that there were no supportive housing agencies in the community. Therefore, the hospital directed community benefit dollars toward this need. Health systems need to rethink what counts as health care and identify needs and connect the dots in terms of public health services as well.

Healthy People 2030 can help by providing direction about where the needs are and where we should be. The lagging indicators measured by Healthy People (e.g., rates of hospital-acquired infections) can be used with leading indicators about day-to-day measures (e.g., hand hygiene rates). Additionally,

Healthy People needs to facilitate data partnerships and leverage big data to engage and empower non-traditional partners.

Presentation from Mary Pittman, DrPH, Public Health Institute

Dr. Pittman spoke from the perspective of the Public Health Institute, which is one of the oldest and largest public health institutes and is part of the National Network of Public Health Institutes. Most of the member institutes work in defined geographic areas and are knowledgeable about the data in their local communities. The institutes typically use Healthy People data for planning and guiding practice. Often, they work closely with state and local government partners and focus on inter-sectoral work to address health equity.

Dr. Pittman provided a few case examples. The first was California's efforts to establish targets for the state and incorporate Healthy People 2020 targets and metrics. This statewide effort, Let's Get Healthy California, included tools for each county to look at data for their area. Local data enhances utilization. San Diego County also used Healthy People as a guide to identify areas for improvement, track their progress toward their goals, and incorporate 2020 data.

Dr. Pittman concluded with suggestions on how to enhance Healthy People 2030:

- Tools to help link data at more local level
- Identify more specific metrics on determinants of health related to correctional/criminal justice system
- Identify specific metrics on quality of life
- Link funding to national health objectives
- Encourage multi-sector training on use
- Put high-priority set of objectives in mobile app and use social media to communicate progress
- Engage local philanthropy

Discussion and Questions

There was discussion among the panelists about engagement with businesses and large employers. Ms. Kelsay noted that the employer community could be leveraged. The key to engagement with employers is tying initiatives, such as wellness or well-being initiatives, to business outcomes.

Dr. Halverson asked whether any hospital compensation formulas are reliant on public health goals. Dr. Shah noted that most are related to health care delivery, not community health. While they are not drivers of hospital compensation, they could be used in that way, particularly if there are ways that hospitals can act to achieve changes in these areas.

The panelists noted that the key to engagement is to make achieving Healthy People goals compelling for the stakeholders in their areas. For example, the military needs a healthy population for recruitment and retention. Using language that is comfortable for and understood by the target group is also critical for successful engagement. The panelists agreed that engagement at the local level with local data is also compelling for stakeholders in other sectors. Dr. Halverson noted that it was difficult as a state health officer to gain traction with the legislature with national data but that local data was compelling.

Dr. Sondik commented that it seems like certain areas (e.g., San Diego) have a culture of using data and responding to data to drive action. He asked the panelists what it takes for that to develop in communities. Dr. Shah suggested that strong leadership is key to this type of approach, and often it just

takes one person pushing stakeholders to engage around an issue. Dr. Schwarz added that it doesn't always have to be a leader in public health either; sometimes a mayor or Chamber of Commerce executive can play that role.

The Committee then took a 10-minute recess.

Development of Healthy People 2030 Logic Graphic and Video

3:40 p.m. – 4:20 p.m.

Dr. Shiriki Kumanyika provided an overview of the process for creating the Healthy People 2020 logic model. The 2020 Secretary's Advisory Committee wanted to bring together the various elements (i.e., vision, mission, and overarching goals) of Healthy People 2020 in one graphic, showing their relationships to one another. As SDOH were introduced for the first time in Healthy People 2020, the 2020 Committee took care to nest SDOH in an ecological model. The 2020 Committee also took a life course perspective and endeavored to create a final product that was action oriented and could help Healthy People articulate, motivate, or inform specific actions.

The 2020 Committee adapted their graphic from a commonly used ecological model that appeared in a 2002 Institute of Medicine (IOM) Report,² which was adapted from the Dahlgren-Whitehead model.³ The 2020 Secretary's Advisory Committee created the *Action Model to Achieve Healthy People 2020 Goals*. The center of this model is nearly identical to the IOM graphic, and the 2020 Secretary's Advisory Committee's model contains an arrow from interventions moving through determinants and running to outcomes. The model also contains an arrow running from outcomes to interventions, indicating processes of assessment, monitoring, evaluation, and dissemination, and contains a lifespan arrow pointing to outcomes.

Dr. Kumanyika displayed FIW's adaptation of the Healthy People 2020 graphic, which contains fewer layers and less detail but still conveys how physical environment, social environment, health services, individual behavior, and biology and genetics contribute to health outcomes. FIW also created a video showing SDOH in action through people interacting with different environments.

When discussing the development of a Healthy People 2030 logic model, the subgroup considered the following items:

- What are the similarities and differences in thrust or innovation for 2030 vs. 2020?
- What, if anything, should be carried forward from the 2020 model?
- What is most important to convey for an HP2030 graphic?
- Is there an existing resource to be adapted, as for the 2020 graphic?

HP2030: Initial Product Concepts

Ms. Sarah Pomerantz and Ms. Katrina Lanahan from CommunicateHealth described their process for working with the logic model subgroup to develop initial concepts for a graphic or a suite of products representing Healthy People 2030.

² Institute of Medicine of the National Academies, Board on Health Promotion and Disease Prevention. *The Future of the Public's Health in the 21st Century*. Washington, DC: National Academies Press; 2003. p. 52, figure 2-2.

³ Dahlgren and Whitehead (1991). Used with permission of the Institute for Futures Studies, Stockholm, Sweden.

Ms. Katrina Lanahan explained CommunicateHealth’s product development process. The first step is to **define** the product, including audience, format, purpose, and other parameters; the Healthy People 2030 products are in this stage. The second step is to **discover** other concepts and ideas that could influence the model; CommunicateHealth has begun to explore other products that may influence the products under development. The third step is to **create** a more concrete product and define components and the relationships between components. The fourth step is to **refine** and test the product with users and subject matter experts to gather feedback. The final step is to **deliver** the product as part of the Healthy People 2030 initiative and website.

Ms. Lanahan outlined the development process more specifically related to the Healthy People 2030 products:

1. Define product requirements — including audiences, purpose, use, formats, and key messages.
2. Identify main components for static graphic (up to 7).
3. Determine relationships between components.
4. Create visual design to illustrate those relationships.
5. Test with users and iterate on design.
6. Launch as part of HP2030 initiative.

Ms. Lanahan displayed a slide listing the following audiences for the Healthy People 2030 products:

- Engage professionals **across sectors**, such as:
 - Public health
 - Hospitals, health care delivery, and insurance
 - Housing and transportation
 - Education
 - Justice and law enforcement
 - Food and agriculture
- Target users who are or are not already **familiar** with Healthy People.

The subgroup proposed the following purposes for the products:

- **Be easy to understand** — whether or not you’re familiar with Healthy People.
- Increase **engagement** with the HP2030 vision, mission, goals, foundational principles, plan of action, and objectives.
- **Be goal driven**, leading us toward a healthy nation.
- Help everyone go in the **same direction**.
- **Be action oriented**, indicating opportunities to participate.
- Encourage **shared responsibility** across sectors.

The subgroup proposed the following product value to users:

- Understand **what** HP2030 is trying to achieve and the goals that support that vision.
- Understand **why** it’s important to take action to achieve HP2030 goals and objectives.
- Understand **how** they can take action.

Ms. Lanahan introduced the 3 initial product concepts:

1. **Static overview graphic** to capture main components
2. **Detailed, interactive graphic** to expand on overview graphic and elaborate on what each component means for users
3. **Video** to illustrate HP2030 in action with a real-world example

Ms. Lanahan showed an example interactive graphic⁴ created by RWJF. The graphic has a static 5-component graphic that allows the user to click on each facet to navigate to additional pages and learn more; the Healthy People 2030 graphic could function similarly and could lead to objectives or measures themselves.

Ms. Lanahan presented a common health communications approach that CommunicateHealth is taking in the creation of these products. The Bite, Snack, Meal content strategy increases reader engagement and message retention.

- **Bite** (overview graphic): The main message, without details
- **Snack** (video): Concise summary, includes a few details
- **Meal** (interactive graphic): Thorough explanation, resources

The interactive graphic will function best on the web and social media; the video product will be used on the web and social media as well as in slide presentations; and the overview graphic can be used in either of those formats or in print. Content from the interactive graphic could also be included in slide presentations and in print.

The purpose of the overview graphic is to:

- Give a high-level, visual overview — the “**bite**”
- Focus on the **what** of the HP2030 framework
- Capture key words from framework, but not full elements (rule of 7)
- Introduce the detailed, interactive graphic

Ms. Lanahan also talked about the framing for the graphic and gave 2 options for the main messages:

- **Value focus:** Why we are here (mission) and what guides our actions (foundational principles)
- **Outcome focus:** What HP2030 is hoping to achieve (overarching goals) and how to move toward those goals (plan of action)

The overview graphic will focus on 1 of the following potential relationships:

- **What HP can do for you:** What actions HP is organizing and promoting (plan of action)
- **How you can help HP:** What actions organizations and communities can take to help achieve HP2030 goals (plan of action)

Ms. Lanahan reviewed the purpose of the interactive graphic:

- Expand on the content in the overview graphic — including the **why** and the **how** — the “**meal**.”
- Take a deeper dive into each of the components and how they support the main message.
- Include full framework elements (vision, mission, goals, foundational principles, plan of action) with supporting details.
- Indicate opportunities to take action, such as via other HP2030 resources and partnering across sectors.

Ms. Lanahan reviewed the purpose of the video:

- Narrate an overview of the framework — the “**snack**.”

⁴ Building a Culture of Health [Internet]. Taking Action. Princeton (NJ): Robert Wood Johnson Foundation. [c2017]. Available from: <http://www.cultureofhealth.org/en/taking-action.html>

- Walk through a real-world example of **how** an organization can apply the HP2030 framework.
- Show how taking action and building partnerships will help lead us toward a healthier nation.

Ms. Pomerantz asked the Committee for feedback on (1) whether the products should take a value focus or an outcome focus, and (2) whether the products should focus on what Healthy People can do for you, or what you can do for Healthy People.

Dr. Fielding commented that the products assume that the user's interests are already aligned with those of the Healthy People initiative, and suggested that the subgroup consider a user's perspective of "Why should I care, and what's in it for me?" Dr. Richmond replied that Dr. Fielding's comments reinforced her preference that the products take a value focus, i.e., focus on why we are here (mission) and what guides our actions (foundational principles).

The Committee discussed the 2 broad audiences for the products: those who have already bought in to and are interested in Healthy People, and those who are unfamiliar or uninterested in the initiative. The Committee also discussed how the products can appeal to a broad range of sectors. Dr. Pittman suggested that the suite of products contain different products for different sectors, e.g., a graphic explaining what Healthy People looks like for businesses, children, schools, clinicians, etc. Dr. Kleinman suggested that the interactive graphic first present the value-focused foundational principles and then drill down to action-oriented graphics for each sector, as seeing a graphic that they can identify with is more likely to prompt action and buy-in from stakeholders. The Committee will ensure that any graphics targeted to specific sectors are easy to access and able to be embedded in social media, presentations, and print.

Approaches Subcommittee and Recommendations Regarding the HP2030 Framework's Sections Entitled "Objectives," "Stakeholders," and "The Future"

4:20 p.m. – 5:10 p.m.

Dr. Richmond, Approaches subcommittee chair, provided an update on the subcommittee's work. The subcommittee met once since the last Committee meeting, after receiving input from the other subcommittees on Part 2 of the framework. The subcommittee's recommendation is to endorse the content of the final 3 sections of the framework, which are referred to as Part 2 of the framework and includes the objectives, stakeholders, and future sections of the framework. Dr. Richmond reminded the Committee that Part 1 was approved during the June 27, 2017, Committee meeting and is out for public comment through September 29, 2017.

For Part 2, the Approaches subcommittee received input from other relevant subcommittees and the Approaches subcommittee synthesized the content and harmonized it with the rest of the document in terms of language and style. Dr. Richmond noted that all of the subcommittees were reflective in their feedback, and there was general agreement among subcommittees in their input to the framework. She noted that some revisions were made to ensure the new sections had the right level of detail, noting that the overall framework is intended to provide broad conceptual guidance and not detailed operational direction.

Dr. Richmond reviewed the proposed text for the 3 sections. She noted that the objective section was broken into 2 pieces to describe how objectives should be selected and then how they should be prioritized. For the stakeholder section, Dr. Richmond noted that the Stakeholder Engagement and

Communications subcommittee had sent a bulleted list of stakeholder types to include in this section. The Approaches subcommittee felt the list was not exhaustive and perhaps too detailed for the framework, so instead of the proposed list, they included a narrative description for the stakeholder section. A similar approach was used for the future section; bullets provided by the Data subcommittee were revised to a narrative to fit the style of the framework.

Dr. Richmond explained the subcommittee's next steps. First, they will address any feedback and concerns resulting from the Committee discussion. Then, they will review the public comment and refine the framework as needed based on the public comment. Finally, a final version of the framework will be shared with the Committee for review and approval at a forthcoming Committee meeting.

Committee Discussion

Dr. Halverson commented on the list of stakeholders, noting that their subcommittee struggled with the list as well. It is difficult to determine a narrow list that represents a wide group of stakeholders or a comprehensive list to ensure all are included. He liked the narrative that the Approaches subcommittee developed for that section. He raised 2 issues: 1) whether any language needed to be included about territorial or tribal stakeholders, in addition to state and local; and 2) any changes that are made to the Prioritization and Objective Selection Criteria subcommittee criteria and language should also be reflected in the framework. Dr. Richmond agreed that any changes made to other subcommittees' language would need to be reflected in the framework. She also suggested that a short narrative at the beginning of the objectives section would be helpful to provide context.

Dr. Wrenn Gordon noted the earlier discussion about incorporating qualitative data, which would be difficult to do. However, there could be a mention of this in the section about how progress will be assessed that could note different types of data and how to present them in accessible ways. Dr. Richmond agreed it could be incorporated in that section.

Dr. Sondik provided some specific comments on the language of the framework. In the section describing how progress will be assessed, it states, "Healthy People 2030 will assess progress toward meeting the identified objectives." He suggested it would be more accurate to say "progress toward meeting the objectives' targets." He also suggested the last paragraph in the future section was more of a driving principle and could be moved.

Dr. Pittman questioned the principles for selecting objectives, wondering how emerging issues might be captured using these principles. She wanted to be sure that these principles were complete and would capture these types of issues (e.g., opioid issues or water quality). Additionally, in the stakeholder section, one sentence reads, "Stakeholders are active partners, working across sectors, who help to develop objectives, prioritize decisions, and take actions that impact the state and local levels to achieve optimal health and well-being for the population." Dr. Pittman thought there may be more explanation needed about the population and who is included in it. Dr. Richmond also noted that they should reconsider "optimal health and well-being" as that language had been changed elsewhere in the framework.

Given the Committee comments, Dr. Pronk noted that there would need to be some work to ensure consistent language was used across all subcommittee reports and recommendations. Dr. Richmond agreed that there needs to be alignment across all of the documents and recommendations. She also suggested it might make sense to turn the objectives section into a narrative instead of bullets, as to not

duplicate the prioritization language precisely, but to summarize it in a narrative, much like the other sections.

Dr. Goekler noted that the last paragraph of the stakeholder section enumerates some other sectors beyond health. She suggested removing this language as to not highlight only some sectors. Dr. Richmond agreed with Dr. Goekler, but noted that the subcommittee also wanted to provide examples so individuals could identify with the framework. Dr. Halverson suggested using a recognized framework for a list of stakeholders/sectors, like the Department of Labor (DOL), which is what the Stakeholder Engagement and Communications subcommittee used. Dr. Richmond was not opposed to this approach, but noted that the DOL list didn't include some key groups like advocacy groups or faith-based groups. Dr. Pittman suggested considering the purpose of this section more clearly; her thought was that it is more like an executive summary document to get stakeholders interested in Healthy People, so the detail may not be necessary. Dr. Kleinman suggested that the types of stakeholders could be a topic for a brief or companion document describing the sectors.

Dr. Kleinman appreciated the discussion and suggested that a vote be postponed until other subcommittees have finalized their language so that consistent language can be included in the framework. Dr. Richmond agreed and noted that the Approaches subcommittee will change the objectives section to a narrative based on the forthcoming discussion of the Prioritization and Objective Selection Criteria subcommittee.

No Approaches subcommittee recommendations were approved during this meeting.

The Committee co-chairs adjourned Day 1, stating they would pick back up the next morning.

Day 2: September 7, 2017

Recap of Day 1 and Charge for Day 2

8:30 a.m. – 8:45 a.m.

Ms. Blakey welcomed Committee members and participants to Day 2 of the 5th meeting of the Secretary's Advisory Committee. Dr. Pronk reviewed the agenda, which included public comment and further discussion on subcommittee recommendations.

Public Comment on the Proposed HP2030 Vision, Mission, Overarching Goals, Foundational Principles, and Plan of Action

8:45 a.m. – 9:20 a.m.

Ms. Ayanna Johnson facilitated the public comment process. Each individual was allotted 2 minutes to provide their public comment. The following individuals provided public comment:

- Ron Goetzel – Individual
- Stefanie Winston Rinehart (on behalf of Amy Wotring) – Diabetes Advocacy Alliance
- Grace Denault – Academy of Sleep and Wellness
- Rebecca Earlie Royer – Susan G. Komen
- Stefanie Winston Rinehart – Academy of Nutrition and Dietetics
- Darcy Phelen-Emrick – Individual
- Meredith Whitmire – Defeat Malnutrition Today

- Yvonka Hall – Northeast Ohio Black Health Coalition
- Ayanna McKnight – National Coalition for Promoting Physical Activity
- Colin Stephenson – Men’s Health Network
- Michelle Chavez – Individual
- Glenna Tinney – National Center of Homeopathy
- Pamela Price – Priceless Enterprises & The Balm in Gilead, Inc.
- Lashale Pugh – Northeast Ohio Black Health Coalition

Committee Discussion on Data Subcommittee Recommendations

9:20 a.m. – 10:35 a.m.

On Day 2, the Committee continued to discuss the recommendations presented by the Data subcommittee. At the end of Day 1, the Committee slightly revised the 3 recommendations for the timeliness of data. These revised recommendations were as follows:

- **Recommendation 1.A:** Data should ideally be made available within 1 year of the end of data collection.
- **Recommendation 1.B:** For Healthy People 2030 objectives, data should be made available as soon as possible and no longer than 1 year after the end of data collection.
- **Recommendation 1.C:** For Healthy People 2030 objectives, data should be made available no more than 2 years after data collection.

Mr. Teitelbaum suggested combining Recommendations 1.A and 1.C. Dr. Halverson added that the word “ideally” should be omitted from the recommendation. Dr. Goekler agreed data should be made available as soon as possible; however, she cautioned that new methods of data analysis will need to be considered as the Committee becomes more inclusive of diverse data sources. The Committee also agreed to add language implying data should be made available as soon as possible and not longer than 1 year after collection. After further discussion, the Committee members decided Recommendation 1 should read: “For Healthy People 2030 objectives, data should be made available as soon as possible and no longer than 1 year after the end of data collection.” Recommendation 1 as revised above was **approved unanimously**.

Next, the Committee discussed Recommendation 2, which states that data collection should occur at least every 2 years. The Committee expressed some concerns with this recommendation, including the need for a rationale for the requirement for data collection every 2 years; ensuring that data is collected at a frequency that maximizes actionability; and ensuring the recommendation accounts for changes to data in the future.

Dr. Wrenn Gordon added that information supporting the recommendation could be included in the rationale portion of the report. For example, the recommendation could state data collection should occur at a frequency of at least every 2 years for the objectives, and the rationale would state that this frequency ensures meaningful data and trend analysis. Dr. Sondik proposed the rationale section describe the purpose of the 2-year data collection frequency as a mechanism for ensuring a minimum of 3 data points. Dr. Goekler proposed years be removed if the recommendation includes collecting 3 data points; 2 years and 3 data points do not align. Removing the 2-year time limitation also allows a 3rd data point to be captured by pulling in information from the previous decade. After further discussion, there was general agreement around constructing the recommendation to include data collection at a frequency that maximizes actionability at both the national and state levels.

The Committee continued to discuss several versions of this recommendation, shown below, but ultimately decided the original recommendation was the most appropriate. Dr. Halverson expressed concern about this recommendation, and said he could not approve it as written. He said it is possible that stakeholders, especially at the state level, will interpret the recommendation as action not being needed more frequently than 2 years. Dr. Halverson would like the Committee to find a way to be more precise about the importance of frequent data collection.

- **Option A:** Data collection should ensure at least 3 data points (OR frequency sufficient for meaningful trend analysis). Data sources that do not meet these standards for periodicity of the data are encouraged to increase their periodicity.
- **Option B:** Data collection should occur at a frequency that maximizes actionability at the national, tribal, state, and local level at least every XX years. (*The Data Subcommittee should recommend a value for XX.*)
- **Option C:** Intervals of data collection and availability should occur at a frequency and quality that supports actionability at the national, tribal, state, and local level.
- **Option D:** Data collection should occur at 2-year intervals if possible.

This recommendation was sent back to the Data subcommittee for revision. The Committee asked the Data subcommittee to address the issues of data collection frequency within the context of actionability, future data needs, and data infrastructure. The Data subcommittee was also charged to modify their report as follows:

- Include more discussion of the role of data emphasizing its critical importance in managing the Healthy People process over the decade, including evaluating progress and making changes to the interventions and strategies associated with meeting the objectives' targets.
- Restate the recommendations without reference to LHIs. The subcommittee should address this item after the LHI subcommittee has met and had some discussion regarding the LHI database.

The Committee took a 10-minute recess.

Following the break, Dr. Pronk proposed next steps for the Data subcommittee recommendations. The Data subcommittee will reconvene and revise their report to include a series of clear statements related to timeliness, frequency, and trend—and to address quality and actionability in the broader framing of the report.

Committee Discussion on Prioritization and Objective Selection Criteria Subcommittee Recommendations

10:45 a.m. – 11:55 a.m.

The Committee revisited the recommendations from the Prioritization and Objective Selection Criteria subcommittee and reviewed the changes that were suggested on Day 1. Dr. Pronk suggested that it may be helpful to add a preface to the report that sets the overarching context and describes how these recommendations relate to the charge.

The Committee began by discussing **Recommendation 3: Criteria for Selecting Objectives for the Framework**. The Committee discussed changing the title of this section of the report to “**Criteria for Selecting Objectives and Reviewing Existing Objectives**.” Dr. Goekler asked whether Healthy People 2020 objectives will be reviewed for inclusion in Healthy People 2030 or whether the selection process

for Healthy People 2030 objectives will begin with no assumption that existing objectives will be included, with objectives selected on their own merit. This will be important to resolve in the context of this recommendation. The shortened versions of these criteria are provided below with comments by the Committee.

- The result to be achieved should reflect issues of **national importance, be broadly useful and understandable, and support the 2030 goals.**
 - Committee members discussed the criterion of **national importance**. There was discussion of whether something that is not of national importance would be included in Healthy People. The Committee ultimately decided they were comfortable with this wording.
- Objectives should be **prevention and protection oriented** and should address **achievable health improvements**.
- Objectives should **drive actions** that will work toward the achievement of the proposed objectives (quantitative values to be achieved by the year 2030).
- Objectives should be **measurable** and should **address a range of issues directed toward improving health and well-being**.
 - Dr. Goekler expressed concern regarding objectives being required to be measurable, particularly in terms of SDOH and policy objectives. Dr. Halverson said he believes data should be discussed as “currently available or will be made available.”
 - Dr. Sondik suggested adding that each objective should have a target in this criterion. The Committee discussed whether objectives that do not have baseline data should be included in Healthy People 2030. These objectives in the past have been considered “developmental.”
 - Dr. Gómez suggested separating “measurable” and “address a range of issues. . .” into 2 bullets.
- **Continuity and comparability** of measured phenomena over time are important.
 - Dr. Wrenn Gordon noted that this criterion may conflict with the work of the Data subcommittee. She thought the text after the words “continuity and comparability” in the longer version of the criterion was acceptable, but suggested potentially removing the words “continuity and comparability.”
- Objectives should be supported by the **best available scientific evidence**.
 - Dr. Sondik said there should be specification that reflects the scientific evidence. For example, there should be scientific evidence that the target is achievable.
- Objectives should **address health inequities** in defined populations.
 - This should be revised to say, “address health disparities and health inequities.”
- Healthy People 2030 is heavily data driven. **Valid, reliable, nationally representative data and data systems** should be used.
 - Committee members discussed what the criteria should be in terms of data availability. Dr. Halverson said he thought data should be available at a minimum at

the state level, because if it is not available at a state level, it will not be actionable. Dr. Sondik noted that this would be a huge change in Healthy People that greatly impacts the scope. He suggested the Committee consider the implication and reaction at the state and national level.

Dr. Wrenn Gordon suggested adding “rationale” and “issues for consideration” sections to this subsection (**Recommendation 3: Criteria for Selecting Objectives for the Framework**) of the report. Dr. Kleinman also noted there needs to be an explanation of the 3 “buckets” objectives will be sorted into (objectives, research objectives, developmental objectives).

The Committee resumed discussion on SDOH and Health Equity subcommittee Recommendation 2.2, which was related to objective selection criteria. Recommendation 2.2 was **approved unanimously**.

Stakeholder Engagement and Communications Subcommittee and Recommendations Regarding Engaging Stakeholders in the Development of HP2030, Communicating with Stakeholders About Public Comment, and Increasing the Value of HP2030 for Stakeholders

11:55 a.m. – 12:35 p.m.

Dr. Halverson provided an overview of the ongoing work of the Stakeholder Engagement and Communications subcommittee. The subcommittee was given the charge to: 1) Recommend an approach to increase awareness and utilization of Healthy People 2030; and 2) Delineate the primary and secondary audiences for Healthy People 2030. The Stakeholder Engagement subcommittee has met twice since the June 27, 2017, Committee meeting. Discussion has primarily focused on:

- How to engage stakeholders in the development of 2030
- How to communicate with stakeholders regarding the development, public comment, and value of Healthy People 2030

The subcommittee has also discussed the following issues: identifying stakeholder groups for Healthy People 2030; creating a 2-way dialogue between HHS and stakeholders; and using simulation and gamification tactics in development, dissemination, and engagement.

Based on these discussions, the subcommittee has developed 3 recommendations:

Recommendation 1: Adopt the “Health in All Policies” approach in identifying sectors for inclusion in the process.

- **Rationale:**
 - Developing health and well-being objectives for the nation will require the inclusion of input from more than the health sector alone if we are to achieve our goals in changing the culture of health and well-being in America.
 - Health and well-being are determined not just by medical care provided, but even more so by improving upon the social determinants that are shaped outside of the doctor’s office. Medical care implies an integration of primary care, behavioral health, pharmaceutical care, dental health, and overall health care.
 - The subcommittee can prioritize and develop example use cases to communicate with major sector representatives to begin the process of engagement.

The **major sectors** identified by the subcommittee include:

- Non-agriculture wage and salary
- Goods producing, excluding agriculture
 - Mining
 - Construction
 - Manufacturing
- Agriculture, forestry, fishing, and hunting
 - Agricultural wage and salary
 - Agricultural self-employed workers
- Non-agricultural self-employed workers
- Services providing
 - Utilities
 - Wholesale trade
 - Retail trade
 - Transportation and warehousing
 - Information
 - Financial activities
 - Professional and business services
 - Educational services (private)
 - Health care and social assistance
 - Leisure and hospitality
 - Other services
 - Federal government
 - State and local government

Recommendation 2: Broad engagement should include more than structured public comment periods for testimony or written comment.

- **Rationale:**
 - The Committee should pursue multiple ways to both solicit and receive feedback, particularly considering those that might not even recognize the health implications of their interest.
 - Engaging speakers to disseminate information about the Healthy People process in other scientific meetings and panels in both health and non-health venues is important.
 - A systematic and targeted approach to broadly communicating in industry-specific newsletters, blogs, and online and print journals should be encouraged, with an emphasis on highlighting the relevance of the Healthy People process.
 - Encourage the targeted use of social media platforms and web-based tools to inform the public of the presence and relevance of the Healthy People process and products as well as provide easy and convenient ways for comment and feedback.

Recommendation 3: Simulation and gamification should be considered as tactics for improving development, dissemination, and engagement strategies.

- **Rationale:**
 - The subcommittee is attempting to find ways to more meaningfully engage policymakers and others in the value of the Healthy People process and products.
 - The subcommittee recognizes budget limitations to these tactics but recommends that this approach be considered should funds become available.

Dr. Halverson also provided an overview of important considerations the subcommittee noted in relation to the proposed recommendations. Some key items include:

- Engagement with non-traditional sectors is important and will require specific strategies and budget to reach out and bring in perspectives and recommendations
- The need to be proactive in reaching out to key stakeholders in the development of measures rather than completing work and then asking for feedback through public meetings and public comment.
- The reduction in objectives will require a careful plan to communicate priorities as compared to importance or value
- Traditional modes of engagement will probably lead us to advocacy positions in favor of maintaining the current state

Committee Discussion

Dr. Fielding thought the information presented could be appropriate for a mobile application and encouraged Dr. Halverson to prioritize what this app would look like. Dr. Fielding encouraged the subcommittee to discuss using the Healthy People 2030 materials for teaching and educational purposes, not only for schools of higher education, but for the entire education sector including grade school, high schools, and colleges and universities. In addition, Dr. Fielding emphasized the use of success stories as a mechanism to engage and motivate key audiences.

The Committee suggested that the subcommittee reframe Recommendation 1 around SDOH in place of a “Health in All Policies” framework. Dr. Pittman highlighted that simulation can be cost effective if it is designed efficiently. She also proposed the creation of a contest to stimulate the creation of simulations. The Committee discussed the sectors outlined by the Stakeholder Engagement and Communications subcommittee in relation to the first recommendation. Dr. Halverson noted that the DOL sector outline was used for reference and could be adjusted if desired. The subcommittee will continue to discuss further edits, ensuring all stakeholders are able to identify with the highlighted sectors.

Finally, the Committee agreed the subcommittee should revise Recommendation 3. In particular, the Committee would like the recommendation to be modified to include technology as an umbrella concept. For example, the subcommittee should think about technology innovation and products as an engagement strategy for outreach and education.

Recommendation 2 was **approved unanimously**.

The Committee adjourned for lunch.

Development of Briefs and Next Steps for Subcommittees

1:40 p.m. – 2:00 p.m.

Dr. Kleinman provided an update on the development of the briefs, which was initially discussed at the June 27, 2017, Committee meeting. Four briefs are currently under development:

1. **Law and Policy:** Mr. Teitelbaum, Dr. Richmond, and Angela McGowan (ODPHP) are working on this brief. The group has developed an outline and writing assignments, which are in progress.
2. **Health Equity:** Dr. Gómez and Dr. Wrenn Gordon are leading this brief and are in the process of developing a first draft.

3. **Well-Being:** Dr. Pronk held a meeting with the group and they are moving forward with developing the brief on this topic.
4. **Health Literacy:** Dr. Kleinman is leading this brief, which builds on a paper presented to the National Academy of Medicine Roundtable on Health Literacy. The brief-writing group will be meeting in the next few weeks.

Other potential areas for brief development that have been discussed include disease prevention and health promotion, systems and modeling, and summary measures. These briefs will provide context for the framework. The Committee can continue to discuss these topics and others that may be appropriate as a topic for a brief.

Dr. Kleinman noted that several of the subcommittees have had at least 1 recommendation approved and have identified next steps for the remaining recommendations. She noted that several cross-cutting topics have been raised, largely about the role of data, measurement, and data management. The subcommittees will continue to address these topics. She asked if the subcommittee members had any questions about their next steps.

Dr. Richmond clarified that the Approaches subcommittee language was contingent on the outcome of discussion of the Data subcommittee, Prioritization and Objective Selection Criteria subcommittee, and Stakeholder Engagement and Communications subcommittee, and therefore wanted to confirm they should wait until those recommendations have been finalized before finalizing the framework document. Dr. Kleinman confirmed the Approaches subcommittee should wait for further input from those 3 subcommittees. A revised version of the framework will be presented at a future meeting that incorporates updates based on the subcommittees' decisions as well as the review of public comment.

Dr. Gómez asked whether the subcommittee recommendations will need to be incorporated into 1 report or if multiple reports will be consolidated into 1 report to the Secretary. Ms. Ochiai noted that the reports should be timely, so the recommendations do not have to be sent together if some are ready while others need further revisions. However, they should have the same overall tone.

The Committee also discussed that the framework sets the tone for the subsequent recommendations. Dr. Kleinman noted that the Committee co-chairs had discussed referencing the first report and highlighting how new recommendations relate to the framework in subsequent reports. Dr. Richmond agreed with this approach.

Meeting Adjourned
2:00 p.m.