

Office of Disease Prevention and Health Promotion
Health in the United States — A Review of the First Decade of the 21st Century
Healthy People 2010 Final Review Webinar, October 6, 2011, 11:00 am ET

OPERATOR: Thank for attending this webinar on the Healthy People 2010 Final Review. I would now like to introduce Carter Blakey, the Acting Director of the Office of Disease Prevention and Health Promotion at the U.S. Department of Health and Human Services.

CARTER BLAKEY: Thank you and good morning everyone. Welcome to Health in the U.S. — A Review of the First Decade of the 21st Century.” Today’s webinar will highlight key findings from the Healthy People 2010 Final Review.

We are joined today by Dr. Howard Koh, Assistant Secretary for Health, Dr. Edward Sondik, Director of the National Center for Health Statistics, and Dr. Jewel Mullen, Commissioner of the Connecticut Department of Health. Our first two speakers will provide a national perspective of progress in improving the nation’s health.

Dr. Howard Koh serves as the 14th Assistant Secretary for Health for the U.S. Department of Health and Human Services, after being nominated by President Barack Obama and confirmed by the U.S. Senate in 2009. He serves as the Senior Public Health Advisor to the HHS Secretary, and oversees the Office of the Assistant Secretary for Health, which is comprised of 13 offices, including the Office of the Surgeon General, the Commissioned Corps of the U.S. Public Health Service, ten regional health administrators across the country, and nine Presidential and Secretarial advisory committees.

The Office of the Assistant Secretary for Health includes an array of interdisciplinary programs relating to disease prevention, health promotion, women’s and minority health, adolescent health, HIV/AIDS, vaccine programs, physical fitness, bioethics, population affairs, blood supply, research integrity and human research protection.

As the Assistant Secretary for Health, he is dedicated to the mission of creating better public health systems for prevention and care so that all people can reach their highest attainable standard of health. Dr. Koh previously served as the Harvey V. Feinberg Professor of the Practice of Public Health, Associate Dean for Public Health Practice, and Director of the Division of Public Health Practice at the Harvard School of Public Health. Dr. Koh served as Commissioner of Public Health for the Commonwealth of Massachusetts from 1997 until 2003, after being appointed by Governor William Wells.

Our second speaker is Dr. Edward Sondik, who is the Director of the Centers for Disease Control and Prevention, National Center for Health Statistics, the nation’s principle health statistics agency responsible for monitoring America’s health and health system.

In carrying out its mission to meet current and future data needs for health policy and research, NCHS conducts a wide-ranging program of research and analysis in health and vital statistics, epidemiology and the statistical sciences. Dr. Koh also serves as the Senior Advisor to the Secretary of the Department of Health and Human Services, providing technical and policy advice on statistical and health information issues.

In this capacity, he serves on the HHS Data Council, the body that reviews data policy and related issues. He is also a member of the Interagency Committee on Statistical Policy, with leaders of the other designated statistical agencies.

Prior to becoming NCHS Director in 1996, he was with the National Institutes of Health for 20 years, most recently as Acting Director of the National Cancer Institute. Dr. Sondik has also served on the faculty of Stanford University. So welcome Dr. Koh.

DR. HOWARD KOH: Carter, thank you so much and what a privilege it is for me to kick off this review of the first decade of the 21st Century with respect to Healthy People. Let me start by thanking you and all of our colleagues assembled here, our leaders in the Office of Disease Prevention and Health Promotion, Dr. Ed Sondik, the Director of the National Center for Health Statistics, and all of our wonderful colleagues at CDC.

This is a presentation that reflects the work of thousands of people across the country over many, many years. So it's a tremendous honor for me to help kick off this review today. So let's move onto the second slide.

You all know that Healthy People is part of our public health history, and it's a comprehensive set of national objectives that gets monitored, updated and reviewed every ten years. Having a framework like this is absolutely vital to drive action, to see where we are as a country with respect to public health outcomes and where we need to go. It helps us set priorities and guide actions for the future, and it has developed its own history and legacy that we're very, very proud of, and this announcement today furthers that legacy, in our view.

On the third slide you'll see the history of this tremendous effort started with my predecessor, mentor and friend Dr. Julius Richmond in 1979. So over the last 30 years, we have had multiple iterations of Healthy People. Today, we are updating Healthy People 2010 that was launched a decade ago.

So if you look at this from the broadest possible lens, you see progress in many areas of the country, and then identification of new areas where we need to go as a society to become even healthier than before.

On the fourth slide you see some key features of Healthy People and what it's intended to do. It addresses issues of prominence with respect to public health. It's data-driven. It sets hard targets and objectives. We measure progress over time, and we use that information to drive action not just at the federal level but particularly and very importantly on the state and local level, and you're going to be hearing from a key state leader about that in just a second, and it's absolutely vital with respect to building collaboration.

So it's prevention-oriented, action-oriented, based on excellent science and evidence and data, but most important of all, appeals to everybody in this heterogeneous country.

The next slide is one of my favorite slides, even though it's very, very simple. On the left we see that we have many non-aligned random acts of innovation, and there are so many on this call land throughout

the country who are very dedicated to improving public health, doing it in their own way, setting their own goals and targets.

But if we can put all those efforts onto a broad Healthy People umbrella, as you see on the right, we can really maximize the efforts of all these groups going forward, and really unify our efforts as one country. So we call Healthy People a road map and a compass for the country, and we're very proud to call it that, and unveiling this particular report at this particular time is very critical, because we have tremendous activity throughout the Department in unveiling a whole array of new national public health plans, in HIV, in tobacco, in flu vaccination.

Just yesterday, we unveiled one in environmental justice. This is being done now in the context of the Affordable Care Act, which has tremendous emphasis on prevention and public health, a new prevention fund, a new prevention strategy. So using the Healthy People foundation is absolutely critical in a moment like this to continue to align all these good efforts.

The sixth slide shows the key players and I've mentioned many of them. Our Office of Disease Prevention and Health Promotion, federal agencies throughout HHS, in fact throughout government, and we're very proud of the broad health in all policies approach that's being put forward through such a broad federal collaboration.

Dr. Sondik and others in the National Center for Health Statistics have been absolutely invaluable, and Dr. Sondik's personal commitment to this is extraordinary. I just want to thank him so many times, because we would not be here without his leadership.

I can say, as a former State Health Commissioner, that we really want state and local health departments to also use this information to make change locally, and we're eager to hear from the Health Director from Connecticut in just a second.

The next slide just shows how this process has evolved over the last number of years. We now have four overarching goals, as you can see there, for 2020. But for 2010 that we're reviewing today, we're still focusing on the two, increasing quality and years of healthy life and eliminating health disparities.

There's some 28 topic areas and over 900 objectives that set over a decade ago. The next slide, slide 8, stresses again that this is a federally-led but stakeholder-driven process. So we at HHS and Office of Disease Prevention and Promotion are pleased and honored to coordinate this. But the real work goes through the federal interagency work group, the state and local governments, to so many people who arrived and spoke at regional and state meetings around the country, people from the community whose voices we want to hear, and then ultimately individuals and families across the country who care about their health and want to improve the health of others.

On slide 9, we show how people can use Healthy People moving forward, not just for data, but also for a broad perspective on how we're doing as a country. We want to use this information for goal-setting and agenda-building. You can obviously use it for education, setting benchmarks to compare progress around the country. The more we have non-traditional partners, particularly health in all policies approach, the better off we're going to be.

So slide 10 reminds you of those two overarching goals, and we'll be seeing more in just a second. The second goal, in particular eliminating health disparities, is getting increased attention again, especially since the Department recently unveiled its greatest federal commitment to reduce disparities everywhere through a strategic action plan. So you'll be hearing more about that in just a second as well.

Slide 11 stresses that of the many areas, the 28 topic areas and over 900 objectives that were set ten years ago, that we could also put forward a subset of these that represent truly major public health concerns, and are used and chosen because they can motivate action. We have good data for them to track progress and they're highly relevant in terms of public health topics.

So you'll see ten leading health indicators identified a decade ago, in collaboration with the Institute of Medicine. So if you don't want to look at all 900 objectives and you want to focus in on a subset, here are the ten that you can look at, the so-called leading health indicators or LHIs.

Then slide 12 shows the 28 focus areas that I've already alluded to. Some of these were continued from past versions of Healthy People. Others are new for Healthy People 2010, and we're going to be reviewing highlights of many of these in just a couple of minutes. So people always ask now, at times like this, have we made progress as a country? How do we measure progress? What do the outcomes mean?

On slide 13, we stress that we want to make some assessment based on objectives for which we have good, reliable data for which we've tracked progress over the years. Out of over 900 initial objectives, we have good, hard evidence to assess progress in some three-quarters of them, over 700. So that's what we're going to be reporting on today.

Then on slide 14, you can see where we have met the targets made a decade ago, where we have made progress, and then where we have moved unfortunately away from the targets. All together, we have some 71 percent of objectives, where we can measure outcomes where we have made progress. That is, we've either met the target or exceeded the target in some 23 percent, or made progress in another 48 percent.

So that's the big picture overview on these objectives. To make progress in some 71 percent of outcomes represents substantial progress, according to this measure. But of course we can always look down at some analyses to decide where we need to do more work in the future.

This is the last slide I'm going to show before turning it over to Dr. Sondik. This is more detailed information about the 28 focus areas. Some of them have many objectives, such as immunization and infectious diseases, as you can see here. Other areas have fewer objectives like medical product safety. But we are tracking all of these and then trying to present these in a succinct way to you for general review and use.

So with that, I'm going to turn it over to Dr. Sondik, and thank you again for your attention to this overview.

DR. EDWARD SONDIK: Okay, thank you. Thank you so much, Dr. Koh, for your commitment to this and to staff ODPHP, NCHS and the staff all across Health and Human Services that are really committed to making a difference. This slide shows the 28 focus areas, and gives a snapshot -- it's probably difficult to see, out in the ether there.

But it shows how many of these met or exceeded the target, that's the dark color, and those are the ones that's the area at the bottom of each of these columns. Then it goes up to some, all the way up to some objectives that were dropped at mid-course. But we'll get into this in more detail.

Let me return to the first slide again, which is the next slide. This just shows, this is immunization and infectious diseases, and then we can see medical product safety. But we'll get into this in more detail, and I'm happy to answer questions about it.

Then the next slide...please. Yeah, there it is, the two overarching goals. So I want to really kind of begin to the top. We started out with 900 objectives, and then we've got 733 that are evaluable because we have the data. And at the top of all of this are these two overarching goals, one to increase the quality and years of healthy life, and the second to eliminate health disparities.

The template that was used for Healthy People 2010 had these seven topics or factors or areas, race and ethnicity, all the way down to sexual orientation. We have differing amounts of data for each of these, but we do have data on just about all of this, at least for some of the objectives.

So turning to the next slide, okay. This is the picture of life expectation from the millennium; I guess we could say, from the Year 2000 up to the most recent data, which is 2006-07. Actually, there is more recent data, and you'll be able to find that on the NCHS website, if you look at the mortality data. But in terms of putting the report together, this was the most recent year that we had.

This shows a remarkable change, okay. It shows that life expectancy at birth actually increased by one year. That's in less than a decade, which is really quite remarkable to see that. It also shows that there is a considerable disparity between Black life expectancy at birth and White life expectancy at birth. Now many of you, I'm sure, understand exactly what that means, but let me just take a minute, because I think it's tremendously important.

It means that a child, based on the statistics that we have today, that a child born today, a Black child today will live, on the average, five years less than a White child. That's the heart and that's really probably the signal statistic when we look at disparities. We can look at the rest of all of this as kind of feeding into that. What are the differences due to? Have there been changes over time?

But it's interesting, though. There's another factor that we can look at, fact that we can take from this, which is if we look at the difference between the Black and the White rates in the Year 2000, the difference was five and a half years. Today, in 2006-07, the difference is actually 4.9 years. So in fact the disparity is going down, okay, and that's a positive point.

Turning to the next slide, we can look at life expectancy at age 65, and this has a couple of imports here. First, it says that if one is aged 65, there's about 18 years of life remaining, on the average. It could be

more than; of course, it could be less than that. What we see is progress between 2000 and 2006-2007, where it's just about a year of additional life that has been obtained.

But there are other ways to look at this, particularly from the standpoint of the quality of life. So if we go to the next slide, we see that we also analyzed this in terms of whether those years are in good or better health, free of activity limitation or free of chronic diseases. We see there's about 14 years of life remaining in good or better health. Of course, this is on the average again, and about 12 years free of activity limitation. We can see progress with both of those, in which both of those have gone up since 2000.

However, in terms of being free of chronic diseases, there's only about three years that we can expect over 65, on the average, where one would be free of chronic diseases. Some more, some less, some enter 65, of course, with chronic disease. But it's really interesting that there's been no change there.

Go to the next slide, okay, and this brings us to Goal 2, Health Disparities. We looked at one case here, life expectancy. But when we look across the 733 objectives that we can evaluate, we see substantial health disparities, period. Not much I can say, and we'll see more of that. Most objectives had actually no change in disparity over this time, and the word that keeps coming to my mind here is that health disparities persist. I think that's the operative word. They were there in 2000; they continue today with relatively little change.

Well, the report, on the next slide, the report goes into tremendous detail on all of these objectives, all 900 for that matter, and there are many, many different ways to analyze it. One way is to look at these disparities by race and ethnicity. So each column here represents a particular race or ethnicity, and what we look at here is whether or not that particular race or how often, among all these objectives, that race had the best rate, okay, or had a wealth of gradations down to the worst rate.

And we could do it, you know, talk an hour or more about this. But going to the next slide, I think I can summarize sort of the key point here, which is that in the case of Whites, 51 -- Whites had the best rate in an objective, the best value, the best measure; not all of these are rates, but the best measure for 51 percent of the objectives in which they were measured, okay. In not all, but in 51 percent of those, okay. It turns out in this case there were 354, I know, from the prior slide, that -- in which they were measured.

The case for Blacks who were measured in 345 of these objectives, they had the best rate 20 percent of the time. Hispanics 17 percent of the time had the best rate, and American Indian or Alaska Natives had the best rate six percent of the time, just to pick these four. This is again, I think, a very strong statement of disparities.

What about change over time? The next slide is an -- it shows how; it doesn't show how exactly, but it gives the results of looking at the change in disparities over time. I said earlier that there really, the disparities persisted and there wasn't much change. Well here is the case for race, okay, in which we could look at the different races. And summing this up, we see that there was no significant change in disparity for 117 of the 169 objectives in which we could calculate this.

So for that 169, 70 percent, essentially 70 percent showed no change, and the bright green shows the number of objectives in which there was considerable disparity decrease, very positive, and the bright, I guess that's maroon, I'm not good on that color, shows the disparities or shows the number of objectives in which disparities in fact greatly worsened. The point is there are some, of course, across the spectrum, but in general there's relatively little change.

Now let's get into some of the indicators. If we could go to the next chart, this shows, and we've picked five areas here to take a quick look at. These are examples of charts that you're going to find throughout the entire report, okay. So if we look at the very first one, it's immunization. I hope you can read this over the web. It's immunization, and the measure is or the objective is fully immunized young children 19 to 35 months.

The 71.4 percent says that 71.4 percent, okay, of the target that had been set, of the distance between where we were in 2000 and the target, actually had been met. So we're not there. If we drop down, and then I'll give you more on this in a second, but if we drop down to the dark blue line, that's access to health care, and it's one aspect of it.

It's the decrease in -- what we're seeking here is a decrease in hospitalizations for pediatric asthma, feeling that in fact those hospitalizations can be decreased if there's appropriate care ahead of time. Here, 142 percent of the difference between where we are in 2000 and where we wound up in the Year 2010 had actually been achieved. So it's a tremendous difference.

If we can go to the next slide, this provides the detail, on the next slide, that you need to really understand these figures. Well, we seem to have actually missed something here, but I'll go onto this one and I'll show you here with physical activity, or actually with overweight and obesity. The table part on the right, okay, gives the figures for the target, okay, for the baseline of the measure, for where we wound up, okay, and then questions of the difference, the percent change, and whether or not the differences were statistically significant.

And so for obesity in adults, we see the arrow on the left going, if you will, in the wrong direction, okay, and the target was to be 15 percent, and starting out in '88 to '94 here in the baseline. We were at 23 percent of adults were obese, okay, adults being people 20 years or more of age. We wound up here at the end of this period, the data coming from the NHANES program, at 34 percent.

So instead of going down, we actually went up by about almost 50 percent actually. It says in the far right on that slide 47.8 percent. So we have a chart like this for every one of the 733 objectives in which that we could evaluate, which really summarizes where we were, where we are, did we make progress, and in effect, I guess that's the bottom line.

Now there's other data as well in here. If we could go to the next slide. Let's turn to a couple of the reasons, I guess one could say, that the longevity has increased, and that longevity has increased because the leading causes of death have actually decreased. The first one we're looking at is overall cancer mortality, which pardon me... [pause]... Oh. I'm giving stage directions... But in any case, so what we've got here is a considerable decrease in this, which I think is about 11 percent, if I recall correctly, in overall cancer mortality. This is a decrease again that's more than one percent per year, which from a

public health point of view, a statistical significance point of view, there's no question that it's significant and extremely important.

At the same time, we didn't meet the target. The dotted line is the target, and we lie above that line. Going to the next slide, okay, we can see that in fact the rates by race are quite different, okay. The overall rate, because of the prominence of the numbers of the White population, is very similar to the overall total rate. Other rates for other races are below, are below this and in effect are doing better than the target, and started out doing better than the target.

The thing I want to draw your attention to, though, is the difference between the White and the Black rate. The difference that was in 1999 in effect has persisted over the decade, okay. Although there's been some, the decrease among the Black population has actually been greater and faster than the decrease among the White population.

So what we see here is progress, but we see persistent disparities, okay. If we look at the next slide, this is an example of charts that we have throughout the report, showing the geographic difference. Going to the next slide, many of the objectives have to do with interventions, okay. This shows interventions related to colorectal, for colorectal cancer screening, and so it's a screening.

Here we see considerable progress, in fact more, doing better than the target in terms of the rate of screening, and in fecal occult blood tests heading down, which in fact was the recommendation. So we actually have done well in terms of that.

Going to the next slide, we turn to coronary heart disease, okay. If we look and we can see the parallel lines here, the persistence of the differences by race, and if we look at the end point on the next slide, which I thought would circle the end point, but you can look just as well. At 2007, we can see that the Black rate persists as considerably higher than the White rate, okay, with the Asian rate much, much lower. In effect, that's the best rate.

The next slide looks at another critical factor in health, which is obesity, and the green bars here are from the '88 to '94 data, from '88 to '94. The blue bars are the most recent data, and we can see that in every case here, the total differences by race, difference by sex, the direction is not what was desired, okay, and we've moved away from this.

If we turn to the next slide and look at this for children and adolescents, we see essentially the same picture, but with changes that are even greater. So the agenda, if you will, is before us, and of course there are a number of interventions underway, including the intervention and program campaign under the First Lady. But this is the challenge. A lot of change over a very short period of time in the wrong direction.

Another factor on the next slide that's important in cardiovascular disease is high blood pressure control. Here, we wanted an increase and in fact what we've seen is an increase across the board by race, ethnicity, by sex. This is all very positive. Below the target that was set, but still these are significant changes over a short period of time.

Another critical risk factor, of course, is cigarette smoking, and that's on the next slide. What we wanted here was, as the little box says, a decrease is desired. And in fact, that's what we've seen pretty much across the board, okay. Well, as far as this slide is concerned, it is across the board, okay. This is for adults.

On the next slide, we can take a longer -- well no, go back one. We can take a longer look at this going back to 1965, and see that in fact the cigarette smoking has declined over all of this time, with the rates of decline much greater than. The thing to be concerned about here is the fact that the pace of decrease really has slackened over the last several years. We've been in the right direction during this decade, but not at the same rate we saw before.

On the next slide, we look at this for children, and go to the next slide. We can see again the change over time. The direction here is actually positive, in the sense that we're going down.

Just a couple of more slides here. The next one is one of the critical measures of health of the entire population. When we compare health across countries, we often use infant mortality, we use longevity. It's really a critical measure. What we see here is that we see the persistence again of disparities; very little change from 1998 to 2006 in these measures.

The next slide goes back much further, back to 1940, and we can look at the difference between the White population and the Black population in infant mortality. What we see is of course the slowing, the slackening of the rate of change in the more recent time. But the other interesting point here is that the disparity, which on the slide looks much greater in 1940, it turns out the relative disparity has actually increased. If we look at the difference between the Black rate and the White rate, it's actually greater today than it was then. Even though in magnitude it's higher, if we did it on a percentage basis it's actually greater today.

Next slide. All of this data comes from -- well, it comes from many, many different sources. About 45 percent come from just four sources, which actually is very positive that we have. It's localized. We don't have all the detail that we would like in these sources, but we have a good deal of it. The remaining 55 percent though come from another 150 sources, and it is a challenge to corral all of this data and do it in the kind of demographic specificity that we really need to understand the disparities.

So my takeaway messages on the next slide are that we have made significant progress toward the objectives. I don't think there's any question about that. However, this is tempered by the fact that these health disparities persist, and there's been very, very little change there. Obesity stands out as perhaps the factor, the risk factor that has gone most in the wrong direction over this period of time, and what's clear is that we need to have data to be able to mount these programs, track these programs, set the goals for these programs, track them and understand and evaluate them so it has to be a priority.

Much more, on the last slide, there's much more information on the web. I encourage you to take a look at it, and this report, I think, is going to be extremely valuable as we understand the progress that we've made and the challenges for the future.

CARTER BLAKEY: Thank you very much, Dr. Koh and Dr. Sondik. That's a lot of important information you've shared with us this morning. Our next speaker is Dr. Jewel Mullen, who will provide a picture of progress from the state perspective.

In December 2010, Governor Dan Malloy announced his appointment of Dr. Mullen as the Commissioner of the Connecticut Department of Public Health. As commissioner, Dr. Mullen oversees the state's leading public health agency, whose mission is to protect and improve the health and safety of Connecticut residents.

Prior to joining the Department, Dr. Mullen was Director of the Bureau of Community Health and Prevention at the Massachusetts Department of Public Health. Board-certified in Internal Medicine, she is also the former medical director at Bay State Mason Square Neighborhood Health Center in Springfield, Massachusetts. So Dr. Mullen, welcome. The podium is yours.

DR. JEWEL MULLEN: Thank you. First, let me just say that my staff and I want to thank you, because we feel honored to be included in today's presentation, and I especially need to say that because I wasn't here during the last decade, so it's up to me to do my best to represent their work, and talk about what we're going to do going forward.

We can go onto the next slide. Our approach to Healthy Connecticut was based on the Healthy People 2010's leading health indicators. We adapted our state objectives to fit with the data available to us, and sometimes we used alternative or modified objectives and indicators that were more specific for our population. We can go on.

Before highlighting for today some of our results in Connecticut, or our lack of progress, I should describe a little bit of our state demographics and events that influenced population health and public health practice during the decade.

Next slide. First, I'll say that compared to the United States, Connecticut's population has a higher median age, a higher proportion of Whites, a higher degree of educational attainment, a higher per capita income and a lower proportion of people living in poverty. Also, depending on which reports you look at, we're described as having the highest per capita debt, the highest degree of income and inequality, and the widest achievement gap among high school students.

Next slide. And this is in part because Connecticut's statewide demographic profile really doesn't accurately portray the characteristics of its largest towns. For example, while Whites comprise 71 percent of the state's population, the population of its largest three cities are Hartford, Bridgeport and New Haven, are made up of 50 to 80 percent Blacks and Hispanics.

Next slide. In those three larger cities, there are a higher proportion of adults with less than a ninth grade, high school or postsecondary education, compared to the state as a whole.

Next slide. And the per capita income is significantly lower in those cities. Not surprisingly, a higher proportion of people who speak a language other than English at home also reside in those cities. It's

also probably no surprise that among those urban populations, the rates of uninsurance are one and a half to two times the statewide rate.

Before I go on, I also need to point out that as we focus on the difference between the urban areas and our state, we also know that there are big disparities in Windom County, Connecticut's Northeast corner, which ranks at the bottom of Connecticut's eight counties in this year's county health rankings, and number seven out of eight in health outcomes. Windom, our most rural county, is 90 percent White.

Next slide. So as I describe our progress in Healthy People 2010, I just want to recap a bit of what we consider some of the significant events of the decade, and you see them listed here. I had to include "Unnatural Causes," the documentary that explored the socioeconomic and racial inequality in health, because my observation was that a number of the state, local and community agencies that I was engaged with continued to cite Unnatural Causes as they started to think about how to approach their work going forward.

Next slide. With regards to our progress in Connecticut, we met most Healthy People 2010 targets that were measured with statewide statistics or by our total population. However, our statewide statistics also masked striking disparities across racial and ethnic groups and our urban and rural population.

We can go to the next slide. We've already referenced the progress in smoking in the country, and what I'll say here is that we did experience a 32 percent reduction in current smoking that's reported by adults, and the 14 and 40 percent increase expectedly of influenza and pneumococcal vaccine was administered, or people reported having received during that decade.

We can track the progress in smoking alongside a number of policy changes that occurred in the state, and the next slide. As we attribute our improvements in vaccination rates to a number of initiatives that occurred here at the Department and within the state, including designating a DPH staff person to work solely on adult immunizations and collaborations with a number of community partners, local health departments and our asthma and diabetes programs to increase influenza and pneumococcal vaccinations.

Next slide. Nevertheless, we ended the decade facing several ongoing challenges. Connecticut is included in the nationwide number one problem of rising obesity prevalence, and then I'll have more to say about our observations regarding unintentional injuries and low birth weight and premature deliveries. We can go on. We can skip this slide, and I'll say that we also experienced here an increasing prevalence of adult obesity, with disparities that we've seen before, and while -- we can go on.

While our obesity prevalence among adolescents was lower than the national average, obesity among Hispanic females and males was 48 percent higher than among Whites in the state.

Next slide. Also of concern for us were trends in leading causes of injury death, with the number and race of deaths from poisonings, motor vehicle accidents and falls increasing over the decade. The death rate from unintentional poisonings actually replaced motor vehicle accidents as the leading cause of injury-related deaths.

We can go on. Since I talked about falls a little bit, I'll skip that and move onto low birth weights. We haven't made any progress addressing the disproportionately high rates of a low birth weight and high premature deliveries among African-American women. The incidence of low birth weight is twice as high among Black women compared to Whites in the state, and we're very concerned about this link to equally disproportionate rates of infant mortality, particularly in New Haven.

I could cite what we're doing to start addressing Healthy People 2020, but instead I think I'll move onto my conclusions, in order to leave time for questions.

Summarizing, I just want to say that I know we could all feel as if we could get lost in all of the indicators that we might want to address, and feel compelled to address when we look at the challenges in our own localities. But we can't do them all, and there are some things that we should think about. As far as I'll start with where Dr. Sondik concluded, which was with data.

Something that I have said to my staff over the years is that we only know the data that we choose to look at. So not only is it that we need more and better data, to figure out exactly what's happening and how we need to move forward with the indicators, we have to look inside our state, our statewide data, to really understand not what's just happening in urban and rural populations, but in specific population groups.

We also need to identify our priorities before we start planning programs, which is a shift in the way many of us do our work, especially in state departments of public health. It's important for us to determine what we have capacity and support to actually implement. So we're talking about employing new initiatives and the correct strategic existing initiatives to address 2020.

It's very important, as we've already talked about, to maximize our community partnerships, particularly as we focus on policy and systems changes to address the social determinants of health. And when I talk about regularizing program integration and collaboration, it's not just a matter of addressing chronic disease prevention when I'm talking about that, because for a lot of the indicators that we're trying to improve upon, the risk factors are shared ones.

It doesn't really matter whether or not we as a state agency or a local agency are directly responsible for a particular program, such as tobacco, to address tobacco prevention and tobacco cessation; we have to collaborate across agencies. For us, that includes ensuring that we include our Healthy Homes program, our work in performance improvement, our indicators for our maternal child health block grant, our new, I'm happy to say, Community Transformation Grants, along with a number of ongoing DPH programs, with the hope that we'll also be able to preserve some prevention block grant funding to do some of this work.

I'll go on to the next slide. We know that we have to exploit all the resources available to us and the partnerships within our state, and we work very closely with ASTHO, NACCHO, NACCD, CDC, HHS for guidance and support as we do our work. What I said about Windom County reminds us that there's no particular race, ethnicity, language or color associated with health disparities. So that's important for us to remember, because we know glaringly what we need to do to address racial disparities in health. But we shouldn't overlook what else we might need to be thinking about along the way.

Then I'll just conclude by saying that for the past several years, I spent a lot of time thinking about one of my challenges was to help identify what the role of public health and health reform is, and I have two things to say about that, one of which I think Dr. Koh already referenced, which is that working on the Healthy People 2020 objectives is really advancing health reform.

Then finally for me, part of the brilliance of the Affordable Care Act is that public health is totally embedded within it. So there's no distinction between public health and health reform in that regard. I'll stop there, to leave time for questions.

CARTER BLAKEY: Okay, thank you very much, Dr. Mullen, and thank you to all of our presenters for their terrific reports today. We do have a few minutes left for some Q&A. I'd like to thank everyone who has been sending their questions in over the Internet during the presentations.

I'd like to send the first question toward Dr. Koh, and it has to do with one of the reports, overarching goals and the findings that the report had. So given the finding that disparities persist, what is happening in the country and in the government to help eliminate disparities today?

DR. HOWARD KOH: So thank you for that very good question. Now first of all, for Healthy People 2020, we've continued that overarching goal, to eliminate disparities, because it's such a critical issue, and our country is getting more diverse by the day. We have four states that are minority majority states, for example, so this is a key issue for the future.

We just came this morning from a conference sponsored by the *Journal of Health Affairs* and the October issue is completely dedicated to health disparities and approaches to studying and reducing them, and as part of that effort, we at the Department have unveiled a comprehensive action plan to address and reduce health disparities. It represents the greatest federal commitment to doing this ever.

This was a charge given us by Secretary Sebelius. We unveiled this plan this past April. We're coming up to the six month mark, and you'll be hearing much more about commitments, developments, deliverables of that plan, a lot of that linked to resources and directions provided by the Affordable Care Act. So this is a time for renewed commitment to this area, and it's very important. Thank you.

CARTER BLAKEY: Okay, thank you. Also the next question to Dr. Sondik; with respect to the findings on infant mortality and life expectancy, is there a connection between the lower rate of life expectancy among the Black population and the high rate of infant mortality?

DR. EDWARD SONDIK: Yes. That's a very good question. In fact, I've done some calculations on that, and the infant mortality rate really has a very small effect on life expectancy; to understand that, the infant mortality rate in the Black population's about 1.4 percent. In other words, for every birth, there's a 1.4 percent chance that the child will die. That has a relatively small effect overall on life expectancy.

CARTER BLAKEY: Thank you. We do have time for a couple more questions, which is wonderful. Given the number of objectives, and this is for Dr. Koh, the number of objectives in Healthy People 2010 and going forward with 2020, how are public health agencies or other stakeholders able to determine what to focus on? How do they know what the priorities are?

DR. HOWARD KOH: So thanks for that question. A couple of ways to answer that; first of all, we are very proud that Healthy People is now web-based; so if you don't know, please visit <http://www.healthypeople.gov>, and you can access all this information by web. In fact, you can fashion reports and look at objectives however you wish by going online and doing so that way.

The other obvious way is to focus on our so-called leading health indicators, and for Healthy People 2020, we're about to finalize a concrete set of leading health indicators, about a dozen or so, and at the upcoming American Public Health Association meeting here in D.C. on October 31st at 10:30 a.m., we will be unveiling our final leading health indicators for Healthy People 2020. So that's one way to focus attention on a finite number of objectives moving forward.

CARTER BLAKEY: Thank you, and Dr. Mullen, we've received one for you. What do you think needs to be improved at the federal level that can help you at the state level, and even for some of your communities within your state, to improve health?

DR. JEWEL MULLEN: I actually think it's already happening. Just my observation since I arrived in Connecticut, the amount of work that's being done with the support for moving us towards accreditation has been tremendous. We also have felt, through the Office of State, Territorial, Local and Tribal Support through CDC, a much stronger link with the Centers for Disease Control, state and local departments of public health.

And in addition to the conferences that we have, I have to say there's been such an ease of having direct communication with people in the agencies, that for me, it feels as if we really are working in a larger system. Probably what needs to happen in part is the willingness on both sides to know that that's the way people are working together now, with an understanding that that's how it would advance the work going forward.

CARTER BLAKEY: Okay, thank you, and Dr. Sondik, here's one for you. You talked a lot about the need for data and the importance of data. How are states and communities able to compare themselves with the national data?

DR. EDWARD SONDIK: Well, there are good sources here. I think the BRFSS, which certainly every state uses, which certainly every state uses, I think is very, very important. There are differences that you see between that and some of the national surveys. I think we need to make clear what those differences are, and we have an idea as to why those differences persist and exist. But looking at trends is extremely valuable. So that's a very important source.

But there are other sources of data, and I think we hear that old maxim that if you don't want the perfect to be the enemy of the good I think is extremely important, okay. I think periodically getting the best data that one can have, and use that to sort of set benchmarks is crucial. But then looking at change over time, a variety of data sources can be used. Whether this is data from insurance companies, whether it's public health data, surveillance data of various kinds, I think there are a number of ways to do this, and we're happy to work with communities around the country and our colleagues in CDC especially so, on ways to do this, to track and provide credible data sources.

CARTER BLAKEY: Thank you, and we have time for one final question, that I think either Dr. Koh or Dr. Sondik could answer. This has to do with the targets. We know that there are many different indicator sets that's out in the world. One thing that makes Healthy People unique is that its indicators establish targets. Can you tell us how the targets are set and how they are updated?

DR. HOWARD KOH: Sure. That's a very important conversation, and inherent in any discussion about target-setting. So for every target set, you have to balance the aspirational with the achievable, and this takes many hours of conversation. A decade ago, the group that coordinated this, led by the Assistant Secretary and Surgeon General at the time, Dr. David Satcher, leaned toward making it much more aspirational. That's why you don't see progress on at least some of these objectives, and some would say oh gee, you didn't meet this target or that target and that's disappointing.

I think any kind of progress is positive, and I'd like to recite the famous quote that if you aim for the stars and only hit the moon, you are still out of this world. So I think that applies to some of these areas where you've made progress, but didn't quite hit the target. For 2020, the consensus has been to move down much more toward the achievable end. So we'll see ten years from now how we do. But these are very, very important conversations and critical to guiding the country moving forward.

DR. EDWARD SONDIK: I think it's important to look at the targets and also look at the individual situation. I think Dr. Mullen actually was very insightful in the way she talked about the different communities in Connecticut, and how those communities differ from the overall measures on the state, and look at the targets in that light.

CARTER BLAKEY: Thank you. Dr. Mullen, would you like to add anything with respect to Connecticut establishing targets?

DR. JEWEL MULLEN: I have staff sitting here with me, saying we want to have targets next time, and we actually are spending some time, not right now, looking at what our data capacity and shortcomings are, so that we can at least choose targets that we can feel confident in. We're still really trying to understand our population even better.

In general though, I think if we're moving in the right direction, not wanting to be the enemy of the, you know, the good to be, the enemy of the perfect once again or vice-versa, sorry, I think we should just keep trying to move forward, move forward, because there are too many influences that are also out of our control sometimes, for us to get exactly where we want to land.

CARTER BLAKEY: Okay, thank you. I think you kind of hit the nail on the head with accountability and targets. It's sometimes frightening to set those targets. We all want to do better, but it's a challenge to meet our targets.

So I would like to thank everyone for joining us today. I thank our speakers, really did establish our road map for the next decade. We know what work we have to tackle in the next ten years, and we'll be back here in another ten years to wrap up Healthy People 2020.

So thank you Dr. Koh, Dr. Sondik and Dr. Mullen, and especially thank you to all of our participants in the Internet, and stay tuned to Healthily People 2020 by going to <http://www.healthypeople.gov>, where you'll also be able to eventually download some of our slides and information that was presented today. Thank you all.

OPERATOR: Thank you for joining this Healthy People webinar. Your session is now ending.

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