- **Recommendation 4a:** Healthy People 2030 should proactively engage stakeholders to provide meaningful input on the development of objectives.
- **Recommendation 4b:** Healthy People 2030 topic area workgroups should include representatives from other sectors and those within government, and should engage other sectors and those within government.
- **Recommendation 4c:** Healthy People 2030 topic area workgroups should meaningfully engage with the public during the development and implementation processes. Such engagement should include involving other sectors in the development of Healthy People 2030 objectives.

Action Items

1. The Health Equity, Complex System Science and Modeling, and Summary Measures briefs will be revised to incorporate approved Committee revisions.
2. The Stakeholder Engagement and Communications recommendations will be revised per Committee discussion.
3. The Logic Model, Data, and Implementation subcommittees will continue to meet and develop recommendations.
4. The Objective Review subcommittee that was established to review the proposed Healthy People 2030 objectives and provide recommendations for the Committee's consideration will meet and develop recommendations for the Committee to consider at its next in-person meeting.

(NCHS) and ODPHP will conduct an analysis of FIW-approved objectives, reviewing for balance across multiple issues and ensuring measurement integrity. Then, the Objective Review Subgroup (ORS) will review the reduced set of proposed objectives to provide a high-level, broad, public health perspective; identify critical issues that may be missing; and ensure alignment with Administration policies and priorities. Afterward, the objectives will return to the FIW for approval. The public comment process will follow, which will invite a variety of different opinions and reshape how the FIW considers the objectives. Topic area workgroups will have the opportunity to review comments and revise the objectives as appropriate. Targets and target-setting methods for proposed objectives will be established after public comment and before departmental clearance.

Committee Discussion

Dr. Pronk asked about the status of developmental and research objectives. Mr. McNellis replied that the topic area workgroups expect to have a rough outline of these objectives in October 2018. Some developmental objectives may become core objectives throughout the decade.

Dr. Namvar Zohoori asked how the FIW approached reducing the number of objectives. Mr. McNellis responded that the FIW's approach was informed by the Committee's recommendations, NCHS's data set requirements, and the need to have evidence-based interventions that can impact each objective. The FIW used an iterative process to identify which objectives had the most value, including assessing those public health issues for which so much progress has been made that there is little left to do, as well as issues that represent new and emerging areas, such as opioid use.

Dr. Glenda L. Wrenn Gordon asked how the FIW approached objectives that appear positive among the entire population but have stark disparities when broken down by different demographic groups. Mr. McNellis explained that the FIW is interested in preserving objectives for which profound disparities exist and noted that the topic area workgroups are charged with identifying disparities among various sub-populations for each objective.

Dr. Edward J. Sondik asked whether topic area workgroups had begun setting targets, raising concern that workgroups may have begun the process without incorporating the Committee's recommendations on target setting. Mr. McNellis responded that workgroups have not yet set targets for their objectives, and Ms. Carter Blakey indicated that target setting will occur while the core objectives undergo public comment.

Dr. Mary A. Pittman asked about tracking progress for objectives whose targets have previously been met, voicing concern that regression would not be captured if those objectives were not included in Healthy People 2030. She raised the idea of new methods for large data analysis or use of new data sets. Mr. McNellis affirmed that public health issues that contribute to significant causes of disease, death, and disability will remain in Healthy People 2030 but explained that Healthy People 2030 is not designed solely for monitoring, which can be accomplished by other agencies and initiatives. He expressed enthusiasm about the idea of large data analysis or using data sets such as electronic health records (EHRs) or registry data but indicated that the FIW would need to be cautious to ensure the data set meet the criteria for Healthy People 2030.

Dr. Nirav R. Shah asked whether any topic areas or objectives could be consolidated, raising concern about having approximately 42 topic areas for Healthy People 2030. Mr. McNellis replied that the FIW Objective Review Subgroup will be responsible for those decisions in the next phase of the objective

selection process. He also explained that there may be an opportunity to assign tags to different objectives, such as by topic area, population, disorder, or infrastructure.

The following questions were posed for the record, but not discussed with Mr. McNellis at this time:

Dr. Paul K. Halverson asked how the FIW has approached objectives related to system and infrastructure building. He also asked whether the FIW has considered how they can engage other sectors in the objective review process.

Dr. Susan F. Goekler asked if any objectives utilize data sets that track upstream determinants of health.

Dr. Jonathan Fielding asked about the logistics of the FIW objective review meetings, such as how many people participated in the discussions and whether each workgroup focused on multiple topic areas. He also asked whether Healthy People 2030 will include any cross-cutting or broad topic areas, as opposed to the more siloed topic areas historically included in Healthy People.

Dr. Sondik asked how agency leadership was involved in the development of objective proposals. He also suggested that, beyond a detailed midcourse assessment, the FIW consider conducting an assessment of stakeholders' activities at the midpoint to evaluate how they have been driving action.

Overview and Purpose of the Issue-Specific Briefs Developed by Subcommittees

10:30 a.m. – 10:35 a.m.

Dr. Kleinman provided an overview of the next series of presentations from subcommittees that have been developing issue-specific briefs for the Committee's consideration. During the July 10, 2018 meeting, the Committee discussed, vetted, and approved the issue briefs for Health Promotion, Health Literacy, Health and Well-Being, and Law and Policy. Today, the Committee will review the briefs for Health Equity, Complex Systems Science and Modeling, and Summary Measures.

Dr. Kleinman reminded the Committee and the audience how the concept of the issue-specific briefs arose, as well as their purpose and intended audience. As the Committee developed its recommendations for the Healthy People 2030 framework, there were questions regarding definitions, terminology, and the roles that particular concepts or paradigms can play in Healthy People 2030. The briefs were born out of the Committee's interest in informing the Committee's work, identifying definitions and terminology, and clarifying the roles that certain concepts and approaches can play in Healthy People 2030.

The Committee originally set out to develop the issue-specific briefs as a means to inform the Committee and its work. Along the way, the Committee decided that, when possible, the briefs should be written in plain language so that the briefs also may be used by stakeholders. There is an understanding that it will be difficult to write some of the briefs in plain language due to the nature of the issues being discussed (e.g., the briefs on Complex Systems Science and Modeling and Summary Measures).

It is the Committee's intention that the briefs reflect the Committee's current thinking, represent rapidly evolving areas that will benefit from monitoring and updating throughout the decade, and not be exhaustive treatises. Furthermore, the Committee has requested that the briefs be limited in length.

Once the briefs have been vetted, revised (if necessary), and approved by the Committee, the collection of briefs will be packaged into a compilation with an introduction and delivered to the HHS Secretary. After the Secretary's receipt of the briefs, the compilation will be published online at HealthyPeople.gov.

Health Equity Brief Subcommittee: Review and Discussion of the Brief

10:35 a.m. – 11:30 am

Dr. Cynthia A. Gómez, chair of the Health Equity subcommittee, presented the Health Equity brief to the Committee. The purpose of the brief is to provide a current understanding of the history and definition of "health equity" and related terms. Originally, the brief was written to only focus on health equity, but it was later expanded to include definitions of social determinants of health and examples of implementation. Dr. Gómez noted that the brief has been through several rounds of revision in order to incorporate feedback from the Committee and the Stakeholder Engagement and Communications subcommittee.

Dr. Gómez emphasized the importance of aligning the brief with the Healthy People 2030 framework, particularly with the Foundational Principle that states, "Healthy physical, social, and economic environments strengthen the potential to achieve health and well-being." The subcommittee also discussed issues of nomenclature distinguishing environmental conditions from environmental factors from the physical environment. The brief uses the term "determinants of health" rather than "social determinants of health" to ensure that it includes a broad range of determinants and appeals to a wider range of sectors.

The brief includes a table explaining the determinants of health and well-being, including behavioral, biological, environmental (physical), and social. For each determinant, the table provides a definition, types, and examples. Dr. Gómez noted that economic determinants are considered a subset of social determinants. She also explained the difference between social and environmental determinants by noting that social determinants reflect what is available (e.g., access to housing), while environmental or physical determinants reflect what is present (e.g., good housing quality). The brief also recognizes the interaction between the determinants of health and well-being. Dr. Gómez noted that the brief focuses more on social class-level disparities rather than disparities by race/ethnicity, which may create discriminatory ideas. Additionally, the brief notes that the ability of Healthy People 2030 to measure its success in achieving health equity will require a new or different method of measurement.

Committee Discussion

Dr. Shah asked whether data should be considered a determinant of health, and Dr. Gómez asked him to consider the role that data may have in achieving health equity. Dr. Kleinman noted disparate economic and physical investments into data collection and said that data are essential for creating an evidence base.

Dr. Goekler suggested that the table row on social determinants of health could benefit from including "learn" in the definition and "education" as a type or example. Dr. Fielding suggested that the subcommittee add epigenetic determinants to the list of biological determinants, add discrimination (e.g., racism or classism) to the list of social determinants, and add the high cost of health care in the U.S. (compared to other Organisation for Economic Co-operation and Development (OECD) countries) as an economic determinant. Dr. Fielding added that water availability, quantity, and distribution will be key in the next several decades, as will climate change. He also suggested adding public health systems

as an example determinant. Dr. Gómez explained that the table provides select examples rather than an exhaustive list of determinants. Dr. Sondik suggested that Figure 1 be revised to include law and policy.

Dr. Fielding noted overlap between the table rows; for example, alcohol and drug use is listed as a behavioral determinant but is also broadly influenced by the environment and by genetic factors. Dr. Therese S. Richmond expressed concern that the table siloes the determinants and does not sufficiently demonstrate overlap and interaction; she suggested that the physical and social environments could be combined. Dr. Pronk suggested that the table include 1 row for environmental determinants, with physical, social, economic, cultural, legal, and political determinants as subtypes that may overlap. He also suggested that the subcommittee add a row to the bottom of the table reflecting the interaction between the determinants. Dr. Zohoori suggested that the table include adverse childhood events (ACEs) as an example of an interaction between determinants.

Dr. Wrenn Gordon expressed concern that the current version of the brief no longer serves its original purpose, which was to consider the role of health equity in Healthy People 2030. She suggested that the brief be revised to re-focus on health equity, with social determinants of health potentially highlighted in a separate brief. Mr. Joel B. Teitelbaum agreed, noting that a separate brief was written on law and policy as determinants of health and suggesting that the brief be written on inequity and inequality as determinants of health. Dr. Richmond wondered whether the brief intended to look at health equity as a determinant or to look at what drives inequity. Dr. Gómez replied that health equity is considered a visionary goal in the Healthy People 2030 framework.

Dr. Gómez agreed that the brief should be revised to focus on health equity, and suggested that a future, more robust paper could be written on the determinants of health. Dr. Pittman noted that the original 3-page brief would serve the original purpose of the brief, which was to explore the concept of health equity and its use in Healthy People 2030. Dr. Fielding asked that the revised brief contain 1 or 2 examples to help readers understand the difference between health equity, health inequity, health disparities, and health inequalities (in addition to the definition text); Dr. Kleinman replied that the examples could be placed in an appendix.

The Health Equity Brief subcommittee agreed to revise the brief and re-present to the Committee during the second day of the Committee meeting (September 7, 2018).

Complex System Science and Modeling Brief Subcommittee: Review and Discussion of the Brief

11:30 a.m. – 12:00 p.m.

Dr. Pronk, chair of the Complex System Science and Modeling subcommittee, presented the Complex System Science and Modeling brief to the Committee. The brief begins with a relevant example of complex system science and modeling, which is followed by an explanation of complex systems science and modeling and discussion of the concepts' application to Healthy People 2030.

Dr. Pronk explained that systems may be simple, complicated, or complex. Both simple and complicated mechanical systems are designed to remove surprise so that they become predictable across many different types of circumstances. For example, an automobile is a complicated system, while many automobiles driving down the highway constitute a complex system as the drivers interact and adjust their behaviors based on multiple factors. Public health is a complex system; the brief explores how Healthy People 2030 can best set achievable health and well-being goals for 2030.

Various approaches, methods, and tools have been developed to help researchers and decision makers better understand and address complex systems. Major categories include qualitative and quantitative approaches such as systems mapping and systems modeling, respectively. Systems mapping helps researchers and decision makers to better "see" a system by developing a diagram, illustration, or other type of visualization of relevant system components and the connections among them. Systems modeling goes several steps further by representing how the system operates. A systems model uses a set of mathematical equations or computational algorithms to represent the components, relationships, and processes of a system. Dr. Pronk emphasized the importance of thoroughly and continually involving stakeholders in systems modeling.

Determinants of health and well-being, the social relationships in which people engage, the human body, health care delivery, public health, and the interdependent relationships among these levels all represent complex systems. The manner in which these systems operate may prolong or alleviate suffering and increase or reduce health equity, health disparities, or health literacy. Considering the manner in which local sub-systems of organizations, populations, communities, and states are nested within the overarching national system, all of these systems work on the production of health and well-being at their own levels as well as in the aggregate. Together, they produce an average level of health and well-being aligned with Healthy People goals and objectives, although some sub-systems may produce more while others may produce less than average levels, thereby making disparities visible.

Healthy People 2020 introduced complex systems science into the target-setting process, albeit in a limited fashion (a total of 10 objectives used modeling as a target-setting methodology, accounting for 1.1% of all objectives). The brief outlines several potential actions that may support the development of Healthy People 2030, including:

- Systems mapping to support identification of factors of importance
- Systems mapping to support identification of places within systems most suitable for intervention
- Visualization of major interrelated factors impacting the overarching goals of Healthy People 2030
- Selection of most appropriate target-setting methodologies (see Example Box 8)

- Modeling the impact of achieving various degrees of progress toward objective targets
- Mapping of stakeholders and the relationships among them
- Identification of unattainable targets
- Ability to raise questions regarding the value of certain processes or pathways that support resource allocation

Committee Discussion

Dr. Kleinman noted that this brief, along with the Summary Measures brief, provides insight into how the concepts may apply to the planning, implementation, and monitoring of Healthy People 2030 objectives. Dr. Gómez suggested that these briefs be highlighted as tools for implementation.

Dr. Kleinman suggested that the brief could discuss the importance of developing a workforce that is able to contribute to and benefit from systems science and modeling. Dr. Halverson agreed that schools and programs in public health could provide additional training on complex systems science and noted that systems science and modeling require substantial resources. Dr. Sondik described modeling as research and emphasized the importance of confirmatory research to compare results and confirm findings; resources are essential for supporting these activities. Dr. Fielding suggested that the concept of backcasting could be added to the brief and noted that systems science and modeling have the potential to drive targeted resource allocation. He wondered whether a Healthy People 2030 objective could measure workforce development or capacity to conduct systems science and modeling.

Dr. Halverson noted that the Stakeholder Engagement and Communications subcommittee has recommended the use of system science and modeling to engage stakeholders, particularly policymakers. Dr. Gómez suggested that the brief discuss errors in system science and modeling due to problematic data; he discussed HIV as an example.

Dr. Zohoori noted that only some aspects of a complex system are controllable; some may be influenced, while others may not be. Dr. Pittman considered how to use incentives or regulations to affect complex systems. Dr. Pittman added that the brief made her consider how to allow laypeople to effectively use systems science and simulations; she discussed the ReThink Health initiative[1] as an example.

Committee Vote

The Committee voted unanimously to approve the brief, pending these potential revisions:

- Consider adding information on the benefits of systems science and modeling workforce. development, the importance of confirmatory research, and backcasting.
- Add note about incorrect or inaccurate data input causing inaccurate modeling.
- Highlight the Complex System Science and Modeling and the Summary Measures briefs as tools (while other briefs may provide definitions or explanations).

[1] https://www.rethinkhealth.org/

Summary Measures Brief Subcommittee: Review and Discussion of the Brief
1:25 p.m. – 2:15 p.m.

Dr. Sondik, chair of the Summary Measures subcommittee, presented the Summary Measures brief to the Committee. He emphasized that summary measures provide an intuitive, simple way to report on overall progress and enable comparison of health and well-being in the United States with health and well-being in other countries. The subcommittee proposed criteria to assure that summary measures meet their objectives, requiring that they be limited, material, scientifically acceptable, understandable, relevant, and actionable. Beyond 1 concise measure, Dr. Sondik indicated that summary measures could have a 2-part structure, which would include a single overarching objective that addresses the entire population and a second set of measures to show how health outcomes vary among population groups.

Dr. Sondik highlighted the measure of life satisfaction, noting that it is gaining traction internationally but may not exist as a major national measure in other U.S. programs. He emphasized that it is important for summary measures to align with other well-known measures, such as those from the National Academy of Medicine, and with Healthy People 2030's overarching goals. Dr. Sondik stated that summary measures should not necessarily be drawn from other Healthy People 2030 objectives or Leading Health Indicators (LHIs) but that they should align with other measures such as county health measures or *Health, United States*, the annual report from NCHS that provides an overall compendium of health in the United States.

Committee Discussion

Dr. Goekler suggested that the summary measures criteria include the availability of comparable international data to facilitate country-to-country comparisons. Dr. Sondik affirmed that the subcommittee had discussed this and agreed that it should be included in the brief. Dr. Goekler specifically suggested international comparisons for the life satisfaction measure; Dr. Pronk confirmed that data on life satisfaction are typically reported by OECD countries.

Dr. Fielding raised concerns about the phrase "at a cost that is considered value," saying that it is unclear whether the phrase refers to health system costs or the costs of anything that influences health. Dr. Sondik replied that the cost of care in the United States and how it compares with other countries is often part of discussions about the U.S. health care system, so it is an important dimension to consider. Dr. Pittman suggested that a paper co-authored by Dr. Fielding, "A Health Dividend for America: The Opportunity Cost of Excess Medical Expenditures," could inform descriptions of costs in the brief; the paper explored the concept of value and how to apply cost in the broader health continuum.

Dr. Fielding expressed uncertainty about the inclusion of a life satisfaction metric because a variety of factors beyond health determine life satisfaction and many actions to influence life satisfaction are outside the purview of HHS. He raised concern about Healthy People 2030 being solely accountable for influencing this summary measure and suggested that life satisfaction be disaggregated to show the health-related determinants and weight them differently. Dr. Sondik responded that many different countries track the summary measure of life satisfaction, so it could be a key way to make international comparisons. Dr. Pronk added that life satisfaction is a well-being indictor, not a health indicator; its inclusion would align with the inclusion of well-being throughout the Healthy People 2030 initiative. Dr. Wrenn Gordon explained that the broadness of life satisfaction inherently incorporates a multi-sectoral approach and noted that life satisfaction is holistic and embeds the concept of health equity.

Dr. Richmond acknowledged that summary measures provide an overall view of health and asked whether they drive actionable activities, as compared to individual objectives or LHIs. Dr. Sondik replied that summary measures can prompt decision makers to address health issues. Dr. Fielding indicated that many disparities cannot be prevented so it is important to recognize which disparities HHS can and cannot impact.

Dr. Halverson suggested that the Committee consider how to meaningfully bridge LHIs or summary measures to state and local health officials so that Healthy People 2030 statistics can inform their interventions or their interactions with policy makers. Dr. Sondik responded that ODPHP could prepare an annual report by integrating Healthy People 2030 data with state rankings and other U.S. health summaries. Dr. Zohoori added that Healthy People 2030 should be relevant to every jurisdiction, regardless of how far ahead or how far behind they are from the objective target. Dr. Pittman shared that publishing measures does not mean stakeholders will see them; she indicated there should be a clear purpose for the dissemination of the measures to increase state and local buy-in.

Committee Vote

The Committee voted unanimously to approve the brief, pending the potential revisions described below:

- Consider inclusion of data that are also collected by other countries, to allow for international comparisons.
- Specify what "a cost that is considered good value" refers to—whether costs in the health care system or the costs of anything that influences health—and consider how to acquire that data.
- Emphasize the importance of measuring spending on social programs relative to spending on medical services.
- Clarify that life satisfaction is not a main metric by which to gauge the progress of Healthy People 2030, but emphasize that it complements the program's focus on health and well-being.
- Highlight that a life satisfaction metric would necessitate multi-sectoral partnerships.
- Consider how to bridge LHIs or summary measures to state and local health officials.
- Consider how to make Healthy People 2030 objectives relevant to every jurisdiction, regardless of whether they are ahead of or behind the target.
- Highlight the Complex System Science and Modeling and the Summary Measures briefs as tools for implementation (while other briefs may provide definitions or explanations).

HHS's Healthy People Regional Listening Sessions

2:15 p.m. – 2:45 p.m.

Ms. Ayanna Johnson (ODPHP) provided a summary of the 4 listening sessions conducted by ODPHP in 2018. The listening sessions reached over 400 participants and served as a platform to gather public feedback about the Healthy People initiative. The listening sessions had 5 overarching goals:

1. Strengthen the overall Healthy People 2030 development process through public input.
2. Provide opportunities for non-traditional partners and stakeholders to actively participate in and provide feedback in the Healthy People 2030 development process.
3. Understand the value of Healthy People to stakeholders.

4. Cultivate new partners for Healthy People and identify ways to develop partnerships on Healthy People 2030 activities.
5. Identify best ways to engage and communicate with diverse stakeholder groups.

Listening sessions were held at: the National Association of County and City Health Officials (NACCHO) Annual Conference in Washington, District of Columbia; the American Public Health Association (APHA) conference in Atlanta, Georgia; the Association for Prevention Teaching and Research (APTR) conference in Philadelphia, Pennsylvania; and the National Conference on State Legislatures (NCSL) conference in Los Angeles, California. Each listening session focused on how Healthy People can meet the needs of stakeholders and the public. Groups discussed how various professions and sectors could reference and implement the Healthy People framework.

Ms. Johnson discussed the key findings from each session and noted that findings across sessions were similar. Attendees reported that they think the Healthy People initiative is a useful tool and framework, but they said that the initiative should communicate how Healthy People aligns with other federal priorities. Attendees also wanted more guidance about how to navigate the HealthyPeople.gov website and how to incorporate the initiative into their specific sector. Session attendees suggested that ODPHP make HealthyPeople.gov more usable and relevant for stakeholders, expand opportunities and resources for community and stakeholder engagement at the local level, and increase visibility of the Healthy People initiative.

Ms. Johnson explained the main limitations of the listening sessions, which included:

1. Large forums made it difficult to extract in-depth information.
2. The group setting led to open-ended conversations and some discussions that were not directly related to the session activity.
3. The session methods required individuals to take their own notes and conduct their own report-outs. There was not a note-taker at every breakout session, so some points were not fully captured.
4. The sessions occurred within existing professional conferences, which created a potential bias in the responses received.

Session feedback also highlighted that Healthy People data may be technical and hard for people to understand. Participants recommended that ODPHP communicate more clearly that Healthy People objectives use data from highly vetted national- and federal-level surveys.

ODPHP will continue to host listening sessions across the country to inform recommendations for the planning and development of Healthy People 2030 and related products. There are 2 upcoming listening sessions: at the Annual Conference of Epidemiologists in Cincinnati, Ohio (September 2018) and at the National Public Health Law Conference in Phoenix, Arizona (October 2018). ODPHP also will continue to leverage partnerships with federal and non-federal partners to maintain engagement in Healthy People 2030 development.

Questions and Answers

Dr. Kleinman and Dr. Shah asked how ODPHP plans to implement feedback from the listening sessions and incorporate non-health sectors in these discussions. Ms. Johnson explained that ODPHP is creating a

report based on the 2018 listening sessions. Additionally, ODPHP would like to conduct listening sessions with non-health sector professionals in 2019, potentially through virtual listening sessions. Dr. Halverson supported this idea and suggested that the Stakeholder Engagement and Communications subcommittee could help further define what questions should be asked of non-health sector professionals. Dr. Wrenn Gordon and Dr. Fielding agreed that ODPHP should engage non-health sectors in listening sessions. Dr. Fielding emphasized that addressing health issues requires multi-sector and multi-disciplinary approaches. Dr. Goekler offered to assist Ms. Johnson in developing material for a listening session with the education sector. Ms. Johnson indicated that ideas for future listening sessions should be directed to Ms. Emmeline Ochiai (ODPHP) via email.

Dr. Wrenn Gordon expressed surprise that the NCSL session attendees focused on public health crises and emergencies. Dr. Fielding suggested that Healthy People should develop partnerships with states, regions, and counties to provide technical assistance at the local level.

HealthyPeople.gov Website Design

2:45 p.m. – 3:15 p.m.

Ms. Theresa Devine (ODPHP) and Ms. Sarah Pomerantz (CommunicateHealth) shared updates about the Healthy People 2030 website design. Formative and usability research with current site users found that users want to: be able to quickly find objectives relevant to their work; plan and measure progress to improve health outcomes; and prioritize the most important health issues for their interest area. Users currently struggle to find information that is relevant to their work because much of the web content is not centralized around the objectives. Ms. Devine explained that the goal of the Healthy People 2030 website is to create a dynamic tool for health professionals to plan, implement, and monitor progress toward achieving the Nation's public health objectives. The key priorities for the new site are:

1. Align website services with health professionals' workflows and real-time needs.
2. Organize information in a way that is simple, intuitive, and accessible to a diverse, multidisciplinary user base.
3. Let users customize their experience and focus on information that is relevant to their specific work (by population, locality, and/or subject area).
4. Provide up-to-date, accurate data on objectives.

Ms. Pomerantz discussed the high-level timeline for the Healthy People 2030 website, which includes 4 phases: Discovery (2016-2017); Gather Requirements (2017-2018); Development (2018-2019); and Launch and Promotion (2020). She discussed key milestones and how the development will be conducted in 2 phases: alpha and beta. The alpha site build includes core features that need to be functional and tested at launch; the beta site build involves additional testing. Ms. Pomerantz shared the 4 key prototype concepts (cross-cutting topics and objectives, personalized topic dashboard, streamlined data display, and integrated search) and their preliminary wireframes.

Ms. Pomerantz also shared the next steps for the website design, which include continuing to test and refine categories for objective taxonomy; developing and refining visual design; finalizing technical requirements; and beginning the alpha build. Ms. Pomerantz added that the website will communicate progress, motivation, credibility, and power via a clean and flexible design and it will be credible, engaging, and appealing to a diverse group of users.

Questions and Answers

Dr. Pronk asked whether ODPHP plans to track users' searched text. Ms. Devine confirmed that ODPHP and CommunicateHealth will conduct user analytics. Dr. Shah suggested a number of features that could be added to the website to increase data sharing, including: open access to API to facilitate data access; provision of RSS so that users can feed data directly into their own sites; provision of Slack or SharePoint capabilities to allow users a bidirectional relationship to the Healthy People 2030 website; provision of guidance regarding translating clinically captured data to patient-reported outcomes; open access to state, national, and local data that would allow compassion; and the addition of analytic abilities. Dr. Goekler suggested that there be some way to notify a user when there is an update in their particular field of interest. Ms. Devine agreed that updating users will be an important component of these efforts.

Dr. Fielding asked how implementation information that is not captured on the website will be managed, how users will find information that is most relevant to them, and if there will be a frequently asked questions section from data gathered at listening sessions. Dr. Halverson emphasized the importance of making the website welcoming for health colleagues and non-health stakeholders, possibly in the form of a tab that describes other sectors and engagement strategies. He also suggested that local governments could benefit from local dashboards to use Healthy People information. Dr. Zohoori asked if the "my topics" dashboards created by states will be cookie- or account-based; Ms. Devine responded that they will be account-based.

Dr. Wrenn Gordon suggested that there be 2 user pathways: one for students and individuals that is filtered and not overwhelming, and a second that is for organizations looking to use the data. Dr. Sondik asked if disparity data would be automatically generated and if there will be links to further resources on a certain objective. Ms. Devine responded that they are considering providing a snapshot of information about an objective with the option to access more information and linked sources. Dr. Sondik added that he dislikes website search functions and appreciates that CommunicateHealth is working to make the website more of a "one-stop shop" for users.

Healthy People 2030 Logic Model and Video: Development of Concept Ideas

3:45 p.m. – 4:00 p.m.

Ms. Pomerantz reviewed progress to date for the Healthy People 2030 framework model products. She provided an overview of the 3 proposed products, which include an overview graphic, a clickable graphic, and a video; the products complement each other and will be crosslinked on the Healthy People 2030 website.

The static overview graphic will provide a high-level visual overview of the "what" of Healthy People 2030 by building a shared understanding of basic public health concepts. It will also serve to introduce the interactive graphic. The content will be developed to reach all sectors and be accessible to a diverse audience. Key target audiences may include public health professionals, non-public health sector professionals, and government staff; discussions with the Logic Model subcommittee to finalize the target audiences are ongoing.

The graphic's main message will convey the desired outcome of health and well-being founded on concepts including health equity; health literacy; social, physical, and economic environments; and

shared responsibility across sectors. The subcommittee has also discussed including law and policy in the graphic.

Ms. Pomerantz presented a draft concept of the overview graphic, and noted that the Healthy People 2030 visual branding has not yet been applied. The graphic includes 4 categories (context, strategies, lens, and outcome) that the user will not necessarily see. Context includes the physical, social, and economic environments; strategies include shared responsibility, law and policy, and health literacy; the lens is health equity; and the outcome is health and well-being across the lifespan.

Each concept in the graphic will be clickable to allow users to view addition information on "key concept pages," which will summarize key message and action steps. Key concept pages will include information about why these concepts are vital to the Nation's health; how the concepts relate to the overall Healthy People 2030 initiative, with crosslinks to related paged; examples of how the concepts are being used to plan, implement, and evaluate public health programs; supporting images and graphics; opportunities to get involved; and links to additional information. Ms. Pomerantz provided a draft content template for Health Equity and noted that the content may change prior to the launch of Healthy People 2030.

CommunicateHealth will continue to work with the Logic Model subcommittee to develop the overview graphic and clickable graphic for launch in 2020. ODPHP will continue to draft content for each key component based on the content template. CommunicateHealth will design the overview graphic based on the approved Healthy People 2030 look and feel.

Logic Model Subcommittee: Update and Recommendations

4:00 p.m. – 4:40 p.m.

Dr. Shiriki Kumanyika, chair of the Logic Model subcommittee, introduced the subcommittee members. The subcommittee has many connections to other subcommittees: Dr. Halverson is the chair of the Stakeholder Engagement subcommittee; Dr. Pittman is the chair of the Implementation subcommittee; and Dr. Richmond is the chair of the Leading Health Indicators subcommittee and the Approaches subcommittee. The subcommittee has met 7 times in the past year to discuss the proposed graphics and ensure that the drafts are in line with the Committee's recommendations and intended main messages.

The objective of the Logic Model is to tell the overall story, highlight key elements, and emphasize unique aspects or contributions of Healthy People 2030. Dr. Kumanyika added that the logic model will appeal to key audiences, including those not in the field of public health, and suggested rewording the key target audiences to refer to "all professionals, including health professionals" so as to no longer use the phrase "non-public health professionals."

In order to engage other sectors, the subcommittee has considered the benefits of health to these sectors, including the linkage between good health in the workforce and increased productivity, lower absenteeism, and lower health care costs. Dr. Kumanyika suggested that this information may be useful when marketing Healthy People 2030 to other sectors and noted that additional information on this could be posted to the Healthy People 2030 website.

Committee Discussion

Dr. Gómez noted that the draft concept includes 3 environments (physical, social, end economic), though the Committee has previously discussed the economic environment as a subset of the social

environment. Dr. Wrenn Gordon replied that the graphic may include the economic environment separately to highlight its importance.

Dr. Gómez suggested that the 3 strategies included in the graphic (shared responsibility, law and policy, and health literacy) may not convey the breadth of strategies discussed by the Committee. Dr. Goekler suggested that the graphic include the concept of health promotion, and Dr. Fielding suggested that it include programs or systems change. Dr. Sondik noted that the graphic does not contain any individual-level actions and may be too abstract to engage users. Dr. Kumanyika will engage the subcommittee in future discussions with CommunicateHealth about the concepts that should be included in the graphic.

Dr. Gómez distinguished benefits of health to other sectors from other sectors' role in achieving health equity; she suggested that promoting health and achieving health equity can be considered a benefit to these other sectors being involved in Healthy People 2030. Dr. Goekler replied that when these other sectors understand that health is important for them to succeed, they will be more likely to dedicate resources toward health promotion. Dr. Zohoori recalled a CDC diagram portraying all sectors as interlinked partners within a public health system; Dr. Wrenn Gordon suggested that sectors should be portrayed with icons, and Dr. Fielding suggested that the graphic include clickable pages for each sector (e.g., housing, education, etc.).

Dr. Richmond noted that law and policy affect the 3 environments, as well as vice versa; Dr. Sondik suggested reversing the order of the first and second concepts so that the strategies flow through the context. Committee members expressed concerns that the graphic is too linear and suggested that the model may not need to include linear arrows. Dr. Kumanyika noted that the Healthy People 2020 Committee developed an ecological, circular model. Dr. Fielding suggested that the graphic could allow users to click through to deeper and deeper levels, and Dr. Goekler recalled how Prezi presentation software shows interrelationships. Dr. Wrenn Gordon suggested that the static graphic be conveyed simply and colloquially to engage users without diluting its message and suggested that Dr. Giroir's simple message of "health for all, health by all, health in all" could effectively communicate the graphic's main message. CommunicateHealth's visual design team will consider how to creatively portray the concepts in a non-linear manner.

Committee members noted that health equity appears minor, or "squished," both visually and conceptually, and they suggested that revisions clarify that it is an important, cross-cutting, visionary goal and/or outcome. Dr. Sondik added that health equity is at the core of Healthy People 2030 and agreed that the concept should be pulled out more to clarify that Healthy People 2030 provides objectives and targets to work toward achieving health equity.

Dr. Fielding noted that health literacy is often associated with health care and may not resonate with individuals beyond that application. Dr. Zohoori noted that the concept of health literacy is being included more prominently in public health and state health agencies, and he added that the Arkansas Department of Health (ADH) includes health literacy in its health communication strategy.

Dr. Goekler suggested that the clickable concepts in the graphic could provide an opportunity to link to the briefs developed by subcommittees.

Open Committee Discussion

4:40 p.m. – 4:45 p.m.

Dr. Pronk asked whether members had additional topics they would like to address prior to adjourning for the day.

Dr. Gómez noted that the Health Equity Brief subcommittee plans to revise the brief based on Committee feedback and will re-present tomorrow for additional discussion and potential approval. Dr. Richmond summarized Committee discussion on whether health equity is a lens, an outcome, or a driver, and she suggested that the revised Health Equity brief should try to clarify this. She added that the Overarching Goals portray health equity as a driver, but it may be more than that. Dr. Halverson noted that users may not read the briefs in their entirety and suggested that the briefs should contain clear and deliberate language.

Dr. Goekler observed that many of the briefs overlap and could be crosslinked; Dr. Pronk replied that the briefs will be presented this way when they are posted to the Healthy People 2030 website.

Summary of Day 1 and Charge for Day 2

4:45 p.m. – 4:50 p.m.

Dr. Pronk thanked the Committee for participating in the first day of the meeting. He summarized the presentations, including remarks from Dr. Giroir and a presentation on the work of the Federal Interagency Workgroup, and noted that the Committee approved 2 issue-specific briefs developed by subcommittees on complex systems science and modeling and on summary measures. The Health Equity brief will be revised to reflect Committee discussion. Additionally, Dr. Pronk summarized Committee discussion regarding the development of the Healthy People 2030 framework model products.

Day 2: September 7, 2018

Opening Remarks

8:40 a.m. – 8:45 a.m.

Dr. Pronk provided an overview of the first day of the meeting and reviewed the agenda for the second day of the meeting. During the second day of the meeting, the Committee will hear presentations from the Surgeon General, NCHS, the Stakeholder Engagement and Communications subcommittee, and the Implementation subcommittee and will discuss the revised Health Equity brief.

Remarks from the U.S. Surgeon General

8:45 a.m. – 9:25 a.m.

Dr. Pronk introduced VADM Dr. Jerome Adams, MD, MPH, the 20th Surgeon General of the United States. As Indiana State Health Commissioner, Dr. Adams presided over Indiana's response to the state's unprecedented HIV outbreak, which was caused by the sharing of needles among people who inject drugs. In this capacity, he worked directly with the CDC, as well as with state and local health officials and community leaders, and brought the widest range of resources, policies, and care available to stem the epidemic. Dr. Adams' motto as Surgeon General is "better health through better partnerships." He is committed to maintaining strong relationships with the public health community and forging new partnerships with non-traditional stakeholders.

Dr. Adams thanked the Committee members for their service and noted that the Healthy People initiative has been important to him throughout his career. He noted that the Healthy People goals are closely tied with the Surgeon General's priorities, which include community health and economic prosperity. A healthier community is more prosperous, is safer, and attracts a greater workforce. He explained that he is focusing his upcoming Surgeon General's report on the economy because the economy and jobs are the top issue that voters care about, and election results dictate resource allocation. The goal of his upcoming report is to convey that communities that invest in health are more prosperous and have better employment opportunities and lower health care costs. He hopes that his report, coupled with the Healthy People 2030 goals, can help spur policy decisions to improve health and well-being.

He discussed his priority of promoting partnerships for health improvement and how the Healthy People initiative can play a role in encouraging partnerships. He asked the Committee to discuss ways to operationalize Healthy People objectives. Additionally, he recommended that the Committee explore how Healthy People fits with and can complement other initiatives, such as HI-5 (Health Impact in 5 Years).

Dr. Adams commended the Committee on its goal to reduce the number of objectives for Healthy People 2030, especially in addressing upstream issues that affect many health outcomes. He noted that the Healthy People initiative has emphasized the importance of measurement in health initiatives and outcomes, and he encouraged the Committee to explore new ways of tracking and monitoring trends, including using new technology.

Finally, Dr. Adams emphasized the importance of health equity and encouraged the Committee to incorporate health equity into Healthy People goals, objectives, and metrics.

Committee Dialogue with Surgeon General Adams

Dr. Teitelbaum asked about the role of the Surgeon General in promoting the use of legal services to achieve healthier communities and health equity. Dr. Adams agreed about the importance of providing tools so that stakeholders, including those in the legal system, can understand the impact that they have on health. He noted the importance of better health through better partnerships, including encouraging partnerships beyond those with traditional stakeholders. He explained that, in order to address the HIV outbreak in Indiana, he had to ensure that all stakeholders were included, especially those in non-health sectors such as the Sheriff, the head of the Chamber of Commerce, and the faith-based community. He noted the importance of framing Healthy People 2030 goals so that legal, law enforcement, business, military, and faith-based institutions see how they can contribute to health.

In response to a comment by Dr. Wrenn-Gordon, Dr. Adams noted the importance of engaging hospitals and health care institutions, as they often tend to focus on individual-level outcomes rather than population-level health outcomes. Additionally, he noted the importance of using language that resonates with the intended audiences; the language that resonates with a lawyer is not the same as the language that would resonate with a nurse, dentist, or doctor. He recommended the Robert Wood Johnson Foundation (RWJF) report, *A New Way to Talk about the Social Determinants of Health,* as a resource for engaging with stakeholders and demonstrating that health equity affects everyone.

Dr. Goekler asked how the Surgeon General is bringing together key stakeholders in the interest of working across silos. Dr. Adams replied that he is working with the Federal Reserve to talk about metrics, goals, and tools to work toward a healthier society. He added that in the past, the development of Surgeon General's reports was often fragmented, with a large amount of time between when the report was announced and presented, with little communication to stakeholders during the development process. Instead, Dr. Adams would prefer to continually talk about the report, convene meetings, and iterate on drafts. He plans to hold at least 1 meeting a month in different states to discuss community health and economic prosperity; these meetings will occur around the country to ensure that they are engaging a variety of partners to demonstrate how everyone can benefit from a healthier society. If anyone is interested in being part of or organizing a meeting, they may invite the Surgeon General to their town to talk with key partners.

Additionally, Dr. Adams discussed the opioid epidemic, noting that it is a tragedy but, because of its reach in society, brings with it an opportunity to convene a diverse set of stakeholders, including businesses, faith-based institutions, hospitals, legislators, and sheriffs. Dr. Adams noted that the public health community can use the epidemic as an opportunity to engage in dialogue on the importance of health and well-being to the success of communities, and how to tie these into key resources.

Monitoring Progress Throughout the Decade

9:25 a.m. – 10:30 am

Dr. Pronk introduced Dr. Charles Rothwell, the Director of the National Center for Health Statistics (NCHS). Dr. Rothwell previously served as the Associate Director of NCHS responsible for IT and Information Services; he became the Director of the Division of Vital Statistics in 2003. Dr. Rothwell first presented to the Committee in December 2016 and has returned to share his expertise regarding the ways that HHS monitors Healthy People's progress and the health of the Nation across the decade.

NCHS has partnered with the Office of the Assistant Secretary for Health (OASH) since the inception of Healthy People in 1979. NCHS, which is part of the CDC, is one of 13 federal statistical agencies. The role of a statistical agency includes compiling, analyzing, and disseminating information for statistical

purposes such as describing population characteristics and trends, planning and monitoring programs, and conducting research and evaluation. NCHS uses information from surveys, censuses, government administrative records, private-sector data sets, and internet sources that are judged to be of suitable quality and relevance for statistical use. Dr. Rothwell noted that identifying and using quality statistical data can be challenging in an environment where survey participation rates are declining and funding is not always readily available.

NCHS supports Healthy People in a variety of ways, including:

- Serving as statistical advisor to HHS and the topic area workgroups on health promotion data
- Conducting research and developing methods for measuring the overarching goals of Healthy People (e.g., health disparities)
- Creating analytic and graphical presentations, and analytic products, to display progress towards reaching the goals and objectives
- Maintaining a comprehensive database for all the Healthy People objectives
- Providing expertise and technical assistance to national, state, and local health monitoring efforts

Dr. Rothwell discussed HealthyPeople.gov, noting that the site includes 200 data sources spanning 1,104 Healthy People 2020 measurable objectives. Of those, 430 objectives (or 38.9%) are monitored by NCHS data systems.

NCHS influences data included on HealthyPeople.gov, including data systems that are not produced by NCHS, through the following ways:

- The searchable, tabulated data for all objectives, by a variety of population subgroups
- Trends, including assessment toward progress toward targets and relative to baseline
- A health disparities tool that lets data users do a deep dive on relative progress of subgroups
- Data for monthly infographics and the interactive midcourse review
- National and state maps, for example the stroke deaths per 100,000

ODPHP and NCHS have produced progress reviews of Healthy People 2020's 42 topic areas since the launch of Healthy People 2020 in December 2010. Topic areas were paired into "affinity" areas so that all topics could be covered over the course of the decade through progress review webinars. For each progress review, NCHS analysts and programmers work with the topic area workgroups to identify the most important objectives to present. NCHS also leads the development of the midcourse and final reviews for the decade, including analyses of all the objectives, summaries by topic area, and assessments for the LHIs.

NCHS's main work as a statistical agency is dedicated to:

- The development of measures that are core to understanding health and the determinants of health
- Understanding how to collect high-quality data on populations of concern
- Measuring health disparities and progress toward their elimination
- Anticipating the application of new classifications, such as the ICD-10 and analytic considerations in developing health indices

- Understanding health outcomes and their relationship to social determinants when developing the data

Dr. Rothwell noted that the primary use of Healthy People 2020 is as a data source. He further noted it is critically important that the data in Healthy People be of the highest quality for the initiative to be credible. Planning for the next decade presents the opportunity to improve the focus of Healthy People and the usefulness of its data.

Dr. Rothwell provided an overview of the evolution of Healthy People, including the number of topic areas, objectives, the population group topic areas, and the overall framework. He thanked the Committee for its key recommendations in guiding the development of objectives, including criteria for identifying preliminary objectives, prioritization of objectives, and recommendations pertaining to data.

In planning for Healthy People 2030, NCHS has been working with the FIW to:

- Examine the content and structure of Healthy People, the data sources, and the way data have been presented over the years
- Operationalize the criteria used to develop objectives (e.g., national importance, evidence based, etc.)
- Review the data sources used now and formalize the way we evaluate data systems for inclusion in Healthy People 2030
- Develop guidance for the agencies to critically consider objectives and data source quality

Committee Discussion

Dr. Shah asked whether it would be possible to publish every data set from every objective on HealthyPeople.gov, provide data visualization tools, and encourage state and local governments to upload their data to HealthyPeople.gov. Dr. Rothwell noted that Dr. Shah's idea corresponds with administrative priorities regarding data innovations and agreed that taking advantage of internal resources, particularly using and disseminating data sets that are already being collected, is an important next step. He added that if data sets can be easily accessible on the website, local, state, and national organizations will have an easier time using and referring to Healthy People objectives. Dr. Rothwell described previous efforts to link NHANES data, NHIS data, and data from the Department of Housing and Urban Development (HUD), which resulted in findings that blood lead levels for children of parents who were receiving HUD services were lower than those of comparable demographics that were not receiving those services. This finding was a good justification for HUD services and could be used to encourage other agencies to more freely share their data sets.

In response to a question from Dr. Richmond, Dr. Rothwell clarified that he would potentially have concerns about data quality if a data system has not been previously used to monitor key outcomes. Alternatively, if a data system only reports national data (rather than state-level data) and/or is only released every 3 to 4 years, it may not be useful for Healthy People. Additionally, a data system that lacks demographic data to analyze disparities may not be appropriate for Healthy People. Dr. Rothwell noted that the Committee's recommendations are on target with NCHS priorities and beliefs about data quality.

Dr. Halverson asked how state- and national-level data can support vital records and ensure data are timely and readily available. Dr. Rothwell replied that the Healthy People initiative should bring states,

HHS, and epidemiologists together, and he emphasized the role that states can play. He noted that states have made large improvements in how they report on vital statistics and that NCHS has received Patient-Centered Outcomes Research (PCOR) funding to make similar improvements in vital statistics reporting. For example, NCHS is reporting drug overdose deaths on a monthly basis, within 5 months of the event. Dr. Rothwell noted that medical examiners are experiencing difficulties reporting on opioid overdose deaths because of siloed data systems; NCHS is working with medical examiners to link vital registration systems with medical examiner systems. Dr. Rothwell also emphasized the importance of using electronic medical records and merging those systems with the vital records system, including providing training and information to physicians on how to merge systems. Finally, he noted that more state-level funding may be required and that buy-in from state leadership is key.

Dr. Zohoori asked how the Healthy People initiative can be improved. Dr. Rothwell replied that, if objectives are more focused, NCHS could do more to address the media, including social media, and to publish data on how communities compare to states and to the Nation. He noted that Healthy People should be HHS's data-driven, decision-making, driving force and suggested that the initiative should be part of the budget development process.

Dr. Pittman noted that Dr. Robert Francis (NCHS) recently presented to the Implementation subcommittee, where he discussed the Healthy People 2020 website, available tools, ways in which state-level estimates have been previously used, and the health disparities toolkit. Dr. Francis noted that the disparities toolkit allows searches by topic area keyword and by data source, but Dr. Pittman asked Dr. Rothwell to provide additional context about the tool. Dr. Rothwell suggested that the tool may benefit from being promoted more by individual agencies for use among stakeholders. Dr. Pittman recommended marketing these tools as part of the Healthy People initiative while also promoting the independent use of the tools by individuals with more specific needs.

Dr. Fielding asked what NCHS is doing in respect to interpolating data and asked if NCHS has sufficient data to provide estimates within shorter time periods, specifically on issues such as infant mortality or opioid overdose. Dr. Rothwell replied that RWJF funded NCHS to assess census-level responses on vital information; while it is a useful tool to provide people with an idea of the severity of certain health outcomes, providing life expectancy estimations using small data requires making many assumptions. He noted that NCHS is struggling to provide overdose deaths data on a monthly basis; they currently report on 2 trend lines: what the data are reporting and what NCHS estimates as the actual burden. NCHS is working on publishing provisional reports much earlier than in the past, using good confidence intervals and continuously improving estimates over time.

In response to a question from Dr. Richmond, Dr. Rothwell noted that he does not expect any unintended consequences of the Committee's recommendations. He echoed the Surgeon General's sentiment that the Healthy People initiative should be flexible, especially in adding objectives when data are available for monitoring. Dr. Rothwell hopes that Healthy People 2030 will be able to address issues as they arise during the decade.

Dr. Kleinman asked how the Healthy People initiative can acquire data sources for developmental objectives that are seen as valuable to monitoring the Nation's health but may require expertise and development of partnerships. Dr. Rothwell replied that each objective in Healthy People should have a data system that measures it.

Dr. Zohoori asked about the feasibility of using a standardized EHR platform, which would allow more immediate access to data. Dr. Rothwell suggested that encouraging a standard EHR platform could be feasible, but there would need to be widespread support from HHS leadership and resources available to do so. He emphasized the importance of involving Healthy People in the decision-making process within HHS, which can inform Congress as it makes decisions that benefit public health.

Stakeholder Engagement and Communications Subcommittee Report with Recommendations Regarding Engaging Stakeholders in the Development of Healthy People 2030 and Increasing the Value of Healthy People 2030 for Stakeholders

10:45 a.m. – 11:25 am

Dr. Halverson reviewed the charge of the Stakeholder Engagement and Communications subcommittee, which is to increase awareness and use of Healthy People 2030. He explained that non-health-related stakeholders are critical to engage and personally involve in Healthy People 2030 moving forward. He provided an overview of the final sector list, which includes a wide variety of occupational and organizational groups in the broader economy that the subcommittee considers important to engage. The subcommittee developed sector templates, which describe how health is relevant to each respective sector, to serve as resources to begin purposeful conversations with stakeholders from sectors outside of health and ultimately engage them in the Healthy People 2030 process. In particular, these templates aim to move engagement beyond aspects of the medical system—such as health insurance, which is relevant to the majority of the sectors—toward prevention and overall health.

Dr. Halverson presented revised recommendations on approaches to engagement, sector information sheets, and engagement with a variety of sectors. He acknowledged that some aspects of the recommendations address processes that have already taken place, but reiterated that the purpose of the recommendations overall is to engage multiple sectors in various stages of the Healthy People 2030 development process. He reminded the Committee that the inclusion of "well-being" in Recommendation 2 was a discussion point during the last Committee meeting, and the subcommittee believes that it is consistent with previous decisions to integrate well-being into the fabric of Healthy People 2030. He explained that Recommendations 4a through 4c indicate the importance of engaging stakeholders during early stages so that they can be integrated into the development process, rather than waiting until everything is complete and then attempting to convince stakeholders how Healthy People 2030 applies to their work.

- **Recommendation 1:** Broad engagement should include more than structured public comment periods for testimony or written comment.
- **Recommendation 2:** Adopt a Health and Well-Being in All Policies approach to identify sectors for inclusion in the process.
- **Recommendation 3:** Use the existing sector-specific information sheets in targeted conversations to encourage greater participation of other sectors in developing, disseminating, and using Healthy People. Such activities should yield further insight into how these templates can be used to engage diverse stakeholders.
- **Recommendation 4a:** Healthy People 2030 should proactively engage stakeholders to provide meaningful input on the development of objectives.
- **Recommendation 4b:** Healthy People 2030 topic area workgroups should include representatives from other sectors and should engage other sectors.

- **Recommendation 4c:** Healthy People 2030 topic area workgroups should meaningfully engage with the public during the development process. Such engagement should include involving other sectors in the development of Healthy People 2030 objectives.

Committee Discussion

Mr. Teitelbaum commented that, apart from the criminal justice and public safety sector template, the civil legal sector was missing from the sector list. He indicated that this sector is critical to moving upstream of health outcomes. He described 3 relevant subsectors: civil legal aid, which helps individuals with social determinants of health problems; national law firms, which have pro bono programs that could address underlying legal causes of poor health; and more broadly, general counsel, health organizations, health systems, and other large corporations in non-health sectors.

Addressing another aspect of the sector list, Dr. Zohoori suggested separating identity-based organizations and faith-based organizations. He stated that they represent 2 different sectors, especially given increasing immigration and growing minority populations.

Dr. Goekler asked whether the subcommittee would accept additional input from Committee members on templates for sectors that relate to their respective areas of expertise. Dr. Halverson replied that their input was welcome, indicating that the templates are still a work in progress.

Dr. Fielding suggested that the reference to "Health in All Policies" in Recommendation 2 include programs and systems change, reminding the Committee that policy is not the only mechanism that may influence change.

Dr. Richmond suggested that Recommendations 4a and 4c include an operational definition of "meaningful," potentially as a footnote. With regard to Recommendation 4c, she proposed that topic area workgroups include representatives from sectors outside of health. Dr. Richmond also suggested that recommendations addressing objectives also apply to developmental and research objectives, not just those in the core.

Dr. Wrenn Gordon recognized that some recommendations relate to processes that have already taken place, but she expressed that the Committee should consider opportunities to apply the recommendations moving forward in the Healthy People 2030 process, such as during any development processes yet to come or during implementation. Dr. Pittman indicated that the Implementation subcommittee will likely continue the work of the Stakeholder Engagement and Communications subcommittee.

Dr. Pittman suggested that the Committee be mindful of the geographic spread of stakeholders that engage with Healthy People 2030 so as to ensure that the objectives ultimately serve the entire Nation and do not disregard regions that are traditionally underserved.

Dr. Halverson reminded the Committee that, while stakeholder engagement will enrich Healthy People 2030, the development and implementation processes may become less streamlined and less efficient as more stakeholders are involved. Dr. Gómez shared that this was true of the robust stakeholder engagement in Healthy People 2020; she suggested that the Committee explore how stakeholders were engaged and whether or not that engagement changed process outcomes for Healthy People 2020, and what the Committee wants to accomplish for Healthy People 2030. Dr. Halverson also suggested

stakeholder engagement shift away from simply tallying which special interests are represented toward thoughtfully incorporating different points of view.

Committee Vote

The Committee approved Recommendations 1 through 4c, as amended and/or described below, by unanimous vote.

- **Recommendation 1:** Broad engagement should include more than structured public comment periods for testimony or written comment.
- **Recommendation 2:** Adopt a Health and Well-Being in All Policies, Programs and Systems approach to identify sectors for inclusion in the process.
- **Recommendation 3:** Use the existing sector-specific information sheets in targeted conversations to encourage greater participation of other sectors in developing, disseminating, implementing, and using Healthy People. Such activities should yield further insight into how these templates can be used to engage diverse stakeholders.
- **Recommendation 4a:** Healthy People 2030 should proactively engage stakeholders to provide meaningful input on the development of objectives.
- **Recommendation 4b:** Healthy People 2030 topic area workgroups should include representatives from other sectors and those within government, and should engage other sectors and those within government.
- **Recommendation 4c:** Healthy People 2030 topic area workgroups should meaningfully engage with the public during the development and implementation processes. Such engagement should include involving other sectors in the development of Healthy People 2030 objectives.

Beyond specific edits that the Committee agreed upon, the approval of the recommendations are contingent upon the follow changes to be made by the subcommittee:

- Provide an operational definition of "meaningful," as included in Recommendations 4a and 4c.
- Include civil legal sector in the sector list.
- Rephrase "identity groups" for clarity and specificity.
- Reference geographic representation.
- Include core, developmental, and research objectives in relevant recommendations.

Implementation Subcommittee

11:25 a.m. – 12:10 p.m.

Dr. Pittman reviewed the charge of the Implementation subcommittee, which is to provide advice and guidance on approaches to implement Healthy People 2030 before, during, and after its launch. She then presented the subcommittee deliverables and timeline to the Committee, indicating that the subcommittee has begun to consider how they will build on the recommendations from other subcommittees. Dr. Pittman shared that the subcommittee is open to inviting individuals to advise on issues for which they do not have expertise and involve sectors that are not already represented. The subcommittee expects to organize implementation activities chronologically: pre-launch, during launch, and post-launch. Dr. Pittman reviewed recommendations from the Social Determinants of Health and

Health Equity, Prioritization, Data, and Stakeholder Engagement and Communications subcommittees, noting when they would be applicable relative to launch.

Dr. Pittman shared that the subcommittee is interested in learning about implementation successes and challenges in past iterations of Healthy People to inform the development of the subcommittee's implementation recommendations. Since technology has advanced in the past decade, Dr. Pittman shared that there may be new tools available to support different strategies. She described the Healthy People 2020 user study conducted in 2015, which indicated that smaller organizations were less aware of Healthy People 2020 and less likely to have the tools to integrate it into their work; she stressed the importance of developing low-cost strategies for low-resource groups. Dr. Pittman referenced presentations on implementation successes by various Healthy People 2020 topic area workgroups. The Tobacco Use topic area workgroup emphasized the importance of a strong social media presence, comprehensive branding of materials, easily accessible brochures and infographics, and tech-savvy features (QR codes, links to data, etc.); the Social Determinants of Health topic area workgroup shared implementation strategies related to intergovernmental collaboration and effective interface with stakeholders outside of government.

Dr. Pittman reviewed the subcommittee's next steps. The Implementation subcommittee's Engagement Crosswalk document will be updated to integrate sector recommendations from the Stakeholder Engagement and Communications subcommittee; this is expected to be completed in September 2018. Throughout September and October of 2018, the subcommittee will identify potential sector presentations for future meetings. Afterward, they will develop proposed Healthy People 2030 implementation recommendations through January 2019, and then they will develop Healthy People 2030 implementation process recommendations through March 2019.

Health Equity Brief Subcommittee: Review and Discussion of the Brief
1:55 p.m. – 2:25 p.m.

Dr. Wrenn Gordon presented an updated version of the Health Equity brief, with revisions made in accordance with Committee discussion on September 6, 2018. In the introduction, the subcommittee included language from the Healthy People 2030 framework to address concerns from Committee members that the framework was not clear in the previous version. Additionally, the subcommittee added an introduction to health equity. Within this section, they added an RWJF graphic that represents the difference between equity and equality. They also reordered the introduction of key terms, including disparities, inequalities, and inequities, because they wanted the terms to build upon each other to make it evident that inequities are avoidable, unfair, and unjust.

The brief then discusses the history of health equity in Healthy People and how the term has been used; this section emphasizes that the concept has evolved over time as knowledge and values have changed. This parallels the shift away from focusing on disease outcomes driven by individual behaviors towards an approach that recognizes the role of historical contextual environments.

The next section describes existing health equity frameworks, and common aspects are listed as bullet points. This section includes graphics from 3 organizations that have customized health equity frameworks. The following section focuses on health equity measurement, which highlights 5 guiding principles. In addition, it includes examples for operationalizing health equity measurement; these represent opportunities to further strengthen the integration of health equity into Healthy People 2030. The subcommittee also revised the brief to emphasize the decision to include health equity as a cross-

cutting theme in Healthy People 2030. The brief includes issues in Healthy People 2020 that should be considered for Healthy People 2030, such as identifying where there are data gaps and areas where there is insufficient information on some determinants.

Committee Discussion

Dr. Richmond requested that the subcommittee bold the sentence "The emphasis on health equity marks a critical shift away from focusing on disease outcomes, which are often attributed to individual behaviors," as this approach should drive how the Committee thinks about Healthy People 2030.

With regard to data considerations, Dr. Pittman raised concerns about recent changes to the U.S. Census that might make it difficult to compile and compare data by race and ethnicity, which may skew data on underrepresented groups; she emphasized the importance of these specific changes because the Census is a fundamental data set. Dr. Kleinman shared that she and Dr. Pronk plan to identify other challenges in the overarching introduction to all of the issue-specific briefs, and can incorporate Census data concerns in that document as well.

Dr. Zohoori suggested that the subcommittee add a graphic to the second example of health equity frameworks in order to balance it with the first and third examples that have graphics. Dr. Gómez indicated that it was removed at the request of Committee members because it was difficult to see; Dr. Wrenn Gordon responded that the subcommittee could edit the graphic's color scheme to make it more visually accessible.

Dr. Halverson raised concern that an individual with little background on Healthy People 2030 may read "Health equity is an overarching goal of Healthy People 2030" and interpret it as the only goal of Healthy People 2030. He also expressed concern that outside the health sector, people may not understand that health equity inherently suggests health improvement. Dr. Pittman suggested that the subcommittee could edit the statement to read, "Health equity is one of the overarching goal**s** of Healthy People 2030" to avoid confusion.

Dr. Goekler reminded the Committee that determinants of health are no longer included in the brief, and expressed concern about losing an opportunity to address them. Dr. Kleinman shared that determinants of health will likely be discussed in the introduction to all of the issue-specific briefs and will be thematically present throughout all of the briefs.

Committee Vote

The revised version of the issue brief was unanimously approved pending revisions agreed upon by the Committee, which have been described below. Dr. Sondik and Dr. Fielding were not present during the vote on September 7, 2018.

- Bold the statement "The emphasis on health equity marks a critical shift away from focusing on disease outcomes, which are often attributed to individual behaviors."
- In both the Health Equity brief and the introduction to all of the issue-specific briefs, indicate that recent changes to Census data collection practices have implications for health equity by skewing data on underrepresented groups.
- For the second example of frameworks, include a revised version of the accompanying table graphic; remove the purple color from the table background.

- Clarify that health equity is one of multiple overarching goals for Healthy People 2030, not the only overarching goal.

Committee Discussion: Implementation and Approach for Developing Implementation Recommendations

2:25 p.m. – 2:50 p.m.

Dr. Shah proposed that the Implementation subcommittee consider how to empower topic area workgroups to enthusiastically take ownership of implementation activities, since they are already heavily involved with the objectives. Dr. Pittman suggested that the Committee could work to identify barriers that past Healthy People non-users faced in order to inform development of future implementation efforts.

Dr. Richmond asked for clarification on what constitutes the "during" stage of implementation. Ms. Ochiai responded that "during" refers to the rollout of different key elements, such as the objectives, the framework, and the website; the rollout of all components could occur in a single instance or over the course of a month. Ms. Ochiai confirmed that the Implementation subcommittee could provide recommendations on the timeline of rollout phasing, with the exception of the rollout of certain components that are already decided by ODPHP, such as the decision to roll out objectives between January and March of 2020 and the release of LHIs. Dr. Wrenn Gordon commented that she found the terms "pre-," "during," and "post-launch" to be unhelpful and preferred to refer to sequential phases; Ms. Ochiai affirmed that was acceptable.

Dr. Goekler indicated that the subcommittee should consider the different sector networks that cross through the Committee as a whole, such as her own connections to education or Mr. Teitelbaum's connections to the legal sector, and how the government can leverage those channels during implementation and dissemination. Dr. Pittman responded that the subcommittee may consider creating task forces to support the government's implementation strategies.

Dr. Kleinman suggested that the subcommittee consider Healthy People 2030 to be a living document and consider the potential for it to be modified or for it to evolve over the course of the decade, possibly to allow course correction. She indicated that the subcommittee could start by learning more about the midcourse review process.

Dr. Richmond recommended that the subcommittee identify the implementation best practices from previous iterations of Healthy People. Ms. Ochiai responded that the FIW surveyed all Healthy People 2020 implementation activities, including evaluations of sustainability and resource allocation; assessed them to identify the best and worst activities; and picked the top 5 considerations to share with the Implementation subcommittee for Healthy People 2030.

Dr. Gómez emphasized that the subcommittee should ensure implementation efforts are new and innovative, particularly in the context of rapidly evolving technology. Dr. Pittman responded that the subcommittee has been considering new approaches to data science and new ways to analyze data, in addition to gamification, simulations, virtual reality, and new learning models. Dr. Wrenn Gordon indicated that innovation could be grounded in health equity, and suggested that the subcommittee should consider how to eliminate disparities in implementation. Dr. Pronk reminded the subcommittee

that they should balance keeping up with accelerating changes in technology with ensuring approaches are reliable and effective.

Other Committee suggestions are listed below:

- Explore how to engage the FIW in implementation and leverage their relationships with governmental agencies and other public health organizations.
- Ensure that implementation efforts include robust engagement with practice-based organizations.
- Thoughtfully consider how more recommendations from other subcommittees are relevant to the pre-launch stage, since implementation requires a lot of planning.
- Segment implementation efforts in order to tailor strategies to different sub-populations, such as those defined by age, educational attainment, or language.
- Recognize resource constraints, given recent cuts to funding for prevention activities.
- Evaluate not only Healthy People 2030 outcomes but also the implementation process itself; evaluation planning should ideally occur in the beginning stages and it could be informed by previous implementation successes and challenges.
- Determine whether implementation should incorporate sustainability.
- Explore opportunities to engage with implementation science specialists
- Determine how to obtain and vet resources from other agencies or organizations, as opposed to everything coming from the Healthy People 2030 program itself.
- Consider an intergovernmental assessment of data-related capabilities and capacity to support the implementation of Healthy People 2030.

Subcommittee Retirement

2:50 p.m.

The Committee voted unanimously to retire the following subcommittees:

- Complex System Science and Modeling Brief
- Health and Well-being Brief
- Health Equity Brief
- Health Literacy Brief
- Health Promotion Brief
- Law and Health Policy Brief
- Stakeholder Engagement and Communications
- Summary Measures Brief

Summary of Day 2

2:50 p.m. – 2:55 p.m.

Dr. Kleinman summarized the presentations from the second day of the meeting, including remarks from Dr. Adams and a presentation on the work of the NCHS. She noted that the Committee approved the Health Equity brief, which was revised based on the previous day's discussion, and that recommendations on stakeholder engagement and communications were approved. Additionally, the Implementation subcommittee summarized their approaches and actions to date, and the Committee discussed issues and questions related to implementation moving forward. The subcommittees on issue-

specific briefs and Stakeholder Engagement and Communications were disbanded, and a new Objective Review Subcommittee was officially formed. Dr. Kleinman thanked the Committee members and ODPHP staff for their work over the last 2 days of the meeting and thanked members of the audience for their attendance.