DEVELOPING HealthyPeople 2030

Secretary's Advisory Committee on
National Health Promotion and Disease Prevention Objectives for 2030
Sixth Meeting: October 16, 2017, 1:00 p.m. – 3:00 p.m. ET, via webinar

Co-chairs

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

Chair Emeritus

- Jonathan Fielding, MD, MPH, MA, MBA

Members

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

Committee Recommendations Approved by Vote

Recommendation 1: Healthy People 2030 should offer users the flexibility to array objectives according to different interests or dimensions. As one example, the organization of Healthy People 2030 could offer analysis by age group across the life course. It could also be organized by several other approaches, such as by: general domain (social environment, physical environment, behavior, clinical), intervention type (policy, education, clinical, system, etc.), risk factors, disease or injury, or target audience (business, schools, states, local government, federal government, clinical care system, non-profit health-interested organizations, etc.).

> Recommendation approved by unanimous vote.

Recommendation 2: The U.S. Department of Health and Human Services (HHS) should use a blended, public-private approach to prioritizing and objective setting. For some topics, the preferred approach should involve leadership and coordination from a Federal Interagency Work Group (FIW), but with meaningful involvement from relevant private organizations. For others, it would be preferable to have private-sector organizations provide leadership and coordination, but with involvement of appropriate federal organizations. We also recommend that HHS, working with FIW, develop guidelines for how to distribute responsibilities in a manner that builds on the strength of both the public and private sectors, and promotes efficiency and transparency.

> Recommendation approved by unanimous vote pending refinement of the language regarding public and private sectors to clarify that the recommendation is inclusive of a broader range of sectors, including non-profit organizations.

Recommendation 3: The following 10 criteria should be taken into consideration when commenting on the proposed objectives or suggesting additional ones. Weighting of criteria may differ depending upon

the topic area. For most objectives all criteria are relevant, but for others not all criteria are relevant.

- The result to be achieved should **reflect issues of national importance** and **support the Healthy People 2030 goals**. Federal agencies, states, localities, non-governmental organizations, and the public and private sectors should be able to use objectives to direct efforts in schools, communities, work sites, health practices, and other environments.
- Objectives **should be measurable**; when a baseline has been established they should have a quantifiable measure of progress, and when the objectives are developmental, they may establish a baseline and interim measures of progress (i.e., specifying how much movement toward the objective is expected at different points in time over the 2020–2030 decade to understand the degree of progress).
- Objectives should be **useful and understandable** to a broad audience.
- The objective selection and review processes should be flexible enough to **allow revisions to objectives that reflect major updates or new knowledge**. If an important objective does not have any evidence of improvement through an effective intervention, it should become a prioritized research agenda item. Decisions about maintaining or archiving an objective should not be determined by whether it has met its target in a previous Healthy People iteration.
- **Objectives should address a range of issues** such as: behavior and health outcomes; availability of, access to, and content of behavioral and health service interventions; socio-environmental conditions; and community capacity.[1] They should be **directed toward improving health and well-being outcomes and quality of life** across the life span.
- Objectives should be **prevention and protection oriented**, with quantitative (measurable) measures achievable by 2030 through population-based and individual actions that affect policy, health, and medical care systems, infrastructure, and/or programs.
- The objectives should be **supported by scientific evidence that the quantifiable measure is achievable OR evidence that we can move toward it**.
- Objectives should **address health inequities and health disparities in defined populations**. These include populations categorized by race/ethnicity, socioeconomic status, gender, disability status, sexual orientation, and geographic location. For specific health issues, additional special populations should be addressed, based on an examination of the available evidence on vulnerability, health status, and disparate care.
- Healthy People 2030, like past versions, is heavily data driven. **Valid, reliable, representative data and data systems at the national, state, tribal, and community levels should be used** for Healthy People 2030 objectives. Each regular objective must have 1) an identified data source, or potential data source, 2) baseline data, and 3) assurance of at least 1 additional data point (a total of at least 3 data points) throughout the decade. One additional data point (in addition to the 2 that are required) is recommended, but not required.
- **Address social determinants of health**[2] wherever they impact attainment of health objectives.

  Recommendation approved by unanimous vote pending revision to the criterion on valid, reliable, representative data and data systems, which will be reworded to clarify that while annual data is ideal, 3 total data points are required (baseline data plus 2 additional data

[1] Community capacity is defined as the ability of a community to plan, implement, and evaluate health strategies.
[2] As explained by Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And What Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017, page 3. (in this context, "Health means physical and mental health status and well-being, distinguished from health care.")

points), and in certain situations 1 data point can be from the previous decade, so long as it is comparable (parallel to Recommendation 3B from the Data subcommittee report).

Recommendation 4.1: Healthy People 2030 objectives should include quantifiable measures of progress that employ best current knowledge to estimate what can be achieved, and how quickly, for systematically identified opportunities.

Recommendation approved by unanimous vote.

Recommendation 4.2: Healthy People 2030 should not be a static document, but should be subject to revisions based on new knowledge and experience in efforts to achieve defined objectives.

Recommendation approved by unanimous vote.

Recommendation 5.1: Identify core, developmental, and research objectives to include in Healthy People 2030.

Recommendation approved by unanimous vote.

Recommendation 5.2: HHS, through its many agencies, needs to play an enhanced role in helping stakeholders meet the Healthy People objectives. It should prioritize financial and policy support for activities that, based on the best evidence, have a high likelihood of improving measurable outcomes. It should assure alignment of Healthy People 2030 objectives with the responsibilities and accountability of all its agencies and support the identified priority developmental and research needs. HHS should also explore whether the priorities and activities of other advisory bodies are consistent with this recommendation, if such an activity would be permissible under FACA regulations.

Recommendation approved by unanimous vote.

Action Items

1. The Prioritization and Objective Selection Criteria subcommittee will revise its approved recommendations to reflect Committee discussion.
2. Committee members interested in participating in the Leading Health Indicators subcommittee will email Dr. Pronk and Dr. Kleinman.

Welcome
1:00 p.m. – 1:05 p.m.

Ms. Carter Blakey thanked the Committee members and meeting attendees for joining the sixth meeting of the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. Ms. Blakey reviewed the agenda for the meeting, which included a presentation from Dr. Jonathan Fielding on behalf of the Prioritization and Objective Selection Criteria subcommittee.

Goals for the Meeting
1:05 p.m. – 1:10 p.m.

Dr. Nico Pronk provided an overview of the goals for the meeting. Dr. Fielding will present the Prioritization and Objective Selection Criteria subcommittee's charge and its recent work. Dr. Fielding will then discuss the subcommittee's report, including its recommendations, priorities, proposed methods, and underlying rationale. Dr. Fielding will moderate Committee discussion of the subcommittee report, and Dr. Dushanka Kleinman will facilitate a vote on each recommendation.

Presentation on Prioritization and Objective Selection Criteria Subcommittee Recommendations from Jonathan Fielding, MD, MPH, MBA, MA
1:10 p.m. – 1:25 p.m.

Dr. Fielding, chair of the Prioritization and Objective Selection Criteria subcommittee, gave an update on the subcommittee's work since the September Committee meeting. The charge of the subcommittee is to identify criteria to be used in prioritizing and setting quantifiable objectives, and consider how to reduce the overall number of measurable objectives.

During the September Committee meeting, the Committee voted to approve the prioritization criteria, listed as Recommendation 2 in the September 17, 2017, draft of the report and listed as Step 3B in the current proposed approach. Following the September Committee meeting, the subcommittee revised their proposed recommendations based on Committee feedback during the October 3, 2017, subcommittee meeting and through extensive email discussions. In addition to revising the language of the recommendations and criteria, the subcommittee has developed a step-wise approach that applies the criteria for proposing and selecting objectives.

Dr. Fielding provided on overview of the subcommittee recommendations:

- A step-wise approach should be used to prioritize and select Healthy People 2030 objectives.
- Healthy People 2030 should offer users the flexibility to array objectives according to different interests or dimensions.
- HHS should use a blended, public-private approach to prioritizing and objective setting.
- Ten criteria (listed below) should be taken into consideration when commenting on the proposed objectives or suggesting additional ones.
- Healthy People 2030 objectives should include quantifiable measures of progress that employ best current knowledge to estimate what can be achieved, and how quickly, for systematically identified opportunities.
- Healthy People 2030 should not be a static document, but should be subject to revisions based on new knowledge and experience in efforts to achieve defined objectives.
- Identify both core objectives and research objectives to include in Healthy People 2030.
- Healthy People 2030 should identify priorities and opportunities by applying a prioritization framework, generalizable to and useable by all target audiences.
- HHS, through its many agencies, needs to play an enhanced role in helping stakeholders meet the Healthy People objectives.

Dr. Fielding introduced the proposed step-wise approach for prioritizing and selecting objectives for Healthy People 2030. Dr. Fielding noted that the Committee is charged with providing guidance to the HHS Secretary, and added that the recommendations of the Committee can be adapted for use by stakeholders at other levels, such as states and localities.

Dr. Fielding provided an overview of the proposed step-wise approach. First, decisions are made on topics that can be used to organize objectives, and topic working groups are convened with federal and non-federal stakeholders. Next, a list of preliminary objectives is developed by considering overarching issues for Healthy People 2030; this list of preliminary objectives is refined by applying quality control criteria. The refined list of objectives is then categorized into 3 groups of objectives: core, research, and developmental. The list of core objectives is then prioritized by consistently applying a limited number of criteria.

Dr. Fielding further discussed each step of the process for prioritizing and selecting objectives for Healthy People 2030.

Step 1: Decide how the objectives should be organized
The first task is to compile a list of topics that can be used to organize the objectives. While there is no one, correct way to organize the objectives, options for an organizing framework might include:

- Revising and updating the list of topic areas from Healthy People 2020
- Offering analysis by developmental stage over the life course (e.g., infancy, childhood, adolescence, adulthood, and old age)
- General domain (e.g., social environment, physical environment, behavioral, clinical)
- Intervention type (e.g., policy, education, clinical, system, etc.)
- Disease or injury risk factors (e.g., physical inactivity, living in high crime neighborhoods)
- Target audience (e.g., business, schools, states, local government, federal government, clinical care system, non-profit health-interested organizations, etc.)

The list of topics for Healthy People 2030 objectives must be refined to reflect the "most important" aspects of health, based on reducing deaths, reducing morbidity, reducing disability, reducing health disparities/increasing health equity, and increasing well-being. Stakeholder organizations such as national non-profits or associations must also be recruited to participate in topic workgroups and in objective development.

Step 2: Develop and refine the set of objectives
Topic workgroups should develop a preliminary set of objectives; however, the list of topic objectives for Healthy People 2030 should not mirror Healthy People 2020 objectives. Workgroups should add, subtract, and modify objectives from the Healthy People 2020 list as appropriate. Some quantifiable measures from Healthy People 2020 may deserve more attention this decade (e.g., because the burden has increased), while some quantifiable measures may deserve less attention this decade (e.g., because no evidence-based intervention is available to drive progress). At this stage, involved parties must consider whether the objective addresses an issue of national importance, and whether it is quantifiable.

Next, a central decision-making body such as FIW should refine the preliminary list of objectives by answering the following questions:

- Is the objective understandable?
- If an objective from Healthy People 2020 is selected, does it reflect major updates or new knowledge?
- Does the set of objectives address a range of issues across topics? For example:
    - Behavior and health outcomes; behavioral and health service interventions (availability, access, content); social determinants of health; and community capacity
- Does the objective meet the following quality control criteria for Healthy People 2030?

- Be **prevention and protection oriented**
- Be **supported by scientific evidence** that the quantifiable measure is achievable OR evidence that significant progress can be made toward it
- **Address health inequities and health disparities** in defined populations, including those categorized by race/ethnicity, socioeconomic status, gender, disability status, sexual orientation, and geographic location
- Use **valid, reliable, representative data** and data systems at the **national, state, and community levels**
- **Address social determinants of health** wherever they impact attainment of objectives

Step 3: Categorize objectives to develop 3 lists
The refined, prioritized list of objectives will then be categorized into 3 groups: core objectives, research objectives, and developmental objectives. Each core objective must have an identified data source or potential data source, baseline data, and assurance of at least 2 additional data points over the course of the decade. Research objectives should reflect high-priority issues for which no effective intervention is readily available. Developmental objectives should reflect high-priority issues that do not meet the data standards for inclusion as a core objective, but are associated with effective evidence-based interventions. When objectives are developmental, a baseline and interim quantifiable measures of progress should be established.

Finally, the refined set of core objectives will be prioritized based on each objective's expected impact (e.g., high, medium, or low benefit) on overall health burden, preventable burden, potential to reduce inequities/disparities, and cost effectiveness and prevention effectiveness.

The high-priority core objectives will constitute the final set of objectives for implementation of Healthy People 2030. These will be centrally managed by the topic workgroups and FIW. Medium-priority core objectives may be overseen by HHS, but managed by public, independent, and private-sector national stakeholder organizations through formal partnerships. The purpose of such partnerships will be to catalyze progress on issues that may not score as highly based on impact or priority, but that warrant national attention.

Committee Discussion
1:25 p.m. – 1:40 p.m.

Dr. Fielding thanked the members of the subcommittee for their work on the development of the recommendations and opened the floor for comments. Dr. Paul Halverson noted that Step 1B discusses recruiting national non-profits and associations. He suggested adding that stakeholder organizations should represent multiple sectors where possible in order to engage a broader audience. Dr. Fielding agreed; the report highlights cross-cutting issues such as social determinants of health, but making the multi-sector approach explicit would be helpful.

Dr. Halverson asked how the subcommittee decided to recommend 2 additional data points over the course of the decade. He noted that the Committee had previously emphasized that the data be available, timely, and actionable, yet 2 or 3 data points over a decade may not be frequent enough to be timely and actionable. Dr. Fielding agreed, and noted that requiring 2 data points in addition to a baseline data point is not ideal, but would be an absolute minimum when deciding whether a topic would be a core objective rather than a developmental objective. Dr. Edward Sondik added that the Data subcommittee's report emphasizes the importance of data as a measure of progress and to inform

changes in strategy throughout the decade; thus, the subcommittee is recommending annual data collection if possible, but recognizes that not all objectives will have annual data. Dr. Sondik added that requiring 3 data points throughout the decade would allow for meaningful trend analysis. The Prioritization and Objective Selection Criteria subcommittee will clarify this in its report to ensure consistency with the Data subcommittee report.

Dr. Halverson asked how many Healthy People 2020 objectives would be excluded if 3 data points within the decade were required. Dr. Sondik estimated that less than 20% of Healthy People 2020 objectives do not have 3 data points; 38% of Healthy People 2020 objectives have annual data available and a high percentage will have at least 3 data points throughout the decade. He added that a high percentage of Healthy People 2020 objectives come from the National Health Interview Survey (NHIS) and National Vital Statistics System, both of which provide data at least annually. NHIS even provides quarterly information on 15 key health indicators. Some objectives come from the National Health and Nutrition Examination Survey, which provides 3 or 4 data points over the decade. However, the sample size is not large enough to create annual data points.

Dr. Susan Goekler noted that much data on youth is collected by the Youth Risk Behavior Surveillance System, which provides information every other year. For that reason, Dr. Goekler cautioned specifying an annual data requirement for objectives. She also clarified that data does not have to come from HHS sources or from states, particularly regarding social determinants of health data; the Committee should consider a broad range of datasets in determining whether an objective can be considered a core measure. Dr. Fielding agreed, and suggested that the subcommittee can make clear that the data can come from different levels of aggregation, depending on what is available. Dr. Goekler added that data can also come from other national agencies, such as the Department of Education, and Dr. Fielding agreed.

Dr. Mary Pittman emphasized the importance of highlighting rural populations in the subcommittee's recommendations; Dr. Fielding agreed that rurality is an important variable. Dr. Pittman suggested explicitly indicating the intent to look at rural populations within the recommendations, and Dr. Fielding agreed. Dr. Kleinman noted that Morbidity and Mortality Weekly Report (MMWR) has recently published reports that highlight rural and urban metropolitan and non-metropolitan areas. These reports could be used as a reference in future Committee work.

Dr. Pronk suggested that the Data subcommittee crosswalk their report and recommendations with the Prioritization and Objective Selection Criteria subcommittee report, particularly with its recommendations regarding required and suggested data sources. Dr. Fielding noted that Dr. Sondik has provided input on the work of the Prioritization and Objective Selection Criteria subcommittee, and Dr. Sondik offered to do this at an upcoming Data subcommittee meeting. Dr. Kleinman added that the Prioritization and Objective Selection Criteria report is also relevant to the Stakeholder Engagement and Communications subcommittee.

Committee Votes
1:40 p.m. – 2:35 p.m.

Dr. Kleinman proceeded to call a vote on each of the subcommittee's recommendations. The Committee reviewed each recommendation in turn. For some recommendations, additional discussion occurred, as

noted below. In addition, the Committee agreed to some wording changes, reflected in the text of the recommendations below. Red text denotes language added; strikethrough denotes language removed.

Recommendation 1: Healthy People 2030 should offer users the flexibility to array objectives according to different interests or dimensions. As one example, the organization of Healthy People 2030 could offer analysis by age group across the life course. It could also be organized by several other approaches, such as by: general domain (social environment, physical environment, behavior, clinical), intervention type (policy, education, clinical, system, etc.), risk factors, disease or injury, or target audience (business, schools, states, local government, federal government, clinical care system, non-profit health-interested organizations, etc.).

This recommendation was **approved** by unanimous vote.

Recommendation 2: The U.S. Department of Health and Human Services (HHS) should use a blended, public-private approach to prioritizing and objective setting. For some topics, the preferred approach should involve leadership and coordination from a Federal Interagency Work Group (FIW), but with meaningful involvement from relevant private organizations. For others, it would be preferable to have private-sector organizations provide leadership and coordination, but with involvement of appropriate federal organizations. We also recommend that HHS, working with FIW, develop guidelines for how to distribute responsibilities in a manner that builds on the strength of both the public and private sectors, and promotes efficiency and transparency.

Dr. Fielding expressed a desire to refine the language regarding public and private sectors to clarify that the recommendation is inclusive of a broader range of sectors, including non-profit organizations. The alternate phrase "federal–non-federal approach" was suggested, but Committee members decided that it did not adequately convey the breadth of the stakeholders involved. Dr. Kleinman suggested that the final language for this recommendation mirror the language used in the Stakeholder Engagement and Communications subcommittee report.

This recommendation was **approved** by unanimous vote, pending the above clarification.

Recommendation 3: The following ~~9~~ 10 criteria should be taken into consideration when commenting on the proposed objectives or suggesting additional ones. Weighting of criteria may differ depending upon the topic area. For most objectives all criteria are relevant, but for others not all criteria are relevant.

- The result to be achieved should **reflect issues of national importance** and **support the Healthy People 2030 goals**. Federal agencies, states, localities, non-governmental organizations, and the public and private sectors should be able to use objectives to direct efforts in schools, communities, work sites, health practices, and other environments.
- Objectives **should be measurable**; when a baseline has been established they should have a quantifiable measure of progress, and when the objectives are developmental, they ~~should~~ may establish a baseline and interim measures of progress (i.e., specifying how much movement toward the objective is expected at different points in time over the 2020–2030 decade to understand the degree of progress).

Dr. Sondik asked whether developmental objectives lacking identified data sources can be defined as measurable using this definition. Dr. Kleinman agreed to revise this recommendation to read "when the objectives are developmental, they may establish a baseline and interim measures of progress" in order to clarify that developmental objectives can exist without an identified data source. Dr. Kleinman also noted that Recommendations 5.1 and 5.2 refer more directly to developmental objectives.

- Objectives should be **useful and understandable** to a broad audience.
- The objective selection and review processes should be flexible enough to **allow revisions to objectives that reflect major updates or new knowledge**. If an important objective does not have any evidence of improvement through an effective intervention, it should become a prioritized research agenda item. Decisions about maintaining or archiving an objective should not be determined by whether it has met its target in a previous Healthy People iteration.

Dr. Sondik noted that the above criterion is not strictly a criterion but rather speaks to the objective selection process as a whole. Dr. Glenda Wrenn Gordon replied that Recommendation 3 is intended to describe the overall process, and other Committee members agreed.

- **Objectives should address a range of issues** such as: behavior and health outcomes; availability of, access to, and content of behavioral and health service interventions; socio-environmental conditions; and community capacity.[3] They should be **directed toward improving health and well-being outcomes and quality of life** across the life span.
- Objectives should be **prevention and protection oriented**, with quantitative (measurable) measures achievable by 2030 through population-based and individual actions that affect policy, health, and medical care systems, infrastructure, and/or programs.
- The objectives should be **supported by scientific evidence that the quantifiable measure is achievable OR evidence that we can move toward it**.
- Objectives should **address health inequities and health disparities in defined populations**. These include populations categorized by race/ethnicity, socioeconomic status, gender, disability status, sexual orientation, and geographic location. For specific health issues, additional special populations should be addressed, based on an examination of the available evidence on vulnerability, health status, and disparate care.
- Healthy People 2030, like past versions, is heavily data driven. **Valid, reliable, representative data and data systems at the national, state, tribal, and community ~~and local~~ levels should be used** for Healthy People 2030 objectives. Each regular objective must have 1) an identified data source, or potential data source, 2) baseline data, and 3) assurance of at least 1 additional data point (a total of at least 3 data points) throughout the decade. One additional data point (in addition to the 2 that are required) is recommended, but not required.

Dr. Pronk requested that this criterion refer to valid, reliable, representative data and data systems at the tribal level, and suggested that "local" instead be referred to as "community."

[3] Community capacity is defined as the ability of a community to plan, implement, and evaluate health strategies.

Dr. Sondik clarified that each regular objective should have 3 total data points (1 baseline data point and 2 additional data points), as any fewer than 3 data points minimizes the possibility that data can be used to evaluate progress and adjust intervention strategies accordingly.

Committee members also noted that the criterion language needs to be modified to reflect Recommendation 3B from the Data subcommittee's draft report: "To establish reliable trends, data points from a prior decade may be included if those data points are comparable." Though annual data are ideal, 3 data points within the decade are desirable; however, in certain situations 1 data point may be from the previous decade.

This criterion will be clarified with language from the Data subcommittee report.

- **Address social determinants of health**[4] wherever they impact attainment of health objectives.

This recommendation was **approved** by unanimous vote, pending the above clarifications.

Recommendation 4.1: Healthy People 2030 objectives should include quantifiable measures of progress that employ best current knowledge to estimate what can be achieved, and how quickly, for systematically identified opportunities.

This recommendation was **approved** by unanimous vote.

Recommendation 4.2: Healthy People 2030 should not be a static document, but should be subject to revisions based on new knowledge and experience in efforts to achieve defined objectives.

This recommendation was **approved** by unanimous vote.

Recommendation 5.1: Identify ~~both core objectives and~~ core, developmental, and research objectives to include in Healthy People 2030.

Dr. Goekler suggested that this recommendation be inclusive of developmental objectives in addition to core and research objectives, and the Committee members agreed.

This recommendation was **approved** by unanimous vote, pending the above clarification.

Recommendation 5.2: HHS, through its many agencies, needs to play an enhanced role in helping stakeholders meet the Healthy People objectives. It should prioritize financial and policy support for activities that, based on the best evidence, have a high likelihood of improving measurable outcomes. It should assure alignment of Healthy People 2030 objectives with the responsibilities and accountability of all its agencies and support the identified priority developmental and research needs. HHS should also

[4] As explained by Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And What Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017, page 3. (in this context, "Health means physical and mental health status and well-being, distinguished from health care.")

explore whether the priorities and activities of other advisory bodies are consistent with this recommendation, if such an activity would be permissible under FACA regulations.

Mr. Joel Teitelbaum and Dr. Sondik asked whether this recommendation refers to HHS's "enhanced role" compared to its previous involvement with Healthy People. Dr. Kleinman clarified that the word "enhanced" is meant to communicate importance rather than indicate that HHS has been less involved in prior decades. No changes were made to this recommendation.

This recommendation was **approved** by unanimous vote.

Meeting Summary: Recommendations, Action Items, and Next Steps
2:35 p.m. – 2:45 p.m.

Dr. Pronk discussed the Committee's plans to establish a Leading Health Indicator (LHI) subcommittee, and asked Committee members to volunteer to lead and/or participate in it. The LHI subcommittee will be charged with developing recommendations regarding the criteria for selecting LHIs, which are drawn from Healthy People objectives to communicate the highest-priority health issues. The LHI subcommittee will lead a pre-report discussion in December 2017 and will aim to complete its report for Committee discussion by the end of February 2018.

Dr. Sondik asked whether the effectiveness of the Healthy People 2020 LHIs has been assessed; Ms. Blakey replied that the Healthy People 2020 LHIs have been disseminated through many communication avenues, including webinars and bulletins, and noted that their uptake seems to have increased this decade compared to last. Data on the LHIs can be found in the Healthy People 2020 Midcourse Review and in monthly webinars.

Dr. Therese Richmond asked if the Committee envisions any subcommittees' work ending in the near future; she noted that the Approaches subcommittee is likely nearing completion of their work. Dr. Richmond and Dr. Goekler volunteered to participate in the LHI subcommittee. Other interested Committee members should email Dr. Pronk.

The Committee will convene next via webinar in early December 2017 to discuss the recommendations of the Approaches subcommittee; updates from the LHI subcommittee; and 4 briefs currently being drafted on well-being, health literacy, health equity, and law and policy.

Meeting Adjourned
2:45 p.m.