

## Healthy People 2030 and the Leading Health Indicators February 25, 2021

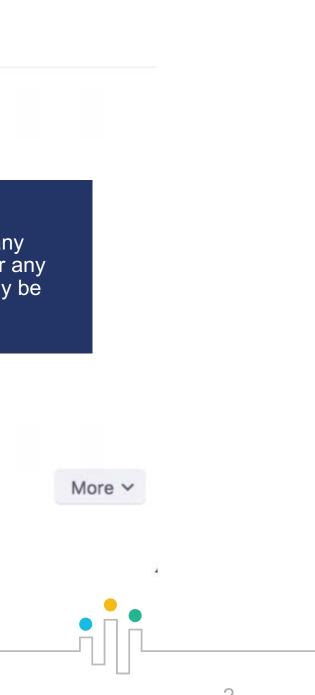




# Webinar Logistics

Q&A All questions (1) My questions	~	Chat
Lee 01:54 PM		
Will there be a follow-up session?		
Comment	commen	se this space to share any ts and resources, and/or ar gical challenges you may b cing
Q&A Box Please use this feature to type questions at any point during webinar for the panel to addre	the	
Type your question here		veryone -







## **Carter Blakey**

Deputy Director, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services







# **Today's Presenters**



## **Peter Holtgrave**

Senior Director, Public Health Infrastructure and Systems, National Association of County

and City Health Officials



## Vicki Collie-Akers, PhD, MPH Associate Professor, Department of Population Health, Kansas Health Foundation Professor of Public Health Practice, University of Kansas Medical Center



### **RADM** Paul Reed, MD

**Deputy Assistant Secretary for** Health, Director of the Office of **Disease Prevention and Health** Promotion, U.S. Department of Health and Human Services





## **Peter Holtgrave**

Senior Director, Public Health Infrastructure and Systems, National Association of County and City Health Officials







## **RADM** Paul Reed, MD

**Deputy Assistant Secretary for Health,** Director, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services







# What is Healthy People?

- Provides a strategic framework for a national prevention agenda that communicates a vision for improving health and achieving health equity.
- Identifies science-based, measurable objectives with targets to be achieved by the end of the decade.
- Requires tracking of data-driven outcomes to monitor progress and to motivate, guide, and focus action.
- Offers model for international, state, and local program planning.
- Represents collective input from federal, state, local, public, private stakeholders.







# Healthy People 2030 Framework - Vision & Mission

## Vision

 A society in which all people can achieve their full potential for health and well-being across the lifespan.

## Mission

• To promote, strengthen, and evaluate the nation's efforts to improve the health and well-being of all people.











# **Healthy People 2030 Goals**

- Attain healthy, thriving lives, and well-being free of preventable disease, disability, 1. injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to 2. improve the health and well-being of all.
- 3. Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life 4. stages.
- Engage leadership, key constituents, and the public across multiple sectors to take 5. action and design policies that improve the health and well-being of all.





## Healthy People Social Determinants of Health Framework











# Healthy People 2030 and COVID-19



## Healthy People 2030 sets a

shared vision to improve the nation's health. Because of COVID-19, that's now more important than ever.

Healthy People 2030 COVID-19 custom list https://health.gov/healthypeople/custom-list?list=odphps-covid-19-custom-list









## Healthy People 2030 and COVID-19

Increase the proportion of people with health insurance — AHS-01

Increase the proportion of adults with broadband internet — HC/HIT-05

Increase the proportion of state public health agencies that are accredited — PHI-01

Increase the proportion of local public health agencies that are accredited — PHI-02

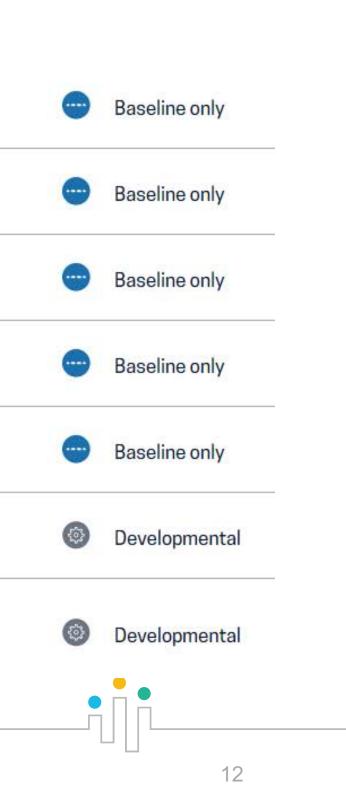
Increase the number of tribal public health agencies that are accredited — PHI-03

Increase the proportion of people who donate blood - BDBS-DO1

Increase the number of individuals trained globally to prevent, detect, or respond to public health threats — GH-D01







# **Evolution of Healthy People Objectives**







# Healthy People 2030

# HEALTHY PEOPLE 2030

### **355 objectives**



## Healthy People 2030 Objective Types

### **Core Objectives**

- Measurable objectives with valid, reliable, nationally representative data, including baseline data and targets for the decade.
- Reflect high-priority public health issues and are associated with evidence-based interventions.

### **Developmental Objectives**

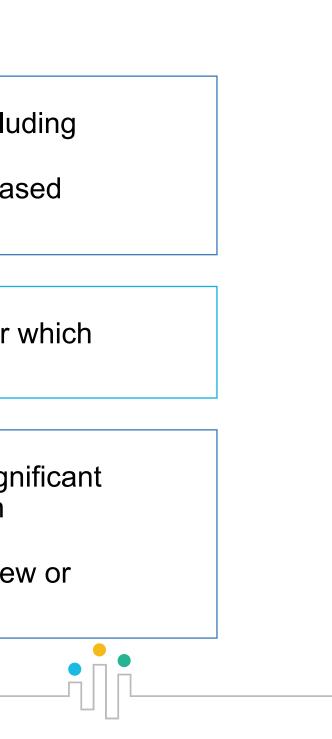
 Represent high priority issues that do <u>not</u> have reliable baseline data, but for which evidence-based interventions have been identified.

### **Research Objectives**

- Represent public health issues with a high health or economic burden or significant disparities between population groups — but they aren't yet associated with evidence-based interventions.
- Require more research to build a stronger evidence base and may reflect new or emerging health issues.







# Healthy People 2030 Objectives & Measures

### Vision

A society in which all people can achieve their full potential for health and well-being across the lifespan.

### **Overall Health and Well-Being Measures**

8 broad, global outcome measures intended to assess the Healthy People 2030 vision

### **Core Objectives**

355 measurable public health objectives that have 10-year targets and are associated with evidence-based interventions

### Leading Health Indicators

A small subset of 23 high-priority Healthy People 2030 core objectives selected to drive action toward improving health and well-being

### Developmental Objectives

Public health issues with evidence-based interventions but lacking reliable data

### Research Objectives

Public health issues that are not yet associated with evidence-based interventions







## Healthy People 2030 Leading Health Indicators – Selection Criteria

- Are Healthy People 2030 **Core** objectives
- Focus on upstream measures such as risk factors/behaviors rather than disease outcomes including, prevention
- Address issues of national importance, including leading causes of morbidity and mortality, and alignment with HHS priorities
- Have known evidence-based interventions and strategies to motivate action
- Are able to measure determinants of health, health disparities, and health equity
- As a set, cover the lifespan
- Meet rigorous data requirements







## Healthy People 2030 Leading Health Indicators – Across Life Stages

Consumpti sugars Drug overc	al health care system* ion of calories from added dose deaths to unhealthy air	Hou: Vaco	nicides sehold food insecurity cinations against seasonal enza	Persons who status* Persons with i Suicides *Apply t
Infant deaths	<ul> <li>Children and adolescents</li> <li>4<sup>th</sup> grade reading skills at or above grade attainment level</li> <li>Treatment received for majo depressive episodes</li> <li>Obesity rates</li> <li>Current use of any tobacco products</li> </ul>		Adults and older ad Binge drinking of alcoholic b Adults who meet minimum g strengthening activity Adults who receive a colore Adults with hypertension wh Cigarette smoking Employment among the wor Maternal deaths New cases of diagnosed dia	everages during guidelines for aer ctal cancer scree lose blood pressu
Note: for the fo	ormal full titles of the Leading Health Indic	ators o	to the Healthy People 2030 website	

Note: for the formal, full titles of the Leading Health Indicators, go to the Healthy People 2030 website

- o know their HIV
- n medical insurance\*
- y to most of the life stages
- ig the past 30 days erobic and muscle-
- eening sure is controlled
- lation
- pulation

# **Using Healthy People 2030**

2. Set your own targets

1. Identify needs and priority populations



- Find HP measures and data related to your work
- Set local targets that contribute to national goals

3. Find inspiration and practical tools

- Identify populations most ۲ vulnerable to COVID-19 and other health conditions
- Stay current on the latest data in your community

- Leverage existing resources (i.e., framework, models)
- Look for evidence-based resources and tools





۲

### 4. Monitor national progress



Use HP data as a benchmark Use HP data to inform policy & program planning Monitor how your progress compares to national data



# **Healthy People 2030 Implementation**

- Proposed Implementation Strategies:
  - Webinars
  - Population data, including Leading Health Indicators
  - Frequent data updates and reporting
  - Robust data visualizations
  - Progress Reports (Midcourse Review; Final Review)
  - Stories from stakeholders on Healthy People implementation
  - Enhanced outreach, communication and partner engagement













## Healthy People 2030

# Using Healthy People 2020 to support community health planning

Presented By Vicki Collie-Akers, PhD, MPH, Associate Professor, Kansas Health Foundation Professor of Public Health Practice, Department Of Population Health

NACCHO & DHHS Healthy People 2030 Leading Health Indicators Webinar February 25<sup>th</sup>, 2021



### **Overview**

- Describe the context of public health practice in a mid-sized, Midwest community
- Describe use of the Healthy People 2020 Objectives to inform community health improvement planning







### Background: Douglas County, Kansas

- Located in Northeast Kansas
- Population of 110,000
- Primary community of Lawrence
- Progressive university community
- 40 miles from Kansas City





### Background: Lawrence-Douglas County Public Health



- Mission: To advance policies, practices, and programs that promote health for all, prevent disease, and protect the environment
- One of 105 local health departments in decentralized state of KS
- One of two remaining city-county funded local health departments in KS
- Accredited in 2015
- In a typical year staff size is between 40-45; Annual budget  $\approx$  \$2.5 million





Established the Lawrence-Douglas County Public Health and University of Kansas Academic Health Department in 2013

- Includes partnership principles and an outline of activities
  - Ongoing support for community health assessment and improvement planning efforts
- Includes contract for shared personnel
- LDCPH provides space for faculty and students





Contribute to the evidence-base of what works in public health



44

Build the capacity of the current and future workforce



The University of Kansa

### **Community Health Assessment and Improvement Planning**

- Community Health Assessment and Improvement Planning part of the 10 Essential Public Health Services
- Public Health Accreditation Board (PHAB) requires a community health assessment and plan to be completed every 5 years
- Lawrence-Douglas County Public Health embarked on a new assessment and planning process in 2017





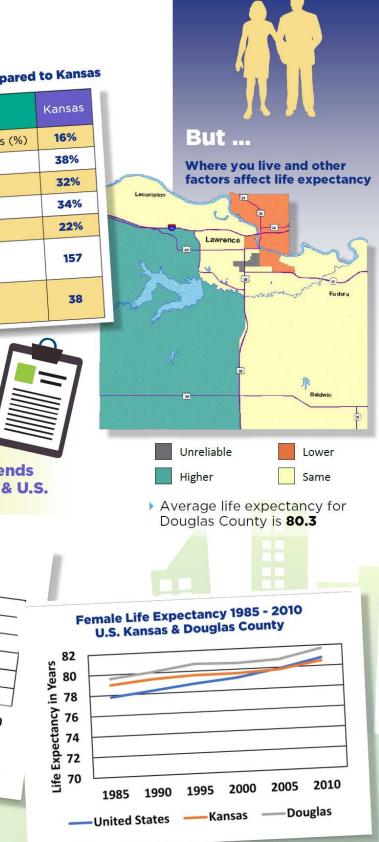
### Community Health Assessment

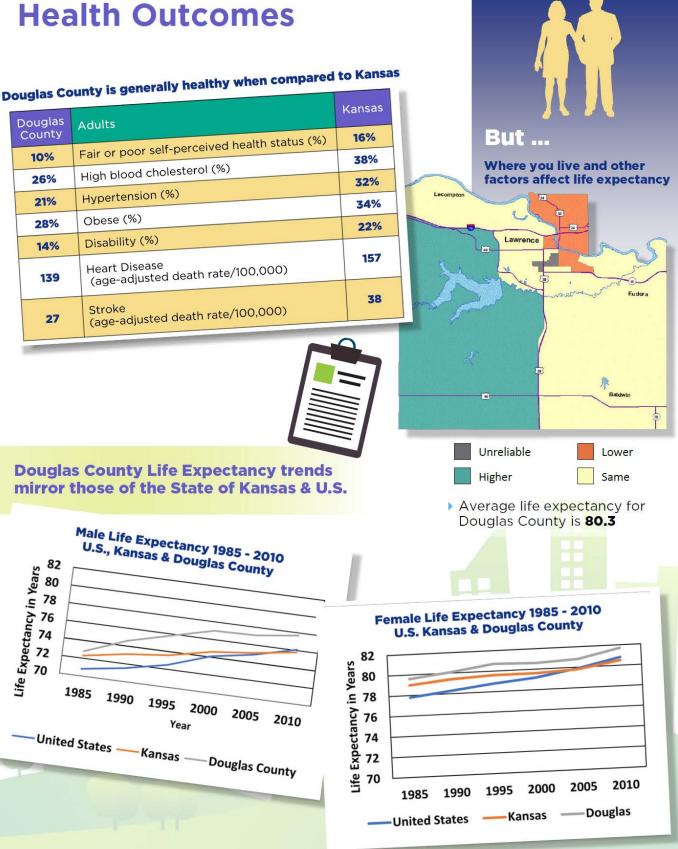
Completion of Community Health Assessment

### Selection of 4 contributing factors + 1 Lens

- Access to health care
- Alcohol, tobacco, and other drugs +Mental Health → Behavioral Health
- Child abuse and neglect
- Discrimination
- Healthy food + Physical activity  ${\color{black}\bullet}$
- Housing •
- Poverty & Jobs  ${\bullet}$

ouglas County is generally healthy when compared					
Douglas County	Adults				
10%	Fair or poor self-perceived health status (%)				
26%	High blood cholesterol (%)				
21%	Hypertension (%)				
28%	Obese (%)				
14%	Disability (%)				
139	Heart Disease (age-adjusted death rate/100,000)				





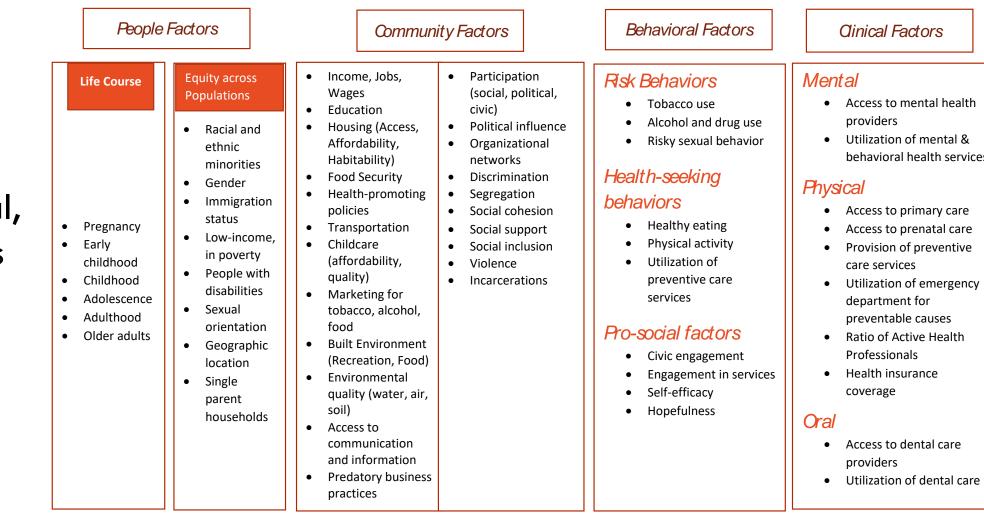
Healthy People 2020 influenced efforts in three key ways:

- Adoption of an ecological, determinants approach  $\bullet$
- Engagement of multiple sectors to support identification of strategies and  $\bullet$ implementation
- Use of Healthy People 2020 to develop measurable objectives  $\bullet$





Lawrence-Douglas County Framework for Understanding and Addressing Health and Health Equity



Broader Context: National, regional, and state values, beliefs, history, attitudes, and media; history of accumulated race privilege; barriers to opportunities; contemporary culture.

Adoption of an ecological, determinants approach

Strategies for Addressing Health and Health Equity :

- Data collection. monitoring, and surveillance
- Community engagement and capacity building
- Policy and environmental changes
- Systems change
- Coordinated interagency efforts

- behavioral health services
- Utilization of emergency

### Population Outcomes

### Quality of Life

- Quality adjusted life vear
- Chronic stress

### Morbidity

- Burden of:
  - 0 Infectious disease
  - Chronic disease 0
  - Injury (intentional & unintentional)
  - o Oral/dental disease
  - Mental & behavioral 0 illness

### Mortality

Life expectancy/Length of life

nsas

Infant mortality

• Population-based interventions to address health factors

Engagement of multiple sectors to support identification of strategies and implementation



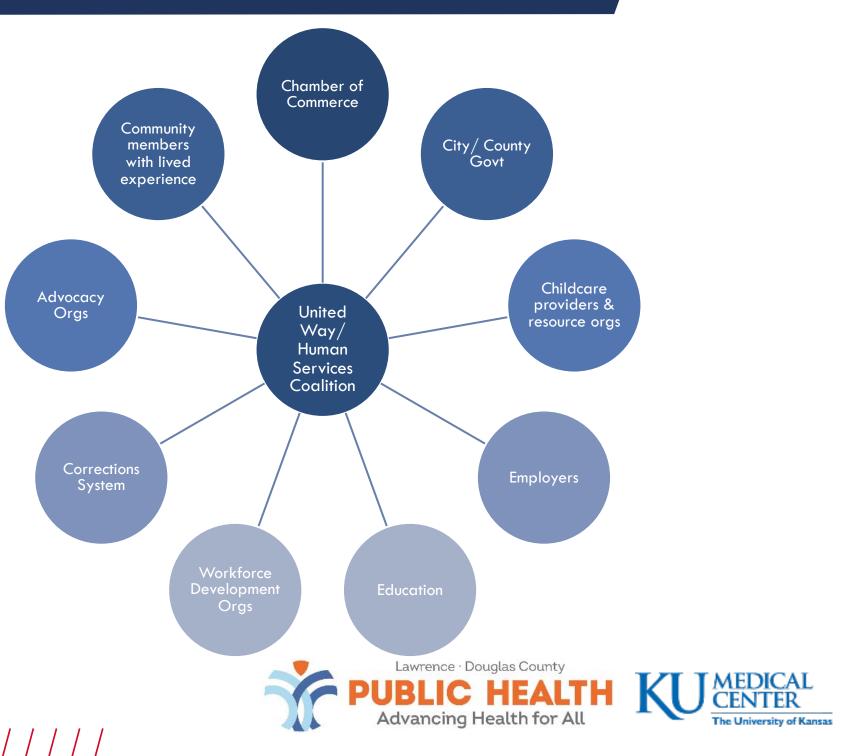


### Anti-Poverty

Convener: United Way/ Human Services Coalition

> Access to Healthy Foods & Healthy Built Environment Convener: LiveWell DG CO

 Engagement of multiple sectors to support identification of strategies and implementation



Use of Healthy People 2020 to develop measurable objectives 



Alignment to national benchmarks and plans. Support staff from the LDCHD and KUCCHD provided objectives from Healthy People 2020 to consider when selecting or constructing objectives. As appropriate, strategies or approaches from national plans were integrated.



Use of Healthy People 2020 to develop measurable objectives

### **Behavioral Health**

- By 2023, decrease the age-adjusted suicide rate from 16.0 to 14.0 per 100,000 population.
- Increase the proportion of adults 18 and older with serious mental illness (SMI) who receive treatment by 10%
- Increase the proportion of adults who are homeless with mental health problems who receive mental health services by 5%



MHMD-1

**MHMD-9.1** Increase the proportion of adults aged 18 years and older with serious mental illness (SMI) who receive treatment

Increase the proportion of homeless adults with mental health problems who receive MHMD-12 mental health services



### **Access to Safe and Affordable Housing**

By 2023, reduce the proportion of all households that spend more than 30% of income on housing from 26.0% to 24.0%

### Anti-Poverty

By 2023, ensure no change in the proportion of Black, Indigenous, and Children of color (aged 0-17 years) living in poverty.

## Access to Healthy Foods and Healthy Built **Environment**

By 2023, reduce household food insecurity from 16.5% to 15.5%.

SDOH-4.2.1 Proportion of all households that spend more than 50% of income on housing

**SDOH-3.2** 

**NWS-13** Reduce household food insecurity and in doing so reduce hunger





### Proportion of children aged 0-17 years living in poverty

### **Conclusions and Future Directions**

- HP 2020 framework and objectives offered tools and model objectives which • supported our community's planning efforts in a meaningful way
  - Supported our progress from addressing the manifestation of inequities to addressing root causes
- Looking ahead to initiate new cycle of CHA/ CHIP in mid-late 2022
- Build on and deepen our efforts to address root causes of inequities, create • conditions for health, and to advance health for all
- Continued use of HP 2030 to guide our efforts  $\bullet$



### **Acknowledgements**

Dan Partridge and colleagues at Lawrence-Douglas County Public Health ullet

### To learn more, please contact:

Vicki Collie-Akers: vcollieakers@kumc.edu







### KU MEDICAL CENTER The University of Kansas



## Moderated Q & A







# **Stay Connected With Healthy People & NACCHO**

- Visit the Healthy People 2030 Website at https://health.gov/healthypeople
- Follow the Healthy People 2030 initiative using the Twitter handle @healthgov and #HP2030
- Visit the National Association of County and City Health Officials' Website at https://www.naccho.org/











# Thank you!



| Office of Disease Prevention | and Health Promotion



