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IssueBrief

April 2022

Healthy People 2030: A tool to improve the health of clients

The Healthy People initiative, established in 1979, "identifies public health priorities to help individuals, organizations and communities across the United States improve health and well-being." Since the inception, at the beginning of every decade, a new iteration of the initiative is launched to address the latest public health priorities and challenges along with measurable objectives and tools to track progress over the next 10 years.

Healthy People is administered by the Office of Disease Prevention and Health Promotion in the Department of Health and Human Services.

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

GOALS:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury and premature death.
- Eliminate health disparities, achieve health equity and attain health literacy to improve the health and well-being of all.
- 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 stages.
- Engage leadership, key constituents and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

"Understanding Healthy People 2030 can help case managers and certified disability management specialists better support their clients—as the initiative itself states—to help them lead healthy, thriving lives free of preventable disease, disability, injury and premature death."

— VIVIAN CAMPAGNA, DNP, RN-BC, CCM, ICE-CCP, CHIEF INDUSTRY RELATIONS OFFICER (CIRO) FOR THE COMMISSION FOR CASE MANAGER CERTIFICATION

equity VS disparities

Among its goals, Healthy People seeks to achieve health equity and reduce health disparities. Health disparities and health inequities are not identical, Brewer explains. "The distinction between health inequities and health disparities is that health inequities are unfair, unjust and avoidable. Health disparities are sometimes unavoidable. However, things can get muddy."

Take rates of diabetes and obesity, she says. Genetics may factor into the equation that contributes to susceptibility if one has a long family history of diabetes, for example. "But if you're living in a neighborhood where it's not safe to go for a walk; or where there's no grocery store where you can easily access fresh, healthy, affordable foods; or if you're homeless—all those things are going to affect your susceptibility to diabetes to a much greater extent than if you were living an optimal lifestyle."

Achieving health equity requires multi-sectoral societal efforts. Eliminating disparities is one component of that.

The fifth iteration, Healthy People 2030, seeks to identify nationwide health improvement priorities and increase public awareness and understanding of the determinants of health, disease and disability and the opportunities for progress.

To accomplish this, Healthy People sets data-driven national objectives to improve health and well-being over the next decade. This iteration of the initiative, Healthy People 2030, includes 355 core objectives as well as developmental and research objectives. (See chart on next page.)

So how can Healthy People 2030 support case managers and disability management specialists?

A valuable resource

Healthy People 2030 can help case managers and disability management specialists to improve their clients' health outcomes in a variety of ways, Vivian Campagna, DNP, RN-BC, CCM, ICE-CCP, chief industry relations officer, Commission for Case Manager Certification, explains. For example, case managers can make sure their clients with diabetes receive formal diabetes education, which is core objective D-06.

Knowing trends and national priorities can also help with resource development. For example, Objective OA-03 (reduce the rate of emergency department visits due to falls among older adults) may prompt organizations to step up resources for older adults who are aging at home and are at risk of falling.

Disability management specialists may want to know about the national objective to reduce work-related injuries resulting in missed work dates (OSH-02), Campagna explains. "If they understand that a federal or state program is tracking problems with workplace safety, they can review this information and see how a particular workplace compares to national data." For example, Healthy People points out that in 2017, 89.4% of nonfatal, work-related injuries resulted in one or more days away from work for 10,000 full-time, private industry workers.

Practical applications: Putting it to work

Case management programs, communities and organizations can use Healthy People 2030 to improve clients' population health, explains Karen Brewer, a consultant who has worked on Healthy People. Case managers can also gain insights into how their clients' experiences fit into and reflect a larger national story.

Healthy People 2030 can help case managers and disability management specialists to improve their clients' health outcomes in a variety of ways.

Healthy People 2030 includes a wealth of data, including historical trends, national benchmarks and examples of successful efforts throughout the country. It also includes resources such as literature reviews that summarize currently available evidence on interventions to address the social determinants of health. Such resources give case managers

Public health vs. population health

Healthy People 2030 can be a valuable tool for working at the intersection of population health and public health. The concepts overlap, but they're not the same, Brewer explains.

"From a case management perspective, population health aims to help high-risk individuals with chronic conditions to stay as healthy as possible for as long as possible. Public health protects and improves community health through policy recommendations, health education and outreach and research to detect disease and prevent injury," she explains.

Population health refers to the health outcomes of a group of individuals, including the distribution of such outcomes within the group.[1] Achieving the health of populations is one of public health's aims.

Categories of Topics for HP2030 Core Objectives

Health Conditions	Health Behaviors	Populations	Settings & Systems	SDOH
Addiction	Child and Adolescent Development	Adolescents	Community	Economic Stability
Arthritis	Drug and Alcohol Use	Children	Environmental Health	Education Access and Quality
Blood Disorders	Emergency Preparedness	Infants	Global Health	Health Care Access and Quality
Cancer	Family Planning	LGBT	Health Care	Neighborhood and Built Environment
Chronic Kidney Disease	Health Communication	Men	Health Insurance	Social and Community Context
Chronic Pain	Injury Prevention	Older Adults	Health IT	
Dementias	Nutrition and Health Eating	Parents or Caregivers	Health Policy	
Diabetes	Physical Activity	People with Disabilities	Hospital and Emergency Services	
Foodborne Illness	Preventive Care	Women	Housing and Homes	
Health Care-Associated Infections	Safe Food Handling	Workforce	Public Health Infrastructure	
Heart Disease and Stroke	Sleep		Schools	
Infectious Disease	Tobacco Use		Transportation	
Mental Health and Mental Disorders	Vaccination		Workplace	
Oral Conditions	Violence Prevention			
Osteoporosis				
Overweight and Obesity				
Pregnancy and Childbirth				
Respiratory Disease				
Sensory or Communication Disorders Sensory				
Sexually Transmitted Infections				

1 Kindig D, Stoddart G. What Is Population Health? Am J Public Health [Internet]. 2003 Mar https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447747/

and disability management specialists the tools to identify needs and priority populations, set targets, find practical tools and examples and use national data as a benchmark. (The site includes a simple explanation of how to do this here.)

Brewer offers a few examples of how to use Healthy People:

- **Access research summaries:** For instance, SDOH Literature Summaries on the Healthy People 2030 website give a snapshot of recent research on 19 specific social determinants of health, from crime and violence to early childhood development and education.
- **See what's replicable:** The website provides a wealth of evidence-based resources that can be used to develop effective programs and that may be replicable, scalable and (often) sustainable. "It's a window into how others around the country have been able to affect changes in these areas."
- **Make a list:** A useful feature allows case managers and disability management specialists to build a list of objectives, find evidence for what works and track and manage care coordination.

"By building a custom list of objectives, you'll be able to use them as benchmarks for specific measures that you might be following for your own clients. There will be additional data points for the national data over the decades," Brewer explains. "You'll be able to see how the trends are moving at the national level toward the target unchanged or away from a target, and then how your clients are doing relative to those trends."

Unmistakenly case management

Healthy People is clearly and obviously case management, Brewer explains. "Both represent efforts to use collaboration to break down silos and to think holistically about what is needed to improve health and wellbeing."

Brewer breaks down the correlation into five areas (see Figure 2, next page.)

Campagna, too, sees an alignment with the work of both case managers and disability management specialists. "Understanding Healthy People 2030 can help case managers and certified disability management specialists better support their clients—as the initiative itself states—to help them lead healthy, thriving lives free of preventable disease, disability, injury and premature death." ■

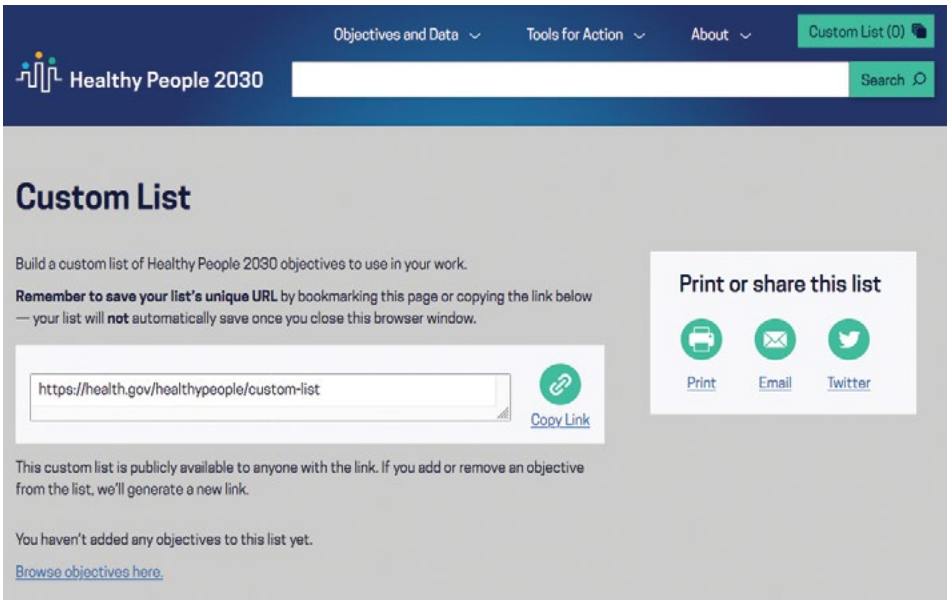

Figure 1. Healthy People 2030 Custom List.

> ***"By building a custom list of objectives, you'll be able to use them as benchmarks for specific measures that you might be following for your own clients. There will be additional data points for the national data over the decades"***
>
> — KAREN HARRIS BREWER, INDEPENDENT CONSULTANT AND FOUNDER OF HEALTH CONTEXTS

Healthy People	Case Management
Acknowledges and addresses the complexity of health.	Coordinates care for people who have complicated health needs at the individual level.
Focuses efforts to shift the health status of the population as a whole.	Manages the social, medical, behavioral, financial and other issues that individuals face.
Uses assessments of the people who are being served as a guide for their clinical care.	Uses assessments of the people who are being served as a guide for their clinical care.
Engages states, communities and organizations to stimulate innovation.	Uses team-based models and case managers coordinate care.
Seeks to work across sectors and inspire shared responsibility for decision making and policy formulation.	Case managers work to bring down care silos that increase risks for error.

Figure 2.

Helpful Resources

- Pronk N, Kleinman DV, Goekler SF, Ochiai E, Blakey C, Brewer KH. Promoting Health and Well-being in Healthy People 2030. Journal of Public Health Management and Practice (Internet). 2021 Apr 30 (cited 2021 May 7); Available from: https://journals.lww.com/jphmp/abstract/9000/promoting_health_and_well_being_in_healthy_people.99211.aspx

- Gómez CA, Kleinman DV, Pronk N, Wrenn Gordon GL, Ochiai E, Blakey C, et al. Addressing Health Equity and Social Determinants of Health Through Healthy People 2030. Journal of Public Health Management and Practice (Internet). 2021 Apr 30 (cited 2021 May 7);Available from: https://journals.lww.com/jphmp/Abstract/9000/Addressing_Health_Equity_and_Social_Determinants.99191.asp

- Santana S, Brach C, Harris L, Ochiai E, Blakey C, Bevington F, et al. Updating Health Literacy for Healthy People 2030: Defining Its Importance for a New Decade in Public Health. Journal of Public Health Management and Practice (Internet). 2021 Dec (cited 2021 Dec 19);27:S258. Available from: https://journals.lww.com/jphmp/Fulltext/2021/11001/Updating_Health_Literacy_for_Healthy_People_2030_.10.aspx

About the Experts

Karen Harris Brewer, Independent Consultant and Founder of Health ConTexts

Vivian Campagna, DNP, RN-BC, CCM, ICE-CCP, Chief Industry Relations Officer (CIRO) for The Commission for Case Manager Certification

Karen Harris Brewer is an independent consultant and founder of Health ConTexts. With a background in health communications research and health promotion, she is a forward-thinking innovator who identifies connections across disciplines and synthesizes evidence to address community health problems. Highlights of Karen's career have included drafting reports for the Secretary's Advisory Committees for Healthy People 2030 and Healthy People 2020, conducting qualitative research for public relations and social science research organizations and acting as coalition coordinator for a state cardiovascular disease prevention coalition. As a lay case manager at a community-based organization in the Bronx, NY, Karen supported low-income families at risk of eviction and/or facing HIV/AIDS. A native New Yorker, Karen grew up with awareness of ways that city neighborhoods are demarcated by race and class and how educational and health care institutions reflect such boundaries. She has a master's degree in Health Education and Communication, two decades of experience in applying social ecological principals to public health and longstanding dedication to preventing chronic disease and promoting health equity. Karen received an MPH from the Tulane School of Public Health and Tropical Medicine in New Orleans, LA and a BA in Asian Studies from Pomona College.

Vivian Campagna, DNP, RN-BC, CCM, ICE-CCP, works with individuals and organizations interested in certification (CCM®/CDMS®), related products and services through the Commission's broader marketing and promotions efforts. She fosters strategic partnerships and alliances and provides insight and guidance related to industry trends and developments. Campagna has been involved in case management for more than twenty-five years. She has held staff and administrative positions on both the independent and acute care side of the industry. She has published articles on case management topics and is a frequent presenter and educator. She was a founding member of the Long Island chapter of CMSA and served on the board and the conference committee of the NYC chapter of CMSA. Campagna was a member of the inaugural class of certified case managers and worked with CCMC as a volunteer for more than 10 years. She is a former Commissioner and past chair for the Commission. Campagna earned her nursing diploma from St. Clare's Hospital and Health Center School of Nursing, her bachelor's degree from CW Post Center of Long Island University, her master's degree in nursing from Seton Hall University and her DNP from American Sentinel University. She is certified in case management by both the Commission for Case Manager Certification and the American Nurses Credentialing Corporation.

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