Improving Population Health Outcomes Depends on Transforming the Health System to Coordinate and Integrate Primary Care, Public Health and Community Prevention Efforts

**Interventions at the intersection** of primary care, public health and the social determinants of health require:
- Common agendas and goals
- Shared responsibility
- A compelling story
- Partnerships and collaboration
- Leadership and Integrators
- Data
- Financing systems
- Accountability mechanisms

Primary care & team based care
- Patient assessments include personal data and SDOH regarding patients’ homes and communities
- Quality improvement
- Leveraging, linkages and referrals to community resources
- Data collection & EHRs contribute to community health database
- Coordination with community health outreach workers
- Chronic disease management

Social and support services
- Disease prevention and management programs
- Outreach and referral to clinicians
- Education, including health education
- Coalitions and advocacy to address SDOH
- Community engagement

Policy leadership on programs and policies that improve community health
- Community health assessments
- Educating policymakers, agencies, and stakeholders regarding population health
- Population health data tracking and analytic tools

**Public policy** is a critical lever to support all of these activities

Trust for America’s Health
Updated 8/9/2012