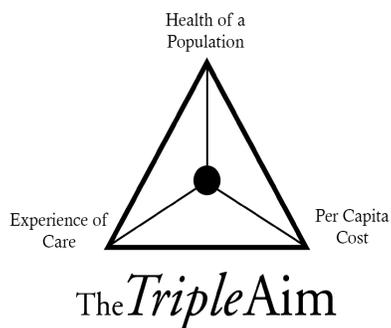


Meeting the Middle Aim: Public Health & the CCO



Public Health roles in meeting the Middle Aim:

Collaboratively identify, prioritize, and direct resourcing of population health goals to ensure better health for populations.



Public Health roles in helping CCOs achieve the Triple Aim:

- 1.) Community Health Assessments---including CHNA requirement from IRS for non-profit hospitals
 - a.) Social Assessment (perceived community need)
 - i. Health impact
 - ii. Risk-benefit
 - iii. Cost-benefit
 - iv. Quality of life
 - b.) Health Sector Assessment (evidence-based identifiable health needs)
 - i. Epidemiological
 - ii. Behavioral
 - iii. Environmental
 - iv. Motivational
 - c.) Feasibility (resources, politics)
 - i. Administrative
 - ii. Policy
 - iii. Implementation
- 2.) Community Health Improvement Plans: Creation, implementation, and tracking via:
 - a.) CHANGE Action Guide
 - b.) The Community Guide
- 3.) Health Equity:

Public Health has expertise in engaging diverse community groups, addressing health disparities, and improving health equity
- 4.) Creating metrics and a system to track health outcomes & process outcomes in:
 - a.) Preventive health
 - b.) Care coordination

- c.) Patient safety
 - d.) Patient experience
 - e.) "At risk" populations
- 5.) Creating & implementing community-based prevention guidelines addressing identified local concerns (In Lane County these include declining immunization rates; maternal smoking rates double the national average; and Chlamydia rates 30% higher than the Oregon average.)
- 6.) Worksite wellness policy development
- 7.) Serve as nexus for clinical and community interventions for prioritized chronic conditions as well as select policy, systems, and environmental change initiatives. For Lane County:
- a.) Addressing obesity epidemic
 - b.) Reducing Tobacco use rates
 - c.) Addressing substance abuse rates
 - d.) Responding to falling vaccination rates
- 8.) Serve as the central agency for the collection, classification, analysis, and distribution of information for primary care practices fostering:
- a.) Data sharing
 - b.) Structured, multi-party interventions for prioritized chronic conditions
- 9.) Information Technology infrastructure
- a.) Leverage EHR systems to support Medical Homes and Public Health disease reporting needs
 - b.) Utilize community-level data to create and share actionable population level data (e.g., community antibiogram)

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