Third Annual Population Health Summit: "From Innovators to Early Adopters: A Closer Look at Bridging Health Care and Population Health"

Annotated Bibliography

Bakken E, Griffin K. "Community Benefit Investments by New York State Hospitals, 2012," The New York Academy of Medicine, September 2015.
http://www.nyam.org/publications/publication/community-benefit-investments-by-new-york/
This data brief charts trends in nonprofit hospital spending on community health improvement and community building, highlighting investments that represent opportunities to advance population health and New York State's effort to achieve the Triple Aim of improved care, reduced costs, and better health.

Boufford JI, Garcia A. "Achieving the Triple Aim in New York State: The Potential Role of Hospital Community Benefit," The New York Academy of Medicine, 2014.
http://www.nyam.org/publications/publication/achieving-the-triple-aim-in-new-york/
This issue brief explores how nonprofit hospitals can use the community benefit provision under the Affordable Care Act to support broad-based community prevention.

Butler S, Grabinsky J, Masi D. "Hospital as Hubs to Create Healthy Communities: Lessons from Washington Adventist Hospital," Brookings, September 2015.
http://www.brookings.edu/research/papers/2015/09/28-hospitals-as-hubs-to-create-health-communities-butler-grabinsky-masi
This paper explores the experience of Washington Adventist Hospital, a Maryland community hospital that has taken on community initiatives, including linking patients to social services and addressing the transition needs of the homeless. The paper highlights the challenges for hospitals seeking to be community hubs: measuring the full community impact of hospital efforts; regulatory and budget flexibility at the state and county level; and the need for improved data sharing amongst partners.

Garrett K. "Bridging Health Care and Population Health: Payment and Financing Models," The New York Academy of Medicine, January 2015.
http://www.nyam.org/publications/publication/bridging-healh-care-and-population-health/
This white paper summarizes the outcomes of the "Population Health Summit II, Bridging Health Care and Population Health – Payment and Financing Models," organized by the New York State Health Foundation in partnership with The New York Academy of Medicine and the NYU/LMC Department of Population Health. Outlined in this white paper are the four main areas that the summit's sponsors identify as requiring ongoing attention in New York State: influencing the evolution of the State's payment reform initiatives; ensuring a voice for population health in the governance of health reform; developing population health resources; and creating and maintaining a robust learning system for population health.

Gourevitch MN, Cannell T, Boufford JI, Summers C. "The Challenge of Attribution: Responsibility for Population Health in the Context of Accountable Care,"American Journal of Public Health 2012.102.S3: S322-S324.
http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2011.300642
This article discusses divergent concepts of population health held by care delivery organizations and public health agencies and suggests potential approaches to bridging these gaps.

Institute of Medicine "Primary Care and Public Health: Exploring Integration to Improve Population Health," National Academies Press, 2012.
http://iom.nationalacademies.org/~/media/Files/Report%20Files/2012/Primary-Care-and-Public-Health/Primary%20Care%20and%20Public%20Health_Revised%20RB_FINAL.pdf

This report on primary care and public health identifies five principles of successful integration: (1) a shared goal of population health improvement; (2) community engagement in defining and addressing population health needs; (3) aligned leadership that (a) bridges disciplines, programs, and jurisdictions, (b) clarifies roles and ensure accountability, (c) develops and supports appropriate incentives, and (d) manages change; (4) sustainability, shared infrastructure, and building for enduring value and impact; and (5) the sharing and collaborative use of data and analysis.

Institute of Medicine "Vital Signs: Core Metrics for Health and Health Care Progress," National Academies Press, April 2015.
https://iom.nationalacademies.org/~/media/Files/Report%20Files/2015/Vital_Signs/VitalSigns_RB.pdf
This report explores how to measure and promote healthier people, better quality care, affordable care, and engaged individuals and communities. It specifies a streamlined set of 15 core measures that can be standardized and applied at national, state, local, and institutional levels nationally. This report also describes the general activities and leadership activities necessary to refine, apply, maintain, and revise the measures over time, as well as how they can improve the focus and utility of additional health measures.

Kindig, DA. "A Pay-for-Population Health Performance System." ***JAMA,*** **296(21):2611-2613, December 2006.**
http://jama.jamanetwork.com/article.aspx?articleid=204338
This article outlines how pay-for-performance in medical care alone will not improve population health, the challenges associated with pay-for-population health performance, and the potential to improve population health by developing appropriate financial mechanisms.

Mattessich PW, Rausch EJ. "Collaborating for Community Health: Cross-Sector Collaboration to Improve Community Health: A View Of The Current Landscape," ***Health Affairs,*** **33(11):1968-1974, November 2014.**
http://content.healthaffairs.org/content/33/11/1968.full
This article outlines results from a Robert Wood Johnson Foundation national survey and case examples that shows that cross-sector collaboration to improve community health occurs in all regions of the United States and that such collaboration has, in many cases, succeeded in producing positive measurable outcomes. It also highlights opportunities for building on present momentum in a way that expands the evidence base on effective collaborative efforts between the health and community development sectors.

Michener JL, Koo D, Castrucci CB, Sprague JB. "The Practical Playbook: Public Health and Primary Care Together," Oxford University Press, October 2015.
This book, produced by The Practical Playbook online resource (a joint product by the de Beumont Foundation, Duke Community and Family Medicine, and the Centers for Disease Control and Prevention), provides a roadmap for how U.S. primary care and public health professionals can integrate their work with the larger goal of working to improve population health.

Prybil L, Scutchfield FD, Killian R, Kelly A, Mays G, Carman A, Levey S, McGeorge A, Fardo DW. "Improving Community Health through Hospital-Public Health Collaboration: Insights and Lessons. Learned from Successful Partnerships," Commonwealth Center for Governance Studies, Inc., November 2014.
http://www.uky.edu/publichealth/sites/www.uky.edu.publichealth/files/Research/hospital-public%20health%20partnership%20report_12-8-14.pdf
This report outlines the core characteristics and related indicators of successful partnerships involving hospitals, public health departments, and other sectors by analyzing 12 partnerships that meet their criteria for successful partnerships.

Rosenbaum S, Amber R, Byrnes M. "Encouraging Nonprofit Hospitals To Invest In Community Building: The Role Of IRS 'Safe Harbors'," *Health Affairs Blog*, 2014.
http://healthaffairs.org/blog/2014/02/11/encouraging-nonprofit-hospitals-to-invest-in-community-building-the-role-of-irs-safe-harbors
This blog article reviews public health investments as part of a community benefit strategy and proposes that the Internal Revenue Service establish "safe harbors" to enable hospitals to use evidence-based investments to advance community health improvement.

Sandberg SF, Erikson C, Owen R, Vickery KD, Shimotsu ST, Linzer M, Garrett NA, Johnsrud KA, Soderlund DM, DeCubellis J. "Hennepin Health: A Safety-Net Accountable Care Organization For The Expanded Medicaid Population," *Health Affairs,* 33:1975-1984, November 2014.
http://content.healthaffairs.org/content/33/11/1975.full
This article describes how Hennepin Health, an accountable care organization in Minnesota, has forged community-level partnerships that address the behavioral, social, and economic determinants of health for an expanded community of Medicaid beneficiaries. Early outcomes suggest that the program has had an impact on shifting care from hospitals to outpatient settings, as well as using innovative payment models to amass health care system savings and reinvest them in future improvements.

Shih A, Siegel S. "Measuring Progress Towards a Population Health Perspective: A Framework for a New Type of Population Health Scorecard," The New York Academy of Medicine, February 2015.
http://www.nyam.org/publications/publication/measuring-progress-towards-a-population-health/
This issue brief proposes a framework to assess progress toward the effective promotion of population health in a state or other geographic region. The framework consists of five domains: payment reform, financial resources, policy environment, engagement of other, and population health activities.