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.

This issue brief explores how nonprofit hospitals can use the community benefit provision under the Affordable Care Act to support broad-based community prevention.

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.

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.

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.

http://iom.nationalacademies.org/~/%7Emedia/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.

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.

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.

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.

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.

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.

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.


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.


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.