

Health Affairs **Blog**

To Launch And Sustain Local Health Outcome Trusts, Focus On 'Backbone Resources'

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It is not hard for even an optimist to become cynical and frustrated about our painfully slow improvement in population health and health disparities. Today's world has limited resources for addressing the critical social determinants of these outcomes, such as education and child poverty. So perhaps it's time in the New Year to get behind something more immediate: **local health outcome trusts.**

These trusts are less expensive, more politically feasible, and present a path to longer run solutions than counting on unlikely new federal or state appropriations... And they do more than simply provide a consistent revenue stream as the well known and important Massachusetts Health and Wellness Trust does. Rather, local health outcome

trusts serve as stable and permanently staffed governance bodies, multi-sectoral coordinating entities whose public- and private-sector leaders would meet regularly, establish local goals and priorities, and identify resources for substantial and continuous investment in improving in overall health and health equity.

Such entities have enormous potential, but in order to sustain^[1] significant activity and results they require^[2] dependable “backbone” resources. In this post, I make the case for such investment and identify several potential sources of funds that could be braided into our communities’ and regions’ efforts.

Investing Beyond Medical Care

The need for such local health outcome trusts is rooted in the multiple determinants of population health. We now know that medical care alone is not enough. Instead, improvement requires a balanced portfolio that includes medical care, health behaviors, and the social and physical environments. The County Health Rankings^[3] population health model, for example, attributes 50 percent of general health improvement to the social and physical environments.

Therefore, no one sector in our society or our communities can take responsibility for the policies and investments of the whole portfolio of health determinants. And no one sector—neither medical care, nor public health, nor schools, nor businesses, nor community nonprofits—is likely to have the resources or the infrastructure to make its own independent investments in the most cost-effective way to maximize overall health outcomes and reduce disparities. So careful coordination—including collaboration in finding the best health-promoting opportunities—is necessary.

The National Prevention Strategy, created under the Affordable Care Act (ACA), is exploring how agencies from different sectors could work together more effectively at the federal level. That is important, but it is not enough. Investments are needed most at the local community level. Indeed, this is where such multi-sectoral, community-integrating trust structures should be based.

What Do Local Health Outcome Trusts Do?

The person who has thought most extensively about local health outcome trusts is Debbie Chang, the Enterprise Vice President of Policy and Prevention for the Nemours Children’s Health System. In 2012, she identified three ways that trusts can serve as integrators^[4] at the community level: May 2012.

- Providing leadership and partner engagement to integrate services and mobilize

interventions.

- Ensuring spread, scale, and sustainability to expand what works so that the entire population can benefit. This includes using both existing and new sources of funding, developing innovative uses of current sources, and testing payment reforms that promote value.
- Promoting continuous learning and improvement, that is, learning from the data at the individual and population levels and providing feedback at several levels for affected sectors, systems, and communities.

Who Takes The Lead?

Some communities already have one or more organizations performing these functions, though full implementation is rare. In some places, local public health agencies, progressive health care systems, community organizations like the United Way, and even local businesses carry out many of these integrating tasks.

In fact, an effective integrating partnership is one of the criteria for the Robert Wood Johnson [Culture of Health Prize](#) ^[5] competition. But these tasks, particularly in those places with fewer resources, have not been expanded. And the pathway to full implementation—as described in the five stages of the Rippel Foundation’s [ReThink Health Pathway](#) ^[6]: campaign, engage, align, redesign, and integrate—is long, complex, and rife with potential pitfalls.

The Need For Backbone Resources

One reason for the limited development of successful trusts is the lack of sufficient resources to support and sustain basic organizational functions. Successful models are the ones that find such “[backbone](#) ^[7]” or “quarterback” resources in order to hire key staff who can provide a dependable structure, set priorities, and build up trust in the community.

Multiple sources of funds from community partners can ensure that the effort is sustained. A recent report from ReThink Health lays out the different funding sources used by a number of current partnerships, but [warns](#) ^[8] that “there is heavy reliance by most groups on short term, often insecure financing mechanisms such as grants, contracts, and prizes.”

Where Else Might Financial Support Come From?

Local sponsors of health outcome trusts run the gamut of place-based philanthropy, local governmental agencies, progressive health care organizations, community

organizations, academic centers, and others who devote some discretionary resources and vast amounts of in-kind support to help these multi-sector partnerships to form and in some cases thrive.

But to really ensure such trusts can develop in diverse communities across the nation, I believe federal sources can and should provide partial but sustainable funding. Here's how that might work:

First, community health trusts should be able to take advantage of the significant dollars that nonprofit hospitals are required by the IRS to spend on community benefit in order to maintain their tax-exempt status. Indeed, scholars and public health policymakers have been advocating^[9] the greater use of these funds for external community health improvement and community building beyond charity care, internal research, training investments, and Medicaid shortfalls. In meeting the IRS requirement, communities with more than one nonprofit hospital should be encouraged to pool a portion of their community benefit spending for the purpose of establishing and supporting a local health outcome trust.

Second, a portion of Medicare and Medicaid dollars should be used to support such organizations as a part of the programs' payment reform models — especially those increasingly focused on nonclinical determinants of health. To be sure, there are regulatory challenges to the idea of drawing on the Medicare Trust Fund for anything that might provide services to non-beneficiaries.

The long view however recognizes that everyone will eventually be a beneficiary, so it is appropriate to begin allowing the kind of investments at earlier life stages to improve the health of future beneficiaries. It is a hopeful sign that the recent announcement from the Center for Medicare and Medicaid Innovation's (CMMI) Accountable Health Communities has one track focused on Alignment in which funding^[10] is allowable for "backbone" organizations "that will facilitate data collection and sharing among all partners and try to enhance service capacity."

Other opportunities exist in Medicaid and Medicaid managed care organizations, and in states that are engaging in all-payer reform efforts that include private payers. Perhaps all participants can be required to contribute to a local health outcome trust. Likewise, in a recent article^[11] in *The Journal of the American Medical Association*, Josh Sharfstein, former Secretary of the Maryland Department of Health and Mental Hygiene, proposed allowing Medicaid managed care programs that end up spending less than the required 85 percent of funds on clinical care, to spend that "loose change" on community health. He did not suggest backbone resources for trusts, specifically, but why not?

These federal contributions could be braided into other funding in a way that matches

local resources and ensures local acceptance. If most communities spent several hundred thousand dollars every year on such community-integrating functions and activities, identified by the local health outcome trusts, and aligned with the required triennial IRS community needs assessment, the chance for ongoing and multi-sectoral population health improvement should dramatically increase and be sustained for the long-run effort.

The Case for Pragmatic Action

To establish a viable trust significant investment is necessary. But those costs are far smaller than the alternative: leaving unchecked the rising expenses associated with preventable disease and costly health care services.

One reason that such trusts have been slow to evolve is because of the prevailing short-term orientation that guides most health care institutions. That doesn't work for population health, which requires long-term investment and action, with sustainable programs, policies, and leadership that trusts can provide.

To be sure, such trusts alone cannot achieve the major shifts to long-term investment in education, economic development, and poverty reduction required to reduce unacceptable health disparities. But they can make a significant impact at the local level and they can also build support for greater investments at the state and national level. Providing the backbone resources that such trusts require could put us more quickly and sustainably on the path toward resolving these often overwhelming and challenging threats to national and community well being.

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