

# BLUEPRINT FOR COMPLEX CARE



► Advancing the field of care for individuals with complex health and social needs ◀

## Executive Summary

**The US spends more on healthcare than any other industrialized nation, and much of that spending is concentrated on a small percentage of the population for whom behavioral health and social needs are major contributors to poor health outcomes.**

To address these gaps and provide better care at lower cost, policymakers, health systems, providers, payers, and philanthropists are innovating and experimenting with models of complex care. Complex care seeks to improve the health and well-being of a relatively small, heterogeneous group of individuals who repeatedly cycle through multiple healthcare, social service, and other systems but do not derive lasting benefit from those interactions. It operates at the personal level by coordinating care for individuals. Complex care also works at the systemic level by creating complex care ecosystems, the local networks of organizations that collaborate to serve individuals with complex health and social needs. Through these efforts, complex care addresses the root causes of poor health that defy existing boundaries among sectors, fields, and professions. At its heart, complex care seeks to be person-centered, equitable, cross-sector, team-based, and data-driven.

Complex care programs may be housed in many settings, ranging from health care clinics and health plans to community-based organizations and social service agencies. Because of the broad set of stakeholders who are providing complex care, there is risk of duplicating and siloing efforts, which may stymie innovation. Knowing this, three organizations—the Camden Coalition of Healthcare Providers’ National Center for Complex Health and








*The most expensive and challenging populations for the current health care system will remain underserved until there is a unified effort—rather than small, incremental steps—to improve care for the nation’s high-need patients.*

- National Academy of Medicine, *Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value and Health*

Social Needs, the Center for Health Care Strategies, and the Institute for Healthcare Improvement—came together to create the *Blueprint for Complex Care*, a guide for advancing the field of complex care. We gathered diverse, far-reaching perspectives through reviews of published literature, interviews, surveys, and an expert convening to develop a comprehensive understanding of the current state of complex care, and to shape our recommendations strengthening the field.

## Assessment of the Current State of Complex Care

The *Blueprint for Complex Care* outlines the current state of complex care and our recommendations for the future. We used the established *Strong Field Framework* to guide our assessment of the field:

Framework Component	 Strengths	 Weaknesses
 <p><i>Shared Identity</i></p>	<ul style="list-style-type: none"> <li>Stakeholders agree on the problems to address</li> <li>The community shares principles and goals</li> <li>The potential community of stakeholders is vast and diverse</li> </ul>	<ul style="list-style-type: none"> <li>The field lacks a shared language</li> <li>There has been confusion on who comprises the target population</li> </ul>
 <p><i>Standards of Practice</i></p>	<ul style="list-style-type: none"> <li>Validated care models and promising practices exist and are spreading</li> <li>Common features of promising models and practices have been identified</li> </ul>	<ul style="list-style-type: none"> <li>Data sharing limitations hamper progress</li> <li>There is a shortage of providers prepared to deliver complex care</li> </ul>
 <p><i>Knowledge Base</i></p>	<ul style="list-style-type: none"> <li>A growing evidence base demonstrates complex care’s positive impact</li> <li>Segmentation of the target population is improving</li> <li>A community of researchers is emerging</li> </ul>	<ul style="list-style-type: none"> <li>Current metrics do not reflect whole-person outcomes</li> <li>Stakeholders disagree on the types of evaluation that are necessary</li> </ul>
 <p><i>Leadership and Grassroots Support</i></p>	<ul style="list-style-type: none"> <li>Complex care is a high priority for many healthcare payers, providers, policymakers, and philanthropies</li> <li>Influential stakeholders in key segments of the field are increasing buy-in</li> </ul>	<ul style="list-style-type: none"> <li>People with lived experience are not adequately included</li> <li>Multiple barriers impede cross-discipline and cross-sector partnerships</li> </ul>
 <p><i>Funding and Supporting Policy</i></p>	<ul style="list-style-type: none"> <li>The shift toward value-based payment supports complex care investment</li> <li>Public investment has accelerated interest in complex care</li> </ul>	<ul style="list-style-type: none"> <li>Healthcare-based programs struggle with financing in a shifting payment environment</li> <li>Social and behavioral health services are funded differently and less robustly than healthcare</li> </ul>

## Recommendations

Based on these strengths, weaknesses, and the input we gathered from stakeholders, we believe the following activities represent near-term priorities for strengthening the field of complex care:

### 1. **Develop core competencies and practical tools to support their use.**

Complex care requires a diverse workforce with the knowledge, skills, and abilities to support intersecting, complex needs. Identifying competencies allows for the development of standardized educational programs and resources. Over time, the core competencies could evolve to become formal practice standards that are measured, tested, and formally certified.

### 2. **Further develop quality measures for complex care programs.**

Standard measures for complex care can accelerate learning and quality improvement, and enable providers to demonstrate value to payers and other stakeholders. While cost and utilization are common metrics, the health and well-being measures vary considerably. This contributes to over-reliance on cost and utilization as the primary way to define success, and insufficient attention to complex care's positive impact on patient well-being and overall health.

### 3. **Enhance and promote integrated, cross-sector data infrastructures.**

Improved access to integrated, cross-sector data is critical to building the field's knowledge and its ability to serve people with complex health and social needs. Efforts must address the financial, legal, and technical barriers to data integration.

### 4. **Identify research and evaluation priorities.**

While there has been a proliferation of research and evaluation work related to complex care, significant gaps remain. Some of these gaps have already been identified—such as deeper understanding of subpopulations, effective implementation strategies, and designing new payment systems—but additional work is necessary. Convening a research community can help accelerate progress.

### 5. **Engage allied organizations and healthcare champions through strategic communication and partnership.**

Complex care must collaborate with overlapping fields and communities that are aligned (or beginning to align) with the values, principles, and tactics that complex care employs and serve the same population. Potential partners include: criminal justice, community development, social services, palliative care, primary care, addiction medicine, population health, patient advocacy groups, and public health.

### 6. **Value the leadership of people with lived experience.**

Individuals' personal experiences and insights into the systemic issues impacting people with complex needs, as well as potential solutions, are powerful assets that are not adequately represented in the field. The field must prioritize and support their involvement in continued field development.

### 7. **Strengthen local cross-sector partnerships.**

The local complex care ecosystem requires robust, equitable, and effective multi-sector partnerships. Heightened attention to social determinants and health equity has generated a lot of interest and activity in cross-sector relationships, yet true collaboration remains difficult. Tools and coaching can help teach leaders critical elements of effective partnerships.

## 8. Promote expanded public investment in innovation, research, and service delivery.

Dedicated public funding for innovation, research, and program implementation focused on populations with complex health and social needs has slowed over the last several years. Achieving increased funding will require coalition building and federal advocacy.

## 9. Leverage alternative payment models to promote flexible and sustainable funding.

Value-based purchasing creates incentives to invest additional resources in individuals with complex needs, particularly addressing social needs. More work, in close collaboration with payers and accountable care organizations, is required to build and test sustainable payment models.

## 10. Create a field coordination structure that facilitates collective action and systems-level change.

To create accountability to the field, we recommend the development of a multi-organizational coordinating structure convened by the National Center for Complex Health and Social Needs. This structure would convene stakeholders, monitor and organize major field-building activities, and serve as an entry point for individuals and organizations who want to contribute to the field.

## 11. Foster peer-to-peer connections and learning dissemination.

The field should also invest in infrastructure to connect individuals and organizations directly to one another and facilitate discussion and shared learning. As the field is building its foundational elements, access to individuals, and organizations with common experience can provide essential advice, support, and camaraderie for new members.

## Conclusion

Our recommendations are ambitious but necessary for the field to achieve its goal of improving the well-being of individuals with complex health and social needs. Success will require leadership and collaboration from many organizations and individuals. We call on you, the field, to join the many innovators, early adopters, and champions of complex care to lend your support and expertise to strengthen the field and, in turn, improve the lives of those with the most complex needs.

## About the Blueprint for Complex Care

Three organizations—the **Camden Coalition of Healthcare Provider's National Center for Complex Health and Social Needs**, the **Center for Health Care Strategies**, and the **Institute for Healthcare Improvement**—came together to develop a national framework for coordinating the complex care community. Just as a blueprint is necessary to guide the construction of a home, this *Blueprint for Complex Care* is a guide for advancing the field of complex care. The *Blueprint for Complex Care* aims to drive a collective strategy for the field as a whole, bringing together the ongoing efforts of hundreds of discrete programs into a cohesive and singularly identifiable field of practice. To learn more, visit [www.nationalcomplex.care/blueprint](http://www.nationalcomplex.care/blueprint).