

The Blueprint for Complex Care: Laying the Groundwork to Build a Field Across Sectors

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Two data points have preoccupied the national discussion on healthcare spending over the past several years: (1) that a small percentage of the US population drives a disproportionate amount of healthcare spending¹ and (2) that the United States has the highest per capita healthcare spending among “high-income” countries.² So far, results of efforts to bend the cost curve are mixed, at best. A third data point, which shows that spending on social services in the United States is lowest among industrialized nations compared with healthcare spending,^{3,4} is driving new thinking in the emerging field of complex care.

In recent years, we have seen increasing numbers of programs that radically redesign the delivery of healthcare and social services around the needs of individuals with complex health and social needs.⁵⁻⁷ Many share a commitment to person-centered, equitable care that bridges sectors, is delivered by interprofessional teams, and is driven by cross-sector data. Some health systems are already implementing large-scale screening and referral programs to address social drivers of health, but more targeted interventions are needed.

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The vibrant innovation and variation among complex care models have drawn growing interest from large health systems, payers, and government agencies. In order for these successful models to spread and scale up, the field needs to move toward the development of clear standards of practice, shared research agendas, and clearer policy and payment solutions that create durable funding streams. To lead this effort, 3 organizations—the Camden Coalition of Healthcare Providers’ National Center for Complex Health and Social Needs, the Center for Health Care Strategies, and the Institute for Healthcare Improvement—joined together to create a framework to advance the field of complex care, namely, the Blueprint for Complex Care.⁸ The effort was supported by The Commonwealth Fund, the Robert Wood Johnson Foundation, and The SCAN Foundation.

Seeking Consensus on Complexity

The Blueprint is organized along the Strong Field Framework,⁹ a methodology developed by the Bridgespan Group for assessing any given field of activity using 5 specific components. Emerging fields such as complex care must (1) unite around a shared identity, (2) advance standards of practice, (3) build a collective knowledge base, (4) bolster leadership and grassroots support,

and (5) solidify funding and supporting policy. The framework recognizes that a key strategy for realizing social change is developing a field and its workforce. The Strong Field Framework was designed to illuminate complex care's strengths and weaknesses and help structure the development of the Blueprint's recommendations for the field.

In addition to the Blueprint's cross-organizational leadership, the development process was designed to be as inclusive as possible. The analysis of the current state of the field and the recommendations for its advancement were informed by interviewing complex care innovators, convening complex care model builders, and surveying nearly 400 individuals with an interest in complex care. The Blueprint's authors also sought to learn from other recently developed fields, such as palliative care, hospital medicine, and tobacco cessation.

Defining Complex Care

One of the major gaps identified by stakeholders was the lack of a shared definition and common language to describe complex care. Many definitions of complex care rely solely on high cost and high utilization patterns as the 2 main gauges of complexity,¹⁰ but there is increasing interest in more comprehensive descriptions that include behavioral health and social needs as additional key indicators of complexity. Stakeholder input was invaluable in leading the Blueprint authors to propose a definition that will bring much-needed clarity to the field. The Blueprint defines complex care as follows:

Complex care is a person-centered approach to address the needs of people who experience a combination of medical, behavioral health, and social challenges that result in extreme patterns of healthcare utilization and cost. Complex care coordinates individuals' care while reshaping ecosystems of care to deliver integrated services for those whose root causes of poor health defy existing boundaries among sectors, fields, and professions. These programs seek to be person-centered, equitable, cross-sector, team-based, and data-driven.⁸

Although the intended population of complex care programs can vary significantly from program to program, the Blueprint proposes that complex care shares these common traits:

Complex care seeks to improve the health and well-being of a relatively small, heterogenous group of individuals who are repeatedly cycling through multiple healthcare, social service, and other systems but who do not derive lasting benefit from those interactions.⁸

Complex Care Ecosystems in Practice

Successful complex care programs create coordinated, community-based ecosystems around the individuals they serve. These complex care ecosystems include traditional healthcare institutions, such as

hospitals, primary care, and outpatient services, and more specialized services, including home healthcare and behavioral health services. Notably, they also integrate social services sectors, such as housing, transportation, criminal justice, and legal services.

Creating well-integrated complex care ecosystems requires overcoming deeply entrenched silos between organizations and sectors. Major challenges include data sharing, workforce development, and integrated funding and payment. Below are some recommendations for the field that are outlined in the Blueprint for Complex Care, along with examples of organizations that are addressing each of these challenges well.

Complex care programs need cross-sector data¹¹ to identify individuals with complex health and social needs, meet those needs, and evaluate and improve service delivery. The Blueprint outlines strategies to address data-sharing barriers, including technical assistance and low-cost information technology overlays for complex care programs that include social services data and also communicate with larger electronic health record and health information exchange systems. AllianceChicago, a health data organization in Chicago, Illinois, recently partnered with Chicago community health centers to pilot HealthyRx, a program in which providers used an integrated data system to "prescribe" nonmedical community services.¹²

Complex care providers encompass a spectrum of licensed and unlicensed healthcare and social service providers, including social workers, lawyers, community health workers, physicians, and nurses. To advance a cohesive field, core competencies must be codified for both patient-facing staff and organizational leaders. This will allow for the establishment of standard educational programs and materials and potentially include formal certification standards for complex care providers. This means that despite their different roles, all complex care providers should be proficient in a number of core areas, including trauma-informed care, team-based practice, and care planning. In advancing its field, the Center to Advance Palliative Care has developed a robust repository of educational materials and courses designed to codify and standardize best practices across providers. Such standardization ensures that providers and systems have the right tools and knowledge to deliver the best care in their own communities. The National Center for Complex Health and Social Needs, along with 4 regional academic hubs, operates a national interprofessional education program known as Student Hotspotting.¹³ The curriculum exposes students of allied health professions to the theories, skills, and practices of other health professionals working with individuals who have complex health and social needs in their own communities.

The current shift from fee-for-service to value-based payment provides incentives for health systems and others to focus on those with complex needs.¹⁴ However, sustainable, fully integrated payment models needed to support complex care are still rare. The Blueprint recommends continued experimentation, research, and

technical assistance to develop and test alternative payment models that sustain complex care models and ecosystems. For example, accountable care organizations (ACOs) are among the entities most interested in and incentivized to invest in complex care.¹⁵ The National Association of Accountable Care Organizations has been working with leading ACOs to develop tailored payment models and interventions for patients with complex health and social needs.¹⁶

Building a Strong Field

In implementing these and other recommendations, the emerging field of complex care will have to balance the need for cohesion and leadership with the desire for inclusivity and shared ownership. To do that, the Blueprint proposes a coordinating structure for the field, to be convened by the National Center for Complex Health and Social Needs, that includes working committees of experts from across organizations. This structure will help orchestrate major field-building activities, develop resources, and serve as an entry point for individuals and organizations who want to contribute to the field.

Clearly, the current healthcare and social service systems are not working for those with complex needs, and this population would be better served by a cross-sector field tailored to their needs. The Blueprint is an important step toward advancing this field of complex care. It is the hope of the Blueprint authors and proponents that it helps clarify the shared values, principles, goals, and current state of the growing, dynamic complex care community. Others are invited to join experts to discuss, align, and lend expertise to further the common goal of improving the lives of people with complex health and social needs.

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