SECTION III.
RECOMMENDATIONS

Based on the current state of complex care and lessons from other fields, we propose the following recommendations as high-priority opportunities to strengthen the field.

These proposed activities emerged from our interviews, polls, literature review, and expert convening, and were refined through discussions with key stakeholders. The recommendations represent a consensus of the authoring organizations and are intended to be specific, relevant, and achievable within the next three to five years. For a detailed description of our process, see **Appendix B**; for additional insight into the interviews, convening, and surveys, see **Appendices C through G**. We believe that the following recommendations are effective ways for the field to achieve its goal of improving the lives of individuals with complex health and social needs.

Table 1. Recommendations by *Strong Field Framework* Components

	Shared identity	Standards of Practice	Knowledge Base	Leadership/ Grassroots Support	Funding/ Supporting Policy
1. Develop core competencies and practical tools to support their use.		✔			
2. Further develop quality measures for complex care programs.		✔	✔		✔
3. Enhance and promote integrated, cross-sector data infrastructures.			✔		✔
4. Identify research and evaluation priorities.			✔		
5. Engage allied organizations and healthcare champions through strategic communication and partnership.	✔			✔	
6. Value the leadership of people with lived experience.				✔	
7. Strengthen local cross-sector partnerships.				✔	
8. Promote expanded public investment in innovation, research, and service delivery.					✔
9. Leverage alternative payment models to promote flexible and sustainable funding.					✔
10. Create a field coordination structure that facilitates collective action and systems-level change.	✔	✔	✔	✔	✔
11. Foster peer-to-peer connections and learning dissemination.	✔	✔	✔	✔	✔

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

We recommend the development of a set of core competencies for complex care leaders and practitioners as a first step toward building effective teaching and training programs for the current and future workforce. The field should convene a diverse, cross-sector group of practitioners, educators, and individuals with lived experience. This group should go through a consensus process to identify the core competencies that are essential to providing person-centered, equitable, cross-sector, team-based, and data-driven care to people with complex needs. Specific competencies may be required for certain subpopulations or program types, but the core set of knowledge, skills, and abilities should be broadly applicable. Additional competencies should also be developed for leaders of organizations providing complex care. The competencies may change over time, but they would create a framework and language for describing what defines the practice of complex care.

Identifying competencies allows for the development of standardized educational programs and resources that can be delivered through traditional educational institutions, professional associations (including those in overlapping fields), continuing education programs, and workplace training. Similarly, leadership development programs, like that offered by the Palliative Care Leadership Centers, could be developed based on these competencies.[23] Over time, the core competencies could evolve to become formal practice standards that could be measured and tested. The field may ultimately consider formal certification standards that would allow individuals within their own professional specialties to demonstrate a sub-specialization within complex care.

2. Further develop quality measures for complex care programs

Examples of existing work on developing quality measures:

- CMS' Medicaid Innovation Accelerator Working Group on Metrics for High Needs Populations
- National Quality Forum's Getting to Measures that Matter

The field should develop a common set of process and outcome metrics for programs serving populations with complex needs. There are currently a variety of efforts underway to improve measurement for this population that should be aligned and ultimately integrated.[104]

The process to define appropriate metrics will need to be carefully designed. It should involve diverse stakeholders, including researchers, healthcare and non-healthcare practitioners, government, payers, and individuals with lived experience. Building on related efforts that are already underway, the field should:

- Inventory the range of metrics currently used across different populations and settings.
- Identify shared principles, goals, and outcomes that can be translated into metrics. Such goals may include quality of life, recovery, and progress toward individual goals, as well as more traditional measures of cost and utilization.
- Match existing, validated measures to goals and outcomes, where possible.

- Explore new measures in current gap areas (e.g., measures that capture progress toward patient identified goals).

- Align with existing metrics that impact payment, ratings (e.g., STAR ratings), and other elements that matter to system leaders.

- Standardize methodologies for calculating changes in cost and utilization.

- Streamline measurement. Providers are already subject to significant measurement requirements and this effort should avoid further contributing to that problem.

Ultimately, the field should align around some measures that are common across programs, and should avoid a singular focus on cost and utilization outcomes. This does not preclude the use of other metrics that are customized to particular programs or populations. The collection of common metrics can facilitate faster progress in quality improvement, demonstrate effectiveness, and help generate evidence.

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 to promote data sharing and integration within the healthcare system and across sectors must address the cultural, technical, and legal barriers that exist. Keeping these considerations in mind, these steps should be taken:

- Provide resources, formal guidance, and technical assistance to address real and perceived legal barriers to data sharing.

- Invest in improved data collection, management and analytics among community-based organizations and local government.

- Partner with technology companies to develop low-cost IT overlays for complex care programs that can communicate with larger EHR and HIE systems. Opportunities for this exist because of new interoperability requirements and the Fast Healthcare Interoperability Standard that facilitates data exchange.

- Identify a limited set of data fields related to social needs to become standard and incorporated into large health IT systems to ensure social data are shared throughout the complex care ecosystem.

- Incorporate data sharing as a key component of cross-sector partnerships at the community level, including local government. Provide technical assistance and resources to local and regional organizations that serve as data integrators.

Examples of existing work on enhancing and integrating cross-sector data infrastructures:

- Data Across Sectors for Health's All In: Data for Community Health learning network

- Academy Health and Office of the National Coordinator for Health Information Technology's Community Health Peer Learning Program

4. Identify research and evaluation priorities

Examples of existing work on research and evaluation priorities:

- Social Innovation Research and Evaluation Network (SIREN)
- AcademyHealth's high needs research session at their 2018 Annual Research Meeting

While there has been a proliferation of research and evaluation work related to complex care, significant gaps remain. We recommend that the field actively engage leading complex care researchers to develop shared research and evaluation questions and frameworks. While some work is already underway, the development of a community of researchers and an initial set of research questions can be accelerated though these activities:

- Convene researchers in an ongoing network to share research, foster new collaborations, and build connections between researchers and innovative practices.
- Perform a systematic literature review to identify the most pressing research and evaluation priorities.
- Develop key principles and goals for complex care research.
- Incorporate providers and people with lived experience as research collaborators.
- Connect with researchers in other fields who have shared interest in complex care research topics and whose work can be applied in the context of complex care.
- Investigate the potential role that learning health systems could have in creating rapid research and quality improvement capacity among networks of complex care programs.

The Blueprint development process has already identified a number of important research areas:

- Deeper understanding of subpopulations and continued refinement of the NAM complex care patient taxonomy, including how to identify individuals at risk of developing complex health and social needs.
- Continued study of the components of complex care interventions individually and in combination, including dosage response and criteria for reduction in program intensity and graduation.
- Design of implementation systems for replicating and adapting evidence based models in new systems and communities.
- Development of appropriate metrics, as described above.
- Design of payment systems that incentivize and support complex care ecosystems and programs.

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

As a field that consists of many sectors, 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—for example, criminal justice, community development, social services, palliative care, primary care, addiction medicine, population health, patient advocacy groups, and public health. Such partnerships allow for collaboration on cross-cutting issues like research, policy, and payment. They also facilitate the spread of complex care practices and knowledge to larger, more developed communities that are able to deploy them and extend the community that identifies as part of complex care.

Many inter-organizational relationships already exist and can be deepened through formal partnerships between convening entities (e.g., the authoring organizations) and professional organizations within those communities. Simple activities like presenting at the others' events, sharing educational resources and curricula, and cross-promoting key information and opportunities create immediate value. Over time, the relationships can deepen to involve collaborative work on shared issues, technical support for programs and members, and joining forces in coalitions to educate and advocate for shared concerns.

Strategic communications efforts are required to influence public and private decision-makers who shape our health and healthcare systems.[106] While enhanced communication will help to provide clarity about what the field is and the value it offers, it also requires a set of shared values and definitions. The field should continue to build on the progress made by the *NAM report* and the *Blueprint for Complex Care* to define core aspects of complex care and its value.

Additionally, particular attention and support should be given to the leadership of health systems, insurers, ACOs, and other healthcare stakeholders who are adapting to dramatic changes in the healthcare landscape and are motivated to find new solutions for those with complex health and social needs. They are critical members of the field and advancing complex care ultimately requires their collaboration and support.

6. Value the leadership of people with lived experience

Because active participation of individuals in the design of systems is a component of person-centered care and principle of complex care, people with lived experience should be among the field's leaders and spokespeople. Individuals' experience and insight 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. Moreover, the development of leadership skills and opportunities can be an important aspect of building capacity with these individuals.

Examples of existing work to promote leadership and inclusion of people with lived experience:

- Community Catalyst
- Planetree
- Paraprofessional Healthcare Institute

The field should make inclusion of people with lived experience a high priority. We recognize that this goal runs counter to existing power structures in our society that contribute to many

of the problems complex care seeks to address, so deliberate intention and sustained commitment is required.[107] The following represents a non-exhaustive set of recommendations to help progress toward this important goal:

- Incorporate people with lived experience in decision-making and oversight bodies, including local boards, advisory committees, community health needs assessments, and quality improvement efforts. The field should partner with organizations focused on this goal to help health systems overcome barriers to meaningful inclusion.

- Include leaders in peer recovery, disability, patient advocate, and other consumer-led communities in field-building activities. Existing leaders are potential allies who can help connect complex care to larger social movements in ways that are mutually beneficial.

- Through partnership with local and regional networks, develop a cohort of at least 50 national advocates who have lived experiences. Opportunities exist to partner with local organizations and networks to recruit, train, and sustain the engagement of advocates over time. Creating a cohort connected to a national field can elevate their voice, promote the sharing of promising practices, and provide further opportunities for leadership development.

7. Strengthen local cross-sector partnerships

Examples of existing work to strengthen cross-sector partnerships:

- ReThink Health
- America's Essential Hospitals

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 collaboration, yet creating effective, sustained partnerships is challenging.[108] We recommend these focused efforts to support the development and strengthening of multi-sector partnerships:

- Document promising models, core components, and key practices of effective cross-sector partnerships, particularly those focused on people with complex needs. Key elements may include governance and shared decision-making, data sharing, financing, leadership support and culture.

- Support development of cross-sector partnerships through coaching, learning collaboratives, and other technical assistance.

- Create public and private payment models to sustain collaboratives.

- Partner with other organizations focused on cross-sector partnerships to support implementation of evidence-based complex care models within existing partnerships. Activities could include the development of case studies, learning collaboratives, and other resources.

- Promote use of rigorous planning, design, and evaluation as part of all complex care implementation projects through education, funding, and access to expert resources.

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. Investments are necessary to continue progress and should include:

- Continued investment through CMMI in innovative delivery models and payment models focused on complex care populations.

- Continued use of Medicaid waiver programs and managed care authority to support integration of services and attention to complex needs.

- Working with state and federal partners to develop improved risk adjustment and other rate setting mechanisms to reflect higher costs of people with complex social needs.

- Use of federal funding to support complex care research, including quality metric development, learning health system formation, and the design, dissemination, and implementation of services and models for those with complex health and social needs.

- Promoting use of community benefit funds to support complex care models and ecosystems.

- Use public funding for workforce development, including Graduate Medical Education credits, technical assistance and training, and program implementation, particularly in under-resourced communities.

Achieving increased funding will require coalition building and federal advocacy. The attention and funding around the opioid epidemic also provides opportunities to expand services and create infrastructure to serve those with complex health and social needs.

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, but much work needs to be done to build sustainable payment models. We recommend these actions to help the field achieve sustainable funding in the current environment:

- Communicate the business case for payers, ACOs, and health systems to invest in complex care programs and ecosystems.

- Document promising uses of alternative payment models to support complex care programs.

- Collaborate with federal and state partners, Medicaid MCOs, D-SNPs, and Medicare Advantage plans to pilot and test alternative payment models for complex care programs and services.

Examples of existing work to leverage alternate payment models:

- Nonprofit Finance Fund's Advancing CBO Networks for Stronger Healthcare Partnerships

- Center for Health Care Strategies' State Innovation Model Technical Assistance

- Develop resources, case studies, training and coaching to support community-based organizations' capacity to enter into contractual arrangements with managed care and ACOs.

- Promote, within a fee-for-service environment, the development and use of billing codes for services like care planning, care coordination, health coaching, home visiting, and other person-centered services that are common to complex care and other aligned fields. Such codes should be billable by various professions, para-professionals, peers, and community health workers.

- Work with CMS and Medicaid MCOs, to expand coverage and increase incentives for funding social services, including housing and food support.

- Use performance incentives for Federally Qualified Health Centers and other safety net providers to invest in additional resources and services for those with complex needs.

- Work with Medicare Advantage plans to expand coverage of non-medical needs under new authority.

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

These recommendations are ambitious but necessary to continue to formalize, strengthen and grow the field of complex care. Many are foundational investments that require collective action and must reflect the needs, goals, values, and expertise of the field. They will require various organizations to take leadership on behalf of the field. To coordinate activities and 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.

This structure should include topical working committees of experts who draw on their own and others' experiences to develop resources and positions on issues that are important to the field of complex care. Committees should be inclusive and transparent, formed through an open nominating process involving people with varying backgrounds and lived experience. All committee proceedings, plans, and decisions should be publicly available. Potential committees include Standards and Competencies, Research, Metrics, Implementation, and Policy/Advocacy. Supporting such working committees will require considerable effort and resources; this responsibility can be assigned to different organizations that have the expertise and commitment in the particular topic. The organizations leading each committee should also sit on an overarching steering committee.

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

While the field requires coordination, it should also invest in infrastructure to connect stakeholders 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. The following elements will foster stronger connections among and between members of the complex care community:

Examples of existing work on building peer-to-peer network:

- IHI's Better Care Playbook
- Center for Health Care Strategies' Complex Care Innovation Lab

- A searchable directory of individuals and organizations within the complex care community with information about their programs, populations served, and areas of research.

- A learning management system that hosts resources, training, and curricula from individuals and organizations throughout the field.

- Online communities that enable individuals to interact, post questions, and share resources with one another.

- Local and regional complex care chapters or affiliates that facilitate communities of practice and advocacy.