Designing Your Roadmap for Complex Populations

#IHIFORUM

Sunday, December 9
1:00 – 4:30 pm
Nothing to Disclose

The presenters, Lauran Hardin, Kedar Mate, Catherine Mather, Cory Sevin, and Mark Humowiecki, have no relevant financial or nonfinancial relationship(s) within the services described, reviewed, evaluated, or compared in this presentation.
Objectives

- Describe what is known about “what works” for moving individuals with complex needs and high healthcare costs toward better health and lower costs.
- Identify resources available to support this work of redesigning care for individuals with complex needs and high healthcare costs.
- Apply to your own context a tested process for designing or redesigning care programs for populations with complex medical, social and behavioral needs.
- Apply core attributes of complex care programs (as defined by the National Academies of Medicine) to your own complex care programs.
- Consider a business case to support implementation and sustainability of your complex care program.
Presenters

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Senior Director  
Institute for Healthcare Improvement

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Senior Advisor  
The National Center for Complex Care

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Director  
Institute for Healthcare Improvement

Mark Humowiecki  
Senior Director  
The National Center for Complex Care

Kedar Mate  
Chief Innovation Officer  
Institute for Healthcare Improvement
Disclosures

- These presenters have nothing to disclose
Attendees

- Accenture Health Practice
- AHS/U of C
- Ascension Saint Agnes
- Carolinas Medical Center/Levine Children's Hospital
- Central DuPage Hospital
- Cheyenne Regional Medical Center
- Cleveland Clinic
- Company
- Geisinger
- Hamad Medical Corporation
- Health and Research Educational Trust of New Jersey
- Indian Health Service
- Institute of Mental Health
- Kaiser Permanente
- Mercy Hospital Springfield
- Methodist Healthcare Ministries
- Nemours
- Norwegian Medical Association
- OneCare Vermont
- Qualis Health
- Santa Clara Valley Medical Center-Hospital and Clinics
- SCAN Health Plan
- Southcentral Foundation
- Trillium Health Partners
- UFHealth Shands
- Washington University in Saint Louis
Agenda

- Welcome and introduction
- What is the problem you are trying to solve?
- Teams and model design
- Assets and resources
- Evaluation and business case
- The future of complex care
Framing the day

- Interactive session
- Flipped classroom
- Learn from the experts and each other
- Linked to resources for on-going learning and development
Ways of being

Share your experience

Practice “Yes…and” vs. “Yes….but”

Stay curious

Respect time

Expect to experience varied emotions

Show up, CHOOSE to be present
**Aim and problem statement:**
What population will this serve?
What data do you need?
Who are your key stakeholders?

**FIRST STEP:**

**Team and model design:**
What are the existing care models serving your population?
What will be the focus of your first model?

**FIRST STEP:**

**Assets and resources:**
What existing resources are available?
Where are your gaps in resources?
Who might you partner with to build resources?

**FIRST STEP:**

**Business case and evaluation:**
What data will you collect for evaluation?
What will you include in your business case?
Who will you partner with for evaluation?

**FIRST STEP:**
Four corners: Goals

- Get to know other Learning Lab participants
  - Common goals
  - Common challenges
- Understand who else is working in a similar context or with a similar population as you
- Lay foundations for asks and offers
How would you describe your organization?

- Health System
- Payer
- Community-based organization
- Social services provider
- Other
What population are you redesigning care for?

- Adults under 65 with disabilities
- People with behavioral health or social needs
- Frail older adults
- People with multiple chronic conditions
- People with advancing illness
Take a seat...but don’t get too comfortable

- Based on discussions during the four corners activity, consider sitting near someone a group of people you may want to engage with in small group activities
- You are strongly encouraged to move around throughout the session
Change is possible
What is the Problem You’re Trying to Solve?
5% of the population accounts for 50% of the cost

Why this? Why now?

- Chronic Heart Failure
- COPD
- Schizoaffective Disorder
- History of Addiction to IV Drugs and Alcohol
- Type 2 Diabetes
- Intermittent Homelessness

October 2011: Admitted to the hospital for almost a month for acute complications of his Chronic Heart Failure. Had a previous 25 day admission 5 months earlier.
Variation of patient complexity

Camden Coalition of Healthcare Providers
What is complex care

- Complex care seeks to improve the health and well-being of a relatively small, heterogeneous group of people who repeatedly cycle through multiple health care, social service, and other systems but do not derive lasting benefit.
- Complex care operates at the personal and system levels:
  - Personal: By coordinating care for individuals.
  - System: Creating complex care ecosystems, local networks of organizations that collaborate to serve individuals with complex health and social needs.
- At its heart, complex care seeks to be person-centered, equitable, cross-sector, team-based, and data-driven.
The swiss cheese model
Population/cost segments

- Long, dwindling course
- Organ system failure
- Short period of decline near death
- Stable, significant disability
- Chronic condition, normal function
- Acutely ill mostly curable
- Maternal & infant
- Healthy

Source: Lynn J, Straube BM, Bell K, Jencks SF, Kambic RT in Milbank Quarterly, Vol 85 No. 2, 2007 (pp. 185-208)
Utilization matrix
Population Health Intelligence Report - January 2016 - December 2017

The left graph shows the number of IP and ED Encounters by Financial Class. The right graph shows corresponding Charges.

**Top 1% Patients**

**Population by Gender**
- F: 63.31%
- M: 36.79%

**Population by Age Group**

**Primary Language**
- English: 84.13%
- Spanish: 15.66%
- Other: 0.02%

**Top 1% of Utilization Patients by ICD 10 Codes**
- Unspecified abdominal pain (39.12%)
- Chronic
- Dorsalgia

**Top 1% of Utilization Patients with 5 or more IP Visits**
- Chronic obstructive pulmonary disease w (acute) exacerbation (9.136%)
- Unspecified abdominal pain (5.309%)
- Sepsis, Type 2
- Heart failure, unspecified (2.716%)
- Acute

Other conditions and codes are also listed in the report.
Targeting your population

- Utilization
- Cost
- Payer
- Diagnoses
- Age
- Language
- Zip code
- Behavioral health
- Substance use disorder
- Social determinants of health, e.g. housing
- Cross sector data
1—2—4—All activity

- Answer the following questions:
  - What data do you have?
  - What data do you need?
  - Who are your stakeholders?
  - What questions should you target?
- Take 1 minute: By yourself, write down your answers
- Take 2 minutes: Discuss with a partner
- Take 4 minutes: In groups of 4, surface themes amongst the group for report out.
Six foundations are partnering with the Institute for Healthcare Improvement to offer you the latest information about improving care for people with complex health and social needs. Visit the User's Guide to learn how to navigate the Playbook and consider submitting your own content to be featured on the Playbook.

Key Questions
Find curated resources about promising approaches to improving care for people with complex needs.

- Why invest in redesigning care for people with complex needs?
  - 38 Resources

- Who are people with complex needs?
  - 29 Resources

- What care models are promising?
  - 63 Resources

- What practical tools can I use to redesign care?
  - 14 Practical Plays

www.bettercareplaybook.org
Resources for further exploration

- The Playbook: Who are people with complex needs?
- Play: Conduct a Three-Part Data Review to Understand Patient Needs
- Play: Identify Patients with Qualitative and Quantitative Criteria
- 10 Questions to Better Understand and Serve Your Complex Population
- Effective Care for High-Need Patients: Opportunities for Improving Value, Outcomes, and Health
- Segmenting High-Need, High-Cost Patients: A Video Presentation
- The CHRONIC Care Act of 2018: Advancing Care for Adults with Complex Needs
- Using Data to Better Serve the Most Complex Patients: Highlights from NGA’s Intensive Work with Seven States
- Persistence and Drivers of High Cost Status among Dual Eligible Medicare and Medicaid Beneficiaries

CHCS Center for Health Care Strategies, Inc.  Institute for Healthcare Improvement  The National Center for Complex Health and Social Needs
Teams and Model Design
At its heart, complex care seeks to be:

- **Person-centered**: Individuals’ goals and preferences guide all aspects of care. Care delivery is designed around the whole person, their needs, and their convenience, rather than the delivering institutions’ priorities. Providers develop authentic healing relationships with individuals and are sensitive to the ongoing impact of adverse life experiences.

- **Equitable**: Complex care addresses the consequences of systemic issues such as poverty and racism. Individuals with complex needs and their communities have valuable insights into the structural barriers that affect their lives and should be partners in developing solutions.

- **Cross-sector**: In order to address individuals’ array of needs, complex care works at the system level to break down the silos dividing fields, sectors, and specialties. Cross-sector collaboration is critical for creating the systemic changes necessary to provide whole-person care.

- **Team-based**: Complex care is delivered through interprofessional, non-traditional, and inclusive teams. These teams incorporate peers, community health workers, the individual themselves, and loved ones whom the individual chooses to include, in addition to medical, behavioral health, and social service providers.

- **Data-driven**: Timely, cross-sector data are freely shared across all care team members and are used to identify individuals with complex needs, enable providers to effectively meet the needs of their patients, and evaluate success.
Care attributes of successful care models

- **Multidimensional Assessment**: medical, functional, and social
- **Targeting**: those most likely to benefit
  (IHI: and persistently high cost if lowering costs is a strategic aim)
- **Evidence-based care planning**
- **Alignment** with patient goals and functional needs
- **Engagement** of patient and care partner—education and coaching
- **Communication**: coordination of care and communication among and between patient and care team
- **Patient monitoring**
- **Linking**: facilitation of transitions

Source: https://nam.edu/initiatives/clinician-resilience-and-well-being/effective-care-for-high-need-patients/
Delivery features of successful care models

- **Teamwork.** Multidisciplinary care teams with a single, trained care coordinator as the communication hub and leader
- **Coordination.** Extensive outreach and interaction among patient, care coordinator, and care team, with an emphasis on face-to-face encounters among all parties and collocation of teams
- **Responsiveness.** Speedy provider responsiveness to patients and 24/7 availability
- **Feedback.** Timely clinician feedback and data for remote patient monitoring
- **Medication management.** Careful medication management and reconciliation, particularly in the home setting
- **Outreach.** The extension of care to the community and home
- **Integration.** Linkage to social services
- **Follow-up.** Prompt outpatient follow-up after hospital stays and the implementation of standard discharge protocols

Source: https://nam.edu/initiatives/clinician-resilience-and-well-being/effective-care-for-high-need-patients/
Lessons from the field

- Defining a successful care model starts with the goals of the stakeholders involved
- The success of even the best care models depends on the particular needs and goals of the intended patients, and those will vary even within segments of the high-need population
- Different high-need segments will require different services and workforce competencies.
- Effective, robust and systematic learning and execution are necessary

Sources: https://nam.edu/initiatives/clinician-resilience-and-well-being/effective-care-for-high-need-patients/, http://www.careredesignguide.org/
Types of complex care models

- Clinics
- Hospital
- Home Visits
- Primary Care
Integration in the ecosystem

Healthcare Eco System

- Federal, S&L Government
- Research & Education
- Home Health
- Payers
- Prescription Benefit Management
- Employer
- Private Insurance
- Finance
- Reference Laboratory
- Emergency Services
- Screening Registers
- Ambulatory Centers
- Medical Supplier
- Public Health
- Clinical Documents
- Diagnostic Imaging Center
- Speciality Clinic
- Academic Medical Center
- Long-Term Care
- Hospital
- Pharmacy
- Physicians
1—2—4—All activity

- Answer the following questions:
  - What are the existing models?
  - Where will you focus your model?
- Take 1 minute: By yourself, write down your answers
- Take 2 minutes: Discuss with a partner
- Take 4 minutes: In groups of 4, surface themes amongst the group for report out.
What matters most

**Questions for My Care Team...**

- Birth Certificate
- Social Security Card
- Non-drivers N.J. I.D.
- Housing*
- Schooling*
- Employment
- Addictions Support
- Primary Care Physician
- Medication Support
- Nutritional Support
- Transportation
- Phone Communication
- Clothing
- Food - Welfare?
Self-actualization
desire to become the most that one can be

Esteem
respect, self-esteem, status, recognition, strength, freedom

Love and belonging
friendship, intimacy, family, sense of connection

Safety needs
personal security, employment, resources, health, property

Physiological needs
air, water, food, shelter, sleep, clothing, reproduction
Traumatic life experience
Using a root cause framework

- Medical
- Behavioral
- Social
- System
Underneath the surface

Social determinants of health
- Housing
- Transportation
- Food insecurity
- Social isolation
- Legal issues
- Health literacy/language
- Safety

System barriers:
- Access
- Disorganized services
- Disconnect between medical/social/behavioral services
- Complex health problems – fragmented treatment silos
New core competencies & practices

- Interprofessional teaming
- Integrating SDOH in assessment
- Trauma-informed care
- Harm reduction
- Motivational interviewing
- Medication assisted treatment
- Guardianship
- Financial/legal navigation
- System case conferencing
- Safety protocols
Sustaining practices for teams

- Trauma informed team facilitation – moral distress
- Embracing ambiguity
- Huddle and rounds
- Incremental success
- Marathon mind
Activity

- Designing models for complex populations
- Key questions
Resources for further exploration

- The Playbook: What care models are promising?
- Quick Reference Guide to Promising Care Models
- The Better Care Playbook State Map
- Play: Define Care Management Team
- Play: Use Human-Centered Design Methods to Develop Your Care Model
- Play: Integrate Health Coaches into Your Care Team
- Play: Engage Stakeholders with Storyboards
- Geisinger Health System Deploys Community Health Workers to Address Social Determinants of Health
- Are Social Workers Missing from Your Complex Care Teams?
- Lessons from the Front Lines: Insights into Trauma-Informed Care for Medicaid’s complex populations
- Development of a Care Guidance Index Based on What Matters to Patients
- Perspectives on Root Causes of High Utilization that Extend Beyond the Patient
Break (20 min)
Assets and Resources
Asset Mapping
What are the resources for Complex Patients?
Managing services for a population

Community, Family and Individual Resources

Needs Assessment for Segment

Goals

Service Design

Coordination

Delivery of Services at Scale

Population Segmentation

Population Outcomes

Integrator

Feedback Loops

Feedback Loops

Needs Assessment for Segment = Service Design

= Coordination

= Delivery of Services at Scale
Leveraging social determinants

Step 1: Match unmet needs to available services

● Use 5-patient care planning process to identify pressing needs that lie outside your scope
  ○ *Deliberately investigate social determinant needs!*

● List the top 2-3 pressing needs, and look for resources in the community that provide related services

● Identify the value you can bring to others’ work
  ○ *How will the partner help your complex care population?*
  ○ *How can your work help the partner organization?*
Elephant in the room

Healthcare

Community organizations

This Photo by Unknown Author is licensed under CC BY-SA
Matching services to the needs of your population

<table>
<thead>
<tr>
<th>Patient experienced issues /needs identified</th>
<th>Services required</th>
<th>Partners required and at what level?</th>
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<tbody>
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Identifying partners

- Behavioral health
- Housing providers
- Transportation providers
- Social services
- Addiction medicine
- Pain management
- Neuro-psych
- Medical-legal partners
- Guardians
- Peer support
- Ethics and risk management

Internal partnerships

“We want to figure out how to leverage our colleagues who are already supporting these existing programs and their skills. To get started we pulled together people who represent all those different sites of care, which sometimes can be siloed even though we’re one organization, and try to figure out what’s currently in place. Our goal was to evaluate the enhanced care model against these different existing programs, with input from people who understand these programs:

- What are the gaps?
- Where is the overlap?
- What are the things that we’re not currently providing well?
- What can we learn from others within and outside of our organization?
- How might we reorganize what we’re doing to better meet the needs of this subset of our population rather than build an enhanced care program from scratch?
- Now, there’s an increased awareness about the need to integrate, coordinate, and avoid duplication and fill gaps. We’ve gotten started on the process of coordinating across those programs.”

Diane E. Craig, M.D., F.A.C.P, Assistant Physician-in-Chief, The Permanente Medical Group, Santa Clara Medical Center

Source: http://www.careredesignguide.org/strengthening-partnerships/lessons-from-the-field/
Core partnership activities

- Identify overlapping patient populations served by teams from all partner organizations.
- Learn about how each team serves patients or clients. What services does the team deliver? Who directly serves patients? What eligibility criteria does each team have in place, and why?
- Verbally recognize the contributions that the partner makes to the health and well-being of the patient population.
- Identify and discuss any potentially competing priorities among partners.
- Develop shared goals, including deciding on a population of focus and defining a measurable and time-bound aim.
- Determine the scope of the partnership. Be clear about capacity from the beginning: how many people can the partnership organization teams serve in collaboration? Continually plan around matching capacity to demand for services.
- Commit to sharing data, which may require extended legal support and negotiation for teams that report to different organizations.
- Test collaboration strategies together, leading to the development of shared work processes. This often includes developing shared or complementary assessment processes and honing referral processes that include feedback loops to ensure communication.
- Hold monthly collaborative case conferences to bring members of different care teams together to solve problems, learn about each team’s care delivery, try out new ways to serve individual patients, develop work processes to shape care delivery for all patients, and identify areas to advocate for systemic change.
- Commit to developing shared decision-making methods. This might involve a commitment that those who attend a meeting are empowered to make decisions, rotating leadership from partner teams, or election of a lead decision-maker.
- Build cohesion among partners. Celebrate successes, acknowledge contributions by all partners, and create opportunities to gather together to develop relationships beyond the work.

Source: http://www.careredesignguide.org/strengthening-partnerships/#core-activities
Lessons learned

- Partnership structures to facilitate success
Partnership: Rules of the road

- “You have one mouth and two ears, use them proportionally”
- Decisions are made by the those who show up
- Assume that you will need to lose a bit of control for much, much more power
Activity: The Challenge Capsule
Resources for further exploration

- Play: Use 5X Scale-up Grid to Plan Implementation
- Play: Integrate the Complex Care Program with Primary Care
- Play: Link Patients to Community Resources
- Play: Partner with Payers
- Practical Tools to Foster and Sustain Partnerships between Health Care and Community
- Why Strong Relationships Matter Financing Complex Care Management
- Leveraging Social Determinants of Health: What Works
- Three Tips to Make the Most of Your Community Health Needs Assessment
Evaluation and the Business Case
## Four quadrant outcomes

<table>
<thead>
<tr>
<th>Cost &amp; Utilization</th>
<th>Quality Improvement</th>
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<tbody>
<tr>
<td>Patient/Provider Satisfaction</td>
<td>Story</td>
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</table>
Activity evaluation metrics

Take 5 Minutes to write on individual post it notes every evaluation metric you think will be valuable for your program.

Include Cost & Utilization Metrics, Quality Metrics, Patient/Provider Satisfaction Metrics and any other Metrics you think would be valuable
Outcomes — 339 patients in 24 months

<table>
<thead>
<tr>
<th>Hospital Utilization</th>
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<tbody>
<tr>
<td>Admissions Reduction</td>
</tr>
<tr>
<td>195</td>
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<tr>
<td>44%</td>
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<tr>
<td>Emergency Visit Reduction</td>
</tr>
<tr>
<td>1,498</td>
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<tr>
<td>43%</td>
</tr>
<tr>
<td>Outpatient Visit Reduction</td>
</tr>
<tr>
<td>199</td>
</tr>
<tr>
<td>17%</td>
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<table>
<thead>
<tr>
<th>Patient Economics</th>
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<tbody>
<tr>
<td>High Frequency Population</td>
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<tr>
<td>Net Revenue Reduction</td>
</tr>
<tr>
<td>42%</td>
</tr>
<tr>
<td>Direct Expense Reduction</td>
</tr>
<tr>
<td>47%</td>
</tr>
<tr>
<td>Operating Margin Increase</td>
</tr>
<tr>
<td>$632k</td>
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</table>

Outcomes — 339 patients in 24 months

<table>
<thead>
<tr>
<th>Quality Measurements</th>
<th>Patient Housing</th>
<th>Primary Care Physician</th>
<th>Insured</th>
</tr>
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<tbody>
<tr>
<td>14%</td>
<td>15%</td>
<td>16%</td>
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</table>

<table>
<thead>
<tr>
<th>Patient Utilization</th>
<th>Length of Stay 41%</th>
<th>CAT Scans 62%</th>
<th>ED/Urgent Care Minutes 49%</th>
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</thead>
</table>

Complex Care Business Plan  
Financial Performance

Outcomes Over a Two Year Time Period

<table>
<thead>
<tr>
<th>Proposal</th>
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<tbody>
<tr>
<td>• Proposed investment of $3 million over 5 years</td>
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<tr>
<td>• Estimated return on investment of 28% within 5 years</td>
</tr>
<tr>
<td>• Targeted population of 900 patients</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Actual Financial Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Actual investment of $760,000 over 2 years</td>
</tr>
<tr>
<td>• Actual return on investment of 23% over 2 years</td>
</tr>
<tr>
<td>• Actual patient population exceeded 1,000</td>
</tr>
</tbody>
</table>
Health Care Results

28 high-frequency patients experienced the following outcomes in health care and community services utilization for the 12 months following initial enrollment in the complex care/intensive case management initiative*

- **78% reduction in ED visits**
- **60% reduction in inpatient admissions**
- **51% increase in fee-for-service outpatient utilization**
- **38% reduction in inpatient days (LOS)**
- **$827,786 savings in direct health care expenses attributed to this population**

*Comparing 12 months pre-intervention. Preliminary Data*
Community Results

28 high-frequency patients experienced the following outcomes in health care and community services utilization for the 12 months following initial enrollment in the complex care/intensive case management initiative*

- **82% reduction in police encounters**
  - A direct cost savings of $45,537

- **95% reduction in EMS responses**
  - A direct cost savings of $58,900.

- **$211,257 savings in community partner costs attributed to this population**

- **81% reduction in jail days**
  - A direct cost savings of $106,820

*Comparing 12 months pre-intervention. Preliminary Data.*
Building the business case

- Partners and shared data
- 360 degree view
- Four quadrant outcomes
- What is the why?
- Scaffolding implementation
Building the business case

- Take 5 minutes to write your top five on an index card
- Take 10 minutes to share them at your table
- Capture the most important themes on one index card for your table
Resources for further exploration

- The Playbook: Why Invest in Redesigning Care for People with Complex Needs?
- No More Excuses: It’s time to Treat Opioid Addiction
- Webinar: Value-Based Payment Strategies for Patients with Complex Health and Social Needs
- The Return on Investment Calculator: The Business Case and Person-Centered Care
- The ROI Calculator for Partnerships to Address the Social Determinants of Health
- Complex Care Interventions: Building a Sustainable Business Case
- Complex Care Program Development: A New Framework for Design and Evaluation
- Investing in Social Services as a Core Strategy for Healthcare Organizations: Developing the Business Case
The Future of Complex Care
Reminder: What is complex care

● Complex care seeks to improve the health and well-being of a relatively small, heterogeneous group of people who repeatedly cycle through multiple health care, social service, and other systems but do not derive lasting benefit.

● Complex care operates at the personal and system levels
  ○ Personal: By coordinating care for individuals.
  ○ System: Creating complex care ecosystems, local networks of organizations that collaborate to serve individuals with complex health and social needs.

● At its heart, complex care seeks to be person-centered, equitable, cross-sector, team-based, and data-driven.
In 2016, Camden Coalition launched the National Center for Complex Health and Social Needs.

The National Center collaborates with partners across the country to strengthen the emerging field of complex care. Its programming includes:

- Connecting the field through the annual “Putting Care at the Center” conference and other events;
- Inspiring change by sharing stories of successful programs and transformed lives; and
- Supporting leaders and practitioners through training, technical assistance, and resources.

This year’s Putting Care at the Center conference was held on December 5-7 in Chicago, IL. Resources from conference are at: www.centering.care
What is the Blueprint?

- Drives a collective strategy for the complex care field to help it reach its potential
- Collaboration between the National Center, CHCS, and IHI funded by The Commonwealth Fund, RWJF, and The SCAN Foundation
- Includes an assessment of the current state of the field and actionable recommendations
- Will guide our work as a field for years to come, so we need your active involvement
Developing the Blueprint

- **Project Launch**: Fall 2017
- **Winter 2017**: Expert Convening and Stakeholder Survey
- **Fall 2018**: Blueprint Published
- **Spring 2018**: Environmental Scan
## Strong field framework

### Strong Field Framework (Created By The Bridgespan Group)

**Shared Identity:**
Community aligned around a common purpose and a set of core values

<table>
<thead>
<tr>
<th>Standards of Practice</th>
<th>Knowledge Base</th>
<th>Leadership and Grassroots Support</th>
<th>Funding and Supporting Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Codification of standards of practice</td>
<td>• Credible evidence that practice achieves desired outcomes</td>
<td>• Influential leaders and exemplary organizations across key segments of the field (e.g., practitioners, researchers, business leaders, policymakers)</td>
<td>• Enabling policy environment that supports and encourages model practices</td>
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<tr>
<td>• Exemplary models and resources (e.g., how-to guides)</td>
<td>• Community of researchers to study and advance practice</td>
<td>• Vehicles to collect, analyze, debate, and disseminate knowledge</td>
<td>• Organized funding streams from public, philanthropic, and corporate sources of support</td>
</tr>
<tr>
<td>• Available resources to support implementation (e.g., technical assistance)</td>
<td>• Respected credentialing/ongoing professional development training for practitioners and leaders</td>
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<tr>
<td>• Respected credentialing/ongoing professional development training for practitioners and leaders</td>
<td>• Vehicles to collect, analyze, debate, and disseminate knowledge</td>
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<tr>
<td>• Broad-base support from major constituencies</td>
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- Enabling policy environment that supports and encourages model practices
- Organized funding streams from public, philanthropic, and corporate sources of support
## Assessment of current state of complex care

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<tr>
<th>Framework Component</th>
<th>Strengths</th>
<th>Weaknesses</th>
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<tbody>
<tr>
<td>Shared Identity</td>
<td>- Stakeholders agree on the problems to address</td>
<td>- The field lacks a shared language</td>
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<td></td>
<td>- The community shares principles and goals</td>
<td>- There has been confusion on who comprises the target population</td>
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<td></td>
<td>- The potential community of stakeholders is vast and diverse</td>
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<tr>
<td>Standards of Practice</td>
<td>- Validated care models and promising practices exist and are spreading</td>
<td>- Data sharing limitations hamper progress</td>
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<td>- Common features of promising models and practices have been identified</td>
<td>- There is a shortage of providers prepared to deliver complex care</td>
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<tr>
<td>Knowledge Base</td>
<td>- A growing evidence base demonstrates complex care’s positive impact</td>
<td>- Current metrics do not reflect whole-person outcomes</td>
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<td></td>
<td>- Segmentation of the target population is improving</td>
<td>- Stakeholders disagree on the types of evaluation that are necessary</td>
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<td></td>
<td>- A community of researchers is emerging</td>
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<tr>
<td>Leadership and Grassroots Support</td>
<td>- Complex care is a high priority for many healthcare payers, providers,</td>
<td>- People with lived experience are not adequately included</td>
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<td></td>
<td>policymakers, and philanthropies</td>
<td>- Multiple barriers impede cross-discipline and cross-sector partnerships</td>
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<td></td>
<td>- Influential stakeholders in key segments of the field are increasing</td>
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<td></td>
<td>buy-in</td>
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<td>Funding and Supporting Policy</td>
<td>- The shift toward value-based payment supports complex care investment</td>
<td>- Healthcare-based programs struggle with financing in a shifting payment</td>
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<td>- Public investment has accelerated interest in complex care</td>
<td>environment</td>
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<td></td>
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<td>- Social and behavioral health services are funded differently and less</td>
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<td>robustly than healthcare</td>
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</tbody>
</table>
# Recommendations

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

● Sign up for our newsletters
  ○ National Center for Complex Health and Social Needs newsletter
  ○ This Week at IHI
  ○ The Better Care Playbook
● Provide feedback to the Blueprint or the Playbook
● Upcoming (to be announced) activities related to the Blueprint (e.g. meetings, networks, etc.)
● Become a Complex Care Champion - https://www.nationalcomplex.care/our-work/blueprint-for-complex-care/
The Camden Coalition invites you to

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November 13-15, 2019 | Memphis, TN

Putting Care at the Center 2019

nationalcomplex.care
@naticomplexcare

2019 Co-Host Regional One Health

For more information, visit www.centering.care.
Resources for Continuous Learning

- IHI Care Redesign Guide
- Playbook
- National Center for Complex Care
- www.complex.care
- Camden Coalition Hotspotting Curriculum
- AHRQ: Clinical Community Linkages
- The Assets Based Community Development Institute-Asset Mapping
Publications and Webinar

- Hardin, L., Kilian, A., & Murphy, L. (2017). Bundled Payments for Care Improvement: Preparing for the Medical Diagnosis-Related Groups. *Journal of Nursing Administration, 47* (6), 313 – 319. [http://journals.lww.com/jonajournal/Citation/2017/06000/Bundled_Payments_for_Care_Improvement__Preparing.5.aspx](http://journals.lww.com/jonajournal/Citation/2017/06000/Bundled_Payments_for_Care_Improvement__Preparing.5.aspx)


