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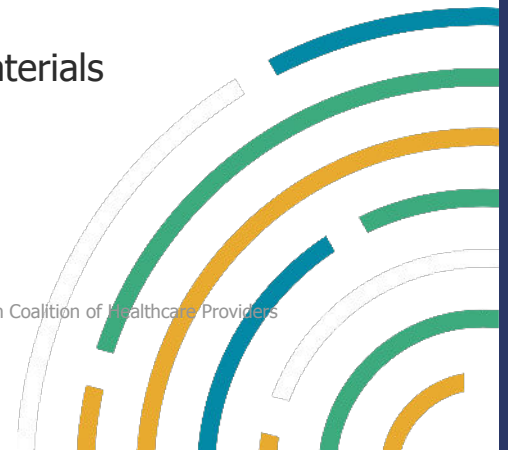

I'm hopeful that the endgame is a more human approach.

ANAND SHAH, MD, VP of Social Health, Kaiser Permanente

Introduction

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As the old adage goes, "No margin, no mission." Making a business case is a core competency of any clinical leader who wants to transform the delivery of healthcare for people with complex health and social needs. While we may know the value of our programs and services, we must also know how to communicate that value to stakeholders who control access to the resources (people, time, space, and technology) to operate these programs.

This toolkit is designed to help you gain support of key stakeholders within your organization, as well as with outside funders, partners, and payers. "Making the case" is not just about showing a financial return on investment. As we've learned from dozens of leaders nationwide, there are financial, quality, moral, personal, and political considerations at play when determining whether a program receives financial support.

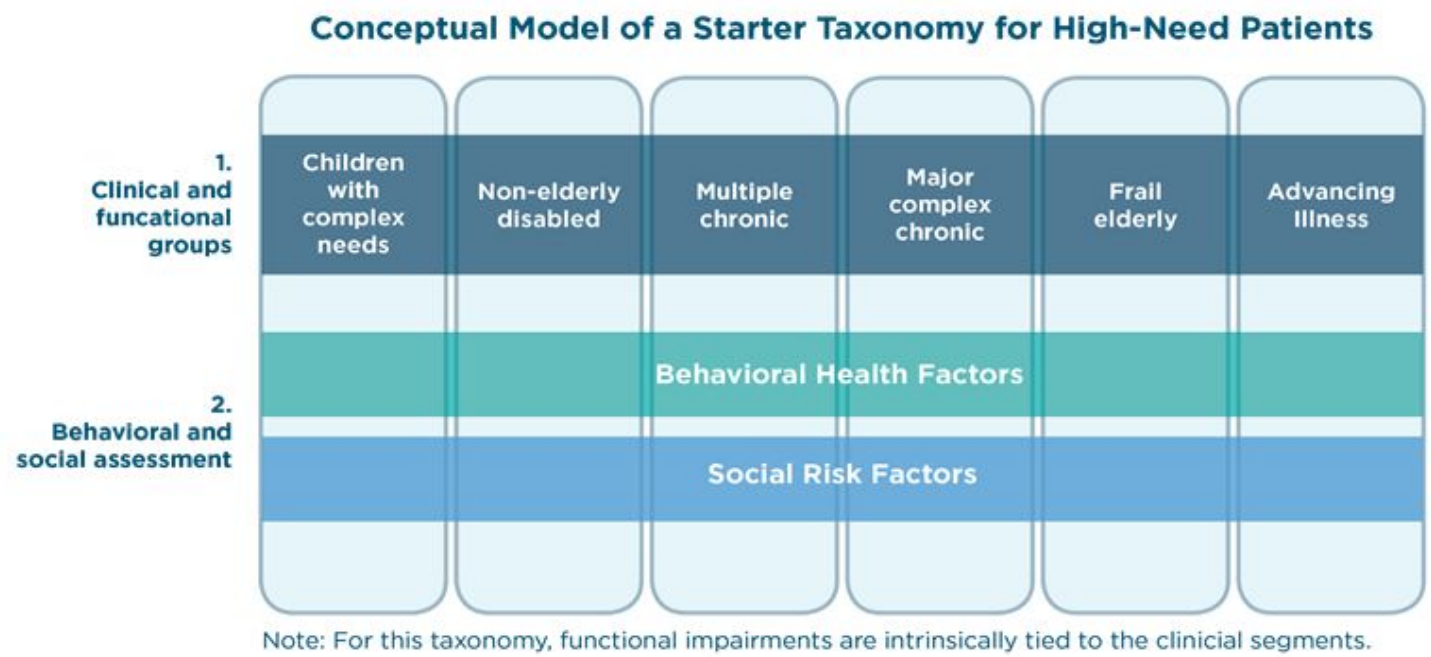
Creating this toolkit

With support from the Commonwealth Fund, we interviewed more than 100 health and social system leaders and innovators to understand what matters most in creating the case for complex care, how to adjust the case in times of crisis, and ways to champion efforts in various environments. In partnership with the Center for the Advancement of Palliative Care, we also adapted lessons from their Payment Accelerator course into the toolkit and resources. We've captured those lessons and translated years of experience into accessible tools and resources to help make the case for individual programs.

Know that this tool is iterative, and the "times they are a-changing." We invite you to share your own best practices with us for inclusion in the next version of this guide.

What is complex care?

Complex care is a new field of practice that seeks to improve the health and well-being of individuals who experience combinations of physical, behavioral, and social health needs that result in excessive utilization of the healthcare system. Complex care includes a variety of models, such as comprehensive care management by a health, behavioral health or social services agency, integrated primary care, and coordinated systems of care. These programs can be operated by health plans, primary care clinics, health systems, and community-based organizations to serve a diverse range of subpopulations – from children with complex needs to frail elders facing dementia and other chronic diseases.



Read the National Academy of Medicine **report** on the heterogeneity of high need populations

DEFINITIONS OF POPULATIONS FROM THE CONCEPTUAL MODEL

- **Children with complex needs**: Have sustained severe impairment in at least four categories together with enteral/parenteral feeding or sustained severe impairment in at least two categories, and requiring ventilation or continuous positive airway pressure. Categories for children with complex needs are: learning and mental functions, communication, motor skills, self-care, hearing, and vision

- **Non-elderly disabled:** Under 65 years and with end-stage renal disease or disability based on receiving Supplemental Security Income

- **Multiple chronic conditions:** Only one complex condition and/or between one and five non-complex conditions

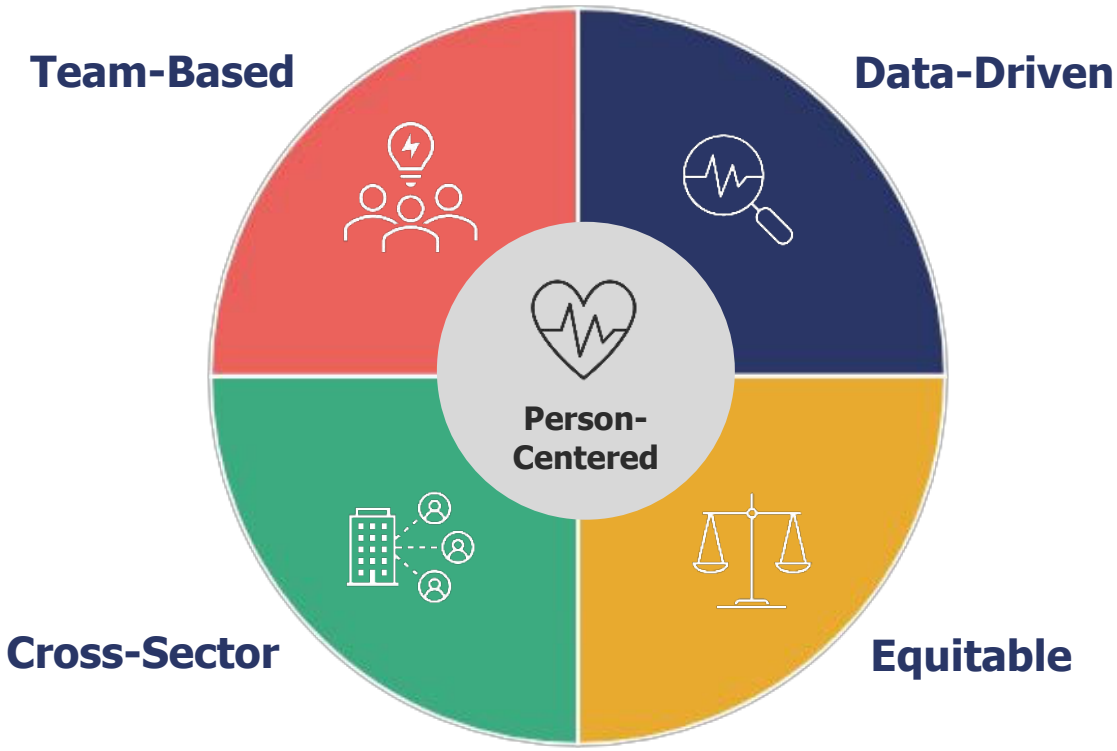
- **Major complex chronic**: Two or more complex conditions or at least six non-complex conditions. Complex conditions, as defined in Joynt et al., 2016, are listed in Table 2–1. Non-complex conditions, as defined in Joynt et al., 2016, are listed in Table 2–1.

- **Frail elderly:** Over 65 years and with two or more frailty indicators. Frailty indicators, as defined in Joynt et al., 2016, are gait abnormality, malnutrition, failure to thrive, cachexia, debility, difficulty walking, history of fall, muscle wasting, muscle weakness, decubitus ulcer, senility, or durable medical equipment use.

Despite the heterogeneity of models, settings, and populations, complex care programs share common elements and embrace the following principles:

- **Person-centered**
- **Team-based**
- **Cross-sector**
- **Equitable**
- **Data-driven**

While many complex care programs begin as a single care management program, the principles of care are best realized in a complex care ecosystem. Ecosystems are organizations across sectors within a community that work collectively and intentionally to better address the root causes of poor and inequitable health and well-being among populations with complex health and social needs. You can learn more about these concepts in the **Blueprint for Complex Care.**



The imperative for complex care

COMPLEX CARE IN THE TIME OF COVID-19

Making the case for complex care has never been more important, as the COVID-19 pandemic shed light on systems failures that impact the health of every individual in the nation. The pandemic has highlighted the vulnerability of the homeless, the fragility of isolated seniors, children's dependence on school for regular meals, the need for safe harbor for those in domestic violence situations, and the abundance of people one paycheck away from financial disaster. Furthermore, behavioral health needs and **deaths from drug overdoses** skyrocketed, and the spike in unemployment exposed the problematic connection between insurance and employment. All this is against a backdrop of rising inequality and increasing violence against Black, Indigenous and People of Color (**BIPOC**) communities that reveal deep cultural divides.

The explicit link between social determinants of health and physical health is well-established in the literature. We know that communities of color are disproportionately impacted by issues like unstable housing, lack of food security, and the deeper implications of poverty.

In the context of the pandemic, these social determinant factors had compounding implications for the physical health of BIPOC communities. The work of complex care is the deep systems work needed to change the trajectory of racial health equity in our country.

Policy changes in response to the pandemic have opened new possibilities for complex care. The expansion of **telehealth**, cross-state delivery of care, and integration of other disciplines signal progress, as does a shift in **bringing care into the home** to avoid hospitalization, and new community partnerships to facilitate **distributed models** of care. More emphasis is also being put on the need to address the housing and homelessness crises, and the value of **wraparound care** management services. **Virtual behavioral** health and addiction treatment interventions for social isolation have identified new levers for better access and outcomes. These important changes are expanding opportunities for complex care programs to think differently about historically underserved populations in new and collaborative ways.

Evolving financial models

The challenge of making the case for complex care is further complicated by the fact that our healthcare system is in the midst of a transition from fee-for-service to value-based care. Policymakers have long identified the fee-for-service system as a source of rapidly growing spending and misplaced financial incentives, pushing CMS to shift financial incentives in healthcare through programs like Accountable Care Organizations, bundled payments, and direct contracting. All these programs aim to realign incentives so that providers and health systems can benefit financially by delivering care more efficiently.

At the most basic level, making the financial case for complex care is more challenging in a fee-for-service (FFS) environment. This is because individuals living with complexity often frequent hospitals, and in a fee-for-service environment each visit is a reimbursable event, increasing hospital revenue. Therefore, understanding root causes, and driving people away from "sick care" results in diminished returns for the healthcare system. In a value-based environment, incentives are more aligned with reimbursement based on making people better, rather than simply paying a "fee for each service" rendered. This toolkit provides resources to make the value case in both settings or somewhere in between.

The pandemic further complicated the financial picture and exposed the vulnerability of a healthcare system in a fee-for-service model.

In 2020, health systems lost significant amounts of revenue from the cancellation of elective procedures and the increased cost of scaling up to provide staffing and care. Primary care, dental care, specialty care, community-based behavioral health, and federally qualified health centers have experienced declining revenue from patient visits and increased costs to obtain personal protective equipment, redesign delivery for COVID-19 safety, and implement telehealth and other workflows to provide care while physically distancing. These actions, although necessary, have resulted in layoffs and furloughs of healthcare workers, as well as the closing of some sites of delivery.

In 2021, new funding emerged to accelerate re-building communities and public health in response to the pandemic. Cities, counties and states received grants to accelerate attending to the needs of marginalized populations and building stronger cross community collaboration. Building understanding of these various financial models and how to articulate your value case in the context of your unique community is covered in this toolkit.