Core competencies for frontline complex care providers

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- Institute for Healthcare Improvement
- Center for Health Care Strategies
- Community Catalyst's Center for Consumer Engagement in Healthcare Innovation
- Alliance for Strong Families and Communities

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Executive summary

Complex care is a growing field that seeks to improve health and well-being for people with complex health and social needs — those who have multiple chronic physical and behavioral health conditions combined with social barriers such as homelessness and unstable housing, food insecurity, lack of transportation, and more that are exacerbated by systemic problems such as racism and poverty. Complex care seeks to serve people with complex needs in meeting their own health and well-being goals by coordinating or integrating a wide range of services and supports across diverse human needs.

While there is growing awareness that complex care has its own foundational knowledge, skills, and attitudes, to date the field has not named or defined a comprehensive set of core competencies.

The complex care core competencies capture the necessary knowledge, skills, and attitudes for members of teams or individual practitioners that are working in programs dedicated to coordinating and providing services for people with complex needs. These competencies are also for healthcare, behavioral health, and social service practitioners who may not work in dedicated complex care programs, but regularly encounter people with complex needs. These individual-level competencies apply across discipline, profession, and context.

The complex care competencies and this report reflect an extensive research process and the diverse input of key stakeholders and experts, the broader complex care field, and a year-long iterative developmental process conducted by 16 working group members and National Center staff.

The complex care core competencies working group brainstorming and refining competencies in February 2020.

The core competencies are divided into six domains:

Human complexity and context: The competencies in this domain capture that delivering effective complex care requires an empathetic understanding that the human experience is complicated and that poor health and inadequate living conditions have multiple causes, including an interplay of physical and behavioral health, structural and social conditions, racism, stigma, and bias.

Personal and professional commitment and ethics: The competencies in this domain capture that complex care team members are deeply and ethically committed to improving the lives of individuals experiencing vulnerability, believe in transformative change at the individual and system levels, engage in continuous learning and self-improvement, and serve as examples of hope and ingenuity.

Person-centered, relationship-powered care: The competencies in this domain capture that complex care team members value the autonomy and agency of individuals and families and recognize the importance of authentic healing relationships that support efforts to improve health and well-being.

Integrated team collaboration: The competencies in this domain capture how complex care relies on highly functioning, collaborative care teams that coordinate across multiple settings and in partnership with individuals and families.

Diverse information management: The competencies in this domain capture the collection and use of quantitative and qualitative sources of information, including the individual and their family, to identify clients, assess needs, adapt best practices, and continuously improve the delivery of care and supports. The term "information" includes both quantitative and qualitative data, including stories that derive from a variety of sources.

Systems complexity and context: The competencies in this domain capture that individuals with complex needs interact with multiple, often incongruous systems that can contribute to the challenge of improving health and well-being. The complex care workforce analyzes individual problems from a systems perspective and advocates for systems reform and policies that foster whole-person health.

The core competencies are a first step toward a comprehensive workforce development strategy that includes formative and continuing education. It also provides a national workforce standard that individual communities can apply and adapt within their individual setting and context.

About the Complex Care Field Coordinating Committee
One of *the Blueprint* recommendations was to form the Complex Care Field Coordinating Committee (FCC). The FCC — which includes the National Center for Complex Health and Social Needs (National Center), the Institute for Healthcare Improvement, the Center for Health Care Strategies, Community Catalyst's Center for Consumer Engagement in Healthcare Innovation, and the Alliance for Strong Families and Communities — coordinates and aligns the complex care field-building activities.

Introduction

Complex care is a growing field that seeks to improve health and well-being for people with complex health and social needs — those who have multiple chronic physical and behavioral health conditions combined with social barriers such as homelessness and unstable housing, food insecurity, lack of transportation, and more that are exacerbated by systemic problems such as racism and poverty.

Complex care seeks to serve people with complex needs in meeting their own health and well-being goals by coordinating and/or integrating a wide range of services and supports across diverse human needs. Complex care works at individual and systemic levels to address the root causes of poor health that defy existing boundaries among sectors, fields, and professions.[1] It builds on years of efforts taken by the fields of social work, nursing, community health, palliative care, behavioral health, and disability advocacy. Complex care arises from recent trends within healthcare to address social drivers of health and health equity and to create payment models that support those initiatives.[2,3,4,5]

While there is growing awareness that complex care has its own foundational knowledge, skills, and attitudes, to date the field has not named or defined a comprehensive set of core competencies. *The Blueprint for Complex Care (Blueprint)*, along with several published reports, have called for the development of core competencies for the workforce as a necessary next step in strengthening the field of complex care.[1,2,6]
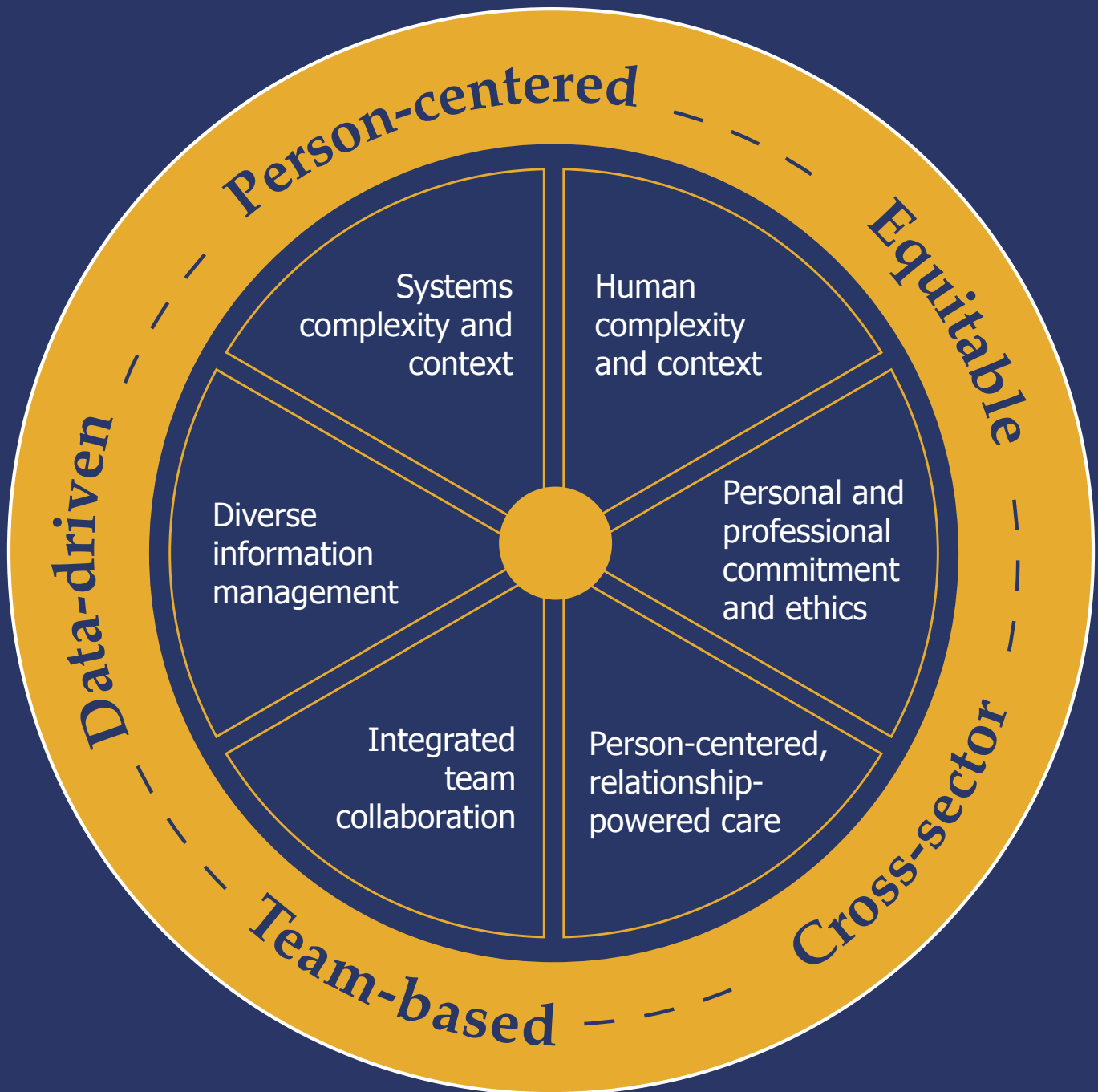
In the fall of 2019, the Complex Care Field Coordinating Committee chartered the National Center to convene a diverse, interprofessional working group of 16 complex care experts. The National Center supported the working group through an extensive research process including literature reviews, key stakeholder interviews, and feedback from the field, including from individuals with complex needs. Through consensus-building activities, the working group identified six domains for the competencies:

- Human complexity and context
- Personal and professional commitment and ethics
- Person-centered, relationship-powered care
- Integrated team collaboration
- Diverse information management
- Systems complexity and context

In this document, an individual in the population that complex care serves is interchangeably referred to as "individual," "person/individual with lived experience," "patient," or "consumer." Each of these terms is preferred in different settings and contexts and, due to historical and stigmatizing factors, each is rejected in other settings and contexts. There is no consensus on a single term and thus several terms are used interchangeably.

Section 1 of this report provides an overview of complex needs and complex care. Section 2 outlines which members of the complex care workforce should master these competencies. Section 3 provides background on the specific competencies. Section 4 defines the domains of the competencies, provides context for each domain, and lists the competencies that fall under each of the domains. Section 5 provides an overview of how the competencies should be applied and identifies next steps to implement the competencies in the field.

Complex care principles and core competency domains

Person-centered

Equitable

Cross-sector

Team-based

Data-driven

Systems complexity and context

Human complexity and context

Diverse information management

Personal and professional commitment and ethics

Integrated team collaboration

Person-centered, relationship-powered care

Why we need complex care core competencies:
A consumer's perspective

The core competencies are based in the experiences of individuals with complex health and social needs. Stories were used throughout the development process to identify the unique traits of complex care team members. Cynthia's story is one example of how a complex care team uses knowledge, skills, and attitudes beyond those of their discipline to support an individual with complex needs in reaching her goals.

Cynthia was tired of retelling her story. It was the same every appointment: Cynthia would meet a new practitioner who had no idea about her leg pain as a child, her diagnoses of lupus, fibromyalgia, diabetes, and hypertension, or the mislabeling in her chart of "drug seeking" due to a lab error. By this point her harmful personal experiences in medical settings — in the context of centuries of systemic and interpersonal racism against her community — had led her to generally distrust medical practitioners. In 2006, Cynthia's blood sugar was 500-600 mg/dL and she was diagnosed with diabetes. She looked into prescription assistance programs that would make her medications affordable for her, but she did not qualify for any due to her age.

In 2010, Cynthia experienced a complication with her public insurance that resulted in disenrollment from her HMO. In the years that followed, she struggled to establish care with a practitioner in her insurance network. Eventually in 2013, she located a community clinic that would see her, but her initial experience with practitioners there was less than positive. At one memorable appointment, the doctor asked, "Are you taking your medicine?" When she replied that she wasn't, he asked, "Well why do you even waste my time coming in here if you don't want to get well?"

Cynthia thought, "I've had this body for 60 years. I could probably doctor it better than you could."

Cynthia considered the doctor's question and found another team at a different clinic who changed her experience of care. The nurse practitioner (NP) who Cynthia started seeing for primary care was her first medical provider who listened, showed compassion, and never asked Cynthia to repeat her story. Cynthia found that she could trust this NP and her care team and that she felt safe with them.

With that trust, Cynthia was more forthcoming and told the care team that she was struggling with finances, regularly facing the choice between buying the $254 per vial of insulin or putting food on her table.

Cynthia says, "she wasn't just treating my conditions, she was listening to what I had to say."

The NP was observant and gathered information beyond a traditional assessment. She noticed that Cynthia was in several health education classes for diabetes and pain management, and experienced depression. She took that information, assessed the complexity and depth of Cynthia's health and social needs, and adapted her care based on that understanding.

The care team also encouraged Cynthia to work with local community-based organizations to meet her non-medical needs. The care team, in concert with local partners, supported Cynthia in obtaining free insulin, reliable transportation, a better insurance plan, and a peer group with which Cynthia could practice healthy behaviors and socialize.

Cynthia says that working with the care team reignited her will to live. The team recognized Cynthia's diverse and complex needs, listened to her, conveyed empathy, and supported her as she moved toward achieving her goals.

About complex needs and complex care

Individuals with complex health and social needs are a heterogeneous group with needs that span the medical, behavioral, and social spheres.[1] Complex needs appear and can change throughout the life cycle — from children to adults to seniors.[7,8,9] Many people with complex needs repeatedly cycle through multiple systems — including healthcare, social services, behavioral health, and criminal justice — without deriving lasting benefit from those interactions.[1] This cycling and lack of coordination leads to ineffective service provision; the exacerbation of existing illnesses, conditions, and emotional difficulties; mental and physical health issues; and financial costs.[10,11,12] Other individuals with complex needs avoid or do not have access to needed services due to barriers including political and funding decisions, systemic racism, homophobia, transphobia, immigration status, and poverty.[13,14,15,16] Missing much-needed care and services causes underlying conditions to worsen and increases the likelihood of poor outcomes and high costs.[17,18]

The Blueprint states that complex care team members require significantly different knowledge, skills, and attitudes than traditional practice.[1] Before and since the release of *the Blueprint*, a growing and diverse set of programs have developed organically by partnering with consumers, finding out what works, and replicating successful practice. There have been a handful of efforts to teach this new practice to students including the Camden Coalition's Interprofessional Student Hotspotting Learning Collaborative.[19] The field is now at a new stage in its development where competencies can be articulated and systematically taught and trained.

Complex care principles

The Blueprint identified five principles of complex care. Each principle represents a distinct attribute of complex care. Complex care is:

- **Person-centered:** Individuals' goals and preferences guide all aspects of care. Care delivery is designed around the whole person, their needs, and their convenience. Practitioners develop authentic healing relationships[20] with individuals and are sensitive to the ongoing impact of adverse life experiences.

- **Equitable:** Complex care seeks to improve health equity by addressing the consequences of systematic 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 systems level to break down the silos dividing fields, sectors, and specialties. Cross-sector collaboration is critical to create the systematic 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 individuals themselves, and families whom the individual chooses to include, in addition to health, behavioral health, and social service practitioners.

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

Who are these competencies for?

The core competencies for complex care capture the necessary knowledge, skills, and attitudes for members of the complex care workforce. The unifying characteristic of the complex care workforce is the ongoing wellness-driven interactions with people with complex health and social needs. This includes members of teams or individual practitioners that are working in programs dedicated to coordinating and providing services for people with complex needs. These competencies are also for healthcare, behavioral health, and social service practitioners who may not work in dedicated complex care programs, but regularly encounter people with complex needs.

> "Sometimes, you need a social worker to help your patient, but they're working with other clients or your program doesn't employ one. So as a complex care provider, you have to have some of those social work skills in your toolbox."
> – Timothy Farrell, MD

Complex care efforts exist in many settings, ranging from primary care clinics and health plans to community-based organizations and social service agencies. The models that these teams or individuals deploy are diverse, including community-based care management, integrated primary and behavioral healthcare, as well as more targeted services like supportive housing and re-entry programs.

The competencies constitute the breadth of knowledge, skills, and attitudes needed by each member of the complex care team and outline competencies for all complex care practice regardless of geography, population, or intervention. They are designed to add to rather than replace discipline- and profession-specific competencies. The competencies are applicable to all members of a complex care team, but different competencies may be of greater importance for a particular team member based on the design of the team, workflow, population, and specific area of practice. For example, one's position may require advanced competencies in managing teams, analyzing data, or pursuing sophisticated advocacy efforts.

The complex care competencies often overlap with the competencies of related fields (Appendix 7*). This is intentional: complex care is a product of multiple disciplines and team members often belong to another discipline, practice, or profession with its own set of competencies and expectations. These overlaps indicate that many practitioners are already preparing their trainees and/or students in some of these areas. However, all members should obtain this set of knowledge, skills, and attitudes, which may not have been previously recognized as core to their discipline.

* See additional appendices online at www.nationalcomplex.care/core-competencies

> "Identifying competencies allows for the development of standardized educational programs and resources that can be delivered through traditional educational institutions, professional associations, continuing education programs, and workplace training."
> – *The Blueprint for Complex Care*

About the competencies

Core competencies provide structure for the way that frontline complex care practitioners approach their work and support the field of complex care in five ways:

1. Standardize and define the knowledge, skills, and attitudes needed by complex care team members;
2. Guide cross-sector collaboration to serve the whole-person needs of individuals;
3. Provide the foundation for a learning continuum in complex care across disciplines, practices, and professions throughout the learning trajectory;
4. Inform licensing and credentialing bodies in defining content for complex care education and practice, and
5. Support managers in designing, hiring, and evaluating complex care teams.

The competencies are organized by domain — the major categories of critical knowledge, skills, and attitudes that team members must develop to effectively practice complex care. These competencies apply to each complex care professional at the individual level. They should be used across the learning continuum from pre-professional education through continuing education for an experienced workforce (see Appendix 6 for application suggestions*). Individual competencies are designed broadly enough to allow individual variation, interpretation, and adaptation among educational and workforce settings. The competencies balance current standard practices with aspirational activities that may have been considered outside the scope of frontline care teams but should be incorporated as foundational.

However, it is important to note that the context within which complex care teams work plays an essential role in their ability to practice effective complex care. Competencies are not a singular solution to produce effective complex care. The components and structure of the intervention, leadership and management practices, and partnership between organizations in a community are critical as well.

The development of the competencies was informed by the lived experiences of individuals with complex health and social needs and the experiences of those who deliver complex care. Both consumers and practitioners participated in the working group, gave feedback on drafts, and shared their stories. The complex care competencies and this report reflect an extensive research process and the diverse input of key stakeholders and experts, the broader field, and a year-long iterative developmental process conducted by 16 working group members and National Center staff (see Appendix 5 for more on Methods*).

The competencies will be evaluated on an ongoing basis and updates will be made as appropriate and necessary. The National Center recognizes and appreciates the contributions of all of those who read this and consider themselves part of the complex care community and welcomes feedback about the core competencies. We will be collecting and showcasing examples that illustrate how complex care teams and organizations use the core competencies and the tools created to facilitate their use at www.nationalcomplexcare/core-competencies.

* See additional appendices online at www.nationalcomplex.care/core-competencies

The complex care core competencies

Domain: Human complexity and context

Description: Delivering effective complex care requires an empathetic understanding that the human experience is complicated and that poor health and inadequate living conditions have multiple causes, including an interplay of physical and behavioral health, structural and social conditions, racism, stigma, and bias.

Context: These competences constitute an orientation that complex care team members apply to interactions with individuals, teams, and systems. Using that orientation to inquire about, listen for, and adapt to an individual's context is especially important in complex care because the intersection of health and social needs, exposure to trauma, and stigma evolve throughout the lifespan. Complex care team members understand these complexities and support individuals in reaching their goals within their own context. Additionally, many challenges and inequities faced by individuals are ingrained in governmental, cultural, and social systems and thus environment and context are not always immediately modifiable. Complex care team members aim to balance seeking to change an individual's environment and supporting them within it.

"Clinical practice for people with complex needs means understanding what health actually means to them and what is aligned with their values and desired outcomes. It requires understanding their home and social environment, and having an interdisciplinary team that understands, addresses, and communicates around those needs."

– Toyin Ajayi, MD, Chief Health Officer, Cityblock Health

The *human complexity and context* core competencies are:

1. Obtain and apply foundational knowledge in:
   a. Physical and behavioral health as relevant to the discipline and context
   b. Social drivers of health
   c. Interplay and compounding effects of multiple health and social needs
   d. Frameworks used in the care of people with complex needs such as recovery model, strengths-based practice, resilience, and person-in-environment
   e. Trauma-informed care, including the impact of adverse childhood experiences, historical trauma, and structural oppression (e.g., racism, sexism, etc.)
   f. Philosophy and practice of harm reduction
   g. Models and techniques of behavior change

2. Evaluate, respect, and incorporate the diversity of values, strengths, cultures, and personal preferences of individuals, families, and colleagues.

3. Apply tenacity, ingenuity, and divergent thinking to actively work to eliminate complex and deeply ingrained individual- and community-level health disparities.

Domain: Personal and professional commitment and ethics

Description: Complex care team members are deeply and ethically committed to improving the lives of individuals experiencing vulnerability, believe in transformative change at the individual and system levels, engage in continuous learning and self-improvement, and serve as examples of hope and ingenuity.

Context: The work of complex care can be both deeply challenging and rewarding. It requires significant self-reflection to identify and overcome ingrained biases. Routine personal and team check-ins can help sustain a commitment to working with individuals who have complex needs despite the systemic barriers and challenges individuals are facing.

"But the fact that we just kept showing up, I really did see that progression of him trusting us."

– Social worker, Connecticut

The *personal and professional commitment and ethics* core competencies are:

1. Develop, implement, and evaluate innovative approaches to supporting individuals and families.

2. Champion resilience and a strengths-based perspective for individuals, families, communities, teams, and systems.

3. Identify and develop strategies of self-care to address moral injury and foster joy in work.

4. Employ the skills and perspective of self-reflection, cultural humility, anti-racism, and unconditional positive regard to mitigate personal and systemic biases and stigmas and to repair historical and personal harms.

5. Understand and maintain appropriate professional boundaries and limitations within relationship-delivered care.

Domain: Person-centered, relationship-powered care

Description: Complex care team members value the autonomy and agency of individuals and families and recognize the importance of authentic healing relationships that support efforts to improve health and well-being.

Context: Complex care team members appreciate both the autonomy of the individual (including their right to determine their goals and care plan) and the importance of mutual, respectful, therapeutic relationships between individual and care team to support the individual in achieving those goals. The team members support the individual's capacity and self-direction through the provision of discipline- and profession-specific medical and/or social expertise and access to resources.

"You don't have to say stop smoking on the first visit. You don't have to fix their diabetes on the first visit, you don't have to fix everything on the visit. And in fact, that's much more important is establishing a full relationship, knowing the person, journeying with them over time. Saying things like, I'm gonna be here with you. Let's figure this out. I'll see you next time."

– Physician, Georgia

The *person-centered, relationship-powered care* core competencies are:

1. Build authentic healing relationships that prioritize self-determination and encourage bi-directional feedback to inform goal setting and care delivery.

2. Create and maintain relevant shared care plans that reflect the goals and priorities of the individual and family.

3. Partner with individuals and families to anticipate and address challenges in implementing care plans, including navigating complex systems and nonlinear pathways.

4. Employ established techniques to meet people where they are, create safety, and explore behavior change.

5. Coordinate access to social and medical care and supports with continuity.

6. Cultivate individuals' resilience, ability, and self-efficacy in high-stakes moments and ability to navigate setbacks, barriers, and complex systems.

Domain: Integrated team collaboration

Description: Complex care relies on highly functioning, collaborative care teams that coordinate across multiple settings and in partnership with individuals and families.

Context: A complex care team is most successful when its members from diverse disciplines, practices, professions, and perspectives are collaborating to support the individual in reaching their goals. Interprofessional teams support individuals with numerous, diverse, and interrelated needs by effectively integrating social care and healthcare delivery.[21] An interprofessional complex care team also coordinates with practitioners and partners from other departments within their organization and with other organizations. The role of each team member and partner is well-defined but may also depend on the context, needs, and goals of the individual receiving care and the specialty of the team member.

> "Roles within a complex care team need to be defined based on aptitude, training, and efficiency. Not everyone has to know how to conduct a biopsychosocial assessment, but everyone on the team needs to know how to act on the results of that assessment."
>
> – Rebecca Ramsey, MPH, BSN, Chief Executive Officer, Housecall Providers

Complex care team members have more access to and opportunity for decision-making, leadership opportunities, and changemaking through collective leadership. Collective leadership posits that everyone on a team can and should lead. The collective leadership philosophy is based on the principles of trust, shared power, transparent and effective communication, accountability, and shared learning.[22]

The *integrated team collaboration* core competencies are:

1. Understand and respect the distinct role of each care team member, including the individual and family.

2. Develop mutual trust, support, and shared identity among care team members.

3. Communicate clearly and directly, orally and in writing, to coordinate activities and collaborate with the individual, family, and service partners.

4. Employ techniques of conflict resolution, bi-directional feedback, and active listening to build, sustain, and repair relationships with colleagues.

5. Contribute to collaborative decision making and collective leadership.

Domain: Diverse information management

Description: Complex care team members collect and use quantitative and qualitative sources of information, including the individual and their family, to identify clients, assess needs, adapt best practices, and continuously improve the delivery of care and supports. The term "information" includes both quantitative and qualitative data, including stories that derive from a variety of sources.

Context: Complex care is in a formative stage and, therefore, the field needs to develop knowledge through research, quality improvement, and evaluation. Complex care also should look to adapt best practices from more frequently studied interventions for populations without complex needs. At the individual level, complex care promotes the integration of whole-person information. At the systems level, integrating cross-sector information allows team members to identify individuals who need the most support and to collaborate to address their specific needs, potentially maximizing impact and improving outcomes across systems.[23]

"We don't have all the data we could and should have because complex care doesn't have easily-defined outcomes the way medical care does. We're looking for things like cognitive decline or functional status to stay one half-step in front of a catastrophe for our patients."

– Ken Coburn, MD, DrPH, FACP, President, CEO, & Medical Director, Health Quality Partners

The *diverse information management* core competencies are:

1. Understand best practices in gathering, documenting, and sharing individual level information, and the impact of bias inherent in those processes on the delivery of care.

2. Assess the root cause of individual health needs and population disparities to inform care, programmatic, and systems-level decisions.

3. Carefully evaluate and implement the current available evidence base to inform care appropriate for each individual's context, as well as programmatic interventions and systems-level policy.

4. Continuously collect, use, and evaluate information to drive resource allocation, improve the quality of care, and improve team member experiences in delivering that care.

5. Disseminate lessons, resources, and best practices to individuals, colleagues, community partners, policymakers, and others in the field.

Domain: Systems complexity and context

Description: Individuals with complex needs interact with multiple, often incongruous systems that can contribute to the challenge of improving health and well-being. The complex care workforce analyzes individual problems from a systems perspective and advocates for systems reform and policies that foster whole-person health.

Context: Complex care team members understand that individuals' opportunities for health and well-being are determined in part by the interplay of multiple actors (e.g., political, community, environment) within systems including healthcare, human services, and public health. Care team members operate within existing systems while also working to improve those systems through collaboration, coalitions, and advocacy. Team members support individuals in creatively navigating and problem-solving within these systems. Team members often become liaisons between their organization's policies and systems and the individuals with whom they are working. Cross-system operational and cultural literacy allows team members to collaborate and coordinate services to better meet the diversity of health and social needs.

> "There are a lot of lessons complex care can learn from community organizing. Coalition building requires understanding and meeting the needs of your organizational partners. At the individual level, it's all about building relationships and deep listening while trying to move people to collective action."
>
> – Jill Feldstein, MPA, Chief Operating Officer, Penn Center for Community Health Workers

The *systems complexity and context* core competencies are:

1. Understand essential elements of healthcare, human services, and public health sectors and strategies for sharing information and integrating service delivery across sectors.

2. Understand basic elements of the local, state, and federal civic processes.

3. Collaborate and organize with members of the health and social sectors and with community members to build and maintain coalitions and collaborative structures.

4. Use collective power, privilege, and access to question the status quo and advocate for policy change.

5. Inform others' understanding of challenges and potential systems-level solutions by synthesizing personal narratives and aggregating information.

6. Recognize and adapt to the current processes and structures of organizations, systems, and policies while seeking to effect positive and aspirational change.

Looking ahead

The core competencies are a significant milestone in the development of the field of complex care. They define the essential capacities required of individuals to fulfill the diverse and demanding functions of serving people with complex needs.

They are grounded in the principles of complex care — person-centered, equitable, cross-sector, team-based, and data-driven — and create a common language and structure for the complex care community to talk about the workforce, its capacity, and its need for development. By formalizing the requirements of the complex care workforce, we hope to standardize and elevate the special skills and abilities that the frontline workforce exhibits each day in serving those with complex health and social needs.

Now that the competencies have been identified and described, the task ahead is to use these competencies to prepare and support the people doing this work. The competencies are a framework for developing current and future workforce education and training programs. This will be done both by integrating components into existing programs and curricula and by creating dedicated complex care education and training, including certifications. They can also be used by leaders to help assess their current staff as well prospective hires, and to identify areas for individual and team development.

The National Center and the Complex Care Field Coordinating Committee seek the partnership of established industry, professional, and educational organizations and institutions to implement the competencies. With the growth of value-based payment and increased focus on health equity, many health professions and healthcare institutions are increasingly interested in applying core elements of complex care to broader populations. For instance, there is a growing emphasis on addressing social needs among all patient populations[24]. This new focus creates opportunities to expose the general healthcare workforce to the principles and competencies of complex care.

The competencies can also be applied to design and deliver new educational opportunities for the complex care workforce. Online courses that are designed for adult learners, have an accessible price point, and are available asynchronously should be developed. Existing resources and tools that support competency development should be curated. The core competencies should also be used to create measurable standards and assessments to accompany and inform the curriculum and to establish certifications in complex care that are recognized by employers and payers.

We also hope to see the continued growth of interprofessional experiential programs in complex care. Programs like the Interprofessional Healthcare Hotspotting Learning Collaborative ("Student Hotspotting")[19] have given hundreds of students a real-world opportunity to practice complex care in an interprofessional environment. Through programs like this, providers-in-training learn how to provide complex care through interprofessional teams and intentional relationships with individuals with complex needs. Likewise, a handful of complex care fellowships and residency programs have also emerged across the nation. These programs are critical to training the next set of practitioners and leaders for the field.

The field must embrace the competencies to achieve their promise. We hope that complex care leaders and practitioners will find a variety of ways to use them to clarify and enhance the quality of services in their individual and organizational practices. We know that the competencies will require periodic updates to ensure their continued relevance. We encourage you to provide ongoing feedback and to share the ways that you use the competencies to help support practitioners as they transform the way care is delivered and radically change the lives of people with complex health and social needs.

Appendices

See additional online appendices at www.nationalcomplex.care/core-competencies.

Appendix 1: Glossary

The following definitions have been selected by the working group to describe how these terms are used within this report.

Authentic healing relationships: Secure, genuine, and continuous connections between individuals and complex care team members[20]

Behavioral health/mental health: The promotion of mental health, resilience, and well-being; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.[25]

Biopsychosocial: A model that posits illness, health, and wellness as the result of an interaction between biological, psychological, and social factors.[26]

Collective leadership: "In collective leadership, there is shared responsibility and decision making, accountability, and authentic engagement. All members are involved in creating the vision and are committed to working to achieve that vision. Collective leadership is based on the assumption that everyone can and should lead. Collective leadership requires specific conditions for the success of the whole: trust, shared power, transparent and effective communication, accountability, and shared learning. It is based on the recognition that without the gifts, talents, perspectives, and efforts of many, sustainable change is difficult to achieve."[22]

Complex care: Person centered, team-based, cross-sector care for people with complex health and social needs. It seeks to improve health and well-being through greater integration and coordination of care and attention to psychosocial factors impacting health and healthcare utilization.

Complex care population: The population for whom a complex care approach is most appropriate are those who have a high burden of physical and/or psychosocial needs.

Complex care workforce: The workforce includes members of teams or individuals that are working in programs dedicated to coordinating and providing services for people with complex needs. The unifying characteristic of these teams and individuals is the ongoing wellness-driven interactions with people with complex health and social needs.

Core competency: A core competency is the knowledge, skill, and/or attitude that all frontline team members need to have to be able to provide care and support to individuals with complex health and social needs.

Cross-sector: "An alliance between organizations from two or more sectors with the intention to share responsibility for a project, product, process, or other activities."[1]

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 individuals, and evaluate success."[1]

Equitable: Complex care recognizes the societal, structural, historical, and ongoing barriers to health (e.g., racism, sexism, classism, ageism, heterosexism, xenophobia, etc.) and supports consumers and communities to address them.

Family: Biological, adopted, or chosen individuals who could play a variety of roles and are involved in the care of an individual with complex health and social needs.

Peer: A member of the complex care team who offers and receives help, based on shared understanding, respect and mutual empowerment between people in similar situations.[27]

Person-centered: An approach to care delivery in which "individuals' values and preferences are elicited and, once expressed, guide all aspects of their healthcare, supporting their realistic health and life goals. Person-centered care is achieved through a dynamic relationship among individuals, others who are important to them, and all relevant providers. This collaboration informs decision-making to the extent that the individual desires.[28]

Practitioner/provider: A practitioner or "frontline practitioner" is any person trained to deliver physical and mental healthcare, social services, and/or community-based services, which includes but is not limited to advanced practice providers, nurses, social workers, community health workers, peer workers, counselors, care coordinators, and nurse navigators. These practitioners comprise the complex care workforce.

Recovery: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[29] The 10 principles of recovery are hope, person-driven, many pathways, holistic, peer support, relational, culture, addresses trauma, strengths/responsibility, and respect.[29]

Shared identity: A marker of group development for a collection of individuals moving towards a common goal during which the group identifies as *we* instead of *I and you*.

Team-based: "The provision of health [and social service supports and] services to individuals, families, and/ or their communities by at least two health providers who work collaboratively with [individuals] and their caregivers — to the extent preferred by each [individual] — to accomplish shared goals within and across settings to achieve coordinated, high-quality care."[30]

Trauma-informed care: "A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization."[31]

Appendix 2: Expert interviewees

Toyin Ajayi, *Cityblock Health*

Barbara Brandt, *National Center for Interprofessional Practice and Education*

Ken Coburn, *Health Quality Partners*

Darla Spence Coffey, *Council on Social Work Education*

Timothy Farrell, *University of Utah*

Jill Feldstein, *Penn Center for Community Health Workers*

David Labby, *Health Share of Oregon*

Sherry Marcantonio, *Health Quality Partners*

Nick Marzano, *Society of Hospital Medicine*

Suzanne Miyamoto, *American Academy of Nursing*

Rebecca Ramsey, *Housecall Providers*

Nirav Shah, *Stanford University*

Michelle Troseth, *MissingLogic*

Michelle Wong, *Kaiser Permanente*

Appendix 3: Association support

The following professional, educational, and industry associations are early supporters of the complex care core competencies:

America's Essential Hospitals

American Academy of Pediatrics – New Jersey Chapter

American Association of Colleges of Pharmacy

American College of Clinical Pharmacy

American Society for Consultant Pharmacists

American Society of Health-System Pharmacists

Association of American Medical Colleges

Council on Social Work Education

National Association of Social Workers

National PACE (Programs of All-Inclusive Care or the Elderly) Association

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Camden Coalition
of Healthcare Providers

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The National Center
for Complex Health & Social Needs

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About the Camden Coalition

We are a multidisciplinary nonprofit working to improve care for people with complex health and social needs in Camden, NJ, and across the country. The Camden Coalition works to advance the field of **complex care** by implementing person-centered programs and piloting new models that address chronic illness and social barriers to health and wellbeing. Supported by a robust data infrastructure, cross-sector convening, and shared learning, our community-based programs deliver better care to the most vulnerable individuals **in Camden** and **regionally**.

The National Center for Complex Health and Social Needs, an initiative of the Camden Coalition, connects complex care practitioners with each other and supports the field with tools and resources that move complex care forward. The National Center's founding sponsors are the Atlantic Philanthropies, the Robert Wood Johnson Foundation, and AARP.