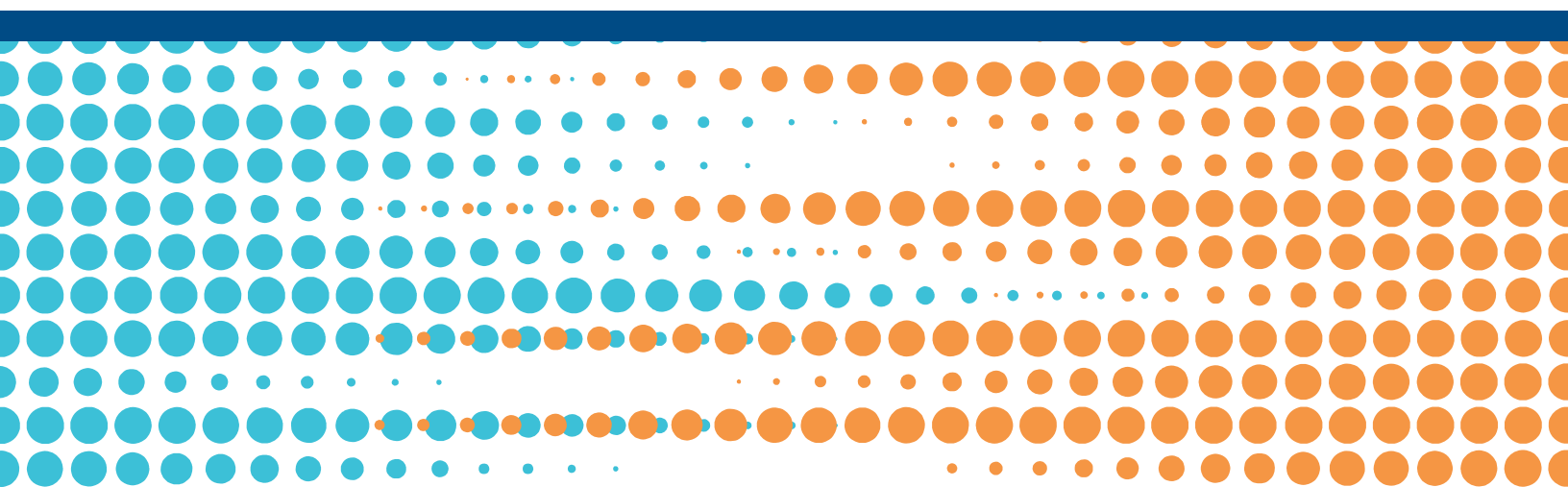




CREATING NEW CONNECTIONS

*How Philanthropy Can Support
Better Care for People with
Complex Health and Social Needs*



About Grantmakers In Aging (GIA)

Grantmakers In Aging - a national membership organization of philanthropies - acts as a relevant and responsive network, resource, and champion, amplifying the voices of older people and issues of aging. Believing a society which is better for older adults is better for people of all ages, GIA seeks a just and inclusive world where older people are fully valued, recognized, and engaged in ways that matter. Learn more at www.GIAging.org.

About Grantmakers In Health (GIH)

Grantmakers In Health (GIH) is a nonprofit, educational organization dedicated to helping foundations and corporate giving programs improve the health of all people. Its mission is to foster communication and collaboration among grantmakers and others, and to help strengthen the grantmaking community's knowledge, skills, and effectiveness. Learn more at www.gih.org.

About the Seven Foundations Collaborative

To improve the health outcomes and daily lives of people in America with the most complex health care needs, seven foundations — [Arnold Ventures](#), [The Commonwealth Fund](#), [The John A. Hartford Foundation](#), [the Milbank Memorial Fund](#), [the Peterson Center on Healthcare](#), [the Robert Wood Johnson Foundation](#), and [The SCAN Foundation](#) — are working together to accelerate health system transformation.

This collaborative aims to help health care organizations participating in value-based payment models and adopting evidence-based interventions improve outcomes and lower overall costs of care. [Learn more.](#)



Executive Summary

People with complex health and social needs cannot reliably get the care and support that they need -- a problem that resonates with any funder concerned with health care or social services delivery, health equity, social justice, or vulnerable populations. The field of complex care seeks to create, expand, support, and improve models and innovative approaches to care that can better serve these hard-to-reach individuals.

This report, *Creating New Connections: How Philanthropy Can Support Better Care for People with Complex Health and Social Needs*, summarizes key issues relevant to understanding complex care and offers resources and case studies for funders interested in entering the field or deepening their existing work. In the hope of engaging more funders and inspiring increased investment in this space, it profiles funding opportunities, explores existing models, and shares philanthropic lessons learned.

By presenting a range of approaches, large and small, the report may assist funders of all types and sizes whose grantees deliver important forms of community and system-based care to view their work through the lens of complex care.

Topics include the social determinants of health; the need for new partnerships between health systems and community and nonprofit organizations; a sampling of models of care and modes of financing that are fueling change; the need to listen to patients, families, and communities in creating and executing programs, and to build a workforce well-suited to doing so; programs to help small organizations collaborate with large health systems fairly and sustainably; a reflection on the health and social inequalities laid bare by COVID-19 and how the pandemic may help shape complex care policy; and insights from key practitioners and thought leaders in the field, elicited through several original interviews.

This work is in its early days. There is much still to do and a great need for philanthropy's participation. This report concludes with a discussion of important roles for funders in championing this work and suggestions offered by funders and for funders of promising avenues of grantmaking and areas in need of greater exploration, such as:

- Convening diverse stakeholders to help build critical cross-sector relationships, and encouraging and incentivizing collaboration.
- Championing new approaches, including helping organizations shift their focus toward the root causes of health and reframing work already happening in communities or in organizations that they support.
- Building knowledge and solidifying and evaluating the evidence base to support a new approach to complex care, and sharing insights with other funders.
- Scaling and disseminating evidence-based models that are not yet nationally available and supporting replication work.

- Filling gaps, particularly in times of challenges like the COVID-19 pandemic, when health systems and organizations that rely on highly regulated public funding streams can have difficulty pivoting quickly.
- Showing flexibility in grantmaking and providing extra funds and time in grants to help community-based organizations and health systems build trusting relationships.
- Supporting community engagement to ensure that community and patient voices are solicited and heeded in program design and care delivery.



We hope you will join us in exploring and supporting this critically important work.”

[BACK TO TOP](#)



Table of Contents

Executive Summary

Examining Complex Needs Through a Health Equity Lens	1
From DNA to ZNA: Decoding the Drivers of Health	2
The Complex Care Difference: An Emphasis on ‘Matchmaking’	3
Building the Field: Philanthropy and Complex Care	4

System-Level Solutions: Better Insights, Better Finances, Better Care	5
A Deeper Understanding	6
‘It’s Up to Us to Create the Communities We Want’	6
An Innovation Rooted in the Past: Home-Delivered Care	7
Successful Long-Distance Relationships: Telehealth	8

Models of Care: Person-Centered Care in the Real World	9
Aging in Community, Safely: CAPABLE	9
Extra Assistance with Transfers: Transitional Care Model (TCM)	10
Care Management to Support Social and Physical Health: SASH	11
An Antiracist Culture for “Next Generation” Care: AIM	12

The Camden Coalition: Engine Room for Complex Care	13
The Camden Coalition Vision	15
Amplify: A Consumer Voices Bureau	16

Speak My Language: Community Health Workers	17
--	-----------

Business Skills for Better Care	18
Building Business Acumen	18
The Root Cause Coalition: ‘Closing the loop’	19

COVID-19, Context, and Complex Care Policy	20
Pandemic-Driven Policy and Beyond	21

Roles for Philanthropy	22
An Unfinished Agenda: Ideas for Funders, from Funders	24

The Seven Foundations Collaboration	25
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Note: This is an interactive Table of Contents. Click on any header above to be taken to that section.

Examining Complex Needs Through a Health Equity Lens

A central challenge for any society is how best to lift up those who fall between the cracks. The U.S. health care system offers a case study of why even the most sincere efforts sometimes do not succeed. Despite advanced therapies and technologies and the highest per capita spending in the developed world, traditional U.S. health care often fails people whose complex health and social needs lead them to spiral downward in health and wellbeing. Whether living with chronic illness, disabilities, hunger, trauma, homelessness, HIV, poverty, or any of a long list of other challenges, “people with the most complex health and social needs are generally left behind,” says **Ann Hwang, MD**, director of the [Center for Consumer Engagement in Health Innovation](#) at [Community Catalyst](#).

This report explores efforts to engage and unite the health care, social service, and philanthropic sectors in engaging individuals, families, and communities in new ways to fulfill a common mission of helping people with complex health and social needs. This work is sometimes referred to as complex care.





We can
make

people's lives much better and
we have an obligation to do that.”

Complex care seeks fundamental change guided by the principle of health equity. Using the **definition** advanced by the **Robert Wood Johnson Foundation**, health equity means ensuring that, “everyone has a fair and just opportunity to be as healthy as possible.” This framing, with its emphasis on health justice, is building momentum. “There is really a moral argument that people are suffering because we designed the system poorly,” says **Mark Humowiecki**, senior director of the **National Center for Complex Health and Social Needs**, an initiative of the **Camden Coalition of Healthcare Providers**. “We can make people’s lives much better and we have an obligation to do that.”

In the field of complex care, “complex” does not refer to the care itself (for instance, interventions that might be delivered in an Intensive Care Unit); rather, it refers to the challenges facing individuals who are struggling and the fact that many have spent a lot of time churning through health care, social service, and other systems without much lasting benefit. Because such problems are multifaceted, solutions are, too. They focus on leveraging new models of health care financing, policy, and delivery to transform care and building patient and community partnerships. They also reflect a major shift in thinking about what actually supports (or erodes) our health.

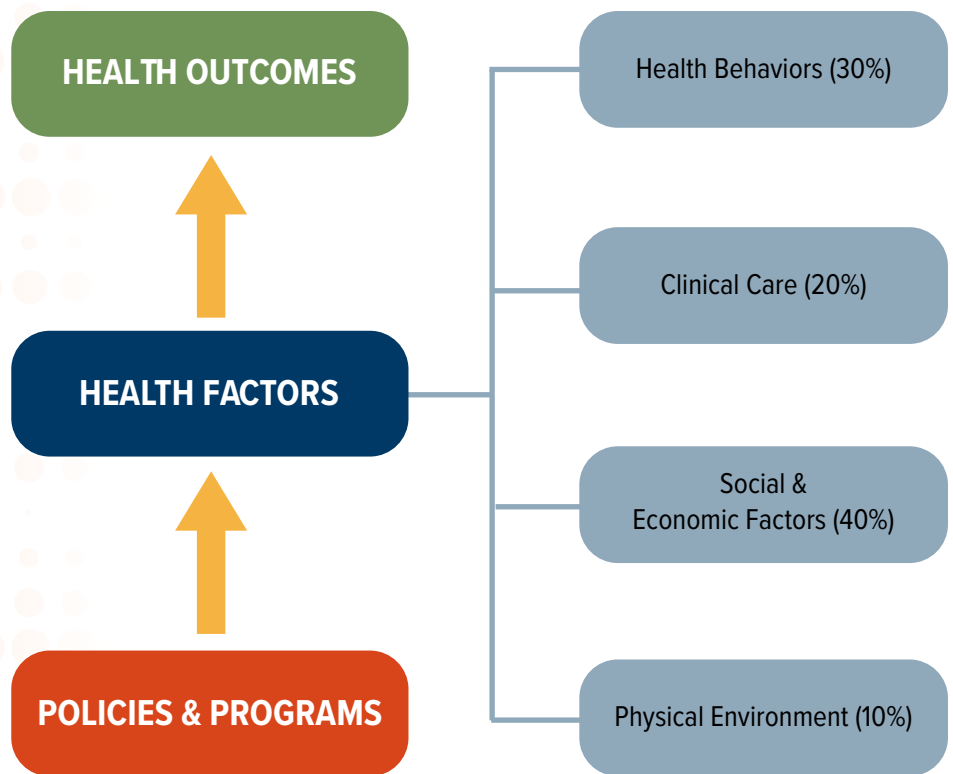
From DNA to ZNA: Decoding the Drivers of Health

Twenty years ago, anyone telling a physician, funder, or policymaker that the most significant predictor of someone’s health and life expectancy was their zip code would have drawn a blank stare. No more. There is now widespread acknowledgment that our health results from a combination of factors, many of them not related to traditional health care.

These factors are collectively known as the social determinants of health (SDOH). **The World Health Organization (WHO)** takes a life course view, describing “the conditions in which people are born, grow, live, work, and age.” The U.S. government’s **Healthy People 2030** initiative identifies five SDOH sectors: Health Care, Education, Economic Stability, Social and Community Context, and Neighborhood and Built Environment.

As the social determinants model has gained traction, **further analysis** has determined that clinical medical care is not just a single factor among many in our health outcomes – it is also a relatively small factor, accounting for only 10-20% overall. Environmental, societal, and economic factors account for at least 50% of outcomes.

The new shorthand for this paradigm shift: DNA makes room for ZNA, or zip code at birth. ZNA is a proxy for income, access, and opportunity, and the uneven ways they are often distributed.



County Health Rankings model ©2014 UWPHI

The Complex Care Difference: An Emphasis on ‘Matchmaking’

Recognizing the power of the social determinants of health is just the beginning. “All of us have social needs ... but for some, because of social circumstances, those needs go unmet,” reflects **Kedar Mate, MD**, CEO of the **Institute for Healthcare Improvement (IHI)**. “Now it’s about how do we work on these factors in a fundamentally different way?”

Complex care pursues a few key strategies: promoting transformation in health systems and leveraging the work of social service organizations in communities, while centering care and decision making on the people who receive it. Historically, the health care and social care sectors have worked independently. But as it is becoming clear that neither can fulfill the complex care mission alone, another facet of the work focuses on ways to improve collaboration.

“I think we can do a much better job of matchmaking,” says **Melanie Bella**, Head of Partnerships & Policy at **Cityblock Health** and former director of the **Medicare-Medicaid Coordination Office**. “Even starting with helping them speak each other’s language, because it’s so foreign for them.”

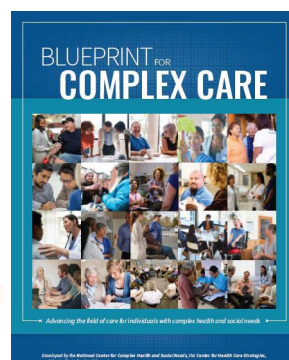
The fit is not always easy. Health system and community organization values may overlap, but their cultures and skillsets often do not. The budget of even a well-established community-based organization (CBO) often resembles a rounding error in the budget of the smallest health system. Still, both sides have much to contribute. For example, CBO business practices are sometimes less developed, but their wealth of hands-on experience and deep community ties could be indispensable to any forward-looking health system executive exploring service lines that would have been unimaginable a few years ago, such as food pantries, job training, lead paint [screening](#), or transportation. (See: [Building Business Acumen](#))

“I think the way to be successful is to put together the strengths of many organizations, versus trying to assume that one organization will be able to do it all well,” Bella says. “Often you see an organization try to do it all. They try to build up strengths that are never going to be their core competency, but they don’t need to, because they can partner for that.”

Building the Field: Philanthropy and Complex Care

Philanthropy is also playing a variety of roles. In addition to providing financial support, funders are helping reimagine how large systems can fulfill new roles, bolstering the capacity of small community-based organizations, evaluating new models, assessing policy barriers or options, helping to spread successful ones, and building bridges.

In one of several joint projects, the Seven Foundations Collaborative has been working since 2017 with [Grantmakers In Aging \(GIA\)](#) and [Grantmakers In Health \(GIH\)](#) on the Engaging Philanthropy in Complex Care [initiative](#). The seven foundations are **Arnold Ventures**, **The Commonwealth Fund**, **The John A. Hartford Foundation**, **Milbank Memorial Fund**, the **Peterson Center on Healthcare**, the **Robert Wood Johnson Foundation**, and **The SCAN Foundation**. The initiative reviews the evidence base and engages more funders in complex care, particularly those who already fund various aspects of this work but may not construe their investments or think of their grantees in these terms.



Individually, each foundation supports a diverse set of grantees in the field, while jointly they have funded several initiatives, including work by IHI and the [Center for Health Care Strategies \(CHCS\)](#) to develop a comprehensive online resource hub known as the [Better Care Playbook](#), and the [Blueprint for Complex Care](#), a strategic plan to accelerate change that is a joint project of IHI, CHCS, and the National Center for Complex Health and Social Needs.

System-Level Solutions: Better Insights, Better Finances, Better Care

Some change at the health system level is connected to policy and financial incentives. Five percent of people [account](#) for half of all health spending in the U.S. health system. As more Accountable Care Organizations (ACO), Medicare Advantage plans, Medicaid managed care plans, and private insurance plans adopt a bundled payment or value-based model, health systems are being required to deliver the care people need for a fixed payment rather than being paid on a fee-for-service basis. To stay on budget, it quickly becomes essential to understand a person's holistic health picture, particularly when there are complex health and social needs, and to try to address root causes.

Policy can help change the parameters of care as well. For example, the Affordable Care Act imposes penalties on hospitals with high rates of readmissions – return trips to the hospital by people who need more care for the same problem within thirty days of discharge. Some readmissions are an inevitable part of a disease or injury, but others trace back to life issues, such as no transportation to get to follow-up appointments, no refrigerator to store temperature-sensitive drugs like insulin, no food in the refrigerator, or no home in which to recover. When problems like these go unaddressed, they cause patients to “bounce back” to the hospital, which hurts the individual and can get expensive for the health system. (See: [Extra Assistance with Transfers](#))

“You can't work with this population and not understand that solutions have to go well beyond the medical component,” says **Mark Humowiecki** of the National Center for Complex Health and Social Needs. “You quickly realize that housing, for instance, has more to do with their overall health than their A1C does.”

A Deeper Understanding

These individuals share a high degree of need but are also different in many ways. Some are frail older adults. Some are living with disabling chronic conditions or serious illness. Some have mental health conditions. Some are experiencing homelessness or hunger.

The population health strategy known as **segmentation** – identifying key subgroups and the unique needs and challenges of each segment – helps providers and payers understand these nuances and is the focus of **The Commonwealth Fund’s** High-Need, High-Cost (HNHC) **portfolio**. This research has yielded the **Personas Project**. By creating composite patient profiles (such as Active Albert or Struggling Sam), the project identifies gaps in care, helps health systems address these flaws, and puts a human face on a population that is all too often seen only through a lens of clinical or cost data.

‘It’s Up to Us to Create the Communities We Want’

The bottom line is that many health systems are finding themselves responsible, or incentivized, or both, for helping people get non-medical services that the systems themselves may have little idea how to deliver.

Some, like **ProMedica**, have dived in with a passion. A not-for-profit health system headquartered in Toledo, Ohio, ProMedica operates 13 hospitals, a health plan, and nearly 400 assisted living facilities, skilled nursing centers, rehabilitation clinics, and hospice and home health agencies in 28 states. What sets ProMedica apart, however, is the fact that it also owns and operates a grocery store, a food pharmacy, three food clinics, a mobile farmers market, a Financial Opportunity Center offering credit and



career coaching, and a real estate re-development division, all focused on addressing non-medical social needs. Funding has come from ProMedica, foundation grants, and a transformational gift from a board member, the late Russell Ebeid.

“The more we do, the more we realize we need to do,” says CEO **Randy Oostra**. “Many in health care say they do social determinants of health, but many are very minor things and not what they could do. It’s up to us to create the communities we want.”

Oostra likes to share this cartoon depicting the skeptical questions he gets from industry peers. “Sometimes we talk to boards who say, ‘Are you sure you can do all this?’” he says. “And we say, ‘Well, it’s our mission, and it’s why we believe we exist.’”

While few do as much as ProMedica, health system investment in the social determinants is trending. In late 2019, fourteen of the country’s largest hospital systems pledged more than \$700 million toward community-based initiatives. A study funded by the **Robert Wood Johnson Foundation** and published in *Health Affairs* identified 78 unique programs at 57 health systems that invested \$2.5 billion of health system funds over a two-year period.



How do

you work with a patient who believes that the health care system is out to get them and isn't to be trusted?”

An Innovation Rooted in the Past: Home-Delivered Care

Another successful approach to complex care is adding new types of medical services – or reviving old ones. For some four million people, particularly frail older adults and people with disabilities, a critical barrier to better health is their lack of mobility. A creative solution championed by **The John A. Hartford Foundation** is home-based primary care, or house calls.

Care provided face-to-face at home is inherently more person-centered as providers come to a deeper understanding of individuals’ overall health by seeing their home environment. Patients have expressed high rates of

satisfaction and the approach has been shown to save money by reducing the need for emergency care. A useful resource for dissemination is the [American Academy of Homecare Medicine's toolkit, *Building Awareness and Engaging Payers to Bring Home-Based Primary Care into the Mainstream*](#).

Successful Long-Distance Relationships: Telehealth

Unequal access to expert care also drives poor outcomes. An early innovator in telehealth, [Project ECHO \(Extension for Community Health Outcomes\)](#) has democratized care by providing intensive training for community practitioners with support from specialists provided through “tele-mentoring.” Project ECHO Care was originally created to help people in remote rural New Mexico get specialist-level care for Hepatitis C. The virtual model now operates internationally, expanding specialist care for geriatrics, addiction, chronic pain, diabetes, HIV, tuberculosis, and many other conditions.

That list now includes complex care. Between 2013 and 2016, the [CMS Innovation Center](#) funded an adaptation of ECHO Care to serve more than 750 Medicaid patients with complex health and social needs in New Mexico through “ambulatory intensive care units.” These teams included a nurse practitioner or physician assistant, a registered nurse, one or two community health workers, and a licensed mental health provider, working from six Complex Care clinics in hot-spot communities. (See: [Speak My Language: Community Health Workers](#))

A major focus was trauma-informed care – bringing attention and sensitivity to principles of safety, trustworthiness and transparency, peer support, collaboration, empowerment and choice, and cultural, historical, and gender issues.

“You can't get there unless the patient overcomes their distrust of the medical system, agrees to come out of their house and get the tests that are needed,” [explains](#) former ECHO care lead and ECHO Institute associate director **Miriam Komaromy, MD**.

“We used the ECHO videoconferencing sessions to address basic questions: How do you work with a patient who believes that the health care system is out to get them and isn't to be trusted? What are the baby steps that you can take to connect with this mostly alienated patient population and start working with them?”

In addition to the funding from the U.S. Defense Health Agency, the Veterans Health Administration, the CDC, the Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA), ECHO has received support from private funders including the **Robert Wood Johnson Foundation, Bristol Myers Squibb Foundation, Tata Trusts**, and the **Leona and Harry Helmsley Charitable Trust**.

Models of Care: Person-Centered Care in the Real World

Community-level social service providers are on the front lines. They engage people with complex health and social needs in real world settings: senior centers, clinics, shelters, jails, schools, houses of worship, and private homes. They tend to have tight budgets, but forge trusted relationships and deep roots in their communities. Many nonprofits and independent models of care are nimble, creative, and effective, making them important incubators of new ideas.

A [survey](#) in the Better Care Playbook examines several evidence-based models of care that have been able to document solid health benefits and cost savings from their program of enhanced social support. Many could be replicated with a relatively modest investment, offer a good starting point for a community or system not looking for wholesale transformation, or could fit into a strategy of upfront investment to improve complex care in a community. Here are a few examples.



Aging in Community, Safely: CAPABLE

Johns Hopkins School of Nursing professor **Sarah Szanton** co-created **CAPABLE** while making house calls as a nurse practitioner to homebound, low-income elderly patients in West Baltimore and observing that environmental challenges were often as pressing as health challenges, particularly for those trying to “age in place” or stay out of a nursing home.

The program teams a nurse, an occupational therapist, and a handy worker with an older adult. Together, they identify the older person’s functional priorities, like being able to walk to church or cook for themselves at home, then provide home repairs, coaching, and therapy to help the older person achieve his or her goals.

Strong results include decreased disability, lower rates of depression, reduced hospital readmissions, and average Medicare savings of \$22,000 over two years, and Medicaid savings of \$867 per month, per participant.

CAPABLE also aligns well with new opportunities in health care financing. Its services are eligible to be covered in some states under Medicaid Section 1115 waivers and, in some instances, through Medicare Advantage plans, which enroll one out of three Medicare beneficiaries over age 65. Partnerships with community organizations like local **Meals on Wheels** groups and **Habitat for Humanity** have also extended CAPABLE's reach.

CAPABLE has been funded by the **National Institutes of Health**, the **Centers for Medicare and Medicaid Services**, **National Institute of Disability, Independent Living and Rehabilitation Research**, the **Rita & Alex Hillman Foundation**, the **Harry and Jeanette Weinberg Foundation**, **St. David's Foundation**, the **Robert Wood Johnson Foundation**, **The John A. Hartford Foundation**, and **RRF Foundation for Aging**.



© Johns Hopkins School of Nursing

Extra Assistance with Transfers: Transitional Care Model (TCM)

Moving from one health care setting (such as the hospital, emergency department, nursing home, or rehabilitation center) to another, or leaving a facility to move back home can be a risky and overwhelming maneuver. People may be frail, weak, or even still sick, and the outcome when things go wrong is often a costly and discouraging hospital readmission.

The **Transitional Care Model (TCM)** aims to make these transfers more manageable, particularly for older people. TCM provides a master’s-level transitional care nurse to work with the patient, family, and doctor on an individualized care plan before the person ever leaves the hospital. That nurse goes with the patient on the first post-hospital visit and provides further support for the next three months on home visits.

The program was developed by University of Pennsylvania nursing professor **Mary Naylor** with funding for further testing provided by The Commonwealth Fund, **The John A. Hartford Foundation**, and the **Jacob and Valeria Langeloth Foundation**. Based on its track record (which includes a 50% reduction in re-hospitalizations and net care savings of about \$4,500 per patient), **Arnold Ventures** recently awarded TCM a \$6 million grant for implementation in four health systems — Swedish Health Services, Trinity Health, University of California San Francisco (UCSF) Health, and the Veterans Health Administration — as part of Arnold’s Moving the Needle initiative.



Friendly visiting, social and wellness groups, exercise classes, and congregate meals address social isolation.”

Care Management to Support Social and Physical Health: SASH

SASH (Support and Services at Home) helps low-income older adults and people with special needs live independently at home by formalizing connections among many support organizations across Vermont. A home-based care coordinator and a SASH wellness nurse provide comprehensive care management of services from home health, behavioral health, and primary care providers, as well as Meals on Wheels, physical therapy, transportation, and medication management. Friendly visiting, social and wellness groups, exercise classes, and congregate meals address social isolation, which SASH nurses screen for twice a year.

Participants in this housing-and-health model reported improvements in physical and mental health status, with average **savings** of \$1,227 per person per year in Medicare expenditures.

SASH is **supported** by a variety of public and private funders, including the **MacArthur Foundation, Enterprise Community Partners Housing Assistance Council, United Way of Chittenden County, the Vermont Community Foundation, and the University of Vermont Medical Center Foundation.**

An Antiracist Culture for “Next Generation” Care: AIM

The Center for Health Care Strategies leads the [Advancing Integrated Models \(AIM\)](#) program, funded by the **Robert Wood Johnson Foundation**, to help health systems and community providers formulate “next-generation” person-centered approaches that integrate strategies such as complex care management, physical and behavioral health integration, and trauma-informed care, while engaging the community. Its eight pilot sites are also collaborating with state Medicaid or health plan partners.

Drexel University’s [Stephen and Sandra Sheller 11th Street Family Health Services](#) is already known for delivering comprehensive primary care, behavioral health, dental services, and wellness programs to more than 6,000 patients annually in an area of Philadelphia where the median family income is \$15,000. The Center is the first ambulatory care center to earn certification from The Sanctuary Model®, a trauma-informed, whole culture approach to change.

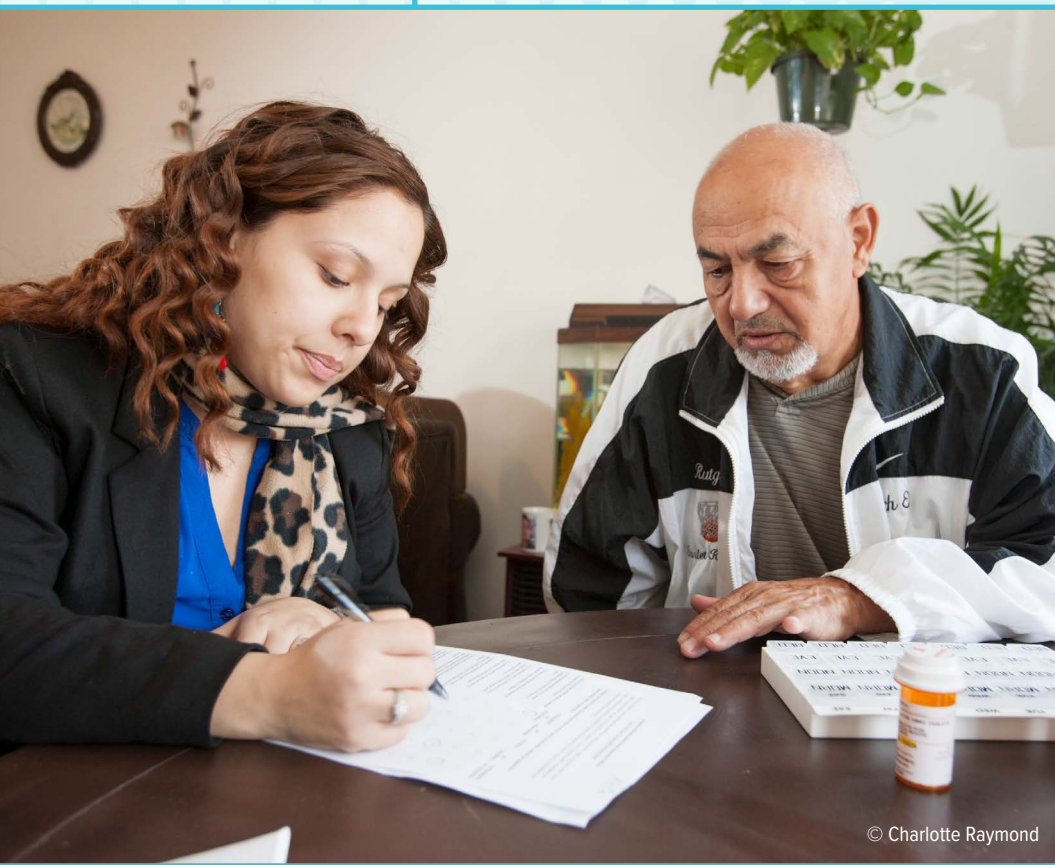
The focus of the 11th Street Center’s new work will be expanding behavioral health and trauma-informed care services to include acknowledgment of the impact of racism and develop race-conscious programming to improve patient engagement.

“We desire to create change that is not merely academic; this change will become rooted in the DNA of our organization,” says executive director **Roberta Waite**, who is also associate dean of Community-Centered Health and Wellness and Academic Integration in Drexel University’s College of Nursing and Health Professions.

[BACK TO TOP](#)

The Camden Coalition: Engine Room for Complex Care

Any discussion of complex care eventually turns to the **Camden Coalition of Healthcare Providers**. Founded in 2006 by Jeffrey Brenner, MD, a family physician who wanted to practice in a new way, the Camden Coalition came to prominence with its “hot-spotting” project (profiled in *The New Yorker* in 2011 by Atul Gawande) which identified small clusters of people with complex, hard-to-manage needs and chronic conditions who lived in particular neighborhoods and even specific apartment buildings in Camden, New Jersey. They receive intensive, data-driven service that emphasizes multi-disciplinary care: arranging for social services, including housing, nutrition, and income support, and creating connections to behavioral health and addiction care providers.



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In 2017, the Camden Coalition launched the National Center for Complex Health and Social Needs, which brings together clinicians, researchers, policymakers, and consumers who are developing, testing, and scaling new models of team-based, integrated care. The National Center hosts an annual **conference** (Putting Care at the Center) and several regional convenings, provides technical assistance to communities trying to replicate its work, and helps raise the voices of people with lived experience of complex needs. (See: **Amplify: A Consumer Voices Bureau**) Founding sponsors are the **Atlantic Philanthropies**, the **Robert Wood Johnson Foundation**, and **AARP**.



“We see ourselves as a bridge between traditional health care and the social services and public health sectors,” says Mark Humowiecki, who directs the National Center. “A big part of our message is: ‘We must deliver care differently.’”

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Part of this bridging role includes generating the data and interoperable infrastructure to inform the new approach. The **Camden Coalition Health Information Exchange** links health records from sources such as regional hospitals, primary care practices, laboratory and radiology groups, correctional facilities, skilled nursing facilities, the perinatal collaborative, behavioral health providers and others across southern New Jersey for use in real time. Data users are a diverse group that includes behavioral health providers, homeless services providers, and churches. The Camden Coalition also participates in the New Jersey Health Information Network and the **Strategic Health Information Exchange Collaborative**.


Health systems that assume responsibility for the total cost of care of high-risk patients see a growing need for care management solutions to help with patient identification, population health training, data capture, and more. When the **Peterson Center on Healthcare** wanted to accelerate adoption of a leading model, the **Advanced Preventive Care (APC)** model, it turned to the National Center and Health Quality Partners (HQP) to help practices improve implementation, infrastructure, and evaluation. A recent study **showed** that APC, which works to prevent avoidable complications among chronically ill older adults, decreased all-cause mortality (34%), hospitalizations (39%), and healthcare costs (28%).

Progress is not always linear or predictable. Early in 2020, a **randomized control trial (RCT)** of **Camden's signature hot-spotting program** yielded disappointing findings: the study found no difference between the treatment and control groups on hospital readmissions within 180 days. It did find a statistically significant rise in the number of participants receiving food assistance (SNAP benefits). Debate ensued. For its part, the Camden Coalition, while **noting** relevant nuances (“our population is younger, and our model is designed to serve a population with diverse medical needs and extensive social complexity”), **affirmed** its commitment to “reflection and continuous learning” and went back to work.

Supporters largely agreed, including **The Commonwealth Fund**, which advanced the view that the model should and does continue to evolve, **writing** in *Health Affairs* that, “Properly interpreted, the insights from a single RCT, even when null, are less like cold water and more like rocket fuel.”

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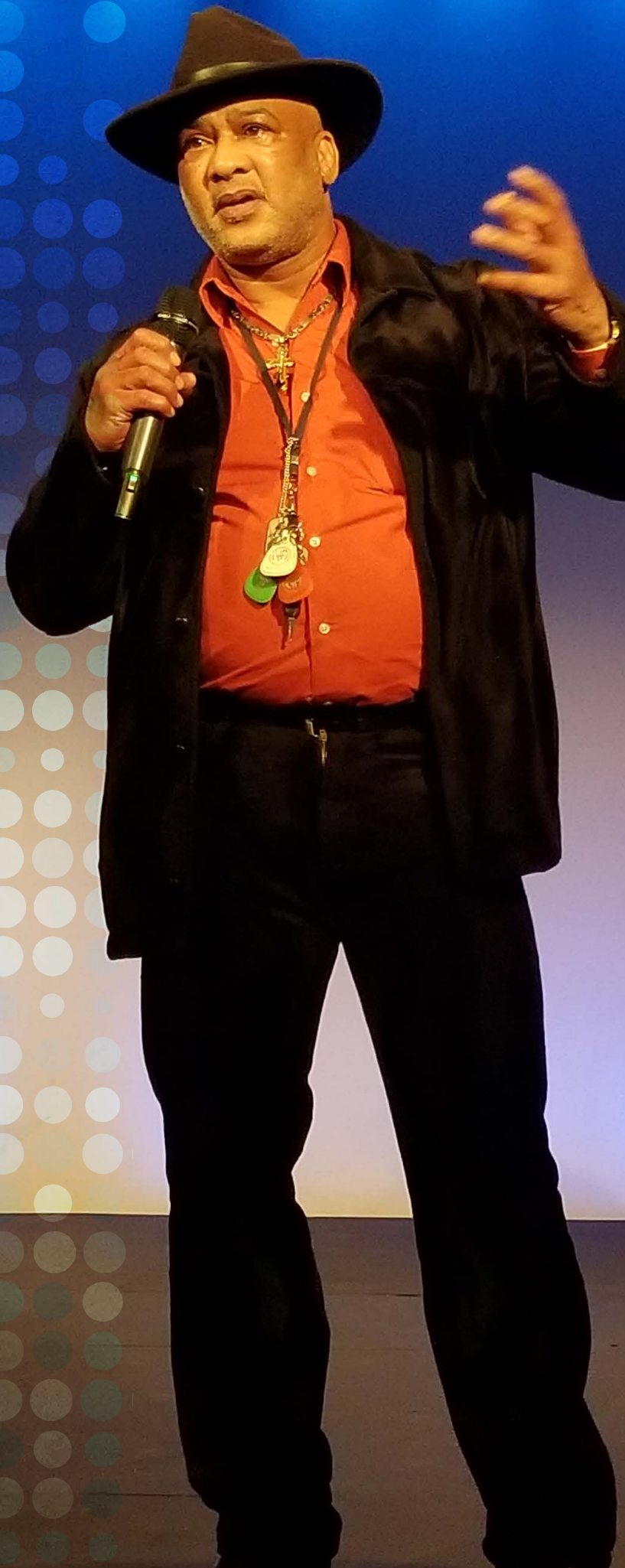
The Camden Coalition Vision

A more amorphous but powerful contribution by the Camden Coalition is its visioning. To date, a universal definition of complex care has largely eluded the field and discussions often default to the dry and the technical. Helping new people and organizations see their own work as related to the effort and feel inspired to join are critical elements of success.

The National Center tackled this challenge by developing a consensus document titled *Core Competencies for Frontline Complex Care Providers*. It calls on changemakers to work within the status quo when necessary (“Recognize and adapt to the current processes and structures of organizations, systems, and policies”), but also exhorts providers in almost poetic terms to think and work differently whenever possible, specifically to:

- Champion hope and optimism for individuals, families, communities, teams, and systems.
- Build healing authentic relationships.
- Serve as examples of hope and ingenuity.
- Use collective power, privilege, and access to question the status quo and advocate for policy change.

As Mark Humowiecki reflects, “All humans are complex. Doing good complex care means understanding that.”



Amplify:

A Consumer Voices Bureau

Honoring the power of human connection, the Camden Coalition seeks opportunities for graduates of its 18-month National Consumer Scholars program and others with lived experience of managing complex needs to inform the field by speaking about their lives. The goal of *Amplify: A Consumer Voices Bureau* is to hear more first-person perspectives from podiums and panels, and to help organizations learn to engage community members and draw on their experience in program design and evaluation.

“Not only do you get to tap into their expertise, but I know many of our Consumer Scholars share a passion to be involved and to help people the way they were helped,” says **Evelyne Kane**, the Camden Coalition’s Program Manager for Community Engagement.

Andre Davis embodies that passion to help others. Davis struggled with addiction to crack cocaine for more than 40 years and got to know members of the Camden Coalition’s care team during a hospitalization in 2017. He calls that meeting as “the best experience in the world.” Now in recovery, he has since participated in the National Consumer Scholars program and joined the Camden Coalition’s Community Advisory Committee, a committee of the organization’s Board.

“These people love to love. I call it the Love Zone,” Davis says. “We continue to talk about tough topics and try to find solutions. They’re just as human as you can get, and that’s really effective and it’s necessary for the addict who’s suffering from the disease of addiction. It takes work, it takes loyalty. It’s worked for me. They are such an honest program.”

Speak My Language: Community Health Workers



Navigating a complex and decentralized health care system adds one more layer of stress to the life of anyone with medical and social needs. Add structural barriers to transportation, high quality medical care, and healthy food, language differences, literacy and health literacy levels, and issues of stigma, cultural sensitivity, implicit bias, and racism, and the stakes get even higher. Community health workers (CHW) can provide the missing link.

Also **known** as *promotores*, outreach educators, lay health advocates, peer providers, or navigators, CHWs are individuals who share life experience and sometimes cultural background with people who need help. They receive training in how to use that affinity to empower and teach people to pursue better care and better health. They also help health systems raise their level of cultural competence.

“Community Health Workers can help the health care system to truly be patient-centric,” says **Shreya Kangovi, MD**, founding executive director of the Philadelphia-based **Penn Center for Community Health Workers**. “Doctors, nurses, and social workers are defined by their training. Community health workers are defined by who they are and what they do.”

A 2019 **report** from **FamiliesUSA** found that community health workers are highly versatile, even lynchpin providers who serve as advocates on issues that matter to people — access to food, battling eviction, talking to employers. In St. Louis, community health workers are even **working** with the police department to address social needs, racial justice, and trauma.

“The key question many community health workers ask their patient is, ‘What do you think you need to improve your life or health?’” Kangovi adds. “It’s a magical question, putting them in the agenda-setting role. It is not just about keeping people out of the hospital; it’s asking, ‘What do you want to do?’ and then doing it with them.”

Despite sometimes being underestimated, this person-to-person approach can drive significant improvements in care and cost outcomes. (This **brief** in the Better Care Playbook assesses a considerable body of evidence.)

A flagship example is **IMPACT** (Individualized Management for Patient-Centered Targets), a standardized, scalable program developed by Shreya Kangovi at the Penn Center, which is the most widely disseminated community health worker program in the U.S. IMPACT has been replicated in 20 states and the Veterans Administration. Three randomized controlled trials have demonstrated improvements in chronic disease control, mental health, and quality of care. Total hospital days for IMPACT participants dropped 65% compared to a control group and IMPACT **reports** a \$2.47:1 annual return on investment.

Funding for IMPACT has included research support from **NIH, PCORI**, and **The Commonwealth Fund**; direct care delivery in Philadelphia supported by **Penn Medicine** and local Medicaid plans; technical assistance self-paid by the client organizations; and policy work also supported by the **Community Health Acceleration Partnership**.

Business Skills for Better Care

As health systems invest more in social care, nonprofits and CBOs are seeing more demand for their expertise. This new involvement between two sectors that have historically worked separately is creating opportunities and some tension. Some CBOs feel pressure to integrate into health systems through subcontracting or buy-outs, while others are facing unaccustomed competition from them. Health systems may not know how to work with small nonprofits or the federally funded aging services network, and some are **bringing** services in-house.

Some CBOs are struggling to get business-ready and need help adjusting to the new landscape. This can mean expanding data collection, building knowledge of insurance and payment systems, assessing their true costs, and learning to negotiate deals to ensure they are fairly paid.

Building Business Acumen

The **Aging and Disability Business Institute** was created to help. A project of the **National Association of Area Agencies on Aging (n4a)**, the Business Institute is funded by **The John A. Hartford Foundation**, **The SCAN Foundation**, and the federal **Administration for Community Living**.

The Institute provides **toolkits and others resources** that community organizations need to assess their business readiness, define a value proposition, conduct market and competitor analysis, and build a business case for partnership with health systems.

A related tool, particularly useful for creating sustainable arrangements to fund delivery of social services, is the **Return on Investment (ROI) Calculator for Social Determinants of Health**, provided by **The Commonwealth Fund** and built on original work by Dr. Victor Tabbush and **The SCAN Foundation**. **Fundamentals for Nonprofits** also offers numerous resources to foster successful partnerships between health systems and nonprofits.

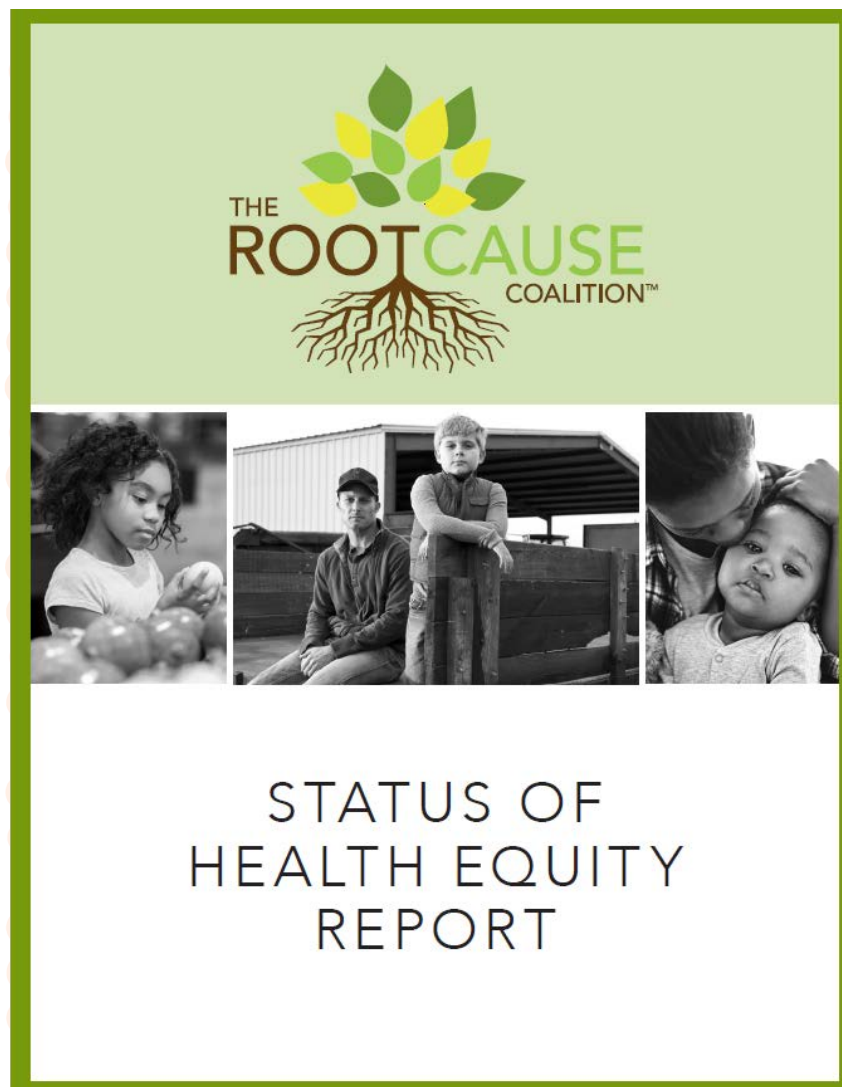
The Root Cause Coalition: 'Closing the loop'

Increased screening for social determinants of health is critical but important work remains. “One of the biggest areas is what I call ‘closing the loop,’” says **Emily Allen**, senior vice president for programs at **AARP Foundation**. “We know that clinicians don’t like to screen for something unless they can treat it. Often they would screen and refer, but never really know if the individual got the services or what the health outcome was.”

Closing the loop is central to the mission of the **Root Cause Coalition**, co-founded by AARP Foundation and ProMedica in 2015. Today, the coalition unites more than 75 health systems, foundations, businesses, nonprofits, health insurers, academic institutions, and policy centers working to achieve health equity through cross-sector collaboration.

In its 2020 *Status of Health Equity Report*, the Coalition issued an ambitious call to “disrupt and begin a simultaneous deconstruction and reconstruction of health care in this country, while maintaining and protecting components that are solid.”

“Health systems cannot bear the full burden of addressing all these social issues,” says Allen. “But health systems are a natural place for initiatives to get connected.”



[BACK TO TOP](#)

COVID-19, Context, and Complex Care Policy



The COVID-19 pandemic has had mixed impact on complex care. Its urgent demands have brought important attention to many core concerns, but have also placed enormous functional and financial stress on the nonprofits and health systems that address them.

“COVID-19 is the funhouse mirror that amplifies all these longstanding issues,” says **Shreya Kangovi** of the Penn Center for Community Health Workers. “Systemic injustice is the real pandemic.”

The emergency has brought widespread policy relaxation within Medicare and Medicaid. Telehealth is a case in point. In just a few weeks in early 2020, this relatively minor health care player moved to center stage. Pre-COVID, only about 13,000 Medicare fee-for-service beneficiaries typically received telehealth services in a week. By the end of April, CMS had loosened regulations to double the number of covered services and the number of beneficiaries using telehealth **rocketed** to nearly 1.7 million.



Funders concerned with complex care have been monitoring these fast-moving changes. The **California Health Care Foundation** is conducting tracking polls to assess Californians' use of the health care system and physicians' assessment of availability of ICU beds, ventilators, and personal protective equipment during COVID-19.

The **SCAN Foundation** funded **Manatt Health** to create a [guide](#) to the many temporary Medicaid flexibilities and how they affect access to long-term services and supports for vulnerable populations.

Systemic injustice is the real pandemic.”

Pandemic-Driven Policy and Beyond

Another important question is which of these policy changes are worth keeping. A [brief](#) by Health Management Associates and funded by **The Commonwealth Fund** and **The SCAN Foundation** found that most COVID-related changes are expected to be temporary, adding that, “most changes to Medicare regulations bring both potential positive and negative impacts,” and urging that they be evaluated accordingly.

Some want to see an even more ambitious approach. Writing in *Health Affairs*, **John Auerbach**, president and CEO of **Trust for America's Health** and **Brian Castrucci**, president and CEO of the **de Beaumont Foundation**, call attention to the difference between an individual's personal social needs and the broader issues that can only be affected through social and economic policy change.

“This is not an either/or,” the authors declare. “Improvements in our nation's health can be achieved only when we have the commitment to move even further upstream to change the community conditions that make people sick.”

Roles for Philanthropy

Philanthropies of all types and sizes can play important roles in advancing, improving, and expanding complex care. While most U.S. foundations are relatively **small**, with assets under \$50 million, many see outsized impact from their giving. Community, family, and private foundations often fund in a defined geographic area or specific field, yielding deep understanding of places, populations, and needs, and building trusted relationships with community organizations. Larger and national foundations may tend to take the lead on system-level transformation, but to flourish, the field needs both.

Here are some key ways philanthropy can contribute:

CONVENING. Creating cross-sector relationships can be hard; philanthropy can help break the ice by setting up events, making introductions, and funding conferences and working groups. The recently formed **Aging Intersections** funder network in Northern California is the first to focus on equity in aging, with support from a diverse network that includes the **May and Stanley Smith Charitable Trust, Metta Fund, Dolby Foundation, the Marin Community Foundation,** and a growing list of other foundations, nonprofits, and agencies.

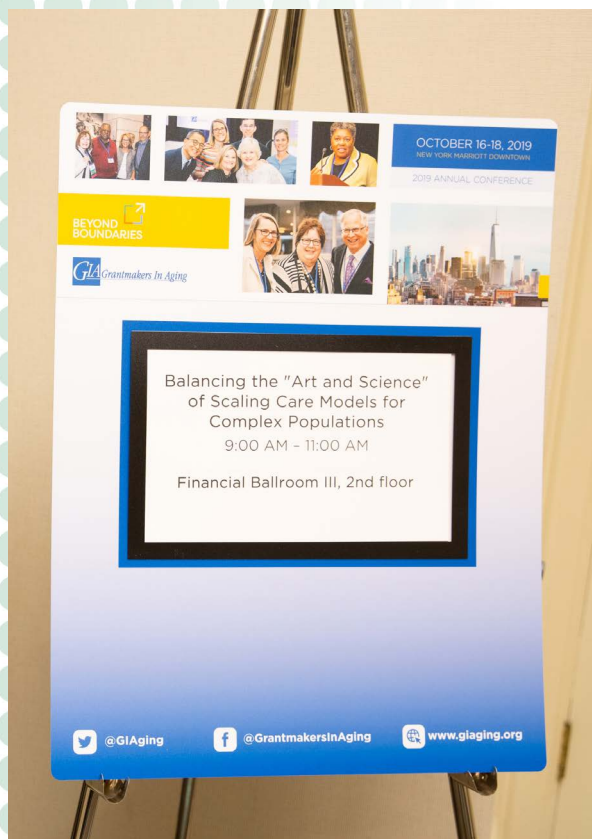


“You have a lot more power when you get different groups of stakeholders together because they tend to aggregate in their own communities and don’t really get cross-pollination of ideas,” says **Melanie Bella** of Cityblock Health. “Philanthropy does a great job of that.”

KNOWLEDGE BUILDING. Amassing the evidence base for a new approach to complex care is an ongoing process and support for research and analysis is essential.

A key example is the 2019 report from the National Academies of Sciences, Engineering and Medicine, *Integrating Social Care into the Delivery of Health Care*, which identified three key elements: an appropriately trained workforce, including social workers and/or community health workers; health information technology to support data sharing; and alternative financing models to support integration.

Funders included the **Robert Wood Johnson Foundation, The SCAN Foundation, Archstone Foundation, Bader Philanthropies, Episcopal Health Foundation, the Health Foundation of Western and Central New York, Healthy Communities Foundation, the Josiah Macy Jr. Foundation, Kaiser Permanente National Community Benefit, and New York Community Trust.**



CHAMPIONING. New perspectives do not take hold overnight and helping organizations shift their focus toward the root causes of health will require creativity and patience. Philanthropy can help by reframing the work already happening in communities or organizations they support and encouraging and incentivizing collaboration.

EVALUATING, SCALING, AND DISSEMINATING. As a young field, complex care is still in a period of exploration and adjustment. Many evidence-based models are not yet nationally available and need support to scale up and get better known. Supporting replication work and sharing insights with other funders can help move the needle.

FILLING GAPS. Health systems and organizations that rely on highly regulated public funding streams, like Medicaid, can have a hard time pivoting quickly, even in a crisis. Foundations can act more quickly, and many did in response to COVID-19.

Grantmakers In Aging’s [Philanthropy Responds](#) page catalogs many COVID-19-related examples, from the **United Methodist Retirement Communities Foundation** offering “Hero Support” to nursing home staff in the form of food, rent, and childcare subsidies, to the **Rapid Response Network for Nursing Homes**, funded by **The John A. Hartford Foundation**, which offered daily virtual “huddles” during the pandemic to provide expert technical assistance and practical solutions to nursing homes when time was short and lives were at stake.



An Unfinished Agenda: Ideas for Funders, from Funders

At the 2019 GIA Annual Conference, funders noted that much remains to be done and brainstormed innovations in grantmaking that could help build up the field of complex care. Suggestions included:

- Add extra funds and time to grants to give CBOs and health systems the chance to build trusting relationships.
- Address the power and financial imbalance that can exist between CBOs and health care systems attempting to work together for the first time.
- Consider bridge loans to CBOs struggling with health system payment cycles.
- Reconsider due diligence requirements for small CBOs in emerging partnerships.
- Consider providing greater core operating support and coverage of CBOs' indirect costs during periods of change and transition, including upfront costs for new technology and software.
- Support patient engagement councils and other organizations able to speak authentically about community needs and preferences.
- Make community engagement part of all grants to ensure that community and patient voices are solicited and heeded.

The Seven Foundations Collaborative

Creating New Connections: How Philanthropy Can Support Better Care for People with Complex Health and Social Needs is supported by the [Seven Foundations Collaborative](#):

- [Arnold Ventures](#), increasing coordination of care for dual-eligible beneficiaries by promoting evidence-based models that provide seamless and integrated care across the continuum of services.
- [The Commonwealth Fund](#) supports independent research on health care and makes grants to improve health care practice and policy to promote a high-performing health care system that achieves better access, improved quality, and advances equity.
- [The John A. Hartford Foundation](#), with a specific focus on improving care for older adults by creating age-friendly health systems, supporting family caregivers and improving serious illness and end-of-life care.
- [The Milbank Memorial Fund](#) is an endowed operating foundation that works to improve population health by connecting leaders and decision makers with the best available evidence and experience. We work with states and regions health policy decision makers on issues they identify as important to population health, particularly in areas related to primary care, aging, and total costs of care.
- [The Peterson Center on Healthcare](#), finding innovative solutions that improve quality and lower costs of care and accelerating their adoption on a national scale.
- [The Robert Wood Johnson Foundation](#), building the field and movement with a focus on community voice and equity and supporting a complex care hub through the National Center for Complex Health and Social Needs, among other projects.
- [The SCAN Foundation](#), transforming care for older Americans who live with chronic health conditions and daily living challenges so they can live well regardless of age, health, or ability.



GIA *Grantmakers In Aging*

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Editorial & Design Services

Written by Elliott Sparkman Walker and designed by Carly Warner
of SCP (Strategic Communications & Planning.)