

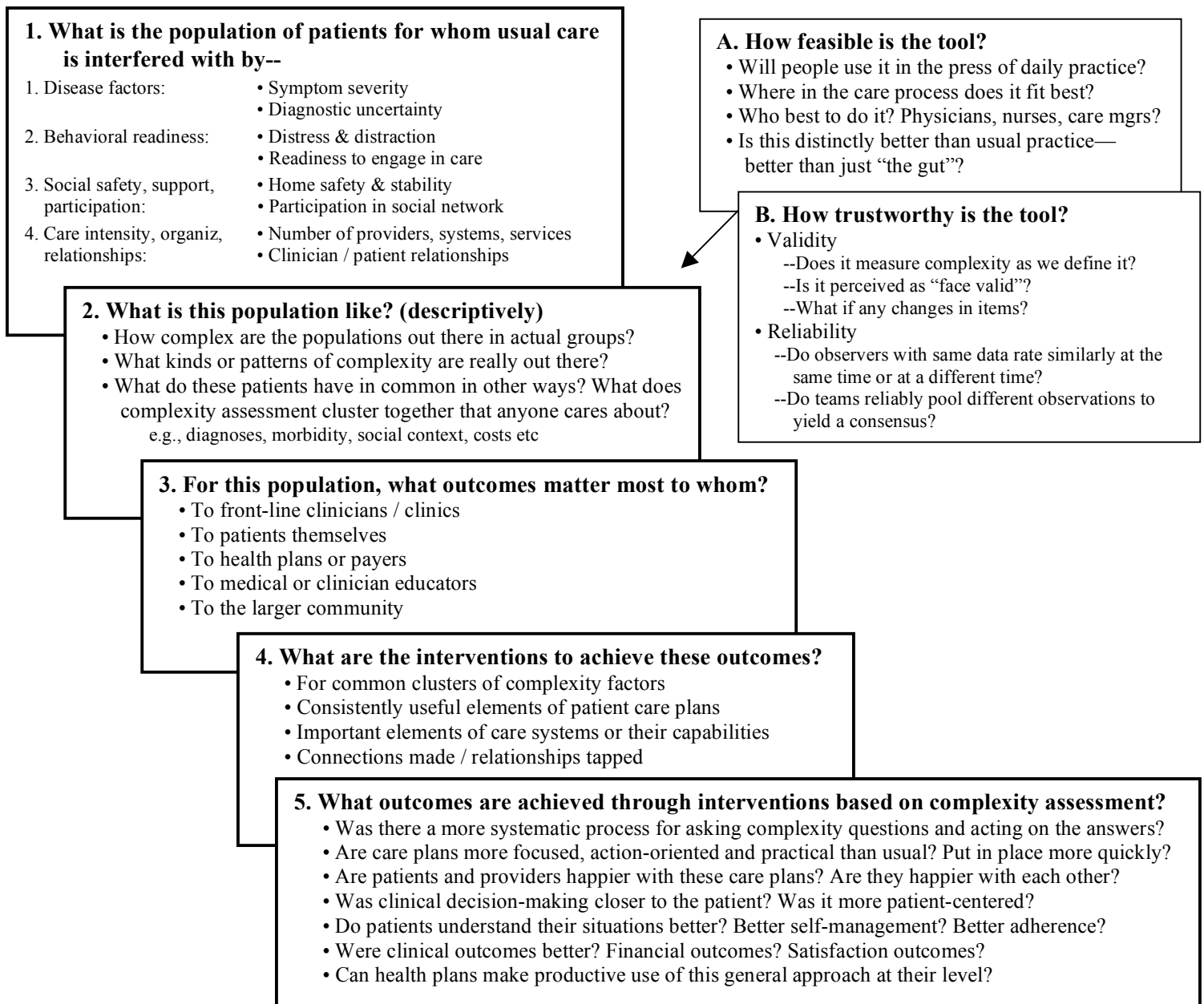
Orienting definition: *Complexity is interference with usual care for a condition*

“Patient complexity is thought of as *interference with standard care* caused by severity or diagnostic uncertainty, behavioral unreadiness, lack of social safety or participation, and disorganization of care or difficult care system relationships”. (From Huyse et al, 2006 as adapted by Peek, Baird, Coleman)

“A complex patient . . . is one for whom *clinical decision-making and required care processes are not routine or standard*. . . many recommendations from evidence-based medicine are unlikely to apply in a straightforward manner because of “exceptions” such as: multiple interacting chronic conditions, other co-morbid conditions . . . and socioeconomic factors such as homelessness or the absence of adequate family caregivers or other support systems.”

(From Weiss, K., 2007; VA State of the Art Conference, GJIM 22(Suppl 3):374-8, 12/07)

Map of development questions



Feasibility:

- Concepts and item language: Faculty from Family Medicine and other specialties have adjusted these to the point that no one trips over them anymore.
- Feasibility in a family physician practice: One physician did 360 consecutive assessments on own patients and reported it was easy to incorporate. Other smaller tests in progress.
- Feasibility in teams or care conferences: Faculty teams assembled for practice sessions with case vignettes or their own cases found the tool reasonably easy to use. But in real clinic life, office processes or routines of practice don't yet enable this particularly well.
- Better than usual practice?
 - A. Faculty teams assembled for practice sessions generally regarded the use of this systematic vocabulary for complexity and action planning distinctly better than what usually happens or reliance only on "gut feelings".
 - B. Many faculty in these practice sessions commented that the tool helped to structure the case conference and lead more quickly from description to consensus action.
 - C. Most believed this approach structured resident precepting conversations better than usual

Trustworthiness:

Inter-rater reliability informally seen as sufficient by faculty groups assembled for practice sessions with case vignettes or their own cases. Consensus usually achieved on top areas of complexity, ratings, and kinds of action to address it.

Validity:

- "Face validity": The intuitive appeal is strong—as if the concepts and questions are indeed getting at what people mean by complexity and the factors
- More or different items: The one recurrent suggestion is to include a socio-cultural domain or at least a "language/interpreter" item as another indicator of what we mean by complexity—interference with usual care and protocols.

Population description:

- Distribution: One distribution of 360 consecutive family medicine patients revealed a small number of very complex patients in a distribution not particularly surprising. Other distributions by physician or in a different specialty in progress.

What outcomes matter most to faculty:

- At point of service with individual patients:
 - A. The ability to more quickly articulate just what is complex about a particular patient and gain consensus on what to do about it—sharper focus more quickly with shared vocabulary
 - B. Feeling more competence and less "heartsink"—with patients, colleagues, and residents--provider satisfaction and hopefully improved quality
 - C. Engaging complex patients better in their own care—self-management and satisfaction
 - D. Being able to carry out multifaceted care plans—a system really built for the interventions
- At population level:
 - A. Better physician or clinic panel / population management geared to level and kind of complexity, not just diagnosis, disease, or symptom severity.
 - B. Better resident education—systematic vocabulary and care planning skills for complexity
 - C. Better resource use, better care management, and perhaps potential to explore different models to reimburse for complex care—not so dependent on diagnostic groups, but on complexity groups.

What interventions? Consistent theme: Provide examples of complexity-related interventions and care plans—the beginnings of feasible pathways or perhaps eventually even complexity-related "protocols"

What now: First things first?

Draft 3/6/08

1. Broaden the exploration of feasibility / acceptability in practice settings

Example:

Purpose:	Test concepts and tool for feasibility / acceptability
Select:	3-5 clinics with 1-5 doctors or teams
Test with:	Maybe 20 patients each
Design:	Consecutive patients? Random? Purposeful sample of some kind?
Tests:	<ul style="list-style-type: none"> • Try different ways of administering the tool (by whom, where in care process) • Consider exploring utility of a “socio-cultural” domain not now included
Questions:	<ul style="list-style-type: none"> • What are the perceived benefits over usual practice—better than just “the gut”? • Where in the care process does it fit best? What would it take to properly embed? • Who best to do it? Physicians, nurses, care mgrs? How does this change care management practices and action plans? • Will people use it in the press of daily practice? Or what would make it so? • What really matters to people in the clinic regarding complex patients?
Support:	Research assistant to work with staff, do F/U interviews, etc?

2. Add to this same exploration? Starter exploration of the population

Example:

Questions:	<ul style="list-style-type: none"> • What is the distribution of complexity encountered by clinic, physician, population? • What patterns of complexity are actually observed? • What do these patients seem to have in common that anyone cares about?
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3. Add to this same exploration? Starter exploration of reliability/validity of concepts and tool

Example:

Questions:	<p>Validity:</p> <ul style="list-style-type: none"> • Does this strike people as intuitively on target—“face validity” • Does high complexity score flag patients identified ahead of time as not responding well to usual care or protocols? • Does inclusion of new “socio-cultural” items improve this? <p>Reliability:</p> <ul style="list-style-type: none"> • Do individuals or teams more or less agree on level and kind of complexity and what the action areas are? • Does it help teams reach consensus on what to do?
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Later steps could involve:

- Formal studies or evaluation in promising areas identified above
- Creation and testing of complexity-related point-of-service interventions
- Exploration of complexity-related system support for those interventions, including how to embed in care management practices
- Exploration of complexity-related financial models.
- Studying specific outcomes achieved as a result of using complexity assessment to formulate and carry out complexity-related care plans