Synopsis: Preliminary testing done in with Family Medicine faculty and residents 2006-08

Face validity, appeal, and clarity of language was explored with at least six groups of different University of Minnesota affiliated family medicine residency faculty members and residents. This was done at first using standard case vignettes and later with real situations facing care teams at the time. This led to a version that was acceptable to Minnesota family medicine clinicians and residents—something with face validity, appeared useful in clinical and educational contexts, and no longer contained language that was confusing or raised objections. Teams practicing with vignettes or their own cases---

- Found the tool gives patients and providers a common vocabulary to discuss care goals and develop a care plan that may entail medical, mental health and community services support.
- Found the tool easy to use, but in real clinic life, office processes or practice routines aren’t usually set up for it.
- Regarded the use of this systematic vocabulary for complexity and action planning distinctly better than what usually happens or reliance only on “gut feelings”.
- Commented that the tool helped to structure the case conference and lead more quickly from description to consensus action.
- Believed this approach structured resident precepting conversations better than usual, and left preceptors with an improved sense of their own effectiveness.

Additional feedback on clarity and usefulness of concepts and language was gathered through a series of presentations to Minnesota, regional, and national audiences which attracted a few practices for a feasibility testing mini-collaborative.

One physician’s experience: A preliminary distribution of complexity assessment ratings (3/5/08)

One family medicine physician: Patient complexity total score distribution (sum across all 8 items on the May 2006 form) May 2006 form; N = 363 consecutive primary care patients; some familiar, some new. Impressions: No problem to incorporate in daily practice; helped ask questions that might go by otherwise

- Most patients weren’t all that complex; some had been complex at an earlier time, but now were not—or at least those sources of complexity were under better control.
- Would use again in daily practice to support next and more systematic level of method development

The 5% and 1% refers to the percentage of the 363 patients whose complexity score fell in those ranges

Learnings sketch as of 8/26/08
Synopsis of learnings from ICSI-sponsored feasibility testing collaborative.

With the language of the checklist stabilized for acceptability, a few other Minnesota practices participated in a small feasibility testing collaborative facilitated by the Institute for Clinical Systems Improvement (ICSI) in Minnesota to share the results of QI-level “small tests of change”, using it briefly in different places in the patient care or resident education process, recording results and then moving on to another test. The basic findings were:

- It is a “one minute tool” during a typical session of patients that you already know. Mostly people knew enough already to answer the questions. If you don’t know, it reminds you to take time to ask—but these are things you should know about anyway.
- It helped to make patient complexity more specific rather than ephemeral or impressionistic.
- It fits well into residency clinic care and precepting workflow and helps residents reflect on complexity factors more systematically before.
- Different team members tune into different parts of complexity, e.g., physicians, nurses, or behavioral health providers. Teams could quickly pool their data after a session of patients and preferred this to doing it as separate providers, and found few significant disagreements when pooling their data.
- Nurses gathering the information gathered during “rooming visits” or phone triage useful in alerting other providers to issues to take into account.
- The clinic isn’t geared up to handle some kinds of complexity, and need connections outside the clinic.

More detailed learnings sketch from MCAM feasibility testing:
From ICSI “feasibility testing mini-collaborative” in 2008

A sample of general impressions of individuals doing the rating separately

- It is a one-minute tool—rather than a longer one—and not really a problem to use during a typical session of patients
- Helped put patient complexity in a more specific rather than ephemeral or impressionistic format.
- In a small random sample of mostly well-known patients it didn’t expand my actual knowledge—which was substantial already. Most turned out complex and I was already aware of that.
- A couple of people I didn’t know well were in for limited problems and this led to a different process than using the form than with chronic patients. This raises the question of what level of visit makes sense to use the form. Most of my small random sample were level-4 returns.
- In another small sample, there were things indicated from the ratings that you knew about, but hadn’t thought real hard about or tried to address. This raises the question of what more to do about it because we are already trying to marshal resources to do something, but these resources often aren’t that available or sufficient

Different providers may tune into different parts of complexity.

- The first two items (severity and diagnostic uncertainty) are mostly physician-type questions, followed by the nursing-type questions later in the form—social safety and support. Nurse and physician scores may differ in part due to which part of the situation they are mostly responsible or trained for. This speaks to the possible need to make it a team-based evaluation.
For learners, the tool can portray the full range of complexity we want to pay attention to, knowing that some on the team may be more “tuned in” to different domains—but that each person is more sensitive to different domains.

**Rating complexity as a team.**

One example: The doctor, MA, and nurse rated the morning patients together after seeing them all—merging their thoughts without the patient present.

- Was very efficient and went really fast.
- The team preferred doing it together so each could put forward their piece of it.
- There were no disagreement or large differences in perspective between team members. Liked coming up with this one rating as a team—and having one resulting set of numbers. Total scores ranged from 1 to 14, although we know that complexity isn’t so much a total score as specific high points along those domains.
- Mostly these were things we already knew about these patients.
- We have a big range of readiness to change—many are ready but others are not, unless there is almost an ultimatum or crisis—depending on their specific situation rather than a total score.
- Many underinsured patients, and many not doing their part of the treatment. How can we have social services or other supports in place to help the patients be more active in their care? Sometimes the clinic has to spend more time with the patient arranging social support services for the patient (especially with the homeless) than on medical care.

**Diagnostic challenge vs. no good treatment available:** One patient had a clear diagnosis but no good treatment is available. Is this to be considered a complexity in the “diagnostic challenge” category? Resolution at this point: This situation represents a current treatment challenge, not a diagnostic challenge. If complexity is defined as interference with usual care and decision-making, the absence of usual care and decision-making would not be “complexity”, although it certainly calls for careful conversations that may “complicate” the visit.

**Mostly we knew enough to fill out the form with our outpatients**

- Most patients tested were known well enough already that we were satisfied with the information we had. This may not be true with new patients, very complex patients, or larger samples. It is 1-2 minute tool, but if you didn’t know the person, and had to get more information through an interview you could add some time to the overall visit. This info might be appropriate in a rooming visit.
- On the other hand, when a provider did the scale with patients who were on another providers panel but coming in for acute concerns it was more difficult to know how to score some of the domains, but it made the provider ask some questions that might not always be asked. Overall it was quite feasible to do it in this context when seeing even these unfamiliar patients with the residents.

**We may not know enough to score MCAM with newly admitted inpatients—and it may change as we understand them better**

- It was very fast to fill out the form at bedside while rounding, maybe 40 seconds to 1.5 minutes. Residents may “moan and groan” about a new form initially, but found it worked well in practice on rounds.
- But with newly admitted patients who have not been fully worked up, providers may not yet know enough to fill out all the fields. In its place, there may be global assessments of “complexity”—but
based more on how “complex” or intimidating the case is expected to be for the physician. They may overestimate complexity compared to actual scores when the perceived stress or uncertainty is there in this newly admitted patient.

- This raises the need to clarify that “complexity” is interference with usual care and decision-making, not a measure of how difficult, stressful, tough, anxiety-producing, or challenging the case will be to the physician.
- Presence of a mental health condition may be experienced by providers as automatic evidence of high complexity, but again the definition says “interference with usual care and decision-making”. Even mental health and chemical dependency conditions can have clear diagnoses and straightforward plans—without that much interfering with them—hence not complex according to this definition.
- Rated complexity may shift over time as diagnostic uncertainties or other interferences are identified and dealt with. A question is whether you can graph time by level of complexity and use this tool over time as a measure of whether your interventions are working?

We are ready to do the ratings with patient present—and have started to do so

- Nurses are interested in conducting the assessment with the patient during the rooming visit (if this is OK with the physician). Knowing what the complexity dimensions and questions, the nurse was engaging more in conversation with the patient—leading to be more involved than in the usual rooming process.
- We don’t know how this would be received by a larger sample of patients, or how it would be received by physicians if they did it themselves during the provider visit and possibly got behind.
- We definitely need to try a patient version—something that is written in terms for the patient to self-assess on those dimensions of complexity. Patients also need the vocabulary for what is complex about their own situations or what can interfere with their medical care.
- We are interested in knowing how different providers use the tool during their own part of the care process—faculty physicians, residents, and mid-levels. We are also interested in the implications of this tool for triage—knowing ahead of time what type of patients need what type of providers.
- Using MCAM by the nurse during the rooming visit in a small sample appeared to lead to more accuracy in the ratings, especially on home life, financial issues, and distress/readiness to engage. Patients appeared to forthcoming and honest with their answers. This took a couple of extra minutes to read the question. Doing MCAM this way with patient present during rooming visit took 5-8 minutes but went well and appears worth it.
- It would help to have a more formal type of script for introducing this tool and questions to the patient—something perhaps building off or adapted from the briefer “intermed interview” in the orientation booklet but more specific to the rooming visit.

Patients and providers may judge complexity scores differently

In one situation, a patient who was being interviewed gave self a low score on distress, whereas the provider rated distress much higher because of what the provider perceived as dysfunction at home—even though the patient thought home was not so stressful. Ideas:

- This difference could be due to habituation to the home stressors, like getting used to loud background noise in a room. Sometimes patients have little insight into their stress at first and it takes time for them to see it for themselves.
- Or cognitive dissonance—it is hard for a person to let in that distress. The scale and differences of provider-patient observation might be a way to engage the patients in a discussion about what is
going on. And it also highlights the possibility that the provider or team needs to make their own independent assessment in the case if it quite different than the patient view.

It was a 5-10 minute tool doing it as an interview with the patient present. But once a patient version comes out, it may be shorter or done ahead of time by the patient on their own.

Scale item wordings

- Some confusion about meanings on the insurance question—“abundant resources” Should be “adequate resources”. Or this question should probably be geared to adequacy of health insurance rather than the more global socioeconomic status or solvency: How about “has insurance” = 0; “underinsured” = 1; and moving up from there, perhaps with “has money to buy meds” included somewhere.

- On second page (historical) there is a statement about negative experience with providers.

- On the “language” item in fifth domain:
  A. Isn’t having a family translator more complex than having a professional interpreter? There may be a need to adjust that scale and annotate the reasons to use professional translators and the potential pitfalls of depending on family translators. Example: A woman who does not speak English, refused an interpreter (her husband interprets) and husband appears controlling, with ongoing issues with the patients getting clear messages.
  B. Some learners may think of diagnoses that interfere with communication, e.g., CP or dementia as reasons to score higher complexity on “language”. First impression from team on this is that the item was intended to gauge the degree to which the patient and providers share a common linguistic system and culture, not the presence of another diagnosis that has language problems as a major symptom. At the same time, having a diagnosis that interferes with communication does complicate care and decision-making for all the conditions at issue. However, the team did not suggest including presence of those other diagnoses as part of why a person would score a person “more complex” on the language question.
  C. Other learners might first see this question as “shared medical language”. Clarify that the intent of this item isn’t patient familiarity with medical talk, but the shared linguistic / cultural base.

- As a teacher and learner, it may help to have a glossary or annotation about what is being asked in those questions to avoid common misperceptions. To teach this, do you have to define the terms closely--using common definitions in primary care rather than trying to construct a whole new technical lingo for MCAM, which would go against the philosophy of “communimetrics” (Lyons) that is intrinsic to this approach.

Acting on complexity discovered

- We were hoping the form would give us a brainstorm of what to do when encountering complexity, but mostly it didn’t suddenly point to interventions. At the same time it is good to have something there to kick you to do it.

- It was interesting to see how high the scores were (from this select population). Some of these had a complicated medical aspect or are limited by what the system could do for them or what could be done outside. But it forced me to think about what kinds of side things are going on and you get used to them as part of the scene that plays out side by side with medical care.

- Some weren’t responding to care as you were expecting them to, some probably weren’t buying the medicines. The biggest numbers came from symptom severity and diagnostic challenge and usually had something to do with pain.
• When we bring all this complexity out in the open, it will allow us to recognize the boundaries of our own services--and where we are unable to help directly, and need to connect with others instead. It will help our residents and learners to take some of the burden off of them personally. For example, “These are complex, here is why, and here is the limit to what you can do. And now we will get things in the community and resources that are outside our medical clinic” (public health, social work, educational services).

• In the residency clinic, the assessments led quickly to things like “I wish we had some tools and resources in place to respond to what I am seeing here”.

• Some groups feel it is important to begin to catalog the kinds of interventions that would be useful to have, given the complexity that is observed, while others feel there is lots of value in simply measuring and identifying complexity even if we don’t always know what to do on the “right side of the form” that calls for specific actions.

Medical education
• In asking 3rd yr resident to pick the patient where your heart sinks and pick the one you are most looking forward to seeing. At the visit, the resident completed the assessment. Resident said something like “I never thought about this complexity in a systematic way. It allowed me to reflect on a couple of other patients I am seeing”.

• Complexity assessment can fit into our residency clinic workflow. Was not very time consuming at 1-2 minutes. The conversation quickly led to “I wish we had some tools and resources in place”.

• Using a systematic approach such as in a chronic disease model: A portion of our patients who are difficult to control their diabetes with high complexity scores, could come in on a day when the social worker or other resource is available. Or perhaps cluster patient visits with an intense team.

• It is important in residency program to distinguish the kinds of patient complexity that stress doctors more than other kinds and help new doctors manage this for themselves as well as for the patient.