Integrated Care for Complex Patients
We dedicate this book to Roger Kathol, MD. Roger is truly the father of “clinical complexity.” It is with his inspiration that we plan to continue to reinforce and build upon the platform he has so dedicatedly established. There is little in medicine that is more logical, more inherent, than “complexity.” Systemic medicine and psychiatry combined make up only part of that picture. As Roger has shown us, the social and care delivery dimensions must be added to approach a true picture of the patient, and his or her clinical needs and circumstances. The VB IM-CAG, so much of which is Roger’s creation, is a seminal blueprint for the continued development of what we hope will eventually become a “complexity specialization” within medicine.

Roger, you are not just far-seeing about medical matters, but you have laid a groundwork for the clinical practice of medicine that is both precise and at the same time humanistic. With this book we acknowledge you and celebrate your work.
Health-care systems and clinicians increasingly recognize that a relatively small number of persons account for a significant amount of medical cost and utilization, with 10% of patients accounting for almost two-thirds of total health-care costs [1]. While these individuals often have multiple chronic systemic conditions and functional limitations, a major subset of these persons also has comorbid psychiatric illness and chaotic social situations. For clinicians, these individuals are “complex.” Systemic medical and psychiatric illnesses, demographics, experiences with society, and the health-care system; and social capital\(^1\) all contribute to their health status and to their illnesses. These contributing factors are interdependent and are not easily disentangled.

This population with complex care needs presents particular challenges to clinicians. As highlighted by Frankel and Bourgeois [2], their complexity can have several dimensions: diagnostic complexity, operational complexity, and management complexity. Diagnostic dilemmas arise when patients already have multiple co-occurring conditions and high symptom burden. Teasing out what symptoms represent a new condition versus a medication or ongoing illness effect can be difficult in a busy practice. Operational complexity arises when a patient with metastatic cancer also has chronic delirium, depressive disorder, and diabetes mellitus. Treatment of one condition can negatively interfere with treatments for others, and no one clinician can optimally care for a complex patient without conferring with others. Aggressive pharmacologic management of diabetes mellitus, when a person is marginally housed or treatment of heart failure without concomitant attention to comorbid psychiatric illness and nutritional support likely will fall short. Finally, management complexity is often seen in the context of comorbid personality disor-

\(^1\)The networks of relationships among people who live and work in a particular society, enabling that society to function effectively.
ders impacting compliance or substance misuse. Regardless of the type of complexity, a traditional medical or biological approach to providing care to persons with complex needs offers insufficient support.

Care of persons with complex needs requires a comprehensive understanding of the wide array of factors contributing to poor wellbeing and a well-equipped interprofessional team to prioritize and address concerns. This team has to be as comfortable navigating hoarding disorder as they do navigating hypertension treatment.

For the past four decades, a variety of care delivery approaches to support persons with complex care needs have been developed and tested. Those that have shown the most benefit have included (1) comprehensive assessment of patients’ needs, (2) tailored person-centered care planning based on the individual assessment, (3) support of patients in overcoming barriers to accessing needed services, (4) open and regular communication among treatment team members, (5) comprehensive care coordination, and (6) ongoing monitoring of care and care outcomes.

As a geriatrician, palliative care physician, and medical director of our health system’s complex care program, I have had the privilege of caring for many persons with multiple chronic serious illnesses and complex care needs. These persons have done best when assessed in the context of a biopsychosocial and spiritual framework and supported by a dedicated and well-trained team.

Until recently, however, most primary care medical practices have not been able to access many of these services. Fee-for-service reimbursement did not facilitate interprofessional care or care that is time consuming. With the advent of new payment models and the patient-centered medical home, population health-focused complex illness care programs have begun to emerge that seek to better assist patients with complex care needs. Alternative advanced payment models are designed to hold medical practices accountable for patient quality of care and cost across settings of care. Patient-centered medical homes, which evolved out of pediatrics, involve patients, caregivers, and multiple care disciplines as the care team. These care delivery models have finally provided the impetus to proactively identify those with complex care needs and to integrate effective complex care into the fabric of health care.

While it is encouraging that health systems and providers are reaching out to those most in need of holistic care, many clinicians are still poorly prepared to care for these patients. In a 2004 survey of US physicians, the majority felt inadequately prepared to care for chronically ill patients or to engage in interdisciplinary teamwork with allied health providers [3]. Even several years later, primary care clinicians express frustration about the fragmentation of care available to those with chronic complex illnesses [4]. Integrated Care for Complex Patients: A Narrative Medicine Approach seeks to fill these gaps and address these frustrations by providing multidimensional perspectives on complex care and strategies to manage them. It breaks down the various dimensions of complexity and highlights pragmatic approaches to manage these domains of need. In addition to explicating the many aspects of complex care, Frankel and Bourgeois provide numerous case studies that bring home important issues in the care of patients with complex care needs.
Integrated Care for Complex Patients: A Narrative Medicine Approach provides refreshing pragmatic, real-world perspectives to an increasingly important aspect of clinical care today.

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References

Preface

We are excited. In creating this book, we intend to contribute to a revolution in the structure and delivery of health care. We are referring to “integrated care,” care rendered by a multidisciplinary treatment team and prioritizing collaboration between team members [1].

“Comprehensive care,” incorporating all components of care required by patients with complex needs, has been described since at least 1980 [2]. In the form of the patient-centered medical home, it has been shown to improve primary medical care and reduce its cost. Well, that is logical, isn’t it? If pieces of the medical equation are missing, the results cannot possibly be as good as when they are included. Good care usually also involves the efficient use of medical resources. But, add to that description a precise fit between parts. Treatment components honed, so they work together with precision. With this consideration added, we have “integrated care.”

Consider, for example, adding a psychiatrist to a treatment team dealing with a critical case of metastatic colon cancer. You have already incorporated oncologists who specialize in the diagnosis and treatment of this particular type of cancer. Next, bring in a member of the clergy if impending death is a consideration and the patient wants spiritual counseling. The medical regimen for the cancer is wearing and painful. It lasts for months and the side effects from both chemotherapy and radiation erode hope and vitality. It is no secret that having psychiatric support and other sources of emotional reinforcement can make all the difference. Consultation among team members is a requirement for success. The team leader needs to be skilled in understanding all the systemic medical and psychiatric requirements of the case and in guiding team members to work with impeccable coordination.

As we see it, there is a difference between “comprehensive” care and “integrated” care. In well-conceived “integrated care,” the efficacy of the care reliably exceeds the sum of its parts. Components reinforce each other and do not just add up.

For this book, we have tapped into the “real world” of treatment, the craft of the primary care physician, illustrating how often it functions as a unified, albeit com-
This book chronicles the decision making by physicians who take total care of their patients. There is little about this process that has been withheld from the narrative descriptions by the chapter authors. In this book we have included, even emphasized, aspects of the treatment puzzle that are often not considered to be of major significance by treating physicians. These “hidden” factors, however, may play a key role in the success (or failure) of treatment. Complex treatment cases have been deliberately chosen for purposes of illustration. Included are 17 of them. Truthfully, there are few medical cases that are devoid of complexity, but for most of the cases described in this book it is the complexity that leads.

Treatments for cases involving complex patients are the order of the day in much of contemporary medicine. In this book, we illustrate integrated approaches required to effectively treat these complicated patients. We cap our effort with a proposal to formalize integration of medical care through introducing a new diagnostic classification emphasizing systemic medical-psychiatric comorbidity, “clinical complexity,” with the hope that it will become recognized and accepted in the medical community. In effect, we will be advocating for the establishment of a new medical specialization dedicated to the assessment and treatment of these cases. In support of this idea, we also encourage the creation of treatment centers exclusively devoted to the treatment of clinically complex cases.

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References

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