DEPARTMENT OF VETERANS AFFAIRS
Jesse Brown VA Medical Center
Chicago IL 60612
Center of Innovation for Complex Chronic Healthcare

TOOLKIT FOR *PREVENTING CONTEXTUAL ERRORS* (PCE) PROGRAM

Subject: The *Preventing Contextual Errors* (PCE) Program

Dear _____

I am writing to you about a novel program to improve care of Veterans based on data collected from direct observation of care, complementing and enriching current measures of quality which draw on the medical record and patient experience (e.g. CAHPS and SHEP). This initiative, *Preventing Contextual Errors* (PCE) in Veterans Care, started in Chicago (at Jesse Brown VAMC and Hines VA Hospital) and supported by VISN 12 and VA Health Services Research & Development, is designed to draw attention to the life challenges Veterans face that complicate their care. The program invites Veterans to audio record their visits, and then feeds back data extracted from the audios to physicians, pharmacists and nurses, to heighten awareness of missed opportunities to address Veteran needs, like transportation, respite care, diabetes education and so forth. Several studies have demonstrated this approach is effective, leading to better Veteran outcomes.

I am highly enthusiastic about the opportunity to bring the program to our facility. Attached is a proposal. As you can see, the cost is about $11-12K/year to cover the expenses of the coding and analytics team (which is based at Hines VA Hospital), plus some staff time at our facility.

Also note, that the PCE program now counts towards critical element 1A of the Executive Compensation Fund (ECF), which rewards facility and VISN leaders who “adopt or replicate at least 1 promising or best practice throughout the network or medical center” with additional credit for documenting meaningful improvement. It is also approved for board certification (MOC) credit from the American Board of Internal Medicine and for CME, both of value to our providers.

Please let me know your thoughts. I would welcome a chance to meet and discuss further. I believe this is a valuable for both our Veterans and clinical staff.

Best,

DEPARTMENT OF VETERANS AFFAIRS **Memorandum**

Date:
From:
Subj: Request to adopt the VA Program to Prevent Contextual Error

To:

DESCRIPTION OF PROPOSED QUALITY IMPROVEMENT PROGRAM

The VA Preventing Contextual Errors (PCE) program, which was developed in VISN 12 and is currently active at six sites nationally, has been sponsored by VISN 12 and HSR&D since 2016.[1] This proposal is a request to [NAME OF FACILITY] leadership to adopt the program in outpatient care. The PCE program employs a groundbreaking methodology of measurement by direct observation, inviting Veterans to audio record their visits. It complements current measures of quality which draw on the medical record and patient experience (e.g. CAHPS and SHEP). The protocol protects the confidentiality of all parties and integrates seamlessly into care delivery processes.

The goal of the PCE program is to increase the proportion of Veterans who receive care that is not only evidence-based but also adapted to their particular life circumstances and behaviors, to achieve desired outcomes. It is approved by the American Board of Internal Medicine for maintenance of certification (MOC) and counts towards critical element 1A of the Executive Compensation Fund (ECF), which rewards facility and VISN leaders who "adopt or replicate at least 1 promising or best practice throughout the network or medical center." In Chicago the PPCE has also received approval from regional accreditors for medicine, pharmacy and nursing continuing education, which may be extended to other regions as well.

Background: The failure to contextualize care can result in a "contextual error." A contextual error occurs when a care plan for a Veteran appears appropriate based on the limited information in the medical record, but is, in fact, inappropriate because it does not address specific life challenges ("contextual factors") the Veteran is facing that complicate care, and that the facility and its providers could address.[2] These contextual factors sort into a handful of broad contextual domains. Health care providers should be looking for contextual factors anytime they see clues ("contextual red flags") that a patient may be struggling with one. Addressing a contextual factor avoids a contextual error (and is called "contextualizing care"). In the following examples, contextual red flags and their associated *contextual factors* (i.e. in italics) are in the second column, sorted by contextual domain, with columns three and four illustrating a contextual error and contextualized care plan, respectively:

Contextual Domain	**Contextual red flag and *contextual factor***	**Inappropriate care (contextual error)**	**Appropriate care (contextualized care plan)**
Skills deficit	Poor diabetes control *due to failing vision; cannot read insulin syringe*.	Provider increases insulin dosage	Provider refers patient to ophthalmology; Rx pre-filled syringes and follow up with nurse.
Competing responsibility	Frequent missed appointments *because of work conflicts*.	Provider unaware. No action taken	Provider checks appointment show rate in CPRS, discusses with Veteran and notifies them of evening hours
Environment	Poor blood pressure *because mailed meds stolen outside apartment*.	Provider re-orders to resend meds	Provider re-routes meds to VA pharmacy for patient to pick up.
Emotional state	Veteran stops taking medications consistently *because of depression*.	Provider only tells patient "it is important to take meds as directed."	Provider diagnoses and treats depression; discusses with patient impact of mood on medication adherence and how to address.
Social Support	Disabled Veteran goes to ED when symptoms severe, *because his wife is too ill to take him to appointments*.	Provider tells patient it's important to not miss appointments	Provider arranges for VA transportation to appointments until wife recovers.

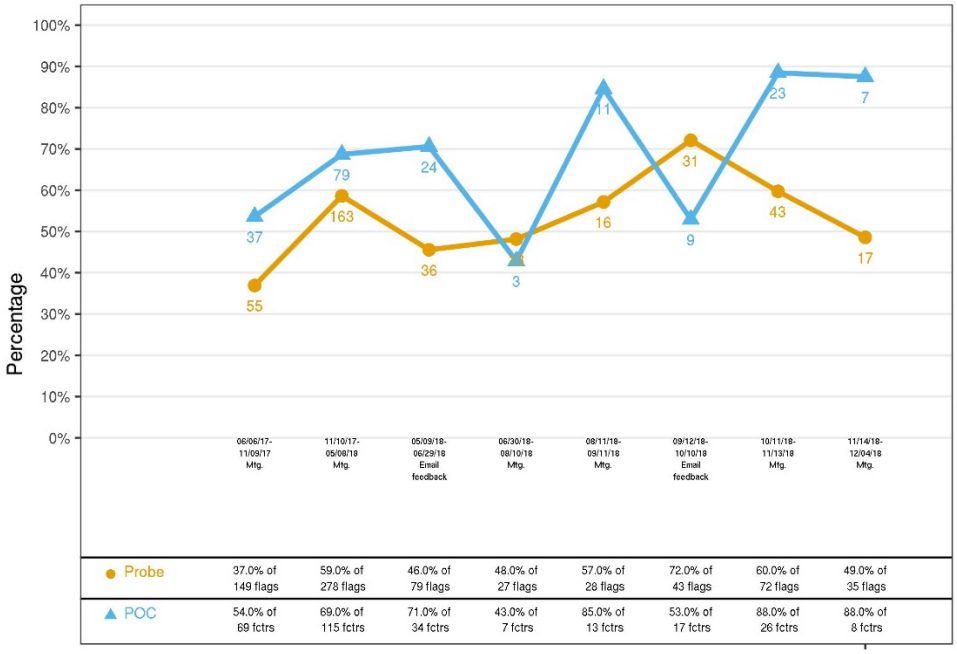
Financial Situation	Veteran with frostbite *after being evicted from home in rent unstable housing*.	Provider treats frost bite in urgent care, but does not address housing situation.	Provider refers patient to homeless Veteran program.

Each of these examples was compiled by inviting a Veteran to carry an audio recorder into their visit. Patient-collected audio, as the process is called, is the only way to track whether contextual factors are missed --resulting in contextual errors, or addressed --resulting in contextualized care plans. The audios are uploaded to a secure server and centrally audio coded in Chicago utilizing a system called "Content Coding for Contextualization of Care," or "4C."[3] The main difference between encounters in which care is contextualized versus those resulting in a contextual error is that, in the former, the provider recognizes signs that a Veteran is struggling and asks about them. For instance, in the first example above, the effective provider says "I notice your diabetes is no longer under good control. Can you tell me what you think is the reason?" For the second, they say "I notice you've missed several appointments with specialists that we agreed on. Can you tell me why you didn't make it to those appointments?"

About 70% of encounters have at least one contextual red flag,[4] such as loss of control of a chronic condition, missed appointments, or poor medication adherence. A contextual red flag should prompt a provider to ask about underlying contextual factors – present in about 40% of encounters -- and utilize VA resources to assist when feasible.[4] Coders compile all data into anonymized reports that are then shared with PACT teams, and made available to individual providers upon request. This feedback increases appropriate care over time. It also has been shown to lead to better Veteran outcomes.[4] As noted, both of these findings have been verified through independent peer review and published in high impact medical journals.

Over the course of this program, now in its third year, there have been over 8000 audio recorded visits across eight facilities, with data fed back to providers so that they can identify opportunities to improve their care. Getting the care plan right requires looking for contextual factors when a contextual red flag is present, and addressing them in the plan of care. Data from audios collected at one site, as an example, are shown in figure 1, tracking improvement with feedback from June 2017 to the present. The yellow line represents the percent of audios in which providers ask Veterans about a red flag issue when present, and the blue represents the percent of times they address an underlying contextual factor in the care plan (i.e. contextualize care.). As shown, at the start of the program, the percent of contextual factors addressed in care plans has increased from 53% to 88% of encounters (Blue line).

Figure 1: Provider attention to Veteran life issues in care planning: Improvement with Feedback



This improvement benefits the 40% of Veterans with contextual factors complicating their care. As noted, these improved care plans predict better Veteran health care outcomes, a finding documented in prior research and evident across participating sites.[4] They are also associated with a reduction in overall cost – cost savings that are far in excess of the cost of the program.[5]

PROPOSAL:

As the program expands to new VHA facilities, the project leads (based at Jesse Brown VAMC) are recommending modifications both to increase integration into existing facility business processes, and reduce costs so as to enhance long term sustainability. Table 1 presents the original protocol, its limitations from a sustainability perspective, and the proposed modifications:

Table 1: Proposed modifications of the protocol to achieve long term sustainability

Current Protocol	Limitations	Proposed Modifications
Project assistant hands out and collects encrypted audio recorders from Veterans in waiting area per week	Relies on paid project assistant. Does not take advantage of existing clinic staff or volunteers	Audio recorders handed out and collected post visit by front desk staff, volunteers, and/or passively at the kiosks
Project assistant uploads audios to VA server based in Chicago	Same as above	Identify a site coordinator to upload audios to secure server and log activity on a weekly basis.
Audios coded centrally by Chicago team which generates feedback reports.	None: Centralized coding enables scaling while maintaining quality	Continue centralized coding done in Chicago
Feedback given by onsite clinical champions in aggregate (CME credit), as individual reports to providers, and as email exercises for board recertification (MOC credit).*	Insufficient evidence that continuous monthly feedback superior to intermittent feedback.	Feedback provided intermittently, e.g. for two weeks each three-month period.

*Feedback is provided in four formats:

(a) PowerPoint presentations of instructive cases taken from audio coded data and presented by clinical champions to peers, organized in a standardized format (see Appendix A).

(b) Individual reports provided to interested providers confidentially upon request (Appendix B).

(c) Weekly or bi-weekly blast emails to providers and staff featuring examples of contextualized care and contextual errors (alternating) without any identifiable data (Appendix C).

(d) Brief emailed cases for reflection and response are optional but required for MOC credit (Appendix D).

All materials are prepared by coding team in Chicago and, except for the PowerPoint presentation itself, fully managed and tracked by the Chicago team.

EXPECTED OUTCOME(S):

1. Primary Care: The goal is to establish a baseline and then reduce contextual error rates by 25% in first year.
2. Specialty Care: Once program is established in primary care it may be extended to interested specialty care services as well with similar expected performance improvement targets.
3. Outcome measures: Continued tracking of resolution of contextual red flags will show and document that the program is increasing desired outcomes (e.g. fewer missed appointments, improved indicators of medication adherence, reduced ER utilization etc…).

INFRASTRUCTURE TO SUPPORT:

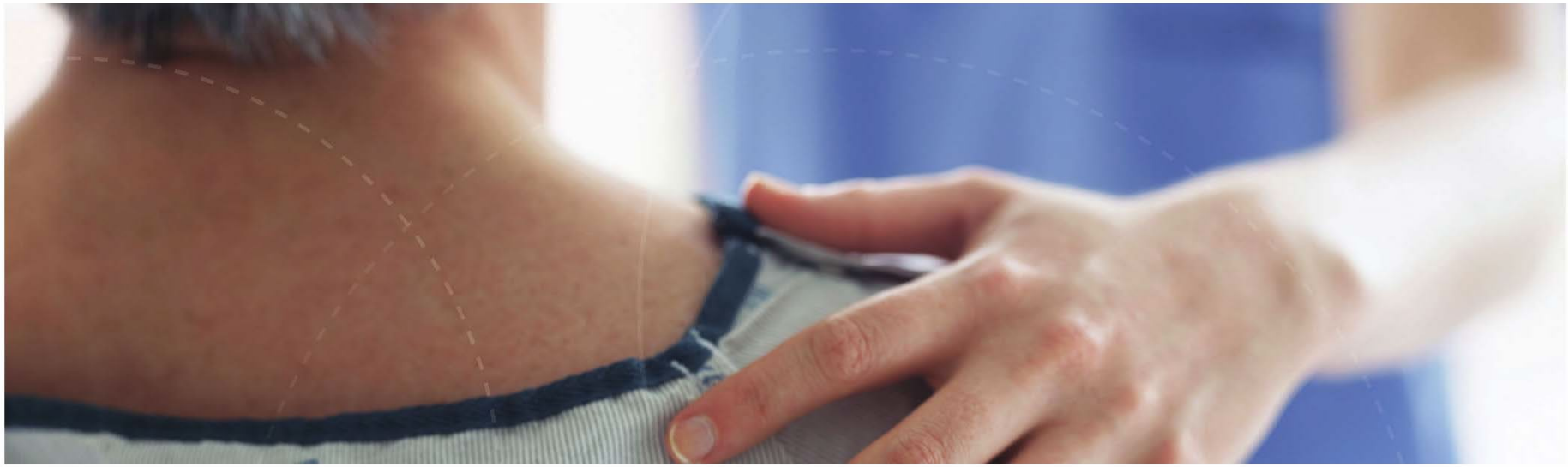
PERSONNEL	Role	%	Salary + Fringe
_____, MD	Clinical champion	5%	Contributed
GS 7	Project Assistant	20%	Contributed*
GS 7/7	Audio coder	15%	$11,028
TOTAL			$11,028

*One or more [NAME OF FACILITY] employees will carry out project assistant duties as specified in Table 1 above. In addition, VHA approved encrypted audio recording devices cost about $500 and it is helpful to have three of them. They can be ordered and shipped by the Chicago team and charged to the facility, or ordered directly.

EVALUATION PLAN:
We will track the program's continued impact on outcomes of Veterans coded as having contextual factors (aka complex psychosocial needs) by monitoring over 70 contextual red flags, including ED visits, urgent care visits, medication adherence rates, clinic show rates, and test and specialty follow up care.

References:

1. Weiner SJ SA, Sharma G, Binns-Calvey A, Ashley N, Kelly B, Weaver FM. Patient collected audio for performance assessment of the clinical encounter. *Jt Comm J Qual Patient Saf.* 2015;42(6):273-278.
2. Weiner SJ, Schwartz A, Weaver F, et al. Contextual errors and failures in individualizing patient care: a multicenter study. *Ann Intern Med.* 2010;153(2):69-75.
3. Weiner S, Ashley N, Binns-Calvey A, Kelly B, Sharma G, Schwartz A. . Content Coding for Contextualization of Care. Dataverse Network Project. http://dvn.iq.harvard.edu/dvn/dv/4C (accessed December 24, 2012).
4. Weiner SJ, Schwartz A, Sharma G, et al. Patient-centered decision making and health care outcomes: an observational study. *Ann Intern Med.* 2013;158(8):573-579.
5. Weiner S, Schwartz A, Altman L, et al. Evaluation of a Patient-Collected Audio Audit and Feedback Quality Improvement Program on Clinician Attention to Patient Life Context and Health Care Costs in the Veterans Affairs Health Care System. *JAMA Netw Open.* 2020;3(7):e209644.



Patient-Collected Audio Recorded Encounters for Provider Audit & Feedback to Reduce Contextual Errors

Title of presenter here….

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

Background: What is a "contextual error"?

A contextual error occurs when a care plan is consistent with research evidence but inattentive to patient context.

Examples:

- A patient's diabetes is out of control since he started working the night shift and is no longer eating on the same schedule. The clinician adds more medicine rather than revise his dosing schedule.

- A patient is not taking his medications because they have been stolen twice from the entryway to his apartment where packages are delivered. The clinician re- sends them instead of having the patient pick them up at the on site pharmacy.

How are contextual errors avoided?

Contextual errors are avoided when clinicians follow a four-step process during clinical encounters:

1) Look for clues that a Veteran is struggling with life challenges that complicate their care. These are called "*contextual red flags*."

2) When present, ask about them. This is called "*contextual probing*."

3) Identify any life challenges that should be addressed in the care plan. These are called "*contextual factors.*"

4) Address contextual factors in the care plan. This is called "*contextualizing care*."

Example of avoiding a contextual error

Patient presents with an elevated HgB A1c of 8.7, that was previously 7.2.

1. Contextual red flag: Unexpected loss of diabetes control (suggests something happened in patient's life.)
2. Contextual probe: "Mr. Jones, I noticed you're having trouble keeping your diabetes under control recently. Is there anything going on in your life that might explain this change?"
3. Contextual factor: "Yes, Dr. Smith. I recently started working the night shift as a security guard and my diet and when I eat has totally changed."
4. Contextualized care plan: "Okay. Let's have a look at your log and revise when you take your meds. Let's also talk about what you're eating. I may want you to see our diabetes nurse."

Contextual Factors sort into 12 Domains

Areas to consider when there are clues that a patient's circumstances or behaviors may need to be addressed when planning their care.

1	**Access to Care**	7	**Attitude Towards Illness**
2	**Competing Responsibility**	8	**Cultural Perspective/Spiritual Beliefs**
3	**Environment**	9	**Emotional State**
4	**Financial Situation**	10	**Health Behavior**
5	**Resources**	11	**Relationship with Health Care Provider and System**
6	**Social Support**	12	**Skills, Abilities and Knowledge**

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How do you detect contextual errors?

- Invite Veterans to audio record their visits

- Follow three principles:

1. Safe: Assure confidentiality for all participants and follow all VA rules for data security.
2. Not Burdensome: Embed program in ongoing activities for clinicians and patients.
3. Worthwhile: Make value evident to clinician/staff and patients.

Has is data analyzed?

Content Coding for Contextualization of Care (4C)

- Contextual red flags extracted from medical record and audio
- Contextual probes, factors and plan of care from audio
- Also track outcome of contextual red flag
- 90% inter-rater agreement
- Coding Manual and spreadsheet at: https://dataverse.harvard.edu/dataverse/4C

VA research findings on contextual error

- In about 40% of ambulatory visits, effective care depends on identifying and addressing patient context.
- In about 40% of these encounters, clinicians overlook context --i.e. there is a contextual error.
- Contextual errors *predict worse health care outcomes* .
- They also *result in overuse and misuse of medical services with higher costs*.
- Clinicians vary greatly in their attention to patient context.
- Addressing context during an encounter to avoid a contextual error does not lengthen the visit.

Current QI project: Data collection

1. Veterans volunteer to carry recorder into their visits. Recorders are distributed and collected in waiting room by staff and/or volunteers, carried out in open or concealed, whichever Veteran prefers.

2. Recordings are uploaded to a secure server and analyzed by trained coders employing the "Content Coding for Contextualization of Care" or "4C" system.

3. To date at six VHA facilities: Chicago (Jesse Brown), Hines, Milwaukee, Madison, Los Angeles (Sepulveda), Cleveland.

Feedback reports

Coders produce reports for PACT teams that present findings (a) in narrative form, and (b) as graphical summary of two performance indicators over time:

a. Percentage of encounters in which the clinician probed contextual red flags.

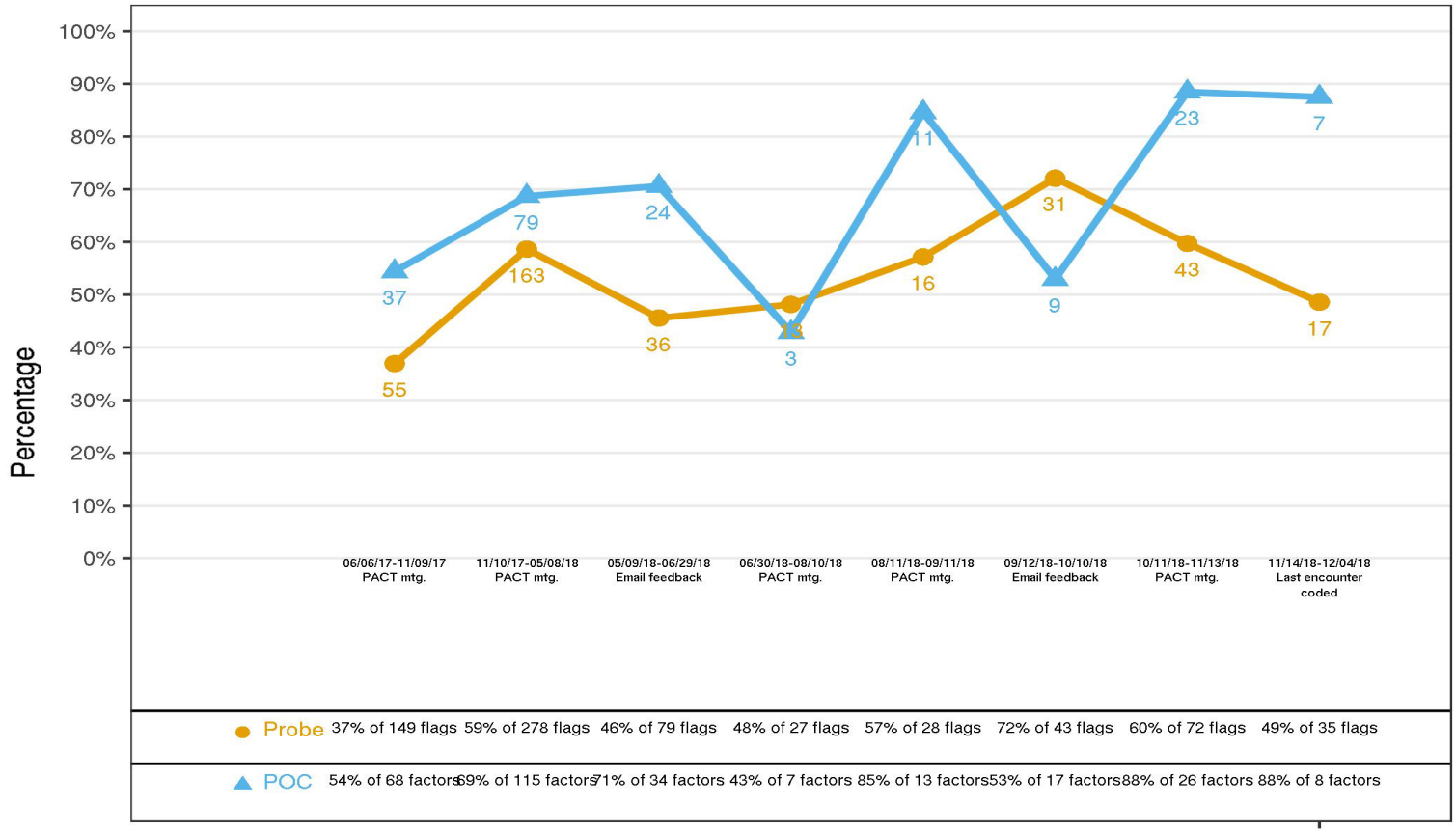
b. Percentage of encounters in which clinician contextualized care.

Narrative example:
How encounters are reported back to PACT teams

Example of clinician probe, contextual factor revealed, no plan of care:

- **Red Flag:** Pt.'s A1C is 8.5. Patient says he hasn't been checking his sugars.
- **Probe:** "What's the hang up (with checking sugar levels at home)?"
- **Contextual Factor:** Patient say he doesn't like poking his finger. It is also discovered he is taking wrong dose of insulin.
- **No Contextual Plan of Care:** The provider does not discuss preventing fingertip pain (e.g. warm hands first, Lance on side of finger, alternate fingers daily). Also doesn't probe further as to why the patient was taking the wrong dose.

Graphical data as reported to PACT teams:
Rate of Probing *Contextual Red Flags* and of *Contextualizing Plan of Care* in response to feedback and training



Los Angeles (Sepulveda)

How data is used for feedback

- Reports discussed at PACT team meetings (CME credit).
- Clinicians may request data on own performance.
- Reflection exercises are offered to clinicians to complete via email for MOC credit.
- Project expanded to include nurses, pharmacists and front desk clerks.
- Participating patients are followed for several months after visit to see if presenting problem improves.

Summary: Multiple methods of feedback to heighten awareness of importance of paying attention to patient context in care planning.

Benefits of Program
Example: Jesse Brown VAMC

- Improved provider attention to Veteran life challenges in care planning from 45% to 70% of encounters.

- Represents a 25% improvement in the care of Veterans with care needs complicated by psychosocial issues. 10% of all visits to primary care positively impacted.

- Has consistently improved Veteran health care outcomes at 4-6 months post-visit.

- May have boosted select SHEP and SAIL measures.*

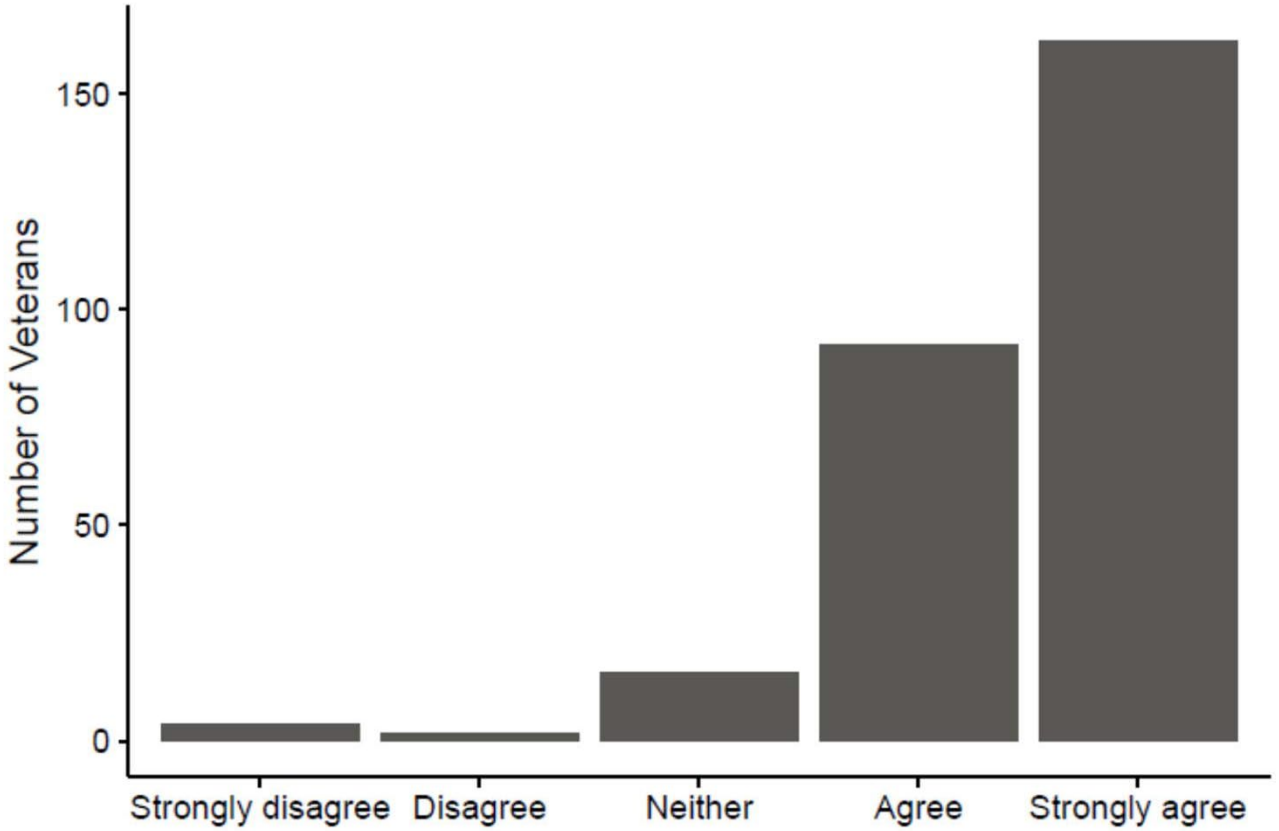
*e.g. For the comprehensiveness composite, in which patients are asked whether their providers pay attention to their mental or emotional health, JBVAMC has moved up into the 2nd quintile (49/128).

Analysis of Program Across 6 VA facilities

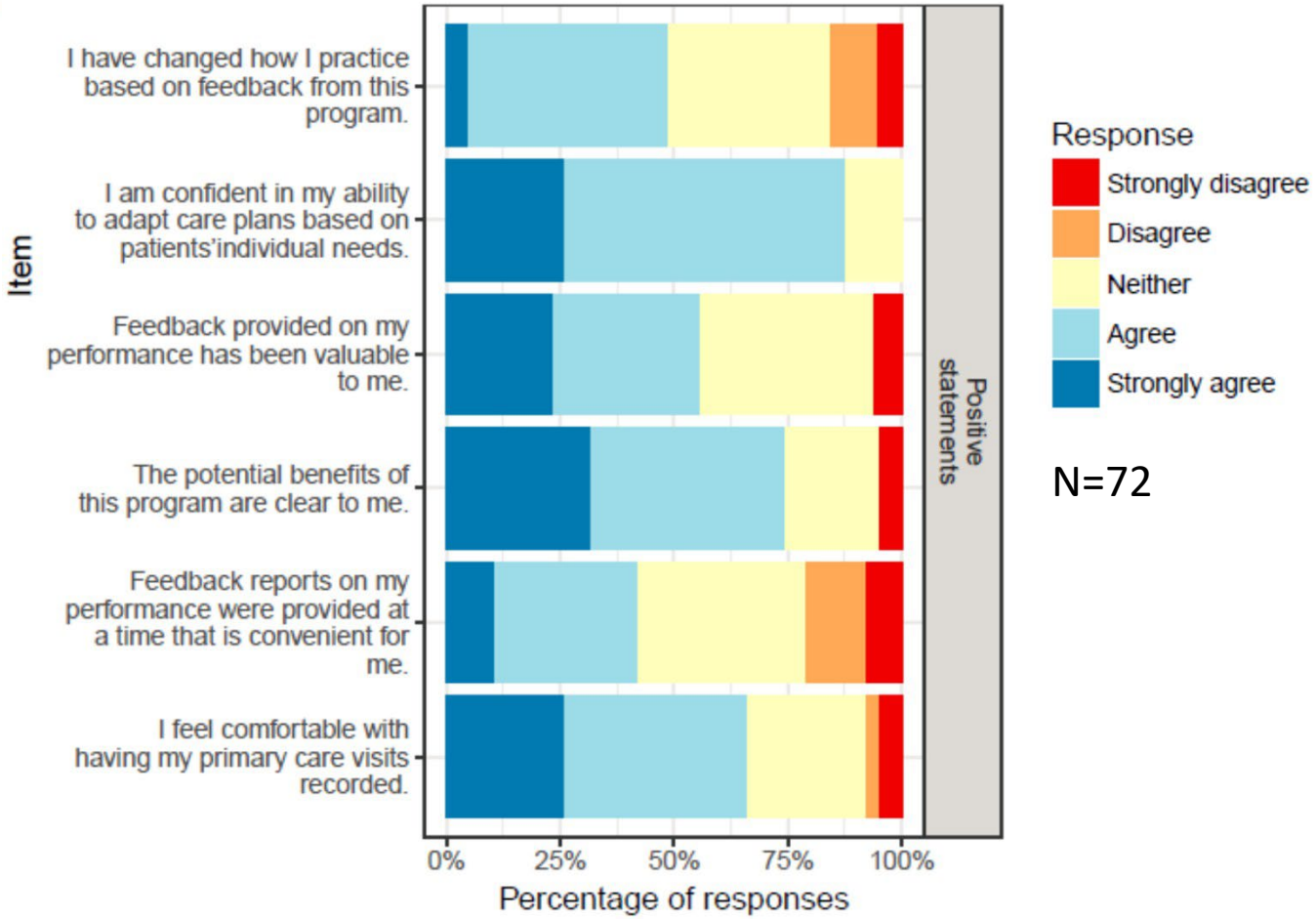
- 4496 encounters recorded with 666 providers.
- 67% of audio recordings contained at least one contextual red flag → 55% of contextual red flags were probed → 57% of probes uncovered a contextual factor.
- 67% of care plans were contextualized prior to feedback and 72% post-feedback, a significant improvement.
- Good outcomes (resolution of red flag) in 46% of non-contextualized care plans compared with 73% of contextualized care plans, a significant difference.
- Hospitalization rates decreased from 19% to 16.5% for patients seeing providers before compared with after they'd received feedback. Approx 987 hospitalizations avoided at a cost savings of $25.2M.
- Cost of intervention $337,242.

Patient experience

Q1 = I felt comfortable recording my visit with my doctor.



Physician experience



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Patient perspectives

- *Anything that would improve my care I'm all in*
- *Frankly, I was not thinking about it. I hit play & didn't cross my mind.*
- *Hope to aid in improvement of an already excellent & competitive medical system*
- *It required no extra work nor did it disturb the appointment.*
- *I think maybe this should be a requirement for patients as this shows the VA cares about my health, and the doctors or medical staff desire to help.*

Physician perspectives

- *"There's no other way to get feedback like this. I mean you can look at notes and at outcomes and all those other things but there's nothing like this interaction piece and it's just something that happens behind closed doors all the time. So how else are you going to know?"*

- *"…when I know it's being recorded I think that I have that extra part- "Did we discuss everything? Is there any questions you have?" I just make that extra step. I think I try to do that always, I'm just a little more aware of it when I know I'm being recorded."*

- *"To tell you the truth I rarely think about the program and usually I don't think I'm aware of it until on rare occasion* a patient shows the recorder … *Once that happened I was a little aware of it for a few minutes but there's just so much to do and so much to cover that it just quickly went out of my brain."*

We are inviting Veterans to participate in a quality improvement project by audio recording their visits with their primary care provider. These recordings will be used to improve the quality of care Veterans receive.

If you have questions or would like more information, feel free to contact us before your next primary care appointment.

Call 312-569-6486
or email brendan.kelly@va.gov.

Thank you for your continued service!

This project is funded by the Department of Veterans Affairs.

It has been approved by the Jesse Brown Quality Improvement Committee.

It is overseen by the VHA National Advisory Board to Prevent Contextual Error which includes practitioners and Veterans.

Jesse Brown VA Medical Center
Quality Improvement
820 South Damen Avenue
M/C 151
Chicago, IL 60612

Phone: 312-569-6486
E-mail: brendan.kelly@va.gov

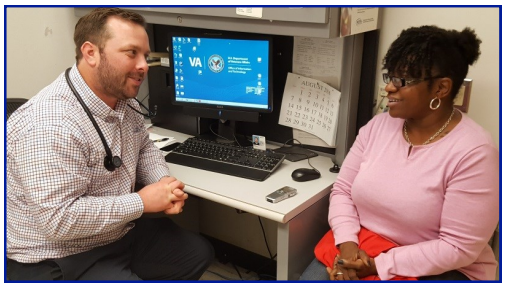
JESSE BROWN
VETERANS AFFAIRS MEDICAL CENTER
Putting Veterans first

Jesse Brown
VA Medical Center

QUALITY IMPROVEMENT

Help your provider help you!

Use an audio recorder during your clinic visit.



What is this "quality improvement" project about? Our goal is to help providers learn more about their patients' individual life challenges so that each Veteran's care is tailored to fit their needs.

Why use a tape recorder? Having a record of the conversations with your provider about your life situation is essential to knowing if your care plan is customized to fit your personal needs and circumstances.

What happens with the recording? It is stored on an encrypted VA server (just like your medical record) and is only listened to by a member of our quality improvement team. When the quality improvement team puts together a report, ALL names are removed.

Does my provider know about this? Yes! All the providers know about the project but they don't know which of their patients is recording the visit, unless you decide to tell them.

Does the recorder need to be hidden? Many providers prefer not to know about the recorder - that way the visit is the same as any other visit. But if you feel more comfortable, you can tell your provider.

Isn't this spying? Good question - No! All providers at our VA outpatient clinics have been informed about the project. This project is for their benefit, so they can find new ways to help their patients.

What happens after the visit? We also ask permission to look at your medical record. Sometimes life challenges have an impact on your ability to manage your health. We may be able to spot clues (such as you having trouble refilling your medicines on time) that let us know there might be an issue your provider can help with.

How does my provider benefit from this project? We put together reports for the providers and staff who then discuss ways to improve care. We **never** use patient or provider names!

Can this get my provider in trouble? No! Providers' names are not identified in the results. This is used only as a learning tool.

What if I don't want to participate? No problem! Nothing about your relationship with the VA will change by participating or not participating.

What if I decide to participate and then change my mind during my visit? Again, no problem! Tell the person who gave you the recorder you are no longer interested (you do not have to give a reason) and ask them to delete the recording. They will be happy to do so.

How does this help me and my fellow Veterans? Providers learn a lot from textbooks and articles but don't often have a chance to learn from information collected directly from audio recordings of actual care. By giving your providers new opportunities to learn, you are helping improve the quality of care you and other Veterans receive. A similar project was done at two other VA facilities, and we saw improvements in care. Providers and staff found it interesting and helpful.

Do I have to do this every time I come? That's up to you. You may participate as many times as you like or not at all!

Is this a way I can voice my displeasure with the VA? That is not the purpose of this project. If you have concerns about the care you are being given, please contact the Patient Advocate at your facility.

Caring in Context: Weekly Case

From the 4C Coding Team

To help our VA provide care that is patient-centered, we who listen to and code Veterans' visits to the clinics would like to share weekly examples of patient context that matter to care. We've heard and seen how care plans that address our Veterans' unique circumstances and needs lead to better outcomes.

When a provider asked a patient if he was still using his CPAP, the patient replied that he was not. The provider asked, "Why not?" The patient responded that he "had a lot going on in his life." The provider continued with "Can you tell me more?" The patient said that he was under a great deal of financial stress and was also in the process of moving and changing who he lived with. He said he felt overwhelmed and was having trouble keeping things together. The provider asked the patient if he thought it would be helpful to see a mental health counsellor and, perhaps, a social worker. The patient agreed that he might benefit from both. This provider picked up on two areas of patient context, emotional state and financial situation based on a single red flag: the patient had stopped using his CPAP.

- *Amy, Ravisha , Rafe, and Gunjan*

These examples are compiled by the Quality Improvement Coding Team using

4C Content Coding for Contextualization of Care

CONTEXTUALIZING CARE *DOMAINS OF CONTEXT*
Competing Responsibility An obligation or commitment the patient has that impacts their ability to manage their health care.
Access to Care The patient's ability to receive care in a timely manner.
Social Support A patient's access to a supportive network of individual(s) able to assist if needed.
Financial Situation The patient's ability to afford health and health care needs.

Environment The physical and social setting that encompasses a patient.
Resources The possessions and materials available to a patient that can facilitate a person's ability to manage their care.
Skills, Abilities and Knowledge A patient's intellectual understanding and physical ability to manage health care.
Emotional State The emotional condition of a patient as it relates to their ability to manage their health care.
Cultural Perspective/Spiritual Beliefs The customs or a faith-based practice a patient has that impacts health care.
Attitude Towards Illness The feelings a patient has towards their condition that impacts their ability to manage it.
Attitude Towards Health Care Provider and System The patient's feelings and attitudes towards their providers and the health care system that impact their ability to manage their health care.
Health Behavior The patient's actions and lifestyle choices that impact their health care.

Name:

Date:

Contextual Care Exercise[1]

What is the best next thing for this *patient at* this *time?*

The following case exercise is intended to facilitate reflection on the challenges of adapting Veterans' care to their individual needs and circumstances, or context. It is constructed from an audio recorded encounter between a clinician and a Veteran. This exercise will count toward both category 1 CME credit and ABIM Maintenance of Certification (MOC) Credit for physicians participating in the Quality Improvement Project to Reduce Contextual Errors.

Please read each of the examples below and respond to the questions (type your answers in the boxes below).

CASE Example:

A patient, who was complaining of back pain, declined to return to see a chiropractor for a second visit when his primary care doctor suggested doing so.

What clue(s) suggest there are contextual factors that are relevant to this patient's health care?

What would be your next step?

[1] These materials have been developed with support from the Department of Veterans Affairs. Any views expressed are those of the authors and do not necessarily reflect the position or policy of the U.S. Department of Veterans Affairs or the United States government.

Example continued:

The provider in our example asked the patient to elaborate on why he didn't want to return for a second visit.

What are some reasons providers DON'T ask a patient why they decline to schedule appointments?

The patient explained that the chiropractor he saw "spent the whole time talking" and "Didn't do anything. He barely touched me."

What contextual issue did the patient just reveal?

How would you adapt your plan of care to incorporate this patient's life context?

Example continued:

Now that the provider had elicited the contextual factor, they offered to see if they could arrange for the patient to see a different chiropractor or, alternatively, see if they qualified for outside chiropractic care. The patient said he'd appreciate that.

Do you think the patient, with the interventions you propose, is now more likely to attend to his own care?

Can you think of an example from your own work where a patient's attitude towards their healthcare provider or the healthcare system has impacted their ability to attend to their own health or health care?

CONTEXTUALIZING CARE *DOMAINS OF CONTEXT*	
1.	**Access to Care** The patient's ability to receive care in a timely manner.
2.	**Competing Responsibility** An obligation or commitment the patient has that impacts their ability to manage their health care.
3.	**Social Support** A patient's access to a supportive network of individual(s) able to assist if needed.
4.	**Financial Situation** The patient's ability to afford health and health care needs.
5.	**Environment** The physical and social setting that encompasses a patient.
6.	**Resources** The possessions and materials available to a patient that can facilitate a person's ability to manage their care.
7.	**Skills, Abilities and Knowledge** A patient's intellectual understanding and physical ability to manage health care.
8.	**Emotional State** The emotional condition of a patient as it relates to their ability to manage their health care.
9.	**Cultural Perspective/Spiritual Beliefs** The customs or a faith-based practice a patient has that impacts health care.
10.	**Attitude Towards Illness** The feelings a patient has towards their condition that impacts their ability to manage it.
11.	**Attitude Towards Health Care Provider and System** The patient's feelings and attitudes towards their providers and the health care system that impact their ability to manage their health care.
12.	**Health Behavior** The patient's actions and lifestyle choices that impact their health care.