



DEPARTMENT OF VETERANS AFFAIRS
Jesse Brown VA Medical Center, IL 60612

VHA Center of Innovation for Complex Chronic Healthcare (CINCH):
Preventing Contextual Errors in Ambulatory Care
Quality Improvement Initiative
PI CME and MOC Activity

Purpose: To improve staff and provider attention to Veterans' individual circumstances and needs, or "context," when assisting them or planning their care.

Background: This project is grounded in research on methods of assessing *contextualization of care* and providing feedback to PACT teams to improve quality of care for Veterans. Care is contextualized when the plan addresses personal barriers to effective care for which the VA has available resources. A care plan that is inappropriate to a patient's individual circumstances and needs contains a *contextual error*. Research has shown that contextual errors are common,¹ that avoiding them improves healthcare outcomes,² as well as reducing costs.³ Information about contextual errors that occur during the clinical encounter is obtained when patients volunteer to audio record their visit.⁴

QI Program: In 2012, VISN 12 initiated this quality improvement initiative for improving contextualization of care. It has recently expanded to VHA facilities in Madison, Milwaukee, Cleveland and Los Angeles. The project consists of the following elements:

1. Veterans volunteer to audio record their visits with their provider.
2. Those who participate are provided with an audio recorder in the waiting area which they return after the visit. They are encouraged, but not required, to conceal the audio recorder to avoid disruption of the visit and to increase authenticity.
3. A team of trained coders listens to the audio recordings and extracts data from the chart using the "4C" method, which stands for Content Coding for Contextualization of Care.⁵ Coders listen for four steps during each encounter as evidence for contextualization of care. Providers should be:
 - a) looking for clues, called "contextual red flags", that Veterans are confronting challenges in their lives that have implications for planning their care;
 - b) asking Veterans, or "probing", about these contextual red flags to see if there is an opportunity to personalize the care plan;
 - c) listening for affirmative evidence of life challenges, or "contextual factors," for which PACTs can assist in some way.
 - d) addressing the contextual factors in the care plan, i.e. "contextualizing care", so that each Veteran leaves the visit with a care plan that optimizes services and support to address barriers to care.
4. 4C coders generate periodic reports that are de-identified. PACTs are periodically provided with these reports so they can see how they are doing at contextualizing care, with both examples and quantitative trends data:

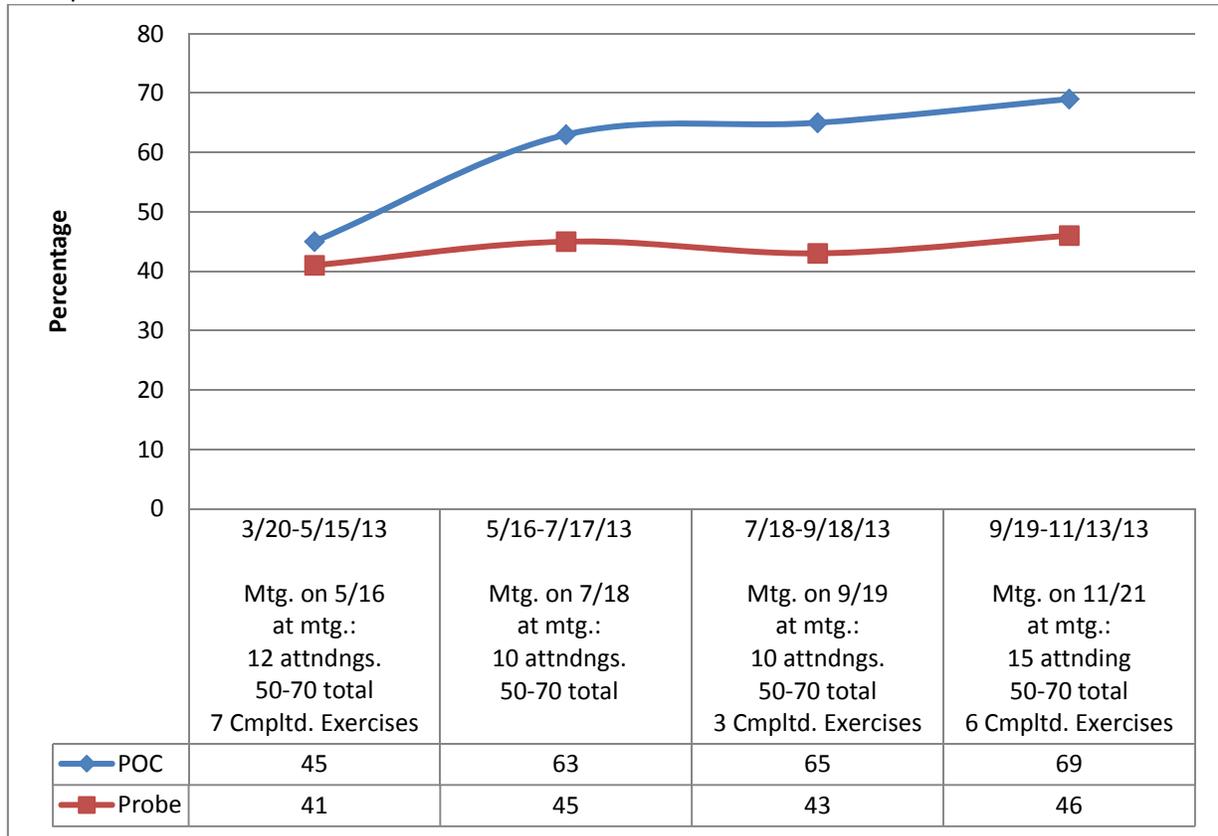


Example from a report of a physician probing, contextual factor revealed and contextual plan made

Red Flag: Veteran has lost control of his diabetes and hypertension.
Probe: Physician asks, "What challenges are you having managing your diabetes and hypertension?"
Contextual Factor: Veteran reveals that his medications packages have been stolen twice in the hallway in his apartment building.
Contextual Plan of Care: Physician discusses with Veteran re-routing them so that he picks them up at the pharmacy instead. Veteran agrees and physician re-directs all meds via CPRS to facility pharmacy.

For questions or more information contact Saul J. Weiner, MD at saul.weiner@va.gov

Example from a Report: Changes in the percentage of contextual red flags that are probed (“Probe”) and the percentage of contextual factors addressed in care plans (“POC”). Educational interventions and participation levels noted.



Principles: *The QI protocol honors three principles:*

1. Providers must feel secure that their data and confidentiality are protected. Information in reports shared with PACTs is de-identified. Individual providers may request reports on their own data. Audio recorded information would never be disclosed with identifiers unless it contained evidence of behavior that is illegal or flagrantly violates VA standards.
2. Providers should see the evidence documenting the value of the project.
3. The project should be integrated into usual care so as not to add a work burden.

Receiving CME and MOC Credit for this Activity:

Participants can earn 5, 10, 15 or 20 AMA PRA Category 1 Credits for participation in this activity. Criterion for earning these points are outlined in the FAQ below. Upon successful completion of Stage C (i.e. earning 20 CME credits) participants may also earn 20 Practice Assessment points in the American Board of Internal Medicine’s (ABIM) Maintenance of Certification (MOC) program. It is the sponsor’s responsibility to submit participant completion information to ABIM for the purpose of granting the MOC points. Hence, we will be tracking the participation of all physician participants for CME and MOC reporting purposes.

Frequently Asked Question about Performance Improvement CME

What is a PI CME Activity?

PI CME is a long-term three-stage process by which a physician or group of physicians who have learned about specific performance measures, (A) assess their practice using those measures, (B) implement interventions to improve performance related to the measures, and then (C) re-assess their practice using the same measures.

How many AMA PRA Category 1 Credits are designated for PI CME?

A PI CME Activity is designated for up to 20 AMA PRA Category 1 Credits based on the extent to which participants complete the project, rather than on the numbers of hours invested.

Physicians that complete only one or two stages are awarded 5 credits for each stage. Physicians completing all three stages are awarded 20 credits

What are the three stages of this project?

Stage A is designed to collect data for physicians to assess their current practice: For this project, participating patients audio record encounters, audio recorded data is provided to coding technicians trained in “4C” (Content Coding for Contextualization of Care) to code, and coded data is de-identified and aggregated. For each encounter, coders record whether:

1. There were contextual issues identified either from the medical record or the audio-recording (e.g. missed appointments, loss of control of a chronic condition, per medication adherence etc...). These are called “Contextual Red Flags.”
2. If there were contextual red flags, did the clinician inquire about them? This is called “Contextual Probing.”
3. If the physician probed, did the patient reveal information that is important to address in the care plan to overcome a barrier to care? Or, if the physician did not probe, did the patient reveal such information spontaneously? Such information is called a “Contextual Factor.”
4. If the patient revealed a contextual factor, did the physician take it into account in the care plan? This is called “Contextualizing Care.”

The 4C report to the physician group includes:

1. The proportion of contextual red flags that were probed
2. The proportion of contextual factors that were addressed in the care plan
3. Examples of both missed and addressed contextual probes and contextual factors.

All participating physicians receive this data.

Stage B is an educational intervention to promote performance improvement that is customized to the performance deficits identified in Stage A. For this project, Stage B involves participating physicians convening in groups to review the findings of the 4C report and discuss strategies for increasing probing of contextual red flags and increasing contextualization of care based on identified contextual factors.

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Stage B is not restricted to a single session. This PI CME occurs over the course of a 12 month period and involves several rounds of data collection, and convening of physicians to review data and plan strategies for performance improvement.

At the first session, physicians are provided with general background information including the terminology described above and a cognitive tool, which is the “Domains of Context.” The Domains of Context, divides all patient context into 12 Domains: Access to care; competing responsibility; social support; financial situation; environment; resources; skills, abilities and knowledge; emotional state, cultural perspective/spiritual beliefs; attitude towards illness; attitude towards health care provider and system; health behavior.

Stage C provides a re-assessment of physicians’ performance after the intervention in Stage B using the same data collection methods employed in Stage A. Again, this stage is not restricted to a single session. Stages B and C will cycle through several rounds with data from C driving attending designed interventions in Stage B.

How will CME Credits be designated based on participation?

- a. Attendings receive 5 credits for participating in data collection and showing up at one session to receive and review the data.
- b. Attendings receive an additional 5 credits for proposing an intervention. This can be provided to the Activity Director, Dr. Saul Weiner, as an email.
- c. Attendings receive an additional 5 credits for returning to a subsequent meeting to review the data and propose any changes to further improve performance, again as an email to Dr. Weiner.
- d. Attendings receive an additional 5 credits for returning to a third session to review the data.

References

1. Weiner SJ, Schwartz A, Weaver F, et al. Contextual errors and failures in individualizing patient care: a multicenter study. *Ann Intern Med* 2010;153:69-75.
2. Weiner SJ, Schwartz A, Sharma G, et al. Patient-centered decision making and health care outcomes: an observational study. *Ann Intern Med* 2013;158:573-9.
3. Schwartz A, Weiner SJ, Weaver F, et al. Uncharted territory: measuring costs of diagnostic errors outside the medical record. *BMJ Qual Saf* 2012.
4. 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 In Press* 2014.
5. Weiner SJ, Kelly B, Ashley N, et al. Content Coding for Contextualization of Care: Evaluating Physician Performance at Patient-Centered Decision Making. *Med Decis Making* 2013.