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Contextualizing Patient-Centered Care to Fulfill Its Promise of Better Health Outcomes: Beyond Who, What, and Why

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Efforts to improve patient outcomes have focused, in large part, on technical processes of health care, which are ideally informed by the most up-to-date evidence on effective care practices. Technical quality is often viewed as the “science” of medicine as opposed to its “art,” which involves such less tangible and potentially harder to capture aspects of care as the interpersonal and cognitive processes underlying patient–physician communication and decision making. Yet, as Donabedian said more than 2 decades ago, “The interpersonal process is the vehicle by which technical care is implemented and on which its success depends” (1). Therefore, to achieve desired health outcomes, it is essential to focus on optimizing both the technical and the interpersonal processes in care (1).

Optimizing interpersonal care, however, requires the ability to rigorously study and measure its core elements, a matter that may be even more challenging than measuring technical care, which may be captured via medical record reviews. The past 2 decades have seen great strides toward improving our ability to measure the elements of interpersonal care. Several objective methods of analyzing patient–physician communication and describing the interpersonal process have been developed and are widely used in research settings (2). For example, the Roter Interaction Analysis System provides a quantitative analysis of patient–physician dialogue. It codes “utterances” in the dialogue into categories of talk that are combined into such composites as information exchange, rapport building, and facilitation or patient activation. A measure of patient-centered communication can be calculated as the ratio of psychosocial, rapport-building, and facilitative utterances to utterances that further only the biomedical agenda of the dialogue. There is ample evidence that patient-centered processes of communication can influence patient satisfaction, perceptions of care, shared

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decision making, and health behaviors (3, 4). The communication process can also have major implications on whether adherence to treatment—a critical pathway to improving outcomes—is achieved (5).

In this issue, Weiner and colleagues (6) offer a novel and in-depth approach to analyzing the content of patient–physician communication. To examine the relationship between patient-centered decision making and health outcomes, they used a systematic approach in which trained coders flagged visits with evidence of specific contextual “red flags” (for example, missed appointments or lack of control of hypertension or diabetes); coded whether underlying factors for the red flag surfaced during the visit; and measured whether physicians tailored patient care plans to address the underlying factors, which the authors referred to as “contextualizing” the care plan. The study provides unique evidence for improved health outcomes among patients whose physicians contextualize care plans.

Contextualization represents a desirable blending of many of the concepts of patient-centeredness and cultural competence. Patient-centered care is “care that is respectful and responsive to individual patient preferences, needs and values, and ensures that patient values guide all clinical decisions” (7). Cultural competence in health care is the ability of health professionals and systems to provide care to patients with diverse values, beliefs, and behaviors and includes tailoring delivery to meet patients’ social, cultural, and linguistic needs (8). At the core of patient-centeredness and cultural competence is the ability of health care professionals to see patients as individuals; build effective rapport; use the biopsychosocial model; explore patient beliefs, values, and attitudes toward illness; and find common ground regarding treatment plans (9). Most interventions to improve patient-centeredness target patient–physician communication or coordination of health care services for patients. Accordingly, these interventions frequently take place within the walls of health care establishments rather than in patients’ homes and communities, and they rarely adapt approaches to the context in which patients live or create solutions to specific challenges posed by that context. Not surprisingly, most interventions to improve patient-centeredness of clinical interactions show positive changes in patient–physician communication behaviors, patient behaviors, and perceptions of care; however, improvements in health outcomes are reported infrequently (2, 4, 5). In contrast, most interventions to improve cultural competence involve communication strategies tailored to the social and cultural needs of patients and are based in community settings; these studies have found early evidence for the effectiveness of contextualization in health care (10).

Interestingly, in the study by Weiner and colleagues (6), various contextual red flags received different levels of attention by physicians. For example, although lack of adherence to treatment plans frequently led to exploration of underlying factors and contextualized care plans to help address it, frequent emergency department visits or missed appointments received less exploration. This may reflect the hesitance of physicians to explore problems they feel unable to solve. Interventions, therefore, may need to focus not only on advancing physicians’ attention to the “patient context” and their patient-centered decision-making skills but also on creating linkages to needed services and support systems that empower physicians to solve their patients’ problems and develop contextualized care plans.

Public health interventions are increasingly using ecological models to address multilevel contributors to health care problems. However, until recently, interventions in health care have remained focused primarily on individual physicians and patients. As the focus on improving health care outcomes increases and health care organizations are increasingly being held accountable for them, it is becoming more important than ever to broaden efforts for improving health care quality and outcomes. Innovative interventions that go beyond individual patients and physicians within the walls of clinics and hospitals are needed. These interventions must forge alliances with key stakeholders who have not been traditionally thought of as important health care players but may hold keys to addressing the challenges patients face in their various contexts. To make substantial improvements in health outcomes and health care quality, health care professionals and organizations should move beyond traditional health care provision models; redefine their responsibilities to and partnerships with patients, families, and other community groups and institutions; and build systems that couple elicitation of patients' contexts with services and support structures that address their particular social determinants of health. We agree wholeheartedly with Weiner and colleagues that further contextualization of patient-centered health care is required to improve health outcomes. Patient-centered care can become more contextualized by addressing not only the "who," "what," and "why" of health care but also the "who else," "what matters most," "where," "when," and "how" of improving patient outcomes and, in so doing, can fulfill its promise.

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