## Center for Evaluation of Practices & Experiences of Patient-Centered Care (CEPEP)



## Spring 2014

The Center for Evaluation of Practices and Experiences of Patient-Centered Care (CEPEP) is funded by the VA Office of Patient-Centered Care and Cultural Transformation and the Quality Enhancement Research Initiative. The purpose of CEPEP is to evaluate the processes and outcomes of approaches to implementing patient-centered care (PCC) at the patient, family/ caregiver, provider/ employee, and organizational/ system levels within and across the VHA Centers of Innovation (COIs) to identify the most effective ways to change (improve) culture throughout the organization.

PCC Evaluation UPDATES is disseminated to VA leadership, health care providers, and to Veteran consumers of VA health care. It provides information related to the implementation and impact of PCC interventions ongoing at VA COIs and designated pilot sites.

The Director of *CEPEP* is Dr. Sherri LaVela who leads a superb team of talented scientists, clinicians, and evaluation staff with years of valuable experience.

For more information about the resources available through CEPEP and for past issues of Evaluation UPDATES, please visit http://www.cmc3.research.va.gov/ CEPEP\_Newsletters.asp.

## **Evaluation Features**

*What is "4c"?* Saul Weiner, PhD

To say that a care plan is "patientcentered" means that it's been customized according to the needs and preferences of the patient so that it is most likely to benefit them. That is the working definition at the heart of an evaluation system called "Content Coding for Contextualization of Care", or "4C" designed to assess whether care is patient-centered. 4C was developed as a tool for analyzing about 700 interactions between Veterans and their physicians to assess whether care was patientcentered, or "contextualized." In a blinded analysis in which these patients were followed for nine months following their index encounter, 4C predicted their health care outcomes, meaning that the patients of physicians who were coded as contextualizing care fared better (published in Annals of Internal Medicine).<sup>1</sup>

4C essentially measures four sequential elements of an encounter: First, are there clues, called "contextual red flags" or factors in a patient's life that may be complicating their care? Such clues include loss of control of a chronic condition or missing appointments. Second, if there are red flags, does the provider notice and ask about them during the visit? Third, If so, does the patient provide additional information indicating that, yes, there are things going on that are complicating care? And, finally, if so, does the provider attempt to customize a plan to accommodate those complicating factors? If he/ she has, that's patient-centered decision making!

The mechanics of 4C are a bit more complicated than the concepts above, but the process is fundamentally about identifying the four elements of an encounter. A manual describing the process in detail, can be found at: <u>http://</u> <u>dvn.iq.harvard.edu/dvn/dv/4C</u>. We found that with careful adherence to the instructions, different coders agree nearly 90% of the time.

Of course, to code data, it is necessary to audio-record encounters. There is also a chart extraction step to look for red flags that might not be heard during an encounter. In our work we provided patients with small audiorecorders to carry concealed into their visit. This has always been done with provider's knowledge, of course, however they don't know which patients are audio-recording them. While not essential, hidden recording is thought to provide a more authentic record of a physician's usual behavior during an encounter.

#### 4C Findings: Health Coaching and Patient-Centered Decision Making Saul Weiner, PhD

As part of CEPEP's evaluation strategy of health coaching, patients seeing providers trained in health coaching were invited to carry a hidden audiorecorder into their visit. Clinicians were aware they would be recorded but did not know when. Audio recordings were coded using the "4C" methodology, "Content Coding for Contextualization of Care," which is designed to determine whether care is customized and takes into account each patient's individual circumstances and needs to optimize care.

To date we have coded 30 encounters involving physicians trained in patient-centered care (PCC) health coaching and compared them to 50 not trained, looking for two specific metrics: the first, known as "probing for contextual red flags," refers to evidence that a provider has noticed a clue that a patient has complicating life circumstances that could impact their care and has asked about it. The second, known as "contextualizing the care plan," refers to customizing care to accommodate identified complicating factors. Both are desirable behaviors. For the former, we found that providers trained in health coaching were significantly more likely to probe (p=0.028). For the latter, we see a trend towards significance, but too small a sample size to document significance. In sum, "4C" provides evidence that health coaching promotes patientcentered decision making.

## **Economic Analysis**

### Effects of Patient-Centered Care on Health Care Costs

Neil Jordan, PhD; Kevin Stroupe, PhD

Early evidence about cost reductions associated with patient-centered medical home and related models of patient-centered care (PCC) has been mixed.<sup>2</sup> Cost savings associated with PCC have not been systematically studied in VHA; our CEPEP evaluation is exploring the economic impact of PCC in the VA. This article shares early findings about changes in facility-level health care costs since the implementation of PCC innovations at Centers of Innovation (COI). Much of VA health care costs are associated with inpatient (IP) and outpatient (OP) health services. Using VA administrative data, we first identified every unique user of IP or OP services at each COI and comparison site (referred to here as health care system users) annually for fiscal year FY08–FY12, and then captured the costs of all IP and OP services received by health care system users at those sites. We then divided total costs by total health care system users to get average costs/year.

Longitudinal trends in average health services costs were similar in 3 of 4 COI-comparison site pairs. However, site 4 and its comparison showed a different trend. From year 2 (FY11) to year 3 (FY12) of PCC implementation, average costs declined at COI Site 4 from \$7200 to \$6665, an 8% decline. At the comparison site, average costs declined by only 2% (from \$7325 to \$7189) (Figure 1).

Our findings are consistent with the literature, which suggests that PCC may not be achieving reductions in costs of care. As we continue this work, we will explore other approaches to how health care costs have changed since implementation of PCC innovations. In particular, we will explore if there are differences in average IP costs over time, as PCC's economic impact may be in reducing avoidable hospitalization. We will conduct additional analyses on some disease subgroups. Finally, we will explore differences in costs between COIs and comparison sites for Veterans with acute illnesses, which represent 25% of all health care spending in the civilian non-institutionalized population.<sup>3</sup>

Figure 1: Average utilization costs per health care system user



# PATIENT-CENTERED CARE Evaluation UPDATES

## The Patient Experience: Survey Findings

### Examining Patient Activation in Veterans

Alex Malhiot, MS

Patient-centered care (PCC) often encourages patients to take a more active role in their own health care. Patient activation, which refers to a patients' knowledge, motivation, skills, and confidence to make effective decisions to manage their health and health care<sup>4</sup>, can be measured to determine a patient's activation level.

The Patient Activation Measure (PAM) was developed to more accurately capture patient activation than previous measurement tools.<sup>5</sup> Using the validated PAM-13, levels of activation describe that patients at lower activation levels (stage 1 or 2) may need to gain basic knowledge and awareness of their health and conditions while patients at higher

levels (stage 3 or 4) tend to be more engaged but may struggle with maintaining their health behavior over time.<sup>6</sup>

We surveyed Veterans receiving care from Centers of Innovation (COI) (n=5,284). More than 54% of Veterans reached the higher levels of activation and more than 25% of Veterans at the highest level, stage 4. The mean PAM score for Veterans at COIs was 56. This means, on average, Veteran activation at COIs is at the low end of stage 3; indicating that, in general, Veterans are aware of and understand their conditions but may • We conducted a cross-sectional, national survey of Veterans receiving care at VA facilities during the last half of FY2012.

• A survey packet was mailed to Veterans' homes, with a 4-week follow -up for non-responders. The Veteran survey packet collected data on demographics and several validated PCC measurement instruments (e.g., PAM).

• A separate survey was included for their family member/friend (applicable if someone helped them with their care) to assess family-centered care.

The Family Experience: Survey Findings

# Perceptions of Family-Centered Care in the VA

Bella Etingen, MA

Family members, friends, and/or caregivers of patients often aid in the health care process, and play a large role in making sure the patient's health and well-being is maintained outside of health care facilities.<sup>8</sup> Family-centered care (FCC) involves health care facilities partnering with patients <u>and</u> <u>their families</u>, engaging them in decisions, and providing support.<sup>9</sup>

To better understand FCC from the perspective of those involved in a Veteran's health care, we conducted a survey with friends and family members of Veterans receiving care from Centers of Innovation (COI) (n=2,266). We used a modified Family-Centered Care Survey (FCCS),<sup>10</sup> a 30-item

questionnaire measuring demographics and family member/ caregiver characteristics, FCC constructs of *Respect*, *Collaboration*, and *Support*. Response options assessing FCC constructs range from 1=never to 4=always; higher scores indicate higher perceptions of FCC. Mean values were examined.

Overall, perceptions of respect (3.31), collaboration (3.08), and support (3.00) were high among caregivers of Veterans. We also looked at perception of FCC by caregiver age. Family members/ caregivers aged 60/older (vs. 59/

struggle with taking the necessary actions to improve their health and maintain it over time.

Studies have shown, and many researchers agree, that higher levels of patient activation are associated with a variety of positive health outcomes and improvements in health behaviors.<sup>4,7</sup> As PCC continues to evolve and PCC continues to spread, there will be more opportunities for increasing patient activation levels. younger) were more likely to be spouses of the Veteran patient and white race/ethnicity. Older caregivers (vs. younger caregivers) reported higher perceptions of respect (3.36 vs. 3.22, p<0.001), collaboration (3.14 vs. 2.98, p<0.0001), and support (3.07 vs. 2.88, p<0.0001).

FCCS survey findings suggested that perceptions of FCC are high in the VA overall, but may be better in older family members/friends of Veterans.

### Employee/Health Care Provider Experiences and Views

### **Optimizing the Care Environment: Guided Tours with Employees** Sara Locatelli, PhD

In our previous newsletter, we discussed the results of guided tours conducted with Veterans. Guided tours are a qualitative, participatory research method, in which participants lead the researcher through an environment, commenting on their surroundings, thoughts, and feelings.<sup>11</sup> We also conducted guided tours with 25 employees and providers at 2 patient-centered care (PCC) Centers of Innovation (COI), who walked through the facility as though they were a Veteran. Not only does this help employees and providers to consider and understand their patients' experiences, these types of walkthroughs are routinely used for quality improvement and compliance assessments.

Participants were mostly women (84%), an average age of 41.3 years (SD=10.43), and included clinical management (e.g., nurse manager; n=9), support staff (e.g., staff assistant; n=6), non-clinical management (e.g., chief of facilities maintenance; n=4), clinicians (e.g., physician; n=3), customer support (n=1), facilities maintenance/beautification (n=1), and psycho-social workers (n=1).

Many discussed the need for health care facilities to abandon the idea of an "institutional" appearance, and highlighted instances where areas had succeeded in shedding these qualities:

"I mean [this unit] is a beautiful area, it's open, it's airy, it doesn't [look] institutionalized... [It looks] warm... more homelike."

Participants also discussed why the appearance matters; the way a facility looks communicates information to patients about the type of care they will receive:

"As a patient, I am going to look at how [the facility] looks when I walk it. Because then I know that they are caring about the patient and the environment the patient is... treated in."

Many participants compared their VA facility with non-VA facilities at which they receive some or all of their care:

"Right when I walked in I was already greeted and they told me exactly where to go and how to report to it. And then if you needed any additional assistance... [they] get you a wheelchair."

"[Surgery at a non-VA hospital] had this really neat process where they had computerized screens and as the patient moved locations somebody updated the screen and so we could see from the... waiting room."

Participants offered many suggestions for improvements to the environment that could make it more entertaining and soothing for patients:

"We could [ask] a local pet store... [to] bring in a fish tank... keep it filled with fish and take care of it weekly. Something that the patients can look at to keep their minds busy. A lot of hospitals will get a small baby grand donated and... musicians will come in and play music softly for the veterans... to help entertain as part of the care."

"[Patients need] a place to get away... to get out of the room... Something nice and soothing or that makes [them] feel like [they] have actually gotten away from the hospital."

The movement toward PCC requires changes to the health care system at multiple levels and involves multiple groups, including patients, providers, and other health care employees. These results highlight the importance of considering the environment and

how it influences care delivery and patient perceptions. It may be beneficial to consider innovations at non-VA hospitals for implementation at VA facilities, if appropriate and helpful.

Data Reflections

By providing a rich, detailed picture, qualitative data afford the opportunity to glean unanticipated findings.

## The Employee Experience: Survey Findings

## Professional Quality of Life in COI Employees/Providers

Sara Locatelli, PhD

Occupational stress represents a real health risk among employees. Though employee's personal characteristics can have an impact, work environment and job factors can also contribute to occupational distress and low professional quality of life (QOL).<sup>12</sup> Health care workers (HCWs) are also at risk for distress that uniquely affects people in helping professions, who need to provide compassionate care to individuals who have experienced trauma.

Surveys were conducted with 76 VA employees/ providers from 4 Centers of Innovation (COI), to assess employee voice and quality of communication. The Professional Quality of Life (PRoQOL) scale measures:

- Compassion satisfaction (CS): the pleasure a worker derives from working in a helping profession
- Compassion fatigue: divided into two subscales burnout and secondary traumatic stress (STS)<sup>13</sup>

Overall scores (mean, sd) for CS (50.5, 9.77), burnout (9.85, 9.69), and STS (50.44, 10.19) were in the moderate range. No differences among employee positions were found. Burnout scores were lower among participants who agreed/strongly agree that they were involved in change decisions (47.3 vs. 52.9, p=0.02) and that managers encouraged staff to suggest ideas for changes (47.3 vs. 54.6, p=0.003) than participants who disagreed with these statements. Additionally, participants who felt managers encouraged staff to suggest ideas showed a trend toward higher CS (52.2 vs. 47.5, p=0.07).

Though it is unclear whether work practices lead to burnout, or whether burnout impacts how the employee views his or her workplace, attempts to improve employee involvement in change decisions may decrease burnout and increase CS.

### **On Being Present: COI Staff Reveal Connection to Patients** Carol Kostovich, PhD, RN

Providing personalized care requires that health care providers and staff get to know their patients as individuals. Providing staff with a way to go beyond superficial interactions to learn about their patients as unique individuals in order to personalize care may be referred to as 'being present.'

*Being present* requires that staff members focus completely on the patient, removing physical and psychological barriers that would impede this. Staff members in all roles have the opportunity to *be present* to their patients, whether they are administering medications, providing therapy, delivering a meal tray, or cleaning the room. If a health provider completes all of the tasks of their assigned role, and yet the patient feels neglected or depersonalized, care was not truly patient-centered.

Currently, no instruments are available to measure the presence of all health care team members. The Presence of Nursing Scale - RN Version (PONS-RN)<sup>14</sup>, was developed to measure nurses' perceptions of being present for patients. We used a modified PONS tool to measure elements of presence in RN and non-RN staff. Staff with direct patient contact (n=49) at 4 VA Centers of Innovation completed the self-reported PONS. Items were rated on a 1 (low) to 4 (high) scale. Data revealed that staff perceived themselves to be both emotionally and physically present for their patients. Their mean score on the 6-item emotional presence subscale was 19.14 (possible range 6-24; SD=4.1) and their mean score for the 12-item Physical Presence subscale was 43.35 (possible range 12-48; SD=5.54). Specifically, staff participants made time to listen attentively to the patients (m=3.8; SD=0.46), treat patients as individuals (m=3.8; SD=0.53), and take additional action on behalf of the patient if needed (m=3.8; SD=0.41). Providing emotional comfort (m=3.3; SD=0.94) and being sensitive to the beliefs of patients (m=3.6; SD=0.46) were also highly rated by these participants.

*Being present* facilitates the delivery of holistic PCC. It allows for an emotional engagement between patient and health care team and staff, recognizing the unique humanness of each.

# PATIENT-CENTERED CARE Evaluation UPDATES

## Secondary Data Collection: VA Administrative Databases Analysis

### Patient-Centered Care: It Begins with Changing the Status Quo

Lisa Burkhart, PhD; Neil Jordan, PhD; Elizabeth Tarlov, PhD; Min-Woong Sohn, PhD; Brian Bartle, MPH; Scott Miskevics, BS

We present an analysis comparing 4 Centers of Innovation (COI) to matched non-COI (comparison) sites on PACT Compass measures of care coordination, continuity, and access.

**Care Coordination:** We examined the proportion of patients contacted within 2 and 7 days following hospital discharge and found that COIs and comparison sites had similar patterns. Beginning at near zero in FY2010, rates increased sharply in FY2011 and reached 80-100% by FY 2012, suggesting that PCC innovations had no additional impact on post-hospitalization contact rates.

**Care Continuity:** We examined how often patients saw their own primary care provider (PCP) versus another and found an increase at COIs and comparison sites over time, but larger increases at some COIs. For example, the proportion of visits to the PCP increased by 7.7 absolute percentage points at COI Site1 but only 5.6 absolute percentage points at the comparison site (Figure 2). This suggests that COI innovations may have acted synergistically with PACT implementation to bring about greater improvements in continuity of care.



Patients' use of emergency or urgent care (ER/UC) (reflecting *dis*continuity of primary care) revealed that COI Sites 1, 3, and 4 had fewer ER/UC visits at all time points. No ER/UC data were available for Site 2 during this time period. These findings suggest COIs offer greater primary care continuity, a necessary starting point for building a collaborative relationship between patients and providers, which is a core PCC aim.<sup>15,16</sup>

Access to Care: We examined how often patients (new, established, and all) were seen same day and within 1, 7, and 14 days of their desired appointment date. We found notable wait time improvements at COI sites 1, 2, and 3 and their respective comparison sites. At COI sites, more patients were consistently able to schedule appointments on or near their desired date, relative to their respective comparison site. For example, 85% of COI Site 1 patients scheduled same day appointments on their preferred day in FY 2010 and 92% in FY 2012 (at the comparison site, 56% in FY 2010 and 68% in FY 2012) (Figure 3). COI 4 did not show these trends.





Findings show that care coordination, primary care continuity, and access to care improved markedly at both COI and comparison sites since FY 2010. Some COIs had larger improvements in care continuity relative to comparison sites. PCC innovations appear to take effect in provider behaviors first, and over time, innovations may affect facility-level outcomes, which is consistent with the literature.<sup>15,16</sup> Our analysis revealed some significant facility-level outcome changes.

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## **Implementation Tips**

### Use of a Checklist to Assess Range and Spread of PCC Innovations Jennifer N. Hill, MA

Achieving cultural transformation requires a large range of innovations which are implemented across multiple years. This creates a need for evaluation of a broad range of innovations occurring along with the spread of those innovations; to accomplish this, we created the *PCC Innovations Checklist* (PCC-IC) to assess a number of innovations and the extent of their implementation.

The PCC-IC was created based on literature,<sup>17</sup> strategic plans from Centers of Innovation (COI), and expert review from the CEPEP Advisory Committee. The final checklist contained 100 potential innovations. We worked with the PCC Coordinator and other team members involved at each facility to complete checklists. For each innovation we collected information on: (1) when the innovation began/will begin, (2) extent of implementation, and (3) comments or background on the history of the intervention.

Table 1: Number of PCC innovations at VA Centers of Innovation: A Snapshot

Site	In Place Before Becoming a COI	Expanded/ Implemented Since Becoming COI	Planned for Future Implementation	Total
1	60	23	6	89
2	42	10	9	61
3	63	28	2	93
4	30	28	4	72
Average	49	25	5	

Table 1 gives an idea of PCC innovations at each facility. As of 2013, COIs have a range of 61-93 diverse PCC innovations. The facility leaders reported that the checklist offered a way to quantify their PCC efforts, and provided a comprehensive list of possible PCC innovations, while allowing for expansion of the list if necessary. As PCC innovations continue to spread across the VA system of care, this checklist may be used to assess the types and extent of implementation at facilities. It may also be used by VAs looking to start or expand PCC innovations at their facility. For a copy of the PCC tool, please contact CEPEP.

## Measuring Patient-Centered Care: Tools and Recommendations

### **Identifying Instruments to Measure PCC**

Carol Kostovich, PhD, RN; Frances Weaver, PhD

Delivering patient-centered care (PCC) requires consideration of the influence of multiple factors on individual patient perceptions and outcomes. Because PCC includes multiple constructs, measurement might best be achieved through the use of a variety of instruments. After conducting literature reviews to identify currently available instruments and key constructs to assess PCC, we convened a Delphi panel of 16 experts (health providers, CEPEP Advisory Board members, and researchers) to identify constructs appropriate to measuring PCC within VA and missing constructs. Identified constructs included communication, care preferences, shared decision-making, therapeutic relationship, empowerment/activation, holistic care, contextual care, environments of care, evidencebased care, and care access.

Literature searches were conducted to identify potential measures, which could measure single or multiple constructs of PCC. Instruments were considered if they met at least one of the following criteria: measured PCC from the patients' perspective, demonstrated acceptable reliability and validity, used and tested frequently, and used within a VA population. We selected 9 single and 8 multiple construct instruments that met these criteria. The Delphi panel was then asked to review all 17 instruments, and give feedback on reliability and validity, respondent burden, appropriateness for VA use, and the extent to which each measured PCC. This left 3 single and 3 multiple construct instruments.

To engage Veterans' we conducted a focus group to gain their insights about the quality, understandability, and length of the 6 instruments. When asked which instrument was best at measuring PCC, Veterans chose the 3 multiple construct instruments.

While some instruments are better suited than others to measure PCC, no single instrument captures the complexity of PCC in its entirety. This supports the need to use a variety of instruments, or items from multiple instruments, to measure PCC.

## Center of Innovation Spotlight

### VA New Jersey HCS

Mary Therese Hankinson, MBA, MS, RD, EDAC

**Community Involvement:** The Greenhouse Project at VA NJHCS involves a green job skills program focused on sustainable landscaping, master gardening, and storm water management. The master gardening classes include sites for growing plants, vegetables and culinary herbs on VA grounds. The greenhouse is a sustainable strategy for Veterans to receive therapeutic, and vocational rehabilitation, compensated work therapy, education, and continuous employment opportunities. Veterans participate in a Sustainable Landscaping and Storm Water Management Training Program. Classroom lectures are supplemented with hands-on training, field trips, and networking with local landscapers.

Outcomes: Many Veterans have successfully graduated; this has increased their awareness of storm water management, sustainable landscaping, and environmental issues. Veterans also became proficient in rain garden installation to reduce storm water pollution on VA grounds and in the community. Veterans are also exposed to potential employment opportunities while expanding their environmental stewardship to local neighborhoods and communities. The facility Green Environmental Management System Coordinator collaborated with the Greenhouse Project to measure sustainable outcomes. Installation of storm water management controlled and reduced storm water generated onsite by 37,000 gallons/year. The demand for drinking water at the facility has been reduced by 12,000 gallons/year, with more savings expected as additional rain barrels are installed. In one year, community gardens at the East Orange campus produced more than 2,000 pounds of local, sustainably-grown vegetables.

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