


The Impact of Job Role on Health-Care Workers' Definitions of Patient-Centered Care

Journal of Patient Experience
2020, Vol. 7(6) 1634-1641
© The Author(s) 2020
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/2374373520910335
journals.sagepub.com/home/jpx


Jessica L Moreau, PhD, MPH¹ , Alison B Hamilton, PhD, MPH^{1,2},
Elizabeth M Yano, PhD, MSPH^{1,3} , Lisa V Rubenstein, MD, MSPH, FACP^{3,4,5},
and Susan E Stockdale, PhD¹

Abstract

While patient-centered care (PCC) is a widely accepted aspect of health-care quality, its definition is still the subject of debate. We investigated health-care workers' definitions of PCC by level of patient contact in job roles. Our qualitative study involved semi-structured interviews with key stakeholder employees (n = 66) at 6 Veterans' Affairs health-care locations in Southern California. Interviews were recorded, transcribed, coded for definitions of PCC, and analyzed by participants' self-described level of patient contact. Stakeholders whose role primarily involved patient contact tended to define PCC through: patient as a person, patient preferences, and shared decision-making. Stakeholders whose role did not primarily involve patient contact tended to define PCC through: patient-centered redesign, customer service, and access to services. Stakeholders with more patient contact emphasized patient-level and interpersonal concepts, while those with less patient contact emphasized system-level and business-oriented concepts. The focus on PCC-as-access may reflect influence of changing institutional climate on definitions of PCC for some stakeholders. To facilitate successful PCC efforts, health-care systems may need to leverage differing but complementary definitions of PCC within its workforce.

Keywords

patient-centered care, health-care workforce, patient-centered medical home, qualitative research, veterans

Background

While patient-centered care (PCC) is a widely accepted centerpiece of conversations around health-care quality (1–5), its definition is still the subject of debate (6–8). The lack of consensus around PCC's definition is reflected in vigorous debates about what should be excluded in definitions of PCC (9–13), such as superficial aspects of patient experience (14) (eg, hospital décor), or technological and infrastructure changes (15) (eg, electronic medical records) which miss the target of PCC as being about patient care. One large, frequent-cited literature review by Mead and Bower (8) noted a general lack of consensus around essential components of PCC. They distilled from the literature key 5 conceptual dimensions that help outline PCC: “biopsychosocial perspective; ‘patient-as-person’; sharing power and responsibility; therapeutic alliance; and ‘doctor-as-person’” (8).

Less represented in this ongoing debate, however, are the definitions of PCC that are held by the workers in health-care systems. For systems that have chosen to shift toward delivering care that is more patient-centered, health-care

workers are charged with the everyday task of carrying out this process. As has been pointed out previously (7,16), it is difficult to enact PCC across a health-care system if the workers themselves do not agree on how to define PCC. Previous studies (16–21) suggest that health-care workers'

¹ VA HSR&D Center for the Study of Healthcare Innovation, Implementation and Policy (CSHIIP), VA Greater Los Angeles Healthcare System at Sepulveda, North Hills, CA, USA

² Department of Psychiatry and Biobehavioral Sciences, UCLA Geffen School of Medicine, Los Angeles, CA, USA

³ Department of Health Policy & Management, UCLA Fielding School of Public Health, Los Angeles, CA, USA

⁴ Department of Medicine, UCLA Geffen School of Medicine, Los Angeles, CA, USA

⁵ RAND Corporation, Santa Monica, CA, USA

Corresponding Author:

Jessica L Moreau, Center for the Study of Healthcare Innovation, Implementation and Policy, VA Greater Los Angeles Healthcare System, Building 25, 16111 Plummer Street, North Hills, CA 91343, USA.
Email: jessica.moreau@va.gov



understanding of PCC varies; however, potential sources of this variation, such as job role, are unknown.

Given the focus of PCC on the individual patient, it is plausible that workers' job role within the health-care system, their daily duties, and their degree of contact with patients within those duties may impact their definition of PCC. Two US-based studies (16,21) found variation in employees' apparent concepts of PCC but did not distinguish between different job roles in their analyses. Neither study answered the question of how individuals' job roles may have contributed to the variation that they found. To address this gap and build on the existing literature, our objective was to assess health-care workers' definitions of PCC and evaluate if level of patient contact in job roles was associated with patterns in those definitions.

Methods

Setting and Participants

Our study was conducted at 6 sites within 3 Veterans Affairs (VA) health-care systems in Southern California between September 2013 and January 2015. Data were collected as part of an evaluation by the Veterans Assessment and Improvement Laboratory for Patient-Centered Care (VAIL) (22), 1 of 5 demonstration laboratories funded by the VA's Office of Patient Care Services to evaluate the VA's approach to patient-centered medical home (PCMH) implementation.

Potential key stakeholder participants were identified by their job title and role in PCMH implementation as having unique and important first-hand knowledge of PCMH implementation processes at their location (23). They included regional leaders (administrative, information technology, etc), local health-care system leaders (eg, administrative, nursing, medicine, system redesign, social work, pharmacy, behavioral health), site-level leaders (eg, administrative, nursing, medicine, social work, pharmacy, and behavioral health), research project leaders and staff involved in local PCMH implementation efforts, and other site-level participants, such as primary care clinical staff (eg, physicians, nurses, dietitians, pharmacists), nonclinical staff, and other employees directly involved with the PCMH. Key stakeholders were contacted via e-mail and invited to participate in an interview at a time of their convenience.

Informed consent was obtained verbally from all individual participants included in the study. All procedures were approved by the institutional review boards of the Greater Los Angeles VA Healthcare System (2011-070725 and 2011-030295) and the RAND Corporation (HSPC Project ID: 2010-0870).

Data Collection

A team of trained qualitative researchers conducted in-person and telephone interviews lasting 45 to 60 minutes, which were audio-recorded, professionally transcribed, and spot-checked for accuracy. The interview guide was

developed by an interdisciplinary project leadership team including physicians and social scientists, and based on the PCMH implementation literature. The guide was designed to elicit descriptions and reflections on various aspects of local PCMH implementation progress from the perspective of the stakeholder, such as primary care restructuring, team-based care and workflow, and continuity of care, in addition to feedback on an intervention supporting locally driven PCMH quality improvement efforts. Relevant to this analysis, one question on the interview guide directly asked participants to define PCC in their own words. We asked: "How would you define patient-centered care?"

Data Analysis

Transcripts were summarized by the qualitative team in a template of key domains based on the interview guide (24). All transcripts were coded in ATLAS.ti (version 8) by the first author (J.M.). The analytic focus of "definitions of patient-centered care" was derived a priori from the interview guide. In this first phase of analysis, we used a single code to identify all stakeholder definitions of PCC across all transcripts. We coded definitions of PCC which came in response to the interview guide question: "How would you define patient-centered care?" in addition to any definitions of PCC which arose spontaneously during the interview. Coded sections of text were iteratively grouped and refined using a constant comparative (25), modified inductive approach consistent with Grounded Theory (26). Sections of text describing similar concepts were grouped into related categories in an iterative process in which the categories were repeatedly refined with the addition every new coded segment, and the characteristics of the categories developed by constantly comparing text segments within and across categories. The resulting categories generated through this process formed the 6 themes reported here.

After the initial analysis phase was complete, we considered strategies to analyze the resulting data set by job role to explore the role of patient contact. In this second phase of analysis, we initially attempted dividing the transcripts into 2 analytic groups by presence or absence of a clinical degree based on administrative data but discovered that clinical degree was not a proxy for patient contact for our sample. In the VA, most PC clinical leaders also have patient panels and split their time to some degree between administrative work and clinical work. Thus, some stakeholders with clinical degrees had minimal patient contact in their daily roles. Instead, we reviewed the transcripts for stakeholders' self-described level of patient contact and divided the transcripts into the following 2 analytic groups: primarily patient contact and primarily nonpatient contact. Self-reported level of patient contact was assessed directly from the transcript through asking participants to describe their job role and indirectly through their responses over the entire interview (patient contact > nonpatient contact = "primarily patient contact" group; nonpatient contact > patient contact = "primarily

Table 1. Participant Roles in the Organization.

Leadership Level	Role	Total Number (n = 66)	Primarily Patient Contact Group (n = 35)	Nonprimarily Patient Contact Group (n = 31)
Higher	Regional-level leaders (administrative, information technology, etc)	7	1	6
	Local health-care system-level leaders (administrative, nursing, medicine, system redesign, social work, pharmacy, behavioral health)	19	12	7
	Site-level leaders (administrative, nursing, medicine, social work, pharmacy, behavioral health)	21	14	7
	VAIL research project leaders and staff involved in local PCMH implementation efforts	13	2	11
Lower	Other site-level participants (such as physicians, nurses) involved in local PCMH implementation efforts	6	6	0

Abbreviations: PCMH, patient-centered medical home; VAIL, Veterans Assessment and Improvement Laboratory for Patient-Centered Care.

Table 2. Summary of Themes: Definitions of PCC.

Theme	Description
Key stakeholders with primarily patient contact job roles	
Patient as a person	Definitions of PCC revolving around the patient as a person, and care based on relationships with each individual person
Patient preferences	Definitions of PCC closely tied to the importance of patient preferences; the need for patient engagement and involvement in care; care should be patient-led and patient-driven
Shared decision-making	Definitions of PCC related to the process of shared medical decision-making between patients and providers; a joint process marked by cooperative partnership and balance
Key stakeholders with nonprimarily patient contact job roles	
Patient-centered design	Definitions of PCC related to various aspects of system redesign: system-level changes to improve care processes; workflow processes and clinical spaces all designed around the patient
Customer service	Definitions of PCC related to customer service principals; patients treated by all staff as if they were paying customers; the patient's business is welcome and appreciated
Access to services	Definitions of PCC focused on patients' timely access to needed services and providers; the patient getting the appointment day and time desired; the patient having phone access to primary care team

Abbreviation: PCC, patient-centered care.

non-patient contact" group). For example, if a physician held an administrative leadership position and reported only one half-day of clinical time per week, we assigned this participant to the primarily nonpatient contact category. We sorted coded sections of text by theme from the first round of analysis and by patient contact group from the second round of analysis and identified overarching patterns in the relationship between themes and patient contact categories. Coding and analysis was checked at multiple points by a second qualitative expert (A.H.) and discrepancies resolved by consensus.

Results

Eighty-seven individuals were invited to participate and 73 interviews were completed (response rate = 84%) between September 2013 and January 2015. Two interviews were dropped from the data set for not being VA employees, and 5 were dropped for no relevant content, resulting in an analytic sample of 66. To analyze by patient contact in job role, 35 stakeholders were categorized as primarily having patient

contact and 31 as primarily not having patient contact. Table 1 describes sample characteristics.

Key stakeholders' definitions of PCC included 6 themes summarized in Table 2. Key stakeholders whose role primarily involved patient contact tended to define PCC through the following concepts: patient as a person, patient preferences, and shared decision-making. Key stakeholders whose role did not primarily involve patient contact tended to define PCC through the following concepts: patient-centered design, customer service, and access to services. While there was cross-over between the analytic groups in themes discussed, our analysis found that key stakeholders overall prioritized the themes associated with their analytic group.

Themes: Key Stakeholders With Primarily Patient Contact Job Roles

Patient as a person. Key stakeholders described definitions of PCC revolving around the patient as a person and care based on relationships with each individual person. They felt that

the patient should be familiar with their team from seeing the same individuals consistently, visit after visit, and that the team should know the patient as a person, including family. They focused on warm connections with the patient based on that familiarity. They said care should be based on a relationship with the person that is the patient and rejected the idea of impersonal or anonymous care.

The individual attention and the fact that there is a nurse who knows you and calls you and you've seen her and you have a face to that name is very empowering for the patient. -Nurse

[PCC] is that continuity with each of the follow-up persons so [primary care team members get to know the [patient]]. So the nurse or the clerk can say, You know, he doesn't look right today, or, His wife was coming and she's not here today. Maybe you should ask what happened. -Primary Care Provider

Patient preferences. Key stakeholders described definitions of PCC closely tied to the importance of patient preferences. They highlighted the need for patient engagement and involvement in care that is patient-centered and felt that care should be patient-led and patient-driven. To facilitate this, they underscored the need to listen to patient values and priorities and include the patient's family in these discussions.

[PCC] means to me: what does the patient want? What are they really there for? What's the most meaningful thing in their life at the time? -Behavioral Health/Health Promotion Educator

[PCC] involves [the patient's] family and those type of things. It's not just the Veteran. It's everything that surrounds the Veteran. -Nurse

I think I would define [PCC] in terms of... the interaction that [patients] have with us as [PCMH] members and for us to be really partnering with them and addressing [patients'] goals. -Primary Care Provider

Shared decision-making. Key stakeholders described definitions of PCC related to the process of shared medical decision-making between patients and providers. They saw this as a joint process marked by a cooperative partnership and balance, with both sides having responsibilities. They described the provider in the role of educator, motivator, and facilitator.

From my perspective, [PCC] is like the translation of the Bible. When everything was in Latin, we believed, but we didn't know what we believed. And now, the information sharing has now opened up and there's less mystery and more knowledge. And there's going to be more interaction and it's forced from both sides because even revealing the doctor's notes has changed the attitude. Why not tell [patients] exactly what's wrong with them, or why not do this because I think there's going to be more honesty and more interaction between clinical staff and patient and less mystery. -Patient-Provider Communication Coordinator

[PCC] means letting [patients] share in the decision-making, making sure they have the knowledge that they need to make

those decisions, and respecting it when it's different than your own. -Primary Care Provider

Patient-centeredness, to me, means that the patient is at the helm of the wheel, so to speak. They are steering the care in that we are trying to get them well or keep them well and we have to meet them where they're at. So, to do that, you need to bring them in on decision making and buy-in on areas that they have challenges that they need to improve on. -Nurse

Themes: Key Stakeholders With Nonprimarily Patient Contact Job Roles

Patient-centered design. Key stakeholders described definitions of PCC in terms related to various aspects of patient-centered design, that is, system-level changes to improve care processes. They expressed the need for team members to go to the patient location (as opposed to the patient physically walking to different staff members' locations) and that clinical spaces should be set up to facilitate this team-based care. They emphasized the need for redesigned physical spaces such that clinical processes can center around the patient. They described PCC as workflow processes and clinical spaces, all designed to meet a variety of patient needs.

It wasn't uncommon in the past that you might have a patient be called in from the waiting room, have their vital signs done and sent back to the waiting room and so forth. Maybe they'd go from room to room to see the doc, to the dietician, to the whoever else. And now we're trying to really change that and have the providers go to the patient rather than the patient go to the providers. -Medical System Leadership

Everybody comes to the patient instead of the patient going from room to room. When they go through those types of designs, I think that that can help. -Pharmacy Lead

Customer service. Key stakeholders described definitions of PCC related to customer service principals. They felt that patients needed to be treated by all VA staff as if they were paying customers, similar to private industry, in which the patient's business is welcome and appreciated. Patients should be addressed respectfully, treated politely, and the attitude of staff should be one of seeking to increase customer satisfaction by delivering excellent customer service.

So [PCC] is [...] customer service. It's providing excellent customer service and picking up their phone calls. -Primary Care Lead

PCC is] being timely, it's being courteous, it's having excellent front office staff. -Primary Care Lead

[PCC] is... 'what can we do to help you today, sir or ma'am'? -Business Operations Lead

Access to services. Key stakeholders described definitions of PCC that focused on the patient's timely access to needed services and providers. They saw it as the patient getting the appointment day and time desired (including lunch hour,

evening, and weekend hours), the patient being seen the same day if needed, and the patient having phone access to the primary care team. They felt that PCC meant patients not having long waits for an appointment, or long waits in the waiting room, and having an easy-to-use phone system that provided immediate phone access or prompt return calls and secure messaging.

[PCC] means make an appointment when a patient wants to make an appointment. -Primary Care Lead

What I consider to be [PCC] would be, first of all, access to my provider when I need it, both a reasonable time of appointments and hopefully to be able to communicate outside of the usual [if] I have to call him, like a messaging system and so forth. -Regional Leadership

Patient-centered, to me, means that if I want to be seen that day I should be able to see either my provider or I should have an alternative to see another provider if my provider is full. I should be able to have a choice in the scheduling and everything, like if I provider referred me to a subspecialist, I should be able to get in within seven days. -Nurse Lead

Crossover Between Themes and Key Stakeholder Groups

Key stakeholders also discussed themes that belonged to the other patient contact-level analytic group. That is, key stakeholders from the primarily patient contact group discussed themes associated with the nonprimarily patient contact group, and vice versa. However, in these instances, they emphasized themes from their own analytic group over those from the opposite group. For example, one key stakeholder assigned to the primarily patient contact group, a PCP, emphasized a definition of PCC as orienting to preferences of the patient (an example of the patient preferences theme). This stakeholder also included an element of the access to services theme, a theme from the nonprimarily patient contact group, when they mentioned different non-face-to-face modalities for a clinical encounter that VA offers to increase access to services. Then they returned again to the idea of individual patient preferences as emphasis of the patient preferences theme.

The way I view [PCC] is you give the care that the patient feels is needed. They're not going to say I need my [mandatory clinical] reminders done. They're going to say they're in pain and they want someone to adjust their pain. So focusing on what the patients want to talk about or what they need for their own care and trying to provide care the way that it works for them. Whether it's on the phone, whether it's face to face, whether it's [secure video interface]. I mean it's based on individualizing [care] to the patient. -Primary Care Provider

In a second example of crossover between groups and themes, a key stakeholder assigned to the nonprimarily patient preferences group initially refers to the patient's

perspective in their definition of PCC (a crossover to the patient preferences theme). However, they go on to emphasize their own group's patient-centered design theme through a business-oriented and system-oriented clarification of PCC as about the VA does business.

PCC is look[ing] into the patient's perspective of how to navigate through the system. So it's re-looking at our entire way of doing business. -Primary Care Leadership

Discussion

In our analysis, definitions of PCC varied as a function of patient contact in key stakeholders' job roles. Key stakeholders with more patient contact tended to define PCC through patient-level and interpersonal concepts (patient as a person, patient preferences, and shared decision-making themes), while those with less patient contact tended to define PCC through system-level and business-oriented concepts (systems redesign, customer service, and access to services themes). This suggests that greater everyday job responsibilities for direct patient care may be associated with definitions of PCC more closely tied to the patients themselves, and those with job roles more distant from patients may hold definitions of PCC related to the broader health-care system and business operations.

Our findings build on previous work on hospital employee concepts of PCC by asking how definitions of PCC may vary by characteristics of job role. One notable previous study by Fix et al (16) mapped findings of hospital employees' concepts of PCC to established concepts of PCC in the literature based on the Mead and Bower review (8). However, that study did not analyze the influence of workers' job roles and could not answer the question of whether there were patterns in employees' concepts of PCC. Tantalizingly, Fix provides a breakdown of participant roles by category but does not report findings by those roles. Thus, while previous work establishes that workers' conceptions of PCC vary in important ways, our study's contribution helps to better describe one possible source of this variation: job role level of patient contact.

Our findings related to the PCC definitions of key stakeholders with jobs primarily involving patient contact (patient as a person, patient preferences, and shared decision-making themes) fit well within established concepts in the literature. Two of our themes from key stakeholders with nonprimarily patient content (patient-centered design and customer service themes) are similar to extensions on established PCC concepts that Fix found (16). However, the third theme, access to services, does not fit well within Mead and Bower's established concepts of PCC (8). Some have cautioned against health-care systems' focus on changes to infrastructure (such as electronic medical records, and improvements in scheduling) as a misread of the meaning of PCC (15). That is, while these infrastructure upgrades that improve patients' access, for example, may indirectly help

facilitate care that is patient-centered, they are not in themselves PCC. Thus, rather than defining PCC itself, a focus on access could be seen as addressing the mediators that would enable those in direct patient contact to deliver PCC.

One explanation for the theme of access's prominence among VA key stakeholders whose jobs roles did not primarily involve patient contact is the recent historical emphasis on access within the VA institutional context. In the 12 years previous to this work, government reports (27,28) and VA internal audits (29–31) criticized Veterans' lack of timely access to services and extensive wait times, and VA's lack of accurate accounting for patient wait times. Shortly following the beginning of our data collection, CNN reported in January 2014 (32) and April 2014 (33) on Veterans' delayed access to care. The negative news coverage prompted a VA audit and intense internal and external scrutiny of access issues (34) and ignited new efforts to improve access and PCC that are still ongoing (35). The coincidence of this VA institutional focus on access issues with the various PCMH and PCC improvement efforts occurring in VA nationwide (36,37) may have caused the concept of access to services to become wrapped up in VA-specific concepts of PCC for key stakeholders with less direct patients contact with in their jobs.

Key stakeholders comprise a crucial factor in the success or failure of efforts to enact policy (23). If discrepancies in PCC definitions between key stakeholders may be problematic for a health system attempting to implement PCC, then potential confusion between patient-level and interpersonal concepts versus system-level and business-oriented concepts of PCC may cause stakeholders to "talk past" each other. However, while system-level and business-oriented concepts of PCC are not the definition of PCC, per se, they potentially represent important prerequisites to PCC. For example, access to care is a necessary precondition to PCC: patients must have first access to their primary care team in order to experience PCC. System-level thinking about facilitators and barriers to everyday PCC delivery is an important role for high-level members of health-care system leadership.

Our analytic groups may reflect the relationship of the key stakeholder to the system, as either delivering direct PCC as a part of the patient-provider dyad within a given system or working to make the system reflect PCC values through its organization and administration. One group has self-efficacy for interpersonal PCC, while the other group has self-efficacy for supporting PCC through health-care system design. Thus system-level and business-oriented concepts, such as a focus on access, may play complement and support PCC in the VA context. For health-care systems continuing to implement and improve PCC, their efforts may benefit from understanding differences in health-care workers' definitions of PCC and promoting discussion to bring different definitions of PCC into conversation with each other within local institutional contexts. In this way, differing definitions of PCC within a health-care workforce can potentially work together and be leveraged as a strength.

This study has limitations of note. While our study took place at 6 VA sites across three VA health-care systems, all of these health-care systems were from one region in Southern California and may not generalize to other areas of the country. As discussed, local institutional contexts may be a factor that influences some workers' definitions of PCC, and as a result, some of the themes of our findings may vary by health-care system. Level of patient contact is the final common pathway of other job role differences such as management, leadership, or research responsibilities that are not assessed in this study. Our analysis instead identified job role in relationship to patient contact as a key factor in shaping PCC definitions; however, the modest size of our sample limited any analysis by finer grained job role groupings. Larger future studies should investigate more specific job role characterizes that may impact definitions of PCC.

Veterans Affairs health-care workers with primarily patient contact job roles held definitions of PCC that related to patient-level and interpersonal concepts and aligned well with definitions of PCC in the literature. Those with nonprimarily patient contact roles defined PCC through system-level and business-oriented concepts that were overall more distant from the PCC literature but may be important as prerequisites to providing PCC. To our knowledge, previous work has not addressed the role of specific institutional contexts in local definitions of PCC, and how factors such as media attention or internal efforts, such as the VA's work to address access, may impact some workers' definitions of PCC. More work is needed to explore how new programs, initiatives, or other large-scale change within a health-care system may have unintended consequences for bleed-over into local interpretations of PCC, especially for those in leadership positions involving less patient contact.

Differences in stakeholders' perspectives between the groups are each important and are potentially complementary within initiatives to enhance PCC. Based on these findings, however, PCC initiative leaders should anticipate the need to facilitate effective communication between these 2 groups of key stakeholders, in order to identify crossover where it exists and leverage differing but complementary definitions of PCC within its workforce. More research designed to tease out the factors that influence health-care workers' definitions of PCC is required both within VA and outside VA in order to determine how far our findings will bear out in other VA contexts and non-VA contexts.

Authors' Note

The views expressed in this presentation are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs or the United States Government.

Acknowledgments

The authors would like to thank our key stakeholder participants, the Veterans Assessment and Improvement Laboratory for Patient-Centered Care (VAIL-PCC) clinical partners, the VA Office of Primary Care Analytics Team (formerly PACT Demonstration

Laboratory Initiative Coordinating Center), and VAIL site leads for making this work possible. The authors thank the following team members: Dr Hector Rodriguez; Ms Barbara Simon; Drs Sabine Oishi, Alexis Huynh, Karleen Giannitrapani, and Jackie Fickel for their work with data collection and analysis; Mr John McElroy for his assistance with data collection and project management; Ms Jill Darling for her assistance on the human patients application and with the IRB interface.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Funding for the VAIL-PCC Patient Aligned Care Teams (PACT) Demonstration Laboratory initiative was provided to Drs. Lisa V. Rubenstein, Elizabeth M. Yano, Lisa Altman, and Susan E. Stockdale from the VHA Office of Patient Care Services (Project #XVA 65–018). Dr. Yano's effort was funded by a VA HSR&D Senior Research Career Scientist Award (RCS 05-195).

ORCID iDs

Jessica L Moreau, PhD, MPH  <https://orcid.org/0000-0001-7625-1832>

Elizabeth M Yano, PhD, MSPH  <https://orcid.org/0000-0002-9385-0025>

References

1. Committee on Quality of Health Care in America; Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington DC: National Academy Press; 2001.
2. Nelson K, Sylling PW, Taylor L, et al. Clinical quality and the patient-centered medical home. *JAMA Intern Med*. 2017;177:1042-4.
3. Little P, Everitt H, Williamson I, et al. Observational study of effect of patient centredness and positive approach on outcomes of general practice consultations. *BMJ*. 2001;323:908-11.
4. Weiner SJ, Schwartz A, Sharma G, et al. Patient-centered decision making and health care outcomes: an observational study. *Ann Intern Med*. 2013;158:573-9.
5. Agency for Healthcare Research and Quality (AHRQ). Six domains of healthcare quality. 2018. <https://www.ahrq.gov/talkingquality/measures/six-domains.html>. Accessed August 23, 2019.
6. Gerteis M, Edgman-Levitan S, Daley J, eds. *Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care*. 1st ed. San Francisco, CA: Jossey-Bass; 1993.
7. Scholl I, Zill JM, Härter M. An integrative model of patient-centeredness—a systematic review and concept analysis. *PLoS One*. 2014;9:e107828.
8. Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. *Soc Sci Med*. 2000;51:1087-110.
9. Stewart MA, Brown JB, Weston W, eds. *Patient-Centered Medicine—Transforming the Clinical Method*. Abingdon: Radcliffe Medical Press; 2003.
10. Scholl I, Zill JM, Härter M. How do health services researchers understand the concept of patient-centeredness? Results from an expert survey. *Pat Pref Adher*. 2014;8:1153.
11. van Dulmen S. Patient-centredness. *Patient Educ Couns*. 2003;51:195-6.
12. Zill JM, Scholl I, Härter M. Which dimensions of patient-centeredness matter?—Results of a web-based expert Delphi survey. *PLoS One*. 2015;10:e0141978.
13. Hodgkin P, Taylor J. Power to the people: what will bring about the patient centered revolution? *BMJ*. 2013;347:f6701.
14. Epstein RM, Street RLJ. The values and value of patient-centered care. *Ann Fam Med*. 2011;9:100-103.
15. Epstein RM, Fiscella K, Lesser CS. Why the nation needs a policy push on patient-centred health care. *Health Aff (Millwood)*. 2010;29:1489-95.
16. Fix GM, Van Deusen LC, Bolton RE. Patient-centred care is a way of doing things: how healthcare employees conceptualize patient-centred care. *Health Expect*. 2018;21:300-7.
17. Gillespie R, Florin D, Gillam S. How is patient-centred care understood by the clinical, managerial and lay stakeholders responsible for promoting this agenda? *Health Expect*. 2004;7:142-8.
18. Coyne I, Murphy M, Costello T. A survey of nurses' practices and perceptions of family-centered care in Ireland. *J Fam Nurs*. 2013;19:469-88.
19. Esmaili M, Cheraghi MA, Salsali M. Critical care nurses' understanding of the concept of patient-centered care in Iran: a qualitative study. *Holist Nurs Pract*. 2014;28:31-7.
20. Taylor A, Groene O. European hospital managers' perceptions of patient-centred care. *J Health Organ Manag*. 2015;29:711-28.
21. Balbale SN, Turcios S, LaVela SL. Health care employee perceptions of patient-centered care. *Qual Health Res*. 2015;25:417-25.
22. Rubenstein LV, Stockdale SE, Sapir N. A patient-centered primary care practice approach using evidence-based quality improvement: rationale, methods, and early assessment of implementation. *J Gen Intern Med*. 2014;29:S589-S97.
23. Brugha R, Varvasovszky Z. Stakeholder analysis: a review. *Health Policy Plann*. 2000;15:239-46.
24. Hamilton A. *Qualitative Methods in Rapid Turn-Around Health Services Research*. VA Health Services Research and Development Cyber Seminar; 2013.
25. Glaser BG. The constant comparative method of qualitative analysis. *Soc Probl*. 1965;12:436-45.
26. Glaser BG, Strauss AL. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New Brunswick, NJ: Aldine Publishing Company; 1967.
27. United States General Accounting Office. Report to the Committee on Veterans Affairs, House of Representatives: VA Health Care, More Action Needed to Reduce Waiting Times, But Some Clinics Have Made Progress. GAO 01-953; 2001.

28. President's task force to Improve Health Care Delivery for Our Veterans, Final Report, May 2003. In: The State of VA Health Care: Hearing Before the Committee on Veterans Affairs, United States Senate One Hundred Thirteenth Congress, Second Session, S HRG. 2014;113-617.
29. VA Office of Inspector General. Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3. Report 07-03505-129; 2008.
30. VA Office of Inspector General. Audit of the Veterans Health Administration's Outpatient Waiting Times. Report 07-00616-199; 2007.
31. VA Office of Inspector General. Audit of Veterans Health Administration Outpatient Scheduling Procedures. Report 04-02887-169; 2005.
32. Bronstein S, Black N, Griffin D. Veterans Dying Because of Health Care Delays. Atlanta, GA: CNN; 2014.
33. Bronstein S, Griffin D. A Fatal Wait: Veterans Languish and Die on a VA Hospital's Secret List. Atlanta, GA: CNN; 2014.
34. US Department of Veterans Affairs. VA access audit & wait times fact sheet system-wide overview. June 9, 2014. <https://www.va.gov/health/docs/VAAccessAuditSystemWideFACTSHEET060914.pdf>. Accessed January 2, 2019.
35. SoRelle R, Shea JA, Shasha B. Patient engagement, access to care, and perceptions of competing priorities in the VA primary care setting [published online June 27, 2019]. *J Gen Intern Med*. 2019;34:1971-72. doi:10.1007/s11606-019-05092-6.
36. Fihn SD and the Offices of Primary Care Services and Primary Care Operations/Analytics and Business Intelligence, Veterans Health Administration, Department of Veterans Affairs. PACT Demonstration Laboratories Synthesis Project Panel Final Report; 2014.
37. Bulter A, Wakefield B. VA Demo Lab Initiative Patient Engagement Workgroup Final Report; 2016.

Author Biographies

Jessica L. Moreau, is a medical anthropologist and the Qualitative Methods Group Lead at the VA HSR&D Center for the Study of Healthcare Innovation, Implementation & Policy (CSHIIP).

Alison B. Hamilton, is Chief Officer of Implementation & Policy, VA HSR&D Center for the Study of Healthcare Innovation, Implementation & Policy (CSHIIP), and Research Anthropologist in the Department of Psychiatry and Biobehavioral Sciences, University of California Los Angeles's Geffen School of Medicine.

Elizabeth M. Yano, is Director of the VA HSR&D Center for the Study of Healthcare Innovation, Implementation & Policy (CSHIIP), and Adjunct Professor in the Department of Health Policy and Management, University of California Los Angeles's Fielding School of Public Health.

Lisa V. Rubenstein, is a Physician Policy Researcher at the RAND Corporation and Professor Emeritus, University of California Los Angeles's Geffen School of Medicine and Fielding School of Public Health.

Susan E. Stockdale, is a sociologist/health services researcher and Core Investigator at the VA HSR&D Center for the Study of Healthcare Innovation, Implementation, and Policy (CSHIIP), and an Assistant Research Sociologist in the Department of Psychiatry and Biobehavioral Sciences, University of California Los Angeles's Geffen School of Medicine.