FORUM *translating research into quality health care for veterans*

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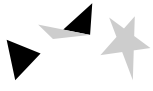

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What Does Patient-Centered Care Mean for the VA?

By Gerald M. Cross, M.D., National Director, Primary Care

Patient-centered care means partnering with patients. It means arranging health care in such a way that patients routinely participate in decisions about their own treatment. It means creating an atmosphere where staff naturally solicit patients' input and accept that input with respect. It means building a system that doesn't waste patients' time, offers easy access to care, and meets patients' needs for information, education, and preventive care. Most importantly, patient-centered care means better outcomes for patients —and rewards for staff in knowing that they provide excellent care.

Patient-centered care also means hard work — otherwise, we would see more of it.

At VA, patient-centered care has become increasingly important as we've shifted our focus from inpatient to outpatient care. Although we maintain a large number of robust medical centers — more than 150 — VA now operates more than 800 community-based outpatient clinics. This is all part of a strategic move to establish primary care near where our veterans live. To make this strategy work, we need a more effective approach to patient encounters, and that's where patient-centered care comes in.

The Employee Education System and the Primary Care Central Office promote patient-centered care within VA through our national meetings, conference calls, and educational presentations. Advanced Clinic Access coaches support patient-centered care through a variety of meetings and their soon-to-be-released handbook.

Several new initiatives support patient-centered care, including the directive on panel size released earlier this year to ensure that resources match demand. The directive sets a panel size standard and identifies quantitative adjustments based on factors such as the number of exam rooms and the number of support personnel. As described in this directive, continuity of care, enrollment to panels, and adjustments to panel size serve as a structural foundation for patient-centered care, even though these things are largely invisible to patients.

Ultimately, however, patient-centered care thrives where innovative leaders and dedicated staff members join forces to care for veterans. Each time a patient calls for an appointment, contacts a nurse advice line, or visits one of our clinics, we have an opportunity to exceed that veteran's expectations. Each staff member who encounters a patient should understand and practice the fundamentals of patient-centered care.

Patient-centered care is largely determined by the rules that define the health care environment. All medical facilities have rules. Rules determine what patients may or may not do, from the moment they enter the parking lot until they leave. And while the rules differ, they probably have one thing in common: They were made by the facility staff, with little input from the patients themselves. Rules may either serve as a source of patient dissatisfaction or they may form a solid foundation for patient-centered care.

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Director's Letter

The past year has been one of transition in organization and leadership within HSR&D, the Office of Research and Development, and VHA as a whole.

In HSR&D, we wished a happy retirement to John Demakis, M.D., who guided the Service during a period of unprecedented growth. John left us with an exceptionally strong program nationally and an excellent team in Central Office. I am particularly pleased to have Joe Francis, M.D., as the new Associate Director for QUERI/ Implementation. Our programs remain strong due to our capacity in the field, a vigorous and established health services research tradition, and enhanced partnerships among our research and clinical leaders.

We had hoped to have a new HSR&D Director by the time John retired, and a search yielded some excellent candidates. However, because of the rapidly changing environment in Central Office and the imminent turnover in leadership at several levels, the position will not be filled at this time. We anticipate that the search will be reopened in the near future.

Meanwhile, I am privileged to serve for the third time as Acting Director of HSR&D. I expect this next year to yield both challenges and opportunities. We have expanded our capacity to meet growing demand among managers and clinicians for answers to questions they face in caring for patients, and for enhancing evidence-based practice and management. We have implemented a new system of program and portfolio management, which we hope will enhance program effectiveness and responsiveness. As described in this issue of *FORUM*, meeting the needs of patients remains the focus of our attention.

Shirley Meehan, M.B.A., Ph.D.
Acting Director, HSR&D

Case in point: A new medical center director heard from his staff how they had solved a persistent problem, that of patients showing up late for their appointments. The solution seemed simple. The staff made a rule to have the front desk clerks tell any patient who showed up as little as five minutes late that he or she would not be seen and must re-schedule.

"Each time a patient calls for an appointment, contacts a nurse advice line, or visits one of our clinics, we have an opportunity to exceed that veteran's expectations."

The director later attended a meeting that included many patients. There he heard a very different story. The patients told him how long they had to wait for appointments. When they finally arrived for the appointment, the nearest parking space was blocks away. When they entered the hospital, they found no one to give them directions. And of course when they finally got to the clinic, the clerk told them they were late, their appointment was canceled, and they should return home and call for another appointment.

At the next staff meeting, the director explained that the rule had to be changed. Staff members, wanting to accommodate the new director, recommended that the grace period be extended to 10 minutes.

The director knew that the battle for patient loyalty was often won or lost at a clinic's front desk. He told staff they should never create a situation where patients would automatically be turned away. Whether the patient was 30 minutes late or a day late, the response should always be: "We are glad to see you. Sorry you missed your appointment. Let's see if we can work you in, but if we can't, I'll help you get another appointment."

He then enlisted a group of volunteers, gave them red jackets to wear and assigned some to drive golf carts to distant parking lots to pick up patients — a job the volunteers loved. (Some innovative VA medical centers have created valet parking services to help ensure that their patients arrive on time). Other red jacket volunteers were assigned the task of providing directions to patients entering the lobby. Then the director developed a customer service training program for the entire staff and began to deal with the access problem.
This is just one example of how to create a patient-centered environment.

As we care for service members returning from their missions across the globe, we should review our rules and how they are perceived by today's veterans, who may have different needs and preferences than our established veterans. For example,

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Resources on Patient-Centered Care

The Advanced Clinic Access Handbook, now under development, will be an excellent source of information for VA staff. VHA Information Letter 99-02 promoted shared decision-making, a component of patient-centered care. The Institute of Medicine report *Crossing the Quality Chasm: A New System for the 21st Century* (National Academy Press, 2001) advocated patient-centered care while providing a broad view of our nation's health care. *For information about ongoing HSR&D studies focused on patient-centered care, check the studies database on the HSR&D web at www. hsrd.research.va.gov/research/.*

Response to Commentary

Patient-Centered Care in the VA: A Research Perspective

By Lisa V. Rubenstein, M.D., M.S.P.H., Edmund F. Chaney, Ph.D., HSR&D Centers of Excellence, Sepulveda and Seattle, respectively; Jeffrey L. Smith, Ph.D., Candidate, HSR&D Mental Health QUERI

Increasing the patient-centered focus of care potentially holds great promise for improving the quality of health care delivered to veterans. Making care more patient-centered involves encouraging an increasingly diverse veteran population to take an active role in partnering with their health care team. These changes have implications both for VA clinical managers and staff and for health services researchers. Just as patients and clinicians work best together, teams made up of VA clinical managers, staff, and researchers will be in the best position to evaluate whether organizational redesign, structural enhancements, and other accommodations intended to facilitate the provision of patient-centered care— such as those described in Dr. Cross' commentary— produce desired results.

Clinical staff in a patient-centered VA health care system will actively seek to elicit patient preferences about health care decisions, and will demonstrate that patients are valued by responding to stated preferences when an alternative course of care is not clearly indicated. Indeed, evidence has suggested that patients may experience more favorable outcomes when they receive the care they prefer; and quality improvement interventions that support patient choice have been shown to improve the likelihood of patients receiving preferred treatments.

To help ensure that patient preferences reflect *informed* decisions about care alternatives, researchers will need to partner with patients and clinicians to develop effective patient education tools and strategies to enhance patient awareness of the most effective evidence-based treatments.

Traditional research designs such as randomized controlled trials may need to be enhanced to allow greater consideration of patient and clinician treatment preferences and to more closely reflect routine clinical practice. Clinicians have often criticized the traditional research enterprise as taking too long to produce relevant clinical findings. In helping to make effective care more patient-centered, investigating and disseminating results quickly will be an even greater challenge.

Chronic care is an important issue for many veterans. Research is needed to identify and implement effective strategies to help patients with chronic illness be informed and activate health care consumers and to help them improve their ability to self-manage their care, consistent with the chronic care model. With its Computerized Patient Record System, the VA may be an ideal health care system for researchers to develop and test innovative informatics tools to help support patient self-management of chronic illness. For instance, the Office of Care Coordination has a specific focus on evaluating technology that will improve the ability of patients and clinicians to communicate important care information quickly and easily between the patient in his home and the physician in her office.

More fundamentally, developing a health care system that is truly patient-centered will likely require VA researchers to increasingly incorporate participatory research methods into their work, where veterans are provided the opportunity to have a more active voice in setting the research agenda, defining the specific issue(s) to be addressed in quality improvement research initiatives, and in proposing and suggesting refinements to intervention tools and strategies that may help improve the quality of care. Participatory research requires different approaches than more traditional health services research, and increased use of participatory methods may require some researchers to develop new skills and knowledge.

Researchers within the VA Quality Enhancement Research Initiative (QUERI) are becoming increasingly adept at using participatory research strategies to implement evidence-based practices in VA health care settings. More information on QUERI research strategies and tools is available in the on-line QUERI Guide to Implementation Research at www.hsrd.research.va.gov/queri/implementation. Also, the Agency for Healthcare Research and Quality (AHRQ) recently released a systematic review of the evidence concerning participatory research in the community, which VA may find useful in its efforts to partner effectively with veterans in projects to improve patient care and outcomes.

Finally, as noted in Dr. Cross' commentary, many VA facilities and clinicians are already providing high-quality patient-centered care. Researchers should work actively with administrators, clinical leaders, and patients in these facilities to learn about key determinants and best practices that facilitate their provision of patient-centered care. They should then seek to transfer such knowledge and innovative practices to other VA facilities through novel intervention strategies. *In essence, researchers should play the role of both student and teacher of innovation within the VA health care system.* In that way, researchers may enhance their capacity to play an active and critical role in helping the VA realize its purpose to make care for veterans increasingly patient-centered. ■

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Measuring the Patient's Experience of VA Health Care

By Charles Humble, Ph.D., Jim Schaefer, M.S.P.H., Director of Analyses, and Barbara Fleming, M.D., Ph.D., VA Office of Quality and Performance

Until the mid-1990s, patient satisfaction surveying in the VA was essentially the responsibility of local facilities. Though these local surveys may have been adequate for quality improvement purposes, they were usually a side duty of staff inexperienced in survey methods and statistical analysis. Without a standard system-wide process, it wasn't possible to develop national data and compare facility scores across the system.

In the early 1990s, the Picker Institute used national focus groups with patients and close collaboration with health care providers to identify "dimensions" of the patient experience that resonated with providers. In 1993, VA's Office of Quality Management (predecessor of today's Office of Quality and Performance or OQP) partnered with the Picker Institute to develop a national program of patient satisfaction surveys for veterans.

We conducted our own focus groups with veterans around the country and produced separate questionnaires for Inpatients and Outpatients. These questionnaires are based on the Picker dimensions (called "standards" in VA surveys; see accompanying chart) but include extra dimensions and questions for aspects of care important to VA patients.

After a pilot survey in 1994, VA conducted the first national surveys of inpatients and outpatients in 1995. In 2002, OQP further expanded the questionnaires by including items on health status (SF-12V), sources of care (VA versus non-VA), availability of health insurance, healthy behaviors, and body mass. These expanded surveys are referred to as the Survey of Health Experiences of Patients (SHEP). Since 2002, questions on immunizations, complaint resolution, women's issues, and spiritual needs have been included by request from other VA offices.

The SHEP serves both quality improvement and performance measurement functions. The standard scores serve as high-level flags that providers and administrators can use to identify areas that need attention. When a given standard falls substantially below national benchmarks in a particular bed section or clinic, process action teams can examine the question scores to identify specific barriers to patient service.

Similarly, question scores for specific programs, such as immunization use, have been used to identify subgroups of veterans who are underusing VA services. This information can then be used to develop outreach programs to address the disparities. The surveys also help VA facilities meet the requirements of the Joint Commission on Accreditation of Healthcare Organizations.

Finally, five VA Performance Standards are based on specific SHEP questions regarding overall ratings of care and access to care. Survey management in OQP relies heavily on input from the SHEP Advisory Group, with half of its membership drawn from field-based colleagues.

Since SHEP was created, weighted sampling and analyses have been used to counterbalance the greater probability of selection in smaller bed sections and clinics in our earlier surveys. To provide data more frequently and more rapidly, we concentrated survey efforts on monthly samples and web-based results reporting.

Recently, we have conducted pilot tests to test the importance of various components of the Dillman Method, the industry standard for collecting data via mailed surveys. The goal is to identify which mailings might be eliminated to speed the survey cycle and reduce costs without affecting accuracy. ■

Access to SHEP data is available by filing a Data Use Agreement to OQP through Dr. Steven M. Wright, Steven.Wright@va.gov.

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Veteran Health Care Service Standards

- Provide timely access to health care
- Treat patients with courtesy and respect
- Support patient's emotional needs
- Provide information and education about condition, treatments and tests
- Have one provider or team in charge of care
- Coordinate both visit specific and overall health care needs
- Insure patient involvement in decisions about care
- Meet physical comfort needs
- Provide timely and appropriate pharmacy services
- Provide a smooth transition between inpatient and outpatient care
- Overall rating of VA health care

New Study Finds Teamwork Culture Linked to Higher Patient Satisfaction in VA Hospitals

By Mark Meterko, Ph.D., Center for Organization, Leadership, Management and Research

Increasingly, organization culture is being recognized as an important factor in the performance and adaptability of health care organizations. A number of studies have pointed to the importance of teamwork or employee collaboration in particular as being associated with such positive outcomes as the implementation of quality improvement processes and lower nurse turnover. However, we could find no studies that examined the relation between teamwork culture and one key health care outcome: patient satisfaction. This is a potentially important area of inquiry for VA where patient satisfaction is used as a measure of performance. Why might teamwork culture affect patient satisfaction? We believed that the connections could be both direct and indirect. On one hand, a culture emphasizing teamwork may help cultivate effective coordination among health care providers, which several studies have shown to be positively associated with quality of care. More indirectly, social exchange theory and research on "service climate" suggest that the exchange of support among employees who collaborate to serve customers will strengthen employee motivation to provide excellent service, which in turn could lead to higher customer satisfaction.

We set out to test the hypothesis that a teamwork-oriented culture in hospitals was positively associated with patient satisfaction using the extensive and unique national databases available in VA. Specifically, organizational culture data were obtained from a survey of VHA employees that we conducted in 2000 as part of the National Quality Improvement Survey (NQIS). A component of that survey, yields scores on a 0-100 scale for four dimensions of culture that represent competing values or priorities for organizations:

- teamwork (emphasis on collaboration among departments and employees)
- entrepreneurial (emphasis on calculated risk-taking and innovation)
- bureaucratic (emphasis on formal policies and chain of command)
- rational (emphasis on task completion and production)

The NQIS survey questionnaire was mailed to as many as 150 employees at each VHA hospital, based on a stratified random sampling procedure. A total of 16,405 employees were surveyed; 8,454 (52 percent) responded.

We obtained data on patient satisfaction from the VHA national database created and maintained by the Office of Quality and Performance. For this study, we used the inpatient and outpatient satisfaction data collected in 2000, the year for which the organization culture data were also available.

Ultimately, we collected complete data for 125 acute-care facilities. Among the four types of culture, bureaucratic received the highest score (mean = 44.1), followed by rational (23.7), teamwork (18.6), and entrepreneurial (13.2). Thus, the bureaucratic dimension was most prevalent across VA hospitals and entrepreneurial the least. The mean hospital-level score for inpatient satisfaction was 73.6 and the mean hospital-level score for outpatient satisfaction was 79.2.

Our analysis showed that two of the four culture dimensions were statistically significant in the inpatient models. Specifically, teamwork culture was positively associated with inpatient satisfaction and bureaucratic culture was negatively associated with inpatient satisfaction.

We found that teamwork culture had the strongest relation to patient satisfaction. In the study sample, organizations with relatively high scores on teamwork culture had significantly better inpatient satisfaction scores. The research literature suggests that a relation between teamwork culture and inpatient satisfaction may be mediated, at least in part, through more effective coordination among employees and through greater cohesion among employees working toward the same goal.

The relation between bureaucratic culture and inpatient satisfaction was somewhat smaller but negative: the greater the emphasis on bureaucracy, the lower the level of inpatient satisfaction. Certainly, in a hospital setting, adherence to rules and regulations is necessary to ensure quality control in the delivery of patient care. However, a high emphasis on bureaucratic culture may deter employees from finding new ways of improving patient care that contribute to better patient satisfaction.

Outpatient satisfaction was not related to any of the culture dimensions. This finding might reflect in part the relatively limited amount of time that some patients have with their hospital and its employees when receiving outpatient care.

This study extends a growing line of research demonstrating the importance of teamwork culture to the performance of health care organizations. Our investigation is the first we are aware of to examine the relation between independent measures of organizational culture and patient satisfaction. ■

For detailed results, see: Meterko M, Mohr DC, Young G.J, Teamwork culture and patient satisfaction in hospitals. Medical Care *2004; 42(5): 492-8.*

Seriously Ill Patients Care More About Outcomes of Care Than Treatment Burdens in End-of-Life Decision-Making

By Terri Fried, M.D., VA Connecticut Healthcare System

Grounding treatment decision-making in patients' preferences is at the core of patient-centered care. Yet incorporating preferences into end-of-life decision-making poses considerable challenges. Several studies supported by HSR&D have helped to elucidate these challenges and provide the data and tools necessary to overcome them.

In order to make patient preferences a part of everyday treatment, we must first find a way to elicit those preferences in a way that is meaningful to patients. Other research has shown the importance of treatment outcomes to decision-making among the elderly. We developed a novel instrument to elicit preferences based on a comprehensive assessment of patients' attitudes toward treatment burden weighted against the likelihood of desired versus undesirable outcomes.

The instrument pairs descriptions of low-burden and high-burden therapies with a range of possible outcomes, such as physical and cognitive impairment. It first asks the patient whether he or she would want therapy if the outcome were known with certainty and then as the likelihood of the outcome varies. Using visual aides, the instrument allows patients to consider the complex concept of uncertainty in their preferences.

We administered this instrument among 226 older persons with advanced congestive heart failure, chronic lung disease, and cancer to illustrate the central role that health outcomes play in the preferences of elderly people. We found that many more patients chose not to have therapy on the basis of a poor outcome than on the basis of the burdens imposed by the therapy. In addition, a large majority of patients were unwilling to risk an outcome of severe physical or cognitive impairment.

This study and the work of other VA investigators help shift the framework for eliciting preferences, from one based on preferences for specific treatment interventions, such as resuscitation, to one based on preferences for the outcomes of those interventions.

"The outcomes patients desire for themselves frequently differ from the outcomes that caregivers desire for the patient."

A second challenge to ensuring patient-centered end-of-life care involves communication between patients and caregivers, who frequently are called upon to make decisions on behalf of seriously ill patients. Examining patient-caregiver pairs in this same study group, we found that large proportions of both patients and caregivers desired greater communication with one another. Unfortunately, these desires were frequently mismatched. Among the pairs in which caregivers desired more communication, 83 percent of patients did not. And among the pairs in which patients desired more communication, 67 percent of caregivers did not. In addition, caregivers who desired greater communication had significantly higher caregiver burden scores than caregivers who did not, suggesting that enhancing caregiver-patient communication may decrease caregiver burden. This lack of communication likely underlies the finding that the outcomes patients desire for themselves frequently differ from the outcomes that caregivers desire for the patient.

Improving patient-physician communication is a third challenge to eliciting and honoring patients' preferences. Communication about prognosis, a critical determinant of preferences, is particularly problematic. In this study, patients and caregivers alike frequently disagreed with their clinicians as to whether communication on prognosis had actually occurred. Even among physicians who reported having discussed the possibility of death with their patients— certainly a fundamental question—69 percent of patients said they had not.

Patient-centered care for seriously ill patients means that patients' preferences should guide treatment decision-making. Eliciting and understanding those preferences will depend on improving patient-physician and patient-caregiver communication, with a focus on patients' valuations of the outcomes of care. ■

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For complete references, please contact terri.fried@med.va.gov.

HSR&D Study Identifies Barriers to Shared Decision-Making Among Newly Diagnosed Prostate Cancer Patients

By Charles L. Bennett, M.D., Ph.D., and E. Allison Lyons, B.A.
Midwest Center for Health Services and Policy Research

More than 220,000 men are diagnosed with prostate cancer each year. Upon diagnosis, each man faces a choice of five treatments: radical retropubic prostatectomy (RRP), external beam radiation therapy (XRT), brachytherapy, hormonal therapy, or watchful waiting (WW). With the exception of watchful waiting, each of these treatments is associated with several side effects, such as sexual functioning and incontinence with RRP, bowel function with XRT, and hot flashes and impotence with hormonal therapy.

Because of these considerations, physicians have begun to work with prostate cancer patients to choose the treatment that would work the best for the patient. This process is termed shared-decision making. In our current study of newly diagnosed prostate cancer patients at four sites in the Chicago area, including two VA hospitals, we have found two barriers that may affect shared decision-making: older age and low literacy skills.

Of the 258 patients participating in our study, 134 were over age 65. These geriatric patients were assessed for impairment using several validated tools, including the Mini-Cog, Mini Nutritional Assessment Short Form, and the Vulnerable Elderly Survey. Impairments dentified included: no social support (33 percent); cognitive impairment (33 percent); increased risk of decline in activities of daily living and death (13 percent); mobility (11 percent); undernutrition (19 percent); sensory impairment (36 percent); depressive mood (7 percent); and lack of social support (6 percent).

These impairments could easily prevent patients from actively participating in shared decision-making. Considering that more than 60 percent of our geriatric patients had at least one impairment, we conclude that older age can have serious effects on the patient's ability to participate in a shared decision-making process.

Race is another factor often cited as a barrier to screening, access to care, and treatment. In our study, we found that low literacy may be an even more significant barrier than race in the case of prostate cancer patients. We found that African American men had higher PSA levels (median of 9.8 versus 6.3 ng/ml) and were more likely to have literacy skills below a seventh-grade level (25.3 percent versus 9.7 percent) than white men. But after adjusting for age, annual income, marital status, and site of care, individuals with low health literacy skills were 2.1 times as likely to have high PSA levels at the time of diagnosis, while the odds of presenting with an elevated PSA were similar for African American versus white men. This information is significant because patients presenting with higher PSA levels and low health literacy may have greater difficulty understanding educational materials about their treatment options and gaining access to health care systems, including the VA.

The availability of different treatments for prostate cancer enables each patient to work with his physician to choose a treatment that is most appropriate and will provide the best quality of life for him. It is important for physicians to recognize and address barriers to shared decision-making, such as older age and low health literacy. ■

2005 HSR&D National Meeting

The Veterans Health Administration faces many challenges, including the aging of and increasing prevalence of significant medical comorbidities among the veteran patient population. The 2005 HSR&D National Meeting will address these challenges with the theme "Improving Care for Veterans with Chronic Illnesses." The conference will be held February 16-18, 2005 in Washington, DC. VA health services researchers will come together to present a broad array of their research methodologies and results with particular emphasis placed on productive patient/provider interactions, specifically improvements in care that are evidence-based, population-based, or patient-centered.

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we're seeing increasing numbers of women veterans. Rather than make assumptions, we should ask them how they would like their health care environment arranged. Several small studies have indicated that women veterans have mixed opinions about enrollment to separate "women-only" clinics. However, we do know that privacy is paramount to them. Remember that simple things can make a big difference — to all patients. For example:

- Always knock before entering the exam room if the patient is already there (and wait for a reply!).
- Ask for permission before allowing anyone else to enter the room or participate in any part of the exam.
- Ensure that privacy curtain is used and arrange the room for maximum privacy during gynecological exams.

Many of today's returning veterans are young, and they may be accompanied by small children. How will our patient-centered medical facilities accommodate them? Some medical facilities, recognizing the difficulty and expense of arranging for child care, allow patients to bring their child into the exam room during the parent's routine visit.

We're also seeing more veterans who enjoy using computers. They may rely on the Internet for medical advice. One innovative VA medical center, recognizing the importance of Internet access for this generation of veterans, created a special room where patients could surf the Internet during their inpatient stay.

Finally, let's recognize that having the patient come to see us is not always the best answer. Patients respond well to phone follow-up for some conditions. And as we figure out how to meet the requirements of the Health Insurance Portability and Accountability Act, more providers will stay in touch with their patients via email. As technology advances, more and more health care monitoring will be performed in the comfort of the patient's own home, or in the workplace.

Many VA facilities are already providing patient-centered care, even if they have not put that label on it. But many improvements can be made. Research can help us become more patient-centered by identifying best practices for meeting the needs of our changing veteran population.

So, let us take pride in our progress, understanding all the while that there is always more to be done. ■

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