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Statewide Survey Identifies Major Opportunities to Improve Patient-Centered Care

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Statewide Survey Identifies Major Opportunities to Improve Patient-Centered Care
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“The most important way to improve my practice is to improve the quality of electronic medical record (EMR) products, so that they actually help rather than hinder patient care. I appreciate the potential promise of EMR, but current EMR quality is far below that promised by bureaucrats, researchers, and EMR vendors.”-Physician in a mid-sized community health center

“Coaches or site coordinators would help to navigate the maze.” - Small Private Clinic Physician

“I am supportive of processes that pay me to do better with what I can control, such as ordering specific tests, doing specific exams, or NOT doing things that evidence suggests I should not do. I am less supportive of payment for RESULTS...I can’t change outcomes when patients can’t or won’t comply sometimes” -Physician in a mid-sized hospital/outpatient clinic

INTRODUCTION

Primary care physicians (PCPs) are being challenged to provide higher quality and more patient-centered care. The Patient-Centered Medical Home Model has been demonstrated to improve healthcare quality as well as patient and physician satisfaction by fostering patient self-management, team-based care, work flow redesign, care coordination, patient–centered care, population health focus, and open access.1-3 Many states like North Carolina and Louisiana have launched major statewide efforts to support the development of patient-centered medical homes.4,5 However, poorly aligned reimbursement mechanisms and inadequate quality improvement (QI) infrastructure make adoption of emerging best practices difficult. Little is known regarding PCPs’ practice improvement needs and preferences and their willingness and ability to implement new models for delivery of effective primary care.6 This study seeks to assess challenges faced by PCPs in their efforts to improve quality of care, their level of interest in adopting new best practices in the ambulatory setting, and to learn what types of ambulatory QI support they need most to improve care for the patients they serve.

METHODS

The data for this study were collected using an on-line survey of a convenience sample of PCPs (including internal medicine, family practice, and general practice specialties) and practice managers in practices throughout Tennessee. The survey was conducted using Qualtrics, an online data collection tool widely used by academic and business professionals around the world. The survey instrument was developed using key informants and focus groups to identify domains of interest, piloted in a convenience sample of 70 physicians and practice representatives at a regional ambulatory QI conference, and revised. The final survey assessed: practice/respondent characteristics (5 questions), challenges to improving care delivery (7 questions), and quality improvement preferences (8 questions). Physicians were identified using the Tennessee Medical Association physician directory database and the Tennessee Board of Medical Examiners database of actively practicing physicians and were invited to participate through e-mail, regular mail, personal invitation by peers, medical society outreach and publications, and direct communication at regional and statewide medical meetings. Pre-survey communication, intensive phone follow up, flexible response options (computer-based survey vs. phone interview), multiple e-mail reminders and telephone calls, and expansion of the original period of data
collection were used to increase response rate. Despite repeated efforts to encourage participation, the current sample includes 255 completed surveys. No incentives were offered to respondents for their participation. Once the data were collected, the records were exported to SPSS for analysis. All research protocols were reviewed and approved by the Institutional Review Boards of the University of Memphis and the University of Tennessee prior to launching the survey.

RESULTS

Respondent Characteristics
The majority of respondents (N = 255) were physicians (94.5%), and 5.5% were practice managers. Of the physician respondents 75.7% were practicing PCPs and the remaining 18.8% included specialists, hospitalists, residents, emergency physicians, and physicians with blended roles. Fifty-eight percent of practice settings were private clinics, 22.0% hospital or university-based outpatient clinics, 2.7% federally qualified health centers, and 2.7% other safety net community health centers. The remaining respondents (14.1%) worked in nursing homes, emergency departments, local health departments, and student health centers.

Practices ranged widely in size from those employing less than one full-time physician to those employing 250 or more providers. The majority of physicians surveyed (89.2%) work in small or medium-sized practices consistent with the makeup of primary care practices in Tennessee as a whole. Large practices with 25 providers or more represent 10.8% of all respondents, medium-sized practices with 4-24 providers—47.9%, and small providers with 3 or fewer providers—41.2%. The mean number of providers per practice, including MDs, nurse practitioners, and physician assistants, was 13.7 (standard deviation [sd] = 31.2). The number of practice locations also varied from 1-72 with a mean of 3.7 sites (sd = 8.0). The number of patients served per day in each practice averaged 77.6 patients (sd = 86.9).

Over half of small practices and three quarters of large practices reported having implemented electronic health records (EHR). Patterns of adoption were directly related to practice size. Large practices were much more likely to use EHRs than small practices. Furthermore, the majority of respondents agreed that EHR functions including clinical decision support, electronic receipt of lab and other diagnostic testing results, and exchange of health information across care settings are important for high-quality patient care. However, EHR functions such as patient access of personal health information or the ability to report quality performance measures were considered less critical.

Challenges to Improving Care Delivery
Survey respondents acknowledged that many patients do not receive needed services in a timely manner, and the percentage of patients always receiving recommended care varied considerably according to the needed service considered (Figure 1). Whereas approximately two-thirds reported that patients in their practice always received follow up appointments within 30 days of hospital discharge, only 15% reported that patients in their practice always received needed resources for self-management support. Overall, patients always received recommended care less than half of the time for six of eight recommended services. These results suggest significant potential to improve quality in the primary care setting.

Approximately two-thirds of provider practices reported staff participation in some level of structured quality improvement strategies (Figure 2). However, practice improvement activities were less likely to be data-driven. Two-thirds of respondents agreed or strongly agreed that their practice had sufficient resources and infrastructure to commit to practice improvement. Perceived availability of resources and infrastructure to commit to practice improvement was not found to vary by practice size.
Figure 1: Percentage of respondents reporting that patients in the practice always receive the following recommended services when needed.

Quality Improvement Preferences
The majority of providers were very interested in resources to support practice improvement in the following critical components of high quality care: open access (66.4%), patient engagement (57.9%), work flow redesign (57.7%), patient-centered care (55.8%), and care coordination (54.7%). The majority of providers (86.3%) also reported being receptive to sharing quality improvement resources among providers within the community.

Respondents preferred the following organizations for each of the following specific types of practice improvement support: academic centers were preferred for continuing medical education (43%), private consultants for EHR adoption (27%) and practice improvement coaches (24%), the Tennessee Medical Association (TMA) for peer to peer learning networks (26%) and formal group processes (22%), and regional health improvement collaboratives for care coordination nurse training (16%) and community-wide coordination of care (22%). However, the Medicare quality improvement
organization, regional medical societies, health plans, and provider networks were viewed as valuable sources of support in several areas.

**Figure 2:** Frequency of practice participation in the following quality improvement strategies.

The majority (68.2%) of respondents were very or somewhat supportive of pay for performance (P4P) in general. Furthermore, 87.4% were very or somewhat supportive of P4P for processes of care (e.g., diabetic A1c testing and LDL testing), 67.7% were supportive of P4P for health outcomes (e.g., diabetic A1c and LDL control), 80.4% were supportive of P4P for improvements in processes of care, and 69.4% were supportive of P4P for improvements in health outcomes.

**DISCUSSION**

This study underscores the need for primary care practice improvement across the State of Tennessee. These efforts need to be evidence-based and coordinated across local care delivery markets. Tennessee PCPs recognize that their practices often struggle to provide the care their patients need most and they are interested in expanded access to practice improvement resources and assistance in developing primary care infrastructure. PCPs are ready to transform their practices into medical homes and are
eager to deliver more effective population-based care. But they know they cannot do this alone.

PCPs and practice managers in Tennessee see practice EHR data as critical to improving care, yet few practices are adept at using data-driven strategies to galvanize practice improvement efforts. The adoption of EHR by primary care practices has increased significantly over the past few years as a result of EHR incentive programs and Regional Extension Center support to providers for adoption and meaningful use and private consultants have been critical supports for implementation. However, PCPs are often disappointed in EHR capabilities and they still need support to implement critical EHR functionalities. This survey confirms that Tennessee PCPs have made major steps to employ advanced health information technology but that this technology, while necessary, is not sufficient to substantially improve ambulatory care.

Federal initiatives are helping Tennessee invest in patient-centered medical home capacity. The Center for Medicare and Medicaid Innovation’s State Innovation Models program is supporting Tennessee’s work with multiple payers to test episode-based payment models for specialty care and comprehensive care payment for primary care. Under Tennessee’s Health Care Innovation Initiative, Tennessee plans to “move from a visit- and volume-focused primary care payment and delivery system to population- and value-based models, with the intent to cover 80% of lives under value-based payment over the next five years.”7,8 State support of payment models for population-based comprehensive care within the context of a patient-centered medical home has the potential to jump start primary care practice improvement efforts in Tennessee.

Market forces driving ongoing payment reforms also may help to support collaborative practice improvement efforts. The report of the National Commission on Physician Payment Reform recently recommended changes from fee-for-service to payment approaches based on quality and value that would “encourage...[small] practices to form virtual relationships and thereby share resources to achieve higher quality care.”9 Small practices care for roughly nine out of ten Americans both in Tennessee and the U.S. as a whole. With the growth of new payment models that pay for quality and value, these small practices can greatly benefit from virtual relationships that allow them to share critical practice improvement resources. Regional health improvement collaboratives and medical societies can provide invaluable support for such virtual relationships. For example, Healthy Memphis Common Table and Memphis Medical Society are leading Project Better Care precisely to support sharing of critical practice improvement resources among small practices in West Tennessee. Such regional efforts to organize small practices to work together to build patient-centered medical home capacity are to be applauded.

PCPs are generally supportive of pay for performance models. However, PCPs show preference for payment models that incentivize improved processes of care rather than improved health outcomes. Physicians recognize that patients also bear responsibility for health outcomes, and some are leery of payment incentives that hold them responsible for factors outside of their direct control. This survey suggests that PCPs in Tennessee will appreciate assistance in employing patient engagement strategies that support shared accountability between patients and providers for improving health outcomes.

Tennessee physicians are widely supportive of collaborative QI approaches that share practice resources across communities and they recognize that regional health improvement collaboratives can help support community-wide coordination of care. Given the small size of most primary care practices in Tennessee, this approach seems realistic. This research suggests that PCPs would welcome regional efforts to share such community-based resources that small individual practices cannot afford to develop on their own. Now is the time to organize on a regional level to share critical practice improvement resources in order to raise the standard of care in Tennessee.
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References


