Tennessee Survey Shows Primary Care Physicians Lack Critical Resources to Improve Patient Care

Introduction

This statewide survey of primary care physicians was designed to give voice to the real practice improvement needs of Tennessee physicians. The survey sought to learn from Tennessee physicians what supports they need most in order to improve care for the patients they serve. The survey was conducted in collaboration with the Tennessee Medical Association (TMA), the Tennessee Academy of Family Physicians, and regional health improvement collaboratives in Tennessee with the support of BlueCross BlueShield of Tennessee. The purpose of the study was to assess both challenges faced by primary care physicians in Tennessee in their efforts to improve care for their patients and the types of quality improvement (QI) support they prefer most. The results of this study will be used to support regional efforts to develop the ambulatory QI supports most needed by primary care physicians throughout Tennessee.

Primary care physicians and practices are being challenged to develop medical home capacity and to serve their patients in new ways. The Chronic Care and Patient-Centered Medical Home Models championed by the American College of Physicians, American Academy of Family Practice, and Society of General Internal Medicine have been demonstrated to improve care by fostering patient self-management, team-based care, work flow redesign, care coordination, patient-centered care, population health focus, and open access for patients to ambulatory care when and where they need it. However, little is known regarding providers’ practice improvement needs and their level of interest in adopting new best practices in the ambulatory setting. This survey seeks to address this gap in knowledge and explores options for supporting the practice improvement efforts of primary care physicians in Tennessee.

Highlights

- Chronic illness care can be improved through known best practices, but little is known regarding physician readiness to adopt these improvement practices.

- Less than two-thirds of physicians indicated that their practice routinely participates in common practice improvement activities.

- Less than one-third of physicians strongly agree that their practice has the resources and infrastructure to commit to practice improvement.

- Primary care physicians recognize that a large percentage of their patients do not get needed care.

- 86.3% of respondents support collaborative quality improvement efforts that share practice improvement resources among practices throughout the community.

Patient Quality of Care

Primary care physicians want to provide a high quality of care to their patients. However, historical reimbursement approaches do not pay for many of the services such as care coordination that contribute to high quality of care. System-level changes are needed to make sure all patients get the right care at the right time. Survey respondents acknowledge that many patients do not receive needed services in a timely manner (Figure 1). Fewer than half reported that their patients had access to needed education classes, counseling sessions, or support groups for chronic disease education or self-management support. Few physicians (15%) reported their pa-

Figure 1: Estimated Percentages of Patients Always Receiving Services
Respondent Characteristics

A total of 255 respondents participated in this research. The majority were physicians (94.5%), and 5.5% were practice managers. Of the physician respondents 75.7% were practicing primary care physicians and the remaining 18.8% included specialists, hospitalists, residents, emergency physicians, and physicians with blended roles. 58.4% 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 are 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 (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

“...The most important way to improve my practice is to improve the quality of 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

Electronic Health Records

Large practices are much more likely to use electronic medical records than small practices. Regional Extension Centers (RECs) are an important source of support to providers for EHR adoption and getting to meaningful use. As of November 2011, RECs across the country have worked with over 100,000 primary care providers (1/3 of all primary care providers) to transition from paper records to certified EHRs [HHS, 2011]. However, 2012 is the last year that providers can participate in the Medicare EHR Incentive Program and still receive the maximum incentive payment. Although EHR adoption has not likely reached critical mass across the State of Tennessee, 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.

![Figure 2: EHR Use by Practice Size](image-url)

- Practices that Use EHR by Size

- Yes
- No
Research Methodology

The data for this study were collected using an online survey of a convenience sample of primary care providers (including internal medicine, family practice, and general practice specialties) and practice managers in practices throughout three grand regions across Tennessee. The survey was conducted using Qualtrics, an online data collection tool. The survey instrument was developed collaboratively by the authors and was divided into three sections: (1) practice/respondent characteristics, (2) challenges to improving care delivery, and (3) quality improvement preferences. Although a quota sampling approach was planned to ensure representation of providers practicing in small-, medium-, and large-size practices throughout each region, a convenience sample was ultimately employed because of low response rates. Physicians were identified using the Tennessee Medical Association physician directory database and the Tennessee Board of Medical Examiners database of actively practicing physicians. Physicians were invited to participate through email, letters of introduction with a survey link, 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. The current sample includes 255 completed surveys. The mean time to complete the survey online was just over 11 minutes. 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.

Practice Improvement Activities

Approximately two-thirds of provider practices reported some level of staff engagement in activities related to practice improvement (e.g., staff meetings, goal setting, strategic planning by practice leadership. However, these activities are less likely to be data-driven. Less than one-third of all practices felt strongly that their practice had sufficient resources and infrastructure to commit to practice improvement (Figure X). Although we anticipated some variation in this finding by practice size, the findings did not support this hypothesis.

Providers in this study were interested in resources that can support practice improvement in all critical components of high quality care. The ability to improve open access to care was of greatest interest among providers followed by helping patients to become more involved in decisions about care [patient engagement] and supporting patients’ ability to manage chronic diseases [self-management support].

The majority of providers also seem receptive to sharing resources for quality improve among providers within the community with 86.3% saying they would be supportive of such an initiative.

“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

![Figure 3: Percentage of Service Activities Usually or Always Done](image-url)
When asked which organizations were best be able to support primary care practice quality improvement needs, physicians indicated that: 1) Academic centers are best-suited to provide CME, 2) Private consultants are preferred for electronic health record adoption and practice improvement coaching, 3) The Tennessee Medical Association (TMA) is preferred for facilitating peer-to-peer learning networks and formal practice improvement group processes, and is also commonly recommended for practice improvement coaching, 4) Regional health improvement collaboratives are preferred for community-wide coordination of care and care coordination nurse training, and 5) Health plans, regional medical societies, and the TMA are also viewed as leading sources of support for nurse training and community-wide coordination of care. Few physicians feel that practice improvement activities could be best coordinated through state agencies.

**Conclusion**

This study underscores the need for practice improvement. Physicians acknowledge that some patients do not always receive needed services in a timely manner. The use of electronic health records, which has the potential to affect practice improvement, is more common in larger practices. Perhaps the most important finding of this research is the fact that physicians are widely supportive of collaborative QI approaches in which practice resources can be shared across communities. One-third of those surveyed did not believe their own practice had the resources and infrastructure to commit to practice improvement. By maximizing the use of limited resources in communities, practice improvement is an achievable goal and providers seem amenable to working together to achieve these goals. Improvements in patient engagement, patient-centered care, and overall care coordination were recurring themes throughout this project. Physicians in this study have acknowledged the gaps in services but they have also voiced their shared interests in pursuing QI.

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**Figure 4: Available Resources and Infrastructure**

**Figure 5: Percentage of Physicians Very Interested**

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**Sources:**
