'Gatekeeper' Model Linked To Worse Patient Outcomes

BY BRUCE JANCIN
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ATLANTA — The primary care gatekeeper model in which physicians have financial incentives to minimize specialist referrals was associated with poorer quality of care in a large study of cardiovascular outcomes in diabetic patients, Dr. Shaista Malik reported at the annual meeting of the American College of Cardiology.

In addition to examining the impact of financial incentives, the study also looked at the relationship between physician use of computerized clinical information systems (CIS) and cardiovascular outcomes. The investigators found that the more reliant a provider group was on CIS that promote care in accordance with national guidelines, the better the patients' cardiovascular outcomes, said Dr. Malik of the University of California, Irvine.

She presented an analysis from Translating Research Into Action for Diabetes (TRIAD), a large observational study involving adults with diabetes enrolled in managed care plans. Her analysis encompassed nearly 10,000 patients in six states, along with 57 primary care provider groups participating in 10 health plans. Data were obtained via highly detailed physician surveys, patient records, and administrative databases.

During the study period of 2000-2001, slightly more than half of the physicians functioned as gatekeepers, meaning they were paid more for fewer referrals to specialists. In a multivariate analysis, their patients proved to be 55% more likely to be out of control with respect to LDL cholesterol levels, as defined by an LDL level of at least 130 mg/dL, than were patients of physicians who weren't gatekeepers.

Gatekeepers' diabetic patients were also an adjusted 25% more likely to have a systolic blood pressure of 140 mm Hg or above, and twice as likely to be hospitalized for heart failure, a cardiovascular end point that health policy analysts often use as a proxy for suboptimal care, Dr. Malik continued.

In contrast, physicians who were paid extra for higher patient satisfaction and quality of care measures were 24% more likely to have patients on lipid-lowering therapy when warranted than were providers without such incentives. Similarly, the compensated physicians' patients with a history of coronary heart disease were 30% more likely to be on a β-blocker and only half as likely to be hospitalized for heart failure, compared with patients whose physicians didn't have financial incentives aligned with quality and patient satisfaction measures.

"These data indirectly suggest that pay for performance may be an effective strategy," she observed.

Patients whose physicians made extensive use of guideline-based clinical information systems had a 45% reduction in the relative risk of heart failure hospitalization, compared with the patients of physicians who made little or no use of these computer tools. The physicians using CIS also had patients with coronary heart disease who were 41% more likely to be on a β-blocker. Moreover, cardiovascular mortality was 51% less in patients whose doctors relied on CIS.

Asked which components of the CIS correlated most strongly with favorable patient outcomes, Dr. Malik singled out electronic provider feedback. An example would be a computerized system that notifies the physician about patients who have an unacceptable LDL or blood pressure level.

Dr. Malik's study was funded by the National Institutes of Health and the Centers for Disease Control and Prevention, which recently provided additional money for the research. ■

Lawmakers Share Their Health Care Reform Ideas With Docs

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — Wouldn't reform be nice? That seemed to be the message from politicians speaking at a national advocacy conference sponsored by the American Medical Association.

Democrats and Republicans told the audience of politically active physicians about their ideas for addressing problems with Medicare reimbursement, the medical liability system, and, more generally, a health care system that is failing both physicians and patients.

"If our health care system doesn't work for doctors, it doesn't work," said Sen. Hillary Clinton (D-N.Y.).

"It's fair to say that the AMA and I did not see to eye to eye," said Sen. Clinton, referring to her failed health care reform proposal when she was First Lady. "But it is 12 years later, and we have many of the same problems."

Sen. Clinton may not have been speaking to the friendliest audience, but she drew resounding applause from the physicians when she proposed that Congress stop legislating Medicare reimbursement freezes and replace the sustainable growth rate formula with something better.

Physicians at the meeting heard similar rhetoric from other lawmakers.

"Most of us don't want to go through this annual ritual," said Rep. Nathan Deal (R-Ga.). However, he also said that fixes are expensive and doctors should not expect them to happen this year.

Rep. Edward Markey (D-Mass.) proposed that Congress form a task force to review the sustainable growth rate over a 2-year period and increase physician reimbursement 5% a year in the interim.

Lawmakers from both parties also noted that physicians need relief from skyrocketing medical liability premiums in many states.

Republicans continue to push for caps on noneconomic damages in medical malpractice lawsuits, an approach supported by states in which similar caps have been linked to slower increases in liability premiums. Democrats oppose caps because caps put limits on legitimate lawsuits.

"Caps don't get to the heart of the problem," said Sen. Clinton. Instead, Congress needs to bridge the gap between medical liability reform and error-reporting legislation.

She cited the University of Michigan's "Sorry Works!" initiative—a program that encourages doctors and their insurers to be honest when mistakes happen, offer apologies, and provide compensation up front to patients and their attorneys—which has cut liability costs, freeing up new money to improve systems that can reduce errors.

Democrats and Republicans showed a similar divide on the uninsured.

Rep. Markey said that the government should expand Medicare, Medicaid, and the Federal Employees Health Benefits program to include more of the uninsured.

Rep. Tom Price (R-Ga.) said the last thing government should do is take over the responsibility for providing health care from private entities.

The Democrats said that the government should spend more money on prevention and research, which has the potential to lower costs over the long run. Republicans said that what is needed is a marketplace that allows individuals to "own" their coverage while making them more aware of the cost of health care. ■