UCLA
UCLA Previously Published Works

Title

Physician compensation and quality of diabetes care: Preliminary results from the triad study

Permalink

https://escholarship.org/uc/item/4r18p0mn

Authors

Kim, C
Steers, WN
Herman, WH
et al.

Publication Date

2006

Peer reviewed

eScholarship.org Powered by the California Digital Library
University of California

higher proportion of women than men engaged in each activity. There were no differences by physician specialty, practice size, or age. Among the 102 intervention physicians (88 men and 14 women), 64% accessed the toolbox, 51% the guidelines, 27% the literature watch and 16% participated in all 3 of these intervention components as well as completing at least one case (intense users). Though not statistically significant, physician participation in the intervention components appeared inversely related to physician practice size and women appeared more likely than men to participate in all components except accessing guidelines; 29% of women vs. 14% of men, p=0.2, were intense users. There were no differences in the use of intervention options by physician specialty or age.
CONCLUSIONS: Given the very large and still expanding population of physicians reachable through the Internet, a recruitment rate of 10% represents a potentially significant group to be enlisted in Internet-delivered quality improvement interventions. Our findings of differences in recruitment and participation rates by physician specialty and sex, and of differential use of the options offered by the intervention, should guide future efforts to use the Internet as a delivery system for quality improvement efforts.

PHYSICIAN CHARACTERISTICS ASSOCIATED WITH BEING A PROFICIENT LEARNER-CENTERED TEACHER. E. Menachery[1]; A.M. Knight[1]. [1]Johns Hopkins University, Baltimore, MD. *(Tracking ID # 156666)*

BACKGROUND: Medical education relies heavily upon medical learners' self-awareness and motivation. Clinical competence and professional growth is thought to occur more efficiently, effectively, and satisfyingly when a learner-centered approach to medical education is taken. This study's primary objective was to identify characteristics that are associated with physician teachers' proficiency in leaner-centered teaching skills.
METHODS: A cohort of 363 physicians, who were either past participants of the Johns Hopkins Faculty Development Program or members of a comparison group, were surveyed by mail in July 2002. Survey questions asked the physicians about personal characteristics, professional characteristics, teaching activities, self-assessed teaching proficiencies and behaviors, and scholarly activity. The learner-centeredness scale, a composite learner-centeredness variable, was developed using factor analysis. Logistic regression models were then used to determine which faculty characteristics were independently associated with scoring highly on a dichotomized version of the scale.
RESULTS: Two hundred and ninety-nine physicians responded (82%) of whom 262 (88%) had taught medical learners in the prior 12 months. Factor analysis revealed that the six questions from the survey addressing learner-centeredness clustered together to form the 'learner-centeredness scale' (Cronbach's Alpha: 0.73). Eight items, representing discrete faculty responses to survey questions, were independently associated with high learner-centered scores: (i) proficiency in giving lectures or presentations (OR=5.1, 95% CI: 1.3–19.6), (ii) frequently helping learners identify resources to meet learners' needs (OR=3.7, 95% CI: 1.3–10.3), (iii) proficiency in eliciting feedback from learners (OR=3.7, 95% CI: 1.7–8.5), (iv) frequently attempting to detect and discuss emotional responses of learners (OR=2.9, 95% CI: 1.2–6.9), (v) frequently reflecting on the validity of feedback from learners (OR=2.8, 95% CI: 1.1–7.4), (vi) frequently identifying available resources to meet the teacher's learning needs (OR=2.8, 95% CI: 1.1–7.2), (vii) having given an oral presentation related to education at a national/regional meeting (OR=2.6, 95% CI: 1.1–6.0), and (viii) frequently letting learners know how different situations affect the teacher (OR=2.5, 95% CI: 1.1–5.5).
CONCLUSIONS: It may now be possible to identify medical educators that are more learner-centered in their approach to medical education. Beyond providing training to help physicians become more proficient learner-centered teachers, training programs that want to improve the overall quality of teaching among their faculty may wish to promote the teaching behaviors and proficiencies that are associated with high learner-centered scores identified in this study.

PHYSICIAN COMPENSATION AND QUALITY OF DIABETES CARE: PRELIMINARY RESULTS FROM THE TRIAD STUDY. C. Kim[1]; W.N. Steers[2]; W.H. Herman[1]; C.M. Mangione[2]; K.M. Venkat Narayan[3]; S.L. Ettner[2]. [1]University of Michigan, Ann Arbor, MI; [2]University of California, Los Angeles, Los Angeles, CA; [3]Centers for Disease Control and Prevention (CDC), Atlanta, GA. *(Tracking ID #150277)*

BACKGROUND: Few studies have explicitly examined the association between physician compensation and quality of care. One study suggested that physicians paid primarily by salary provided better quality care than those paid fee-for-service.
METHODS: We examined the cross-sectional association between physician-reported compensation strategies and quality of care in the Translating Research Into Action for Diabetes (TRIAD), a study of diabetes care in managed care. Eight of the 10 TRIAD health plans contracted with 1 to 26 provider groups (total of 68 groups) to provide care; participants in this analysis included 4200 individuals with diabetes and their physicians (n=1248). Main outcome measures included diabetes process measures over the past year (assessment of hemoglobin A1c (HbA1c), proteinuria, and lipids; performance of dilated eye exam, foot exam, influenza vaccination; and advice to take aspirin), intermediate outcomes (HbA1c<8.0%, low-density lipoprotein cholesterol level <130 mg/dL, and systolic blood pressure level <140 mmHg), and management intensity (2 or more oral agents or medications for glucose control; 1 or more lipid-lowering agents for hypercholesterolemia; and 2 or more anti-hypertensive agents for hypertension). The primary independent variable was physician-reported percent of total compensation from salary as compared to fee-for-service. Percent compensation was modelled as a continuous variable. Physician covariates included gender, race/ethnicity, specialty, and years of practice; patient covariates included age, gender, education, income, body mass index, smoking, type of diabetes treatment, quality of life, and presence of other insurance. Hierarchical mixed-effects models adjusted for clustering within health plans and physicians. We calculated the difference in predicted probabilities of each outcome associated with a change in the percent compensation from salary from 10% to 90% (i.e., the predicted probability if the sample had reported 90% compensation from salary, minus the predicted probability if the sample had reported 10% compensation from salary). Differences greater than zero indicated a higher probability of the outcome with a greater percent compensation from salary.
RESULTS: Patients of physicians who reported higher percent compensation from salary (>90% vs. <10%) were not any more likely to receive any diabetes process measures, nor were they more likely to have better intermediate outcomes. Greater percent compensation from salary was also not associated with reports of getting needed care or satisfaction with communication.
CONCLUSIONS: Salary, as opposed to fee-for-service compensation, was not associated with diabetes processes and intermediate outcomes. Financial incentives may not be an effective means of improving diabetes quality of care.

PHYSICIAN FACTORS ASSOCIATED WITH DISCUSSIONS ABOUT END-OF-LIFE CARE. N.L. Keating[1]; M. Landrum[1]; S. Rogers[2]; S. Baum[3]; B. Virnig[4]; H.A. Huskamp[5]; C. Earle[6]; K.L. Kahn[7]. [1]Harvard University, Boston, MA; [2]Brigham and Women's Hospital, Boston, MA; [3]University of Alabama, Birmingham, AL; [4]University of Minnesota, Minneapolis, MN; [5]Harvard Medical School, Boston, MA; [6]Dana-Farber Cancer Institute, Boston, MA; [7]University of California, Los Angeles, Los Angeles, CA. *(Tracking ID # 152854)*

BACKGROUND: Guidelines recommend advanced care planning for patients with terminal illness and life expectancy of 1 year or less. We described physicians' reports of when they discuss prognosis, do not resuscitate (DNR) status, hospice, and preferred site of death for terminally ill patients and identified factors associated with timing of these discussions.
METHODS: Survey of physicians (57% response rate) from 7 population-based sites in the U.S. who cared for lung or colorectal cancer patients participating in the CanCORS study–a national study of patterns and outcomes of cancer care. Physicians were named by patients as providing key roles in their care. The survey asked physicians to assume they were caring for a patient newly diagnosed with metastatic cancer who is otherwise feeling well, with an estimated life expectancy of 4–6 months. They were asked when they would discuss prognosis, DNR status, hospice, and preferred site of death. Response options were "now", "when the patient first has symptoms", "when there are no more non-palliative treatments", "only if the patient is hospitalized", and "only if the patient or family bring it up". We used logistic regression models to identify physician factors independently associated with having discussions "now".
RESULTS: The mean age of the 2,699 responding physicians was 50.2 (SD 9.9), 82% were male, and 25% were surgeons, 16% medical oncologists, 7% radiation oncologists, and 52% non-cancer specialists. Sixty-six percent of physicians would discuss prognosis "now", while 18% would have this discussion only if the patient/family brings it up. Forty percent would discuss DNR status "now" with 20% waiting for the patient to have symptoms and another 25% waiting until there were no more nonpalliative treatments. Only 25% would discuss hospice "now" with 16% waiting for symptoms and 50% waiting until there are no more nonpalliative treatments. Finally, 20% would discuss preferred site of death now. In multivariable analyses, younger physicians were more likely to discuss prognosis, DNR status, hospice, and preferred site of death "now" (all P<0.001). Surgeons were more likely than noncancer specialists to discuss prognosis "now" (P=0.008), but noncancer specialists were more likely than surgeons, medical oncologists, and radiation oncologists to discuss DNR status, hospice, and preferred site of death "now" (all P<0.001). Physicians with more terminally ill patients were more likely than others to discuss prognosis "now" (P=0.04) and physicians in office (vs. hospital) practice were more likely to discuss hospice "now" (P=0.001).
CONCLUSIONS: Many physicians do not discuss end-of-life options with terminally ill patients while they are still feeling well, instead waiting for onset of symptoms or until there are no more non-palliative treatments to offer. Younger physicians and noncancer specialists are generally more likely to discuss end-of-life options sooner than older physicians and cancer specialists. Despite guidelines recommending these discussions occur early, our findings suggest that different types of physicians have very different views regarding the appropriate timing. More research is needed to understand physicians' reasons for timing of their discussions, patients' preferences for timing, and the role of physicians' propensity to treat metastatic cancer on the timing of discussions. Education and physician interventions may be necessary to increase advanced care planning for terminally-ill cancer patients.

PHYSICIAN RESPONSE TO THE "BY-THE-WAY" SYNDROME IN PRIMARY CARE. P. Rodondi[1]; J. Maillefer[1]; N. Rodondi[1]; P. Singy[2]; J. Cornuz[1]; M. Vannotti[2]. [1]Department of Community Medicine and Public Health, University of Lausanne, Lausanne; [2]Department of Psychiatry, University of Lausanne, Lausanne. *(Tracking ID # 151310)*

BACKGROUND: Exploring all patient's requests during a medical encounter represents a difficult task. In some encounters, the patient raises a new problem just at the end of the visit, which has been called the "by-the-way" syndrome. Little is known about the content of the questions asked and physician response. We aimed to analyze this syndrome, physician response to it and the predictors of its apparition.
METHODS: We videotaped a gender-stratified random sample of 24 encounters in a primary care outpatient clinic. Patients were aged 19–90 and 50% were women. We performed a qualitative and quantitative analysis of patient-physician encounters and examined the predictors of the apparition of the "by-the-way" syndrome, defined as a new problem raised by the patient during the