



PHYSICIAN PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

January 2007

EDITORIAL

Study Shows Value of Integrated Medical Groups 2

STRATEGY

System Delivers Outcomes Feedback 3

TECHNOLOGY

Web Presence Builds Patient Loyalty 6

PATIENT CARE

Physician and Pharmacist Collaboration Boosts Quality 9

PRACTICE MANAGEMENT

Here's Help for Patients in Part D 12

CAPITAL IDEAS

Liability Risks in General Partnerships 15

Study Shows Value of Integrated Medical Groups

Physician Practice Options has often reported on how organizational structure of physician groups influences results. Now, as we enter our 12th year of publishing the newsletter, it is interesting to note that a new study supports this contention. The study shows that the structure of physician groups influences the quality of care groups deliver. The study was supported by a grant from the Commonwealth Fund (at www.cmwf.org), a foundation in New York that promotes a high-performing health care system.

In an article, "Do Integrated Medical Groups Provide Higher-Quality Medical Care than Individual Practice Associations?" in the *Annals of Internal Medicine*, Dec. 5, researchers reported that integrated medical groups (IMGs) provided higher-quality care compared with individual practice associations (IPAs).

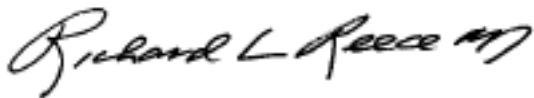
At one end of a wide spectrum of physician group organizations are IMGs, which the researchers defined as centralized organizations that employ physicians in partnership arrangements and own and manage their facilities. At the other end of the spectrum are physicians in IPAs who work under non-exclusive contracts and typically manage their own offices. In the middle were physician groups that the researchers called hybrids.

Using data from physicians in California, the researchers examined the use of three preventive measures (percentage of eligible patients who had mammography, Pap tests, and chlamydia screening) and three chronic disease management measures (percentage of diabetic patients receiving a retinal examination, asthma patients receiving controller medication, and patients receiving a beta blocker after acute myocardial infarction), the fund reported.

Patients in IMGs were more likely than those in IPAs to receive four of six services: mammography, Pap test, chlamydia screening, and diabetic eye screening, the study showed. On these four measures, hybrid groups performed in the middle range between IMGs and IPAs. Even after adjusting the scores for factors including number of eligible patients, use of electronic medical records (EMRs), and proportion of board-certified physicians, IMGs had higher quality-of-care scores on the same four measures than IPAs, and hybrids were in the middle.

The authors suggest that the use of centralized decision-making and close collaboration in IMGs may be one reason these groups provided higher-quality care. Also, physician groups that cared for a larger number of patients were more likely to have greater resources to invest in improving care, the researchers suggested. The study is important because most physicians work independently in small practices, the researchers added.

It's gratifying to read these results because it validates our mission. Just as we have done for years, we will report once again in the coming year on physician groups that are striving to improve patient care through increased practice efficiency.



Richard L. Reece, MD

Editor in chief

Phone: 860/395-1501

Fax: 860/395-1512

E-mail: Rreece@premierhealthcare.com

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Neil Baum, MD
Urologist
New Orleans

Daniel Beckham
President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.

Thomas M. Gorey, JD
President and CEO
Policy Planning Associates
Crystal Lake, Ill.

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Premier Practice Management
San Diego

Harold B. Kaiser, MD
Allergy & Asthma Specialists, PA
Minneapolis

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President
The Kaufman Group
Division of Superior Consultant Co. Inc.
Physician and Hospital Consultants
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Evidence-based Medicine
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Medical Director
Carilion Healthcare Corp.
Roanoke, Va.

Bernard Rineberg, MD
Physician Consultant
BAR Health Strategies
New Brunswick, N.J.

James M. Schibanoff, MD
Editor in chief
Milliman Care Guidelines
Milliman USA
San Diego

Jacque Sokolov, MD
Chairman
Sokolov, Sokolov, Burgess
Scottsdale, Ariz.

Publisher

Premier Healthcare Resource, Inc.
150 Washington St.
Morristown, NJ 07960
888/457-8800; Fax: 973/682-9077
publisher@premierhealthcare.com

Editor

Joseph Burns
508/495-0246
editor@premierhealthcare.com

System Delivers Outcomes Feedback

A national registry that amasses comparative treatment and outcomes data on patients with rheumatic diseases is helping rheumatologists improve their quality of care. The registry, called the Consortium of Rheumatology Researchers of North America (CORRONA), collects data on 14,000 patients at 92 sites around the country, making it the largest registry in rheumatology that collects data from both rheumatologists and patients.

Particular aspects of the rheumatology specialty, such as the need to treat patients with complex conditions and use a variety of treatment options, make a national database such as CORRONA particularly important.

The CORRONA database is a good example of the kind of system that physicians in various specialties could use to manage the vast amounts of disparate data needed to provide quality care over time to patients with chronic disease.

Managing Complex Data

The development of CORRONA offers many lessons for other specialists interested in creating a registry. "In a few months, the federal Agency for Healthcare Research and Quality in Rockville, Md., will post a how-to, white paper on its Web site (at www.ahrq.gov) that will have full information about how to develop a registry," says Joel Kremer, MD, a rheumatologist with the Center for Rheumatology in Albany, N.Y., and

president of CORRONA. Kremer also offered some general suggestions for other specialists regarding lessons learned in developing CORRONA: include as much information as possible in the registry; expect, but don't be discouraged by, setbacks during development; and don't expect instant success, he says. "It's a marathon, not a sprint," he comments.

"Rheumatologists prescribe many complex medical therapies that have the potential for toxicity," says Joel Kremer. "Adding to this complexity is the fact that some of our patients also have significant comorbidities, such as compromised renal function, hypertension, or a history of infection. Furthermore, rheumatologists not only have to analyze the overall performance of the drugs they prescribe for individual patients, but they also have to consider the effect of therapies across groups of patients as well."

The database can help rheumatologists manage this complexity. "In an era when rheumatologists are struggling with the concept of electronic medical records, we are supplying rheumatologists with an electronic database they can mine for their own practices," Kremer continues. "CORRONA is more than just descriptive. Besides offering patient profiles, the database allows rheumatologists to interact with the information to create their own analyses. This feature has attracted a lot of interest among academics about the project."

Before CORRONA, there was no national database that could collect

drug safety and efficacy data moving forward in a prospective manner on all the drug therapies in use, Kremer continues. "The post marketing surveillance executed by an individual pharmaceutical company is limited to its own product," he explains. "Furthermore, because post-marketing surveillance depends heavily on voluntary reports by physicians, information on the safety and efficacy of drugs in widespread use is incomplete. More formal collection of drug performance data is important given the number of new rheumatology therapies developed in recent years."

The registry collects data on patients with rheumatoid arthritis and psoriatic arthritis. It is also used to collect data on osteoporosis, osteoporosis risk, and osteoarthritis in these patients. Data are collected every three months. "This ongoing data collection enables participants to see how these diseases are evolving around the country in real time as physicians can compare the characteristics of their practice to means within the database," Kremer says. "We can determine numerous outcomes such as hospitalization rates, adverse event rates, and comparative lab values."

Benefits for Physicians

Not only are participating rheumatologists contributing to the specialty's understanding of rheumatic diseases, but by completing the data collection forms they can provide a better level of patient care in their own practices. "The data collection forms are thor-

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The CORRONA database is a good example of the kind of system that physicians in various specialties could use to manage the vast amounts of disparate data needed to provide quality care over time to patients with chronic disease.

(Continued from page 3)

ough and inclusive, and as such they supply the rheumatologists with all the information they need moving forward for the treatment of their patients," Kremer says. "Collecting and analyzing the data facilitates better patient care, particularly for those patients who have complex diseases and are on different drug therapies."

CORRONA data allow rheumatologists to track the progress of individual patients. "Rheumatologists can create graphics to help them follow the development of clinical issues, using data such as joint counts or lab values," Kremer explains. "The physician can print out the graphics, which can be included in the patient's chart or given to the patient."

In addition, the rheumatologists can group their patients by diagnosis or by treatment to find patterns in care. Group practices can compare profiles of clinical populations among rheumatologists within the same practice.

Information Management

In fact, rheumatologists can do any number of analyses that will help them improve the quality of care they deliver to their patients. "For example, suppose a practice was interested in the incidence of disability in patients on different disease-modifying anti-rheumatic drugs (DMARDs)," suggests Kremer. "The rheumatologists in the group, who record disability in all their patients on the form, can mine the data after correcting for joint counts at baseline and disease severity to ensure that similar patients are being compared. The analysis would reveal the difference in disability among similar patients on various DMARDs." Similarly, rheumatologists could compare x-ray data, lab values, the incidence of opportunistic infections, and liver enzyme abnormalities among patients on different DMARDs or DMARD combinations. Then, they could change their own practice patterns or the drugs they prescribe based on the data.

Incentives Foster Data Collection

To encourage physicians to collect the data, CORRONA includes long-term data gathered from patients and physicians. The project provides monetary incentives to physicians who are paid for each form they complete. And, it provides non-monetary incentives to physicians by giving them electronic data summaries on their patients that they can use to pursue their own analyses.

Joel Kremer, MD, president of CORRONA, asserts that the physician and patient forms used to collect the data are efficient, user friendly, and streamlined. "The form takes the rheumatologist about eight minutes to complete for a baseline visit, and 2 to 3 minutes for a follow-up visit," Kremer says. "It is very important for the doctors to have a form that works well, that they can complete efficiently, and that gives them a sense that they are doing something worthwhile for their patients. We also wanted to provide incentives to the rheumatologists such that they would want to participate and would continue to participate over time."

The form collects the patient's diagnosis, the rheumatologist's estimation of the severity of the disease, and the disease activity. For rheumatoid arthritis patients, the form asks for a 28-joint count. "This count is essentially from the shoulders to the knees," explains Kremer. "An experienced rheumatologist can do it very quickly."

In another box, the rheumatologist indicates with a "yes" or "no" whether a patient has been hospitalized, whether he or she has developed a comorbidity, whether he or she has had a new x-ray or bone densitometry scan, and whether the rheumatologist has ordered new laboratory tests. "If the answer is no to these items, the form is complete," Kremer says. "If the answer is yes, then the rheumatologist provides further information by, for example, indicating the outcome of the lab tests."

The form also includes a modified version of a health assessment questionnaire (HAQ) that the physician completes. The HAQ yields data on functional ability and quality of life.

The forms comply with the Health Insurance Portability and Accountability Act, because the system is anonymous, Kremer adds. "CORRONA assigns each patient a nine-digit numerical code," he explains. "No one at the CORRONA offices ever sees the patient's identity or identifying information. Only the local site has the key to the codes."

After completing the form, the rheumatologists enter the data digitally on the Web or mail the forms to CORRONA's office where the data are entered. All data rheumatologists supply are available to them for analysis. "The compiled, computerized data facilitate rheumatologists' understanding of their patients' responsiveness to drug therapy," Kremer says.

—DJN

"There are many potential combinations of clinical data that can be analyzed using CORRONA," Kremer explains. "The database allows us to go beyond the realm of anecdotal impressions, which is the art of medicine that

we rely on currently. Rheumatologists are limited only by their imaginations in developing different analyses. Any academic or epidemiological interest in rheumatic diseases can be pursued."

As a Web-based system, the data-

base is available to physicians anywhere there is Internet access. "Thus, the database affords rheumatologists an opportunity to enhance the quality of care they provide, because all their patient information is easily accessible, and both patterns of care and trends in outcomes can be easily determined," Kremer says.

The registry also provides documentation for billing levels. "In order to bill at a certain level, rheumatologists must include a social review of systems, a symptom review of systems, a complete musculoskeletal examination, and a review of comorbidities," Kremer explains. "CORRONA is an extremely efficient system to capture all this information electronically.

Beginning next month, patients will be able to access their outcomes in CORRONA on the Web. "Patients will be able to view graphics illustrating trends in their health status with indicators such as joint counts and laboratory test values," Kremer says.

CORRONA data are being used to support state-of-the-art knowledge in rheumatology. Last fall, researchers at the American College of Rheumatology annual meeting presented 11 abstracts based on research from the CORRONA database. "We want to provide a legacy of improved care for patients," Kremer asserts. "If we, as an organization of experienced clinician researchers, can use our own database to garner good insights about best practices, suggest hypotheses that could be followed up in randomized controlled trials, and determine cost effectiveness of expensive drugs, we will meaningfully enhance the quality of care for

For More Information

Rheumatologists interested in participating in the CORRONA database and other physicians who have questions about the initiative can contact Joel Kremer, MD, a rheumatologist with the Center for Rheumatology in Albany, N.Y., and president of CORRONA. Kremer's e-mail address is jkremer@joint-docs.com. Physicians also can call Kim Hinkle, the CORRONA project coordinator, by phone at 518-533-1326.

patients with rheumatic diseases."

Kremer and his colleagues at CORRONA are planning to enhance the system in the coming months. "Over the next year, we would like to develop a system in which an actual number can be assigned to standardized outcome measures so that physicians will be able to determine from visit to visit whether the patient is numerically better or not," he says. "This type of measurement will help physicians track patients' health over time."

Decision Support

Kremer also wants to develop clinical decision support capability. "We would like to provide physicians with feedback on their outcomes as related to clinical guidelines that represent certain standards of care," he says. "Clinical decision support based on evidence-based medicine that offers appropriate prompts for care will enhance the value of our system and help rheumatologists improve their outcomes."

The database likely will have some utility when pay-for-performance initiatives expand. "Physicians need a tool to demonstrate that they are doing quality work," Kremer notes.

"The array of possibilities CORRONA provides means that physicians can quickly and easily track care given to individual patients or patient populations, get feedback on that care, improve their own quality, and track outcomes."

Quality Tracking

These types of quality tracking possibilities are similar to those available to physicians who use electronic medical records. "But the problem with EMRs is that none of them are tuned to rheumatology," Kremer notes. "CORRONA can provide those quality and outcome-related functions."

In addition, CORRONA executives are considering how to link CORRONA to popular EMRs to provide a value-added service to physicians. "If CORRONA can interface with an EMR, rheumatologists who use EMRs will not feel that they are duplicating their data collection activities. Instead, they will have access to the array of services we provide in terms of quality documentation specific to our discipline and still be able to tap into the benefits of their EMR system."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md.

"Physicians need a tool to demonstrate that they are doing quality work," says Joel Kremer, MD, of the Center for Rheumatology. "The array of possibilities CORRONA provides means that physicians can quickly and easily track care given to individual patients or patient populations, get feedback on that care, and track outcomes."

Web Presence Builds Patient Loyalty

As more patients become comfortable with the Internet, physicians have considered options for using the Web to help them build and maintain a loyal patient base. Two of the most common methods currently in use are e-mail communication and Web site development.

E-mail communication, which is so commonly used personally and professionally, is still not widespread between physicians and patients. "Physician-patient e-mail is not very well entrenched. Fewer than 25% of physicians are using e-mail to communicate with patients regularly," says Daniel Z. Sands, MD, MPH, senior medical informatics director of Cisco Systems, in San Jose, Calif. "However, e-mail is growing in popularity. As physicians overcome their reluctance to try it, they are enjoying the benefits of e-mail while finding that their initial concerns are largely unfounded."

Timely Communication

A primary care physician, Sands practices at Beth Israel Deaconess Medical Center and is assistant clinical professor of medicine at Harvard Medical School in Boston. An internationally known expert, author, and speaker, Sands co-authored the physician-patient e-mail guidelines from the American Medical Informatics Association in Bethesda, Md.

One benefit of e-mail communication is that it is asynchronous. "The two people communicating do not need to do so at the same time," Sands notes. "That allows patients and physicians to take their time when composing their messages. Moreover, when a physician sends a response to a patient's question, the patient can read it multiple times and show it to loved ones, facilitating understanding of the content. In contrast, the patient may forget more than half of what the physician says immediately following a telephone call or in-person conversation."

E-mail also can save time, reducing after-hours telephone calls, telephone tag, and the need to repeat information. "E-mail communication allows me to be more efficient," he says. "If I am waiting for a patient who is five minutes late for an appointment, I can't have a phone conversation in that amount of time but I can certainly send off a few e-mail messages."

Patient loyalty to a practice is another potential benefit. "The opportunity to e-mail their physician appeals to patients," Sands says. "Theoretically, if patients like e-mail, they will be more inclined to stay with a practice that offers it."

Despite patient interest, many physicians are reluctant to offer such communication. Frequently, physicians are concerned about legal lia-

bility. "Physicians fear that something they say on e-mail might be misconstrued, leading to a lawsuit," he says.

Legal Benefits

However, Sands counters by emphasizing that e-mail communication provides documentation that can protect a physician in a lawsuit. "Research has shown that only about 40% of telephone communication between physicians and patients are documented in the patients' records, a risk management nightmare," he says. "If there is nothing written in the record about a particular phone conversation, the doctor is in a questionable situation. In contrast, e-mails automatically provide a written record of communications that can easily be filed in patient records." There has been no increase in lawsuits among doctors who use e-mail to correspond with patients, he adds.

A second concern is that e-mail will be time consuming. "Physicians worry that they will be inundated with e-mails, which will take a long time to address," Sands notes. "And, generally, this is time that will not be reimbursed by payers. But this fear seems to be unfounded. In fact, data from Beth Israel Deaconess Medical Center and other sites around the country show that not only do physicians not experience the avalanche of e-mails they fear, but the e-mails

"When a physician sends a response to a patient's question, the patient can read it multiple times and show it to loved ones, facilitating understanding of the content. In contrast, the patient may forget more than half of what the physician says immediately following a telephone call or in-person conversation."

—Daniel Z. Sands, MD, MPH, Harvard Medical School

they do receive can often be answered quickly—many in less than two minutes.”

A Productivity Question

Another concern involves the potential loss of revenue-generating office visits if patient questions are addressed via e-mail. This too seems to be unfounded, Sands explains. “Studies show that physicians are not seeing a loss in productivity when they use e-mail,” he adds. “In fact, e-mail often helps physicians solidify their relationships with patients.”

Some physicians are apprehensive that patients will not use e-mail appropriately. “For example, physicians do not want a patient to communicate with them in an emergency when immediate attention is required,” Sands says.

Finally, physicians may have privacy and security concerns about e-mail, but these can be addressed satisfactorily. “Physicians can use an encrypted system, such as secure Web messaging or tools that allow for e-mail encryption,” notes Sands. “Many patients are comfortable using ordinary unencrypted e-mail to address medical issues, since they feel that they don’t have anything to hide given the nature of the messages they are sending to doctors.”

Handle with Care

Physicians can alleviate many of their concerns by developing an e-mail policy and reviewing it with patients. “It is incumbent upon physicians to have a discussion with patients explaining the appropriate and inappropriate use of e-mail, who may read the messages besides the physician, that messages will be included in the medical record, and

that security issues are a concern,” Sands says.

Susan Keane Baker, a practice management consultant in New Canaan, Conn., and an expert in physician-patient communication, agrees that e-mail should be used carefully. “For example, when communicating lab test results, the message sent if the test results are normal should be, ‘the test results are normal.’ If the test results are not normal, the message should be, ‘Please contact me.’ The patient may reply to the e-mail with a lot of questions and expect to receive a prompt response,” Baker says. “The notification of test results should give clear information about when the physician will be available to discuss the results.” Baker is the author of *Managing Patient Expectations: The Art of Finding and Keeping Loyal Patients* (San Francisco: Jossey-Bass, 1998).

A Deft Touch

As in all communication, misunderstanding is quite possible with e-mail. A misinterpretation of tone, a misunderstanding of information, and the loss of the personal touch are all risks when using e-mail. “Addressing the recipient of the e-mail within the body with a simple ‘Dear Mrs. Epp’ and ending with something such as ‘Warm regards’ can soften the e-mail message,” Baker suggests.

If a physician or other staff member in the practice is responding to a concern that is emotional or addresses a complaint, then that response should be made face-to-face or over the telephone, Baker recommends.

Some physicians may choose to implement an e-communication system that is more full-featured than

standard e-mail. “For example, physicians can use a secure messaging portal whereby the physician and the patient log in to a Web page in order to pick up their messages,” Sands says. “An added advantage is that such tools can be built around the messaging system. For example, at Beth Israel Deaconess, patients can request prescription renewals, appointments, and consultations, and can view their records online.”

Sands has a Web site, www.e-pcc.org, that offers advice about electronic patient communication and links to guidelines for patient-provider e-mail. He also provides e-mail rules that can be printed on the back of a business card; articles related to physician-patient e-communication; a list of practices that use e-communication; and companies that offer secure e-mail and Web-based e-communication.

Across the Web

Another common form of communication with patients involves the use of Web sites. Medical groups are developing sites to provide information about their practices, health education, and interactive communication for patients. “Every time a question can be answered for patients via a practice Web site, the patient is helped, and other patients are helped as well,” Baker says. “Furthermore, when a Web site provides an answer to a patient’s question, it means one less telephone call for your support staff, who can then concentrate on patients who have more pressing medical issues.”

Practice Web sites facilitate efficient information sharing among a practice’s entire patient base. A practice can post “Important: Flu Vaccine

(Continued on page 8)

Some physicians fear e-mail messages might be misconstrued, leading to a lawsuit but experts say e-mail communication provides documentation that can protect a physician in a legal case.

(Continued from page 7)

Information” in a red box on its home page, for example. Doing so allows patients to see at a glance how to obtain the vaccine. Also, the practice could explain any rules it has about the vaccine, such as one that requires a patient to have been seen in the practice within the past two years or other timeframe.

“It’s easy to provide up-to-date patient registration and patient education on a Web site,” Baker continues. “Patients can complete a medical history and registration form prior to their visit. Patient education can be accessed when it is most needed by the patient.”

A practice also can build patient loyalty by providing information about its providers on the Web. “Many patients want to feel a sense of connection with the person as well as the physician,” Baker says. “Physicians should be identified on the Web with at least a photograph. The practice also can highlight education, training, and professional interests. And, it’s a good idea to provide some personal information to make the physician seem more approachable.”

Online Tools

Practice Web sites vary in quality and detail. The Gastroenterology Center of Connecticut (at www.gastrocenter.org) is an example of an excellent site. The site provides extensive patient educational resources, including details about treatment and procedures and a streaming video on colonoscopy. The site also offers online patient registration, a list of accepted insurance plans, and links to each plan’s Web page. In addition to including physicians’ clinical qual-

ifications, the site provides personal profiles of all physicians, physician assistants, and nurses, and details about their families, hobbies, or personal philosophy regarding patient care. The information attempts to communicate that the practice is a warm and comforting place to receive care.

Site Work

When developing a site, practices should create one from the patient’s perspective, Baker counsels. “A list of frequently asked questions (FAQs) should pose questions as patients ask them,” she says. “For example, ‘How can I schedule an appointment?’ is more patient-oriented than ‘How you can schedule an appointment.’”

Physicians also should ask their support staff to determine which questions patients ask most frequently. “Their answers will guide you in providing the most helpful information,” Baker says.

Also provide information that will help orient patients to the practice, especially first-time visitors. “I often note practice Web sites that do not show a photograph of the building, which is important for patients trying to find the office,” Baker says. “And, some sites don’t provide information about where to park. Even if the news about parking isn’t good, it’s better to prepare patients than have them learn about it the hard way. Recently I contacted an organization and the support staff told me about a parking lot across the street. She advised me that they would want to keep my car keys, which allowed me to take my home and office keys off the key ring before arriving at the parking lot. She also

said, ‘Please remember to bring your ticket in with you, so that we can validate your parking for you.’ That was very helpful information for me to have and I appreciated it. Patients would appreciate that kind of information on a Web site as well.”

If new patients need to complete paperwork when they arrive, put these forms on the Web site, so they can fill them out at home. In addition, practice sites should avoid the following mistakes, which can be highly irritating:

- Failure to show contact information on every page
- Links that don’t work
- No link back to the home page on every page.

Building Trust

Furthermore, outdated information, such as a profile for a physician who has left the practice, or hours of operation that are no longer valid, will undermine the value of the site and dissuade patients from visiting. “Saying that the group participates with an insurance company when that is no longer the case is asking for trouble,” Baker warns. In terms of reliability and building trust, Baker adds that sites should show the dates when pages were last updated.

“Someone should be responsible for reviewing the site from start to finish at least once every six months,” she adds. “In multidisciplinary practices, the Web pages should be printed and distributed for review and sign-off at least twice a year. A Web site is not a one-time initiative, but rather an ongoing project for review.”

—Reported and written by Deborah J. Neveleff, in North Potomac, Md.

“When a Web site provides an answer to a patient’s question, that means one less telephone call for your support staff, who can then concentrate on patients who have more pressing medical issues,” says consultant Susan Keane Baker.

Physician and Pharmacist Collaboration Boosts Quality

Coordination of care by physicians and pharmacists can improve the quality of patient care, according to pharmacists and physicians. Each profession brings specialized training and skills to medicine, and working collaboratively enhances the value of individual experience. Physicians are beginning to realize that pharmacists can provide the expertise needed to improve drug therapy and patient self-care skills.

Quality and safety in patient care depend on a conscious collaborative effort among health care providers, says Barbara Muller, MD, a professor of clinical medicine in the Department of Internal Medicine at the University of Iowa Hospitals and Clinics in Iowa City. "Using the clinical expertise of all frontline professionals is critical to ensuring quality," she adds. "The role of the pharmacist at the point of care has evolved from a dispensing-based role to that of being an integral member of the health care team."

Working Together

"An empathetic and trusting pharmacist-patient relationship is now widely recognized as the cornerstone of pharmaceutical care," says Randal McDonough, PharmD, an associate professor in the College of Pharmacy at the University of Iowa who has developed a model for successful collaborative practice.

"It's long overdue," says Timothy P. Stratton, PhD, an associate professor

in the Department of Pharmacy Practice and Pharmaceutical Sciences in the University of Minnesota's College of Pharmacy. "Physicians and pharmacists working closely together is a very good idea, but professional rivalries remain too common."

Rivalries notwithstanding, McDonough and others say that several societal trends are leading to an increased need for greater collaboration among pharmacists and physicians. These include:

- The presence of considerable drug-related morbidity and mortality
- Rapid innovations in medicine and pharmaceuticals
- The growth of managed care, causing the movement of patients from inpatient to outpatient care
- More demands on physicians' time
- The growing need for pharmaceutical care in an aging population.

Yet some physicians resist collaborative arrangements. "While all five of those factors call for closer pharmacist-physician collaboration, efforts to convince physicians to fully use pharmacists' skills to help manage patients' drug therapy have had limited success," McDonough says. "There are always boundary or turf concerns, and communication between all medical professionals can be difficult. For one thing, power issues can arise around who has the final say about a patient's care. Then there can be a lack of trust in another practitioner's competence, an issue made worse if practice sites are distant from each other."

Older practitioners, especially those who have not had training in interdisciplinary care, may be slower to support collaboration with pharmacists, McDonough adds. Another factor is education. "Practitioners whose training included an interdisciplinary approach to patient care are more likely to collaborate with other practitioners," he comments.

The type of practice can also play a factor. Although primary care physicians may have opportunities to interact with other team members and form collaborative working relationships, specialists are more accustomed to working with other providers because their education and training reinforce this concept, McDonough explains. Endocrinologists often work with nurses, dietitians, and pharmacists to care for patients with diabetes, for example.

Arrangements Fall Short

Ironically, most pharmacists are already working with physicians, says McDonough, although the arrangements typically fall short of true collaboration. "This usually begins with engaging in interactions of a discrete nature, such as dispensing prescriptions that are faxed or telephoned to the pharmacy, identifying adverse drug interactions, and answering drug information questions," he says. "Most community pharmacists limit their interactions with physicians to such activities and do not regularly discuss whether a drug is therapeutically opti-

(Continued on page 10)

"An empathetic and trusting pharmacist-patient relationship is now widely recognized as the cornerstone of pharmaceutical care."

—Randal McDonough, PharmD, University of Iowa

(Continued from page 9)
mal for the patient.”

Pharmacists have come to expect unbalanced exchanges with physicians, says McDonough. “Efforts to increase the quality of interactions with physicians tend to be unilateral, meaning the pharmacists prompt the exchanges,” he says.

Indeed, he adds, pharmacists should make physicians aware of the resources they can provide. He suggests these five steps:

1. Inform targeted physicians of their interest in collaborating
2. Identify pharmacy services that complement a physician's practice
3. Discuss ideas with physicians to judge their interest
4. Refine ideas to meet the needs of physicians
5. Meet with physicians to discuss collaborating.

An Evolving Role

Muller of University of Iowa Hospitals and Clinics says the evolving role of physician-pharmacist collaboration in multidisciplinary settings appeared to become more prevalent after The Institute of Medicine issued a report in 1999, *To Err is Human: Building a Safer Health System*. The immense variety and complexity of medications make it impossible for nurses or doctors to know all that's required for safe medication use, the report said, adding that the pharmacist has become an essential resource. “That report changed things,” Muller says. “The medical and pharmacy professions began recognizing and even seeking an evolving collaborative role.”

Soon after the IOM study was published, the 115,000-member American College of Physicians (ACP) emphasized the need for increased collaboration between physicians and pharmacists. “Given the changing role of pharmacists and pharmacy automation, physicians need to be proactive and find new ways of working with pharmacists in order to enhance patient safety and

Medication Therapy Management Programs

The American Pharmacists Association, a trade organization in Washington, D.C., of more than 57,000 pharmacists, lists services to include in medication therapy management programs in a report, *Understanding Medicare Reform: What Pharmacists Need to Know*. These include:

- Selecting, initiating, modifying, or administering medication therapy
- Monitoring and evaluating a patient's response to therapy and providing recommendations regarding necessary changes
- Managing and monitoring drug therapy in patients receiving treatment for cancer or chronic conditions such as asthma and diabetes
- Consulting with patients and families on proper medication use
- Conducting wellness and disease prevention programs to improve public health
- Overseeing medication use in such settings as homes, hospitals, ambulatory and long-term care facilities, clinics, and intensive care units.

care. Working with pharmacists, particularly in the area of medication errors, is one way to do that,” said former ACP President Sandra Adamson Fryhofer, MD.

The ACP encourages continued research into the effects on pharmacy practice of automation and an increasing professional emphasis on the PharmD degree. It also endorses physician-directed pharmacist-physician collaborative practice agreements, but only if they limit pharmacist involvement to patient education and hospital rounds. It supports the use of pharmacists, as allowed by state laws, as an immunization information source, host of immunization sites, and provider of immunizations.

“By partnering collaboratively with pharmacists, physicians will be able to avoid turf battles and focus on their primary mission: high quality patient care,” the ACP says. “Pharmacists can educate physicians on drug interactions and cost savings, as well as educate patients on drug safety, while physicians provide safe, effective care to patients.”

Although an ACP position paper allows for limited therapeutic substitutions in institutional settings, the

ACP opposes allowing pharmacists prescriptive privileges and initiation of drug therapy. However, state and federal law has evolved. Since the IOM report, 41 states allow collaborative practice agreements (CPAs) between physicians and pharmacists, says the American Society of Health-System Pharmacists (ASHP) in Bethesda, Md.

Practice Agreements

The American College of Clinical Pharmacy (ACCP) in Kansas City, Mo., says CPAs are arrangements “between one or more physicians and pharmacists wherein qualified pharmacists working within the context of a defined protocol are permitted to assume professional responsibility for performing patient assessments; ordering drug therapy-related laboratory tests; administering drugs; and selecting, initiating, monitoring, continuing, and adjusting drug regimens.”

In most states, a CPA requires a drug therapy management protocol, which the ACCP defines as “a written plan that delegates legal prescriptive authority to pharmacists under designated circumstances.”

Seven states (Alabama, Delaware,

Maine, Massachusetts, Missouri, New York, and Oklahoma) ban the practice outright. The laws and regulations of the remaining states are open to interpretation, ASHP says.

Some states, such as Louisiana, Pennsylvania, and West Virginia, have adopted collaborative practice legislation but implementation is highly regulated. For example, the Pennsylvania Pharmacy Practice Act was amended in June 2002 to permit drug therapy management in institutions, but the regulations the pharmacy board was required to write to implement the law are not finalized.

ASHP officials say no one knows how many pharmacists are taking advantage of new CPA laws. But Susan Winckler, RPh, vice president for policy and communications of the American Pharmacists Association (APhA), says the profession is making great progress. "In some states you might have physicians willing to collaborate on immunizations and emergency contraception but who are more hesitant about collaborating on treating patients with diabetes or asthma," she adds.

The Part D Effect

The federal government may be moving ahead of the states. The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) mandates that health plans and pharmacy benefit management companies participating in the Part D drug benefit pay pharmacists for medication therapy management (MTM).

Under MMA, MTM would:

1. Enhance enrollee understanding through beneficiary education,

counseling, and other means

2. Increase enrollee adherence to prescription medication regimens, for example, through refill reminders or special packaging
3. Detect adverse events and patterns of overuse and underuse of prescription drugs.

The law requires that drug plans have an MTM program and offer it to beneficiaries:

- With multiple chronic diseases (including, diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure)
- Who use multiple medications covered under Part D
- Whose expenses on those medications will cost more than \$4,000.

Plans are required to compensate MTM providers only for services provided to targeted beneficiaries. However, pharmacists may provide MTM services to non-targeted beneficiaries, but they must be informed that the services are not covered by Medicare and that the beneficiary is responsible for 100% of the cost. Beneficiaries are not obligated to participate in an MTM program. As of now, the law says that any provider (including physicians and nurses) can provide MTM services.

A consortium of professional organizations recommended these services to the Centers for Medicare & Medicaid Services (CMS) as possible sources of MTM compensation:

- Assessing the status of patients' health
- Formulating prescription drug treatment plans
- Managing high cost specialty medications

- Evaluating and monitoring patient response to drug therapy
- Coordinating medication therapy with care management services
- Participating in collaborative drug therapy management.

Cognitive Services

A consortium of state pharmaceutical organizations worked with ACCP to prepare guidelines that the state pharmaceutical boards want CMS to follow. If CMS follows the ACCP recommendations, pharmacists will get paid for any cognitive service, such as diabetes management or smoking cessation counseling, offered to Medicare patients under Part D. Private plans may do so as well if MTM is cost effective. "Pharmaceutical care can be part of care management, especially for chronic diseases," says Glen Stettin, MD, vice president of clinical products for Medco Health Solutions of Franklin Lakes, N.J.

Pharmacists say pharmaceutical care is about enhancing the management of high maintenance patients. As government initiatives begin, McDonough and others believe collaborative relationships between physicians and pharmacists will evolve. "As pharmacists and physicians begin to exchange information, each provider assesses the other's performance," McDonough says. "These assessments help the providers recognize each other's value, build trust, and develop satisfaction with the relationship. The main beneficiary will be the patient."

—Reported and written by Martin Sipkoff, in Gettysburg, Pa.

“By partnering collaboratively with pharmacists, physicians will be able to avoid turf battles and focus on their primary mission: high quality patient care,” says the ACP. “Pharmacists can educate physicians on drug interactions and cost savings, as well as educate patients on drug safety, while physicians provide safe, effective care to patients.”

Here's Help for Patients in Part D

By Michael Bihari, MD

More than 20 million Medicare beneficiaries are enrolled in prescription drug plans, either freestanding plans or one that is part of a Medicare managed care plan. Most of these plans have a coverage gap, the so-called doughnut hole, during which an enrollee must pay for the full cost of their prescription drugs.

Inevitably, patients who fall into this coverage gap have questions for their physicians and office staff. While it's impossible to answer every question satisfactorily, there are steps physicians can take to ease the burden of having to explain the intricacies of a complex federal law. These strategies involve being prepared for the questions you'll get, identifying a staff member to answer most of them, and preparing material that patients can read at home.

Providing Assistance

According to a Kaiser Family Foundation survey, almost 40% of Medicare beneficiaries will look to their physicians for information about the prescription drug plans (PDPs). Since physicians are at the forefront, they must be familiar with the basic structure of Part D and be able to answer questions, discuss potential issues, and know where to refer patients (or family members in some circumstances) for more assistance. Many physicians are not comfortable with such dialogue. However, such interaction is necessary, not only to provide comfort and reassurance, but to manage patients' care effectively.

Recognizing the law's complexity, physicians should be willing to educate their patients about the benefits and pitfalls of Part D. By being engaged in addressing issues that may

prevent patients from filling prescriptions, physicians may help their patients adhere to their treatment plans. Many physicians, of course, aim to maximize the time they can spend with their patients. Therefore, it may be best to designate a staff member to educate patients about Part D and to help them address their concerns.

Prescription Drug Plans

Under Part D, most PDPs do not offer the standard Medicare benefit. A Kaiser Family Foundation report, *The Medicare Prescription Drug Benefit, An*

- The amount of premium charged
- The extent of drug coverage in the doughnut hole. There could be no coverage or coverage for generic drugs only, or for brand-name drugs.
- Which pharmacies to use.

The Doughnut Hole

The doughnut hole, or coverage gap, is one of the most controversial parts of the Medicare Part D prescription drug benefit and of concern to many beneficiaries. Although all prescription drug plans must explain the coverage gap in their literature, the doughnut hole comes as a shock to

The doughnut hole, or coverage gap, is one of the most controversial parts of the Medicare Part D prescription drug benefit and of concern to many beneficiaries.

Updated Fact Sheet, published in November, showed that 12% of PDPs nationwide will offer the standard drug benefit this year. In addition, the majority of PDPs (60%) have no deductible, and 86% charge tiered co-payments for covered drugs rather than the 25% co-payment in the standard Medicare plan.

Most PDPs have a coverage gap and less than 2% of PDPs nationwide cover both brand-name and generic drugs in the gap, the report said. In 11 states, there are no PDPs available that offer gap coverage for brand-name drugs, it said.

As long as it exceeds the Medicare standard benefit, a prescription drug plan may vary in such ways as:

- The prescription drugs available on the formulary and the tier position for any covered drug
- The deductible and co-payment amounts

many enrollees when they go abruptly from making co-payments for their drugs to paying 100% of the cost.

In addition, many enrollees may be confused about the \$2,400 limit for 2007 in their initial coverage period, thinking it is the only amount of money they would pay out-of-pocket. In fact, the amount includes the total cost of drugs, meaning what the enrollee pays plus what the plan paid.

Here's how it works. Medicare enrollees pay the first \$265 of their drug costs. In the initial coverage phase, the drug plan pays 75% of the covered prescription drug costs after the deductible is met, and enrollees pay a co-payment of 25% until the total drug costs (including the deductible) reach \$2,400 this year.

Once an enrollee reaches \$2,400 in total drug costs, he or she will be in the doughnut hole and must pay the full cost of prescription drugs until the

total reaches \$3,850. This annual out-of-pocket spending amount includes the yearly deductible and co-pay amounts.

When enrollees spend more than \$3,850, the coverage gap ends and the drug plan pays for 95% of the rest of the covered drug costs for the year. Enrollees are still responsible for either a small co-payment (usually \$2 or \$5) or a coinsurance payment of 5%, whichever is greater.

Premium Payments

In addition, beneficiaries must also pay a monthly premium, even while they are in the coverage gap. Last year, the average premium for a Part D drug plan was approximately \$25. Premiums vary widely depending on additional cost savings provided to an enrollee. For example, with a higher premium, a drug plan may eliminate the deductible or provide some prescription drug coverage in the doughnut hole.

According to research for the Kaiser Family Foundation by Actuarial Research Corporation, approximately 4 million Medicare beneficiaries were projected to have spending in the coverage gap in 2006. Estimates, however, range from 3 million to 6 million.

Also, the size of the coverage gap is projected to increase by approximately 8.5% annually because the cutoffs are indexed to the average per person drug expenditures for people included in the Medicare drug benefit. The scheduled expansion of the doughnut hole is mandated by law. And, according to Families USA, a consumer health advocacy organization in Washington, D.C., prescription drug plans are likely growing more expensive because they are attracting seniors with higher drug costs.

The result of the coverage gap last year was that many patients who hit the doughnut hole had trouble affording their drugs. They also peppered their physicians with questions about

Resources for Patients

One of the most helpful online resources is the Medicare site (at www.medicare.gov), which allows users to compare PDPs, learn about plans offered in each state, view each plan's formulary, and download appeal and exception forms. The site also has suggestions for lowering costs in the coverage gap. Beneficiaries who are comfortable using the Internet can select and enroll online. Patients can get the same information by calling the Medicare help line at 800-633-4227.

Other sources of information for patients include:

- AARP Prescription Drug Coverage: Provides step-by-step information on how to select an appropriate plan. (www.aarp.org/health/medicare/drug_coverage/)
- *Medicare Prescription Drug Plan Guide—How to Choose Your 2007 Plan*. This guide is easy to follow and comes from a trade organization representing health insurance plans. (www.healthdecisions.org/guide/index.html)
- SHIPtalk: The State Health Insurance Assistance Program provides one-on-one counseling and assistance to Medicare patients and their families. (www.shiptalk.org)
- Social Security Administration: Enrollees with limited income may qualify for extra help with Medicare prescription drug costs. (www.socialsecurity.gov/prescriptionhelp/ or 800-772-1213).
- Partnership for Prescription Assistance: Some drug manufacturers offer free or low-cost drugs to qualified Medicare beneficiaries. (www.pparx.org or 888-477-2669).

what to do.

Of course, many patients have questions for their physicians about the Medicare prescription drug benefit in general, including which plan to choose. Physicians and their office staff should be prepared to help patients understand the complexities of the program and where to send patients for advice and support. Although the end-of-year enrollment period is of great concern to patients, physicians can expect questions throughout the year as new patients become eligible for Medicare and others, already enrolled in a drug program, approach the doughnut hole.

Offices with at least four physicians usually have adequate staff to help counsel patients about their prescription drug plans. At a minimum, offices should:

- Designate a nurse or assistant to be an expert on Part D. Having one individual responsible for counsel-

ing patients may help reduce patient confusion and improve efficiency of response.

- Have patient education materials available for patients or their caregivers. These materials should anticipate commonly asked questions about local prescription drug plans and about formularies and ways to decrease drug costs.
- Provide a list of online and community resources.
- Encourage patients to ask questions after they read the information to make sure they understand it. Doing so may help to prevent surprises and may decrease the number of unfilled prescriptions due to cost.

Patients will want to know if their PDP will cover the medications physicians prescribe. So physicians need to be familiar with the formularies in the more popular drug plans in their communities and be prepared to make adjustments in a patient's regimen, if

(Continued on page 14)

Lowering Costs in the Coverage Gap

Medicare suggests the following five ways for patients to lower their prescription drug costs:

1. Consider switching to less-expensive drugs
2. Explore national and community-based charities, which may have programs that can help with drug costs. Information on programs is available on the Benefits Checkup website (www.benefitscheckup.org).
3. Look into pharmaceutical assistance programs. Many drug manufacturers offer assistance programs for patients enrolled in Medicare Part D. Access to these programs is available at www.medicare.gov.
4. Consider state pharmaceutical assistance programs. There are 21 states that offer help with paying drug plan premiums and other drug costs. Access to these programs is available at www.medicare.gov.
5. Apply for extra help. Enrollees who have limited income and resources may qualify for extra help paying for prescription drugs. Available through the Social Security Administration (www.socialsecurity.gov/prescriptionhelp/).

(Continued from page 13)

needed and appropriate.

Patients will also want to know if there are ways they can reduce their co-payments and, most important, delay falling into the coverage gap. There are measures that physicians can take to help their patients deal with the financial complexities of a PDP. Depending on a patient's diagnosis and medication regimen, a number of steps may be helpful.

Options to Consider

Patients new to Medicare who have not yet chosen a drug plan should be counseled about their options based on their medication profile. For patients on few or inexpensive medications, the appropriate option may be a plan with a lower premium and no or a small deductible. For a patient with high drug costs, the appropriate option may be a plan with a higher premium and deductible, some coverage in the doughnut hole, and a formulary with wide coverage and a favorable tier placement of commonly prescribed medications.

One of the easiest ways to help

patients lower their prescription drug costs is to switch to lower cost or generic drugs, as available and appropriate. Doing so can help patients in

two ways. The co-pay for lower-cost or generic medications may be lower than that for other drugs and since the total cost is lower, it will take patients longer to reach the coverage gap. Most plans include several choices within the same drug class.

Another tactic to help patients save money is to write a prescription for an extended supply of a medication, such as for 90 days. This strategy may make the most sense for any enrollee with a chronic condition. Many PDPs offer enrollees a discount for using a mail-order program and local pharmacies often provide an extended supply of medications for the same price as a mail order plan.

Some patients need more information than the physician's office can provide, especially new enrollees who want to compare prices and formularies from PDPs. Staff can refer these patients to appropriate online and community resources.

—Michael Bihari, MD, is a health care writer in Falmouth, Mass.

Medicare Facts at a Glance

All Americans who receive Medicare coverage are entitled to prescription drug coverage, regardless of their income and financial resources, health status, or current prescription costs.

More than 38 million Medicare recipients have prescription drug coverage, of which 22.5 million are enrolled in Medicare Part D plans. The remaining beneficiaries receive drug coverage from other creditable sources, such as employer and union-sponsored retirement plans, federal employee retirement plans, employer benefits for actively working Medicare recipients, Veteran's Administration, and state-sponsored pharmaceutical assistance programs.

Medicare offers its drug benefit through two types of private plans: stand-alone prescription drug plans (PDPs) for beneficiaries getting Medicare benefits through the fee-for-service program (Medicare Parts A and B); and Medicare Advantage prescription drug (MA-PD) plans, such as HMOs or PPOs, which cover drugs and other Medicare benefits. This year, 1,875 PDPs are being offered, an increase of more than 400 PDPs over last year. In most states, beneficiaries have a choice of at least 50 stand-alone PDPs.

The cost of the prescription benefit depends on which plan a Medicare recipient chooses. Every plan approved to participate in the Part D program must have benefits that are the same or better than a standard set of benefits designated by Medicare. —MB

Liability Risks in General Partnerships

By David B. Mandell, JD, MBA, and Steve P. Dunbar

Physicians should never operate any business or practice as a general partnership. Such an arrangement could be a creditor or plaintiff's dream and a partner's liability nightmare.

Instead of a general partnership, physicians should consider a limited partnership, a C or S corporation, or a limited liability company. These entities have limited liability provisions for owners.

If a physician does use a general partnership, each physician should set up a corporation and the corporations should become the partners in the general partnership. Many medical professionals and attorneys using

personally. By structuring the partnership in this way, the underlying corporate owner's personal assets remain protected from claims against the partnership. As with any corporation, however, the partners must follow rules and regulations governing the corporation in order to protect their assets.

Pitfalls to Avoid

For physicians and other professionals, there are three hidden dangers with general partnerships. First, partners have unlimited liability for partnership debts. Many business professionals and other entrepreneurs don't realize this tragic fact about general

Tort Report Association. Therefore, a plaintiff who successfully sues the partnership can collect the full judgment from any one partner.

Consider this example of a general partnership that we'll call Jane and Ted's Real Estate Venture. Jane and Ted were friends who decided to go into a real estate venture together to refurbish old three-family homes and sell them as condominiums. Events went well for a while, but after the real estate market went sour, they defaulted on a \$650,000 bank loan. Jane was much wealthier than Ted, so the bank pursued Jane for the full amount, ignoring Ted.

Unlimited Liability

The second pitfall is like the first one. In general partnerships, the partners have unlimited liability for their partners' acts, meaning one partner assumes all the risk that any other partner will cause a lawsuit. When the lawsuit arises from one partner's act or omission in the ordinary course of business, all other partners are personally liable. The dreaded joint and several liability rule then applies. If one of your partners gets into trouble, you can be personally liable for the entire amount, even if you were neither involved in the alleged incident, nor aware of it.

Of course, there are many ways a partner could get into trouble. He or she could commit malpractice, get into a car accident while on business for the practice, defraud someone through the business, sexually harass an employee, or wrongfully fire a worker. By multiplying this risk by the number of partners, you have a liability nightmare.

Here's an example. Michael was the founding partner in a successful three partner software development

(Continued on page 16)

Many medical professionals and attorneys use a professional corporation (PC), which becomes the official partner in the partnership, thereby protecting the professionals personally.

professional corporations (PCs) follow this advice. Each doctor or lawyer sets up a PC and the PC is the official partner in the partnership, thereby protecting the professionals

partnerships until it's too late. In effect, each member of the partnership personally guarantees every partnership debt and personally assumes the risk for malpractice, accidents, and other liability sources of the entire partnership.

Joint and Several Liability

Often partners do not realize that each one's liability as a partner is joint and several with other partners. The common law rule of joint and several liability, sometimes called the "deep pocket" rule, makes each and every defendant in a tort lawsuit liable for the entire amount of the plaintiff's damages regardless of the defendants' relative degrees of fault or responsibility, says the American

David B. Mandell, JD, MBA, is an attorney, lecturer, and author of The Doctor's Wealth Protection Guide and Wealth Protection, M.D. He is also a co-founder of The Wealth Protection Alliance (WPA), a nationwide network of legal, accounting, and financial firms that help clients preserve their wealth. Steve P. Dunbar is a principal with Wealth Solutions, Inc., and provides business planning to physicians. For more information, contact the Wealth Protection Alliance at 800-554-7233 or email info@wealthprotectionalliance.com.

firm near Portland, Oregon. One of the firm's customers sued the firm when a program malfunctioned, causing a loss of valued data. The lawsuit alleged breach of contract, product liability, and punitive damages.

Settlement negotiations were unsuccessful and the trial jury awarded an extremely large verdict against the partnership, exceeding its liability policy limit. Since Michael was the wealthiest of the partners, the plaintiff's lawyer pursued him first. Michael was made to pay the entire \$250,000 amount (above the insurance policy limit) from personal savings even though Michael had less contact with this customer than his partners did.

The Unaware Partner

A general partnership does not require a formal written agreement, as does a limited partnership. One can verbally

agree to start a venture with another and create a general partnership with all of the attendant liability problems. Few professionals think about the inherent liability when starting a new venture in a general partnership.

A Hidden Liability

Even if the professionals involved make no agreement to partner with one another, the law may impose general partnership liability on the parties if the general public reasonably perceives them as partners. In other words, many professionals may already be part of a liability-ridden general partnership and not know it.

Consider the example of Roger who was one of four physicians who shared space in a common office arrangement. Each physician had his own patients, which they did not share. They did share a common waiting

area, support staff, and accounting system. Each professional had his own practice methods, set his own hours, and was not otherwise accountable to the others.

A Rude Awakening

When a patient sued one of the doctors for professional misconduct, Roger and the two others had a rude awakening. Although only the client's physician was negligent, all four were named as defendants in the lawsuit. The court found that the patient could reasonably conclude the four professionals were partners together because they shared office space and common support staff. Therefore, the court allowed the plaintiff to proceed with the suit against all four as a general partnership, with each jointly and severally liable for the plaintiff's losses.

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