Prepare for Medicare Part D Launch in January

BY ELAINE ZABLOCKI
Contributing Writer

SAN DIEGO — Physicians will face many questions about the new Medicare Part D benefit in coming months as patients decide whether to enroll and which plan to select in the voluntary prescription drug program, Elizabeth Carder-Thompson said at the annual meeting of the American Health Lawyers Association.

CMS has begun posting informational resources on its Web site, and additional materials will become available over the next few months. The best resource at this time is the "Outreach Toolkit," available by download or on CD-ROM, said Ms. Carder-Thompson, a lawyer with Reed Smith LLP.

"The Outreach Toolkit doesn't answer all the questions we want answered, but it's a good start," she said.

Enrollment for Part D begins on Nov. 15, 2005, and patients are required to enroll by May 15, 2006, or face a financial penalty when they do.

The new coverage goes into effect Jan. 1, 2006, and the interim discount drug card program ends at that time. This means Medicare beneficiaries will need to make fairly complicated choices within a short time.

There will be at least two part D prescription drug plans available in each geographic area, and plans may include several subplans.

A Kaiser Family Foundation survey, conducted March/April 2005, found that seniors are more likely to turn to their doctor (49%) or pharmacist (33%) for help in making these decisions, rather than to Medicare information sources (23%). About two-thirds (68%) of those surveyed said they did not have a good understanding of the new benefit.

In October 2005, Part D plans will start to send marketing materials. CMS will distribute its "Medicare and You," handbook to all beneficiaries via mail, with a description of the new benefit. A "Plan Comparison Web Tool" and "Medicare Personal Plan Finder" will be posted at www.Medicare.gov, and there will be special mailings for low-income beneficiaries.

The interim discount drug card program ends on Jan. 1, 2006, so Medicare beneficiaries will need to make fairly complicated choices within a short time.

"CMS says it will provide materials as they did for the drug discount card but this is far more complicated than the card," Ms. Carder-Thompson said.

According to Robert J. Hill, also of Reed Smith LLP, the CMS marketing guidelines on Part D include a great deal of material that will affect physicians. For example, enrollment cannot be taken at the point of care, such as a physician's office. If physicians offer their patients information on any Part D plan then they must offer information on all available Part D plans.

CMS has not released the final version of its marketing guidelines, and Mr. Hill expects these issues to be dealt with in more detail in the second part.

Once Part D becomes effective, doctors will face a different set of concerns, Ms. Carder-Thompson said.

When a plan does not cover a prescribed drug, physicians will need to provide supporting statements in order to get an exception, but many details are not clear at this time.

"The regulation is confusing," Ms. Carder-Thompson said. "CMS says they don't want it to be hard to seek exceptions. However, it may well become an administrative burden. This is something that's going to evolve as we go along."

Ms. Carder-Thompson advised doctors to "stay tuned" on the details of Part D, since they seem to change every day. ■

Survey Examines Disclosure of Medical Errors

BY KATHLEEN LOUDEN
Contributing Writer

CHICAGO — Four percent of primary care physicians and third-year medical students surveyed in a regional study reported that they made errors resulting in a patient's death but did not disclose them to their institution, Lauris C. Kaldjian, M.D., said at the combined annual meeting of the Central Society for Clinical Research and the Midwestern section of the American Federation for Medical Research.

Dr. Kaldjian surveyed faculty, residents, and third-year medical students in the departments of internal medicine, family medicine, and pediatrics at two medical schools and three hospitals in the Midwest and Northeast. The 538 responses were weighted more heavily toward residents and students than faculty members.

Of respondents, 17% did not disclose to their institution medical errors that prolonged the course of treatment or caused discomfort, and 12% did not disclose to the patient.

Still, more primary care physicians and students voluntarily disclosed medical errors than those who did not, said Dr. Kaldjian, a bioethicist at the University of Iowa.

Of the respondents, 27% revealed to the patient a medical error that prolonged therapy, and 18% disclosed such a mistake to their institutions.

The study was designed to develop a comprehensive taxonomy of the factors that influence voluntary disclosure of errors by physicians and to use the taxonomy in a cross-sectional survey of primary care physicians. The survey asked about factors that facilitate the voluntary disclosure of medical errors in four domains: a sense of responsibility to the patient, oneself, the medical profession, and the community. It also solicited reasons that impede disclosure of errors in four domains: attitudinal barriers, uncertainties, helplessness, and fears and anxiety.

Of respondents, 17% did not disclose to their institution medical errors that prolonged the course of treatment or that caused patient discomfort.

These eight domains included 59 factors that either facilitate disclosure, such as the belief that telling patients about mistakes increases their trust in the physician, or hinder disclosure—for example, fear of legal liability.

"This study is trying to get at the deepest motivations and barriers that come into our minds and even our hearts when it comes to talking to patients about medical errors," said Dr. Kaldjian, whose work was funded by the Robert Wood Johnson Foundation. "The issue of disclosure of errors has come to the fore in recent years because of the patient safety movement."

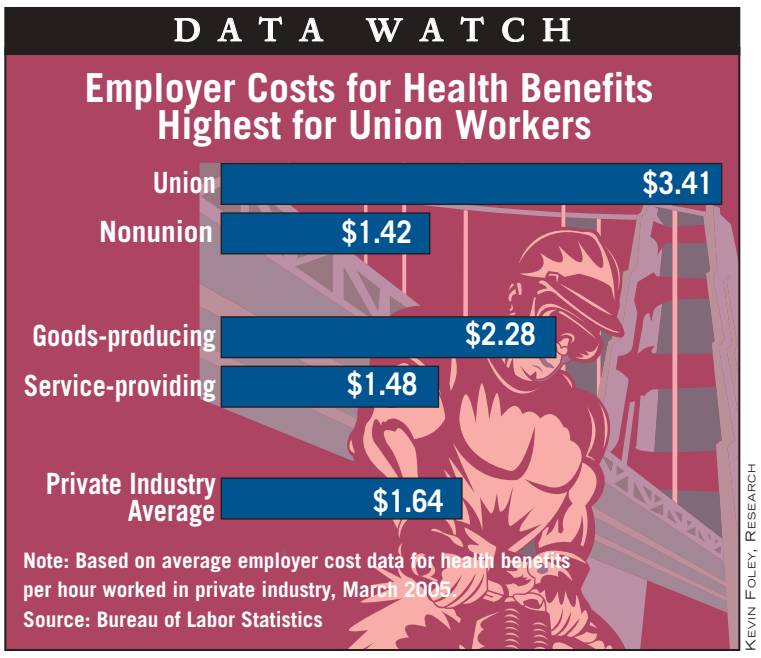
Among fears, the most common reason survey respondents did not disclose an error was fear of the patient's or family's reaction (88%).

Women in the study were more inclined than men to disclose their errors to patients. Faculty members appeared more willing than trainees to disclose errors to their patients but not as willing to disclose to their colleagues.

Dr. Kaldjian did not break down medical errors other than those that prolonged therapy or caused discomfort and those that caused death, he told FAMILY PRACTICE NEWS.

The taxonomy he developed may assist in the design of systems for reporting medical errors and might be helpful for educational interventions, Dr. Kaldjian said. ■

DATA WATCH



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