Physicians Ask for Federal Incentives to Fund EMRs

BY ALICIA AULT
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WASHINGTON — Several individual physicians and professional organizations urged members of Congress to extend tax credits or deductions and small business loans to physicians who purchase information systems and to require Medicare to offer an incentive payment to physicians who make the move to electronic medical records.

Adopting electronic medical records (EMRs) can make practices more efficient, but the initial expense—both monetary and in staff training—can be devastating to small physician offices, the witnesses told the panel members at a House Small Business Subcommittee on Regulation, Healthcare and Trade hearing.

The Subcommittee chairman, Charles Gonzalez (D-Tex.), agreed that the federal government should give physicians some kind of financial carrot to invest in health information technology.

"Right now there are inadequate incentives for health care providers to adopt many of these technologies," he said.

"Without changes in the way we promote health IT, small physician practices will be left behind the technological curve, and as a result, patients will fail to benefit from the quality of care electronic health records provide," added Mr. Gonzalez, who recently reintroduced his National Health Information Incentive Act. The bill was aimed at assisting smaller practices but would also direct Medicare to make add-on payments for office visits facilitated by EMRs.

The American College of Physicians has called for just such a payment for several years, Dr. Lynne Kirk, ACP president, said at the hearing.

Mr. Gonzalez also noted that the full Small Business Committee recently passed the Small Business Lending Improvements Act of 2007 (H.R. 1332). That bill would let small practices borrow from the Small Business Administration to finance information systems.

Coming up with the capital for health IT is particularly tough for smaller physician groups, Dr. Kirk noted. One 2006 study showed that only 13%-16% of solo practitioners had adopted health IT, she said. Small practices are the lifeblood of internal medicine, she said, adding that 20% of internists are in solo practices and 50% are in practices of five or fewer physicians.

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ACP President Lynne Kirk (far left) and CCHIT Chairman Mark Leavitt (right of her) urged Congress to support EMRs.

Acquisition costs average $44,000 per physician and yearly upkeep amounts to about $8,500 per physician, according to a 2005 study published in Health Affairs, Dr. Kirk said.

To help defray both the initial investment and ongoing maintenance costs, ACP advocates an add-on payment from Medicare scaled to the complexity of the technology. The initial capital costs could be offset by grants, loans, or tax credits from the federal government, Dr. Kirk said.

The lack of reimbursement for using health IT is a major obstacle to adoption, said Dr. Mark Leavitt, chairman of the Certification Commission for Healthcare Information Technology, a publicly funded agency that for the last year has been vetting hardware and software systems.

CCHIT has certified 57 office-based systems, he said. Some payers are now offering financial incentives to physicians who use these certified systems, Dr. Leavitt said. The Hawaii Medical Service Association (Blue Cross and Blue Shield of Hawaii) announced in November 2006 that it was setting aside $20 million to help individual physicians buy EMR systems, though it required those investments to be in CCHIT-certified systems.

Dr. Margaret Kelley, an obstetrician in a two-person practice with her father in San Antonio, said they had spent $100,000 to purchase an EMR system. Initially, the system devastated the practice's efficiency, said Dr. Kelley, who also spoke on behalf of the American College of Obstetricians and Gynecologists.

"It took our practice nearly 2 years to be able to accommodate as many patients as we could before we invested in our EMR system," Dr. Kelley said. Even so, they would not consider returning to their old way of practice, noting that one of the biggest benefits has been the ability to access patient charts 24 hours a day, she said.

Similarly, Dr. David O. Shober said that buying and implementing an EMR system at his two-physician family practice has been draining but beneficial. In 2004, the practice—then comprising four physicians and two offices—spent $200,000 to buy a system. Yearly costs have averaged $50,000-$60,000, said Dr. Shober, who is based in New Castle, Pa. The system has allowed the practice to create more thorough notes, standardize charts, and retrieve records easily and quickly. But the physicians have run into obstacles, including the inability of their system to communicate with radiology centers and labs, and the refusal of many pharmacies in their community to accept an e-prescription, he said.

"The only way to provide incentives for the adoption of health IT is to provide financial assistance," said Dr. Shober, adding that the federal government should make no-interest loans available.

Dr. Kevin Napier, an internist in a nine-physician family and internal medicine practice in Griffin, Ga., said that he and his colleagues had spent $400,000 for the purchase of a system and subsequent training since 2005. The physicians are financing the system at a cost of $1,000 a month each, and their payments will continue for the next 3 years, he said.

There was a huge drop in patient volume and income the first year of implementation, but the benefits have outweighed the risks, Dr. Napier said. ■

Tips to Say 'I'm Sorry' for Unanticipated Outcomes

BY DENISE NAPOLI
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WASHINGTON — An empathetic disclosure that a medical error has occurred, accompanied by a genuine apology, may help avoid a malpractice lawsuit, according to Dr. Neil S. Prose, director of pediatric dermatology at Duke University Medical Center, Durham, N.C.

On an almost daily basis, doctors are called upon to deal with patient disappointment. Some cases involve medical mistakes and others do not. In any case, "How we communicate with patients and their families is really half of the work we do as doctors, and the other half is diagnosis and treatment," Dr. Prose said at an annual meeting of the American Academy of Dermatology.

'Our biggest pitfall [as physicians] is trying to talk people out of the way they're feeling.'
DR. PROSE

"Unfortunately, we spend a lot of time on diagnosis and treatment and never talk about what we say to patients and how they respond, and so a whole half of our lives is neglected," he added.

In a presentation designed by the Institute for HealthcareCommunication (formerly the Bayer Institute), a nonprofit group dedicated to improving communication between physicians and patients, Dr. Prose discussed empathetic ways of speaking with patients when they have experienced disappointing outcomes, either with or without a medical mistake, on the health care provider's behalf.

Dr. Prose stressed that his recommendations are generic skills and that, when appropriate, the counsel of a lawyer or risk management team should be heeded:

► **Create the right setting.** Close the door and make sure that the room is quiet. If possible, turn off any phones or pagers. Sit down. Offering the apology while seated, rather than standing, can aid in the patient's eventual acceptance of the apology.

► **Be as sincere and specific as possible.** In addition to telling the truth about what happened—whether the mistake is a botched biopsy or something more serious—Dr. Prose said that offering a sincere and simple apology can make a huge difference. Also, specificity is crucial. Saying, "I'm sorry that your family has been through so much pain this last week as a result of this procedure" is preferable to "I'm sorry this happened."

Dr. Prose added, "saying, 'I wish things were different' is a wonderful way to create an alliance with the patient and his or her family."

► **Have a plan.** A pledge to correct the mistake also is important. "People want to know how you're going to prevent this from happening again. You want to have a plan before you go in the room," he said.

► **Be aware of your own feelings.** Often, the fear of confrontation and the desire to rectify the situation as quickly as possible can prevent physicians from taking into account their own feelings about the situation. "Wanting to run away is a natural response. You have to be aware of how you're feeling before you walk in the room [with a patient]. We have to be knowledgeable about ourselves and our own natural tendencies." Being either defensive or overly despondent, for instance, can alienate the patient and his or her family. "Seek a balance by knowing who you are and what you tend to do," he advised, including knowing "what kinds of patients drive you crazy."

"For those of us who internalize [mistakes] and lose sleep over them, you have to be able to talk to yourself and say, 'I'm trying to be a good doctor, and now I'm going to try and do my best to make the situation right.' It's hard sometimes. It's a struggle," said Dr. Prose.

► **Be a good listener.** "Our biggest pitfall [as physicians] is trying to talk people out of the way they're feeling," he said. "Listen before giving advice, and relisten to the story, as much as you don't want to hear it."

► **Get permission to proceed.** Finally, after telling the truth and listening patiently, "you reach a point where you actually ask permission before moving on. Say, 'Would this be an okay time for me to tell you what I think we should do next?' That process has a remarkable effect," said Dr. Prose. ■