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Statement of

Philip W. Tally, MD

on behalf of the

American Association of Neurological Surgeons

and the

Congress of Neurological Surgeons

before the

Committee on Small Business

U.S. House of Representatives

July 31, 2008

On the Subject of:

Cost and Confidentiality: The Unforeseen Challenges of Electronic Health Records in Small Specialty Practices

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Testimony of Philip W. Tally, MD
Before the House Committee on Small Business
Hearing on “Cost and Confidentiality: The Unforeseen Challenges of Electronic Health Records in Small Specialty Practices."
Thursday, July 31, 2008

Good morning Chairwoman Velazquez, Ranking Member Chabot and Members of the Committee. Thank you for inviting me to appear today to discuss the challenges small physician specialty practices face in adopting electronic medical records. My name is Doctor Philip W. Tally and I am one of three neurosurgeons in a small, full-service neurosurgical practice in Bradenton, Florida. I am here today on behalf of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons, which represent 4,000 neurosurgeons in the United States. I also currently serve as the Chairman of the Florida Medical Association’s Health Information Technology Committee and I am a member of the American Medical Association’s HIT Advisory Panel. I’d like to spend my time with you this morning telling you my story about how we integrated electronic medical records (EMR) into our practice, some of the challenges we faced, the costs we incurred and, ultimately, the benefits we have reaped both for our practice and our patients.

Our practice was the fifth medical practice in the country and the first neurosurgical practice to go fully “paperless.” In 1992, after looking at different electronic systems for several months, we decided to purchase a text-based system. Implementing this new system was no easy feat. We could not simply plug in the machine and flip the switch. Because these systems are typically set-up in a one-size-fits-all manner, it required approximately 1,000 hours to configure our system and create neurosurgical templates since there were no existing specialty-specific programs. All tolled, implementing this first system required about one year of preparation time to purchase, configure and implement the hardware and software.

The costs of setting up and maintaining this system were also fairly significant. We spent approximately $50,000 on the initial setup, which was amortized over 18-24 months. They system also required regular maintenance and upgrades, which cost approximately $5,000 per month. During the early years, our vendor continued to create new systems and

upgrades for both the EMR and practice management programs and neither upgrade was seamless. Every "improvement" resulted in some unintended consequence that required a software engineer's time to repair.

In addition to the direct financial expense our practice incurred when we first implemented our EMR system, we also experienced additional costs. Implementing this system was particularly difficult on the staff and not everyone was pleased to move to this new practice paradigm. These changes, coupled with the daily stress of working in a busy full-service neurosurgical practice, simply proved too much for staff. We had a 30 percent staff turnover rate, which was considered standard, as staff had difficulty in adapting to and learning entirely new office procedures and methods. This produced problems with continuity of patient care and loss productivity in the practice as we went the through process of hiring and training new staff.

As our practice transitioned to an electronic format, we also had to keep the paper records in addition to our EMR system. Interoperability was not even a concept at that point and there was no "talking" between systems. Every paper document had to be scanned and transferred into the EMR or practice management portion of the record.

Notwithstanding these challenges, once implemented, the physicians and our staff recognized the benefits of going paperless. The efficiency of the practice increased significantly. Staff no longer had to go searching for paper charts to answer patient phone calls and they could quickly get information to the neurosurgeons. Our ability to review and create new charts allowed us to spend more time with our patients. We improved our communications with other physicians since the completed patient record was never misplaced, it was always legible, and all test results resided in a distinct "folder" within the electronic medical record.

In 1997, we converted to a Windows-based system. This required us to use a graphical user interface (GUI), so our data could be “seen” in the Windows environment. At that time, most systems were built around a central server, limiting the amount of work that could be accomplished by office staff. We therefore spent considerable time and money

converting all terminals to be PC compatible, which allowed multiple staff to work within the same program and even on the same medical record at the same time. This significantly expedited patient care since the “back office” was able to ascertain patients’ insurance coverage, obtain prior-authorizations, schedule tests, and process insurance claims simultaneously. As a result, patient satisfaction was very high.

Maintaining this system for the past ten years has been a challenge. Hardware has failed, servers have been "hacked", security requirements (particularly HIPAA) are onerous and keeping a full-time information technology (IT) employee in a competitive job market has been difficult. Our software maintenance costs have typically been $1,000 per month, per physician. Increasing capacity for the volume of data is also a challenge. Our system now has up to 8 terabytes (8,000 gigabytes) for charts, we have 6 million scanned documents, and 300,000 x-rays/scans for 50,000 patient encounters.

The UNIX-based system with the GUI is now out-of-date and once again our practice has had to move to a new model. We are using an ASP model based on the “.net” platform. We believe this new environment is the future, but again, implementing this new generation of EMR cost about $40-50,000 to purchase the hardware and software, and practice’s monthly maintenance costs are approximately $3,000. This equipment has a 3-5 year lifespan, which means we will have to reinvest $25,000-30,000 in a few years. Neurosurgery is the most complex template to construct, and as with our original system, we have spent a full year working with our vendor to customize the software to apply to a neurosurgical practice. Even with our practice’s lengthy history and experience with EMR, this upgrade has been a costly and difficult process, with considerable loss of productivity. Furthermore, and notwithstanding our experienced eyes, after we purchased this system we have found flaws in the vendor’s product. These include problems with the billing, prescribing, and documentation elements of the system.

Madam Chairman, as you can see, our practice has been ahead of the curve in adopting EMR. Unfortunately, most physicians have not shared our same experience. Despite the fact that electronic medical records have the potential to improve the delivery of health care, most physicians have been slow or reluctant to adopt these systems. Indeed, in

the July 3, 2008 issue of the *New England Journal of Medicine*, a report entitled "Electronic Health Records in Ambulatory Care – A National Survey of Physicians," found that only 4 percent of physicians reported having an extensive, fully functional electronic records system, and only 13 percent reported having a basic system. We therefore have a long way to go, and it is estimated that a 3-4 year timetable for broad EMR implementation is "optimistic" at best. Perhaps the new electronic prescribing provisions that were enacted in H.R. 6331, the "Medicare Improvements for Patients and Providers Act" will help encourage physicians to implement this entry level mode of EMR. I would point out, however, that over 70 percent of the 3 billion prescriptions written every year are by primary care and emergency physicians – the two groups with the lowest adoption rates of EMR. In addition, despite the government's assurances that e-Rx is ready and waiting, there remain significant implementation issues, such as: end-user (pharmacies) familiarity and compatibility, new (and fatally flawed) DEA rules for Schedule II drugs and rigid rules that may make compliance by most neurosurgical practices difficult.

Congress can help pave the way to widespread adoption of health information technology by passing legislation that will ensure the implementation of standards for interoperability and by providing financial assistance and incentives to physicians and practices. Congress must also be mindful that we cannot rush this process or force physicians to adopt EMR using a "stick" approach, as this will only create more resentment among physicians. Remember, it took over 10 years for the stethoscope to be widely accepted as a medical tool! While it will take time, medicine is on the right path in promoting this conversion. There is general agreement that the implementation of health information technology will improve patient safety, enhance quality of care, result in more efficient medical practice and better health outcomes should follow. We should not deviate from this premise, nor should we rush launching a complex system to satisfy political or administrative goals.

Thank you for the opportunity to share my experience and thoughts with you today. I would be happy to answer any questions.