

INTERVIEW

Action Through Collaboration: A Conversation With David Brailer

The national coordinator of HIT believes that facilitation, not mandates, are the way to move the agenda forward.

by Robert Cunningham

ABSTRACT: Progress toward widespread adoption of health information technology (HIT) by providers remains uncertain and fraught with obstacles. But since his appointment as national coordinator for HIT in May 2004, David Brailer has observed a flowering of initiatives at the state level and the stirring of grassroots demand for action by providers. Brailer sees the creation of a new leadership group to spur adoption of technical standards as an important step forward. He remains concerned that small provider organizations will fall behind larger ones and that IT adoption will move forward without adequate standardization, compromising opportunities for interoperability in the future.

Encouraging The Use Of Standards

Rob Cunningham: Recently the secretary of health and human services (HHS) announced plans to form a new advisory group to encourage adoption of technical standards that would facilitate widespread electronic data exchange in health care. A number of organizations are already working to establish such standards, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 already mandates standards for administrative transactions. What will this new group add to these efforts?

David Brailer: When I came into this role, I didn't spend a lot of time thinking about standards, because I, like many people, assumed that we had lots of good organizations that were developing standards and that the issue was the will to get something done and the demand for solutions on the part of the doctors and the hospitals. My intent was to spend

most of my time focusing on demand-side solutions: how to get doctors to want to put these tools in place, how to get hospitals to put them in place, how to get consumers to start using health information.

After a year of doing that, it became very clear that we had the theory but not the practice of standards. Many organizations are developing standards, but they reflect the health care industry itself: They're highly fragmented; there are many of them; they're semi-overlapping. And we don't have, for that reason, a set of standards that we can hand to a vendor, to a hospital, to a health plan, to a federal agency, and say, Here's the standard; go to work and implement this.

If you develop things, you have to pick among different competing standards, you have to resolve ambiguities, you have to fill in the holes, you have to accept big chunks that are missing. And so what happens is that peo-

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ple make different choices—they fill in the holes differently. The old joke is, every vendor has an HL7 [Health Level Seven] implementation; they're just all different. It's true, because we have a world that just has not committed itself to having one unified, comprehensive set of standards.

So were faced with the option of going in and changing the standard organizations themselves, which I think is not a good use of time. It's a long-term effort, and many of them are tied into international organizations. So we decided to create a new layer on top of that, which is a standard harmonization process, where we'll get the standard organizations to come together and get agreement and work on a national solution.

Cunningham: Is the lack of standards the main reason that adoption of health information technology (HIT) seems to be moving so slowly?

Brailer: Getting the standard organizations to agree on a single set of standards is necessary but not sufficient for interoperability. If you look at the requests for proposals [RFPs] that we issued, they address the key barriers: the certification of products, national architecture, strengthening security and privacy. But the barrier at the very root is agreement on the technical standards, and I do think it's a significant barrier.

If there are two ways to represent lab data or three ways to represent a prescription or five ways to represent a patient's physical findings, then we have numerous permutations. And what often happens is many organizations just say, We're not ready to implement standards.

So it's the same problem as having railroads of a different gauge or VHS versus Betamax [videotape], although I think there's more at stake with health care than with videotapes. And you know, the wi-fi [wireless Internet] industry took off because the three different standards that were out there caused people to step back, not only because they didn't know whether a product they bought could connect to somebody else's hub. The bigger question was that they didn't know which one would

prevail in the end, so they just waited it out. The wireless industry came together and cleared a single standard for wi-fi because they knew that would grow the market substantially.

Cunningham: For some reason, the voluntary process hasn't moved quickly. Divergent stakeholder interests seem to be involved. Can we resolve that with another layer that is still voluntary and consensual?

Brailer: Remember, the other thing we announced is the formation of the American Health Information Community [AHIC]. I think what's been missing from health IT and certainly from standards has been political will—someone or some group of people who are not technical experts but rather decision-makers, who are able to commit capital and resources, standing at the helm saying, It's time to do this. We just had a leadership panel report come to us from the Fortune 100 CEOs, who said very adamantly, "It's time. The federal government needs to step forward and do this." What's missing is the will and the leadership to get it done, not the technical know-how. The reason the standard organizations are taking a long time is because there's no one standing by the door saying, "Would you please hurry up?"

The other part of it is that we don't view standards as being relevant to solving the problems we face in health care. We have people showing up at emergency rooms all the time and their data are not there. We've never stopped to ask, What are the standards that we need to get someone's data to the emergency room?

E-prescribing is a big challenge, and we're finally working through the issues of standards, although there are still several remaining. But it wasn't until the Medicare Modernization Act [MMA] came through and called for e-prescribing that the standards were actually done. It was political will.

So I think not having standards in place is a big limitation. The organizations will take a long time because they're very deliberative bodies if they don't have an imperative. And I think we've provided the imperative through

this new process. But they're still voluntary. We're not going to mandate standards.

Cunningham: So it's the people who are going to be in this group who are going to make the difference. Does the RFP that was issued this week have specifications for who will be in AHIC?

Brailer: That's not in the RFPs. That's not been announced yet, but we've set it up to be seventeen people: federal agency heads, leaders of key health care industry sectors, payers, providers, consumers, surrounded by a bunch of work groups and task groups. The key thing is that they're decisionmakers. They're groups who can commit their organizations and, hopefully, through the deliberative process, their industry to a certain timetable for adoption of certain standards or certain technologies.

I think the miracle of what we've done—and it's experimental, it's risky—is that we have not dictated the outcome as a typical government regulation would. That's what regulation does: It dictates the outcome; it says, "End of game, here's the answer. No questions asked."

Cunningham: We didn't even seem to get that kind of closure with the mandated standards for administrative transactions in HIPAA.

Brailer: That shows you how hard it is to mandate standards when people don't want them. You can't legislate will. And what we're doing is a market-based process. We're going to bring the purchasers, public and private, to the table and show them why it's in their interest to support these standards and to help finance them. We're going to bring the providers to the table and help them understand why they need to put this in place.

It's difficult, it's complicated, it's messy—but it is so much preferable to the alternative. Even if we were able to do this with regulations, as soon as we were done, the regulations would be out of date, and we would have

locked in standards forever.

This is the first step that I think we've seen taken in a long time in health care about following a process and letting the outcome go where it may. We're taking the risk because the status quo is so bad that I think we have a moral obligation to not follow the same old failed policies whenever they aren't working.

To mandate standards or certain technology adoptions in the industry would be disastrous, I think. We already have a third of physicians who have tried to put health IT in place and have failed. If we required it, we would have a 70 percent failure rate. It's got to be something in the end that somebody wants to do, and our job is to help increase the benefits and lower the barriers so that the people who want to do this can do it.

The first thing you'll see, I think, is that AHIC is going to look through all the possible breakthroughs that health IT can bring to health care, prioritize those, and focus on some near-term wins. They're going to get private payers, public payers, private providers, public providers, and other related constituents to agree that we're going to go after four or five or six goals—personal health data in the ER, or wherever it is. And then they're going to ride herd on that to make sure it gets done by coordinating the actions of public agencies and private-sector payers. They're going to bring clout.

We're making it very clear to federal agencies that we expect them to follow along. Our biggest concern is federal agencies operating in a vacuum without the private-sector peers on board, and the private-sector peers are worried about federal agencies surprising them with something that's not related to what they're doing. So we're going to make it visible and transparent, and everyone is going to know what everyone else is doing.

Any disagreements about what the priorities should be or how it should be done will get worked out in the committee. But we're

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going to focus on what we can get done. So I think that it's going to take this up to a much higher profile, and it's going to translate it from this generic health IT into specific, tangible value propositions that people are going to begin to see coming through in their lives.

I'll say it again: The lasting real breakthrough of what we've done is that we have taken a major step away from action through regulation. This is action through collaboration, it's action through government as a major purchaser and as a major payer. It's not action through regulation, and I think this is a first in health care for a long time.

If we succeed, it's not about doctors using computers. It is about error reduction, but it's also about something much bigger: finding a way to integrate health care on a clinical basis, without all the asset merger issues.

We're trying to stitch together a highly decentralized market where the power shifts out to the periphery, but yet doctors who don't know each other can act as a team caring for a patient because they can share information and communicate about that patient. Or a patient with a chronic illness can be cared for seamlessly in different sites of care, without necessitating their being owned by the same corporate entity. We're trying to preserve the industry's capacity to be highly decentralized and flexible.

Agenda For Integration

Cunningham: We chased after a very ambitious vision of integration in the 1990s and came up short. Is there an issue here with realistic expectations for where we want to get to in ten years?

Brailer: We're eight years, eleven months, and two days away from the president's ten-year deadline—much farther along than I thought we would be. My office has been through a challenging first few months that resulted from the dynamics between the White House and HHS when my office was formed, through the election, through a zero appropriation, through the transition to a new HHS secretary. Despite all that, we're where I thought we would be, at best, in two years.

Cunningham: What are the primary indicators of that?

Brailer: It's these RFPs. We have very specific projects under way now that are setting the infrastructure in place that we thought would be a three-year effort; I now think this will be a two-year effort.

But I think your question is a broader one: Can we get the goal? One indicator is that we're further along than we thought we'd be, during a very challenging period. Second, we already have pockets of adoption in the United States where things that we want to see happen across the country are starting. Now that we have a more than 10 percent adoption rate of electronic health records [EHRs] and some demonstrations of interoperability, I think that it becomes incredibly hard for a provider to resist doing this because the evidence is so overwhelming that care is better whenever it is done. Many providers—no matter how narrow-minded they are and how much focused they are away from this—will find it harder and harder to explain to their patients, their payers, and other professional colleagues why they're not doing this.

Growth In Regional Organizations

Cunningham: Last year we were hearing about a strategy that was focused on regional organizations that would be designed to ultimately be compatible with each other. What kind of growth have you seen over the past year in these regional efforts?

Brailer: We didn't call for regional information networks. We called for regional organizations to bring the stakeholders together but called for a national architecture—national networks. This is a common misunderstanding. But the technology itself is not the key issue. It's the convening of the stakeholders, the development of common policies, common privacy infrastructure, common security, a business model. Those are business tasks, and that's what we need the regional organizations to do. This can't be done from Washington: to get stakeholders together and say, "We're going to use this architecture to do improvement in diabetes

and to fix the ER problem.” In other words, this architecture will be vast and broad—it’s like the Internet, right? You can do many things with it, but you have to get together with local stakeholders and figure out what you’re going to do and what the rules of the game are, how you’re going to pay for it, and things like that.

We called for regional organizations as business conveners, and that is happening broadly. There are more than 150 regional projects under way in the United States. Thirty states have legislation or executive orders from the governor, but the regional organizations are active in almost every state that we know of. Philanthropies have put money into them, state governments have put money into them, local hospitals or health clinics have put money into them. This is what strikes you the most about this—the breadth and depth of the grassroots movement—because I think it represents something much bigger than health IT. It’s about what health IT is about, which is dealing with the waste, inefficiency, chaos, and nonresponsiveness of the health care industry. People are basically saying, “We’re going to do something about it.” That is the big issue.

Participation Of Small Medical Group Practices

Cunningham: Are the small-practice doctors getting involved?

Brailer: Often, particularly in county or state medical societies. Many are involved because they see this as being a really important new area to go into. And you know, in the past several months, several national professional societies have taken a positive, forward-looking stand on health IT and these networks and have really become a great supporter of what we’re doing.

I am concerned that we will have this adoption gap where we have large systems that have health IT and small systems that don’t if we don’t address it on a policy basis. But I think beyond that, to me, the question isn’t how to keep small practice alive; it is how to stitch it together into a virtually integrated network. That might be a little bit of a pipe dream, but it

happens in very small steps. Medicare is supporting this through some of the Chronic Care Improvement Program Demonstrations to create more of a virtual care network for patients. Independent practice associations [IPAs] have begun rejuvenating themselves around how they provide more collaborative care among disparate parties. It’s happening in home health. Lots of new, open, high-quality networks are looking at this, so I think it’s a good starting point.

Cunningham: Is the up-front investment a major barrier to the small practice?

Brailer: Absolutely. Providers lose money when they put in health IT, because we have obsolete payment policies that still reward volume over quality. So why are large groups doing it? Because they get a strategic benefit. They get more market share, they get better control of their costs, they get better negotiating positions for contracts, and they’re able to have a better customer service profile.

Small practices don’t have the capacity to invest today for a strategic benefit five years from now. So they do what’s in their financial interest: They don’t adopt. The problem there is we don’t pay for quality, we don’t pay for efficiency; we pay for volume. If we want health IT, we have to start paying for value. But if we want to pay for value, we need health IT to help us measure value. That’s the question: How do we grapple with it?

Cunningham: So is pay-for-use a logical strategy?

Brailer: I think pay-for-use is. I don’t think pay-for-performance is a good strategy to use for small practices. I don’t think they want it, and I don’t think they are confident that they can relentlessly improve performance.

Pay-for-use gives us a chance to get those physicians in the game and get them moving in the right direction so that they can increase their capacity to share information, but also to be able to deliver better performance. So pay-for-use is, I think, a good starting point. We’ve seen between ten and twenty health plans that have offered some kind of a pay-for-use benefit. So it’s not sweeping the nation, but it’s not sitting at zero, either.

A major event happened in April, when the Office of Personnel Management [OPM] issued its annual call letter, asking health plans to bid on being a plan in the Federal Employees Health Benefits Program for the following year. The first three pages of that letter talked about the OPM's commitment to health IT and how it wanted to always, in the spirit of collaboration with health plans, make sure they were committed to health IT and asked the health plans to go through in detail what programs they had in place or intended to put in place to support the adoption of health IT among the physicians in their networks.

It was a major statement that the administration is serious about this and that we're going to do everything we can to not push health plans to do this, but to make sure that they understand that we're very supportive of their doing this and that it's consistent with the administration's view of having a market-based solution.

Insurers' View

Cunningham: In a paper in this issue of *Health Affairs*, Bob Miller and colleagues found that a sampling of small practices recouped their investment in IT after only a couple of years, which was surprising and encouraging. But much of the revenue gain was the result of improved charge capture. This is good for doctors, but how are the insurance companies going to feel about it?

Brailer: I think many of the actuaries are concerned. They saw this coming early on—that the primary way physicians would recoup is by using health IT to improve charge capture. And obviously, there's a concern that the use of IT goes beyond just normal charge capture, to a point that might be considered fraudulent.

One of the first tasks we did was to convene a fraud task force to develop cyberfraud prevention and detection capabilities so we could begin understanding what we could do to give assurance to payers that while physicians

might use health IT solutions to bring their charges to a more fair basis, one time only, we were not going to introduce the technology into the physicians' offices and give them the capacity to become fraudulent.

There is a new debate about who will control health information. I want it to be the patient. I want to see consumers control their health information—decide who gets it, when they get it, who doesn't get it—to make sure they can see their information and can make decisions based on it.

But a lot of parties are staking out how they get control of the information. I think that payers have decided that they're the ones who are going to do this, so they're very much engaged in the game right now because

they see the huge shift in the market that health information is going to bring.

There are a lot of questions about financing IT adoption that haven't been addressed. Another one that's relevant is about the Stark exceptions and the antikickback exceptions that would allow hospitals to expand their data-sharing activities. I think that there's been a lot of interest in that, in terms of being able to understand how we could do that.

Cunningham: Is there legislation coming?

Brailer: It comes down to the mechanism. There are conflicting values. Everyone recognizes that the Stark and antikickback laws are critical to protecting American consumers. On the other hand, they can't be so stringent that they prevent health IT from being put in place, which itself is beneficial to consumers.

The question is, What's the mechanism to allow IT to be pushed through, without creating a big open hole? There are a lot of mechanisms that are being looked at.

Reflections On The Job Of National Coordinator

Cunningham: You've been on the job for thirteen months. What are the things that you feel good about, and what things do you

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wake up in the middle of the night and worry about?

Brailer: I feel good that we are more than a year into this and that we have the consistent and steadfast support of the president. He has many other things challenging his time, but I always get access when I need it, and he's always supportive of us.

Two, we got our strategic framework out within seventy-six days of my coming here. We now have our RFPs out. I wanted to do this by next January, but here it is June and we're doing it. This is a major step forward, putting down the infrastructure.

Next, we have been able to be part of—and I certainly don't think we're responsible for it—a huge resonance with this topic. And the reason I think we've been able to contribute is that everyone thought IT was about computers, but we've refined that to say that IT is about health care—it's about the experience that we really have. And that's allowed people for the first time to not be afraid of the technical issues they don't understand and for people to elevate it so that they understand that IT is about health care. The debate about whether or not people have IT is the modern version of every other issue we've ever debated in health care. And that allows lots of people to access it and to be part of it and to start to own it.

So again, I can't take credit for all of this, but I think it's fair to say that those were priorities that I came in with, and we're pretty much operating, as I said, ahead of schedule. I'm pretty happy with how that's going.

Things I worry about? I'm very worried about a privacy backlash, something happening in another industry or in health care itself that raises questions. Health IT is like other forms of innovation, where the science and technology are marching much faster than the social dialogue. And the privacy rules that we have today are designed to protect against disclosure of health information.

But in a world of information portability,

where information necessarily flows around electronically about the patient, disclosure is not the issue, because the data are disclosed the second they are generated. It has to do with how the data are accessed and controlled and how they flow. I'm worried that we don't have that policy debate under way, and it needs to start to happen.

I'm worried about the adoption gap. I'm worried about what happens to small practices because I see how much of a leg up large

practices have and just what they're able to do and what that connotes as health IT really becomes a vector of shifting power in the market and concentration of power. Not that I'm committed to small practices as a genetic reflex. I view IT and the Internet as

being enablers of decentralization, not centralization. That's the power of it. And it would be perverse in health care if we have a policy posture that allows IT to become a vector of centralization. I'm worried about that.

I'm worried about interoperability. In fact, I would tell you that I think the likely outcome—unless we're smart, aggressive, and lucky—is for IT adoption to occur with lip service to interoperability. Interoperability is hard; it takes lots of moving pieces for us to actually be able to have a portable flow of information.

We have a very low IT adoption rate now, and that gives us a one-time opportunity to put the foundation for interoperability in place before that adoption rate starts to go up. And I am concerned, given the history of legacy preservation in health care, of how long the IT investments we make are amortized over and how long they last—that if we don't take the opportunity today, it'll be lost for thirty years. It's a one-time opportunity because of low adoption.

I think that the consumer benefit is completely locked up in interoperability because if your doctor's using a PC that has an EHR and has decision support, you can reduce the errors you might be subject to. But if we really

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want to shift power to the consumers and have them begin managing their care more completely and understanding their information and getting customized treatment profiles, and having information and options about their treatments that are customized to them, and getting profiles about their doctor, they have to have portable information to do that.

So to me, the question is whether or not the health care industry going to get serious about being consumer-centric. IT is the name of that game right now, and interoperability is the challenge. We can never be consumer-centric if every medical office is just an automated island.

So I think we now have a one-time chance and a one-time responsibility. Many consumer organizations see this for what it is: It's their shot to get back into control of health care, to get much more stable health care.

So it might be dreaming, you know, but frankly, the reason I took this job is to give this its best shot forward. I mean, I'm not a long-term federal person. I came here to get something done, and that thing is getting interoperability in place and setting the foundations for adoption.

Our role is to make sure that someday we don't suddenly turn around and say, Wow, isn't it too bad we didn't figure this out ten years ago, before we invested in this vast noninterconnected health IT infrastructure?

I want to make sure that on my watch, we don't do it wrong. And I think "wrong" would be letting doctors put in IT and just let the winners win and the losers lose. As much of a free-market thinker as I am, I think there's a different way for the industry to transform.

American consumers are already deciding that they have to get in the game. When you look at the Markle and Kaiser Family Foundation surveys that show that between 30 and 50 percent of Americans carry some form of their own personal health record with them when they go to see their doctors or to a hospital because they understand what it's like to be there, watching providers shuffle around and not have the information and do guesswork, and they understand the consequences for

them and their care.

I don't think people sitting in Washington understand what the American consumer wants. American consumers know what they want. It's going to happen in pockets: parents looking out for their children's care, adults looking out for their parents' care, people looking out for their own care in selected areas—maybe not the typical diabetic with congestive heart failure that always becomes the proxy of our thinking—but in lots of other areas. Middle-aged people who are managing minor diseases want to know.

One of the things that I've done is collect many personal stories. I know this is anecdotal, but when you hear the passion and the real truth coming through of what having access to their health information means to consumers, even if it's the doctor calling and saying, "I've got an abnormal lab result. Can you come in next week?"—even if it's to understand that it's high cholesterol and doing your homework and understanding what questions to ask and how to be more engaged.

That's powerful, and it's something that is deeply embedded in the consciousness of the American consumer. Our goal is not to answer those questions, it's to make it possible, and so that's what we're focused on.

There is a whole new generation of young doctors today who were born after the IBM PC came to market; they are the computer generation. They shop online, they arrange travel online, they bank online, they date online. They're not going to accept, as doctors, anything other than this, and I think it's true for their peers who are consumers.

The question that I face is, Can we make it happen faster than the cultural change over thirty years? Because I think that if it takes that long, we'll have left so much benefit on the table that we can't ever get it back.

And so we view our role as beating the slow wave of cultural change that is inevitably going to happen. Our competition is not inertia—it's the agent of young people behind us, and I very much want to make sure that we get that done.