## Introduction

The following is the complete transcript for a *iHealthBeat* special audio interview with former National Health IT Coordinator Dr. David Brailer. In the interview, Brailer reflects on the year ahead in 2007 for health IT.

## About David Brailer

Brailer was appointed the first national health IT coordinator in May 2004 by President George W. Bush. Bush's April 2004 Executive Order called for widespread deployment of health IT within 10 years to help realize improvements in safety and efficiency. Prior to his appointment, Brailer was a senior fellow at the Health Technology Center, a not-for-profit research and education organization that provides strategic information and resources to health care organizations about the future impact of technology in health care delivery. Brailer also served for 10 years as chair and CEO of CareScience, a provider of care management services and Internet-based applications that aim to reduce medical errors and improve physician and hospital-based performance. Brailer holds doctoral degrees in both medicine and economics. He continued his work as vice chair of the American Health Information Community after leaving Washington, D.C., in May 2006.

Q: As the former National Coordinator for Information Technology you spent a lot of time on Capitol Hill when you were in Washington, so I just wanted to ask you to take a look ahead to the next congressional session. What do you think the odds are of getting a substantial health IT bill through the 110th Congress?

DAVID BRAILER: Well, I think there are a couple of factors that are going to determine how Congress acts on health IT, Kris. The first is, is there fundamental interest in the members who are on the Hill or who have come to the Hill? Several of the key leaders of health IT have left in the last Congress, but there are certainly a large number of members of the Congress of both parties who are interested in this topic. And I don't think that the failure to pass the health IT bill this year is any indicator of a lack of interest. So I'm encouraged by that.

On the other hand, I think health IT has now been placed squarely within the context of the debate about health care. I think certainly since I started as

coordinator until I think just about now, health IT was seen as a separate space, something that was unique and not part of the give and take of the broader health care debate. And I think, therefore, it's going to be subject to many of the concerns that will play out with general health care: What's the role of the private market? How should the government act? How much should we direct and steer the market? How much should we allow voluntary activity to move forward versus government mandates? And I think that's going to be the primary determinant of anything that happens with health care in this Congress, let alone health IT.

Q: Well, do you think Congress is going to be starting from scratch? The Senate passed the Wired for Health Care Quality Act. There was a House bill, 4157, that passed. They were never reconciled during conference. So do you think either of those bills is going to come back, or do you think that there will be a fresh start, a fresh take at this?

BRAILER: Well, I think those bills, Kris, were certainly reasonable starting points. But in the end, I couldn't say to Congress, 'We have to have these bills to be able to move forward with our agenda.' In fact, as I wrote in the *New York Times*, given the direction the House bill was going, I felt we were much better off without a bill at all given the way it would have treated the Stark provisions.

I think what's going to be interesting is since those bills were authored quite a while ago and percolated through that Congress, a lot has happened, and, particularly, this spring there's going to be a lot happening with privacy and security, with standards requirements, with experience with the Stark exception, with the experience with the Certification Commission, and I would expect that any bill that is authored originally now based on our experience would be fundamentally different than something from two years ago. It would be much more specific, much more anticipating the real issues, which are mostly policy barriers.

And so I hope that Congress takes a fresh look because I don't see that any fundamental problems are addressed by the legislation that was on the Hill in the last Congress.

Q: So what policy barriers are you referring to?

BRAILER: Well, I think there's a few. Clearly, I think we don't have the right privacy and security regiment. The one that we have under HIPAA and state laws was created largely in a world that didn't anticipate electronic information that was stored for, or by, or used on behalf of the patient. That's why an online personal health record is not a covered entity. That's why a patient can't compel their information to be sent to a third party in an electronic form that can be used. That's why there's such a long waiting period that it's theoretically allowed in the law for information to be shared. It just didn't treat health information as a clinical asset, and, therefore, it created more barriers than challenges. And I think the American public has been very clear that they want to see privacy protections in place before they're really willing to jump into this. That's one big area.

Secondly, is the area of incentives for adoption. We had the one-year fix to the sustainable growth rate happen here just at the end of the last Congress, which gave physicians a bonus for submitting quality data. That has no effect whatsoever on health IT adoption. So it's time to come back to the question that we've put aside during the whole pay-for-performance discussion for three years about the market incentives and the policy incentives to bring us into full adoption of electronic records. I, as a very keen supporter of incentives, withheld my judgment on that during the pay-for-performance period. I think it has now had its chance, and it hasn't been able to deliver a policy with the impact that I think convinces me that it's going to help us with adoption, particularly among doctors in rural areas, in a safety net and even small practices. So it's time to come back to that.

So those are probably two of the largest issues that have to be dealt with.

Q: Do you think health IT would be best not dealt with as a separate issue but folded into a larger bill, a larger effort to look a the whole landscape of American health care?

BRAILER: I think, Kris, health IT has its own particular issues. I think privacy and security and information standards are two of them, and I think there's some particular economic anomalies that could be spoken to. But I don't know that I would, on the flipside, take the sweeping view of integrating this into the health care debate because there isn't one. There's a lot of border skirmishes, there's a lot of crosstalk. There is no fundamental crucible of health care debate in the national policy world that is moving

toward resolution. I don't expect this Congress to do this, to address this, the incoming Congress to be, if you would, the catalyst for a major health care debate. I'm not even sure that the 2008 presidential election will do that. So I would hate to attach something as clean and helpful and transformational as health IT to that.

On the other hand, should health IT be linked to our challenges of efficiency, of patient-centeredness, of patient control, of consumer rights, the needs for improved quality and real accountability on quality? Absolutely. We shouldn't think of those without thinking about the implementation mechanism, which is largely technology, and we shouldn't think of technology devoid of the solutions that it brings. So I'm 100% focused, as we've been in the American health information community, on taking IT out of a vacuum and creating a solution context.

Q: You talked about a lot of things coming up in the spring. Can you talk about that?

BRAILER: Well, I think the particular thing to watch for here will be two things. First, is the report of the Health Information Security and Privacy Collaboration. This is a group that's gotten very little attention because it's been quietly working for the past year-and-a-half. It is 38 state leaders -- 38 states that have come together to perform their own in-state analysis of privacy and security requirements -- what they need, the state of their policies, how big the gap is, how they could close it -- and then all of those states talking together at the federal level about how to make sure that we don't have a patchwork of privacy and security polities. We can't have a world where information can't be shared because two states have equally good but different privacy and security policies. That doesn't mean they all have to be cut from the same cloth, but they have to think about policy interoperability just like we think about technical interoperability, which is designed to allow collaboration where it's intended.

That report will be coming out in late January or early February 2007, and I think it promises to be quite hard-hitting because its substance is deep and rich. There's been a very, very deep amount of analysis about how to anticipate the privacy regime for the future. And, secondly, it represents 38 states more or less saying to the federal government, 'If you guys don't act on this and get something in place, we'll just do it ourselves, and we'll do it

through a series of coordinate state and legislative policies.' And I think those are both viable options, but I think it will raise the debate about the form of the solution, as well as the substance.

The other is the Nationwide Health Information Network final report. As you might have seen last week, there was an announcement of Phase II of that project, which for anyone who looked at the strategic framework that we published in July 2004 knows that it's actually Phase III, but we really skipped a phase. And the piece that will really bring this forward is the profoundly substantive report about what it takes to create a medical information backbone in the U.S., the secure information-sharing highway that really allows information to flow between doctors and for public health purposes and others.

So I think those are the two things that I'm watching for, particularly, but clearly in the background of this, Kris, there's going to be a large number of other smaller activities. For example, the American Health Information Community work groups will all start reporting out their next round of recommendations on breakthroughs starting in January 2007, and there will be other reports from the Certification Commission and other groups. So there's just a lot of activity going on right now at the federal level, let alone what's happening at the state level, with various state initiatives and taskforces beginning their report-outs in early 2007.

Q: When you were in Washington with ONCHIT, you sort of acted as … I don't know whether 'cheerleader' is the right word, but you were definitely out there talking the talk about health care technology. As I listen to you now, you're not in that role anymore, are you as optimistic as you once were? What's your take about the amount of movement that has been made, the amount of progress that has been made?

BRAILER: I first tried to do two things, and I did focus a lot of my attention on how to set expectations appropriately because I felt that the overwhelming share of public leaders, and certainly the public and many doctors, significantly underestimated the benefit and impact that appropriate health IT could bring to the practice of medicine, to the social dilemmas that we have in health care, to some of the physical challenges. And I spent a lot of time raising their expectations. I made it a point to make sure that I was with every governor talking about health IT; that I talked with any

legislature that wanted to talk; that members of Congress, opinion leaders, boards of hospitals, physician leaders, opinion leaders, if they wanted to support and talk about health IT, I wanted to support and talk with them. And that was one of my largest goals -- to set the potential for this disruption in both a positive and inevitable framework.

On the other hand, and this was less noticeable publicly, I spent a lot of time lowering expectations, particularly from the health IT communities themselves, vendors, medical informaticists, academics, well wishers, dreamers, people who see change in health care being friction-free -- I spent a lot of time lowering their expectations and trying to get them focused not on the joyous benefits that technology can bring because I think the overwhelming share of people who support that, who know about it, and there doesn't seem to be a lot of dispute but on what it takes to go from this potential reality to a real reality of the future.

And this is really what you're hearing more, I think, coming out publicly because not so much of my change -- I, you know, tried to make a point to be bluntly candid about anything that I believed in front of any group -- but I think what you're seeing is it's a stage of where health IT is now, Kris, that these issues of how do you grind it out, how does it happen day-to-day, there is no easy solution. There are members of Congress who will become more prominent in the next Congress who can talk easily about mandates and requiring the industry to do these various things. And that's a pipedream because of the incredible voluntary change that has to happen fundamentally in how a doctor treats a patient, and you can't legislate that.

So what you're seeing me focused on now and trying to focus everyone on is don't lose the dream but focus on the day to day realities of making this work in a good way.

Q: So where is the change going to come from, David?

BRAILER: Well, I think the change, Kris, comes from every place but Washington. You know, there was a reason I spent the overwhelming share of my time outside of Washington, in states and in the private sector, because that's where change occurs. I see states moving quickly, and they will do more in 2007 to create a more fertile environment for health IT. I think, in fact, some of the leading states are now in a contention for who gets

to become the headquarters of health IT, where companies want to locate, where they have a specially trained workforce, where they have the environment for health IT companies to innovate. I think they do this by creating change in their own health care industry and an environment that's quite welcoming. I also see states competing to understand that health IT is a way to train many, many health care workers who have never touched technology as part of their job. So I think some will come from the states -- not all, but some.

The private sector is there. Remember that in the backdrop of all this, adoption has been going up. The CDC reported at three AHIC meetings that the adoption rate was up 20% year-over-year during a two-year period and that we should have a reason to expect that to continue. Now, this is clearly adoption of the willing, those that want to drive change. But that is, really, I think, a remarkable change. So it's coming from the private sector.

Remember that in the end, what I was doing was accelerating the inevitable. I always told people that the battle over health IT adoption was over. It was just a matter of time. The real fight, and this one I don't have such optimism about, is the fight over patient centricity, or patient control of their health care, and, therefore, control over their health care information. I think largely speaking, everyone in the industry agrees that if anyone should not be doing that, it's the patients. And the lip service that we see really is a recognition that people just don't see how to make that happen without disrupting so many of the things in the health care industry. So I think that really is where the fight is. And that's not so much a health IT battle. That is a battle over the heart and soul of who owns controls and who sets the priorities for the health care system. And I think that's a cultural debate that will play out in various ways, and that is a 20-year fight.

Q: Let's get back to … you talked about innovation coming from the state. Which states do you think are particularly noteworthy?

BRAILER: Well, I think New York has to be applauded for the efforts it's had with the grants and loans that support health IT adoption. It's certainly done a lot, and it's got more to do. Massachusetts has to stand out for the state support of innovative projects, of projects that really create a regional environment. I think Florida has to be applauded for the work of health IT and Medicaid, that Medicaid is a change lever. I think Louisiana, New

Orleans, in particular, has to be singled-out for health IT as a change vehicle in the care system as it's being redesigned. And I would certainly have to call attention to California, where I think health IT becomes part of a fundamental calculus of cost savings in the industry so that access can be expanded.

I think after those states, there are a lot of them that I would still consider noteworthy -- Michigan, Arizona, Kansas, to name a few. Tennessee, I think, recently, has really stepped to the front, and, obviously, Indiana, are a few states that have just stepped out to say this is important, and we're going to explore this, and we're going to take this someplace, although I can't tell you quite where today.

Q: You mentioned personal health records earlier. It seems as I watch the media that that's sort of being touted as the next big thing. A number of major U.S. employers recently announced they were going to fund a not-for-profit institute to give their employees and retirees access to portable PHRs. What's your take on that?

BRAILER: I think we're in the early foothills of PHRs. I think that they clearly support the kind of health care industry that's person-centric and patient-controlled, consumer-driven, if you would. But I think that it's early. We don't have standards for what a PHR is. Clearly, there are often huge flaws in how policies don't protect privacy of those information tools. There are clear gaps in how information gets into them because they were never deemed to be part of, if you will, the ethical health care industry as it was conceptualized under HIPAA and other rules.

So, I think there are some barriers. And these are areas where, as I identified earlier, it's up to those entities, Congress and the executive branch that created the dilemma by not anticipating this, to fix those. I don't think anyone else can do that.

But I think the promise of personal health information being shared goes beyond a record. I'm particularly excited by remote monitoring, remote patient management; things where it's not just a static database but where we're monitoring someone in their home so they don't have to be in a nursing home or where someone can be monitored in an ICU bed and a doctor doesn't have to be present all the time but can be tele-present all the

time, you know, and I won't go through the other examples. That is the same concept of a personal set of health information that is centered around the person, but it probably doesn't meet our definition of what we would call a PHR today. I view more convergence happening between that concept of the database and the streaming set of information, as we really ask the questions about what problems the PHR solves or what opportunities it creates. I think as we start thinking that way, we will come back to this set of functional tools that help us improve the patient role in health care, just like health information has helped us in traditional care delivery beyond the electronic health record -- medication administration, reduced errors in inventory management, the way communication occurs, let alone computerized physician order entry. These things that are unheralded heroes of how IT does help are a broad bundle of change, and I think you'll see that on the personal side as well.

Q: Let's get back to something you discussed earlier so I can understand. You talked about the 20-year debate over patient control in health care. Can you talk some more about that? What is that debate … what's going to be at the heart of that debate?

BRAILER: I think there are two subdebates that will play out, so it creates kind of a two-by-two table with four outcomes.

The first one is whether we will go beyond all of the lip service. The patient should be in control of the health care system, in control of their care. They should have information to make treatment choices. They should have information to make a choice about a doctor. They should have the information to be able to make tradeoffs when it comes to various outcomes. And I think this is quite pronounced as we start thinking about the genomic world, where you have so many genomic risks, like, you know, you might have heart disease in the future, or you may have breast cancer, or you may have memory loss. And you have to decide if you're going to act on that 20 or 30 years in advance. This question about whether we are going to move beyond the promise and actually make the health care industry centered on that, which is profoundly disruptive to the established interests that rely upon a very high volume of hospitalizations, or bouncing patients around, and churning patients a lot because we can't quite create integrate care processes around them, you know, that's disruptive. And I think that's a debate about how far the industry will come towards focusing on patient

control and consumer choice.  And so you could think about that as either happening or not.

Secondly, and I think apart from that, there's a debate about the role of government. We're sitting in a hybrid system now.  Government intrusion in private sector, or participation -- neither one is dominant and neither one has the leverage to make it cohesive.  The industry can't do what it's done in other industries, which is squeeze out the inefficiencies and create, really, a seamlessly integrated experience.  Look at the financial sector, elsewhere. Nor can government do this because it doesn't have control, and I think it has a lot of conflicts of interest with respect to how to make health care work versus the Medicare Trust Fund be solvent.  And so you see kind of that being … now sitting at a point of maximum agony.  I think that's going to flip one way or the other. So we could have a very government-controlled system that's consumer responsive or a government-controlled system that is quite provider-driven, and we could have a private-sector system that's one or the other.

And I think those two subdebates will determine where the zones of play are.  But as I said, I think it's a cultural war.  I believe that from the beginning of health care until now, you know, we've relied upon a passive patient.  And even the concept of the patient as a consumer has become derisive.  And I think that's a term of respect, to some degree, to recognize an autonomous active participant who really is driving care and who is seeking professionals to help them frame those kind of choices and treatments.  That is a cultural issue about whether patients will continue what I've seen as their activation as consumers. Will they be able to continue to choose providers who want to respond to their needs that way? That's going to play out beneath all of this.

Q:  So how do consumers get engaged beyond where they're engaged now?

BRAILER:  Well, I think it depends on the consumer.  There are some things you can do. First, you have to choose a provider.  Most people choose providers by word of mouth.  There's growing information that's available about doctors' outcomes and how well they're doing. And even if that's not quite ready for prime time, you can ask doctors a lot about their volume of experiences with a procedure or a treatment, what their outcomes are, and I

think, as importantly, how they interact. Do they frame choices to you? Are they available to you via electronic means?

I think, secondly, it's about treatments. Consumers can do a lot to understand new treatments options. And I think the emergence of vertical search; a more specialized health care search is going to help really frame those kinds of alternatives. I think patients can become advocates for their care to make sure that they use their various rights and responsibilities to get maximum options and maximum benefits. And, you know, I've watched this. If you watch a middle-age person, and, usually, these are middle-class people, so it's not a general lesson yet, who, for example, get a diagnosis of a chronic illness or of a nonfatal cancer -- a severe cancer but something that they don't die from in a short period time -- a large share of those become really activist. They know what's going on with research. They're out online chatting about various doctors and who is delivering what treatments, what the state-of-the-art issues are and how to manage complications and side effects. I think this is the image of the future.

The question is how can it become something that is across a broad array of illnesses and is across a broad array of types of people? And, you know, I think the question really is whether that will broaden out and become the way people consume health care, just like they shop, almost, for everything else. That, I think, is the fundamental question about how that plays out.

Q: Before we wrap it up here, let's get back to Washington. I want to talk about ONCHIT. How important is it that the office is codified? And, also, right now, the office still has an interim director. There's nobody that's in a permanent position. How important do you think that's going to be?

BRAILER: Well, I think it's helpful for ONCHIT to have both a sense and reality of permanence. I, personally, did not advocate for a permanent office because I think the role of a coordinator is something that is not a permanent role. We should not need this in 10 years. Either we will have succeeded in having this done or we will have failed, and, at that point, I think it's time to reinvent. So I think there's a debate about whether it should be a permanent office, but, for all intents and purposes, it is as an executive order of the president. It would take an executive order of a president to undo this office, and those are unprecedented, they're really unusual. Would it help to have congressional statutory support for it? Of course. I think it would give

everyone that sense that it's here, and it's here to play in Congress -- more importantly -- have skin in the game with the office, as opposed to it being somebody else's idea. But I still would think it should sunset and have a real review after seven years or ten years at the outside and ask, 'Is there really a role for a coordinating vehicle, given that, again, the war will largely either be over or we will have failed to achieve the goals and then have to evaluate?'

Q: What's been the problem with going beyond an interim director?

BRAILER: Well, it's been a very long and complicated search. And I've been a very, very strong advocate -- both in public but I think even more behind closed doors -- for the next coordinator knowing how the levers of government work -- for understanding how the bureaucracy behaves, how budget decisions are made, how congressional oversight really happens on a day-to-day basis with these physical and policy decisions. So I'm very happy, very happy, that Rob Kolodner came over. He's actually one of the first people I ever talked with when I was contemplating leaving. Rob, of course, was very happy and secure with what he was doing.

I would expect that you will see movement on this soon. I expect that you will see the priority that's been placed on having a permanent coordinator become visible and public soon. And so I'll leave it at that. But I think it's fair to say that this has been a very difficult and complicated assessment of the kinds of people, the kinds of experience and the kinds of direction that this office needs to have.

But once you bear in mind that the four office directors are Senior Executive Service, they're the most senior-level government executives outside of a political appointee, and they are permanent civil-service positions. So there is a permanent staff there. An interim coordinator is there. Rob has done an outstanding job. And I think you will hear more about this soon, and I think the industry will be very happy with how this is going to play out.

Q: So what's next for David Brailer. I know you're still involved with AHIC but have you plotted your next course of action?

BRAILER: Well, I've been thinking about this a lot, Kris, and I appreciate you asking. I decided to sit out for several months to give me flexibility to

support the office, the initiative and other things and to have a chance to evaluate where the health industry was and where issues are going to play out. After the first of the year, I'm going to be making some announcements about directions and activities. My focus is going to continue to be on things that fundamentally improve health care quality and efficiency, that continue private-sector innovation, that allow new ideas to come forward. I will leave it at that. But I would characterize it, Kris, by saying I've done the same thing my whole career. I've brought good ideas to the floor that have helped change the fundamentals of health care, and I'm not going to stop now.

Q: Well, that sets up our next session for some time after the first of the year. Thank you, David.

BRAILER: Thank you, Kris. It was good chatting with you.

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