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Ask the Experts: Health Information Technology
June 30, 2005

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JILL BRADEN BALDERAS: Good day. I'm Jill Braden Balderas with Kaisernetwork.org. Thanks for tuning in to Ask the Experts; our regular web show that allows you to interact directly with the nations top policy experts. Today our subject is health information technology. And as always, we want to include you question in the mix. You can either email us at ask@kaisernetwork.org. That is ask@kaisernetwork.org or you can call directly to the studio – 1-888-Kaiser 8. That's 1-888-524-7378.

So what will a national information network look like and who will pay for it? Can it improve care for patients, reduce waste and save money all while protecting privacy? And just what will it take to achieve interconnectedness between the various parts of our often-fragmented health care system?

To help us work though these questions and more, we're joined by Dr. David Brailer, National Coordinator for Health Information Technology; Dr. Winston Price, President of the National Medical Association; and Dean Rosen, Director of Health Policy for Senate Majority Leader Bill Frist. For more information on our guests we posted their bios on the Ask the Experts website.

David Brailer, I will start with you. First of all, thanks so much for joining us; all three of you. You've been in your position for a little bit more than a year now. Can

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you start off first of all talking about what your charge is as the National Coordinator and what are the various moving parts that you are dealing with in order to build this national network?

DAVID BRAILER, M.D., Ph.D.: Sure. There really are four parts to the charge that we have. First is to give advice to the leaders in the federal government about health information technology. To wit: to raise the IQ of the government about this new area. Secondly, to coordinate among the federal agencies that are involved with health information technology of which there are more than thirty. Thirdly, is to coordinate activities in the private sector to be able to make sure that it's a public-private solution. And then finally, to make sure that we move in a very directed way towards the goal the president set, which is having widespread use of electronic health records within now nine years.

The key pieces to this are first, interoperability or portability of data – to make sure that information is portable; that it follows the patient. That when you show up for care, that your information is there. Or, contrarily when you don't want it to, that the information doesn't go someplace. The other half is insuring that we have widespread adoption. Today we have an adoption gap, meaning that some organizations have electronic records; some do not. And we want to make sure that it is ubiquitous, widespread and that

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it's a very level playing field.

JILL BRADEN BALDERAS: Now Winston Price, he just talked about the adoption gap and one key piece of that, is physicians and hospitals. Where do you see their part in the adoption gap – why are some adopting and why are some not?

WINSTON PRICE, M.D., FAAP: Well we live in difficult times right now for physicians as well as a consumer group and access to health care as well as the affordability of health care is an issue both side of the equation. I know physicians now are stressed with respect to the issue of malpractice insurance and rising premiums for many groups and so the investment issue, which I am sure Dr. Brailer is struggling with from the government side. It's a major issue in terms of the adoption and the acceptability of that for physicians.

Larger groups in hospitals obviously have a greater stake in being able to invest large sums of money and look at the long term return on investment as it pertains to electronic medical records and information systems. But the small practice, the one and two physician practice to expend twenty to fifty thousand dollars looking down the road of how that investment is going to portend for them in terms of increased revenue as well as improvement in health care is one of the things that we have to overcome.

JILL BRADEN BALDERAS: And what are the considerations that they have? There's obviously the business side of thing

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and then there's also the quality of care side. Do you think those things are equal or are they weighed differently in the minds of physicians? And those – some people, even in the small practices have adopted these electronic health records, what has made those who've been early adopters actually go through with it?

WINSTON PRICE, M.D., FAAP: Well, I think across the board physicians who have been early adopters, agents for change, have seen the benefits and the reduction in terms of medical errors; the improvement in terms of efficiency and actually most of them have begun to see the return in investment in terms of the lack of having to spend money on paper and lost records. And the improvement and satisfaction of the patients have been a tremendous boon for those physicians who have met with the challenge of the technology. But there are the nay Sayers who are very resistant, and Dr. Brailer knows, in making that leap of faith.

JILL BRADEN BALDERAS: This issue has a lot of momentum on Capitol Hill. Actually Dr. Brailer just testified today before a committee hearing and a new piece of legislation was introduced even today. So, Dean Rosen, can you just start off by talking about the momentum on Capitol Hill – there are several bills that have been introduced. What are the similarities and the difference between the bills and do they have bipartisan support?

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DEAN ROSEN: Sure. Well this is an area Jill, as you know, where it is sort of surprising in health care policy because you've got republicans and democrats coming together around something, which is actually very exciting, I think. The president and Secretary Levitt and Dr. Brailer really led the way, but there is a lot of things that I think that Congress feels like they want to work together on; they want to be helpful in reaching this goal of now nine years and making sure everyone has these interoperable health record s and that leads to quality improvement.

So, there's a lot of energy around it. My boss Senator Frist introduced a bill a couple of weeks ago with Senator Hillary Clinton, so you can see they don't agree on very much but came together around this issue, so that's an example of the momentum that's out there. Today Senator Enzy, Senator Kennedy, Senator Baucus, Senator Grasse, the Chairman of the Key Committees in the Senate came together around products that are very similar; and so, I think we all want to try to work together so to support the president's goal; fill in the pieces legislatively that they may not have the authority to do and that they can't do looking at those key areas that both Dr. Price, Dr. Brailer touched on in terms of quality adoption dealing with the adoption gap in dealing with this connectivity or interoperability.

JILL BRADEN BALDERAS: And another interesting

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political odd couple too out of this is Hillary Rodham Clinton and Newt Gingrich as well. Newt Gingrich has been a real big player in this whole issue as well.

Now one of the words that I think all of you have used is interoperability in standards. Dr. Brailer, can you talk about interoperability in standards; a) what that means and how difficult that is to achieve and what it is actually going to take to achieve that?

DAVID BRAILER, M.D., Ph.D.: It's a – it is a challenging issue and it is one that is new to health care, but it is not new to other industries. I think the best way to define interoperability is around what results whenever it exists, rather than what it is.

What results is portability of information. Many people see more than one doctor; or admitted at more than one hospital; receive drugs from more than one pharmacy; or go to multiple laboratories. Certainly over time we all do that. So that the portability challenge is can you get all of your information in one place in a relatively seamless way that is useful? Beneath that are many are many other parts of what you would call interoperability. For example, can a hospital or a doctor report data to the government that's need for quality monitoring or for bio-surveillance or public health issues without having an economic burden without being expensive or burdensome.

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Or could two different hospitals or other entities in the health care industry share data in a way that allows them to eliminate paper processes; without having a significant investment in very specialized technologies. So interoperability really implies the ability to have information be, if you will pardon the term, "plug and play," so that information can be shared.

To make it happen requires a lot of moving parts. First, standards have been talked about a lot. The United States is quite standards rich. We have many different standards, but we don't have a seamless, unified, coherent set of standards. One of the things that we've asked through the RFPs that we have out today; more of the features it is common with many of the proposed legislations is to have a coherent set of standards; a single one for the United States. Clearly necessary but it is not sufficient.

Secondly, we have to have the ability of information to have a network, if you would, that moves it securely. Not unlike how e-mail moves or cellular telephone calls move; there have to be components that move the information; know where to send it, that can protect it along the way; can handle other features. And we've addressed this through the National Health Information Network architecture contracts that we've put out.

The third piece is having electronic health records that can, if you would, plug in to that and can share data.

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Can get data that a doctor needs or provide data that the doctor wants to send. This is the equivalent of someone's cellular phone connecting to a wireless service. We want to make sure that electronic health records are able to connect to those streams and therefore we put out an RFP for a certification process.

And finally, this is probably one of the largest policy dilemmas. As we move from this paper-based world to an automated world of health information exchange on an electronic basis, there are new policy regimes around security and privacy. It would anticipate that portability and we've asked to begin defining what that looks like through another contract.

So, we're trying to address head on all of the interoperability issues because the strategy that we have laid out is to become quite forward looking on interoperability so that every time an electronic health record is purchased in the future, it becomes something that can be part of a greater synergistic hole of health care information to serve doctors, patients and the rest of us.

DEAN ROSEN: Jill, I think the one thing that I want to add too, is sometimes we have good examples now of where things go or could I think – helps people understand this, but most people know that even if your bank is in Cleveland, Ohio, you can be in Los Angeles, California and take out money and it

will tell you what your balance is almost instantaneously.

But, if you are visiting a physician here in the Washington, D.C. area, in Maryland and you have to go the emergency room at a hospital in D.C., or in Virginia, they can't generally transfer your records of your key health information across county lines or even sometimes across departments within hospitals. So that has critical health care issues when someone is in an accident while they are traveling or even when they are not traveling. Part of this goes in this adoption issue too, of the small practices because – and one of the reasons I think standards are some important; not only for consumers and is with physicians. I spoke to cardiologist a couple months ago who told me they practice at three different hospitals. Their cardiology group, each of those hospitals is using a different kind of medical records standard. They can't transfer any of those back to their own patients that have to spend all this time adapting.

If we had sort of a single standard where they could all connect and talk to each other, I think it would help give physicians and other providers the confidence to buy into this and to move more toward it.

S, I think those are some examples of why some of the standards are really important.

DAVID BRAILER, M.D., Ph.D.: And you know Jill, the National Medical Association has a stake in this because the

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populations that we serve are a fragmented population in terms of access to health care. So, the very things that Dean described, creates an environment where there are patients that have different segments of the health care environment that they have to touch.

Not only on a daily basis, but over the course of their life span. And so you can imagine a health care system with electronic medical records that can talk to one another. And that is a population because of the disparities in that population that would benefit most from the efficiency and the interoperability of systems so that they can talk to one another to minimize the expense and the waste.

We lose probably somewhere between 44 and 98,000 individuals a year to medical errors, inefficiency and waste. And as Dr. Brailer is coming to grips with, that translates to somewhere between 200 and 300 billion dollars a year in waste.

Well, I can tell you a population suffering from health disparities that can benefit from the use of some of those funds.

JILL BRADEN BALDERAS: Let’s stay on that topic of undeserved communities and then I want to broaden it back out a little bit, because I think we need to touch on certification and efforts to actually certify these systems; that they are actually interoperable and then I also want to talk about, if I am a doctor, where do I start? Are there resources for me?

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We actually got an email from a viewer in New York with the Children's Health Fund, wanting to ask about access to these services and its technology for the underserved. How will policy makers ensure that providers of primary care to the poor, uninsured, and underserved have equal access to the same high quality, state of the art health information technology, as providers and hospitals with greater resources? Dr. Price if you'd go ahead and then open it up, I'd like to get everyone's comments on how that could be possible?

WINSTON PRICE, M.D., FAAP: Obviously if the government can set some standards and everyone is concerned after going through the whole HIPAA evolution of trying to move the government in having more and more control over their practice of medicine.

I think that the government has to set the pace and tone in terms of the cost of adopting this technology. Physicians have been burnt through the years in terms of the systems that don't talk to one another. Legacy systems, as they are referred to, who have had to reinvest as technology changed to keep pace. Those populations who are most at risk are the practices in the communities where they really don't have the margin to reinvest in new technology every two or three years as the technology changes.

So, one of the key opportunities that I know is part of Phase 1 for the Office of Health Information Technology is to

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look at making sure that the systems that are put in place are adaptable to practices and assures that transparency and interoperability, so that when a physician invests in that particular system, they know that is going to benefit their patients; it's going to benefit their practice; it's going to benefit the community. In turn, the return of investment to the health care expenditures for the nation is going to increase.

JILL BRADEN BALDERAS: So, what about certification? So if I am a physician, how do I know that the software that I actually invest in is going to be able to communicate and what's going on in the certification process to actually let physicians be confident in these systems that they purchase, because it is a great investment?

DAVID BRAILER, M.D., Ph.D.: Well first I think certification we highlighted because it is one of the central hubs of many things that we want to achieve. You've identified one, which is, giving confidence to the physician buyer. That what they are buying is interoperable; that in can connect to the streams of data that they want and that it doesn't require specialized configuration.

Secondly, those certifications also, if done correctly, and we've laid out in our RFP how we think that this should be done would also ensure that the product they buy have certain kinds of clinical prompts and reminders.

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A physician using a computer perhaps is valuable. A physician using an electronic health record with decision support that reminds them about when to do mammograms or cholesterol testing; or alerts them when a drug that they're giving has a serious interaction with another drug; or, gives them information that help them make better treatment choices or avoid redundancy or wasteful treatments is an extremely valuable electronic health record.

We want to see certification also begin to determine what those kinds of prompts and reminders should be. Thirdly, certification should allow physicians to know what security features an electronic health record can have because security is the gating factor to one form of privacy breaches, which is information being made available because it isn't adequately protected.

Certification also plays a very important role of lowering the cost of electronic health records. It does so because once the certification that's available, physicians can look at two electronic health records and see that they are both certified and then ask the next question, which is why does one cost more than the other.

That doesn't mean that the product should cost more than others, but it begins to start the dialogue about what do you get for the extra money? So the market begins to stratify according to basic features and advanced features.

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We think that will stimulate demand in its own right without any other forms of subsidy. So certification plays in the middle of privacy and security. It plays in terms of demand and adoption and it plays in terms of clinical value that we ultimately derive. So this is one of the critical features that we want to see move forward.

JILL BRADEN BALDERAS: Dean Rosen, as these physicians are wanting to adopt these systems, another issue that they are going to be faced with is cost. Can you talk about what's the consensus or if there is a consensus on Capitol Hill of what kind of initiatives that can be offered physicians and hospitals to encourage them to adopt these?

We actually got several emails about whether reimbursements would be a way to get physicians to adopt these systems?

DEAN ROSEN: I think that's really a critical question in the kind of the thing that Dr. Price spoke to too, which is how do you get this everywhere? You've got places like Vanderbilt in Nashville that are doing a great job but there are sort of an island out there and how do you make sure that there isn't this disparity or this gap.

One thing that is a feature of one provision of a lot of bills that are now before congress and our bill is a grant program that is needs based and it is not just – and I think this is an emergent consensus – it's not just giving money out

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to buy software or hardware. But it's giving some money out and saying we're going to put some matching federal dollars on the table but the private sector has to invest in this too.

At the same the goal is not just to purchase the hardware or software, as I've said, but, to try to bring people together to work together within the community. Whether it's in a local area or regional area; large or small; with an eye toward including everybody, including some of the providers that often get left behind and patients that often get left behind to work together so that the communities themselves are interoperable and they are helping to build this broader national network.

So, I think some federal funding, as an incentive is part of it. The other thing that I think is really important is that we too often today in some our federal government programs and I think this is followed in the private sector too, send the wrong signals with the way we do reimburse. It is not always necessarily just giving more money; but paying in the right way - rewarding quality instead of quantity. I think that an electronic health record with decision support tools is clearly an important part of that.

We also need to deal with some of these other issues, where costs are growing for providers like medical liability and other things which are related, but not directly, but important in terms of the environment.

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I think one of the things that I think Congress feels they can do working with the administration on a national level is to provide some grant money; number one, in areas of need; moving toward collaboration, cooperation, but also trying to look at Medicare for example. Look at the payment system and try to send the right signals in terms of rewarding the adoption technology but not for technology's sake; the use of technology for proven quality.

WINSTON PRICE, M.D., FAAP: There are some success stories. In looking at anesthesiology, they have been able to reduce their malpractice premiums by the adoption of technology and the use of electronic clinical systems.

We're hoping that the message will get out there with respect to the import that the electronic medical records and clinical management systems. These are two different things. The impact it will have on reducing health disparities and proving efficiency and ending medical errors.

JILL BRADEN BALDERAS: We actually had a question from an ABC News correspondent, if there were any other examples besides the anesthesiologists; of specific groups that had actually been able to reduce their medical errors. So could you first explain what the difference is between medicals records and then a management system? And then are they are other examples?

WINSTON PRICE, M.D., FAAP: The electronic medical

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records is really a fancy bookkeeping or indexing method to electronically capture and keep the data that physicians heretofore in our antiquated health care system were put into paper. What the clinical management system integrated with that, as Dr. Brailer described, puts in the decisiontry, puts in the interface without outcomes and to create an environment for best practices. So that they physician who is inundated with a myriad of clinical data, inundated with a myriad of laboratory tests that come back all the time and also faced with more than they need in terms of the pharmacal field. And articles that come across their desk everyday.

It' impossible; really impossible for physicians in the 21st Century going into the 22nd Century to encompass all of that information in clinical decisiontry. So the clinical management system takes this electronic medical record and crunches that information and gives them the extra support electronically that they so desperately need. And indeed, what we're going to see – I know there have been issues about whether this interferes with the doctor-patient relationship and the warm, fuzzy feeling. But what patients really enjoy are physicians and health care providers who really known them; who really can relate to the myriad of test and their history and there is no way to do that, without an electronic clinical management system.

JILL BRADEN BALDERAS: We talked a little bit earlier

about funding and grant making. Can you just talk about the importance of that so not only the money aspect of getting people to adopt these systems? Then also the importance of the federal government setting an example for private sector to actually adopt these systems?

DEAN ROSEN: Sure, I think you are asking about two pieces that are the critical ones about driving change. The first is how do we create the imperative to have this new future become reality as opposed to a dream?

The federal government has played the catalyst role in many industries including health care and our fundamental choice here was not to move this forward on a regulatory basis. We issued RFPs and not notices of proposed rule making on a very purposeful basis which is if we want to have market forces or if we want to increase the capacity of the consumer to have better information and have doctors have an alternative on a better way of practicing medicine; we have to make them want to do that. We have to help them achieve their goals rather than telling them they have to.

I think this was a breakthrough because it's so much easier just to issue a large document telling the industry what to do. That means though that the government has to begin using its purchasing power. We've seen some elements of this. You'll see from the Veterans Affairs Department from the Department of Defense, how they'll use their purchasing power

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to move this forward. The Office of Personnel Management that uses – that manages the federal employee health benefits program has already created its first round of notices around health information technology programs for its health plans that are involved there.

You'll see Medicare continue to move forward and we've even see in Medicaid where states have waivers that health information technology is considered part of a successful waiver process. So there are many elements and we'll have others to come but we want to use our power as catalysts; as a purchaser, as a market mover to be able to make this happen. Partially it's for the other reason you mentioned which is how do we fund the change.

This is quite expensive and the old adage is "you can't buy love," you also can't buy quality in health care. We have to create the institutional capacity, not just within a doctor's office, but in the market itself for good quality. So these mechanisms that we're setting up with the RFPs and other things that will come are to create the capacity for change.

Capital we want to come from the private sector as well. We want to create a market for health information that means that investments will be made so that information can be shared. We want to create a better market for health information technology so that capital will come and be invested.

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Clearly there will come a point where the federal government will continue to invest. It is doing it now. We wan to make the conditions right so that we not only achieve interoperability and adoption but we do so on a basis that delivers real value for the American people.

JILL BRADEN BALDERAS: You talked about several federal initiatives to adopt this technology. We actually got an email from some at HERSA saying, "Why are your numerous efforts relating to electronic medical records being duplicated by various federal entities? Collaboration among government agencies would result in compatible electronic medical records, saving federal dollars and be the most cost-effective over time." How would you respond to that?

DEAN ROSEN: Well I guess at the most rude it is human nature, but here's what I mean. That question could easily be asked two hospitals share the same the patient population and many common doctors, why is it that they are not sharing information? And the answer is there are separate organizations with separate goals and with separate means of achieving their goals.

That is true of federal agencies. They have different policy purposes; they come to be for reasons that are different than health information technology. They are there to reimburse for case, to deliver care, to provide health benefits, it could be a myriad of different federal agencies.

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They are all quite diligent about achieving their goals, which means they want to achieve them in the most expeditious way possible.

Health information technology using electronic means of collecting data, using electronic means of being able to management their own information is not their primary purpose. And therefore they don't want to cooperate with other agencies because it takes much longer and it puts their own initiatives at risk.

What we've done in our coordinating role within the government is begin a dialogue to say did you know that this agency is doing something similar and often they don't know. Sometimes when they do know we need to have a process to begin a dialogue so we have developed many opportunities within the government where we can streamline and align, not just so we can get better buying value out of our taxpayer dollars when it comes to federal agencies, but much, much, much more importantly, many of the agencies don't exist in a vacuum, they are collecting data from doctors and hospitals and laboratories and pharmacies for a wide variety of reasons. And that's opposing huge costs on the private sector where they have to submit data in various different formats and different methodologies.

We want to see that streamlined, maybe not ever down to one way, but down to the minimum few number of ways

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that we can collect data to have a very streamlined way so that the whole health care silo can work can work including research via surveillance, health care reporting, quality monitoring and other legitimate government purposes.

JILL BRADEN BALDERAS: Now, one big part of this, too, is protecting privacy. When you are talking about all of this information that's being collected and possibly used for monitoring any sort of bio-terrorist attack, public health surveillance, all of that, Dean Rosen, can you first of all, start off by talking about what's included in the some of the bills on Capitol Hill to protect privacy, how big of an issue that is for law makers.

DEAN ROSEN: It's a big issue because one of the things we haven't talked a lot about, we have talked a lot about the government role and the provider role, but it is the consumer role and the patient role. And I think that to get patients to buy in to this one aspect of that is giving them a level of confidence that their records are going to be secure and that doesn't mean private necessarily, but it means confidential. By that I mean you want to have a sharing of information between a physician and a patient, but you don't want to have that information broadcast to the outside world, but you want to have it interoperable and you want to have it secure.

We fortunately have in place some federal rules that were adopted as part of the Health Insurance Portability and

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Accountability Act. It was passed in 1996 so several years after that, but almost a decade ago, that gives us a platform least to start with that says that your information is going to be secure and what the bills says that we have introduced with Senator Clinton and Senator Frist says that we want to be very clear that those federal privacy protections that are in place under regulation today apply to any information or any activities that take place under this bill or with electronic records to make it crystal clear and to give patients that assurance.

So I think we have got a platform, we have probably got to look at those rules over time and make sure that like anything they keep up with the information age, but I think that's an important goal that's shared across the board by policy makers.

JILL BRADEN BALDERAS: Dr. Price, I was going to take the next, on the same subject.

WINSTON PRICE, M.D., FAAP: Absolutely.

JILL BRADEN BALDERAS: As someone who interacts regularly with physicians and patients, do you feel like A: this whole notion of a national health information network is on their radar screen? And B: Do you think at this point that they actually do feel confident that their records will be kept safe?

WINSTON PRICE, M.D., FAAP: Right, and particularly for

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the population that we serve, one of the key issues with respect to a population affected by health disparities and this is the whole issue that relates the digital divide. If there is a population of individuals who don't have regular access in a private setting, one of their access portals to using the technology is through the public environment. And so they are going to be particularly apprehensive about putting their health information in a public place using Kios [ph] either in hospitals or Kios in the medical offices or Kios in the airports or wherever they be, if there is not the assurance about the confidentially and the privacy.

And as you know, certain populations have been concerned throughout our history with respect to being experimented on and having some hesitation about their privacy. And so I think it's very important that this privacy issue be paramount in all of the legislation and all of the technology as we develop it.

Unfortunately for minority populations, we are more at risk with respect to HIV AIDS and illnesses where privacy is key. And so if you are putting that information in an environmental situation electronically, you want to be darn sure that those individuals and those companies and forces that may discriminate against you don't have access to that information.

JILL BRADEN BALDERAS: Dr. Brailer, I know that privacy

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is paramount to everything that you are working on, so could you just talk about what efforts you guys are – what are the great pains that you are going to to secure privacy?

DAVID BRAILER, M.D., Ph.D.: Sure. Well, first and I think Dean already spoke about this, we certainly see with the HIPAA framework in place it gives us a platform to work from. And the at the same time we are trying to anticipate first what the questions are about this information age. As information bombs port table, how do we make sure that the concepts of privacy that were developed in a paper age continue to play forward? They are different concepts; perhaps the principles are the same. So we are trying to find that and one of the projects that we have laid out for the coming year is to begin asking those questions.

Secondly, as security continues to evolve over time, in other industries there is a very organic method of developing new security regimes and challenges to those regimes. And health care needs to be part of that. One of the things that we think is important is that health care not be its own environment with respect to security, that we stay at the state of the art across the board. Not only to protect patients' privacy, but as our health care information systems become a critical part of care delivery and Bio surveillance, they become a critical infrastructure for the United States. And you can imagine the horror of a bioterror attack.

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Imagine that if our information network would allow us to do early detection, resource, planning and delivery was taken out at the same time. So we have real challenges to deal with security and we want to step up to those, but ultimately the questions that are the furthest out there are fundamental questions that consumers have. Do I control my data? Do I get to determine who sees it and what they do with that? Is it mine or is it someone else's? And these are very large policy questions that I think are still at the very edge of social debate.

So we want to make sure that we begin a process to begin bringing those in to very real discussion.

JILL BRADEN BALDERAS: Now, a lot of this information that will be shared will be done within communities, so can you talk about what Rios [ph] are, kind of explain what that is because that's a big part of the plan. And then we actually had an email in from someone from the University of Utah saying what do you think local health departments should be doing to help build Rios in their community? What do they need to do to be prepared to exchange the data through a Rio?

DAVID BRAILER, M.D., Ph.D.: Well, a Rio is a term that has been given to describe the coming together of community leaders, physicians, hospitals consumers around creating a capacity to share and protect health information. And it's, when you think about it on the one hand, it seems obvious that

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that would happen because health care is such a local activity and some people have so much at stake in it. And there is nothing better than being able to look across the table and see the people that are involved in your health care delivery.

On the other hand, it's really kind of surprising, in fact, it's one of, to me, the great surprises of health information technology that the American public doesn't view it as a dry issue that's going on in Washington. What they see is something that's happening in their local community. It's a sweeping grass-roots movement that's happening in nearly every state at this point. It's touched more than half of our legislatures, the state governors mansions, it's affecting various aspects of care delivery in the local area because people want to see something happen.

Despite the abstractions and the theory and the statistics, people see that when they go to see their doctor, they don't have information and it's hard for them to get it and they are worried about that. And even Kaiser Family Foundations surveys have shown some of the if you would, voting with their feet, personal health records. And I think that Rio is the response to that let's organize and let's do something.

So what they are doing is quite broad. Many are coming together to develop protocols and moves and ideas of how to protect information. Many are coming together to work on projects. A common project is, I want to show up at the

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emergency room and have my data with me. We call that a "follow me to the emergency room" project.

Others are doing things with public health agencies to advance public health reporting or to get public health alerts or advisories to doctors' offices. Many are doing initiatives to try to help doctors rationalize all the information coming forward. Some are doing projects to help doctors reach out that have email or electronic communications with their patients.

It's a very bootstrap effort to try to do this. There's not a lot of order or structure to it, some are developing their own technology, some are simply enabling it and trying to figure out how to bring the parties together. And we are watching this.

In fact, the government, the federal government is the largest funder of these regional projects today through the Agency for Health Care Research and Quality and every one of them has to report back to us their experience and what they have learned and what the issues are. And as that information comes in, we are using that to try to decide, what is the local basis? What is the local component of this infrastructure that we are building?

I don't think anyone believes that this is a Washington at word effort. It's really Washington reacting to the leadership of the local communities and so we want to accident

in a way to help elevate that and build that and not try to steer it or in any way change its direction because it's such a genuine and authentic energy.

JILL BRADEN BALDERAS: Now, Dean Rosen, I know that Rios are included in some of the bills on Capitol Hill. Do you get the sense or the feeling of law makers as what Dr. Brailer said, that this should be coordinate the outside of Washington that this isn't something that should come from Washington?

DEAN ROSEN: I think that there is clearly a role for Washington to play and I think we have talked about it and touched on a lot of those aspects today in terms of standard setting where the private sector can come to the table and set standards in a collaborative way and the government can help adopt those and sues those in there program. So there is clearly a role for the federal government.

But I think David is right, that a lot of the activity is going to have to take place in local communities and physicians offices and hospitals in clinics across the country and I want to come back to a moment to this issue I touched on before which is if the consumer is, I think, weighing even the privacy issues when they see and when they have experienced the benefits of what a personal health record or a clinical management system can do in terms of reducing the hassle factor for them or improving the care or the communication with the physician, want to buy into this so I think there clearly is a

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role for government.

But just like with cable television, where consumers wanted more channels and clearer pictures and just like the cell phones where they wanted to be able to calling everywhere, I think that once this is out I think consumers are going to help and patients are going to help be a key part of driving this and using this information to work with their physicians to help manage and self manage their own health care and so that’s an important aspect, too.

So clearly Washington has a role, the communities have a role in terms of collaborating and helping to build these. But I think the consumers demand, once we set the platform and once we help pave the right way so that we are not working against consumers, I think is really going to fuel the development of records and the interoperability across the country.

JILL BRADEN BALDERAS: So Dr. Price, what can we do to get consumers involved? How can this network be made? We actually had a number of emails about how this network can be made to be consumer friendly. So the data that is being pulled from other sources is probably very technical. How can this system actually be used to be output into a personal health record?

And if you also can talk about had a a personal health record is, too because I don’t think we have gone over that,

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but how can this very technical information be made user friendly for people?

WINSTON PRICE, M.D., FAAP: Making it user friendly is part of what the United States have been able to do with ATM machines, with people checking into airports, with people taking care of a lot of their banking transactions on a daily basis telephonically. And I think if we do anything right with electronic medical records, most consumers won't notice anything different than picking up the remote for their TV or programming their VCR. Which some people still have problems with, I see the 12 flashing all the time.

But I think there are a number of technological ways to make this transparent. Obviously using radio frequency devices, the fact that the implantable electronic health record was approved by the FDA some time ago, but consumers have to feel that they don't have to do anything other than continue with drawing from the benefits - as Dean said - drawing from the benefits of the electronic clinical records.

And once they feel that benefit, one they feel their health care is improved, their access to health care, the whole environment of that health care interaction is improved, they will drive the business in terms of what's going to make it work for everybody.

I think one of the key issues with respect to what consumers are going to find that makes their adoption of

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electronic medical records beneficial to them is the fact that their cost of health care is going to go down. And I think the efficiency has to transmit back to the consumer and back to the regional health organizations so that communities dealing with problems of diabetes or asthma begin to see some of those programs put in place through the money that's saved through the adoption of electronic medical records.

JILL BRADEN BALDERAS: And there have been any number of studies recently talking about how a great part of health care spending is because of chronic illnesses. Do you get a sense that people on Capitol Hill realize this and that's one element of wanting to implement this national network because of the vast savings in health care spending?

DEAN ROSEN: I think that sort of speaks to the fact that it's not just information for information sake but it's information technology and information toward an end which is to improve quality. And if you look at people with chronic diseases, something like diabetes I think it would be tremendously empowering to have the results of the glucose monitoring loaded by themselves into an electronic record.

It doesn't have to be anything really fancy, they could type it in themselves or they could set a little monitor and down load it, just like you do with an IPOD today or something else that you plug into a computer and the next time they go to the doctor three months later or six months later, a year later

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that record can be there and it could help give them some goals and that's true with diabetes, I think that's true with heart disease and helping people get more engaged in monitoring their own cholesterol so that they don't just scribble it on a piece of paper and every year they see a doctor and have to call up. It's a tremendously empowering, I think, it doesn't have to be very complicated, but that is an important aspect.

And also, again, it's not just patients, but patients with providers working together in ways where the information is there, it's there in real time. You can look back historically and see that the trend information which can help in terms of adjusting medications and those kinds of things.

So this isn't a silver bullet for every health care ill that's out there, but I think it is something, and I think this is why there is so much bipartisan support and it really is a nonpartisan issue in terms of the politics is controlling costs, reducing paperwork and sort of a hassle factor, and also improving overall quality and can, I think, play a critical role in all those areas.

WINSTON PRICE, M.D., FAAP: I think one area we haven't touched on is the issue of health literacy and many Americans suffer from health literacy at all socioeconomic levels, also individuals with all levels of intellect. But if we can't transmit the health information to consumers in a way that they understand and a way that they can act on and a way that makes

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sense to them, then we have failed in what we have done until the health care system.

And the electronic medical records can bridge that gap between different cultures, different languages, different communities, and making sure that the patients get reinforced with knowing about the disease and the importance of the disease and what they need to do about it.

As Dean said, with respect to diabetes, there are excellent programs that have demonstrated with asthma in particular, using the technology of cell phones reminding asthmatics to do their T-flow testing and reminding them to take their inhale steroids and this has been done with diabetics and hypertensives and several other opportunities for those areas where we are wasting money in health care and not delivering health care to populations most depressed.

I think once people feel they are spending less time in emergency rooms and there is less hospitalization, they will begin to see the benefits of electronic clinical management systems to their benefit and cost saving to the community as well

JILL BRADEN BALDERAS: So Dr. Brailer, what do you think is the best way to get this message out to the consumers about how this actually can affect their lives positively?

DAVID BRAILER, M.D., Ph.D.: Well, you know it's interesting, the research that guides our thinking is somewhat

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dissonant. I mentioned already that many consumers carry some version of a personal health record, paper based usually, because they understand that there is a kind of a paper chase that happens when they visit a hospital or an emergency room or a doctor's office.

On the other hand, research has shown that patients understand that it's important but assume that their doctor has it. So I am going to speak to that piece, which is not to have an undo reliance. I think the number one thing that any consumer can do is have a dialogue with their physician about the physician's use of an electronic health record.

Let's strip it down to its most essential aspect. Electronic health record is a form of therapy. It's no different in terms of its impact on health status as a drug or procedure or something else that the physician does or knows. And it's certainly a different thing, we don't take a computer, we use it. And it has to be appropriate just like a medication, but in the end physicians that use it according to the research can deliver systematically better more error free, more evidence appropriate, less wasteful care than physicians that do not.

So consumers need to have a dialogue with that. And there are many good reasons why doctors don't have electronic health records today; it's a very difficult process, as we've talked about, there are lots of challenges along the way and

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many doctors have tried it in the past and were just not able to get it to work an they put it aside. But the consumer needs to ask, they need to know. And they need to be able to understand what that doctor's thinking is about this and make sure that it matches their own values. Some consumers may not care, others may. But they need to have a physician whose sentiments about this are aligned with theirs, same thing with the hospital.

I think for more sophisticated consumers, people that are really surfing the web a lot and really understand information, they need to be looking for a personal health record and they need to begin thinking about how they put that together. There are numerous solutions, many health plans offer them, many large practices offer them, there are individual project products that are available through shareware, or that can be purchased. The challenge is getting information in.

But this is something that I think some share people will want to do. They want to begin managing their own health information, viewing it like their own bank account. That, I keep track of that, I would keep track of this. It's responsible and it's something that is correlated with a longer healthier life.

So I think if we ask doctors what they are doing with health records and for some if we start looking for personal

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health records, it will begin a dialogue that will take us very far down the road.

DEAN ROSEN: I think one of the issues today is that because you don't have every physician, every practice, every hospital in America that are using these, the consumers aren't necessarily as exposed to it as they are to other things. And when they start to see it, they see the demands.

I have had a dentist for example that for the last six or seven years has had an electronic record and they load the information in there, not only do they type in it, but they load the x-rays in and they load everything else and now I have got six or seven years, five years of records every time I go and it's a tremendous tool. If I went to another dentist that didn't have it, I would really question that.

And I think it's that kind of empowerment having consumers see it. We talk about these direct to consumer ads about prescription drugs, well, imagine David could write the ad for medical records and say, if your doctor has this you are going to spends less time in the emergency room, you are going to spend less time with your doctor, you are going to have to fill out less paperwork, the errors are going to be reduced, go talk to your doctor about this.

I think if consumers knew about that, just like they do when they see these drugs that are going to cure them, the benefits of this are really tremendous, but I think the more

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consumers are exposed to it, the more they are going to demand it.

WINSTON PRICE, M.D., FAAP: I think that consumers recognize now the wealth of medications that are now available to physicians and the choice that physicians have to make. There are also aware that physicians handwritings for the most part are poor. It sets up a tremendous avenue for errors when a prescription, a paper prescription has to go from the physician's office to a pharmacy to be transmitted and filled. In electronic prescribing, it's just part of the electronic medical record and management system.

That assures that there are no errors in terms of patients receiving medications that they are allergic to, it makes sure that the right dosage is written for that particular patient, that it matches the diagnosis for that patient, and that it's easily transmitted to the pharmacy in real time so that the patient can leave the medical office or the hospital or the emergency department, go to the pharmacy and pick up the medication, the right medication the first time.

JILL BRADEN BALDERAS: We have actually got quite a few more emails that I would like to get to. Dr. Brailer had mentioned earlier some early adopters that ended up failing. Because the system just didn't work. We actually had an email from someone with Cawpers, which is the California public employees retirement system asking about the Kaiser Permanente

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System. And I just have to add that the Kaiser Family Foundation is not associated with Kaiser Permanente.

And then the VA, they have their various fits and starts of implementing these systems, and now the systems that they have are deemed pretty successful. So this person writes, to what extent does either provide a model that might be a starting point for specifications or standards for health information technology?

DEAN ROSEN: Well, I think they are both leading lights in their own right and I wouldn't even limit to those two. I think in fact if you look at the adoption of electronic health records today, it's largely concentrated in the hands of very hearth organized, usually at risk delivery systems, and Kaiser and the VA are two who have the best shining examples in the U.S. in a way it's a no brainer that they have this done because they have clinical alignment, they have operation alignment and they have financial alignment.

And those organizations therefore have done very well and many others have. Are they a model? I think in terms of how they have exercised their buying process, their implementation process, how they have gone through the engagement with the clinicians to recognize that this is not about technology, it's about changing the way decisions get made, the way communication occurs, the way the culture of the organization begins to shift, they have really defined that and

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those lessons are things that are available to many and should be followed because I think they really have developed some of the best practices.

However, I don't think it's right to say that we could just take what Kaiser or VA did and put it into other organizations. The adoption gap emanates from a scale based phenomenon. Very large systems can do this, very small doctors and hospitals which make up most of health care cannot. They lack the management capacity to oversee something that's this long-term and this expensive, they lack the technical know-how, they lack the organizational change capacity, they lack many of the lever arms that large organizations have.

And I think the question that we have dealt with is how do we make this a mass retail phenomenon in health care so it doesn't take a very large, very capable delivery system to be able to do that. And many of the things that I have already talked about that we have under way are at least starting points for that, but I think beyond that is this notion that is perhaps a little abstract, but it's the idea that ultimately these technologies will allow these doctors and hospitals who are in small practices to operate as virtually integrated as Kaiser can without being part of an integrated system. That's what the internet has done for many industries is allowed power to go out to the periphery and that's what I think can happen here. But we have a long way to go before we get there.

JILL BRADEN BALDERAS: Now these two examples, Kaiser Permanente and the VA, obviously one is private sector and one is the government, can you just talk a little bit about how you see that delicate balance of the government possibly laying the ground work for the network, but then what's the private sector role and what balance are you trying to achieve?

DAVID BRAILER, M.D., Ph.D.: Well, we have started our initiative around, if you would, the network around the national health information network architecture. It's government initiated, we are using a procurement process to do this. But we are not procuring a network that the government will use, we are procuring a network to evaluate for the purposes of designing solutions in the private sector. We hope this will attract private capitol, it will attract private innovation and it will stimulate the kind of market for health information that we want to have.

Said another way, today health information lacks the infrastructure to move, it lacks people understanding what they could do with all that information if they had it, and we are trying to move both forward at the same time in the private sector.

It's our hope though that once that infrastructure gets developed and many of the federal agencies that I have described who have information collection needs for various statutory purposes would use that network instead of a

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customized mechanism that they would use to collect information for their agency purposes. So the government in many ways will initiate, but then the government will follow as well behind the private sector lead. I think it's a multi-handed dance that we are really trying to get underway.

WINSTON PRICE, M.D., FAAP: One of the concerns for the physician community is there is so much oversight and control of the physician reimbursement in their business model an the private sector given freedom as you described certainly will look to physician community particularly the small are practices as free game for the free enterprise.

And one of the big drawbacks of many physicians who won't make the leap of faith is because they feel that the electronic medical records management systems as you would have it are over priced for what they are getting. And we have been able to get around that in several other industries. You have described the banking industry; no one personally has to decide on the software package for a particular interface with the bank electronically. That's done by the bank.

Similarly, the federal government has moved with respect to filing your income tax, they took care of providing the software in a way that the consumer simply has to log on and conduct their transactions in filing their income tax. Why is it the federal government in taking the lead on this can't develop the standard, the interoperability, the

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transportability and the interface with what we know are the key elements for the personal health records and say, here it is setup on the internet for individuals to access an electronic clinical record and management system for the good of the health of the nation?

DAVID BRAILER, M.D., Ph.D.: Well, it's a great question and you know if, if the government could do that and only that and leave it there and pass it off and not have regulations attached to it or requirements or have other kinds of rules or things that become mandatory, which I think would go along with that, then I think that's not a whim because it becomes something that's depended on, ongoing federal action, and more importantly it be comes something imposed on the industry and not of the industry.

So the dance here, and I admit that this is a novel way to go about health care policy, but in my view if we want to move towards more free market activities, we have to start someplace and this is a good place to start. We want to start it in the private sector and act as this catalyst, this nurturer, so that it from day one has ownership in the industry. It's definitely hard, but I think the sustainability and the value and frankly the risk of it is lower that way.

WINSTON PRICE, M.D., FAAP: But I think there is room for both and what the other system - and it's being done to a certain extent with some HIV care by Herser and Care-net, it

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provides an internet base interface for physicians who want to adopt electronic clinical records without the investment of dollars. And if we believe what we are saying and I truly believe that the efficiency in terms of health care and the outcomes are going to improve, then those naysayers who are simply logging on and starting to use electronic medical records without any outward cost on their part will adopt the more private sector in Hasper electronic medical records.

DAVID BRAILER, M.D., Ph.D.: And I think to that component of it, I agree with you. The federal government has a responsibility. The President was quite articulate about this when he announced the executive order for my office that we had to pay particular attention to the safety net in the underserved and those who don't have the means to be able to do this.

As you know, on August 1st Vista Office EHR is coming out, which is the office version of the VA system for physician offices. And we are also paying particular attention to the cost performance of technology for small practices, one to find physician practices. That's the one place where I think we have kind of an orphaning process that's underserved by technology and the price performance is quite high and we have asked the industry to pay attention to that market segment and to understand that that's a very, very large growth area that should be invested in.

So there is more that can be done, but the net effect that we need is to be able to have a much more rapidly growing industry of health IT adoption which translates into better price performance across the board.

WINSTON PRICE, M.D., FAAP: Absolutely.

JILL BRADEN BALDERAS: Any comments on how this issue of the dance, as Dr. Brailer describes it, between government and private sector, how that's thought of on Capitol Hill?

DEAN ROSEN: Well, I think we are in a lot of ways following the lead of the President and the administration and I think it is a novel waste as Dr. Brailer said, to do policy which is that we, I think, and even as a republican, we think the government has a role here in leading, but also has a role here in following, and trying to create the conditions that will allow the private sector to adopt it.

And part of it is setting standards, and part of it is reducing financial barriers, and part of it is trying to think about ways we can reorient some of the programs that are within our control where we are still paying based on a 1965 model of reimbursement like Medicare, and how we bring that in to the information age to again help enable it.

So I think that's right. I think it's going to be a difficult balance, but what's interesting to me at this point is the broad agreement, and in a sense almost a nonpartisan not even a bipartisan, but a nonpartisan agreement that we need to

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do this and the steps that we need to take are pretty well agreed upon so we just need to get moving.

JILL BRADEN BALDERAS: I have got one more email that I would like to take and then we can get to a closing comments, because believe it or not we are almost at an hour.

Dean Rosen, I will direct this one to you, this is actually from someone at the GAO. The GAO issued a report concerning various laws referring to the Stark and Anti-Kickback laws that present barriers to the adoption of health IT. What has been done since then to address such concerns?

DEAN ROSEN: The Stark law, I will just take that for an example is it basically prohibits hospitals for example from giving things of value to physicians that would appear to cause them to want to refer to their hospital. I mean, that's the basic notion of Stark and in some context that makes sense. In this context we don't really think it does, and in fact it's one of these barriers to adoption.

One of the things we have talked about it there is a cost here, and but there is also a tremendous benefit in terms of quality of care in terms of savings and efficiency to physicians widely adopting these. And federal government, I don't think can afford to buy the hardware and software for every doctor in America.

And so - but, there are for example a lot of hospitals that see the benefit and would like to give, let's say PDAs or

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other equipment to physicians, but the concern is that they may be barred by doing that from these self referral laws or some of these other laws.

The legislation that's been introduced on Capitol Hill, the bill that we have basically provides an exception. It says that physicians can get this from hospitals, can get it from health plans, and it's not going to be a violation of these self-referral laws as long as the purpose of giving the hardware, for example, to a physician is to improve quality, to improve efficiency.

And again, this is in the legislation that we sponsored with Senator Clinton two people who don't always agree on things politically Bill Frist and Hillary Clinton, but I think again it shows that we recognize that this is a barrier and this is just one of the many barriers that we need to move out of the way to allow the technology to proliferate and get where we want to go. But there is, I think, a lot of agreement on that aspect of it.

JILL BRADEN BALDERAS: So closing comments, I'll start with you Dean Rosen. Where do you think we will be in this whole process in five years? Do you think legislation will have passed and been signed by the President?

DEAN ROSEN: Well, I think that we will pass legislation. I hope we pass legislation in this congress. Again, we are trying to work very closely with David and with

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the administration and make sure that what we are doing on the Hill is complimentary to what the President has done in setting out this broad goal. And that we are trying to fill in gaps where the administration may not have the authority, but I think fundamentally believe and agree that the President is set forward the right direction.

So I think the legislation is a part of it, I also thinks it's important to have buy in from congress and toward the President's goal. But then again, I think if we move forward at the pace that the President has been able to move forward, that Dr. Brailer has been able to move forward in his work over the last year in the administration, I believe in five years we are going to be a good way toward the President's goal.

We may not be all the way there, but I think we are going to see health care dramatically transformed and I think that use of this technology both in terms of decision support for providers and in terms of patient self-management to patient empowerment, it can be and will be transformational.

The benefits are so obvious that I think once people understand it, once we knock down barriers and help lay some of the basic framework for it, I do think it's going to take off, and I think we will be in a lot better position in five years from now than we are today.

JILL BRADEN BALDERAS: Winston Price, where do you

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think we will be in five years?

WINSTON PRICE, M.D., FAAP: I would agree with Dean and I think we have a tremendous opportunity particularly as we approach the health care individual suffering from health disparities, as well as the rural community. And the advent of using telemedicine and the ability to reach out to communities who heretofore do not have adequate access to health care. The ability to drive best practices in terms of looking at data and analyzing and making sure we are getting to the ultimate outcomes with respect to our intervention with populations is going to be the boom to making sure that there is rapid and ongoing adoption of electronic clinical management symptoms.

And lastly, I think to the extent that legislation and the government and private sector did work together and really look at the cost saving because it's going to be key to analyze the millions and billions of dollars that are saved, and that if we can turn that into two things, one have a community empowerment to help build and reinforce the regional health information centers.

And also to also build on the physician side because I think you can drive behavior change by appropriately reimbursing the physicians and hospitals for the care that they are rendering. I think that that's going to continue to move us in a direction that we want to be in five years from now. I am looking forward to it much better.

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JILL BRADEN BALDERAS: And David Brailer, we will give you the last word.

DAVID BRAILER, M.D., Ph.D.: Well, I think we are on a learning curve now. We as an industry and we as a government. I think certainly five years from now that things that seem very complicated and very daunting and just almost difficult for people to conceive, that we are watching many people begin to master today will become quite obvious long before five years from now.

We may choose to not climb this mountain, I think we will. I think all the fundamentals are there and I think while we will not have the President's goal completely met within five years, despite the fact that I promised him in seven we would achieve his goal, we will be at the point where the market forces will have flipped from being against us to being for us.

I think the market will require physicians in practice to do this. I think the market will require interoperability require as a feature of the care delivery, and the standard of care will be built around that because of just how professional practice evolves.

I think then we will be having a different debate, which is the consumer component. We see today health information as laboratory data and images and prescriptions, but many of us as we go forward in our lives will walk around

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on-line with devices in our body that monitor our health status, with things in the homes of elderly people that make sure that they are up and around doing activities of daily living, with devices that monitor our stress at work or at exercise, dietary intake, certainly look at our genetic characteristics as part of that.

And I don't think that would be happening in five years, but we are seeing so much of that start now. The real phenomena that will start then will be a debate about how to bring consumers into this. Just like other information revolutions have pushed way past the businesses out to the consumers, and I think that's going to be well underway. And that will be the novel debate of the time then about how do we make that happen and how do we make sure that everyone is able to be part of this new way where health information technology is just not seen as supporting health care, but it becomes a mode of delivering health care, and that's going to be come I think the very long-term 20-year debate because it's quite vast in its potential.

So you have got a long way to go, but I think this first round is going to be a very successful one.

JILL BRADEN BALDERAS: Well, we look forward to having all three of you back in five years. We can have those future debates.

Thank you all so much for joining us, Dr. David

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Brailer, National Health Coordinator, National Health Information Technology Coordinator; Dr. Winston Price, President of the National Medical Association; and Dean Rosen, who heads up health policy for Senator Frist on Capitol Hill.

Thank you so much for joining us, and thank you all for tuning in for Ask the Experts and all of your great email questions. I am Jill Braden-Balderas for KaiserNetwork.org.

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