States Will Transform Healthcare through Health IT and HIE Organizations

A Report from the HIMSS State Advisory Roundtable

JUNE 2012
Introduction
It is well known that information technology has revolutionized the U.S. economy and health information technology (IT), as a part of broader system reform that offers the chance to help reduce costs and improve quality in healthcare. With rapidly rising healthcare costs—which make up one-fourth of most state budgets through Medicaid alone — the promise of increased effectiveness and efficiency through the implementation of health IT has drawn significant policy interest and action at both the state and federal level. In the past five years, many states have aggressively begun the broad adoption of health IT.

People want to enjoy good health and have access to quality care when problems arise. Even though cost is cited as a primary concern, the primary goal of any health IT system is to improve the quality of and access to health services. This paper addresses the state-led and federal initiatives that have potential to facilitate high quality, cost-effective outcomes.

The State Alliance for e-Health (State Alliance) was initiated in late 2006, established by the National Governors Association Center for Best Practices through a contract with the U.S. Department of Health and Human Services (HHS). It was designed to advance state-level health IT decisions and approaches through the use of a collaborative body that brought together key state decision makers. The State Alliance was a consensus-based, executive-level body of elected and appointed state officials, formed to address the unique role that states played in facilitating electronic health information exchange through the exploration of solutions to programmatic and legal issues.

The Health Information Technology for Economic and Clinical Health (HITECH) Act was signed into law in February 2009, bringing with it an unprecedented investment of nearly $30 billion in health IT to improve the quality, safety and efficiency of healthcare. Most of this investment is in the form of incentive payments from the Centers for Medicare & Medicaid Services (CMS) in specific ways to improve healthcare.\(^1\)

The funds under the Medicare and Medicaid EHR Incentive Programs\(^2\) will provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified electronic health record (EHR) technology. The legislation also allocated $2 billion for the development of state Health Information Exchanges (HIEs), emphasizing a strong relationship between EHRs and HIEs in advancing the electronic access, collection and storage of patient information. Initially, this legislation has provided “seed” funding from the federal government to not only encourage the continued implementation of EHRs as one of the building blocks for participation in an HIE/HIO (Health Information Organization),

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but also to help foster the eventual participation of providers by providing funding during the early years of these HIEs/HIOs. The HITECH Act included funds administered through the State HIE Cooperative Agreement Program for the specific purpose of funding state efforts to rapidly build capacity for exchanging health information across the healthcare system, both within and across states.

In addition, there are many other federal and state grant and funding programs promoting adoption and use of health IT and information exchange. These programs support the ultimate goals of health IT, which include bringing together patient information for clinical decision making and long-term data analysis, such as patient population surveillance. Having this data at the point of care also supports the goals of facilitating high quality care, and reduces duplicative tests and procedures.

The industry is currently addressing many of the challenges and issues to achieving this seamless flow of patient information. For example, policy concerns have surfaced in states around the use and management of data, as well as the aggregation and sharing of information in a secure fashion.

Health IT is an enabler for a number of broader reforms in healthcare that can help bend the cost curve and save healthcare costs in state budgets. The implementation of health IT has been shown to greatly improve the ability of the health system to conduct comparative effectiveness research and quality reporting. The evolving nationwide agenda focused on quality and performance improvement already spans Medicaid, SCHIP, and Medicare, and will be an integral component of the forthcoming health insurance exchanges. New models of care and payment reforms, including pay-for-performance, will require states to have fully functional and integrated health information data systems. This improved information will help facilitate many of the proposed payment reforms that will align incentives around the delivery of coordinated and improved healthcare. Utilization of health IT has provided greater accessibility of data, which can be transformed into information used for clinical decision making, and which can support proposed payment reforms and emerging healthcare delivery models. Strengthening these initiatives will more closely align incentives with the delivery of patient care, resulting in higher quality and decreased duplication of services. However, the interim impact of health IT adoption to the provider community today, the majority of which remains in a fee-for-service payment model, creates a significant disruption to business and leaves providers hesitant to embrace the change.

States have a critical and essential role in health IT deployment and adoption, and currently have a significant impact at the local, regional and state level. This critical role means that states are shaping, and will continue to shape, the future of healthcare through technology and health information exchange. State Coordinators, American Recovery and Reinvestment Act (ARRA) supported HIOs and Regional Extension Centers (RECs) are working directly with HIMSS National and local Chapters to advance the development of EHR interoperability on a local, state, regional and national level.

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Snapshot of Health IT States Legislation and Executive Orders

All across the U.S., a variety of initiatives are underway to encourage the widespread adoption of health IT as a means to increase efficiencies in the healthcare system, improve healthcare quality and outcomes, and ensure patient safety. These state and regional initiatives continue to grow in both number and diversity given the recent availability of federal funding under the HITECH provisions of ARRA. This funding has been established to encourage physicians and hospitals to adopt and meaningfully use EHRs, and activities like e-prescribing are at the core of Meaningful Use—positioning all stakeholders involved with e-prescribing initiatives to play an important role as the focus on health IT increases.

Federal funding has developed RECs, which act as a resource to educate and advise physicians on their journey to becoming meaningful users of EHRs.

State Regulatory History

Preserving the health status of U.S. citizens is the primary responsibility of the states in financing, providing, and regulating quality healthcare. In most cases, laws and regulations are created at the state level to create agencies, appropriate funding, and reduce medical errors *sui juris* to protect the lives and health of populations.

States maintain greater responsibility in adopting certifiable EHR systems and overall health IT. Through a number of state legislative efforts, laws have been passed to make this process simpler. Legislation financing health IT oversight agencies and infrastructure development are requisite to creating functional health IT that meets Meaningful Use requirements set by CMS.

Currently, the largest share of health IT financing comes in the form of Federal incentives for adoption and Meaningful Use. Pooled funds from both private and public resources have been created for adoption efforts among the states as well. Appropriations and shifting funds from state revenues are widely seen as the health IT race continues to progress.

Examples of just some of the ways states have impacted the health IT landscape are identified below.

State Timeline

2007 In 2007, the resonant theme in healthcare IT was financing. Appropriations bills were passed to either fund the creation of committees and task forces or for infrastructure development as the impending transition from paper records to electronic records were seen as convenient, safe, and efficient for healthcare organizations nationally. Convenience was a limited benefit as healthcare organizations realized limited gains on matched investments in healthcare IT.

2008 State funded appropriations phased out as more legislation was passed targeting providers; hospitals, pharmacists, physicians, and other healthcare providers were given greater responsibility for organized health IT efforts. Providers pre-empted this shift of responsibility by financing advancement of health IT solutions early enough to have a head start in infrastructure overhaul (software, hardware), albeit a costly overhaul. In an American Hospital Association report from 2007, hospitals were surveyed to define a barrier to healthcare IT transition. From
2006 survey data, 94 percent of hospitals agreed that cost was a significant barrier to achieving and adopting reliable healthcare IT. This barrier is still present in 2012.

2009 Federal regulatory efforts sprung forward for the first time in 2009 since passage of HIPAA. The HITECH Act was passed to rein in any adverse use of patient medical and health information. The target of this legislation was—and remains—hospitals, physicians, pharmacies, and other providers to enable coordination and connectivity while preserving private, secure transfer of information. Developing agencies and codifying federal means of implementation and enforcement were the impetus of HITECH.

2010 Legislation authorized more authority for oversight in 2010 at the state level. Here, states targeted established agencies proffering regulatory clarity or enhancing responsibilities. Health information network expansion was also a common theme in 2010.

2011 Medicaid payment systems and incentive programs were employed in 2011 to increase meaningful use of patient health information. CMS criteria were developed to ease adoption of certifiable EHRs among eligible providers. Telemedicine, broadband health, and e-health phenomena emerged as innovations in health IT enhanced.

**State Health IT Legislation Activities**

States enacted more than 300 pieces of health IT legislation from 2007 to 2011. **Figure 1** shows the number of laws enacted each year. The average number of enacted laws each year was 62 with the fewest (32) in 2010 and the most (76) in 2007. The graph illustrates that states have been actively developing legislation over the course of five years, where the healthcare market still needs to change substantially from volume-based to quality-based care.
Legislative activity around health IT during this period was not uniform across the country. Figure 2 maps the number of enacted health IT legislation for each state. During this time, Texas, Louisiana and Minnesota had enacted the majority of health IT related legislation; with Louisiana and Texas in response to both Hurricane Katrina (most destructive, 6th strongest) and Hurricane Rita (4th strongest) hitting their coasts’ in 2005. The common legislative themes in these three states were interoperable health records, electronic medical records, financing and authorizing health IT-related agencies.

Other states have passed legislation with similar targets and technology focus. North Carolina’s health IT legislation is focused heavily on financing and authorizing health IT-related agencies with resolutions created to closely monitor the actions of these agencies. The time frame in which state legislation was enacted is directly attributed to federal legislation passed by both the George W. Bush and Obama Administrations, citing the political importance of health IT-related legislation. Hospitals and healthcare service providers have also acknowledged trends in the political environment—fulfilling Meaningful Use requirements to adjust in a changing market.

In the legislation descriptions, we saw directives posturing government officials to bring closer attention to necessary healthcare matters in some states. Resolutions had a recognizable presence as well, totaling 5.7% of the total enacted legislation. Financial incentives were essential to states given the continued economic downturn. January 2011 began the registration process for EHR incentive programs. States’ reactions could be seen in the Figure 1 as health IT related legislation peaked to levels seen only in 2007. This important uptick demonstrably illustrates an evolving market for EHR system transformation rightly financed by the federal government (ARRA [HITECH], 2009; PPACA, 2010)
State Initiatives

What are states doing today to prepare for the future of healthcare?
States are shaping and will continue to shape the future of healthcare through technology and health information exchange. Successful states are leveraging health IT across multiple initiatives with the state-level health information exchange (state-level HIE) serving as the primary backbone. States are focusing the state-level HIE as a primary foundation to deploy reusable health IT infrastructure and services across multiple states, regional and local initiatives.

Benefits realized by leveraging the state-level HIE and state deployed IT infrastructure outside of federal funded initiatives includes:

- Increased efficiency of Medicaid programs working across other state agencies and engagement of the Medicaid population and providers
- Increase administrative efficiencies within the state
- Facilitation of patient engagement
- Decreased redundancy of health IT deployment and maintenance expense
- Facilitation of collaboration: Across state lines, within the State, within specific programs

State-level HIEs may be the organization that connects the various nodes within a state including not only regional HIEs but also private health information sharing initiatives (Private HIEs). State-level HIEs and the regional HIEs can serve to exchange data across all providers and provider networks supporting care coordination and care transition. Shared services provided by the state-level HIE are providing a connection node for all state program participants.

States are collaborating with each other by leveraging the state-level HIE. Interstate and intrastate sharing of resources between consumers, payers and other healthcare stakeholders is leading to greater support for transition of patient care. This collaboration also provides extraordinary resources and information during an emergency where residents are relocated from one state to another without their medical records or other critical information.

States are exploring their state-level HIE and health IT initiatives across multiple services and programs, which may include Medicare, ACO, Medicaid and Public Health. Some general examples include:

- Financial/Business Administration
  - Payments, eligibility checking, referrals
- Analytics and reporting
  - Examples: Readmission rates across state programs, payer claims data bases, Medicaid reporting, Meaningful Use reporting and other state based quality reporting, etc.
  - Moving from simple to advance data analytics around patient populations such as public health, Medicaid, child health and CHIP
- Supports payment reform and movement to value based purchasing, rate setting and adjustments
- Fraud and abuse prevention
  - Support tools focused on this area
- Collaborations across services with stakeholders such as providers, RECs, public health, consumers, other states and Medicare.
- Health transformation and reform facilitation
  - Facilitate deployment and integration of medical home, ACOs, care coordination,
  - Accelerating Meaningful Use achievement by providers
  - Facilitating alignment of Medicaid payment reform with health IT
  - Facilitating patient and family engagement through deployment of health IT related services, which actively engages the group

Anticipated state opportunities that can be realized by leveraging the state-level HIE and state-deployed IT infrastructure outside of the federal HITECH requirements that support the healthcare transformation agenda includes (e.g., outside of Meaningful Use)

- Increased efficiency of Medicaid programs working across other state agencies as well as with the federal Medicare program
- Alignment of Medicaid payment reform with healthcare IT
- Provide new payment levers that advance care coordination
- Facilitate true patient engagement and enablement by providing health information sharing through the use of public and private personal health and wellness tools (e.g., Personal Health Records (PHRs), mobile apps and personal health devices)
- Consolidation of disparate reporting and data integration services with state agencies including lab, infectious disease, immunizations, quality measures, prescription drug monitoring, health facility usage and other public and quality health reporting programs.

Each state is driving change though collaboration and innovative models. However, while there can be lessons learned from each other, the deployment of HIE will vary from one state to another due to differences in geography, demographics and market drivers.
Case Studies
Here is a sampling of what states are doing today and planning for in the future. The list of states below is meant to be illustrative of innovation and collaboration and is not all inclusive. The State Advisory Roundtable invites other states to put forward their initiatives.

<table>
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<tr>
<th>State</th>
<th>Merits</th>
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<tr>
<td>California</td>
<td>CalHIPSO, (California Health Information Partnership &amp; Services Organization) is California’s Regional Extension Center (REC) and the largest in the country. The REC began February 2010, serving 56 of California’s 58 counties, covering both urban and rural areas. Target providers are those receiving subsidized technical assistance services or Priority Primary Care Providers (PPCP). Success in numbers includes the fact that tasked with aiding more than 6,000 providers in California to navigate the EHR world and to achieve Meaningful Use, over 7,500 providers are now enrolled, covering over 23,000,000 patients throughout the counties. In addition to CalHIPSO, Cal eConnect, Inc., a nonprofit California public benefit corporation was designated by the State of California to lead a collaborative process for ensuring the meaningful use of Electronic Health Information Exchange (HIE) in California. Cal eConnect works with key stakeholders across the state to establish policies, procedures and services that support the appropriate, private, and secure electronic exchange of health information between clinicians, hospitals, health plans, patients, and government agencies (for example, public health, Medi-Cal) for the purposes of improving the quality of healthcare. <a href="http://www.caleconnect.org/">http://www.caleconnect.org/</a></td>
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<td>Delaware</td>
<td>The Delaware Health Information Network (DHIN) was the first operational state-wide health information exchange in the U.S. While its official “go live” date was March 2007, the seeds of its success go back to 1997 when it was formally established by the state’s General Assembly. By law, its Board of Directors encompasses representatives from health plans, hospitals, insurers, employers, consumers, and physicians. This broad representation and the protracted period of discussion prior to settling upon a business model helped all parties to overcome any competitive or trust issues and to understand the benefit the exchange might have for all parties. Bipartisan political support not only from state officials, but from its Member of Congress and two U.S. Senators was also instrumental in ensuring that the exchange became a winning proposition for all concerned. Today, the DHIN covers all the state’s acute care hospitals, all 46 of its skilled nursing facilities, and 86% of all healthcare providers practicing in the state. <a href="http://dhss.delaware.gov/dhss/dhic/dhin.html">http://dhss.delaware.gov/dhss/dhic/dhin.html</a></td>
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<td>Florida</td>
<td>In 2003, Florida’s Agency for Health Care Administration (AHCA) implemented one of the first ePrescribing programs for Medicaid. In 2004, Governor Jeb Bush signed the Executive Order creating the Health Information Infrastructure Advisory Board to develop a statewide health information infrastructure. The Florida Health Information Network Grant Program began in 2005 and provides matching grants for the development of regional health information organizations. In 2008, AHCA initiated a project to use Medicaid claims data to provide information to clinicians. In 2009, the Florida Medicaid Health Information Network was launched. The Florida Center for Health Information and Policy Analysis was established to create a statewide health</td>
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Georgia

In 2006, the State of Georgia issued two Executive Orders championing health information technology and creating the Health Information Technology and Transparency (HITT) Advisory Board consisting of public and private sector leaders. The Georgia Department of Community Health (DCH) created the State’s Office of HITT in 2007 to coordinate the state’s HITT activities, develop Georgia’s Health IT Multi-year Strategic Plans and implemented Georgia’s strategic initiatives. In 2009, Georgia launched the Georgia Health eConnect Project, an EHR program. In addition, the State Office of HITT developed the Georgia Medicaid HIT Advance Planning Document and partnered with the National Center for Primary Care at the Morehouse School of Medicine to create the Georgia Regional Extension Center (GA-HITEC). In 2011, Georgia received approval for the Statewide Health Information Exchange (HIE) from the Office of the National Coordinator for Health Information Technology (ONC).

http://dch.georgia.gov/00/channel_title/0,2094,31446711_154959664,00.html

Louisiana

In response to recommendations made by the Louisiana Health Care Redesign Collaborative in 2006, the Louisiana Health Care Quality Forum (LHCQF) was created and tasked with addressing healthcare issues in the state following Hurricanes Katrina and Rita. During the 2007 Louisiana Regular Legislative Session, the organization was formally established and organized through the efforts of more than 40 healthcare and consumer groups. Serving as the state-designated entity, the LHCQF launched the Louisiana Health Information Exchange (LaHIE) in November 2011 as a state-wide HIE utility. LaHIE’s initial service offerings are those that have the clearest clinical value and technical achievability and that fit within the privacy and security framework defined by the ONC. These services are in the process of being tested with pilot participants (healthcare organizations). The core services that are in place now include Master Patient Index (MPI), Record Locator Service (RLS), User Identity Management and Authentication, Secure Access and Audit Reporting, Consent Management and Tracking. LaHIE plans to expose these core services to the Medicaid Enterprise as appropriate.

http://www.lhcqf.org/

New Jersey

The State of New Jersey has developed a strategic Plan for a Health Information Network (NJ-HIN) that includes first strengthening the exchange of information in local nodes and then creating a “network-of-networks” linking the Regional Health Information Organizations (HIOs) to create statewide coverage. These HIOs are generally groups of hospitals that have joined together to interoperably share EHRs. New Jersey’s HIT State Coordinator’s Office is leading this effort with support from NJ-HITEC (NJ’s REC) as well as numerous HIOs including, hospitals, nursing homes, physician offices, EMS, etc. Additionally, NJ has an extremely close collaboration with all the major stakeholders including the Department of Health and Senior Services; NJ Medicaid; Office of Information Technology; New Jersey and Delaware Valley HIMSS Chapters.

http://www.nj.gov/njhit/
Texas

Texas’ approach to implementing HIE builds on existing regional initiatives and a strong history of state-level planning and policy development around health information technology. The Texas Health and Human Services Commission (HHSC) is administering the state HIE program in Texas with contracted programmatic support from the Texas Health Services Authority (THSA). To capture the current HIE landscape and gaps, Texas undertook an environmental scan of the state and existing exchange organizations. One key finding of the scan was the identification of a large geographic white space that lack coverage by existing HIEs. Texas has a three pronged approach to enabling HIE across the state and filling the identified gaps:

**General state-level operations:** HHSC will identify and implement state-level operations, such as policies and procedures, to enable the establishment and operation of HIE capacity.

**Local HIE grant program:** A competitive grant program was established to leverage existing local HIEs and expand their capacity.

**White space coverage:** For geographic areas and providers that lack coverage through the local HIE grant program, THSA under contract with HHSC is administering a managed marketplace of qualified health information service providers (HISPs) to provide, at a minimum, push-based connectivity via the Direct Project protocols. Connectivity by providers in the white space areas is subsidized through a voucher program that allows providers to “shop” among the qualified HISPs.

http://www.thsa.org/

Vermont

The State of Vermont enacted legislation establishing a single, statewide HIE, operated by a non-profit organization called VITL (Vermont Information Technology Leaders, Inc.) which includes Board members appointed by the Governor and the Legislature, as well as representatives from the healthcare provider and consumer communities. Operated in a "public utility" model with fair share funding from a 2/10ths of 1% assessment on health insurance claims, matched by Medicaid funds, VITL connects every hospital in Vermont and a steadily increasing percentage of primary care and specialist practices to the HIE. Policy governance and oversight is provided by the State's Department of Vermont Health Access, Division of Health Reform, which oversees implementation of both the ONC State HIT Plan and the State Medicaid HIT Plan in close collaboration with VITL.

http://www.vitl.net/

**Challenges**

Some challenges being experienced by the states:

- **Increase in Medicaid enrollees** – The Affordable Care Act of 2010 will expand Medicaid to millions of Americans by 2014. How many enroll will greatly affect healthcare access, demand for clinicians, and the federal budget, yet the precision and validity of enrollment estimates made to date is unknown. Predictions have been made that the number of additional people enrolling in Medicaid under health reform may vary by more than 10 million. Some states anticipate over 50% increase in enrollment.
• **Patient Engagement, Data Liquidity and Liberation** – Putting data in the hands of patients should be a major component in both enabling transparency and driving responsibility of the individual’s and family’s health. This is a challenge due to the complete lack of transparency between the care giver, the payer and the patient today. The need to “liberate” healthcare data to the patient and then provide incentives around the use of that data to track and improve health is a major factor and component to the successful implementation of HIEs. A natural effect of efforts focused on enabling the consumerization of health information data through the patient or family is a breakdown of “walled gardens” that we experience today between patients, health care providers and payers.

• **Success of State-Level HIE** - Almost all states have large contracts in place for a more extensive build that is just getting underway now. The money appears unspent but it is obligated in most cases. Stage 2 Meaningful Use will drive much more rapid development but that is no guarantee of success of state run HIEs. There has always been a concern about state run HIEs being able to compete with private options that are emerging as the market organizes.

• **Sustainability of HIEs** – Much has been written about the long-term sustainability of state-level HIEs, particularly with the emergence of private HIEs. With few exceptions such as Rhode Island and Vermont, the state-level HIE business model is almost completely void of private investment, leveraging mostly State and Federal funds for development and implementation activities. Most models that have found success to date are based on driving efficiencies to providers in a fee-for-service model. As we see change to that of a pay-for-quality model through payment reform, the sustainability model for HIEs also must change. This will likely come in the form of leveraging HIEs for Care Coordination, Telehealth visits and Quality and Payment Analytics. Therefore, the business of state HIEs will likely need to shift from “facilitator of sharing” to “data aggregator and analyzer” in order to build a sustainable business plan. The challenge will be to provide a basis for comparison across private providers.

• **Health Literacy** - The delivery and use of high quality healthcare is dependent upon many essential factors. Each of these elements plays a critical role in the success of the healthcare improvements that this Country is embarked upon. Clearly, highly trained and properly motivated healthcare providers of all disciplines are a fundamental necessity. Properly functioning support, exchange of EHRs and EMRs, high level equipment and other resources are also a necessity. Funding for each of these elements has already been identified and is being deployed. The one essential partner of the healthcare delivery system that has so far been ignored is the Patient. There is a palpable and easily observable absence of “Health Literacy” in the general population that must be addressed and lessened if the other improvements in the healthcare delivery network are to live up to their expectations. The concern is that we will never be able to deal with the major healthcare issues that we face if we do not engage with the patients and their families to take ownership and responsibility for effectively implementing the steps outlined by providers for dealing with chronic illnesses. Until patients, their families and consumers become shared decision makers and participants in the healthcare delivery process,
we will continue to be plagued with runaway costs and poor outcomes. Patients must become health literate and put into practice the necessary and effective measures prescribed or recommended by their physicians. This is the responsibility of the patients and their families but their failure to do so will negatively impact on all the other positive steps that we are taking.

- **Funding and Payment Reform** – needs to be spread out among patients and consumers; not just federal but all sources, government and non-government alike
- **State licensure** – Telemedicine and disaster response across state lines
- **State-based Laws and Regulations**
- **Privacy and Security**
- **Unique Economic and Demographic Pressures Across States**
- **Medicaid/Medicare Rate Equalization**

**Recommendations**

1. States should continue to leverage their state-level HIE and state level health IT infrastructure in new and innovative ways. Close working partnerships between State governmental entities, Federally supported RECs, Beacon Communities, Medicaid Offices, Professional Trade Associations and HIMSS National and local Chapters will expedite the implementation of health IT in the States.

2. Health IT transcends political lines and should be on the federal and state agendas over the next several years in order to continue the current momentum and improvement of care quality and healthcare spending.

3. Encourage states to facilitate, engage and educate patients and consumers with the delivery of their healthcare services and promote overall increase in health literacy. The delivery of high quality healthcare requires patient participation and shared decision making in which the patient, families and providers use the most effective steps to improve healthcare outcomes. Population Health Literacy is the essential first step in maximizing improvements in healthcare.

4. Health IT is a necessary and vital precursor to a lot of the other healthcare reform actions that are contemplated by both private payers and public payers both at the state and federal level.

5. State-level HIEs need to be prepared to shift their business models as Federal and State health reform policies continue to shift from fee-for-service to pay-for-quality models in order to develop and maintain sustainability. “Health Information Exchange” will likely need to shift to “Health Care Coordination Facilitation.”

6. Better coordination between and among federal agencies and state health agencies to ensure the value of state-level HIEs and funding sources are aligned to ensure success.
Acknowledgements

2011-2012 HIMSS State Advisory Roundtable
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