State Health Policy Briefing provides an overview and analysis of emerging issues and developments in state health policy.

Recent federal, state, and local efforts have resulted in a proliferation of both health information technology (HIT) and delivery system transformation activities, yet efforts are often uncoordinated and unaligned. This *State Health Policy Briefing* captures the main themes of an April 2012 meeting of state and national leaders to discuss their vision for a future in which delivery system transformation capitalizes on the true potential of technology to improve the health care system. It includes a description of challenges leaders identified across four dimensions of reform activity: provider and plan measurement and feedback, payment reform, care delivery innovation, and consumer engagement. The brief also describes successful strategies leading states are using to overcome these challenges and concludes with leaders' recommended next steps to make significant progress.

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Briefing

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Aligning Health Information Technology and Delivery System Transformation Efforts: Themes from a Discussion among State and National Leaders

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Countless efforts are underway to address the fragmentation and lack of coordination that negatively affect care and costs in the U.S. health care system. These efforts include health information technology (HIT) adoption and use, along with other activities to tackle delivery system transformation. Yet the efforts themselves are far too fragmented to achieve their maximum potential for transformation, especially with the urgency warranted by several new opportunities for real progress. In April 2012, the National Academy for State Health Policy (NASHP), in partnership with the Office of the National Coordinator for Health Information Technology (ONC), held the kick-off meeting for a new initiative: HIT Trailblazer States. The meeting brought together high-level leaders from states, the private sector, and the federal government to discuss alignment of HIT and health care transformation activities at the state, local and national levels. (See Appendix A for a list of meeting participants.) At the meeting, states shared their activities,

progress, and challenges to inform the conversation and to design a strategy for the future. Leaders discussed goals and specific steps they and federal officials could take to ensure HIT and system transformation efforts are mutually supportive.

This brief captures the main themes and specific steps leaders saw as important to make significant progress. It begins with the context for the alignment of HIT and delivery system transformation and describes the aspects of leaders' vision and commitment to garner the support of stakeholders to take action. The next section discusses goals and challenges leaders saw across four dimensions of reform activity: provider and plan measurement and feedback, payment reform, care delivery innovation, and consumer engagement. The final section describes leading states' strategies for achieving alignment, and concludes with leaders' recommended next steps. The brief is intended to disseminate the call for alignment more broadly, and to broadcast a leadership agenda of specific steps that can move states and the federal government toward delivery system transformation that capitalizes on the true potential of technology to improve the health care system.

A vision for HIT and delivery system transformation

These leaders discussed their vision of HIT and transformation initiatives fitting together to achieve greater health system improvement than either set of efforts could realize in isolation. Across diverse states, they agreed that the underlying goal for all of the HIT and transformation initiatives should be to change the basic structure of the delivery system to result in high quality care, affordable costs, appropriate incentives, and a healthy population. In the words of one leader, "we've got a diagnosis—we've got access and value issues."

Recently, HIT has proliferated across the health care system. The American Recovery and Reinvestment Act (ARRA) largely spurred this growth by: giving incentives to providers for electronic health record (EHR) adoption; funding states to develop Health Information Exchanges (HIEs) for information sharing; funding Beacon Communities to advance innovative uses of HIT; and establishing local Regional Extension Centers (RECs) to educate providers on the effective use of HIT. Besides ARRA, many states are updating their Medicaid claims systems (MMIS), building all-payer claims databases, and using Affordable Care Act funds and a new enhanced Medicaid match to modernize their health and human services IT systems.

Many leaders see their states' health care systems approaching the "tipping point," when HIT is pervasive enough that states can start "getting HIT investments to connect with outcomes." They see this as an exciting time to harness the power of HIT to drive system change. As one meeting participant put it, "HIT is a tool" with the potential to quickly give all stakeholders standardized, actionable, and reliable information about the health care delivery system.

Leaders recognize HIT as a key building block for the infrastructure of delivery system transformation, to enable far-reaching reforms that are targeted to solve the biggest issues. However, because HIT and delivery system initiatives have not been well aligned historically, leaders face significant challenges in orienting siloed efforts toward a common goal. State and federal governments can play a major role in overcoming challenges and achieving alignment. While meeting participants represented states with different political and cultural orientations and differed on the role government should play in system transformation, most agreed that it is important for state and federal leaders to adopt an overarching vision around which to align efforts. In their "unique role as a facilitator and convener," and as large payers for health care, state and federal governments can bring together stakeholders from many different initiatives. The next sections describe specific challenges leaders identified and the leaders' strategies to solve them.

Aligning HIT Across Four Dimensions of Delivery System Transformation

The meeting was organized around a framework of four categories of delivery system transformation activities: provider and plan measurement and feedback, payment reform, care delivery innovation, and consumer engagement. Readers should note that the boundaries of the categories are not always clear and there is overlap across categories. As apparent in the "State Alignment Profile" boxes throughout this section, comprehensive delivery system reforms draw from all four dimensions of

activity. The following subsections describe the leaders' discussion of alignment in each category, including their definition and goals for the category and alignment challenges the leaders identified in that area.

State Alignment Profile: Louisiana

Louisiana recently became one of the last states to adopt Medicaid managed care, including for behavioral health. Building on the lessons from many other states, Louisiana developed two models, pre-paid and shared savings, and incorporated HIT requirements into the MCOs, requiring extensive data reporting and EHR use. The state has had success with improvement through transparency in the past (for example with hospital birth outcomes) and plans to include public reporting as part of the MCO program. Louisiana's Beacon community is building out into a state HIE and, coupled with aggressive EHR incentives, the state hopes to build a robust infrastructure that can start showing value for providers in taking advantage of HIT.

Provider and Plan Measurement and Feedback

Measuring and reporting provider and plan performance allows providers, payers, and government to gauge performance, increase accountability, and improve care. Initiatives range from collecting clinical and administrative data, to various methods of data analysis, to mechanisms for feedback to plans and providers that support improvement. Leaders identified a central alignment goal:

> **Goal:** Measure and report performance quickly, accurately, and comprehensibly so that it is actionable and drives improvement. This goal includes both feedback to plans and providers on their own performance, and transparency to other plans and providers to drive accountability and competition toward improvement.

Leaders discussed several barriers to achieving the goal of quick, accurate, and comprehensible measurement and feedback. Chiefly, states lack a unified, electronic infrastructure to collect, analyze, and report back data from all plans and providers. Collecting non-standardized data from many sources is resource-intensive for states, and few entities at the local or state level have the capacity to receive quality measurement data from disparate clinical information systems across providers, transform the data into valid measurements, and return meaningful feedback to plans and providers. While the federal government does have this analytic capacity for Medicare data, the large size of the nationwide dataset, adjudication, and other issues create delays in feedback that limit actionability of data by the time feedback is received.

In addition, without a streamlined infrastructure, providers and plans must report to multiple sources, in various formats, on a broad array of overlapping measures. This situation creates "reporting fatigue" and "a tsunami of too much data," in which the feedback providers receive is scattered and difficult to use. Further, some plans and providers are reluctant to share their data, considering data a "private commodity" rather than a "public good." This data hoarding makes for incomplete datasets. Finally, leaders noted that plans and providers must see the value in reporting—such as useful feedback for improving performance—to build a business case for investing in reporting high-quality data.

Payment reform

It is widely recognized that fee-for-service payment does not hold providers and payers accountable for their performance, and in the words of one leader, "the call for payment reform is now at an earsplitting level." Effective payment reforms move away from paying for volume of health care and toward incentivizing value, quality, and efficiency. Leaders shared two major goals for the intersection of HIT and payment reform:

> **Goal One:** Base payments on trustworthy and comprehensive data, to effectively reward performance.
>
> **Goal Two:** Use data to monitor the success of payment reforms in improving the delivery system.

Leaders discussed several barriers to achieving payment reform facilitated by HIT. Namely, payers lack "data that describes care sufficiently." While incomplete data may be useful for feedback purposes, the high stakes of payment mean existing data is no longer sufficient. Clinical data, which would give the best picture of care provided, is difficult to extract from EHRs in a standard format and too burdensome to collect manually. Moreover, payers

may not trust data that comes directly from providers for payment purposes. Short of clinical data, claims data could be used for payment reform, but leaders lamented the lack of Medicare claims data, which creates big gaps in accurately determining a provider's overall performance.

Some leaders advocated combining both clinical and claims data to neutralize the downsides of each dataset. However, there are technical and policy challenges in integrating claims and clinical data, including the lack of common data standards, need for mapping standards to facilitate measurement and analysis, and privacy and security risks. Finally, data analysis is currently too slow for payments to be linked to outcomes. Meeting participants emphasized that until data that sufficiently describes care is available to payers in a timely manner, it will be difficult, if not impossible, to use payment to improve the delivery system on a wide scale.

Care Delivery Innovation

While the previous two dimensions relate to monitoring and motivating improvement, the care delivery innovation category encompasses improvement activities themselves. This includes the plethora of initiatives underway to better organize the way care is delivered, such as by standardizing care, forming teams to deliver care, or coordinating care and transitions across multiple settings. Leaders identified two main goals for aligning HIT and care delivery innovation initiatives:

> **Goal One:** Use HIT to quickly give providers access to clinically relevant, evidence-based information to support decision-making and patient population management.
>
> **Goal Two:** Use HIT to enable open communication flow across providers to "create virtual organizations of providers in teams."

The challenges of timeliness and lack of standardization in the current reporting infrastructure that leaders noted in previous sections carry over here. Further, the data needs in this dimension differ in that providers need patient-specific, up-to-the-moment information as they deliver care, and cannot make due with retroactive, provider-level results. These issues are further complicated by the lack of shared patient-level data across providers. Leaders from diverse states agreed that a single patient's data are difficult to track across multiple formats and sources because there is no system-wide patient identifier (such as an ID number). In addition, because not all providers participate in data sharing—whether due to lack of technological capacity, perceived privacy issues, or data hoarding—a provider can typically only see a patient's data related to care within the same organization, or perhaps a few others. Given that they can only access partial information about patients, providers are reluctant to rely on HIT in their decision-making.

Besides accessing patient data, other challenges prevent providers from taking advantage of care delivery technologies. Many providers still lack EHRs, especially in rural areas, and in behavioral health, mental health and long-term care settings. Most of all in this category, leaders stressed the need to "corral efforts," because with so many care delivery innovations going on at once, providers may not be using technologies in a coordinated or efficient way.

State Alignment Profile: Maryland

Maryland is the only state with an all payer hospital rate-setting system. The state's Payment Systems Readmission Program adjusts hospital payments based on performance data on avoidable complications. As a result, rates of avoidable complications have gone down. Maryland is moving toward using its HIE to assess performance and catch misreporting, as well as for inter-hospital data exchange. Currently, the HIE connects all hospitals and they are beginning to transmit their data. In primary care, Maryland's medical homes are also connected to the HIE and can pull clinical data out of the HIE, as well as upload data into it. A major area of new focus is facilitating care transitions across hospitals and medical homes using the HIE. Finally, Maryland is introducing community health data into outcomes measurement in an effort to engage hospitals to work in the broader community.

Consumer Engagement

As patients and constituents, consumers drive demand for health care transformation. This final dimension

builds on the previous three because consumers are the one constant directly affected by reforms to care delivery and IT systems at the provider, plan, state, and local levels. Consumers must be empowered to manage their care and well being outside the health care system while also actively participating in the care delivery and decision-making processes. This will be particularly important for ACOs and PCMHs. As one leader noted, "we could lose progress if we do not make patients aware of how far we have come." Leaders identified two goals for HIT alignment in consumer engagement:

> **Goal One:** Use HIT to make data transparent and understandable for consumers, enabling them to make fully informed decisions and actively participate in health care.
>
> **Goal Two:** Engage consumers in solution development as HIT and delivery system efforts are aligned, to ensure that these initiatives are designed to work well for consumers.

Leaders discussed a range of challenges around consumer engagement. First, maintaining and monitoring consumer engagement is difficult because consumers shift across providers, payers, and demographic and geographic boundaries. In addition to the challenge of consumers obtaining their own health data, described in the previous section, this flux is problematic because consumers must adapt to each new entity's methods of engagement and learn new technologies as they access the health care system at different entry points. Leaders also lamented a lack of effective HIT tools that enable consumers to make use of already available information about their care. Finally, leaders noted that because consumer engagement has been low historically, many consumers lack awareness, education, and a sense of accountability about their own health care utilization. This means that consumers do not always take advantage of the tools and other opportunities for engagement that are available.

Strategies to achieve alignment

Acknowledging that substantial challenges to alignment exist, leaders affirmed that alignment is critical. In the words of one leader, "our mission here is to proceed knowing that as much noise as there is, the sky isn't going to fall. The sky is only going to fall if we stick with what we're doing now." Leading states are already working to overcome challenges and harness HIT as a foundation of successful delivery system transformation. To further this transformation, the meeting participants called for continued collaboration of federal, state, and local partners around a series of recommended strategies for alignment.

Develop an electronic, streamlined reporting and feedback infrastructure. Leaders identified a pressing need to unify and automate reporting to make data analytics more timely, reliable, and understandable. Several states are working toward developing such an infrastructure. First, states are exploring mechanisms to securely pull data from EHRs; Rhode Island, for example, uses Direct messaging to aggregate EHR data in its HIE. Second, several states are working across state and federal agencies to consolidate reporting streams; Oregon,

State Alignment Profile: Oregon

Oregon passed major legislation in 2012 creating Coordinated Care Organizations (CCOs), "a hybrid of the ACO idea with Medicaid MCOs." CCOs will pay for outcomes, starting with a global budget and increasingly stepping up the bar with achievements and benchmarks. After 75 public meetings, the state settled on an initial set of outcome metrics that are mostly aligned with Meaningful Use and other CMS initiatives. CCOs will align providers and plans within a community: one CCO will serve all of Portland, meaning that the entire community will be able to share data. A goal of CCOs is to use HIT to unify currently fragmented teams of rural providers, extension and alternative providers, including mental and behavioral health and long-term care. Because many of these providers do not yet have EHRs, the state opted not to require EHR use for CCOs. However, CCOs are required at least to have Direct messaging capability, and to demonstrate progress on EHR adoption and information exchange in their communities. The state is currently writing an HIT strategic plan for the fall to help guide the next steps, including plans to incorporate their new APCD and HIE into the CCO model.

State Alignment Profile: Virginia

Virginia is building out several initiatives, looking for the right balance for the state between the role of the government and the private market in aligning HIT and delivery system reform efforts. On the government side, Medicaid is piloting new care coordination strategies, and with a large military population, the state is working with the Department of Veterans Affairs on EHR adoption. The Virginia Center for Health Innovation, located within the Chamber of Commerce, brings together private and government stakeholders to develop, pilot, and disseminate HIT and delivery system initiatives. Under the Virginia Health Reform Initiative, the state is building new electronic eligibility and enrollment systems for Medicaid and other human services program, making Virginia a leader in infrastructure on the program administration side.

for example, is working in conjunction with the CDC to reduce overlap in public health reporting. Third, states are working with "intermediaries," third-party entities responsible for harmonizing and analyzing data collected from providers and/or payers, to analyze data in a timely and efficient manner; Minnesota, for example, is partnering with the non-profit Minnesota Community Measurement. Leaders highlighted the need to further develop these three lines of activities, moving toward a future infrastructure. This infrastructure would greatly reduce the reporting burden on providers and governments, while ensuring providers, plans, consumers, and other stakeholders have access to useful and transparent information.

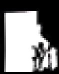
Promote a new paradigm of data as a public resource rather than a private commodity. Meeting participants urged more work to address the issue of plan and provider reluctance to share data. While some states have had success in requesting data on a voluntary basis, other states have mandatory data sharing. Oregon and Colorado both require providers participating in their Coordinated Care Organization (CCO) and Regional Care Collaborative Organization (RCCO) initiatives, respectively, to report specified data to the state, and to make data available to other providers. Other states collect data through Medicaid managed care contracting; Louisiana for example used its new Medicaid managed care program to enact EHR and reporting requirements for Medicaid providers. Leaders agreed that clearer guidelines are needed around data permissions and sharing across payers, providers, and agencies.

Align metrics across programs and agencies. To overcome reporting overload through duplicative reporting requirements, some states are aligning metrics across multiple programs. Oregon based its CCO reporting requirements as much as possible on Meaningful Use and other required CMS measures. Rhode Island used its established medical home clinical metrics for its Beacon initiative. Leaders agreed that states and the federal government should evaluate the array of available data collection and measurement tools before creating new ones, and consolidate functions where possible.

Create standard and simplified statewide metrics. In addition to aligning current metrics, leaders encouraged the development of clear and concise metrics that capture a core set of necessary data elements and can be used by a variety of HIT and delivery system improvements statewide. For example, Minnesota convened stakeholders to develop standard measures for its provider peer grouping system. North Carolina works with provider professional societies to develop statewide standard metrics. Colorado's RCCO initiative holds providers accountable for each other's patients, so providers convened themselves to set statewide standards. Standard and simplified metrics implemented throughout a state will enable initiatives and practices to operate in tandem, while reducing reporting burden and facilitating coordination to achieve broader state goals.

Focus on metrics that "matter most." States are honing in on a few priority goals for health system improvement, and selecting a few metrics at a time to work on statewide. Not only does limiting the number of metrics increase simplicity and ease of use for reporting and feedback, it also helps streamline initiatives around a common target. For instance, Colorado looks specifically at ER use, readmission, and redundant imaging; Louisiana focuses on measures around birth outcomes; and Hawaii focuses on cardiovascular disease measures. Leaders

State Alignment Profile: Rhode Island



For its organizing vision, Rhode Island has embraced the World Health Organization definition of health, working toward a healthy population defined as physical, mental, and social well being, not just the absence of disease. (https://apps.who.int/aboutwho/en/definition.html) Rhode Island has established a multi-payer PCMH program called the Chronic Care Sustainability Initiative and a statewide Beacon Community. Furthermore, Rhode Island's Office of the Health Insurance Commissioner has put standards in place requiring insurers to devote a certain percentage of their medical spending to building the primary care infrastructure. This includes spending to support HIT adoption by providers, incentives for providers that encourage care delivery innovations, and support for various initiatives of the Rhode Island Quality Institute (RIQI) including a regional extension center (REC), a statewide HIE and the Beacon Community. From the outset, the state has used its Beacon to electronically enable PCMH, and built the Beacon accountability measures based on the already existing PCMH measure set. Beacon funds were also used to overlay a sophisticated quality reporting and analytics infrastructure on top of the state's HIE. Rhode Island also developed a method using secure Direct messaging to lift data out of EHRs and into its statewide HIE, which addressed interoperability issues. Using this method, and training providers through the REC, they have been able to help providers demonstrate and measure their quality. They have also used Direct messaging to give plans clinical data to better understand claims. In their work they have learned that transparency and tracking are key to getting the most out of resource investments.

note that these initiatives must balance the needs of providers who may want a broader array of measures to reflect their outcomes. Still, leaders stressed the need at both the state and federal levels to prioritize a few crucial metrics to use very effectively to achieve tangible health improvement goals.

Build upon resources, best practices, and infrastructure available both within and across states. Leaders urged states and federal governments to think creatively about leveraging initiatives to support a common infrastructure, so that rather than perpetuating silos, HIT fosters coordination across diverse programs seeking to achieve similar goals for delivery system transformation. For example, Meaningful Use stages 1 and 2 require Medicare providers to use their EHRs toward delivery system improvements to receive EHR incentive payments. Similarly, states participating in CMS's Comprehensive Primary Care Initiative, a program focused on coordinating primary care, must incorporate technology into their care improvement programs. Additionally, leaders suggested leveraging new systems (e.g. MMIS, health insurance exchanges, and HIEs) to attain broader goals, rather than building separate systems. This will save resources and help tie together data streams making reporting easier and giving providers, plans, states, and consumers a better picture of care.

Engage multiple payers. Meeting participants saw the challenge of poorly coordinated efforts pervading all four dimensions of transformation, and the challenge of multiple payers conducting initiatives within a single practice exacerbates the issue. They urged states and the federal government to bring all payers—Medicaid, Medicare, states, and private payers—together, aligned around a common vision for improvement such as the Triple Aim, or Washington State's five-point plan for health improvement. States are already working to unify and motivate multiple payers toward payment reform. Vermont's payment reform initiative rewards outcomes across all payers; Virginia is testing EHR adoption strategies in Medicaid with an eye toward encouraging other payers to use these same strategies. The leaders agreed that goals and strategies must be aligned across payers to maximize their impact on overall health system improvement.

Promote provider and consumer education and engagement. Leaders emphasized that any successful transformation strategy must engage and motivate provider and consumer communities on the ground. States are educating and supporting providers as they incorporate HIT into their practices for care delivery improvement through vehicles such as Rhode Island's REC and North Carolina's Area Health Education Centers (AHECs). On the consumer front, states including

Vermont and Lousiana are pursuing statewide options to assist consumers with accessing personal data, such as a "Bluebutton" on an HIE that gives consumers easy access to their data. Others are exploring how to engage consumers through new technology, such as mobile applications and telehealth. One Beacon community in Utah, for example, uses text messaging to interact with diabetic populations. Finally, states like Massachusetts are working to give consumers greater access to data about providers, introducing transparency on costs. Leaders agreed that alignment can only be achieved when multiple health care players are motivated to change, willing to embrace new technologies, and open to working cohesively with other stakeholders.

Conclusion and next steps

Leaders agreed it is time to raise the bar for care transformation through the strategic use of HIT. They identified two key next steps to achieve alignment of HIT and other heath care transformation activities:

1. **Advance work on recommended strategies.** Participants suggested convening leading states to work together intensively on the strategies identified above. By advancing their work on successful strategies, these leading states will become models for alignment from which other states can learn. In addition, as they further their efforts on the recommended strategies, these model states should work with federal and local partners to tackle challenges that impede these strategies, blazing the trail for the rest of the nation. To this end ONC and NASHP launched a learning collaborative of Trailblazer states in summer 2012 to work on the development of enhanced electronic, streamlined reporting and feedback infrastructure. As part of this learning collaborative, states will develop model action plans, and work with federal partners and other experts to tackle challenges.
2. **Continue to identify new challenges and solutions.** The leaders urged for a continuing dialogue among state and federal leaders to further refine goals, identify barriers, and develop solutions at the federal, state, and local levels. While the recommended strategies are an important foundation, many additional issues were raised throughout the day. A starter list of such issues identified by participants at the meeting for further exploration can be found in Appendix B. In the coming year, NASHP and ONC will continue to host open dialogue on these issues and others through regular conference calls among meeting participants, federal officials, and other key players.

With these two steps, leaders hope to develop an evolving framework for alignment of HIT and other transformation efforts, moving toward a vision for health system improvement.

Appendix A. Participant List

NASHP and ONC invited leading states and national experts who have been working on HIT, delivery system transformation, or both. Most of these leaders were able to attend, although a few invited state leaders were unable to participate.

Asterisk (*) indicates advisory committee member. Positions listed were as of the meeting date. Some have since changed titles or agencies

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Appendix B. Issues Identified for Further Exploration !

- Fostering environments of transparency and data sharing across providers and payers within states and communities.
- Refining the role of data intermediaries, and developing trustworthy relationships with intermediaries to analyze data.
- Creating a standard set of "vocabulary" or core data elements—to be used by states, federal, and private sector entities—that can be used to determine the majority of needed measures.
- Coordinating across states, ONC, and CMS to ensure that the identity management infrastructure for providers and individuals shares a common "trust fabric."
- Optimizing the use of HIT and delivery system payment reform initiatives, such as by developing payment bundles with analytics, and integrating bundles with EHRs or convening by states to discuss HIT-related issues related to ACO development.
- Using HIT to drive community-level health improvement efforts and public health initiatives.
- Developing methods for linking various IT assets within a state's inventory such as HIE, MMIS, health insurance exchanges, public health surveillance, and other systems.
- Reducing opportunities for waste by heightening awareness of duplicative efforts, and incentivizing opportunities to leverage existing work and infrastructure.
- Better leveraging the power of Medicare as a payer to advance HIT adoption, delivery system transformation, and alignment.
- Encouraging states to promote IT innovation through requirements in State Plan Amendments and waiver requests.
- Developing mechanisms for states to track and coordinate local initiatives, including those that are federally funded (e.g. Beacon Communities, RECs) and leveraging lessons and infrastructure from those initiatives at the state-level.
- Developing sustainable models of support for state HIE (including resources to maintain collection and analysis of data).
- Enhancing statewide HIT governance.
- Unifying/integrating fragmented medical home efforts and creating greater connection between desired medical home outcomes and those required by Meaningful Use.
- Leveraging pharmacy data and practices into HIT and care delivery alignment efforts (e.g. developing models for prior authorization before drugs are dispensed) as part of clinical decision support tools.
- Developing new mechanisms to connect the dots of Meaningful Use and delivery system improvement—strategies for leveraging Meaningful Use to promote quality improvement, enhance payment reform initiatives and facilitate consumer engagement.
- Developing strategies for incentivizing and motivating providers toward HIT adoption and use including by incorporating HIT-enabled delivery systems transformation into provider training and graduate medical education reform.

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The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

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