

Final Report

Technical Assistance for Health IT and Health Information Exchange in Medicaid and CHIP

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Chapter 1. Executive Summary

Over the past 5 years Medicaid and the Children's Health Insurance Program (CHIP) have moved from the periphery of the health information technology (IT) landscape to center stage. Health care consumers, providers, and payers alike are exploring innovative models to address the rising costs of health care and how the quality of care can be improved. The national conversation about health care reform has focused attention on the role public sector payers, including Medicaid and CHIP, will play going forward. Federal legislation and related policies that have been adopted recently, combined with the emergence of numerous health IT and health information exchange (HIE) initiatives, have created both opportunities and challenges for Medicaid and CHIP programs. Through this project, the Agency for Healthcare Research and Quality (AHRQ) developed a program of training and technical assistance (TA) opportunities that focused on the immediate and short-term needs of Medicaid and CHIP agencies as they work to implement health IT and HIE activities. The following report summarizes the progress the agencies have made in adopting and implementing health IT and HIE initiatives as well as the types of support provided for those initiatives throughout the course of the project.

In 2007, AHRQ published a report that described the potential that Medicaid and CHIP agencies had to influence the use of health IT and HIE to improve care for the vulnerable populations that are served by these agencies. AHRQ recognized that for Medicaid and CHIP to be able to take advantage of health IT and HIE to improve care for their beneficiaries, they would require assistance. The requirements of the American Recovery and Reinvestment Act (ARRA) of 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA), and the Patient Protection and Affordable Care Act of 2010 expanded the role of Medicaid in health IT and HIE and increased the need for coordination across a range of programs and initiatives. Over the course of this project, we developed and delivered 30 Webinars, 11 Web-based workshops, and 7 in-person workshops.

Needs Assessment

In August 2007, the Office of Inspector General, published a report titled *State Medicaid Agencies Initiatives on Health Information Technology and Health Information Exchange*. The report documented 16 current health IT/HIE initiatives in 12 States. This report served as the baseline to track the progress of Medicaid and CHIP programs over time. In 2008, we conducted a formal needs assessment that documented 43 planned or implemented health IT and HIE projects and activities.

Through the needs assessment process, the project team gathered information related to issues confronting Medicaid and CHIP agencies across the country as they planned their responses to emerging health IT and HIE challenges. The survey process and instrument RTI International used were designed to be administered to all Medicaid and CHIP agencies. The instrument was constructed to facilitate collecting information that would then be used to identify the most critical and relevant training and TA support the project could provide.

During year 1 (2007–2008) of the project, we conducted a pilot study of a select group of State agencies (12 States were targeted for the pilot, 7 agreed to participate) to assess the efficacy of the assessment process and survey instrument. The pilot survey was conducted to ensure that the assessment instrument was comprehensive and that the mode of data collection was suitable

for either telephone interviews or site visits. Based on the results of the pilot study, modifications in both the initial survey instrument and assessment process were made. The information collected from the pilot study helped identify specific training and TA topics and areas of interest for Medicaid and CHIP agencies.

We conducted the needs assessment in year 2 (2008–2009) inviting all Medicaid and CHIP agencies in all 56 States and territories to participate. Those agencies that participated in the pilot study were not asked to participate in the final assessment. Of the 56 agencies contacted, 7 participated in in-person interviews and 27 participated in a phone interview. Twenty-two agencies elected not to participate.

We supplemented the data collected with feedback from the project’s Technical Expert Panel (TEP), and anecdotal information collected from organizations, such as National Association of State Medicaid Directors (NASMD), various work groups supported by NASMD, and other groups and associations to develop a program of technical assistance.

We used a multipronged approach in year 3 (2009–2010) to gather and validate additional information needed develop the TA and training plan for the year. This approach was intended to minimize the burden on the agency staff. We collected information and data from existing surveys, attendance at related conferences and meetings, collaborations with NASMD and various work groups, as well as feedback, comments, and recommendations from the TEP. This approach was followed for the remainder of the project and allowed us to ensure that our TA offerings were relevant and timely and coordinate with other programs and initiatives to avoid duplication.

Summary of Needs Assessment Findings

The needs assessments identified critical challenges facing Medicaid and CHIP agencies nationwide as they planned and implemented emerging health IT/HIE initiatives that were then used to develop a comprehensive program of TA. The approach used varied and included Web-based and in-person workshops and seminars; Communities of Practice (CoPs); a Repository of Medicaid and CHIP-specific reference materials, and a knowledge library; and online access to related tools and resources, all focused on enhancing State agencies’ readiness and competency to successfully implement their health IT and HIE initiatives.

The project followed several key principles in planning the series of Webinars, Web-based workshops, and in-person workshops. The key principle was to minimize burden on the agency staff. Webinars were used to provide an overview of key topics. Web-based and in-person workshops were offered on more sophisticated topics, allowing for enhanced participant interaction. Each event required a descriptive title, statement of overall purpose, learning objectives, selected target audiences, and a list of potential speakers. For the Webinars and Web-based workshops, we invited a speaker to provide an overview and provide a common foundation of knowledge about a particular topic; then, additional speakers were invited to discuss a particular implementation or example of the topic, usually from an agency perspective. Prior to Web-based workshops, participants were asked to answer prepared questions to form a baseline for workshop evaluation and discussion points to be raised during the workshop. Participants received group guidance as to what materials or activities should be completed prior to the workshops.

Challenges

Planning TA events takes a significant amount of lead time to identify a topic, speakers, and materials and to distribute logistics information. The Standard Operating Procedures manual developed for the project mitigated some, although not all, of these challenges by providing a standard work schedule, templates, and supporting documents. However, agency staff and subject matter experts are often busy, which can lead to slippages in the schedule.

Lessons Learned

Medicaid and CHIP agency staff seek learning opportunities that target their needs and do not add burden. Staff turnover at Medicaid agencies means that some agencies continue to need introductory information on a number of topics. However, the majority of agencies have developed a sufficient base of knowledge on which to build more specialized and sophisticated offerings. Medicaid agencies still needed assistance in balancing multiple projects and priorities.

In-person workshops should be carefully targeted because Medicaid staff often have limited time to attend in-person workshops. Traveling to events creates a burden on agency staff in terms of time out of the office and the need to seek travel approvals. Many States implemented a travel freeze when the economy became tight, regardless of whether travel would be funded by an external source. Nonetheless, providing funds for travel costs is essential. Identifying appropriate topics, providing adequate lead time (at least 8 weeks), and ensuring that agencies can send a team of staff all support successful outcomes.

Communities of Practice

CoPs were developed as peer learning networks for Medicaid and CHIP agencies and served as open, collegial platforms for staff to access and exchange up-to-date information on health IT issues that were most important to them. This necessitated restricting CoP membership to Medicaid and CHIP agency staff only. The Medicaid and CHIP CoPs were developed and directed by the members of the CoP from the very beginning by maintaining a planning team of Medicaid and CHIP agency staff that met between CoP meetings.

The steps followed to initiate and maintain an active CoP are as follows:

1. Identify domain, community, and practices (i.e., choose topics for the CoP).
2. Recruit CoP members and a planning team.
3. Conduct activities before, during, and after each meeting.
4. Sustain activities between events (CoP infrastructure).

Challenges

The main challenge to developing CoPs was sustaining the interest and commitment of CoP membership, particularly for those who volunteered to be on the planning team for each CoP. Competing priorities can cause participants to have to forego participation in these groups.

CoP members were most enthusiastic in their participation in meetings, but less interested in initiating e-mail conversations with their peers on the CoP membership lists between meetings (despite frequent reminders that this would be an option) or taking advantage of private work space for sharing documents and discussing issues that we provided on the National Resource

Center for Health IT (NRC) Web site. Thus, some of the unique opportunities inherent in developing a CoP rather than individual TA events may have been missed.

Lessons Learned

A number of techniques were developed to foster the most productive environment for knowledge sharing among busy professionals who were interested in a CoP. These techniques grew out of the lessons learned from organizing and supporting CoPs over time.

One lesson learned was that it is not necessary to convene a CoP in person before convening subsequent Web-based meetings. Web-based meetings often generated a very productive exchange of ideas among participants, even those who had not met in person prior to the Web-based meetings. In several instances, however, it was more productive to design an in-person meeting based on ideas and discussion that originated in a CoP. Planning an in-person CoP meeting based on these discussions allowed participants to delve into topics more deeply than they could during a 90-minute virtual CoP meeting.

Another lesson learned was that certain techniques helped ensure that all participants—regardless of their experience in planning and implementing health IT and HIE initiatives—contributed their thoughts during the Web-based meeting. To counteract the reluctance of some CoP participants to speak up during meetings, we e-mailed individual registrants before each CoP meeting, to encourage them to respond to the discussion questions that were on the agenda. When individuals were primed to think about their responses to the discussion questions ahead of time—sometimes even sending written responses in reply to the e-mail—they were more likely to offer their responses during the meetings.

Other slight modifications to the CoP format enhanced the value of the CoPs. For example, when the planning team members suggested meeting topics, we reached out to relevant experts who could briefly frame the topic for discussion at the beginning of each meeting. In addition, we recruited some CoP members to facilitate the meeting or make presentations so that they became involved in the discussion early in the meeting. We also used the WebEx functionality to take polls during the meeting so that even when people did not speak, they expressed their thoughts or opinions.

Section of AHRQ National Resource Center for Health IT Web Site and Repository

AHRQ maintains the NRC as a resource to the health care community to share knowledge and findings relevant to health IT. The project Web site was incorporated as part of AHRQ's NRC, and it has served as a reliable source of current project information and as a gateway to health IT and HIE resources specific to Medicaid and CHIP agencies.

NRC Web Site

In March 2008, the project Web site was opened to the public as part of AHRQ's NRC Web site. The Medicaid project Web site provides information about the components, goals, and objectives of the project.

The information contained on the project's public page is intended to be a combination of static and dynamic content. The static elements of the page include the landing page text, which

provides a general overview of the project and its goals, and the Fast Facts page, which has an FAQ about the project scope, objectives, and resources.

The public site maintained current information about upcoming TA events and an up-to-date calendar of all TA events. For upcoming events, an active link led users to the registration information. All materials from sessions and events were posted here along with a link to the recorded session and a transcript of the session.

The project also maintained a private workspace for each of the three active CoPs. These areas allowed agency representatives to share documents, carry out discussions, and share opportunities with one another through a logon/password-protected area of the NRC Web site. These areas were used occasionally to distribute materials to CoP participants. Meeting minutes, presenter slides, contact lists, and other relevant information for each CoP were also posted to this site.

Repository

Although a significant number of tools and resources exist currently within various parts of the NRC Web site, the Repository seeks to categorize materials specific to the Medicaid and CHIP environment. The information Repository is an important tool for educating Medicaid and CHIP personnel about resources for planning, implementation, and evaluation of health IT and HIE.

Following the release of the Repository, ongoing activities have included the following:

- Monitoring potential content for the Repository.
- Brainstorming additional topic areas that will support agency needs.
- Developing agency success and best practice highlights.
- Developing versions of materials that are compliant with Federal regulations on access to information by persons with disabilities.
- Coordinating with Oracle for support.
- Coordinating with AHRQ's Office of Communications and Knowledge Transfer for Web site content approval.
- Monitoring other resources available on the NRC to prevent unnecessary overlap.

Challenges

The project's public Web site served as an essential communication tool, especially for TA events. A challenge was maintaining an appropriate balance between the necessary core information about the project and dynamic content that would keep users familiar with the project and returning for updated information.

Lessons Learned

The Web site statistics provided valuable lessons on site traffic. Information about the types of documents accessed provided insight about the usefulness of the Repository. Web site traffic increased when legislation was being developed and when new topics were being widely discussed. The increased traffic during periods of rapid activity points to the need for quick updates during these times. Consistent efforts to keep the information current and to ensure the site met the needs of our targeted population led to the success of this site. We

also learned that mentioning the listserv on the Webinars was an effective way of increasing the number of subscribers. We frequently gained new members following a TA event.

The private workspace was not used as frequently as expected with CoP members preferring to e-mail one another with attachments rather than remember another password and log into another site.

Case Studies

Early on we identified a need for models of successful health IT and HIE work by Medicaid and CHIP staff. The case studies were targeted to support peer-to-peer learning and development. To identify potential candidates for inclusion in the case studies series, we reviewed information from the needs assessment, specifically referencing the question that asked if the agency had identified any best practices in its health IT/HIE work. We also reviewed the list of States that served as presenters for the TA events and those who participated actively in the CoPs for potential participants. Once a topic was identified, we conducted an interview with representatives from the agency, and drafted the case study based on the interview.

Challenges

One challenge was identifying, contacting, and following up with appropriate Medicaid staff. Many agency staff were reluctant to share their experiences if the project did not have the expected outcome, even though those lessons may be the most important to share, and others were simply too busy to share the information.

Lessons Learned

Agency staff members are generally very interested in sharing information about their progress and accomplishments. Given the overall lack of information specific to Medicaid and CHIP health IT and HIE, the case studies provide a valuable vehicle for disseminating information.

Literature Review

The purpose of the literature review was to identify peer-reviewed and grey literature that would provide a broad overview of issues facing Medicaid and CHIP agencies as they implement health IT. The materials from the literature review were posted to the Repository.

Challenges

Locating materials that were publicly available was the biggest challenge in this task. All documents posted to the Repository must be available without a subscription or payment. This limited the content that could be posted; as a result, some high-quality articles were omitted from the Repository.

Lessons Learned

The body of literature related to health IT and HIE expanded in the wake of ARRA and the Health Information Technology for Economic and Clinical Health (HITECH) Act, particularly given Medicaid's prominent role in State health IT initiatives. More high-quality, relevant articles are being published, although this has tapered off as the initial interest and enthusiasm for the new programs mandated under ARRA has waned.

Project Reports

Four reports were supported by AHRQ through the TA to Medicaid and CHIP contract mechanism: Quality Oral Health Care in Medicaid through Health IT,¹ A Guide to Calculating the Costs and Value of E-Prescribing,² the Assessment of Medicaid and CHIP Health IT Activities and Needs,³ and the Barriers to Meaningful Use Among Medicaid Providers report (three reports prepared by RTI to be posted in 2012). The oral health report details whether and how health IT and the Medicaid electronic health record (EHR) incentive program can be used as tools to improve access to quality oral health care for children enrolled in Medicaid and CHIP. The cost-value guide provides a detailed discussion of the stages in e-prescribing where costs and value may occur and where and to whom value may accrue. The report provides a scan of relevant literature and summary of techniques that can be used to calculate cost and value. The needs assessment report describes activities, challenges, planning, evaluations, and external factors facing Medicaid and CHIP agencies across the country as they undertake initiatives in health IT and HIE based on a survey of Medicaid and CHIP staff conducted in late 2007.

Evaluation of Activities and Overall Satisfaction

The evaluation questionnaires administered after each Webinar and Web-based workshop collected participant ratings of the quality of each event and the extent to which participants felt learning objectives were met. Results from the combined evaluation data for the contract overall are described herein. Participant ratings were also collected from each in-person workshop.

Ratings of Webinar quality were very positive, on the whole. Where negative ratings were given, these were discussed with the project team and the project officer, and addressed throughout the life of the project to continuously improve the quality of the Webinars.

Ratings of workshop quality were very positive, similar to ratings of Webinars. Participants responded very well to the Web-based workshop format.

Transitions

Over the past few years a number of sources of technical assistance have been developed to support HITECH- and CHIPRA-mandated activities and, unlike at the start of this contract when resources were few, Medicaid and CHIP agencies now have multiple resources. Topics that continue to be of great interest to the agencies are those related to managing multiple ongoing initiatives and implementing the EHR incentive program and HIE. The Office of the National Coordinator (ONC), Centers for Medicare & Medicaid Services, and the Health Resources and Services Administration all offer TA programs that may meet the needs for Medicaid and CHIP going forward.

Chapter 2. Evolution of the Medicaid/CHIP Health IT and Health Information Exchange Environment from 2007 to 2012

At the inception of this project in 2007, Medicaid and Children's Health Insurance Program (CHIP) played a limited role in health information technology (IT) and health information exchange (HIE), which, between 2007 and 2012, has evolved and grown in many important ways. In 2007, the Agency for Healthcare Research and Quality (AHRQ) published a report⁴ that described the potential that Medicaid and CHIP agencies had to expand their use of health IT and HIE and improve care for the vulnerable populations that they serve. Also, during that period, a number of Medicaid leaders were working to develop plans to transform Medicaid through the use of health IT supported in large part by the Medicaid Transformation Grants funded by the Centers for Medicare & Medicaid Services (CMS). The American Recovery and Reinvestment Act of 2009 (ARRA), the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), and the Patient Protection and Affordable Care Act (ACA) of 2010 substantially expanded the role of Medicaid in health IT and HIE and increased the need for coordination across a range of programs and initiatives. ARRA required that CMS implement the Medicaid electronic health record (EHR) incentive program aimed at promoting the adoption and meaningful use of EHRs among Medicaid providers. At the same time, the Office of the National Coordinator was charged with developing a program aimed at advancing State Health Information Exchanges and stipulated that Medicaid Directors be included in the planning and submission of State applications to participate in the State HIE Cooperative Agreement program. In addition, the ACA requires that States develop and implement health insurance exchanges, in which Medicaid plays a key role, and streamline eligibility and enrollment processes. CHIPRA required that States identify, enroll, and retain health coverage for children in need and develop a core set of children's quality measures. This report documents the evolution of this AHRQ-funded project to provide technical assistance to Medicaid and CHIP and expand their role in implementing health IT and HIE programs aimed at improving care for the populations which they serve.

In August 2007, the Office of Inspector General (OIG) published one of the first studies to examine Medicaid's participation in health IT and HIE. The OIG report⁵ focused on whether Medicaid agencies had any current or planned health IT and HIE initiatives. At the time of their review, they documented 16 current health IT/HIE initiatives in 12 States. To track progress over time, we used the OIG's comprehensive and methodologically sound survey as a baseline against which to track progress. This information was supplemented with the findings of a 2008 needs assessment that RTI conducted, which documented 43 planned or implemented health IT and HIE activities. Between 2008 and 2011, we continued to track the activity of the Medicaid and CHIP agencies. The following subsections summarize the progress the agencies have made in adopting and implementing health IT and HIE initiatives since 2007 and also detail the external factors that have impacted the adoption and implementation of health IT and HIE in Medicaid.

Changes in Health IT Initiatives

Since 2007, Medicaid agencies’ participation in health IT and HIE has increased dramatically. Table 1 summarizes the increase in EHR initiatives, electronic prescribing, personal health records, and HIE. These changes took place during a time of great change in the overall environment around health IT and HIE, which included the passage of the ARRA Health Information Technology for Economic and Clinical Health (HITECH) Act and ACA. This information was supplemented with the findings of a 2008 needs assessment RTI conducted that documented 43 planned or implemented health IT and HIE activities. Between 2008 and 2011, we continued to track the activity of the Medicaid and CHIP agencies, reviewing agency Web sites and the peer-reviewed and gray literature to assess the number of current initiatives.

Table 1. Medicaid agency participation in health IT initiatives

Type of Initiative	Number in 2007	Number in 2011	Percent Increase
Electronic Health Records	12	21	75%
Electronic Prescribing	5	27	440%
Personal Health Records	0	13	N/A

State Health Information Exchange Cooperative Agreements

Authorized under HITECH, the State Health Information Exchange Cooperative Agreements were awarded to a State or a State-designated entity (SDE) in all 56 States and territories and are intended to—

- Enable statewide capacity for HIE to allow eligible professionals and hospitals to qualify for Medicare and Medicaid Meaningful Use incentives.
- Ensure that States address privacy and security issues to allow for the proper access to and use of personal health information.
- Build from existing State-level and regional efforts to advance HIE.
- Encourage the use of shared resources, services, and State directories to reduce HIE development costs and facilitate interoperability among providers within States.
- Provide States with enough flexibility to accommodate their unique requirements, yet ensure nationwide interoperability on a policy and technical level.⁶

In some instances, the Medicaid agency is the SDE; where this is not the case, the grant requires coordination with Medicaid for governance, technical infrastructure, and business and technical operations. The specific requirements include ensuring the coordination, integration, and alignment of efforts with Medicaid; leveraging existing regional and State-level efforts and resources that can advance HIE, including the State’s Medicaid Management Information Systems; and coordinating and aligning efforts to meet Medicaid and public health requirements for HIE and evolving Meaningful Use criteria.

Each State is required to develop a State health IT plan that includes a chapter dedicated to Medicaid’s role in HIE. Medicaid agencies participating in the Medicaid EHR incentive program are required to develop a State Medicaid Health IT Plan (SMHP). The SMHP developed by the Medicaid agencies for the Medicaid incentive program will be incorporated into the State-level documents. Together, the requirement for Medicaid participation in the State-level HIE efforts

and the funding available are meant, in part, to address the challenges of coordination of HIE efforts within the State and lack of funding for pursuing HIE opportunities.

EHR Incentive Program

One of the goals of HITECH is to provide financial incentives to providers who adopt and “meaningfully use”⁷ EHRs. Medicaid agencies can choose whether to administer a Medicaid EHR incentive program for eligible professionals and hospitals in their States. For States to receive Federal matching funds (90 percent for administering the incentive program, 100 percent for the incentives themselves), they must develop the planning structure and implementation roadmap for the incentive program that consists of the following documents:

- A Health Information Technology Planning Advance Planning Document, and
- An SMHP, and A Health Information Technology Implementation Advance Planning Document (more detailed information regarding the content of these documents can be found at the CMS Web site).⁸

To implement an EHR incentive program, Medicaid agencies must have their SMHP approved by CMS. CMS has published an optional template for States to use in developing their SMHPs, which outlines a number of wide-ranging issues that Medicaid agencies should consider to maximize the success of the EHR incentive program.⁹ The template for the SMHP implies that CMS expects Medicaid agencies to become involved in fostering HIE and promoting Meaningful Use of EHRs. The template specifies that the SMHP should demonstrate how a State will “support provider adoption of certified EHR technologies” and “leverage existing infrastructure and/or build new infrastructure to foster health information exchange (HIE) between Medicaid’s trading partners within the State, with other States in the area where Medicaid clients also receive care, and with any Federal providers and/or partners.”

As of March 1, 2012, 43 States had launched their incentive program. According to data from CMS, 66,663 eligible professionals registered for the Medicaid EHR Incentive Program between January 2011 and February 2012 and received more than \$348 million in incentive payments.

CHIPRA Demonstration Grants

The CHIPRA reauthorized CHIP and, in particular, provided funding for grants to evaluate promising ideas for improving the quality of children’s health care. The CHIPRA legislation proscribed four broad categories for the grants:

1. Experiment with, and evaluate the use of, new measures for quality of Medicaid and CHIP children’s health care.
2. Promote the use of health IT for the delivery of care for children covered by Medicaid and CHIP.
3. Evaluate provider-based models that improve the delivery of Medicaid and CHIP children’s health care services.
4. Demonstrate the impact of the model EHR format for children (developed and disseminated under section 401(f)) on improving pediatric health, and pediatric health care quality as well as reducing health care costs.

In February 2010, CMS awarded 10 grants to 18 States totaling \$100 million over 5 years. Seven participating States will be implementing new health IT strategies to improve children’s health care quality, including leveraging HIE projects co-occurring in the State. These grants

may offer evidence of how health IT can improve children's health care and offer lessons for other States that wish to implement such a program. A contract to evaluate these demonstration grants was awarded in September 2010; final results of this evaluation are expected in 2015.

Health Care Reform

The ACA is an expansive piece of legislation that encompasses a wide range of health insurance and care delivery components, including an individual mandate to purchase health insurance, changes to employer-provided insurance, and modifications to the tax code. The two provisions most closely tied to Medicaid are an expansion of Medicaid eligibility and the creation of the American Health Benefit Exchanges and Small Business Health Options Program Exchanges (insurance exchanges). The constitutionality of the ACA was litigated before the Supreme Court in March 2012. The final ruling, expected in summer 2012, could significantly impact Medicaid agencies if the law is found to be unconstitutional. The following sections describe actions that will be required of Medicaid agencies, provided the law is upheld.

The ACA expands Medicaid eligibility to all individuals under age 65 with incomes up to 133 percent Federal poverty level (FPL); the Congressional Budget Office estimates that this expansion will add 16 million individuals to the Medicaid rolls. To further expand insurance coverage, the ACA also provides for subsidies for those who earn between 133 percent and 400 percent FPL to purchase coverage through the insurance exchanges. To support enrollment in Medicaid, CHIP, and subsidized coverage, States are required to develop systems and processes that streamline the application and eligibility determination processes. The enrollment systems must be consumer friendly, coordinated, simplified, and technology enabled (for a detailed overview of these provisions of the ACA, see Morrow and Paradise¹⁰). States will not be required to scrap existing systems, but they will be required to develop a consumer-facing application that effectively communicates with other internal systems to process eligibility determinations.

The Center for Consumer Information and Insurance Oversight (CCIIO),^a within CMS, oversees changes to the private insurance markets required under the ACA. In this capacity, CCIIO awarded "Early Innovator" grants to six States plus a consortium of New England States to implement the IT infrastructure required to launch and operate the insurance exchanges. CCIIO has been working to proactively provide guidance, technical standards, and other information that States will require as they work toward the January 1, 2014 go-live date for the insurance exchanges. In 2010, OCIIO and CMS issued joint guidance titled *Guidance for Exchange and Medicaid Information Technology Systems*, which provides early information regarding support for business operations and processes required under the ACA. An updated version was published in May 2011. In addition, in April 2011, CMS implemented regulations that allow States to draw down an enhanced match for the development and maintenance of Medicaid eligibility systems. Under the rule, States are able to receive a 90-percent match for development costs (through 2015) and a 75-percent match for maintenance costs (no end date specified).

^a The Office of Consumer Information and Insurance Oversight (OCIIO) was originally an independent office within the Department of Health and Human Services (HHS). In January 2011, OCIIO became a Center within CMS and renamed the Center for Consumer Information and Insurance Oversight (CCIIO). In this report, we refer to the organization as OCIIO for events or actions that occurred prior to the reorganization and CCIIO for those that occurred afterward.

Remaining Challenges for Medicaid and Health IT and HIE

The recent litigation of the ACA has introduced uncertainty in the activities of Medicaid staff. Although resolution is expected this summer, if the ACA is overturned, Medicaid agencies may need to rush to reassign resources and reconsider organizational structure and services.

Building the new eligibility systems and ensuring interfaces between the insurance exchanges and Medicaid and CHIP will require significant management and IT expertise. The need to create the insurance exchanges and associated interfaces will take substantial time and effort that might have otherwise been devoted to other health IT and HIE projects. The changes mandated by the ACA may also necessitate organizational moves, such as creating a new office to manage the insurance exchanges or integrating Medicaid with a new or existing office that will manage the insurance exchanges. These technological and organizational changes may draw efforts away from health IT and HIE. Alternatively, the careful planning and level of effort associated with developing, launching, and maintaining the insurance exchanges may provide resources that can support HIE.

Chapter 3. Technical Assistance Program: Assessment through Implementation

Assessing Technical Assistance Needs in an Evolving Landscape

Over the past 5 years an unprecedented set of events has occurred that have the potential for significantly transforming the health care delivery in the United States. Health care consumers, providers, and payers alike are exploring innovative models to deal with the rising costs of health care and how the quality of this care can be improved. The national conversation about health care reform has focused particular attention on the role public sector payers, including Medicaid and the Children's Health Insurance Program (CHIP) will assume in this transformation process. Federal legislation and related policies that have been recently adopted, combined with the emergence of numerous health information technology (IT) and health information exchange (HIE) initiatives, have created an enormous set of challenges and training needs for Medicaid and CHIP programs.

In response to these challenges, the project developed a series of training and technical assistance (TA) opportunities that focused on the immediate and short-term needs of Medicaid and CHIP agencies, particularly as they relate to health IT and HIE activities. Throughout the project period, RTI implemented and sustained a needs assessment process that was open and engaging and prioritized direct stakeholder input related to agency-specific health IT and HIE matters. Opinions, observations, and recommendations on various training topics were routinely solicited throughout the project. Information was sought from agency representatives, their associations, and related stakeholders. This input was instrumental in shaping the type, nature, content, and mode of delivery RTI used to fulfill its training responsibilities.

Methods

Through the needs assessment process, the project team gathered information related to issues confronting Medicaid and CHIP agencies across the country as they planned their responses to emerging health IT and HIE challenges. The survey process and instrument RTI used were designed to be administered to all Medicaid and CHIP agencies. The instrument was constructed to facilitate collecting information that would then be used to identify the most critical and relevant training and TA support the project could provide.

During year 1 (2007–2008) of the project, RTI conducted a pilot study of a select group of Medicaid agencies (12 States were targeted for the pilot, 7 agreed to participate) to assess the efficacy of the assessment process and survey instrument. The pilot survey was conducted to ensure that the assessment instrument was comprehensive and that the mode of data collection was suitable for either telephone interviews or site visits. Based on the results of the pilot study, modifications in both the initial survey instrument and assessment process were made. These changes enhanced both the process for data collection and detail of information ascertained. The information collected from the pilot study helped identify specific training and TA topics and areas of interest. Thus, RTI could consider potential TA and training needs before the national survey was conducted.

Results of the pilot study as well as recommended revisions were presented to the Agency for Healthcare Research and Quality (AHRQ) Task Order Officer (TOO) for review, consideration, and approval. Once approved, a final needs assessment instrument and accompanying materials were submitted to the Office of Management and Budget (OMB). OMB approval was then granted for all 3 years of the original project, through September 2010.

RTI completed all revisions to the needs assessment instrument in year 2 (2008–2009) and began data collection. All Medicaid and CHIP agencies that did not complete a pilot interview were contacted and offered the opportunity to participate in the full assessment. The needs assessment was conducted between September and December 2008. Of the 56 agencies contacted, 7 participated via in-person interview and 27 participated via phone interview.

Twenty-two agencies elected not to participate. After carefully analyzing the characteristics of those States that participated in the survey, RTI concluded that the results/findings of the needs assessment process were reliable and could be used to forecast agency training and TA needs.

As agency interviews were completed, project personnel entered agency-specific responses (closed-ended and open text) into an electronic version of the needs assessment. Other members of the survey team then reviewed the information. After all project staff agreed on the interview responses and notes, a compiled version of the responses were imported to a Medicaid/CHIP Microsoft® Access database developed for the project for further analysis.

After careful analysis of this information, discussions with the TOO, feedback from the project's Technical Expert Panel (TEP), and anecdotal information RTI collected from organizations (including the National Association of State Medicaid Directors [NASMD], various work groups supported by NASMD, and other groups and associations with whom RTI regularly consulted), RTI developed an initial menu of training and TA offerings. RTI's collaboration with NASMD also assisted in promoting the project to Medicaid agencies across the country.

The AHRQ TOO and the RTI project director agreed to eliminate a formal reassessment of Medicaid and CHIP agencies in year 3 (2009–2010)². This decision was made based on the following factors: (1) the time it would take RTI and the agencies to complete a reassessment process, (2) an awareness that significant policy changes were being enacted at a Federal level that would drastically reshape and expand roles for Medicaid agencies, (3) the need for immediate training and TA for agencies to address these new Federal policies and mandates, and (4) a confidence that the training and TA needs already established remained relevant. Based on these factors, RTI proposed an alternative assessment process: a multipronged approach to gather and validate additional information to develop the TA and training plan for the year. AHRQ and RTI agreed that information and data gathered from existing surveys, attendance at related conferences and meetings, collaborations with NASMD and various work groups of the Association, as well as feedback, comments, and recommendations from the project's TEP were sufficient to guide the development of the TA plan for year 3 and avoid duplication of TA offerings supported by other initiatives. This decision allowed RTI to proceed with the immediate planning and organization of TA trainings and establish the approach to identifying high-priority TA topics during the remainder of the project.

² In September 2010, AHRQ granted a 5-month extension to the contract. Year 3 lasted 17 months, from September 28, 2009 to February 28, 2011. Throughout this report we refer to this period as "year 3."

Summary of Needs Assessment Findings

The needs assessments conducted during the project were intended to identify critical challenges facing Medicaid and CHIP agencies nationwide as they plan and implement measures to maximize their use of emerging health IT/HIE capabilities. RTI used information from the assessment process as the basis for developing a comprehensive program of TA, including Web-based and in-person workshops and seminars; the formation of several Communities of Practice (CoPs); a Repository of Medicaid and CHIP-specific reference materials consisting of lessons learned, best practices, and a knowledge library; and online access to related tools and resources, all focused on enhancing agencies' readiness and competency to fulfill their health IT and HIE initiatives.

The needs assessment process undertaken in years 1 and 2 of the project was the primary source for the development of the TA delivered in years 2 and 3.

In addition to identifying a set of specific training and TA topics for Medicaid and CHIP agencies, the needs assessment process confirmed the assumption that great variation existed in current and planned health IT and HIE projects among agencies. As of fall 2008, the health IT initiatives reported as planned or implemented by Medicaid and CHIP agencies fell into five groups: quality improvement (14 agencies), electronic prescribing (e-prescribing; 14), electronic health records (EHRs; 8), personal health records (3), and other types of initiatives (4). More than half of the agencies interviewed had at least one HIE initiative, 5 agencies had two initiatives, and the remaining 9 agencies had no initiatives.

Medicaid and CHIP agencies reported a belief that implementation of health IT and HIE initiatives would accomplish important goals for themselves and their beneficiaries. The most common goal across health IT initiatives was reduction in cost to Medicaid program(s). Other common goals for health IT and HIE were improving quality of care, increasing communication/interoperability, and improving administrative processes.

Medicaid and CHIP agencies also elaborated on the challenges in implementing these initiatives that were fundamental to building a practical and useful set of TA tools in years 2 and 3 of the project. Cost of implementing health IT initiatives was the most significant challenge reported, but for HIE initiatives, access to infrastructure (e.g., broadband), sustainability of HIE, and meeting regulatory expectations were also challenges. Many agencies reported limited or no evaluations of initiatives' progress toward goals or analysis of cost and value of initiatives currently planned.

Priorities for TA focused on policy, but depended on several factors. As part of the needs assessment, Medicaid and CHIP agencies ranked topics to identify their priorities for TA in nine categories. Overall, health IT and HIE policy issues ranked highest, based on the means and the number of States listing this topic as one of their top three priority areas. Privacy and security and using health IT and HIE for quality improvement were also top priorities for TA.

To further explore how priorities might differ among agencies, external factors were considered, as well as differences based on the types of health IT and HIE initiatives that an agency reported. Of the external factors, the status of an agency's Medicaid Management Information Systems and the poverty rate within the State affected the priorities for TA, while there was no difference based on how rural a State is or the level of Medicaid spending per enrollee.

When RTI examined how Medicaid and CHIP agencies planned or implemented health IT and HIE initiatives, differences in priorities that depended on the type of initiative and its stage

of development were identified. Agencies often requested information regarding components of their initiatives or related topics (e.g., agencies planning EHRs were interested in quality improvement). However, no clear common priorities emerged for agencies planning or implementing HIE initiatives, most likely because agencies play a variety of roles and may require TA based on their role in the HIE activity. Overall, the rankings demonstrated that agencies' needs and priorities are often contingent on a variety of factors that affect how the TA is designed, targeted, and implemented.

Based on the results of the needs assessment, the TA provided in year 2 took into account the status of the agencies' health IT and HIE initiatives. In addition, sufficient numbers of agencies were promoting EHRs, e-prescribing, and quality initiatives, so that targeted TA for initiative-specific issues was feasible.

Two overarching issues for which TA was a priority were confirmed following the needs assessment. First, agencies were unsure about general health IT and HIE policy issues and wanted guidance on regulations and policies. Second, several agencies had begun to consider how to quantify the benefits of participating in health IT or HIE and the costs of their participation. Based on this feedback, specific TA offerings were developed.

The economic recession of 2008–2010 significantly impacted most State budgets and caused Medicaid and CHIP agencies to reassess and, in many instances, defer action on health IT- and HIE-related initiatives. Agencies consistently reported that the lack of available State funds and limitations related to the availability of internal technical resources were major barriers to their participation (or lack thereof) in health IT or HIE activities. Although the project could not provide funds directly to the agencies, a TA program focused on how to analyze the cost and value of initiatives could help them to obtain funding. The project could also provide a mechanism through which agencies could share their experiences about funding for health IT initiatives.

Finally, many agencies wanted to share their knowledge, policies, and documents with other agencies. Workshops, CoPs, and an online Repository were developed to address this interest. As reported by agencies that used these techniques, valuable and actionable suggestions were identified. The table in Appendix A describes training and TA opportunities offered to agencies by year and type.

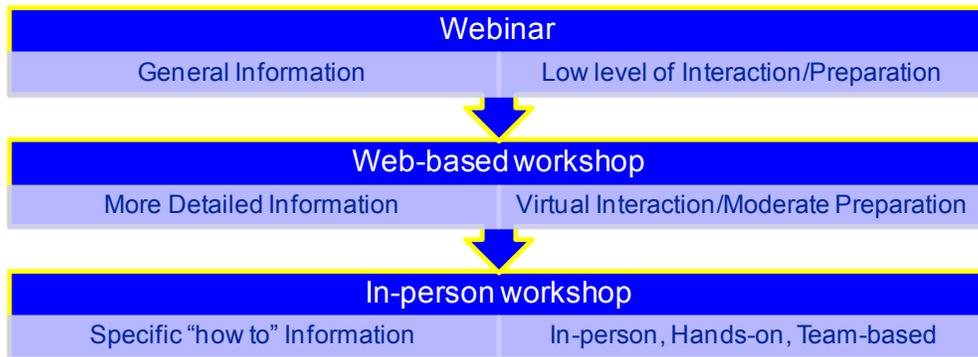
Decisions About Mode of Technical Assistance Delivery

The program of TA events included Webinars, more intensive Web-based workshops, and larger, in-depth workshops delivered in-person. To determine the mode for each TA offering, we considered the topic, the potential number of participants, the need for participant interaction, and the amount of work that Medicaid and CHIP agency staff would have to complete for the event.

Initially, the project team targeted a maximum of 50 attendees at Webinars but, as the project continued, found that as many as 100 could be accommodated in response to demand with no detrimental effect on delivering content or managing the session. Workshops, whether Web-based or in-person, were targeted at smaller groups of 30 to 40 participants in total, with participants working in small, State-based teams of two to four team members.

As delivery mode progressed from Webinar to Web-based workshop to in-person workshop, both the intensity of the learning experience and the time commitment required escalated (see Figure 1). In some instances the project provided TA on a single topic that progressed from a Webinar, to a Web-based workshop, to an in-person workshop when sufficient, sustained interest in a topic existed and as agencies matured in their implementation or utilization of a health IT/HIE solution.

Figure 1. Progression of technical assistance delivery mode



Webinars convey information to a broad audience on a topic or speaker of general interest, while demanding little of participants in preparation and interaction. Web-based workshops allow smaller virtual groups to work together to explore topics more deeply and apply newly acquired knowledge to real-world challenges. They require a moderate amount of preparation and a willingness to participate in exercises and discussion. In-person workshops allow teams working in groups to benefit from a more intensive learning experience, but are both time and resource intensive. They provide Medicaid and CHIP agency teams opportunities to plan for longer-term initiatives.

The pros and cons of the three modes of TA delivery are summarized in Table 2.

Webinars and Workshops

Methods

In planning the series of Webinars, Web-based workshops, and in-person workshops, RTI developed several key principles. Priority topics were introduced in overview sessions provided by Webinar. Deeper explorations of more sophisticated topics were provided by Web-based workshops and in-person workshops and required greater levels of participant interaction. Topics were selected to coincide with ongoing Medicaid activities for implementation of HIE and health reform objectives. In addition, we periodically requested feedback via the project listserv for new topics and via personal contacts at Medicaid agencies to inquire about additional TA topics that would be useful to them.

Table 2. Summary of pros and cons of event modalities

Type of Event	Pros	Cons
Webinar	<ul style="list-style-type: none"> • Is easy to set up and use • Accommodates a large audience • Provides interactivity via phone and chat panels • Makes instant polling available • Allows recording, transcribing, and posting for future access • Provides broad overview on a topic 	<ul style="list-style-type: none"> • Not well suited for small group work • Not well suited for in-depth discussion
Web-Based Workshop	<ul style="list-style-type: none"> • Offers ability to discuss topics in greater detail • Provides interactivity via phone and chat panels and discussion with subject matter experts • Makes instant polling available • Provides ability to leverage prework for more specific work in small groups • Provides broad overview of a topic combined with more in-depth treatment of certain facets 	<ul style="list-style-type: none"> • More time and labor intensive to prepare
In-Person Workshop	<ul style="list-style-type: none"> • Allows discussion of topics in great detail • Fosters team building and peer-to-peer learning • Allows both intensive small group and large group learning • Provides relative isolation that limits distractions 	<ul style="list-style-type: none"> • Most time and labor intensive to prepare • Limited number of participants

Webinars generally last 90 minutes, feature two 30-minute presentations, and allow for a 30-minute question-and-answer period. A Webinar is an effective delivery method for presenting an overview of a topic. For example, a Webinar is appropriate for an overview of privacy and security law and regulation in health IT and HIE. A Web-based workshop differs from a presentation; it is a working session with a smaller group exploring a specific topic in more detail. Web-based workshops usually involve two or more modules, a working document for users, a facilitator/presenter for each module, interactive involvement of participants through exercises, and dedicated short periods of time concentrated on a defined area of concern. Web-based workshops also involve preworkshop preparation by participants and defined actionable deliverables that participants prepare. Web-based workshops usually last 3 hours, although we held 6-hour Web-based workshops divided between 2 days. An in-person workshop follows the principles and characteristics of a Web-based workshop, but participants are gathered in a common location, in person, for a longer period, usually a day and a half. An in-person workshop is more appropriate to assist agency staff in strategic planning processes, for example.

For each Webinar, Web-based workshop, and in-person workshop, we developed suggested titles, statements of overall purpose, learning objectives, target audiences, and possible speakers. For the Webinars and Web-based workshops, we decided to have overview speakers address the more didactic material and provide a common foundation of knowledge about particular topics; then, additional speakers discussed a particular implementation or example of the topic, usually from an agency perspective. Before the Web-based workshops, participants were asked to answer prepared questions to form a baseline for evaluation of the workshop and discussion

points to be raised during the workshop. Participants received group guidance as to what materials or activities should be completed prior to the workshops.

During the project, 30 Webinars, 11 Web-based workshops, and 7 in-person workshops were delivered. The slide presentations for the Webinars and Web-based workshops were posted on the project Web site. Appendix A contains a complete list of all TA events.

Challenges

Planning TA events takes a significant amount of lead time to identify a topic, speakers, and materials and to distribute logistics information. The Standard Operating Procedures manual we developed mitigated some, although not all, of these challenges by providing a standard work schedule, templates, and supporting documents. However, agency staff and subject matter experts are often busy, which can lead to slippages in the schedule.

Achieving Section 508 compliance of Web resources to ensure useful access to project materials by Americans with disabilities was challenging. Section 508 was implemented as an amendment in 1998 to the Rehabilitation Act of 1973, which mandated that electronic and information technology be accessible to persons with disabilities. For example, Web-based material must be accessible to those who have limited sight or those who are blind by being made compatible with screen readers. We needed to budget additional time to provide the alternative narrative text to accompany the PDF versions of the presentations. Each slide required about 15 minutes of time to create the alternative text by an individual knowledgeable about the subject matter.

The reliability of the WebEx service also proved challenging on a few occasions. For future TA offerings, alternate Web conferencing services should be considered.

Lessons Learned

Medicaid agency staff members are eager for learning opportunities that specifically target their needs and do not create a burden on them to participate. Staff turnover at Medicaid agencies means that some agencies continue to need introductory information on a number of topics on a regular basis. However, the majority of agencies have developed a sufficient base of knowledge on which to build more specialized and sophisticated offerings.

The level of enthusiasm for the project and participation in the Webinars, Web-based workshops, and in-person workshops remained high over the course of the project. Although more TA offerings were available from a number of sources following the passage of the American Recovery and Reinvestment Act (ARRA) of 2009 and the Affordable Care Act (ACA) of 2010, Medicaid agencies still needed assistance in balancing multiple projects and priorities and on topics not specifically addressed by other agencies or organizations.

In-person workshops should be carefully targeted because Medicaid staff often have limited time to attend in-person workshops. Traveling to events creates a burden on agency staff in terms of time out of the office and the need to seek travel approvals. Many States implemented a travel freeze when the economy became tight, regardless of whether travel would be funded by an external source. Nonetheless, providing funds for travel costs is essential if agency staff are to be able to attend. Identifying appropriate topics, providing adequate lead time, and ensuring that staff can attend as a team all support successful outcomes for the workshops.

Communities of Practice (CoPs) and Evaluation of CoPs

The purpose of this task was to develop several peer learning networks for Medicaid and CHIP agencies that serve as open, collegial platforms for staff to access and exchange up-to-date information on health IT issues that are most important to them. The vision for CoPs for this project was to create environments in which Medicaid and CHIP professionals could openly share their challenges, successes, and failures to accelerate the learning curve of all participants in a particular topic area. By definition, this restricted CoP membership to Medicaid and CHIP agency staff, in contrast to most of the other TA activities.

The decision to limit CoP membership to Medicaid and CHIP agency staff exclusively stemmed from the definition of a CoP. A CoP is “a group of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise by interacting on an ongoing basis.”^{11,12,3} Establishing one or more CoPs can be an effective mode of providing TA when the objective is to accelerate a group’s learning curve on a topic, especially when the group wants to develop or improve upon implementation of an ongoing common practice or line of business. The structure of a CoP lends itself to sustaining an organic system of support within a topic area beyond other TA educational programming that may be of limited duration. The decision made for this project was that the most naturally occurring communities were Medicaid and CHIP agency staff who might have more in common with regard to the policies under which they work, their budget constraints, and the projects on which they are focusing.

In addition, one tenet of traditional CoPs is that they are directed by members themselves. The Medicaid and CHIP CoPs embodied this principle from the very beginning, maintaining a planning team of Medicaid and CHIP agency staff that met between CoP meetings.

The following Methods Section describes the methods for initiating and maintaining an active CoP:

- Identify domain, community, and practices (i.e., choose topics for the CoP).
- Recruit CoP members and a planning team.
- Conduct activities before, during, and after each meeting.
- Sustain activities between events (CoP infrastructure).

Sections that follow describe the challenges with building CoPs in this area (Challenges Section); the lessons learned identified throughout this project that improved the CoPs’ functioning and led to continuous feedback and improvement in CoP operations (Lessons Learned Section); and evaluation of CoPs (Evaluation Section).

Methods

The main methods to designing and maintaining a CoP involve choosing a topic, recruiting CoP members and a planning team, conducting CoP meetings, and sustaining activities between meetings. This project developed an approach to each of these steps in supporting CoPs for Medicaid and CHIP agency staff.

First, RTI and AHRQ collaboratively developed an informal set of criteria for selecting CoP topics. Among the initial criteria to consider is whether the topic is broad enough to be an

³ For more background information on Communities of Practice, please see CDC’s Public Health Information Network Community of Practice Resource Kit, “Introduction to Communities of Practice” (from which this definition is drawn) and other resources available at: <http://www.cdc.gov/phinf/communities/>

attractive focus for a series of meetings over time. Furthermore, the topic should be one in which enough CoP participants have sufficient experience to lead a discussion and share their own experiences. Finally, in the last year of the project, the main method used to select from among a set of topics that met these criteria was a poll to the Medicaid and CHIP agency staff who had participated in previous CoPs and TA events.

The three components necessary to initiate a CoP are—

1. A domain—the shared interest that provides the incentive and passion for the group to come together.
2. A community—the group of people who come together with a common interest to share their perspectives and knowledge with one another.
3. The practice—the set of experiences or problem-solving approaches that participants share to address common challenges in the domain and to improve upon them.

In the case of the CoPs established under this project, the selected domain (topic) often drove the description of the community (recommended CoP members) specified in the announcements at the beginning of each CoP, and drove the practice (focus of discussion questions) further developed by the planning team of each CoP.

The second main step in creating and maintaining a CoP is recruiting members, both for the CoP and for the CoP's planning team. The CoP's planning team is particularly important to the strength of the CoP, since every CoP is intended to be led and managed by members themselves.

Recruiting the CoP members can happen in two ways; one approach is to consider all attendees at the first meeting of the CoP as members, with additional members added as each subsequent meeting attracts new attendees. This approach was used to recruit members of the Medicaid Involvement in State HIE CoP and the Health IT for Child Health CoP. Alternatively, a general e-mail to gauge interest in a CoP topic could recruit the initial set of CoP members who would be among those targeted with the announcement for the first CoP meeting, again with additional members added as each subsequent meeting attracts new attendees. This approach was used to develop the CoP on Managing Multiple Health IT Projects in Medicaid and CHIP.

Each method for developing CoP membership can lead to different approaches for recruiting a CoP planning team. When interest is gauged primarily according to who attends the first meeting, one agenda item for the meeting could be to ask for volunteers to plan the next meeting. In the second instance, the initial e-mail to gauge interest in the CoP topic could also include a request for potential participants to indicate their interest in being on a planning team as well as a member of the CoP. A third method to recruit CoP planning team members, which was not used in the final project year, is to identify opinion leaders in a topic area and recruit them specifically to participate on a CoP planning team.

The third major step in establishing a CoP is planning and conducting CoP meetings. Usually, the announcement for a CoP meeting is developed collaboratively with the planning team (assuming one is in place). If a planning team has not yet been recruited, project staff may develop the announcement of the first CoP meeting.

The main decisions that a planning team (or meeting organizer) must make about an upcoming CoP meeting are—

- What will be the meeting's theme or subtopic within the overall CoP domain?
- Will there be a featured speaker to kick off the discussion on that theme or subtopic? If so, who is it?
- What discussion questions will participants be asked to answer during the facilitated discussion part of the meeting?

- Who will facilitate the meeting?
- When (date and time) will the meeting take place? (It is usually 90 minutes long.)

Once those decisions are made, the project staff draft and send a meeting announcement to the appropriate group, either the CoP membership list (as established by attendees at previous CoP meetings) or a broader group of Medicaid and CHIP agency staff that may want to join the CoP. The meeting announcement includes the meeting date and time, theme, featured speaker (if any), name of the facilitator, and link to register for the Web-based meeting in advance.

To prepare for the CoP meeting itself, four main activities took place. First, project staff monitored registration, and several days before the meeting, e-mailed the discussion questions to all participants in individual e-mails that each went to all registrants from a particular State. For example, all registrants from Arizona received an e-mail that indicated it was sent only to registrants from Arizona; a similar e-mail went to all registrants from Alaska; and so forth. The text of the e-mail asked registrants to come to the meeting prepared to respond to these discussion questions. There are two reasons for sending separate e-mails (with the same content) to State teams. First, the “To” field of the e-mail highlights all the people who have registered from a single State. This informs people from the same State—but perhaps different agencies or programs—about who else may be attending from their State, so that they can discuss and coordinate a response ahead of time, if desired. Second, by “personalizing” the e-mail in this way, we found that we were more likely to get a response ahead of time from attendees as to whether they would be able speak to the discussion questions in depth.

The second task in preparation for a Web-based meeting is to ensure that the meeting slide deck is ready. The standard slide deck contains the following slides in the MS PowerPoint template for this project: title, agenda, introductions by State, discussion questions, and slides with additional project information (e.g., upcoming events, how to join the listserv, etc.). For earlier meetings, there may be a slide to review next steps for the CoP, such as recruiting a planning team and/or requesting future meeting topics. The slide deck also includes any slides used by a featured speaker.

Third, the CoP Coordinator supports and prepares the facilitator before and during the meeting in whatever way possible (e.g., sending a list of registrants to the facilitator ahead of time to help him or her lead introductions during the meeting).

Fourth, the CoP Coordinator designs any evaluation questions that should be used at the end of the meeting, and requests that they become a part of the Web-based meeting format.

During the meeting, the CoP Coordinator introduces the meeting facilitator and usually reviews the next steps at the end of the meeting. Otherwise, the facilitator leads the meeting, and the CoP Coordinator takes notes to be distributed after the meeting.

The final activity involved with maintaining a CoP is the work that contributes to supporting the overall CoP infrastructure between meetings. This work includes—

- Distributing CoP meeting notes.
- Updating any calendars of events on the project Web site.
- Updating the description of all CoPs on the project Web site.
- Updating and maintaining the CoP member list with all attendees at each CoP meeting.

Challenges

The main challenge to developing CoPs was sustaining the interest and commitment of CoP membership, particularly those who volunteered to be on the planning team for each CoP. For example, in the case of the CoP for Medicaid Involvement in State HIE, at least one planning

team member who was highly interested in the topic eventually stepped down because of other commitments at his agency. Nonresponse from the other planning team members after multiple requests for a planning meeting and/or input on future CoP meeting plans put this CoP on temporary hiatus.

Another example of the challenge of sustaining interest occurred in the final year of the project. Although respondents indicated high interest in Health IT for Child Health (in the initial poll on potential CoP topics), after the first CoP meeting was held, no attendees volunteered to be on a planning team. After two e-mail reminders and requests for volunteers, the decision was made to not pursue this CoP without a planning team.

During the project, CoP members were most enthusiastic in their participation in meetings, but less interested in initiating e-mail conversations with their peers on the CoP membership lists between meetings (despite frequent reminders that this would be an option). Thus, some of the unique opportunities inherent in developing a CoP rather than individual TA events were missed.

Lessons Learned

Over the course of the project, a number of techniques were developed to foster the most productive environment for knowledge sharing among busy professionals who were interested in a CoP. These techniques grew out of the lessons learned from organizing and supporting CoPs over time.

One lesson learned was that it is not necessary to convene a CoP in person before convening subsequent Web-based meetings. While the first CoP in this project—Privacy and Security—was the only CoP to attempt this, it became clear that more Medicaid and CHIP agency staff were interested in a CoP than could attend an in-person meeting—thus, the value of in-person interaction was diluted in an effort to recruit additional CoP members. Furthermore, Web-based meetings often generated a very productive exchange of ideas among participants, even those who had not met in person prior to the Web-based meetings. Finally, in several instances, it was more productive to design an in-person meeting based on ideas and discussion that originated in a CoP. Planning an in-person CoP meeting based on these discussions would allow participants to delve into topics more deeply than they could during a 90-minute virtual CoP meeting.

Another lesson learned was that certain techniques helped ensure that all participants—regardless of their experience in planning and implementing health IT and HIE initiatives—contributed their thoughts during the Web-based meeting. To counteract the reluctance of some CoP participants to speak up during meetings, the CoP Coordinator e-mailed individual registrants before each CoP meeting to encourage them to respond to the discussion questions that were on the agenda for each CoP meeting. When individuals were primed to think about their responses to the discussion questions ahead of time—sometimes even sending written responses in reply to the e-mail—they were more likely to offer their responses during the meetings.

Other slight modifications to the CoP format enhanced the value of the CoPs. For example, when the planning team members suggested meeting topics, the CoP coordinator reached out to relevant experts who could briefly frame (in no more than 15 to 20 minutes) the topic for discussion at the beginning of each meeting. This strategy attracted participants with decision-making authority within their agencies to attend the meetings. In addition, the CoP Coordinator recruited selected CoP members to facilitate the meeting or make presentations so that they became involved in the discussion early in the meeting. Finally, RTI used the WebEx

functionality to take polls during the meeting so that even when people did not speak, they expressed their thoughts or opinions.

All of these enhancements to conducting CoPs created a model of support that allowed CoP planning team members to generate ideas (despite their busy schedules), while the project team carried out the tasks that could make the CoP a success.

Evaluation

The methods used to evaluate CoP meetings mirror those used to evaluate TA events described in Evaluation of Technical Assistance Section. Briefly, the questionnaire template is customized to address the specific topic and event and delivered to participants via the Web conference. On some occasions, such as when response is very low, it is also sent via e-mail. Responses are tabulated and analyzed, and a report is prepared for the AHRQ TOO. The CoPs can be evaluated along two dimensions: (1) the number of people who participated in each CoP event and (2) the experience of participants at each event.

An example of participation data from the final year of the project is provided in Table 3. Complete CoP evaluation data from the final year of the project can be found in Appendix B. CoP evaluation data from prior years is available in annual project reports.

Table 3. Participation in CoP meetings, final year of project

Community of Practice	Meeting Date	Number of Participants from Medicaid and CHIP	Number of States Represented
Health IT for Child Health	11/7/11	29	18
Managing Multiple Health IT Projects in Medicaid and CHIP	3/28/12	10	6
Managing Multiple Health IT Projects in Medicaid and CHIP	4/25/12	16	10
Medicaid Involvement in State HIE	8/17/11	30	22
Medicaid Involvement in State HIE	10/19/11	27	14
Medicaid Involvement in State HIE	12/20/11	27	12
Medicaid Involvement in State HIE	5/1/12	22	12

Two additional examples of CoP evaluation data taken from the November 7, 2011, meeting of the Health IT for Child Health CoP are shown below in Figures 2 and 3. Figure 2 shows the data collected on the roles of participants within their agency. Figure 3 shows participants' responses to a question about whether the meeting met their expectations.

Figure 2. Roles of participants within their agency

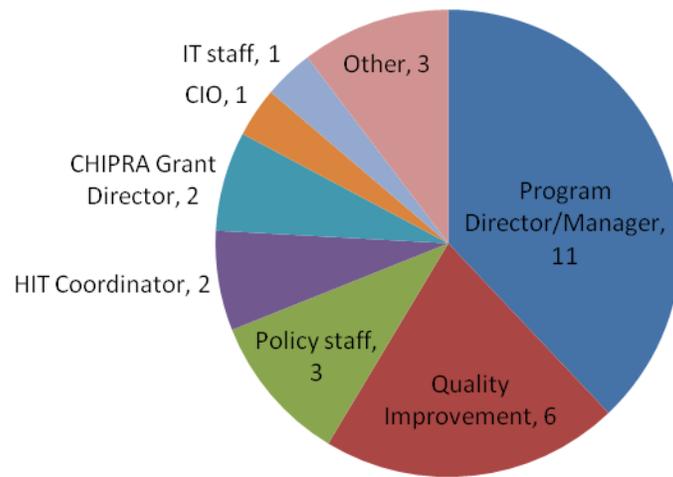
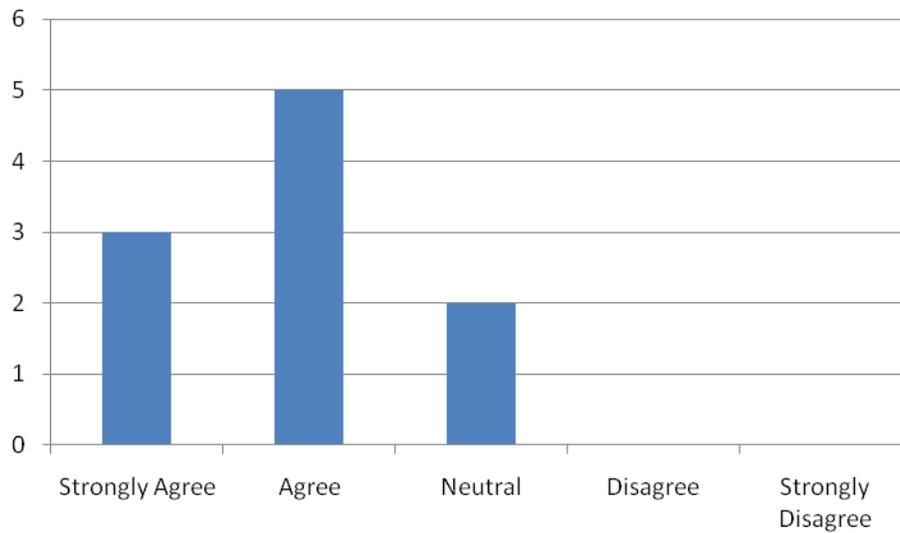


Figure 3. “This CoP meeting met my expectations for discussing health IT for child health with other Medicaid and CHIP colleagues”



Section of AHRQ National Resource Center for Health IT Web Site and Repository

National Resource Center for Health IT Web Site

AHRQ maintains the National Resource Center (NRC) for Health IT as a resource to the health care community to share knowledge and findings relevant to health IT transformation. The project Web site is incorporated as part of AHRQ's NRC and is intended to be a reliable source of current project information and a gateway to health IT and HIE resources specific to Medicaid and CHIP agencies. The project's public site was an essential communication tool, especially for TA events.

Listserv Development and Use

In addition to the Web site, the project maintained a project e-mail account and listserv that were used to communicate information about upcoming project TA activities to participants. Each project event was communicated via the listserv, which reached over 264 individuals, including 164 from State agencies in 41 States, plus the Virgin Islands and District of Columbia; 13 from the Federal government; 52 from vendor or other organizations; 18 from research/professional organizations; and 17 from RTI International.

Instructions for joining the project listserv were provided to visitors to the project Web site. Listserv subscribers were classified as affiliated with a State agency/organization, the Federal government, research/professional organization, RTI International, or a vendor/other. Messages could be sent to the entire list or to one or more of these classifications as appropriate.

The listserv was used as a push e-mail. Those who wanted to reply were instructed to reply to a project staff member via a provided e-mail address. Sending to the list could only be initiated by authorized project staff after logging into the AHRQ Webmail system.

Methods

NRC Web site. In March 2008, the project Web site was released to the public as part of AHRQ's NRC. The project site was intended to provide information about the components, goals, and objectives of the project to the general population. At go-live, the site had two major components: a main home page with general information about the project and a Fast Facts document that provided more information about activities the project would be supporting. During the project, additional features were added: a link to the Repository, a calendar of all project TA events, access to previous event materials, and the ability to register for individual events.

The information contained on the project's public page is intended to be a combination of static and dynamic content. The static elements of the page include the landing page text, which provides a general overview of the project and its goals, and the Fast Facts page, which has an FAQ about the project scope, objectives, and resources. Figure 4 provides information about the frequency of use of the project Web site from April 2008 to June 2010 and from May 2011 to April 2012, and Figure 5 provides frequency of use information from April 2008 to June 2010. The peak in January 2012 reflects responses to an e-mail that was sent out via the listserv pointing users to new additions to the Repository and Web page.

Figure 4. Frequency of Web site use, May 2011 to May 2012

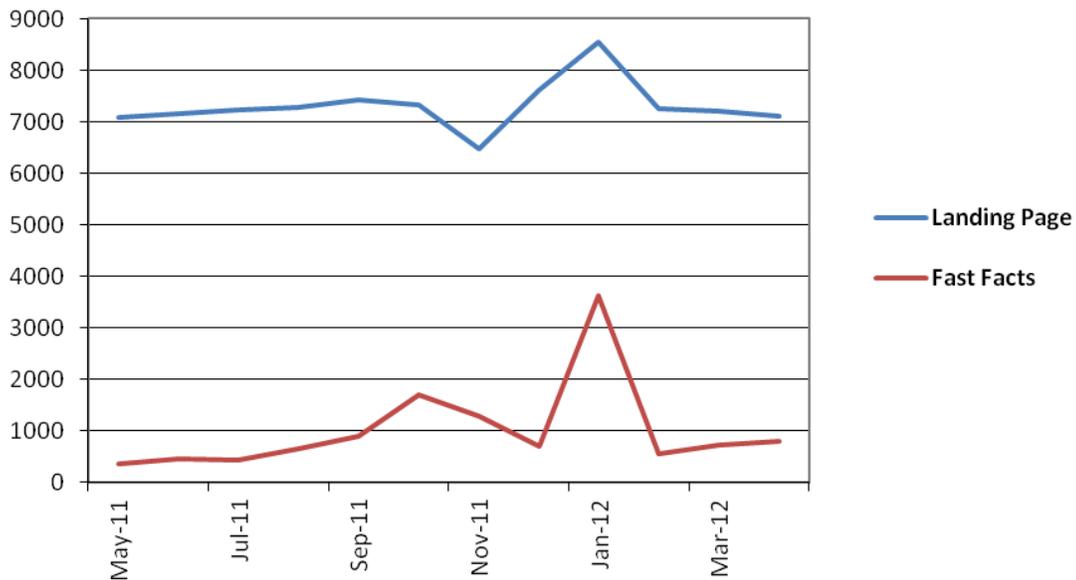
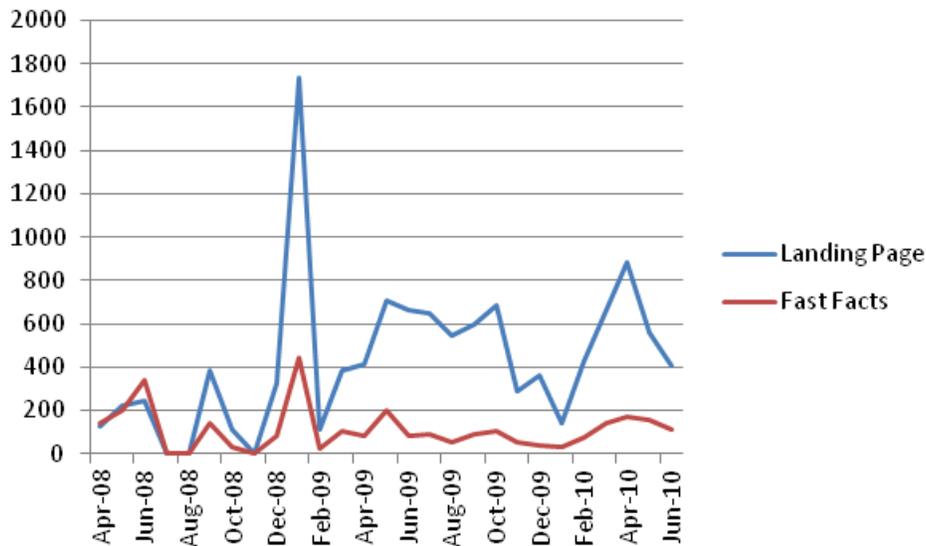


Figure 5. Frequency of Web site use, April 2008 to June 2010



The public site also maintained a few dynamic components updated during the project, such as information about upcoming TA events. The portlet made it easy to update information as events were scheduled. This portlet had blanket approval for updates, which facilitated the dissemination of event information to the public. The site also included an up-to-date calendar of all TA events. For upcoming events being publicized, Web site users could use an active link to get registration information. Links were created to materials from sessions and events that had already taken place. All Webinar session materials include the final combined slide presentation

from all presenters, a link to the recorded session, and the transcript of the session, including the question-and-answer period. The final workbooks and other relevant resources from the Web-based workshops and in-person workshops were also included.

The project also maintained a private workspace for active CoPs. These areas allowed agency representatives to share documents, carry out discussions, and share opportunities with one another through a logon/password-protected area of the NRC Web site. These areas were used occasionally to distribute materials to CoP participants. The CoP Coordinator posted meeting minutes, presenter slides, contact lists, and other relevant information for each CoP. These private workspace areas were not active for the final year of the project, although the content remained available for those with login information.

For the final year of the project, the Web pages were reviewed at the beginning of the year and then on a quarterly basis thereafter. The quarterly Web page review was submitted to AHRQ. Within 2 weeks of AHRQ approval, suggested changes were sent to the Office of Communication Knowledge Transfer (OCKT) for approval. OCKT promotes the communication of information to AHRQ's internal and external customers. It designs, develops, implements, and manages programs for disseminating and implementing the results of Agency activities with the goal of changing audience behavior. Changes approved by OCKT were implemented within 4 weeks following approval.

Repository. Although a significant number of tools and resources currently exist within various parts of this Web site, the Repository seeks to categorize materials specific to the Medicaid and CHIP environment. The information Repository is an important tool for educating Medicaid and CHIP personnel about resources for planning, implementation, and evaluation of health IT and HIE. Providing access to a targeted and timely set of materials clearly filled an important role in helping individuals find the health IT information they were seeking. The Repository provided a central location for information that hundreds of individuals used.

At the outset of this project, a search of the NRC's knowledge library using the keyword Medicaid produced over 500 resources, but provided little direction about the relevance or significance of these documents to the agencies. The Medicaid and CHIP Repository is smaller, but offers materials directly targeted to agency staff working to plan and implement health IT initiatives.

To achieve the goal of formulating a functioning Repository of Medicaid- and CHIP-related information during year 1, RTI subcontracted with BEA, the software vendor that supplies the NRC's basic platform. BEA was later incorporated into the Oracle Corporation during year 1 of the contract. RTI staff members worked closely with BEA/Oracle to undergo a knowledge transfer process. This allowed an RTI programmer to build and manage all project components within the NRC structure and environment.

At the beginning of the project, RTI developed a plan for structuring the Repository that was submitted to both AHRQ and BEA/Oracle. This document, finalized in January 2008, included specifications and requirements, including the distinction between the public site, the private workspace area, and the Repository. RTI specified that the Repository would be available via a direct link on the project's public NRC page. It was also specified that the Repository would be programmed as a subsection of the NRC knowledge library and would have a more advanced searching mechanism allowing simultaneous keyword and topic area search.

After programming for the Repository resource keyword/topic area search function began, staff members from RTI met with a group of AHRQ staff members selected by the AHRQ TOO to discuss the overall direction of the Repository. A significant outcome of this meeting was the

suggestion to offer a resource in addition to the keyword search that mirrored the NRC's health IT bibliography. Although the intent of the keyword search was to allow users who knew what they were looking for to find it more easily, the bibliography would also allow users new to health IT and HIE (and their unique relationship to Medicaid and CHIP agencies) to access a small number of highly valuable documents that were preselected and available without keyword search. RTI proceeded with selecting documents in the major topic areas of technology, policy, evaluation, and basic overview resources. After programming the Repository architecture, the keyword search interface, and the bibliography interface, RTI submitted all information to the AHRQ TOO. All materials were passed on to OCKT, including an MS Excel spreadsheet that captured compliance with AHRQ's policy for all links to external Web sources. At the end of year 1, the Repository was programmed in formative stages, with plans for expansion in accordance with the results of the full needs assessment and feedback from agency personnel as they became more frequent users of the resource. All items were classified under the broad headings of technology, policy, and evaluation. The Repository also offered an overview that provided some basic documents about the relationship between Medicaid and CHIP agencies and the adoption of health IT and HIE. The Repository was primarily populated by carefully selected, up-to-date resources gathered as part of the literature review task. It also includes all of the documents available as part of the TA task, including Webinar slides, transcripts, and links to recorded sessions.

At the outset of year 2, the basic structure of the Repository was programmed and populated. In April 2009, after working extensively with OCKT staff, the Repository of the Web site was released to the public. The Repository included documents with information specifically for Medicaid and CHIP agencies about health IT and HIE issues and initiatives. The site contained a searchable database of all relevant articles and information collected as part of the Repository and a bibliography that contained a short list of hand-picked reference materials, and it served as the home for the case studies developed under another task of this contract. A concerted effort was made to create a flexible structure that allowed for expansion, and also focused on documents specifically related to Medicaid and CHIP, not general health IT information that could be found in other similar resources. The Repository was important because information related to Medicaid and CHIP involvement with health IT and HIE initiatives was not easy to locate nor was it transparent on other sites.

Shortly after its release, RTI engaged a group of national experts to review the structure and the content of the materials to be posted in the Repository. The experts agreed that the major topic areas covered by the site should be overview, policy, technology, and evaluation, and in addition, that resources should be separated at the top level depending on whether they related to health IT or HIE applications. These experts also identified articles that should be highlighted specifically in the bibliography section of the site, thus providing a short list of foundational articles for those looking for quick references. Adjustments were made to the site to reflect the feedback from experts, and an update of the Repository was released.

In September 2009, RTI staff conducted a usability study of the Web site to ensure that the information on the site was accessible and organized in a way that met the needs of our target stakeholder group. Testers were recruited from individuals attending the 2009 Medicaid Management Information Systems conference, and 11 people engaged in the full usability test. This test asked users to perform four basic activities on the site, such as conducting a keyword search or locating the articles contained in one of the bibliography reference pages. A number of

recommendations about the organization of the site resulted from this activity, and a third version of the site was approved by OCKT and released to the public in early 2010.

Following the release of the Repository, ongoing activities included:

- Monitoring potential content for the Repository.
- Brainstorming additional topic areas that support agency needs.
- Developing agency success and best practice highlights.
- Developing Section 508 compliant versions of materials.
- Coordinating with BEA/Oracle for support.
- Coordinating with OCKT for content approval.
- Monitoring other resources available on the NRC to prevent unnecessary overlap.

RTI maintained the portal throughout the remainder of the project by compiling and updating new materials on a quarterly basis, including input from the best practices and literature search tasks. By the end of the project, the Repository contained approximately 173 links to resources such as journal articles, white papers, and policy briefs.

Challenges. The project public site is an essential communication tool, especially for TA events. One challenge was maintaining an appropriate balance between the necessary core information about the project and dynamic content that would keep users who are familiar with the project returning for updated information.

The initial coordination and contracting process with BEA/Oracle was time consuming and resulted in the necessary software knowledge transfer, but no direct link to the architecture and management of the NRC site itself. This situation was remedied in years 2 and 3 by purchasing consulting services from BEA/Oracle and working directly with their representative at the National Opinion Research Center (NORC), the organization that holds the NRC contract.

The process of 508 conversion for Web-based resources required more time than was originally anticipated. Tools to track and manage this process were developed and used.

Lessons learned. The Web site statistics provided valuable lessons on site traffic. Information about the types of documents accessed provided insight about the usefulness of the Repository. Web site traffic increased when legislation was being developed and when hot topics were being widely discussed. The increased traffic during periods of rapid activity points to the need for quick updates during periods of frequent activity. Consistent efforts to keep the information current and to ensure the site met the needs of our targeted population led to the success of this site. The Repository Coordinator worked closely with other members of the project team to ensure that information from TA activities, case studies, and literature reviews were all included in the Repository as appropriate. The Repository Coordinator also monitored a number of listservs and other relevant information sources to ensure that relevant, current information was added to the Repository. An update of selected resources was sent to OCKT on a quarterly basis for review and approval, and subsequently posted as part of the site.

We also learned that mentioning the listserv during TA events was an effective way to increase the number of subscribers, and we frequently gained new members after an event.

The project's experience with the private workspaces developed for specific CoPs also provided a valuable lesson. CoP members never became accustomed to using the space and needed password support on the rare occasions when they did use it. They preferred to use the listserv to exchange material and discuss topics rather than remember another log in and password combination. Those wishing to provide a similar private workspace in the future should consider ways to simplify the login process to maximize use.

Case Studies

Methods

As the adoption of health IT and participation in HIE accelerated, AHRQ identified the need for models of successful health IT adoption and HIE participation in Medicaid and CHIP. The case studies were targeted to support peer-to-peer learning and development.

Although originally conceived as a study of best practices and lessons learned and described to potential agency participants accordingly, agency staff were reluctant to label their work as a “best practice.” Using the term “case studies” more effectively encouraged their participation and engagement when asked to discuss their accomplishments. The project developed a form that framed the discussion and provided a structure that could be consistently employed.

To identify potential candidates for inclusion in the case studies series, information was reviewed from the needs assessment, specifically information referencing the question that asked if the agency had identified any best practices in its health IT/HIE work. A list was also reviewed of States that served as presenters for the TA events and participated actively in the CoPs.

Once a topic was identified, an interview was conducted with representatives from the agency, a case study was drafted based on the interview, and several iterations of review, editing, and approvals were completed before final submission to AHRQ. All case studies were posted to the Repository and a notification was sent via the project listservs. Table 4 contains a list of the published case studies.

Table 4. Published case studies

Case studies
Developing a State Medicaid Health IT Plan (SMHP): Lessons Learned From Oklahoma Medicaid
Minnesota: Leveraging Existing Leadership to Support Health IT and HIE
New York: Developing an Electronic Prescribing Incentive Program
Developing a Universal Consent Form: Lessons Learned from Florida Medicaid
Collaborating to Improve the Quality of Care: Lessons Learned from the Alabama Medicaid Agency

Challenges

The initial challenge encountered in this task was to identify the right way to frame the opportunity for potential participants. Once it was decided to describe the end products as case studies rather than best practices, identifying and recruiting staff to participate became easier. Another challenge was identifying, contacting, and following up with appropriate Medicaid staff.

Two case studies were not fully completed. One case study was prepared, but subsequent follow-up efforts with agency staff for final approval were unsuccessful. In the second instance, the staff member who participated subsequently left the Medicaid agency. Her colleagues subsequently indicated that the project profiled had been discontinued and requested that the case study be withdrawn from further consideration.

Lessons Learned

Agency staff members are generally very interested in sharing information about their progress and accomplishments. Given the overall lack of information specific to Medicaid and CHIP health IT and HIE, the case studies provide a valuable vehicle for disseminating information.

The case studies are necessarily specific to one State and, as a result, can reflect a local environment that may not be applicable to other agencies (e.g., a limited number of insurers may be operating within the State or there may be alignment across different agencies around a given topic). As a result of these differences, the case studies emphasized the lessons learned that apply broadly to other agencies and States. For example, although the market may be very different from one State to the next, all agencies can benefit from leveraging existing relationships and expanding partnerships. The case studies can also illuminate possibilities that other States may not have considered. For example, in developing their e-prescribing incentive program, New York State completed extensive research into the costs and benefits of e-prescribing that may spur other States to consider a similar program.

The Centers for Medicare & Medicaid Services (CMS) is currently sponsoring a number of initiatives to support Medicaid agencies in peer-to-peer learning on the topics of health IT and HIE.

Literature Review

Methods

The goal of the literature review was to gather information that provided a broad overview of the issues facing Medicaid and CHIP agencies as they implement health IT, with a focus on documents particularly relevant to Medicaid and CHIP agency staff. The materials from the literature review were posted to the Repository to provide a user-friendly access point to relevant Medicaid and CHIP health IT and HIE.

To complete the literature review, search parameters and audience for the literature review were first defined and then an initial search was run. The initial search located a significant number of articles (853 peer-reviewed articles and 58 gray literature articles), although many of them were of questionable relevance to Medicaid and CHIP agency staff. Once relevant articles were located, they were passed on to the Repository Task Leader. The Repository Task Leader performed another scan of the abstracts and identified those suitable for posting in the repository, contingent upon public availability. The search terms were updated twice during the project: once to reflect the knowledge gained through the needs assessment and once to include terms related to ARRA and the provisions specific to Medicaid. Throughout the project, the literature review was updated bimonthly, with articles routed for posting to the Repository. We focused on identifying resources that were most relevant for Medicaid and CHIP agency staff to reduce the time needed to search for resources on health IT, HIE, and Medicaid and CHIP. The number of articles identified in each year are summarized in Table 5.

Table 5. Relevant articles retrieved by year

Year	Peer-Reviewed Articles	Gray Literature	Total
Year 1 (February 2008–August 2008)	368*	52	420
Year 2 (October 2008–August 2009)	138	11	149
Year 3 (October 2009–February 2011)	143	12	155
Final Year**	456*	22	478
Total	1,105	97	1,202

* Includes initial search

** The process for conducting the literature review changed in the final year of the project. The number of peer reviewed articles identified in the final year may not be directly comparable with the number identified in prior years.

Challenges

Locating materials that were publicly available was the major challenge in this task. Documents must be available without a subscription or payment to be posted, which limited content. As a result, some high-quality articles were omitted from the Repository.

Lessons Learned

The body of literature related to health IT and HIE expanded in the wake of ARRA and the Health Information Technology for Economic and Clinical Health (HITECH) Act, particularly given Medicaid’s prominent role in State health IT initiatives. More high-quality, relevant articles are being published, although this had begun to taper off by the end of the project. To further aid Medicaid staff in identifying top quality articles, each piece selected was carefully reviewed for posting to the Repository. Articles were selected based on their degree of relevance to Medicaid agencies, the quality of information, and timeliness. The bibliography allows time-strapped agency staff to quickly locate articles of interest, rather than requiring them to sift through large volumes of literature.

Project Reports

In addition to the Web site materials discussed previously, there are also three project reports on the Web site: *Quality Oral Health Care in Medicaid through Health IT* (prepared by NORC), *A Guide to Calculating the Costs and Value of E-Prescribing*, and *The Assessment of Medicaid and CHIP Health IT Activities and Needs* (both prepared by RTI.) A fourth report, on the barriers to meaningful use among Medicaid providers, is expected to be posted in 2012.

The oral health report details whether and how health IT and the Medicaid EHR incentive program can be used as tools to improve access to quality oral health care for children enrolled in Medicaid and CHIP. The cost-value guide provides a detailed discussion of the stages in e-prescribing where costs and value may occur and where and to whom value may accrue. This report also provides a scan of relevant literature and summary of techniques that can be used to calculate cost and value. The needs assessment report describes the range of activities, challenges, planning, evaluations, and external factors facing Medicaid and CHIP agencies across the country as they undertake initiatives in health IT and HIE based on a survey of Medicaid and CHIP staff conducted in late 2007.

Evaluation of Technical Assistance

Methods

The purpose of the Evaluation of Technical Assistance tasks were to assess the degree to which consultative and TA services, resources, and tools provided to the Medicaid and CHIP agencies effectively met their identified needs. Results from evaluation activities are used to ensure the quality and utility of TA provided.

Evaluation included the following major activities:

- Develop instruments to measure the quality and utility of TA provided (e.g., Web-based and in-person workshops, CoPs).
- Distribute evaluation forms to participants immediately following each TA event.
- Maintain a database to track evaluation responses.
- Analyze results from the evaluation forms.
- Make recommendations to improve TA provision based on the evaluation results.

A standard evaluation form was developed early in the project and revised as needed throughout the project. By the end of the project, the approved evaluation form was adapted for each event by updating the questions about the learning objectives.

The evaluation task evolved during the project to meet the formative and summative needs of the project as they have emerged. Each annual report presents findings from the relevant project year on TA participation and participant satisfaction. For this report, combined data from the entirety of the project are used to describe the following key aspects of the project:

- Tracking participation over time by TA modality.
- Tracking project reach over time (the number of States participating in the project. total number of unique participants combined across the project and split out for each year).
- Monitoring consumer satisfaction by TA modality.

Findings

Agency participation in TA events. Across the entirety of the project, all 50 States were represented, as well as the District of Columbia and two territories, the United States Virgin Islands and American Samoa. Forty-five States and the District of Columbia participated in year 1; 44 States, the District of Columbia, the United States Virgin Islands and American Samoa participated in year 2; 46 States and the District of Columbia participated in year 3. Forty-one States and the District of Columbia participated in the last year of the project.

Project reach. Webinars. Since the start of the project, 30 Webinars have been conducted. For all but one, attendance and evaluation data were captured. This includes 9 Webinars in year 1, 7 in year 2, seven in year 3, and 7 in the final year of the project. A total of 997 people, attended these 30 Webinars, representing 564 participants attending their first TA event and 433 participants attending more than one event.

- In year 1, there were 357 Webinar attendees, averaging 45 participants per Webinar. Across all year 1 Webinars, there were 253 new participants and 104 repeat participants.
- In year 2, there were 225 Webinar attendees, averaging 38 participants per Webinar. Across all year 2 Webinars, there were 123 new participants and 102 repeat participants.
- In year 3, there were 182 Webinar attendees, averaging 30 participants per Webinar. Across all year 3 Webinars, there were 84 new participants and 97 repeat participants.

- In the final year of the project, there were 199 Webinar attendees, averaging 28 participants per Webinar. Across all final year Webinars, there were 104 new participants and 95 repeat participants.

Evaluation questionnaires were distributed via WebEx following each Webinar. On some occasions, the questionnaires were e-mailed to participants in addition to or instead of appearing in the WebEx event. These questionnaires included questions about the type of agency or other profession represented by each participant. Across all Webinars, there were 313 responses to the evaluation survey, representing 31 percent of all participants. These respondents represented the following types of organizations:

- Medicaid agencies (47 percent)
- Stand-alone CHIP agencies (5 percent)
- Combined Medicaid and CHIP agencies (43 percent)
- Other (5 percent)

In the “Other” category, some of the most commonly represented affiliations were vendors, consultants, universities, and professional organizations.

Web-based workshops. Eleven Web-based workshops were conducted during the project, two in year 2, six in year 3, and three in the final year. Across all Web-based workshops, there were 412 participants (36 in year 2, 235 in year 3, and 141 in the final project year). Average attendance was 18 participants in year 2, 39 in year 3, and 47 in the final project year. Across all of the Web-based workshops, 90 participants (22 percent) responded to the evaluation questionnaire immediately following each workshop. Of those respondents, the following types of organizations were represented:

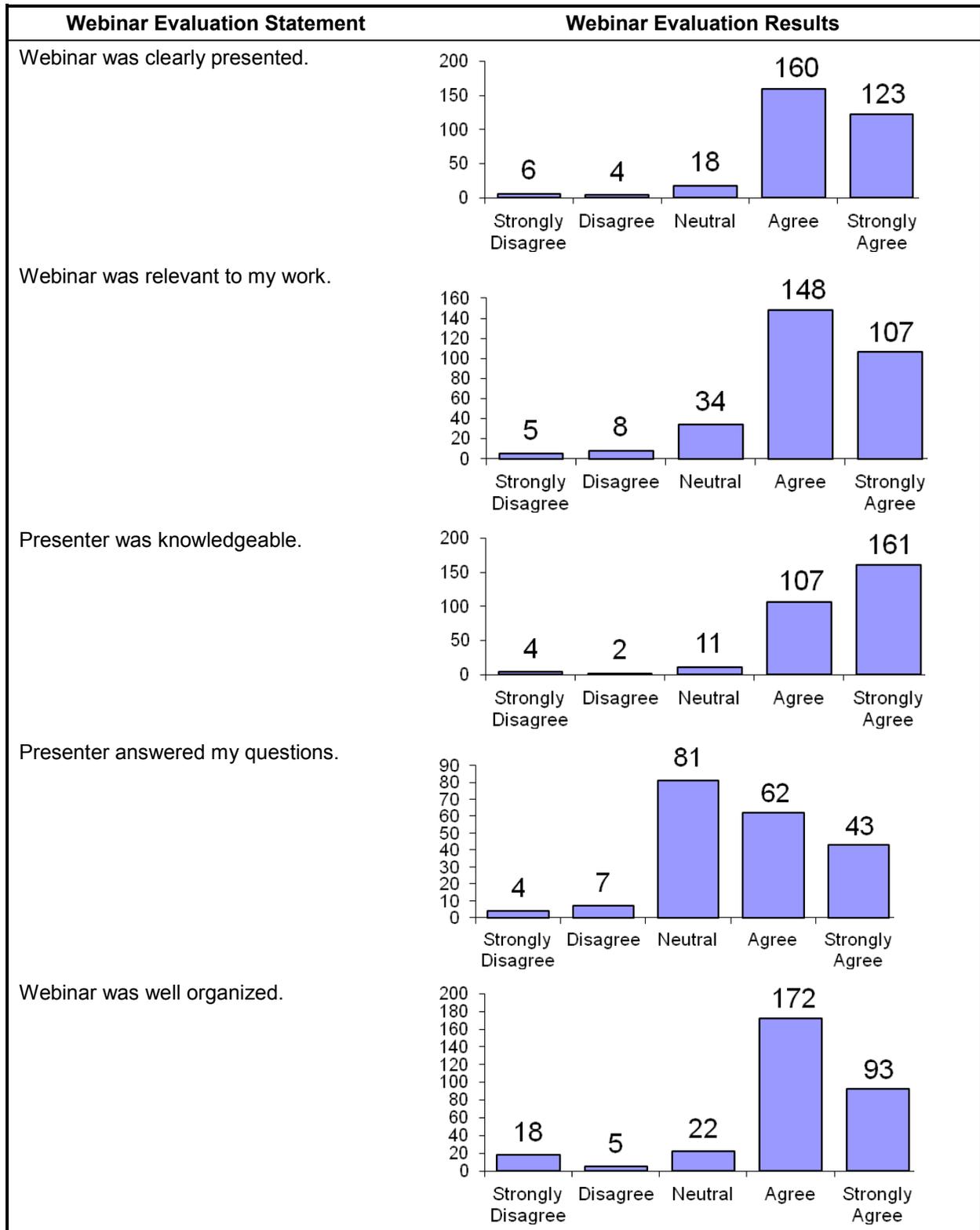
- Medicaid agencies (54 percent)
- Stand-alone CHIP agencies (3 percent)
- Combined Medicaid and CHIP agencies (38 percent)
- Other (5 percent)

As in the case of Webinars, the “Other” category most often included participants from vendors, universities and professional organizations, and consultants.

In-person workshops. Seven in-person workshops were conducted over the course of the project. Two were conducted in year 2, four were conducted in year 3, and one was conducted in the final project year. Across all in-person workshops, there were 233 participants (54 in year 2, 148 in year 3, and 31 in the final project year). Average attendance at the workshops was 33 participants. Across the seven workshops, 163 participants responded to the evaluation questionnaire immediately following each workshop. The response rate cannot be accurately calculated as some evaluations were completed by others such as observers in addition to registered participants.

Overall satisfaction. The evaluation questionnaires administered after each Webinar and Web-based workshop also collected participant ratings of the quality of each event and the extent to which they felt the learning objectives were met. Results from the combined evaluation data for the project overall are presented in Figure 6. Individual evaluation reports were provided to the AHRQ TOO throughout the project. Participant ratings were also collected from each in-person workshop and provided to the AHRQ TOO, but the results cannot be aggregated. Information regarding these ratings can be found in year 2 and year 3 annual reports.

Figure 6. Webinar quality ratings



Ratings of Webinar quality were generally very positive (see Figure 6). Negative ratings were discussed with the project team and the AHRQ TOO. In most instances, negative ratings were followed by positive written comments, leading us to suspect that the response categories had been used incorrectly. Genuinely negative comments (e.g., those indicating that a specific learning objective had not been met) were addressed throughout the life of the project and led to procedural refinements that allowed us to improve the quality of the Webinars.

Overall, ratings of workshop quality were very positive, similar to ratings of Webinars (see Figure 7). Participants responded very well to the Web-based workshop format. As with Webinars, genuinely negative ratings were discussed with the project team and the AHRQ TOO, and were used over the life of the project to continuously improve the quality of TA workshops.

Challenges

The major challenge in evaluating TA activities during the project was to solicit a sufficient number of evaluation responses from each event to yield useful insights. The evaluation form was sent via e-mail after the earliest TA events. As the project progressed, participants were regularly reminded during events to complete the evaluation, and the process was modified to automatically deliver the evaluation form to participants via the WebEx at the end of each session. Despite these efforts, the extremely busy Medicaid and CHIP agency participants often chose not to fill out the evaluation form. When necessary, we sent the evaluation form to participants via e-mail, even if it had been delivered automatically at the end of a session.

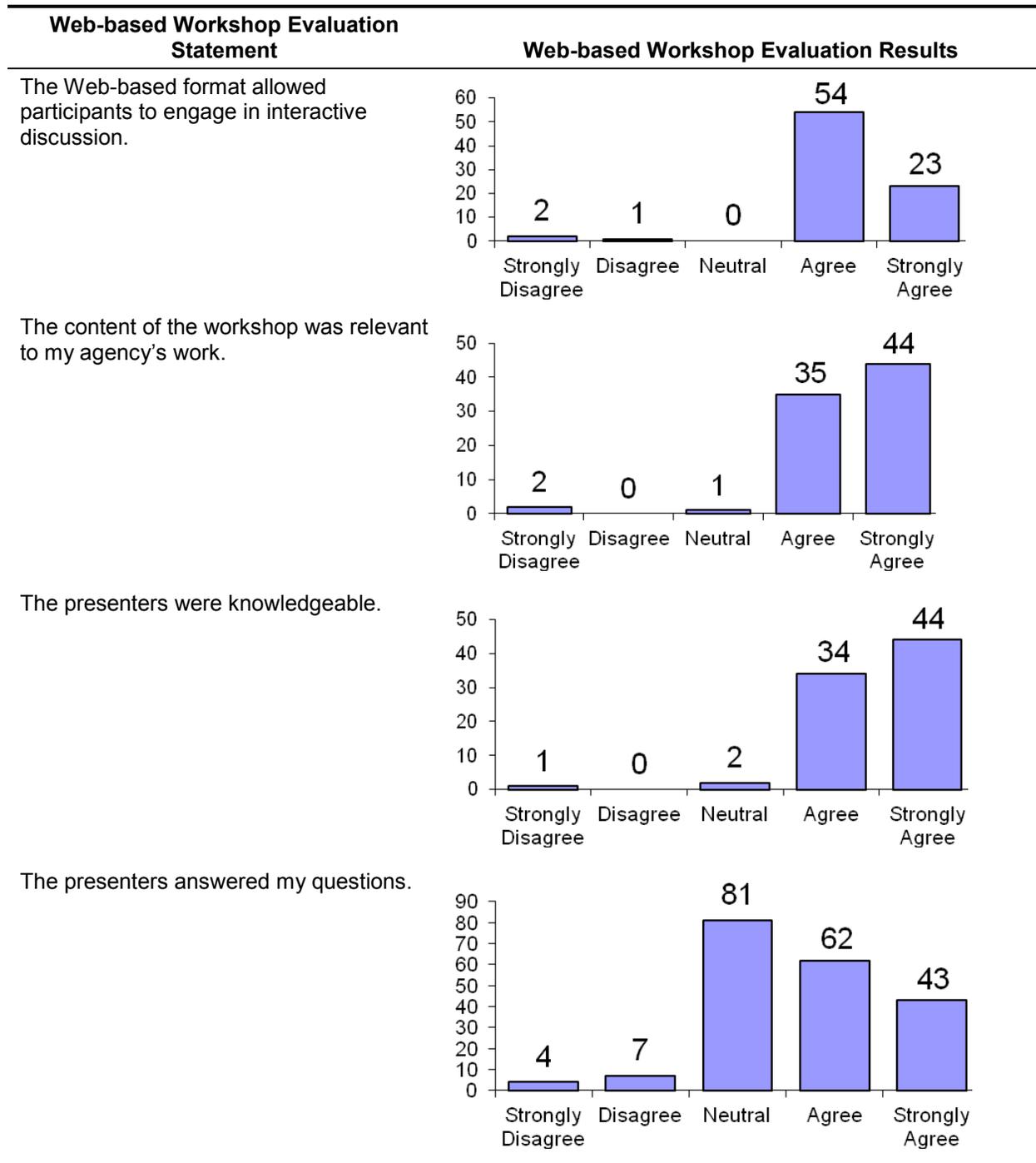
Other challenges include gathering comparable data from in-person workshops. We decided to evaluate each in-person workshop individually and report on the results in individual reports. As a result, annual reports do not include aggregated evaluation data for in-person workshops.

Lessons Learned

Analysis of evaluation data from TA events provided useful information on how they were received and guidance on areas for improvement. The positive evaluations, with a few neutral ratings on some items, coupled with the qualitative comments, suggested actions that allowed for improvement to TA events over time:

- Ensure participants understand the intent of the TA.
- Clarify learning objectives in Webinar-led materials and carefully build Webinar curricula based on these learning objectives.
- Use specific agency examples when possible. Discuss specific lessons learned and how barriers were addressed and perhaps overcome.
- Ensure that examples, when used, provide information that is useful for participants representing a range of job functions.
- Continue to target Medicaid and CHIP agency representatives in future Webinars, given the distribution of respondent affiliations. Presenters can be told in advance that most participants will likely be agency representatives.
- Continue to use a variety of formats to present the information to participants.
- Provide advance materials as appropriate and necessary.
- Some agencies need introductory information on a limited number of topics; the majority of agencies have developed a sufficient knowledge base on which to build more specialized and sophisticated offerings.

Figure 7. Web-based workshop quality ratings



- The level of enthusiasm for the project and participation in the Webinars, Web-based workshops, and in-person workshops has been high. Expand the maximum number of Web-based workshop attendees to accommodate the demand for participation.
- Effectively managing the discussion phase of Web-based workshops is possible despite expanding the maximum number of attendees.
 - Enlisting speaker participants has been challenging because of conflicting schedules, other priorities, and inadequate resources to balance already high workloads. Extend multiple invitations and identify appropriate agency presenters in advance.
 - The HITECH Act has provided numerous opportunities for Medicaid and CHIP agencies to obtain funding for their health IT and HIE initiatives. The rapid turnaround and multiple, intersecting opportunities and funding streams have increased the need for coordination with other organizations working to provide appropriate and timely TA. Most Medicaid and CHIP agencies participated in Web-based and in-person workshops during fall 2009 to acquire the in-depth information they needed to become better prepared to take advantage of available funding.

Participants also had the opportunity to provide feedback via the project's 800 number and e-mail address, although these were used very rarely. The lesson learned was that these additional communication channels did not add value for this busy audience. Future TA providers should consider discontinuing 800 number support, although establishing a project e-mail address for an agency to submit requests for TA is a simple and cost-effective way to provide an additional communication option.

Transitions

Over the past few years a number of sources of technical assistance have been developed to support HITECH- and Children's Health Insurance Program Reauthorization Act-mandated activities and, unlike at the start of this project when resources were few, Medicaid and CHIP agencies now have multiple resources. Topics that continue to be of great interest to the agencies are those related to managing multiple ongoing initiatives and implementing the EHR incentive program and HIE.

Although the CMS-funded TA program is a likely candidate to take on the continuing needs for TA among Medicaid agencies, it is not clear that CHIP will also be covered. The Health Resources and Services Administration also has a TA contract that may provide offerings of interest to Medicaid and CHIP staff.

The CoPs started during this project may be covered by ongoing work at the Office of the National Coordinator (ONC) under the Health IT Research Center CoPs. One project CoP that was focused on privacy issues was already transitioned to ONC. The State HIE program TA contractor may be able to assist Medicaid and CHIP with their ongoing need to learn more about HIE. It is less clear how to manage the update of content and resources posted to the Medicaid Web site and Repository on the AHRQ NRC. It will be important to link to these important resources to from Web sites funded by other contracts so that Medicaid and CHIP staff can continue to have access to these tools. However, there is currently no specific plan to curate the Medicaid Web site or to keep the Repository current.

Chapter 4. References

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Appendix A: List of Technical Assistance Events, All Years

Table A-1. List of technical assistance events, all years

Event Title	Event Type	Event Date	Number of Participants*	Number of States Represented
Unraveling Privacy and Security in HIEs: An Overview of Requirements and Options for Medicaid/SCHIP Programs	Webinar	3/20/2008	38	22
Identity Management for Interoperable Health Information Exchanges	Webinar	3/26/2008	NA	NA
Decoding Standards: The Importance of Technical and Data Standards for Medicaid and SCHIP Programs	Webinar	4/3/2008	75	29
Evaluating Health IT Projects: A Primer	Webinar	5/1/2008	70	29
Understanding EHRs: Common Features and Strategic Approaches for Medicaid/SCHIP	Webinar	6/5/2008	45	24
HIEs for Medicaid and SCHIP Agencies: An Overview of Core Characteristics, Components, and Approaches	Webinar	6/19/2008	38	16
Evaluating Health IT Projects: A State Perspective	Webinar	7/10/2008	35	22
Clinical Decision Support Systems to Improve HIEs for Medicaid and SCHIP Agencies: An Overview of Core Characteristics, Components, and Approaches	Webinar	8/14/2008	30	17
Managing Consent Directives: Electronic Standards to Capture, Report, and Implement Health Information Privacy Consent	Webinar	8/27/2008	26	15
Implementing e-Prescribing in the Medicaid/SCHIP Programs: Experiences and Lessons Learned	Webinar	9/30/2008	34	20
Improving Quality through Health IT and HIE in Medicaid/CHIP Programs: Approaches and Experiences from the Field	Webinar	10/23/2008	27	14
Remote Disease Monitoring	Webinar	11/19/2008	27	16
The Role of Master Patient Index (MPI) and Record Locator Services (RLS) on the Implementation of HIEs for Medicaid and CHIP	Webinar	12/17/2008	26	16

(continued)

Table A-1. List of technical assistance events, all years (continued)

Event Title	Event Type	Event Date	Number of Participants*	Number of States Represented
Positioning Medicaid and CHIP for the Future: Health IT Regulations, Initiatives, and Opportunities	Webinar	4/29/2009	60	28
Improving Children's Health Through the Adoption of Health IT by Medicaid and CHIP Agencies	Webinar	6/4/2009	39	19
Understanding and Implementing the ARRA Provisions to Support Medicaid and CHIP Health IT and HIE Projects: A Practical Guide	Web-based Workshop	6/29/2009	21	14
Planning and Conducting a Cost-Benefit Analysis of Health IT and HIE Projects: A Workshop for Medicaid and CHIP Agencies	Web-based Workshop	8/13/2009	15	14
The Importance of Business Process Analysis in Health IT Project Planning and Implementation	Webinar	8/24/2009	46	23
Developing a Health IT and HIE Framework and Strategic Plan: A Practical Workshop for Medicaid and CHIP Agencies (held twice)	In-person Workshop	9/9/2009 to 9/10/2009	24	9
Developing a Health IT and HIE Framework and Strategic Plan: A Practical Workshop for Medicaid and CHIP Agencies (held twice)	In-person Workshop	9/10/2009 to 9/11/2009	30	11
e-Prescribing in Medicaid and CHIP Agencies: Implementation Approaches, Challenges, and Opportunities	Web-based Workshop	9/29/2009	15	11
Practical Approaches to Using Health IT to Improve Quality and Business Processes in Medicaid/CHIP Agencies	Web-based Workshop	10/27/2009	29	21
Developing a Health IT and HIE Framework and Strategic Plan: A Practical Workshop for Medicaid and CHIP Agencies	In-person Workshop	11/12/2009	27	13
Implementing an EHR in Medicaid/CHIP Agencies: A Practical Review of Benefits, Costs, Models, Opportunities, and Challenges	Web-based Workshop	12/15/2009	45	27
Developing a Health IT and HIE Strategic Plan: A Practical Guide for Medicaid and CHIP Agencies	Web-based Workshop	1/20/2010	47	27

(continued)

Table A-1. List of technical assistance events, all years (continued)

Event Title	Event Type	Event Date	Number of Participants*	Number of States Represented
Health IT and HIE Initiative Governance: Establishing the Medicaid Presence within the State HIE Governance Structure: A Workshop for Medicaid/CHIP Agencies	Web-based Workshop	2/25/2010	36	25
Health IT as a Means, not an End: How Health IT Supports Broad Quality Improvement for Medicaid and CHIP Beneficiaries	Webinar	3/29/2010	32	20
Unlocking Quality Information: Understanding the Value of Health IT for Quality Measurement and Improvement	Web-based Workshop	4/26/2010	63	35
What Are Medicaid's Potential Roles and Responsibilities in the Development and Enforcement of Consent Policies for Health Information Exchange?	Webinar	5/18/2010	16	12
Finding the Right Person for the Job: Leveraging Health IT Workforce Initiatives to Successfully Achieve your Agency's Health IT/HIE Goals	Webinar	6/8/2010	25	20
An Introduction to Personal Health Records for Medicaid/CHIP Agencies	Webinar	7/12/2010	27	14
Using Health IT to Measure and Improve Children's Health Care Quality	In-person Workshop	8/24/2010	55	17
Catalyzing Innovation for Health System Reform Post-2014	Webinar	8/30/2010	20	12
Medicaid-CHIP Quality Measurement Strategies: HITECH, CHIPRA and the Affordable Care Act	Webinar	12/3/2010	39	25
Using Health IT To Measure Achievement of the Patient-Centered Medical Home	Webinar	1/31/2011	23	16
Coordinating Health IT Efforts Across ICD-10 Conversion, HITECH, and Affordable Care Act Requirements	In-person Workshop	2/8/2011 to 2/9/2011	31	10
Using Health IT to Measure and Improve Adult Health Care Quality And for Use in The Health Home	In-person Workshop	2/9/2011 to 2/10/2011	35	12
Preparing for Multiple Health IT Initiatives at Once Using Common Project Management Techniques	Webinar	8/15/2011	32	20
Use of Health IT and HIE in Section 2703 Medicaid Health Homes	Webinar	9/29/2011	41	12
Emerging Applications in Medicaid and CHIP Programs Utilizing Telemedicine	Webinar	10/11/2011	28	13

(continued)

Table A-1. List of technical assistance events, all years (continued)

Event Title	Event Type	Event Date	Number of Participants*	Number of States Represented
Leveraging Health IT to Support State Policy: Strategies for Bridging Communication Gaps between Medicaid Management Information Systems Technical Staff and Policy Staff	In-person Workshop	11/29/2011 to 11/30/2011	31	10
EHR Data to Measure Medicaid Quality: Opportunities for the Initial Core Set of QMS for Medicaid-Eligible Adults	Web-based Workshop	3/5/2012	25	16
Patient Portals to Health Information: Using Health IT to Engage Medicaid/CHIP Patients and Families in Health Care	Webinar	4/5/2012	33	15
Data Linkage and Exchange: Opportunities for Improved Services for Children with Special Health/Developmental Needs	Webinar	4/16/2012	21	10
Barriers to Meaningful Use among Medicaid and CHIP providers: Findings from a recent study	Webinar	4/23/2012	20	16
Medicaid Health IT Initiatives Boot camp: Understanding and Managing Multiple Medicaid Health IT Projects	Web-based Workshop	5/8/2012 to 5/9/2012	67	11
Medicaid and Health Information Exchange: The Potential Role of Direct Exchange	Webinar	5/15/2012	24	12
Medicaid Health IT Initiatives Boot camp: Understanding and Managing Multiple Medicaid Health IT Projects	Web-based Workshop	5/16/2012 to 5/17/2012	49	12

* The number of participants reported here excludes AHRQ and RTI International project staff and any presenters who provided training or technical assistance.

Appendix B: CoP Evaluation, Final Year

Health IT for Child Health. This CoP met only once because no one volunteered for the planning team or expressed interest in specific topics in this domain as a focus for future meetings. However, there was high interest in the initial meeting and meeting topic (29 participants from 18 States—see Table B-1 and Figure B-1), and most reported that the meeting met their expectations (see Figure B-2).

Table B-1. Participants in health IT for child health CoP

Overview of Participants	Number
Number of participants from Medicaid and CHIP	29
Number of States represented	18

Figure B-1. Roles of participants in health IT for child health CoP, within their agency

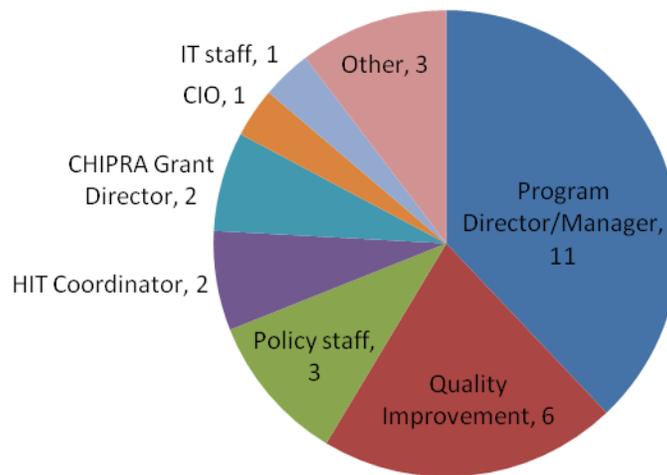
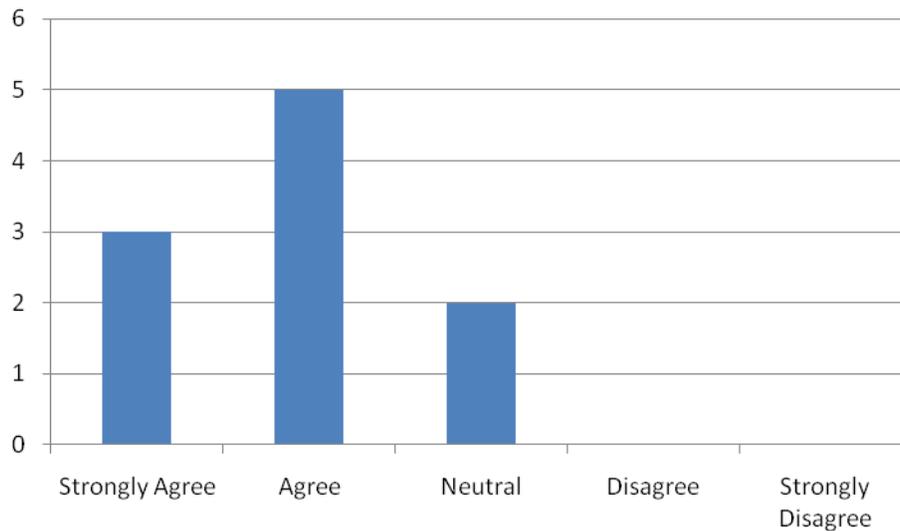


Figure B-2. “This CoP meeting met my expectations for discussing health IT for child health with other Medicaid and CHIP colleagues”



Managing Multiple Health IT Projects in Medicaid and CHIP

This CoP met in March 2012 and again in April 2012. Table B-2 describes the number of participants and the number of States represented. Figure B-3 displays the roles of participants in their agencies for the March and April meetings. Figure B-4 shows that of the people who responded to the evaluation; all felt that the March meeting met their expectations. In addition, all respondents indicated that they were interested in attending the second meeting on April 25, 2012. Figure B-6 shows that all respondents felt that the April meeting also met their expectations. In addition, all four respondents indicated that they would be interested in attending future meetings on this topic.

Table B-2. Participants in managing multiple health IT projects in Medicaid and CHIP CoP

Overview of Participants	March 28, 2012	April 25, 2012
Number of participants from Medicaid and CHIP	10	16
Number of States represented	6	10

Figure B-3. Roles of participants in managing multiple health IT projects in Medicaid and CHIP CoP, within their agency (attendees across all meetings)

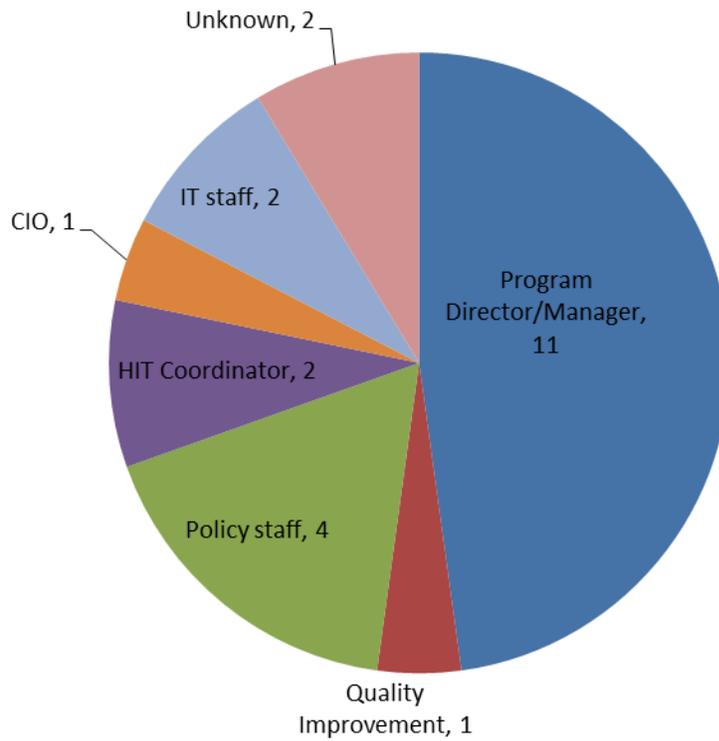


Figure B-4. March 28, 2012: “This CoP meeting met my expectations for discussing how to manage multiple health IT projects with other Medicaid and CHIP colleagues”

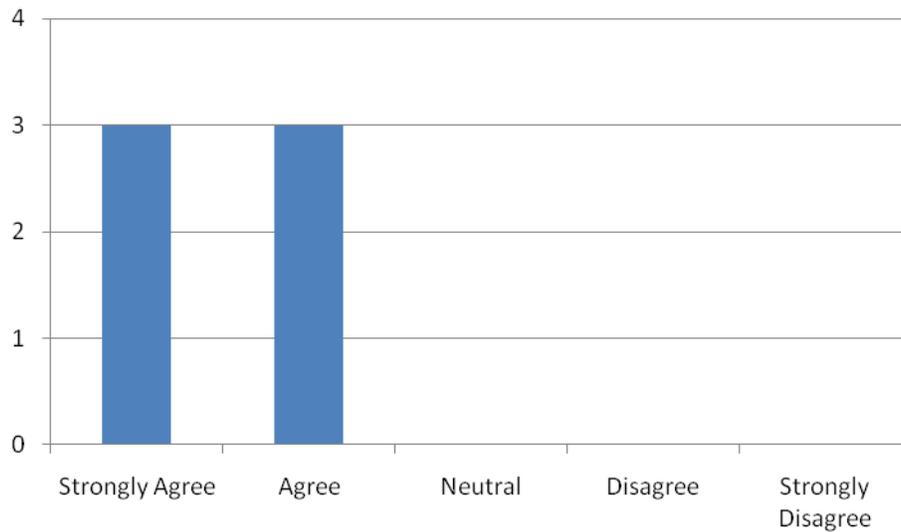
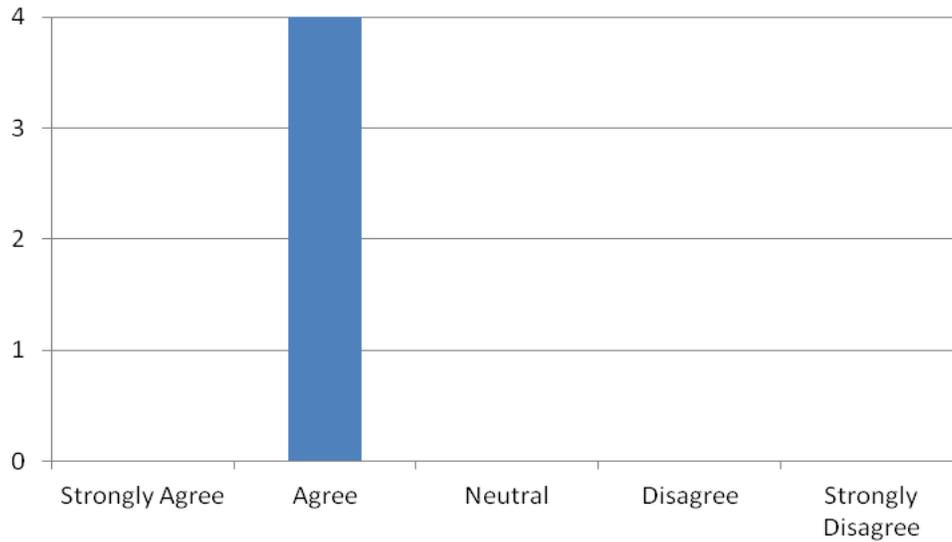


Figure B-5. April 25, 2012: “This CoP meeting met my expectations for discussing how to manage multiple health IT projects with other Medicaid and CHIP colleagues”



Medicaid Involvement in State HIE

This CoP met four times in 2011 and 2012. Table B-3 describes the number of participants and States represented in the four meetings. Figure B-6 describes the roles of participants in their agencies. Figure B-7 displays the number of people who attended each meeting and whether they had participated in another meeting of this same CoP previously—nearly one half to one third of participants were “return customers.” Figure B-8 shows that of the people who responded to the evaluation, most said that the first meeting on August 17, 2011 met their expectations (one person was neutral and one person stated the CoP did not meet his expectations). Figure B-9 shows that of the people who responded to the evaluation, most said that the May 1, 2012 meeting met their expectations (one person was neutral).

Table B-3. Participants in meetings of the Medicaid involvement in State HIE CoP

Overview of Participants	August 17, 2011	October 19, 2011	December 20, 2011	May 1, 2012
Number of participants from Medicaid and CHIP	30	27	27	22
Number of States represented	22	14	12	12

Figure B-6. Roles of participants in Medicaid involvement in State HIE CoP, within their agency (attendees across all meetings)

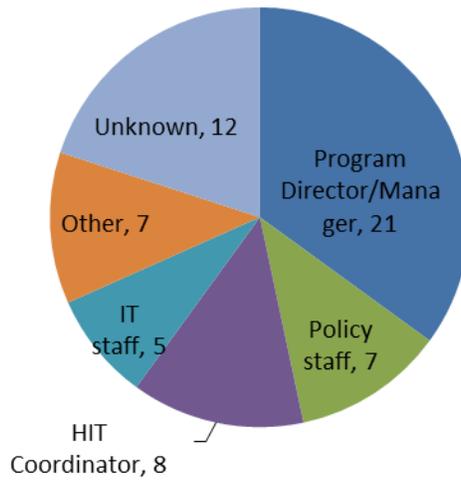


Figure B-7. New and returning participants at each meeting of the Medicaid involvement in State HIE CoP

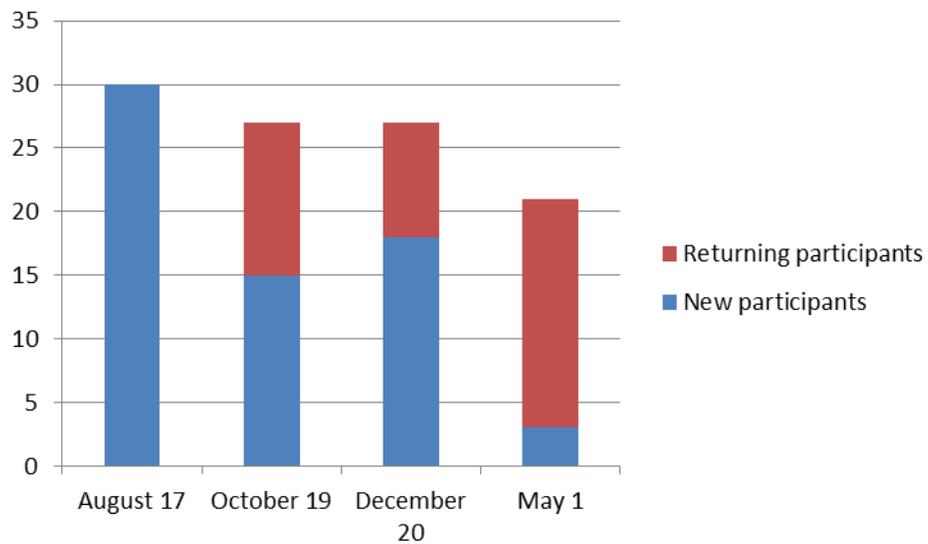


Figure B-8. August 17, 2011: “This CoP meeting met my expectations for discussing Medicaid involvement in State HIE with other Medicaid and CHIP colleagues”

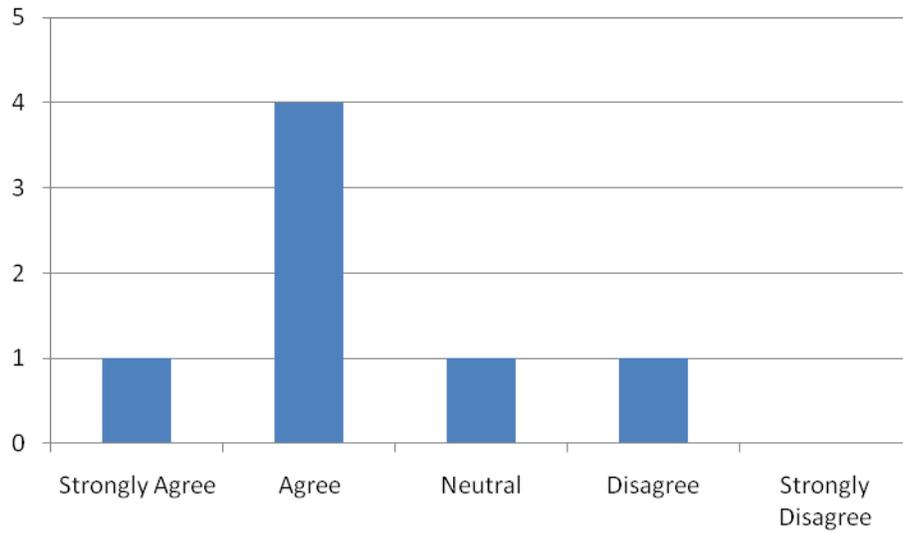


Figure B-9. May 1, 2012: “This CoP meeting met my expectations for discussing Medicaid involvement in State HIE with other Medicaid and CHIP colleagues”

