

**SUPPORTING STATEMENT**

**Part B**

Focus Groups on Consumer Engagement in  
Developing Electronic Health Information Systems

July 3, 2008

Agency of Healthcare Research and Quality (AHRQ)

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## **B. Collections of Information Employing Statistical Methods**

### ***1. Respondent universe and sampling methods***

The respondent universe for this project is U.S. healthcare consumers. For purposes of this project, we are defining healthcare consumers to be persons who have visited a doctor or other healthcare provider (either for their own care or the care of a family member) at least once in the previous two years. The participants will have a variety of healthcare needs and health insurance arrangements, such as coverage by HMOs, non-managed care plans, Medicare, Medicaid, as well as persons without health insurance. We will recruit participants varying in gender, age, racial/ethnic background, and education levels. The study will include persons residing in multiple regions of the country, including large cities, medium-sized cities, and rural locations. Furthermore, four focus groups will be with Spanish-speaking participants.

It is not practical or cost-effective to conduct focus groups with participants selected through scientific probability-based sampling methods. Thus, this study, like any focus group study, is not designed produce findings that can be statistically generalized to a broader population of persons. Focus group research is designed to yield a deeper, richer understanding of people's beliefs and perceptions on a topic, rather than statistical estimates of population parameters.

### ***2. Information Collection Procedures***

We will conduct 20 focus groups with healthcare consumers. Participants will be recruited, using a standardized screening questionnaire, by established research firms using their databases of research volunteers and newspaper ads. Most of the groups will be constructed so as to be homogenous with respect to the presence or absence of either of the following characteristics: a) Managing a chronic health condition (or the condition of a close family member), or b) Having visited at least three healthcare providers in the past two years. We also plan to construct several groups to be homogenous with respect to whether or not participants are covered by an HMO.

Participants will gather together for a 2-hour session with a focus group moderator who will pose the topics and lead the discussion, ensuring that all viewpoints are heard and that the discussion stays on track. The structure of the focus group discussions can be summarized as follows:

- The moderator will first give a brief background of the study, noting the confidentiality of their comments, acknowledging any observers, video-taping, and so on. To “break the ice” we will also ask participants to briefly introduce themselves;

- The discussion will begin with assessing participants’ awareness and experience with Health IT. Much of this discussion will concern what they have observed in the offices of their doctor (or other health provider) with regards to computer usage. But we will also ask participants to tell us about ways they may use a computer as it relates to health, or what they are aware of others doing;
- The next topic of the discussion will concern participants’ beliefs and perceptions of Health IT. We will ask participants to tell us whether they think computers can help their doctor do a better job, probing them on specific medical tasks such as writing prescriptions, ordering blood tests, etc. In addition, participants who use computers in some health-related way will be asked to discuss the benefits this has for them, as well as any disadvantages they perceive. The discussion will then move on to several subtopics, including:
  - **Functionality:** Views about doctors using computers to help in making decisions about patients’ treatments;
  - **Medical errors:** Views as to whether computers reduce the likelihood of medical errors, or make errors easier to detect and correct;
  - **Doctor-patient relationship:** Reactions to having a doctor working on a computer while talking and listening to a patient;
  - **Privacy and Confidentiality:** Views as to whether medical information is better protected when stored on a computer, as compared to paper;
  - **Control of information (secondary use):** Views about researchers obtaining medical information on patients, and the role that computers play in this.
- The final part of each session will focus on how healthcare consumers may like to be engaged in the development of Health IT. We will ask for their views on who should be involved in making decisions about how computers are used in medical care. We will ask for their ideas as to how healthcare consumers could give input on this issue, probing them on specific possibilities (being asked by companies, being asked by their doctor, responding to a survey, etc.). We will also ask if there are any organizations they would trust to speak their behalf.

### **3. Methods to Maximize Response Rates**

Not applicable. Participants will be persons who have volunteered for a research study and are not being selected on the basis of probability-based sampling methods. A “response rate” has no clear meaning in the context of a focus group study.

#### **4. Tests of Procedures**

Prior to conducting the 20 focus groups, we will conduct two pretest focus groups. These two groups will essentially serve to test the discussion guide we have developed for this project. In these pretest groups, we will examine and judge whether the topics and questions in the discussion guide are presented to focus group participants in an appropriate way, and whether the moderator probed in an effective manner. If necessary, we may alter the wording or order of questions in the discussion guide before proceeding with the 20 planned focus groups. However, we do not expect major changes to the discussion guide to be made as a result of the pretest groups.

#### **5. Statistical Consultants**

Westat, a social science research firm in Rockville, MD, will be responsible for overseeing the recruitment of participants, moderating all focus groups, and analyzing and reporting the findings. The project director is Jeffrey Kerwin. He can be reached at 301-517-4028, or by email at [jeffreykerwin@westat.com](mailto:jeffreykerwin@westat.com).

#### **6. Analysis Plan**

The analysis of the focus group discussions will occur on an iterative basis. Once a set of four focus groups have been completed in a given region, Westat will provide AHRQ with a brief summary of the major findings of each group within 3 days. These summaries will be based on the moderators' notes and impressions of each group, rather than a thorough analysis of the discussions. In-depth review and analysis of recordings and transcripts will then be conducted. In general, the project director will serve as the lead analyst for each region's analysis and reporting. He will review and interpret the data, sorting it into meaningful topics (which is expected to closely mirror the discussion guide) and descriptive categories. A second analyst (one of the other moderators involved in the focus groups) may also assist. A thorough report for each region will be written that provides AHRQ with detailed findings, highlighting any observed differences between groups composed of "heavy" users of healthcare and those containing "light" users of healthcare. Each region's report will also acknowledge any ambiguities in the findings, discuss any areas that participants had particular difficulty understanding or discussing, and offer remedies for AHRQ and Westat to consider in subsequent focus groups. Once all of the focus groups have been conducted, findings as a function of other variables of interest will be explored, such as HMO members versus nonmembers, rural versus nonrural, and Spanish-speaking versus English-speaking.