

SUPPORTING STATEMENT

Part A

Overcoming Barriers to Expanded Health Information Exchange (HIE)
Participation in Indiana

August 13th, 2008
Revised December 9th, 2008
Revised June 10, 2009

Agency of Healthcare Research and Quality (AHRQ)

Table of contents

A. Justification.....3

- 1. Circumstances that make the collection of information necessary.....3
- 2. Purpose and use of information.....4
- 3. Use of Improved Information Technology.....5
- 4. Efforts to Identify Duplication.....5
- 5. Involvement of Small Entities.....5
- 6. Consequences if Information Collected Less Frequently.....5
- 7. Special Circumstances.....6
- 8. Consultation outside the Agency.....6
- 9. Payments/Gifts to Respondents.....6
- 10. Assurance of Confidentiality.....6
- 11. Questions of a Sensitive Nature.....7
- 12. Estimates of Annualized Burden Hours and Costs.....7
- 13. Estimates of Annualized Respondent Capital and Maintenance Costs.....8
- 14. Estimates of Annualized Cost to the Government.....8
- 15. Changes in Hour Burden.....9
- 16. Time Schedule, Publication and Analysis Plans.....9
- 17. Exemption for Display of Expiration Date.....9

List of Attachments.....9

A. Justification

1. Circumstances that make the collection of information necessary

The mission of the Agency for Healthcare Research and Quality (AHRQ) set out in its authorizing legislation, The Healthcare Research and Quality Act of 1999 (see Attachment A), is to enhance the quality, appropriateness, and effectiveness of health services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health systems practices, including the prevention of diseases and other health conditions. AHRQ shall promote health care quality improvement by conducting and supporting:

1. research that develops and presents scientific evidence regarding all aspects of health care; and
2. the synthesis and dissemination of available scientific evidence for use by patients, consumers, practitioners, providers, purchasers, policy makers, and educators; and
3. initiatives to advance private and public efforts to improve health care quality.

Also, AHRQ shall conduct and support research and evaluations, and support demonstration projects, with respect to (A) the delivery of health care in inner-city areas, and in rural areas (including frontier areas); and (B) health care for priority populations, which shall include (1) low-income groups, (2) minority groups, (3) women, (4) children, (5) the elderly, and (6) individuals with special health care needs, including individuals with disabilities and individuals who need chronic care or end-of-life health care.

Many healthcare stakeholders have hailed the development of health information exchange (HIE) as a redefining breakthrough in healthcare. HIE provides the means to electronically move clinical data between health care systems and organizations to facilitate clinical data access and retrieval to improve patient care. Others have demonstrated the value of health information exchange to improve efficiencies.¹

AHRQ recognized the potential of health information technology and health information exchange to improve the quality, safety, effectiveness and efficiency of healthcare and the need to test this hypothesis. In 2004, AHRQ awarded five state-based contracts to develop networks to support state-wide or regional data sharing and interoperability activities. A sixth contract was awarded in 2005. The projects are designed to identify and support State and regional data sharing and interoperability activities to demonstrate measurable improvements in care resulting from clinical data exchange. The demonstrations allow access to patient information at the point of care, connect systems

Overhage JM, Dexter PR, Perkins SM, Cordell WH, McGoff J, McGrath R, McDonald CJ. A randomized, controlled trial of clinical information shared from another institution. *Ann Emerg Med.* January 2002;39:14-23

of various local health care providers for better care coordination, and allow public and private health care providers to share patient data for better care. In addition to the SRD contractors who proposed to develop secure statewide networks to use health IT to communicate and share information, other leaders have begun to address these issues as well.²

HIE helps to improve quality and coordination of care by allowing providers access to a comprehensive, longitudinal record of a patient's health and health care. The more providers participating in an HIE, the more comprehensive the information will be. However, HIE developers often face challenges when engaging particular key stakeholders to participate. AHRQ proposes to complete a case study using a well-established HIE with a successful history of exchanging comprehensive clinical data in order to assess barriers to participation in HIE. As such, AHRQ proposes to complete this case study through the Regenstrief Institute which will use its experience to date of managing HIE through the INPC and working with a variety of organizations to discover specific barriers to engagement in HIE cited by stakeholders, define the barriers and evaluate them, and document actual and potential solutions to overcoming those barriers. The Regenstrief Institute's experience as one of the longest running HIEs in the country makes it an ideal setting for such a case study.

This project is being conducted pursuant to AHRQ's statutory mandates to conduct and support research, evaluations and initiatives to advance information systems for health care improvement (42 U.S.C. 299b-3) and to promote innovations in evidence-based health care practices and technologies by conducting and supporting research on the development, diffusion, and use of health care technology (42 U.S.C. 299b-5(a)(1)).

2. Purpose and Use of Information

The Regenstrief Institute will develop and implement a phone interview process to identify barriers that may exist throughout the State of Indiana to participation in the Indiana Network of Patient Care (INPC). The INPC is a local HIE infrastructure that includes information from five major hospital systems (fifteen separate hospitals), the county and State public health departments, and Indiana Medicaid and RxHub. The INPC began operation several years ago and is one of the first examples of a regional HIE, containing healthcare information for a majority of the State's population.

This case study will elicit and aggregate feedback from large and small physician groups, as well as small hospitals, throughout the State of Indiana. The goal is to identify the gaps in understanding, barriers and disconnects that may exist with providers' adoption of, and participation in HIE.

The Regenstrief Institute will survey three key stakeholder groups in the State of Indiana: small hospitals, small physician practices (less than 5 providers) and large physician practices (greater than 20 providers) to identify barriers for each of these groups to

Julia Adler-Milstein, Andrew P. McAfee, David W. Bates, and Ashish K. Jha. The State Of Regional² Health Information Organizations: Current Activities And Financing. *Health Affairs*, January/February .2008; 27(1): w60-w69

participate in a HIE in general, and specifically the INPC. It is difficult to predict the barriers that will be identified, but based on experience to date, anecdotal evidence suggests that the cost of interfaces and the management attention needed to participate will be the two major barriers.

The data will be aggregated, analyzed and a final report will be prepared that focuses on the following major topic areas:

- a. General perceptions on electronic sharing of health information;
- b. The extent to which electronic health information sharing exists in the contact's current environment;
- c. Barriers to the adoption and implementation of electronic health information sharing; and
- d. Recommendations for addressing and resolving issues preventing the adoption of HIE (general as well as entity-specific recommendations).

In addition to other sources, the information gathered through this case study will assist AHRQ's mission to advance "the creation of effective linkages between various sources of health information, including the development of information networks." 42 U.S.C. 299b-3(a)(3).

3. Use of Improved Information Technology

After an initial informational mailing, information will be collected in a phone interview. This interview is described in detail in Supporting Statement Part B.

4. Efforts to Identify Duplication

Through a literature search conducted in the last quarter of 2007 and first quarter of 2008, and extensive contacts with organizations and individuals in both the private and public sectors, similar data to establish specific barriers cited by healthcare stakeholders in the state of Indiana is not known to be available, nor was there found to be a case study of HIE on this topic.

5. Involvement of Small Entities

The information requested has been held to the absolute minimum required for the intended use.

6. Consequences if Information Collected Less Frequently

This is a one-time data collection effort.

7. Special Circumstances

This request is consistent with the general information collection guidelines of 5 CFR 1320.5(d)(2). No special circumstances apply.

8. Federal Register Notice and Outside Consultations

8.a. Federal Register Notice

As required by 5 CFR 1320.8(d), notice was published in the Federal Register on June 10, 2008 (Volume 73, Number 112) [Page 32711-32712] for 60 days (See Attachment B).

One comment was received via e-mail from the Federal Register Online via GPO Access [wais.access.gpo.gov][DOCID:fr10jn08-49]. There was no action taken in response to this comment.

The comment suggested that this work should be conducted by the State of Indiana rather than by the federal government. The commenter had not requested the study materials which we believe address why Indiana is an appropriate choice for this case study

8.b. Outside Consultations

Regenstrief Institute, Inc. has, and will continue, to consult with representatives of AHRQ to obtain their views on these data collection efforts, and data elements to be recorded, disclosed, or reported. There are currently no unresolved issues concerning these efforts.

9. Payments/Gifts to Respondents

No payment or gift will be made to respondents.

10. Assurance of Confidentiality

Individuals and organizations will be assured of the confidentiality of their replies under Section 934(c) of the Public Health Service Act, 42 USC 299c-3(c). They will be told the purposes for which the information is collected and that, in accordance with this statute, any identifiable information about them will not be used or disclosed for any other purpose.

Individuals and organizations contacted will be further assured of the confidentiality of their replies under 42 U.S.C. 1306, and 20 CFR 401 and 4225 U.S.C.552a (Privacy Act of 1974). In instances where respondent identity is needed, the information collection will fully comply with all respects of the Privacy Act.

Non-health information that can directly identify the institutions and respondents, such as name, title, and address (but not social security number) will be collected. Only those directly involved in the data collection and analysis will have access to the identifiable data. We will take the following measures to safeguard the information: (1) locking cabinets and doors; (2) information located in an area with limited public access; (3) computers and files will be password-protected; and, (4) all electronic data will be

backed-up on a regular basis. This non-health data will be retained for a minimum of three years before it is discarded.

Reasonable safeguards will be used when sharing this non-health data within the research team. This is a minimal risk study, and the only potential risk to respondents is loss of confidentiality.

11. Questions of a Sensitive Nature

There are no questions of a sensitive nature.

All respondents are provided information about the nature of the study in the initial phone contact script (See Attachment C). The respondent is provided a description of the reason for the phone interview, i.e., the grant project to determine barriers to implementation of health information and exchange and how to overcome them. The respondent is reassured that they will not receive any marketing calls related to their participation in this survey.

12. Estimates of Annualized Burden Hours and Costs

Exhibit 1 shows the estimated annualized burden hours for the respondents' time to participate in this research. A screener interview will be completed once by each of the 20 small hospitals and 80 physician practices and is expected to require about 5 minutes to complete. The telephone interview will be conducted with each person identified in the screener interview and is expected to last about 20 minutes. The total burden hours for the participating health care providers is estimated to be 55 hours.

Exhibit 2 shows the estimated annualized cost burden to the responding health care providers based on their time to participate in this research. The total cost burden is estimated to be \$2,562.

Exhibit 1. Estimated annualized burden hours

Form Name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Screener	100	1	5/60	8
Telephone Follow-up Interview	100	1.4	20/60	47
Total	200	na	na	55

Exhibit 2. Estimated annualized cost burden

Form Name	Number of respondents	Total burden hours	Average hourly wage rate*	Total cost burden
------------------	------------------------------	---------------------------	----------------------------------	--------------------------

Screener	100	8	\$46.58	\$373
Telephone Follow-up Interview	100	47	\$46.58	\$2,189
Total	200	55	na	\$2,562

*Based upon the average of the "Wage estimates, mean hourly" for the following occupation codes and titles: 11-101/Chief executives; 13-0000/Business and financial operations occupations; 15-1071/Network and computer systems administrators; 29-1062/Family and general practitioners; 11-9111/Medical and health services managers, from the "May 2007 State Occupational Employment and Wage Estimates, Indiana; Occupational Employment Statistics, U.S. Department of Labor, Bureau of Labor Statistics, <http://www.bls.gov/oes/current/oes_in.htm>."

13. Estimates of Annualized Respondent Capital and Maintenance Costs

Capital and maintenance costs include the purchase of equipment, computers or computer software or services, or storage facilities for records, as a result of complying with this data collection. There are no direct costs to respondents other than their time to participate in the study.

14. Estimates of Annualized Cost to the Government

This project will last for one year and is estimated to cost the government \$120,000. The scope of work includes the development of the survey instruments and data collection (\$90,000), and data analysis (\$10,000) to establish specific barriers to HIE participation cited by stakeholders and to define and evaluate them (\$20,000).

15. Changes in Hour Burden

This is a new collection of information.

16. Time Schedule, Publication and Analysis Plans

The timetable for the entire project follows:

- 06/29/09 Begin data collection
- 08/14/09 End data collection
- 09/07/09 Data aggregation / analysis
- 10/05/09 Complete report and present work on or before 03/31/10

17. Exemption for Display of Expiration Date

AHRQ does not seek this exemption.

List of Attachments:

Attachment A: AHRQ's Authorizing Legislation

Attachment B: 60 Day Federal Register Notice

Attachment C: Screener Script

Attachment D: Communication Packet

Attachment E: Telephone Interview