Survey of Medical Care Providers for the Evaluation of the Regional Extension Center (REC) Program

SUPPORTING STATEMENT-Part A

Justification

December 4, 2013

The Office of the National Coordinator for Health Information Technology (ONC)

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A. Justification

1. Circumstances that make the collection of information necessary

The Office of the National Coordinator for Health Information Technology (ONC) is the principal federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. The position of National Coordinator was created in 2004, through Executive Order 13335, and legislatively mandated in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009.[1] (Attachment A-1)

To achieve this goal, ONC has funded 62 Regional Extension Centers (RECs) to help more than 100,000 primary care providers adopt and use electronic health records (EHRs). Eligible providers who adopt and meaningfully use EHRs may receive incentive payments through the Medicare and Medicaid EHR Incentive Programs. REC services include outreach and education, EHR support (such as working with vendors, or helping providers choose a certified EHR system), and technical assistance in implementing health IT and using it in a meaningful way to improve care. The RECs' focus is to provide on-the-ground assistance for:

- Individual and small practices
- Medical practices lacking resources to implement and maintain EHRs
- Those who provide primary care services in public and critical access hospitals, community health centers, and other settings that mostly serve those who lack adequate coverage or medical care [2]

ONC's contractor, the American Institutes for Research (AIR), is performing an evaluation of the effectiveness of the REC program in supporting health care providers in their adoption and use of HIT and in meeting the requirements of the HITECH Act to facilitate diffusion and adoption of HIT and HIE. This portion of the evaluation of the REC program examines the following research questions:

1. Is REC participation associated with adoption of EHRs and meaningful use of EHRs?
2. Is REC participation associated with attestation in the Centers for Medicare and Medicaid Services (CMS) Medicare and Medicaid incentive programs?
3. Is REC participation associated with satisfaction and positive opinions about EHRs?
4. Is REC participation associated with use of assistance services?
5. Is REC participation associated with experiencing less difficulty in adoption of EHRs?
6. Is REC participation associated with being part of a care transformation program?

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http://www.healthit.gov/newsroom/about-onc [1]

http://www.healthit.gov/providers-professionals/regional-extension-centers-recs [2]

To answer these questions, we will use a mail screener (Step 1) and a computer assisted telephone interview (CATI) survey (Step 2) with physicians who have enrolled with a REC program and a comparison group of matched physicians who have not. To capture the most accurate data, sampled physicians may ask colleagues (e.g., other physicians in the practice, nurses, practice managers, or health information technology staff) most familiar with EHR selection, implementation, and use in their practices to help answer screener and survey items.

A survey of participating primary care professionals from small medical practices is necessary to collect data on outcomes listed in the research questions and to collect information about the professionals and their medical practices. Collecting data from a matched comparison group of professionals that do not participate in the REC program is necessary to determine if participating affects the listed outcomes.

2. Purpose and Use of Information

This new, one-time data collection activity is needed to provide a statistically valid representation of REC participants. The resulting data will inform policy decisions by ONC, REC program administrators, and the broader community of policy makers and researchers interested in HIT adoption. Findings will:

- **Show overall impact** of the REC program on use of technical assistance, EHR adoption, and achievement of meaningful use of EHRs by primary care practices. These findings will inform future program and infrastructure development by ONC and other stakeholders supporting HIT use in healthcare.
- **Identify challenges** faced by primary care practices when adopting EHRs. We will document whether they received help addressing the challenges, and these findings will inform ONC's dissemination of best practices and identification of gaps and barriers to EHR adoption to prioritize in the future.
- **Capture opinions** about how EHRS are benefitting practices, which will enable ONC and program adminsitrators to assess how receptive primary care providers and practices are to existing and future HIT efforts.

3. Use of Improved Information Technology

We will offer the screener (part 1) on paper and over the phone for non-responders of the paper screener. We will offer the survey over the phone using Computer Assisted Telephone Interviewing (CATI) software and on paper for non-responders to the CATI.

These options are intended to make completing and submitting the survey:

- **Convenient**. Respondents can take the paper survey whenever they like and stop and return to where they left off. Administration of the phone versions of the survey can be scheduled at a time most convenient for the provider.
- **Less time consuming**. CATI tools allow participants to skip to only the relevant items. For example, practices without EHRs will not be asked questions about challenges with meaningful use of EHRs.
- **Clear**. Respondents can get definitions of concepts and words by asking the interviewer to repeat questions and clarify definitions on the CATI mode.

- **Error free**. CATI tools can reduce coding errors because codes will be automatically linked to responses housed in the software.

4. Efforts to Identify Duplication

We compared our survey to the National Ambulatory Medical Care Survey (NAMCS) from the National Center for Health Statistics and identified the following similarities and differences.

Similarities to the NAMCS

Certain items were included or modified from the NAMCS survey by design in order to allow for comparison to national trends, a key objective in this research. We designed our survey to be similar to the NAMCS on the following topics:

- EHR adoption
- Practice characteristics
- Benefits and satisfaction with the EHR
- Participation in care transformation programs

Where possible we used NAMCS questions because these have been well-vetted among respondents given the survey's long tenure, or modified them to fit better in the context of our survey.

Differences from the NAMCS

Our survey and study differ from the NAMCS in two key ways. First, the NAMCS survey instruments do not include all the constructs, domains, or questions that we require to conduct our evaluation. For example, we include specific and separate items about participation in the Medicare and Medicaid incentive programs to estimate the effect of the REC program on attestation for each incentive program separately. This will allow ONC to better understand how REC participation may influence the attestation rate, which is a vital measure of meaningful use. We also ask items about the difficulty of adopting EHRs and different organizations that may have provided technical assistance. This will support ONC's efforts to identify challenges faced by small primary care practices and will inform program and infrastructure development.

Second, the NAMCS survey sample does not include a sufficient number or percentage of REC participants for an evaluation of the REC program. In the 2011 NAMCS Physician Workflow survey, only 8% of respondents (weighted) reported that they received REC assistance (n=157).

5. Involvement of Small Entities

We are taking the following steps to minimize burden to small, primary care practices.

- **We will administer a screener first**. We will administer a screener (part 1) to identify participants eligible to respond to the full survey (part 2). We expect this 2-step process to decrease burden by over 870 hours because providers not meeting eligibility requirements will not be asked to take part in the survey.

Eligibility includes: work in small practices of 10 providers or less or with >=30% Medicaid or uninsured populations AND have EHRs

- **The survey will use skip patterns**. The skip patterns mean participants only respond to items that are most relevant to their circumstances.
- **We include only essential questions**. We are requesting the minimum amount of information required to answer the evaluation research questions.

6. Consequences if Information Collected Less Frequently

This is a one-time data collection activity.

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 (HHS-OS-20475-60D) on September 19, 2013 on pages 57638 -57639 for 60 days (see Attachment A-2).

8.b. Outside Consultations

ONC has consulted with staff of American Institutes for Research (AIR), Pacific Consulting Group (a subcontractor to AIR), and the American Academy of Family Physicians (a subcontractor to AIR). AIR and Pacific Consulting Group offer expertise in study design and quantitative and qualitative methodology. The American Academy of Family Physicians provided the perspective of primary care providers. (Exhibit A1)

Exhibit A1. Individuals Consulted on Study Design and Implementation

Affiliation	Name	Telephone	Email
AIR	Johannes Bos	650-843-8110	jbos@air.org
	Kristin Carman	202-403-5090	kcarman@air.org
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	David Schneider	650-843-8257	dschneider@air.org
	Grace Wang	650-843-8191	gwang@air.org
Pacific Consulting Group	Andrea Ptaszek	617-314-9397	aptaszek@pcgfirm.com
American Academy of Family Physicians	Steven Waldren		swaldren@aafp.org

Feedback from expert reviewers from the American Academy of Family Physicians (AAFP), American Academy of Pediatrics, American College of Physicians (ACP), and

American Congress of Obstetricians and Gynecologists (ACOG) was also obtained to inform the development of the study design and survey instrument.

9. Payments/Gifts to Respondents

We anticipate that many physicians will participate in this study out of interest and to contribute to policy making. To understand conditions that encourage response, we will distribute a $0, $2, $5, or $10 cash payment as a token of appreciation for taking the screener. Accompanying the incentive payment will be a cover letter explaining the study and the paper screener. This package will be mailed to 4,712 health care providers. Based on screener results, we will determine providers eligible for the survey. These providers will receive a $15 cash payment as a token of appreciation for taking the survey.

We include small, pre-paid incentives based on reccomendations from previous studies. Incentives viewed by clinicians as a "token of appreciation" (a moderate amount) had the best result compared to other incentive amounts. Large incentives were viewed as a payment and resulted in a lower response.[3] We anticipate that payment will increase the efficiency of recruitment and, thus, potentially be offset by savings that will lower the total cost of the study.

Varying the incentive denomination allows us to contribute to the limited and largely outdated evidence base on practices that maximize response rates for health care providers.[4] [5] We will show: 1) the effect of any incentives on response rates and 2) the effect of denomination on response rates. Future studies will use our findings and recommendations about incentive denomination thresholds in designs.

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.

All participants will be assigned a unique study identifier (AIR ID). Participants' contact information and other identifiable information will be kept separate from screener and survey responses. We will maintain a cross walk that links AIR ID, contact information,

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[3] Flanigan T, McFarlane E, Cook S. 2008. "Conducting Survey Research among Physicians and Other Medical Professionals—A Review of Current Literature." Proceedings of the Survey Research Methods .Section, American Statistical Association, pp. 4136–47

[4] VanGeest JB, Johnson TP, Welch VL. Methodologies for improving response rates in surveys of .physicians: a systematic review. Eval Health Prof. 2007 Dec;30(4):303-21

[5] McLeod CC, Klabunde CN Willis GB, Stark D. Health Care Provider Surveys in the United States, 2000-2010. Eval Health Prof March 2013 vol. 36 no. 1 106-126

and collected data. The cross walk will be password protected, stored on a secure server, and accessed by only key research staff.

11. Questions of a Sensitive Nature

This survey does not include any questions of a sensitive nature.

12. Estimates of Annualized Burden Hours and Costs

The estimated annual hour burden is shown in Exhibit A2.

Completion of Form A Screener Administered on Paper. The length of time required for screener completion is estimated to be 5 minutes. This is based on the written length of the survey. The maximum number of respondents is 4,712 respondents.

Completion of Form B Survey Administered as a Computer-Assisted Telephone Interview. The length of time required for survey completion is estimated to be 30 minutes. This is based on the conducting the survey over the telephone. The maximum number of respondents is estimated to be 1,425 respondents.[6]

Completion of Form C. Shortened Survey Administered on Paper for Non-Responders of Telephone Survey. The length of time required for survey completion is estimated to be 10 minutes. This is based on conducting the survey by paper. The maximum number of respondents is estimated to be 356 respondents.

We are sampling physicians to participate in the study, but we will invite physicians to work with colleagues familiar with EHR selection, implementation, and use to answer questions. Therefore, we base our burdern hour and cost estimates on a mix of respondents who are employed as physicians, registered nurses, and practice managers.

We use the following wages for each job class:

- $86.00 per hour for primary care physicians. The Bureau of Labor Statistics reports a median hourly wage of $80.29 in May 2011 for family and general practitioners.[7] Our estimate allows for inflation and represents a conservative estimate of the wages of the respondents.
- $34.00 per hour for registered nurses. The Bureau of Labor Statistics reports a median hourly wage of $31.71 in May 2011 for registered nurses.[8] Our estimate allows for inflation and represents a conservative estimate of the wages of the respondents.
- $44.00 per hour for practice managers. The Bureau of Labor Statistics reports a median hourly wage of $41.54 in May 2011 for Medical and Health Services

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[6] This number assumes: a) 75% response rate for the screener questionnaire; b) 30% of screener respondents will be ineligible for the full survey because they work in large practices (http://www.cdc.gov/nchs/data/ad/ad383.pdf); c) 28% of the remaining screener respondents will be ineligible because they do not have EHRs (http://www.cdc.gov/nchs/data/databriefs/db111.htm); and d) .80% of eligible respondents complete the survey by phone while 20% complete the survey on paper

[7] http://www.bls.gov/oes/current/oes291062.htm

[8] http://www.bls.gov/oes/current/oes291111.htm

Managers.[9] Our estimate allows for inflation and represents a conservative estimate of the wages of the respondents.

Exhibit A2. Estimated annualized burden hours

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
Physicians	Form A Screener Administered on Paper	1571	1	5/60	131
Nurses	Form A Screener Administered on Paper	1571	1	5/60	131
Practice Managers	Form A Screener Administered on Paper	1570	1	5/60	131
Physicians	Form B Survey Administered as a Computer-Assisted Telephone Interview	475	1	30/60	238
Nurses	Form B Survey Administered as a Computer-Assisted Telephone Interview	475	1	30/60	238
Practice Managers	Form B Survey Administered as a Computer-Assisted Telephone Interview	475	1	30/60	238
Physicians	Form C Shortened Survey Administered on Paper	119	1	10/60	20
Nurses	Form C Shortened Survey Administered on Paper	119	1	10/60	20
Practice Managers	Form C Shortened Survey Administered on Paper	118	1	10/60	20
Total					**1167**

[9] http://www.bls.gov/oes/current/oes119111.htm

Exhibit A3. Estimated annualized cost burden

Type of Respondent	Form Name	No. of Respondents	Total Burden hours	Average Hourly Wage Rate*	Total Cost Burden
Physicians	Form A Screener Administered on Paper	1571	131	$86.00	$11,266
Nurses	Form A Screener Administered on Paper	1571	131	$34.00	$4,454
Practice Managers	Form A Screener Administered on Paper	1570	131	$44.00	$5,764
Physicians	Form B Survey Administered as a Computer-Assisted Telephone Interview	475	238	$86.00	$20,468
Nurses	Form B Survey Administered as a Computer-Assisted Telephone Interview	475	238	$34.00	$8,092
Practice Managers	Form B Survey Administered as a Computer-Assisted Telephone Interview	475	238	$44.00	$10,472
Physicians	Form C Shortened Survey Administered on Paper	119	20	$86.00	$1,720
Nurses	Form C Shortened Survey Administered on Paper	119	20	$34.00	$680
Practice Managers	Form C Shortened Survey Administered on Paper	118	20	$44.00	$880
Total					**$63,796**

*Based upon the median wages, "May 2011 Occupational Wage Estimates United States," U.S. Department of Labor, Bureau of Labor Statistics. (http://www.bls.gov/oes/current/oes_nat.htm#29-0000, retrieved February 15, 2013)

13. Estimates of Annualized Respondent Capital and Maintenance Costs

There are no direct costs to respondents other than their time to participate in the study.

14. Estimates of Annualized Cost to the Government

The cost to the Government for the provider survey will be approximately $330,000. This includes: screener and survey development; cognitive testing and revisions of instruments; data collection and data analysis; and reporting.

15. Changes in Hour Burden

There are no changes in hour burden because this is a new collection of information.

16. Time Schedule, Publication and Analysis Plans

Schedule

AIR's contract for the overall evaluation of the REC program lasts from 2010 to 2014. Data collection is scheduled to begin upon OMB approval, estimated in January 2014. Data collection is scheduled to be completed by June 2014. (Exhibit A4)

Publication

Exhibit A4 summarizes the planned reporting and publication activities. We anticipate one manuscript suitable for publication in a peer-reviewed health services research journal to be completed 8-11 months following OMB clearance for data collection, depending on when OMB clearance is obtained. Other manuscripts might be produced by AIR.

Exhibit A4. Schedule of Reporting Activities

Activity / Deliverable	Time Schedule / Date
Participant screening and recruitment begins	0-1 Months after OMB approval
Data Collection Begins	0-1 Months after OMB Approval
Data Collection Concludes	4-6 Months after OMB Approval
Final Project Report / Analyses	4-8 Months after OMB Approval
Publication submitted	8-11 Months after OMB Approval

Analysis plan

The analysis will be conducted by our contractor, AIR.

Outcomes

Proposed strategies for measuring the outcomes for the 6 research questions are listed below in Exhibit A5. The data sources for the outcomes are the screener (Form A) and the survey (Forms B and C).

Exhibit A5. Research question (RQ) and associated outcomes for the impact analysis

RQ	Outcomes	Measurement	Data source
1	adoption of EHRs	no (0) or yes (1)	Screener
	meaningful use (MU) of EHRs	number of core MU EHR features routinely used.	Survey
2	attestation in the Medicare program	no (0) or yes (1)	CMS admin
	self reported attestation in the Medicaid incentive program	no (0) or yes (1)	Survey
3	opinion about benefits (financial, efficiency, patient care) *	strongly disagree (-2) to strongly agree (2)	Survey
	satisfaction with the EHR	very dissatisfied (-2) to very satisfied (2)	Survey
4	use of assistance services	number of service providers help with adoption, implementation, MU functionalities, and attestation – no (0) or yes (1)	Survey
5	difficulty with adoption *	not at all difficult (0) to extremely difficult (5)	Survey
6	participation in an accountable care organization	no (0) or yes (1)	Survey
	participation in patient centered medical home		
	participation in pay for performance program		

* This outcome may be the average score for several survey items, pending the results of factor analyses.

Modeling approaches

The general approach for analyzing each research question is two-fold. First, we will conduct propensity score matching to match REC participants to non-participants. We will examine descriptive statistics to ensure equivalence of REC participants to non-participants. Second, we will conduct regression modeling to examine the association of

REC participation to outcomes. If needed, we may include adjustment variables, such as the variables shown below.

$$E_i = \beta_0 + \beta_1 REC_i + \delta_1 age_i + \delta_2 sex_i + \delta_{3-6} field_i + \delta_{7-12} practice_i + \delta_{13-62} state_i + \in_i$$

Where:

E_i	is the outcome measure for participant *i.*
REC_i	is the independent variable of interest and an indicator = 1 if an REC participant and = 0 otherwise.
age_i	is an adjustment variable measured as a continuous variable.
sex_i	is an adjustment variable measured as an indicator = 1 if female and =0 otherwise.
$field_i$	are adjustment variables measured as a series of dummy variables representing obstetrics and gynecology; pediatrics; geriatrics; internal medicine; and all others.
$practice_i$	are adjustment variables measured as a series of dummy variables representing private solo practice; private practice with 2 to 10 providers; private practice with 11 to 24 providers; private practice with 25 to 49 providers; private practice with 50 or more providers; federally qualified health center; and all others.
$state_i$	are adjustment variables measured as a series of dummy variables representing the 50 states.

For each set of dummy variables, the largest category will be used as the reference group.

A finding that $\beta_1 \neq 0$ for each specified outcome measure indicates that participation in the REC program has an impact on that outcome.

17. Exemption for Display of Expiration Date

ONC does not seek this exemption.

Attachment A-1: ONC's Authorizing Legislation

The Regional Extension Center was established by the American Recovery and Reinvestment Act, Title XIII.[10]

[10] The full text is available here: http://www.gpo.gov/fdsys/pkg/BILLS-111hr1enr/pdf/BILLS-111hr1enr.pdf

Attachment A-2: 60 Day Federal Register Notice

Billing code 4150–45–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Document Identifier: HHS-OS-20475-60D

Agency Information Collection Activities; Proposed Collection; Public Comment Request

AGENCY: Office of the Secretary, HHS

ACTION: Notice

SUMMARY**:** In compliance with section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Office of the Secretary (OS), Department of Health and Human Services, announces plans to submit a new Information Collection Request (ICR), described below, to the Office of Management and Budget (OMB). Prior to submitting that ICR to OMB, OS seeks comments from the public regarding the burden estimate, below, or any other aspect of the ICR.

DATES**:** Comments on the ICR must be received on or before November 18, 2013.

ADDRESSES**:** Submit your comments to Information.CollectionClearance@hhs.gov or by calling (202) 690-6162.

FOR FURTHER INFORMATION CONTACT: Information Collection Clearance staff, Information.CollectionClearance@hhs.gov or (202) 690-6162.

SUPPLEMENTARY INFORMATION: When submitting comments or requesting information, please include the document identifier HHS-OS-20475-60D for reference.

Information Collection Request Title: Survey of Medical Care Providers for the Evaluation of the Regional Extension Center (REC) Program

Abstract: This new, one-time data collection activity is needed to collect information from practices that are utilizing assistance from the Regional Extension Center program to implement and meaningfully use health information technology, as well as practices that are not working with a Regional Extension Center. The survey data will be analyzed to determine whether there is an association between REC participation and the use of technical assistance, EHR adoption, and achievement of meaningful use of electronic health records by primary care practices. The data will also be used to identify challenges faced by primary care practices when adopting and meaningfully using EHRs. The resulting data will inform policy decisions by the Office of the National Coordinator for Health Information Technology (ONC), REC program administrators, and the broader community of policy makers and researchers interested in electronic health record (EHR) adoption.

Need and Proposed Use of the Information: The Office of the National Coordinator for Health Information Technology has funded an independent national program evaluation of the Regional Extension Center program. The proposed information collection effort is necessary to collect information to answer the following research questions: (1) Is REC participation associated with adoption of EHRs and meaningful use of EHRs? (2) Is REC participation associated with attestation in the Centers for Medicare and Medicaid Services (CMS) Medicare and Medicaid incentive programs? (3) Is REC participation associated with satisfaction and positive opinions about EHRs? (4) Is REC participation associated with use of assistance services? (5) Is REC participation associated with experiencing less difficulty in adoption of EHRs? (6) Is REC participation associated with being part of a care transformation program? There is no existing data source that can be used to answer these research questions.

Likely Respondents: The survey targets small primary care practices, and asks for the staff member most knowledgeable about electronic health record (EHR) adoption and utilization to answer the survey.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose or provide the information requested. This includes the time needed to review instructions, to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information, to train personnel and to be able to respond to a collection of information, to search data sources, to complete and review the collection of information, and to transmit or otherwise disclose the information. The total annual burden hours estimated for this ICR are summarized in the table below.

Estimated annualized burden hours

Type of Respondent	Form Name	No. of Respondents	No. Responses per	Average Burden per Response	Total Burden Hours

			Respondent	(in hours)	
Physicians	Form A Screener Administered on Paper	1571	1	5/60	131
Nurses	Form A Screener Administered on Paper	1571	1	5/60	131
Practice Managers	Form A Screener Administered on Paper	1570	1	5/60	131
Physicians	Form B Survey Administered as a Computer-Assisted Telephone Interview	475	1	30/60	238
Nurses	Form B Survey Administered as a Computer-Assisted Telephone Interview	475	1	30/60	238
Practice Managers	Form B Survey Administered as a Computer-Assisted Telephone Interview	475	1	30/60	238
Physicians	Form C Shortened Survey Administered on Paper	119	1	10/60	20
Nurses	Form C Shortened Survey Administered on Paper	119	1	10/60	20
Practice Managers	Form C Shortened Survey Administered on Paper	118	1	10/60	20
Total					**1167**

OS specifically requests comments on (1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions, (2) the accuracy of the estimated burden, (3) ways to enhance the quality, utility, and clarity of the information to be collected, and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

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Darius Taylor,

Deputy Information Collection Clearance Officer