

Behavioral Health Information Technologies Survey

SUPPORTING STATEMENT

A. JUSTIFICATION

A.1. Circumstances of Information Collection

The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) and Center for Behavioral Health Statistics and Quality (CBHSQ) is requesting approval from the Office of Management and Budget (OMB) for data collection activities for SAMHSA's Behavioral Health Information Technologies and Standards (BHITS) program.

BHITS is authorized by Section 503A of the Public Health Service Act (42 USC 290aa-2a – Report on Individuals with Co-Occurring Mental Illness and Substance Abuse Disorders).

SAMHSA is the entity within the U.S. Department of Health and Human Services (HHS) that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. In order to achieve this mission, SAMHSA has identified six (6) Strategic Initiatives (<http://www.samhsa.gov/about/strategy.aspx>) to focus the agency's work on improving lives and capitalizing on emerging opportunities in healthcare. They include: (1) Prevention of Substance Abuse and Mental Illness, (2) Health Care and Health Systems Integration, (3) Trauma and Justice, (4) Recovery Support, (5) Health Information Technology, and (6) Workforce Development. These Strategic Initiatives play a vitally important role in crafting SAMHSA's response to the nation's concerns regarding the prevention and treatment of mental illness and substance use disorders. They drive the development of national programs and also targeted projects that address the unique needs of State, Territorial, Tribal, and local entities.

Strategic Initiative 5—Health Information Technology—specifically addresses the need for behavioral health provider participation in the evolving electronic network of healthcare providers. It is intended to support behavioral health provider access to the basic tools of health information technology (HIT) and health information exchange (HIE). These basic tools are the foundation for implementing the statutory expansions described, and for participating in the evolution of the nation's system of healthcare.

The barriers to behavioral health provider participation in HIT and HIE can be addressed with information technology tools capable of managing this type of information in full compliance with federal and state rules and regulations. Recent advances in HIT and HIE ensure the availability of needed information technology tools for addressing barriers. Specifically, there are two new information technology tools that address the need to share patient health information, while giving patients meaningful choices for electronically sharing sensitive and specially protected health information:

- “Data Segmentation for Privacy” provides detailed guidance in the form of data and technology standards for managing the exchange of HIPAA-protected information that includes “specially protected” health information.¹
- “Consent2Share” is a freely available, open source module that builds on the Data Segmentation for Privacy standards.² It is designed to facilitate the exchange of patient health information containing data protected by 42 C.F.R. Part 2. “Part 2” outlines the provisions for the confidentiality of alcohol and drug abuse patient records.³

These breakthroughs facilitate the exchange of sensitive and specially protected patient health information, in full compliance with federal and state regulations, and organizational policies. But the development and successful testing of new technology does not necessarily lead to its widespread adoption and use. SAMHSA is proposing the conduct of this survey to assess current HIT adoption and use among SAMHSA grantees in part to support the adoption of these recent advances.

The survey will provide the baseline information needed to guide the agency’s Strategic Initiative — Health Information Technology, which is aimed at “ensuring that the behavioral health system, including States, community providers, and peer and prevention specialists, fully participate within the general health care delivery system in the adoption of HIT and interoperable electronic health records (EHRs).” This Strategic Initiative will support the inclusion of the behavioral health system in HIT adoption and HIE-enabled care by:

- Developing the behavioral HIT infrastructure for interoperability (HIE)
- Delivering technical assistance on the adoption of HIT and the implementation of HIE
- Enhancing HIT capacities to support patient engagement and to improve patient outcomes

The survey will support this initiative by collecting baseline data on the status of behavioral health information technologies adoption and use among SAMHSA grantees. These data, vital to SAMHSA planning and implementation activities in this area, are not otherwise available. The survey will:

- Offer information necessary for assessing and evaluating the state of adoption and use of HIT among a representative subset of SAMHSA grantees
- Help SAMHSA and its Centers understand what technologies are available to grantees and how they are used
- Pinpoint the barriers and challenges behavioral health providers face along the continuum of participation in HIT, up to exchanging patient health information among a network of primary and specialty care providers

¹ Standards and Interoperability Framework. “SAMHSA Consent2Share Project.” Retrieved January 2015 from <http://wiki.siframework.org/SAMHSA+Consent2Share+Project>

² Standards and Interoperability Framework. “Data Segmentation for Privacy.” Retrieved January 2015 from <http://wiki.siframework.org/Data+Segmentation+for+Privacy+Charter+and+Members>

³ Title 42, Chapter 1, Subchapter A, Part 2. “Confidentiality of Alcohol and Drug Abuse Patient Records.” Retrieved January 2015 from <http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2>

- Allow SAMHSA to describe how electronic health records, along with telehealth, mobile technology, social media, and other information technology tools are incorporated into the SAMHSA-funded grant program activities

The data collected by the survey will indirectly support the implementation of SAMHSA's Strategic Initiative 2—Health Care and Health Systems Integration. This initiative focuses in part on supporting coordinated care and services across systems through the electronic exchange of patient health information. This exchange is central to both the quality, and the effectiveness and efficiency, of healthcare. It is facilitated by a network of providers using certified EHRs to implement the collaborative care model. The survey will collect data that fill in some of the information gaps regarding the capacities for behavioral healthcare providers to participate in a system of integrated healthcare.

A.2. Purpose and Use of Information

Recent data on the use of HIT by “safety net” providers indicate that behavioral healthcare is on the wrong side of a growing “digital divide.” With the help of targeted federal investments, aggressive outreach and a national network of technical assistance, 2009-2013 saw the successful construction of a health information technology network among both public and private healthcare providers of many different types. But there are strong indications that this expansion and growth bypassed the national community behavioral healthcare system. This is difficult to discuss, because there are no data to reliably describe the extent to which behavioral healthcare providers have been unable to adopt and use HIT or participate in HIE, even among SAMHSA-funded programs and initiatives. This survey will collect these baseline data from a small but representative group of SAMHSA grantees.

To help demonstrate the nature of the information gap, SAMHSA can reference the data readily available on the adoption rates of certified EHRs by hospitals, primary care physicians and Federally Qualified Health Centers (FQHCs). We are able to say that between 2009 and 2013, adoption of certified EHR technology by FQHCs increased by 133 percent, from about 30 percent to at least 93 percent.⁴ At least 78 percent of all office-based physicians and about 60 percent of hospitals also made the transition.⁵

But since these data are not collected from behavioral healthcare providers, we cannot quantify their progress in adopting and using certified electronic health record technology, analyze the barriers, or plan to help them address challenges that may be on the horizon.

Instead, SAMHSA's understanding of the status of behavioral health provider adoption of HIT is limited, superficial, and fragmented. For example, the most recent data available on this subject comes from a survey conducted in 2011 by the National Council for Community Behavioral Healthcare, which limited data collection to its membership. This survey focused on the readiness of their membership to participate in Meaningful Use, a program where financial incentives are offered to eligible professionals who adopt, implement and use certified EHRs.

⁴ Ryan, J., et al. 2014. *The Adoption and Use of Health Information Technology by Community Health Centers 2009-2013*. The Commonwealth Fund. Retrieved December 2014 at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2014/May/1746_Ryan_adoption_use_hlt_IT_CHCs_rb.pdf

⁵ Health and Human Services. *More physicians and hospitals are using EHRs than before*. Retrieved December 2014 at <http://www.hhs.gov/news/press/2014pres/08/20140807a.html>

This survey will collect the necessary standardized, baseline data on the state of adoption of HIT by behavioral health providers within SAMHSA grant programs. The data collection effort is designed to address the following research questions:

- What is the nature of the existing HIT infrastructure among SAMHSA grantees?
- What types of HIT are used by SAMHSA-funded grant programs?
- What are the barriers of HIT use (e.g. cost, workforce) and facilitators for adopting and sustaining (e.g. efficiency) use of HIT?
- What types of collaborations exist between local agencies to provide coordinated care using HIT?
- How does HIT use (accessibility, engagement) vary between urban, suburban and rural areas?⁶

The survey was developed with attention to the varying types of levels of HIT tools and applications that behavioral health providers might be adopting into their practices. To ensure this snapshot survey assesses the full array of available HIT, the survey development focused on eight key HIT domains. A copy of the definitions of these key domains is provided as Attachment 2.

1. EHRs and Practice Management Systems
2. Interoperability/HIE Functionality
3. Telehealth
4. Mobile Tools
5. Web Portals
6. Consumer Engagement Tools
7. Personal Health Records
8. Dashboard/Tools for Integration of Care

To effectively capture the broad research questions across each of the eight domains, the survey questions were organized into six sections:

Section Number	Section Title
Section 1	Grantee Program Information and Characteristics
Section 2	Grantee Program Information Technology Infrastructure
Section 3	Use of Certified Electronic Health Record Technology
Section 4	Use of Telehealth
Section 5	Use of Mobile Technology
Section 6	Use of Social Media

The development of the analytic file will include review of data of questionable quality. The use of web-based data collection is designed to insure the appropriate application of skip patterns within each of the survey sections and limit respondents to allowed answers. The vast majority of the questions use forced-choice, categorical data, limiting the opportunity for the respondent to introduce out-of-range values.

⁶ United States Census Bureau, Urban and Rural Classifications, 2014. Retrieved December 2014 from <https://www.census.gov/geo/reference/urban-rural.html>

The survey team will review responses on an ongoing basis during the data collection period to identify problem patterns, most notably respondents who fail to complete at least half of the requested items. SAMHSA will follow-up with the respondents by telephone to determine if what problems or issues they encounter in completing the survey, resolving these issues as possible. Our intent is to use data from any respondent that provided any information beyond Section 1: Grantee Program Information and Characteristics.

SAMHSA’s analysis plan will be guided by the research questions stated above. SAMHSA will provide descriptive statistics for each questions in Sections 2 through 6 of the questionnaire, including counts of actual responses out of eligible responses for an item.

The following is an example table for the first research question, “What is the existing Health Information Technology (HIT) infrastructure among SAMHSA grantees”:

Use of Health Information Technologies by SAMHSA Grantees				
	Certified EHR	Telehealth	Mobile Technology	Social Media
Yes	%* (N)	%* (N)	%* (N)	%* (N)
No	%* (N)	%* (N)	%* (N)	%* (N)
Not applicable	(N)	(N)	(N)	(N)
Missing or Don’t Know	(N)	(N)	(N)	(N)
*Percentages calculated by $(Y/(Y+N))$; those responding not applicable and missing cases are excluded from the calculation.				

SAMHSA will also examine cross tabulations of items by geographic setting and size of the sponsoring organization. If the resulting sample is sufficient SAMHSA will also exam cross tabulations of select variables by other organizational characteristics including types of services provided, whether the grant program seeks reimbursement for services, and Center funding the grant.

A.3. Use of Information Technology

The data collection strategy will leverage familiar, widely-used information technology readily available online and at no-cost to the general public. Specifically, the strategy will use a free online survey tool called SurveyMonkey to build, test and administer the survey; implement quality control procedures that support participant engagement and a high response rate; collect responses; and generate reports to support analysis of the data.

This approach offers several advantages. When constructing the survey, it offers question-format templates, making it simple to match the question type (e.g., multiple choice, matrix of selections) to the question design. The implementation of “skip logic” is also easily accomplished, ensuring that the participant follows the correct path through the series of questions. The survey can be previewed and pilot-tested in this environment by multiple stakeholders, with all responses centralized and immediately available, and none of the limitations imposed by time and geography.

The online format supports the rapid initiation and closing of the survey, with multiple options for engaging participants. The survey itself can be accessed by the participant using the survey link. Only potential participants will receive the survey link and password. The approach supports monitoring and controlling of the technological aspects of the survey administration by the BHITS project team members, which also supports data integrity.

The security and privacy of this online survey tool was also assessed. SurveyMonkey is most able to address these concerns when compared to other “free” online tools available. For example, the SurveyMonkey business model is not based on archiving and then selling participant information and survey data. It is based on upselling the free product to a paid subscription version. It is its own business entity, not a subsidiary of a corporate entity that sells data collected through their “free” online service. In addition, it is a member of the privacy-seal program “Truste”⁷ and is self-certified to the U.S.-E.U. Safe Harbor standards.⁸

There are also specific activities the BHITS project team will take to better ensure participant security and privacy. For example, SurveyMonkey allows the end-user to send invitations via a participant email list inputted into their system. But this would make the participants somewhat more vulnerable to SPAM and other types of unwelcome email. We will protect participant information by emailing the invitations via the BHITS project team organization member with primary responsibility for managing the data.

Access to the data is another important consideration. The ability to generate reports from the data defines the overall utility of the data collected. SurveyMonkey helps the novice develop a wide range of different types of reports for organizing and interpreting the data. This allowed the BHITS project team to develop a data analysis plan as a component of survey development. The level of effort that is usually expended in organizing and analyzing data is minimized, and the resources that will be necessary are easily anticipated. The effort of skilled data analysts will be better spent in implementing the plan for the manipulation and analysis of the data, rather than developing sets of queries and “scrubbing” the database contents to ensure meaningful answers.

A.4. Efforts to Identify Duplication and Use of Similar Information

Efforts to identify duplication were implemented before and during the survey design. BHITS project team members conducted a literature search to confirm the absence of data collection efforts concerning the type of data this survey will collect. The search guided the identification and selection of two types of questions used in previous surveys. The first type of question concerned behavioral healthcare providers, but did not address the survey topic area of HIT. The second type of question addressed some aspect of the use of HIT, but did for other types of healthcare providers and not behavioral health. These two types of questions were collected into a single workbook. Modifications to the original questions were developed by the BHITS project team in a series of iterative teleconferences. The modifications tailored the data collection to answering the research questions.

The original sources for the survey questions were documented in this workbook. To fill persistent gaps not addressed by either type of survey questions, the BHITS project team created

⁷ Truste Data Privacy Management. Retrieved January 2015 from <http://www.truste.com/about-TRUSTe/>

⁸ The U.S.-EU Safe Harbor List. Retrieved January 2015 from <https://safeharbor.export.gov/list.aspx>

unique questions specific to the area of interest. The resulting final set of survey questions collect data that are unique to the topic area and to the survey population, while retaining a degree of comparability to previous data collection activities regarding either behavioral health or health information technology. This approach supports both the quality and the usability of the data collected.

A.5. Involvement of Small Entities

Participation in this survey will not impose a significant impact on small entities.

A.6. Consequences if Information Collection is Not Conducted or is Conducted Less Frequently

The data collected by the survey will play a vital role in operationalizing the identified strategic initiatives by providing baseline information on the adoption of HIT by a representative subset of SAMHSA grantees from each of the three SAMHSA Centers; that is, the Center for Mental Health Services (CMHS), CSAT, and the Center for Substance Abuse Prevention (CSAP). It will be used to guide efforts to promote future appropriate use of health information technologies. If the data are not collected, the knowledge gap regarding the adoption of health information technologies will persist. The agency will lack the baseline information needed to effectively and efficiently operationalize the identified strategic initiatives.

A.7. Consistency With the Guidelines in 5 CFR 1320.5(d)(2)

This data information collection complies full with 5 CFR 1320.5(d)(2).

A.8. Consultation Outside the Agency

The notice soliciting public comment on this survey data collection, required in 5 CFR 1320.8(d), was published in the *Federal Register* on March 17, 2015, (80, FR 13867). One set of comments was received, see Attachment 7. Responses to those comments are in Attachment 8.

The SAMHSA survey of grantee use of HIT represents a cross-center collaboration among the SAMHSA Centers, including the Center for Substance Abuse Treatment (CSAT), the Center for Mental Health Services (CMHS), the Center for Substance Abuse Prevention (CSAP), and the Center for Behavioral Health Statistics and Quality (CBHSQ). Although the survey is a CBHSQ and CSAT-led effort, input was obtained by each of the SAMHSA Center Directors and other SAMHSA stakeholders during the development of the survey. The process was informed by their comments on both the survey design and the survey questions.

A.9. Payment to Respondents

No payment, cash incentives, or gift will be provided to respondents for participation in either the survey pilot or the administration of the survey itself.

A.10. Assurance of Confidentiality

The survey does not collect data that requires assurances of confidentiality. Therefore, the participants will not receive this assurance. In order to support candid and complete responses, the BHITS project team will inform participants that the survey report will not identify or associate any individual response with a specific grantee. Responses will be analyzed and the analysis presented on groupings of aggregate data. In the event that an individual response is used to illustrate these data, it will not be attributed to a specific grantee or organization.

A.11. Questions of a Sensitive Nature

No questions of a sensitive nature will be included in the BHITS data collection.

A.12. Estimates of Annualized Hour Burden

Part Description of the Collection Activity

The duration of the survey was confirmed in a small pilot study of nine (9) volunteers selected from the universe of respondents. The pilot study protocol, associated documents and schedule are organized as Attachment 4—Survey Pilot Protocol. The data to be collected is readily available, and does not require the participant to gather information, search data sources, conduct research, or review information.

Please refer to the table below for the estimated annual hour burden, calculated by estimating the average amount of time the survey will take; the number of respondents; and the frequency of response.

Type of Grantee or Respondent	Number of Respondents	Number of Responses Annually per Respondent	Total Responses	Average Hours per Response	Total Burden Hours	Hourly Wage	Total Hour Cost
SBIRT	18	1	18	.4	7.2	\$31.51	\$226.87
TCE/TAC	17	1	17	.4	6.8	\$31.51	\$214.27
Offender Re-entry Program	13	1	13	.4	5.2	\$31.51	\$163.85
PBHCI	89	1	89	.4	35.6	\$31.51	\$1,121.84
NCTSI	56	1	56	.4	22.4	\$31.51	\$705.82
Suicide Lifeline Crisis Center Follow-up	12	1	12	.4	4.8	\$31.51	\$151.25
Garret Lee Smith Youth Suicide Prevention Program	56	1	56	.4	22.4	\$31.51	\$705.82
MAI	113	1	113	.4	45.2	\$31.51	\$1,424.25

Total of Annual Responses	374		374		149.6		\$4,713.98
----------------------------------	-----	--	-----	--	-------	--	------------

Estimates of Annualize Cost to Respondent for the Hour Burdens for Collections of Information Using Appropriate Wage-Rate Categories

The data for calculating the Annualized Cost to Respondents for the Hour Burdens for Collections of Information is drawn from the Bureau of Labor Statistics Occupational Employment and Wages, May 2013. The Wage-Rate Category is “11-9151 Social and Community Service Managers.” The description states that workers in this category “plan, direct, or coordinate the activities of a social service program or community outreach organization. Oversee the program or organization's budget and policies regarding participant involvement, program requirements, and benefits. Work may involve directing social workers, counselors, or probation officers.” This category describes the targeted group for responding to the survey. The mean hourly wage for this group is 31.61.⁹

The survey will be administered electronically over the Internet using a product (SurveyMonkey) that is well known and available to the public at no cost. The interface is user-friendly and often familiar to participants. With the exception of text fields for the participant to enter their name and contact information, questions do not require data entry. Answers are instead selected through multiple choice. The participant will select answers using radio buttons (when answer selections are mutually exclusive) and check boxes (when more than one selection is allowed). There is a text field available in each section for the participant who wants to include comments, but this is offered as a courtesy to the participant, since the question answers provide the data needed. The paper-based version of the survey instrument is included as Attachment 1—Survey Instrument.

A.13. Estimates of Total Cost Burden to Respondents

There are no respondent costs for capital, start-up, operations, or maintenance associated with this data collection.

A 14. Estimates of Annualized Cost Burden to Government

The total estimated cost to the government for the data collection is \$662,747. This includes approximately \$606,427 to a contractor over a 2-year period for developing the instruments and other aspects of the data collection protocol; programming and maintaining the online data collection system; providing data collection training to grantees; processing, cleaning, and housing data; and analyzing and reporting data. Approximately \$28,320 per year represents SAMHSA’s costs to manage/administer the data collection and analysis (10% of two employees). The total annualized cost for this data collection is approximately \$331,374.

⁹ Bureau of Labor Statistics, Occupational Employment and Wages, May 2013. Retrieved January 2015 from <http://www.bls.gov/oes/current/oes119151.htm>

Survey Design, Data Collection, Data Processing and Creation of the Analytic Data File.

These activities include the design of the survey including the data collection instrument, management of the sample frame, and development of a web-based version of the survey; development of all communication materials to potential respondents; development and implementation of a system for tracking and monitoring response status throughout the data collection period; procedures for communication with non-respondents during the data collection period; ongoing review of the data collected throughout the data collection period; and, creation of the analytic file.

Preparation of Survey Report. A report will be developed that provides an overview of the methods used to collect the data including the response rate and completeness of the data along with the key findings from the survey. This report will be distributed throughout the Agency.

Contract Monitoring. The cost for SAMHSA staff charged with monitoring the contract and carrying out related work is estimated.

A.15. Changes in Burden

This is a new collection of information.

A.16. Time Schedule, Publication and Analysis Plans

A.16.a. Time Schedule

The time schedule for this data collection activity will be linked to the date of approval from OMB (“Approval Date”.) All dates are in calendar days.

Activity Time Schedule	
Activity	Completion Date from Approval Date
Advance letter mailing	+10 days
First email to potential respondents, including instructions about how to complete survey on the Internet	+ 20 days
Reminder email to non-responders (2 weeks)	+ 34 days
Second reminder email to non-responders (5 weeks)	+55 days
Final reminder email to non-responders (7 weeks)	+69 days
Data collection period closed (60-day period)	+ 80 days
Thank you notification to survey respondents	Ongoing throughout data collection
Development of analytic data file	+100 days

Analytic report	+ 140 days
-----------------	------------

A.16.b. Analyses and Publications

It is anticipated that the data collection will be collected between August-October of 2015.

Information collected for this project will be used to directly impact SAMHSA’s performance measurement activities that are designed to support the HIT Strategic Initiative.

Data collection for this project will provide valuable information that may inform the literature on HIT. SAMHSA plans to disseminate information in report and or publications. The publications will not intend to make broad generalizations about behavioral health provider use of HIT. Rather, the information will describe the use of various types of HIT among SAMHSA grantees.

A.17. Display of Expiration Date

The expiration date for OMB approval will be displayed on all data collection instruments.

A.18. Exceptions to Certification Statement

This collection of information involves no exceptions to the Certification for Paperwork Reduction Act Submissions. The certifications are included.