

**Behavioral Health Information Technologies and Standards  
In-Depth Qualitative Data Collection Activities**

**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 Budget (OMB) for in-depth, qualitative data collection activities for SAMHSA’s Behavioral Health Information Technologies and Standards (BHITS) initiative.

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 to capitalize on emerging opportunities to improve behavioral health services delivery systems. 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.

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 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 use of health information technologies and participation in the exchange of health information can be addressed with tools that are fully compliant with Federal and state rules and regulations. Recent advances in health information technologies and the exchange of patient health information 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.<sup>1</sup>
- “Consent2Share” is a freely available, open source module that builds on the Data Segmentation for Privacy Standards.<sup>2</sup> 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.<sup>3</sup>

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 technologies does not necessarily lead to its widespread adoption and use.

There are several data collection-related activities under the SAMHSA BHITS initiative. One of these tasks includes conducting a survey of 374 SAMHSA-funded grants across eight (8) grant programs, which is pending at OMB. The survey participant responses will generate quantitative data on behavioral health provider adoption of a range of health information technologies, including social media, mobile health, telehealth and certified electronic health records (EHRs).

To complement the abovementioned survey, SAMHSA is proposing to conduct two separate qualitative data collection activities - ten (10) focus groups and ten (10) site visits - to further assess the current state of health information technology adoption and use practices among behavioral health providers. The proposed formats permit an in-depth exploration of the key issues.

Together with the survey, the focus groups and site visits proposed in this application will inform the agency’s “Strategic Initiative (5) Health Information Technology” which supports the inclusion of the behavioral health system in health information technologies and exchange by:

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

The focus groups and site visits will support this initiative by collecting qualitative data on the nature of the how behavioral health information technologies are being adopted and used among behavioral health providers and the priorities they have identified in this area. These data, vital to

---

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

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

<sup>3</sup> 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>

SAMHSA planning and implementation activities in this area, are not otherwise available. Conducting the proposed data collection activities will:

- Provide in-depth information from behavioral health providers selected for their direct experience in implementing various types of health information technologies
- Enhance SAMHSA’s understanding of the technologies available to grantees and why and how they are used
- Identify the barriers and challenges behavioral health providers face along the continuum of participation in and use of health information technologies, including the electronic exchange of patient health information among a network of primary and specialty care providers
- Highlight behavioral health programs with recognized success in the adoption of information technologies by detailing how and why these technologies were implemented and used

The qualitative data collected by the site visits and focus group activities will also indirectly support the implementation of SAMHSA’s Strategic Initiative (2) Health Care and Health Systems Integration. This initiative supports coordinated care and services across health care systems through the electronic exchange of patient health information. This exchange is central to improving the effectiveness, efficiency and quality of healthcare in the United States.<sup>4</sup> Exchange is facilitated by a network of health care providers using certified electronic health records to implement models of coordinated and collaborative care. The in-depth qualitative data collection activities will provide needed information to populate gaps in understanding regarding the capacities for behavioral health providers to participate in electronically networked systems of integrated care.

## **A.2. Purpose and Use of Information**

Data on the use of health information technologies by community-based public health care “safety-net” providers indicate that behavioral health 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; however, there are strong indications that this expansion and growth bypassed the national behavioral health provider system.

The initial impact of the exclusion of behavioral health from various funding mechanisms was documented as early as 2012, in the “Health Information Technologies Adoption and Readiness for Meaningful Use in Community Behavioral Healthcare” report on a survey of National Council for Behavioral Health members.<sup>5</sup> This report found that only 2 percent of behavioral health organizations had the capacity to use certified electronic health record technology to meet the standards for the “Eligible Professional Incentive Program,” also known as “Meaningful Use” of patient health information. At that time, 27 percent of Federally Qualified Health

---

<sup>4</sup> Health Information Exchange (HIE). Retrieved 5/21/2015 from <http://www.healthinformationtechnologies.gov/HIE>

<sup>5</sup> National Council for Community Behavioral Health. 2012. “HIT Adoption and Readiness for Meaningful Use in Community Behavioral Healthcare.” Retrieved January 2015 from <http://www.thenationalcouncil.org/wp-content/uploads/2012/10/HIT-Survey-Full-Report.pdf>

Centers (FQHCs) and 20 percent of hospitals were already meeting at least some of these standards.

Concern that the “digital divide” not only persists but has widened can be partially demonstrated. Data are readily available on the current adoption rates of certified electronic health records by hospitals, primary care physicians and FQHCs. For example, we are able to say that between 2009 and 2013, adoption of certified electronic health record technology by FQHCs increased by 133 percent, from around 30 percent to 93 percent.<sup>6</sup> At least 78 percent of all office-based physicians and about 60 percent of hospitals also made the transition.<sup>7</sup>

Since these data are not collected on behavioral health providers, it is not possible to assess behavioral health provider progress in adopting and using certified electronic health records and other healthcare-related technologies. It is also not possible to describe the nature of the barriers and challenges providers face or offer assistance to effectively plan for the future.

### **Focus Group Research Topics and Discussion Questions**

The qualitative data collection effort for the focus group session will collect in-depth information to inform the following proposed topical research areas:

- 1) Health information technology priorities for behavioral health providers in the areas of certified electronic health record technology, telehealth, mobile health, and social media.
- 2) Organizational and system drivers for identifying priorities.
- 3) Most significant challenges experience by behavioral health providers in addressing health information technology priorities.
- 4) Behavioral health providers’ perceptions of SAMHSA’s role in addressing HIT-related planning and implementation priorities.
- 5) Specific actions that SAMHSA might take to assist in addressing these challenges.

The general discussion questions that will be explored with the focus groups mirror these topical research areas:

- 1) What kinds of processes does your organization engage in for identifying health information technology priorities?
- 2) When your organization is identifying health information technology priorities, what factors typically influence the decisions you make?
- 3) What kinds of barriers and challenges does your organization encounter when addressing health information technology priorities?
- 4) How do SAMHSA-funded grant programs and initiatives help your organization meet these health information technology priorities?

---

<sup>6</sup> 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](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2014/May/1746_Ryan_adoption_use_hlt_IT_CHCs_rb.pdf)

<sup>7</sup> 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>

- 5) How might SAMHSA best help your organization meet its health information technology priorities in the future?

Focus group moderators will ask general, specific, and probing questions to explore the abovementioned proposed topical areas. The discussion for each focus group will be recorded, transcribed, and indexed (coded) for thematic analysis, including anticipated and emerging themes. The analyses categories will also be cross-referenced for discovery of commonalities and differences in themes, particularly by geographic setting.

Participant inclusion criteria will be matched for level of influence – that is, the focus group participants will be recruited from behavioral health provider organizations.

The financing mechanisms for health information technologies and health information exchange largely excluded behavioral health providers, focus group participants may not have sufficient information about the kinds of technologies available or the understanding necessary to drive sophisticated demand for health information technology tools. For this reason, a “meta-level” thematic analysis is also planned. This analysis anticipates the emergence of themes related to provider limitations in knowledge and understanding about health information technologies.

See Attachment 4 “Focus Group Materials” for details.

### **Site Visit Research Questions**

The proposed qualitative data collection effort for site visits will collect in-depth information to develop a set of case studies to serve as examples of how behavioral health providers may successfully adopt and use different types of health information technologies, including certified electronic health records technologies, telehealth, mobile health and social media.

The word “exemplary” means worthy of imitation and serving as a model or pattern. In this context, the effort will identify “exemplary” practices in the adoption and use of health information technologies among behavioral health providers. SAMHSA-funded grant program nominations will be made by the SAMHSA Government Project Officers and SAMHSA BHITS Task Leaders. The nominations will be screened by subject matter experts at the National Council for Behavioral Health, the trade association for behavioral health providers. The screening will review the adoption and use of the technologies over five categories, assigning scores of “High,” “Medium,” or “Low.” The ratings will be assigned according to the behavioral health providers’ effective and efficient leveraging of resources to make the most out of technology to:

- Address drivers for adoption
- Implement methodology for planning, adopting and using the technology
- Address challenges and barriers encountered
- Ensure quality, availability and utility of the data
- Address financing and sustainability issues

The abovementioned categories frame the proposed topical outline for the individual case studies template to be used for site visit data collection and analysis. Each category contains a range of descriptors that enumerate the types of information to be gathered within that category.

Data from the site visits will be coded and analyzed using a qualitative, mixed-method approach, with the five categories and their descriptors serving as parent and child themes, respectively. This approach will support identification of specific themes across all types of technologies and geographic settings, along with individual thematic analysis of the case studies themselves.

See Attachment 3 “Site Visit Materials” for details.

### **A.3. Use of Information Technology**

Focus group participants will be made aware in advance that meetings will be recorded (audio only). Focus group participants will be informed that, although final report materials will not attribute content to individuals or organizations, SAMHSA will maintain ownership of the database used to collect, organize, and analyze the data.

Site visit participants will also be made aware of the fact that information shared during the site visit about the exemplary adoption and use of health information technologies will be entered into a database for thematic analysis. SAMHSA will maintain ownership of this database.

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

Efforts to identify duplication were implemented before and during the design of the qualitative data collection research questions. A literature search was conducted to locate materials identifying and discussing behavioral health provider concerns regarding health information technologies (focus groups topic area) and health information technologies adoption and use successes (site visits topic area).

In regard to the focus group activities: Materials that reliably identify, discuss and offer insight into the issues and concerns of behavioral health providers from the perspective of these providers are not available.

In regard to site visit activities: Although some of the proposed sites have been recognized for their health information technology efforts, initiatives as a whole have not been studied or researched. There are no reliable, centralized sources of information on the topic of exemplary adoption and use of different types of health information technologies by behavioral health providers.

There are no research studies underway that delve into these topic areas.

### **A.5. Involvement of Small Entities**

Participation in the in-depth qualitative data collection activities 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 focus groups and site visits will play a vital role in operationalizing identified strategic initiatives by providing in-depth information on adoption practices by a selected subset of SAMHSA grantees from each of the three SAMHSA Centers; that is, CSAT, the Center for Mental Health Services (CMHS), and the Center for Substance Abuse Prevention (CSAP). Data will be used to guide efforts to promote future health information technology implementation strategies. If the data are not collected, the knowledge gap regarding health information technology adoption will persist. The agency will lack the 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 in full with 5 CFR 1320.5(d)(2).

#### **A.8. Consultation Outside the Agency**

The notice soliciting public comment on these in-depth qualitative data collection activities, required in 5 CFR 1320.8(d), was published in the *Federal Register* on July 28, 2015, (80, FR 44982).

The in-depth qualitative examination of health information technology adoption by the behavioral health community represents collaboration across 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 this initiative is a CBHSQ and CSAT-led effort, input was obtained by each of the SAMHSA Center Directors and other SAMHSA stakeholders. The process was informed by comments on both question design and participant selection. In addition, 9 semi-structured interviews were completed to inform both the focus group and site visit questions.

#### **A.9. Payment to Respondents**

No payment, cash incentives, or gifts will be provided to individuals participating in the focus groups or site visits.

#### **A.10. Assurance of Confidentiality**

The focus groups and site visits do not collect data that require assurances of confidentiality. Therefore, the participants will not receive this assurance. The nature of the in-depth qualitative data collection activities warrant identification of the individuals and groups participating in the sessions.

#### **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**

Focus Groups:

This project will complete ten (10) in-person focus group sessions of 90 minutes in duration. The focus group format was selected to gather qualitative data in a structured, directive manner that supports the expression of various opinions and needs.

The main purpose of the focus groups is to gather information on the behavioral health provider's perspective on the adoption and use of health information technologies. Questions will elicit discussion on organizational priorities and facilitators and barriers encountered. The research questions will provide data on the extent to which behavioral health providers are responding to the emergence of information technologies in the field of health care, despite their exclusion from the financing and technical assistance mechanisms available to other types of public health care providers.

Participants will include organizational leadership from behavioral health providers in all 10 SAMHSA regions. The number of participants in each focus group will be limited to no less than six (6) and no more than eight (8) individuals.

The information to be collected during the focus group sessions is readily available to the participants and will not require participants to gather or review additional information, search data sources, or conduct research outside of the time allocated for the focus group session.

#### Site Visits:

This project proposes completing up to ten (10), in-person site visit sessions. The site visits will be used to collect in-depth, detailed information on exemplary adoption and use of health information technologies by behavioral health providers.

The site visit sessions will be no more than eight hours in duration. The invitation will request the participation of individuals, identified by the organization as most capable of speaking to the financial, practice management, and operational (clinical services) aspects of the technology adopted. The site will identify staff who are in the best position to address each of these areas. The visit will include, on average two (2) participants at any one time.

Please refer to the table below for the estimated annual hour burden calculated by estimating the amount of time the focus groups and site visits will take; the number of participants; and the frequency of response.



Focus Group and Site Visit Estimated Annual Hour Burden:

Activity	Number of Respondents	Number of Responses Annually per Respondent	Total Responses	Average hours per Response	Total Burden Hours	Hourly Wage	Total Costs
Focus Groups	80	1	80	1.5	120 hours	\$86.88	\$10,425.60
Site visits	20	1	20	8.0	160 hours	\$32.56	\$5,209.60
TOTAL	100		100		280		\$15,635.20

**Estimates of Annualize Cost to Participants 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 2014.

The Wage-Rate Category for site visits 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; and work may involve directing social workers, counselors, or probation officers.” This category accurately describes the targeted group to participate in the site visits. The mean hourly wage for this group is \$32.56.<sup>8</sup>

The Wage-Rate Category for focus groups is “11-1011 leaders.” The description states that workers in this category “Determine and formulate policies and provide overall direction of companies or private and public sector organizations within guidelines set up by a board of directors or similar governing body. Plan, direct, or coordinate operational activities at the highest level of management with the help of subordinate executives and staff managers. This category accurately describes the targeted group to participate in the focus groups. The mean hourly wage for this group is \$86.88.<sup>9</sup>

The focus groups and site visits will be conducted in-person and will not require significant preparation efforts on behalf of participants beyond determining the most appropriate

<sup>8</sup> Bureau of Labor Statistics, Occupational Employment and Wages, May 2014. Retrieved June 2015 from <http://www.bls.gov/oes/current/oes119151.htm>

<sup>9</sup> Bureau of Labor Statistics, Occupational Employment and Wages, May 2014. Retrieved June 2015 from <http://www.bls.gov/oes/current/oes111011.htm>

representatives to attend the sessions. Site visit participants will be asked to attend the full site visit session. See Attachment 5 “Site Visit Materials” for more details.

**A.13. Estimates of Total Cost Burden to Respondents**

There are no participant costs for capital, start-up, operations, or maintenance associated with this data collection effort. Travel costs to participate in the focus group and site visit sessions will be covered by the contractor assigned to complete the tasks.

**A.14. Estimates of Annualized Cost Burden to Government**

The total estimated cost to the government for the data collection is \$554,071. This includes approximately \$525,742 to a contractor over a two-year period for planning, developing the instruments and other aspects of the data collection protocol; conducting the actual data collection including both site visits and focus groups; coding and housing the qualitative data; and analyzing and reporting data. Approximately \$28,329 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 \$277,036.

**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 data collection.

**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.

<b>Activities Time Schedule</b>	
Implement meeting planning and logistics activities	Month 1
Focus Groups 1 and 2, Site Visits 1 and 2	Month 2
Focus Groups 3 and 4, Site Visits 3 and 4	Month 3
Focus Group 5 and 6, Site Visits 5 and 6	Month 4
Focus Groups 7 and 8, Site Visits 7 and 8	Month 5
Focus Groups 9 and 10, Site Visits 9 and 10	Month 6
Submit Focus Groups and Site Visits final reports	Month 7

**A.16.b. Publications {SAMHSA PLANS FOR PUBLISHING}**

It is anticipated that the data will be collected between February and September of 2016.

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 behavioral health providers, including SAMHSA grantees.

#### **A.16.c. Analysis Plans**

It is anticipated that the data collection activities will be conducted between February 2016 and August 2016. Scheduling of the focus group and site visit sessions will be synchronized in order to maximize resources, as noted in Section A.16.a. Development of the analysis materials will begin at the conclusion of each event. Analysis will occur on an ongoing basis to shorten the amount of time needed for producing final analyses and reports.

Information collected in this project will be used to directly impact SAMHSA's performance measurement activities designed to support the Health Information Technology Strategic Initiative, and the Strategic Initiative on Health Care and Health Integration.

Data collection for this project will provide valuable information that may inform the literature on behavioral health provider priorities concerning health information technologies from the perspective of the providers themselves. It will also provide detailed, individual case studies of how these technologies are already being adopted and used by leaders in the field. SAMHSA plans to disseminate information in reports and or publications. The publications will not intend to make broad generalizations about behavioral health provider use of health information technologies. Rather, the information will describe the use of various types of health information technologies 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.