

Health IT Adoption and Interoperability across Behavioral Health Organizations

SUPPORTING STATEMENT

A. JUSTIFICATION

A.1. Circumstances That Make the Collection of Information Necessary

Purpose

Substance Abuse and Mental Health Services Administration (SAMHSA) and Office of the National Coordinator for Health IT (ONC) are jointly conducting a survey of SAMHSA grant programs that have been identified by SAMHSA as potentially benefiting from the use of health IT. For SAMHSA the goals of the survey are to assess the overall use of health IT and interoperability *across* multiple behavioral health grant programs which have been identified as potentially benefiting from health IT. SAMHSA also seeks to examine variation in use of health IT and interoperability between and within behavioral health grant programs. For ONC, the goal is to advance the measurement of health IT and interoperability among behavioral health care providers by using this survey to identify questions to include in future national surveys to be conducted in partnership with SAMHSA. Additionally, although this survey is not generalizable nationally, ONC will benefit from insights into the use of health IT and interoperability across these grant programs that have the potential to benefit from the use of health IT.

ONC requests OMB approval to conduct a new 0990 data collection for this project entitled, “Health IT Adoption and Interoperability across Behavioral Health Organizations.” Section 301 of the Public Health Service Act (42 U.S.C.241) provides ONC the authority to support this data collection effort.

Background

Mental health and substance abuse disorders are prevalent and costly to treat. In 2014, there were an estimated 9.8 million adults aged 18 or older in the United States with a serious mental illness (SMI) and an estimated 20.2 million adults with a substance use disorder (SUD).¹ These individuals have health care costs that are 75% higher than those without a mental health diagnosis. Most of the individuals diagnosed with SMI and/or SUD also have at least one chronic physical health condition,² such as hypertension, diabetes, obesity, or cardiovascular disease. These co-occurring health concerns may be inadequately treated in expensive or inappropriate settings (e.g., emergency departments, jails), resulting in greater costs.²

Enabling greater care coordination is critical to effectively treating these conditions, particularly those that straddle the behavioral and physical health settings. In a recent review of seven state-level studies, there were consistent findings showing higher medical costs

¹ Hedden, S., Kennet, J., Lipari, R., Medley, G., Tice, P. “Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health.” Substance Abuse and Mental Health Services Administration. Retrieved December 2016 from <http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.htm>

² NASMHPD Research Institute, Inc. . The Un-coordinated Costs of Behavioral and Primary Health Care: An Analysis of State Studies. 2015.

and greater use of intensive, more expensive settings under uncoordinated care for behavioral health care clients.³ Furthermore, efforts to integrate behavioral health and primary care settings seek to enhance coordination between the physical and behavioral health settings in order to improve health outcomes and provide delivery of care that is more cost-effective.

The nation’s strategy for reducing these costs partially relies on the coordination of care, enabled by the electronic exchange of patient health information, and the adoption of health information technology (health IT)⁴. Section 6005 of the 21st Century Cures Act calls for SAMHSA to develop a strategic plan that will identify strategic priorities, goals, and measurable objectives for mental and substance use disorder activities and programs, and identify ways to improve program quality. The adoption and use of health IT and greater interoperability will likely be critical to many of these strategic priorities. Behavioral health organizations are realizing the importance of health IT to enabling care coordination. Care coordination was among the top reasons (81%) cited among SAMHSA grantees for adopting certified EHRs in 2015.⁵

Improving interoperability and exchange across behavioral health settings is also a key component of national efforts to improve interoperability more broadly. To evaluate progress of these efforts, it is critical to measure interoperability across these settings. In 2015, The ONC issued *Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap*⁶ (known as the Interoperability Roadmap) which lays out the milestones, calls to action and commitments for public and private stakeholders to work together to achieve interoperability. As part of this Interoperability Roadmap, there is a call to measure and report on the state of interoperability across the care continuum, including for behavioral health care providers. This will help ONC report on progress related to interoperability across a spectrum of providers that are along the care continuum. Given the important role that behavioral health care providers play within the care delivery system, assessing their current levels of interoperability has been identified as a near-term priority (2015 to 2017) by the Interoperability Roadmap. Furthermore, in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), (Pub. L. No. 114–10, Section 106(b) (1) (C), enacted April 16, 2015), Congress declared it a national objective to achieve widespread exchange of health information through interoperable certified electronic health record (EHR) technology nationwide by December 31, 2018.

Measurement of health IT and interoperability across physician and hospital settings uses a robust set of comparable measures. National surveys that are conducted on an annual basis have been in place to measure and report on health IT adoption and interoperability across physicians and hospital sectors.^{7,8,9,10} A common set of measures developed by ONC are used across hospital and physician settings to report on health IT adoption and interoperability. These

³ **ibid**

⁴Substance Abuse and Mental Health Services Administration (SAMHSA). “Health Care and Health Systems Integration.” Retrieved December 2016 from <http://www.samhsa.gov/health-care-health-systems-integration>

⁵ National Council for Behavioral Healthcare. Use of Health Information Technology in Grant Programs Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). December, 2015.

⁶ <https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf>

measures were based upon concepts considered high priority to measure in the Interoperability Roadmap. The interoperability-specific domains include examining the proportion of providers who electronically send, receive, find (query), and integrate information in their electronic health records (EHRs without special effort, such as manual entry). In addition to measuring interoperability, assessing whether interoperability results in information being more readily available and used for clinical decision-making is also considered important to measure. The measures previously used to assess health IT adoption and exchange across behavioral health care settings in other surveys (OMB No. 0930-0352, OMB No. 0930-0106, OMB No. 0930-0119) conducted by SAMHSA are not consistent with these concepts, and how ONC is reporting on progress related to interoperability. To address these measurement gaps and inconsistencies, ONC is partnering with SAMHSA to develop measures consistent with how ONC is measuring health IT adoption and interoperability across other settings. This will allow for a more valid assessment of progress that can be compared across health care sectors.

In contrast, health electronic adoption and electronic exchange of health information has been measured in a limited manner across behavioral health settings. In 2015, the rate of health IT adoption among certain types of behavioral health settings and providers lagged behind that of physicians and hospitals. Based on a 2015 ONC sponsored national survey of physicians working in ambulatory care settings conducted by the National Center of Health Statistics, the National Electronic Health Record Survey (NEHRS) (OMB No. 0920-1015), psychiatrists' adoption of certified EHRs was significantly lower than physicians nationally (41% vs. 78%, $p < 0.05$).¹¹ In 2015, based upon a nationally representative survey of hospitals conducted by the American Hospital Association (AHA), ONC conducted analyses that found psychiatric hospitals rates of basic EHR adoption (15% vs. 84%, $p < 0.05$) were also significantly lower.¹² However, these only represent a few types of behavioral health care providers nationally. With regards to interoperability, several different methods of electronic exchange were measured in 2015 among SAMHSA grantees. Forty-four percent of SAMHSA grantees in behavioral health settings used DIRECT secure messaging and 38% participated in a health information exchange (HIE). Among those that had adopted a certified EHR, about 3 in 10 used a certified EHR to share patient health information among a network of providers in order to coordinate care. However, these are not the only methods available to enable exchange. As previously described, these measures of exchange are not consistent with how ONC has been measuring and reporting on interoperability in other settings.

⁷ Henry, J., Pylypchuk, Y., Searcy T. & Patel V. (May 2016) Adoption of Electronic Health Record Systems among U.S. Non-Federal Acute Care Hospitals: 2008-2015. ONC Data Brief, no.35. Office of the National Coordinator for Health Information Technology: Washington DC.

⁸ Patel V., Henry J., Pylypchuk Y., & Searcy T. (May 2016) Interoperability among U.S. Non-federal Acute Care Hospitals in 2015. ONC Data Brief, no.36. Office of the National Coordinator for Health Information Technology: Washington DC.

⁹ Patel V., Pylypchuk Y., Henry J., & Searcy T. (July 2016) Variation in Interoperability among U.S. Non-federal Acute Care Hospitals in 2015. ONC Data Brief, no.37. Office of the National Coordinator for Health Information Technology: Washington DC.

¹⁰ Heisey-Grove, D., Patel, V., Searcy, T. (September 2015) Physician electronic exchange of patient health information, 2014. ONC Data Brief, no. 31. Office of the National Coordinator for Health Information Technology: Washington DC.

¹¹ Yang N, Hing E. Table of Electronic Health Record Adoption and Use among Office-based Physicians in the U.S., by Specialty: 2015 National Electronic Health Records Survey. 2017.

¹² Henry, J., Pylypchuk, Y., Searcy T. & Patel V. (May 2016). Adoption of Electronic Health Record Systems among U.S. Non-Federal Acute Care Hospitals: 2008-2015. ONC Data Brief, no.35. Office of the National Coordinator for Health Information Technology: Washington DC.

Thus, there is a need for a more comprehensive assessment that is consistent with how ONC is measuring interoperability across other sectors. ONC has been measuring interoperability in terms of providers' engagement in 4 domains: electronically sending, receiving, finding (or querying), and integrating health information into EHRs or other systems. ONC proposes to measure behavioral health care providers' engagement across these 4 domains using established measures that will be used to report to Congress on progress related to interoperability.^{13,14} However, these measures need to be developed and tested within behavioral health settings prior to inclusion on a national survey. Additionally, although not nationally representative, these diverse set of SAMHSA grantees would provide useful insights on how health IT is used in settings that have the potential to benefit from its use.

A.2. Purpose and Use of Information

Goal 1: Use Grantee Survey to Enhance Future Health IT Measurement Efforts

ONC and SAMHSA have developed measures that align with both the Interoperability Roadmap and are consistent with the manner in which EHR adoption and interoperability are measured in other settings (ambulatory care and hospitals). ONC and SAMHSA plan to apply this standardized set of measures to a survey of SAMHSA grantees. ONC, working with SAMHSA, will also use the survey results to evaluate the applicability of the survey questions to behavioral health and substance abuse settings and refine the survey questions for inclusion in national surveys conducted by SAMHSA bi-annually on a rotating basis (OMB No. 0930-0106, OMB No. 0930-0119). ONC and SAMHSA have an Interagency Agreement in place to work on adding items to SAMHSA's national surveys (the National Mental Health Services Survey and the National Substance Abuse Treatment Services Survey). A separate modification to the OMB package for those surveys will describe the planned changes for those surveys.

Goal 2: Monitor SAMHSA Grantees Adoption of Health IT and Engagement in Interoperability

The information collected through the proposed survey will contribute to strategic efforts to improve behavioral healthcare providers' adoption and use of health IT. ONC will use these survey results to gain situational awareness of providers' adoption of EHRs and interoperability, including methods to electronically exchange health information.

For SAMHSA, the survey results will provide critical information on their grantees' state of health IT adoption and interoperability. Specifically, the results will provide the information needed to guide SAMHSA's strategic initiative in health IT.¹⁵ SAMHSA designated health IT as

¹³Fulfilling Section 106(b) (1) (C) of the Medicare Access and CHIP Reauthorization Act of 2015. https://www.healthit.gov/sites/default/files/fulfilling_section_106b1c_of_the_medicare_access_and_chip_reauthorization_act_of_2015_06.30.16.pdf

¹⁴ ONC Health IT buzzblog. Measuring Interoperability: Listening and Learning. July 1, 2016. <https://www.healthit.gov/buzz-blog/electronic-health-and-medical-records/interoperability-electronic-health-and-medical-records/measuring-interoperability-listening-learning/>

¹⁵ For further information please see: <https://www.samhsa.gov/about-us/strategic-initiatives> and

a strategic initiative in its strategic plan for 2015-2018. As outlined in the document, Strategic Initiative #5 focuses on health IT and the development and dissemination of health IT programs and resources. It provides guidance on ensuring that states, community organizations, behavioral healthcare providers, patients, peers, and prevention specialists are able to fully participate within the general healthcare delivery system in adopting health IT. This initiative promotes the use of EHRs and health information exchanges (HIEs), and other electronic training, assessment, monitoring, and recovery tools.

The grantee survey will help assess the extent to which SAMHSA's grantees are adopting EHRs, participating in HIEs and other health IT tools in accordance to this initiative. Exploring variation (qualitatively) in the achievement of these goals related to the strategic initiative can help SAMSHA better understand what technologies are available to grantees and how they are used. Such information can help identify grant programs/grantees in need of further support and those that are progressing well. Among those in need of further support the results can shed light on the barriers they face in the adoption of EHRs and in becoming interoperable. The qualitative assessments can also help inform the direction of future funding opportunity announcements. In addition, results from the survey can be used to respond to request from stakeholders interested in health IT adoption among its grantees.

A subset of grantees currently funded by SAMHSA's Center for Mental Health Services (CMHS), Center for Substance Abuse Prevention (CSAP), and CSAT will be the focus of the survey. SAMHSA's health IT strategic initiative lead selected the specific grant programs to be included in the survey to represent various types of services and providers supported by SAMHSA. The selection criteria (which is described in part B in detail) focuses on including grant programs that provide services and/or treatment directly to clients in settings would benefit from the use of health IT. Those that were excluded included grantees who did not meet the criteria (e.g., do not provide direct services (e.g. recipients of infrastructure or training grants); grant programs currently involved in an evaluation; and grants in their 4 month start-up phase We reviewed the grantees to ensure that there was no duplication in the list of grantees selected for this survey.

The data collected will also support performance measurement of the various behavioral health programs developed in relation to this initiative. Possessing data on grantees' health IT adoption, use and engagement in interoperability will allow SAMHSA and ONC to work together to make more informed decisions on how to:

- Develop behavioral health IT infrastructure that supports interoperability;
- Deliver technical assistance on the adoption and implementation of health IT and interoperability;
- Enhance efforts to support patient engagement and to improve patient outcomes

<https://www.samhsa.gov/health-information-technology>

SAMHSA also supports health IT initiatives within the behavioral health care settings independently of ONC. Thus, this data is vital to SAMHSA's planning and implementation activities in this area. For example, survey data will also indirectly support the implementation of SAMHSA's strategic initiative related to health care and health systems integration. This initiative focuses, in part, on supporting coordinated care and services across systems by using HIE and providers' use of certified EHRs to implement the collaborative care model.

The data collection effort is designed to provide insights for programmatic purposes and for the purpose of developing national survey questions. To address its program needs, SAMHSA plans to conduct exploratory analyses for the purpose of generating hypotheses related to health IT adoption and use, and exchange and interoperability. Questions that SAMHSA is interested in exploring are listed below. These questions will lead to the generation of hypotheses which can subsequently be tested, quantitatively using subsequent national surveys which SAMHSA plans to develop with ONC in the future. ONC will use the overall estimates (across grantees) along with item non-response rates to inform the future development of national survey questions.

Adoption and Use of Health IT

1. What are grantees' rates of adopting various types of health IT (EHRs, telehealth and mHealth)? How do these vary by program? By funding center?
2. What factors influence the adoption of health IT among grantees and within grant programs?
 - a. **Qualitatively explore the** ~~How do rates of adoption vary by~~ organizational and area characteristics **of participants who have and have not adopted EHR.** ~~including value-based payment and delivery system reform and participation in the Meaningful Use program?~~
 - i. Area characteristics: rural vs. urban location
 - ii. Organizational characteristics are listed in Part b of the survey. These characteristics include:
 1. Participation in value-based payment vs. not participating in value-based payment
 2. Providers participating in Meaningful Use vs. No providers participating in Meaningful Use
 3. Primary Treatment focus (substance abuse, mental health, mixture of both)
 4. Service setting
 5. Funding sources
 6. System ownership vs. not system owned
 7. IT staff on site vs. no IT staff on site
 8. Organizational size
 - b. What are the most frequently cited barriers to using EHRs?

- c. Among EHR adopters, are EHRs perceived as resulting in improved care, and how does this perception vary (by grantee program, the area and organizational characteristics listed above)?

Interoperability and Exchange of Health Information

3. What are grantees' rates of electronically sending, receiving, finding/querying and integrating key clinical information with providers outside their organization? Qualitatively explore potential reasons why rates vary by program and within programs?
4. What methods are used to electronically exchange (send or receive) key clinical information with providers outside their organization? Qualitatively explore potential reasons why rates vary by program and within programs?
5. What factors influence interoperability across grantees and by grant program?
 - a. How do rates of engaging interoperability (sending, receiving, finding, integrating) vary by organizational and area characteristics, including value-based payment and delivery system reform participation (see characteristics listed above)?
 - b. What types of services are used to enable exchange of health information, such as participation in health information exchange organizations and use of HIE specific vendors?
 - c. Qualitatively explore the most frequently cited barriers to interoperability?
6. What are the key benefits from both the client and provider perspective resulting from interoperability and exchange of health information across grantees and by grant program? These potential benefits impacting both clients and providers that we plan to measure include: quality of care, efficiency, patient safety, duplicate test ordering and care coordination.

A.3. 3. Use of Improved Information Technology and Burden Reduction

The data will be collected via an online survey. An online survey tool called 123ContactForm will be used 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 choices, 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. 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. 123ContactForm is most able to address these concerns when compared to other online tools available. In addition, 123ContactForm is hosted on Amazon Web Services, a FedRAMP officially approved product which guarantees a high level of data security and protection.

Access to the data is another important consideration. The ability to generate reports from the data defines the overall utility of the data collected. 123ContactForm allows the user to easily develop a wide range of different types of reports for organizing and interpreting the survey data. The paper version of the form is included as Attachment 3.

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

Various efforts were made to identify potential duplication. As part of the survey design, a literature search was conducted by the project team members to confirm the absence of data collection efforts related to this effort. The last survey of behavioral health care providers on the topic of health IT was conducted by SAMHSA (in partnership with the National Council for Behavioral Health) in 2015 of its grantees (OMB No. 0930-0352). Many of the survey questions have been modified to align with ONC's measurement approach as defined by the Interoperability Roadmap and its prior surveys of physicians and hospitals. However, questions in certain domains, such as telehealth and mobile health technology use remain consistent with the 2015 survey and will enable comparisons with prior survey results.

The project team developed the questions in a series of iterative teleconferences. While external stakeholders were involved with pilot testing they were not participating in the regular teleconferences. However, the National Council is a member-based organization representing many behavioral health care providers. As noted earlier, prior national survey questions used in hospital and ambulatory physician settings were modified specifically for behavioral healthcare providers to answer questions related to the interoperability of health IT and certified EHRs. This will allow for direct comparisons to findings in other settings.

The final set of survey questions collect data that are unique to the topic area and to the survey population, however, these questions retain a degree of comparability to previous data collection activities. For example, items related to use of certified EHR technology and the barriers to EHR adoption are comparable in both surveys. This approach supports both the quality and the usability of the data collected.

A.5. Impact on Small Businesses or Other 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

Consequences to federal program or policy activities

Participants will respond to the survey one-time only. The data collected will play a vital role in operationalizing the identified strategic initiatives by providing needed information on the adoption of health IT and of interoperability of systems used by behavioral health providers. If the data are not collected, the agency will lack the information needed to effectively and efficiently operationalize the identified strategic initiatives for behavioral health.

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

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

A.8. Comments in Response to the Federal Register Notice/Outside Consultation

A 60-day Federal Register Notice was published in the *Federal Register* on February 16, 2016, vol. 82, No. 31; pp. 10909-10 (see attachment 7). There were no public comments.

The National Council for Behavioral Health’s Information Technology Survey represents a cross-agency collaboration among the ONC and SAMHSA. The data collection efforts are being completed under a contract with FEi Systems, Inc. (FEi), which has a subcontract with the National Council for Behavioral Health (National Council). ONC and SAMHSA have worked with both of these entities to design the survey. The survey project team, which includes the National Council, is responsible for the data collection of the information collection. ONC and SAMHSA will be responsible for analyzing and reporting the results.

Since September 2016, ONC has consulted with the following persons regarding this information collection.

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A.9. Payment to Respondents

No payment, cash incentives, or gift will be provided to respondents for participation in the survey.

A.10. Assurance of Confidentiality

The Chesapeake IRB determined deemed this proposed data collection effort as an exempt from IRB oversight because survey does not collect data, such as personally identifiable information, that requires assurances of confidentiality. Therefore, the participants will not receive this assurance. Attached is a copy of the waiver (Attachment 6). To support candid and complete responses, the project team will inform participants that the survey report will not identify or associate any individual response with a specific individual or organization. Responses will be analyzed and the analysis presented on groupings of aggregate data.

A.11. Questions of a Sensitive Nature

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

A.12. Estimates of Annualized Hour and Cost Burden

Part Description of the Collection Activity

The duration of the survey was confirmed in a small pilot study of four (4) volunteers with the professional experience and background of the average respondent being targeted. 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 respondent	Form Name	Number of Respondents	Number of Responses Annually per Respondent	Total Responses	Average Burden per Response (in hours)	Total Burden Hours
SAMHSA grantees	National	400	1	400	.333	133.33

	Council for Behavioral Health's Information Technology Survey					
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Estimates of Annualized 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 2015. 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 (Social and Community Service Managers) is \$34.07.¹⁶ Per HHS guidance, if we incorporate overhead and benefits, this hourly wage increases by 31% to \$44.63. Thus, the total cost will be \$5,950.74 for an estimated 133.33 burden hours.

Type of Respondent	Total Burden Hours	Annual salary (adjusted to include overhead and benefits)	Annualized cost to respondents
SAMHSA grantee	133.33	\$44.63	\$5,950.74

A.13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers /Capital Costs

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

14. Annualized Cost to Federal Government

The total estimated cost to the government for the data collection is \$300,000 per year; this includes \$260,000 for a contractor to conduct the survey and an estimated \$40,000 for the

¹⁶ Bureau of Labor Statistics, Occupational Employment and Wages, May 2015. Retrieved November 2016 from <http://www.bls.gov/oes/current/oes119151.htm>

government to monitor the contractor, conduct analyses and develop reports and presentations for public dissemination. The costs include the costs for the contractor to develop the instrument and conduct other aspects of the data collection protocol; programming and maintaining the online data collection system; and processing, cleaning, and housing data.

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
OMB Expected approval date- June 16, 2017	
Email to Grantees from SAMHSA and ONC informing them about survey	+3 days (June 19 th)
First email from National Council to potential respondents, including instructions about how to complete survey on the Internet	+ 5 days (June 21 st)
Reminder email to non-responders	+ 10 days (June 26 th)
Second reminder email to non-responders	+24 days (July 10 th)
Final reminder email to non-responders	+31 days (July 17 ^h)
Telephone follow-up with non-responders	+33 days-+ 61 days (July 19 th -August 16 th)
Data collection period closed (60-day period)	+61 days (August 16 th)
Thank you notification to survey respondents	Ongoing throughout data collection
Development of analytic data file and documentation	+ 81days (September 7 th)
Quality Assurance of file and documentation	+90 days (September 16 th)
FEi Contract Period ends September 17, 2017	
Analysis and reporting by ONC and SAMHSA	91days-180 days

A.16.b. Analysis and Publication Plan

Analysis will begin shortly after data are collected from the Web-based survey. Exploratory, descriptive analyses will be conducted to generate hypotheses and provide insights to inform programs and for survey development on the questions described earlier using the grantee survey. Examples of basic descriptive analysis to report on rates of health IT adoption across the grantees and rates of electronically sending, receiving, finding and integrating data across grantees, as shown in the two tables below.

Use of Health Information Technologies by SAMHSA Grantees			
	EHR	Telehealth	Mobile Technology
Yes	%* (N)	%* (N)	%* (N)
No	%* (N)	%* (N)	%* (N)
Not applicable	(N)	(N)	(N)
Missing or Don't Know	(N)	(N)	(N)

*Percentages calculated by $(Y/(Y+N))$; those responding not applicable and missing cases are excluded from the calculation.

Engagement in Interoperability by SAMHSA Grantees				
	Send	Receive	Find or Query	Integrate into EHR
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.

The previously described questions will form the basis of various data products, including data and presentations that will be authored and published by the ONC in partnership with SAMHSA, as well as peer-reviewed manuscripts that provide more in-depth analyses of these findings using multivariate modeling (should it be possible given sample size).

The findings from these data products will help ONC provide situational awareness and guide the future evolution of the Interoperability Roadmap. It will also guide efforts within ONC to support interoperability across the behavioral health sector, such as through technical assistance and support or future funding opportunities.

Contract Monitoring. The cost for monitoring the contract and carrying out related work is estimated and included in the overall estimate.

A.17. Display of Expiration Date

The expiration date for OMB approval will be displayed on all data collection instruments for which approval is being sought.

A.18. Exceptions to Certification Statement

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