

**Supporting Statement A for
National Physician Survey of Practices on
Diet, Physical Activity, and Weight Control**

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ATTACHMENTS

- 1 Journal articles on the topics of diet, physical activity, and weight control
- 2 Statement Regarding the Privacy Act Systems of Records
- 3 Documentation of IRB Review
- 4 Data Collection Instruments
- 5 Klabunde, Frame, Meadow, *et al.*, 2003
- 6 Letters, Instructions to Respondents, and Telephone Scripts

A. JUSTIFICATION

A.1. Circumstances Making the Collection of Information Necessary

Managing obesity is one of the biggest health challenges that healthcare providers face today. Almost two thirds of the US population is now considered overweight; one-third of these are classified as obese¹. As a result of the increasing recognition given this problem, there has been a recent focus on keeping energy intake (calories) and energy expenditure (physical activity) in balance, as diet and physical activity can play a key role in combating this growing obesity epidemic. Recent studies indicate that poor weight control and sedentary lifestyles are linked to increased risk, adverse prognosis, and poor quality of life for cancer and many other chronic diseases. For example, comprehensive research summaries from the 2002 International Agency for Research on Cancer *Handbook on Cancer Prevention Weight Control and Physical Activity*² and *Cancer Prevention and Management through Exercise and Weight Control*³ indicate that obesity and physical inactivity contribute greatly to the increased incidence of many common cancers, adversely affect prognosis and mortality for several common cancers and adversely affect quality of life and outcomes among cancer survivors.

As the premier institution for cancer research at the National Institutes of Health (NIH), the National Cancer Institute (NCI) is responsible for the National Cancer Program, which consists of (1) an expanded, intensified, and coordinated cancer research program encompassing the research programs conducted and supported by the Institute, and the related research programs of the other national research institutes, including an expanded and intensified research program for the prevention of cancer caused by occupational or environmental exposure to carcinogens, and (2) the other programs and activities of the Institute. NCI's Division of Cancer Control and Population Sciences (DCCPS) aims to reduce risk, incidence, and deaths from cancer. DCCPS monitors the use of factors that have an impact on the cancer burden at the national level, working to understand the causes and distribution of cancer in the general public, support the development and delivery of effective interventions, and monitor and explain cancer trends in all segments of the population. A key research area of focus for NCI is prevention: how to understand and support practices that prevent and control cancer, particularly those cancers with high prevalence rates leading to death. The authorizing legislation for the National Physician Survey of Practices on Diet, Physical Activity, and Weight Control is in 42 USC 285.

1 Flegal KM, Carroll MD, Ogden CL, Johnson CL. Prevalence and trends in obesity among U.S. adults, 1999–2000. *JAMA* 2002; 288(14):1723–1727.

2 Vanio H, Bianchi F. International Agency for Research on Cancer. Handbooks for cancer prevention. Volume 6: weight control and physical activity. Lyon, France: IARC Press; 2002.

3 McTiernan, A (Editor). *Cancer Prevention and Management through Exercise and Weight Control*, CRC Taylor & Francis; 2005.

Primary care physicians (PCPs) play a key role in the dissemination of information about healthy behaviors and disease prevention activities, including those involving diet, physical activity, and weight control. This survey of primary care physicians will obtain current, national data on PCP knowledge, attitudes, and practices related to these health practices, also known as energy balance. The current survey will support and further the NCI, NIH, and the Department of Health and Human Services (DHHS) work to monitor and evaluate providers' cancer control knowledge, attitudes, and practices and their impact on population health. Further, it will enable monitoring of progress toward achieving DHHS goals (DHHS 20-Wide Objectives; Secretary's 500 Day Plan), and NIH obesity research plans. Finally, the study supports NCI energy balance research priorities related to improving diet, physical activity and weight control among adults and children, where physician behaviors related to these preventive services have been identified as the next priority area. Data from the survey will also be used to understand the administrative structures supporting physician practices, to identify barriers to counseling and referral, and to inform methods for improving the utilization of these services for adults and children.

Physicians belonging to the primary care specialties of family practice, obstetrics/gynecology, pediatrics, and internal medicine will be the focus of the survey. Two questionnaires are to be completed: one by the sampled physician, and a second to be completed by an office administrator. The second questionnaire, fielded to the administrator to reduce burden on the physician, will obtain information on the characteristics of the medical system and office in which the physician practices medicine. Questionnaires will be administered by mail or telephone to a randomly-selected national sample of 2,000 physicians belonging to primary care specialties.

In this document we provide supporting information for approval by the Office of Management and Budget (OMB) for survey data collection under the Paperwork Reduction Act. The primary method for data collection will be a self-administered instrument sent via Federal Express.

A.2. Purpose and Use of the Information

The purpose of this survey is to obtain current, national data on PCP knowledge, attitudes, recommendations, and practices related to diet, physical activity and weight among patient populations from infants to older adults. The survey will identify factors that aid or hinder the dissemination of information about diet, physical activity, and weight through physicians' offices to the general patient population.

Of particular analytic interest are:

- National estimates of the proportion of physicians in primary care specialties that engage in assessment, counseling, and referral related to diet, physical activity, and weight.

- Comparisons between primary care specialties (family practice, OB/GYN, pediatrics, and internal medicine) in terms of their attitudes and recommendations for diet, physical activity, and weight; and
- Factors that may affect physicians' decisions to engage in practices related to diet, physical activity and weight. These include office protocols, the presence of medical staff dedicated to supporting the practices, organizational policies, and reimbursement.

Study results will be disseminated through published papers and conference presentations, and are expected to reach a range of audiences within the U.S. public health research community and health care system. Findings will also be used to provide context for other NCI research projects, such as those involving patient reports and findings from managed care organizations.

A.3. Use of Information Technology and Burden Reduction

Data will be collected through an electronically scannable pencil and paper survey distributed to physicians by Federal Express. The feasibility of developing an automated, electronic data collection approach (*i.e.*, a web-based survey) was explored but found to be less convenient and efficient for PCPs, who are likely to be frequently interrupted while filling out the survey and who tend to be highly mobile, working in different offices without consistent Internet access. Physicians will be given the option of completing the questionnaire over the telephone with an interviewer who will record answers on paper. Westat, the contractor that will conduct the survey, found in surveys of addiction medicine specialists (OMB Nos. 0930-0246 Evaluation of Buprenorphine Waiver Program Addiction Physician Survey and 0930-0262 Evaluation of Buprenorphine Waiver Program Waivered Physician Survey) and primary care physicians (OMB No.0925-0562) that fewer than 5 percent of the sample used the telephone option. Notably, all three surveys achieved response rates above 70 percent using pencil and paper methods.

The contractor has found that data entry using electronically scannable survey forms is more efficient than data entry by hand. The automated data capture system converts respondents' check marks and 'x's into variable values, and recognizes handwritten numbers and text, placing the information into viewable text fields. Both the scanning company and the contractor will conduct quality control review.

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

Based on a review of the literature, attendance at conferences, and personal communication with experts in the field, NCI has determined that the planned data collection activities do not duplicate any other current data collection effort. A search of literature on health providers' attitudes and practices related to diet, physical activity, and weight or obesity yielded hundred of articles, with only 26 articles referencing provider surveys. Among these, there were none that reported on national data on all primary care specialties, except for the National Ambulatory Medical Care Survey. Though this survey has been used to examine physician

practices related to diet, physical activity, and weight control, findings are limited to physician visits for diagnosed disease, and lack information about assessment, referral, and counseling in primary prevention populations. Furthermore, the NAMCS primary care sample size is less than 1,000, which is too small to detect differences of interest to the present study. A list of the survey articles found in the literature is provided in Attachment 1.

NCI has been collaborating with several agencies within the Department of Health and Human Services (DHHS) for this project. Specifically, NCI has established partnerships with three offices/institutes at the NIH (Office of Behavioral and Social Science Research, the National Institute of Child Health and Human Development, the National Institute of Diabetes and Digestive and Kidney Diseases). The scientific team also includes affiliates from the National Heart, Lung, and Blood Institute, the Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality. Additionally, NCI staff have participated in inter-agency meetings with the Robert Wood Johnson Foundation, the National Center for Quality Assurance, and has presented information about this project at the NIH Obesity Research Taskforce. Based on conversations with persons from these various organizations, no other agency is proposing a similar project.

Over the last several years, NCI staff has also spoken to numerous experts in the field, and has presented at and attended multiple conferences on energy balance and disease prevention. In that time, conversations with other attendees has yielded no information about any data collection efforts comparable to the data collection described in this document.

A.5. Involvement of Small Entities

Some physicians will be in private practice and thus may be considered small entities. The instrument has been designed to minimize burden, including an easy-to-read format, checkboxes for responses, and consistent response choices across questions. Time-to-complete for the physicians' survey is estimated at 20 minutes and for the practice administrator, less than 20 minutes.

A.6. Consequences of Collecting the Information Less Frequently

Funding has been allocated for a one-time survey of PCPs and practice administrators. If this information is not collected, there will be no national information available about PCPs' practices regarding diet, physical activity and weight control.

A.7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5(d) (2)

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

A.8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside Agency

In accordance with the Paperwork Reduction Act of 1995, NCI published a notice in the Federal Register announcing the intention to request OMB review of PCP Screening Survey data collection activities. The notice was published on June 28, 2007, Volume 72, Number 35499, Page 35,499, and provided a 60-day period for public comment. NCI has received one public comment by email that stated that the information on the subject was already available and that funding would be better spent researching the causes of disease. An email reply was sent acknowledging the receipt of the comment and confirming that the concern would be taken into consideration.

As noted earlier, The Office of Behavioral and Social Science Research, National Institute of Child Health and Human Development, and National Institute of Diabetes and Digestive and Kidney Disease are collaborating with NCI in all aspects of the project, including scientific and financial input. Contacts at the agencies include:

- Mary Horlick, M.D., Director, Pediatric Clinical Obesity Program, National Institute of Diabetes and Digestive and Kidney Disease, 301-594-4726;
- Terry T-K Huang, Ph.D., MPH, Health Scientist Administrator, National Institute of Child Health and Human Development, 301 594-1846; and,
- Deborah Olster, Ph.D., Deputy Director/Senior Advisor, Office of Behavioral and Social Science Research, 301 402-114.

A.9. Explanation of Any Payment or Gift to Respondents

Payment for participating in an interview or survey is standard practice when seeking participation of professionals such as physicians and practice administrators. The incentive payment is an effective method of drawing physicians' attention to the Study and gaining their cooperation in completing the survey. It is not intended to be a payment for their time. Historically, physicians are one of the most difficult survey populations, partly because of the number of surveys they receive as well as the demands on their professional time, so incentives assume an even greater importance with this group.

NCI believes that in order to achieve an adequate response rate for this survey, an incentive is essential and proposes to offer \$30 per questionnaire (physician and office administrator). There is considerable

evidence in the literature showing that the most effective way to increase response rates among professionals (particularly physicians) is by offering a monetary incentive. In a survey of physicians, Gunn and Rhodes found the response rate to an initial survey with no incentive was 58 percent, with a \$25 incentive, 69 percent, and with a \$50 incentive, 77 percent⁴. Many other studies confirm that a monetary incentive is the best way to achieve acceptable response rates from physicians. Incentives were used successfully in 2002, 2004, and 2006 by the contractor to obtain response rates above 70 percent for three physician surveys (OMB No. 0930-0246 and 0930-0262 and 0925-0562).

Some studies show that physicians may be becoming accustomed to the much greater monetary incentives (\$100-\$150) offered by private concerns such as pharmaceutical companies. This shift in expectations is thought, in some cases, to render surveys without an incentive meaningless. For this reason, NCI believes that an incentive of at least \$30 is essential to attract enough attention to the survey to achieve acceptable response rates. A \$30 incentive for completing a Federally-sponsored survey about a subject of importance to public health should be high enough to gain the attention of the potential respondent and to communicate the importance NCI places on a completed survey. Each questionnaire will be accompanied by a \$30 incentive, and thus a total of \$60 will be offered per sampled physician.

A.10. Assurance of Confidentiality Provided to Respondents

The Privacy Act does not apply to this data collection, as data will be collected by the contractor, and data files delivered to NCI will exclude personal identifiers. The survey data will be analyzed in the aggregate and no individual respondents will be identified. A statement from the Privacy Act Officer at the NIH is found in Attachment 2.

The contractor's Institutional Review Board (IRB) reviewed the physician and practice administrator surveys and gave them expedited approval since the questions focus on non-sensitive issues related to the physician's clinical opinion and practice, and there is low risk of breach of confidentiality. (See Attachment 3 for IRB approval documentation).

Each physician's survey will have a unique ID label at the top of the cover page. This number will be used as a unique record identifier during data entry. The data file containing physicians' names and ID numbers will be maintained separately by The contractor and used only for mailing the surveys and subsequent follow up in the case of non-response.

⁴ Gunn WJ, Rhodes IN. Physician response rates to a telephone survey: effects of monetary incentive level. *Public Opinion Quarterly* 1981; 45(1):109-115.

Each practice administrator's survey will likewise have a unique ID label at the top of the cover page. Also, on the instructions page, the name and address of the doctor's practice will be shown to focus the practice administrator's responses on the practice or clinical site of the sampled PCP.

Instructions on the survey and a document providing background information on the Study will apprise the respondent of the following:

- The survey is sponsored by the NCI, an agency of the Federal Government;
- Survey data will be used to improve public health experts' understanding of how disease prevention information involving diet, physical activity, and weight is disseminated in primary care, with the ultimate goal being to improve the quality of health care;
- Information provided will be kept confidential, and will not be disclosed to anyone but the researchers conducting this Study, except as otherwise required by law; and
- Providing the information is voluntary, and there are no penalties for not responding to the information collection as a whole or to any particular questions.

A.11. Justification for Sensitive Questions

No questions of a sensitive nature are being asked. Questions about patient characteristics are of a general nature and information is collected in the aggregate rather than on specific individuals.

A.12. Estimates of Hour Burden Including Annualized Hourly Costs

Response burden estimates are shown in Table A.12 - 1. The physician survey questionnaires will require 20 minutes to complete and the practice administrator's survey will require less than 20 minutes. (Copies of the instruments are included in Attachment 4). The number of respondents to the physician questionnaire is targeted at 2,000 primary care physicians, who may be working in for-profit or not-for-profit medical practices or clinics, with a corresponding completed questionnaire to be obtained from their office administrators. Table A12-1 shows the average burden hour per physician is .33, with the estimated total annual burden hours estimated at 666. The average burden hour per practice administrator is .33 with the estimated total annual burden hours estimated at 666. This estimate is based on experience with the cognitive interviews described in Section B.4, page 26. The total annualized cost to respondents is estimated at \$65,048 as shown in Table A.12-2.

The hourly wage rate for physicians with responsibilities comparable to those in the target population is based on U.S. Department of Labor, Bureau of Labor Statistics data from the National Compensation Survey, for November 2005 (the latest data available).⁵

Table A.12 - 1 Estimates of Hours Burden

Type of Respondents	Estimated Number of Respondents	Estimated Number of Responses per Respondent	Average Burden Hours per Response	Estimated Total Annual Burden Hours Requested
Family Practice	800	1	0.33	264
General Internists	400	1	0.33	132
OB/GYNs	400	1	0.33	132
Pediatricians	400	1	0.33	132
Practice Administrators	2,000	1	0.33	660
TOTAL	4,000			1,320

Table A.12 - 2 Annualized Cost to Respondents

Questionnaire	Estimated # respondents	Estimated # responses per respondent	Hourly Earnings	Average burden hours per response	Estimated total annual burden hours	Costs
Physicians' Questionnaire	2,000	1	62.52	0.333	666	\$41,638
Medical Practice Administrators' Questionnaire	2,000	1	35.15	0.333	666	\$23,410
Total	4,000	1		0.333	1,332	\$65,048

A.13. Estimate of Other Total Annual Cost Burden to Respondents or Record keepers

There is no capital or start-up cost, and no costs to the respondents for operation and maintenance of services.

5 U.S. Department of Labor, Bureau of Labor Statistics. *National Occupational Employment and Wage Estimates, November, 2005*. Accessed at http://www.bls.gov/oes/current/oes_nat.htm on March 22, 2007.

A.14. Annualized Cost to the Federal Government

The annualized cost to the government to conduct and analyze the physician survey is \$257,700 per year over the 4 years of the project. The budget includes the costs of survey design and development, all data collection and follow up, incentive payments to physicians, data file preparation and documentation, initial analyses, and other miscellaneous costs such as supplies, expenses, and postage. Professional service time is included for study management and overhead costs. Costs have been added for both the contractor and for NCI staff, who have developed the survey and will provide oversight of the contractor.

Table A.14 - 1 Estimates of Annualized Cost to the Government

Year	Contractor Costs	Estimated NCI Costs
2006	\$50,000	\$16,000
2007	\$230,000	\$32,400
2008	\$650,000	\$32,400
2009		\$20,000
Total Over Four Years		\$1,030,800

A.15. Explanation for Program Changes or Adjustments

This is a new collection of information.

A.16. Plans for Tabulation and Publication and Project Time Schedule

The current plan is to mail the survey in January 2008, if it has received OMB clearance by that date. Otherwise, the survey will be fielded as soon as possible after clearance has been received.

Table A.16 - 1 Tentative Survey Activity Timeline

Activity	Date
Confirmation calls to sampled physicians and practice administrators	Oct. 2007
Send physician survey package	Jan. 4, 2008
Send physician reminder letter and replacement survey	Jan. 18, 2008
Begin phone contacts to encourage physician response	Jan. 21, 2008
Begin sending administrator surveys (Administrator surveys for physician surveys received after this date will be sent on a flow basis)	Feb. 11, 2008
Send administrator reminder letter and replacement survey	Feb. 25, 2008
Begin phone contacts to encourage administrator response	Feb. 26, 2008
Send final physician survey non-response follow up package	April 1, 2008
Send final administrator survey non-response follow up package	May 1, 2008
Complete data entry and check for physician survey, begin analysis	June 1, 2008
Complete data entry and checks for administrator survey, begin analysis	July 1, 2008
Analyses completed by The contractor	Sept. 1, 2008
Final report submitted by The contractor	Sept. 15, 2008
Initial papers submitted for publication	Jan, 2009
Additional papers submitted for publication	June, 2009

Publication Plan

NCI has a history of success in conducting primary care surveys and publishing peer-reviewed papers based on those surveys. For example, NCI has published nine papers based on data collected from the National Survey of Colorectal Cancer Screening Practices in 1999-2000 (OMB No. 0925-0468). (A copy of the first paper published by Klabunde, Frame, Meadow, *et. al.*⁶ may be found in Attachment 5). NCI is also completing data collection on a second survey, the National Survey of Primary Care Physicians' Recommendations and Practice for Breast, Cervical, Colorectal, and Lung Cancer Screening (OMB No. 0925-0562) with plans to publish several manuscripts in the coming year.

Upon completion of the Energy Balance Survey, NCI and its partners plan to publish a number of papers. Topics identified for papers include:

- PCP's Counseling Practices for Diet, Physical Activity, and Weight Control among Adult Patients
- PCP's Counseling Practices for Diet, Physical Activity, and Weight Control among Child/Adolescent Patients
- Variation in Counseling, Referral and Follow-up for Energy Balance Practices by PCP Specialty
- PCP's Attitudes toward Counseling for Diet, Physical Activity, and Weight Control

⁶ Klabunde CN, Frame P, Jones E, Meadow A, Nadel M, Vernon S. A national survey of primary care physicians' colorectal cancer screening recommendations and practices. *Prev Med* 2003;36:352-62.

- Influence of PCP's Personal Health Behaviors on Diet, Physical Activity, and Weight Control Counseling
- PCP's Knowledge of Guidelines regarding Diet, Physical Activity, and Weight Control among Adults and Children
- Barriers to Counseling, Referral and Follow-Up for Energy Balance Practices among PCPs
- Practice-based Factors Influencing Implementation of Energy Balance Practices by PCPs

It is expected that two papers will be submitted by the end of 2008, with the remainder submitted for publication in 2009.

Analysis Plan

This survey will obtain current, national data on PCP knowledge, attitudes, recommendations, and practices related to health behaviors involving diet, physical activity, and weight. There are three main types of analyses to be conducted for the Study. The first involves descriptive data based on estimates of the proportion of PCPs nationally that engage in practices that promote healthy diet, physical activity, and weight, or that encounter certain barriers or facilitators to these practices. All estimates will incorporate sample weights, described in detail in Section B.2, page 19.

The second type of analysis involves making comparisons between physicians in different specialty groups who may differentially implement practices related to diet, physical activity, and weight.

The third type of analysis involves the identification of factors associated with physicians engaging in practices involving diet, physical activity, and weight management. These factors may include personal attitudes, awareness of national guidelines, the presence of standardized protocols at the practice level, staffing levels, or reimbursement policies.

In the following sections we provide greater detail on these analyses, including examples of table shells.

Descriptions of Practices That Promote Healthy Diet, Physical Activity, and Weight. Table A.16 - 2 indicates examples of planned national estimates of the percentage of physicians who are engaged in specific practices or who follow specific recommendations. Weighted estimates of the proportion of PCPs engaged in the assessment, referral, and counseling for each of the energy balance topic areas (diet, physical activity and weight) will be reported, along with estimates related to perceptions of barriers to practice and reported personal health habits. Weighting procedures are described in detail in Section B.2, page 19. Statistical comparisons between different practices (*e.g.* counseling vs. referral) used across diet, physical activity, and

weight may be made using a simple chi-square test. Table A.16 - 2 shows how the results of such analyses may be presented.

Table A.16-2 Percent of Primary Care Physicians Reporting Practices, Knowledge, or Attitudes Related to Energy Balance

	Diet	Physical Activity	Weight Control
Often or always assess for all patients			
Children			
Adults			
Often or always refer for treatment related to these areas			
Children			
Adults			
Often or always provide counseling in these areas			
Children			
Adults			
Report reimbursement policies are a barrier to providing services			
Report personal health habits consistent with national guidelines			
Showed knowledge of national guidelines in these areas			

Comparisons of PCP Specialties. Physicians from four medical specialties that provide primary medical care in the U.S. will be included in the survey. These are: family practice physicians (FP), who treat both children and adults; pediatricians (Ped), who treat children only; general internists, who treat adults only; and obstetrician/gynecologists (OB/GYNS), who treat adults only. Comparisons of particular interest are those between the three groups treating adults and between the two groups treating children. Hypothesis tests involving the proportion of physicians reporting specific practices within each specialty, or the distribution of physicians by specialty across a set of responses will be undertaken. In addition, mean scores on Likert scales for the groups on a number of key items will be examined using linear and logistic regression models to determine whether there are statistically significant differences between the groups. Table A.16 – 3 shows how some results may be presented.

Table A.16 - 3 Percent of Physicians Reporting Often or Always Engaging in Energy Balance Practices

Energy Balance Activity	Type of Specialty		
	FP	Ped	
Assessment of Children for:			
Diet			
Physical Activity			
Weight			
Counseling of Children for:			
Diet			
Physical Activity			
Weight			
Referral / Follow-Up of Children for:			
Diet			
Physical Activity			
Weight			
	FP	Internist	OB/GYN
Assessment of Adults for:			
Diet			
Physical Activity			
Weight			
Counseling of Adults for:			
Diet			
Physical Activity			
Weight			
Referral / Follow-Up of Adults for:			
Diet			
Physical Activity			
Weight			

Factors associated with physician practices involving diet, physical activity, and weight

management. Composite scores indicating high versus low levels of engaging in activities involving diet, physical activity, and weight management will be constructed based on observed distributions. Physicians implementing these activities will be compared with those not implementing these practices on a number of different variables, including personal health habits, knowledge of guidelines, type of practice, size of practice, volume of patients treated, the use of physician extenders, access to computerized medical records, and specialty. Logistic and linear regression modeling will help identify predictors of successful implementation. Chi-square analyses will be used to explore relationships.

Non-response. As described in Section B.3 page 24, considerable effort will be expended to minimize rates of nonresponse. Analyses will be conducted on the characteristics of individuals who do not respond to the survey based on information available on the frame. For this Study, variables reflecting both physician demographics and practice location will be assessed to identify those that characterize the propensity to respond. Logistic regression and the software package CHAID (a categorical search algorithm) will be used to identify variables to be incorporated into models for nonresponse adjustment. The contractor statisticians have made extensive contributions to the literature on the effectiveness of such approaches.^{7,8} A report will be provided to NCI describing the findings of these evaluations, indicating subpopulations with higher levels of nonresponse and thus with a greater potential for contributing to any bias in estimates.

Dealing with issues of survey nonresponse is a standard part of the weighting effort associated with the estimation and analysis of the survey data. In developing sample weights, we will adjust the weights to reduce the potential for bias associated with nonresponse.

A.17. Reason(s) Display of OMB Expiration Date is Inappropriate

The expiration date for OMB approval will be displayed.

A.18. Exceptions to Certification for Paperwork Reduction Act Submissions

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

7 Rizzo L, Kalton G, Brick JM. A comparison of some weighting adjustment methods for panel nonresponse. *Survey Methodology* 1996; 22(1):43-53.

8 Kalton G, Flores-Cervantes I. Weighting Methods. *Journal of Official Statistics* 2003; 19(2):81-97.

