

**Trends in U.S. Public's Awareness of Racial and
Ethnic Health Disparities
(1999- 2008)**

Request for OMB Clearance on a New Collection

Supporting Statement

August 6, 2008

Submitted by:

NORC at the University of Chicago
[4350 East-West Highway, Suite 800](#)
[Bethesda, MD 20814](#)
(301) 634- 9300

TABLE OF CONTENTS

- A. Justification
 - A.1 Need and Legal Basis
 - A.2 Information Users
 - A.3 Improved Information Technology
 - A.4 Duplication of Similar Information
 - A.5 Small Businesses
 - A.6 Less Frequent Data Collection
 - A.7 Special Circumstances
 - A.8 *Federal Register* Notice/ Outside Consultation
 - A.9 Payment/Gift to Respondents
 - A.10 Confidentiality
 - A.11 Sensitive Questions
 - A.12 Burden Estimate (Total Hours and Wages)
 - A.13 Capital Costs (Maintenance of Capital Costs)
 - A.14 Cost to Federal Government
 - A.15 Program or Burden Changes
 - A.16 Publication and Tabulation Dates
 - A.17 Expiration Date
 - A.18 Certification Statement

- B. Collection of Information Employing Statistical Methods
 - B.1 Respondent Universe and Sampling Methods
 - B.2 Information Collection Procedures
 - B.3 Ways to Maximize Response Rates
 - B.4 Test of Procedure
 - B.5 Statistical Consultants

Exhibits

1. Estimated Annualized Burden Hours
2. Estimated Annualized Cost to Respondents
3. Schedule for Completion
3. Observed (1999) and Expected (2008) Survey Interviews, by Strata

ATTACHMENTS

- A Summary and Status of OMH's Program Improvement Plan and Approved Program Performance Measures
- B Government Performance and Results Act of 1993
- C Title 42, Section 1707 of the Public Health Service Act
- D *Americans' Perceptions of Racial Disparities in Health Care*, 1999 Questionnaire prepared by Henry J. Kaiser Family Foundation and Princeton Survey Research Associates
- E-1 Crosswalk of Revisions and Additions Made to the 1999 KFF/PSRAI Instrument, General Population
- E-2 Crosswalk of Revisions and Additions Made to the 1999 KFF/PSRAI Instrument, Physician Population
- F-1 *National Survey of U.S. Public's Awareness of Racial and Ethnic Health Disparities* Questionnaire, General Population
- F-2 *National Survey of U.S. Public's Awareness of Racial and Ethnic Health Disparities* Questionnaire, Physician Population
- F-3 Spanish Translation of *National Survey of U.S. Public's Awareness of Racial and Ethnic Health Disparities* Questionnaire, General Population
- G Federal Register Notice
- H Pilot Test Report
- I NORC Institutional Review Board Certification of Approval
- J Items from the 1999 KFF/PSRAI Instrument Excluded From the Revised Instrument
- K General Population Survey: Telephone Interview Scripts
- L Operationalization of Research Questions and Data Analysis Plan
- M-1 Physician Survey: Pre-notification Letter
- M-2 Physician Survey: Cover Letter for Initial Questionnaire Mailing
- M-3 Physician Survey: Cover Letter for Follow-up Mailings
- M-4 Physician Survey: Telephone Prompting Scripts for Mail Non-Respondents
- N Frequently Asked Questions about the Survey
- O Description of Power and Precision
- P-1 New Items Added to the Revised 1999 KFF/PSRAI Instrument, General Population
- P-2 New Items Added to the Revised 1999 KFF/PSRAI Instrument, Physician Population
- Q Survey Instrument Booklet for Physician Population
- R Summary of Revisions Made to the Survey Instruments and Study Procedures

Supporting Statement

The Office of Minority Health (OMH) is a staff office in the Office of the Secretary (OS), Department of Health and Human Services (HHS). OMH serves as a focal point for leadership, coordination, and guidance on policies and programs aimed at improving minority health and ameliorating long-standing racial and ethnic health disparities. The proposed survey seeks to collect data for one of OMH's annual performance measures, approved by OMB in February 2007, following Office of Management and Budget (OMB)'s examination of OMH using the Program Assessment Rating Tool (PART). This measure is to "increase awareness of racial/ethnic health status and health care disparities in the general population." Findings from this data collection will enable OMH to track progress on this measure over time as mandated by OMB PART requirements.

Background

In 2005, OMH was assessed on its compliance with Government Performance and Results Act of 1993 (GPRA) requirements via OMB's PART. Subsequent to the PART assessment, OMH worked with OMB in the development of a program improvement plan, which included various performance measures (see Attachment A).¹ The lack of general awareness and understanding about the nature and extent of racial and ethnic health disparities in the U.S. and the impact that such disparities are having on the overall health of the Nation have been cited as a major barrier to the provision of programmatic, budgetary, and policy attention to these issues. Therefore, one of the long-term, annual measures agreed upon was to "increase awareness of racial/ethnic health status and health care disparities in the general population."

Findings from a survey of public perceptions and experience about racial and ethnic disparities in health care conducted in 1999 by the Kaiser Family Foundation (KFF) and Princeton Survey Research Associates International (PSRAI), were used as the baseline. However, since then, a number of seminal events – towards which OMH has played a key role – have occurred, including, but not limited to: the establishment of an "eliminating health disparities" goal in the national disease prevention and health promotion objectives released by HHS in 2000 (i.e., *Healthy People 2010*); release in 2003 of the OMH-funded study by the Institute of Medicine which resulted in the report, *Unequal Treatment*; two OMH-sponsored national summits (2002 and 2006) on racial and ethnic health disparities; and the release (since 2003) of the annual *National Healthcare Disparities Report* by HHS's Agency for Healthcare Research and Quality (AHRQ). Although there have been other studies that utilized some of the items from the KFF/PSRAI study that focus on awareness of health disparities², there has not been a high-fidelity replication of the survey that makes comparisons between 1999 and current levels of awareness- the proposed data collection intends to fulfill this purpose.

¹ OMH's PART results and current performance measures are available on the ExpectMore.Gov website at: <http://www.whitehouse.gov/omb/expectmore/detail/10003526.2005.html>.

² *Racial and Ethnic Disparities in Healthcare: A Public Opinion Update* (2003), supported by AETNA and the National Conference for Community and Justice; and *Medical Student, Physician, and Public Perceptions of Health Care Disparities* (2004).

A. JUSTIFICATION

1. Need and Legal Basis

The proposed data collection is in response to Section 306 of the GPRA (see Attachment B), which calls for the heads of each agency to submit strategic plans to OMB that include a clearly articulated mission, as well as operational processes that will be used to measure the success of the agency at achieving its mission. *Trends in US Public's Awareness of Racial and Ethnic Health Disparities (1999-2008)* will provide support for OMH's mission, as outlined below.

Since its establishment under Title 42, Chapter 6a, Subchapter XV, § 300u-6(a) of the Public Health Service Act (see Attachment C), OMH has worked to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that focus on eliminating health disparities. Established in response to the 1985 Report of the Secretary's Task Force on Black and Minority Health, OMH is mandated to focus on "...improving and protecting the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities." Specifically, OMH advises HHS on health policy issues affecting health status and access to care among minority populations.

Although persistent disparities in health status and health care have been well-documented, data indicate that the general public (including racial and ethnic minorities, health care providers, employers, and policy and decision-makers), are uninformed about the nature and extent of these disparities. On the individual level, this lack of awareness and understanding means that members of affected communities and their health care providers may not make an effective case for tests and treatment modalities. At the societal level, lack of awareness creates barriers that impede the flow of attention and resources that are needed to satisfactorily address these complex problems.

In 1999, the Kaiser Family Foundation and Princeton Survey Research Associates conducted a nationally representative survey to measure the U.S. public's awareness of racial and ethnic disparities in health care (*Race, Ethnicity, and the Health Care System: Public Perceptions and Experiences*). The survey found that a majority of Americans (62%), including many racial and ethnic minorities, were not aware that African Americans and Hispanics fare worse than non-Hispanic whites in: life expectancy, infant mortality, health insurance coverage, and other key health indicators.

Since the fielding of the KFF/PSRAI study in 1999, various initiatives and health campaigns have taken place to raise awareness of racial and ethnic disparities in health, though there has been no concerted effort to determine their effectiveness. OMH has been involved, either directly or indirectly, in many of these efforts. For instance, in 2000 OMH contributed to HHS' *Healthy People 2010*, including helping to frame the overarching goal to eliminate health disparities. OMH provided support for the 2002 Institute of Medicine (IOM) study, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, which found widespread evidence that racial and ethnic minorities are treated differently than non-Hispanic whites in the U.S. health care system, resulting in poorer health care and poorer health outcomes for millions of Americans. In 2004 and 2006, OMH convened National Health Disparities Summits, which emphasized the need for greater awareness and understanding of racial and ethnic disparities in health care and health status to generate greater attention and resources to solving these persistent and insidious issues. While these initiatives reached millions of Americans, no follow-up studies were conducted to gauge whether there were changes in the U.S. public's awareness of health disparities.

The proposed data collection will: (1) replicate the 1999 KFF/PSRAI survey, collecting a second round of data which can be used to determine if there have been any changes in the percentage of the population who are *aware* of the existence of racial and ethnic disparities in health care; (2) strengthen the methodology and expand the data collected to: (a) include other racial and ethnic groups and population subgroups of interest as well as (b) illuminate the nature and extent of the public's awareness about health *status* disparities; and (3) provide trend data, which will enable OMH to track progress on a related measure for performance monitoring and reporting purposes under the GPRA and PART requirements.

2. Information Users

The results from this study will have several uses. First, the Deputy Assistant Secretary for Minority Health (DASMH) will be able to use the results to report on one of OMH's newly approved annual performance measures, and to track progress on this measure over time as mandated by OMB PART requirements. This data collection will also help the DASMH to make administrative and programmatic decisions about the operations of OMH. Additionally, OMH can use the findings about progress made in *raising awareness* to identify collaborative partners in the federal government, at the state and local levels, among businesses and non-profits, and among the faith community, in order to reach a wider audience. Further, these results can be used by program decision-makers and policy-makers, within and outside of HHS, who are interested in capturing progress made in the last eight years after exposing the U.S. population to information which confirms the existence, and societal effects, of racial and ethnic health disparities. Intended users include, but are not limited to, HHS agencies, other governmental health entities at the regional, state, and local levels, institutions of higher education, foundations, and minority-serving organizations and institutions.

Replicating the 1999 KFF/PSRAI study will help OMH answer the following program-related questions:

- 1) To what extent is the U.S. public *aware* of the existence of racial and ethnic differences in health status and health care, and their impact on the overall health of the Nation?
- 2) Has the level of public awareness of health disparities in the U.S. changed between 1999 and 2008?
- 3) Do Americans differ by race and ethnicity in their perception of how race and ethnicity affect their own health status and health care as well as that of others?
- 4) Are attitudes about racial disparities in the overall physician population comparable to those found among the general population?

3. Improved Information Technology

The contractor (the National Opinion Research Center (NORC) at the University of Chicago) will be contacting a random sample of U.S. households by telephone, oversampling for African American, Hispanic, and Asian American/Pacific Islander groups. In order to program and implement the survey instrument, NORC will utilize a sophisticated Computer Assisted Telephone Interviewing (CATI) system. This software has enhanced call scheduling capabilities that supports intelligent calling rules. The CATI system features a state-of-the-art auto-dialer that has been customized for social science surveys with the goal of maximizing response rates. The CATI interviewing software also supports a set of validations, skip logic, hard and soft range checks, and inter-item consistency checks, facilitating the capture of high-quality data.

In its survey of U.S. practicing physicians, NORC will draw a random sample of approximately 700 physicians from the American Medical Association's (AMA's) Masterfile. Individual respondents will review and complete a self-administered mail survey. Physician respondents will be given a choice of data submission method, including via mail, a secure fax line or over the telephone utilizing the CATI technology.

4. Duplication of Similar Information

The proposed data collection does not duplicate any other studies. The contractor conducted a detailed review of the literature and found that although similar surveys have been fielded, none have addressed changes in the awareness of racial and ethnic health disparities, nor have they focused on public awareness and the difference in perceptions by race and ethnicity. The survey fielded by KFF/PSRAI in 1999 included items that focused on awareness of health disparities that the proposed instrument also includes. The proposed data collection will allow a trend analysis to be conducted as well as the opportunity to obtain baseline data on the awareness of health disparities in the physician population as well as the AA/PI subgroup. Attachment D includes the KFF/PSRAI instrument, Attachment E-1 and E-2 describe the modifications that were made to the original instrument, and Attachments F-1 to F-3 include the General Population, Physician, and Spanish Version General Population instruments, respectively.

5. Small Businesses

This information collection is based upon a survey of individuals. Information will be sought concerning individuals' awareness of racial and ethnic health disparities. Respondents to this survey may be employed by small businesses; however, the information collected will be based upon the individual's personal perspectives.

6. Less Frequent Collections

This data collection project will require regular (annual) fielding of the survey in order to develop an understanding of changing levels of awareness of health disparities over time, in accordance with GPRA. However, the consequences for any particular sample in a given year are low, as we will draw new samples from the U.S. population each year. Likewise, for the physician's study, we will ensure that any physician sampled in one year will not be in the sample frame for subsequent years.

Findings from this study are intended for use by OMH to report on a newly approved and mandated performance measure: to increase awareness of racial/ethnic health disparities in the general population. Not fielding the survey instrument will severely limit OMH's ability to be in compliance with their OMB PART reporting requirements.

In addition, the proposed data collection will inform and support the HHS objectives for transforming the health care system (by reducing racial and ethnic health disparities) and the Healthy People 2010 goal of eliminating health disparities. Should the survey not be completed, the opportunity to identify areas of improvement for expanding the public's and physicians' perceptions of racial and ethnic disparities in health care will be lost.

7. Special Circumstances

No special circumstances apply. This request complies with the information collection guidelines of 5 CFR 1320.5(d)(2).

8. Federal Register Notice/Outside Consultation

In addition to internal review by staff from the HHS OS and OMH, planning for this survey solicited input on data collection efforts from outside reviewers in three ways: (1) comment from the public as response to a *Federal Register Notice*; (2) consultations with respondent representatives and (3) consultations with technical experts.

A 60-day Federal Register notice was published in the *Federal Register* on June 3, 2008; Vol. 73, No. 107, p.31689- 31690. No public comments were received. (See Attachment G).

Secondly, both data collection instruments were piloted in May 2008 by conducting interviews with nine individuals per instrument. In addition to completing the draft survey questionnaire, pilot test respondents were asked to participate in a brief interview to assess the questionnaire. The interview focused on: 1) the appropriateness of response categories; 2) clarity of instructions; 3) information recall; and 4) question comprehension. Results from the pilot test are included as an attachment in this clearance package (Attachment H).

Thirdly, the survey instruments and the corresponding protocols have been reviewed and revised by an experienced group of researchers who are familiar with previous national surveys that included some of the items (included in the proposed instrument) which speak to awareness of health disparities.

- Cara V. James, Ph.D.
Senior Policy Analyst
Kaiser Family Foundation
1330 G St., NW
Washington, DC 20005
Phone: (202) 347-5270
- Elisabeth Wilson, MD, MPH
Assistant Clinical Professor
Family and Community Medicine
University of California, San Francisco
Box SFGH - B80 WD83 , 1001 Potrero Ave, SFGH 80 Wd83
San Francisco, CA. 94143
Phone: (415) 206-8717

To ensure protection of human subjects, all NORC data collection efforts undergo rigorous Institutional Review Board (IRB) review. The board, comprising of 9 members, reviewed the protocols and procedures related to data collection and granted full approval to the study. The certification of approval is attached (Attachment I).

NORC Institutional Review Board Members	
Karen H. Grigorian, NORC Member	

Catherine C. Haggerty, NORC Member	NORC Institutional Review Board 1155E 60th Street Chicago, IL 60637 Phone: 1-866-309-0542
Thomas B. Hoffer, Vice Chair	
Alma M. Kuby, Chair	
Michael A. Kuby, IRB Manager	
Lisa Lee, NORC Member	
Victor D. Lofgreen, Community Member	
Kathleen Parks, IRB Administrator	
Ann Cusick Spittle, Community Member	

9. Payment/Gift to Respondents

NORC will include a pre-paid incentive of \$150 in the initial mailings to the sample of 700 physicians. Prior research has shown (Berk, et al., 1987, 1993; Halpern et al., 2002; Barry and Kanouse 1987) that improvements in response rates with physicians were found when monetary incentives were employed. Barry and Kanouse (1987) used a \$20 monetary incentive and found that the group of physicians who were paid the incentive at the time the survey was mailed had a 12 point response rate differential above that obtained from the group that was promised an incentive upon survey completion. Berk and colleagues (1993) reported a 30 percent difference where a prepaid incentive was used compared to no incentive at all. Gunn and Rhodes (1981) tested no payment against promised payments of \$25 and \$50 and found corresponding response rates of 58, 69, and 77 percent.

The proposed incentive amount of \$150 for physicians was selected based on: 1) NORC’s extensive experience interviewing physicians in various settings³ and 2) recent wage information for physicians (see Exhibit 2).

In addition, following the protocol of the 1999 KFF/PSRAI survey, in their follow-up calls to general population non-responders (refusals and breakoffs), the interviewer will offer an incentive of \$15 to complete the interview.

10. Confidentiality

We will not be seeking a certificate of confidentiality, given that these data are not of a sensitive nature. However, NORC perceives respondent privacy to be of vital importance. All NORC staff are required to sign statements that they understand NORC’s commitment to privacy and the professional ethics pledge to uphold strict privacy rules. In addition, NORC’s interviewer training incorporates a module on the interviewer responsibilities regarding privacy.

The privacy of all respondents will be protected through a number of additional measures. All respondents will be informed that the information they provide will be kept private. They will also be made aware that their participation is strictly voluntary. All final reports will be presented in statistical format so that individual respondents cannot be identified. Data files and reports delivered to OMH will contain study ID numbers only, and will not contain personal identifiers such as names or addresses. At the conclusion of the study, all hard copy documents will be stored in secure locked location and/or eventually shredded. Electronic files will be archived in password-protected files.

³ National Opinion Research Center and the University of California, Berkeley. “National Study of Physician Organizations and the Management of Chronic Illness.” Details can be viewed at <http://nspo.berkeley.edu/index.htm>

11. Sensitive Questions

The proposed data collection, *Trends in US Public's Awareness of Racial and Ethnic Health Disparities (1999-2008)* does not contain sensitive questions.

12. Burden Estimate (Total Hours and Wages)

In Exhibit 1, we provide estimates of the annualized collection burden on participants for this effort. Study participants will participate in data collection one time only. Based on internal pilot testing of the instrument, it is estimated that the average amount of time required to complete the questionnaire is 14 minutes.

12A. Estimated Annualized Burden Hours

Exhibit 1. Estimated Annualized Burden Hours

Type of Respondent	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
General Population	4,100	1	14/60	957
Physician	360	1	14/60	84
Total				1,041

12B. Below we provide an estimate of the annualized cost to respondents for the hour burdens for collection of the survey information. We estimated the cost for physicians using the Department of Labor website listing average wages for U.S. physicians. The only cost to the general population respondents will be their time. As shown above in 12A., the total burden in hours is estimated at 1,041 person hours. The total imputed cost is estimated at \$5,251.68.

Exhibit 2. Estimated Annualized Cost to Respondents

Type of Respondent	Total Burden Hours	Hourly Wage Rate ¹	Total Respondent Costs
General Population	957	n/a	n/a
Physician	84	\$62.52	\$5,251.68
Total			\$5,251.68

¹Based on hourly wage for U.S. Physicians, "National Compensation Survey: Occupational Wages in the United States, June, 2005," U.S. Department of Labor, Bureau of Labor Statistics. Extracted January 17, 2008 from www.bls.gov.

13. Capital Costs (Maintenance of Capital Costs)

This section does not apply to this submission. Data collection for this study will not result in any additional capital, start-up, maintenance, or purchase costs to respondents or record keepers.

Therefore, there is no burden to respondents other than that discussed in the previous section (A.12).

14. Cost to Federal Government

The overall cost to the federal government for conducting the research requiring OMB clearance will be \$549,000. This cost is associated with a contractor's reimbursement for developing the survey protocol, selecting the samples, conducting data collection, processing data, producing a dataset, performing statistical analyses and writing a report on the study's survey methods and findings.

15. Program or Burden Changes

Although the proposed data collection is new (i.e., has never received clearance from OMB), it will utilize a number of items and adopt the methods used to field the survey conducted in 1999 by KFF/PSRAI. The replication of the 1999 survey is necessary in order to report on changes in the percentage of the U.S. population that indicates being aware of racial and ethnic health disparities (i.e., *U.S. public's awareness of health disparities*). Given this objective, there were significant changes in burden observed in the 1999 survey that are described below.

A preliminary analysis of the 1999 KFF/PSRAI instrument showed that the average questionnaire administration time was 45 minutes per respondent. The analysis also revealed that there were a number of items (N=56) that do not correspond to the primary topic of inquiry of the proposed data collection (i.e., awareness of health disparities). As such, the project team determined that the survey instrument, without modification, was too long and presented too great a burden on respondents. As a result of these analyses, the research team excluded 56 items that do not directly speak to health disparities. Attachment J lists all the items that were excluded from the proposed instrument.

In addition, for general population instrument, the research team identified eleven (11) new items that needed to be added to the base instrument, as well as ten (10) items that required slight modifications in the way they were worded. Similarly, for physician survey twelve (12) new items were added to the base instrument and eight (8) items were modified. Attachments E-1 and E-2 describe the various modifications and additions made to the base instrument. All total, including deletions and additions of instrument items, the revised survey instrument for which OMB clearance is sought requires an administration time of 14 minutes, including all relevant scripts. Thus, there is a total change in burden from the 1999 instrument of 31 minutes. This represents a significant reduction in respondent burden that will ultimately result in reduced respondent fatigue, which in turn will improve the response rate and reduce the amount of missing data thereby improving the overall quality of the data collected.

16. Publication and Tabulation Dates

Findings from the proposed information collection are intended to be published. A description of how research questions will be addressed by the instrument and its corresponding protocols is

included in Attachments K, L, and M-1 to M-4. The schedule for completion of this study from the date of OMB approval is presented in Exhibit 3 on the following page.

Exhibit 3: Schedule for Completion

Task Description	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 13	Month 14
Submit OMB Clearance Package for protocols and instrument	D													
Revised OMB Clearance Package		D												
Findings/ recommendations from survey pilot			D											
Revised survey protocols and instrument				D										
Obtain general population sample														
Initial telephone Calls														
Follow up telephone calls (minimum 10)														
Obtain physician sample														
Send pre-notification letter														
Send questionnaire														
Send reminder letter/2 nd questionnaire mailing														
Telephone follow-up non-respondents														
Status report on survey of pop sample														
Status report on survey of physician sample														
Draft survey report outline/initial data analysis														
Draft survey report and full data analyses														
Summary, deliberations on draft survey report/findings														
Final survey report and findings														
Presentation of Survey report to DHHS														
Presentations at National Conferences*														
Progress Reports (monthly)	R	R	R	R	R	R	R	R	R	R	R	R	R	R
Progress Reports (quarterly)		D			D			D			D			D

*To be determined.

Key:
D = Deliverable
R = Recurring

17. Expiration Date

This collection of information does not seek approval to exclude the expiration date for OMB approval from any data collection instruments.

18. Certification Statement

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

B. COLLECTION OF INFORMATION EMPLOYING STATISTICAL METHODS

1. Respondent Universe and Sampling Methods

General Population

The potential respondent universe for the proposed information collection includes all adults age 18 and older who reside in telephone households in the continental U.S.—from which, NORC will draw a nationally representative sample. This study will use a stratified, random digit dial (RDD) sample. To produce reliable estimates for racial and ethnic minorities, the project team will oversample geographic areas that have large concentrations of racial and ethnic minority populations. Such oversampling will be achieved by completing the following steps: (1) the racial and ethnic composition of each telephone exchange will be estimated by matching the exchange to block group level census data; (2) the RDD frame of telephone numbers will be stratified by telephone exchange based on the racial and ethnic composition of each exchange; (3) the racial and ethnic composition of each stratum will be estimated from exchange level information; (4) the stratum sample size/allocation will be determined based on the required number of interviews per racial/ethnic group and the tradeoff between cost and variance with the minority strata being sampled at a higher rate relative to their share in the sampling frame; and, (5) the sample will be selected systematically and independently from each stratum.

In order to meet the targeted number of completed surveys, the project team will use targeted list samples to supplement the RDD sample. For instance, should the RDD sample not produce a sufficient number of surveys completed by Asians or Hispanics, the team will use list frames to sample Asians and Hispanics more efficiently. Such list frames are compiled based on Asian and Hispanic surnames. Estimates from the RDD sample and the list sample can be combined to derive the composite estimate. NORC plans to work with GENESYS Sampling Systems (the same company which was used by KFF/PSRAI to draw the sample in 1999) to implement the proposed RDD sample design.

The project team will determine the optimal allocation of the sample based on our past experience, and on information provided by the sample vendor. We will determine the sample size and the stratum allocation by considering a series of expected outcome rates, including resolution rate, working residential number rate, screener completion rate, eligibility rate, and interview completion rate. Some of these rates will differ by stratum and by race/ethnicity, increasing design effects, which reduces the effective sample size. The potential for increases in design effects is another important consideration in sample allocation. Within each stratum, telephone numbers will be selected systematically, with equal probabilities, from working phone banks that contain one or more residential listings. See below exhibit for observed (1999) and Expected (2008) Survey Interviews, by Strata:

Exhibit 4: Observed (1999) and Expected (2008) Survey Interviews, by Strata

R/E Group (Strata)	1999	2008*	Difference
White**	1,479	1,200	(279)
Black	1,189	1,200	11
Hispanic	983	1,200	217
Asian/Pacific Islander	***	500	-
Physicians	***	360	-
Not coded (missing)	233	0	-
Total Completes	3,884	4,460	576

Source: Americans' Perception of Racial Disparities in Health Care, Princeton Research Associates, The Kaiser Family Foundation: Methodology. September, 1999.

*Figures in this column represent the total number of expected or targeted number of completed interviews.

**Refers to Whites non-Hispanics

***AA/PI subjects were not included in the 1999 sample, and the survey was not administered to physicians in 1999.

Practicing Physicians

In addition to the survey of U.S. households, the instrument will be fielded to a national probability sample of U.S. practicing physicians. This administration will be used to obtain a baseline estimate of the overall physician population given that this instrument has not been fielded in this population. The survey is a pilot effort that will lay the foundation for additional work while at the same time providing data that will be of immediate interest. Although the survey will provide estimates that are representative of all US physicians providing patient care and will give unbiased estimates, it will not allow subgroup analysis such as of Black or Hispanic physicians, or physicians practicing in localities with high minority populations. We believe that the focus on *all* practicing physicians will provide the most accurate picture of current perceptions of disparities and will allow the project team to best answer one of the core research questions regarding the comparability of attitudes about racial disparities in the overall physician population and the general population.

A random sample of approximately 700 physicians from the AMA Masterfile will be purchased from one of the vendors authorized by the AMA to develop and deliver these sampling frames. Based on the project team's experience using this sampling frame, it is anticipated that approximately 100 cases will be ineligible (e.g., the doctor may have retired, died, or is no longer involved in direct patient care). Also, a response rate of 60 percent is expected, which will yield about 360 completed cases. Given that a simple random sample will be used, sampling weights will not be required.

2. Information Collection Procedures

General Population

As stated in B1., the instrument will be fielded to a random sample of U.S. households, oversampling for African American, Hispanic, and Asian American/ Pacific Islander groups. The mode of data collection will be a telephone survey. Interviews will be conducted by experienced NORC interviewers who will receive training specific for the planned data collection. In addition

to the computerized interview and related procedures, interviewers will be given scripts for contacting, consenting and re-contacting respondents (Attachment K). In addition, interviewers will be provided a list of Frequently Asked Questions (Attachment N) to refer to during the telephone calls. NORC will utilize software providing enhanced call scheduling capabilities that support intelligent calling rules. Not only can these rules guarantee a minimum number of call attempts to reach a household within the required data collection period, but they can also reference both case-level call history and questionnaire embedded sample management data to distribute future call attempts to new days and times and finalize sample that has reached the maximum call attempts. NORC's Computer Assisted Telephone Interviewing (CATI) system also features an exclusive state-of-the-art auto-dialer that has been specifically customized for social science surveys with the chief goal of maximizing response rates while containing costs.

Interviewers will make a minimum of 10 attempts to complete an interview at every sampled telephone number. The calls will be staggered over different times of the day and days of the week to maximize the chances of making a contact with a potential respondent. All interview break-offs and refusals will be re-contacted at least once in order to attempt to convert them to completed interviews. All of those with an initial refusal will be re-contacted at least once and offered an incentive of \$15 to complete the interview.⁴

In each contacted household, interviewers will ask to speak with the "resident eighteen and older who most recently had a birthday." If that person is not at home an appointment will be scheduled.

Practicing Physicians

Below are brief descriptions of the various steps and methods that will be required to field the instrument to physicians. NORC will first mail a pre-notification letter to all sampled U.S. practicing physicians (Attachment M-1). Approximately 10 days following the pre-notification letter, the project team will mail the initial questionnaire to all sampled respondents. This mailing will utilize all updated address information resulting from returned pre-notification letters. Integrated into each questionnaire will be a cover letter (Attachment M-2) and instruction pages. The personalized cover letter will describe the purpose of the study and request participation. NORC proposes that the letter encourage cooperation by making sure respondents have the most convenient means available to respond. We will offer a choice to respond via phone, mail or a secure, dedicated fax-line. Included in the initial mailing will be a pre-paid incentive of \$150. Follow-up mailings (Attachment M-3) will be sent to respondents whose questionnaires have not been received within one week of distribution. These second versions will be identical to the initial mailings, with the exception of the cover letter, which will be revised to acknowledge the earlier mailing and express gratitude to those who have already responded. If, after two weeks we have not received a completed survey; we will begin the telephone prompting effort (Attachment M-4). These calls will serve to boost the response rate achieved from the original mailing.

Telephone interviewers will prompt providers who have not yet returned their completed surveys despite receiving the initial and follow-up packages via U.S. mail. They will gain cooperation and offer options of re-mailing the questionnaire, faxing or conducting a telephone interview. An important task for the interviewer will be the management of resistance from gatekeepers, such as office managers, to achieve contact with sampled physicians.

⁴ In the 1999 survey a total of 270 of 2,318 refusals (12%) were converted to completes, using this method.

Sample size and power analyses were performed to determine the degree of accuracy and level of confidence in which inferences can be made from the proposed survey sample to the universe of respondents. See Attachment O.

3. Ways to maximize response rates

The project team will be adhering to various survey administration methodologies and procedures that are designed to achieve the highest possible response rate. As mentioned in Section A15., the project team will be making significant reductions to the number of instrument items. A crosswalk of revisions made to the 1999 KFF/PSRAI Survey, which includes a brief description of the revisions as well as the rationale for the modification, appears in Attachments E-1 and E-2. The items from the 1999 questionnaire which were excluded from the revised instrument can be found in Attachment J, and lists of new items added to the revised questionnaires are contained in Attachments P-1 and P-2.

The hardcopy questionnaire will be designed to minimize the burden on the respondent by using a layout that is attractive in appearance and easy to complete. For instance, the questionnaire will be printed in booklet format; it will have a vertical flow of questions and sections of questions based on content will be created (see Attachment Q). In addition, respondent will be given a choice of data submission method, either via mail, secure fax or telephone.

In addition to reducing respondent burden, the project team intends to provide incentives to survey participants. NORC project staff members have implemented experiments to study the effect of incentives both in the general population (Berk, et al., 1987) as well as on physician surveys (Berk, et al., 1993) and the results of our work as well as others (Berry and Kanouse, 1987) have generally suggested that incentives on physician surveys are quite effective. As such, the project team will follow the protocol followed in the 1999 KFF/PSRAI administration of conducting follow-up calls to non-responders and offering an incentive of \$15 to complete the interview. For the administration to physicians, the project team will include a pre-paid incentive of \$150 in the initial mailing to physicians.

General Population

The sample will be released for interviewing in replicates, which are random subsamples of the overall sample, to facilitate sample management at the NORC call center. Releasing the sample by replicates ensures that only enough telephone numbers are screened to achieve the target sample size. To the extent possible, NORC will follow the same calling protocol used in the KFF/PSRAI study to reduce bias due to design changes. For example, at least ten attempts will be made to complete an interview at every sampled telephone number. To maximize the chances of making a contact with a potential respondent, the calls will be spread over various times of the day and days of the week. All interview break-offs and refusals will be re-contacted at least once to attempt to convert them to completed interviews.

Practicing Physicians

Pre-notification Letter. The pre-notification letter (Attachment M-1) will be printed on OMH letterhead and personalized with respondent name, address and appropriate salutation. We propose to use business quality window envelopes showing OMH logo.

Initial Questionnaire Mailing. Approximately 10 days following the pre-notification letter (Attachment M-1), the project team will mail the initial questionnaire to all sampled respondents. This mailing will utilize all updated address information resulting from returned pre-notification letters. Integrated into each questionnaire will be a cover letter and instruction pages. The personalized cover letter will describe the purpose of the study and request participation (Attachment M-2). NORC proposes that the letter encourage cooperation by making sure respondents have the most convenient means available to respond. We will offer a choice to respond via phone, mail or a secure, dedicated fax-line. Included in the initial mailing will be a pre-paid incentive of \$150.

Second Questionnaire Mailing. Follow-up mailings (Attachment M-3) will be sent to respondents whose questionnaires have not been received within one week of distribution. These second versions will be identical to the initial mailings, with the exception of the cover letter, which will be revised to acknowledge the earlier mailing and express gratitude to those who have already responded.

Telephone Prompting. If, after two weeks we have not received a completed survey; we will begin the telephone prompting effort (Attachment M-4). These calls will serve to boost the response rate achieved from the original mailing. Telephone interviewers will be responsible for conducting the following activities:

- Telephone prompting of providers who have not yet returned their completed surveys despite receiving the initial and follow-up packages via U.S. mail.
- Gaining cooperation and offering options of re-mailing the questionnaire, faxing or conducting a telephone interview.
- Managing resistance from gatekeepers, such as office managers, to achieve contact with sampled physicians.

4. Test of Procedure

A pilot test of the data collection instruments and study design will be conducted during the OMB initial OMB review period, using nine (9) adults over 18 years of age and nine (9) practicing physicians. A summary of revisions made to the instruments and study procedures is included in Attachment R.

5. Statistical Consultants

The project was awarded to the National Opinion Research Center (NORC) at the University of Chicago in 2007. The main NORC personnel on this contract are:

Oscar Espinosa, M.A.
Project Director
National Opinion Research Center, at the University of Chicago
(301) 634-9344

Alma Kuby, Ph.D.
Senior Survey Director, II
National Opinion Research Center, at the University of Chicago

(312) 759-4007

Bernard Dugoni, Ph.D.
Senior Survey Methodologist
National Opinion Research Center, at the University of Chicago
(773) 256-6193

Contractor personnel will implement the sample design, conduct data collection, handle data receipt/editing/keying, produce the data file, conduct statistical analysis and develop a survey report. OMH will provide direction and review functions to the contractor. Data collection is planned for September through mid-December of 2008.

REFERENCES

Berk ML, Mathiowetz NA, Ward EP, White AA. The effect of prepaid and promised incentives: results of a controlled experiment. *Journal of Official Statistics*, 3(4): 449-457, 1987.

Berk ML, Edwards WS, Gay NL. The use of a prepaid incentive to convert nonresponders on a survey of physicians. *Evaluation and the Health Professions*, 16(2): 239-45, 1993.

Berry, H. and Kanouse, D.E. Physician response to a mailed survey. *Public Opinion Quarterly*, 54: 102-114, 1987.

Gunn, W. and I. Rhodes. Physician Response Rates to a Telephone Survey: Effects of Monetary Incentives on Response Level. *Public Opinion Quarterly*, 45:109-115. 1981.

Halpern, SD, Ubel, PA, Berlin, JA, Asch, DC. Randomized Trial of \$5 Versus \$10 monetary incentives, envelope size, and candy to increase physician response rates to mailed questionnaire. *Medical Care* 40 (9):834-39, 2002.