

**SUPPORTING STATEMENT**

**Part A**

A Survey of Physicians in Solo and Smaller Primary Care Practices

**Version** *July 23, 2012*

Agency for Healthcare Research and Quality (AHRQ)

Submitted under AHRQ's generic pretesting clearance 0935-0124

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## **A. Justification**

### **1. Circumstances that make the collection of information necessary**

The mission of the Agency for Healthcare Research and Quality (AHRQ) set out in its authorizing legislation, The Healthcare Research and Quality Act of 1999 (see <http://www.ahrq.gov/hrqa99.pdf>), is to enhance the quality, appropriateness, and effectiveness of health services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health systems practices, including the prevention of diseases and other health conditions. AHRQ shall promote health care quality improvement by conducting and supporting:

1. research that develops and presents scientific evidence regarding all aspects of health care; and
2. the synthesis and dissemination of available scientific evidence for use by patients, consumers, practitioners, providers, purchasers, policy makers, and educators; and
3. initiatives to advance private and public efforts to improve health care quality.

Also, AHRQ shall conduct and support research and evaluations, and support demonstration projects, with respect to (A) the delivery of health care in inner-city areas, and in rural areas (including frontier areas); and (B) health care for priority populations, which shall include (1) low-income groups, (2) minority groups, (3) women, (4) children, (5) the elderly, and (6) individuals with special health care needs, including individuals with disabilities and individuals who need chronic care or end-of-life health care.

To support AHRQ's goals, AHRQ has established the National Integration Academy Council (NIAC). Members of the NIAC represent diverse areas of content expertise, experience and approach. NIAC members are established or emerging leaders with significant experience in some area of health care, many having first hand expertise with integration. They include primary care physicians, psychiatrists, researchers and academicians, patients, policy experts, financial consultants and actuaries, and government at the Federal and state levels. Through the recommendations of the NIAC, AHRQ is planning to conduct exploratory research and a pilot survey of physicians in solo and smaller primary care practices to examine how physicians in these practices consider and manage common mental health conditions

While there has been a considerable volume of research on approaches to integrated healthcare in community health centers, patient centered medical homes, community mental health centers, vertically integrated health delivery systems, and other primary

care practice settings, very little has been done to systematically enhance our understanding of current practices around the delivery of behavioral health services in the solo and smaller primary care practice settings. Primary care physicians (PCPs) in solo and smaller practices (with up to 10 physicians) constitute 89.3 percent of physicians in the country (NAMCS 2003-04).

The goal of this research is to pretest a questionnaire designed to collect data from physicians in solo and smaller primary care practices regarding the delivery of behavioral health services to their patients; there is no existing tested and validated instrument available for use.

The questionnaire is designed to answer the following questions:

- How does the physician in solo and smaller practices currently address behavioral health disorders (i.e., mental health disorders such as depression, anxiety, or others; or substance use disorders such as alcohol or drug abuse or addiction) in patients?
- Does the physician have concerns with the adequacy of their current approaches to addressing behavioral health disorders in presenting patients? Would they be interested in adopting alternate approaches to addressing behavioral health disorders? Have they considered or attempted to implement alternate approaches?
- Does the physician use standardized screening instruments to identify behavioral health disorders? What other methods do they use to identify behavioral health disorders?
- Is the physician aware of and currently using the screening, brief intervention, and referral to treatment (SBIRT) model? How is it structured in their setting?
- Is the physician aware of and have they attempted to implement a stepped care model for the treatment of depression, such as the IMPACT model? Have they worked with an external group to assist them in implementing the model, and if so, which group?
- Does the physician use standardized instruments to assess change/improvement over time in response to treatment for behavioral health disorders? Does the physician have protocols to change the level and type of intervention in response to change/improvement?
- Does the physician have established working relationships with any behavioral health specialty providers such as community behavioral health centers or others? What form do these relationships take currently? Have there been discussions or plans developed to move toward stronger or more coordinated working relationships? Do those relationships provide adequate access to services they deem appropriate? Is the timeliness of access satisfactory?
- What types of behavioral health professionals (e.g., psychiatrist, psychologist, social worker, psychiatric nurses, or other counselors) are available to provide treatment or consultation? Where are these behavioral health professionals located in relation to

the physician's practice? What is the nature of the respective employment relationships between the physician and the behavioral health professionals?

- Is the progress reporting procedures and other client related communications between the physician and behavioral health practitioners satisfactory? Are issues of patient confidentiality addressed so as to assure patient satisfaction and availability of sufficient information to craft an appropriate treatment plan?
- Does a physician's approach to addressing behavioral health disorders in their patient population differ significantly across demographic groups?
- Is the availability of insurance coverage a significant impediment to obtaining needed treatment for behavioral health disorders in solo and small independent primary care patient populations? Do physicians see significant differences in the adequacy of behavioral health insurance coverage by type of coverage (e.g., across private insurance plans, Medicare, Medicaid, uninsured, or other types)?
- Are the services provided by physician reimbursed by any means other than typical fee-for-service reimbursement? For example, are physicians compensated differently based on measures of quality or patient outcome; are physicians compensated differently based on the level of care coordination provided?

To achieve the goals of this project, AHRQ seeks to conduct the following data collection activities:

- 1) Cognitive testing – the draft questionnaire will be subjected to cognitive testing with up to 25 physicians in solo and smaller practices (see Attachment A). Participating physicians will be interviewed with the draft questionnaire and asked follow-up questions to determine their understanding of each question. The purpose of this is to ensure that the questions are constructed so they are interpreted as intended by the respondent. The cognitive testing is essential and critical to finalizing the survey instrument for the pilot survey;
- 2) Pilot survey – after the questionnaire is cognitively tested it will be pilot tested with 300 physicians in solo and smaller practices (see Attachment B). The purpose of the pilot test is to collect information on the lay of the land in both urban and rural areas in states known to have integrated care modules and those that do not and collect data to further test the survey instrument and methods; and
- 3) Follow-up interviews – in-depth interviews will be conducted with up to 30 physicians with a mix of approaches to behavioral care determined by their responses to questions 16 and 19 of the pilot survey. The purpose of the follow-up interviews is to explore their responses related to integration and barriers to integration (see Attachment C). Based on the results of these interviews additional changes may be made to the questionnaire.

See Attachments D, E and F for the initial contact letter, reminder/thank you postcard, and follow-up reminder letter, respectively.

This study is being conducted by AHRQ through its contractor, Westat Inc., pursuant to AHRQ's statutory authority to conduct and support research on healthcare and on systems for the delivery of such care, including activities with respect to the quality, effectiveness, efficiency, appropriateness and value of healthcare services and with respect to quality measurement and improvement. 42 U.S.C. 299a(a)(1) and (2).

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

The questionnaire will collect data on the integration of behavioral health care into primary care and barriers to integration among primary care providers in settings with at most 10 physicians by assessing topics related to the primary care practitioner, his/her practice characteristics, his/her patient characteristics, financial characteristics of the practice, and quality assurance methods of the practice. As there is currently no context for how to measure levels of behavioral healthcare integration into primary care the data gathered at this stage will guide the framework for future data collection and measurement.

The information collected from the cognitive testing will inform the questionnaire to be used for the pilot survey. The pilot survey and the follow-up in-depth interviews will further guide the approach for a future national survey. The information collected during this phase will not be used to develop national estimates.

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

The survey data will be collected using scannable paper forms. Data from completed surveys will be captured by scanning in the paper forms.

## ***4. Efforts to Identify Duplication***

While there are a number of surveys of physicians and physician practices occurring, none meet the needs of this study. For example, there is a national survey of primary care policies for managing patients with high blood pressure, high cholesterol, or diabetes being conducted by the CDC, a survey of federally qualified health centers being conducted by HRSA, the National Ambulatory Medical Care Survey being conducted by NCHS, and a study of offered psychiatric services being conducted by SAMHSA and AHRQ. While the sample frame of physicians and/or physician practices may be similar the content and purpose of these studies differs considerably.

AHRQ's proposed study described in this package focuses on how PCPs, in settings with at most 10 physicians, manage patients with behavioral health conditions through

treatment and collaboration with other physicians. Further this first round is considered a pilot study. As a pilot study the scope of PCPs surveyed will be limited and specific to guide the approach to an eventual national survey. There are no other identified studies with comparable scopes able to obtain similar information.

Additionally, through environment scans there have been no identified published studies with a similar scope. Through the extensive network of NIAC experts (the NIAC contacts are listed in 8.b Outside Consultations) it is also known that there are no similar data known to be available about how primary physicians in solo and smaller care practices manage and treat behavioral health conditions. Literature is available on similar topics of integrating behavioral health and primary care services and has been frequently authored by members of the NIAC; however this literature does not meet the needs of the current study because the focus of the proposed study is physicians in solo and smaller practices. Physicians in these solo and smaller practices differ significantly from larger practices in their ability to integrate services with respect to collocation and cooperation given the nature of their smaller setting. Currently available literature on this topic of integration does not apply to the unique barriers associated with smaller primary care settings.

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

While the physician practices participating in this project may be considered small businesses, the data collection has been kept to the minimum needed to achieve the goals of the project and should not impose an unreasonable burden on them.

### ***6. Consequences if Information Collected Less Frequently***

This is a one-time pilot study. There will not be repeated collection of data.

### ***7. Special Circumstances***

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

## 8. Federal Register Notice and Outside Consultations

### 8.a. Federal Register Notice

This project is being submitted under AHRQ’s generic pretesting clearance (OMB Control Number 0935-0124) and is therefore not required to be published in the Federal Register.

### 8.b. Outside Consultations

The Project Officer, Charlotte Mullican, consulted with the following members of Westat and the NIAC to obtain their views on how to best engage and survey primary care physicians in solo and smaller practices

Westat	Garrett Moran	Phone: 301-294-3821 email: GarrettMoran@westat.com
	Rebecca Noftsinger	Phone: 240-453-5636 email: RebeccaNoftsinger@westat.com
	Vasudha Narayanan	Phone: 301-294-3808 email: VasudhaNarayanan@westat.com
	Paul Weinfurter	Phone: 714-262-1856 email: PaulWeinfurter@westat.com
Project Staff	Benjamin F. Miller University of Colorado School of Medicine	Phone: 303-724-9706 email: Benjamin.miller@ucdenver.edu
	Deborah Cohen Oregon Health and Science University	Phone: 503-494-7840 email: cohendj@ohsu.edu
NIAC Members	Frank DeGruy University of Colorado School of Medicine	Phone: 303-724-9753 email: Frank.degruy@ucdenver.edu
	Teresa Chapa Office of Minority Health, HHS	Phone: 240-453-6904 email: Teresa.Chapa@hhs.gov
	Macaran A. Baird University of Minnesota Medical School	Phone: 612-624-4641 email: baird005@umn.edu
	Dave DeBronkart e-patient Dave	Phone: 603-459-5119 email: dave@epatientdave.com
	Alexander Blount University of Massachusetts Medical School	Phone: 774-443-2147 email: alexander.blount@umassmemorial.org
	Michael Hogan New York State Office of	Phone: 518-474-4403 email: Michael.Hogan@omh.ny.gov



	Mental Health	
	Roger Kathol Cartesian Solutions, Inc.	Phone: 952-426-1626 email: roger-kathol@cartesiansolutions.com
NIAC Members (Continued)	Ned Calonge The Colorado Trust	Phone: 303-837-1200 email: ned@coloradotrust.org
	Parinda Khatri Cherokee Health System	Phone: 865-765-0304 email: Parinda.Khatri@cherokeehealth.com
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	Neil Korsen Maine Health	Phone: 207-675-3515 email: KORSEN@mainehealth.org
	Jürgen Unützer University of Washington	Phone: 206-543-3128 email: unutzer@u.washington.edu
	Stephen P. Melek Milliman	Phone: 303-672-9093 email: steve.melek@milliman.com
	Steven E. Waldren American Academy of Family Physicians	Phone: 913-906-6000 x4100 email: swaldren@aafp.org
	Kavita K. Patel The Brookings Institution	Phone: 202-797-2475 email: kpatel@brookings.edu

## **9. Payments/Gifts to Respondents**

An incentive will be paid to physicians who participate in the cognitive testing. It is customary practice to pay an incentive for participating in testing, especially when there's a substantial time commitment. An incentive of \$150 will be provided to those primary care physicians selected to participate in the cognitive testing. These interviews will each be 30 to 60 minutes long. This length of time is required to obtain feedback on the comprehensiveness and utility of the questionnaire before it is used for the pilot survey.

The pilot survey includes a \$25 incentive. The incentive will be a gift card for the practice in the amount of \$25 and will be sent out with the first mailing (prepaid incentive). There is research evidence that a prepaid incentive can increase response rates.<sup>1</sup> More importantly, if the incentive improves the response rate, it is more cost effective than introducing non-response follow-up by telephone.

The follow-up in-depth interview will also require an incentive for participating given the considerable time commitment required to further explore the pilot survey responses. We expect these interviews to take up to 30 minutes each. An incentive of \$75 will be provided to those primary care physicians selected to participate in the in-depth interview.

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Petrolia, Daniel R., Bhattacharjee, Sanjoy. 2009. "Revisiting Incentive Effects: Evidence from a Random-<sup>1</sup> Sample Mail Survey on Consumer Preferences for Fuel Ethanol." Public Opin Q 73:537-50

## **10. Assurance of Confidentiality**

Individuals and organizations will be assured of the confidentiality of their replies under Section 934(c) of the Public Health Service Act, 42 USC 299c-3(c). They will be told the purposes for which the information is collected and that, in accordance with this statute, any identifiable information about them will not be used or disclosed for any other purpose.

Information that can directly identify the respondent, such as name and/or social security number will not be collected.

We will include this statement in the cover letter that is sent with the survey:

“That law requires that information collected for research conducted or supported by AHRQ that identifies individuals or establishments be used only for the purpose for which it was supplied unless you consent to the use of the information for another purpose.”

## **11. Questions of a Sensitive Nature**

This survey does not collect any questions of a sensitive nature.

## **12. Estimates of Annualized Burden Hours and Costs**

Exhibit 1 shows the estimated annual burden hours for the respondent’s time to participate in this project. Cognitive testing will be conducted with 25 physicians and will last for one hour. The pilot survey will include 300 physicians and will take 10 minutes to complete. Follow-up interviews will be conducted with 30 physicians and will last for 30 minutes. The total burden is estimated to be 90 hours annually.

Exhibit 2 shows the estimated annual cost burden associated with the respondent’s time to participate in the project. The total cost burden is estimated to be \$7,862 annually.

### **Exhibit 1. Estimated annualized burden hours**

Form Name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Cognitive testing	25	1	1	25
Pilot survey	300	1	10/60	50
Follow-up interviews	30	1	30/60	15
<b>Total</b>	355	na	na	90

**Exhibit 2. Estimated annualized cost burden**

Form Name	Number of respondents	Total burden hours	Average hourly wage rate*	Total cost burden
Cognitive testing	25	25	\$87.35	\$2,184
Pilot survey	300	50	\$87.35	\$4,368
Follow-up interviews	30	15	\$87.35	\$1,310
<b>Total</b>	355	90	na	\$7,862

\*Based upon Average of the mean wage of family practitioners and internal medicine specialists, National Compensation Survey: Occupational wages in the United States May 2009, U.S. Department of Labor, Bureau of Labor Statistics, [http://www.bls.gov/oes/current/oes\\_nat.htm#b29-0000](http://www.bls.gov/oes/current/oes_nat.htm#b29-0000).

**13. Estimates of Annualized Respondent Capital and Maintenance Costs**

There are no direct costs to respondents other than their time to participate in the study.

**14. Estimates of Annualized Cost to the Government**

Exhibit 3 provides a breakdown of the costs. The costs below include labor hours as well as other direct costs, such as copying and printing, postage, incentives for the experiment, supplies, telephone and computing costs. The total cost is estimated to be \$257,740 annually for 2 years.

**Exhibit 3. Estimated Total and Annualized Cost**

Cost Component	Total Cost	Annualized Cost
Survey Design and testing	\$114,520	\$57,260
Pilot Survey	\$245,959	\$122,980
Data Processing and Analysis	\$50,000	\$25,000
Publication of Results	\$35,000	\$17,500
Project Management	\$70,000	\$35,000
<b>Total</b>	\$515,479	\$257,740

**15. Changes in Hour Burden**

This is a new collection of information.

**16. Time Schedule, Publication and Analysis Plans**

The detailed timeline is shown below in Exhibit 4.

#### Exhibit 4. Time Schedule

<b>Task</b>	<b>Beginning date</b>	<b>Ending Date</b>
Complete cognitive testing and finalize survey design	11/15/2012 (or earlier on receiving OMB approval)	12/1/2012
Sampling and Preparation for Data Collection	11/12/2012	12/31/2012
Data collection	1/7/2013	3/29/2013
Draft Survey Findings Report	4/1/2013	6/28/2013
In-Depth Follow-up Interviews	4/23/2013	5/22/2013
Draft manuscript for publication	7/1/2013	8/1/2013
Final Report	8/1/2013	9/4/2013

The analysis conducted at each phase of the study will feed into revising the questionnaire and survey design for the next phase. The first phase is the cognitive testing. The purpose of the cognitive testing is to ensure the questions are interpreted as intended, they are clear and unambiguous, and every term and question is understood uniformly by all respondents. This qualitative feedback will be consolidated and reviewed to revise and finalize the questionnaire. This revised questionnaire will be used for the pilot survey.

The next stage is the pilot survey. The purpose of the pilot survey is to determine if the data generated from the survey can help us understand how physicians in solo and smaller practices manage and treat behavioral health conditions. To this end the following analyses will be conducted:

- item level frequencies to assess extent of missing data;
- comments written on the margins to determine if the response options were insufficient or confusing;
- univariate, bivariate and multivariate frequencies to determine range of responses and if the survey was able capture differences; and
- a qualitative analysis of the open ended items to determine if any further revisions have to be made to the questionnaire.

Another aspect of the pilot is to determine if any improvements can be made to the survey methodology. Hence during data collection attention will be paid to the timing of each mailout and response rates to each wave. These observations will help determine changes that may need to be made to the sample design, data collection material and protocol.

The third stage is the follow-up in-depth interview with 30 physicians. The in-depth interviews will be used to explore specific aspects of integrating behavioral health and primary care. The results from the pilot survey along with feedback from the in-depth interviews will be consolidated. The analysis of the combined data will result in a revised questionnaire and related data collection material, sample design and data collection protocol for a future national survey.

***17. Exemption for Display of Expiration Date***

AHRQ does not seek this exemption.

**List of Attachments:**

Attachment A: Cognitive testing questionnaire

Attachment B: Pilot survey questionnaire

Attachment C: Follow-up interview guide

Attachment D: Initial Contact Letter

Attachment E: Reminder/Thank you Postcard

Attachment F: Follow-up Reminder Letter