

**Trends in U.S. Public's Awareness of Racial and  
Ethnic Health Disparities  
(1999- 2015)**

**Request for OMB Clearance on an Existing Collection:  
Control No: 0990-0335, Expiration 03/31/2012**

*Supporting Statement*

March 23, 2012

Submitted by:

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## Supporting Statement

The Office of Minority Health (OMH) resides in the Office of the Assistant Secretary for Health (OASH), in the U.S. 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 the Office of Management and Budget (OMB) in February 2007, following 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 necessitated by current OMB-approved program assessment 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 the identification of increased public awareness as a long-term outcome measure. 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, outcome measures agreed upon was to "increase awareness of racial/ethnic health status and health care disparities in the general population." This measure is currently included in the HHS Program Performance Tracking System and in the Online Performance Appendix as part of OMH's budget planning processes.

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, following that survey, a number of seminal events – towards which OMH has played a key role – 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*; three OMH-sponsored national summits (2002, 2006, and 2009) on racial and ethnic health disparities; the release (since 2003) of the annual *National Healthcare Disparities Report* by HHS's Agency for Healthcare Research and Quality (AHRQ) the release of *Healthy People 2020* and its goal to "achieve health equity, eliminate health disparities, and improve the health of all groups," and the launch in April 2011 of the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities* as part of OMH's *National Partnership for Action to End Health Disparities*. Although there were studies that utilized some of the items from the KFF/PSRAI study that focus on awareness of health disparities<sup>1</sup>, no high-fidelity replications of the survey made comparisons between 1999 and current levels of awareness.

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<sup>1</sup> *Racial and Ethnic Disparities in Healthcare: A Public Opinion Update* (2003), supported by AETNA and the National Conference for Community and Justice; *Medical Student, Physician, and Public Perceptions of Health Care Disparities* (2004); and *Awareness of racial and socioeconomic health disparities in the United States: the National Opinion Survey on Health and Health Disparities, 2008-2009* (2011)

Under the current clearance, OMH conducted replications of the KFF/PSRAI study in 2009 and 2010 using NORC at the University of Chicago (NORC) as the contractor for data collection and analysis. The 2009 and 2010 OMH/NORC studies found that across all broad indicators, awareness in the general population of racial and ethnic health disparities did increase, but only modestly.<sup>2</sup> These studies also collected baseline data on awareness of racial and ethnic health disparities affecting the Asian American/Pacific Islander population, and, collected baseline data on physician awareness of racial and ethnic health disparities. The proposed renewal will provide OMH the ability to continue tracking this awareness measure over time to assess its long-term objective to increase awareness of racial/ethnic health status and health care disparities in the general population.

## A. JUSTIFICATION

### **1. Circumstances Making the Collection of Information Necessary**

The proposed renewal is in response to Section 306 of the GPRA (Attachment A), 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 (1999-2015)* 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 (Attachment B), 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 (55%), 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. The 2009 and 2010 OMH/NORC studies found that across all broad indicators, awareness in the general population of racial and ethnic health disparities did increase from 1999 to 2010. However the increase was modest. The percent of the total population aware of disparities for

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<sup>2</sup> Results were published in a 2011 special issue of Health Affairs. J. K. Benz, O. Espinosa, V. Welsh, and A. Fontes. Awareness Of Racial And Ethnic Health Disparities Has Improved Only Modestly Over A Decade. *Health Aff (Millwood)* 2011 30: 1860-1867.

African Americans and Hispanics/Latinos compared to Whites rose from 55 percent in 1999 to 59 percent in 2010.

The 2009 and 2010 studies collected baseline data on awareness of racial and ethnic health disparities affecting the Asian American/Pacific Islander population. In 2010, a total of 18 percent of all respondents were aware of disparities between Whites and Asian Americans/Pacific Islanders, which is a statistically significant difference from the 59 percent who were aware of African American and White disparities and the 61 percent who were aware of Hispanic/Latino and White disparities.

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 if public awareness has increased in concert with the increased attention on racial and ethnic health disparities.. 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.

Even in the time between the 2009 and 2010 OMH/NORC data collections, several key initiatives and campaigns occurred with a focus on racial and ethnic health disparities. The nation undertook a comprehensive health care reform effort. On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. In addition to provisions to expand coverage, control health care costs, and improve the health care delivery system, the new law includes requirements for enhanced collection and reporting of health disparities data and establishes health promotion and disease prevention programs focused on reducing health disparities. Additionally, in the fall of 2009, HHS issued the draft objectives for *Healthy People 2020* which included a focus on the social determinants of health and eliminating health disparities as one of the overarching goals. In the spring of 2010, the IOM released a set of recommendations for improving the annual *National Healthcare Disparities Report*, produced by the AHRQ, which includes several recommendations for including health equity as a primary factor in assessing the quality of care in the United States. Finally, in April 2011 HHS launched the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities* as part of OMH's *National Partnership for Action to End Health Disparities*.

These initiatives have the potential to reach millions of Americans, and this data collection will gauge whether there are corresponding changes in the U.S. public's awareness of health disparities. The proposed data collection will: (1) replicate the 1999 KFF/PSRAI and 2009 and 2010 OMH/NORC surveys, collecting another 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 to reflect the changing telephony environment and respondent attitudes toward participation ; (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 program assessment requirements; and, (4) consider other racial and ethnic groups and population subgroups of interest (e.g., American Indians/Alaska Natives) as resources permit.

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

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 continue to report on one of OMH's approved outcome measures, and to track progress on this measure over time per OMB program assessment 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 in accordance with the goals of the NPA. 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 since 1999 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.

Continuing this trend 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) What are the trends in public awareness of health disparities in the U.S. between 1999 and 2015?
- 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. Use of Improved Information Technology and Burden Reduction**

A contractor will contact a random sample of U.S. households by telephone, oversampling for African American, Hispanic, Asian American/Pacific Islander, and other racial and ethnic minority groups as resources permit. In order to program and implement the survey instrument, this contractor may utilize a 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, the contractor 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. Efforts to Identify Duplication and Use of Similar Information**

This renewal does not duplicate any other ongoing 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. This data collection provides a trend analysis to be conducted that no other studies provide. Attachment C includes the KFF/PSRAI instrument from 1999, Attachments D-1 and D-2 describe the modifications that were made to the original instrument, and Attachments E-1 to E-3 include the General Population, Physician, and Spanish Version General Population instruments, respectively.

## **5. Impact on Small Businesses or Other Small Entities**

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 or may be small business owners as 53% of physician respondents in the 2010 OMH/NORC survey cited "private practice" as their primary practice type; however, the information collected will be based upon the individual's personal perspectives.

## **6. Consequences of Less Frequent Data Collection**

This data collection project will require regular (at minimum, every 3 years) 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 in which data collection occurs. Likewise, for the physician's study, we will ensure that any physician sampled in any given year will not be in the sample frame for subsequent years.

Findings from this study are intended for use by OMH to report on an 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 performance budgeting and reporting requirements under GPRA.

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 2020* goal to achieve health equity, eliminate disparities, and improve the health of all groups. 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 Relating to the Guidelines of 5 CFR 1320.5**

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

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

In addition to internal review by staff from the HHS OASH 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 January 30, 2012; Vol. 77, No. 19, p.4561. No public comments were received. (Attachment F).

Secondly, both data collection instruments were piloted in 2008 and additional questions for this data collection will be piloted during the OMB review period 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 2008 pilot test are included as an attachment in this clearance package (Attachment G).

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.

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## **9. Explanation of any Payment/Gift to Respondents**

NORC will include a pre-paid incentive of \$100 in the initial mailings to the sample of 700 physicians. The incentive amount of \$100 for physicians was selected based on results of the monetary incentive experiment conducted in the 2009 OMH/NORC study, extensive experience interviewing physicians in various settings<sup>3</sup> and recent wage information for physicians. In the 2009 OMH/NORC incentive experiment, 58 percent of physicians who received a \$150 pre-paid incentive completed and returned the questionnaire compared to only 13 percent in the no incentive group. In support of these findings, prior research (Berk et al. 1987, 1993; Berry and Kanouse 1987) has shown that improvements in response rates with physicians were found when monetary incentives were employed. Berry 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 pre-paid 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,

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<sup>3</sup> 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>

69, and 77 percent. Finally, in a 2003 study, extensive telephone survey interviews with physicians were conducted with a 70 percent response rate using \$150 incentives (Casalino et al. 2003).

No incentives will be offered to the general population sample. A \$15 incentive to convert refusals in the general population was used in the 1999 and 2009 studies, but eliminated in 2010 when the 2009 data suggested that the incentive did not yield many conversions.

**10. Assurance of Confidentiality Provided to Respondents**

We will not be seeking a certificate of confidentiality, given that these data are not of a sensitive nature. However, OMH perceives respondent privacy to be of vital importance and will ensure that the data collection contractor will have strict corporate procedures in place to protect respondent privacy and data.

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 a 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.

**11. Justification for Sensitive Questions**

The proposed data collection, *Trends in US Public’s Awareness of Racial and Ethnic Health Disparities (1999-2015)* does not contain sensitive questions.

**12. Estimates of Annualized Hour and Cost Burden**

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 15 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	3,159	1	15/60	790
Physician	340	1	15/60	85
<b>Total</b>				<b>875</b>

\*Based on actual completion rates from the 2010 OMH/NORC survey.

**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 875 person hours. The total imputed cost is estimated at \$7,281.95.

**Exhibit 2. Estimated Annualized Cost to Respondents**

Type of Respondent	Total Burden Hours	Hourly Wage Rate <sup>1</sup>	Total Respondent Costs
General Population	790	n/a	n/a
Physician	85	\$85.67	\$7,281.95
<b>Total</b>			<b>\$7,281.95</b>

<sup>1</sup>Based on hourly wage for U.S. Physicians and Surgeons, “National Compensation Survey: Occupational Wages in the United States, June, 2010,” U.S. Department of Labor, Bureau of Labor Statistics. Extracted November 23, 2011 from www.bls.gov.

**13. Estimates of other Total Annual Cost Burden to Respondents or recordkeepers/ 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. Annualized Cost to Federal Government**

The overall cost to the federal government for conducting the research requiring OMB clearance will be \$600,000. 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. Explanation for Program Changes or Adjustments**

Based on the 2009 and 2010 OMH/NORC studies, the burden of the survey experience for respondents was fifteen minutes. It is anticipated that the response burden will remain the same at fifteen minutes as the same interview scripts and protocols will be utilized. Additionally, based on the 2009 and 2010 data collections, the size of the general public household and physician samples have been reduced. Adequate statistical power was achieved with a national household sample of 3,159 (reduced from the original estimate of 4,100) and 340 physicians (reduced from the original estimate of 360). This corresponds to an 875 burden hour estimate – a 166 burden hour decrease from the previous study.

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

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 Attachment I. 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**

<b>Task Description</b>	<b>Month 1</b>	<b>Month 2</b>	<b>Month 3</b>	<b>Month 4</b>	<b>Month 5</b>	<b>Month 6</b>	<b>Month 7</b>	<b>Month 8</b>	<b>Month 9</b>	<b>Month 10</b>	<b>Month 11</b>	<b>Month 12</b>	<b>Month 13</b>	<b>Month 14</b>
Submit OMB Clearance Package for protocols and instrument	D													
Revised OMB Clearance Package		D												
Test and Revise survey 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 <sup>nd</sup> 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. Reason(s) Display of OMB Expiration Date is Inappropriate**

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

### **18. Exceptions to Certification for Paperwork Reduction Act Submissions**

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

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