

Federal Register Notice of Intent to Request New Information Collection

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Notices

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DEPARTMENT OF AGRICULTURE
Economic Research Service

Notice of Intent To Request New Information Collection

AGENCY: Economic Research Service, USDA.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice invites the general public and other public agencies to send comments regarding any aspect of this proposed information collection. This is a new collection for a Survey on Rural Community Wealth and Health Care Provision.

DATES: Written comments on this notice must be received on or before November 14, 2011 to be assured of consideration.

ADDRESSES: Address all comments concerning this notice to John Pender, Resource and Rural Economics Division, Economic Research Service, U.S. Department of Agriculture, 1800 M. St., NW., Room N4056, Washington, DC 20036-5801. Comments may also be submitted via fax to the attention of John Pender at 202-694-5774 or via e-mail to jpender@ers.usda.gov.

Comments will also be accepted through the Federal eRulemaking Portal. Go to <http://www.regulations.gov/>, and follow the online instructions for submitting comments electronically.

FOR FURTHER INFORMATION CONTACT: For further information contact John Pender at the address in the preamble. Tel. 202-694-5568.

SUPPLEMENTARY INFORMATION: All written comments will be open for public inspection at the office of the Economic Research Service during regular business hours (8:30 a.m. to 5 p.m., Monday through Friday) at 1800 M. St., NW., Room N4056, Washington, DC 20036-5801.

All responses to this notice will be summarized and included in the request for Office of Management and Budget approval. All comments and replies will be a matter of public record. Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on those who are to respond, including use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Title: Survey on Rural Community Wealth and Health Care Provision.

OMB Number: 0536-XXXX.

Expiration Date: Three years from the date of approval.

Type of Request: New collection.

Abstract: This survey will collect information on the assets and investments of rural communities and their influence on recruitment and retention of rural health care providers, and on the effects of rural health care provision on economic development of rural communities. This information will contribute to a better understanding of the roles that rural communities play in promoting or retarding the development and provision of health care services, and of how improved health care provision contributes to development of these communities. Such understanding is critical to develop effective policies to address the challenge of inadequate access to health care services in many rural communities, and to realize the opportunities offered by improved health care provision to attract and keep residents in rural areas, provide employment, and improve the quality of life.

Health care services is one of the largest and most rapidly growing industries in rural America, and adequate provision of health care services is increasingly critical for achieving economic development and improved well-being of rural people. In many rural communities, health care services is the largest employer, and rapid growth in this sector is occurring and will continue to occur, especially as the Baby-Boom generation retires. Provision of adequate health care services is likely to be one of the key factors in attracting retirees and other migrants to rural areas, helping to stem persistent outmigration from many of these areas and in some cases, contributing to rural growth and prosperity. Despite recent growth and potential for continued growth in this sector, many rural communities suffer from poor access to health care services, especially because of the limited supply of health care professionals. Addressing these access problems likely will become increasingly important as the Patient Protection and Affordable Care Act is implemented, increasing rural people's access to health insurance.

Although substantial research has investigated the problems of attracting and retaining health care providers in rural areas, very little of this research addresses the issue from the perspective of rural communities themselves. For example, prior research has established that physicians who grew up in a rural area, who attended a medical school with a rural emphasis, or who completed a residency in a rural hospital are more likely than other

physicians to locate their practice in a rural community. Policies and programs that provide incentives to physicians to locate in rural areas have also been shown to increase recruitment of physicians to rural areas, although the impacts on retention of physicians are more questionable. Much less research has focused on factors affecting recruitment and retention of health care providers other than physicians to rural areas, or on the roles local communities play in affecting these decisions. Of the research that investigates the roles of local communities, the studies have been conducted in only a few communities with a small number of respondents, limiting the ability to draw conclusions applicable to broader rural regions.

The proposed rural community survey will address this information gap by collecting information from representatives of 150 rural communities in three regions of the United States and from health care providers in the same communities. The

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survey will investigate the perspectives of community leaders and organizations concerning the need for improved access to health care services, the local community assets that attract or repel health care providers, the investments and efforts undertaken or planned to recruit and retain health care service providers, and the effects of changes in health care service provision on other aspects of community development. The survey will also investigate the perspective of health care providers on the factors affecting their decisions to locate, continue and change their operations in these rural communities, including the influence of community assets and investments such as improvements in local schools, availability of Internet broadband or other infrastructure, provision of child care services, recreational opportunities, and other factors.

The three proposed study regions include the lower Mississippi Delta region (including parts of the States of Mississippi, Louisiana, Arkansas and Tennessee), the Southern Great Plains region (including parts of Texas, Oklahoma, Kansas, Nebraska, New Mexico, and Colorado), and part of the Upper Midwest region (including parts of Missouri, Iowa, Minnesota, Wisconsin and Illinois). These regions include areas with high rates of poverty and severe constraints to health care access--especially in the Delta and Southern Great Plains--while incomes and health care access are relatively more favorable in the Upper Midwest region. All three of these regions include rural areas where growth in health sector employment has been an important contributor to overall employment growth in recent years, as well as areas where less growth has occurred. These regions also include important variations in health status of the populations, presence of different racial and ethnic groups, social capital, and other key factors hypothesized to be related to rural health care provision.

The communities (towns and surrounding counties and hospital service areas (HSAs)) studied in the survey will be selected using a stratified random sample. Potential respondents for each sampled community will be identified by accessing public information sources and by telephone screening. From the town, community leaders such as the town mayor, council representatives, business leaders or other stakeholders involved in recruiting and integrating health care providers to the community will be included on the respondent sample list. A sample of local health care providers in the selected town--in most cases limited to primary health care providers such as administrators of rural clinics, physicians, nurse practitioners, and dentists--will also be identified. At the county level, the list will include relevant representatives of the county government--such as the county executive and officials in the health and economic development

departments--as well as civil society organizations and others involved at that level in seeking to improve health care provision. At the HSA level, the sample will include hospital administrators and other provider representatives. A total of 10 to 15 respondents will be interviewed in each selected community (including health care providers and leaders/stakeholders in the town, county and HSA). The interviews will be conducted by telephone and are expected to require on average about 20 minutes per respondent, based upon the experience of the organization that will implement the survey (Survey and Behavioral Research Services Group, Iowa State University) in implementing community level surveys of similar scope and size.

The sample for each selected community will be strategically managed in order to provide the maximum survey response. Advance letters and a colorful information sheet/brochure will be mailed to potential respondents. A project Web site will be available with additional information, and a toll-free number will be provided for those who have questions or concerns. Confidentiality of responses will be both assured and ensured. After the advance letters/packets are sent, all reasonable efforts will be made to contact and interview the respondents in the sample. Paper or online copies of the survey will be made available to those who are unable or unwilling to complete a telephone interview.

All study instruments will be kept as simple and respondent-friendly as possible. Participation in the survey will be voluntary and confidential. Survey responses will be used for statistical analysis and to produce research reports only; not for any other purpose. Data files from the survey will not be released to the public. Responses will be linked to secondary data to augment information with no additional respondent burden. For example, the survey data will be combined with available county level data from the Census Bureau on community socioeconomic and demographic characteristics and data from the Department of Health and Human Services on health care provision and health status indicators, to analyze factors affecting local changes in health care provision.

The telephone survey will be conducted within a six month period during 2012. After the telephone survey and analysis of its results are completed, a follow up information collection will be conducted in a sub-sample of the surveyed communities (at most 40), with the goal of deepening understanding of (i) how and why the community factors that appear to influence recruitment and retention of health care providers (as will be identified by the telephone survey) are able to do so, and (ii) how development of the health care sector contributes to broader economic development in rural communities. This second phase will use more qualitative methods, including in depth individual and focus group interviews, and will be completed in 2013. This notice focuses on the telephone survey; another notice will be provided before the second phase begins.

Authority: These data will be collected under the authority of 7 U.S.C. 2204(a) and sec. 501 of the Rural Development Act of 1972 (7 U.S.C. 2661). Individually identifiable data collected under this authority are governed by 7 U.S.C. 2276, which requires USDA to afford strict confidentiality to non-aggregated data provided by respondents. This Notice is submitted in accordance with the Paperwork Reduction Act of 1995, Pub. L. 104-13 (44 U.S.C. 3501, et seq.) and Office of Management and Budget regulations at 5 CFR part 1320. ERS also complies with OMB Implementation Guidance, ``Implementation Guidance for Title V of the E-Government Act, Confidential Information Protection and Statistical Efficiency Act of 2002 (CIPSEA)'', 72 FR 33362, June 15, 2007.

Affected Public: Respondents will include health care providers, local government and community leaders, and other stakeholders involved in recruiting and retaining health care providers in rural communities.

Estimated Number of Respondents and Respondent Burden: The telephone survey will be completed at one point in time within a six month period in 2012. The survey will have a complex mixed survey administration to include telephone screening, pre-notification letter with Web access, multi-contact telephone interviewing, and follow-up non-respondent mail questionnaires. The time required for respondents and non-respondents to read the notification materials, review instructions, participate in the screening interview, and decide whether to complete the questionnaire is estimated to average 15 minutes per person. Completion time for each questionnaire respondent is estimated to average 20 minutes per completed questionnaire. In addition, the screening interviews used to select

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the sample will involve telephone conversations with knowledgeable people in each community. We estimate that this may require 15 minute interviews with up to 8 people per community, or a maximum burden of 2 hours per sample community.

Full Study: The maximum sample size for the full study is 2,812 respondents (15 respondents maximum per community x 150 communities/80% response rate). The expected overall response rate is 80 percent. The maximum total estimated response burden for all of those participating in the study is 1,313 hours (2,250 respondents x 35 minutes per respondent \1\) and for the non-respondents is 141 hours (562 non- respondents x 15 minutes per non-respondent \2\). In addition, we estimate a maximum burden of 300 hours on non-sample interviewees contacted during the pre-sample screening process for the full study (150 communities x 8 interviewees/community x 15 minutes per interviewee).

\1\ The 35 minutes per respondent includes 15 minutes to review the materials, participate in the screening interview, and decide whether to participate, and 20 minutes to complete the questionnaire.

\2\ The 15 minutes per non-respondent is to review the materials, participate in the screening interview, and decide whether to participate.

Pilot Study: A pilot test of the survey will be done in advance of the full survey. The purpose of the pilot is to evaluate the survey protocol, and test instruments and questionnaires. The initial sample size for this phase of the research is 100 respondents (10 respondents per community x 10 communities). The expected response rate is 80 percent. The total estimated burden for full respondents in the pilot testing is 47 hours (100 respondents x 80 percent x 35 minutes per respondent), and for non-respondents is 5 hours (100 respondents x 20 percent x 15 minutes per non-respondent). In addition, we estimate a maximum burden of 20 hours on non-sample interviewees contacted during the pre-sample screening process for the pilot study (10 communities x 8 interviewees/community x 15 minutes per interviewee).

The total respondent burden, including the pilot and full study, is estimated at 1,826 hours (see table below).

Table--Estimated Respondent Burden for the Survey on Rural Community

Wealth and Health Care Provision

Item	Pilot study	Full study	Total
Sample size.....	100	2,812	2,912
Responses			
--Number.....	80	2,250	2,330
--Minutes/response.....	35	35	
--Burden hours.....	47	1,313	1,360
Non-responses			
--Number.....	20	562	582
--Minutes/response.....	15	15	
--Burden hours.....	5	141	146
Pre-sample screening interviews			
--Number.....	80	1,200	1,280
--Minutes/interview.....	15	15	
--Burden hours.....	20	300	320
Total burden hours.....	72	1,754	1,826

Dated: August 31, 2011.
 Laurian Unnevehr,
 Acting Administrator, Economic Research Service.

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