Supporting Statement: Part A

Survey of Primary Care Physicians on Oral Health

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May 15, 2012

Table of Contents

LIST OF ATTACHMENTS

A. JUSTIFICATION

1. Circumstances Making the Collection of Information Necessary

The Office on Women's Health (OWH) at the Department of Health and Human Services is requesting OMB approval to conduct a new, one time information collection, surveying primary care physicians on oral health knowledge, attitudes, and professional experience. We are requesting two years of OMB approval to enable sampling, screening, survey implementation, and follow-up.

Background

It has been 10 years since the Surgeon General's report, *Oral Health in America: A Report of the Surgeon General,* identified oral health as essential to general health and well-being and called for a national effort to improve oral health among all Americans[1]. As the report noted, most oral diseases and conditions are complex and result from genetic, socioeconomic, behavioral, and environmental interactions as well as general health influences. In addition to the direct health consequences of these diseases, the report reviewed the growing evidence that these diseases contribute to other health problems. Based on this relationship between oral and systemic health, the report advocated for interdisciplinary training between medical and dental providers and participation of physicians in oral disease prevention. While oral health and systemic health are often treated through separate systems of care, a growing body of evidence is demonstrating a clear link between the two. In addition to poor oral health contributing to systemic health problems, oral health can be affected by various diseases and conditions.

Because the major oral diseases are largely preventable or amenable to early intervention, the disparities and health effects could be alleviated, in part, through increased physician training and participation in oral disease prevention. Although 10 years ago the Surgeon General's report advocated interdisciplinary training between medical and dental providers and integrating oral health checks into routine care delivery, it appears only modest progress has been made on this front. First, very little research has been done on the oral health knowledge, attitudes, and practices of primary care physicians, although there have been some studies of pediatricians that revealed a paucity of knowledge[2]. Second, the limited available research suggests that primary medical care providers are still not comfortable performing basic oral health assessments and many consider oral health outside their realm of practice. Information about oral health remains absent in health professional education outside of dental health professionals, perhaps suggesting to health professionals that health of the mouth is separate from a patient's general health.

[1] Department of Health and Human Services. (2000). Oral Health in America: A Report of the Surgeon General-Executive Summary. Rockville, MD: Westat.

[2] Lewis, C., Grossman, D., Domoto, F., & Deyo, R. (2000). The Role of the pediatrician in the oral health of children: A national survey. *Pediatrics,* 106(6):E84.

This survey of primary care physicians on oral health will provide the agency with information on oral health knowledge, attitudes, and professional experience among practicing physicians throughout the US. The study will explore oral health training and support needs, knowledge of guidelines, attitudes and views of their role in oral health, current practices and barriers to further involvement, such as a lack of sufficient reimbursement or referral care options. Specific research questions include:

1. What level of training and knowledge do primary care physicians have about oral health? (Survey questions: 1-6, 8, 9)
2. What are primary care physicians' attitudes and perceptions about their role in oral health? (Survey questions: 7, 10, 11, 12, 16, 25)
3. Do primary care physicians conduct oral exams, and if so, what do they look at? (Survey questions: 13-15)
4. What advice do primary care physicians provide to patients about oral health? (Survey questions: 17- 19)
5. What oral health referrals do primary care physicians make? (Survey questions: 20- 21)
6. Do they collaborate with oral health providers? (Survey questions: 23- 24)
7. What are the barriers to primary care physicians in addressing oral health? (Survey questions: 16, 22)
8. What resources would help primary care physicians address oral health? (Survey questions: 26, 27)

Authorization:

Section 301 of the Public Health Services Act (42 U.S.C. 241) authorizes the collection of this data. Please see **Attachment 1** for a copy of this legislation.

The survey of Primary Care Physicians on Oral Health will be a one-time mail survey of a national sample of physicians drawn from databases maintained within the National Plan and Provider Enumeration System (NPPES that contain the National Provider Identifier (NPI) records). Physicians will be screened by telephone to confirm their eligibility, and correct contact information. Eligible physicians will receive a survey package via USPS. Physicians who do not respond to this voluntary survey within 13 days of the first mailing will be sent a second survey package. The survey will be conducted by Westat under contract with OWH. Westat interviewers will make follow-up calls to non-responding physician offices to verify receipt of the survey package. Six to eight weeks after the end of follow-up calls, a third survey package will be sent to physicians who have not yet responded before following up with one more phone call. Respondent contact and eligibility information and survey completion status will be tracked by a Study Management System developed by Westat. Individual identifying information is stripped from the response data prior to delivery to OWH.

2. Purpose and Use of Information Collection

This survey will provide knowledge about primary care physicians that could be used by HHS or other entities to inform initiatives designed to improve the quality of care delivered to adult patients and increase collaborative efforts among dentists and physicians. Published manuscripts will add depth to the peer-reviewed scientific literature with regard to the extent that the evidence base has been adopted into practice. If there is a need to educate primary care physicians on oral health, a window of opportunity currently exists under the HHS Oral Health Initiative to engage in a cross-collaborative federal effort.

3. Use of Improved Information Technology and Burden Reduction

In a 2008 review paper focused on conducting survey research among physicians and other medical professionals, physicians were found to prefer mail surveys to other modes.[3] The literature identifies a number of barriers to good response rates regarding web surveys, including: an inability to provide active notification and email reminders by a key senior person (such as the Chief Resident) in order to respond; [4-5] infrequent access to office Internet accounts; the expressed feeling that web surveys need to be short;[3] and limited use of computers in the office (around 50% for PCPs and specialists combined).

Considering the published literature on web and email surveys, response rates, physician preference and physician access to information technology during daily work, data will be collected through a pencil and paper survey and distributed to physicians by Priority Mail.

To further reduce respondent burden, prior cognitive testing among nine physicians has ensured a streamlined questionnaire including an easy to read format with skips, eliminating a cumbersome design and reducing burden. The use of a short (five minute) telephone screener in addition to several eligibility questions in the beginning of the survey quickly assess if the respondent is not eligible for the study, further reducing burden.

4. Efforts to Identify Duplication and Use of Similar Information

Extensive literature and Internet searches, including searches of federal agency web sites, were conducted by Westat project staff to assess if information regarding primary care physicians' oral health knowledge, attitudes, and professional experience had been previously collected. In addition, OWH project staff conferred with colleagues from AHRQ, HRSA, and CDC, including the USPHS Chief Dental Officer/Chair of the Oral Health Coordinating Committee and the lead

[3] Flanigan T, McFarlane E, Cook S. Conducting Survey Research among Physicians and other Medical Professional-A Review of the Current Literature. AAPOR. RTI International, 2008.
[4] McKinley T, Rogers R, Maclean R. Collecting data from physicians via web-based surveys: recommendations for improving response rates. The Internet Journal of Medical Informatics. 21003; 1:1-7.
[5] Beebe TJ, Locke R, Barnes SA, Davern ME, Anderson KJ. Mixing web and mail methods in a survey of physicians. HSR.2007; 42:1219-1233.

for the Healthy People 2020 Oral Health Workgroup, as well as experts outside government such as, a primary care provider at Boston Medical Center, a professor of dentistry at the University of Washington, and a researcher in dental public health at the University of North Carolina.

A review of the literature and consultations reveal the paucity of information regarding oral health knowledge, attitudes, and practice of primary care physicians in the United States. There are currently no known efforts to collect generalizable national data from primary care physicians on these topics regarding the care of adult patients. In **Attachment 2**, we provide a table, summarizing information on past surveys that are related to these efforts but address only specific diseases or topics, focus on treatment of infants and children, or produce data that are not representative of all U.S. family practice physicians and internists specializing in primary care. Please see **Attachment 3** for a reference list of literature and other information sources relevant to this study.

5. Impact on Small Businesses or Other Small Entities

While some physician practices are large and have multiple sites, some practices may include just a few physicians and thus may be considered small entities. The survey instrument has been designed to minimize respondent burden, including an easy-to-read format with skips to eliminate some questions based on previous responses. Time-to-complete is estimated at 20 minutes or less.

6. Consequences of Collecting the Information Less Frequently-OWH

There are no legal obstacles to reduce the burden. This is a one-time collection of information.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This request fully complies with the regulations of 5 CFR 1320.5.

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

A. Federal Register Notice

A 60-day Notice was published in the Federal Register on February 13th, 2012 (Volume 77, Number 29, page 7581) (**Attachment 4**). OWH received no public comments in response to this notice.

B. Consultations Outside the Agency

OWH project staff convened a 13 member Technical Advisory Group to help design the study and review the questionnaire. The representatives from outside HHS were mostly from the academic sector (from the Universities of North Carolina, Maryland, Colorado and Washington) but also included a primary care provider at Boston Medical Center and leadership from the

National Interprofessional Initiative on Oral Health. We had a series of conference calls, as well as one-on-one contacts with the Group from November 2011 to February, 2012.

9. Explanation of Any Payment or Gift to Respondents

Payment for participating in an interview or survey is standard practice when seeking participation of professionals such as physicians. The incentive payment is an effective method of drawing physician attention to the study and gaining cooperation in completing the questionnaire. It is not intended to be a payment for their time, but an incentive to increase response rate. Historically, physicians are one of the most difficult populations to survey, partly because of the demands on their professional time. Consequently, incentives assume an even greater importance with this group.

OWH believes that in order to achieve an adequate response rate for this survey, it is essential to offer a modest incentive of $50. There is considerable evidence in the literature showing that the most effective way to increase response rates among professionals (particularly physicians) is by offering a monetary incentive. In a survey of physicians, Gunn and Rhodes (1981)[6] found the response rate to an initial survey with no incentive was 58%, with a $25 incentive, 69%, and with a $50 incentive, 77%, with the difference between the $50 and the $25 incentive rate being statistically significant. Recent studies conducted by the contractor support these findings. Some studies show that physicians may be becoming accustomed to the much greater monetary incentives ($100-$150) offered for participation in research funded by the private, for-profit sector. This shift in expectations is thought, in some cases, to severely compromise the generalizability of surveys conducted without incentives. For this reason, OWH feels that an incentive of at least $50 is essential to attract enough attention to the survey to achieve acceptable response rates. A $50 incentive for completing a federally sponsored survey about a subject of importance to public health should be high enough to communicate the importance of physician responses to the survey and to gain their attention.

10. Assurance of Confidentiality Provided to Respondents

A number of procedures will be implemented to safeguard respondent identity, and will be explained to respondents. Each physician's survey will have a unique ID number at the top of the cover page. This number will be used as a unique record identifier during data entry. The data file containing physicians' names and ID numbers will be maintained separately by Westat and used only for mailing the surveys.

Furthermore, employees of the data collection contractor, Westat, are required to sign a non-disclosure agreement (see **Attachment 5**). Westat provides all safeguards mandated by the Privacy Act to protect privacy of data gathered for this study. Westat's data security procedures

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

comply fully with procedural safeguards for computerized records as outlined in the U.S. Department of Health and Human Service's *General Administrative Manual* under "Safeguarding Records Contained in Systems of Record" and specified by the National Institute of Standards and Technology Federal Information Processing Standards.

IRB Approval

The screening and survey portions of this study have been approved by Westat's Institutional Review Board (IRB). Please see **Attachment 6** for the approval documentation.

11. Justification for Sensitive Questions

This survey will not include questions of a personally sensitive nature; however, respondents will be asked to share information about their opinions, knowledge and professional experience treating patients with respect to oral health care. Respondents may assume that their answers reflect the quality of care provided by their practice. Therefore, the survey questions may be perceived as organizationally sensitive. Respondents will be informed of safeguards that ensure their data are not identifiable by OWH and information will be maintained in a secure manner.

The Department of Health and Human Services (HHS) requires that race and ethnicity be collected from all HHS data collection instruments. In compliance with this requirement, the survey will ask the respondent their race and ethnicity.

12. Estimates of Annualized Burden Hours and Costs

Screening

The telephone screener will be administered to the individual who answers the phone at the selected practice (see **Attachment 7**). We anticipate that this will likely be an office assistant or medical secretary. The primary purpose of the screener is to determine whether the physician is still with the office and eligible for the survey. We anticipate that an office assistant or medical secretary will be able to answer the screener questions in a short amount of time. We have estimated 5 minutes per response. Screening for the survey will involve approximately 1,300 respondents. Over the period of this information collection request, the average annualized number of respondents for the screening information collection is 1,300 respondents, and the average annualized burden is 108 hours.

Mail Survey

The target population for the mail survey are physicians who are either Internal Medicine or Family Practitioners who spend at least 20% of their time seeing patients. The estimated burden per response is 20 minutes (see **Attachment 8**). The goal of the study is to obtain 600 completed surveys. Over the one year period of this information collection request, the average annualized

number of respondents for the mail survey is 600 respondents, and the average annualized burden is 200 hours.

This is a one-time data collection, so once a respondent has completed the instrument, he/she will not be contacted again. Table A12-1 below summarizes the proposed number of respondents and the estimated burden hours. The total estimated annualized burden hours are 308.

Table 12A: Estimated Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in Hours)	Total Burden (in Hours)
Medical Secretary	Screener	1,300	1	5/60	108
Physician	Survey	600	1	20/60	200
Total					308

B. Table 12B summarizes the estimated cost to respondents. The hourly wages reflect the mean hourly earnings reported by the National Compensation Survey[7]. The hourly wages for the physician are those of family and general practitioners. The total estimated annualized cost to respondents is $29,920.20.

Table 12B: Estimated Annualized Burden Costs to Respondents

Type of Respondent	Form Name	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
Medical Secretary	Screener	108	$16.05	$1,733.40
Physician	Survey	200	$94.17	$18,834.00
Total				$20,567.40

13. Estimates of other Total Annual Cost Burden to Respondents or Record Keepers

There are no capital or start-up costs, and there are no costs to the respondents or record keepers for operation and maintenance of services.

[7] National Compensation Survey, All United States, December 2009 – January 2011. *Table 4: Full-time private industry workers: Mean and median hourly, weekly and annual earnings and mean weekly and annual hours.* Bureau of Labor Statistics, US Department of Labor.

14. Annualized Cost to the Government-OWH

Westat will conduct the majority of tasks associated with this data collection effort, including screening participants through telephone, sending reminder letters to participants, mailing the survey instrument, collecting and safeguarding data, and performing data cleaning and analysis. The OWH contract with Westat is for $292,469 over 2 years, or $146,234.50 per year. Costs to the government also include OWH time and effort for overseeing the contract, providing technical expertise, and answering questions posed by the contractor. Two OWH staff will lead this project. Estimated personnel time is 20% of a FTE. The total estimated annual cost to the government is $168,234.50.

Table A14-1: Annualized Cost to Government

	Annualized Cost
OWH total	$22,000.00
Contractor total	$146,234.50
Total	$168,234.50

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

The survey will be conducted 1-4 months after OMB approval is obtained (Table A16-1).

Table A16-1: Project Time Schedule

Study Activity	**Time Schedule**
Initial tracing	Immediately following OMB approval
Screening telephone calls	1 month after OMB approval
1st mailing of survey package	1 month after OMB approval
2nd mailing of survey package	2 months after OMB approval
Follow-up phone calls	2 months after OMB approval
3rd mailing of survey package	4 months after OMB approval
Follow-up phone calls	4 months after OMB approval
Data cleaning and weighting	5 months after OMB approval
Data analysis	5 months after OMB approval
Data delivery	6 months after OMB approval
Final report submitted	7 months after OMB approval
Journal article drafted	8 months after OM B approval

Briefing materials submitted	8 months after OMB approval

Once data collection is complete, analysis will begin. Westat will provide tabular summaries for each survey item. Westat will conduct bivariate analyses to compare and contrast responses by physician background characteristics. Westat will also explore the correlation between responses across questions. Specifically, Westat will explore how knowledge of oral health and perceived barriers to including oral health in routine visits affects current practices. Sample size will ultimately dictate the granularity of data analysis. To ensure broad distribution of the findings, we plan to publish the results of this study in a peer-review journal and on the OWH webpage, and to present these findings in meetings with federal decision-makers and at professional conferences.

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

The expiration date for OMB approval of data collection will be displayed as required.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification statement.