Supporting Statement: Part B

Monitoring Changes in Attitudes and Practices among Family Planning Providers and Clinics

Submitted by:

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B. COLLECTIONS OF INFORMATION EMPLOYING STATISTICAL METHODS

B1. Respondent Universe and Sampling Methods

The proposed samples are intended to be nationally representative, as the sample frames will represent a complete census of the target samples. For example, to sample private-sector physicians specializing in obstetrics and gynecology, family medicine, and adolescent medicine (specialties that provide the bulk of family planning services in the United States), we will use the AMA Physician Masterfile, which includes information on AMA member and nonmember board-certified physicians residing in the United States and United States territories. To sample public-sector family planning providers and health center administrators, we will use the Guttmacher Institute Database of Publicly-funded Family Planning Health Centers, which is regularly updated and maintained by the Guttmacher Institute.

For each respondent type, the table below summarizes the sampling frame that will be used, the number of entities in the respondent universe, the desired number in the final sample, the expected response rate, the number to be sampled (taking into account the desired number in the final sample and the expected response rate), and the sampling fraction to be used (taking into account the number to be sampled and the number of entities in the respondent universe).

Respondent Type	Sampling Frame	Number in Respondent Universe	Desired Number in Final Sample	Expected Response Rate [a]	Number to be Sampled	Sampling Fraction
Private-sector office-based OB/GYN physicians	AMA Physician Masterfile	34,426	500	50%	1,000	1/34
Private-sector office-based family medicine physicians	AMA Physician Masterfile	77,927	362	50%	725	1/107
Private-sector office-based adolescent medicine physicians	AMA Physician Masterfile	275	138	50%	275	1/1 [b]
TOTAL private-sector office-based physicians			**1,000**		**2,000**	
Public-sector Title X clinics [c]	Guttmacher Institute database of publicly-funded family planning health centers	4,095	1,000	50%	2,000	1/2
Public-sector non – Title X clinics [c]	Guttmacher Institute database of publicly-funded family planning health centers	3,903	1,000	50%	2,000	1/2
TOTAL public-sector health centers that provide family			**2,000**		**4,000**	

Respondent Type	Sampling Frame	Number in Respondent Universe	Desired Number in Final Sample	Expected Response Rate [a]	Number to be Sampled	Sampling Fraction
planning services						

[a] Some respondent types were included in our Phase 1 data collection (EPI AID No. 2010-024; OMB No. 0920-0008) with the following response rates: OB/GYN physicians=52%, family medicine physicians=45%, adolescent medicine physicians=68%, and Title X clinic providers=77%. Given that response rates fluctuate over time and slight changes in methodology between Phase 1 and Phase 2, we assume 50% response rate for all respondent types here.

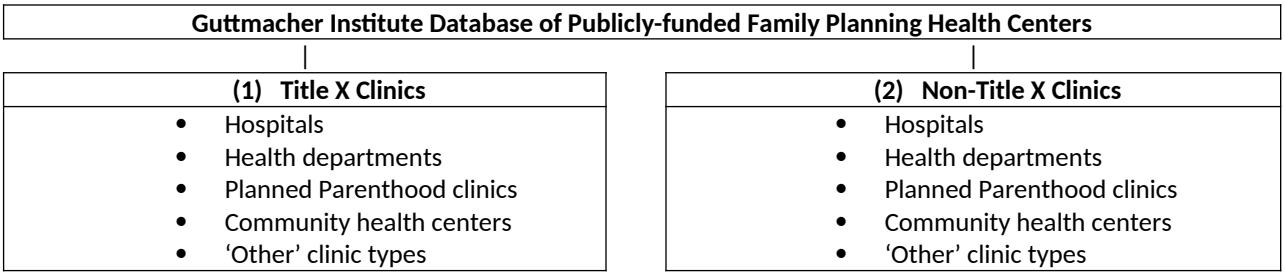
[b] For office-based adolescent medicine physicians, the entire universe will be sampled to ensure an adequate number of providers from this specialty being represented in the sample.

[c] These consist of hospitals, health departments, Planned Parenthood clinics, community health centers, and 'other' clinic types; these strata of clinic types will be sampled proportionate to their representation in the universe.

For the two major respondent type categories (i.e., private-sector office-based physicians and public-sector health centers that provide family planning services), the estimates in the "desired number in final sample" column for the "total" for that respondent type category (highlighted in table in bold), are derived from power calculations conducted when collecting our baseline data in Phase 1 (EPI AID No. 2010-024; OMB No. 0920-0008). We sought to power the sample to detect a 5% change from baseline levels based on a 2-tailed test at 5% significance with 80% power, assuming 50% non-response.

For private-sector office-based physicians, when drawing the sample for each specialty (i.e., OB/GYN, family medicine, adolescent medicine), the respondent universe will be sorted first by zip code and the sample fraction employed.

For public-sector health centers that provide family planning services, after sorting clinics by receipt of Title X funding status (i.e., Title X clinic versus non-Title X clinic), the universes will be sorted by clinic type (i.e., hospital, health department, Planned Parenthood clinic, community health center, and 'other'), and then sorted by zip code (*see below Figure*). Clinic types will be sampled proportionate to their representation in the universe. For example, if 50% of Title X clinics are health departments, then health departments will represent 50% of the Title X sample.



B2. Procedures for the Collection of Information

Project staff at the CDC will obtain and provide to the data collection contractor the list of sampled public-sector health centers that provide family planning services. The data collection contractor will obtain the list of sampled private-sector physicians.

The data collection contractor will prepare the mailed survey packages and send to the 6,000 sampled private-sector physicians and public-sector health centers nationwide (recall that 1 survey will be sent to 2,000 private-sector physicians and 2 surveys will be sent to 4,000 public-sector health centers).

The mailed survey packages will include a cover letter (**Attachments C-1 and C-2**) addressed personally to the physician or health center, and will include a description of the assessment, will address the importance of participation, and will include a point of contact to direct inquiries. The cover letters will also include signatures of support from partner organizations (i.e., AAFP, AAP, ACOG, ASRM, HRSA/BPHC, NACHC, NFPRHA, and PPFA).

For private-sector physicians, each mailed survey package will include a single survey (**Attachment D-1**) with survey cover sheet (**Attachment D-2**), to be completed by the physician.

For public-sector health centers, each mailed survey package will include two surveys (**Attachments D-1 and E-1**) with two survey cover sheets (**Attachments D-2 and E-2**) – one to be completed by a clinician who provides family planning services to women of reproductive age at least twice per week, and the second to be completed by a health center administrator. Each respondent will only be asked to complete a single survey.

Each survey will contain a unique identification number (UID), assigned by the data collection contractor. CDC will not have access to any file linking names and addresses of physicians and health centers in our sample with their assigned UIDs. Each mailed survey will be accompanied by a postage-paid return envelope addressed to the contractor via a rented postal office box. Respondents will also be given the option to complete the survey online via a password-protected web-based data collection system.

Anticipating non-response, a reminder postcard will be sent to those who have not responded to the first mailing after approximately 2-4 weeks (**Attachments F-1, F-2, and F-3**). A second copy of the survey, along with a follow-up cover letter (**Attachments G-1, G-2, and G-3**) will be sent to those that have not responded to the first survey or reminder postcard approximately 2-4 weeks after the reminder postcard. Phone calls will be made and emails sent (if email addresses are available) to those that have not responded to any of the contact attempts to encourage participation.

Data collected online will be downloaded into an electronic database on a regular basis. Paper-copy survey data will be entered into an electronic database. The two databases, stripped of any identifiers other than the UID, will be permanent federal records and will be maintained in accordance with CDC's records control schedule (http://isp-v-maso-apps/RecSched/ViewSchedule.aspx?RID=29). Paper-copy surveys will be shredded within eight months after completion of data entry. Respondents will not be re-contacted after survey completion to validate any potentially unclear data elements.

The data collection contractor will develop a data entry database and analytic codebook to facilitate valid and efficient data entry and analysis. For quality control purposes, 10-25% of paper-copy completed surveys will be double-entered.

The study design for this ICR is not experimental, but is instead a cross-sectional assessment.

B3. Methods to Maximize Response Rates and Deal with No Response

To maximize response rates, aspects of Dillman's "Tailored Design Method" will be followed.[1]

For example, each mailed survey package will include a cover letter that is addressed personally to the sampled physician or health center, and will include pieces of information that have been shown to be critical for enhancing response (e.g., the request, how the individual or health center was selected, and the usefulness of the information). The cover letter will also include signatures of support from partner organizations (i.e., AAFP, AAP, ACOG, ASRM, HRSA/BPHC, NACHC, NFPRHA, and PPFA), some of which the recipients may belong to.

We will also request that select partner organizations (e.g., PPFA), if they choose, send a pre-survey email to their constituents. The content of the email will be left up to the discretion of the partner organization, but may include a positive and timely notice that the constituent may be receiving a request from the CDC and OPA to help with an important survey, and encourage their participation.

Once initial survey packages are mailed to respondents, multiple contacts will be made to non-respondents by the data collection contractor to encourage participation. These include sending a reminder postcard approximately 2-4 weeks after the initial mailing, a second copy of the survey sent approximately 2-4 weeks after the reminder postcard, followed by phone calls and email contacts (if email addresses are available) to those that have not responded to any of the previous contact attempts.

Additionally, potential respondents will be offered the option of completing the survey online, and each survey will include a postage-paid return envelope to remove cost barriers.

Last, to maximize the response rate, as well as to provide important family planning information and provider tools, a package of "US MEC provider tools" will be sent to all physicians returning a survey (complete or non-complete), as well as all health centers returning at least one survey (complete or non-complete). The materials will be distributed at the end of data collection. If project funds allow, all non-responding private-sector physicians and public-sector health centers will also receive a package of "US MEC provider tools". The package may include the following: paper-copy US MEC MMWR and updates, US MEC color-coded and laminated summary chart, and US MEC wheel.

As the proposed samples are intended to be nationally representative (see B1), after data collection, data will be weighted to account for the probability of selection into the sample, as well as nonresponse bias. In addition, we will know basic information about each of the sampled physicians and health centers, which will be analyzed to understand general differences between respondents and non-respondents. For example, for the publicly-funded family planning health centers, we will know the type of health center (e.g., Planned Parenthood, hospital, community health center). For physicians, we will know background information such as specialty, gender, and graduation year from medical school.

B4. Tests of Procedures or Methods to be Undertaken

The data collection procedures are mostly the same as those employed during our baseline data collection in Phase 1 (EPI AID No. 2010-024; OMB No. 0920-0008), which proved to work smoothly and efficiently. Slight changes include allowing more time between contacts (e.g., 2-4 weeks versus 2 weeks), allowing more follow up time, and offering an incentive for participation.

The data collection instruments were developed using input from internal and external consultants to improve clarity and validity. The instruments were then pilot tested with a sample of no more than nine individuals. Prior to launching the online survey data collection system, CDC and contractor staff will test the system including skip patterns to ensure ease of online data entry.

Select questions or very similar questions on the provider survey (Part A, Attachment D-1) were also included in our Phase 1 data collection (EPI AID No. 2010-024; OMB No. 0920-0008): 1-3, 5-16, 18-20, 29.

B5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data

Name	**Organization**	**Role**
Brian Morrow, (770) 488-6349, bxm0@cdc.gov	CDC/DRH	Statistician
Gary Jeng, (770) 488-6216, gaj9@cdc.gov	CDC/DRH	Statistician/Data analyst
Michele Mandel, (770) 488-6361, mgm2@cdc.gov	CDC/DRH	Statistician/Data analyst
To be determined	Manila Consulting	Collecting data
Lauren Zapata, (770) 488-6358, dvq8@cdc.gov	CDC/DRH	Data analyst
Maura Whiteman, (770) 488-6293, acq5@cdc.gov	CDC/DRH	Data analyst
Naomi Tepper, (770) 488-6506, gdq2@cdc.gov	CDC/DRH	Data analyst

References

[1] Dillman DA. Survey Implementation. *Mail and Internet Surveys*. 2nd edn. New York: John Wiley & Sons, Inc 2000; 149-93.