

ANNEX K

FEDERAL REGISTER NOTICE

**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 (44 U.S.C. Chapter 35), this notice announces the Economic Research Service's intention to request approval for a new information collection for a Survey on Rural Community Wealth and Health Care Provision.

DATES: Comments must be received by August 16, 2013 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, 1400 Independence Ave. SW., Mailstop 1800, Washington, DC 20250-0002.

Comments may also be submitted via fax to the attention of John Pender at 202-694-5773 or via email to jpender@ers.usda.gov.

FOR FURTHER INFORMATION

CONTACT: John Pender, jpender@ers.usda.gov. Tel. 202-694-5568.

SUPPLEMENTARY INFORMATION:

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

OMB Number: To be assigned by OMB.

Expiration Date: Three years from the date of approval.

Type of Request: New information

collection.

Abstract: The primary purpose of the proposed survey is to collect information on how rural small towns can attract and retain primary health care providers, considering the broad range of assets and amenities that may attract providers. The secondary purpose is to provide information on

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how improving health care may affect economic development prospects of rural small towns. The Economic Research Service (ERS) intends to address these purposes by collecting primary data from health care providers and community leaders in 150 rural small towns in nine states in three regions: Mississippi, Louisiana, and Arkansas (representing the Mississippi Delta region); Texas, Oklahoma, and Kansas (Southern Great Plains region); and Iowa, Minnesota, and Wisconsin (Upper Midwest region).

This information will contribute to improved understanding of the roles that rural communities play in attracting and retaining health care providers, and of how improved health care provision contributes to economic development of these communities. Such understanding is critical to develop effective policies and local strategies 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 and businesses in rural areas, provide employment, and improve the quality of life.

The study will focus on small rural towns (population 2,500 to 20,000) because it is expected that the ability to attract and retain health care providers is most likely to be affected by local assets and amenities for such towns. The universe of small towns in the three regions selected includes about 9 percent of the rural population of the United States and represents considerable diversity in levels of economic development and access to health care services. The set of 150 small towns included in the study will be selected using a probability based sample, so that the information collected will be representative of this universe of rural small towns in the nine states.

Although much research has investigated the problems of attracting and retaining health care providers in rural areas, very little research addresses the relationships between economic development and health care provision

in rural areas. Virtually no research addresses the issue from the perspective of rural communities themselves, investigating whether and how rural communities seek to attract and keep health care providers, and how they think this influences their economic development prospects. The proposed information collection will address this information gap. It will consist of three phases: (1) Key informant telephone interviews with select local government leaders and health care administrators in the study towns; (2) a dual mode telephone/mail survey of

primary health care providers in the towns; and (3) follow up focus groups and/or in-person key informant interviews in a subset of selected towns. The information collected will be augmented by publicly available secondary information on health care provision and economic development in the study regions. The objectives of the initial key informant interviews with local government leaders and health care administrators are to collect or verify information assembled from secondary sources on (i) which health care services and providers are available in the town, (ii) how provision of health care services in the town has changed in the past five years, (iii) the extent to which recruiting and retaining health care providers is seen as a priority by leaders in the town, (iv) what efforts have been made to recruit and retain providers, and (v) perceived impacts of these efforts on aspects of economic development in the town. Key informant interviews will be conducted with up to four individuals, including at least one representative of the local government—either the chief executive officer (mayor or city/town manager) or a knowledgeable representative designated by that officer—and the administrator of at least one primary health care facility (hospital or clinic), if such facilities are available, in the town. If a hospital or clinic is not available in the town, other informants with knowledge about health care in the town will be sought. Semi-structured interviews will be used, and are

expected to last up to 60 minutes each. The key informant interviews will be conducted before the telephone/mail survey of health care providers, since they will help to validate the sample frame of providers and may yield information useful in the design of the provider survey. The dual mode telephone/mail survey will investigate the perspective of primary health care providers in rural small towns on the factors affecting their decisions to locate, continue and change their operations in these rural communities, including the influence of community assets and amenities. The target population of health care providers includes primary care physicians, physician assistants, nurse practitioners, certified nurse midwives, and dentists. A random sample of up to 8 health care providers will be surveyed in each sample town. The telephone interviews are expected to average about 20 minutes per respondent, based upon cognitive interviews testing a draft of the survey instrument with three rural health care providers. Paper copies of the survey will be mailed to those who are unable or unwilling to complete a telephone interview. It is expected that the paper surveys will also require about 20 minutes to complete. After the provider survey and analysis of its results are completed, focus groups and/or follow up key informant interviews (possibly including some of the people interviewed during the initial key informant interviews) will be conducted in person 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. The communities included in this phase of the study will be purposefully selected to be representative of different conditions with regard to region, access to health care providers, and level of economic development. Participants will be individuals knowledgeable about health care and/or economic development issues in the community, including representatives of local government, the business sector, the non-profit sector, and the health care industry. Current plans are to conduct at least one focus group with up to 10 participants in each of the sub-sample of communities, with one-on-one semi-structured interviews as circumstances require. We expect to interview no more than 12 people per community regardless of whether one or more focus groups or one-on-one interviews are conducted. It is anticipated that each focus group and one-on-one interview will last 60 minutes. A semi-structured instrument will be used to guide these focus groups and interviews. All study instruments will be kept as simple and respondent-friendly as possible. Participation in the interviews will be voluntary and confidential. Survey responses will be used for statistical analysis and to produce research reports only; not for any

other purpose. 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 town and 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, to analyze factors affecting local changes in health care provision.

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Authority: These data will be collected under the authority of 7 U.S.C. 2204(a) and 7 U.S.C. 2661. ERS will comply 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. Respondent information will be protected under the CIPSEA and the 7 U.S.C. 2276.

Estimate of Burden: Public reporting burden for this collection of information is estimated to average 0.91 hours per response.

Type of Respondents: Respondents to the first phase key informant telephone interviews will include chief executive officers (or their designated representatives) of the towns, administrators of health care facilities (in towns having such facilities), or other individuals knowledgeable about health care (particularly in towns not having such facilities) in the 150 rural small towns selected for the study. Respondents in the second phase telephone survey will

include primary health care providers in the selected towns, including primary care physicians, physician assistants, nurse practitioners, certified nurse midwives, and dentists. Respondents in the third phase focus groups and in-person key informant interviews will include representatives of local government, the local health care industry, businesses, and non-profit organizations concerned with health care and/or economic development.

Estimated Number of Respondents: (i) Key informant telephone interviews: 4 respondents per community · 150 communities = 600 respondents (assuming 67% response rate); (ii) Telephone/mail survey of health care providers: 8 respondents per community (assuming 80% response rate) · 150 communities = 1,200 respondents; (iii) Focus group participants and key informant interviews: 12 respondents per community · 40 communities = 480 respondents (assuming 80% response rate). Total number of respondents = 2,280. Total number of non-respondents = 720.

Estimated Number of Responses: 2,280 from respondents, 720 refusals from non-respondents.

Estimated Number of Responses per Respondent: 1.08 maximum, if all respondents in first phase key informant interviews participate in third phase focus groups/interviews.

Estimated Total Burden on Respondents: 2,730 hours (see table for details).

Comments: Comments are invited on:

(1) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) 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; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on those who are to respond, including the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Comments may be sent to John Pender, Resource and Rural Economics Division, Economic Research Service, U.S. Department of Agriculture, 1400 Independence Ave. SW., Mailstop 1800, Washington, DC 20250-0002.

Comments may also be submitted via fax to the attention of John Pender at 202-694-5773 or via email to jpender@ers.usda.gov. All comments received will be available for public inspection during regular business hours at the same address.

All responses to this notice will be summarized and included in the request for OMB approval. All comments will become a matter of public record.

Dated: June 10, 2013.

Mary Bohman,
*Administrator, Economic
Research Service.*

[FR Doc. 2013-14202 Filed 6-14-13;
8:45 am]

BILLING CODE 3410-18-P

Reporting Burden

Description	Estimated Number of Respondents or Non-respondents	Responses or Non-responses per Respondent	Total Responses or Non-responses	Estimated Average Number of Minutes per Response or Non-response	Estimated Total Hours of Response and Non-response Burden
Phase 1: Key informant telephone interviews					
Identify and contact key informants – admin. Staff	900	1	900	10	150
Respondents review request and decide	600	1	600	15	150
Key informant interviews	600	1	600	60	600
Non-respondents review request and decline	300	1	300	15	75
Phase 2: Telephone/Mail surveys with health care providers					
Identify and contact respondents	1500	1	1500	10	250
Respondents review request	1200	1	1200	15	300
Telephone/Mail surveys	1200	1	1200	20	400
Non-respondents review request and decline	300	1	300	15	75
Phase 3: Focus group and in-person key informant interviews					
Identify and contact participants	600	1	600	10	100
Participants review request	480	1	480	15	120
Focus groups & key informant interviews	480	1	480	60	480
Non-respondents review request and decline	120	1	120	15	30
Total Burden					2,730