"SURVEY OF STD PROVIDER POLICIES AND PRACTICES IN THE UNITED STATES"
(OMB No. 0920-XXXX)
Exp. xx/xx/xxxx

SUPPORTING STATEMENT A

October 23, 2017

Submitted by:
Division of Sexually Transmitted Disease Prevention
Centers for Disease Control and Prevention
Department of Health and Human Services

Refer questions to:

Jami Leichliter, PhD
Policy Science, Team Lead
Division of STD Prevention
Centers for Disease Control and Prevention

1600 Clifton Rd NE, MS E-02
Atlanta, Georgia 30329
(404) 639-1821
FAX (404) 639-8622
Email: jleichliter@cdc.gov

Table of Contents

List of Attachments

1. Authorizing Legislation
2. 60-Day FRN
   2a. Public Comments
3. Mailed Survey
4. Web Survey Screen Shots
5. Mail Survey Invite
6. Mail Survey Reminder 1
7. Mail Survey Reminder 2
8. Thank You Letter –Web Survey
9. Web Survey Invite
10. Web Survey Reminder
11. IRB Approval
12.

Goal of the study: The primary goal of this study is to better understand policies and practices for STD care delivery among medical providers in five specialties. Another goal is to assess awareness and use of CDC's STD treatment guidelines.

Intended use of the resulting data: Resulting data will be used to help CDC prioritize STD prevention activities and determine STD prevention needs by provider type.

Methods to be used to collect data: Surveys will be sent to a random sample of 5,000 U.S. physicians across five specialties using the American Medical Association Master file. Using a multimode design (mail and web), multiple reminders will be sent to non-responders in order to reach the target of 3,500 completed surveys.

How data will be analyzed: Data will be weighted to generate unbiased population estimates. Data will be analyzed and summarized using quantitative statistical methods specifically for complex survey data.

Justification

A.1 Circumstances Making the Collection of Information Necessary

The Division of Sexually Transmitted Diseases Prevention (DSTDP) at the Centers for Disease Control and Prevention (CDC) and the U.S. Department of Health and Human Services (USDHHS) is seeking a 3-year approval from the Office of Management and Budget (OMB) to conduct a "Survey of Sexually Transmitted Disease (STD) Provider Practices in the United States" (hereafter STD Provider Survey). CDC's authority to collect information for the STD Provider Survey is provided by Section 301 of the Public Health Service Act (42 U.S.C. 241) [280-1a] (**Attachment 1**).

Each year, 19.7 million sexually transmitted diseases (STDs) occur in the U.S., half of which strike youth 15−24 years of age.[1-2] The public health burden of STDs is compounded by their economic impact. In 2010, an estimated $15.6 billion in direct medical costs were attributed to STDs.[3] Undiagnosed and untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young adult women. For example, every year, about 24,000 young women become infertile as a result of undiagnosed and untreated STDs.[4] The STD Provider Survey will collect much needed data from U.S. health care providers in five specialties: primary care (including internal medicine), general or family practice, obstetrics/gynecology, emergency medicine, and pediatrics. Knowledge of provider practices relative to guidelines and state-level laws and policies will provide information useful to stakeholders at all levels regarding the delivery of STD preventive services and treatment by health care providers in the U.S. As providers are one of the few professionals who have face-to-face contact with persons infected with STDs, they are also a potential intervention point for attempts to reduce re-infection and halt the further transmission of STDs.

The mission of the DSTDP is "to provide national leadership, research, policy development, and scientific information to help people live safer, healthier lives by the prevention of STDs and their complications."[5] A major component of this objective is delivering timely STD preventive and treatment services to reduce the number of newly acquired STDs and prevent STD-related sequelae. Monitoring service delivery by healthcare providers is critically important to understanding practice

trends and adherence to STD-related guidelines and policies. The STD Provider Survey will provide data to aid in this goal. Specifically, the DSTDP will use survey data to assess current provider: (1) policies and practices in relation to several STD-related policy issues including the Affordable Care Act (ACA) and passage of state laws permitting Expedited Partner Therapy (EPT or providing infected patients with medication to give to their sex partners); and (2) awareness and use of the CDC's newly released STD Treatment Guidelines.[6] In 1998-99, DSTDP funded and completed its first survey of providers from five specialties (primary care including internal medicine, general or family practice, obstetrics/gynecology, emergency medicine, and pediatrics).[7] The current survey will allow DSTDP to make comparisons over time for provider practices related to STD screening, clinical actions and partner notification (efforts to notify partners of patients diagnosed with a STD).

A.2 Purpose and Use of the Information Collection

The purpose of this survey is to conduct a nationally representative survey of physicians in five specialties: primary care (including internal medicine), general or family practice, obstetrics/gynecology, emergency medicine, and pediatrics. This will allow for national estimates and comparisons among specialties. A sample of 5,000 U.S. physicians will be selected from the American Medical Association (AMA) Master File, restricted to the target specialties and stratified along two dimensions. First, we will classify physicians based on their specialty. Second, we will classify physicians based on whether they have a public or private practice, using primary practice location or another similar variable available in the AMA Master File. We anticipate a 70% response rate with a total of 3,500 responding physicians.

The survey will provide national estimates for comparisons between providers in the public and private sectors. Information collected will also be used to determine what STD prevention activities may be needed by type of providers (by specialty or public/private) based on survey findings related to screening and treatment practices for STDs including EPT. Additionally, some subgroups have a disproportionate burden of STDs; therefore, it is important for us to ask selected patient demographic information. The survey contains sections on the physician's specialty areas, primary practice setting, primacy practice policies, patient demographics, STD testing and diagnosis, STD care and treatment, and respondent demographics.

We will use a multimode design for the STD Provider Survey starting with a self-administered questionnaire (see **Attachment 3 - Mailed Survey**) followed by a web survey (see **Attachment 4 - Web Screen Shots**) to non-respondents as illustrated in our contact strategy in Exhibit 1. First an invitation letter with consent (see **Attachment 5 -Mail Survey Invite**) will be sent along with a mail survey. Providers who do not return a completed survey will be sent up to two additional reminder letters with mailed surveys (see **Attachments 6 and 7**). For all **non-respondents**, we will send two follow-up mail reminders containing a URL and a Quick Response Code (QR Code) for those who wish to complete the web survey (see **Attachments 8 and 9**). These invitations and reminders should bypass gatekeepers and increase our chances for a direct contact. ICF will send a thank you letter, along with $40, to physicians that complete the survey either by mail or web.

Exhibit 1. Data Collection Communication Protocol for the STD Provider Survey

Mail Survey 1 (Attachment 5)	Personalized cover letter with support from professional organizations, and paper questionnaire.	All sampled physicians	Day 1

Mail Survey 2 (Attachment 6)	Cover letter and paper questionnaire.	All non-responding physicians	Day 14
Mail Survey 3 (Attachment 7)	Cover letter and paper questionnaire.	All non-responding physicians	Day 28
Invitation for web survey 1 (Attachment 8)	1-page invitation to complete a web survey. Letter will contain the URL and a QR code.	All non-responding physicians	Day 42
Invitation for web survey 2 (Attachment 9)	1-page reminder to complete the web survey. Letter will contain the URL and a QR code.	All non-responding physicians	Day 56
Thank you letter (Attachment 10)	$40 token of appreciation after completion of mail or web survey.	All physicians completing mail or web survey	

A.3 Use of Improved Information Technology and Burden Reduction

Surveys of providers are known to be challenging for several reasons.[8,9,10,11] First, physicians are a highly specialized group of individuals frequently solicited to participate in surveys. Second, their demanding work schedules negatively impact survey participation rates. Third, any forms of communication with physicians are typically filtered by receptionists, administrative assistants, or other "gatekeepers"—making it difficult to contact the physician directly.

To address these barriers, we will use several strategies. First, we will survey physicians using their preferred survey mode to increase the likelihood of participation. Several studies have shown that mail surveys seem to be physicians' preferred survey mode[9,12,13] and that a multi-mode design encompassing an initial mailing of a self-administered questionnaire (see **Attachment 3 - Mailed Survey**) followed by a web survey (see **Attachment 4 - Web Screen Shots**) to non-respondents improves overall response rates.[8,10] For these reasons, we propose using the multimode design. We anticipate that 75% of physicians will respond to the mail survey for a total of 2,625 respondents to the mail survey and 875 respondents to the web survey. The mail survey takes 20 minutes and the web survey takes 32 minutes, on average.

Web data collection is 100% electronic. The contractor, ICF will design the website to facilitate the interview process for the respondent and reduce burden. These features include:

- Basing the visual layout of the questions on principles that people follow in interpreting visual cues (quick, hands-on learning);
- Making the survey easy to move from page to page;
- Incorporating user assistance tools, such as help screens for certain items (e.g., the respondent could click a link to get a definition that would come up if needed);

- Inserting placeholders so that respondents can pause and leave the system and then re-enter (at the point of departure) without losing the responses previously entered; and
- Programming in consistency checks.

ICF has tested the website by using several different devices (e.g., laptops, smartphones, and tablets) and operating platforms to ensure that the survey functions properly and is easily navigated in the many ways respondents will access the survey. ICF will compare the mail and web responses for systematic differences in response rate, responses, missing data, and respondent breakoff (for those who end the survey without completing it).

A second strategy we will use is to have the survey supported by professional organizations, as this positively impacts response rates.[7,8] Specifically, to enhance physician buy-in and increase the proportion of physicians who complete the survey, each mail survey will include a cover letter indicating support of four professional organizations: the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Congress of Obstetricians and Gynecologists (ACOG), and the American College of Emergency Physicians (ACEP).

A.4 Efforts to Identify Duplication and Use of Similar Information

CDC/DSTDP conducts ongoing searches of all major health-related electronic databases, reviews related literature, consults with key outside partners and other experts, and maintains continuing communications with Federal agencies with related missions. These efforts have identified no previous, current or planned efforts to conduct a comprehensive cross-sectional survey of policies and practices in relation to several STD-related policy issues or awareness and use of the CDC's newly released STD Treatment Guidelines among a nationally representative sample of STD providers.

DSTDP is aware that CDC's National Center for Health Statistics (NCHS) conducts two surveys of physicians – the National Ambulatory Medical Care Survey (NAMCS) and the National Hospital Ambulatory Medical Care Survey (NHAMCS). NAMCS incudes very limited information on STD (limited to chlamydia screening only). DSTDP and NCHS discussed fielding a NAMCS special survey focusing on STD; however, there were several limitations with this approach. The primary limitation was that emergency physicians could not be included. Given the major shift in the healthcare system subsequent to the Affordable Care Act (ACA) and the number of states who chose not to expand Medicaid, it is imperative that we survey emergency physicians as they often serve as a safety net provider for STD services.

Other national surveys that ask some STD-related questions include Kaiser's National Survey of Women's Health Care Providers on Reproductive Health: Emergency Contraception and CDC's Medical Monitoring Project HIV Provider Survey. However, this should in no way suggest that other surveys represent duplications. These surveys do not include all or even most of the relevant STD information and/or do not include all of the major physician specialties that we are focusing on for this data collection. For example, the Medical Monitoring Project HIV Provider Survey did not include content related to the diagnosis and treatment of other STDs. The Kaiser National Survey of Women's Health Care Providers on Reproductive Health: Emergency Contraception was limited primarily to obstetricians and gynecologists and focused on emergency contraception prescriptions practices. Other surveys have tended to be administered in geographic areas below the national level; for instance, a 2005 New York City Department of Health survey among STD Practices that focused on the knowledge, opinions and practices regarding STD diagnosis screening, reporting and partner notification. Localized surveys do not address CDC's need for national data to support its planning and program development activities.

A.5 Impact on Small Businesses or Other Small Entities

There will be limited impact on small businesses or other small entities. The collection of information involves randomly selected eligible physicians restricted to the target specialties. It is possible that a small percentage of providers who own their own practice or who are in a practice with a small network of providers may be asked to complete the survey. The survey only takes 20-32 minutes to complete (depending on survey version); therefore, the impact on a small business would be minimal.

A.6 Consequences of Collecting the Information Less frequently

The activities involve one collection of data that will span approximately 4 months.

Not collecting this information would hinder the DSTDP's ability (1) to better understand policies and practices for STD care delivery among medical providers , (2) assess awareness and use of CDC's STD treatment guidelines, (3) help CDC prioritize STD prevention activities, and (4) determine STD prevention needs by provider type.

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

No special circumstances require the collection to be conducted in a manner inconsistent with the guidelines in 5 CFR 1320.6.

A.8 Comments in Response to the FRN and Efforts to Consult Outside the Agency

A 60-Day Federal Register Notice was published in the *Federal Register* on October 4, 2016, volume 81, number 192, pp. 68417-68419 (see Attachment 2 - 60-Day FRN). Three comments were received (see **Attachment 2a** – Public Comments). One of the comments from NYC received a direct response from the program as the other 2 comments did not provide contact information for a response.

CDC has also contracted with ICF to conduct the STD Provider Survey. ICF has extensive experience with data collection, data analysis, and statistical methods, particularly with respect to national surveys. ICF has supported the CDC in the collection of data for the BRFSS for twenty years and has provided particular expertise in web and mail survey administration. For this project, ICF augmented their technical team with experts from Insight Policy Research and the Guttmacher Institute. Laura Lindberg, PhD., from the Guttmacher Institute provided expert advice about the survey content prior to cognitive testing. Denise Bellows, PhD, from Insight Policy Research recruited and conducted cognitive interviews with physicians, and also co-authored the final report detailing both the methodology and findings of the testing. Three key staff from ICF contributed to this project. Shelley Osborn, PhD, is the project manager and consulted on the survey content. Melissa Cidade, PhD, is a survey methodologist, and provided expert opinion about the content and placement of survey questions. Ronaldo Iachan, PhD, is a senior sampling statistician with ICF and designed the sampling strategy.

A.9 Explanation of Any Payment or Gift to Respondents

The first contact will be an invitation letter and a survey packet mailed to physicians. Up to two reminder survey packets will be sent to non-responding physicians. Each physician in the sample will receive a unique Master ID. This ID will be barcoded onto each envelope and survey, which will allow ICF to process and track all returned mail (undelivered mail, completed surveys, partial surveys, refusals, etc.) daily. Therefore, ICF will have an up-to-date list of people that have or have not completed the survey. Physicians that return a completed mailed survey will be provided with $40 as a token of appreciation. Research suggests that providing an incentive upfront significantly increases the response rate among physicians (71% response rate when check is mailed with survey compared to 56% when incentives sent subsequent to survey completion).[14] Additionally, two other studies tested amount of monetary incentives and found that higher amounts translated into higher response rates.(15-16) For

instance, one study found that increasing monetary incentives are needed in surveys of physicians.[15] Another study found that a $50 check resulted in a significantly higher response rate (68%) from physicians than a $20 check (52%).[16]

At least two weeks after the last mailed survey, physicians that did not complete the paper survey will be mailed a letter containing a URL and a Quick Response Code (QR Code) so that they can take a web version of the survey. Waiting at least two weeks to initiate web data collection will allow ICF to process completed surveys and remove physicians from the sample that will receive the web invitation. The web invitation letter will inform physicians that they will receive a $40 token of appreciation check after they complete the survey via web. A reminder letter containing the same information will be sent to non-responders. Both letters will contain the unique Master ID, which will serve as the password to unlock the web survey—it will be valid only one time (although physicians will be able to pause and restart the survey).

ICF will process token of appreciate checks for web responders approximately once per week. This delay will provide ICF with sufficient time to verify that the completion does not duplicate a recently submitted paper survey. Therefore, we believe there is minimal risk that any respondent will receive more than a $40 token of appreciation. Please see **Attachment 10** for the letter that will be mailed to physicians that complete the mail or web survey.

A.10 Assurance of Confidentiality Provided to Respondents

The CDC NCHHSTP Privacy and Confidentiality Review Officer and the NCHHSTP IT Security Information System Security Officer (ISSO), have assessed this package for applicability of 5 U.S.C. § 552a, and determined that the Privacy Act does apply to the overall information collection. This information collection is covered under the Privacy Act system of records notice 09-20-0136, "Epidemiologic Studies and Surveillance of Disease Problems. HHS/CDC", which enables the Centers for Disease Control and Prevention (CDC) officials to collect information to better understand disease patterns in the United States, develop programs for prevention and control of health problems, and communicate new knowledge to the health community.

Names and addresses constituting personally identifiable information (PII) for physicians in five specialties: primary care (including internal medicine), general or family practice, obstetrics/gynecology, emergency medicine, and pediatrics, will be selected from the American Medical Association (AMA) Master File and used by the CDC contractor, ICF, to create a unique Master ID.

The Master ID will be barcoded onto each envelope and survey, which will allow ICF to process and track all returned mail (undelivered mail, completed surveys, partial surveys, refusals, etc.). ICF will maintain an up-to-date list of providers that have or have not completed the survey. Potential respondents may be contacted multiple times. Physicians that return a completed mailed survey will be provided with a token of appreciation. Survey information collected will be used to determine what STD prevention activities may be needed by type of providers (by specialty or public/private) based on survey findings related to screening and treatment practices for STDs including Expedited Partner Therapy (EPT or providing infected patients with medication to give to their sex partners).

To comply with CDC's security requirements, defined as LOW security categorization per the National Institute of Standards and Technology (NIST) framework, ICF will utilize a private cloud environment. This environment provides an area with public-facing web servers to collect data, which are then passed through internal firewalls to hardened servers in a client-specific virtual local area network (VLAN) and to a client-specific database instance in a firewalled structured query language (SQL) server

environment reserved for U.S. Government clients. Federal Information Processing Standards (FIPS) 140-2 compliant encryption is available for data in transit and at rest. Availability is enhanced by the resiliency of our virtualized server architecture.

All relevant NIST controls are covered in ICF's Security Planning process and implemented in our Security Policies and practices. The servers and workstations used in ICF's MODERATE security projects have consistently received top scores as rated against U.S. Government Configuration Baselines and during vulnerability assessments. ICF's environment undergoes regular Security Reviews both by its independent internal Information Security Team and by Federal clients. ICF also has reserved an external, American Institute of Certified Public Accountants- (AICPA-) accredited accounting firm to perform a SOC2 Type 2 audit of its environment. ICF employees all receive annual security training provided internally, and its security-cleared technical support and project administration staff all receive additional levels of security training from multiple sources.

The physical security of the data is ensured by the location of file servers, tapes, and tape back-up units in locked areas. Written material stored on-site is kept in locked file cabinets. Information on the servers is protected from unauthorized users via user names and user level passwords. The files are not encrypted. Access to the data or codes that could identify respondents is controlled by different levels of password-protected access to ICF's computer systems. Access is granted to individuals and specified user groups who need to work with the data, including project management staff and sampling statisticians. Data with subject identifiers will not be released. ICF retains all project materials and documentation until five years after the expiration or termination of the contract. After five years, or as instructed by the client, all materials will be deleted, shredded, or otherwise destroyed.

The NCHHSTP IT Security Information System Security Officer (ISSO), Mr. Ralph Vaughn, is consulting on the system security described in this section. The data system for this collection will reside with the contractor at an external data site and was subject to a Privacy Impact Assessment (PIA) during the SA&A process (Enterprise Systems Catalog, IT Record ID: 2871, STD Provider Survey). The data collection is forecast to begin in January 2018. The contractor's external system is in process of completing the SA&A process but has not yet been granted Full Authority to Operate. AO certification will be obtained from Mr. Vaughn's office before data collection commences.

A.11 Institutional Review Board (IRB) and Justification for Sensitive Questions

IRB

ICF has its own IRB (see Attachment 11-IRB Approval), which meets all of the Federal requirements as specified in 45 CFR 46, is registered with the Office for Human Research Protections, and has a Federal Wide Assurance (#FWA00000845). This ensures that all of its projects involving human subjects comply with Federal regulations. The ICF IRB approval letter is included in (**Attachment 11-** IRB Approval).

Justifications for Sensitive Questions

While questions about STDs can often be considered sensitive, the proposed survey intends to collect information on STD treatment from providers—not patients. Thus, it is unlikely that a respondent will have an adverse reaction to the proposed questions. Regardless, it should be noted that respondents are made aware that participation is completely voluntary, and that they may refuse to answer any questions with which they feel uncomfortable. It will also be clear that no identifying information about their patients will be requested and that only data that is aggregated to a group level will be made available to

individuals who are not part of the study team.

A.12 Provide an Estimate in Hours of the Burden of the Collection of Information

Included in the appendices are the survey instrument that will be mailed to physicians (see **Attachment 3 - Mailed Survey**) and screen shots of the web-based survey that will be offered to physicians that do not respond to the mailed survey (see **Attachment 4** - Web Screen Shots). The full process is as follows: First an invitation letter with consent (see **Attachment 5 -Mail Survey Invite**) will be sent along with a mail survey. Providers who do not return a completed survey will be sent up to two additional reminder letters with mailed surveys (see **Attachments 6 and 7**). For all non-respondents, we will send two follow-up mail reminders containing a URL and a Quick Response Code (QR Code) for those who wish to complete the survey via web (see **Attachments 8 and 9**). Finally, for those who respond and complete a mail or web survey, a thank you letter will be sent along with a $40 token of appreciation (see **Attachment 10**). The only difference between the mail and web-based introduction and consent is that the web will use a "continue" button to advance to the survey.

We estimate that to reach our target of 3,500 completed interviews, we will need to make contact with 5,000 physicians for each data collection. Additionally, we estimate that 75% of respondents will reply to the mail survey for a total of 2,625 mail survey respondents and 875 web survey respondents. Based on previous experience, most respondents reply after the first few notifications; thus, we estimated that only 25% will complete the web survey. Based on a pilot test with five physicians, we expect that the mail survey (with the introduction/consent) will take 20 minutes to complete on average. Based on a pilot test with two physicians, we expect that the web survey (with the introduction/consent) will take 32 minutes to complete on average (this omits one physician who stopped, and then restarted the survey over a two-day period). The mail survey takes less time as there are several series of questions that are easy to answer quickly in a grid. Despite repeated attempts to make the grid fit in web-format, we were unable to do so for respondents who may use technology other than a desktop computer. Thus, the survey takes longer in web-format. There are a limited number of skip patterns in the survey so almost all physicians will be asked to answer each question. Thus, we provide an estimated average for the entire survey—separately for mail and web given the increased time necessary to complete the web version. The total estimated burden hours for this data collection is 1,342 – 875 hours for mail survey and 467 hours for web survey.

Table A.12.a. Estimated Annual Burden Hours

Type of Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
Physicians responding via Mail	STD Provider Mail Survey	2,625	1	20/60	875
Physicians responding via Web	STD Provider Web Survey	875	1	32/60	467
				Total Annual Burden Hours	1,342

For this information collection, there are no direct costs to the respondents themselves. However, the cost to physician respondents can be calculated in terms of the time it will take to respond to the survey. Table A.12.b illustrates the total calculation of costs to respondents for the survey. The estimated respondent burden hours have been multiplied by an estimated average hourly salary for "physicians and

surgeons." The estimated burden cost in terms of the value of time physicians spend in responding is based on information provided by the U.S. Department of Labor, Bureau of Labor Statistics, at http://www.bls.gov/oes/current/oes_nat.htm, which estimates the latest (May 2015) mean hourly earnings among physicians and surgeons (Occupation code 29-1060) of $97.33/hour. At that hourly rate, the total annual cost burden for the time spent by physicians is $130,617.

Table A.12.b. Estimated Annual Burden Cost

Type of Respondent	Form Name	Total Burden Hours	Average Hourly Wage Rate (in dollars)	Total Respondent Costs
Physicians responding via Mail	STD Provider Survey	875	$97.33	$85,164
Physicians responding via Web	STD Provider Survey	467	$97.33	$45,453
			Total Annual Burden Cost	$130,617

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

No capital or maintenance costs are expected.

A.14 Annualized Cost to the Government

The estimated annualized contractor cost is $453,708 for this data collection. Additional costs will be incurred indirectly by the government in personnel costs of staff involved in the study oversight and data analysis. It is estimated that two CDC employees will be involved for approximately 5% of their time each (for federal personnel 100% time = 2,080 hours annually). The two salaries are $37.95 and $65.00 per hour. The direct annual costs in CDC staff time will be approximately $11,540 annually.

Table A.14.a. Annualized Cost to the Government

Type of Cost	Annualized Cost
Contractor Costs: ICF	$453,708
Federal Employee Time Costs	$11,540
Total Annual Estimated Costs	**$465,248**

A.15 Explanation for Program Changes or Adjustments

This ICR is for a new data collection that is a follow-up to a previously approved ICR. In 1998-99, CDC conducted the first STD provider survey (OMB # 0920-0431; exp. date 06-30-2000). There are several differences between the study design of the proposed current STD Provider Survey and the 1998-99 STD Provider Survey. First, we plan to complete surveys with 3,500 physicians for the current survey. This is smaller than the 1998-99 survey, during which 4,226 physicians were surveyed. Second,

while the 1998-99 STD Provider survey was limited to a single mode of administration (mail) the proposed survey will have an option to complete by web. Several studies have shown that mail surveys seem to be physicians' preferred survey mode[9,11,12] and that a multi-mode design encompassing an initial mailing of a self-administered questionnaire followed by a web survey to non-respondents improves overall response rates.[8,10] For these reasons, we propose using a multimode design starting with a mailed questionnaire. Providers who do not return a completed survey will be sent up to two additional survey packets. For all non-respondents, we will send two follow-up mail reminders containing a URL and a Quick Response Code (QR Code) for those who wish to complete the web survey. These invitations and reminders should bypass gatekeepers and increase our chances for a direct contact.

A third difference is that the 1998-99 STD Provider Survey included a $15 cash pre-token of appreciation. All responding physicians will receive a $40 token of appreciation disbursed upon completion of the survey. Lastly, there are many differences in survey items between the 1998-1999 survey and the proposed survey; however, key items have been retained to allow for trend analysis.

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

Item non-response will be analyzed to identify any potentially problematic questions or survey sections that may be increasing respondent break-off. Both mail and web datasets will be carefully reviewed for apparently unusual or inconsistent responses that might also signal problems of comprehension, recall, or reporting in either the questions or the response categories. Survey response rates, survey cooperation rates, survey completion rates, survey ineligibility rates, and survey completion times will be calculated. Additionally, responses to the web and mail modalities will be compared for systematic differences in response rate, responses, missing data and respondent breakoff.

As part of analysis, weighting adjustments will be developed to increase the sample representativeness relative to the population. Representativeness will be evaluated by comparing the sample to benchmarks such as the American Medical Association Master File. Weights will be appended to each survey record ("case" weights) in the final data file from which national incidence estimates will be generated.

Initial publications will focus on providing updated information on providers' STD screening practices, clinical actions and partner notification. Publications will also focus on differences in EPT practice by state policies and will examine changes potentially related to the ACA. All publications will be submitted to peer-reviewed journals or published as government reports. The publications will include detailed descriptions of the applicable aspects of the methodology. Major publications will be available via links on the Division of STD Prevention website. All publications will be submitted to CDC's clearance process for scientific documents to ensure that any results that are released will maintain the privacy of respondents (i.e., no data that could be used to identify a given respondent will be publicly released).

For the first data collection, the timeline to collect data is August through October 2017 (pending OMB approval).

Exhibit 2. Project Time schedule

Activity	Time Period
Implement Survey	Within 1 month of OMB approval
Develop Secure Data Repository Develop Data Sharing Plan	Within 1 month of OMB approval
Develop Data Dictionary	1-2 months after OMB approval

Provide Quality Checks of all Data Deliverables	2-3 months after OMB approval
Develop Data Analysis Plan and Analysis	1-2 months after OMB approval
Survey Implementation Status Reporting	1 –3 months after OMB approval (throughout 60 day data collection period)
Data Submission Final Report on Pilot Data from ICF to CDC	3-4 months after OMB approval 4 months after OMB approval
Anticipated publications	9-12 months after OMB approval

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

CDC will display the expiration date for OMB approval.

A.18 Exceptions to Certification for Paperwork Reduction Act Submissions

No exceptions to the certification are made.

[1] Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2013. Atlanta: U.S. Department of Health and Human Services; 2014. http://www.cdc.gov/std/stats13/.
[2] Satterwhite CL, Torrone E, Meites E, et al. Sexually transmitted infections among US women and men: prevalence and incidence estimates, 2008. Sex Transm Dis. 2013;40(3):187-193.
[3] Owusu-Edusei K, Jr., Chesson HW, Gift TL, et al. The estimated direct medical cost of selected sexually transmitted infections in the United States, 2008. Sex Transm Dis. 2013;40(3):197-201.
[4] Division of STD Prevention website http://www.cdc.gov/std/stats08/trends.htm#f3.
[5] Division of STD Prevention website http://www.cdc.gov/std/dstdp/default.htm, retrieved October 20 2015
[6] Workowski KA, Bolan GA. Sexually transmitted diseases treatment guidelines, 2015. MMWR Recomm Rep. 2015;64(RR-03):1-137.
[7] St. Lawrence JS, Montano DE, Kasprzyk D, Phillips WR, Armstrong K, Leichliter JS. STD screening, testing, case reporting, clinical and partner notification practices: A national survey of US physicians. American Journal of Public Health 2002;92:1784-1788.
[8] VanGeest JB, Johnson TP, Welch VL. Methodologies for improving response rates in surveys of physicians: a systematic review. Eval Health Prof. 2007;30(4):303-321.
[9] Pit SW, Vo T, Pyakurel S. The effectiveness of recruitment strategies on general practitioner's survey response rates – a systematic review. BMC Med Res Methodol. 2014;14:76.
[10] Burns KE, Duffett M, Kho ME, et al. A guide for the design and conduct of self-administered surveys of clinicians. CMAJ. 2008;179(3):245-252.
[11] Beebe TJ, Locke GR, 3rd, Barnes SA, Davern ME, Anderson KJ. Mixing web and mail methods in a survey of physicians. Health Serv Res. 2007;42(3 Pt 1):1219-1234.
[12] Raziano DB, Jayadevappa R, Valenzula D, Weiner M, Lavizzo-Mourey R. E-mail versus conventional postal mail survey of geriatric chiefs. Gerontologist. 2001;41(6):799-804.
[13] Martins Y, Lederman RI, Lowenstein CL, et al. Increasing response rates from physicians in oncology research: a structured literature review and data from a recent physician survey. Br J Cancer. 2012;106(6):1021-1026.
[14] Delnevo CD, Abatemarco DJ, Steinberg MB. Physician response rates to a mail survey by specialty and timing of incentive. American journal of preventive medicine. 2004;26(3):234-6.
[15] Recklitis CJ, Campbell EG, Kutner JS, Bober SL. Money talks: Non-monetary incentive and Internet administration fail to increase response rates to a physician survey. Journal of clinical epidemiology. 2009;62(2):224-6.
[16] Keating NL, Zaslavsky AM, Goldstein J, West DW, Ayanian JZ. Randomized trial of $20 versus $50 incentives to increase physician survey response rates. Medical Care. 2008;46(8):878-81.