ECONOMIC RESEARCH SERVICE OMB CLEARANCE PACKAGE

SECTION A. JUSTIFICATION

for

CLEARANCE TO CONDUCT THE SURVEY ON RURAL COMMUNITY WEALTH AND HEALTH CARE PROVISION FROM FY2013 THROUGH FY2015

Prepared by

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1. Need and authority for the Information Collection

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 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 critical for achieving economic development and improved well-being of rural people. In many rural communities, the health care services sector is the largest employer, and rapid growth in this sector is occurring and likely will continue, especially as the Baby-Boom generation retires.[1] Provision of adequate health care services may be a key factor attracting retirees and other migrants to rural areas, contributing to rural growth and prosperity.[2]

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 primary health care professionals. For example, 85% of nonmetropolitan counties

[1] For example, analysis of employment growth trends by industry and county from 2002 to 2007 revealed that two of the top six industries experiencing rapid employment growth in the largest number of non-metropolitan counties were in the health care sector: hospitals and nursing care facilities.
[2] For example, the mean number of active non-Federal medical doctors per 100,000 population in non-metropolitan retirement destination counties was 103 in 2007, compared to 84 in other non-metropolitan counties.

were entirely or partly classified as a primary care Health Professional Shortage Area (HPSA) at some time during 1996 to 2004, with 34% of nonmetropolitan counties classified as whole county persistent primary care HPSAs during this period.[3] People living in these areas suffer from fewer primary care physicians and other health care providers, a smaller share of the population with access to a regular primary care provider, and a larger share of the population who do not receive needed care due to costs. Access to quality health services is the top rural health priority identified by state and local rural health leaders across the nation.[4] Addressing these access problems likely will become increasingly important as the Patient Protection and Affordable Care Act is implemented.

Although substantial research has investigated the problems of attracting and retaining health care providers (especially physicians) in rural areas, very little of this research addresses the issue from the perspective of rural communities themselves. For example, a large number of studies have investigated the influence of "nature vs. nurture" on physicians' decision to practice in a rural location; i.e., factors in physicians' backgrounds, such as growing up in a rural area, demographic characteristics, or professional motivations and intentions vs. the location and nature of the medical school they attended, their residency experience, or Federal and State programs providing incentives to practice in rural areas.[5] Much less research has focused on the factors affecting location choices by non-physician

[3] Doescher, et al. (2009). References are included in Annex A.
[4] Gamm, et al. (2003).
[5] Excellent reviews of this literature are provided by Crandall et al. (1990); Brooks et al. (2002); Gamm et al. (2003); Laven and Wilkinson (2003); Rabinowitz et al. (2008); Ballance et al (2009); and Rosenblatt et al. (2010). See Annex A for the list of references.

rural health care providers,[6] or on the economic development impacts of rural health care provision in rural areas.[7]

A few large quantitative studies have investigated the effects of some community-level factors such as population level, proximity to an urban center, presence of a hospital or college, and median income and housing values on the practice location choice of physicians using available county-level data.[8] However, these studies did not investigate the perspectives of community members or health care providers regarding the factors affecting recruitment and retention of providers in their communities, including less readily quantified assets such as community social capital or local efforts to integrate providers into the community. Some qualitative or small quantitative studies have investigated these issues in some depth, but only in a few communities with a small number of respondents, limiting the ability to draw conclusions applicable to broader rural regions.[9] A few studies describe program approaches to link community development and provider recruitment efforts, but these lack empirical evidence regarding the factors affecting the success of these approaches.[10]

The proposed survey will address gaps in existing knowledge about the relationships between community development and rural health care provision by investigating these issues from the perspective of members of rural communities, including health care providers and community leaders. In contrast to the small number of communities included in the

[6] Examples of research on factors affecting recruitment and retention of health care providers other than physicians include Lin et al. (1997); Anderson and Hampton (1999); Fairbanks et al (2001); and Daniels et al. (2007).
[7] Most of the studies investigating the economic impacts of rural health care provision in the United States are based on predictions of input-output models rather than data on actual *ex post* impacts; e.g., see Doeksen et al. (1998); Doeksen and Schott (2003); St. Clair, Doeksen, and Schott (2007); and St. Clair and Doeksen (2009).
[8] Newhouse et al. (1982); Dionne et al. (1987); Langwell et al. (1987); and Carpenter and Neun (1999).
[9] Cutchin (1997); Hancock et al (2009); Hanlon et al. (2010); Quinn and Hosokawa (2010).
[10] Felix et al. (2003); Shannon (2003).

handful of previous studies, this study will be based on a sample of 150 communities in three major regions of the country.

The primary purpose of the proposed study is to collect information on how rural small towns attract and retain primary health care providers, considering the broad range of community assets and amenities that may attract providers. The secondary purpose is to provide information on 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). ERS will complement the survey by analysis of county-level secondary data.

The study will focus on small rural towns (population 2,500 to 20,000) because 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 include about 9 percent of the rural population of the United States and represent considerable diversity in levels of economic development and access to health care services. The set of 150 small towns included in the study has been 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.

The research questions to be addressed by the study are:

1) What community level factors (e.g., community assets, amenities) attract health care providers to practice in rural small towns? How important are these different factors to health care providers?
2) What factors affect whether health care providers decide to keep practicing in rural small towns, and how important are they?
3) To what extent is recruiting and retaining health care providers seen as an important priority by local health care providers and community leaders?
4) What efforts and investments do rural communities make to recruit and retain health care providers? How effective are these efforts, from the point of view of health care providers and community leaders?
5) What major changes in health care availability and quality have occurred in the community in the past five years, and have changes in the recruitment and retention of health care providers affected this, from the perspective of health care providers and community leaders?
6) How are changes in health care availability and quality perceived to have affected other aspects of community economic development, such as the ability to attract or retain young families, retirees, or businesses?

The proposed information collection will address these questions using three phases of primary data collection, augmented by publicly available secondary data on health care provision and economic development in the study regions. The three phases will be: 1) semi-structured key informant telephone interviews with select local government leaders and health care administrators in the study towns; 2) a mail/web 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 objectives of the initial key informant interviews with local government leaders and health care administrators are to verify and update information assembled from secondary sources on which primary health care services and providers are available in the town and how provision of primary health care services in the town has changed in the past five years; and to obtain the perceptions of local leaders and health care administrators concerning the answers to all of the research questions. Key informant interviews will be conducted with up to four individuals in each study town, 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 45 minutes each. The key informant interviews will be conducted before the mail/web survey of health care providers, since they will help to validate the sample frame of providers.

The mail/web survey is focused on addressing research questions 1) through 5), from the perspective of primary health care providers. It will investigate their perspectives on the factors affecting their decisions to locate, continue and change their operations in these rural communities; their perceptions of community efforts to recruit and retain health care providers; and their perceptions of how health care availability and quality have changed in the community in recent years. Where possible, these perceptions will be compared to

secondary sources of information on these issues, such as changes in the numbers of providers working in the community. 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 mail/web survey is expected to average about 15 minutes per respondent, based upon cognitive interviews testing a draft of the survey instrument.

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 or the provider survey) will be conducted in person in a sub-sample of the surveyed communities (at most 30), 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 first two phases) are able to do so, and ii) how development of the health care sector contributes to broader economic development in rural communities. This phase is thus intended to deepen understanding related to research questions 1), 2) and 6). The communities included in this phase of the study will be selected to represent 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. We plan 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 up to 60 minutes. A semi-structured instrument will be used to guide these focus groups and interviews.

This information will be collected under the authority of 7 U.S.C. 2204(a), 7 U.S.C. 2204(b), and 7 U.S.C. 2661.

2. Use of the information to be collected

The information collected will be used for socioeconomic research on the influence of rural communities' assets and investments 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 research will be led by ERS. Analysis of the information collected and related secondary information will be used to produce research reports and other peer reviewed publications on this research topic.[11] The data collected will be made publicly available to other research organizations using procedures to protect the strict confidentiality of the survey respondents, in accordance with 7 U.S.C. 2276, and 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. As one of the statistical agencies of the Federal Government, ERS has established procedures for sharing survey data consistent with these laws and regulations, which will be followed in sharing the data collected by this survey.

[11] Detailed information on the analysis to be conducted and the research reports to be produced is provided below in the response to question 16.

3. **Use of information technology/other advanced technology in information collection**

The key informant interviews in the first phase of the research will be conducted by telephone by the Survey and Behavioral Research Services, Iowa State University. This mode is more appropriate for a semi-structured interview than mail or internet communication. The second phase health care provider survey will use a mixed-mode mail/web survey. During the past 10 years, mail surveys have been found to yield higher response rates than alternative modes in surveys of health care providers, although web response rates among health care providers show signs of increasing (Klabunde et al. 2011). Mail surveys will be sent to providers as well as a link to the online survey and a secure username/password. Non-respondents to the mail/web survey will be contacted by telephone and encouraged to complete the survey. They will have the option at that time to complete the survey by telephone if they prefer. All telephone contacts and interviews will be conducted from the SBRS Computer-Assisted Telephone Interviewing (CATI) lab under the supervision of trained professional staff. A minimum of 10% of any telephone interviews will be monitored for quality control using a silent audio/visual monitoring software system. The third phase focus groups and key informant interviews will be conducted in person in the communities selected for this phase of the research. Face to face communication is most appropriate for these interviews, which will seek to probe more deeply into the issues than will be possible in the first or second phase of the study.

Information technology and publicly available data sources are being used to collect secondary information on each study community and to identify the population of potential respondents to the key informant interviews and health care provider survey. An initial list of health care providers and administrators of health care facilities has been developed for

each sampled community by using the National Provider Identifier (NPI) database, which we downloaded from the website of the Centers for Medicare & Medicaid Services (CMS). These data will be validated and augmented using other publicly available information. Web searches of community and local health system websites will be conducted to locate and confirm names and contact information for both community leaders and health care professionals. Telephone calls may be required to verify names and contact information for the most appropriate community leaders for the key informant interviews, particularly in small communities with minimal website information available. Web resources for providers include directories maintained by associations such as the American Medical Association and the American Dental Association; provider databases available for particular states; websites of health care facilities; and general business directories such as Yelp and Yellow Pages. Cross-checking multiple resources will help to ensure that the list of providers is as current and complete as possible. The list of providers assembled from these sources will also be verified by local health care administrators and community leaders during the key informant interviews in the first phase of the study.

4. Efforts to identify and avoid duplication

A review of relevant literature, publicly available data sources, and consultations with experts on rural health care and rural development issues was conducted and found limited research and data on the specific topic of this information collection. A list of the experts consulted is included in Annex B. Among the experts consulted were Thomas Morris, Associate Administrator for Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services (HHS), and several of his

senior staff. As indicated in a letter from Thomas Morris to John Pender, dated March 13, 2012 (Annex C), none of the research centers funded by the Office of Rural Health Policy has done any survey research on health care and economic activity in the 15 years that he has served in this Office. The only research group that has investigated the link between rural health care and economic activity is the National Center for Rural Health Works at Oklahoma State University, and that research has been based upon input-output models of economic linkages, not upon a large survey.[12] The research team has also consulted with officials in the National Center for Health Statistics (NCHS) of HHS, which conducts national surveys of health care facilities and providers; the Center for Studying Health System Change, which conducts a national Health Tracking Study (formerly the Community Tracking Study); and other organizations and individuals involved in conducting community level research related to health care and economic development. Several individuals knowledgeable about health care research issues participated in a Technical Review Panel (TRP) for this study, which met in February 2013 to review the study design and make recommendations on the study design and methodology. The recommendations of the TRP have been incorporated into the study methodology (Annex D).

In addition to these consultations, the project leader conducted a webinar on the survey objectives and design, organized by the North Central Regional Center for Rural Development (NCRCRD) (based at Michigan State University), was advertised by the NCRCRD and on the Community Economics Network listserve of the Applied and Agricultural Economics Association (AAEA), and was open to all interested parties. 15 experts participated in the webinar, including seven researchers, five extension specialists,

[12] See the citations given in footnote 7 for examples of the research led by this research center.

and three lecturers. The backgrounds of the experts included economics, health care and sociology.

All of the experts consulted in preparation for this survey agreed that the objectives of the proposed study are important and do not duplicate existing research. Several offered suggestions for improvement in the design of the approach and questionnaires, and these have been taken into account in the proposed design.

In addition to consultations and a webinar, a review of surveys related to health care conducted or supported by Federal Government agencies was conducted, and none was found that addressed the objectives of this Information Collection. Among the surveys reviewed were the National Health Care Surveys conducted by NCHS (http://www.cdc.gov/nchs/dhcs.htm); the Medical Expenditure Panel Survey conducted by the Agency for Healthcare Research and Quality (AHRQ) of HHS (http://meps.ahrq.gov/mepsweb/); national and state databases of the Healthcare Cost and Utilization Project of AHRQ; the Medicare Current Beneficiary Survey conducted by the Centers for Medicare and Medicaid Services (CMS) (https://www.cms.gov/MCBS/); other data on hospital quality and health outcomes collected by CMS; and other national and state level data sources cited by the AHRQ's website and reports (http://www.ahrq.gov/data/dataresources.htm). Although these data sources cover a wide range of topics related to health care access, costs, quality and outcomes, none of these sources collects information on economic determinants or outcomes of health care provision in rural areas, and none surveys community leaders involved in recruiting or retaining rural health care providers.

The most relevant national survey to the objectives of the proposed Information Collection is the Community Tracking Study (CTS), which was supported by the Robert Wood Johnson Foundation (http://www.icpsr.umich.edu/icpsrweb/content/HMCA/community-tracking-study.html). The CTS was a large longitudinal survey conducted in 60 sites, including 51 metropolitan areas and 9 nonmetropolitan areas, which investigated health system change and its effects on people. The CTS included four rounds of surveys of households and physicians between 1996 and 2005. Although there is some overlap between the information collected by the CTS and the proposed Information Collection (for example, both surveys collect data on the basic characteristics of physicians and their practices, their satisfaction in practicing medicine, and factors affecting their ability to provide quality and affordable care), none of the CTS questions investigated how the assets of a community influence its ability to recruit and retain health care providers, or how the provision of health care services affects the economic development of the community. No health care providers besides physicians and no community leaders (other than employers in one round) were included as respondents in the CTS surveys, and very few rural communities were included in the sample. Furthermore, the CTS was discontinued after 2005 and the household and physician surveys replaced by a Health Tracking Household Survey (two rounds in 2007 and 2010) and Physician Survey (one round in 2008), which used a national sampling frame not clustered by communities. Hence, it would not be possible to address the objectives of the proposed Information Collection using data from the CTS or the subsequent Health Tracking surveys.

5. Economic impacts on small businesses or other small entities

This survey will not have a significant economic impact on small businesses or other small entities.

6. Consequence to Federal program and policy activities if collection not conducted

If the proposed information collection is not conducted, research and knowledge on the roles rural communities play in recruiting and retaining health care providers will remain limited. This lack of knowledge will continue to limit the effectiveness of Federal, State and local government efforts to improve provision of health care in rural areas and realize the potential for this to contribute to improved economic development and quality of life in these areas.

7. Special circumstances

There are no special circumstances.

8. Federal Register notice

A "Notice of Intent to Request New Information Collection" related to this ICR was published in the Federal Register on June 17, 2013 (78 FR, No. 116, pages 36160-36162).[13] We received no public comments.

With regard to efforts to consult with persons outside the agency to obtain their views on data availability, frequency of collection, clarity of instructions and recordkeeping, disclosure or reporting format, and on the data elements to be recorded, disclosed, or reported: The individuals consulted on the design of the survey are listed in Annex B, as noted previously. These people were able to comment on issues related to sampling design,

[13] The Federal Register notice for this ICR is included in Annex K.

data collection frequency (one-time survey), availability of the data requested of the respondents, and specific data elements. No concerns were raised related to the data collection frequency or the availability of the data, since the questions in the survey focus on individual characteristics or personal opinions that the respondents will readily know. None of the questions requires a review of the respondents' records, or future recordkeeping. Concerning the clarity of instructions and interpretations of the specific questions, cognitive interviews were conducted with different types of respondents. A report on these cognitive interviews in included in Annex E. Based on the comments of the experts consulted and those received from participants in the cognitive interviews, several revisions were made to the survey questionnaires, including rewording or deleting questions that were not clear or judged to be less necessary for the objectives of the survey. The survey questionnaires are provided in Annexes F and G. Annex F provides the mail/web questionnaire that will be used with health care providers, and Annex G provides the semi-structured questionnaire for key informant interviews with community leaders.

9. Incentives for respondents

No monetary or non-monetary incentives will be provided to survey respondents.

10. Assurance of confidentiality

The confidentiality of the Rural Community Wealth and Health Care Provision Survey data is protected under the statutes of U.S. Code Title 18, Section 1905, U.S. Code Title 7, Section 2276, and Title V of the E-Government Act, Confidential Information Protection and Statistical Efficiency Act of 2002 (CIPSEA), (Public Law 107-347). Questionnaires include a

statement that answers to the survey will be kept confidential, and that under no circumstances will identifying information about individuals be released to any unauthorized individuals, agencies, or institutions. The statement assures respondents that only aggregated statistics will be reported, and that providing answers to any or all questions is strictly voluntary. Detailed disclosures regarding confidentiality, citing CIPSEA and providing the OMB Control Number for the Information Collection, will be provided in an advance letter to respondents (see Annex H), and enumerators will check to ensure that respondents have received and read the letter and disclosures prior to conducting the survey. ERS will use established procedures for survey storage and disposal to ensure that individual identifiers are protected from disclosure. ERS will also use statistical disclosure limitation methods to ensure that individual identifying information does not appear in any public data product.

ERS and ERS contractors 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), (Public Law 107-347)". In conformance with existing law and Departmental regulations, it is the policy of the ERS that personally identifiable information collected or maintained by, or under the auspices of, the ERS for exclusively statistical purposes and under a pledge of confidentiality shall be treated in a manner that will ensure that the information will be used only for statistical purposes and will be accessible only to authorized persons.

11. Sensitive questions

The survey will not ask any sensitive questions.

12. Estimated hour burden on respondents

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 mail/web 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 and Non-Respondents: i) Key informant telephone interviews: 3 respondents on average per community x 150 communities = 450 respondents and 607 non-respondents (based on the response rate found in the pilot study); ii) Mail/web survey of health care providers: 8 respondents per community x 150 communities = 1,200 respondents and 300 non-respondents (assuming 80% response rate); iii) Focus group participants and key informant interviews: 12 respondents per community x 30 communities = 360 respondents and 90 non-respondents (assuming 80% response rate). Total number of respondents = 2,010. Total number of non-respondents = 997.

Estimated Number of Responses and Non-Responses: 2,010 from respondents, 997 refusals, referrals, or ineligibles from non-respondents.

Estimated Number of Responses per Respondent: In most cases, one response per respondent. In some cases, a respondent to the Phase 1 interview or Phase 2 survey may be

asked to participate in the Phase 3 focus groups or interviews, for a maximum of two responses from such respondents. If all respondents in the Phase 1 interviews and Phase 2 survey were to participate in the Phase 3 focus groups/interviews in the (maximum of) 30 communities selected for Phase 3, a maximum of 360 respondents would provide two responses. We expect the number of respondents with two responses to be much less than this maximum, however.

Estimated Total Burden on Respondents: 1,613 hours (see Table 1 for details)

Estimated Cost of Hour Burden: The total estimated cost of the hour burden, based on estimated mean hourly salary/wage rates for the different types of respondents involved, is $82,950 (Table 1).[14]

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[14] We assumed that 50% of the respondents to the mail survey will be physicians and dentists and 50% will be other health care professionals (nurse practitioners, physician assistants, and certified nurse midwives). We assumed mean hourly wage rates of $100 for physicians and dentists, $40 for other health care professionals, $40 for health care facility managers, $40 for community leaders and other stakeholders, and $20 for administrative staff. These wage rates are based on the May 2012 Metropolitan and Nonmetropolitan Area Occupational Employment and Wage Information from the Bureau of Labor Statistics website (http://www.bls.gov/oes/current/oessrcma.htm), using the data for nonmetropolitan regions of the States included in this study.

Table 1. Estimated Respondent Hour Burden and Cost

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	Unit Cost ($/hour)	Total Cost ($)
Phase 1: Key informant telephone interviews							
Identify and contact key informants – admin. staff*	150	1	150	6	15	$20	$300
Respondents review request and decide*	450	1	450	9	67.5	$40	$2,700
Key informant interviews*	450	1	450	33	247.5	$40	$9,900
Non-respondents answer calls, review request and decline or provide referrals*	606.5	1	606.5	5.9	60	$40	$2,400
Phase 2: Mail/web survey with health care providers							
Respondents review request	1200	1	1200	15	300	$70	$21,000
Respondents complete survey	1200	1	1200	15	300	$70	$21,000
Non-respondents review request and decline	300	1	300	15	75	$70	$5,250

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	Unit Cost ($/hour)	Total Cost ($)
Phase 3: Focus group and in-person key informant interviews							
Identify and contact participants	450	1	450	10	75	$20	$1,500
Participants review request	360	1	360	15	90	$40	$3,600
Focus groups & key informant interviews	360	1	360	60	360	$40	$14,400
Non-respondents review request and decline	90	1	90	15	22.5	$40	$900
Total Burden					**1612.5**		**$82,950**

* The estimates for the key informant interviews are based on the pilot study of the key informant interviews in 12 communities.

13. Estimated annual cost burden on respondents or record keepers

There are no capital/start-up or ongoing operation/maintenance costs associated with this information collection.

14. Estimated annualized costs to the Federal Government

The estimated total and annualized costs of the Information Collection to the Federal Government are shown in Table 2. The estimated total cost is $688,822, including $23,498 in Fiscal Year (FY) 2011, $31,876 in FY 2012, $29,327 in FY 2013, $346,585 in FY 2014, and $257,536 in FY 2015.

These costs include salaries, wages and associated fringe benefits of the Principal Investigators (PIs) at Iowa State University's Center for Statistics and Survey Methodology (CSSM), Project Director (PD) at Iowa State University's Survey and Behavioral Research Services (SBRS), and other professional personnel affiliated with CSSM and SBRS ($438,703 in total); travel expenses, mainly for the Phase 3 interviews ($94,412); expenses for Iowa State University to obtain FISMA compliance ($85,400); automated data processing costs ($52,029); and other miscellaneous expenses (supplies, telephone, printing, postage, incentives for cognitive interview participants) ($18,278).

Table 2. Estimated Total and Annualized Costs of the Project to the Federal Government

Budget Category Descriptions	TOTAL	Yr 1 (10-11)	Yr 2 (11-12)	Yr 3 (12-13)	Yr 4 (13-14)	Yr 5 (14-15)
Salaries and Wages						
PIs / PDs	$32,476	$4,160	$5,098	$3,779	$8,000	$11,439
Other Professional Personnel	$294,579	$10,932	$16,748	$14,996	$158,898	$93,005
TOTAL SALARIES AND WAGES	$327,055	$15,092	$21,846	$18,775	$166,898	$104,444
Fringe Benefits	$111,648	$5,208	$6,779	$6,211	$59,498	$33,952
TOTAL SALARIES, WAGES, & FRINGE BENEFITS	$438,703	$20,300	$28,625	$24,986	$226,396	$138,396
Nonexpendable Equipment	$0	$0	$0	$0	$0	$0
Materials and Supplies	$420	$125	$50	$0	$125	$120
Travel - Domestic	$94,412	$0	$0	$1,372	$0	$93,040
Publication Costs	$0	$0	$0	$0	$0	$0
Automated Data Processing (computer) Costs	$52,029	$2,518	$2,744	$2,748	$21,761	$22,258
All Other Direct Costs:						
Telephone	$5,130	$180	$50	$5	$3,795	$1,100
Interviewer and Project Supplies	$1,424	$375	$102	$16	$375	$556
Printing	$4,800	$0	$0	$0	$4,300	$500
Postage	$6,004	$0	$5	$0	$4,433	$1,566
Cognitive Interview Incentives	$500	$0	$300	$200	$0	$0
Fisma Vendors	$79,000	$0	$0	$0	$79,000	$0
Fisma Supplies (server, misc.)	$6,400	$0	$0	$0	$6,400	$0
TOTAL ALL OTHER DIRECT COSTS	$103,258	$555	$457	$221	$98,303	$3,722
TOTAL DIRECT COSTS	**$688,822**	**$23,498**	**$31,876**	**$29,327**	**$346,585**	**$257,536**

15. Reasons for program changes or adjustments

Not applicable; this is a new information collection.

16. Plans for tabulating and publishing survey results

The Phase 1 key informant interviews are expected to begin in January 2014. The interviews will be conducted first in 12 pilot communities (2 per community stratum) and a first report submitted to OMB describing any necessary changes to the key informant interview approach based on the initial results. After OMB approval of any changes, the key informant interviews will be completed in the remaining 138 communities, and the Phase 2 provider survey will be implemented in the 12 pilot communities. A second report will be submitted to OMB describing any changes to the provider survey based on the initial results. After OMB approval of any changes, the provider survey will be completed in remaining 138 communities. A technical report will be prepared based on analysis of the Phase 1 and 2 results, and used to guide the design of the Phase 3 field interviews. The Phase 3 field interviews will be conducted initially in six pilot communities (1 per stratum), and a fourth report submitted to OMB describing the detailed design of the Phase 3 field interviews. After approval by OMB, the Phase 3 field interviews will be completed in the remaining communities selected for this phase (no more than 24 additional communities). Based on analysis of the results of all three phases, a research report will be prepared and submitted for publication by ERS.

The data collection for Phases 1 and 2 is expected to be completed by April 2015, and the data collection for Phase 3 completed by September 2015. The initial technical report tabulating and discussing the results of Phases 1 and 2 is expected to be completed by August

2015, and the research report based upon all three phases of the study is expected to be submitted for publication by December 2015. The reports will focus on answering the research questions presented in section 1 of this document, and the tabulations of results will accord with that objective. Table 3 summarizes the tabulations that will be provided and the sources of data for the tabulations. The Phase 1 key informant interviews will provide qualitative information relative to all of the research questions. The Phase 2 survey will provide information on research questions 1-5 only. Secondary data on health care facilities and workforce from the Department of Health and Human Services (HHS) will also be used to address question 5) about changes in health care services in the study communities.

The research questions can be answered using simple descriptive statistics tabulating results of the survey. For example, question 1) will be answered in large part by tabulating the distribution of responses to Question 21 of the provider survey concerning the importance of each specific factor. Similar tabulations of frequency distributions (for multiple response and open ended questions) and means (for binary response questions) and standard errors (for all questions) will be used to identify the dominant responses for all questions.

In addition to descriptive statistics for the entire study population, similar descriptive statistics will be computed for sub-populations of interest, such as different types of health care providers, the three regions of study, communities with vs. without a hospital, communities close to urban areas vs. remote communities, more populated vs. less populated communities, and wealthier vs. poorer communities. These tabulations will enable investigation of how the answers to the research questions vary across the respondent population. Further investigation of these issues will be conducted using multivariate

econometric methods, combining secondary data on the study communities with the survey results.

Table 3. Data Tabulations to Address Research Questions

Research question	Tabulations	Sources of data
1) What community factors attract health care providers to rural small towns, and how important are they?	Providers' importance ranking of specified factors; frequency of most important factors; community leaders' perceptions of most important factors	Provider survey (Q21-23, 36-37); key informant interviews (Q14-15, 23)
2) What factors affect whether providers keep practicing in rural small towns, and how important are they?	Importance ranking of specified factors; frequency of most important factors; provider involvement in community; reasons for leaving (if planning to leave); community leaders' perceptions of most important factors	Provider survey (Q24-27, 38-43, 44-45); key informant interviews (Q31)
3) To what extent is recruiting and retaining health care providers seen as a priority by local health care providers and community leaders?	Provider involvement in recruitment and retention efforts; community leaders' perceptions of importance of efforts to recruit and retain providers	Provider survey (Q34-35); key informant interviews (Q32)
4) What efforts/investments do communities make to recruit and retain providers, and how effective are they?	Recruitment experience of providers; community leaders' descriptions of efforts to recruit and retain providers and perceptions of success	Provider survey (Q18-20), key informant interviews (Q16-22, Q24-30)
5) What major changes in health care availability and quality have occurred in the community in the past five years, and have changes in recruitment and retention of providers affected this?	Distribution of provider perceptions of changes in health care availability and quality, and of reasons for changes; community leaders' perceptions of changes and causes; secondary data on changes in health care facilities and workforce	Provider survey (Q28-33); key informant interviews (Q9-10); HHS data on health care facilities and workforce
6) How are changes in health care availability and quality perceived to have affected economic development in the community?	Community leaders' perceptions of effects of changes in health care services on economic development	Key informant interviews (Q11-12)

The initial technical report will not be published, but the results will be presented in technical seminars at ERS and elsewhere. The analysis in that report will be used to define key issues for investigation via field interviews in a subset of the communities in Phase 3. The objective of that phase will be to broaden and deepen understanding of the issues addressed in the first two phases. Understanding of these issues will be broadened by interviewing other types of stakeholders not included in the first two phases, such as members of the business community and civil society concerned with health care and economic development issues. Understanding will also be deepened by probing more into issues such as how local community efforts are facilitating or hindering recruitment and retention of health care providers and how these issues affect local community development. The research report will be based on all three phases of the study and will be published.

17. Reasons to not display the expiration date for OMB approval

Not applicable; the OMB approval expiration date will be displayed.

18. Exceptions to the certification statement

Not applicable; there are no exceptions to the certification statement for this information collection.