# Supporting Justification for OMB Clearance Package

# FORMATIVE RESEARCH ON ISSUES RELATED TO THE USE OF MASS MEDIA IN AFRICAN AMERICAN WOMEN
# PHASE II

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# TABLE OF CONTENTS

Attachment O: Sample Data Table

# A. JUSTIFICATION

## A1. CIRCUMSTANCES MAKING THE COLLECTION OF INFORMATION NECESSARY

One of the objectives of Healthy People 2010 is to increase the proportion of women aged 40 years and older who have received a mammogram within the preceding 2 years (U.S. Department of Health and Human Services, 2000). In August 1990, Congress enacted the Breast and Cervical Cancer Mortality Prevention Act, thereby authorizing CDC to establish a national public health infrastructure to increase breast and cervical cancer screening among low-income women who are uninsured (Attachment A). In 1991, CDC established the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), a comprehensive women's health initiative implemented through cooperative agreements with qualifying health agencies. The NBCCEDP seeks to increase breast and cervical cancer screening among uninsured, low-income women. Participating programs provide breast and cervical cancer screening; diagnostic testing; surveillance and follow-up; case management; public education and outreach; professional education and training; quality assurance of screening tests; coalition and partnership development; and program evaluation.

The NBCCEDP has had success in delivering mammography and Papanicolaou (Pap) screening tests to participants; however, nationally, the program is estimated to reach only approximately 18% of eligible women aged 40 to 64 years with mammograms (Tangka et al., 2005). As a result, a priority of the NBCCEDP is to identify effective strategies to increase enrollment among program-eligible women who have never received breast or cervical cancer screening. There is a need to improve outreach to this population of at-risk women for whom services exist and are accessible, but who are not participating for reasons not yet identified in previous studies.

Why NBCCEDP-eligible women do not participate in screening is not well understood. CDC's strategic priorities include addressing why women do not participate, as well as the disparity in screening detection rates among African American women. The results of the proposed data collection will inform the design, planning, and implementation of future CDC efforts to reach never or rarely screened women, particularly African American women, to increase their participation in the NBCCEDP.

The Centers for Disease Control and Prevention (CDC), Division of Cancer Prevention and Control, is requesting Office of Management and Budget (OMB) approval for the second phase of an ongoing research study to test communication concepts and radio messages with low-income, African American women aged 40 to 64 years in Macon and Savannah, Georgia.

In phase I of this study, CDC obtained approval (OMB number 0920-0652) to investigate, through a series of eight focus groups, the reasons why low-income, African American women aged 40 to 64 years and eligible for participation in the NBCCEDP in Macon and Savannah, Georgia do or do not participate in the program and the viable sources, messages, and channels through which to reach this population with promotional screening messages to motivate them to obtain annual mammograms.

Phase I of the study produced the following findings:

- Across groups, participants (especially NBCCEDP enrollees) believed that African American women in general were at increased risk of developing breast cancer due to family history of cancer, poor diet, and lack of health insurance.
- Participants were generally unaware of national guidelines for getting a mammogram. They offered varied thoughts about when a woman should obtain a mammogram, including the following: if she detects a lump in her breast; when she turns 40; at 18 years of age; when she becomes sexually active; every 3 to 6 months; and twice a year.
- NBCCEDP enrollees who had recently received a mammogram through their local breast and cervical cancer program (BCCP) were more likely than non-enrollees to exhibit awareness of local screening services; however, overall, participants did not know the name of their local BCCP.
- Across groups, many participants voiced concerns about mammograms, including exposure to radiation during screening, discomfort, pain, and embarrassment.
- Non-enrollees (of the NBCCEDP) were extremely skeptical about the quality of low- or no-cost mammograms and were ambivalent about technician qualifications; correct interpretation of results; technicians' treatment of them because they are African American, poor, and uninsured; and follow-up care if diagnosed with breast cancer.
- Participants preferred to receive health information via print media in the mail, at doctor's offices, and from the health department; however, they were also receptive to receiving health information via the radio. Across groups, they stated that they wanted factual, serious health messages about breast cancer and mammography disseminated to them via print media, radio, and television.
- Participants commonly identified the health department, hospitals, churches, breast cancer survivors, doctors, and health care professionals as trusted organizations and individuals to provide health information to African American women.
- Participants reported that serious messages showing concern, sympathy, and reassurance; messages providing statistics about breast cancer risk among African American women specifically; and messages stating how early detection can save lives would be the most effective in motivating African American women to get screened for breast cancer.

The purpose of phase II of this study is to (1) test audience response to concepts that arose in the phase I formative research related to breast cancer and screening and (2) test audience response to radio health messages about breast cancer and screening. Specifically, the objective of concept testing is to determine whether the ideas, words (e.g., strength, live long), images (e.g., African American women, reflections of self), or concepts (e.g., shared experiences) developed on the basis of phase I formative research findings are clear and understandable to the target audiences; are personally relevant to the target audiences; have sensitive or controversial elements; capture the audience's attention; match the audience's preferences for wording and format; and

confirm that selected settings and activities are appropriate. The objective of message testing is to explore participants' thoughts about radio messages identified and developed on the basis of phase I formative research findings. Participants will be asked questions about message comprehension, source credibility, approval of the voices, and message ability to reinforce and/or motivate desired behaviors (e.g., breast cancer screening/mammography).

The information collection for this approval was sought and approved in accordance with CDC's mission to conduct, support, and promote efforts to prevent cancer and to increase early detection of cancer, authorized by Section 301 of the Public Health Service Act (42 U.S.C. 241) (Attachment B).

## A2. Purpose and Use of the Information Collected

The results of this study will inform the development of health communication to women eligible for services through local programs in Georgia. The specific planned use of the information gained from this study will help improve NBCCEDP outreach to eligible African American women and, consequently, work to address health disparities related to mammography and breast cancer in this population.

To develop effective interventions, the project must consider the audience, message, medium, and source of the message. The purpose of this ongoing research project is to use focus groups to test communication concepts and radio messages targeting African American women who are between the ages of 40 and 64 years and eligible for participation in their local BCCP. Although the findings from focus groups are neither quantitative nor generalizable to the population as a whole, the information gained from the focus groups will assist the NBCCEDP in determining more effective avenues for reaching the target population in Georgia with tailored interventions aimed at increasing participation rates among these women. The NBCCEDP received $4 million for fiscal year 2006 to provide screening services to eligible women across the country.

There is an expected phase III of this project, which will use the findings from phases I and II to develop, implement, and evaluate a radio campaign aimed at promoting breast cancer screening in the target population.

## A3. Use of Improved Information Technology and Burden Reduction

The proposed project does not involve automated, electronic, mechanical, or other advanced technologies in the collection of information other than the use of audiotape to retain an accurate record of the focus group discussions. Focus group data will be collected in hotel conference rooms in Macon and Savannah, Georgia. Participants' use of information technology is not applicable, as the Pre-Discussion Information Sheet (PDIS) (Attachment D) will be administered via a pencil-and-paper format and focus group discussions will be conducted in person.

Because of the nature of this study and the population with which it is conducted, it is not feasible to employ information technology in the form of electronic respondent reporting. A recent systematic review of the evidence on literacy and health outcomes found that people who live in the South or Northeast, are female, are from certain racial or ethnic groups, are elderly, or have completed fewer years of education have higher prevalence of low literacy (Berkman et al., 2004). Because many of the respondents in this study are likely to have low literacy and, as a result, may have difficulty using complicated

information technology in reporting, efforts have been made to design a written study protocol and instruments that are brief, easy to use, and understandable. In addition, the study investigators have carefully considered the content, appropriateness, and phrasing of questions in both the PDIS and the focus group discussion.

Only the minimum information necessary for the purposes of this project will be collected. Standard focus group methodology recommends conducting multiple focus groups with any one type of participant (Krueger & Casey, 2000). This is done to ensure that comparisons can be made among groups of the same type of participant and that saturation (the point when the range of all ideas is heard and no new information is collected) is reached. Despite this suggestion, the project will include only one focus group with each audience segment, to reduce burden by collecting the minimum information necessary for the study as was previously approved for the first phase of study (OMB number 0920-0652).

## A4. Efforts to Identify Duplication and Use of Similar Information

The literature review on the utility of mass media outlets in communicating public health messages showed that radio and television can play a role in health promotion in the African American community. Studies indicated that airing health messages on radio stations serving the African American population can be an effective way to reach a broad African American audience with information about important health issues (Johnson & Birk, 1993). Other studies indicate that visual aids and media outlets may be even more effective than print materials in sharing health information, given health literacy issues among this particular population (O'Malley, Kerner, & Johnson, 1999; Davis et al., 1998).

However, these studies are limited, and there is a dearth of literature on how effective using radio stations that target African Americans can be in broadcasting health information to this population and, more importantly, in motivating them to seek breast cancer screening. The initial study gathered information on preferred sources and channels of health promotion messages targeted specifically to African American women, in two locations in Georgia, with a sample size large enough to identify common themes and yield reasonable estimates.

This study (phase II) proposes to test concepts and messages with information identified as important to the target audience in the phase I formative research. Specifically, this study will test communication concepts and radio health messages developed to increase mammography screening among low-income, African American women aged 40 to 64 years in selected Georgia cities. The goal of this study is to determine the cultural appropriateness of the message, determine its effectiveness in promoting screening among these women, and confirm that selected settings and activities are appropriate.

## A5. Impact on Small Businesses or Other Small Entities

No small businesses or other small entities will be impacted by this data collection.

## A6. Consequences of Collecting the Information Less Frequently

This is a one-time study. Reducing the respondent burden below the estimated levels (i.e., reducing the number of focus groups or number of participants per group) would diminish the utility of the study. Although it is methodologically desirable to have at least two focus groups per audience segment (Krueger & Casey, 2000), the study has already reduced the number of focus groups to one per segment to minimize burden (see Table B2). Collecting the information less frequently would detract from the purpose of the study. There are no legal obstacles to reducing the burden further.

## A7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This project fully complies with all guidelines of 5 CFR 1320.5.

## A8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

***A8a. 60-Day Federal Register Notice***

A 60-day notice for public comments on the proposed data collection activities required by 5 CFR 1320.8(d) was published in the Federal Register on February 16, 2006, volume 71, number 32, pages 8306–8307. One comment was received and a response was given. A copy of the notice is included in Attachment I.

***A8b. Efforts to Consult With Persons Outside the Agency***

The evaluation plan and instruments were developed and/or revised on the basis of discussions with Kimberly Redding, M.D., M.P.H., medical director, State of Georgia Department of Human Resources, Division of Public Health (GA DHR). Discussions with Dr. Redding in December 2005 through January 2006 helped clarify and focus the goals and objectives for phase II of this study and ensure that the data collected would inform health communication and outreach to African American women eligible to participate in their local (i.e., Georgia) NBCCEDP. The GA DHR was a partner in the first phase of study where focus groups were held with women who had been screened through the state screening program. The following information was requested about consultation with representatives outside of the agency to obtain their views on this research and data collection.

| | |
|---|---|
| **Consultation Year(s)** | 2005, 2006 |
| **Contact information for those consulted** | Dr. Kimberly Redding<br>Division of Public Health<br>Georgia Department of Human Resources<br>Two Peachtree Street NW<br>Atlanta, GA 30303-3186<br>Phone: 404-657-2700 |
| **Summary of problems not resolved during consultation** | No problems arose during consultation that were not addressed at that time.<br>One issue of concern raised during discussions with Dr. Redding was whether the local BCCP could absorb additional women who may present for screening as a result of this project's current efforts or a phase III campaign for this project. It was decided that |

| | |
|---|---|
| | if this work and/or a phase III intervention/campaign caused a significant increase in eligible women seeking screening, the study would revisit a discussion about additional funding or consider placing eligible women on a waiting list for screening services. |

## A9. Explanation of Any Payment or Gift to Respondents

Incentives serve as an acknowledgment that the information and time provided by respondents are valuable (Salant & Dillman, 1994). Multiple studies using a variety of data collection methodologies have shown that offering incentives increases response rates (Davis et al., 1998; Salant & Dillman, 1994; Church, 1993; Groves & Couper, 1998; Singer, Gelber, Van Hoewyk, & Brown, 1997; Singer, Van Hoewyk, & Maher, 2000). Incentives are offered to increase the likelihood of participation and to thank respondents for their time and input to the study. Although the incentive amount may vary (e.g., by the type of interviewees, the length and burden of the interview), the impact of an incentive on the response rate does not vary by data collection type (Salant & Dillman, 1994).

In the phase I study (OMB number 0920-0652), a $65 incentive was given to respondents for their participation in the focus groups. Women who were recruited and eligible for a focus group were encouraged to arrive at least 15 minutes before the group was scheduled to begin in order to participate in an Early Bird Raffle. The drawing took place at the beginning of each focus group session, and the winner received a prize of $25. In addition, a light meal was served. Of the eight focus groups conducted in phase I, seven were filled to capacity, with 10 participants each. The remaining group consisted of eight participants.

For the phase II study, focus group participants will again be given $65 for their participation. In addition, they will be encouraged to arrive at least 15 minutes before the group is scheduled to begin to participate in the Early Bird Raffle. The drawing will take place at the beginning of each focus group session, and the winner will receive a $25 prize. This gift is not large enough to be an inappropriate influence on the decision to participate. As before, a light meal will be provided.

## A10. Assurance of Confidentiality Provided to Respondents

The CDC Privacy Act Officer has reviewed this OMB application and has determined that the Privacy Act does not apply to this data collection. Response data will not be identified, stored or retrieved by respondent name.

Efforts will be made to ensure that respondents' personal information is secure at every step of the protocol, including recruitment and focus group discussions. Although full names and contact information of respondents will be recorded for tracking purposes throughout recruitment (see p.8), identifiable information will be destroyed after recruitment is completed and participation is confirmed. The identifiers used for recruitment and scheduling purposes are not linked to response data at any time.

Full names and contact information for follow-up correspondence during the recruitment protocol will be kept in locked file cabinets or password-protected computer files. All recruitment activities will be recorded and updated in a recruitment tracking database in Microsoft Access. Audiotapes of the focus groups will not be transcribed and all will be destroyed at the end of the study.

All study results will be presented in aggregate form. In every instance, respondents will be told that the information they provide in the focus groups and on the PDIS will be treated in a secure manner and will not be disclosed except as required by law.

The full names of focus group participants will be recorded for tracking purposes throughout recruitment, but they will not be identified in the notes or in any of the analysis or written reports. Only the Contractor, ORC Macro, and the LSRs facilitating recruitment of the respondents will have access to respondents' full names. CDC will see only participants' first names on name tents during the focus group.

***Check In Process.*** At the time of the focus groups, ORC Macro staff will check in each focus group respondent using a roster of participant names provided by the LSRs who conducted respondent recruitment. Following check-in, each respondent will be provided with a name tent indicating their first name only. Respondents will be directed to a waiting area where they will be provided light refreshments before the focus group convenes. Once all respondents are checked in, the focus group hostess will direct them to the focus group room where they will meet the moderator and start the focus group discussion.

***Access to and Protection of Respondent Names****.* At the time of the groups only ORC Macro staff and the LSRs will have access to respondent names. After the focus groups have been conducted, the LSRs will provide all screeners, original copies of the recruitment logs and any lists of respondent names or other identifying information to ORC Macro. ORC Macro staff will then be the only persons with access to respondent names and will store all materials with identifying information in locked file cabinets or password-protected computer files. At the conclusion of the project, all identifying information and audiotapes of the groups will be destroyed.

To further protect identifying information, all focus group observers (ORC Macro and CDC researchers) will be asked to sign an observer confidentiality form (Attachment J), stating that they will treat all information they hear in a secure manner, unless otherwise required by law. The local site recruiters subcontracted by ORC Macro are also being required to complete a confidentiality agreement (Attachment K).

The focus group discussion notes will be recorded in such a way that respondents cannot be identified, directly or through identifiers linked to them. In addition, identifiable, potentially sensitive screening data are maintained separately from the response data collected during focus group discussions.

Focus group participants will be asked to complete an informed consent form (Attachment C). At the start of each focus group, the consent form will be read out loud by the focus group moderator. The consent form details the limited risks and benefits of their participation, the purpose of the group, the expected duration of the group, their

rights as respondents, and contact information of study personnel. The form also informs the respondents that participation is voluntary. Respondents will be asked about any concerns or questions they might have, before they are asked to provide their signature, indicating consent. The moderator will serve as a witness and will also sign the consent form of each respondent.

Respondents will be given a copy of the informed consent form to take with them. The form includes contact information for the Project Manager, who can be contacted by respondents if they have any questions once the groups are over. Consent is an ongoing process, and respondents may withdraw at any time and still receive the full incentive.

ORC Macro will maintain continual communication with the LSRs throughout the recruitment process. LSRs will be instructed to ask all questions in the recruitment screener before terminating due to ineligibility. LSRs will be instructed to complete a daily log documenting their recruitment efforts and will fax the logs to ORC Macro staff daily. The logs will capture the date, type of activity (such as attending a church social), and time spent in each attempted recruitment location. First and last names as well as contact information will only be recorded for women who are screened and eligible to participate in a focus group. LSRs will be instructed not to record names and contact information for women who are screened but found to be not eligible for focus group participation.

ORC Macro staff will then conduct reminder calls; mail reminder cards and directions to respondents; and ensure that respondents check-in at the time of the groups.

Per their required confidentiality agreement (Attachment K), LSRs will keep all screeners and original copies of the logs used to track recruitment in a secure place until meeting with ORC Macro on the first day of the focus groups. At that time, all screeners and original copies of the logs will be given to ORC Macro.

ORC Macro will record and update all recruitment activities in a Microsoft Access database. In order to protect respondents' confidentiality, ORC Macro will keep all identifying information about participants in locked cabinets and password protected computer files which will be destroyed at the end of the study.

On May 26, 2006, the project obtained notice from CDC's Human Research Protection Office that this protocol was exempt from IRB review. The expiration date is May 25, 2007. A copy of the notice of exemption is included in Attachment L.

## A11. JUSTIFICATION FOR SENSITIVE QUESTIONS

Respondents will provide limited personal (i.e., demographics) information. The questions in the PDIS or moderator guides ask about respondents' opinions and thoughts regarding the message concepts and appropriateness. Questions are designed to determine if the concepts and messages are clear and understandable to the target audiences; are personally relevant to the target audiences; have sensitive or controversial elements; capture the audience's attention; match the audience's preferences for wording and format; and confirm that selected settings and activities are appropriate. Other questions are about opinions and thoughts regarding message

concepts and appropriateness; participants will not be asked about their own personal health in focus groups.

This data collection involves requesting information on several topics that may be viewed as sensitive by a portion of respondents. These topics include race/ethnicity, income, educational level, and previous diagnosis of cancer. Although potentially sensitive, these questions are necessary because the research investigates a health disparity related to African American women's use of breast cancer screening services, and seeks input about concepts and messages aimed at promoting mammography in a specific target population. The questions are a necessary part of the screening process to ensure 1) eligibility to participate and 2) to ensure that the focus groups are racially homogeneous, which facilitates group interviewing.

## A12. Estimates of Annualized Burden Hours and Costs

***A12a. Burden***

Burden for this effort is based on an 80% response rate (i.e. 80% of persons who are recruited to participate, are eligible, and agree to participate). Therefore, of the 150 women who are approached during recruitment for the 8 focus groups, a total 120 (15 per group) will be eligible and agree to participate. These 120 eligible women will be scheduled to attend groups to account for attrition, however only 80 women will actually participate in the groups in total (10 per group). Additionally, of the 120 eligible women scheduled to attend the focus groups, 20% (24 total, 3 per group) will be re-screened by ORC Macro for quality assurance purposes.

The recruitment screener will take approximately 5 minutes to complete, the completion of the PDIS will take approximately 30 minutes, and the focus group discussion will take approximately 90 minutes. Table A12a shows the total burden hours, using this information. The Attachments include one version of the PDIS adapted for focus group respondents (Attachment D) and one version of the PDIS adapted for the moderator's use (Attachment E).

Table A12a. Estimated Annualized Burden Hours

| Type of Respondent | Form Name | Number of Respondents | Number of Responses per Respondent | Average Burden per Response (in hours) | Total Burden (in hours) |
|---|---|---|---|---|---|
| **African American women, aged 40–64 years** | **Recruitment Screener (initial)** | 150 | 1 | 5/60 | 13 |
| | **Recruitment Screener (spot-check)** | 24 | 1 | 5/60 | 2 |
| | **Pre-discussion Information Sheet** | 80 | 1 | 30/60 | 40 |

| | | | | | |
|---|---|---|---|---|---|
| | **Moderator's Guide (used to facilitate Informed Consent and Focus Group Discussion)** | 80 | 1 | 90/60 | 120 |
| | | | | TOTAL | 175 |

***A12b. Respondent Cost***

Table A12b presents the calculations for cost of annualized burden hours. Georgia State minimum hourly wage rate information is from the Web site of the U.S. Department of Labor (http://www.dol.gov/esa/minwage/america.htm#Georgia). The total annualized respondent cost of burden hours is estimated at $898.00.

Table A12b. Estimated Annualized Burden Hours

| **Type of Respondent** | **Form Name** | **Number of Respondents** | **Number of Responses per Respondent** | **Average Burden per Response ( in hours)** | **Average Hourly Wage Rate** | **Total Cost** |
|---|---|---|---|---|---|---|
| **African American women, aged 40–64 years** | **Recruitment Screener (initial)** | 150 | 1 | 5/60 | $5.15 | 64 |
| | **Recruitment Screener (spot-check)** | 24 | 1 | 5/60 | $5.15 | 10 |
| | **Pre-discussion Information Sheet** | 80 | 1 | 30/60 | $5.15 | 206 |
| | **Focus Group Discussion** | 80 | 1 | 90/60 | $5.15 | 618 |
| | | | | | TOTAL | $898 |

## A13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

Respondents will incur no capital or maintenance costs to complete this data collection.

## A14. Annualized Cost to the Federal Government

Table A14 presents the costs to the Federal Government. Two types of Government costs will be incurred:

**1. Government personnel.** The Technical Monitor is assigned for 50% of their FTE. Assuming an annual salary of $85,000 for the Technical Monitor, the total amount paid to Government personnel is $42,500.

**2. Contracted data collection.** The project design and data collection is being conducted under a contract with ORC Macro. The contract is for a total of $147,500 and includes costs for subcontracting to local site recruiters and conducting the focus groups.

Therefore, total annualized cost to the Federal Government for this data collection is $190,000.

Table A14. Estimates of Annualized Cost to the Government

| Item | Annualized Cost |
|---|---|
| Technical Monitor at 50% of their FTE | **$42,500** |
| Contractor | **$147,750** |
| TOTAL | **190,000** |

## A15. Explanation for Program Changes or Adjustments

This is a new data collection.

## A16. Plans for Tabulation and Publication and Project Time Schedule

***Analysis Plan***

The analysis plan for this study was developed by taking into account the resources available for analysis, the anticipated quantity of data that will be generated from eight focus groups, and the anticipated use of the findings.

Data from the PDIS will be analyzed with Statistical Package for the Social Sciences (SPSS), version 13.0. PDIS data will be entered into an SPSS database, and frequencies will be run for each of the questions on the PDIS. The resulting analyses will be used only as a means of describing the study participants and drawing comparisons between groups or segments. Data obtained from the PDIS will not be used to make generalizations about any larger population and will be reported and analyzed in aggregate form.

Once the focus groups are completed, the notetakers will analyze the field notes across the groups for a specific segment and enter their notes into a data table prepared for analysis of the phase II focus group data. A sample data table is attached (Attachment O). The data table will be organized by the sections of the moderator guide, divided into age and enrollee versus non-enrollee segments. This will allow for the easy recording of age and enrollee/non-enrollee themes and differences and will guide notetakers in how to record details in each section of the table.

The ORC Macro team will use a rigorous, systematic process when completing the data tables, to ensure reliability and consistency among the notetakers in how the data are summarized and to ensure neutrality in the reporting and interpretation. The ORC Macro analysis team will meet on a regular basis to compare findings and discuss the interpretation of the data. Should differences in interpretation occur, team members will reexamine and discuss the data tables and field notes until they reach agreement in their findings and interpretation of the data.

Particular attention will be given to capturing the frequency of topics, extensiveness of the response across participants, and the intensity of the response. For example, the analysis team will identify patterns or themes that are clearly and frequently expressed within each group, as well as those that are more subtle or less often voiced. The team will consider ideas or thoughts that are voiced once or several times and nonverbally supported by group members, but not necessarily repeated frequently by others in the groups. On the basis of these discussions, the themes that are common across the segments and themes that distinguish among the segments will be identified. The themes from the focus groups will be either articulated directly by participants or identified by the analysis team.

Analysis team members will also review the field notes to flag any specific quotes that were recorded, to illustrate the themes and primary patterns and capture additional group dynamics. If possible (from the quotes recorded in the notes), quotes will be included in each segment to illustrate common themes.

The analysis of field notes will serve as the basis of the bullet-point topline summary of general themes and patterns from the focus groups. The topline summary will include the terms “several,” “a lot of support,” and “not a lot of support” to describe focus group discussions. Other acceptable terms to use to describe participants’ comments and ideas include “some,” “many,” “most,” and “a few.” Setting numerical parameters to quantify terms such as “some,” “many,” “most,” and “a few” is not a standard practice when describing qualitative data, and every attempt will be made to ensure that all comments and insights are reported in a consistent and accurate manner.

ORC Macro will meet with CDC to obtain feedback and comments on the topline summary, then revise it accordingly.

***Publication***

Results from this data collection will likely be disseminated in peer-reviewed publications.

***Study Timeline***

Table A16 presents the estimated timeline for this study. A 1-year clearance is requested.

Table A16. Study Timeline

| Study Activity | Estimated Date of Completion |
|---|---|
| Recruit participants in location 1 | 3 to 6 weeks after OMB clearance |
| Conduct groups in location 1 | 6 to 8 weeks after OMB clearance |
| Recruit participants in location 2 | 6 to 8 weeks after OMB clearance |

| | |
|---|---|
| Conduct groups in location 2 | 8 to 10 weeks after OMB clearance |
| Analyze data | 14 weeks after OMB clearance |
| Produce topline summaries | 14 to 18 weeks after OMB clearance |

## A17. Reason(s) Display of OMB Expiration Date Is Inappropriate

An exemption to displaying the OMB expiration date is not being requested.

## A18. Exemptions to Certification for Paperwork Reduction Act Submissions

There are no requested exemptions to the certification.