

Racial and Ethnic Approaches to Community Health across the U.S. (REACH US) Evaluation

Supporting Statement Part A (2nd Revision)

February 20, 2009

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Table of Contents

- A. Justification.....
 - 1. Circumstances Making the Collection of Information Necessary
 - 2. Purposes and Use of Information Collection
 - 3. Use of Improved Information Technology and Burden Reduction
 - 4. Efforts to Identify Duplication and Use of Similar Information
 - 5. Impact on Small Businesses or Other Small Entities
 - 6. Consequences of Collecting the Information Less Frequently
 - 7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5
 - 8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency
 - 9. Explanation of Any Payment or Gift to Respondents
 - 10. Assurance of Confidentiality Provided to Respondents
 - 11. Justification for Sensitive Questions
 - 12. Estimates of Annualized Burden Hours and Costs
 - 13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers
 - 14. Annualized Cost to the Government
 - 15. Explanation for Program Changes or Adjustments
 - 16. Plans for Tabulation and Publication and Project Time Schedule
 - 17. Reason(s) Display of OMB Expiration Date is Inappropriate
 - 18. Exceptions to Certification for Paperwork Reduction Act Submissions

List of Attachments

- Attachment 1. Authorizing Legislation
- Attachment 2. 60-day Federal Register Notice
- Attachment 3a. Introductory Call (Screening) Questionnaire
- Attachment 3b. Household Member Interview Questionnaire
- Attachment 4. Power and sample size calculation table
- Attachment 5. Advance letter
- Attachment 6. IRB approval letter
- Attachment 7. Nonresponse plan
- Attachment 8. Postcard
- Attachment 9. REACH US Grantees
- Attachment 10. Weighting Plan
- Attachment 11. Incentive Experiments

A. Justification

1. Circumstances Making the Collection of Information Necessary

In 1999, the Centers for Disease Control and Prevention (CDC) launched the Racial and Ethnic Approaches to Community Health (REACH) 2010 demonstration project as authorized by Public Health Service Act, Title 42 United States Code, Chapter 6A - Public Health Service, Subchapter II - General Powers and Duties, Section 241 Research and Investigation (42USC241) (**Attachment 1**). This was a community intervention program targeting six health priority areas: cardiovascular disease, diabetes, improving breast and cervical cancer screening and management, improving adult or childhood immunizations, infant mortality, and HIV/AIDS. The funded communities targeted at least one of the following six racial/ethnic groups: African Americans, Alaska Natives, American Indians, Asian Americans, Hispanic Americans, or Pacific Islanders. Evaluation is of critical importance in documenting and assessing the reduction of health disparities among racial and ethnic populations. CDC conducted the REACH 2010 Risk Factor Survey from 2001 through 2006 in the residents of 27 communities focusing on cardiovascular disease, diabetes, and deficits in breast and cervical cancer screening and treatment (OMB number 0920-0502). The results from the survey have provided valuable information regarding efforts by the REACH 2010 communities to reduce health disparities.

CDC is to continue the program in eliminating the health disparities in minority communities. Starting September 30, 2007, a similar program, “Racial and Ethnic Approaches to Community Health across the US” (REACH US) further moves into establishing a national multilevel program that approaches the elimination of racial and ethnic health disparities through the application, synthesis, and dissemination of promising practices within public health practice. Consequently, two levels of interlinked 5-year funding are supported 1) 18 Centers of Excellence in the Elimination of Disparities serving as expert centers by providing the infrastructure to coordinate, refine, and disseminate programmatic activities within specified racial and ethnic group(s) and along selected health priority areas, and 2) 22 Action Communities that implement practice-based or evidence-based practice/programs within a minority community, also along selected health priority areas. The priority areas are cardiovascular disease (heart disease and stroke), diabetes, breast and cervical cancer, adult/older adult immunization and infectious disease [limited to hepatitis B and tuberculosis], respiratory (limited to asthma), and infant mortality. This new intervention program includes some communities that previously participated in REACH 2010 and some new communities.

CDC requests OMB approval to continue the valuation of the program through a similar annual survey in 27 communities focusing on cardiovascular disease, diabetes, and deficits in breast and cervical cancer screening and treatment over 5 years. Within each community a total of 900 persons will be surveyed each year (24,300 respondents each year). Respondents will be persons over the age of 18 years who are within the race and ethnic group targeted by the specific REACH community. The methodologies will be similar to those used in the previously approved REACH 2010 evaluation instrument. The REACH U.S. questionnaire will have minor changes tailored to the new features of the program (**Attachment 3a for the Introductory Screening Interview and Attachment 3b for the detailed Family Member Interview**). The

survey focuses on the following areas: socio-demography, health-related quality of life, access to health care, physical activity, fruits and vegetables intake, cigarette smoking, diabetes, hypertension, cholesterol and cardiovascular disease screening and intervention, mammography and cervical cancer screening, and adult immunizations. The questionnaire in Attachment 3b includes some modules that may be used in selected communities targeting specific health priority area (e.g., cardiovascular disease) and in communities implementing specific intervention (e.g., weight control).

2. Purposes and Use of Information Collection

The purpose of this data collection will be to assess the prevalence and changes of self-reported risk behaviors associated with cardiovascular disease, diabetes, deficits in breast and cervical cancer screening, and other preventive services. Data will be collected on a yearly basis enabling investigators to assess changes in the performance measures during the intervention and will assess community progress towards meeting performance objectives. While state-based risk factor data exist from the Behavioral Risk Factor Surveillance System, these data do not reflect the level of health behaviors within local communities. This necessitates the collection of data within local communities.

The results of previous REACH 2010 Risk Factor Surveys have served multiple purposes. First, the data gathered have been utilized to determine the extent of health disparities across the racial and ethnic groups served by the REACH communities. Second, the communities and CDC have used these data to track progress in reducing and eliminating disparities. Third, the information has provided a scientific basis to assist CDC and other governmental agencies in determining the need and direction of additional programs and served as a model for potential future assessments. The annual data collected in the survey were sent to grantees of the surveyed communities with support documentation (e.g., methodology, data tables, data format, and data use instruction). These data have been used in numerous community newsletters, flyers, reports, briefings to local government and congress persons, conferences, as well as publications in scientific journals. CDC has used these data in CDC publications, websites, congressional briefing, national conferences, and scientific journals. The data to be collected in the proposed REACH U.S. evaluation survey will serve the similar purposes.

It is essential that valid epidemiological studies be performed on representative samples from varying racial and ethnic groups with collection of data from appropriate comparison populations. This study within the REACH communities represents the only epidemiologic study of a random sample of adults. Since the questions are derived from performance measures widely employed in public health and the data collection methods will be similar to those conducted in the state-based Behavioral Risk Factor Surveillance System (BRFSS), CDC will be able to use data from the BRFSS as a control for the REACH communities and minimize the burden of data collection. In addition, since each community questionnaire is identical, the REACH communities will also serve as control communities for each other, further minimizing the data collection burden.

This study is essential to the evaluation of the REACH program. If this study is not conducted, knowledge regarding the health disparities within and among the REACH communities will be limited and CDC will not be able to assess progress towards the national

objectives including the goal of eliminating health disparities in the REACH communities. Without this information CDC's ability to evaluate each community's progress in eliminating disparities in health will be greatly hampered.

3. Use of Improved Information Technology and Burden Reduction

In order to increase efficiency and consequently decrease respondent burden, participants will be interviewed utilizing Computer Assisted Telephone Interview (CATI) and Computer Assisted Personal Interview (CAPI) technology for the telephone and in-person interviews, respectively. The mailed survey will contain skip instructions so that respondents need only answer the questions that apply to them. The surveys will be administered by a contractor. All data collection tools, including the subject interview, interview guide and script have been adapted from established performance measures and from existing surveys. Only those items which are essential in determining the previous and present health behaviors of the interviewee or to validate the responses are included.

We propose to conduct the survey using an address-based sampling (ABS) approach. An ABS sample will improve information technology and burden reduction in three important ways:

- ABS provides a basis for a variety of data collection approaches – telephone, mail, and in-person – thereby increasing response rates as respondents have more than one means to participate in the survey.
- ABS enables us to sample within the very specific geographic boundaries of the REACH catchment areas, which will make the process of determining eligibility for the REACH survey significantly more efficient.
- Compared to RDD, the ABS approach is expected to lower respondent burden hours and increase response rates for the same number of completed interviews. As noted above, sampled addresses can be matched precisely to the target geography through GIS, eliminating the need to screen households for geographic eligibility. As a result, less time is needed to screen households, which lowers respondent burden. In the previous REACH 2010 surveys using the RDD approach, approximately 4 completed screeners were needed to obtain 1 completed household member interview. We estimate that the ratio will be 2 to 1 using the ABS approach. We anticipate that the annualized respondent burden hours recognized under an ABS approach could be lower than the annualized burden expected for an RDD approach.

4. Efforts to Identify Duplication and Use of Similar Information

An extensive review of scientific literature, medical journals, and governmental publications has been conducted to locate other studies regarding racial and ethnic disparities in health. Most of the current knowledge comes from epidemiologic studies in selected local areas in a small scale. These data did not reflect the prevalence of health behaviors in the REACH communities.

The concept of the study during initial planning of REACH 2010 was presented in 1998 to the Surgeon General, the Assistant Secretary for Program Evaluation, the Office of Minority Health DHHS, and the REACH 2010 Investigators. In addition there were presentations to a working group of subject matter experts that assisted the REACH 2010 grantees, the Cardiovascular Health Program, Division of Adult and Community Health, CDC, Division of Cancer Prevention and Control, CDC, Division of Diabetes Translation, CDC, and the National Immunization Program, CDC. As a result of these interactions and ongoing communications, it has been determined that no other epidemiologically valid study which assesses the pre- and post intervention health effects within the REACH communities has been conducted. In addition, morbidity and mortality data which may be available to some REACH communities are not appropriate for evaluation of intervention change given the short duration of intervention. Therefore data on health risk behaviors which are more likely to respond to intervention effects will be collected within the intervention community.

5. Impact on Small Businesses or Other Small Entities

The data to be collected in this study will be obtained from individual study subjects. No data will be collected from small businesses.

6. Consequences of Collecting the Information Less Frequently

The data collection in this study will consist of yearly surveys in the communities. If the information were collected on a less frequent basis, we would run the risk of missing changes in several performance measures. This would greatly increase the likelihood of not demonstrating statistically significant improvements in health disparities. Each year a random sample of the residents in the community is selected. Given the size and population of most of the communities, it is very unlikely that the same resident will be surveyed more than once over the years.

There are no legal obstacles to reduce the burden.

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

This data collection will not involve any of the special circumstances relating to the guidelines of 5 CFR 1320.5.

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

A 60-day Federal Register Notice was published in the Federal Register on November 16, 2007 (volume 72, number 221, pp. 64652-64653) (see **Attachment 2**). There were no public comments received.

In the past 5 years, we obtained consultations and input from academic scientists in the fields of epidemiology, biostatistics, survey design, and the evaluation of intervention studies. Our contractors have performed two site visits to every surveyed community and two

environmental scan interviews with grantees and have received input on the study design, data collection procedure, instrument, as well as data usage. The surveyed communities also provided comments on the Vietnamese, Khmer and Haitian Creole versions of questionnaire.

9. Explanation of Any Payment or Gift to Respondents

We propose to conduct two experiments in the use of survey incentives.

(1) If households for which telephone number can not be obtained, do not complete the CATI interview after eligibility has been established, or if respondents have been unreachable during CATI (i.e., the household remains unscreened in CATI), they will be mailed a Self-Administered Questionnaire (SAQ) study booklet. A \$5 incentive will be included in the SAQ package for half the household sample. For another half of the households, no incentive will be included in the SAQ package. Within the experimental group, i.e., those who received \$5 incentive, half of the households will receive a promise of an additional \$10 upon return of the completed SAQ.

(2) For cases that have completed the household telephone screener, are known to meet the REACH US interview eligibility criteria for the community, half of the sample in each REACH community will receive a refusal conversion letter and a \$5 incentive after the second CATI refusal. (Another half of the sample will receive the refusal conversion letter only.) Respondents who complete the interview after receiving the refusal conversion letter with \$5 will receive a thank you letter with an additional \$10 token of appreciation.

These experiments are motivated by a number of factors. First, ABS surveys are relatively new and thus little is known about the interaction of the methodology with incentive methodology. Second, and specifically related to our mail SAQ incentive experiment, mail surveys are more burdensome on respondents and thus tend to suffer relatively low response rates. Mail surveys require additional motivation and effort on the part of the respondent in order to comprehend, complete, and return the instrument. Third, relatively little data are available on the use of incentives in minority communities. The incentive experiment will allow us to both increase participation and measure the extent to which the minority populations require incentives to encourage participation. Fourth, we believe the use of incentives will reduce overall burden of this survey. Given the relatively low survey eligibility in some study areas, each completed interview requires a substantial number of contacts to ineligible households. By offering incentives to potential respondents, we increase the likelihood that an eligible household will complete the survey and thus decrease the overall number of households we will need to contact.

Additional information on the incentive experiments is provided in **Attachment 11**.

10. Assurance of Confidentiality Provided to Respondents

This information collection request has been reviewed by Privacy staff who determined that the Privacy Act is not applicable. The data collection contractor will purchase lists of addresses that are associated with names, however, names will be removed from the call lists

provided to the interviewer, and names of participating respondents will not be collected by the interviewer. In limited situations, the interviewer may have temporary access to a potential respondent's first name or initials, such as when it is necessary to schedule a call-back to conduct the complete interview. In these situations, the first name or initials will be deleted from the interviewer's scheduling notes as soon as the interview has been completed. Response data will be identified and retrieved by a unique identification number assigned to each respondent. Neither the names nor any other information by which respondents could be individually identified will be recorded. Therefore, answers cannot be linked to individual respondents. Only aggregate data will be analyzed and reported.

The survey protocol for the contractor utilizes widely accepted practices to treat data in a confidential manner ensuring that the integrity of the survey will not be jeopardized by careless or inappropriate use of the data. All staff members are trained in and clearly understand the need to uphold confidentiality rules. Should a contractor staff member violate confidentiality and privacy procedures at any time, they will be removed from the project or reprimanded, as appropriate.

The data collection contractor will observe information management practices established by the National Institute of Standards and Technology (NIST), as specified in the *Guide for Developing Security Plans for Information Technology Systems* (special publication 800-18), *An Introduction to Computer Security: The NIST Handbook* (special publication 800-12), and *Generally Accepted Principles and Practices for Securing Information Technology Systems* (special publication 800-14). Security methodologies include physical access control; logical control of access to the IT environment as a whole; specific authorization and logical control of access rights to data and programs, based upon specific need for access; extensive network and Internet security control; management and operational controls; and monitoring, audit and variance detection.

11. Justification for Sensitive Questions

Questions relating to race/ethnicity and income can be considered of a sensitive nature. However, these questions are important and are necessary in order to reach the intended audience for the REACH US program. The evaluation (survey) component needs to be consistent with the intervention program. Collection of income data will enable investigators to determine whether improvements in health status have occurred within certain segments of the community including those with low socioeconomic status. The privacy safeguards above are being implemented in recognition of the potentially sensitive nature of some questions in this information collection.

12. Estimates of Annualized Burden Hours and Costs

Random samples of community residents will be selected. The introductory call (Attachment 3a) will screen for eligibility by race/ethnicity, and age criteria. The average burden per respondent will be approximately two minutes. If a telephone number cannot be matched to a sampled address, a brief postcard sent to the address will solicit the household's telephone number so that they can be called to complete the interview. The average burden per respondent who completes the postcard will be approximately 1 minute. If the respondent is eligible and

willing to participate in the interview, it will take an average of 15 minutes to complete the family member questionnaire interview (Attachment 3b). Based on experience from the REACH 2010 information collection, approximately 37,000 persons will need to be screened in order to obtain 24,300 completed interviews (900 respondents in each of the 27 REACH U.S. communities). The estimated response rate is 75% and the total estimated annualized burden hours are 7,558.

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
Adults ages 18 and older who live in communities participating in the REACH U.S. program	Introductory Screening Interview	37,000	1	2/60	1,233
	Postcard	15,000	1	1/60	250
	Family Member Interview	24,300	1	15/60	6,075
	Total				7,558

Based on a mean hourly wage rate of \$11, the estimates of annualized costs to respondents are as follow. Eleven dollars/hour was used since the survey will be administered in minority populations with moderate to low income levels. The total estimated annualized cost to respondents is \$83,142

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Avg. Burden per Response	Average Hourly Wage Rate	Respondent Cost
Adults ages 18 and older who live in communities participating in the REACH U.S. program	Introductory Screening Interview	37,000	1	2/60	\$11	\$ 13,567
	Postcard	15,000	1	1/60	\$11	\$2,750
	Family Member Interview	24,300	1	15/60	\$11	\$ 66,825
	Total					\$83,142

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

There are no additional costs to respondents.

14. Annualized Cost to the Government

The annual cost to the government includes the costs for contracted data collection and the personnel costs of federal employees involved in oversight and data analysis. We will select a contractor through open competition to perform the survey. The Contractor's responsibilities include: identify appropriate geographic areas of the surveyed community; identify a sampling frame from which to select households; instrument refinement; sampling plan, design, and selection; training of interviewers; administration of the appropriate survey; data management; and transfer data to CDC. Based on the experience and the costs in the previous surveys, the annual contract cost is estimated as \$5,000,000. The personnel costs of federal employees are about \$100,000 per year, based on 100% of an FTE at GS-14. Hence, the total annual cost to the Government is about \$5,100,000.

15. Explanation for Program Changes or Adjustments

The REACH U.S. program is replacing the REACH 2010 program which was discontinued in September 2007. The OMB clearance for the information collection under the REACH 2010 program (0920-0502) will be discontinued upon receipt of OMB approval for the proposed new information collection for REACH U.S. The burden estimate for each respondent has not changed. However, the revised burden estimate reflects an increased number of survey communities (29) compared to REACH 2010 (27 communities).

16. Plans for Tabulation and Publication and Project Time Schedule

Data collection for this study is scheduled to begin four weeks after OMB approval, and to continue on an annual basis. A three-year approval period is being requested for this information collection. During the third-year another application for OMB approval will be submitted in order to continue data collection for another two years.

As in the REACH 2010 clearance, the actual data collection will take 6-8 months each year. Data will be cleaned within a month. Raw data, tabulation of data, as well as supporting documentation will be sent to each community within two months after completion of data collection. CDC and the communities will use these data, including data analysis for presentation and publication, immediately after the data are available. When the subsequent years data are available, analysis will include multiple years of data. CDC will analyze aggregated data by priority area and by racial/ethnic group. Secular trend analyses have been performed in the past and will be continued.

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

Display of the OMB Expiration date is reasonable and will be displayed.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

No exemptions to the certification are requested.