Section A and Section B: Justification and Statistical Methods

OMB control # 0920-08BP

Audience Profiling for Carbon Monoxide Poisoning Prevention

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Supporting Statement

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Audience Profiling for Carbon Monoxide Poisoning Prevention

A. JUSTIFICATION

1. Circumstances Making the Collection of Information Necessary

Classification and Authorization

This information collection request is new and approval is being requested for three years. This is a one-time study. The collection of data is authorized under §301 of the Public Health Service Act (42 U.S.C. 241). (Attachment 1)

Background

Carbon monoxide (CO) is one of the leading causes of poison-related deaths in the United States. The Centers for Disease Control and Prevention (CDC) estimates that each year approximately 500 people die of unintentional, nonfire-related CO exposure, and another 15,000 individuals visit emergency rooms for treatment from exposure to CO gas (CDC, 2005b). Dubbed the silent killer for its lack of odor and color, CO is a by-product emitted from fuel-burning devices as a result of the incomplete combustion of fossil fuels. CO-emitting devices include many household appliances—such as gas-burning furnaces, gas stoves, hot water heaters, and kerosene heaters—as well as other items found around homes, such as portable generators, charcoal and gas grills, and automobiles.

A number of different products and scenarios cause CO poisoning every year. However, because there is no comprehensive surveillance system for CO exposures, no one information source can depict which products, situations, and behaviors are most likely to trigger these poisonings or which populations are most likely to be affected.

A comprehensive review of the literature shows that residential settings—including homes, apartments, mobile home/trailers, hotels, and resorts—are the most common locations for CO poisoning (CDC, 2005b; Scheerer & Struttmann, 2002). Residential poisonings are also more likely to occur during the winter months (December–February), and almost half (49%) of residents are asleep at the time of poisoning (Scheerer & Struttmann, 2002; Yoon et al., 1998). One of the main reasons that poisonings occur more frequently in the winter months is because of CO exposure from home heating systems. Faulty furnaces and heating systems account for almost all residential poisonings—fatal and nonfatal alike (Scheerer & Struttmann, 2002; Liu et al., 2000). More than 85% of all households in the United States use natural gas, oil, or wood to power their heating systems, indicating that a major of households are at risk for CO exposure (Runyan et al., 2005). Different geographic regions are also more likely to use different heating fuels: oil fuel is more common in New England (37%), electric heat is most common in the South (54%), and natural gas is most prevalent elsewhere (Runyan et al., 2005). Nevertheless, all geographic areas have a substantial number of households that use fossil fuel-burning furnaces.

Summer storms, winter storms, and other emergency scenarios also account for a predictable number of CO poisonings. In these conditions, individuals are often poisoned by products that provide

electrical power and heat or clean up debris. Hurricanes, tornados, floods, and snow/ice storms are major risk factors for summer and winter poisonings because they cause power outages and severely damage property (Van Sickle et al., 2007; CDC, 2006; CDC, 2005a; Daley et al., 2001). Such power outages lead to portable generator and heater use, and property damage leads to using chainsaws, pressure washers, and other gasoline-powered tools for restoration. Power outages and generator use, in particular, are often widespread following storms. Following the 2004 Florida hurricane season, more than 18% of households reported using generators, and every CO poisoning victim reported losing power after the hurricanes hit (Van Sickle et al., 2007; CDC, 2005a). Sales of generators have also been increasing steadily since 2000, and individuals use these products to power items ranging from refrigerators (86%) to televisions (49%) and air conditioners (46%) (Van Sickle et al., 2007; CDC, 2005a).

Despite our current knowledge of scenarios and products that lead to CO poisoning, questions remain about when and how individuals use CO-emitting products, why they engage in certain risk behaviors, how best to inform them about the CO poisoning, and how receptive they are to existing prevention materials. The current study aims to address these questions and, ultimately, strengthen educational materials about CO poisoning prevention.

Privacy Impact Assessment

Below we give (i) an overview of the data collection system, (ii) a listing of items of information to be collected and (iii) a statement on web utilization.

Overview of Data Collection System:

The study team will collect data using four methods: 1) a focus group; 2) a triad (3 person) interview, 3) a paper questionnaire or 4) a telephone interview.

For the focus groups and triads interviews, a convenience sample of individuals will be recruited based on their ownership of either of the following products: 1) a portable gas powered generators and 2) gas or oil burning home appliances. A professional focus group recruiting firm will be used to recruit these participants. Telephone interview are with key informants, identified for their expertise in the area of carbon monoxide injury prevention.

In Phase I, the formative stage of this project, CDC will recruit respondents to participate in focus groups based on their ownership of specific gas or oil burning products or appliance (e.g. portable electric generators, gas or oil burning stoves, gas or oil burning heating systems, gas or oil burning appliances). All participants in the focus groups will also complete a brief paper questionnaire as part of the focus groups session. At a later point in the project (Phase III), additional respondents will be recruited to participate in triad interviews. Triad interviews are a smaller version of a focus group, where three people participate in a discussion with a single moderator. CDC will conduct these to test potential prevention messages with members of the target audiences. In addition, CDC will conduct key informant interviews by telephone with a select sample of experts in the area of carbon monoxide injury prevention. Section B1 describes in full the respondent universe.

Items of Information to be Collected:

For the purposes or recruitment and reminders only, the following IIF (Information in Identifiable Form) items will be collected: Name, gender, mailing address, email address and phone number. This information will be collected for sole purpose of recruiting participants for the study, and sending them reminder calls, letters or emails. The names of participants or any other IIF will not appear in any report nor will they be made available to the CDC or publicly unless compelled by law.

Other information collected will be opinions on non-controversial issues (such as their thoughts about carbon monoxide poisoning). All these non-IIF items will be aggregated into a report with no personally-identifiable markers to allude to the source of the opinion.

No personally identifiable information will be transmitted to the CDC. Please see section A10 for further discussion.

Identification of Website(s) and Website Content Directed at Children Under 13 Years of Age:

No websites are being developed as part of this project.

2. Purpose and Use of the Information Collection

The information gained through this project will help CDC develop an understanding of the perceptions and experiences of individuals related to CO poisoning. This information will be used to determine the need for future research and to develop interventions related to this topic as well as to revise existing educational materials about CO poisoning and risk behaviors. The findings will also highlight effective dissemination channels for distributing potential prevention materials.

If CDC does not conduct this formative research, CDC will not know the needs of this population in terms of CO poisoning prevention. In addition, CDC will not have the information it needs to create targeted educational campaigns that addressed consumer safety needs related to CO poisoning.

Privacy Impact Assessment Information

IIF data is being collected for the sole purpose of recruiting and making reminder calls. For example, an address is necessary to send the recruitee directions to the focus group facility and reminding him/her of the appointment. Age will be collected to describe the sample population (e.g. to state the average age of respondents).

At the conclusion of data collection, all IIF (except age which will be kept but not linked to persons) will be destroyed and will not be part of a report. Additionally, no IIF, expect a median, age, will be transmitted to the CDC.

This information collected as part of the study is not sensitive, nor is the topic of discussion sensitive or controversial. Even in the event of a breach of confidentiality, the proposed data collection will have little or no effect on the respondents' privacy.

3. Use of Improved Information Technology and Burden Reduction

For this study, CDC will employ qualitative research methods, including focus groups, triads (3 participants), and telephone interviews. Upon consent from the participant, CDC will audio tape interviews to capture all information and assist with preparation of reports.

The use of electronic respondent reporting is not being utilized for two reasons. 1) For a qualitative study, while there are some qualitative software programs, the use of electronic reporting is typically not feasible, as opposed to quantitative studies which lend itself better to electronic reporting. 2) The small number of interviews being done does not justify the utilization of electronic reporting. Qualitative software programs typically involve a heavy investment of time and money to program the criteria for a particular project, as well as to report the finding. The time and expense to the government of utilizing electronic reporting would greatly exceed that of not using it.

4. Efforts to Identify Duplication and Use of Similar Information

In order to identify duplication and use of similar information, CDC conducted an extensive review of the literature by examining several large periodical journal databases. In addition to reviewing published information, CDC searched for "gray" literature by exploring the Internet. CDC also searched the Internet using several Internet search engines, including Google, Yahoo, AltaVista, Medline, and Science Direct. CDC was unable to find duplication or the use of similar information. There is no other study that duplicates our proposed efforts.

5. Impact on Small Businesses or Other Small Entities

No small business will be involved in this study. CDC will schedule all interviews at the convenience of the participant and CDC will not impact the participant's employer. There are no legal obstacles to reducing the burden.

6. Consequences of Collecting the Information Less Frequently

This is an ad hoc data collection (i.e., a one-time study with consumers and CO experts and does not require periodic collection of data). There are no legal obstacles to reduce burden.

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

This request fully complies with the regulation 5 CFR 1320.5) There are no other special circumstances that require the data collection to be conducted in a manner inconsistent with 5 CRF 1320.5. This data collection request fully complies with the regulation.

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

A. A 60-Day *Federal Register* notice published on September, 17, 2008 (Volume 73, Number 181, pages 53,876-53,877) solicited comments on Audience Profiling for Carbon Monoxide Poisoning Prevention, formative research activities. Attachment A2 is the copy of the 60-day *Federal Register* notice.

One public response was received. No changes were made to the proposed project based on this response, as the public comment did not relate to the utility and scope as proposed.

B. The CDC study team collaborated with RTI International staff (contractor) on the study design, screening instruments, and interview guides. RTI staff is trained and experienced in formative research. CDC recognizes the importance of gaining valuable insights directly from experts in areas of home and health safety. In developing this research, CDC consulted with the individuals listed in Table 8.1.

Table 8.1. Individuals Consulted During the Development Research Project

Consultation	Title	Affiliation	Phone	Date
Neil Hampson, MD Neil.Hampson@vmmc.org	Medical Director, Center for Hyperbaric Medicine	Virginia Mason Medical Center 1100 Ninth Ave. Seattle, WA 98101	(206) 583-6543	12/10/2007
Jim McVay, DrPA jmcvay@adph.state.al.us	Director, Health Promotion and Chronic Disease	Alabama Department of Public Health 201 Monroe Street Suite 968 Montgomery, Al. 36104	(334) 206-5600	12/11/2007
Daniel Kovacs, PhD dkovacs@decisionpartners.com	Senior Scientist	Decision Partners	(330) 259-7779	12/14/2007
Sarah Thorne, MA dprc@decisionpartners.com.	Senior Scientist	Decision Partners	(416) 861-8367	12/14/2007

9. Explanation of Any Payment or Gift to Respondents

CDC will give participants in the consumer research reimbursement to thank them for their time and effort in the study. The reimbursement amounts are as follows:

Telephone Interview (with experts)	$0.00
Focus Groups (consumers)	$75.00
Triads (consumers)	$75.00

The reimbursement amounts for consumers (which includes both home appliance owners and generator owners) were determined based upon the burden to the participants, taking into account the May 2007 average US hourly wage of $19.56 (Bureau of Labor Statistics http://www.bls.gov/oes/current/oes_nat.htm#b00-0000), the length of the interview, the fact that participants may have to travel a considerable distance to and from the focus group facility, parking costs, and our previous experience conducting interviews with consumers. The honoraria are intended to recognize the time burden placed on the participants, encourage their cooperation, and to convey appreciation for contributing to this important study. Numerous empirical studies have shown that honoraria can significantly increase response rates (e.g., Abreu & Winters, 1999; Shettle & Mooney, 1999; Greenbaum, 2000).

The safety experts, whom CDC is to interview by telephone, will not be reimbursed for their time. All of the participants are experts in the areas of fire, emergency, and household safety and will participate as part of their regular professional responsibilities. Given that these interviews are conducted over the phone and do not require travel, the burden is minimal. In addition, unlike the interviews with consumers, the interviews with experts are about their professional opinions, and CDC does not collect personal data.

10. Assurance of Confidentiality Provided to Respondents

This data collection received IRB approval from RTI International's Human Research Protection Office (protocol 12085, expiration 03/28/2009). RTI's IRB approvals are provided in Attachment A3). (Note: CDCs IRB deferred to RTI's IRB approval, as documented in Attachment A16.)

Personal information concerning the participants and organizations will only be collected as part of the screening process and reminders. In recruiting focus group and triad interview participants, all individual information will be gathered by the focus group recruiting firm and de-identified before shared with RTI and the CDC. The focus group recruiting firm will be instructed to destroy their records at the conclusion of the study. In conducting the focus group and triads, only first names will be used with participants. Moreover, the selection criteria and individuals' personal information will not be shared with other participants.

Privacy Impact Assessment Information

Below we discuss information related to PIA.

Privacy Impact Assessment Information (Part A: Applicability of Privacy Act):

This submission has been reviewed by the Information Collection Review Office (ICRO), who determined that the Privacy Act does not apply.

Privacy Impact Assessment Information (Part B: Information Safeguards)

RTI will not link personal information collected during screening with responses from the focus groups and interviews. The recruitment firms will create a list of participants and their screening criteria for the team, but will not include contact information (e.g., address, phone number). In conducting the focus groups and interviews, moderators will use only first names as identifiers. Likewise, only first names will be used as identifiers in the notes.

Personal information from the potential participants will be maintained and secured to the extent allowed by law. At each facility, the screeners (Attachment 4-6) used to recruit the participants will be kept in locked filing cabinets. All identifying information (name, address, telephone number) will be recorded on the last page of the screener, which will enable the recruitment firms to remind participants about scheduled focus groups/interviews. The last page of the screener will be torn off and destroyed after the focus groups are conducted and participants have received their reimbursements.

After the focus groups and interviews, RTI will secure the de-identified screeners in a locked file cabinet (accessible only to select project staff) throughout the duration of the project. Once the project ends, these forms will be transferred into a locked RTI storage facility and, after 3 years, will be destroyed.

Any information or data that contains personally identifiable will be de-identified before transmission to the CDC. Unless compelled by law, no personally identifiable information will be disseminated to a third party.

Privacy Impact Assessment Information (Part C: Respondent Consent)

For the focus groups and triads, consent from respondents will be gathered in two parts. First, before a potential respondent is screened, they will be asked for their consent to be screened. The consent will be obtained verbally as the screening will take place over the phone. Second, at the time of the focus group or triad, participants will be asked to complete and sign a written consent form (see Attachments 7-9).

For the telephone interviews with experts at various organizations, consent will be obtained verbally. The consent script is included at the beginning of the discussion guide (Attachment 10). This data collection involves information about organizations rather than personal information; therefore, the Privacy Act does not apply.

Privacy Impact Assessment Information (Part D: Respondents' enrollment by their own volition):

11. Justification for Sensitive Questions

Sensitive information will not be collected as part of this study.

12. Estimates of Annualized Burden Hours and Costs

The total annualized response burden is estimated at 276 hours. Tables 12.1 and 12.2 provide details about how this estimate was calculated. Timings were conducted during our instrument development process to determine the overall burden per respondent. Administration of the screening instrument is estimated to take 10 minutes. Participation in a focus group or triad is estimated to take 2 hours. Completion of the Exit Questionnaire (focus group, phase 1 only) is estimated to take 10 minutes. Participation in the telephone interview is estimated to take 1 hour. In total, and in the course of one year or less, CDC will complete 64 screenings each for both the home appliance owners and generator owners focus group (10.7 hours for each segment), interview 32 participants each for both the home appliance owners and generator owners focus group (64 hours each segment), complete 32 exit questionnaires each for both the home appliance owners and generator owners focus group (5.3 hours for each segment), interview 4 experts by phone (4 hours), complete 48 screenings each for both the home appliance owners and generator owners triad (8 hours for each segment) and interview 24 participants each for both the home appliance owners and generator owners triad (48 hours each segment).

Table 12.1. Estimated Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
Owners of Gas or Oil Burning Household Appliances	Focus Group Screener	64	1	10/60	11
	Focus Group	32	1	2	64
	Exit Questionnaire	32	1	10/60	5
	Triad Screener	48	1	10/60	8
	Triad	24	1	2	48
Owners of Portable Gas Burning Generators	Focus Group Screener	64	1	10/60	11
	Focus Group	32	1	2	64
	Exit Questionnaire	32	1	10/60	5
	Triad Screener	48	1	10/60	8
	Triad	24	1	2	48
Expert	Telephone Interview	4	1	1	4
Total					276

In calculating the burden, CDC used the May 2007 average US hourly wage of $19.56. CDC used the mean hourly wage for all occupations in the United States Department of Labor, Bureau of Labor Statistics (May, 2007). Available online at: http://www.bls.gov/oes/current/oes_nat.htm#b00-0000.

Actual hourly wage rates will vary by education, work experience and other factors. The estimated annual cost to participants for the time burden for collections of information is $5,398.

Table 12.2 Estimated Annualized **Burden Costs**

Type of Respondent	Activity	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours	Hourly Wage	Total Respondent Costs
Home Appliance Owners	Focus Group Screener	64	1	10/60	11	$ 19.56	$ 215.00
	Focus Group	32	1	2	64	$ 19.56	$ 1,252.00
	Exit Questionnaire	32	1	10/60	5	$ 19.56	$ 98.00
	Triad Screener	48	1	10/60	8	$ 19.56	$ 156.00
	Triad	24	1	2	48	$ 19.56	$ 939.00
Generator Owner	Focus Group Screener	64	1	10/60	11	$ 19.56	$ 215.00
	Focus Group	32	1	2	64	$ 19.56	$ 1,252.00
	Exit Questionnaire	32	1	10/60	5	$ 19.56	$ 98.00
	Triad Screener	48	1	10/60	8	$ 19.56	$ 156.00
	Triad	24	1	2	48	$ 19.56	$ 939.00
Expert	Telephone Interview	4	1	1	4	$ 19.56	$ 78.00
						TOTAL	$ 5,398.00

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

Respondents participate on a purely voluntary basis and, therefore, are subject to no direct costs other than their time to participate; there are no start-up or maintenance costs. CDC does not require any additional record keeping.

14. Annualized Cost to the Government

The total annualized cost for this study is estimated to be $138,410.00. This includes the CDC FTE s and a contractor. (see Table 14.1). Details of the annualized costs are contractor's costs are based on estimates provided by the contractor who will carry out the data collection activities. This is the cost estimated by the contractor, RTI, and includes the estimated cost of coordination with the CDC, data collection, analysis, and reporting.

Table 14.1. Estimated Cost to the Government

Expense Type	Expense Explanation	Annual Costs (dollars)
Direct Cost to the Federal Government		
• CDC oversight of contractor and project	CDC Project Officer	$5,000.00
	Subtotal, Direct Costs to the Government	$5,000.00
Contractor and Other Expenses		
• Recruitment and Data Collection (Contractor)	Labor hours and Other Direct Costs	$88,940.00
• Analysis and Reporting (Contractor)	Labor hours and ODCs	$44,470.00
	Subtotal, Contracted Services	$133,410.00
	TOTAL COST TO THE COVERNMENT	$138,410.00

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

The team will take notes during the audio recording of the focus groups and material testing interviews and will audio record the focus groups and materials testing interviews. The audio recordings with supplemental notes will be stored in a locket filing cabinet at RTI for the duration of the project only to be accessible by select project staff.' At the end of the project all recordings will be destroyed.

During the focus groups, triad interviews, and telephone interviews, a note taker will enter the participant responses directly into a Microsoft Word file on a laptop computer. The note taker will use a password-protected RTI laptop for data entry, and the data files will be kept on the RTI project share drive (accessible only by select project staff). The data will not contain any identifying information. The Phase II dataset and trend analysis findings also will be stored on the RTI project share drive. The dataset is completely anonymous and will contain no identifying information.

Screeners, consent forms, paper-and-pencil questionnaires, and hard copy notes will be stored in a locked filing cabinet at RTI (accessible only by select project staff) for the duration of the project. At the end of the project, the materials will be transferred to a locked storage facility and will be destroyed 3 years later.

All primary data (focus groups, materials testing, and phone interviews) will be analyzed using both NVivo software and a data matrix. The software will help the team identify themes and trends across all respondents, and the data matrix will allow the team to identify specific trends within each research

question. Existing data on media usage and preferences will be analyzed using Microsoft Excel, and the team will identify trends within each audience segment.

Table 16.1**. Project Time Schedule**

Activity	Time Schedule
(Phase 1) Begin recruitment	1 month after OMB approval
(Phase 1) Begin Focus Group and Telephone Interview Data Collection	2 months after OMB approval
(Phase 1) Analyze and Summarize Data	3 months after OMB approval
(Phase 2) Conduct analysis on media usage*	2 months after OMB approval
(Phase 3) Recruit for Triads	7 months after OMB approval
(Phase 3) Begins Triad Data Collection	8 months after OMB approval
Deliver Draft Final Report	10 months after OMB approval
Deliver Final Report	11 months after OMB approval

* Phase 2 does not involve collecting data from individuals and thus was excluded from this OMB package

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

CDC is not seeking OMB approval to exempt the display of the expiration date on the forms submitted within this information collection request.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification statement.

B. STATISTICAL METHODS

1. Respondent Universe and Sampling Methods

The study population will include individuals in three audience segments mostly at risk for unintentional CO poisoning—homeowners with fossil fuel-burning furnaces, portable generator owners, and recent Asian immigrants that use charcoal and grills during power outages (represented by organizations that serve this population). Members from the first two audience segments will be actively recruited for focus groups and materials testing interviews (Phases I and III) and will be represented in the existing dataset used to analyze media usage and preferences (Phase II).

Because of language and recruitment barriers, CDC will interview organizations that represent and serve the third at-risk audience segment—recent Asian immigrants that use charcoal and grills during power outages. CDC has not yet identified specific organizations to interview, but we anticipate speaking with 3-4 organizations that provide services to recent immigrants from Southeast Asian countries. We also anticipate that organizations will be knowledgeable about the audience segment and will not need to interview audience members before participating. These organizations will be actively recruited by telephone (Phase I).

CDC has identified several inclusion criteria for the study participants. To be eligible to participate in the study, participants must meet the following criteria (outlined below by phase and audience segment):

<u>Phase I—Focus Groups/Phase III—Materials Testing with consumers</u>

Home Appliance Owners

- English speaking
- Aged 18 or older
- Own and currently reside in a single-family home
- Rely on a fossil fuel-burning furnace as the primary source of heat (e.g., natural gas, oil)
- Live within the greater Chicago area (as determined by ZIP code)

Portable Generator Owners

- English speaking
- Aged 18 or older
- Own a portable gasoline-powered generator
- Have operated the portable generator during a power outage caused by a storm (e.g., hurricane, tornado, flood, snow/ice storm)
- Live in North Carolina

<u>Phase I—Telephone Interviews with Experts</u>

- Nonprofit, government, or academic organization

- Serve non-English-speaking immigrant or migrant populations

- or -

- Currently conduct CO poisoning prevention activities

Statistical power is not applicable because this is a qualitative study. The results are not generalizable to the general population.

2. Procedures for the Collection of Information

For the Phase I focus groups, the team will conduct eight focus groups (6 to 8 participants per group) with up to 64 individuals. Each focus group will last approximately 2 hours and will be held at a professional focus group facility. A trained team member will moderate the focus groups using a semi-structured focus group guide (Attachments 11-12). The focus groups will include questions about CO awareness, furnace safety and use, generator safety and use, and receptivity to prevention messages. A second team member will be present to take notes either behind a one-way mirror or in the presence of the group. Focus groups will also be audio recorded using digital recorders. Audio recordings will supplement notes and will be stored in a locked filing cabinet in the project leader's office. CDC staff members may also attend and view the focus groups from behind a one-way mirror. In addition, individuals participating in the Phase I, focus groups will be asked to complete a brief exit questionnaire at the conclusion of the discussion (see Attachments 14-15)

For the Phase I telephone interviews, the team will conduct three to four individual telephone interviews with community organizations that serve non-English speaking recent Asian immigrant populations with a high prevalence of indoor charcoal/grill use. Each interview will last approximately 1 hour. A trained team member will conduct the interview using a semi-structured discussion guide (Attachment 10). The interviews will include questions about the awareness of CO poisoning among non-English-speaking populations as well as current CO poisoning prevention activities the groups are conducting. A second team member will be present to take notes.

For the Phase II media behavior examination, the team will examine anonymous survey data previously collected by Mediamark Research Inc.'s Survey of the American Consumer. RTI team members will identify trends in mass media exposure, usage, and preferences among each audience segment and will use these trends to identify effective dissemination routes for prevention messages.

For the Phase III materials testing interviews, the team will conduct 16 triads (three participants per interview) with up to 48 individuals. Each triad will last approximately 2 hours and will be held at a professional interview facility. A trained team member will conduct the triad using a semi-structured interview guide (Attachment 13). The triads will include questions about existing prevention materials, including relevance, credibility, clarity, impact, and dissemination channels. A second team member will be present to take notes either behind a one-way mirror or in the presence of the group. Interviews will

also be audio-recorded using digital recorders. Audio recordings will supplement notes and will be stored in a locked filing cabinet in the project leader's office. CDC staff members may also attend and view the interviews from behind a one-way mirror.

3. Methods to Maximize Response Rates and Deal with Nonresponse

The following procedures will be used to maximize cooperation and to achieve the desired participation rates:

- For consumer interviews (home appliance and generator owners), reminder letters/e-mails will be sent with directions to the focus group facility 1-2 days prior to the scheduled focus group or triad. Participants will not be contacted again after the interview is over.
- For consumer interviews, a provision of honoraria to thank participants for their time and effort in the study (please see Section A-9 for more information about the honoraria).
- For the expert telephone interview, a reminder email will be sent.

4. Test of Procedures or Methods to Be Undertaken

To estimate the burden for administering the screening questionnaire, two different project team members were consulted. The project team members conducted mock screening interviews and provided affirmative responses to most or all questions that branched to further follow-up questions. In this way, the burden estimate most closely resembles a maximum average burden, since almost all screening questions were presented in the interview. In addition, the project team members deliberately read each item at a slow rate of speed. The project team members estimated the maximum average burden to be 10 minutes for each of the screening instruments. The screening instruments are shown in Attachments 4-6.

5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data

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