IMPROVING THE QUALITY AND DELIVERY OF CDC'S HEART DISEASE AND STROKE PREVENTION PROGRAMS

SUPPORTING STATEMENT PART A

Contact: Lauren Gase, Health Scientist
Division for Heart Disease and Stroke Prevention
Centers for Disease Control and Prevention
Atlanta, GA
Telephone: (770) 488-8007
Fax: (770) 488-8151
Email: lgase@cdc.gov

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TABLE OF CONTENTS

a. Estimated Annualized Burden Hours
b. Estimated Annualized Burden 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

    a. Project Time Schedule

    b. Data Analysis Plan

    c. Plans for Tabulation and Publication

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

18. Exceptions to Certification for Paperwork Reduction Act Submissions

LIST OF ATTACHMENTS

Attachment 1	Section 301 of the Public Health Service Act
Attachment 2A	Federal Register Notice
Attachment 2B	Summary of Public Comments and CDC Response
Attachment 3	Reference Set of Relevance, Quality, and Impact Questions
Attachment 4	DHDSP Evaluation Plan Overview and Logic Model
Attachment 5	Example Solicitation Letter
Attachment 6	Example Web-based Survey
Attachment 7	Example Interview Guide
Attachment 8	Example Focus Group Guide
Attachment 9	Generic Clearance Users Guide
Attachment 10	Data Collection Request Form
Attachment 11	Annual Report to OMB Template

A. JUSTIFICATION

A-1. Circumstances Making the Collection of Information Necessary

Background

Heart disease and stroke are the first and third leading causes of death for both men and women in the United States, accounting for more than 35% of all deaths. They are also among the leading causes of disability in the U.S. workforce, with projected costs of more than $448 billion in 2008, including health care expenditures and lost productivity from death and disability. While heart disease and stroke are among the most widespread and costly health problems facing our nation today, they are also among the most preventable. In 2006, CDC created the Division for Heart Disease and Stroke Prevention (DHDSP) in response to the epidemic of heart disease and stroke facing our nation. The DHDSP provides national leadership for efforts to reduce the burden of disease, disability, and death from heart disease and stroke for all Americans. The DHDSP's key partners include state and local health departments, public health organizations, nonprofit organizations, professional organizations, and academic institutions.

The DHDSP supports the development of CDC-funded programs, as well as external partners, by conducting trainings, providing scientific guidance and technical assistance, and producing scientific information and supporting tools. For example, the DHDSP provides training to States on how to implement and evaluate their programs and provides guidance on how to best apply evidence-based practices. In addition the DHDSP translates its scientific studies into informational products, such as on-line reports and data on heart disease and stroke trends.

The DHDSP recognizes the importance of ensuring that its activities are useful, well implemented, and effective in achieving its intended public health goals. To evaluate its current and future program activities, the DHDSP has developed a comprehensive Evaluation Plan (See Attachment 4) based on the criteria of relevance, quality and impact. This assessment strategy is being implemented in a phased approach. In 2008, the DHDSP implemented Phase I to assess the effectiveness of its internal processes in translating CDC scientific work into materials intended for state public health partners. The next step is to look externally to assess the relevance, quality, and impact of DHDSP's activities and services.

Over the next three years, DHDSP plans to conduct a series of information collections based on a reference set of questions that address relevance, quality and impact of DHDSP trainings, technical assistance, and guidance. Respondents will be the DHDSP's partners in state and local government as well as partner organizations in the private sector including public health organizations, nonprofit organizations, professional organizations, and academic institutions. A generic clearance is requested in order to provide flexibility in the content and timing of specific information collections. The evaluation information will be used to determine whether DHDSP activities and services are reaching the intended partners, whether they are deemed to be useful by those partners, and whether DHDSP efforts improve public health practices. In addition, the

information gathered under the generic clearance will allow the DHDSP to identify new programmatic opportunities and to respond to partners' concerns.

To provide maximum benefit for DHDSP program planning and evaluation activities, information collection must sometimes be coordinated with other events and opportunities, such as the release of a product or a meeting with external partners. In order to be responsive to such opportunities, DHDSP requests permission to conduct information collections without specific, prior OMB approval, when information collections (i) are consistent with the purposes outlined in this generic clearance request, and (ii) utilize questions in a reference set that has received prior OMB approval (See Attachment 3).

DHDSP proposes the following internal controls to ensure conformance with approved standards:

1.) Each proposed data collection will be reviewed by the DHDSP contact to ensure that:
    a. it is consistent with the DHDSP evaluation plans and goals, as outlined in this ICR
    b. the data collection instruments utilize only verbatim questions from the pre-approved reference set (question bank)
    c. the existing exemption from IRB approval applies
2.) Each proposed data collection will be reviewed by the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) PRA contact to ensure that:
    a. the data collection conforms to the terms of the clearance
    b. the total burden hours do not exceed the pre-approved cumulative total
    c. there are no changes that affect the Privacy Act determination
3.) DHDSP/NCCDPHP will provide an annual summary report to OMB.
4.) If an information collection utilizes questions that have not been pre-approved by OMB, DHDSP will request specific, prior OMB approval through the Change Request mechanism.

The proposed data collection is authorized by Section 301 of the Public Health Service Act (Attachment 1).

Privacy Impact Assessment Information

In accordance with the privacy impact assessment, the following items are described below: 1) an overview of the data collection system, 2) a delineation of the items of information to be collected and 3) an indication of whether the system hosts a website.

Overview of the Data Collection System

The DHDSP compiled a reference set of questions to measure the relevance, quality, and impact of its training, technical assistance, and guidance (See Attachment 3). Surveys, interviews, and focus groups, tailored to specific public health partners, activities, or

other programmatic initiatives will be developed from the reference set of pre-approved questions.

In order to minimize burden, whenever possible, information will be collected through online surveys. In-person and telephone interviews will only be used when web surveys are impractical, more burdensome, or in-depth responses are required from respondents. If interactions among respondents are desirable, the survey questions may be simultaneously asked in a focus group format. The DHDSP estimates that it will conduct up to 17 web-based surveys, 120 interviews, and 12 focus groups each year over the three year life of the project. The DHDSP will prioritize which products and activities are most in need of evaluation, based on its Division Evaluation Plan (See Attachment 4).

CDC employees, fellows, full-time contractors, or contract vendors will collect the data. All computer data such as results from web surveys or MP3 files of in-person interviews will be stored in secured electronic files on CDC-secured computers or secure contractor computers. Similarly, physical files containing respondent information such as audiotapes or written transcriptions will be kept in locked file cabinets. Both computer and physical files will be retained for the minimum amount of time necessary to comply with records retention requirements.

Items of Information to be Collected

The question bank contains questions designed to measure the relevance, quality, and impact of the DHDSP's training, technical assistance, and guidance (See Attachment 3). Questions about relevance solicit information about the extent to which DHDSP activities and products are novel, easy to access, timely, appropriate for the target partner, pertinent, have a clear purpose, and solve a problem or need. Questions about quality solicit information about the extent to which DHDSP activities and products are understandable, credible, accurate, consistent, feasible, user friendly, and meet the user's expectations. Questions about impact examine the use, reach, and benefits of DHDSP services and products.

A small number of demographic and descriptive questions may be included in specific information collections to assess the extent to which perceptions and use of DHDSP services vary across types of respondents. The demographic and descriptive questions include race/ethnicity, gender, education level, and job experience. A senior statistician in the DHDSP was consulted and does not anticipate that this descriptive information will allow individuals to be identified.

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

To administer web-based surveys, a web-based data collection tool, such as SurveyMonkey, will be utilized. Upon completion of the survey, respondents will be directed to the DHDSP home page.

Data collection proposed as a part of this clearance will not target children less than 13 years of age.

A-2. Purpose and Use of Information Collection

The primary user of the information collected through this clearance is the DHDSP. As mentioned, the DHDSP has developed an Evaluation Plan (See Attachment 4) to assess the relevance, quality, and impact of its activities. The Evaluation Plan is being implemented in a phased approach to evaluate the DHDSP's short- and long-term progress in achieving its strategic plan, public health goals, and mission.

In 2008, the DHDSP implemented Phase I to assess the effectiveness of its internal processes in translating CDC scientific work into materials intended for state public health partners. The next step is to look externally to assess the relevance, quality, and impact of DHDSP's guidance and services. Over the next three years, DHDSP plans to conduct a series of information collections to assess the relevance, quality and impact of DHDSP training, technical assistance, and guidance.

Results of the evaluation will be used to strengthen relationships between the DHDSP and its partners, enhance the impact and effectiveness of the DHDSP's activities and products, strengthen the organizational effectiveness of the DHDSP, and, ultimately, enhance its ability to affect the public health workforce so that the U.S. can become a Healthiest Nation.

An effective program improvement process requires understanding the type and scope of products and services that can best meet the needs of DHDSP partners. By asking partners to identify their current needs, to describe how DHDSP activities address these needs, and to identify new DHDSP activities that they would find helpful, DHDSP will be better able to improve existing activities as well as prioritize areas for additional or expanded services.

Furthermore, these assessments will enable DHDSP to assess how effectively it is supporting its partners and to gauge its progress in meeting goals. This will allow the DHDSP to prioritize service areas that need improvement and to identify successful activities that should be maintained, replicated, or expanded. The proposed data collection activities will result in a stronger DHDSP, and a stronger CDC, that is better able to meet the needs of its partners and, subsequently, demonstrate the results of its activities on public health.

A single survey is unable to address the needs of DHDSP's diverse partner base and the range of its activities. Without the proposed collection of information, DHDSP's evaluation initiatives would be based on informal and partial feedback from a limited number of partners.

Results of this evaluation will be used for program improvement, to strengthen the activities undertaken by the DHDSP. The DHDSP Logic Model (See Attachment 4) depicts how DHDSP activities influence public health practice and, ultimately, impact

public health. By implementing this Evaluation Plan, DHDSP can measure its progress on, and improve its ability to meet its expected outcomes, including:

- An engaged network of states and partners
- An enhanced external application of Division goals and strategies
- An enhanced ability of programs to apply findings to improve public health
- Enhanced competency of the public health workforce
- Enhanced integration among chronic disease programs

Privacy Impact Assessment Information

The purpose of these information collections is to assess the impact and effectiveness of the DHDSP's activities. More specifically, information is being collected to assess the relevance, quality, and impact of the training, technical assistance, and guidance that the DHDSP provides. Information will be used to improve existing activities and prioritize areas for additional or expanded services. In addition, information will be used to strengthen the organizational effectiveness of the DHDSP and to enhance its ability to improve the capacity of the partners it serves.

The DHDSP plans to minimize the amount of information in identifiable form that is collected. As described in A1, only a small number of demographic and descriptive questions, including education level, job experience, and job role, may be included in specific information collections. Conformance with this standard will be verified for each information collection.

A-3. Use of Improved Information Technology and Burden Reduction

Response burden will be minimized by collecting the majority of information through online surveys. Web surveys reduce respondent burden by enabling them to easily access the survey and complete it at a convenient time and location. The web survey will use easy-to-read response scales or text boxes that are embedded in mainstream online survey software such as SurveyMonkey. Any skip patterns included in the survey (that is, questions that are only appropriate for a proportion of respondents) will be automatically programmed into the Web-based form.

In-person and telephone interviews will only be used when web surveys are impractical, more burdensome, or in-depth responses are required. When asking respondents a number of in-depth questions, collecting data through in-person interviews or telephone interviews is less burdensome because the interviewer can audiotape or record respondents answers. This allows the respondent to provide their answers orally and eliminates the burden of writing down their responses. If interactions among respondents are desirable, the survey questions may be simultaneously asked in a focus group format. In this case, burden will be reduce by holding the conversation over the phone or convening the group at a meeting or conference so respondents will not have to travel for the focus group.

In addition, time limits will be established for all surveys in order to limit the burden on respondents. The length of web surveys will be limited to thirty minutes, in-person or

telephone interviews to one hour, and focus groups to one hour. Interviews require more time because they will be designed to provide respondents the chance to provide detailed responses. Establishing time limits for surveys will prevent respondents from being burdened by very long surveys. Before releasing the survey, the time needed to complete a survey will be assessed through limited pilot testing. It is inappropriate to gauge the length of surveys based on number of questions because the question bank includes both open-ended (e.g., How have you used this product? Please give specific examples) and close-ended questions (e.g., Did you find this DHDSP product easy to use? Please rate on a scale of 1 to 10 where 1=not easy to use and 10=very easy to use). Consequently, surveys with the same amount of questions will take a different amount of time to complete depending on the mix of close-ended and open-ended questions.

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

The proposed data is being collected in order to evaluate the relevance, quality, and impact of DHDSP activities. This data to be collected is specific to DHDSP activities; therefore, data collected on the relevance, quality, and impact of the activities of other organizations is not appropriate or useful for this project.

Currently, DHDSP monitors the Heart Disease and Stroke Prevention State Programs using a MIS that is OMB approved (OMB# 0920-0679, exp. 5/31/2011). State health departments are responsible for recording programmatic information in the MIS including a list of staff, a description of interventions, a delineation of program objectives, a progress report on performance measures, and a listing of accomplishments. Information collected via this mechanism will not meet the needs of this evaluation, as States are not expected to provide feedback on DHDSP activities. However, to ensure that survey questions cannot be answered with data contained in the MIS system, a DHDSP staff will review the MIS before the development of each data collection instrument to verify that the information desired is not collected in the MIS.

CDC secured OMB approval to conduct web usability surveys (See OMB# 0920-0735, exp. 3/31/2010). This clearance is not expected to meet the needs of this information collection, since this information collection is not intended to assess the usability of the website.

This generic clearance will allow the DHDSP to consolidate its evaluation activities and, therefore, prevent duplicative efforts. The DHDSP conducts a wide range of activities to support its partner base and cannot evaluate them all. The DHDSP will prioritize which products and activities are most in need of evaluation, based on its Division Evaluation Plan (See Attachment 4). By creating a common framework and an approval path within the DHDSP for information collections, the DHDSP will be able to avoid any duplicative information collections or overburdening any subset of partners.

A-5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this data collection.

A-6. Consequences of Collecting the Information Less Frequently

The DHDSP estimates that it will conduct up to 17 web-based surveys, 120 interviews, and 12 focus groups each year over the three year life of the project. Because the DHDSP's guidance and products are often audience-specific (geared toward the State or local program manger, epidemiologist, or program evaluator), no one type of respondent will be asked to participate in more than two surveys, interviews, or focus groups annually.

DHDSP is consistently releasing new products and improving existing activities. A vital component of quality improvement is regularly collecting partner feedback on activities as well as soliciting ideas from partners about how to improve services. In the absence of this information, DHDSP's evaluation efforts are based on informal and partial feedback from a few partners. While informal feedback is useful, informal feedback does not capture the full range of opinions about DHDSP activities, fails to provide partners the opportunity to provide anonymous feedback, and does not accurately measure the impact of the DHDSP's work on the capacity of the public health workforce.

There are no legal obstacles to reduce the burden.

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

There are no special circumstances with this information collection package. This request fully complies with the guidelines of 5 CFR 1320.5.

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

A. A 60-day Federal Register Notice was published in the Federal Register on December 12, 2008, vol. 73, No. 240, pp.75721-75722 (see Attachment 2A). A non-substantive public comment was received and acknowledged (see Attachment 2B).

B. In addition to obtaining public comment, CDC consulted with persons inside and outside the agency to obtain their input on multiple phases of the project, including: the development of the CDC Evaluation Plan (see Attachment 4); development of a timeline for implementation of the Evaluation Plan; identification of the appropriate dimensions of relevance, quality, and impact to measure; identification of relevant partner groups; development of the questions to be included in the question bank; identification of data collection mechanisms; and development of a plan for data analysis. The project has been a true collaborative effort across all the Teams and Branches of the DHDSP. Results of the DHDSP evaluation will impact all staff; therefore, obtaining their input on how to design a useful and meaningful evaluation has been a high priority. In addition, engaging external evaluation experts familiar with DHDSP activities, products and services allowed for additional review of project activities by individuals with considerable evaluation expertise. Table A8.1 lists individuals who have provided consultation on the project.

Table A8.1 Individuals Who Have Provided Consultation on the Project

Consultant	Title	Affiliation	Email	Phone	Year of Consultation
Barri Burrus, PhD	Senior Community Health Psychologist	RTI	barri@rti.org	(941) 486-0245	2008
Erica Fulmer, MHA	Health Research Analyst	RTI	fulmer@rti.org	(770) 986-5054	2008
Jeannette Renaud, PhD	Health Research Psychologist	RTI	jrenaud@rti.org	(770) 234-5011	2008
Pat Shifflett, MPH	Vice President	The Cloudburst Group	ps@cloudburstgroup.com	(404) 797-2668	2008
Steve Sullivan, PhD	Director	The Cloudburst Group	sts@cloudburstgroup.com	(301) 918-4400	2008

A-9. Explanation of Any Payments or Gift to Respondents

We do not plan to supply payments or gifts to respondents. We anticipate respondents are highly motivated to provide direct feedback on DHDSP programs because they utilize DHDSP products and services and are motivated to help the DHDSP improve.

A-10. Assurance of Confidentiality Provided to Respondents

This data collection will conform to ethical practices for survey administration and implement procedures to protect the security of respondents. Participation for surveys, interviews, and focus groups will be solicited through email, phone calls, or written correspondence. The contact information used to solicit participation will be kept separate from participant responses and no effort will be made to link responses with the contact lists.

All data collected by DHDSP will be treated in a confidential manner unless otherwise specified by the law. All respondents will be informed that their responses will be treated in a confidential manner unless otherwise specified by the law. Only aggregate numbers, summary statistics, or de-identified quotations will be included in evaluation reports. Additional procedures designed to protect participant security for surveys, interviews, and focus groups are described below.

<u>Surveys</u>
DHDSP plans to use web survey technology in a manner that collects no identifying information on respondents. Currently, web survey technology, such as SurveyMonkey, the software to be used for web data collection, is not able to link survey responses to Internet Protocol (IP) addresses of respondents. This protects the identity of respondents when they submit their responses over the web. In order to provide respondents the

opportunity to discuss needs or issues raised in a web survey while maintaining their security, DHDSP, on each survey, will provide respondents DHDSP contact information in written form or a link to an email address or phone number where respondents can send questions or ask for guidance. This strategy separates respondents' requests for technical assistance from their survey responses. All computer data will be stored in secured electronic files on CDC-secured computers or secure contractor computers. Computer files will be retained for the minimum amount of time necessary to comply with records retention requirements, at which time the files will be destroyed.

Interviews and Focus Groups

Interviews and focus groups will be audio taped, with permission from respondents. Each respondent will be de-identified though assignment of a unique ID. For surveys, interviewers will assign an ID number to each respondent; this ID number, and not the participants' name, will appear on the survey. No attempt to link the ID numbers to the names will be made. Similarly, for focus groups, participants will be instructed to choose a pseudonym and will be referred to by this pseudonym throughout the entire focus group. No attempt will be made to link pseudonyms to names.

Physical files containing respondent information such as audiotapes or written transcriptions will be kept in locked file cabinets. Both computer and physical files will be retained for the minimum amount of time necessary to comply with records retention requirements, at which time the records will be destroyed.

IRB Approval

The DHDSP and the Center for Chronic Disease Prevention and Health Promotion Human Subjects contacts have reviewed this generic clearance package and all supporting documents and have characterized the information collections as Public Health Practice, which do not require IRB approval. Conformance with this standard will be verified for each information collection.

Privacy Impact Assessment Information

A. The DHDSP believes that the proposed information collections are not subject to the Privacy Act, as the information to be collected is neither personal nor sensitive. Partners participating in information collections are speaking as representatives for their organization to answer questions about the relevance, quality, and impact of the DHDSP's training, technical assistance, and guidance. States and partners are being provided the opportunity to offer feedback on ways that the DHDSP can improve its activities and products to be of further support. Administering these data collections through a third party, assuring respondents that they will not be penalized for non-participation, and taking steps to de-identify respondents, will create an opportunity for respondents to provide candid feedback on ways in which DHDSP can further support its partner base.

Each information collection will be reviewed to determine whether it is subject to the Privacy Act.

B. All computer data such as results from web surveys or MP3 files of in-person interviews will be stored in secured electronic files on CDC-secured computers or secure contractor computers. Similarly, physical files containing respondent information such as audiotapes or written transcriptions will be kept in locked file cabinets. Both computer and physical files will be retained for the minimum amount of time necessary to comply with records retention requirements, at which time the files will be destroyed.

C. Before taking the survey, respondents will be informed about the purpose of the survey, provided an estimate of how long the survey will take to complete, and supplied with a list of individuals who will have access to their responses. They will be notified that their participation is purely voluntary and will be assured that they will not be penalized in any way if they choose not to take the survey or to skip any of the survey questions. Consent will be obtained from all participants before they begin the survey. The consent form for web-based surveys will be the presented in the email sent to participants soliciting their participation as well as within the survey itself. An example of this language is provided. (See Attachment 5 for an example solicitation letter and Attachment 6 for an example web based survey).

Before participating in an interview or focus group, respondents will be informed about the purpose of the interview or focus group, provided an estimate of how long the interview or focus group will last, and supplied with a list of persons who will have access to their responses. Furthermore, respondents will be notified that their participation is purely voluntary. Consent for interviews and focus groups will be obtained through an oral process after information about purpose of the interview or focus group and use of the data is provided. An example of this language is provided in the example instruments. (See the Attachment 7 for an example interview guide and Attachment 8 for an example focus group guide).

D. Before taking the survey, or participating in a focus group or interview, respondents will be informed about its purpose, provided an estimate of how long the survey, interview or focus group will take, and notified that their participation is purely voluntary. Furthermore, respondents will be assured that they will not be penalized in any way if they choose not to participate or to skip any of the questions. An example of this language is provided in the example instruments. (See Attachment 6 for an example web based survey, Attachment 7 for an example interview guide, and Attachment 8 for an example focus group guide).

A-11. Justification for Sensitive Questions

Respondents will report their satisfaction with DHDSP activities as well as provide suggestions to improve the program. This information is critical in assessing the quality of DHDSP activities and improving these products. Because some partners receive funding from or may apply for future funding from DHDSP, these responses could be considered sensitive information. The security of responses will be preserved by following the procedures outlined in section A-10**.**

A-12. Estimates of Annualized Burden Hours and Costs

A customized instrument will be designed for each information collection. Questions will be exclusively drawn verbatim from the referenced set of preapproved questions (See Attachment 3). Instructions on how to use the reference set of question are included within the question bank itself (See "Instructions to Users" section of Attachment 3). In addition, instructions are provided to users on the procedures for use of the Generic Clearance and the process for submitting the request to the DHDSP and NCCDPHP PRA contacts (See Attachment 9).

A. Estimated Annualized Burden Hours:

The DHDSP estimates that it will conduct up to 17 web-based surveys, 120 interviews, and 12 focus groups each year over the three year life of the project. To see an expanded discussion of how the number of respondents in each category was estimated see B-1. Because the DHDSP's guidance and products are often partner-specific (geared toward the State or local program manger, epidemiologist, or program evaluator), no one type of respondent will be asked to participate in more than two surveys, interviews, or focus groups annually. The length of online surveys will be limited to 30 minutes and interviews and focus groups to one hour. Because in-person surveys and focus groups involve responses to primarily open-ended questions, they require more time to complete.

The estimated annualized burden hours are presented in Table A12.1. The total annualized burden hours of 491 is based on the following estimates:

- Five web-based surveys per year to 50 State and local health department employees (5 x 50 = 250 responses) which take 0.5 hours to complete (250 responses x 0.5 hours = 125 hours)
- Thirty interviews per year with State and local health department employees which take 1 hour to complete (30 interviews x 1 hour = 30 hours)
- Four focus groups per year with 8 State and local health department employees (4 x 8 = 32 responses) which take 1 hour to complete (32 responses x 1 hour = 32 hours)
- Nine web-based surveys per year to 60 private sector partners (9 x 20 = 180 responses) which take 0.5 hours to complete (180 responses x 0.5 hours = 90 hours)
- Ninety interviews per year with private sector partners which take 1 hour to complete (90 interviews x 1 hour = 90 hours)
- Six focus groups per year with private sector partners (6 x 8 = 48 responses) which take 1 hour to complete (32 responses x 1 hour = 32 hours).
- Three web-based surveys per year to 20 academic partners (3 x 20 = 60 responses) which take 0.5 hours to complete (60 responses x 0.5 hours = 30 hours)
- Thirty interviews per year with academic partners which take 1 hour to complete (30 interviews x 1 hour = 30 hours)
- Two focus groups per year with academic partners (2 x 8 = 16 responses) which take 1 hour to complete (16 responses x 1 hour = 16 hours).

Table A12.1. Estimated Annualized Burden Hours

Type of Respondent	Data Collection Mechanism	Number of Respondents	Average Burden per Response (in hours)	Total Burden (in hours)
State and Local Health Departments	Web-based survey	250	30/60	125
	Interview	30	1	30
	Focus group	32	1	32
Private Sector Partners	Web-based survey	180	30/60	90
	Interview	90	1	90
	Focus group	48	1	48
Academic Institutions	Web-based survey	60	30/60	30
	Interview	30	1	30
	Focus group	16	1	16
			Total	**491**

The DHDSP contact and the NCCDPHP PRA contact will independently track burden hours and compare on a quarterly basis. Updates will be provided on an annual basis to OMB (See section A-16 for more information about annual reports to OMB).

B. Estimated Annualized Burden Costs:

Because partners accessing DHDSP's activities are diverse and include individuals with very different positions, an average salary estimate was deemed to be more accurate than an attempt to quantify the salaries of the diverse group surveyed. Specifically, an estimated hourly salary of $18.62 is assumed for all respondents, based on the results from the 2005 Department of Labor National Compensation Survey. With the maximum respondent burden of 415 hours, the overall annual cost of respondents' time for the proposed data collection is estimated to be a maximum of $9,142 (491 hours x $18.62) per year. See Table A12.2 to see how this estimate was derived. There will be no direct costs to the respondents other than their time to participate in each survey.

Table A12.2. Estimated Annualized Burden Costs

Type of Respondent	Data Collection Mechanism	Number of Respondents	Average Burden per Response (in hours)	Total Burden (in hours)	Hourly Wage Rage	Total Respondents Costs
State and Local Health Departments	Web-based survey	250	0.5	125	$18.62	$2327.50
	Interview	30	1	30	$18.62	$558.60
	Focus group	32	1	32	$18.62	$595.84
Private Sector Partners	Web-based survey	180	0.5	90	$18.62	$1675.80
	Interview	90	1	90	$18.62	$1675.80
	Focus group	48	1	48	$18.62	$893.76

Academic Institutions	Web-based survey	60	0.5	30	$18.62	$558.60
	Interview	30	1	30	$18.62	$558.60
	Focus group	16	1	16	$18.62	$297.92
Total				**491**		**$9142.42**

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

Because the data collection involves surveys, interviews, or focus groups that are either collected on-line, in person, or via telephone there are no additional costs to the respondents once data collection is completed. There are no costs associated with record keepers because DHDSP or a government contractor will collect, store and analyze the data.

A-14. Annualized Cost to the Federal Government

The surveys will be supervised by a DHDSP coordinator. The DHDSP coordinator will be a federal employee. The DHDSP coordinator, in close consultation with the NCCDPHP PRA contact, will review all the data collection instruments to monitor the number of partners being surveyed, confirm that instruments comply with time limits, ensure that a group of partners is not being overburdened by multiple surveys, and verify that the instruments comply with the guidelines outlined in this OMB request. Most instruments will be designed, distributed, and analyzed by a collaborative team consisting of a contractor and a DHDSP staff member or solely by internal DHDSP staff. The amount of time the contractors and DHDSP staff spend designing and analyzing the survey will vary depending on the number of people surveyed, the length of the survey, and the distribution method (i.e., web, in-person, or telephone). Because the instruments are built using the question bank, the time and cost associated with instrument design will be reduced.

The estimated cost to the federal government is $133,257.Table A14.1 describes how this cost estimate was calculated.

Table A14.1: Estimated Annualized Cost to the Federal Government

Staff or Contractor	Average Hours per Study	Average Hourly Rate	Average Cost
FTE coordinator (GS-14)	3 per data collection	$45.48	$136/ data collection
FTE instrument preparation, data collection, data analysis (GS-13)	40 per data collection	$38.57	$1,543/ data collection
Contractor instrument preparation, data collection, data analysis (GS-	40 per data collection	$35.50	$1,420/ data collection

12 to GS-13 equivalent)			
Average cost per information collection			$3,099
Average Annual Cost (17 surveys, 14 rounds of interviews, 12 focus groups)			$133,257

A-15. Explanation for Program Changes or Adjustments

This is a new data collection.

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

Project Time Schedule

Over the next three years, DHDSP plans to conduct a series of information collections to assess the relevance, quality and impact of DHDSP services and guidance. Although a number of different interviews, surveys, and focus groups will be conducted under this generic clearance, the process for developing, distributing, analyzing, and using the data will adhere to a common process and timeline described in Table A16.1.

Table A16.1: Time Schedule for Information Collection

Activity	Time Schedule
1. Based on DHDSP evaluation priorities and questions, select topic	Within 14 days of topic being identified
2. Determine respondent audience	
3. Determine data collection mechanism (survey, interview, or focus group)	
4. Select questions from question bank	
5. Determine recruitment method	
6. Determine distribution method (web, in-person, or telephone)	
7. Complete data collection request form and submit to DHDSP Coordinator	Within 21 days of topic being identified
8. Data collection request form approved by DHDSP Contact and NCCDPHP PRA Contact	Within 30 days of topic being identified
9. Recruit participants (See B-1)	Within 7 days of approval
10. Information collection completed	Within 50 days of approval
11. Analysis of data completed	Within 90 days of approval
12. Discussion of program adjustments suggested by data	Within 120 days of approval
13. If needed, implement changes related to findings	Within 240 days of approval
14. Publication of evaluation results	Within 480 days of approval

Data Analysis Plan

Both quantitative and qualitative data will be collected under this request. Quantitative data, drawn from surveys, will be analyzed to draw conclusions in terms of percentages, proportions, averages, and other values. Qualitative data, drawn from focus groups, interviews, and surveys, will be analyzed in terms of themes, ideas, or events.

The majority of quantitative data will be analyzed using basic descriptive analyses. Because the major purpose of this data collection is program improvement, DHDSP does not anticipate needing to use complex statistical techniques. Means (averages) and standard deviations (measure of the variability) will summarize continuous variables (variables for which, within the limits the variable ranges, any value is possible). Frequency and percentages will summarize categorical variables (variables take a value that is one of several possible categories). The analyses of Likert-type rating scales will depend on the distribution of responses to each response category.

Qualitative analyses will be performed though identification of key points and themes from each question area. Detailed notes will be taken during interviews or focus groups or audiotapes will be transcribed. Analysts will use common scoring tools for coding answers to individual questions. One potential mechanism for qualitative data analysis includes using a software package called QSR NVivo which is useful in standardizing and managing results when data from a large number of interviews or focus groups must be analyzed jointly. Transcripts for each interview or focus group are recorded as text passages and then coded into NVivo using analytic categories developed based on the evaluation questions. The text passages are then grouped by code to consolidate findings across each data collection method for each topic of interest. Another potential mechanism for qualitative data analysis includes card sorting. Card sorting is a less expensive analysis method by which statements made during interviews or focus groups are written on index cards and sorted according to similar characteristics or themes.

All analyses will be conducted by a member of the evaluation team trained in research methods or a contractor with appropriate training.

Plans for Tabulation and Publication

As each phase of the evaluation concludes, CDC, or its contractor will develop an evaluation report that will include information on all aspects of data collection and analysis, as well as results, any relevant discussion, and recommendations. Evaluation results will also be summarized in a PowerPoint presentation presented to all interested individuals within the DHDSP. In addition, as appropriate, the results of this evaluation will be published on the DHDSP website or in professional journal articles.

Accountability

DHDSP/NCCDPHP will provide an annual summary report to OMB. This report will summarize all of the information collections that have occurred or are in process under this generic clearance. Any individual within the DHDSP who wishes to use this generic clearance must submit a “Data Collection Request Form” (See Attachment 10). These

forms will be included as an attachment to the report. Each report (See Attachment 11) will summarize the following information:

- Project ID number
- Purpose of the data collection
- Timeframe for data collection
- Respondent universe
- Number of respondents
- Burden hours

The report will allow for project monitoring and oversight to ensure that each information collection clearly aligns with the purpose of the OMB generic clearance, thus preventing misuse of the clearance for its intended purpose. In addition, the reports will allow DHDSP/NCCDPHP and OMB to closely monitor the total number of burden hours used to ensure that this number is not exceeded.

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

Exemption is not being sought. The OMB expiration date will be displayed.

A-18. Exceptions to Certification for Paperwork Reduction Act Submission

There are no exceptions to the certification.