MONITORING AND REPORTING SYSTEM FOR CHRONIC DISEASE PREVENTION AND CONTROL PROGRAMS

PART A: JUSTIFICATION

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Abstract

CDC seeks OMB approval to collect progress and activity information from health departments in states, territories, and the District of Columbia. Information will be collected electronically through a new, electronic Management Information System (MIS) that will replace two previously approved systems used by tobacco control programs (OMB No. 0920-0601, exp. 5/31/2010) and diabetes prevention and control programs (OMB No. 0920-0479, exp. 4/30/2013). The new MIS harmonizes the progress reporting framework for these programs and will also be used to collect progress reports from two programs that currently utilize the SF-424 form and supplements (OMB No. 4040-0004, exp. 3/31/2012). Advantages of the unified reporting framework include: 1) improved ease of use and overall reduction of burden to respondents, 2) a common set of performance metrics for describing program performance and improving program management, and 3) enhanced communication among programs, thus facilitating collaboration and information sharing.

The initial set of respondents will be health departments in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. CDC currently funds these health departments through a cooperative agreement that includes four programmatic components: tobacco control, diabetes prevention and control, Healthy Communities, and state-based behavioral risk factor surveillance. Each of the four state-based programs will submit its progress and activity information to CDC semi-annually.

The MIS has been designed so that additional respondents or programs can be incorporated over time. The framework for reporting program objectives and progress reflects CDC's support for more integrated approaches to the prevention and control of chronic conditions. Effective partnerships and collaborations are expected to enhance program impact, reduce duplication of effort, maximize the use of federal funds, and enhance initiatives to implement policy and environmental changes.

A. JUSTIFICATION

1. Circumstances Making the Collection of Information Necessary

Background

Chronic diseases—including heart disease, cancer, stroke, diabetes, arthritis, and related risk factors, such as tobacco use, physical inactivity, poor diet, and obesity—are the leading causes of death and disability in the United States, accounting for 7 of every 10 deaths and affecting the quality of life of 90 million Americans**.** Chronic diseases represent 83% of all U.S. health care spending; medical care costs of people with chronic diseases account for more than 75% of the nation's $2 trillion medical care costs. The direct and indirect costs of diabetes alone are $174 billion a year. The estimated direct and indirect costs associated with smoking exceed $193 billion annually.

Although chronic diseases are among the most common and costly health problems, they are also among the most preventable. The Centers for Disease Control and Prevention (CDC) works with states, territories, tribal organizations, and the District of Columbia (collectively referred to as "state-based" programs) to develop, implement, manage, and evaluate chronic disease prevention and control programs. Support and guidance for these programs have been provided through cooperative agreement funding and technical assistance, administered by CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). Partnerships and collaboration with other federal agencies, nongovernmental organizations, local communities, public and private sector organizations, and major voluntary associations have been critical to the success of these efforts.

In 2009, CDC announced a new cooperative agreement program for chronic disease prevention and health promotion programs (RFA DP09-901). The purpose of the program is to reduce the morbidity and premature mortality associated with chronic diseases and to eliminate associated health disparities by supporting capacity building, program planning, development, implementation, evaluation, and surveillance for chronic disease conditions and chronic disease-related risk factors. The program addresses the specific content areas of tobacco control, diabetes prevention and control, state-based surveillance and data analysis for chronic disease prevention and health promotion through the Behavioral Risk Factor Surveillance System (BRFSS), and in the Healthy Communities initiative. Awardees are health departments in states, territories, and the District of Columbia (see List of Awardees, **Attachment 3**). The cooperative agreement encourages awardees to collaborate with partners (both internal and external to the state health department) to develop and implement a multi-year, statewide strategic plan for achieving objectives. The increased emphasis on partnership and collaboration is intended to identify priorities, gaps in chronic disease prevention and health promotion, and opportunities to leverage CDC and state (federal and non-federal) resources. Each awardee's process will result in implementation of a multi-year statewide strategic plan. The collaborative cooperative agreement is part of an overall initiative within NCCDPHP to standardize and streamline the funding and performance monitoring processes for programs funded through the Center; to promote more efficient ways to use resources; and to achieve greater health impact.

CDC requests OMB approval to collect information from awardees in order to document, monitor, and evaluate their progress toward accomplishing the objectives defined in their strategic plans. Information will be collected semi-annually through a new, electronic Management Information System (MIS). The new MIS replaces two previously approved, content-specific information collections for tobacco control programs (OMB No. 0920-0601, exp. 5/31/2010) and diabetes prevention and control programs (OMB No. 0920-0479, exp. 4/30/2010), which are being phased out. The new MIS also provides a single, unified framework for awardees to report information about state-based behavioral risk factor surveillance and the Healthy Communities initiative.

The cooperative agreement program addresses the Healthy People 2010 focus areas of Diabetes (focus area 5), Educational and Community-Based Programs (focus area 7), Public Health Infrastructure – Data and Information Systems (focus area 23), and Tobacco Use (focus area 27). This program also addresses the CDC goals for "Healthy People in Every Stage of Life" and "Healthy People in Healthy Places". CDC's authority to conduct these activities is authorized by

the Public Health Service Act (sections 301, 307, 310, and 311; 42 U.S.C. sections 241 and 247(b)(k)), the Comprehensive Smoking Education Act of 1984, and the Comprehensive Smokeless Tobacco Health Education Act of 1986 (**Attachments 1a-1c**). The overarching goal is to improve public health programs and systems for achieving measurable health impact.

The design of the MIS is extensible to additional CDC-funded chronic disease prevention and control programs in states, territories, and the District of Columbia. Additional respondents (i.e., awardees) or additional programs (i.e., prevention and control activities for other chronic diseases or conditions) may be incorporated in the future, upon receipt of OMB approval through revision of this Information Collection Request.

Privacy Impact Assessment

A) Overview of the Data Collection System

The MIS is a new mechanism that builds on CDC's previous experience with electronic collection of progress and performance information from funded programs. Information will be collected semi-annually.

B) Items of Information to be Collected

The MIS will collect information about the staffing resources dedicated by each awardee to four areas: tobacco control, diabetes prevention and control, behavioral risk factor surveillance, and the Healthy Communities initiative. The MIS will also collect information about each program's work plan objectives, activities, and partnerships. The MIS will collect a limited amount of information in identifiable form (IIF) for key program staff (e.g., Program Director). Each awardee will provide the names of these individuals as well as their professional contact information. The contact person will only provide information about the state program, not personal information.

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

The MIS is a Web-based application. Access to the MIS will be controlled by a password-protected login for authorized users. There is no Website content directed at children less than 13 years of age.

2. Purpose and Use of the Information Collection

The information collection will enable the accurate, reliable, uniform and timely submission to CDC of each program's strategic plans and progress reports. The information collection and reporting requirements have been carefully designed to align with and support the goals outlined in the cooperative agreement and the objectives defined within each program's strategic plan. The electronic MIS enables collection and reporting of the information in an efficient, standardized, and user-friendly manner. The MIS will generate a variety of routine and customizable reports. Local level reports will allow each state or program to summarize its

activities and progress towards meeting work plan objectives. CDC will also have the capacity to generate reports that describe activities across multiple states and/or programs.

CDC will use the information collected in the MIS to monitor each program's progress and to identify its strengths and weaknesses. Monitoring allows CDC to determine whether a program is meeting performance goals and to make adjustments in the type and level of technical assistance provided to them, as needed, to support attainment of their objectives. CDC's monitoring and evaluation activities also allow CDC to provide oversight of the use of federal funds, and to identify and disseminate information about successful prevention and control strategies implemented by awardees. These functions are central to the NCCDPHP's broad mission of reducing the burden of chronic diseases. CDC will also use the information collection to respond to Congressional and stakeholder inquiries about chronic disease control activities, program implementation, and program impact. Finally, the information collection will allow CDC to monitor the increased emphasis on partnerships and programmatic collaboration, and is expected to reduce duplication of effort, enhance program impact and maximize the use of federal funds.

States and programs will use the information collection to manage and coordinate their activities and to improve their efforts to prevent and control chronic diseases. The MIS will allow awardees to fulfill their reporting obligations under the cooperative agreements in an efficient manner by employing a single instrument to collect necessary information for both progress reports and continuation applications including work plan. This approach, which enables programs to save pertinent information from one reporting period to the next, will reduce the administrative burden on the yearly continuation application and progress review process. Awardee program staff will be able to review the completeness of data necessary to submit required reports, enter basic summary data for reports, and finalize and save required reports for upload into Grants.gov. Most important, burden to awardees is reduced through the common approach to reporting on the content areas of diabetes control, tobacco control, behavioral risk factor surveillance, and Healthy Communities. The common framework for reporting reduces training time for respondents and is expected to be more effective in capturing information about partnerships and collaborations.

The information collection is designed to address specific objectives outlined in FOA DP09-901 relating to program integration and collaboration in state-based tobacco control, diabetes prevention and control, behavioral risk factor surveillance, and Healthy Communities.

The MIS is extensible to additional state-based activities. CDC will use the results of this information collection to evaluate the model for future program reporting efforts.

Privacy Impact Assessment Information

The MIS is a centralized, Web-based system that supports the collection and reporting of information that will be used by CDC to help assess the impact of state-based programs in tobacco control, diabetes control, behavioral risk factor monitoring, and policy and environmental change initiatives. The MIS will be used to describe, evaluate and enhance opportunities for collaborative efforts and partnerships. Having all this information in a single

and secure database will allow CDC Project Officers to search across multiple programs, help ensure consistency in documenting progress and technical assistance, and enhance accountability of the use of federal funds.

3. Use of Improved Information Technology and Burden Reduction

The MIS takes advantage of electronic database technology to improve information quality by minimizing errors and redundancy. The structure of the MIS will minimize or eliminate many elements that would otherwise be repeated within stand-alone systems. Having all of the information collected in the same place in the same manner will reduce the level of burden attributable to redundancy and reduce the workload to enter and maintain the data. Programs will be able to transfer data from one year to another to minimize data re-entry.

Other elements such as program plan requirements, data reporting and the terms that are used to define similar data requirements often vary greatly from one program to another. With the new MIS, the use of a standard set of data elements, definitions, and specifications at all levels will help to improve the quality and comparability of performance information that is received by CDC for multiple program areas. Further, standardization will enhance the consistency of work plans and reports, enable cross-program analysis, and will facilitate a higher degree of inter-program reliability by ensuring that the same information is collected on all objectives and activities regardless of the funding stream. Finally, the report generation capabilities of the electronic MIS will reduce the respondent burden associated with paper-based reports. Without the automated MIS and the integrated approach to information collection and reporting, respondents and CDC would need to continue to use time consuming, labor intensive procedures for information collection and reporting.

4. Efforts to Identify Duplication and Use of Similar Information

The collection of this information is part of a federal reporting requirement for funds received by awardees. The MIS will consolidate information necessary for both continuation applications and progress reports so that information entered once can be used to generate multiple types of reports without having to duplicate efforts. The information collected from awardees is not available from other sources.

5. Impact on Small Businesses or Other Small Entities

No small businesses will participate in the MIS data collection.

6. Consequences of Collecting the Information Less Frequently

Reports will be collected semi-annually in fulfillment of requirements outlined in the cooperative agreement announcement. The interim progress report is due by January 30, and the annual progress report is due 90 days after the end of the project period. Less frequent reporting would negatively impact monitoring progress of national, state, tribal, and territorial efforts to enhance diabetes control, tobacco control, behavioral risk factor surveillance, and Healthy Communities, and undermine accountability efforts at all levels. The semi-annual reporting schedule ensures

that CDC responses to inquiries from Congress and other stakeholders are based on timely and up-to-date information.

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

There are no special circumstances related to the MIS, and the request fully complies with the regulation.

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

A. Federal Register Notice

A 60-day Notice was published in the Federal Register on May 25, 2010 (Volume 75, Number 100, pages 29347-29348) (Attachment 2). No public comments were received in response to the Notice.

B. Other Consultations

The MIS was designed collaboratively by CDC staff, awardees, and the data collection contractor. Consultation will continue throughout the system development and implementation process.

9. Explanation of Any Payment or Gift to Respondents

Respondents will not receive payments or gifts for providing information.

10. Assurance of Confidentiality Provided to Respondents

A. **Privacy Act Assessment**. Staff in the CDC Information Collection Review Office have reviewed this Information Collection Request and have determined that the Privacy Act is not applicable. The data collection does not involve collection of sensitive or identifiable personal information. Respondents are state-based chronic disease control programs. Although contact information is obtained for each program, the contact person provides information about the state program, not personal information.

B. **Security**. Access to the MIS will be controlled by a password-protected login. Access levels vary from read-only to read-write, based on the user's role and needs. Each grantee will have access to its own information and decide the level of access for each user. The extent to which local partners may access a grantee's information will be decided by that grantee. Aggregated information will be stored on an internal CDC SQL server subject to CDC's information security guidelines. The MIS will be hosted on NCCDPHP's Intranet and Internet Application platforms, which undergo security certification and accreditation through CDC's Office of the Chief Information Security Officer.

C. Consent. The MIS data collection is not research involving human subjects. Awardees are cooperative agreement awardees. The information collection does not require consent from individuals, or IRB approval.

D. Requirement to Respond. Awardees are required to respond as a condition of cooperative agreement funding.

11. Justification for Sensitive Questions

The MIS instrument does not collect sensitive information. No personal information is requested. The MIS will collect a limited amount of information in identifiable form (IIF) for key program staff (e.g., Program Director). Each awardee will provide the names of these individuals as well as their professional contact information. The contact person will only provide information about activities conducted under the collaborative award, not personal information.

12. Estimates of Annualized Burden Hours and Costs

A. Estimated Annualized Burden Hours

Current respondents are the 53 awardees of FOA DP09-901 (see **Attachment 3**), including the 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Each awardee is funded in four programmatic areas: tobacco control, diabetes prevention and control, behavioral risk factor monitoring, and the Healthy Communities initiative (with the exception of the District of Columbia, which is not funded as part of Healthy Communities). Each program area will report information to CDC about its objectives and activities. The estimated burden per program area is 6 hours. The total estimated burden per response for each state or territory awardee is 24 hours.

Information will be submitted to CDC electronically twice per year through the web-based MIS (see **Attachment 4**). The annualized burden per state or territorial awardee is estimated at 48 hours for all four program areas. The total annualized total for the information collection is 2,532 hours, as summarized in Table A.12-1.

Table A.12-1. Estimated Annualized Burden to Respondents

Type of respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden
State Diabetes Program	53	2	6	636
State Tobacco Program	53	2	6	636
State BRFSS Program	53	2	6	636
State Healthy Communities Program	52	2	6	624
			Total	2,532

The MIS will produce reports that meet the reporting requirements established by Grants.gov, thus replacing those submissions.

The structure of the MIS is extensible. In the future, additional state-based programs may use the MIS to submit progress information to CDC.

B. Estimated Annualized Cost to Respondents

A program manager in each content area (tobacco control, diabetes prevention and control, behavioral risk factor monitoring, and Healthy Communities) will prepare the progress report for each area. The average hourly wage for a program manager is $30.65. The hourly wage rates for program managers are based on wages for similar mid-to-high level positions in the public sector. The total estimated annualized cost to respondents is $77,605, as summarized in Table B.12-1.

Table B.12-1. Estimated Annualized Cost to Respondents

Type of respondents	Number of respondents	Number of responses per respondent	Average burden per response	Average hourly wage	Total cost
State Diabetes Program	53	2	6	$30.65	$19,493
State Tobacco Program	53	2	6	$30.65	$19,493
State BRFSS Program	53	2	6	$30.65	$19,493
State Healthy Communities Program	52	2	6	$30.65	$19,126
					$77,605

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

The MIS is designed to use existing hardware within funded sites, and all respondents currently have access to the Internet to use the information system. No capital or maintenance costs are expected. Additionally, there are no start-up, hardware or software costs.

14. Estimates of Annualized Cost to the Federal Government

A. Development, Implementation, and Maintenance

Major cost factors for the MIS include application design and development costs and system maintenance costs. The MIS developer and data collection contractor is Northrup-Grumman. Over the three years of this clearance request, the total estimated annualized cost to the government is $161,667, as summarized in the table below.

Table A.14-1.

Phase	Development Phase	Average Annualized Cost Estimate
Release 1.0 User Management and Security, Core Data Entry Pages, Required Reports	Scope & Definition	$984
	Analysis & Design	$40,250
	Construction	$58,567
	Testing	$23,683
	Deployment	$5,767
	Training	$4,983
	Project Management & Support	$27,433
	Total	**$161,667**

15. Explanation for Program Changes or Adjustments

This is a new collection. It will replace the previously approved collections for tobacco control programs (0920-0601, exp. 5/31/2010) and diabetes prevention and control programs (0920-0479, exp. 4/30/2013). In addition, two state-based programs that previously reported progress information to CDC through standard cooperative agreement report forms (the state-based behavioral risk factor surveillance system programs and Healthy Communities programs), will transition to reporting through the new MIS.

16. Project Time Schedule and Plans for Publication and Analysis

A. Time schedule for the entire project

The cooperative agreement cycle is 5 years. OMB approval is being requested for the initial 3 years and will be extended for the duration of the cooperative agreement. Reports will be generated by the grantees per the FOA requirements twice a year, in April and November. Data collection began with the awarding of the grants and will continue throughout the funding cycle. Data previously collected has been recorded by the grantees utilizing a

variety of software programs. Future data will be recorded into this electronic instrument beginning immediately upon OMB approval.

B. Publication plan

Information collected through the MIS will be reported in internal CDC documents and shared with state-based programs.

C. Analysis plan

CDC will not use complex statistical methods for analyzing information. All information will be aggregated and reported with no program identifiers present in external documents. Most statistical analyses will be descriptive. Statistical modeling may be included to examine predictors of specified outcomes.

A.16 - 1 Project Time Schedule

Activity Time Schedule	
Notification of Electronic Tool Availability	Immediately upon OMB approval
User Training	Immediately upon OMB approval and ongoing through expiration date
Data Collection	1-36 months after OMB approval
Data Publication	Twice annually
Data Analysis	1-36 months after OMB approval

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

The CDC MIS program will display the expiration date for OMB approval of the information system data collection on its Internet home page.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification statement.