Date: November 4, 2010

To: OMB

From: CDC/NCCDPHP

Through: CDC/ICRO

Subject: MONITORING AND REPORTING SYSTEM FOR CHRONIC DISEASE PREVENTION AND CONTROL PROGRAMS, ICR Reference # 201008-0920-002 (CDC #0920-10DT)

Exhibit 1. Explanation of Burden Reduction

On October 15, 2010, OMB requested a conference call with CDC to discuss the ICR for a new MIS. The MIS will support monitoring and reporting functions for four chronic disease prevention and control programs (diabetes prevention and control, tobacco prevention and control, behavioral risk factor monitoring, and Healthy Communities). The estimated annualized burden per program (respondent) is 12 hours (2 responses per year at 6 hours per response; see **Exhibit 1**). CDC believes that the MIS will improve data quality and reduce overall reporting burden for participating programs. At OMB's request, CDC is clarifying these statements.

Exhibit 1.

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

Overview of Cooperative Agreement Funding and Reporting Using Standard Forms

Respondents are health departments based in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. In general, respondents currently use the OMB-approved HHS 5161 and related forms to apply to CDC for funding that supports state-based chronic disease prevention and control activities. In addition to using the PHS 5161 forms for the initial application, selected PHS 5161 materials are also used to prepare and submit an interim and annual progress report. The interim progress report also serves as the awardee's annual application for continued funding throughout the five-year term of the Funding Opportunity

Announcement (FOA). Preparation of the narrative of each application is estimated at 4-50 hours per response (OMB No. 0990-0317, see Section A.12-A, page 8). The core application consists of a Program Narrative and a Checklist. For the interim progress report, these documents are prepared in narrative form and uploaded to Grants.gov, along with any necessary supplementary documents. The information submitted in these applications is used by CDC's Procurement and Grants Office and NCCDPHP's program offices (e.g., diabetes, tobacco, etc.) to monitor each awardee's activities, make adjustments in the level of CDC technical assistance provided to the awardee, and determine level of state/territory accountability for federal funding.

Overview of Revised Reporting Obligations Using the New MIS

The new MIS provides a standardized data entry and reporting interface for much of the information requested in the PHS 5161 application. The MIS data entry screens require each awardee to define its project period objectives, annual objectives, annual activities, progress, and other elements in a standardized way. Awardees are encouraged to update the information in the MIS as activities and changes occur. Twice per year, each awardee will run a pre-programmed report and then upload the report output into Grants.gov. These reports will satisfy the interim and annual progress reporting requirements established by the FOA for collaborative chronic disease prevention and health promotion programs.

Advantages of the New MIS

Advantages of the new MIS include:

I. A unified framework for standardizing the descriptions of program objectives, activities, outcomes, and resources, which will improve CDC's ability to monitor progress within programs and to compare performance across programs.

II. Ability to record activities and changes in real-time, thus distributing burden across the reporting period, improving data quality, and improving real-time communications involving CDC and the state- and territory-based programs.

III. Functional improvements that enhance data quality. The new MIS data entry screens are supported by database programs that enforce data definitions. For example, CDC has asked programs to define their objectives in SMART format (i.e., Specific, Measurable, Attainable, Relevant, Time-limited) for some time. In response to this directive, the information submitted to CDC through narrative progress reports has been of variable quality (e.g., objectives were not submitted in SMART format, or "activities" were misclassified as "objectives"). The data entry rules embedded in the new MIS will eliminate errors of this type, and – more importantly – assist programs in formulating appropriate objectives, as well as clarifying the activities, resources, and expected outcomes associated with each objective. Respondent's program development and CDC support of the program will be greatly enhanced because the program elements will be

clearly defined at the beginning of the process versus on-going changes and adjustment to identify the required program components.

Advantages of the MIS are also described in the Information Collection Request.

Reduction in Burden to Respondents

CDC/NCCDPHP believes that the following factors will result in an overall reduction in burden to respondents:

1. Reductions in burden attributable to the functional improvements in the MIS. For example, one expected outcome is a reduction in the number of objectives that need to be tracked.
2. Reductions in data entry. Where possible, CDC will pre-populate the new MIS with information downloaded from other CDC electronic systems. After the initial population of the MIS (Year 1 of data entry), the new MIS system allows grantees to pre-populate the system with the previous year's data, as appropriate. Programs will only need to enter updates or changes to existing objectives and any new information as may be appropriate. The new MIS will also reduce duplicative data entry in that information regarding collaborative efforts will be entered only by the lead program but will be available for use by all collaborating programs and CDC Project Officers.
3. Reduction of burden associated with the PHS 5161 forms (e.g., elimination of the Program Narrative report). The production of a written narrative report is time-consuming and has not always been viewed as productive by awardees. The new MIS will produce a pre-formatted report that can be uploaded to Grants.gov (probably in one hour or less). Some of the burden associated with the new, more efficient MIS thus replaces more labor-intensive reporting activities associated with the previous narrative progress reporting method.
4. Reduced training burden. The new MIS design builds on CDC's experience with older systems, and implements an interface with a common look and feel for a variety of state-based programs. CDC anticipates that the common interface will streamline training and allow state-based programs to assist each other, in keeping with the principles of the collaborative FOA.

Estimating the Burden to Respondents

The initial Information Collection Request has been submitted with an estimated annualized burden of 6 hours per response (12 hours per program per year). In all cases, we anticipate that burden will be highest in Year 1 of the OMB clearance period, and will decrease in Years 2 and 3 as programs complete the initial population of the MIS and become familiar with its operation.

Although the four programs differ in size and complexity, we have estimated the average burden per response as 6 hours for all programs. Diabetes and tobacco are mature programs with a diverse array of activities; however, these programs also have a high degree of expertise with MIS reporting due to ongoing (or recent) experience with electronic data collection systems. We believe the estimated burden of 6 hours per response is a reasonable first approximation given their relatively well-defined objectives and prior experience with the SMART format.

Programs funded for state-based behavioral risk factor surveillance and Healthy Communities currently provide narrative progress reports to CDC. These programs will not be able to utilize existing electronic data sources for the initial population of their data entry screens; however, they support a narrower range of activities. As a result, we anticipate that their burden will consist of modest data entry, and a higher proportion of time spent in data preparation and instructional activities.

The estimated burden of 6 hours per response is thus an initial estimate that reflects a number of factors. If needed, we will revise the estimated burden based on actual experience.

Thank you for the opportunity to provide clarification.