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

SUPPORTING STATEMENT PART A

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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 their intended public health goals. To evaluate its current and future program activities, the DHDSP has developed a comprehensive Division Evaluation Plan (See Attachment 3) 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.

The DHDSP is requesting a three-year approval for a generic clearance to assess the 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. 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. 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.

For each information collection, an information collection request will be prepared and submitted to OMB for review and approval. With this request for a generic clearance, two information collection requests have been included as attachments (see Attachments 4 and 5).

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. These descriptions are intended to serve as general guidelines. Each information collection request, which will be submitted to OMB for its review and approval, will be reviewed to determine whether it is subject to the Privacy Act.

Overview of the Data Collection System

Surveys, interviews, and focus groups will be developed tailored to specific public health partners, activities, or other programmatic initiatives. 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 eight web-based surveys, eight rounds of interviews, and eight 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.

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 questions will be designed to measure the relevance, quality, and impact of the DHDSP's training, technical assistance, and guidance. The Division's logic model, included in our submission as Attachment 3 and posted on DHDSP's website, http://www.cdc.gov/DHDSP/docs/DHDSP_Evaluation_Plan.pdf, describes how products

and services will be evaluated on three over-arching dimensions: their relevance, their quality, and their impact.

The dimension of relevance is central to DHDSP's logic model and to our evaluation. DHDSP products and services must be relevant to the needs of our intended audience in order to achieve the intended outcomes. Questions about relevance will 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. Similarly, the dimension of quality is central to the logic model and our evaluation. Questions about quality will 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. Finally, impact measures include the benefits to the public health workforce (did our products and services increase knowledge, skills and abilities?), ability to leverage resources to engage partners in accomplishing goals, and reaching desired health outcomes. We believe it is particularly important to assess and understand impact, especially in an era of increased emphasis on government accountability.

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 a Division Evaluation Plan to assess the relevance, quality, and impact of its activities. The 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 and to strengthen the activities undertaken by the DHDSP. The DHDSP Logic Model (see Attachment 3) depicts how DHDSP activities influence public health practice and, ultimately, impact public health. By implementing this Evaluation Plan, DHDSP can measure its progress toward, and improve its ability to meet, 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 majority of information collections will not collect any information in an identifiable form. However, there may be some circumstances, when, with permission of the respondent, some identifiable information will be collected. For example, an information

collection may ask respondents to report information on behalf of their organization (e.g., health department). Such information may be used to develop "strategies from the field" or "promising practices," within which the organization may be identified.

Each information collection request will describe whether information will be collected in an identifiable form, and if so, how data will be used and reported and how these concepts will be explained to respondents.

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. Web surveys will use easy-to-read response scales or text boxes that are embedded in mainstream online survey software such as Survey Monkey. 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 or typing 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. In general, 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 questions may be either open-ended (e.g., *How have you used this product? Please give specific examples.*) or 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 number 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, State Health Departments funded under DHDSP's National Heart Disease and Stroke Prevention Program report semi-annually using a Management Information System (MIS) (OMB No. 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. While information collected through the MIS describes state activities, it does not provide any evaluation information specific to CDC's products or services, or elicit recommendations and comments from users of DHDSP's products and services. Thus, this new information collection will fill a gap in allowing CDC to evaluate its products and services intended for state health department support.

CDC obtained 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. 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 eight web-based surveys, eight rounds of interviews, and eight focus groups each year over the three-year life of the project. Because the DHDSP provides support to a large range of external partners (state health departments, academic institutions, nonprofit organizations, professional organizations, etc) and because products are often audience-specific, no one type of respondent will be asked to participate in more than two surveys, interviews, or focus groups annually.

DHDSP frequently releases new products and works continuously to improve 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 Division Evaluation Plan; development of a timeline for implementation of the plan; identification of the appropriate dimensions of relevance, quality, and impact to measure; and identification of relevant partner groups. The project has been a true collaborative effort across all the teams of the DHDSP. Results of the DHDSP evaluation will impact all staff; therefore, obtaining their input about 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 A-8.1 provides a list of individuals who have provided consultation on the project.

Table A-8.1 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	Director	The	sts@cloudburstgr	(301) 918-4400	2008

Sullivan, PhD		Cloudburst Group	oup.com		

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 privacy of respondents as appropriate. 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 secure manner and will not be disclosed unless otherwise required by the law. All respondents will be informed that their responses will be treated in a secure manner unless otherwise specified by the law. Only aggregate numbers, summary statistics, or de-identified quotations will be included in evaluation reports. As explained in A-2, there may be some circumstances, when, with permission of the respondent, some identifiable information will be collected. Each information collection request will describe whether information will be collected in an identifiable form, and if so, how data will be used and reported and how these concepts will be explained to respondents.

Additional procedures designed to protect participant privacy 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 Survey Monkey, 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 may be audio taped, but only with permission from respondents. If interviews or focus groups are audio taped, 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. For the majority of information collections, 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. For the majority of information collections, no attempt will be made to link pseudonyms to names.

There may be some circumstances, when, with permission of the respondent, where the respondents' organization may be reported and linked to the data. Each information collection request will describe whether information will be collected in an identifiable form, and if so, how data will be collected, used and reported and how these concepts will be explained to respondents.

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. However, each information collection request, which will be submitted to OMB for its review and approval, will be reviewed to determine whether it is subject to the Privacy Act.

These descriptions are intended to serve as general guidelines. 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. 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.

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 in the attached information collection requests (see Attachments 4 and 5).

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 attached information collection requests (see Attachments 4 and 5).

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.

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 in some limited circumstances. 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. Estimated Annualized Burden Hours:

The DHDSP estimates that it will conduct up to eight web-based surveys, eight rounds of interviews, and eight 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 Section B-1. Because the DHDSP's guidance and products are often partner-specific (directed 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 A-12.1. The total annualized burden hours of 723 is based on the following estimates:

- Six web-based surveys per year to 51 health department employees (6 x 51 = 306 responses) which take 0.5 hours to complete (306 responses x 0.5 hours = 153 hours)
- Three hundred and six interviews per year with State and local health department employees which take 1 hour to complete (306 interviews x 1 hour = 306 hours)
- Four focus groups per year with eight State and local health department employees (4 x 8 = 32 responses) which take 1 hour to complete (32 responses x 1 hour = 32 hours)
- Two web-based surveys per year to 100 private sector partners (2 x 100 = 200 responses) which take 0.5 hours to complete (200 responses x 0.5 hours = 100 hours)
- Two hundred interviews per year with private sector partners which take 1 hour to complete (100 interviews x 1 hour = 100 hours)
- Four focus groups per year with eight groups of private sector partners (4 x 8 = 32 responses) which take 1 hour to complete (32 responses x 1 hour = 32 hours).

Table A-12.1. Estimated Annualized Burden Hours

Type of Respondent	Form Type	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
State and Local Health Departments	Web-based survey	306	1	30/60	153
	Interview	306	1	1	306
	Focus group	32	1	1	32
Private Sector Partners	Web-based survey	200	1	30/60	100
	Interview	100	1	1	100
	Focus group	32	1	1	32
				Total	**723**

B. Estimated Annualized Cost to Respondents:

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 estimated annualized respondent burden of 723 hours, the overall annual cost of respondents' time for the proposed data collection is estimated to be a maximum of $13,463 (723 hours x $18.62) per year. See Table A-12.2 to see how this estimate was derived. There will be no direct costs to the respondents other than their time to participate in each information collection.

Table A-12.2. Estimated Annualized Burden Costs

Type of Respondent	Form Type	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Average Hourly Wage Rate	Total Cost
State and Local Health Departments	Web-based survey	306	1	30/60	$18.62	$2,849
	Interview	306	1	1	$18.62	$5,698
	Focus group	32	1	1	$18.62	$596
Private Sector Partners	Web-based survey	200	1	30/60	$18.62	$1,862
	Interview	100	1	1	$18.62	$1,862
	Focus group	32	1	1	$18.62	$596
Total						$13,463

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

There are no additional costs to respondents for data collection or record keeping.

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).

The estimated cost to the federal government is $74,376. Table A-14.1 describes how this cost estimate was calculated.

Table A-14.1: 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-12 to GS-13 equivalent)	40 per data collection	$35.50	$1,420/ data collection
Average cost per information collection			$3,099
Estimated Total Average Annual Cost of 24 information collections (eight surveys, eight rounds of interviews, eight focus groups)			$74,376

A-15. Explanation for Program Changes or Adjustments

This is a new generic data IC.

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

Project Time Schedule

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 A-16.1.

Table A-16.1: 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. Develop data collection instrument	
5. Determine recruitment method	
6. Determine distribution method (web, in-person,	

or telephone)	
7. Complete information collection request and submit to OMB	Within 30 days of topic being identified
8. Recruit participants (See B-1)	Within 7 days of approval
9. Information collection completed	Within 50 days of approval
10. Analysis of data completed	Within 90 days of approval
11. Discussion of program adjustments suggested by data	Within 120 days of approval
12. If needed, implement changes related to findings	Within 240 days of approval
13. 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.

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.