Case Studies of Selected Communities and States Funded under Community Activities under the Communities Putting Prevention to Work (CPPW) Initiative

Information Collection Request

New

Supporting Statement

Part A—Justification

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Form 83-I

CONTENTS

List of Tables

List of Attachments

A. JUSTIFICATION

A.1 Circumstances Making the Collection of Information Necessary

This is a new Information Collection Request (ICR) for implementation of a qualitative evaluation of a new chronic disease prevention initiative that focuses on policy, systems, and environmental change approaches to the prevention and control of obesity and tobacco use. Through semi-structured interviews in case study site visits, this effort will collect narrative information on the local context, planning effort, and implementation, with a focus on how each community/state has implemented its strategies, challenges encountered and addressed, things that have facilitated implementation, and lessons learned along the way. Findings will be used to improve immediate efforts and inform future efforts to achieve the goals of spreading and replicating community-based strategies for promoting health and preventing chronic disease through reductions in obesity and tobacco use.

The Centers for Disease Control and Prevention (CDC) is the primary Federal agency for protecting health and promoting quality of life through the prevention and control of disease, injury, and disability. CDC is committed to programs that reduce the health and economic consequences of the leading causes of death and disability, thereby ensuring a long, productive, healthy life for all people (see authorizing legislation in **Attachment 1a**, Sections 301 (a) and 317 (k) of the Public Health Service Act).

Chronic diseases such as cancer, heart disease, and diabetes are among the leading causes of death and disability in the United States. Chronic diseases account for 70% of all deaths in the U.S., which is 1.7 million deaths each year. These diseases also cause major limitations in daily living for almost 1 out of 10 Americans or about 25 million people. Although chronic diseases are among the most common and costly health problems, they are also among the most preventable. Adopting healthy behaviors such as eating nutritious foods, being physically active, and avoiding tobacco use can prevent or control the devastating effects of these diseases.

The Department of Health and Human Services (HHS) has created a comprehensive initiative for the $650 million allotted for chronic disease prevention efforts in the American Recovery and Reinvestment Act of 2009 (see **Attachment 1b**). The cornerstone of the initiative is the *Communities Putting Prevention to Work* (CPPW) *Community Program*, with cooperative agreements awarded through a competitive selection process to both urban and rural communities. The goal of this initiative is to reduce risk factors, prevent/delay chronic disease, promote wellness in children and adults, and provide positive, sustainable health change in communities. In March 2010, CDC awarded $373 million to 44 communities (see **Attachment 3**). Over a 24-month period, these communities are implementing evidence-based policy, systems, and environmental change approaches to the prevention and control of obesity and tobacco use.

Funding provided by the Patient Protection and Affordable Care Act (P.L. 111-148, Section 4002, see **Attachment 1c**) is also being used to address the underlying drivers of chronic disease, and to help the country move from today's sick-care system to a true "health care" system that encourages health and well-being. The Affordable Care Act created a new prevention and Public Health Fund designed to expand and sustain the necessary infrastructure to prevent disease, detect it early, and manage conditions before they become severe. This new initiative supports prevention activities to reduce health care costs and improve the promotion of health and wellness. HHS directed $34 million allocated by the Affordable Care Act to support federal, state, and community initiatives to use evidence-based interventions to address tobacco control, obesity prevention, and better nutrition and physical activity.

In September 2010, the CPPW process was expanded to include additional communities funded through the $34 million allotment from the Affordable Care Act. The awardees include four previously funded CPPW communities (Chicago, Illinois; Santa Clara, California; Southern Nevada; and DeKalb County, Georgia) to work in the obesity arena and four newly funded communities: three for obesity and one for tobacco. (Note: throughout this document we will refer to the conceptual approach as CPPW, but when we are referring to specific communities and counts, we will describe communities as CPPW communities or Affordable Care Act communities and give the specific numbers under consideration.) A complete list of Affordable Care Act Communities is provided in **Attachment 4**.

CPPW will address the leading preventable causes of death and disability--namely obesity and tobacco use--by expanding the use of evidence-based strategies for policy, systems, and environmental change; mobilizing local resources at the community level; and strengthening the capacity of states. As a result of these efforts, powerful models of success are expected to emerge that can be replicated in other states and communities. Specific prevention outcomes targeted by the CPPW are:

a. Increased levels of physical activity;
b. Improved nutrition;
c. Decreased overweight/obesity prevalence;
d. Decreased tobacco use; and
e. Decreased exposure to secondhand smoke.

Each CPPW- or Affordable Care Act-funded community has been funded to establish a Community Action Plan (CAP) that defines objectives for policy, systems or environmental change in either the physical activity/nutrition "track" or the tobacco "track" or both. CPPW and Affordable Care Act communities are implementing a set of evidence-based interventions related to the behaviors listed above which aim to achieve broad reach, high impact, and sustainable change.

The interventions chosen by each CPPW and Affordable Care Act community were selected from a group of evidence-based strategies in media, access, price, point of purchase decision, and support services (MAPPS) previously identified by HHS/CDC.

Strategies in each of the five MAPPS categories have been defined for physical activity, nutrition, and tobacco use (see **Attachment 5** for a summary of strategies and references). The underlying logic of the CPPW initiative is that effective MAPPS strategies will create supportive policies, systems, and environments (PSE), which, in time, will drive risk behavior changes that are related to chronic disease health outcomes (see **Attachment 5a** for a table of sample outcome objectives for these PSEs). For each track (physical activity/nutrition or tobacco), CPPW communities have selected at least one strategy from each of the five MAPPS categories. Affordable Care Act communities are also expected to select at least one strategy from each of the five MAPPS categories. The specific amount of funding per community was determined by the mix of interventions, population size, ability to reduce health disparities, and likelihood of success.

To implement the selected interventions, each community has assembled a communitywide consortium and Leadership Team with a history of working with partners to promote health and prevent chronic diseases. Partners include local and state health departments and other governmental agencies, health centers, schools, businesses, community and faith-based organizations, academic institutions, health care, mental health/substance abuse organizations, health plans, and other community partners. Communities are working with other community development and livability efforts, and building on and leveraging existing place-based revitalization and reform projects funded by US Government agencies including other Recovery Act efforts in multiple sectors, such as transportation, education, health care delivery, agriculture and others, as well as coordinating with HHS Regional Offices. Examples of coordinated efforts include Steps to a HealthierUS (variety of CPPW communities), Race to the Top (West Virginia) and the Statewide Health Improvement Program (Minnesota).

The CPPW initiative includes three components for states, territories, and the District of Columbia. Through Component I, approximately $119 million was awarded to states, Washington, D.C., Puerto Rico, and six Pacific Island Territories to carry out similar MAPPS strategies for changing policies, systems, and environments at the state level. Each state selected one MAPPS strategy in tobacco, nutrition, and physical activity. Component II provided an opportunity for states to compete for additional funds to implement additional MAPPS strategies in any of the three areas. Thirteen states received these additional competitive awards. Component III provided supplemental funding to enhance state-based tobacco cessation quitlines and to support related media efforts for tobacco control (see **Attachment 6** for a summary of CPPW awards for states, territories, and the District of Columbia).

CDC proposes to collect information from a subset of CPPW awardees (both through the community and state initiatives) and a subset of Affordable Care Act awardees to gain insight into the implementation of the MAPPS strategies and the ways in which awardees have achieved the desired policy, systems, and environmental changes. The information collection will focus on how each community/state has implemented its strategies, challenges encountered and addressed, things that have facilitated implementation, and lessons learned along the way. Intensive case studies will

be conducted with 21 CPPW sites (six states and 15 communities) and three Affordable Care Act communities that reflect a mix of state or community characteristics related to population density, geographic region, and targeted population. The information to be collected does not currently exist for large scale, nationwide, community-based programs that employ multiple combinations of strategies. The insights to be gained from this data collection will be critical to improving immediate efforts and achieving the goals of spreading and replicating community-based strategies for promoting health and preventing chronic disease through reductions in obesity and tobacco use.

OMB approval is requested for two years. If additional funding comes available, CDC may request OMB approval to extend or expand the case study information collection.

Privacy Impact Assessment

The proposed study involves a minimum amount of information in identifiable form (IIF). Respondents will be recruited from the CPPW states and communities and Affordable Care Act communities selected for case study participation. The data collection contractor, RTI International (RTI), will have access to respondents' names, role in the CPPW effort, telephone numbers, and e-mail addresses, in order to schedule their participation in the case study interview.

The information to be obtained through interviews concerns organizational activities and priorities rather than personal matters, and is not considered highly sensitive. IIF will be stored separately from response data. A linking file will be created and available only to senior project management at the data collection contractor, RTI International. This information will only be used to ensure completeness of the data files. The linking file will include the role of the respondent and their organization (it will not include the individual's name or contact information), the community or state name, the date of interview and the code assigned to the data file. This will ensure that no personally identifiable information, outside of the individual's role and organization is re-linkable. The linking file will be an administrative file used by the RTI project management team and will not be available to CDC staff. The IIF used for recruitment and scheduling purposes will not be linkable to the response data collected subsequently. Sites are required to participate in the case study evaluation if requested to do so by CDC; however, participation in the interviews is voluntary for individual respondents.

During the interview, some participants will be asked to identify organizations and individuals who are key staff and/or partners in their CPPW effort. No contact information will be collected for individuals who are discussed during the interviews with key respondents. The purpose of collecting information about key staff and partners is to improve CDC's understanding of the organizations that are interested in and engaging in policy, systems and environmental change work, and to identify the types of individuals (by role) within those organizations who should be engaged. Our primary interest is in the roles of the individuals engaged, not the person/individual in that role.

Overview of the Data Collection System

Case studies will be conducted with a subset of 21 CPPW awardees and 3 Affordable Care Act awardees to gain insight into the factors and variables that facilitate or hinder the successful implementation of MAPPS strategies and the effective creation of the desired policy, system, and environmental changes.

Upon OMB approval each site will be notified by email (**Attachment 7b**) that they have been selected for participation in the Case Study and will be provided a Case Study FAQ (**Attachment 7c**) to help answer any questions they may have.

Sites selected for inclusion in the case study will be asked to help plan the site visit schedule. About 6 weeks in advance of the site visit, follow-up communication will be conducted via e-mail (**Attachment 7d)** to introduce case study staff and schedule a preparatory site visit call to discuss involvement in the case study (**Attachment 7e**). Five weeks in advance of the site visit, the site visit preparatory call will be conducted and 2-3 potential site visit dates will be determined and the Interview Planning Tool (**Attachment 7a**) will be reviewed with the program leadership to help guide the site visit planning process. The dates of the site visit will be finalized at least 4 weeks in advance of the site visit. Two weeks in advance of the site visit the sites will provide a schedule of interviewees and their roles and any travel logistics will be finalized.

Intensive semi-structured individual interviews will be conducted with approximately 20 key informants at each site selected for this evaluation. Respondents at each site will typically include project management (2), project staff (4), community partners (7), and policy makers/community decision makers (7). To reduce burden and ensure that questions are tailored to each respondent type, separate interview guides have been created for Project Management and Staff (**Attachment 8**); Community Partners, Leadership Team, and Implementers (**Attachment 9);** and Policy/Decision Makers (**Attachment 10**). Project staff will assist the data collection contractor by identifying and scheduling the interviews to be conducted during the site visit (see **Attachment 7a)**. The information collection process will be discussed during the introductory phone call with each site and then completed by the CPPW program management and staff. A site visit interview worksheet (**Attachment 11**) will be completed by program staff at each site and a final site visit agenda returned to the RTI site visit team lead. Any changes to the schedule and or individuals selected for participation will be discussed with the site until a final schedule is agreed up on. Site visits will be conducted by teams of 3-4 contractor staff, including at least one senior staff member and two supporting staff.

Items of Information to be Collected

The topics to be addressed during the site visit interviews include:

- Capacity
    - Context
    - Program Identity
    - Administrative Infrastructure
    - Partnerships/Collaboration

    - Evaluation
    - Communication
    - Budget
- Planning
    - Context
    - Program Planning (CAPs and MAPPS)
- Implementation
    - Development
    - Enactment (enacting, adopting or passing a Policy, System, or Environmental change "PSE")
    - Execution (implementation, application, and enforcement of policies passed and social and environmental changes adopted)
    - Evaluation
- Outcomes
    - Participants' Perception of Key Outcomes
    - Sustainability
    - Lessons Learned

The unit of analysis is the site and/or organizations that are participating in the effort at each CPPW site. The information collected will be analyzed and the results used to develop both site-specific and cross-site reports.

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

This IC does not involve web-based data collection methods or refer respondents to websites. There are no websites with content directed at children under 13 years of age, and there are no issues of privacy related to web-based data collection for this IC.

A.2 Purpose and Use of the Information Collection

The case studies will provide critical information about the implementation process of carrying out policy- and environmental change-focused strategies at the state and community level.

Information collected in this study will be used to:

1. Describe the variation in implementation of MAPPS strategies across sites; probe for patterns (within and across communities and states) in the context and other situational variables that seem related to successful implementation; and describe the key factors and variables that are associated with successful implementation of policies aimed at changing environmental determinants of risk factors for chronic disease.

2. Describe variations in the time and effort incurred by states and communities pursuing the same combination of strategies, and examine the factors that might be driving these differences (e.g., differences in specific activities under each strategy, as well as variations in geographical size of community/state, population of community/state, population characteristics, staff resources, media, collaboration activities, and materials).
3. Identify additional factors related to community and state implementation of MAPPS strategies.
4. Assess the ways in which efforts to target hard-to-reach populations are linked to implementation success.
5. Explore how different combinations of strategies affect the implementation process, and determine whether there are economies of scale and scope on which multiple strategies can draw.
6. Modify and improve efforts within each CPPW site after the conclusion of the funded period.
7. Develop practitioner-focused enhanced case study reports to inform future federal, state, and local efforts to implement similar interventions. Understanding the key variables and contextual factors that shaped the implementation process of MAPPS strategies in CPPW-funded sites would allow future communities to anticipate such issues in advance, adapt their environment and context so it is more supportive of strategy implementation, or choose only strategies that seem to map well to their current environment and context.
8. Provide context for other federal monitoring and evaluation activities related to the CPPW initiative, such as ongoing communications with CDC project officers; the review and analysis of awardees' quarterly performance and progress reports (submitted through www.Recovery.gov); and review and analysis of information about the costs of implementing strategies for change (see CPPW Cost Study Instrument, Federal Register, March 19, 2010, Vol. 75, No. 53, pp. 13289-13290, submitted to OMB on 11/08/10 and currently pending approval http://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201011-0990-001).
9. Inform the analysis and interpretation of information related to key CPPW outcomes. Although some key CPPW outcomes cannot be adequately assessed during the initial 24 months of CPPW funding (e.g., changes in risk behavior or the prevalence of chronic diseases attributable to obesity and tobacco), CDC plans to use system dynamic modeling techniques to produce preliminary estimates of changes in key outcomes. The insights gathered through the CPPW case studies will thus be used to provide context and lessons learned that should improve understanding of the impact of community strategies on risk behavior changes that are expected to occur after the funded period.

CDC will develop a variety of reports and publications to ensure dissemination of the case study findings to the sites and other key stakeholders. These reports include case and cross case reports that will summarize findings after both initial and follow up site visits, as well as enhanced case study reports intended for practitioners hoping to replicate these efforts. CDC will also oversee the development of several manuscripts over the course of the evaluation. The topics to be addressed and publications to be targeted will be developed once case study findings are available to ensure that they focus on the issues most salient to the sites and program stakeholders at that time.

Privacy Impact Assessment Information

As noted earlier, the unit of analysis is the CPPW or Affordable Care Act site (community or state). Contact information collected for respondents will be used to schedule interviews; however, only the individual's role, organization, state/community and date of interview will be recorded in the data linking file. For the CPPW case studies, CDC is primarily interested in the organizational partners involved in implementing MAPPS strategies and the roles of the individuals within those organizations who are involved, not the individual in that role. As a result, collection of names is not necessary. Interviews will be coded prior to data entry by the contractor and then entered into the database or qualitative analysis software for further analysis. Only senior project management with the contractor will have access to the linking file. Outside of that file, no personal identifiers will be maintained that would allow contractor team members or CDC staff to link a participant's responses to his or her name. As can be seen in the list of data collection elements, the information being collected pertains to the organization and site and not to the specific respondent; hence the proposed data collection will have little or no effect on the respondent's privacy.

A.3 Use of Improved Information Technology and Burden Reduction

The proposed IC is based on qualitative methods, primarily semi-structured individual interviews. While several efforts are being made to reduce burden on respondents, electronic information collection methods have limited utility for these case studies.

Because the intent is to understand the context in each community, all data will be collected during on-site, personal interviews involving key informants at each site. Interviews will be facilitated by an interview guide that will be customized based upon the chosen strategies in each community. To facilitate and streamline the on-site interviews, CDC will prepare interviewers by summarizing information from existing, publicly available sources. For example, information from each CPPW community's Community Action Plan will be abstracted in advance, and the interviewer will routinely be provided with the ratings on the output and outcome performance measures for the case study communities and states. Prior to conducting the site visit, all site visit team members will review available information about the case, developed from a preceding document review. This will streamline the interviews by ensuring that all site visit team members are familiar with the specific activities of each site in advance of the interviews.

Only the minimum information necessary for the purposes of this project will be collected.

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

The Communities Putting Prevention to Work (CPPW) program is a new initiative with new requirements for carrying out a specified set of evidence-based community strategies to develop or enhance policies, systems, and environments that foster health and wellness. Since this is a new program, no instruments exist to collect data at the level of these specific sets of strategies. The interview questions were developed by a workgroup of evaluators from across HHS to ensure that the most useful questions were being asked and to minimize redundancy. The workgroup carefully considered the content, appropriateness, and phrasing of the case study questions so that they are brief, easy to use, and understandable.

CDC project officers communicate with CPPW and Affordable Care Act awardees on an ongoing basis, including through monthly conference calls. However, routine calls and progress reports do not provide a systematic overview of larger context and key issues that seem to hinder or facilitate the implementation of strategies and achievement of the intended policy, system, and environmental changes in states and communities.

A.5 Impact on Small Businesses or Other Small Entities

The primary respondents for the CPPW case studies are state and community grantees and sub-grantees (local governments and nonprofit agencies) receiving Recovery Act funding through the CPPW initiative or the Affordable Care Act. A small number of businesses may be involved as respondents. Examples include daycare centers, community gardens, local farms, local storefronts, and vending machine operators. Participation in the interviews is voluntary and does not involve a record-keeping requirement.

A.6 Consequences of Collecting the Information Less Frequently

This information collection is critical to the overall evaluation of the CPPW initiative and essential for future program planning. Without this information collection, HHS will not be able to conduct an adequate assessment of the programs' operations, identify and understand factors that affect the implementation process, assess efficiencies for specific mixes of strategies, or identify implications of targeting hard-to-reach populations.

In-depth interviews will be conducted at two time points: once after OMB approval for information collection is obtained (interview to be conducted approximately January 2011 - May 2011 for CPPW communities, and May 2011-August 2011 for Affordable Care Act communities), and again within the last two quarters of the funding

period (approximately November 2011-March 2012 for CPPW communities and July 2012-September 2012 for Affordable Care Act Communities). Reducing the frequency to a single site visit would eliminate the possibility of discerning trends over time, limit opportunities for sharing "lessons learned" in real time, and reduce the utility of the study. There are no legal obstacles to reduce the burden.

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

This project fully complies with all guidelines of 5 CFR 1320.5. There are no special circumstances required.

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

A. As required by 5 CFR 1320.8(d), a Notice for public comments was published in the Federal Register on March 10, 2010 (Vol. 75, No. 46, pp. 11183-11184; see **Attachment 2a**). Three comments were received in response to this notice. **Attachment 2b** presents these comments and CDC's response. No adjustments to the data collection plan were suggested or required.

B. The protocol was designed in collaboration with researchers at HHS, CDC and consultants at RTI International. Additional personnel involved in design of the protocol and data collection instrument are:

Table A.8-A. Staff within the Agency and Consultants Outside of the Agency Consulting on Study and Case Study Protocol

Non-CDC Staff	
Julia Spencer Senior Public Health Policy Analyst HHS/ASPE	Phone: (202) 690-7287 E-mail: Julia.Spencer@hhs.gov
Jane Tilly Director Consumer Direction and Health Policy Administration on Aging	Phone: (202) 357-3438 E-mail: Jane.Tilly@AoA.hhs.gov
Barry Portnoy Senior Adviser for Disease Prevention NIH	Phone: (301) 402- 4337 E-mail: Bp22z@nih.gov
Staff from CDC's Division of Adult and Community Health	
Robin Soler CPPW Technical Monitor and Principal Investigator ARRA/Communities Putting Prevention to Work CDC/ONDIEH/NCCDPHP	Phone: 770-588-5103 E-mail: RSoler@cdc.gov
Rebecca Bunnell Program Director ARRA/Communities Putting Prevention to Work	Phone: 770-488-5269 E-mail: RBunnell@cdc.gov

CDC/ONDIEH/NCCDPHP	
Rebecca Payne Community Interventions Team Lead, Implementation Team ARRA/Communities Putting Prevention to Work CDC/ONDIEH/NCCDPHP	Phone: 770-488-5167 E-mail: RLPayne@cdc.gov
Staff from Other CDC Divisions	
Thomas J. Chapel Senior Health Scientist Office of the Director CDC/ONDIEH/NCCDPHP	Phone: 404.639.2116 E-mail: TChapel@cdc.gov
René Lavinghouze Senior Evaluation Scientist Office on Smoking and Health CDC/ONDIEH/NCCDPHP	Phone: 770-488-5905 E-mail: rlavinghouze@cdc.gov
Don Compton Senior Health Scientist Division of Nutrition, Physical Activity and Obesity CDC/ONDIEH/NCCDPHP	Phone: 770-488-5258 E-mail: dcompton@cdc.gov
Linda Bilheimer Associate Director Office of Analysis and Epidemiology CDC/NCHS	Phone: (301) 458-4652 E-mail: LBilheimer@cdc.gov
Richard Klein Health Statistician Health Promotion Statistics Branch Office of Analysis and Epidemiology CDC/NCHS	Phone: (301) 458-4317 E-mail: Rjk6@cdc.gov

Additionally, selected CDC project officers who have worked closely with the CPPW sites on their project implementation plans were consulted on the content, areas of emphasis, and feasibility of the information collection plan and instruments. Their comments and recommendations have been incorporated into this revised version. The names of these staff are listed in Table A.8-B.

Table A.8-B. CPPW Project Officers Reviewing Information Collection Plan and Instruments

Wendy Heirendt Project Officer, Implementation Team ARRA/Communities Putting Prevention to Work CDC/ONDIEH/NCCDPHP	Phone: 770.488.5288 E-mail: wheirendt@cdc.gov
Paul Hunting Project Officer, Implementation Team ARRA/Communities Putting Prevention to Work CDC/ONDIEH/NCCDPHP	Phone: 770-488-1165 E-mail: PHunting@cdc.gov
Ron Todd Project Officer, Implementation Team	Phone: 770.488.5329 E-mail: rhtodd@cdc.gov

A.9 Explanation of Any Payment or Gift to Respondents

No remuneration will be provided to CPPW grantees for participating in the case study. Grantees agreed to participate in evaluation activities, including the case studies, as a condition of award.

A.10 Assurance of Confidentiality Provided to Respondents

Privacy safeguards that will be instituted to protect respondents include de-identification of response data obtained through interviews, physical security controls, and administrative controls (described in detail, below). CDC has determined that the data collection is exempt from IRB approval requirements. Data collection contractors will be subject to a non-disclosure agreement (**Attachment 12**).

Privacy Impact Assessment Information

A. <u>Privacy Act Determination</u>

Staff in CDC's Information Collection Review Office have reviewed this submission and determined that the Privacy Act is not applicable. Respondents are employees or representatives of CPPW and Affordable Care Act awardee organizations and their public health partners, including local governments and non-profit organizations. Respondents will be speaking from their roles as representatives of these organizations and will not provide personal information during the interviews. The data collection contractor, RTI International, will maintain a minimum amount of identifiable contact information (IIF, including name, role, work telephone number and work email address) in order to schedule interviews with respondents. Respondents will provide information on organizational structure, infrastructure, strategy-based activities, and other activities. The names and contact information of those interviewed during the initial site visits will be maintained so that if appropriate and applicable, these individuals can be contacted for follow up interviews during the second phase of data collection. The IIF will be maintained in a document that is separate from the interview response data and separate from the linking file which will contain only respondent role and organization, so that response data remain de-identified. After the first interview, respondents will be asked to give permission to be contacted for participation in the second phase of data collection. Only the contact information of those granting permission to be contacted will be maintained. Individuals interviewed during the second phase of data collection will be asked if they participated in the first phase of data collection. The individuals contacted during both phases of data collection will be selected based on their roles with the CPPW or Affordable Care Act community program. Therefore, any follow up will be conducted with individuals in key roles and if an individual is no longer involved with the initiative, he or she will not be contacted or recruited for participation.

As discussed in Section A.1, some respondents will be asked to identify organizations and individuals who are key staff and/or partners in their CPPW effort. No contact information will be collected for these individuals. The purpose of collecting this information is to improve CDC's understanding of organizations that are interested in and engaging in policy, systems and environmental change work, and which individuals (by role) within those organizations should be engaged. Our primary interest is in the roles of the individuals engaged, and not the person/individual in that role.

B. Safeguards

Although the data collection contractor will have temporary access to identifiable information for recruitment and scheduling purposes, response data will not be recorded in a manner that is linkable to respondent identifiers. The contractor will assign a unique identifier code to each interview respondent. Information collected during the in-depth interview will be stored and analyzed by identifier code. The personal contact information for respondents will not be shared with CDC or used for reporting purposes. Because interviews will be conducted at each site with multiple respondents in the same role/category, response data will not be indirectly identifiable on the basis of the respondent's role.

Audio recordings of the interviews will be destroyed after the notes and/or transcripts are complete. All electronic project files (e.g. digital audio recordings, notes and transcripts) will be stored at RTI on a limited-access project share drive on RTI's secure network servers; only project staff who have been authorized by the project director can access the share drive. Five years after project completion, all electronic files (e.g., notes, documents, data) will be archived on RTI's project share drive for five years and then deleted permanently. Any paper files will also be destroyed. All paper files will be stored and locked in a project file cabinet at RTI, which will be accessible only to select project staff.

C. Consent

The data collection contractor's Case Study teams will explain the nature of the data collection to each interview respondent. The interview will include an oral consent process that indicates the voluntary nature of participation as well as the purposes and uses of the information collection. The script for the oral consent is provided in **Attachment 13**. It will also include the statement that "Data will be treated in a secure manner and will not be disclosed, unless otherwise compelled by law" along with a description of the safeguards to prevent connecting responses to specific responses such as the method for assigning codes to interviews, the destruction of the list of names and contact information upon completion of interview scheduling, and the aggregate nature of the analysis and reporting.

D. Nature of Response

CPPW-funded states and communities and Affordable Care Act communities that are selected for the case study are required to participate and to identify a pool of

potential respondents for the case study interviews. Individual respondents will participate in the interviews on a voluntary basis. No individuals are required to respond to the interviews or particular interview questions. Respondents will be informed of the voluntary nature of their participation as part of the oral consent process that precedes the interview (**Attachment 13**).

A.11 Justification for Sensitive Questions

The CPPW Case Study protocol will collect information about factors that impede or facilitate the implementation of community-based approaches to chronic disease prevention and control. Personal information about individual respondents will not be requested, however, respondents may provide professional judgments and opinions, as well as facts, during their interviews. Some of the information relates to organizational effectiveness and could therefore be considered sensitive by a portion of respondents, however, the information is not considered highly sensitive because it is not personal in nature.

A.12 Estimated Annualized Burden Hours and Cost to Respondents

A.12.A Estimated Annualized Burden Hours

Information will be collected through in-depth, personal interviews conducted in the 24 communities and states selected for the case study. An average of 20 respondents will be interviewed at each site. The length of the interview and the questions asked will vary according to the type of respondents being interviewed. On average, interviewees at each site will consist of the Program Director and one additional member of the site management team; four additional CPPW staff members; a mix of seven Community Partners, Leadership Team Members and implementers; and a mix of seven policy- and decision-makers.

The Program Director for each site will be provided with an Interview Planning Tool (**Attachment 7a)** to assist in identifying potential interviewees of each type. This form will be used internally at the CPPW site and will not be reported to CDC or the data collection contractor. The estimated burden for completing the Interview Planning Tool is one hour. A CPPW staff member will use the completed form to initiate contact with potential respondents and begin scheduling in-depth interviews. The interview scheduling process is estimated to take five hours per site, including the time to review FAQs on the case study process (see **Attachment 7c**), and time to ask/answer questions in a site visit preparatory call (see **Attachment 7e**). The final Worksheet for Scheduling Site Visit Interviews (**Attachment 11**) will be provided to the data collection contactor prior the site visit.

Three Interview Guide instruments have been developed to facilitate interviews with three major groups of respondents. The instruments are based on a unified evaluation scheme, but have been tailored to target different respondent groups for information about specific issues and experiences. This strategy supports the collection

of all information needed for the case study evaluation, but minimizes burden to respondents and avoids overlap in questions for respondent groups except in circumstances where a variety of perspectives is needed to fully address an evaluation question.

The Interview Guide for Project Management and Staff (**Attachment 8)** will be used to facilitate interviews with two members of the management team at each site and four members of the site staff. The estimated burden for site managers is 2 hours and the estimated burden for site staff is 1.5 hours.

The Interview Guide for Community Partners, Leadership Team and Implementers (**Attachment 9**) will be used to facilitate interviews with seven respondents at each site. To obtain a variety of perspectives, approximately three respondents will be drawn from agencies of state and local government (total of 72 respondents) and four respondents will be drawn from the private sector (either for-profit or not-for- profit organizations; total of 96 respondents). The estimated burden is one hour per response.

Similarly, the Interview Guide for Policy/Decision Makers (**Attachment 10**) will be used to facilitate interviews with seven respondents at each site. Approximately two respondents will be drawn from agencies of state and local government (total of 48 respondents) and five respondents will be drawn from the private sector (either for-profit, or not-for-profit) organizations; total of 120 respondents. The estimated burden is 45 minutes per response.

To schedule and conduct an average of 20 interviews per site at 24 sites, the total estimated burden to respondents is 678 hours, as summarized in Table A.12-A.

Table A.12-A. Estimated Annualized Burden Hours

Types of Respondent	Form Name	Number of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
CPPW Project Management	Interview Planning Tool	24	1	1	24
	Interview Guide for Project Management and Staff	48	1	2	96
CPPW Project Staff	Worksheet for Scheduling Site Visit Interviews	24	1	5	120
	Interview Guide for Project Management and Staff	96	1	1.5	144
Community Partners, Leadership Team and Implementers (state and local govt.)	Interview Guide for Community Partners, Leadership Team and Implementers	72	1	1	72
Community Partners, Leadership Team and Implementers (private sector)	Interview Guide for Community Partners, Leadership Team and Implementers	96	1	1	96
Policy/ Decision Makers (state and local govt.)	Interview Guide for Policy/ Decision Makers	48	1	45/60	36
Policy/ Decision Makers (private sector)	Interview Guide for Policy/ Decision Makers	120	1	45/60	90
				Total	678

A.12-B. Estimated Annualized Cost to Respondents

Average hourly wage estimates were obtained from the U.S. Department of Labor, Bureau of Labor Statistics. The estimated annualized cost to respondents is $23,814, as summarized below in Table A.12-B.

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

Types of Respondent	Form Name	Number of Respondents	No. of Responses per Respondent	Average Hourly Wage*	Total Burden (in hours)	Total Cost
CPPW Project Management	Interview Planning Tool	24	1	$48	24	$1,152
	Interview Guide for Project Management and Staff	48	1	$48	96	$4,608
CPPW Project Staff	Worksheet for Scheduling Site Visit Interviews	24	1	$33	120	$3,960
	Interview Guide for Project Management and Staff	96	1	$33	144	$4,752
Community Partners, Leadership Team and Implementers (state and local govt.)	Interview Guide for Community Partners, Leadership Team and Implementers	72	1	$40	72	$2,880
Community Partners, Leadership Team and Implementers (private sector)	Interview Guide for Community Partners, Leadership Team and Implementers	96	1	$27	96	$2,592
Policy/ Decision Makers (state and local govt.)	Interview Guide for Policy/ Decision Makers	48	1	$40	36	$1,440
Policy/ Decision Makers (private sector)	Interview Guide for Policy/ Decision Makers	120	1	$27	90	$2,430
					Total	$23,814

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

There are no costs to respondents other than their time, as described in A.12.

A.14 Annualized Cost to the Federal Government

The total annualized cost to the government is $1,571,528, as summarized in Table A.14-A. Two types of government costs will be incurred: 1) contracted data collection and analysis, and 2) government personnel.

TableA.14-A. Estimated Annualized Cost to the Federal Government

Activity/Personnel	Total Cost
Data Collection Contractor	
Scheduling and conducting sites visits, collecting, summarizing and analyzing data, doing interim and final reports, for CPPW Sites	1,260,056
Scheduling and conducting sites visits, collecting, summarizing and analyzing data, doing interim and final reports, for Affordable Care Act Sites	275,472
Subtotal	**1,535,528**
CDC Personnel	
• Technical Monitor at 20% FTE (project management and oversight)	24,000
• Co-Technical Monitor at 10% FTE (project management and oversight)	12,000
Subtotal, Federal Personnel	**36,000**
Grand Total	**1,571,528**

A.15 Explanation for Program Changes or Adjustments

This is a new information collection request.

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

CDC will develop a variety of reports and publications to ensure dissemination of the case study findings to the sites and other key stakeholders. These reports include case and cross case reports that will summarize findings after both initial and follow up site visits, as well as enhanced case study reports intended for practitioners hoping to replicate these efforts. CDC will also oversee the development of several manuscripts over the course of the evaluation. The topics to be addressed and publications to be targeted will be developed once case study findings are available to ensure that they focus on the issues most salient to the sites and program stakeholders at that time. CDC will also use the findings to update the data-informed community profiles that are housed on the CPPW website and updated periodically over the course of CPPW implementation.

Table A.16-A.Project Time Schedule

Task	**Time Schedule**
Notification of Selection for Case Study Involvement	January 2011
Schedule & Coordinate Site Visits - Introductory Email - Conduct Preparatory Call - Finalize Site Visit Dates Obtain Schedule & Finalize Logistics	January 2011 – May 2011 - 6 weeks in advance of site visit - 5 weeks in advance of site visit - 4 weeks in advance of site visit - 2 weeks in advance of site visit
Completion of 21 Initial Site Visits to CPPW Sites	February 2011 - June 2011
Completion of 21 Site Visit Reports	March 2011 - July 2011
Completion of 3 Initial Site Visits to Affordable Care Act Sites	May 2011 - August 2011
Cross Site Analysis	October 2011
Schedule & Coordinate Site Visits - Introductory Email - Conduct Preparatory Call - Finalize Site Visit Dates - Obtain Schedule & Finalize Logistics	September 2011 – January 2012 - 6 weeks in advance of site visit - 5 weeks in advance of site visit - 4 weeks in advance of site visit - 2 weeks in advance of site visit
Completion of 21 Follow-up Site Visits to CPPW Sites	November 2011 –March 2012
Completion of 21 CPPW Follow-up Site Visit Reports	December 2011 - April 2012
Completion of 3 Follow-up Site Visits to Affordable Care Act Sites	July 2012-September 2012
Completion of 3 Follow-up Site Visit Reports	August 2012 – October 2012
Cross Site Analysis	August 2012- November 2012
Final Report	September 2012 - February 2013
Briefings—2 Atlanta and 3 DC	November 2011, May 2013, June 2013

Completion of 3 manuscripts	December 2011 - July 2013

Target dates for data collection and analysis will be adjusted if OMB approval is not received by January 1, 2010. Final reports and manuscripts will be prepared during the period February 2013 and July 2013.

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

No request for an exemption from displaying the expiration date for OMB approval is being sought.

A.18 Exceptions to Certification for Paperwork Reduction Act Submissions

These data will be collected in a manner consistent with the certification statement identified in Item 19 “Certification for Paperwork Reduction Act Submissions” of OMB Form 83-I. No exceptions are requested.