

**USE OF EVIDENCE-BASED PRACTICES FOR
COMPREHENSIVE CANCER CONTROL**

New

Supporting Statement – Part A

October 26, 2011

Primary Contact:

C. Brooke Steele
Technical Monitor

National Center on Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention (CDC)
4770 Buford Highway NE, MS K-57
Atlanta, GA 30341-3724

Telephone: (770) 488-4261

Fax: (770) 488-4335

Email: cks9@cdc.gov

Table of Contents

SUPPORTING STATEMENT PART A. JUSTIFICATION.....	1
A.1. CIRCUMSTANCES OF INFORMATION COLLECTION.....	1
A.2. PURPOSE AND USE OF INFORMATION.....	3
A.3. USE OF INFORMATION TECHNOLOGY AND BURDEN REDUCTION.....	5
A.4. EFFORTS TO IDENTIFY DUPLICATION AND USE OF SIMILAR INFORMATION.....	5
A.5. IMPACT ON SMALL BUSINESSES OR OTHER SMALL ENTITIES.....	5
A.6. CONSEQUENCES OF COLLECTING THE INFORMATION LESS FREQUENTLY.....	6
A.7. SPECIAL CIRCUMSTANCES RELATING TO THE GUIDELINES OF 5 CFR 1320.5.....	6
A.8. COMMENTS IN RESPONSE TO THE FEDERAL REGISTER NOTICE AND EFFORTS TO CONSULT OUTSIDE THE AGENCY.....	6
A.9. EXPLANATION OF ANY PAYMENT OR GIFT TO RESPONDENTS.....	6
A.10. ASSURANCE OF CONFIDENTIALITY PROVIDED TO RESPONDENTS.....	6
A.11. JUSTIFICATION FOR SENSITIVE QUESTIONS.....	7
A.12. ESTIMATES OF ANNUALIZED BURDEN HOURS AND COSTS.....	7
A.13. ESTIMATES OF OTHER TOTAL ANNUAL COST BURDEN TO RESPONDENTS OR RECORD KEEPERS.....	8
A.14. ANNUALIZED COST TO THE GOVERNMENT.....	8
A.15. EXPLANATION FOR PROGRAM CHANGES OR ADJUSTMENTS.....	9
A.16. PLANS FOR TABULATION AND PUBLICATION AND PROJECT TIME SCHEDULE.....	9
A.17. REASON(S) DISPLAY OF OMB EXPIRATION DATE IS INAPPROPRIATE.....	10
A.18. EXCEPTIONS TO CERTIFICATION FOR PAPERWORK REDUCTION ACT SUBMISSIONS.....	11

REFERENCES

List of Attachments

Attachment A:	Authorizing Legislation
Attachment B.1:	Federal Register Notice
Attachment B.2:	Summary of Public Comments and CDC Response
Attachment C.1:	Program Director Web Survey Questionnaire
Attachment C.2:	Program Director Telephone Interview Script
Attachment C.3:	Program Director Advance Letter
Attachment C.4:	Program Director Survey Scheduling Script
Attachment C.5:	Program Director Follow-up E-mail Messages
Attachment D.1:	Program Partner Web Survey Questionnaire
Attachment D.2:	Program Partner Invitation E-mail Message
Attachment D.3:	Program Partner Follow-up E-mail Messages
Attachment D.4:	Program Partner Follow-up Postcard Messages
Attachment D.5:	Program Partner Thank You E-mail Message
Attachment E:	Battelle IRB Notice of Exemption

Supporting Statement Part A. Justification

A.1. Circumstances of Information Collection

Background

This is a new Information Collection Request and is authorized by Section 301, "Research and Investigation," of the Public Health Service Act (42 U.S.C. 241).

There have been increasing calls in the fields of public health generally¹⁻⁴ and cancer control specifically⁵⁻⁹ for the dissemination, adoption, and implementation of evidence-based practices (EBPs). EBPs are public health practices (interventions, programs, strategies, policies, procedures, processes, and/or activities) that have been tested or evaluated and shown to be effective. The evidence for a public health practice may be based on the results of a single study or on the systematic review of the accumulated results over multiple studies.^{9, 10} In addition, there is also a need for practitioners to develop practice-based evidence to identify innovative and effective approaches to dealing with public health problems.¹¹ Promising practices designed to address public health priorities are increasingly subjected to comprehensive, systematic review processes by independent third parties (e.g., the Task Force on Community Preventive Services, U.S. Preventive Services Task Force, the Cochrane Collaboration) that determine the strength of the evidence for effectiveness and make recommendations as to which should be utilized widely. EBPs cover a wide range of health issues, including cancer, and are compiled in numerous publications and websites affiliated with the review bodies.¹²⁻¹⁶

However, while the development, review, and compilation of EBPs has steadily increased over time, there is concern that the adoption and implementation of those practices, including among cancer control planners and practitioners, has not kept pace.^{2-4, 6, 8, 9, 17-19} A survey of cancer control planners found that respondents' awareness and use of web-based EBP resources was low—only 65% had ever heard of the resources and less than half of respondents (48%) had ever used EBP resources.¹⁷ Further, recent reviews of CCC plans have found that EBPs are not consistently cited as the basis for addressing goals and objectives.^{19, 20}

Given the gap between the development/identification of EBPs and their use, public health and cancer control organizations need to place greater emphasis on the promotion and dissemination of these practices among those who can use them to improve population health.^{2, 3, 5, 6, 9, 10, 18} The CDC is in a good position to promote EBPs by raising awareness and improving knowledge, encouraging the use of EBPs among program grantees, and through building the capacity of state and local public health organizations to utilize existing resources to identify, adopt, and implement those practices.^{4, 18}

Through the National Comprehensive Cancer Control Program (NCCCP), the CDC's Division of Cancer Prevention and Control has promoted the use of EBPs for cancer control in a number of ways. First, NCCCP grantees are strongly encouraged to use data and research to define the cancer burdens in their jurisdictions, set priorities, and develop goals, objectives, and strategies to ensure that their CCC plans are evidence-based and defensible.²¹⁻²³ Second, current NCCCP priorities include ensuring impact through the use of evidence and evaluation, and NCCCP funding requirements and standards explicitly include the use of EBPs—the use of evidence-based interventions and the reporting on this are now part of annual performance measures, and all future interventions implemented by CCC programs should be based upon scientific or practice-based evidence.

While efforts to promote cancer control EBPs have increased, questions remain whether these efforts will result in widespread adoption and implementation of EBPs in the context of CCC in the states, tribes, and U.S. Associated Pacific Island Jurisdictions/territories. There are a number of barriers to the utilization of cancer control EBPs, including those related to intervention characteristics (availability, cost, ease of use), characteristics of cancer planners and practitioners (awareness and knowledge of EBP resources, training and skills, attitudes toward EBPs and EBP resources) and organizational characteristics (resources, leadership, commitment to EBPs).^{9, 17} In addition, the broad scope of CCC – which includes interventions across the full spectrum of the cancer control

continuum and in a variety of practice contexts (public health, primary care, oncology) – increases the complexity of utilizing EBPs.^{3,6} Thus, NCCCP grantees may face a number of challenges to incorporating EBPs into CCC efforts in their jurisdictions.

In order to address these barriers effectively and better promote the use of EBPs for cancer control, CDC would like to understand (1) how evidence-based approaches are currently being used to develop CCC plans; (2) how CCC programs identify EBPs; (3) what EBPs have been adopted by CCC programs; and (4) what challenges and unintended consequences have been encountered in their implementation. Despite a few relevant examples,^{17, 19} the public health literature does not adequately address these issues. A recent survey of cancer control planners' perceptions and use of EBPs was limited to those affiliated with the eight centers that are part of the Cancer Prevention and Control Research Network, and it is unclear to what extent NCCCP program directors were represented among respondents.¹⁷ Content reviews of CCC plans have shed light on these issues, but have their limits as well. For example, one review by CDC included the 31 plans that were available in electronic format as of December 2004.²⁰ Many plans have been updated since then and more funded programs exist. Another content review included all published CCC plans available on Cancer Control P.L.A.N.E.T. as of January 2008, but was limited to EBPs applied to colorectal cancer.¹⁹ In addition, both of those content reviews identified EBPs through keyword searches of the formal CCC plans and did not include the required action plans that all grantees must provide to CDC on a regular basis. Thus, those reviews may not have been able to identify all EBPs that were part of the CCC efforts at the time.

These gaps need to be filled by examining cancer control planners' use of scientific and practice-based information to inform the development of CCC plans and to select evidence-based interventions. On behalf of CDC, Battelle (the contractor) will conduct surveys among key stakeholders in the NCCCP-funded states, tribes, and U.S. Associated Pacific Island Jurisdictions/territories. In order to understand how the NCCCP-funded programs are using evidence-based practices for cancer prevention and control in their respective jurisdictions, it is necessary to collect data on this topic from two groups of key stakeholders with the most involvement in selecting and implementing those practices: (1) directors of the NCCCP-funded programs (or their designees); and (2) program partners/collaborators identified by the program directors as instrumental to the selection and implementation of cancer control EBPs.

The survey results will help the NCCCP enhance existing efforts, and identify new potential strategies, to promote the use of evidence-based approaches to CCC. The surveys will identify technical assistance needs of the programs related to selection and implementation of EBPs and will contribute to CDC's efforts to build the capacities of states, tribes, and Pacific Island Jurisdictions/territories toward more effective efforts in cancer prevention and control. In addition, the results may lead to new insights and questions that can be addressed in future studies.

Privacy Impact Assessment

Overview of the Data Collection System

The data collection systems will be developed and implemented by CDC's contractor (Battelle).

Program Director Survey. The program director survey consists of two distinct components: (1) an on-line self-administered web survey; and (2) a telephone interview conducted by a Battelle team member. The web survey questionnaire consists largely of close-ended structured items, with a few open-ended items included (Attachment C.1). The telephone interview consists entirely of qualitative open-ended questions, and will allow the interviewers greater flexibility in clarifying responses, and probing more deeply on relevant topics or issues that arise during the interview (Attachment C.2). This multi-mode approach will facilitate the capture of distinctly different types of data that are of interest to CDC.

Program Partner Survey. The program partner instrument is designed to be a web-based self-administered questionnaire with similar content to the one used for the program directors, but with appropriate differences in terms of questions included and their wording (Attachment D.1). Overall, the partner instrument is shorter with a

smaller number of total items and less burden on the respondents. The partner instrument is focused on understanding how the partners help the CCC programs utilize EBPs, including identifying, adapting, implementing, and evaluating those practices. Compared to the program director instrument, the partner instrument places less emphasis on collecting data about the specific EBP resources that are used and the extent to which they are used. In addition, there is less emphasis on organizational context.

Items of Information to Be Collected

The survey questionnaire items for the two surveys are designed to address several key topics, including:

- Use of evidence-based practices and EBP resources;
- Knowledge and attitudes about EBPs;
- Characteristics of the respondents;
- Characteristics of respondent organization; and
- Technical assistance and capacity-building needs.

The web survey questionnaires consist largely of close-ended structured items, with a few open-ended items included. The telephone interview component of the program director survey consists entirely of qualitative open-ended questions, and will allow the interviewers greater flexibility in clarifying responses, and probing more deeply on relevant topics or issues that arise during the interview.

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

Not applicable.

A.2. Purpose and Use of Information

The *purpose* of the proposed project is to examine CCC planners' use of scientific and practice-based information to inform development of CCC plans and to select evidence-based interventions. Related to this purpose, the *key study questions* for this project are:

1. How do NCCCP planners use scientific and practice-based evidence to develop and implement their CCC plans?
2. What evidence-based resources do they use?
3. What technical assistance needs do they have related to selection and implementation of evidence-based interventions?

On behalf of CDC, the contractor (Battelle) will develop the study protocol and all data collection instruments and supplementary survey materials (see Attachments C.1 to D.5) and will subsequently conduct two surveys among key CCC stakeholders in the NCCCP-funded states, tribes, and U.S. Associated Pacific Island Jurisdictions/territories. The first will be a survey with the Directors of the NCCCP-funded programs. The second will be a web-based survey of key program partners/collaborators identified by the Program Directors (2–3 partners per Director) as instrumental to the selection and implementation of cancer control EBPs. The survey results will help CDC enhance existing NCCCP efforts and identify new potential strategies to promote the use of evidence-based approaches to CCC. The surveys will identify technical assistance needs of the programs related to selection and implementation of EBPs and will contribute to CDC's efforts to build the capacities of states, tribes, and Pacific Island Jurisdictions and territories toward more effective efforts in cancer prevention and control. In addition, the results may lead to new insights and questions that can be addressed in future studies.

Privacy Impact Assessment Information

- (i) Why the information is being collected:

The *purpose* of the proposed project is to examine CCC planners' use of scientific and practice-based information to inform development of CCC plans and to select evidence-based interventions. There have been increasing calls in the fields of public health generally¹⁻⁴ and cancer control specifically⁵⁻⁹ for the dissemination, adoption, and implementation of evidence-based practices (EBPs). However, while the development, review, and compilation of EBPs has steadily increased over time, there is concern that the adoption and implementation of those practices, including among cancer control planners and practitioners, has not kept pace. Given the gap between the development/identification of EBPs and their use, public health and cancer control organizations need to place greater emphasis on the promotion and dissemination of these practices among those who can use them to improve population health. While efforts to promote cancer control EBPs have increased, questions remain whether these efforts will result in widespread adoption and implementation of EBPs in the context of CCC in the states, tribes, and U.S. Associated Pacific Island Jurisdictions/territories. **These questions need to be addressed** by examining cancer control planners' use of scientific and practice-based information to inform the development of CCC plans and to select evidence-based interventions.

(ii) Intended use of the Information:

The survey results will help the NCCCP enhance existing efforts, and identify new potential strategies, to promote the use of evidence-based approaches to CCC. The surveys will identify technical assistance needs of the programs related to selection and implementation of EBPs and will contribute to CDC's efforts to build the capacities of states, tribes, and Pacific Island Jurisdictions/territories toward more effective efforts in cancer prevention and control. In addition, the results may lead to new insights and questions that can be addressed in future studies.

(iii) Impact on Privacy to Respondents:

CDC will not receive any identifiable information.

A.3. Use of Information Technology and Burden Reduction

The majority of data will be collected via web surveys for both program directors (approximately 90%) and program partners (100%).

Web Surveys. Both web surveys will be on-line questionnaires consisting of structured, close-ended questions with a small number of brief open-ended questions. The web survey approach was chosen specifically to reduce the burden of answering questions that would have been complicated or awkward to deliver and respond to via telephone interview. The web survey component also reduces burden compared to a hard copy survey by eliminating the work required for receiving and returning paper documents in a survey packet. The populations targeted for the surveys consist of professionals who spend a large portion of their daily work time using internet-connected computers, so participating in a web survey will be efficient and easy.

Program Director Telephone Interviews. In addition to the web survey, program directors will be asked to participate in a brief telephone interview (20 minutes). Some of the questions (q=4) that need to be asked of the program directors are *not* amenable to the structured/close-ended format of the web-survey questionnaire. These questions are open-ended and are designed to allow the program directors to provide more detailed descriptive information about how they use evidence-based cancer control practices, and to allow the interviewers more flexibility for probing and clarifications. We will minimize the burden of this component by limiting the amount of time for the interview to 20 minutes and scheduling the call at a time that is convenient to the respondent.

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

No similar data are available that meet the needs of the proposed study. In order to better promote the use of EBPs for cancer control, we need to better understand (1) how evidence-based approaches are currently being used to develop CCC plans; (2) how CCC programs identify EBPs; (3) what EBPs have been adopted by CCC programs; and (4) what challenges and unintended consequences have been encountered in their implementation. The scientific literature does not adequately address these issues at this time. A recent survey of cancer control planners' perceptions and use of EBPs is similar to the planned survey,¹ but is limited in a number of ways: (1) it did not specifically target the NCCCCP-funded programs and their key partners for using EBPs, and its results are not reported for those two populations; (2) it is limited in geographic coverage (administered only in eight states served by the Cancer Prevention and Control Research Network) and so does not cover the full range of areas covered by the NCCCCP program (all U.S. states, D.C. plus 7 tribal areas and 7 US-affiliated territories); and (3) it did not include all questions/variables relevant to the proposed study.

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 consequence of not collecting the information would be to limit CDC's efforts to promote the use of evidence-based public health practices among states, tribes and US-affiliated territories funded by the National Comprehensive Cancer Control Program (NCCCCP). Without the data collected by the proposed surveys, CDC would not have essential information necessary to provide support to and help the NCCCCP-funded programs develop their capacity to utilize the most effective, research-based approaches to cancer prevention and control.

This request is for a one-time study, and each respondent will be asked to respond once.

There are no legal obstacles to reduce the burden.

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

This request fully complies with regulation 5 CFR 1320.5.

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

- A. A copy of the agency's 60-day Federal Register Notice is attached (*60-day Federal Register Notice* Attachment B.1). The notice, as required by 5 CFR 1320.8 (d), was published on August 22, 2011 (vol. 76, no. 162, pp. 52329-52330). One public comment was received and acknowledged (see Attachment B.2).

¹ Hannon PA, Fernandez ME, Williams RS, et al. Cancer control planners' perceptions and use of evidence-based programs. *J Public Health Manag Pract.* May-Jun 2010;16(3):E1-8.

A.9. Explanation of Any Payment or Gift to Respondents

Respondents will not receive any monetary payment or incentive for participating in the study. However, as an incentive to participate all respondents will receive a CDC-approved copy of the executive summary of the survey findings at the conclusion of the study.

A.10. Assurance of Confidentiality Provided to Respondents

The proposed data collection will have no effect on the respondent's privacy.

The contractor (Battelle) responsible for collecting the data will take steps to assure that study participants' responses are maintained in a secure manner.

Each survey participant will be assigned a unique study identification number. All completed surveys, as well as the electronic data files containing the survey data, will be identified only by study identification number. Neither the Internet surveys nor the electronic files of the survey data will contain names, addresses or telephone numbers of respondents. The Privacy Act does not apply. All project files will be password protected and access to files will be limited to authorized study staff. Upon completion of the study, all identifying information will be destroyed. Project reports and manuscripts will contain aggregated data only; results will not be associated with any individual respondent. Any data sent to CDC will not contain individual identifiers.

For the telephone interviews among program directors, all handwritten notes, typed notes, and audio recordings will be maintained in a secure manner. Hardcopies of these materials will be stored in a locking filing cabinet. The interview notes, or any other materials produced from the interviews, that include identifiers will be handled or viewed only by Battelle staff who are directly responsible for data collection and analysis. In the typed interview notes, names of respondents will be replaced by their study identification number, and any other identifying information (e.g., references to affiliated organizations or names of colleagues/co-workers) will be deleted to prevent indirect identification. Digital audio recordings will be stored on password-protected file servers and deleted upon study completion.

Respondents will be informed of the purpose of the study, what their participation will involve, and the steps taken to maintain their responses in a secure manner. They will be reminded that their participation is voluntary and that they may choose not to answer any question or may withdraw from the study at any time without penalty to themselves or their NCCCP-funded program.

Institutional Review Board Approval

CDC has determined that the information collection does not involve research with human subjects, thus IRB approval is not required. In addition, the study was determined to be exempt by the contractor's (Battelle) IRB, since it does not meet the definition of research in 45 CFR 46 (see Attachment E. Battelle IRB Notice of Exemption).

A.11. Justification for Sensitive Questions

Topics typically considered to be of a sensitive nature include sexual practices, alcohol or drug use, religious beliefs or affiliations, immigration status, and employment history. No questions regarding these topics or any other topic of a sensitive nature will be asked in this data collection activity.

A12. Estimates of Annualized Burden Hours and Costs

Estimated burden to respondents is based on the estimated time it will take to complete the survey by the two types of respondents (See Table 1).

Program Directors. The estimated burden and cost for the program directors are based on the time it will take them to:

1. Provide consent to participate, schedule the telephone interview component of the survey, and provide names and contact information for 3-4 program partners (average 15 minutes; form=Survey Scheduling Script; see Attachment C.4);
2. Complete the web questionnaire component of the survey (average 30 minutes; form=Program Directors Web Survey; see Attachment C.1); and
3. Complete the telephone interview component (average 20 minutes; form=Program Directors Telephone Interview Guide and Script; see Attachment C.2).

We will invite the directors (or their designees) of 66 NCCCP programs to participate in the survey, anticipating a 100% response rate.

Program Partners. The estimated burden and cost for the program partners are based on the time it will take them to complete the on-line web survey (average 30 minutes). Each program director will be asked to recommend 3-4 key partners involved with the utilization of evidence-based public health practices (EBPs) in their jurisdictions to be invited to participate in the program partner survey. All recommended partners for whom we have complete contact information will be invited to participate in the survey, with a final expected sample size of 130 or about 2 partners per program on average (approximately 50% response).

The total estimated burden for all respondents is 138 hours.

Table 1. Estimated Response Burden in Hours

Type of Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Response Burden (in hours)
NCCCP Directors	Survey Scheduling Script	66	1	15/60	17
	Program Directors Web Survey Questionnaire	66	1	30/60	33
	Program Directors Telephone Interview Guide and Script	66	1	20/60	22
NCCCP Partners	Program Partners Web Survey Questionnaire	132	1	30/60	66
Total		198	--	--	138

The annualized cost to respondents is \$4,110, as summarized in Table 2.

Table 2. Estimated Cost to Respondents

Type of Respondent	Number of Respondents	Total Response Burden (in hours)	Average hourly wage rate (\$/hour)*	Total Respondent Cost
Program Directors	66	72	\$25	\$1,800
Program Partners	132	66	\$35	\$2,310
Total	198	138	--	\$4,110

* Wage rate data were obtained from the U.S. Department of Labor, Bureau of Labor Statistics, May 2010 National Occupational Employment and Wage Estimates, http://www.bls.gov/oes/current/oes_nat.htm.

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

There are *no* costs to respondents associated with either capital and startup efforts or operation and maintenance of services for this project.

A.14. Annualized Cost to the Government

The average annualized cost to the Government to collect this information is \$285,108 for the requested one-year OMB approval period. However, actual costs are distributed over a two-year project period that includes project planning and follow-up activities such as analysis and report writing. CDC is responsible for project oversight, review and approval of project materials and deliverables, and oversight of publications and other dissemination activities. The contractor is responsible for (1) development of all project materials and deliverables; (2) data collection, management, and analysis; and (3) report and publication writing.

Table 3. Annualized Cost to the Federal Government

	Annualized Cost
Federal Government Costs (salaries for 5% time for one FTE @ GS-14 2.5% time each for three FTEs @ GS-13 2.5% time for one FTE @ GS-15)	\$33,082
Contractor Costs	\$252,026
Total	\$285,108

A.15. Explanation for Program Changes or Adjustments

This is a new data collection.

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

Plan for Tabulation

Tabulation and analysis of the survey results will be conducted by the contractor (Battelle) on behalf of CDC. The statistical analyses of the data from the two web surveys will be primarily descriptive, employing univariate statistical methods with tables and graphs for display and summarization. In addition, we will conduct comparisons between responses of NCCCP Program Directors and their partners on comparable items between the two surveys. For questions of particular interest we may also conduct appropriate bivariate analyses to determine what factors may influence selection and use of EBPs. For example, we could assess whether

organizational or respondent characteristics, including knowledge and attitudes about EBPs, are associated with the use of web-based resources to identify and select specific EBPs.

The data from the telephone interview component of the program director survey will be examined using qualitative content analysis methods. Battelle analysts will examine the interview data and categorize the responses using a predefined set of codes listed in an initial codebook that reflect anticipated topics and themes. In addition, the analysts will be allowed to identify new topics and themes in the data, and then create and define new coding categories in consultation with one another and the Battelle study leader. This approach will allow us to identify both anticipated and emergent topics, thus accounting for all of the relevant response categories found in the interview data.

Plan for Publication and Dissemination

The plan for publication and dissemination of the survey results will include two main components: (1) final report; (2) 1-2 manuscripts for publication in peer reviewed scientific journals. The contractor (Battelle) will provide support for these two main publication/dissemination efforts. Other dissemination activities may also be pursued given time and resources.

Final Report

Battelle will develop a final report that describes all project activities and outputs, including (1) an executive summary; (2) the methods and results of the two surveys; (3) assessment and review of prior literature; (4) procedures for developing the study protocol, instruments, and survey materials, including instrument pilot test procedures and results; (5) methods for developing IRB and OMB packages; and (6) documentation of decisions made during the course of the project. The final report will include appendices for all study materials such as survey protocols and instruments. The final report will also provide recommendations for applying the results of the project to promote the use of EBPs for CCC among the NCCCP grantees and their partners.

Manuscripts

Concurrently with the preparation of the final report, Battelle will develop 1-2 manuscripts ready for submission to relevant peer-reviewed journals. The manuscripts will be part of the overall dissemination plan for the project, and Battelle will work closely with CDC in specifying the topics, purpose, content, and target journals of the two manuscripts so that they meet CDC's communications needs. Topics of the manuscripts might include: (1) methods and results of the two surveys and (2) methods and results of the grantee workplan review. Relevant journals could include those where similar or related articles have been published, including (1) Cancer Causes and Control; (2) Preventing Chronic Disease; and (3) the Journal of Public Health Management and Practice.

Other potential dissemination activities

An important part of the plan can include dissemination of results directly to the NCCCP directors and their partners who are in a position to apply the results in their cancer control programs. Battelle will send the final approved executive summary of results to the survey respondents as appreciation for their participation. In addition, to ensure that results go to NCCCP partners, the plan can also include development of a study brief that the NCCCP grantees can distribute more broadly among their partners using existing channels (e.g., newsletters, e-mail listserves, or regular meetings). The plan will also include posting information about the project to a variety of web sites used by the national cancer control community (e.g., DCPC and NCCCP websites, Cancer Control P.L.A.N.E.T, cancerplans.org). CDC staff may also submit abstracts to meetings relevant to NCCCP directors such as grantee meetings, world cancer summits, or the American Public Health Association annual meeting.

Project Time Schedule

The contractor (Battelle) will begin conducting the surveys the first month following OMB clearance, and data collection will be completed within 3 months of clearance. Data cleaning and analysis will be completed within 4

months of OMB clearance. Report writing will be ongoing during the data analysis, and a Final Report will be completed within 6 months of OMB clearance. Dissemination of results through CDC websites and publications will be carried out in months 13-15 after OMB clearance. Table 4 provides a summary of the study activities and the months following OMB clearance during which they will be performed.

Table 4. Project Time Schedule

Activity	Time Period (Months after OMB Clearance)
Conduct surveys	1-3
Data cleaning and analysis	3-4
Report/manuscript writing	3-6
Submit final report and manuscripts	6

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

Not Applicable.

A.18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

References

1. Glasgow RE, Klesges LM, Dzewaltowski DA, Bull SS, Estabrooks P. The future of health behavior change research: what is needed to improve translation of research into health promotion practice? *Ann Behav Med.* Feb 2004;27(1):3-12.
2. Kerner J, Rimer B, Emmons K. Introduction to the special section on dissemination: dissemination research and research dissemination: how can we close the gap? *Health Psychol.* Sep 2005;24(5):443-446.
3. Kerner JF. Knowledge translation versus knowledge integration: a "funder's" perspective. *J Contin Educ Health Prof.* Winter 2006;26(1):72-80.
4. Wandersman A, Duffy J, Flaspohler P, et al. Bridging the gap between prevention research and practice: the interactive systems framework for dissemination and implementation. *Am J Community Psychol.* Jun 2008;41(3-4):171-181.
5. National Cancer Institute. *The NCI Strategic Plan for Leading the Nation to Eliminate the Suffering and Death Due to Cancer.* Bethesda, MD: National Cancer Institute, US Department of Health and Human Services;2006.
6. Bowen DJ, Sorensen G, Weiner BJ, Campbell M, Emmons K, Melvin C. Dissemination research in cancer control: where are we and where should we go? *Cancer Causes Control.* May 2009;20(4):473-485.
7. Ciliska D, Robinson P, Armour T, et al. Diffusion and dissemination of evidence-based dietary strategies for the prevention of cancer. *Nutr J.* 2005;4:13.
8. Glasgow RE, Marcus AC, Bull SS, Wilson KM. Disseminating effective cancer screening interventions. *Cancer.* Sep 1 2004;101(5 Suppl):1239-1250.
9. Kerner JF, Guirguis-Blake J, Hennessy KD, et al. Translating research into improved outcomes in comprehensive cancer control. *Cancer Causes Control.* Oct 2005;16 Suppl 1:27-40.
10. Rabin BA, Brownson RC, Haire-Joshu D, Kreuter MW, Weaver NL. A glossary for dissemination and implementation research in health. *J Public Health Manag Pract.* Mar-Apr 2008;14(2):117-123.
11. Green LW. Public health asks of systems science: to advance our evidence-based practice, can you help us get more practice-based evidence? *Am J Public Health.* Mar 2006;96(3):406-409.
12. Cancer Control P.L.A.N.E.T. <http://cancercontrolplanet.cancer.gov/index.html>. Accessed Aug 13, 2010.
13. Research-tested Intervention Programs (RTIPs). <http://rtips.cancer.gov/rtips/>. Accessed Aug 13, 2010.
14. Guide to Community Preventive Services. <http://www.thecommunityguide.org/index.html>. Accessed Aug 13, 2010.
15. Guide to Clinical Preventive Services.com. <http://www.uspreventiveservices.com/index.cfm>. Accessed Aug 13, 2010.
16. Cochrane Reviews. <http://www.cochrane.org/cochrane-reviews>. Accessed Aug 13, 2010.
17. Hannon PA, Fernandez ME, Williams RS, et al. Cancer control planners' perceptions and use of evidence-based programs. *J Public Health Manag Pract.* May-Jun 2010;16(3):E1-8.
18. Kreuter MW, Bernhardt JM. Reframing the dissemination challenge: a marketing and distribution perspective. *Am J Public Health.* Dec 2009;99(12):2123-2127.
19. Townsend JS, Richardson LC, Steele CB, White DE. Evidence-based interventions and screening recommendations for colorectal cancer in comprehensive cancer control plans: a content analysis. *Prev Chronic Dis.* Oct 2009;6(4):A127.

20. Division of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion, CDC. Comprehensive Cancer Control Plans: A Content Review. 2005 Dec; <http://www.cdc.gov/cancer/ncccp>. Accessed 2010 Aug 13.
21. CDC. *Guidance for Comprehensive Cancer Control Planning*. Atlanta, GA: Department of Health and Human Services;2002.
22. Abed J, Reilley B, Butler MO, Kean T, Wong F, Hohman K. Developing a framework for comprehensive cancer prevention and control in the United States: an initiative of the Centers for Disease Control and Prevention. *J Public Health Manag Pract*. Mar 2000;6(2):67-78.
23. Abed J, Reilley B, Butler MO, Kean T, Wong F, Hohman K. Comprehensive cancer control initiative of the Centers for Disease Control and Prevention: an example of participatory innovation diffusion. *J Public Health Manag Pract*. Mar 2000;6(2):79-92.
24. Rogers EM. *Diffusion of Innovations*. 5th ed. New York, NY: Free Press; 2003.