

**Racial and Ethnic Approaches to Community Health across the U.S.
(REACH US) Evaluation
OMB No. 0920-0805**

Request for Revision

Supporting Statement Part A

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Table of Contents

- A. Justification.....
 - 1. Circumstances Making the Collection of Information Necessary
 - 2. Purposes and Use of Information Collection
 - 3. Use of Improved Information Technology and Burden Reduction
 - 4. Efforts to Identify Duplication and Use of Similar Information
 - 5. Impact on Small Businesses or Other Small Entities
 - 6. Consequences of Collecting the Information Less Frequently
 - 7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5
 - 8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency
 - 9. Explanation of Any Payment or Gift to Respondents
 - 10. Assurance of Confidentiality Provided to Respondents
 - 11. Justification for Sensitive Questions
 - 12. Estimates of Annualized Burden Hours and Costs
 - 13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers
 - 14. Annualized Cost to the Government
 - 15. Explanation for Program Changes or Adjustments
 - 16. Plans for Tabulation and Publication and Project Time Schedule
 - 17. Reason(s) Display of OMB Expiration Date is Inappropriate
 - 18. Exceptions to Certification for Paperwork Reduction Act Submissions

List of Attachments

- Attachment 1. Authorizing Legislation
- Attachment 2a. Household Screening Interview
- Attachment 2b. Household Member Interview
- Attachment 2c. REACH Study Booklet (self-administered questionnaire)
- Attachment 2d. Advance Letter and Follow-up Letter
- Attachment 3a. 60-day Federal Register Notice
- Attachment 3b. Summary of Public Comments and CDC Response
- Attachment 4. Incentive Experiments Report
- Attachment 5. IRB approval letter
- Attachment 6. Summary of Questions Changed
- Attachment 7. MMWR Surveillance Summaries
- Attachment 8. Non-Response Plan

Abstract

In 2007, the Centers for Disease Control and Prevention (CDC) launched Racial and Ethnic Approaches to Community Health across the U.S. (REACH US), a national multilevel program to reduce and eliminate health disparities in racial and ethnic minorities. Each state or community funded through the REACH US program developed a community action plan based on promising community public health practices in one or more priority areas: breast and cervical cancer; cardiovascular disease; diabetes mellitus; adult/older adult immunization, hepatitis B, and/or tuberculosis; asthma; and infant mortality. As part of the REACH US evaluation plan, CDC sponsored household-based risk factor surveys in 2009, 2010, and 2011 (OMB No. 0920-0805, exp. 2/28/2012). The survey sample was drawn from specific geographic areas where REACH US interventions have been implemented. The risk factor survey data allow CDC to track trends in community health in the areas where REACH US interventions have been launched, and to assess progress toward the national goal of eliminating health disparities within minority populations.

CDC is requesting continued OMB approval for two years to conduct two additional cycles of data collection in 2012 and 2013. Risk factor surveys will be conducted in 28 REACH US communities (900 individuals per community). Respondents will be adults ages 18 years and older. Changes described in this information collection request include 1) an improved estimate of the total number of risk factor surveys to be collected, based on finalization of the number of funded REACH communities, 2) disaggregation of the number of responses collected through self-administered questionnaires vs. interviews, 3) improved estimates for telephone-based screening, 4) minor additions and deletions to the questions on the risk factor survey (**Attachment 6**), and 5) discontinuation of the previously approved telephone number postcard.

A. Justification

1. Circumstances Making the Collection of Information Necessary

Background

This information collection request is being submitted to obtain two additional years of data for the Racial and Ethnic Approaches to Community Health across the U.S. (REACH US) Evaluation.

In 1999, the Centers for Disease Control and Prevention (CDC) launched the Racial and Ethnic Approaches to Community Health (REACH) 2010 demonstration project. This was a community intervention program targeting six health priority areas: cardiovascular disease, diabetes, improving breast and cervical cancer screening and management, improving adult or childhood immunizations, infant mortality, and HIV/AIDS. The funded communities targeted at least one of the following six racial/ethnic groups: African Americans, Alaska Natives, American Indians, Asian Americans, Hispanic Americans, or Pacific Islanders. Evaluation is of critical importance in documenting and assessing the reduction of health disparities among racial and

ethnic populations. CDC conducted the REACH 2010 Risk Factor Survey from 2001 through 2006 in the residents of 27 communities focusing on cardiovascular disease, diabetes, and deficits in breast and cervical cancer screening and treatment (REACH Evaluation, OMB number 0920-0502, exp. 6/30/2007). The results from the survey have provided valuable information regarding efforts by the REACH 2010 communities to reduce health disparities.

Starting September 30, 2007, a similar program, “Racial and Ethnic Approaches to Community Health across the US” (REACH US) further moves into establishing a national multilevel program that approaches the elimination of racial and ethnic health disparities through the application, synthesis, and dissemination of promising practices within public health practice. Consequently, two levels of interlinked 5-year funding are supported 1) 18 Centers of Excellence in the Elimination of Disparities serving as expert centers by providing the infrastructure to coordinate, refine, and disseminate programmatic activities within specified racial and ethnic group(s) and along selected health priority areas, and 2) 22 Action Communities that implement practice-based or evidence-based practice/programs within a minority community, also along selected health priority areas. The priority areas are cardiovascular disease (heart disease and stroke), diabetes, breast and cervical cancer, adult/older adult immunization, hepatitis, asthma, and infant mortality.

OMB approved the evaluation of the REACH US program through a similar annual survey in communities focusing on cardiovascular disease, diabetes, adult immunization, hepatitis, and deficits in breast and cervical cancer screening. The approval was for three years through Feb 29, 2012 (OMB number 0920-0805). Since then, three repeated REACH US Risk Factor Surveys have been conducted in REACH communities. Currently, the REACH US intervention project is still on-going. We propose to extend the evaluation for another 2 years through Feb 28, 2014.

We propose to continue data collection in 28 communities with 900 completed interviews in each community each year. Respondents will be persons over the age of 18 years who are within the race and ethnic group targeted by the specific REACH community. The methodologies will be similar to those used in the previously approved proposal. This information collection is authorized by the Public Health Service Act, Title 42 United States Code, Chapter 6A - Public Health Service, Subchapter II - General Powers and Duties, Section 241 Research and Investigation (42USC241) (**Attachment 1**).

Privacy Impact Assessment

This is an address-based multi-mode survey including telephone interviews, mail survey, and person-to-person interviews in adults aged 18 years and older. Data are not collected through the web. The items of information to be collected focus on the following areas: socio-demography, health-related quality of life, access to health care, physical activity, fruits and vegetables intake, cigarette smoking, diabetes, hypertension, cholesterol and cardiovascular disease, knowledge of heart attack and stroke, mammography and cervical cancer screening, adult immunizations, and hepatitis. Data collected are regarded as being no greater than minimally sensitive. Therefore, the data collection will have little or no effect on the

respondent's privacy. Nevertheless, safeguards will be put in place to ensure that all collected data remain private.

Overview of the Data Collection System

We will conduct the survey using an address-based sampling (ABS) approach using three modes of data collection: a telephone interview or an in-person interview (see **Attachment 2b**), or a paper REACH Study Booklet, which is a self-administered questionnaire (SAQ, see **Attachment 2c**). Interviews completed by telephone and in-person consist of a short screening interview (see **Attachment 2a**) to determine the age, race, and ethnicity of the adult household members at the sampled address in addition to the main survey instrument. The advance letter and the follow-up letter are included in **Attachment 2d**.

Sampled addresses that can be matched to a telephone number are initially attempted by telephone. If a sampled address cannot be reached by telephone, a self-administered questionnaire (SAQ) packet is mailed to the address. The SAQ packet contains a cover letter, a community endorsement letter (if applicable), two SAQ booklets, a pre-paid \$5 incentive, and a postage-paid business reply envelope for returning the completed booklets. In-person interviews are conducted in two REACH US communities: in the North Carolina Eastern Band of Cherokee Indians community, all interviews are conducted in person, and in the Boston Haitian Diabetes Action Community, in-person interviews are conducted with respondents that cannot be reached by telephone.

CDC has contracted with NORC at the University of Chicago to conduct the REACH US Risk Factor Survey. The identifiable data (e.g., address or phone number) are not delivered to CDC. NORC will destroy these files upon completion of the project.

Items of Information to be Collected

The REACH US Risk Factor survey collects information from individual respondents on their health status, including height and weight, physical activity, fruit/vegetable intake, hypertension, cardiovascular disease, diabetes, breast and cervical cancer screening, adult immunizations, hepatitis B and C, and smoking status. The survey also collects demographic information, including race/ethnicity, gender, education, employment status, income, and access to health care. All information is solicited from the respondent directly, and the respondent may refuse to answer any question. Minor changes to the survey will be implemented for the next two cycles of data collection (see **Attachment 6**). Additional questions will be added pertaining to hepatitis, which is one of the priority intervention areas for REACH US communities. These questions have never been studied in a large scale survey in minority populations. In order to keep the REACH US survey at its current length, we are also deleting a number of questions. These questions were previously used in a number of state BRFSS surveys, and we used them to compare REACH communities with states. Since the questions have been dropped from the state BRFSS surveys, they no longer serve this purpose and will thus be eliminated from the survey.

The REACH US Risk Factor Survey does collect or maintain Information in Identifiable Form (IIF) during the survey administration. The following IIF is collected or maintained during the course of the REACH US Risk Factor Survey administration. **Mailing Address:** available in the data collection system as the sampled unit. Addresses are stripped from files prior to delivery to CDC. **Phone Numbers:** available in the data collection system for the purposes of placing telephone calls. Phone numbers are stripped from the data files prior to delivery to CDC.

Identification of Website(s) and Website content directed at Children Under 13 Years of Age

Respondents will be adults aged 18 years and older. There is no contact directed at children < 13 years of age. Information is not collected through a website.

2. Purposes and Use of Information Collection

The purpose of this data collection will be to assess the prevalence and changes of self-reported risk behaviors associated with cardiovascular disease, diabetes, hepatitis, deficits in breast and cervical cancer screening, and other preventive services. Data will be collected on a yearly basis enabling investigators to assess changes in the performance measures during the intervention and will assess community progress towards meeting performance objectives. While state-based risk factor data exist from the Behavioral Risk Factor Surveillance System, these data do not reflect the level of health behaviors within local communities. This necessitates the collection of data within local communities.

The results of the survey have served multiple purposes. First, the data gathered have been utilized to determine the extent of health disparities across the racial and ethnic groups served by the REACH communities. Second, the communities and CDC have used these data to track progress in reducing and eliminating disparities. Third, the information has provided a scientific basis to assist CDC and other governmental agencies in determining the need and direction of additional programs and served as a model for potential future assessments. The annual data collected in the survey were sent to grantees of the surveyed communities with support documentation (e.g., methodology, data tables, data format, and data use instruction). These data have been used in numerous community newsletters, flyers, reports, briefings to local government and congress persons, conferences, as well as publications in scientific journals. CDC has used these data in CDC publications, websites, congressional briefing, national conferences, and scientific journals (1-4).

It is essential that valid epidemiological studies be performed on representative samples from varying racial and ethnic groups with collection of data from appropriate comparison populations. This study in the REACH communities represents the only large scale epidemiologic study of random samples from the minority communities across the U.S. Since the questions are derived from performance measures widely employed in public health and the questions used in the survey are similar to those conducted in the state-based Behavioral Risk Factor Surveillance System (BRFSS), CDC is able to use data from the BRFSS as a control for the REACH communities, thus minimizing the burden of data collection. In addition, since each community questionnaire is identical, the REACH communities serve as control communities for each other, further minimizing the data collection burden.

This study is essential to the evaluation of the REACH program. If this study is not conducted, knowledge regarding the health disparities within and among the REACH communities will be limited and CDC will not be able to assess progress towards the national objectives including the goal of eliminating health disparities in the REACH communities. Without this information CDC's ability to evaluate each community's progress in eliminating disparities in health will be greatly hampered.

Privacy Impact Assessment Information

The items of information to be collected focus on the following areas: socio-demography, health-related quality of life, access to health care, physical activity, fruits and vegetables intake, cigarette smoking, diabetes, hypertension, cholesterol and cardiovascular disease, knowledge of heart attack and stroke, mammography and cervical cancer screening, adult immunizations, and hepatitis. Data collected are regarded as being no greater than minimally sensitive. Therefore, the data collection will have little or no effect on the respondent's privacy. Nevertheless, safeguards will be put in place to ensure that all collected data remain private.

3. Use of Improved Information Technology and Burden Reduction

In order to increase efficiency and consequently decrease respondent burden, participants will be interviewed utilizing Computer Assisted Telephone Interview (CATI) and Computer Assisted Personal Interview (CAPI) technology for the telephone and in-person interviews, respectively. The mailed survey will contain skip instructions so that respondents need only answer the questions that apply to them. The surveys will be administered by the contractor, NORC at the University of Chicago. All data collection tools, including the subject interview, interview guide and script have been adapted from established performance measures and from existing surveys. Only those items which are essential in determining the previous and present health behaviors of the interviewee or to validate the responses are included.

We conducted the survey using an address-based sampling (ABS) approach. This approach increased the coverage. In 2009, 25% of U.S. homes had only cellular phones. In addition, 15% received most or all of their calls on cellular phones even though they had a landline. Therefore, up to 40% of U.S. homes might not be reachable by traditional random-digit-dialing (RDD). Minority populations have embraced cellular phones at a higher rate than the majority, increasing the risk of coverage bias in REACH communities. Our previous rounds of surveys showed that about 42% of the mail questionnaire respondents reported having only cellular phones or no phone service. They would not be reached if we used the RDD approach.

ABS approach also improves information technology and burden reduction in three important ways:

- ABS provides a basis for a variety of data collection approaches – telephone, mail, and in-person – thereby increasing response rates as respondents have more than one means to participate in the survey.
- ABS enables us to sample within the very specific geographic boundaries of the REACH catchment areas, which makes the process of determining eligibility for the REACH survey significantly more efficient.

- Compared to RDD, the ABS approach is expected to lower respondent burden hours for the same number of completed interviews. As noted above, sampled addresses can be matched precisely to the target geography through GIS, eliminating the need to screen households for geographic eligibility. As a result, less time is needed to screen households, which lowers respondent burden. In the previous REACH 2010 surveys using the RDD approach, approximately 4 completed screeners were needed to obtain 1 completed household member interview. The ratio is 3 to 2 using the ABS approach. Hence, the annualized respondent burden hours recognized under an ABS approach is lower than the annualized burden expected for an RDD approach.

4. Efforts to Identify Duplication and Use of Similar Information

An extensive review of scientific literature, medical journals, and governmental publications has been conducted to locate other studies regarding racial and ethnic disparities in health. Most of the current knowledge comes from epidemiologic studies in selected local areas in a small scale. These data did not reflect the prevalence of health behaviors in the REACH communities.

The concept of the study during initial planning of REACH 2010 was presented in 1998 to the Surgeon General, the HHS Assistant Secretary for Program Evaluation, the Office of Minority Health DHHS, and the REACH Investigators. In addition there were presentations to a working group of subject matter experts that assisted the REACH grantees, the Cardiovascular Health Program, Division of Adult and Community Health, CDC, Division of Cancer Prevention and Control, CDC, Division of Diabetes Translation, CDC, and the National Immunization Program, CDC. As a result of these interactions and ongoing communications, it has been determined that no other epidemiologically valid study which assesses the pre- and post intervention health effects within the REACH communities has been conducted. In addition, morbidity and mortality data which may be available to some REACH communities are not appropriate for evaluation of intervention change given the short duration of intervention. Therefore data on health risk behaviors which are more likely to respond to intervention effects will be collected within the intervention community.

5. Impact on Small Businesses or Other Small Entities

REACH is a household-based survey of individuals. No data will be collected from small businesses or other small entities.

6. Consequences of Collecting the Information Less Frequently

The data collection in this study will consist of yearly surveys in the communities. If the information were collected on a less frequent basis, we would run the risk of missing changes in several performance measures. This would greatly increase the likelihood of not demonstrating statistically significant improvements in health disparities. Each year a random sample of the residents in the community is selected. Given the size and population of most of the communities, it is very unlikely that the same resident will be surveyed more than once over the years.

There are no legal obstacles to reduce the burden.

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

This data collection will not involve any of the special circumstances relating to the guidelines of 5 CFR 1320.5.

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

A 60-day Federal Register Notice was published in the Federal Register on October 6, 2011 (volume 76, number 194, pp. 62070-62071) (see **Attachment 3a**). CDC received one expression of opinion and provided a courtesy reply (see **Attachment 3b**). No substantive comments about the information collection instrument or methodology were received.

In the past three years, we obtained consultations and input from academic scientists in the fields of epidemiology, biostatistics, survey design, and the evaluation of intervention studies. We also contacted and met with grantees from every surveyed community and have received input on the study design, sampling, data collection procedure, instrument, as well as data usage.

9. Explanation of Any Payment or Gift to Respondents

The incentive plan for the the next two cycles of data collection is based on results of an incentives experiment conducted during the first year of REACH US data collection. We plan to include \$5 in all questionnaire mailings. In addition, in 15 selected communities, we plan to implement the following approach for refusal conversion: we will mail \$5 with a refusal conversion letter and promise an additional \$10 payment when the interview is completed.

The complete report on prior incentive experiments is included in **Attachment 4**, and the main findings of the experiments are summarized below.

- (1) For cases that have completed the household telephone screener, are known to meet the REACH US interview eligibility criteria for the community, half of the sample in each REACH community received a refusal conversion letter and a \$5 incentive after the second CATI refusal. Another half of the sample received the refusal conversion letter only. Respondents who completed the interview after receiving the refusal conversion letter with \$5 received a thank you letter with an additional \$10 token of appreciation. The refusal conversion rates in the experiment (incentive) and control groups for all communities combined are shown in the table below.

Incentive Experiment Group	Total	Completed	% Completed
No Incentive	1,851	167	9.0%
Incentive	1,888	192	10.2%

In general, a greater percentage of respondents offered an incentive completed the interview than did respondents in the control group, but this increase was not statistically significant. There were large variations in the impact of an incentive refusal conversion rates among different communities.

After the Year 1 experiment, NORC mailed refusal conversion letters to all households that were known to be eligible for the member interview and had refused to complete the interview via telephone. These letters were sent without any monetary incentive and served as an attempt to convert initially hesitant respondents into completed cases. After NORC mailed the letter, an interviewer called the respondent to answer any questions and attempt to complete the interview. Toward the end of Year 2 data collection, NORC and CDC offered monetary incentives to increase interview completion rates in 10 selected communities and to obtain the requisite number of completed interviews. As with the Year 1 experiment, a conversion letter and \$5 was sent to the respondent with a promise of an additional \$10 upon completion. In contrast to Year 1, the Year 2 incentives resulted in a 18.9% conversion rate for pending interviews. Hence, the same approach was followed for Year 3 data collection – the Year 3 refusal conversion letters (without incentive) resulted in a 6% conversion rate. When NORC mailed refusal conversion letters and offered incentives to pending interviews, 29% of pending interviews converted. We conclude that incentives are a valuable and useful tool for the purposes of completing the required number of interviews and converting initial refusals.

- (2) A Self-Administered Questionnaire (SAQ) study booklet was mailed to the following households: (1) the households for which a telephone number could not be obtained, (2) the households that do not complete the CATI interview after eligibility has been established, and (3) the respondents have been unreachable during CATI (i.e., the household remains unscreened in CATI). A \$5 incentive was included in the SAQ package for half the household sample. For another half of the households, no incentive was included in the SAQ package. Within the experimental group, i.e., those who received the \$5 incentive, half of the households received a promise of an additional \$10 upon return of the completed SAQ. The household level response rates are presented in the following table.

Categories	Control	Experimental			Overall
	No. Incentive Offered	\$5 Initial only	\$5 Initial & \$10 Thank You	Total Across Experimental Conditions	
Households Mailed	21,490	10,704	10,769	21,473	42,963
Undeliverable Addresses	1,706	878	836	1,714	3,420
Households with at least one completed SAQ	2,178	2,729	3,158	5,887	8,065
Percent Households Responding	11.0%	27.8%	31.8%	29.8%	20.4%

The average cost per SAQ response is shown in the following table.

	Control	Experimental	
Categories	No Incentive Offered	\$5 Initial only	\$5 Initial & \$10 Thank You
Cost	\$96	\$106	\$131

The experiment shows that incentives result in much higher response rates when compared to a control condition. Although \$5 + \$10 has further yield in response rate, the cost is also higher. Hence including \$5 in SAQ mailing is most cost effective. After the Year 1 experience, we included \$5 in all SAQ mailings.

10. Assurance of Confidentiality Provided to Respondents

The REACH US Risk Factor Survey uses address, telephone number, and possible first name during the administration of the survey. They are delinked from the main survey data once data collection has been completed. The data collection contractor, NORC, assigned a unique identification code to each individual respondent before delivering data to CDC. The data that CDC receives will never be relinked back to identifiers.

IRB Approval

This study has been reviewed and approved by CDC IRB. Please see the **Attachment 5 for IRB approval letter**.

Privacy Impact Assessment Information

A. This information collection request has been reviewed by Privacy staff who determined that the Privacy Act is not applicable. The data collection contractor will obtain lists of addresses without names and names of respondents will not be collected by the interviewer. In limited situations, the interviewer may have temporary access to a potential respondent’s first name or initials, such as when it is necessary to schedule a call-back to conduct the complete interview. In these situations, the first name or initials will be deleted from the interviewer’s scheduling notes as soon as the interview has been completed. Response data will be identified and retrieved by a unique identification number assigned to each respondent. Neither the names nor any other information by which respondents could be individually identified will be recorded. Therefore, answers cannot be linked to individual respondents. Only aggregate data will be analyzed and reported.

B. Precautions will be taken in how the data are handled to prevent a breach of security and privacy. Survey data and all identifying information about respondents will be handled in ways that prevent unauthorized access at any point during the study. All interviewers will be required

to sign a non-disclosure agreement on the date of hire, which will be reinforced at training. The data collection contractor will observe information management practices established by the National Institute of Standards and Technology (NIST), as specified in the *Guide for Developing Security Plans for Information Technology Systems* (special publication 800-18), *An Introduction to Computer Security: The NIST Handbook* (special publication 800-12), and *Generally Accepted Principles and Practices for Securing Information Technology Systems* (special publication 800-14). Security methodologies include physical access control; logical control of access to the IT environment as a whole; specific authorization and logical control of access rights to data and programs, based upon specific need for access; extensive network and Internet security control; management and operational controls; and monitoring, audit and variance detection. Should a contractor staff member violate security and privacy procedures at any time, they will be removed from the project or reprimanded, as appropriate.

C. In the CATI and CAPI interviews, verbal consent will be elicited from participants. Before each interview, the interviewer will describe the survey, the types of questions that will be asked on the survey, the risks and benefits of participation, and participants' rights, and it provides information on whom to contact with questions about any aspect of the study. The consent script also indicates that participation is completely voluntary and that participants can refuse to answer any question or discontinue the interview at any time.

D. Participation in the survey is voluntary. The introductory section of the Household Members Interview (**Attachments 2b and 2c**) contains the advisements to respondents.

11. Justification for Sensitive Questions

The questions in the survey are for the most part, not of a sensitive nature and are commonly found in surveys of health behavior. Therefore, the data collection will have little or no effect on the respondent's privacy. Questions relating to race/ethnicity and income can be considered of a somewhat sensitive nature. However, these questions are important and are necessary in order to reach the intended audience for the REACH US program. The evaluation (survey) component needs to be consistent with the intervention program. Collection of income data will enable investigators to determine whether improvements in health status have occurred within certain segments of the community including those with low socioeconomic status. The privacy safeguards above are being implemented in recognition of the potentially sensitive nature of some questions in this information collection.

12. Estimates of Annualized Burden Hours and Costs

Risk factor information will be collected from a total of 25,200 respondents annually (900 respondents in each of the 28 REACH US communities). Respondents will be randomly selected, adult residents.

Selected residents will be screened for eligibility by race/ethnicity, gender, and age criteria during an introductory screening interview conducted by telephone or in-person visit (**Attachment 2a**). The average burden per respondent will be approximately three minutes. If the respondent is eligible and willing to participate in the interview, it takes an average of 15

minutes to complete the household member interview (**Attachment 2b**), either by telephone or in-person. We anticipate screening approximately 14,700 individuals annually in order to obtain 10,600 complete responses per year.

If a telephone number cannot be matched to a sampled address, a self-administered questionnaire (SAQ) called the REACH Study Booklet (see **Attachment 2c**) will be sent to the address with a request for the adults in the household to complete it. The REACH Study Booklet contains the family member interview, but in a self-administered format and takes approximately 15 minutes to complete (**Attachment 2c**). We anticipate receiving an average of 14,600 completed SAQ forms per year.

The most recent round of the survey showed that the overall eligibility rate was 60% and member interview completion rate was also 60%. On average, two family members were selected and completed the interviews. Hence approximately 14,700 households will need to be screened in order to obtain 10,600 completed interviews through telephone or in-person surveys. The recent survey also showed that about 60% of SAQ respondents meet race/ethnicity eligibility requirements. Hence, the total number of completed SAQ (including eligible and non-eligible respondents) would be 24,300. The total estimated annualized burden hours are estimated to be 9,460.

Estimated Annualized Burden Hours					
Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
Adults who live in REACH US communities	Screening Interview	14,700	1	3/60	735
	Household member interview	10,600	1	15/60	2,650
	REACH Study Booklet self-administered questionnaire	24,300	1	15/60	6,075
Total					9,460

Based on a mean hourly wage rate of \$11, the estimates of annualized costs to respondents are as follow. Eleven dollars/hour was used since the survey will be administered in minority populations with moderate to low income levels. The total estimated annualized cost to respondents is \$104,060.

Estimated Annualized Costs to Respondents						
Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Avg. Burden per Response	Average Hourly Wage Rate	Respondent Cost
Adults who live in REACH US communities	Screening Interview	14,700	1	3/60	\$11	\$ 8,085
	Household member interview	10,600	1	15/60	\$11	\$29,150
	REACH Study Booklet self-administered questionnaire	24,300	1	15/60	\$11	\$ 66,825
Total						\$104,060

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

There are no additional costs to respondents.

14. Annualized Cost to the Government

The annual cost to the government includes the costs for contracted data collection and the personnel costs of federal employees involved in oversight and data analysis. The Contractor's responsibilities include: identify appropriate geographic areas of each of the 28 surveyed communities; identify a sampling frame from which to select households; instrument refinement; sampling plan, design, and selection; training of interviewers; administration of the appropriate survey; data management; and transfer data to CDC. The annual contract cost is \$4,700,000. The personnel costs of federal employees are about \$100,000 per year, based on 100% of an FTE at GS-14. Hence, the total annual cost to the Government is about \$4,800,000.

15. Explanation for Program Changes or Adjustments

There are a number of program changes or adjustments compared to the previous OMB approval period.

- The number of survey communities will increase from 27 to 28. The added community is B Free National Center of Excellence in the Elimination of Hepatitis B Disparities in New York City.
- The estimated burden for the telephone Screening Interview (**Attachment 2a**) is being increased from two minutes per response to three minutes per response based on the experience from the previous years. However, due to increased use of the Self-Administered Questionnaire (SAQ) mode of the survey (**Attachment 2c**), there will

- be a substantial decrease in the number of respondents to be screened by telephone, resulting in an overall decrease in screening burden.
- Changes in content of the Household Member Interview (see **Attachment 6, Summary of Questions Changed**). New questions were added pertaining to the REACH US priority area of hepatitis. In addition, questions that were no longer useful for analysis were dropped. Since the number of questions removed is similar to the number of newly added questions, the total interview time does not change.
 - We have refined and disaggregated our estimates for the number of surveys conducted by interview versus the number of surveys collected through the mailed SAQ version of the instrument.
 - In the next two annual data collections, we will conduct face-to-face interviews in only two communities. In the Year 1 survey, non-responders to telephone and mail attempts were subsampled for face-to-face follow-up interviews. The results of this effort indicated that face-to-face follow-up interviewing was not necessary to obtain 900 completed interviews in most of the communities. As a result, face-to-face follow-up interviews were not conducted in Year 2 and 3 surveys in order to save cost. However, we will still conduct face-to-face interview in two communities, the Haitian community in Boston and the Eastern Band of Cherokee community in North Carolina. It is difficult to obtain 900 completed interviews through telephone plus mailing in these two communities. About half of the complete interviews in the Haitian community will be completed from face-to-face interview. We have obtained a complete 911 emergency list for the Eastern Band of Cherokee American Indians. Information collection in this community will be conducted entirely by face-to-face interviewing.
 - We will formally discontinue the Telephone Number Worksheet/Postcard. In the Year 1 survey, if the vendor was unable to match an address to a telephone number, NORC mailed a telephone number worksheet/postcard to the sampled address. The worksheet asked the recipient to provide a home or cell phone number so that NORC could call them to conduct the survey. Overall, less than 3% of all households returned a completed worksheet, which was much lower than expected. The worksheet mailing was discontinued early in Year 1 and for later years.

Please note that the burden hours approved by OMB on 2/25/2009 reflect estimates in the original submission, which was received by OMB on 4/25/2008. However, the final OMB approval was based on a revised version of the supporting statement, dated 2/20/2009. The current information collection request represents a net increase in burden when compared to the 2/20/2009 version of the supporting statement. It represents a net decrease when compared to the original submission posted on 4/25/2008.

16. Plans for Tabulation and Publication and Project Time Schedule

The actual data collection will take 6-8 months each year. Data will be cleaned within a month of receipt. Raw data, tabulation of data, and supporting documentation will be sent to each community within two months after completion of data collection. CDC and the communities will use these data, including data analysis for presentation and publication, immediately after

the data are available. An example of tabulation/publication of Year 1 data is attached in **Attachment 7 MMWR Surveillance Summaries**. When the subsequent years of data are available, analysis will include multiple years of data. CDC will analyze aggregated data by priority area and by racial/ethnic group. Secular trend analyses have been performed in the past and will be continued.

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

The OMB Expiration date will be displayed.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

No exemptions to the certification are requested.

REFERENCES

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2. Liao Y, Tsoh JY, Chen R, Anne Foo M, Garvin C, Grigg-Saito D, Liang S, McPhee S, Nguyen TT, Tran JH, Giles WH. Decreases in smoking prevalence in Asian communities served by the Racial and Ethnic Approaches to Community Health (REACH) Project. *AJPH* 2010;100:853-60
3. Liao Y, Bang D, Cosgrove S, Dulin R, Harris Z, Taylor A, White S, Yatabe G, Liburd L, Giles W. Surveillance of health status in minority communities - Racial and Ethnic Approaches to Community Health Across the U.S. (REACH US) Risk Factor Survey, United States, 2009. *MMWR Surveill Summ.* 2011;60:1-44
4. Miles IW, Kruger J, Liao Y, Carlson SA, Fulton JE. Walking Increases Among African American Adults Following a Community-based Physical Activity Intervention: Racial and Ethnic Approaches to Community Health. *J Health Disparities Res Practice* (in press)