

Community Transformation Grants: Use of System Dynamic Modeling and Economic Analysis in Select Communities

Supporting Statement

Part A

Contact:

Robin Soler, PhD
Technical Monitor and Principal Investigator
Division of Community Health
Centers for Disease Control and Prevention
4770 Buford Hwy, NE MS K-45
Atlanta, GA 30341
Telephone: (770) 488-5103
FAX: (770) 488-6450

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LIST OF ATTACHMENTS

- Attachment 1a. Authorizing Legislation: American Recovery and Reinvestment Act of 2009
- Attachment 1b. Authorizing Legislation: Patient Protection and Affordable Care Act
- Attachment 1c. Authorizing Legislation: Public Health Service Act
- Attachment 2. 60-day Federal Register Notice
- Attachment 3. CTG Strategic Directions and Examples of CDC-Recommended Evidence- and Practice-Based Strategies
- Attachment 4. List of CTG Awardees
- Attachment 5. Overall CTG Evaluation Questions
- Attachment 6a. CTG Cost Study Instrument (CTG-CSI)

A. JUSTIFICATION

A.1 Circumstances Making the Collection of Information Necessary

This is a new Information Collection Request (ICR). This OMB approval is being requested for the first three years of a five-year project. CDC plans to seek an extension of OMB approval to support continued data collection through the final two years of the five-year CTG award period. CDC requests OMB approval by June 1, 2012, in order to initiate data collection by July 1, 2012.

In 2009, Title VIII of the American Recovery and Reinvestment Act (ARRA), Public Law 111-5 (Attachment 1a), provided \$650 million to carry out evidence-based prevention and wellness strategies. The Department of Health and Human Services (HHS) has developed an initiative in response to ARRA—the Patient Protection and Affordable Care Act (ACA) (Attachment 1b)—that is helping to reorient the U.S. health care system from primarily treating disease to promoting population health and well-being. The ACA 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. In fiscal year (FY) 2011, funding of \$102.6 million was authorized to the Community Transformation Grants (CTG) program (CDC-RFA-DP11-1103PPHF11) to finance national networks of community-based organizations, as outlined in Section III-Eligibility Information, to support, disseminate, and amplify successful program models and activities as prescribed under statutory authority (Section 4201[c][5] of the ACA). The measurable outcomes of the overall CTG program are in alignment with performance goals for the National Center for Chronic Disease Prevention and Health Promotion in the Centers for Disease Control and Prevention (CDC) to reduce death and disability related to tobacco use, obesity via nutrition and physical activity, and stroke.

The CTG awardees are required to focus on five strategic directions (Attachment 3): (1) tobacco-free living, (2) active lifestyles and healthy eating, (3) high impact evidence-based clinical and other preventive services, (4) social and emotional well-being, and (5) healthy and safe physical environments. Out of these, CTG awardees are required to address (1) tobacco-free living; (2) active lifestyles and healthy eating; and (3) high impact evidence-based clinical and other preventive services, specifically prevention and control of high blood pressure. CTG awardees will create healthier communities through implementation of sustainable, broad,

evidence- and practice-based policy, environmental, programmatic, and infrastructure changes in counties, states, tribes, and territories.

In September 2011, HHS made 61 awards under the CTG to states and communities serving approximately 120 million Americans. These awards are distributed among state and local government agencies, tribes, and territories, and state and local nonprofit organizations within 36 states, including seven tribes and one territory. Thirty five of the awards are for implementation, and 26 are for capacity building (Attachment 4). The proposed system cost data collection will be conducted with a subset of 30 CTG implementation awardees.

The evaluation plan for CTG fulfills the requirements and goals established in Section 4201 of the ACA and provides for a robust and multicomponent evaluation of policy, environmental, programmatic, and infrastructure changes; short-term and intermediate changes; changes in other nonbehavioral risk factors and related health outcomes; and intervention characteristics, the policy environment, and health-related costs and savings. The overall evaluation plan for the CTG will incorporate seven key evaluation approaches (Attachment 5) to assess the degree to which activities and strategies selected by CTG awardees result in changes that increase health equity, eliminate health disparities, and improve health of all groups. For each of the approaches that require data collection, distinct packages will be submitted for Office of Management and Budget (OMB) approval. This OMB document specifically addresses *Use of System Dynamics Modeling and Economic Analysis in Select Communities* and concentrates on approaches four and five listed in Attachment 5: (4) **cost-effectiveness, cost, and health benefits studies** will collect and analyze data related to the direct costs and health benefits incurred by awardees implementing select intervention approaches drawn from the CTG Strategic Directions; and (5) **simulation modeling** will integrate the cost data to simulate selected chronic disease outcomes and their associated monetary impacts under various scenarios, using a system dynamics approach. The new cost data that are collected by CTG awardees will be used to update and customize a system dynamics model to calculate the likely short- and long-term health and economic consequences of particular policy, environmental, programmatic, and infrastructure changes of interest to CTG. This system dynamics model has been developed previously and already contains all the health outcomes data necessary to simulate the effect of CTG interventions on morbidity, mortality, and related medical and

productivity costs. New cost data to be collected from CTG awardees will be integrated with the existing data in the systems dynamics model to conduct the analyses described above; no health outcomes data will be collected from CTG awardees for this effort. CDC is authorized to collect this information by the Public Health Service Act (Attachment 1c).

Privacy Impact Assessment

Overview of the Data Collection System

Cost data will be collected via a Web-based CTG Cost Study Instrument (CTG-CSI). The CTG-CSI will be user-friendly and easily accessible for CTG awardees. The data collection will occur on a quarterly basis starting approximately in July 2012 and ending in July 2016. Access to the Web-based CTG-CSI system will be controlled by a password-protected login that allows varying degrees of access for HHS personnel, contract personnel, and project personnel associated with each CTG awardee. CTG awardee personnel will have access only to the data for their own awardee.

Items of Information to Be Collected

A draft version of the CTG-CSI is presented in Attachment 6a. The CTG-CSI requests quarterly expenditure details in the following areas:

1. Labor/Personnel Expenditures
2. Partner Expenditures
3. Consultant Expenditures
4. Costs Associated with Materials, Travel, Services
5. Other Administrative Costs (e.g., telephone, rent)
6. Labor and Non-Labor In-Kind Resources

No individually identifiable information will be collected. Information collected during the initial 36-month OMB approval period will be maintained for the duration of the five-year project. The information will be used to revise a mathematical cost model. The model maintained by CDC will comply with federal records retention requirements.

Identification of Web Site(s) and Web Site Content Directed at Children Younger than 13 Years of Age

The CTG-CSI is a Web-based tool that will be hosted on a secure server (<https://ctgcost.rti.org>). Access to this Web site will be controlled by a password-protected login.

Access will be restricted to CDC CTG staff, RTI project staff, and awardee cost study respondents. Content of this Web site will not be directed at children younger than 13 years of age. To protect the database server and network infrastructure, RTI will monitor, control, and protect communications at external and internal boundaries of information systems and employ architectural designs, software development techniques, and systems engineering principles. RTI has implemented an information security program based on the Defense in Depth concept, which combines the capabilities of people, operations, and technology.

A.2 Purposes and Use of the Information Collection

The goal of the information collection for *Use of System Dynamic Modeling and Economic Analysis in Select Communities* is to provide CTG awardees with the ability to analyze data related to the direct costs and health benefits associated with particular intervention approaches, based on their timeframe. These data collected by RTI will be used to augment a system dynamics model with actual intervention cost data to calculate new economic metrics within the model, such as cost-effectiveness and cost and health benefits. These analyses and the refined model will assist CTG awardees, CDC, and HHS in simulating various evidence-based scenarios in order to strategically choose intervention approaches for particular populations that are both cost-effective and cost and health beneficial.^{1,2} This refined modeling s will also assist community leaders as they create work plans for transforming specific characteristics in their area, such as creating social and physical environments that support healthy living or establishing policies and laws that provide access to improved preventive care.

Cost data currently do not exist for large-scale, nationwide, community-based programs that employ multiple combinations of policy, environmental, programmatic, and infrastructure strategies. Integrating these economic metrics is advantageous both to the government and to community planners that want to make informed choices for developing policies, making programmatic choices, and identifying efficient resource allocation. These new cost data will enable HHS to identify cost-effective and cost and health beneficial intervention approaches.

Economic analysis will provide critical information to inform decision making by assessing the actual costs of carrying out policy- and environmental change-focused strategies at the community level. The literature contains numerous examples of using costing methodologies to obtain detailed cost data to perform economic evaluations of health programs in the United

States and internationally. In the United States, there is a long history of using an activity-based costing approach to perform cost-effectiveness evaluations of substance abuse programs,³⁻⁵ which recently has been extended to cancer interventions.⁶⁻⁹

Data collected in this cost and modeling evaluation will be used to answer the following questions:

Measuring direct costs associated with implementation:

1. What are the direct costs (budgetary and volunteer/in-kind), both in aggregate and per unit, incurred for select implementation strategies being conducted in communities that have implemented those strategies?
2. How do different combinations of strategies affect costs? Are there economies of scale and scope when enacting multiple interventions?
3. How do the direct costs incurred by communities pursuing the same combination of strategies differ, and what factors might drive these differences (i.e., differences in specific activities under each strategy; variations in geographical size of community/state, population of community/state, population characteristics, staff resources, media, collaboration activities, and materials)?
4. How do efforts to target historically underserved and hard-to-reach populations affect costs and cost benefits?
5. What additional factors related to community implementation of strategies are related to costs incurred and to cost-effectiveness?

Addressing health and economic consequences over time:

6. What are the plausible health and economic consequences associated with specific strategies or combinations of strategies?
7. How strong (population reach and intervention intensity) do the interventions have to be to yield meaningful changes in specified outcomes (e.g., smoking prevalence, obesity, hypertension control, cardiovascular events), and does this vary by population characteristics?
8. How long might it take to see the influence of a particular strategy or combination of strategies on its direct or indirect consequences?
9. In what ways do the effects of strategic interventions differ in the short vs. long term?
10. Under what conditions is it possible to transform the trajectories of health and economic indicators in CTG sites?

In addition, the cost data collected can also be used by the awardees themselves to achieve efficiencies within their programs in the future. Detailed activity-based cost data

collected using the CTG-CSI can be used by the programs to evaluate their activities and identify areas for improvement.

Privacy Impact Assessment Information

The proposed collection will have little or no effect on the respondent's privacy. No information in identifiable form (IIF) is being collected.

A.3 Use of Improved Information Technology and Burden Reduction

All data will be collected electronically via a Web-based instrument (Attachment 6a) to reduce respondent burden, data collection errors, and delays in receiving data. A draft version of the CTG-CSI (Attachment 6a) will be pilot tested with fewer than five individuals representing CTG implementation awardees to assess its ability to provide requested data and identify approaches to minimize burden. During the pretest, the clarity of the instrument, usability of the system, and accuracy of the data entered will also be evaluated.

The instrument will be easily accessible through the Web and will include several features to specifically reduce data collection burden and collect high quality data. Specifically, the CTG-CSI will include automated data checks so that it can be used by the awardees to perform self-directed quality checks on the data as they input the information. For example, when costs are allocated across the interventions, the sum must equal 100% and the respondent will be alerted if the total is less than or greater than 100%. In addition, the tool will include pre-loaded descriptions of awardees' interventions (to which costs will be allocated). Users will also have an option to pre-load cost entries from a previous round of data collection. This will preclude the necessity of reentering costs that are constant across quarters. These features will significantly reduce the time spent typing in text and entering data.

The tool will also contain an interactive User's Manual that will provide variable definitions and instructions for providing the required data. RTI will develop a guidance document that will provide general background information, detail the approach used to capture costs of the program implemented by each awardee, and provide guidance to awardees on how to collect and report costs. Each data element collected by the tool will be explained. The document will also include a frequently-asked-questions section with answers to questions on the costs of community-based interventions. The guidance document will be made available to awardees in

both written and electronic formats. All awardees participating in the study will be provided with detailed instructions and training to input the required data. RTI will conduct a Web-based training for all awardees, technical assistance/training at an awardees' meeting, an in-person site visit, and telephone technical assistance for awardees to ensure that all users are fully prepared to report accurate data.

RTI will collect and tabulate the data provided by the awardees. We expect to collect minimum information necessary to address the research project's research questions. Efforts have been made to design the instrument to be brief, easy to use, and understandable. The study investigators have carefully considered the content, appropriateness, and phrasing of the questions.

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

The CTG program is a new initiative with new requirements to create healthier communities through implementation of sustainable, broad, evidence- and practice-based policy, environmental, programmatic, and infrastructure changes in counties, states, tribes, and territories. These collective approaches broaden a systems-level design beyond particular settings, such as an individual health care setting, and apply systems development to the entire community. Given this wider, systems-level perspective and combination of approaches, no data are currently available that include implementation costs at the community level on these approaches. Thus, the data collection will not duplicate or use similar, existing information from other sources. Portions of the CTG-CSI are based on standard well-established methods for cost data collection.^{3,4,6,10,11} Components of a previously developed and tested instrument used for the Study of the Costs Associated with Community Activities under the CPPW Initiative were modified for development of the CTG-CSI. The CPPW CSI was approved by OMB on January 21, 2011 (OMB control number 0990-0365, expiration date January 31, 2014). Although the format and structure of the CTG-CSI will be similar to the CPPW CSI, the two instruments collect data from different awardees and relate to different types of programs, objectives, and interventions.

This data collection will allow HHS and other government agencies such as CDC to perform in-depth cost estimation (cost-effectiveness and cost and health benefit) evaluation of the CTG that would not have been possible using existing budget information alone. The main

advantage of this cost and modeling approach is that the cost-effectiveness and cost and health benefits of specific policy, environmental, programmatic, and infrastructure changes of the CTG program can be quantified and compared for a variety of strategies and for populations representing an array of demographic and historically underserved and hard-to-reach groups. Unlike budget or total federal spending, the intervention cost data collected by the CTG-CSI will provide details to answer the 10 key evaluation questions (A.2), thus helping CTG communities as well as other communities in the future to develop and implement consequential strategies that improve health outcomes and costs for chronic diseases and other health problems. The system dynamics model will be used to assist CDC staff and community leaders as they create work plans for transforming specific characteristics in their area.

In identifying data collection requirements for this cost and modeling study, CDC has also worked with internal teams conducting other evaluation components of the CTG program to identify potential data that can be shared across focused projects and thus avoid duplication of data that are being collected by the other evaluation teams.

A.5 Impact on Small Businesses or Other Small Entities

No small businesses are involved as respondents to this data collection effort.

A.6 Consequences of Collecting the Information Less Frequently

Without these cost data, HHS will not be able to assess the cost-effectiveness and cost and health benefits associated with particular intervention approaches (drawn from a core set of CTG Strategic Directions, Attachment 3) over time. This economic analysis will provide critical information to inform decision making and future resource allocation by assessing the actual costs of carrying out policy- and environmental change-focused strategies in many communities and hard-to-reach, diverse populations. This information is vital to the overall evaluation of the CTG program and essential for future, successful program planning and implementation. It is anticipated that over the five-year award period, awardees will collect and report these cost data a total of 18 times on a quarterly schedule, beginning at the end of the third quarter (approximately July 2012) through the end of the 20th quarter (approximately July 2016) of the CTG funding period. It is methodologically desirable to collect data at least quarterly to reduce the likelihood of errors in recall on items such as volunteer and in-kind contributions as well as

staff time allocated to specific implementation of interventions. CTG awardees will be required to report quarterly on other aspects of program implementation, so this protocol will align with those reporting cycles. Reducing the respondent burden below the estimated levels (that is, reducing the frequency of the data collection) would diminish the utility of the study and inhibit the ability of HHS to respond to anticipated requests for cost data associated with this program. There are no legal obstacles to reduce the burden.

A.7 Special Circumstances Relating to the Guidelines of 5 CFR1320.5

This request 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. A 60-day notice for public comments on the proposed data collection activities required by 5 CFR 1320.8(d) was published in the *Federal Register* on December 9, 2011 (Volume 76, Number 237, pages 76976-76977) (Attachment 2). No public comments have been received.
- B. The mathematical model being developed through this project is a CDC product. CDC also consulted with Dr. Patty L. Mabry, Senior Advisor in the Office of Behavioral and Social Science Research (OBSSR) in the Office of the Director, NIH. Dr. Mabry is a behavioral scientist with expertise in systems (computational) science. Her contact information is 301.402.1753 (voice) or Patty.Mabry@nih.hhs.gov (electronic mail).

A.9 Explanation of Any Payment or Gift to Respondents

HHS does not provide remuneration to CTG awardees for completing and submitting the evaluation data. Awardees agreed to participate in evaluation activities as a condition of award.

A.10 Assurance of Confidentiality Provided to Respondents

Respondents are local governments and nonprofit organizations that are providing information on their organizational structure, infrastructure, intervention strategy costs, and other expenditures. No IFF is being collected

- A. Privacy Act Determination. CDC has reviewed this submission and determined that the Privacy Act does not apply. Although a primary contact person will be identified for each awardee's organization, the contact person will be speaking from their role as a representative of the responding CTG awardee's organization. The information collection does not involve collection of sensitive or personal information.
- B. Safeguards. Data collection will be conducted via a Web-based instrument managed by RTI. Data will be submitted to HHS according to approved Internet-based communication protocols and a written security plan. Access to the Web-based CTG-CSI system will be controlled by a password-protected login that allows varying degrees of access for HHS personnel, contract personnel, and project personnel associated with each CTG awardee. CTG awardee personnel will have access only to the data for their own awardee. The systems to be put in place will ensure that stored information is accessible to authorized users yet secure. The system contractor will oversee compliance with the written security plan developed by CDC.
- C. Consent. Because the information collection does not involve research with human subjects, IRB approval and individual consent requirements are not applicable.
- D. Nature of Response. No information in identifiable form (IIF) is being collected. The proposed collection will have little or no effect on the respondent's privacy. Participation in the information collection is a condition of funding for selected CTG awardees.

A.11 Justification for Sensitive Questions

We are collecting program-level cost data and not individual-level data. The CTG-CSI does not request sensitive or personally identifiable information.

A.12 Estimates of Annualized Burden Hours and Costs to Respondents

A.12.1 Estimated Annualized Burden Hours

The total number of respondents for the CTG cost collection will be 30 respondents. The 30 respondents will represent a subset of 35 CTG implementation awardees. The 30 respondents

will be selected by CDC based on the list of priority interventions selected for the cost study (currently under development). Exact selection criteria will be established after awardees finalize their Community Implementation Plans (CTIPs). Each of the 30 respondents will be asked to report a set of data via the Web-based CTG-CSI (Attachment 6a). The data collection process will be conducted quarterly and the estimated burden per response is 13 hours.

We anticipate that the person completing the Web-based CTG-CSI will be a program director or manager or another staff person, such as the financial manager, who is familiar with everyday operations, management, and administration of all activities conducted under the CTG grant. However, we expect that this person responsible for the cost data collection and reporting will require assistance from another program staff member (e.g., someone whose daily responsibilities include financial management of the program). Based on previous experience with a similar cost instrument for the CPPW program, we estimate that the awardees will require approximately 52 hours per year to attend training sessions, gather the required data quarterly, and enter the information into the Web-based CTG-CSI. Specifically, we estimate that each quarter the program director and the support staff will spend 1 hour each in training and 5.5 hours each obtaining required cost information and completing the CTG-CSI for a total of 13 hours per quarter or 52 hours per year. *Exhibit A.12-1* summarizes the annualized burden hours. These burden estimate is based on results of pretesting with four awardees conducted in January-February 2012.

Exhibit A.12-1. Estimated Annualized Burden Hours

Types of Respondent	Number of Respondents	No. Responses per Respondent (quarters)	Average Burden per Response (hours)	Total Burden (hours)
CTG awardee	30	4	13	1,560

A.12.2 Estimated Annualized Cost to Respondents

The estimated annualized cost to respondents is \$54,600, which is included in their grant awards (*Exhibit A.12-2*). This annualized cost to respondents is based on the average wage of program directors and finance staff persons from a sample of 11 CTG awardees who were also funded for CPPW. This wage information was obtained from awardees’ cost data submitted

under CPPW . The 11 awardees represent a mix of small and large communities from various parts of the country.

Exhibit A.12-2. Estimated Annualized Cost to Respondents

Type of Respondent	Number of Respondents	Total Burden (hours)	Average Hourly Wage	Total Respondent Cost (\$)
CTG awardees'	30	1,560	\$35	\$54,600

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

No costs other than those described in A.12 will be incurred by the respondents to complete this data collection.

A.14 Annualized Cost to the Federal Government

Exhibit A.14-1 presents the two types of costs to the government that will be incurred:

(1) external contracted data collection and analyses and (2) government personnel.

1. The project is being conducted under a contract that was awarded on September 26, 2011. The contract is for a total of 5 years. The annualized cost for the cost data collection task for the data contractor is estimated at \$136,625.
2. The government costs include personnel costs for federal staff involved in project oversight and development of this ICR; these efforts involve approximately 10% of a GS-13 public health analyst, 20% of a GS-13 scientist, and 5% of a GS-14 scientist. The total cost to the federal government is \$29,596.

The total annualized cost to the federal government for the duration of this data collection is \$166,221.

Exhibit A.14-1. Estimated Annualized Federal Government Cost Distribution

Type of Government Cost	Annualized Cost
Data Contractor	\$136,625
Federal Staff	\$29,596
GS-13 public health analyst at 10% FTE	\$8,242
GS-13 scientist at 20% FTE	\$16,484
GS-14 scientist at 5% FTE	\$4,780
Total	\$166,221

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

A.16.1 Publication Plan

Results of the study will be disseminated to various awardees and other stakeholders through reports, Web conferences, presentations at professional meetings, and publication of manuscripts in peer-reviewed journals. It is anticipated that the results of this project will be developed into several scientific and nonscientific reports.

A.16.2 Project Timeline

The expected time schedule for project activities is presented in **Exhibit A.16-2**.

Exhibit A.16-2. Estimated Time Schedule for Project Activities

Activity	Expected Timeline
Development of final version of the Web-based CTG-CSI based on OMB comments	November 2011 - June 2012
Receive OMB Approval	June 1, 2012
Technical assistance	Ongoing, concentrated during the first and subsequent quarterly data collections
Quarterly data collections	1st data collection: July 2012 2nd–17th data collections: within 60 days of quarter end (15 days after CTG quarterly reports due date) 18th (last) data collection: July 2016
Interim quarterly cost analyses	Within 1 month of quarterly data collection
Final cost data analysis, updates of the system dynamics model using cost data for cost-effectiveness and health and cost benefit analyses, report, and publications	Within 3 months of last data collection

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

There are no exceptions to the certification.

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