OMB SUPPORTING STATEMENT: Part A

SCHOOL HEALTH POLICIES AND PRACTICES STUDY

OMB No. 0920-0445
Reinstatement with Changes

Submitted by:

Division of Adolescent and School Health
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Centers for Disease Control and Prevention
Department of Health and Human Services

Project Officer:

Nancy D. Brener, PhD
Division of Adolescent and School Health
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention
4770 Buford Highway, NE
Mailstop K-33
Atlanta, GA 30341-3717
Phone: 770-488-6184
Fax: 770-488-6156
E-mail: nad1@cdc.gov

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APPENDICES

A. JUSTIFICATION

A.1. CIRCUMSTANCES MAKING THE COLLECTION OF INFORMATION NECESSARY

The purpose of this request is to obtain approval for a reinstatement of a previously approved information collection to conduct the School Health Policies and Practices Study (SHPPS) in 2014 and 2016. SHPPS is a national study of school health policies and practices at the district, school, and classroom levels. Earlier versions of this study were known as the School Health Policies and Programs Study, and much of the information collected in the current study will expand upon data gathered from the 1994 (OMB No. 0920-0340, exp. 1/31/1995), 2000 (OMB No. 0920-0445, exp. 10/31/2002), 2006 (OMB No. 0920-0445, exp. 11/30/2008) and 2012 (OMB no. 0920-0445, exp. 9/30/2012) studies. Current plans call for SHPPS to be conducted at the school level and classroom level in 2014 with a district-level information collection occurring in 2016. The study is funded by the Division of Adolescent and School Health (DASH), National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention (CDC). A three-year approval of this study is being requested.

The proposed study is a reinstatement of the SHPPS 2012 study, with changes. Due to insufficient funding to conduct all parts of the OMB-approved study in 2012, school- and classroom-level information collection, as well as a vending machine observation component, did not occur as planned. However, state- and district-level information collections, which were approved as part of the 2012 study, were conducted in their entirety. The intention of this request is to collect the school, classroom, and vending machine observation data in 2014 that could not be collected in 2012 due to funding cuts. This request also seeks approval to conduct a SHPPS in 2016 that will collect information only at the district level and will replicate methods and processes approved and followed during the conduct of the 2012 cycle of SHPPS. Unlike previous cycles of SHPPS where data collection occurred concurrently at the school and district levels, budget constraints do not allow sufficient funding within a single year to conduct both levels of data collection at the same time. It is anticipated that funding levels will not change in the future to allow a single cycle of data collection at both the school and district levels; we anticipate using a de-coupled data collection model for SHPPS moving forward.

The study will examine eight components of school health: health education, physical education and activity, health services, nutrition services, healthy and safe school environment, mental health and social services, faculty and staff health promotion, and family and community involvement. Sixteen questionnaires will be used in the study; seven at the district level, seven at the school level, and two at the classroom level. Five instruments will be involved in recruitment efforts, two at the state level, two at the district level, and one at the school level. The proposed information collections will use the previously OMB-approved instruments (updated only to refer to the correct academic year), sampling strategy, and data collection procedures. SHPPS will no longer seek to collect information at the state level regarding school health policies or practices.

SHPPS results will have significant implications for planning and implementing school health programs. Schools offer the most systematic and efficient means available

to enable young people to avoid the health risk behaviors that lead to morbidity, mortality, and social problems. SHPPS will examine nationally the roles that schools and districts are playing in addressing these behaviors.

The results will be used by Federal agencies, state and local education and health agencies, the private sector, and others to support school health programs; monitor progress toward achieving health and education goals and objectives; develop educational programs, demonstration efforts, and professional education/training; and initiate other relevant research initiatives to contribute to the reduction of health risk behaviors among our nation's youth.

Background

The legal justification for the survey may be found in Section 301 of the Public Health Service Act (42 USC 241) in ***Appendix A***. Further justification for a national survey of school health policies and practices at the district, school, and classroom levels is based on four factors: (1) public health implications of health risk behaviors among youth; (2) specific mandates to monitor and/or reduce health risk behaviors and/or associated health outcomes; (3) the need to monitor the impact of Federal HIV prevention efforts in schools; and (4) the need to monitor the impact of Federal health education efforts in schools.

A.1.a. Public Health Implications of Health Risk Behaviors among Youth

A limited number of health risk behaviors established during youth accounts for the overwhelming majority of immediate and long-term sources of mortality, morbidity, and social problems among adolescents. These behaviors include those that contribute to unintentional injuries and violence, tobacco use, alcohol and other drug use, sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STD), including human immunodeficiency virus (HIV) infection, unhealthy dietary behaviors, physical inactivity, carrying a weapon, physical fighting, attempted suicide, drinking alcohol while operating a motor vehicle, and lack of seatbelt use while driving or riding in a motor vehicle.

Among youth and young adults aged 10-24 years, approximately 72% of all deaths are due to only four causes: motor vehicle crashes (26%), other unintentional injuries (17%), homicide (16%), and suicide (13%).[1] Compared to older adults, young adults ages 15 to 24 are at higher risk for getting STDs, evidenced by more than 1 million new cases of STDs occurring in this age group each year[2] and an estimated 9,102 cases of HIV/acquired immunodeficiency syndrome (HIV/AIDS) occurring among 13-24 year-olds.[3] Further, in 2008, 733,010 girls age 15-19 experienced unintentional pregnancies.[4] These morbidity and mortality data, however, do not adequately reflect the *long-term* health and social consequences of risk behaviors among youth.

Among adults 25 years of age or older in the U.S., 57% of deaths are due to only two causes: cardiovascular disease (34%) and cancer (23%).[1] The behaviors that contribute to these health problems are preventable and are often established during

youth, but generally do not result in mortality and morbidity until adulthood. These behaviors include use of tobacco, unhealthy dietary behaviors, and insufficient physical activity. As a result of widespread tobacco use, approximately 443,000 Americans die from tobacco-related illnesses, such as cancer and heart disease, each year,[5]and diabetes affects an estimated 25.8 million people in the United States and is the 7th leading cause of death.[6]

Importantly, as pointed out by a report from the Institute of Medicine, *Schools and Health, Our Nation's Investment*,[7] of the four major "systems of influence" – family, friends or peers, school, and community – the *school* is the only one that is an *organized public institution*, amenable to being mobilized to promote societal goals. Schools are the only institution that allows access on a daily basis to almost all children between the ages of 5 and 17 in the nation. (p. 296).

Schools, then, offer the most systematic and efficient means available to enable young people to avoid the health risk behaviors that lead to health problems. SHPPS will examine nationally the roles that schools are playing in addressing these behaviors.

A.1.b Mandates to Monitor Health Risk Behaviors and Associated Health Outcomes

The *Healthy People 2020* objectives establish a set of goals for the nation to reduce the significant preventable causes of morbidity and mortality. *Healthy People 2020* contains approximately 100 objectives that relate to the health of school-aged children. SHPPS will measure 15 of these objectives (***Appendix C***). School health policies and practices can have a direct impact on the success of meeting these objectives through, for example:

- the adoption of specific policies requiring instruction on health topics, e.g., increase the proportion of elementary, middle, and high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity (Objective ECBP-2)
- the adoption of policies regarding the physical school environment, e.g., increase the proportion of the Nation's primary and secondary schools that have official school policies and engage in practices that promote a healthy and safe physical school environment (Objective EH-16)
- the adoption of policies regarding bullying and harassment, e.g., increase the proportion of middle and high schools that prohibit harassment based on a student's sexual orientation or gender identity (Objective AH-9)
- schools' nutrition services programs, e.g., increase the percentage of schools with a school breakfast program (Objective AH-6)
- classroom instruction on the health consequences of substance abuse, which can help increase the proportion of adolescents who disapprove of substance abuse (Objective SA-3).

SHPPS 1994 was the first nationwide study to examine school health policies and programs for multiple components of the school health program, and thereby the first to measure the extent to which schools were meeting the national health objectives that focused on school policies and practices. SHPPS 1994 collected data on five of the eight components of a school health program at the state, district, school, and classroom levels, and focused on middle schools and high schools. SHPPS 2000 expanded on the 1994 study by including questions on the other three components of school health and collecting information from elementary schools as well as middle and high schools. SHPPS 2006 expanded the School Policy and Environment questionnaire to include three new topic areas– physical school environment; crisis preparedness, response, and recovery; and school climate – in order to provide a more complete picture of the status of state, district, and school efforts to provide a safe and healthy learning environment. Emerging areas of interest captured in the SHPPS 2012 questionnaires include the availability of free sources of drinking water in schools; the availability of fresh fruits and vegetables through participation in farm-to-school programs and school gardens; increased opportunities for physical activity during the school day; and implementation of local wellness policies. Questions related to these areas will therefore be included in the questionnaires that will be fielded in 2014, since those questionnaires were not fielded in 2012 as originally planned.

A.1.c Monitoring Federal HIV Prevention Efforts in Schools

Since 1988, CDC has provided funds to almost all state education agencies, local education agencies in large U.S. cities with the highest rates of HIV infections, and more than twenty national organizations to improve the quality of HIV prevention education in our nation's schools. CDC has invested over $450 million in school-based HIV prevention and health education programs. These efforts have been supported by other efforts at CDC and by other Federal, state, local, and private agencies which target HIV prevention education at the broader population, with particular emphasis on high risk populations. It is important to monitor the extent to which school districts and schools have HIV prevention education programs in place. Such programs are incorporated into a wide range of academic subject areas. The National HIV/AIDS Strategy calls for the Nation to ensure that school-based health education is age-appropriate and provides sound information about HIV transmission and risk reduction strategies.[5] Therefore, determining the diffusion and content of HIV prevention education requires examination of a wide range of academic subject areas and discussions with school health education teachers, health services providers, and other school personnel. With the exception of SHPPS, previous studies have not examined HIV-related policies and HIV prevention education efforts at the district, school, and classroom levels nationwide.

A.1.d Monitoring Federal Health Education Efforts in Schools

The role of schools in promoting health, preventing disease, and enhancing the continuing readiness of students to learn has attracted increasing attention over the past two decades in both the Legislative and Executive branches of government, as well as the larger society. Over this time, numerous government and private sector reports have addressed the problems of adolescent health and called for the Nation to re-conceive and

expand its school health programs. This increasing attention to school health programs is based on a complex combination of concerns about the need to control health care costs, reverse declines in academic achievement, meet the need for a technologically sophisticated work force, reduce youth violence, and provide equitable access to health care, especially among the economically needy.

This call for increasing Federal involvement in promoting the health of children and adolescents through schools, and initial steps toward that goal, has occurred with little information about the current status of school health programs nationally. SHPPS provides this information, but also tracks changes in these school health policies and programs over time. Reports of the SHPPS 2006 results included analyses of trends over time in all comparable variables. Similar analyses are underway for the SHPPS 2012 reports. SHPPS 2014 and 2016 will provide data that can be compared to those collected in previous years, allowing assessment of change over time.

A.1.e Privacy Impact Assessment

This study will collect information on policies and practices at the district, school and classroom levels related to eight components of school health: health education, physical education and activity, health services, nutrition services, healthy and safe school environment, mental health and social services, faculty and staff health promotion, and family and community involvement. Also, a vending machine observation component will collect information on the snacks and beverages available to students during the school day. This component will produce the only nationally representative dataset of food and beverage options available to students in school vending machines. The 2014 study involves a nationally representative sample of schools in the United States, and the 2016 study involves a nationally representative sample of school districts. Data on school and district policies and practices are generally considered public information and are regarded as being no greater than minimally sensitive. Questions focus on public policies and practices rather than information about the respondents themselves. The only exceptions to this are a few questions in each questionnaire that ask about the respondent's educational background (e.g. degrees and certifications) so that CDC can assess the qualifications of those persons responsible for overseeing each of the components of the school health program. No questions will be asked about demographic characteristics of respondents (e.g. age, gender, race/ethnicity). 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.

A.1.e.1 Overview of the Data Collection System

In 2014, school-level questionnaires will be administered to respondents in a nationally representative sample of public, private, and Catholic schools. Respondents will be identified by a school-level contact as those most knowledgeable about a given content area. At each school, a random sample of class sections (at the middle and high school levels) or grades (at the elementary school level) providing required instruction on physical education and health education topics will be taken. Up to two class sections or grades will be selected at each school for both health education and physical education. Both the school- and classroom-level questionnaires will be administered via computer-assisted personal interviewing (CAPI) by trained field interviewers.

In 2016, district-level questionnaires will be administered to respondents in a nationally representative sample of districts. Respondents will be identified by a district-level contact as those most knowledgeable about a given content area. Questionnaires will be web-based and self-administered via the Internet. Respondents have the ability to respond to the questionnaires at a time and place of their choosing from any Internet-connected computer.

A.1.e.2 Items of Information to be Collected

No individually identifiable information is being collected as part of the SHPPS questionnaires. In order to facilitate scheduling in-person data collection and the distribution of study materials, such as instructions on how to access the web-based questionnaires, respondents' name, email address, mailing address, and phone number will be collected. However, this information is captured in a separate system and is never part of the study dataset. Respondents are assigned a unique study identifier that will allow researchers to track completed questionnaires. See Section A.10 for further description of the process for maintaining contact information separate from respondent data.

A.1.e.3 Identification of Website(s) and Website Content Directed at Children Under 13 Years of Age

The 2014 school-level information collection does not involve web-based data collection methods nor refer respondents to websites.

SHPPS 2016 will use a web-based data collection methodology at the district level. No links or references to outside websites will appear on the study website. Access to the questionnaires is limited to those with valid passcodes, which will be created and managed by the study team. Non-persistent cookies will be installed on respondents' browsers and will be removed when the browser session is closed. A statement will appear on the log-in page describing the privacy policy and rules of conduct. A version of the website that will be used in 2016 is available at: https://shppswebstage.icfwebservices.com/. To enter the website, use the following access ID: S16OMB05.

A.2 PURPOSE AND USE OF INFORMATION COLLECTED

The information generated by SHPPS will be used by several Federal agencies, including CDC. The information will have a broader use by state and local governments, non-governmental organizations, and others in the private sector.

A.2.a Survey Purposes

The specific purposes of the survey, to be conducted with nationally representative sample of schools in 2014 and a nationally representative sample of districts in 2016, include:

1. Provide data to help monitor relevant national health objectives for 2020 (***Appendix C***). The information generated by SHPPS will be used by decision-makers at the Federal, state, and local levels for policy and program planning and implementation.
2. Determine the extent to which district policies and school practices that address youth risk behaviors and promote the inclusion of eight components of school health programs are in place.
3. Determine the extent to which school health programs (and supporting policies and practices at the district level) that address youth risk behaviors are in place and include the recommended components of school health programs.
4. Determine the characteristics of school health policies at the district level and school health practices at the school level nationwide.
5. Provide data to help monitor the changes in school health policies and practices over time.
6. Provide objective data on the foods and beverages available to students during the school day through vending machines located at schools.

A.2.b Anticipated Uses of Results by CDC

In addition to funding from the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), SHPPS has received funding from several other centers within CDC that will use its data, including the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP); the National Center for Immunization and Respiratory Diseases; the National Center for Environmental Health; the National Center for Injury Prevention and Control; and the Office of Public Health Preparedness and Response. The anticipated uses of SHPPS data by CDC include the following:

1. Assess the need for school- and community-based initiatives to modify behaviors that contribute to the leading causes of mortality and morbidity among youth and adults, and plan, develop, and encourage the implementation of such initiatives.

2. Measure the extent to which school districts and schools have adopted new school health program initiatives and guidelines. In particular, CDC has developed seven sets of guidelines for school health programs:

   - Strategies for Addressing Asthma Within a Coordinated School Health Program
   - Guidelines for School Programs to Prevent Skin Cancer
   - School Health Guidelines to Prevent Unintentional Injuries and Violence
   - School Health Guidelines to Promote Healthy Eating and Physical Activity
   - Guidelines for School Health Programs to Prevent Tobacco Use and Addiction
   - Guidelines for Effective School Health Education to Prevent the Spread of AIDS

   These guidelines cover topics such as policy development, curriculum development and selection, instructional strategies, staff training, family and community involvement, evaluation, and linkage between different components of the school

health program.

3. Provide the Office on Smoking and Health with information on the extent to which school districts and schools have tobacco-use prevention policies in place and provide tobacco-use prevention education.

4. Monitor progress toward attaining relevant national health objectives in those priority areas for which CDC is the lead or co-lead agency.

5. Focus technical assistance efforts provided to local agencies on strategies to modify behaviors that contribute to the leading causes of mortality and morbidity among youth and adults.

6. Provide local agencies with a national profile of school health policies and practices against which to compare their own efforts.

7. Identify the need for additional research to monitor changes in school health policies and practices locally and nationally.

8. Create the only nationally representative dataset detailing the foods and beverages available to students through school vending machines.

9. Perform secondary analyses to explore the relationship between school vending machine offerings and other key school health policies.

A.2.c Anticipated Uses of Results by Other Federal Agencies and Departments

The survey results are of interest not only to CDC, but also to other Federal agencies/departments that participated in the delineation of the survey content and selection/construction of questionnaire items. Widely shared potential applications include monitoring progress toward relevant national health objectives and providing a generalized measure of the overall degree to which schools have policies and practices in place that are designed to have an effect on specific health risk behaviors within the mission of a given Federal agency. The following are illustrative of the intended uses of data by Federal agencies outside of CDC:

Maternal and Child Health Bureau (MCHB) within the Health Resources and Services Administration provided resources and funding to develop the Health, Mental Health, and Safety Guidelines for Schools, which were released in 2004. SHPPS data will be used to measure the extent to which schools in the United States are implementing these Guidelines.

Environmental Protection Agency (EPA)'s mission is to protect human and environmental health, and one means of accomplishing this mission is to educate the public about everyday environmental contaminants that may impact human health. SHPPS includes questions about policies on inspections of school facilities, mold remediation, bus idling, indoor air quality, integrated pest management, and hazardous materials. EPA will be provided with

standardized data on the status of district and school efforts to address environmental health hazards within schools and whether EPA's educational efforts on these topic areas are evident at the school level. EPA will also be able to track progress in these efforts from 2006.

Within EPA, the Indoor Environments Division (IED) has developed tools to assist schools with the identification and remediation of environmental hazards, for example the Indoor Air Quality Tools for Schools. SHPPS data will be used to track the progress of asthma, indoor air quality, radon, and mold programs in schools and can monitor changes since 2006.

Within EPA, the Office of Ground Water and Drinking Water (OGWDW) has developed guidance and tools for schools on reducing the levels of lead and other contaminants in drinking water. SHPPS will provide information on the status of school-initiated monitoring efforts and what problems schools have identified as a result. This information will assist OGWDW by identifying what educational needs schools may have to establish better monitoring and remediation programs.

Within EPA, the Stratospheric Protection Division's (SPD) SunWise program distributes educational materials to schools to develop sustained sun-safe behaviors in children and encourages schools to provide a sun-safe infrastructure. The division will use SHPPS data as a baseline measure of schools' efforts to promote the use of sunscreen and sun protective clothing when students are in the sun during the school day. Trends at the district level can be monitored between 2012 and 2016.

Within EPA, the Compliance and Innovative Strategies Division's (CISD) Diesel Emissions Reduction Program includes goals for the reduction of school bus emissions. Specifically, the program encourages school policies and practices to eliminate unnecessary school bus idling; retrofitting buses with modern emission-control technologies and/or using cleaner fuels; and replacing the oldest buses in the fleet with new, less-polluting buses. SHPPS will provide data on the extent to which district policies and school practices align with these goals to reduce pollution from public school buses.

Within EPA, the Pollution Prevention Division's (PPD) Environmentally Preferable Purchasing Program provides guidelines for finding, evaluating, and purchasing "green" products. Although not specifically targeted by the program, school districts possess great purchasing power and SHPPS will provide the division with data on district policies and practices that favor the purchase and use of products that have a minimal effect on human health and the environment.

Within EPA, the Biopesticides and Pollution Prevention Division's (BPPD) Integrated Pest Management in Schools Program seeks to reduce student and staff exposure to pesticides by advocating the use of integrated pest management (IPM) and has set a goal for all schools in the United States to have adopted the practice by 2015. SHPPS will enable the division to assess progress toward achieving this goal.

Within EPA, the Office of the Administrator/Office of Policy/Office of Sustainable Communities/Federal and State Division has developed resources to assist

communities, including schools, use creative strategies to develop in-ways that preserve natural lands and critical environmental areas, protect water and air quality, and reuse already-developed land. These created strategies conserve resources by reinvesting in existing infrastructure and reclaiming historic buildings. SHPPS data will be used to understand how smart growth concepts such as walkability are incorporated into school policies and how new school siting decisions are made.

Within EPA, the Office of Resource Conservation and Recovery has developed tools to help schools reduce the use of and clean out hazardous chemicals from their school buildings. SHPPS data will be used to track policies and practices related to the use and storage of hazardous chemicals.

Within EPA, the Office of Policy, Economics and Innovation has developed tools to help communities design and build green buildings. Green or sustainable building is the practice of creating and using healthier and more resource-efficient models of construction, renovation, operation, maintenance and demolition. SHPPS data will be used to understand policies and practices related to designing sustainable school buildings and engaging in sustainable practices such as recycling, water and energy conservation, and native landscaping.

National Heart, Lung, and Blood Institute (NHLBI) conducts school-based intervention studies on the promotion of physical activity and sound nutrition. SHPPS results will help plan related initiatives and assess the extent of adoption of NHLBI model programs by school systems nationally.

National Institute of Child Health and Human Development (NICHD) will continue to use SHPPS data to provide contextual information about the school setting in their evaluations of surveys of child and adolescent risk behavior, such as the Health Behavior in School-aged Children (HBSC) survey (OMB No. 0925-0557, exp. 1/31/2012).

National Institute on Drug Abuse (NIDA) allocates a significant part of its prevention research resources to interventions involving schools. NIDA will use SHPPS data to formulate intervention strategies that might be investigated in future prevention research studies.

The President's Council on Fitness, Sports, and Nutrition (formerly the President's Council on Physical Fitness and Sports) has used SHPPS data in fact sheets and will continue to use SHPPS results to assess whether school physical education programs are taking appropriate steps to help youth develop life-long patterns of regular physical activity. The results of the study will be used to assess the extent to which the Council's fitness testing program is in place and will help plan cooperative efforts with the private sector in promoting physical activity and fitness among youth through schools and community organizations.

Department of Agriculture will use SHPPS data to understand the extent to which local wellness policies have been implemented at the school level. USDA can also use SHPPS data to see what data elements districts require schools to submit as part of their local wellness policy. Previously, USDA used SHPPS data in presentations at their Obesity Prevention Conference and in their report, *Making it Happen! School Nutrition Success Stories* (USDA, 2005). They also

will use SHPPS results in the Food and Nutrition Service (FNS) and Nutrition Education and Training (NET) programs. The survey will provide FNS with data on how schools have used *Guidance on School Nutrition Programs.* NET will be provided with information about nutrition education and, in particular, how the school cafeteria is being incorporated into classroom nutrition education efforts. SHPPS will gather complementary but different information than the School Nutrition Dietary Assessment (SNDA) study coordinated by FNS.

Department of Education (ED) has used SHPPS data at Physical Education Program grantee meetings. ED will continue to use SHPPS results to understand and assess school and district policies related to drug and violence prevention and physical education. ED also will use the data related to the physical school environment and crisis preparedness, response, and recovery to determine how to best meet the needs of their constituents in these areas.

Department of Homeland Security (DHS) has responsibility for training state and local education agency personnel to prepare their school systems for potential national and local emergencies and to increase their preparedness for such emergencies. Toward this end, DHS conducts trainings of trainers based on currently available information about the status of emergency preparedness in school systems nationwide. SHPPS will provide DHS with current, up-to-date information on the status of emergency preparedness in school systems, which then will be used in updating and targeting DHS's national training programs.

Department of Justice (DOJ) is responsible for overseeing the implementation of the Americans with Disabilities Act. Under that legislation, efforts to include students with disabilities in the general school environment must be made. SHPPS data will help identify ways that school systems are responding to the educational and physical needs of these students.

Office of Disease Prevention and Health Promotion (DPHP) is responsible for tracking the *Healthy People 2020* objectives through cooperation with other Federal agencies that serve as "lead" in particular areas. *Healthy People 2020* contains approximately 100 objectives that relate to the health of school-aged children, and SHPPS data can be used to measure 15 of them.

A.2.d Use of Results by Those Outside Federal Agencies

The results of the survey also are expected to be used in a variety of ways by state and local governments; educational administrators; teachers; physicians and other health services providers; mental health and social services providers; voluntary health organizations; teacher training institutions; and parents:

- Policy makers in state and local government will have information on how schools currently address behaviors that contribute to the leading causes of mortality and morbidity among youth. This information may be used to develop appropriate policies and establish funding priorities.
- State and local education agencies will have a national profile against which to compare their local programs and to plan implementation of new initiatives.

- Educational administrators will use the data to assist them in justifying and planning school health programs designed to modify health risk behaviors and to create an environment conducive to learning.
- Teachers will have accurate information about how school health programs currently are provided nationwide as the basis for planning their own local programs.
- School health, mental health, and social services personnel will have an accurate portrait of how such services currently are provided in schools as the basis for formulating alternative models for provision of services, including the expanded role that might occur with an infusion of Federal resources.
- Nutrition services staff will use SHPPS data to plan and implement services designed to help improve the nutrition-related behaviors of students.
- Voluntary health organizations will use SHPPS data to help design programs, set program goals, and monitor progress toward achievement of national goals. For example, the American Cancer Society will use SHPPS data to measure progress in obtaining primary goals for its comprehensive school health initiative.
- Teacher training institutions will use SHPPS data to provide information on the educational programs that target health-risk behaviors.
- Parents, who help create the environment in which children develop and practice health-related behaviors, will understand better the current and potential roles schools can play in promoting health and preventing disease among their children.

Other non-federal users of SHPPS data include, the American Academy of Pediatrics (AAP); American Medical Association (AMA); American School Health Association (ASHA); Council of Chief State School Officers (CCSSO); National Association of School Nurses (NASN); National Association of State Boards of Education (NASBE); National Policy and Legal Analysis Network to Prevent Childhood Obesity (NPLAN); National School Boards Association (NSBA); National Trust for Historic Preservation; and Society of State Leaders of Health and Physical Education.

Publications and presentations have been targeted to reach audiences listed above. Further details are provided in Section A.16.b.

A.2.e Privacy Impact Assessment

The results of the study will be shared with the Federal agencies, state and local governments, nongovernmental organizations, and others in the private sector, as noted above. This information will all be presented in aggregate form, with no respondent being identified. 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. The only individually identifiable information that is being collected is contact information for respondents who have been identified by a district or school contact as the most knowledgeable person for a given content area. Respondents' name, email address, mailing address, and telephone number will be collected to facilitate the distribution of study-related materials and scheduling of in-person data collections. This information is captured outside the questionnaire instrument and will never be included in study datasets.

A.3 USE OF IMPROVED INFORMATION TECHNOLOGY AND BURDEN REDUCTION

The 2014 study will involve face-to-face, in-school interviews with administrators, teachers, nurses, counselors, and other school personnel responsible for the following components of school health: health education; physical education and activity; health services; mental health and social services; nutrition services; faculty and staff health promotion; and healthy and safe school environment. As in previous cycles of SHPPS, trained field interviewers will administer questionnaires to school and classroom personnel, using computer-assisted personal interviewing (CAPI) technology.

The 2016 study will involve web-based questionnaires with district personnel responsible for the following components of school health: health education; physical education and activity; health services; mental health and social services; nutrition services; faculty and staff health promotion; and healthy and safe school environment. A web-based methodology was used to collect district data in SHPPS 2012.

Using CAPI and web-based technology offers a number of advantages in the collection of these data. First, a computer-assisted methodology permits more complex routings in the questionnaires compared to a paper-and-pencil method. The CAPI and web-survey programs can implement complex skip patterns and fill specific wording based on answers previously provided by the respondent. Errors made by respondents due to faulty implementation of skip instructions are virtually eliminated. Thus, this approach will reduce respondent burden insofar as respondents will only be asked questions relevant to their situation based on previous responses and will not need to navigate complex skip patterns by hand. Second, both the CAPI and web-based surveys will be programmed to identify inconsistent responses and attempt to resolve them through respondent prompts. This reduces the need for most manual and machine editing, thus saving both time and money and resulting in more consistent data. In addition, it is likely that respondent-resolved inconsistencies will result in data that are more accurate than when inconsistencies are resolved using editing rules. Third, web-based questionnaires offer greater flexibility over other paperless survey programs, such as computer-assisted telephone interviews (CATI), because respondents can elect to do the survey from any Internet-connected computer at the time of their choosing.

For both the 2014 and 2016 implementations of SHPPS, CAPI and web-based questionnaires, respectively, will be programmed to accommodate more than one respondent per questionnaire. This feature will be used in the event that the expertise of two or more respondents is needed to complete a single questionnaire. For example, a school principal might be able to address all of the questions in the Healthy and Safe School Environment questionnaire, with the exception of the physical school environment questions, for which she refers the data collector to the head custodian. The interview with the head custodian will consist solely of those questions the principal could not address. This capability reduces respondent burden while improving the accuracy of the data collected.

CAPI and Web-based technologies also permit greater efficiency with respect to data processing and analysis (e.g., a number of data processing steps, including editing, coding, and data entry become part of the data collection process). These efficiencies save time due to the speed of data transmissions, as well as receipt in a format suitable for

analysis. Tasks formerly completed by clerical staff will be accomplished by the CAPI and web-based programs. In addition, the cost of printing paper questionnaires and associated shipping to respondents and field interviewers is eliminated. The specific CAPI software used will require minimal technological expertise on the part of data collectors, such that data can be submitted to a central repository automatically, merely by having an Internet connection. Any gaps in collected data will create a flag for the data collector while still on site, thereby enabling immediate efforts to fill gaps in data before moving to another location.

The study will also involve the use of digital photography for vending machine observations. This creates minimal burden on the schools as interviewers will also be trained in the use of digital cameras and will be supplied with one for the duration of the project. Digital photography will take place on the same school visit to conduct school- and classroom-level interviews. Further, digital photography uses few resources as the images will be imported from the camera into the same software that manages the SHPPS interviews and transmitted electronically to an existing central data repository.

A.4 EFFORTS TO IDENTIFY DUPLICATION AND USE OF SIMILAR INFORMATION

CDC conducts ongoing searches of all major educational and health-related electronic databases, reviews related literature, consults with experts in survey research, and maintains continuing communications with Federal agencies with related missions. These efforts have identified no previous, current, or planned comprehensive efforts to conduct a survey of the current policies and practices related to school health in a nationally representative sample of schools or districts.

The planned implementations of SHPPS in 2014 and 2016 to a large degree are continuations of SHPPS 1994, 2000, and 2006, as well as the district-level data collection that was unaffected by budget cuts in 2012. However, given many changes in school health policies and practices over the past several years and modifications to the questionnaires in preparation for the school and classroom data collection planned for 2012, the data collected by SHPPS will be unique.

Several sources were consulted to identify redundancy with any completed or on-going studies:

1. A comprehensive literature review was conducted using the following resources:
   - MEDLINE ®
   - PsycINFO®
   - Educational Research Information Clearinghouse (ERIC)
   - Sociological Abstracts
2. Staff in other Federal agencies with mandates to improve some aspect of adolescent or school health were involved in the design of the study.
3. National meetings at which completed, on-going, or contemplated school health studies were discussed revealed insignificant duplication.

One of the reasons SHPPS does not duplicate other ongoing or contemplated studies is because other Federal agencies and other users have increasingly come to look upon SHPPS as a

vehicle through which to gather comprehensive data about school health programs and policies. As a result, SHPPS has helped to avoid generation of redundant or overlapping studies focused narrowly on single aspects of the school health program.

A.5 IMPACT ON SMALL BUSINESSES OR OTHER SMALL ENTITIES

No small businesses will be involved in this data collection. Many school districts and schools have populations < 50,000 people and therefore are considered small entities. These entities are the focus of this study. The questions have been held to the absolute minimum required for the intended use of the data. There will be no significant economic impact on these small entities.

A.6 CONSEQUENCES OF COLLECTING THE INFORMATION LESS FREQUENTLY

The planned data collections will occur once. There are no legal obstacles to reduce the burden.

A.7 SPECIAL CIRCUMSTANCES RELATING TO THE GUIDELINE OF 5 CFR 1320.5

The data collection will be implemented in a manner consistent with 5 CFR 1320.5. No special circumstances are applicable to this proposed survey.

A.8 COMMENTS IN RESPONSE TO THE FEDERAL REGISTER NOTICE AND EFFORTS TO CONSULT OUTSIDE THE AGENCY

A.8.a 60-Day Federal Register Announcement

CDC published a 60-day *Federal Register* notice of the proposed data collection on February 12, 2013, Volume 78, Number 29, pages 9919-9921 (***Appendix B***). One non-substantive public comment was received.

A.8.b Consultations

Consultations on the design, instrumentation, and statistical aspects of the survey have occurred at critical junctures during the original design of SHPPS and have continued since it originally received OMB clearance. The purposes of such consultations were to ensure the technical soundness and user relevance of survey results; to verify the importance, relevance, and accessibility of the information sought in the survey; to assess the clarity of instructions; and to minimize respondent burden.

A.8.b.1 Consultations with Sampling Experts

The sampling experts who have contributed to the project design are:

- Dr. James R. Chromy, Chief Scientist

Research Triangle Institute
3040 Cornwallis Road
Research Triangle Park, NC 27709
919-541-7739
jrc@rti.org

- Dr. Ronaldo Iachan, Senior Statistician
  ICF International
  11785 Beltsville Drive
  Calverton, MD 20705
  (301) 572-0538
  Ronaldo.Iachan@icfi.com

- Dr. William Kalsbeek, Professor
  Survey Research Unit and Biostatistics
  University of North Carolina at Chapel Hill
  730 Airport Road, Suite 103
  Chapel Hill, NC 27599-2400
  919-962-3249
  bill_kalsbeek@unc.edu

- William H. Robb, Statistician
  ICF International
  40 Wall Street
  New York, NY 10005
  (646) 695-8182
  William.Robb@icfi.com

- Joshua T. Brown, Statistician
  ICF International
  126 College Street
  Burlington, VT 05401
  802-863-9600
  Joshua.Brown@icfi.com

- Mirna Moloney, Statistician
  ICF International
  11785 Beltsville Drive
  Calverton, MD 20705
  (301) 572-0943
  Mirna.Moloney@icfi.com

A.8.b.2 Other Consultations on Study and Questionnaire Design

Extensive consultations occurred during the development of SHPPS 1994, 2000, 2006, and 2012. In January 1993, expert panels were convened on five components of school health policies and programs (i.e., health education, physical education, health services, food service, and school policy and environment) to discuss priority variables for measurement in the SHPPS 1994 questionnaires. Using the list of priority variables established at this meeting, study staff developed items, which then were subjected to a review by representatives of other Federal agencies, state and local education agencies, national professional organizations, and the academic community. District and school administrators, teachers, and other school personnel also participated in this review. The 1994 questionnaires then were refined based on feedback provided by the reviewers.

Similar consultations occurred during the development of the SHPPS 2000 questionnaires. The process began in January 1998 with the convening of expert content panels to address components of school health programs that had not been covered in SHPPS 1994 and one that had been only partially covered. The three components not previously addressed were: (1) school mental health and social services, (2) faculty and staff health promotion, and (3) family and community involvement. The fourth component, school policy and environment, was partially covered by SHPPS 1994, but required expansion. Following the content panel meetings, the study staff developed the 23 draft questionnaires, which then were sent for review to approximately 150 potential users of SHPPS data, including the expert panel members, who represented federal agencies and national education and health organizations. Reviewers were asked to review and comment on draft questionnaires in terms of appropriateness and scope of content, clarity, and user relevance. Reviewer comments and suggestions were discussed by CDC and study staff, and revised versions of the questionnaires were produced. Pilot testing of the draft questionnaires and cognitive interviews on select items were then conducted to obtain respondents' insights into the suitability of the questionnaires, ensure items were interpreted as intended, and identify any problematic terms, phrases, or wording. A separate consultation activity focused on the use of CAPI technology to collect the school and classroom data.

For SHPPS 2006, expert panels were convened in September 2004 on three topic areas new to the study: crisis preparedness, response, and recovery; physical school environment; and school climate. Panelists were provided with a list of potential variables within each content area and were asked to comment on the list, provide their thoughts on what variables should be added or removed from consideration, and identify the priority issues that should receive coverage in SHPPS 2006. Based on feedback provided by the panelists, study staff developed draft items, which then were circulated to the panelists for comment. A pretest of the draft questionnaires was then conducted within OMB guidelines with a diverse sample of volunteer state, district, and school personnel. The purpose of this pretest was two-fold: 1) to conduct cognitive interviews to assess and obtain feedback on new items and items that had undergone extensive revisions and 2) to obtain an empirical estimate of respondent burden. A list of the content panel participants for SHPPS 2006 is included in ***Appendix D-1***.

Due to an increased focus on variables associated with a safe and healthy school environment, for SHPPS 2012, extensive consultations with the Environmental Protection Agency (EPA) occurred prior to and during the development of the questionnaires. In addition,

the American School Health Association leadership board provided feedback and proposed variables for inclusion in SHPPS 2012. After incorporating comments from these consultations, as in 2006, a pretest of the draft questionnaires was conducted within OMB guidelines with a diverse sample of state, district, and school personnel to assess the comprehension and/or sensitivity of items new to SHPPS 2012. In addition, a pretest of the programmed questionnaires was conducted to obtain an empirical estimate of respondent burden. In January 2011, the 22 draft questionnaires were sent for review to approximately 350 potential users of SHPPS data, who represented Federal agencies and national education and health organizations. Reviewers were asked to review and comment on draft questionnaires in terms of appropriateness and scope of content, clarity, and user relevance.

No revisions to the 2012 OMB-approved questionnaires, beyond changing references to the correct academic year, are planned for the school and classroom data collection in 2014. Because of funding cuts, these questionnaires were not fielded in 2012; however, there was broad consultation for their revision for 2012 as described here, which the 2014 implementation seeks to use to its advantage. Similarly, because of broad consultation on the revision of the district-level questionnaires for 2012, only minor revisions (i.e., academic year) will be made to the instruments for the 2016 district data collection.

A.8.b.3 Systematic Solicitation of Comments From Federal and Non-Federal SHPPS Users

In February 2011, draft questionnaires were distributed to approximately 350 potential users of SHPPS data who represented federal agencies, state and local education agencies, national education and health organizations, and the academic community. These reviewers included members of the 2004 expert panels, as well as several of the same people who had served as reviewers for SHPPS 2006. Reviewer comments were compiled and reviewed by CDC and study staff and further revisions were made to the questionnaires accordingly. A list of the national reviewers is included in ***Appendix D-2***.

A.9 EXPLANATION OF ANY PAYMENT OR GIFT TO RESPONDENTS

Schools participating in the 2014 cycle of SHPPS will be given educational materials and $250 in appreciation for their participation. No payments will be offered or made directly to school- or classroom-level respondents. In addition, in the rare event that a school incurs unanticipated direct costs in participating in SHPPS 2014—for example, hiring a substitute teacher for a day—such costs will be reimbursed.

For the 2016 district-level data collection, small tokens of appreciation (on the order of $5-$10) may be introduced to respondents during non-response follow-up efforts to ensure a high enough participation rate to produce generalizable data.

A.10 ASSURANCE OF CONFIDENTIALITY PROVIDED TO RESPONDENTS

This data collection has received IRB approval from the data collection

contractor's IRB and from CDC's IRB. The data collection is exempted from the research areas regulated by 45CFR46, "Protection of Human Subjects," according to paragraph 46.101(b) of the regulations.

A.10.a Privacy Impact Assessment Information

A. Privacy Act Determination. In review of this application, it has been determined that the Privacy Act DOES NOT APPLY to information collected through the SHPPS questionnaires. Although identifiable information (name, school address, etc.) will be collected the Privacy Act is not applicable because the participants will be speaking from their roles as staff knowledgeable about school health policies and practices such as health services, violence prevention, crisis preparedness, etc., and will be providing only limited personal information (degrees, certification, etc.) about themselves. No identifying information will be retained in data records. Upon identification of a respondent by the school or district contact as the most knowledgeable respondent in a given content area, study participants are assigned a unique identification number, or passcode. The identifying information used to schedule in-person data collections and distribute study materials (i.e., respondents' name, email address, mailing address, and phone number) is maintained in a file that is separate from the response data. The connection between respondents' passcode and their identifying information is retained only long enough to permit responses. Once a submission is received, the data record is given a new unique identifier that is only viewable to the systems administrator. These data can only be linked with effort because they are stored in separate data files.

B. Information Security. The data collection contractor has several security procedures in place to safeguard data. All electronic data will be stored on secured servers and will be accessible only to staff directly involved in the project. Study servers have undergone Certification & Accreditation (C&A) procedures and have received Authorization to Operate (ATO) from the Office of the Chief Information Security Officer (OCISO). Also, all contractor staff involved with the project will be required to sign a Data Collector Confidentiality Agreement, which is a statement of personal commitment to guard the confidentiality of data.

C. Consent. School, classroom, and district respondents will receive a participant notification document in a mailing prior to data collection. These notification documents will apprise the respondent of his/her rights as a research participant, including the voluntary nature of the study and his/her right to refuse to answer any question. Copies of the notifications are in ***Appendices E-1, E-2, and E-3.***

With regard to the face-to-face interviews in 2014, the interviewer will introduce himself/herself and the session with a statement which will appear on the initial CAPI screens of each questionnaire version. This statement will highlight key information contained in the participant notification document.

With regard to the web-based surveys in 2016, once the respondent has logged in, the program will display the consent statement prior to any questions being displayed. Respondents will be directed to click a button indicating their consent to participate before advancing.

D. Voluntary Nature of Participation. Provision of the information provided by respondents is voluntary and sample members will be assured that there is no penalty if they decide not to respond, either to the information collection as a whole or to any particular question. All school, classroom, and district respondents will be informed that security will be maintained throughout data collection (to the extent permitted by law), all data will be closely safeguarded and no institutional or individual identifiers will be used in study reports; only aggregated data will be reported.

A.11 JUSTIFICATION FOR SENSITIVE QUESTIONS

The questionnaires do not ask any personally invasive or personally sensitive questions. The only questions assessing personal characteristics of respondents are those related to educational background and certifications. The questionnaires do not ask about gender, race, or ethnicity of respondents because those characteristics are not relevant to the study. The data collection pertains to the organizations represented by respondents, not about respondents themselves. Participants will be speaking from their roles as staff knowledgeable about school health policies and practices and will be providing only limited personal information (degrees, certification, etc.) about themselves.

Administrators and other school personnel may be somewhat reluctant to report how their schools operate in certain areas. This is most likely when questions are asked about the enforcement of policies regarding drug use or violence, or the implementation of state laws. In conducting interviews with school personnel, it will be made clear that we are trying to understand how each of hundreds of randomly selected schools operate and what their needs are, not whether any one school or individual performed effectively. The questions were developed in close cooperation with representatives from school systems across the nation and many national education organizations.

A.12 ESTIMATES OF ANNUALIZED BURDEN HOURS AND COSTS

The planned study involves the use of 21 data collection instruments. SHPPS has 16 different questionnaires. Of these, nine will be administered to school personnel in 2014, and the remaining seven will be administered to district officials in 2016. School questionnaires will be administered via CAPI interviews and district questionnaires will be administered via the web. SHPPS also has data collection instruments at the state (2), school (1) and district levels (2), corresponding to recruitment efforts, for a total of five more.

For the 2014 study, the cooperation of educational administrators at the state, district, and school levels will be sought in recruitment of sampled schools. School personnel will be asked to respond to questionnaires, to assist in the identification of the classroom teacher sample members, and to help schedule the interviews.

For the 2016 study, the cooperation of educational administrators at the state and

district levels will be sought in the recruitment of sampled districts. District personnel will be asked to respond to questionnaires and to assist with identifying respondents.

The estimated burden of completing each of the SHPPS questionnaires ranges from 20 minutes to 1.5 hours. Some respondents could be asked to complete more than one questionnaire, depending on variety of roles played in a school or district. Table 1 also includes estimates for assistance with identifying respondents, recruiting districts and schools, and scheduling respondents. The burden of assisting in any one of these other tasks is estimated at 1.0 hours.

The combined total burden hours estimated for the 2014 and 2016 SHPPS and associated support activities are 9,722. Of these, 5,941 burden hours are attributable to the school-level data collection; the remaining 3,781 hours are attributable to the district-level data collection. The number of respondents and responses in ***Table A.12.A*** and ***Table A.12.B*** represent project totals for the three-year approval being requested.

Table A.12.A Total Burden Hours

Type of Respondent	Data Collection Instrument	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
State Officials	State Recruitment Script (for 2014 study)	42	1	30/60	21
	State Recruitment Script (for 2016 study)	44	1	30/60	22
District Officials	District Recruitment Script (for 2014 study)	320	1	30/60	160
	District Recruitment Script (for 2016 study)	902	1	1	902
	District Health Education	685	1	30/60	343
	District Physical Education and Activity	685	1	40/60	457
	District Health Services	685	1	40/60	457
	District Nutrition Services	685	1	30/60	343
	District Healthy and Safe School Environment	685	1	1	685
	District Mental Health and Social Services	685	1	30/60	343
	District Faculty and Staff Health Promotion	685	1	20/60	229
School Officials	School Recruitment Script	821	1	1	821
	School Health Education	640	1	20/60	214
	School Physical Education and Activity	640	1	40/60	427
	School Health Services	640	1	50/60	534
	School Nutrition Services	640	1	40/60	427
	Healthy and Safe School Environment	640	1	1.5	960
	School Mental Health and Social Services	640	1	30/60	320
	School Faculty and Staff Health Promotion	640	1	20/60	214
Classroom Teachers	Classroom Health Education	1,229	1	50/60	1,024
	Classroom Physical Education and Activity	1,229	1	40/60	819

	Total				**9,722**

There are no direct costs to the respondents themselves or to participating schools and districts. The costs may, however, be calculated in terms of the costs of staff time spent in responding to the questionnaires. There are 10 categories of respondents for SHPPS: state officials, district officials; school principals; health education teachers; physical education teachers; health services providers; mental health and social services providers; food service managers; faculty and staff health promotion coordinators; and school support staff. ***Table A.12.B*** illustrates the calculation of respondent burden. In each category, the estimated respondent burden hours have been multiplied by an estimated average hourly salary for persons in that category. The Bureau of Labor Statistics is the source for hourly wages.[8] The total respondent burden costs across all respondent categories and across both questionnaire and assistance activities is $370,399, of which $193,465 is attributable to the school study and the remaining $176,934 is attributable to the district study.

Table A.12.B Total Costs to Respondents

Type of Respondent	Data Collection Instrument	Total Burden (in hours)	Hourly Wage Rate	Respondent Cost
State Official	State Recruitment Script (for 2014 study)	21	$37.48	$787
State Official	State Recruitment Script (for 2016 study)	22	$37.48	$825
District Official (Assist with recruiting sampled schools)	District Recruitment Script (for 2014 study)	160	$46.85	$7,496
District Official (Assist with identifying most appropriate district respondents)	District Recruitment Script (for 2016 study)	902	$46.85	$42,259
District Official	District Health Education	343	$46.85	$16,070
District Official	District Physical Education and Activity	457	$46.85	$21,410
District Official	District Health Services	457	$46.85	$21,410
District Official	District Nutrition Services	343	$46.85	$16,070
District Official	District Healthy and Safe School Environment	685	$46.85	$32,092
District Official	District Mental Health and Social Services	343	$46.85	$16,070
District Official	District Faculty and Staff Health Promotion	229	$46.85	$10,729
Principals, secretaries, or designees (Assist with identifying and scheduling school level respondents)	School Recruitment Script	821	$43.44	$35,664
Health education lead teachers, principals, or designees	School Health Education	214	$26.57	$5,686
Physical education lead teachers, principals, or designees	School Physical Education and Activity	427	$26.57	$11,345
School nurses, principals, or designees	School Health Services	534	$20.21	$10,792
Food service managers, principals, or designees	School Nutrition Services	427	$25.30	$10,803
Principals, head custodians, or designee	Healthy and Safe School Environment	960	$43.44	$41,702
Counselors, principals, or designees	School Mental Health and Social Services	320	$34.14	$10,925
Principals or designees	School Faculty and Staff Health Promotion	214	$43.44	$9,296
Health education teachers	Classroom Health Education	1,024	$26.57	$27,208
Physical education teachers	Classroom Physical Education and Activity	819	$26.57	$21,761
Total				**$370,399**

A.13 ESTIMATES OF OTHER TOTAL ANNUAL COST BURDEN TO RESPONDENTS AND RECORD KEEPERS

There will be no respondent capital and maintenance costs.

A.14 ANNUALIZED COSTS TO THE FEDERAL GOVERNMENT

The survey is funded under Contract No. 200-2012-F-42654. The total contract award to ICF Macro is $5,336,597. Some activities will be conducted during the pre-clearance period and others will occur post-clearance. These costs cover the activities listed in ***Table A.14*** below. Additional costs will be incurred indirectly by the government in personnel costs of staff involved in oversight of the survey and conduct of data analysis. It is estimated that 3 CDC employees will be involved for approximately 30%, 20%, and 10% of their time at salaries of $63, $46, and $44 per hour, respectively. The total project direct cost in CDC staff time is $135,200, at an average annual cost of $45,067 across 3 years, or $67,600 in each of the 2 study years (2014 and 2016).

Table A.14 Estimated Annualized Study Hours and Cost

Data Collection Year	Activity	Cost
2014	*Contract Costs*	
	Survey Design and Planning	$65,583
	Developing and Implementing a Sampling Plan	$89,306
	Developing CATI Instruments and Case Management System	$217,247
	Recruiting School Districts and Schools	$783,987
	Recruiting and Training Field Staff	$198,694
	Data Collection and Processing	$967,563
	Cleaning and Weighting Data and Producing a Datafile with Documentation	$105,009
	Report Writing and Assisting with Dissemination of Results	$293,221
	Subtotal	$2,720,610
	Federal Employee Time Cost	$67,600
	Subtotal for SHPPS 2014	**2,788,210**
2016	Survey Design and Planning	$78,074
	Developing and Implementing a Sampling Plan	$104,458
	Developing Web-based Questionnaires and Case Management System	$194,553
	Recruiting School Districts	$1,186,614
	Data Collection and Processing	$631,850
	Cleaning and Weighting Data and Producing a Datafile with Documentation	$292,653
	Report Writing and Assisting with Dissemination of Results	$127,785
	Subtotal	$2,615,987
	Federal Employee Time Cost	$67,600
	Subtotal for SHPPS 2016	**$2,683,587**
	Total	**$5,471,797**
	Average Annualized Cost	**$1,823,932**

A.15 EXPLANATION FOR PROGRAM CHANGES OR ADJUSTMENTS

The proposed study is a reinstatement of the SHPPS 2012 study, with changes. Due to insufficient funding to conduct all parts of the OMB-approved study, school- and classroom-level information collection, as well as a vending machine observation component, did not occur as planned. However, state and district information collection, which were approved as part of the 2012 study, were conducted in their entirety. The intention of this request is to collect the school, classroom, and vending machine observation data in 2014 that could not be collected in 2012 due to funding cuts.

This request also seeks approval to conduct a SHPPS in 2016 that will collect information only at the district level and will replicate methods and processes approved and followed during the conduct of the 2012 cycle of SHPPS. The proposed information collections will use the previously OMB-approved instruments (updated only to refer to the correct academic year), sampling strategy, and data collection procedures. SHPPS will no longer seek to collect information at the state level regarding school health policies or practices.

Unlike previous cycles of SHPPS where data collection occurred concurrently at the school and district levels, budget constraints do not allow sufficient funding within a single year to conduct both levels of data collection at the same time. This is the reason why school data collection has been de-coupled from the district data collection so that they will be conducted in different years.

A.16 PLANS FOR TABULATION AND PUBLICATION AND PROJECT TIME SCHEDULE

A.16.a Tabulation Plans

Data will be tabulated in ways that will address the principal research purposes outlined in A.2. The initial types of analysis to be performed will include descriptive statistics, such as frequency distributions, means, and medians. Analyses will produce weighted data, using software appropriate for preparing estimates based on complex sampling designs. We plan to use the SAS and SUDAAN analytic packages for these analyses.

A.16.b Publication Plans

Three major publications are planned as a result of this data collection:

- General descriptive report of all results
- Summary of district-level policies for CDC-funded districts (2016 only)
- A set of fact sheets on individual topics

The publications will be distributed to federal agencies, state and local health and education agencies, professional associations in health or education, foundations, and others interested in the role of schools in promoting the health of our nation's youth,

including the general public.

The following journals have carried articles on the SHPPS design and results and are expected to serve as continuing vehicles for distribution of SHPPS results: *American Journal of Health Education; American Journal of Public Health; Journal of Adolescent Health; Journal of School Health;* and *Research Quarterly for Exercise and Sport.* The *Journal of Health Education* published a supplement devoted to secondary analyses of SHPPS 1994 data (Volume 30, Number 5, 1999). The *Journal of School Health* devoted an entire issue to the findings of SHPPS 1994 (Volume 65, Number 8, 1995), SHPPS 2000 (Volume 71, Number 7, 2001), and SHPPS 2006 (Volume 77, Number 8, 2007). Finding from SHPPS 2012 are scheduled to be released in August 2013.

SHPPS results have also been published in other publications, such as *Institute of Medicine Report on Childhood Obesity* and *Morbidity and Mortality Weekly Report*.

In addition, SHPPS results have been and will be distributed through the publications and annual conferences of many national health and education organizations including the following: the American Public Health Association; the American School Health Association; and the Center for School Mental Health Assistance. SHPPS results also have been presented at the National Injury Prevention and Control Conference, the National Chronic Disease Conference, and the National HIV Prevention Conference.

The following materials are available via the Internet at http://www.cdc.gov/HealthyYouth/SHPPS/index.htm: an overview of SHPPS, the SHPPS 2006 questionnaires, and SHPPS 1994, 2000, and 2006 fact sheets, summaries of state-level policies, and state report cards. Similar findings will be posted for the recently completed SHPPS 2012 cycle, and similar content will be generated from the 2014 and 2016 implementations.

A.16.c Time Schedule for the Project

The following represents our proposed schedule of activities for SHPPS 2014. The end date for data collection is constrained by the dates on which schools close for the summer. In addition, given that the final month of school is often extremely busy (finals, field trips, graduation), it is highly desirable to complete data collection at least 1 month before schools close for the summer (i.e., by the end of May). This schedule assumes receipt of OMB clearance by September 1, 2013. Key project dates will occur during the following time periods:

Activity	**Time Period**
Recruit and schedule schools	1 to 6 months after OMB clearance
Finalize CAPI programs and Case Management System	1 to 6 months after OMB clearance
Train field data collectors	4 to 5 months after OMB clearance
Collect data	5 to 10 months after OMB clearance
Process data	6 to 11 months after OMB clearance

Weight/clean data	8 to 11 months after OMB clearance
Produce data file with documentation	11 to 13 months after OMB clearance
Analyze data	13 to 16 months after OMB clearance
Publish results	16 months after OMB clearance

The activities and time schedule for the 2016 data collection will be analogous to that of the 2014 data collection, with the following exceptions:

- Districts will be recruited, but no scheduling is necessary for completion of the Web-based questionnaires
- Data collection will begin immediately after recruitment begins
- Web-based questionnaires will be used in 2016, rather than CAPI instruments
- No field data collectors are necessary for 2016, therefore no data collector training will be conducted

A.17 REASON(S) DISPLAY OF OMB EXPIRATION DATE IS INAPPROPRIATE

The OMB expiration date will be available for disclosure both via the interviewers in face-to-face interviews and the Web. To provide options to district-level respondents in how to review the questionnaires, PDF versions of the SHPPS questionnaires, displaying the OMB expiration date, are available for respondents to download and print from the Internet after they have logged into the questionnaire site.

A.18 EXCEPTIONS TO CERTIFICATION FOR PAPERWORK REDUCTION ACT SUBMISSIONS

No exemptions from the certification statement are being sought.

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