Older Adult Safe Mobility Assessment Tool

SUPPORTING STATEMENT: *PART A*

OMB No. 0920-XXXX

Submitted by:

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A. JUSTIFICATION

A.1. Circumstances Making the Collection of Information Necessary

Background

The Centers for Disease Control and Prevention (CDC) is seeking a 1-year OMB approval to conduct a **new** information collection for a project entitled, "Older Adult Safe Mobility Assessment Tool,"

As the baby boomer generation ages, the population of adults 65 years and older is rapidly increasing. At present 10,000 Americans reach 65 every day, and this will continue for the next 20 years, such that by 2030, it is expected that nearly 20% of the US population, or more than 71 million people, will be age 65 or older (Federal Interagency Forum on Aging-related Statistics, 2010). The motivation to better understand the mobility experience of older adults comes from a recognition that public health and other authorities are ill-prepared to service the needs of this growing population as communities rate transportation as their second leading challenge in meeting the needs of their older adult population (National Association for Area Agencies on Aging, 2011). With most adults aging in place, rather than in retirement or nursing homes, it is absolutely critical to better prepare the field, and older Americans, for what is on the horizon (Frey, 2007).

There is widespread agreement that older adults in the U.S. do not adequately plan for their future mobility needs, nor are most aware of existing mobility resources in their communities. Thus, when an individual's mobility becomes impaired they are ill prepared to adapt their lifestyle to their changing needs (Bailey, 2004). Once at this stage, an individual's ability to access resources may be compromised because their mobility is compromised. Therefore, a tool to help people understand their mobility situation and plan accordingly, so that they can remain safely mobile as they age, would be of use to many older adults.

This project involves developing, refining and validating a Safe Mobility Tool that allows older adults to assess their current mobility situation and receive actionable feedback on how to improve and protect their mobility as they age. This project involves three phases. Phase 1 has been completed and involved collecting information via subject matter expert interviews, an expert panel, and performing an environmental scan to determine the need, approach, and framework for such a tool. Upon completion of Phase 1, we concluded that there is currently a fragmented approach to older adult safe mobility in the U.S (See **Attachment C**: Phase I Report for more information). With siloed research and siloed practice, there is poor understanding of trends and patterns in overall older adult safe mobility in this country. We also found that we do not know nearly enough about the safe mobility experience of older adults in the United States. While information about falls, driving, social networks, home safety, community walkability, and other silos of research are out there, no one has linked all of these silos together to address overall mobility. We currently cannot paint a picture of what adults age 65 and older experience

when they try to get where they want to go. There are anecdotes, compelling data from assessments focused on certain aspects of older adult safe mobility, glimpses provided by national surveys, but when it comes to a holistic nationwide understanding of the trends and patterns in older adult safe mobility, there is a gap in knowledge. An older adult safe mobility assessment, linking the domains of older adult safe mobility together and empowering the individual with a way to improve their mobility, would begin to help fill this gap.

Phase 2 of this project (current project for which we are seeking OMB approval) builds upon the results of Phase 1 and involves developing an Older Adult Safe Mobility Assessment Tool and assessing the feasibility and audience acceptability of such a Tool. Phase I did not require OMB approval as the contractor reviewed secondary data, conducted internal CDC interviews and convened an expert panel of less than 9 non-federal participants. Phase 3 will occur in the future and will involve the dissemination of the final Tool.

The current protocol for Phase 2 specifically involves developing a tool that assesses older adult safe mobility and conducting evaluation activities around feasibility and audience acceptability of such a Tool. Phase 2 objectives are**:**
1. To complete qualitative consumer testing to further develop concepts and shape the Assessment Tool;
2. To obtain expert input as needed on key content and technical issues;
3. To draft the Assessment Tool based on consumer input, expert panel feedback, and available mobility assessment resources;
4. To develop a sampling frame for pilot testing and create plans for distribution, data collection, and analysis of pilot-test survey results;
5. To field the survey to understand feasibility and audience acceptability, and identify needed refinements to the Tool; and
6. To analyze results and finalize the content, analytics, and protocol of the Assessment Tool.

Data will be collected through qualitative and quantitative components in order to develop and refine the tool, and assess feasibility and audience acceptability. In particular, data collection will include key informant interviews, focus groups, and intercepts, as well as a telephone survey.

The proposed data collection fits into the National Center for Injury Prevention and Control (NCIPC) Research Agenda Priorities in Transportation Safety (http://www.cdc.gov/injury/ResearchAgenda/index.html) with regard to Tier 2 Part F: “Among older adults, identify and measure factors that affect safe motor vehicle use and develop and evaluate interventions that reduce motor vehicle-related deaths and injuries.” This data collection involves many aspects of mobility, and motor vehicle safety is one critical aspect. The proposed data collection also addresses one of the three NCIPC priority areas of “motor vehicle injury prevention” and is one of the six CDC “Winnable Battles” (http://www.cdc.gov/winnablebattles/).

Authority for CDC’s National Center for Injury Prevention and Control to collect this data is granted by Section 301 of the Public Health Service Act (42 U.S.C. 241) (**Attachment A**). This act gives federal health agencies, such as CDC, broad authority to collect data and do other public health activities, including this type of study. A 60-day notice to solicit public comments was published in the Federal Register (See **Attachment B.1**).

Privacy Impact Assessment

i) Overview of the Data Collection System

Data collection methods: This project will involve a variety of qualitative and quantitative methods over two primary data collection stages. First, qualitative data collection will include key informant interviews, focus groups and intercepts in urban and rural communities. In brief, these methods will include:

- Key informant interviews of community stakeholders in 2 states with 3 people each- California and Illinois- for a total of 6 key informant interviews
- Two older adult consumer in-person focus groups in urban locales with 7 people each, one in California (San Diego) and one in Illinois (Chicago)- for a total of 14 people.
- 40 older adult consumer in-person intercepts in 2 rural locations (Alpine, CA and Kankakee, Illinois) with 15 people in each and 2 urban locations (San Diego, CA and Chicago, Illinois) with 5 people each.

The collected qualitative information will help inform a quantitative stage of work to include a national sample of geographically and socio-demographically diverse older adult consumers (N = 1,000) who will be recruited and interviewed by telephone.

Data collection partners: The contractor, Strategic e-Business Solutions, Inc. (SeBS), will conduct all qualitative and quantitative information collection listed above, partnering with ResearchWorks, Inc (RWI). SeBS and RWI employ and contract with professional and highly trained market research staff, contractors and vendor firms. All SeBS and associated data collectors will have had previous professional experience in national-scale market research and evaluation. CDC will have, at a minimum, monthly conference calls with SeBS and RWI to discuss data collection procedures and handle any issues that may arise.

***Length of time that information will be maintained*:** Information from all qualitative and quantitative sources will be maintained by SeBS only for seven years following the completion of the study. The data maintained by SeBS will be de-identified and anonymized (i.e., there will be no way to link it back to the respondent). CDC will own and store the de-identified and anonymized data collected from the project after the study.

ii) Items of Information to be Collected

As listed above, both qualitative and quantitative information will be collected using a variety of data collection methods. All information collection methods will involve some Information in Identifiable Form (IIF). The following table lists the IIF categories to be collected per method.

Information Collection Method	**IIF Categories Collected**
Key informant interviews	Name, phone number, email address, employment status

Focus groups	Name, year of birth, mailing address, phone number, medical information and notes (only general self report health status), financial account information (only general income level), email address, employment status, education level, race/ethnicity
Intercepts	Name, year of birth, mailing address (city/state only), phone number, medical information and notes (only general self report health status), financial account information (only general income level), email address, employment status, education level, race/ethnicity
Telephone surveys	Name, year of birth, mailing address, phone number, medical information and notes (only general self report health status), financial account information (only general income level), email address, employment status, education level, race/ethnicity

SeBS will not store any identifiable information with the questions/responses received through data collection. All data will be anonymized so that it cannot be linked back to the participants. Additionally, all study respondents will be assured that the information they provide will not be shared with anyone outside of the study investigators and only the de-identified and anonymized information will be transmitted to CDC. (See Section A.10 for more information.)

A.2. Purpose and Use of the Information Collection

The information collected under the proposed data collection will be used to conduct Tool refinement and analysis activities that help determine the feasibility and audience accessibility of the Older Adult Safe Mobility Assessment Tool. The information collected will allow the contractor to create a final version of the Tool that can be used by CDC for older adults across the U.S. After collection of this data, the contractor will be able to incorporate the information collected and finalize the Tool by the end of the contract period (September 2014). CDC will own the Tool and data collected to refine the Tool; however, all data received and stored by CDC will be de-identified and anonymized.

At present there are several mobility-related assessments actively used throughout the U.S. However, most are designed to collect information from just one particular mobility silo, such as assessments that focus on fall prevention. None of these existing tools cut across mobility silos while focusing on older adults (See Results of Phase 1, **Attachment C**). None create a national picture of older adult safe mobility that captures an individual's physical and emotional health, their social network, or the ease of mobility in their home, transportation, their neighborhood, their city, and beyond. None provide the comprehensive data needed to gain an understanding of the overall safe mobility situation of older adults in the nation as a whole. And no existing older

adult tools are both mobility holistic and empowerment driven self-administered assessments. The data collected in this project will allow CDC to finalize a Tool that will address gaps in what is currently available and help older adults both assess and improve their complete mobility.

The first priority of the Older Adult Safe Mobility Assessment Tool is helping older adults understand and improve their complete mobility situation. In designing a Tool that can be used by older adults nationwide to make mobility improvements, we can make a significant public health impact. The financial costs of preventable injuries that improved safe mobility could mitigate are staggering and well documented by NCIPC (CDC, 2012; Naumann et al., 2010; Stevens et al., 2006). In addition, providing a complete and holistic Older Adult Safe Mobility Assessment Tool that includes measures that have traditionally been included in separate, individual assessments eliminates redundant costs while delivering a better overall product.

Privacy Impact Assessment Information

i. A description of how the information will be shared and for what purpose

The information collected under the proposed data collection will be used to conduct tool refinement, as well as feasibility and accessibility analysis activities. The information will be used to measure the feasibility and audience acceptability of the Older Adult Safe Mobility Assessment Tool. The information collected will allow us to create a final version of the Tool that can be used by older adults across the U.S. All information will be stored on password-protected computers and handled by only those researchers involved in the Tool development. Additionally, no sensitive information will be collected; therefore, we expect little or no effect on respondents' privacy.

SeBS will use individually identifiable information to contact older adult respondents for the interviews, focus groups, and telephone surveys; however, as indicated above, this information will not be stored with the responses received. All stored data will be de-identified and anonymized (i.e., there will be no way to link it back to the respondent).

ii. A statement detailing the impact the proposed collection will have on the respondent's privacy

The information will be collected to refine and improve the Older Adult Safe Mobility Assessment Tool, as well as to conduct feasibility and audience acceptability analysis of the Tool. The key informant interviews, focus groups, intercepts and telephone survey data collection will allow us to gain information about the feasibility and usefulness of the Older Adult Safe Mobility Tool; about what impacts the Tool may have on older adults (e.g., motivation to change/behavior intent, and changes in knowledge, attitude, and awareness); about which mobility domains are most valuable to include in the Tool (e.g., which are of greatest interest and can be improved by older adults), and about what other areas of the Tool could be refined and improved. This information will allow us to create the most useful Tool possible for U.S. older adults.

A.3. Use of Information Technology and Burden Reduction

Key informant interviews and the quantitative survey will be conducted by telephone. As telephone survey participants are recruited, they may elect to receive draft Tool materials (prior to the survey) either by mail or electronically via email. In addition, focus group participants may receive communications (confirmation and reminder notices) via email or mail as they prefer.

Email communication will be used with key informant, focus group and telephone survey respondents, however each will be given the option of mail rather than email as their preferred communication method. Email will be provided not only as a courtesy to respondents, for those respondents that prefer email rather than mail, but also, it will allow more open and swift communication between SeBS and the study participants.

Recruitment/screening for the focus groups and telephone surveys, as well as administration of the telephone surveys will use Computer Assisted Telephone Interview (CATI) systems for data collection, which are designed to reduce the burden to respondents. Data will be entered manually during the phone conversation. Other than the CATI system, no information will be collected using electronic techniques. Further, SeBS will design interview, focus group, intercept and survey questions so that only the minimum information necessary for the purposes of the project is collected.

In order to collect a depth of thoughts, reactions and opinions, the qualitative information collection efforts need to be conducted person-to-person either by phone (key informant interviews) or face-to-face (focus groups and intercepts) rather than with electronic or other technology. The key informant interviews, focus groups and intercepts will use primarily pre-identified questions, however, some follow-up and clarification questions may be asked through the discussions and interactions. Electronic questionnaires would not be appropriate methods for this qualitative data collection, as they would not allow us to gather the type of information needed.

Quantitative telephone survey participants will be asked pre-identified questions related to the draft Assessment Tool they receive at least 24 hours prior to the pre-scheduled call. This draft Tool will be sent to participants by U.S. mail or via email communication. Because the target population for this study is adults age 60 and older, using only electronic means to provide the draft Tool to participants or to conduct the survey is not feasible and has a greater biasing potential. Although many older adults regularly use computers, this technology is neither readily available nor common practice for a number of older adults. Further, for some older adults, it may be difficult or burdensome to complete a survey online, and could narrow and bias the study population, if computer access and ability were required.

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

Phase 1 of this project was conducted in 2010-2011. The main purpose of this Phase was to:

1. conduct an environmental scan to identify best practices and tools and
2. insure CDC's effort in this arena is complementary and non-duplicative of existing efforts

An environmental scan, subject matter expert interviews, and an expert panel were conducted to ensure that this effort would not duplicate any other efforts (See Attachment C: Phase I Report for more information). . The results concluded that there was a gap in the field for this type of Tool and that nothing similar had already been developed. While there are numerous mobility assessments actively used throughout the U.S., most are designed to collect information from only one particular mobility silo, such as assessments that focus on falls prevention. In addition, most mobility tools are designed to be administered by trained service providers or academicians. None of these existing tools cut across mobility silos while focusing on older adults nor are they designed to be self-administered or intended to provide actionable feedback. This Tool is unique and nothing else like it exists. New information must be collected to refine, test, and improve this Tool before widespread release.

A.5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this data collection.

A.6. Consequences of Collecting the Information Less Frequently

The present study will provide the primary data needed to test audience acceptability, validate, and refine the Older Adult Safe Mobility Assessment Tool. Less frequent data collection would not allow us to improve and test the Tool before it is distributed for widespread use, so we would not know whether the Tool is appropriate or useful for older adults. Respondents will provide data one time only.

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

This request fully complies with the regulation 5 CFR 1320.5.

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

A.8.A. A 60-day notice to solicit public comments was published in the Federal Register (volume 78, No. 74, pages 22884-22886) on April 17, 2013. Attachment B.1 contains a copy of the notice. There were two comments in response to the Federal Register Notice (**Attachment B.2**).

The first comment stated that this research is not necessary because:

1. this is not a priority for the CDC as they are supposed to come up with cures for disease,
2. this information is already available, and
3. the states are handling it.

The second comment was that the study was too expensive and intrusive.

CDC's mission is to collaborate to create the expertise, information, and tools that people and communities need to protect their health – through health promotion, prevention of disease, injury and disability, and preparedness for new health threats. CDC seeks to accomplish its mission by working with partners to monitor health, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, and foster safe and healthful environments. As one-fifth of our nation will soon be older adults, it is important to ensure that this group can protect and maintain their health and mobility as they age. The information needed to develop the safe mobility assessment tool is not already available, as shown in our findings from Phase I of this project which included environmental scans, subject matter expert interviews, and expert panel feedback. Additionally, recent research has indicated that communities rate transportation as their second leading challenge in meeting the needs of their older adult population and that they need help in handling this challenge (National Association for Area Agencies on Aging, 2011). The study requires a small amount of time from subjects, and identified information will only be available to study investigators. Any information presented will be aggregated so that no single individual can be identified. Efforts have been made to minimize the expense of this study, and it is comparable in expense to similar studies.

A.8.B. One of the primary activities of Phase 1 of this project (previously completed in a contract from 2010-2011) was to create and convene an expert panel to establish scientific and implementation parameters for the Older Adult Safe Mobility Assessment Tool. Expert panelists were consulted on multiple occasions between 2010 and 2011, followed by two rounds of small group conference calls and a final debrief call. All of these consultations took place during 2010 and 2011. The input of the expert panelists was critical to shaping the Tool development. The following people made up our expert panel and provided significant input to this project:

Name	Title	Organization	Telephone Number	E-mail Address
Lynda A. Anderson	Director	Healthy Aging Program, Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, CDC	(770) 488-5998	LAnderson4@cdc.gov
Chris Kochtitzky	Associate Director for Policy Planning and Evaluation	Division of Emergency and Environmental Health Services, CDC Office of the Director	(770) 488-0545	CKochtitzky@cdc.gov
Gloria Krahn	Director	Division of Human Development and Disability, National Center on Birth Defects and Developmental Disabilities, CDC	(770) 498-6160	GKrahn@cdc.gov
Dee Merriam	Community Planner	Division of Emergency and Environmental Health Services, National Center for Environmental	(770) 488-3981	DMerriam@cdc.gov

		Health, CDC		
Katie Sobush	Transportation Planner	Buildings and Facilities Office, CDC	(404) 639-0161	KSobush@cdc.gov
Basia Belza	Lead & Professor	Lead of Coordinating Center, CDC-Healthy Aging Research Network; Aljoya Endowed Professor in Aging, University of Washington	(206) 685-2266	basiab@u.washington.edu
Doug Farquhar	Program Director	Environmental Health, National Conference of State Legislatures	(303) 856-1397	doug.farquhar@ncsl.org
Elinor Ginzler	(Formerly) Senior Vice President	Livable Communities Strategies, Office of Social Impact, AARP	(301) 255-4242	
Kimberley Hodgson	Manager	Planning and Community Health Research Center, American Planning Association	(202) 872-0611	hodgson.kimberley@gmail.com
Kathryn Lawler	Program Director	Aging Atlanta, Atlanta Regional Commission	(404) 463-3224	klawler@atlantaregional.com
Mary Leary	Senior Director	Easter Seals Project ACTION, National Center on Senior Transportation & Other Transportation Initiatives	(800) 659-6428	mleary@easterseals.com
Barbara McCann	Executive Director	National Complete Streets Coalition	(202) 234-2745	barbara@bmccann.net
Sandra Rosenbloom	Professor of Planning	Adjunct Professor of Civil Engineering, University of Arizona	(520) 626-2821	rosenblo@u.arizona.edu
Jim Rimmer	Professor & Director	Professor, Department of Disability and Human Development, Director, Center on Health Promotion Research for Persons with Disabilities; Director, National Center on Physical Activity and Disability, University of Illinois at Chicago	(312) 413-9651	jrimmer@uic.edu
Jon Sanford	Director & Associate Professor	Director of Center for Assistive Technology and Environmental Access; Associate Professor of Architecture, Georgia Tech	(404) 894-1413	jon.sanford@coa.gatech.edu
Bill Satariano	Professor	Epidemiology and Community Health, School of Public Health, UC Berkeley	(510) 642-6641	bills@berkeley.edu

In this current phase of work (Phase 2), expert panelists will be reconvened individually to share older adult and mobility-related insights on the cities where qualitative data will be collected. In group form, expert panelists will be consulted in further development of the draft Tool and leading to next steps of the project.

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

It is standard practice to provide remuneration to respondents in order to maximize response rates. We have worked on numerous projects with populations similar to that in the proposed research, for which financial incentives were necessary to obtain the desired number of respondents. These include studies conducted with AARP on physical activity and other health behaviors (proprietary report), CMS /HCFA on health plan choices (Fyock, 2001), and currently the ACA's Health Insurance Exchanges (in progress).

Focus group, intercept, stakeholders, and telephone survey respondents will receive a cash or check gift, a gift card or a nonprofit donation in their name (e.g., United Way) as a show of gratitude for their involvement.. Payment for each method is estimated as follows:

- Focus group participant = $75 for 1.5-2 hours in-person involvement and $50 for travel expenses and time
- Intercept participant = $10 gift card or nonprofit donation for 30 minutes in-person
- Stakeholders= $15 for telephone interview (30 minutes)
- Survey participant = $45 for review of stimulus materials (15 minutes) and telephone interview (~12 minutes)

The amount of $125 for the focus groups is higher than usual; however, focus groups will be conducted in Chicago, IL and San Diego, CA. Both cities have a cost of living that is higher than the average.

A.10. Assurance of Confidentiality Provided to Respondents.

This submission has been reviewed by staff in CDC's Information Collection Review Office who determined that the Privacy Act does not apply. In order to recruit individuals for the key informant interviews, focus groups and telephone surveys, their names, phone number, and mail and email addresses may be obtained by SeBS. However, no personally identifiable information will be collected during the interviews, and names, phone numbers, and addresses will not be stored with the data collected. Data that is stored will be de-identified and anonymized (i.e., there will be no way to link it back to the respondent). CDC ultimately owns all data collected and the data received by CDC will not include personally identifiable information and will be anonymized. Additionally, all respondents will be assured that the information they provide will be treated in a secure manner and will be used only for the purpose of this evaluation and validation study.

IRB Approval

This data collection and project has obtained local IRB Approval (**Attachment M**).

Privacy Impact Assessment Information

A. This project is not subject to the Privacy Act.

B. Data that are collected will be stored on password-protected computers. Hard copies of the data collected will be locked in a file cabinet with a locking mechanism and in an office with a locked door. The contractor and subcontractor will not store any personally identifiable information in databases and will only email de-identified datasets. Personally identifiable information for each respondent along with an identification number will be in a password protected file on a password protected hard drive. The data with the identification number but no personally identifiable information will be in a different password protected file on a password protected hard drive. Paper copies of each dataset will be stored in separate locked cabinets. CDC will receive de-identified data only and will never be able to link the participants' data to their identity.

C. Key informants and older adults will be informed about the intended use of the information and assured that the information they provide will be treated in a secure manner and will be used only for the purposes of this evaluation study. Key informants will be given an informed consent form and/or asked to provide verbal consent. They will be told about the purpose and procedures of the study, be notified of any risks or benefits, assured of the data confidentiality, told who to contact if they have questions about the research, and told that their participation is voluntary and they can withdraw or refuse to answer questions at any time (**Attachment D**).

D. Respondents will be assured that participation in the focus groups, intercepts and telephone surveys is voluntary and that data will be treated in a secure manner. Older adult respondents will be given an informed consent form and/or asked to provide verbal consent. They will be told about the purpose and procedures of the study, be notified of any risks or benefits, assured that the information they provide will not be shared with anyone outside of the study investigators, told who to contact if they have questions about the research, and told that their participation is voluntary and they can withdraw or refuse to answer questions at any time (**Attachments E, F, & G**).

A.11. Justification for Sensitive Questions

No sensitive questions are to be asked in the interviews, focus groups, intercepts, or telephone survey.

A.12. Estimates of Annualized Burden Hours and Costs

A.12.A. Burden

Table A-12 details the annualized number of respondents, the average response burden per interview, and the total response burden for the interviews, focus groups, intercepts and telephone survey. CDC anticipates that data collection will begin in December 2013 and that all data collection will be completed by July 2014. CDC estimates the following burden for one-time respondents: key informant interviews (**Attachment D**) will be administered to 6 individuals and will take approximately 30 minutes to complete for a total burden of 3 hours, focus groups will be conducted for 14 older adults requiring up to 15 minutes per participant to review the consent form and screener and 120 minutes (**Attachments E & H, respectively**) to

participate in the focus group for a total burden of 32 hours, intercept interviews will be administered to 40 older adults requiring up to 15 minutes to review the consent and screener form and 30 minutes (**Attachments F & I, respectively**) to participate in the interview for a total burden of 30 hours, and the telephone survey will survey 1000 older adults involving an on-your-own review of materials (approximately 15 minutes) and a pre-scheduled telephone survey (approximately 27 minutes) (**Attachments G & J, respectively**) for a total burden of 700 hours.
Key informant interviews and the quantitative survey will be conducted by telephone. As telephone survey participants are recruited, they may elect to receive stimulus material (i.e., a draft version of the Tool) prior to the survey either by mail or electronically via email, whichever they prefer. In addition, focus group participants may receive communications (confirmation and reminder notices) via email or mail. Email communication will be used with key informant, focus group and telephone survey respondents, however each will be given the option of mail rather than email as their preferred communication method. Email will be provided not only as a courtesy to respondents, for those respondents that prefer email rather than mail, but also, it will allow more open and swift communication between CDC and the study participants. Additionally, recruitment/screening for the focus groups and telephone surveys, as well as administration of the telephone surveys will use Computer Assisted Telephone Interview (CATI) systems for data collection, which are designed to reduce the burden to respondents.
There are no costs to respondents other than their time. The total estimated annual burden hours are 765.

Table A.12.A. Estimate Annualized Burden Hours

Type of Respondent	**Form Name**	**No. of Respondents**	**No. of Responses per Respondent**	**Average Burden per Response Burden (hours)**	**Total Burden Hours**
Key informant interview respondents	Interview guide (**Attachment D**)	6	1	30/60	3
Focus group respondents	Focus Group Consent and Screener **(Attachment E)**	14	1	15/60	4

Intercept respondents	Intercept Consent and Screener **(Attachment F)**	40	1	15/60	10
Telephone survey respondents	Telephone Survey Consent **(Attachment G)**	1000	1	15/60	250
Focus group respondents	Moderator guide (**Attachment H**)	14	1	2	28
Intercept respondents	Intercept interview guide (**Attachment I**)	40	1	30/60	20
Telephone survey respondents	Survey (**Attachment J**)	1,000	1	27/60	450
Total					765

A.12.B. Estimated Annualized Burden Costs

The hourly wage used to calculate the key informant interview respondent costs was $28.00, which is the current average wage of those in "professional services," according to the Bureau of Labor Statistics (BLS, 2012). The hourly wage used to calculate the Respondent Cost is $7.25, which is the minimum wage under the Fair Labor Standards Act (FLSA). Total Respondent Cost for this evaluation is $5,608.50.

Type of Respondent	**Form Name**	**No. of Respondents**	**No. of Responses per Respondent**	**Average Burden per Response Burden (hours)**	**Total Burden Hours**	**Hourly Wage Cost**	**Respondent Cost**
Key informant interview respondents	Interview guide **(Attachment D)**	6	1	30/60	3	$28.00	$84.00
Focus group respondents	Focus Group Consent and Screener **(Attachment E)**	14	1	15/60	4	$7.25	$29,00
Intercept responsents	Intercept Consent and Screener **(Attachment**	40	1	15/60	10	$7.25	$72.50

	F)						
Telephone survey respondents	Telephone Survey Consent **(Attachment G)**	1000	1	15/60	250	$7.25	$1812.50
Focus group respondents	Moderator guide (**Attachment H**)	14	1	2	28	$7.25	$203.00
Intercept respondents	Intercept interview guide (**Attachment I**)	40	1	30/60	20	$7.25	$145.00
Telephone survey	Survey (**Attachment**						

respondents	**J**)	1,000	1	27/60	450	$7.25	$3262.50
	Total				765		$5,608.50

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

Respondents will incur no capital or maintenance costs.

A.14. Estimates of Annualized Cost to the Federal Government.

Two types of government costs will be incurred: (1) government personnel, and (2) contracted data collection.

- NCIPC has assigned a Project Officer and Science Officer to assist with and oversee this data collection. Each of these personnel is assigned for 10 percent time for the duration of the contract. Based on combined annual salary of about $137,000, this equates to $13,700 for each year for cost of government personnel ($137,000 for 2 employees at 10% effort = $13,700).

- The anticipated SeBS contracted data collection budget for the Older Adult Safe Mobility Assessment Tool is $125,000 for 1 year.

The average annualized direct costs for this project are $138,700 for 1 year. This averaged amount includes all costs for the contracted data collection, plus the personnel costs of federal employees involved in oversight and analysis.

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.A. Tabulation and Analysis Plan

Data analysis will focus primarily on analyzing the data collected during Tool refinement and evaluation. Data analysis for the study will involve descriptive analyses of qualitative information to examine thoughts and perceptions of the draft Tool feasibility and usefulness to participants with varied mobility and socio-demographic characteristics. Quantitative analysis of the telephone survey will include examining the correlations between specific mobility and socio-demographic characteristics with perceived knowledge gain, attitude change, and behavior change intent related to completing the draft Older Adult Safe Mobility Assessment Tool. Multivariable analysis and modeling may be used to further disentangle the associations between mobility characteristics, accounting for potentially confounding variables.

A.16.B. Publications

The results of the analysis will be reported in a Final Report by SeBS, including a brief executive summary written in clear language. The report will include details on what was done during the study, the methods used, major results, final Tool, and recommendations for next steps. The

results of the study also will be used to develop peer-reviewed journal articles for publication in journals, such as *American Journal of Public Health, Journal of Safety Research,* or *Journal of the American Geriatric Society*; conference presentations and/or posters; and Web-based informational summaries to be disseminated to other researchers and the public.

Table A.16-1. Time Schedule

Activity	**Time schedule**
• Recruitment of qualitative study participants	1 month after OMB approval
• Qualitative data collection (interviews, focus groups and intercepts)	2-3 months after OMB approval
• Refinement of the Tool	3-4 months after OMB approval
• Recruitment of quantitative study participants	4-5 months after OMB approval
• Quantitative data collection (telephone survey)	5-6 months after OMB approval
• Data cleaning and analysis	6-7 months after OMB approval
• Report writing	8-12 months after OMB approval

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

The display of the OMB expiration date is not inappropriate

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

There are no exceptions to the certification.

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