

Institutional Awareness and Commitment to Ensuring Safe, Stable, and Nurturing Relationships
and Environments for Children

SUPPORTING STATEMENT
INFORMATION COLLECTION REQUEST

Part A

Supported by:

Department of Health and Human Services (DHHS)
Centers for Disease Control and Prevention (CDC)
National Center for Injury Prevention and Control (NCIPC)
Division of Violence Prevention (DVP)

Project Officer: Renee Wright
Phone #: 770-488-1146
Email: rid2@cdc.gov
Fax #: 770-488-4222

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A. Justification

1. Circumstances Making the Collection of Information Necessary

Background

This is a new Information Collection Request (ICR). Approval is requested for two years.

Child maltreatment (CM) is a significant public health problem affecting physical and emotional health throughout the lifespan. Children who experience intensive and prolonged stress (such as CM) especially in early life, are at increased risk for disrupted early brain development, compromised functioning of the nervous and immune systems as well as health problems in later life including mental health problems (e.g., depression, anxiety), risky health behavior (e.g., smoking and other substance use, eating disorders), chronic diseases (e.g., heart disease), subsequent violence perpetration or victimization during adolescence or adulthood, and early death.

Safety, stability, and nurturing are three essential qualities of children's relationships with caregivers and for a broader environment that supports healthy child development. Safe, stable and nurturing relationships and environments set children on a positive trajectory for optimal child development and health, provide a buffer against the effects of adverse child experiences, and are fundamental to healthy brain development. They also shape the development of children's physical, emotional, social, behavioral, and intellectual capacities, which ultimately affects their health as adults. As a result, promoting safe, stable, nurturing relationships and environments can have a positive impact on a broad range of health problems and on the development of skills that will help children reach their full potential.

Although the CM prevention and positive child development fields have hundreds of preventive interventions, few are evidence based, and the majority focus on changing individual behavior rather than the broader context in which CM occurs. Individual or family approaches do not take into account that CM and safe, stable, nurturing relationships and environments emerge from and are sustained or constrained by the social contexts. In turn, the social context is shaped by a wider set of forces (e.g., culture, economics, social policies, and politics). Thus, there is reason to believe that community and societal-level strategies (e.g., policies, changing broad social norms, and increasing support for evidence-based interventions) may increase safe, stable, nurturing relationships and environments and decrease CM.

However, coordinated action by multiple sectors is important to develop, implement, and evaluate evidence-based, comprehensive CM prevention approaches. Sectors with the potential to support safe, stable, nurturing relationships and environments include, but are not limited to, public health, social services, health services, business, community organizations, the media, education, labor, urban planning, housing, transit, and faith-based and youth-serving organizations.

The Division of Violence Prevention at the National Center for Injury Prevention and Control recently published guidance for communities on what they can do to prevent CM and ensure safe, stable, nurturing relationships and environments (*Essentials for Childhood: Steps to Create Safe, Stable, and Nurturing Relationships*; EfC; <http://www.cdc.gov/violenceprevention/childmaltreatment/essentials/>) and has funded 5 state health departments in FY14 to: 1) coordinate and manage existing and new partnerships with other sectors to promote safe, stable, nurturing relationships and environments for children; 2) work with partners to identify strategies across sectors that promote safe, stable, nurturing relationships and environments; 3) coordinate, monitor, and report on the strategies implemented by multi-sector partners; 4) coordinate improvement processes (e.g., continuous quality improvement) for multi-sector partners to refine strategies that support safe, stable, nurturing relationships and environments; and 5) establish state-level impact of these efforts. Among the impacts expected is an increase in partners' awareness and commitment to ensuring safe, stable, and nurturing relationships and environments for children and preventing CM.

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 perform other public health activities, including this type of study.

1.1 Privacy Impact Assessment

This information collection is one piece of a larger evaluation plan that includes details on what and how strategies are implemented (process evaluation), collection of existing data to track yearly child maltreatment reports and indicators of determinants of child maltreatment and its inequitable distribution, and baseline and post-intervention changes in public awareness, commitment, and norms.

The information to be collected in this ICR includes organizations' (not individuals') awareness of the magnitude and consequences of child maltreatment, and the importance of ensuring safe, stable, nurturing relationships and environments for healthy child development; use of data to inform action; implementation of strategies that support safe, stable, nurturing relationships and environments in their state and among their own staff; and existing partnerships. For example, the survey asks what percent of the staff in their agency/organization would know facts related to the prevalence, cost, and health consequences of child maltreatment or if their agency would agree or disagree with statements about the role of genes versus relationships and environments in healthy child development. The answers to these questions will be collected using SurveyMonkey^R (an electronic web-based interface for designing, administering, and collecting information through surveys; www.surveymonkey.com).

In this program (FOA CE13-1303), the funded state health departments have been asked to partner with other sectors to form a steering committee. This ICR will collect the information described above from the state health department and their steering committee partners (10 partner organizations) in each of the 5 states once (at the start of the funding cycle). CDC will send an e-mail with the link to the survey to each health department and will ask that the health department forward the link to each of their partners (see appendix E). In this e-mail, we ask that respondents bring in others from their agency to answer the questions collectively (as a group). If a respondent answers the survey alone, they are asked to try to answer the questions from their agency's perspective.

Privacy protections: SurveyMonkey complies with the Safe Harbor and European Union Data Protection Requirements developed by the U.S. Department of Commerce regarding the collection, use, and retention of personal information from European Union member countries and Switzerland. Survey Monkey has also been awarded TRUSTe's Privacy Seal signifying that they have verified SurveyMonkey's adherence to Safe Harbor and that their privacy policy and practices have been reviewed by TRUSTe, an independent third party. SurveyMonkey is also protected by Norton (formerly VeriSign) and McAfee.

Data will be maintained for five years after which all raw data will be deleted by CDC.

No individually identifiable information will be collected.

2. Purpose and Use of Information Collection

The purpose of this ICR is to collect information that will establish state health departments' and their partners' baseline-level of awareness and commitment to ensuring safe, stable, and nurturing relationships and environments for children and preventing CM. This information will be collected once by grantees from each partner they engage in their steering committee at the start of the funding period. It will be used by state health departments and CDC to develop training and technical assistance sessions to increase levels of awareness and commitment among partners engaged in this initiative. CDC will also use this information, along with other sources, to determine whether this funding announcement was successful in achieving its goals. Without this standardized data collection at baseline to compare progress to, our judgment of the success of this funding announcement would not be sufficiently objective.

2.1 Privacy Impact Assessment

The site-specific information will be sent to each health department via email and in aggregate format. This information will inform each health department of where they and their partners are

at the start of the funding cycle. The aggregate data will identify each health department's awareness and commitment to the project. This information will allow CDC and the health departments to plan activities to raise awareness and commitment as needed.

The information collected will have no impact on the respondents' privacy because no individually identifiable information will be collected.

3. Use of Information Technology and Burden Reduction

One-hundred percent of the information collected in this ICR will be collected through a web-based standardized survey formatted in Survey-Monkey. Using computerized technology to collect this information will substantially reduce the burden of administering the survey and tabulating the results. It will also reduce respondent burden because computerized surveys can be programmed to include skip patterns and so the respondent only sees the questions he/she needs to answer. The quality of the information collected is also improved because the computerized survey automatically checks for responses out of range or missing.

Screen shots of the entire survey are in Attachment C.

4. Efforts to Identify Duplication and Use of Similar Information

With the goal of identifying current data collections of similar information as well as conceptualizations of our construct of "institutional commitment" and potential measures, we conducted a literature search for the period 2008 to current of MEDLINE (included up to week 1 of April 2013), PsycINFO (include up to week 2 of April 2013), and Health and Psychosocial Instrument (included up to January 2013) to identify existing measures or assessments of "institutional commitment" using the following search strategy:

(institution adj (commit* or support) and (child* or family or parent)). We excluded dissertations, books or book chapters and review articles. Of the 82 unduplicated citations identified, we retrieved 9 for full review (open-ended questions). Although these publications were useful in refining our conceptualization of "institutional commitment", none were related to a commitment to promoting safe, stable, and nurturing relationships and environments for children or preventing child maltreatment.

5. Impact on Small Business or other Small Entities.

No small businesses will be involved in this data collection.

6. Consequences of Collecting Information Less Frequently.

This ICR is for a one time data collection. Respondents will respond to this data collection once. There are no legal obstacles to reduce the burden. A major consequence of not conducting this data collection would be the lack of an objective measure of success of the funding effort.

7. Special Circumstances Relating to the Guidelines of 5CFR 13205

This request fully complies with the regulation 5 CFR 1320.5.

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

A 60-day notice to solicit public comments was published in the Federal Registrar (volume 78, No.135, page 42075) on July 15, 2013 (Attachment B). Two public comments were received.

On June 14, 2013, we e-mailed the following members of the Federal Interagency Child Abuse and Neglect Workgroup's Prevention Subcommittee whether they knew of any efforts to collect information from state health departments and their partners on their agency's awareness and commitment to ensuring safe, stable, nurturing relationships and environments for children and families and preventing child maltreatment:

Melissa Brodowski, Office on Child Abuse and Neglect, ACF (Email: melissa.brodowski@acf.hhs.gov)

Rosie Gomez, ACF (e-mail: Rosie.Gomez@ACF.hhs.gov)

Lauren Supplee, ACF (e-mail: Lauren.Supplee@ACF.hhs.gov)

Catherine Luby, ACF (e-mail: catherine.luby@acf.hhs.gov)

Bocella, Irene ACF (e-mail: irene.bocella@acf.hhs.gov)

Cathy Overbagh, ACF (e-mail: cathy.overbagh@acf.hhs.gov)

Carmen Bovell, ACF (e-mail: carmen.bovell@acf.hhs.gov)

Elaine Stedt, ACF (e-mail: elaine.stedt@acf.hhs.gov)

Catherine Nolan, ACF (e-mail: catherine.nolan@acf.hhs.gov)

Julie Lee, ACF (e-mail: julie.lee@acf.hhs.gov)

Dena Green, HRSA (e-mail: DGreen@hrsa.gov)

Gail Ritchie, SAMHSA/CMHS (e-mail: Gail.Ritchie@samhsa.hhs.gov)

David DeVourney, SAMHSA (e-mail: David.DeVoursney@SAMHSA.hhs.gov)

Larke Huang, SAMHSA/OA (e-mail: Larke.Huang@SAMHSA.hhs.gov)

Phyllis Stubbs, HRSA (e-mail: PStubbs@hrsa.gov)

Stephanie Bryn, HRSA (e-mail: SBryn@hrsa.gov)

Joseph Zogby, HRSA (e-mail: JZogby@hrsa.gov)

Isadora Hare, HRSA (e-mail: IHare@hrsa.gov)

Amy Madigan, HHS/ASPE (e-mail: Amy.Madigan@hhs.gov)

Jerry Silverman, HHS/ASPE (e-mail: Jerry.Silverman@HHS.GOV)

Dawn Ellis, DOE (e-mail: dawn.ellis@ed.gov)

Julia Martin Eile, DOE (e-mail: Julia.Martin.Eile@ed.gov)

David Lloyd, OSD (e-mail: david.lloyd@osd.mil)

Brian Ross, OSD (e-mail: brian.ross@osd.mil)

Gerry Carlon, OSD (e-mail: gerry.carlon@osd.mil)

Mary Campise, CIV OSD PR (e-mail: Mary.Campise@osd.mil)
Brent Elrod, (e-mail: belrod@csrees.usda.gov)
Caroline Crocoll (e-mail: ccrocoll@csrees.usda.gov)
Kristen Kracke (e-mail: kristen.kracke@usdoj.gov)

We received a suggestion to contact Jim Scanlon, HHS, ASPE and e-mailed him on June 25, 2013. No response was ever received.

9. Explanation of Any Payments or Gifts to Respondents.

No incentives or gifts will be offered to respondents.

10. Assurance of Confidentiality Provided to Respondents.

This ICR will only collect data pertaining to organizations. We will not request information that would identify the person(s) responding on behalf of the organization (Attachment G).

IRB Approval

CDC/NCIPC Associate Director of Science has classified this data collection as Not Involving Human Subjects or Research because the information collected will be used for program evaluation (Attachment F).

10.1 Privacy Impact Assessment Information

Individuals will be informed that:

1. Completion of this survey is voluntary; they can stop answering the survey at any time;
2. By responding to the survey they are consenting to this information being shared with their state health department and the project evaluator;
3. Information collected will be maintained in a secure manner by use of Survey Monkey's secure website.
4. No system of record will be created under the Privacy Act.

No individually identifiable information is being collected.

11. Justification for Sensitive Questions.

No questions of a sensitive or private nature are included in this survey, such as criminal behavior, sexual behavior and attitudes, alcohol or drug use, religious beliefs, and other matters that are commonly considered private. Lack of institutional commitment to children and families could result in a competitive disadvantage to an organization.

12. Estimates of Annualized Burden Hours, and Costs.

State health departments will choose which agencies they will partner with.

A. Table A-12 details the annualized number of respondents, the average response burden per survey, and the total response burden for the survey. Estimates of burden for the survey are based on the pilot test with three staff and three outside managers from different sectors who have had experience in a state-level government agency or community organization. On average, it required 28 minutes for respondents to complete the survey.

With five health departments, each with 10 partner organizations and 3 staff at each organization responding, the total number of respondents for this project is 165 (83 respondents per year). Total project burden over the two years of data collection is 78 hours (39 hours per year).

Table A.12- Estimate of Annual Burden Hours.

Estimated Annualized Burden Hours

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Avg. Burden per Response (in hrs.)	Total Burden (in hrs.)
State Health Departments	Institutional awareness and commitment survey	8	1	28/60	4
Partner Organizations	Institutional awareness and commitment survey	75	1	28/60	35
Total					39

B. Estimated Annualized Burden Cost

To estimate cost, we assumed all respondents would be in a management level position at their organization. Based on data from the Bureau of Labor Statistics, the median wage of a manager in 2011 was \$99,500 (or \$47.83 an hour). This hourly wage multiplied by the annualized burden as estimated above results in a total annualized burden cost of \$1865.37.

Type of respondent	Form name	Total Burden hours	Hourly Wage Rate	Total Respondent Cost
State Health Departments	Institutional awareness and commitment survey	4	\$47.83	\$191.32
Partner Organizations	Institutional awareness and commitment survey	35	\$47.83	\$1674.05
			Total	\$1865.37

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

Respondents will incur in no capital or maintenance costs.

14. Annualized Costs to the Federal Government

The Division of Violence Prevention has assigned a Science Officer to assist with and oversee this data collection and analysis of the data. This Science Officer is assigned for 5% of her time

for the 2 years of data collection. Based on a yearly salary of \$111,148, this equates to \$11,115 for this data collection.

15. Explanation for Program Changes

This is a new data collection.

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

Data will be extracted from SurveyMonkey to an Excel spread sheet to obtain simple frequencies of responses to each item by site.

No publications will result from this ICR. The site-specific tabulated data will be shared with each site funded.

Project time schedule:

Activity	Time Schedule
Health department representative asked to respond to survey	Immediately after OMB approval
Health department asks existing partners to respond to survey	Immediately after OMB approval
Health department asks new partners to respond to survey	1 -24 months after OMB approval
Analyses	12, 24, 36 months after OMB approval
Dissemination to sites	12, 24, 36 months after OMB approval

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

The display of the OMB expiration date is not inappropriate.

18. Exemptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.