School Health "Water Toolkit": Assessing Awareness, Satisfaction, and Utility

OSTLTS Generic Information Collection Request
OMB No. 0920-0879

Supporting Statement – Section A

Submitted: 8/11/14

Program Official/Project Officer
Sarah Sliwa
School Health Branch/Division of Population Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention
4770 Buford Hwy, NE, MS E-70, Atlanta, GA 30341
Cubicle 6221.4, mailstop F78
Phone: 770-488-0946
Fax: 404-488-5771
ssliwa@cdc.gov

Section A – Justification

1. Circumstances Making the Collection of Information Necessary

Background

This information collection is being conducted using the Generic Information Collection mechanism of the OSTLTS OMB Clearance Center (O2C2) – OMB No. 0920-0879. The respondent universe for this information collection aligns with that of the O2C2. Data will be collected from 85 State Department of Public Health and 6 State Department of Education staff acting in their official capacities to implement strategies to support healthier school nutrition environments, which encompasses all 50 states and the District of Columbia. These staff are State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health/1305 ("1305/State Public Health Actions") grantees funded by the Centers for Disease Control and Prevention (CDC).

The universe includes state health officers, public health information officers, school health coordinators, directors in chronic prevention sections of state health departments, as well as school health coordinators and similar positions based in state health and education departments. Implementing strategies to support physical activity, nutrition, and coordinated management of chronic conditions in school settings are the responsibilities of both the health department and public school staff. Staffing configurations vary among the 1305/State Public Health Actions grantees such that in some states, the primary contact for the implementation of school-based strategies is based in the health department and in others the main contact is in the Department of Education or Public Instruction. In order to reliably reach those leading the implementation of activities to improve students' access to drinking water, the respondent universe includes personnel from both settings.

This information collection is authorized by Section 301 of the Public Health Service Act (42 U.S.C. 241). This information collection falls under the essential public health services of 1) evaluating effectiveness, accessibility, and quality of personal and population-based health services, and 2) informing, educating, and empowering people about health issues.[1]

Ensuring that students have access to safe, free drinking water throughout the school environment advances several public health objectives. It provides a healthy alternative to sugar-sweetened beverages before, during, and after school. Access to safe, free drinking water helps to increase students' overall water consumption, maintain hydration, and reduce energy intake, if substituted for sugar-sweetened beverages.[2-4] Further, adequate hydration may improve cognitive function among children and adolescents, which is important for learning.[5-9] Drinking water, if fluoridated, also plays a role in preventing cavities.[10] The Institute of Medicine and the Centers for Disease Control and Prevention

recommend that plain drinking water be available throughout the school day at no cost to students, and if other beverages are available or sold during the school day, they should only include plain water (i.e., no flavoring, additives, or carbonation), fat-free or low-fat milk, and 100% fruit juice in specified portions.[11,12] Similar recommendations are promoted in several voluntary school recognition programs, including the Alliance for a Healthier Generation's Healthy Schools Program and U.S. Department of Agriculture's (USDA) Healthier US School Challenge (HUSSC).[13,14] The American Academy of Pediatrics (AAP) also recommends the following: (a) Children and adolescents should be taught to drink water routinely as an initial beverage of choice as long as daily dietary caloric and other nutrient (e.g., calcium, vitamins) needs are being met; (b) Water is also generally the appropriate first choice for hydration before, during, and after most exercise regimens, and (c) Children should have free access to water, particularly during school hours.[15]

Recognizing the importance of providing students with easy access to clean drinking water, the Healthy, Hunger-Free Kids Act of 2010 requires schools participating in the National School Lunch Program (NSLP) to make free water available to students during meal times in the locations where school meals are served (see **Attachment A—Child Nutrition Reauthorization 2010**). The standards also require schools in the School Breakfast Program (SBP) to make drinking water available when breakfast is served in the cafeteria.[16,17]

Practice-based evidence has identified various barriers that schools and school districts may encounter when working to increase access to free drinking water.[18] Additional guidance may be needed to implement the changes needed to meet or exceed the USDA guidelines. To support schools and teams that work with schools in their efforts to increase the availability and consumption of water in schools, CDC's School Health Branch, in collaboration with the Division of Nutrition Physical Activity and Obesity Prevention and experts from the field, has developed the "Increasing Access to Drinking Water in Schools" toolkit (see **Attachment B—Water Toolkit**).

The toolkit was released in May 2014. This resource outlines critical steps that schools can take to develop and implement a plan to meet federal requirements for drinking water during the meal periods, as well as to make drinking water available and accessible across the school campus. To this end the toolkit includes A School Drinking Water Needs Assessment Checklist and Planning Guide that guides schools through the process of assessing current policies and practices related to water, developing and prioritizing actions to increase access to drinking water, and evaluating changes. Lastly, the toolkit includes key resources for promoting water consumption and making water more available and accessible throughout the school day.

The successful dissemination of this product may help schools identify and adopt strategies to increase the free availability of drinking water throughout the school day. Since water access is a new area for the School Health Branch, we are actively seeking input on the

utility of the toolkit as well as feedback regarding areas for improvement from state health and education department staff.

The School Health Branch has worked to disseminate the toolkit by asking critical partners that work directly with schools and with teams or agencies that work with schools to support healthier school nutrition environments to share an announcement about the toolkit release by sending it to their list-servs, cross-posting on social media, and placing a link on their websites. These include partner non-governmental organizations that work to help support the State Public Health Department grantees working to implement School Health Strategies as part of 1305/State Public Health Actions, such as SHAPE America (Society of Health and Physical Educators) and Action for Healthy Kids. The state health and education department grantees are priority audiences for dissemination activities and end users for the product.

To this end, the purpose of this information collection is to better understand 1) state health and education department grantees' awareness of the toolkit, method of access, and their intentions to use this tool and 2) the extent to which the toolkit met their planning and implementation needs. The timing of the information collections intentionally aligns with the beginning and end of the school year.

Privacy Impact Assessment

Overview of the Information Collection System – The information collection system consists of two web-based questionnaires. The Awareness and Planning Assessment will be administered at the beginning of the school year to assess target state health and education department grantees' awareness of the product and their intentions to use this tool during the 2014-2015 academic calendar (see **Attachment C—Assessment Instrument: Word Version** and **Attachment D—Assessment Instrument: Web version**).

Towards the end of the school year, in late April/May, the Utilization Feedback Tool will be administered to those same respondents in the fall. The Utilization Feedback tool collects respondents' input on their experience using the Water Toolkit and additional information about other resources that would help support efforts to increase students' access to drinking water in schools. (see **Attachment E—Feedback Tool: Word Version** and **Attachment F—Feedback Tool: Web version)**.

The online assessment was programmed using Survey Monkey and was pilot tested by 4 CDC public health professionals. Feedback from this group was used to refine questions as needed, ensure accurate programming and skip patterns, and establish the estimated time required to complete the assessment instrument.

Items of Information to be Collected –
Awareness Assessment and Planning Instrument: The primary goal of this tool is to assess participants' familiarity with the Water Toolkit, the dissemination channels through which they may have heard about the toolkit, and their intentions to implement or disseminate components of the toolkit as part of their work for 1305/State Public Health Actions.
The core content areas of the survey address

- Respondent characteristics (multiple choice questions regarding the respondent's work with local education agencies),
- Dissemination channels through which respondents learn about and share the Water Toolkit (multiple choice and short answer),
- Planned use of the Water Toolkit, preliminary reactions to the Water Toolkit (multiple choice and short answer), and
- Resources and support (multiple choice and narrative).

To this end, the instrument consists of a maximum of 22 questions of various types including dichotomous, multiple response, filter and open-ended questions. To minimize respondent burden, the following steps have been taken

- Filter questions and skip patterns have been utilized wherever possible. For example, individuals who have not heard of the Water Toolkit (Q7) skip to Question 20 about resources.
- The majority of the questions 14/22 are multiple choice.
- Of the 8 narrative response questions, 3 are short-answer and 2 are only seen by respondents who "disagree strongly" to a prior prompt.

Utilization Feedback Tool: This instrument collects feedback from the original respondent universe. This tool will be implemented at the end of the 2014-2015 academic year in order to identify how respondents used the water toolkit, the extent to which they found it helpful, and additional resources or assistance that are needed to advance work in this area.

The data collection tool consists of 23 questions of various types including dichotomous, multiple response, filter and open-ended questions. To reduce respondent burden, the following steps have been taken:

- Filter questions and skip patterns have been utilized wherever possible. For example, individuals who have not read the Water Toolkit (Q7) skip to Question 21 about resources and support.
- The majority of the questions (14 out of 23) offer multiple choice answers.
- Of the 9 narrative response questions, 3 are short-answer and 2 are only seen by respondents who "disagree strongly" to a prior prompt.

Identification of Website(s) and Website Content Directed at Children Under 13 Years of Age – The information collection system involves using a web-based information collection instrument. Respondents will be sent a link directing them to the online instrument only (i.e., not a website). No website content will be directed at children.

2. Purpose and Use of the Information Collection

This information will be collected in two stages, described below.

Phase 1: Awareness Assessment and Planning Instrument (to be conducted September 2014)
The purpose of this phase is to assessing toolkit awareness among state health and education department grantees and intended applications. By collecting information from these priority end users, we will have a better sense of the extent to which our current dissemination channels are reaching this target audience and, from respondents who are familiar with this product, we will learn more about their intentions and plans for using it or rationale for not using it. The timing intentionally coincides with "Back-to-School" and is positioned to inform the School Health Branch's dissemination approach for the 2014-2015 school year.

Phase 2: Utilization Feedback Tool (to be conducted April/May 2015)
The purpose of this phase is to collecting feedback about toolkit utilization and utility. Because the toolkit is a novel product addressing a relatively new topical area for the School Health Branch, staff are eager to learn which components of the action planning process outlined in the "Water Toolkit" are feasible to implement over the course of a school year and the perceived effectiveness of these actions in increasing students' access to drinking water throughout the school day. This data collection, near the end of the school year, will collect feedback specific to toolkit use, usability, and perceived effectiveness from the state health and education department grantees.

As the participants are working to implement school-based strategies through 2017, the feedback generated through this process is well-timed to spur revisions that could still positively influence their efforts to improve students' access to drinking water in schools. By identifying which dissemination channels reached the target audience, data collected from phase 1 will inform future communications approaches for the water toolkit and resources developed for the state health and education department grantees.

Privacy Impact Assessment

No sensitive information is being collected. The proposed data collection will have little or no effect on respondent privacy because respondents are participating in their official capacity as staff in state or territorial health agencies. Information will only be reported in the aggregate. The CDC will not publish or share any identifying information about individual respondents with the CDC or any partner organizations, etc.

3. Use of Improved Information Technology and Burden Reduction

Data will be collected via two web-based questionnaires using Survey Monkey and allowing respondents to complete and submit their responses electronically. This process is compliant with Section 508 of the Rehabilitation Act, therefore meeting Federal Web Accessibility Standards set to ensure that electronic and information technology utilized by Federal agencies are accessible to people with disabilities. This method was chosen to

reduce the overall burden on respondents. The information collection instruments were designed to collect the minimum information necessary for the purposes of this project and skip patterns have been utilized to decrease the burden on participants.

4. Efforts to Identify Duplication and Use of Similar Information

With the exception of information collected regarding web metrics, there are no other efforts to collect information regarding the dissemination and utilization of the Water Toolkit in schools. The ongoing collection of web metrics provides limited information about state health and education department grantees—about how they work with schools, what they plan to do with the Water Toolkit, and whether this product meets their needs.

5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this information collection.

6. Consequences of Collecting the Information Less Frequently

The consequences to the program of not collecting this information under this mechanism and within these timeframes are as follows:

- Inability to assess the usefulness of School Health Branch and its partners' dissemination activities in reaching priority end users
- Inability to make informed and timely revisions to dissemination approaches
- Inability to understand the scope of actions end users intend to take, using the toolkit as a guide, to increase student's access to drinking water in schools
- Inability to assess the feasibility of implementing actions outlined in the toolkit within the course of a school year
- Inability to make informed and timely adjustments to the Water Toolkit or to identify necessary accompanying materials/supports

There are no legal obstacles to reduce the burden.

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

There are no special circumstances with this information collection package. This request fully complies with the regulation 5 CFR 1320.5 and will be voluntary.

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

This information collection is being conducted using the Generic Information Collection mechanism of the OSTLTS OMB Clearance Center (O2C2) – OMB No. 0920-0879. A 60-day Federal Register Notice was published in the Federal Register on October 31, 2013, Vol. 78, No. 211; pp. 653 25-26. No comments were received.

CDC partners with professional (define the STLT acronym) STLT organizations, such as the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the National Association of Local Boards of Health (NALBOH) along with the National Center for Health Statistics (NCHS) to ensure that

the collection requests under individual ICs are not in conflict with collections they have or will have in the field within the same timeframe.

9. Explanation of Any Payment or Gift to Respondents

CDC will not provide payments or gifts to respondents.

10. Assurance of Confidentiality Provided to Respondents

The Privacy Act does not apply to this information collection. STLT governmental staff and / or delegates will be speaking from their official roles and will not be asked, nor will they provide individually identifiable information.

This information collection is not research involving human subjects.

11. Justification for Sensitive Questions

No information will be collected of a personal or sensitive nature.

12. Estimates of Annualized Burden Hours and Costs

The estimate for burden hours is based on pilot tests of the information collection instruments by 4 public health professionals.

Awareness Assessment and Planning Instrument

In the pilot test, the average time to complete the instrument including time for reviewing instructions, gathering needed information and completing the instrument, was approximately 10 minutes. Based on these results, the estimated time range for actual respondents to complete the instrument is 7-12 minutes. For the purposes of estimating burden hours, the upper limit of this range (i.e., 12 minutes) is used.

Utilization Feedback Tool

In the pilot test, the average time to complete the instrument including time for reviewing instructions, gathering needed information and completing the instrument, was approximately 7.5 minutes. Based on these results, the estimated time range for actual respondents to complete the instrument is 5-11 minutes. For the purposes of estimating burden hours, the upper limit of this range (i.e., 11 minutes) is used.

Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) National Compensation Survey estimate for management occupations – medical and health services managers and education managers in state government. (http://www.bls.gov/ncs/ocs/sp/nctb1349.pdf). Based on DOL data, an average hourly wage of $57.11 is estimated for state health department staff and an hourly wage of $42.10 is estimated for department of education staff. Table A-12 shows estimated burden and cost information.

Table A-12: Estimated Annualized Burden Hours and Costs to Respondents

Data Collection Instrument: Form Name	Type of Respondent	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
Awareness and Planning Assessment Instrument	State health agency staff working on school health strategies for 1305/SPHA	85	1	12/60	17	57.11	970.87
Awareness and Planning Assessment Instrument	State department of education staff working on school health strategies for 1305/SPHA	6	1	12/60	1	42.10	42.10
Utilization Feedback Tool	State health agency staff working on school health strategies for 1305/SPHA	85	1	11/60	16	57.11	889.96
Utilization Feedback Tool	State department of education staff working on school health strategies for 1305/SPHA	6	1	11/60	1	42.10	42.10
	TOTALS	**182**	**2**		**35**		**1945.03**

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

There will be no direct costs to the respondents other than their time to participate in each information collection.

14. Annualized Cost to the Government

There are no equipment or overhead costs. The only cost to the federal government would be the salary of CDC employees and fellows supporting the data collection activities and associated tasks.

The primary staff member for this project is a CDC Evaluation Fellow (GS-11) in the School Health Branch, who consulted with the health scientist team lead (GS-14) for the School Health Branch Research Applications and Evaluation Team (RAET). Four RAET team members pilot tested the materials to develop burden estimates and identify additional refinements to the instruments.

The primary staff member will collect the data, code, enter, and prepare the data for analysis; conduct data analysis; and prepare a report, with ongoing consultation from the other team member. Hourly rates of $28.74 for the GS-11 (step 1) fellows, $35.60 for GS-12 (Step 2) fellow, $42.33 for GS-13 (Step 2), $48.41 for GS-14 (step 1), and $53.25 GS-14 (Step 4), were used to estimate staff costs. The estimated cost to the federal government is $6,207.93.

Table A-14: Estimated Annualized Cost to the Federal Government

Staff (FTE)	Average Hours per Collection	Average Hourly Rate	Average Cost
Evaluation Fellow [GS 11]: Instrument development, pilot testing, OMB package preparation, data collection, data coding and entry, quality control, data analysis, report preparation	160	28.74	4598.40
Health Scientist [GS 14]: Instrument development, response frame development, overview of data analysis, report preparation	24	53.25	1278.00
Health Scientist [GS 13]: Instrument development	6	42.33	253.98
Fellow [GS 12]: Pilot testing	0.5	42.33	253.98
Fellow [GS 11]: Pilot testing	0.5	35.60	17.80
Medical Officer [GS 13]: Pilot testing	0.5	42.33	21.17
Health Scientist [GS 14]: Pilot testing	0.5	48.41	24.21
Estimated Total Cost of Information Collection			**6207.93**

15. Explanation for Program Changes or Adjustments

This is a new information collection.

16. Plans for Tabulation and Publication and Project Time Schedule

Data will be exported from Survey Monkey into a Microsoft Excel file. Data will be reviewed for completion and simple descriptive statistics will be run looking at response frequencies. Depending on the response distribution, frequencies may be cross-tabulated to identify response similarities and differences among respondents who work for the Department of

Public Health as compared to those based in the Department of Education. These findings will be transferable to the response pool and not the total population of professionals working in state health and education departments to advance school health strategies.

Following data analysis, key findings will be shared with several audiences:

1) School Health Branch staff , and internal and external collaborators involved with the development of the Water Toolkit and other resources that address students' access to drinking water in school
2) Communications team that works to disseminate School Health Branch products to priority end users
3) Partner agencies that have helped to disseminate the Water Toolkit

We expect that our findings will inform dissemination approaches as well as potential revisions and/or additions to the resources we make available to grantees and other agencies working with school districts and schools to support efforts to increase students' access to drinking water throughout the day.

Project Time Schedule

Task	Timeline/Time to Completion
Project Timeline Schedule for Parts I and II	***May 2014-November 2014***
• Launch Water Toolkit	*Complete*
• Track web metrics	*Ongoing*
• Design assessment and feedback instruments	*Complete*
• Develop assessment protocols, instructions, follow up notifications, and analysis plan	*Complete*
• Pilot test assessment instruments	*Complete*
• Prepare Generic Clearance Package	*Complete*
• Submit Generic Clearance Package	*Complete*
• Generic Clearance Approval	*Pending*
• Collect Information via Awareness and Planning Assessment Instrument	(3 weeks)
• Download, clean, code, enter, and analyze data	(1 week)
• Prepare evaluation brief and presentation	(3 weeks)
• Share evaluation products with SHB team	November
Project Timeline Schedule for Part III	***May-July 2015***
• Collect Information via Utilization Feedback Tool	(3 weeks)
• Download, clean, code, enter, and analyze data	(1 week)
• Prepare evaluation brief and presentation	(3 weeks)
• Share evaluation products with SHB team	July

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

We are requesting no exemption.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification. These activities comply with the requirements in 5 CFR 1320.9.

LIST OF ATTACHMENTS – Section A

Note: Attachments are included as separate files as instructed.

A. **Child Nutrition Reauthorization 2010**
B. **Water Toolkit**
C. **Assessment Instrument: Word Version**
D. **Assessment Instrument: Web version**
E. **Feedback Tool: Word Version**
F. **Feedback Tool: Web version**

REFERENCE LIST

1. Centers for Disease Control and Prevention (CDC). "National Public Health Performance Standards Program (NPHPSP): 10 Essential Public Health Services." Available at http://www.cdc.gov/nphpsp/essentialservices.html. Accessed on 8/14/14.
2. Kaushik A, Mullee MA, Bryant TN, Hill CM. A study of the association between children's access to drinking water in primary schools and their fluid intake: can water be 'cool' in school? *Child Care Health Dev.* 2007;33:409-415.
3. Muckelbauer R, Libuda L, Clausen K, Toschke AM, Reinehr T, Kersting M. Promotion and provision of drinking water in schools for overweight prevention: randomized, controlled cluster trial. *Pediatrics.* 2009;123:e661-e667.
4. Wang Y C, Ludwig DS, Sonneville K, Gortmaker SL. Impact of change in sweetened caloric beverage consumption on energy intake among children and adolescents. *Arch Pediatr Adolesc Med*. 2009; 163(4):336-343.
5. Popkin BM, D'Anci KE, Rosenberg IH. Water, hydration, and health. *Nutr Rev.* 2010;68(8):439-458.
6. Kempton MJ, Ettinger U, Foster R, et al. Dehydration affects brain structure and function in healthy adolescents. *Hum Brain Mapp.* 2011;32:71-79.
7. Edmonds CJ, Jeffes B. Does having a drink help you think? 6-7-year-old children show improvements in cognitive performance from baseline to test after having a drink of water. *Appetite.* 2009;53:469-472.
8. Edmonds CJ, Burford D. Should children drink more water? The effects of drinking water on cognition in children. *Appetite.* 2009;52:776-779.
9. Community Services Task Force. Preventing Dental Caries: Community Water Fluoridation. http://www.thecommunityguide.org/oral/fluoridation.html. Accessed May 1, 2014.

10. Benton D, Burgess N. The effect of the consumption of water on the memory and attention of children. *Appetite.* 2009;53:143-146.
11. Institute of Medicine. *Nutrition Standards for Foods in Schools: Leading the Way Toward Healthier Youth*. Washington, DC: National Academies Press; 2007.
12. Centers for Disease Control and Prevention. School health guidelines to promote healthy eating and physical activity. *MMWR Morb Mortal Wkly Rep*. 2011;60(5).
13. Alliance for a Healthier Generation Healthy Schools Program. https://schools.healthiergeneration.org. Accessed May 1, 2014.
14. US Dept of Agriculture. Healthier US School Challenge. http://teamnutrition.usda.gov/healthierUS/index.html. Accessed May 1, 2014.
15. American Academy of Pediatrics. Committee on Nutrition and the Council on Sports Medicine and Fitness. Sports drinks and energy drinks for children and adolescents: are they appropriate? *Pediatrics.* 2011;127:1182-1189.
16. National School Lunch Program and School Breakfast Program: Nutrition Standards for All Foods Sold in School as Required by the Healthy, Hunger-Free Kids Act of 2010, 7 CFR § 210.10(a)(1). http://www.gpo.gov/fdsys/pkg/FR-2013-06-28/pdf/2013-15249.pdf. Accessed May 1, 2014.
17. US Dept of Agriculture. SP 28-2011 Revised Child Nutrition Reauthorization 2010: Water Availability During National School Lunch Program Meal Service-Revised. http://www.fns.usda.gov/sites/default/files/SP28-2011_osr.pdf. Accessed May 1, 2014.
18. Cradock AL, Wilking CL, Olliges SA, Gortmaker SL. Getting back on tap: the policy context and cost of ensuring access to low-cost drinking water in Massachusetts schools. *Am J Prev Med.* 2012;43(3S2):S95-S101.