MONITORING AND REPORTING SYSTEM FOR CHRONIC DISEASE PREVENTION AND CONTROL PROGRAMS

REVISION
OMB APPROVAL NUMBER 0920-0870

PART A: JUSTIFICATION

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Abstract

The Centers for Disease Control and Prevention (CDC) currently collects progress and activity information from awardees funded through Funding Opportunity Announcement *CDC-RFA-DP14-1415* (formerly *CDC-RFA-DP09-901*), *Collaborative Chronic Disease, Health Promotion and Surveillance Program Announcement: Healthy Communities, Tobacco Control, Diabetes Prevention and Control, and Behavioral Risk Factor Surveillance System* (OMB 0920-0870, expiration date November 30, 2014). This cooperative agreement program was initiated as a 5-year program with 53 tobacco control awardees and is currently operating with 51 awardees under a one year cost extension ending March 28, 2015. Current awardees include health departments in all 50 states and the District of Columbia. Two of the original awardees (Puerto Rico and the Virgin Islands) are not participating in the one-year cost extension and will not report through this clearance.

CDC requests OMB approval to (1) continue the collection of progress and activity information from tobacco control awardees for one year; (2) decrease the number of respondents from 53 to 51; and (3) decrease reporting frequency from semi-annual to annual. This revision request describes plans to continue use of an electronic, Web-based management information system to collect awardee progress and activity information. There are no changes to information collection methods or the estimated burden per response. There is a net reduction in burden due to a decrease in the number of respondents and the decrease in reporting frequency. OMB approval of this revision request will allow CDC to collect progress and activity information from awardees during the final budget period (March 29, 2014 – March 28, 2015). The final progress report will be due in Summer/Fall 2015.

A. JUSTIFICATION

1. Circumstances Making the Collection of Information Necessary

Background

Tobacco use is the single most preventable cause of death and disease in the United States. Tobacco use causes heart disease and strokes, lung cancer and many other types of cancer, chronic obstructive pulmonary disease, lung disorders, pregnancy problems, sudden infant death syndrome, gum disease and vision problems. Approximately 480,000 Americans die from tobacco-related illnesses annually, causing more deaths than HIV/AIDS, alcohol use, cocaine use, heroin use, homicides, suicides, motor vehicle crashes, and fires combined. For every person who dies from tobacco use, 20 more people suffer with at least one serious tobacco-related illness. There are also severe economic costs of tobacco use as the U.S. spends approximately $280 billion annually in direct medical expenses and lost productivity.

Although chronic diseases are among the most common and costly health problems, they are also among the most preventable. CDC works with states, territories, tribal organizations, and the District of Columbia (collectively referred to as “state-based” programs) to develop, implement, manage, and evaluate chronic disease prevention and control programs, including tobacco control programs. Support and guidance for these programs have been provided through

cooperative agreement funding and technical assistance administered by CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). Partnerships and collaboration with other federal agencies, nongovernmental organizations, local communities, public and private sector organizations, and major voluntary associations have been critical to the success of these efforts.

In 2009, CDC announced a new cooperative agreement program for chronic disease prevention and health promotion programs (*CDC-RFA DP09-901*). The purpose of the program was to reduce the morbidity and premature mortality associated with chronic diseases and to eliminate associated health disparities by supporting capacity building, program planning, development, implementation, evaluation, and surveillance for chronic disease conditions and chronic disease-related risk factors such as tobacco use. The program addressed the specific content areas of Healthy Communities, tobacco control, diabetes prevention and control, and state-based surveillance and data analysis for chronic disease prevention and health promotion through the BRFSS.

Due to organizational and funding changes within CDC, three programmatic components (Healthy Communities, diabetes prevention and control, and BRFSS) were discontinued from the original cooperative agreement program. Only the tobacco control component remains.

Current awardees are health departments in all 50 states and the District of Columbia (**see List of Awardees, Attachment 3**). Two original awardees (Puerto Rico and Virgin Islands) are not participating in the one-year cost extension and will not report through this clearance.

CDC requests OMB approval to continue the collection of progress and activity information from awardees for one year in order to document, monitor, and evaluate their progress toward accomplishing the objectives defined in their work plans during the last year of the cooperative agreement (March 29, 2014 – March 28, 2015). A final report will be due in July 2015, 90 days after the funded project period. The one-year clearance request will allow CDC to collect the final report in Summer/Fall 2015, accommodating any final reports that may be submitted after the July 2015 due date.

Progress and activity information will continue to be collected through the current electronic, Web-based Management Information System (MIS).

This cooperative agreement program addresses and supports the following national initiatives and strategic plans:

- CDC's Winnable Battles (Reducing Tobacco)
- HHS's Strategic Plan (Promote Prevention and Wellness – Reduce Cigarette Consumption and Cigarette Smoking)
- Government Performance Results Modernization Act (Priority Goal – Reduce Cigarette Smoking)
- The National Prevention Council's National Prevention Strategy – A*mericas Plan for Better Health* (Tobacco Free Living)
- *Healthy People 2020* (Tobacco Use)

- HHS's *Ending the Tobacco Epidemic: A Tobacco Control Strategic Action Plan for the Department of Health and Human Services*
- The Institute of Medicine's, *Ending the Tobacco Problem – A Blueprint for the Nation*

CDC's authority to conduct these activities is authorized by the Public Health Service Act (sections 301, 307, 310, and 311; 42 U.S.C. sections 241 and 247(b)(k)), the Comprehensive Smoking Education Act of 1984, and the Comprehensive Smokeless Tobacco Health Education Act of 1986 (**Attachments 1a-1c**). The overarching goal is to improve public health programs and systems for achieving measurable health impact.

The design of the MIS is extensible to additional CDC-funded chronic disease prevention and control programs in states, territories, and the District of Columbia. Advantages of using the MIS include: 1) improved ease of use and overall reduction of burden to awardees, 2) a common set of performance metrics for describing program performance and improving program management, and 3) enhanced communication among programs, thus facilitating collaboration and information sharing.

Privacy Impact Assessment

A) Overview of the Data Collection System

The MIS is the current mechanism for collecting progress and activity information from awardees. Awardee reports that summarize challenges, progress and accomplishment will continue to be collected on an annual basis the remainder of the cooperative agreement which ends March 28, 2015.

B) Items of Information to be Collected

The MIS will continue to collect information about the staffing resources dedicated to tobacco control program awardees. The MIS will also collect information about work plan objectives, activities, and partnerships. The MIS collects a limited amount of information in identifiable form (IIF) for key program staff (e.g., program director/program coordinator). Each awardee provides the names of these individuals as well as their professional contact information. The contact person only provides information about the state tobacco control program, not personal information. Information will be reported regarding the state-based tobacco control program; no personal information will be reported.

C) Identification of Website(s) and Website Content Directed at Children Under 13 Years of Age

The MIS is a Web-based application. Access to The MIS is controlled by a password-protected login for authorized users. There is no Website content directed at children less than 13 years of age.

2. Purpose and Use of the Information Collection

The information collection enables the accurate, reliable, uniform and timely submission to CDC on awardee progress and activities. The information collected and reporting requirements have been carefully designed to align with and support the goals outlined in the cooperative agreement and the goals defined within the CDC's, Office on Smoking and Health strategic plan. The MIS enables collection and reporting of the information in an efficient, standardized, and user-friendly manner. The MIS generates a variety of routine and customizable reports. The MIS also has the capacity to generate reports that describe activities across multiple states and/or programs.

CDC uses the information collected in the MIS to monitor each awardee's progress and activities and to identify programmatic strengths and weaknesses. Monitoring allows CDC to determine whether an awardee is meeting performance goals and to make adjustments in the type and level of technical assistance provided to them, as needed, to support attainment of their objectives. CDC's monitoring and evaluation activities also allow CDC to provide oversight of the use of federal funds, and to identify and disseminate information about successful prevention and control strategies implemented by awardees. These functions are central to the NCCDPHP's broad mission of reducing the burden of chronic diseases and the Office of Smoking and Health's national goals to (1) Prevent initiation of tobacco use among youth and young adults; (2) Promote tobacco use cessation among adults and youth; (3) Eliminate exposure to secondhand smoke; and (4) Identify and eliminate tobacco-related disparities

CDC also uses the information collected to respond to Congressional and stakeholder inquiries about tobacco control program activities, program implementation, and program impact. Finally, the information collected allows CDC to monitor the increased emphasis on partnerships and programmatic collaboration, which reduces duplication of effort, enhances program impact and maximizes the use of federal funds.

Awardees use the information collected to manage and coordinate activities and to improve their efforts to prevent and control tobacco use and secondhand smoke exposure. The MIS allows awardees to fulfill their reporting obligations under the cooperative agreement in an efficient manner by employing a single instrument to collect necessary information for progress reports and work plans. This approach, which enables awardees to save pertinent information from one reporting period to the next, reduces the administrative burden on the yearly continuation application and progress review process. Awardees are able to review the completeness of data necessary to submit required reports, enter basic summary data for reports, and finalize and save required reports for upload into Grants.gov.

The information collected is designed to address specific performance measures outlined in FOA DP14-1415 related to infrastructure, capacity, and interventions.

Privacy Impact Assessment Information

The MIS is a centralized, Web-based system that supports the collection and reporting of information that will be used by CDC to help assess the impact of awardees. The MIS is used to describe, evaluate and enhance opportunities for collaborative efforts and partnerships. Having this information in a single and secure database allows CDC project officers to search across

multiple programs, helps ensure consistency in documenting progress and technical assistance, and enhances accountability of the use of federal funds.

3. Use of Improved Information Technology and Burden Reduction

The MIS takes advantage of electronic database technology to improve information quality by minimizing errors and redundancy. The structure of the MIS minimizes or eliminates many elements that would otherwise be repeated within stand-alone systems. Having information collected in the same place in the same manner reduces the level of burden attributable to redundancy and reduces the workload to enter and maintain the data. Awardees are able to transfer data from one year to another to minimize data re-entry.

The MIS uses a standard set of data elements, definitions, and specifications at all levels that helps to improve the quality and comparability of performance information that is received by CDC. Standardization enhances the consistency of work plans, reports, and enables cross-program analysis. The report generation capabilities of the MIS reduce the respondent burden associated with paper-based reports. Without the automated, electronic, Web-based MIS and the integrated approach to information collection and reporting, awardees and CDC would need to continue to use time consuming, labor intensive procedures for information collection and reporting.

4. Efforts to Identify Duplication and Use of Similar Information

The collection of this information is part of a federal reporting requirement for funds received by awardees. The MIS consolidates information necessary for both continuation applications and progress reports so that information entered once can be used to generate multiple types of reports without having to duplicate efforts. The information collected from awardees is not available from other sources.

5. Impact on Small Businesses or Other Small Entities

No small businesses participate in the MIS data collection.

6. Consequences of Collecting the Information Less Frequently

Less frequent reporting would negatively impact monitoring the progress and activities of awardees and undermine accountability efforts at all levels.

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

There are no special circumstances related to the MIS, and the request fully complies with the regulation.

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

A. Federal Register Notice

A Notice announcing this Revision request was published in the Federal Register on June 25, 2014, Volume 79, Number 122, Pages 36065 – 36066 (**Attachment 2**). No public comments have been received.

B. Other Consultations

The MIS was designed collaboratively by CDC staff, awardees, and a system development contractor. Consultation has continued throughout the system development and implementation process.

9. Explanation of Any Payment or Gift to Respondents

Respondents will not receive payments or gifts for providing information.

10. Assurance of Confidentiality Provided to Respondents

A. **Privacy Act Assessment**. Staff in the CDC Information Collection Review Office have reviewed this Information Collection Request and have determined that the Privacy Act is not applicable. The data collection does not involve collection of sensitive or identifiable personal information. Respondents are state-based tobacco control programs funded through a cooperative agreement with CDC. Although contact information is obtained for each program, the contact person provides information about the state program, not personal information.

B. **Security**. Access to the MIS is controlled by a password-protected login. Access levels vary from read-only to read-write, based on the user's role and needs. Each awardee has access to their own information and can decide the level of access for each user. The extent to which local partners may access an awardees' information is decided by that awardee. Aggregated information is stored on an internal CDC SQL server subject to CDC's information security guidelines. The MIS is hosted on the NCCDPHP's Intranet and Internet Application platforms, which undergo security certification and accreditation through CDC's Office of the Chief Information Security Officer.

C. **Consent**. The MIS data collection is not research involving human subjects. Respondents are cooperative agreement awardees. The information collected does not require consent from individuals or IRB approval.

D. **Requirement to Respond**. Awardees are required to respond as a condition of cooperative agreement funding.

11. Justification for Sensitive Questions

The MIS does not collect sensitive information. No personal information is requested. The MIS collects a limited amount of information in identifiable form (IIF) for key program staff (e.g., program director/program coordinator). Each awardee provides the names of these individuals as well as their professional contact information. The contact person only provides information about activities conducted under the collaborative award, not personal information.

12. Estimates of Annualized Burden Hours and Costs

A. Estimated Annualized Burden Hours

Current respondents are the 51 awardees (**see Attachment 3**), including the 50 states and the District of Columbia. Awardees will report information to CDC about their progress and activities. The total estimated burden is 6 hours per response. One final report will be required during the period of this one-year clearance request.

Information will be submitted to CDC electronically through the MIS (see **Attachment 4**). The total annualized total for the information collection is 306 hours, as summarized in Table A.12-1.

Table A.12-1. Estimated Annualized Burden to Respondents

Type of respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden
State Health Department Tobacco Control Programs	51	1	6	306

B. Estimated Annualized Cost to Respondents

The tobacco control program director/coordinator will prepare the annual progress report. The average hourly wage for a program director/coordinator is $30.65. The hourly wage rates for program director/coordinators are based on wages for similar mid-to-high level positions in the public sector. The total estimated annualized cost to respondents is $9,379, as summarized in Table B.12-1.

Table B.12-1. Estimated Annualized Cost to Respondents

Type of respondents	Number of respondents	Number of responses per respondent	Average burden per response	Average hourly wage	Total cost
State-Based Tobacco Control Program	51	1	6	$30.65	$9,379

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

The MIS is designed to use existing hardware within funded sites, and all awardees currently have access to the Internet to use the information system. Additionally, there are no start-up, hardware or software costs.

14. Estimates of Annualized Cost to the Federal Government

A. Development, Implementation, and Maintenance

The major cost factor for the MIS is related to maintenance of the system. The MIS maintenance is provided by the contractor, Northrup-Grumman. The total estimated annualized cost to the government for the remainder of the cooperative agreement is $100,000 as summarized in the table below.

Table A.14-1.

Phase	**Implementation and Maintenance Phase**	**Average Annualized Cost Estimate**
System Maintenance and Required Reports	Project Management and Support	$90,000
	Training of New Users	$10,000
	Total	$100,000

15. Explanation for Program Changes or Adjustments

There are no changes to information collection methods or the estimated burden per response (6 hours). During the one-year period of this Revision request there will be a net reduction of 330 annualized burden hours.

- The number of respondents will decrease from 53 to 51. Two of the original awardees (Puerto Rico and Virgin Islands) are not participating in the one-year cost extension and will not report through this clearance. The result is a reduction of 24 annualized burden hours (2 respondents x 2 responses/year x 6 hours/response = 24 hours).
- The reporting frequency will change from semi-annual to annual. The result is a reduction of 306 annualized burden hours (51 respondents x 1 response/year x 6 hours/response = 306 hours).

16. Project Time Schedule and Plans for Publication and Analysis

A. Time schedule for the entire project

This is a 5-year cooperative agreement program with a 1-year cost extension ending March 28, 2015. OMB approval is being requested to continue the collection of progress and activity information from awardees for the remainder of the cooperative agreement which ends March 28, 2015. Final reports will be due in July 2015 (90 days after the end of the funding period). One additional year of OMB clearance for information collection is requested. This will ensure CDC authority to receive any final reports that may be submitted after the due date.

B. Publication plan

Information collected through the MIS will be reported in internal CDC documents and shared with awardees.

C. Analysis plan

CDC will not use complex statistical methods for analyzing information. All information will be aggregated and reported with no program identifiers present in external documents. Most statistical analyses will be descriptive. Statistical modeling may be included to examine predictors of specified outcomes.

A.16 - 1 Project Time Schedule

Activity Time Schedule	
Notification of Electronic Tool Availability	Immediately upon OMB approval
User Training	Immediately upon OMB approval and ongoing through expiration date
Data Collection	Immediately upon OMB approval
Data Publication	Annually
Data Analysis	Immediately upon OMB approval

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

CDC will display the expiration date for OMB approval of the MIS collection of awardee progress and activity information on the login page.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification statement.