

# **Assessment of Tobacco Control Program (TCP) Infrastructure**

OSTLTS Generic Information Collection Request  
OMB No. 0920-0879

## **SUPPORTING STATEMENT – Section A**

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- **Goal of the study:** Assist state-based Tobacco Control Programs (TCPs) in assessing their program infrastructure, using the Component Model of Infrastructure (CMI) framework
- **Intended use of the resulting information:** Help CDC identify funded programs' infrastructure-related technical assistance and support needs; inform ongoing CDC programmatic monitoring efforts
- **Methods to be used to collect information:** Telephone interviews; no sampling
- **The subpopulation to be studied:** 51 state and District of Columbia Tobacco Control Program (TCP) managers
- **How information will be analyzed:** Basic descriptive statistics; analyses of narrative responses and appropriate findings from those responses

## Section A. JUSTIFICATION

### 1. Circumstances Making the Collection of Information Necessary

#### Background

This data collection is being conducted using the Generic Information Collection mechanism of the Office of State, Tribe, Local, and Territorial Support (OSTLTS) OMB Clearance Center (O2C2) – OMB No. 0920-0879. The respondent universe for this data collection aligns with that of the O2C2. Information will be collected from 51 state and District of Columbia Tobacco Control Program (TCP) managers acting in their official capacities.

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 assuring a competent public health and personal health care workforce and evaluating effectiveness, accessibility, and quality of personal and population-based health services (CDC, 2014a).<sup>1</sup>

- 1. Monitoring health status to identify community health problems
- 2. Diagnosing and investigating health problems and health hazards in the community
- 3. Informing, educating, and empowering people about health issues
- 4. Mobilizing community partnerships to identify and solve health problems
- 5. Development of policies and plans that support individual and community health efforts
- 6. Enforcement of laws and regulations that protect health and ensure safety
- 7. Linking people to needed personal health services and assure the provision of health care when otherwise unavailable
- 8. Assuring a competent public health and personal health care workforce
- 9. Evaluating effectiveness, accessibility, and quality of personal and population-based health services
- 10. Research for new insights and innovative solutions to health problems <sup>1</sup>

Although the prevalence of cigarette smoking among U.S. youth and adults has declined significantly over the past 50 years, the current pace of progress is not sufficient for achieving Healthy People 2020 tobacco control targets (US DHHS, 2013).<sup>2</sup> Racial, ethnic and socioeconomic disparities in tobacco use persist, and, in recent years, the decline in prevalence of current smoking among adults has slowed. Moreover, tobacco use patterns are changing with more occasional use of cigarettes and increased use of other tobacco products. Comprehensive state tobacco control programs have been shown to reduce rates of tobacco use and tobacco related diseases and deaths; however, these programs continue to be underfunded (CDC, 2014b; Farrelly et al., 2003, 2008).<sup>3,4,5</sup>

State tobacco control programs require a fully functioning infrastructure to achieve the level of capacity needed to respond to the Surgeon General's call to accelerate declines in tobacco use (US DHHS, 2013).<sup>2</sup> For decades, public health leaders and researchers have emphasized the importance of infrastructure to the successful implementation of public health efforts (Lavinghouze et al., 2013).<sup>6</sup> Within the context of tobacco control specifically, the focus of program efforts and the degree to which efforts lead to intended intermediate and long-term outcomes are determined by "whether the state has the funding to build and sustain a basic tobacco control infrastructure and by each state's unique economic, political, and other contextual factors" (NCI, 2006, p. 53).<sup>7</sup>

Infrastructure measurement offers valuable program management insights. For example, infrastructure measurement can enhance our understanding of how state tobacco control programs address the challenges of working in a funding-constrained environment and illuminate the factors that facilitate and challenge program sustainability. Measurement is also a necessary step toward eventually quantifying the relationship between infrastructure and public health outcomes. However, in order to measure infrastructure, it must be clearly defined. The Component Model of Infrastructure (CMI) includes the following elements; networked partnerships, multi-level leadership, responsive plans/planning, managed resources, engaged data and describes functioning public health program infrastructure in a way that is conducive to measurement and implementation (CDC, 2014b; Lavinghouze, Snyder, & Rieker, 2014).<sup>3,8</sup>

Within CDC, the Office on Smoking and Health (OSH) is the lead agency for comprehensive tobacco prevention and control, whose mission is to develop, conduct, and support strategic efforts to protect the public's health from the harmful effects of tobacco use. To achieve this mission, OSH focuses on the goals of preventing initiation of tobacco use among youth and young adults, promoting tobacco use cessation among adults and youth, eliminating exposure to secondhand smoke, and identifying and eliminating tobacco related disparities. The National Tobacco Control Program (NTCP) (a division of OSH) is responsible for working toward this mission and goals by funding health departments in all 50 states, the District of Columbia, and seven U.S. territories for comprehensive tobacco control, and work collaboratively with state and national partners and networks in providing strategic leadership, a solid science base, and technical assistance to advance evidence-based interventions at the state and local levels. The four components of the (NTCP) are population-based community interventions, counter-marketing, program policy/regulation, and surveillance and evaluation.

Under CDC Funding Opportunity Announcement CDC-RFA-DP15-1509, National State-Based Tobacco Control Programs, awarded March 29, 2015, state-based TCPs are expected to maintain or increase their levels of infrastructure. In support of this objective, OSH proposes a two-pronged information collection approach to assist in defining, monitoring, and providing relevant technical assistance for program infrastructure. First, this GenIC outlines a plan to use

the CMI tool to do a “deep dive” with TCP awardees, early in the FOA funding period, to obtain detailed information about program infrastructure. OSH supported the development of the CMI measurement tool in order to help develop timely technical assistance programs and plans and to assess program performance. The CMI was included in the 2014 publication, Best Practices for Comprehensive Tobacco Control and Prevention Programs (CDC, 2014b),<sup>2</sup> thus, OSH’s use of the CMI aligns with best practices recommendations. Second, TCPs will report on selected infrastructure measures in their annual progress reports. OMB approval for the annual progress reports will be obtained through a separate ICR. Findings from the initial CMI-based assessment may be used to refine the infrastructure-related elements of the annual report. The two information collections are organized in a complementary, non-duplicative manner that will facilitate evaluating the linkages between program infrastructure, implementation, and outcomes.

Additionally, the information will be used to determine how ongoing infrastructure monitoring of funded state-based tobacco control programs can be strengthened and streamlined. This is a new information collection effort using the CMI measurement tool that is not available from other data sources or through other means.

### **Overview of the Information Collection System**

OSH’s information collection instrument was developed to capture information on the CMI measurement tool core components: networked partnerships (24 questions – one having 12 items), multi-level leadership (2 questions - one having 4 items), responsive plans/planning (9 questions), managed resources (9 questions), and engaged data (14 questions - one having 2 items)

The CMI measurement tool is administered by phone (**see Att. A – Interview Guide**). Data collection will be conducted by a two-member team: one interviewer and one note taker. Data collection teams will consist of OSH assessment team members and contractors. The instrument will be used to gather information from TCP managers regarding their program infrastructure. A pilot test was conducted with nine state TCP managers through interviews to elicit feedback on the clarity, comprehensiveness, and relevance of instrument items. Feedback from this group was used to refine questions as needed, ensure accurate skip patterns, and establish the estimated time required to complete the information collection instrument.

### **Items of Information to be Collected**

The data collection instrument consists of multiple response and short open-ended questions to gather initial, in-depth information on state-based TCP infrastructure. The instrument will collect information on the following five core CMI components:

- **Networked Partnerships**—Networked partnerships are composed of multi-level relationships between the state TCP and individuals and organizations that are stakeholders. These partnerships occur at all levels (national, state, local) and are characterized by diversity and coordinated efforts toward common goals. Networked partnerships extend the reach of the TCP, build champions, and contribute to sustainability. (24 questions – one having 12 items),
- **Multi-Level Leadership**—Multi-level leadership refers to individual people (not partnerships) who provide direction for the program and the processes by which that direction is provided. Leaders and leadership processes occur at multiple levels (above, below, within, and lateral). (2 questions - one having 4 items)

- **Responsive Plans/Planning**—Plans include the state plan (i.e., a written document that defines and prioritizes program goals and objectives and includes strategies for achieving them) and companion plans (e.g., communication, coordination, evaluation, and health equity plans). Responsive plans and planning are developed and implemented collaboratively with diverse stakeholders, reflect the current evidence base, are appropriate for contextual realities, are dynamic (i.e., adapt to changes in the evidence base and contextual realities), and include assessment components and feedback loops. (9 questions)
- **Managed Resources**—Resources are funding and staff. Managed “funding” refers to leveraging funds from diverse sources and using those funds to meet the program’s goals and objectives. Managed “staff” refers to recruiting staff with the skills and knowledge to plan and implement the program’s goals and objectives and continuously updating their skills/knowledge to incorporate emerging research and address new challenges. (9 questions)
- **Engaged Data**—Engaged data are defined as identifying (or collecting) and working with data in a way that promotes action. (14 questions - one having 2 items)

## 2. Purpose and Use of Information Collection

Infrastructure is identified as a key component of comprehensive tobacco control programs in OSH’s 2014 Best Practices guidance document (CDC, 2014b).<sup>2</sup> Under CDC Funding Opportunity Announcement DP15-1509, state-based TCPs are expected to maintain or increase their levels of infrastructure as defined by the Component Model of Infrastructure (CMI) included in Best Practices, 2014. In order to strengthen infrastructure, it must be defined in clear and practical terms. That is the premise under which Lavinghouze and colleagues developed the CMI.<sup>8</sup> The purposes of this information collection are to assist state-based TCPs in assessing their program infrastructure, identify funded programs’ infrastructure-related technical assistance and support needs, and to inform ongoing CDC programmatic monitoring efforts.

The CMI measurement tool will ultimately allow CDC to gather infrastructure information across TCPs that will inform program management activities. This information collection effort is intended to be complementary with the development and execution of the monitoring and reporting system for state-based TCPs. Information gathered will inform the best methods and key variables to capture infrastructure elements needed for ongoing monitoring of state-based TCPs. For example, collected information will inform the development of infrastructure-related fields in the new OSH management information system. Findings will also help CDC identify funded programs’ infrastructure-related technical assistance and support needs. Based on the data collection, the CMI measurement tool and analytic approaches will be refined. We will also look for opportunities to contribute to the infrastructure literature and broader study of infrastructure within the public health field by publishing manuscripts based on this data collection and presenting findings at national conferences.

## 3. Use of Improved Information Technology and Burden Reduction

All information collected under this effort will be gathered using telephone interviews. Phone-based information collection was chosen based on pilot results demonstrating that TCP managers preferred this method. The one-on-one data collection format may help to reduce the burden on respondents by focusing discussion on the most pertinent issues for open-ended items and providing immediate clarification regarding other elements of the CMI measurement

tool. Telephone interviews can also help to minimize the burden on CDC staff by reducing the time required for follow-up—teams can verify responses and request clarification as needed during the information collection process. An effort was made to limit questions requiring narrative responses from respondents whenever possible. However, pilot testing indicated the TCP managers wanted to be able to provide more context in some places.

#### **4. Efforts to Identify Duplication and Use of Similar Information**

The information gathered with the CMI measurement tool is not available from other data sources or through other means. There is no similar information available that meets the needs of this proposed assessment. The proposed information collection does not duplicate any information currently being collected from state TCP program managers or staff members. This information collection effort is intended to be complementary with the development and execution of the monitoring and reporting system for state-based TCPs. Information gathered will inform the best methods and key variables to capture infrastructure elements needed for ongoing monitoring of state-based TCPs.

#### **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**

This request is for a one time information collection. There are no legal obstacles to reduce the burden. If no data are collected, CDC will be unable to:

- Capture in-depth information about state-based TCP program infrastructure early in the funding cycle
- Assess the linkages between state TCP program infrastructure, implementation, and outcomes
- Inform ongoing infrastructure monitoring of funded state-based tobacco control programs
- Use infrastructure data to inform timely program management enhancements
- Aid state-based TCP grantees in program implementation

#### **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 guidelines of 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 Survey 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 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 the 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. IRB approval is not required.

### **10.1 Privacy Impact Assessment Information**

No individually identifiable information (IIF) will be collected. The names and contact information for state TCP managers are available to OSH through cooperative agreement documentation.

## **11. Justification for Sensitive Questions**

No information will be collected that are of personal or sensitive nature.

## **12. Estimates of Annualized Burden Hours and Costs**

The estimate for burden hours is based on the pilot test of the CMI measurement tool (Attachment B) conducted with a purposive sample of nine state TCP managers. The pilot test was conducted through interviews to elicit feedback on the clarity, comprehensiveness, and relevance of instrument items. Feedback from this group was used to refine questions as needed, ensure accurate skip patterns, and establish the estimated time required to complete the information collection instrument. Results from our testing indicate that program managers understood the questions posed, had the knowledge to answer them, and confirmed that CMI measurement tool constructs and questions were relevant to their tobacco control programs.

In the pilot test, the average time to complete the information collection instrument, including time for reviewing instructions, was approximately 75 minutes. Based on these results, the estimated time range for actual respondents to complete the instrument is 60 to 90 minutes. For the purposes of estimating burden hours, the upper limit of this range (i.e., 90 minutes) is used.

Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) National Compensation Survey Estimate for a Social and Community Service Manager (<http://www.bls.gov/ncs/ocs/sp/nctb1349.pdf>). Based on DOL data, and average hourly wage of \$34.50 is estimated for all 51 respondents. Table A-12 shows estimated burden and cost information.



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

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
State Tobacco Control Program Managers	51	1	1.5	77	\$34.50	\$2,657
<b>TOTALS</b>	<b>51</b>	<b>1</b>		<b>77</b>		<b>\$2,657</b>

**13. Estimate 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 the information collection.

**14. Annualized Cost to the Government**

There are no equipment or overhead costs. Contractors, however are being used to support data collection and analysis. The only cost to the federal government would be the salary of CDC staff and contractors. The total estimated cost to the federal government is \$10,953. Table A-14.1 describes how this cost estimate was calculated.

**Table A-14.1: Estimated Annualized Cost to the Federal Government**

Staff or Contractor	Hours	Average Hourly Rate	Average Cost
<b>Public Health Advisor (GS-13):</b>	22	\$48.93	\$1076.46
<b>Public Health Advisor (GS-13):</b>	22	\$48.93	\$1076.46
<b>4 Contractors (GS-13):</b> Conduct data collection	55	\$160	\$8800
<b>Estimated Total Cost of Information Collection</b>			<b>\$10,953</b>

**15. Explanation for Program Changes or Adjustments**

This is a new information collection.

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

Following completion of all information collection calls, data from the electronic instrument will be downloaded, cleaned and analyzed in SPSS. The majority of information will be analyzed using basic descriptive analyses. OSH will explore opportunities for presenting and publishing information collection findings following completion of the analysis and reporting activity.

## Project Time Schedule

Activity	Beginning Spring 2015
Design questionnaire	Complete
Develop protocol, instructions, and analysis plan	Complete
Pilot test questionnaire	Complete
Prepare and submit OMB package	Complete
OMB approval	TBD
Email announcing scheduling of telephone interviews	4 weeks before information collection period commence
Reminder e-mail sent to schedule telephone interview date	3, 2, and 1 week(s) before information collection period commence to non-respondents
Telephone reminder calls made	2 days before information collection period commence to non-respondents
Data collection (telephone interviews) conducted	13 weeks to complete following the beginning of data collection
Completed measurement tools compiled for CDC; data analyzed and findings summarized in an internal topline report.	17 weeks to complete following the beginning of data collection

### 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

Att. A Interview Guide

### REFERENCE LIST

1. Centers for Disease Control and Prevention (CDC). *The Public Health System and the 10 Essential Public Health Services*. (2014a). Retrieved January 12, 2015, from <http://www.cdc.gov/nphpsp/essentialservices.htm>
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