Attachment B – Project Description

Older Adult Mobility Planning Brochure

Project Description:

"Mobility" refers to all types of movement, such as walking, biking, and driving within and between environments to accomplish daily living tasks.[1] Optimal mobility (an individual's ability to safely and reliably move to chosen locations by desired means) is an important component of healthy aging and is critically important for maintaining physical and mental health.[2] As noted in the Centers for Disease Control and Prevention's (CDC's) 2013 "State of Aging and Health in America" report, ensuring that mobility for older adults is addressed effectively has significant public health implications.[3] U.S. Census projections indicate that by the year 2030, when the last baby boomer turns 65, approximately 20% of Americans—about 72 million people—will be older adults.[4]To address the needs of this rapidly growing population, CDC developed the Mobility Planning Tool ("MyMobility"; Attachment A).

The purpose of this request is to refine message concepts and to test informative materials for clarity, appeal, and usability of the MyMobility brochure, as well as the best ways for CDC to disseminate the brochure. This information will be collected through a series of six focus groups CDC will use findings from the data collected to refine the effectiveness of messages for the intended audiences through the MyMobility brochure. Feedback gathered, including message delivery and content, dissemination strategies, partners to assist with dissemination efforts, and dissemination channels will help ensure NCIPC is providing quality messages and prevent waste in the dissemination of health information by CDC to the public.

Who are we trying to influence?

Primary Audience: Respondents will be community-dwelling, English-speaking U.S. residents aged 60 to 74 years old living independently with good or very good self-rated mobility, with a diverse racial/ethnicity composition.

What do we want them to DO as a result of this communication?

We will get their reactions to existing materials (MyMobility brochure, Att. A). We will use what we learn from focus group discussions to adapt existing messages or refine the message provided through the MyMobility brochure. Feedback gathered, included satisfaction with delivery and content, dissemination strategies, partners to assist with dissemination efforts, and dissemination channels.

How do we expect communications to work towards achieving this?

Content strategy will include:

- Time-saving — focus on the messages and useful tips / tools / facts that are easy to absorb given our audience.

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[1] Prochaska TR, Anderson IA, Hooker SP, Hughes SI & Belza B (2011) Mobility and aging: Transference to transportation. Journal of Aging Research, 2011, 1-3. Doi: 10.4061/2011/392751.

[2] Satariano WA, Guralnik JM, Jackson RJ, Marottoli RA, Phelan FA, & Prochaska TR (2012). Mobility and aging: New directions for public health action. American Journal of Public Health, 102: 1508-1515.

[3] Centers for Disease Control and Prevention, The State of Aging and Health in America 2013. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2015.

[4] Wan H, Sengupta M, Velkoff VA, DeBarrow KA. 65+ in the United States: 2005 Current Population Reports. P23-209. Washington, DC: US Census Bureau; 2005. http://www.census.gov/prod/2006pubs/p23-209.pdf.

- Relevance — ensure new or revised materials meet our audiences' current needs for optimal mobility as an important component of healthy aging and critically for maintaining physical and mental health.
- Accessible — ensure the tone is direct, clear, real and salient with our audiences.

What are we trying to convey?
In our planned focus groups, our goal is to learn opinions about the health messages contained in the Mobility Planning brochure (Att. A). We want to get subjects' reactions to the materials and to determine if they are receiving and understanding these messages. We also want to determine the best channels for dissemination of the Mobility Planning Tool to older adults. We will use what we learn from focus groups to 1. Refine the Mobility Planning brochure to create the final version for distribution; and 2. Understand the best methods and places to disseminate the Mobility Planning brochure to older adults.

Recruitment of Participants
A third-party vendor, will identify prospective respondents meeting the inclusion criteria using their database of individuals who have expressed an interest in participating in projects. Contact information including name, and address of those respondents who wish to participate will be used to communicate location of the focus group (Att. E). Also, signed consent forms from focus group participants (Att. D) will be collected. Signed consent forms will be kept by the interviewer and stored in locked filing cabinets at Battelle offices, contractor. These forms will be stored separately from other project records so that names are not stored in the same folders. During the focus groups, respondents will be referred to only by first name. Focus group recordings will be transcribed. All identifiers will be stripped from the recordings and transcripts. At no time will personal information be linked or linkable to focus group data. At no time does CDC have access to, or will receive, potentially identifiable information. At no time is this information linked or linkable to focus group information.

Incentives
Is an incentive (e.g., money or reimbursement of expenses, token of appreciation) provided to participants? [X] Yes [ ] No

Each focus group participant will receive $75 in cash for their participation. The amount of this incentive aligns with the general limitations of the overarching Generic ICR. Providing incentives to respondents is necessary to successfully recruit individuals for qualitative projects conducted in person[5] [6]. Review of literature reveals that the payment of incentives can provide significant advantages to the government in terms of direct cost savings and improved data quality. It also should be noted that message testing is a marketing technique, and it is standard practice among commercial market researchers to offer incentives as part of respondent recruitment.

Protection of the Privacy and Confidentiality of Information Provided by Respondents

[5] National Cancer Institute. (2001) *Making Health Communication Programs Work*, http://www.cancer.gov/cancertopics/cancerlibrary/pinkbook/Pink_Book.pdf

[6] Krueger, RA and Casey, MA. (2008). *Focus Groups: A Practical Guide for Applied Research, 4th ed*. Sage Publications, Inc., Thousand Oaks, CA.

The NCIPC-CIO has determined that the Privacy Act does not apply. Contact information including name, and address of those respondents who wish to participate is secondary data already collected by a third-party vendor. At no time will personal information be linked or linkable to focus group data. All identifiers will be stripped from the recordings and transcripts. At no time does CDC have access to, or will receive, potentially identifiable information. At no time is this information linked or linkable to focus group information.

All data will be reported in aggregate unlinked form. All procedures have been developed, in accordance with federal, state, and local guidelines, to ensure that the rights and privacy of respondents will be protected and maintained.

BURDEN HOURS

Category of Respondent	**No. of Respondents**	**Participation Time (Hours)**	**Burden**
Individuals - Recruitment/Screening Phone Call (Att. C - Participant Screener)	300	5/60	25
Individuals – Confirmatory Letter (Att. E)	36	15/60	9
Individuals – Focus Group Moderator Guide (Att. F)	36	2	72
Totals			**106**