

**Monitoring and Reporting System for the
Division of Community Health's Cooperative Agreement Programs**

New

Supporting Statement

Part A - Justification

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A. JUSTIFICATION

1. Circumstances Making the Collection of Information Necessary

CDC requests OMB approval to collect information needed to monitor cooperative agreement programs authorized by the Public Health Service Act (**Attachment 1a**) and the Prevention and Public Health Fund of the Affordable Care Act (**Attachment 1b**). The programs are administered by the Division of Community Health (DCH), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Prevention and Control (CDC). DCH community-level work is grounded in three core principles: 1) maximizing the public health impact of community-based programs; 2) achieving health equity by improving opportunities for health, particularly in communities with greater disease burden; and 3) using and expanding the evidence base for community-based strategies for improving public health.

Chronic diseases—including heart disease, cancer, stroke, diabetes, arthritis, and related risk factors, such as tobacco use, physical inactivity, poor diet, and obesity—are the leading causes of death and disability in the United States, accounting for seven of every ten deaths and affecting the quality of life of 90 million Americans. Reducing death and disability through the prevention and control of chronic conditions, and their risk factors, has critical importance for public health. However, solving the nation’s chronic disease problems requires the work of multiple sectors. Collaborations of governmental agencies via federal, state, local and tribes, and non-governmental organizations are needed to create environments that support health and healthy behaviors and reduce health disparities. When all sectors work toward common chronic disease prevention priorities, improvements in health can be amplified and accelerated.

The Centers for Disease Control and Prevention (CDC) established the Division of Community Health (DCH) to support multi-sectorial, community-based programs designed to promote healthy living in a variety of environments where people live, learn, work, and play. In 2014, NCCDPHP/DCH announced three new cooperative agreement programs to improve and/or implement sustainable, community-based programs that address the primary causes of chronic diseases:

1. Partnerships to Improve Community Health (PICH; Funding Opportunity Announcement (FOA) DP14-1417);
2. Racial and Ethnic Approaches to Community Health (REACH; FOA DP14-1419PPHF14); and
3. National Implementation and Dissemination for Chronic Disease Prevention (DP14-1418).

These programs are specifically designed to facilitate the work of state, local, and tribal governmental agencies, non-governmental organizations, and national organizations that need additional support to implement evidence- and practice-based interventions for reducing the prevalence of chronic diseases and risk factors for chronic diseases. The cooperative agreements will build on awardees’ previous efforts to establish coalitions or networks of multi-sector organizations, analyze local health issues, or develop plans to shape systems and environments that promote and sustain health and quality of life. Awardees will implement population-based

interventions that address poor nutrition, low physical activity, tobacco use and exposure, and lack of access to chronic disease prevention or risk reduction opportunities.

Interventions will be implemented across various settings (i.e., community, community institution/organization, faith-based, health care, school, work site) to increase access to healthier living for at least 75% of the population in a targeted jurisdiction. While the FOAs differ with regard to aspects of their approach, all three build on this understanding and propose steps to improve and /or implement sustainable, community-based improvements that address the primary causes of chronic diseases.

Each DCH program awardee funded under DP14-1417, DP14-1419PPHF14, or DP14-1418 is charged with implementing a community- or awardee-specific work plan that will lead to explicit, measurable health outcomes in its jurisdiction (or service area) among an entire population or a specific population subgroup. Although the programs emphasize policy and environmental improvements, activities that may be supported with DCH program funding include: establishing or strengthening community coalitions; participating in appropriate training; conducting community-specific needs assessments; promoting community engagement with populations experiencing health disparities; analyzing gaps in existing policies, systems, and environments; implementing evidence-based strategies and evaluating promising interventions; and supporting, disseminating, and amplifying the evidence base of the DCH strategies within national networks.

CDC awarded 93 cooperative agreements in September 2014 (41 awards to state, local and tribal governmental agencies and 52 awards to non-governmental organizations; see **Attachment 2** for a List of Awardees). Each DCH program awardee will be required to provide semi-annual reports to CDC describing its work plan, activities, and progress toward achieving objectives. CDC requests OMB approval to collect this information through an electronic management information system (MIS). During the developmental phase, the MIS was called the Policy, Environment, Programmatic, and Infrastructure Database (PEPID). The version prepared for release has been renamed the DCH-Performance Monitoring Database (DCH-PMD; see **Attachment 3a**). Initial work plans will be entered into the DCH-PMD in Fall/Winter 2014, and the first interim reports are due in Spring 2015. Each awardee will receive an instructional manual for the MIS (see **Attachment 3b, DCH-PMD User Guide**) as well as technical assistance from DCH, as needed.

CDC also requests OMB approval to conduct one special-purpose data collection per year (on average) for awardees funded under DP14-1417, DP14-1419PPHF14, or DP14-1418. CDC anticipates that additional, targeted information may be needed due to substantial interest in the new cooperative programs from a variety of stakeholders. This expectation is based on CDC's previous experience in implementing new cooperative agreement programs. In similar circumstances, CDC has received ad hoc inquiries from various stakeholders, such as the National Association of Chronic Disease Directors (NACDD), CDC leadership, the White House, HHS, and Congress. Given that the new DCH awardees represent many non-traditional organizations (in addition to state and local public health agencies) there is a renewed interest in understanding where these organizations are focusing their efforts. For example, CDC could be asked to specify how DCH awardees are working in (or with) census tracts, cities, rural areas,

tribes, or specific diverse populations to achieve their goals. DCH cannot fully anticipate the questions that may be asked, but proposes a mechanism for contacting awardees to obtain additional or clarifying information that may be needed to accurately respond to ad hoc requests. Moreover, because many DCH awardees are private sector entities, DCH's ability to fulfill some ad hoc requests through existing generic clearances (such as OSTLTS 0920-0879) is constrained. We have thus included a provision for targeted, supplemental information collection in the overall monitoring and reporting plan for DCH awardees.

DCH proposes to use the Change Request mechanism to document the specific justification for each special data collection, the proposed methodology, and mode of information collection (telephone interview, in-person interview, Web-based survey, or paper-and-pencil survey).

CDC may also use the Change Request mechanism:

1. To update the List of Awardees and the burden estimate associated with this clearance, if the level of funding allows for additional awards under the three FOAs itemized above.
2. To update the List of Awardees and the burden estimate associated with this clearance, if DCH announces new FOAs. CDC anticipates that data collection for all DCH programs will be unified by DCH's core principles and the performance monitoring strategies (i.e., CDC review of work plans and progress reports) outlined in this information collection request.
3. To revise the DCH-PMD data elements and/or the DCH-PMD User Guide based on feedback from awardees, DCH's experience in providing technical assistance to awardees, or needs identified through special purpose data collection requests.

2. Purpose and Use of the Information Collection

The purpose of the DCH programs is to create healthier communities through implementation of broad, evidence- and practice-based policy and environmental improvements in large and small cities, urban rural areas, tribes, multi-sectorial community coalitions, and racial and ethnic communities experiencing chronic disease disparities. This program advances the National Prevention Strategy and aligns with its strategic directions and "Healthy People 2020" focus areas.

The information collection and reporting requirements have been carefully designed to align with and support the goals outlined in the DCH cooperative agreements. The electronic DCH-PMD facilitates collection and reporting of the information in an efficient, standardized, and user-friendly manner. It will enable the accurate, reliable, uniform and timely submission to CDC of each awardee's objectives, work plans, milestones, and progress reports. The system requires awardees to present their Objectives in "SMART" format. SMART is an acronym for Specific, Measurable, Achievable, Relevant and Time-framed. DCH selected this framework because it helps awardees communicate their objectives in ways that are clear, consistent, and action-oriented. Our goal is to systematically educate awardees to re-format their plans into this structure.

The DCH-PMD will be used to generate a variety of routine and customizable reports. Local level reports will allow each awardee to summarize its activities and progress towards meeting work plan objectives. DCH awardees will use the DCH-PMD to manage and coordinate their activities and to improve their efforts to prevent and control chronic diseases. The system will allow awardees to fulfill their semi-annual reporting obligations under the cooperative agreements in an efficient manner by employing an integrated platform to organize the information needed for producing work plans, progress reports and continuation applications. The electronic system will thus reduce the administrative burden on the yearly continuation application and the progress review process by allowing awardees to save pertinent information from one reporting period to the next. Awardee program staff will be able to review the completeness of information necessary to submit required reports, enter basic summary information for reports at least semi-annually, and finalize and save required reports for upload into Grants.gov.

CDC will use the information collected in the DCH-PMD to monitor each awardee's progress and to identify its 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. Although each awardee's progress is assessed principally in terms of its own objectives and work plan, the DCH-PMD will also provide some capacity to generate reports that monitor progress or describe activities across multiple awardees.

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. Finally, the information collection will allow CDC to monitor the increased emphasis on partnerships and programmatic collaboration, and is expected to reduce duplication of effort, enhance program impact and maximize the use of federal funds.

The information collection is designed to address specific objectives outlined in each FOA: DP14-1417, DP14-1419PPHF14, and DP14-1418. In addition to routine performance monitoring, CDC will use the information collected through the DCH-PMD and special data requests to respond to inquiries from the HHS, the White House, Congress and other stakeholders about DCH program activities and their impact. Finally, CDC will use the results of this information collection to evaluate the program model for future program reporting efforts.

3. Use of Improved Information Technology and Burden Reduction

There are significant advantages to collecting information with the electronic DCH-PMD system:

- The use of a standard set of data elements, definitions, and specifications at all levels will help to improve the quality and comparability of performance information that is received by CDC for multiple awardees and multiple award types. Further, standardization will enhance the consistency of work plans and reports, enable cross-program analysis, and

will facilitate a higher degree of reliability by ensuring that the same information is collected on all objectives and activities with slightly different areas of emphasis, depending on the awardee type (Local and tribal government entities and Non-governmental entities).

- The structure of the DCH-PMD will minimize or eliminate many elements that would otherwise be repeated within stand-alone systems. Having all of the information collected in the same place in the same manner will reduce the level of burden attributable to redundancy and reduce the workload to enter and maintain the data. Programs will be able to transfer data from one year to another to minimize data re-entry.
- The DCH-PMD data structures and business rules will help awardees formulate objectives that are specific, measurable, achievable, relevant and time-framed (SMART). This formulation is intended to facilitate successful achievement of objectives and is integral to CDC's evaluation strategy for the DCH programs.
- The information being collected provides crucial information about each awardee's work plan, activities, partnerships and progress over the award period.
- Awardees will have the capacity to enter updates on an ongoing basis. This feature of the DCH-PMD is expected to facilitate real time communications with and interim review by CDC, resulting in more timely technical assistance. The ability to enter updates as activities occur may also result in more complete enumeration of DCH-funded efforts.
- The report generation capabilities of the electronic DCH-PMD will reduce the respondent burden associated with paper-based reports. Without the automated DCH-PMD 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.
- Capturing the required information electronically will allow CDC to formulate ad hoc analyses and reports that would be impracticable using paper-based information sources. Prior to adopting an electronic method of progress reporting, CDC's ability to respond to ad hoc requests was limited, and required CDC staff to spend many hours combing through hard copies of reports to organize and summarize information. Use of the keyword-searchable, electronic DCH-PMD system significantly improves CDC's ability to identify items of interest in an efficient manner.

DCH has successfully implemented similar DCH-PMD-based awardee monitoring strategies for other programs (see "Monitoring and Reporting System for Community Transformation Grant Awardees," OMB No. 0920-0946, exp. 8/31/2015).

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 DCH-PMD will consolidate 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 will participate in the DCH-PMD data collection.

6. Consequences of Collecting the Information Less Frequently

Reports will be collected semi-annually. The interim progress report is due no less than 90 days before the end of the budget period and also serves as a non-competing continuation application. The annual progress report is due no more than 90 days after the end of the budget period. Less frequent reporting would undermine accountability efforts at all levels and negatively impact monitoring awardee progress. The semi-annual reporting schedule ensures that CDC responses to inquiries from HHS, the White House, Congress and other stakeholders are based on timely and up-to-date information. The provision for special-purpose data collections is included to allow CDC to respond in a timely manner to ad hoc requests for information from the White House, Congress, HHS, or other stakeholders; or to obtain additional information needed by CDC for program planning or management.

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

There are no special circumstances related to the DCH-PMD, 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 was published in the Federal Register on July 17, 2014, Volume 79, Number 137, pages 41691-41693 (see **Attachment 5**). No public comments were received.

B. Other Consultations

The DCH-PMD was designed collaboratively by CDC staff and the data collection contractor. Consultation will continue throughout the implementation process. There were no other external consultations.

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

10.1 Privacy Impact Assessment Information

Overview of data collection

Information will be collected from DCH awardees through an electronic DCH-PMD. Information placed into the system produces interim and annual reports as PDFs that awardees can use to upload into grants.gov. This procedure satisfies the routine, semi-annual cooperative agreement reporting requirements. Progress reports are required twice per year, but data entry can occur on a real-time basis. As a result, the DCH-PMD can also be used for ongoing program management, and supports more effective, data-driven technical assistance between NCCDPHP and awardees.

The DCH-PMD is a centralized, electronic system that supports the collection and reporting of information that will be used by CDC to help assess the impact of DCH funding. The DCH-PMD will be used to describe, evaluate and enhance opportunities for collaborative efforts and partnerships. Having all this information in a single and secure database will allow CDC Project Officers to search across multiple programs, help ensure consistency in documenting progress and technical assistance, enhance accountability of the use of federal funds, and provide timely reports as frequently requested by HHS, the White House, and Congress.

This information collection request includes a provision for special-purpose data collections that may be needed as DCH implements new cooperative agreement funding programs. The objectives, content, and methods of each request will be described in a Change Request.

Information to be collected

Awardees will store information in the DCH-PMD about their personnel, work plan objectives, milestones and activities, resources, and facilitators and barriers to success. The DCH-PMD will also collect information about the staffing resources dedicated by each awardee as well as partnerships with external organizations. The DCH-PMD requires DCH awardees to define their objectives in action-oriented SMART format (Specific, Measurable, Achievable, Relevant, and Time-Framed).

The DCH-PMD will collect a limited amount of information in identifiable form (IIF) for key program staff (e.g., Program Director). Each awardee will provide the names of these individuals as well as their professional contact information. No individually identifiable information will be collected; and, no personal contact information will be collected.

How the information will be shared and for what purpose

The DCH-PMD will generate a variety of routine and customizable reports. Local level reports will allow each awardee to summarize its activities and progress towards meeting work plan objectives. CDC will also have the capacity to generate reports that describe activities across multiple awardees. CDC will also use the information collection to respond to inquiries from the HHS, the White House, Congress and other stakeholders about DCH program activities and their impact. We have learned that in standing up new programs, we often receive inquiries about use of funds and want to provide for that type of circumstance in this request. Each time a special

data call occurs, CDC would provide the request for information to OMB for review and approval.

Impact the proposed collection will have on the respondent's privacy

Information will be not being collected about individuals; rather the data that is collected from DCH awardees consists of work plans and progress reports, including objectives and milestones.

Whether individuals are informed that providing the information is voluntary or mandatory

Awardees are required to respond as a condition of cooperative agreement funding.

Opportunities to consent, if any, to sharing and submission of information

The DCH-PMD data collection does not involve research with human subjects. Awardees are cooperative agreement awardees. The information collection does not require consent from individuals, or IRB approval.

How the information will be secured

Access to the DCH-PMD will be 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 will have access to its own information and decide the level of access for each of its authorized users. The extent to which local partners may access an awardee's information will be decided by that awardee. CDC staff, and evaluation, and technical assistance and training contractors will have varying levels of access to the system with role-appropriate security training, based on the requirements of their position(s). Aggregated information will be stored on an internal CDC SQL server subject to CDC's information security guidelines. The DCH-PMD will be hosted on NCCDPHP's Intranet and Internet Application platforms, which undergo security certification and accreditation through CDC's Office of the Chief Information Security Officer.

Privacy Act Determination

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 and local governmental agencies, tribes and territories, state or local non-profit organizations, and national networks of community-based organizations. Although contact information is obtained for each awardee, the contact person provides information about the organization, not personal information.

11. Justification for Sensitive Questions

The DCH-PMD instrument does not collect sensitive information. No personal information is requested. The DCH-PMD will collect a limited amount of information in identifiable form (IIF) for key program staff (e.g., Program Director). Each awardee will provide the names of these individuals as well as their professional contact information. The contact person will only provide information about activities conducted under the collaborative award, not personal information.

12. Estimates of Annualized Burden Hours and Costs to Respondents

A. Estimated Annualized Burden Hours

Awardees will report information to CDC about their objectives and activities through the DCH-PMD, an electronic interface (see **Attachment 3a**). Current respondents are the 93 awardees for PICH, REACH, and National Implementation FOAs. Of these awardees, 41 are from the state, local, and tribal government sector, and 52 awardees are from the private sector.

CDC anticipates that burden to respondents will vary substantially over the three-year clearance period. The time commitments for DCH-PMD data entry and training are greatest during the initial population of the MIS, typically in the first six months of funding. Estimated burden for the one-time population of the DCH-PMD is 15 hours and will be annualized over the 3-year clearance period. The initial burden estimate of 15 hours is based on previous experience with a similar MIS that has been used with other DCH awardees in the past (OMB No. 0920-0946, exp. 8/31/2015). The estimate of 15 hours provides sufficient time for awardees to learn the DCH-PMD interface and enter their information into the system, given that their routine operations are likely to be based on different systems and assumptions. A DCH-PMD User Guide (see **Attachment 3b**) will be provided to awardees as a reference and guidance tool. The annualized number of respondents is 14 respondents in the state, local, and tribal government sector (41/3), and 18 respondents in the private sector (52/3).

The efficiencies of the electronic DCH-PMD are realized in subsequent reporting periods. After the initial population of the DCH-PMD has been completed, ongoing maintenance of the system is limited to entering changes, progress information, and new activities. The estimated burden for routine semi-annual reporting is 3 hours per response. The annual updates and reports are important for quality assurance and accountability.

Overall, using DCH-PMD permits CDC to streamline information gathering and reporting with a common and consistent approach that is most useful for program monitoring; making comparisons; aggregating information; and keeping CDC updated on progress.

Each awardee may be required to participate in special-purpose data collection requests (on average, one per year). The estimated burden per response is 6 hours. Special-purpose data collections may be conducted by in-person interview, telephone interview, paper survey, or Web-based survey.

Over the three-year period of this information collection request, the total estimated annualized burden for the 93 current awardees is 1,596 hours, as summarized in Table A.12-A.

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

Type of respondents	Form Name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
DCH Program Awardees (state, local, and tribal government entities)	DCH DCH-PMD: Initial population	14	1	15	210
	DCH DCH-PMD: Semi-annual reporting	41	2	3	246
	Special Data Request	41	1	6	246
DCH Program Awardees (private sector entities)	DCH DCH-PMD: Initial population	18	1	15	270
	DCH DCH-PMD: Semi-annual reporting	52	2	3	312
	Special Data Request	52	1	6	312
Total					1,596

B. Estimated Annualized Cost to Respondents

A program manager will prepare the progress report for each area. The average hourly wage for a program manager is \$30.65. The hourly wage rates for program managers are based on wages for similar mid-to-high level positions in the public sector. The total estimated annualized cost to respondents is \$48,919 as summarized in Table A.12-B.

Table A.12-B. Estimated Annualized Cost to Respondents same as above with hourly cost

Type of respondents	Form Name	Number of respondents	Number of responses per respondent	Average burden per response	Average hourly wage	Total cost
DCH Program Awardees	DCH DCH-PMD: Initial	14	1	15	\$30.65	\$6,437

(state, local, and tribal governmental agencies)	population					
	DCH DCH-PMD: Semi-annual reporting	41	2	3	\$30.65	\$7,540
	Special Data Request	41	1	6	\$30.65	\$7,540
DCH Program Awardees (private sector organizations)	DCH DCH-PMD: Initial population	18	1	15	\$30.65	\$8,276
	DCH DCH-PMD: Semi-annual reporting	52	2	3	\$30.65	\$9,563
	Special Data Request	52	1	6	\$30.65	\$9,563
Total						\$48,919

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

The DCH-PMD is designed to use existing hardware within funded sites, and all respondents currently have access to the Internet to use the information system. No capital or maintenance costs are expected. 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 average annualized cost to the federal government is \$178,864, as summarized in Table A.14-A. Major cost factors for the DCH-PMD include application design and development costs and system maintenance costs. The DCH-PMD developer and data collection contractor is ICF International.

Table A.14-A. Annualized Cost to the Federal Government

Cost Category	Total
CDC Personnel	
<ul style="list-style-type: none"> • 100% GS-12 @\$71,901/year = \$71,901 • 50% GS-13 @ \$85,500/year = \$42,750 • 25% GS-14 @ \$101,035/year = 25,259 	
Subtotal, CDC Personnel	\$ 139,910
Data Collection Contractor	\$ 38,954
Total	\$ 178,864

15. Explanation for Program Changes or Adjustments

This is a new collection.

16. Plans for Tabulation and Publication and Project Time Schedule

A. Time schedule for the entire project

The cooperative agreement cycle is three years. OMB approval is being requested for three years. Reports will be generated by the awardees per the FOA requirements twice a year, in April and November. Data collection will begin with the awarding of the co-operative agreements and will continue throughout the funding cycle.

B. Publication plan

Information collected through the DCH-PMD will be reported in internal CDC documents and shared with state-based and community-based programs.

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	1-36 months after OMB approval
Data Publication	Twice annually
Data Analysis	1-36 months after OMB approval

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

The DCH DCH-PMD program will display the expiration date for OMB approval of the information system data collection on its Internet home page.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification statement.