Supporting Statement: Section A

Assessment of Targeted Training and Technical Assistance (TTA) Efforts on the Implementation of Comprehensive Cancer Control

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Table of Contents

Attachments

1 Authorizing Legislation: Public Health Service Act, Research and Investigation
2 Federal Register Notice
3a List of Awardees for DP13-1314 and DP13-1315
3b DP13-1314 and DP13-1315 Conceptual Framework
4 Evaluation Matrix
5a Case Study Interview Introductory Letter
5b Worksheet for Identifying Case Study Interviewees
5c Case Study Interview Introductory Email
5d Case Study Interview Matrix
6a Case Study Interview Guide for DP13-1314 Program Directors or Managers
6b Case Study Interview Guide for DP13-1315 Program Directors or Managers
7a Case Study Follow-Up Interview Guide for DP13-1314 Program Directors or Managers
7b Case Study Follow-Up Interview Guide for DP13-1315 Program Directors or Managers
8a Case Study Interview Guide for DP13-1314 Evaluators
8b Case Study Interview Guide for DP13-1315 Evaluators
9a Case Study Interview Guide for DP13-1314 Partners
9b Case Study Interview Guide for DP13-1315 Partners
10a Web-based survey Pre-notification Email
10b Web-based survey Invitation Email
10c Web-based survey First Reminder Email
10d Web-based survey Second Reminder Email
10e Web-based survey Thank You Email
10f Screen shots of Web-based Survey Multiple Options
10g Screen shots of Web-based Survey Single Option
11a In-depth Interview Recruitment Email
11b In-depth Interview Guide
12 Data Collector Non-Disclosure Agreement
13a Case Study Interview Informed Consent
13b In-depth Interview Informed Consent
14 IRB Approval Letter

Summary Table

- Goal of the study. The goal of this information collection is to document the implementation of training and technical assistance (TTA) administered by 10 awardees to National Comprehensive Cancer Control Program (NCCCP) and National State-Based Tobacco Control (NSBT) grantees and to explore how TTA implemented is associated with NCCCP and NSBT program outcomes.
- Intended use of the resulting data. CDC will use findings to monitor TTA and inform the development of future TTA models to effectively support NCCCP and NSBT grantees.
- Methods to be used to collect information. CDC will use a mixed-methods approach to collect relevant information, utilizing case studies, a web-based survey, and in-depth interviews.
- The subpopulation to be studied. Information will be collected from the 10 awardees that deliver TTA. Eight of the 10 awardees are funded under DP13-1314 and 2 of the 10 awardees are funded under DP13-1315. In addition, information will be collected from the recipients of the TTA. Recipients include NCCCP and NSBT grantees, partners, and coalition members.
- How data will be analyzed. Data analysis will include thematic analysis of qualitative data and descriptive statistics (e.g., counts, means, range, standard deviation) for survey responses.

A. Justification

A1. Circumstances Making the Collection of Information Necessary

This is a new Information Collection Request for which CDC is authorized to collect by the Public Health Service Act **(Attachment 1).** The 60-day Federal Register Notice was published on October 24, 2016 and is further discussed in Section A8 **(Attachment 2**). OMB approval is requested for two years.

Cancer is the second leading cause of death in the United States, and health care costs for cancer care are expected to rise to $158 billion by 2020.[1,2] Addressing this public health problem requires primary prevention, early detection and treatment, cancer survivorship support systems, and a reduction in health disparities. Positioning state, tribal, territorial and local entities to

[1] Detailed tables for the National Vital Statistics Report d*eaths: Final data for 2013. National Vital Statistics Report, 64 (2)*. Retrieved August 3, 2015, from http://www.cdc.gov/nchs/data_access/Vitalstatsonline.htm

[2] Mariotto, A. B., Yabroff, K. R., Shao, Y., Feuer, E. J., & Brown, M. L. (2011, January). Projection of the cost of cancer care in the U.S.: 2010–2020. Journal of the National Cancer Institute.

implement evidence-based strategies through the coordination of resources and activities has the potential to impact population-level cancer outcomes and reduce the burden of cancer.

The Centers for Disease Control and Prevention (CDC) has helped to provide support to a variety of state, tribal, territorial and local entities through a number of different programs. CDC's National Comprehensive Cancer Control Program (NCCCP) has been a primary funder for state and community-based cancer control interventions since its inception in the late 1990s. The program supports states and communities in developing a comprehensive approach to cancer prevention and control that includes supporting an infrastructure for state, local, and population-based interventions and multi-sectoral partnerships and coalitions. Currently, NCCCP supports 65 cancer control program grantees including programs in all 50 states, the District of Columbia, and in a number of tribes, tribal organizations, and U.S. Associated Pacific Islands/territories. Since 1999, CDC's Office on Smoking and Health (OSH) also has worked to build state health department infrastructure and capacity to conduct coordinated comprehensive tobacco prevention and control activities. In fiscal year 2015, OSH provided funding to a number of state health departments and local partners through the National State-Based Tobacco Control Program (NSTB) to support the implementation and evaluation of evidence-based environmental, policy, and systems interventions, strategies, and activities to reduce tobacco use, secondhand smoke exposure, tobacco-related disparities and associated disease, disability, and death. CDC has also worked to support these funded programs, coalition members, and affiliated partner organizations with training and technical assistance (TTA) that facilitates the implementation of local programs and contributes to the achievement of local and national program aims.

CDC has focused on developing and implementing innovative programs to further enhance the capacity of NCCCP and NSBT grantees, their coalitions, and partners in an effort to improve program implementation and outcomes. CDC funds 10 organizations **(Attachment 3a)** (hereafter referred to as "awardees") under two cooperative agreements: the *Consortium of National Networks to Impact Populations Experiencing Tobacco-Related and Cancer Health Disparities, DP13-1314* (hereafter referred to as DP13-1314; 8 awardees) and the *National Support to Enhance Implementation of Comprehensive Cancer Control Activities, DP13-1315* (hereafter

referred to as DP13-1315; 2 awardees). Awardees of these cooperative agreements provide TTA to NCCCP and NSBT grantees and their partners to support local implementation of high-impact cancer control and prevention strategies that align with CDC priorities. This collaboration ensures that program design, monitoring, and evaluation is conducted by both DCPC and OSH. The TTA approaches used by D13-1314 and DP13-1315 awardees aim to impact short and long-term outcomes across awardee, NCCCP and NSBT program, and population levels as depicted in the evaluation conceptual framework **(Attachment 3b)**. DP13-1314 awardees are charged with building the capacity of and administering TTA to state NCCCP- and NSBT grantees through the administration of a national network to reduce the burden of cancer- and tobacco-related health disparities among vulnerable populations. DP13-1315 awardees are charged with developing and delivering high-quality TTA for NCCCP funded programs, coalition members, and partners focused on improving implementation of evidence-based strategies for cancer prevention and control. As identified by the evaluation team, the TTA approach used by D13-1314 and DP13-1315 awardees share five key components: identification of needs, capacity building, planning and development of TTA, implementation, and evaluation and maintenance. (**Attachment 3b**).

Published evidence, though limited, suggests that easily accessible, collaborative TTA approaches are best suited to build the capacity of TTA recipients. However, to date, CDC has not collected information that would allow for the assessment of the TTA provided by DP13-1314 and DP13-1315 awardees. In order to assess whether these cooperative agreements have been implemented as intended and contributed to NCCCP and NSBT grantees' achievements in program goals and outcomes, CDC is conducting a mixed-method evaluation. Evaluating DP13-1314 and DP13-1315 will provide CDC with a better understanding of the TTA provided across both cooperative agreements and help to identify the extent to which core elements of TTA were administered and most effective across models. This evaluation will also provide the information and guidance needed to develop CDC's future TTA support efforts to more effectively and efficiently support NCCCP and NSBT grantees.

A2. Purpose and Use of Information Collection

The purpose of this data collection is to conduct an assessment of the DP13-1314 and DP13-1315 cooperative agreements to: (1) document how TTA was provided by DP13-1314 and DP13-1315 awardees and the extent to which each cooperative agreement was able to achieve planned short-term outcomes; (2) identify the extent to which DP13-1314 and DP13-1315 TTA efforts contributed to NCCCP and NSBT grantees' efforts; and; (3) identify elements of TTA administered across both cooperative agreements that could inform the development of a viable TTA model for enhancing future tobacco and cancer prevention and control efforts. The team created an evaluation conceptual framework **(Attachment 3b)** that was used to develop five primary process- and outcome-related evaluation questions and an evaluation matrix to map all corresponding evaluation questions to appropriate indicators, data sources, and potential analysis (**Attachment 4**). The evaluation questions are:

1. How are DP13-1314 and DP13-1315 awardees implementing the components of their respective cooperative agreement to build capacity among their target audience(s) (e.g., NCCCP and NSBT programs)?
2. To what extent are DP13-1314 and DP13-1315 awardees implementing TTA?
3. To what extent did DP13-1314 and DP13-1315 awardees achieve planned short-term outcomes for their respective cooperative agreements?
4. To what extent did DP13-1314 and DP13-1315 awardees' TTA activities contribute to enhanced program implementation and achievement in NCCCP and NSBT program priorities and goals?
5. What are the essential elements of a TTA model that build the capacity of NCCCP and NSBT grantees?

All questions are informed by multiple indicators that examine the following: implementation of each cooperative agreement (e.g., DP13-1314, DP13-1315); perceptions of the TTA received and their contributions to achieving NCCP and NSBT program outcomes; and the identification of essential elements of TTA identified across each cooperative agreement. CDC will use findings from the assessment to inform the development of future TTA efforts that best support NCCCP and NSTB state programs.

This proposed data collection will involve three complementary efforts: 1) case studies of DP13-1314 and DP13-1315 awardees; 2) a web- survey with NCCCP and NSBT grantees, partners and coalition members; and 3) in-depth interviews with NCCCP and NSBT grantees who report receiving the most TTA from DP13-1314 and DP13-1315 awardees.

The case studies will entail document review and interviews with staff and partners of DP13-1314 and DP13-1315 awardees involved with administering TTA. The contractor will work with a program administrator from each of the DP13-1314 and DP31-1315 awardees to recruit and identify and select appropriate interview respondents and will contact potential respondents to schedule interviews using an introductory letter, a worksheet for identifying interviewees, and a preparatory call (**Attachments 5a, 5b, and 5c).** Interview guides are tailored for each respondent type and include questions and probes designed to gather the most pertinent information across respondent types, with some questions and probes asked across all respondent types and some questions and probes specific to individual respondent types **(Attachment 5d).** Program directors or managers from DP13-1314 and DP13-1315 will be interviewed using a tailored guide at two time points during the evaluation period – time one will occur immediately after OMB approval (early 2017) and time two will occur 12-15 months after time one data collection. **(Attachments 6a – 7b)**. All other participants, including DP13-1314 and DP13-1315 evaluators and partners, will be interviewed only once using tailored guides **(see Attachments 8a – 9b).** Information gathered via case studies will be used to describe implementation of the DP13-1314 and DP13-1315 and TTA components, the factors that affect implementation, and perceived effectiveness of activities. The web-survey with individuals from NCCCP and NSBT grantee, partner and coalition member organizations will assess the amount and type of TTA received and the perceived effectiveness of TTA received. The contractor will recruit and communicate with web-based survey participants using standardized templates and administer the web-based survey with recruited individuals one time during the study period **(see Attachments 10a – 10g).** The in-depth interviews with NCCCP and NSBT grantees who report receiving the most TTA from DP13-1314 and DP13-1315 awardees will be administered one time during the study period and will be used to provide further in-depth information about the type, quality, and perceived effectiveness of TTA received. The contractor will recruit for and conduct all in-depth interviews **(Attachments 11a – 11b).**

Collectively, the proposed information collection activities and tools have been designed specifically to meet the aims of this assessment and will contribute to CDC's ability to demonstrate the results of TTA administered by DP13-1314 and DP13-1315 awardees. This information will also help to inform CDC in the types of TTA activities that best enhance NCCCP and NSTB grantees' capacity to implement high-quality, evidence-based strategies for tobacco and cancer prevention and control. CDC can use this information to develop new TTA support systems for NCCCP and NSTB grantees in the future.

A3. Use of Improved Information Technology and Burden Reduction

All information collection will be conducted remotely – in-depth interviews will be conducted via phone and the survey will be conducted via the Web (**Attachments 6a-9b; 10f-g; and 11b)**. Both methods use pre-existing web infrastructure and were chosen to reduce the overall burden on respondents.

A4. Efforts to Identify Duplication and Use of Similar Information

The proposed information collection is unique in that there are no other data collection efforts currently underway to assess implementation of TTA across both DP13-1314 and DP13-1315. Document review was conducted on progress reports, work plans and evaluation plans to ensure information collected through the case study interviews, web-based survey and key informant interviews was not duplicative. This assessment is the first data collection effort to assess the two approaches to administering TTA used by DP13-1314 and DP13-1315 awardees among the NCCCP and NSBT grantees.

A5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this data collection.

A6. Consequences of Collecting the Information Less Frequently

This information collection is critical to expanding CDC's understanding of how TTA implemented under DP13-1314 and DP13-1315 cooperative agreements is being implemented

and in which context each approach has the potential to be most successful. Without this information collection, CDC will have limited insight to plan and provide comprehensive TTA to NCCCP and NSBT grantees which will limit CDC's ability to adequately account for federal dollars spent on this public program. Less frequent data collection would compromise CDC's ability to fully understand and document changes in the implementation of TTA over time and the potential success of each cooperative agreement.

A7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

There are no special circumstances relating to the guidelines of 5 CFR 1320.5, and the project fully complies with the regulation.

A8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A 60-day Notice was published in the Federal Register on October 24, 2016 [Vol. 81, No. 205, pages 73110-73112] **(Attachment 2).** No public comments were received.

Data collection instruments were developed by multi-disciplinary evaluation teams at CDC and ICF International, the contractor. Interview and survey questions were informed by a preliminary review of existing TTA frameworks and models used to better understand how to best assess their implementation across awardees.

A9. Explanation of Any Payment or Gift to Respondents

Respondents will not receive any payment or gifts for their participation in this data collection effort.

A10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

This submission has been reviewed by CDC's Information System Security Office, which determined that the Privacy Act does not apply. The proposed study involves a minimum amount of information in identifiable form (IIF).

Respondents will be recruited from DP13-1314 and DP13-1315 awardees (i.e., program directors or managers, evaluators, and partners), as well as NCCCP- and NSBT-funded programs (i.e., program directors, managers, coalition members, and partners). The data collection contractor, ICF International, will have access to professional contact information for the program director or manager, evaluator, and key partners from each selected organization, including work telephone numbers and e-mail addresses, in order to recruit and schedule their participation in in-depth interviews. A snowball sampling technique will be used to administer the web-survey, and CDC will not have access to participants' professional contact information.

IIF will be stored separately from response data. A linking file will be created and available only to senior project management at ICF International. This information will only be used to ensure completeness of the data files. The linking file will include the role of the respondent and their organization (and will not include the individual's name or contact information), the date of interview/survey completion, and the code assigned to the data file. This will ensure that no personally identifiable information, outside of the individual's role and organization, is re-linkable. In addition, all data collectors will be asked to complete a Data Collector Non-disclosure Agreement prior to conducting data collection **(Attachment 12)** and will be trained on the project's protocol and procedures related to security requirements and privacy.

Key individuals from DP13-1314 and DP13-1315 awardees (i.e., program directors or managers, evaluators, and partners), and NCCCP- and NSBT- funded programs (i.e., program directors, staff, coalition members, and partners) will be recruited to participate in this information collection. Participation in data collection is voluntary for all participants; respondents who decline participation will not face penalty of any kind. For case study and in-depth interviews, all participants will be read an informed consent statement prior to participating in the interviews **(Attachment 13a and 13b).** An informed consent statement will be included on the cover page of the survey instrument prior to the instrument questions **(Attachment 10f and 10g)**. All informed consent statements inform participants that their participation in data collection is voluntary, and they can choose not to answer individual questions, end the interview/survey at any time, or decline participation without penalty. Whether or not individuals choose to

participate will not impact current or future funding. Respondents will be required to either agree to or decline participation prior to participating in data collection. During interviews, respondents may be asked to identify and describe entities and key staff members or partners who have familiarity with DP13-1314 and DP13-1315 awardees' programs. No contact information will be collected for individuals who are discussed during the interviews. The purpose of collecting information about key staff and partners is to guide CDC in identifying the number and types of individuals that should be engaged in similar efforts across various settings. The information collected will be concentrated on planning and implementation of the FOAs, not personal information about the individual in any specific role.

Although the data collection contractor will have temporary access to identifiable information for recruitment and scheduling purposes, response data will not be recorded in a manner that can be linked to respondent identifiers. The contractor will assign each interview respondent a unique identifier code, and will store and analyze interview data by identifier code. The personal contact information for respondents will not be used for analysis or reporting purposes. Survey data will not be linked with individual respondents. All data collected will be analyzed in aggregate and discussed in summary reports that do not contain any personal identifiers.

Study information and data, including contact information for respondents, linking identifiers, and interview and survey responses, will be destroyed within 3 years of the project end date. All electronic data files (e.g. interview notes, exported survey responses) will be stored at ICF on a project shared drive on ICF's secure network servers; only project staff who have been authorized by the project manager will have access the shared drive.

A11. Institutional Review Board and Justification for Sensitive Questions

No sensitive information is requested. CDC's information collection contractor obtained IRB approval for conduct of this assessment **(Attachment 14)**.

A12. Estimate of Annualized Burden Hours and Costs

Information will be collected via three methods – case studies, in-depth interviews, and a web-survey. The estimate for all burden hours for the identification of case study participants and all

other interviews conducted (e.g., case studies and in-depth interviews) are based on previous experience with similar data collection efforts by the project staff.

For the case studies of TTA providers, we will work with a program administrator from each of the 8 DP13-1314 awardee organizations, and each of the 2 DP13-1315 awardee organizations, to identify appropriate case study interview respondents and schedule interviews (estimated burden per response is one hour) **(Attachment 5b, Worksheet for Identifying Case Study Interviewees)**. We will conduct baseline interviews with 4 individuals (1 program director or manager, 1 program evaluator, and 2 program partners) from each awardee organization. The estimate for burden hours per respondent for the baseline program directors or managers interviews is 90 minutes **(Attachment 6a – 6b)**, and the estimate of burden per respondent for all other baseline case study interviews is 60 minutes **(Attachment 8a – 9b)**. We will also conduct follow up case study interviews with program directors or managers, and the estimated burden per respondent is 60 minutes **(Attachment 7a – 7b)**. Interviews are tailored for each respondent type and include questions and probes designed to gather the most pertinent information across respondent types, with some questions and probes asked across all respondent types and some questions and probes specific to individual respondent types **(Attachment 5d).**

We will also collect information from TTA recipients (NCCCP and NSBT grantees, coalition members, and partners). The estimate for burden hours for the web-based survey is guided by a pilot test of the information collection instrument by 6 public health professionals. In the pilot test, the average time to complete the instrument including time for reviewing instructions was 15 minutes. We estimate approximately 1,560 respondents for the web-based survey. The survey screen shots **(Attachment 10f – 10g)** show two options for respondents, depending on their answers to question #7. Finally, we will conduct 10 in-depth interviews with selected individuals from NCCCP and NSBT grantee programs, including program directors, staff, partners, and coalition members. The estimated burden per respondent is 30 minutes **(Attachment 11b)**.

Information will be collected over a two-year period. The annualized estimated number of respondents is 815 and the total annualized estimated burden is 231 hours.

Table A12-1. Estimated Annualized Burden Hours

Type of Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hrs)	Total Burden (in hrs)
DP13-1314 and DP13-1315 Awardee Organizations	Worksheet for Identifying Case Study Interviewees	5	1	1	5
DP13-1314 Program Directors/ Managers	Case Study Interview Guide for DP13-1314 Program Directors/ Managers	4	1	1.5	6
	Case Study Follow-Up Interview Guide for DP13-1314 Program Directors/ Managers	4	1	1	4
DP13-1315 Directors/ Managers	Case Study Interview Guide for DP1-1315 Program Directors/ Managers	1	1	1.50	2
	Case Study Follow-Up Interview Guide for DP1-1315 Program Directors/ Managers	1	1	1	1

DP13-1314 Evaluators	Case Study Interview Guide for DP1-1314 Evaluators	4	1	1	4
DP13-1315 Evaluators	Case Study Interview Guide for DP1-1315 Evaluators	1	1	1	1
DP13-1314 Partners	Case Study Interview Guide for DP1-1314 Partners	8	1	1	8
DP13-1315 Partners	Case Study Interview Guide for DP1-1315 Partners	2	1	1	2
NCCCP and NSBT Program Directors, Staff, Coalition Members, and Partners	Web-based survey	780	1	15/60	195
NCCCP and NSBT Program Directors, Staff, Coalition Members, and Partners	In-Depth Interview Guide	5	1	0.50	3
TOTAL		**815**			**231**

Table A12-2 presents the calculations for cost of annualized burden hours. Average hourly wage estimates were obtained from the U.S. Department of Labor, Bureau of Labor Statistics.

- The average annual salary of $42,450 for health educators and community health workers was used to calculate the hourly wage of $20.41 for program administrators.

- The average annual salary of $117,200 for general and operational managers was used to calculate the hourly wage of $56.35 for NCCCP and NSBT Program Directors, Staff, Coalition Members, and Partners.

- The average annual salary of $54,730 for survey researchers was used to calculate the hourly wage of $26.31 for program evaluators.

- The average annual salary of $80,040 for social scientists and related workers was used to calculate the hourly wage of $38.48 for all other NCCCP partners.

The estimated annualized cost to respondents is $12,451 as summarized below in Table A.12-2.

Table A12-2. Estimated Annualized Cost to Respondents

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hrs)	Average Hourly Wage	Total Cost
DP13-1314 and DP13-1315 Awardee Organizations	Worksheet for Identifying Case Study Interviewees	5	1	1	$20.41	$102
DP13-1314 Program Directors/ Managers	Case Study Interview Guide for DP13-1314 Program Directors or Managers	4	1	1.50	$56.35	$338
	Case Study Follow-Up Interview Guide for DP13-1314 Program Directors or Managers	4	1	1	$56.35	$225
DP13-1315 Program Directors/ Managers	Case Study Interview Guide for DP1-1315 Program Directors or Managers	1	1	1.50	$56.35	$85
	Case Study Follow-Up Interview Guide for DP1-1315 Program Directors or Managers	1	1	1	$56.35	$56

DP13-1314 Evaluators	Case Study Interview Guide for DP1-1314 Evaluators	4	1	1	$26.31	$105
DP13-1315 Evaluators	Case Study Interview Guide for DP1-1315 Evaluators	1	1	1	$26.31	$26
DP13-1314 Partners	Case Study Interview Guide for DP1-1314 Partners	8	1	1	$38.48	$308
DP13-1315 Partners	Case Study Interview Guide for DP1-1315 Partners	2	1	1	$38.48	$77
NCCCP and NSBT Program Directors, Staff, Coalition Members, and Partners	Web-based Survey	780	1	15/60	$56.35	$10,988
NCCCP and NSBT Program Directors, Staff, Coalition Members, and Partners	In-Depth Interview Guide	5	1	0.50	$56.35	$141
TOTAL		815				$12,451

A13. Estimate of Other Total Annual Cost Burden to Respondents or Record Keepers

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

A14. Annualized Cost to the Government

Total operations and maintenance costs includes work performed by both the contractor and CDC personnel. Governmental costs for this project include CDC personnel costs, including an FTE (GS-14) to lead the project and coordinate all related activities of each information collection as well as another FTE (GS-13) to help with data management, analysis, and reporting. For this information collection, 208 hours of staff time were estimated for each FTE annually. Cost of the contractor represents an estimated 75% ($244,911) of total annual contract funds ($326,762) allocated for evaluation activities. The contractor is responsible for leading all data collection, including recruitment, scheduling of interviews, collecting and analyzing data. The estimated total cost (CDC FTEs plus contract costs) to the federal government is $253,976. Table A.14 describes how the cost estimate was calculated.

Table A14-1. Estimated Annualized Cost to the Federal Government

Staff (FTE)	Average Hours per Collection	Average Hourly Rate	Average Cost
Public Health Advisor (GS-14) Project planning, management, OMB review, analysis of findings, and report writing	104	$47.86	$4,977
Public Health Advisor (GS13) time for project planning, management, OMB review, analysis of findings, and report writing	104	$39.31	$4,088
Contractor			$244,911
Estimated Total Cost of Information Collection			$253,976

A15. Explanation for Program Changes or Adjustments

This is a new data collection.

A16. Plans for Tabulation and Publication and Project Time Schedule

Baseline case study interviews will be completed one time within 3 months of OMB approval; follow-up case study interviews will be completed one time within 12-15 months of OMB approval. The web-based survey will be completed one time within 6 months of OMB approval. In-depth interviews will be completed one time within 10 months of OMB approval. Data validation, analysis, and report preparation will follow. CDC plans to disseminate the outcomes

of the study within and outside the federal government in the form of scientific presentations, peer-reviewed publications, and tools and resources developed for program grantees.

OMB approval is requested for two years. The project timeline is outlined in Table A16-1. If data collection isn't initiated by July 3, 2017, the follow-up timeline would need to be compressed to ensure data collection is completed by the end of the contract. Otherwise, a contract modification to extend the period of performance would need to be sought. Compressing the data collection timeline may impact response rates and also the quality of the follow-up data with less time to assess changes that occurred throughout the cooperative agreement.

A16-1 Estimated Project Schedule

Activity	Time Schedule*
Send introductory letter and email	July 3, 2017 (1 month after OMB approval)
Select case study interview participants	July 3, 2017 (1 month after OMB approval)
Conduct case study interviews (baseline)	September 1, 2017 (3 months after OMB approval)
Send web-based survey pre-notification email	October 2, 2017 (4 months after OMB approval)
Administer web-based survey – first wave	October 2, 2017 (4 months after OMB approval)
Administer web-based survey – second wave	November 1, 2017 (5 months after OMB approval)
Administer web-based survey – third wave	December 1, 2017 (6 months after OMB approval)
Send first web-based survey reminder email	October 2 – December 1, 2017 (4-6 months after OMB approval)
Send second web-based survey reminder email	October 2 – December 1, 2017 (4-6 months after OMB approval)
Send survey thank you emails	October 2 – December 1, 2017 (4-6 months after OMB approval)
Analyze case study interview data (baseline)	February 1, 2018 (8 months after OMB approval)
Analyze web-based survey data	March 1, 2018 (9 months after OMB approval)
Conduct in-depth interviews	April 2, 2018 (10 months after OMB approval)
Conduct case study interviews (Follow-up)	June 1 – September 3, 2018 (12-15 months after OMB approval)
Finalize data analysis, develop final report, and conduct dissemination activities on study findings	September 3 – December 3, 2018 (15-18 months after OMB approval)

*Assumes start date of June 1, 2017

A17. Reason(s) Display of OMB Expiration Date is Inappropriate

The OMB expiration date will be displayed on all information collection instruments.

A18. 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.