CDC WORKSITE HEALTH SCORECARD

Reinstatement with Change

Supporting Statement: Part A

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- The goal of this collection is the establishment and evaluation of the *updated* CDC Worksite Health Scorecard, a web-based organizational assessment tool. The resulting data will be used to support research and increase understanding of the organizational programs, policies, and practices that employers of various sizes and industry sectors have implemented to support healthy lifestyle behaviors. It will also document changes in organizational practices over time and allow CDC to provide better technical assistance to employers seeking guidance on building or maintaining workplace health promotion programs.
- A validity and reliability evaluation will be conducted to pilot test the updated CDC Worksite Health Scorecard to include quantitative analysis of concordance rates for respondents from the same worksite.
- 200 respondents will be recruited in 2017 to pilot test the updated Scorecard. A subset of about 15 of these employers will be recruited for follow-up telephone interviews.
- In addition to direct feedback, we expect that this data will also be used to support statistical analyses (e.g., using linear and non-linear regression models and hierarchical or multilevel models).

A-1. Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) is the primary Federal agency for protecting health and promoting quality of life through the prevention and control of disease, injury, and disability (see authorizing legislation through the Public Health Service Act (section 42 U.S.C. 280l-280l-1, Sections 399MM and 399MM-1; see Attachment A-2). The CDC Worksite Health Scorecard is funded through the Patient Protection and Affordable Care Act Prevention and Public Health Fund (PPHF); P.L. 111-148, Section 4002; see Attachment A-2) which was enacted to address the underlying drivers of chronic disease and to help the country move from today's sick-care system to a true "health care" system that actively encourages health and wellbeing. The PPHF is designed to expand and sustain the necessary infrastructure to prevent disease, detect it early, and manage conditions before they become severe.

Workplace health promotion (WHP) programs offer a potentially powerful strategy to improve the health and wellbeing of the 159 million American workers, and possibly their dependents. (U.S. Census Bureau, 2016) The workplace is where most American adults spend the majority of their waking hours during a typical workweek. While job-related pressures can negatively influence health behaviors, the workplace also presents an underutilized setting for positive programs designed to lower health risks, and, in turn, have an impact on the prevalence, severity, and cost of chronic disease. Through workplace health promotion programs, employers have the unique opportunity to reach a large segment of the population who would not normally be exposed to, or engaged in, health improvement efforts. Along with this opportunity, employers

also have strong *incentive* to offer health promotion programs, understanding that, if they can keep their employees healthy and fit, their workers will consume fewer healthcare resources, miss fewer workdays, and be more productive.

The approach that has proven most effective is to implement an evidence-based comprehensive health promotion program that includes individual risk reduction programs, coupled with environmental supports for healthy behaviors and is coordinated and integrated with other wellness activities (Goetzel, 2007); Soler 2007; Heaney 1997). However, only 6.9% of employers offer a comprehensive worksite health promotion program, according to a 2004 national survey (Linnan, 2008).

Several studies have concluded that well designed worksite health promotion programs can improve the health of employees and save money for employers instituting these programs. For example:

- In 2005, Chapman summarized results from 56 qualifying financial impact studies conducted over the past two decades and concluded that participants in workplace programs had 25%–30% lower medical or absenteeism expenditures than non-participants.

- In 2010, Baicker et al. published a literature review in Health Affairs focused on cost savings garnered by worksite wellness programs. The investigators found the medical costs return on investment (ROI) to be $3.27 for every dollar spent and the absenteeism ROI to be $2.73 for every dollar spent.

One of the significant barriers to wider adoption of these programs is a lack of organizational capacity to plan, implement, monitor, and evaluate such programs.

Employers need credible tools and guidance to help them design comprehensive health promotion programs that include interventions that are effective and evidence-based. This need is particularly acute among small businesses, who often do not have the human resources, capital, or expertise to plan and evaluate best-practice health promotion programs.

The CDC Worksite Health Scorecard *(hereafter referred to as the "Scorecard")* was launched in 2012 to address this need**.** It was updated in 2014 to include four additional topics and to be available as an online application (OMB #0920-1014, exp. 4/30/2017). The Scorecard approval expired at a time when it was unclear if resources would be available to continue its use. Strong commitments from internal and external stakeholders have enabled CDC to continue to offer a revised Scorecard to employers nationwide allowing CDC to request a reinstatement with revision.

In order to remain relevant and comprehensive, the Scorecard has recently undergone further update, informed by a series of systematic literature reviews. The updated Scorecard includes

four new topics of particular relevance to the health and wellbeing of Americans today – Sleep, Alcohol & Other Substance Abuse, Cancer, and Musculoskeletal Disorders; new and revised questions in previously existing modules such as minor wording changes to improve clarity based on user feedback or new questions based on observed changes in employer practice such as active transportation to improve physical activity over the past three years that ensure the Scorecard represents the best-available evidence. This has resulted in a slight increase in the overall number of questions to the core instrument and a corresponding increase in the time for respondents to complete the Scorecard.

As before, employers will be able to access this updated version of the Scorecard through a web-application that includes features such as automatic reports, benchmarking against similarly-sized employers, and year-to-year progress tracking.

To ensure that employers have access to the most up-to-date evidence-based strategies made available through a revised version of the Scorecard, CDC is proposing to conduct a 1 year pilot study to put forth the updated information, as stated above, to select employers who agree to complete the Scorecard and provide feedback to make any enhancements to the piloted data collection instruments. Upon completion of the pilot testing, CDC will submit a finalized, updated version of the Scorecard in a revised Information Collection request for 3 year clearance enabling a larger number of employers to access the online system and complete annual assessments of their workplace health programs.

A-2. Purpose and Use of Information Collection

Purpose and Format of the Information Collection

The CDC Worksite Health Scorecard is an organizational assessment and planning tool designed to facilitate three primary goals:

1. Assist employers in identifying gaps in their health promotion programs, and help them to prioritize high-impact strategies for health promotion at their worksites;

2. Improve the health and wellbeing of employees and their families through science-based workplace health interventions and promising practices; and

3. Support research and increase understanding of the organizational programs, policies, and practices that employers of various sizes and industry sectors have implemented to support healthy lifestyle behaviors.

The Scorecard consists of 154 core yes/no questions with an additional 20 optional demographic questions divided into 19 modules (risk factors/conditions/demographics). The questions assess elements of the workplace environment, culture, programs, practices, and policies related to

health and safety. This includes, for example, health benefits, health education, exercise facilities, healthy food offerings, and ergonomic workstations.

The Scorecard is a completely voluntary survey. Information will be collected from employers who are interested in using the tool. Respondents will be employers of various sizes, industry sectors (public, private, and non-profit) and geographic locations. The primary mode of information collection will be an online survey, which will allow participants to respond to the questions at their own pace and at their own convenience. To get the full benefit of the tool, employers are encouraged to reassess their progress on an annual basis and track improvements over time. Employers with a strong commitment and motivation to improve employee health will be recruited through a variety of methods including through large membership and association organizations representing a broad array of industries. These “gatekeeping” organizations have the existing infrastructure to reach their constituents quickly and provide credibility to invitations to participate in Scorecard assessment; marketing of the CDC Worksite Health Scorecard through existing employer partnerships who have already created a Scorecard account and completed a Scorecard assessment since 2014 and are more likely to reassess in the future; meetings and conferences where employers gather; webinars; newsletters; social media and websites.

Information will be collected for one year during which the Scorecard is pilot tested and validated. A revision request for a three year approval will be submitted after the updated Scorecard is finalized to be made launched and publically available for access and technical assistance to a larger number of employers.

CDC contracts with Northrupp Grumman, Truven Health, and Johns Hopkins University (Hopkins) for this information collection. Interviews will be led by trained facilitators from Hopkins. Truven, and Hopkins will also be involved in the analysis, interpretation, and implementation of the results from the information collection process. Truven, and Hopkins will identify themes in responses for improvements to the Scorecard.

Respondents to the Scorecard, interviews, and pilot evaluation will be recruited and sent an invitational email (**Attachment C-8**) prior to scheduling participation in the information collection. The interviews will be held via conference call and screen sharing software. At the start of each interview (**Attachment C-3**), respondents will be read the informed consent and give verbal consent to proceed with the interview. Anyone who wishes to remain anonymous shall be allowed to do so. Participation will be voluntary.

During the pilot testing of the Scorecard, CDC will collect information from interviewees using open ended questions such as “Were there any items that you answered YES or NO, but answered with uncertainty? and “Is there any other general feedback that you would like to offer about the tool?” (**Attachments C-3 and C-4**). The interviews will also be used to capture any

difficulty or challenges respondents have with completing the Scorecard accurately as well as areas of improvement.

The pilot test will consist of the following steps:

Recruited respondents will first complete The CDC Worksite Health Scorecard Registration Application (**Attachment C-1**) to initiate the pilot test and gather demographic and contact information. Employers will be recruited through a variety of methods including through large membership and association organizations (gatekeeping organizations) who have the existing infrastructure to reach their constituents quickly and provide credibility to invitations to participate in Scorecard assessment as well as offer meetings and conferences where employers gather; webinars; newsletters; social media and websites that can be used to reach out to employers.

Respondents next will complete the CDC Worksite Health Scorecard (**Attachment C-2**)The Scorecard instrument will collect information at the organizational level (e.g., "During the past 12 months, did your worksite provide an exercise facility on site?"). The Scorecard will collect information to verify employer contact information and identify the individual(s) responsible for maintaining the employer profile and completing the survey. The CDC and its collaborators (Hopkins and Truven Health for the pilot-testing of the updated tool, and Northrupp Grumman for ongoing data collection) will have access to the files that link employer representative identifiers, such as name and business address, to unique employer ID codes.The CDC Worksite Health Scorecard survey will ask basic questions about type of evidence-based programs, policies, environmental supports, and health benefits present at the worksite (**Attachment C-2**).

Following completion of the Scorecard, respondents will complete The CDC Worksite Health Scorecard Cognitive Telephone Interview will gather general impressions of the Scorecard— particularly the new modules— and also to discuss items where there were discrepancies (and items that were left blank) to understand the respondent's interpretation and perspective of their answers these questions. (**Attachment C-3**).

Lastly, the CDC Worksite Health Scorecard Pilot Evaluation will be given to respondents who will be asked open ended questions to assess their general feedback with the Scorecard and determine if any additional refinements are necessary to improve question clarity (**Attachment C-4**).

Once the pilot has been completed, employers will be given a summary report of their Scorecard benchmarked against other pilot participants (**Attachment C-5**) comparing the employer to others in the same size/industry category. The system also provides tailored feedback, directing users to evidence-based workplace health promotion strategies that are appropriate for the needs and interests of their workforce, and resources that may assist in implementation.

In addition to the immediate use of providing employers with tailored feedback, benchmarking reports, and customized resources **(see Attachment C-6**) to assist with implementation efforts, this data collection will serve to support research and increase understanding of the organizational programs, policies, and practices that employers of various sizes and industry sectors have implemented to support healthy lifestyle behaviors. Further, it will document changes in organizational practices over time. CDC will also use the information gathered from the Scorecard to provide better technical assistance to employers seeking guidance on building or maintaining workplace health promotion programs.

From 2014-2016, 1,531 worksites have submitted CDC Worksite Health Scorecards from employers in 40 different states. The average employer is implementing a little more than half of the recommended programmatic, policy, environmental support, and health benefit intervention strategies assessed in the Scorecard. And those employers who have re-assessed at least once during this time period have seen their Scorecard score improve from an average of 95.85 points to 139.72 points. This represents an improvement in the total number of intervention strategies being implemented as well as the number of best practice and high impact strategies which garner more points. Overall, exposure to the Scorecard is contributing to better and more effective workplace health programs being offered to employees but gaps in practice remain and high number of employers across the country remain unaware of the benefits of evidence-based workplace health programs or are not implementing effective strategies in a coordinated manner (Meador, 2016).

CDC will review benchmarking report data and work with employer respondents to provide education, training, and technical assistance to assist employers in identifying areas of opportunity to improve or expand their workplace health programs. Scorecard results can be used to prioritize strategies as users set near- and long-term goals for developing their worksite's health promotion program. Scores can identify gaps in the worksite's health promotion program (that is, topic areas where the organization currently has few strategies in place). CDC technical assistance and support will include working with employer to:

- Identify the highest impact strategies not currently in place at your worksite.
- Use this information and the employer's scores to prioritize future strategies that are relevant, feasible, and consistent with the organizations and employee's needs, health issues, and health promotion budget.
- Identify which of the priority strategies are feasible for short- or long-term accomplishment.

Employers will then be directed to CDC tools and resource to support the implementation of the priority strategies and interventions that have been selected (**see Attachment C-6)**.

The CDC Worksite Health Scorecard allows for comparisons among employer cohorts receiving various levels of CDC workplace health program support. CDC is currently working with cohorts of employers through the Work@Health Program (OMB #0920-1006; Exp 04/30/2019). This program's goal is to provide support to employers to build effective and sustainable comprehensive workplace health programs. The Work@Health program operationalizes program support through professional formal training and structured ongoing technical assistance. Work@ Health is a very intensive training intervention including a lot of individual interaction and support from CDC staff. Important outcome measures are changes in organizational programs, policies, and practices that result from the method of support and assistance provided. These organizational outcomes are measured utilizing the CDC Worksite Health Scorecard.

New users of the online version of the CDC Worksite Health Scorecard who are directed to less intensive interventions such as referral to online workplace health program tools and resources (**see Attachment C-6**), archived webinars and educational content, and group CDC technical assistance will be compared to participants in the CDC Work@Health program in terms of overall score progression over three years.

Individual topic scores related to individual health risks or conditions of which specific online information, tools, and resources exist will also be monitored to develop specific tools, resources, and guidance to support tailored workplace health program efforts in priority health areas and how those tools improve individual health risk or condition scores over time.

Information Collection to Date

From 2014-2016, 1,531 worksites have submitted Scorecards (OMB# 0920-1014). The average employer is implementing a little more than half of the recommended programmatic, policy, environmental support, and health benefit intervention strategies assessed in the Scorecard. Some individual intervention strategy examples include:

Of employers using the online Scorecard:

- 92% report providing coverage with no or low out-of-pocket costs for flu vaccination.
- 73% report providing coverage with no or low out-of-pocket costs for blood pressure control medications.
- 69% report having a written policy banning tobacco use.
- 52% report subsidizing or discounting the cost of on-site or off-site exercise facilities.
- 41% report providing educational seminars, workshops, or classes on nutrition.
- 38% report providing free or subsidized self-management programs for weight management.

Scorecards have been received from employers in 40 different states. Seventy-two percent of these employers are private, for profit businesses, 19% are government, and 9% are nonprofit organizations. Most employers (74%) are small, 18% are mid-sized, and 8% are large organizations with more than 750 employees.

Revisions/Updates to the Scorecard

To ensure the Scorecard remains current, valid, and comprehensive, CDC has recently made the following revisions/updates to the Scorecard. The CDC Worksite Health Scorecard Summary of Revisions and Updates provides a detailed summary of all the changes to the updated tool from the prior version (**see Attachment C-7**). The current Scorecard now includes the following modules based on the following revisions:

1. Reviewed the evidence supporting each question sometimes resulting in changes to the scoring (possible points) to 23 questions;

2. Minor changes in wording of the question(s) for clarity resulting in revised text where necessary to 106 questions;

3. Added new questions and modules to reflect changes in employer priorities and practices, and sufficient new evidence to support their adoption in workplace programs to 48 questions;

4. Deleted questions from the previous version of the tool (OMB #0920-1014, exp. 4/30/2017), primarily to reduce redundancy or to reflect a shifting evidence base to 20 questions.

Module	**Previous version**		**Revision**		**Summary of Changes to Questions**			
	# Questions	**Possible Points**	**# Questions**	**Possible Points**	**Revised Text**	**New**	**Deleted**	**Un-changed**
Background/Community Resources (optional)	*15*	*0*	*20*	*0*	*15*	*0*	*4*	*4*
Organizational Supports	18	33	25	44	15	8	1	2
Occupational Health and Safety	10	22	9	18	6	3	5	0
Maternal Health and Lactation Support	6	15	7	15	6	1	0	0
Nutrition	13	21	14	24	12	1	0	1
Physical Activity	9	24	10	22	7	2	1	1
Sleep and Fatigue	**N/A**	**N/A**	**8**	**11**	**N/A**	**8**	**N/A**	**N/A**
Tobacco Use	10	19	8	18	7	1	2	0

Cancer	**N/A**	**N/A**	**7**	**11**	**N/A**	**7**	**N/A**	**N/A**
Heart Attack and Stroke	13	21	12	19	6	0	1	6
High Blood Pressure	7	17	6	16	4	0	1	2
High Cholesterol	6	15	5	13	4	0	1	1
Musculoskeletal Disorders	**N/A**	**N/A**	**7**	**8**	**N/A**	**7**	**N/A**	**N/A**
Prediabetes and Diabetes	6	15	6	15	6	0	0	0
Vaccine-Preventable Diseases	6	18	6	13	5	1	1	0
Weight Management	5	12	4	8	4	0	1	0
Alcohol and Other Substance Use	**N/A**	**N/A**	**6**	**9**	**N/A**	**6**	**N/A**	**N/A**
Depression	7	18	7	16	7	0	0	0
Stress Management	7	14	7	14	2	3	2	2
TOTAL	**123 core**	**264**	**154 core**	**294**	**106**	**48**	**20**	**15**

Bolded modules are those newly added to this update of the Scorecard. Below we describe some of the new content added to the instrument, and the impetus for some of these changes.

Alcohol and Other Substance Abuse – The original Scorecard specifically addressed tobacco use, but did not holistically capture the importance of alcohol and other substance use (e.g., stimulants, hallucinogens, and prescription opioids) prevention for worksite health promotion. Substance use directly impacts employee health, safety and productivity. The workplace has become an increasingly significant, though still underutilized, vehicle for the delivery of substance abuse prevention services. To address this gap, a new module on Alcohol and Other Substance Use has been developed and is included in the updated version of the Scorecard (**See Attachment C-2**). It includes 6 questions on workplace policies and programs that can reduce the incidence of substance misuse, identify problems early, and connect employees to appropriate treatment.

Sleep and Fatigue – A large proportion of American adults do not get adequate sleep. According to recent Behavioral Risk Factor Surveillance System (BRFSS) data, 35% reported fewer than seven hours of sleep during a typical 24-hour period, 38% reported unintentionally falling asleep during the day at least once in the preceding month, and 4.7% reported nodding off or falling asleep while driving at least once in the preceding month. (CDC, 2015) Research has shown that insufficient sleep, defined as less than 7 hours per day for adults, increases the incidence of obesity, diabetes, cardiovascular disease and depression (Gangwisch, 2006; Ayas, 2003; Cappuccio, 2010). Furthermore, inadequate sleep reduces productivity, impairs decision-making, and contributes to accidents. Studies indicate that workplace interventions may be effective for improving general sleep hygiene and addressing common sleep disorders (e.g., insomnia and sleep apnea). Although this topic is critical to health and wellbeing, and may be addressed in a health promotion program, it was not previously included in the Scorecard. In order to prompt employers to consider this critical health topic, a new module on Sleep has been developed and is included in the updated version of the Scorecard (**See Attachment C-2**). It includes 8 questions on workplace policies and programs that can improve the sleep habits of employees and therefore improve general health.

Cancer – Cancer is one of the leading causes of death among American adults (National Center for Health Statistics, 2015). Behavioral and environmental changes at the worksite can aid in the prevention of cancer-related risk factors. This update of the Scorecard includes a newly developed module on Cancer. While some of the interventions that can reduce the risk of cancer are included elsewhere in the Scorecard (e.g., in the Tobacco and Weight Management modules), this module adds new questions about environmental supports that reduce cancer risk (e.g., providing outdoor workers with sun protection), insurance coverage, and offering educational materials and programming that promote evidence-based cancer screenings and vaccinations that may reduce the incidence of cancer.

Musculoskeletal disorders (MSDs) are injuries or disorders of the muscles, nerves, tendons, joints, cartilage, and spinal discs. These include highly prevalent and costly conditions such as back pain, arthritis and carpal tunnel syndrome that can be mitigated through workplace policy and design. This update of the Scorecard includes new questions on reducing the risk of MSDs through workplace design, job requirements, training to managers/workers, and insurance coverage that includes evidence-based therapies and treatment for musculoskeletal disorders.

New questions within existing modules**.** This update of the Scorecard also includes new questions that have been added to existing modules. For example:

- Active Transportation – Active transportation is defined as physical activity undertaken as a means of transport and not purely as a form of recreation. One new question in the Physical Activity module asks if employers encourage active transportation to and from work offer (e.g., by providing secure bicycle storage, lockers and shower facilities for

employees; having a flexible dress code; offering pre-tax contributions for public transportation; and/or organizing workplace challenges).

- Drinking Water – Increasing water consumption can positively impact health. For example, there may be a substitution effect where it reduces the consumption of sugary beverages. One new question was added to the Nutrition module to assess if water consumption is promoted in the workplace (e.g., through education or improved access).

- Vision Impairment – Vision impairment is highly prevalent, with increasing incidence, and significant burden in terms of morbidity, quality of life, and cost. But it may be mitigated through worksite health promotion programming. A single question was added to the Occupational Health and Safety module, to assess whether employers evaluate the design of the workplace and make adjustments or provide resources to reduce the risk of eye injury or vision impairment.

Many of the existing questions were also revised to improve clarity and ease of completing the Scorecard. For example, in many of the modules:

- We combined questions that separately asked about the provision of "lifestyle counseling" and "self-management programs," since this distinction is not clear to most users and the evidence supporting these interventions is linked.

- We refined the verbiage of education questions to clarify the distinction between "educational materials" and "interactive educational programming". Educational materials include brochures, videos, posters, pamphlets, or newsletters, while interactive educational programming includes seminars, workshops or classes.

Pilot testing the updated Scorecard
To test the validity and reliability of the updated Scorecard, we will do a special pilot-testing in 2017. This is a revision to the original ICR which did not include question validity. We believe pilot testing will add additional credibility and uptake to the Scorecard as employers have come to recognize CDC's tool as one of the marketplace leaders based on it comprehensiveness and adherence to the scientific evidence. Pilot testing and validation will be especially important for the new modules and questions as these have not routinely been asked of employers and we need to understand if they are posed in a clear and specific manner.

We will aim to recruit a convenience sample of 200 respondents (from 100 organizations) to participate in the pilot testing. We will seek a diversity of employers by size, region and industry. As for size, and to be consistent with our prior analysis, the pilot study sample will be stratified as follows size, and in accordance with CDC employer size definitions: very small (0-99 employees); small (100-249); medium (250-749); and large (750+).

To ensure a heterogeneous sample across organization sizes, business types, and U.S. geographic areas, we will collaborate with national business coalitions and associations (i.e., NBGH, NBCH, National Safety Council [NSC]), as well as state health departments. We will provide collaborating entities with a template cover letter to send to prospective study participants that explains the study requirements. Interested employers may volunteer to participate in the study by completing and submitting an online application.

Recruited employers will not be required to have active health promotion programs in place to participate in the study. As noted earlier, the unit of analysis for the Scorecard validation will be a worksite (single campus/building as opposed to the entire organization). In situations where large organizations have multiple worksites, we will ask respondents to restrict their feedback to a single worksite location (which may include a cluster of buildings within walking distance) since program offerings can vary widely across worksites.

We will create a temporary online version of the updated Scorecard using a platform such as Qualtrics. The platform will enable the team to invite each participant with a unique web link so he/she can complete the Scorecard in multiple sessions. An informed consent form will be included as the first page of this online survey, and worksite representatives will not advance to the survey if they decline consent.

To test inter-rater reliability of the Scorecard, all enrolled worksites will be asked to have two knowledgeable employees (e.g., worksite wellness practitioners, human resources specialists, or benefits managers) independently complete the online Scorecard survey. Respondents will be encouraged to consult with others within their organizations to get answers to questions where they lack knowledge, as would be the case in a real-world setting when the Scorecard is administered to employers. However, the two respondents will be asked not to consult with each other in completing the instrument.

Participants will also be instructed to answer each question about the presence of a given program, policy, or practice currently in place at their worksite or in place within the past 12 months. Information about the organization's demographics (e.g., business type, size, industry) and survey respondents (e.g., job title, number and type of individuals they consulted to complete the survey) will also be requested during this pilot test.

We will follow up the inter-rater reliability assessment with cognitive interviews with a subset of about 15 participating employers. We will ask at the conclusion of the online survey whether respondents are willing to be contacted by telephone for follow-up discussions. This phase of data collection is designed to further assess the face validity of the tool, to identify and explain any issues with wording or content underlying questions with low reliability (i.e., low levels of agreement between respondents), and determine specific ways to refine the Scorecard if necessary. The interviews will be conducted by telephone, for one hour each, using a written protocol to ensure a consistent approach between interviewers and across interviews. Rather than

reviewing each question of the survey, interviewers will probe respondents by health topic, with special emphasis on individual questions where there is a discrepancy between the two survey responses and on new items/modules (**see Attachment C-3**).

Interview probes will be structured to assess respondents' comprehension of questions, the information retrieval process, decision process, and response process. For example, we will ask respondents to explain their understanding of the general intent of the question; the meaning of specific terms; with whom they consulted to gather relevant information; how much effort was required to answer the question; and whether they were able to match their actual program configuration to the response options offered by the survey.

A-3. Use of Improved Information Technology and Burden Reduction

The primary mode of information collection for the pilot-testing of the updated tool will be an online survey. This will allow participants to respond to the questions at their own pace and at their own convenience. This technology will also allow them to easily assess their performance in different topic areas and track improvements over time. CDC designed the information collection to minimize the burden to respondents and to the government, to maximize convenience and flexibility, maximize employer participation and engagement, and to ensure the quality and utility of the information collected and its efficient analysis.

A-4. Efforts to Identify Duplication and Use Similar Information

Unique data collection is necessary to test the validity of the updated Worksite Health Scorecard, as the survey will, for the first time, evaluate new/revised modules and questions. The specificity and uniqueness of the questions in the Scorecard necessitate independent data for verifying validity which does not exist elsewhere. Although other comparable instrument are available in the marketplace, few have been validated in the manner proposed in this information collection request, and if they have, they are largely proprietary so the results of that testing is not available.

With regard to the general administration of the Scorecard, the project team conducted a rigorous environmental scan to identify similar tools and resources. While other tools exist in the marketplace that enable employers to evaluate their workplace health promotion programs, the CDC Worksite Health Scorecard stands out as a very robust, evidence-based approach to program evaluation and planning, incorporating input from a panel of nationally recognized subject matter experts. In addition, it is uniquely modularized by health condition/risk factor to help employers build programs that progressively address the specific concerns of their workforce.

A-5. Impact on Small Businesses or Other Small Entities

The CDC Worksite Health Scorecard is open to any employer in the United States regardless of size or other characteristics. However, research suggests that although small/medium-sized companies employ the majority of Americans, they are much less likely to sponsor worksite health promotion programs (Linnan, 2008). This is partially due to common misconceptions among small/medium-sized business owners that implementing worksite health promotion is expensive and geared toward large organizations that can realize the benefits primarily on the strength of numbers. It is also based on the fact that smaller organizations may have fewer resources, lower capacity, and less expertise to provide supports in the worksite that improves employee health making small businesses a main priority for CDC. Because the focus of outreach and registration will be smaller enterprises that can benefit from the organizational assessment and support tools and resources that accompanying it, we anticipate that approximately 75% of employers will be small businesses.

Since the program is voluntary and the employer has indicated their desire to participate by completing the registration process, the impact of the data collection on respondents—including small businesses—is expected to be minimal. The online administration of the survey allowing respondents to complete it in multiple sessions at their convenience over several weeks will also minimize the burden on small employers.

CDC will provide technical assistance on an ongoing basis. It is possible that small businesses may need, and receive, more technical assistance than large businesses.

A-6. Consequences of Collecting the Information Less Frequently

Information collection will occur in two phases. The data collection for the pilot testing and validation process is expected to occur in summer/fall 2017, to be followed up with a revision request for the finalized data collection instrument to be in use through summer/fall 2021.

If pilot-testing information is not collected, CDC will not be able to effectively validate the inclusion of new modules and the updated questions to determine if there are any problems with the new questions. In addition, a key focus of the pilot testing is to streamline the questions wherever possible, in order to reduce the burden of completing the tool. Further, if the administration of the CDC Worksite Health Scorecard is not planned, implemented, and evaluated effectively, the program will be unsuccessful and could potentially be harmful to the reputation of NCCDPHP, and undermine efforts to encourage employers to participate in future CDC programs.

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

This request fully complies with the regulation 5 CFR 1320.5.

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

A. CDC published a Notice in the Federal Register on Thursday, March 2, 2017, Vol. 82, No. 40, pp. 12354-12356 (**see Attachment B-1**). CDC received three public comments and provided courtesy replies (**see Attachment B-2**).

B. The CDC Worksite Health Scorecard organizational assessment and data collection plan was developed in collaboration with subject matter experts at CDC, NIOSH, SAMHSA, Truven Health, Johns Hopkins University, Northrupp Grumman, and nationally recognized subject matter experts and leaders in the field of workplace health.

Table 8-A. Staff within the Agency and Consultants outside the Agency Consulting on Data Collection Plan and Instrument Development

Name	Organization	Email contact
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A-9. Explanation of Any Payment or Gift to Respondents

No payments or gifts will be offered to employers or employees that complete the CDC Worksite Health Scorecard organizational assessment.

A-10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

Privacy Act Determination

CDC has reviewed this Information Collection Request and has determined that the Privacy Act does not apply to the identifiable employer-level information collected in the CDC Worksite Health Scorecard Registration Application (Attachment C-1), CDC Worksite Health Scorecard (Attachment C-2), the Cognitive Telephone Interview (Attachment C-3) and the Pilot Evaluation (Attachment C-4). CDC's Office of the Chief Information Security Officer (OCISO) determined on 12/12/2014 while the Privacy Act was not applicable, the appropriate security controls and Rules of Behavior would be incorporated to protect the confidentiality of information, proprietary, sensitive, and Personally Identifiable Information (PII) the Contractor (RTI) may come in contact with during the performance of the project. The CDC Worksite Health Scorecard survey will collect information to verify employer contact information and identify an individual(s) responsible for completing the survey. Truven Health, Northrupp Grumman, and Johns Hopkins University and CDC will have access to the file that links employer representative identifiers such as names and addresses to unique employer ID codes. This contact

information will be used to send benchmarking reports to participating employers near the end of the project. The applicable SORN is 0920-0136, Epidemiologic Studies and Surveillance of Disease Problems.

Information collection relates to workplace-related activities and is not personal in nature. Activities do not involve the collection of individually identifiable information.

Hopkins, Truven Health, Northrupp Grumman, and CDC will be the only organizations to collect, store, and maintain information that identifies specific individuals or employers. Computer data files used for analysis will identify individuals and employers using ID numbers and will not include employers' names or contact information.

Participation in the CDC Worksite Health Scorecard data collection will be completely voluntary. In agreeing to voluntarily participate in the CDC Worksite Health Scorecard, the employers also agree to complete the survey instrument, cognitive testing and pilot evaluation. All respondents will receive background information about CDC Worksite Health Scorecard and will be assured that (1) their participation is voluntary (2) their responses will be kept private and only seen by CDC and contractor staff, and (3) that there are no personal risks or benefits to them related to their participation.

Organizations that participate in the organizational scorecard assessment are under no obligation to complete the surveys and they may withdraw at any time. CDC expects a high level of commitment from employers based on the access to individual and benchmarking reports available by completing the survey.

Technical safeguards. CDC, Truven Health, Hopkins, and Northrupp Grumman will be the only organizations to collect, store, and maintain individual identifiable information. No personally identifiable health information is captured in the interviews or surveys. Given that the information being collected is not considered sensitive, information will be stored on Johns Hopkins Box (JHBox), a password-protected cloud-based file storage service. Hopkins, Northrupp Grumman and the CDC program have consulted with CDC's Office of the Chief Information Security Officer to review the data acquisition, storage, and processing procedures to ensure that they comply with the Privacy Act and required government data privacy and security procedures. The electronic file linking the employer and the identification number will be securely stored. All information will be password protected and only accessible to evaluation staff. IT servers and data rooms have additional security. All hard drives on the server are encrypted.

Additional safeguards. Survey results will only be reported in aggregate. Individual level data will not be reported.

No information collection involves children under 13 years of age. The following instruments will be administered via a Web-based survey: CDC Worksite Health Scorecard (**Attachment C-2**), and CDC Worksite Health Scorecard Pilot Evaluation (**Attachment C-4**).

A-11. Institutional Review Board (IRB) and Justification for Sensitive Questions

No personal or sensitive information will be collected.

A- 12. Estimates of Annualized Burden Hours and Costs

OMB approval is requested for 1 year. The interviews and pilot evaluation will be conducted in the first year. The final validated Scorecard will follow upon approval of the revision to the Information Collection Request. Table A.12.1 and Table A.12.2

Employers will be respondents for the following information collections.

- CDC Worksite Health Scorecard Registration Application page (**Attachment C-1**) will be completed once by employers who agree to be a part of the pilot test. The annualized number of respondents to the pilot is estimated to total 200, the time to complete the registration process is estimated to take 1-2 minutes per respondent, the total estimated annualized burden is 4 hours. (2 minutes per response). This is part of the updated Scorecard pilot testing procedures and was not part of the original ICR.

- CDC Worksite Health Scorecard (**Attachment C-2**) The annualized number of respondents taking the pilot is estimated to be 200 and it will take each respondent 75 minutes to complete this will bring thetotal estimated annualized burden to 250 hours. This is a decrease of 50 burden hours as the number of respondents have been reduced for the purposes of pilot testing the updated Scorecard. However, as the length of the new Scorecard has increased, the estimated burden has also increased from the original 30 minutes per response.

- CDC Worksite Health Scorecard Cognitive Telephone interview (**Attachment C-2**) will be completed once in Year 1 by telephone by employers. The annualized number of respondents is 32, it will take each respondent 60 minutes to complete and the total estimated annualized burden is 32 hours. This is part of the updated Scorecard pilot testing procedures and was not part of the original ICR.

- CDC Worksite Health Scorecard Pilot Evaluation (Attachment C-3) will be completed once in Year 1 online by employers. The annualized number of respondents is 200 it will take each respondent 5 minutes to complete the evaluation making the total estimated

annualized burden 17 hours .This is part of the updated Scorecard pilot testing procedures and was not part of the original ICR.

Employer respondents will be knowledgeable representatives of an organization or a single worksite within an organization (e.g., worksite wellness practitioners, human resources specialists, or benefits managers).

The total estimated annualized burden hours are 303. This represents an increase of 3 burden hours from the original ICR of 300 estimated annualized burden hours.

Table A.12.1. Estimated Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hrs)	Total Burden (in hrs)
Employers	CDC Worksite Health Scorecard Registration Application	200	1	2/60	7
	CDC Worksite Health Scorecard	200	1	1.25	250
	CDC Worksite Health Scorecard Cognitive interview	32	1	1	32
	CDC Worksite Health Scorecard Pilot evaluation	200	1	5/60	17
				Total	**303**

The total estimated annualized cost to respondents is $11,595.81.

The current estimated cost of the time devoted to this information collection by respondents is $11,873 as summarized in Table A.12.2. To calculate this cost, we used the mean hourly wage of $38.27, which represents the Department of Labor estimated mean for state, local, and private industry earnings (Wages and Hour Division, https://www.dol.gov/whd, 2017) for a typical HR manager who would be responsible for completing the Scorecard on behalf of their employer. This rate has increased from $36.25 found to be the prevailing average hourly rate in the original information collection request in 2014 resulting in increase in the total estimated annualized cost to respondents of $998 above the original estimates of $10,875. There are no direct costs to respondents associated with participation in this information collection.

Table A.12.2. Estimated Annualized Costs to Respondents
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Type of Respondent	Form Name	No. of Respondents	No. of Responses per Respondent	Total Burden (in hours)	Hourly Wage Rate	Total Respondent Cost
Employers	CDC Worksite Health Scorecard Registration Application	200	1	7	$38.27	$242
	CDC Worksite Health Scorecard	200	1	250	$38.27	$9,768
	CDC Worksite Health Scorecard Cognitive interview	32	1	32	$38.27	$1,225
	CDC Worksite Health Scorecard Pilot evaluation	200	1	17	$38.27	$638
					Total	**$11,873**

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

CDC does not anticipate that employers using the online CDC Worksite Health Scorecard will incur any additional costs or burden for record keeping.

A-14. Annualized Cost to the Government

The current data collection costs include the cost of CDC personnel for oversight of CDC Worksite Health Scorecard planning, implementation and evaluation, and costs associated with two contracts: one to Truven Health (Washington, DC) to develop and validate the Scorecard; and the second to an informational technology developer, Northrupp Grumman Corporation (Falls Church, Virginia). A full-time CDC employee will serve as the technical monitor for the project, directing regular planning and coordination meetings with the contractor staff. These meetings serve to plan and coordinate the programs and activities of the CDC Worksite Health

Scorecard Web application development including: communications with internal and external stakeholders; planning and developing protocols for the registration process and organizational assessments, and outcome evaluations. The role of the CDC employee also involves regular reporting and review of all materials and products before acceptance by the government by coordinating input from multiple CDC National Center for Chronic Disease Promotion and Health Promotion Divisions (Division of Diabetes Translation, Division for Heart Disease and Stroke Prevention, Office on Smoking and Health, Division of Population Health, and Division for Nutrition, Physical Activity, and Obesity), the CDC National Institute for Occupational Safety and Health, and CDC National Center for Immunization and Respiratory Diseases targeting the health risk factors and health conditions addressed by the CDC Worksite Health Scorecard.

Northrupp Grumman will provide operational management of the CDC Worksite Health Scorecard and coordinate activities among the participating employers. Northrupp Grumman's responsibilities include providing technical support to employers during the registration process, in navigating the online survey, and data collection. Northrupp Grumman will also provide guidance in establishing the program management infrastructure; assist in communication activities such as reporting progress to CDC, preparing reports and publication materials, and managing a static Web site with descriptive information about the CDC Worksite Health Scorecard; and provide training to participating employers

Truven Health will provide operational management for the development and testing of the Scorecard and coordinate activities among its participants and users. Truven's responsibilities include developing the Scorecard instrument, and conducting and analyzing the interviews and pilot evaluation. Truven Health and Northrupp Grumman will also provide guidance in establishing the Scorecard infrastructure; assist in communication activities such as reporting progress to CDC and preparing reports and publication materials.

CDC will be responsible for evaluation of the CDC Worksite Health Scorecard using quantitative methods. Information will be self-reported and provided to CDC by Northrupp Grumman in an aggregate/de-identified format to conduct analyses to describe adoption, reach, and sustainability of the workplace health interventions.

The ongoing data collection costs and associated project support costs are assumed constant for the useful life of the project. The average annualized cost of the contracts with respect to data collection is estimated at $418,000 per year for 4,180 hours of labor (@$100/hour).

The total estimated annualized cost to the Federal government is $446,500.

Table A-4. Annualized Costs to the Government

Cost Category	Approx. Cost	Avg. Annual Cost
Survey Development	$39,000	$418,000
Application Development and Programming	$360,000	
Data Collection	$11,000	
Web Design	$8,000	
CDC GS-14 25% GS-14 @ $114,000/year		$28,500
Total		$446,500

A-15. Explanation for Program Changes or Adjustments

This is a reinstatement with change information collection request, of a previously a approved OMB package (OMB #0920-1014, exp. 4/30/2017). The Scorecard was updated to ensure the scientific credibility of the tool, incorporating new and validating previously included questions and modules. This includes the deletion of 20 original questions and the addition of 48 new questions primarily across 4 new modules (cancer [7 questions], alcohol and substance abuse [6 questions], sleep and fatigue [8 questions] and musculoskeletal disorders [7 questions]) (**see Attachment C-7**) These changes to the data collection instrument are described in detail in section A-2 of this document. The revised and updated instrument has resulted in a net addition of 28 questions, which—based on previous pilot testing of the tool conducted after the revised instrument was completed in the fall of 2016— we anticipate will add 15 minutes to the time required to complete the tool.

We proposed to test this updated Scorecard with 200 respondents representing 100 employers during a one year pilot. This represents a reduction of 400 annualized respondents than the original ICR as the purpose to gather feedback on the instrument and validate it before finalizing which does not require a large number of respondents. The final validated version will be submitted as a revision to this ICR to allow a larger number of employers interested in assessing their workplace health programs to utilize the online instrument for regular annual assessment achieving the same purpose as the original ICR.

There has been a slight increase in the total number of burden hours from 300 to 303 estimated annualized burden hours despite the reduction in the number of respondents due to three additional instrument being added to the ICR solely to be used in Year 1 during the pilot test. These include a new registration/application (**Attachment C-1**), the cognitive interview (**Attachment C-3**) and the pilot evaluation (**Attachment C-4**). Subsequent revisions will expand the number of employers recruited to complete the Scorecard using the updated, validated version which no longer require participation in the pilot test instrument (**Attachments C-3, C-4**)

A-16. Plans for Tabulation and Publication and Project Time Schedule

The assessment and project timeline are outlined below in Table 16A.

Table 16A. Project Assessment Time Schedule

Respondents/Sources	Method	Content	Timing/Frequency	Attachment #
OMB Approval – Interested Employers/Gatekeeper Organizations				
OMB Approval	N/A	N/A	Summer/fall 2017 (estimated) for launch of web application	N/A
Employers	Recruitment for pilot testing		2 months after OMB Approval (approx. Nov 2017)	C-8
Employers	Administer pilot Scorecard to employers	Gather input on new topic modules for clarity, specificity, inter-rater reliability, and face validity	4 months after OMB approval (approx. Jan 2018)	C-1, C-2, C-3, C-4
Employers	Offered following pilot testing	Review benchmarking data, lend support through technical assistance to program planning, and implementation through education and access to online tools and resources	Beginning at the conclusion of pilot testing (approx. Feb 2018)	C-5, C-6

Quantitative and qualitative data elements will be used for the evaluation of the CDC Worksite Health Scorecard.

The validity and reliability evaluation will include quantitative analysis of concordance rates for respondents from the same worksite. This will help identify problematic questions for refinement or deletion. We will also conduct on- and off-site interviews with worksite representatives. The qualitative data gathered in these interviews will help to assess the validity of the tool and identify specific revisions that may improve question reliability.

After the initial pilot testing and validity evaluation, the CDC will continue the information collection until the expiration of OMB clearance. During this time, it is anticipated that the team will conduct several analyses and publish the results of these studies. Below we describe some of the analyses that our team expects to conduct during this time horizon.

We will first examine baseline differences between worksites and between communities in terms of pre-implementation worksite characteristics, such as organizational structure. For categorical variables, we will display relative and absolute frequencies in tables or histograms. For continuous variables we will report means, standard deviations, and distribution plots. The second part of the descriptive analysis will examine, at the worksite, community, and national level, the change in key outcomes between the time of the baseline and follow-up data collection. These outcomes include organizational changes in the number of workplace health interventions and strategies (e.g., have a written policy regarding tobacco use) that have been implemented between baseline and follow-up. The changes over time will be summarized both numerically and graphically. Observed differences within and between time points will be tested for statistical significance with paired t-tests, chi-squared tests, and analysis of variance (ANOVA).

We expect that this data will also be used to support statistical analyses (e.g., using linear and non-linear regression models and hierarchical or multilevel models). The purpose of using these models is to relate the observed differences in outcomes to a set of observed characteristics. Of particular interest is how certain organizational features, such as the level of management support for health promotion programs, influence the effective implementation of programs.

For data aggregated at the worksite level, regression models will be the main analysis tool. When the outcome variable is continuous, linear regression models will be used (with transformations for non-normality when needed). When outcomes are discrete or fractional, nonlinear models such as the Logit model will be used. The models will predict which organizational factors increase employer awareness of or adoption of health promotion programs. Applied to the baseline to follow-up changes in worksite outcomes, the models will determine which factors are most effective in terms of reaching the desired organizational outcomes.

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

The OMB expiration date will be displayed on the CDC Worksite Health Scorecard assessment used for process and outcome evaluation collected from employers.

A-18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to this certification.

References

U.S. Census Bureau (2012). Statistical Abstract of the United States: 2012. Section 12: Labor Force, Employment, and Earnings. Retrieved from: http://www.census.gov/prod/2011pubs/12statab/labor.pdf>. Accessed on March 28, 2017.

Goetzel RZ, Shechter D, Ozminkowski RJ, Marmet PF, Tabrizi MJ, Roemer EC. Promising practices in employer health and productivity management efforts: findings from a benchmarking study. J Occup Environ Med. 2007;49(2):111.

Soler RE, Leeks KD, Razi S, et al. A systematic review of selected interventions for worksite health promotion: the assessment of health risks with feedback. Am J Prev Med. 2010;38(suppl 2):S237-S262.

Heaney CA, Goetzel RZ. A review of health-related outcomes of multi-component worksite health promotion programs. Am J Health Promot. 1997;11(4):290.

Linnan, L., Bowling, M., Childress, J., Lindsay, G., Blakey, C., Pronk, S., ... & Royall, P. (2008). Results of the 2004 national worksite health promotion survey. American Journal of Public Health, 98(8), 1503-1509.

Chapman LS. Meta-evaluation of worksite health promotion economic return studies: 2005 update. Am J Health Promot. 2005 Jul-Aug;19(6):1-11.

Baicker K, Cutler D, Song Z. Workplace wellness programs can generate savings. Health Aff (Millwood). 2010;29(2):304-311.

Meador A, Lang JE, Davis WD, Jones-Jack NH, Mukhtar Q, Lu H, et al. Comparing 2 National Organization-Level Workplace Health Promotion and Improvement Tools, 2013–2015. Prev Chronic Dis 2016;13:160164. DOI: http://dx.doi.org/10.5888/pcd13.160164.

Centers for Disease Control and Prevention (2015). Insufficient Sleep Is a Public Health Problem. http://www.cdc.gov/features/dssleep/. Accessed on March 28, 2017.

Gangwisch, J. E., Heymsfield, S. B., Boden-Albala, B., Buijs, R. M., Kreier, F., Pickering, T. G et al. ... & Malaspina, D. (2006). Short sleep duration as a risk factor for hypertension. *Hypertension*, 47(5), 833-839.

Ayas, N. T., White, D. P., Al-Delaimy, W. K., Manson, J. E., Stampfer, M. J., Speizer, F. E., ... & Hu, F. B. (2003). A prospective study of self-reported sleep duration and incident diabetes in women. *Diabetes care*, 26(2), 380-384.

Cappuccio, F. P., D'elia, L., Strazzullo, P., & Miller, M. A. (2010). Quantity and quality of sleep and incidence of type 2 diabetes. *Diabetes care*, 33(2), 414-420.

National Center for Health Statistics (2015). Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities. Hyattsville, MD. 2016. Retrieved from: https://www.cdc.gov/nchs/data/hus/hus15.pdf#019. Accessed on March 28, 2017.