

Implementing the 6|18 Initiative: Case Studies

New

Supporting Statement – Section A

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Program Official/Project Officer

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LIST OF ATTACHMENTS – Section A

Note: Attachments are included as separate files as instructed.

- A. Att. 1—Authorizing Legislation**
- B. Att. 2—60-Day FRN**
- C. Att. 3—Interview Guide**
- D. Att. 4—Advance notice email**
- E. Att. 5—IRB approval letter**
- F. Att. 6—6|18 Frequently Asked Questions**
- G. Att. 7—6|18 Conditions: Burden, Cost, and Associated Evidence-Based Interventions**
- H. Att. 8—6|18 States**

Goal of the data collection: To describe: 1. Facilitators and barriers to implementation of the 6|18 Initiative interventions; 2. How collaboration between public health and Medicaid contributed to success in implementing changes to Medicaid payment policy and/or increasing utilization of evidence-based preventive services; 3. How CDC’s 6|18 Initiative supported progress; and 4. How state-level factors facilitated or posed barriers



Section A – Justification

A1. Circumstances Making the Collection of Information Necessary

Background

The 6|18 Initiative links health care and public health sectors

Major trends in health care are providing new opportunities to pay for and deliver prevention and to improve population health. New and alternative health care payment and delivery models are more patient-centered and facilitate the delivery of greater comprehensive care and prevention. Public health departments have been eager to play an active role alongside the health care sector in this time of dynamic health system change and opportunity.

In this context, the Centers for Disease Control and Prevention’s (CDC) 6|18 Initiative was developed for public health to provide health care purchasers, payers and providers with rigorous evidence about high-burden health conditions and associated evidence-based interventions to inform their coverage decisions to have the greatest health and potential cost impact in the short term, generally in less than five years. This initiative promotes proven interventions that prevent chronic and infectious diseases by increasing the coverage of, access to, utilization of, and quality of preventive services. Additionally, it aligns evidence-based preventive practices with emerging value-based payment and delivery models.

This initiative links the health care and public health sectors by providing a shared focus across a spectrum of prevention interventions, from traditional clinical settings to care outside the clinical setting. CDC is partnering with health care purchasers, payers, and providers to improve health and potentially contribute to controlling health care costs. Public health's strength in identifying and analyzing scientific evidence complements the purchaser, payer and provider role of financing and delivering care. The name “6|18” comes from the initial focus on **six** common, costly and preventable health conditions (tobacco use, high blood pressure, diabetes, asthma, healthcare-associated infections and unintended pregnancies) and, initially, **18** evidence-based prevention and control interventions.

The number of conditions and/or interventions may fluctuate over time as evidence for the effectiveness of additional proven interventions becomes available. The criteria for selecting 6|18 conditions, described later in the background section in “*Criteria for selecting 6|18 conditions*,” will remain the same. For ease of communication with states, partners, and other stakeholders, we will continue to refer to this as the “6|18 Initiative.” More information on the Initiative content and progress can be found at <http://www.cdc.gov/sixeighteen> (**also see Attachment 6 – 6|18 Frequently Asked Questions**).

Key 6|18 partners are State Medicaid and State Public Health

As part of the 6|18 Initiative, CDC is partnering with state teams that include representatives from state Medicaid and Public Health agencies in states and large cities (hereafter referred to as states). CDC's goals in working with state teams through the 6|18 Initiative are to: 1. Improve health and potentially contribute to controlling costs using specific evidence-based interventions; and 2. Establish sustainable cross-sector partnerships between public health and health care purchasers, health plans, and providers to address shared health priorities.

To assess whether the 6|18 Initiative has supported state efforts to improve preventive service utilization by establishing cross-sector partnerships and providing technical assistance, CDC seeks, through the proposed data collection, to describe the following aspects of 6|18 Initiative-related activities: 1. Facilitators and barriers to implementation of the 6|18 Initiative interventions; 2. How collaboration between public health and Medicaid contributed to success in implementing changes to Medicaid payment policy and/or increasing utilization of evidence-based preventive services; 3. How CDC's 6|18 Initiative supported progress; and 4. How state-level factors facilitated, or posed barriers to, success.

Criteria for selecting conditions for the 6|18 Initiative

CDC selected as a starting point 6 high-burden, preventable conditions that met the following five criteria: (1) They affect large numbers of people; (2) They are associated with high health care costs; (3) There are underutilized evidence-based interventions associated with the conditions, (4) The evidence-based interventions may prevent or control these conditions in a short time horizon (generally less than five years) and may potentially contribute to control health care costs, and (5) The evidence-based interventions can be implemented by the health care sector - health care purchasers, health plans, and providers. The 6 conditions are: tobacco use, hypertension, healthcare-associated infections, asthma, unintended pregnancy, and diabetes. CDC applied criteria, using a systematic process, to select and identify the interventions (please see **Attachment 6 – 6|18 Initiative Frequently Asked Questions**). The interventions themselves were presented as opportunities for payers and providers to consider. States determine which conditions and interventions to focus on.

Conditions targeted in the 6|18 Initiative are common, costly, and preventable

For a list of the 18 effective interventions within the 6 high-burden health conditions that CDC is prioritizing to improve health and potentially control health care costs, please see **Attachment 6 – 6|18 Frequently Asked Questions**. For more information on each of the conditions, including burden estimates, estimated associated costs, and the evidence-based interventions that may prevent or control the condition, please see **Attachment 7 – 6|18 Conditions: Burden, Cost, and Associated Evidence-Based Interventions**.

6|18 Initiative activities: CDC and its partners provide technical assistance to state teams

CDC is leading the 6|18 Initiative with support from the Centers for Medicare & Medicaid Services (CMS), and the Center for Health Care Strategies (CHCS). CDC and partners are collaborating to support and provide technical assistance to the state teams. States select the 6|18 conditions and interventions that are best aligned with their existing efforts. State teams receive targeted technical assistance and opportunities for peer learning, to support implementation through CDC in partnership with the Robert Wood Johnson Foundation and CHCS.

In Year 1 (2016), CDC and its partners provided technical assistance to nine state public payer teams to support and accelerate their implementation of the 6|18 Initiative's interventions. In Year 2 (2017), CDC and its partners will provide technical assistance to eight new public payer teams from seven states and one large city. Among Year 1 states, up to six state teams have elected to continue receiving technical assistance in 2017. The remaining three Year 1 states have "graduated" from the 6|18 Initiative, as their activities and technical assistance needs have progressed beyond the targeted scope of technical assistance provided by 6|18.

Overview of the proposed information collection

Methodology

In order to better understand qualitative lessons learned in cross-sector collaboration, CDC and co-operative agreement sub-contractor George Washington University seek OMB approval to conduct interviews, either in-person or by phone, with 6|18 participants. These include staff from State Public Health Departments and State Medicaid Agencies. We seek to conduct semi-structured individual interviews with up to 82 participants in up to 17 states. As part of their ongoing work with 6|18, states were asked to participate in assessment activities. However, participating in this assessment is not required as a condition of joining 6|18 or receiving support from 6|18; we will only interview states and individuals that agree to our invitation.

Respondent universe for the proposed data collection

This is a new information collection. Data will be collected from up to 82 respondents. The respondent universe for this information collection consists of Public Health and Health Care respondents. Public Health respondents will consist of: State Public Health Officials, and State Public Health Analysts. Health Care respondents will consist of: State Medicaid Directors, and State Medicaid Analysts. All participants will be responding in their official capacities. OMB approval is requested for 3 years.

Intended use of the proposed data collection to fill a knowledge gap

Since cross-sector public health-health care collaboration to improve population health is still not a standard practice, information regarding public or private payer collaboration with public health agencies to jointly improve population health is scarce. There are few or no existing case studies related to public health-health care collaboration around increasing the utilization of preventive services. This data collection is intended to fill this knowledge gap. However, the proposed information collection does not address the potential cost-savings or cost-

effectiveness of preventive services. CDC will use the data from this data collection to describe, disseminate, and scale best practices to participating and non-participating states; and for program improvement of the CDC's 6|18 Initiative.

Legislative authorization

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. CDC is committed to programs that reduce the health and economic consequences of the leading causes of death and disability, thereby ensuring a long, productive, healthy life for all people. CDC's authority to collect this information is provided by the Public Health Service Act, 42 USC 241, Research and Investigation (**Attachment 1**).

A2. Purpose and Use of the Information Collection

The purpose of this data collection is to:

1. Describe the facilitators and barriers to implementation of the 6|18 Initiative interventions selected by the participating state.
2. Describe how collaborative activities between the health care and public health sectors informed changes to Medicaid payment policy and increased utilization of evidence-based preventive services.
3. Describe how participation in CDC's 6|18 Initiative informed changes to (or accelerated progress towards) Medicaid payment policy and increased utilization of evidence-based preventive services.
4. Describe how state-level factors (e.g., organizational state-level infrastructure, federal investments in improving the delivery of state-level health care) facilitated, or posed barriers to, implementing changes to Medicaid payment policy and increasing utilization of evidence-based preventive services.

CDC will use the data to:

1. Describe, disseminate, and scale best practices to participating and non-participating states. State teams who are participating in the 6|18 Initiative can use the data to highlight their progress when engaging with their own stakeholders.
2. For program improvement of the CDC's 6|18 Initiative.

A3. Use of Improved Information Technology and Burden Reduction

Data will be collected via phone or in-person interview. This method was chosen to reduce the overall burden on respondents, since preparation and information gathering time will be minimal. The information collection instruments were designed to collect the minimum information necessary for the purposes of this project: questions are limited to information that is not available elsewhere. Interview length will be capped at one hour.

A4. Efforts to Identify Duplication and Use of Similar Information

The 6|18 Initiative is a CDC initiative that provides partners with rigorous evidence about six specific high-burden health conditions and associated preventive interventions to inform their decisions to have the greatest health and potential cost impact. We are not aware of any other ventures to gather information regarding state interdisciplinary collaborations between State Public Health and State Medicaid.

The Center for Health Care Strategies (CHCS) and 6|18 program staff hold ongoing monthly or bi-monthly technical assistance (TA) calls with participating states. The topics discussed are driven by state needs. The 6|18 Case Study team may use ad hoc notes from the TA calls as background to understand state context and to inform interview preparation. However, because of the ad hoc nature of the state calls, they are not a systematic or in-depth inquiry into the topics of this proposed data collection. Therefore, this proposed data collection does not represent a duplication of effort.

CDC discussed the proposed data collection instruments with colleagues from programs within the CDC, to ensure that the collection requests under individual ICs do not duplicate efforts of collections from other CDC programs. Program staff from the 6|18 Initiative consulted in October 2016 - September 2017 with: CDC program staff (Asthma—National Center for Environmental Health, Division of Reproductive Health, Office for Smoking and Health, Division of Heart Disease and Stroke Prevention, Healthcare Associated Infections—Division of Healthcare Quality Promotion, and Division of Diabetes Translation). Contact information for CDC division staff consulted is listed below.

In August 2017, CDC shared the draft supporting statements and information collection instrument with the Centers for Medicare and Medicaid Services (CMS) for their review, since they have been strong partners in the 6|18 Initiative, and this information collection may be of interest to them. CMS staff confirmed that this proposed data collection does not duplicate existing CMS data collection. No changes to the information collection plan were requested during final CMS review. Contact information for CDC’s primary point of contact in CMS is listed in Table A4-a.

Table A4-a. Staff within the Agency and in Another Federal Agency (CMS) Consulting on Data Collection Plan and Instrument Development

<u>Staff from CDC</u>	
<i>Office Of Health System Collaboration CDC/OD/OADP</i>	
Naomi Chen-Bowers Lead Evaluator, 6 18 Initiative Senior Service Fellow, Behavioral Scientist	Phone: (770) 488-6036 Email: jtv4@cdc.gov
Laura Seeff	Phone: (404) 639-7063

Medical Director	Email: lvs3@cdc.gov
Melanie Ross Public Health Specialist	Phone: (404) 639-8840 Email: bge7@cdc.gov
Kristin Brusuelas Public Health Analyst	Phone: (404) 498-6545 Email: kmb0@cdc.gov
<i>Office On Smoking And Health CDC/ONDIEH/NCCDPHP</i>	
Stephen (Steve) Babb Public Health Analyst	Phone: (770) 488-1172 Email: zur4@cdc.gov
<i>Division of Reproductive Health CDC/ONDIEH/NCCDPHP</i>	
Shanna Cox Associate Director For Science	Phone: (770) 488-6477 Email: cio8@cdc.gov
<i>Asthma -- Division of Environmental Hazards & Health Effects CDC/ONDIEH/NCEH</i>	
Joy Hsu Medical Officer	Phone: (770) 488-0788 Email: xdd6@cdc.gov
Maureen Wilce Health Scientist	Phone: (770) 488- 3721 Email: muw9@cdc.gov
<i>Division Of Diabetes Translation CDC/ONDIEH/NCCDPHP</i>	
Patricia (Pat) Schumacher Senior Team Lead	Phone: (770) 488- 5968 Email: prs5@cdc.gov
<i>Division Of Heart Disease And Stroke Prevention CDC/ONDIEH/NCCDPHP</i>	
Rebekah Buckley Deputy Branch Chief	Phone: (770) 488-6215 Email: eut9@cdc.gov
Haley Stolp Public Health Specialist	Phone: (770) 488-7442 Email: vul4@cdc.gov
<i>Division Of Healthcare Quality Promotion CDC/OID/NCEZID</i>	
Katherine Fleming-Dutra Medical Officer	Phone: (404) 639-4243 Email: ftu2@cdc.gov
<u>Staff from CMS</u>	
Deidra Stockmann Health Insurance Specialist Division of Quality and Health Outcomes Center for Medicaid and CHIP Services	Phone: (410) 786-2433 Email: deidra.stockmann@cms.hhs.gov

Additionally, during the development of this information collection, a CDC fellow conducted literature searches and consulted with Center for Health Care Strategies and the Association of State and Territorial Health Officials to confirm that this effort is not duplicative. The importance of population health and interdisciplinary collaboration has only recently become widely acknowledged; therefore, information regarding state programs addressing these

principles is scarce. The information that will be gathered through this information collection is not available from other data sources or through other means.

A5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this information collection.

A6. Consequences of Collecting the Information Less Frequently

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

1. Describe the collaboration between the health care and public health sectors as they partner with a shared focus across a spectrum of prevention interventions.
2. Describe the specific contribution of the 6|18 Initiative to the cross-sector health care-public health collaboration
3. Describe how contextual factors (e.g., delivery system reform efforts) facilitated, or posed barriers to the cross-sector collaboration
4. Promote best practices for collaboration between State Health Departments and State Medicaid Agencies.
5. Disseminate lessons learned from the cross-sector collaboration key stakeholders that can support state agencies who are doing similar work

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

There are no special circumstances with this information collection package. This request fully complies with the regulation 5 CFR 1320.5 and will be voluntary.

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

Federal Register Notice

This is a new information collection. A 60-day Federal Register Notice was published in the Federal Register on October 13, 2017, Vol. 82, No. 197; page 47738 (**Attachment 2 – 60-Day FRN**). No public comments were received.

Other Consultations

CDC developed the data collection plan in collaboration with staff at George Washington University (co-operative agreement sub-contractor), and subject matter experts at CDC. Consultation will continue throughout the implementation process.

CDC also discussed the proposed data collection instruments with colleagues from state public health departments and state Medicaid agencies that are actively involved in 6|18 or related activities, with the intent of creating synergies with the data being collected and reducing any duplication of effort as well as accessing expertise in the field of public health-health care partnerships to improve population health. 6|18 Initiative program staff consulted in October 2016 - June 2017 with Year 1 6|18 states who voluntarily provided feedback (MI, RI, SC).

Table A8-a. Consultants outside the Agency Consulting on Data Collection Plan and Instrument Development

<u>Staff from 6 18 State Teams</u>	
Sophia Hines Public Health Consultant Michigan Department of Health and Human Services	Phone: (517) 335-6965 Email: HinesS3@michigan.gov
Julian Rodriguez-Drix Asthma Program Manager Division of Community, Health & Equity Rhode Island Department of Health	Phone: (401) 222-7742 Email: Julian.Drix@health.ri.gov
Christina Galardi Project Manager South Carolina Department of Health and Human Services	Phone: (803) 462-4962 Email: Christina.Galardi@scdhhs.gov
<u>Staff from George Washington University (GWU)</u>	
Milken Institute School of Public Health Dept. of Health Policy and Management	
Leighton Ku Professor Director, Center for Health Policy Research	Phone: (202) 994-4143 Email: lku@gwu.edu
Erin Brantley Senior Research Associate	Phone: (202) 994-8606 Email: ebrantley@email.gwu.edu

A9. Explanation of Any Payment or Gift to Respondents

CDC will not provide payments or gifts to respondents.

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

Information collection for the 6|18 Initiative Case Studies is for the purpose of assessing 6|18 participating states' functioning and activities at the organizational level.

Privacy Impact Assessment

All participants, i.e., State Public Health Department and State Medicaid Agency staff, will be speaking from their official roles. Information in identifiable form (IIF) that is collected will only include business contact information for each respondent (i.e., name, office/work telephone number, and office/work email address). The interview questions do not collect Personally Identifiable Information (PII). The information to be obtained through interviews concerns organizational activities rather than personal matters and is not considered highly sensitive. During interviews, respondents will be asked to identify their organization, role, and perceptions about activities conducted within their organization. The information collected will focus on respondents' thoughts and experiences related to programmatic partnerships, the contribution of the 6|18 Initiative, and contextual factors that were barriers or facilitators to activities. All information, including IIF, will be kept on secure, password protected servers accessible only to project team members. As part of the consent process, which includes an advance notice email (**Attachment 4 – Advance Notice Email**) and an opportunity to ask any questions at the beginning of the interview (**Attachment 3 – Interview Guide**), we will make respondents aware of the intended use of the findings (e.g., manuscripts and in-depth case studies to share lessons learned with the field). Respondents will be given an opportunity to review products before they are shared publicly.

Interview responses will be linked to respondents' organizations and roles to ensure that interview findings can be grouped by organization, to generate in-depth organizational case study profiles. GWU, the data collection sub-contractor, will have access to IIF for program leadership and staff recruited for participation. No other personal identifiers will be collected. All data files will be stored in a secure electronic folder on a password-protected CDC external-facing server that is only accessible by authorized project staff.

A. Privacy Act Determination

CDC has reviewed this Information Collection Request and has determined that the Privacy Act does not apply to the identifiable staff-level information collected in the 6|18 Case Study interview guide (**Attachment 3 – Interview Guide**). Respondents will be speaking from their roles as officials or staff of state health departments, and state Medicaid agencies. Respondents will not supply personal information. GWU and the CDC evaluation team staff 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 government data privacy and security procedures.

B. Safeguards

The personal contact information for respondents will not be used for analysis or reporting purposes. Although contact information is obtained for each participant, the contact person provides information about the organization, not personal information. Study information and data, including contact information for respondents and interview responses, will be destroyed within 3 years of the project end date. All electronic data files (e.g. audio recordings) will be stored at CDC on an external-facing system on CDC's servers. Only CDC and GWU staff who have been authorized by the CDC Project Official can access the external-facing system.

C. Consent

As part of the advance notice email (**Attachment 4 – Advance Notice Email**) and at the beginning of the interview (**Attachment 3 – Interview Guide**), CDC will share the goals of the interview, and ask for verbal consent to conduct and record the interview. Participating in the interview will be considered consent by the participant. In cases where a participant(s) decline(s) to be recorded, we will rely on the notes taken during the interview. The consent statement at the beginning of the interview informs participants that their participation in the interview is voluntary, and they can choose not to answer individual questions, to end the interview at any time, or to decline participation without penalty. Whether or not states or individuals choose to participate will not impact current or future participation in 6|18.

D. Nature of Participation

As previously stated, organizations who are actively participating in the 6|18 Initiative will be recruited to participate in this information collection. Participation in the interview is voluntary for all participants; respondents who decline participation will not face penalty of any kind.

A11. Institutional Review Board (IRB) and Justification for Sensitive Questions

Respondents are 6|18 Initiative participants. The information collection does not involve research with human subjects and does not require IRB approval. No information will be collected that are of personal or sensitive nature.

A12. Estimates of Annualized Burden Hours and Costs

Respondents will be drawn from 17 states participating in the CDC-funded 6|18 initiative. Interviews will be requested with 4-7 individuals per state who serve in the following roles: the State Public Health Director (1), State Public Health Manager (1-4), State Medicaid Director (1),

and State Medicaid Manager (1). All interviews are based on the same Interview Guide (see Attachment 3) and are expected to last one hour. The estimated burden of 1 hour and 15 minutes (75 minutes) includes time for the respondent to prepare for the interview.

Up to 82 respondents will participate in interviews over a 3-year clearance period. When stratified by role and annualized, the estimated annualized number of respondents is 29 per year. The burden table displays the estimated annualized number of respondents, by role, and estimated annualized burden hours. The total estimated annualized burden is 38 hours. Total burden is slightly overestimated due to annualization and rounding.

Table A12-a. Estimated Annualized Burden Hours

Type of Respondent	Form name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
State Public Health Director	Interview Guide	6	1	75/60	8
State Public Health Manager	Interview Guide	11	1	75/60	14
State Medicaid Director	Interview Guide	6	1	75/60	8
State Medicaid Manager	Interview Guide	6	1	75/60	8
		29		Total	38

Estimates for the average hourly wage for respondents are based on the mean hourly wages reported in the May 2016 National Occupational Employment and Wage Estimates: United States, from the Department of Labor (DOL) Bureau of Labor Statistics, https://www.bls.gov/oes/current/oes_nat.htm (last accessed September 8, 2017). Based on DOL data, an average hourly wage of \$93.44 for occupational employment for Chief Executives is estimated for all director-level respondents. Based on DOL data, an average hourly wage of \$52.58 for occupational employment for Medical and Health Services Managers is estimated for all manager-level respondents. Table A12-b shows estimated burden and cost information. The total estimated annualized burden cost is \$2,518.

Table A12-b: Estimated Annualized Burden Cost

Type of Respondent	Form name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Average Hourly Wage	Total Cost
State Public Health Director	Interview Guide	6	1	75/60	\$93.44	\$701

State Public Health Manager	Interview Guide	11	1	75/60	\$52.48	\$722
State Medicaid Director	Interview Guide	6	1	75/60	\$93.44	\$701
State Medicaid Manager	Interview Guide	6	1	75/60	\$52.48	\$394
					Total	\$2,518

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

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

A14. Annualized Cost to the Government

There are no equipment or overhead costs. The only cost to the federal government would be the salary of CDC staff and sub-contractors. Partners, specifically staff of the George Washington University (co-operative agreement sub-contractor), will support the development and implementation of the assessment tools, data collection, and data analysis. The total estimated cost to the federal government is \$111,011.50. The paragraphs and Table A14-a below describe and summarize how this cost estimate was calculated.

Government personnel – Governmental costs for this project include personnel costs for federal staff involved in providing oversight and guidance for the planning and design of the 6|18 Case Studies, refinement of the semi-structured Interview Guide, development of OMB materials, collection and analysis of the data, reporting, and dissemination. These activities involve approximately 50 percent of one GS-13 behavioral scientist. Assuming a \$90,023 annual salary for behavioral scientists, the total estimated annualized cost to the Federal Government is \$45,011.50.

Contracted data collection –The project design and data collection is being conducted under a sub-contract with CDC’s co-operative agreement data collection sub-contractor, George Washington University (GWU). GWU is a sub-contractor to ChangeLab, CDC’s co-operative agreement grantee. Approximately \$66,000 per year of GWU’s current sub-contract with CDC is dedicated for this information request to plan, implement, and analyze the data collection.

Table A14-a. Estimated Annualized Cost to the Federal Government	
Activity/Personnel:	Cost
CDC Personnel 50% Behavioral Scientist’s time Project planning, management, OMB review, conducting interviews, collecting and analyzing findings, report writing, and approving contract deliverables	\$45,011.50

Contractor Project planning, management, OMB review, scheduling and conducting interviews, collecting and analyzing findings, and report writing	\$66,000.00
Total estimated cost	\$111,011.50

A15. Explanation for Program Changes or Adjustments

This is a new information collection.

A16. Plans for Tabulation and Publication and Project Time Schedule

CDC will develop a variety of reports and publications to ensure dissemination of the case study findings to the sites and other key stakeholders. These reports include case study reports intended for practitioners hoping to replicate these efforts. CDC will also oversee the development of several manuscripts over the course of the evaluation. The topics to be addressed and publications to be targeted will be developed once case study findings are available to ensure that they focus on the issues most salient to the sites and program stakeholders at that time.

After data are collected, notes will be cleaned. Research staff will compose an initial case memo detailing what we have learned from the interviews around each of our four specific aims. This memo will be provided to the state for confirmation and any corrections. Data from the interviews and documents analysis will be triangulated to identify the key descriptive and explanatory themes for each case. Our analysis for specific aim 2, the results of collaboration between public health and health care sectors, will be descriptive. We will develop an initial descriptive framework to document this collaboration prior to data collection but will adapt our framework based on the interviews. The framework would be an outline of the sections we anticipate presenting in a case study (e.g., complementary capacities, shared mission). For specific aims 1, 3 and 4, identifying the role of 6|18 and key contextual barriers and facilitators, we will use a combination of inductive and deductive thematic analysis. We list a number of expected themes as probes in the interview guide (deductive) and will also include additional factors described by participants (inductive).

The interview guide questions and probes were influenced by frameworks and resources such as the Wilder collaboration factors inventory (Mattesich et al. 2001), the National Implementation Science Network (NIRN) Hexagon Tool (Blase et al. 2013), the NIRN Implementation Drivers framework (Fixen et al., 2013), and Klein and Knight’s list of challenges to innovation implementation (2005).

Below, we have listed our anticipated timeline. In order to formally recruit states and schedule the initial set of interviews beginning in April/May 2018, we will need to obtain OMB approval in February/March 2018. However, we are requesting a three-year data collection period to allow

time for unanticipated delays; and to accommodate state team schedules, busy seasons, and holidays.

Table A16-a. Project Time Schedule

Task	Time Schedule
Advance notice calls made, and emails sent, to states	April 2018 – August 2018
Schedule Interviews	April 2018 – August 2018
Information collection: Conduct interviews	Year 1 states: May 2018 – November 2018 Year 2 states: July 2018 – April 2019
Analyses; draft manuscript and in-depth case studies	April 2019 – September 2019
Submission for publication	November 2019 – February 2020

Target dates for data collection and analysis will be adjusted if OMB approval is not received by April 9, 2018.

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

We are requesting no exemption.

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.

References:

1. Blase K, Kiser L, Van Dyke M. "The hexagon tool: Exploring context." Chapel Hill, NC: National Implementation Science Network (2013).
2. Fixsen D, Blase K, Naoom S, Duda M. "Implementation drivers: Assessing best practices." Chapel Hill, NC: National Implementation Science Network (2013).
3. Klein KJ, Knight AP. Innovation implementation: Overcoming the challenge. Current directions in psychological science. 2005 Oct;14(5):243-6.
4. Mattessich P, Murray-Close M, Monsey B. "Wilder collaboration factors inventory." St. Paul, MN: Wilder Research (2001).