Implementing the 6|18 Initiative: Case Studies

New

Supporting Statement – Section B

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Program Official/Project Officer
Naomi Chen-Bowers
Senior Service Fellow
Office of Health System Collaboration
Office of the Associate Director for Policy
Centers for Disease Control & Prevention
1600 Clifton Road NE
Atlanta, Georgia 30333
Phone Number: (404) 488-6036
Email: jtv4@cdc.gov

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Section B – Information Collection Procedures

1. Respondent Universe and Sampling Methods

Respondent Universe

Overview: Information will be collected from a purposively selected convenience sample of 17 jurisdictions (hereafter, "states") participating in the 6|18 initiative (see **Attachment 8 - 6|18 States**). Each state team will be represented by up to 4-7 respondents with the following job titles: state public health director (1), public health manager (1-4), Medicaid director (1), and Medicaid manager (1). From the list of health conditions targeted by the 6|18 initiative, each state has selected 1-4 health conditions and has assigned a public health manager to each condition. As a result, the number of respondents will vary by state. A summary of the number of respondents, by role and year of 6|18 participation, is provided in Table B1. The table provides both the actual targeted number of respondents and the annualized number of respondents used to estimate burden for this information collection.

Table B1. Number of Respondents, by Role and Year of 6|18 Participation

State Team Respondents, by Role	Number of Respondents			
	Year 1 (Actual)	Year 2 (Actual)	Total (Actual)	Total (Annualized) [(i)]
Public Health Director	9	8	17	6
Public Health Manager	16 [(ii)]	15 [(iii)]	31	11
Medicaid Director	9	8	17	6
Medicaid Manager	9	8	17	6
Total	43	39	82	29

(i) Information collection has been annualized over a 3-year period to provide flexibility in scheduling options

(ii) Colorado (2), Georgia (2), Louisiana (1), Massachusetts (1), Michigan (3), Minnesota (1), New York (2), Rhode Island (2), South Carolina (2)

(iii) Alaska (4), District of Columbia (2), LA County (1), Maryland (1), Nevada (1), North Carolina (3), Texas (1), Utah (2)

Background: Through the 6|18 Initiative, CDC has been supporting and accelerating the work of state teams, composed of State Medicaid and State Public Health, as they implement evidence-based preventive service clinical interventions for: reducing tobacco use, controlling high blood pressure, preventing healthcare-associated infections, controlling asthma, preventing unintended pregnancy, and controlling and preventing diabetes.

State teams from Years 1 and 2 constitute the respondent universe. We are inviting a census of participants because each state has a unique context and activities, and collecting information

from a census of participants will allow us to understand a range of different contexts and activities. Collecting information from a census of participants will also allow us to understand a broad range of lessons learned. Data collection will take place for states that agree to participate. The unit of analysis is the participant (state or large city team) and not individuals within these states. Because participants are volunteers, they will constitute a non-random sample.

Year 1: In Spring 2016, CDC began partnering with a first group of 9 public payer state teams as part of the 6|18 Initiative (see **Attachment 8 – 6|18 States**). The 9 states were selected because they had the following factors critical for success: (1) They had active efforts in place to control one or more of the 3 priority health conditions targeted in Year 1 (i.e., Asthma, Tobacco, and Unintended Pregnancy), (2) They were working to implement the specific interventions highlighted within the set of 18, and (3) The state supported the Medicaid Agency and the Department of Public Health working on this initiative in partnership. (4) Additionally, CDC prioritized working with states that had already made significant progress in addressing their selected health conditions, where success would be achievable and best practices could be provided for other states just beginning this work. Based on meeting the three criteria above, the nine states that participated in the 6|18 Initiative in Year 1 included: Colorado, Georgia, Louisiana, Massachusetts, Michigan, Minnesota, New York, Rhode Island, and South Carolina.

Year 2: In Summer 2017, CDC began partnering with a second group of eight new public payer teams (seven state teams and one large city team, hereafter, "states") (see **Attachment 8 – 6|18 States**). The states in Year 2 are at an earlier stage in their program life cycle. Whereas many Year 1 states were leaders in their field that had already been working in 6|18-related work prior to formal engagement in 6|18, Year 2 states may be newer to 6|18-type interventions and activities. The goal of partnering with states that are earlier in their program life cycle is to broaden our understanding of facilitators, barriers, technical assistance needs, and best practices that are specific to states that are in an earlier stage of their program life cycle. We want to understand activities, barriers, and facilitators, and lessons learned across the project life cycle spectrum in order to be able to generate and disseminate toolkits and resources that will be useful to other states that are implementing 6|18-type work at varied points in their project life cycle. Based on meeting the criteria above, the 8 states that are participating in the 6|18 Initiative in Year 2 include: Alaska, the District of Columbia, Los Angeles County, Maryland, Nevada, North Carolina, Texas, and Utah.

Sampling Methods
Selection criteria for states

Because the universe of states and large cities who are participating in 6|18 is small, and they represent considerable variation in context and choice of 6|18 intervention (see **Attachment 8 – 6|18 States**), a random sample of states would not ensure that the case study pool includes the appropriate mix of states and large cities, and would not support meaningful examination of

the range of approaches to collaboration that may vary by the type of stakeholder. We therefore propose to interview a census of public team participants when they have achieved programmatic milestones that can be meaningfully discussed in an interview. We have listed the upper range of the estimated number of state team members that will be interviewed, but the actual number interviewed may be smaller if the amount of time needed to achieve meaningful milestones is longer than anticipated. We have planned for a long time window (eight months) for conducting interviews each year to accommodate state schedules.

Our sample will be a census. Because of the small sample size and the uniqueness of individual state situations, the results are not generalizable to the general population. Statistical power is not applicable because this is a qualitative study. The total estimated sample size is shown in Table B1-a.

CDC will confirm, by calls or emails made to each state assessing their interest in participating in the 6|18 Case Study Interviews, that states are able to participate without being overburdened given other project responsibilities, turnover of staff, and other unforeseen issues.

Selection criteria for interview participants

Respondents from state public health agencies and state Medicaid agencies were chosen based upon their roles and responsibilities in their respective organization. If respondents wish to nominate known partners (e.g., non-profit organizations, foundations) who have an integral role in the partnership, we will interview them at the suggestion of respondents. The purpose of this qualitative research study is to describe the collaborative efforts between the stakeholders in the health care and public health sectors, and the factors that impede or facilitate their collaboration. Qualitative methods provide flexible in-depth exploration of the participants' perceptions and experience, and the interviews yield descriptions in the participants' own words. They also allow the interviewer flexibility to pursue relevant and important issues as they arise during the discussion. Our discussion guides include probes to ensure that we obtain input on specific items of interest, while open-ended questions ensure that participants' responses and perceptions are fully addressed and captured.

We have projected the maximum anticipated number of interviewees, assuming a 100% participation rate among 6|18 participating states and their staff members. In reality, these numbers may be lower if more time is needed for meaningful outcomes to occur, for which it would be meaningful to conduct interviews.

We reserve the opportunity to conduct site visits with a limited number of states. Out of respect for state staff's time, we will only visit if and when it is meaningful to do so (e.g., they have achieved milestones that would be meaningful to discuss in depth during a site visit). Visits are contingent on budgetary resources, state staff availability, and state staff agreement to host a site visit.

2. Procedures for the Collection of Information

This is a one-time data collection. CDC and co-operative agreement sub-contractor George Washington University will collect data once from each state, approximately eight to fifteen months after initiating a partnership with 6|18. This period of time was chosen because it: (1) allows time for some partnership outcomes to develop; (2) is within, or close to, the one-year timeframe that states are initially committing to work with 6|18; (3) is relatively short, to reduce the possibility that state staff turnover will pose a barrier to data collection; and (4) allows flexibility so we can schedule interviews at a time that is most convenient for the state, and potentially join existing CDC division site visits to reduce burden and duplication of effort for the state. In cases where the state's partnership milestones are still in progress eight to fifteen months after initiating a partnership with 6|18, the CDC and/or the state may decide to postpone the interviews for another six to nine months, or until tangible partnership outcomes have occurred, whichever is more appropriate. As a courtesy, we will share interview questions with states in advance. If, for convenience, respondents wish to have multiple interviewees in an interview, we will conduct the interviews concurrently.

Respondents will be asked to grant permission for the interview team to audio record the interview for note taking, clarification and to verify quotes only. Study information and data, including contact information for respondents and audio recordings, will be destroyed on or before May 2021, three years after data collection begins.

Prior to conducting interviews for each state, we will use existing data resources, such as workplans and notes from calls with the technical assistance provider, Center for Health Care Strategies (CHCS), to assemble a state-specific summary. The summary will be used to verify that the information obtained from these sources is complete, and to prepare the interviewer(s) to conduct the interviews in a focused and efficient manner.

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).

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. We will transfer files (i.e., audio recordings and written notes) between CDC and GWU using secure mechanisms such as Filezilla, a third-party FTP client. We will store files on an outward-facing external infrastructure, such as an encrypted FTP site, hosted by CDC.

3. Methods to Maximize Response Rates Deal with Nonresponse

CDC designed this information collection to minimize the burden to respondents and to the government, to maximize convenience and flexibility, and to ensure the quality and usefulness of the information collected. Participation in this assessment is voluntary for both states and individuals within states. All Year 1 and 2 states have been invited to participate in assessment activities, as part of their 6|18 activities. Year 2 states agreed to participate in assessment activities as part of their original statement of interest to join 6|18. Therefore, we expect that the majority of states will agree to participate.

To maximize response rate and minimize burden, we will send the advance notice email (see **Attachment 4 — Advance Notice Email**) in advance of scheduled monthly technical assistance calls, and follow up with states during the scheduled call. To minimize response burden, we have designed the information collection tools so they do not require the participant to prepare in advance of the interview.

Because we are seeking theoretically rather than statistically generalizable findings, we do not anticipate that a response rate below 100% will be a significant problem for our study. We anticipate a sufficiently high response rate to reach saturation in our thematic analysis. However, if some states decline to participate, we will acknowledge the fact that they may be different than participating states as a limitation when publishing and/or disseminating findings.

4. Test of Procedures or Methods to be Undertaken

The estimate for burden hours of the average time to complete the instrument including time for reviewing instructions, gathering needed information and completing the instrument; is based on pilot tests of the interview guides by public health professionals, as follows. Program staff from 6|18, and other testers, pilot tested the instrument. Burden estimates for the interview only ranged from 00:58-1:08, for an average of 1:04. The burden estimates in **Table B4-a** below include an estimated additional 00:15 to allow for time that respondents may spend preparing for the interview.

Table B4-a. Estimate for burden hours, based on pilot testing

Instrument	# Testers	Average time (min.)	Range (min.)

Interview Guide	4	79	73 to 83

5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data

Naomi Chen-Bowers, of the Centers for Disease Control and Prevention, is the Principal Investigator for the study. She has overall responsibility for overseeing the design and administration of the project and reporting of the case study information. CDC will provide overall direction for the 6|18 Case Studies, directing regular planning and coordination meetings with GWU staff, including the data collection protocol and data reporting.

The protocol, including statistical aspects, was designed in collaboration with the cooperative agreement sub-contractor for implementation, GWU. GWU and CDC will collaborate to schedule and administer the semi-structured key informant interviews from select program leaders and staff members within participating 6|18 states. GW will analyze and report interview results.

Table B5-a. Principal contacts for each organization

Staff Name	Role	Contact Information
CDC Office Of Health System Collaboration CDC/OD/OADP/OHSC		
Naomi Chen-Bowers, PhD Senior Service Fellow, Health Scientist	Project design including statistical aspects, data collection, data analysis	Phone: (770) 488-6036 Email: jtv4@cdc.gov
Jocelyn Wheaton, MPH Public Health Advisor	Cooperative agreement technical monitor; receives and approves contract deliverables	Phone: (404) 639-1048 Email: kzw9@cdc.gov
George Washington University (GWU) Milken Institute School of Public Health Dept. of Health Policy and Management		
Leighton Ku Professor Director, Center for Health Policy Research	Project design including statistical aspects, data collection, data analysis	Phone: (202) 994-4143 Email: lku@gwu.edu
Erin Brantley Senior Research Associate	Project design including statistical aspects, data collection, data analysis	Phone: (202) 994-8606 Email: ebrantley@email.gwu.edu
ChangeLab Solutions		
Manel Kappagoda, JD, MPH Senior Staff Attorney and Project Director ChangeLab Solutions	Cooperative agreement contractor; responsible for receiving and approving contract deliverables	Phone: 510-388-2477 (cell); 510-302-3343 (office) mkappagoda@changelabsolutions.org

Naomi Chen-Bowers, PhD
Senior Service Fellow, Health Scientist
Office of Health System Collaboration
Office of the Associate Director for Policy
Office of the Director
Centers for Disease Control and Prevention
1600 Clifton Rd NE, MS D-28
Atlanta, GA 30329
OFFICE: 770-488-6036
FAX: 404-639-5172