INFORMATION COLLECTION REQUEST

Revision

Monitoring and Reporting System for the Division of Community Health's Cooperative Agreement Programs OMB control No. 0920-1053

Supporting Statement: Part A

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In 2014, NCCDPHP announced a new three-year cooperative agreement program to improve and/or implement sustainable, community-based programs that address the primary causes of chronic diseases, Racial and Ethnic Approaches to Community Health (REACH; FOA DP14-1419PPHF14). In 2017, REACH awardees were provided supplemental funding for an additional year. CDC requests to extend the current OMB approval to March 31, 2019 to continue collecting information from currently funded REACH awardees describing their work plan, activities and progress toward achieving objectives. Previously funded Partnership to Improve Community Health Awardees (44 awardees) will not be included, decreasing the number of respondents and burden. CDC intends that REACH awardees continue to use the same electronic management information system to provide the semi-annual reports to CDC during the fourth year.

The resulting data will be used by CDC to monitor each awardee's progress or describe activities across multiple awardees, to provide oversight of the use of federal funds, and to identify and disseminate information about successful prevention and control strategies implemented by awardees. CDC will use the data to monitor the increased emphasis on partnerships and programmatic collaboration to reduce duplication of effort, enhance program impact and maximize the use of federal funds as well as to evaluate the program model for future program reporting efforts. In addition to routine performance monitoring, CDC will use the information to respond to inquiries from the HHS, the White House, Congress and other stakeholders about REACH program activities and their impact.

Information will be collected twice per year via a centralized, electronic management information system called the DCH-Performance Monitoring Database (DCH-PMD) from all REACH awardees. Each REACH awardee will have access to their own information. Users will log into the DCH-PMD at their worksite computer and provide progress reporting information through prompted data entry points.

Respondents are 49 current REACH awardees funded through the Funding Opportunity Announcement. Eighteen awardees are state, local, and tribal governmental agencies, and 31 awardees are private sector organizational entities.

CDC will not use complex statistical methods for analyzing information. Most statistical analyses will be descriptive and all information will be aggregated. Statistical modeling may be included to examine predictors of specified outcomes.

A. JUSTIFICATION

1. Circumstances Making the Collection of Information Necessary

CDC requests OMB approval of a revision to extend the collection of information for an additional year through the Racial and Ethnic Approaches to Community Health cooperative agreement. Forty-four Partnership to Improve Community Health awardees are no longer included, resulting in a decrease in respondents and burden; the initial population of the Management Information System is no longer necessary resulting in further burden reduction. CDC plans to collect information to monitor this cooperative agreement program as authorized by the Public Health Service Act (**Attachment 1a**) and the Prevention and Public Health Fund of

the Affordable Care Act (**Attachment 1b**). The program is administered by the Division of Nutrition, Physical Activity and Obesity (DNPAO), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Prevention and Control (CDC).

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

In 2014, NCCDPHP announced a new cooperative agreement program to improve and/or implement sustainable, community-based programs that address the primary causes of chronic diseases, Racial and Ethnic Approaches to Community Health (REACH; FOA DP14-1419PPHF14). REACH was designed to be a three-year cooperative agreement. In 2017, REACH was provided supplemental funding for an additional year.

The REACH Program is specifically designed to facilitate the work of state, local, and tribal governmental agencies, non-governmental organizations, and national organizations that need additional support to implement evidence- and practice-based interventions for reducing the prevalence of chronic diseases and risk factors for chronic diseases. The cooperative agreement builds on awardees' previous efforts to establish coalitions or networks of multi-sector organizations, analyze local health issues, or develop plans to shape systems and environments that promote and sustain health and quality of life. Awardees are implementing population-based interventions that address poor nutrition, low physical activity, tobacco use and exposure, and lack of access to chronic disease prevention or risk reduction opportunities.

Interventions are being implemented across various settings (i.e., community, community institution/organization, faith-based, health care, school, work site) to increase access to healthier living for at least 75% of the population in a targeted jurisdiction. The FOA proposes steps to improve and /or implement sustainable, community-based improvements that address the primary causes of chronic diseases.

Each REACH program awardee funded under DP14-1419PPHF14 is charged with implementing a community- or awardee-specific work plan that will lead to explicit, measurable health outcomes in its jurisdiction (or service area) among an entire population or a specific population subgroup. Although the program emphasizes policy and environmental improvements, activities that may be supported with REACH program funding include: establishing or strengthening community coalitions; participating in appropriate training; conducting community-specific needs assessments; promoting community engagement with populations experiencing health

disparities; analyzing gaps in existing policies, systems, and environments; and implementing evidence-based strategies and evaluating promising interventions.

CDC awarded 49 REACH cooperative agreements in September 2014 (18 awards to state, local and tribal governmental agencies and 31 awards to non-governmental organizations; see **Attachment 2** for a List of Awardees). Each REACH program awardee is required to provide semi-annual reports to CDC describing its work plan, activities, and progress toward achieving objectives. CDC requests OMB approval to extend the current OMB approval timeframe to collect this information through the electronic management information system (MIS) for the fourth year of the program ending in March 31, 2019. This will allow REACH awardees to continue to provide semi-annual reports to CDC describing their work plan, activities and progress toward achieving objectives during the fourth year of funding. During the developmental phase, the MIS was called the Policy, Environment, Programmatic, and Infrastructure Database (PEPID). The version prepared for release has been renamed the DCH-Performance Monitoring Database (DCH-PMD; see **Attachment 3a**). Initial work plans were entered into the DCH-PMD in Fall/Winter 2014, and interim reports have been (or will be) submitted approximately every six months thereafter. In year four, an interim report and final report will be entered into the DCH-PMD in April 2018 and December 2018, respectively. Each awardee received an instructional manual for the MIS (see **Attachment 3b, DCH-PMD User Guide**) as well as on-going technical assistance from DNPAO, as needed.

CDC also requests OMB approval to conduct one special-purpose data collection per year (on average) for awardees funded under DP14-1419PPHF14. CDC anticipates that additional, targeted information may be needed due to substantial interest in the new cooperative programs from a variety of stakeholders. This expectation is based on CDC's previous experience in implementing new cooperative agreement programs. In similar circumstances, CDC has received ad hoc inquiries from various stakeholders, such as the National Association of Chronic Disease Directors (NACDD), CDC leadership, the White House, HHS, and Congress. Given that the REACH awardees represent many non-traditional organizations (in addition to state and local public health agencies) there is a renewed interest in understanding where these organizations are focusing their efforts. For example, CDC could be asked to specify how REACH awardees are working in (or with) census tracts, cities, rural areas, tribes, or specific diverse populations to achieve their goals. DNPAO cannot fully anticipate the questions that may be asked, but proposes a mechanism for contacting awardees to obtain additional or clarifying information that may be needed to accurately respond to ad hoc requests. Moreover, because many REACH awardees are private sector entities, DNPAO's ability to fulfill some ad hoc requests through existing generic clearances (such as OSTLTS 0920-0879) is constrained. We have thus included a provision for targeted, supplemental information collection in the overall monitoring and reporting plan for REACH awardees.

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

2. Purpose and Use of the Information Collection

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

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

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

CDC will use the information collected in the DCH-PMD to monitor each awardee's progress and to identify its strengths and weaknesses. Monitoring allows CDC to determine whether an awardee is meeting performance goals and to make adjustments in the type and level of technical assistance provided to them, as needed, to support attainment of their objectives. Although each awardee's progress is assessed principally in terms of its own objectives and work plan, the DCH-PMD will also provide some capacity to generate reports that monitor progress or describe activities across multiple awardees.

CDC's monitoring and evaluation activities also allow CDC to provide oversight of the use of federal funds, and to identify and disseminate information about successful prevention and control strategies implemented by awardees. These functions are central to the NCCDPHP's broad mission of reducing the burden of chronic diseases. Finally, the information collection will allow CDC to monitor the increased emphasis on partnerships and programmatic

collaboration, and is expected to reduce duplication of effort, enhance program impact and maximize the use of federal funds.

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

3. Use of Improved Information Technology and Burden Reduction

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

- The use of a standard set of data elements, definitions, and specifications at all levels will help to improve the quality and comparability of performance information that is received by CDC for multiple awardees and multiple award types. Further, standardization will enhance the consistency of work plans and reports, enable cross-program analysis, and will facilitate a higher degree of reliability by ensuring that the same information is collected on all objectives and activities with slightly different areas of emphasis, depending on the awardee type (Local and tribal government entities and Non-governmental entities).
- The structure of the DCH-PMD will minimize or eliminate many elements that would otherwise be repeated within stand-alone systems. Having all of the information collected in the same place in the same manner will reduce the level of burden attributable to redundancy and reduce the workload to enter and maintain the data. Programs will be able to transfer data from one year to another to minimize data re-entry.
- The DCH-PMD data structures and business rules will help awardees formulate objectives that are specific, measurable, achievable, relevant and time-framed (SMART). This formulation is intended to facilitate successful achievement of objectives and is integral to CDC's evaluation strategy for the REACH program.
- The information being collected provides crucial information about each awardee's work plan, activities, partnerships and progress over the award period.
- Awardees will have the capacity to enter updates on an ongoing basis. This feature of the DCH-PMD is expected to facilitate real time communications with and interim review by CDC, resulting in more timely technical assistance. The ability to enter updates as activities occur may also result in more complete enumeration of REACH-funded efforts.
- The report generation capabilities of the electronic DCH-PMD will reduce the respondent burden associated with paper-based reports. Without the automated DCH-PMD and the integrated approach to information collection and reporting, awardees and CDC would need to continue to use time consuming, labor intensive procedures for information collection and reporting.

- Capturing the required information electronically will allow CDC to formulate ad hoc analyses and reports that would be impracticable using paper-based information sources. Prior to adopting an electronic method of progress reporting, CDC's ability to respond to ad hoc requests was limited, and required CDC staff to spend many hours combing through hard copies of reports to organize and summarize information. Use of the keyword-searchable, electronic DCH-PMD system significantly improves CDC's ability to identify items of interest in an efficient manner.

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

4. Efforts to Identify Duplication and Use of Similar Information

The collection of this information is part of a federal reporting requirement for funds received by awardees. The DCH-PMD will consolidate information necessary for both continuation applications and progress reports so that information entered once can be used to generate multiple types of reports without having to duplicate efforts. The information collected from awardees is not available from other sources.

5. Impact on Small Businesses or Other Small Entities

No small businesses will participate in the DCH-PMD data collection.

6. Consequences of Collecting the Information Less Frequently

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

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

There are no special circumstances related to the DCH-PMD, and the request fully complies with the regulation.

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

A. Federal Register Notice

A Notice was published in the Federal Register on September 26, 2017, Docket No. CDC-2017-0079, Volume 82, No.185, pages 44798-44800 (see **Attachment 5a)**. CDC received four non-substantive comments (see **Attachment 5b**). No changes were made.

B. Other Consultations

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

9. Explanation of Any Payment or Gift to Respondents

Respondents will not receive payments or gifts for providing information.

10. Assurance of Confidentiality Provided to Respondents

10.1 Privacy Impact Assessment Information

Overview of data collection

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

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

This information collection request includes a provision for special-purpose data collection that may be needed as DNPAO responds to requests from stakeholders about the REACH Program. The objectives, content, and methods of each request will be described in a Change Request.

Information to be collected

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

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

How the information will be shared and for what purpose

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

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

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

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

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

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

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

How the information will be secured

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

Privacy Act Determination

Staff in the CDC Information Collection Review Office have reviewed this Information Collection Request and have determined that the Privacy Act is not applicable. The data collection does not involve collection of sensitive or identifiable personal information. Respondents are state and local governmental agencies, tribes and territories, state or local non-profit organizations, and national networks of community-based organizations. Although contact information is obtained for each awardee, the contact person provides information about the organization, not personal information.

11. Justification for Sensitive Questions

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

12. Estimates of Annualized Burden Hours and Costs to Respondents

A. Estimated Annualized Burden Hours

Awardees will report information to CDC about their objectives and activities through the DCH-PMD, an electronic interface (see **Attachment 3a**). Current respondents are the 49 awardees for REACH FOA. Of these awardees, 18 are from the state, local, and tribal government sector, and 31 awardees are from the private sector.

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

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

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

Over the one-year period of this information collection request, the total estimated annualized burden for the 49 current REACH awardees is 588 hours, as summarized in Table A.12-A.

Table A.12-A.

A. Estimated Annualized Burden to Respondents for Year 4

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Avg. Burden per Response (in hrs.)	Total Burden (in hrs.)
REACH Program Awardees (state, local and tribal government sector)	DCH MIS: Semi-annual reporting	18	2	3	108
	Special Data Request	18	1	6	108
REACH Program Awardees (private sector)	DCH MIS: Semi-annual reporting	31	2	3	186
	Special Data Request	31	1	6	186
	Total				588

B. Estimated Annualized Cost to Respondents

A program manager will prepare the progress report for each area. The average hourly wage for a program manager is $30.65. The hourly wage rates for program managers are based on wages for similar mid-to-high level positions in the public sector. The total estimated annualized cost to respondents is $18,022 as summarized in Revised Table A.12-B.

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

Type of Respondents	Form Name	Number of respondents	Number of responses per respondent	Average burden per response (in hrs.)	Average hourly wage	Total cost
REACH Program Awardees (state, local and tribal government sector)	DCH MIS: Semi-annual reporting	18	2	3	$30.65	$3,310
	Special Data Request	18	1	6	$30.65	$3,310
REACH Program Awardees (private sector)	DCH MIS: Semi-annual reporting	31	2	3	$30.65	$5,701
	Special Data Request	31	1	6	$30.65	$5,701
				Total		$18,022

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

The DCH-PMD is designed to use existing hardware within funded sites, and all respondents currently have access to the Internet to use the information system. No capital or maintenance costs are expected. Additionally, there are no start-up, hardware or software costs.

14. Estimates of Annualized Cost to the Federal Government

A. Development, Implementation, and Maintenance

The average annualized cost to the federal government is $117,655, as summarized in Table A.14-A. Major cost factors for the DCH-PMD include system maintenance costs. The DCH-PMD developer and data collection contractor is ICF International.

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

Cost Category	**Total**
CDC Personnel • 50% GS-12 @$71,901/year = $35,951 • 50% GS-13 @ $85,500/year = $42,750 Subtotal, CDC Personnel	$ 78,701
Data Collection Contractor	$ 38,954
Total	$ 117,655

15. Explanation for Program Changes or Adjustments

The requested revisions include extending the current OMB approval time frame to collect information for an additional year ending in March 31, 2019 using the existing DCH-PMD. The previous respondents included 44 Partnership to Improve Community Health PICH Awardees who are no longer funded; 49 REACH Awardees will continue to collect and report information through this revision request. The total estimated annualized burden has decreased from 1,596 to 588 hours due to fewer respondents and not needing the initial population of the information system.

16. Plans for Tabulation and Publication and Project Time Schedule

A. Time schedule for the entire project

OMB approval is requested for an additional year due to an extension of the cooperative agreement. Reports will be generated by the awardees per the FOA requirements twice a year, in April and November. Data collection began with the awarding of the co-operative agreement and will continue throughout the funding cycle.

B. Publication plan

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

C. Analysis plan

CDC will not use complex statistical methods for analyzing information. All information will be aggregated and reported with no program identifiers present in external documents. Most statistical analyses will be descriptive. Statistical modeling may be included to examine predictors of specified outcomes.

A.16 - 1 Project Time Schedule

Activity Time Schedule	
Notification of Electronic Tool Availability	Immediately upon OMB approval

User Training	Immediately upon OMB approval and ongoing through expiration date
Data Collection	1-36 months after OMB approval
Data Publication	Twice annually
Data Analysis	1-36 months after OMB approval

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

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

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification statement.