Paul Coverdell National Acute Stroke Program (2015-2020) Assessment

Information Collection Request

New

Supporting Statement

Part A—Justification

January 5, 2018

Kincaid Lowe, Health Scientist
CDC/NCCDPHP/Division for Heart Disease and Stroke Prevention
4770 Buford Highway NE, MS-F73
Atlanta, GA 30341-3717
Phone: 404.718.6633
Email: klowe@cdc.gov
Fax: 770.488.8151

1TABLE OF CONTENTS

LIST OF ATTACHMENTS – Section A

Attachment A1	Public Health Service Act (42 U.S.C. 241)
Attachment A2	Screenshots of Partner Cost Collection Tool
Attachment A3	Partner Cost Collection Tool User Manual
Attachment A4	RTI IRB Determination Memo
Attachment A5	Principal Investigator Telephonic Interview Protocol
Attachment A6	Program Manager Telephonic Interview Protocol
Attachment A7	Support Staff Telephonic Interview Protocol
Attachment A8	QI Specialist Telephonic Interview Protocol
Attachment A9	Data Analyst Interview Protocol

Overview

- **Goal of the assessment:** CDC and RTI International propose to collect information from all nine funded Paul Coverdell National Acute Stroke Program (PCNASP) grantees and a sample of their partners to (1) assess the actual partner costs of establishing statewide comprehensive stroke systems of care; and (2) increase CDC's understanding of funded programs' implementation of effective state-based stroke systems of care and PCNASP specific contributions.

- **Intended use of the resulting data:** The insights to be gained from this data collection will be critical to improving immediate efforts and achieving the goals of spreading and replicating state-level strategies that are proven programmatically and are cost-effective in contributing to a higher quality of care for stroke patients.

- **Methods to be used to collect data:** Two components of the information collection include: (1) program implementation cost data collection from program partners using a cost collection tool; and (2) telephone interviews with key program stakeholders. We are collecting program-level cost and qualitative implementation data. We are not collecting individual-level data. This assessment does not request sensitive or personally identifiable information.

- **How data will be analyzed:** Each organization's cost data submission will be assessed for missing information and incorrect data (e.g., inappropriate range of values). After ensuring the data integrity of each submission, we will create an aggregated analysis file for generating reports and publications.

  Interview data will be analyzed using NVivo qualitative analysis software. Interview data will be analyzed in aggregate and discussed in summary reports that do not contain any personal identifiers.

A. JUSTIFICATION

A.1 Circumstances Making the Collection of Information Necessary

This is a new Information Collection Request (ICR).

Background

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 (see authorizing legislation in ***Attachment A1***, the Public Health Service Act).

Stroke remains a leading cause of serious, long-term disability and is the fifth leading cause of death in the United States after heart disease, cancer, chronic lower respiratory diseases, and accidents.[1] Estimates indicate that approximately 795,000 people suffer a first-ever or recurrent stroke each year with more than 130,000 deaths annually.[1-2] Although there have been significant advances in preventing and treating stroke, the rising prevalence of heart disease, diabetes, and obesity has increased the relative risk for stroke, especially in African American populations.[3] Moreover, stroke's lifetime direct cost of health care and indirect cost of lost productivity is staggering and imposes a substantial societal economic burden. Coverdell-funded state programs are in the forefront of developing and implementing system-change efforts to improve emergency response systems, enhance the quality of care for stroke, and improve transitions across stroke systems of care, including pre-event; transitions from EMS to acute care in hospitals; and transitions from hospitals to home, rehabilitation, stroke specialist care, and primary care providers.

When Congress directed the Centers for Disease Control and Prevention (CDC) to establish the Paul Coverdell National Acute Stroke Program (PCNASP) in 2001, CDC intended to monitor trends in stroke and stroke care, with the ultimate mission of improving the quality of care for stroke patients in the United States. Since 2015, CDC has funded and provided technical assistance to nine state health departments to develop comprehensive stroke systems of care. A comprehensive system of care improves quality of care by creating seamless transitions for individuals experiencing stroke. In such a system, pre-hospital providers, in-hospital providers, and early post-hospital providers coordinate patient hand-offs and ensure continuity of care. CDC contracted with RTI International to conduct a national assessment of the state health departments awarded grants in 2015 to assess their implementation in their state-based contexts and progress toward short- and intermediate-term outcomes. The Coverdell Program, has another information collection submitted by CDC, called the Coverdell Reporting System (#0920-1108, expiration 3/31/2019). The Coverdell Reporting System focuses on the patient-level quality of

care performance measures which provide program accountability, are a critical component to track the progress and completion of meeting essential program aims and outcomes, and provide an opportunity to assess quality and opportunities for improvement across the stroke care continuum.

Overview of the Proposed Assessment

CDC and RTI International propose to collect information from all nine funded PCNASP grantees to gain insight into the effectiveness of implementation of their quality improvement strategies, development (and use) of a data integrated management system, and partner collaboration in building comprehensive state-wide stroke systems of care. The information collection will focus on describing PCNASP specific contributions to effective state-based stroke systems of care and the costs associated with this work. Two components of the information collection include: (1) program implementation cost data collection from program partners using a cost collection tool; and (2) telephone interviews with key program stakeholders. Cost data collection will focus on a stratified sample of partners' cumulative spending to support PCNASP activities, spending by reporting period, and spending associated with specific strategies related to building comprehensive state-wide stroke systems of care. Interview questions will target how each grantee implemented its strategies, challenges encountered and how they were overcome, factors that facilitated implementation, lessons learned along the way, and observed outcomes and improvements. The information to be collected does not currently exist for large scale, statewide programs that employ multiple combinations of strategies to build comprehensive stroke systems of care. The insights to be gained from this data collection will be critical to improving immediate efforts and achieving the goals of spreading and replicating state-level strategies that are proven programmatically and are cost-effective in contributing to a higher quality of care for stroke patients.

OMB approval is requested for three years.

A.2 Purposes and Use of the Information Collection

The purpose of the assessment is to (1) assess the actual partner costs of establishing statewide comprehensive stroke systems of care to support PCNASP activities; and (2) increase CDC's understanding of funded programs' implementation of effective state-based stroke systems of care and PCNASP specific contributions. Two components of the information collection include: (1) program implementation cost data collection from program partners using a cost collection tool; and (2) telephone interviews with key program stakeholders. The intended use of each component of the data collection is described below.

Cost Collection Tool

The goal of the information collection for the cost collection tool (CCT) is to provide CDC, PCNASP grantees, and their partners with the ability to analyze data related to the direct and indirect costs associated with particular intervention approaches, based on their timeframe. These data collected by RTI International will be used to augment a simulation model with actual intervention cost data to calculate new economic metrics within the model, such as cost-effectiveness and cost and health benefits. These analyses and the refined model will assist PCNASP grantees, CDC, and HHS in simulating various evidence-based scenarios to strategically choose intervention approaches for particular populations that are both cost-effective and cost and health beneficial.[4-5] This refined modeling will also assist grantee program staff as they create work plans creating comprehensive stroke systems of care in their states.

Cost data currently do not exist for large-scale, state-based public health programs that employ multiple combinations of policy, environmental, programmatic, and infrastructure strategies to address stroke care and quality improvement. Integrating these economic metrics is advantageous both to state health department staff and partners that need to make informed choices for developing policies, making programmatic choices, and identifying efficient resource allocation. These new cost data will enable CDC to identify cost-effective and cost- and health-beneficial intervention approaches.

Economic analysis will provide critical information for decision making by assessing the actual costs of establishing statewide comprehensive stroke systems of care. The literature contains numerous examples of using costing methodologies to obtain detailed cost data to perform economic assessments of health programs in the United States and internationally. In the United States, there is a long history of using an activity-based costing approach to perform cost-effectiveness assessments of substance abuse programs,[6-8] which recently has been extended to cancer interventions and a significant proportion of costs are shared by program partners.[9-12]

Data collected in this cost and modeling assessment will be paired with outcome data from secondary data sources and will be used to determine the long-term cost-effectiveness of the program.

Telephonic Interviews

The goal of the information collection for the telephonic interviews is to provide CDC with the opportunity to unearth valuable details not otherwise obtainable through quantitative data analysis and expand on key strategies that contributed to improved stroke systems of care and greater infrastructure to support data linkages, data collection, and data-driven quality improvement activities.

Information collected through the telephonic interviews will be used to:

1. Identify successful strategies that contributed to improved stroke systems of care and greater infrastructure to support data linkages, data collection, and data-driven quality improvement activities.
2. Understand the processes undertaken to implement strategies that had an impact on improving stroke systems of care, the efficiency and quality of stroke care, and stroke patient health outcomes.
3. Explain how different combinations of strategies affect implementation success, and determine whether there are economies of scale and scope.
4. Demonstrate how the Coverdell program promotes evidence-based practice by addressing the American Stroke Association's Task Force recommendations for the establishment and development of stroke systems of care.
5. Develop practitioner-focused enhanced dissemination products to inform future federal, state, and local efforts to implement similar interventions. Understanding the key variables and contextual factors that inhibited or accelerated successful implementation of strategies in PCNASP-funded states would allow future communities to anticipate such issues in advance, adapt their environment and context so it is more supportive of strategy implementation, or choose only strategies that are effective in their current environment and context.

Privacy Impact Assessment Information

The proposed collection will have little or no effect on the respondent's privacy. No information in identifiable form (IIF) is being collected.

A.3 Use of Improved Information Technology and Burden Reduction

Cost Collection Tool

All cost data will be collected electronically via a Web-based instrument (***Attachment A2***) to reduce respondent burden, data collection errors, and delays in receiving data. The survey includes five items and can be completed at the convenience of the respondent. The Cost Collection Tool may be pilot tested with one PCNASP program partner to assess its ability to provide requested data and identify approaches to minimize burden. During the pretest, the clarity of the instrument, usability of the system, and accuracy of the data entered will also be assessed. The tool will be streamlined to only include the most important questions to inform the relevant assessment questions; therefore, no extraneous information will be collected. A similar tool was piloted as part of a prior assessment of the Coverdell program in May of 2015; important learnings from this data collection were incorporated into this most current version of CCT.

The instrument will be easily accessible through the Web and will include several features to specifically reduce data collection burden and collect high quality data including the ability to import information such as staff that worked on the project from a previous yearly submission and validity checks such as making sure that percentages in a row sum to 100% and no data elements were missed by the respondent.

The tool will also contain an interactive User's Manual (***Attachment A3***) that will provide variable definitions and instructions for providing the required data. RTI will develop a guidance document that will provide general background information, detail the approach used to capture costs of the program implemented by each program partner, and provide guidance to program partners on how to collect and report costs. Each data element collected by the tool will be explained. The document will also include a frequently-asked-questions section with answers to questions on the cost data collection. The guidance document will be made available to program partners in electronic format. Program partners participating in the study will be provided with detailed instructions and training to input the required data. RTI will conduct a Web-based training for program partners and telephone technical assistance for program partners to ensure that all users are fully prepared to report accurate data. As discussed in ***Statement B***, CDC will ask each PCNASP grantee to identify a sample of their partners to invite to participate in the PCNASP partner cost data collection. Specifically, CDC will email managers of each state PCNASP program to ask them to complete a simple table that contains contact information for a sample of partners from small, medium, and large organizations. In the table, the PCNASP manager will be asked to fill out the partner organization's name, name of the contact person at the organization, and email address of the contact person.

RTI will collect and tabulate the data provided by program partners. We expect to collect minimum information necessary to address the research project's research questions. Efforts have been made to design the instrument to be brief, easy to use, and understandable. The study investigators have carefully considered the content, appropriateness, and phrasing of the questions.

Telephonic Interviews

We will email managers of each state PCNASP program to invite them to participate in a planning call for the interviews (see ***Attachment B5***). During the planning call, we will discuss logistics of the interviews and identify key stakeholders who will receive an email invitation to participate in the interviews. During the interviews, respondents will be asked approximately ten questions over the course of a 60-minute interview. Telephone interviews will collect qualitative data without the costs and respondent burden associated with traditional face-to-face site visits. RTI International will work individually with each respondent to find convenient times for them to complete the interview. Once mutual availability has been established, RTI International will send each interviewee an electronic meeting request containing information for a secure

conference line. RTI International will be responsible for setting up and initiating the conference line for the interviews; respondents will be able to easily join a secure conference line using a passcode provided to them in advance. Respondents will not be asked to make special preparations in advance of the call.

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

While PCNASP has existed since 2001, the goal and mission of the program has evolved with each funding cycle. The 2015-2020 funding cycle is the first such initiative to focus on establishing comprehensive stroke systems of care. This is an enhanced program mission with new requirements for implementing quality improvement and collaborative strategies in the funded states to improve transitions of care and the quality of stroke care across the care continuum. Given this, no instruments from previous assessments of PCNASP exist to collect data at the level of these specific sets of strategies and their costs to program partners. The proposed information collection is unique in that there are no other surveys administered to Coverdell funded states that assess program implementation related to building state-wide comprehensive stroke systems of care and the associated partner costs. This is the first data collection effort to assess an initiative of this nature. In addition, the interview and partner cost data will provide complementary information that is not obtained through regular grantee progress reporting and stroke registry reporting to the CDC (Paul Coverdell National Acute Stroke Program (PCNASP) Reporting System, OMB Control Number 0920-1108, Expiration Date 3/31/2019). CCT and the interview questions were developed by a panel from RTI and CDC to ensure that the most useful questions were being asked and to minimize redundancy. The panel carefully considered the content, appropriateness, and phrasing of the interview questions so that they are brief, easy to use, and understandable. Similarly, the panel reviewed each cost item for appropriateness, clarity, and utility in an analysis.

CDC project officers communicate with PCNASP grantees on an ongoing basis, including through monthly conference calls. However, routine calls and progress reports do not provide a systematic overview of larger context and key issues that seem to hinder or facilitate the implementation of strategies and achievement of the intended system-level changes in the state from multiple, diverse stakeholder perspectives. Similarly, the financial reporting required of grantees, the Federal Financial Report (FFRs) and program budgets, do not include detailed information of the true program costs, including partner cost contributions.

A.5 Impact on Small Businesses or Other Small Entities

Small businesses and other small entities will not be targeted to participate in this assessment. Recruited participants will primarily include program staff employed by state health departments (i.e., program directors, evaluators, and program staff with subject matter expertise) and their partners. It is possible that some partners who will be recruited to complete the CCT

may be representatives of a small business. However, CDC anticipates that this will be a rare occurrence. There are no specific requirements for small businesses.

In addition, because the survey and interviews are voluntary and each recruited participant will indicate their desire to participate at the start of the survey or interview, the impact of the information collection on respondents—including small businesses—is expected to be minimal. The online administration of the survey will allow respondents to complete the survey in multiple sessions at their convenience over several weeks, which will also minimize the burden on small employers.

A.6 Consequences of Collecting the Information Less Frequently

Cost Collection Tool

Without these cost data, CDC will not be able to assess the cost-effectiveness and cost and health benefits associated with strategies to establish comprehensive stroke systems of care. This economic analysis will provide critical information to inform decision making and future resource allocation by assessing the actual costs of PCNASP grantees and their partners. This information is vital to the overall assessment of the PCNASP program and essential for future, successful program planning, implementation, and sustainability. It is anticipated that over the three-year assessment period, program partners will collect and report these cost data at two time points – once in April-May 2018 and once in April-May 2019. Reducing the respondent burden below the estimated levels (that is, reducing the frequency of the data collection) would diminish the utility of the study and inhibit the ability of CDC to respond to anticipated requests for cost data associated with this program. There are no legal obstacles to reduce the burden.

Telephonic Interviews

This information collection is critical to the overall assessment of the PCNASP initiative and essential for future program planning, developing a detailed description characterizing established comprehensive stroke systems of care, and adding to practice-based evidence in the stroke care and public health fields. Without this information collection, CDC will not be able to conduct an adequate assessment of the programs' operations, identify and understand factors that impact successful implementation, assess efficiencies for specific mixes of strategies, or identify the cost effectiveness of funded strategies. In-depth interviews will be conducted at one time point: February 2019. There are no legal obstacles to reduce the burden.

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

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

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

The 60-Day Federal Register Notice was published on Tuesday, October 10, 2017, Vol. 82, No. 194 [46993-46994]. There were no public comments received during the 60-day FRN period. There were no additional efforts to consult outside the agency.

A.9 Explanation of Any Payment or Gift to Respondents

No remuneration will be provided to PCNASP study participants. Grantees agreed to participate in assessment activities as a condition of the CDC 5-year cooperative agreement award.

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

Respondents are local governments, health care organizations, and health-focused nonprofit organizations that are providing information on their organizational structure, infrastructure, intervention strategy costs, and other expenditures. No information in identifiable form (IIF) is being collected. Information collection for the CCT and interviews is for the purpose of assessing CDC-funded programs' activities at the organizational level, and partner organizational costs.

Privacy Impact Assessment

The proposed study involves a minimum amount of IIF, and includes only contact information for each respondent (i.e., name, telephone number, and email address). The information to be obtained through surveys and interviews concern organizational activities and costs rather than personal matters and is not considered highly sensitive. Within interviews, respondents will be asked to identify their state health department, role, and perceptions about activities conducted within, and facilitated by, their organization, but they will not be asked to provide specific names or information about individual program staff or partners. The interview data collected will focus on respondents' thoughts and experiences related to programmatic activities. The cost information collected will focus on programmatic spending; CCT will not ask individuals to input any IIF.

Survey and interview responses will be linked to respondents' state health departments and roles to ensure that findings can be linked to organizations and other existing organizational data. RTI, the data collection contractor, will have access to IIF for program leadership and staff recruited for participation. No other personal identifiers will be collected.

IIF will be stored separately from response data. A linking file will be created and available only to project management at RTI International. This information will only be used to ensure completeness of the data files. The linking file will include the role of the respondent and their organization (and will not include the individual's name or contact information), the date of survey/interview completion, and the code assigned to the data file. This will ensure that no IIF outside of the individual's role and organization is re-linkable. All data files will be stored in a secure electronic folder on a password-protected shared computer drive that is only accessible by authorized project staff.

A. Privacy Act Determination. CDC has reviewed this submission and determined that the Privacy Act does not apply. Although a primary contact person will be identified for each grantee's organization, the contact person will be speaking from their role as a representative of the responding PCNASP grantee's organization or partner organization. The information collection does not involve collection of sensitive or personal information.

B. Safeguards. For the CCT, data collection will be conducted via a secure Web-based instrument managed by RTI International. Data will be submitted to CDC according to approved Internet-based communication protocols. Access to the Web-based CCT system will be controlled by a password-protected login that allows varying degrees of access for RTI staff, CDC personnel, and project personnel associated with each PCNASP partner organization. Identifiable partner data will not be shared with grantees. The systems to be put in place will ensure that stored information is accessible to authorized users yet secure. We are collecting other data that are not included in this information collection request; these data are collected from all nine PCNASP grantees. Since there are only nine PCNASP grantees, this other data collection could never be directed at 10 or more respondents and – therefore – does not require Paperwork Reduction Act Clearance.

Data collection for the telephonic interviews will take place on a secure telephone line that is passcode-protected. Data from telephonic interviews will be securely stored on RTI servers. Furthermore, data will be de-identified to protect the confidentiality of respondents.

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

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

C. Consent. Because the information collection does not involve research with human subjects, IRB approval and individual consent requirements are not applicable. An informed consent statement will be included on the cover page of the survey instrument or interview prior to the instrument questions (***Attachment A5-A9***).

The consent statement informs participants of how the data will be used and that their participation in the survey and interviews is voluntary. They can choose not to answer individual questions, end the survey or interview at any time, or decline participation without penalty. Whether or not individuals choose to participate will not impact current or future funding. Respondents will be required to either agree to or decline participation prior to completing the survey or interview.

As part of the informed consent, respondents will be asked to grant permission for the interview team to audio record the interview for note taking and clarification purposes only. The audio tapes will be destroyed once they have been used to fill in any gaps in the notes taken by the note taker.

D. Nature of Response. No IIF is being collected. The proposed collection will have little or no effect on the respondent's privacy. Participation in the survey is voluntary for all participants; respondents who decline participation will not face penalty of any kind.

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

We are collecting program-level cost and qualitative implementation data. We are not collecting individual-level data. This assessment does not request sensitive or personally identifiable information.

CDC's information collection contractor's Institutional Review Board (IRB) determined that this project does not constitute research with human subjects as defined by the US Code of Federal Regulations (45 CFR 46.102). RTI's IRB determination memorandum is included as ***Attachment A4*****.**

A.12 Estimates of Annualized Burden Hours and Costs

A.12.1 Estimated Annualized Burden Hours

OMB approval is requested for three years. Over this period, CDC will administer the CCT Survey at two time points – once in April-May 2018 and once in April-May 2019. The interviews will be completed once in February 2019. Annualized estimates of the number of respondents involved in the information collection activities are provided below.

- To complete the online CCT (***Attachment A2***) with a subset of program partners working with the nine Coverdell-funded health departments, the total estimated burden to respondents is 820 hours. The estimated burden per response is 2.0 hours. The total estimated annualized number of respondents is 137 and the total estimated annualized burden is 274 hours.

- To schedule and conduct an average of six telephone interviews (see ***Attachment A5-A9***) per site at nine sites, the total estimated burden to respondents is 54 hours. Respondents will be program staff of Coverdell-funded health departments and partners. The estimated burden per response is 1.0 hour. To obtain a variety of perspectives, the interviews will be completed by up to 6 staff per site: 1 principal investigator, 1 grantee program manager, 1 quality improvement specialist, 1 data analyst/ program evaluator, and 2 partner support staff. The total estimated annualized number of respondents is 18 and the total estimated annualized burden is 18 hours. These calculations are summarized in Table A.12.1.

Table A.12.1. Annualized Estimated Response Burden Table (Hours)

Type of Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
Partner Program Manager	Cost Resource and Utilization Tool	137	1	2	274
Principal Investigator	Telephonic Interviews	3	1	1	3
Grantee Program Manager	Telephonic Interviews	3	1	1	3
Quality Improvement Specialist	Telephonic Interviews	3	1	1	3
Data Analyst/ Program Evaluator	Telephonic Interviews	3	1	1	3
Partner Support Staff	Telephonic Interviews	6	1	1	6
				Total:	292

A.12.2 Estimated Annualized Cost to Respondents

Average hourly wage estimates were obtained from the U.S. Department of Labor, Bureau of Labor Statistics. The estimated annualized cost to respondents is $16,141.72, as summarized below in Table A.12-B.

- The average annual salary of $117,200 for general and operational managers was used to calculate the hourly wage of $56.35 for principal investigators and program managers.
- The average annual salary of $53,920 for survey researchers was used to calculate the hourly wage of $25.92 for quality improvement specialists and data analyst/ program evaluators.
- The average annual salary of $68,450 for registered nurses was used to calculate the hourly wage of $34.70 for support staff, which can include post-hospital staff participating in PCNASP, the head of the state EMS, or EMS responders.

Table A.12-B. Annualized Estimated Response Burden Table (Annualized Wages)

Type of Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Average Hourly Wage Rate	Total Cost
Partner Program Manager	Cost Resource and Utilization Tool	137	1	2	$56.35	$15,439.90
Principal Investigator	Telephonic Interviews	3	1	1	$56.35	$169.05
Grantee Program Manager	Telephonic Interviews	3	1	1	$56.35	$169.05
Quality Improvement Specialist	Telephonic Interviews	3	1	1	$25.92	$77.76
Data Analyst/ Program Evaluator	Telephonic Interviews	3	1	1	$25.92	$77.76
Partner Support Staff	Telephonic Interviews	6	1	1	$34.70	$208.20
Total						**$16,141.72**

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

No costs other than those described in A.12 will be incurred by the respondents to complete this data collection.

A.14 Annualized Cost to the Federal Government

Exhibit A.14-1 presents the two types of costs to the government that will be incurred: (1) external contracted data collection and analyses and (2) government personnel.

1. The project is being conducted under a contract that was awarded on August 31, 2016. The contract is for a total of 3 years. The annualized cost for the cost data collection task for the data contractor is estimated at $35,766. The

annualized qualitative data collection task for the data contractor is estimated at $53,253.

2. Governmental costs for this project include personnel costs for federal staff involved in providing oversight and guidance for the planning and design of the assessment, refinement of the data collection tools, development of OMB materials, collection and analysis of the data, and reporting. These activities involve approximately 5% of a GS-12 health scientist and 5% of a GS-13 health scientist. The total cost of federal staff to the federal government is $8,886. The total annualized cost to the federal government for the duration of this data collection is $97,905.

Exhibit A.14-1. Estimated Annualized Federal Government Cost Distribution

Type of Government Cost	Annualized Cost
Data Contractor	$89,019
Federal Staff	$8,886
GS-12 health scientist at 5% FTE	$ 3,785
GS-13 health scientist at 5% FTE	$5,101
Total	$97,905

A.15 Explanation for Program Changes or Adjustments

This is a new data collection.

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

A.16.1 Publication Plan

Results of the study will be disseminated to grantees and other stakeholders through reports, briefings, presentations at professional meetings, and publication of manuscripts in peer-reviewed journals. It is anticipated that the results of this project will be developed into several scientific and nonscientific reports.

A.16.2 Project Timeline

The expected time schedule for project activities is presented in ***Exhibit A.16-2***.

Exhibit A.16-2. Estimated Time Schedule for Project Activities

Activity	Expected Timeline
Development of final version of the Web-based CCT based on OMB comments	May 2017 – June 2017
Development of final version of telephonic interview protocols based on OMB comments	May 2017 – June 2017
Receive OMB Approval	March 2018
Recruitment emails sent to CCT and telephonic interview participants	March 2018 March 2019
Technical assistance for CCT	Ongoing in 2018, 2019, concentrated during yearly data collection
Yearly data collections for CCT	1st data collection: April-May 2018 2nd data collection: April-May 2019
Telephonic Interview data collection	February 2019
Base Year cost analyses	Within 3 month of 1st CCT data collection
Final cost data analysis	Within 3 months of 2nd CCT data collection
Qualitative data analysis	Within 3 months of telephonic interview data collection
All data collected to CDC	1st data collection: August 2018 2nd data collection: August 2019

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

The OMB expiration date will be displayed on all information collection instruments. No request for an exemption from displaying the expiration date for OMB approval is being sought.

A.18 Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

REFERENCES

1. American Stroke Association (ASA). *Impact of stroke*. http://www.strokeassociation.org/STROKEORG/AboutStroke/Impact-of-Stroke-Stroke-statistics_UCM_310728_Article.jsp. Last updated June 6, 2016.

2. Matchar, D. B., & Duncan, P. W. (1994). Cost of stroke. *Stroke Clinical Updates, 5*, 9-12.

3. Gillum, R. F. (1999). Stroke mortality in blacks: Disturbing trends. *Stroke, 30*(8), 1711–1715. http://dx.doi.org/10.1161/01.STR.30.8.1711

4. Homer, J., Milstein, B., Wile, K., et al. (2010). Simulating and evaluating local interventions to improve cardiovascular health. *Preventing Chronic Disease*, 7(1). Retrieved March 30, 2010, from http://www.cdc.gov/pcd/issues/2010/jan/08_0231.htm.

5. Homer, J., Milstein, B., Wile, K., Pratibhu, P., Farris, R., & Orenstein, D. (2008). Modeling the local dynamics of cardiovascular health: risk factors, context, and capacity. *Preventing Chronic Disease*, 5(2). Retrieved March 30, 2010, from http://www.cdc.gov/pcd/issues/2008/apr/07_0230.htm.

6. French, M. T., Roebuck, M. C., & McLellan, A. T. (2004). Cost estimation when time and resources are limited: the Brief DATCAP. *Journal of Substance Abuse Treatment, 27*(3), 187–193.

7. Zarkin, G. A., Lindrooth, R. C., Demiralp, B., & Wechsberg, W. (2001). The cost and cost-effectiveness of an enhanced intervention for people with substance abuse problems at risk for HIV. *Health Services Research, 36*(2), 335–355.

8. Salome, H. J., & French, M. T. (2001). Using cost and financing instruments for economic evaluation of substance abuse treatment services. *Recent Developments in Alcoholism*, *15*, 253–269.

9. Subramanian, S., Ekwueme, D. U., Gardner, J. G., & Trogdon, J. (2009, September). Developing and testing a cost-assessment tool for cancer screening programs. *American Journal of Preventive Medicine*, *37*(3), 242–247.

10. Ekwueme, D. U., Gardner, J. G., Subramanian, S., Tangka, F. K., Bapat, B., & Richardson, L. C. (2008). Cost analysis of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP)—selected states, 2003–2004. *Cancer*, *112*, 626–635.

11. Legood, R., Gray, A. M., Mahé, C., Wolstenholme, J., Jayant, K., Nene, B. M., Shastri, S. S., Malvi, S. G., Muwonge, R., Budukh, A. M., & Sankaranarayanan, R. (2005). Screening for cervical cancer in India: How much will it cost? A trial based analysis of the cost per case detected. *International Journal of Cancer*, *117*(6), 981–987.

12. Goldie, S. J., Gaffikin, L., Goldhaber-Fiebert, J. D., Gordillo-Tobar, A., Levin, C., Mahé, C., Wright, T. C., & Alliance for Cervical Cancer Prevention Cost Working Group. (2005). Cost-effectiveness of cervical-cancer screening in five developing countries. *New England Journal of Medicine, 353*(20), 2158–2168.