

CDC WORKSITE HEALTH SCORECARD

Revision OMB #0920-1014, Exp. 02/28/19

Supporting Statement: Part A

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January 8, 2019

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- **Goal of the study:** The goal of this revision information collection (OMB #0920-1014, Exp 02/28/19) is the ongoing usage by the employer community of the *updated* CDC Worksite Health Scorecard, a web-based organizational assessment tool. The resulting data will be used to support research and increase understanding of the organizational programs, policies, and practices that employers of various sizes and industry sectors have implemented to support healthy lifestyle behaviors. It will also document changes in employer organizational practices over time and allow CDC to provide better technical assistance to employers seeking guidance on building or maintaining workplace health promotion programs.
- **Intended use of the resulting data:** The focus of the last clearance for the CDC Worksite Health Scorecard (OMB #0920-1014, Exp 02/28/19) was to update the instrument including adding new topics and questions, retiring questions no longer applicable, and reorganizing the sequence of questions to reduce respondent burden; and to pilot test the instrument to include quantitative analysis of concordance rates for respondents from the same worksite.
- With the completion of the update and pilot test, this revised information collection eliminates cognitive interview and pilot evaluation instruments; increases the number of annual respondents from 200 to 800 for full-scale implementation; and includes minor additions/deletions in questions, and wording and scoring changes to questions to improve clarity, flow, and account usability.
- **Methods to be used to collect:** Each employer who participates in using the CDC Worksite Health Scorecard will complete an employer registration establishing their online account. Upon registration, they will complete an online CDC Worksite Health Scorecard assessment annually to establish benchmarks and follow-up organizational practices and capacity changed over three years which will be provided through a benchmarking report.
- **The subpopulation to be studied:** 800 employer respondents of all sizes and industry sectors will be recruited annually for three years to complete the CDC Worksite Health Scorecard and use the results to develop tailored and specific worksite health improvement plans, select priority interventions for individual employer-based workplace health programs, and evaluate changes in organizational practice.
- **How data will be analyzed:** In addition to direct feedback, we expect that this data will also be used to support statistical analyses (e.g., using linear and non-linear regression models and hierarchical or multilevel models). CDC will use pre/post comparison information for program improvement.

A-1. Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) is the primary Federal agency for protecting health and promoting quality of life through the prevention and control of disease, injury, and disability [see authorizing legislation through the Public Health Service Act (section 42 U.S.C. 2801-2801-1, Sections 399MM and 399MM-1; see **Attachment A-1**)]. The CDC Worksite Health Scorecard is funded through the Prevention and Public Health Fund (PPHF) (**Attachment A-2**).

Workplace health promotion (WHP) programs offer a potentially powerful strategy to improve the health and wellbeing of the 155 million American workers, and possibly their dependents. (Accessed U.S. Bureau of Labor Statistics, September 7, 2018). The workplace is where most American adults spend the majority of their waking hours during a typical workweek. While job-related pressures can negatively influence health behaviors, the workplace also presents an underutilized setting for positive programs designed to lower health risks, and, in turn, have an impact on the prevalence, severity, and cost of chronic disease. Through workplace health promotion programs, employers have the unique opportunity to reach a large segment of the population who would not normally be exposed to, or engaged in, health improvement efforts. Along with this opportunity, employers also have strong *incentive* to offer health promotion programs, understanding that, if they can keep their employees healthy and fit, their workers will consume fewer healthcare resources, miss fewer workdays, and be more productive.

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

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

- In 2005, Chapman summarized results from 56 qualifying financial impact studies conducted over the past two decades and concluded that participants in workplace programs had 25%–30% lower medical or absenteeism expenditures than non-participants.
- In 2010, Baicker et al. published a literature review in *Health Affairs* focused on cost savings garnered by worksite wellness programs. The investigators found the medical costs return on investment (ROI) to be \$3.27 for every dollar spent and the absenteeism ROI to be \$2.73 for every dollar spent.

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

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

The CDC Worksite Health Scorecard (*hereafter referred to as the “Scorecard”*) was launched in 2012 to address this need. It was updated in 2014 to include four additional topics and to be available as an online application (OMB #0920-1014, Exp. 4/30/2017) and updated again in 2017 to address new and emerging issues and maintain its scientific integrity (OMB #0920-1014, Exp 02/28/2019).

In order to remain relevant and comprehensive, the Scorecard has recently undergone further update, informed by a series of systematic literature reviews. CDC conducted a 1 year pilot study in 2017 (OMB #0920-1014, Exp 02/28/19) to test the validity and reliability of a revised instrument with select employers who agreed to complete the Scorecard and provide feedback to make any enhancements to the piloted data collection instruments. The pilot Scorecard included: four new topics of particular relevance to the health and wellbeing of Americans today – Sleep, Alcohol & Other Substance Use, Cancer, and Musculoskeletal Disorders; new and revised questions in previously existing modules such as minor wording changes to improve clarity based on user feedback or new questions based on observed changes in employer practice such as active transportation to improve physical activity over the past three years that ensure the Scorecard represents the best-available evidence. This resulted in a slight increase in the overall number of questions to the core instrument and a corresponding increase in the time for respondents to complete the Scorecard.

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

In this Revision, CDC requests OMB approval for three years to use the finalized, updated version of the Scorecard from the pilot enabling a larger number of employers to access the online system and complete annual assessments of their workplace health programs. There are no changes to information collection methods for administration of the Scorecard. Two instruments (cognitive interview and pilot evaluation) will not be administered moving forward. There has been a net increase of one question and one overall point to the final version as a result of the pilot testing. There are minor changes to the content of the Scorecard including small changes to the question ordering to improve clarity and group like questions together and minor wording changes to the contextual/supplemental information for questions to improve clarity. Recruitment, enrollment, and information collection will continue, as previously approved, with a larger cohort of employers increasing from 200 to 800.

A-2. Purpose and Use of Information Collection

Purpose and Format of the Information Collection

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

1. Assist employers in identifying gaps in their health promotion programs, and help them to prioritize high-impact strategies for health promotion at their worksites;
2. Improve the health and wellbeing of employees and their families through science-based workplace health interventions and promising practices; and
3. Support research and increase understanding of the organizational programs, policies, and practices that employers of various sizes and industry sectors have implemented to support healthy lifestyle behaviors.

The Scorecard consists of 154 core health topic yes/no questions, 8 core worksite demographic questions, with an additional 8 optional worksite demographic questions divided into 19 modules (risk factors/conditions/demographics). The questions assess elements of the workplace environment, culture, programs, practices, and policies related to health and safety. This includes, for example, health benefits, health education, exercise facilities, healthy food offerings, and ergonomic workstations.

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

The Scorecard has been successful and well received in its first three years. A number of lessons were learned during the initial approval precipitating a review and update of the instrument to keep it current, relevant, and consistent with the evidence-base for workplace health practice. Therefore, based on experience and feedback from employers, CDC undertook a pilot test to update and revise the instrument.

Information Collection to Date

From April 2014 – April 2017, 1,681 worksites have submitted Scorecards (OMB# 0920-1014, Exp 04/30/2017). The average employer is implementing a little more than half of the recommended programmatic, policy, environmental support, and health benefit intervention strategies assessed in the Scorecard. Some individual intervention strategy examples include:

Of employers using the online Scorecard during this period:

- 82% report providing coverage with no or low out-of-pocket costs for diabetes medications and supplies.
- 79% report conducting onsite flu vaccination.
- 73% report providing subsidized tobacco cessation counseling.
- 38% report providing an onsite exercise facility.
- 32% report having a written policy making healthier food and beverages available in cafeterias or snack bars.

Scorecards have been received from employers in 44 different states. Sixty-three percent of these employers are private, for profit businesses, 23% are government, and 14% are nonprofit organizations. Most employers (76%) are small, 11% are mid-sized, and 13% are large organizations with more than 750 employees.

And those employers who have re-assessed at least once during this time period have seen their Scorecard score improve from an average of 95.85 points to 148.26 points. This represents an improvement in the total number of intervention strategies being implemented as well as the number of best practice and high impact strategies which garner more points. Overall, exposure to the Scorecard is contributing to better and more effective workplace health programs being offered to employees but gaps in practice remain and high number of employers across the country remain unaware of the benefits of evidence-based workplace health programs or are not implementing effective strategies in a coordinated manner (Meador, 2016).

Pilot Test

During the pilot testing 178 respondents representing 89 employers (two knowledgeable respondents from each employer) were recruited, sent an invitational email, and invited to complete the Scorecard assessment. Follow up interviews collected information using open ended questions such as “Were there any items that you answered YES or NO, but answered with uncertainty?” and “Is there any other general feedback that you would like to offer about the tool?”. The interviews were also used to capture any difficulty or challenges respondents had with completing the Scorecard accurately as well as areas of improvement. At the conclusion of the pilot test, employers were given a summary report of their Scorecard benchmarked against other pilot participants (**Attachment C-3**) comparing the employer to others in the same

size/industry category. Employers were also provided feedback, directing them to evidence-based workplace health promotion strategies that are appropriate for the needs and interests of their workforce, and resources that may assist in implementation (**Attachment C-4**).

The main goal of the pilot was to test the inter-rater reliability of the Scorecard. All enrolled worksites were asked to have two knowledgeable employees (e.g., worksite wellness practitioners, human resources specialists, or benefits managers) independently complete the online Scorecard survey. Respondents were encouraged to consult with others within their organizations to get answers to questions where they lack knowledge, as would be the case in a real-world setting when the Scorecard is administered to employers. However, the two respondents were asked not to consult with each other in completing the instrument. We also assessed the face validity of the tool, to identify and explain any issues with wording or content underlying questions with low reliability (i.e., low levels of concurrence between respondents). We needed to understand if the questions were posed in a clear and specific manner. Our goal was 70% agreement between respondents from the same organization.

Table 1. Overall Score Distributions for the Study Sample (n=89)

Worksite Size	Count	Score Distribution		
		Minimum	Mean	Maximum
Very small (10-99)	13	55.0	162.0	234.0
Small (100-249)	14	62.5	157.7	237.5
Medium (250-749)	16	130.0	214.2	282.0
Large (750+)	33	95.5	212.6	279.5
All Organizations	91	55.0	193.9	288.5
Not provided	12	63.5	189.3	288.5

Table 2. Average Concurrence Rates by Module¹

Health ScoreCard Modules	# of Questions in Each Module	Percent Concurrence
Alcohol and Other Substance Use	6	69.9
Blood Pressure	6	79.2
Cancer	7	76.0
Cholesterol	5	71.9
Depression	7	68.0
Heart attack and stroke	12	76.3
Maternal Health and Lactation Support	7	77.8
Musculoskeletal Disorders	7	74.4
Nutrition	14	81.5
Occupational Health and Safety	9	79.1

Organizational supports	25	76.1
Physical activity	10	81.3
Prediabetes and Diabetes	6	74.7
Sleep and Fatigue	8	70.5
Stress management	7	72.4
Tobacco Use	8	78.5
Vaccine-Preventable Diseases	6	80.5
Weight management	4	76.8
TOTAL	154	75.8

¹ Orange shading denotes newer modules not previously tested

Most of the health topic areas and module exceeded our concurrence goals and we focused on topics such as depression and alcohol and substance use through the interviews as areas where revisions may be warranted and needed.

Revisions to the Scorecard

CDC has made the following revisions to the Scorecard based on input received from employer respondents learned during the pilot test. The CDC Worksite Health Scorecard Summary of Revisions provides a detailed summary of all the changes to the updated tool from the prior version (**Attachment C-5**). The current Scorecard now includes the following revisions based on the pilot test results:

1. Three new questions were added to the Scorecard from the last approval. This includes:
 - a. One question added to the tobacco use module that was included in the original CDC Worksite Health Scorecard from 2014-2017, but dropped for the pilot testing.
 - b. One question added to the vaccine-preventable disease module on hand hygiene that pilot test respondents indicated was a significant contributor to reduced illness and absenteeism
 - c. One question added to the cancer module as a skip pattern question related to whether the employer has outdoor workers or not. Many employers do not have outdoor workers and can thus be skipped out of the final two questions regarding skin cancer protection and sun exposure.

2. Two questions were deleted from the Scorecard from the last approval.
 - a. Two questions were removed from the sleep and fatigue module because respondents reported that these interventions were unattainable and impractical for most employers.

3. Changes were made to the wording of eight question from the last approval including:

- a. Organizational supports (2 questions); physical activity (2 questions); depression (1 question); musculoskeletal disorders (2 questions); maternal health and lactation support (1 question). These changes were principally to address uncertainty about concepts or definitions; provide additional specificity to guide employer actions; and provide clarity.
4. Changes were made to the scoring of one question from the last approval.
 - a. Interest from respondents in one musculoskeletal disorder intervention prompted further review of the literature resulting in a one point increase to that question.
 5. Minor reordering of questions to list critical foundational question first and group like questions together to improve clarity to 18 questions - organizational supports (16 questions); occupational health and safety (2 questions)
 6. Minor changes in wording of the contextual/supplemental information for question(s) for clarity to 14 questions - organizational support (2 questions); depression (4 questions); alcohol and other substance use (6 questions); heart attack and stroke (1 question); sleep and fatigue (1 question).
 7. No changes were made to 8 of 19 the health topic modules: 1) tobacco use; 2) high blood pressure; 3) high cholesterol; 4) weight management; 5) prediabetes and diabetes; 6) stress management; 7) vaccine-preventable diseases; 8) cancer.

Information using the updated and finalized version of the Scorecard will be collected once annually for three years. We will aim to recruit a convenience sample of 800 employer respondents annually to participate and increase from 200 employers used in the pilot. We will seek a diversity of employers by size, region and industry. As for size, and to be consistent with our prior benchmarking, the sample will be stratified as follows size, and in accordance with CDC employer size definitions: very small (0-99 employees); small (100-249); medium (250-749); and large (750+). Recruited employers will not be required to have active health promotion programs in place to participate. The unit of analysis for the Scorecard will be a worksite (single campus/building as opposed to the entire organization).

To ensure a heterogeneous sample across organization sizes, business types, and U.S. geographic areas, we will collaborate with national business coalitions and associations (i.e., NBSGH, National Alliance for Healthcare Purchaser Coalitions, National Safety Council [NSC]), as well as state health departments. We will provide collaborating entities with a guidance and frequently asked questions and answers (**Attachment D**) that explains the Scorecard. Interested employers may volunteer to participate by completing and submitting the online registration.

In addition to the immediate use of providing employers with tailored feedback, benchmarking reports, and customized resources (**Attachment C-3 and C-4**) to assist with implementation

efforts, this data collection will serve to support research and increase understanding of the organizational programs, policies, and practices that employers of various sizes and industry sectors have implemented to support healthy lifestyle behaviors. Further, it will document changes in organizational practices over time. CDC will also use the information gathered from the Scorecard to provide better technical assistance to employers seeking guidance on building or maintaining workplace health promotion programs.

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

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

Employers will then be directed to CDC tools and resource to support the implementation of the priority strategies and interventions that have been selected (**Attachment C-4**).

The CDC Worksite Health Scorecard allows for comparisons among employer cohorts receiving various levels of CDC workplace health program support. CDC is currently working with cohorts of employers through the Work@Health Program (OMB #0920-1006; Exp 03/31/2019). This program's goal is to provide support to employers to build effective and sustainable comprehensive workplace health programs. The Work@Health program operationalizes program support through professional formal training and structured ongoing technical assistance. Work@ Health is a very intensive training intervention including a lot of individual interaction and support from CDC staff. Important outcome measures are changes in organizational programs, policies, and practices that result from the method of support and assistance provided. These organizational outcomes are measured utilizing the CDC Worksite Health Scorecard.

New users of the online version of the CDC Worksite Health Scorecard who are directed to less intensive interventions such as referral to online workplace health program tools and resources (**Attachment C-4**), archived webinars and educational content, and group CDC technical assistance will be compared to participants in the CDC Work@Health program in terms of overall score progression over three years.

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

CDC contracts with Northrop Grumman, and Johns Hopkins University (Johns Hopkins) for this information collection. The implementation contractors will provide operational management of the CDC Worksite Health Scorecard including development, deployment, and maintenance of the online application; as well as collecting and analyzing Scorecard results from participating employers.

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

The CDC Worksite Health Scorecard will be Web-based to maximize convenience. CDC designed the information collection to minimize the burden to respondents and to the government, to maximize convenience and flexibility, maximize employer participation and engagement, and to ensure the quality and utility of the information collected. An online (electronic) set of instructions, and frequently asked questions (**Attachment D**) will be available to all registered users.

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

The Scorecard plans to continue its initiative to assess organizational capacity to enable employers to plan and implement evidence-based interventions to promote employee health and well-being at the worksite. The project team conducted a rigorous environmental scan to identify similar tools and resources. While other tools exist in the marketplace that enable employers to evaluate their workplace health promotion programs, the Scorecard stands out as a very robust, evidence-based approach to program evaluation and planning, incorporating input from a panel of nationally recognized subject matter experts. In addition, it is uniquely modularized by health condition/risk factor to help employers build programs that progressively address the specific concerns of their workforce.

The proposed revision will assist CDC to understand employer workplace health program strengths and gaps and give CDC the information needed to evaluate training programs and other initiatives for employers who use the Scorecard as an evaluation tool. The information collection instruments for the CDC Worksite Health Scorecard were based on results for the Scorecard pilot test (OMB #0920-1014, Exp 02/28/19). Although other comparable instruments are available in the marketplace, few have been validated in the manner conducted by CDC in the pilot test, and if they have, they are largely proprietary so the results of that testing is not available. The

program team carefully considered the content, need, and structure of the questions so that they are brief, easy to use, understandable, and relevant to the program objectives.

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

The CDC Worksite Health Scorecard is open to any employer in the United States regardless of size or other characteristics. However, research suggests that although small/medium-sized companies employ the majority of Americans, they are much less likely to sponsor worksite health promotion programs (Linnan, 2008). This is partially due to common misconceptions among small/medium-sized business owners that implementing worksite health promotion is expensive and geared toward large organizations that can realize the benefits primarily on the strength of numbers (McPeck, 2009; Baicker, 2010). It is also based on the fact that smaller organizations may have fewer resources, lower capacity, and less expertise to provide supports in the worksite that improves employee health making small businesses a main priority for CDC. Because the focus of outreach and registration will be smaller enterprises that can benefit from the organizational assessment and support tools and resources that accompanying it, we anticipate that approximately 75% of employers will be small businesses.

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

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

A-6. Consequences of Collecting the Information Less Frequently

Information collection for individual employer account holders will be encouraged every 12 months during the three year approval. Baseline and follow-up assessments are instrumental to characterize changes resulting from employer workplace health program efforts. If information is collected less frequently, CDC will not be able to effectively conduct the planning, implementation, and evaluation activities required to meet the program's objectives and document outcomes. If the administration of the CDC Worksite Health Scorecard is not planned, implemented and evaluated effectively, the program will be ineffective and could potentially be harmful to the reputation of NCCDPHP, and undermine efforts to encourage employers to participate in future CDC programs.

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

This request fully complies with the regulation 5 CFR 1320.5.

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

- A. CDC published a Notice in the Federal Register on October, 22, 2018, Vol. 83, No. 204, pp. 53252-53253 (**Attachment B-1**). CDC received two public comments and provided replies (**Attachment B-2**).
- B. The CDC Worksite Health Scorecard organizational assessment and data collection plan was developed in collaboration with subject matter experts at CDC, NIOSH, SAMHSA, Truven Health, Johns Hopkins University, Northrop Grumman, and nationally recognized subject matter experts and leaders in the field of workplace health.

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

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

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

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

Privacy Act Determination

CDC has reviewed this Information Collection Request and has determined that the Privacy Act does not apply to the identifiable employer-level information collected in the CDC Worksite Health Scorecard Registration (**Attachment C-1**) and CDC Worksite Health Scorecard (**Attachment C-2**). CDC's Office of the Chief Information Security Officer (OCISO) determined on 9/25/2018 while the Privacy Act was not applicable, the appropriate security controls and Rules of Behavior would be incorporated into the NCCDPHP Platform covering PIA for multiple systems to protect the confidentiality of information, proprietary, sensitive, and Personally Identifiable Information (PII) the Contractor (RTI) may come in contact with during

the performance of the project. The CDC Worksite Health Scorecard survey will collect information to verify employer contact information and identify an individual(s) responsible for completing the survey. Northrop Grumman, Johns Hopkins, and CDC will have access to the file that links employer representative identifiers such as names and addresses to unique employer ID codes. This contact information will be used to work with participating employers on troubleshooting and correcting any account technological issues, send benchmarking reports, and/or provide technical assistance. The applicable SORN is 0920-0136, Epidemiologic Studies and Surveillance of Disease Problems.

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

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

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

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

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

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

No information collection involves children under 13 years of age. The following instruments will be administered via a Web-based survey: CDC Worksite Health Scorecard Registration (**Attachment C-1**), and CDC Worksite Health Scorecard (**Attachment C-2**).

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

The information collection is not research involving human subjects. IRB approval is not required. No personal or sensitive information will be collected.

A- 12. Estimates of Annualized Burden Hours and Costs

OMB approval is requested for 3 years. CDC will administer the CDC Workplace Health Scorecard with up to 800 employers of various sizes and industry sectors on an annual basis over the period of three years. Table A.12.1 and Table A.12.2

Employers will be respondents for the following information collections.

- CDC Worksite Health Scorecard Registration (**Attachment C-1**) will be completed once by employers who agree to participate. The annualized number of respondents is estimated to total 800, the time to complete the registration process is estimated to take 5 minutes per respondent, the total estimated annualized burden is 67 hours. (5 minutes per response). This is part of the updated Scorecard pilot testing procedures and was also part of the pilot test ICR (OMB #0920-1014, Exp 02/28/2019).
- CDC Worksite Health Scorecard (**Attachment C-2**) will be completed once every 12 months. The annualized number of respondents is estimated to be 800 and it will take each respondent 45 minutes to complete the Scorecard will bring the total estimated annualized burden to 600 hours. This is an increase of 350 burden hours from the pilot as the number of respondents have been increased for the purposes of full-scale implementation. However, the pilot test revealed that despite an increase in the length of the new Scorecard, the average response time decreased 30 minutes from the original 75 minutes per response. This is part of the updated Scorecard pilot testing procedures and was also part of the pilot test ICR (OMB #0920-1014, Exp 02/28/2019).
- CDC Worksite Health Scorecard Cognitive Telephone interview and CDC Worksite Health Scorecard pilot evaluation used in the pilot test are no longer necessary for the full-scale implementation and will not be used going forward. No additional, new information collection instruments have been added to this revision.

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

The total estimated annualized burden hours are 667. This represents a net increase of 364 burden hours from the pilot test ICR (OMB #0920-1014, Exp 02/28/2019) of 303 estimated annualized burden hours due to 1) an increase in the total number of employer respondents from 200 to 800 as the ICR is moving to full-scale implementation from the pilot test and 2) the elimination of two information collection instruments used in the pilot test (CDC Worksite Health Scorecard Cognitive Telephone interview and Pilot Evaluation) going from 49 estimated burden hours to zero.

Table A.12.1. Estimated Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hrs)	Total Burden (in hrs)
Employers	CDC Worksite Health Scorecard Registration	800	1	5/60	67
	CDC Worksite Health Scorecard	800	1	45/60	600
				Total	667

The total estimated annualized cost to respondents is \$35,311.

The current estimated cost of the time devoted to this information collection by respondents is \$35,311 as summarized in Table A.12.2. To calculate this cost, we used the mean hourly wage of \$52.94, which represents the Department of Labor estimated mean for state, local, and private industry earnings (Wages and Hour Division, <https://www.dol.gov/whd>, 2017; Bureau of Labor Statistics, <https://www.bls.gov/ooh/management/human-resources-managers.htm>) for a typical HR manager who would be responsible for completing the Scorecard on behalf of their employer. This rate has increase from \$38.27 found to be the prevailing average hourly rate in the Scorecard pilot test information collection request in 2017 resulting in increase in the total estimated annualized cost to respondents of \$23,438 above the original estimates of \$11,873. There are no direct costs to respondents associated with participation in this information collection.

Table A.12.2. Estimated Annualized Costs to Respondents

Type of Respondent	Form Name	No. of Respondents	No. of Responses per Respondent	Total Burden (in hours)	Hourly Wage Rate	Total Respondent Cost
Employers	CDC Worksite Health Scorecard Registration	800	1	67	\$52.94 (\$38.27)	\$3,547
	CDC Worksite Health Scorecard	800	1	600	\$52.94 (\$38.27)	\$31,764
					Total	\$35,311

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

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

A-14. Annualized Cost to the Government

The current data collection costs include the cost of CDC personnel for oversight of CDC Worksite Health Scorecard planning, implementation and evaluation, and costs associated with two contracts: one to Johns Hopkins (Baltimore, MD) to evaluate the Scorecard; and the second to an informational technology developer, Northrop Grumman Corporation (Falls Church, Virginia). A full-time CDC employee will serve as the technical monitor for the project, directing regular planning and coordination meetings with the contractor staff. These meetings serve to plan and coordinate the programs and activities of the CDC Worksite Health Scorecard Web application development including: communications with internal and external stakeholders; planning and developing protocols for the registration process and organizational assessments, and outcome evaluations. The role of the CDC employee also involves regular reporting and review of all materials and products before acceptance by the government by coordinating input from multiple CDC National Center for Chronic Disease Promotion and Health Promotion Divisions (Division of Diabetes Translation, Division for Heart Disease and Stroke Prevention, Office on Smoking and Health, Division of Population Health, Division of Cancer Prevention and Control, and Division for Nutrition, Physical Activity, and Obesity), the CDC National Institute for Occupational Safety and Health, and CDC National Center for Immunization and Respiratory Diseases targeting the health risk factors and health conditions addressed by the CDC Worksite Health Scorecard.

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

Northrop Grumman and Johns Hopkins will also provide guidance in establishing the Scorecard infrastructure; assist in communication activities such as reporting progress to CDC and preparing reports and publication materials.

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

The ongoing data collection costs and associated project support costs are assumed constant for the useful life of the project. The average annualized cost of the contracts with respect to data collection is estimated at \$60,000 per year for 600 hours of labor (@\$100/hour).

The total estimated annualized cost to the Federal government is \$93,250.

Table A-4. Annualized Costs to the Government

Cost Category	Approx. Cost	Avg. Annual Cost
Application Development and Programming	\$30,000	\$60,000
Data Collection	\$15,000	
Web Design	\$15,000	
CDC GS-14 25% GS-14 @ \$133,000/year		\$33,250
Total		\$93,250

A-15. Explanation for Program Changes or Adjustments

This is a revision information collection request, of a previously approved OMB package (OMB #0920-1014, exp. 2/28/2019). The Scorecard was updated and pilot tested to ensure the scientific credibility of the tool, incorporating new and validating previously included questions and modules. The updated Scorecard is based on a 2017 pilot test to determine the validity and

reliability involving 89 employers (each represented by two knowledgeable employees) who completed the survey and follow-up telephone interviews to gather general impressions of the Scorecard—particularly the new modules—and also to discuss items where there were discrepancies (and items that were left blank) to understand the respondent’s interpretation and perspective of their answers these questions. The revised instrument includes some reorganization of the instrument and minor wording revisions, particularly to the new modules/questions, to better explain and define the context, concepts, or administration of the strategies and interventions contained in the questions has been completed (**Attachment C-5**).

Changes from the pilot test resulted in a net increase of one question being added to the total (3 new questions added and two removed) to the Scorecard and only minimal changes to the wording of the base question or related supplemental information provided for context. These changes to the data collection instrument are described in detail in section A-2 of this document. The revised instrument has 154 core health topic yes/no questions, 8 core worksite demographic questions, with an additional 8 optional worksite demographic questions divided into 19 modules (risk factors/conditions/demographics)

There has been a slight increase in the total number of burden hours from 303 to 667 estimated annualized burden hours due predominately to an increase in the number of employer respondents from 200 for the pilot test to 800 for broader implementation. We also found during the pilot test that respondents took slightly more time to complete the registration (**Attachment C-1**) from an estimated 2 minutes to 5 minutes but a significantly shorter time to complete the Scorecard assessment (**Attachment C-2**) from an hour and 15 minutes to 45 minutes. The cognitive interview and pilot evaluation instruments used in the pilot have been dropped and are no longer needed for broader implementation reducing burden for these instruments.

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

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

Table 16A. Project Assessment Time Schedule

Respondents/Sources	Method	Content	Timing/Frequency	Attachment #
<i>OMB Approval - Interested Employers/Gatekeeper Organizations</i>				
OMB Approval	N/A	N/A	Spring 2019 (estimated) for launch of web application	N/A
Employers	CDC Worksite Health Scorecard Registration	Employer contact information and organizational demographics, access to frequently	Spring 2019 (estimated) for launch of web application	C-1, D
Employers	CDC Worksite Health Scorecard	Status of worksite health policies/practices/programs across health risk and condition topic areas	Baseline and every 12 months	C-2
Employers	Technical assistance	Review benchmarking	Beginning on a rolling	C-3, C-4

	offered following Scorecard assessment	data, lend support for program planning, and implementation through education and access to online tools and resources	basis at the conclusion of Scorecard assessment	
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Quantitative data elements will be used for the overall evaluation of the CDC Worksite Health Scorecard. The outcome evaluation will include statistical models to determine the extent to which the program affected the target outcomes.

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

Statistical Modeling. The primary statistical models in the outcome evaluation will be linear and non-linear regression models and hierarchical or multilevel models. The purpose of using these models is to relate the observed differences in outcomes to a set of observed characteristics. Of particular interest is how certain organizational features, such as the level of management support for health promotion programs, influence the effective implementation of programs.

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

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

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

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

There are no exceptions to this certification.

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