Formative and Summative Evaluation of Scaling the National Diabetes Prevention Program (National DPP) in Underserved Areas

Reinstatement with Change
OMB No. 0920-1090; Exp. xx/xx/xxxx

Supporting Statement: Part A

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Formative and Summative Evaluation of Scaling the National Diabetes Prevention Program in Underserved Areas

Summary Table

- Goal of the study. The goal of this information collection is to allow CDC an additional three years of OMB approval to continue collecting information needed to assess the effectiveness of the CDC's new cooperative agreement, DP17-1705 "Scaling the National Diabetes Prevention Program (National DPP) in Underserved Areas", succeeding the DP12-1212 cooperative agreement, to address gaps in reaching both general and priority populations in underserved areas with few or no in-person delivery programs. This information will be used to develop and disseminate best practices for scaling and sustaining the National DPP in underserved areas. Based on experience and lessons learned from the DP12-1212 grantees, and feedback from internal and external partners, CDC has revised the associated information collection.

- Intended use of the resulting data. This data collection effort is a key component of CDC's assessment of implementation progress by the ten DP17-1705 grantees. The objective is to use the data to provide high quality programmatic technical assistance to grantees and to identify best practices for scaling and sustaining the National DPP to priority populations in underserved areas.

- Methods to be used to collect information. CDC will collect de-identified data directly from the grantees and their affiliate delivery sites via a web-based data system annually per the requirements of the Notice of Funding Opportunity (NOFO). Through the data system, both grantee and affiliate site respondents will be asked to submit data describing the components of their program implementation, including participant recruitment and retention strategies, barriers and facilitators to implementation, and necessary resources for implementation.

- The subpopulation to be studied. The DP17-1705 cooperative agreement targets both general and priority populations at risk of developing type 2 diabetes. The web-based data system will be completed by leadership at both the grantee and affiliate delivery sites who are responsible for delivering the evidence-based lifestyle change program to the targeted populations at risk.

- How data will be analyzed. Both quantitative and qualitative data will be analyzed at an aggregated grantee and affiliate site level using appropriate statistical methods. Both grantee level and cross-grantee level reports will be generated.

A. JUSTIFICATION

A.1 Circumstances Making the Collection of Information Necessary

Diabetes takes a significant toll on the public's health, and subsequently on our nation's health care system. In addition to the 30.2 million people in the U.S. diagnosed with diabetes, CDC estimates that 84.1 million adults aged 20 or older have prediabetes. Fortunately, findings from randomized controlled trials and translation studies have demonstrated that type 2 diabetes can be prevented or delayed in those at high risk through a structured lifestyle intervention that can be delivered cost effectively in real-world settings. The lifestyle change intervention focuses on achievement of modest weight loss (5-7%) and moderate increases of an average 150 minutes per week in physical activity, which was shown to be effective in preventing or delaying the onset of type 2 diabetes in adults with prediabetes.

To achieve public health impact in reducing the burden of type 2 diabetes, the strategies that are effective for individuals must be adopted on a large scale. Toward this end, CDC established the National DPP, administered through the Division of Diabetes Translation (DDT), to make the lifestyle intervention for preventing type 2 diabetes broadly available to individuals at high risk for type 2 diabetes. The National DPP lifestyle change program is a year-long, evidence-based lifestyle change program aimed at increasing knowledge and awareness of healthy eating and physical activity among people at high risk for type 2 diabetes. To assure quality and fidelity in delivery of the program, CDC collects organizations' and participants' information through the Diabetes Prevention Recognition Program (DPRP) (OMB No. 0920-0909, exp. 02/28/2021), the quality assurance arm of the National DPP. Through the DPRP, CDC recognizes organizations that successfully deliver the evidence-based lifestyle change program to participants who have prediabetes or are at high risk for type 2 diabetes. Criteria for obtaining recognition through the DPRP are documented in the DPRP Standards (https://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf).

From 2012-2016, CDC funded six national organizations through a cooperative agreement (DP12-1212) to establish and expand multistate networks of over 200 CDC-recognized organizations. CDC has conducted a formative and summative evaluation of DP12-1212 (OMB No. 0920-1090, exp.12/31/2018) and used the evaluation findings and lessons learned to provide data-driven technical assistance to the grantees and other organizations delivering the National DPP lifestyle change program. The data and lessons learned from DP12-1212 were also used to inform decision making and policy, including the development of the Centers for Medicare & Medicaid Services (CMS) Medicare Diabetes Prevention Program (MDPP). As of April 1, 2018, the MDPP Expanded Model provides coverage for the National DPP lifestyle change program for eligible Medicare beneficiaries.

While DP12-1212 was instrumental in helping to build the national infrastructure to scale the National DPP, there are still gaps. Despite the fact that over 1,700 CDC-recognized organizations in 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, and other U.S.-affiliated island jurisdictions/territories offer the National DPP lifestyle change program, there are still many geographic areas with few or no in-person delivery programs. In addition, some populations, including Medicare beneficiaries, men, African-Americans, Asian-Americans, Hispanics, American Indians, Alaska Natives, Pacific Islanders, and people with visual impairment or physical disabilities, are under-enrolled relative to their estimated numbers and disease burden. To address these gaps, CDC funded a new, five-year cooperative agreement with national organizations in September 2017 to succeed DP12-1212. Through the new agreement, "Scaling the National DPP in Underserved Areas" (DP17-1705), CDC funded ten national organizations with affiliate program delivery sites in at least 3 states each to start new CDC-recognized organizations in underserved areas and to enroll both general and priority populations in new or existing CDC-recognized organizations. While both cooperative agreements funded national organizations to scale the National DPP, DP12-1212 focused on the general population, and DP17-1705 has a more specific focus on priority populations in underserved areas. The DP17-1705 grantees will work on activities designed to accomplish three main goals:

1) Build the infrastructure in underserved areas necessary to deliver the National DPP lifestyle change program to the general population and to priority populations, including Medicare beneficiaries, men, African-Americans, Asian-Americans, Hispanics, American Indians, Alaska Natives, Pacific Islanders, and non-institutionalized people with visual or physical disabilities;
2) Tailor and adapt the program to address the unique needs and challenges of the enrolled participants; and
3) Provide participants with specialized support needed to successfully complete the program and achieve 5-7% weight loss. Through this new cooperative agreement, it is anticipated that enrollment, retention, and achievement of 5-7% weight loss goals for the targeted populations will increase.

The DP17-1705 grantees are required to plan and carry out activities that support all 5 strategies to achieve the outcomes stated in the Program Logic Model to scale program delivery efforts:

- Strategy 1: Increase the availability of CDC-recognized organizations in underserved areas.
- Strategy 2: Increase clinician screening, detection, and referral of adults with prediabetes or at high risk for type 2 diabetes to CDC-recognized organizations.
- Strategy 3: Increase awareness of prediabetes and enrollment in the National DPP lifestyle change program.
- Strategy 4: Increase retention rates for participants in the lifestyle change program.
- Strategy 5: Increase health benefit coverage for participants in the lifestyle change program.

CDC has updated the comprehensive Evaluation Framework (**Attachment 7**) and the DP12-1212 data collection instruments (OMB No. 0920-1090, exp.12/31/2018) to include information specific to the focus of DP17-1705 on priority populations. This is a Reinstatement with Change of Information Collection Request OMB No. 0920-1090, exp.12/31/2018 supporting an evaluation of grantees' work to scale and sustain the National DPP under DP17-1705, also known as a formative and summative evaluation of scaling the National DPP in underserved areas, led by the CDC. The National DPP programmatic activities are authorized by Section 399V-3 of the Public Law 111-148 (**Attachment 1A**). CDC's general authority for research and investigations is provided by the Public Health Service Act (**Attachment 1B**). This current Reinstatement request describes changes that affect the annualized burden estimates.

CDC requests OMB approval for 3 years to collect the information needed to conduct a full formative and summative evaluation of work under cooperative agreement DP17-1705. The data collection will allow CDC to continue to provide data-driven, tailored programmatic technical assistance to ensure continuous quality improvement for each year of the cooperative agreement. Respondents will include the ten DP17-1705 grantees and their affiliate delivery sites. Each respondent will complete an annual evaluation form. The revised evaluation form for the DP17-1705 grantees (**Attachment 3A**) and affiliate delivery sites (i.e. CDC-recognized organizations) (**Attachment 3B**) is based on the OMB-approved evaluation instruments developed for the DP12-1212 cooperative agreement (OMB No. 0920-1090, exp.12/31/2018), the DP17-1705 evaluation framework (**Attachment 7**), and the program logic model referenced in the DP17-1705 NOFO as well as the public comments received from the 60-day Federal Register Notice (Attachment 2A).

A number of additional changes to the evaluation forms are proposed to reduce burden on respondents and to ensure that reporting and evaluation requirements are consistent with the new NOFO, DP17-1705. This reinstatementres request also describes a number of changes that are based on experience from DP12-1212 and lessons learned from the funded national organizations and their affiliate delivery sites. Evaluation data elements have been added or modified accordingly. Finally, some changes related to burden estimates have been made to reflect the revised data collection instruments and changes in the method of data collection from using an Excel spreadsheet to a web-based data system to allow for real-time feedback and technical assistance. An overview of all changes is provided in **Attachment 6**. The overview clarifies how key changes in data collection instruments are reflected in the revised Evaluation Form for National DPP Grantees (**Attachment 3A**) and the revised Evaluation Form for National DPP Implementation Sites (**Attachment 3B**).

CDC anticipates that information collection will continue throughout the five-year DP17-1705 cooperative agreement. At this time, CDC requests an additional three years of

OMB approval (January 1, 2019 thorugh December 31, 2021) to collect the information needed to assess the effectiveness of the DP17-1705 grantees' efforts, and to determine best or promising practices for scaling and sustaining the National DPP in underserved areas for priority populations.

A.2 Purpose and Use of Information Collection

The main purpose of the Formative and Summative Evaluation of DP17-1705 is to collect information needed to identify program-level factors that contribute to successful implementation and best practices for achieving program sustainability and scalability at the community level. The Evaluation Form to be completed by the grantees is included as **Attachment 3A**. The Evaluation Form to be completed by the program delivery sites is included as **Attachment 3B**. Each grantee will be responsible for completing a grantee-level evaluation form in addition to reviewing site-level evaluation forms for their affiliate delivery sites for quality and completeness. Questions in the Evaluation Forms across both grantee-level and site-level versions are similar. Both grantees and affiliate delivery sites will report on program components, recruitment strategies, resource use, reimbursement systems, and implementation progress, including barriers and strategies used to overcome them. In addition, the affiliate delivery sites will report information about participant retention incentives, lifestyle change class locations and settings, types of training for lifestyle coaches, and the average cost of enrollment per participant.

The data to be collected is a key component of CDC's quality improvement process with current DP17-1705 grantees. The target audience for the collection and sharing of information is the grantees and their affiliate delivery sites. CDC will return an annual assessment report in the form of a data dashboard (**Attachment 5D**) within the Data Reporting for Evaluation and Monitoring of 1705 (1705 DREM) system to each grantee and affiliate site. CDC will disseminate the evaluation findings via an in-person grantee meeting, series of webinars, and individualized phone calls upon request to provide tailored technical assistance to the grantees and affiliate sites. CDC will also prepare and disseminate other evaluation products based on cross-grantee, de-identified, aggregate assessments. These could include Power Point presentation slides, consumer-friendly program briefs, infographics, tip sheets, emerging/promising practice documents, materials, resources, and tools. These products and reports will form the basis for technical assistance to grantees as they scale their lifestyle change programs to reach priority populations, foster sustainable funding relationships, and provide technical assistance on the CDC recognition process to their affiliate delivery sites.

The data collected will also be used to develop and disseminate best or promising practices for all the users of the CDC National DPP CSC. As a result of the national evaluation of DP12-1212, CDC was able to develop a portfolio of key technical

assistance tools and resources for the CSC. The national evaluation of DP17-1705 will allow us to refine those tools and resources to help organizations serving priority populations.

Ultimately, the comprehensive formative and summative evaluation plan supports CDC's ability to identify barriers and facilitators to program implementation across a wide variety of affiliate delivery sites, geographic locations, and client populations, and to share this information to strengthen program reach, success, and sustainability.

A.3 Use of Improved Information Technology and Burden Reduction

All (100%) of the data described in this Information Collection Request will be collected through the web-based 1705 DREM system accessible using a web browser on a PC, MAC, or mobile device. By using an electronic format for data collection, which allows data to be collected in real-time, we will reduce the burden of respondents having to use a paper or Word/Excel format and then mailing/e-mailing their responses back to CDC or creating a separate tracking system to enter partial data before submission is due to CDC. To further minimize burden on grantees and affiliate delivery sites, the data collection is due only once a year and includes comprehensive drop-down response options along with pre-populated information (i.e., grantee name, site name, site code, grant year, and fiscal year) and skipping patterns. In addition to drop-down response options, the evaluation forms include free-text response boxes to accommodate reporting unique program characteristics. Grantees will be offered technical assistance on how to collect and submit data to CDC on webinars and through e-mail correspondence and regular conference calls with their assigned evaluators and project officers. In addition, the archives of webinar recordings, Step-by-Step User Guides, Glossary of Terms for Completing National DPP Evaluation Forms (**Attachment 3C**), and Evaluation Form Instructions attached to the account login (Data System Screenshots, **Attachment 4**) will be available in the Evaluation Resource and Communication Portal of the 1705 DREM System. A data system specialist will also be available to provide individualized technical support to the grantees and affiliate delivery sites.

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

There are no similar data available that meet the needs of this proposed assessment. The proposed information collection is distinct from, but complementary to, other information collection by CDC to monitor and evaluate National DPP efforts. The evaluation forms will provide information that is not included in the annual progress reports and performance measures submitted to CDC by the 10 DP17-1705 grantees. Similarly, the information requested on the evaluation forms is distinct from the information that affiliate delivery sites will provide to CDC through the Diabetes Prevention Recognition

Program (OMB No. 0920-0909, exp. 02/28/2021). The Formative and Summative Evaluation of work conducted under DP17-1705 looks at grantee and site-level data related to implementation processes, including barriers and facilitators to program delivery and sustainability. The DPRP process looks at de-identified data about individuals who are participating in the National DPP lifestyle change program, which will be used for determination of CDC recognition status only. CDC is proposing to collect a few participant-level variables (disability status, attendance at session zero, and zip code for online participants). We are also proposing to collect a few class-level variables (class setting, curriculum, language, delivery modality, and in-person class location address). This information is needed to assess program reach for priority populations in targeted underserved areas specified in the NOFO. As previously noted , CDC will develop technical assistance tools and resources based on the evaluation of this information and make them available to all National DPP stakeholders through the CSC.

A.5 Impact on Small Businesses or Other Entities

Some affiliate delivery sites may be small businesses. The impact on small businesses is anticipated to be minimal (average of 5 hours per annual submission), and relates to their interaction with National DPP-funded organizations during the next three years. The information collection does not impose an ongoing record-keeping or reporting burden on affiliate delivery sites. The data collection burden on grantees is an average of 3 hours per annual submission, but none of these grantees are small businesses.

A.6 Consequences of Collecting the Information Less Frequently

Collecting this assessment data will allow CDC to identify best practices for achieving national scale for the National DPP and, therefore, will increase access to the National DPP lifestyle change program for the 84 million individuals with prediabetes or at high risk for type 2 diabetes. CDC has set ambitious annual enrollment targets for each grantee. Not collecting these data annually would significantly reduce CDC’s capacity to support the DP17-1705 grantees and affiliate delivery sites through tailored technical assistance to help them meet their enrollment targets. Failure to collect data for this assessment annually would also hinder identification of organizational-level best or promising practices to reach the priority popuations most at risk and could result in an increase in health-related disparities. Further, the collection of annual data will allow CDC to develop, disseminate, and update timely technical assistance resources and tools through the National DPP Customer Service Center. The National DPP is evolving rapidly, especially with the use of new technologies to deliver the lifestyle change program. National DPP stakeholders have an urgent need for access to the most up-to-date information on a timely basis so they can continuously improve delivery to reach the populations at highest risk of developing type 2 diabetes.

Information will be collected once per year. There are no legal obstacles to reducing the burden.

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 the Agency

A 60-day Notice was published in the Federal Register on October 4, 2018; Volume 83, No. 193, pp. 50098-50099 (**Attachment 2A**). CDC received and responded to 5 sets of unique public comments that were related to this notice from both individuals and organizations that are outside of CDC. Within those 5 sets of comments, there were 48 unique questions/comments that CDC responded to. The table contained within "**Attachment 2B** Summary of Public Comments" summarizes the public comments and how CDC plans to address them.

A.9 Explanation of Any Payment or Gift to Respondents

Respondents will not receive any payment or gifts as a result of their completing and submitting the electronic evaluation data collection.

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

Respondents to the data collection will be DP17-1705 grantee program-level directors and managers and affiliate delivery site-level program coordinators. All information will be collected electronically via the 1705 DREM system.

Privacy Act Determination

CDC will not receive any personally identifiable information from individual participants. The national grantee and affiliate site users of the 1705 DREM System will provide their business email addresses for system authentication and communication purposes only. Only the 1705 system administrator will have access to the users' business email addresses to assist users in gaining access to the system if they forget their usernames or passwords. Although CDC knows the names of the grantee organizations and program delivery sites, electronic responses will not be directly linked to actual

program participants. The evaluation forms do not collect participants' personally identifiable information.

No system of records is being created under the Privacy Act for this data collection. The Privacy Act does not apply. Once the electronic evaluation forms are submitted to CDC by the grantees and affiliate delivery sites, the CDC evaluation contractor (ICF) will conduct data quality checks and publish the final aggregated de-identified data tables in the 1705 DREM system. This will allow CDC to generate an annual assessment report in the form of a data dashboard (**Attachment 5D**) for grantees and sites. ICF will also share the final raw datasets with the CDC evaluators and statisticians through a CDC Secure File Transfer Protocol (SFTP) site.

Access to the data collected will be limited to CDC authorized program staff. Project reports and manuscripts will contain aggregated de-identified (by grantee and grantee site) data only; results will not be associated with any individual respondent.
All data collection will be in the form of electronic data files. The evaluation forms will be identified by the name of the grantee organization, the name of the affiliate delivery site (if different from the grantee organization), and an assigned unique identification number for the site. Any file transfer will occur through a SFTP site.

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

The proposed information collection does not involve research with human subjects, and IRB approval is not required from CDC and ICF (**Attachment 8A and 8B**). Program directors and managers at the grantee level will be informed in an e-mail that submission of the grantee and affiliate delivery site-level data collection will occur (**Attachment 5A**), and will be provided instructions on how to create a new online account to access the National Evaluation Reporting Portal of the 1705 DREM system. They will also be informed that the resulting data will be shared with them for program improvement purposes. Program directors and managers will also be informed that the data collected are part of the DP17-1705 mandatory data collection for national evaluation, and that they will only be shared with the grantees themselves or across grantees in a de-identifed, aggregate manner. Some data collected are voluntary (i.e., cost/salary data) and will be indicated as such on the evaluation forms.

It is possible that discussion of organizational barriers and average cost/salary data could be construed by a grantee or their affiliate delivery site as sensitive. Therefore, the response option of "not able to answer" is included within the evaluation forms; no response at all is also permitted. No grantee is being required to answer sensitive questions.

A12. Estimate of Annualized Burden Hours and Costs

OMB approval is requested for annual information collection over a three-year period.

Each DP17-1705 grantee will complete an evaluation form (**Attachment 3A**). The number of grantees is expected to remain constant (10), and the estimated burden per response is between 3 and 5 hours with an average of 4 hours. This estimate includes the time needed to answer grantee-specific questions, and to review the collection of site-specific questions within the 1705 DREM system.

Each affiliate delivery site will complete an evaluation form (**Attachment 3B**). The annualized estimated number of respondents is 100, based on 50 sites in 2018, 100 sites in 2019, and an estimated 150 sites in 2020. The estimated burden per response is between 5 and 7 hours with an average of 6 hours. A Glossary of Terms for Completing the National DPP Evaluation Forms (**Attachment 3C**) will be provided to all respondents to ensure uniform reporting. The total estimated annualized burden is 640 hours, as summarized in ***Table A.12-1*** below.

Table A.12-1. Estimated Annualized Burden Hours

Type of Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
National DPP Affiliate Delivery Sites	Evaluation Form for Sites	100	1	6	600
National DPP Grantees	Evaluation Form for Grantees	10	1	4	40
Total					640

Table A12-2 presents the calculations for cost of annualized burden hours. Estimates for the average hourly wage of respondents are based on the Department of Labor (DOL) National Compensation Survey Estimate for a Social and Community Service Manager. Actual wages are unknown and may vary significantly depending on respondent employment status and the state, tribe, or territory in which they reside.

Table A.12-2. Estimated Annualized Cost to Respondents

Type of Respondent	Form name	No. of respondents	No. of responses per respondent	Hourly wage rate	Total burden (in hours)	Total Cost
National DPP Affiliate Delivery Sites	Evaluation Form for Sites	100	1	$24.50	600	$14,700
National DPP Grantees	Evaluation Form for Grantees	10	1	$34.50	40	$1,380
					Total	$16,080

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

There are no costs to respondents other than their time.

A14. Annualized Cost to the Federal Government

Government personnel – Governmental costs for this project include personnel costs for federal staff involved in planning and designing the original assessment and the data collection forms and OMB materials; collecting and analyzing the data; and reporting, which includes approximately 5% of two GS-14/Step 5 team leads (assuming $122,718 annual salary), 60% of one GS-13/Step 4 epidemiologist (assuming $100,794 annual salary), and 15% of one GS-13/Step 3 heatlh scientist (assuming $97,740 annual salary).

Contracted assessment –The data system development, assessment reporting, assessment technical assistance, and data collection and cleaning are being conducted under a contract with CDC's evaluation contractor, ICF. The annualized cost of these tasks under the contract is estimated at $75,207 and includes costs for data management, programming, reporting, and technical assistance. The entirety of this amount is dedicated to assessment implementation and reporting.

Table A.14-1. Estimated Annualized Cost to the Federal Government

Labor:	
5% of two GS-14/Step 5 team leads time for project planning, management, OMB review, and report review	$12,272
60% of one GS-13/Step 4 epidemiologist time for project planning, management, OMB packet preparation, coordination of data collection, data analysis, analysis of findings, and report writing and	$60,476

dissemination	
15% of one GS-13/Step 3 health scientist time for project planning and coordination, data analysis, analysis of findings, and report writing and dissemination	$14,661
Contractors	$75,207
Total estimated cost	$162,616

A15. Explanation for Program Changes or Adjustments

The reporting burden of this collection of information is estimated to vary between 3 and 5 hours with an average of 4 hours per grantee response (decreased from 12 hours), and between 5 and 7 hours with an average of 6 hours per affiliate delivery site response (increased from an average of 45 minutes per response). These estimated burden hours include the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and entering information in the web-based 1705 DREM system. This eliminates the burden on the grantee associated with compiling consolidated responses from each affiliate delivery site. The completion of the automated, online evaluation form also involves skipping patterns and drop-down boxes to facilitate data entry. A few changes are proposed for each information collection instrument (the Evaluation Form for Grantees and Sites) as outlined in **Attachment 6**, which results in changes in the estimated burden hours per type of respondent. The proposed changes to the estimated number of respondents are described below.

In 2015, under the DP12-1212 cooperative agreement, CDC estimated that the six national organization grantees would establish 120 affiliate delivery sites per year. In this three-year reinstatement period for Years 1-3 of the DP17-1705 cooperative agreement, CDC estimates that the ten new national organization grantees will establish approximately 100 new affiliate delivery sites per year to offer the CDC-recognized lifestyle change program in underserved areas where there are no or few existing programs, given the estimated burden of the population at risk for type 2 diabetes. These changes result in a net increase of 478 annualized burden hours. The distribution of these changes is summarized in Table A.15-1. below.

Table A.15-1 Estimated Data Collection Burden Hours by Respondent, 2015 to 2018

Type of Respondent	2015	2018	Change

and Form Name								from 2015-2018
Type of Respondent	Form Name	No. of Respondents	No. of Responses per Respondent	Total Burden Hours*	No. of Respondents	No. of Responses per Respondent	Total Burden Hours	Total Burden Hours
National DPP Affiliate Delivery Sites	Evaluation Form for Sites	120	1	90	100	1	600	510
National DPP Grantees	Evaluation Form for Grantees	6	1	72	10	1	40	-32
			Total	162			640	478

A16. Plans for Tabulation and Publication and Project Time Schedule

Once all data collection forms from grantees and affiliate delivery sites are submitted within the 1705 DREM system, the data will be securely transferred to the CDC evaluator through a CDC SFTP site and stored on a secure server, which is password protected and only accessible to CDC-authorized staff. Program-level data will be analyzed using descriptive statistics and bi-variate correlations to create an annual assessment report in the form of a data dashboard for grantees and affiliate delivery sites. Some correlations will utilize existing DPRP outcome data in a de-identified, aggregated manner by site and grantee. Multivariate regression and multilevel models will also be used in the cross-site analyses to discern lessons learned and effective strategies to scale and sustain the National DPP and reach priority populations in underserved areas.

This data collection effort will result in several dissemination products including but not limited to Power Point presentation slides, consumer-friendly program briefs, infographics, tip sheets, emerging/promising practice documents, materials, resources, tools, and at least one manuscript.

CDC's preferred timeline is outlined below. In order to complete the grantee and site assessment by December 31, 2019, OMB approval is requested no later than April 1, 2019 (sooner would be preferable).

Table A.16-1. Data Collection Time Schedule

Annual Activity	Annual Time Schedule

Distribute introductory e-mails and instructions	May/June, 2019
Evaluation data due	December, 2019
Data analysis	January – March, 2020
Feedback dashboard reports to respondents	April, 2020
Dissemination products on cross-site findings	September, 2020

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

The display of the OMB expiration date is not inappropriate.

A18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.