National Survey of Community Based Policy and Environmental Supports for Healthy Eating and Active Living

New

Supporting Statement A

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June 15, 2020

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JUSTIFICATION SUMMARY

- **Goal of the project:** Provide data on the progress municipal governments have made in policies and practices to support healthy eating and physical activity for their residents.

- **Intended use of the resulting data:** Results will be used to examine policy and practice supports favorable for healthy diets and regular physical activity and progress since 2014, help identify the extent to which communities implement strategies consistent with current national recommendations, and guide CDC program activities and communities and researchers in local efforts to implement and evaluate policies and practices that support healthy behaviors.

- **Methods to be used to collect:** A web-based, self-administered questionnaire, or computer-assisted telephone interview will be used to collect the survey data.

- **The subpopulation to be studied:** A nationally representative sample of 4,417 municipalities within the United States.

- **How data will be analyzed:** Statistical analyses to identify differences in categorical responses between 2014 and 2021 and variation by municipality characteristics include chi-square tests and logistic regression analyses.

A. JUSTIFICATION

A1. Circumstances Making the Collection of Information Necessary

The Division of Nutrition, Physical Activity, and Obesity of the Centers for Disease Control and Prevention (CDC) requests an 24-month OMB approval for a new data collection for a second iteration of the National Survey of Community-Based Policy and Environmental Supports for Healthy Eating and Active Living (CBS HEAL). CDC is authorized to collect the information under Public Health Service Act, Title 42, Section 301 (Attachment 1). This data collection effort is a national survey to assess local governments' policies and practices that support healthy eating and active living among their residents. This national survey will provide nationally representative data and will serve as the second data collection effort for this survey to track data across time for CDC.

Heart disease and cancer were the leading U.S. causes of death for both men and women in 2017, accounting for 44.3 percent of all deaths.[1] Millions of Americans live with chronic conditions; more than 93 million Americans have obesity[2] and over 30 million have type 2 diabetes.[3] Poor nutrition and inadequate physical activity increase risk for chronic diseases including heart disease, cancer, type 2 diabetes, and obesity.[4,5,6] However only one-half of adults meet the recommended amounts of physical activity and less than 1 in 10 adults consume enough vegetables.[2]

Across the country, public health practitioners are working with communities to improve community levels supports for diet and physical activity. This includes three programs within CDC's Division of Nutrition, Physical Activity, and Obesity:

- High Obesity Program (HOP, CDC-RFA-DP18-1809)
- Racial Ethnic Approaches to Community Health (REACH, CDC-RFA-DP18-1813)
- State Physical Activity and Nutrition Programs (SPAN, CDC-RFA-DP18-1807)

Local governments can support healthy eating and active living.[7-9] However, there is limited systematically collected information on the types of policies and practices of local governments that support healthy eating and active living.

In 2014, CDC conducted the first nationally representative CBS HEAL to address this gap (OMB Control Number 0920-1007). This survey documented the extent to which local communities were implementing strategies consistent with its program strategies and recommendations from expert groups, such as CDC and the Institute of Medicine (IOM)[7,8,9]and the characteristics of communities who implement them.[10-17] The current effort builds upon the 2014 study. CBS-HEAL II will update this information as well as document progress in changing these supports since 2014. Results from this new survey will be used to assess how strategies currently promoted in CDC and other public health programs have changed over time and what strategies are still not being implemented and may need additional support.

A2. Purpose and Use of Information Collected

The purpose of this survey is to conduct a nationally representative survey of municipalities selected from the 2017 Census of Governments file and to document the current prevalence of policies, practices, and standards under the purview of local governments related to diet and physical activity. Data will be primarily collected via a web based, self-administered questionnaire; a computer-assisted telephone interview will also be available if needed.

Results from this survey will provide information that is relevant to multiple CDC initiatives and to other stakeholders, Specifically it will be used to (1) document the current state and local progress on recommended strategies for communities from CDC and other expert bodies; (2) provide benchmark data for communities nationally; (3) provide participants information on how their community compares to other similar communities; and (4) provide researchers outside of the federal government a dataset to conduct their own analyses.

Communities and local agencies can use the data collected as benchmarks to evaluate how they compare nationally or with other sampled municipalities of a similar geography, population size, and urban status. From this information, communities may learn which policy supports are being enacted by their peers and better understand what is most feasible toward policy and environmental interventions or solutions for healthy behaviors or choices. The reports disseminated in municipalities who participate in the survey can also serve as validation of municipalities' efforts toward improving healthy eating and active living supports in the community.

CDC will share results from this study with other Federal agencies and additional colleagues. CDC has contacted U.S. Department of Transportation (DOT), the U.S. Department of Agriculture (USDA), and the National Institutes of Health (NIH) to make them aware of the study and has offered to provide the summary of findings and methodology, if requested. Aggregate data will be shared with other Federal agencies upon request. CDC will also share aggregated information on the findings through webinars, scientific papers, and presentations. Sampled municipalities will receive individualized reports presenting findings for the municipality. In addition, a de-identified dataset will be made publicly available for researchers to analyze.

Data collection procedures. The questionnaire will be administered to a key informant representing each of the 4,417 sampled municipalities. The key informants (city or town managers or planners or persons with similar responsibilities for the sampled municipality) were identified as the individuals possessing the broadest knowledge of the healthy eating and active living policies and practices being implemented within the municipalities. The questionnaire was designed to allow for collaboration with other employees of the sampled municipality, should a respondent need additional information to provide the most accurate information.

Questionnaires will be administered via a web-based survey (Attachment 3a), self-administered hardcopy questionnaire (Attachment 3b), or computer-assisted telephone interview (CATI).

Respondents have the ability to respond to the questionnaire at a time and place of their choosing from any Internet-connected computer or mobile device, as well as the option to complete the questionnaire via a hardcopy questionnaire that can be mailed to them or printed from their own computer. While respondents will be encouraged to complete the self-administered versions of the survey (web-based survey or hardcopy questionnaire), respondents may contact NORC to complete the survey with a trained telephone interviewer should they choose.

No individually identifiable information is being collected as part of the questionnaire. Sources of information for the survey items are the existing public documents within the local governments. The questionnaire consists of 60 items divided into seven sections.

- Section 1: Structure of Your Local Government asks if the local government contains different departments or offices (e.g. transportation, parks and recreation, housing).
- Section 2: Communitywide Planning Efforts for Healthy Eating and Active Living asks questions about the planning documents local municipalities may have in place that support healthy eating and active living.
- Section 3: The Built Environment and Policies That Support Physical Activity asks respondents to indicate what policies, standards, and practices they have in place to support aspects of the built environment that support physical activity.
- Section 4: Zoning That Supports Healthy Eating and Active Living contains questions related to zoning or development codes that support healthy eating and active living.
- Section 5: Public Transportation Policies that Support Healthy Eating and Active Living covers policies and procedures related to public transportation in relation to healthy eating and active living.
- Section 6: Other Policies and Practices That Support Access to Healthy Food and Healthy Eating asks questions related to policies that may affect access to healthy food options within the community.
- Section 7: Policies That Support Employee Breastfeeding covers policies that support employee breastfeeding.

Data collection will involve a series of mailings and nonresponse follow-up activities. All communications to the municipalities sampled for the project – including pre-notification letter (Attachment 4), invitation letter (Attachment 5a), and reminder letters/emails (Attachment 6a-6d) – will be personalized with respondent name, web survey link, and individual Personal Identification Number (PIN). The letters will also contain a project specific email address and a toll-free number that respondents can use to contact project staff. A case management system will be used to track respondent status.

Pre-notification and Survey Invitation Letter Mailings. All selected municipalities will be sent an initial pre-notification letter using CDC letterhead, which announces the upcoming data collection and importance of participation (Attachment 4).

Following the pre-notification to the survey, each sampled municipality will be sent a survey invitation letter via USPS (Attachment 5a). The letter will include the survey URL and a unique PIN for the sampled respondent to access the survey. The survey invitation letter will be sent on CDC letterhead and will included a list of frequently asked questions on the reverse side (Attachment 5b). A letter of support from a supporting agency (e.g. National Association of County and City Health Officials (NACCHO) or the American Planning Association (APA)) will be included with the invitation letter as well. The mailing envelope used will include NORC's return address to process undeliverable returns. NORC receipt control clerks will be trained on proper receipt control procedures and how to record the case status within the case management system.

Reminder letters and emails. Personalized reminder letters or emails will be sent to all survey non-responders beginning in week 3 after mailing the survey invitation letter and throughout the field period (Attachments 6a-6d). Each letter, whether paper or email, will be personalized and contain the web URL and PIN to access the survey. Reminders will be sent each week on an alternating basis, so that a reminder email is mailed in week 3, a reminder letter in week 4, a reminder email in week 5, and so on. Near the end of data collection (approximately week 14), the final reminder will be a last-chance letter to all non-respondents that will stress the importance of the survey and alert the respondent that their opportunity for inclusion is coming to an end.

Telephone follow-up. Starting at week 6 of data collection, telephone prompting will begin for any non-responders at that time. NORC telephone interviewers will call respondents to remind them to complete the survey, but also offer the option to complete the survey by telephone if they are able to respond immediately (Attachment 7).

Critical item survey. The critical item survey will be a shortened version of the full survey, only to be used during the final weeks of data collection. The critical item survey will collect data for 7 key survey questions from the remaining non-responders (Attachment 8).

A3. Use of Improved Information Technology and Burden Reduction

The survey will be offered through a multi-mode approach using both computer-assisted web interviewing (CAWI), a self-administered hardcopy questionnaire (SAQ), and computer-assisted telephone interviewing (CATI). Based on the 2014 CBS HEAL administration, it is expected that the majority of respondents will respond via the web (over 90% in 2014). CAWI will be the first mode offered and can be accessed via any internet-enabled device. However, offering respondents the opportunity to complete the survey in any of these modes (web, paper, or telephone) reduces respondent burden as it allows the respondent to respond in a way that is most convenient to the individual.

The web-based questionnaire will be programmed in Voxco, a computer aided interviewing (CAI) system that can administer the web survey with minimal user errors, such as missing data or incorrect

skip patterns. Use of a web survey will also reduce the time needed to complete the questionnaire. Transfer of data collected electronically eliminates the need for data entry.

The Voxco system produces fully responsive, 508-compliant web pages capable of being comfortably viewed on a PC or Mac, tablet, or smartphone. It can be viewed through most modern browsers (including Internet Explorer, Chrome, Firefox, and Safari). Each questionnaire is programmed to create visual consistency across questions, examine potential user proficiency and technology limitations, and accommodate multiple technology platforms. Questionnaires are formatted to maximize readability, including appropriate question spacing, pixilation, font type and size, and properly programmed branching patters. Questionnaire formatting considerations also include the use of color, diagrams, and pictures to enhance respondent comprehensions. Screenshots of the formatted questionnaire can be found in Attachment 9.

Similar to the CAWI instrument, the CATI instrument for this project will include programmed skips and error checks throughout the survey. Both of these enhancements reduce respondent burden when completing the survey with a telephone interviewer.

A4. Efforts to Identify Duplication and Use of Similar Information

CDC contacted several other Federal agencies with interests in healthy eating and active living to discuss the scope and intent of this data collection and identify any possible existing duplication of efforts, particularly the collection of data on policy and environmental supports that exist at the local or community levels. The Federal agencies that were contacted were DOT, USDA, and NIH. CDC has verified that there are no other Federal data collections that duplicate the data collection tools and methods included in this request.

Name	Title	Affiliation	Phone	Email
Jason Broehm	Transportation analyst	Office of the Under Secretary for Policy U.S. Department of Transportation	202-366-1374	jason.broehm@dot.gov
David Berrigan	Program director	National Institute of Health	240-276-6752	berrigad@mail.nih.gov
Kelley Scanlon	Director, Special Nutrition Research and Analysis Division, Office of Policy Support	U.S. Department of Agriculture	703-457-7767	kelley.scanlon@usda.gov

CDC reviewed its own funded programs with work in communities (HOP, REACH, and SPAN), to determine whether or not there was potential duplication of data collection efforts and determined that no such duplication of efforts existed. HOP funds land grant universities who work with communities with adult obesity rates higher than 40%. REACH funds 61 community level grantees to chronic disease and chronic disease risk factors in high risk populations defined by race/ethnicity. SPAN funds

16 state recipients to implement evidence-based strategies at state and local levels to improve nutrition and physical activity; part of this work involves states working with communities. Data collection efforts for these program primarily focus on the selected communities receiving grants and do not provide a national baseline set of prevalence estimates for the policy supports of interest to CDC.

CDC also carefully reviewed the NIH's National Heart, Lung and Blood Institute (NHLBI) Healthy Communities Study, which also collects some information on community level policies (OMB No. 0925-0649, exp. 8/31/2016). The NHLBI study was a 6-year observational research study completed in 2015 that focused on determining the associations between specific community programs and policies most likely to impact childhood obesity, such as duration of program or policy and amount of funding tied to it and body mass index (BMI), diet, and physical activity in 5,000 children in 130 communities. In contrast, CDC is proposing a second iteration of a national survey that focuses on the presence or absence of policies, standards, and practices under the jurisdiction of local governments that more broadly impact healthy eating and active living in the American population and how these policies and practices have changed over time. There are currently no plans to repeat the Healthy Communities Study at this time.

A5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this study. Many municipalities have populations of less than 50,000 people and therefore are considered small entities. These entities are among the focus of this study. The questions have been held to the absolute minimum required for the intended use of the data. There will be no significant economic impact on these small entities.

A6. Consequences of Collecting the Information Less Frequently

The respondents will respond to the proposed information collection once. The proposed data collection will provide a data set on community policies related to healthy eating and active living that can be compared with the data from the 2014 data collection effort. Since the 2014 study, there has been no additional extant data source available that provides nationally representative and comprehensive data on policy and practice supports for healthy eating and active living at the municipal level. Without this study, CDC will lack the data needed to assess the current status of recommended community-level policies and practices and will be unable to show how these policies and practices have changed over time. Because CDC and groups within and outside of the federal government have funded communities to address supports for diet and physical activity, data that shows changes in the policies and practices may demonstrate the effectiveness of these efforts.

A7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This request fully complies with the regulation 5 CFR 1320.5.

A8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

Part A: PUBLIC NOTICE

A 60-day Federal Register Notice was published in the Federal Register on July 20, 2020, vol. 85 No. 139 , pp. 43851-43852 (Attachment 2a). CDC received 2 non-substantive comments and 1 substantive comment (Attachment 2b) and provided replies to each. CDC's response and how it addressed these comments are summarized in Attachment 2b.

Part B: CONSULTATION

Prior to the development of the 2014 survey, CDC convened a panel of experts to provide individual advice on the need for the survey and the best methods for the data collection. This panel included experts outside of the federal government in policy, data sources, nutrition, physical activity, and public health programs. The 2014 survey was also reviewed by four experts within and outside of the government. Their input resulted in the design and questions used in the 2014 and repeated in this survey.

The survey for this OMB request was discussed with Dr. Sagar Shah at the American Planning Association who previewed questions and helped identify contacts for the cognitive testing. His contact information is listed below. In addition to the project lead, Dr. Deborah Galuska, a CDC survey team includes experts on diet, physical activity, breastfeeding, program evaluation, and survey methodology.

Table A8.a External Consultations

Name	Title	Affiliation	Phone	Email	Role
Sagar Shah	Manager, Planning and Community Health Center	American Planning Association	202.349.1011	sshah@planning.org	A8

Table A8.b Consultations within CDC

Name	Title	Affiliation	Phone	Email	Role
Susan Carlson	Lead Scientist, Physical Activity and Health Branch, Epidemiology and Surveillance Team	CDC	770.488.6091	clo3@cdc.gov	Reviewed survey and provided feedback
Stephen Onufrak	Epidemiologist, Obesity Prevention and Control Branch	CDC	770.488.5551	seo5@cdc.gov	Reviewed survey and provided feedback
Carol MacGowan	Deputy Branch Chief, Nutrition Branch	CDC	770.488.5626	dvx2@cdc.gov	Reviewed survey and provided

					feedback
Anu Pejavara	Lead Evaluation Scientist, Program Development and Evaluation Branch	CDC	770.488.6214	bkz5@cdc.gov	Reviewed survey and provided feedback
Latetia Moore	Deputy Associate Director of Science, Division of Nutrition Physical Activity, and Obesity	CDC	770.488.5213	ggi9@cdc.gov	Reviewed survey and provided feedback
Deborah Galuska	Associate Director of Science, Division of Nutrition Physical Activity, and Obesity	CDC	770.488.6017	dbg6@cdc.gov	Reviewed survey and provided feedback

A9. Explanation of Any Payment or Gift to Respondents

No monetary or non-monetary incentives will be provided. Participating communities will receive an individualized report comparing their responses to similar communities based on findings from the national survey.

A10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

NCCDPHP's Information Systems Security Office has reviewed this submission and has determined the Privacy Act does not apply. Activities do not involve the collection of individually identifiable information. The Privacy Narrative is included as Attachment 10.

CDC is contracting with NORC at the University of Chicago to collect the survey data. NORC will have access to the name and title of individuals within each selected municipality. NORC will use the Census of Governments file to obtain the list of municipalities within the United States. Upon selection into the study, NORC will assign the selected municipalities with a case identification number that will be stored within the dataset. The survey instrument is designed to minimize the collection of personal identifier information and contain only information necessary to conduct the study; the respondent is not asked to report any personal identifier information about themselves.

At the conclusion of the study, the final dataset will be delivered to CDC in a de-identified format. Additionally, the data files will be delivered using a secure file transfer protocol (SFTP) site. CDC will receive the FIPS code associated with the municipality for analysis purposes; however, no identifying

information will be contained within the dataset when the data is made publicly available. When reporting data from the study, only aggregate data will be used to report study results.

Key safeguards have been put in place to assure respondents that their responses will be treated in a secure and private manner. Prior to the start of the survey, the prospective respondent will be shown a landing page with informed consent text, written in simple language. In addition to the landing page, a Frequently Asked Questions (FAQs) link will be provided.

Consent includes a brief description of the project study and contains the following key points:

- Purpose of the study;
- Study procedures;
- Estimated time required to participate;
- Potential risks and benefits;
- Statement that participation is voluntary;
- Telephone number and email address they can use if they have further questions; and
- Authority for the data collection.

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

IRB Approval

CDC determined that the project is not human subjects research and therefore not needing IRB approval (Attachment 11).

Sensitive Questions

The proposed data collection effort does not include sensitive questions.

A12. Estimates of Annualized Burden Hours and Costs

The estimate of burden for the instrument (30 minutes per completed response) is based on cognitive interviews with 7 respondents and the burden of the prior 2014 survey. Responses for the main data collection are expected to be primarily collected via a web-based survey instrument (90% were collected via the web-based survey in 2014); a hard copy self-administered questionnaire (paper-and-pencil) and computer-assisted telephone interview (CATI) will also be offered. The annual burden hours requested (1,693) are based on the number of completed responses we expect to collect over the requested period for this clearance.

The survey, which will only be administered once, is estimated at no longer than 30 minutes per respondent. We anticipate that we will need to draw a sample of 4,417 municipalities from the Census of Governments file in order to meet our target of 2,650 completes.

Tables A.12.a and A.12.b. display the annualized estimated hour and cost estimates for data collection. There are no direct costs to the respondents themselves. However, the costs may be calculated in terms of the costs of staff time spent in responding to the questionnaire (row 1 in each table). Row 2 in the tables below represent the estimated time trained telephone interviewers may spend with respondents to confirm they are speaking with the correct person, answer any questions he/she may have prior to the start of the full survey, or prompt for completion via the web. Sampled municipalities are expected to receive a minimum of three (3) nonresponse follow-up telephone contacts of which 1 is expected to result into result in full contact with the identified respondent. The follow-up full telephone contact is estimated to carry a burden of 5 minutes. Not all municipalities will require follow-up telephone calls and not all telephone contacts will result in full contact with the identified respondent for the municipality.

Table A.12.a. Estimated Annualized Burden Hours

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in Hours)	Total Burden Hours
City or Town Planner or Manager	National Survey of Community-Based Policy and Environmental Supports for Healthy Eating and Active Living	2,650	1	30/60	1,325
	Telephone Non-response Follow-up Contact Script	4,417	1	5/60	368
	TOTAL				**1,693**

The annualized wages are based on data from the United States Department of Labor, Bureau of Labor Statistics (2019) for urban and regional city planners who work an estimated 40-hour work week and usual median hourly earnings of $35.12 (see https://www.bls.gov/ooh/life-physical-and-social-science/urban-and-regional-planners.htm). The total cost to respondents is $59,458.16, as summarized below in Table A.12-b.

Table A.12.b. Estimated Annualized Burden Costs

Type of Respondents	Form Name	Total Annual Burden Hours	Average Hourly Wage Rate	Total Respondent Labor Cost
City or Town Planner or Manager	National Survey of Community-Based Policy and Environmental Supports for Healthy Eating and Active Living	1,325	$35.12	$46,534

	Telephone Non-response Follow-up Contact Script	368	$35.12	$12,924.16
			TOTAL	**$59,458.16**

A13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers
There will be no respondent capital and maintenance costs.

A14. Annualized Cost to the Government
The total contract award to CDC's data collection contractor, NORC at the University of Chicago, is $584,955. This amount represents the total cost to execute the study and includes the cost of (1) developing instruments, correspondence, and administrative forms; (2) developing the sampling plan and sample selection; (3) developing the data collection and analysis plans; (4) systems programming of the data collection software and tracking systems; (5) study pretest; (6) data collection; (7) data cleaning and processing; (8) data tabulation and analyses; (9) report writing; and (10) overall project management.

Additional costs will be incurred indirectly by the government in personnel costs of staff involved in oversight of the survey and data analysis. Direct costs in CDC staff time will be approximately $68,333. These costs are derived from the estimated hours and salary of the project team, staff to obtain government clearances, and staff to address administrative issues related to the contract
The total estimated annualized cost to the government is $653,288.

Table A14.a. Total Cost to the Federal Government

Operational and Maintenance Costs	Estimated Annualized Federal Government Cost	Total Annualized Cost (O&M + Labor)
$584,955	**$68,333**	**$653,288**

A15. Explanation for Program Changes or Adjustments
This is a new data/information collection; an 24-month approval is requested.

A16. Plans for Tabulation and Publication and Project Time Schedule
Publication plans for the study include the production of community-level data dissemination reports and publication of scientific articles. The community-level data dissemination report will be provided to communities completing the study and will include individualized community data compared with summary data from communities of similar demographic characteristics (e.g., region, size). Additional reporting of findings will consist of publications in scientific journals (e.g., public health, epidemiologic journals), which will describe the updated prevalences and characteristics of communities that have policy and environmental supports for healthy eating and active living as well as how these have changed since 2014.

The proposed data collection, analysis, and reporting study timeline is shown in Table A.16.a. OMB clearance is expected by Spring 2021. Data collection would begin approximately 1 month after OMB approval is obtained, with a duration of 4 months. We may adjust the timeline, depending on the date of OMB approval and other implementation factors.

Table A.16.a. Project Time Schedule for Data Collection, Analysis, and Reporting Activities

Project Time Schedule	
Activity	**Time Schedule**
Letters sent to respondents	1 month after OMB approval
Information/Data collection	2-4 months after OMB approval
Preparation of SAS data file (data cleaning, processing, tabulation, and analysis using SAS software)	5 months after OMB approval
Final data dissemination reports	7 months after OMB approval
Final report summarizing procedures, findings, and lessons learned	8 months after OMB approval

Data analysis will include tables that document the overall prevalence of the different supports and the prevalence of supports by demographic characteristics. Data will be weighted to account for the survey design and non-response. Data will be linked to census data on community characteristics (e.g. region, urban status) by FIPS codes. Difference in the prevalence of characteristics by community characteristic will be assessed using chi square tests. Logistic regression analysis will be used to determine whether estimates of supports vary by community characteristics. Changes in estimates between 2014 and 2021 will be assessed using chi square test. Two illustrative table shells are shown below.

Example Table A. Prevalence and changes in policy or practice XX among U.S. municipalities, CBS HEAL, United States, 2014 and 2021

Municipality Characteristic	N	Reported use of practice or policy X in 2014		Reported use of practice or policy X in 2021		Difference between 2021 and 2014	
		% (95% CI)	p-value[a]	% (95% CI)	p-value[a]	% (95% CI)	p-value[a]
Overall							
Population Size							
<2500 people							
2500 – 49,999 people							
≥50,000 people							
Urban Status							
Rural (≤50% urban)							
Urban (>50% urban)							
Geographic Region							
West							
Northeast							
South							
Midwest							
Median Education Level							
≤High school							
≥Some college							
Poverty Prevalence							
<20% below FPL							
≥20% below FPL							
Race/Ethnicity							
>50% non-Hispanic white							
≤50% non-Hispanic white							

Example Table B. Adjusted odds ratio of association between municipality characteristics and policy/practice X, CBS HEAL, United States, 2021

Municipality Characteristic	Reported use of practice or policy X		Reported use of practice or policy X		Reported use of practice or policy X	
	AOR[a] (95% CI)	p-value	AOR[a] (95% CI)	p-value	AOR[a] (95% CI)	p-value
Population Size						
<2500 people	Ref					
2500 – 49,999 people						
≥50,000 people						
Urban Status						
Rural (≤50% urban)	Ref					
Urban (>50% urban)						
Geographic Region						
West	Ref					
Northeast						
South						
Midwest						
Median Education Level						
≤High school	Ref					
≥Some college						
Poverty Prevalence						
<20% below FPL	Ref					
≥20% below FPL						
Race/Ethnicity						
>50% non-Hispanic white	Ref					
≤50% non-Hispanic white						

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

The display of the OMB expiration date is appropriate.

A18. Exceptions to Certifications for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

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