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**Focus Group Testing to Effectively Plan and Tailor Cancer Prevention and Control  
Communication Campaigns**

Generic Information Collection  
OMB No. 0920-0800  
Reinstatement

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Supporting Statement Part A

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# Contents

<b>A. Justification</b> .....	4
A1. Circumstances Making the Collection of Information Necessary.....	4
A2. Purpose and Use of the Information Collection.....	5
A3. Use of Improved Information Technology and Burden Reduction.....	6
A4. Efforts to Identify Duplication and Use of Similar Information.....	6
A5. Impact on Small Businesses or Other Small Entities.....	6
A6. Consequences of Collecting the Information Less Frequently.....	6
A7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5.....	7
A8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency.....	7
A9. Explanation of Any Payment or Gift to Respondents.....	7
A10. Assurance of Confidentiality Provided to Respondents.....	8
A11. Institutional Review Board (IRB) and Justification for Sensitive Questions.....	9
A12. Estimates of Annualized Burden Hours and Costs.....	10
A13. Estimates of Other Total Annual Cost Burden to Respondents or Recordkeepers.....	11
A14. Annualized Cost to the Government.....	11
A15. Explanation for Program Changes or Adjustments.....	11
A16. Plans for Tabulation and Publication and Project Time Schedule.....	12
A17. Reason(s) Display of OMB Expiration Date Is Inappropriate.....	12
A18. Exemptions to Certification for Paperwork Reduction Act Submissions.....	12
<b>References</b> .....	13

## List of Tables

Table A8-A. Consultations within DCPC.....	6
Table A12-A: Estimated Annualized Response Burden for each Method.....	9
Table A12-B: Estimated Annualized Cost to Respondents.....	10

## List of Appendices

- A1. Legislative Authority: Public Health Service Act, 42 U.S.C. 241
- A2. The Gynecologic Cancer Education and Awareness Act of 2005
- A3. Education and Awareness Requires Learning Young (EARLY) Act
- B. 60-Day Federal Register Notice
- C1. Example of a Screening Form
- C2. Example of a Consent Form
- C3. Example of a Discussion Guide
- D. Health Messages for DCPC's Current Campaigns

**Goal of the project:** To plan, develop, and/or tailor cancer-related health messages and communication campaigns.

**Intended use of the resulting data:** To design, produce, and disseminate cancer educational materials and information for the general public.

**Methods to be used to collect data:** Focus groups, in-depth interviews.

**The subpopulation to be studied:** General public.

**How data will be analyzed:** Focus-group and in-depth interview methodology.

## A. Justification

### A1. Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC), Division of Cancer Prevention and Control (DCPC), requests a three-year Office of Management and Budget (OMB) approval for an existing generic collection (OMB number 0920-0800, expires 10/31/2021) with reinstatements. As noted in the original application, the cancer burdens had evolved, priorities have shifted, and DCPC has engaged in additional communication campaign efforts, such as one for breast cancer for women under age 45. The modes available to gather information to inform health communication campaigns have also changed. The original application included focus groups conducted in person or by telephone. This reinstatement includes four other modes: (1) online focus groups and in-depth interviews conducted (2) in person, (3) by phone, or (4) online (using a videoconferencing platform). Each application using this generic information request would specify the mode and audience. In addition, the original application focused on the general public and healthcare professionals. This reinstatement includes the general public only to align with the current communications contracts. There is no change in burden hours and respondents at this time.

The generic information collection request is in accordance with CDC's mission to conduct, support, and promote efforts to prevent cancer, reduce its risk, increase early detection and better treatment, and improve the quality of life for cancer survivors authorized by Section 301 of the Public Health Service Act (PHSA, 42 U.S.C. 241) (**Attachment A1**). To date, there is authorizing legislation for two current DCPC campaigns: (1) the Gynecologic Cancer Education and Awareness Act of 2005, Section 247b-17 of the PHSA, also known as Johanna's Law (**Attachment A2**) and (2) the Education and Awareness Requires Learning Young (EARLY) Act, section 280m) (**Attachment A3**).

Cancer is the second leading cause of death in the United States, exceeded only by heart disease. In 2018 (the most recent year numbers are available), more than 1.7 million were diagnosed with cancer and nearly 600,000 died of the disease in the United States (<http://www.cdc.gov/uscs>). It is also a group of related diseases that have different calls to

action to lower risk depending on the risk factors and/or availability of recommending screenings.

Since its approval in 2009, this generic collection has been used to collect information via in-person focus groups to inform DCPC's *Inside Knowledge: Get the Facts About Gynecologic Cancer Campaign*, *Screen for Life: National Colorectal Cancer Action Campaign* and other CDC cancer communication campaign initiatives like *Bring Your Brave*. This data collection has enabled CDC to design, produce, and disseminate colorectal cancer, gynecologic cancer, and breast cancer in young women educational materials and information for the public and for health care providers more effectively.

DCPC's health communication campaigns are rooted in the Health Communication Process (HCP), a scientific model with four stages: 1) planning and strategy development, 2) developing and pretesting concepts, messages, and materials, 3) implementing the program, and 4) assessing effectiveness and making refinements (National Cancer Institute, 2002). Strategic participation in evaluation increases the ability to achieve the goals and/or objectives of a health communication campaign. Evaluation can occur during different stages, namely formative evaluation (stage 2), process evaluation (stage 3), and extending to outcome or summative evaluation (stage 4) (Cooper et. al, 2005).

## **A2. Purpose and Use of the Information Collection**

DCPC's communication campaigns are at different stages in the HCP. The purpose of this generic clearance request is to continue moving current campaigns and new health messages toward the next stage, conducting the complementary evaluation components, and starting at the beginning of the HCP as needed. In instances when focus group testing and in-person interviews can contribute information, this generic would be used. OMB approval will be requested separately for each information collection activity describing each activity's specific purpose with respect to the HCP, methods, and burden estimate, including a screening form, example consent form, and discussion guide. Samples are presented in **Attachments C1** (screening form), **C2** (consent form), and **C3** (discussion guide).

The ability to tailor information collections to specific circumstances and the ability to move rapidly from one stage of the HCP to another is the major advantage of this generic clearance. In cases for new cancer prevention or control health messages, preliminary ones may already exist, and DCPC could begin focus groups or in-depth interviews at a later stage of the HCP. Also, tailored information collections can be conducted on an as-needed basis.

This generic has helped to inform the health messages for DCPC's campaigns (**Attachment D**). Over the past three years, this generic has informed breast cancer in young women messages for African-American and American Indian/Alaska Native women. The materials from these focus groups are in development.

There is an opportunity to modify our existing messages as new cohorts become eligible for recommended cancer screenings, increases in rates of new cancers that are diagnosed are reported (when rates are decreasing for all cancers combined), or as screening recommendations change.

### **A3. Use of Improved Information Technology and Burden Reduction**

Electronic data collection methods have limited applicability to focus groups, other than video- or audio-taping discussions. However, whenever possible, DCPC staff will employ electronic technology to collect and process data in order to reduce respondent burden and aid in data processing and reporting efficiency.

Efforts have been made to design items that are easily understandable, not duplicative in nature, and least burdensome. In all instances, the number of items posed will be held to the minimum required in order to elicit the necessary formative or materials-testing data. One indirect cost of online modes is the saving in travel costs and facility rentals and in-depth interviews allows for flexibility of scheduling.

### **A4. Efforts to Identify Duplication and Use of Similar Information**

CDC has determined that the planned data collection efforts do not duplicate any other current or previous data collection efforts at other Federal agencies. Congress has authorized CDC to manage *Inside Knowledge: Get the Facts About Gynecologic Cancer Campaign* and *Bring Your Brave. The Screen for Life: National Colorectal Cancer Action Campaign* has been managed by CDC for more than 20 years.

### **A5. Impact on Small Businesses or Other Small Entities**

As is the case with many communication campaigns, DCPC incorporates health care professionals into the target populations. When formative, materials-testing, and/or outcome research is a necessity with this audience, CDC works through established medical and professional societies and contractors to gain access and obtain necessary participation. Efforts will be carefully planned to minimize the burden on physician practices and other small entities.

### **A6. Consequences of Collecting the Information Less Frequently**

As the HCP illustrates, formative evaluation is a critical segment of a scientifically sound campaign effort. Formative evaluation, often encompassing concept, message, and materials testing activities, is essential in pre-testing materials to evaluate a wide variety of dimensions that include, but are not limited to, appeal, saliency, clarity, cultural appropriateness and readability/understandability. If a concept and/or a message is not tested, then resources could be expended without necessary attention and preparation paid to the overall communication

objective. Forgoing testing can also increase the likelihood of unintended consequences from an irrelevantly perceived message and/or decreased credibility of an organization and/or a Federal health official (Wallendorf, 2001 & Harris-Kojetin et. al, 2001). Finally, if materials are not tested with the intended audience, a poor execution strategy could weaken a sound concept.

There are no legal obstacles to reducing the burden.

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

There are no special circumstances. The activities outlined in this package fully comply with all guidelines of 5 CFR 1320.5.

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

**A8.a Public Notice**

As required by 5 CFR 1320.8(d), a notice for public comments was published in the Federal Register on July 26, 2021 (Vol. 86, FR. 40050, pages 40050-40051; **Appendix B**).

**A8.b Consultation**

The proposed protocol and examples of the data collection instruments were developed and reviewed by DCPC staff noted who are directly involved in implementing the DCPC communications campaigns.

**Table A8-A. Consultations within DCPC**

<b>Name</b>	<b>Title</b>	<b>Phone</b>	<b>Email</b>	<b>Role</b>
Temeika Fairley	Health Scientist	770-488-4518	tff9@cdc.gov	COR
Virginia Kincaid	Health Communication Specialist	770-488-2914	ycn6@cdc.gov	Subject matter expert
Allyson Moehring	Health Communication Specialist	404-498-1576	nhx1@cdc.gov	Subject matter expert

**A9. Explanation of Any Payment or Gift to Respondents**

Incorporating modest incentives to aid in recruitment is considered justifiable in order to boost response rates and defray the cost of participation (e.g., transportation and childcare). Also, it is

standard practice among commercial market researchers to offer incentives to participants in message and materials-testing focus groups.

As shown by the literature referenced below, the payment of incentives can provide significant advantages to the government in terms of direct cost savings and improved data quality.

While impact of monetary compensation of focus group participation has not been empirically studied, Krueger (1994) cautions that without providing minimal levels of monetary compensation, insufficient numbers of participants will attend and results will not be useful. However, there is substantial evidence that monetary incentives increase response rates to focus groups (Krueger, RA and Casey, MA (2009)).

#### *Level of Incentive Payment*

Focus group participants may be provided with a modest incentive for their participation. If CDC determines that an incentive is needed to support successful completion of a project, the information collection request submitted to OMB will include a case-specific justification describing the circumstances, amount, and type of incentive proposed. CDC understands that approval of any incentive offered under each individual genIC is at the discretion of OMB.

#### *Reduced Data Collection Cost*

While there is minimal published literature on focus group incentive rates, empirical evidence suggests that motivation is increased when an incentive is present. Discussion of remuneration as a technique to speed responses and expand response rates is not complete without mentioning the trade-off between the costs of incentives and the costs of efforts to foster timely and complete participation. The goal is to find the highest response rate at the lowest overall cost to the government.

In the National Adult Literacy Survey by Berlin (1992) and colleagues (OMB No. 1850-0654, exp. 8/31/1993), a \$20 incentive resulted in not only higher response rates from the sample cohort but also lower costs per completed case than the comparison group. Importantly, the incentives provided higher response rates from adults with lower-than-average levels of education and basic literacy and numeracy skills (e.g., the NELS: 88 subset of high school dropouts).

#### *Reduced Bias*

The most important aspect of an incentive plan may be its potential for reducing response bias, underreporting bias, and similar sources of error. Findings from the [National Survey of Family Growth](#) demonstrated that incentives not only had positive effects on response rates, but they also increased the accuracy of reporting. Incentives are necessary for testing in order to ensure that those who are willing to participate are as representative as possible of the wider public.

Failure to provide a basic incentive is likely to bias samples in the direction of well-educated individuals who are generally predisposed to be helpful.

#### **A10. Assurance of Confidentiality Provided to Respondents**

The National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) has reviewed this OMB submission and determined that the Privacy Act is not applicable. Privacy Act applicability will be re-reviewed for each individual information collection request submitted under this generic clearance.

##### **A. Safeguards**

Respondents will be recruited by the data collection contractor using commercial focus group companies, and other sources. CDC will not create a record system for this project. Although respondent names and contact/demographic information may be used to determine eligibility and to schedule focus group participation, personal identifying information will not be linkable at any time to response data collected during these discussions. A minimum amount of demographic information may be retained in notes for purposes of reporting novel findings but will not be sufficient to identify respondents. Participants will be informed that discussions will be video and/or audio-taped and transcribed, and that recordings will be destroyed after completion of each report on findings. DCPC staff, in conjunction with a communications contractor, will collect and evaluate the audience research data.

##### **B. Consent**

All information provided by respondents will be treated in a secure manner and will not be disclosed, unless otherwise compelled by law. Typically, informed consent will be obtained from respondents (example in **Attachment C2**) and they will be informed that participation is voluntary; they do not have to answer questions if they do not want to, their responses will be treated in a secure manner, and they can stop participating at any time. Typically, the information collection activities conducted under this generic will not require IRB review and approval since this the primary purpose is to inform and improve existing public health awareness campaigns. If a specific information collection is determined to require IRB approval, DCPC will obtain the required approval.

##### **C. Nature of Response**

Respondent participation is entirely voluntary, as noted in the example consent form (**Attachment C2**).

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

The majority of questions asked will not be of a highly sensitive nature. However, some respondents may find thinking about and discussing the disease of cancer unpleasant. A portion of respondents could consider questions about race, ethnicity, or other demographic characteristics to be sensitive, although such questions are unlikely to be highly sensitive.



Additionally, a portion of respondents may feel uncomfortable answering some questions about their individual cancer experiences, level of disease awareness, and/or adopted preventive behaviors (or lack thereof) associated with cancer. Such questions, if asked, would be necessary for the purposes of a targeted communication campaign and thus to the information collection. To minimize psychological distress, the moderator will inform participants that they do not have to respond to any questions they do not want to answer and they may stop participating at any time.

**A12. Estimates of Annualized Burden Hours and Costs**

A. DCPC estimates that 800 respondents will be involved in focus groups or in-depth interviews. The discussion guide will generally consist of questions similar to the example in **Attachment C3** and changed according to the type of cancer and target population. The average burden for a focus group or in-depth interview will be one to two hours.

Potential respondents will be screened for interest and eligibility using a customizable screening form similar to the example in **Attachment C1**. Based on our experience recruiting focus group participants from master lists of eligible or interested persons, it is estimated that twice the target number of needed respondents must be screened to yield the targeted number of respondents. The estimated burden per response for screening is three minutes.

The estimated burden to respondents is summarized in Table A12-A below.

**Table A12-A: Estimated Annualized Burden to Respondents**

Type of Respondents	Form Name	Number of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
General Public	Screening Form	1600	1	3/60	80
General Public	Discussion Guide	800	1	2	1,600
Total					1,680

Information will be collected over a three year time period. There are no costs to respondents except their time to participate in the focus groups. The total annualized burden to respondents is 1,680 hours.

B. Table A12-B presents the calculations for cost of respondents' time using two categories of mean hourly wages from U.S. Department of Labor, Bureau of Labor Statistics [National](#)

[Occupational Employment and Wage Estimates](#) (May 2020). The total estimated annualized respondent cost (including the screening form) is \$45,478.

**Table A12-B: Estimated Annualized Cost to Respondents**

Type of Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Total Burden (in hours)	Average Hourly Wage Rate	Total Cost
General Public	Screening Form	1600	1	80	\$27.07	\$2,166
General Public	Focus Group Guide	800	1	1600	\$27.07	\$43,312
Total						\$45,478

**A13. Estimates of Other Total Annual Cost Burden to Respondents or Recordkeepers**

None.

**A14. Annualized Cost to the Government**

The estimated average annual cost to the Federal government for the proposed focus group activities is \$491,600 (\$245,800 per campaign). This figure encompasses the salary of two GS-13 employees, communication contract costs, as well as fees for identifying and recruiting participants, incentive payments, facility rental, and transcription.

<b>Estimated Annualized Cost to the Government, per Campaign and Total</b>	
Cost Category	Estimated Annualized Cost
Federal employee costs, per campaign (20% FTE of 2 GS-13, Step 5 @ \$110,000/year)	\$44,000
Contractual costs for focus group facility rental (if needed), focus group moderator, participant recruitment, and report on findings, per campaign	\$225,000
<b>Subtotal, per campaign</b>	<b>\$269,000</b>
<b>Total, average of 3 campaigns per year</b>	<b>\$807,000</b>

**A15. Explanation for Program Changes or Adjustments**

There are three reinstatements in this renewal. First, another Congressionally-mandated communication campaign (*Bring Your Brave*) is included. Second, the modes available to gather information to inform health communication campaigns have expanded to include (1) online

focus groups and in-depth interviews conducted (2) in person, (3) by phone, or (4) online (using a videoconferencing platform). These modes were added to allow for flexibility in recruiting and scheduling respondents. Third, this reinstatement focuses on the general public to align with the upcoming communications contracts.

#### **A16. Plans for Tabulation and Publication and Project Time Schedule**

Project timelines will vary and will be completed with each genIC including plans for recruitment, testing, analysis, or reporting of any novel findings, if needed.

In general, findings will inform campaign planning efforts, provide guidance on efforts to refresh existing materials, and aid in the sound development of new communication products for specific cancer communication initiatives. When applicable, findings will be disseminated through presentations and/or posters at meetings and publications in peer-reviewed journals. All abstracts, poster presentations, and manuscripts will undergo CDC clearance review prior to submission to conferences or journals.

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

The OMB expiration date will be displayed.

#### **A18. Exemptions to Certification for Paperwork Reduction Act Submissions**

No certification exemption is being sought.

## References

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