

**Supporting Statement A for Paperwork Reduction Act Collection Submissions
for the Collection of Quantitative and Qualitative Evaluation and Assessment”**

Project Title: National Hypertension Control Initiative

Department of Health and Human Services
Office of Minority Health
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SUPPORTING STATEMENT
NATIONAL HYPERTENSION CONTROL INITIATIVE

This is an initial OMB submission.

A. Justification

1. Circumstances Making the Collection of Information Necessary

As part of the federal response to COVID-19, the U.S. Department of Health and Human Services (HHS) has funded a new initiative involving two cooperative agreements with the American Heart Association (AHA) to improve COVID-19-related health outcomes by addressing hypertension (high blood pressure) among racial and ethnic minority populations. According to the Centers for Disease Control and Prevention, having high blood pressure may increase the risk of severe illness from COVID-19.

The \$32 million project from the HHS Office of Minority Health (OMH) and the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care will implement a national initiative to improve blood pressure control among the most at-risk populations, including racial and ethnic minorities. The three-year project will support 350 participating HRSA-funded health centers by providing patient and provider education and training for effective hypertension control as well as integration of remote blood pressure monitoring technology into the treatment of hypertension for patients served by participating health centers. The project will also utilize the American Heart Association's targeted media campaigns and collaborating community-based organizations (CBOs) to help reach Black, Latino, and other impacted communities with i) culturally and linguistically appropriate messages, ii) access to blood pressure screenings, and iii) connection to health centers to encourage proper treatment and management of hypertension of screened individuals. **This initiative serves to increase the number of adult patients with controlled hypertension and reduce the potential risk of COVID-related health outcomes.**

AHA's objective is to identify promising approaches/best practices that combine new blood pressure measurement technology, lifestyle/behavioral modifications, and locally targeted media campaigns to address uncontrolled – including undiagnosed – high blood pressure, especially in racial and ethnic minority, American Indian/Alaska Native and other at-risk populations, given the association of hypertension with worse COVID-19 health outcomes.

AHA proposed a three-pronged strategy to meet this objective:

1. Community outreach & integration
2. Healthcare professionals training
3. Patient and public education

This OMB ICR request describes data collection activities for each of these three areas involving methods such as: individual interviews with staff from HRSA-funded health centers participating in the NHCI initiative, focus groups, web-based polls and surveys provided via online educational workshops, webinars, one-on-one question and answer sessions, surveys related to content provided via public service announcements (PSAs), various forms of feasibility testing such as piloting data collection protocols and procedures to establish a deeper understanding of the interests and needs of NHCI participants for educational delivery and materials, and providing information using online data reporting portals. Each data collection method is described in detail in Section 2.

2. Purpose and Use of Information Collection

This information request describes data collection activities involving a set of research activities with consumers and professionals from community based organizations (CBOs) and community health centers (CHCs) to better understand their needs and preferences related to participation in the NHCI initiative and improving hypertension control in their respective communities. The AHA will use the information collected to improve its implementation of the NHCI initiative and report ongoing outcomes.

Purpose

AHA's objective is to identify promising approaches/best practices that combine new blood pressure measurement technology, lifestyle/behavioral modifications, and locally targeted media campaigns to address uncontrolled – including undiagnosed – high blood pressure in racial and ethnic minority, American Indian/Alaska Native and other vulnerable populations, given the association of hypertension with worse COVID-19 health outcomes. AHA will produce reports and publications highlighting lessons learned during program implementation, activity outcomes, and best practices gleaned from the demonstration project.

The information collected by AHA will also provide formative input and feedback on how best to reach and engage intended audiences for the NHCI project. It will also allow AHA to make appropriate adjustments in content and methodology used in development and testing stages in order to improve the final products.

The quantitative data collected by AHA will not be used to infer statistical significance or generalize to a broader population.

The research methods outlined in this supporting statement have five major purposes:

1. Conduct a needs assessment and feasibility analysis to identify capacity, need, fit, and usability among CHCs and CBOs given the focus on systems change. This will be the primary focus for Year 1 of evaluation activities and will guide project implementation and evaluation plans for years 2 and 3.
2. Evaluate changes in health outcomes, such as rates of blood pressure control, among participating health center sites. Research questions include: To identify

- and verify audience segmentation strategies for providing disease prevention and health promotion information
3. Monitor performance of all program activities.
 4. Assess changes in clinical behaviors and practices related to hypertension management and best practices among healthcare professionals.
 5. Assess changes in knowledge, attitudes and behaviors related to blood pressure among individuals targeted by a public awareness campaign and patient education activities.

How the information will be collected

Data collection methods will be qualitative and quantitative and may include in-depth interviews, focus groups, web-based surveys, card sorting, and various forms of usability testing of materials and interactive tools to assess the public's understanding of disease health content, responses to prototype materials, and barriers to effective use.

Specifically, the AHA will engage in:

1. Primary Data Collection

- a. **Qualtrics Survey.** Collecting participation and outcome data from CHCs and CBOs using an online survey administered using Qualtrics. This will be used during the first two quarterly data collection periods. (Appendix A and Appendix B)
- b. **DREaM.** Collecting participation and outcome data from CHCs and CBOs using an online Data Reporting, Evaluation, and Monitoring (DREaM) dashboard. This is the evolution of the Qualtrics survey and will be used after the first two quarterly data collection periods. Appendix A and Appendix B)
- c. **Feasibility Assessments.** Engaging in qualitative and quantitative data collection using focus groups, interviews and questionnaires from CHCs and CBOs to assess the feasibility of various data collection and program implementation approaches. (Appendix C)
- d. **EmPOWERED to Serve.** Administering health lessons to community members via Community-based Organizations and assessing awareness, education, and referral outcomes. (Appendix D)

2. Secondary Data Collection

- a. **Social Needs Platforms.** CBOs and CHCs will be asked to use one of two publicly-available social needs platforms (Find Help or Unite Us) and CHCs will be asked to use the Unite Us social needs platform to connect individuals receiving services at the CBOs to Community Health Centers (CHCs), and vice versa, to receive additional blood pressure-related services. (Appendix E and Appendix F)

- b. **Remote Patient Monitoring.** AHA will be partnering with Canary Telehealth to collect aggregate metrics from a subset of Community Health Centers (CHCs).
- c. **Blood Pressure Control Metrics via Electronic Health Records.** AHA will be partnering with external research partners to obtain reports of aggregated blood pressure control metrics from NHCI CHCs to inform clinical decision making, clinical quality improvement, and clinical outcomes.

Primary Data Collection Details

- a. **Qualtrics Survey.** AHA will administer a web-based survey to CHCs and CBOs using Qualtrics. The purpose of the survey is to track activities across the NHCI initiative regarding efforts to raise public awareness, strengthen health center care, and build health center-community linkages to improve blood pressure control. Specifically, CHCs and CBOs will provide qualitative and aggregated quantitative data regarding patient blood pressure health metrics, referrals, practitioner training, and patient blood pressure control education on a quarterly basis throughout the duration of the grant. Access to the survey will be via email links sent along with a hardcopy of the survey. Qualtrics was selected as a test platform prior to full development of DREaM due to its easy user interface, and the ability to quickly revise and update questions and response options, compared to developing an online dashboard (DREaM). AHA will administer the Qualtrics survey twice (for the first two quarterly data collections following OMB approval of this ICR).
- b. **Data Reporting, Evaluation, and Monitoring (DREaM) Dashboard.** AHA will take the lessons learned from the Qualtrics survey to develop an online data collection dashboard – DREaM. The purpose of the tool is to track and monitor systems change implementation process information from CHCs and CBOs. An advantage of using the dashboard is the ability to minimize burden on CHCs and CBOs by linking data fields to previous data collection and other information AHA has to minimize repeated data entry every quarter. Ultimately, DREaM will be collecting operational and programmatic data from the CHCs and the CBOs and enable respondents and AHA to view data summaries and reports on-demand, facilitating easier data collection and program implementation. CHCs and CBOs will complete DREaM 4 times (on a quarterly basis from May 2022 to December 2023).

CHCs and CBOs will receive technical assistance on how to navigate and respond to the data requested in the DREaM.

- c. **Feasibility Assessments.** Upon OMB approval, AHA will conduct feasibility assessments to assess how CHCs and CBOs are implementing the NHCI. The

feasibility assessments will be conducted annually at the beginning, middle and end of the year. AHA will purposively select a subset of CHCs and CBOs to complete no more than 16 CHC and 16 CBO focus groups. Information gleaned from the feasibility assessments will inform NHCI programmatic and implementation improvements.

- d. **Empowered to Serve.** AHA will engage CBOs in the EmPOWERED to Serve (ETS) Health Lessons, a curriculum offering a way to engage communities and motivate community members to take steps towards creating a culture of health. AHA will collect information from participants seeking services at CBOs via an online pre-/post- quiz. The quizzes all follow the same structure and in addition to requesting participant demographic information, will collect information on the following topics: i) knowledge about blood pressure control and management, ii) confidence related to blood pressure and lifestyle changes related to blood pressure control, and iii) participant feedback related to ETS modules.

CBOs will report the following aggregated metrics to AHA: the number of participants that completed the curriculum, the number that completed each quiz, and the number of referrals to clinical care.

The curriculum consists of four training modules:

- i. Control your Blood Pressure
- ii. Get Active
- iii. Know Diabetes by Heart
- iv. Salt and Cardiovascular Risk

Secondary Data Collection

- a. **Social Needs Platforms.** CBOs and CHCs will be asked to use one of two publicly-available social needs platforms (Find Help or Unite Us) to connect individuals receiving services at the CBOs to CHCs, and vice versa, to receive additional blood pressure-related services. The AHA has entered into an agreement with CBOs, Find Help, and Unite Us to facilitate the data collection.

Specifically, when participants seek services at a CBO, they will access the social needs platform online and complete information about i) participant demographic characteristics, and ii) social needs such as transportation needs, food insecurity, and perceived stress. Each CBO could then use the social needs platform to refer participants to CHCs. Similarly, CHCs will also be able to make participant referrals to CBOs for enhanced social service needs. In turn, the social needs platform will share the deidentified data collected at each CBOs and CHCs in aggregate to AHA, including the number of referrals made to CHCs.

Prior to CBOs and CHCs utilizing the social needs platforms as part of their service delivery process, they will be asked to complete a standard readiness assessment developed by Unite Us to determine the need, willingness, and experience level of CBOs and CHCs related to using the Unite Us platform. Information from the assessment will be used by Unite Us to inform the level of support and resources needed by each CBO/CHC to utilize the Unite Us platform and determine the corresponding timing of onboarding to the Unite Us platform.

- b. **Remote Patient Monitoring.** AHA will be partnering with Canary Telehealth to collect aggregate metrics from a subset of CBOs. Canary Telehealth will aggregate metrics on key questions pertaining to blood pressure self-management across participating CBOs and report aggregate data to AHA. AHA will not have access to primary person-level data, rather, AHA will be receiving secondary data from Canary Telehealth.

Canary Telehealth currently engages with community partners to collect patient-level data through an app-based method. As such, Canary Telehealth and their partners are engaged in independent data sharing agreements, and privacy and confidentiality agreements. As part of this evaluation, the AHA has entered into data sharing agreements with CBOs, enabling Canary Telehealth to share data with AHA.

- c. **Blood Pressure Control Metrics via Electronic Health Records.** AHA will be partnering with external research partners to obtain reports of aggregated blood pressure control metrics from CHCs to inform clinical decision making, clinical quality improvement, and clinical outcomes. These data will be aggregated at the CHC level and allow NHCI to tailor technical assistance to better meet the needs of each CHC. AHA will not have access to primary person-level data, rather, AHA will be receiving secondary aggregated data from this process.

3. Use of Improved Information Technology and Burden Reduction

Remote, web-based testing is a cost-efficient method to obtain quantitative and qualitative input from a greater number of participants who are more representative of the intended audience, at large. Below is a description of how AHA will use technology, when possible, to reduce response burden.

Online data reporting portal (DREaM) will be used to simplify quarterly data collection from CHCs and CBOs. The online platform will be pre-populated with available information from administrative data and previously completed CHC/CBO assessments to minimize participant data entry.

Interviews and focus groups are recorded so that written transcripts of the interviews are available for review. Remote interviews and focus groups may be conducted by telephone or through web conferencing software.

Online surveys may be conducted remotely and online through a survey tool such as Qualtrics or SurveyMonkey.

Usability testing of the various data collection approaches proposed can be conducted either in person or remotely using Web conferencing software. The participant's screen and voice are typically recorded during both in-person and remote sessions so they can be reviewed later for reporting purposes.

4. Efforts to Identify Duplication and Use of Similar Information

It is not expected that any of the information to be submitted to AHA during these formative research studies is duplicative or is already in the possession of the federal government. Specifically, publicly available data sources including the Uniform Data System (UDS) will be utilized to obtain information related to demographics and hospital infrastructure to ensure minimal reporting burden on our CHCs. The proposed information collection will allow AHA to significantly improve their ability to develop and implement the components of the NHCI project among intended audiences.

5. Impact on Small Businesses or Other Small Entities

Not applicable.

6. Consequences of Collecting the Information Less Frequently

Collecting the information less frequently would impair the ability of AHA to effectively evaluate the formation and community health impact of the NHCI project and make required changes to improve quality. Because NHCI is a 3-year, demonstration project with intended use to broaden findings for larger audiences, it is imperative that quality improvement processes happen frequently within this timeframe. DREaM data will be collected quarterly from CHCs and CBOs. Feasibility assessment data will be collected no more than three times a year from CHCs and CBOs throughout the three-year project duration. EmPOWERED to serve data from CBOs will be collected quarterly.

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

Various data collection activities may be conducted under the auspices of this request. This request fully complies with regulations.

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

There were no public comments received in response to the 60-day Federal Register (86 FR 51673) Notice published on 09/16/2021.

9. Explanation of Any Payment or Gift to Respondent

Individual participants will not receive any payment apart from the grant funds received by the HRSA-funded health center at which they are employed. Participating Community-Based Organizations (CBOs) will receive grant-based awards to assist with their implementation of program activities.

10. Information Regarding Confidentiality Provided to Respondents

AHA and their contractors will follow procedures for assuring and maintaining privacy to the extent allowed by law during all stages of data collection. Respondents will receive information about privacy via on-screen text prior to online survey initiation, in an advance email and verbally prior to initiation of interviews and focus groups. Respondents will be informed that all information will be kept private by the research team and that comments will not be associated with their names and will only be reported at a health center level to inform NHCI program implementation and tailor corresponding program assistance. Data will be kept private to the extent allowed by law.

Respondents in focus-group sessions will not know each other and will be asked to introduce themselves by first name only. The focus-group sessions will be held via Zoom or another online platform and require participants to be admitted by AHA staff to ensure only invited participants are in attendance. Participants will be encouraged to join the online focus-group from a room with a closed door so passersby cannot overhear the discussion. In-person research sessions will not be held to ensure the safety of participants due to COVID-related concerns.

At the beginning of each testing session, the facilitator will explain that the respondents' names and addresses will not be associated with the formative input session results. All data retrieved for the project, such as administrative data or interview notes, will be maintained in a secure password-protected environment. Access will be limited to staff working directly on the project that need to use the data for project purposes.

11. Justification for Sensitive Questions

No questions will be asked that are of a personal or sensitive nature and will focus on knowledge and behaviors related to hypertension and corresponding NHCI program implementation. In addition, all participants will have the opportunity to opt out of any survey questions they deem too sensitive to answer.

12. Estimates of Annualized Burden Hours and Cost

A. Burden Hours

Information collected in year 1 of this project was approved under OMB control number 0990-0379. The current ICR incorporates lessons learned from year 1 and covers years 2

and 3 of the project. The total annual estimated burden imposed by this collection of information is 8141 hours per year over a 2-year period. NHCI plans to implement certain strategies to ensure participant burden is as minimal as possible. Of note, this total annual estimated burden is a high-end estimate as the burden table includes all planned information collection, even though some items listed are only expected to occur in year 2 or year 3.

AHA will be engaging a total of 350 CHCs each year in NHCI-related activities. However, NCHI will continue to engage and expand the number of CBO partners implementing program activities and providing related data as the project progresses. As such, the estimated number of respondents for CBO-related data collection should increase with each project year. Thus, for the purposes of estimating annual burden hours, the number of CHC respondents and CBO respondents are defined as follows:

- CHCs: 350
- CBOs: 16 (i.e, the maximum number of CBO partners we expect to have each year of the project)

While quarterly CHC and CBO data entry will be via an online data platform (either via Qualtrics or the DREaM system), CHCs and CBOs will additionally be emailed a printable version containing all possible survey questions. This will allow participants to efficiently review all questions and confirm corresponding answers prior to accessing the online survey, which due to its online display, would present one to two survey questions at a time. Further, CHC and CBO participants will be provided a one-time training on how to utilize the DREaM system to ensure a smooth transition from survey delivery in Qualtrics versus DREaM. The estimated burden time per response for CHC/CBO quarterly data collection includes any time to research question responses, as well as the time associated with accessing and entering these responses into the online data platform.

Focus groups will be held with 16 CHCs and 16 CBO partners up to three times each year (beginning of year, mid-year, end of year). Each focus group session will take no longer than 1.5 hours.

AHA will engage up to 16 CBO partners to facilitate educational health lessons and providing related data. Individual consumers receiving health lessons will be asked to complete corresponding questionnaires; questionnaires should take an individual no longer than 10 minutes to complete. We anticipate each of our collaborating CBOs to deliver quarterly health lessons, with up to 200 individuals joining each lesson. Further, CBOs will work to collect questionnaire submissions from approximately 30 percent of attendees. Thus, for the purposes of estimating annual burden hours, the number of individual consumer respondents are calculated as follows:

- Consumers estimate: $16 \text{ CBOs} \times 4 \text{ lessons/year} \times 200 \text{ participants per lesson} \times 30\% \text{ response rate} = 3,120 \text{ consumers/year}$

Due to the nature of COVID, delivery of health lessons is anticipated to be via online platforms which then allows CBOs to reach a much larger number of individual community members. However, when it is safe to do so, CBOs may opt to have in-person

delivery of health lessons, and as such, fewer participants are expected to be in attendance at each lesson. Thus, given the uncertainty as to the timeframe of safe in-person activities, the estimated burden hours for this activity are conservatively inflated.

Social needs platforms will be utilized by CHCs and CBOs to assist with linkage of patients to needed services. In order to determine level of support needed by CHCs/CBOs to implement this process, a readiness assessment developed by Unite Us will be conducted. The assessment should take no longer than 15 minutes for each CHC/CBO to complete. Upon implementation, up to 10,000 individual consumers (approximately 2.5% of the number of patients identified as having hypertension in NHCI CHCs via UDS 2020 data) will be targeted to participate in SDOH-related activities annually, with an estimated maximum burden of 10 minutes per individual to be associated with this activity.

Remote patient monitoring (RPM) will be utilized by a subset of our CBO partners to collect aggregate metrics, with an estimate of up to 5 CBOs per year participating in this activity. A one-time training will be provided to our CBO partners to educate them on how to implement the RPM process. This training should take no longer than 1 hour to complete. Upon implementation, up to 2,750 individual consumers will be targeted to participate in the RPM activity annually, with an estimated maximum burden of 1-hour per individual to be associated with this activity. Canary Telehealth will provide aggregated metrics to AHA on a quarterly basis, with the estimated burden of this reporting totaling 1-hour per quarter, or 4 hours annually.

Blood pressure control metrics via Electronic Health Records (EHRs) will be utilized as a secondary data source. As such, processes are already in place to receive this information and therefore will have no corresponding data-reporting burden.

Type of Respondent	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
CHCs: Qualtrics survey (4 quarters)	350	2	1.5	1050
CBOs: Qualtrics survey (4 quarters)	16	2	2	192
CHCs: Training on data entry into DREaM	350	1	1	350
CBOs: Training on data entry into DREaM	16	1	1	16
CHCs: Feasibility assessment focus groups (2 times a year)	16	3	1.5	72
CBOs: Feasibility assessment focus groups (2 times a year)	16	3	1.5	72

Individual Consumers: ETS health lesson learning questionnaires	3,120	1	10/60	1,872
CHCs: Social Needs Platforms Readiness Assessment	350	1	15/60	88
CBOs: Social Needs Platforms Readiness Assessment	16	1	15/60	4
Individual Consumers: Social Needs Platform Participation	10,000	1	10/60	1,666
Management Occupation: Remote Patient Monitoring Provider data delivery	1	4	1	4
CBOs: Remote Patient Monitoring (RPM)	5	1	1	5
Individual Consumers: Remote Patient Monitoring (RPM)	2750	1	1	2750
Blood Pressure Control Metrics via Electronic Health Records	350	0	0	0
Total				8141

B. Burden Cost (average hourly rate)

Type of Respondent	Total Burden Hours	Hourly Wage Rate Respondent	Respondent Cost
CHCs: Qualtrics survey (4 quarters)	1050	\$43.80	\$122,640
CBOs: Qualtrics survey (4 quarters)	16	\$28.01	\$3585
CHCs: Training on data entry into DREaM	350	\$43.80	\$15,330.00
CBOs: Training on data entry into DREaM	16	\$28.01	\$448.16
CHCs: Feasibility assessment focus groups (2 times a year)	72	\$28.01	\$2689
CBOs: Feasibility assessment focus groups (2	72	\$43.80	\$4205

times a year)			
Individual Consumers: ETS health lesson learning questionnaires	1,872	\$28.01	\$87391
CHCs: Social Needs Platforms Readiness Assessment	87.5	\$43.80	\$15330
CBOs: Social Needs Platforms Readiness Assessment	4	\$28.01	\$112.04
Individual Consumers: Social Needs Platform Participation	1, 666	\$28.01	\$280,100
Management Occupation: RPM provider data delivery	4	\$59.31	\$237.24
CBOs: Remote Patient Monitoring (RPM)	5	\$28.01	\$140.05
Individual Consumers: Remote Patient Monitoring (RPM)	2750	\$28.01	\$77,027.50
Blood Pressure Control Metrics via Electronic Health Records	350	\$0	\$0.00
Total			\$609,235

The \$28.01 hourly wage rate for Individual Consumers (consumers/general public and community) and CBOs (social service occupations) is derived from the mean hourly wage across all occupations via the U.S. Department of Labor, Bureau of Labor Statistics May 2021 report “National Occupational Employment and Wage Estimates United States”¹. The \$43.80 hourly wage rate for CHCs (health care professionals) is based on the U.S. Department of Labor, Bureau of Labor Statistics May 2021 report “National Occupational Employment and Wage Estimates United States” for Healthcare Practitioners and Technical Occupations. The \$59.31 hourly wage rate for RPM services is based on the U.S. Department of Labor, Bureau of Labor Statistics May 2021 report “National Occupational Employment and Wage Estimates United States” for Management Occupations. The total estimated cost for this information collection for **9997** hours of reporting time is **\$609,235**.

The number of respondents and length of response was determined on the basis of survey length estimates from Qualtrics and other survey instruments. The actual numbers will vary depending upon the topic of interest.

¹ See https://www.bls.gov/oes/current/oes_nat.htm.

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

There will be no new annual capital or maintenance costs to the respondent as a result of this data collection.

14. Annualized Cost to the Government

The OMH may incur the following estimated costs annually through NHCI subcontract awards with implementation vendors for the purpose of setting up the NHCI program logistics and evaluation:

- Contract - External Evaluation (Summit Consulting, LLC), \$ 100,000.00
- Contract - Project Management (Pensivia, LLC), \$ 50,000.00
- Consultant Pool, \$ 17,000.00
- AHA Business Technology / Systems Development, \$ 217,000.00

- American Medical Association (AMA), \$ 330,000
- Ambulatory Data Platform and Maintenance , \$ 100,000.00
- E-Learning Modules Preparation (Multicultural Healthcare Marketing Group), \$ 33,000.00
- E-Learning Modules Digitization Vendor, \$ 42,000.00
- Aunt Bertha/Unite Us, SDOH Integration Training and Resource Development , \$ 140,000.00

- Contract/Subgrant: Self-Monitoring Data Routing Tool, \$ 33,000.00
- Contract/Subgrant: Umbrella Organizations - Faith Based (5), \$ 167,000.00
- Contract/Subgrant: Umbrella Organizations - Community Based (5), \$ 500,000.00

- The Ad Council , \$ 361,000.00
- UniWorld, Full Service Marketing and Communications Agency, \$ 264,000.00

Estimated Annualized Cost to Government: \$2,354,000

15. Explanation for Program Changes or Adjustments

There are no program changes or adjustments included in this request.

16. Plans for Tabulation and Publication and Project Time Schedule

The American Heart Association will not be employing statistical methods in assessing the National Hypertension Control Initiative (NHCI). There are four data collection

activities that will result in tabulations and reporting for internal project purposes and publication. All data collection activities will result in summary descriptive statistics and means testing as appropriate. The data collection will not result in metrics generalizable to the population, but findings will inform future implementation of similar activities.

The four data collection activities to be conducted are:

1. Qualtrics Survey to be completed by Community Health Centers (CHCs) within 1 month of OMB approval
2. Data Reporting, Evaluation, and Monitoring (DREaM) to be completed by CHCs and Community-based Organizations (CBOs) within 6 months of OMB approval and quarterly thereafter.
3. Feasibility assessment focus groups with CHCs and CBOs to be completed within 9 months of OMB approval and yearly thereafter
4. Empowered to Serve Health lessons curriculum assessing hypertension awareness, education and corresponding quizzes to be administered to CBO participants within 3 months of OMB approval and on an ongoing basis throughout years 2-3 of the NHCI initiative. In years 2-3, CBOs will also report the aggregate number of referrals they make to CHCs.

The units of analyses for the Qualtrics Survey, DREaM, and EmPOWERED to Health Lessons are CHCs and CBOs. AHA will generate descriptive statistics for data collected using these activities/data collection tools. When possible, the data will be cross-sectioned by urban/rural status of the CHCs with T-tests being conducted to determine true differences in urban/rural status. Per quarter, these data would be presented in a bar chart but could be presented in a line chart once more quarterly data collection periods have been completed.

The Feasibility assessments will collect qualitative information from up to 16 CHCs and 16 CBOs annually to inform implementation adjustments and improvements. All information collected will be synthesized into narratives comparing CHCs and CBOs of different characteristics, for example size (number of participants served), urban/rural location, and type of CBO.

In conclusion, no complex or analytical techniques will be used for the results of the collection of information. Findings from all data collection will be included in individual summary reports. The reports will describe the testing methods, findings, conclusions, implications, and recommendations for use in development and refinement of disease prevention and health promotion messages, materials, and tools. No attempt will be made to generalize the findings to be nationally representative.

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

Expiration date display exemption is not requested.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

The data encompassed by the projects discussed in this supporting statement will fully comply with all guidelines of 5 CFR 1320.9. No exception is requested to certification for Paperwork Reduction Act Submission.

B. Collection of Information Employing Statistical Methods

Information will not be collected requiring statistical analysis employing statistical methods.

APPENDICES

- A. Qualtrics and DREaM CHC quarterly survey questions
- B. Qualtrics and DREaM CBO quarterly survey questions
- C. Feasibility Assessments-CHCs and CBOs
- D. Empowered to Serve Surveys
 - a. ETS Control Your Blood Pressure
 - b. ETS Salt and Cardiovascular Risk
 - c. ETS Get Active
- E. CBO Readiness Assessment for SDOH platform
- F. CHC Readiness Assessment for SDOH platform