Information Collection Request

New

Healthy Schools Program Evaluation

Supporting Statement A

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JUSTIFICATION SUMMARY

Goal of the project: CDC awarded funds through cooperative agreement DP23-0002 (2302, henceforth) to 20 state entities (including state education agencies, state departments of health, universities, and one tribe) to improve health, academic achievement, and well-being of students in K-12 schools. A portion of this funding within each state is allocated to one priority local education agency (also known as a school district, and here referred to as priority LEA), equaling 20 total priority LEAs across all recipients, and their corresponding schools in which program activities are implemented. The priority LEAs and their corresponding schools will support the implementation of evidence-based policies, practices, and programs to increase students' physical activity, healthy dietary behaviors, and self-management of chronic health conditions. CDC is conducting an evaluation of the 2302 program, which is the focus of this information collection request. The results will help recipients improve their programs and aid CDC in understanding and communicating the impact of its funding.

Intended use of the resulting data: Process and outcome performance measure data will be used to improve the program by guiding CDC's technical assistance and professional development delivered to the funded recipients and by informing the types of tools and resources CDC develops to support the work of the funded recipients. Outcome data collected from this evaluation will be used to communicate the impact of the funded program (e.g., improvements in student physical activity and dietary behaviors). Evaluation results may also be disseminated through practice literature and spaces (e.g., public health evaluation journals and/or conferences) to create a public record and to inform public health professionals, K-12 policymakers, state education staff, and other constituents of the programmatic approach.

Methods to be used to collect data: This evaluation employs a mixed-methods multilevel design. ICF, a CDC evaluation contractor, will collect information from relevant funded recipients, priority LEAs, schools, and students. Program monitoring information will be collected from recipients via a monthly reporting tool. Virtual or in-person semi-structured key informant interviews will be conducted in years two and four with program staff among funded recipients and their priority LEAs to understand implementation strategies, successes, barriers, and lessons learned. In addition, an electronic school-level questionnaire will be administered annually to school leaders in participating schools within the 20 priority LEAs to measure implementation of healthy school policies, practices, and programs. Finally, a student questionnaire will be administered annually to a random sample of students in elementary, middle, and high schools (grades 4-12) located within the priority LEAs to measure physical activity, dietary behaviors, management of chronic health conditions, and wellbeing and academic attainment. The student sample will be representative at the LEA level and provide sufficient power to estimate program effects.

The subpopulation to be studied: This evaluation has four subpopulations: funded recipients (state, university, and tribal entities), priority LEAs, corresponding schools, and their students.

How the data will be analyzed: Monthly monitoring data will be compared to recipients' work plans to assess implementation fidelity and timeliness. Key informant interview transcripts will be coded and thematically analyzed using qualitative software (e.g., NVivo or MAXQDA) to ascertain implementation strategies, successes, barriers, and lessons learned within and across funded recipients. Data from the school and student questionnaires will be uploaded into a quantitative software program (e.g., Microsoft Excel, SAS, SPSS) to produce descriptive statistics and examine associations between school and student variables. The mixed-methods multilevel findings will be integrated to provide a full assessment of program processes and outcomes.

A. JUSTIFICATION FOR INFORMATION COLLECTION

A1. Circumstances Making the Collection of Information Necessary

The Division of Adolescent and School Health (DASH) at the Centers for Disease Control and Prevention (CDC) requests OMB approval for new information collection activities to evaluate the CDC's five-year cooperative agreement, CDC-RFA-DP-23-0002, "School-Based Interventions to Promote Equity and Improve Health, Academic Achievement, and Well-Being of Students." This program is authorized under Section 301(a), 42 U.S.C. 241(a) and Section 317(k)(2) of the Public Health Service Act [42 U.S.C. 247b(k)(2)] and is the successor to the cooperative agreement with state education agencies titled CDC-RFA-DP18-1801. A copy of the enabling legislation is included in **Attachment 1.** This information collection request is for the period of July 2023 through June 2028. We will submit an extension request for information collection activities beyond the initial three-year approval period, as required.

The evaluation of the DP-23-0002 cooperative agreement and associated information collection activities are necessary to demonstrate the impact of the implementation of school health policies and practices in schools; build support for school health policies and practices at state, district, and school levels; and inform key recommendations to improve program strategy, implementation, impact, and sustainability. Information collection also allows CDC to provide technical assistance and professional development to recipients as needed in a timely fashion. Data collection for this program evaluation is authorized under the Foundations for Evidence-based Policymaking Act of 2018 (Evidence Act) § 101(e)(4)(B) (citing 5 U.S.C. § 311(3)). A copy of this enabling legislation is included in **Attachment 2**.

Background

Long-standing systemic health and social inequities have put many children and adolescents at increased risk for chronic diseases, including racial and ethnic minorities, youth living in low socioeconomic and rural areas, and youth with disabilities. The COVID-19 pandemic further exacerbated health and education disparities among youths (Oberg et al., 2022), and recent results from the Youth Risk Behavior Survey (YRBS) show that rates of healthy eating and physical activity among youth have remained low or declined in recent years (Michael et al., 2023). Education, food security, social connectedness, the built environment, and community-clinical linkages can influence children's and adolescents' overall physical, emotional, mental health and academic attainment through factors such as access to basic health information, access to healthy foods and safe spaces for physical activity, access to health services, and health insurance coverage (Berry, Bloom, Foley, & Palfrey, 2010; Liu, Kia-Keating, & Nylund-Gibson, 2019; Price, Khubchandani, McKinney, & Braun, 2013).

With nearly 50 million American youth spending much of their daily lives in school settings, schools play a critical role in advancing the health of students (Kolbe, 2019) and are an ideal setting to address social determinants of health; teach healthy behaviors; and provide students with opportunities to improve dietary and physical activity behaviors and manage chronic health conditions. Healthy school environments are associated with healthier student behaviors and stronger academic achievement (Michael et al., 2015). Coordinated school health programs that promote healthy behaviors among

children and adolescents are critical to addressing health disparities and promoting academic achievement (Basch, 2011). CDC's DASH, inclusive of the former Healthy Schools Branch, works with state and local education agencies, communities, and national partners to prevent chronic diseases and promote the health and well-being of children and adolescents in schools.

CDC's DP-23-0002, "School-Based Interventions to Promote Equity and Improve Health, Academic Achievement, and Well-Being of Students" supports 20 recipients to improve the health of students in underserved communities. Recipients include state education and health agencies, universities, and a tribal nation. Using the child-centered Whole School, Whole Community, Whole Child (WSCC) framework (ASCD & CDC, 2014), recipients aim to build the capacity of local education agencies (LEA) to implement evidence-based policies, practices, and programs that improve nutrition, physical activity, and management of chronic conditions among school-age youth in underserved and disproportionately affected communities. Program activities fall under two strategies: (1) statewide support, and (2) intensive localized support to a single priority LEA and corresponding schools within the priority LEA.

Supported statewide activities (Strategy1) include:

(a) provide statewide professional development (PD) and technical assistance (TA);
(b) establish and maintain school health councils and teams;
(c) establish and maintain a state-level school health leadership coalition; and
(d) establish new and strengthen existing partnerships.

Supported activities directed to the priority LEA and corresponding schools (Strategy 2) include:

(a) provide PD and TA;
(b) provide follow-up support after PD events;
(c) support the assessment of school health policies, practices, programs, and services;
(d) support the implementation of evidence-based school health policies, practices, programs, and services; and
(e) disseminate accomplishments and lessons learned.

DASH is working with ICF, a contractor, to evaluate the 2302 cooperative agreement. The purpose of the mixed-methods multilevel evaluation is to measure program implementation (process evaluation) and associated short-term and intermediate outcomes (outcome evaluation). Process data will allow CDC to monitor program implementation and inform CDC's technical assistance provided to funded recipients. Outcome data will measure the impact of program implementation; that is, the extent to which implementation of 2302 program activities impacted school health infrastructure and student health behaviors. The evaluation involves collecting information from recipients, priority LEAs, schools, and students.

Collection of personal identifiable information (PII) will be limited to names and email addresses for the purposes of scheduling key informant interviews and will not be linked to any responses. No personal identifiable information will be collected from school staff or students. PII used in scheduling will only be accessible to the ICF evaluation team and will be destroyed when data collection is complete. All data

collected for this project will be securely stored and maintained locally under strict access controls limited to the local project leader/manager or his/her designate; the data will be stored without PII. Under no circumstances will an individual be identified using a combination of variables such as gender, race, birth date, and/or other descriptors.

A2. Purpose and Use of the Information Collection

The 2302 cooperative agreement evaluation will provide CDC with critical information to better understand and document the effects of the 2302 program strategies, including the extent to which recipients increase or improve partnerships to support school health; increase awareness and implementation of CDC school health tools; improve physical activity and nutrition school health policies, practices, and services; and improve student nutrition and physical activity behaviors. The information gathered will be used by CDC, 2302 recipients, ICF, and other key partners to help schools, communities, and decision-makers at all levels of government improve youth health by strengthening the evidence base for physical activity and nutrition school-based policies and programs in underserved and disproportionately affected communities. Information collection activities are described below under four respondent groups: 1) recipients/state level information collection; 2) priority local education agency (LEA) personnel; 3) school information collection; and 4) student information collection. Information collection activities are designed to provide a robust understanding of implementation, outcomes, and impacts and include a monthly progress reporting form, qualitative interviews, a school questionnaire, and a student questionnaire.

Recipient/State and priority LEA Information Collection

Monthly Reporting Form. The monthly web-based reporting form **(Attachment 3**) will be used to collect information monthly from each recipient (n = 20) in years 2-5 to monitor implementation of statewide and priority LEA program activities. This form will be completed by recipient program staff (e.g., program directors, program coordinators). Per the cooperative agreement, recipients are required to submit six monthly program monitoring indicators (labeled below as M1-M6). Three of the indicators are designed to monitor progress implementing statewide activities (Strategy 1) and three are designed to monitor progress implementing activities in the priority LEA (Strategy 2).

M1: PD events delivered and attendees.
M2: TA events provided and attendees.
M3: Health equity PD and TA implemented.
M4: Priority LEA corresponding schools with completed school health assessments.
M5: Priority LEA corresponding schools that have submitted a fully developed action plan.
M6: Help provided to priority LEA corresponding schools to implement their action plans.

ICF has developed a form in Qualtrics to collect these data from recipients. Each month, ICF will send recipients an email notification with a unique Qualtrics URL link to access the data reporting form and submit their monthly program indicator data (**Attachment 4**). After reports are submitted, ICF will

conduct monthly data quality control checks and follow up with recipients to verify data as needed. ICF's data team will clean and manage the monthly program indicators data and prepare the data for analysis and inclusion in reports and other evaluation products. All data will be stored in a secure password protected Qualtrics account only accessible to the team. Once exported from Qualtrics, all data will be stored on ICF's secure network servers, and access will be restricted to approved team members identified by user ID and password. Ongoing data collection will allow CDC to closely monitor program implementation and adjust technical assistance as needed. Summative data across grant years will provide a measure of program uptake, or the extent to which program activities were implemented by each recipient and their priority LEA and corresponding schools. We pilot tested the form with current funded recipients and it should take no longer than 30 minutes each month to complete. Screenshots of the monthly reporting form programmed in Qualtrics are included in **Attachment 5**.

Key Informant Interviews. Qualitative key informant interviews will be conducted in years 2 and 4 with recipient staff and priority LEA staff to assess program implementation, key successes and lessons learned, the structure and function of partnerships in implementing school health activities, perceptions of CDC support, and barriers and facilitators to implementing school health activities. The recipient interview guide is included in **Attachment 6**. The priority LEA interview guide is included in **Attachment 7**. We will conduct 20 interviews with 40 recipient staff, averaging two participants per interview with a range of 1–3 participants per interview. Similarly, for the priority LEA interviews, we will conduct 20 interviews with 40 recipient staff, averaging two participants each interview. We pilot tested the interviews and found them to take no longer than 60 minutes. ICF will send interview invitations to recipient and priority LEA staff by email (see **Attachment 8**).

Interviews will be audio-recorded for transcription and thematic analysis. Audio files for the interviews will be transcribed verbatim and all personally identifiable information will be deleted. The ICF evaluation team will review transcripts to ensure complete and accurate transcriptions. An initial codebook will be developed using the qualitative interview guide(s), program framework, and relevant literature. Intercoder reliability will be established and trained ICF team members will code the qualitative interview data using the qualitative data management software, MAXQDA. Open and axial coding will be conducted, and salient categories of information representing themes will be identified. ICF will produce a summary of key findings to be shared with DASH.

School Information Collection

Healthy Schools Questionnaire. A school questionnaire will be administered annually in years 2-5 to a designated staff member in corresponding schools within the priority LEAs. Corresponding schools are those schools in the priority LEAs that have agreed to work with 2302 funded recipients on healthy schools activities. Corresponding schools thus represent a convenience sample of schools within the priority LEAs. We hope to administer the school questionnaire in all corresponding schools (n = 250).

The school questionnaire, with versions for elementary schools and middle/high schools, will collect information on school health infrastructure, school physical education and physical activity opportunities and environment, school nutrition environment and services, and support for students with chronic health conditions (**Attachment 9**). The information collected from the school questionnaire will be used to

measure and report short-term outcomes (e.g., changes in the school health practices, policies, and environment) resulting from state and district level implementation.

The questionnaire was developed using validated questions from previous research and national surveillance systems (e.g., School Health Profiles) and will be administered via Qualtrics. Each spring of the cooperative agreement (i.e., 2025, 2026, 2027, 2028), priority LEAs will distribute a link to the school questionnaire to school principals in their district. Principals will be encouraged to consult with school health councils, committees, or teams, and other school health staff (e.g., PE teachers, school food service staff, etc.) as needed to provide accurate data on school health policies, practices, and services related to physical activity, nutrition, and chronic health condition management. The school questionnaire should take no longer than 30 minutes to complete each program year. Screenshots of the Healthy Schools Questionnaires programmed in Qualtrics are included in **Attachment 10**.

Student Information Collection

Healthy Students Questionnaire. To assess the impact of 2302 program activities on student health behaviors, a student questionnaire will be administered annually in years 2-5 to a sample of students in grades 4-12 in all of the corresponding schools of the priority LEAs in a way that is representative of the students in those corresponding schools. The student questionnaire will be used to collect data on student behaviors that align with intermediate outcomes including physical activity and nutrition behaviors, and management of chronic health conditions. The student questionnaire will collect data needed to measure annual student behavior outcomes and intermediate performance measures of the 2302 cooperative agreement. The Healthy Students Questionnaire is included in **Attachment 11** and includes a version for elementary students in grades 4 and 5 and a version for middle and high school students in grades 6-12.

After a comprehensive review, the student questionnaire was developed using validated questions from previous research and national surveillance systems (e.g., Youth Activity Profile (YAP), YRBS and SPAN). The questionnaire will be administered through Qualtrics. The questionnaire was pilot tested with eight student participants in grades 4-12. ICF obtained parental consent, administered the survey, and asked a series follow-up questions to assess newly developed items on the questions (e.g., chronic condition items). All participants completed the questionnaire in under 20 minutes and found the questionnaire to be clear and of appropriate length. The team made minor revisions to the questionnaire based on pilot participant feedback. We anticipate the questionnaire will take under 30 minutes to administer, factoring in time to set up and read instructions.

The student questionnaire was programmed by ICF in Qualtrics. Screenshots of the Healthy Students Questionnaire in Qualtrics are included in **Attachment 12**. Each corresponding school will receive a unique, password protected link, which can be distributed to students in classes that are randomly selected to participate in the questionnaire. ICF will provide step-by-step instructions to recipients and their priority LEAs to administer the electronic survey within a specific date range during the spring semester of each program year. ICF will provide materials to priority districts and schools, who will be responsible for notifying parents of the survey procedures and securing passive or active parental consent as required by the district.

Without the state, school, and student data collection, DASH would be unable to assess the following:

1. To what extent did recipients implement the strategies and activities under the 2302 cooperative agreement?
2. What were the barriers and facilitators to implementing the 2302 program at the recipient level?
3. What changes were observed in school practices and policies after implementing 2302 program strategies and activities?
4. What changes were observed in student behavior in priority LEAs in the 2302 program?
5. How did CDC support implementation of program strategies and activities among 2302 recipients?

A3. Use of Improved Information Technology and Burden Reduction

Every effort has been made to limit the burden on individual respondents who participate in the 2302 cooperative agreement evaluation through technology. A web-based quantitative survey will be used for the monthly reporting form and was designed to collect the minimum information necessary for the purposes of this project using built-in skip logic. This will reduce burden because this approach ensures data quality but decreases respondent burden with built-in skip logic where possible.

Key informant interviews will take place virtually or in person. If in person, the ICF evaluation team will travel to the participant to reduce any burden on the participant. If conducted virtually, interviewees will only need access to a telephone. The ICF evaluation team will audio-record telephone or in-person interviews. This limits the burden on the participant (no additional burden after completing the interview) and allows the interviewer to focus on building and maintaining rapport with participants.

The school and student questionnaires will be administered using a web-based administration. Web-based administrations allow respondents to easily access the data collection instrument at a time and location that is most convenient for them. All student data collection will be web-based except for students who do not have computer access, in which case a paper-pencil version of the survey will be provided.

A4. Efforts to Identify Duplication and Use of Similar Information

The information obtained through this collection is unique and not already available for use or adaptation from another cleared source. The evaluation team, in developing the data collection activities, consulted existing literature to avoid duplication in data collection activities and the use of similar information. Monthly reporting and interviews during years 2 and 4 with funded recipients and priority LEA program leaders are our only ways to gain monitoring and progress information from funded recipients. There are no other avenues that exist to get this data to provide technical assistance and professional development to improve programs as they are implemented.

We have undertaken every effort to ensure that the school- and student-level questionnaires do not duplicate any other existing data collections in schools and among students. First, we referred to our prior five-year state entity award (CDC-RFA-DP18-1801) and its evaluation to ensure 2302 evaluation is not

duplicative. We collaborated with other CDC centers, divisions, and branches while designing both our school- and student-level questionnaires to ascertain and cross-check existing collection efforts. We also received input on specific questions from academic institutions and non-governmental organizations (NGOs) specializing in school and student health and wellbeing, which confirmed that no other data sources exist with the information we need to assess 2302 program progress and impact.

We also consulted with a team in the CDC's Division of Adolescent and School Health (DASH) that conducts national health surveillance in schools and among students. Together with DASH, we reviewed CDC's Youth Risk Behavior System (YRBS) and School Health Profiles (Profiles) to ascertain whether the surveys would be adequate for evaluating the 2302 program. We found that while YRBS and Profiles contain useful validated questions for assessing some aspects of school and student health, the way the surveys are administered, and their content, make them unfit for use in the 2302 evaluation. Specifically, the surveys' questions do not adequately assess the 2302 performance measures, and neither survey provides full K-12 coverage at school or student levels annually, which are factors that are needed for a meaningful 2302 evaluation.

A5. Impact on Small Businesses or Other Small Entities

No small businesses or other small entities will be involved in or impacted by this data collection.

A6. Consequences of Collecting the Information Less Frequently

The rigor of the 2302 cooperative agreement evaluation design and its ability to answer the primary evaluation questions is dependent on the frequency of the data collected. Additionally, because the evaluation is designed to monitor the implementation of the program, the frequency with which data collection activities are administered is critical to CDC's overall assessment and support of the program. The consequence of collecting the monthly reporting form less frequently is decreased awareness of program implementation over time, limiting CDC's ability to provide timely technical assistance to funded recipients. The consequence of conducting the interviews less frequently is less ability to explain contextual factors affecting program implementation over time and to help recipients overcome challenges that they identify mid-way through the program in year 2 interviews. The consequences of conducting the school and student surveys less frequently would be less ability to monitor changes in school policies and practices and student health behaviors following 2302 program implementation.

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

This request fully complies with the requirements of 5 CFR 1320.5.

A8. Comments in Response to the FRN and Efforts to Consult Outside the Agency

Part A: PUBLIC NOTICE

A 60-day Federal Register Notice was published in the *Federal Register* on December 11, 2023, vol. 88 No. 236, pp. 85888-85889 **(Attachment 13)**.

CDC received three non-substantive comments and replied with a standard CDC response. The public comments and CDC responses are provided in **Attachment 14**.

Part B: CONSULTATION
CDC contractors, cooperative agreement recipients, and DASH subject matter experts provided extensive input into the clarity of the instructions, content of the survey questions, and the respondent universe. A list of subject matter experts consulted is provided in Tables 3 and 4. There were no major problems that arose during the consultation, and all issues raised were resolved.

Table 3. External Consultations

Name	Title	Affiliation	Email	Role
Gregory Welk, PhD	Distinguished Professor	Iowa State University, Department of Kinesiology	gwelk@iastate.edu	Technical guidance

Table 4. Consultations within CDC

Name	Title	Affiliation	Email	Role
Yulia Chuvileva, PhD	Health Scientist and Evaluation SME	CDC/DASH	Qna8@cdc.gov	Technical monitor
Leah Robin, PhD	Health Scientist	CDC/DASH	Ler7@cdc.gov	Technical monitor

A9. Explanation of Any Payment or Gift to Respondents

Recipient respondents will not receive an incentive for responding to information requests for this evaluation as their participation is expected under the terms of the cooperative agreement. Priority LEA participants agreeing to participate in the 60-minute qualitative interviews will receive a $50 token of appreciation in the form of a gift card. Offering tokens of appreciation is important to demonstrate our gratitude for the time of subject matter experts, like district or school administrators. This amount is consistent with the hourly wage rate of administrators.

Corresponding schools that respond to the school questionnaire and administer the student survey in selected classrooms will receive $200 as a token of appreciation for school staff's time and effort. Numerous studies have suggested that tokens of appreciation can significantly increase response rates, and the use of a school-level token of appreciation is expected to enhance survey response rates among students without biasing responses. This improves the validity and reliability of the data, which is of utmost importance in this evaluation.

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

The CDC NCCDPHP Privacy and Confidentiality Review Officer has assessed this package for applicability of 5 U.S.C. § 552a and has determined that the Privacy Act does not apply to the

information collection. No individually identifiable information will be collected for the evaluation, and no sensitive information is being collected. CDC will not receive any personally identifiable information. Recipient staff names and emails are publicly available on organization/district websites. All data collection will be conducted by ICF staff and no CDC staff will be involved in the collection of data.

No individual PII will be collected from the healthy school questionnaire. The school questionnaire is voluntary and school designees that are invited to participate must read and sign the consent form before participating. The student questionnaire is anonymous and no PII will be collected. No sensitive information is being collected and no PII will be recorded or stored as part of the questionnaire or database. Once data collection is complete, data will be downloaded and stored on a secure network location with respondent ID only. Information gained from the interviews will be presented in aggregate narrative format and will not contain names or other PII.

All data files will be stored on secure, password-protected, network servers. Access will be restricted to approved team members and will be protected by user ID and password. Our information security process is based on the approach prescribed by the Federal Information Security Management Act of 2002 (FISMA, 44 U.S.C. § 3541 et seq.) as implemented by the Office of Management and Budget (OMB) in Circular A-130 and other policy documents. Electronic data are set up using a "least privilege" protocol that permits users the least amount of access required to perform their duties.

Consent

For interview participants, an informed consent form will be shared with participants before the interview and verbal consent will be obtained at the start of each interview (see **Attachment 15**).

For the school questionnaire, recipients and their priority LEAs will send information about the Healthy Schools Questionnaire to corresponding schools. Designated school personnel will be provided a link to the school questionnaire which contains the consent form (**Attachment 16**).

For the student questionnaire, districts will be provided active and passive parent consent forms to distribute to parents of students who are under 18 years of age and randomly selected to participate in the student questionnaire (see **Attachment 17**). The study will follow the district's requirements for either active or passive parental consent. A separate consent form will be available for students who are 18 years of age or older (see **Attachment 18**). For students who receive parent consent (either passive or active consent), students will receive a password protected link to access the student questionnaire. A student assent form will be included on the first page of the survey (**Attachment 19**). If they click next, they will be taken to the survey. If they choose not to participate, no action is needed. All consent forms for the evaluation include a contact name and phone number for the ICF evaluation team and ICF IRB for participants to contact if they have any questions or concerns.

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

IRB Approval

The proposed web-based data collection and qualitative interviews have been reviewed and approved by ICF's IRB. The IRB approval letter is included in **Attachment 20**.

Sensitive Questions

No sensitive questions are being asked on the web-based quantitative questionnaire and no identifiable information is being collected. Responses will only be reported in aggregate across the program and disaggregated only by state; responses will not be disaggregated by school or individual student respondents. All respondent information associated with the study will be collected and stored in a password-protected electronic file on a secure network accessible only by the Contractor's study team.

A12. Estimates of Annualized Burden Hours and Costs

The annualized response burden is estimated at 6,900 hours. Table 5 provides details about how this estimate was calculated. Timings were conducted during the instrument development process to support the overall burden per respondent. Burden hours are provided for three years. We will submit a request for renewal to collect information in the program's final year.

Table 5. Estimated Annualized Burden

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in minutes)	Total Burden Hours
Recipient personnel	Recipient Monthly Reporting 2024, 2025, 2026	20	12	30/60	120
Recipient personnel	Interviews in 2025, 2027	40	1	60/60	40
Priority LEA personnel	Interviews in 2025, 2027	40	1	60/60	40
School personnel	Healthy Schools Questionnaire in 2025, 2026, 2027	250	1	30/60	125
Students	Healthy Students Questionnaire in 2025, 2026, 2027	13,150	1	30/60	6,575
Total		13,500			6,900

The annualized cost to the respondent is shown in Table 6. The United States Department of Labor, Bureau of Labor Statistics Occupational Employment and Wage Statistics (https://www.bls.gov/oes/) were used to estimate the labor category for recipient personnel and school administrators. The labor category of Community and Social Service Specialists, All Other (code 21-1099) is the labor category identified that most closely matched the recipient personnel sample. The Educational Administrators, All Other (code 11-9039) was used to estimate the hourly wage rate for school administrators. For youth, minimum wage was used to estimate the annual cost to the respondent. The total anticipated annual cost to respondents for collections of information will be $59,840.45.

Table 6. Estimated Annualized Burden Costs

Type of Respondents	Form Name	Total Annual Burden Hours	Average Hourly Wage Rate	Total Respondent Labor Cost
Recipient personnel (Program Coordinator)	Recipient Monthly Reporting Form	120	$24.82[1]	2,978.40
Recipient personnel (Program Coordinator)	Interviews	40	$24.82	992.80
Priority LEA personnel (Education administrators)	Interviews	40	$49.70[2]	1,988.00
School administrator	Healthy Schools Questionnaire	125	$49.70	6,212.50
Youth	Healthy Students Questionnaire	6575	$7.25[3]	47,668.75
Total				$59,840.45

[1] BLS OES May 2022 National Industry-Specific Occupation Employment and Wage Estimates average annual salary for Community and Social Service Specialists, All Other (code 21-1099); https://www.bls.gov/oes/current/oes_nat.htm#21-0000

[2] BLS OES May 2022 National Industry-Specific Occupation Employment and Wage Estimates average annual salary for Educational Administrators, All Other (code 11-9039); https://www.bls.gov/oes/current/naics5_541720.htm#11-0000

[3] US Department of Labor. Minimum wage; https://www.dol.gov/agencies/whd/minimum-wage

A13. Estimates of Other Total Annual Cost Burden to Respondents and Record Keepers

CDC does not anticipate providing start up or other related costs to private entities.

A14. Annualized Cost to the Federal Government

The total annualized cost to the government, including direct costs to the federal government and contractor expenses is $462,739.35. Cost will be incurred by the government in personnel time for overseeing the project. CDC time and effort for general project oversight of the contractor for project design, data collection, and analysis and dissemination are estimated $16,335.00.

A contract has been awarded to ICF for evaluation of the 2302 cooperative agreement. The current evaluation contract with CDC is funded to conduct the evaluation with 20 recipients over the next 4 years with a value of $2,232,021.75. The estimated average annual cost of the contract will be $446,404.35.

This covers expenses related to developing and monitoring the evaluation including, but not limited to developing the evaluation design and instrumentation; developing training and technical assistance resources (e.g., manuals, training materials); conducting training and technical assistance; and analyzing data and disseminating findings.

Table 7. Estimated Annual Costs to the Government by Expense Type

Expense Type	Expense Explanation	Annual Costs (dollars)
Direct Costs to the Federal Government		
CDC oversight of the project	GS-13 Health Scientist at 5% FTE GS-14 Health Scientist at 5% FTE	$5,464.00 $8,394.00
CDC oversight of contractor and project	GS-13 Public Health Advisor at 2%	$2,477.00
	Subtotal, Direct costs	**$16,335.00**
Assistance with evaluation planning and implementation including data collection, processing, and analysis	Labor and other direct costs for assistance with evaluation planning and implementation including data collection, processing, and analysis	$446,404.35
	TOTAL COST TO THE GOVERNMENT	**$462,739.35**

A15. Explanation for Program Changes or Adjustments

This is a new information collection.

A16. Plans for Tabulation and Publication and Project Time Schedule

The estimated timetable for project activities is outlined in Table 8. We are requesting to receive OMB approval for this information collection by the end of August 2024 so that collection can begin in September 2024. It is critical this data collection to begin no later than September 2024 in order to engage recipients and their priority LEAs to participate in the evaluation over the 2024-2025 academic year.

Data analysis will begin within two weeks after completion of the web-based quantitative survey instruments. ICF will produce a summary of key findings to be shared with DASH. Descriptive statistics will be used to summarize the data collected through the monthly reporting form, and school and student surveys to address questions related to statewide and priority LEA program activities and expected outcomes. Data from the monthly reporting form will be summarized to indicate the proportion of schools that are implementing a given policy/practice, and as the project proceeds, the summary will describe the change in proportions over time. The school and student survey data will be summarized to describe implementation and outcomes at the district and overall levels. These summaries will also include the internal consistency of scales using Cronbach's alpha. Policy evaluation will consist of analyzing multiple outcomes, accounting for confounding characteristics at multiple levels, including clustering of schools within districts and students within schools, and student level characteristics. To this end, we propose using multiple methods depending on the evaluation question. For instance, multilevel

modeling accounts for grouping of data, which is essential to analysis of school programming because significant variance is detectable at the district and school levels. Our evaluation also proposes a repeated cross-sectional approach, and as such it will be important to capture systematic differences across schools and over time. One potential approach to this challenge is the inverse probability of treatment weighting, which includes developing two models: a model predicting the probability of a student attending a school with high degrees of implementation, and the second model calculates weights as the inverse of the propensity score. The weights are then applied to the study population, allowing for a better comparison of students receiving varying degrees of intervention.

Further, to obtain rich, in-depth information and description related to implementation experiences, we have included interviews to supplement the questionnaire findings. We will analyze qualitative data generated from interviews for themes, patterns, and interrelationships relevant to the evaluation questions. Transcripts will be entered into a qualitative database software program, MAXQDA, for analysis. The evaluation team will collaborate to develop an initial list of deductive codes aligned with the study questions and systematically code the data to identify relevant themes in preparation for unique and common thematic analyses. The themes that emerge from the synthesis of findings will be discussed at length with the coders and the larger evaluation team to ensure the validity of the conclusions.

Table 8. Estimated Time Schedule for Project Activities

Activity	**Timeline**
Design information collection instruments	Complete
Develop data collection protocol and analysis plan	Complete
Pilot test information collection instruments	Complete
Receive ICF IRB approval	Complete
Prepare OMB package	Complete
Receive OMB approval	In Progress
Monthly Reporting Form	September 2024 or 1 month following OMB approval, monthly data collection
Qualitative Interviews	6 – 12 months following OMB approval, 2025 and 2027
School and Student Survey	6 – 12 months following OMB approval, annual data collection beginning in 2025

The scope of this OMB request includes information collected in program years 2-4. We will submit a continuing review for information collected in program year 5 of the 2302 cooperative agreement.

Primary Data Collection Activities	Timeframe				
	PY1 2023-2024	PY2 2024-2025	PY3 2025-2026	PY4 2026-2027	PY5 2027-2028
Monthly					
Monthly Reporting Form		•	•	•	•
Every Two Years					
Key Informant Interviews		•		•	
Annually					
Healthy Schools Questionnaire		•	•	•	•
Healthy Students Questionnaire		•	•	•	•

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

The display of the OMB expiration date is appropriate. The web-based quantitative surveys will display the expiration date for OMB approval of the information collection. We are not requesting an exemption.

A18. Exceptions to Certification for Paperwork Reduction Act Submission

There are no exceptions to the certification.

REFERENCES

ASCD, & Centers for Disease Control and Prevention. (2014). *Whole school, whole community, whole child: A collaborative approach to learning and health.* ASCD.

Basch, C. E. (2011). Healthier students are better learners: A missing link in school reforms to close the achievement gap. *The Journal of School Health, 81*(10), 593–598. https://doi.org/10.1111/j.1746-1561.2011.00632.x

Berry, J. G., Bloom, S., Foley, S., Palfrey, J. S. (2010). Health inequity in children and youth with chronic health conditions. *Pediatrics, 126*, S111-S119.

Kolbe, L. J. (2019). School health as a strategy to improve both public health and education. *Annual Review of Public Health, 40*, 443–463. https://doi.org/10.1146/annurev-publhealth-040218-043727

Li, S. R., Kia-Keating, M., & Nylund-Gibson, K. (2019). Patterns of family, school, and community promotive factors and health disparities among youth: Implications for prevention science. *Prevention Science, 20*, 1103-1113.

Michael, S. L., Merlo, C. L, Basch, C. E., Wentzel, K.R., & Wechsler, H. (2015). Critical connections: Health and academics. Journal of School Health, 85(11), 740-758. doi:10.1111/josh.12309.

Michael, S. L., Jones, S. E., Merlo, C. L., Sliwa, S. A., Lee, S. M., Cornett, K., et al. (2023). Dietary and physical activity behaviors in 2021 and changes from 2019 to 2021 among high school students—Youth Risk Behavior Survey, United States, 2021. *Morbidity and Mortality Weekly Report, 72*(Suppl. 1), 75–83. http://dx.doi.org/10.15585/mmwr.su7201a9.

Price, J. H., Khubchandani, J., McKinney, M., & Braun, R. (2013). Racial/ethnic disparities in chronic diseases of youth and access to health care in the United States. *BioMed Research International*, 787616.

Oberg, C., Hodges, H. R., Gander, S., Nathawad, R., & Cutts, D. (2022). The impact of COVID-19 on children's lives in the United States: Amplified inequities and a just path to recovery. *Current Problems in Pediatric and Adolescent Health Care, 52*(7), article 101181. https://doi.org/10.1016/j.cppeds.2022.101181