

SUPPORTING STATEMENT: PART A

OMB# 0920-1425

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**REPORTING OF THE ESSENTIALS FOR CHILDHOOD (EFC):
PREVENTING ADVERSE CHILDHOOD EXPERIENCES
THROUGH DATA TO ACTION PROGRAM**

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Summary Table

Goal of the project:

The purpose of this Information Collection Request (ICR) is to continue data collection aimed at monitoring the project performance from grantees funded under Essentials for Childhood (EfC): Preventing Adverse Childhood Experiences through Data to Action.

Intended use of the resulting data:

Information collected from recipients will be used to monitor and evaluate progress of program goals and objectives, identify technical assistance needs, and be accountable for the funding by responding to requests for information about the cooperative agreement from the Department of Health and Human Services (HHS), the White House, Congress, and other sources in a timely manner.

Methods to be used to collect:

Recipients will report performance data to CDC annually using a web-based system (i.e., Partners' Portal). No research design or human subjects involved. Information will be also collected via virtual interview sessions, surveillance and implementation capacity assessments, and evaluation and surveillance surveys.

The subpopulation to be studied:

The population studied will include 100% of EfC funded recipients. Therefore, a sampling method is not required.

How the data will be analyzed:

Quantitative data will be analyzed using descriptive and summary statistics. Qualitative data will be analyzed through thematic analysis to define priority area topics and emerging themes.

A. JUSTIFICATION

A.1. Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) seeks OMB approval for this revision information collection request to continue to collect data from recipients funded through CDC's Essentials for Childhood (EfC): Preventing Adverse Childhood Experiences through Data to Action. OMB approval is requested for an additional 3 years. CDC will collect data from EfC recipients to assess how recipients are improving a surveillance infrastructure, implementing and evaluating prevention strategies to expand efforts to prevent adverse childhood experiences, and using data to inform prevention action. The proposed information collection is authorized by the PHS Act which provides the legislative means for states to advance public health across the lifespan and center and engage communities. CDC is authorized to collect information for public health purposes by Section 301(a) (Att. 1).

Adverse childhood experiences (ACEs) are preventable, potentially traumatic events that occur in childhood and adolescence (0-17 years).^{1,2} As the number of ACEs experienced increases, so does the risk for negative health and life outcomes,³ including health risk behaviors, chronic health conditions, mental health challenges, limited educational and economic opportunity, and early death. Social

conditions that affect health and safety like multigenerational poverty, living in under-resourced neighborhoods, or experiencing food insecurity can exacerbate the effects of ACEs.⁴ However, ACEs can be prevented. Preventing ACEs has the potential to reduce leading causes of death, mental health challenges, health risk behaviors such as substance use, verified reports of child abuse and neglect, increase productivity and educational attainment, and saves billions of dollars each year.^{3,5-7} By addressing the conditions that give rise to ACEs and simultaneously addressing the needs of children and parents, communities can take a multigenerational approach to prevent ACEs.

For this Notice of Funding Opportunity (NOFO), 12 funded recipients are expected to leverage multisector partnerships and resources to improve and sustain ACEs and positive childhood experiences (PCEs) surveillance infrastructure that collects, uses, and disseminates data on ACEs and PCEs, including data that contextualize risk factors to inform implementation of ACEs prevention strategies across the state. Funded recipients will work to center and engage communities and improve conditions for health and safety. In addition, the NOFO will require recipients to 1) Build or improve surveillance infrastructure and capacity; 2) Implement and sustain ACEs prevention strategies; and 3) Utilize ACEs/PCEs data for action.

This NOFO includes base and enhanced funding. EfC recipients who apply for and receive enhanced funding will conduct base and additional activities for the enhanced funding, including: (1) collecting ACEs data using syndromic surveillance approaches, (2) implementing ACEs primary prevention strategies at the local level; and/or (3) linking state and local data on the conditions for health and safety to youth-based ACEs data.

Recipients' annually submitted progress, outcomes, performance indicators and related measures will inform the CDC evaluation of the cooperative agreement by capturing program impact as well as inform performance monitoring and continuous program improvement.

A.2. Purpose and Use of Information Collection

The purpose of the information collection effort is to collect EfC program recipient data related to surveillance, implementation, program evaluation, and performance monitoring. This data collection is necessary to ensure that programs are progressing toward achievement of their stated goals and objectives, as well as consistently demonstrating efficient and appropriate use of federal funds. CDC will use the information collected to further understand the facilitators, barriers, and critical factors to implementing specific ACEs prevention strategies and conducting related program evaluation activities. Data collected will also be used to inform CDC's training and technical assistance, program improvement, and the development of future funding opportunities.

Data collection is designed to address the following key program evaluation questions:

- *Q1 What has the recipient accomplished to achieve the overall goals and objectives of the NOFO, and the short-term and intermediate- outcomes in their logic model?*
- *Q2: How has the recipient leveraged multi-sector partnerships and resources among state agencies (additional funding at the local level) and other sectors to prevent ACEs, including forming sustainable systems and partnerships, and realigning/focusing/mobilizing resources to prevent ACEs?*
- *Q3: In what ways has the recipient built or enhanced their state-level surveillance system to monitor ACEs?*

- *Q4: How has the recipient integrated the centering and engaging of communities and conditions for health and safety in preventing ACEs?*
- *Q5: In what ways has the recipient enhanced their statewide action plan to implement complementary ACEs prevention strategies (additional funding for implementation at the local level)?*
- *Q6: What factors are critical to implementing ACEs prevention program strategies?*
- *Q7: In what ways has the recipient enhanced their ability to use ACEs and PCEs surveillance and evaluation data to inform prevention strategy allocation? In what ways has the recipient enhanced their ability to disseminate and use data to inform partner, policy, or other action?*
- *Q8: To what extent has the recipient seen a sustainable increase in capacity and activities related to routine monitoring of ACEs and PCEs data among youth? To what extent has the recipient seen a sustainable increase in capacity and activities related to routine monitoring of near real-time surveillance to monitor indicators of ACEs?*

Information will be collected annually from recipients through the DVP Partners Portal, a web-based data collection system. The DVP Partners Portal allows recipients to fulfill their annual reporting obligations efficiently by employing user-friendly, easily accessible web-based instruments to collect necessary information for both progress reports and continuation applications. Because information from previous reports will be carried over and pre-populated for the next annual reporting, recipients will only need to enter changes, update progress, and add any new information after the first year of reporting, which will help to reduce recipient burden.

Information will be collected through the following instruments:

Att. 3 Annual Performance Report (APR) Tool

The data collected using the APR tool are used for program monitoring and evaluation purposes and are submitted to the Grants Management Module of Grant Solutions to serve as the official record of the APR and continuation application. Recipients will complete the APR for each budget period of years 1 through 5.

CDC will use the information to be collected to do the following:

- Enhance accountability of the use of federal funds
- Provide timely program reports and responses to information requests
- Improve real-time communications between CDC and recipients
- Strengthen CDC's capacity to provide responsive and data-driven Technical Assistance
- Strengthen CDC's capacity to monitor and evaluate recipients' progress and performance towards activities required as part of the cooperative agreement
- Allow both CDC and recipients to track their own state activities and outcomes, and ensure alignment between their state and local activities
- Generate a variety of routine and customizable reports specifically for each recipient

Att. 4a Instrument and Protocol: Key Informant Interview (KII) – Principal Investigator (PI)

Web-based interviews will be conducted with the PI from each recipient. The qualitative data collected will provide valuable insight into the overall statewide plan to expand efforts to prevent adverse childhood experiences. Interviews will be conducted with one principal investigator from each recipient

once over the project period. Interview guide questions are tailored to focus on topics that are most relevant to the PI role.

Att. 4b Instrument and Protocol: Key Informant Interview (KII) – Principal Investigator (PI)/ Implementer

Web-based interviews will be conducted with the PI and/or implementer from each recipient where the PI also serves as an implementer or is most knowledgeable about program implementation. The qualitative data collected will be heavily focused on both the PI and program implementer perspectives and will provide valuable insight into how recipients are implementing prevention strategies to prevent adverse childhood experiences. This interview will include a deeper understanding of the quality of feasibility statewide implementation efforts and their relationship with internal and external partners to achieve desired outcomes. Interviews will be conducted with the PI and/or implementer from each recipient once over the project period. Interview guide questions are tailored to focus on topics that are most relevant to the principal investigator and/or implementer role.

Att. 5a Instrument and Protocol: Surveillance Capacity Assessment (SCA) – Surveillance Lead

The primary surveillance contact for each recipient will report information about their ACEs surveillance infrastructure. The web-based assessment will be conducted in year 1 to assess each recipient's capacity to collect, analyze, and use data to inform prevention strategy implementation. CDC will use the data from the assessment to tailor technical assistance and training for recipients and to track changes in infrastructure over the project period. The information collection will allow CDC to measure the aggregate increase in support for, and resources devoted to an ACEs surveillance infrastructure across all recipients.

Att. 5b Instrument and Protocol: Implementation Capacity Assessment (ICA) – Principal Investigator/Implementer

The primary implementation contact for each recipient will report information about their infrastructure and capacity to implement primary prevention strategies and approaches. The web-based assessment will be conducted in year 1 to assess change in leadership, collaboration, and partnership, staffing and resources, skills and expertise, and evaluation among the recipients. CDC will use the data from the assessment to tailor technical assistance and training for recipients and to track changes in general institutional capacity over the project period. The information collected will allow CDC to measure the aggregate increase in support for and resources devoted to prevention across all recipients.

Att. 6 Instrument and Protocol: Evaluation and Surveillance Survey – Surveillance Lead/ Evaluator

The web-based survey will be conducted with surveillance, and evaluation leads from each recipient. The evaluation approach collected will provide valuable insight into how recipients are evaluating their surveillance and evaluation activities, including how they have leveraged existing and new resources and multi-sectoral partnerships to expand efforts to prevent adverse childhood experiences. Web-based surveys will be conducted with one implementer and evaluator from each recipient once over the project period. Survey questions are tailored to focus on topics that are most relevant to the principal investigator and evaluator roles.

There are significant advantages to collecting information with these data collection methods:

- The information collected will provide unique insight into the collaboration and coordination between recipients and partners.

- The mixed methods approach takes advantage of the strengths of both quantitative and qualitative approaches.
- Tailoring the data collection tools to the recipients will allow CDC to identify facilitators and barriers, best practices, and areas for improvement for implementing prevention efforts in different contexts.

CDC will use the information collected across all years to understand each recipient's experiences and progress toward outcomes as well as to identify facilitators, barriers, and key factors to improving a surveillance infrastructure and implementation of prevention strategies. In addition, data collected in project years 1, 4, and 5 will inform adjustments in the type and cadence of technical assistance provided to recipients to support achievability of goals. The information collection will allow CDC to monitor the impact of surveillance infrastructure activities and strategies implemented by the recipients on outcomes related to adverse childhood experiences (ACEs) and positive childhood experiences (PCEs). It is also expected to reduce duplication of effort and maximize the use of federal funds.

Program evaluation is an essential public health function and important for performance monitoring. Evaluation activities allow CDC to identify and disseminate information about best practices for successful implementation of violence prevention programs by recipients. EfC is a non-research (i.e., programmatic) NOFO. Per CDC's NOFO requirements, data collected for non-research NOFOs are not population-based samples and are only generalizable to the EfC recipients. The intention of this data collection is not to make causal inferences. The conclusions drawn from these data may not be generalized to the entire country due to differences in the demographics of targeted populations, policies, and implementing agencies. In addition, because this is not a research cooperative agreement, states are not required to implement rigorous research designs that have strong internal validity and produce generalizable knowledge. As such, the information CDC collects may make a strong inference of correlation, but causation cannot be inferred.

The Annual Federal Financial Report (OMB# 0920-1132) is also required to be submitted to OFR separately by recipients. This report is not required, developed, or reviewed by CDC program staff as part of any ICRC evaluation and performance monitoring. It is handled by OFR as part of its grant's financial management responsibilities. As such, it is not included as part of this request.

A.3. Use of Improved Information Technology and Burden Reduction

Annual Performance Report (APR):

Each recipient is required to complete an APR for each budget period during years 1 through 5 to report on progress toward performance outcomes as described in their logic model. The performance report includes updates to their work plan, implementation plan, and evaluation plan. It also includes items to report successes, challenges, and requests for technical assistance. While the APR is a federal oversight requirement and serves as a non-competing continuation application, the CDC will use some of the data provided for program evaluation.

Recipients will enter APR data into the DVP Partners Portal, a web-based system that collects performance data from funded recipients annually. The use of the DVP Partners Portal facilitates several advantages:

- The online interface requires minimal training, is user friendly, and intuitive for recipients to enter data.

- Creates standard data elements, definitions, and specifications at all levels to improve quality and comparability of information that recipients submit. This standardization enhances the consistency of reports to examine information across recipients.
- The data collection structure is flexible such that each recipient is able to capture and report information relevant to their program context and structure.
- Reports are easily generated from the system, which allows recipients to fulfill their annual reporting obligations and continuation application efficiently into one document.
- Recipients can generate multiple formats of their report (i.e., .docx, pdf, etc.).
- Recipients can pre-populate from one reporting period to the next, thereby increasing the efficiency of data entry, reducing errors and redundancies, and increasing the quality and reliability of information that recipients submit each year.

Key Informant Interviews:

Data will be collected via web-based qualitative interviews. CDC evaluators will employ qualitative methodological strategies such as “member checking” after each interview has been completed and synthesized, allowing for the interviewee to review their responses and confirm they reflect the actual content from the interview.

The interview protocol and guides are designed to collect the minimum information necessary for evaluation. Additional probes and prompts are included to aid the interviewers with clarifying contexts for questions.

Surveillance and Implementation Capacity Assessments:

Data will be collected via a web-based survey. The automated nature of the information collection greatly increases the efficiency of data collection over standard paper-and-pencil data collection methods given the geographic diversity of the participants. The web-based survey will contribute to data quality as built-in prompts and skip patterns will ensure only relevant questions are presented to respondents.

Evaluation and Surveillance Survey:

Data will be collected via a web-based survey. CDC evaluators will employ qualitative collection methods which will help solicit rich data on how recipients implemented surveillance and evaluation activities. CDC program evaluators will employ qualitative methodological strategies such as “member checking” after each survey has been completed and synthesized, allowing for the recipients to review their responses and confirm they reflect the actual content from the survey.

The survey protocol and guides are designed to collect the minimum information necessary for evaluation. Additional probes and prompts are included to aid the interviewers with clarifying contexts for questions.

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

EfC occupies a unique niche within the larger scope of Health and Human Services’ (HHS) ACEs prevention initiatives and will not duplicate other efforts. The collection of this information is part of a federal reporting requirement for funds received by recipients.

A.5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this data collection.

A.6. Consequences of Collecting the Information Less Frequently

The cooperative agreement requires the APR as well as data collection activities necessary for the monitoring and evaluation of the programs' implementation and outcomes. This request is for performance monitoring information to be collected annually. Key Informant Interviews will be conducted once over the project period for both project leads and lead evaluators to monitor changes across years. Surveillance and Implementation Capacity Assessments will be collected during year 1. Evaluation and Surveillance Survey will be collected during the program cycle.

Less frequent reporting would undermine accountability efforts at all levels and negatively affect monitoring and evaluation of recipient progress. If less frequent or no data are collected, CDC will be unable to:

- Evaluate impact and changes of the EfC program over the project period,
- Assess the barriers, facilitators, and critical factors to evaluate and implement primary prevention efforts identified by EfC recipient and subrecipients,
- Identify areas for improvement and additional technical assistance by CDC to help recipients achieve the goals outlined in the NOFO for EfC in the remaining funding period,
- Develop an in-depth understanding of how national, state, and local approaches can be coordinated and implemented to prevent ACEs,
- Respond in a timely manner to inquiries, such as Congressional requests mandated by the authorizing legislation.

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

This request fully complies with the regulation 5 CFR 1320.5.

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

A.8.a) Federal Register Notice

A 60-day Federal Register Notice was published in the Federal Register on June 18, 2026, Volume 91, Number 117, pp 36838 (Att. 2). For this notice CDC received 2 substantive comments. No changes were made to the supporting statement or data collection instruments as a result of these comments (Att. 2a).

A.8.b) Efforts to Consult Outside the Agency

No outside consultations will occur during the EfC cooperative agreement funding period. The evaluation questions for assessing the overall program were identified by NCIPC and further refined by feedback and lessons learned from Essentials for Childhood and Preventing ACEs: Data to Action cooperative agreements.

CDC staff and contractors designed the information collection instruments and DVP Partners Portal. Data elements were informed by APRs of previous and other existing DVP programs. Consultations resulted in streamlining questions for improved reporting.

A.9. Explanation of Any Payment or Gift to Respondents

Respondents will not receive payments or gifts for providing information.

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

The NCIPC Information Systems Security Officer has reviewed this submission and has determined that the Privacy Act does not apply. Activities do not involve the collection of sensitive or personally identifiable information. The Privacy Act Determination is attached (Att. 7).

Submission and access to data will be controlled by password-protected login to the secure site. To access the DVP Partners Portal, staff must have been authenticated and have a Secure Access Management Services (SAMS) login and password. Access is limited to staff members of the organization who are authorized to enter data on behalf of their organization. No User IDs or passwords are maintained or used by the DVP Partners Portal.

All data will be reported in aggregate form, with no identifying information included. Recipients will provide programmatic information only and will not include any personally identifying information. All procedures have been developed, in accordance with federal, state, and local guidelines, to ensure that the rights and privacy of key recipients' program staff (e.g., principal investigator) will be protected and maintained. While consent is not required to report aggregate data, recipients will be notified of the intent to use aggregate data, and approval will be obtained if data specific to any particular coalition is used for publications, reports, or other publicly disseminated information. CDC will maintain all data collected in the information technology systems (i.e., Partners Portal and CDC Microsoft OneDrive Excel datasets) utilized to monitor progress and outcomes. The information and passwords to these IT systems kept by CDC are private and secure to the extent permitted by law. Administrators cannot view user password credentials.

A.11. Institutional Review Board (IRB) and Justification for Sensitive Questions

IRB Approval

The CDC NCIPC's OMB and human subject's liaison has determined that this collection is non-research, and IRB approval is not needed. The information does not involve the collection of personal information or participation of Human Subjects (Att. 8).

Sensitive Questions

The proposed information collection does not collect sensitive information.

A.12. Estimates of Annualized Burden Hours and Costs

A.12.a) Annual Burden Hours

The estimate for annual burden hours is based on actual hour burden for projects using similar types of interviews and surveys.

Annual Performance Report (Att. 3)– Project leads for EfC will complete the APR annually. The APR is expected to take an average of 10 hours per report to account for time for reviewing instructions, searching existing data sources, gathering, and maintaining data needed for reporting, and completing and reviewing the collection of information.

Key Informant Interviews (Att. 4a & 4b)– Key Informant Interviews will be conducted once during the 5-year project period. The interview is designed to take 60 minutes for each respondent conducted with a principal investigator and implementor. Annualized average burden (60 minutes per response / 5 years) = 12 minutes per response per year.

Capacity Assessments (Att. 5a & 5b)– Principal investigators, surveillance leads, or evaluators will complete the capacity assessments once during the 5-year program cycle. Most questions will be close ended using a multiple-choice format, with some open-ended questions. Each survey takes 30 minutes to complete. Annualized average burden (30 minutes per response / 5 years) = 6 minutes per response per year.

Evaluation and Surveillance Survey (Att. 6) – Surveillance Leads or Evaluators will complete the evaluation and surveillance survey once during the 5-year program cycle. Most questions will be close ended using a multiple-choice format, with some open-ended questions taking 60 minutes to complete. Annualized average burden (60 minutes per response / 5 years) = 12 minutes per response per year.

Table A.12-A. Estimated Annualized Burden Hours

Type of respondents	Form Name	No. of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
ESSENTIALS FOR CHILDHOOD GRANTEEES	Annual Performance Report (APR) – Project Leads (Att. 3)	12	1	10	120
	Key Informant Interview – Principal Investigators (Att. 4a)	12	1	12/60	2.4
	Key Informant Interview – Principal Investigator/ Implementor (Att. 4b)	12	1	12/60	2.4
	Surveillance Capacity Assessment – Surveillance Lead (Att. 5a)	12	1	6/60	1.2
	Implementation Capacity Assessment (Att. 5b)	12	1	6/60	1.2
	Evaluation and	12	1	12/60	2.4

	Evaluation and Surveillance Survey – Surveillance Lead or Evaluator (Att.6)	2.4	\$42.73	\$103	2	\$206
Total				\$5,539	NA	\$11,078

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

This data collection will not result in costs for respondents or record keepers. No capital, maintenance, start-up, hardware, or software costs are expected for respondents or record keepers.

A.14. Annualized Cost to the Government

The average annualized cost to the federal government is \$58,323 with a fully loaded cost of \$116,646. CDC personnel costs follow the [General Schedule](#). HHS currently assumes that benefits plus indirect costs equal approximately 100 percent of wages. In other words, multiplying wages by a factor of 2 provides an estimate of the fully loaded wage rate, as summarized in Table A.14-A.

Table A.14. Estimated Annualized Federal Government Cost Distribution

Type of Cost	Description of Services	Annual Cost	Wage Rate Multiplier	Fully Loaded Cost
CDC Personnel	20% of GS-13 Behavioral/Health Scientist at \$112,556/year for data collection design, collection, analysis, and reporting	\$22,511	2	\$45,022
	20% of GS-13 Health Informatician at \$112,556/year for data system design, development, and maintenance	\$22,511	2	\$45,022
	10% of GS-14 Behavioral Scientist at \$133,007/year for data collection design, collection, analysis, and reporting	\$13,301	2	\$26,602
Total		\$58,323	NA	\$116,646

A.15. Explanation for Program Changes or Adjustments

Substantial revisions were made to streamline the reporting process and comply with CDC's priorities and Presidential Executive Orders [EO 14168](#) "Defending Women From Gender Ideology Extremism

and Restoring Biological Truth to the Federal Government” and [EO 14151](#) “Ending Radical and Wasteful Government DEI Programs and Preferencing”.

Revisions include

- Form 1 was updated to include reporting on barriers, facilitators, and successes for each objective.
- Form 2 was updated to remove the reporting requirement for Section 4: Needed Resources.
- Since barriers, facilitators, and successes are reported in Form 1, they have been removed from Form 3. Form 3 has been updated to focus solely on training, technical assistance, and capacity building.
- Language was updated to comply with CDC priorities and EO 14168 and 14151.
- Forms 5 - 7 were streamlined to minimize the burden.

A.16. Plans for Tabulation and Publication, and Project Time Schedule

A. Time schedule for the entire project

The cooperative agreement cycle is five years. OMB approval is being requested for three years. Per the NOFO, data collection must begin 6 months post award with the APR Tool. Other data collections will occur per the NOFO requirements once a year and is due 120 days before the end of the budget period. Data collection will begin with the awarding of the grants and will continue throughout the funding cycle.

B. Publication plan

Information collected from the recipients will be reported in internal CDC documents and shared with recipients. Raw data will not be made public as it is used for internal program evaluation to assess recipient progress and outcomes. Any reported data will be provided in aggregate form. Publication in a peer-reviewed scientific journal will be determined post-data collection.

C. Analysis plan

CDC will use statistical methods for analyzing information. For example, the difference between baseline rates and achieved rates on indicators will be documented and analyzed. Information will be synthesized for specific reporting purposes and responses to inquiries. These reports may include aggregate reports or filtered by certain characteristics or information.

Activities	Timeline
Annual data collection as described in Section A.2 and A.12	Ongoing once annually 1-60 months after OMB approval.
Data cleaning and analysis	Ongoing annually 4-60 months after OMB approval.
Reporting of evaluation data and findings to recipients and stakeholders	Ongoing annually 8-60 months after OMB approval.

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

The display of the OMB expiration date is appropriate.

A.18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to certification.

References

1. Centers for Disease Control and Prevention. Preventing adverse childhood experiences: leveraging the best available evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2019. <https://stacks.cdc.gov/view/cdc/82316>
2. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*. 1998; 14(4), 245–258. [https://doi.org/10.1016/S0749-3797\(98\)00017-8](https://doi.org/10.1016/S0749-3797(98)00017-8)
3. Merrick MT, Ford DC, Ports KA, et al. Vital Signs: Estimated Proportion of Adult Health Problems Attributable to Adverse Childhood Experiences and Implications for Prevention — 25 States, 2015–2017. *MMWR Morb Mortal Wkly Rep*. 2019;68:999-1005. DOI: <http://dx.doi.org/10.15585/mmwr.mm6844e1>
4. Nurius, PS, Logan-Greene P, Green S. Adverse Childhood Experiences (ACE) Within a Social Disadvantage Framework: Distinguishing Unique, Cumulative, and Moderated Contributions to Adult Mental Health. *Journal of Prevention & Intervention in the Community*. 2012; 40(4), 278-290. DOI: [10.1080/10852352.2012.707443](https://doi.org/10.1080/10852352.2012.707443)
5. Peterson C, Florence C, Kleven J. The Economic Burden of Child Maltreatment in the United States, 2015. *Child Abuse & Neglect*. 2018; 86,178-183. <https://doi.org/10.1016/j.chiabu.2018.09.018>
6. Jones CM, Merrick MT, Houry DE. Identifying and Preventing Adverse Childhood Experiences, Implications for Clinical Practice. *JAMA*. 2020;323(1):25-26. DOI: [10.1001/jama.2019.18499](https://doi.org/10.1001/jama.2019.18499)
7. Olds DL, Eckenrode J, Henderson CR Jr, Kitzman H, Powers J, Cole R, Sidora K, Morris P, Pettitt LM, Luckey D. Long-term effects of home visitation on maternal life course and child abuse and neglect: fifteen-year follow-up of a randomized trial. *JAMA*. 1997;278(8):637-643. DOI: [10.1001/jama.1997.03550080047038](https://doi.org/10.1001/jama.1997.03550080047038)