

**Supporting Statement: Part A**

**An Assessment of the State Public Health Actions (“1305”) Program**

Supported by:

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## Overview

- CDC plans to conduct an assessment of health departments currently funded through the *State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health, 1305* (hereafter referred to as State Public Health Actions 1305) cooperative agreement to increase understanding of program functioning with a particular focus on partnerships and the achievement of synergy.
- The information will be used to inform future program funding, program implementation, reporting requirements, and the provision of CDC technical assistance (TA) to funded programs. In addition, key findings will be reported to division- and center-level leadership within CDC, and members of the U.S. Congress, to inform future planning and implementation of coordinated, cross-cutting funding models for chronic disease prevention.
- CDC will use a prospective cohort design to assess all 50 states and the District of Columbia. Information will be collected through administration of the State Synergy Survey, a web-based questionnaire designed to gather information on state-level partnerships and synergy within the coordinated model. The survey will be administered in 2016 (program year 4) and 2018 (program year 5) to explore changes over time.
- Data analysis will include, descriptive statistics (e.g., counts, means, range, standard deviation); factor analysis to assess residual correlations; and reliability tests and linear regression analysis to predict synergy. All information will be aggregated within each state and reported with no program identifiers present in external documents.

### A. Justification

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

##### Background

The CDC defines chronic diseases and conditions as health issues that “last a year or more and require ongoing medical attention, or that limit activities of daily living” (CDC, 2016). Chronic diseases and conditions – such as heart disease, stroke, diabetes, and obesity – are the leading causes of death and disability in the U.S., and are major drivers of sickness and high health care costs (CDC, 2016). In 2012, 117 million people – about half of all adults in the U.S. – had at least one chronic health condition, and seven of the top ten causes of death were chronic diseases (CDC, 2013; Ward, Schiller & Goodman, 2014). While chronic conditions increase an individual’s risk for hospitalization or premature death, having multiple chronic conditions further increases the risk for these negative health outcomes while also increasing risk for poor day-to-day functioning. Chronic diseases are also associated with significant health care costs. In 2010, 86% of all health care spending was attributed to individuals with at least one chronic medical condition—71% for individuals with multiple chronic conditions (Gerteis et al., 2014).

To address these challenges, the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) supports activities to prevent chronic diseases and their risk factors. NCCDPHP provides funding for cross-cutting chronic disease programs within state and local health agencies to implement public health programs; conduct public health surveillance; translate research; communicate health prevention messages; and develop and implement tools and resources for state- and local-level stakeholders.

In 2007, a publication in the CDC journal *Preventing Chronic Disease* recommended actions for states and CDC to support the integration of chronic disease programs, including modifying guidelines in requests for applications to encourage and facilitate the integration of chronic disease programs (Slonim et al., 2007). In accordance with this recommendation, CDC developed a funding opportunity announcement (FOA) in 2013, titled *State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health, 1305* (hereafter referred to as State Public Health Actions 1305) to support states in the design and implementation of strategies to reduce the complications from multiple chronic diseases and associated risk factors. This 5-year cooperative agreement addresses six public health priorities:

1. uncontrolled hypertension;
2. prevention and control of diabetes;
3. incidence of obesity;
4. increased physical activity and healthy eating by children and adults;
5. increased breastfeeding; and
6. improved management of chronic conditions among students.

Through this cooperative agreement, CDC currently provides over \$100 million to state health departments in all 50 United States and the District of Columbia. Due to the funding, complexity, coordination and collaboration in implementing State Public Health Actions 1305, there are a number of reporting requirements related to categorical spending, chronic disease outcomes, efficiencies and accomplishments. These routine reporting requirements allow CDC to monitor awardee progress towards programmatic goals, but do not collect specific information about the processes that support implementation plans.

### Cross-Cutting Funding Model

Through the State Public Health Actions 1305 cooperative agreement, CDC has engaged state health departments in an important transition from separately funding and implementing four categorical programs (i.e., diabetes; heart disease and stroke; nutrition, and physical activity, and obesity; and school health) to working collaboratively on comprehensive, cross-cutting initiatives. The cooperative agreement allows states to build capacity and expertise within each categorical area, while also building capacity across all four categorical areas, in order to address the six public health priorities (**Attachment 3**).

State Public Health Actions 1305 has a strong focus on synergy. The program has defined synergy as occurring when collaboration, coordination, alignment, and a combination of inputs and activities (i.e., the assets and skills of all the participating partners) produce outputs and outcomes greater than those that would have occurred if they had been used separately. States are required to describe their synergistic approach to addressing multiple risk factors and chronic diseases to CDC. The proposed

strategies are aligned to attain greater success in achieving measurable outcomes that address each categorical area and the program as a whole. The synergistic approach prescribed by State Public Health Actions 1305 is expected to reduce redundancies at the state level, which should allow a greater proportion of funds to be used for program activities across the four categorical areas.

### Overview of the Proposed Assessment

CDC proposes to conduct an assessment of state health departments that are funded through the State Public Health Actions 1305 cooperative agreement to better understand state-level partnerships and synergy within programs. The assessment is guided by three process-related research questions informed by multiple indicators that examine changes in processes, organizational structure, capacity, synergy, and cross-cutting approaches to program implementation (**Attachment 4**).

This information collection request seeks approval for for administration of the State Synergy Survey, a 32-item web-based questionnaire designed to explore characteristics of program functioning, with a focus on state-level partnerships and synergy among health departments funded through the State Public Health Actions 1305 cooperative agreement (**Attachment 4**). The survey will be administered to health departments receiving funding through the State Public Health Actions 1305 cooperative agreement, including all 50 states and the District of Columbia receiving basic and enhanced funding. CDC plans to administer the web-based State Synergy Survey in 2016 (beginning of program year 4) and 2018 (end of program year 5) to explore changes in partnerships and synergy throughout the 5-year cooperative agreement. CDC will use findings from the assessment to inform future TA guidance and resources for funded programs, and the development and implementation of future cross-cutting cooperative agreement funding models. CDC's authority to collect this information is provided by the Public Health Service Act, 42 USC 241, Research and Investigation (**Attachment 1**).

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

The purpose of the proposed assessment is to explore the nature and impact of state-level partnerships and synergy among health departments funded through the State Public Health Actions 1305 cooperative agreement. CDC will use findings from this study for the following purposes:

- Understand how funded programs are functioning
- Understand staff roles and responsibilities within 1305 coordinated model
- Understand nature and impact of collaboration within the 1305 coordinated model
- Understand changes in efficiency and effectiveness within the 1305 coordinated model
- Understand resources needed to implement a cross-cutting, coordinated model
- Inform future TA provision to funded programs
- Inform future cross-cutting, coordinated funding models

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

Information collection will be conducted via the web-based survey. The survey can be completed at the convenience of the respondent. In addition, the survey is limited to 32 items and was streamlined to only include the most important questions to inform the relevant research questions; therefore, no extraneous information will be collected.

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

The proposed information collection is unique in that there are no other surveys currently administered to funded states that assess synergy across the four categorical areas. This survey is the first data collection effort to assess a cross-cutting coordinated funding model for multiple chronic disease prevention initiatives. In addition, the survey will provide complementary information that is not obtained through progress reporting (*Monitoring and Reporting System for the State Public Health Actions Cooperative Agreements*, OMB Control Number 0920-1059, Expiration Date March 31, 2018).

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

Small businesses and other small entities will not be targeted to participate in this assessment. Recruited participants will primarily include program staff employed by state health departments (i.e., program directors, evaluators, and program staff with subject matter expertise). It is possible that some program evaluators who will be recruited to complete the survey serve as contractors and are representatives of a small business. However, CDC anticipates that this will be a rare occurrence. There are no specific requirements for small businesses.

In addition, because the survey is voluntary and each recruited participant will indicate their desire to participate at the start of the survey, the impact of the information collection on respondents—including small businesses—is expected to be minimal. The online administration of the survey will allow respondents to complete the survey in multiple sessions at their convenience over several weeks, which will also minimize the burden on small employers.

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

This information collection is critical to expanding CDC's understanding of how State Public Health Actions 1305 programs are functioning, and how program operations - particularly with respect to partnerships and synergy - change throughout the 5-year cooperative agreement. Without this information collection, NCCDPHP will have limited insight to plan and execute future coordinated funding models, or provide comprehensive TA to health departments receiving cross-cutting funding.

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

There are no special circumstances relating to the guidelines of 5 CFR 1320.5, and the project fully complies with the regulation.

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

**A8a.** The 60-Day Federal Register Notice was published on March 7, 2016, Vol. 81, No. 44, pages 11796-11798] (**Attachment 2a**). One non-substantive public comment was received (**Attachment 2b**).

**A8b.** The State Synergy Survey was adapted from a questionnaire developed by Jones and Barry (2011) that measured synergy and dimensions of partnerships in health promotion. Adaptation of the survey, including the addition of survey items to further explore the planning, implementation, and impact of cross-cutting initiatives, were incorporated with input from members of the CDC and ICF project teams.

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

Survey respondents will not receive any payment or gifts for their participation in this data collection effort.

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

Information collection for the State Synergy Survey is for the purpose of assessing CDC-funded programs' functioning and activities at the organizational level.

##### Privacy Impact Assessment

The proposed study involves a minimum amount of information in identifiable form (IIF), and includes only contact information for each respondent (i.e., name, telephone number, and email address). The information to be obtained through surveys concerns organizational activities rather than personal matters and is not considered highly sensitive. Within surveys, respondents will be asked to identify their state health department, role, and perceptions about activities conducted within their organization, but they will not be asked to provide specific names or information about individual program staff or partners. The information collected will focus on respondents' thoughts and experiences related to programmatic partnerships and collaboration.

Survey responses will be linked to respondents' state health departments and roles to ensure that survey findings can be linked across program years. ICF, the data collection contractor, will have access to IIF for program leadership and staff recruited for participation. No other personal identifiers will be collected.

IIF will be stored separately from response data. A linking file will be created and available only to project management at ICF International. This information will only be used to ensure completeness of the data files. The linking file will include the role of the respondent and their organization (and will not include the individual's name or contact information), the date of survey completion, and the code assigned to the data file. This will ensure that no IIF outside of the individual's role and organization is re-linkable. All data files will be stored in a secure electronic folder on a password-protected shared computer drive that is only accessible by authorized project staff.

#### **A. Privacy Act Determination**

CDC has reviewed this Information Collection Request and has determined that the Privacy Act does not apply to the identifiable staff-level information collected in the State Synergy Survey (**Attachment 5**). Respondents are affiliated with state health departments and will be speaking from their roles. Respondents will not supply personal information. ICF International and CDC will have access to the file that links employer representative identifiers, such as names and contact information, to unique employer ID codes. ICF and the CDC evaluation team staff have consulted with CDC's Office of the Chief Information Security Officer to review the data acquisition, storage, and processing procedures to ensure that they comply with government data privacy and security procedures.

## **B. Safeguards**

Although the data collection contractor will have temporary access to identifiable information for recruitment and scheduling purposes, response data will not be recorded in a manner that can be linked to respondent identifiers. The contractor will assign each survey respondent a unique identifier code, and will store and analyze survey data by identifier code. The personal contact information for respondents will not be used for analysis or reporting purposes. All data collected will be analyzed in aggregate and discussed in summary reports that do not contain any personal identifiers.

Study information and data, including contact information for respondents, linking identifiers, and survey responses, will be destroyed within 3 years of the project end date. All electronic data files (e.g. exported survey responses) will be stored at ICF on a project shared drive on ICF's secure network servers; only project staff who have been authorized by the project manager can access the shared drive.

## **C. Consent**

An informed consent statement will be included on the cover page of the survey instrument prior to the instrument questions (**Attachment 5**). The consent statement informs participants that their participation in the survey is voluntary, and they can choose not to answer individual questions, end the survey at any time, or decline participation without penalty. Whether or not individuals choose to participate will not impact current or future funding. Respondents will be required to either agree to or decline participation prior to completing the survey.

## **D. Nature of Participation**

As previously stated, organizations currently receiving funding through the State Public Health Actions 1305 cooperative agreement will be recruited to participate in this information collection. Participation in the survey is voluntary for all participants; respondents who decline participation will not face penalty of any kind.

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

No sensitive information is requested. CDC's information collection contractor obtained IRB approval for conduct of this assessment (**Attachment 7**).

## **A12. Estimate of Annualized Burden Hours and Costs**

### **A. Estimated Annualized Burden Hours**

OMB approval is requested for two years. Over this period, CDC will administer the State Synergy Survey at two time points – once in summer/fall 2016 and once in spring 2018. Annualized estimates of the number of respondents involved in the information collection activities are provided below.

- The State Synergy Survey (**Attachment 5**) will be completed online. Survey respondents will be drawn from 51 health departments (50 states and the District of Columbia) funded through the State Public Health Actions (“1305”) program. The estimated burden per response is 45 minutes. To obtain a variety of perspectives, the State Synergy Survey will be completed by up to 8 respondents per health department: 1 Principal Investigator, 1 Chronic Disease Director, 1 Program Evaluator, 1 Epidemiologist, and 4 Subject Matter Experts. The total estimated annualized number of respondents is 408 (51 x 8) and the total estimated annualized burden is 306 hours (408 x 45/60).

**Table A12-1. Estimated Annualized Burden Hours**

Type of Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hr)	Total Burden (in hr)
State Health Department Staff	State Synergy Survey	408	1	45/60	306

**B. Estimated Annualized Burden Costs**

Table A12-2 presents the calculations for cost of annualized burden hours. Average hourly wage estimates were obtained from the U.S. Department of Labor, Bureau of Labor Statistics.

- The average annual salary of \$80,040 for social scientists and related workers, all other was used to calculate the hourly wage of \$38.48 for principal investigators.
- The average annual salary of \$117,200 for general and operational managers was used to calculate the hourly wage of \$56.35 for chronic disease directors.
- The average annual salary of \$54,730 for survey researchers was used to calculate the hourly wage of \$26.31 for program evaluators.
- The average annual salary of \$74,120 for epidemiologists was used to calculate the hourly wage of \$35.63 for epidemiologists.
- The average salary of \$42,450 for health educators and community health workers was used to calculate the hourly wage of \$20.41 for program staff with subject matter expertise.

The estimated annualized cost to respondents is \$9,080.00 as summarized below in Table A.12-2.

**Table A12-2. Estimated Annualized Cost to Respondents**

Type of Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Average Hourly Wage	Total Burden (in hr)	Total Cost
Principal Investigators	State Synergy Survey	51	1	\$38.48	38	\$1,462
Chronic Disease Directors	State Synergy Survey	51	1	\$56.35	38	\$,2141

Evaluators	State Synergy Survey	51	1	\$26.31	38	\$1,000
Epidemiologists	State Synergy Survey	51	1	35.63	38	\$1,354
Program staff with subject matter expertise	State Synergy Survey	204	1	\$20.41	153	\$3,123
Total						\$9,080

**A13. Estimate of Other Total Annual Cost Burden to Respondents or Record Keepers**

CDC does not anticipate any other costs to respondents or record keepers.

**A14. Annualized Cost to the Government**

**Government personnel** – Governmental costs for this project include personnel costs for federal staff involved in providing oversight and guidance for the planning and design of the State Public Health Actions 1305 assessment, refinement of the State Synergy Survey, development of OMB materials, collection and analysis of the data, and reporting. These activities involve approximately 5 percent of two GS-14 public health advisors. Assuming a \$114,649 annual salary for public health advisors, the total estimated annualized cost to the Federal Government is \$11,464,90.

**Contracted data collection** –The project design and data collection is being conducted under a contract with CDC’s data collection contractor, ICF International. Approximately \$10,000 of ICF International’s current contract (\$10,922,477.97) with CDC is dedicated for this information request to plan, implement, and analyze the data collection.

<b>Table A14-1. Estimated Annualized Cost to the Federal Government</b>	
Labor:	
5% Public Health Advisor’s time for project, planning, management, OMB review, analysis of findings, and report writing	\$5,732.45
5% Public Health Advisor’s time for project, planning, management, OMB review, analysis of findings, and report writing	\$5,732.45
Contractor	\$10,000.00
Total estimated cost	\$21,464.90

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

This is a new data collection.

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

CDC plans to disseminate the outcomes of the study within the federal government and outside of it through the development of scientific presentations, peer-reviewed publications, and tools and resources developed for program grantees. Additional dissemination channels may include publications that are commonly read by public health program managers.

The assessment and project timeline are outlined below in Table A16-1.

<b>A16-1 Assessment Time Schedule</b>	
<b>Activity</b>	<b>Time Schedule</b>
Send recruitment emails	2 weeks after OMB approval
Send participant emails	3 weeks after OMB approval
Administer survey	1-2 months after OMB approval
Analyze and report on survey findings	3 months after OMB approval
Send recruitment emails	20 months after OMB approval
Send participant emails	20 months and 1 week after OMB approval
Administer survey	20 months and 2 weeks – 21 months and 2 weeks after OMB approval
Analyze and report on survey findings	22-23 months after OMB approval

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

The OMB expiration date will be displayed on all information collection instruments.

**A18. Exceptions to Certification for Paperwork Reduction Act Submissions**

No certification exemption is being sought.

## References

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