

Information Collection Request

New

National Tobacco Education Campaign

Rough-Cut Testing of Television Advertisements

(OMB No. 0920-0910)

Supporting Statement: Part A

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LIST OF ATTACHMENTS

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Attachment 2: Online Questionnaire Recruitment Screener

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Attachment 5: Panel Terms and Conditions

Attachment 6: Battelle Institutional Review Board Approval

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Notes on Excluded Attachments. In this information collection request (ICR), CDC outlines a plan to test rough-cut advertisements (ads) with content that may be considered sensitive. The draft materials are not included because the near-final, “rough-cut” ads have not been approved for public distribution by HHS/Assistant Secretary for Public Affairs (ASPA). To support adequate review of this Gen IC by OMB, the Centers for Disease Control and Prevention requests permission to provide OMB with a secure link to the scripts used to develop the rough-cut ads.

Supporting Statement: Summary

- **Goal of the Proposed Project:** The goal of this proposed project is to test reactions to 12 rough-cut television ads designed to encourage people who smoke to quit. Rough-cut ads are near-final versions of ads with unedited photos, placeholder voiceovers, etc. These ads will illustrate the harmful effects that smoking-related diseases, such as heart disease, peripheral artery disease, throat cancer, gum disease, kidney cancer, and stroke, have on the people who used to smoke. Findings from rough-cut testing will be used to refine and finalize ads for placement in a future *Tips From Former Smokers*® (*Tips*®) campaign.

Part A. Justification for Information Collection

A.1 Circumstances Making the Collection of Information Necessary

While significant improvements have been made in reducing the smoking rate in the United States since the first Surgeon General's Report came out more than 50 years ago, cigarette smoking is still the leading cause of preventable disease and death in the United States, accounting for more than 480,000 deaths every year, or one of every five deaths (U.S. Department of Health and Human Services (HHS), 2014). In addition, more than 16 million Americans live with a smoking-related disease (HHS, 2014). In 2021, the prevalence of cigarette smoking among adults was 11.5% (Cornelius et al., 2023). However, the burden of tobacco use is not evenly distributed across the U.S. population. Decades of research have linked a broad array of social, environmental, psychological, and genetic factors to tobacco use (U.S. NCI, 2017). These factors, combined with targeted marketing from the tobacco industry, have led to higher rates of tobacco use, including higher rates of menthol cigarette use, among people of low socioeconomic status. Cigarette smoking is higher among people with a GED (30.7%) than higher levels of education, and among people with low income levels (18.3%) than middle (12.3%) or high income levels (6.7%) (Cornelius et al., 2023). Further, people who smoke menthol cigarettes can be less likely to successfully quit than people who smoke non-menthol cigarettes (CDC, 2024). Continuing to reduce the public health burden of smoking will require developing interventions that effectively reach people of low socioeconomic status, including people who smoke menthol cigarettes, with smoking cessation messages and evidence-based free quitting resources.

In March 2012, the Centers for Disease Control and Prevention (CDC) launched the first-ever paid national tobacco education campaign—*Tips From Former Smokers (Tips)*¹ The *Tips* campaign profiles real people who are living with serious long-term health effects from smoking and secondhand smoke exposure. The primary audience is adults who smoke. Secondary audiences include family members, health care providers, and faith communities. The goals of the *Tips* campaign are to:

- Build public awareness of the immediate health damage caused by smoking and exposure to secondhand smoke;
- Encourage people who smoke to quit, and let them know that free help is available;
- Encourage people who smoke not to smoke around others and encourage people who don't smoke to protect themselves and their families from exposure to secondhand smoke.

The *Tips* campaign has had a significant impact on cessation behaviors among U.S. adults who smoke over time because of the continued use of graphic, hard-hitting, emotional ads (Davis,

¹ Use of trade names is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services

Patel, Shafer et al., 2017). CDC estimated that between 2012—2018, more than 16.4 million Americans tried to quit smoking cigarettes, and one million have successfully quit because of the campaign (Murphy-Hoefer et al., 2020). The *Tips* campaign has helped prevent an estimated 129,000 early deaths and helped save an estimated \$7.3 billion in smoking-related healthcare costs (Shrestha et al., 2021). The *Tips* campaign has also been associated with increased knowledge of tobacco-related health risks (Huang, Thrasher, Abad et al., 2015.) In addition, during the first year of the campaign, an estimated 6 million people who don't smoke talked with friends and family about the dangers of smoking. More information about the impact of the campaign can be found at <https://www.cdc.gov/tobacco/campaign/tips/about/impact/campaign-impact-results.html>.

Given that more than 480,000 Americans still die from tobacco-related diseases every year, it is important to continue a national tobacco education campaign that motivates people who smoke to try to quit and lets them know that free resources are available to help them if needed. Standard accepted advertising practices include developing new ads to continue to motivate the audience to change their behavior. CDC, in collaboration with their contractor, The PlowShare Group, and subcontractor Battelle, will test 12 rough-cut television ads for a future *Tips* campaign media buy.

Rough-cut testing is a standard advertising research activity used in the development of communication campaigns and is the step that immediately precedes the development of final ads. Rough-cut testing is crucial to ensuring that the ad informs the intended audience of the health consequences caused by smoking cigarettes and motivates them to take action (e.g., quit smoking cigarettes). Additionally, rough-cut testing is a way to measure any unanticipated confusion, ambiguity, or lack of understanding of the ad's message.

The objective of the proposed project is to test rough-cut television ads among adults who smoke, aged 18 to 64. The content in these ads is derived from the life experiences of adults who used to smoke cigarettes. Ad reactions will be analyzed with the full sample, as well as between and within subpopulations defined by socioeconomic status (SES). Additionally, we will recruit supplemental samples of participants who will be assigned to view rough-cut ads based on their race/ethnicity. English-Speaking American Indians and Alaska Natives will be randomly assigned to view one of two ads featuring an American Indian. English-Speaking Asians will view an ad featuring a Native Hawaiian. These participants will be assigned to view a rough-cut ad depicting a member of their racial/ethnic group to test whether the ad resonates with members of that group and represents their culture appropriately.

Recruitment quotas are detailed in **Table A.1**. In order to assess how the rough-cut ads are perceived across a number of measures, including perceived effectiveness (PE) (Davis, Duke, Shafer et al., 2017), believability, comprehension, and emotional reactions, approximately 10,800 respondents will view and react to rough-cut television ads. Of these, a minimum of 400 respondents with low-SES and 400 respondents who are not of low-SES will view each of the 12

ads.² An additional 400 English-Speaking American Indians or Alaska Natives will view each of two ads featuring an American Indian, and 400 English-Speaking Asians will view one ad featuring a Native Hawaiian. These participants will not be stratified by SES. **Section A.12** and **Part B** include additional information on sample size calculations.

² To achieve this final sample size, it is anticipated that the total number of respondents who need to initiate the screener is 13,579 accounting for attrition. More detail on how this number was calculated this is included in **Section A.12**.

Table A.1 Minimum Number of People Who Smoke ¹ to View Each Ad		
People With Low-SES	People Who Are Not of Low-SES	Supplemental Sample Participants ²
400	400	400

¹Adults who smoke are defined as persons aged 18 years of age to 64 who report smoking > 100 cigarettes during their lifetime and who, at the time of the survey, report smoking cigarettes every day or some days, and have smoked at least one cigarette in the past 30 days.

²Supplemental sample participants include English-Speaking American Indians and Alaska Natives, and English-Speaking Asians.

Recruitment for each stratum will close when that stratum is filled. The maximum number of respondents for each ad is 1,200 (800 + 400) and the maximum number of respondents for all ads is 10,800 ([1,200 x 3 ads] + [800 x 9 ads]).

A.2 Purpose and Use of Information Collection

This proposed project is part of a collection of ICRs submitted under a dedicated generic clearance to develop campaign ads. Previous ICRs approved under this generic clearance to assist with ad development include rough-cut testing, in-person and online focus groups, and pre-testing ads for the *Empower Vape-Free Youth*TM campaign. For example, the program received OMB approval to test rough-cut ads on June 22, 2020 (OMB No. 0920-0910). The ads tested in June 2020–August 2020 aired as part of the 2022 *Tips* campaign. The program received OMB approval to test two cycles of rough-cut ads on February 21, 2023. The first cycle of ads tested in February–April 2023 aired as part of the 2024 *Tips* campaign. The second cycle of ads were tested in May–July 2024 and will air as part of a future *Tips* campaign. The rough-cut ads that test well with the intended audience in the proposed project will be used as part of a future *Tips* campaign. If this information collection is not performed, CDC will not know whether these rough-cut ads communicate credibly and effectively with the intended audience. This could result in the production of ads that are not effective in encouraging people who smoke to quit.

Potential participants will be recruited from existing, online, convenience panel providers such as Sago, Toluna, Prodege, Quest Mindshare, RFG, Torfac, Solugo, Savanta, and Mfour. The panel providers maintain demographic information about panelists in their proprietary databases, which are not released (see Panel Privacy Policies, Attachment 7), and this information will be used to ensure that the invitation to participate in this project (Attachment 1) will reach only individuals who are likely to be eligible. An online, project-specific screener (Attachment 2) will be used to confirm respondents' age, state of residency, level of education, income, employment status, racial/ethnic group membership, household size, and tobacco use behavior.

Following the screening process, eligible respondents will complete the online questionnaire (Attachment 3). The purpose of the online questionnaire is to assess how they perceive the

rough-cut ads. The questionnaire will measure demographic characteristics, tobacco use behaviors and perceptions, and reactions to the ads (e.g., perceived effectiveness, confusion, believability, emotional response, effect on motivation to quit smoking, etc.). People with low-SES who smoke and people who are not of low-SES who smoke will be randomized to one of the 12 ads. Randomization of respondents ensures that there is a similar distribution of individuals with different measured and unmeasured characteristics across ads. Responses among supplemental sample participants will not be compared to the responses of main sample participants who are randomly assigned to view an ad. Overall, this data collection is designed to have high internal validity even though external validity (i.e., generalizability) is low because of the volunteer sample. The project design is summarized in **Figure A.1** and key variables are summarized in **Table A.3**.

Figure A.1. Diagram of Proposed Project Design

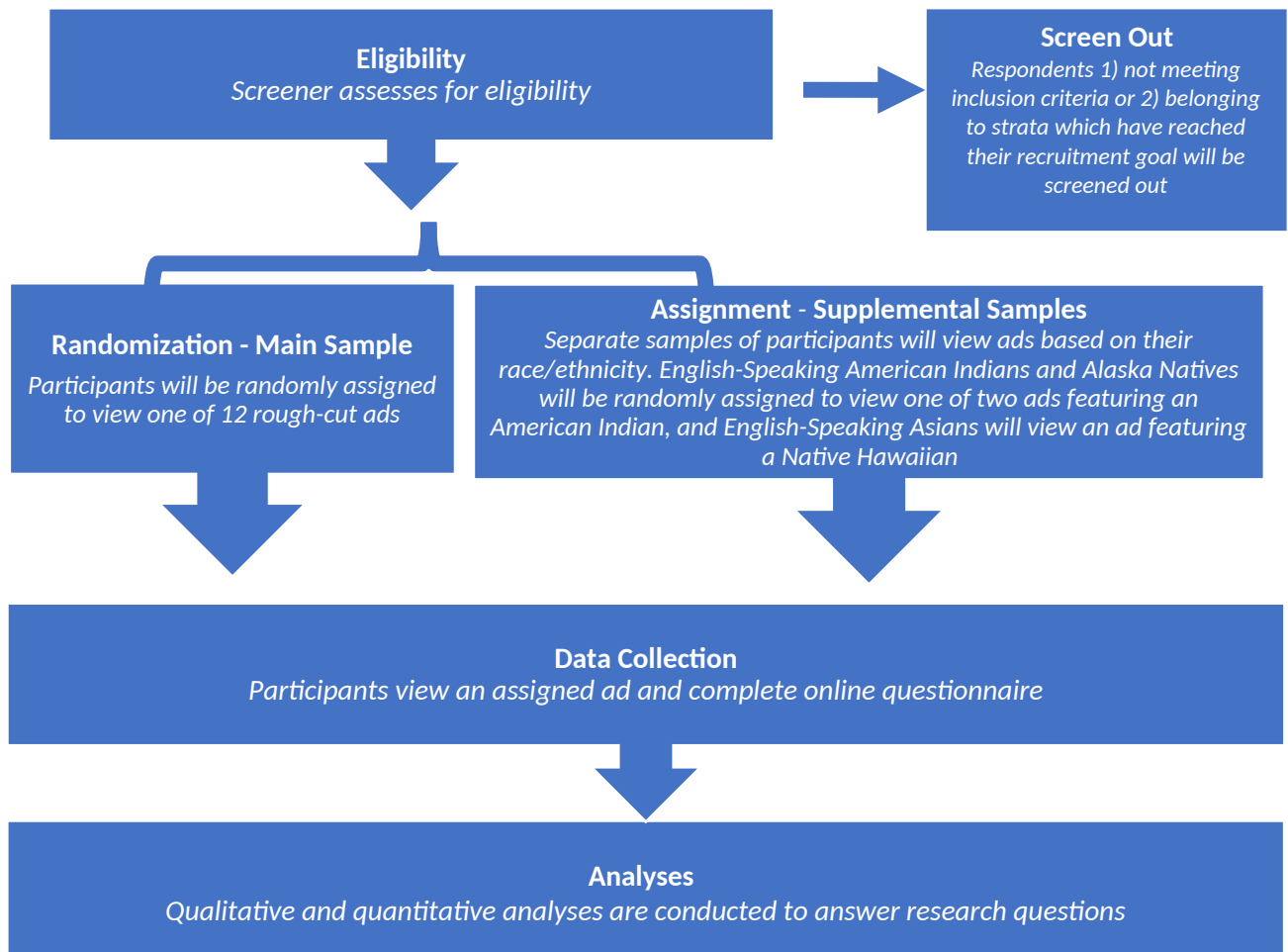


Table A.3. Key Variables

Inclusion Criteria		
Screener	Age	DAGE2
	State of Residency	DEMO2
	SES (Education; Income; Household Size; Employment)	SES1; SES2; SES3; SES4
	Race/ethnicity	RACE
	Tobacco Use Status	TS1; TS2; TS3
Demographic Variables		
Questionnaire	Gender Identity	SOGI1; SOGI2
	Sexual Orientation	SOGI3
	Tobacco Variables	
	Tobacco Use Status/Behaviors	TS1a; TS1b; TS2
	Menthol Cigarette Use	B3; B5
	Beliefs About Menthol Cigarettes	B6a; 86b; B7a; 87b
	Quit Attempts	QA1; QA2; QA30; QA4; QA5; QA102; QA6
	Tobacco Attitudes and Beliefs	C1; C2; C3; P5b2; P5d
	Outcome Variables	
	Ad Reactions	M1; M2; RC5a; RC5b; M3; M4; M5a; M5b; M6a; M7b; M8a; M600; RC14; RC15; RC16; RC17; RC14b; B6b; B7b; RC31; RC32; UAR_Art1; AR_Art2

A.3 Use of Improved Information Technology and Burden Reduction

During data collection, all information (from the screener and the questionnaire) will be collected electronically utilizing an integrated Web-based software platform (see Attachment 4). Web-based surveys are an especially convenient option for eliciting feedback on visual, audio, and textual stimuli such as the rough-cut ads to be tested. The use of a web-based platform also offers a number of benefits for managing the quantitative data collection:

- First, use of existing online panels will allow CDC to obtain information quickly so that needed adjustments to health messaging can be made expeditiously and campaign development can progress rapidly from planning to implementation. Several panels are being used for this data collection due to their ability to recruit people who smoke with desired demographic profiles. While the smallest panel being used has 220,000 participants, the largest panel being used has over seven million participants. This will allow efficient selection of participants from extremely small subgroups of the population. Using several panels will ensure feasibility of reaching the desired audiences, including supplemental samples. Samples from these panels are not designed to generate nationally representative samples or precise population parameters but rather are used as a highly efficient, low cost, and low burden method of data collection for

formative rough-cut testing.

- Second, when a respondent enters the screener for this project, the link to the contact and demographic information maintained by the panel provider is severed. None of the information collected through screening or the online questionnaire is linked to their panel-maintained contact or demographic information, providing a secure environment for participants.
- Third, this technology permits participants to complete the instruments in private. Providing the participant with a methodology that improves privacy makes reporting of potentially embarrassing or stigmatizing behaviors (e.g., tobacco use) less threatening and enhances response validity and response rates.
- Finally, the web-based software system includes embedded logic that will route respondents efficiently through the screener and onto the online questionnaire (or a “thank you” screen, if the respondent is found to be ineligible). This approach can increase participation rates (which decreases time and costs related to information collection procedures) by reducing the number of respondents needed to complete the screener in order to achieve the desired enrolled sample size (i.e., by reducing drop off between the screener and questionnaire).

Overall, the software supports an efficient assignment and routing process, as well as a smooth user experience that would be difficult to attain in other modes of data collection.

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

The U.S. Department of Health and Human Service’s Office of the Assistant Secretary for Planning and Evaluation (ASPE) has reviewed this proposed collection of information and has determined that it does not duplicate other collections. To prepare for data collection, CDC reviewed existing published literature, and unpublished qualitative pretesting reports (e.g., the findings from previous formative testing) when they were available.

CDC collaborates with other federal government agencies that sponsor or endorse health communication projects, such as the Food and Drug Administration’s (FDA) Center for Tobacco Products (CTP). Staff members in CDC’s Office on Smoking and Health work closely with staff in CTP’s Office of Health Communication and Education. Regularly scheduled conference calls are held to review plans and share research findings of mutual interest. These collaborations serve as information channels, help prevent redundancy, and promote use of consistent measures of effectiveness. Coordination activities include the review of data collection instruments and other support materials for testing purposes.

FDA CTP is investing in a number of public education campaigns aimed at youth and young adults (i.e., *The Real Cost*, *Fresh Empire*, and *This Free Life*) to educate them about the dangers of regulated tobacco products. In addition, FDA CTP also makes available to state partners materials from its *Every Try Counts* campaign, an adult-focused campaign that uses encouraging messages to get people to quit smoking, however they are no longer doing paid placements for this campaign. CDC continues to share findings from its information collection efforts with CTP

to ensure that message and campaign development is complementary and not duplicative.

Points of contact for this coordination are:

- CDC: Michelle O’Hegarty, Health Communications Specialist, Campaign Development, Health Communications Branch, telephone (770) 488-5582, email mohegarty@cdc.gov
- CDC: Lauren Boyle-Estheimer, Sr. Health Communications Specialist, Health Communications Branch, telephone (404) 498-2283, email LBoyleEstheimer@cdc.gov
- CDC: Rebecca Murphy, Research and Evaluation Team Lead, Health Communications Branch, telephone (770) 488-8964, email Rebecca.Murphy@cdc.hhs.gov
- FDA: Allison Kulas, Social Scientist, Office of Health Communication and Education, telephone (301) 837-7453, email Alison.Kulas@fda.hhs.gov
- FDA: Emily McDonald, Health Communications Specialist, Office of Health Communication and Education, telephone (301) 796-6151, email Emily.McDonald@fda.hhs.gov
- FDA: Anh Zarndt, Health Scientist, Office of Health Communication and Education, telephone (240) 402-5875, email anh.zarndt@fda.hhs.gov

A.5 Impact on Small Business or Other Small Entities

This data collection will not involve small businesses or other small entities.

A.6 Consequences of Collecting the Information Less Frequently

This is a one-time information collection request.

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

There are no special circumstances that require data collection to be conducted in a manner inconsistent with 5 CFR 1320.5 (d) (2). The information collection fully complies with the guidelines in 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 Announcement

A 60-day Notice was published in the Federal Register on January 23, 2023, volume 88, number 2023-01162, pp. 3992-3994. A 30-day Notice was published in the Federal Register on July 21, 2023, volume 88, number 47143, pp. 66467-64468. The CDC did not receive any public comments regarding this information collection.

A.8.b Consultations

The *Tips* campaign has been funded primarily with funds from the Affordable Care Act/Public Health Fund designated for smoking education since 2010. CDC did not consult outside of the agency on the rough-cut ads.

A.9 Explanation of Any Payments or Gift to Respondents

Participants will be drawn from established panel systems, which provide points to panelists to encourage participation (see Attachment 5: Panel Terms and Conditions). Immediately upon completion of the survey, each respondent will be provided with points for their participation equivalent to at least \$0.50. The cash value of points will vary slightly depending on the panel used and phase of recruitment (e.g., participants may be offered a larger incentive later in recruitment, where outreach is directed at members of a hard-to-reach population). These points are accrued with other points when the panelist takes part in other surveys through the panel systems. At any time, the panelist can redeem their points for different products, such as gift cards. Studies have indicated that a monetary gift can increase response rates (Church, 1993; Greenbaum, 2000; Haveman, 2010).

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

This submission has been reviewed by staff in CDC's National Center for Chronic Disease Prevention and Health Promotion, who determined that the Privacy Act does not apply. This determination is based on the fact no personal identifiers will be collected in this proposed project to reduce the likelihood of identification or re-identification. CDC has contracted with The PlowShare Group for this information collection and their data collection and formative research subcontractor is Battelle. Battelle partners with Sago, a global research company, to recruit participants and collect data. Further, the information that will be reported to and maintained by CDC is not considered a record as defined by the Privacy Act: it will not include individuals' education, financial transactions, medical history, and criminal or employment history and name, or the identifying number, symbol, or other identifier assigned to any individual, such as a finger or voice print or a photograph. Staff from CDC and Battelle participated in planning the information collection; staff from each will interpret data. Battelle's Institutional Review Board (IRB) reviewed this project and determined it to be exempt (Attachment 6). The IRB's primary concern is protecting respondents' rights, one of which is maintaining the privacy of participant information to the fullest extent of the law.

Privacy and Confidentiality of Online Questionnaire System

All information for the self-administered screening process and self-administered questionnaire will be collected electronically in a secure, web-based data collection system (as described in Section A2 and Part B). Contact and demographic information about panelists is maintained in proprietary records systems and is not released to CDC or other contractors/subcontractors (see Attachment 7: Panel Privacy Policies). Although demographic information (e.g., age, sex, gender identity, state of residency, socioeconomic status, race/ethnicity) and tobacco use status will be confirmed through screening, no direct personal identifiers (e.g., date of birth [including day, month, year], name, phone number, address, email address, social security number, photograph, biometric information, or any other unique identifier that can be linked to an individual) will be collected or maintained as part of the Screener or Questionnaire (Attachments 2 and 3). A system of records notice (SORN) is not required because (1) the information collected is not considered a record as defined by the Privacy Act and (2) the records are not retrieved using a personal identifier. Panel providers employ a double opt-in process for individuals to participate in a survey – they must opt-in to become panelists, and

they must also opt-in to each survey.

When the respondent begins the questionnaire, all identifiable links to the existing system of records are severed. As such, because it does not exist, CDC will not have direct contact with or access to any PII about participants during this stage. The panel providers do have access to the email address of panel subscribers, but no match back is possible with the survey response data. IP addresses will not be stored by the online questionnaire system, and no first- or third-party cookies will be stored during questionnaire completion. No link between the respondent's email and the specific survey is made after the potential respondent clicks on the link to start the survey.

Data Security

All findings will be reported in aggregate form only. All information will be stored on password-protected databases to which only Battelle employees working on this project have access. Battelle will keep the quantitative data in non-aggregate form for five years after the end of the PlowShare subcontract with Battelle, and then the respondent-level data will be deleted from the password-protected databases. Battelle will provide CDC with the anonymously collected data, to be used for analyses. Only CDC and Battelle employees involved in data analysis will have access to the data. CDC will handle the data in accordance with the record control schedule (maintained at least six years, but no longer than ten years). No desktop or laptop computer will contain any PII. To prevent unauthorized access to their data servers (such as "hacking"), the Battelle corporate network is configured to meet National Institute for Standards and Technology (NIST) Special Publication (SP) 800-171 and restricts access to Battelle resources through the use of firewalls; routers; intrusion detection/prevention systems; security information and event management (SIEM); and isolated segments between web, application, and database zones to restrict unnecessary traffic. Battelle uses the SIEM system for continuous real-time analysis of security alerts generated by applications and network hardware. Sago has achieved the distinguished ISO 27001 accreditation and complies with high international standards for computer security and the protection of personal information. CDC will retain and destroy records in accordance with the applicable CDC Records Control Schedule (**Table A.4.**).

Table A.4. Access Controls		
Technical Controls	Physical Controls	Administrative Controls
<ul style="list-style-type: none"> • User identification • Passwords • Firewall • Virtual Private Network (VPN) 	<ul style="list-style-type: none"> • Guards/Security Officers • 24-hour maintenance of Video/Audio of all data centers and all offices • Identification badges • Key Cards 	<ol style="list-style-type: none"> 1. The system security plan for the information collection is that survey data and all identifying information about respondents will be handled in ways that prevent unauthorized access at any point during the proposed project. 2. The contingency plan for this information collection is that the screeners will be kept only on password-protected computer files stored on a Battelle server. No directly identifying information will be transmitted to CDC (thus, the Privacy Act does not apply). 3. Backup file storage: Systems and data on the Battelle network are backed up daily in compliance with Battelle's internal (i.e., proprietary) IM Disaster Recovery Plan. As part of disaster recovery procedures, each office has contracts with local certified storage facilities for pick up and storage of system backups. Backups are encrypted, and backup and archive media stored onsite are kept in areas with electronic card-controlled access that is restricted to select employees trained in IT security and policies. Systems and data on the Battelle network are backed up in compliance with the CIT Disaster Recovery Plan. As part of disaster recovery procedures, encrypted data backups are stored online at a Disaster Recovery Site. Backup and archive media stored on site are kept in areas with electronic card-controlled access that is restricted to select employees trained in Battelle Information Technology (IT) security and policies. 4. Reports will not include any identifiable information. 5. There will not be user manuals for this information collection effort. 6. Personnel who use the system will be trained to protect the information being collected and maintained by adhering to a procedure that removes identifiers from response data. 7. Contractors who are operating/using the system will include clauses in the contracts that adhere to privacy provisions and practices. 8. Methods will be in place to ensure least privilege. Data and all identifying information about respondents will be handled in ways that prevent unauthorized access at any point during the proposed project. 9. There are policies/guidelines in place regarding the retention and destruction of PII.

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

IRB Approval

All procedures have been developed in accordance with federal, state, and local guidelines to ensure that the rights and privacy of participants are protected and maintained. Battelle's IRB has reviewed this proposed project and determined it to be exempt (Attachment 6).

Sensitive Questions

The majority of questions asked in the Online Questionnaire Recruitment Screener (Attachment 2) and Online Questionnaire (Attachment 3) will not be of a sensitive nature. There will be no requests for a respondent's Social Security Number (SSN). Questions asked during the screening about tobacco use and some demographic information (e.g., age) could be considered sensitive, although these items would not generally be considered highly sensitive. It will also be necessary to ask some questions considered to be sensitive in order to assess individuals' attitudes and behaviors about tobacco products and to test ads about the specific health behavior of cigarette smoking. These items are not generally considered highly sensitive either. Participants will be informed of the applicable privacy safeguards. Sensitive information will only be requested when necessary to describe sample characteristics. Questions assessing race/ethnicity, sexual orientation, and gender identity will adhere to OMB-approved best practices. Race/ethnicity will be collected using the less detailed race/ethnicity option provided in the Revisions to OMB's Statistical Policy Directive No. 15 because this level of detail is sufficient for the research needs of the proposed project. This proposed project also includes a number of procedures and methodological characteristics that will minimize potential negative reactions to potentially sensitive questions, including the following:

- The online questionnaire is entirely self-administered and maximizes participant privacy by being conducted online, without the need to verbalize responses.
- Participants will be provided with a phone number and email for the principal investigator and for the IRB, should they have any questions or concerns about the proposed project or their rights as a participant.

A.12 Estimates of Annualized Burden Hours and Costs

The 12 rough-cut ads will be tested with approximately 10,800 respondents. As described in **Section A.1**, each rough-cut ad will be tested with 800 to 1,200 people who smoke. This will include 400 people with low-SES who smoke and 400 people who are not of low-SES who smoke for each of the 12 ads. Additionally, 400 English-Speaking American Indians and Alaska Natives who smoke will view each of two ads and 400 English-Speaking Asians who smoke will view one ad. English-Speaking American Indian and Alaska Native, and English-Speaking Asian samples will not be stratified by SES.

To obtain this sample size, approximately 13,579 respondents are anticipated to initiate the online screener (Attachment 2); this estimate is based on two factors from prior experiences in the field. First, it is anticipated that roughly 18% of screener respondents (n=2,445) will be deemed ineligible for the proposed project because of not meeting inclusion criteria. Second, of those deemed eligible (n=11,135), an estimated three percent (n=335) will start but not complete the questionnaire. Thus, 13,579 respondents are needed to obtain the sample size of 10,800.

The burden per respondent for completing the screener is two minutes. The total estimated burden for respondents who complete the screener (N=13,579) is 453 hours. The burden per respondent for completing the online questionnaire is 13 minutes. The total estimated burden

for those who complete the questionnaire (n=10,800) is 2,340 hours. Those who start but do not complete the questionnaire are estimated to spend about one-half of that time (7 minutes) on the questionnaire. Thus, the total estimated burden for those who start but do not complete the online questionnaire (n=335) is 40 hours. As outlined in **Table A.5.**, the total estimated burden for the entire project is 2,833 hours.

Type of Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in minutes)	Total Burden (in hours)
Adult who smoke and adults who are ages 18 to 64	Online Recruitment Screener (Attachment 2)	13,579	1	2	453
	Online Questionnaire (Attachment 3)	10,800	1	13	2,340
		335	1	7	40
Total					2,833

The estimated cost of the time devoted to this information collection by respondents is \$98,854 as summarized in **Table A.6.** To calculate this cost, we used the mean hourly wage of \$34.91, which represents the Department of Labor estimated mean for private industry earnings (Bureau of Labor Statistics, 2024). There are no direct costs to respondents associated with participation in this information collection.

Type of Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in minutes)	Total Burden (in hours)	Hour Wage Rate	Total Cost
Adults who smoke and who are ages 18 to 64	Online Recruitment Screener (Attachment 2)	13,579	1	2	453	\$34.91	\$15,801
	Online Questionnaire (Attachment 3)	10,800	1	13	2,340	\$34.91	\$81,689
		335	1	7	39	\$34.91	\$1,364
Total							\$98,854

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

There will be no respondent capital and maintenance costs.

A.14 Annualized Cost to the Government

Approximately 6.25% of one full-time equivalent (FTE) and 1.9% of one senior manager will be required to oversee the information collection activities for one month. Responsibilities will include internal coordination and review of materials and reports and maintaining proper accounting of burden hours. The agency estimates that it will take a GS-13, at a wage rate of

\$68.07/hour, approximately 10 hours to manage the project, totaling about \$680.70. It is estimated to take a GS-15, at a wage rate of \$85.43/hour, approximately three hours to oversee the total project, totaling \$256.29. The total average annualized cost to the government for CDC oversight is \$936.99.

Contractors will conduct the majority of information collection and management activities on CDC’s behalf. The total cost of the data collection contractors is \$97,000 which includes consultation, instrument design and development, respondent incentives, data collection and analysis, and final report. Battelle will collect the information from the participants in collaboration with their recruitment partner Sago. Activities are coordinated through a contract with The PlowShare Group, a specialist in media campaigns. The grand total cost for the project, including government and contractor cost, is \$97,936.99.

Table A.7. Total Project Costs				
Government Personnel	Percent Time Commitment	Hour Time Commitment	Hourly Basic Rate	Total
GS-13	6.25%	10	\$68.07	\$680.70
GS-15	1.9%	3	\$85.43	\$256.29
Subtotal, Government Personnel				\$936.99
Contract Costs				\$97,000
Total Costs				\$97,936.99

A.15 Explanation for Program Changes or Adjustments

This is a new data collection.

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

Data Tabulation Plans

The information will be used to inform the development of final television ads for a future *Tips* campaign. It is anticipated that information collection will begin April 24, 2025, therefore, an **OMB approval date of March 24, 2025**, is requested. The resulting quantitative data will be analyzed using conventional tabulation techniques. These dates may be adjusted depending on the approval process of this package.

Publication and Dissemination Plans

These television ads will be aired as part of future media buys. Additionally, a comprehensive formative evaluation report summarizing findings from this information collection will be provided to CDC. Results that may be of interest to the public may be disseminated through presentations at professional meetings.

Project Time Schedule

Table A.8 Project Time Schedule

Table A.8. Project Time Schedule	
Activity	Time Schedule
Email invitations sent to respondents for quantitative testing	1-30 days after OMB approval
Online data collection	1-30 days after OMB approval
Complete field work	30-45 days after OMB approval
Validation	45-55 days after OMB approval
Data analysis	55-65 days after OMB approval
Report writing	65-150 days after OMB approval

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

An exemption to this requirement is not being requested. The expiration date of OMB approval will be displayed on all information collection instruments.

A.18 Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

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