

## Training and Technical Assistance Performance Measures

### A. Product/Activity to be Assessed

SAMHSA/CSAP supports a community-based approach to substance abuse prevention through the Strategic Prevention Framework (SPF) in order to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the individual's life span. One aspect of CSAP's work is to provide training and technical assistance (TTA) through independent contractors to state substance abuse agencies and other grantees. The Substance Abuse and Mental Health Services Administration (SAMHSA) is requesting approval from the Office of Management and Budget (OMB), for seven common TTA measures to implement the Executive Order 12862 in relation to satisfaction of our customers, broadly defined as customer perception of the value of services provided. SAMHSA considers it important to assess the customer's perception of the value of services rendered through this contractual mechanism. The four contracts that will be using these common measures include:

TTA Provider	Description of Services	Segment of the Population Served
SAMHSA's Collaborative for the Application of Prevention Technologies (CAPT)	The Collaborative for the Application of Prevention Technologies (CAPT) provides responsive, tailored, and outcomes-focused training and technical assistance (TTA) to prevent and reduce substance abuse and associated public health issues across the lifespan. The CAPT also assists SAMHSA/CSAP grantees in the application of data-driven decision-making to the selection and implementation of evidence-based practices and programs.	States, Tribes, Jurisdictions (STJ) and their sub-recipient communities
SAMHSA's Prevention Fellowship Program (PFP)	In 2006, SAMHSA/CSAP launched the Prevention Fellowship Program (PFP) to address the critical shortage of substance abuse prevention professionals throughout the nation. The PFP is a key part of SAMHSA's overarching public health approach that aims to enable States and communities to build prevention infrastructures and sustainable prevention programming. The PFP provides fellowships to state agencies, promotes a workforce development approach and increases the fellows' likelihood for being certified according to recognized standards.	Substance Abuse Prevention workforce
FASD	The SAMHSA FASD Center for Excellence was launched in 2001. Congress authorized the Center in Section 519D of the Children's Health Act of 2000, which included six mandates ( <a href="#">Section b of 42 USC 290bb-25d</a> or <a href="#">Public Law 106-310</a> ) which focus on exploring innovative service delivery strategies, developing comprehensive systems of care for FASD prevention and treatment, training service system staff, families, and individuals with an FASD, and preventing alcohol use among women of childbearing age.	At risk women, FASD children, providers of FASD support programs.

TTA Provider	Description of Services	Segment of the Population Served
SAMHSA's Native American Center for Excellence	The Native American Center for Excellence (NACE) was established by SAMHSA's Center for Substance Abuse Prevention (CSAP) as a national resource to address issues related to substance abuse prevention and behavioral health in Native American communities. Specifically, NACE also provides training and technical assistance support for urban and rural prevention programs serving AI/AN populations	Tribes/Tribal Government  Native American-serving organizations

## B. Brief Statement of Objectives

The collection of the common satisfaction measures will be used for three primary purposes. First, these data will assist SAMHSA/CSAP in strengthening the overall quality of TTA services provided directly to the public. Second, the collection and analysis of these data will enable SAMHSA/CSAP to fully comply with Executive Order 12862 that requires Federal agencies to assess satisfaction with services provided directly to the public. Lastly, these data will also enable SAMHSA/CSAP to reporting requirements set forth by the GPRA Modernization Act of 2010.

The performance measures information is used by SAMHSA and by the individual contractors. The information is used to monitor and manage the individual contracts by the COR. It is used at the Federal level to track performance over time and in relation to previously established targets or benchmarks. These findings are used for GPRA reporting in quarterly and annual documents. It is also used to assess Center progress over all of its TTA mechanisms over time. In addition, the contract staff uses the information to improve the quality of the TTA services it provides.

The information is gathered through voluntary customer surveys and is used to identify strengths and weaknesses in current services provided by CSAP and to make improvements that are practical and feasible. Information from these customer surveys is used to plan and to redirect resources and efforts to improve or maintain a high quality of service to prevention providers and members of the public.

If this information is not collected, vital feedback regarding customers' perception of the value various aspects of the Agency's program services will be unavailable. This would inhibit SAMHSA's ability to develop, implement and refine programs, products, and services in a manner that is most consistent with customers' needs.

## C. Overview of Methods to Collect Information

### Data Collection Method

- Data will be collected at the end of the learning event and again electronically 3-6 months following the event for implementation related questions.

- Analyses will primarily consist of descriptive statistics (e.g., frequency distributions, means, and other measures of central tendency) to better understand associations between recipient characteristics and their satisfaction with, and perceived value of TTA services.

**Identifying respondents**

- All recipients of TTA will be eligible and encouraged to participate in the data collection.
- Participation will be fully voluntary, and non-participation will have no impact on eligibility for or receipt of future services. Given the voluntary nature of the data collection efforts, efforts will be made to achieve the highest response rate possible. To the extent feasible, efforts will be made to assess non-response bias. Historically, response rates to satisfactions surveys from recipients of TTA services have ranged from 70 to 90 percent.
- The protection of respondents’ identifying information will be assured and, to the extent possible, responses will be anonymous. In instances where respondent identity is needed for follow-up, the information collection will fully comply with relevant aspects of the Privacy Act, as well as 42CFR Part II. As mandated by the Paperwork Reduction Act of 1995, respondents will be assured that their decision to participate will not have any effect on their eligibility to receive TTA services.

**Frequency of data collection**

- Information will be collected after the event and 3-6 months following the event on the implementation questions. Follow-up efforts will take place in accordance with contractual agreements and at an interval that is appropriate to accurately measure the effect of services provided.

**Methods for Identifying Duplications**

- The identified common measures resulted from an internal effort to reduce duplication and maximize data collection efforts among TTA providers. Any potential for further duplication will be identified during SAMHSA’s internal review and approval process. This and other proposed data collection activities will also be shared among SAMHSA staff in an effort to increase awareness within SAMHSA about the proposed data collection activity. In turn, this will help prevent duplication and increase coordination of TTA-related data collection activities within SAMHSA.

**D. Annualized Response Burden Estimate**

TTA Provider	Number of respondents	Responses per respondent	Total Number of Responses	Hours/responses	Total hours	Hourly Wage <sup>1</sup>	Total Hour Cost

<sup>1</sup> Hourly Wage: Given that most TTA providers serve management-level personnel, the \$37.72 rate is used as the mean hourly wage as reported on the Bureau of Labor Statistics website (<http://www.bls.gov/>). However, FCBSI primarily serves direct service personnel and uses the \$25.00 rate. Lastly, the Prevention Fellow Program uses the \$15.00 rate to reflect the rate that fellows are paid during their term in the program.

TTA Provider	Number of respondents	Responses per respondent	Total Number of Responses	Hours/ response	Total hours	Hourly Wage	Total Hour Cost
CAPT	3,750	1	1	.083	311	37.72	11,740
FASD	379	1	1	.083	31	37.72	1,169
NACE	500	1	1	.083	42	37.72	1,584
FELLOWS	65	1	1	.083	5	37.72	188
<b>TOTAL</b>	4,694				389		14,681

The estimated annualized cost to respondents for the proposed data collection activities is \$14,681. For the purposes of estimating annual cost, it is assumed that the participants will complete each survey once. The average burden was estimated based on independent review of the survey by contractor and Federal staff.

#### **Estimates of Annualized Cost to the Government**

The estimate annualized cost to the government for the proposed data collection activities is \$7,680 and includes the expected cost for each of the COTRs who oversee TTA provider contracts.

Position	Percent FTE	Annual Hours	Rate	Total Annual Cost <sup>2</sup>
FASD GPO	2.50%	48	40	\$1,920
CAPT GPO	2.50%	48	\$40	\$1,920
NACE GPO	2.50%	48	\$40	\$1,920
Prevention Fellows GPO	2.50%	48	\$40	\$1,920
<b>Totals</b>	<i>varies</i>	<b>192</b>	<i>varies</i>	<b>\$7,680</b>

#### **E. Methods used to develop the questions**

The questions were selected based on a review of existing TTA items in current use and multiple phases of discussion and consensus building across all existing TTA contractors and CORs during 2010.

<sup>2</sup>Annual hours are based on a 40-hour work week for 48 weeks per year.

## **F Consultants within SAMHSA/ CSAP and outside the Agency**

The common measures submitted here for OMB approval are the result of lengthy consultation and discussion among SAMHSA/CSAP personnel, training and TA contract representatives, and the DACCC staff. See Attachment D for staff and consultants involved (see Attachment B). The final selection of these measures was made by SAMHSA/CSAP senior officials.

### **List of Attachments:**

Attachment A: Common Training and TA Satisfaction Measures

Attachment B: Staff and Consultants Involved