

**Generic Clearance  
Formative Research and Tool Development**

OMB No. 0920-0840

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## **Formative Research and Tool Development Supporting Statement**

### **A. JUSTIFICATION**

#### **A.1 Circumstances Making the Collection of Information Necessary**

The Centers for Disease Control and Prevention requests a extension and 3 year approval of the currently approved generic information collection, Formative Research and Tool Development (OMB#0920-0840, exp. 1/31/2013), that supports formative research in HIV/AIDS, sexually transmitted diseases, tuberculosis, and viral hepatitis.

A.1.3. The project activities and methods that were previously approved will remain the same. The burden was increased by 20% to accommodate a project increase if projects. The previous year's approval estimated 10 individual projects per year. That projection has increased to 12 individual projects per year; which is a 20% increase over the previous approval period.

The National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) conducts formative research for developing new tools and methodologies that respond to the changing epidemiology of the four (4) groups of diseases that cause 80% of the disease morbidity in the U.S. A generic clearance mechanism would increase productivity of CDC programs and improve the quality of public health interventions.

To date, sixteen generic information collection requests (ICRs) have been approved under the Formative Research and Tool Development Generic Clearance.

#### **Background**

CDC conducts surveillance and prevention research projects as part of its response to the domestic HIV/AIDS epidemic, STD prevention, TB elimination, and viral hepatitis control with local partners. National Advisory Committees require evidence for considering revisions to existing prevention and intervention methods, and new recommendations.

The behavioral, clinical, and surveillance research projects implemented by the National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Elimination Programs are the pillars upon which recommendations and guidelines are revised and updated.

Disease Specific Advisory Committees that debate and approve the national recommendations and guidelines proposed by CDC require that each process and hypothesis is based on scientific evidence and are acceptable to the community and the local health care providers. Formative research is the mechanism by which this evidence is obtained for each of the four (4) priority diseases. The data collection and evidence are developed using a multitude of information sources including internal and external subject matter experts, field experience, consultation with external colleagues, piloting activities, and formal evaluations. The involvement of external and internal subject matter experts produces scientifically valid instruments, interventions, and methods that enable CDC to be responsive to the changing epidemiology and community needs of these four (4) priority diseases.

For health communications, target audience members or representatives provide the information for developing clear and influential health messages<sup>1</sup>. Provisional versions of the messages must be tested with members of the target audience.<sup>2,3</sup> In order to reduce the burden of HIV, STDs, TB, and viral hepatitis in the United States, CDC invests in public education campaigns and social marketing strategies to integrate population-level interventions. An integrated research effort is needed to fill in the gaps of HIV/AIDS and STD knowledge, awareness, screening, and prevention behaviors and could simultaneously work to reduce stigma surrounding these topics within special populations, explore cultural issues, and increase the demand for, and uptake of screening by health care providers.

Short term qualitative interviewing and cognitive research techniques have previously proven invaluable in the development of scientifically valid and population-appropriate methods, interventions, and instruments. These activities will be used to inform many aspects of surveillance, communications, health promotion, and research project development for the 4 priority diseases (HIV, STDs, TB, and viral hepatitis).

The activities include the utility and acceptability of recruitment methods, intervention contents and delivery, questionnaire domains, individual questions, and interactions with project staff or electronic data collection equipment. These activities will also provide information about how respondents answer questions and ways in which question response bias and error can be reduced. Overall, these development activities are intended to provide information that will increase the success of the surveillance or research project through increasing response

rates and decreasing response error thereby decreasing future data collection burden to the public.

Data collection for this project is authorized under 42 U.S.C. 241 (OSCN 2007), CHAPTER 6A - PUBLIC HEALTH SERVICE; SUBCHAPTER II - GENERAL POWERS AND DUTIES Part A - Research and Investigations (**Attachment 1**).

### **A.1.2 Privacy Impact Assessment**

Information might be collected electronically or on paper (depending on the individual information collection request). Electronic means include handheld devices, computer-assisted self-interview (ACASI), computer assisted telephone interview (CATI), web-based surveys, or other point of service collection devices. Paper copies are the common mode for Focus group interviews.

CDC will not receive any personally identifiable information. All individually identifiable information collected by local partners would be unlinked or stripped from the data base that is submitted to CDC. Web-based methods for survey or intervention delivery may also be evaluated under this generic approval, and may involve the hosting of a website in order to conduct the evaluation. There will be no websites or internet content directed at children under the age of 13. Individual collection requests submitted under this generic approval will describe any web-based material involved.

### **A.1.3 Overview of the Data Collection System**

The types of information collection activities included in this generic package for NCHSTP's 4 priority diseases are:

- 1) Qualitative interviewing will use volunteer respondents for exploratory and formative research, intervention methods, concept, material, and product development and testing. Interviews may be individual or group conducted in-person, on the telephone, or via the internet (i.e. internet focus groups). Results of qualitative interviews are used to develop population-appropriate methods, interventions, messages, products, campaigns, and data collection materials for current and future projects.
- 2) Cognitive interviewing and in-depth interviews (IDIs) may be conducted among the consumer clients or the implementors. These may be individual interviews or focus group interviews. Cognitive interviews are commonly used for development and testing of specific data collection instruments and frequently involve several rounds of cognitive interviews with each iteration of the product. Results of cognitive

interviews are used to make instrument design decisions that minimize response error and reduce burden to the public.

- 3) Methodological research may be conducted with consumers or implementers to evaluate alternative instrument design, non-response, perceptions of enrollment procedures, and other general methodological research questions. Procedures used for this research are similar to testing of surveys and materials, but focus more on the methods of enrollment and administration and less on the content of the materials themselves. The purpose of the research would be to enhance understanding of the psychology of participation and response, to develop better standards for project methodology and instrument design, or to improve data collection and other study procedures.
- 4) Usability testing of technology-based instruments and materials may be conducted with end-users who may be consumers or implementers. This testing would use qualitative and quantitative data collection methods with volunteer respondents in order to assess the design and use of technology-based instruments and materials. The purpose of this testing is to develop new methods that address the rapid evolution of technology-based surveys, interventions, and communications and use those technologies to enhance CDC's projects and reduce burden of future data collections.
- 5) Field testing of new methodologies and materials may be conducted with a small number of participants using the enrollment, study methods and observations by experienced study methodologists. Unlike full pilots of data collection activities, the purpose of a field pilot will be to evaluate project methods and materials not yet used by CDC on a limited scale. Information from field testing can be used to improve methods, materials, and interventions to reduce the burden of future data collections.

- 6) Mental models elicitation and communication frames.

Schema theory from the cognitive sciences describes processes and interpretative mental structures that a person uses to organize their experience. These intrinsic internal representation systems play a role in health decision-making. The purpose of health communication mental modeling is to understand mental models of health by eliciting information on how individual and groups see relationships among health, health determinants, health risk, and good health for specific health topics, and the relationships among health issues and other factors. This enables better message design as one can address more accurately health risk factors and

outcomes in terms of, for example: 1) how persons can take action, 2) if health is seen as collectivist or individualistic oriented. By understanding mental models, one can also take into account in message design 3) decision points at-risk individuals (or groups) undergo when they move between internal-based reality (e.g., intra-personal attitudes, knowledge, values, perceived stigma, racism, discrimination, sexism, beliefs and skills) and external-based, actionable reality (e.g., outward behaviors, environmental constraints, health inequity).

**A.1.4 Items of Information to be Collected (Attachment 3)** is a partial list of the types of questions that could be used by the studies listed in this request.

The information collected by local implementors may contain personally identifiable information such as, name, address, medical information, referred individuals etc. Projects that involve Respondent Driven Sampling (RDS) or other risk-based surveys or interviews with affected persons will also include personal information that the local implementors will need in order to provide continuity of service, follow-up of referrals, and other outreach activities. Personally identifiable information will be kept in a separate location and accessible only to the interviewer. This information will be destroyed when the client's contribution to the project has ended.

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

Information in Individual Identifiable Form (IIF) may also be collected by grantees of cooperative agreements such as local and state health departments, or contractors implementing surveillance with diagnostic testing. In these projects, state and local health departments will de-identify IIF from the databases, encrypt and, transmit the data to CDC using the secure data network.

The data bases created for CDC will not include personal information. Line listings of affected persons when used will use project generated identification number independent of any personal identity of the participants.



Because this request includes a wide range of studies, specific requests will include items of information to be collected and copies of the data collection instruments.

#### **A.1.5 Identification of Websites and Website Content Directed at Children Under 13 Years of Age**

Web-based methods for survey or intervention delivery may involve the creation of a website with controlled access. Web-based investigations will include surveys, and components of formative research collecting public evaluations of health communication messages or materials. Under no circumstances will CDC sponsored websites be directed at children under 13 years of age. Individual collection requests submitted under this generic approval will describe any web-based material involved.

#### **A.2. Purpose and Use of Information Collection**

Many questionnaire design recommendations are based on cognitive testing; others are based upon past experience or general principles of questionnaire design. Changes to the structure of a question based on existing theories will make it easier to understand and more efficient to administer. Field experiments where original and alternative versions of a question are each administered to half of a sample are a proven method to test the theory in the environment where the change is needed.

Because of CDC's need to respond rapidly to changes in the epidemiology of the 4 priority diseases through development of new projects, the exact nature of every activity is not always known until just prior to the need for its development. It is most likely that a combination of the listed studies will be employed. For example, focus groups and interviews will provide the information to make the changes which then need to be tested both qualitatively and quantitatively to ensure that the changed instrument is acceptable to the target audience but is also more efficient than the existing version in providing the needed information.

- o CDC's ability to process and/or integrate the information into an on-going national program in a timely manner. Formative research is an integral part of the operations research and surveillance activities at NCHHSTP because they are dependent upon the consumers and the health department staff to obtain the data needed to monitor changes in disease epidemiology and design more efficient interventions.
- o None of the studies proposed intend to produce results that can be generalized beyond the scope of each study. The objective of this request is to enable NCHHSTP to improve the quality of the data collection systems and respond to the needs of the

affected persons and the community in a timely manner. The improved timeliness of this development will improve data quality, increase the efficiency of data collection, and decrease burden to the public.

The major activities fall into six categories:

- 2.1 Qualitative interviewing for surveillance, research, interventions and material development.
- 2.2 Cognitive interviewing for development of specific data collection instruments
- 2.3 Methodological research
- 2.4 Usability testing of technology-based instruments and materials (eg ACASI)
- 2.5 Field testing of new methodologies and materials
- 2.6 Testing of communication mental models

#### **A.2.1 Qualitative interviewing for surveillance, research, and intervention methods and material development**

The purpose of this data collection is to use qualitative interviewing methods to identify appropriate project methods, intervention content and delivery, and instrument domains and questions. NCHHSTP will conduct qualitative interviews with volunteer respondents, either individually or in groups, using standardized methods. Results of qualitative interviews will be used in conjunction with other information to develop the most appropriate and successful surveillance or research methods, interventions, and data collection instruments for current and future projects.

Field experience with prototype data collection instruments is crucial for the development of methods, interventions, and instruments that may improve surveillance and other research projects. In a few instances, open discussions with members of the target population with opportunities to provide input on project methods, interventions, and instruments assure success in implementation. The combined methods are especially relevant for projects intending to reach vulnerable populations or to explore novel areas in HIV/STD/TB/hepatitis research.

#### **A.2.2 Cognitive interviewing for development of specific data collection instruments**

The purpose of this data collection is to use cognitive interviewing methodology to identify and correct instrument flaws, such as questions which are vague or ambiguous, cannot be answered readily or accurately, or otherwise contribute to the non-sampling errors of the data collection instrument. The methods used will vary depending on the stage of development of the various data

collection instruments to be studied. When questions have been used successfully in earlier surveys, testing will evaluate whether the questions function appropriately in the new context. In cases where there is evidence that previously developed questions were not entirely reliable or valid, more extensive evaluation will be conducted. The most extensive instrument development activities will be applied to untested draft questions and undeveloped lists of data objectives.

### **A.2.3 Methodological Research**

- a)** *Research on the effects of alternative instrument designs*  
Many instrument design recommendations are based on cognitive testing; others are based upon past experience or general principles of questionnaire design. In any case, it is often advantageous to quantify how these design decisions affect data collection in the field. For example, we may develop theories that certain changes to the structure of a question will make it easier to understand and more efficient to administer. One way to explore this possibility is to conduct field experiments where original and alternative versions of a question are each administered to half of a sample of respondents. In addition to comparing response distributions of the two versions, interviews can be tape recorded and coded so that a variety of interviewer and respondent behaviors can be compared. Such experiments may focus on grammatical structure of questions, number of questions used to measure a particular concept, context of the question, and similar design decisions. This research may be embedded into field surveys, conducted as a separate project, or some combination of the two. Research may also be conducted by comparing survey data to other data sources such as external records or detailed respondent diaries.
- b)** *Research on cognitive aspects of non-response*  
Non-response creates numerous analytic difficulties for surveillance and research projects. Minimizing this problem requires a greater understanding of the cognitive processes that lead respondents to not answer particular questions. NCHHSTP may conduct cognitive interviews using a variety of types of survey questions in order to explore these decision processes further. Survey non-response will be explored through examination of reasons that non-responders provide for their unwillingness or inability to complete surveys. It is also possible that data will be collected through research questionnaires that explore the effect of various design decisions on item non-response.

c) *Respondent perceptions of enrollment procedures*

To encourage participation and protect the rights of respondents in projects, NCHHSTP often utilizes standard consent forms and respondent enrollment procedures. However, it is not known how well they are generally understood and believed by respondents. Therefore, NCHHSTP may conduct interviews to examine comprehension and attitudes regarding respondent enrollment procedures. The results will be used to propose modifications to procedures used to communicate key issues related to informed consent, and to explain the need and purpose for the data collection in a way intended to increase participation.

d) *General methodological research*

NCHHSTP regularly evaluates and refines HIV/AIDS surveillance and research methods, especially in response to advances in current methodologies or changes in the epidemic itself. In order to meet this need, NCHHSTP plans to conduct research on the development of these new methods. The issues examined during these activities may include, but are not limited to: 1) differences between interviewer-administered and self-administered interviewing, 2) differences between in-person interviewing and telephone interviewing, 3) reactions of both survey respondents and survey interviewers to the use of different forms of survey administration, and 4) social, cultural and linguistic factors in the response process. Procedures for each of these activities will be similar to those applied in the usual testing of survey questions. For example, current questionnaires may be evaluated using several of the techniques described above. Different versions of a survey question could also be developed and the variants administered to separate groups of respondents in order to study the cognitive processes that account for the differences in responses obtained across different versions. The results of these studies will be applied to our specific questionnaire development activities in order to improve the methods that we use to conduct questionnaire testing, and to guide questionnaire design in general.

A.2.4 Usability testing of technology-based instruments and materials

This research examines how questions, instructions, and supplemental information are presented on computer instruments (e.g., Computer Assisted Personal Interview (CAPI), Computer Assisted Self Interview (CASI), or Web-based instruments), and investigates how the presentation affects

the ability of users to effectively utilize these instruments. Authors of computer-assisted instruments make numerous design decisions: how to position the survey question on a computer screen; how to display interviewer instructions that are not to be read to respondents; the maximum amount of information that can be effectively presented on one screen; how supplemental information such as "help screens" should be accessed; whether to use different colors for different types of information presented on the screen; and so on. Research has shown that these decisions can have a significant effect on the time required to administer survey questions, the accuracy of question-reading, the accuracy of data entry, and the full exploitation of resources available to help the user complete his or her task.

Usability testing has many similarities and shares the same main purpose as does questionnaire-based cognitive interviewing (described in Section A.2.2), since it focuses on the ability of individuals to understand and process information in order to accurately complete survey data collection. It is also somewhat different, in that the typical user can be a staff interviewer (in the case of CAPI instruments) as well as a survey respondent (in the case of CASI or Web-based instruments). It also focuses more heavily on matters of formatting and presentation of information than traditional cognitive testing does.

#### **A.2.5 Field testing of new methodologies and materials**

The purpose of this data collection is to conduct field tests of new methods, interventions and data collection instruments; also referred to as pilot testing. Pilot testing in this instance is defined as the evaluation of methods proposed by subject matter experts or published articles but new to CDC. The objective of such pilot studies would be to evaluate the feasibility of the 'new' strategies in CDC-funded projects. The pilot may also include two different versions of particular questions or novel intervention components of interest, in order to determine which version functions better in the actual field environment. With verbal consent of the respondents, pilot interviews or interventions may be unobtrusively observed by experienced methodologists who can objectively evaluate the process (e.g. proper survey/intervention administration and interviewer-respondent interaction). Information from pilot testing can be used to improve the existing instruments, interviewer

training materials, or survey methodologies, that would reduce the public burden

#### **A.2.6 Testing of Communication Mental Models**

The purpose of this data collection is to develop and test mental modeling methodologies and protocols for qualitative methods that may include: elicitation guides, Q methodology, mental models expressionism (e.g., hexagons, causal diagrams and flow diagrams), card sorts, feedback, single, or double-loop learning and health risk or health prevention vignettes. The information collected will be used to revise, augment or finalize communication campaign platforms and systems within the context of the audiences' sense of reality and how they may decide to act in accordance with how they plan to act.

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

Testing may be conducted using the most current modes of survey data collection, including CAPI/CASI, ACASI, web-based surveys, or other modes applied to specific national surveys. Though these technologies will be used by many of the individual projects in this data collection, the nature of many of these proposed activities typically requires direct interaction between respondents and project staff, especially in the case of qualitative interviewing and cognitive testing.

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

CDC has three generic collections that are related to the proposed collection. The NCHS Laboratory-based Questionnaire Research, OMB # 0920-0222, that expires 6/30/2015 provides survey questionnaire development and testing based on cognitive interviewing methodology to be used in CDC, other federal agencies, or other academic or professional institutions. The CDC and ATSDR Health Message Testing System (HMTS, OMB Control Number 0920-0572, expiration 2/28/2015) is designed to refine message concepts and to test draft materials for clarity, salience, appeal, and persuasiveness with external audiences. The generic "Health Marketing" (OMB Control Number 0920-0798, expired 01/31/2011) was approved "for purposes of survey/informative materials development and customer satisfaction surveys". While there may be overlap or duplication of specific projects from NCHHSTP with the QDRL collection these projects cannot be accommodated within the QDRL burden and will be submitted under this proposed collection. NCHHSTP has verified through RegInfo.gov that there are no other federal generic collections that duplicate the six study types included in this request.

**A.5. Impact on Small Businesses and Other Small Entities**

Some HIV/AIDS surveillance or research activities involve data collection from small business (e.g. medical offices) or small governmental entities; therefore, methods and instrument development activities may also be conducted with these groups. If such activities are conducted, these businesses will be approached in the same manner as the individuals we normally recruit: we will ask the organization to identify the appropriate staff members with whom to conduct the activities.

**A.6. Consequences of Collecting the Information Less Frequently**

The activities involve a one-time collection of data. There are no legal obstacles to reducing the burden.

**A.7. Special Circumstances Relating to 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 Agencies**

The Federal Register notice was published for this collection on August 2, 2012 (Vol. 77, No. 149, pp. 4604-46095. (see Attachment 2A) There were no comments received from the public.

**No other agency was consulted for the development of this request**

Other individuals: Agency officials and researchers who have special interest and expertise in the individual activities and topics will be contacted as necessary. The following individuals were consulted for the development of this request:

|   |  |
|---|--|
| Frederick Bloom PhD<br>Deputy Associate Director for<br>Science, Division of STD<br>Prevention,<br>NCHHSTP, CDC<br>1600 Clifton Road, MS e07<br>Atlanta, GA 30333             | Donata Green, PhD<br>Behavioral Scientist<br>Division of HIV/AIDS Prevention<br>NCHHSTP, CDC<br>1600 Clifton Road, MS e07<br>Atlanta, GA 30333.              |
| Travis Sanchez, DVM, MPH<br>Associate Chief for Science<br>Behavioral and Clinical<br>Surveillance Branch<br>NCHHSTP, CDC,<br>1600 Clifton Road, MS e07<br>Atlanta, GA 30333. | Ann Forsythe, PhD<br>Health Communications<br>Specialist<br>National Center for Health<br>Marketing, CDC. 1600 Clifton<br>Road, MS e07<br>Atlanta, GA 30333. |
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| Madeline Y. Sutton, MD, MPH,<br>FACOG<br>CAPT, USPHS<br>Lead, Minority Health & Health<br>Equity Activity<br>CDC/NCHHSTP/DHAP/Epi Branch<br>1600 Clifton Road, MS E-45<br>Atlanta, GA 30333 | Natasha Ptomey, MPH<br>OMB PRA Contact<br>ORAU - ORISE - HCTT<br>CDC/NCHHSTP/DHAP<br>1600 Clifton Road NE, MS-D21<br>Atlanta, GA 30333   |
| Yuko Mizuno, PhD<br>Associate Chief for Science<br>Prevention Research Branch<br>Division of HIV/AIDS Prevention<br>NCHHSTP, CDC<br>1600 Clifton Road NE, MS-E37<br>Atlanta, GA 30333       |  |

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

A review of survey methodologists and practitioners in October, 1992, The "Symposium on Providing Incentives to Survey Respondents," sponsored jointly by OMB and the Council of Professional Associations on Federal Statistics (COPAFS), considered a number of incentive-related issues, including the impacts on response rates, biases, and incentive types, recommended OMB "seriously consider the use of incentives" for surveys that target difficult-to-engage respondent populations, surveys that are long or time consuming, surveys with items that are potentially sensitive or require detailed record keeping, surveys for which relatives serve as gatekeepers to respondent access, and surveys that are part of longitudinal panels." In many cases incentives will not be necessary, but when they are, incentives will not exceed \$40 per hour for such intensive interviews like focus groups and cognitive interviews unless compelling evidence is provided that recruitment is very difficult for a particular subgroup.

Tokens of appreciation may be offered in cash or kind for these activities for several reasons:



- Eligibility criteria for respondents are usually very specific. Some of these criteria are determined by the subject matter of the survey or intervention study (e.g., questions or interventions may be relevant only to people with certain health conditions). The more specific the subject matter, the more difficult it is to recruit eligible respondents; tokens of appreciation may help to attract them.
- Qualitative and cognitive interviews require an unusual level of mental effort, as respondents are asked to explain their mental processes as they hear the question, discuss its meaning and point out any ambiguities, and evaluate the acceptability of response options that are provided.
- Respondents are usually asked to travel to an interview site, which involves transportation and parking expenses. Many respondents may also incur additional expenses such as leaving their jobs during business hours or making arrangements for child care. This may be especially true of some key respondents who may be economically disadvantaged but would provide valuable information in the development of these projects.
- Some major metropolitan areas may be highly saturated with other research activities (e.g., academic research initiatives), which typically provide remuneration and may compete for respondents' time.

#### **A.10. Assurances of Confidentiality Provided to Respondents**

Many of the individual data collection activities will require respondents to provide identifying or potentially identifying information to local project staff and answer sensitive questions. This information will be removed from any data sent to CDC, and CDC will, at no time, have access to any local data that contains identifiers. Local project staff will verify that any individually identifiable information that has been collected during the course

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<sup>1</sup> Delong, D.W., & Fahey, L. (2000) Diagnosing cultural barriers to knowledge management. *The Academy of Management Executive*, 14(4): 113-127.

<sup>2</sup>. Andreasen, A. 1995 *Marketing Social Change*. San Francisco, Jossey-Bass.

<sup>3</sup>. Black, D.R., Blue, C.L., & Coster, D.C. (2001) Using social marketing to develop and test tailored messages. *American Journal of Health Behavior*, 25(3): 260-271.

of their activities has been removed from information transmitted to or shared with CDC.

The proposed activities may also be part of the development of the HIV surveillance systems and, as such, are covered under the HIV Surveillance Assurance of Confidentiality (**Attachment 8**) awarded under CDC's statutory authority according to section 308(d) of the Public Health Service Act (42 USC 242m).

Certificates of confidentiality may be sought for individual data collection activities that involve sensitive and potentially identifiable information at the local project level but are not covered by the HIV Surveillance Assurance of Confidentiality (e.g., some prevention or epidemiologic research development activities).

Documentation of the applicability of the Assurance of Confidentiality or application for a Certificate of Confidentiality (if applicable) will be provided with each individual data collection request.

Because methods and materials may differ between individual projects, appropriate human subjects review procedures will be conducted for each project as they are developed. Projects that need IRB approval will be submitted with a copy of the approval document.

### **Informed consent**

Participation in development activities is strictly voluntary. Respondents will be provided with an informed consent form prior to the start of information collection, and will be allowed to ask questions about the project before deciding whether to participate or not (**Attachment 9**). Any variation from these templates will be included in each individual collection request. The consent form describes the purpose of the study, specifies specific procedures that will be conducted, and describes protections for the respondent's privacy and confidentiality.

On occasion, interviewing respondents about sensitive topics (e.g., HIV testing behaviors or sexual behaviors) requires that we do not collect personal identifiers at any point. Collection of these identifiers may place the respondent at risk of potential harm resulting from breach of confidentiality. In these cases, a waiver of documentation of informed consent is requested (i.e., no respondent signatures on a consent form), but the same consent and confidentiality protection information is still imparted to the respondent.

### **Confidentiality of responses and safeguarding of materials**

Respondents of HIV surveillance and incidence projects receive **Attachment 8**, the Assurance of Confidentiality and a consent form (**Attachment 9**), which describes the procedures by which confidentiality of information will be maintained. Formative research projects in STD, TB and Viral hepatitis and behavioral research projects for HIV prevention will use Certificates of Confidentiality as appropriate.

Persons participating in all projects conducted by NCHHSTP, will be informed that their data will be maintained in a secure manner, and that the data will only be used for purposes stated in the consent form. Although the identities of respondents may be known to local project personnel who conduct interviews and interact with respondents, data will not be stored or accessed in a Privacy Act system of records, and the respondents' identifying information will not be submitted to CDC. Only authorized project staff will be allowed to have access to study information (whether identifiable or not) and all information will be kept in a locked cabinet and/or locked office with limited access.

If individually identifiable information will be accessed by the Division of TB elimination, syphilis, name based HIV reports, AIDS cases, the collections would most likely fall under the following SORNs 09-20-0089(Studies of Treatment of Tuberculosis and other Mycobacterioses. HHS/CDC/NCHSTP), 09-20-0103(Alien Tuberculosis Follow-up Program. HHS/CDC/NCID.), 09-20-0160 (Records of Subjects in Health Promotion and Education Studies. HHS/CDC/NCCDPHP.), or 09-20-0136 (Epidemiologic Studies and Surveillance of Disease Problems. HHS/CDC).

For the most part, state and local health department personnel who conduct HIV/AIDS surveillance activities are subject to the data security and confidentiality policies described in the CDC Technical Guidance for HIV/AIDS surveillance Programs, Volume III: Security and Confidentiality Guidelines ([www.cdc.gov/hiv/surveillance.htm](http://www.cdc.gov/hiv/surveillance.htm)). In order to provide for maximal and comparable confidentiality protection, all project personnel for any of the proposed development activities will be subject to the same security and confidentiality requirement as the HIV/AIDS surveillance programs.

All CDC permanent employees and contractors who are involved in HIV/AIDS surveillance activities will be required to attend annual confidentiality training, to sign a nondisclosure agreement and notice about data use policies, and to update their confidentiality agreements and training on an annual basis. In addition, non-surveillance development activities (i.e., research

and intervention development) conducted under this generic approval will also adhere to these same security standards.

### **Privacy Impact Assessment**

Electronic data collection and data management systems used for these activities must comply with the current encryption security standards from National Institute of Standards and Technology (NIST) Federal Information Processing Standards (FIPS), which meet or exceed Advanced Encryption Standards (AES). Each individual request under this generic clearance will provide adequate descriptions of information systems that will be used in their study.

#### **A.11. Justification for Sensitive Questions**

The 4 priority diseases that will be covered by this request involve sexual attitudes and practices, use of illegal substances and, other matters that are commonly considered private. Race and ethnicity data, as well as diagnoses of medical conditions that may affect employability or insurability (e.g., HIV/AIDS) may also be viewed as sensitive or even threatening by a portion of respondents. The reasons for collection of sensitive information and their application for the improvement of CDC's prevention efforts for the specific population sub-group will be addressed in specific requests. The procedures used to obtain consent and the content of the consent form will also be explained and justified. In no case will a participant's social security number be obtained.

Collection of sensitive data will be used to understand barriers to engaging in protective behaviors and to using prevention services.

#### **A.12. Estimates of Annualized Burden Hours and Costs**

##### **A.12. Estimates of Annualized Burden Hours and Costs**

**A.12.A.** The annualized response burden is estimated at 46529 hours. Exhibits A.12.A provides details about how this estimate was calculated. Timings were conducted during instrument development process in previous studies to support the overall burden per respondent. Administration of the screening instrument is estimated to take 10 minutes. A participant reading and signing the consent form is estimated to take 5 minutes. Participation in an interview is estimated to take 1 hour and participation in a

group interview is estimated to take 2 hours. It is estimated that during a single year, 10 different studies are likely to use 81200 screening questionnaires (13560 hours), complete 30000 individual surveys (15000 hours), 40600 consent form (3369 hours) 6600 individual interviews (6600 hours) and 4000 focus group respondents (8000 hours), totaling 46529 hours.

**Exhibit A.12.A Annualized Burden Hours**

| Type of Respondent                       | Form Name            | Number of Respondents | Number of Responses per Respondent | Average Hours Per Response | Total Response Burden (Hours) |
|--|----------------------|-----------------------|------------------------------------|----------------------------|-------------------------------|
| General public and health care providers | Screener             | 81200                 | 1                                  | 10/60                      | 13533                         |
| General public and health care providers | Consent Forms        | 40600                 | 1                                  | 5/60                       | 3383                          |
| General public and health care providers | Individual interview | 6600                  | 1                                  | 1                          | 6600                          |
| General public and health care providers | Group interview      | 4000                  | 1                                  | 2                          | 8000                          |
| General public and health care providers | Survey of Individual | 30000                 | 1                                  | 30/60                      | 15000                         |
| <b>Total</b>                             |                      |                       |                                    |                            | <b>46517</b>                  |

**A.12.B Estimated Annualized Costs**

Collections by health jurisdictions are generally funded through cooperative grants and these will be noted in the specific collection requests. During the past 2 years 70% of the projects from NCHHSTP requiring PRA compliance have involved the general public and 30% private health care providers. The annualized cost to the respondent is segmented accordingly in Exhibit A.12.B.

The United States Department of Labor, Bureau of Labor Statistics May, 2005 (<http://www.bls.gov/oes/current/oes291069.htm>.) was used to estimate the hourly wage rate for the general public and for private providers for the purpose of this generic request. Each project will have cost specific to the category of the respondents.

Because it is not known what the wage rate category will be appropriate for the specific projects (or even whether they will be employed at all), the figure of \$20.00 per hour was used as an estimate of average hourly wage across the country.

For private physicians, an average cost of 70.00 per hour is used as the mean hourly wage for physicians and surgeons. Thus, the total anticipated annual cost to participants for collections of information for all study types will be **\$1,628,083.**

**Exhibit A.12.B. Annualized Cost to Respondents**

| <b>Activity</b>                      | <b>Total Burden Hours</b> | <b>Hourly Wage Rate</b> | <b>Total Respondent Cost</b> |
|--------------------------------------|---------------------------|-------------------------|------------------------------|
| Screener Public (70%)                | 9473                      | \$20.00                 | \$189,467                    |
| Screener Provider (30%)              | 4060                      | \$70.00                 | \$284,200                    |
| Consent Forms Public (70%)           | 2368                      | \$20.00                 | \$47,367                     |
| Consent Forms Provider (30%)         | 1015                      | \$70.00                 | \$71,050                     |
| Individual Interviews Public (70%)   | 4620                      | \$20.00                 | \$92,400                     |
| Individual Interviews Provider (30%) | 1980                      | \$70.00                 | \$138,600                    |
| Group                                | 5600                      | \$20.00                 | \$112,000                    |

|   |              |         |                    |
|---|--------------|---------|--------------------|
| Interview<br>Public (70%)               |              |         |                    |
| Group<br>Interview<br>Provider<br>(30%) | 2400         | \$70.00 | \$168,000          |
| Surveys<br>Public (70%)                 | 10500        | \$20.00 | \$210,000          |
| Surveys<br>Provider<br>(30%)            | 4500         | \$70.00 | \$315,000          |
| <b>Total</b>                            | <b>46529</b> |         | <b>\$1,628,083</b> |

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

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

**A.14. Annualized Costs to the Federal Government**

Actual annualized costs to the government will vary depending on the specific needs of the individual information collection activity. Generally, each development activity will involve participation of at least one CDC project officer (GS-12, 13 or 14 levels) who will be responsible for the project design, obtaining IRB approvals, providing project oversight, and analysis and dissemination of the results. The CDC project officer will provide remote and onsite technical assistance to the local areas implementing the data collection. Travel may be required to provide this technical assistance. In some cases, a CDC data manager's (typically a contractor equivalent to GS-9) time may also be required. An estimated average cost per individual activity is listed below, but detailed costs will be submitted with each individual collection request.

| <b>Expense Type</b>                             | <b>Expense Explanation</b>     | <b>Annual Costs (dollars)</b> |
|---|--------------------------------|-------------------------------|
| Direct<br>Costs to<br>the Federal<br>Government |                                |                               |
|   | CDC Project Officer (GS-12/13, | \$156,000                     |

|                                   |  |                  |
|-----------------------------------|--|------------------|
|                                   | 0.5 FTE)   |                  |
|                                   | CDC Data Manager (GS-9/10, 0.25 FTE)   | \$48,000         |
|                                   | CDC Travel (15 trips)  | \$45,000         |
|                                   | <b>Subtotal, Direct costs</b>  | <b>\$249,000</b> |
| Cooperative Agreement or Contract | Cooperative Agreements, Task orders, or Contracts for implementation or information management | \$325,500        |
|                                   | <b>TOTAL COST TO THE GOVERNMENT</b>  | <b>\$574,500</b> |

**A.15. Explanation for Program Changes or Adjustments**

Not applicable - new information collection request.

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

Individual data collections under this generic approval will be time-limited and generally conducted only once, except in the cases of individual interviews conducted during pilot testing of interventions where respondents may have to be approached several times on the same or similar topic under evaluation. No single data collection activity will take longer than 1 year to complete from inception of information collection to the first report of findings. Proposed timelines will be submitted for each individual data collection activity.

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

OMB Expiration Date will be displayed.

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

There are no exceptions to the certification.

**References**