Formative Research and Tool Development: Survey of HIV Medical Care Providers to Guide the Medical Monitoring Project

Generic Information Collection Request under 0920-0840

February 6, 2013

Supporting Statement
Part A

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A. JUSTIFICATION

A.1 Circumstances Making the Collection of Information Necessary

This request is for one year sub-collection under the generic approval (Formative Research and Tool Development, OMB Control No. 0920-0840, exp. 2/29/2016), for a survey of physicians, nurse practitioners, and physician assistants providing medical care to HIV-infected adults in the US and Puerto Rico. This formative research is needed 1) to help guide decisions about changes being considered for the CDC-funded Medical Monitoring Project (MMP), a nationally representative supplemental surveillance project designed to monitor ongoing care and treatment of HIV-infected persons(OMB Control No. 0920-0740, expiration 5/31/2015); and 2) to inform the development of MMP data collection instruments.

This request is authorized by Title III – General Powers and Duties of the Public Health Service, Section 301 (241.)a. Research and investigations generally (**Attachment 1**).

Formative work is needed to evaluate the implications of alternative methods being considered for MMP. The major change being considered would involve a shift from sampling patients from health care facilities to sampling patients from health department HIV surveillance databases. This change would expand the MMP target population to HIV-diagnosed persons not receiving medical care, in addition to HIV-diagnosed persons receiving care, and might necessitate recruitment of patients directly rather than through health care providers, as is the current practice. If these changes are adopted, health care providers' support for MMP would continue to be needed, but their role would change. Formative work is proposed to explore health care providers' acceptance of this change in their role and their level of comfort with direct recruitment of their patients for participation in MMP.

Formative research is also needed to guide changes in interview instrument design that would be necessary if the MMP methods and target population change. HIV-infected persons often experience barriers to accessing medical care. If the MMP target population is expanded to include persons who are not in care or who access care episodically, a key use of MMP data will be to identify the factors associated

with failure of engagement and retention in care for HIV disease. New interview questions would need to be developed focusing on the challenges experienced by patients navigating the healthcare system. Formative research is proposed to obtain input from HIV providers on healthcare facility and patient-level barriers that should be included as response options to these questions.

Finally, formative research is needed to prioritize questions for the section of the MMP interview instrument regarding receipt of HIV prevention services. Recommendations for prevention with HIV-positive individuals describe a broad range of behavioral and biomedical interventions that reduce transmission behaviors and the infectiousness of adults and adolescents with HIV, including many effective interventions that have been underutilized (CDC 2003). Information about the receipt of prevention services by HIV-infected persons is required to monitor the effectiveness of these services. The MMP interview instrument elicits patients' receipt of screenings, counseling, and referrals. In order for MMP to successfully identify gaps in the delivery of prevention services, the selection of interview questions must be prioritized to include those services most likely to be received inconsistently. Information from providers about which prevention services they may be offering inconsistently is needed to identify questions with high priority for inclusion.

A.1.1 Privacy Impact Assessment

The only information in identifiable form (IIF) that CDC will receive for this formative research data collection, hereafter referred to as "the MMP Provider Survey," is age and gender, which are publicly available for HIV care providers. The contractor will transfer all electronic survey information, including age, gender, and other HIV care provider characteristics, to CDC using a secure data transfer system. The secure transmission will encrypt all data transferred from the client machine and stored on the Secure Data Network server. Provider gender and age will only be available to the CDC staff who oversee Provider Survey data collection (i.e., will not be included in analysis datasets). The response data collected will not be linked to any other personally identifiable information, therefore Provider Survey data will not be able to be used to reveal the identity of any one person.

A.1.1.1 Overview of the Data Collection System

The proposed formative research involves health care providers whose patients have been sampled to participate in MMP. The proposed survey is designed to explore healthcare providers' acceptance of proposed changes in MMP's sampling methodology, to elicit providers' perceptions of barriers experienced by HIV-infected persons not in care or inconsistently engaged in care, and to describe providers' awareness and adoption of CDC HIV prevention guidelines. The goal of this project is to inform decisions about the future design and content of Medical Monitoring Project (MMP) data collections.

A CDC contractor will be responsible for all data collection and management activities. MMP Provider Survey data will be collected using a self-administered web-based application **(Attachment 2)** developed and hosted by Altarum Institute (altarum.org). Providers who do not wish to access the survey electronically will have the option to use a paper form **(Attachment 3)** which may be mailed to a postal address when completed.

Healthcare facilities eligible to participate in MMP will be contacted by staff at health departments in the 23 project areas with which CDC has cooperative agreements to conduct MMP in order to obtain the names of all eligible providers working at those facilities. The health department staff will document the name, profession (physician, nurse practitioner, or physician assistant), business address, phone number, and email address of each provider. They will document the number of providers per facility and assign a unique MMP Provider Survey identification number to each provider from a list of sequential ID numbers for each facility provided by CDC. Health departments will email this information with password encryption to the CDC contractor.

The CDC contractor will use the provider names and addresses to create individualized recruitment packets on CDC letterhead, and mail the recruitment packets directly to providers. It is estimated that surveys will be sent to 3,000 providers based on a total of approximately 600 participating facilities with an average of 5 providers per facility. The recruitment packets will include a CDC recruitment letter **(Attachment 4)** that will explain the purpose of the survey, instructions on how to complete the survey (including instructions on how to access a web-based version of the survey via the provider's unique identification number), and a $20 cash token of appreciation to complete the survey. An additional recruitment letter

from the health department funded to conduct MMP may also be included along with a copy of the paper survey and a pre-stamped envelope addressed to the contractor, to be used by the providers who elect to complete the paper survey.

89.

90. The provider will enter his/her unique provider identification number to complete the Web or paper survey. These unique provider identification numbers will be used to identify which providers have completed the survey and which providers need to be followed-up. The Dillman method will be used to follow-up on non-responders (Dillman 1978; Dillman 1983). Dillman suggests three follow-up contacts in order to assure adequate response rates. Providers who have not responded within two months will receive one or more telephone reminders from the CDC contractor, including the link to the web-based survey option **(Attachment 4)**.

91.

92. Those providers in the sample who have valid email addresses will also receive one or more emailed invitations to complete the survey on the web-based survey site **(Attachment 4)**. These emailed survey invitations will be personalized with the provider's name and will contain an embedded clickable link that will transfer the provider's browser to the web-based survey site. This clickable link will contain a unique identifier that will allow the contractor to register the response and suppress any further email reminder and mailed survey recruitment packets. The emailed invitations and reminders will be timed to arrive approximately one or two days after the mailed recruitment packets. The emailed survey invitations are complementary to the mailed recruitment packets and will offer an alternative and convenient response mode which should enhance overall survey response.

93.

94. Responses received on paper will be entered via the web-based application. The contractor will verify the accuracy of provider identification numbers, perform selected statistical analyses and provide final datasets to CDC and to the health departments participating in MMP. The database of provider names and contact information will be kept separate from the web-based application and from survey responses and upon completion of data collection, the contractor will destroy the dataset of provider names and contact information.

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96. A.1.1.2 Items of Information to be collected

97. Surveyed providers will be asked to complete a survey of not more than 100 questions that:

98.

- Elicit providers' level of support for proposed changes in MMP patient sampling and recruitment methodology.
- Obtain providers' input on the content of questions addressing barriers to care; these questions would be included in future MMP surveys if the proposed change to MMP methods is made, which would expand the MMP target population to include HIV-infected individuals who are not engaged in medical care or who access care inconsistently.
- Describe providers' awareness and adoption of US Public Health Service (USPHS)/CDC prevention guidelines for HIV-infected individuals.

99.

100. The survey describes the change being considered for MMP which involves a shift from sampling patients from health care facilities to directly sampling from health department HIV surveillance databases with recruitment by health department staff rather than providers and asks respondents if their level of support for MMP would increase, decrease, or be unaffected if the proposed change were implemented.

101.

102. A set of questions elicit providers' perceptions of barriers to medical care experienced by HIV-infected individuals. Survey respondents are asked to rate the frequency of several possible causes of patients' failure to return for scheduled follow-up visits and to describe whether various prescription drug plans meet the treatment needs of their patients. A set of questions assess the capacity of providers to accept patients seeking care into their practices. A section of the survey addresses providers' awareness and adoption of US Public Health Service (USPHS)/CDC prevention and treatment guidelines. A question asks which sources of information about HIV care and treatment providers have used within the past year. Providers are asked for what proportion of HIV patients they have performed recommended screenings, counseling activities, and other interventions; at what CD4 lymphocyte level they routinely initiate antiretroviral treatment and their reasons for deferring initiating treatment, if applicable; and for what proportion of patients they order a genotype, i.e., a test for drug resistance, as part of their initial laboratory evaluation. Providers are also asked about their experience prescribing pre- and post-exposure antiretroviral prophylaxis.

103.

104. Ancillary data include aggregate demographic characteristics and transmission risk factors of the

providers' patients. Data on provider characteristics include gender, age, race/ethnicity, sexual orientation, profession, board certification, continuing education, professional memberships, amount and level of care provided, whether providers are obligated to practice in a designated shortage area, and their satisfaction with their practices.

105.

106. The only information in identifiable form that will be transmitted to CDC is providers' age and gender **(Attachment 5)**. HIV-infected persons not presently receiving health services may seek medical attention and the capacity of the HIV provider workforce to accommodate their needs and the experiences of those individuals seeking care may be affected by the age distribution of HIV providers. Older providers may be closer to retirement and therefore a workforce with a larger proportion of older providers may have more difficulty absorbing the influx of new patients. Information about providers' age distribution will be used to inform future interview questions exploring barriers to care including difficulty getting appointments to see a provider. Providers will also be asked their gender and sexual orientation, as well as their race/ethnicity and whether they communicate in another language besides English when they provide medical care. Concordance between medical providers and patients on these characteristics has been shown to affect patients' perceptions of quality of care and willingness to access care. Questions about perceived provider-patient concordance and its affect as a barrier to care will be included in future MMP interview instruments. In order to prioritize the characteristics to include, it is necessary to understand actual concordance of these characteristics between HIV-infected persons and HIV care providers. The MMP interview asks participants to describe themselves in terms of these characteristics and asking providers to do the same will allow assessment of concordance.

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108. Data collected through the MMP Provider Survey will be stored and accessed by a provider identification number, both by the contractor and at CDC.

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

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112. This information collection does not involve websites or website content directed at children less than 13 years of age.

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A.2. Purpose and Use of Information Collection

The purpose of the survey is threefold: 1) to explore health care providers' acceptance of direct recruitment of patients by health department staff for participation in MMP that would result from a proposed change in MMP sampling methodology; 2) to inform future MMP surveys of HIV patients and HIV-diagnosed persons not receiving care or receiving care inconsistently; and 3) identify prevention services inconsistently offered to patients by HIV providers, allowing prioritization of questions about these specific services on the MMP patient interview instrument.

If the proposed change to MMP is adopted, participants would no longer be sampled from lists of patients seen at healthcare facilities during a defined period of time. However, healthcare providers would still have a role in locating patients and providing medical records for abstraction and their continued support for the project would be required. Survey responses will be used to assess the level of support among providers for the proposed changes to MMP. Information obtained from providers about barriers their patients have encountered in seeking HIV medical care will be used in the development of questions and response sets for future data collection instruments if the scope of MMP is broadened to permit monitoring of delayed linkage to care and poor retention in care.

Information about whether medical providers are aware of and act on specific care recommendations in HIV prevention guidelines will allow identification of prevention services inconsistently provided and allow prioritization of questions about these specific services on the MMP patient interview instrument. In this way, information from the provider survey will maximize the value of MMP patient interview data to public health agencies, policy makers, and community-based stake-holders by identifying gaps that should be addressed.

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

The MMP Provider Survey will be collected electronically through a web-based application **(Attachment 2)** to minimize the burden to respondents and improve the quality of the data. A paper survey **(Attachment 3)** will be sent to respondents and will be completed only by providers who do not wish to access the survey electronically. At

least fifty percent of provider surveys are expected to be collected electronically.

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126. Those providers in the sample with email addresses will receive an email invitation to participate in the MMP Provider Survey containing a clickable link to the web-based application in addition to the mailed survey recruitment packet. Clicking the link will eliminate the need to type the URL for the web-based application in web browser.

127.

128. The web-based application will be programmed to reduce the burden to the survey respondent by incorporating features such as the use of checkboxes and drop-down lists. Any skip logic will be programmed into the survey so that it occurs automatically, and the user will be able to continue to the desired question or section. The survey will also be programmed to save respondent's answers automatically, so that users can stop the survey at any point and return to the question that they last completed. Burden is minimized since respondents may participate in the study at their convenience and proceed at their own pace.

129.

130. CDC will require the contractor to monitor data collection daily to ensure that any problems with the website or survey software are immediately identified and remedied. CDC and the contractor will maintain regular meetings to discuss problems and lessons learned as well as to help reduce the burden to respondents participating in the proposed information collection.

131.

132. Electronic data collection results in a reduction in the time to prepare the final analysis dataset because automated edit checks and skip patterns are built into the survey program for real-time quality control and the need for entry of survey response data has been eliminated.

133.

134. An evaluation of health-related surveys and research using web-based data collection methods has shown the following: 1) an improvement of data quality has been found with the addition of definitions (e.g., through pop-up windows)to increase respondents' understanding of questions, pre-programmed skip patterns to ensure respondents are not asked irrelevant questions, and automated validation checks incorporated into the survey to assist the respondent when incomplete or implausible responses are provided; 2) the need for data cleaning associated with data entry and the errors listed above is eliminated, resulting in a reduction in the time between the data collection and the production

of a final analysis dataset; and 3)web-based systems greatly reduce the financial costs of surveys despite the increased start-up costs associated with website design, testing, and implementation(van Gelder, Bretveld et al. 2010).

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

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139. Some federal surveys contain questions similar to the MMP Provider Survey but none is focused on a nationally representative sample of HIV care providers and none can be used for the purpose that this data collection is designed: to elicit providers' perceptions about proposed changes in MMP patient sampling methodology, to provide information about barriers to receiving medical care experienced by HIV-infected persons not in care or inconsistently engaged in care; and to describe awareness and adoption of the national HIV prevention and treatment guidelines. No other federal survey duplicates the content of all these subject area domains. The HIV Provider Workforce Capacity Survey conducted by the Health Resources Services Administration (OMB No. 0915-0349) was limited to questions about workforce capacity and survey recipients were restricted to providers at healthcare facilities receiving Ryan White CARE Act funding.

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

141.

142. Data collection will be kept to a minimum to lessen the burden on small businesses, i.e., privately owned medical practices. Because providers are sampled proportional to size, providers that are small businesses and have small patient loads will be less likely to be included compared with hospitals, clinics and group practices with larger patient loads. Participation in the provider survey is voluntary and it can be completed in 20-30 minutes.

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

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146. The proposed project involves a one-time data collection. There are no legal obstacles to reducing burden.

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

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149. 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 the Generic Clearance 0920-0840 on August 2, 2012 (Vol. 77, No. 149, pp. 4604-46095. There were no comments received from the public.

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

The ability of a survey to be representative of the underlying population from which the survey sample was drawn is dependent on achieving a maximal survey response rate. CDC recognizes the time burden associated with survey completion. Incentives paid to respondents have been shown to increase response rates, which in turn improves the validity and reliability of the data (Abreu and Winters 1999; Shettle and Mooney 1999). A meta-analysis (Church 1993) of survey methodologies found that studies using prepaid monetary incentives yielded an average increase in response rates of 19.1 percentage points, representing a 65% average increase in response. Physician surveys published in JAMA using $20 prospective cash incentives have achieved response rates of greater than 60%(Weissman, Betancourt et al. 2005; DesRoches, Rao et al. 2010; full references in Attachment 10).

The providers selected for this survey will receive a prospective $20 cash token of appreciation to complete the survey. Tokens have been used in other Department of Health and Human Services medical provider surveys to help increase participation rates including the Health Resources and Services Administration HIV Clinician Workforce Survey (OMB No. 0915-0349 exp. 6/30/2015), which offered a prospective $20 token of appreciation along with a promise of an additional $20 for completing a paper survey or $40 for completing a web-based survey ($60 total). Data collection for this survey is ongoing. The CDC HPV Clinician Survey (OMB No. 0920-0629) offered a prospective $50 incentive for completing the survey. Response rates among all specialties of providers were at least 60%.

A.10.Assurances of Confidentiality Provided to Respondents

MMP Provider Surveys will not contain specific

identifiers (e.g., name, address, social security number). Local health department staff of health departments funded to conduct MMP will record contact information for the HIV medical providers at sampled healthcare facilities within the health department's jurisdiction. The local MMP staff will transfer this information to the CDC contractor who will prepare survey packets for mailing to survey recipients. The database of provider names and contact information will be kept separate from the survey response dataset and upon completion of data collection, the contractor will destroy the dataset of provider names and contact information.

165.

166. The Web-based software, which will provide a means for providers to enter their survey responses, supports the ability to encrypt response data and password-protect surveys so that unauthorized users are unable to view, export, or modify collected data. The contractor will not save internet protocol (IP) addresses of survey respondents who complete the web-based survey.

167.

168. The CDC contractor will be responsible for data entry of surveys completed on paper into the electronic application. The CDC contractor will be responsible for shipping the paper survey forms to CDC for locked storage after the responses have been entered. The CDC contractor will not be permitted to make copies of these completed paper surveys. The CDC contractor will transfer all electronic survey information to CDC using a secure data transfer system. All data will be encrypted for transmission. Each record in the MMP Provider Survey database will be identified by the pre-assigned unique provider ID and will not contain any information that would allow directly or indirectly personal identification of respondents. At the end of the survey period, CDC will provide project area-specific combined weighted datasets to each health department funded to conduct MMP, via the Data Coordinating Center data portal.

169.

170. Privacy Impact Assessment

171.

172. Health care providers will complete the survey online by logging in to a secure web site hosted by Altarum Institute with an identification number and password provided in the survey packet and email invitation. Respondent IP addresses will not be recorded or associated with any responses. Respondents will have the alternative option of completing a paper survey form on which the unique

identification number is pre-printed and returning it to the contractor in a non-transparent envelope.

Data will be stored on a secure server maintained by a CDC contractor. The contractor will back up the survey data on a separate, secure server nightly. Access to the backup files will be subject to the same restrictions as access to the primary database. The Contractor's computer systems are password protected to ensure that unauthorized users are not able to view, export, or modify collected data.

The Contractor will transmit the web-based survey data to CDC via a Secure Data Network (SDN). Encryption security for all survey data will meet the current National Institute of Standards and Technology (NIST) Federal Information Processing Standards (FIPS), which meet or exceed Advanced Encryption Standards (AES).

The contractor will inform its workforce of the non-public nature of the data collection system and will limit access to employees. These principles will be based upon theories of least privileges and minimum necessary, as set out in current (National Institute of Standards and Technology) NIST Publications. Each contractor employee who may have access to survey data will complete the "Centers for Disease Control and Prevention (CDC) Contractors' employee Non-disclosure Agreement" **(Attachment 6)**. Each contractor employee will complete the HHS Computer Security Awareness Training course (or another course designated by CDC) prior to performing any contract work, and thereafter complete the HHS-specified annual refresher course during the period of performance of the contract.

A project determination request has been submitted for the MMP HIV Provider Survey. If the MMP HIV Provider Survey is determined to be research, then the Provider Survey protocol will be reviewed by the CDC IRB. If the MMP HIV Provider Survey is determined to be non-research, review by the CDC IRB will not be necessary. Each participating health department may obtain local IRB approval before data collection, according to requirements in the jurisdiction.

A.11.Justification for Sensitive Questions

Providers who participate in the survey will be asked to indicate their sexual orientation in a standardized question developed and tested by the National Center for Health Statistics **(Attachment 5)**. Providers who participate

will also be asked their gender, age, race/ethnicity and whether they communicate in another language besides English when they provide medical care. Concordance between medical providers and patients on these characteristics has been shown to affect patients' perceptions of quality of care and willingness to access care. Questions about perceived provider-patient concordance and its affect as a barrier to care will be included in future MMP interview instruments. In order to prioritize the characteristics to include, it is necessary to understand actual concordance of these characteristics between HIV-infected persons and HIV care providers. The MMP interview asks participants to describe themselves in terms of these characteristics and asking providers to do the same will allow assessment of concordance. Although the information requested is sensitive, the purposes of this project cannot be accomplished without its collection.

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186. Respondents not wishing to answer individual survey questions describing their personal characteristics have the option to skip items and continue the survey. The use of encrypted, password-protected computers for data collection addresses concerns the respondent might have about privacy (that others can see their answers).

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189. A.12.Estimates of Annualized Burden Hours and Costs

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191. **A.12.A. Estimated Annualized Burden Hours**

192.

193. Staff in 23 health departments funded to conduct MMP will collect and transfer contact information for eligible providers to the CDC contractor who will conduct the survey. The goal for the MMP Provider Survey is to survey 3,000 HIV medical providers. If the response rate is 80%, 2,400 providers will complete the survey. Each survey will take about 30 minutes to complete. It is estimated that 70% of respondents will be physicians, 21% will be nurse practitioners, and 9% will be physician assistants.

194. Exhibit A.12.A Annualized Burden Hours

195. Type of Respondent	196. Form Name	197. 198. Number of 199. Respondents	200. 201. Number of 202. Responses per 203. Respondent	204. 205. Average Hours 206. Per Response	207. 208. Total Response 209. Burden 210. (Hours)
211. Physicians, nurse practitioners, physician assistants	212. MMPPS Provider Survey	213. 2,400	214. 1	215. 30/60	216. 1,200
217. Facility office staff	218. None (providing health department staff with provider names and contact infor-mation)	219. 3,000	220. 1	221. 2/60	222. 100
223. **Total**	224.	225.	226.	227.	228. 1,300

229.

230. A.12.B. Estimated Annualized Costs

231. The annualized cost to respondents for the burden hours is estimated to be **$91,026**; details are provided in Exhibit A.12.B. The estimates of hourly wages were obtained from the Department of labor (Bureau of Labor Statistics Wage Data (http://www.bls.gov/oes/current/oes_nat.htm#43-0000).

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

233.

234. Activity	**235. Total Burd**	**236. Hourly Wage**	**237. Total Respo**

	en Hours	Rate	ndent Cost
238. Sampled physicians completing Provider Survey	239. 840	240. $90.97	241. $76,415
242. Sampled nurse practitioners completing provider survey	243. 252	244. $33.23	245. $8374
246. Sampled physician assistants completing provider survey	247. 108	248. $43.01	249. $4645
250. Facility office staff providing names and contact information of providers to health department staff	251. 100	252. $15.92	253. $1592
254. Total	**255. 1300**	256.	**257. $91,026**

258.

259.

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

261. There are no other costs to respondents or record keepers.

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

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265. The annualized cost of this project is estimated to be $467,617.

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268. Expense Type	269. Expense Explanation	270. 271. Annual Costs (dollars)
272.	273.	274.

Direct Costs to the Federal Government	MMP – Personnel Epidemiologist-14 1 80% Epidemiologist-14 1 10% Public Health Advisor-12 1 10% Data Manager 1 10%	$79,139 $8,622 $7,040 $8,000
	Total MMP Provider Survey Personnel	$102,801
Incentives to Providers (Paid by contractor)		$60,000
Contractor and other Expenses		$364,816

The personnel related to the Provider Survey data collection include project officers at the GS 14 level, a GS 12 level public health analyst, and a data manager. Incentives of $20 that will be offered to each respondent are included in the contractor costs.

A.15.Explanation for Program Changes or Adjustments

Not applicable – request is for a sub-collection under a generic approval.

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

All data collection will be completed during the 12 month period after OMB approval. The following is a brief overview of the Provider Survey timeline.

309. Exhibit 16.A Project Time Schedule

310.

311. 312. Activity	313. 314. Time Schedule
315. Survey distribution begins	316. Immediately after OMB approval
317. Follow-up communication to non-respondents	318. within 4 months of OMB approval
319. Data collection completed	320. 6 months after OMB approval
321. Verify completeness of data	322. 6-7 months after OMB approval
323. Clean data entry errors	324. 7-8 months after OMB approval
325. Analyze data files for quality assurance	326. 9-12 months after OMB approval
327. Transfer final dataset to CDC	328. 12 months after OMB approval

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

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333. The OMB Expiration Date will be displayed. No exception is requested.

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

336. There are no exceptions to the certification.

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346. References

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