

Aggregate Reports for Tuberculosis Program Evaluation
OMB Control Number: 0920-0457 Exp. 9/30/2013

Supporting Statement A

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Table of Contents

A. Justification

1. Circumstances Making the Collection of Information Necessary
2. Purpose and Use of the Information Collection
3. Use of Improved Information Technology and Burden Reduction
4. Efforts to Identify Duplication and Use of Similar Information
5. Impact on Small Businesses or Other Small Entities
6. Consequences of Collecting the Information Less Frequently
7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5
8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency
9. Explanation of Any Payment or Gift to Respondents
10. Assurance of Confidentiality Provided to Respondents
11. Justification for Sensitive Questions
12. Estimates of Annualized Burden Hours and Costs
13. Estimates of Other Total Annual Cost Burden to Respondents and Record Keepers
14. Annualized Cost to the Federal Government
15. Explanation for Program Changes or Adjustments
16. Plans for Tabulation and Publication and Project Time Schedule
17. Reason(s) Display of OMB Expiration Date is Inappropriate
18. Exceptions to Certification for Paperwork Reduction Act Submissions

List of Attachments

- | | |
|---------------|---|
| Attachment 1 | Section 301 (a)-Public Health Service Act [42 U.S.C. 241 (a)] |
| Attachment 2 | 60-day Federal Register Notice |
| Attachment 3a | Follow-up and Treatment of Contacts to Tuberculosis Cases, form and instructions (OMB No. 0920-0457) |
| Attachment 3b | Targeted Testing and Treatment for Latent Tuberculosis Infection, form and instructions (OMB No. 0920-0457) |
| Attachment 4 | NCHHSTP Project Determination Form |

A. Justification

1. Circumstances Making the Collection of Information Necessary

Background

The Centers for Disease Control and Prevention requests an extension and 3 year approval of the currently approved “*Aggregate Reports for Tuberculosis Program Evaluation*”, (OMB # 0920-0457, exp. 9/31/2013). There are no changes to the existing collection. This data collection is authorized under Section 301 of the Public Health Service Act 42 U.S.C. 241, (**Attachment 1**). The burden has not changed.

The Division of Tuberculosis Elimination (DTBE), National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC), maintains cooperative agreements with the health departments of the 50 states, 10 large cities, and 8 trust territories and protectorates who submit tuberculosis program management reports. CDC also provides ongoing technical consultation about tuberculosis control for these health departments. Since 2000, the “*Aggregate Reports for Tuberculosis Program Evaluation*”, replaced several outdated reports and are used nationwide. The changes in these reports corresponded to the evolving national tuberculosis control strategy and the new data-systems technology.

The two reports (**Attachments 3a and 3b**), measure the extent, the efficiency, and the yield of tuberculosis (TB) control activities. For TB control, 68 federal cooperative agreement sites encompass the United States, and they are the respondents for the reports. These sites have adopted the “Aggregate Reports for Tuberculosis Program Evaluation” as their generic tool for assessing their TB prevention activities. They use the reports for generating the indicators used in program evaluation as stipulated in the 2013 cooperative agreement, for monitoring the workload of tuberculosis prevention, and for estimating the epidemiological status of tuberculosis in their jurisdictions.

During the previous approval period (September 2010-September 2013), CDC completed and achieved the following activities and outcomes:

- Served as the only agency collecting national data on TB contact investigations
- Hosted a webinar for respondents on how and when to report data; this webinar provided an opportunity for respondents to discuss the report, clarify reporting requirements with CDC and provide recommendations for consideration of future data collections
- Achieved a response rate of 82% from TB control jurisdictions
- Disseminated an annual report of national aggregate contact investigation data to TB control jurisdictions in 2011, 2012, and 2013
- Presentation of aggregate contact investigation data and trends at national and international conferences (i.e. the National TB Controllers Association; the International Union for Tuberculosis and Lung Disease, North America Region)

During the next approval period (2013-2016), CDC plans to achieve the following:

- Continue data collection and analysis as the only agency collecting national data on TB contact investigations

- Increase reporting response rate from TB control jurisdictions to 90%
- Disseminate annual reports of national aggregate contact investigation data to TB control jurisdictions
- Host at least one consultation session with TB control jurisdictions and/or the National TB Controllers Association regarding data collection and reporting

1.1 Privacy Impact Assessment

Overview of the Data Collection System

Data are collected by state and local health departments as part of routine contact investigation activities for providing information on cases of tuberculosis disease or infection. Data aggregation varies by site, with computerized methods becoming the norm at large jurisdictions. Respondents provide the data following the format as outlined on the “*Aggregate Reports for Tuberculosis Program Evaluation*”. The respondents have a choice of submitting their aggregated data to CDC by encrypted computer transmission, by facsimile copy, by email, or by US Postal service. There is no current plan for data retirement as the data is used for monitoring trends over an indefinite period of time.

Information to be Collected

No information in identifiable form (IIF) will be collected. The two reports submitted here (**Attachments 3a and 3b**) identify the types of non-individually identifiable information that will be collected. The source data for the “*Aggregate Reports for Tuberculosis Program Evaluation*” are gathered as part of standard public health practice for tuberculosis control under the authority of state and local health departments. No respondents submit these data with individual patient records to CDC. Although health departments may collect IIF for local tuberculosis control purposes, consistent with state and local laws, this information is retained at those levels, and health departments do not transmit person-level data or identifiable data to CDC. The data associated with this OMB clearance are submitted to CDC only in an aggregate format (*refer to Supporting Statement A. Section 10.A*).

2. Purpose and Use of Information Collection

CDC uses the data from these reports for monitoring local, state, and national tuberculosis control programs, for planning national tuberculosis control strategy, and in estimating funding needs. The results in these reports are compared to the national performance goals, and they indicate progress toward achieving tuberculosis elimination. These data address Government Performance Results Act (GPRA) section IIIH, Tuberculosis Performance Goal 1 Item 3 (“Increase the percentage of contacts of infectious acid-fast bacilli smear positive cases who are placed on treatment for latent tuberculosis infection and complete a treatment regimen”) and Item 4 (“Increase the percentage of other high risk infected persons who are placed on treatment for latent tuberculosis infection and complete a treatment regimen”). The “*Aggregate Reports for Tuberculosis Program Evaluation*” show that approximately 68% of contacts of infectious tuberculosis cases start and finish a treatment regimen, which informs CDC and the respondents that the current prevention activities are not at their full potential. This informs strategy and resource allocation.

CDC has disseminated the results from these reports in the following ways:

- An annual “dear-colleague” letter from the director of DTBE, for data years 2000–2010, to the respondents, who are the 68 state, territorial, and big city tuberculosis control officials. This letter reiterates the purposes of the data collection and provides a national interpretation of the results for the year.
- A journal publication of the baseline data that some of the respondents submitted to CDC during the first year of the reporting cycle (Jereb J, Etkind S, Joglar O, Moore M, Taylor Z. Tuberculosis contact investigations: outcomes in selected areas of the United States, 1999. *The International Journal of Tuberculosis and Lung Disease* 2003;7:S384-S390).
- CDC poster presentations of the national summary results and interpretation at the annual conference of the National Tuberculosis Controllers Association (NTCA, i.e., the official organization representing the report respondents). Presentations in this forum will continue annually.
- CDC poster presentation of the national summary results and interpretation at the International Union of Tuberculosis and Lung Disease, North America Region Conference (IUATLD, NAR).
- Results from the reports are incorporated into the National Tuberculosis Indicators Project (NTIP). NTIP is a secure web-based monitoring system that allows state and local health authorities to access reports and review data. The NTIP system provides TB programs with reports to describe their progress, based on data already reported to the Centers for Disease Control and Prevention (CDC), and facilitates the use of existing data to help programs prioritize activities and focus program evaluation efforts.

CDC uses the reports for assessing the effective use of federal tuberculosis cooperative agreement funds. Reports for program evaluation are stipulated in the cooperative agreements. The CDC tuberculosis program consultants, who use the reports as the standard measurement of workload and performance, visit the 68 cooperative agreement sites at least annually to review local progress toward tuberculosis elimination.

All state health departments have adapted the “*Aggregate Reports for Tuberculosis Program Evaluation*” for their own tuberculosis control programs. Most health departments use the identical reports that they submit to CDC, while a few, such as the health departments in California and Florida, have elaborated on the reports to meet their specialized needs. Health departments that have their own comprehensive data management systems for tuberculosis control, such as in New York State and Illinois, have designed their systems so that information for the “*Aggregate Reports for Tuberculosis Program Evaluation*” are generated automatically and thus at no added burden for the respondents, who already were collecting the data for their own use.

There are no revisions to the “*Aggregate Reports for Tuberculosis Program Evaluation*”. The majority of technical-support questions about the reports have been related to data definitions. CDC has addressed these questions by preparing extended on-line instructions that are linked to the DTBE web page (http://www.cdc.gov/nchstp/tb/pubs/PDF/ARPEs_manual.pdf). The on-line instructions include guidance about how the respondents (i.e., the state and local public health departments) can use the reports for monitoring the results of their own tuberculosis control programs.

Difficulties have been reported anecdotally for specific complex large tuberculosis outbreaks in institutional settings (e.g., prisons or homeless shelters) two or three times per year. The data structure required by these outbreaks is too complex for the “*Aggregate Reports for Tuberculosis Program*

Evaluation”. These issues have been resolved collaboratively between the respondents and the CDC tuberculosis program consultants by collapsing the data into simpler formats that were compatible with the reports. CDC is not proposing revisions to the reports to accommodate more complex data because the current reports are sufficient for most data. If the reports were expanded for rare instances of complex data, this would increase the burden to the respondents without sufficient compensatory benefit to the respondents or to CDC.

State and local public health officials have cited improved convenience and usefulness of the current reports in comparison to the older CDC reports. The reports document that the scope of prevention activities is large: according to the most recent final reports, at least 68,219 persons in the United States were listed as exposed to tuberculosis in 2010, and approximately 20% of the persons who underwent diagnostic testing were found to have tuberculosis infection. The reports also have shown that approximately 5% of contagious tuberculosis patients in the United States do not have contacts listed, which demonstrates a particular need for improvements in tuberculosis prevention.

These data from the “*Aggregate Reports for Tuberculosis Program Evaluation*” continue to demonstrate the scope of the public health problem and the prevention activities for which CDC is jointly accountable, in collaboration with U.S. state and local health departments. Without the “*Aggregate Reports for Tuberculosis Program Evaluation*” reports, CDC does not have a standard measurement of workload, yield, efficiency, and effectiveness of the prevention activities carried out by state and local tuberculosis control programs. National data about the transmission of tuberculosis infection and the prevention of tuberculosis cases will not be available. CDC needs a fair, standard assessment of the utilization of the funding disbursed through the federal tuberculosis cooperative agreements. Even if CDC could not collect the reports, state health departments would continue using them for monitoring the efforts of their own tuberculosis programs, because they have found the reports to be feasible and useful.

2.1 Privacy Impact Assessment

No individually identifiable information will be collected or reported. The proposed data collection will have little or no effect on the respondent’s privacy.

The information relates to the two priority areas of TB prevention and control (1) evaluating all contacts to contagious tuberculosis and treating the contacts who are infected, and (2) carrying out targeted testing for latent tuberculosis infection in selected populations and treating the persons who are infected.

The intended use of the information is to continue dialogue between CDC and federally funded TB control jurisdictions regarding TB control and prevention activities. The results in these reports are compared to the national performance goals, and they indicate progress toward achieving tuberculosis elimination.

3. Use of Improved Information Technology and Burden Reduction

The federal tuberculosis cooperative agreements include funds for computer equipment and support. From 1997 through 2008, all the project areas were using the Tuberculosis Information Management System (TIMS), a software package developed at CDC for the electronic collection, storage, collation, and transmission of tuberculosis data. Tuberculosis cases (OMB #. 0920-0026 exp. 5/31/2014) were first reported through TIMS in 1998. In 2000, CDC added the “*Aggregate Reports for Tuberculosis Program Evaluation*” to TIMS. During the discontinuation of TIMS in 2009, CDC accepted facsimile transmissions and paper copies for the reports, particularly from low-burden respondents who report so few data that the electronic format was not advantageous. CDC continues to work with the respondents

in adopting new technology. Some jurisdictions transferred to the CDC-led National Electronic Disease Surveillance System (NEDSS) (OMB #. 0920-0728 exp. 1/31/2014), but the future of the tuberculosis-specific module for NEDSS is uncertain. In 2009, jurisdictional health authorities submitted data by the electronic media of their choice. Since 2010, a web-based module in the National Tuberculosis Indicators Project (NTIP) is now available for providing a new, secure web-based option for direct data entry and electronic submission to CDC. Overall estimates from prior submissions indicate that 73.5% of the responses will be electronic and the remainder (26.5%) will be manual.

4. Efforts to Identify Duplication and Use of Similar Information

The “*Aggregate Reports for Tuberculosis Program Evaluation*” is a comprehensive standard summary of priority tasks for controlling and eliminating tuberculosis in the United States. Some state health departments (e.g., in California, New York, Illinois, and Florida) subsequently have designed their own similar reports for program evaluation, in accordance with their specific programmatic needs. Their reports are compatible with the national reports, but those reports are either too specific or too complex for national adoption. No federal agency besides CDC collects uniform data on tuberculosis prevention nationwide. Through literature searches, attendance at national tuberculosis meetings and conferences, and ongoing consultations with tuberculosis experts nationwide, CDC has determined that the “*Aggregate Reports for Tuberculosis Program Evaluation*” are unique and that no other similar data are available within or outside the federal government.

5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this data collection. Data are requested from state, local, and territorial health departments. Data are collected only once a year and are kept to an absolute minimum to lessen the reporting burden.

6. Consequences of Collecting the Information Less Frequently

Annual reporting is linked to the annual funding cycle and program evaluation of the tuberculosis cooperative agreements. Less frequent reporting would delay feedback and technical consultation to the respondents and would leave CDC without current data for monitoring the national tuberculosis situation. The reporting frequency is once a year. The respondents collect the data for these reports continuously as part of standard public health practice. There are no legal obstacles to reducing the burden to the respondents.

7. Special circumstances Relating to the Guidelines of 5 CFR 1320.5

This request fully complies with the guidelines in 5 CFR 1320.5, and no special circumstances require the information to be collected in any other manner.

8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A 60-day Federal Register Notice was published in the *Federal Register* on Monday, April 15, 2013, Volume 78, Number 72, Pages 22267-22268 (see **Attachment 2**). There were no public comments.

The CDC tuberculosis program consultants, who use the reports as the standard measurement of workload and performance, visit the 68 cooperative agreement sites at least annually to review local progress toward tuberculosis elimination. During the administrative site visits made by CDC tuberculosis program consultants, the consultants not only provide ongoing technical consultation about

tuberculosis control for these health departments, but also may receive consultation from the programs as to the utility of the reports.

In 2009, TB control officials from California (Jennifer Flood, Chief, 510-620-3020, jennifer.flood@cdph.ca.gov); Colorado (Gayle Schack, no forwarding contact information available), New York State (Stephen Hughes, Assistant Director, 518-474-4845, seh03@health.state.ny.us), Tennessee (Katie Garmin, no forwarding information available), and Texas (Ann Tyree, no forwarding contact information available) reviewed the indicators that are in the “*Aggregate Reports for Tuberculosis Program Evaluation*” and recommended their inclusion in the National Tuberculosis Indicators Project (NTIP).

In 2009, CDC launched a new web-based user interface, the National Tuberculosis Indicator Project (NTIP), for returning data and reports in a convenient format to state and local public health authorities. The cumulative “*Aggregate Reports for Tuberculosis Program Evaluation*” are integrated into NTIP. During the design and the implementation of NTIP, CDC sought consultation from public health authorities from the state health departments mentioned above and with representatives of the National Tuberculosis Controllers Association, which advocates for the respondents for the Aggregate Reports. In these consultations, CDC was advised to continue the Aggregate Reports for Tuberculosis Evaluation in their current form and to make them accessible through NTIP.

Attendees: CDC Webinar-“Reporting ARPE Data: When and How to Report”				
Name	Title	Phone	Email	Organization
Michelle Cummings	Unknown	Not available	mhc09@health.state.ny.us	New York State TB Control
Peter Dupree	Deputy TB Program Manager	303-692-2677	peter.dupree@state.co.us	Colorado Department of Public Health and Environment
Melissa Ehman	Epidemiologist / Assistant Chief Surveillance and Epidemiology	510-620-3039	melissa.ehman@cdph.ca.gov	California Department of Public Health
Diana Fortune	TB Nurse Consultant	505-827-2471	diana.fortune@state.nm.us	New Mexico Department of Health
Laura Gano	Epidemiologist	765-208-5723	lgano@isdh.in.gov	Indiana State Department of Health
Pat Infield	Tuberculosis Program Manager	402-471-6441	pat.infield.nebraska.gov	Department of Health and Human Svcs
Denise Ingman	TB Program Manager/Nurse Consultant	406-444-0275	dingman@mt.gov	State of Montana
Lindsay Lane	TB Epidemiologist	971-673-0160	Lindsay.m.lane@state.or.us	Oregon Health Authority
Michelle Macaraig	Assistant Director for Strategic Planning and Program	347-396-7536	Mmacarai@health.nyc.gov	New York City Health Dept

Attendees: CDC Webinar-“Reporting ARPE Data: When and How to Report”				
Name	Title	Phone	Email	Organization
	Evaluation			
Sandra Matus	Epidemiologist	410-767-6692	smatus@dhhm.state.md.us	Maryland Department of Health & Mental Hygiene
Marcee Mortensen	ADAP Administrator / Tuberculosis Health Educator	801-538-6042	marceemortensen@utah.gov	Utah Department of Health
Ann Poole	PHSO Nurse Consultant	404-657-2618	abpoole@dhr.state.ga.us	Georgia Department of Public Health
Dee Pritschet	TB Controller, HIV/AIDS Surveillance Coordinator	701-328-2377	djpritschet@nd.gov	North Dakota Department of Health
Steve Quilter	Branch Director	601-576-7700	squilter@msdh.state.ms.us	Mississippi State Department of Health
Patricia Raines	TB Nurse Consultant	517-373-3740	RainesP@michigan.gov	Michigan Department Of Community Health
Jeanette Rodman	Tuberculosis Nurse Consultant/Program Manager	302-744-1052	Jeanette.rodman@state.de.us	Deleware Division of Public Health Tuberculosis
Sarah Solarz	Epidemiologist,	651-201-5588	sarah.solarz@state.mn.us	Minnesota Department of Health
Anne Tyree	TB Evaluation Program Analyst	512-776-6534	ann.tyree@dshs.state.tx.us	Texas Dept of Health
Ellen Zager-Hill	Epidemiology Program Specialist	208-344-6961	Hille@DHW.Idaho.Gov	Department Of Health & Welfare
Elizabeth Zeringue	TB Nurse Consultant	919-663-4600	elizabeth.zeringue@dhhs.nc.gov	North Carolina T B Control

On June 6, 2012, CDC hosted a webinar on “Reporting ARPE Data: When and How to Report”. Following the webinar was an open forum for comments and questions regarding ARPE data collection. Webinar attendees included TB controllers, program managers, nurse consultants, and data analysts/epidemiologists. Attendees were the users of and respondents for ARPE reports from the federally funded TB control jurisdictions. From this forum, CDC was able to clarify mandatory reporting requirements, the purpose of the report, and how to report contact investigation data. There were no major problems that could not be resolved.

On September 11, 2012, staff from DTBE attended a meeting with the National Tuberculosis Controllers Association (NTCA) to discuss ARPE reporting requirements and data collection. In these consultations, CDC was advised to continue the Aggregate Reports for Tuberculosis Evaluation in their

current form and to host consultations in 2013 and 2014 to further discuss mechanisms for collecting contact investigation data in the future. Representatives from (NTCA) included Jon Warkentin (President-NTCA, TB Control Officer, Tennessee Dept. of Health, 615-253-1364, jon.warkentin@tn.gov); and Jennifer Flood (President-Elect-NTCA, Chief, TB Control Branch, California Department of Health, 510-620-3020, jennifer.flood@cdph.ca.gov). There were no major problems that could not be resolved.

9. Explanation of Any Payment or Gift to Respondents

The respondents do not receive payments or gifts for providing the “*Aggregate Reports for Tuberculosis Program Evaluation*”.

10. Assurance of Confidentiality Provided to Respondents

Privacy Impact Assessment Information

This submission has been reviewed by the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention and determined not to involve human subjects (**Attachment 4**). This surveillance activity does not require IRB review and approval. The Privacy Act is not applicable. Respondents are state and local health departments that provide CDC with aggregate information on cases of tuberculosis disease or infection. Although health departments may collect identifiable information for local tuberculosis control purposes, consistent with state and local laws, this information is retained at those levels, and health departments do not transmit person-level data or identifiable data to CDC. No individually identifiable information is being collected.

The aggregate data are not stratified by age, sex, or specific medical conditions except for tuberculosis, and therefore the accidental identification of any patient who is counted in the reports is extremely unlikely. CDC previously has not made any assurance of confidentiality to the respondents. Data from specific respondents will be treated in a secure and private manner and will not be disclosed unless otherwise compelled by law.

- A. Through the federal cooperative agreement respondents are informed about the voluntary or mandatory nature of their response. The requirements for submission are clearly described in the cooperative agreement.
- B. As the primary users of the data, the respondents are informed about the intended uses of the information collection through the cooperative agreement and are able to access the results of the aggregate reports through NTIP. The respondents requested in 1999, and CDC agreed, that local public health authorities will be notified before locality-specific data is published or shared outside CDC. CDC publishes the national data and shares the national summaries with the respondents at least annually after aggregating the reports.
- C. The information submitted by respondents will be secured with the appropriate safeguards currently in place to minimize the possibility of unauthorized access, use, or dissemination of the information being collected. Technical controls include user identification, passwords, firewall, virtual private network (VPN), and encryption. All data which are submitted electronically through NTIP are encrypted and files are password protected. Any reports that are transmitted by telephone facsimile are sent unencrypted, to the CDC office where the data are collected, under the privacy-statement cover sheet of the submitting agency as guided by state or local law. Any printed records from specific jurisdictions are kept in a locked file cabinet. The summary national reports contain no

sensitive or private information.

Physical controls include security guards, identification badges, key cards, and locked file cabinets. Any printed records from specific jurisdictions are kept in a locked file cabinet. Administrative controls include training manual and user guides for information collection, completion of required security training for computer access and data collection annually by all CDC personnel, and role-based access to data.

11. Justification for Sensitive Questions

As part of their routine public health practices, health department officials (i.e., the respondents) collect sensitive information (e.g., address, occupation, country of origin, infection with the human immunodeficiency virus and risk factors for it, and the use of alcohol or illegal drugs) from persons who have tuberculosis infection or who have been exposed to tuberculosis. For preparing the reports, the respondents interpret some of this sensitive information, but the sensitive information is not recorded per se in the reports, and it is not extractable from the reports. The aggregate format of the reports precludes linking any sensitive information to any persons who are counted in the reports.

12. Estimates of Annualized Burden Hours and Costs

A. The data that the respondents need to prepare the “Aggregate Reports for Tuberculosis Program Evaluation” are accrued during the normal operations of a tuberculosis control program following standard accountability practices. Therefore the annualized burden-hour estimates are based on the time for studying the report instructions, searching the existing data sources, and tabulating and reviewing the results. The reports are submitted annually. The annualized burden is estimated partly from the experience with older reports, the Tuberculosis Program Management Reports (formerly, portions of OMB # 0920-0026 exp. 5/31/2014). A series of pretests of the current report forms was done in 1999 with four volunteer respondents who tabulated their data for the report manually.

The respondents are the tuberculosis control officials of the 68 U.S. jurisdictions receiving federal tuberculosis funding. The officials ideally assign the responsibilities for preparing and submitting these reports to administrative personnel, such as data clerks and program managers. CDC does not request data on who prepares or submits the reports.

The estimates for annualized burden hours are variable because some respondents use custom automated data management systems for tabulating results while others tabulate results manually and then either enter the results into computer spreadsheets or maintain paper files. The tuberculosis incidence at a site also influences the annualized burden hours, because greater numbers of cases generate greater amounts of data. The maximum estimate for annualized burden hours is shown in the table.

For completion of the *Follow-up and Treatment of Contacts to Tuberculosis Cases Form*, we expect 50 data clerks and 50 program managers will spend 30 minutes completing the electronic version for a total of 50 burden hours. Eighteen program managers will spend approximately 30 minutes completing the manual version of the form for a total of 9 burden hours. Additionally, 18 data clerks will spend 3 hours to complete the manual version of the form for a total of 54 burden hours. For completion of the

Targeted Testing and Treatment for Latent Tuberculosis Infection Form, we expect 50 data clerks and 50 program managers will spend 30 minutes completing the electronic version for a total of 50 burden hours. Eighteen program managers will spend approximately 30 minutes completing the manual version for a total of 9 burden hours. Additionally, 18 data clerks will spend 3 hours to complete the manual version of the form for a total of 54 burden hours.

Table A.12.1: Estimated Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
Data clerks and Program Managers	Follow-up and Treatment of Contacts to Tuberculosis Cases Form (3a)	100	1 (electronic)	30/60	50
Program Managers	Follow-up and Treatment of Contacts to Tuberculosis Cases Form	18	1 (manual)	30/60	9
Data clerks	Follow-up and Treatment of Contacts to Tuberculosis Cases Form	18	1 (manual)	3	54
Data clerks and Program Managers	Targeted Testing and Treatment for Latent Tuberculosis Infection (3b)	100	1 (electronic)	30/60	50
Program Managers	Targeted Testing and Treatment for Latent	18	1 (manual)	30/60	9

	Tuberculosis Infection				
Data clerks	Targeted Testing and Treatment for Latent Tuberculosis Infection	18	1 (manual)	3	54
Total					226

B. The annualized costs to the respondents are estimated here based on estimated savings from using electronic storage and transmission of reports. The entire costs are labor. Part of the reporting is done by (1) the 37 CDC field-staff employees who are assigned to the TB control programs of state and local health departments and (2) the health department personnel who work in positions funded by the federal tuberculosis cooperative agreements, which reduce direct costs to the correspondents, and therefore the costs that are shown likely represent an overestimation.

Table B.12.1: Estimated Annualized Burden Costs

Type of Respondents	Form Name	Total Burden Hours	Hourly Wage Rate*	Total Respondent Costs
Data clerks & Program Managers	Follow-up and Treatment of Contacts to Tuberculosis Cases electronic	50	\$26.99	\$1349.50
Program Managers	Follow-up and Treatment of Contacts to Tuberculosis Cases manual	9	\$32.73	\$294.57
Data clerks	Follow-up and Treatment of Contacts to Tuberculosis Cases manual	54	\$21.25	\$1147.50
Data clerks & Program Managers	Targeted Testing and Treatment for Latent Tuberculosis Infection 3b electronic	50	\$26.99	\$1349.50
Program Managers	Targeted Testing and Treatment for Latent Tuberculosis Infection manual	9	\$32.73	\$294.57
Data clerks	Targeted Testing and Treatment for Latent Tuberculosis Infection manual	54	\$21.25	\$1147.50
Total				\$5,583.14

*Estimated hourly rates for data clerks obtained from Department of Labor (www.dol.gov); estimated hourly rates for program managers obtained from U.S. Office of Personnel Management (www.opm.gov).

13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

None. The reports do not cause additional capital and maintenance costs to the respondents. The systems that are used for data collection, collation, and storage are already in place for routine public health practice.

14. Annualized Cost to the Government

The reporting is recurrent and ongoing. The costs that are estimated here reflect a public health system that is assumed to be stable. Travel for training in Atlanta is no longer included in the costs because CDC provides comprehensive instructions for reporting on the CDC TB website. The upkeep for NTIP is minimal because programming is complete. Routine checks on the functionality of the reporting system are part of routine annual site visits made by CDC tuberculosis program consultants for the federal cooperative agreements, and the costs of these visits are not shown because the visits would be made regardless of the “*Aggregate Reports for Tuberculosis Program Evaluation*”.

Annualized Cost to the Government:

NTIP programming @25,000/yr	\$25, 000.00
Quarter-time medical epidemiologist GS-14 @ \$114,505/yr.....	\$28,626.25
Quarter-time data clerk GS-13 @ \$96,899/yr.....	\$24,224.75
Annualized cost – government: \$77,851.00	

This amount reflects an increase of \$9,876 due to increases in salaries of personnel conducting data collection and analysis since the last ICR approval (\$67,975).

15. Explanation for Program Changes or Adjustments

There are no program changes or adjustments. The burden has not changed from the burden shown in the current inventory.

16. Plans for Tabulation and Publication and Project Time Schedule

The data accumulation is intermittent, it represents continuous public health practice throughout the United States, and the reporting is annual and recurrent. A 3-year clearance cycle is requested.

No analytical methods beyond simple tabulation and trend description are applied to the results of the reports. The indices that are used for program evaluation are unadjusted. The interpretation of the results from each reporting area is discussed between the respondents and their CDC tuberculosis program consultants. Specific data from one respondent are not shared with other respondents by CDC without prior notification because the data ownership (i.e., intellectual property) remains with the respondents as per general agreement between CDC and the Council of State and Territorial Epidemiologists.

The data that are reported to CDC are summed up for the U.S. national tuberculosis program statistics, which are sent to all the respondents annually. At least annually, the program consultants from CDC use the data that are reported by their tuberculosis cooperative agreement project sites for reviewing the effectiveness of existing tuberculosis control programs and for planning new local strategies for tuberculosis control.

A.16-1 Project Time Schedule	
Activity	Time Schedule
Notification of Respondents	1 week after OMB approval
Earliest data collection by Respondents	1 month after OMB approval
Webinar on data collection and submission	8 months after OMB approval
Earliest reports submitted to CDC	9 months after OMB approval
Data validation	13 months after OMB approval
Data analysis	15 months after OMB approval
Year 1 published summary report by CDC	17 months after OMB approval
Year 2 data collection by Respondents	15 months after OMB approval
Year 2 reports submitted to CDC	21 months after OMB approval
Year 2 data validation	23 months after OMB approval
Year 2 data analysis	25 months after OMB approval
Year 2 published summary report by CDC	27 months after OMB approval
Year 3 data collection by Respondents	25 months after OMB approval
Year 3 reports submitted to CDC	33 months after OMB approval

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

No exemption is sought. The display of the OMB expiration date is not inappropriate.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification included in this request. Paper forms generally are not used for this report, because the respondents either submit the report electronically or print the form from NTIP, where CDC can update the form certification easily.