Aggregate Reports for Tuberculosis Program Evaluation

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Supporting Statement B

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Collections of Information Employing Statistical Methods

Justification

The data accumulation is intermittent, it represents continuous public health practice throughout the United States, and the reporting is annual and recurrent. 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.

1. Respondent Universe and Sampling Methods

The "Aggregate Reports for Tuberculosis Program Evaluation" measure the extent, the efficiency, and the yield of TB control activities. For tuberculosis control, 68 federal cooperative agreement sites encompass the United States, and they are the respondents for the reports. In 2012, 82% of respondents submitted reports. No sampling, stratification, or estimation procedures are used in this data collection. The data are entirely in an aggregate format. For summing the U.S. national tuberculosis program statistics, the data are left unadjusted.

2. Procedures for the Collection of Information

The source data for the "Aggregate Reports for Tuberculosis Program Evaluation" are gathered annually as part of standard public health practice for tuberculosis control under the authority of state and local health departments. No individually identifiable information is being collected. Although health departments may collect identifiable information for local tuberculosis control purposes, consistent with state and local laws, this information is retained at those level, and health departments do not transmit person-level data or identifiable data to CDC. No respondents submit these data with individual patient records to CDC. Administrative controls to ensure data quality includes a training manual and user guide for information collection. The data associated with this OMB clearance are submitted to CDC only in an aggregate format (refer to Supporting Statement A, Section 10.A). 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. Data aggregation varies by site, with computerized methods becoming the norm at large jurisdictions.

The respondents submit data to CDC using the format outlined in the "Aggregate Reports for Tuberculosis Program Evaluation" (see Attachment 3a -Follow-up and Treatment of Contacts to Tuberculosis Cases and Attachment 3b-Targeted Testing and Treatment for Latent Tuberculosis Infection). Respondents have a choice of submitting their aggregated data annually to CDC by encrypted computer transmission in NTIP, by facsimile copy, or by U.S. postal mail. 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.

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. 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. CDC publishes the national data and shares the national summaries with the respondents routinely after aggregating the reports. The summary national reports contain no sensitive or private information.

3. Methods to Maximize Response Rates and Deal with Nonresponse

The CDC tuberculosis program consultants routinely work with the respondents in all types of data reporting. When reports to CDC are delayed, the CDC tuberculosis program consultants contact and meet with the respondents to determine the programmatic needs and to assist in the reporting process. Respondents who are unable to submit reports by the designated submission deadline for data analysis will be excluded from the national aggregate report.

4. Tests of Procedures or Methods to be Undertaken

CDC tested the "Aggregate Reports for Tuberculosis Program Evaluation" (OMB Control N0920-0457) as part of the design and implementation strategy in 1999 by visiting four state and local health departments and entering sample data. Computer systems (i.e., TIMS and NTIP) were tested in 2003 and 2010 for the completion of automated report transmission.

5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data

Consultation on statistical aspects is not applicable. The public health officials who tested the trial reports (see item #4, directly above) were experts in tuberculosis control, and they were consulted on the data collection methods in 1999. In 2009, TB control officials from New York State, Colorado, Tennessee, Texas, and California reviewed the indicators that are in the "Aggregate Reports for Tuberculosis Program Evaluation" and recommended their inclusion in the National Tuberculosis Indicators Project (NTIP). The CDC, DTBE, field services and evaluation branch designed the data collection and will collect and analyze the data in aggregate from the 68 reporting TB control jurisdictions. The 68 reporting TB control jurisdictions may collect and analyze identifiable information for local tuberculosis control purposes, consistent with state and local laws, however, this information is retained at those levels, and health departments do not transmit person-level data or identifiable data to CDC. The data is submitted to CDC in aggregate form.