

# Extensively Drug Resistant Tuberculosis Contact Investigation: A Cost Assessment

OSTLTS Generic Information Collection Request  
OMB No. 0920-0879

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- The purpose of this information collection is to estimate the direct costs to state and county tuberculosis (TB) programs of investigating and following contacts of an imported extensively drug resistant tuberculosis (XDR-TB) patient who arrived in the United States in April 2015.
- The resulting data will inform guidance documents for use by county, state, and federal decision makers, to develop a tool to help programs calculate costs for future contact investigations, and raise awareness about TB within the health system of the United States.
- Data will be collected using a spreadsheet instrument and semi-structured telephone interviews. Information gathered will include risk factors for developing active TB disease, resources needed, amounts consumed, and economic values to estimate direct costs to TB programs.
- Respondents will consist of officials who were involved in the contact investigation described above. Officials are expected to hold the roles of program manager and accountant.
- We will use standard methods for cost analysis including identification of resource components, quantification of amounts of each resource consumed, and valuation of each component to calculate the total cost to the government and society.

## Section A – Justification

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

#### Background

This information collection is being conducted using the Generic Information Collection mechanism of the OSTLTS OMB Clearance Center (O2C2) – OMB No. 0920-0879. The respondent universe for this information collection aligns with that of the O2C2. Data will be collected from up to 45 respondents including 15 TB Controllers and up to 30 other TB Officials acting in their official capacities within 14 state Departments of Health and 1 county health department (McHenry County, IL health department; see **Attachment A State and county collaborators**).

Specifically, respondents will include TB officials that were directly involved in a contact investigation of an imported extensively drug resistant tuberculosis (XDR-TB) case. These officials, who are knowledgeable about the activities of the investigation, are expected to hold the roles of program managers and accountants.

This information collection is authorized by Section 301 of the Public Health Service Act (42 U.S.C. 241). This information collection falls under the essential public health service(s) (3) informing, educating, and empowering people about health issues; and (9) evaluating effectiveness, accessibility, and quality of personal and population-based health services.

1. Monitoring health status to identify community health problems

- 2. Diagnosing and investigating health problems and health hazards in the community
- 3. Informing, educating, and empowering people about health issues
- 4. Mobilizing community partnerships to identify and solve health problems
- 5. Development of policies and plans that support individual and community health efforts
- 6. Enforcement of laws and regulations that protect health and ensure safety
- 7. Linking people to needed personal health services and assure the provision of health care when otherwise unavailable
- 8. Assuring a competent public health and personal health care workforce
- 9. Evaluating effectiveness, accessibility, and quality of personal and population-based health services
- 10. Research for new insights and innovative solutions to health problems <sup>1</sup>

Tuberculosis is a significant public health problem in the United States, with 9,421 cases occurring in 2014, of which 91 were multidrug resistant (MDR).<sup>1</sup> About 6-10 cases of XDR-TB are confirmed every three years nationally.<sup>1</sup> XDR-TB is dangerous to patients themselves and to their contacts, because the two main antibiotics (rifampin and isoniazid), any fluoroquinolone, and at least one of three injectable antibiotics (amikacin, capreomycin, and kanamycin) are not effective in curing this form of TB disease.<sup>2</sup> All TB cases are potentially fatal, with 555 deaths in 2013,<sup>1</sup> and can also lead to long term sequelae such as chronic obstructive pulmonary disease (COPD),<sup>3</sup> or permanent damage to several organ systems.<sup>4</sup> Treatment of XDR-TB is extremely expensive,<sup>5</sup> increasing the importance of monitoring contacts with latent tuberculosis infection (LTBI) to ensure that they do not spread the infection further if they develop active TB disease.

Contact investigations are seen as essential activities for the United States to achieve elimination of tuberculosis.<sup>6</sup> Contact investigations involve both the Centers for Disease Control (CDC) and state and county health departments in four phases of investigation, including 1) identifying contacts, 2) testing them, 3) treating them, and 4) following up with medium and high risk contacts (sometimes low priority contacts if resources permit and the program is meeting its targets).<sup>7</sup> After an index case with pulmonary or laryngeal TB disease is detected (defined as ‘the initial TB case that prompts a contact investigation’<sup>8</sup>), the period of infectiousness is determined, and an investigation may be initiated to reveal and manage people with whom the case was in contact during this period. Identified contacts are prioritized according to criteria defining the likelihood that they will develop TB disease if infected, and contacts are tested for TB infection and disease according to their classification.<sup>7</sup> Infected contacts are given treatment for LTBI if their infection is thought to be susceptible to an approved drug combination and able to tolerate therapy, and are monitored for the development of symptoms if not.<sup>9</sup> CDC guidelines state that contacts to MDR or XDR-TB patients, if not treated, are to be followed up for two years.<sup>7</sup>

We are requesting permission to collect data from state and county TB program officials to calculate the programmatic costs of the specific contact investigation conducted after the arrival to the United States of an index case with XDR-TB in April 2015. This investigation is particularly important as the index case had significant contact with people from 14 states via flight and ground travel before reporting to a health care facility. In addition, this contact investigation involved five times as many contacts as an average investigation.<sup>6</sup> This information is expected to be of interest to state and county health departments involved in the contact investigation and to the CDC. Monitoring contacts with LTBI identified through this investigation has the potential to prevent them from spreading the infection further if any of them develop MDR active TB disease. While we can potentially use risk factor and outcomes data on the airline contacts already collected by CDC’s

Division of Global Migration and Quarantine (DGMQ), we need to collect data relevant to costs, and full data on the ground contacts. Since economic data on contact investigations are not regularly collected, our objective is to produce a 'bottom-up' estimate that is specific to activities associated with this particular event.

The purpose of this data collection request is to estimate the direct costs and productivity losses to state and county tuberculosis (TB) programs from investigating and following contacts of this imported extensively drug resistant tuberculosis (XDR-TB) patient who arrived in the United States in April 2015. Information on the costs of interventions or strategies for preventing XDR-TB in the United States is considered a public health priority, as stated in its Plan to Combat Extensively Drug Resistant Tuberculosis of the CDC.<sup>10</sup>

This data collection will be beneficial, and non-duplicative of past efforts. The benefits of collecting data from state and county health departments and TB programs include obtaining a more precise estimate of the activities that actually occurred than is published in literature,<sup>11</sup> and results will be useful to state departments of health to make future projections. The collection of information will provide needed information to help develop useful tools to help departments of health assess the cost of contact investigations in the future. Results will be given to CDC's Division of Tuberculosis Elimination (DTBE) Communication, Education, and Behavioral Science Branch (CEBSB) to raise public awareness about the economic impact of these investigations. In addition, the process may raise awareness among state TB controllers to help identify areas in which they can make the process more efficient. The collected data will be useful to CDC researchers interested in conducting economic research, particularly for setting lower and upper limits for cost estimates in models of other policy questions.

### **Overview of the Information Collection System**

To identify respondents, the analyst will conduct an introductory phone call (**Attachment\_B\_Introduction\_to\_the\_TB\_controller\_and\_solicitation\_of\_respondents\_instrument**) with TB controllers in 14 states and 1 local health jurisdiction (n=15). On these calls, the analyst will explain the purpose of the study, establish rapport, and ask for recommendations of up to two staff representatives per jurisdiction to participate in the information collection. Respondents are expected to hold the roles of program manager and accountant per jurisdiction. Once this pool of respondents has been identified (n = up to 30), procedures for data collection will be as follows:

#### Phase I

- This information collection will include a spreadsheet instrument for all respondents identified by TB controllers (**Attachment\_Ca\_Data\_Collection\_instructions, Attachment\_Cb\_State\_and\_county\_representative\_data\_collection\_spreadsheet\_instrument**). Respondents will have the option to complete the spreadsheet in their office and fax their findings to the CDC analyst, or communicate results during an interview with the analyst (**Attachment\_Da\_Information\_transmitting\_interview\_guide\_instrument\_program\_manager, Attachment\_Db\_Information\_transmitting\_interview\_guide\_instrument\_accountant**). If the respondent has completed and faxed the spreadsheet in advance, the analyst will review during the interview the information provided, clarify questions, and fill in any missing information. All information gathered in this process will be documented on a master spreadsheet maintained by the analyst.

## Phase II

- After the conduct of all interviews, the analyst will re-contact the respondents (n = up to 30) to discuss any data that are missing, inconsistent, or incomplete; ask about any changes that may affect projections, and discuss level of accuracy or limitations (**Attachment\_E\_Phone\_script\_followup\_instrument**).

### Items of Information to be Collected

TB controllers: will be asked to identify one or two people to complete the spreadsheet instrument. (**Attachment\_B\_Introduction\_to\_the\_TB\_controller\_and\_solicitation\_of\_respondents\_instrument**). This phone call will consist of the following elements:

1. Introduction: The Field Services Branch (FSB) consultant will introduce the analyst and TB controller, allowing an opportunity to build rapport and familiarity.
2. Purposes of the assessment: The analyst will describe the objective of this work and reasons why it is important.
3. Indication about how the study will benefit state and county collaborators: The analyst and collaborators will discuss why this assessment will be useful to state and local jurisdictions.
4. Data collection steps that are relevant to state and county offices: The analyst will outline the steps to data collection to help the TB controller identify who would be the most appropriate respondents.
5. Types of data to collect: The analyst will identify the relevant types of data to help the TB controller identify respondents.
6. Timeline and closing: The analyst and TB controller will agree on a deadline for when the data will be available, and the TB controller will indicate when they would like to communicate their decision about who will collect data.

## Phase I

The spreadsheet data collection instrument (**Attachment\_Ca\_Data\_Collection\_instructions, Attachment\_Cb\_State\_and\_county\_representative\_data\_collection\_spreadsheet\_instrument, Attachment\_Da\_Information\_transmitting\_interview\_guide\_instrument\_program\_manager, Attachment\_Db\_Information\_transmitting\_interview\_guide\_instrument\_accountant**) consists of 20 clusters of questions of various types (807 total blanks), including quantitative data questions and qualitative notes and descriptions. The spreadsheet instrument will collect information on the following:

### Preparation and initial assessments

1. Location and collaborator information: We will have the state and name of the person reporting data before the phone call begins.
2. Contact investigation outcomes: The total number of hours, contacts identified, classifications of contacts, and contacts evaluated for TB disease will give us descriptive statistics on our population. In addition, we will ask the level of confidence that the respondent has that all contacts were identified.
3. TB diagnostic testing and results: We will ask for numbers of tuberculin skin tests (TST), interferon gamma release assays (IGRA), X-rays, and bacteriologic examinations administered along with their results.
4. Risk factors for developing TB disease after infection: We will assess medical and non-medical risk factors to add to descriptive statistics about our population.

5. Cost of testing for TB infection and disease: We will collect information on the cost per test for LTBI or TB disease and who paid for it. Results will be checked against section 3 for internal validity.
6. Cost of testing for other illnesses that are risk factors for TB: We will collect information on the cost of testing for comorbidities that can increase the probability that an infected person will develop TB disease, such as HIV, diabetes, kidney disease, and any other immunosuppressive conditions.
7. Personnel costs: We will assess the costs of personnel directly associated with the contact investigation, and administrative and support personnel that were involved.
8. Travel costs: We will assess the costs of vehicle use, per diem allocations, and any other resources consumed for travel.
9. Training costs: We will assess the costs of training that were specific to contact investigation activities, and without which the investigation would not have occurred.
10. Costs of incentives and enablers: We will assess the cost of resources used to influence people to both make the decision to keep appointments with health workers, and actually help them keep their appointments.
11. Any other miscellaneous costs: We will ask respondents to indicate the cost of any other resources that were used during contact investigation activities.

The interview guide for the program manager and accountant respondent types will serve as a resource to be used by the analyst to review during the interview the information provided, clarify questions, and fill in any missing information in the spreadsheet instrument.

**(Attachment\_Da\_Information\_transmitting\_interview\_guide\_instrument\_program\_manager, Attachment\_Db\_Information\_transmitting\_interview\_guide\_instrument\_accountant)** All respondents, regardless of their type (i.e., program manager, accountant) will receive a full copy of the spreadsheet. However, the interviews will be geared toward each respondent type's specific area of expertise. For example, program managers will be asked about contact investigation outcomes, the tests administered, TB results for infection and disease, risk factors for developing TB disease, number of personnel, travel components, training sessions and their components, number of incentives and enablers, and number of miscellaneous components. Accountants will be asked about the cost of testing for TB infections and disease, the cost of testing for other illnesses that are risk factors for TB disease, cost of LTBI treatment, the personnel cost, travel cost, training cost, incentives and enablers costs, miscellaneous costs. For each jurisdiction, data collected from the project manager interview will be cross-checked against data from the accountant interview for accuracy and completeness. The analyst will clear any discrepancies during the follow up interview (see Phase II).

## Phase II

The follow-up phone interview (**Attachment\_E\_Phone\_script\_followup\_instrument**) will ask about any data to add or update, whether the analyst found any inconsistencies or inaccuracies based on review of the spreadsheet instrument, and discuss the overall accuracy and quality of the data. This process will ensure that the quality of the data is acceptable, and highlight any issues that should be mentioned in limitations.

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

The purpose of this information collection is to estimate the direct costs to state and county tuberculosis (TB) programs of investigating and following contacts of an imported extensively drug resistant tuberculosis (XDR-TB) patient who arrived in the United States in April 2015.

Results will be used to inform guidance documents for use by county and state decision makers to develop a tool to help programs calculate costs for future contact investigations, and raise awareness about TB within the health system of the United States. Specifically, benefits of collecting data from state and county health departments and TB programs include obtaining a more precise estimate of the activities that actually occurred than is published in literature,<sup>11</sup> and results will be useful to state departments of health to make future projections. The collection of information will provide needed information to help develop useful tools to help departments of health assess the cost of contact investigations in the future. Results will be given to CDC's DTBE Communication, Education, and Behavioral Science Branch (CEBSB) to raise public awareness about the economic impact. In addition, the process may raise awareness among state TB controllers and help them identify areas in which they can make the process more efficient. The collected data will be useful to CDC researchers interested in conducting further analyses, or to set lower and upper limits for cost estimates in models of other policy questions.

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

A spreadsheet will be used to collect data as respondents will all have Microsoft Excel installed on their computers. Semi-structured phone interviews will be used to transmit data to the master spreadsheet, and follow-up on any missing data, inconsistencies, or questions. Respondents will have the option of sending completed spreadsheets in advance via fax, as well as sending in questions and follow-up via email. This method was chosen to reduce the overall burden on respondents. The information collection instrument was designed to collect the minimum information necessary for the purposes of this project. While 20 clusters of questions (807 in total) are included, not all data collection items will be relevant to all respondents.

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

Previous published estimates of the cost of contact investigations exist, including an estimate of the cost of contact investigations involving air travel from a top-down perspective, the overall costs of an investigation among Hmong refugees, and a modeled estimate of a novel strategy for testing contacts.<sup>11-13</sup> However; no other assessment is being conducted on the cost of this particular contact investigation to our knowledge, and PubMed or Google searches reveal that no similar assessment has been published. CDC/DGMQ has not reported any similar costing activities to DTBE.

## **5. Impact on Small Businesses or Other Small Entities**

No small businesses will be involved in this information collection.

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



This request is for a one-time information collection. If no data are collected, consequences will include:

- CDC will be unable to report on the overall cost of the contact investigation, the cost to individual states, and the cost to McHenry County, IL.
- Uninformed concerns about the cost of contact investigations may lead to illogical decisions that do not advance progress towards TB elimination.

**7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5**

There are no special circumstances with this information collection package. This request fully complies with the regulation 5 CFR 1320.5 and participation will be voluntary.

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

This information collection is being conducted using the Generic Information Collection mechanism of the OSTLTS OMB Clearance Center (O2C2) – OMB No. 0920-0879. A 60-day Federal Register Notice was published in the Federal Register on October 31, 2013, Vol. 78, No. 211; pp. 653 25-26. No comments were received.

CDC partners with professional STLT organizations, such as the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the National Association of Local Boards of Health (NALBOH) along with the National Center for Health Statistics (NCHS) to ensure that the collection requests under individual ICs are not in conflict with collections they have or will have in the field within the same time frame.

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

CDC will not provide payments or gifts to respondents.

**10. Protection of the Privacy and Confidentiality of Information Provided by Respondents**

The Privacy Act does not apply to this information collection. State, Tribal, Local, and Territorial (STLT) governmental staff will be speaking from their official roles and will not be asked, nor will they provide individually identifiable information. This information collection is not research involving human subjects.

**11. Institutional Review Board (IRB) and Justification for Sensitive Questions**

No information will be collected that are of personal or sensitive nature.

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

The time burden associated with each component of the study, based on pilot testing with four public health professionals, includes the following:

- a. **Introductory Phone Call:** The introductory phone call that will be used to introduce the analyst to the TB controllers to identify participants (n = up to 30) for data collection activities is estimated to take no more than 30 minutes. See **Attachment\_B\_Introduction\_to\_the\_TB\_controller\_and\_solicitation\_of\_respondents\_instrument**.
- b. **Data collection:** Data collection using the Spreadsheet instrument is estimated to take a total of 2.5 hours for program managers, and 1.5 hours for accountant (including time to review instructions and compile data). Specifically, 1 hour has been estimated for all respondents to review instructions, and 1.5 hours is estimated for program managers to complete the spreadsheet instrument and 30 minutes for accountants to complete the spreadsheet instrument. See **Attachment\_Ca\_Data\_Collection\_instructions**, and **Attachment\_Cb\_State\_and\_county\_representative\_data\_collection\_spreadsheet\_instrument**
- c. **Phone interview:** This call is estimated to take up to 1 hour for program managers and 30 minutes for accountants if data is transmitted during the call. If spreadsheets are completed in advance, the time necessary for the call will be less. See **Attachment\_Da\_Information\_transmitting\_interview\_guide\_instrument\_program\_manager**, **Attachment\_Db\_Information\_transmitting\_interview\_guide\_instrument\_accountant** for each version of this call.
- d. **Follow-up phone interview:** The average time for the follow-up phone interview across respondents is estimated to take no longer than 20 minutes. See **Attachment\_E\_Phone\_script\_followup\_instrument**

Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) Bureau of Labor Statistics for occupational employment for Physician internists (\$94.48) and local government general and operations managers (\$46.43) [http://www.bls.gov/oes/current/oes\\_nat.htm](http://www.bls.gov/oes/current/oes_nat.htm). Table A-12 shows estimated burden and cost information.

**Table A-12:** Estimated Annualized Burden Hours and Costs to Respondents

Information collection Instrument: Form Name	Type of Respondent	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
<b>Attachment_B_Introduction_to_the_TB_controller_and_solicitation_of_respondents_instrument</b>	State TB Controllers	14	1	30/60	7	\$94.48	\$661
	County TB Controller	1	1	30/60	1	\$94.48	\$94

<b>Attachment_Ca_Data_Collection_instructions, Attachment_Cb_State_and_county_representative_data_collection_spreadsheet_instrument</b>	State program manager	14	1	150/60	35	\$46.43	\$1,625
	State accountant	14	1	90/60	21	\$46.43	\$975
	County program manager	1	1	150/60	3	\$46.43	\$139
	County accountant	1	1	90/60	2	\$46.43	\$93
<b>Attachment_Da_Information_transmitting_interview_guide_instrument_program_manager Attachment_Db_Information_transmitting_interview_guide_instrument_accountant</b>	State program manager	14	1	60/60	14	\$46.43	\$650
	State accountant	14	1	30/60	7	\$46.43	\$325
	County program manager	1	1	60/60	1	\$46.43	\$46
	County accountant	1	1	30/60	1	\$46.43	\$46
<b>Attachment_E_Phone_script_followup_instrument</b>	State program manager	14	1	20/60	5	\$46.43	\$232
	State accountant	14	1	20/60	5	\$46.43	\$232
	County program manager	1	1	20/60	1	\$46.43	\$46
	County accountant	1	1	20/60	1	\$46.43	\$46
	<b>TOTALS</b>	<b>45</b>			<b>104</b>		<b>\$5,213</b>

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

There will be no direct costs to the respondents other than their time to participate in each information collection.

**14.**

**Annualized Cost to the Government**

There are no equipment or overhead costs. Costs to the federal government would be the time of a Prevention Effectiveness Fellow (GS-12), five Public Health Program Specialists (GS-13/14), three Medical Officers (GS-14), an Epidemiologist/Economist (GS-13), one General Education and Training Specialist (GS-13), and a General Health Scientist (RG). The total estimated cost to the federal government is \$25,988 Table A-14 describes how this cost estimate was calculated.

**Table A-14:** Estimated Annualized Cost to the Federal Government

Staff (FTE)	Average Hours per Collection	Average Hourly Rate	Average Cost
<b>Prevention effectiveness fellow (GS-12)</b> Develop protocol, compile data, perform analysis, write report	441	\$34.34	\$15,144
<b>Public Health Program Specialist 1 (GS-13)</b> Project supervision: field services and project management, facilitation of first collection, and contribution to report	23	\$41.32	\$950
<b>Public Health Program Specialist 2 (GS-13)</b> Project supervision: facilitation of first collection	18	\$41.32	\$744
<b>Public Health Program Specialist 3 (GS-14)</b> Project supervision: facilitation of first collection	18	\$48.25	\$869
<b>Public Health Program Specialist 4 (GS-14)</b> Project supervision: field services and project management, facilitation of first collection	17	\$48.25	\$820
<b>Medical Officer (GS-14)</b> Senior supervision: field services and medical management	17	\$48.25	\$820
<b>Epidemiologist/Economist (GS-13)</b> Senior supervision: economics, editorial feedback, instrument development support, and project management, and contribution to report	65	\$41.32	\$2,686
<b>General education and training specialist (GS-13)</b> Communications input and data collection	20	\$41.32	\$826
<b>Medical Officer (GS-14)</b> Data collection, contribution to report	20	\$48.25	\$965
<b>General health scientist (RG)</b> Epidemiology and program input, data collection, and contribution to report	20	\$32.05	\$641
<b>Public health program specialist (GS-13)</b> Project supervision: Division of Global Migration and Quarantine, and contribution to report	17	\$41.32	\$702
<b>Medical officer (GS-14)</b> Senior supervision: Division of Global Migration and Quarantine, and contribution to report	17	\$48.25	\$820
<b>Estimated Total Cost of Information Collection</b>			\$25,988

This is a new information collection.

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

Analysis plan

All data from telephone interviews will be entered into a Microsoft Excel Spreadsheet, which will be copied into another linked Microsoft Excel spreadsheet to perform calculations. We will prepare a short report for each state or organization presenting results for their context in aggregate form. We will publish results in an academic journal.

Project Time Schedule

- ✓ Design interview guides and data collection instrument .....(COMPLETE)
- ✓ Develop protocol, instructions, and analysis plan .....(COMPLETE)
- ✓ Pilot test interviews ..... (COMPLETE)
- ✓ Prepare OMB package .....(COMPLETE)
- ✓ Submit OMB package ..... (COMPLETE)
- OMB approval ..... (TBD)
- Conduct telephone interviews ..... (Assessment open 3 weeks)
- Quality control, and analyze data..... (4 weeks)
- Prepare reports ..... (4 weeks)
- Feedback and revisions ..... (4 weeks)
- Clearance process ..... (6 weeks)
- Publish / Disseminate reports ..... (4 weeks)

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

We are requesting no exemptions.

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

There are no exceptions to the certification. These activities comply with the requirements in 5 CFR 1320.9.

**LIST OF ATTACHMENTS – Section A**

- Attachment\_A\_State\_and\_county\_collaborators
- Attachment\_B\_Introduction\_to\_the\_TB\_controller\_and\_solicitation\_of\_respondents\_instrument
- Attachment\_Ca\_Data\_Collection\_instructions
- Attachment\_Cb\_State\_and\_county\_representative\_data\_collection\_spreadsheet\_instrument
- Attachment\_Da\_Information\_transmitting\_interview\_guide\_instrument\_program\_manager
- Attachment\_Db\_Information\_transmitting\_interview\_guide\_instrument\_accountant
- Attachment\_E\_Phone\_script\_followup\_instrument



## REFERENCE LIST

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