HIV Health Improvement Affinity Group (HHIAG) Assessment

OSTLTS Generic Information Collection Request
OMB No. 0920-0879

Supporting Statement – Section A

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- **Purpose of the data collection**
  The purpose of this data collection is to (1) assess the extent to which, and how, participation in the HIV Health Improvement Affinity Group (HHIAG) was useful to state health departments and Medicaid/Children's Health Insurance Program (CHIP) agencies for developing and implementing an action plan to improve health outcomes for persons living with HIV that are enrolled in Medicaid/CHIP and (2) document the lessons learned from implementing the action plans including successes, challenges, and promising practices.

- **Intended use of the resulting data**
  The Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), and Health Resources and Services Administration (HRSA) will use the results to (1) guide decisions about the future of HHIAG beyond the first year, (2) disseminate lessons learned to participating and non-participating states, federal partners (i.e., CDC, CMS, HRSA, Department of Health and Human Services), and the larger public health community, and (3) inform potential applicability of the affinity group model for other programs (e.g. STD Prevention, Hepatitis).

- **Methods to be used to collect data**
  CDC, CMS, and HRSA will collect data via a web-based assessment instrument and group telephone interviews. The two instruments will be used to gather information from state health department and Medicaid/CHIP agency staff.

- **Respondent Universe**
  The respondent universe for this information collection are 110 state health department and Medicaid/CHIP agency officials (67 state health department staff; 43 Medicaid/CHIP agency staff) across 19 states (Alaska, California, Connecticut, Georgia, Illinois, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Nevada, New Hampshire, New York, North Carolina, Rhode Island, Virginia, Washington, and Wisconsin) participating in HHIAG activities.

- **How data will be analyzed**
  For the web-based assessment, information will be reviewed for completeness, simple descriptive statistics will be run looking at response frequencies, and narrative responses will be summarized. Depending on the response distribution, frequencies may be cross-tabulated to identify response similarities and differences among sub-groups of respondents, such as those who work in a Health Department as compared to those affiliated with Medicaid/CHIP, or by learning community. For the telephone interviews, qualitative analysis will be conducted and the data will then be coded to identify common themes.

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 a total of 110 state health department and Medicaid/Children's Health Insurance Program (CHIP) staff acting in their official capacity as medical and health service managers (67 state health department staff; 43 Medicaid/CHIP agency staff) across 19 states (Alaska, California, Connecticut, Georgia, Illinois, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Nevada, New Hampshire, New York, North Carolina, Rhode Island, Virginia, Washington, and Wisconsin). Respondents acting in their official capacities as Medical and Health Services Managers include epidemiologists, analysts, program administrators, program deputy directors, program directors/chiefs, program managers, and program specialists. See **Attachment A** for the respondent list by state governmental entity.

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) of

- ☐ 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 [1]

The Centers for Disease Control and Prevention (CDC) estimates that about 1.1 million Americans are living with HIV, and that about 15% of these persons do not know they are infected. The number of people living with HIV is increasing, as effective new drug therapies keep HIV-infected persons healthy longer and dramatically reduce the death rate. CDC programs work to improve treatment, care, and support for persons living with HIV and to build capacity and infrastructure to reduce HIV transmission. As part of its overall public health mission, CDC provides leadership in helping reduce HIV transmission by working with state and federal partners in surveillance, prevention, and assessment activities.

Medicaid is the single largest source of health care coverage for persons living with HIV in the United States. The Federal National HIV/AIDS Strategy: Updated to 2020[2] calls for CDC, the Centers for Medicare and Medicaid Services' (CMS) and the Health Resources and Services Administration (HRSA) to form an HIV Health Improvement Affinity Group (HHIAG).

The HHIAG was launched in October 2016 to bring together state health departments and Medicaid/CHIP agencies to develop and implement action plans that will lead over time to improved HIV care outcomes for people living with HIV (PLWH) who are enrolled in Medicaid and CHIP. All states were invited to join HHIAG. Nineteen states returned an expression of interest form indicating a willingness to form state teams composed of health department and Medicaid/CHIP agency staff: Alaska, California, Connecticut, Georgia, Illinois, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Nevada, New Hampshire, New York, North Carolina, Rhode Island, Virginia, Washington, and Wisconsin. By participating in the HHIAG, the 19 state teams benefit by direct technical assistance from CDC, CMS, and HRSA, state-to-state learning, and network building to improve health outcomes for PLWH.

During the 12-month project period (November 2016-November 2017), each of the 19 state teams, led by state health departments and Medicaid/CHIP staff and with assistance from federal partners, are developing and implementing an action plan that will lead to improved health outcomes (in the short-term or long-term) for PLWH who are enrolled in Medicaid/CHIP. Because state teams selected and developed their action plans based on the unique needs (as determined from HIV surveillance and program data, as well as Medicaid administrative data) and priorities of the state team, no two projects are identical. However, common "themes" emerged and CDC grouped the 19 states into three informal learning communities based on the goals and objectives outlined in their draft action plans: (1) Data Linkage and Outcome, (2) Data Analysis and Utilization for Delivery System Improvement, and (3) Provider Engagement and Quality Improvement. Within a learning community, support, networking, and technical assistance can be better focused. However, a state may participate in more than one learning community.

This is the first affinity group to include a specific goal around increased collaborations between public health and Medicaid/CHIP. This is also the first affinity group to be co-led and co-managed by multiple agencies (CDC, CMS, and HRSA). CDC, CMS, and HRSA provide resources (including staff subject matter experts and capacity building assistance/technical assistance products and providers) in support of the affinity group's operations. Through a contract with HRSA, the National Academy for State Health Policy (NASHP) provides meeting and other logistical support.

Federal activities to support HHIAG and promote collaboration include an in-person meeting of the state teams, monthly conference calls and webinars (overall and by learning community), and feedback on state action plans, and provision of technical assistance upon request.

The purpose of this data collection is to (1) assess the extent to which, and how, participation in the HIV Health Improvement Affinity Group (HHIAG) was useful to state health departments and Medicaid/Children's Health Insurance Program (CHIP) agencies for developing and implementing an action plan to improve health outcomes for persons living with HIV that are enrolled in Medicaid/CHIP and (2) document the lessons learned from implementing the action plans including successes, challenges, and promising practices.

The data will be used to (1) guide decisions about the future of HHIAG beyond the first year, (2) disseminate lessons learned to participating and non-participating states, federal partners (i.e., CDC, CMS, HRSA, Department of Health and Human Services), and the larger public health community, and (3) inform potential applicability of the affinity group model for other programs (e.g., STD Prevention, Hepatitis).

CDC staff from the Program Evaluation Branch, Division of HIV/AIDS Prevention, National Center for HIV, Viral Hepatitis, STD and TB Prevention are leading the HHIAG assessment with additional assistance from CMS, HRSA, and Emergint Technologies, Inc. Emergint Technologies, Inc., is a subsidiary of CACI a provider of technology solutions focused on the data-driven needs of national health organizations. The company offers a wide range of services that support the missions of federal and state customers. The Program Evaluation Branch uses Emergint Technologies, Inc. to provide HIV prevention program data collection and management support. CDC will lead the web based assessment, data analysis, and reporting. CMS and HRSA will participate in the data analysis and reporting for the web based assessment. The telephone interviews will be conducted by staff from CDC, CMS, and/or HRSA. Emergint Technologies, Inc. will transcribe the telephone interviews. Two staff from CDC and HRSA will conduct the qualitative data analysis. CDC, CMS, and HRSA will participate in the reporting of the telephone interviews.

Overview of the Information Collection System

Data will be collected via a web-based assessment instrument from all 110 state health department and Medicaid/CHIP agency officials from the 19 states that joined HHIAG and formed teams of health departments and Medicaid/CHIP staff. A subset of the 110 respondents invited to participate in the web-based assessment will be invited to also participate in a telephone interview. From the 19 states participating in HHIAG, we will purposively select 12 governmental entities (6 state health department entities and 6 Medicaid/Children's Health Insurance Program (CHIP) entities) with up to 3 persons per entity for each interview for a total of 36 respondents.

The two instruments will be used to gather information from state health department and Medicaid/CHIP staff to assess the extent to which, and how, participation in (HHIAG) was useful to state health departments and Medicaid/Children's Health Insurance Program (CHIP) agencies, and document the lessons learned from implementing the action plans including successes, challenges, and promising practices.

A summary of the two information collection instruments is provided below.

Web-based Assessment Instrument
Information collected via the web-based instrument (see **Attachment B—Web-based Assessment Instrument_Word version and Attachment C—Web-based Assessment Instrument_Web version**) will allow respondents to complete and submit their responses electronically. The web-based assessment instrument was pilot tested by 3 public health professionals. Feedback from this group was used to refine questions as needed, ensure accurate programming and skip patterns, and to establish the estimated time required to complete the information collection instrument.

Telephone Interview Guide
Information collected via telephone interviews will be performed using a structured interview guide (see **Attachment D—State-Level Phone Interview Guide**). The telephone guide was pilot tested by 3 public health professionals. Feedback from this group was used to refine questions as needed and establish the estimated time required to complete the information collection instrument.

Items of Information to be Collected

Web-based Assessment Instrument
The web-based assessment instrument consists of 25 questions of various types, including yes/no, multiple response, interval (rating scales), and open-ended. All questions reflect the assessment's key focus areas. The open-ended questions requiring a narrative response are needed to understand the usefulness and value of this model of collaboration given the variety of action plans proposed and implemented. The assessment will be sent to the 110 state health department and Medicaid/CHIP Agency staff named on the master contact list.

The web-based assessment instrument will focus on aspects of participation in the HHIAG and will collect data on the following:

- Respondent state agency affiliation (state health department or Medicaid/CHIP) and HHIAG learning community affiliation ((1)data linkage and outcome, (2) data analysis and utilization for delivery system improvement, and (3) provider engagement and quality improvement)
- Opportunity to establish or strengthen state partnerships
- Usefulness of HHIAG activities
- Lessons learned from participating in HHIAG

Telephone Interview Guide
The telephone interview guide (**see Attachment D—State-Level Phone Interview Guide**) consists of 15 questions, most of which are open-ended. The interviews will be conducted by staff from CDC, CMS, and/or HRSA. A total of twelve interviews will be conducted using up to 3 officials per state health department or Medicaid/CHIP entity (36 respondents). Two staff from CDC will conduct five interviews, two staff from HRSA will conduct five interviews, and 1 staff from CDC and 1 staff from CMS will conduct two interviews. Interviews will be recorded in

order to capture the conversation accurately. Verbal permission to be recorded will be obtained from the participant prior to the beginning of the interview.

The telephone interview guide will explore in more detail areas highlighted in the quantitative assessment, specifically the extent and usefulness of participation, establishment or strengthening of partnerships, outputs and lessons learned, and how can HHIAG processes be improved. Information will be collected on the following:

- Respondent background (job title, length in position, job responsibilities)
- Value of HHIAG participation
- Opportunity to establish or strengthen state partnerships
- Lessons learned
- Suggestions for improving HHIAG

2. Purpose and Use of the Information Collection

The purpose of this data collection is to (1) assess the extent to which, and how, participation in the HIV Health Improvement Affinity Group (HHIAG) was useful to state health departments and Medicaid/Children's Health Insurance Program (CHIP) agencies for developing and implementing an action plan to improve health outcomes for persons living with HIV that are enrolled in Medicaid/CHIP and (2) document the lessons learned from implementing the action plans including successes, challenges, and promising practices.

CDC, in collaboration with CMS and HRSA, will use the results to (1) guide decisions about the future of HHIAG beyond the first year, (2) disseminate lessons learned to participating and non-participating states, federal partners (i.e., CDC, CMS, HRSA, Department of Health and Human Services), and the larger public health community, and (3) inform potential applicability of the affinity group model for other programs (e.g. STD Prevention, Hepatitis).

3. Use of Improved Information Technology and Burden Reduction

Data will be collected via two methods: web-based assessment and telephone interviews.

Web-based Assessment
The web-based assessment was chosen to allows respondents to complete and submit their responses electronically, reducing the overall burden on respondents. This information collection instrument was designed to collect the minimum information necessary for the purposes of this project (i.e., limited to 25 questions).

Telephone Interviews
Although web-based assessments are quick, effective methods for collecting quantitative data and brief narrative responses from many respondents, telephone interviews can solicit rich qualitative data, which aligns to the purpose of this information collection. Collecting data via telephone interviews will also help to minimize the burden on CDC, CMS, and HRSA staff by reducing the time required for follow-up. Staff will be able to verify responses and request

clarification in real time as needed during the information collection process. The telephone interview guide was designed to collect the minimum information necessary for the purposes of this project (i.e., telephone interview guide limited to 15 questions).

4. Efforts to Identify Duplication and Use of Similar Information

To date, no other information collection has been conducted to (1) assess the extent to which, and how, participation in the HIV Health Improvement Affinity Group (HHIAG) was useful to state health departments and Medicaid/CHIP agencies for developing and implementing an action plan to improve health outcomes for persons living with HIV that are enrolled in Medicaid/CHIP and (2) document the lessons learned from implementing the action plans including successes, challenges, and promising practices.
The information that will be gathered through this information collection is not available from other data sources or through other means. Prior to developing this information collection, CDC consulted with the federal affinity group leads to confirm that this effort is not duplicative.

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 data collection. There are no legal obstacles to reduce the burden. If no data are collected, CDC will be unable to:

- Determine if the federal resources provided over the one-year project period were useful to HHIAG participants and had impact in enhancing the development and implementation of the state action plans
- Make data-driven decisions whether to continue HHAIG beyond the first year
- Use information from state participants to consider the potential applicability of the affinity group model for other programs (e.g. STD Prevention, Hepatitis)

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

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

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

This data 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 May 16, 2014, Vol. 79, No. 95; pp. 28513. 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 timeframe.

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 data collection. STLT governmental staff and / or delegates will be speaking from their official roles.
This data 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 estimate for burden hours is based on pilot tests of the web-based assessment instrument by 3 public health professionals and the telephone interview guide with 3 public health professionals.

In the pilot test of the web-based assessment instrument, the average time to complete the instrument, including time for reviewing instructions and completing the instrument, was approximately 25 minutes (range: 15 to 25 minutes). For the purposes of estimating burden hours, the upper limit of this range (i.e., 25 minutes) is used.

In the pilot test of the telephone interview guide, the average time to complete the interview was approximately 60 minutes (range: 45 to 60 minutes). For the purposes of estimating burden hours, the upper limit of this range (i.e., 60 minutes) is used.

Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) Bureau of Labor Statistics for occupational employment for Medical and Health Services Managers (11-9111) (http://www.bls.gov/oes/current/oes_nat.htm). Based on DOL data, an average hourly wage of $52.58 is estimated for all 110 respondents. Table A-12 shows estimated burden and cost information.

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

Data 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
Web-based Assessment	Medical and Health Services Managers	110	1	25 / 60	46	$52.58	$2419
Telephone Interview	Medical and Health Services Managers	36 (subset of the initial 110)	1	60 / 60	36	$52.58	$1893
	TOTALS	**146**	**1**		**82**		**$4312**

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 data collection.

14. Annualized Cost to the Government

There are no equipment or overhead costs. The only cost to the federal government would be the salary of CDC, CMS, and HRSA staff to develop the data collection instrument, collect data, and perform data analysis and the use of an Emergint Technologies, Inc. public health analyst (under CDC contract) for interview transcription. The total estimated cost to the federal government is $18,249. 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	Total Average Cost
CDC Behavioral Scientist – GS-[14], Step [10];	75	$66.27 /hour	$4970

Instrument development, OMB package preparation, data collection, quantitative data analysis, report preparation			
CDC Behavioral Scientist – GS-[12], Step [4]; Instrument development, OMB package preparation, data collection, qualitative and quantitative data analysis, report preparation	75	$39.90 /hour	$2993
CMS Health Insurance Specialist – GS-[13], Step [10]; Instrument development, OMB package preparation, data collection, quantitative data analysis, report preparation	50	$59.05 /hour	$2953
HRSA Health Scientist - GS-[13], Step [3]; Instrument development, OMB package preparation, data collection, qualitative and quantitative data analysis, report preparation	50	$48.45 /hour	$2423
HRSA Public Health Analyst - GS-[12], Step [1]; Instrument development, OMB package preparation, data collection, quantitative data analysis, report preparation	50	$38.20 /hour	$1910.00
Emergint Technologies, Inc. Public Health Analyst Interview Transcription Services	50	$60.00 /hour	$3000.00
Estimated Total Cost of Information Collection			**$18,249**

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

Web-based Assessment

Once the data collection period for the web-based assessment has closed, CDC will export the quantitative data from SurveyMonkey into a Microsoft Excel file. The file will be shared with CMS and HRSA. CDC, CMS, and HRSA will store the file on a multi-user share that is a network-based file folder that can only be accessed by a designated group of users at their respective agency. CDC staff will lead the web-based assessment analysis, with input from CMS and HRSA. Information will be reviewed for completeness and simple descriptive statistics will be run looking at response frequencies. Depending on the response distribution, frequencies may be cross-tabulated to identify response similarities and differences among sub-groups of respondents, such as those who work in a Health Department as compared to those affiliated with Medicaid/CHIP, or by learning community. These findings will be representative only of the response pool and not the total population of professionals working in health departments and Medicaid/CHIP agencies to improve health outcomes for persons living with HIV enrolled in Medicaid/CHIP.

Telephone Interviews

Once the data collection period for the telephone interviews has closed, an Emergint Technologies, Inc. staff person (under CDC contract) will transcribe the interviews. Each of the transcribed interviews will be compared against the recording to ensure accuracy. Emergint will copy the transcribed data and share with CDC, CMS, and HRSA. Each agency will store the data on a network-based file folder that can only be accessed by a designated group of users. Data will then be coded to identify common themes. Two analysts (CDC and HRSA) will independently code transcriptions and then discuss their coding decisions to reach agreement on coding. EZtext will be used.
Following information analysis, key findings will be shared in aggregate form with several audiences:

1. HHIAG state and federal participants – staff involved in the assessment will conduct a webinar following the distillation of the results
2. CDC communications team that works to disseminate CDC products to priority end users

Staff at CDC, CMS, and HRSA will condense key findings from the web-based assessment and telephone interviews, and refine them into a manuscript format, and submit for publication.

Project Time Schedule

- ✓ Design instruments ..... (COMPLETE)
- ✓ Develop protocol, instructions, and analysis plan ..... (COMPLETE)
- ✓ Pilot test instruments ..... (COMPLETE)
- ✓ Prepare OMB package ..... (COMPLETE)
- ✓ Submit OMB package ..... (COMPLETE)
- ❑ OMB approval ..... (TBD)
- ❑ Administer web-based assessment ..... (3 weeks)
- ❑ Clean and analyze web-based information ..... (4 weeks)
- ❑ Collect interview data ..... (3 weeks)
- ❑ Transcribe and analyze qualitative data ..... (6 weeks)
- ❑ Prepare summary report(s) ..... (8 weeks)
- ❑ Disseminate results/reports ..... (4 weeks)

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

We are requesting no exemption.

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

A. Attachment A – Respondent List

B. Attachment B – Web-based Assessment Instrument_Word version
C. Attachment C – Web-based Assessment Instrument_Web version
D. Attachment D – State-Level Phone Interview Guide

REFERENCE LIST

1. Centers for Disease Control and Prevention (CDC). "National Public Health Performance Standards Program (NPHPSP): 10 Essential Public Health Services." Available at http://www.cdc.gov/nphpsp/essentialservices.html. Accessed on 8/14/14.
2. National HIV/AIDS Strategy for the United States: Updated to 2020. Available at https://www.hiv.gov/sites/default/files/nhas-update.pdf. Accessed on June 14, 2017.