

“Assessing Community-Based Organizations’ Partnerships with Schools for the Prevention of HIV/STDs”

OMB #0920-new

Supporting Statement Part A

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2	60 Day FRN
3	CBO Assessment Questionnaire
4	HWC Assessment Questionnaire
5	Web-based CBO Assessment Questionnaire
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Section A: Justification for Information Collection

Goal: The goal of this study is to learn about areas of partnerships between the three local education agencies (LEAs) funded under strategy 4 of cooperative agreement PS13-1308 and the community-based organizations (CBOs) and health and/or wellness centers (HWCs) those LEAs collaborate with to conduct HIV prevention activities for youth. The study will assess services offered by partner CBOs and HWCs, and the relationships between the LEAs (and their schools) and the partner CBOs and HWCs.

Intended use of resulting data: The data will be used to identify areas of partnership that are working well and other areas that will need improvement. The data also will allow the CDC to determine the potential impact of currently recommended strategies and make changes to those recommendations if necessary.

Methods: The information collection will use two versions of a self-administered web-based questionnaire—the Community-based Organization (CBO) Assessment Questionnaire and the Health and/or Wellness Center (HWC) Assessment Questionnaire. Representatives from up to 10 CBOs and 10 HWCs partnering with each of the three LEAs (for a total of up to 60 organizations—30 CBOs and 30 HWCs) will receive the questionnaires in 2015, fall of 2016, and spring of 2018. Samples will be cross-sectional and treated independently.

Subpopulation to be studied: The questionnaire will be administered to selected staff members from CBOs and HWCs (which include both school wellness centers and school-based health centers) collaborating with the three funded LEAs.

Data analysis: Data will be analyzed using both descriptive and inferential statistics. Data reduction techniques/factor analyses and item correlation analyses will be used to develop scales as needed. T tests and chi-square analyses will be used to assess differences between years; linear or logistic regression will be used to examine predictors of outcomes of interest (such as successful partnerships).

A. 1 Circumstances Making the Collection of Information Necessary

Background

The Centers for Disease Control and Prevention (CDC) requests a 3-year OMB approval to conduct a new information collection entitled, “Assessing Community-Based Organizations’ Partnerships with Schools for the Prevention of HIV/STDs.” The information collection uses two versions of a self-administered web-based questionnaire—the Community-based organization (CBO) Assessment Questionnaire and the Health and/or Wellness Center (HWC) Assessment

Questionnaire—to conduct an in-depth assessment of selected staff from CBOs and HWCs, which include school wellness centers and school-based health centers. The assessment will ask about HIV and STD prevention efforts that are taking place in conjunction with the three local education agencies (LEAs) funded by the Centers for Disease Control and Prevention (CDC), Division of Adolescent and School Health (DASH) under strategy 4 (School-Centered HIV/STD Prevention for Young Men Who Have Sex with Men) of PS13-1308: *Promoting Adolescent Health through School-Based HIV/STD Prevention and School-Based Surveillance*.

This information collection will provide data and reports for the three funded LEAs, and will allow each LEA to identify areas of the partnerships with CBOs and HWCs that are working well and other areas that will need additional improvement. In addition, the findings will allow CDC to determine the potential impact of currently recommended strategies and make changes to those recommendations if necessary. Data will be collected from up to 10 CBOs and 10 HWCs partnering with each of the three LEAs (for a total of up to 60 organizations—30 CBOs and 30 HWCs) in 2015, fall of 2016, and spring of 2018. It is expected that any organization participating in data collection will be asked to participate in subsequent data collection rounds. In addition, if LEAs add new organizations to their current group of partners, representatives from those new organizations may be asked to complete questionnaires in the 2016 or 2018 round of data collection, providing that the maximum number of respondents had not already been reached. The questionnaires will include questions on the following topics: services offered by the organization; the respondent’s role within the organization; and the organization’s relationships with the school district and participating schools in the LEA. The same questionnaires will be used for each round of data collection. CDC’s role in this information collection is that it is helping provide technical assistance and support for the LEAs to conduct this evaluation of their CDC-funded programmatic work.

HIV infections remain high among young men who have sex with men (YMSM).¹ The estimated number of new HIV infections increased between 2008 and 2010 both overall and among MSM ages 13 to 24.² Furthermore, sexual risk behaviors associated with HIV, other sexually transmitted diseases (STD), and pregnancy often emerge in adolescence. For example, 2011 Youth Risk Behavior Surveillance System (YRBSS) data revealed 47.4% of U.S. high school students reported having had sex, and among those who had sex in the previous three months, 39.8% reported having not used a condom during last sexual intercourse.³ In addition, 2001-2009 YRBSS data revealed high school students identifying as gay, lesbian, and bisexual and those reporting sexual contact with both males and females were more likely to engage in sexual risk-taking behaviors than heterosexual students.⁴

Given the disproportionate risk for HIV among YMSM ages 13-24, it is important to find ways to reach the younger youth (i.e., ages 13-19) in this range to decrease sexual risk behaviors and increase health-promoting behaviors such as routine HIV testing. Schools provide one opportunity for this. Because schools enroll more than 22 million teens (ages 14-19)⁵ and often have existing health and social services infrastructure, schools and their staff members are well-positioned to connect youth to a wide range of needed services, including housing assistance, support groups, and sexual health services such as HIV testing. As a result, CDC’s DASH has focused a number of HIV and STD prevention efforts on strategies that can be implemented in, or centered around, schools.

DASH in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) awarded funds to implement PS13-1308: *Promoting Adolescent Health through*

School-Based HIV/STD Prevention and School-Based Surveillance in order to build the capacity of state education agencies (SEAs) and LEAs and support the efforts of national, non-governmental organizations (NGOs) to help priority school districts and schools develop and implement sustainable adolescent-focused program activities. Within that cooperative agreement, three local education agencies and one NGO were funded under strategy 4 for specific HIV and STD prevention work focused on reaching 13-19 year old black and Latino YMSM. In this project, YMSM are defined to include young men who report sexual activity with other males, attraction to other males, or who identify as gay or bisexual. The distal program goals for the project funded by strategy 4 of the cooperative agreement are to:

- Increase the number of teen YMSM who are tested and treated for HIV/STDs;
- Decrease sexual risk behaviors among teen YMSM; and
- Reduce rates of absenteeism and school dropout among teen YMSM.

Program activities funded by the cooperative agreement will focus on impacting short-term and intermediate outcomes believed to lead to the prevention of HIV and STDs. Of specific interest, are increasing access of students (particularly YMSM) to key sexual health services and making the school environment safer and more supportive for YMSM. In order to achieve these outcomes, funded LEAs are working to build and strengthen relationships with a variety of community partners, including CBOs and HWCs. These increased and improved relationships are a key outcome of the funded LEAs' work, and it is this outcome that will be assessed by the proposed information collection.

The proposed information collection applies to only strategy 4 of PS13-1308, and it is part of a multi-component assessment of the HIV and STD prevention work conducted by the three LEAs funded for strategy 4. The selected schools in each of the 3 LEAs are working to develop new or improved systems for referring teen YMSM to school-based or school-linked health and social service providers in the community; improve the school climate for lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) youth (specifically YMSM); use LGBTQ-inclusive social marketing promotion of sexual health and related services; and create procedures for school staff to provide YMSM referrals for HIV/STD testing. The proposed information collection will involve administration of web-based questionnaires to representatives from CBOs and HWCs working with the schools in Strategy 4. This component of the assessment is designed to provide in-depth assessment findings for the baseline level of partnerships (and later, follow-up assessments of partnerships) between the schools and districts and the CBOs and HWCs working with schools at each of the three LEAs. The questionnaire (either the CBO Assessment Questionnaire or the HWC Assessment Questionnaire) will be sent to one representative from each CBO or HWC, who will be encouraged to consult with up to two additional staff, as needed, to complete the questionnaire.

CDC is authorized to collect the data described in this request by Section 301 of the Public Health Service Act (42 USC 241). A copy of this enabling legislation is provided in **Attachment 1**. In addition to this legislation, there are several national initiatives and programs that this information collection would serve to support, including but not limited to:

- *Healthy People 2020*, which provides national health objectives and outlines a comprehensive plan for health promotion and disease prevention in the United States. Of the Healthy People 2020 objectives, 31 objectives align specifically with PS-13-1308

activities related to reducing HIV infection, other STD, and pregnancy among adolescents.

- The National HIV/AIDS Strategy for the United States provides a plan of action across the U.S. for preventing the spread of HIV, increasing access and use of HIV treatment services, and the overall reduction of HIV/AIDS disparities.⁶
- The NCHHSTP program imperative calls for *Program Collaboration and Service Integration (PCSI)* to provide improved integration of HIV, viral hepatitis, STD, and TB prevention and treatment services at the user level.⁷
- *CDC Winnable Battles*, including prevention of HIV infection and TPP, have been chosen by CDC based on the magnitude of the health problems and the ability to make significant progress in improving outcomes. These are public health priorities with large-scale impact on health with known, effective strategies to address them.⁸

A.1.1 Privacy Impact Assessment

Participant email addresses will be obtained for recruitment purposes only. Any PII (e.g. participant email addresses) provided by the LEA for the purposes of participant recruitment will remain completely separate from the information gathered through the Web-based instrument and will be kept confidential by the project team. While recruitment includes PII, data collection itself involves collecting anonymous data from staff through the use of self-administered Web-based questionnaires. Questionnaires will ask for the name of the respondent's CBO/HWC and the physical address of the CBO/HWC. At the end of the assessment, data will be shared in an aggregate summary report with participating LEAs. In the summary report, LEAs will know which CBOs/HWCs participated, but will not be provided with organizational- or individual-level data.

Overview of Information Collection System

This information collection system involves administration of two versions of a Web-based questionnaire—the CBO Assessment Questionnaire [see **Attachment 3** (Microsoft Word version) and **Attachment 5**] and the HWC Assessment Questionnaire [see **Attachment 4** (Microsoft Word version) and **Attachment 6**] to representatives from up to 60 organizations (30 CBOs and 30 HWCs) (20 organizations per LEA) that are participating in the HIV/STD prevention project with the three LEAs (Broward County Public Schools in Broward County, Florida; Los Angeles Unified School District in Los Angeles, California; and San Francisco Unified School District in San Francisco, California) that are funded with support from CDC's PS13-1308. Data collection partners include LEA staff and CDC contractors (with oversight from CDC staff). The Web-based questionnaire is explained in detail below.

The Web-based questionnaires (see **Attachments 5 and 6**) will be administered to up to 60 CBO or HWC staff members across the three LEAs. Each CBO or HWC representative will receive either the CBO Assessment Questionnaire (see **Attachment 5**) or the HWC Assessment Questionnaire (see **Attachment 6**), depending whether he/she works for a CBO or a HWC. The CBO and HWC versions of the questionnaire include 54 questions that are identical except that the stem of the questions in the CBO version of the questionnaire refers to the respondent's

organization, and the stem of the HWC version refers to the respondent's HWC. The CBO assessment includes an additional 5 questions that ask about the manner in which agreements were formalized between the CBO and LEA; these questions were not applicable for the HWCs. The HWC version of the questionnaire includes two additional questions—one question about whether or not the HWC is accessible to students from schools other than the one where the HWC is located and one question about requirements of parental consent for use of the HWC; these questions were not applicable for the CBOs. The information collection instrument was pilot tested by 4 individuals who have experience working in a CBO or HWC serving youth populations. Feedback from this group was used to refine questions as needed, ensure accurate programming and skip patterns and establish the estimated time required to complete the information collection instrument.

For both versions of the questionnaire, the format and administration have been designed to ensure that information from staff members is kept private. The questionnaire was developed for this study through an iterative process of reviewing existing instruments, and identifying gaps in the inventory of available items to be filled by study-created questions. Whenever possible, items were selected from valid and reliable survey instruments. We anticipate the questionnaire will be administered in 2015, then again in Fall 2016 and Spring 2018. These data collection points coincide with the initiation of partnership activities and the mid-way and end points of the PS13-1308 cooperative agreement. We anticipate that each year of data collection will yield data from up to 60 total respondents from the CBOs and HWCs across all three LEAs. We expect there to be fewer than 20 organizations per LEA in the baseline year but that this number may grow closer to 20 organizations per LEA as they develop partnerships with more organizations. Personally identifying information (PII) will not be recorded or stored as part of the questionnaire. Business PII will be used only to administer the questionnaire and will be stored separately with no information that links staff members to their responses. The questionnaire will be offered through a secure Website, SurveyMonkey™.

The questionnaire will take between 40-60 minutes to complete. Evaluators will work with each LEA to identify their relevant CBO and HWC partners. Evaluators will ask the LEA to provide a list of CBOs and HWCs and contact information (email address) for a contact at each location. The instrument will be sent to one representative from each of those CBOs or HWCs. CBO or HWC representatives will be encouraged to consult with up to 2 other staff, as needed, to complete the questionnaire.

Data collectors will send an email (**Attachment 7—Introductory Email/Study Information Sheet**) to each potential participant with the link to the questionnaire and allow for a 2 week response time. Three reminders will be sent to non-responders. When respondents access the link, they will view a consent statement (**Attachment 8—Web-based Informed Consent Form for the CBO Questionnaire** and **Attachment 9—Web-based Informed Consent Form for the HWC Questionnaire**) before entering the Web-based questionnaire. The consent statement emphasizes the voluntary nature of participation and lack of any consequences to them for choosing not to complete any or all of the questionnaire. The consent statement will also state that responses will not be attributable to them or linked with any personally identifying information. Participants will see a prompt to click on the button to proceed with the questionnaire, which will indicate that they have read the information in the consent statement and agree to participate. This process will be the same for each year of the data collection. Upon completion of the questionnaire, the Web-based program will indicate the questionnaire is over

and will thank the participant for his/her participation.

Items of Information to be collected

Although both versions of the questionnaire (included in **Attachment 5** and **Attachment 6**) were developed for this study, questionnaire items were selected from valid and reliable instruments whenever possible. The questionnaire contains questions on the following topics: services offered by the organization; the respondent's role within the organization, and the organization's relationships with the school district and participating schools in the LEA. The instrument for CBOs contains a maximum of 59 questions (see **Attachment 5**). The instrument for HWCs contains a maximum of 56 questions (see **Attachment 6**).

The instruments include programmed automatic skip patterns, so it is expected that not all respondents will be presented with all questions. (As a note, skip patterns are noted in the Microsoft Word versions of the instrument for the reviewers of this information collection request, but are not visible to respondents in the Web-based versions that they will use.) Three questions are open ended and all other questions are multiple choice. For several of the multiple-choice questions, respondents have the opportunity to add another response option under the "Other, please specify" answer choice. The instruments will be distributed and data will be collected using the Web-based data collection tool, SurveyMonkey®. The required OMB number and related language, a preliminary draft of which can be seen on the first page of the questionnaire (see **Attachment 5** and **Attachment 6**), will be updated on the first page of the Web-based questionnaire once approval is received. The Web-based questionnaire will collect information on the following:

- a. Respondent's organization. This information will be collected with 2 questions that ask the name of the respondent's CBO/HWC and the physical address of the CBO/HWC
- b. CBO/HWC service information assessing the characteristics of the client population. This information will be collected with 12 questions.
- c. Youth service environment which describes the services offered by the CBO/HWC. This information will be collected with 4 questions for the CBOs and 5 questions for the HWCs.
- d. LGBTQ Friendliness. This information will be collected with 3 questions for CBOs and 3 questions for HWCs that asks about continuing education trainings for staff, LGBTQ specific materials, and having an LGBTQ person on staff.
- e. Linkage with schools. These questions assess the CBO/HWC relationship with the school district. This information will be collected with 38 questions for the CBOs and 34 questions for the HWCs.

No individually identifiable information is to be collected that would make participant's identity discernable.

A. 2 Purpose and Use of Information Collection

Data gathered from these questionnaires will allow the funded local education agencies to assess program activities conducted under PS13-1308. It will allow them to ensure their activities are helping improve and strengthen partnerships with CBOs and HWCs in their

communities that can influence the HIV/STD prevention practices and services in schools. In particular, the approach of collecting data from key CBO and HWC partners participating with the program schools allows the LEAs to assess the quality of the partnerships and linkages with the schools and the types of services offered by community partners. These partnerships and services support a major public health goal of reducing disparities in HIV/STD infections experienced by adolescent YMSM. The conceptual model for the program is based in part on the idea that as LEAs build and enhance their partnerships with CBOs and HWCs, student access to and use of critical health services such as HIV and STD testing will increase. In addition, we hypothesize that as LEAs build relationships with their community organizations and wellness centers, those organizations and centers may actually offer more services that are tailored to YMSM. The data collected through this information collection will enable us to determine if implementation of program strategies such as partnership efforts, collaborations, etc. are associated with an increase in quality of partnerships and linkages between LEAs and HWCs over time. We can also use this data to look for associations between improvements in partnerships and linkages and increases in HIV and STD testing (note: testing data is being collected through other mechanisms but is available as secondary data upon request from health departments). Looking at both pathways in the conceptual model [(1) do the current program activities appear to relate to improved partnerships/linkages and (2) does the quality of partnerships/linkages appear to relate to HIV and STD testing among adolescent YMSM] will allow CDC to make recommendations about the utility of focusing on partnerships between schools and CBOs/HWCs, and if it appears important, what strategies may (or may not) be helpful in improving linkages/partnerships.

Data are expected to be analyzed after each data collection point by the project team, and data summaries will be provided to the LEAs. The analyses (which, depending on sample size limitations, may include summative frequencies and means, t tests and chi square tests, and comparison of results between baseline and follow-up data collections) will be used by the LEAs to identify areas for program improvement and to assess program impact. The data should enable LEAs to draw general conclusions about whether or not their partnerships/linkages with CBOs/HWCs are improving, but should also allow for a more nuanced view of the quality and characteristics of their partnerships. As an example, an LEA might be able to determine that CBO/HWCs have strong connections to district-level staff but weaker connections to school level staff. As another example, an LEA might be able to determine that it has a lot of partners who serve YMSM with emotional or mental health services but few that offer HIV/STD testing or other clinical services.

Furthermore, this data collection will provide an important piece of the evaluation to identify best practices for linking schools to CBOs in order to increase HIV and STD testing as part of the work being supported under PS13-1308, CDC FOA project period 2013–2018. The findings from this information collection have practical utility to the government because they will directly impact both the activities used by the CDC-funded LEAs and the strategies and approaches the CDC recommends for use in linking schools to CBOs and HWCs in current and future program efforts, ultimately improving access to YMSM-friendly organizations.

Without this data collection, the LEA would be unable to determine if their linkages to CBOs and HWCs are increasing access among YMSM to social services and HIV/STD testing or know the quality/strength of these partnerships. In addition, without collecting this data, the CDC would have little evidence of the linkages and partnerships created and sustained with

cooperative agreement funding to enhance HIV and STD prevention strategies for YMSM in schools.

A. 3 Use of Improved Information Technology and Burden Reduction

This proposed information collection uses a secure Website, SurveyMonkey™ to automate data collection and ease the burden of respondents. The questionnaire Website (SurveyMonkey™) has been selected based on ease of use and built-in security measures. This provider utilizes Secure Socket Layer (SSL) technology, which protects user information by using both server authentication and data encryption, ensuring that user data is secure and available only to authorized persons. Individual questionnaire responses are also protected by the SSL technology, which ensures that the responses of questionnaire respondents are transmitted over a secure, encrypted connection. Once transmitted, the data will be accessible only to study team staff in possession of the password necessary to access and download the data.

The use of a web-based questionnaire in the CBO and HWC settings actually makes it easier for staff to participate in data collection with minimal disruption to their work day. They can use their own computers or work computers and can choose the most convenient time to complete the questionnaire. Furthermore, the information collection instrument was designed to collect the minimum information necessary for the purposes of this project through the use of automated skip patterns.

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

The complete content of the questionnaire used in this information collection is not duplicated in any other single data collection system. However, a few items on this questionnaire have been pulled from other existing data collection systems. Some questions were derived from the Clinic Assessment of Youth Friendly Services: A Tool for Rapid Assessment and Improving Reproductive Health for Youth. This tool was developed to facilitate the assessment of youth friendly characteristics to improve the quality of services provided in clinics. Additional questionnaire items were based on the Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER) tool which allows organizations to measure collaboration over time. Questions from this tool were used to develop questionnaire items focused on school linkages. However, neither of these tools are currently being used with the CBOs and HWCs participating in the proposed data collection. Because this is such a unique information collection, many of the questions for the assessment had to be developed since they are so specific to this project.

The assessment instruments (see **Attachment 5** and **Attachment 6**) were developed for this study through an iterative process of reviewing existing measures related to coalitions, clinical service qualities, and social network analysis tools that the contractor developed for this data collection in collaboration with CDC. Whenever possible, items were selected from valid and reliable survey instruments. The questionnaire contains questions about the services offered by the organization and the organization's relationships with the school district and participating schools. There is no other source of information that can provide the relevant data specifically about the participating LEAs.

The purpose of this information collection is to measure the strength and quality of

linkages between schools and CBOs/HWCs in the three LEAs; and the improvements among the partners as they serve YMSM. It intends to track changes over time through Strategy 4 program efforts. Due to the specificity of this project, questions needed to be tailored for this particular data collection. A list of organizations and individuals providing consultation on the information collection is provided in **Attachment 10**.

A. 5 Impact of Small Businesses or Other Small Entities

Because the LEAs will select the CBOs/HWCs that should be included in this data collection (and that has not been finalized at this time), it is not possible to provide an exact percentage of CBOs/HWCs that are small entities. Based on our knowledge of the LEAs, we estimate that approximately half of the CBOs and HWCs will be small entities, largely non-profit organizations. Most community-based organizations would fall into this category, and most health and wellness centers (specifically the school-based health centers that we are classifying as HWCs) are part of larger hospital or medical organizations. For the 50% of CBOs/HWCs that we anticipate may be small entities, we do not expect this information collection to have a significant impact. The extent of the data collection is that staff members affiliated with CBOs and HWCs will be asked to complete the Web-based questionnaire. The questions have been held to the absolute minimum required for the intended use of the data, and will take minimal time from participants. There is no financial burden associated with the data collection for the participating CBOs or HWCs other than the time it takes to complete the questionnaire.

A. 6 Consequences of Collecting the Information Less Frequently

This information collection is scheduled to occur in 2015, 2016, and 2018. These time points align with the initiation of program activities (for baseline data collection in early 2015) and then the mid-way point (late 2016) and end point (early 2018) of program activities funded under PS13-1308. All data collections (2015, 2016, and 2018) will be covered by this Information Collection Request.

There would be a number of consequences to collecting the data less frequently. First of all, this was designed to use the fewest data collections to achieve project goals. The first data collection is essential to provide a clean baseline for the assessment and present an accurate picture of linkages and relationships between schools and CBOs/HWCs, prior to initiation of program activities and strategies. Without this first data collection, it would be impossible to determine if the program had any impact. Furthermore, this initial baseline data collection provides critical information that LEA staff can use to determine the most appropriate focus of their activities. It will allow them to determine areas of greatest need that can be incorporated into program planning. The second (mid-point) data collection (in 2016) is really essential for good public health practice. One of the key purposes of the assessment is not simply to know if activities worked but to be able to make mid-course corrections to improve the likelihood that future activities can have even greater impact. The mid-program data collection will allow the LEAs to assess their relationships with CBO and HWC partners midway through the program and to make improvements based on strengths or weaknesses revealed by the 2016 data. In addition, the mid-point data is most likely to reflect the impact of the program development process (because most development will happen prior to this data collection) on the relationships

with partners. Finally, the 2018 data collection is essential for determining the full impact of the funded program on partner relationships and service offerings. By the time of this data collection, partners should have been working together for several years to implement activities directly for youth. The outcome of their collaboration to provide services will be most visible in this third data collection. Without these three data collection points, the LEAs and CDC would not be able to achieve both goals of improving program activities (including the development and strengthening of partnerships) and assessing their impact on services available to YMSM who are at disproportionately higher risk for HIV and STDs.

A. 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 will be voluntary.

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

A. As required by 5 CFR 1320.8(d), a 60-day Notice was published in the *Federal Register* on January 22, 2015, volume 80, number 14, pages 3238-3239 (see **Attachment 2**). One substantive public comment requesting a copy of the information plan and instruments was received and a CDC's response was sent (see **Attachment 11**). [Explanation of comments].

B. CDC contractors provided extensive input into the clarity of instructions and reporting format and the data elements that will be reported. A few CBO and HWC representatives (who will not be included in the proposed data collection) also provided feedback on the questionnaires through a piloting process. A list of consultants can be found in **Attachment 7**.

A. 9 Explanation of Any Payment or Gift to Respondents

No payment or gift will be given to the respondents.

A. 10 Assurance of Confidentiality Provided to Respondents

CDC staff have reviewed this information collection requests and determined that the Privacy Act does not apply. The privacy act does not apply as no sensitive or personally identifiable information (PII) will be collected through this data collection. Any business PII that is provided by the local education agency for the purposes of participant recruitment will remain completely separate from the information gathered through the Web-based instrument and the in-person interviews, and will be kept securely by the project team.

IRB Approval

This proposed data collection has been reviewed and approved by the contractor's IRB (see **Attachment 12**).

10.1 Privacy Impact Assessment Information

No individually identifiable information (IIF) is being collected.

A. 11 Justification for Sensitive Questions

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

A. 12 Estimates of Annualized Burden Hours and Costs

Burden hours. **Table A.12-1** provides estimates of burden for the data collection. The amount of time required to complete the questionnaires is based on estimates that DASH compiled relying on their experience with previous data collections with CBOs/HWCs and their discussions with the local education agency during the process undertaken to develop measures. Administration of the questionnaire will be on individual computers via the web-based questionnaire. The questionnaire is listed in the burden table below. The estimated burden time is based on a pilot with 4 respondents. These individuals were selected based on their experience working at a CBO or HWC. The estimated burden time includes the time for reading the information sheet, instructions, reviewing the consent form online, gathering information from up to two colleagues, and completing the questionnaire. It is estimated that respondents will take 20 minutes to collect information from their colleagues and 40 minutes to complete the questionnaire for a total of 60 minutes (1 hour).

An estimated 60 staff total (from up to 60 CBOs and HWCs, with no more than 10 CBOs and 10 HWCs from each of the three LEAs) will complete the questionnaire in 2015, 2016, and 2018. The estimated burden per response ranges from 40-60 minutes. This variation in burden is due to the slight variability in skip patterns that may occur with certain responses, variations in the reading speed of staff, and variations in the time required to compile necessary data for completing the questionnaire. The burden estimates presented here are based on the assumption of up to 60 minutes response time per response. This is only an estimated response time as some respondents may take less time to complete the questionnaire. The same staff may complete the questionnaire each data collection period if deemed the most appropriate person to respond to the questions. Annualizing this collection over three years results in an estimated annualized burden of 60 hours.

Table A.12-1 Estimated Annualize Burden to Respondents

Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
CBO staff	CBO Assessment Questionnaire	30	1	1	30

HWC staff	HWC Assessment Questionnaire	30	1	1	30
Total					60

Annualized cost. **Table A.12-2** provides estimates of the annualized cost to respondents for the collection of data. Because staff will likely work for a non-profit community based organization or a school-based health or wellness center, cost estimates for the value of time staff spend in responding to the questionnaire are based on Department of Labor (DOL) data from May 2013 providing national industry-specific occupational employment and wage estimates. These hourly wage estimates can be found on the DOL website (http://www.bls.gov/oes/current/naics4_999200.htm). Based on DOL data, an average hourly rate for community and social service specialists is \$23.10 and for registered nurses is \$30.77. In addition, the DOL data reports the average salary of community and social service specialists is \$48,040 and the average salary for registered nurses is \$64,000. Total cost has been rounded up to the nearest whole dollar and are presented in Table A.12-2.

Table A.12-2 Annualized Costs to Respondents

Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Average Hourly Wage Rate	Total Cost
CBO staff	CBO Assessment Questionnaire	30	1	1	\$23.10	\$693
HWC staff	HWC Assessment Questionnaire	30	1	1	\$30.77	\$923
Total						\$1,616

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

There will be no direct costs to the respondents or record keepers other than their time to participate in each information collection. No capital, start-up, operation, or maintenance costs are involved.

A. 14 Annualized Cost to Federal Government

Cost will be incurred by the government in personnel time for overseeing the project. CDC time and effort for overseeing the contractor's assistance with data collection and answering questions posed by the contractor and funded agencies are estimated at 4% for two GS-13 (step 7) level Atlanta-based CDC employees and 2% for a GS-14 (step 8) level Atlanta-

based senior CDC employee a year for the three years of the project. The senior level employee supervises the two GS13-level employees. The average annual cost to the federal government for oversight and project management is \$10,807 (**Table A.14-1**).

The contractor’s costs are based on estimates provided by the contractor who will carry out the data collection activities. With the expected period of performance, the annual cost to the federal government from contractor and other expenses is estimated to be approximately \$43,679 (**Table A.14-1**). This is the cost estimated based on the current funding level of the contractor at approximately \$609,969 for base year (Aug 2014-2015), \$681,963 for option year 2 (Aug 2016-2017), and \$852,474 for option year 3 (Aug 2017-2018) and the percentage of the contractor’s effort that is anticipated for this specific information collection. It is estimated this data collection will take approximately 6% of the contractor’s effort in the base year, 5% of the contractor’s effort in option year 2, and 4% of the contractor’s effort in option year 3. This totals \$104,795.25 over the three years, which annualizes to \$34,932 per year. This includes the estimated cost of coordination with DASH, providing assistance to the LEA for data collection and processing, and support for analysis and reporting.

The total annualized cost to the government, including direct costs to the federal government and contractor expenses is \$45,739.

Table A.14-1. Annualized and Total Costs to the Federal Government

Expense Type	Expense Explanation	Annual Costs (dollars)
<i>Direct Cost to the Federal Government</i>		
CDC employee oversight for project	CDC supervisor labor costs for 1 employee at 2% time	\$2,517
CDC oversight of contractor and project	CDC non-supervisory employee labor costs for 2 employees, each at 4% time	\$8,290
Subtotal, Direct Costs to the Government per year		\$10,807
<i>Contractor and Other Expenses</i>		
Assistance with data collection, processing, and preliminary analysis	Labor and other direct costs for supporting data collection, processing, and analysis	\$34,932
Subtotal, Contract and Other Expenses per year		\$34,932
<i>Total of all annualized expenses</i>		\$45,739

A. 15 Explanation for Program Changes or Adjustments

This is a new information collection.

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

Current plans for tabulation and publication of data from this information collection include analyzing data for differences in key outcomes between baseline and follow-up data collections and publication of these findings in written reports for the associated LEAs and possibly, peer-reviewed journals. In addition, basic analyses of baseline (2015) data will be shared in written reports for the LEAs and may also be shared in published reports for other stakeholders. Since this is a recurring data collection, a 3-year clearance is requested. All data collections (2015, 2016, and 2018) will be covered by this Information Collection Request.

Analysis Plan

Data will be analyzed using both descriptive and inferential statistics. As relevant, data reduction techniques/factor analyses and item correlation analyses will be used to develop scales from within the questionnaire items, as needed. Descriptive statistics of data will assist in data cleaning, generating additional hypotheses, and summarizing service characteristics (not data on relationships between the CBOs/HWCs and the LEAs) for each CBO and HWC, then pooling all the data (including data on the relationships between the CBOs/HWCs and the LEAs) together for each LEA/community, and at each data collection time point.

To address our primary evaluation question about the effect of the PS13-1308 activities on building and strengthening relationships with CBO and HWC partners and increasing services available to YMSM, we plan to pool the data from CBOs and HWCs that are linked to the schools involved in the program in each LEA. We will examine the characteristics and qualities of the CBO and HWC partners using descriptive statistics; examine changes in the partnership quality between respondents and the LEAs over time; and predictors of successful partnerships with the LEAs, for example. The samples will be successive independent samples (non-linked). Descriptive statistics will be presented by LEA and across LEAs using means, percentages, and counts as appropriate. T tests and chi-square analyses will be used to assess differences between years (e.g. baseline, 2016, and 2018). Linear or logistic regression will be used to examine predictors of outcomes of interest. A few example table shells are provided in **Attachment 13**. Qualitative data will be summarized from open-ended questions.

Project Time Schedule

Baseline data are scheduled to be collected in 2015. The baseline data are likely to be analyzed, summarized, and reported (through unpublished or published reports) in 2015. The first round of follow-up data (data collected at the mid-point of the program) will be collected in Fall 2016 and the second round of follow-up data will be collected in Spring 2018. These data, and differences in baseline and follow-up data, are likely to be analyzed, summarized, and shared through unpublished or published reports in 2016 and 2018. A three year clearance is being requested.

Figure A.16-1: DASH Project Time Schedule

Activity	Time Schedule
First round of data collection (baseline)	
Design Web-based questionnaire	Complete
Pilot test Web-based questionnaire	Complete
Prepare OMB package	Complete
Collect e-mail addresses for participating CBO and HWC staff	1-2 months prior to anticipated OMB approval
Receive OMB approval	TBD
Administer Web-based questionnaire	0-2 months after OMB approval
Clean questionnaire data	2-3 months after OMB approval
Analyze questionnaire data	4-6 months after OMB approval
Writing (and revising) of baseline data summaries, reports, and/or manuscripts	7-12 months after OMB approval
Second Round of Data Collection (program mid-point)	
Collect e-mail addresses for participating CBO and HWC staff	16-17 months after OMB approval
Administer Web-based questionnaire	17-19 months after OMB approval
Clean questionnaire data	19-20 months after OMB approval
Analyze questionnaire data	21-23 months after OMB approval
Writing (and revising) of mid-point data summaries, reports, and/or manuscripts (will include comparison of mid-point and baseline data)	24-30 months after OMB approval
Third/Final Round of Data Collection (program end-point)	
Collect e-mail addresses for participating CBO and HWC staff	33-34 months after OMB approval
Administer Web-based questionnaire	34-35 months after OMB approval
Clean questionnaire data	35-36 months after OMB approval
Analyze questionnaire data	37-39 months after OMB approval
Writing (and revising) of mid-point data summaries, reports, and/or manuscripts (will include comparison of mid-point and baseline data)	40-46 months after OMB approval

The CDC contractor, with the review and approval of the CDC staff and the funded

LEAs, will develop specific reports for the LEAs to use for program improvement and communication with the LEAs' stakeholders. CDC will use the LEAs' assessment findings during the project period to establish key recommendations for partners on program impact, sustainability, and continued program improvement.

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

The display of the OMB expiration date is not inappropriate. All data collection instruments will display the expiration date for OMB approval of the information collection. We are requesting no exemption.

A. 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.

References

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