DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Centers for Disease Control and Prevention

National Center for Health Statistics
3311 Toledo Road
Hyattsville, Maryland 20782

September 28, 2017

Margo Schwab, Ph.D.
Office of Management and Budget
725 17th Street, N.W.
Washington, DC 20503

Dear Dr. Schwab:

The staff of the NCHS Collaborating Center for Questionnaire Design and Evaluation Research (CCQDER) (OMB No. 0920-0222, exp. 07/31/2018) plans to conduct a cognitive interviewing study to examine questions developed for the first hospital-based victim services survey, the National Survey of Hospital-Based Victim Services (NSHVS). NCHS' Division of Health Care Statistics (DHCS) and the U.S. Department of Justice's Bureau of Justice Statistics (BJS) are collaborating on the development of the survey. While BJS has developed the National Census of Victim Service Providers (NCVSP) (OMB No. 1121-0355, exp. 05/31/19) and is developing the National Survey of Victim Service Providers (NSVSP) to capture all types of victim service providers, this effort is designed to better understand the range of hospital services specifically available to crime victims.

We propose to start recruiting for volunteer participants as soon as we receive clearance and to start testing as soon as possible after that.

<u>Background Information about Cognitive Testing of Questionnaires</u>

The overall purpose and use of the requested cognitive testing is to inform the development of the new National Survey of Hospital-Based Victim Services (NSHVS) screening instrument. The administration of the NSHVS is a joint effort between the Bureau of Justice Statistics (BJS) and National Center for Health Statistics (NCHS), and builds upon BJS's larger efforts to better understand how victims of crime or abuse access services and the capacity for service providing agencies to respond to victims' needs. Hospitals are an important sector of the victim services field, oftentimes victims' first point of contact with formal systems after experiencing victimization. However, hospitals do not tend to identify as a "victim service provider," and do not tend to receive funding through traditional victim service funding streams (e.g., federal funding through the Office for Victims of Crime). As a result, the information collected to date from the victim service provider field (e.g., through BJS's National Census of Victim Service Providers, or counts of providers receiving federal funding for victim services) does not provide comprehensive, reliable information on how hospitals serve victims. On a national level, no data has ever been collected on the number of

hospitals that provide services (beyond immediate medical treatment) to victims of crime or abuse, how hospitals are structured to provide services, and the types of crime or abuse for which hospitals provide services.

The proposed NSHVS screener tool (Attachment 1) was informed by BJS's National Census of Victim Service Providers (NCVSP), the only other national survey on victim service providers that involves some hospitals. The NCVSP is the first-ever survey of all types of victim service agencies across the nation, including criminal justice agencies, non-profit or faith-based agencies, campus-based agencies, and health agencies. The NCVSP collection recently ended (July, 2017), and data cleaning is currently underway. Although some hospitals were included in the NCVSP, the NCVSP was designed to collect data from agencies that formally identify as victim service providers. The NCVSP cannot provide information on victim services among all hospitals nationally, because:

(1) the NCVSP project roster was created based on lists of victim service providers, and hospitals are traditionally not defined as a victim service provider so are likely to be left off the list;
(2) hospitals would have to identify as providing direct services to crime victims to screen into the NCVSP, and evidence to date suggests that terms such as "crime" would not resonate with most hospital staff (instead the NSHVS focuses on "intentional injury");
(3) information gathered from hospitals for the NCVSP was collected for the hospital as a whole (i.e., the unit of analysis was the hospital), and it is unclear whether this information represents only certain programs within the hospital or all programs and services across the hospital.

Among the limited hospitals that were included in the NSVSP, the data will not provide details on the structure of victim services within those hospitals since the NCVSP was focused on the larger field of victim service providers and captured general information relevant to all providers, whether community-based, government-based, or hospital based.

Recognizing these limitations of the NCVSP in capturing the scope of hospital-based victim service structures and capabilities, BJS entered into an Inter-Agency Agreement (IAA) with NCHS to design the NSHVS.

The project team took a number of measures to ensure that the NSHVS screener instrument was informed by BJS's ongoing work in the area of victim services and any recent local-area work related to victim services within hospital settings. First, the team reviewed literature from academic, government, and other outlets on victim services within hospitals. In addition, in August, 2016 the team presented at a conference attended by many hospital-based victim service program staff members (Healing Justice Alliance), sharing information on the upcoming work and soliciting feedback about the project. During this time, the project team also conducted interviews with individual stakeholders (e.g., nurses, hospital-based administrative staff, hospital-based program directors, experts in crime victim compensation, etc.) to learn about different types of service programming and structures across hospitals.

A 2-day expert panel meeting was convened in October 2016 to share initial project goals and domains of interest for the NSHVS instrument. Experts included a range of professionals with expertise in various types of crimes (e.g., sexual assault, domestic violence, human trafficking) and a wide range of expertise in the area of victim services (e.g., victim compensation, direct programming, administration of programs). Attendees were also active in key professional organizations or networks on the forefront of thinking about victim services within hospital settings (e.g., National Network on Hospital-Based Violence Intervention Programs). Also present at the expert panel were federal stakeholders from agencies that conduct programming and/or research in the areas of victimization, crime, services, and health, including Office for Victims of Crime (OVC), Violence against Women (OVW), National Institute of Justice (NIJ), and other divisions within CDC outside of NCHS. Over the course of the two days, participants shared much information about important items to include on the first survey, whom to direct the survey to within hospitals, and important considerations for outreach and gaining cooperation for the full implementation of the survey. After the meeting, these experts also reviewed a first draft of the NSHVS instrument, which led the project team to further revise and refine the instrument.

Together, this work led to a consensus that the NSHVS screener, which assesses whether hospitals have staff or programs to respond to crime victims, is needed to fill current informational gaps and build a foundation for future efforts to examine victim assistance within hospital settings. Following cognitive testing and modifications to the instrument based on feedback from respondents, the project team will administer the NSHVS screener to the full hospital frame. (A separate data collection activity outside the scope of this GenIC submission.)

As a first step in surveying hospitals about victim services, this instrument was designed to be brief and screen for basic level information on the number of hospitals that offer services and how hospitals deliver services. When administered to the full frame of hospitals, findings will provide a sense of the scope of victim service programming within hospitals and details about the appropriate unit of analysis, information that is required before conducting future research on hospital-based victim services. The NSHVS screener will set the stage for being able to survey hospitals about more detailed information on their capacity to meet victims' needs, for example assessing gaps in our current knowledge about whether hospitals are able to identify victims, connect or deliver services victims need, and dedicate adequate staffing and funding to meet the demand for victim services.

Proposed project: Evaluation of the National Survey of Hospital-Based Victim Services (NSHVS) questions

The first draft of the NSHVS screening instrument was developed based on extensive input from victim services experts in the medical field, key policy stakeholders, and an extensive review of existing literature. Given that this is a new instrument, as well as a new topical area for most hospitals, cognitive testing is an important next step to:

- Assess any comprehension issues associated with the questions, including whether respondents interpret questions consistently across hospitals;

- Sharpen the wording of questions so that respondents to the final survey receive the clearest instructions possible concerning how victims and services should be defined within the hospital setting;
- Determine whether the different types of service structure categories provided in the instructions and asked about in questions 1, 2, and 3 make sense to the hospital staff who would be responsible for completing a survey on victim services;
- Determine whether the proposed list of crime types is comprehensive and appropriate for hospital settings;
- Roughly estimate the amount of burden needed to complete the instrument, including assessing how long it takes for respondents to answer the questions and determining whether respondents can complete the survey on their own or would need to consult with colleagues.

The proposed NSHVS questions for cognitive testing are included as Attachment 1. The National Survey of Hospital-Based Victim Services (NSHVS) is designed to gather basic information about hospital services provided to victims of crime or abuse. It is understood that in some hospitals different services are offered for different types of victims based amongst various programs, units, and departments. Consequently, the survey questions include topics related to the various services hospitals provide to victims of crime or abuse, including programs supported by hospital resources, partnerships and other inter-agency collaborations in which the hospital participates and staffing teams that may be made up of volunteers.

Analysis of the cognitive interviews will determine the types of experiences or perceptions that respondents include in their answers, ideally relating to victim services provided at small (< 50 beds) to medium (< 199 beds) sized hospitals. Interviews will also determine difficulties experienced by respondents when answering the questions, preferred question language, as well as identify potential response error. The testing procedure conforms to the cognitive interviewing techniques that have been described in CCQDER's generic OMB clearance package (No. 0920-0222, exp. 07/31/2018).

We propose to recruit up to 20 respondents aged 18 and over who work at small to medium hospitals and can answer questions about victim services at the hospital.

Recruitment will be carried out through a combination of invitation letters, flyers, and word-of-mouth. The invitation letter used to recruit respondents is shown in Attachment 2. The flyer used to recruit respondents is shown in Attachment 3. As a follow-up to the invitational letter and the flyer, CCQDER staff will call individuals to talk to them about the study, what they will be asked to do, and to ascertain their interest in participating in the study. There will be no coercion. Individuals will be told that their participation in the study is entirely voluntary. In addition, in order to maximize recruitment efforts of this hard-to-reach population, two additional letters may be sent to potential respondents. A support letter may be sent to potential respondents who wish to have more detailed information regarding the study and provide further endorsement for the study. The support letter is shown in Attachment 4. Finally, an interviewer introduction letter may be sent to potential

respondents to personally introduce the interviewer and remind respondents of the study. The interviewer introduction letter is shown in Attachment 5. The 5 minute telephone screener used to determine eligibility of individuals responding to the invitational letter and newspaper advertisement/flyer is shown in Attachment 6. Note that wording of the template has been approved and is contained within our umbrella package. Only project specific information has been added to the document. It is anticipated that as many as 72 individuals may need to be screened in order to recruit 20 participants.

Interviews averaging 60 minutes (including the completion of a Respondent Data Collection Sheet) will be conducted by CCQDER staff members with English speaking respondents. Interviews will be conducted in the Questionnaire Design and Evaluation Research Laboratory as well as at off-site locations. All interviews conducted in the Questionnaire Design and Evaluation Research Laboratory will be video and audio recorded to allow researchers to review the behaviors and body language of the respondents. Interviews conducted off-site will only be audio recorded. These recordings will allow researchers to ensure the quality of their interview notes. In the rare case that a study participant initially agrees to audio recording during the telephone screening, but changes their mind and checks “no” to allowing the interview to be recorded on the informed consent document the interview will proceed without audio recording. In this case the interviewer will depend on their handwritten notes when conducting analysis. In addition, individuals who select “yes” for allowing the audio recording on the informed consent form, but “no” for retaining the recording for future research (final text before signatures on informed consent form), will be allowed to participate in the study.

After respondents have been briefed on the purpose of the study and the procedures that CCQDER routinely takes to protect human subjects, respondents will be asked to read and sign an Informed Consent (Attachment 7). Only project specific information has been added to the document. Respondents will also be asked to fill in their demographic characteristics on the Respondent Data Collection Sheet (Attachment 8). This document is contained in our umbrella package. The burden for completion of this form is captured in the interview.

The interviewer will then ask the respondent to confirm that he/she understands the information in the Informed Consent, and then state that we would like to record the interview. The recorder will be turned on once it is clear that the procedures are understood and agreed upon.

The interviewer will then orient the respondent to the cognitive interview with the following introduction:

[fill staff name] may have told you that we will be working on some questions that will eventually be added to national surveys. Before that happens, we like to test them out on a variety of people. The questions we are testing today are about victim services at your hospital. We are interested in your answers, but also in how you go about making them. I may also ask you questions about the questions—whether they make sense, what you think about when you hear certain words, and so on.

I would first like you to fill out this questionnaire, and then we will discuss the questions and how you formulated your answers. Please answer the best you can, and mark any questions that you don't understand or are having difficulty answering and we will discuss them once you have finished, and I'd like you to answer as best you can. Please note on the instrument if:

there are words you don't understand,
the question doesn't make sense to you,
you could interpret it more than one way,
it seems out of order,
or if the answer you are looking for is not provided.

The more you can tell us, the more useful it will be to us as we try to develop better questions. Okay? Do you have any questions before we start?

After the interview, respondents will be given the thank-you letter (document contained in umbrella package) signed by the Charles J. Rothwell, Director of NCHS (Attachment 9), a copy of the informed consent document, and $100. This amount has been increased over and above the normal cognitive interview incentive level due to the imperative to recruit certain medical facility professionals. The proposed incentive level will be critical to obtaining a high response rate and reducing the number of cancelations from this busy, specialized population.

After the cognitive interview is over respondents will be asked to read the Special Consent for Expanded Use of Audio Recordings (Attachment 10). There will be no coercion and the respondents will be told that they can call and reverse the decision at any time if they change their minds. If respondents do sign the special consent form they will be given a copy of that as well.

Extreme care will be taken with all recordings and paperwork from the interviews conducted off-site. Recordings and identifying paperwork will be stored in a secured travel case until returned to NCHS, at which point they will be transferred to the usual secured locked storage cabinets.

In total, for this project, the maximum respondent burden will be 26 hours. A burden table for this project is shown below:

Form Name	**Number of Participants**	**Number of Responses/ Participant**	**Average hours per response**	**Response Burden (in hours)**
Telephone Screener	72	1	5/60	6
NSHVS Screener Questionnaire	20	1	60/60	20

Attachments (10)
cc:
V. Buie
T. Richardson
DHHS RCO