

Capacity Building Assistance Program: Assessment and Quality Control

OMB No. 0920-New

SUPPORTING STATEMENT - Section A

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- **Goal of the study (e.g., determine behavioral factors that influence changes in weight over time or evaluate program delivery processes)**

The Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention (DHAP) Capacity Building Branch provides capacity building assistance (CBA), such as training and technical assistance, to community-based organizations, health departments, and healthcare organizations that provide HIV prevention services (e.g., HIV testing, risk reduction counseling, linkage to medical care, HIV awareness information). CBA services ensure that on-the-ground HIV prevention programs and their staff have the skills, information, and organizational support they need to reduce the spread of HIV. CBA services are most often provided to staff in positions such as HIV educator, clinical supervisor, HIV prevention specialist, clinician, outreach worker, case manager director, program coordinator, program manager, disease intervention specialist, partner services provider, physicians, nurses, and health educators, etc. These staff will be asked questions about the CBA services that they received, such as how satisfied they were with the CBA services and how they benefitted from them. This study will assess the degree to which the recipients of CBA services were satisfied with CBA services (e.g., training and technical assistance) and the degree to which they benefitted from CBA services, including changes in knowledge and skills.

- **Intended use of the resulting data (e.g. , provide suggestions for improving community-based programs)**

The resulting data will be used to improve the CBA program processes and operations; to assess quality, customer satisfaction and short-term outcomes of the CBA program; and to monitor the CBA provider grantees service delivery.

- **Methods to be used to collect (e.g., prospective cohort design; randomized trial; etc.)**

The assessment relies on mixed methods, including quantitative and qualitative information collection. Data will be collected either in-person at training and technical assistance events, online, or on the telephone.

- **The subpopulation to be studied (e.g., school-age children in North Carolina)**

The information will be collected from recipients of capacity building assistance (CBA) services (i.e., training and technical assistance) who are health professionals from Community-Based organizations, health departments, and healthcare organizations, most of whom are funded directly or indirectly by the CDC, and involved in HIV prevention service delivery.

- **How data will be analyzed (e.g., logistic regression)**

The following analytic tests will be applied to the quantitative data: frequencies and cross-tabulations, ANOVA, correlations,

means, non-response adjustment, and logistic regression to explore relationships within the data. Analyses of the qualitative data will be informed by grounded theory and principles of content analysis, including constant comparative method. Qualitative data will be coded and grouped by thematic categories, and analyses will be used to determine the frequency of categories.

Section A. JUSTIFICATION

1. Circumstances Making the Collection of Information Necessary

Background

The Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention (DHAP) requests new approval for 3 years of this information collection request (ICR) entitled, "Capacity Building Assistance Program: Assessment and Quality Control."

Data will be collected over a 3-year period from agency staff from community-based organizations (CBOs), health departments, and healthcare organizations, most of whom are funded directly or indirectly by the CDC, involved in HIV prevention service delivery. Their positions include HIV educator, clinical supervisor, HIV prevention specialist, clinician, outreach worker, case manager director, program coordinator, program manager, disease intervention specialist, partner services provider, physicians, nurses, and health educators, etc.

This information collection is authorized by Section 301 of the Public Health Service Act (42 U.S.C. Sec. 792[295k] (a) (**Attachment 1: Authorizing Legislation**)). This information collection falls under the essential public health service of 1) informing, educating, and empowering people about health issues; 2) mobilizing community partnerships to identify and solve health problems; 3) linking people to needed personal health services and assure the provision of health care when otherwise unavailable; 4) assuring a competent public health and personal health care workforce.

With an estimated 50,000 new HIV infections each year, more must be done with existing resources to maximize the impact of every federal prevention dollar and achieve the goals of the National HIV/AIDS Strategy (NHAS). CDC's Division of HIV/AIDS Prevention (DHAP) provides health departments and CBOs with more than \$300 million annually to conduct HIV prevention activities. In addition, DHAP's Capacity Building Branch (CBB) provides funds for Capacity Building Assistance (CBA) services in which considerable resources are allocated to serve CBOs, health departments, and healthcare organizations for HIV prevention services nationwide. The CBB provides national leadership and support for capacity building assistance to ensure that DHAP's grantees and healthcare organizations have the knowledge, skills, and

technology to effectively and efficiently conduct HIV prevention across the United States and its territories. CBA means the provision of free (not for fee) information, training, technical assistance, and technology transfer to individuals, organizations, and communities to improve their capacity in the delivery and effectiveness of evidence-based interventions and core public health strategies for HIV prevention. CBA is provided to support health departments, community-based organizations, and healthcare organizations in the implementation, monitoring and evaluation of evidence-based HIV prevention interventions and programs; building organizational infrastructure; and community mobilization to decrease stigma and increase HIV testing in high risk communities.

DHAP has funded the CBA program since 1999. Prior to that, the program was called the National and Regional Minority Organizations Program. In all, DHAP has funded some form of capacity building strategy for DHAP grantees for approximately 15 years (e.g., PS04-4019, PS09-906). Most recently, on April 1, 2014, CDC awarded \$115 million over five years to train and strengthen 21 capacity building assistance organizations and ensure on-the-ground prevention programs and their staff have the skills, information, and organizational support they need to best serve organizations serving individuals living with, and at high risk for, HIV in their communities. The new CBA program aligns with the goals of the NHAS and CDC's High-Impact Prevention (HIP) and Community High-Impact Prevention (CHIP) approaches by supporting a defined set of scalable, cost-effective activities and placing new emphasis on the delivery of high-quality prevention and care services for persons living with HIV; effective new prevention strategies for those at high-risk for HIV; policy change to advance HIV prevention goals among health departments; and collecting and using care continuum data for policy planning and program prioritization. The program also continues to emphasize key activities with demonstrated potential to reduce new infections such as HIV testing, condom distribution, and use of surveillance data to improve program efficiency and effectiveness. The CBA provider grantees provide culturally competent information dissemination, training, and technical assistance in the areas of HIV testing, prevention with HIV-positive persons, prevention with high-risk HIV-negative persons, condom distribution, organizational development and management, and policy.

Even though CBA has been funded for over 15 years, there has not been a systematic assessment of CBA services provided to CBOs, health departments, and healthcare organizations to support their HIV prevention services. In addition, there has not been an assessment process in place to determine whether CBA customers were satisfied with CBA services nor an assessment of whether CBA services resulted in improved HIV prevention practice. Since these data are lacking, the CBA providers do not have adequate feedback on the quality of their work and may continue on a course for 4 or 5 years with no customer feedback to inform CBA quality assurance and to direct CBA program improvement. The CBB, as the major leader in CBA services, is in the

position to conduct such an assessment and use this information to improve capacity building efforts by CBB grantees. To that end, the purpose of this information collection is to assess how well the CBB's CBA program meets the needs of its consumers in order to enhance its capacity building strategy over time. The information will be collected from recipients of CBA services (CBOs, health departments, and healthcare organizations). This assessment will continue to provide the CBB with necessary information to improve program processes and operations. Improving the quality of HIV prevention programs is a key evaluation activity, among others, promoted by the CDC and DHAP. The assessment relies on mixed methods, including quantitative and qualitative information collection. Data will be collected either in-person at training and technical assistance events, online, or on the telephone.

2. Purpose and Use of the Information Collection

Although CBB has funded CBA services for HIV prevention efforts for over 15 years, there has not been a systematic assessment of CBA services provided health professionals from community-based organizations (CBOs), health departments, and healthcare organizations, most of whom are funded directly or indirectly by the CDC, involved in HIV prevention service delivery. Moreover, there has not been an assessment process in place to determine the degree to which CBA consumers were satisfied with CBA services nor an assessment of whether CBA services resulted in improved HIV prevention practice or enhance organizational capacity. As a result, the CBA providers have not had adequate feedback on the quality of their work and may continue on a course for 4 or 5 years with no customer feedback to inform CBA quality assurance and to direct CBA program improvement. The CBB, as the major leader in CBA services, is in a unique position to conduct such an assessment and use this information to improve capacity building efforts by CBB's grantees.

The purpose of this information collection is to assess how well the CBB's Capacity Building Assistance (CBA) program meets the needs of its consumers in order to enhance its capacity building strategy over time. More specifically, information collection will help us answer questions such as:

1. To what extent are CBA recipients satisfied with the CBA services they receive?
2. How do CBA services impact CBA recipients' capacity to implement evidence-based prevention practices and public health strategies?
3. How do CBA recipients think that CBA services can be improved?
4. What factors correlate with CBA recipient satisfaction and capacity building outcomes?
6. To what extent do recipient satisfaction and capacity building outcomes improve over time for individual CBA providers and for the overall CBA program?

7. How is the capacity of CBA recipients' organizations to implement evidenced-based prevention practice and public health strategies impacted as a result of CBA?

The information will be collected from recipients of CBA services (i.e., training and technical assistance) who are health professional from CBO s, health departments, and healthcare organizations, most of whom are funded directly or indirectly by the CDC, involved in HIV prevention service delivery. Their positions include HIV educator, clinical supervisor, HIV prevention specialist, clinician, outreach worker, case manager director, program coordinator, program manager, disease intervention specialist, partner services provider, physicians, nurses, and health educators, etc. This assessment will continue to provide the CBB with necessary information to improve program processes and operations. This data collection provides CDC with information to determine whether the CBA provider grantees are reaching their target audiences in terms of provider type, the types of organizations in which participants work, the focus of their work and the population groups and geographic areas served. CDC will use the data to monitor and evaluate performance of grantees funded by Division of HIV/AIDS Prevention (DHAP) and CDC/Division of STD Prevention (DSTDP) that offer STD and HIV prevention training and TA to STD and HIV prevention health professionals. The CBB is committed to continuous quality improvement of its CBA services and products. The assessment of consumer satisfaction will take place within a utilization-focused assessment framework, which emphasizes practical utility. In the absence of this assessment, the CBB's ability to make timely and essential mid-course correction, if needed, to better meet the needs of its consumers will be greatly impaired. Specifically, this information will be used to:

- Assess the quality of services delivered by CDC-funded CBA providers and CBA partners;
- Assess short term outcomes of CBA service delivery;
- Identify and address the technical assistance needs of CBO s, health departments, and healthcare organizations;
- Identify and address programmatic areas of improvement;
- Respond promptly to emerging problems identified through feedback from consumers;
- Provide timely, current, and accurate information in response to requests from Executive Branch officials, the Congress, constituents, or other federal, state, and local agencies on the needs of grantees and the types and quality of CBA services delivered.

CBB will disseminate the summarized information through reports to CBB and its grantees, and possibly publications or presentations. All data will be shared in the aggregate. No CBA provider or CBA partner will know how any individual described their satisfaction with its

services. If results are shared with the public via presentations or publications, results will be shared in the aggregate, and any information that may identify an agency or individual will be masked. As individuals participating in CBA events (training or technical assistance) will be representing their organizations, there will be no impact on their personal privacy.

Overview of the Data Collection System

The information collection system consists of four instruments administered to the recipients of CBA services (i.e., training and TA). Recipients of CBA services include agency staff from community-based organizations (CBOs), health departments, and healthcare organizations, most of whom are funded directly or indirectly by the CDC. CBA services are provided by request as needed and proactively through training. Some respondents will have received training or TA or both. Step one: Before the CBA services are delivered, the CBA service recipients will complete the Health Professional Application for Training (HPAT) (**Attachment 3: Health Professional Application for Training (HPAT) Word version; Attachment 4: Health Professional Application for Training (HPAT) screenshots**) as part of registration for training and TA services. The HPAT is administered online or by paper depending on whether the registration process is web-based or completed in person. CDC contracts with Danya International to coordinate online registration and data collection for the HPAT for some of the CBA trainings. The CBA provider grantees coordinate registration and data collection for the HPAT for other trainings and TA services. During the training or TA services, CBA recipients will be given the opportunity to opt-out of further data collection.

Step two: After CBA services are delivered, each CBA recipient will receive an email invitation (**Attachment 9: Training Intro Email or Attachment 10: Technical Assistance (TA) Intro Email**) to complete the web-based instruments. The email will contain a link to the web-based Training Follow-up Instrument (**Attachment 5: Training Follow-up Instrument Word version; Attachment 6: Training Follow-up Instrument screenshots**) or the web-based Technical Assistance (TA) Satisfaction Instrument (**Attachment 7: Technical Assistance (TA) Satisfaction Instrument Word version; Attachment 8: Technical Assistance (TA) Satisfaction Instrument screenshots**) and instructions for completing the instruments online. Those CBA recipients who participate in a training will get the Training Intro Email (**Attachment 9: Training Intro Email**) with the link to the web-based Training Follow-up Instrument, and those who participate in technical assistance will get the Technical Assistance (TA) Intro Email (**Attachment 10: Technical Assistance (TA) Intro Email**) with the link to the Technical Assistance (TA) Satisfaction Instrument. The CBA Request Information System (CRIS) application will send the email invitation to complete the Training Follow-up Instrument 90 days after the training or for the Technical Assistance (TA) Satisfaction Instrument, 45 days after the technical assistance (TA) is completed.

Step three: Two weeks after the emails for the Technical Assistance (TA) Satisfaction and Training Follow-up instruments are sent out, a reminder (**Attachment 11: Training Reminder Email and Attachment 12: Technical Assistance (TA) Satisfaction Reminder Email**) will be emailed to respondents who have not completed the online instruments.

Step four: One week after the reminder emails are sent, SciMetrika (contractor) will contact the nonresponders by telephone to administer the telephone script version of the Training Follow-up Instrument (**Attachment 13: Training Telephone Script for non-responders**) or the Technical Assistance (TA) Satisfaction Instrument (**Attachment 14: Technical Assistance (TA) Telephone Script for non-responders**) by telephone if they are willing. Given the typically low response rate to online assessments, this telephone follow-up strategy increases the responses to the instruments.

In addition, a subset of up to 40 CBA recipients will be asked by email (**Attachment 15: CBA Key Informant Interview Email**) to participate in one qualitative telephone interview. SciMetrika will conduct telephone interviews with those health professionals who agree to participate. SciMetrika will use the CBA Key Informant Interview Script (**Attachment 16: CBA Key Informant Interview Script**) designed to assess CBA consumers' perception about the impact of CBA services on their organizational capacity (e.g., application of knowledge and skills, potential organization changes as a result of CBA services) and to solicit information about how the CBA program can be improved. The CBA Key Informant Interview will collect more qualitative information which will build on the quantitative information collected with the web-based instruments.

All data collection tools have been pilot tested by six public health experts and professionals. 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 instruments.

Items of Information to be Collected

The information collection system consists of four instruments administered to the recipients of CBA services (i.e., training and TA): 1) the Health Professional Application for Training (HPAT) (Attachments 3 and 4); 2) the Training Follow-up Instrument (Attachments 5, 6, and 13); 3) the Technical Assistance (TA) Satisfaction Instrument (Attachments 7, 8 and 14); and the CBA Key Informant Interview Script (Attachment 16). The type of information collected with each instrument is described below.

For the quantitative data collection, web-based administration of the HPAT, Training Follow-up Instrument and the Technical Assistance (TA) Satisfaction Instrument was chosen to facilitate ease of instrument completion for the respondents. For TA and some training where the registration process is not web-based, the HPAT will be administered

by paper. For the qualitative data collection, brief telephone administration of the Key Informant Interviews was chosen as the least burdensome way to collect more in-depth, qualitative information from the respondents about their satisfaction with CBA services and recommendations for improving the CBA program. The CBA Key Informant Interview will only be administered by telephone to a subset of up to 40 CBA recipients to collect more qualitative information.

The Health Professional Application for Training (HPAT)(Attachment 3: Health Professional Application for Training (HPAT) Word version; Attachment 4: Health Professional Application for Training (HPAT)screenshot) (OMB Control No. 0920-0995; Exp. Date: 10/31/2016) has OMB PRA approval for use through two CDC-funded programs, the STD/HIV Prevention Training Centers (PTCs) grantees and the HIV Capacity Building Assistance (CBAs) provider grantees. The HPAT collects information from TA and training participants on their 1) occupations, professions, and functional roles; 2) principal employment settings; 3) location of their work settings; and 4) programmatic and population foci of their work. This data collection provides CDC with information to determine whether the CBA provider grantees are reaching their target audiences in terms of provider type, the types of organizations in which participants work, the focus of their work and the population groups and geographic areas served. The HPAT is used to monitor and evaluate performance of grantees funded by Division of HIV/AIDS Prevention (DHAP) and CDC/Division of STD Prevention (DSTDP) that offer STD and HIV prevention training and TA to STD and HIV prevention health professionals. The HPAT also serves as the single registration form used when PTC grantees collaborate on training activities with training program grantees funded by other HHS agencies (e.g. HRSA, OPA, and SAHMSA) so that participants do not need to complete multiple agency-specific registration forms for each agency participating in a given training activity. This data collection also serves to standardize TA and training registration processes across the two CBA programs (e.g., the PTC program and the CBA provider program) and multiple grantees funded by each program.

The Training Follow-up Instrument(Attachment 5: Training Follow-up Instrument Word version; Attachment 6: Training Follow-up Instrument screenshots; Attachment 13: Training Telephone script) consists of 44 quantitative questions designed to elicit information from CBA consumers about their satisfaction with training and trainers, changes in capacity building outcomes (e.g., changes in knowledge, skills, self-efficacy as a result of training), barriers to implementation, and additional CBA needs. Questions are of various types including multiple response, interval, and two open ended. Effort was made to limit questions requiring narrative responses and include optional narrative questions for respondents to elaborate on their feedback if they choose to do so. The first part of the instrument reminds the respondent of the training or technical assistance received (i.e., training title or TA topic, and date). This information collection instrument will be administered as a web-based instrument. The

information collection instrument was pilot tested by six public health professionals. 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.

The Technical Assistance (TA) Satisfaction Instrument (Attachment 7: Technical Assistance (TA) Satisfaction Instrument Word version; Attachment 8: Technical Assistance (TA) Satisfaction Instrument screenshots; Attachment 14: Technical Assistance (TA) telephone script) consists of 41 quantitative questions designed to elicit information from CBA consumers about their satisfaction with technical assistance (TA) and TA provider, changes in capacity building outcomes (e.g., changes in knowledge, skills, self-efficacy as a result of the TA), barriers and facilitators to implementation, preferences for methods of TA delivery (e.g., phone, email, in-person, etc.), and additional CBA needs. Question types include multiple response, interval, and open ended. Effort was made to limit questions requiring narrative responses and include optional narrative questions for respondents to elaborate on their feedback if they choose to do so. The first part of the instrument reminds the respondent of the TA service received. This information collection instrument will be administered as a web-based instrument. The information collection instrument was pilot tested by six public health professionals. 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.

The CBA Key Informant Interview Script (Attachment 16: CBA Key Informant Interview Script Word version) has 14 open ended questions designed to collect qualitative information to assess the impact of CBA services on organizational capacity (e.g., application of knowledge and skills gained from CBA services, barriers and facilitators to application of knowledge and skills, potential organizational changes as a result of CBA services, dissemination of CBA benefits within the organization) and to solicit information about how the CBA program can be improved. Administered by the project contractor, the CBA key informant interviews will be conducted via telephone with a subset of up to 40 recipients of CBA services. The information collection instrument was pilot tested by six 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

3. Use of Improved Information Technology and Burden Reduction

Web-based versions of the quantitative data collection tools were chosen as much as possible to reduce the overall burden on respondents. Quantitative assessment data will be collected via web-based questionnaires allowing respondents to complete and submit their responses electronically. These information collection instruments were designed to collect the minimum information necessary for the purposes of this project (i.e., limited to a maximum of 44 quantitative questions and qualitative questions). The TA and training registration tool, HPAT, is administered online or by paper depending on whether the registration process is web-based or completed in person. Qualitative information will be collected via key informant interviews conducted by telephone with a sample of up to 40 recipients of CBA services. The CBA Key Informant Interview will collect more qualitative information which will build on the quantitative information collected with the web-based instruments. Careful consideration was given to telephone interview design and length, and layout to minimize respondent burden. The interview was designed to collect the minimum information necessary for the purposes of this project (i.e., limited to 14 questions). Approximately 40% of the collection of information involves the use of automated or electronic processes, such as web-based data collection instruments.

4. Efforts to Identify Duplication and Use of Similar Information

The information being collected is specific to DHAP/CBB's CBA program, the CBA service delivery, and CBA provider grantees. This data collection represents the Branch's initial attempt to assess consumer satisfaction and outcomes for CBA services provided by its CBA provider grantees under its CBA program. There is currently no information available that can substitute for the responses to the data collection instruments and provide program improvement information. This data collection builds on the data already being collected with the HPAT (OMB Control No. 0920-0995; Exp. Date: 10/31/2016) which is already in use by the DSTDP and DHAP/CBB CBA provider grantees.

5. Impact on Small Businesses or Other Small Entities

This data collection will not involve small businesses or other small entities.

6. Consequences of Collecting the Information Less Frequently

This request is for a one time information collection for each episode of CBA service (training or technical assistance) received by each CBA consumer. Each CBA consumer may receive an average of two episodes of CBA service (training or technical assistance) per year, and therefore will respond to an average of two data collections per year. There are no legal obstacles to reduce the burden.

If data are not collected, there will be no systematically obtained information for the CBB to make timely and essential mid-course corrections, if needed, to better meet the needs of its consumers. Specifically, not collecting this information would hinder the Branch's ability to:

- Monitor and assess the PTC and CBA grantee performance;
- Assess the quality of services delivered by CDC-funded CBA providers and CBA partners;
- Identify and address the technical assistance needs of health professionals from health departments, CBOs, and healthcare organizations conducting HIV prevention activities;
- Identify and address programmatic areas of improvement;
- Respond promptly to emerging problems identified through feedback from consumers;
- Provide timely, current, and accurate information in response to requests from Executive Branch officials, the Congress, constituents, or other federal, state, and local agencies on the needs of grantees and the types and quality of CBA services delivered.

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

This request fully complies with the regulation 5 CFR 1320.5.

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

A. The 60-day federal register notice to solicit public comments was published in the Federal Register on 2/24/2015, pages 9724-9725, Vol. 80, Number 36 (**Attachment 2: 60-Day FRN**). No public comments were received. No consultations outside CDC occurred.

9. Explanation of Any Payment or Gift to Respondents

CDC will not provide payments or gifts to respondents.

10. Assurance of Confidentiality Provided to Respondents

The CIO's Information Systems Security Officer reviewed this submission and determined that the Privacy Act does not. Employees of health departments, CBOs, and healthcare organizations will be speaking from their official roles and will not be asked, nor will they provide individually identifiable information.

Of the four instruments, the HPAT tool is the only tool which collects categories of information in identifiable format from individual respondents such as: name, work mailing address, work phone numbers,

work email address, and organization. This identifiable HPAT data are needed to schedule qualitative interviews and for telephone follow-up with respondents who do not complete the online surveys within two weeks. The demographic data are needed to complete registration and conduct training and technical assistance. To remove identifiers from the demographic response data, procedures to limit the linkage of the identifiable data to response data will include entering, storing, and transmitting identifiable HPAT data in a one database and the demographic data in another database. The data transmitted to CDC will be in the delinked format described above. A unique identifier will be used on all data collection instruments to enable the linking of data from multiple data collection tools. The unique identifier consists of first two letters of the first name, first two letters of the last name, month of birth, and day of birth.

There are several safeguards in place to handle data. Data will be stored and managed based on current CDC/OCISO (Office of the Chief Information Security Officer) requirements and standards (**attachment 17**). This includes protecting stored data within the CDC Internet Firewall. The data are stored and managed based on current CDC/OCISO requirements and standards which also includes the process for handling security incidents and the event monitoring and incident response. All administrative controls required by OCISO are validated through a "Certification and Authorization" (C&A) process as conducted by OCISO prior to moving any software application into "Production" on the CDC network.

The system security plan is included in the OCISO C&A process and the contingency (or backup) plan for this information collection, (as mandated by OCISO), is to manage this information from a pre-determined OCISO approved off-site location.

<http://www.cdc.gov/about/leadership/leaders/seligman.htm>.

Files are backed up daily and stored both onsite and offsite in accordance with CDC standards and OCISO guidelines. Contractors who operate and use the system are managed via the "CDC Information Management Services" (CIMS) contract which requires signed confidentiality agreements. All users' access is "role based" and reflects a "need to know" policy established by CDC. Accountability is maintained with a user access log file which tracks users' access to the system. Records will be retained and destroyed in accordance with the applicable CDC Records Control Schedule as mandated by OCISO.

(<http://www.cdc.gov/about/leadership/leaders/seligman.htm>)

(<http://aops-mas-iis.od.cdc.gov/Policy/Doc/policy449.htm>)

No electronic media will be used and no IIF data are collected. A non-research determination was made and therefore, IRB review is not needed (Attachment 18). This data collection is not considered research based on the description and justification and based on the definition of research as defined by the federal policy for the protection of human subjects (45 CFR 46)(Attachment 18).

10.1 Privacy Impact Assessment Information

No sensitive information is being collected. Respondents are participating in their official capacity as health professionals in CBOs, health departments, and healthcare organizations. Consistent with CDC Office of the Chief Information Security Officer (OCISO) requirements and standards, all data collection instrument responses will be stored in a secure database accessible only by the contractor staff and CBB lead on the assessment. Data will be analyzed and reported in aggregate only. Participation in the information collection activities is voluntary for the respondents.

The information collection is voluntary. The following statement is displayed on each of the information collection instruments, "Your responses will be kept secure; results will only be shared in aggregate form. Therefore, CBA providers will not know how you, personally, rated their services. Your participation in the assessment is completely voluntary, and failure to participate will not jeopardize your employment or CDC funding of your organization." Potential respondents are given the opportunity to opt-out of data collection by indicating on the assessments or by not answering the questions. Potential respondents are provided with CBA services regardless of whether they opt-out of data collection.

No individually identifiable information is being collected on three of the four data collection instruments. PII is collected on one instrument, the HPAT, the respondent must complete at least the contact information and basic registration information for training and technical assistance registration (i.e., name, work address, work phone and work email, organization). Also, to obtain continuing education credit, the respondent is required to provide the demographic data. The demographic data are needed to create a transcript or summary of training completed at the participant's request. The data are also needed to generate management reports; to maintain training and accreditation statistics; and to improve CDC training processes and reach. These reports have assisted and will continue to assist CDC with managing its training and technical assistance programs. Personally identifiable information will be filed and retrieved by the name of the individual, and/or the organization for registration or CEU purposes. Aggregate data are used for all reports and publications.

Data on paper forms are kept in locked files in locked rooms, with access limited to staff with a bona fide need to know to perform their official duties. Hard copy forms are shredded after information has been computerized. Data collected on electronic forms are stored on a secured Microsoft SQL Server located behind the firewall.

All data reside behind a strict firewall with security protection. Security provisions for data storage also meet all requirements established by CDC's Health Information System and Surveillance Board (HISSB).

The applicable System of Records Notice is 09-20-0161, "Records of Health Professionals in Disease Prevention and Control Training

Programs," last published in entirety in the Federal Register, Vol. 51, No. 226, November 24, 1986, pp. 42485-87 and last updated in 1994.

11. 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 a pilot test of the information collection instruments by six public health professionals. In the pilot test, the average time to complete the instruments including time for reviewing instructions, gathering needed information and completing the instrument, was approximately five minutes for the HPAT (**attachment 3**), 15 minutes for the Training Follow-up Instrument (**attachment 5**) or the Technical Assistance (TA) Satisfaction Instrument (**attachment 7**), and 15 minutes for the telephone CBA key informant interview (**attachment 16**). Respondents have a choice completing the web-based version of the Training Follow-up Instrument (**attachment 6**) and Technical Assistance (TA) Satisfaction Instrument (**attachment 8**) or the telephone version of these instruments (i.e., Training Telephone Script for non-responders and Technical Assistance (TA) Telephone Script for non-responders). Both versions take 15 minutes to complete. We estimate 3,700 respondents will be surveyed using the Training Telephone Script (**attachment 13**). We estimate having to survey 3,700 respondents using the Technical Assistance (TA) Telephone Script (**attachment 14**). Based on these results, the estimated time range for actual respondents to complete the instruments is 20 minutes most respondents plus an additional 15 minutes for a sample of 40 respondents who also participate in the key informant interview. For the purposes of estimating burden hours, the upper limit of this range (i.e., 30 minutes) is used.

The number of respondents is calculated based on an average of the number of health professionals, including doctors, nurses, health educators and disease intervention specialists, trained by the CBA and PTC grantees during the years 2010 and 2011. We estimate 7,400 health professionals will provide two responses for the HPAT; and 3,700 health professionals will provide two responses per instrument for each episode of training or technical assistance they participate in on an annual basis. The total annualized burden hours is 8,643. The following table shows estimated burden.

Table 12A: Estimates of Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
Healthcare	Health	7,400	2	5/60	1233

Professionals	Professional Application for Training (HPAT)				
Healthcare Professionals	Training Follow-up Instrument	3,700	2	15/60	1850
Healthcare Professionals	Training Telephone Script	3,700	2	15/60	1850
Healthcare Professionals	Technical Assistance (TA) Satisfaction Instrument	3,700	2	15/60	1850
Healthcare Professionals	Technical Assistance Telephone Script	3,700	2	15/60	1850
Healthcare Professionals	CBA Key Informant Interview Script	40	1	15/60	10
Total					8,643

Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) National Compensation Survey estimate for management occupations - medical and health services managers in state government (<http://www.bls.gov/ncs/ocs/sp/nctb1349.pdf>). Based on DOL data, an average hourly wage of \$57.11 is estimated for the respondents. The following table shows estimated burden and cost information.

Table 12B: Estimated Annualized Burden Costs to Respondents

Type of Respondent	Form Name	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
Healthcare professionals	Health Professional Application for Training	1233	\$57.11	\$70,417

	(HPAT)			
Healthcare professionals	Training Follow-up Instrument	1850	\$57.11	\$105,653
Healthcare professionals	Training Telephone Script	1850	\$57.11	\$105,653
Healthcare professionals	Technical Assistance (TA) Satisfaction Instrument	1850	\$57.11	\$105,653
Healthcare professionals	Technical Assistance (TA) Telephone Script	1850	\$57.11	\$105,653
Healthcare professionals	CBA Key Informant Interview Script	10	\$57.11	\$571
Total				\$493,600

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

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

14. Annualized Cost to the Government

There are no equipment or overhead costs. The only cost to the federal government would be the salary of CDC staff and contractors supporting the data collection activities and associated tasks.

Annually the estimated cost of the assessment is \$726,734. The personnel cost of the CDC oversight of the project and contractors will be \$23,468 for the Lead Behavioral Scientist. The cost of the Scimetrika contractor to provide assistance in the preparation of the OMB package, assessment design, instrument development, data collection, quality control, data analysis, and report preparation will be \$604,840. The cost for Acentia contractor to provide the development and programming for the web-based information collection and data transmission to CDC and SciMetrika will be \$44,226. For a cost of \$54,200, Danya International contractor will provide training registration and data collection and tracking. Information collection tools were prepared by CDC staff (FTE) and the SciMetrika contractor. An FTE manager reviewed all information collection tools. A senior

level FTE reviewed and approved the activities. Table 14 describes how this cost estimate was calculated.

Table 14: Estimated Annualized Cost to the Federal Government

Staff (FTE)	Average Hours per Collection	Average Hourly Rate	Average Cost
Lead Behavioral Scientist (GS-14): OMB package preparation; review and oversight of assessment design, instrument development, pilot testing, data collection, quality control, data analysis and report preparation	400	58.67	23468
Acentia contractor: Web-based information collection instrument programming, data collection			44226
SciMetrika contractor: OMB package preparation, assessment design, instrument development, pilot testing, data collection, quality control, data analysis, and report preparation			604840
Danya International contractor: training logistics, data collection and tracking.			54200
Estimated Total Cost of Information Collection			726734

15. Explanation for Program Changes or Adjustments

This is a new information collection.

16. Plans for Tabulation and Publication and Project Time Schedule

Both quantitative and qualitative analyses will be performed. Prior to conducting any formal analyses on quantitative data, exploratory univariate and bivariate tests will be performed first to determine trends and patterns in the data. This will be accomplished using frequencies and cross-tabulations, and by examining univariate distributions and correlations. The frequency analysis will give various chi-squared tests for association for categorical ordinal or nominal data, while the ANOVA will provide F-tests for continuous data. We will also take into account input from DHAP experts, the SciMetrika contractor, and the literature to include variables that have exhibited previous associations with the outcome.

Qualitative data include open-ended responses within the web-based information collection tools, as well as the findings from key informant interviews. Open-ended responses in otherwise categorical

questions within the information collection instruments (e.g., “Other, please specify”) will be abstracted and grouped by thematic categories, and analyses will be used to determine the frequency of categories. Key informant interview analysis will be an iterative process geared toward providing recommendations for the improvement of CBA program and service delivery. It will be informed by grounded theory and principles of content analysis, including constant comparative method. SciMetrika will develop a codebook and will train coders in order to ensure coder agreement. SciMetrika will apply structural codes to the transcripts and will generate code reports from which primary and secondary codes based on emerging themes will be developed. Primary and secondary coding will then be applied to the transcripts. Matrices based on codes may be generated in MS Excel to further develop analyses.

The results of this assessment will be shared internally with CDC/DHAP leadership and CBB staff as well as externally with CBB’s CBA provider grantees. The results will be used by CBB and its grantees for continuous quality improvement of CBB’s CBA services and products and to improve program processes and operations. CBB staff will receive annually a more detailed summary report of the yearly findings. By September 2016, a report summarizing all cumulative years of data collection will be shared with CDC/DHAP leadership and CBB staff as well as externally with CBB’s CBA provider grantees.

In addition to CBB staff, each CBA provider grantee will get a personalized summary of the assessment findings for the CBA services provided by its organization as well as a summary of the overall CBA program each year. The CBA provider grantees will use this information to identify strengths and areas of improvement for their CBA service delivery. No respondents or respondent organizations will be identified in any reports.

Table 16: Project Time Schedule

Collect, code, enter, quality control, and analyze data	Upon OMB approval - three years
Prepare report	12 months after OMB approval to 36 months
Disseminate results/reports	12 months after OMB approval to 36 months

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

The display of the OMB expiration date is not inappropriate

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

REFERENCE LIST

The White House. "National HIV/AIDS Strategy for the United States." Available at http://www.cdc.gov/hiv/pdf/policies_nhas.pdf. Accessed on 12/22/14

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