

National HIV Prevention Program Monitoring and Evaluation (NHM&E)  
Data

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**REVISION**

Supporting Statement A

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- The goal of the National HIV Prevention Program Monitoring and Evaluation (NHM&E) Data is to monitor and evaluate HIV prevention programs funded by the Division of HIV/AIDS Prevention (DHAP) at the Centers for Disease Control and Prevention. This includes, but is not limited to, HIV Testing, Partner Services, Risk Reduction Activities.
- The data will be analyzed to produce multiple reports for stakeholders, including reports to Congress and the White House, State Health Departments, other grantees, and the public. These reports will be used to make funding decisions, better target resources and efforts, improve service delivery, and make HIV prevention more effective.
- Grantees will report data on all HIV prevention programs funded by DHAP. Data will be submitted through the EvaluationWeb® reporting software provided to each grantee.
- The populations to be studied are the grantees receiving HIV prevention funding from DHAP.
- All grantees report all data; no sampling is involved. Data will be analyzed in multiple ways, including comparing grantees to national goals and to average, determining trends over time, geographical distribution, etc.

## **Section A. Justification**

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

The Centers for Disease Control and Prevention requests a revision to OMB approved data collection 0920-0696 (expiration date 03/31/2016) entitled, "National HIV Prevention Program Monitoring and Evaluation (NHM&E) Data," for a period of 3 years.

This ICR covers the collection of standardized program monitoring and evaluation data from all organizations funded by CDC, directly or indirectly through health department funding under all program announcements to conduct HIV prevention

programs. This ICR also covers all data collection for special monitoring and evaluation projects that provide additional funding for expanded data collection using the approved variables. This is to include all types of HIV prevention programs, including but not limited to, Risk Reduction Activities (RRA) (which includes Health Education/Risk Reduction, Health Communication/Public Information, Community-Level Interventions, and Outreach), Partner Services, HIV Testing (and associated Counseling and Referral), and other CDC-funded HIV prevention programs. This ICR does not cover HIV disease surveillance or research into biomedical interventions or the efficacy of new behavioral HIV prevention programs, which are covered under separate ICRs. A review of the current OMB-approved CDC HIV data collections shows that no other approved data collection collects program monitoring and evaluation data on CDC-funded HIV prevention programs currently being conducted by health departments and CBOs.

The revision of the currently approved data collection is intended to adjust the data collection to meet the monitoring and evaluation needs of new CDC HIV prevention goals developed in response to the White House National HIV/AIDS Strategy (NHAS) and "High Impact Prevention". There are also adjustments to streamline data collection and account for changes in HIV prevention technology and policy.

The NHM&E data are a set of standardized variables to assist Health Departments and Community-Based Organizations (CBOs) in monitoring and evaluating their activities to help them develop, deliver, and refine successful HIV prevention interventions. These data are also used to report key program performance indicators to CDC to show whether the programs implemented or supported are efficient and effective in achieving their stated goals. NHM&E data supply program managers with service-level information regarding intervention processes (e.g., who delivered what to whom, how many, where, and when) and client-level information (e.g., client demographics, behavioral risk factors, exposure to services, verified referrals into other services, and changes in risk-behaviors for selected interventions) for monitoring and enhancing local HIV prevention programs. Much of these data are collected by CBOs and HDs using locally developed forms as part of their usual business process.

NHAS specifies goals and objectives for HIV prevention in the United States. In response to these new goals, the CDC Division of HIV/AIDS Prevention developed a strategic plan that focuses on high-impact prevention, treatment as prevention, and use of new testing and prevention technology. As these plans are implemented through changes to requirements in funding announcements, the NHM&E variables needed to be modified to monitor and evaluate the changed requirements

These changes in requirements have been incorporated into several recent funding opportunity announcements (FOAs). For example, the flagship FOA for Community-Based Organizations, 15-1502, began in July 2015. The next flagship FOA for health departments is currently being written and will be awarded in 2016. This revision is to modify the currently approved NHM&E variables in order to monitor and evaluate these FOAs and other FOAs for the territories and various disproportionately affected minority groups. These revisions are also needed to continue monitoring interventions that are critical to NHAS. Data collected and reported will be used to inform progress toward meeting goals and objectives of the NHAS.

CDC is requesting to adjust the variables by deleting some of the client-level variables related to determining risk factors during the HIV Testing process and replacing these variables with aggregate testing variables that have previously been reported by grantees as part of their progress reports. This will streamline and simplify data submission for the grantees. The other significant change is to add budget allocation data variables for CBOs but offset that addition with reductions in client-level variables and conversion of some variables to aggregate-level reporting. There are other minor changes in variables and values to adjust to new technologies and interventions and to improve reporting related to linkage to care and retention in care for

HIV positive persons **Attachment 10**. The net result is no change in the grantee reporting burden. The revised variable set is in **Attachment 5**.

The CDC currently funds HIV prevention programs in all state and territorial health jurisdictions (including the Pacific Island territories), 9 city health departments, and approximately 150 CBOs through cooperative agreements. These numbers of grantees vary over time and, as noted, may increase, and some grantees may be funded under more than one program announcement. To allow for an estimated maximum number of grantees, as in the last ICR, we have calculated the burden based on up to 200 CBOs.

These HIV prevention programs conduct interventions to reduce HIV-related behaviors in targeted populations. Monitoring and evaluation of these HIV prevention programs are essential for strengthening CDC's overall monitoring of HIV/AIDS prevention. Consequently, accurate and reliable program process and outcome monitoring and evaluation data must be collected. The CDC depends on the NHM&E variables for standardized data from all grantees to adequately monitor program performance at both the local and national levels.

In addition, the President's Management Agenda requires all federally funded grantees to report key program performance indicators as a method for demonstrating accountability. The CDC HIV prevention program performance indicators include the



grantee's capacity to deliver and monitor prevention services, the implementation of these processes, and outcomes associated with HIV prevention program activity. The grantees and CDC will use performance indicators to show that the programs they implement or support are efficient and effective in achieving their stated HIV prevention program goals and objectives. HIV prevention program performance indicators are calculated using data included in this ICR for NHM&E data.

The NHM&E data make possible national program evaluation; performance indicator calculation; accountability reporting to Congress, the administration, and other HIV prevention program stakeholders; and informed decision-making about funding and HIV prevention. These data will be used for planning and monitoring the delivery of prevention services to clients, implementing and improving HIV prevention programs, and reporting the required program performance indicators. Additionally, NHM&E data will enable CDC to provide valuable feedback to these programs and to better account for the use of HIV prevention resources. All funded health jurisdictions and CBOs, under any and all CDC HIV prevention program funding, will be required to submit the NHM&E data.

Collection of these data is authorized under Section 306 of the Public Health Services Act [42 U.S.C. 242(k)] (**Attachment 1**). Respondents are required to submit NHM&E data semiannually and

are accountable for conducting monitoring and evaluation of major HIV prevention program activities and services, including data collection on interventions provided and clients served. CDC may place conditions or restrictions on the award of funds to respondents that fail to meet these requirements.

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

The NHM&E data variables provide a comprehensive, yet parsimonious, standardized set of program data variables essential to monitoring and evaluating HIV prevention programs. As program evaluation, the results of analyses of NHM&E data are not generalizable (i.e., it is not possible to induce or derive a general conclusion or principle about all HIV prevention from the particulars of the evaluation of a particular grantee's activities). Moreover, given the variety in implementation of HIV prevention interventions among health departments and CBOs, when used for assessing outcomes associated with CDC-funded HIV prevention program activities, the results of analyses of NHM&E data will not be generalizable. However, the NHM&E data enable CDC to track program activity, identify best practices, and assist grantees in redesigning interventions that do not accomplish stated goals, such as the reduction of high-risk behaviors in targeted populations. CDC has used the NHM&E data received to date, in combination with surveillance and research data, for the following purposes:

- Publish annual reports on HIV testing at the national and jurisdiction levels, including HIV positivity rates
- Disseminate rapid feedback reports to the grantees showing progress toward NHS goals, grantee comparison to national averages, and grantee comparison to other grantees
- Disseminate Division of HIV/AIDS Prevention updates on data quality, geographic distribution of prevention activities, and reach to targeted groups, etc.
- Assess CDC HIV budget allocations with respect to prioritized risk populations at the jurisdiction level
- Publish peer-reviewed articles on the fidelity of delivery and effectiveness in the field of Evidence-Based Interventions disseminated by CDC
- Identify gaps in HIV prevention service provisions
- Respond to data requests from Congress, the administration, HIV researchers, and other interested parties
- Assess the extent to which HIV prevention programs have reached their target population
- Highlight opportunities to strengthen collaboration among CDC, its prevention partners, and other federal agencies
- Assess the annual performance of CDC and its grantees in meeting priority goals and objectives
- Produce other standardized and specialized reports in EvaluationWeb to inform grantees, CDC project officers, and

other stakeholders of the status and trends of a host of process, outcome, impact, and accountability measures. Reports include reports for quality assurance, comparison of planned activities to actual activities, data for calculating required performance indicators, and data on specific interventions. These types of reports are available on the grantee, jurisdiction, and national level.

The NHM&E data variables have been developed with extensive input from respondents (representatives of health jurisdictions and community-based organizations), other HIV prevention partners, and the leadership of the Division of HIV/AIDS Prevention (NCHHSTP/CDC). See **Attachment 4** for a list of external organizations and persons who provided input to the development or modification of the NHM&E variables during the past three years. The data variables are based on HIV prevention business processes and sound scientific approaches to HIV prevention. Specifically, the NHM&E data variables cover a range of HIV prevention activities such as agency information, HIV testing, partner services, and a range of risk reduction activities including health communication/public information activities and community-level interventions.

Collection of the NHM&E data will supply program managers with service-level information regarding intervention processes (e.g., who delivered what to whom, how many, where, and when) and

client-level information (e.g., client demographics, behavioral risk factors, exposure to services, verified referrals into other services, and changes in risk-behaviors for selected interventions) for monitoring and enhancing local HIV prevention programs. See **Attachment 5** for the NHM&E data variables and values. See **Attachment 3** for a sample of the EvaluationWeb Home Page.

Without these data, CDC would be unable to determine what is being done with the funding it provides, what populations are being served, what services are being provided, or which programs are having the most effect in preventing HIV. It would be unable to account to the administration, Congress, or other stakeholders for the proper use of public money or provide transparency for the programs it funds.

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

Each respondent will determine how data are to be collected. There are no required forms or other data collection instruments. For some types of data, CDC provides optional, modifiable data collection templates that grantees change and adapt for their own procedures and additional, local data needs. Many grantees use their own data system and extract data in specified formats for upload into EvaluationWeb®.

For grantees who choose to key enter data directly into the EvaluationWeb® system, grantees are allowed to customize the system within specified limits to include data for local use that is not reported to CDC. In addition, the system is set up by an administrator who specifies the type of funding received from CDC, the prevention programs that funding supports, and other default information that automatically modifies what appears on data entry screens in order to simplify data entry. Moreover, some directly funded CBOs enter all of their data, in addition to their HIV Testing data, into their jurisdiction's Health Department instance of the system, but the data required from CBOs directly funded by CDC is slightly different from what is asked of CBOs who are funded by jurisdiction health departments using CDC funds, so the system adjusts the data entry screens for CBOs based on the type of funding. The result of this automatic modification of data entry screens to match the unique situation of each grantee is that there is not a standard set of data entry screens, but rather hundreds of possible variations of system screens that adjust to the needs of the specific grantee.

All NHM&E data are to be submitted to CDC electronically. While grantees may collect the data by whatever means they choose, data must be submitted to CDC electronically from EvaluationWeb® using the Secure Socket Layer/Transport Layer

Security. Grantees are given the option of using their own software system to collect NHM&E data and uploading to EvaluationWeb® or key-entering data directly into the CDC-provided EvaluationWeb® software. Grantees who use their own software must collect the standardized NHM&E data and then convert those data into one of several CDC-specified formats for upload to EvaluationWeb®. Grantees who choose to enter data directly into EvaluationWeb® are provided a free, browser-based, secure electronic mechanism for collecting and reporting the standardized NHM&E HIV prevention program data. The data from both sources is checked for quality and conformity to NHM&E requirements by the contractor before being compiled into analyzable databases and submitted to CDC.

The optional EvaluationWeb® software application was designed with input from representatives of health jurisdictions, community-based organizations, and other HIV prevention partners. The EvaluationWeb® software was designed to combine agency, intervention, and client data into one system. This integrated system reduces the burden of entering client data separately by intervention and allows for enhanced flexibility in monitoring and analyzing data across a range of HIV prevention activities.

Data variable business rules have been built into the EvaluationWeb software application to enhance the reliability and integrity of the data. These business rules establish the

interrelationships among variables and serve as system performance checks for accurate data entry. CDC grantees gain access to EvaluationWeb® after authentication of user identities.

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

Efforts to identify duplication of NHM&E data include the assessment of existing or previously used HIV prevention data collection systems used by CDC, other federal agencies, as well as health department jurisdictions and community-based organizations. It should be noted that because the NHM&E data reporting requirements are specific to CDC-funded HIV prevention activities, the only possible duplication is if other federal or state organizations or entities are also funding the same HIV prevention activities to be performed by the same grantees.

Within CDC, the only duplication of data elements and grantees is in the STD Management Information System (MIS) developed by CDC/NCHSTP/DSTDP and used by some state health jurisdictions in collaboration with HIV prevention programs to collect Partner Services (PS) data. The data collected on STD/MIS have been modified to match NHM&E data for those items related to HIV PS so that funded state or city health departments have the option of using EvaluationWeb®, STD/MIS, or their own system to collect PS data. Other STD/MIS data are not reported to CDC, except for morbidity data, which are reported through the NETSS system. The STD/MIS collects additional information



outside the purview of HIV prevention. Only NHM&E Partner Services data collected in STD/MIS are reported to CDC as part of the NHM&E data collection. In addition, the STD/MIS system is being phased out, replaced by an optional PartnerServicesWeb software that became available in 2013 that grantees may choose to use to collect Partner Services data. Grantees may also choose to use their own data collection system. In either case, only the required NHM&E data will be uploaded to EvaluationWeb for submission to CDC.

In addition to systems at CDC, other federal systems were reviewed. Specifically, consultations were held with the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to identify and match similar data elements to avoid duplication. Given that HRSA and SAMHSA do not collect detailed HIV prevention program data, very few similarities were identified. The only overlap detected was in the collection of HIV testing data, and SAMHSA determined that they would use the NHM&E HIV testing data variables to collect data from their grantees. SAMHSA submitted a separate ICR for this data collection. The burden for the SAMHSA data collection is not included in the burden calculations for this ICR.

If the number of new HIV infections is to be reduced, the quality of HIV prevention programs designed to reduce high-risk

behaviors in persons most likely to acquire or transmit HIV must be improved. The NHM&E data significantly advance the monitoring and evaluation of HIV prevention programs by providing national, standardized information. Using standardized data will allow CDC to evaluate programs on national and regional scales and to compare programs providing similar services or targeting similar populations. On the local level, use of the standardized NHM&E variables will enhance the capacity of HIV prevention programs to thoroughly assess and refine their HIV prevention interventions and to identify unmet needs and redundancies while providing accountability to their stakeholders.

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

State health department jurisdictions and community-based organizations that receive CDC funding for HIV prevention vary greatly in size and in their capacity to collect and report the NHM&E data. Some of them would qualify as small businesses or other small entities. The NHM&E variables represent a set of data with sufficient detail to monitor and improve client outcomes, service delivery, and program design and implementation. In addition, collection of the data will enable agencies to meet their program indicator reporting mandates. Required NHM&E data variables have been kept to a minimum, and thus all respondents will be expected to complete the required data. Moreover, the

cost of collecting and reporting this data are included in the CDC funding to all grantees. For small organizations, collection and use of these data are essential to maintaining and improving their HIV prevention activities. When faced with limited resources, these agencies will have the data needed to defend and make the case for expanding existing programs, thereby ensuring continued service delivery to populations in need.

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

Respondents are required to submit data to the CDC on a semiannual basis. Less frequent data submission would result in a lag time between the occurrence of program problems and their identification. This lag time could result in costly program inefficiencies, defects, and failures to continue or worsen without a timely opportunity for CDC to provide valuable assistance and corrective measures to agencies funded to prevent the spread of HIV. There are no legal obstacles to reducing the burden.

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

This request fully complies with the guidelines of 5 CFR 1320.5.

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

A 60-day notice to solicit public comments was published in the *Federal Register*, 04/21/2015, Volume 80, Number 76 pages 22197-8. See **Attachment 2** for a copy of the *Federal Register* notice. CDC received no comments.

CDC developed the NHM&E data variables with feedback from state, territorial, and local health jurisdictions and CBOs. Developing the NHM&E data variables has been a long and collaborative process. There was extensive consultation on revisions to the variables during a series of advisory panel and all-grantee webinars held during 2012. A detailed listing of agencies and persons consulted during consultations, web-conference, workshops, etc. is found in **Attachment 4**. Representatives from funded agencies continue to be informed through monthly phone calls and e-mail correspondence. Additional consultations, workshops, and web-conferences will occur as needed.

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

No payments or gifts will be provided to respondents.

**10. Assurance of Confidentiality Provided to Respondents**

All NHM&E data is covered by a CDC Assurance of Confidentiality specific to NHM&E data under the Public Health Services Act 308(d), as well as state confidentiality laws.

Health jurisdictions may collect identifiers (name, address, etc.) on clients who receive HIV prevention services, including HIV testing. The Privacy Act is not applicable to the client-level data because the information will become a part of the health department jurisdictions' already established record systems; moreover, its availability and use will be limited to the provision of services at the local level.

#### IRB Approval

This data collection has been determined not research involving human subjects. Therefore, IRB approval is not required.

#### **10.1 Privacy Impact Assessment Information**

CDC provides EvaluationWeb®, an HIV prevention program data collection and reporting software system operated by Luther Consulting, LLC. EvaluationWeb® is an electronic, secure, browser-based software application designed to provide the necessary mechanism for collecting and reporting standardized, sensitive HIV prevention data.

The EvaluationWeb® application uses Secure Sockets Layer (SSL) between web-browser clients and the web server that accepts data from users. Each of these SSL sessions employs the same type of encryption used by all major financial services and electronic commerce sites today. Thus, from a user's perspective, sensitive

information is encrypted from the time it leaves the PC to the time it is stored in the database.

EvaluationWeb® also supports persistent encryption of specific data variables (identified as sensitive by the CDC) using the 3DES algorithm. This algorithm is also known as Triple DES, employs a 168-bit encryption key, and is FIPS 140-2 compliant. Thus, in addition to being encrypted with SSL during transit, some information remains encrypted within the database, visible only to the agency that entered it. The process for handling security incidents is defined in the system's Security Plan. Event monitoring and incident response is a shared responsibility between the system's team and the Office of the Chief Information Security Officer (OCISO). Reports of suspicious security or adverse privacy-related events should be directed to the component's Information Systems Security Officer, CDC helpdesk, or to the CDC Incident Response Team. The CDC OCISO reports to the HHS Secure One Communications Center, which reports incidents to US-CERT as appropriate. The EvaluationWeb® system has passed the full Certification and Accreditation Process and has an authority to operate (ATO) until July 14, 2016 (**Attachment 7.**) This means that our security measures meet the requirements of the NIST 800-53, HHS, and CDC.

About half the health department jurisdictions maintain their own electronic data collection systems and upload data from

their systems into EvaluationWeb®. The other health departments and almost all community-based organization (CBO) grantees key-enter data directly into EvaluationWeb®. CDC grantees gain access to EvaluationWeb® through a secure internet connection, which requires electronic authentication of the users and maintains data confidentiality and security. All data, from all systems, are submitted electronically, using approved encryption. Access is limited to appropriate grantee and CDC staff. Cookies are not used. Grantees are required to certify that they comply with the NCHHSTP Security and Confidentiality Guidelines (see **Attachment 6**).

Information about agencies and programs is required as part of the Program Announcement. Information about clients is collected by the agencies as part of their routine data collection, and clients are informed of any consent required by the agency or state regulations. Whether data is uploaded to EvaluationWeb using CDC-specified formats or directly entered into EvaluationWeb, no IIF is submitted to CDC. Each individual client record will be identified by a randomly generated unique key that is linked to a particular agency and state. This key is maintained in EvaluationWeb, but only at the local level can the client key be re-linked to identifiers.

Program data accessible by CDC will not contain client names, but will include "sensitive" information such as client

demographics (age, gender, race, pregnancy status, HIV status, risk behaviors, etc.) and exposure characteristics. Information in Identifiable Form (IIF), such as name, address, birthday, etc., may be collected by the health department or CBO working with the individual for purposes of local program activity such as case management, but no individually identifiable information will be submitted to CDC. Data will be transmitted to CDC from Luther Consulting over the Internet using Secure Socket Layer/Transport Layer Security (SSL/TLS software to encrypt data between EvaluationWeb and CDC).

#### **11. Justification for Sensitive Questions**

Some of the client-level data to be collected are highly sensitive. HIV can be transmitted from person to person through sexual contact and the sharing of HIV contaminated needles and syringes. These modes of transmission necessitate the collection of sensitive data regarding sexual practices as well as alcohol and drug use. Because collection of these data will be used to provide improved HIV prevention services to high-risk populations, to enhance HIV prevention programs at the local level, and to reduce high-risk behaviors in persons most likely to acquire or transmit HIV, specific information about client demographics and client risk profiles is essential to designing appropriate interventions and programs and to monitoring and evaluating these programs.



This data collection also includes race and ethnicity questions, which may also be viewed as sensitive by some respondents, for use in data analysis (e.g., designing and evaluating programs, as discussed above).

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

The estimates for the number of annualized burden hours are provided in the table below. The calculations on which these estimates are based are provided in Attachment 8. There are two types of organizations that are required to provide data. The first is State, Territorial, and directly funded local health departments, whose burdens are summarized in the burden table. There are 69 health jurisdictions and the data required by respondents for this ICR include variables for the following NHM&E data sets:

- Agency Data
- Health Education and Risk Reduction (RRA) Data
- HIV Testing Data
- Partner Services (PS) Data

The numbers on the burden table (Table A.12-A) are estimates since new program announcements may alter the number and types of services provided at any time. All health departments will also receive training on NHM&E, as noted in the burden table.

The second type of organization providing information is community-based organizations (CBOs). CBOs conducting HIV testing report their data through their jurisdiction health department, so CBO testing burden will be calculated as part of health department burden. Also, CBOs generally do not conduct Partner Services beyond identifying index cases, so that burden will also be incorporated into the burden for health departments. CBO burdens for agency data and RRA are summarized on the table.

The calculations for annualized burden are derived from the health department and CBO time needed to search the EvaluationWeb® database for existing records, gather and maintain the data, complete the collection of records, and review the information prior to submission to CDC.

The annual NHNM&E data reporting burden is summarized in the following table. For simplicity, the burdens for Agency Data and for RRA data (and for PS data for health departments) have been combined since all agencies report these data.

**Table A.12-A. Estimated Annualized Burden Hours**

Type of Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per response (in hours)	Total Burden Hours
Health jurisdictions	Health Department Reporting (att 5)	69	2	1377	190,026
Community-Based Organizations	Community-Based Organization Reporting (att 5)	200	2	40.5	16,200

<b>Type of Respondents</b>	<b>Form Name</b>	<b>Number of Respondents</b>	<b>Number of Responses per Respondent</b>	<b>Average Burden per response (in hours)</b>	<b>Total Burden Hours</b>
<b>Total</b>					206,226

The total estimated annualized hourly burden anticipated for all data collections would be approximately 206,226 hours. A total 206,226 burden hours per year were approved under the existing ICR covering August 31, 2013 – March 31, 2016. We are continuing to work with the grantees to keep the burden to a minimum while still obtaining the data necessary for national reporting and program management.

## B. Annualized Cost to Respondent

The collection and reporting of NHM&E data are part of the activities specified in the HIV prevention program announcements as part of the funded activities. Any expense incurred collecting and submitting the NHM&E data, above the routine collection of data required to conduct business, is supported by CDC funding. There is no actual cost to the respondent.

The estimated cost to be supported by CDC funding is as follows. Based on a review of salaries reported by eight health department jurisdictions representing a range of sizes and HIV prevalence in their funding applications, it is estimated that health jurisdiction staff who collect NHM&E information will be paid about \$54,000 annually. Based on the OMB Pay Tables for the Atlanta area, comparable annual salary for Federal General Schedule (GS) employees is that of a GS-9 step 3 (\$53,949 annually or \$25.85/hour).

Based on a review of salaries of HIV prevention staff at eight CBOs of various sizes reported in funding applications, the average salary is about \$38,500 annually. Comparable annual salary for Federal General Schedule (GS) employees is that of a GS-6, step 2 (\$38,450 annually or \$18.42/hour).

**Table A.12-B. Annualized Cost to Respondents**

Type of Respondents	Number of Respondents	Form Name	Number of Responses per respondent	Average Burden per Response (in hours)	Hourly Wage Rate	Total Respondent Cost
Health jurisdictions	69	Health Department Reporting (Att 5)	2	1,377	\$25.85	\$4,912,172
Community-Based Organizations	200	Community-Based Organization Reporting (Att 5)	2	40.5	\$18.42	\$298,404
					TOTAL	\$5,210,576

Source:

<http://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2015/ATL.pdf>

See Attachment 8 for calculation of Average Burden per Response.

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

There are no costs to respondents that are not supported by CDC funding under the program announcement beyond usual and customary business practices that would be carried out even if NHM&E data collection were not required. The conditions of the cooperative agreements that CDC awards for HIV prevention programs require recipients to conduct evaluation of major program activities, interventions, and services, including data collection on interventions and clients served. Program announcements specify that a portion of the funding is to be used

for evaluation activities, including data collection. Although the data previously collected by health jurisdictions and CBOs varied widely from state to state and program to program, it is the usual and customary business practice of the grantees to gather and maintain HIV prevention program data, complete the collection of records, and review the information prior to submission to CDC. Since the collection of data is a routine and customary practice, grantees that collect NHM&E data should incur little or no net additional costs to respond to this data collection.

Overall, respondents may choose one of the following options in which to enter and submit the required NHM&E data variables:

- 1) Directly key-enter data into the EvaluationWeb software provided by CDC at no cost to the respondent
- 2) Revise their existing HIV prevention information technology system and upload the required NHM&E data in one of the allowed formats into EvaluationWeb

Services offered to the grantees by CDC to support NHM&E data collection include training, technical assistance, and continued support to grantees through a help desk, website, and various forms of correspondence. Implementing the EvaluationWeb software will require no start-up costs for the respondents.

Release of various EvaluationWeb software versions will be necessary over time, but it is anticipated that EvaluationWeb®

and the NHM&E data variables will be essential tools for monitoring and evaluating HIV prevention programs for many years and there will be no cost to the grantees for these updates.

#### **14. Annualized Cost to the Federal Government**

The NHM&E data collection is a multi-year project expected to be in use for many years. For the purposes of this submission, a three year life expectancy has been used to estimate the annualized cost to the government.

CDC supports costs for HIV prevention program cooperative agreements using funds budgeted for these purposes. Additional expenses will be incurred by CDC for training grantees, providing technical assistance, monitoring and analyzing the submitted NHM&E data, and generating assorted reports. Total costs for these activities, using the Atlanta locality salary schedule, are estimated at \$804,211 annually (see table below).

Training for grantees is currently available online and is being revised to reflect these revised data requirements. Instruction will include topics such as confidentiality and computer security, evaluation principles, and use of data for program improvement. The base Federal General Schedule (GS) salary for full-time employees (FTEs) with experience in these areas is estimated to be a GS-13 step 9. It is expected that the equivalent of two FTEs paid \$52.94/hour will each expend

approximately twenty-five percent (25%) of their time or 1040 hours/FTE annually to oversee these trainings.

Technical assistance will be provided through an e-mail and telephone service center overseen by a CDC FTE. It is expected that the equivalent of two GS-13 step 9 (\$52.94/hour) FTEs will expend approximately twenty-five percent (25%) of working hours (1040 hours) to oversee this service center.

Monitoring, analyzing, and reporting the NHM&E data are projected to require the expertise of the equivalent of two data managers and six data analysts. The data managers would be at the pay scale of GS-13 step 5 (\$47.36/hour) and the data analysts would be at the pay scale of GS-12 step 5 (\$39.83/hour).

**Table 14.A Annualized Cost to the Government**

<b>Employee Function</b>	<b>Annual Burden (in hours)</b>	<b>Hourly Wage Rate</b>	<b>Annual Cost</b>
Training	1,040	\$52.94	\$ 55,057.60
Technical Assistance	1,040	\$52.94	\$ 55,057.60
Monitoring, Analyzing and Reporting	4,160 (Data Managers)	\$47.36	\$197,017.60
	12,480 (Data Analysts)	\$39.83	\$497,078.40
<b>TOTAL ANNUAL FEDERAL GOVERNMENT COSTS:</b>			<b>\$804,211.20</b>

Source: <http://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2015/ATL.pdf>

**15. Explanation for Program Changes or Adjustments**



This is a program change of a currently approved data collection. The burden approved in 2013 was 206,226 hours. We currently request approval for 206,226 burden hours.

The costs above the normal cost of doing business are covered by the CDC funding rather than imposing a financial cost on the grantee. All of these data collections will be part of HIV prevention programs funded by CDC so that even the hours spent collecting the data are part of the CDC funded activities, so, in effect, there is no burden. These activities should be made visible to OMB through the normal program announcement approval process, so that OMB is aware of the programs that are covered under this ICR.

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

Data are being collected under the existing approved ICR, and is anticipated to continue semiannually for the 3 year requested approval period without interruption if this ICR is approved.

Analysis is focused on improving program monitoring, conducting national analysis of HIV prevention programs, identifying needs for prevention research and evaluation studies, and responding to data requests from Congress and the Executive Branch. All of these activities are currently in process. Annual

reports on the data, starting with reports on the 2009-1010 data, have been produced or are in production for more recent years. NHM&E data will also be analyzed in conjunction with data from other Division of HIV/AIDS Prevention (DHAP) collection systems for enhanced monitoring of the HIV epidemic.

In addition, NHM&E data is being used to improve knowledge of local prevention practices, implementation of effective HIV prevention interventions, adherence to program reporting requirements, and compliance with the National HIV/AIDS Strategy. Reports generated by the system include reports for quality assurance, comparison of planned activities or expenditures to actual activities or expenditures, data for calculating required performance indicators, data on specific interventions, data for contract monitoring, and data for assessing needs. These types of reports are available on the grantee, jurisdiction, or national level.

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

Not applicable.

**18. Exceptions to Certification for Paperwork Reduction Act (PRA) Submissions 5CFR 1320.3(h)(1)-(10)**

There are no exceptions to the certification.