

Colorectal Cancer Control Program (CRCCP) Monitoring Activities

REINSTATEMENT WITH CHANGE

Supporting Statement – Section A

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- Goal of the study. The goal of this information collection is to systematically collect information about the implementation and outcomes of the CRCCP, a program including 31 grantees.
- Intended use of the resulting data. CDC will use resulting information to monitor the implementation of CRCCP activities and evaluate outcomes achieved across all grantees.
- Methods to be used to collect information. CDC will conduct an annual grantee survey and collect clinic-level information from grantees' health system partners.
- The subpopulation to be studied. The subpopulation for the grantee survey is the 31 CRCCP Program Managers/Program Directors. Clinic-level information, including a CRC screening rate, represents clients ages 50-75 in partner health systems. The information will be reported to CDC by the CRCCP Program Managers/Program Directors.
- How data will be analyzed. CDC will use descriptive statistics to produce reports for CDC program management and CRCCP grantees.

ABSTRACT

CDC is requesting a reinstatement with change of OMB No. 0920-1074, an information collection for the Colorectal Cancer Control Program (CRCCP). The Colorectal Cancer Control Program (CRCCP) was originally funded from July 2009 through June 2015. Based on evaluation results, the CDC significantly redesigned the CRCCP and issued a new Funding Opportunity Announcement and funded 31 grantees in July 2015. Consistent with programmatic changes, the information collection plan has also been redesigned. Changes include a redesigned grantee survey and a new clinic-level information collection. The information collection will allow CDC to provide routine monitoring feedback to grantees based on their information submissions, tailor technical assistance as needed, support program planning, and assess program outcomes. OMB approval is requested for three years.

A. Justification

A1. Circumstances Making the Collection of Information Necessary

CDC is requesting a reinstatement with change of OMB No. 0920-1074. The number of respondents will increase. In the previous OMB approval period, information collection consisted of an annual grantee survey. In the next cycle, information collection will consist of a redesigned grantee survey and a new clinic-level information collection. Total estimated annualized burden will increase. OMB approval is requested for three years.

Colorectal cancer (CRC) is the second leading cause of death from cancer in the United States among cancers that affect both men and women. CRC screening has been shown to reduce incidence of and death from the disease. Screening for CRC can detect disease early when treatment is more effective and prevent cancer by finding and removing precancerous polyps. Of individuals diagnosed with early stage CRC, more than 90% live five or more years. Despite strong evidence supporting screening, only 65% of adults currently report being up-to-date with CRC screening as recommended by the U.S. Preventive Services Task Force, with more than 22 million age-eligible adults estimated to be untested. To reduce CRC morbidity, mortality, and associated costs, use of CRC screening tests must be increased among age-eligible adults with the lowest CRC screening rates.

The Centers for Disease Control and Prevention's (CDC) Colorectal Cancer Control Program (CRCCP) was originally funded from July 2009 through June 2015. The purpose of the CRCCP was to increase CRC screening through delivery of CRC screening services to low-income, uninsured men and women. Twenty-five state health departments and four tribal organization grantees were funded to provide CRC screening and related support services. An annual survey was conducted among grantees to collect information about implementation activities (OMB No. 0920-1074, exp. 6/30/2018). Information collection for the CRCCP was completed in September 2015 and the OMB approval was discontinued on 12/31/2015, in anticipation of a reinstatement with changes. The ICR title has been updated reflecting the change in focus.

Based on evaluation results, the CDC significantly redesigned the CRCCP and issued a new Funding Opportunity Announcement, CDC-RFA-DP15-1502 (hereafter, DP-15-1502), which

was funded in July 2015. The purpose of the redesigned program, “Colorectal Cancer Control Program (CRCCP): Organized Approaches to Increase Colorectal Cancer Screening,” is to increase CRC screening rates among an applicant defined target population of persons aged 50-75 years of age within a partner health system serving a defined geographical area or disparate population. The redesigned CRCCP is more prescriptive than its previous iteration, and has two distinct program components:

Component 1:

Funding for component 1 is limited to partnerships with health systems to implement up to four priority evidence-based interventions (EBIs) described in the Guide to Community Preventive Services as well as other supporting strategies. Grantees must implement at least two EBIs in each partnering health system.

Component 2: Funding for component 2 is used by grantees to provide direct screening and follow-up clinical services for a limited number of individuals aged 50-64 in the program’s priority population who are asymptomatic, at average risk for CRC, have inadequate or no health insurance for CRC screening, and are low income.

Under the new FOA, the CRCCP has increased to 31 grantees who are state governments or bona-fide agents, universities, and tribal organizations. All 31 grantees received component 1 funding to implement four priority EBIs (i.e., provider assessment and feedback, provider reminders, patient reminders, and reducing structural barriers) along with supporting strategies (i.e., patient navigation, small media, and activities facilitating community-clinical linkages) in order to increase clinic-level CRC screening rates within partner health systems. Six of the 31 grantees received component 2 funding to support clinical service delivery. Component 2 grantees fund health care providers in their jurisdiction to deliver CRC screening, diagnostic evaluation, and treatment referrals for those diagnosed with cancer.

Consistent with programmatic changes, the information collection plan has also been redesigned. CDC is authorized to collect information by the Public Health Service Act (**see Attachment 1 – Authorizing Legislation**).

A2. Purpose and Use of the Information Collection

CDC is required by DP-15-1502, to monitor and evaluate both process and outcome measures for the CRCCP. Grantees are required to report information to CDC to support these efforts. In redesigning the CRCCP, CDC developed detailed program logic models, one for each component, to reflect processes and expected outcomes over time (**see Attachment 2– CRCCP Logic Models**). The logic models guided development of a new monitoring and evaluation plan for the CRCCP. An important limitation of the former iteration of the CRCCP was an inability to effectively measure changes in colorectal cancer screening rates. The redesigned CRCCP focuses programmatic efforts at the health system clinic level where we can more effectively monitor changes in screening rates over time and assess program effectiveness.

Two forms of information collection are proposed to assess program implementation (i.e., processes) and outcomes. While a survey was used to monitor implementation of the previous iteration of the CRCCP, the instrument was entirely reconstructed to reflect the focus of the redesigned program. The survey now closely examines grantee use of the four priority EBIs required by CDC and supporting activities implemented in partner health systems. For the subset of six grantees implementing component 2, the survey includes questions about clinical service delivery. Questions are of various types including dichotomous, multiple response, and free text. (**See Attachment 3a – CRCCP Annual Grantee Survey (screenshots)**). CDC will conduct the CRCCP annual grantee survey among all 31 grantees following the end of each program year.

Second, given that Component 1 of the CRCCP requires grantees to implement EBIs in partner health systems, CDC proposes to collect new information at the clinic level. This information will allow assessment of the CRCCP's primary outcome of interest, CRC screening rates within partner health systems. CRCCP grantees will collect and report CRCCP clinic-level information for all health system partners' primary care clinic sites (**See Attachment 4a - CRCCP Clinic-Level Collection Instrument (screenshots)**). Health systems typically include multiple primary care clinic sites. As health system partnerships are established, grantees will collect baseline information about the clinic setting, patient population characteristics, CRC screening rates, and EBI/supporting activities implementation. Grantees will then collect and report a CRC screening

rate and updated information about EBI/supporting activity implementation annually for the duration of the FOA (**See Attachment 4b – CRCCP Clinic-Level Data Dictionary**). This information will help CDC to describe program reach, the clinic settings, characteristics of the population being served, program activities implemented at the clinic-level, and changes in CRC screening rates over time.

In partnership with the health system, grantees assess the specific needs of each participating clinic and gather information, including size and demographic characteristics of the patient population of recommended screening age (50-75), current CRC screening rate, clinic characteristics and capacity, and activities that are currently in place to support CRC screening. This process provides baseline information to identify gaps and plan program interventions at the clinic site. Grantees will continue to work with health system partners and clinics throughout the 5-year grant period to develop, implement, and monitor interventions and assess program outcomes and impact. To assess the outcomes of interventions implemented in clinic sites, grantees acquire clinic-level screening rates each year, using a consistent 12-month assessment period and a standardized method to calculate the measure. Many health systems have an established quality measure and methodology in place to report CRC screening rates. For example, Community Health Centers use the Uniform Data System methodology for annual performance reporting and the Indian Health Service uses a defined measure for Government Performance and Results Act (GPRA) reporting. Health systems can use other institutional methods or the National Quality Forum (NQF) endorsed measure to compute the rate. CDC has provided grantees with a guidance manual for measuring CRC rates in health system clinics. Each year, grantees will report a standardized clinic-level subset of information to CDC that includes baseline information for new clinic partners and annual updates on intervention implementation activities and screening rates for all clinic partners. A data dictionary is available to grantees to promote standardization (**Attachment 4b - CRCCP Clinic-level Data Dictionary**).

Together, the proposed information collection activities will contribute to a more effective CRCCP and strengthen CDC's ability to demonstrate program results. These monitoring

activities will also help to identify successful activities that need to be maintained, replicated, or expanded, as well as provide insight into areas needing improvement.

The scope of information collection is limited to monitoring the public health activities and experiences of CRCCP grantees acting in their official capacity. Personal identifying information will not be collected, and the information collection will not yield information that can be generalized. As such, this information collection will not require IRB review. CDC will use this information to better understand the range of experiences among grantees and as one of many inputs into decision-making and/or program management. In addition, the findings will be reported back to the grantees to help them identify successful implementation models and focus networking for shared experiences, lessons learned, and best practices.

A3. Use of Improved Information Technology and Burden Reduction

Grantee survey information will be collected annually via a web-based questionnaire allowing respondents to complete and submit their responses electronically. Clinic-level information will be collected annually through a web-based instrument. **(See Attachment 4a - CRCCP Clinic-Level Collection Instrument (screenshots))**. Both methods use pre-existing web infrastructure and tools already in place for the CRCCP grantees. These methods were chosen to reduce the overall burden on respondents.

A4. Efforts to Identify Duplication and Use of Similar Information

The information to be collected from the CRCCP grantees is unique to the current program and, therefore, not duplicative of other efforts. Component 2 continues screening delivery activities original to the prior FOA. There is a complementary information collection to monitor Component 2 service delivery (OMB No: 0920-0745 exp. 04/30/2016) however, the program has submitted a request for a discontinuation due to the change in scope of the FOA away from providing direct cancer screening clinical services to low-income uninsured individuals. The Cost Assessment Tool collection, which was covered by 0920-0745, has been completed and the clinical data collection is reduced from 29 to 6 grantee respondents.

A5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this information collection.

A6. Consequences of Collecting the Information Less Frequently

The purpose of this request is to ensure collection of information that is not otherwise available in a current, time sensitive, or standardized format to specific or emergent priorities of HHS and CDC. Specifically, without this information there would be:

- No systematic information collection regarding the implementation of program activities and outcomes, as required in the current FOA.
- No systematic assessment of training and technical assistance needs.
- Less effective and less timely assessment of implementation partners and their program activities.
- Fewer resources from which to make data-driven decisions that are often required of CDC as well as required of its grantees.

OMB approval is requested for three years. There are no legal obstacles to reduce the burden.

A7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

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

A8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

Notice of this project was published in the Federal Register on 20, January, 2016 in Vol. 81, No. 12, pages 3139-3140. **(See Attachment 5 – Federal Register Notice)**. No public comments were received.

Table A.8.1. Individuals Who Have Provided Consultation on the Project

Consultant	Title	Affiliation	Email	Phone	Year of Consult
Cam Escoffery	Associate Professor	Emory University	cescoff@emory.edu	404-727-4701	2015
Peggy Hannon	Director, Associate Professor	University of Washington School of Public Health	peggyh@uw.edu	206-616-7859	2015
Thuy Vu	Research Coordinator	University of Washington School of Public Health	thuytvu@uw.edu	206-616-4724	2015
Annette Maxwell	Professor	University of California – Los Angeles	amaxwell@ucla.edu	310-794-9282	2015
Kathleen McNamara	Associate Vice President, Clinical Affairs	National Association of Community Health Centers (NACHC)	kmcnamara@nachc.com	301-347-0400	2015
Ben Reisler	Clinical Data Specialist	National Association of Community Health Centers (NACHC)	breisler@nachc.com	301-347-0411	2015

A9. Explanation of Any Payment or Gift to Respondents

CDC will not provide payments or gifts to respondents.

A10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

This submission has been reviewed by CDC's Information System Security Office, which determined that the Privacy Act does not apply. Activities do not involve the collection of individually identifiable information, and all information is programmatic in nature.

Overview of the Information Collection System

CDC proposes to collect information in two forms from Colorectal Cancer Control Program (CRCCP) grantees, who are 31 state governments or bona-fide agents, universities and tribal organizations. The information collection will support monitoring and evaluation of program implementation and outcomes of the CRCCP. The two forms include a CRCCP annual grantee survey and a set of CRCCP clinic-level information acquired through health system partnerships. Program policy requires grantees to report both forms of information to CDC.

The **CRCCP annual grantee survey information collection** system consists of a web-based questionnaire designed to collect grantee-level information from all 31 CRCCP grantees. The Program Director or Manager for each cooperative agreement will serve as the survey respondent. Contact information for the grantee is obtained from program administrative systems and used to distribute survey introductory and reminder emails (**See Attachment 3b - Survey Introductory Email and Attachment 3c – Survey Reminder Email**). The CDC contactor will manage primary information collection and send respondents a unique link to an online instrument, and not to a website, that will enable grantees access to view and enter their survey information. After receiving responses to the survey, the contractor will prepare a validated analysis file and set of reports for CDC to assist in interpreting results. CDC will prepare and distribute grantee-specific and CRCCP summary feedback reports. The web-based information collection instrument software will be developed using an open-source product called LimeSurvey (limesurvey.org). This effort will build on a pre-existing survey information collection and set of development tools used for another national cancer screening program also

administered by CDC's Division of Cancer Prevention and Control: The Annual Survey of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Grantees' Program Implementation (OMB No. 0920-1046 exp. 1/31/2018).

The **clinic-level information collection** consists of information on each clinic site where CRCCP program interventions are implemented. Grantees establish formal agreements with health systems to implement evidence-based interventions to increase CRC screening within clinics where primary care preventive services are delivered or supported. Information will be reported through a web-based information entry instrument accessible to grantees on the pre-existing secure CRCCP program website (www.crccp.org) to simplify the reporting process with centralized information collection, validation, access control and technical support (**Attachment 4a - CRCCP Clinic-Level Collection Instrument (screenshots)**).

Both forms will be collected within three months after the end of each grantee program year which runs from July-June. For both information collections, the contractor will host the instrument and archive information on secure network servers. The contractor will aggregate and validate the information for quality and completeness, and prepare an analysis file and reports for delivery to CDC.

Items of information to be collected

The information to be collected is programmatic in nature and does not involve research with human subjects. IRB approval is not required. No personally identifiable information is collected.

The grantee survey consists of 6 sections. The number of items completed by a respondent will vary due to skip logic. Questions are of various types including dichotomous and multiple response. To minimize burden, there are a limited number of questions requiring open-ended or

narrative responses (**Attachment 3a –CRCCP Annual Grantee Survey (screenshots)**). The six sections of the survey include:

- 1) Respondent background information
- 2) Program management
- 3) Implementation activities, health IT and partnerships
- 4) Information use
- 5) Training and technical assistance
- 6) CRC screening delivery (for component 2 grantees only)

Clinic-level information include the name of the partner health system and clinic, clinic address, a description of clinic and patient characteristics that relate to planning and implementing CRC screening interventions such as patient population demographic information, clinic-level capacity, baseline and annual CRC screening rate denominator and numerator, and baseline and annual implementation stage of evidence-based interventions to increase CRC screening (e.g. provider reminders, provider assessment and feedback, patient reminders, reducing structural boundaries) and supporting activities (e.g., patient navigation, community health workers, health information technology) (**Attachment 4b - CRCCP Clinic-Level Data Dictionary**).

How information is shared and for what purpose

For both collections, each grantee respondent will receive a customized feedback report relating to their program. Grantees will not have access to other grantees' submissions or individualized reports. Program summary information and CRCCP aggregate results such as performance ranges, will be shared across programs for grantees to compare performance and identify networking opportunities with others engaging in similar activities.

Information will be used by CDC to monitor and evaluate the CRCCP, provide feedback to grantees and stakeholders on program processes and outcomes, and inform program planning decisions for future programs. DCPC investigators will prepare formal reports periodically. CDC does not plan to create a public use dataset given the programmatic nature of the information and

its strict application for monitoring the 31 CRCCP grantees. Program Announcement CDC-RFA-DP15-1502, the CRCCP funding announcement, requires that CDC monitor and evaluate CRCCP processes (i.e. implementation) and outcomes.

Statement of impact on the respondent's privacy

The annual grantee survey includes programmatic information and does not contain direct personal identifiers. As such, the information collection will have little or no effect on the respondent's privacy.

The clinic-level information identifies the partner health system and clinic by name and includes the clinic address – both of which are publicly available. The name, in addition to an assigned ID, are used to ensure accurate identification of the clinic when reporting longitudinal (annual) information, and to compare clinic implementation activities with grantee work plans. Except for in feedback reports to grantees, CDC will not identify the name of the Health System or Clinic partner. Information is treated in a secure manner and will not be disclosed, unless otherwise compelled by law.

Opportunities to consent to sharing and submission of information

Survey respondents are notified that their information will be maintained in a secure manner and that they will receive individualized feedback reports for their use. There are no advisements that relate to data sharing since CDC has no plans to share information or develop a public-use data set. There is no impact on the respondent's privacy.

How information is secured

Both information collections are secured by technical, physical, and administrative safeguards as outlined below.

Technical

- All data reside on a dedicated server on the contractor's local area network behind the contractor's firewall and is password protected on its own security domain. Access to the server is limited to the contractor's authorized project staff. No non-project staff is allowed access to the data. All of the contractor's project staff is required to sign a confidentiality agreement before passwords and keys are assigned.
- Access to the CRCCP program website is restricted via a password-protected secure website. Access to grantee-specific reports and clinic-level data entry systems (**Attachment 4a - CRCCP Clinic-Level Collection Instrument (screenshots)**) are further restricted within the website. Each grantee has its own directory location so no grantee has access to another grantee's information. The CRCCP program website utilizes the Hypertext Transfer Protocol Secure (HTTPS) to ensure secure connections. In addition, the website will enable Strict Transport Security (HSTS), which is in compliance with OMB memorandum M-15-13, Policy to Require Secure Connections across Federal Websites and Web Services.
- Once information has been compiled by the contractor and delivered to CDC via courier, all data are maintained for restricted access on CDC's secure LAN server with access permission grantee by the CDC CRCCP data manager.

Physical

- The contractor's server is housed in a secure facility with restricted access.
- Receipt and processing logs are maintained to document data receipt, file processing and report production. All reports and electronic storage media containing grantee information are stored under lock and key when not in use and will be destroyed when no longer needed.
- Once data have been compiled by the contractor and delivered to CDC, all datasets are maintained for restricted access on a secure LAN server, which is housed in a secure facility. All CDC staff are issued identification badges and access to the building is controlled by key cards.

Administrative

- CDC and contract staff have developed and implemented an information system security plan

to ensure that the information is kept secure. Periodic review and update of the contractor's security processes is conducted to adjust for needed changes and will be amended as needed to maintain the continued security of the information.

- The contractual agreement between CDC and the contractor includes non-disclosure terms. The contractor's project security team oversees operations to prevent unauthorized disclosure of the CRCCP data.
- Once the information have been delivered to CDC, data are housed on CDC's secure LAN server and restricted access is controlled by the CRCCP data manager.

A11. Institutional Review Board (IRB) and Justification for Sensitive Questions

No information will be collected that are of personal or sensitive nature. IRB approval is not required.

A12. Estimates of Annualized Burden Hours and Costs

The estimate for burden hours for the CRCCP annual grantee survey (**Attachment 3a**) is based on a pilot test of the information collection instruments by 5 public health professionals. In the pilot test, the average time to complete the instrument including time for reviewing instructions and completing the instrument was approximately 45 minutes. The estimate for burden hours for the CRCCP clinic-level information collection template (**Attachment 4a**) is based on a pilot test of the information collection instrument by 4 public health professionals. In the pilot test, the average time to complete the instrument was approximately 30 minutes. We estimate an average of 12 responses per grantee annually to correspond with the number of health system partners. The total estimated annualized burden hours are 209.

Table A.12.A. Estimated Annualized Burden Hours

Type of Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hr)	Total Burden (in hr)
CRCCP Grantees	CRCCP Annual Grantee Survey	31	1	45/60	23
	CRCCP Clinic-level Information Collection Template	31	12	30/60	186
Total					209

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 all respondents. The total estimated annualized cost to respondents is \$11,936.

Table A.12.B. Estimated Annualized Burden Costs

Type of Respondent	Form Name	Number of Respondents	Total Burden Hours	Hourly Wage Rate	Total Cost
CRCCP Grantees	CRCCP Annual Grantee Survey	31	23	\$57.11	\$1,314
	CRCCP Clinic-level Information Collection Template	31	186	\$57.11	\$10,622
Total					\$11,936

A13. 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.

A14. Annualized Cost to the Government

Total operations and maintenance costs includes work performed by both the contractor and CDC personnel. Salary cost of CDC staff include an FTE (GS-13) to lead the project and coordinate all related activities of each information collection as well as another FTE (GS-12) to help with data management, analysis and report preparation. 120 hours of staff time was estimated for each FTE annually for this information collection. Cost of the contractor represents an estimated 35% (\$154,913) of total annual contract funds (\$491,788) allocated for CRCCP data management activities. The estimated cost to the federal government is \$165,209. Table A.14 describes how the cost estimate was calculated.

Table A.14. Estimated Annualized Cost to the Federal Government

Staff (FTE)	Average Hours per Collection	Average Hourly Rate	Average Cost
Health Scientist (GS-13) Lead health scientist to prepare OMB package, overall coordination, and consult on information collection, analysis, report preparation	120	\$45.97	\$5516
Health Scientist (GS-12) Data management support, analysis, report preparation	120	\$39.83	\$4780
Contractor Costs			
Annualized Cost of Contract with Information Management Services Responsible for building web-based application, information collection, coding and entry, quality control, analysis, report preparation			\$154,913
Estimated Total Cost of Information Collection			\$165,209

A15. Explanation for Program Changes or Adjustments

This is a request to reinstate with change OMB No. 0920-1074. For the CRCCP annual grantee survey, the number of respondents increases from 29 to 31, and the total burden decreases from

36 hours to 23 hours, a net reduction of 13 hours. The CRCCP Clinic-level Information Collection Template is new, involves all 31 respondents and 186 estimated burden hours. The overall burden has increased from 36 hours to 210 hours, a net increase of 173 hours.

Table A.15. Changes in Information Collection

Information Collection Instrument	Previous Approval		Proposed Changes for Current Revision			
	No. Respondents	No. Burden Hrs.	No. Respondents	No. Burden Hrs.	Change in Respondents	Change in Burden Hrs.
CRCCP Annual Grantee Survey	29	36	31	23	+2	-13
CRCCP Clinic-level Information Collection Template			31	186	+31	+186
						173

A16. Plans for Tabulation and Publication and Project Time Schedule

The CRCCP Annual Grantee Survey and CRCCP Clinic-Level Information Collection Template will be completed annually within 3 months after the end of each program year (July – September). Data validation, analysis, and report preparation and dissemination will follow. A summary timeline is provided below:

Estimated Project Time Schedule

Activity	Time Schedule
Introductory emails for CRCCP Annual Grantee Survey sent to respondents with link to survey, information collection begins. CRCCP Clinic-Level Data Template available for reporting, information collection begins.	Begin 1-3 months after end of program year, information collection continued for up to 6 weeks
Survey reminder emails sent to non-	

responders (survey only)	10 days after introductory letters sent
Data Validation	Completed 1 month after end of information collection
Data Analyses	Completed 4 months after end of information collection
Report Preparation	Completed 6 months after end of information collection
Report Dissemination	Completed 7 months after end of information collection

A17. Reason(s) Display of OMB Expiration Date is Inappropriate

We are requesting no exemption.

A18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification. These activities comply with the requirements in 5 CFR 1320.9.