

State, Territorial and Local Health Department Partner Services Program Assessment

OSTLTS Generic Information Collection Request
OMB No. 0920-0879

Supporting Statement – Section A

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- **Purpose of the data collection**

The purpose of this data collection is to learn about the structure and functions of Partner Services (PS) programs across CDC-funded health departments. We will collect data to document how CDC-funded HIV PS programs are organized within each health department and how their required HIV PS activities are implemented.

- **Intended use of the resulting data**

The data collected will be used to identify gaps in services within PS programs, and provide enhanced PS technical assistance to state, territorial and local health departments.

- **Methods to be used to collect data**

An online data collection instrument will be used to collect data for this initiative.

- **Respondent Universe**

Respondents will consist of 60 staff of HIV Partner Services Program Directors from CDC-funded health departments in all 50 states, 2 territories, Puerto Rico and the U.S. Virgin Islands, as well as 8 local health departments serving Baltimore, Chicago, Houston, Los Angeles County, Philadelphia, New York City, Washington, D.C., and San Francisco.

- **How data will be analyzed**

Data will be analyzed using both quantitative and qualitative analysis. Information will be reviewed for completeness, simple descriptive statistics will be run looking at response frequencies, and narrative responses will be summarized.

Section A – Justification

1. Circumstances Making the Collection of Information Necessary

Background

This information collection is being conducted using OMB No. 0920-0879 “Information Collections to Advance State, Tribal, Local and Territorial Governmental Agency System Performance, Capacity, and Program Delivery” nicknamed the “CSTLTS Generic.” The respondent universe for this information collection aligns with that of the CSTLTS Generic. Data will be collected from a total of 60 staff consisting of HIV Partner Services Program Directors from CDC-funded health departments in all 50 states, 2 territories Puerto Rico and the U.S. Virgin Islands, as well as 8 local health departments serving Baltimore, Chicago, Houston, Los Angeles County, Philadelphia, New York City, Washington, D.C., and San Francisco. Respondents acting in their official capacities include Program Directors, all of which are Division of HIV/AIDS Prevention (DHAP) grantees (Please see Attachment A: **Respondent Breakdown**).

This information collection is authorized by Section 301 of the Public Health Service Act (42 U.S.C. 241). This information collection falls under the essential public health service(s) of

- 1. Monitoring health status to identify community health problems
- 2. Diagnosing and investigating health problems and health hazards in the community
- 3. Informing, educating, and empowering people about health issues
- 4. Mobilizing community partnerships to identify and solve health problems
- 5. Development of policies and plans that support individual and community health efforts
- 6. Enforcement of laws and regulations that protect health and ensure safety
- 7. Linking people to needed personal health services and assure the provision of health care when otherwise unavailable
- 8. Assuring a competent public health and personal health care workforce
- 9. Evaluating effectiveness, accessibility, and quality of personal and population-based health services
- 10. Research for new insights and innovative solutions to health problems ¹

For decades, HIV partner services (PS) has been a core component of HIV prevention programs at local and state health departments throughout the United States. Partner services is a key strategy for identifying people with HIV infection—those with undiagnosed infection and those with previously diagnosed infection who are not receiving HIV medical care—and helping them access care and treatment. All persons with newly diagnosed HIV infection should receive partner services to help them identify sex and needle-sharing partners who may also be infected or may be at very high risk for becoming infected. These partners can then be notified of their potential exposure and offered HIV testing. Those who test positive for HIV can then be linked to HIV medical care and other services. Partner services can also help persons living with HIV and their partners address other needs, such as reducing behavioral risk for transmitting or acquiring HIV; accessing treatment for mental health issues and substance abuse; and obtaining social services to address unmet housing, transportation, employment, and other needs.

PS programs are intended to appropriately use public health resources to identify HIV infected persons (index patients), notify their partners of their potential exposure, and provide index patients and their partners a range of medical, prevention, and psychosocial services. The ultimate goals of PS programs are to facilitate positive behavior changes, decrease further transmission of HIV, and improve public health¹.

While the goals of PS programs remained the same over the years, the structure, functions, and implementation of these programs are changing due to advances in science and technology related to HIV prevention and care. Some of these changes include the use of molecular surveillance for identifying HIV clusters; data-to-care strategies to identify and link people not in care; availability of pre-exposure prophylaxis (PrEP) to prevent transmission of HIV from index patients to their partners; and availability of new technologies (e.g., text messaging and other applications) for partner notification, referral and tracking of delivery of services^{2,3,4}.

Additionally, CDC provides funds and technical assistance to local and state health departments to implement HIV prevention programs, including PS. As part of the Program Evaluation Branch's (PEB) National HIV Prevention Program Monitoring and Evaluation (NHM&E) system, health departments are required to report program data on partner elicitation, notification, HIV testing, and referral and linkage to care and prevention services (OMB 0920-0696, exp. date 10/31/2021). While the quality of reported data has improved over the years, there are significant challenges in the collection and reporting of some data elements⁵. Some of these challenges may be related to the structure of the PS program within the health department and others to how a health department implements its PS activities. For example, because of legal issues, some health departments cannot use new methods (e.g., dating sites or other apps) that have been shown to be effective for partner location and notification.

The purpose of this data collection is to learn about the structure and functions of Partner Services (PS) programs across CDC-funded health departments. We will collect data to document how CDC-funded HIV PS programs are organized within each health department and how HIV PS activities are implemented.

The data collected will be used to identify gaps in services within PS programs, and provide enhanced PS technical assistance to state, territorial and local health departments.

Data analysis and report preparation will be led by PEB staff.

Overview of the Information Collection System

Data will be collected from 60 health department HIV PS program directors (50 state, 8 local, and 2 territorial) via a web-based assessment (**see Attachment B – On-line Assessment Instrument-Word and Attachment C – On-line Assessment- Web**). The instrument will be used to gather information from health department HIV PS program directors to understand how CDC-funded HIV PS programs are organized within a health department and how CDC-funded HIV PS activities are implemented by the health department.

The web-based assessment instrument was pilot tested by 8 public health professionals. Feedback from this group was used to refine questions as needed, ensure accurate programming and skip patterns, and to establish the estimated time required to complete the information collection instrument.

Items of Information to be Collected

The web-based assessment instrument consists of 71 questions of various types, including dichotomous (yes/no), multiple response, interval (rating scales), and open-ended. The

instrument will collect data on key elements involved in assessing the structure and functions of HIV partner services programs and the implementation of their CDC-required activities. The instrument will focus specifically on the following:

- Goals, Organization, and Resources
- Staffing & Training
- Partner Services Activities and Policies
- Reporting Requirements for Index Patients with HIV Infection
- Locating and Contacting Index Patients with HIV Infection
- Locating, Contacting, and Notifying Partners

2. Purpose and Use of the Information Collection

The purpose of this data collection is to learn about the structure and functions of Partner Services (PS) programs across CDC-funded health departments. We will collect data to document how CDC-funded HIV PS programs are organized within each health department and how HIV PS activities are implemented.

The data collected will be used to identify gaps in services within PS programs, and provide enhanced PS technical assistance to state, territorial and local health departments.

3. Use of Improved Information Technology and Burden Reduction

Data will be collected via a web-based assessment. The web-based data collection instrument was designed with a focus on streamlining questions to allow for skipping narrative questions based on a 'no' response to a previous question, thereby minimizing response burden. The web-based assessment instrument used close-ended questions whenever possible while still providing space to expand answers. The data collection instrument was designed to collect the minimum information necessary for the purposes of this project (i.e., limited to 71 questions).

4. Efforts to Identify Duplication and Use of Similar Information

The National HIV Prevention Program Monitoring and Evaluation (NHM&E) data (OMB No. 0920-0696, exp. date 10/31/2021) collects quantitative data on HIV testing and partner services activities conducted by the health department and their delegates to assess program processes (e.g., who is being tested by demographic and risk population) and outcomes (e.g., number of HIV positive partners linked to HIV medical care). It is not designed to collect qualitative information for a more in-depth understanding of program implementation. PEB's routine monitoring and evaluation activities often prompt questions about how and why HIV prevention programs are implemented the way they are. There is no national assessment to date that details how CDC-funded HIV PS programs are organized within a health department and how CDC-funded HIV PS activities are implemented by the health department.

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5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this information collection.

6. Consequences of Collecting the Information Less Frequently

This request is for a one-time data collection. There are no legal obstacles to reduce the burden. If no data are collected, CDC will be unable to:

- Understand how CDC-funded HIV PS programs are organized within a health department
- Understand how CDC-funded HIV PS activities are implemented by the health department
- Identify gaps in services within PS programs
- Provide enhanced PS technical assistance to state, territorial and local health departments.

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

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

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

This information collection is being conducted using OMB No. 0920-0879 “Information Collections to Advance State, Tribal, Local and Territorial Governmental Agency System Performance, Capacity, and Program Delivery” nicknamed the “CSTLTS Generic.” A 60-day Federal Register Notice was published in the Federal Register on April 27, 2017, Vol. 82, No. 80, pp 19371-19373. One non-substantive comment was received. CDC sent forward the standard CDC response.

CDC partners with professional STLT organizations, such as the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the National Association of Local Boards of Health (NALBOH) along with the National Center for Health Statistics (NCHS) to ensure that the collection requests under individual ICs are not in conflict with collections they have or will have in the field within the same timeframe.

9. Explanation of Any Payment or Gift to Respondents

CDC will not provide payments or gifts to respondents.

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

The Privacy Act does not apply to this data collection. STLT governmental staff will be speaking from their official roles.

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

No information will be collected that are of personal or sensitive nature. This data collection is not research involving human subjects.

12. Estimates of Annualized Burden Hours and Costs

The estimate for burden hours is based on a pilot test of the data collection instrument by 8 public health professionals. In the pilot test of the web-based assessment instrument, the average time to complete the instrument, including time for reviewing instructions and completing the instrument, was approximately 47 minutes (range: 35 to 60 minutes). Therefore, for the purposes of estimating burden hours, the upper limit of this range (60 minutes) is used.

Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) Bureau of Labor Statistics for occupational employment for Medical and Health Services Managers http://www.bls.gov/oes/current/oes_nat.htm. Based on DOL data, an average hourly wage of \$54.68 is estimated for all 60 respondents. The hourly wage rate has been doubled to \$109.36 to account for fringe benefits and overhead (<https://aspe.hhs.gov/pdf-report/guidelines-regulatory-impact-analysis>). Table A-12 shows estimated burden and cost information.

There will be a total of 60 respondents and 60 responses.

Table A-12: Estimated Annualized Burden Hours and Costs to Respondents

Data Collection Instrument: Form Name	Type of Respondent	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
DHAP/PEB Instrument	State Program Directors	50	1	1	50	\$109.36	\$5,468.00
	Local Program Directors	8	1	1	8	\$109.36	\$874.88
	Territorial Program	2	1	1	2	\$109.36	\$218.72

	Directors						
	TOTALS	60	1		60		\$6,561.60

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 data 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 to develop the data collection instrument, collect data, and perform data analysis. The total estimated cost to the federal government is \$4,267. Table A-14 describes how this cost estimate was calculated.

Table A-14: Estimated Annualized Cost to the Federal Government

Staff (FTE)	Average Hours per Collection	Average Hourly Rate	Total Average Cost
Behavioral Scientist – GS-14 Step 7 Development of assessment tool, dissemination of assessment tool, plan and implement data collection/analysis	25	\$63.38	\$1,585
Behavioral Scientist – GS-13 Step 7 Development of assessment tool, dissemination of assessment tool, plan and implement data collection/analysis	25	\$53.64	\$1,341
Health Scientist- GS-13 Step 7 Development of assessment tool, and data analysis	25	\$53.64	\$1,341
Estimated Total Cost of Information Collection			\$ 4,267

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

As resources and respondents may be impacted by the COVID-19 pandemic, we propose that data collection begin in September 2020. Information collected from the online assessment will be stored in a secure environment on the password-protected computers and on secure CDC servers. Once the data collection period for the web-based assessment has closed, CDC will export the quantitative data from SurveyMonkey into a Microsoft Excel file. CDC will store the file on a multi-user share that is a network-based file folder that can only be accessed by a designated group of users at their respective agency. CDC staff will lead the web-based assessment analysis. Information will be reviewed for completeness and simple descriptive statistics will be run looking at response frequencies. Data collected will be used to identify gaps in required services within HIV PS programs and provide enhanced PS technical assistance to state, territorial and local health departments. Following analysis of responses, key findings will be shared in aggregate form with project staff, DHAP leadership, and other stakeholders. Findings may also be disseminated through presentations at public health conferences such as AEA (American Evaluation Association) and USCA (United States Conference on AIDS) as well as through manuscript publication in scientific journals.

Project Time Schedule

- ✓ Design instrument (COMPLETE)
- ✓ Develop protocol, instructions, and analysis plan (COMPLETE)
- ✓ Pilot test instrument (COMPLETE)
- ✓ Prepare OMB package (COMPLETE)
- ✓ Submit OMB package (COMPLETE)
- OMB approval (TBD)
- Conduct data collection (Commences September 2020-Open 3 weeks)
- Code data, conduct quality control, and analyze data..... (4 weeks)
- Prepare summary report(s) (5 weeks)
- Disseminate results/reports (6 weeks)

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

We are requesting no exemption.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

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

LIST OF ATTACHMENTS – Section A

Attachment A – Respondent Breakdown

REFERENCE LIST

¹Centers for Disease Control and Prevention (CDC). Recommendations for partner services programs for HIV infection, syphilis, gonorrhea, and chlamydial infection. *MMWR Recomm Rep.* 2008 Nov 7;57(RR-9):1-83.

²Golden MR, Katz DA, Dombrowski JC. Modernizing Field Services for Human Immunodeficiency Virus and Sexually Transmitted Infections in the United States. *Sex Transm Dis.* 2017 Oct;44(10):599-607. doi: 10.1097/OLQ.0000000000000652.

³Hochberg CH, Berringer K, Schneider JA. Next-Generation Methods for HIV Partner Services: A Systematic Review. *Sex Transm Dis.* 2015 Sep;42(9):533-9. doi: 10.1097/OLQ.0000000000000335.

⁴Udeagu CC, Bocour A, Shah S, Ramos Y, Gutierrez R, Shepard CW. Bringing HIV partner services into the age of social media and mobile connectivity. *Sex Transm Dis.* 2014 Oct;41(10):631-6. doi: 10.1097/OLQ.0000000000000181

⁵Centers for Disease Control and Prevention (CDC). Partner services annual report, 2016. Atlanta, GA(CDC). <https://www.cdc.gov/hiv/pdf/library/reports/cdc-hiv-ps12-1201-partner-services-annual-report-2015.pdf>. Accessed on December 14, 2017.