

Medical Countermeasure Training Needs Assessment

OSTLTS Generic Information Collection Request
OMB No. 0920-0879

Supporting Statement – Section A

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Program Official/Project Officer

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- **Purpose of the data collection**

The purpose of this information collection is to gather data to assess the gaps in MCM Officials' ability to perform the MCM Coordinator Common Responsibilities and Associated Skills. These consist of six CDC-identified responsibilities, each with six to nine associated skills, that are beneficial to MCM Officials in working toward preparing their jurisdictions for emergencies requiring MCMs (see **Attachment A – MCM Coordinator Common Responsibilities and Associated Skills**). CDC created this document to aid in assessing the training needs of MCM Officials across the country. The information collected will gather baseline data on which skills need the most attention, how training needs change over the course of one's MCM-related career, and how CDC can better design MCM trainings that will fit within the current training models at the state, territorial, local, and tribal health departments.

- **Intended use of the resulting data**

The data will be used to inform the development and delivery of CDC-sponsored MCM trainings and create a comprehensive five-year MCM training plan based on the stated needs of respondents. This needs assessment and the resulting trainings will address the priority areas of the Workforce Development section of the Joint External Evaluation of the United States of America for the World Health Organization's Global Health Security Agenda.¹

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

An electronic assessment and virtual group interviews will be used for data collection.

- **Respondent Universe**

The respondent universe consists of two main groups of participants:

1. Sixty-two MCM officials from the Public Health Emergency Preparedness (PHEP) cooperative agreement (CDC-RFA-TP17-1701) recipient health departments, which include 50 states, eight territories and freely associated states, and four cities.
2. 995 MCM Officials from local health departments, including 118 large LHDs, 287 medium LHDs and 599 small LHDs.

- **How data will be analyzed**

Both quantitative and qualitative methods will be used to analyze the data. Close-ended questions will be analyzed using quantitative methods, specifically descriptive and inferential statistics. Open ended questions will be analyzed using qualitative methods, specifically thematic analysis to extract themes among participant responses.

Section A – Justification

1. Circumstances Making the Collection of Information Necessary

Background

This information collection is being conducted using the Generic Information Collection mechanism of the OSTLTS OMB Clearance Center (O2C2) – OMB No. 0920-0879. The respondent universe for this information collection aligns with that of the O2C2. Data will be collected from a total of 1,057

medical countermeasure (MCM) officials across 1,057 state, territorial, and local health departments. Respondents include:

- 62 Public Health Emergency Preparedness (PHEP) awardees (CDC-RFA-TP17-1701) from 50 states, eight territories and freely associated states, and four cities.
- 995 MCM officials from 118 large, 287 medium, and 599 small local health departments (LHDs) across 45 states. Note: Rhode Island and Hawaii do not have local health departments, and therefore no respondents from those states will be included in the sample for LHDs; Delaware, Alaska, and South Carolina are also not included in the sample in an effort to reduce burden because the limited number of local health departments in these states have been used for recent assessments for NACCHO.

More information on the health departments targeted for this data collection can be found in Attachments B and C. Attachment B is a high level summary of the sample groups (see **Attachment B – Sample of MCM Officials Table**). Attachment C describes the sample groups by number of respondents, as well as STLT type, size, and location. It also lists the specific local health departments in the sample by state and size (see **Attachment C – Respondent Universe**). MCM officials are senior staff within health departments whose responsibilities include MCM coordination and preparedness efforts within their jurisdictions. The respondents are likely to have a good sense of the variety of MCM training needs in each health department, so this information is critical to assessing the MCM training needs across the country.

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 problems²

The terrorist and anthrax attacks of 2001 demonstrated the importance of public health preparedness and response in the United States. As a result of these attacks, Congress set up the PHEP cooperative agreement to support state, territorial, local, and tribal health departments in building their preparedness capacity for natural, biological, chemical, radiological, and nuclear incidents.³ The Division of State and Local Readiness (DSLRL) manages this PHEP cooperative

agreement among 50 state, eight territorial and freely associated state, and four local city public health departments across the nation.⁴ This funding supports field staff who focus on preparedness activities and enable recipients to establish and maintain laboratories that have the capability to rapidly identify and respond to chemical threats.⁵

Recently, even greater emphasis has been placed on public health preparedness and response with the launch of the Global Health Security Agenda by the World Health Organization (WHO). This agenda aims to build the capacities of all countries to create a world safe from infectious disease and other threats. To determine each county's preparedness capacity, the WHO created the Joint External Evaluation (JEE) tool; the U.S. voluntarily participated in a 2016 JEE assessment. The JEE identified local workforce assessments as a major area that needs strengthening in the United States, and the JEE team's first recommendation for United States Public Health Workforce Development is to study the gaps in needs and staffing at the state and local levels. This was recommended in order to inform a CDC plan for national public health workforce development.¹

DSLRL supports public health workforce development by providing technical assistance to state, local, territorial, and tribal health departments to ensure they are able to effectively respond to a range of public health threats. Through funding and technical assistance, the PHEP program aims to advance six main areas of preparedness: community resilience, incident management, information management, countermeasures and mitigation, surge management, and biosurveillance.⁶ This information collection focuses on the countermeasures and mitigation preparedness area. This area involves getting MCMs to where they are needed in a public health emergency. MCMs are life-saving medicines and medical supplies regulated by the U.S. Food and Drug Administration that can be used to diagnose, prevent, protect from, or treat conditions associated with chemical, biological, radiological, or nuclear threats, emerging infectious diseases, or a natural disaster. These include biologic products, such as vaccines; drugs, such as antivirals; and devices, such as respirators and ventilators.⁷

Training is essential for ensuring that health departments are able to efficiently distribute and dispense MCMs during an emergency. The DSLRL Applied Learning and Development Team (ALDT) designs and conducts these trainings to enhance MCM readiness nationwide. Because public health preparedness has evolved greatly in the past 10-15 years,³ the ALDT must update these trainings to meet the current needs of the nation. However, the nation's MCM training needs have not been definitively established, as consultations with CDC MCM subject matter experts and extensive literature searches conducted by CDC librarians have uncovered that a comprehensive MCM training needs assessment has never been systematically conducted. To begin identifying potential MCM training needs, the DSLRL ALDT worked with federal, state, and local partners to develop a comprehensive list of common responsibilities and associated skills for MCM Officials. These consist of six CDC-identified responsibilities, each with six to nine associated skills, that are beneficial to MCM Officials in working toward preparing their jurisdictions for emergencies requiring MCMs (see **Attachment A – MCM Coordinator Common Responsibilities and Associated Skills**).

The purpose of this information collection is to gather data to assess the gaps in MCM Officials' ability to perform these common responsibilities and associated skills. The information collected will gather baseline data on which skills need the most attention, how training needs change over the course of one's MCM-related career, and how CDC can better design MCM trainings that will fit within the current training models at state, territorial, local, and tribal health departments. The data from this information collection will be used to make decisions regarding the content of CDC-developed MCM trainings and inform the creation of a comprehensive five-year MCM training plan while addressing one of the priority areas established by the Global Health Security Agenda goals in the United States.¹

The National Association of County and City Health Officials (NACCHO) is funded through the PHEP cooperative agreement (CDC-RFA-TP17-1701) by CDC for this information collection. NACCHO is an organization comprised of almost 3,000 local health departments across the United States. They work closely with local health departments providing support in preparedness and response to public health emergencies. NACCHO's approach aligns closely with that of the CDC PHEP program. NACCHO sends out a preparedness profile to assess the general state of preparedness in local and tribal health departments.⁸ In this information collection, NACCHO programmed the electronic assessment and has the role of sending it to the respondent universe via email. NACCHO will also conduct group interviews with MCM Officials from both local health departments and those under the PHEP cooperative agreement. NACCHO will share de-identified data with CDC from both the online assessment and group interviews.

Overview of the Information Collection System

Data will be collected from 62 PHEP and 995 local MCM officials via electronic training needs assessment and a virtual group interview sign-up form (see **Attachment D – Training Needs Electronic Assessment, Word Version, Attachment E - Training Needs Electronic Assessment, Web Version Screenshots, Attachment F – Virtual Group Interview Sign-up Form, Word Version, and Attachment G – Virtual Group Interview Sign-up Form, Web Version Screenshots**). Virtual group interviews (see **Attachment H – Virtual Group Interview Discussion Guide, Word Version and Attachment I- Virtual Group Interview Discussion Guide, Web Version Screenshots**) will be conducted with a portion of respondents that completed the electronic assessment (see **Attachment B – Sample of MCM Officials Table and Attachment C - Respondent Universe**). The MCM Coordinator Common Responsibilities and Associated Skills were used to inform the development of the data collection instruments (see **Attachment A – MCM Coordinator Common Responsibilities and Associated Skills**). The instruments will be used to gather information from MCM officials nationwide regarding their MCM training needs, including which skills need the most attention, how their training needs have changed over the course of their MCM-related career, and how CDC can better design trainings that will fit within their jurisdiction's training model.

All information collection instruments were pilot tested by the same nine public health professionals. Feedback from this group was used to refine questions as needed, ensure accurate

programming and skip patterns, and establish the estimated time required to complete the information collection instruments.

Items of Information to be Collected

The first primary data collection for this assessment is the electronic assessment instrument (see **Attachment D –Training Needs Electronic Assessment, Word Version** and **Attachment E - Training Needs Electronic Assessment, Web Version Screenshots**). The assessment instrument consists of 38 main questions of various types, including dichotomous (yes/no), multiple response, interval (rating scales), and open-ended text entry. The electronic assessment instrument will be used to gather information on the training needs of MCM officials.

In order to determine which MCM skills need the most attention in future trainings, how training needs may change over the course of one’s MCM-related career, and how CDC can better design trainings that fit within a variety of jurisdiction types, the instrument will collect data on the following areas:

- Section 1: Eligibility (e.g., whether the respondent is a primary person responsible for MCM planning and operations in their health department)
- Section 2: Demographics (e.g., number of years working in MCM and size of jurisdiction)
- Section 3: Training experiences (e.g., types of training taken and barriers to receiving and conducting training)
- Section 4: Planning and exercise experience (e.g., contributions to MCM preparedness and response plans and number of exercises participated in during the past year).
- Section 5: Current training needs for the six MCM Coordinator Common Responsibilities and Associated Skills and disaster medicine concepts (e.g., which associated skills are part of their position, confidence in performing the common responsibilities, and knowledge of disaster medicine concepts.) The six MCM Coordinator Common Responsibilities include:
 - Emergency response communication and information management
 - Incident management
 - Leveraging partnerships
 - Program evaluation and technical assistance
 - Program planning and operations
 - Grants management and administration.

Respondents will be asked to indicate their interest in participating in a virtual interview by completing the sign up form (see **Attachment F – Virtual Group Interview Sign-up Form, Word Version, Attachment G – Virtual Group Interview Sign-up Form, Web Version Screenshots**). This signup form will ask participants for their name, email address, health department, which group interview discussion they are volunteering to participate in, and their consent to be recorded during the group interview. This information will not be shared with CDC. The purpose of this sign-up form is to ensure at least 5 participants will attend each group interview discussion and provide NACCHO with contact information to share instructions on joining the virtual group interview discussion.

The final method of primary data collection is the virtual group interview discussion instrument (see **Attachment H – Virtual Group Interview Discussion Guide, Word Version and Attachment I – Virtual Group Interview Discussion Guide, Web Version Screenshots**). This consists of 6 main, open-ended questions. Each of these questions has one to four follow up questions, which the facilitator may choose to ask if the participants of the group interview need clarification or do not answer the main question. In order to gather in-depth information on current MCM training models at the state, territorial, and local levels, how CDC can design training to fit within these models, and necessary skills for MCM Officials during various stages of their careers, the focus groups will collect data on the following topics:

- Necessary MCM Skills:
 - Essential skills for MCM Officials
 - Changes in skills and training needed throughout career
- MCM Training Models:
 - All-hazards preparedness planning trainings in participants’ jurisdictions
 - How MCM training is implemented in participants’ jurisdictions
 - Who needs MCM training within participants’ jurisdictions
 - Barriers and facilitators to MCM training within their jurisdiction
- CDC’s role:
 - What trainings and resources CDC can provide
 - CDC resources that are currently being used

2. Purpose and Use of the Information Collection

The purpose of this information collection is to assess the gaps in MCM Officials’ ability to perform the MCM Coordinator Common Responsibilities and Associated Skills. These consist of six CDC-identified responsibilities, each with six to nine associated skills, that are beneficial to MCM Officials in working toward preparing their jurisdictions for emergencies requiring MCMs (see **Attachment A – MCM Coordinator Common Responsibilities and Associated Skills**). CDC created this document to aid in assessing the training needs of MCM Officials across the country. These responsibilities and skills were developed with input from Centers for Disease Control and Prevention (CDC) MCM subject matter experts, the National Association of County and City Health Officials (NACCHO), and the Association of State and Territorial Health Officials (ASTHO). The information collected will gather baseline data on which skills need the most attention, how training needs change over the course of one’s MCM-related career, and how CDC can better design MCM trainings that will fit within the current training models at the state, territorial, local, and tribal health departments.

The data will be used to inform the development and delivery of CDC-sponsored MCM trainings and create a comprehensive five-year MCM training plan based on the stated needs of respondents. This needs assessment and the resulting trainings will address the priority areas of the Workforce Development section of the Joint External Evaluation of the United States of America for the World Health Organization’s Global Health Security Agenda.¹

3. Use of Improved Information Technology and Burden Reduction

An electronic assessment was deemed the most appropriate method to gather information from a large audience to quantify and prioritize MCM training needs. The electronic assessment will provide the DSLR ALDT with a quantitative snapshot of the training needs of MCM officials nationwide. The group interviews were chosen to provide CDC with more insight into the quantitative results, capture in-depth detail regarding how the CDC can best meet MCM training needs, as well as uncover information that could not be effectively asked in electronic assessment form, such as detailed descriptions of how training needs have changed over their career and existing MCM training models at the state, local, and territorial levels. The data collection instruments were designed to collect the minimum information necessary for the purposes of this project (i.e., limited to 38 electronic assessment questions and six focus group questions).

4. Efforts to Identify Duplication and Use of Similar Information

To our knowledge, no prior MCM-focused training needs assessment has been conducted among local, state, and territorial health departments nationwide. The DSLR ALDT and the Division of the Strategic National Stockpile (DSNS) Learning Team are the only two teams in the federal government developing trainings on medical countermeasures for state and local health departments. While the DSNS Learning Team assessed prior course attendees several years ago, these questions focused on the usefulness of the trainings attended, not to broadly identify needs. To our knowledge, based on inquiry of MCM staff at CDC and extensive literature reviews conducted by CDC librarians, there has been no other nationwide assessment of medical countermeasure training needs. Therefore, this assessment is the first of its kind. Additionally, CDC is coordinating externally with ASTHO and NACCHO to ensure assessment questions do not duplicate those asked of state and local health departments in questionnaires distributed by those organizations.

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:

- Systematically identify gaps in MCM officials' abilities to perform common MCM responsibilities and associated skills
- Determine the training needs for MCM officials across the country
- Develop a comprehensive MCM training plan that meets the needs of MCM officials and other MCM staff across the country

- Design and implement targeted trainings that meet the needs of MCM officials and staff across the country
- Sufficiently address a major priority area for United States Public Health Workforce Development identified by the WHO's Global Health Security Agenda's JEE: to study gaps in needs and staffing at state and local levels to inform a national plan for public health workforce development

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 data collection is being conducted using the Generic Information Collection mechanism of the OSTLTS OMB Clearance Center (O2C2) – OMB No. 0920-0879. 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.

The Centers for Disease Control and Prevention partners with professional state, territorial, local, and tribal organizations, such as ASTHO, NACCHO, and the National Association of Local Boards of Health along with the National Center for Health Statistics to ensure that the collection requests under individual information collections 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. State, territorial, local, and tribal governmental staff and / or delegates will be speaking from their official roles.

This data collection is not research involving human subjects.

Although NACCHO will collect some individually identifiable information (IIF) related to the official roles of respondents, including participant names, emails, and name of jurisdiction, to send email invitations to participants for the focus group corresponding with their jurisdiction

size. NACCHO will collect this information, and it will not be shared with CDC. The data will be stored in NACCHO's secure Qualtrics account, downloaded onto password protected computers, and stored on servers accessible only to NACCHO project team members. Data collected during the assessment will be shared only in aggregate form. No IIF will be distributed, and CDC will not have access to any IIF collected by the partner

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

No information will be collected that are of sensitive nature.

12. Estimates of Annualized Burden Hours and Costs

MCM Training Needs Electronic Assessment: The estimate for burden hours is based on a pilot test of the electronic assessment instrument by nine public health professionals. In the pilot test, the average time to complete the electronic assessment instrument, including time for reviewing instructions, gathering needed information, and completing the instrument, was 31 minutes (range: 7 – 59 minutes). For the purposes of estimating burden hours, the average time (i.e., 31 minutes) is used.

Virtual Group Interview Sign-Up Form: The estimate for burden hours is based on a pilot test of the group interview sign-up form by the same nine public health professionals from the electronic assessment. The software used for this assessment demonstrates that each response was submitted within the same minute. For the purposes of estimating burden hours, one minute will be used.

MCM Training Needs Virtual Group Interviews: The estimate for burden hours is based on a pilot test of the group interview instrument (see **Attachment H – Virtual Group Interview Discussion Guide, Word Version and Attachment I – Virtual Group Interview Discussion Guide, Web Version Screenshots**) by the same nine public health professionals who piloted the assessment instrument. In the pilot test, the time to complete the group interview instrument including time for reviewing instructions, gathering needed information and completing the instrument, ranged from 50-90 minutes. For the purposes of estimating burden hours, the average time (i.e., 73 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 MCM Coordinators. Based on DOL data, an average hourly wage of \$27.84 is estimated for all 1,057 respondents. Table A-12 shows estimated burden and cost information.

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

| | 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 |
|--------------------------------------|--|--------------------|---------------------------------|--|--------------------|------------------|------------------------|
| Electronic Assessment | MCM Officials – PHEP cooperative agreement | 62 | 1 | 31/ 60 | 32 | \$27.84 | \$891 |
| | MCM Officials – NACCHO Contacts | 995 | 1 | 31/ 60 | 514 | \$27.84 | \$14,310 |
| Virtual Group Interview Sign-up Form | MCM Officials – PHEP Cooperative Agreement | 62 | 1 | 1/60 | 1 | \$27.84 | \$28 |
| | MCM Officials – NACCHO Contacts | 995 | 1 | 1/60 | 17 | \$27.84 | \$473 |
| Virtual Group Interview Discussions | MCM Officials – PHEP Cooperative Agreement | 15 | 1 | 73 / 60 | 18 | \$27.84 | \$501 |
| | MCM Officials – NACCHO Contacts | 45 | 1 | 73 / 60 | 55 | \$27.84 | \$1,531 |
| | TOTALS | 2174 | | | 637 | | \$17,734 |

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 and Oak Ridge Institute for Science and Education (ORISE) Fellows to

develop the data collection instrument, collect data, and perform data analysis. The total estimated cost to the federal government is \$38,500. 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 |
|---|------------------------------|---------------------|--------------------|
| Training Specialist – GS-12, Step 4 (project lead) | 420 | \$39.90 | \$16,758 |
| Health Scientist – GS-12, Step 5 (instrument design and data analysis) | 120 | \$41.10 | \$4,932 |
| ORISE Fellow – core staff for instrument design, data collection, and data analysis | 560 | \$20.50 | \$11,480 |
| ORISE Fellow – core staff for data collection and data analysis | 260 | \$20.50 | \$5,330 |
| Estimated Total Cost of Information Collection | | | \$38,500 |

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

De-identified data collected from NACCHO will be stored on the password-protected computers of DSLR staff and on secure CDC servers. The DSLR ALDT and Applied Sciences and Evaluation Branch will analyze the data through a mixture of quantitative methods, descriptive and inferential statistics, for closed-ended questions and qualitative methods and thematic analysis, for open-ended questions.

All information shared with stakeholders will be reported in aggregate form. Formal reports will be written for view and use by the DSLR ALDT and DSNS Learning Team. The data will be used to inform the development and delivery of CDC-sponsored MCM trainings and create a comprehensive five-year MCM training plan based on the stated needs of respondents. The data collected will allow the DSLR ALDT to design updated trainings that target the most highly needed knowledge and skills, as identified by the population intended to benefit from MCM trainings. This will maximize the efficient use of the DSLR, as the resulting trainings will fill the identified knowledge and skill gaps to better prepare the nation to respond in a public health emergency requiring MCMs. Sections of this report will also provide CDC with information that can inform development of a public health workforce development plan, as was established as a priority area by the Joint External Evaluation of the United States of America for the World Health Organization’s Global Health Security Agenda.

Project Time Schedule

| Task | Timeline | Status |
|---|---|------------|
| Design instruments | 8 weeks | COMPLETE ✓ |
| Develop protocol, instructions, and analysis plan | 8 weeks | COMPLETE ✓ |
| Pilot test instruments | 2 weeks | COMPLETE ✓ |
| Prepare OMB package | 16 weeks | COMPLETE ✓ |
| Submit OMB package | 4 weeks | TBD -- |
| OMB approval | In process | TBD -- |
| Conduct data collection | Weeks 1-6 after OMB approval | TBD -- |
| Code, quality control, and analyze data | Within 4 weeks after data collection | TBD -- |
| Prepare summary reports | Within 8 weeks after data analysis | TBD -- |
| Disseminate final results/reports | Within 4 weeks after summary reports prepared | TBD -- |

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 – MCM Coordinator Common Responsibilities and Associated Skills
- Attachment B – Sample of MCM Officials Table
- Attachment C – Respondent Universe
- Attachment D – Training Needs Electronic Assessment, Word Version
- Attachment E – Training Needs Electronic Assessment, Web Version Screenshots
- Attachment F – Virtual Group Interview Sign-up Form, Word Version
- Attachment G – Virtual Group Interview Sign-up Form, Web Version Screenshots
- Attachment H – Virtual Group Interview Discussion Guide, Word Version
- Attachment I – Virtual Group Interview Discussion Guide, Web Version Screenshots

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