

Assessment of Partnerships Impacting STD Outcomes in Areas of Service Reduction

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 assess the value, need, gaps, and impact of strategic partnerships between territorial and local health departments (LHD) with the highest STD morbidity (syphilis, chlamydia and gonorrhea) and their STD clinical partners.
- **Intended use of the resulting data:** The results will be used to inform territorial and LHD partnership building efforts to ensure effective strategies for achieving desired outcomes for priority STD clinical partnerships, and thereby, quality local STD services nationwide. Specifically, the results will be used to better understand: 1) what factors led to territorial and LHD to develop strategic clinical partnerships; 2) how territorial and LHD are using priority clinical partners to provide STD clinical services to at-risk populations and whether STD clinic reduction, declining resources and/or limited resources have led to clinical partnerships; 3) what the essential components and characteristics of successful clinical partnerships are; 4) what specific successes were achieved as a result of priority clinical partnerships; 5) what specific contributions of clinical partners and desired outcomes of STD clinical partnerships are; and 6) what types of costs are associated with the priority clinical partnerships.
- **Methods to be used to collect data:** Information will be collected via two different methods: a web-based assessment and in-person interviews.
- **Respondent Universe:** The respondent universe for this information collection will consist of a total of 154 state, territorial and local health department respondents from 59 jurisdictions with the highest morbidities of syphilis, gonorrhea and chlamydia in each of the 50 states, 2 US territories (the US Virgin Islands and Puerto Rico), and the 7 directly-funded cities (Baltimore, Chicago, District of Columbia, Los Angeles, New York City, Philadelphia and San Francisco) funded under the CDC Assessment, Assurance, Policy Development, and Prevention Strategies, or STD-AAPPS (“PS14-1402”) cooperative agreement. Respondents acting in their official capacities include STD program managers, STD coordinators, and data managers/epidemiologists.
- **How data will be analyzed:** For the web-based assessment, information will be reviewed for completion and simple descriptive statistics will be run looking at response frequencies. Depending on the response distribution, frequencies may be cross-tabulated to identify response similarities and differences among subgroups of respondents. For the in-person interviews, a directed form of content analysis will be performed to analyze data, using the project’s assessment questions as guides.

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 154 state, territorial and local health department respondents from 59 counties/cities with the highest morbidities of syphilis, gonorrhea and chlamydia in each of the 50 states, 2 US territories (the US Virgin Islands and Puerto Rico), and the 7 directly-funded cities (Baltimore, Chicago, District of Columbia, Los Angeles, New York City, Philadelphia and San Francisco) funded under the CDC Assessment, Assurance, Policy Development, and Prevention Strategies, or STD-AAPPS (“PS14-1402”) cooperative agreement. Respondents acting in their official capacities include STD program managers, STD coordinators and data managers/epidemiologists (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 problems¹

The mission of the Program Development and Quality Improvement Branch (PDQIB) and the Division of STD Prevention (DSTD) at the Centers for Disease Control and Prevention (CDC) is to provide national leadership, research, guideline development, and scientific information to help people live safer, healthier lives by the prevention of STDs and their complications. DSTD funds 59 state, territorial and local health departments (50 states, 2 US territories (the US Virgin Islands and Puerto Rico), and the 7 directly-funded cities: Baltimore, Chicago, District of Columbia, Los Angeles, New York City, Philadelphia and San Francisco) for STD prevention and control. STD programs have long sought and maintained relationships with clinical partners to ensure that high quality STD services are accessible to all who need them in the communities

they serve². These partnerships arguably have become even more important more recently, as the infrastructure of both healthcare and public health sector in the US changes rapidly³.

Clinical partners are defined as an entity that supports STD clinical services, which may include private health care provider or organization, community health center or federally qualified health center, correctional facility, educational institution, family planning/ reproductive health clinic, HIV/AIDS prevention or care program, hospital, maternal and child health program, behavioral or mental health agency, tribal organization or other community based organizations.

Specific to STD clinical services, in recent years many STD clinics have reduced hours and services, or closed due to dwindling resources. However, it is unclear what services are provided by LHD, how partnerships are used to provide services, when or why partnerships were created between territorial and LHD and external partners. Not knowing this information makes it difficult to build efforts to ensure effective strategies for achieving desired outcomes for STD clinical partnerships.

An infrastructure assessment conducted in 2013-2014 found that 33% of responding STD programs indicated at least one negative impact due to recent budget cuts. Among those identifying negative impacts, 43% cited a reduction in clinic hours, 40% cited a reduction routine screening, and 40% cited reductions in partner services for STDs other than early syphilis⁴. The findings highlighted additional gaps regarding how STD programs were using partnerships to achieve desired clinical outcomes, in the face of declining resources and STD clinic closures. Since that assessment, anecdotal information indicates the problem has worsened. Although it is difficult to ascertain where people now go for STD clinical services as a direct result of the STD clinic reductions or closures, it is easy to see that STD clinical partnerships are as critical as ever to the success of STD prevention and control.

In this assessment, we are asking territorial and LHD respondents to identify the top three clinical partnerships used to ensure quality STD clinical services. PDQIB is aware of some of the types of clinical partnerships that territorial and LHD have developed over the years. However, it is unclear 1) what factors led territorial and LHD to develop strategic clinical partnerships; 2) how territorial and LHD are using priority clinical partners to provide STD clinical services to at-risk populations and whether STD clinic reduction, declining resources and/or limited resources have led to clinical partnerships; 3) what essential components and characteristics of successful clinical partnerships are and specific successes achieved as a result of priority clinical partnerships; 4) what specific contributions of clinical partners and desired outcomes of STD clinical partnerships are; and 6) what types of costs are associated with the priority clinical partnerships.

To gather key information to better understand these critical areas, the purpose of this data collection is to assess the value, need, gaps, and impact of strategic partnerships between

territorial and LHD with the highest STD morbidity (syphilis, chlamydia and gonorrhea) and their priority STD clinical partners.

PDQIB executed a contract with The Cloudburst Group, LLC, who have subcontracted with John Snow, Inc. (JSI), the Association of State and Territorial Health Officials (ASTHO), and Waypoints Consulting to conduct the following tasks: instrument development, instrument piloting, data collection, data analysis and report development. The Cloudburst Group has prior experience conducting assessments, including piloting and scoping studies, impact assessments, as well as environmental assessments. They have conducted both single and multi-site assessments for state and federal clients including CDC, United States Agency for International Development (USAID), US Housing & Urban Development Department (HUD), and the Substance Abuse and Mental Health Services Administration (SAMHSA). We have also asked of the National Coalition of STD Directors (NCSO) and the National Association of County and City Health Officials (NACCHO) for their support with the data collection effort, which would include allowing us to state that they are supportive of this assessment (to improve assessment response rates). They will not be involved in data collection efforts.

The results will be used to inform territorial and LHD partnership building efforts to ensure effective strategies for achieving desired outcomes for priority STD clinical partnerships, and thereby, quality local STD services nationwide. This assessment will help PDQIB provide better guidance to territorial and LHD on how to mobilize community partnerships to identify and solve health problems, specifically STDs. Because of this assessment activity, PDQIB will be able to develop guidelines strategies to territorial and LHD for their development of guidelines and plans that support individual and community health efforts related to STD clinical services.

Overview of the Information Collection System

Two data collection instruments will be used in this collection and two referral forms. The referral forms will be used to collect contact information to administer the web-based assessment and in-person interviews (see **Attachment B- STD Program Manager Referral Form and Attachment C- In-person Interview Referral Form**). There will be: one web-based assessment on the value, need, gaps, and impact of strategic partnerships between territorial and LHD with the highest STD morbidity (syphilis, chlamydia and gonorrhea) and their STD clinical partners (see **Attachment D- Web-based Assessment Instrument- Word and Attachment E- EPP Web-based Instrument- Web Version**); and two in-person interview guides to glean contextual information on territorial and LHD strategic STD clinical partnerships, lessons learned and promising practices that will inform guidance to territorial and LHD on how to mobilize community partnerships (see **Attachment F- EPP- In-Person Interview Guide STD Program Manager and STD Coordinator and Attachment G- EPP- In-Person Interview Guide Data Manager**). Data will be collected from state, local, and territorial STD program managers, local STD coordinators, and local data managers/epidemiologists.

Information collection instruments were pilot tested by a total of 8 public health professionals. Feedback 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

A description of each of the information collection instruments is provided below.

Web-based Assessment

The web-based assessment instrument (see **Attachment D- Web-based Assessment Instrument- Word and Attachment E- Web-based Assessment Instrument-Web version**) consists of 38 questions of various types, including dichotomous (yes/no), multiple choice and response interval (rating scales). The web-based assessment instrument will collect information on the following:

- Respondent descriptive information such as the county/city name. This information will be collected as a way to stratify results by morbidity and geographic location.
- Status of STD clinic closures within the jurisdiction
- Basic information about provision of safety net STD services
- Reduction of clinical and in-kind resources
- Types of clinical partnerships
- Status of clinical partnerships (e.g., length of partnership, reasons for partner selection, types of agreement)
- Priority at-risk populations addressed due to priority partnerships
- Resources and collaborative activities provided by priority partnerships
- Frequency of priority partner engagement
- Partnership structure
- Barriers associated with implementing priority partnerships
- Most important partnership components
- Assessment of desired outcomes (e.g., defining desired outcomes and goals, assessed outcomes, measured quantitative outcomes, assessed economic value)

Additionally, contact information to recruit participants for the web assessment will be obtained via referral form (see **Attachment B- STD Program Manager Referral Form**). Information that will be collected will include: name, business role, business email address and business phone number.

In-person Interviews

The in-person interview guide will complement the web-based assessment and provide much-needed context. The in-person interview guides (See Attachment F- EPP- In-Person Interview Guide STD Program Manager and STD Coordinator and Attachment G- EPP- In-Person Interview Guide Data Manager/Epidemiologist) consists of 30 questions for the STD Program Manager and other STD Program Staff and 13 questions for Data Managers, most of which are open-ended.

The in-person interview guides for **STD Program Manager and STD Coordinator** will collect information on the following:

- Respondent descriptive information, related to their official duties, including position title, amount of time in professional position, and level of involvement with partner agencies. This information is being collected as these factors may influence perception of clinical partnership and clinical outcomes associated with priority partnerships.
- Context of partnership selection criteria and development
- Relationship between partnership selection and budget cuts
- Examples of how partner resources are utilized to address STD clinical gaps
- Actual STD clinical partnership outcomes
- STD clinical partnership effectiveness
- Barriers to developing and maintaining STD clinical partnerships
- Essential components of STD clinical partnerships in practice
- Additional partners needed

The in-person interview guide for the **Data Manager/Epidemiologist** will collect information on the following:

- Data collection and management at your organization related to STD screening and treatment
- Effect budget cuts on STD prevention data collection and management
- Importance of STD clinical partners identified in assessment
- Completeness of the STD positivity and treatment data from partners
- Partner-specific data sharing guidelines, procedures, protocols
- Data collection and extraction barriers
- Data analysis with top three STD clinical partners
- Utilization of partner data to inform program planning or implementation

Contact information to recruit participants for the interviews will be obtained via referral form (see **Attachment C- In-person Interview Referral Form**). Information that will be collected will include: name, business role, business email address and business phone number.

2. Purpose and Use of the Information Collection

The purpose of this data collection is to assess the value, need, gaps, and impact of strategic partnerships between territorial and LHD with the highest STD morbidity (syphilis, chlamydia and gonorrhea) and their STD clinical partners.

The results will be used to inform territorial and LHD partnership building efforts to ensure effective strategies for achieving desired outcomes for priority STD clinical partnerships, and thereby, quality local STD services nationwide. Specifically, the results will be used to better

understand: 1) what factors led to territorial and LHD to develop strategic clinical partnerships; 2) how territorial and LHD are using priority clinical partners to provide STD clinical services to at-risk populations and whether STD clinic reduction, declining resources and/or limited resources have led to clinical partnerships; 3) what the essential components and characteristics of successful clinical partnerships are; 4) what specific successes were achieved as a result of priority clinical partnerships; 5) what specific contributions of clinical partners and desired outcomes of STD clinical partnerships are; and 6) what types of costs are associated with the priority clinical partnerships.

3. Use of Improved Information Technology and Burden Reduction

Web-based Assessment

The web-based assessment was chosen to allow respondents to complete and submit their responses electronically, reducing the overall burden on respondents. This information collection instrument was designed to collect the minimum information necessary for the purposes of this project (i.e., limited to 38 questions). Also, skip patterns were incorporated to allow for streamlining responses, further reducing overall burden on respondents.

In-Person Interviews

Although web-based assessments are quick, effective methods for collecting quantitative data from many respondents, in-person interviews can solicit rich qualitative data, which aligns to the purpose of this information collection. The in-person interview guides were designed to collect the minimum information necessary for the purposes of this project (i.e., interview guide limited to 30 questions for STD Program Managers/STD Coordinators and the interview questions for the Data Managers/Epidemiologists limited to 13 questions). Embedded within each interview guide are skip patterns which will customize the interview to respondent answers, minimizing the overall burden on respondents. The advantages of the in person interviews are that they facilitate the exchange of ideas and are conducive to asking more complex questions and obtaining more detailed responses, allowing for a visual connection and personal interaction between the interviewer and respondent.

4. Efforts to Identify Duplication and Use of Similar Information

In 2017, DSTDP conducted an assessment through the 0920-0879 entitled STD Prevention and Control: Assessment of the STD AAPPS Funding Program. That assessment was a broad data collection effort to obtain the status of STD prevention and control activities funded through the federal "STD AAPPS" funding program. This proposed information collection is different, as the previous collection did not collect partnership information, nor was STD clinical partnerships the focus of the assessment. To date, no other information has been conducted on the value, need, gaps, and impact of strategic partnerships between territorial and LHD with the highest STD morbidity (syphilis, chlamydia and gonorrhea) and their priority STD clinical partners. The information that will be gathered through this information collection is not available from

other data sources or through other means. Prior to developing this information collection, staff at The Cloudburst Group conducted literature searches and collaborated with CDC partners to confirm that this effort is not duplicative.

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 assess the value, need, gaps, and impact of strategic partnerships between territorial and LHD with the highest STD morbidity (syphilis, chlamydia and gonorrhea) and their STD clinical partners. Additionally, we would not be able to inform territorial and LHD partnership building efforts to ensure effective strategies for achieving desired outcomes for priority STD clinical partnerships.

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.

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 and / or delegates will be speaking from their official roles. Although The Cloudburst Group will collect some individually identifiable information (IIF) related to the official roles of respondents, including name, work email, and office telephone numbers, all information will be kept on secure, password protected servers accessible only to project team members. The Cloudburst Group will store data on a secure server and a private file transfer protocol (FTP) will be used to transfer computer files to CDC. Data collected during the assessment will be shared only in aggregate form. No IIF will be distributed. In reports of study findings, data on IIF will be reported in aggregate form and no statistics or quotes will be linked to individuals.

This data collection is not research involving human subjects.

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

No information will be collected that are of personal or sensitive nature.

12. Estimates of Annualized Burden Hours and Costs

Pilot tests were conducted with a total of 8 public health professionals. The estimate for burden hours is based on pilot tests of the STD program manager referral form and the in-person interview referral form with 2 public health professionals, the web-based assessment instrument and the in-person interview guide for STD Program Managers and STD Coordinator by 4 public health professionals, and the in-person interview guide for data managers/epidemiologists with 2 public health professionals.

In the pilot tests, the average time to complete the **STD program manager referral form** including time for reviewing instructions and completing the referral form was 10 minutes (range: 5 - 15 minutes). For the purposes of estimating burden hours, the upper limit of this range (i.e., 15 minutes) is used. Although 15 minutes may seem like a lot of time to complete a referral form, the pilot test showed that frequent staff turnover led to instances where contact information was not always readily accessible.

In the pilot test of the **web-based assessment instrument**, the average time to complete the instrument, including time for reviewing instructions, gathering needed information and completing the instrument, was approximately 38 minutes (range: 30 to 60 minutes). For the purposes of estimating burden hours, the upper limit of this range (i.e., 60 minutes) is used.

In the pilot tests, the average time to complete the **in-person interview referral form** including time for reviewing instructions and completing the referral form was 15 minutes (range: 10 - 20 minutes). For the purposes of estimating burden hours, the upper limit of this range (i.e., 20 minutes) is used. Although 20 minutes may seem like a lot of time to complete a

referral form, the pilot test showed that frequent staff turnover led to instances where contact information was not always readily accessible.

In the pilot test of the **In-Person Interview Guide for STD Program Manager and STD Program Coordinators**, the average time to complete each of the instruments, including time for reviewing instructions and completing the instruments, was approximately 50 minutes (range: 45 to 60 minutes). For the purposes of estimating burden hours, the upper limit of this range (i.e., 60 minutes) is used.

In the pilot test of the **In-Person Interview Guide for Data Manager/Epidemiologist**, the average time to complete each of the instruments, including time for reviewing instructions, gathering needed information and completing the instruments, was approximately 35 minutes (range 25-40 minutes). For the purposes of estimating burden hours, the upper limit of this range (i.e., 40 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 (11-9111), Other Healthcare Practitioners (29-9000) and Epidemiologists (19-1041) (http://www.bls.gov/oes/current/oes_nat.htm). Based on DOL data, an average hourly wage of \$52.58 is estimated for STD program managers, an average hourly wage of \$30.41 for STD coordinators, and an average hourly wage of \$37.37 is estimated for data managers/epidemiologists. Table A-12 shows estimated burden and cost information. There will be a total of 154 respondents and 184 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
STD Program Manager Referral form	AAPPS State STD Program Manager	50	1	15/60	13	\$52.58	\$684
In-person interview referral form	Local STD Program manager	15	1	20/60	5	\$52.58	\$263
Web-based assessment instrument	Territorial and Local STD program manager	59	1	60 / 60	59	\$52.58	\$3,102
In-Person	Local STD	15	1	60 / 60	15	\$52.58	\$789

interviews	program manager						
In-Person interviews	Local STD program coordinator	30	1	60/60	30	\$30.41	\$912
In-person interviews	Local Data manager/Epi demologist	15	1	40/60	10	\$37.37	\$374
	TOTALS	184	1		132		\$6,124

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 contractors to develop the data collection instrument, collect data, perform data analysis, and develop summary reports and presentations. Contractors are being used to support the following tasks: instrument development, instrument piloting, data collection, data analysis and report development. The total estimated cost to the federal government is \$227,938.00. 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
CDC Public Health Analyst – GS-14, Step 10; Instrument development, IT security clearance preparation, overview of information analysis and report preparation.	100	\$67.45/hour	\$6,745.00
CDC Health Scientist: (GS 13, Step 6) Instrument development, OMB package preparation, overview of information analysis and report preparation.	100	\$51.22/hr	\$5,122.00
Contractor Staff Time			
Contractor: The Cloudburst Group (4 staff) Subcontractors: JSI (2 staff); ASTHO (1 staff); Waypoints Consulting (1 staff)—8 total			\$216,071.00
Estimated Total Cost of Information Collection			\$227,938.00

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

The Cloudburst Group will manage the analysis of the data collected. The Cloudburst Group will export the quantitative data for the web-based assessment from their Survey Monkey account into a Microsoft Excel file. The Cloudburst Group maintains strict security controls on electronic data. Shared aggregate data will be stored on CDC servers using a Sharefile portal and restricted to authorized project staff only. To protect respondents, The Cloudburst Group will store the raw dataset, email recipient name and email address, separately from the analytic dataset, which will use a project-assigned id to replace identifying variables. The Cloudburst Group will be stored on secure, password-protected servers accessible only to project staff. The Cloudburst Group's staff will review information for completeness and simple descriptive statistics will be run looking at response frequencies. Depending on the response distribution, frequencies may be cross-tabulated to identify response similarities and differences among sub-groups of respondents, such as those with longer versus shorter duration in their current position. These findings will be representative only of the response pool and not the total population of professionals working in county and city health departments to advance STD prevention partnerships.

Data from the participant responses for the in-person interviews will be stored in a secure database maintained by The Cloudburst Group. The Cloudburst Group will transcribe the qualitative information. Each of the transcribed interviews will be compared against the recording to ensure accuracy. A directed form of content analysis will be used to analyze data, using the project's conceptual framework and key questions as guides. The data will then be coded using the qualitative software management program NVIVO. The Cloudburst Group will condense key findings from the web-based assessment and in-person interviews and refine them into a final report to CDC, presentations to CDC and state, local and territorial jurisdictions, and a manuscript, and submit for publication.

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)
- Administer web assessment (Open 4 weeks)
- Code data, conduct quality control, and analyze data..... (2 weeks)
- Conduct interviews (12 weeks)
- Code data, conduct quality control, and analyze data..... (4 weeks)
- Prepare summary report(s) (8 weeks)

- Disseminate results/reports (4 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

Attachment B- STD Program Manager Referral Form

Attachment C- In-person Interview Referral Form

Attachment D- Web-based Assessment Instrument- Word

Attachment E- EPP Web-based Instrument-Web Version

Attachment F- EPP- In-Person Interview Guide STD Program Manager and STD Coordinator

Attachment G- EPP- In-Person Interview Guide Data Manager

REFERENCE LIST

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