

“District of Columbia Public Schools (DCPS) Student Perspectives on Access to Recommended Adolescent Preventive Health Services”

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Supporting Statement Part A

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Supported by:

Division of Adolescent and School Health
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List of Attachments

Attachment Number	Document Description
1	Public Health Service Act Legislation
2	60 Day FRN
3	Student Focus Group Guide
4	IRB Approval Documentation
5	Focus Group Parental Consent Form (minor students)
6	Focus Group Adult Student Consent Form
7	Focus Group Youth Consent Form (CBO)
8	Focus Group Student Verbal Assent
9	Privacy Impact Assessment (PIA)

Goal: The goal of this qualitative assessment is to understand a unique model of school health service delivery and to inform program refinements that promote scientifically-valid interventions that strengthen use of recommended adolescent preventive health services including those for sexual and reproductive health services (e.g. HIV and STD testing) by students in District of Columbia Public Schools (DCPS), a local education agency (LEA) funded by CDC's Division of Adolescent and School Health (DASH) under PS13-1308: *Promoting Adolescent Health through School-Based HIV/STD Prevention and School-Based Surveillance*.

Intended use of resulting data: The data will be used to provide information and summary reports for DCPS, and will allow DCPS district staff to refine their program to better prepare their staff to strengthen student access to recommended adolescent preventive services. These findings may also help CDC/DASH identify important lessons learned that can be shared with other CDC/DASH-funded education agency partners.

Methods: The information collection will be conducted by CDC's contractor; CDC staff will not interact with participants in any way. The collection involves an assessment of student perspectives on access to recommended adolescent health services among DCPS students using focus group methodology. We propose to conduct a total of nine focus groups with DCPS students (up to ten students per group). Eight of the focus groups will be conducted in four DCPS high schools (two focus groups per school). One focus group will be conducted with DCPS students who identify as LGBTQ in collaboration with a local community-based organization (CBO) to help ensure that LGBTQ students' needs and perceptions are included in the study.

Subpopulation to be studied: We will invite up to 108 high school students (n=12 students per group: 48 females and 48 males; and 12 self-identified LGBTQ youth) across 4 DCPS high schools and one community-based organization with the expectation that up to ten students will participate in each of the nine focus groups (n=90).

Data analysis: Analysis of data from the focus groups will involve iterative code development, establishment of intercoder reliability, use of qualitative data analysis software (such as MAXQDA or ATLAS.ti), and identification of major themes within the data.

family, are of one of the primary entities responsible for the development of young people. Schools can influence students' risk for HIV infection and other STD in a variety of ways, including through the provision of recommended adolescent preventive services.

CDC's Division of Adolescent and School Health (DASH) in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) awarded funds to implement PS13-1308 in order to build the capacity of state and local education agencies and support the efforts of national, non-governmental organizations (NGOs) to help priority school districts (districts) and schools develop and implement sustainable adolescent-focused program activities. Within that cooperative agreement, education agencies are funded to implement multiple approaches to HIV and STD prevention, including improving student access to adolescent preventive services including HIV and STD testing and contraceptive services.

Of the 17 local education agencies (LEAs) funded under PS13-1308, DCPS was selected

to receive enhanced support from CDC to better understand their unique model of improving student access to health services, and more specifically, the experiences and perspectives of staff involved in implementing sexual health service programmatic activities and student consumers of the program. The activities included in this information collection request will be used to provide information and summary reports for DCPS, and will allow DCPS district staff to refine their program in order to better support and work with schools to enhance student access to recommended adolescent preventive services. These findings may also help CDC identify important lessons learned that can be shared with other CDC-funded education agency partners.

The proposed assessment will involve qualitative focus groups (n=9). 90-minute, in-person focus groups will be conducted with up to 90 students in nine focus groups (four all-female groups, four all-male groups, and one group of self-identified LGBTQ youth) from four high schools and one community based organization. In focus groups, students will be asked their thoughts and perceptions about: student sexual health service needs and perceived access to services in school and outside of school; facilitators and barriers to accessing sexual health services in school; student awareness of staff liaisons; perception of the liaisons' roles and responsibilities; perception regarding the extent to which students access liaisons and sexual health services at school; and recommendations for enhancing access to sexual health services. Focus groups will not involve questions about individual student sexuality, personal sexual experiences, behaviors, or use of health services.

CDC is authorized to collect the data described in this request by Section 301 of the Public Health Service Act (42 USC 241). A copy of this enabling legislation is provided in **Attachment 1**. In addition to this legislation, there are several national initiatives and programs that this data collection would serve to support, including but not limited to:

- *Healthy People 2020*, which provides national health objectives and outlines a comprehensive plan for health promotion and disease prevention in the United States. Of the Healthy People 2020 objectives, 31 objectives align specifically with PS-13-1308 activities related to reducing HIV infection, other STD, and pregnancy among adolescents.⁴
- The *National Prevention Strategy* (NPS) calls for “medically accurate, developmentally appropriate, and evidence-based sexual health education.” The NPS encourages the involvement of parents in educating their children about sexual health, the provision of sexual and reproductive health services, and the reduction of intimate partner violence.⁵
- The U.S. Department of Health and Human Services' (DHHS) *Teen Pregnancy Prevention Initiative* supports the replication of teen pregnancy prevention (TPP) programs that have been shown to be effective through rigorous research as well as the testing of new, innovative program activities to combat teen pregnancy.⁶
- The NCHHSTP program imperative calls for *Program Collaboration and Service Integration* (PCSI) to provide improved integration of HIV, viral hepatitis, STD, and TB prevention and treatment services at the user level.⁷

The privacy act does not apply as no individually identifiable information will be collected.

The information collection system consists of (1) student focus group guide (see **Attachment 3**), as explained in detail below.

Student Focus Group Guide

The information collection system includes focus groups with DCPS high school students (see **Attachment 3 for the student focus group guide**) and is designed to gather thoughts and perceptions about: student sexual health service needs and perceived access to services provided in school and outside of school; facilitators and barriers to accessing sexual health services in school; student awareness of staff liaisons; the liaisons' roles and responsibilities; perception regarding the extent to which students access liaisons and health services at school; and recommendations for enhancing accessing services. Focus groups will not involve questions about individual student sexuality, personal sexual experiences, behaviors, or health services. The information collection instrument was reviewed for content, clarity, and appropriateness by a DCPS district employee and the full study team (CDC and its contractor) which include several former teachers; revisions were made to refine the guide based on the collective input.

Items of Information to be collected

The student focus group guide includes questions geared toward the student's thoughts and perceptions about: student sexual health needs and perceived access in school and outside of school. Focus groups do not involve questions about individual student sexuality, personal sexual experiences, behaviors, or health services. Each guide is divided into 4 key domains of interest (see **Attachment 3**) and questions are open-ended.

The focus group guide will collect information on the following:

- a. Student sexual health needs and sexual health services. There are 7 items with a total of 10 possible questions (including subquestions/probes).
- b. Resource people at school for sexual health services. There are 5 items with a total of 7 possible questions (including subquestions/probes) that address student perceptions of school, district, or clinic staff that students go to for information about sexual health services.
- c. On-campus services. There are a total of 5 items with a total of 12 possible questions (with additional subquestions/probes) that ask about student access to sexual health services at school and related benefits and challenges. There are an additional 7 questions specifically for the focus group conducted with self-identified LGBTQ youth at a community-based organization.
- d. Student perceptions and recommendations. There are 2 items with 3 possible questions (including subquestions/probes) that ask students what could increase student (including LGBTQ students) use of services at their school.

A. 2 Purpose and Use of Information Collection

The student focus groups will provide DCPS, a CDC-funded LEA, with qualitative assessment data that will be used to inform and refine their program activities conducted under PS13-1308. All data will be collected by CDC's contractor, ICF, and CDC staff will not interact with participants in any way. Data collected by ICF, through student focus groups, will be analyzed by the study team to help DCPS better understand how to link students to appropriate recommended adolescent preventive services and enhance student access from the perspectives of the students (the consumers). It will allow them to ensure their activities are designed to best meet the needs of their students and to determine what types of approaches or strategies are necessary

to have a positive impact on access to recommended adolescent preventive services, and in turn, key health outcomes among their students. More specifically, DCPS district-level staff will use this insight to better support and prepare their staff to strengthen student access to recommended adolescent preventive services including services for HIV, STD, pregnancy testing, contraceptive services, and counseling. This supports a major public health goal of reducing HIV, STD, and unintended pregnancy among youth, and CDC anticipates that these findings also will likely reveal important lessons learned for other CDC/DASH-funded education agency partners.

This Collection will invite up to 108 high school students (n=12 students per group: 48 females and 48 males; and 12 self-identified LGBTQ youth) across 4 DCPS high schools and one community-based organization (CBO) with the expectation that up to ten students will participate in each of the nine focus groups (n=90).

For the in-person focus groups, no sensitive information is being collected. DCPS will provide a list of school staff liaison business PII (specifically, email addresses) and access to students in order to invite people to participate in the focus groups. This information will be used only for recruitment and scheduling. All focus group notes and/or recordings will be kept private and secure and will not be linked to staff business PII.

No PII will be collected from students in the focus groups. Responses will only be reported in aggregate due to the small sample size. However, student name, age and grade will be collected through the parental consent process. This information is not retained, stored with the focus group data or transmitted/shared with CDC.

Business email addresses (publically available) of school staff will be provided by the schools for participant recruitment but will remain completely separate from information gathered through the interviews.

Analysis of data from focus groups will involve iterative code development, use of qualitative data analysis software (such as MAXQDA), and identification of major themes within the data. The findings from this information collection also have practical utility to the government because they can impact both the activities used by DCPS and the strategies and approaches CDC recommends for use in schools more broadly.

Without this data collection, DCPS would be unable to refine their program activities as precisely, which would limited their ability to enhance their health service activities and strategies to be responsive to the needs and experiences of their students. In addition, without collecting this data, CDC would have reduced understanding of how to enhance student access to recommended adolescent preventive services.

A. 3 Use of Improved Information Technology and Burden Reduction

Focus groups will be conducted in-person by trained focus group moderators. All focus groups will be audio-taped with permission of the respondents. This may help reduce the amount of time required of respondents because the moderator will not have to pause for note-taking.

A. 4 Efforts to Identify and Use of Similar Information

In preparation for collection of data from students, the study team reviewed the literature

for any existing instrument or data collection activities that provide in-depth information about students' experiences related to access to adolescent health services, including those for improving sexual health. Although specific items for use in qualitative assessment were not identified, the general themes in the literature (such as student sexual health needs, access to sexual health services, resources, and barriers and facilitators to accessing services) were incorporated into the focus group guide developed by the study team. The team did not find any other source of information that can provide the relevant in-depth information on the experiences of students' interactions with staff liaisons and access to services.

A. 5 Impact of Small Businesses or Other Small Entities

This data collection will not involve small businesses.

A. 6 Consequences of Collecting the Information Less Frequently

This information collection is scheduled to occur one time in Fall 2018. Collecting the data less frequently would mean not collecting the data at all, and there would be a number of negative consequences to this. First, DCPS would not have data on which to refine program activities or by which additional strategies or approaches could better support student access to health services. Without this critical information from consumers (students), the program might not be able to achieve its full potential. In addition, CDC would miss a valuable opportunity to develop a more in-depth understanding of this unique model to increase student access to recommended adolescent preventive services that may be recommended to school districts more broadly.

A. 7 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.

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

- A.** The Federal Register notice was published for this collection on Wednesday, November 8, 2017, Vol. 82, No. 215, pp. 51835. (**See Attachment 2**))

No other public contacts and opportunities for public comments were received.

B. The LEA (DCPS) involved in this information collection was consulted on all aspects of the data collection. They provided extensive feedback on the availability (or in this case, non-availability) of similar existing data, other data collections in their LEA and the data collection procedures for this project. In addition, CDC contractors provided extensive input into the clarity of instructions, content of questions, reporting formats, and the data elements that will be reported.

These consultations took place in 2017 and 2018. A list of organizations and individuals consulted is provided in **Attachment 4: Organizations and Individuals Providing**

Consultation on the Information Collection. There were no major problems that arose during the consultation, and all issues raised were resolved.

A. 9 Explanation of Any Payment or Gift to Respondents

Tokens of appreciation for data collection participation are an important tool used in studies and are particularly important for the populations in this information collection.

For students, participating in the focus group represents a large portion of the “free time” after school, and will require a commitment by the students and their guardians. Participation in the focus group will take scarce discretionary time from both the students and their parents/guardians, some of whom may have to make alternate plans for transportation home from school on the day of the data collection. In our experience conducting focus groups with students, gifts to participants can be a key tool aiding in recruitment. Since participation will require active parental/guardian consent and follow-up action in the form of attending the group on the day of data collection, these gifts are required.

Given the considerations outlined above, the estimated burden of the in-person focus groups, and the fact that focus groups were required to take place after the end of the normal school day, gifts to respondents in the form of goody bag with items such as water bottle, healthy snacks, and a movie ticket (valued at approximately \$30) are proposed for the students participating in the slightly longer (90-minute) focus groups.

Unique aspects of this proposed focus group data collection that are critical to the quality of the assessment include the overall sample size and the participation of the specific individuals who have been invited to participate. Previous studies show that “there is likely to be a strong association with nonresponse and the survey topics of interest”.¹¹ Students who have interest in the topic of the assessment may be more likely to participate in focus groups, introducing a bias and limiting our ability to get a true picture of the experiences and perceptions of a variety of liaisons and students—including those who may find it less appealing to talk about topics such as sexual health. Given that the topic of the proposed information collection includes questions on sexual health services, which is likely to have widely varying levels of appeal to students, the study team believes that the potential for bias from interest in the topic is a particular concern for the data collection. The use of gifts can help minimize bias resulting from variations in interest in the topic by helping to motivate potential participants recruited for focus groups to make the commitment of their time necessary to participate. Krueger and Casey (2009) note that the gift helps emphasize to participants that the assessment is important, which in turn will make them more inclined to make time to participate. More specifically, the gift basically “serves to protect the promised time slot from being preempted.”⁸ In this data collection, the use of participants gifts is expected to reduce bias related to interest in the topic, and therefore, increase the quality of data collected.

Both Goldenkoff (2004)⁹ and Quinn Patton (2002) support the use of gifts/incentives.¹⁰ We expect that a \$30 value per student to be sufficient to improve participation rates and those amounts are consistent with what has been cited in the literature on response rates; for example, in a 2008 article, Cantor, O’Hare, & O’Connor state that “a number of studies have found that promised incentives of \$15-\$35 increase response rates.”¹¹ We therefore believe this value amount is appropriate given that most focus groups will be conducted on the campuses where participants

attend school. IRB has reviewed and approved the gift to students for their participation (see Attachment 5). In addition, DCPS's research office has approved the data collection with these gifts included as part of the protocol and district staff involved in planning the data collection highly recommend the use of such gifts.

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

The CDC Privacy Review Officer has assessed this package for applicability of 5 U.S.C. § 552a, and has determined that the Privacy Act does not apply to this information collection. No individually identifiable information is being collected from respondents in the focus groups. Participants will be informed that providing the information for this data collection is voluntary.

Students participating in in-school focus groups who are under the age of 18 will be required to secure active parental consent and then provide passive student assent prior to participating in the focus groups. Students participating in the school-based focus groups who are aged 18 years and older must actively consent for participation in a focus group. Active parental and adult student consent forms (see **Attachments 5 and 6**) will be distributed to students in their designated classes. From the pool of students who return parental and student consent forms for the in-school focus groups, 96 students will be invited to participate in one of 8 in-school focus groups.

Youth who participate in the focus group in collaboration with the CBO will provide their written consent for participation (see **Attachment 7** for student focus group youth consent form). For this focus group, we sought and were granted an IRB waiver of parental permission because these youth are allowed by law to consent for services at the CBO without their parent's permission and in order to protect adolescent participants with parents who might react negatively to disclosure or discussions of their gender identities. All consent and assent language will inform parents and students that participation is completely voluntary and they may choose not to participate at any time.

In the introduction to all student focus groups (in high schools and with the CBO), students will be read language for which they will be able to provide their verbal assent for participation (see **Attachment 8** for assent language for high school students).

For the in-person focus groups, no sensitive information is being collected. Although DCPS will provide a list of school staff liaison business PII (specifically, email addresses) and access to students in order to invite people to participate in the focus groups, this information will be used only for recruitment and scheduling. All focus group notes and/or recordings will be kept private and secure and will not be linked to staff business PII.

No PII will be collected from students in the focus groups. Responses will only be reported in aggregate due to the small sample size. Reports will focus on experiences and perceptions of students rather than individual responses. In addition, all reports will be written in a way in which no comments will be attributed to any one person. All study team members will be asked to sign privacy agreements and trained on security requirements. During data collection in the field, focus group moderators will maintain data collection materials in their possession or in secured storage at all times. All documents associated with the study will be collected and stored in a password-protected electronic file on a secure network accessible only by the study

team through restricted access settings. A Privacy Impact Assessment (PIA) (**Attachment 9**) was conducted to identify the protections of the data being collected under this activity.

We anticipate no adverse impact of the proposed data collection on respondents' privacy because no individually identifiable information will be collected from respondents through the focus groups.

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

IRB Approval

The proposed student focus group data collection protocols have been reviewed and approved by the existing contractor's IRB (see **Attachment 4**) to conduct 9 student focus groups in Fall 2018. Each student focus group will include up to 10 students and will be stratified by gender and school level (4 focus groups will include female students, 4 focus groups will include male students, 1 CBO focus groups will include self-identified LGBTQ youth). Focus groups will last no more than 90 minutes. All focus groups will be audio-recorded (with participant permission) to ensure an accurate account of what was discussed. Since the focus groups will take place after school hours, student transportation must be pre-arranged by the student's parent/guardian. Focus groups will be scheduled in advance to allow students and parents time to plan accordingly.

Sensitive Questions

Although some of the questions in the focus group guide request information from students about sexual health service needs, perceptions of service use by students more broadly, they do not ask for any information on the participants' own sexual behavior, use of sexual health services, or sexual orientation or gender identity. No sensitive or individually identifiable information is being collected in the student focus groups. All notes and/or recordings will be kept separate from the names of participants. Responses will only be reported in aggregate due to the small sample size. Reports will focus on overall experiences and perceptions of students rather than individual behaviors, experiences, or services received. All transcribers will be asked to sign non-disclosure agreements and team members will be trained on security requirements. During data collection in the field, focus group moderators will maintain data collection materials in their possession or in secured storage at all times. All documents associated with the study will be collected and stored in a password-protected electronic file on a secure network accessible only by the Contractor's study team.

A. 12 Estimates of Annualized Burden Hours and Costs

The estimate for burden hours is based on informal pretests and reviews by individuals with experience conducting qualitative data collection with young people aged 14-19 years. Twelve students will be recruited for each focus group with the expectation that 10 will participate; thus, a total of 90 respondents will be assessed. The estimated time to complete the focus groups including time for reviewing consent materials, introducing the process and topics, and completing the focus group, ranged from 60 to 90 minutes (with 90 minutes needed to address questions for LGBTQ students).

Table A.12-1 Estimated Annualize Burden to Respondents

Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
High school students	Student Focus Group Guide (Att 3)	90	1	1.5	135
Total					135

Annualizing this collection over one year results in an estimated annualized burden of 135 hours.

Annualized Costs to Respondents Table A.12-2 provides estimates of the annualized cost to respondents for the collection of data.

Because student respondents will most likely work in minimum wage jobs, if they work at all, cost estimates for the value of time students spend in responding to the questionnaire are based on a Department of Labor fact sheet describing the minimum wage for nonexempt employees as \$7.25 an hour (it should be noted that youth aged less than 20 can be paid less in some circumstances, but not less than \$4.25 an hour). Estimates for the average hourly wage for respondents are based on Department of Labor (DOL) from March 2018, BLS Report, providing wage estimates for minimum wage workers, (<https://www.bls.gov/opub/reports/minimum-wage/2017/home.htm>) Table A-12 shows estimated burden and cost information.

Table A.12-2 Annualized Costs to Respondents

Activity	Total Burden Hours	Hourly Wage Rate	Total Cost
High school student Focus Group	135	7.25	978.75
Total	135		

A. 13 Estimates of Other 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.

A. 14 Annualized Cost to Federal Government

Cost will be incurred by the government in personnel time for overseeing the project. CDC time and effort for overseeing the contractor’s assistance with data collection and answering questions posed by the contractor and funded agencies are estimated at 6% each for two GS-14 (step 6) level Atlanta-based CDC employees a year for the one year of the project. The grade and step levels were determined based on the experience levels of the staff currently working on the project. The average annual cost to the federal government for oversight and project management is \$15,160 (**Table A-14-1**).

The contractor, ICF International’s, costs are based on estimates provided by the contractor who helped plan the data collection activities. With the expected period of performance, the annual cost to the federal government from contractor and other expenses is estimated to be approximately \$138,371 (**Table A-14-1**). This is the cost estimated based on the current funding level of the contractor at approximately \$922,474 this year and the percentage of the contractor’s effort that is anticipated for this specific data collection. It is estimated this data collection will take approximately 15% of the contractor’s effort. This includes the estimated cost of coordination with DASH, providing assistance to the LEA for data collection and processing, and support for analysis and reporting.

The total annualized cost to the government, including direct costs to the federal government and contractor expenses is \$153,531.

Table A.14-1. Annualized and Total Costs to the Federal Government

Expense Type	Expense Explanation	Annual Costs (dollars)
<i>Direct Cost to the Federal Government</i>		
CDC oversight of the project	1 CDC Health Scientist at 6% time (GS-14)	\$7,580
CDC oversight of contractor and project	1 CDC Senior Health Scientist at 6% time (GS-14)	\$7,580
Subtotal, Direct Costs to the Government per year		\$15,160
<i>Contractor and Other Expenses</i>		
Assistance with data collection, processing, and preliminary analysis	Labor and other direct costs for supporting data collection, processing, and analysis	\$138,371
Subtotal, Contract and Other Expenses per year		\$138,371
<i>Total of all annualized expenses</i>		<i>\$153,531</i>

A. 15 Explanation for Program Changes or Adjustments

This is a new information collection.

A. 16 Plans for Tabulation and Publication and Project Time Schedule

Current plans for tabulation and publication of data from this information collection include development of summary reports for DCPS that describe findings from the student focus groups. Analysis will involve transcription of audio tapes, iterative code development, and thematic analysis. In addition to publication of findings in written reports for DCPS, some findings may be shared through peer-reviewed journals or presentations.

Upon completion of data collection, all recorded focus groups will be transcribed and the transcripts will be provided to the project team. The qualitative data analysis will include iterative code development, establishment of intercoder reliability, single coding of full transcripts using MAXQDA software (or a similar qualitative analysis software), and qualitative analysis of coded data. A team of multiple coders will be used to code the qualitative data. To establish intercoder reliability, team members will select numerous segments of text from two randomly selected transcripts and team members will apply the most relevant primary code to each section of text. The consistent use of these codes will be analyzed for intercoder reliability. The coding team will meet to review any discrepancies and will continue the process until an acceptable level of intercoder reliability is reached. Then, each transcript will be coded by one coding team member for analysis. The team will later systematically analyze the coded transcripts to identify common themes that emerge.

Findings from the data will be summarized into written reports for DCPS and may be shared with other stakeholders through mechanisms such as presentations, executive summaries, or peer-reviewed articles. Findings will be used to enhance student access to recommended adolescent preventive services at DCPS and to help CDC better understand strategies that can strengthen student access to recommended adolescent preventive services via LEAs.

Project Time Schedule

Data collection is scheduled to begin in Fall 2018. It is critical for this data collection to begin no later November 2018 in order to avoid conflicts the schools have with other non-CDC commitments (e.g., standardized testing, holiday schedules) late in the Spring semester that would make data collection challenging. As such, we are hoping to receive OMB approval for this information collection by September 2018. The data are likely to be analyzed, summarized, and reported (through unpublished or published reports) in 2018 and early 2019.

A one year clearance is being requested.

Figure A.16-1: Project Time Schedule

Activity	Time Schedule
Design information collection instruments	Complete
Develop data collection protocol, instructions, and analysis plans	Complete

Review and revise data collection protocol, instructions, and analysis plans	Complete
Prepare OMB package	Complete
Receive OMB approval	TBD
Recruit participants and schedule focus groups	0-1 months after OMB approval
Conduct focus groups	1-2 months after OMB approval
Transcribe focus groups	2-3 months after OMB approval
Determine intercoder reliability for qualitative data analysis of focus group transcripts	4 months after OMB approval
Code and analyze focus group data	5-7 months after OMB approval
Writing (and revising) of baseline data summaries, reports, and/or manuscripts	7-12 months after OMB approval

The CDC contractor, with the review and approval of the CDC staff will develop summary reports for DCPS to use for program refinement and communication with stakeholders. CDC will use the assessment findings to revise or establish key recommendations for school districts on continued program refinement.

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

The display of the OMB expiration date is not inappropriate. All data collection instruments will display the expiration date for OMB approval of the information collection. We are requesting no exemption.

A. 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.

References

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