Request for Sub-collection under the Generic ICR: Formative Research and Tool Development
OMB #0920-0840 Expires 10/31/2021

Health Communication Message Testing on Adolescent Health—Centers for Disease Control and Prevention's Division of Adolescent and School Health

Supporting Statement Part A

March 8, 2019

Supported by:

Division of Adolescent and School Health
Centers for Disease Control and Prevention

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- **Purpose:** The purpose of the CDC DASH Health Communication Message Testing on Adolescent Health project is to conduct formative research to explore:
  - Knowledge, attitudes, and beliefs towards HIV, STD and pregnancy prevention and communication strategies;
  - Reactions to and preferences/opinions of health terminology (language, wording) and messages around the topic of adolescent health and the co-occurrence of risks across sexual behaviors and experiences, substance use, mental health, and violence victimization;
  - And, recommended practices for improving youth academic and health outcomes.
- **Intended Use of Data:** The intended use of this data is to enhance adolescent and school health communication among a national audience of relevant stakeholders, including education and public health professionals, as well as health care providers and community leaders, who work with youth. The formative research findings will be used to inform a multifaceted national social media campaign. More specifically, DASH will use the findings to develop a suite of audience-tailored resources (e.g., print ads, digital/print educational materials, infographics) that will be rolled out as part of the campaign. Formative research findings will also be shared with stakeholders via oral presentations and academic publications as further means for enhancing overall adolescent and school health communication across the nation.
- **Method:** The method that will be used for data collection is focus groups.
- **Participants:** The subpopulation to be studied are up to 135 individuals, including:

A. Justification

1. Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Division of Adolescent and School Health (DASH) is requesting approval for a new data collection titled, “Health Communication Message Testing on Adolescent Health—Centers for Disease Control and Prevention Division of Adolescent and School Health” under the OMB approved Generic Clearance titled “Formative Research and Tool Development” (OMB #0920-0840 exp. 10/31/2021). This new request falls under the larger generic

clearance umbrella as it is a form of formative research that is being used to inform CDC DASH's future communication efforts. Conducting the proposed focus groups will add to CDC's knowledge of the most effective way to communicate adolescent health-related messages/information. The results from the focus groups will be used to inform the development of tools and resources that support sexual health education. CDC is authorized to collect the data described in this request by Section 301 of the Public Health Service Act (42 U.S.C. 241) **(Attachment 1).**

This data collection activity will conclude by September 15, 2019, and the project will be managed by CDC's contractor—IQ Solutions, Inc.

CDC's *Youth Risk Behavior Survey: Data Summary & Trends Report: 2007–2017* spotlights four priority health topics, each associated with increased risk for STDs (including HIV) and teen pregnancy.[1] Studies link "health behaviors and experiences related to (1) sexual behavior, (2) high-risk substance use,(3) violence victimization, and (4) mental health and suicide" to adverse health outcomes for sexual minority youth.[1] High-risk substance use reflects "ever use" of select illicit drugs, injection of illegal drugs, and misuse of prescription opioids.[1] Violence victimization encompasses factors related to school safety, bullying, and dating violence; these experiences may lead to trauma, diminished academic success, sexual risk behavior, substance use, and risk of STDs. Risks related to mental health and suicide include measures of well-being, suicidal ideation, and suicidal behavior.[1] CDC's *Youth Risk Behavior Survey* data suggest that certain groups of adolescents are exposed to multiple risk factors across these four health topics, substantially raising their risk for HIV, STDs, and teen pregnancy.[1] These health behaviors and experiences contribute to substantial morbidity for adolescents.

Studies show:

1. Increased numbers of sexual partners, lack of condom use, forced sex, and injection drug use can directly lead to infection.[1]

[1] Centers for Disease Control and Prevention. *Youth Risk Behavior Survey Data Summary & Trends Report 2007–2017.* https://www.cdc.gov/healthyyouth/data/yrbs/pdf/trendsreport.pdf. Published 2018. Accessed October 26, 2018.

2. Youth who are bullied or who experience mental health problems or suicide ideation are more likely to engage in risky behavior, including sexual risk and drug use.[2,3]
3. Adolescents' misuse of prescription drugs is associated with having sex without a condom, having four or more sexual partners, and experiencing dating violence.[4,5]
4. Substance use is related to sexual risk behavior and violence.[6,7]
5. Adolescents who are bullied are more likely to have multiple sexual partners, have sex without a condom, use substances, and experience depression.[2,8-11]

Addressed separately, these four focus areas are of concern to public health. However, data also indicate that risk behaviors co-occur and that a substantial number of students have experienced multiple risks across these areas. These four health topics also share common protective factors including school connectedness and family engagement.[1] School connectedness—defined as "the belief held by students that adults and peers in the school care about their learning as well as about them as individuals"—is closely linked to increased academic achievement, school attendance, and educational attainment.[1]

Recognizing that the nation's schools are one of the primary settings for the development of youth, DASH aims to support school-based prevention of HIV/STDs and pregnancy. DASH's goal is to develop effective communication materials and strategies to support these prevention efforts, thereby providing youth with fundamental health knowledge and skills as well as helping them to establish healthy behaviors for a lifetime.

It is at this juncture that CDC DASH contracted IQ Solutions, Inc. to implement a qualitative project to help solidify key

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[2] Holt MK, Matjasko JL, Espelage D, Reid G, Koenig B. Sexual risk taking and bullying among adolescents. *Pediatrics.* 2013;132(6):e1481-e1487. doi:10.1542/peds.2013-0401.
[3] Hallfors DD, Waller MW, Ford CA, Halpern CT, Brodish PH, Iritani B. Adolescent depression and suicide risk: Association with sex and drug behavior. *Am J Prev Med.* 2004;27(3):224-231.
[4] Clayton HB, Lowry R, August E, Everett Jones S. Nonmedical use of prescription drugs and sexual risk behaviors. *Pediatrics.* 2016;137(1):e20152480. doi:10.1542/peds.2015-2480.
[5] Clayton HB, Lowry R, Basile KC, Demissie Z, Bohm MK. Physical and sexual dating violence and nonmedical use of prescription drugs. *Pediatrics.* 2017;140(6):e20172289. doi:10.1542/peds.2017-2289.
[6] Tapert SF, Aarons GA, Sedlar GR, Brown SA. Adolescent substance use and sexual risk-taking behavior. *J Adolesc Health.* 2001;28(3):181-189.
[7] Lowry R, Holtzman D, Truman BI, Kann L, Collins JL, Kolbe LJ. Substance use and HIV-related sexual behaviors among US high school students: Are they related? *Am J Public Health.* 1994;84(7):1116-1120.
[8] Gini G, Pozzoli T. Bullied children and psychosomatic problems: A meta-analysis. *Pediatrics.* 2013;132(4):720-729.
[11] Okumu M, Mengo C, Ombayo B, Small E. Bullying and HIV risk among high school teenagers: The mediating role of teen dating violence. *J Sch Health.* 2017;87(10):743-750.

terms and messages that resonate with members of target audiences: intermediaries that influence students and support high-risk groups.

The project team (CDC and IQ Solutions) will use 15 in-person focus groups conducted in 5 geographic locations to collect data. Our qualitative research will use volunteer participants in groups and use standardized methods for: exploratory and formative research; and concept, material, and product development and testing. More specifically, volunteer participants will include parents/caregivers, as well as individuals who work at education agencies and nongovernmental agencies (hereby referred to as professionals).

Short-term qualitative research techniques have previously proven invaluable in the development of scientifically valid and population-appropriate interventions. Research activities—including facilitator guide question domains—will provide information on how target audience members respond to questions and ways in which question response bias and error can be reduced. Ultimately, the results of these research activities will be used to inform many aspects of a national social media campaign, intended to reach a broad audience. The data collected from focus group participants will not include personal identifiers.

In health communications, target audience members or representatives provide information for delivering clear and influential health messages. Provisional versions of messages—which include key terminology—must be tested with members of target audiences.[12,13,14,15] The results from the focus groups will be used to inform the development of a national social media campaign. Resources for the campaign (e.g., print ads, educational materials, infographics) will be developed according to what the research will reveal, and will be tailored to and aimed at a broad audience, including education and public health professionals, as well as health care providers and community leaders, who work with youth. Further, as the results are made available, we plan to share them internally with CDC grantees and

[12] Schmid KL, Rivers SE, Latimer AE, Salovey P. Targeting or tailoring? Maximizing resources to create effective communications. Mark Health Serv. 2008;28(1):32-37.
[13] Randolph W, Viswanath K. Lessons learned from public health mass media campaigns: marketing health in a crowded media world. Annu Rev Public Health. 2004;25:419-37.
[14] Brown KM, Lindenberger JH, Bryant CA. Using pretesting to ensure your messages and materials are on strategy. Health Promot Pract. 2008 Apr;9(2):116-22.
[15] Lapka C, Jupka K, Wray RJ, Jacobsen. Applying cognitive response testing in message development and pre-testing. Health Educ Res. 2008 Jun;23(3):467-76.

externally with relevant stakeholders in the form of oral presentations and through academic publications. It is important to us that these research findings are widely shared with individuals in the field who are working to protect adolescent health and support their academic performance. Lastly, results of the qualitative focus groups will also be used in conjunction with other information to enhance or develop adolescent and school health-related communications among stakeholders across all regions of the United States.

2. Purpose and Use of Information Collection

CDC DASH seeks to conduct formative research (**Attachment 4**) with individuals with a stake in DASH's work in adolescent and school health, as well as obtain feedback on an existing DASH fact sheet titled "How CDC Prepares Healthy Youth for Successful Futures" (**Attachment 5)**. The purpose of this project is to explore CDC DASH target audience reactions to themes, terms, and messages related to:

- Co-occurrence of risks across sexual behaviors and experiences, substance use, mental health, and violence victimization;
- DASH's investment in healthy youth and healthy communities; and
- DASH-recommended practices to improve youth health outcomes. As well as their knowledge, attitudes, and beliefs towards HIV, STD and pregnancy prevention and communication strategies.

Formative research is an integral part of the operations research and surveillance activities at NCHHSTP because they are dependent upon the target audience members (general public, health professionals) to obtain the data needed to monitor changes in disease epidemiology and design more effective and efficient interventions. CDC will process the results from the research activities presented in this document into a national social media campaign in a timely manner.

Data for this project will be collected through focus groups. This methodology was chosen based on the exploratory nature of this project's purpose. The data collection instruments are included with this submission (**Attachments 2a-c)**. A Moderator's Guide will be used to guide all focus group discussions **(Attachment 2a);** a recruitment screener will be used by a

professional recruitment vendor to see if the parent/caregivers qualify to participate (**Attachment 2b);** and another set of screening questions (to be sent via email by one IQ Solutions project staff member) will be used to see if professional organizations qualify to participate **(Attachment 2c).**

The study protocol is also provided as an attachment and provides additional details **(Attachment 6)**.

This project will result in:

- Insights into DASH messages (facts, information, and concepts) and terms (language and wording) that are clear, effective, motivating, and appropriate for a given audience, as well as the best received tones for those messages.
- A better understanding of the variances in knowledge, attitudes, and preferred terminology around high-risk substance use, mental health, sexual risk, and violence victimization across audience segments.
- Recommended practices for improving youth academic and health outcomes.
- Suggestions for effective audience-preferred communication channels and material formats for information materials, to be used ultimately to develop and disseminate tailored resources to inform these youth influencers.

Qualitative methodologies, including focus groups, provide rich, in-depth information that is useful in understanding what and how target audience members think, feel, and behave, and why they do so. Although this project's focus group findings will provide valuable insights, limitations in this methodology must be considered when reviewing the findings. This qualitative methodology (focus groups) does not allow for generalizability of the findings to the population universe of interest as we will not be recruiting participants randomly and the sample size is relatively small. Nonetheless, the sample size is sufficiently large to observe similar themes repeated across focus groups. In addition, there may be biases to the data collected—for example, because of self-selection (e.g., individuals who choose to participate in a focus group may be different in some important ways compared to individuals who decline to participate in a focus group) and/or social desirability (e.g., when participants report answers they think will please the project team or sponsor).

Data collected will be used to better understand target populations': knowledge and attitudes related to high-risk substance use, mental health, sexual risk, and violence victimization among youth; ways to word messages/statements that

will grab the attention of and be effective with youth; and suggested health information sources and formats for reaching youth. Key variables to be explored are described in Exhibit A2.1.

Exhibit A2.1: Items of Information to be Collected

Variables to be explored	Data collection tool and citation	Project Related Procedures	Target Population
General attitudes toward adolescent health; reactions to messages categorized by message themes; suggested information sources, channels, and formats for reaching youth	Attachment 2a. Moderator's Guides	In-person focus groups	Parents/ Caregivers
Grade(s), gender(s), and school type(s) of their children/students; level of education; gender; age; race/ethnicity; total household income; city/state; geographic type	Attachment 2b. Participant Recruitment Screener	Telephone	Parents/ Caregivers
Familiarity with CDC DASH and sexual health education landscape; reactions to messages categorized by message themes; suggested information sources, channels, and formats for reaching youth	Attachment 2a. Moderator's Guides	In-person focus groups	Professionals
First Name; job title; organization department and website; city/state;	Attachment 2c. Professional Recruitment	Email	Professionals

Variables to be explored	Data collection tool and citation	Project Related Procedures	Target Population
phone number; CDC DASH grantee Y/N; gender; race/ethnicity	Outreach Emails and Screener Questions		

IQ Solutions, Inc. will report the findings in summary form in the form of a narrative document and PowerPoint presentation. The project team may present the findings in the aggregate at professional conferences and in articles to be submitted in peer reviewed scientific journals. The purpose of sharing this information is to share lessons learned and best practices with practitioners and community leaders who serve populations at high risk for unplanned pregnancy, sexually transmitted infections, high risk substance use, suicide and other health concerns affecting adolescents.

3. Use of Improved Information Technology and Burden Reduction

Focus groups for this project will be held in person instead of virtually. It is critical for these focus groups to be held in person given the purpose of the project, which is to test highly detailed, information-rich, and sometimes complex messages.

Focus group participants will be asked to carefully review each message, available to them in writing/hard-copy, and to mark-up the messages in response to questions posed by the moderator.

Assessing body language and facial expressions will also be part of the data gathering and observation process.

All focus groups will be audio-recorded so that transcripts can be made available for data analysis. Focus groups will also be live video streamed for project staff to view remotely (the live video streaming will be terminated immediately once each focus group discussion ends). Live video streaming will save the government money as only critical project staff (1 moderator and 1 note-taker) have to travel—all other project staff will not incur travel costs (e.g., flight, hotel).

4. Efforts to Identify Duplication and Use of Similar Information

The focus groups will collect key information that CDC believes is not captured elsewhere. CDC believes no other data collection effort has been conducted, or has been planned to collect similar information, on CDC DASH target populations. CDC conducted a review of similar studies prior to the issuance of the contract and determined that this project is collecting unique information from CDC DASH target populations. This project requires the collection of new, primary/original data.

5. Impact on Small Businesses or Other Small Entities

This data collection effort does not involve any small businesses or other small entities.

6. Consequences of Collecting the Information Less Frequently

The proposed project involves a one-time data collection, with approximately 6 weeks of data collection in five geographic locations.

There are no legal obstacles to reducing burden.

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

This request fully complies with the regulation 5 CFR 1320.5.

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

The 60 Day Federal Register notice was published for the Generic Collection on Monday, April 23, 2018, Vol. 83, No. 78, pp. 17663. No public comments were received.

9. Explanation of any Payment or Gift to Respondents

To encourage focus group participation and to convey appreciation to participants for contributing to this important project, participants who participate in a focus group will receive a $40 token of appreciation for 90 minutes of participation.

Numerous studies have shown that tokens of appreciation can significantly increase response rates and the use of modest tokens of appreciation is expected to enhance response rates

without biasing responses [16,17,18]. Offering tokens of appreciation is considered necessary to recruit minorities and historically underrepresented groups into data collection efforts—a key element to the parent/caregivers this project seeks to recruit. Timely tokens of appreciation have been shown to improve participation rates among minority groups, as a tangible recognition of the participants' time and effort[19].

Further, educators—who also comprise our target audience for this data collection activity—work within extremely regimented schedules that offer little room for flexibility or variation in the way they spend the time during their work days. The lack of time for school personnel is such a substantial concern for school administrators, that local education agencies often restrict the commitments they allow school personnel to make for tasks such as data collection. A study funded by the U.S. Department of Education helped document some of the time constraints faced by school staff. In that study of middle school teachers, researchers identified a number of time-related challenges, two of which included "feeling overwhelmed" and "lack of discretionary time".[16] Discretionary time, in that study, was defined as "the time when teachers are free from scheduled responsibilities and can decide what to do," and the study found that true discretionary time for teachers was rare. Administrators typically set teachers' schedules, and the majority of their time was spent with students. Even "free time" was often spent with set responsibilities such as team meetings, parent conferences, student meetings, supervising lunch rooms, and moving students from one place to another.[20] It is precisely this lack of discretionary time that can make achieving high response rates among educators a challenge. In this particular data collection, it is expected that many educators will need to participate in the data collection outside of their regular work hours, which produces an additional burden for them that threatens to impact response rates. Other researchers have found that providing incentives for school staff such as school counselors[21] and school principals[22] have increased their likelihood of participation.

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[16] Abreu, D. A., & Winters, F. (1999). Using monetary incentives to reduce attrition in the survey of income and program participation. *Proceedings of the Survey Research Methods Section of the American Statistical Association.*

[17] Shettle, C., & Mooney, G. (1999). Monetary incentives in U.S. government surveys. *Journal of Official Statistics, 15*, 231–250.

[18] Göritz, Anja S. (2006). Incentives in web studies: Methodological issues and a review. *International Journal of Internet Science, 1(1)*, 58-70.

[19] Yancey, A. K., Ortega, A. N., & Kumanyika, S. K. (2006). Effective recruitment and retention of minority research participants. *Annual Review of Public Health, 27*, 1-28.

[20] Collinson V, Cook TF. "I don't have enough time" Teachers' interpretations of time as a key to learning and school change. J Educ Admin. 2001;39(3):226-281.

Participants will receive the token of appreciation regardless of whether they skip any questions during the focus group discussions.

The use of a token of appreciation for participation in this project is appropriate because the project seeks to conduct focus groups with not-yet-served and highly selective populations. We anticipate that higher participation rates will lead to a more accurate representation of the underlying populations of interest.

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

The CDC NCHHSTP IT Security Information System Security Officer (ISSO), have assessed this contract for applicability of 5 U.S.C. § 552a, and has determined that the Privacy Act does not apply.

This project does not collect, store, use, maintain or transmit personal identifiable information (PII) from the data collection activities of the focus groups. However, for administrative purposes only, the CDC contractor (IQ Solutions) will collect publically available information for a subset of focus group participants (professionals), including first names, email addresses, and/or telephone numbers. This information will be used for purposes of recruitment and scheduling only by one project team member from CDC's contractor (IQ Solutions). The information will be contained within a password protected computer, on a password protected excel file. The information will never be transmitted to CDC. It will also never be connected to focus group data and will be destroyed within 30 days following the completion of a focus group.

CDC DASH program staff currently maintains a list of professionals/stakeholders and grantees compiled over time and based on established and trusted working relationships. These professionals/stakeholders and grantees are aware that one DASH project team member has their publically available contact information (first and last names, email addresses, organization), as they voluntarily provided this information to CDC/DASH and understand that they could be contacted for requests to support DASH's mission, as needed. For this project, only one

[21] Bauman S. Improving survey response rates of school counselors: Comparing the use of incentives. J Sch Couns. 2007;5(3). Retrieved January 23, 2015, from http://www.jsc.montana.edu/articles/v5n3.pdf

[22] Jacob RT, Jacob B. Prenotification, incentives, and survey modality: An experimental test of methods to increase survey response rates of school principals. J Res Educ Eff. 2012;5:401-418. doi: 10.1080/19345747.2012.698375

IQ Solutions project team member (CDC contractor) will have access to the DASH list of professional/stakeholder and grantee contacts during the professional focus group recruitment phase. The contacts will be kept in a password-protected computer. This IQ Solutions project team member will send an email to those on the DASH contact list of professional/stakeholder/grantee to gauge interest in participating in a focus group and to follow-up with those professionals who express interest in participating in a focus group (i.e., sending information on the date/time/location of a focus group, sending reminders/confirmations prior to a focus group). Should the contacts be interested in participating, the participant will voluntarily provide their first name, email address, and phone number so project staff can follow up with the individual prior to the focus group (e.g., send location details, send reminder email). This information will never be connected to focus group data and will never be transmitted to CDC. Any personally identifiable information that the IQ Solutions team member has access to will be removed from their computer and files 30 days after the completion of the focus groups.

PII for parents/caregivers will never be collected as this subgroup will be recruited through a professional recruitment vendor. This professional recruitment vendor builds and manages its own database of thousands of potential focus group participants—each of whom has voluntarily opted-in to be part of the vendor's database (each of these database individuals has thus agreed to being reached for upcoming projects of potential interest). Although the professional recruitment vendor collects personally identifiable information such as first and last names, telephone numbers, and email addresses so that they can conduct outreach and reminders, the project team (CDC and IQ Solutions) will never see any of the vendor's personally identifiable information. Project team members who will be physically present at a focus group will receive focus group participant grids stripped of all personally identifiable information. None of the data collection questions, moreover, needs focus group participant personally identifiable information to be satisfactorily addressed during the data analysis stage of the project.

We will inform focus group participants that their responses will be kept private to the extent permitted by the law. All participants who participate in a focus group will be informed that the information collected will not be attributable directly to any individual participant and will only be discussed among members of the project team. During the focus group discussions,

we will maintain participant privacy by using first names only (no last names). The moderator will never see individual participants' full names or other personally identifiable information. The data collected from focus group participants will not include personal identifiers.

The CDC/IQ Solutions project team does not need any personally identifiable information when conducting analyses or reporting summary results, thus will strip all PII from the computer prior to analyzing focus group findings. No personally identifiable information will be disclosed in the results or reporting.

Terms of the CDC contract authorizing data collection and management require the contractor to maintain the privacy of all information collected. Project team members from IQ Solutions who will play a role in data collection and analysis have been trained in proper procedures for data handling. We will be prepared to describe these procedures in full detail at the beginning of each focus group.

In conjunction with the data policy, members of the contractor's project staff are required to:

- Comply with procedures to prevent improper disclosure, use, or alteration of private information. Staff may be subjected to disciplinary and/or civil or criminal actions for knowingly and willfully allowing the improper disclosure or unauthorized use of information.
- Access information only on a need-to-know basis when necessary in the performance of assigned duties.
- Notify their supervisor, the Project Manager, and the organizational Security Officer if information has either been disclosed to an unauthorized individual, used in an improper manner, or altered in an improper manner.
- Report immediately to both the Project Manager and the organizational Security Officer all contacts and inquiries concerning information from unauthorized staff and non-project team personnel.

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

IRB Approval

The CDC determined that CDC's role in this project does not constitute engagement in research and thus CDC human subject review action is not required (**Attachment 3a-b**).

Sensitive Questions

Some of the focus group questions may induce negative thoughts, and participants may feel uncomfortable sharing reservations or criticisms they might have. Participants will be assured that the information they provide is voluntary and will be treated as private. We will inform all participants at the start of each discussion that they may skip any focus group question that makes them uncomfortable or stop focus group participation at any time for any reason, without penalty.

12. Estimates of Annualized Burden Hours and Costs

In our experience, we need to screen as many as 50 potential participants to fill one focus group seat. Therefore, we predict that 2,200 parent/caregiver participants will need to be screened in order to reach our target of recruiting 44 parent/caregiver participants, to seat 36 total* focus group participants.

The screening process is anticipated to take 8 minutes (8/60 hours) per parent/caregiver participant for a total of 286.00 burden hours (Parent/Caregiver Participant Recruitment Screener, **Attachment 2b**).[23]

In our experience with recruiting focus group participants through direct agency contacts, we need to screen 3 potential participants to fill one focus group seat. We predict that 363 professional participants will need to be screened in order to reach our target of recruiting 121 professional participants, to seat 99 total* focus group participants.

The screening process is anticipated to take 8 minutes (8/60 hours) per professional participants for a total of 47.19 burden hours (Professional Recruitment Outreach Emails and Screening Questions, **Attachment 2c**).[24]

Focus group participation per participant will take 90 minutes (1.50 hours) per participant (parent/caregiver and professional participants) for a total of 202.50 burden hours (1.50*135 total participants).

The total number of burden hours is 536.

[23] We will work with a professional recruitment vendor to recruit parents/caregivers.

[24] To recruit individuals who work at education agencies and nongovernmental organizations, we will work with CDC DASH program staff to engage participants.

**Per industry best practice (to maximize participant show-rates), the IQS team will overrecruit by approximately 20 percent—or 2 individuals—per focus group. As required, no more than 9 participants will participant in any given discussion, thus no more than 36 parents/caregivers and 99 professionals in total will participate in focus groups.*

Exhibit A12.1: Estimated Annual Burden Hours[25]

Type of Participant	Form Name	No. of Participants	No. of Responses Per Participant	Average Burden Per Response (in Hours)	Total Burden Hours
Parent/ caregiver	Screener Attachment 2b	2,200	1	8/60	286
Professional	Outreach email Attachment 2c	363	1	8/60	47
Parent/ caregiver	Focus Group Attachment 2a	36	1	1.50	54
Professional	Focus Group Attachment 2a	99	1	1.50	148.5
Total					535.5

12B. Estimated Annual Burden Costs

The total costs to the participants are described in Exhibit A12.2. The total estimated cost of the burden to participants is approximately $14,732.96.

Estimates for the average hourly wage for parent/caregiver participants are based on Bureau of Labor Statistics data accessed in February 2019 providing national wage estimates (https://www.bls.gov/news.release/empsit.t19.htm). This cost represents the average hourly earnings of all employees on private, non-farm payrolls ($27.56, January 2019). Estimates for

[25] Numbers may not sum precisely due to rounding.

the average hourly wage for professional participants are based on Bureau of Labor Statistics data accessed in February 2019 providing national wage estimates (https://www.bls.gov/news.release/empsit.t19.htm). This cost represents the average hourly earnings of all employees education and health services payrolls ($27.43, January 2019).

Exhibit A12.2: Estimated Annual Burden Costs[26]

Type of Participant	Form Name	Total Burden Hours	Hourly Wage Rate	Total Participant Costs
Parent / caregiver	Screener Attachment 2b	286	$27.56	$7,882.16
Professional	Outreach email Attachment 2c	47	$27.43	$1,289.21
Parent / caregiver	Moderator's Guides Attachment 2a	54	$27.56	$1,488.24
Professional	Moderator's Guides Attachment 2a	148.5	$27.43	$4,073.35
Total				**$14,732.96**

13. Estimates of Other Annual Cost Burden to Respondents or Record Keepers

There are no costs to participants for participating in this project other than their time.

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 25% for one GS-13 level CDC employee and 1.5% for a GS-13 level contracting officer. The average annual cost to the federal government for oversight and project management is $26,500 (**Table A14-1**).

[26] Numbers may not sum precisely due to rounding.

The contractor's costs are based on the current annual funding level for carrying out the data collection activities. This estimate includes the cost of data collection, analysis and reporting, recruitment, and the cost of the tokens of appreciation.

The estimated cost to carry out the data collection activities annually for this project is **$241,463.**

Exhibit A14.1: Annual Cost to the Government

Expense Type	Expense Explanation	Annual Costs (dollars)
Direct Costs to the Federal Government	CDC, employee oversight (1 GS-13, 0.25 FTE)	$25,000
	CDC, Contracting Officer (GS-13, 0.015 FTE)	$1,500
	Subtotal, Direct Costs	**$26,500**
Cooperative Agreement or Contract Costs	Contract Cost	$214,963
	Subtotal, Contract Costs	**$214,963**
	TOTAL COST TO THE GOVERNMENT	**$241,463**

15. Explanation for Program Changes or Adjustments

This is a new GenIC information collection request (ICR) under the OMB approved Generic Clearance titled "Formative Research and Tool Development" (OMB #0920-0840 exp. 10/31/2021).

16. Plans for Tabulation and Publication and Project Time Schedule

Our aim is to disseminate the results of the research activities widely to grantees and stakeholders in the form of oral presentations as well as through publications. Findings will be reported in summary form in the form of a narrative document and PowerPoint presentation. The project team may present the findings in the aggregate at professional conferences and in articles to be submitted in peer reviewed scientific journals. The purpose of sharing this information is to share lessons learned and best practices with practitioners and community leaders who serve populations at high risk for unplanned pregnancy, sexually transmitted infections, high risk substance use, suicide and other health concerns affecting adolescents. Tabulation will include descriptive characteristics of project

participants as reported in the Parent/Caregiver Participant Recruitment screener and Professional Recruitment Outreach Emails and Screening Questions. **(Attachments 2b & 2c)**.

The project timeline is detailed in exhibit A16.1.

Exhibit A16.1: CDC DASH Health Communication Message Testing on Adolescent Health Project Time Schedule

Activity	Time Schedule
Protocol development, data collection tools	3-4 months before OMB submission
Pilot test data collection (3 virtual focus groups with 8 total participants)	2-3 months before OMB submission
Pilot test data analysis finalized and pilot test report submitted	2-3 months before OMB submission
Full data collection (15 focus groups with up to 135 total participants)	1-3 months after OMB approval
Analysis plan implemented for qualitative data	3-4 months after OMB approval
Summary report written and submitted	5-6 months after OMB approval

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

We do not seek approval to eliminate the expiration date.

18. Exemptions to Certifications for Paperwork Reduction Act Submissions

There are no exemptions to the certification.