Capacity Building Assistance Program: Assessment and Quality Control

OMB No. 0920-1099

SUPPORTING STATEMENT – Section A

REVISION

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- **Goal of the study**

  The purpose is to assess how well the capacity building assistance (CBA) program meets the needs of health care staff from organizations funded directly or indirectly by the CDC, involved in HIV prevention service delivery. The program will assess customer satisfaction with CBA services and changes in capacity, knowledge, skills, and self-efficacy as a result of CBA service delivery.

- **Intended use of the resulting data**

  The resulting data will be used to improve the CBA service provision, program processes and operations; to assess quality, CBA recipient satisfaction and short-term outcomes of the CBA program; and to monitor the CBA provider funding recipients' delivery of CBA services.

- **Methods to be used to collect**

  The ongoing assessment relies on quantitative data collection. Data will be collected either in-person at training and technical assistance events, online, or on the telephone. Qualitative interview data that was previously collected, will not be collected for this collection.

- **The subpopulation to be studied**

  The information will be collected from recipients of capacity building assistance (CBA) services (i.e., training and technical assistance) who are health professionals from community-based organizations, health departments, and healthcare organizations, most of whom are funded directly or indirectly by the CDC, and involved in HIV prevention service delivery.

- **How data will be analyzed**

  The following analytic tests will be applied to the quantitative data: frequencies and cross-tabulations, ANOVA, correlations, means, non-response adjustment, and logistic regression to explore relationships within the data.

Section A. JUSTIFICATION

1. Circumstances Making the Collection of Information Necessary

Background

The Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention (DHAP) requests an revision for 1 year of this information collection request (ICR) entitled, "Capacity Building Assistance Program: Assessment and Quality Control (0920-1099)."

Data will be collected over a 1-year period from agency staff from community-based organizations (CBOs), health departments, and

healthcare organizations, most of whom are funded directly or indirectly by the CDC, involved in HIV prevention service delivery. Their positions include HIV educator, clinical supervisor, HIV prevention specialist, clinician, outreach worker, case manager director, program coordinator, program manager, disease intervention specialist, partner services provider, physicians, nurses, and health educators, etc. The revision consists of removing qualitative interview data collection activity.

This information collection is authorized by Section 301 of the Public Health Service Act (42 U.S.C. Sec. 792[295k] (a) (**Attachment 1: Authorizing Legislation**)). This information collection falls under the essential public health service of 1) informing, educating, and empowering people about health issues; 2) mobilizing community partnerships to identify and solve health problems; 3) linking people to needed personal health services and assure the provision of health care when otherwise unavailable; 4) assuring a competent public health and personal health care workforce.

With an estimated 50,000 new HIV infections each year, more must be done with existing resources to maximize the impact of every federal prevention dollar and achieve the goals of the National HIV/AIDS Strategy (NHAS). CDC's Division of HIV/AIDS Prevention (DHAP) provides health departments and CBOs with more than $300 million annually to conduct HIV prevention activities. In addition, DHAP's Capacity Building Branch (CBB) provides funds for Capacity Building Assistance (CBA) services in which considerable resources are allocated to serve CBOs, health departments, and healthcare organizations for HIV prevention services nationwide. The CBB provides national leadership and support for capacity building assistance to ensure that DHAP's funding recipients and healthcare organizations have the knowledge, skills, and technology to effectively and efficiently conduct HIV prevention across the United States and its territories. CBA means the provision of free (not for fee) information, training, technical assistance, and technology transfer to individuals, organizations, and communities to improve their capacity in the delivery and effectiveness of evidence-based interventions and core public health strategies for HIV prevention. CBA is provided to support health departments, community-based organizations, and healthcare organizations in the implementation, monitoring and evaluation of evidence-based HIV prevention interventions and programs; building organizational infrastructure; and community mobilization to decrease stigma and increase HIV testing in high risk communities.

DHAP has funded the CBA program since 1999. Prior to that, the program was called the National and Regional Minority Organizations Program. In all, DHAP has funded some form of capacity building strategy for DHAP funding recipients for approximately 18 years (e.g., PS04-4019, PS09-906, and PS14-1403). On April 1, 2014, CDC awarded $115 million over five years to train and strengthen 21 capacity building assistance organizations and ensure on-the-ground prevention programs

and their staff have the skills, information, and organizational support they need to best serve organizations serving individuals living with, and at high risk for, HIV in their communities. The CBA services program aligns with the goals of the NHAS and CDC's High-Impact Prevention (HIP) and Community High-Impact Prevention (CHIP) approaches by supporting a defined set of scalable, cost-effective activities and placing emphasis on the delivery of high-quality prevention and care services for persons living with HIV; effective new prevention strategies for those at high-risk for HIV; policy change to advance HIV prevention goals among health departments; and collecting and using care continuum data for policy planning and program prioritization. The program also continues to emphasize key activities with demonstrated potential to reduce new infections such as HIV testing, condom distribution, and use of surveillance data to improve program efficiency and effectiveness. The CBA provider funding recipients provide culturally competent information dissemination, training, and technical assistance in the areas of HIV testing, prevention with HIV-positive persons, prevention with high-risk HIV-negative persons, condom distribution, organizational development and management, and policy.

CBA has been funded for nearly 18 years, this renewal is part of an ongoing initial effort to systematically assess CBA services provided to CBOs, health departments, and healthcare organizations to support their HIV prevention services. We have only recently put in place an assessment process to determine whether CBA recipients were satisfied with CBA services and whether CBA services resulted in improved HIV prevention practice. The CBB, as the major leader in CBA services, is in the position to conduct such an assessment and use this information to improve capacity building efforts by CBB funding recipients. We are asking for another year of data collection to complete the assessment we started nearly three years ago, not wanting to stop prior to full data collection, and process data of those CBA recipients who receive service during our final months of our funded efforts.

To that end, the purpose of this information collection is to continue assessing how well the CBB's CBA program meets the needs of its consumers in order to enhance capacity building strategies over time. The information will be collected from recipients of CBA services (CBOs, health departments, and healthcare organizations). This assessment will continue to provide the CBB with necessary information to improve program processes and operations. Improving the quality of HIV prevention programs is a key evaluation activity, among others, promoted by the CDC and DHAP. The assessment relies on quantitative information collection. Data will be collected either in-person at training and technical assistance events, online, or on the telephone.

2. Purpose and Use of the Information Collection

Although CBB has funded CBA services for HIV prevention efforts for nearly 18 years, it has only been recently that we have had a

systematic assessment of CBA services provided health professionals from community-based organizations (CBOs), health departments, and healthcare organizations, most of whom are funded directly or indirectly by the CDC, involved in HIV prevention service delivery. Moreover, we are seeking to complete our ongoing assessment process currently in place to determine the degree to which CBA recipients were satisfied with CBA services nor an assessment of whether CBA services resulted in improved HIV prevention practice or enhance organizational capacity. The CBA providers have found it useful to have adequate feedback on the quality of their work and need to continue on the current course of CBA recipients' feedback to inform CBA quality assurance and to direct CBA program improvement. The CBB, as the major leader in CBA services, is in a unique position to conduct such an assessment and use this information to improve capacity building efforts by CBB's funding recipients both now and in the future.

The purpose of this information collection is to assess how well the CBB's Capacity Building Assistance (CBA) program meets the needs of its consumers in order to enhance its capacity building strategy over time. More specifically, information collection will help us answer questions such as:

1. To what extent are CBA recipients satisfied with the CBA services they receive?
2. How do CBA services impact CBA recipients' capacity to implement evidence-based prevention practices and public health strategies?
3. How do CBA recipients think that CBA services can be improved?
4. What factors correlate with CBA recipient satisfaction and capacity building outcomes?
6. To what extent do recipient satisfaction and capacity building outcomes improve over time for individual CBA providers and for the overall CBA program?
7. How is the capacity of CBA recipients' organizations to implement evidenced-based prevention practice and public health strategies impacted as a result of CBA?

The information will be collected from recipients of CBA services (i.e., training and technical assistance) who are health professional from CBOs, health departments, and healthcare organizations, most of whom are funded directly or indirectly by the CDC, involved in HIV prevention service delivery. CBA services recipients' positions include: HIV educator, clinical supervisor, HIV prevention specialist, clinician, outreach worker, case manager director, program coordinator, program manager, disease intervention specialist, partner services provider, physicians, nurses, and health educators, etc. This assessment will continue to provide the CBB with necessary information to improve program processes and operations. This data collection provides CDC with information to determine whether the CBA provider funding recipients are reaching their target audiences in terms of provider type, the types of organizations in which participants work,

the focus of their work and the population groups and geographic areas served. CDC will use the data to monitor and evaluate performance of funding recipients funded by Division of HIV/AIDS Prevention (DHAP) and CDC/Division of STD Prevention (DSTDP) that offer STD and HIV prevention training and TA to STD and HIV prevention health professionals. The CBB is committed to continuous quality improvement of its CBA services and products. The assessment of consumer satisfaction will take place within a utilization-focused assessment framework, which emphasizes practical utility. In the absence of this assessment, the CBB's ability to make timely and essential mid-course correction, if needed, to better meet the needs of its consumers will be greatly impaired. Specifically, this information will be used to:

- Assess the quality of services delivered by CDC-funded CBA providers and CBA partners;
- Assess short term outcomes of CBA service delivery;
- Identify and address the technical assistance needs of CBO s, health departments, and healthcare organizations;
- Identify and address programmatic areas of improvement;
- Respond promptly to emerging problems identified through feedback from consumers;
- Provide timely, current, and accurate information in response to requests from Executive Branch officials, the Congress, constituents, or other federal, state, and local agencies on the needs of funding recipients and the types and quality of CBA services delivered.

CBB will disseminate the summarized information through reports to CBB and its funding recipients, and possibly publications or presentations. All data will be shared in the aggregate. No CBA provider or CBA partner will know how any individual described their satisfaction with its services. If results are shared with the public via presentations or publications, results will be shared in the aggregate, and any information that may identify an agency or individual will be masked. As individuals participating in CBA events (training or technical assistance) will be representing their organizations, there will be no impact on their personal privacy.

There are three instruments administered to the recipients of CBA services (i.e., training and TA). CBA services are provided by request as needed and proactively through training. Some respondents will have received training or TA or both. Before the CBA services are delivered, the CBA service recipients will complete the Health Professional Application for Training (HPAT) (**Attachment 3: Health Professional Application for Training (HPAT) Word version; Attachment 4: Health Professional Application for Training (HPAT) screenshots**) as part of registration for training and TA services. The HPAT is administered online or by paper depending on whether the registration

process is web-based or completed in person. CDC contracts with DLH to coordinate online registration and data collection for the HPAT for some of the CBA trainings. The CBA provider funding recipients coordinate registration and data collection for the HPAT for other trainings and TA services. During the training or TA services, CBA recipients will be given the opportunity to opt-out of further data collection.

After CBA services are delivered, each CBA recipient will receive an email invitation (**Attachment 9: Training Intro Email or Attachment 10: Technical Assistance (TA) Intro Email**) to complete the web-based instruments. The email will contain a link to the web-based Training Follow-up Instrument (**Attachment 5: Training Follow-up Instrument Word version; Attachment 6: Training Follow-up Instrument screenshots**) or the web-based Technical Assistance (TA) Satisfaction Instrument (**Attachment 7: Technical Assistance (TA) Satisfaction `Instrument Word version; Attachment 8: Technical Assistance (TA) Satisfaction Instrument screenshots**) and instructions for completing the instruments online. Those CBA recipients who participate in a training will get the Training Intro Email (**Attachment 9: Training Intro Email**) with the link to the web-based Training Follow-up Instrument, and those who participate in technical assistance will get the Technical Assistance (TA) Intro Email (**Attachment 10: Technical Assistance (TA) Intro Email**) with the link to the Technical Assistance (TA) Satisfaction Instrument. The CBA Request Information System (CRIS) application will send the email invitation to complete the Training Follow-up Instrument 90 days after the training or for the Technical Assistance (TA) Satisfaction Instrument, 45 days after the technical assistance (TA) is completed.

Two weeks after the emails for the Technical Assistance (TA) Satisfaction and Training Follow-up instruments are sent out, a reminder (**Attachment 11:Training Reminder Email and Attachment 12: Technical Assistance (TA) Satisfaction Reminder Email**) will be emailed to respondents who have not completed the online instruments.

One week after the reminder emails are sent, SciMetrika (contractor) will contact the non-responders by telephone to administer the telephone script version of the Training Follow-up Instrument (**Attachment 13: Training Telephone Script for non-responders)** or the Technical Assistance (TA) Satisfaction Instrument (**Attachment 14: Technical Assistance (TA) Telephone Script for non-responders**)by telephone if they are willing. Given the typically low response rate to online assessments, this telephone follow-up strategy increases the responses to the instruments.

3. Use of Improved Information Technology and Burden Reduction

Web-based versions of the quantitative data collection tools were chosen to reduce the overall burden on respondents. Quantitative assessment data will be collected via web-based questionnaires allowing respondents to complete and submit their responses

electronically. These information collection instruments were designed to collect the minimum information necessary for the purposes of this project (i.e., limited to a maximum of 44 quantitative questions and qualitative questions). The TA and training registration tool, HPAT, is administered online or by paper depending on whether the registration process is web-based or completed in person.

4. Efforts to Identify Duplication and Use of Similar Information

The information being collected is specific to DHAP/CBB's CBA program, the CBA service delivery, and CBA provider funding recipients. This data collection represents the Branch's initial attempt to assess consumer satisfaction and outcomes for CBA services provided by its CBA provider funding recipients under its CBA program. There is currently no information available that can substitute for the responses to the data collection instruments and provide program improvement information. This data collection builds on the data already being collected with the HPAT (OMB Control No. 0920-1099; Exp. Date: 2/28/2019) which is already in use by the DSTDP and DHAP/CBB CBA provider funding recipients.

5. Impact on Small Businesses or Other Small Entities

This data collection will not involve small businesses or other small entities.

6. Consequences of Collecting the Information Less Frequently

This request is for a one time information collection for each episode of CBA service (training or technical assistance) received by each CBA consumer. Each CBA consumer may receive an average of two episodes of CBA service (training or technical assistance) per year, and therefore will respond to an average of two data collections per year. There are no legal obstacles to reduce the burden.

If data are not collected, there will be no systematically obtained information for the CBB to make timely and essential mid-course corrections, if needed, to better meet the needs of its consumers. Specifically, not collecting this information would hinder the Branch's ability to:

- Monitor and assess the PTC and CBA grantee performance;
- Assess the quality of services delivered by CDC-funded CBA providers and CBA partners;
- Identify and address the technical assistance needs of health professionals from health departments, CBOs, and healthcare organizations conducting HIV prevention activities;
- Identify and address programmatic areas of improvement;

- Respond promptly to emerging problems identified through feedback from consumers;
- Provide timely, current, and accurate information in response to requests from Executive Branch officials, the Congress, constituents, or other federal, state, and local agencies on the needs of funding recipients and the types and quality of CBA services delivered.

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

A. The 60-day federal register notice to solicit public comments was published in the Federal Register on 09/06/2018, pages 45244, Vol. 83, Number 173 (**Attachment 2**). No public comments were received. No consultations outside CDC occurred.

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 Officer for CDC / ATSDR has assessed this package for applicability of 5 U.S.C. § 552a. The Privacy Act is applicable because PII is being collected under this CDC funded activity. Employees of health departments, community-based organizations (CBOs) and healthcare organizations will be speaking from their official roles. Participation in the information collection activities is voluntary for the respondents.

Of the four instruments, the HPAT tool is the only tool which collects categories of information in identifiable format from individual respondents such as: name, work mailing address, work phone numbers, work email address, and organization name. These identifiable HPAT data are needed to schedule telephone follow-up with respondents who do not complete the online surveys within two weeks, to complete registration, and to conduct training and technical assistance. The identifiable data from the HPAT is entered, stored, and transmitted in a separate database from all the other data collected. A unique identifier will be used on all data collection instruments to enable the linking of data from multiple data collection tools. The unique identifier consists of first two letters of the first name, first two letters of the last name, month of birth, and day of birth.

There are several safeguards in place to handle data. Data will be stored and managed based on current CDC/OCISO (Office of the Chief Information Security Officer) requirements and standards (**attachment 17**). This includes protecting stored data within the CDC Internet Firewall. The data are stored and managed based on current CDC/OCISO requirements and standards which also includes the process for handling security incidents and the event monitoring and incident response. All administrative controls required by OCISO are validated through a "Certification and Authorization" (C&A) process as conducted by OCISO prior to moving any software application into "Production" on the CDC network.

The system security plan is included in the OCISO C&A process and the contingency (or backup) plan for this information collection, (as mandated by OCISO), is to manage this information from a pre-determined OCISO approved off-site location.

http://www.cdc.gov/about/leadership/leaders/seligman.htm.

Files are backed up daily and stored both onsite and offsite in accordance with CDC standards and OCISO guidelines. Contractors who operate and use the system are managed via the "CDC Information Management Services" (CIMS) contract which requires signed confidentiality agreements. All users' access is "role based" and reflects a "need to know" policy established by CDC. Accountability is maintained with a user access log file which tracks users' access to the system. Records will be retained and destroyed in accordance with the applicable CDC Records Control Schedule as mandated by OCISO.

(http://www.cdc.gov/about/leadership/leaders/seligman.htm" (http://aops-mas-iis.od.cdc.gov/Policy/Doc/policy449.htm)

No electronic media will be used and no IIF data are collected. A non-research determination was made and therefore, IRB review is not needed (Attachment 18). This data collection is not considered research based on the description and justification and based on the definition of research as defined by the federal policy for the protection of human subjects (45 CFR 46)(Attachment 18).

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

IRB Since this is associated with programmatic improvement, it was determined that this did not require (IRB) oversight. We got an approval signature from the Associate Director of Science for the Center.

Sensitive Questions

No information will be collected that are of personal or sensitive nature. Respondents are participating in their official capacity as health professionals in CBO s, health departments, and healthcare organizations.

12. Estimates of Annualized Burden Hours and Costs

The average time to complete the instruments including time for reviewing instructions, gathering needed information and completing the instrument, was approximately five minutes for the HPAT (**attachment 3**), 15 minutes for the Training Follow-up Instrument (**attachment 5**) or the Technical Assistance (TA) Satisfaction Instrument (**attachment 7**). Respondents have a choice completing the web-based version of the Training Follow-up Instrument (**attachment 6**) and Technical Assistance (TA) Satisfaction Instrument (**attachment 8**) or the telephone version of these instruments (i.e., Training Telephone Script for non-responders and Technical Assistance (TA) Telephone Script for non-responders). Both versions take 15 minutes to complete. We estimate 3,700 respondents will be surveyed using the Training Telephone Script (**attachment 13**). We estimate having to survey 3,700 respondents using the Technical Assistance (TA) Telephone Script (**attachment 14**). Based on these results, the estimated time range for actual respondents to complete the instruments is 20 minutes most respondents plus an additional 15 minutes for a sample of 40 respondents who also participate in the key informant interview. For the purposes of estimating burden hours, the upper limit of this range (i.e., 30 minutes) is used.

The number of respondents is calculated based on an average of the number of health professionals, including doctors, nurses, health educators and disease intervention specialists, trained by the CBA and PTC funding recipients during the years 2016 and 2017. We estimate 7,400 health professionals will provide two responses for the HPAT; and 3,700 health professionals will provide two responses per instrument for each episode of training or technical assistance they participate in on an annual basis. The total annualized burden hours is 8,643. The following table shows estimated burden.

Table 12A: Estimates of Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
Healthcare Professionals	Health Professional Application for Training (HPAT) (att 3)	7,400	2	5/60	1233
Healthcare Professionals	Training Follow-up Instrument (att 5)	3,700	2	15/60	1850
Healthcare Professionals	Training Telephone Script	3,700	2	15/60	1850

	(att 13)				
Healthcare Professionals	Technical Assistance (TA) Satisfaction Instrument (att 7)	3,700	2	15/60	1850
Healthcare Professionals	Technical Assistance Telephone Script (att 14)	3,700	2	15/60	1850
Total					8,633

Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) National Compensation Survey estimate for management occupations – medical and health services managers in state government (https://www.bls.gov/oes/current/oes110000.htm, May 2017, accessed July 2018). Based on DOL data, an average hourly wage of $53.69 is estimated for the respondents. The following table shows estimated burden and cost information.

Table 12B: Estimated Annualized Burden Costs to Respondents

Type of Respondent	Form Name	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
Healthcare professionals	Health Professional Application for Training (HPAT) (att 3)	1233	$53.69	$66,200
Healthcare professionals	Training Follow-up Instrument (att 5)	1850	$53.69	$99,327
Healthcare professionals	Training Telephone Script (att 13)	1850	$53.69	$99,327
Healthcare professionals	Technical Assistance (TA) Satisfaction Instrument (att 7)	1850	$53.69	$99,327
Healthcare professionals	Technical Assistance (TA)Telephone	1850	$53.69	$99,327

	Script (att 14)			
Total				**$463,508**

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 information collection.

14. Annualized Cost to the Government

The annualized cost to the government is $726,734. The personnel cost of the CDC oversight of the project and contractors will be $23,468 for the Lead Behavioral Scientist. The cost of the Scimetrika contractor to provide assistance in the preparation of the OMB package, assessment design, instrument development, data collection, quality control, data analysis, and report preparation will be $604,840. The cost for SeKON Enterprise Inc./Maximus contractor to provide the development and programming for the web-based information collection and data transmission to CDC and SciMetrika will be $44,226. For a cost of $54,200, DLH contractor will provide training registration and data collection and tracking. Information collection tools were prepared by CDC staff (FTE) and the SciMetrika contractor. An FTE manager reviewed all information collection tools. A senior level FTE reviewed and approved the activities. Table 14 describes how this cost estimate was calculated.

Table 14: Estimated Annualized Cost to the Federal Government

Staff (FTE)	Average Hours per Collection	Average Hourly Rate	Average Cost
Lead Behavioral Scientist (GS-14): OMB package preparation; review and oversight of assessment design, instrument development, pilot testing, data collection, quality control, data analysis and report preparation	400	58.67	23468
Maximus contractor: Web-based information collection instrument programming, data collection			44226
SciMetrika contractor: OMB package preparation, assessment design, instrument development, pilot testing, data collection, quality control, data analysis, and report preparation			604840
DLH contractor: training logistics,			54200

data collection and tracking.			
Estimated Total Cost of Information Collection			726734

15. Explanation for Program Changes or Adjustments

This is a revision of the previously approved 0920-1099 information collection to extend our data collection efforts. We have made one modification from the previous collection, in the revision we will no longer collect qualitative interview data. Based on the collection of the qualitative interviews, we have gleaned valuable information to improve our service delivery and program processes. Not having the qualitative data collection, reduces the overall burden by 10 hours.

In the original information collection, SciMetrika conducted 40 key informant interviews with CBA recipients as part of their overall evaluation. The team used a purposeful sampling strategy to randomly select 40 recipients. Interviews were conducted using the OMB-approved script (OMB No. 0920-1099, Exp. Date: 02/28/2019). Interviews were recorded, transcribed, and analyzed. We asked participants about skills and knowledge gained by receiving training or TA, barriers and facilitators to using the skills and knowledge, long-term use of skills and knowledge, and overall impact of CBA services on their organization's ability to deliver evidence-based interventions, programs or other services. Results have been included in reporting delivered to CDC. Results of this qualitative analysis complemented the quantitative information collected with web-based instruments.

16. Plans for Tabulation and Publication and Project Time Schedule

For this revision, only quantitative analyses will be performed. Prior to conducting any formal analyses on quantitative data, exploratory univariate and bivariate tests will be performed first to determine trends and patterns in the data. This will be accomplished using frequencies and cross-tabulations, and by examining univariate distributions and correlations. The frequency analysis will give various chi-squared tests for association for categorical ordinal or nominal data, while the ANOVA will provide F-tests for continuous data. We will also take into account input from DHAP experts, the SciMetrika contractor, and the literature to include variables that have exhibited previous associations with the outcome.

Key informant interview analysis collected previously were used to improve training on the implementation of evidence-based interventions. We will not be collecting any additional key informant interview data for this revision.

The results of this assessment continue to be shared internally with CDC/DHAP leadership and CBB staff as well as externally with CBB's CBA provider funding recipients. The results have been used by CBB and its funding recipients for continuous quality improvement of CBB's CBA services and products and to improve program processes and operations. CBB staff have received annually a more detailed summary report of the yearly findings. The majority of CBA trainees were implementing

evidence-based intervention and most were quite satisfied with the CBA services provided. By September 2020, a report summarizing all cumulative years of data collection will be shared with CDC/DHAP leadership and CBB staff as well as externally with CBB's newer CBA provider funding recipients in order to prepare for the next data collection associated with a new funding cycle of CBA services and processes. No respondents or respondent organizations will be identified in any reports.

Across the previous data collection period there was an overall increase in the mean satisfaction between each evaluation year. In recent data collected between April of 2017 through March of 2018, 89% of training recipients 90 days after they received training were highly satisfied with the services they received (mean score of 4.68 on a 1 to 5 point scale, five being a perfect score). In addition, 78% of training recipients stated that they were either ready or had already begun implementation of evidence-based interventions, 90 days after training. For technical assistance (TA) CBA recipients, 84% stated that their TA needs were met and they were satisfied with their services 45 days after receiving CBA services.

Table 16: Project Time Schedule

Collect, code, enter, quality control, and analyze data	Upon OMB approval - 1 year Desired need for OMB approval 3/1/2019
Prepare report	12 months after OMB approval to 24 month
Disseminate results/reports	12 months after OMB approval to 24 months

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

The display of the OMB expiration date is not inappropriate

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

REFERENCE LIST

The White House. “National HIV/AIDS Strategy for the United States.” Available at http://www.cdc.gov/hiv/pdf/policies_nhas.pdf. Accessed on 12/22/14

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Centers for Disease Control and Prevention (CDC). “Capacity Building Assistance for High-Impact HIV Prevention – PS14-1403: Program Backgrounder.” Available at http://wwwdev.cdc.gov/hiv/pdf/policies_funding_ps14-1403_ProgramBackgroundBrief.pdf . Accessed at 12/22/14.