SUPPORTING STATEMENT: PART A

October 16, 2019

OMB# 0920-NEW

Monitoring and Reporting for the Overdose Data to Action Cooperative Agreement

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Goal: The goal of this data collection is to gather program monitoring and reporting information from jurisdictions (which include states, Washington, D.C., U.S. Territories, cities and counties) currently funded under the Overdose Data to Action (CDC-RFA-CE19-1904) notice of funding opportunity (OD2A NOFO). Reporting requirements have been carefully designed to align with and support the specific goals and outcomes outlined in the OD2A NOFO.
Intended use of the resulting data: Information collected will provide crucial data for program performance monitoring, budget tracking, and where applicable, program success. The information will also improve communication between CDC and funding recipients as well as inform technical assistance and guidance documents.
Methods to be used to collect: Jurisdictions will report activity progress and work plan updates, provide evaluation and performance measuring plan updates, assess operational capacity, and provide a surveillance data dissemination plan using web-based tools and Word templates.
The subpopulation to be studied: All jurisdictions funded by the OD2A NOFO will be expected to complete all reporting. No subpopulations are being studied.
How data will be analyzed: Sampling methods will not be used. Data collection will include 100% of jurisdictions funded under the prevention strategies included in the OD2A NOFO. The data will be analyzed using descriptive and summary statistics, and qualitative summaries.

A.JUSTIFICATION

TIME SENSITIVE

In October 2017, HHS declared a public health emergency to address the national opioid crisis. This information collection request supports CDC monitoring of response efforts in 66 jurisdictions.

A.1. Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) seeks OMB approval to collect information from jurisdictions (which include states, Washington D.C., U.S. Territories, cities and counties) funded under the Overdose Data to Action (CDC-RFA-CE19-1904) funding opportunity. This program is a new initiative. OMB approval is requested for three years (the duration of funding).

Drug overdose deaths in the United States increased by 18% per year from 2014 to 2016. Opioid overdose deaths have increased fivefold from 1999 to 2016 and in 2017, there were more than

47,000 deaths attributed to opioids[1]. While the opioid overdose epidemic worsens in scope and magnitude, it is also becoming more complex. The complex and changing nature of the opioid overdose epidemic highlights the need for an interdisciplinary, comprehensive, and cohesive public health approach.

The purpose of the Overdose Data to Action (CDC-RFA-CE19-1904) notice of funding opportunity (OD2A NOFO), is to support funded jurisdictions in obtaining high quality, complete, and timelier data on opioid prescribing and overdoses, and to use those data to inform prevention and response efforts. There are two required components of this award – a surveillance component and a prevention component. There are ten strategies in the funding opportunity across both components. Three of the strategies (1-3) support the surveillance component while seven support the prevention component (4-10):

1) Emergency Department Data
2) Mortality Data
3) Surveillance Innovation Projects
4) Prescription Drug Monitoring Program
5) Integration of State and Local Prevention and Response Efforts
6) Establishing Linkages to Care
7) Providers and Health Systems Support
8) Partnerships with Public Safety and First Responders
9) Empowering Individuals to make safer choices
10) Prevention Innovation Projects

The intent is to ensure that funded jurisdictions are well equipped to do rigorous work under both components, and to ensure that these components are linked and implemented as part of a system.

This ICR will focus on four tools that funded jurisdictions will be required to use in order to assess performance as well as measure effectiveness. The *Data Dissemination Plan* supports the surveillance component (strategies 1-3 above) while the *Annual Performance Report, Evaluation and Performance Measuring Plan*, and *Overdose Prevention Capacity Assessment Tool* support the overall OD2A NOFO (all strategies above).

A total of 79 jurisdictions were eligible to receive awards under this funding opportunity, and 67 jurisdictions submitted applications and 66 were funded (Attachment 2). Each funded jurisdiction will be required to report the four elements of this ICR. Reporting is based on both web-based tools and Word templates.

This information is being collected to provide crucial data to CDC for program monitoring and budget tracking, to improve timely CDC-recipient communications, and to inform technical assistance and guidance documents produced by CDC to support program implementation among funded jurisdictions. The information feedback loop created by these information collection tools is designed to help jurisdictions decrease fatal and nonfatal overdoses. It will

[1] Lavinghouze SR, Snyder K, Rieker PP. The component model of infrastructure: a practical approach to understanding public health program infrastructure. *Am J Public Health.* 2014;104(8):e14-24.

also provide CDC with the capacity to respond in a timely manner to requests for information about the program from the Department of Health and Human Services (HHS), the White House, Congress, and other sources.

CDC plans to begin implementing the data collections outlined in this ICR immediately once approval is obtained. CDC is authorized to collect information for public health purposes by Section 301(a) of the Public Health Service Act (Attachment 1).

A.2. Purpose and Use of Information Collection

CDC proposes to collect the information specified in this request from all funded jurisdictions. Within six months of award and after OMB approval, funded jurisdictions will report:

1) *Evaluation and Performance Measuring Plans* (Att. 3a) using a Microsoft Word template and
2) *Overdose Prevention Capacity Assessment Tools* (Att. 3b & 3e) using the Partner's Portal.

Annually, funded jurisdictions will report:
1) *Activity Progress Report and work plan tool* (Att. 3c) using the Partner's Portal, which allows funded programs to monitor, evaluate, and report and/or modify relevant content to the CDC via a secure web application;
2) *Evaluation and Performance Measuring Plans* (Att. 3a) using the Partner's Portal; and
3) *Overdose Prevention Capacity Assessment Tools* (Att. 3b & 3e) using an online assessment.

One year after funding begins funded jurisdictions will submit their *Surveillance data dissemination plan* (Att. 3e) using the Partner's Portal.

The information collection and reporting requirements have been carefully designed to align with and support the specific goals and outcomes outlined in the Overdose Data to Action funding opportunity and will enable collection and reporting of the information in an efficient, standardized, and user-friendly manner. Collection of these data is crucial for program monitoring and budget tracking, real-time CDC-recipient communications, and technical assistance and guidance documents produced by CDC to support program implementation. It will also provide CDC with the capacity to respond in a timely manner to requests for information about the program from the Department of Health and Human Services (HHS), the White House, Congress, and other sources.

Specifically, CDC will use the information collected to monitor each recipient's progress and to identify facilitators and barriers to program implementation and achievement of outcomes. Monitoring allows CDC to determine whether a recipient is meeting performance and budget goals, to assess progress with respect to capacity building, and to make adjustments in the type and level of technical assistance provided to funded jurisdictions as needed. Program monitoring also allows the CDC to identify and disseminate information about successful prevention strategies implemented by funded jurisdictions. These functions are central to NCIPC's broad mission of protecting Americans from violence and injury threats.

With the assistance of CDC staff, program funded jurisdictions will use the information collected to manage and coordinate their own activities and to improve their efforts to prevent opioid overdose morbidity, mortality, and associated harm. The tools and templates will allow funded jurisdictions to fulfill their annual reporting obligations under the funding opportunity announcement in an efficient manner by employing user-friendly instruments to collect the necessary information. This approach, which enables funded jurisdictions to save pertinent information from one reporting period to the next, will reduce both the CDC and jurisdictions' administrative burden on the yearly continuation application and the progress review process. The information collected using the four instruments described in this ICR will provide a comprehensive picture of the data available to jurisdiction staff. The collected information will be used to generate reports, summaries, and technical assistance, as well as for other reporting systems as required.

Although program monitoring is an essential element of public health programs, data collected for this purpose are not generalizable. In addition, because this is not a research cooperative agreement, funded jurisdictions are not required to implement rigorous research designs that have strong internal validity, produce generalizable knowledge, or allow for causal attribution.

Funded jurisdictions are required to report four instruments:

1) Evaluation and Performance Measuring Plan (Attachment 3a)

With respect to the evaluation and performance measuring plan, the provided template and Partner's Portal will require funded jurisdictions to develop and share their logic model, data management plan, and their plan to maximize the utility of their program assessment. Specifically, funded jurisdictions will enter the following information:

1) A comprehensive logic model that includes the surveillance and prevention components and that addresses the strategies and activities selected by the jurisdiction for the three-year project period;
2) A plan for data monitoring, data quality assurance, use of the surveillance data to inform program implementation, and a description of methods to be used to track the dissemination and impact of the surveillance data; and
3) A description of how the evaluation of each prevention component strategy will be used, evaluation questions, indicators, data collection methods and a timeline for data collection and analysis for each prevention component strategy.

The evaluation and performance measuring plan template has been used in previous funding opportunities (OMB# 0920-1155). It has been updated to reflect the goals of this funding opportunity, as well as to incorporate feedback from previous users. It is not used for evaluation of OD2A but for the funded jurisdictions' evaluation of their activities and for technical assistance by CDC. The evaluation and performance measuring plan will be submitted six months after funding begins using a Microsoft Word Template and then will be updated using the Partner's Portal each project year.

2) Overdose Prevention Capacity Assessment Tool (Attachment 3b & 3e)

The operational capacity assessment will require funded jurisdictions to report on two types of capacity within their programs: infrastructure capacity and opioid-specific topical capacity. In terms of infrastructure capacity, funded jurisdictions will be asked to rank the capacity of their

funded program on a five-point scale within the following domains: multilevel leadership, networked partnerships, responsive plans & planning, engaged data, and managed resources. In total, there are 25 ranking questions pertaining to operational capacity. In terms of topical capacity, funded jurisdictions will be also asked to rank the capacity of their funded program on a five-point scale, across 14 topical areas.

The operational capacity questions have been adapted from the Component Model of Infrastructure that links capacity, sustainability and outcome measurements as a method for developing a framework and/or guidance documents in order to function more efficiently and effectively. [1] The topical capacity questions have been developed in concert with a contractor and other subject matter experts, but have not previous been deployed within a data collection.

3) Annual Activity Progress Report and Workplan (Attachment 3c)
The extent of the annual progress update will vary based on the activities and sub-activities selected by each funded program, but in general, funded programs will be required to provide: summaries of implemented activities and challenges encountered, detailed descriptions of sub activities and their dates of implementation, success stories, and progress and plans within each sub activity year-over-year. The tool used by the jurisdictions will not change or update; the jurisdictions will provide updates on their progress via the Partner's Portal (see A.3).

4) Surveillance Data Dissemination Plan (Attachment 3d)
Jurisdictions funded for strategies 1 (emergency department data) and 2 (mortality data) will complete a surveillance data dissemination plan at the end of the first year of funding. Funded programs will be required to provide a list of their governmental and non-governmental stakeholders, the types of emergency department and mortality data shared with each stakeholder, and the format of the dissemination product shared (e.g., report, publication, access to a dashboard, etc.). In addition, funded jurisdictions will be asked how their data or dissemination products have been used or will be used for prevention planning or response by the health department and/or stakeholders.

A complete crosswalk of the four required reporting instruments is provided in Attachment 7. The table describes the relationship between the assessment questions and the two required components and 10 strategies of the Overdose Data to Action funded activities.

Overall, the collection of these data is crucial for program monitoring, budget tracking, real-time CDC-recipient communications, technical assistance, and guidance documents produced by CDC to support program implementation. These data will also allow CDC to identify and disseminate information about successful implementation and lessons learned by funded jurisdictions, functions that are central to NCIPC's broad mission of protecting Americans from violence and injury threats. It will also provide CDC with the capacity to respond in a timely manner to requests for information about the program from the Department of Health and Human Services (HHS), the White House, Congress, and other sources.

A.3. Use of Improved Information Technology and Burden Reduction

The CDC developed the aforementioned Partner's Portal as well as Word templates to collect the data outlined in this ICR. The data entry interface of the Partner's Portal was developed using NCIPC-owned, Microsoft Azure, and Platform as a Service (PaaS) cloud solution approved for use by CDC programs. The use of the Partner's Portal provides several advantages:

- This user-friendly online interface requires little training and will be easy and intuitive for recipients to use to enter data for the information collection.
- Standard data elements, definitions, and specifications at all levels improve the quality and comparability of information that recipients submit, and enhance the consistency of reports to examine information across recipients.
- The structure of the data collection in Partner's Portal is flexible such that different recipients are still able to capture and report information relevant to their program context and structure.
- The ability to carry information and populate from one reporting period to the next increases the efficiency of data entry, reduces errors and redundancies, and therefore increases the quality and reliability of information that recipients submit each year.

Another advantage of the Partner's Portal is that recipients can generate reports directly from the system, which allows recipients to fulfill their annual reporting obligations efficiently by submitting necessary information for both progress reports and continuation applications into the system once. This ability to save and update pertinent information from one reporting period to the next, will reduce the administrative burden of the annual reporting on recipients, and the review process on both recipients and CDC staff. Respondents will only need to modify or update the information, report data on measures, provide updates, or add new items as applicable.

These tools improve information quality by minimizing errors and redundancy. Having information consistently collected from all funded jurisdictions in the same manner year-over-year will reduce the level of burden attributable to redundancy and reduce the workload to enter and maintain the data. Additionally, jurisdictions will have data self-populated from one year to another, which minimizes data re-entry, burden, and potential errors. Finally, by providing data collection tools, which all will be using, jurisdictions will experience less burden because each location will not need to figure out how to collect data on their own.

Further, standardization will enhance the consistency of information collected, thereby enabling examination of cross-program strategies. The report generation capabilities of the web-based tools used will reduce the respondent burden associated with paper-based reports. Without the reporting tools and the integrated approach to information collection and reporting, funded jurisdictions and CDC would need to continue to use time consuming, labor-intensive procedures for information collection and reporting.

A.4. Efforts to Identify Duplication and Use of Similar Information

The information collected from grantees is not available from other sources. The information is specific to the Overdose Data to Action (CDC-RFA-CE19-1904, "OD2A") funding opportunity and collection of this information is part of a federal reporting requirement for funds received by grantees. The tools will consolidate information necessary for both continuation applications and

progress reports. The work plans and progress reports provide descriptive summaries of awardees' capacity and activities aimed at mitigating the overdose epidemic, including surveillance (strategies 1 and 2 of the OD2A surveillance component). The epidemiologic data per se are reported to CDC under two separate OMB control numbers.

- Information about overdose-related emergency department admissions (OD2A surveillance component, strategy #1) is reported to CDC under OMB No. 0920-1268 (exp. 8/31/2022), Drug Overdose Surveillance and Epidemiology (DOSE). This information collection allows CDC and participating jurisdictions to rapidly identify outbreaks and provide situational awareness of changes in emergency department (ED) visits involving suspected drug, opioid, heroin and stimulant overdoses at the local, state, and regional level.
- Information about overdose-related mortality (OD2A surveillance component, strategy #2) is reported to CDC under OMB No. 0920-1128 (exp. 10/31/2020), the State Unintentional Drug Overdose Reporting System (SUDORS). This information collection allows CDC and participating jurisdictions to detect state and local community changes in unintentional and undetermined intent drug-related overdose deaths. It also collects information about risk factors for fatal drug overdose deaths that can inform the selection and targeting of interventions.

As one of CDC's primary overdose prevention initiatives, Overdose Data to Action occupies a unique niche within the larger scope of Health and Human Services' (HHS) opioid priority initiative. The Substance Abuse and Mental Health Services Administration (SAMHSA) is also engaged in the opioid overdose space, but their focus is more focused on treatment (i.e., increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid use disorder). As such, SAMHSA-funded efforts are complementary to CDC's OD2A cooperative agreement rather than redundant, and the data/information SAMHSA collects are specific to their funding opportunities.

A.5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this data collection.

A.6. Consequences of Collecting the Information Less Frequently

The evaluation and performance measuring plan, as well as the operation capacity assessment, will be initially due within six months of award. Subsequently, the annual progress report, and the evaluation and performance-measuring plan, and organizational capacity assessment will be due each year 120 days before the end of the budget period and will serve as a non-competing continuation application. The surveillance data dissemination plan will be due one year after the award begins.

Less frequent reporting would undermine accountability efforts at all levels and negatively affect monitoring recipient progress. The annual reporting schedule ensures that CDC responses to inquiries from HHS, the White House, Congress, and other stakeholders are based on timely and up-to-date information.

A.7. Special Circumstances Relating to the Guidelines of five CFR 1320.5

The request fully complies with the regulation 5 CFR 1320.5.

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

A.8.a) Federal Register Notice

A 60-day Federal Register Notice was published in the Federal Register on July 25, 2019, vol. 84, No. 143, pp. 35865 (**Attachment 4**). There were no public comments.

A.8.b) Efforts to Consult Outside the Agency

The data collection instruments were designed collaboratively by CDC staff and selected contractors. Consultation will continue throughout the implementation process. As many components of this ICR are based on existing tools, feedback from partners, both internal and external, may have occurred during their implementation in previous funding opportunities.

A.9. Explanation of Any Payment or Gift to Respondents

Respondents will not receive payments or gifts for providing information.

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

The Office of the Chief Information Officer at the CDC has determined that the Privacy Act does not apply to this information collection request. The Overdose Data to Action reporting system is a component of the Partner's Portal system which has a current Authorization to Operate. The Privacy Impact Assessment (PIA) for the system is attached (Attachment 5a), along with the Privacy Impact Assessment (PIA) for the Overdose Data to Action data templates (Attachment 5b).

Respondents or their designated delegates will provide information about their program efforts funded through the Overdose Data to Action (CDC-RFA-CE19-1904) funding opportunity. No sensitive information or personal contact information will be collected. All data will be reported in aggregate form, with no identifying information included. Because data are maintained in a secure, password-protected system, and information will be reported in aggregate form, there is no impact on respondent privacy. Key program staff will provide information related to programmatic improvement and they will be notified that their responses on the electronic information system will be treated in a secure manner. Staff identifiers will not be used in any progress reports. The information collection does not require consent from individuals. All procedures have been developed, in accordance with federal, state, and local guidelines, to ensure that the rights and privacy of key funded jurisdictions' program staff (e.g. program director) will be protected and maintained.

While consent is not required to report aggregate data, jurisdictional approval will be obtained if jurisdiction-specific data is used for publications, reports, or other publicly disseminated information. Respondents are state, city, county, and U.S. Territory governmental agencies. No system of records will be created under the Privacy Act. Submission and access to funded jurisdiction data will be controlled by a password-protected login site. Access levels vary from read-only to read-write, based on the user's role and needs. CDC staff and contractors will have varying levels of access to the system with role-appropriate security training, based on the requirements of their position(s). Aggregated information will be stored on an internal CDC Access server subject to CDC's information security guidelines.

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

IRB Approval

The CDC National Center for Injury Prevention and Control's OMB and human subject's liaison has determined that this information is non-research and therefore, IRB approval is not needed. The information collection does not involve the collection of personal information or the participation of human subjects in research. (Attachment 6).

Sensitive Questions

The proposed templates do not collect sensitive information.

A.12. Estimates of Annualized Burden Hours and Costs

A.12.a) Annual Burden Hours

Respondents will be the 66 funded jurisdictions of the Overdose Data to Action funding opportunity. Within six months of award, funded jurisdictions will, report 1) evaluation and performance measurement plan (attachment 3a) using a Microsoft Word template and 2) organizational capacity using an online assessment (attachment 3b). One year after funding begins; funded jurisdictions will report their surveillance data dissemination plan (attachment 3d). Annually, funded jurisdictions will report: 1) activity progress and work plan information using a the Partner's Portal (attachment 3c); 2) evaluation and performance measurement plan using the Partner's Portal (attachment 3a); and 3) organizational capacity using a web-based assessment tool (attachment 3b). The estimate burden for each instrument includes time for reviewing instructions, searching sources, data collection, and completion of the templates.

The evaluation and performance measurement plan template (Attachment 3a) has an estimated burden per response of 12 hours for the initial submission and 4 hours for subsequent submissions. The burden is based on feedback from jurisdictions funded by a previous funding opportunity that used a similar template to plan their evaluation and performance measurement opportu*nities (OMB# 0920-1155 - Monitoring and reporting systems for the prescription drug overdose prevention for states coop agreement).* The operational capacity assessment (Attachment 3b) is web-based tool. Based on pilot testing using 9 staff members from the

Association of State and Territorial Health Officials, the estimated burden per response is 1 hour for the initial submission and 1 hour for subsequent submissions.

The annual activity progress report and work plan (Attachment 3c) is web-based tool. The estimated burden per response is 20 hours for the initial submission and 4 hours for subsequent submissions. The burden is based on feedback from jurisdictions funded by a previous funding opportunity that used a similar progress report which was modified for this funding opportunity opportu*nities (OMB# 0920-1155 - Monitoring and reporting systems for the prescription drug overdose prevention for states coop agreement).* The surveillance data dissemination plan (attachment 3d) is a web-based tool. The estimated burden per response is 1 hour for the one-time submission. The burden is based on feedback from jurisdictions funded by a previous funding opportunity that used a similar template which was modified for this funding opportunity.

The total estimated annual burden for all funded jurisdictions is summarized in Table A.

Table A - Estimated Annualized Burden Hours

Type of respondents	Form Name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Overdose Data to Action funded jurisdictions (State, territories, counties and cities) and their Designated Delegates	Evaluation and Performance Measuring Plan Template – Initial Population (Att. 3a)	22	1	12	264
	Evaluation and Performance Measuring Plan Template - Annual reporting (Att. 3a)	66	1	4	264
	Organizational Capacity Assessment - Initial Population (attachment 3b)	22	1	1	22
	Organizational Capacity Assessment - Annual Reporting (attachment 3b)	66	1	1	66
	Activity Progress Report and Work Plan Tool – Initial Population (Att. 3c)	22	1	20	440

	Activity Progress Report and Work Plan Tool – Annual Reporting (Att. 3c)	66	1	4	264
	Surveillance Data Dissemination Plan Tool (attachment 3d)	22	1	1	22
				Total	1,342

A.12.b) Annual Burden Costs

Respondents will be health department program staff or designated delegate, who are program managers or several types of staff. Program manager salaries vary widely based on actual title and institution The salary of an evaluator also varies based on title and institution. The average hourly wage for an evaluator is $33.34. The total estimated cost over three years annualized is $44,742 as summarized in Table B.

Table B. Estimated Annualized Burden Costs –

Type of respondents	Form Name	Total Burden Hours	Average Hourly Wage Rate (in dollars)	Total Costs
Overdose Data to Action funded jurisdictions (State, territories, counties and cities) and their Designated Delegates	Initial Evaluation and Performance Measuring Plan Template	264	$33.34	$8,802
	Annual Evaluation and Performance Measuring Plan Template	264	$33.34	$8,802
	Initial Organizational Capacity Assessment	22	$33.34	$733
	Annual Organizational Capacity Assessment	66	$33.34	$2,200
	Initial Activity Progress Report and Work Plan Tool	440	$33.34	$14,670

	Annual Activity Progress Report and Work Plan Tool	264	$33.34	$8,802
	Surveillance Data Dissemination Plan Template	22	$33.34	$733
			Total:	$ 44,742

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

No capital or maintenance costs are expected. Additionally, there are no start-up, hardware, or software costs.

A.14. Annualized Cost to the Government

The average annualized cost to the federal government is $1,939,659, as summarized in Table C.

Table C Estimated Annualized Cost to the Government

Type of Cost	Description of Services	Annual Cost
CDC Personnel	• 100% GS-12@$71,901/year = $71,901 • 50% GS-13 @ $85,500/year = $42,500 • 25% GS-14 @ $101,035/year = $25,258 Subtotal, CDC Personnel	$139,659
Contractor	Contractor	$1,800,000
	Total Annual Estimated Costs	$1,939,659

A.15. Explanation for Program Changes or Adjustments

This is a new collection.

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

A. Time schedule for the entire project
OMB approval of this ICR is being requested for three years. Annual reporting by the recipients are due 120 days before the end of the budget period. CDC will conduct analysis, visualization, and reporting after data are submitted and finalized each year.

B. Publication plan
Information collected as part of this ICR will not be published, but will be used in internal CDC documents, and may be shared in summary form with funded jurisdictions. With respect to activity progress and work plan reporting, jurisdictions will maintain consistent access to their own submitted information via the described web-based tools.

C. Analysis plan

CDC will not use complex statistical methods for analyzing information. Summary statistics (e.g., counts) will be used to summarize the collected information.

Table D Project Time Schedule

Activity Time Schedule	**Timeline**
Notification of Web-based tool and Template Availability	Immediately upon OMB approval
User Training	Immediately upon OMB approval, then ongoing through the period of performance
Data Collection	Immediately upon OMB approval, then continuing annually
Data Analysis	Immediately upon submission by funded jurisdictions, then continuing annually

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

No exceptions from display of expiration date are requested.

A.18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.