

SUPPORTING STATEMENT: PART A

OMB# 0920-19BOL

**ANNUAL REPORTING OF THE RAPE PREVENTION AND
EDUCATION (RPE) PROGRAM: CE19-1902 COOPERATIVE
AGREEMENT**

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ATTACHMENTS

- Att 1a Public Health Service Act (PHSA) 42 Section 301(a) USC 241a
- Att 1b Public Health Service Act (PHSA) 42 Section 393(a) USC 280b-a
- Att 2 List of RPE-funded Recipients
- Att 3a Annual Reporting for RPE Word Version
- Att 3b Annual Reporting for RPE Screenshots
- Att 4 Crosswalk of RPE Program Evaluation Questions and Indicators
- Att 5 60-Day FRN
- Att 5a Public Comments
- Att 6 Privacy Act Applicability
- Att 7 Human Subject Determination

Summary Table

- **Goal:** The goal of this ICR is to collect information related to implementation and outcomes annually from recipients of the new funding opportunity CDC-RFA-CE19-1902: Rape Prevention and Education (RPE): Using The Best Available Evidence for Sexual Violence Prevention cooperative agreement.
- **Intended use of the resulting data:** Implementation and outcomes information to be collected will provide crucial data for performance monitoring and program evaluation of the implementation of prevention strategies and approaches, outcomes, and budget of the cooperative agreement. Information to be collected will be used to inform technical assistance, program improvement, capacity building, and RPE Program’s impacts on SV outcomes over time.
- **Methods to be used to collect:** RPE Program recipients or designated delegates will submit data annually into the online data system, DVP Partners Portal. Recipients will monitor and report progress on their goals, objectives, and activities, as well as relevant information on the implementation of their prevention strategies, outcomes, evaluation, and state action plan. No research design or human subjects are involved.
- **The subpopulation to be studied:** All 55 (100%) recipients of CE19-1902 cooperative agreement are required to submit information. No statistical sampling will be performed. RPE recipients are health departments in all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the Commonwealth of Northern Mariana Islands.
- **How data will be analyzed:** Descriptive analyses (e.g., frequencies and crosstabs) will be performed on numeric or categorical data, and content analyses (e.g., categorization) on open-ended or text data.

A. JUSTIFICATION

A.1. Circumstances Making the Collection of Information Necessary

The proposed information collection is authorized by the Public Health Services Act (PHS Act) which provides the legislative means for states to advance public health across the lifespan and to reduce health disparities. Section 301(a) of the PHS Act 42 U.S.C. 241(a) authorizes funding grants and cooperative agreements to aid other “other appropriate public authorities, scientific institutions, and scientists in the conduct of, and promote the coordination of, research, investigations, experiments, demonstrations, and studies relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases and impairments of man” (**Attachment 1a**). The Centers for Disease Control and Prevention (CDC) administers the Rape Prevention and Education (RPE) Program, which is authorized under the statutory authorities of the Section 393A Public Health Service Act (PHS) 42 U.S.C. 280b-1a (**Attachment 1b**).

Sexual violence (SV) is a major public health problem: 1 in 3 women and 1 in 4 men experienced sexual violence involving physical contact during their lifetimes. Nearly 1 in 5 women and 1 in 38 men have experienced completed or attempted rape. Sexual violence starts early: 1 in 3 female and 1 in 4 male rape victims experienced it for the first time between 11-17 years old.¹ CDC's Division of Violence Prevention (DVP) provides national leadership in prevention SV perpetration and victimization before it begins, i.e., primary prevention. DVP administers the RPE Program, which provides funding to health departments in all 50 states, the District of Columbia (DC), Puerto Rico, Guam, the U.S. Virgin Islands, and the Commonwealth of Northern Mariana Islands.

In 2016, DVP released a technical package to help communities take advantage of the best available evidence for SV prevention (i.e., STOP SV Technical Package).² DVP put this into practice through the CE19-1902 cooperative agreement. This cooperative agreement builds on previous efforts and cooperative agreements (i.e., CDC-RFA-CE14-1401), but shifts in funding requirements to have comprehensive multilevel primary prevention. The new RPE funding opportunity, CDC-RFA-CE19-1902: Rape Prevention and Education (RPE): Using the Best Available Evidence for Sexual Violence Prevention cooperative agreement, differs greatly from previous funding opportunities provided by CDC through the RPE Program. Specifically, program activities differ from the previous funding cycles, and the program will be collecting information for the first time on recipient outcomes. Recipients of 1902 cooperative agreement are required to

- Develop and implement a state-level action plan to enhance partnerships and prioritize SV prevention (e.g., coordinate with partners)
- Use data-driven decision making for program selection, delivery, and improvement
- Increase alignment between state level goals and local prevention efforts
- Implement prevention strategies that align with focus areas in the DVP STOP SV Technical Package²
- Increase primary prevention at the outer layers (i.e., community and society) of the Social Ecological Model (SEM)
- Implement a minimum percentage of prevention strategies at the community level (Category A recipients is 50%; Category B is 75%), and maximum percentage of prevention strategies at the individual/relationship level (Category A recipients is 50%; Category B is 25%), based on funding category
- Conduct a state-level process and outcome evaluation and track state-level SV indicators aligned with selected outcomes
- Enhance capacity and plan for sustainability of SV prevention

The RPE Program is the principal federally-funded program focused on SV primary prevention. Collecting information about the implementation and outcomes of CE19-1902 cooperative agreement through the online data system, DVP Partners Portal, is crucial to informing SV prevention nationally; enhancing accountability of the use of federal funds; providing timely program reports and responses to information requests, such as Congressional requests mandated by the authorizing legislation; improving real-time communications between CDC and RPE recipients; and strengthening CDC's capacity to provide responsive data-driven technical assistance and to monitor and evaluate recipients' progress and performance.

CDC seeks a three-year approval from OMB for a NEW information collection request (ICR) to collect information related to implementation and outcomes annually from 55 recipients or their designated delegates funded through the new funding opportunity, CE19-1902 (**Attachment 2**). Information

collection will begin immediately upon receipt of OMB approval. As recipients transition to new funding cycles, CDC, will use the change request mechanism to update the list of recipients and to make any needed adjustments to burden estimates.

A.2. Purpose and Use of Information Collection

The purpose of this ICR is to collect information related to implementation and outcomes annually from recipients of CDC-RFA-CE19-1902: Rape Prevention and Education (RPE): Using the Best Available Evidence for Sexual Violence Prevention cooperative agreement. The information collection has been carefully designed to align with and support the goals for CE19-1902 cooperative agreement to answer the following evaluation questions:

1. To what extent has the state built or enhanced partnerships for SV prevention?
2. To what extent has the recipient used data to select and prioritize the sub-recipients, the prevention strategies and approaches and the population of focus?
3. To what extent have selected prevention strategies been implemented in the state?
4. Which factors are critical for implementing selected prevention strategies and approaches?
5. To what extent have targeted risk and protective factors for SV outcomes changed at the state level?
6. To what extent are sub-recipient activities aligned with state level goals and outcomes stated in the state action plan and recipient work plan?
7. To what extent do recipients address health equity?
8. How does recipient capacity change over time?

Information will be collected annually from recipients through the online data system, DVP Partners Portal. The DVP Partners Portal is organized by forms, which are further organized by sections and sub-sections. Recipients and program staff will be able to review information reported in previous years within the DVP Partners Portal per their authenticated access to the Portal. In addition, information from previous reports will be carried over and pre-populated for the next annual reporting as appropriate. Thus, with DVP Partners Portal most of the burden is required during the initial population of information (Year 1), Recipients will only need to enter changes, provide progress information, and add new information after Year 1.

The Annual Reporting for RPE (**Attachment 3a**) in DVP Partners Portal consists of eight forms:

1. Work Plan form collects information on progress towards work plan goals, objectives, and milestones.
2. State Action Plan form collects information on progress towards enhancing partnership, data use, and state SV prevention planning and coordination.
3. Coalition Building form collects information about the recipients' coalition building efforts.
4. Prevention Strategy form collects information about the prevention strategies and approaches, and their implementation measures, including dose delivered, reach, and adaptations.
5. Barriers and Facilitators form collects information about the factors that facilitates or hinders the recipients' efforts.
6. Training and Technical Assistance (TA) form collection information about the recipients' participation in CDC training and TA opportunities and about the recipients' provisions of training and TA.
7. Evaluation form collects information about the recipients' progress on evaluation activities and on indicators measuring the outcomes of their efforts for CE19-1902.

8. Continuation Application Narrative form collects narrative information about the recipients' activities and needs for the new budget period.

A crosswalk of RPE program evaluation questions and indicators is provided in **Attachment 4**. Considered together, the indicators and evaluation questions holistically describe RPE activities, products, and other outcomes relating to the goals of CE19-1902.

The RPE Program is the principal federally-funded program focused on SV primary prevention. Collecting information about the implementation and outcomes of CE19-1902 cooperative agreement through DVP Partners Portal is crucial for CDC to analyze and synthesize information across RPE recipients for performance monitoring and program evaluation of the implementation of prevention strategies and approaches, outcomes, and budget of the cooperative agreement. CDC will use the information to be collected to do the following:

- Enhance accountability of the use of federal funds
- Provide timely program reports and responses to information request
- Improve real-time communications between CDC and recipients
- Strengthen CDC's capacity to provide responsive and data-driven TA
- Strengthen CDC's capacity to monitor and evaluate recipients' progress and performance towards activities required as part of the cooperative agreement
- Allow both CDC and recipients to track their own state activities and outcomes, and ensure alignment between their state and local activities
- Generate a variety of routine and customizable reports specifically for each recipients and in aggregate nationally for CDC stakeholders

CDC will also be able to inform SV prevention nationally and RPE Program's impact on SV outcomes over time. RPE recipients can use the reports generated to manage and coordinate their activities, and to improve their efforts. Both CDC and RPE recipients will be able to use the information collected to

- Assess the increased emphasis on strategies that affect health outcomes and impact, especially at the community level
- Identify facilitators and barriers to program implementation and the achievement of outcomes
- Assess factors and partnerships critical to successful primary prevention of SV
- Identify trends and assess the impact of the program on outcomes across all recipients
- Identify, translate, and disseminate information about the successes of the RPE recipients and their implementation of prevention strategies and approaches.

Using the information to be collected can help CDC and the RPE recipients reduce duplication of effort, enhance program impact, maximize use of federal funds, and improve future efforts. These functions are central to the NCIPC's broad mission of protecting Americans from violence and injury threats.

An Annual Federal Financial Report is also required to be submitted to OFR separately by grantees. This report is not required, developed, or reviewed by CDC-NCIPC program staff as part of any evaluation and performance monitoring. It is handled by OFR as part of its grants financial management responsibilities. As such, it is not included as part of this request.

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

The data entry interface of the DVP Partners Portal was developed using DVP-owned, Microsoft Azure, and Platform as a Service (PaaS) cloud solution approved for use by CDC programs. The use of DVP Partners Portal facilitates 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 DVP Partners 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.

One advantage of the DVP Partners 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. Recipients will be able to generate a PDF report that can be uploaded to Grant Solutions to satisfy funding annual reporting and non-competing continuation application requirements.

Moreover, 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.

This information and data collection system assures compliance with the Government Paperwork Elimination Act (GPEA), Public Law 105-277, title XVII, 1998, lowers the burden to the respondents, as compared to paper-based systems, allows respondents to submit information to CDC electronically, and provides capabilities for CDC to maintain records electronically.

Finally, the capabilities of the data system to generate reports will reduce the burden associated with paper-based reports. Without the reporting system and the integrated approach to information collection and reporting, both recipients and CDC would need to continue to use time consuming, labor-intensive information collection and reporting procedures.

DVP Partners Portal will enable collection and reporting of the information in an efficient, standardized, and user-friendly manner that will be used to generate a variety of routine and customizable reports. CDC will also have the capacity to generate timely national program reports that describe the RPE Program activities and their outcomes for recipients and for response to inquiries from HHS, the White House, Congress and other stakeholders.

An additional advantage of using the DVP Partners Portal is that recipients that received funding from multiple DVP programs can access and report information in one place using forms in a standard format.

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

Since CDC is the only federal agency providing funding for state and territorial health departments to conduct SV primary prevention, the information to be collected from RPE recipients is not available from other sources. This information is specific to the RPE Program and for the funds received by recipients through the cooperative agreement. The DVP Partners Portal facilitates the consolidation of information required for multiple purposes (e.g., annual progress reporting, continuation application, and monitoring and evaluation reporting) to be entered only once. Information collected will be used to generate multiple types of reports without having to duplicate efforts.

As CDC's primary SV prevention initiative, RPE occupies a unique niche within the larger scope of HHS violence prevention initiatives. The U.S. Department of Justice, Office of Violence against Women (OVW) makes funding available to territorial domestic and SV coalitions to focus on victim service provision for individuals. The funding for the CDC RPE Program cooperative agreement, however, may only be used for SV prevention and cannot be used to fund victim services; therefore, information collected from RPE recipients will not duplicate information collected from OVW recipients.

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

Information will be collected annually. The cooperative agreement requires the annual progress report, which is due 120 days before the end of the budget period and serves as a non-competing continuation application. 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, such as Congressional requests mandated by the authorizing legislation, are based on timely and up-to-date information.

A.7. Special Circumstances Relating to the Guidelines of 5 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 June 5, 2019 Volume 84, Number 108, pp 26116 (**Attachment 5**). CDC Received one anonymous non-substantive comment (Attachment 5a). Follow up information was not provided, so there was no reply from CDC to the non-substantive comment.

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

CDC staff and contractor designed the information collection instruments and DVP Partners Portal. Data elements were informed by annual progress reports of previous and other existing DVP programs. The following individuals were consulted in the development of the data elements in 2018 – 2019. The consultations resulted in streamlining of questions and additions of close-ended questions for improved reporting.

DELTA Impact Program
Lindsey Barranco, PhD, Behavioral Scientist,
404.498.5221, yzl9@cdc.gov

Essentials for Childhood Program
Phyllis Ottley, PhD, Behavioral Scientist,
404.498.1613, vcj8@cdc.gov,

DVP Program Evaluation and Translation Team
Kimberley Freire, PhD, MPH, Lead Behavioral Scientist,
770.488.4994, hbz8@cdc.gov

Rape Prevention and Education Program
Kristy Orisma, PhD, Public Health Advisor
770.488.0043, lgi9@cdc.gov

Kathryn Jones, MSW, Public Health Advisor
770.488.1118, yde9@cdc.gov

CDC worked with a contractor who have experiences in designing similar information collection instruments and systems. Not consultations occurred outside of CDC.

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

Respondents will not receive payments or gifts for providing information.

A.10. Assurance of Confidentiality Provided to Respondents

The CDC Office of the Chief Information Officer has determined that the Privacy Act does not apply to this information collection request. The Rape Prevention and Education (RPE) program is housed within the Partner's Portal web-based system. The Partner's Portal system has a current Authorization to Operate. The Privacy Impact Assessment (PIA) is attached (**Attachment 6**).

RPE recipients (health department) or their designated delegates will provide information about their program efforts funded through the CE19-1902 cooperative agreement. No sensitive information or personal identifying information will be collected. Only names of the organizations for whom the RPE recipients partner with or provide sub-awards will be collected. 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 recipients' program staff (e.g. program director) will be protected and maintained.

Submission and access to data will be controlled by password-protected login to the secure site. To access the DVP Partners Portal, staff must have been authenticated and have a Secure Access Management Services (SAMS) login and password. Access is limited to staff members of the organization who are authorized to enter data on behalf of their organization. Since the access to the DVP Partners Portal is external and through SAMS, Active Directory is not used for authentication; therefore, no User IDs or passwords are maintained or used by the DVP Partners Portal.

Information will be reported only in aggregate form. No identifying information included. The recipients' state or territory names will not be included in the national aggregate report. CDC will

produce reports for each recipient and those reports will contain data only for that particular recipient. Aggregated information will be stored on an internal CDC server subject to CDC's information security guidelines. While consent is not required to report aggregate data, recipient approval will be obtained if specific data are used for publications, reports, or other publicly disseminated information.

Access to the data varies from read-only to read-write, based on the user's role and permissions. Each funded recipient will have access to viewing their own information in pre-determined reports, which they can share with designated program staff and sub-recipients. The recipients determine the extent to which sub-recipients may access their state/territory's information. CDC staff will also have varying levels of access to the system with role-appropriate security training based on the requirements of their position, roles, and responsibilities.

The information collected will be stored and archived permanently for future program analysis and reporting. Data storage is encrypted to standard requirements.

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

IRB Approval

The CDC National Center for Injury Prevention and Control (NCIPC)'s OMB and human subject research officer has determined that this collection is non-research and therefore, IRB approval is not needed (**Attachment 7**). The information does not involve the collection of personal information or participation of Human Subjects.

Sensitive Questions

The proposed information collection does not collect sensitive information.

A.12. Estimates of Annualized Burden Hours and Costs

A.12.a) Annual Burden Hours

Respondents will be the 55 RPE recipients (health departments in all 50 states, DC, and U.S. territories) and their designated delegates. Respondents will report information to CDC annually using the DVP Partners Portal. For most of the questions in the data collection (**Attachment 3a**), respondents will only need to enter descriptive information once, and do not need to re-enter them for subsequent annual reporting. Respondents will only need to modify or update the information, report progress on measures, provide updates, or add new items as applicable.

The burden estimates for each information collection tool vary for initial population and subsequent annual reporting. The time commitments for data collection, entry, and training will be greatest during the initial population. The burden for subsequent data entries is for entering changes, providing progress information, and adding new activities. They would not have to re-enter information as the basic information from the previous year will be carried over and pre-populated for the next annual reporting.

For each respondent, the burden per response is estimated to be 12 hours for initial population, and 6 hours for each subsequent data entry. The DVP Partners Portal has also been previously tested and used for annual reporting for other programs. The burden estimates were obtained from these efforts.

With an estimation of 12 hours for initial population, the total burden for the first year of initial population will be 660 hours. The burden estimate for initial population is divided by three to obtain

annualized estimates for each year in the information collection request period. Therefore, over the three-year period, 4 hours of annualized burden are estimated for the initial population for each respondent, totaling 220 annualized burden hours.

With two years of subsequent data entry where 6 hours estimation for each subsequent data entry for each respondent, the total burden of subsequent reporting for the three-year period is 660 hours (330 hours for each of the two subsequent reporting). The burden estimate for initial population is divided by three to obtain annualized estimates for each year in the information collection request period. Therefore, over the three-year period, 2 hours of annualized burden are estimated for each subsequent reporting for each respondent, totaling 220 annualized burden hours for two subsequent reporting.

Over the three-year period of this ICR, the total burden will be 1,320 hours for 55 respondents for all entries. The annualized estimated burden for this ICR is 440 hours, as summarized in Table A.12-A.

Table A.12-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)
RPE-funded Health Departments (State, DC, and Territories) and their Designated Delegates	Annual Reporting— Initial Population (Att. 3a)	55	1	4	220
	Annual Reporting— Subsequent Reporting (Att. 3b)	55	2	2	220
	Total				440

A.12.b) Annual Burden Costs

For each of the 55 RPE Program recipients, respondents will be health department program staff or designated delegate, who are all program managers. The average hourly wage for a social and community program manager is \$34.46 according to the 2018 National Occupational Employment and Wage Estimates from the U.S. Bureau of Labor Statistics. The hourly wage rates for program managers are based on wages for similar mid-to-high level positions in the public sector. The total estimated cost over the three-year period of this ICR is \$45,487.20 with an annualized burden cost of \$15,162.40, as summarized in Table A.12-B.

Table A.12-B. Estimated Annualized Burden Costs

Type of Respondents	Form Name	Total Burden (in hours)	Hourly Wage Rate	Total Respondent Cost
RPE-funded Health Departments (State, DC, and Territories) and their Designated Delegates	Annual Reporting— Initial Population	220	\$34.46	\$7,581.20
	Annual Reporting— Subsequent Reporting	220	\$34.46	\$7,581.20
Total				\$15,162.40

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

This data collection will not result in costs for respondents or record keepers. No capital, maintenance, start-up, hardware, or software costs are expected for respondents or record keepers.

A.14. Annualized Cost to the Government

The average annualized cost to the federal government is \$167,006, as summarized in Table A.14.

Major cost factors for the electronic information collection system include design and development costs as well as data analysis and reporting costs.

Table A.14. Estimated Annualized Cost to the Government

Type of Cost	Description of Services	Annual Cost
CDC Personnel	20% of GS-13 Behavioral/Health Scientist at \$91,631/year for data collection design, collection, analysis, and reporting	\$18,362
	20% of GS-13 Health Informatician at \$91,631 for data system design, development, and maintenance	\$18,362
	10% of GS-14 Behavioral Scientist at \$108,281 for contract management and business product ownership	\$10,282
Contractor	Data System Development	\$100,000
	Data System Maintenance	\$10,000
	Data Reporting and Dashboard	\$10,000
Total		\$167,006

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

The RPE CE19-1902 cooperative agreement project period is five years: February 1, 2019 – January 31, 2024. 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

National reports that describe information across all recipients will be provided to CDC leadership, RPE stakeholders, and RPE recipients. Reports will be generated to respond to inquiries from HHS, the White House, Congress and other stakeholders, and these may include aggregate findings segmented or filtered by certain characteristics or information. CDC will also generate reports specific to each recipients and provide a summary report to that recipients to facilitate their use of data for program planning and improvement.

CDC will report findings to external audiences, as needed, to describe the state of SV violence prevention across the nation; these include scientific and program conferences and meetings. Moreover, findings and program information will be published in a peer-reviewed scientific journal to share lessons learned and findings about the RPE Program’s impact on SV prevention in the U.S.

B. Analysis plan

CDC will not use complex statistical methods for analyzing information. Most statistical analyses will be multilevel descriptive (e.g., frequencies and crosstabs of numeric or categorical data) and content (e.g., categorization of open-ended or text data). Information will be synthesized for specific reporting purposes and responses to inquiries. These reports may include aggregate national reports, or filtered by certain characteristics or information.

Table A.16-C Project Time Schedule

Activities	Timeline
User Training	Immediately upon OMB approval and ongoing
Data Collection Materials Distributed	Immediately upon OMB approval for the first year; once annually
Data Submission	Once Annually, 120 days before the end of the budget period
Technical Review and Quality Assurance	Within 1 month of report submission
Finalized Submission	Within 1 month of new budget period
Data Analysis	1–3 months after Finalized Submission
Data Reports	3–6 months after Finalized Submission

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

No exemptions to certification are sought.

References

1. Smith SG, Zhang X, Basile KC, Merrick MT, Wang J, Kresnow M, Chen J. (2018). The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 Data Brief— Updated Release. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
2. Basile, K.C., DeGue, S., Jones, K., Freire, K., Dills, J., Smith, S.G., Raiford, J.L. (2016). STOP SV: A Technical Package to Prevent Sexual Violence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.