

Supporting Statement A

Bureau of Health Workforce Substance Use Disorder Evaluation

OMB Control No. 0906-XXXX-New

Terms of Clearance: None.

A. Justification

1. Circumstances Making the Collection of Information Necessary

The Health Resources and Services Administration (HRSA) is requesting OMB approval for a new information collection request to evaluate HRSA's Bureau of Health Workforce (BHW) substance use disorder (SUD) investments. In September 2018, the U.S. Department of Health and Human Services' HRSA awarded over \$396 million to combat the opioid crisis. The investments support the national expansion of access to integrated SUD and mental health services for HRSA-funded community health centers, academic institutions, and rural organizations. HRSA's BHW is focusing much of its efforts on increasing the supply of providers and capacity among providers (and thus, the capacity within health systems) to provide new, and enhance existing, prevention and evidence-based treatment in rural and underserved areas.

HRSA will achieve its workforce strategy goals primarily through three objectives:

1. Increasing the number of clinicians delivering medication-assisted treatment (MAT) and SUD services
2. Enhancing the addiction education and clinical training of current and future health care professionals and paraprofessionals in rural and underserved communities
3. Integrating behavioral and mental health into primary care to improve the capacity of the health care delivery system to provide SUD prevention and treatment services

To address the first objective, increasing the number of clinicians delivering MAT and SUD services, HRSA's BHW has employed strategies to increase and retain MAT-trained and certified clinicians in the National Health Service Corps (NHSC). As part of this national expansion, the NHSC Loan Repayment Program (LRP) has expanded to include a NHSC Substance Use Disorder (SUD) LRP, and Rural Community (RC) LRP. The expansion aims to increase licensed and/or certified NHSC clinicians offering MAT and other SUD services to serve in facilities located in rural and underserved communities for a three-year service obligation.

To address objectives #2 and #3, BHW will target training to enhance the addiction education and clinical training of current and future health care professionals and paraprofessionals in rural and underserved communities. In addressing objective #3, HRSA will integrate behavioral and mental health treatments into primary care services to improve the capacity of the health care delivery system to provide SUD treatment services by training providers to deliver mental health and substance abuse services as part of an integrated team. The BHW will provide grants through the following programs to meet these objectives:

- Providing grants to the Behavioral Health Workforce Education and Training (BHWET) Program to increase the number of professionals and paraprofessionals trained to deliver behavioral health and primary care services as part of an integrated team in health centers located in underserved communities
- Creating grants to establish Opioid Workforce Expansion Programs (OWEP) to increase the number of mental and behavioral health professionals and paraprofessionals (including community health workers) prepared to deliver integrated mental health and substance abuse prevention, intervention, and treatment as part of a primary care team in community-based networks
- Establishing specialized training in the provision of opioid use disorder (OUD) prevention and treatment services within the Graduate Psychology Education (GPE) grant program to build the capacity of the health psychology workforce trained in the prevention and clinical treatment of patients with OUD in high-need and high-demand areas

The ultimate goal of the BHW SUD expansion programs is to increase access to well-trained providers, particularly for people who are geographically isolated and economically or medically vulnerable. This will be achieved by increasing the number of faculty and providers trained in integrated and interdisciplinary behavioral health and substance use prevention and treatment services in community health centers, academic institutions, and rural organizations.

This evaluation will assess the four BHW SUD expansion programs - (1) NHSC LRP, (2) OWEP, (3) BHWET, and (4) GPE - with respect to their stated goals of increasing the number of clinicians delivering MAT and other SUD services (NHSC program) and enhancing education and training for substance use prevention and treatment for health care professionals and paraprofessionals in rural and underserved communities (grant programs).

The evaluation will be used by HRSA to assess expansion efforts to strengthen the workforce with the goal of increasing access to treatment for SUDs, with an emphasis on opioids; gain awareness of the types of health care providers that participated in the program and how clinical services were enhanced or expanded at participating sites as a result of the expansion; better understand the unique features of the programs and how they affect the distribution of SUD providers across the nation; and obtain actionable information for future program incentives and investment strategies.

2. Purpose and Use of Information Collection

The purpose of the planned primary data collection activities is to capture key program process and outcome measures that are not otherwise available from administrative sources, which allow HRSA to evaluate the impact of the four BHW SUD expansion programs. The information collected enables BHW to address evaluation questions including, but not limited to, the following:

- What is the impact of the NHSC SUD Workforce LRP and the NHSC Rural Communities LRP on the provision of SUD services, including OUD, in underserved areas compared to those who participate in the non-SUD NHSC LRP?
- What factors shape recruitment and retention of NHSC participants, including individual characteristics and their care delivery experiences at NHSC LRP sites?
- What are the challenges, from the NSHC clinician and site perspective, to providing SUD, including OUD, services at sites?
- To what extent have the OWEF, BHWET, and GPE programs, each and collectively, improved the education and clinical training of current and future health care professionals and paraprofessionals in rural and underserved communities to deliver integrated mental health and substance abuse prevention, intervention, and treatment as part of a primary care team?
- What are the implementation experiences (e.g., curricula development, student recruitment, collaboration with sites, sustainability plans) of each program?
- What are the characteristics of high-achieving grant programs?
- How are the activities in the BHWET, GPE, and OWEF programs contributing to the expansion of service delivery for SUD prevention and treatment, at the individual, educational, and service-delivery system level?
- To what extent are the BHW's programs successful at increasing access to treatment for SUD, including opioid treatment services?
- What actionable information, based on the challenges, solutions, and recommendations of grantees, can be used to guide future program incentives and investment strategies?

The evaluation will collect relevant data through web-based surveys to trainees, grantee organizations, and training sites participating in BHW's opioid expansion programs. In total, six survey instruments will be used in this evaluation: [1] NHSC SUD Workforce Loan Repayment Program/NHSC Rural Community Loan Repayment Program/NHSC Loan Repayment Program- Participant Survey (NHSC LRP Participant Survey), [2] NHSC Loan Repayment Program- Site Survey (NHSC LRP Site Survey), [3] Grantee Training and Educational Programs- Trainee Survey (Grantee Trainee Survey), [4] Grantee Training and Educational Programs- Alumni Survey (Grantee Alumni Survey), [5] Grantee Training and Educational Programs- Site Survey (Grantee Site Survey), and [6] Grantee Training and Educational Programs- Grantee Organization Survey (Grantee Organization Survey). These surveys will be critical to understanding the factors related to the success of current BHW programs, and will assist in SUD prevention and treatment workforce policy development. To reduce the burden on respondents, the surveys have been designed to complement and not duplicate other primary and secondary data, as described further under Section 4 below.

At the trainee/participant level, questions will focus on educational and professional background, motivation and incentives to join or leave the program, training experiences, perceived readiness to deliver SUD treatment services (where applicable), capacity to engage in prevention strategies, and post-graduation employment (where applicable). At the grantee organization level (note: this level is not relevant to the NHSC LRP), questions will focus on recruitment and retention of students, how their training program curriculum was developed, collaboration with training sites, and plans for sustainability, as well as any other benefits that resulted from the program. At the site level, questions will address motivation for the site to participate, whether and what type of integrated care delivery is available, and other organizational factors of the site. At all three levels, and for all programs, we will collect survey data on satisfaction with the program and recommendations for improving it. The data collected will be used by HRSA to assess program progress and inform leaders regarding the status of

the BHW SUD expansion program investment. In addition, the data will provide actionable information for future HRSA investment strategies.

3. Use of Improved Information Technology and Burden Reduction

The data collection plan for this project has been designed to minimize respondent burden by utilizing web-based technology. The surveys will be programmed in Qualtrics, a FedRAMP-certified survey platform.

The web-based Qualtrics survey platform will minimize burden by minimizing the length of the survey using skip patterns, using previous responses to pre-populate later questions, and pre-populating fields when feasible. We will also conduct extensive quality control testing to ensure the skip patterns and logic allow for maximum efficiency. Survey respondents may stop the survey if necessary and return to it, rather than start over, allowing them to divide the time needed to complete the survey into increments of their choosing.

4. Efforts to Identify Duplication and Use of Similar Information

In order to minimize respondent burden while ensuring we meet the objectives noted above, this study will use administrative data that are already being collected by HRSA and other public sources. For the NHSC LRP arm of this evaluation, the study will use data from participants' applications, as well as NHSC LRP site applications, data tables, and site visit data from the BHW Management Information System and Customer Service Portal. We will also use publicly available data from the HRSA Data Explorer on site characteristics, as well as data from the Unified Data System. For the grant program arm of this evaluation, we will review publicly available data sources collected by HRSA as part of routine grant administration, which includes grantee organization applications, progress reports, and performance data.

We reviewed the secondary sources described above to determine what additional data required for the evaluation would be necessary to obtain through a data collection instrument, and to ensure they are not duplicative of information that is already collected. In addition, HRSA staff involved with the administration of the NHSC LRP and grant programs reviewed these surveys to identify whether any of the survey questions are duplicative of data already collected or to identify questions that would be difficult for respondents to answer. Items that were duplicative or difficult have been removed.

In addition to secondary data available through HRSA, we will also use publicly available data, such as the American Community Survey and Area Health Resources File, to understand the community characteristics of the sites.

5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this study.

6. Consequences of Collecting the Information Less Frequently

Given the importance of these four programs in addressing the public health crisis of OUD, it is critical to evaluate their effectiveness in expanding access to SUD, including MAT, to determine what works well, and what future programs may enhance services. The planned schedule for data collection will help HRSA understand program progress and will allow for "course correcting" as needed. All information

collected will be used to understand the impacts of the funding during each year of the expansion, provide feedback on implementation challenges and achievements, and inform the strategic direction of the programs. If HRSA collects less information, or collects it less frequently, the BHW will be unable to determine the performance of each type of possible configuration of site and personnel mix, and use of funding. Without the information, HRSA will be unable to assess or substantiate how site, grantee organization, and trainee characteristics influenced outcomes, as there are no other available data to support an understanding of the experience and comprehensive impact of BHW OUD funding.

All surveys will be fielded annually for three years beginning in 2020 and concluding in 2022, with two exceptions. The first exception is the Grantee Alumni Survey, which will be fielded once in 2021 and 2022. Respondents to this survey will be trainees who received FY2019 or FY2020 BHWET, OWEPE, or GPE funding, but had not completed their training at the time they responded to the survey, and who did not receive any funding in the next fiscal year. Thus, the Grantee Alumni Survey will capture trainee employment status and other outcomes regarding the programs' completion for those who completed their training after they responded to the survey.

Second, the Grantee Organization Survey will be fielded once in 2020 and again in 2022. This will allow us to capture information on grantee organization progress, challenges, and benefits to the community after the initial launch of their programs, and then two years after implementation. In between the surveys, we will continue to analyze administrative data regarding the status of grantee organization progress.

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

The request fully complies with the regulation.

8. Comments in Response to the Federal Register Notice/Outside Consultation

Section 8A:

A 60-day Federal Register Notice was published in the *Federal Register* on January 24, 2020, vol. 85, no. 16; pp. 4327-4329 (see Attachment A). There were no public comments.

Section 8B:

During questionnaire development, input on item content and wording was sought from two subject matter experts. No major problems that could not be resolved during consultation were encountered.

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Year in which consultation took place: 2020

Name: Holly Andrilla, PhD

Title: Biostatistician and Research Scientist, University of Washington Rural Health Research Center

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Year in which consultation took place: 2020

9. Explanation of any Payment/Gift to Respondents

Respondents will not receive any payments or gifts.

10. Assurance of Confidentiality Provided to Respondents

Data will be kept private to the extent allowed by law. Individuals and organizations will be assured of the confidentiality of their replies under Section 934(c) of the Public Health Service Act, 42 USC 299c-3(c). They will be told the purposes for which the information is collected and that, in accordance with this statute, any identifiable information about them will not be used or disclosed for any other purpose. All data will be aggregated for reporting purposes.

11. Justification for Sensitive Questions

There are no questions of a sensitive nature included in this information collection.

12. Estimates of Annualized Hour and Cost Burden

Estimates of annualized hour burden and annualized cost to respondents are shown in Tables 1 and 2, respectively. The total number of estimated respondents is 41,300. The total number of burden hours is 13,289. The estimated total respondent cost is \$359,659.71.

The surveys require one response (i.e., one single questionnaire) per respondent. The burden will be lower in 2020 than in 2021 and 2022, as there will not be a Grantee Alumni Survey, and the burden will be lower in 2021, as there will not be a Grantee Organization Survey.

Table 1: Estimated Annualized Burden Hours

Form Name	No. of Respondents	Total Responses	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
NHSC LRP Participant Survey	8,000	1	8,000	0.33	2,640
NHSC LRP Site Survey	18,000	1	18,000	0.33	5,940
Grantee Trainee Survey	8,000	1	8,000	0.33	2,640
Grantee Alumni Survey	2,000	1	2,000	0.16	320
Grantee Site Survey	5,000	1	5,000	0.33	1,650
Grantee Organization Survey	300	1	300	0.33	99

Total	41,300		41,300		13,289
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Estimates of the annual respondent costs for the NHSC LRP participant arm of the data collection were based on the distribution of the disciplines of the NHSC FY2019 LRP awardees, and their respective wage rates, according to the U.S. Department of Labor Bureau of Labor Statistics (BLS).¹ We used NHSC LRP application data to determine the number of respondents with each type of discipline.

For the Grantee Trainee Survey and the Grantee Alumni Survey, we estimated the number of each type of respondent based on the distribution of projected graduates.² Then, for the Grantee Trainee Survey, we used the maximum amount of stipend allowed in each grant program to calculate the wage rate. For example, the OWEP grant allows \$10,000 of grant funds to be given as a stipend to a master's-level student. The Hourly Wage Rate column in Table 2 for this type of respondent was calculated as \$10,000 divided by 2,088 hours of work in a year.³ Stipends are not allowed for paraprofessionals, and for these trainees, we used BLS wage data on Healthcare Support Occupations. For the Grantee Alumni Survey, we also used BLS data on wage rates for each type of discipline.

For all estimates that used BLS wage rates (NHSC site and clinician, grantee organization, sites and alumni), we multiplied wage rates by a factor of two to account for fringe benefits and overhead, per guidance issued by the Assistant Secretary of Planning and Evaluation.⁴

Table 2: Estimated Annualized Burden Costs

Form Name	Type of Respondent	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
NHSC LRP Participant Survey	Allopathic Physician	205	\$196.04	\$40,188.20
NHSC LRP Participant Survey	Certified Nurse Midwife	30.8	\$102.80	\$3,166.24
NHSC LRP Participant Survey	Dentist	159	\$169.08	\$26,883.72
NHSC LRP Participant Survey	Health Service Psychologist ⁵	77.9	\$82.06	\$6,392.47
NHSC LRP Participant Survey	Licensed Clinical Social Worker	373.2	\$56.22	\$20,981.30
NHSC LRP Participant Survey	Licensed Professional Counselor	336.6	\$47.38	\$15,948.11
NHSC LRP Participant Survey	Marriage and Family Therapist	47.5	\$52.06	\$2,472.85
NHSC LRP Participant Survey	Nurse Practitioner	777.5	\$105.80	\$82,259.50
NHSC LRP Participant Survey	Osteopathic Physician	78.8	\$196.04	\$15,447.95
NHSC LRP Participant Survey	Physician Assistant	172.5	\$104.26	\$17,984.85
NHSC LRP Participant Survey	Psychiatric Nurse Specialist	8	\$72.60	\$580.80
NHSC LRP Participant Survey	Registered Dental Hygienist	85.8	\$72.60	\$6,229.08

1 Please see https://www.bls.gov/oes/current/oes_nat.htm

2 Please see <https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/5-year-estimates-new-graduates-2018.pdf>

3 Based on the U.S. Office of Personnel Management estimate of 261 work days in a year multiplied by 8 hours a day.

4 Guidelines for Regulatory Impact Analysis. U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation. 2016.

5 Health service psychologists' wage rates reflect the BLS category of clinical, counseling, and school psychologists.

NHSC LRP Participant Survey	Substance Use Disorder Professional	212.7	\$46.08	\$9,801.22
NHSC LRP Site Survey	Nonsupervisory Health Services Employee	6000.0	\$49.66	\$297,960.00
Grantee Site Survey	Nonsupervisory Health Services Employee	1,666.0	\$49.66	\$82,733.56
Grantee Trainee Survey	Post-Doctoral Fellow	312	\$22.91	\$7,147.92
Grantee Trainee Survey	Psychiatric Nursing/Doctoral-Level Intern	1011.1	\$13.58	\$13,730.74
Grantee Trainee Survey	Master's-Level Student	1011.1	\$4.79	\$4,843.17
Grantee Trainee Survey	Paraprofessionals ⁶	303.6	\$14.71	\$4,465.96
Grantee Alumni Survey	Psychiatrist	12.3	\$211.90	\$2,606.37
Grantee Alumni Survey	Addiction Counselor	15.8	\$46.08	\$728.06
Grantee Alumni Survey	Marriage and Family Therapist	17.8	\$52.06	\$926.67
Grantee Alumni Survey	Mental Health Counselor	29.9	\$46.08	\$1,377.79
Grantee Alumni Survey	Psychiatric Nurse Practitioner	4.0	\$105.80	\$423.20
Grantee Alumni Survey	Psychiatric Physician Assistant	0.6	\$104.26	\$62.56
Grantee Alumni Survey	Psychologist	21.0	\$83.26	\$1,748.46
Grantee Alumni Survey	School Counselor	64.3	\$57.86	\$3,720.40
Grantee Alumni Survey	Social Worker	154.4	\$56.22	\$8,680.37
Grantee Organization Survey	Post-Secondary PhD-Level Faculty	50.0	\$117.16	\$5,858.00
Grantee Organization Survey	Office Supervisor/Administrator	50.0	\$57.06	\$2,853.00
	Total	13,289.20		\$688,202.51

13. Estimates of Other Total Annual Cost Burden to Respondents or Recordkeepers/Capital Costs

There are no direct costs to respondents other than their time to participate in the study.

14. Annualized Cost to Federal Government

Additionally, the cost to the government consists mainly of the salaries of the HRSA staff who (1) determine the content of the data collection instruments, (2) oversee the scope of work conducted under the aforementioned contract, and (3) assist in the analysis of the results and recommend changes in questionnaire wording. Thus, it is estimated that needed staff time for the contracting representative to cover the above mentioned items is .5 FTE at the GS-13 level for a total of \$51,000. Collectively the estimated annualized cost to the government in staff time is estimated to be \$51,000.

15. Explanation for Program Changes or Adjustments

This is a new information collection.

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

Plans for Tabulation: The analysis of the primary and secondary data will involve producing univariate

⁶ Paraprofessional grants support a wide range of programs, including certificate, associate, and undergraduate courses that train peer-support specialists, peer recovery advocates, and community health workers.

(descriptive) (e.g., means, medians, frequency distributions, and cross-tabulations) and bivariate statistics (t-tests and chi-square tests), and analysis of variance (ANOVA) to describe and compare among sites, grant programs, and NHSC LRP clinicians and individuals. Specifically, we will use survey results and prescription claims data to test the hypothesis that NHSC clinicians in the NHSC SUD and Rural Community programs will provide more SUD and OUD, including MAT services, compared to clinicians in the standard LRP. The SUD and Rural Community programs prioritized applicants with SUD treatment certification, and have minimum service requirements for SUD treatment.

All of the closed-ended responses from the survey and administrative data will be reported in tabular format to facilitate an understanding of results and comparisons across subgroups (e.g., types of clinicians, sites, grant programs). In addition to the survey data, we will produce tables from secondary data sources. For the grant program, we will also analyze grant program documents (e.g., applications and progress reports) to describe and characterize grantee implementation experience, including grantee activities, challenges, and drivers of success. We will categorize these factors and produce summary tables for each program. For NHSC LRP, we will produce tables from site visit data to help contextualize quantitative findings and to elucidate the organizational factors that may contribute to NHSC LRP participant experience.

Using both primary and secondary data, we will construct multivariable regression models for outcomes, such as the intention of individuals to remain working in underserved areas. We will convert coefficients to probabilities of the outcome to facilitate interpretation of results (e.g., the probability of remaining in the community for clinicians in each LRP). We will also conduct cluster and/or latent-class analyses to examine which factors contribute to high, average, and low levels of performance of grantees, using outcomes such as levels of trainee preparedness and satisfaction, and high, average, and low levels of NHSC LRP participants' intention to continue working in underserved areas upon completion. This analysis will help inform the design and implementation of the programs.

Where feasible, we will link survey and administrative data across grantees, trainees/participants, and sites to comprehensively assess program implementation. We will examine correlations between site and individual outcomes, such as how site characteristics are associated with satisfaction and tenure at sites in underserved areas.

Specific planned comparisons include:

- Outcomes (e.g., patients provided with SUD services, including OUD services) across sites that host NHSC LRP participants in the standard loan repayment program compared to NHSC LRP sites that host NHSC SUD and RC participants
- Technical assistance and recruitment needs, across sites that host NHSC LRP participants in the standard loan repayment program, compared to NHSC LRP sites that host NHSC LRP SUD and RC participants
- Characteristics of NHSC LRP sites with high, average, and low NHSC LRP participant intention to continue working at the site beyond service obligation
- Characteristics of grantees and training sites within and across grant programs
- Characteristics of grantees with high, average, and low trainee preparedness and satisfaction
- The characteristics of sites, grantees, and individuals that respond to the survey to those that do not respond to the survey

Beginning with the second year and going forward, we will use public data to understand the socio-demographic characteristics, and SUD treatment and prevalence rates of communities with NHSC LRP

participants and grant program training sites. We will link these data to survey and administrative data by ZIP code or county geographic identifiers to create visual maps to show the geographic distribution of NHSC LRP participants and grant program sites. These maps will also capture the variation in communities in which the NHSC LRP participants and trainees serve. We will also obtain commercial data on prescribing to examine the extent to which NHSC participants are providing medication-assisted treatment.

Reports: We will develop three interim reports and one final report based upon the requirements in the contract and in agreement with our contracting officer's representative (COR). Reports will include an overview of the program, study design, findings, discussion of the results, recommendations, and implications of the results. Results will reflect available survey, interview, and administrative data; survey data will be included in reports in 2021 to 2023. Draft reports are to be completed by July of 2020, 2021, 2022, and 2023. The following reports will be developed:

- *Interim evaluation reports.* These three reports will be based on the qualitative and quantitative data and analyses performed throughout the course of the evaluation to date. These interim evaluation reports will be produced in 2020-2023, and incorporate survey data from 2021-2023.
- *Final report.* A summation of our prior interim evaluation reports (cumulative) and findings in 2023.

Publications: We will produce three manuscripts for publication, which will be developed, from our results. We intend for one paper to be targeted to the health services research literature (such as Academic Medicine), one paper targeted to a journal focused on SUD treatment, and one focused on rural health. Topics will be decided on with approval of our COR and might include:

1. Outcomes of the training program, with a focus on trainee preparedness, intentions to work in underserved areas, and characteristics of high, average, and low retention of grant programs
2. Changes in NHSC LRP sites' capacity to provide SUD services, including medication-assisted treatment, with comparisons across standard NHSC LRP, NHSC SUD LRP, and NHSC RC LRP participants
3. Use of medication-assisted treatment among NHSC LRP participants, and challenges to prescribing it

Manuscripts will be drafted in September 2021, September 2022, and April 2023.

Project Timeline: The contract was signed July 2019. The contract concludes July 2023. Data will be collected from NHSC LRP sites and participants each year from 2020, 2021, and 2022. Data will be collected from grantee organizations and grant program training sites in 2020 and 2022. Data will be collected from trainees in 2020, 2021, and 2022, and from grant program alumni in 2021 and 2022. We are requesting a three-year clearance which will cover June 2020 to July 2023.

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

The OMB number and expiration date will be displayed on every page of every form/instrument.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

Attachments

Federal Registrar Notice

Attachment A: 60-day Federal Register Notice published in the *Federal Register* on January 24, 2020, vol. 85, no. 16; pp. 4327-4329

Survey Instruments

Attachment B1: NHSC SUD Workforce Loan Repayment Program/NHSC Rural Communities Loan Repayment Program/NHSC Loan Repayment Program- Participant Survey (NHSC LRP Participant Survey)

Attachment B2: NHSC Loan Repayment Program- Site Survey (NHSC LRP Site Survey)

Attachment B3: Grantee Training and Educational Programs- Trainee Survey (Grantee Trainee Survey)

Attachment B4: Grantee Training and Educational Programs- Alumni Survey (Grantee Alumni Survey)

Attachment B5: Grantee Training and Educational Programs- Site Survey (Grantee Site Survey)

Attachment B6: Grantee Training and Educational Programs- Grantee Organization Survey (Grantee Organization Survey)

Outreach Materials

Attachment C1: Advance Introduction Email to Grantees

Attachment C2: Contact Information Request Email to Grantees (Pre-Survey)

Attachment C3 Introductory Email from Grantees to Sites and Trainees

Attachment C4: Site and Trainee Contact Information Request Template

Attachment C5: Introductory Email Template – All Surveys

Attachment C6: Reminder Email – All Surveys

Attachment C7: Reminder Email from Grantees to Sites and Trainees - Survey

Attachment C8: Reminder Email from HRSA to Grantees

Attachment C9: Reminder Email from HRSA to NHSC Participants and Sites

Attachment C10: Survey Advertisement Text

Attachment C11: Reminder Email to Grantees about Site and Trainees Contact Information

Attachment C12: Mailed Reminder Letter – All Surveys

Attachment C13: SMS Reminder

Attachment C14: Grantee Follow-up Phone/Voicemail Script