Generic Clearance

"Assessments of adults' professional experiences for improving programs to decrease sexual risk and related behaviors and adverse health outcomes among youth."

OMB #0920-NEW
Expiration: 00/00/0000

Supporting Statement Part A

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Supported by:

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

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Table of Contents

A.1 Circumstances Making the Collection of Information Necessary.....3
A.2 Purpose and Use of Information Collection.....5
A.3 Use of Improved Information Technology and Burden Reduction.....7
A.4 Efforts to Identify Duplication and Use of Similar Information.....7
A.5 Impact of Small Businesses or Other Small Entities.....8
A.6 Consequences of Collecting the Information Less Frequently.....8
A.7 Special Circumstances Relating to the Guidelines of 5 CFR 1320.5.....8
A.8 Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency.....8
A.9 Explanation of Any Payment or Gift to Respondents.....9
A.10 Protection of the Privacy and Confidentiality of Information Provided by Respondents…10
A.11 Institutional Review Board (IRB) and Justification for Sensitive Questions.....11
A.12 Estimates of Annualized Burden Hours and Costs.....11
A.13 Estimates of Other Annual Cost Burden to Respondents or Record Keepers.....13
A. 14 Annualized Cost to Government.....13
A.15 Explanation for Program Changes or Adjustments.....14
A.16 Plans for Tabulation and Publication and Project Time Schedule.....14
A.17 Reason(s) Display of OMB Expiration Date is Inappropriate.....15
A.18 Exceptions to Certification for Paperwork Reduction Act Submissions.....15

List of Attachments

Attachment Number	Document Description
1	Public Health Service Act Legislation
2	60 Day FRN
3	Sample instrument: Community Based Organization Assessment Questionnaire
4	Sample instrument: San Francisco School Staff Questionnaire
5	Sample instrument: DASH PS18-1807 Component 2 Funded Recipient Reporting Template
6	Sample instrument: Local Education Agency, Safe and Supportive Environment Items
7	Sample instrument: School Climate Index Interview/Focus Group Guide – School-Level Administrator Interview Guide
8	Sample instrument: School Climate Index Interview/Focus Group Guide – School Staff Focus Group Guide
9	Sample Informed Consent Language

Section A: Justification for Information Collection

Goal of the study: To conduct qualitative and quantitative data collection from adults who help implement programs and services designed to prevent HIV, other sexually transmitted diseases (STDs), and pregnancy or influence related risk and protective factors; data will be collected for needs assessment and program refinement.

Intended use of resulting data: The data will be used to improve program and service practices and to adapt existing programs to reduce sexual risk behaviors and adverse health outcomes among adolescents. The program and/or services to be refined with information from the collection will be clearly identified in any ICRs under this generic clearance, and data elements will be cross-walked to the aspects of the program that the project team is seeking to improve.

Methods to be used to collect: Methods will include quantitative data collection through paper, telephone, computer-based, tablet-based, and web-based questionnaires; and qualitative interviewing including in-depth interviews and focus groups.

Subpopulation to be studied: The priority population for this generic clearance ICR includes adults (18 years of age and over) who help implement or oversee programs to prevent HIV, other sexually transmitted diseases (STDs), and pregnancy among youth or influence related risk and protective factors; these adults typically serve in roles such as:

- School staff and administrators;
- Staff in state and local education agencies;
- Staff in local health agencies;
- Staff in youth-serving community or national non-governmental organizations;
- Community-based health care providers for youth; and
- School-based health care providers for youth.

How data will be analyzed: Individual data collections will vary in their analytic methods and proposed analysis plans will be submitted for each individual data collection activity.

Impact of COVID-19: In light of the current COVID-19 pandemic, all data collection methods will take into consideration recommendations for lowering risk of COVID-19 transmission. Specifically, virtual or online data collection methods will be prioritized over face-to-face methods as much as possible during the pandemic and when in areas impacted by ongoing community transmission.

A.1 Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) requests a 3-year approval for a new generic information collection package entitled, "Assessments of adults' professional experiences for improving programs to decrease sexual risk and related behaviors and adverse health outcomes among youth" that supports (for the purpose of needs assessment and program refinement) collection of quantitative and qualitative information from adults who provide sexual risk reduction programs and services to youth.

Background

NCHHSTP conducts behavioral and health service assessments and research projects as part of its response to the domestic HIV/AIDS epidemic, STD prevention, TB elimination and viral hepatitis control with national, state, and local partners. Adolescents are a population with specific developmental,[1] health and social,[2] and resource needs.[3] Their health risk factors and access to health care[3] is addressed as a primary mission by the Division of Adolescent and School Health (DASH), and adolescents are a population of interest for several other NCHHSTP divisions. The assessment and research conducted by NCHHSTP is one pillar upon which recommendations and guidelines are revised and updated. Recommendations and guidelines for adolescent sexual risk reduction require a foundation of scientific evidence.[4] Assessment of programmatic practices for adolescents helps improve programs through better identification of strategies relevant to adolescents as a population as well as specific sub-groups of adolescents at highest risk for HIV and other STDs so that programs can be better tailored specifically for them.[5]

DASH has awarded funds to implement PS18-1807: *Promoting Adolescent Health through School-Based HIV Prevention* in order to build the capacity of local education agencies (LEAs) and support the efforts of national, non-governmental organizations (NGOs) to help priority school districts and schools develop and implement effective and sustainable adolescent-focused program activities. Under this cooperative agreement, all funded recipients will be asked to provide periodic assessment of program activities and a small number of recipients will be selected to participate in mixed-methods assessments to better understand program delivery and the strengths and weaknesses of key program strategies. Data collection among adolescents and their parents/caregivers who are served by programs to prevent HIV and other STDs among youth is critical to understand the context, types, and promising strategies of those programs and services. Findings from studies of such programs directly inform CDC recommendations for funded recipients as well as other school districts and youth serving organizations across the country. As promising strategies are identified, CDC can encourage uptake of these activities by its other funded recipients, and can encourage recipients to move away from strategies that appear to be less feasible or less acceptable to the intended audiences. At times, assessing programs in non-funded sites also provides opportunities to identify strategies that could be incorporated into CDC's program approach. Both types of assessments (i.e., those of funding recipients as well as non-funded partners doing related work) allow for better program design and refinement and will be included in the scope of this generic information collection request.

CDC is authorized to collect the data described in this request by Section 301 of the Public Health Service Act (42 USC 241). A copy of this enabling legislation is provided in **Attachment 1**. In addition to this legislation, there are several national initiatives and programs that this information collection would serve to support, including but not limited to:

- *Healthy People 2020*, which provides national health objectives and outlines a

comprehensive plan for health promotion and disease prevention in the United States. Of the Healthy People 2020 objectives, many objectives align specifically with PS18-1807 activities, including those related to increasing protective factors such as connections to parents or trusted adults and those related to reducing HIV infection, other STD, and pregnancy among adolescents.[6]

- The NCHHSTP program imperative calls for *Program Collaboration and Service Integration (*PCSI*)* to provide improved integration of HIV, viral hepatitis, STD, and TB prevention and treatment services at the user level.[5]
- *Ending the HIV Epidemic (EHE)*, an initiative to end the HIV epidemic in the United States within 10 years. This initiative will prioritize 57 geographic focus areas for first year efforts, and 20 of these overlap with communities in which CDC/DASH currently funds education agencies, offering opportunities for alignment between CDC/DASH efforts and the national EHE initiative.[7]
- *CDC Winnable Battles*, including HIV elimination, have been chosen by CDC based as key public health priorities where CDC and its partners can make significant progress in improving outcomes. Many programs and services for adolescents focus on integrated approaches to reduce sexual risk behaviors that result in HIV and other sexually transmitted diseases.[8]

A.2 Purpose and Use of Information Collection

Data gathered under this generic collection will be analyzed to allow CDC, funded education agencies, national non-governmental agencies, CBOs, and healthcare providers, and other program partners to assess needs and refine program activities/services to reduce adolescents' risk of HIV and other STD transmission, including activities conducted under PS18-1807. These data will allow agencies and partners to improve the quality of their programs and services to prevent HIV, other STDs, and pregnancy among adolescents.

CDC will only submit a collection for approval under this generic clearance if it meets the following conditions:

- The collection is voluntary or specifically required of funding recipients in their cooperative agreement;
- The collection consists of qualitative and/or quantitative data collections through electronic, telephone, or paper-based questionnaires, interviews, and/or focus groups;
- The collection is low burden for respondents (based on considerations of total burden hours, total number of respondents, or burden hours per respondent) and are low cost for both the respondents and the federal government;
- The collection includes participants who are adults who help implement or oversee programs and services designed to prevent HIV, other sexually transmitted diseases (STDs), and pregnancy or influence related risk and protective factors (e.g., program implementers);
- The collection focuses on program and service implementation activities, experiences, processes, and reflections as well as implementers' perceptions of participants' needs, program experiences, or proximal indicators of, or precursors to, HIV/STD or pregnancy outcomes [e.g., sexual risk or protective behaviors and related risk or protective factors (such as substance use, school environment, parental engagement)];
- The collection is for the purpose of needs assessment and program refinement for HIV, STD, and/or pregnancy prevention programs for youth or programs that influence related

risk and protective factors;

- The program and/or services to be informed or refined with information from the collection will be clearly identified, and data elements will be cross-walked to the aspects of the program that the project team is seeking to inform or refine.

If these conditions are not met, CDC will submit an information collection request to OMB for approval through the normal PRA process.

Quantitative data collection will allow CDC to assess program and service activities to prevent HIV, other STDs, and pregnancy among youth, and to generate recommendations to better reach and serve both those youth and the professionals who implement programs for them. Data will be provided to participating agencies and organizations and will be used to assess the processes and strategies of programs and services for youth over time, and in a timely fashion that allows on-going program improvements.

Qualitative data will provide valuable information about the program implementers' experiences with and reflections on programs and services for youth. Such data collection can assess the implementation programs and allow for refinement of programs and services in ways that can both better serve the intended youth beneficiaries and ease the ability of adult professionals to implement them. These data will be shared with participating agencies and organizations, and CDC will collaborate with them for program and service improvement. Such data also provides information about strengths and weaknesses of programmatic activities and services that take into account contextual factors and individual experiences.

Participants in data collection include adults (18 years of age and over) who help implement or oversee programs to prevent HIV, other sexually transmitted diseases (STDs), and pregnancy among youth or influence related risk and protective factors; these adults typically serve in roles such as:

- School staff and administrators
- Staff in state and local education agencies
- Staff in local health agencies
- Staff in youth-serving community or national non-governmental organizations
- Community-based health care providers for youth
- School-based health care providers for youth

The participants for this data collection are considered to be the "implementers" of the types of programs that are funded by CDC/DASH or of programs that will directly inform CDC/DASH's programmatic approach. Typically, CDC/DASH programs are intended to have direct impact on proximal indicators such as sexual health-related knowledge, attitudes, perceptions, and behaviors among youth, and although CDC/DASH programs are typically set in schools, they can be implemented by adults who working in a variety of school, community, and health-care roles.

The types of information collection activities included in this generic package are:

1) Quantitative data collection conducted in-person or remotely through electronic (via computers, tablets, other mobile devices, etc.), telephone, or paper questionnaires to gather information about programmatic and service activities related to sexual risk reduction or related adverse health outcomes among youth. Questions relate to work-related experiences, training, context, duties, activities, and youths' health and service needs. Information may also be gathered on program implementers' demographic and social characteristics, program-related knowledge, attitudes, skills, and implementation practices.
2) Qualitative data collection in-person or remotely through electronic, telephone, or paper

means to gather information about program and service activities related to sexual risk reduction or prevention of related adverse health outcomes among youth. Qualitative data collection may involve focus groups and/or in-depth individual or group interviews. Interview and focus group guides may include questions about work-related experiences, training, context, duties, activities, and youths' health and service needs. Information may also be gathered on program implementers' demographic and social characteristics, program-related knowledge, attitudes, skills, and implementation practices.

Attachments 3-8 provide sample qualitative and quantitative instruments with a sample of questions reflecting the type that might be used by studies included in this request. Attachments 3, 4, 7, and 8 are sample instruments from projects with OMB approval under previous ICRs. These sample instruments represent data collections with a variety of program implementers including, local education agency (school district) staff, school staff (e.g., teachers, principals), school health and wellness center staff, and staff of community-based organizations who partner with schools.

As previously stated, data collection instruments used with adult program implementers will include questions on work-related experiences, training, context, duties, activities, and youths' health and service needs. Information may also be gathered on program implementers' demographic and social characteristics, program-related knowledge, attitudes, skills, and implementation practices.

Because this request includes a wide range of possible data collection instruments, specific requests will include items of information to be collected and copies of data collection instruments. It is expected that all data collection instruments will be pilot-tested, and will be culturally and professionally appropriate for the populations included.

A.3 Use of Improved Information Technology and Burden Reduction

When appropriate and feasible, data collection may be conducted using the most current modes of questionnaire data collection, including computer-assisted personal interviews (CAPI), computer-assisted self-administered interviews (CASI), audio computer-assisted self-administered interviews (ACASI), web-based survey, mobile device-based data collection, or other modes. Such methods of data collection reduce burden on participants through use of automated question skips and filters that reduce the number of questions participants must answer. Although these technologies will be used by many of the individual projects in this data collection, the nature of many of these proposed activities may require direct interaction between participants and project staff, particularly in the case of qualitative interviewing and focus groups. When possible and appropriate, qualitative data collection methods such as interviews and focus groups may be conducted via electronic means such as phones or video messaging (i.e., Skype, FaceTime, etc.) to reduce the travel and scheduling burdens on participants. In light of the current COVID-19 pandemic, all data collection methods will take into consideration recommendations for lowering risk of COVID-19 transmission. Specifically, virtual or online data collection methods will be prioritized over face-to-face methods as much as possible during the pandemic and when in areas impacted by ongoing community transmission.

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

CDC has one generic information collection (IC) that is related to the current collection. "Formative Research and Tool Development" (OMB Control # 0920-0840, expiration 10/31/2021) is designed for measurement testing and tool development for HIV, STD,

tuberculosis, and Hepatitis prevention and formative qualitative data collection. The qualitative data collection under this new request allows for assessment of programs that are already in place. In addition, this new request allows for quantitative needs assessment, as well as assessment for the purposes of program refinement that is not covered under the existing generic IC.

In addition, CDC has a related generic IC that is designed to allow for data collection from adolescents and their parents/caregivers who are participating in HIV, other STD, and pregnancy prevention programs (e.g., the program beneficiaries). This generic collection , developed by DASH, is titled "Assessments to Inform Program Refinement for HIV, other STD, and Pregnancy Prevention among Middle and High-School Aged Youth" (OMB Control # 0920-1235, expiration 05/31/2022) and is complementary, but not redundant with this currently proposed generic collection , which is focused on data collection from adults involved in program implementation (e.g., program implementers rather than beneficiaries).

NCHHSTP has verified through RegInfo.gov that there are no other federal generic collections that duplicate the types of studies included in this request.

A.5 Impact of Small Businesses or Other Small Entities

Some assessment activities may involve data collections in collaboration with small businesses (e.g. medical offices) or small non-profit or governmental entities. Therefore, study and instrument development activities may also be conducted with these groups. If such activities are conducted, representatives from these businesses will be approached in the same manner as the individuals we normally recruit; we will ask the organization to identify the appropriate staff members with whom to conduct the activities.

A.6 Consequences of Collecting the Information Less Frequently

The amount of data collection would vary under the requests made under this package. Some data collection requests would involve a one-time collection of data. Other requests may involve multiple data collections. Such data collections are intended to provide timely information to inform quality improvement for programs and practices. Requests for multiple data collections may allow for assessing programs in an ongoing way to better understand whether resulting program refinements were implemented as planned.

In requests for multiple data collections, there could be a number of consequences to collecting the data less frequently. The first data collection is essential to present an accurate picture of programs and services as provided by schools and other agencies and organizations and implementers' perspectives, experiences, knowledge, attitudes, behaviors, and skills. Without this first data collection, we would lack a point of comparison for all future data collections; it allows documentation of where programs and participants are starting. Furthermore, initial baseline data collection provides critical information that program and service providers can use to determine the most appropriate focus of their activities and allow them to determine areas of greatest need. Final data collection allows conclusions to be drawn in terms of full program implementation, need for and timing of training or supplemental activities, necessary program/service changes, and the feasibility and acceptability of programs and services.

Individual requests under this package will use the fewest number of data collections necessary to achieve project goals using sound methods and will provide information and justification for frequency of data collection.

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

There are no special circumstances with this information collection package. This request fully complies with the regulation 5 CFR 1320.5 and will be voluntary.

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

As required by 5 CFR 1320.8(d), a 60-day Notice was published in the *Federal Register* on June 2, 2020, volume 85, number 106, pages 33674-33676 (see **Attachment 2**). No public comments were received. No other agency was consulted for the development of this request.

B. A variety of agency partners are expected to be consulted for each individual data collection request under this generic IC, including agency contractors, education and public health agency staff, school staff, community –based organization staff, and adolescent health care providers.

A.9 Explanation of Any Payment or Gift to Respondents

Tokens of appreciation for data collection participation are an important tool used in many studies and are particularly important for the population in this information collection. Educators (including teachers, principals, school counselors, school nurses, and other school staff) work within extremely regimented schedules that offer little room for flexibility or variation in the way they spend the time during their work days. In the study team's extensive experience working with schools and school staff, we have consistently heard that time is extremely hard to come by for school staff. In our experience, the lack of time for school personnel is such a substantial concern for school administrators, that local education agencies often restrict the commitments they allow school personnel to make for tasks such as data collection. A study funded by the U.S. Department of Education helped document some of the time constraints faced by school staff. In that study of middle school teachers, researchers identified a number of time-related challenges, two of which included "feeling overwhelmed" and "lack of discretionary time".[9] Discretionary time, in that study, was defined as "the time when teachers are free from scheduled responsibilities and can decide what to do," and the study found that true discretionary time for teachers was rare. Administrators typically set teachers' schedules, and the majority of their time was spent with students. Even "free time" was often spent with set responsibilities such as team meetings, parent conferences, student meetings, supervising lunch rooms, and moving students from one place to another.[9] It is precisely this lack of discretionary time that can make achieving high response rates among educators a challenge.

Individual data collections may request tokens of appreciation for participants, and they are expected to provide specific justification for tokens of appreciation and to make clear the need for tokens of appreciation given use of other methods used to increase response rates. Such other methods include strategies such as repeated requests for response; use of short questionnaires when possible; personalized questionnaires and response appeals; use of stamped return envelopes for postal questionnaires; use of fonts, space, and white backgrounds on questionnaires; use of pictures in e-mail response appeals; and development of rapport with participants.[9,10,11] Use of tokens of appreciation for individual data collection requests would also be approved by Institutional Review Boards (IRBs) where applicable, and are not expected to exceed a value of $75.

We suggest that tokens of appreciation be considered for individual data collection requests as appropriate. Response rates have fallen for questionnaires as they have become relatively more common and potential participants reachable by multiple channels, including mail, phone, and electronic recruitment.[10] Monetary and non-monetary tokens of appreciation, and lottery tokens of appreciation (where permitted by law) have been helpful in significantly increasing response rates for mail and electronic questionnaires.[10] Tokens of appreciation provided in advance or along with the questionnaires have been more effective in increasing response rates than lotteries or tokens of appreciation provided on completion. More importantly, several studies have found that tokens of appreciation have improved sample composition in terms of socio-economic status, education, and political affiliation.[12] Furthermore, research suggests that initial tokens of appreciation may decrease the need for tokens of appreciation in subsequent responses, and that a limited number of repeated tokens of appreciation may increase participation among those who declined to take part in prior questionnaires in longitudinal studies. Small to modest tokens of appreciation are useful in increasing response rates, with the advantage that such tokens of appreciation are unlikely to greatly increase research costs.[10,11, 12] For qualitative data collections, time commitments for participation can be greater, as focus groups and interviews may require interviews to take place outside of working hours and possibly at locations that require additional driving time from participants.

Specific justification for the value of tokens of appreciation and need will be clearly described in each generic sub-study request. For the purposes of this generic clearance, packages may include monetary or non-monetary tokens of appreciation (e.g., healthy snacks, water bottle). Use of tokens of appreciation will also be based on the circumstances of the data collection, including administration mode and/or timing (e.g., whether data collections occurred within or outside of the normal work day). Tokens of appreciation for surveys will be limited as much as possible. Any ICR under this generic clearance will include a thorough, comprehensive justification for any kind of proposed tokens of appreciation.

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

The NCHHSTP Associate Director for Science office reviewed this information collection request and determined that the Privacy Act may or may not apply to the sub collections under this generic clearance. Although none of the data collections under the approved Generic package are expected to require identifying or potentially identifying information, in some instances, identifying information (such as name, email, or phone number) may be used for the purposes of recruiting or scheduling participants. In such instances, the collections will be covered under the Privacy Act System Notice 09-20-0136, “Epidemiologic Studies and Surveillance of Disease Problems. HHS/CDC”, which enables the Centers for Disease Control and Prevention (CDC) officials to collect information to better understand disease patterns in the United States, develop programs for prevention and control of health problems, and communicate new knowledge to the health community. PII will be kept separate from other collected data and will be accessible only to data collectors or interviewers. This information will be destroyed when the participant’s contribution to the project has ended. Data will be aggregated in reports and any data shared will always be limited to the level necessary to protect the participants. We do not expect data collections under this generic IC to need certificates of confidentiality because no personally identifiable information will be included in the stored data.

Information might be collected electronically, by telephone, or on paper (depending on the individual information collection request). Electronic means include handheld devices, computer-assisted questionnaires or self-interview, computer assisted telephone interview or questionnaires, web-based surveys, or other point of service collection devices. Web-based methods for questionnaire data collection may involve the hosting of a website. Individual collection requests submitted under this generic approval will describe any web-based material involved. Telephone data collection may be used for questionnaires, in-depth interviews, or focus groups. Paper-based interview or focus group guides are a common type of instrument used for leading qualitative data collection, and paper-based questionnaires may be used in settings where electronic access is not feasible or efficient. Because this request includes a wide range of studies, specific data collection requests will include items of information to be collected and copies of data collection instruments.

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

IRB Approval

Because methods and materials may differ between individual projects, appropriate human subjects review procedures will be conducted for each project as they are developed and will meet any applicable special protections requirements. IRB determinations will be conducted for each project, and where applicable, IRB approval will be submitted with a copy of the approval documents.

Projects under this generic IC are expected to contain no personally identifiable information (PII) in the stored data sets. When possible, projects will avoid collecting PII completely. Anonymous questionnaires would contain no PII. Some data collections may require PII (such as name, address, email, or phone number) to assist in recruiting and scheduling participants, but such PII will be kept separate from other collected data and will be accessible only to data collectors or interviewers. This information will be destroyed when the participant's contribution to the project has ended. Data will be aggregated in reports and any data shared will always be limited to the level necessary to protect the participants.

All participants will provide informed consent following procedures outlined in the approved IRB protocol of each study. All consent procedures will undergo IRB review and approval, and they will be described in detail in each generic sub-study request.

Sensitive Questions

Individual data collection requests are not expected to contain sensitive information.

A.12 Estimates of Annualized Burden Hours and Costs

Burden hours. **Table A-12-a** provides the estimated annualized response burden for up to 10 individual data collections under this generic clearance at 60,000 hours. Average burden per response is based on pilot testing and timing of quantitative and qualitative instrument administration during previous studies. Response times include the time to read and respond to consent forms and to read or listen to instructions. (**Att 9** contains sample informed consent language.)

For a 1-time administration (in a 12-month period) of the questionnaire (sample instruments provided in **Att 3** and **Att 4**), the total number of possible respondents is estimated at 15,000. This burden estimate allows for data collection from multiple community partners, schools, or districts within any given project. The average burden is 1 hour, based on previous

administrations of this sample questionnaire; this aligns with the time restrictions often encountered in school-based data collection planned to occur within one planning period for staff. Total annualized burden for a 1-time administration of the questionnaire is 15,000 hours.

For 2-time (pre-post) administration (in a 12-month period) of the questionnaire (sample instrument provided in **Att 5** and **Att 6**), the total number of possible respondents is estimated at 15,000. The average burden is 1 hour, based on previous administrations of similar questionnaires; this aligns with the time restrictions often encountered in school-based data collection planned to occur within one planning period for staff. Total annualized burden for a 2-time administration of the questionnaire to 15,000 participants is 30,000 hours.

For 1-time administration (in a 12-month period) of an interview/focus group guide (sample instrument provided in **Att 7**), the total number of possible respondents is estimated at 4,000. This allows for an average of 200 participants in each of the 10 data collections. The average burden is 1.5 hours, based on previous administrations of similar interviews and focus groups. Total annualized burden for a 1-time administration of a youth interview/focus group guide to 4,000 participants is 6,000 hours.

For 2-time administration (in a 12-month period) of an interview/focus group guide (sample instrument provided in **Att 8**), the total number of possible respondents is estimated at 3,000. This allows for an average of 150 participants in each of the 10 data collections. The average burden is 1.5 hours, based on previous administrations of similar interviews and focus groups. Total annualized burden for a 2-time administration of an interview/focus group guide to 3,000 participants is 9,000 hours.

Table A.12-1 Estimated Annualized Burden to Respondents

Respondents	Form name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
Adults helping with program implementation (e.g., school or district staff, community partners, NGO staff)	Questionnaire (example: **Att3** and **Att 4**)	15,000	1	1	15,000
Adults helping with program implementation	Pre/Post questionnaire (example: **Att5** and **Att6**)	15,000	2	1	30,000
Adults helping with program implementation	Interview/focus group guide (example: **Att7**)	4,000	1	1.5	6,000
Adults helping with program implementation	Pre/Post Interview/focus group guide	3,000	2	1.5	9,000

	(**Att8**)				
Total					60,000

Annualized cost. **Table A.12-2** provides estimates of the annualized cost to respondents for the collection of data. We have estimated the labor hours for two types of adults helping with program implementation: (1) staff at non-profit community-based organization or school-based health and wellness centers, and (2) school staff.

For non-profit community-based organization or school-based health and wellness center staff, cost estimates for the value of time staff spend in responding to the questionnaire are based on Department of Labor (DOL) data from May 2018 providing national industry-specific occupational employment and wage estimates. These hourly wage estimates can be found on the DOL website (http://www.bls.gov/oes/current/naics4_999200.htm). Based on DOL data, we took the average of the median hourly wages for all community and social service occupations ($22.73) and for family and general practitioners ($102.35) to estimate $62.54 for staff that might span a range of community and social service occupations, including those working at local community-based organizations or those serving as health care providers in health or wellness centers.

For school staff, cost estimates for the value of time staff spend in responding to the questionnaire are based on Department of Labor (DOL) data from May 2018 providing national industry-specific occupational employment and wage estimates. These hourly wage estimates can be found on the DOL website (http://www.bls.gov/oes/current/naics4_999200.htm). Based on DOL data, the median hourly wage for all education, training, and library occupations is $25.87.

Because adults participating in these data collections are likely to be from both of these categories, we have used the average of the two rates ($62.54 and $25.87) for cost estimates. The average of these rates is $44.21. Total cost has been rounded up to the nearest whole dollar and are presented in Table A.12-2. Total estimated annualized costs to respondents is $2,652,600.

Table A.12-2 Annualized Costs to Respondents

Type of Respondent	Form Name	Total Burden Hours	Average Hourly Wage Rate	Total Respondent Costs
Adults helping with program implementation	Questionnaire (example: **Att3 and Att 4**)	15,000	$44.21	$663,150
Adults helping with program implementation	Pre/Post questionnaire (example: **Att5** and **Att6**)	30,000	$44.21	$1,326,300
Adults helping with program implementation	Interview/focus group guide (example: **Att7**)	6,000	$44.21	$265,260
Adults helping with program implementation	Pre/Post Interview/focus group guide (**Att8**)	9,000	$44.21	$397,890
Total				$2,652,600

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

There will be no direct costs to the respondents or record keepers other than their time to participate in each information collection. No capital, start-up, operation, or maintenance costs are involved.

A. 14 Annualized Cost to Government

Actual annualized costs to the government will vary depending on the specific needs of the individual information collection activity. Generally, each development activity will involve participation of at least one, and often two, CDC program consultants or health scientists at 4% time (GS-13) who will be responsible for the project design, obtaining approvals, providing project oversight, and analysis and dissemination of the results. The CDC scientist will provide remote and onsite technical assistance to local areas implementing data collection. A CDC supervisor (GS-14) will provide oversight of the project at 2% time. Costs are estimated based on GS13, step 5 and GS14, step 9 salaries for Atlanta area federal employees. Based on current data collection activities, contract costs were based on an average percentage of contract effort across three data collections involving adults working with adolescents in the school and community. An estimated average cost per individual activity is listed below, but detailed costs will be submitted with each individual collection request. Total estimated annualized cost to the government is $129,269.

Table A.14-1. Annualized and Total Costs to the Federal Government

Expense Type	**Expense Explanation**	**Annual Costs (dollars)**
Direct Cost to the Federal Government		
CDC employee oversight for project	CDC supervisor (GS-14, step 9) labor costs for 1 employee at 2% time	$2,878
CDC oversight of contractor and project	CDC non-supervisory employee (GS-13, step 5) labor costs for 2 employees, each at 4% time	$8,715
Subtotal, Direct Costs to the Government per year		**$11,593**
Contractor and Other Expenses		
Assistance with data collection, processing, and preliminary analysis	Labor and other direct costs for supporting data collection, processing, and analysis	$117,676
Subtotal, Contract and Other Expenses per year		**$117,676**
Total of all annualized expenses		***$129,269***

A.15 Explanation for Program Changes or Adjustments

This is a new data/information collection.

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

Analysis Plan

Quantitative data will be analyzed using both descriptive and inferential statistics. Data reduction techniques/factor analyses and item correlation analyses will be used to develop scales

as needed. Bivariate analyses will be used to assess associations and changes; linear or logistic regression will be used to examine predictors of outcomes of interest (such as successful partnerships), and multi-level data analyses will be performed as appropriate. Qualitative data analysis will be performed on notes or transcripts of interviews or focus groups to identify themes and commonalities across using inductive or grounded analysis or matrix analysis to develop reports, typologies, taxonomies, and/or frequency matrices. Individual data collections will vary in their analytic methods and proposed analysis plans will be submitted for each individual data collection activity. Findings from the data collections will be compiled and shared based on project specific disseminations plans. Most findings will be summarized through project reports shared with CDC staff and key organizations participating in the data collections. Findings may be shared more broadly (e.g., through fact sheets for key stakeholders, presentations to organizations participating in the data collection) if appropriate.

Project Time Schedule

Individual data collections under this generic approval may occur once or at multiple times for purposes of follow-up assessment. Proposed timelines will be submitted for each individual data collection activity.

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

The display of the OMB expiration date is not inappropriate. All data collection instruments will display the expiration date for OMB approval of the information collection.

A.18 Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification. These activities comply with the requirements in 5 CFR 1320.9.

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