**Change Request**

**Monitoring and reporting for the Overdose Data to Action Cooperative Agreement**

(OMB no. OMB# 0920-1283 exp. date 1/31/2023)

# **Proposed Changes: Justification and Overview**

August 25, 2021

## Justification

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

# **Project Description**

The purpose of the Overdose Data to Action (CDC-RFA-CE19-1904) notice of funding opportunity (OD2A NOFO), is to support funded jurisdictions, in getting high quality, complete, and timelier data on opioid prescribing and overdoses, and to use those data to inform prevention and response efforts. CDC will use the information collected to monitor each recipient’s progress and to identify facilitators and barriers to program implementation and achievement of outcomes. *OD2A is currently in Year 3.* ***To obtain key information not originally captured, streamline data collection, and minimize burden to recipients, changes are being requested to the following data collection tools:***

***1) Evaluation and Performance Measuring Plan:*** Items have been added to capture recipient peer-to-peer activities and more detail within the data collection methods. Items have been moved and, in some cases, removed to streamline the reporting form.

***2) Overdose Prevention Capacity Assessment Tool:*** Items have been added that capture key capacity areas not initially included on the form. This information is pertinent to capacity around health equity, harm reduction, and evaluation. Some language has been edited to reflect more appropriate terms (e.g., disproportionately affected populations).

***3) Annual Activity Progress Report and Workplan:*** *Ite*ms have been removed from the Annual Activity Progress Report that were duplicative. Also, to improve clarity, several questions have been reworded or had clarifying language added.

These changes are crucial to the success of our program and ability to continue monitoring whether a recipient is meeting performance and budget goals, assess progress with respect to capacity building, and make adjustments in the type and level of technical assistance provided to funded jurisdictions as needed. These functions are central to NCIPC’s broad mission of protecting Americans from violence and injury threats.

## Proposed Changes

***1) Evaluation and Performance Measuring Plan***

**Table A. Changes from Existing Evaluation Plan 1.0 to Evaluation Plan 2.0 in Partners Portal**

|  |  |
| --- | --- |
| **Existing** | **Change** |
| Indicators field stated “indicators” | We added clarifying fields “indicator name” and “indicator description” |
| Data collection methods section | Added “data source” field |
| Under data collection methods, field “frequency of data collection” currently exists | Delete “frequency of data collection” |
| In the timeline for data collection and analysis, we did not have data reporting | We have moved the timeline field within the new category of data collection and analysis where evaluation data can be reported. New fields include:* Reporting year
* Value (quantitative and qualitative)
* Year
* Notes
 |
| No peer-to-peer evaluation component currently exists in Partners Portal evaluation plan template | An additional “strategy” that would replicate each field for the peer-to-peer funded jurisdictions to complete. |

***2) Overdose Prevention Capacity Assessment Tool***

**Table B. Changes from Existing OPCAT 1.0 to OPCAT 2.0**

|  |  |
| --- | --- |
| **Existing** | **Change** |
| Infrastructure Section |
| No direct mention of health equity  | Additions of health equity into key infrastructure areas * Under multilevel leadership, added a component on “leadership to incorporate health equity in overdose prevention exists across levels” (p3)
* Under networked partnerships, added a component, “Shared planning of health equity efforts” (p8)
 |
| No evaluation capacity section | Added crucial section on Evaluation Capacity as it is a key component of the NOFO* New section on evaluation capacity has components on “evaluation expertise”, “technology for evaluation, data access, management, and analysis”, “staff (internal or contract) capacity to collect, manage, and analyze evaluation data”, “dissemination and use of evaluation findings” (p5-6)
 |
| The word opioid was used in the section Responsive Plans and Planning | Under Responsive Plans and Planning, changed opioid to overdose (p 10 and 11) |
| Under Data to Action, states high risk populations and uses the work stakeholders | Throughout the document, changed the language to align with the CDC health equity guide* Changed high risk to disproportionately affected (p12)
* Changed stakeholders to partners (p14)
 |
| Under Managed Resources, stated “your” jurisdiction | Aligned language to the rest of the document to state “my” jurisdiction (p15) |
| Under Managed Resources, lists types of staff | Added evaluators as a staff type as it was missing (p16) |
| Topical Capacity Section |
| Section Conducting Public Health Surveillance, language states high burden | Throughout the document, changed the language to align with the CDC health equity guide* Changed to disproportionately affected (p18)
 |
| In the scoring of each topic, the last two options stated:* Initiatives are developed but are either 1) targeted to the general population and not specifically to those in need or 2) a few minor program gaps or challenges remain (resource plan in development to fill gaps)
* Have targeted initiatives to those in need (e.g., data may be shared and discussed - multilateral sharing). All gaps and challenges related to implementing strategy has been addressed.
 | * Initiatives are developed but are either 1) implemented with the general population and not specifically to priority populations or 2) a few minor program gaps or challenges remain (resource plan in development to fill gaps)
* Have prioritized initiatives to those disproportionately affected (e.g., data may be shared and discussed - multilateral sharing). All gaps and challenges related to implementing strategy has been addressed.

Changes in the following pages: 22-34, 36 |
| Section name was Highest burden populations identification, assessment of needs, and targeted initiatives to address needs (e.g., AA, NA/AI, Women Reproductive age, Adolescents, Senior Citizens, Chronic Pain Patients) | Section name changed to the following due to changes in health equity language:Identification of populations who are disproportionately affected by overdose, assessment of needs, and prioritized initiatives to address needs (e.g., AA, NA/AI, Women Reproductive age, Adolescents, Senior Citizens, Chronic Pain Patients) (p33) |
| No topical section on health equity | Added section in topical capacity to measure health equity in overdose “Incorporating Health Equity into Overdose Efforts (e.g., implementing health equity initiatives, utilization of health equity indicators, leveraging partnerships to address health equity)” (p35) |
| No topical section on harm reduction | Added section in topical capacity to measure harm reduction efforts, “Harm reduction initiatives (e.g., support of syringe service programs, safer injection education programs, outreach to people who use drugs)” (p37) |

***3) Annual Activity Progress Report and Workplan:***

**Table C. Changes from Existing Annual Progress Report 1.0 to Annual Progress Report 2.0 in Partners Portal**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|   | **Original question from APR**  | **Change Needed**  | **Revised question, if applicable**  | **Any additional comments?**  |
|   | **Summary Level** |   |   |   |
| 1  | Briefly describe how your jurisdiction plans to sustain programmatic successes and how facilitators impacted your successes.   |   | Briefly describe progress to date on this strategy and what factors have facilitated your progress. (e.g., existing/strong partnerships, policies, champion for initiative, etc)  | What aspects facilitated your success?  |
| 2  | Briefly describe how your jurisdiction overcame programmatic challenges/barriers (e.g., budgetary, political, etc.).    |   | Briefly describe how your jurisdiction overcame programmatic challenges/barriers implementing this strategy (e.g., budgetary, political)  |   |
| 3  | Describe what CDC can do to help further address challenges your jurisdiction is experiencing.  | Omit question since it is answered under TA Needs (under each activity)  |   | Make sure to capture contextual progress elsewhere (include instructions in the barriers section)  |
| 4  | How effective were the administrative and assessment processes to ensuring successful implementation and quality assurance?   | Omit question since this information is already captured in the workplan  |   |   |
| 5  | What are examples of how lessons learned were translated and disseminated?  | Change wording of the question  | Provide examples of how the findings of the activity were disseminated.  | What  if any, lessons were learned implementing this activity? Describe implementation lessons learned here (e.g., information others might want to know when implementing a similar activity in their jurisdiction) Was information from this activity disseminated into products? Were resources developed, papers What are some lessons learned (at the strategy level) and what are you going to do with these lessons that you learned? What are some lessons learned and what are some changes that you plan to make based on the lessons learned  |
|   |   |   |   |   |
|   | **Objectives**  | Pre-populated from the workplan  |   |   |
| 14  | Describe your progress to date for this objective  | Omit question, information is captured for each activity  |   |   |
| 15  | How did you address barriers to reaching this objective?  | Omit question, duplicative  |   | Option 1: Potentially keep this question and delete at the summary level  |
| 16  | How effective were the facilitators you used to help reach this objective?  | Omit question, information is captured for each activity  |   | Option 2: Roll this question up to the summary level to streamline  |
|   | ACTIVITY  | Pre-populated from the workplan  |   |   |
| 20  | Activity: Describe your progress to date for this activity  |   |   | Include successes here; include where is the activity to date  |
| 21  | Successes  | Delete question; this can be rolled up into the progress to date question. Successes are oftentimes discussed in that question  |   | Ok to omit  |
| 22  | Challenges  |   |   |   |
| 23  | What steps were taken to engage each target population?  |   |   |   |
| 24  | What was the role of staff and administration in supporting this activity?  | Duplicative question, omit; this information is already captured in the workplan  |   | Ok to omit  |
| 25  | Report progress on the output, if applicable.  | All activities should have an output  | Report progress on the output~~.~~ Including additional outputs that may have been generated by this activity.  | In the instructions provide concrete examples; include translation and dissemination  |
| 26  | Do you need Technical Assistance?  |   |   | Remove  |
| 27  | TA Need  |   |   | Describe what CDC can do to help you with your activity?  |

**Legend**

|  |  |
| --- | --- |
|   |   |
| Omit question from APR  | Orange  |
|   |   |

## Change to Burden and/or Cost

The proposed templates do not collect sensitive information. In addition, these changes are non-substantive and do not include changes to the currently approved burden and/or costs.”

## Current approved burden and cost associated with the collection of data:

**Estimates of Annualized Burden Hours and Costs**

**Annual Burden Hours**

Respondents will be the 66 funded jurisdictions of the Overdose Data to Action funding opportunity. Respondents are starting Year 3 of funding. Annually, funded jurisdictions will report: 1) activity progress and work plan information using a the Partner’s Portal (attachment 3c); 2) evaluation and performance measurement plan using the Partner’s Portal (attachment 3a); and 3) organizational capacity using a web-based assessment tool (attachment 3b). The estimate burden for each instrument includes time for reviewing instructions, searching sources, data collection, and completion of the templates.

The evaluation and performance measurement plan template (Attachment 3a) has an estimated burden per response of 12 hours for the initial submission and 4 hours for subsequent submissions. The burden is based on feedback from jurisdictions funded by a previous funding opportunity that used a similar template to plan their evaluation and performance measurement opportu*nities (OMB# 0920-1155 - Monitoring and reporting systems for the prescription drug overdose prevention for states coop agreement).* The operational capacity assessment (Attachment 3b) is web-based tool. Based on pilot testing using 9 staff members from the Association of State and Territorial Health Officials, the estimated burden per response is 1 hour for the initial submission and 1 hour for subsequent submissions.

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

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

Table D. Estimated Annualized Burden Hours

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Type of respondents | Form Name | Number of respondents | Number of responses per respondent | Average burden per response (in hours) | Total burden (in hours) |
| Overdose Data to Action funded jurisdictions (State, territories, counties and cities)  and their Designated Delegates | Evaluation and Performance Measuring Plan Template – Initial Population (Att. 3a) | 22 | 1 | 12 | 264 |
| Evaluation and Performance Measuring Plan Template - Annual reporting (Att. 3a) | 66 | 1 | 4 | 264 |
| Organizational Capacity Assessment - Initial Population (attachment 3b) | 22 | 1 | 1 | 22 |
| Organizational Capacity Assessment - Annual Reporting (attachment 3b) | 66 | 1 | 1 | 66 |
| Activity Progress Report and Work Plan Tool – Initial Population (Att. 3c)  | 22 | 1 | 20 | 440 |
| Activity Progress Report and Work Plan Tool – Annual Reporting (Att. 3c) | 66 | 1 | 4 | 264 |
| Surveillance Data Dissemination Plan Tool (attachment 3d) | 22 | 1 | 1 | 22 |
| Total | 1,342 |

**Annual Burden Costs**

 Respondents will be health department program staff or designated delegate, who are program managers or several types of staff. Program manager salaries vary widely based on actual title and institution. The average hourly wage for a program manager is $32.35 according to the 2018 National Occupational Employment and Wage Estimates from the U.S. Bureau of Labor Statistics. The salary of an evaluator also varies based on title and institution. The average hourly wage for an evaluator is $33.34. The total estimated cost over four years annualized is $68,213.64 as summarized in Table B.

Table E. Estimated Annualized Burden Costs

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of respondents | Form Name | Total Burden Hours | Average Hourly Wage Rate (in dollars) | Total Costs |
| Overdose Data to Action funded jurisdictions (State, territories, counties and cities)  and their Designated Delegates | Initial Evaluation and Performance Measuring Plan Template | 264 | $33.34 | $8,802 |
| Annual Evaluation and Performance Measuring Plan Template | 264 | $33.34 | $8,802 |
| Initial Organizational Capacity Assessment  | 22 | $33.34 | $734 |
| Annual Organizational Capacity Assessment | 66 | $33.34 | $2,200 |
| Initial Activity Progress Report and Work Plan Tool | 440 | $33.34 | $14,670 |
| Annual Activity Progress Report and Work Plan Tool | 264 | $33.34 | $8,802 |
| Surveillance Data Dissemination Plan Template | 22 | $33.34 | $735 |
|  Total: $ 45,479 |

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

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

**Annualized Cost to the Government**

The average annualized cost to the federal government is $1,939,659.

Table F. Estimated Annualized Cost to the Government

|  |  |  |
| --- | --- | --- |
| Type of Cost | Description of Services | Annual Cost |
| CDC Personnel | * 100% GS-12@$71,901/year = $71,901
* 50% GS-13 @ $85,500/year = $42,500
* 25% GS-14 @ $101,035/year = 25,258

Subtotal, CDC Personnel | $139,659 |
| Contractor | Contractor | $1,800,000 |
| Total Annual Estimated Costs | $1,939,659 |