

SUPPORTING STATEMENT A

[OMB No. 0920-xxxx]

5/16/2023

DELTA Achieving Health Equity through Addressing Disparities (AHEAD) COOPERATIVE AGREEMENT EVALUATION

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statute (42 USC § 10414)

Att. 2 Published 60-Day Federal Register Notice (FRN)

Att. 2a Public comment/response

Att. 3a Annual Performance Report (APR) Tool

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JUSTIFICATION SUMMARY

Goal of the project:

The goal of this ICR is to collect monitoring data project performance and implementation of cooperative agreement for Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Achieving Health Equity through Addressing Disparities (AHEAD).

Intended use of the resulting data:

Information collected from recipients on state- and local-level will provide crucial data for performance monitoring of the cooperative agreement and will provide CDC with the capacity to respond in a timely manner to requests for information about the program from the Department of Health and Human Services (HHS), the White House, Congress, and other sources.

Methods to be used to collect:

Recipients will report progress and activity information to CDC on an annual schedule using a web-based Partners’ Portal and web-based survey tool. No research design or human subjects involved. Information will be also collected via virtual interview sessions.

The subpopulation to be studied:

Population studied will include 100% of DELTA AHEAD-funded recipients, so no sampling method will be required.

How the data will be analyzed:

Quantitative data will be analyzed using descriptive and summary statistics. Qualitative data will be analyzed through thematic analysis to define priority area topics and emerging themes.

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Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) seeks OMB approval for three years for this new information collection request to collect information from 13 recipients (State Domestic Violence Coalitions) funded through CDC’s Domestic Violence Prevention Enhancements and Leadership Through Alliances (DELTA) AHEAD Program cooperative agreement. CDC will collect information from DELTA AHEAD recipients as part of its program evaluation to assess the implementation and impact of the NOFO and further understand the facilitators, barriers, and critical factors to implement specific violence prevention strategies and conduct program evaluation activities.

Intimate Partner Violence (IPV) is a serious, yet preventable public health problem that affects millions of people in the United States each year. Data from CDC’s 2015 National Intimate Partner and Sexual Violence Survey indicate that about 1 in 4 women and 1 in 10 men have experienced contact sexual violence, physical

violence, and/or stalking by an intimate partner during their lifetime and reported some form of IPV-related impact¹. This form of violence disproportionately affects marginalized populations in the United States²⁻⁵. Evidence suggests an increase in new cases and severity of IPV, particularly for marginalized groups, during the COVID-19 pandemic⁶ pointing to the need to adapt IPV prevention strategies during shutdowns and other national and global emergencies. Such disparities in the risk of IPV are created and maintained through systemic health and social inequities. To achieve health equity requires addressing root causes (e.g., discrimination and biases in societal values, public policy) that differentially disadvantage groups based on characteristics such as race, ethnicity, gender, and ability, and are often expressed as racism, sexism, and disability discrimination.

For this NOFO, funded recipients are expected to use data to identify populations and environments at differential risk for violence due to inequitable access to conditions needed for health and safety. By increasing equitable access to Social Determinants of Health (SDOH), funded recipients reduce risk factors for and/or increase protective factors against Intimate Partner Violence (IPV). Authorized by the Family Violence and Prevention Services Act (FVPSA), CDC has funded the Domestic Violence Prevention Enhancements and Leadership Through Alliances (DELTA) Program since 2002. The DELTA program funds State Domestic Violence Coalitions (SDVCs) to implement statewide IPV prevention efforts and assist and fund local communities to do the same.

Different iterations of DELTA have focused funding on increasing organizational capacity, implementation, and evaluation of IPV primary prevention activities, strategic data-driven planning and evaluation, and sustainability. This NOFO will require SDVCs to address SDoH at the community and societal levels of the Social Ecological Model (SEM) through the collection and use of data to inform the IPV prevention strategies and adaptations to better fit state- and community-level context (including adaptations necessary during a pandemic). In addition, the NOFO will require SDVCs to 1) use data to select and implement IPV primary prevention strategies to promote racial, gender, and health equity at the local and state levels, 2) partner with rural communities and/or indigenous communities and populations, and 3) develop or enhance State and Community Action Plans that demonstrates how each activity implemented will work comprehensively in selected communities to address SDoH related to IPV.

This NOFO includes two funding options. Category A recipients will have existing high capacity to implement primary prevention strategies and will build upon existing efforts. Category B recipients will focus on gathering publicly available data to better understand gaps in IPV prevention resources, building capacity to implement and evaluate IPV primary prevention in their state and selected communities, and using evaluation data for quality improvement.

Using recipients' annually submitted progress, outcomes, performance indicators and related measures, CDC will aggregate and synthesize those data to inform the CDC evaluation of the NOFO initiative across all recipients to capture program impact at the community and state levels as well as performance monitoring and continuous program improvement. The CDC evaluation will inform and highlight the progress and achievements that recipients are making toward reducing IPV using community and societal level primary prevention approaches in addressing risk and protective factors.

A2. Purpose and Use of the Information Collection

The purpose of the information collection effort is to collect DELTA AHEAD program recipient data related to implementation, program evaluation, and performance monitoring. This data collection is necessary to ensure that programs are progressing toward achievement of their stated goals and objectives, as well as consistently demonstrating efficient and appropriate use of federal funds. CDC will use the information collected to further understand the facilitators, barriers, and critical factors to implementing specific violence prevention strategies and conducting related program evaluation activities. Data collected will also be used to inform CDC's training and technical assistance, program improvement, progress toward NOFO goals, and the development of future funding opportunities.

Data collection is designed to address the following key program evaluation questions:

1. To what extent have funded Coalitions accomplished the short term and intermediate outcomes in the NOFO Logic Model?
2. To what extent do recipients effectively implement community and societal level primary prevention programs and policy efforts during the project period?
3. To what extent was there an increase in statewide capacity to implement, evaluate and sustain community and societal primary prevention of IPV?
4. What factors are critical to implementing and sustaining community and societal level primary prevention approach to prevent IPV?

Information will be collected through the following instruments:

Att. 3a, 3b Annual Performance Report (APR) Tool - Project Lead

Recipients will enter APR data into the DVP Partners Portal, a web-based system that collects performance data from funded recipients annually.

The data are used for program monitoring and evaluation purposes and submitted to the Grants Management Module of Grant Solutions to serve as the official record of Annual Performance Report and continuation application. Each of the

project leads from the 13 SDVCs will complete the APR for each budget period of years 1 through 4.

CDC will use the information to be collected to do the following:

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

Att. 4a Instrument and Protocol: Key Informant Interview (KII) - Project Lead

Virtual web-based interviews will be conducted with key personnel from each State Domestic Violence Coalition. The qualitative data collected will provide valuable insight into the facilitators and barriers to implementing the State Action Plan, implementing prevention efforts, and coordinating program evaluation and implementation activities. Interviews will be conducted with one project lead from each of the 13 SDVCs twice over the project period. Interview guide questions are tailored to focus on topics that are most relevant to the project lead role.

Att. 4b Instrument and Protocol: Key Informant Interview (KII) - Evaluator

Virtual web-based interviews will be conducted with key personnel from each State Domestic Violence Coalition. The qualitative data collected will provide valuable insight into the role of the evaluators on the team and the factors that facilitate or hinder evaluation of the program. Interviews will be conducted with one evaluator from each of the 13 SDVCs twice over the project period. Interview guide questions are tailored to focus on topics that are most relevant to the evaluator role.

Att. 5a, b Instrument and Protocol: Prevention Infrastructure Assessment (PIA)

The primary contact at each Category B SDVC will report information about their infrastructure and capacity to implement primary prevention at the community and societal level using the Prevention Infrastructure Assessment. The

assessment will be conducted via a web-based survey in years 1, 3, and 5. The tool assesses change in prioritization, resources, and capacity among the SDVCs. CDC will use the data from the PIA Survey to tailor technical assistance and training for recipients and to track changes in infrastructure over the project period. The information collection will also allow CDC to measure the aggregate increase in support for and resources devoted to community and societal level prevention across all 3 Category B recipients.

Att. 6a, b Instrument and Protocol: Health Equity Capacity Assessment (HECA)

A web-based survey will collect data about capacity to enhance and expand health equity work and activities that address social determinants of health and the inequities that create disproportionate burden of intimate partner violence (IPV). One designated staff member from each of the 10 Category A SDVCs for DELTA AHEAD will complete the assessment. The assessment will be conducted via a web-based survey in years 1, 3, and 5. CDC will use the information collected to understand SDVCs capacity to integrate health equity into their primary prevention efforts. The information will allow CDC to identify areas for additional technical assistance to support SDVCs. The survey instrument is designed to assess progress made in reaching intermediate outcomes related to capacity, prioritization, and resources for impacting health equity through community and societal level primary prevention efforts.

The survey instruments provide a systematic format to collect data consistently across all recipients while allowing narrative responses for site-specific insight and context. The findings will be synthesized and communicated to inform similar prevention efforts implemented by practitioners in other communities and states. Due to the diversity of recipients' infrastructure, capacity, and funding strategy for subrecipients, the tools have been designed in a way that collects consistent information across recipients while allowing the flexibility to account for varying prevention strategies.

There are significant advantages to collecting information with these data collection methods:

- The information collected will provide unique insight into the experiences and capacity of the recipients.
- The mixed methods approach takes advantage of the strengths of both quantitative and qualitative approaches.
- Tailoring the data collection tools to the subgroups of recipients will allow CDC to identify facilitators and barriers, best practices, and areas for improvement for implementing prevention efforts in different contexts.

CDC will use the information collected across all years to understand each recipient's experiences and progress toward NOFO outcomes as well as to identify facilitators and barriers to program implementation. In addition, data collected in project years 3 and 4 will inform adjustments in the type and level of technical assistance provided to recipients to support attainment of the goals of the NOFO. Program evaluation activities allow CDC to identify and disseminate information about successful prevention strategies implemented by recipients. These functions are central to the NCIPC's broad mission of protecting Americans from violence and injury threats. The information collection will allow CDC to monitor the impact of the strategies implemented by the recipients on outcomes related to intimate partner violence prevention. It is also expected to reduce duplication of effort, enhance program impact and maximize the use of federal funds.

Program evaluation is an essential public health function and important for performance monitoring. DELTA AHEAD is a non-research NOFO. Per CDC's programmatic NOFO requirements, data collected for non-research (i.e., programmatic) NOFOs are not population-based samples and are only generalizable to the DELTA recipients. The intention of this data collection is not to make causal inferences. The conclusions drawn from these data may not generalize to the entire country due to differences in the demographics of targeted populations, policies, and implementing agencies. In addition, because this is not a research cooperative agreement, states are not required to implement rigorous research designs that have strong internal validity and produce generalizable knowledge. As such, the information CDC collects may make a strong inference of correlation, but causation cannot be inferred.

The Annual Federal Financial Report (OMB# 0920-1132) is also required to be submitted to OFR separately by recipients. This report is not required, developed, or reviewed by CDC program staff as part of any ICRC evaluation and performance monitoring. It is handled by OFR as part of its grants financial management responsibilities. As such, it is not included as part of this request.

A3. Use of Improved Information Technology and Burden Reduction

Annual Performance Report (APR):

Each recipient is required to complete an APR for each budget period during years 1 through 4 to report on progress toward performance outcomes as described in their logic model and work plan, evaluation results, updates to their work plan, successes, challenges, experience receiving program support from the CDC to overcome challenges, and other administrative reporting. While the APR is a federal oversight requirement by the CDC and it serves as a non-competing

continuation application, the CDC will use some of the data provided for program evaluation.

The use of the DVP Partners Portal facilitates several advantages:

- This user-friendly online interface requires little training and will be easy and intuitive for recipients to use to enter data for the information collection.
- Standard data elements, definitions, and specifications at all levels improve the quality and comparability of information that recipients submit and enhance the consistency of reports to examine information across recipients.
- The structure of the data collection in DVP Partners Portal is flexible such that different recipients are still able to capture and report information relevant to their program context and structure.
- The ability to generate reports directly from the system, which allows recipients to fulfill their annual reporting obligations efficiently by submitting necessary information for both progress reports and continuation applications into the system once.
- Recipients will be able to generate a PDF report that can be uploaded to Grant Solutions to satisfy funding annual reporting and non-competing continuation application requirements.
- The ability to carry information and populate from one reporting period to the next increases the efficiency of data entry, reduces errors and redundancies, and therefore increases the quality and reliability of information that recipients submit each year.

Key Informant Interviews:

Data will be collected via virtual web-based interviews. Using qualitative data collection methods will help solicit rich data on how recipients implemented activities. CDC program evaluators will employ qualitative methodological strategies such as “member checking” after each interview has been completed and synthesized, allowing for the interviewee to review their responses and confirm they reflect the actual content from the interview.

The interview protocol and guides are designed to collect the minimum information necessary for the purposes of this project. Additional probes and prompts are included to aid the interviewers with clarifying and elaborating on the main questions.

Health Equity Capacity Assessment and Prevention Infrastructure Assessment:

Surveys will be conducted online using a secure web-based survey engine. The automated nature of the information collection greatly increases the efficiency of data collection over standard paper-and-pencil data collection methods given

the geographic diversity of the participants. The web-based survey will contribute to data quality as built-in prompts and skip patterns will ensure only relevant questions are presented to respondents.

A4. Efforts to Identify Duplication and Use of Similar Information

Since CDC is the only federal agency providing funding for SDVCs to conduct community and societal level IPV primary prevention work by emphasizing prevention of first-time perpetration, the information collected from DELTA AHEAD recipients is not available from other sources and is specific to the DELTA AHEAD Program. As CDC's primary IPV prevention initiative, DELTA AHEAD occupies a unique niche within the larger scope of Health and Human Services' (HHS) violence prevention initiatives. HHS Administration for Children and Families (ACF) makes funding available to territorial domestic and IPV coalitions to focus on victim service provision for individuals. The CDC DELTA AHEAD cooperative agreement, however, can only be used for prevention and cannot be used to fund victim services; therefore, information collected from DELTA AHEAD recipients will not duplicate information collected from ACF recipients.

A5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this data collection.

A6. Consequences of Collecting the Information Less Frequently

The cooperative agreement requires the annual progress report as well as data collection activities necessary for the monitoring and evaluation of the programs' implementation and outcomes. This request is for progress monitoring information to be collected annually for the APR(Att. 3a and 3b).

Key Informant Interviews will be conducted once within the first three years of the five-year project period for both project leads and lead evaluators.

Prevention Infrastructure Assessment will be collected during years 1, and 3 for Coalitions funded as Category B. The Health Equity Capacity Assessment will be collected during years 1, and 3 for Coalitions Funded as Category A. Category A Coalitions are higher capacity and Category B are coalitions that had never received funding before.

Less frequent reporting would undermine accountability efforts at all levels and negatively affect monitoring and evaluation of recipient progress. If less frequent or no data are collected, CDC will be unable to:

- Evaluate impact and changes of the DELTA AHEAD program over the project period
- Assess the barriers, facilitators, and critical factors to evaluate and implement primary prevention efforts identified by DELTA AHEAD recipients
- Identify areas for improvement and additional technical assistance by CDC to help recipients achieve the goals outlined in the NOFO for DELTA AHEAD in the remaining funding period
- Develop an in-depth understanding of how national, state, and local approaches can be coordinated and implemented to prevent primary perpetration of IPV
- Respond in a timely manner to inquiries, such as Congressional requests mandated by the authorizing legislation.

A7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This request fully complies with the regulation 5 CFR 1320.5.

A8. Comments in Response to the FRN and Efforts to Consult Outside the Agency

A.8.a) Federal Register Notice

A 60-day Federal Register Notice was published in the Federal Register on October 17, 2022, vol. 87, No. 199, pp. 62859-62860 (Attachment 2). For this notice CDC received and responded to four non substantive comments (Attachment 2a).

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

No outside consultations will occur during the DELTA AHEAD cooperative agreement funding period. The evaluation questions for assessing the overall program were identified by NCIPC and further refined by feedback and lessons learned from previous iterations of DELTA and other grant programs inside the Center targeting IPV prevention and working with SDVCs.

CDC staff and contractors designed the information collection instruments and DVP Partners Portal. Data elements were informed by annual progress reports of previous and other existing DVP programs. Consultations resulted in streamlining of questions for improved reporting.

The following individuals were consulted in the development of the data elements.

Phyllis Ottley, PhD, Associate Director of Program
404-498-1613
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A9. Explanation of Any Payment or Gift to Respondents

Respondents will not receive payments or gifts for providing information.

A10. Protection of the Privacy and Confidentiality of Information Provided by Respondent

The CDC Office of the Chief Information Officer has determined that the Privacy Act does not apply to this information collection request. The DELTA program annual progress report forms are housed within the Partner's Portal web-based system. The Partner's Portal system has a current Authorization to Operate. The Privacy Impact Assessment (PIA) for the system is attached (Attachment 8).

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

Respondents for data collection are DELTA AHEAD cooperative agreement recipients (SDVCs and local partners) or their designated personnel. No sensitive information or personal contact information will be collected. Each measure includes a section at the beginning to explain to respondents the purpose of the data collection, how data is stored and protected, and how data will be reported in aggregate form without identifying specific coalitions.

Survey data collected via separate web-based system from the Partners Portal, interview data will be collected via web-based video platform. Interview recordings will be kept until data analysis has been completed, and interview summary notes will be kept through the end of the DELTA AHEAD funding period (February 2028) plus two additional years for analysis purposes. All data will be discarded in February 2030. Data will be maintained in a secure, password-protected system and accessed only by relevant CDC personnel working on the

evaluation. All data will be reported in aggregate form, with no identifying information included. Recipients will provide programmatic information only and will not include any personally identifying information. All procedures have been developed, in accordance with federal, state, and local guidelines, to ensure that the rights and privacy of key recipients' program staff (e.g., program director) will be protected and maintained. While consent is not required to report aggregate data, recipients will be notified of intent to use aggregate data and approval will be obtained if data specific to any particular coalition are used for publications, reports, or other publicly disseminated information.

CDC will file and retrieve IIF by names of the organizations who are DELTA AHEAD funding recipients. CDC will maintain IIF in the information technology systems (i.e., Partners Portal and CDC Microsoft OneDrive Excel datasets) utilized to monitor progress and outcomes. The information and passwords to these IT systems kept by CDC are private and secure to the extent permitted by law. Administrators cannot view user password credentials.

A11. Institutional Review Board (IRB) and Justification for Sensitive Questions

IRB Approval

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

Sensitive Questions

The proposed tools do not collect sensitive information.

A12. Estimates of Annualized Burden Hours and Costs

A.12.a) Annual Burden Hours

The estimate for annual burden hours is based on actual hour burden for projects using similar types of interviews and surveys.

Annual Performance Report (APR) Tool (Att. 3a, 3b)– Project leads will complete the Annual Performance Report (APR) annually for years 1-3. The APR tool is expected to take an average of 10 hours each year per APR report per respondent because it will include time for reviewing instructions, searching existing data sources, gathering and maintaining data needed for reporting, and completing and reviewing the collection of information.

Instrument and Protocol: Key Informant Interview (KII) (Att. 4a, 4b) -

Respondents for Key Informant Interviews will be project leads and program evaluation leads. Key Informant Interviews will be conducted once during the years 1-3. The Key Informant Interview protocol is designed to take 30 minutes for each interview conducted with a project lead or evaluator

Prevention Infrastructure Assessment (Att. 5a, 5b) -Project Leads or Evaluators will complete the web-based Prevention Infrastructure Assessment twice - in years 1 and 3. The majority of questions will be close-ended using a multiple-choice format, with some open-ended questions. Each survey takes 30 minutes to complete.

Health Equity Capacity Assessment (Att. 6a, 6b) - Each DELTA AHEAD program recipient funded under Category A will complete the web-based Health Equity Capacity Assessment twice - in years 1 and 3. The survey questions are primarily close-ended multiple-choice questions, with some open-ended questions. Each assessment takes 30 minutes to complete.

Table A12.-A. Estimated Annualized Burden Hours

Type of respondents	Form Name	No. of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
DELTA AHEAD State Domestic Violence Coalition (SDVC) Project Leads	Annual Performance Report (Att. 3a)	13	1	10	130
	Key Informant Interview - Project Lead (Att. 4a)	13	1	1	13
DELTA AHEAD SDVC Evaluators	Key Informant Interview Evaluator (Att. 4b)	13	1	1	13
DELTA AHEAD SDVC staff -	Prevention Infrastructure	3	1	30/60	1.5

Category B Recipients	ture Assessment (Att. 5a)				
DELTA AHEAD SDVC Staff – Category A Recipients	Health Equity Capacity Assessment (Att. 6a)	10	1	30/60	5
Total					163

A.12.b) Annual Burden Costs

For each of the DELTA AHEAD program recipients, the project lead will complete the Annual Performance Report, the project lead and evaluator will each complete the Key Informant Interviews, and a project lead or evaluator will complete the Prevention Infrastructure Assessment survey. The average annual wage for program leads, program evaluators, and similar non-profit or public sector positions is estimated to be \$62,441 per year. The average hourly wage for these positions is \$30.02 as estimated by the Bureau of Labor Statistics (<https://www.bls.gov/oes/current/999001.htm#00-0000>)

The estimated annualized burden cost to respondents is summarized in Table A12.-B.

Table A12.-B. Estimated Annualized Burden Cost

Type of respondents	Form Name	Total burden (in hours)	Hourly wage rate	Total respondent cost
DELTA AHEAD State Domestic Violence Coalition (SDVC) Project Leads	Annual Performance Report (Years 1-4) (Att. 3a; 3b)	130	\$30.02	\$3,902.6
DELTA AHEAD SDVC Project Leads	Key Informant Interview – Project Lead (Att. 4a)	13	\$30.02	\$390.26

DELTA AHEAD SDVC Evaluators	Key Informant Interview - Evaluator (Att. 4b)	13	\$30.02	\$390.26
DELTA AHEAD Category B SDVC staff	Prevention Infrastructure Assessment (Att. 5a)	1.5	\$30.02	\$45
DELTA AHEAD Category A SDVC staff	Health Equity Capacity Assessment (Att. 6a)	5	\$30.02	\$150.1
Average Per Year				\$4,878.2

A13. Estimates of Other Total Annual Cost Burden to Respondents and Record Keepers

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

A14. Annualized Cost to the Federal Government

The annual costs to the government include personnel costs of federal employees involved in the program evaluation. The average annualized cost to the federal government is \$38,832 as summarized in Table A.14-A. There are no costs associated with contractors, website maintenance, licensing, or travel.

Table A14.-A. Estimated Annualized Federal Government Cost Distribution

Type of Cost	Description of Services	Annualized Cost
CDC Personnel	20% of GS-13 Behavioral/Health Scientist at \$97,078/year for data collection design, collection, analysis, and reporting	\$19,416
	20% of GS-13 Health Informatician at \$97,078 for data system design, development, and maintenance	\$19,416
Total		\$38,832

A15. Explanation for Program Changes or Adjustments

This is a new collection of data.

A16. Plans for Tabulation and Publication and Project Time Schedule

CDC will use statistical methods for analyzing information. CDC will use statistical methods for analyzing information. Quantitative data will be analyzed using descriptive and summary statistics. Qualitative data will be analyzed through thematic analysis to define priority area topics and emerging themes. For example, the difference between baseline rates and achieved rates on indicators will be documented and analyzed. Furthermore, the data collected in the mixed methods design will allow for CDC staff to evaluate implementation and provide technical assistance to awardees after an internal qualitative review has been completed.

A. Publication plan

Information collected by the awardees will be reported in internal CDC documents and shared with state-based programs. Raw data will not be made public as it is used for internal program evaluation to assess recipient progress and outcomes. Any reported data will be provided in aggregate form. Publication in a peer-reviewed scientific journal will be determined post-data collection.

B. Time schedule for the entire project

The cooperative agreement cycle is five years. OMB approval is being requested for three years. Per the NOFO, data collection must begin 3 months post award with the Rubric. Other collections will occur per the NOFO requirements once a year due 120 days before the end of the budget period. Data collection began with the awarding of the grants and will continue throughout the funding cycle.

Table B.16. Estimated Time Schedule for Project Activities

Activity	Timeline
Annual data collection as described in Section A.2 and A.12	Ongoing once annually 1-60 months after OMB approval.
Data cleaning and analysis	Ongoing annually 4-60 months after OMB approval.
Reporting of evaluation data and findings to recipients and stakeholders	Ongoing annually 8-60 months after OMB approval.

C. Analysis plan

CDC will use statistical methods for analyzing information. For example, the difference between baseline rates and achieved rates on indicators will be documented and analyzed. Furthermore, the data collected in the mixed methods design will allow for CDC staff to evaluate implementation and provide technical assistance to awardees after an internal qualitative review has been completed.

A17. Reason(s) Display of OMB Expiration Date is Inappropriate

The display of the OMB expiration date is appropriate.

A18. Exceptions to Certification for Paperwork Reduction Act Submission

There are no exceptions to the certification.

REFERENCES

1. Smith SG, Zhang X, Basile KC, et al. The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 Data Brief – Updated Release. Atlanta, GA National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2018.
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