

**Capacity Building Assistance Program:
Data Management, Monitoring, and Evaluation**

OMB No. 0920-1322

Supporting Statement - Section A

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Table of Contents

Section

A. Justification

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

Exhibits

Table 12A Estimates of Annualized Burden Hours

Table 12B Estimated Annualized Burden Costs to Respondents

Table 14 Estimated Annualized Cost to the Federal Government

Table 16 Project Time Schedule

LIST OF ATTACHMENTS

Attachment 1: Authorizing Legislation

Attachment 2: 60-Day FRN

Attachment 3: Learning Group Registration-Word version

Attachment 4: Learning Group Registration-Screenshots

Attachment 5: Post-Training Evaluation Introductory Email

Attachment 6: Post-Training Evaluation-Word version

Attachment 7: Post-Training Evaluation-Screenshots

Attachment 8: Post-Technical Assistance Evaluation Introductory Email

Attachment 9: Post-Technical Assistance Evaluation-Word version

Attachment 10: Post-Technical Assistance Evaluation-Screenshots

Attachment 11: Training and Technical Assistance Follow-up Survey Introductory Email

Attachment 12: Training and Technical Assistance Follow-up Survey-Word version

Attachment 13: Training and Technical Assistance Follow-up Survey-Screenshots

Attachment 14: Training and Technical Assistance Follow-up Survey Reminder Email

Attachment 15: Training and Technical Assistance Follow-up Telephone Script for non-responders

Attachment 16: Security Controls

Attachment 17: Project Determination Form

Attachment 18: Privacy Impact Assessment

- Goal of the study: The purpose of this project is to evaluate the CDC cooperative agreement program entitled CDC-RFA-PS19-1904: Capacity Building Assistance (CBA) for High Impact HIV Prevention Program Integration. Through PS19-1904, CDC funds the CBA Provider Network (CPN) to deliver capacity building services to CDC-funded health departments and community-based organizations (CBOs). The goals of the Data Management, Monitoring, and Evaluation project are to: 1) improve the evaluation design and methods used to capture PS19-1904 outcomes; and 2) increase access and use of PS19-1904 data for continuous quality improvement and performance reporting.
- Intended use of the resulting data: The collection of this data addresses knowledge gaps regarding: 1) HIV prevention capacity building training and technical assistance (TA) outcomes for health departments and CBOs; and 2) emerging HIV prevention capacity building training and TA needs among health departments and CBOs. The information will be used to provide the CBA providers with critical feedback on the quality of their work and inform the Government on how to direct CBA program improvement. Outcome data collected and analyzed by this project increase accountability and improve program planning. Findings that are disseminated as a result of work performed on this project provides transparency and promotes collaboration.
- Methods to be used to collect: There are four data collection tools. For each tool, respondents will provide information electronically through a web-based application. For one of the tools, the Training and Technical Assistance Follow-up Survey, respondents will have the option to complete surveys via a telephone interview (if the respondent does not complete the online survey within 7 days).
- The subpopulation to be studied: The information will be collected from recipients of CBA services (i.e., training and TA) who are health professionals and program managers from CBOs and health departments involved in HIV-prevention service delivery and funded directly or indirectly by the CDC.
- How data will be analyzed: Data analysis will be conducted weekly, monthly, semi-annually, and annually in accordance with the Data Management and Analysis Plan (DMAP). The DMAP will outline the descriptive and inferential statistics that will be conducted given the distribution of the data and the type of variable. Statistical tests that explore association, regression, and comparisons of means are anticipated.

Section A. JUSTIFICATION

1. Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC), National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Division of HIV Prevention (DHP) requests OMB approval for reinstatement with change of 3 years of this information collection request (ICR) entitled, "Capacity Building Assistance Program: Data Management, Monitoring, and Evaluation".

Data will be collected over a three-year period from community-based organizations (CBOs) and health departments involved in HIV-prevention service delivery and funded directly or indirectly by the CDC. Their positions include (but are not limited to) HIV educator; clinical supervisor; HIV-prevention specialist; clinician; outreach worker; case manager director; program coordinator; program manager; disease intervention specialist; partner services provider; physicians; nurses; health educators. This is a reinstatement with change data collection.

This information collection is authorized by Section 301 of the Public Health Service Act (42 U.S.C. Sec. 792[295k] (a) (**Attachment 1: Authorizing Legislation**)). This information collection falls under the essential public health service of 1) informing, educating, and empowering people about health issues; 2) mobilizing community partnerships to identify and solve health problems; 3) linking people to needed personal health services and ensuring the provision of health care when otherwise unavailable; and 4) ensuring a competent public health and personal health care workforce.

The latest HIV incidence estimates show that national prevention efforts are continuing to move in the right direction, but substantial disparities exist.[1]. Black/African American persons and Hispanic/Latino persons are especially affected by longstanding social and economic factors that contribute to health inequities.[1] An estimated 1.2 million persons in the United States are living with diagnosed and undiagnosed HIV at the end of 2022.[1] The Division of HIV Prevention (DHP) provides funds for capacity building assistance (CBA) services in which considerable resources are allocated to serve CBOs and health departments for HIV-prevention services nationwide. DHP provides national leadership and support for CBA to ensure that DHP's funding recipients have the knowledge, skills, and technology to effectively and efficiently conduct HIV prevention across the United States and its territories. CBA means the provision of free (not-for-fee) information, training, technical assistance

(TA), and technology transfer to individuals, organizations, and communities to strengthen capacity to optimally plan, integrate, implement, and sustain HIV-prevention programs and services. CBA should improve the performance of the HIV-prevention workforce by building individual competencies and technical expertise, strengthening organizational capacities, and enabling supportive structural environments. The CBA program aligns with the goals of the National HIV/AIDS Strategy (NHAS) and CDC's High-Impact HIV Prevention (HIP) and Ending the HIV Epidemic (EHE) approaches by supporting CDC-funded programs in the implementation, monitoring, and evaluation of evidence-based, HIV-prevention interventions; building organizational infrastructure; and community mobilization to decrease stigma and increase HIV testing in high-risk communities [2-3]. Prevention efforts are persistently challenged by too few people with HIV who are aware of their infection; many people with HIV who do not receive ongoing treatment; diverse populations in need of equal access to prevention information and tools; social and economic inequities that promote disparities in HIV rates; and limited resources for HIV prevention.

DHP has funded CBA services since 1999. For the past eight years, DHP has been conducting a systematic assessment of CBA services to determine whether CBA customers are satisfied with CBA services and assess whether CBA services resulted in improved HIV-prevention practice (OMB Control No. 0920-1099; Expiration Date 04/30/2020 and OMB Control No. 0920-1322; Expiration Date 02/29/2024). Results from that evaluation revealed high levels of satisfaction, but there is limited information about the implementation and impact of activities taught by CBA-service providers intended for HIV prevention and care. On April 1, 2019, CDC awarded \$120 million over five years to train and strengthen capacity-building assistance organizations and ensure that on-the-ground prevention programs and staff have the skills, information, and organizational support they need to best serve organizations serving individuals living with and at high risk for HIV in their communities. This data collection has been enhanced with a new evaluation plan to fit the new CBA-service providers, incorporate lessons learned, and address the present goals of DHP. The survey tools and how the data are collected are different, but the tools and processes will continue assessing service delivery, identifying barriers, and determining status of implementation. This evaluation is intended to assess whether CBA services facilitate the implementation of interventions that (1) reduce new HIV infections; (2) increase access to care for people with HIV; (3) improve health outcomes and reduce mortality for people with HIV; and (4) reduce HIV-related disparities.

2. Purpose and Use of the Information Collection

The purpose of this information collection is to evaluate the CDC cooperative agreement program entitled CDC-RFA-PS19-1904: Capacity Building Assistance (CBA) for High Impact HIV Prevention Program Integration. Specifically, this information collection will assess how well the DHP's CBA program meets the capacity building needs of programs directly and indirectly funded by CDC to provide HIV prevention services. This information collection will help us answer questions such as:

1. How can CBA services (i.e., course design and delivery, additional needs) be improved?
2. How have CBA services been applied to improve HIV-prevention activities (i.e., quantity and type of interventions/public health strategies implemented, barriers to implementation, additional capacity building needs)?
3. How do CBA services affect CBA recipients' HIV-prevention service delivery (i.e., meeting or improving achievement of CDC performance indicators or workplan objectives)?

The information will be collected from recipients of CBA services (i.e., training and TA) who are health professionals involved in HIV-prevention service delivery. Their positions include (but are not limited to) HIV educator; clinical supervisor; HIV-prevention specialist; clinician; outreach worker; case manager; director; program coordinator; program manager; disease intervention specialist; partner services provider; physicians; nurses; and health educators.

DHP is committed to continuous quality improvement of its CBA services and products. CDC will use the data to monitor and evaluate performance of CBA providers funded by DHP.

This project's monitoring and evaluation relies primarily on quantitative methods of data collection. The data collection system consists of four instruments administered to the recipients of CBA services (i.e., training and TA) and select program managers. Recipients of CBA services include agency staff from CBOs and health departments that are directly or indirectly funded by the CDC. TA services are provided by request. Classroom trainings are also provided by request. Online or eLearning trainings are available on-demand. Some CBA recipients receive training only, TA only, or both.

All data collection tools have been pilot tested by public health experts and professionals. Specifically, the Post-Training Evaluation (PTE) and Post-Technical Assistance Evaluation (PTAE) were pilot tested by seven individuals and the Training and Technical Assistance Follow-up Survey (TTAFS) was pilot tested by six individuals. Feedback from this group was used to refine questions as needed, ensure accurate programming and skip patterns, and establish the estimated time required to complete the information collection instruments. A brief description of each data collection instrument is provided below.

When an individual requests training, they complete the following data collection instrument:

Learning Group Registration (att 3)

- a. **Who responds:** Training recipients
- b. **Where will the instrument be hosted:** Web-based; CDC TRAIN¹
- c. **When will recipients respond:** Upon initial learning group registration
- d. **Will there be follow-up via email or phone:** No
- e. **Instrument Description:** The Learning Group Registration Form collects demographic information about training recipients' including: 1) business contact information (e.g., email and telephone number); 2) primary [employment] functional role; 3) employment setting; and 4) programmatic and population areas of focus. The CDC TRAIN system will store the information for use during future training registrations. The demographic information can be updated by the training recipient as needed.
- f. **Attachments:**
 - Attachment 3: Learning Group Registration-Word version
 - Attachment 4: Learning Group Registration-Screenshots

After an online or in-person training event is completed, training recipients complete the following data collection instrument:

Post-Training Evaluation (PTE) (att 6)

- a. **Who responds:** Training recipients

¹ CDC TRAIN (<https://www.train.org/cdctrain/welcome>), which is a password-protected online portal that allows users to access over 1,000 courses developed by CDC programs, grantees, and funded partners.

- b. Where will the instrument be hosted:** Web-based; CBA Tracking System²
- c. When will recipients respond:** Immediately following the completion of a training event
- d. Will there be follow-up via email or phone:** No
- e. Instrument Description:** The PTE is designed to collect information about training recipients' satisfaction with the training delivery method and course content, their organization's implementation status, and additional training or TA needs.
- f. Attachments:**
 - Attachment 5: Post-Training Evaluation Introductory Email
 - Attachment 6: Post-Training Evaluation-Word version
 - Attachment 7: Post-Training Evaluation-Screenshots

When a CBA provider indicates completion of a TA event in the CBA Tracking System, a link to the following instrument is emailed to TA recipients:

Post-Technical Assistance Evaluation (PTAE) (att 9)

- a. Who responds:** TA recipients
- b. Where will the instrument be hosted:** Web-based; CBA Tracking System
- c. When will recipients respond:** Immediately following the completion of a TA event
- d. Will there be follow-up via email or phone:** No
- e. Instrument Description:** The purpose of this instrument is to obtain feedback on TA-event delivery from CBA recipients. It assesses TA recipients' satisfaction with CBA providers (e.g., provider's knowledge, provider's responsiveness, provider's communication), suggestions for improvement of TA services, barriers to utilizing the TA received, and additional TA needs.
- f. Attachments:**
 - Attachment 8: Post-TA Evaluation Introductory Email
 - Attachment 9: Post-TA Evaluation-Word version
 - Attachment 10: Post-TA Evaluation-Screenshots.

To follow-up on training implementation and TA utilization, a link to the following data collection instrument is emailed:

Training and TA Follow-up Survey (TTAFS) (att 12)

² The Post-Training Evaluation, Post-TA Evaluation, and Training and TA Follow-up Survey will be hosted within the CBA Tracking System application. This application was developed by DHP and is the portal currently used by CBA recipients to request training and TA. The system will send the email invitation to complete the Post-Training Evaluation, Post-TA Evaluation, and Training and TA Follow-up Survey, as applicable.

- a. **Who responds:** Training and TA recipients' program managers
- b. **Where will the instrument be hosted:** Web-based; CBA Tracking System
- c. **When will recipients respond:** Every 6 months for Training and TA administered in that 6-month period
- d. **Will there be follow-up via email or phone:** Yes, via phone and email
- e. **Procedure for follow-up:** 7 business days after the invitation email for the Training and TA Follow-up Survey is sent to program managers, a reminder to complete the survey will be emailed to respondents who have not completed the online instruments. Seven business days after the reminder emails are sent, a member of the program evaluation team will contact the non-responders by telephone to provide another survey reminder and offer a computer assisted telephone interview (CATI) to complete the survey. The contractor will use a telephone script to complete the telephone version of the survey. Given the typically low response rate to online survey instruments, this telephone follow-up strategy increases the responses to the survey.
- f. **Instrument Description:** The TTAFS seeks feedback about how the training and/or TA that was provided impacted their organization. Respondents are asked to provide information about the barriers to implementing an intervention and about additional TA that is needed to facilitate implementation of interventions and/or public health strategies.
- g. **Sampling strategy:** All program managers that have staff who attended a training or TA event will receive a TTAFS.
- h. **Attachments:**
 - Attachment 11: Training and TA Follow-up Survey Introductory Email
 - Attachment 12: Training and TA Follow-up Survey-Word version
 - Attachment 13: Training and TA Follow-up Survey-Screenshots
 - Attachment 14: Training and TA Follow-up Survey Reminder Email
 - Attachment 15: Training and TA Follow-up Survey Telephone Script for non-responders.

The information collection system consists of four instruments. There are two instruments associated with training, one instrument associated with TA, and one instrument associated with follow-up for both training and TA.

- Training Instruments
 - o Learning Group Registration (att 3 and 4)
 - o Post-Training Evaluation (att 5, 6, and 7)
- TA Instrument
 - o Post-Technical Assistance Evaluation (att 8, 9, and 10)
- Follow-up Instrument
 - o Training and TA Follow-up Survey (att 11, 12, 13, 14, and 15).

We chose web-based administration of the instruments to facilitate ease of completion for the respondents. The type of information collected with each instrument is described below.

The **Learning Group Registration (att 3)** consists of 25 questions intended to gather demographic and employment setting information from training recipients. This data collection provides CDC with information to determine whether the CBA providers are reaching their target audiences in terms of provider type; the types of organizations in which training recipients work; the focus of their work; and the population groups and geographic areas served. In addition, business contact information is collected for the follow-up surveys.

The **Post-Training Evaluation (att 6)** gathers information from training recipients about service design and delivery, knowledge change, implementation status, and identification of additional TA needs. Questions are multiple response, Likert scale, and open-ended. The length of this survey is 21 questions.

The **Post-Technical Assistance Evaluation (att 9)** consists of 8 questions that gather information from recipients of CBA TA about service delivery, usefulness of TA, and identification of additional TA needs. Questions are multiple response, Likert scale, and open-ended.

The **Training and TA Follow-up Survey (att 12)** gathers information from CBA training recipients' program managers about both training and TA. Questions will focus on status of implementation, barriers to implementation, and how to access additional TA. Questions include multiple response, Likert scale, and open-ended. The length of this survey is 19 questions.

The Training and TA Follow-up Survey instrument will be administered every 6 months to collect data about the group of training and TA events under a program manager's purview. The justification for this is that training and TA needs change over

time. With this instrument, CDC will have ongoing feedback regarding the extent to which training and TA facilitate implementation, organization's barriers to implementation, and additional training and/or TA needs that can be addressed by CDC.

3. Use of Improved Information Technology and Burden Reduction

All responses will be collected using web-based instruments, which will reduce overall burden on participants who complete and submit their responses. These instruments were designed to collect the minimum information necessary for the purposes of this project. For example, skip patterns are included on all instruments so that only necessary data are collected. For individuals who do not respond to the Training and TA Follow-up Survey (att 12), they will be added to a non-responder follow-up list. The project team will follow-up with individuals on this list and offer them the option to complete the survey via web or using Computer Assisted Telephone Interview (CATI). Further, the Learning Group Registration (att 3) instrument will only need to be completed once but can be revised if a respondent's business-related information changes over time.

4. Efforts to Identify Duplication and Use of Similar Information

The information being collected is specific to DHP's CBA program, CBA-service delivery, and CBA providers. This data collection represents the Branch's continued effort to conduct program evaluation and assess outcomes for CBA services provided by its CBA providers under its CBA program. Based on lessons learned from the previous two data collection periods, DHP has fully revised the instruments to also focus on implementation efforts and long-term sustainability of capacity-building efforts.

There is currently no information available that can substitute the data collection instruments and provide CBA program improvement information. This data collection builds on the data under earlier, separate OMB packages (OMB Control No. 0920-0995; Exp. Date: 10/31/2016 and OMB Control No. 0920-1099; Expiration Date 04/30/2020; OMB Control No. 0920-1099; Expiration Date 02/29/2024).

5. Impact on Small Businesses or Other Small Entities

This data collection will not involve small businesses or other small entities.

6. Consequences of Collecting the Information Less Frequently

This request has a tiered approach for how many times information is collected:

- The Learning Group Registration (att 3) is a one-time information collection and is updated by the respondent as needed.
- The Post-Training Evaluation (att 6) and the Post-TA Evaluation (att 9) is a one-time information collection that is training course or TA event specific.
- The Training and TA Follow-up Survey (att 12) is administered once every six months and combines the training events and TA episodes that occurred within that six-month period. This data collection will be with program managers whose staff received CBA during the six-month period.

Based on prior year estimates, each CBA service recipient may receive an average of two training and two TA events per year. Program Managers will respond to two data collections per year (one every six months) for the Training and TA Follow-up Survey (att 12). There are no legal obstacles to reduce the burden.

In the absence of this assessment, DHP's ability to make a timely and essential mid-course correction to better meet the needs of its consumers will be greatly impaired. Specifically, this information collection will be used to:

- Identify and respond to public health program performance issues identified through feedback from health departments and CBOs;
- Identify and respond to new HIV prevention training and technical assistance needs of health departments and CBOs;
- Provide a timely and accurate response to federal, state, and local agencies and other stakeholders seeking information about the types and quality of CBA services delivered.

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

This request fully complies with the regulation 5 CFR 1320.5.

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

A. The 60-day federal register notice to solicit public comments was published in the Federal Register on Monday, February 5, 2024, pages 7718, Vol. 89, Number 24 (**Attachment 2**). No public comments were received.

B. No consultations outside CDC occurred.

9. Explanation of Any Payment or Gift to Respondents

CDC will not provide payments or gifts to respondents.

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

The Privacy Officer for CDC / ATSDR has assessed this package for applicability of 5 U.S.C. § 552a (att 18). The Privacy Act is applicable because PII is being collected under this CDC-funded activity. The Privacy Act System of Records Notice (SORN) #09-20-0161 "Records of Health Professionals in Disease Prevention and Control Training Programs" is being used to cover this collection. Employees of health departments and CBOs will be contacted based on the business contact information they provide and speaking from their official roles. Participation in the information collection activities is voluntary for respondents.

Of the four instruments, the Learning Group Registration is the only tool which collects categories of information in identifiable format (IIF) from individual respondents, including name, work mailing address, work phone numbers, work email address, and organization name. The demographic and identifiable data are needed to complete registration, disseminate the Post-Training Evaluation, and conduct follow-up with program managers. The identifiable data from the Learning Group Registration is entered, stored, and transmitted in a separate database from all the other data collected. A unique identifier will be used on all data collection instruments to enable the linking of data from multiple data collection tools. The unique identifier is randomly assigned by CDC TRAIN. To remove identifiers from the demographic response data, procedures to limit the linkage of the identifiable data to response data will include entering, storing, and transmitting identifiable registration data in one database and the demographic data in another database. The data transmitted to CDC will be in the delinked format described above.

There are several safeguards in place to handle data. Data will be stored and managed based on current CDC/OCIO (Office of the Chief Information Officer) requirements and standards (**Attachment 16**). This includes protecting stored data within the CDC Internet Firewall. Data are stored and managed using current CDC/OCIO requirements and standards, which also includes the process for handling security incidents and the event monitoring and incident response. All administrative controls required by OCIO are validated through a "System Assessment and Authorization" (SA&A) process as conducted by OCIO prior to moving any software application into "Production" on the CDC network.

The system security plan is included in the OCIO SA&A process and the contingency (or backup) plan for this information collection

(as mandated by OCIO) is to manage this information from a pre-determined OCIO approved off-site location.

Files are backed up daily and stored both onsite and offsite in accordance with CDC standards and OCIO guidelines. Contractors who operate and use the system are required to sign confidentiality agreements. All users' access is "role based" and reflects a "need to know" policy established by CDC. Accountability is maintained with a user access log file, which tracks users' access to the system. Records will be retained and destroyed in accordance with the applicable CDC Records Control Schedule as mandated by OCIO.

No electronic media will be used and no IIF data are collected. A non-research determination was made and therefore, IRB review is not required (Attachment 17). This data collection is not considered research based on the description and justification and based on the definition of research as defined by the federal policy for the protection of human subjects (45 CFR 46) (Attachment 17).

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

IRB Approval

Since this is associated with programmatic improvement, it was determined that this did not require (IRB) oversight. A project determination approval was obtained from the Associate Director of Science for NCHHSTP (att 17).

Sensitive Questions

No information will be collected that are of sensitive nature. Respondents are participating in their official capacity as health professionals in CBOs and health departments.

12. Estimates of Annualized Burden Hours and Costs

The estimate for burden hours is based on a pilot test of the information collection instruments by seven public health professionals for the Post-Training Evaluation (att 6) and Post-Technical Assistance Evaluation (att 9), and six public health professionals for the Training and TA Follow-up Survey (att 12). In the pilot test, the average time to complete the instruments, including time for reviewing instructions, gathering needed information and completing the instrument, was approximately 5 minutes for the Learning Group Registration (att 3); 5 minutes for the Post-Training Evaluation (att 6); and 5 minutes for the Post-TA Evaluation (att 9).

Respondents may complete the web-based version of the Training and TA Follow-up Survey (att 12); if they do not respond to the

initial email invitation to complete the survey, they are converted to a non-responder list where they will have the opportunity to complete via web or telephone (i.e., att 15. Training and TA Follow-up Survey Telephone Script for non-responders). Both versions take approximately 18 minutes to complete. We estimate surveying approximately 25% (or 50 of the 189) of potential respondents by phone using the Training and TA Telephone Script (att 15).

The number of respondents is calculated based on an average of the number of health professionals, including doctors, nurses, health educators, and disease intervention specialists, trained by the CBA providers during the years 2016-2023. We estimate 3,800 health professionals will provide one response for the Learning Group Registration (att 3); 3,800 health professionals will provide a response for the Post-Training Evaluation (att 6) for each training episode; 3,650 health professionals will provide a response for the Post-Technical Assistance Evaluation (att 9) for each TA episode; and 189 program managers will provide two responses to the Training and TA Follow-up Survey (att 12) in the web-based or telephone survey per year. The total annualized burden is 1,671 hours. The following table provides a breakdown of the estimated burden:

Table 12A: Estimates of Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
Healthcare Professionals	Learning Group Registration (att 3)	3,800	1	5/60	317
Healthcare Professionals	Post-Training Evaluation (att 6)	3,800	2	5/60	633
Healthcare Professionals	Post-Technical Assistance Evaluation (att 9)	3,650	2	5/60	608

Program Managers	Training and TA Follow-up Survey (att 12)	139	2	18/60	83
Program Managers	Training and TA Telephone Script (att 15)	50	2	18/60	30
Total					1,671

Estimates for the average hourly wage for respondents are based on the Department of Labor National Compensation Survey estimate for management occupations, which include medical and health services managers in state government [4], and community and social service occupations [5]. Based on Department of Labor data, an average hourly wage of \$23.69 is estimated for healthcare professionals and an average hourly wage of \$54.68 is estimated for healthcare program managers. The following table shows estimated burden and cost information.

Table 12B: Estimated Annualized Burden Costs to Respondents

Type of Respondent	Form Name	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
Healthcare Professionals	Learning Group Registration (att 3)	317	\$23.69	\$7,509.73
Healthcare Professionals	Post-Training Evaluation (att 6)	633	\$23.69	\$14,995.77
Healthcare Professionals	Post-Technical Assistance Evaluation (att 9)	608	\$23.69	\$14,403.52
Program Managers	Training and TA Follow-up Survey (att 12)	83	\$54.68	\$4,538.44

Program Managers	Training and TA Telephone Script (att 15)	30	\$54.68	\$1,640.40
Total				\$43,087.86

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

There will be no direct costs to the respondents other than their time to participate in each information collection.

14. Annualized Cost to the Government

The annualized cost to the government is \$844,155. The personnel cost of CDC oversight of the project and contractors will be \$27,468 for the Lead Behavioral Scientist. The cost of the Copial Business Strategists contractors to assist in the preparation of the OMB package; assessment design; instrument development; data collection; quality control; data analysis; and report preparation will be \$718,261. The cost for SeKON Enterprise Inc./Maximus contractor to provide the development and programming for the web-based information collection and data transmission to CDC and SciMetrika will be \$44,226. For a cost of \$54,200, the CDC TRAIN contractor will provide learning group registration and data collection and tracking. Information collection tools were developed by CDC staff. Table 14 provides cost descriptions and outlines how cost estimates were calculated.

Table 14: Estimated Annualized Cost to the Federal Government

Staff (FTE)	Average Hours per Collection	Average Hourly Rate	Average Cost
CDC Lead Behavioral Scientist (GS-14): OMB package preparation; review and oversight of assessment design; instrument development; pilot testing; data collection; quality control; data analysis; and report preparation	400	\$68.67	\$27,468
SeKON Enterprise			\$44,226

Inc./Maximus contractor: Web-based information collection instrument programming, data collection			
Copial Business Strategists: OMB package preparation, evaluation design, instrument development, data collection, quality control, data analysis, and report preparation			\$359,131
CDC TRAIN contractor: training logistics, data collection and tracking.			\$54,200
Estimated Total Cost of Information Collection			\$485,025

15. Explanation for Program Changes or Adjustments

This is a Reinstatement with Change information collection.

This data collection has been enhanced with a new evaluation plan to fit the new CBA-service providers, incorporate lessons learned, and address the present goals of DHP. The survey tools and how the data are collected are different, but the tools and processes will continue assessing service delivery, identifying barriers, and determining status of implementation. This evaluation is intended to assess whether CBA services facilitate the implementation of interventions that (1) reduce new HIV infections; (2) increase access to care for people with HIV; (3) improve health outcomes and reduce mortality for people with HIV; and (4) reduce HIV-related disparities.

16. Plans for Tabulation and Publication and Project Time Schedule

Quantitative and qualitative analyses will be performed. Prior to conducting any formal analyses on quantitative data, exploratory univariate and bivariate tests will be performed to determine trends and patterns in the data. This will be accomplished using frequencies and cross-tabulations, and by examining univariate

distributions and correlations. The frequency analysis will provide various chi-squared tests for association of categorical ordinal or nominal data, while the ANOVA will provide F-tests for continuous data. We will also consider input from DHP experts, the Copial Business Strategists contractor, and the literature to include variables that have exhibited previous associations with the outcome.

Qualitative data include open-ended responses within the web-based information collection tools. Open-ended responses in otherwise categorical questions within the information collection instruments (e.g., "Other, please specify") will be abstracted and grouped by thematic categories, and analyses will be used to determine the frequency of categories.

The results of this assessment will be shared internally with CDC/DHP leadership and program staff, as well as externally with CBA providers. The results will be used by DHP and its CBA providers for continuous quality improvement of DHP's CBA services and products, and to improve program processes and operations. Annually, DHP staff will receive a more detailed summary report of yearly findings. At the conclusion of the three-year OMB package period, we will share updates to all of the participating parties and, if necessary, make small modifications to the data collection plans and seek further OMB approvals to cover the remaining months of this funded program. At the conclusion of the funding period, a report summarizing all cumulative years of data collection will be shared with CDC/DHP leadership and staff, as well as externally with CBA providers.

In addition to DHP staff, each grantee will have real-time access to their raw data for analysis. They will also receive a short report summarizing feedback from their surveys on a monthly basis. The CBA providers will use this information to identify strengths and areas of improvement for CBA service delivery.

DHP will disseminate the summarized information through reports to DHP and possibly publications and presentations. If results are shared with the public via presentations or publications, results will be shared in the aggregate, and any information that may identify an agency or individual will be masked. There will be no impact on the personal privacy of individuals participating in CBA events (training or TA) who will be representing their organizations and using their business contact information.

Table 16: Project Time Schedule

Project Product	Timeline for Completion
Collect, code, enter, quality control, and analyze data	August 1, 2024 - September 31, 2027
Prepare reports	Monthly beginning September 1, 2024
Disseminate results/reports	Monthly beginning September 1, 2024

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

The display of the OMB expiration date is not inappropriate.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

REFERENCE LIST

1. Centers for Disease Control and Prevention (CDC). Estimated HIV incidence and prevalence in the United States, 2018–2022. HIV Surveillance Supplemental Report 2024;29(No. 1). <https://www.cdc.gov/hiv-data/nhss/estimated-hiv-incidence-and-prevalence.html>. Published May 2024. Accessed 06/03/2024.
2. The White House. “National HIV/AIDS Strategy for the United States.” Available at <https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025>. Accessed on 06/03/2024.
3. CDC. HIV. Capacity Building Assistance. Available at <https://www.cdc.gov/hiv/capacity-building-assistance/index.html>. Accessed on 06/03/2024.
4. U.S. Bureau of Labor Statistics. Occupational Employment and Wage Statistics. Medical and Health Services Managers. Retrieved from <https://www.bls.gov/oes/current/oes119111.htm>.
5. U.S. Bureau of Labor Statistics. Occupational Employment and Wage Statistics. Community and Social Service Occupations (Major Group). Retrieved from <https://www.bls.gov/oes/current/oes210000.htm>.