From:	Mari Millery
To:	HRSA Paperwork
Cc:	Boccher-Lattimore, Daria; Lewis, Gracine S.; Francine Cournos
Subject:	[EXTERNAL] ICR: HRSA Ryan White HIV/AIDS Program Part F Regional AIDS Education and Training Center Program Activities, OMB No. 0906–xxxx—New
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Information Collection Request Title:
HRSA Ryan White HIV/AIDS Program Part F Regional AIDS Education and Training Center Program Activities, OMB No. 0906–xxxx—New (Federal Register Vol 89 Num 139, Friday July 19, 2024)

From: Mari Millery, PhD, Consultant, Evaluation Director, Northeast/Caribbean AIDS Education and Training Center, marimillery@mresearchstudio.com, 646-942-3871

Following are my comments on the proposed new AETC data collection forms (and also attached as a Word document).

Comments that apply to several forms:
Please consider not re-naming the previous AETC forms PIF and ER. This will cause confusion and increased need for user education; discontinue existing datasets and data system structures; and add cost to the implementation of the new forms that is already unfunded in the AETC budgets.

Please also consider keeping data elements the same, to the extent possible, as they are in the current ER and PIF. There are several reasons for this request, including continuity of legacy data for data analyses and reporting; challenges in training users and stakeholders to use new categories; and significant cost, time, and effort required to update existing data systems and map old data elements onto new ones.

AETC number and Regional Partner number should appear on all forms.

Will there not be an equivalent of the current "PL" form that connects the program and participant forms? How will HRSA know which participants attended which events?

IND-PAR
The form is too long and risks alienating potential training registrants. Please consider dropping items that are not absolutely necessary. For example, the information in questions 27-35 is probably best ascertained through organizational level needs assessment and secondary data, and then extrapolated to the numbers of trainees, to present information on the numbers and types of patients that benefit from AETC trainings. Perhaps only keep the highest priority patient characteristics questions, such as whether the AETCs reach non-white

communities. What is the purpose of Question 28? Question 30? Question 6? Does HRSA have critical and specific purposes for these data elements? Do they link to AETC goals and objectives? Are they included only because they would be "interesting" or "seem important"? Respondents are not good at estimating percentages for Questions such as 28-35.

The recommendation is to drop questions 28 and 30-35 but keep question 29 or equivalent. It is important to capture the AETCs' reach among those who serve minority patients. The currently proposed wording of Q29 is awkward but unfortunately, I don't have an alternative suggestion to offer at this time. NECA AETC is happy to participate in brainstorming alternatives to Q29 wording.

Q4: Pharmacist is missing and must be added. We occasionally get people who are truly "Other" and legitimately participating e.g., a lawyer, police officer or other first responder etc. Recommendation: Add "Other, specify". Good survey design practices suggest that all respondents should have an option to select. Is "Counselor" a profession or role? Why is physical therapist not a clinician? Overall, consider keeping all categories as consistent as possible with the old PIF.

Q5. Need to add "Not working". Why are city/local/state gov employee and federal employee primary functional roles? Why is Medical Assistant a functional role (should only be a profession)? Overall, consider keeping all categories as consistent as possible with the old PIF.

Questions 7, 8, 9: Participants will <u>not</u> know their "training track", when it started, and whether they are in an IPE program. Participants often have poor awareness of and memory for the exact names of programs/tracks they are part of. Also, those who are not IPE (or different Tracks) can easily interpret as being part of it. This information on tracks and IPE program is best obtained directly from the AETCs and added to the form as "AETC only" fields.

Q19-20: Respondents should not skip prevention, testing, PrEP because they don't provide care to HIV+.

TAR

Some skip patterns Q5-9 are strange. For example, if EHE funded, why asked to provide IPE site ID?

Q13: Is regular adult ART guideline included? Or only rapid? Please clarify.

Please don't display radio buttons in Q15-20 on form drafts. Always use check boxes when the question is select all that apply. Otherwise - confusion.

Recommendation: Analyze recent national AETC data, find topics that are very infrequently selected, and consider dropping those topics, unless they are critically important to keep track of (i.e. relate to AETC goals and objectives). There are too many topics for trainers and coordinators to choose from and some are very low frequency.

Q24: define "case discussion" and "clinical training", refer to previous AETC definitions as appropriate for definitions of all categories.

Q25: 30 days is arbitrary. Why skip Q26? Is this 30 days when there is training one day a week during 30 days? One hour a week during 30 days? Recommendation – look at existing national AETC data for distributions of training hours and date ranges to find meaningful categories and definitions for this question.

Q28: There already are activity start and end dates on the form – no need to ask about reporting period here - ask about the period within activity dates instead.

PPA

The separate section for IPE participants is not necessary and will not work. Respondents will not know when they are and are not IPE participants and will be guessing. The set of IPE questions would be more appropriate at the conclusion of the entire IPE program and not after every event. The AETC would know when to "trigger" such set of post-IPE questions in the post survey, not the participant. If an IPE post-survey is necessary, we prefer the AETC to implement a special version of PPA for those occasions, and the vast majority of all other trainings should use the regular, short version of the PPA.

Question 2: The question wording is not clear but appears to ask about multiple things at the same time. Is the question about two kinds of knowledge or increasing knowledge and increasing provision of care? Either way, the data would be a mix of many things in the responses and impossible to interpret.
Consider using a Strongly Agree to Strongly Disagree Likert-scale and ask, "As a result of this AETC activity…" This will allow simpler statements.
Many trainings do not directly address "HIV and provision of care for people with HIV". This is particularly a problem for Question #3, which would only apply to a subset of trainings that are directly about "HIV care and treatment" (and many respondents don't perceive HIV testing and PrEP, for example, to be included in this). To have questions that apply to all trainees, NECA AETC has been using the following generic post-training Likert-scale statements:
"I am aware of more factors I need to consider in my work."
"My interest increased in what was covered in the learning experience."

“I am better prepared to do my work.”
There is no easy way around this dilemma of designing good post training questions, as the AETC evaluation community discovered when designing the immediate post evaluation questions for the JSI survey.
The recommendation is to create statements that 1) ask only about one thing per statement 2) create statements that are inclusive of both HIV care and HIV prevention topics, and ideally, also topics that are not directly about HIV.
If it is very important to directly measure the goals and objectives specified in the NOFO, perhaps statements can be worded around those (e.g., “My ability to provide HIV care improved”) but a “Not applicable” option would need to be offered, and the data should only be analyzed for trainings with topics that match the statements (i.e., events directly aimed at improving HIV care ability). Respondents mark low responses for such item when they perceive that the topic was not directly addressed.

IPE-LT

The evaluation design of following up IPE student participants with a survey one year after they complete the IPE program is misaligned with the IPE program. First, AETCs are asked not to work with students directly. Second, many students receive a modest “dose” of IPE intervention, and it is not reasonable to measure this type of impact one year later. Third, students are either difficult to find because they left the school and changed email addresses, or are still enrolled in school one year later, not able to show practice changes. Consider other ways of evaluating the impact of the IPE program, perhaps by designing a special evaluation study to follow up selected students and similar control students, and/or by using sampling. Perhaps focus on students that receive the most robust IPE interventions. The cost of implementing this evaluation instrument is high while the quality and meaningfulness of the data would be questionable. This is not the right program for an “outcome monitoring” instrument collected from all participants.

Furthermore, regarding questions on the proposed IPE-LT instrument, the notion of “HIV care and treatment” is problematic to define and too restrictive. In the NECA region, HIV prevalence is sufficiently high to warrant ALL health care professionals to know about HIV and be prepared to care for HIV-positive individuals they encounter. However, they often don’t define these encounters as “HIV care and treatment”. Additionally, it is confusing whether HIV testing and prevention, including PrEP is included in “HIV care and treatment”. Many respondents would probably say “No” to question 3 and we would not know anything about what they do. For example, a regular primary care dentist may have encountered one HIV positive patient and been more prepared for it because of the IPE education they received. But they don’t perceive practicing “HIV care and treatment” and would miss the survey questions.

PT-SC

Add fields for date of form completion and the reporting period covered. Add instructions for completing the form at the end of the reporting period.

Many of the questions are best filled out by the AETC staff, not the PT site.

There is no baseline. Are the "start dates" intended to provide baseline type information? It is unclear how data on this form would be analyzed to ascertain PT outcomes. It would be helpful to understand what HRSA's data analysis plan is.

There are no definitions. For example, what is "routine testing"? What is meant by "activities and/or policies"? Can examples of those also be provided? Are Q21-28 specifically in reference to work completed with the AETC? If so, please specify that. A distinct "activity and/or policy" may be difficult to define in a consistent manner and this question may not be able to produce good data.

The 6 phases need definitions (Q6).

Questions 5 and 12 are redundant – Q5 not needed.

The table after Question 28 needs clarification for the reporting period. In the past, many PT sites have only been able to provide calendar year data and have required some time to process the data. Please provide a reference to UDS, RSR, or other definition for each data element in the table.

Meaning of "Racial/ethnic minority groups" will be confusing for NECA AETC sites in Puerto Rico. What is the purpose for data on clients age 15-65 (vs. all clients)?

Instruction to enter zero when the service is not applicable or site does not provide the service is problematic. Sometimes a service is applicable and no-one is served -that's when a zero should be used.

Note that there may be PT sites that legitimately work on topics or problems that don't directly fall into the domains covered on this form. Their work will not really be captured on this form, unless at least something is added that describes the work.

IPE-SC

Add fields for date of form completion and the reporting period covered. Add instructions for

completing the form at the end of the reporting period.

Note: All questions are best completed by AETC staff, not the IPE site.

Question 4 should be “all that apply”.

Questions 5 and 6 are redundant, Q5 not needed.

Clarify how “site” is defined, i.e., school, vs. university vs. program etc.

Comments on estimated burden:

The **TAR** takes more time to complete than the estimate of .21 hours. Information needs to be gathered from trainers and other stakeholders for the TAR and one TAR is completed during several separate sessions, some before and some after the event. Once there is a revised draft, NECA AETC is happy provide an estimate of the average TAR burden.

The **combined data set** takes vastly more time than the estimate of 64 hours. It is not entirely clear what should be included in the “combined data set” burden but the annual preparation of the files alone, which involves the work of many individuals, takes many weeks of work. This does not include all the work throughout the year to build and revise the data system, to keep the data entry and management operating, and to clean the data on an ongoing basis. It should be noted that the proposed new forms will impose a highly significant additional burden on the recipients this grant year when the new forms need to be implemented into data management systems, and all users and stakeholders need to be trained. NECA AETC is happy to provide additional information on the combined data set burden. Please contact the Evaluation Director.