

Aggregate Reports for Tuberculosis Program Evaluation (ARPE)

OMB Control Number: 0920-0457 Exp. 01/31/2026

Extension Supporting Statement A

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- The goal of this ICR is to facilitate the monitoring of national progress toward TB elimination.
- Intended use of the resulting data is to generate indicators for program evaluation, monitor the workload of tuberculosis prevention, and estimate the epidemiological status of tuberculosis in public health jurisdictions funded under the CDC cooperative agreement.
- All programs are now reporting the data for the Aggregate Reports for TB Program Evaluation (ARPE) to CDC through a secure, web-based system.
- The populations to be studied include persons in the United

A. Justification

1. Circumstances Making the Collection of Information Necessary

Background

The Centers for Disease Control and Prevention requests a 3-year extension for the currently approved collection, *"Aggregate Reports for Tuberculosis Program Evaluation,"* (OMB # 0920-0457, exp.01/31/2026). This data collection is authorized under Section 301 of the Public Health Service Act 42 U.S.C. 241, (**Attachment 1**). No changes will be made to this document.

The Division of Tuberculosis Elimination (DTBE), National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC), maintains cooperative agreements with the health departments of the 50 states, 8 large cities, 5 US territories and 3 freely associated states (**Attachment 7**) who submit tuberculosis (TB) program management reports. CDC also provides ongoing technical consultation about TB control for these health departments. In 2000, the *"Aggregate Reports for Tuberculosis Program Evaluation"* (ARPE) replaced several outdated reports and are now used nationwide. The changes in these reports corresponded to the evolving national TB control strategy, new data-systems technology, and advancements in science and medicine. There is no current plan for data retirement as the data is used for monitoring trends over an indefinite period of time.

The two reports (**Attachments 3a and 3b**) measure the extent, the efficiency, and the yield of TB control activities. Respondents for the reports are the 66 health departments funded under the federal cooperative agreement that perform TB control activities. These health departments have adopted *Aggregate Reports for Tuberculosis Program Evaluation* as their generic tool for assessing their TB prevention activities. They use the reports for generating the indicators used in

program evaluation as stipulated in the 2015 cooperative agreement, for monitoring the workload of TB prevention, and for estimating the epidemiological status of TB in their jurisdictions.

Data are collected by the health departments as part of routine contact investigation and targeted testing activities for providing information on cases of TB disease or infection. Data aggregation varies by site, with computerized methods becoming the norm at large jurisdictions. Respondents provide the data following the format as outlined in ARPE and submit their aggregated data to CDC by encrypted computer transmission via the National TB Indicators Project (NTIP).

The National Tuberculosis Indicators Project (NTIP) is a secure electronic platform developed by CDC for use by health departments. CDC uses the NTIP platform to distribute selected indicator reports and other communications. The NTIP also includes a module/portal for submitting the aggregate data to CDC.

During the previous approval period (January 1, 2023-January 31, 2026), CDC completed and achieved the following activities and outcomes:

- Continued data collection and analysis as the only agency collecting national data on TB contact investigations
- Maintained reporting response rate from TB control jurisdictions during the COVID-19 epidemic.
- Assessed nativity, adoption of new diagnostic tests and the use of new drug regimens for TB contacts
- Summarized targeted testing and treatment of latent TB infection (LTBI) among populations with a high-risk of developing TB
- Disseminated annual reports of national aggregate contact investigation and targeted testing data to TB control jurisdictions
- Hosted at least one consultation session with TB control jurisdictions and/or the National TB Controllers Association regarding data collection and reporting
- Achieved a response rate of 100% from TB control jurisdictions

During the next approval period (February 2026-February 2029), CDC plans to achieve the following:

- Continue data collection and analysis as the only agency collecting national data on TB contact investigations
- Maintain reporting response rate from TB control jurisdictions
- Assess nativity, adoption of new diagnostic tests, and the use of new drug regimens for TB contacts
- Summarize targeted testing and treatment of LTBI among high-risk

populations

- Disseminate annual reports of national aggregate contact investigation and targeted testing data to TB control jurisdictions

2. Purpose and Use of Information Collection

CDC uses the data from these reports for monitoring TB control programs funded by the CDC cooperative agreement. CDC also uses the data for planning national TB control strategies and in estimating funding needs. The results in these reports are compared to the national performance goals, and they indicate progress toward achieving tuberculosis elimination. These data address Government Performance Results Act (GPRA) section IIH, Tuberculosis Performance Goal 1 Item 3 ("Increase the percentage of contacts of infectious acid-fast bacilli smear positive cases who are placed on treatment for LTBI and complete a treatment regimen") and Item 4 ("Increase the percentage of other high risk infected persons who are placed on treatment for LTBI and complete a treatment regimen"). The ARPE data for follow-up of contacts to TB shows that in 2022 (the most recent year for complete information) approximately 80% of patients diagnosed with LTBI started and finished a treatment regimen. A separate report of ARPE data from the US-Affiliated Pacific Islands shows that 44% of patients diagnosed with LTBI started and finished a treatment regimen. ARPE targeted testing data shows that 69% of patients with LTBI started and finished a treatment regimen. This indicates that current tuberculosis prevention and control activities are often effective but could be improved.

CDC has disseminated the results from these reports in the following ways:

- An annual "dear-colleague" letter from the director of DTBE, for data years 2009–2022, to the TB control officials from the 67 cooperative agreement sites in the previous approval period. This letter reiterates the purposes of the data collection and provides a national interpretation of the results for the year.
- Published article in Morbidity and Mortality Weekly Reports that summarized the treatment completion data of follow-up of contacts to TB: Woodruff R, Pratt R, Kolasa M. Progress Toward Tuberculosis Elimination and Tuberculosis Program Performance – National Tuberculosis Indicators Project, 2016–2022. MMWR Surveill Summ 2024;73(No. SS-4):1–18. DOI: <http://dx.doi.org/10.15585/mmwr.ss7304a1>.
- Published article in Morbidity and Mortality Weekly Reports that summarized the Aggregate Reports for Tuberculosis Program

Evaluation contact investigation data: Young K, Ehman M, Reves R, et al. Tuberculosis Contact Investigations – United States, 2003–2012. MMWR 2016; 64(50):1369-74.

- CDC poster presentations of the national ARPE summary results at annual conferences of the National Tuberculosis Controllers Association (NTCA), the official organization representing the report respondents. CDC poster presentation of the national summary results and interpretation at the International Union of Tuberculosis and Lung Disease, North America Region Conference (IUATLD, NAR).
- CDC TB Notes publications.
- Presented to the TB Program Evaluation Network Open Forum, which consists primarily of Program Evaluation Focal Points.
- Aggregate results from the ARPE reports are incorporated into the NTIP application. NTIP is a secure web-based monitoring system that allows health authorities to access reports and review data. The NTIP system provides TB programs with reports to describe their progress, based on data already reported to CDC, and facilitates the use of existing data to help programs prioritize activities and focus program evaluation efforts.

CDC uses the reports for assessing the effective use of federal TB cooperative agreement funds. Reports for program evaluation are stipulated in the cooperative agreements. The CDC TB program consultants, who use the reports as the standard measurement of workload and performance, communicate with the cooperative agreement sites at least annually to review local progress toward tuberculosis elimination.

All health departments funded by the federal TB cooperative agreement have adapted ARPE for their own TB control programs. Most health departments use the identical reports that they submit to CDC, while a few, such as the health departments in California and Florida, have elaborated on the reports to meet their specialized needs. Health departments that have their own comprehensive data management systems for TB control, such as in New York State and Illinois, have designed their systems so that information for ARPE is generated automatically and thus at no added burden for the respondents, who already were collecting the data for their own use.

Because the majority of technical-support questions about the ARPE have been related to data definitions, CDC addressed these questions by preparing extended instructions that are accessible on to the CDC web page (see **Attachment 5: Aggregate Reports for Program Evaluation: Training Manual and User's Guide**). The instruction manual includes guidance about how the respondents (i.e., the public health departments) can use the reports for monitoring the results of their

own tuberculosis control programs. CDC has also issued Dear Colleague letters to jurisdictions clarifying data definitions to accommodate evolving new technology and science.

Difficulties have been reported anecdotally for specific complex large TB outbreaks in institutional settings (e.g., prisons or homeless shelters) two or three times per year. The data structure required by these outbreaks is too complex for ARPE. These issues have been resolved collaboratively between the respondents and the CDC TB program consultants by collapsing the data into simpler formats that were compatible with the reports. CDC is not proposing revisions to the reports to accommodate more complex data because the current reports are sufficient for most data. If the reports were expanded for rare instances of complex data, this would increase the burden to the respondents without sufficient compensatory benefit to the respondents or to CDC.

Public health officials have cited improved convenience and usefulness of the current reports in comparison to the older CDC reports. The ARPE reports document that the scope of prevention activities is large: according to the most recent final reports of data from all cooperative agreement sites except the U.S. Affiliated Pacific Islands, among the reported 3,406 sputum acid-fast bacillus (AFB) smear-positive TB cases diagnosed in cohort year 2022, 89.9% (3,061) had contacts elicited. Of the 33,576 contacts elicited, 72.5% (24,339) were evaluated for infection or disease and approximately 19.4% of the persons who underwent diagnostic testing were found to have LTBI. Of those diagnosed with LTBI in 2022, 76.2% initiated LTBI treatment, of whom 79.7% completed treatment. The most recent final reports of data from the U.S. Affiliated Pacific Islands reported that among the 72 sputum AFB smear-positive TB cases diagnosed in cohort year 2022, 97.2% (70) had contacts elicited. Of the 1,300 contacts elicited, 77.3% (1,005) were evaluated and approximately 20.9% of the evaluated persons were found to have LTBI. Of those diagnosed with LTBI in 2022, 28.1% initiated LTBI treatment, of whom 44.1% completed treatment. The most recent final reports for targeted testing data reported 60,068 persons who were sought, enlisted, registered, or referred for targeted testing, with 95.3% (57,223) persons evaluated for infection or disease. Of the persons evaluated in 2022, 15.7% were found to have LTBI. Of the persons diagnosed with LTBI in 2022, 45.5% initiated LTBI treatment, of whom 68.5% completed treatment. All reports show that performance for both LTBI treatment initiation (range of 28.1% 76.2%) and completion (range of 44.1% to 79.7%) remain below the 2025 National TB Performance Targets of 92% and 93% respectively.

These data from ARPE continue to demonstrate the scope of the public health problem and the prevention activities for which CDC is jointly accountable, in collaboration with state, local, US territories, and freely associated states' health departments. Without ARPE reports, national data on the transmission of TB infection and the quantity of work carried out by TB control programs to prevent TB cases would not be available. CDC needs a fair, standard assessment of the utilization of the funding disbursed through the federal TB cooperative agreements. Even if CDC could not collect the reports, the health departments would continue using them for monitoring the efforts of their own tuberculosis programs, because they have found the reports to be practical and useful.

3. Use of Improved Information Technology and Burden Reduction

The federal TB cooperative agreements include funds for computer equipment and support. CDC continues to work with the respondents in adopting new technology. In 2010 CDC launched a web-based module in NTIP to streamline reporting processes and reduce burden. The module provided a new, secure web-based option for direct data entry and electronic submission to CDC. Since 2018 100% of the responses are transmitted data electronically via NTIP.

4. Efforts to Identify Duplication and Use of Similar Information

ARPE is a comprehensive standard summary of priority tasks for controlling and eliminating tuberculosis in the United States. Some health departments (e.g., in California, New York, Illinois, and Florida) subsequently have designed their own similar reports for program evaluation, in accordance with their specific programmatic needs. Their reports are compatible with the national reports, but those reports are either too specific or too complex for national adoption. No federal agency besides CDC collects uniform data on TB prevention nationwide. Through literature searches, attendance at national TB meetings and conferences, and ongoing consultations with TB experts nationwide, CDC has determined that ARPE reports are unique, and that no other similar data are available within or outside the federal government.

5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this data collection. Data are requested from the 66 health departments funded under the CDC cooperative agreement. Data are collected only once a year and are kept to an absolute minimum to lessen the reporting burden.

6. Consequences of Collecting the Information Less Frequently

Annual reporting is linked to the annual funding cycle and program evaluation of the TB cooperative agreements. Less frequent reporting would delay feedback and technical consultation to the respondents and would leave CDC without current data for monitoring the national TB burden. The reporting frequency is once a year. The respondents collect the data for these reports continuously as part of standard public health practice. There are no legal obstacles to reducing the burden to the respondents.

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

This request fully complies with the guidelines in 5 CFR 1320.5, and no special circumstances require the information to be collected in any other manner.

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

A 60-day Federal Register Notice was published in the *Federal Register* Monday, June 16, 2025, Vol. 90, No.114, Page 25292. There were no public comments.

The CDC TB program consultants, who use the reports as the standard measurement of workload and performance, visit the 66 cooperative agreement sites at least annually to review local progress toward TB elimination. During the administrative site visits made by CDC TB program consultants, the consultants not only provide ongoing technical consultation about TB control for these health departments, but also may receive consultation from the programs as to the utility of the reports.

In 2009, TB control officials from California (Jennifer Flood, Chief of TB Control Branch at the California Department of Health), Colorado (Gayle Schack, Colorado Department of Public Health and Environment), New York State (Stephen Hughes, Assistant Director, New York State Department of Health), Tennessee (Katie Garmin, Tennessee Department of Health), and Texas (Ann Tyree, Texas Department of State Health Services) reviewed the indicators that are in ARPE and recommended their inclusion in NTIP.

CDC launched NTIP in 2009 for returning data and reports in a convenient format to public health authorities. The cumulative ARPE are integrated into NTIP. During the design and the implementation of

NTIP, CDC sought consultation from public health authorities from the state health departments mentioned above and with representatives of NTCA. In these consultations, CDC was advised to continue ARPE in their current form and to make them accessible through NTIP.

In July 2018, in response to the recommendations from the Association Council for the Elimination of Tuberculosis (ACET), to include nativity, diagnostic tests and drug regimen to ARPE, CDC reached out to the NTCA for feedback. NTCA surveyed and conducted in-person focus group with members in the 67 jurisdictions to assess uses of ARPE data and the feasibility and burden associated with collecting these recommended data elements. NTCA found that 76% of respondents reported ARPE data are useful to their programs. While 43% of the respondents recommended no changes to the current form, most programs reported little or no challenges with regard to their ability to collect and report the recommended data elements. More specifically, 59% of respondents reported little or no difficulties in their capability to collect and report nativity; 77% of respondents reported little or no difficulties in collecting and reporting diagnostic tests used; and 73% of respondents reported little or no difficulties in collecting and reporting drug regimen used. Recognizing that jurisdictions vary in their current capacity to collect, aggregate, and report the proposed new data elements on nativity, diagnostic test, and drug regimen, CDC has incorporated the new data elements into the ARPE form, but has designated them as optional.

9. Explanation of Any Payment or Gift to Respondents

The respondents do not receive payments or gifts for providing ARPE reports.

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

The Privacy Officer for CDC is currently assessing this package for applicability of 5 U.S.C. § 552a to the information collection (**Attachment 6**). NCHHSTP is currently pursuing approval for a renewed Privacy Impact Assessment (PIA) and will submit the PIA for inclusion in this PRA package once it is received. There have been no changes to the Privacy aspects associated with this data collection activity or previously approved PIA. These data collection activities do not involve the collection of personally identifiable information (PII). Respondents are the 66 health departments funded under the CDC cooperative agreement. The health departments provide CDC with aggregate information on cases of tuberculosis disease or infection. Although health departments may collect identifiable information for local tuberculosis control purposes, this information is retained at

those levels, and health departments do not transmit person-level data or identifiable data to CDC. No individually identifiable information is being collected.

The two reports submitted here (**Attachments 3a and 3b**) identify the types of non-individually identifiable information that will be collected. The source data for ARPE are gathered as part of standard practice for TB control under the public health authority of the jurisdiction. No respondents submit these data with individual patient records to CDC. Although health departments may collect IIF for local TB control purposes, this information is retained at those levels, and health departments do not transmit person-level data or identifiable data to CDC. The data associated with this OMB clearance are submitted to CDC only in an aggregate format.

This information collection request does not include data on an individual's age, sex, race, ethnicity, nor specific medical conditions except for TB. Therefore, the accidental identification of any patient who is counted in the reports is extremely unlikely. CDC previously has not made any assurance of confidentiality to the respondents. Data from specific respondents will be treated in a secure and private manner and will not be disclosed unless otherwise compelled by law.

- A. Through the federal cooperative agreement, respondents are informed about the voluntary or mandatory nature of their response. The requirements for submission are clearly described in the cooperative agreement.
- B. As the primary users of the data, the respondents are informed about the intended uses of the information collection through the cooperative agreement and are able to access the results of the aggregate, de-identified reports through NTIP. The respondents requested in 1999, and CDC agreed, that local public health authorities will be notified before locality-specific data is published or shared outside CDC. CDC publishes the aggregate, de-identified national data and shares the national summaries with the respondents at least annually.
- C. The information submitted by respondents will be secured with the appropriate safeguards currently in place to minimize the possibility of unauthorized access, use, or dissemination of the information being collected. Technical controls include user identification, passwords, firewall, virtual private network (VPN), and encryption. All data are submitted electronically through NTIP and are encrypted, and files are password protected. In the event that any reports would be transmitted by telephone facsimile, they would be sent unencrypted to the CDC office where the data are collected, under the privacy-statement cover sheet of the

submitting agency. Any printed records received from specific jurisdictions are kept in a locked file cabinet. Only authorized staff have access to the password-protected electronic files and locked file cabinet. The summary national reports contain no sensitive or private information.

Physical controls include security guards, identification badges, key cards, and locked file cabinets. Any printed records from specific jurisdictions are kept in a locked file cabinet. Administrative controls include training manual and user guides for information collection, completion of required security training for computer access and data collection annually by all CDC personnel, and role-based access to data.

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

IRB Approval

This submission was reviewed by the National Center for HIV, Viral Hepatitis, STD and TB Prevention and determined not to involve human subjects (**Attachment 4**). This surveillance activity does not require IRB review and approval.

Sensitive Questions

As part of their routine public health practices, health department officials (i.e. the respondents) collect sensitive information (e.g., address, occupation, country of origin, country of birth, infection with the human immunodeficiency virus and risk factors for it, and the use of alcohol or illegal drugs) from persons who have tuberculosis infection, who have been exposed to tuberculosis, or who are born outside of the United States in high TB prevalence countries. For preparing the reports, the respondents interpret some of this sensitive information, but most sensitive information is not recorded per se in the reports, and it is not extractable from the reports. The nativity data is the only sensitive information transmitted to CDC. The aggregate format of the reports precludes linking any sensitive information to any persons who are counted in the reports.

12. Estimates of Annualized Burden Hours and Costs

A. Respondents are the 66 health departments funded under the CDC cooperative agreement. On an annual basis, each respondent will submit 2 summary, de-identified reports to CDC. The summary reports are compiled from information collected by the health department's TB control program during routine operations. Burden estimates are based on the time needed to compile each summary report from the respondent's record system. Burden estimates do not include activities

conducted by health departments as primary tuberculosis care and follow-up.

Each respondent will submit the *Follow-up and Treatment of Contacts to Tuberculosis Cases Form (Attachment 3a)* to CDC once per year. The estimated burden per response is 2 hours and the estimated annualized burden for this information collection is 132 hours.

Each respondent will submit the *Targeted Testing and Treatment for Latent Tuberculosis Infection Form (Attachment 3b)* to CDC once per year. The estimated burden per response is 2 hours and the estimated annualized burden for this information collection is 132 hours.

All information collection is conducted electronically. The total estimated annualized burden is 264 hours, as summarized in Table A.12-1.

Table A.12.1: Estimated Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
Health Department Awardee	Follow-up and Treatment of Contacts to Tuberculosis Cases Form (3a)	66	1	2	132
	Targeted Testing and Treatment for Latent Tuberculosis Infection (3b)	66	1	2	132
Total					264

B. CDC does not request data on the staff who prepare or submit the reports, however, reports are typically prepared by program managers and data clerks. To estimate burden cost we have used \$26.99, the mean average hourly wage of a program manager (\$32.73) and a data clerk (\$21.25). The estimated hourly rate for a data clerk was obtained from Department of Labor (www.dol.gov); the estimated hourly rate for a program manager was obtained from U.S. Office of Personnel Management (www.opm.gov).

The total estimated annualized burden cost to respondents is \$7,125.36, as shown in Table B.12-1.

Table B.12-1: Estimated Annualized Burden Costs

Type of Respondent	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Average Hourly Wage	Total Burden Cost
Health Department Awardee	Follow-up and Treatment of Contacts to Tuberculosis Cases Form (3a)	66	1	2	\$26.99	\$3,562.68
	Targeted Testing and Treatment for Latent Tuberculosis Infection (3b)	66	1	2	\$26.99	\$3,562.68
	Total					\$7,125.36

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

None. The reports do not cause additional capital and maintenance costs to the respondents. The systems that are used for data collection, collation, and storage are already in place for routine public health practice.

14. Annualized Cost to the Government

The annualized cost to the government is \$106,720.67. The reporting is recurrent and ongoing. The costs that are estimated here reflect a public health system that is assumed to be stable. The upkeep for NTIP is minimal because programming is complete. Routine checks on the

functionality of the reporting system are part of routine annual site visits made by CDC tuberculosis program consultants for the Tuberculosis Elimination and Laboratory federal cooperative agreements, and the costs of these visits are not shown because the visits would be made regardless of ARPE.

Table A.14.1: Estimated Annualized Study Hours and Cost

Activity		Total Respondent Costs
NTIP programming maintenance		\$40,000.00
Subtotal		
<i>Federal Employee Time Cost</i>		
One third time health scientist	GS-13 @ \$100,081/yr	\$33,360.33
One third time epidemiologist	GS-13 @ \$100,081/yr	\$33,360.33
Average Annualized Cost		\$106,720.67

15. Explanation for Program Changes or Adjustments

There are no changes to the previously approved ICR.

16. Plans for Tabulation and Publication and Project Time Schedule

The data accumulation is intermittent; it represents continuous public health practice throughout the United States, US territories, and freely associated states, and the reporting is annual and recurrent. A 3-year clearance cycle is requested.

Local public health authorities will be notified before locality-specific data is published or shared outside CDC. CDC publishes the national data and shares the national summaries with the respondents at least annually after combining and summarizing the aggregate, de-identified reports.

No analytical methods beyond simple tabulation and trend description are applied to the results of the reports. The indices that are used for program evaluation are unadjusted. The interpretation of the results from each reporting area is discussed between the respondents

and their CDC TB program consultants. Specific data from one respondent are not shared with other respondents by CDC without prior notification because the data ownership (i.e., intellectual property) remains with the respondents as per general agreement between CDC and the Council of State and Territorial Epidemiologists.

The data that are reported to CDC are summed up for the U.S. national TB program statistics, which are sent to all the respondents annually. At least annually, the program consultants from CDC use the data that are reported by their TB cooperative agreement project sites for reviewing the effectiveness of existing TB control programs and for planning new local strategies for TB control.

Table A.16.1: Project Time Schedule

Activity	Time Schedule
Notification of Respondents	1 week after OMB approval
Earliest data collection by Respondents	1 month after OMB approval
Webinar on data collection and submission	8 months after OMB approval
Earliest reports submitted to CDC	9 months after OMB approval
Data validation	13 months after OMB approval
Data analysis	15 months after OMB approval
Year 1 published summary report by CDC	17 months after OMB approval
Year 2 data collection by Respondents	15 months after OMB approval
Year 2 reports submitted to CDC	21 months after OMB approval
Year 2 data validation	23 months after OMB approval
Year 2 data analysis	25 months after OMB approval
Year 2 published summary report by CDC	27 months after OMB approval
Year 3 data collection by Respondents	25 months after OMB approval

Year 3 reports submitted to CDC	33 months after OMB approval
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17. Reason(s) Display of OMB Expiration Date is Inappropriate

No exemption is sought. 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 included in this request.