

DASH DEMO: Comprehensive Health Educator Core Knowledge and Skills (CHECKS) PD Pilot Study

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Supporting Statement Part A

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Contact Information:

Program Official/Project Officer

Name: Natalie Wilkins

Title: Behavioral Scientist

Organization: Division of Adolescents and School Health/NCHHSTP

Address: 1600 Clifton Rd. NE. MS-E75. Atlanta, GA 30329

Phone number: 770-488-1392

Email: nwilkins@cdc.gov

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Goal of the Study: The overall aim of the Comprehensive Health Educator Core Knowledge and Skills (CHECKS) Professional Development (PD) Pilot Study is to better understand the extent to which health education teachers possess instructional competencies (ICs), (i.e., essential knowledge and skills for teaching) and to test the effectiveness of a PD package intended to strengthen those ICs. These efforts have an ultimate goal of developing a PD package that leads to effective teacher delivery of comprehensive health education in schools. The CHECKS PD Pilot Study will be conducted with Portland Public Schools (PPS) middle school and high school health education teachers.

Intended use of resulting data: The Comprehensive Health Educator Core Knowledge and Skills (CHECKS) Professional Development (PD) Pilot Study will be implemented during the 2021-2022 academic year. This pilot PD study is designed to better understand the instructional competencies (ICs), (i.e., essential knowledge and skills) of those delivering health education in schools and to test the effectiveness of a PD package to enhance those ICs. The goal of this package is to strengthen the delivery of comprehensive health education in schools.

Methods to be used to collect data: To evaluate the effectiveness of the package, a survey measurement tool will be used with teachers (virtual pre/post) and students (post-option of virtual or paper survey). A teacher observation tool will also be used with trained observers (post). To test learning for each of the CHECKS PD pilot study modules, teachers participating in the pilot will be asked to complete a total of seven virtual surveys following each of the eight virtual modules and one in-person training.

The subpopulation to be studied: A maximum of 50 middle school or high school health teachers within Portland Public Schools teaching within academic year 2021-2022 will be recruited to participate in the CHECKS PD Pilot Study. Also, a maximum of 1,750 middle or high school students who participated in health class with a teacher receiving the CHECKS PD pilot study within 2021 2022 academic year will be asked to complete the student survey.

How data will be analyzed: The web-based quantitative survey will be analyzed using SPSS. Descriptive statistics will be used to understand the effectiveness of the CHECKS PD pilot study. Data from the teacher pre- and post-survey will be analyzed using descriptive statistics to identify changes in teacher ICs over time. Results will inform refinements to the PD package, with attention on improving training content aligned with ICs that did not change or decreased among health education teachers before and following delivery of PD training. In addition, we will examine correlations among student perceptions of and experiences with teacher ICs in health education and teachers' self-report and expert observation of instructional practices in the classroom.

Section A: Justification for Information Collection

A. 1 Circumstances Making the Collection of Information Necessary

This information collection is being conducted using the currently approved generic information collection, NCHHSTP Generic Clearance Formative Research and Tool Development package (OMB # 0920-0840, expiration 10/31/2021). The overall aim of the “Comprehensive Health Educator Core Knowledge and Skills (CHECKS) Professional Development (PD) Pilot Study”, is to better understand the extent to which health education teachers possess instructional competencies (ICs), i.e., essential knowledge and skills for teaching) and to test the effectiveness of a PD package intended to strengthen those ICs. These efforts have an ultimate goal of developing a PD package that leads to effective teacher delivery of comprehensive health education in schools. The CHECKS PD pilot study will be conducted with Portland Public Schools (PPS) middle school and high school health education teachers.

This pilot study will take place in one phase throughout the 2021-2022 academic year. ICF International, Inc. will lead coordination with PPS to implement the pilot study in academic year 2021/2022. We will conduct a one-day in-person training with participating middle school and high school health education teachers and throughout the year the participating teachers will complete the remaining components of the CHECKS PD pilot study virtually through a Learning Management System (LMS) hosted by ICF. The LMS allows for all of the teacher surveys to be completed online and data is stored within the system. The teachers will provide basic registration information (name and email) for the purpose of communication related to the study, but a unique identification number (ID) will be created and all data will be collected, stored, analyzed and reported using the ID only. The virtual components include 8 self-directed modules. In addition, participating teachers will be asked to participate in four check-in meetings that reinforce and provide follow-up support to the CHECK PD package.

As part of the study, teachers will be asked to complete a pre- and a post- measurement survey tool (N=2; **Attachment 9**) at the start and end of the academic year. They will also be asked to complete brief post-training surveys (N=7) when they complete the CHECKS PD pilot study components. Teachers will also be asked to participate in one classroom observation. A trained observer will complete an observation form on participating teachers during one health class. The observation form will be used to understand how the instructional competencies (ICs) identified by the observer correlate to the teacher and student identified ICs. The observations will not be used to provide any evaluation of teacher performance.

Students in the participating teacher’s health education classes, who have not opted out of participation, will be asked to complete one survey at the end of the course about teacher instructional strategies they observed the teacher use throughout the year. Student survey responses will be used to determine how they correlated with the observer and teacher responses.

The results from this demonstration project will lead to recommendations in the following areas:

1. To what extent can health education teacher ICs be measured with validity and reliability?
2. How well do instructional observations correlate to teacher and student surveys of ICs?
3. Which specific ICs are present in teachers who are identified as being master teachers versus emerging teachers?
4. To what extent does participation in the CHECKS PD pilot change teacher ICs in health education?

5. To what extent are teacher participation in the CHECKS PD pilot and post self-assessment of ICs associated with student perceptions of their relationships with teachers and the relevance of health education instruction they received?

6. How can findings from the CHECKS PD pilot be used to improve the CHECKS PD package for full implementation?

Background

The Division of Adolescent School Health (DASH) resides within the Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) at the Centers for Disease Control and Prevention (CDC). The fundamental goal of DASH is to improve the health and well-being of our nation's youth by working with education and health agencies, and other organizations to promote environments where youth can gain fundamental health knowledge and skills, establish healthy behaviors for a lifetime, connect to health services, and avoid becoming pregnant or infected with HIV or STDs.

The National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), which includes the Division of School and Adolescent Health (DASH), conducts formative research for developing and or testing new tools and methodologies or to build upon existing tools and methodologies that respond to the changing epidemiology of NCHHSTP's five areas of responsibility and four groups of diseases (HIV/AIDS, STD, TB, and viral hepatitis) that cause 80% of the disease morbidity in the U.S.

DASH is a unique source of support for HIV, STD, and pregnancy prevention efforts in the nation's schools. DASH works to protect youth by:

- Collecting data that drive action
- Translating science into innovative programs and tools that work to protect youth
- Supporting a network of leaders in primary prevention by funding education agencies that reach nearly 2 million students

DASH is committed to preventing HIV, STDs, and pregnancy among all youth. Taking a school-based health promotion and disease prevention approach, the Division works to prepare healthy youth for a successful future. The DASH NOFO PS18-1807 funds: (1) Local Education Agencies (LEAs), (i.e. school districts), and (2) Lead agencies of consortia (LEA or Regional Training Education Center). LEA is a commonly used synonym for a school district, an entity which operates local public primary and secondary schools in the United States.

These agencies are funded to build the capacity of districts and schools to effectively contribute to the reduction of HIV infection, other STDs, and related risk behaviors among adolescents, as well as the reduction of disparities in HIV infection and other STDs experienced among specific adolescent sub-populations. NOFO PS18-1807 builds upon and expands work previously accomplished through NOFO PS13-1308 (*Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance*).

In 2019, 38% of high school students in the United States had ever had sexual intercourse and 27% were currently sexually active. Among currently sexually active students, 46% did not use a condom, and 12% did not use any method to prevent pregnancy the last time they had sexual intercourse². In 2019, young people aged 13-24 accounted for an estimated 21% of all new HIV diagnoses in the United States. Half of the nearly 20 million new STDs reported each year were among young people aged 15-24.^{2,3} Today, two in five sexually active teen girls have had an STD that can cause infertility and even death.² Also, though rates of HIV are very low among adolescents, males make up more than 80 percent of HIV diagnoses among 13-

to 19-year-olds.⁴

Adolescents ages 15-24 account for nearly half of the 20 million new cases of STDs each year.³ Today, one in four sexually active teen girls have had an STD that can cause infertility and even death.² Also, though rates of HIV are very low among adolescents, males make up more than 80 percent of HIV diagnoses among 13- to 19-year-olds.⁴ Establishing healthy behaviors during childhood and adolescence is easier and more effective than trying to change unhealthy behaviors during adulthood. In the United States, schools have direct contact with more than 50 million students for at least 6 hours a day during 13 key years of their social, physical, and intellectual development.⁵

After family, schools are of one of the primary entities responsible for the development of young people, and they can influence students' risk for HIV infection and other STDs in a variety of ways, including through the provision of sexual health education. Schools can influence students' risk for HIV infection and other STDs through parental engagement, sexual health education, connection to physical and mental health services, and connecting youth to each other and important adults. DASH funded a five-year cooperative agreement, *PS18-1807 Promoting Adolescent Health through School-based HIV Prevention*, that funds local education agencies (LEAs) and nongovernmental organizations (NGOs) to support efforts to implement school-based programs and practices designed to reduce HIV infection and other STDs among adolescents. Currently, 28 funded recipients, 25 LEAs, and 3 consortia receive CDC funding to deliver high-quality, school-based HIV, STD, and pregnancy-prevention programs, with additional state and local agencies participating in school-based surveillance. Collectively, these LEAs reach 2 million of the 26 million middle and high school students in the United States through systems-level strategies that address (1) sexual health education, (2) access to sexual health services, and (3) safe and supportive environments. Preliminary data suggest that such strategies can influence key health risk behaviors and experiences among young people.⁶

NOFO PS18-1807 supports implementation of these activities at multiple levels of the education system to achieve health goals. School districts generally determine local health education curricula, policies, and services. In this program, the school districts and consortia provide training, resources, and technical assistance to schools to implement school-based strategies through district level actions and decisions. They provide a range of highly trained experts for professional development and technical assistance to advance HIV/STD prevention work. This funding facilitates a multi-component, multi-level effort to support youth reaching adulthood in the healthiest possible way.

DASH is working with ICF, an evaluation contractor, to provide support for a set of demonstration projects. The focus of this demonstration project is on school health education (SHE) professional development (PD). This will be a multi-year project which involves developing valid and reliable measures of teacher instructional competencies (ICs) (i.e., essential knowledge and skills) and developing a PD package designed to enhance ICs among health education teachers.

Data collection for this project is authorized under 42 U.S.C. 241, Chapter 6a - Public Health Service; Subchapter II - General Powers and Duties of the Public Health Service Part A - Research and Investigations Generally (**Attachment 1**).

Personal identifiable information, limited to name and email address, will be kept in a separate location and accessible only to the ICF evaluation team. This information will be destroyed when data collection is complete at the end of the 2021-2022 academic year. The information collected for this project will be maintained or stored locally under strict access controls limited to the local project leader/manager or

his/her designate without personal identifiable information. Under no circumstances will an individual be identified using a combination of variables such as gender, race, birth date, and/or other descriptors.

A.2 Purpose and Use of Information Collection

This information collection supports formative research for the development and improvement of tools for school health education. The purpose of this formative research pilot study is to field test school health education tools and measurement instruments to determine their validity, usability, and appropriateness for promoting effective delivery of comprehensive health education in schools. This study will allow us to determine necessary changes to the intervention tools to increase their utility and also inform changes to data collection process to increase data quality and efficiency and reduce burden. This pilot study will take place throughout the 2021-2022 academic year in Portland Public Schools, beginning in the summer and consists of a total of 20 hours of professional learning via the CHECKS PD pilot study. CHECKS includes a one day in-person (or virtual) training, eight self-paced virtual modules, and follow-up support check-ins. In addition to the CHECKS activities, participating teachers will be asked to complete a pre/post measurement survey tool (N=2) and CHECKS post-training surveys on the in-person training and virtual modules (N=7). Students of teachers in the CHECKS study will be asked to complete a one-time survey, and teachers in the CHECKS PD pilot study will be observed teaching by a trained ICF observer, one time. The CHECKS Study ICF evaluation team will conduct a one-day in-person training with participating middle school and high school health education teachers and throughout the year, the participating teachers will complete the remaining components of the CHECKS PD pilot study virtually through a Learning Management System (LMS) hosted by ICF called Inquisiq.

The LMS allows for all of the teacher post-training (N=7) surveys to be completed online and data is stored securely within the system. The teachers will provide basic registration information (name and email) for the purpose of communication related to the study, but an ID will be created and all data will be collected, stored, analyzed and reported using the ID only. After an online or in-person CHECKS training event is completed, respondents are invited to complete a series of brief CHECKS post-training surveys (N=7). CHECKS post-training surveys are designed to elicit information from respondents about their satisfaction with the training, relevance of the content, and changes in knowledge and skills as a result of participating in the training.

The teacher pre/post measurement survey tool (N=2) will be completed via SurveyMonkey and will be distributed to the respondents with the email they provide with enrollment in the CHECKS PD pilot study. The ICF evaluation team will link the data to the respondent unique ID and all data will be stored, analyzed and reported using the unique ID only. The teacher pre/post measurement survey instrument, observation tool, and student survey were developed from a comprehensive review of seven teacher surveys, six observation tools, and three student surveys. Building on the indicators identified in the Health Education Teacher Instructional Competency (HETIC) Framework⁹ additional items were incorporated and revised to form a master list of IC indicators to be included in the final teacher survey. The observation protocol and student survey include a subset of observable ICs. The student survey also takes readability issues into account. The three instruments were pilot tested with health education teachers, students, and subject matter experts with experience in classroom observation and refined using the results of cognitive interviews.

No sensitive information is being collected. PII is only being collected for contacting and registering teachers. Respondents will provide name and email addresses as basic registration to the LMS but none of this information will be linked to the data collected. An ID will be created upon registration to the LMS and this will be used to store and analyze all data and for communication regarding the CHECKS PD pilot study during the pilot period. The student survey will be conducted either via paper and pencil or virtually via

Survey Monkey, depending on computer access and COVID-19 mitigation, and no identifying information will be collected from the students. The observation will be conducted via paper and pencil by the ICF evaluation team.

Without this data collection, DASH would be unable to assess the following:

1. To what extent can health education teacher ICs be measured with validity and reliability?
2. How well do instructional observations correlate to teacher and student surveys of ICs?
3. Which specific ICs are present in teachers who are identified as being master teachers versus emerging teachers?
4. To what extent does participation in the CHECKS PD pilot change teacher ICs in health education?
5. To what extent are teacher participation in the CHECKS PD pilot and post self-assessment of ICs associated with student perceptions of their relationships with teachers and the relevance of health education instruction they received?
6. How can findings from the CHECKS PD pilot be used to improve the PD for full implementation?

A. 3 Use of Improved Information Technology and Burden Reduction

All data collection will be web-based quantitative surveys for this data collection except for students who do not have computer access, a paper-pencil version of the survey will be provided. This will reduce burden because this approach ensures data quality but decreases respondent burden with built-in skip logic. The information collection instrument was designed to collect the minimum information necessary for the purposes of this project using built-in skip logic. In addition, the web-based administration allows respondents to easily access the data collection instrument at a time and location that is most convenient for them.

A. 4 Efforts to Identify Duplication and Use of Similar Information

In preparation for the collection of data from Portland Public Schools, the project team searched for existing information or data collection activities that asked about the newly developed CHECKS PD package. There was no instrument or data collection that gathered all the information we seek to collect. For this reason, the project team developed the *CHECKS PD Pilot Study Evaluation* data collection tools. The newly developed quantitative surveys will allow the project team to collect the relevant data. There is no other source of information that can provide the relevant data.

A. 5 Impact on Small Businesses or Other Small Entities

No small businesses or other small entities will be involved in or impacted by this data collection.

A. 6 Consequences of Collecting the Information Less Frequently

This pilot study will take place throughout the 2021-2022 academic year in Portland Public Schools, beginning in the summer and consists of a total of 20 hours of professional learning via the CHECKS PD pilot study. There are no legal obstacles to reducing the burden. Collecting the data less frequently would mean not collecting the data at all, and there could be negative consequences. The findings will be used to inform the knowledge and dissemination around the effectiveness of the CHECKS PD package in improving health education teacher's ability to teach health education.

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

This request fully complies with the regulation 5 CFR 1320.5.

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

A. The Federal Register notice was published for the generic umbrella collection on Monday, April 23, 2018, Vol. 83, No. 78, pp. 17663. No public comments were received.

B. CDC contractors in collaboration with DASH subject matter experts provided extensive input into the clarity of the instructions, content of the survey questions, and the respondent universe. A list of subject matter experts consulted is provided in **Attachment 17: Individuals Providing Consultation on the Information Collection**. There were no major problems that arose during the consultation, and all issues raised were resolved.

A.9 Explanation of Any Payment or Gift to Respondents

ICF initiated a self-nomination process, open to all DASH 1807 recipients, to recruit interested sites for participation in the CHECKS PD Pilot study. ICF, in partnership with DASH, selected Portland Public Schools as the site to participate in the CHECKS PD Pilot study. For health teachers that volunteer to participate in the CHECKS PD pilot study, in accordance with labor laws, ICF will work with Portland Public Schools to ensure all respondents are provided an appropriate level of compensation, including the cost of teacher training or coverage for substitute teachers to cover missed classes. All students of participating health teachers that volunteer to participate in the CHECKS PD Pilot study will be asked to complete the brief survey and a token of appreciation will be provided to each health teacher's class. Although there has been some debate on the necessity of offering tokens of appreciation, numerous studies have suggested that tokens of appreciation can significantly increase response rates. This improves the validity and reliability of the data, which is of utmost importance in this evaluation. Based on this research, in order to encourage and improve response rates, classroom-level tokens of appreciation will be provided to thank students for their participation. The token of appreciation will be a \$100 gift card provided to health teachers who are participating in the study to allocate as deemed appropriate among the class. The classroom-level token will be provided to each health teacher's class and is not contingent on parent consent or student assent to take the survey. The use of gifts can help motivate potential survey participants to take the time to participate in a survey. This can help minimize bias in survey results due to variations in students' interest in the topic and yield more valid and reliable data. Krueger and Casey (2009)¹¹ note that the gift helps emphasize to participants that the assessment is important, which in turn will make them more inclined to make time to participate.

It is for these reasons that the study team is proposing to offer gifts for student survey participants. Both Goldenkoff (2004)¹² and Quinn Patton (2002) support the use of gifts/incentives.¹³ We expect the value of the gifts for students to be sufficient to improve participation rates. In consultation with Portland Public School staff, we believe the classroom token of appreciation is appropriate. Portland Public Schools suggested this amount could be used to provide a class lunch, snack, or supplies as selected by the students and teacher. IRB approval of the study included the review and approval of the gift for students (see **Attachment 15** for IRB approval letter).

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

The CDC NCHHSTP Privacy and Confidentiality Review Officer has assessed this package for applicability of 5 U.S.C. § 552a, and has determined that the Privacy Act does not apply to the information collection. No individually identifiable information will be collected, and no sensitive information is being collected. CDC will not receive any personally identifiable information. Staff names and emails are publicly available on district websites. CDC staff have reviewed this information collection request and determined that the Privacy Act does not apply, **Attachment 18- Privacy Impact Assessment**.

The quantitative survey data and all identifying information about the teacher respondents (name and email) will be handled in ways that prevents unauthorized access at any point during the study. Because Portland Public Schools staff will be inviting teachers to participate in the CHECKS PD pilot study, the ICF evaluation team will only have respondent name and email if they consent to participate in the pilot, and each respondent will be provided with an ID. Only name and email addresses will be collected when enrolling in the pilot study. No PII will be collected from the student survey, so it will be completely anonymous. Information will be kept in separate password protected files from the quantitative survey data and not provided to CDC. No sensitive information is being collected and no PII will be recorded or stored as part of the survey or database. Once data collection is complete it will be converted to SPSS file format and stored on a secure network location with respondent ID only.

Electronic data collection and data management systems used for these activities will comply with the current encryption security standards. Our information security process is based on the approach prescribed by the Federal Information Security Management Act of 2002 (FISMA, 44 U.S.C. § 3541 et seq.) as implemented by the Office of Management and Budget (OMB) in Circular A-130 and other policy documents. Electronic data are maintained in our Tier IV data center or in our high-security onsite systems and are set up using a "least privilege" protocol that permits users the least amount of access required to perform their duties.

Consent

Portland Public School staff will invite teachers to participate in the CHECKS PD pilot study using their internal contact lists. ICF will not see any names or email addresses of those who are invited to participate. ICF will not have access to any PII (name and e-mail address) unless teachers consent to participate. Individuals may choose not to provide PII by simply declining to participate. Teachers may choose to opt-out by denying recruitment to the evaluation when initially invited by Portland Public School staff (and therefore, not providing PII). (**Attachment 12**)

Students and parents will be provided consent/assent documents (**Attachment 13 and 14**) prior to participation in the student measurement tool survey. If parents choose to opt- their student out, the student will not be required to complete the measurement tool survey. If the student does not assent, they will not be required to complete the measurement tool survey.

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

IRB Approval

The proposed web-based data collection and qualitative interviews have been reviewed and approved on 12/21/2020 by the existing contractor's IRB (**Attachment 15**).

Sensitive Questions

No sensitive questions are being asked on the web-based quantitative survey and no identifiable information is being collected. Responses will only be reported in aggregate. All respondent information associated with the study will be collected and stored in a password-protected electronic file on a secure network accessible only by the Contractor's study team.

A.12. Estimates of Annualized Burden Hours and Costs

The annualized response burden is estimated at 662 hours. Exhibits A.12.A provides details about how this estimate was calculated. Timings were conducted during instrument development process to support the overall burden per respondent.

The consent will be provided to 50 health teachers requiring one response which is estimated to take 5 minutes to read either accept or decline for a total of 4 burden hours. Fifty (50) health teachers will complete the web-based survey requiring 2 responses estimated to take 20 minutes each for a total of 33 burden hours. Fifty health teachers will also complete 7 brief post-training surveys which are estimated to take 7 minutes each for a total of 42 burden hours. Approximately 1,750 students will complete a consent and quantitative survey requiring just 1 response estimated to take 20 minutes for a total of 583 burden hours.

Exhibit A.12.A Annualized Burden Hours

Type of Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Average Hours Per Response	Maximum Response Burden (Hours)
Health Teachers	Consent Statement (attachment 12)	50	1	5/60	4
Health Teachers	Web-based teacher measurement tool (attachment 9 and 9a)	50	2	20/60	33
Health Teachers	Web-based post-surveys (Att2-att8)	50	7	7/60	42
Students	Consent and quantitative survey (virtual or paper/pencil) (attachments 10, 10a, 13 and 14)	1750	1	20/60	583
Total					662

A.12.B Estimated Annualized Costs

The quantitative surveys are intended to be completed by Portland Public School employees who are middle of high school health teachers as well as middle school and high school students. The labor category of Preschool, Elementary, Middle, Secondary, and Special Education Teachers for PPS middle school and high school teachers and Oregon minimum wage for students are the labor categories identified that most

closely matched the professional samples. The annualized cost to the respondent shown in Exhibit A.12.B is based on this labor category.

The United States Department of Labor, Bureau of Labor Statistics Occupational Employment Statistics (https://www.bls.gov/oes/current/naics4_611100.htm) was used to estimate the hourly wage rate for Preschool, Elementary, Middle, Secondary, and Special Education Teachers for this request. The median hourly wage for this category, \$30.87 per hour, is used to estimate the hourly wage for managers of training and development. Oregon's hourly minimum wage used for middle school and high school students is \$11.25 per hour (<https://www.oregon.gov/boli/workers/Pages/minimum-wage-schedule.asp>). Thus, the total anticipated annual cost to respondents for collections of information will be **\$8,971.97**.

Exhibit A.12.B. Annualized Cost to Respondents

Activity	Total Burden Hours	Hourly Wage Rate	Total Respondent Cost
CHECKS PD Pilot Study Consent Statement	4	\$30.87	\$129.65
Teachers web-based measurement tool	33	\$30.87	\$1,027.97
Web-based post surveys #1-7	42	\$30.87	\$1,253.35
Student Consent and quantitative survey measurement tool	583	\$11.25	\$6,561.00
Total	662		\$8,971.97

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

CDC does not anticipate providing start up or other related costs to private entities.

A.14. Annualized Costs to the Government

The total annualized cost to the government, including direct costs to the federal government and contractor expenses is \$244,794.60. Cost will be incurred by the government in personnel time for overseeing the project. CDC time and effort for general project oversight of the contractor for project design, data collection, and analysis and dissemination are estimated at 5% for a GS-14 (step 7) level Atlanta-based CDC employee and 5% for a GS-13 (step 3) level Atlanta-based CDC employee for the one year of the project. The grade and step levels were determined based on the staff currently proposed to work on the project. The average annual cost to the federal government for oversight is \$11,941 (**Table A.14.A**).

The contractor's costs are based on estimates provided by the contractor that helped plan the data collection activities. With the expected period of performance, the annual cost to the federal government from contractor and other expenses is estimated to be approximately \$232,853.60. This is the cost

estimate based on the incurred and projected labor required to design, program, collect, clean, analyze and report findings of the contractor at approximately 20% of the estimated contract value for the CHECKS PD Pilot Study in the base and option year one (approximately \$582,134).

Exhibit A.14.A

Expense Type	Expense Explanation	Annual Costs (dollars)
Direct Costs to the Federal Government		
CDC oversight of the project	1 CDC Senior Health Scientist at 5% (GS-14)	\$6,815
CDC oversight of contractor and project	1 CDC Health Scientist at 5% (GS-13)	\$5,126
	Subtotal, Direct costs	\$11,941
Assistance with data collection, processing, and preliminary analysis	Labor and other direct costs for supporting data collection, processing, and analysis	\$232,853.60
	TOTAL COST TO THE GOVERNMENT	\$244,794.60

A.15. Explanation for Program Changes or Adjustments

This is a new information collection.

A.16. Plans for Tabulation and Publication and Project Time Schedule

Data collection will take place over the 2021-2022 academic year. It is critical for this data collection to begin no later than June 2021 in order to engage teachers to participate in the CHECKS PD pilot study over the 2021-2022 academic year. As such, we are requesting to receive OMB approval for this information collection by the end of May 2021. Data analysis, summaries, and reports (unpublished) will begin in Spring of 2022. Data analysis will begin within two weeks after completion of the web-based quantitative survey instruments. ICF will produce a summary of key findings to be shared with DASH. For instrument validation, we will first use descriptive analysis to examine teacher survey, observation, and student survey data, separately, focusing on central distributions statistics. In addition, we will conduct exploratory and confirmatory factor analysis to assess the extent to which items load to the domains of the instruments. Items with low loading or loading to the same underlying domains will be removed to improve the validity of the instruments. The internal consistency (reliability) of the instruments will be analyzed using Cronbach's alpha.

Figure A.16: Project Time Schedule

Activity	Time Schedule
Design information collection instruments	Complete
Develop data collection protocol and analysis plan	Complete
Pilot test information collection instruments	Completed
Receive ICF IRB approval	In Progress
Prepare OMB package	In Progress
Receive OMB approval	In Progress
Recruit teachers for participation in the CHECKS PD pilot study	1 month following OMB approval
Data Collection	12 months following OMB approval
Data Analysis	14 months following OMB approval

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

The display of the OMB expiration date is not inappropriate. The web-based quantitative surveys will display the expiration date for OMB approval of the information collection. We are not requesting an exemption.

A.18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

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