service area rather than specific addresses of providers.

*Response:* The purpose of FORHP's rural definition is to delineate the land area of the United States as rural or non-rural. The areas identified as rural by this definition may include both service areas and specific provider addresses.

After consideration of the public comments received, HRSA is implementing the rugged terrain inclusion in the definition of rural area as proposed. FORHP is making this change consistent with its program authority to award grants to support rural health and rural health care services.

**Updated Definition of Rural Area**

HRSA is updating FORHP's rural definition to include geographic areas meeting any one of the following criteria:

(1) Non-metropolitan counties
(2) Outlying metropolitan counties with no population from an urban area of 50,000 or more people
(3) Census tracts with RUCA codes 4–10 in metropolitan counties
(4) Census tracts of at least 400 square miles in area with population density of 35 or less per square mile with RUCA codes 2–3 in metropolitan counties
(5) Census tracts with RRS 5 and RUCA codes 2–3 that are at least 20 square miles in area in metropolitan counties

The changes will go into effect as of November 21, 2024. These changes will apply to FORHP's Notices of Funding Opportunity for FY 2025 and future years for programs that require funded activities and services be provided in rural areas, as defined by HRSA. FORHP will ensure information about the updated rural definition is available to the public on the HRSA website and in funding opportunities. These changes reflect FORHP's desire to accurately identify rural areas using a data-driven methodology that relies on established geographic identifiers and standard, national-level data sources.

**Impact**

Incorporating rugged terrain data into the definition of rural area using the adopted method adds 84 census tracts and approximately 305,000 people to the 60.8 million people living in FORHP-designated rural areas. This is an increase of 0.5 percent in the total number of people living in rural areas. Table 1 show the number of newly rural census tracts by state.

TABLE 1—NUMBER OF NEWLY RURAL CENSUS TRACTS BY STATE

| State | Number of tracts |
|---|---|
| CA | 24 |
| OR | 16 |
| NC | 12 |
| WA | 9 |
| TN | 7 |
| CO | 6 |
| WV | 6 |
| MT | 2 |
| AK | 1 |
| MD | 1 |
| Total | 84 |

**Note:** Table shows the number of newly rural census tracts with RRS 5 and RUCA codes 2–3 that are at least 20 square miles in area in metropolitan counties. Data in this table are based on 2010 census tract geographies and 2020 metropolitan county delineations. For a complete list of impacted census tracts see *https://www.hrsa.gov/rural-health/about-us/what-is-rural/data-files.*

**Carole Johnson,**
*Administrator.*

[FR Doc. 2024–27133 Filed 11–20–24; 8:45 am]

BILLING CODE 4165–15–P

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### National Institutes of Health

### National Human Genome Research Institute; Notice of Closed Meeting

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

*Name of Committee:* Center for Inherited Disease Research Access Committee.

*Date:* January 10, 2025.

*Time:* 11:30 a.m. to 12:30 p.m.

*Agenda:* To review and evaluate grant applications.

*Address:* National Human Genome Research Institute, National Institutes of Health, 6700B Rockledge Drive, Room 3172, Bethesda, MD 20892 (Virtual).

*Contact Person:* Barbara J. Thomas, Ph.D., Scientific Review Officer, Scientific Review Branch, National Human Genome Research Institute, National Institutes of Health, 6700B Rockledge Drive, Room 3172, Bethesda, MD 20892, (301) 402–8837, *barbara.thomas@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.172, Human Genome Research, National Institutes of Health, HHS)

Dated: November 15, 2024.

**David W. Freeman,**
*Supervisory Program Analyst, Office of Federal Advisory Committee Policy.*

[FR Doc. 2024–27167 Filed 11–20–24; 8:45 am]

BILLING CODE 4140–01–P

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Substance Abuse and Mental Health Services Administration

### Agency Information Collection Activities: Proposed Collection; Comment Request

In compliance with section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 concerning the opportunity for public comment on proposed collections of information, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the information collection plans, call the SAMHSA Reports Clearance Officer at (240) 276–0361.

*Comments are invited on:* (a) Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

**Proposed Project: Minority AIDS Initiative: Substance Use Disorder Prevention and Treatment Pilot Program (MAI PT Pilot) Data Collection Instruments**

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT) are requesting approval from the Office of Management and Budget (OMB) to monitor the Minority AIDS Initiative: Substance Use Disorder Prevention and Treatment Pilot Program (MAI PT Pilot)

through administration of a suite of data collection instruments for grant compliance and programmatic performance monitoring. This package describes the data collection activities and proposed instruments. Two instruments will facilitate grant compliance monitoring, and the third instrument is designed for program performance monitoring.

- The *MAI PT Pilot—Organizational Readiness Assessment (MAI–ORA)* is a one-time self-assessment tool intended to guide MAI PT Pilot grant recipients to objectively assess their capacity to provide substance use prevention, substance use disorder or co-occurring mental health disorder treatment, and HIV, viral hepatitis, and sexually transmitted infection prevention, screening, testing, and referral services for racial and ethnic individuals vulnerable to these conditions. Results from the MAI–ORA will allow SAMHSA to determine grantee readiness and capacity to implement their grant program, so that SAMHSA can provide additional support, as needed, to ensure grant compliance.
- The *MAI PT Pilot—Programmatic Progress Report (MAI–PPR)* is a template that grantees will use to report annual progress and will be used to monitor grant compliance.
- The *MAI PT Pilot—Online Reporting Tool (MAI–PORT)* will be used to conduct programmatic performance monitoring. The MAI–PORT is comprised of two main sections: (1) Annual Targets Report section for MAI PT Pilot grant recipients to report annual federal fiscal year programmatic goals, and (2) Quarterly Performance Report for grantees to report grant activities implemented during each federal fiscal quarter. In developing the MAI–PORT Annual Targets Report and the Quarterly Performance Report, CSAP/CSAT sought the ability to elicit programmatic information that demonstrates impact at the program aggregate level.

Data collected through the MAI–PORT are necessary to ensure SAMHSA and grantees comply with requirements under the Government Performance and Results Act Modernization Act of 2010 (GPRA) that requires regular reporting of performance measures. Additionally, data collected through these tools will provide critical information to SAMHSA's Government Project Officers (GPOs) related to grant oversight, including barriers and facilitators that the grantees have experienced, and an understanding of the technical assistance needed to help grantees implement their programs. The information also provides a mechanism to ensure grantees are meeting the requirements of the grant funding announcement as outlined in their notice of grant award. In addition, the tools reflect CSAP's and CSAT's desire to elicit pertinent program level data that can be used not only to guide future programs and practices, but also to respond to stakeholder, congressional and agency inquiries.

**Background and Purpose**

According to the Centers for Disease Control and Prevention (CDC), the spread of HIV in the United States is mainly through anal or vaginal sex or by sharing drug-use equipment. Although these risk factors are the same for everyone, due to a range of social, economic, and demographic factors, such as stigma, discrimination, income, education, and geographic region, some racial and ethnic groups are more affected than others. In 2021, CDC reported that although Black/African Americans represented 13 percent of the US population, they accounted for 42 percent (15,305) of the 36,801 new HIV diagnoses; Latino/Hispanic people represent 18.7 percent of the US population but accounted for 29 percent (10,494) of HIV diagnoses (CDC, 2024; United States Census Bureau, 2024).[1 2] Between 2017 and 2021, American Indian/Alaska Native (AI/AN), Native Hawaiian and other Pacific Islander populations were the only demographic groups identified by the CDC with an increase in HIV diagnoses in the United States (CDC, 2024).[3] Of the 31,800 new HIV infections in 2022, CDC reports that 71% (22,500) were among gay and bisexual men.[4]

Viral hepatitis also impacts some racial and ethnic groups disproportionally. In 2020, non-Hispanic blacks were 1.4 times as likely to die from viral hepatitis, as compared to non-Hispanic whites (Office of Minority Health, 2022). Non-Hispanic blacks were almost twice as likely to die from hepatitis C as compared to the white population, and while having comparable case rates for hepatitis B in 2020, non-Hispanic blacks were 2.5 times more likely to die from hepatitis B than non-Hispanic whites (Office of Minority Health, 2022). Additionally, the percentage of people aged 12 or older with past year substance use disorder (SUD) differed by race and ethnicity with the highest rates among American Indian/Alaska Native populations (24.0 percent), followed by Black, non-Hispanic populations (18.4 percent) (SAMHSA, 2023).[5]

The data clearly show the disproportionate burden faced by minority racial and ethnic groups and that these three issues should not be regarded as separate diseases acting independently, rather as a syndemic. To address this, SAMHSA is taking a syndemic approach to HIV, viral hepatitis, and substance use disorder through the MAI PT Pilot program. The purpose of this program is to provide substance use prevention, SUD treatment, HIV, and viral hepatitis prevention and treatment services for racial and ethnic medically underserved individuals vulnerable to a SUD and/or mental health condition, HIV, viral hepatitis, and other infectious disease (*e.g.,* sexually transmitted infection (STI)). The populations of focus for this program are individuals who are particularly vulnerable to or living with HIV/AIDS, including an emphasis on gay, bisexual, and other men who have sex with men, men who have sex with men and women (MSMW), Black, Latino, and AI/AN men who have sex with men (MSM), Asian and Pacific Islander, Black women, transgender men and women, youth aged 13–24 years, and People who Inject Drugs (PWID).

SAMHSA's MAI PT Pilot is informed by the key strategies and priority jurisdictions outlined in the Ending the HIV Epidemic in the U.S. (EHE) initiative, Viral Hepatitis National Strategic Plan and STI National Strategic Plan. The program also supports the National HIV/AIDS Strategy (NHAS) and 2023–2026 SAMHSA Strategic Plan. Recipients will be expected to take a syndemic approach to SUD, HIV, viral hepatitis, and STI by providing SUD prevention and treatment to racial and ethnic individuals at risk for or living with HIV. MAI PT Pilot is authorized under Sections 509 and 516 of the Public Health Service Act, as amended.

**Annualized Data Collection Burden**

Table 1 and Table 2 provides an overview of the data collection method,

[1] 2020 Census Illuminates Racial and Ethnic Composition of the Country.

[2] HIV Diagnoses.

[3] HIV in the United States by Race/Ethnicity: HIV Diagnoses.

[4] Fast Facts: HIV and Gay and Bisexual Men.

[5] Substance Abuse and Mental Health Services Administration. (2023). Strategic Plan: Fiscal Year 2023–2026. Publication No. PEP23–06–00–002. National Mental Health and Substance Use Policy Laboratory. *https://www.samhsa.gov/sites/default/files/samhsa-strategic-plan.pdf.*

frequency of data collection, and number of data collections for each data collection instruments.

TABLE 1—GRANT COMPLIANCE: MAI–ORA AND MAI–PPR

| Instrument | Data collection method | Frequency of data collection | Maximum number of data collections | Attachment No. |
|---|---|---|---|---|
| MAI–ORA | Grantees submit into SPARS | Once | Once in Year 1 | 1 |
| MAI–PPR | Grantees submit into eRA | Annually | *Annually:* 5 times (1 time per year in Years 1–5). | 2 |

TABLE 2—PROGRAM PERFORMANCE MONITORING: MAI–PORT

| Instrument | Data collection method | Frequency of data collection | Maximum number of data collections | Attachment No. |
|---|---|---|---|---|
| MAI–PORT | Grantees submit into SPARS | *Yearly:* Annual Targets Report (ATR).<br>*Quarterly:* Quarterly Performance Report (QPR). | *Yearly:* 5 times (1 time per year in Years 1–5).<br>*Quarterly:* 20 times (4 times per year in Years 1–5). | 3 |

The estimated time to complete each instrument by year is shown in Tables 3 through 8.

TABLE 3—ESTIMATES OF ANNUAL BURDEN FOR MAI PT DATA COLLECTION: YEAR 1

| Instrument | Number of respondents | Responses per respondent | Total number of responses | Hours per response | Total burden hours | Average hourly wage [1] | Total respondent cost |
|---|---|---|---|---|---|---|---|
| MAI–ORA | 8 | 1 | 8 | 14 | 112 | $48.35 | $5,415.20 |
| MAI–PPR | 8 | 1 | 8 | 3 | 24 | 48.35 | 1,160.40 |
| MAI–PORT/ATR | 8 | 1 | 8 | 1 | 8 | 48.35 | 386.80 |
| MAI–PORT/QPR | 8 | 4 | 32 | 2 | 64 | 48.35 | 3,094.40 |
| Total | 8 | 7 | 56 | 20 | 208 | 48.35 | 10,056.80 |

[1] Average hourly wage is based on the mean hourly wage for state government managers, as reported in the 2022 Occupational Employment (OES) by the Bureau of Labor Statistics (BLS) found at *https://www.bls.gov/oes/current/naics4_999200.htm#11-0000.* Accessed on January 15, 2024.

TABLE 4—ESTIMATES OF ANNUAL BURDEN FOR MAI PT DATA COLLECTION: YEAR 2

| Instrument | Number of respondents | Responses per respondent | Total number of responses | Hours per response | Total burden hours | Average hourly wage [1] | Total respondent cost |
|---|---|---|---|---|---|---|---|
| MAI–ORA | 8 | 0 | 0 | 14 | 0 | $48.35 | $0.00 |
| MAI–PPR | 8 | 1 | 8 | 3 | 24 | 48.35 | 1,160.40 |
| MAI–PORT/ATR | 8 | 1 | 8 | 1 | 8 | 48.35 | 386.80 |
| MAI–PORT/QPR | 8 | 4 | 32 | 2 | 64 | 48.35 | 3,094.40 |
| Total | 8 | 6 | 48 | 20 | 96 | 48.35 | 4,641.60 |

[1] Average hourly wage is based on the mean hourly wage for state government managers, as reported in the 2022 Occupational Employment (OES) by the Bureau of Labor Statistics (BLS) found at *https://www.bls.gov/oes/current/naics4_999200.htm#11-0000.* Accessed on January 15, 2024.

TABLE 5—ESTIMATES OF ANNUAL BURDEN FOR MAI PT DATA COLLECTION: YEAR 3

| Instrument | Number of respondents | Responses per respondent | Total number of responses | Hours per response | Total burden hours | Average hourly wage [1] | Total respondent cost |
|---|---|---|---|---|---|---|---|
| MAI–ORA | 8 | 0 | 0 | 14 | 0 | $48.35 | $0.00 |
| MAI–PPR | 8 | 1 | 8 | 3 | 24 | 48.35 | 1,160.40 |
| MAI–PORT/ATR | 8 | 1 | 8 | 1 | 8 | 48.35 | 386.80 |
| MAI–PORT/QPR | 8 | 4 | 32 | 2 | 64 | 48.35 | 3,094.40 |
| Total | 8 | 6 | 48 | 20 | 96 | $48.35 | $4,641.60 |

[1] Average hourly wage is based on the mean hourly wage for state government managers, as reported in the 2022 Occupational Employment (OES) by the Bureau of Labor Statistics (BLS) found at *https://www.bls.gov/oes/current/naics4_999200.htm#11-0000.* Accessed on January 15, 2024.

TABLE 6—ESTIMATES OF ANNUAL BURDEN FOR MAI PT DATA COLLECTION: YEAR 4

| Instrument | Number of respondents | Responses per respondent | Total number of responses | Hours per response | Total burden hours | Average hourly wage [1] | Total respondent cost |
|---|---|---|---|---|---|---|---|
| MAI–ORA | 8 | 0 | 0 | 14 | 0 | $48.35 | $0.00 |
| MAI–PPR | 8 | 1 | 8 | 3 | 24 | 48.35 | 1,160.40 |
| MAI–PORT/ATR | 8 | 1 | 8 | 1 | 8 | 48.35 | 386.80 |
| MAI–PORT/QPR | 8 | 4 | 32 | 2 | 64 | 48.35 | 3,094.40 |
| Total | 8 | 6 | 48 | 20 | 96 | 48.35 | 4,641.60 |

[1] Average hourly wage is based on the mean hourly wage for state government managers, as reported in the 2022 Occupational Employment (OES) by the Bureau of Labor Statistics (BLS) found at *https://www.bls.gov/oes/current/naics4_999200.htm#11-0000.* Accessed on January 15, 2024.

TABLE 7—ESTIMATES OF ANNUAL BURDEN FOR MAI PT DATA COLLECTION: YEAR 5

| Instrument | Number of respondents | Responses per respondent | Total number of responses | Hours per response | Total burden hours | Average hourly wage [1] | Total respondent cost |
|---|---|---|---|---|---|---|---|
| MAI–ORA | 8 | 0 | 0 | 14 | 0 | $48.35 | $0.00 |
| MAI–PPR | 8 | 1 | 8 | 3 | 24 | 48.35 | 1,160.40 |
| MAI–PORT/ATR | 8 | 1 | 8 | 1 | 8 | 48.35 | 386.80 |
| MAI–PORT/QPR | 8 | 4 | 32 | 2 | 64 | 48.35 | 3,094.40 |
| Total | 8 | 6 | 48 | 20 | 96 | 48.35 | 4,641.60 |

[1] Average hourly wage is based on the mean hourly wage for state government managers, as reported in the 2022 Occupational Employment (OES) by the Bureau of Labor Statistics (BLS) found at *https://www.bls.gov/oes/current/naics4_999200.htm#11-0000.* Accessed on January 15, 2024.

TABLE 8—ESTIMATES OF ANNUAL BURDEN FOR MAI PT DATA COLLECTION: ALL YEARS

| Instrument | Number of respondents | Responses per respondent | Total number of responses | Hours per response | Total burden hours | Average hourly wage [1] | Total respondent cost |
|---|---|---|---|---|---|---|---|
| MAI–ORA | 8 | 1 | 8 | 14 | 112 | $48.35 | $5,415.20 |
| MAI–PPR | 8 | 5 | 40 | 3 | 120 | 48.35 | 5,802.00 |
| MAI–PORT/ATR | 8 | 5 | 40 | 1 | 40 | 48.35 | 1,934.00 |
| MAI–PORT/QPR | 8 | 20 | 160 | 2 | 320 | 48.35 | 15,472.00 |
| Total | 8 | 31 | 248 | 20 | 592 | 48.35 | 28,623.20 |

[1] Average hourly wage is based on the mean hourly wage for state government managers, as reported in the 2022 Occupational Employment (OES) by the Bureau of Labor Statistics (BLS) found at *https://www.bls.gov/oes/current/naics4_999200.htm#11-0000.* Accessed on January 15, 2024.

*No comments were received during the 60-Day **Federal Register** comment period. However, the instruments have been revised to reflect comments received from the cognitive testing. Changes include:*

*MAI PT Pilot Organizational Readiness Assessment (MAI–ORA)*

- Added/revised instructions throughout to clarify meaning.
- Added list of definitions in appendix.
- Combined:
  - ○ service delivery and leveraging resources sections and
  - ○ four narrative sections and moved to the end of the instrument.
- Simplified/reformatted tables to improve flow and reduce grantee burden.
- Revised measures to clarify meaning, eliminate compound constructs, and reduce social desirability bias.
- Renumbered measures.

*MAI PT Pilot—Programmatic Progress Report (MAI–PPR)*

- Corrected typographical error in Public Burden Statement: Changed annual burden estimate from 24 hours to 3 hours.
- Added:
  - ○ general instructions in the beginning,
  - ○ instructions in Section 1 table, and
  - ○ additional instructions and examples throughout.
- Omitted:
  - ○ bottom three signature rows in Section 1 table and
  - ○ budget section.

*MAI PT Pilot Online Reporting Tool (MAI–PORT)*

- Added/updated instructions for clarification.
- Added:
  - ○ skip patterns to reduce grantee burden,
  - ○ two questions regarding content focus and level of implementation of planned prevention strategy, and
  - ○ items to QPR regarding details of inactive strategies.
- Updated:
  - ○ Race/ethnicity measures in ATR and QPR to be compliant with OMB's Statistical Policy Directive No. 15.
  - ○ SOGI measures in ATR and QPR.
  - ○ Appendix A: Added/revised definitions and
  - ○ Appendix B: Revised title from ''list of EBPs'' to ''List of Prevention Strategies,'' and added additional prevention strategies.
- Standardized language (*e.g.,* direct/individual-based, indirect/population based, unduplicated count).
- Reordered reached/served items of ATR and QPR so that ''reached'' is listed first.
- Eliminated demographics for ''reached'' in ATR and QPR.
- Grantees are now asked to report whether interventions are EBPP in ATR (added new status ''community-defined evidence practice'' and ''other'' criteria response options).

Written comments and recommendations concerning the proposed information collection should be sent by December 23, 2024 to the SAMHSA Desk Officer at the Office of Information and Regulatory Affairs, Office of Management and Budget

(OMB). To ensure timely receipt of comments, and to avoid potential delays in OMB's receipt and processing of mail sent through the U.S. Postal Service, commenters are encouraged to submit their comments to OMB via email to: *OIRA_Submission@omb.eop.gov.* Although commenters are encouraged to send their comments via email, commenters may also fax their comments to: 202–395–7285. Commenters may also mail them to: Office of Management and Budget, Office of Information and Regulatory Affairs, New Executive Office Building, Room 10102, Washington, DC 20503.

**Krishna Palipudi,**

*Social Science Analyst.*

[FR Doc. 2024–27294 Filed 11–20–24; 8:45 am]

**BILLING CODE 4162–20–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Substance Abuse and Mental Health Services Administration

### Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a summary of information collection requests under OMB review, in compliance with the Paperwork Reduction Act (44 U.S.C. chapter 35). To request a copy of these documents, call the SAMHSA Reports Clearance Officer on (240) 276–0361.

**Project: Training and Technical Assistance (TTA) Program Monitoring**

The Substance Abuse and Mental Health Administration (SAMHSA) will monitor program performance of its Training and Technical Assistance (TTA) programs. The TTAs disseminate current behavioral health services research from the National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, National Institute of Mental Health, National Institute of Justice, and other sources, as well as other SAMHSA programs. To accomplish this, the TTA programs develop and update state-of-the-art, research-based curricula and professional development training.

The TTA programs hold a variety of events: technical assistance, meetings, trainings, and presentations. A TTA technical assistance event is defined as a jointly planned consultation generally involving a series of contacts between the TTA and an outside organization/institution during which the TTA provides expertise and gives direction toward resolving a problem or improving conditions. Technical assistance events can be categorized into universal, targeted, and intensive. Other TTA events such as meetings, training, presentations, strategic planning and learning collaboratives are utilized to support technical assistance. These events are TTA-sponsored or co-sponsored events in which a group of people representing one or more agencies other than the TTAs work cooperatively on a project, problem, and/or policy. SAMHSA intends to use three (3) instruments for program monitoring of TTA events as well as ongoing quality improvement, which are described below.

1. *TTA Event Description Form (EDF):* The EDF collects event information. The form includes 10 questions of TTA faculty/staff relating to the event focus and format. It allows the TTAs and SAMHSA to track the number of events held (See Attachment 1).

2. *TTA Post Event Form:* The Post Event Form will be administered immediately following the event. The form includes 16 questions of each individual that participated in the event (Attachment 2). The instrument asks the participants to report on general demographic information (gender, race, sexual orientation, level of education, primary profession), principal employment setting, employment zip code, satisfaction with the event, if they expect the event to benefit them professionally, if they expect the event to change their practice and if they would recommend the event to a colleague.

3. *TTA Follow-up Form:* The Follow-up Form will be administered 60-days after all events that last a minimum of three (3) hours. The form will be administered to a minimum of 25% of participants who consent to participate in the follow-up process. The includes 13 questions (Attachment 3). The instrument asks the participants to report if the information provided at the event benefited their professional development, will change their practice, if they will use the information in their future work, if information will be shared with colleagues, how the event supported their work responsibilities, how the TTA can improve the events, and what other topics participants would like to see TTAs address and in what format.

The information collected on the three TTA forms will assist SAMHSA in documenting the numbers and types of participants in TTA events, describing the extent to which participants report improvement in their professional development, and which method is most effective in disseminating knowledge to various audiences. This type of information is crucial to support SAMHSA in complying with GPRA reporting requirements and will inform future development of knowledge dissemination activities.

The chart below summarizes the annualized burden for this project.

| Type of respondent | Number of respondents | Responses per respondent | Total responses | Hours per response | Total annual burden hours | Hourly wage cost | Total hour cost |
|---|---|---|---|---|---|---|---|
| TTA Faculty/Staff: | | | | | | | |
| TTA Event Description Form | 113 | 48 | 5,424 | .16 | 867.84 | $28.89 | $25,071.90 |
| Meeting and Presentations Respondents. | | | | | | | |
| TTA Post-Event Form | 300,057 | 1 | 300,057 | .16 | 48,009.00 | 28.89 | 1,386,983.48 |
| TTA Follow-up Form | 13,566 | 1 | 13,566 | .16 | 2,170.56 | 28.89 | 62,707.48 |
| Total | 313,736 | | 319,047 | | 51,047.40 | | 1,474,762.86 |

**Summary Table**

| Instruments | Number of respondents | Responses per respondents | Annual burden hours |
|---|---|---|---|
| TTA Event Description Form | 113 | 48 | 867.84 |
| TTA Post Event Form | 300,057 | 1 | 48,009.00 |