

**SUPPORTING STATEMENT
PART A
FOR
OMB INFORMATION COLLECTION REQUEST**

**National Public Health Performance Standards Program
State Public Health System Performance Assessment Instrument
(OMB Control Number: 0920-0557)**

July 19, 2010

**Centers for Disease Control and Prevention
Division for Public Health Performance Improvement
Office of State, Tribal, Local and Territorial Support (OSTLTS)
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A. JUSTIFICATION

The Office of Chief of Public Health Practice is requesting an extension without changes and three-year clearance for OMB No. 0920-0557, National Public Health Performance Standards Program, State Public Health System Performance Assessment Instrument.

1. Circumstances Making the Collection of Information Necessary

The mission of the Centers for Disease Control and Prevention (CDC) is to promote health and quality of life by preventing and controlling disease, injury, and disability. The National Public Health Performance Standard Program (NPHPSP) information collection is intended to contribute to this mission by providing optimal standards for public health practice and by measuring the achievement of those standards at the state and local levels. The State Public Health System Performance Assessment Instrument queries respondents and generates data for use in health policy development, resource allocation, and quality improvement efforts.

State and local public health practice form the backbone of the nation's health system, but little is known about capacity and performance. The NPHPSP was established to address this problem and is based on the following three principles:

- Public health must be accountable to its constituencies.
- Public health professionals need a system for assessing the provision of Essential Public Health Services.
- The public health decision-making process must be based on strong evidence and assessment of current needs.

The NPHPSP is a volunteer data collection effort. The assessment instruments are designed to collect the evidence necessary to refine the domestic public health infrastructure. During the past decade, CDC has worked with other Department of Health and Human Services (DHHS) agencies, key national public health associations, state and local health officials, boards of health, and academic institutions to explore and better articulate the state and local public health infrastructure. Through the identification of infrastructure objectives for Healthy People 2010, the development of a national public health systems research agenda, and other related efforts, these organizations and constituencies have identified the need for better data on the status of the public health infrastructure. The NPHPSP was designed, in part, to address this urgent need. These assessments facilitate development of a strong national infrastructure that will result in improved national, state, and local capacity to detect and effectively respond to public health threats.

The NPHPSP is intended to help users answer questions such as, "What are the components, activities, competencies, and capacities of our public health system?" and "How well are the

Essential Services being provided?” The dialogue that occurs in answering these questions will identify strengths and weaknesses; this information can be used to improve and better coordinate public health activities at the state and local levels. Lastly, the results gathered will provide an understanding of how state and local public health systems and governing entities are performing. This information will help local, state, and national policymakers make better and more effective policy and resource decisions that will improve the nation’s public health as a whole.

The NPHPSP is intended to improve the quality of public health practice and the performance of public health systems by:

- Providing performance standards for public health systems and encouraging their widespread use;
- Engaging and leveraging national, state, and local partnerships to build a stronger foundation for public health preparedness;
- Promoting continuous quality improvement of public health systems; and
- Strengthening the science base for public health practice improvement.

The NPHPSP is a collaborative effort of seven national partner organizations:

- Centers for Disease Control and Prevention, Office of State, Tribal, Local and Territorial Support (CDC / OSTLTS)¹,
- American Public Health Association (APHA),
- Association of State and Territorial Health Officials (ASTHO),
- National Association of County and City Health Officials (NACCHO),
- National Association of Local Boards of Health (NALBOH),
- National Network of Public Health Institutes (NNPHI), and
- Public Health Foundation (PHF).

The NPHPSP includes three instruments:

- The State Public Health System Performance Assessment Instrument (State Instrument) focuses on the “state public health system.” This system includes state public health agencies and other partners that contribute to public health services at the state level. The instrument was developed under the leadership of ASTHO and CDC. (OMB No. 0920-0557)

¹ The original clearance package was submitted from CDC’s Public Health Practice Program Office, and previous extension and revision packages were submitted by CDC’s Office of Chief of Public Health Practice. Due to recent CDC reorganization activities, , , the National Public Health Performance Standards Program is now housed in the CDC Office of State, Tribal, Local and Territorial Support. .

- The Local Public Health System Performance Assessment Instrument (Local Instrument) focuses on the “local public health system” or all entities that contribute to the delivery of public health services within a community. This system includes all public, private, and voluntary entities, as well as individuals and informal associations. The local instrument was developed under the leadership of CDC and NACCHO. (OMB No. 0920-0555)
- The Local Public Health Governance Performance Assessment Instrument (Governance Instrument) focuses on the governing body ultimately accountable for public health at the local level. Such governing bodies may include boards of health or county commissioners. The governance instrument was developed under the leadership of CDC and NALBOH. (OMB No. 0920-0580)

Although each instrument was developed under the collaborative leadership of a specific partner organization and CDC, all partners were involved throughout the entire process. Additionally, the instruments were collectively reviewed to ensure that each is complementary and supportive of the others and includes consistent terminology and concepts.

The national partners represent many of the organizations and individuals that use the assessment instruments. Through working groups and field test activities, representatives from these organizations have been continuously involved in developing, reviewing, testing, and refining the instruments. A peer-guided development process occurred during 1998-2002 during the development of the original instruments; this process was replicated recently during the recent revision activities of each instrument.

During 2005-2006, the three NPHPSP instruments were updated based on experience from the field and new developments in public health practice. Updates were undertaken for each of the three NPHPSP instruments: the state public health system assessment, local public health system assessment and local governance assessment. Three work groups of practitioners (representing ASTHO, NACCHO, and NALBOH constituencies) were convened to oversee each set of updates. The general purpose of the process was to assure the standards remain current and also to improve the language and user-friendliness of the instruments. During the revision process, CDC also worked with subject matter experts and key organizations to determine content areas that needed to be updated or modernized. Expert input was solicited in areas such as preparedness, informatics, health marketing, partnerships, workforce, public health law, and laboratory issues. As a result of this entire process, new versions of the instrument (subsequently referred to as “Version 2”) were developed.

A limited field testing process, using four state sites, was undertaken to identify areas for improvement within the instruments, assess the extent to which improvements in utility have been achieved, demonstrate a longitudinal linkage to the currently available instruments, assess the impact of changes made, and gather an understanding of the implementation process related to the updated instruments (including information to inform a revised time burden for OMB clearance). The Version 2 instruments received a three-year OMB approval for data collection

on August 24, 2007.

The use of the NPHPSP instruments is intended to result in numerous benefits, including:

- Improving organizational and community communication and collaboration, by bringing partners to the same table.
- Strengthening the diverse network of partners within state and local public health systems, which can lead to more cohesion among partners, better coordination of activities and resources, and less duplication of services.
- Providing a mechanism for measuring public health practice and performance.
- Identifying strengths and weaknesses that can be addressed in quality improvement efforts.
- Providing a benchmark for public health practice improvements, by setting a “gold standard” to which public health systems can aspire.

There are four concepts that have helped frame the National Public Health Performance Standards into their current format:

1. The standards are designed around the ten Essential Public Health Services. The use of the Essential Services framework assures that the standards cover the gamut of public health action needed at state and community levels.²
2. The standards focus on the overall public health system, rather than a single organization. A public health system includes all public, private, and voluntary entities that contribute to public health activities within a given area. This ensures that the contributions of all entities are recognized in assessing the provision of essential public health services.
3. The standards describe an optimal level of performance rather than provide minimum expectations. This ensures that the standards can be used for continuous quality improvement.
4. The standards are intended to support a process of quality improvement. In responding to the questions, system partners determine which elements of the model standards they do or do not meet. They then should develop action plans for improving their performance in the low-scoring areas.

2. Purpose and Use of Information Collection

This data collection is authorized under Section 301 of the Public Service Act (42, USC 241) (Attachment A). The CDC, state, and local public health systems use this instrument to assess the capacity of public health systems to deliver the ten Essential Public Health Services, and assist in targeting resource investments. This instrument assists both agencies and public health systems representatives. The public health agency submits on behalf of the public health system.

²The Essential Public Health Services are: Monitoring Health Status; Diagnosing and Investigating Health Problems; Informing, Educating, and Empowering People; Mobilizing Community Partnerships; Developing Policies and Plans; Enforcing Laws and Regulations; Linking People to Needed Services; Assuring a Competent Workforce; Conducting Evaluations; and Conducting Research.

The public health system is defined as “The collection of public, private and voluntary entities, as well as individuals and informal associations that contribute to the public’s health within a jurisdiction.”

The NPHPSP is applied as part of a public health system self-assessment process. Public health systems and local boards of health voluntarily conduct data collections for infrastructure self-assessment and quality improvement. CDC and NPHPSP partners support the process by providing technical assistance and training tools, computer-generated data analysis and reports of results.

States and localities self-select and participate voluntarily. States jurisdictions can choose to undertake only the state assessment, but the process is generally encouraged through a statewide coordinated approach. In this manner, both the state assessment and local assessment are used during a similar time period, which assists states and localities in maximizing the assessment results for planning and improvement.

Regardless of whether the instrument is supported through a statewide approach or by a state jurisdiction undertaking only the state assessment, the assessment and data collection are accomplished in the same manner. CDC recommends that the governmental public health agency serve as the lead organization in submitting the instrument responses, although in some jurisdictions other entities have been empowered with this authority. Technical assistance resources, such as the training workshops, the User Guide and NPHPSP staff, instruct responding jurisdictions on how to complete the assessment. Jurisdictions are also informed that they will need a User ID and survey password to enter data into the limited-access website. If they are completing the assessment through a statewide approach, NPHPSP staff provides the User IDs to the state coordinator. Other jurisdictions can contact CDC and its partner PHF (which directly assists with technical support of the limited-access website) at 1-800-747-7649 or by email at phpsp@cdc.gov or nphpsp-support@phf.org. The User IDs are disseminated with an instruction sheet (see Attachment G).

Since the national release in July 2002, 27 states and Washington DC have used the state assessment instrument and submitted data to CDC. Eight states have used the Version 2 instrument since 2007. The majority of these states conducted the assessment as part of a statewide process, in coordination with implementation of the local assessment throughout all of the state’s local jurisdictions. The concept of using both the state and local instruments through a statewide process is critical since it assists states and localities in maximizing the assessment results for planning and improvement.

Furthermore, the Public Health Infrastructure chapter in Healthy People 2010 includes an objective measuring the use of the performance standards. Objective 23-11 cites the NPHPSP as its sole data source and seeks to monitor and provide targets for state and local public health

systems that use the national standards. A similar objective is slated for inclusion in Healthy People 2020. Without continued data collection, there will be no ongoing data source for this important national objective. The NPHPSP also has been discussed as an important tool in significant national policy documents such as the 2003 Institute of Medicine's report, *The Future of the Public's Health in the 21st Century* and was also included in the HR 3962 Tri-Committee Health Reform Bill passed by the U.S. House of Representatives on November 7, 2009.

Other strategic linkages have been made to best assure the utmost value of the NPHPSP assessment instruments. In states such as Colorado, Oklahoma, and New Mexico, the NPHPSP was used as part of their bioterrorism planning activities to identify statewide strengths and weaknesses and priorities for public health infrastructure improvement. States such as Indiana and New Hampshire have used it as part of statewide performance improvement and quality improvement efforts. Further, the Local Instrument is used within a community health improvement tool entitled *Mobilizing for Action through Planning and Partnerships* (MAPP). MAPP includes four complementary assessments – one of which uses the NPHPSP local instrument to measure the performance of the local public health system. The linkage between MAPP and the NPHPSP encourages the use of performance standards within the context of a broader health improvement effort. The Turning Point Performance Management Collaborative (PMC), funded by the Robert Wood Johnson Foundation, also has emphasized the role the NPHPSP standards can play in improvement efforts.

Additionally, the NPHPSP standards have been incorporated into state regulations or legislation for public health infrastructure. This includes states such as Ohio, Illinois, and New Jersey. Both Ohio and New Jersey have incorporated state and local use of the NPHPSP as a required component of larger performance improvement and infrastructure reform efforts. Illinois has included the performance standards as a required assessment in their newly enacted State Health Improvement Plan Act. In these and many other states, the NPHPSP is having a positive impact as a tool for assessing the performance of public health systems.

Finally and most notably, the NPHPSP is also playing a valuable and critical role within new efforts to strengthen public health practice. CDC and its national partners (led by the Public Health Accreditation Board and including NACCHO, ASTHO, NALBOH, and APHA) have been engaged in an effort to design and build a national accreditation system. The NPHPSP standards were used as an important building block for developing the accreditation standards and measures and continue to serve as a critical tool for preparing the field for accreditation. While accreditation is focused on the public health agency and internal performance, the NPHPSP assessment offers an important complement that addresses the public health “system” and partnerships that exist within the jurisdiction. This is a vital complement to accreditation and in fact, the NPHPSP instrument is cited within the PHAB accreditation standards and measures as a process that can be used to demonstrate activity around measures relating to “mobilizing community partnerships.” States such as Indiana, Michigan and New Jersey have been using the NPHPSP to both strengthen system partnerships at the same time they prepare for

national PHAB accreditation.

Due to the many factors mentioned above, there has been increasing interest in the voluntary use of the performance standards. The NPHPSP has held annual training workshops; attendance has grown steadily during the seven years that this workshop has been offered. During the last three years, the Annual Training Workshop has reached its capacity attendance (capped at 120 attendees to ensure interaction and training opportunities) and has drawn participants from 38 different states. Registration and interest has grown so much that NPHPSP partners have created concurrent topic tracks for workshop attendees so as to retain the small-setting value of such a practical in-person training workshop. Further, monthly conference calls, webinars and distance learning training opportunities have further expanded training opportunities. The availability of a stable NPHPSP instrument will enable this momentum to continue.

It is important to recognize and acknowledge the substantial contributions the NPHPSP has made in providing public health leaders, policy makers, and program staff in a multitude of jurisdictions with an effective and efficient assessment and quality improvement process. The examples cited above provide considerable support for an extension of the instruments and their continued availability in the field.

In the years since the request for approval of data collection in 2002 and the more recent release of the NPHPSP Version 2 instruments in August 2007 the landscape of public health has continued to change considerably. The attention of public health leaders – at the national, state, and local levels – has been significantly diverted to bioterrorism preparedness and planning, in addition to other emerging public health issues such as West Nile Virus, SARS and more recently, the H1N1 Novel flu virus and economic challenges in state and local jurisdictions. These challenges, specially within the last two years have diverted several states' plans to undertake the NPHPSP. At the same, many states indicate it is important – “now more than ever” in the words of a Michigan public health leader – to use assessment tools such as the NPHPSP to identify and plan for more effective public health. And with the launch of national accreditation on the horizon and the mention of NPHPSP within the accreditation standards, many state and local jurisdictions will have renewed interest in using the NPHPSP to improve their public health systems

Although it is described above that a statewide coordinated approach is the ideal context for using the NPHPSP, this approach also requires a time investment in order to appropriately plan and coordinate the timing of such a statewide process. Many statewide coordinators will seek to use the assessment instruments during a key juncture in a multi-year health improvement and planning cycle. For example, Florida has incorporated their use of the NPHPSP into a larger state and local performance measurement and improvement program, which establishes a timeline stating their intent to use the NPHPSP in late 2010. Other states have sought to incorporate the NPHPSP into legislation prior to initiating its use. As an example, the Illinois State Health Improvement Plan Act, enacted in August 2004, supports the regular and periodic use of the performance standards as a tool in improving the public health system and health status of

Illinois residents. . From this experience CDC and the national partners have learned that it is critical to support state and local jurisdictions in their use of the NPHPSP at the time that works best for the state and local public health organizations. . Continued availability of the data collection instrument will assist them in assuring this is feasible.

Since its original release in 2002, it is clear that the NPHPSP has proven itself an important step toward achieving more consistently effective, high-performing public health systems in the United States. By providing national performance standards, a means for jurisdictions to assess their performance, and a catalyst for improvement strategies, the NPHPSP supports performance improvement and accountability of public health practice at both the state and local levels. The continued availability of these tools and the data collection instrument is critical to sustaining our ability to support these efforts and to build our understanding of public health practice. .

3. Use of Improved Information Technology and Burden Reduction

To minimize respondent burden, the surveys are web-based. Data collection, analysis, and reporting are automated. The web-based survey is the preferred method of choice; however, CDC recognizes that compliance depends on the availability of appropriate technology at the state and local levels. In areas with limited access to technology, CDC in conjunction with state liaison or national partners can provide technical assistance using hard copy surveys. The coordinated efforts of CDC, state liaisons, and national partners along with automated data processing minimize the burden to respondent.

4. Efforts to Identify Duplication and Use of Similar Information

Extensive literature searches were conducted using online databases such as Medline, Psycinfo, and Sociofile. No duplicative data collection has been conducted to date. Certain national organizations like ASTHO and NACCHO have published profiles of state and local health departments but such data does not contain in-depth information on performance or infrastructure. According to literature searches and evidence provided by public health systems research, to date, no duplicative assessment has been conducted. Although several states have developed performance assessment tools, none of the efforts duplicate the ability to collect and compare national data using a common assessment framework.

The NPHPSP instruments are designed to collect and analyze performance data, and to improve system-wide performance. These tools provide a common framework for measuring performance, define the desired optimal level of public health practice, provide practitioners with specific information on areas for improvement, provide objective data for development of health policy, and provide information to decision-makers to better target the use of their resources.

We are submitting similar extension requests for the Local Public Health System Performance Assessment and the Local Governance Performance Assessment. The primary difference

between these instruments is the scope. The local instrument focuses on the local public health system or all the entities that contribute to the delivery of public health services within a community. The local governance instrument focuses on the board of health or other similar governing entity. The state instrument focuses on the state public health system. The state public health system includes state public health agencies and other partners that contribute to public health services at the state level.

5. Impact on Small Businesses and Other Small Entities

The respondents for this survey will be state health departments. There are no small entities involved.

6. Consequences of Collecting the Information Less Frequently

It is critical to assure the data collection instruments remain viable instruments for the field of public health practice and for the jurisdictions that are seeking to use these tools to understand their state public health system. Numerous states are planning for use of the State Instrument and, if not available, will not have a viable tool for health improvement planning. Some have incorporated the use of the NPHPSP instruments into their legislation or regulation and therefore require its use during prescribed times. Other states have written the use of NPHPSP instruments into grant timelines and require their use during particular time periods; there will be consequences for these states’ ability to comply with their grant deliverables if the instruments are not available for use. Finally, the NPHPSP instruments are mentioned within the voluntary consensus standards developed as part of the national voluntary accreditation program by the Public Health Accreditation Board (PHAB) and many jurisdictions will seek to use the instruments as a component of their accreditation preparation activities. Additionally, if the information collection is undertaken on a less frequent basis, there will be consequences to the availability of current knowledge about state and local public health systems and boards of health. There are no legal obstacles to reduce burden.

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

There are no special circumstances for this data collection. This assessment is expected to take 12 hours to be completed by a workgroup. The table below explains the burden hours.

Explanation of Burden Hours		
TASK	Time Needed (in Hrs)	Explanation

Time for reviewing instructions and preparing for the assessment	2	Based on field test experience it requires 2 hours to review the instructions and prepare for the assessment. This assessment is a group effort, therefore, this step includes initial contact and orientation of workgroup members regarding the effort.
Review data sources, discuss, and respond to questions	8	This assessment will require input from a number of different data sources and partners. The various entities that contribute to the delivery of public health services within a state will make up a workgroup that is responsible for this collective response. During this step, the workgroup compiles information based on their own knowledge and data sources and then discusses the input in order to make a well-informed decision.
Completing and submitting the information	2	Based on field test results, it takes about 2 hours to review the information, finalize responses, and enter this information into the on-line database for analysis.
Total Hours	12	

The table above was produced based on field test results from 4 states, which indicate that there is a slightly smaller burden (12 hours instead of 15 hours) for the revised Version 2 instrument. The previously approved Version 1 instrument has a burden estimate of 15 hours. CDC and its NPHSP partner organizations have found that state jurisdictions' use continue to support these burden estimates.

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

8a: Federal Register Notice

The 60-day Federal Register Notice was published on March 18, 2010, Vol. 75, No. 52, page 13133-13134. No comments were received. A copy of this notice is provided for reference in Attachment B.

8b: Consultations

Representatives from the following organizations reviewed and guided the original development and recent revision of the data collection instrument and have worked with CDC since 2002 to support its use in state jurisdictions. Refer to Attachment C for a list of these individuals.

American Public Health Association (APHA)
Association of State and Territorial Health Officials (ASTHO)
National Association of County and City Health Officials (NACCHO)
National Association of Local Boards of Health (NALBOH)
National Network of Public Health Institutes (NNPHI)
Public Health Foundation (PHF)

9. Explanation of Any Payment or Gift to Respondents

None

10. Assurance of Confidentiality Provided to Respondents

The OMB justification has been reviewed and it has been determined that the Privacy Act is not applicable. While names and titles of contact persons are being collected, individuals will not be providing personal individually identifiable data, but instead speaking from their professional roles as being capable of collecting data to measure the capacity of the state public health system to deliver the 10 Essential Public Health Services. Demographic information requested deals not with the point of contact but with information on the state public health agency. Therefore, the data for the project do not meet the definition of a Privacy Act system of records. A password protected electronic database has been created to store survey results. Access is limited to individuals with a bona fide need to know for official duties. Respondents will be identified by unique identifiers developed under a National Public Health Registry. Data management procedures have not changed since previous approval.

11. Justification for Sensitive Questions

The data collection instrument does not contain questions which are sensitive in nature.

12. Estimates of Annualized Burden Hours and Costs

12a: Hours

State public health agencies will complete the NPHPSP State Instrument with the consensus responses of state public health system representatives. State instrument completion will consume approximately 12 hours of state health department staff time. This includes time

necessary to conduct an orientation, convene representatives of the state public health system, collate responses, and submit data for analysis.

There is no dedicated grant funding for this activity. For this reason, it is critical to support states and local jurisdictions in this effort at a time that best meets their needs and resources. Therefore, CDC and its partners consider it important that this data collection instrument be available to be used on a voluntary and rolling basis.

The universe for this data collection is the 51 state health departments. Based on expert opinion and discussions with territorial representatives, it is clear that the state instrument would not be used in territorial health department settings. The same denominator also was used in estimating the denominator for Healthy People 2010 Objective 23-11.

The table below also reflects estimates for respondents during the next three years. These estimates are based on past use as well as the expert opinion of the NPHPSP staff and partner organizations who are working with states preparing to undertake the assessment. Burden hours also are shown in table A.12.a.

Table A.12.a: Estimates of Organizational Hourly Burden

National Public Health Performance Standards Program State Public Health System Assessment Annualized Burden Table			
Respondents	Response per respondent	Hours/Responses (per year)	Total Burden Hours
8	1	12	96

12b: Costs

A state health official or senior designee will coordinate completion of the instrument by state public health system representatives. Using estimated wages for state health officials and the calculated burden hours, this study represents an estimate annual cost of \$2,770.

Table A.12.b: Estimates of Cost Burden

National Public Health Performance Standards Program
State Public Health System Assessment

Annual Cost Burden Per Respondent

State Public Health Systems	Respondents	Responses per respondent	Total Burden per response	Wage rate** (per hour)	Total cost
Annualized Estimate	8	1	12	\$28.85	\$ 2,770

**This estimate is based on an average annual salary of \$60,000 for all respondents. ASTHO provided an estimated annual salary for state health department senior staff. The total cost to respondents were arrived at by multiplying the number of respondents by total burden hour per response times wage rate (8x12x\$28.85 =\$2,770).

The total universe of all possible respondents (n=50) are represented in Tables A.12.a and A.12.b. The response estimates are based on past use as well as the expert opinion of the NPHPSP staff and partner organizations who are working with states preparing to undertake the assessment.

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

There are no annualized capital and maintenance costs to the respondents.

14. Annualized Cost to the Government

Four FTEs are dedicated to implement the NPHPSP within CDC, Office of State, Tribal, Local and Territorial Support. Based on time allocations for the program, an average annual salary of \$90,000 per FTE (including benefits) is dedicated to the NPHPSP and its three data collection instruments (OMB control numbers: 0920-0555, 0920-0557, and 0920-0580). This is a cost of \$360,000 per year. In addition to the salary, the cost of attending and presenting at national, state and regional meetings is estimated to be approximately \$15,000 in travel expenses each year.

National Public Health Performance Standards Program
Centers for Disease Control and Prevention
Office of State, Tribal, Local and Territorial Support

Number of FTEs For Program Implementation	Annual Salary charged to NPHPSP- Including Benefits (per FTE)	Total Salary Cost (per year)	Number of FTEs attending Regional Meeting	Total Cost of Travel for each Meeting	Number of Trips	Total cost of Travel
4	\$90,000	\$360,000	1	1000	15	\$15,000

Grand Total = \$375,000

15. Explanation for Program Changes or Adjustments

This is a three year extension request, without changes or adjustments for a currently-approved data collection instrument.

There are four components to this information collection effort – the performance standards assessment, a Respondent Information Form which elicits basic information about the responding site, an optional priority questionnaire and an optional agency contribution questionnaire. These four components are part of one information collection that is implemented at the same time by the same respondents. These are found in Attachment E.

16. Plans for Tabulation and Publication and Project Time Schedule

CDC (and its partners through a grantee and contractor support the limited-access website) accept data directly from state jurisdictions. Ideally, state and local public health agencies will choose to conduct the performance assessment through a coordinated statewide approach. CDC and the NPHPSP partner organizations provide training to orient personnel that play key roles in coordinating a statewide process. Generally these personnel include representatives from state health department, state or regional public health institutes, or state associations of local health

officials. CDC and NPHPSP partner organizations also provide statewide “kickoff” training at state conferences, if requested.

Task	Estimated Time Frame
Identify first set of states for implementation; obtain an indication of commitment from the state	Within two months after approval
Provide training and/or work with the state liaisons to plan the assessment	2-4 months after approval
Provide access to web-based assessment; provide support to the state liaison and local jurisdictions in using the assessment; conduct orientation and kick-off activities, if CDC or partner presence is requested at a state conference.	4-7 months after approval
Receive and analyze data; provide automated reports to responding jurisdictions; provide aggregate report to the state	7-9 months after approval
Encourage states and local jurisdictions to use the results for performance improvement	9-11 months after approval
Select second set of states for implementation; obtain an indication of commitment from the state	12 months after approval
Provide training and/or work with the state liaisons to plan the assessment	14-16 month after approval
Provide access to web-based assessment; provide support to the state liaison and local jurisdictions in using the assessment; conduct orientation and kick-off activities, if CDC or partner presence is requested at a state conference.	16-19 months after approval
Receive and analyze data; provide automated reports to responding jurisdictions; provide aggregate report to the state	19-21 months after approval

Encourage states and local jurisdictions to use the results for performance improvement	21-23 months after approval
Select Third set of states of implementation. Obtain an indication of commitment from the state	24 months after approval
Provide training and/or work with the state liaisons to plan the assessment	24-26 months after approval
Provide access to web-based assessment; provide support to the state liaison and local jurisdictions in using the assessment; conduct orientation and kick-off activities, if CDC or partner presence is requested at a state conference.	26-29 months after approval
Receive and analyze data; provide automated reports to responding jurisdictions; provide aggregate report to the state	29-31 months after approval
Encourage states and local jurisdictions to use the results for performance improvement	31-33 months after approval
Publication	36-48 months after approval

Publication

Results generated by the NPHPSP assessment instruments will be primarily used for national public health infrastructure improvement. Results will also be presented to the public health community at professional and CDC-sponsored conferences. Further, results from this collection will be prepared for publication in professional reports and journals. To date, manuscripts utilizing results from the NPHPSP assessment instruments have been published in journals including the *Journal of Public Health Management and Practice*, *Milbank Quarterly*, *Public Health Reports*, *Health Affairs*, *American Journal of Preventive Medicine*, and the *American Journal of Public Health*. Similar publication opportunities will be sought for disseminating future data.

Analysis Plan

The state instrument is a qualitative self-assessment designed to provide state public health systems with a point-in-time analysis of their capacity to deliver the Essential Public Health Services. Data collected using the state instrument are analyzed according to standardized algorithms that generate electronic reports. These reports illustrate strengths, weaknesses, opportunities for improvement, and barriers to infrastructure development for state public health systems. Data analysis and reporting are fully automated.

After state public health systems complete the assessment, results are submitted to the limited access data collection website. CDC recommends that the governmental public health agency serve as the lead organization in submitting the instrument responses, although in some jurisdictions other entities, such as the public health institute, have been empowered with this authority by the state health department. Technical assistance resources, such as the training workshops, the User Guide and NPHPSP staff, instruct responding jurisdictions that they will need a User ID and survey password to enter data into the limited-access website. If they are completing the assessment through a statewide approach, CDC and PHF provide the User IDs to the state coordinator. Other jurisdictions can contact CDC and PHF directly at 1-800-747-7649 or by email at phpsp@cdc.gov or nphpsp-support@phf.org. The User IDs are disseminated with an instruction sheet. (See Attachment F for the Meeting Guide; Attachment G for the data entry instruction sheet; and Attachment H for example screen shots of the web-based system for submitting data and accessing reports).

Based on field testing and sound statistical methods, a detailed scoring methodology was developed for the NPHPSP. It is applicable to all three instruments. It was used for the previously-approved instruments and has been tested with the new Version 2 instruments, with the necessary slight alterations (such as inclusion of the new 5th response option). It is described, in brief, below:

Scores are developed for four different levels:

- I. **First-tier or “stem” question scores** – This score is developed by establishing the weight value for each question, and then multiplying the weight value by the response value. The weight value of each question grouping totals 1 point – lead-in questions are given 0.3 weight while subquestions are assigned 0.7 weight collectively. The weight of each question is multiplied by its response value (“no” responses are given a zero value; “minimal activity” is 0.25; “low partial” is 0.50; “high partial” is 0.75; and “yes” is 1.0). The scores for each question in the question grouping are totaled up to produce the “stem” question score.
- II. **Model Standard scores** – the average of all stem question scores found within this indicator section.
- III. **Essential Service scores** – the average of all model standards found within this Essential Service section.
- IV. **Overall Score** – the average of all ten Essential Service scores.

State public health systems should strive for scores of 75% or above to “fully meet” the model standard. In addition to the numerical scores provided in the reports, respondents are heavily encouraged to record qualitative discussion points that will help to describe areas of weakness in the delivery of the Essential Services. State public health systems are encouraged to review the scores and qualitative data to identify opportunities for performance and infrastructure

improvement planning. CDC and NPHPSP partner organizations provide technical assistance resources and training to assist states and local jurisdictions with using the results for performance improvement. Such technical assistance includes linking the state and local agencies with peers to improve sharing of best practices and providing web-based resources that provide practice models for making improvements in weaknesses identified in their assessment.

An automated sample report is generated for each respondent. Sample reports are available on the CDC website so that potential users can view the reports prior to submitting data.

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

CDC is not seeking an exemption for displaying an expiration date.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exemptions.

List of Attachments

- Attachment A: Public Health Service Act, Section 301
- Attachment B: Federal Register Notice
- Attachment C: List of Project Consultants at Partner Organizations and List of State, Local, and Governance Work Group Members
- Attachment D: Spreadsheet of Possible Respondents by State
- Attachment E: State Public Health System Performance Assessment Instrument, Respondent Information Form, Optional Priority Questionnaire, and Optional Agency Contribution Questionnaire
- Attachment F: National Public Health Performance Standards Program (NPHPSP) Meeting Guide (for State Public Health System Assessment Instrument)
- Attachment G: Web-based Data Entry Instruction Sheet
- Attachment H: Screen Shots of Example Pages from Web-based System – Submitting Data and Accessing Reports