Survey of State, Tribal, Local, and Territorial Health Departments about Pandemic Influenza Nonpharmaceutical Interventions

OSTLTS Generic Information Collection Request
OMB No. 0920-0879

Supporting Statement – Section A

Submitted:

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Section A – Justification

1. Circumstances Making the Collection of Information Necessary

Background

This data collection is being conducted using the Generic Information Collection mechanism of the OSTLTS Survey Center (OSC) – OMB No. 0920-0879. The respondent universe for this data collection aligns with that of the OSC. The data collection will be conducted by the Division of Global Migration and Quarantine's Community Interventions for Infection Control Unit (DGMQ/CI-ICU) with the assistance of the Oak Ridge Institute for Science and Education (ORISE).

Impact of Influenza

The impact of influenza on the U.S. population over the past few years has prompted public health officials to promote the use of nonpharmaceutical interventions (NPIs) to slow the spread of influenza before and during a pandemic. Many public health officials predict that there will not be enough vaccine and antivirals to go around in a pandemic emergency. This commonly held assumption has focused a great deal of attention on the use of NPIs to mitigate human transmission[1].

Also, at the beginning of a pandemic, the virus is new and a vaccine may not be available for several months. NPIs can help slow the spread of influenza until a vaccine becomes available. The first pandemic influenza outbreak since 1968 was declared in 2009, tapering off by April 2010. The outbreak manifested in two major peaks, with the first occurring in June 2009 followed by the second in October 2009[2]. During the first peak, all states in the U.S. had reported cases of H1N1 infections and the largest number of reported cases was primarily in major cities. Within 2 months of the initial outbreak, cases of H1N1 were reported across the country. During the period of April 2009 through August 2009, over 9,000 hospitalizations and 593 deaths due to H1N1 were reported[2].

Nonpharmaceutical Interventions (NPIs)

Nonpharmaceutical interventions (NPIs) are actions individuals and communities can take to help slow the spread of infectious diseases like influenza without the use of vaccines or medicine.

Actions **individuals** should always take include washing hands, covering coughs and sneezes, cleaning surfaces, and staying home when sick.

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[1]Aledort, J., Lurie, N., Wasserman, J., and Bozzette, S. (2007). Non-pharmaceutical public health interventions for pandemic influenza: An evaluation of the evidence base, *BMC Public Health*, 7, 208-216.

[2] Junf, M., Aqwesloq, S., Olawn, A., Jernigan, D., Biggerstaff, M., et al. (2011). Epidemiology of 2009 pandemic influenza A (H1N1) in the United States, *Clinical Infectious Diseases*, 52(S1), S13-S26.

[3] Hatchett, R., Mecher, C., and Lipsitch, M. (2007). Public health interventions and epidemic intensity during the 1918 influenza pandemic, *Proceedings of the National Academy of Sciences of the United States of American*, 104(18), 7582-7587.

[4] Morbidity and Mortality Weekly Report (2010). *Parental attitudes and experiences during school dismissals related to 2009 Influenza A (H1N1)-United States*, 59(35), September 10, 2010, 1131-1134.

Actions **communities** may take during a pandemic include social distancing measures, such as postponing or cancelling mass gatherings, closing schools and childcare facilities temporarily, and teleworking.

The timing of NPIs can vary, with implementation occurring anywhere from the initial onset of an influenza pandemic or at a later stage.

Current available literature suggests that the use, number, and timing of the implementation of NPIs are important factors in reducing disease transmission[3]. Available data on public views of the use of NPIs indicates receptiveness to NPIs. In a 2009 study conducted with 523 parents, 85% of parents reported that school/child care center dismissals to reduce the transmission of H1N1 was very or somewhat effective in preventing the spread of H1N1 among children[4]. Further, 75% of these respondents reported that school dismissal was "not at all" a problem for them. While the available literature provides some insight into the implementation, use, and perception of NPIs, the systematic study of its implementation and various facets of implementation are necessary in order to reduce influenza transmission.

STLTs are frontline providers of pandemic influenza information to community leaders and the general public, including what to do to slow the spread of disease when a vaccine is not available. Therefore, providing appropriate training to these officials is imperative to pandemic influenza preparation.

The respondent population consists of state, tribal, local, and territorial health department officials (STLTs) who have a role in preparing for or responding to an influenza pandemic. Examples of positions these respondents may hold include: that may have the following duties: state epidemiologist, pandemic influenza coordinator, emergency preparedness coordinator, and public health information officer. Materials developed by CI-ICU for use during a pandemic will not be used just by emergency response personnel, influenza personnel or those involved in preparedness. Previous research (2011 focus groups and information collected during the 2009 H1N1 pandemic) has shown that CI-ICU's target communities, particularly childcare and K-12 schools, look to STLTs as a source for information on (1) what to do to protect children and the adult workforce from influenza and other infectious respiratory diseases, and (2) guidance on implementing measures to mitigate the spread of infectious respiratory diseases (**Attachment A**). CI-ICU's other target communities - institutions of higher education (colleges, universities, trade schools); businesses; general public; and venues for mass gatherings (churches, auditoriums, stadiums/arenas, convention and expo centers, festivals and fairgrounds) - also depend on STLTs for guidance in dealing with epidemics and pandemics. During such an influenza pandemic, it is rare that just emergency preparedness or influenza staff is called on to respond to requests. In addition, during an emergency, STLTs may take on new responsibilities and may be deployed into emergency response positions.
CI-ICU's objectives related to this project are (1) to provide guidance and communication materials that can be used by STLTs to help make decisions around NPI implementation and (2) to provide communication materials that STLTs can use to educate administrators, staff, and the general public about measures that can be taken to help mitigate the spread of infectious respiratory diseases.

The purpose of this needs assessment is to determine the best methods for communicating information about pandemic influenza nonpharmaceutical interventions (NPIs) to STLTs so that they can effectively implement, communicate, and monitor pandemic influenza NPIs in their communities. It will also help CDC develop NPIs materials and training for STLTs. This survey is intended to collect data from the STLT staff that will inform the development of these materials regarding: best channels for communication, information needed, how information should be formatted, how information can be disseminated.

In order to inform the web-based survey, we conducted key informant interviews between July and August 2011. Information was collected through six key informant interviews. Five of the interviews were individual interviews and one interview was a group interview consisting of three key informants from the same organization, resulting in a total of eight respondents. Respondents were asked 47 questions, developed in advance and organized into the following topic areas: Demographics and Background, Guidance, Messages, Materials, Channels, Partnerships, Trainings, Monitoring Systems, Needs Assessment Process and Additional Recommendations. All interviews were conducted by ORISE staff with two representatives from CDC listening to the interviews for feedback and improvement purposes only. Interviews were recorded and transcribed (**Attachment B**).

Data for the needs assessment will be collected through a Web-based survey with STLTs. The results from the overall needs assessment will inform pandemic influenza NPI implementation, monitoring, and communication guidance, messages, materials, channels, partnerships, and training for STLTs and community leaders. Participation in the Web-based survey will be voluntary.

This data collection is authorized by Section 301 of the Public Health Service Act (42 U.S.C. 241).

Privacy Impact Assessment

Overview of the Data Collection System

The data collection system consists of a Web-based survey (see **Attachment C: MS Word Doc**) designed to ask public health officials about their needs in communicating, implementing, and monitoring pandemic influenza NPIs. The survey was pilot tested by 8 CDC public health professionals. Feedback from this group was used to refine questions as needed, ensure accurate programming and skip patterns, and establish the estimated time of 20-25 minutes required to complete the survey(see **Attachment D: Web Screen Shots**).

Items of Information to be Collected

The Web-based survey consists of 21 questions of various types, including dichotomous, multiple response, interval, filter, and open-ended. An effort was made to limit questions requiring narrative responses.

The survey will collect information on the following:

a. respondent background – agency/organization, state/district, professional organization affiliation, and current duties (multiple response, open-ended format, open ended response)
b. respondent perceptions about health communication messages (multiple response, filter format, open ended response)
c. respondent perceptions about health communication materials (multiple response, filter format, open ended response)
d. respondent perceptions about health communication channels (multiple response, filter format, open ended response)
e. respondent perceptions about health communication partnerships (filter format);
f. respondent perceptions about health communication trainings (multiple response, filter, open-ended format, open ended response)
g. respondent perceptions about health communication guidance (multiple response, filter format, open ended response)
h. respondent perceptions about health communication monitoring systems (dichotomous, open-ended format, open ended response)

No individually identifiable information is being collected.

Identification of Website(s) and Website Content Directed at Children Under 13 Years of Age

The data collection system involves using a Web-based survey. Respondents will be sent a link directing them to the online survey only (i.e., not a website). No website content will be directed at children.

2. Purpose and Use of the Information Collection

The impact of influenza on the U.S. population over the past few years has prompted public health officials to promote the use of nonpharmaceutical interventions (NPIs) to slow the spread of influenza before and during a pandemic. STLTs are frontline providers of pandemic influenza information to community leaders and the general public, including what to do to slow the spread of disease when a vaccine is not available. Therefore, providing appropriate training to these officials is imperative to pandemic influenza preparation.

CI-ICU's objectives related to this project are (1) to provide guidance and communication materials that can be used by STLTs to help make decisions around NPI implementation and (2) to provide communication materials that STLTs can use to educate administrators, staff, and the general public about measures that can be taken to help mitigate the spread of infectious respiratory diseases.

The purpose of this needs assessment is to determine the best methods for communicating information about pandemic influenza nonpharmaceutical interventions (NPIs) to STLTs so that they can effectively implement, communicate, and monitor pandemic influenza NPIs in their communities. It will also help CDC develop NPIs materials and training for STLTs. This survey is intended to collect data from the STLT staff that will inform the development of these materials regarding: best channels for communication, information needed, how information should be formatted, how information can be disseminated.

Without collecting this information, it would be difficult to judge the perceptions and training needs of STLTs about the best methods for CDC to use when communicating information about pandemic influenza and NPIs. Appropriate training is vital to an effective pandemic response and in assisting STLTs with preventing and slowing the spread of influenza.

Privacy Impact Assessment

No sensitive information is being collected. No individually identifiable information is being collected. The proposed data collection will have little or no effect on respondent privacy.

3. Considerations Given to Information Technology

Data will be collected via a Web-based survey allowing respondents to complete and submit their responses electronically. The survey will be delivered using IBM (formerly SPSS) mrInterview™. mrInterview™ is a highly customizable best-of-breed technology product with sophisticated conditional routing and data validation capabilities. It is fully compliant with Section 508 of the Rehabilitation Act, so it meets Federal Web Accessibility Standards set to ensure that electronic and information technology utilized by Federal agencies are accessible to people with disabilities. Respondents will be asked to complete the survey via a web-based survey link.

The survey is designed to collect the minimum information necessary for the purposes of this project (i.e., limited to 21 survey questions), and it is a cost-effective method for data collection with a large sample size. Screen shots of the web survey instrument can be found in **Attachment D**. Methods were chosen to reduce the overall burden on respondents and costs to the government.

Records will be maintained in a locked filing cabinet and/or on a password-protected computer when not in use.

4. Efforts to Identify Duplication and Use of Similar Information

Although other units within CDC focus on influenza, the Community Interventions for Infection Control Unit (CI-ICU) is the only group focusing on using nonpharmaceutical interventions (NPIs) to slow the spread of flu. We are not duplicating other information collections. CI-ICU meets with other units in CDC to avoid duplication of effort. In addition, we have consulted with the organizations involved in the survey dissemination and although there have been flu surveys; no systematic collection of information or training specific to NPIs was mentioned.

5. **Impact on Small Businesses or Other Entities**
   No small businesses will be involved in this data collection.

6. **Consequences of Collecting the Information Less Frequently**
   The purpose of CDC's request for this generic clearance is to ensure collection of data that is not otherwise available. Specifically, without this data there would be:

   - No timely feedback on data needed to effectively develop appropriate messages, materials, guidance, and training for STLTs about pandemic influenza and NPIs.
   - Potentially less effective dissemination of our materials, guidance, and trainings to better assist STLTs during an influenza pandemic. Effective dissemination is vital to an effective response that could help in preventing slowing the spread of influenza.

   This request is for a one time data collection. There are no known legal obstacles to reduce the burden.

7. **Special Circumstances Relating to the Guidelines of 5 CFR 1320.5**
   There are no special circumstances with this information collection package. This request fully complies with regulation 5 CFR 1320.5.

8. **Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency**
   This data collection is being conducted using the Generic Information Collection mechanism of the OSTLTS Survey Center (OSC) – OMB No. 0920-0879. A 60-day Federal Register Notice was published in the Federal Register on October 22, 2010, Vol. 75, No. 204; pp. 65353-54. Two comments were received from the Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO).

   CDC partners with professional state, tribal, local, and territorial health organizations, such as the ASTHO, NACCHO, and the National Association of Local Boards of Health (NALBOH), along with the National Center for Health Statistics (NCHS) to ensure that the collection requests under individual ICs are not in conflict with collections they have or will have in the field within the same time frame.

9. **Explanation of Any Payment or Gift to Respondents**
   CDC will not provide payments or gifts to respondents.

10. Assurance of Confidentiality Provided to Respondents

The Privacy Act does not apply to this data collection. Employees of state, tribal, local, and territorial public health agencies will be speaking from their official roles and will not be asked, nor will they be required, to provide individually identifiable information.

This data collection is not research involving human subjects.

11. Justification for Sensitive Questions

No sensitive information will be collected.

12. Estimates of Annualized Burden Hours and Costs

The estimate for burden hours is based on a pilot test of the survey instrument by 8 CDC public health professionals. In the pilot test, the average time to complete the survey including time for reviewing instructions, gathering needed information, and completing the survey was 22 minutes (min: 16, max: 31). Depending on the responses selected, some questions may be skipped or follow-up questions may be asked of participants. Therefore, it may take slightly more or less time to complete the survey, but not by a great amount. Based on these results, the estimated time range for actual respondents to complete the survey is 20-25 minutes. For the purposes of estimating burden hours, the upper limit of this range (i.e., 25 minutes) is used.

There are screening questions that are at the beginning of the survey so all respondents may not actually participate. The respondent universe is based on the total number of surveys being disseminated. Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) National Compensation Survey estimate for management occupations – medical and health services managers in state government (http://www.bls.gov/ncs/ocs/sp/nctb1349.pdf). Based on DOL data, an average hourly wage of $57.11 is estimated for respondents. Table A-12 shows estimated burden hours and cost information.

Table A-12: Estimated Annualized Burden Hours and Costs to Respondents

Type of Respondent	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
• Emergency Preparedness Coordinators, • State Epidemiologists • Pandemic Influenza Coordinators • Public Health Information Officers	384	1	25/60	160	$57.11	$9,137.60
TOTAL	**384**			**160**		$9,137.60

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

There will be no direct costs to the respondents other than their time to participate in each survey.

14. Annualized Cost to the Federal Government

There are no equipment or overhead costs. Contractors are being used to support this data collection. The cost to the federal government will be the cost of the contracts with Chenega Government Consulting and the Oak Ridge Institute for Science and Education (ORISE) as well as the salary of the CDC staff supporting the data collection activities and associated tasks.

The estimated average annual cost to the federal government for the proposed information collection activities is $100,188.30. This figure encompasses 25% of three contract employees, 25% FTE of one GS-14 employee and information collection contract costs. The average hourly rate was obtained from the Office of Personnel Management's website (http://www.opm.gov/oca/09tables/html/atl_h.asp). The hourly rate for a GS-14 in metro Atlanta is $51.64 per hour, which is about $91,008 per year.

The contractual cost for an information collection (e.g. instrument development, pilot testing, OMB package preparation, data collection, data coding and entry, quality control, data analysis, report preparation) is estimated at $74,803.50.

Table A-14 describes how this cost estimate was calculated.

Table A-14: Estimated Annualized Cost to the Federal Government

Staff	Average Hours per Collection	Average Hourly Rate	Average Cost
Health Communications Specialists with Chenega Government Contracting 25% of three contractors at $415,771.20/year Instrument development, pilot testing, OMB package preparation, data collection, data coding and entry, quality control, data analysis, report preparation	240 hours	$54.13	$12,991.20
Health Scientist 25% of one GS-14 at $91,008/year Oversee instrument development, pilot testing, OMB package preparation, report preparation.	240 hours	$51.64(GS-14)	$12,393.60
Annualized Cost of Contract - IAA with ORAU/ORISE Project consultation, data collection, data coding and entry, quality control, data analysis, report preparation			$74,803.50/yr
Estimated Total Cost of Information Collection			**$100,188.30**

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

The results will be used internally to improve services and provide accountability to CDC leaders, and externally to communicate results and provide training to STLTs officials.

Project Time Schedule

- ✓ Design survey questionnaire.....(COMPLETE)
- ✓ Develop survey protocol, instructions, and analysis plan.....(COMPLETE)
- ✓ Pilot test survey questionnaire.....(COMPLETE)
- ✓ Human subjects determination.....(COMPLETE)
- ✓ Prepare OMB package.....(COMPLETE)
- ✓ Submit OMB package.....(COMPLETE)
- ❑ OMB approval.....(TBD)
- ❑ Send advance email.....(1 day after OMB approval)
- ❑ Conduct survey.....(1 week after OMB approval)
- ❑ Collect, code, enter, quality control, and analyze data.(2 months after OMB approval)
- ❑ Prepare report.....(2 months after OMB approval)
- ❑ Disseminate results/report.....(4 months after OMB approval)

17. Reason(s) Display of OMB Expiration Date is Inappropriate
CDC does not request exemption from display of the OMB expiration date.

18. Exceptions to Certification for Paperwork Reduction Act Submissions
There are no exceptions to the certification. These activities comply with the requirements in 5 CFR 1320.9.

LIST OF ATTACHMENTS – Section A

Note: Attachments are included as separate files as instructed.

A. Focus Groups Summary

B. Key Informant Interview Report

C. MS Word Version: Survey Instrument

D. Web Screen Shot: Survey Instrument