

Case Study of the Career Epidemiology Field Officer Assignments in Three State Health Departments

OSTLTS Generic Information Collection Request
OMB No. 0920-0879

Supporting Statement – Section A

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Program Official/Project Officer

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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 Data collection Center (OSC) – OMB No. 0920-0879. The respondent universe for this data collection aligns with that of the OSC. Data will be collected from 18 state and Tribal public health officials acting in their official capacity. The 18 are composed of state epidemiologists, state public health emergency preparedness (PHEP) directors, state medical officers, state public health veterinarians, state tobacco project officer, chief administrator, bureau chiefs, and Tribal public health leaders.

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

The Centers for Disease Control and Prevention (CDC) created the Career Epidemiology Field Officer (CEFO) Program in 2002 to strengthen state and local epidemiology capacity for public health preparedness and response. The program was created following the 2001 terrorist attacks, in response to an identified need to enhance and expand epidemiology capability to prepare for, prevent, and respond to public health threats, both natural and manmade. To implement the program, the Department of Health and Human Services Secretary at the time asked CDC to place senior-level Epidemic Intelligence Service (EIS) officers, or the equivalent to work in state and local health departments to strengthen epidemiology capacity. Currently, the CEFO Program has 27 assignees in 23 jurisdictions across the U.S. (see **Attachment A**).

Epidemiology is the core science of public health and an intrinsic component of the national public health preparedness and response infrastructure. Despite improvements, epidemiology capacity across the nation is recognized to be suboptimal. Diminishing public health program funding and local and state government hiring restrictions are leaving many states struggling to meet their epidemiology and preparedness needs. Budgetary constraints are limiting the ability of states to hire new epidemiologists, which places more work load on existing staff. Smaller public health workforces in state and local health departments create a gap in their ability to respond to public health emergencies. The CEFO Program provides an opportunity for state and local health departments to acquire experienced epidemiologists to support their epidemiology and preparedness needs and address critical gaps in their public health infrastructure.

CEFOs are mid - or senior-level CDC epidemiologists serving as field assignees in state and local health departments and serve as leaders for epidemiology and preparedness and response capacity-building. CEFOs are physicians, nurses, veterinarians, PhD-prepared health scientists or other public health professionals, with experience in epidemiology and surveillance, preparedness, research, training, and policy development. Their expertise was acquired in various settings, including academia, state, local and territorial health departments, and positions held in federal agencies. Several CEFOs have held leadership positions in state and local health

departments. CEFOs' diverse backgrounds and public health skills, afford state and local health departments with fluid leaders that can work on a broad range of issues that are essential for community resilience and preparedness.

CEFOs are assigned by request to state and local health departments. Assignments are initially for two years with the potential for annual renewal contingent upon availability of funds, appropriateness of assignment and program priorities. During their assignment, CEFOs are under the supervision of state epidemiologists or a comparable high-ranking state public health official. CEFOs also report to a CEFO Program Headquarter supervisor for purposes of program accountability.

Funding for CEFO positions is principally derived from the CDC Cooperative Agreement on Public Health Emergency Preparedness (PHEP) using the Direct Assistance (DA) mechanism. The PHEP Cooperative Agreement funds state and local public health departments to build and strengthen their preparedness infrastructure to respond to all-hazards events, including infectious diseases, natural disasters, and biological, chemical and radiological threats. State and local health departments allocate PHEP funding through DA requests to support a CEFO position. Although PHEP funding continues to be the primary funding source for CEFO assignments, recent changes in state needs and funding, have prompted the establishment of several split-funded CEFO positions. Split-funded positions are partially funded through PHEP and partially funded through a different federal funding source that allows the use of federal funds for DA-funded federal assignees, which may or may not be directly related preparedness. Consequently, while CEFOs are first and foremost expected to focus their efforts on epidemiology and all-hazards preparedness and response capacity-building, their positions have evolved to require them to address other public health issues as well.

In the context of the CEFO Program, capacity building efforts are broad and diverse across CEFO jurisdictions. First, CEFOs' key role is to build epidemiology capacity for public health preparedness and response. CEFOs also make contributions to work that may not be explicitly related to public health preparedness but is essential for community health and resiliency. Second, each state/local health department has different needs and capabilities; therefore, CEFOs' scope of work varies from jurisdiction to jurisdiction. Variations in state/local organizational structure and leadership also influence the role CEFOs hold in their jurisdiction. Lastly, with the onset of split-funded positions, CEFOs' roles have broadened to include work beyond the typical scope of public health preparedness and response.

Since its inception, the CEFO program has undergone multiple relocations within CDC. From 2002 to 2004, the program was administered by the Division of Applied Public Health Training within the Epidemiology Program Office (EPO), which administered the EIS program at the time. In 2004, the program moved to the Division of Health Partnerships in the National Center for Health Marketing (NCHM), Coordinating Center for Public Health Information and Services. Two years later, the program was moved to the Division of State and Local Readiness (DSLRL) within Office of Public Health Preparedness Health and Response (OPHPR), known at the time as Office of Terrorism Preparedness and Emergency Response. In 2007, the program moved to the Office of Science and Public Health Practice within OPHPR, where it is currently located. On October 1, 2013 the program moved back to DSLRL; this marked the CEFO Program's fifth

organizational relocation within its eleven year age. For the most part, the program's focus on epidemiologic capacity-building to support state and local health departments has remained constant.

CEFO assignments have evolved without a clear understanding of the progression of the assignment and the influence of the changes on the program. As the program is integrating into DSLR once again, gaining further insight into the work of CEFOs is key to guiding and informing strategic planning efforts among the program's new leadership. To attain a more in-depth understanding of the role, work, and contribution of the CEFOs, as well as the factors facilitating and inhibiting their success, a descriptive case study of field assignments in three states will be conducted.

The primary goal of this descriptive case study is to better understand the roles and contributions of CEFOs in their assigned jurisdictions. Although the CEFO Program has been in operation for over a decade, no prior descriptive case studies have been conducted to better understand the roles and contributions of CEFOs to capacity building efforts in state and local health departments. This will serve as a guide for future work for subsequent descriptive case studies of the CEFO Program in other health departments with CEFO assignees. The case study will seek to identify and understand CEFOs roles at the health department level (e.g., implementation, context, supervision, support, funding, others). Three state health departments will be used to assess CEFOs roles and contributions in building epidemiology and preparedness capacity within their state or local jurisdiction. Idaho, Montana and Wyoming health departments will serve as cases. Idaho, Montana and Wyoming were chosen because they are rural states with three different types of health departments and different lengths of tenure by the CEFOs. The health departments are centralized, decentralized, and hybrid with district local health departments. These state health departments will help the program gain a better understanding of functions and state-specific factors that influence the work of CEFOs within different states that share similar public health problems. The case study will draw on experiences of these CEFOs to examine similarities, differences and contextual factors that aid or impede their work. The findings from this case study are not meant to be generalizable to the entire CEFO program.

Privacy Impact Assessment

Overview of the Data Collection System The phone interview data collection consists of 2 questionnaires (**see Attachment C- State health department supervisor; Attachment D – Partner data collection instrument**) designed to query key informant state public health officials based on their role to elicit information about the roles and contributions of CEFOs in improving epidemiology and preparedness capacity-building in their assigned jurisdictions. CEFOs identified eleven CEFO State Supervisors and PHEP Directors and seven CEFO State and Tribal Partners as the individuals who directly work, interact, and collaborate with the CEFO. In an effort to gather information on the full breadth the program responses from both supervisors and key partners are vital, leading to two different respondent universes. The case study plan was extensively reviewed by both CDC and state stakeholders to ensure the case study and data collection methodology reflected both federal and state perspective.

Items of Information to be Collected – The data collection consists of 2 different questionnaires based on the role of the state public health officials, document review, and case studies. The questionnaires contain many probes, but not all will be asked; the probes on the questionnaires are for the interviewer to make sure major topics are discussed. Two different tools were developed to ensure questions are applicable to the state health official’s role and to reduce the burden on the respondents. An effort was made to limit the number of questions. The supervisor and PHEP director instrument consists of 32 open ended and Likert scale questions with skip patterns depending on whether they are a supervisor or PHEP director. The information collected reflects the key questions outlined in the case study plan. The data collection for the supervisors and PHEP directors will collect information on the following:

- a. *Respondent information* – interaction with the CEFO and CEFO Program Office, supervising responsibilities, and expectations of role of CEFO
- b. *CEFO contributions* – CEFO’s involvement in building epidemiology and preparedness capacity; their contributions to state’s ability to prepare for, respond, and recover from public health emergencies
- c. *Sustainability factors*- respondents’ opinion on sustainability
- d. *Facilitators and inhibitors*– factors facilitating and inhibiting CEFOs’ work, information on funding model and supervision, CEFO program support, interaction and communication
- e. *Opportunities for improvement* – respondent’s opinion on how to improve the effectiveness of the CEFO assignment

The partner instrument consists of 11 open ended and Likert scale questions. The data collection for the partners will collect information on the following:

- a. *Respondent information*- description of respondent organization and interaction with the CEFO
- b. *CEFO contributions*– CEFO’s contribution to respondent’s organization
- c. *Sustainability* – CEFO’s most significant contribution(s) to organization
- d. *Opportunities for improvement*- respondent’s opinion on how to improve the effectiveness of the CEFO assignment

Responses are voluntary and will be used to gain an understanding of the role of the CEFO Program and identify opportunities for improvement. Quantitative and qualitative methods will be used to analyze the data. Quantitative methods will be used for the descriptive analysis, as well as to analyze the case study and questionnaire results. Qualitative methods, such as content analysis will be used to extrapolate data from program documents and phone interviews.

Identification of Website(s) and Website Content Directed at Children Under 13 Years of Age – The data collection system does not involve any internet usage.

2. Purpose and Use of the Information Collection

No prior case studies have been conducted to gain a better understanding of the roles of the CEFO Program field assignees in their jurisdiction or the assignment-specific features that influence their work. Moreover, the program has evolved since its inception without a clear understanding of the breadth of changes and its impact on the program. As the program prepares to integrate into DSLR once again, attaining a more practical understanding of the diversity of

CEFO assignments, and factors aiding/impeding their work is critical to informed decision making by its new leadership.

In response to the aforementioned, the program is conducting a case study to gain a more in-depth understanding of the role, and work, of CEFOs in three states, as well as to identify the factors facilitating and inhibiting their work. This case study will use Idaho, Montana and Wyoming as case studies to determine how CEFOs in these states have addressed the epidemiology and preparedness needs of their local or state health department and their role in modifying or improving epidemiologic and preparedness and response capacity. Since CEFOs work in different environments and meet different needs, the case study will draw on experiences of these CEFOs to examine similarities, differences and contextual factors that aid or impede their work.

Information collected will be used to gain a better understanding of the role, and work, of CEFOs in the field and the factors influencing their work and success. This information will be used to improve the program and to inform decision making among the program's new leadership.

Privacy Impact Assessment

No sensitive information is being collected. Responses are voluntary and will be used to help the CEFO Program strengthen epidemiology and preparedness and response efforts nationally. Data collected will not have identifiable information and results will be aggregated for the final report.

3. Use of Improved Information Technology and Burden Reduction

Data will be collected by phone interviews with state public health officials: CEFO State Supervisors and PHEP Directors and CEFO State and Tribal Partners. These different respondent universes will decrease the burden on the respondents by ensuring only relevant questions are asked of the respondents. For example, a partner will not be able to speak to supervisory aspects of the CEFOs assignment.

Phone interviews were chosen over web self-questionnaires to meet program and stakeholder needs. The program's diverse nature in implementation, and delivery of services makes data collection through web self-questionnaires challenging. Since no prior case studies have been conducted to gain in-depth information on the work of the field assignees, developing pre-defined categories and survey items that are typically used in web questionnaires may not be representative of the work of CEFOs and may introduce bias.

Phone interviews will enable the collection of data to identify direct and indirect program factors influencing opportunities to improve the program from both a federal and state perspective, which can be limited through closed or open-ended responses provided on web questionnaires. State public health officials will be given a 2 month period to schedule the phone interview. The individuals we will be interviewing have been engaged in the development process and methodology development. They are aware of the phone interviews and are willing to participate in the project.

4. Efforts to Identify Duplication and Use of Similar Information

Because this is a unique product and unique subscriber list, there is no existing data which could replace the need to gather data through this data collection instrument. No prior descriptive case studies have been done to better understand the roles and contributions of the CEFO field assignees and the factors that aid/impede their work.

5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this data collection.

6. Consequences of Collecting the Information Less Frequently

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

The consequences of not collecting this information would be:

- Failure to systematically collect information on role, work, and the factors impeding and aiding their efforts.
- Failure to identify and address gaps and identify opportunities to improve the program.
- Limited guidance to the program’s new division and leadership on how to enhance the field assignments and tackle program-specific gaps provided by the key stakeholders.

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 the regulation 5 CFR 1320.5 and will be voluntary.

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 Data collection 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 STLT organizations, such as the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (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 timeframe.

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 and local public health agencies will be speaking from their official roles and will not be asked, nor will they provide individually identifiable information.

This data collection is not research involving human subjects.

11. Justification for Sensitive Questions

No information will be collected that are of personal or sensitive nature.

12. Estimates of Annualized Burden Hours and Costs

The estimate for burden hours is based on a pilot test of the interview by public health professionals. In the pilot test, the average time to complete the CEFO state supervisor and state public health emergency preparedness director focus group including time for reviewing instructions, gathering needed information and completing the focus group, was approximately 55 minutes. Based on these results, the estimated time range for actual respondents to complete the focus group is 50-60 minutes. For the purposes of estimating burden hours, the upper limit of this range (i.e., 60 minutes) is used. In the pilot test, the average time to complete the CEFO state partner focus group including time for reviewing instructions, gathering needed information and completing the focus group, was approximately 25 minutes. Based on these results, the estimated time range for actual respondents to complete the focus group is 20-30 minutes. For the purposes of estimating burden hours, the upper limit of this range (i.e., 30 minutes) is used.

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 and social and community service managers in state government (<http://www.bls.gov/ncs/ocs/sp/nctb1349.pdf>). Based on DOL data, an average hourly wage of \$34.50 is estimated for all 11 CEFO state supervisor respondents and public health emergency preparedness directors and an average hourly wage of \$34.50 is estimated for state for CEFO state and tribal partner respondents. Table A-12 shows estimated burden and cost information.

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

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
CEFO State Supervisors and PHEP Directors: State Epidemiologists Section Chiefs	11	1	1	11	\$57.11	\$628.21
CEFO State and Tribal Partners: State Public	7	1	30/60	4	\$34.50	\$138.00

Managers, State Veterinarian						
TOTALS				15		\$766.21

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

There are no equipment or overhead costs. Contractors are not being used to support this data collection. The only cost to the federal government would be the salary of CDC staff supporting the data collection activities and associated tasks.

The lead staffs for this project are a Preventive Medicine Fellow (GS-13) and an ORISE Fellow (GS-11) in the OPHPR Division of State and Local Readiness Field Services Branch. The lead staff developed the survey, and will collect the data, code, enter, and prepare the data for analysis; conduct the qualitative data analysis; and conduct and prepare the evaluation report. Hourly rates of \$36.09 for GS-13 and \$24.10 for GS-11 were used to estimate staff costs. The estimated cost to the federal government is \$3009.50

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

Staff (FTE)	Average Hours per Collection	Average Hourly Rate	Average Cost
Preventive Medicine Fellow (GS-13) Instrument development, pilot testing, OMB package preparation, data collection, data coding and entry, qualitative data analysis, quality control, report preparation	50	\$36.09	\$1,804.50
ORISE Fellow (GS-11) Instrument development, pilot testing, OMB package preparation, data collection, data coding and entry, qualitative data analysis, quality control, report preparation	50	\$24.10	\$1,205.00
Estimated Total Cost of Information Collection			\$3,009.50

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

Both quantitative and qualitative analyses will be performed. Quantitative analyses will involve using descriptive statistics to determine frequency distributions and corresponding variances for responses to likert scale questions. Qualitative thematic analyses will be performed on open-ended questions to better understand the roles and contributions of the CEFO assignees on building epidemiology and preparedness capacity. Qualitative data gathered from open-

ended questions will also be used to compile recommendations both to CDC and state partners on how to improve the CEFO assignment.

Once analyzed, we plan to share the finding internally with CDC leadership and CEFO staff, as well as externally with state stakeholders and partners. Our findings will used to gain a better understanding of the role of the CEFO on building epidemiology and preparedness capacity building in their state. Findings will also delineate recommendations to improve the effectiveness of the CEFO assignment.

Project Time Schedule

- ✓ Design data collection questionnaire..... (COMPLETE)
- ✓ Develop data collection protocol, instructions, and analysis plan.....(COMPLETE)
- ✓ Evaluate data collection questionnaire..... (COMPLETE)
- ✓ Prepare OMB package..... (COMPLETE)
- ✓ Submit OMB package..... (COMPLETE)
- OMB approval..... (TBD)
- Conduct data collection..... (Data collection open 8 weeks)
- Collect, code, enter, quality control, and analyze data..... (3 weeks)
- Prepare report..... (3 weeks)
- Disseminate results/reports..... (4 weeks)

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

We are requesting no exemption.

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. Attachment A-CEFO Field Assignments Map**
- B. Attachment B- Supervisor Data Collection Instrument**
- C. Attachment C-Partner Data Collection Instrument: MS Word version**