Healthy Homes and Lead Poisoning Surveillance System (HHLPSS)

ICR#0920-09by
Supporting Statement – Part A

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A. JUSTIFICATION
A.1.   Circumstances Making the Collection of Information Necessary

This ICR classification is New. This data collection uses Section 301 of the Public Heath
Service Act (42 U.S.C. 241) as the authorizing law (Appendix A).

Background

The mission of CDC's Healthy Homes and Lead Poisoning Prevention Branch (Branch) is to
improve health and quality of life by preventing disability through the control or elimination of
lead exposure (in homes and elsewhere) and other housing related health hazards. HHLPPB
fulfills its mission in a multi-faceted manner, which includes: providing financial and technical
assistance to State, local, and territorial health departments for childhood lead poisoning
prevention programs; providing a sound basis for policy decisions; and facilitating the
integration of health issues in policies established by health, housing, and environmental
agencies at the federal, state, and local levels. The significant and sustained decrease in blood
lead levels among U. S. children is testament to the success of these activities.

Childhood lead poisoning is just one of many adverse health conditions that are related to
common housing deficiencies. Multiple hazards in housing, e.g., mold, vermin, radon and the
lack of safety devices, continue to adversely affect the health of residents. For example, in older
homes water damage could cause leaded paint to peel and also support mold growth.   This in
turn leads to both increased lead and mold exposures and poses a risk not only to increased blood
lead (and neurocognitive deficits of the resident children), but also a risk of more serious asthma.
A visit to the home for either lead or asthma could also identify high risk for radon exposure. It
is in the interest of public health to expand from a single focus on lead poisoning prevention to a
coordinated, comprehensive, and systematic approach to eliminating multiple housing- related
health hazards. CDC, through its experience with lead poisoning prevention and environmental
health programs in states and communities, is recognized as a leader in the field of healthy
housing by the World Health Organization, the U. S. Department of Housing and Urban
Development and the U. S. Environmental Protection Agency.

Housing conditions can significantly affect public health. In 1997, 7% of all U.S. households
and 15% of low-income rental households lived in housing units with severe or moderate
physical problems, with at least 2 million households living in severely inadequate housing
(HUD, 2000). The US Department of Health and Human Services Healthy People 2010 goal
called for a 52% reduction in the number of substandard occupied housing units.   For the past
decade, limited progress has been made towards accomplishing this goal.

The Healthy Homes Lead Poisoning Surveillance System (HHLPSS) builds upon previous
efforts by the National Blood Lead Surveillance System (NBLSS). While the earlier NBLSS
was focused on children less than six years old and adults with elevated blood lead levels, the
new HHLPSS will enable flexibility to evaluate all homes visited by state and local healthy
home programs, regardless of the presence of children or adults with elevated blood lead.

The overarching goal of this system is to establish Healthy Home Surveillance Systems at the
state and national levels. Currently, 40 state and local Childhood Lead Poisoning Prevention
Programs (CLPPP) and the state-based Adult Blood Lead Epidemiology and Surveillance

(ABLES) program report information (e.g., presence of lead paint, age of housing, and occupation of adults) to the NBLSS. The addition of a new panel of housing questions would help to provide a more comprehensive picture of the potentially modifiable risk factors in much of the housing in the United States. Replacing NBLSS with HHLPSS instead of a modification is necessary because the scope and methods of data collection by the funded state and local programs can be much different (e.g., housing inspections vs. report of blood lead levels from a laboratory). Thus, the new surveillance system will be more comprehensive than the NBLSS. (See Part B)

Upon approval of this new surveillance system, NBLSS (0920-0337, exp. 1/31/ 2012) will be discontinued because pertinent portions will be included in HHLPSS.

Privacy Impact Assessment
Below, we discuss three aspects of privacy impact assessment: (i) an overview of the data collection system, (ii) a delineation or listing of the items of information to be collected, and (iii) an indication of whether the system hosts a website

Overview of the Data Collection System

The primary purpose of HHLPPS is to improve program management and oversight. Currently, 40 state and local CLPPPs and the state-based ABLES program report information (e.g., presence of lead paint, age of housing, and occupation of adults) to the NBLSS. HHLPPS allows CDC to determine whether the services provided by cooperative agreement partners are timely and consistent with existing protocols and contracts as well as evaluate whether the medical and environmental interventions provided are effective at both the individual and population level. As was true of the NBLSS, HHLPPS will be the primary tool for targeting federal resources at local, state and federal levels to areas with the most need and specific addresses where housing hazards continue to put generations of residents at risk for poor health outcomes.

The HHLPPB will begin receiving new surveillance data from state, local, and territorial programs following the award of the cooperative agreement. The Branch will work with state, local, and territorial programs to ensure collection and use of healthy housing surveillance data along with Information in Identifiable Form (IIF) Table 2).

All 40 states have mandatory blood lead level reporting laws which require laboratories and/or clinical health care providers to report these levels to the state health agency. Funded programs collect other data in a variety of ways during a home visit. For example, a health department official could be visiting the home of a child with a reported elevated blood lead level, and notice that there are several housing-related risk factors, such as peeling paint, mold on walls, and a water-damaged ceiling. The health department official could conduct a brief housing inspection and then make a referral to the local housing authority. This data would be entered into HHLPSS. Another example would be a fire department outreach event that involves installation of smoke alarms in homes. The fire department could refer a household with frayed electrical cords, and no child-safety devices (for homes with young children) to the health department for a home inspection by a health department official. These data would be entered into HHLPSS.

Recipients of cooperative agreement awards are required to submit a summary data file of healthy housing variables within 90 days of the end of each quarter of the Federal fiscal year. Data is entered by the state, local, and territorial programs into a database (e.g. Microsoft SQL) which is also be password-protected.   State, local, and territorial programs will extract the HHLPSS data and send the encrypted files electronically to HHLPPB staff at CDC. The electronic files will be kept in accordance with CDC Records Control Schedules.

Items of Information to be Collected

Table 1. Home and health information collected by HHLPSS vs. NBLSS.

Type of data	Currently collected under NLBSS	Will be collected under HHLPSS
Blood Lead Test Data	X	X
Race/ ethnicity	X	
Lead-related housing characteristics (e.g., age of home, measurements of lead concentration in paint or soil)	X	X
Safety features (e.g., child safety locks, smoke detectors, show grab bars, window guards)		X
Other Housing characteristics (e.g., water and mold damage, insect and rodent infestations, structural problems)		X
Behavioral characteristics (e.g., smoking in the home, unvented combustion appliances)		X
Resident Health (e.g., asthma of children or adults, recent childhood injuries in the home)		X

Table 2. Information in Identifiable Form (IIF) collected with HHLPSS.

IIF category	Collected by state, local, and territorial health departments but	Collected by state, local, and territorial health departments and

	not sent to CDC	sent to CDC
name		X
date of birth		X
phone numbers	X	
medical information and notes		X
e-mail address	X	
home address		X

CDC requires the home address in order to geocode the address so that we can use it to visualize regional factors that might be related to housing hazards.

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

The state, local, and territorial programs enter their data into a secured website that is housed internally on their premises (cookies are not applicable to this website). Therefore, there is no website content directed at children under 13 years of age.

A.2.   Purpose and Use of Information Collection

Public Health Practice
HHLPSS is not a research study, rather it is a systematic assessment of programmatic activities under the healthy homes cooperative agreement. In fiscal year 2011, the budget authorization, appropriation line and Branch name were changed to reflect Congress's intention that the Branch expand from a sole focus on lead poisoning to a broad mission to improve the nation's capacity to identify and address housing related health hazards.

This surveillance system will help CDC to monitor the activities of the healthy homes programs to ensure that services are timely and consistent with the terms of the cooperative agreement An example of data screens developed for HHLPSS are in Figures 1 & 2 (note the names and dates in the screen shots are imaginary).

Figure 1. General Options (Setup) Screen

HHLPSS
Healthy Housing and Lead Poisoning Surveillance System

Home	Clinical	Environmental	Administrative	Reports

General Options
User Management
Role Management
Jurisdiction Management
Case Management
Investigation Options
Follow-Up Test Scheduling
Confirmatory Testing Options
Alert Options
ELR Processing Options
ELR Processing
Manage Labs
Manage Providers
Manage Institutions
Assign Menus
CDC Extracts
Menu Management
Process ELR Records

Help
Print Screen
Log Out

General System Options

Configured State

State: Texas

State EBLL Definitions

Child	Greater than or Equal to	12	µg/dl
Between Child and Adult	Greater than or Equal to	15	µg/dl
Adult	Greater than or Equal to	25	µg/dl

Address Standardization & Verification Services

Enable real-time address standardization & verification:

For manually entered data: ⦿ Yes ○ No

For electronically imported data: ⦿ Yes ○ No

Figure 2. Case Details Screen

| | (SIMPSON, BARTHOLOMEW) DOB: 10/11/2004 ID#: 1843160 |

HHLPSS
Healthy Housing and Lead
Poisoning Surveillance System

Home | Clinical | Environmental | Administrative | Reports

Find Patient
Clinical Letters
Patient Info
Patient Address
Blood Lead Tests
▶ Case Details
   Case Initiation
▶ Case Information
   Case Disposition
   Disposition History
Case Exposure
Associated Persons
Other Blood Tests
Other Medical
Chelation
Notes
Patient Attachments

Help
Print Screen
Log Out

Case Details

Case Manager:
Lem

Case Status:
Closed

Edit Case Manager Assignment

Case Events

Event Listing

Event Id	Event Type	Letter Type	Date Referred	Date Due	Date Completed	Result	ResponsibleParty	Delete	Edit
29040	Contact Attempt - Telephone		7/26/2011	7/26/2011	7/26/2011	No Answer	Brooks, Barry	X	Edit
29013	Chelation Referral		8/16/2010	8/16/2010	8/16/2010	Busy Signal	Blumenthal, Wendy	X	Edit
29015	Contact Attempt - Face to Face		8/17/2010	8/17/2010	8/17/2010	Yes	Brown, Mary	X	Edit
29016	Employer Education Needed		8/18/2010	8/18/2010	8/18/2010	No Answer	Jesse, James	X	Edit
29019	Contact Landlord – Mail	Contractor Warning	11/01/2009	11/12/2009	11/04/2009	Yes	Jones, Davey	X	Edit
29020	Letter Sent	Summary Letter to Physician	11/08/2010	11/08/2010	11/08/2010	Yes	Manager, Case	X	Edit
29022	Contact Tenant – Face to Face		12/03/2010	12/03/2010	12/03/2010	Yes	Jacobs, Penn	X	Edit
29026	Medical Consultation		4/01/2011	4/01/2011			Leonard, Monica	X	Edit
29029	Letter Sent	Hazard Notice Property Owner	4/01/2011	4/01/2011			Lem, Lem	X	Edit
29039	Chelation Referral	Ad Hoc Letter	7/26/2011	7/26/2011	7/26/2011	Busy Signal	Blumenthal, Wendy	X	Edit

Data regarding housing-related variable and blood lead will be collected quarterly. In Table 3 below, we have justified the data collection in terms of positive needs and the negative consequences of not having the information, and we have emphasized the practical utility to the government of the expected results. Appendix C provides a comprehensive list of all of the healthy homes and lead poisoning surveillance variables that will be collected via HHLPSS.

As described in more detail in Part B, CDC will share the non-identified data and/or results of the surveillance with interested parties through its website, publications, and peer-reviewed manuscripts. The limitations as well as the strengths of HHLPPS data will be described in each of the venues including that HHLPPS is not derived from a population based representative sample. Specifically, consistent with the terms of clearance for this collection, the following language will *always* accompany any aggregate statistics that the Federal government disseminates, including reports or testimony to Congress, on its web site, or as the justification for policy decisions or budget requests.

These data were collected for program management purposes. The data are not generalizable at the national, state, or local level. Furthermore, because inclusion criteria vary across grantees, comparisons of aggregate statistics across programs can be misleading (i.e., state policies and practices for blood lead testing vary and local priorities drive decisions regarding which homes receive assessments for other housing hazards). However, descriptive statistics can be used to compare changes overtime in a given area when the method by which housing units are chosen for inclusion remains the same. With a thoughtful understanding of the approach used to include housing units in a given location, HHLPPS can be used to make associations between the number of

individuals in a given area and a specific housing hazard or health condition and geographic descriptors such as poverty, age of housing, tenancy, and health conditions.

Each of the 40 state, local, territorial health departments will have access only to their respective program's identifiable data. CDC will share address information with HUD and EPA for their use in assessing compliance and enforcing regulations to protect children's health.

For the past several years, CDC's Lead Poisoning Prevention Branch had a congressional appropriation for lead-related activities. For Fiscal year 2010, the appropriation was expanded to include healthy homes activities. The HHLPPB original FY 2010 budget is $31,691,297.

Privacy Impact Assessment Information

A comprehensive list of all variables that will be collected via HHLPSS is found in Appendix C. However, the IIF collected during the course of the HHLPSS is listed below in Table 4. Some of the IIF can be sensitive and will be described in detail below.

Table 3. Information in Identifiable Form (IIF), intended uses, and potential impacts on privacy.

IIF category	Collected by programs and sent to CDC	Purpose
medical information and notes	X	To assess programmatic adherence to program design.
home address	X	To enable CDC to use geographic information systems (GIS) which can be used for adjusting for factors external to the home which could influence both exposures and health outcomes (e.g., outdoor air pollution, age of housing, poverty).
Name	X	CDC will not collect names of people who do not have elevated blood lead and are only contributing data related to the healthy homes inspections. However, CDC will require name of an individual with elevated blood lead because the identification numbers are often not unique (some states and local agencies have used the same ID number, e.g., ID#1) and this has resulted in inaccurate counts. Receiving this information at CDC will allow for more accurate reports to Congress and will be less expensive than providing ongoing training for cleaning and de-duplicating data. For the past 10 years CDC has recommended cleaning data routinely, but there is a large turnover of staff in the state, local, and territorial programs.
Date of birth	X	For de-duplicating data and for analyses that require

		age as a variable.

* CDC is sharing address information with HUD and EPA which can be used to assess compliance and enforce regulations to protect children's environments. A letter describing enforcement of the Federal Lead Disclosure Rule Section 1018 of Title X and Lead-Safe Housing Rule (45 CFR 164.512(b) is in Appendix F.

Respondents use the HHLPPS software to extract requested data elements from existing data sources. Thus, the data are part of the recipients' already existing record systems. Stringent safeguarding measures are generally in effect at state, local, and territorial health departments and only authorized staff will have access to the information.

Data will be entered electronically by the state, local, and territorial programs into a database (e.g. Microsoft SQL) which will also be password-protected. When the state, local, and territorial programs extract the data to be sent to CDC's HHLPPB data surveillance team, they will remove all unique identifiers (except for name, address, and date of birth). Encrypted data files will be sent electronically to staff at CDC. Data will be stored on highly secured CDC servers in Atlanta, GA. The servers are housed in a secure computer room complete with climate control, emergency power, and an uninterruptible power supply (UPS). Daily back-ups and integrated security are implemented through the CDC computer services infrastructure. All data access is password-protected, and all network communications use encryption. All servers and PCs that are part of the CDC infrastructure are protected by both host-based firewalls and software in order to prevent the undetected installation of "spyware".

A.3.   Use of Improved Information Technology and Burden Reduction

In 2008-2010, the Branch met with state and local healthy homes programs and asked them to identify those data elements related to healthy homes that they expected to collect under an expanded healthy homes program. During these meeting the data elements, questions and home assessment tools were standardized across programs. The changes to the asthma and race questions wording will be officially made available to the CDC funded programs through a letter from the Branch Chief and will become part of the cooperative agreement.

Figure 3: Healthy Homes - Asthma Page (Note identifying information is fictitious)
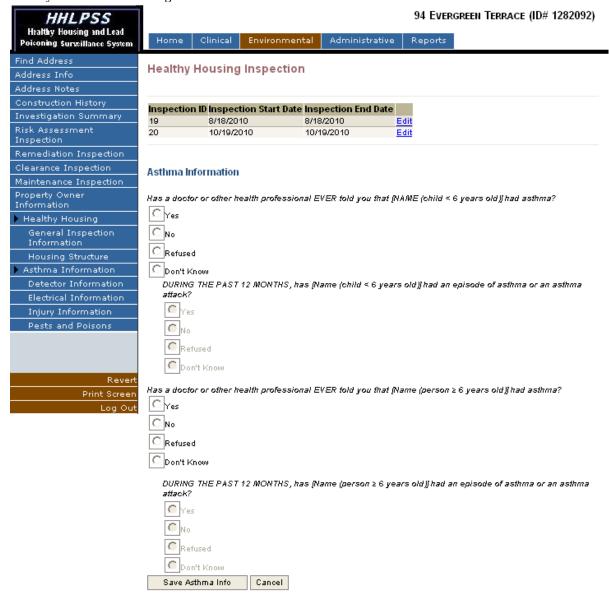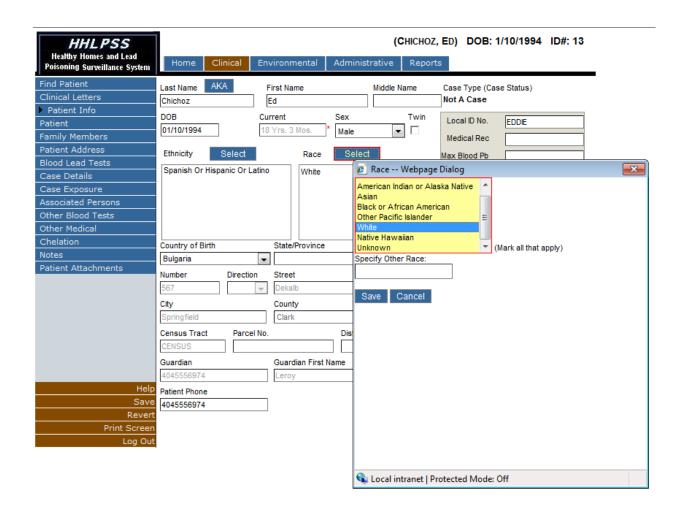
Healthy Homes - Asthma Page

Figure 4: Race Selection (Note identifying information is fictitious)

The questions listed in Appendix C are the questions that programs use in the field when assessing for the presence of one of the 5 priority housing related health hazards. Even if the healthy homes programs were not required to report information to the Branch under the terms of the cooperative agreement, they would ask these standardized questions during home visits.

Reporting data to the Branch using the HHLPSS will not result in an incremental burden on residents of the homes that are visited. The HHLPSS software extracts these data fields from the data currently collected by the healthy home programs. Programs collect far more extensive data during home visits than those which are reported to the Branch. For example, during a typical lead paint hazard inspection, the home visitor records the lead concentration and paint conditions of all painted surfaces inside and outside the house, HHLPSS only collects 8 data fields related to the lead inspection. (See Appendix C) All respondents (State, local, and territorial programs) will submit data electronically to CDC.

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

The HHLPSS is a program management system designed to provide information on health and housing parameters and how they are addressed, and to record and transmit data. No other survey collects all of the elements that will be collected through HHLPSS.   Unlike the nationally representative surveys such as the National Health and Nutrition Examination Survey (NHANES), National Health Interview Survey (NHIS), Behavioral Risk Factor Surveillance System (BRFSS), and the American Housing Survey (AHS), HHLPSS can provide more specific information about addresses and is available in real time. HHLPSS can also be used to provide insight into trends in local areas as well as to understand the relationship with demographic and housing characteristics among those for whom measurements are available.   . For example, in the 2009-2010 NBLSS had information on 291,000 real (un-extrapolated) children with blood lead levels ≥ 5 µg/dL. This allows federal, state and local partners to use all the available data to target resources, to determine priorities and to modify these priorities if necessary. In addition only HHLPSS can be used for program management and to evaluate the effectiveness of housing interventions in specific addresses as they are implemented via the state, local, and territorial programs funded by the CDC HHLPPB.

In addition, CDC's current National Blood Lead Surveillance System (OMB (#0920-0337, exp. 1/31/2012) only collects information for individuals with elevated blood lead. The newly-expanded HHLPSS will subsume the NBLSS, thus, there will be no duplication of that blood lead surveillance system. NBLSS will be discontinued when HHLPSS has been approved by OMB.

A.5.   Impact on Small Businesses or Other Small Entities

The collection of this information does not directly impact small businesses or small entities.

A.6.   Consequences of Collecting the Information Less Frequently

Respondents will submit data on healthy homes and child blood to CDC on a quarterly basis. Adults blood lead levels will be sent to CDC on a semi-annual basis. The collection of these data with this frequency is necessary in order for CDC to monitor short-term trends, to monitor the progress toward elimination of housing hazards, and to oversee programmatic activities in a timely fashion.

There are no legal obstacles to reduce the burden.

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

This request fully complies with the regulation 5 CFR 1320.5.

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

A.   The 60 day Federal Register Notice for this information collection, published in *Federal Register* Volume 75, Number 100, on May 25, 2010, is provided in Appendix B, One public comment was received in response to that notice and it is attached as Appendix E. No change occurred in response to this comment.

B.   During the design phase of the creating HHLPSS, CDC's NCEH Healthy Homes and Lead Poisoning Prevention Branch consulted with researchers from HUD and other CDC branches. We have discussed availability of data and frequency of collection issues with subject matter experts (Table 6).

Table 4. List of experts consulted regarding study design and frequency of data collection

Name	Title	Affiliation	Contact information	Year of Consultation
Peter Ashley, DrPH	Director, Policy and Standards Division	U.S. Dept. of Housing and Urban Development (HUD)	Peter.J.Ashley@hud.gov Phone: 202-402-7595	2009
Ralph Caraballo, Ph.D	Branch Chief,	CDC, Epidemiology Branch, Office on Smoking and Health, National Center for Chronic Disease Prevention & Health Promotion	Rfc8@cdc.gov Phone: 770-488-5732	2009
Michael Ballesteros, PhD	Deputy Associate Director for Science (acting)	CDC, Division of Unintentional Injury Prevention National Center for Injury Prevention & Control (NCIPC)	Zzb0@cdc.gov Phone:770-488-1308	2009
Jeanne Moorman, PhD	Survey Statistician	CDC, Epidemiologist, Air Pollution and Respiratory Health Branch Division of Environmental Hazards and Health Effects	zva9@cdc.gov Phone: 770-488-3726	2009

A.9   Explanation of Any Payment or Gift to Respondents

       No payments will be provided.

A.10   Assurance of Confidentiality Provided to Respondents

This study was approved by the CDC's IRB (protocol #4064) on September 7, 2010 (AppendixD).

Privacy Impact Assessment Information

A. This submission has been reviewed by ICRO who has determined that the Privacy Act does apply. Names and other identifying information will become part of CDC system of records covered under applicable System of Records Notice 09-20-0136, Epidemiologic Studies and Surveillance of Disease Problems.

B. CDC staff will receive electronic files with date of birth, medical and biological information, and home address identified only by name and HLPSS ID number. If there were a breach of security for any of the above IIF at CDC, some effect on the respondent's privacy could occur; however, there are a variety of safeguards in place. All collected data is secured in a password protected surveillance system. Only authorized state, local, and territorial programs and CDC staff will have access to the raw data in HHLPSS. Additionally, data from state, local, and territorial programs are uploaded using encryption software. Encrypted data files will be sent electronically to CDC. Physical controls will also be implemented. Data will be stored on highly-secured CDC servers in Atlanta, GA. Access to all CDC campuses is restricted by armed guards. The servers are housed in a secure computer room complete with climate control, emergency power, and an uninterruptible power supply (UPS). Daily back-ups and integrated security are implemented through the CDC computer services infrastructure. All data access is password-protected, and all network communications use encryption. All servers and PCs that are part of the CDC infrastructure are protected by both host-based firewalls and software in order to prevent the undetected installation of "spyware".

C. No consent form for collection of this data is required as the data are part of state, local, and territorial surveillance efforts. Consent to share with other federal agencies is not required when it involves enforcement of the Federal Lead Disclosure Rule Section 1018 of Title X and Lead-Safe Housing Rule (45 CFR 164.512(b)). Please see Appendix F.

D. CDC's HHLPPB staff will explain to the funded surveillance programs that the intended uses of the data are for assessing trends in lead and housing data, and also to evaluate programmatic benchmarks (e.g., case management and referrals for housing-related problems) of their funded programs. CDC's HHLPPB staff will also explain to the funded surveillance programs with whom information will be shared (i.e., via the HHLPSS website will show data in aggregate form, and to HUD and/ or EPA for enforcement of the Federal Lead Disclosure Rule Section 1018 of Title X and the Lead-Safe Housing Rule (45 CFR 164.512(b)), and the legal authority for the data collection (i.e., through the Public Health Service Act). The caveats associated with drawing conclusions from aggregate data will always be presented.

A.11   Justification for Sensitive Questions

Questions that could be considered sensitive by at least a segment of the population such as information on pregnancy, smoking and injuries such as ever having been scalded because of water in the home are being asked about the individuals living in the homes as part of home inspections and blood lead assessment, and these variables are integral to accomplishing the

purpose of this surveillance system. Table 7 describes the specific use of the possibly sensitive questions.

Table 5. Questions of a possibly sensitive nature

Questions (possibly sensitive)	Specific uses of information
Pregnant at time of test? (at time of blood lead test)	To assess prevalence of pregnant women with elevated blood lead, this provides important data for clinical follow up of women and their fetuses.
Race/ethnicity?	For targeting resources to subpopulations with high risk for elevated blood lead or housing risk factors
In the past 6 months, has anyone been scalded by the water in this home?	To assess efficacy of outreach activities and other interventions to decrease water temperature settings in the home
Do you (inspector) smell a musty odor anywhere in the home?	To assess risk for mold, evaluate effectiveness of related referrals and health education. Mold sampling is highly technical and recent publications have shown that mold odor is a predictor not only of mold exposure but is predictive of respiratory symptoms in some populations.
Does anyone who lives in this home smoke?	To assess risk for exposure to smoking, evaluate effectiveness of related referrals and health education. Smoking affects particulate matter in homes and can affect respiratory symptoms of residents.
Do you see evidence of cockroaches (bodies or fecal pellets)	To assess prevalence of cockroach exposures and efficacy of any interventions.
Do you see evidence of rodents (bodies, fecal pellets or gnaw marks)?	To assess prevalence of rodent exposures and efficacy of any interventions.

A.12   Estimates of Annualized Burden Hours and Costs
   A. The respondents will be CDC grant, cooperative agreement or contract fund recipients from official state or territorial health departments, and/or departments of the environment who have received funds for developing and implementing a healthy homes and lead poisoning prevention program. The funded programs vary from year-to-year base upon conclusions of CDC objective review panels and the amount of funding available.   Past experience with grantees funded by the HHLPPB informed the estimate of burden hours for the responses listed in Table 8. The burden hours were estimated from the previous NBLS. The burden of sending a slightly large electronic file was considered negligible.

Table 6. Estimated Annualized Burden Hours

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
State, local, and territorial Health Departments	Healthy Homes and Lead Poisoning Surveillance Variables	40	4	4	640
Total					640

B. Cost to respondents is estimated to be $35.32 per hour. This is based on the average hourly rate of pay for a computer programmer (http://www.bls.gov/oes/current/oes151021.htm) to extract and format data, initiate computer runs, and verify and transmit data to CDC.

Table 7. Estimated Annualized Burden Costs

Respondents	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)	Hourly Wage	Total Respondent Costs
State, local, and territorial Health Departments	40	4	4	640	$35.32	$22,605
Total				640		$22,605

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

The cost estimate includes the following:
  a) a total capital and start-up cost component – approximately $40,000 for computer hardware and software required for HHLPSS. Many of the state, local, and territorial programs (e.g., health departments) already have existing equipment that can be used for HHLPSS.

  b) a total operation and maintenance and purchase of services – maintenance of HHLPSS is approximately $5,000 per year. However, many of the state, local, and territorial programs (e.g., health departments) already have existing computer servicing and software contracts in place and these can be used for HHLPSS.

A.14. Annualized Cost to the Government

For HHLPSS, five federal and contracted employees, two of whom will be contributing on a full-time basis, will carry major responsibility or oversight of the national surveillance system and management and analysis of the data. These employees will spend approximately 8,320 hours per year working on the surveillance program. Using an estimated salary of $35 per hour, personnel costs will total $291,200 annually. This is based on the average hourly rate of pay for

a computer programmer (http://www.bls.gov/oes/current/oes151021.htm) to extract and format data, initiate computer runs, and verify data that is transmitted to CDC.

A. 15. Explanation for Program Changes or Adjustments

This is a new data collection.

This surveillance system will replace an already-approved ICR from OMB (OMB No. 0920-0337, National Blood Lead Surveillance System, exp. 1/31/2012).

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

Each state, local, and territorial program has developed a plan for timely analysis and dissemination of summary data to appropriate state-level agencies and individuals. CDC will analyze the national data set and on an annual basis will disseminate results to the state, local, and territorial programs and to a broader audience via public health publications and other media. CDC will also provide this information to Executive Branch officials, Congress, healthy homes constituents, and other federal, state, and local agencies.   The dissemination of these results will always include the following caveats:

> These data were collected for program management purposes. The data are not generalizable at the national, state, or local level. Furthermore, because inclusion criteria vary across grantees, comparisons of aggregate statistics across programs can be misleading (i.e., state policies and practices for blood lead testing vary and local priorities drive decisions regarding which homes receive assessments for other housing hazards). . However, descriptive statistics can be used to compare changes overtime in a given area when the method by which housing units are chosen for inclusion remains the same. With a thoughtful understanding of the approach used to include housing units in a given location, HHLPPS can be used to make associations between the number of individuals in a given area and a specific housing hazard or health condition and geographic descriptors such as poverty, age of housing, tenancy, and health conditions.

Table 8. Project Time Schedule

Activity	Time Schedule
States will submit data files quarterly, except for reporting of adult blood lead levels which will be submitted semi-annually	1-3 months after OMB approval and every 3 months thereafter
Analyze data	Approximately 12 months after OMB approval
Disseminate publication/ Data	Approximately 12 months after OMB approval

The analysis plan includes descriptive statistics to show prevalence of environmental exposures and health outcomes (i.e., peeling paint in homes, presence of carbon monoxide and smoke alarms, elevated blood lead levels, and asthma). Statistical approach is described in Part B.

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

No paper forms are used as part of HHLPSS; all data are submitted electronically. Thus, exemption from displaying the expiration date for the OMB approval of forms is not being requested.

A.18   Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.