

## Supporting Statement A

Public Health Systems, Mental Health and Community Recovery Project

New

Centers for Disease Control and Prevention

Office of Public Health Preparedness and Response

Division of State and Local Readiness

Applied Science and Evaluation Branch

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August 15, 2013

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## A. Justification

### 1. Circumstances Making the Collection of Information Necessary

This is a request for Office of Management and Budget (OMB) approval of a new data collection for activities associated with the Public Health Systems, Mental Health, and Community Recovery (PHSMHCR) Project. As part of this project, the Centers for Disease Control and Prevention's (CDC's) Division of State and Local Readiness requests OMB approval to collect information for two years.

The Public Health Systems, Mental Health, and Community Recovery Project stem from, and align with the Office of Public Health Preparedness and Response's (OPHPR's) *National Strategic Plan for Public Health Preparedness and Response* "Strategic Plan."<sup>1</sup> The Strategic Plan aligns with the National Health Security Strategy (NHSS) to provide overall direction for CDC's preparedness and response portfolio. This includes programmatic direction across OPHPR's four divisions (including the Division of State and Local Readiness, which administers the Public Health Emergency Preparedness (PHEP) Cooperative Agreement), as well as the funding of related research activities. Objective 3 of the Strategic Plan calls for the promotion of "resilient individuals and communities." Specifically, this objective describes a key pathway to community resilience by supporting the work of State and local health departments in achieving the 15 Public Health Preparedness capabilities, including Community Recovery (Capability 2). Objective 5 of the Strategic Plan, "Increase the application of science to preparedness and response practice," emphasizes the importance of ensuring that "preparedness science" is translatable and actionable for public health officials, practitioners, and entities within public health systems. Data collection authority is found in Section 301 of the Public Health Service Act (42 U.S.C. 241). Under this legislation, funding has been set aside for evaluating and reporting the effectiveness of preparedness and response programs (**Attachment A**).

The goal of this project is to generate findings useful for future preparedness planning in order to develop strategies and interventions to mitigate the impact of adverse events. The intent is not to conduct epidemiological studies or surveillance for the purpose of identifying and meeting immediate health or mental health needs of any populations studied. To achieve the above stated goal, information will be collected regarding health department performance and the contributions or characteristics of public health and mental health systems in recovery efforts pre- and post-disaster, community social capital, access to services and information post-disaster, and so forth. As all natural disasters take a human and financial toll, it is important that we examine the aftermath of these catastrophic occurrences to learn how systems can mitigate negative effects through the systematic investigation of recovery and resilience.

In April 2011, one of the largest tornado outbreaks ever recorded, a "Super Outbreak," occurred in the southeastern United States, resulting in more than 300 deaths and an estimated \$11 million in damages. This large-scale, interstate tragedy offers a unique opportunity to study how communities with similar cultural and geographic attributes yet different State and local health delivery systems could provide access to care in the same in a similar crisis. The outcomes of these study efforts can inform the field of what effect these differences have on the recovery patterns in each of these communities. By doing so, we

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<sup>1</sup> The Office of Public Health Preparedness and Response, in collaboration with preparedness leaders internal and external to CDC developed A *National Strategic Plan for Public Health Preparedness and Response* ([http://www.cdc.gov/phpr/publications/2011/A\\_Natl\\_Strategic\\_Plan\\_for\\_Preparedness\\_20110901A.pdf](http://www.cdc.gov/phpr/publications/2011/A_Natl_Strategic_Plan_for_Preparedness_20110901A.pdf))

can begin to elucidate best practices for robust community preparedness and recovery, with attention to types of services that most effectively promote survivor resilience.

This study will focus on four regions in Alabama and Mississippi: 1) Jefferson County, Alabama; 2) Tuscaloosa County, Alabama; 3) Marion County, Alabama and Franklin County, Alabama; and 4) Monroe County, and Chickasaw County, Mississippi.

Two primary research questions will guide the proposed study:

1. How did the Alabama and Mississippi State and local public health and mental health (PH/MH) systems prepare for, respond to, and support recovery after the April 2011 tornadoes?
2. To what extent have these communities recovered and what is the overall health and quality of life of individuals affected by these events?

To address these questions, CDC, in collaboration with ICF International (hereafter referred to as ICF) will conduct a mixed-method evaluation using 1) key informant interviews of public health and mental health agency staff at the local, county and State levels and other community organization representatives (See page 7 for a more complete list of potential respondents), and 2) household surveys with the general public in the four study regions to assess community recovery and resilience. Specifically, the study design includes two main components (qualitative and quantitative) designed to comprehensively examine the PH/MH system response to and community recovery and resilience from disasters.

The table below summarizes the data collection instruments and data abstraction (**Table 2**).

*Table 2: Qualitative and Quantitative Study Components*

<b>Study Component and Measures</b>	<b>Overview of the Data Collection</b>	<b>Description of the Information to Be Collected</b>	<b>Domains</b>
Qualitative study component uses the key informant interview guides ( <b>Attachments E and F</b> )	<ul style="list-style-type: none"> <li>• 98 key informant interviews with PH/MH agency staff and community partners in Alabama and Mississippi (<i>approximately 53 with PH/MH agency staff and 45 with community organization respondents</i>)</li> </ul>	<ul style="list-style-type: none"> <li>• The key components of the PH/MH system response</li> <li>• Differences in responses when comparing the communities</li> <li>• Agency administrators' perception of their success in working with key community partners to implement PH/MH services during and after the tornadoes</li> <li>• Challenges encountered in implementing components of these preparedness plans</li> <li>• Information regarding available resources and supports</li> </ul>	<ul style="list-style-type: none"> <li>• Social capital</li> <li>• Interagency collaboration</li> <li>• Information distribution and communication</li> <li>• Community competence</li> <li>• Community-level resilience</li> </ul>
Quantitative study component uses	<ul style="list-style-type: none"> <li>• 860 computer-assisted telephone</li> </ul>	<ul style="list-style-type: none"> <li>• Extent to which individuals in the communities believe their own households and their communities</li> </ul>	<ul style="list-style-type: none"> <li>• Social capital</li> <li>• Exposure to disaster</li> </ul>

<p>the household survey <b>(Attachment D)</b></p>	<p>interviews conducted in each of the four regions <i>(for a total of 3,440 surveys)</i></p>	<p>have experienced recovery</p> <ul style="list-style-type: none"> <li>• Overall health and quality of life of individuals in the communities following the tornadoes, including mental and physical health status, levels of risk behaviors, quality of life, and satisfaction with life</li> <li>• Any differences in perceived recovery, and the overall health and quality of life of individuals in the communities following the tornadoes, including mental and physical health status, levels of risk behaviors, quality of life, and satisfaction with life experienced across communities</li> <li>• Whether social capital affects the relationship between exposure and resilience and recovery (social capital includes neighborhood disorder, collective efficacy, social connectedness, perceived support, participation in providing support to others during the disaster, participation in civic organizations)</li> <li>• Relationship between access to services and information post-disaster on resilience and recovery</li> </ul>	<ul style="list-style-type: none"> <li>• Perceived recovery</li> <li>• Health and well-being</li> <li>• Access to and awareness of services</li> </ul>
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## 1.1 Privacy Impact Assessment

### Overview of the Data Collection System

As mentioned previously, the Public Health Systems, Mental Health, and Community Recovery Project encompass two main components: 1) how PH/MH systems responded to the disasters and 2) individuals' perceptions of and experiences with recovery and resilience in their communities. The qualitative and quantitative study components are described in the following sections:

#### *Qualitative Study Component:*

The qualitative study component will focus on PH/MH systems preparedness, response, and recovery efforts in selected counties of Alabama and Mississippi that were affected by the 2011 "Super Outbreak" tornadoes. The ICF project team will address the research questions through approximately 98 1-hour key informant interviews (conducted in-person and over the telephone) with staff at mental health and public health agencies, and community organizations in affected areas.

A complete list of interview candidates will be generated through purposive snowball sampling. Once a key informant has been identified, an introductory letter (**Attachment C**) will be sent to the individual. The letter will explain the study and alert the recipient that he or she will receive a follow-up telephone

call from ICF to discuss the specifics of the study. During this telephone call, we will determine whether the individual is willing to be interviewed and is available for a site visit, and if he or she has recommendations for additional participants. The letter/telephone process will be repeated with each new potential candidate until the key participants have been identified. Potential respondents may include the following:

- Local public health emergency preparedness staff
- Local mental health emergency preparedness staff
- Local coordinators of disaster/emergency response
- Community leaders: faith leaders, business leaders, utility, and environmental leaders
- First responders: police, fire, emergency medical services
- Media representatives
- State public health emergency preparedness staff
- State mental health emergency preparedness staff
- State coordinators of disaster response

ICF will schedule the site visit to maximize the number of interviews that can be conducted in person. Telephone interviews will be conducted with key informants who are not available during the site visit.

The data collected will be narrative and textual, and analysis will be qualitative. Information collected through the interviews will be coded by site number and interview number. The participant's identifying information will be kept in a separate, password-protected file and will at no time be attached to the data. In addition, all study results will be presented in aggregate form.

#### *Quantitative Study Component*

The quantitative component of this study is designed to assess residents' exposure to the disaster and their current level of recovery, focusing on health and mental health outcomes. Quantitative data will be gathered through the *Household Survey for the General Public (Attachment D)* conducted by telephone in four disaster-exposed regions; 860 Computer-Assisted Telephone Interviews (CATI) will be completed in each of four regions. Each CATI will take approximately 25 minutes to complete. The items in the survey are from existing surveys and validated measures that have been used in other research.

The household survey will be completed by phone, in English and Spanish, using Address-Based Sampling (ABS). By using ABS, we can target specific areas within the study regions that were more directly affected by the tornado outbreak. After obtaining an address file for selected areas with the counties, we will match addresses to phone numbers. On the basis of prior experience, we expect 50% of addresses to have a phone number. Addresses that have a matching phone number will receive a letter in advance, followed by up to 15 call attempts by an interviewer to complete the interview. Potential respondents at addresses that are not matched to a phone number will receive an invitation to call us or provide us with their phone number. Once a potential respondent is reached, they will first be asked several questions to screen for eligibility to participate in the study (**Attachment H**). If the participant is deemed eligible, they will be read the consent and may begin the survey.

#### Items of Information to Be Collected

##### *Qualitative Study Component*

The qualitative interviews with key informants include questions on demographics and approximately 10 open-ended questions to elucidate how the relevant agencies serving these communities prepared for and aided in the recovery from the tornadoes (**Attachment E and F**). The key informant interview guides are based on the conceptual models of disaster preparedness and community resilience from Norris, Stevens, Pfefferbaum, Wyche & Pfefferbaum (2008) and Gurwitch, Pfefferbaum, Montgomery, Lompm & Reissman (2007).

The interviews should take approximately 60 minutes to complete. Information provided by the respondents during the interviews will be recorded, if permission is granted through the consent form (**Attachment G**). The interviewers will also take notes to record the conversation. The interview transcripts generated from the recordings along with the interview summaries will constitute the data records for this project. If a respondent does not grant permission to have the interview recorded, detailed interview notes and the interview summary will form the basis of the data records. Electronic transcripts and notes will be verified against the original interview summaries prior to analysis. ATLAS.ti, a qualitative data analysis software program, will be used to assist in the storage, coding, retrieval, comparing, and linking of the data.

### *Quantitative Study Component*

Responses to the household survey will serve as one data source to measure (self-reported) exposure to the disaster, perceived recovery, social capital indicators, and health indicators. ICF and CDC worked to identify items from existing surveys and validated measures to create the household survey, including the following:

- CDC's Behavioral Risk Factor Surveillance System (BRFSS)
- CDC's Gulf States Population Survey
- The Life Orientation Test, Revised (Scheier, Carver & Bridges, 1994)
- The Neighborhood Disorder Scale (Ross & Mirowsky, 1999)
- The Collective Efficacy Scale (Sampson, Raudenbush & Earls, 1997)
- CDC's Community Assessment for Public Health Emergency Response (CASPER)
- The University of Mississippi Gulf Coast Survey (University of Mississippi/National Science Foundation, 2006)
- The PsySTART (Schreiber, Koenig, Schultz, Shields & Bradley, 2011)
- The Short Screening Scale for *DSM-IV* Posttraumatic Stress Disorder (Breslau, Peterson, Kessler & Schultz, 1999)
- The Communities Advancing Resilience Toolkit (CART) Survey (Pfefferbaum, Pfefferbaum, Van Horn, 2011)

## **2. Purpose and Use of Information Collected**

The information obtained from the proposed data collection activities will be used to inform CDC, policymakers, disaster response and recovery practitioners, researchers, and the general public about effective mental health and public health efforts following a natural disaster. This data collection is intended to ensure that "preparedness science" is translatable and actionable for public health officials, practitioners, and entities within public health systems. Although not exhaustive, the following list illustrates a range of purposes and uses for the proposed information collection:

- Inform future response and recovery programming and planning that may be used in similar situations



- Establish a definitional framework for understanding recovery efforts across public health and mental health systems
- Develop an evidence base regarding the impact of public health and mental health response efforts

CDC plans to publish articles in peer-reviewed journals. ICF will also prepare brief reports for CDC regarding the status of the data collection throughout the project.

## **2.1 Privacy Impact Assessment**

The information being collected will aid in determining and documenting strategies used in response and recovery efforts in the face of the tornado “Super Outbreak” of 2011. The information will be compiled into a report and shared with CDC and partner organizations.

A number of steps will be taken to protect the privacy of respondents. ICF physical facilities have multiple access levels, each requiring authorization for entry. All entry points are monitored and recorded at all times and electronically controlled, granting access to approved personnel only. Survey data are kept in locked containers or locked rooms when not being used. All staff members working on survey projects complete annual privacy and security trainings specific to the terms of individual contracts, and all staff members are required to sign a confidentiality agreement before they can access any project data or information.

Interview notes, transcripts and recordings will be retained by ICF until one year after the expiration or termination of the contract. If requested, clean transcripts and/or notes with all identifiers removed will be provided to CDC. However, recordings will not be provided to CDC. One year after the project expires or is terminated, the project manager, in consultation with CDC, will supervise authorized destruction of transcripts, recordings, and notes. Destruction of all documents will be accomplished by shredding. All recordings and electronic files will be deleted.

Household survey data will be collected electronically. CDC will not receive any information in identifiable form (IIF). All IIF collected by ICF will be delinked or stripped from data delivered to CDC. ICF will retain one copy of all deliverables for five years after the end of the calendar year in which the interviews occurred. We also will retain all project materials and documentation, including all reference materials and interview instructions until five years after the expiration or termination of the contract. Our system security and ability to protect sensitive personal information has been subject to routine audit and confirmation by Federal agencies such as the Internal Revenue Service and the Veterans Health Administration. Our information security process is based on the approach prescribed by the Federal Information Security Management Act of 2002 (FISMA, 44 U.S.C. § 3541 et seq.) as implemented by the Office of Management and Budget (OMB) in Circular A-130 and other policy documents. Our facilities conform to NIST-Low standards for security and can be raised to NIST-medium security level as needed.

## **3. Use of Improved Information Technology and Burden Reduction**

To reduce the burden on respondents, all household-surveys will be conducted via CATI. CATI allows telephone interviewers to conduct interviews by script and to probe the respondents’ disclosures as appropriate. All interviewers will partake in a comprehensive day-long training to ensure that each interviewer is skilled and knowledgeable about the household survey and can respond without hesitation

to questions about the study purpose, sponsor, and other common respondent questions. Specific training topics will include: survey goals and data usage, informed consent, differences between landline and cellular phone instruments (e.g., screeners), CATI program nuances, review of unique or challenging terminology, study dialing and refusal protocols, special considerations for a survey about sensitive topics, methods for dealing with uncooperative respondents and maximizing response rates, methods to ensure privacy and minimize bias, and appropriate responses to frequently asked questions.

ICF and CDC have worked to ensure that burden for the interview respondents is minimal; in-person interviews will be limited to 1 hour and scheduled far in advance to allow for the maximum number of interviews during the one-week site visit. The household surveys will be limited to approximately 25 minutes in length.

#### **4. Efforts to Identify Duplication and Use of Similar Information**

Information proposed for collection in the qualitative study component appears to be unique in that interviews of mental health and public health responders to a natural disaster of this magnitude are limited, according to our research. Prior to finalizing the study design, a comprehensive review of the literature was conducted for this region, specifically for tornadoes as well as natural disasters in general. Results indicated that this research will be unique in its efforts.

To ensure a high level of scientific rigor, items from existing surveys and validated measures will be used for the household survey. The use of existing survey items can potentially allow for a comparison of data gathered through the *Household Survey for the General Public* to data gathered through previous surveys to examine trends in health outcomes and other indicators. We will draw on the existing set of relevant mental and physical health questions from BRFSS and the Gulf State Population Survey (GSPS), supplemented with items from other instruments used in the region or other areas following disasters.

#### **5. Impact on Small Businesses or Other Small Entities**

Small entities, especially those defined as a small government jurisdiction, may be involved in this study. However, overall impact is minimal; the project attempts to minimize that burden by limiting the frequency and length of time required for data collection. In-person interviews will be restricted to 1 hour. All data collected through the CATI will be gathered from individuals, not businesses. The proposed information collection will have no impact on business entities.

#### **6. Consequences of Collecting the Information Less Frequently**

The activities involve a one-time collection of data. Repeated interviews or surveys are not projected.

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

The data collection fully complies with the requirements of 5 CFR 1320.5(d) (2).

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

A 60-day Federal Register Notice was published in the Federal Register on April 29, 2013, vol. 78, No. 82, pp. 25088-89 (**Attachment B**). There were no public comments.

## **9. Explanation of Any Payment of Gift to Respondents**

Remuneration will be used for key informant interviews with community respondents (**Attachments F**), as well as the household survey (**Attachment D**).

### In-Person Key Informant Interviews

Remuneration is not provided to all interview participants as majority of them work for the State, county or local level agencies and receive wages. Community leaders who may reside in the targeted communities or professionals who work for nonprofit agencies and nongovernmental organizations will be remunerated. These respondents will receive a \$50.00 Visa gift card as a token of appreciation.

### Household Survey for General Public

On the basis of our experience implementing telephone surveys, an introductory letter (**Attachments J & K**) will be mailed to all potential households in the sample requesting participation in the telephone survey. This letter will contain the purpose of the study, details on when the telephone surveys will be conducted and who will contact prospective participants. To facilitate and increase participation of respondents without a corresponding phone number, we will provide \$1 with the advance notification letter and a return postcard (**Attachment L**) to facilitate provision of a phone number. Respondents without a corresponding phone number who call in to complete the survey or who provide us with a phone number and complete the survey when we call them will be mailed \$10 within 2 weeks of completing the survey. On the basis of a 2002 meta-analysis of randomized controlled trials of methods intended to influence response rates, it was found that the odds of a response were more than doubled when a monetary incentive was used (odds ratio 2.02; 95% confidence interval 1.79 to 2.27) and almost doubled when incentives were not conditional on response (1.71; 1.29 to 2.26) (Edwards, et al., 2002).

## **10. Assurance of Confidentiality Provided to Respondents**

This submission has been reviewed by OPHPR who determined that the Privacy Act does not apply. Data will be treated in a secure manner and will not be disclosed, unless otherwise compelled by law.

The data collected from the key informant interviews will be coded by site number and interview number. The participant's identifying information will be kept in a separate, password-protected file and will at no time be attached to the data. In addition, all study results will be presented in aggregate form. Similarly, addresses and phone numbers of household survey respondents will be kept in a separate, password-protected file and will not be directly associated with survey responses; no names or other personally identifiable information will be collected.

Our system security and ability to protect sensitive personal information has been subject to routine audit and confirmation by Federal agencies such as the Internal Revenue Service and the Veterans Health Administration. Our information security process is based on the approach prescribed by the Federal Information Security Management Act of 2002 (FISMA, 44 U.S.C. § 3541 et seq.) as implemented by the Office of Management and Budget (OMB) in Circular A-130 and other policy documents. Our facilities conform to NIST-low standards for security and can be raised to NIST-medium security level as needed.

Our physical facilities have multiple access levels, each requiring authorization for entry. All entry points are monitored and recorded at all times and electronically controlled, granting access to approved personnel only. Survey data are kept in locked containers or locked rooms when not in use. All staff working on survey projects complete annual privacy and security trainings specific to the terms of individual contracts, and each employee is required to sign a confidentiality agreement before he or she

can access any project data or information.

Highlights of some of the controls implemented at ICF include the following:

- *Parameter Network Security:* The parameter of our network is secured by an Evaluation Assurance Level (EAL) 5 certified Borderware Firewall. No external Internet traffic is allowed to the internal network. All external resources are located in a DMZ zone on the Borderware Firewall.
- *Data in transit:* All data in transit within our organization are protected by a FIPS-140-2 compliant encryption software, using Tectia SSH/SCP or Microsoft RDP protocols.
- *Data at rest:* All data at rest are protected by FIPS-140-2 compliant encryption software, in the form of Secure Doc Whole disk encryption and PGP.
- *Logical controls:* Different levels of password-protected access to ICF's computer systems are granted to individuals and specified user groups. All projects are protected by group permissions, which only allow approved staff access to the material. Invalid attempts to data are immediately reported to System Administrators.
- *Physical security:* The physical security of the data is also ensured by the location of file servers, tapes, and tape back-up units in locked areas. All facilities within our organization meet NIST 800-53 low protocols. Entry points are monitored and recorded at all times and electronically controlled, allowing only approved personnel into the facility.
- *Written material* stored onsite is locked in file cabinets. We retain one copy of all deliverables for 5 years after the end of the calendar year in which the interviewing occurred. We also retain all project materials and documentation, including all reference materials and interviewer instructions until 5 years after the expiration or termination of the contract. These materials are available to CDC on request.
- *Anti-virus software* is used to manage malicious code incidents (viruses). File integrity monitoring software is also used to ensure critical programs are not modified by malicious code.

Any breaches of security will be investigated immediately and reported to CDC. We are fully confident that our operating procedures for controlling privacy and security will ensure full protection of all contract information.

The following section outlines our staff training procedures and policies surrounding respondent privacy:

*Confidentiality agreement:* All staff, including call center supervisors and interviewers, is required to sign a strict confidentiality agreement upon date of hire. By signing this agreement, staff members agree to this statement: "I will keep completely confidential all information arising from surveys concerning individual respondents to which I gain access. I will not discuss, disclose, disseminate, or provide access to survey data and identifiers except as authorized."

*Confidentiality training:* All newly hired interviewers participate in a 16-hour initial training. Critical components of this training related to protecting respondent privacy include: the role of the interviewer in survey research; procedures for protecting respondent privacy and data security; and our corporate core values and expectations for employee performance, which include expectations for protecting privacy. Both the confidentiality statement that is signed by interviewers and the interviewer training specify that respondent information, including respondents' names, and all information or opinions collected in the course of interviews, as well as any information about respondents learned incidentally must be kept private. This includes refraining from discussing details of interviews outside of the work environment.

*Privacy assurance:* During specific training by the CATI survey coordinator for administering the

household survey, our staff will review and practice reading the informed consent statement (**Attachment D**), which will include a statement about respondent privacy. The training will include role-play scenarios, as well as a review of responses to frequently asked questions, which will include ways to address respondent questions and concerns about privacy. While all household survey respondents will be read the informed consent statement prior to participating, respondents may have questions about confidentiality while the survey is in progress. The CATI team will reiterate our privacy policies during the survey if they sense hesitation or when asked explicitly by a respondent. Similarly, the ICF team members responsible for conducting the key informant interviews will read all participants a consent form and will be familiar with all privacy policies in case further explanation is required.

## IRB Approval

We have our own Institutional Review Board (IRB) that meets all of the Federal requirements as specified in 45 CFR 46, is registered with the Office for Human Research Protections, and has a Federal Wide Assurance (#FWA00000845). This ensures that all of our projects involving human subjects comply with Federal regulations. This study was submitted for IRB approval and received approval on 3/17/2013 (**Attachment I**).

### **10.1 Privacy Impact Assessment Information**

All study respondents will be informed that their participation will be voluntary. After the purpose and expectations of the in-person key informant interviews and the household survey are provided by the interviewer, respondents will be given an opportunity to consent to participation. Respondents will also be informed about how the aggregate data will be shared and disseminated and also that they may choose not to answer any question or stop at any time. All data collected will be stored in our secure facilities. Both the data from interviews and the household survey will be kept in locked containers or locked rooms when not in use. All personally identifiable information from the qualitative interviews will be stored in a separate, locked file. Following data collection of the household survey, personally identifiable information, including addresses and phone numbers, will be stored separately from responses in a password-protected file. During data collection, only survey staff will have access to addresses and phone numbers. Final data files for both components will be submitted to CDC with no personally identifiable information. Staff working on this project is required to complete annual privacy and security trainings and all employees are required to sign a confidentiality agreement before accessing any project data. A system of records associated with this project is not being created under the Privacy Act.

### **11. Justification for Sensitive Questions**

Because this project concerns response and recovery efforts aimed at individuals and communities that have experienced traumatic events, it is necessary to ask questions that are potentially sensitive. However, only information that is central to the study is being sought. Questions address dimensions such as exposure to death, and mental health symptoms associated with the traumatic event. The answers to these questions are used to understand post-disaster recovery efforts and to measure changes over time. Both CATI interviewers and the in-person interviewers will be trained in crisis protocol, respondent cues to ascertain distress levels, and appropriate actions for each distress level. The introductory script for the household survey includes a verbal consent statement that indicates that respondents can skip any question they prefer or stop at any time.

### **A12. Estimates of Annualized Burden Hours and Costs**

In total, we plan to conduct approximately 98 key informant interviews with public health, mental health and community organization staff across the four study regions. We anticipate between 16-24 interviews per region; approximately 8-12 of these individuals will be public health/mental health respondents. The exact breakdown of the key informants cannot be determined at this time because of the snowball sampling. Based on these estimates, between one-third and three-quarters of the interviews are with PH/MH respondents. This averages to be 54% of the 98 interviews which is 53; the remaining 45 surveys will be completed by community organization respondents. All key informant interviews are one-hour.

For the household survey, in each of the four regions, we will identify 13,000 addresses—half will have a corresponding phone numbers and half will not. On those with phone numbers (n=6,500), we anticipate that 40% will be valid (n=2,600); it is expected that 65% of households with valid numbers will have actual phone contact (n=1,690). Of those with contact, we expect that 45% will do the screener. This will result in approximately 761 screeners. Of those without matching phone numbers, we expect that 8.5% of those will return postcards with their telephone number and will complete the phone screener; this will result in 552 completed screeners. Per region we expect 1,313 screeners will be completed; each screener will take approximately 2 minutes to complete. Of the 1,313 screeners, we expect that approximately 860 respondents per region will complete the survey. Each survey will take approximately 25 minutes.

**Table A.12-1. Estimated Annualized Burden Hours**

Type of Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
Mental health/public health agency staff	Key Informant Interview Guide_PH/MH Agency Staff & Key Informant Interview Guide _Consent Form	53	1	1	53
Community Organization Leaders	Key Informant Interview Guide_Community Organization Respondents & Key Informant Interview Guide _Consent Form	45	1	1	45
General public from disaster affected communities	Household Survey for General Public & Consent Form	3,440	1	25/60	1,433
General public from disaster affected communities	Household Survey for General Public_ Study Screener	5,252	1	2/60	175

	<b>Total</b>	1,706
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**Table A.12-2. Estimated Annualized Cost to Respondents**

Type of Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Average Hourly Wage	Total Respondent Cost
Mental health/public health agency staff	Key Informant Interview Guide_ PH/MH Agency Staff & Key Informant Interview Guide _ Consent Form	53	1	1	\$19.25 <sup>2</sup>	\$1020.25
Community Organization Leaders	Key Informant Interview Guide_ Community Organization Respondents & Key Informant Interview Guide _ Consent Form	45	1	1	\$19.25	\$866.25
General public from disaster affected communities	Household Survey for General Public & Consent Form	3,440	1	25/60	\$7.25 <sup>3</sup>	\$10,391.66
General public from disaster	Household Survey for	5,252	1	2/60	\$7.25	\$1,269.23

<sup>2</sup> Assuming the average annual income across all types of staff/service providers/administrators is \$40,000, the wage rate was estimated using the following formula: \$40,000 (annual income)/2,080 (hours worked per year) = \$19.25 per hour.

<sup>3</sup> Minimum wage in Mississippi and Alabama

affected communities	General Public_ Study Screener					
	<b>Total</b>					<b>\$13,547.39</b>

As indicated in Exhibits A-12-1 and A-12-2 the average total annual burden for data collection is estimated at 1,706 hours for a yearly cost of \$13,547.39.

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

There are no other costs to respondents.

### 14. Annualized Cost to the Government

**Government personnel** – Governmental costs for this project include personnel costs for Federal staff involved in the planning and designing of the Public Health Systems, Mental Health and Community Recovery Project, and costs for data collection instruments and OMB materials, collecting and analyzing the data, and reporting, which includes approximately 60% effort of a GS-13 Behavioral Scientist; 20% effort of a GS-13 Behavioral Scientist; 10% effort of a GS-14 Behavioral Scientist, 10% effort of a GS-12 Behavioral Scientist. The total estimated annualized cost to the Federal Government is \$71,834 which is based on the 2012 General Schedule Base Pay Table, Step 1.

**Contracted data collection** – CDC has contracted with ICF for designing and implementing the study under a contract totaling \$741,101 (annual cost of \$385,550). This includes costs for planning and conducting qualitative and quantitative components and analyzing the data collected through these studies.

Labor	
60% Behavioral Scientist (GS-13) time for project, planning, management, OMB review, analysis of findings, and report writing	\$43,004
20% Behavioral Scientist (GS-13) time for project, planning, management, OMB review, analysis of findings, and report writing	\$14,334
10% Behavioral Scientist (GS-14) time for project, planning, management, OMB review, analysis of findings, and report writing	\$8,469
10% Behavioral Scientist (GS-12) time for project, planning, management, OMB review, analysis of findings, and report writing	\$6,027
Contractor	\$385,550
Total estimated cost	\$457,384



## **15. Explanation for Program Changes or Adjustments**

This is a new data collection.

## **16. Plans for Tabulation and Publication and Project Time Schedule**

Qualitative data analysis will be based on an interviewer report and transcriptions of interview recordings. Using a modified grounded theory approach, the data will be analyzed for themes, patterns, and interrelationships relevant to an understanding of how State and local PH/MH systems in the communities prepared for disaster and supported recovery during and after the disaster. The data will be analyzed to identify the key components of the PH/MH system response, such as: 1) substantial differences in responses when communities are compared; 2) how the agency administrators perceived their successes in working with key community partners to implement PH/MH services; 3) challenges encountered in implementing components of these preparedness plans; and 4) if/what the agency administrators would have done differently. Grounded theory is a complex iterative process that begins with the development of a set of general research questions that are meant to be neither static nor all-inclusive. As the researcher begins to gather data, core theoretical concepts are identified. Tentative linkages are developed between the theoretical core concepts and the data. This early phase of the research tends to be very open. Later on, the researcher is more engaged in verification and summary. What emerges from a systematic comparative analysis of the data is theory, grounded in fieldwork that serves to explain what has been observed in the field and provide a basis for providing promising practices and recommendations to PH/MH agencies and CDC regarding system preparedness, response, and recovery (Morse and Field 1995).

In regard to the quantitative data collected, the first step will be to conduct complete descriptive analyses of the data in all communities. Within each community, descriptive statistics will be employed to summarize the characteristics of the respondents in that community, including demographic characteristics, health and mental health status, economic status, connection to the community, and resilience/coping. Subgroup analyses may be performed to assess potential differences among identified groups on descriptive variables (for example, across levels of exposure to the disaster). These analyses will be conducted using cross-tabulation procedures (e.g., chi-square) with categorical variables and between group procedures (e.g., Analysis of Variance (ANOVA) and *t*-tests) with variables that are continuous. Analyses will also be reported with and interpreted in the context of information gained from the qualitative assessments regarding the nature of the disaster response.

Within each community we will use multivariate analyses to determine which of the factors are associated with self-reported health and mental health outcomes. For example, logistic regression will be used to determine whether better self-reported social capital and access to services or exposure to messages about community resources are associated with better health outcomes.

We will also conduct analyses across the communities to determine whether differences exist between the communities across the various domains measured by the household survey. If differences are detected, they can be interpreted in the context of differences in the response to disasters as detected through the qualitative assessments.

Annual and final reports will be submitted to CDC with anticipated subsequent dissemination to other interested parties, such as researchers, policymakers, and program administrators at the Federal, State, and local levels.

<b>Project Time Schedule</b>
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<b>Activity</b>	<b>Time Schedule</b>
Program and test survey	Within 6 weeks of OMB approval
Develop training materials and train interviewers	Within 7 weeks of OMB approval
Send pre-notification letters	Within 7 weeks of OMB approval
Collect data	Within 4 months of OMB approval
Conduct site visits with key informants	Within 4 months of OMB approval
Weighting the data	8 weeks from the end of data collection
Format, process and clean the data	4 weeks from the end of data collection

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

The display of the OMB expiration date is not inappropriate.

**18. Exceptions to Certification for Paperwork Reduction Act Submissions**

There are no exceptions to the certification.

## Reference List

- Breslau, N., Peterson, E. L., Kessler, R. C., & Schultz, L. R. (1999). Short screening scale for *DSM-IV* posttraumatic stress disorder. *American Journal of Psychiatry*, *156*, 908–911.
- Centers for Disease Control and Prevention. (2011, 2010, 2009, 2008, 2007, 2006, 2002, 2000, 1998). *Behavioral Risk Factor Surveillance System Survey questionnaire*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
- . (2011). *Community Assessment for Public Health Emergency Response (CASPER) one year following the Gulf Coast oil spill: Alabama 2011*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
- . (2011). *Gulf States Population Survey*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
- . (2011). *A national strategic plan for public health preparedness and response*. Atlanta, GA: Office of Public Health Preparedness and Response.
- Edwards, P., Roberts, I., Clarke, M., DiGiuseppi, C., Pratap, S., Wentz, R., et al. (2002). Increasing response rates to postal questionnaires: Systematic review. *BMJ*, *324*, 1,183–1,185.
- Gurwitch, R. H., Pfefferbaum, B., Montgomery, J. M., Klopff, R. W., & Reissman, D. B. (2007). *Building community resilience for children and families*. Oklahoma City, OK: National Child Traumatic Stress Network.
- Norris, F. H., Stevens, S. P., Pfefferbaum, B., Wyche, K. F., & Pfefferbaum, R. L. (2008). Community resilience as a metaphor, theory, set of capacities, and strategy for disaster readiness. *American Journal of Community Psychology*, *41*(1–2), 127–150.
- Pfefferbaum, R. L., Pfefferbaum, B., & Van Horn, R. L. (2011). *Communities Advancing Resilience Toolkit (CART): The CART integrated system*. Oklahoma City, OK: Terrorism and Disaster Center at the University of Oklahoma Health Sciences Center.
- Ross, C. E. & Mirowsky, J. (1999). Disorder and decay: The concept and measurement of perceived neighborhood disorder. *Urban Affairs Review*, *34*, 412–432.
- Sampson, R., Raudenbush, S., & Earls, F. (1997). Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science* *277*, 918–924.
- Scheier, M. F., Carver, C. S., & Bridges, M. W. (1994). Distinguishing optimism from neuroticism (and trait anxiety, self-mastery, and self-esteem): A re-evaluation of the Life Orientation Test. *Journal of Personality and Social Psychology*, *67*, 1,063–1,078.
- Schreiber, M., Koenig, K., Schultz, C., Shields, S., & Bradley, D. (2011, May). PsySTART Rapid Disaster Mental Health Triage System: Performance during a full scale exercise. *Academic Emergency Medicine*, *18*(5; Suppl.), s59.

University of Mississippi/National Science Foundation. (2006). Hurricane Katrina Gulf Coast Survey. Retrieved March, 2013, from [http://www.olemiss.edu/depts/population\\_studies/NSF/data/Gulf%20Coast%20Survey%20v10c.pdf](http://www.olemiss.edu/depts/population_studies/NSF/data/Gulf%20Coast%20Survey%20v10c.pdf)