

INFORMATION COLLECTIONS TO ADVANCE STATE, TRIBAL, LOCAL, AND  
TERRITORIAL (STLT) GOVERNMENTAL AGENCY SYSTEM PERFORMANCE,  
CAPACITY, AND PROGRAM DELIVERY

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

SUPPORTING STATEMENT A

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## Part A. JUSTIFICATION

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

The Centers for Disease Control and Prevention (CDC) is requesting approval for a revision within this “generic” clearance under the authority of Section 301 of the Public Health Service Act (42 USC Sec. 301 [241]) (**Attachment A**). The purpose of this generic clearance is to advance state, tribal, local, and territorial (STLT) governmental agency system performance, capacity and program delivery. As a result, revisions focused on clarifying definition of the respondent universe:

- a) STLT government agency staff with a task(s) to improve the public’s health<sup>1</sup>. Task is defined as actions, mission, services, functions or duties that benefit the public's health and not tied to the organization delivering the public health service.
- b) Delegates acting on behalf of STLT government agency staff involved in the provision<sup>2</sup> of essential<sup>3</sup> public health services in the United States. A delegate is defined as: a governmental or non-governmental agent (agency, function, office or individual) acting for a principal or submitted by another to represent or act on behalf of STLT health departments.

This has also resulted in a change in the original title, “Surveys of State, Tribal, and Territorial (STLT) Governmental Agencies”. The new title for this generic more accurately reflects the requested revisions.

CDC’s mission is to create the expertise, information, and tools that people and communities need to protect their health – through health promotion, prevention of disease, injury and disability, and preparedness for new health threats. CDC seeks to accomplish its mission by collaborating with partners throughout the nation and the world to: monitor health, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments, and provide leadership and training.

CDC priorities include addressing the leading causes of disease, injury, and disability in the United States, including a focus on tobacco control; improving nutrition, physical activity, and food safety; reducing healthcare-associated infections; preventing motor vehicle injuries; preventing teen pregnancy; and preventing HIV. Approaches to improvements include – strengthening surveillance, epidemiology, and laboratory science; health promotion and disease

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<sup>1</sup>Public health- the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals.

<sup>2</sup>Provision- the act of (directly or indirectly) planning, providing, or assessing services.

<sup>3</sup>Essential public health services- 10 services identified in 1988 IOM report.

prevention across the lifespan; better supporting efforts in states and communities; and to pursuing policies that have an impact on the population's health.

As such, CDC's relationship with state, local, tribal and territorial (STLT) governmental staff and their delegates is key to its emergency preparedness, health promotion and disease prevention responsibilities. In addition, recent national initiatives have been implemented to support the purpose of this Generic ICR. For example, the goal of the 2011 National Prevention Strategy is to increase the number of Americans who are healthy at every stage of life. This goal is achieved by: 1) strengthening state, tribal, local, and territorial public health departments to provide essential services; 2) enhancing cross-sector collaboration in community planning and design to promote health and safety; 3) supporting integration of prevention and public health skills into health care professional training.

The 2012 Institute of Medicine (IOM) report, 'Primary Care and Public Health: Exploring Integration to Improve Population Health,' further emphasizes the overlap between public health and primary care roles and functions. This overlap or integration of public health and primary care is characterized as a continuum that spans mutual awareness, cooperation, collaboration, and partnership.

To facilitate effective and efficient delivery of STLT and partner public health services and enhance STLT performance/capacity and CDCs flexibility in responding to public health events, we are submitting this application for a framework under which individual data collections could then be expeditiously approved. This framework characterizes the population from whom the data is to be collected and the methods that would be used to collect the data, as well as the topics about which CDC usually collects such data. Individual information collection requests will be submitted to OMB and will include the actual data collection instruments and describing the specific data collection goal, design, and sampling and analysis plans.

Circumstances instigating a collection will vary for each data collection from STLT and delegates input into CDC product design and content, strengthen partnership, collaborations, and communication. The purpose of data collections is to advance STLT governmental agency system performance, capacity and program delivery. Examples of type of data collections include (but not limited to):

- assessing STLT and delegate resource and program capacities,
- identifying technical assistance needs,
- assessing workforce development and training needs
- identifying resource needs and constraints within STLT programs
- assessing and developing communication tools to meet STLT needs
- informing quality improvement activities within CDC programs
- identifying strengths and barriers in STLT and CDC programs
- tailoring CDC products and services to STLT needs
- quick assessment of program impact
- prioritizing CDC program activities
- preparing and evaluating of Health and Human Services (HHS) requests and CDC funding opportunity announcements
- developing of policies and laws

- issues of impact, periodicity of other internal and external collections, data gaps and linking new or existing datasets, need for current, time sensitive information, and information relevant to specific priorities of HHS and CDC will provide the basis for initiation of a collection and many more.

Proposed data collections will conduct an extensive search for existing data collected by CDC or its partners. It is important to note that CDC efforts under this generic clearance will not be duplicative of information collections already conducted by ASTHO, NACCHO and other public health organizations. The resulting burden is an upper-bound estimate and will be adjusted as appropriate as CDC uses the collection.

Identification of Website(s) and Website Content Directed at Children Under 13 Years of Age –  
The data collection system involves using telephone, in-person, focus groups, and web-based assessment. Respondents using the web-based mechanism will be sent a link directing them to the online assessment only (i.e., not a website). No website content will be directed at children.

## **2. Purpose and Use of the Information Collection**

Respondent universe is comprised of STLT governmental staff, delegate acting on behalf of a STLT agency involved in the provision of essential public health services in the United States. The STLT agency is represented by a local, state, tribal or territorial governmental entity or delegate with a task to improve the public's health.

The scope of data collection is limited to responsibilities and duties of governmental staff or delegate acting in their official capacity in delivering essential public health services. Thus individual data collections that require institutional review board review are not covered. OMB will decline individual data collection requests if it includes respondents that are governmental staff or delegates with official tasks other than public health. The collection will include the following categories of STLT governmental officials: 1) State, Tribal, Local, and Territorial governmental staff or delegate; and 2) Local/County/Municipal/City government staff or delegate.

State, territorial and tribal government agency staffs or delegates are in a unique position to provide CDC with the following information for a given jurisdiction: public health threats, status of public health infrastructure, workforce and financing at state, territorial and tribal levels. For that reason CDC will collect data from that category if, for example, the assessment of the magnitude of a particular public health problem is needed (surveillance), or when assessment of the jurisdiction's capacity to respond to a particular health problem (assessment and performance management) is warranted, etc.

County and municipal/city governmental staffs or delegates are at the forefront of public health service delivery and emergency response. Examples of data collections for that category may include, but not be limited to assessment of their performance in provision of public health services, progress they are making in accreditation process, new policy development initiatives, etc.

CDC will conduct brief data collections, across a range of public health topics related to essential public health services, using standard modes of administration (e.g., phone, web, e-mail, and in person). Information will be used to assess situational awareness of current public health emergencies; make decisions that affect planning, response and recovery activities of subsequent emergencies; fill CDC gaps in knowledge of programs and/or STLT governments that will strengthen surveillance, epidemiology, and laboratory science; improve CDC's support and technical assistance to states and communities.

In general, we expect that these collections will be solicited from governmental staff or delegate, in a category (e.g., all epidemiologists, food safety program manager, laboratory technicians or delegate, or to the subset of professional staff) for which a particular health problem was thought to be relevant. This collection of information will employ statistical methods for analysis as described in section B.

Data collections will gather information on administration, quality, quantity, improvement, inputs, activities, outputs, and outcomes related to delivery of essential public health services. Questions will be formulated around one or more of the three themes of the ten essential public health services listed below.

#### **Assessment**

- Monitoring health status to identify community health problems
- Diagnosing and investigating health problems and health hazards in the community
- Evaluating effectiveness, accessibility, and quality of personal and population-based health services

#### **Policy Development**

- Development of policies and plans that support individual and community health efforts
- Enforcement of laws and regulations that protect health and ensure safety.
- Research for new insights and innovative solutions to health problems

#### **Assurance**

- Linking people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assuring a competent public health and personal health care workforce
- Informing, educating, and empowering people about health issues
- Mobilizing community partnerships to identify and solve health problems

In general, CDC does not expect these collections to yield data that can be generalized, but will produce needed information regarding important health topics that affect state and local public health issues. CDC expects to use these findings to understand better the range of experiences among state, local, tribal, and territorial governmental staff or delegate, and as one of many inputs into decision making and/or program management or assessment.

CDC will submit the specific information collections to OMB for review as individual Information Collections (ICs) under this general Generic clearance framework. Individual submissions will include the purpose of the collection, description of sample, target respondent, questions to be asked, and response burden. These specific information collections will be

included in the PRA public docket prior to their use. OMB will review and approve an individual IC in an expedited manner. However, if the specific information collection falls outside the scope of the generic clearance or is otherwise inconsistent with the terms of the generic clearance, OMB will return the proposed information collection to the agency for additional consideration or require that the full PRA process be followed, including public notice and comment, for the review and approval of that information collection.

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

Data collections will be conducted using the most current modes of data collection, including web-based instruments, focus groups, phone or in-person interviews or other modes applied to specific national assessments. Though these technologies will be used by many of the individual projects in this data collection, the nature of many of these proposed activities typically requires direct interaction between respondents and project staff, especially in the case of qualitative interviewing and cognitive testing. Also, in cases when respondents do not have access to electronic means of communication, a paper-based data collection will be implemented on a limited basis.

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

CDC recognizes and understands the fact that many collection requests are made to governmental health agencies, their delegates and thus intends to use this generic clearance judiciously to ensure only the most relevant collections are undertaken and that they are not duplicative of other efforts. CDC will require the program to determine whether or not the information already exists.

### **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**

The purpose of CDC's request for this generic clearance is to ensure collection of data that is not otherwise available in current, time sensitive or relevant formats to specific or emergent priorities of HHS and CDC. Specifically, without this data there would be:

- No timely feedback regarding effectiveness of CDC's support and technical assistance to governmental public health agencies.
- Less effective interventions and data-driven decisions that need to be often made between CDC and state, tribal, local, and territorial governmental health agencies in an expedited manner during emergencies and disease outbreaks.
- Persistent gaps in other extant information collections, because of limited timing, content, or respondent focus, i.e. CDC will not be able to complement data collection activities of other entities
- Limitations to effective and timely assessment of capacities of governmental agencies to fulfill their public health mission.

Existing data collections efforts have several limitations that necessitate need for this generic clearance request. For example:

- Public health infrastructure data collections by CDC partners organizations (NACCHO) are conducted only every 2 years and thus have limited utility for CDC from the point of view

of program monitoring and assessment, which usually require more frequent data collection.

- None of the existing data collections include collection of data that is needed to evaluate many CDC programs, such as Public Health Associate Program, etc. or unique programs and needs.
- Data needed to assure accountability of CDC investments in public health infrastructure through cooperative agreement mechanisms is not routinely collected.
- Data needed to accommodate requests from HHS and Congress may not be available in currently run data collections of state and local government staff or delegates delivering essential public health services.

There are no legal obstacles to reduce the burden.

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

There are no special circumstances with this information collection package. This request fully complies with the guidelines of 5 CFR 1320.5.

**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 October 31, 2013, Vol. 78, No. 211, pp. 65325-26 (see Attachment B). There were no comments from the public.

**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. State, tribal, local, and territorial government agency staffs or delegates 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 sensitive information will be collected.

**12. Estimates of Annualized Burden Hours**

The burden is calculated based on the assumption of querying at most 100% of all available state, territorial (800) and county (3,000) health officials/employees and a representative sample of at most 100 municipal/city employees. An estimate of 800 is made based on 50 states, 8 territories, 566 federally-recognized tribes, and additional room for various positions in health department (chronic disease, lab, infectious, etc.). CDC estimates that it will conduct up to 40 queries with State, territorial or tribal health officials/employees. This includes all state, local, gov't staff, the state programs, and the delegates. These are upper limit parameters assumed for the purpose of calculation of the total burden. The actual number of respondents in a data collection and number of queries per respondent will vary depending on the purpose of each individual generic collection

request. The universe of respondents is described in section B.1 The total annualized burden hours of 54,000 is based on the following estimates. Please note, these estimates are for one year; this is expected on an annual basis only.

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

Type of Respondent	No. of Respondents	No. of Data collections per Respondent Type	Average Burden per Respondent (in Hours)	Total Burden Hours (annual)
State, Territorial, or Tribal government staff or delegate	800	30	1	24,000
Local/County/City government staff or delegate	3,000	10	1	30,000
Total		40		54,000

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

An average hourly salary of approximately \$18.09 is assumed for all respondents, based on the Department of Labor (DOL) National Compensation Survey. Because of the scope of this generic clearance and the variety of the types of participants, the average salary was utilized rather than attempting to estimate salaries for groups of audiences. With a maximum annual respondent burden of 54,000 hours, the overall annual cost of respondents' time for the proposed collection is estimated to be a maximum \$976,860 (54,000 hrs x \$18.09). There will be no direct costs to the respondents other than their time to participate in each data collection.

Estimated Annualized Burden Cost Total Respondent Hours	Hourly pay rate	Total Respondent Burden
54,000	\$18.09	\$976,860

### 14. Annualized Cost to the Government

There are no equipment or overhead costs. The only cost to the federal government would be the salary of CDC staff supporting the data collection activities and associated tasks. GenICs will be prepared by contractors or CDC staff (FTE). An FTE manager will review all data collections. Usability teams will vary across CDC teams but typically an FTE and contractor will work together on data collection preparations, conducting the data collections, and analyzing data. Additionally, a senior level FTE will typically review and approve the activities. The amount of time staff and contractors spend on data collections will vary depending on the number of participants for each data collection, the number of questions. A maximum number of 40 data collections a year was assumed for estimation purposes (35 web-based and 5 in-person). These are higher end estimates due to revision of respondent universe, the number of requests and cleared GenIC's through our mechanism, as well as the number of inquiries that are received. It is assumed that the



cost of in-person data collections will be 3 times higher than web-based. The estimated cost to the federal government is \$80,892. Table A-14 describes how this cost estimate was calculated.

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

<b>Staff or Contractor</b>	<b>Average Hours per data collection</b>	<b>Average Hourly Rate</b>	<b>Average Cost</b>
FTE coordinator (GS-14)	3 per data collection	\$45.48	\$136.44/ data collection
FTE instrument preparation, data collection, data analysis (GS-13)	20 per data collection	\$38.57	\$771.40/ data collection
Contractor instrument preparation, data collection, data analysis (GS-12 to GS-13 equivalent)	20 per data collection	\$35.50	\$710/ data collection
Average cost per information collection (web based)			\$1,617.84
Average cost per information collection (in person)			\$4,853.52
<b>Estimated Total Average Annual Cost of 35 web-based and 5 in-person Information Collections</b>			\$80,892

CDC has assigned a Health Scientist to manage the Generic ICR. The position is housed in the Office of Office for State, Tribal, Local and Territorial Support (OSTLTS). Processes and Procedures have been developed for distribution to CDC programs explaining benefits associated with the renewed Generic ICR. The data collection requests are managed by OSTLTS, the CDC Information Collection Review Office, the numerous and diverse CDC Program Officials, Project Officers, and Principal Investigators.

Each request will be closely reviewed by OSTLTS based on a predefined set of criteria to include but may not be limited to: 1) Scope of Request, 2) Burden/Impact at State/Local/Tribal level, 3) Relevance to CDC Priorities, 4) Applicability of questions associated with State, Local, and/or Tribal government staff or delegate roles and functions.

The information collection request process will include but may not be limited to: 1) Description of a sample (e.g., all 50 states or some sample); 2) Description of Need and Purpose Proposed Work (or SOW); 3) Sampling methods and the target respondent (e.g., food safety officer), 4) Data collection instrument, 5) Estimate of response burden, and 6) supporting documents.

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

This is a revision. Specifically, to include delegates acting on behalf of a STLT agency involved in the provision of essential public health services in the United States. It is important to mention that a change request was granted in October 2011 to correct errors in burden for this clearance. However, corrections were not made in ICRAS. Therefore, the burden estimates in the system are not accurate, which makes the burden requests for this clearance somewhat

artificial. The average burden per respondent has changed from 2 hours to 1 hour for all information collections, the number of estimated information collections per year has changed to 40, and the number of respondents has increased slightly due to the inclusion of delegates in the respondent universe.

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

Data collection will be ongoing.

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

CDC does not request exemption from display of the OMB expiration date.

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

There are no exceptions to the certification.

**LIST OF ATTACHMENTS**

ATTACHMENT A: Public Health Service Act (42 USC Sec. 301 [241]).

ATTACHMENT B: Generic ICR Revision – published 60 Day FRN on Federal Register