Public Health Performance Improvement Professional Association Feasibility Assessment

OSTLTS Generic Information Collection Request
OMB No. 0920-0879

Supporting Statement – Section A

Submitted: 8/15/14

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Section A – Justification

1. Circumstances Making the Collection of Information Necessary

Background

This data collection is being conducted using the Generic Information Collection mechanism of the OSTLTS OMB Clearance Center (O2C2) – OMB No. 0920-0879. Data will be collected from staff within state, local, tribal, and territorial health departments that are acting in their official capacities working on performance improvement within their organization. Common titles of respondents include, but are not limited to: program manager, accreditation coordinator, performance improvement manager, Mobilizing for Action through Planning and Partnerships (MAPP) coordinator, director, administrator, QI coordinator.

This respondent universe depends on the work functions rather than specific job title to broadly encompass all personnel in health departments engaged in performance improvement efforts. The functions include:

- Coordinating efforts to prepare and apply for national voluntary accreditation
- Leading state or community health assessment and improvement planning processes
- Developing an agency strategic plan
- Implementing agency-wide performance management systems
- Engaging in quality improvement (QI) to gain process efficiencies or improve health outcomes
- Selecting and implementing evidence-based public health strategies to address health priorities outlined in a state or community health improvement plan

This data collection is authorized by Section 301 of the Public Health Service Act (42 U.S.C. 241). This data collection falls under the essential public health service of assuring a competent public health and personal health care workforce.[1]

For the past three years (2010-2012), the Center for Disease Control and Prevention's National Public Health Improvement Initiative (NPHII) (see **Attachment A: NNPHI Fact Sheet**) has supported health departments across the country to engage in efforts to accelerate public health accreditation readiness activities; implement performance and improvement management practices and systems; and implement and share practice-based evidence. Seventy-three state, territorial, local, and tribal health departments are funded under the initiative. Each of the 73 funded organizations was required to assign a staff person or hire a new staff person to serve as the Performance Improvement Manager (PIM) for the agency. The CDC Office of State, Territorial, Local, and Tribal Support (OSTLTS) has facilitated a community of practice, the Performance Improvement Managers (PIM) Network.

PIM Network (see **Attachment B: PIM Network Fact Sheet**) activities support ongoing communication and network building, facilitate training and professional development, and build the evidence base for performance management and quality improvement efforts. These activities include

- Hosting monthly educational webinars that often highlight the performance management and quality improvement efforts of the PIM Network members
- Promoting active discussion and peer support via a private listserv and an online community of practice
- Providing training and education opportunities at the annual NPHII Awardee Meeting
- Identifying opportunities for participation in developing, informing, and updating performance management (PM)/QI policies and practices

The network of PIMs has also been connected to a broader Public Health Improvement Workforce that have been supported through other CDC initiatives as well as the Robert Wood Johnson Foundation (RWJF)-funded initiatives, such as the Multi-State Learning Collaborative (MLC) and the Community of Practice for Public Health Improvement (COPPHI) – both of which were managed by the National Network of Public Health Institutes (NNPHI).

The Multi-State Learning Collaborative (MLC) (see **Attachment C: Multi-State Learning Collaborative**) was a six year project managed by NNPHI and supported by the Robert Wood Johnson Foundation that ended in April 2011.The MLC brought together various stakeholders, including state and local health departments, public health institutes, health care providers, and universities, in sixteen states to prepare for public health accreditation and apply quality improvement practices to achieve measurable goals.

The Community of Practice for Public Health Improvement (COPPHI) facilitates the exchange of best practices and builds capacity among the nation's health departments to become accredited and conduct quality improvement through the provision of grants, technical assistance, and shared learning opportunities. COPPHI reaches a broad range of local, state, and tribal health department representatives; researchers; public health institutes; universities; national public health organizations; funders; policymakers; and government agencies through the Open Forum for Quality Improvement in Public Health, the Kaizen Event Program, the Quality Improvement Award Program, the Gaining Ground Program, and the Public Health Quality Improvement Exchange.

The creation and support of these networks has been integral to the forward movement of accreditation. However, as mentioned above, the MLC concluded in 2011 and NPHII funding will end this year. Therefore, in order to explore a model for promoting longevity and sustainability of these efforts in the field, the National Network of Public Health Institutes (NNPHI) will lead an effort to determine the desirability and feasibility for establishing a **professional association** for the state, tribal, local and territorial public health performance improvement workforce. The public health performance improvement workforce includes staff within health departments who hold responsibility for engaging in efforts that advance performance and quality in public health agencies and systems.

To this end, the purpose of this data collection tool is to capture the public health improvement workforce's perspectives on the creation of public health improvement professional association (PHPIPA). This data will assist CDC in determining whether the creation of a professional association serving the public health improvement workforce is feasible as a mechanism to support the sustainability of the networks that have been created.

Privacy Impact Assessment

Overview of the Data Collection System –

The data collection system consists of a web-based questionnaire (see **Attachment C: PHPIPA Assessment Word Version** and **Attachment D: PHPIPA Assessment Web Version**) designed to assess the desirability and feasibility of a professional association for public health practitioners engaged in public health improvement efforts. To complete the assessment, NNPHI has contracted with their member institute Illinois Public Health Institute to co-design and conduct the assessment, and provide results to the CDC. The data collection instrument was programmed using Survey Monkey and pilot tested by five public health professionals. Feedback from this group was used to refine questions as needed, ensure accurate programming and skip patterns and establish the estimated time required to complete the data collection instrument.

Items of Information to be Collected –

The data collection tool consists of 23 questions of various types including dichotomous, multiple response, filter and open-ended questions. The data collection tool is organized into three sections.

a. *Experience* – respondents are asked about their organization type, the number of years they have worked in public health and in performance improvement, and the type of performance improvement activities in which they currently engage.
b. *Public Health Performance Improvement (PHPI) Services and Supports* – respondents are asked to assess the level of importance of specific services and supports, and which organizations currently provide those services and supports.
c. *Professional Association for Public Health Performance Improvement (PHPI)* – respondents are asked to assess whether there is a need for a professional association for public health performance improvement, whether they would be interested in joining, which structure might be preferable an association, challenges for establishing an association, and whether they or their employer would be willing/able to pay to be a member of an association.

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

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

2. Purpose and Use of the Information Collection

The overall purpose of the data collection is to help CDC understand the desirability of a professional association serving the public health performance improvement workforce and ideas from the workforce about what needs an association might be able to meet. The purpose of the Feasibility Assessment is to hear from STLT employees who work on performance improvement activities about the existing services and supports, needs that an association might fulfill, suggestions about how an association might be structured, and desirability of a professional association to serve the public health performance improvement workforce.

The findings will be used for the following purposes:

- *Understanding the experience of the public health improvement workforce* - The findings will describe organizations where respondents work, the number of years they have worked in public health and in performance improvement, and the type of performance improvement activities in which they currently engage.
- *Importance of Public Health Performance Improvement (PHPI) Services and Supports*- Respondent feedback will inform CDC about which types of activities and services are perceived as important for supporting the public health performance improvement field.
- *Existing Public Health Performance Improvement (PHPI) Services and Supports* - The findings will describe which organizations currently provide public health performance improvement services and support to respondents.
- *Desirability of a Professional Association for Public Health Performance Improvement* - The findings will describe whether respondents identify a need for a professional association, whether they would join, and input about how such an association might be structured to be most effective and take advantage of existing assets/resources/expertise.

The information collected will assist CDC to determine whether the creation of a professional association serving the public health performance improvement workforce is feasible as a mechanism to support the sustainability of the networks that have been created. The STLT public health performance improvement workforce will be the target audience for an association; therefore understanding their desirability for such as association, as well as their perceptions on feasibility, are critical.

Privacy Impact Assessment

Data collection and use of findings pose minimal risk to the participating STLT employees. Respondents are participating in their official capacity as employees of state, tribal, local and territorial departments of health that engage in performance improvement activities.

3. Use of Improved Information Technology and Burden Reduction

Data will be collected via a Survey Monkey web-based questionnaire allowing respondents to complete and submit their responses electronically. This online method was chosen to reduce the overall burden on respondents. The data collection instrument was designed to collect the minimum information necessary for the purposes of this project (i.e., limited to 23 questions).

4. Efforts to Identify Duplication and Use of Similar Information

This data collection tool is intended to assess the desirability and feasibility for establishing a professional association for the public health improvement workforce. The public health improvement workforce includes staff within state, tribal, local, and territorial health departments who hold responsibility for engaging in efforts that advance performance and quality in public health agencies and systems. This is exploratory work and no similar data collection tools have been employed in the past to investigate the feasibility of a professional association for this segment of the public health workforce.

5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this data collection.

6. Consequences of Collecting the Information Less Frequently

This request is for a one-time data collection. There are no legal obstacles to reduce the burden. The consequences to the program of not collecting this information under this mechanism and within these timeframes are as follows:

- Inability to assess the feasibility and desirability of a professional association for the public health improvement workforce momentum
- Inability to engage Performance Improvement Managers while they are still funded under the National Public Health Improvement Initiative
- Inability to sustain the gains made in peer learning and shared experiences of the Performance Improvement Managers' Network

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

There are no special circumstances with this information collection package. This request fully complies with the regulation 5 CFR 1320.5 and will be voluntary.

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

This data collection is being conducted using the Generic Information Collection mechanism of the OSTLTS Survey Center (OSC) – OMB No. 0920-0879. A 60-day Federal Register Notice was published in the Federal Register on October 31, 2013, Vol. 78, No. 211; pp. 653 25-26. No comments were received.

CDC partners with professional STLT organizations, such as the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the National Association of Local Boards of Health (NALBOH) along with the National Center for Health Statistics (NCHS) to ensure that the collection requests under individual ICs are not in conflict with collections they have or will have in the field within the same timeframe.

9. Explanation of Any Payment or Gift to Respondents

CDC will not provide payments or gifts to respondents.

10. Assurance of Confidentiality Provided to Respondents

The Privacy Act does not apply to this data collection. Employees of state and local public health agencies will be speaking from their official roles and will not be asked, nor will they provide individually identifiable information. This data collection is not research involving human subjects.

11. Justification for Sensitive Questions

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

12. Estimates of Annualized Burden Hours and Costs

The estimate for burden hours is based on a pilot test of the data collection instrument by five public health professionals. In the pilot test, the average time to complete the data collection instrument including time for reviewing instructions, gathering needed information and completing the data collection instrument, was approximately 15 number minutes. Based on these results, the estimated time range for actual respondents to complete the data collection instrument is between 7-17 minutes. For the purposes of estimating burden hours, the average time for completion (i.e., 15 minutes) is used.

Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) National Compensation Survey estimate for management occupations – medical and health services managers in state government (http://www.bls.gov/ncs/ocs/sp/nctb1349.pdf). Based on DOL data, an average hourly wage of $47.77 is estimated for all x number respondents. Table A-12 shows estimated burden and cost information.

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

Data Collection Instrument: Form Name	Type of Respondent	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
PHPIPA	State, local, tribal, territorial health department performance improvement staff	1744	1	15/60	436	$47.77	$20827.72
	TOTALS						$20827.72

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

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

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.
The estimated cost to the federal government is $1692.41. Table A-14.1 describes how this cost estimate was calculated.

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

Staff (FTE)	Average Hours per Collection	Average Hourly Rate	Average Cost
Lead Public Health Advisor (GS-14) Consultation with staff on OMB package preparation, instrument development, pilot testing, data collection, report preparation	12	$48.90	$586.80
Public Health Advisor (GS-13) Consultation with staff on OMB package preparation, instrument development, pilot testing, data collection, report preparation	12	$41.38	$496.56
Public Health Advisor (GS-9) Pilot testing, OMB package preparation	5	$23.99	$119.95
Health Scientist (GS-14) Assisting with instrument development, consultation on data analysis and report preparation	10	$48.90	$489.00
Estimated Total Cost of Information Collection			**$1692.31**

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

Both quantitative and qualitative analyses will be performed. Quantitative analyses will involve using descriptive statistics to determine frequency distributions for responses to each survey question. Qualitative thematic analyses will be conducted on open-ended questions.

Results of this data collection will contribute to the report and presentation for the broader PHPIPA Assessment that will be used within CDC and NNPHI and also shared with relevant stakeholders. The report will relay the major findings and recommendations, informed by the Needs/Desirability Assessment and other data that will assist with decision-making around the potential creation of a professional association.

Project Time Schedule

PHPIPA Feasibility Assessment (02/01/2014 – 10/31/2014)

Design survey tool……..COMPLETE
Develop protocol, instructions, and analysis plan……..COMPLETE
Pilot test survey questionnaire……..COMPLETE
Prepare OMB package……..COMPLETE
Submit OMB package……..COMPLETE
OMB approval……..Tentative
Conduct data collection …….. Tentative (2 weeks) August 2014
Collect, code, enter, quality control, and analyze data..... Tentative (4 weeks) September 2014
Prepare report…….. Tentative (6 weeks) Oct-Nov 2014
Disseminate results/reports…….. Tentative (2 weeks) Nov 2014

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

We are requesting no exemption.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification. These activities comply with the requirements in 5 CFR 1320.9.

LIST OF ATTACHMENTS – Section A

Note: Attachments are included as separate files as instructed.

A. NNPHI Fact Sheet
B. PIM Network Fact Sheet
C. Multi-State Learning Collaborative
D. PHPIPA Assessment Word Version
E. PHPIPA Assessment Web Version

REFERENCE LIST

1. Centers for Disease Control and Prevention (CDC). "National Public Health Performance Standards Program (NPHPSP): 10 Essential Public Health Services." Available at http://www.cdc.gov/nphpsp/essentialservices.html. Accessed on 8/14/14.