

State and Local Public Health Emergency Preparedness Capabilities: Practice-Driven Research Needs

OSTLTS Generic Information Collection Request
OMB No. 0920-0879

Supporting Statement – Section A

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Program Official/Project Officer

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Section A – Justification

1. Circumstances Making the Collection of Information Necessary

Background

This data collection is being conducted using the Generic Information Collection mechanism of the OSTLTS OMB Clearance Center (O2C2) – OMB No. 0920-0879. The respondent universe for this data collection aligns with that of the O2C2. Data will be collected from the state and local public health preparedness directors or designee, acting in their official capacities, at state, local, and territorial health departments.

This data collection is authorized by Section 301 of the Public Health Service Act (42 U.S.C. 241). This information collection falls under the essential public health services of 1) development of policies and plans that support individual and community health efforts, and 2) assuring a competent public health and personal health care workforce.¹

Public health preparedness and response (PHPR) is a key public health activity supported by the federal government, especially the Office of Public Health Preparedness and Response (OPHPR) within the Centers for Disease Control and Prevention (CDC). It is also supported by other entities, including schools of public health, the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and others. Further, the role of public health in planning and responding to emergencies is set forth in the Ten Essential Public Health Services (**see Attachment A—10 Essential PH Services**), and was recently articulated in the Public Health Accreditation Board (PHAB) Standards and Measures for national accreditation of public health agencies (**see Attachment B—PHAB Standards and Measures**).

A defining characteristic of public health emergency preparedness is the capability of public health systems to prevent, protect against, and quickly respond to public health emergencies, and especially to unpredictable threats, in a coordinated and continuous manner. To lay the groundwork for a coordinated response to disasters, incidents, and other emergencies, the federal government articulates public health's role in Emergency Support Function (ESF) 8 – Public Health and Medical Services (**see Attachment C—ESF 8**). ESF 8 provides assistance to supplement the resources of state, local, and territorial governmental agencies to help them address core functional areas of public health and medical needs following a disaster. Some of these core functions include surveillance, patient evacuation, behavioral health care, and mass fatality management, among others.

CDC administers the primary tool for supporting public health's role in PHPR – the Public Health Emergency Preparedness (PHEP) cooperative agreement. PHEP provides funding to 62 awardees, including 50 states, 4 localities, and 8 insular areas. Since 2002, CDC has provided funding to support and advance the ability of state, local, and territorial health departments to respond to public health threats and emergencies and to build resilience

(see **Attachment D—2013 PHEP Funding**). CDC also provides supplemental funding through the cooperative agreement program in response to specific incidents. For example, CDC provided supplemental funding to improve response capacity for the H1N1 influenza pandemic in 2009. To help guide awardees' PHEP priorities, CDC developed a set of 15 capabilities that serve as preparedness planning standards for public health agencies. CDC developed the capabilities using evidence, literature, and subject matter expertise (see **Attachment E—CDC PHEP Capabilities**).

Throughout each CDC Center, Institute, and Office (CIO), science drives the interventions and practices instituted nationally and globally. OPHPR has made considerable investments to support and develop the science base in the relatively infant field of public health emergency preparedness. One critical component of focus has been establishing priorities and a planned approach to conducting fundamental research not only of scientific rigor, but directly correlated to public health emergency preparedness practice. This practice-driven approach identifies and prioritizes the areas of public health emergency preparedness where research outcomes are most needed and would have the greatest impact in real-world public health settings. The development of a practice-driven research base is progressing. In 2008, the Institute of Medicine (IOM) conducted a fast-track study to identify research priorities for schools of public health, which resulted in a letter report recommending four research priorities (see **Attachment F—Research Priorities Report**). This fast-track study was conducted in response to the Pandemic and All Hazards Preparedness Act (Public Law 109-417, 2006, § 101 et seq). The recommended research priorities included: 1) enhance the usefulness of training; 2) improve communications in preparedness and response; 3) create and maintain sustainable preparedness and response systems; and 4) generate criteria and metrics to measure effectiveness and efficiency. After the IOM set forth the letter report, CDC OPHPR awarded approximately \$10.9 million over five years to seven accredited schools of public health to establish Preparedness and Emergency Response Research Centers (PERRCs) to address the research priorities and to translate that research into practice (see **Attachment G—PERRC Fact Sheet**). CDC awarded another \$2.7 million over four years to two additional schools to establish PERRCs in 2009. PERRCs conduct research focused on “the most critical elements needed to enhance preparedness for all hazards and to close gaps in public health preparedness and response services.” PERRCs have conducted extensive research to advance the evidence base for public health emergency preparedness and response, with the goal of improving public health practice (see **Attachment I—CDC PERRC Updates**). CDC also provided five-year funding to 14 schools of public health for Preparedness and Response Learning Centers (PERLCs), which provide competency-based and specialized training in preparedness and response to public health agencies (see **Attachment H—PERLC Fact Sheet**). Until September 2012, CDC also funded Advanced Practice Centers (APCs) through NACCHO, which created a network of local health departments with the shared goal of developing resources and trainings that could be easily implemented by other local health departments. APCs provided public health emergency preparedness materials that map to

the 15 public health preparedness capabilities for grantee preparedness planning (**see Attachment J—APC Products**).

Outside of CDC-funded initiatives, RWJF currently funds practice-based research networks (PBRNs) in 26 states to conduct research to improve the performance and capacity of the public health system. In April 2013, more than 50 studies were completed or underway among PBRNs, with several research activities focused on public health preparedness that connect to the four priority areas laid out in the IOM 2008 letter report (**see Attachment K—RWJF PBRN Report**). Similarly, Evidence-Based Practice Centers (EPCs), which are funded by the Agency for Healthcare Research and Quality (AHRQ), produce evidence-based reports and assessments on health-related topics, including public health preparedness. For example, one recent report focuses on strategies for allocating resources during mass casualty events (**see Attachment L—Evidence Report: Mass Casualty Event**).

Continued practice-driven research for public health preparedness and response is important given the changing context within which the public health system operates, including the impacts of state and local budget cuts due to the recent economic recession and the changing roles and functions that may result from the implementation of the Patient Protection and Affordable Care Act. Because of these contextual factors, practice-driven research and focused efforts to build community resilience are critical for assuring the capacity of governmental public health agencies to respond to emergencies and high consequence events. Other critical components of public health preparedness and response include training and education for public health professionals, an understanding of emerging issues, and legal preparedness, including civil legal liability, local public health emergency legal preparedness and procedures, and inter-jurisdictional legal coordination, among other topics (**see Attachment M—PHEP Legal Checklist**).

So far, research priorities have been developed for the overall field of public health emergency preparedness without systematically identifying and understanding the practice-driven research needs of state, territorial, and local public health practitioners as it directly relates to CDC's 15 PHEP Capabilities. To that end, OPHPR seeks for the first time to systematically assess practice-driven research knowledge needs directly from Public Health Preparedness Directors, or the appropriate designee with direct knowledge of preparedness activities, at state, local, and territorial health departments. The data collection will allow CDC to identify the important topic areas within PHEP Capabilities, as reported by public health practitioners, in order to develop a prioritized agenda for future OPHPR research.

Privacy Impact Assessment

Overview of the Data Collection System – The data collection system consists of a web-based assessment instrument (**see Attachment N—PHEP Assessment Word Version and Attachment O—PHEP Assessment Web Version**) designed to assess public health practitioners' perceptions on the extent to which specific questions regarding public health emergency preparedness and response represent an area that needs additional research to

validate, improve, and better inform programmatic and policy decisions. The data collection instrument will be administered online. The web-based assessment will be distributed using Liberty, a proprietary web-based system from NORC at the University of Chicago. Liberty has advanced data security features and provides the functionality to build, deploy, and manage surveys. It also provides modules for e-mail prompting. NORC will e-mail respondents a link to the survey instrument via the Liberty system. The assessment instrument was pilot tested by five State Directors of Public Health Preparedness and four representatives from local public health agencies to assess the appropriateness of the survey for these two respondent groups. Feedback from these two groups was used to refine questions as needed, ensure accurate programming, and establish the estimated time required to respond to the questions in the survey instrument.

Items of Information to be Collected – The assessment instrument consists of 79 questions of various types, including open-ended, multiple choice response, and matrix of choices (Likert-scale response options). The survey is organized into two parts:

1. *Background Questions*

- a. Job title
- b. Staff involvement in preparedness research activities
- c. Collaboration on preparedness research activities
- d. Funding for preparedness research activities
- e. Familiarity with existing preparedness literature and research
- f. Additional information and/or training on literature and research

2. *Questions on Topics in Public Health Emergency Preparedness and Response*

- a. Part A: Biosurveillance – important areas and other questions or topics where additional knowledge is needed to advance PHEPR practice related to Capability 13: Public Health Surveillance and Epidemiological Investigation.
- b. Part B: Community Resilience – important areas and other questions or topics where additional knowledge is needed to advance PHEPR practice related to Capability 1: Community Preparedness.
- c. Part C: Countermeasures and Mitigation – important areas and other questions or topics where additional knowledge is needed to advance PHEPR practice related to Capability 8: Medical Countermeasures Dispensing, Capability 9: Medical Materiel Management and Distribution, and Capability 14: Responder Safety and Health.
- d. Part D: Incident Management – important areas and other questions or topics where additional knowledge is needed to advance PHEPR practice related to Capability 3: Emergency Operations Coordination.
- e. Part E: Information Management – important areas and other questions or topics where additional knowledge is needed to advance PHEPR practice related to Capability 4: Emergency Public Information and Warning and Capability 6: Information Sharing.

- f. Part F: Surge Management – important areas and other questions or topics where additional knowledge is needed to advance PHPR practice related to Capability 10: Surge Management and Capability 15: Volunteer Management.
- g. Part G: Cross-Cutting Preparedness Topics – important areas and other questions or topics where additional knowledge is needed to advance PHPR practice related to topics that cut across several CDC Preparedness Capabilities.
- h. Part H: Public Health Laboratory – important areas and other questions or topics where additional knowledge is needed to advance PHPR practice related to Capability 12: Public Health Laboratory Testing.

Identification of Website(s) and Website Content Directed at Children Under 13 Years of Age – The data collection system involves using a web-based assessment. Respondents 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

There are two purposes for the data collection. *Purpose 1: Identify the needs of state, territorial, and local public health departments related to public health emergency preparedness and response* – This data collection effort represents the first time that state, territorial, and local public health departments will be asked to systematically provide input on topics related to public health emergency preparedness and response that require a stronger evidence base to advance PHPR practice. Respondents will be asked to identify which PHPR questions address an area of public health and emergency response that needs additional research to validate, improve, and better inform programmatic and policy decisions. Respondents will be asked to rank the relative importance of each question, ranging from “not at all important” to “extremely important” in addressing an area of PHPR practice that is a problem and would deliver the best initial return on investment if research was conducted to build the evidence base around that issue. *Purpose 2: Identify and address priority research gaps for public health practice* – The assessment will provide the information necessary for CDC to identify the most important public health emergency preparedness and response topics that, according to practitioners, require additional research.

Ultimately, information collection results will be used to inform a final project report, which will be delivered to CDC by NORC. The report will be used internally by CDC leadership and staff and may be shared with a group of external experts in the field. The ultimate objective of the final report is to indicate which PHPR topics/research questions are most important to state, territorial, and local public health respondents. CDC will use this information to lay out a prioritized agenda for future PHPR research. The research agenda will, in the long-run, allow state, territorial, and local public health practitioners to identify and implement evidence-based strategies to ensure optimal response and recovery, which will help public health departments to meet their preparedness goals. CDC will also use this information to

provide input in other program areas related to the development of a research agenda for preparedness, response, and recovery practice.

Privacy Impact Assessment – No sensitive data are being collected. No individually identifiable information is being collected. The proposed data collection will have little or no impact on respondent privacy. Respondents are participating in their official capacity as directors of public health preparedness, or as a staff person with direct knowledge of emergency preparedness activities, within state, territorial, and local health departments.

3. Use of Improved Information Technology and Burden Reduction

Data will be collected via a web-based assessment allowing respondents to complete and submit their responses electronically. This method was chosen to reduce the overall burden on respondents. Web assessments reduce respondent burden by enabling easy access and completion at a convenient time and location. Liberty—the NORC web-based system that will be used to implement the assessment—has browser-independence, which ensures that respondents will be able to view the survey regardless of which Internet browser they are using. The assessment was designed to collect the minimum information necessary for the purposes of this project (i.e., limited to 79 questions). The majority of questions consist of easy-to-read text with Likert-type response options, which reduces overall burden on respondents. Further, the number of open-ended response option was minimized to reduced burden on respondents.

4. Efforts to Identify Duplication and Use of Similar Information

This assessment represents a new effort to identify important PPHR topics, as reported by public health practitioners. The effort will allow CDC to identify appropriate research questions related to these topics in order to develop a prioritized research agenda for future intra- and extra-mural CDC research. This assessment represents the first attempt to assess practitioners' knowledge needs related to public health emergency preparedness and response research areas. There is no information available that can substitute this data collection.

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 data collection is a direct response to CDC's need to conduct practice-based research and to identify and develop a prioritized agenda for future PPHR research. By seeking to understand the areas where additional knowledge is needed to advance public health preparedness, as reported by practitioners, the assessment is responsive to the changing context in which the public health system operates.

The consequences of not collecting this information would be:

- Failure to systematically identify and understand the practice-driven research needs of state, territorial, and local public health practitioners related to public health emergency preparedness and response.
- Failure to identify the most important public health emergency preparedness and response topics that, according to practitioners, require additional research.
- Failure to conduct practice-based research to validate, improve, and better inform programmatic and policy decisions.

This request is for a one time data collection. 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 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 OMB Clearance Center (O2C2) – 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, territorial, 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 is personal or of sensitive nature.

12. Estimates of Annualized Burden Hours and Costs

The estimate for burden hours is based on a pilot test of the survey instrument by 5 individuals serving in official capacity at state health departments and affiliated with national partner ASTHO, and a separate pilot test of the survey instrument by 4 individuals serving in official capacity at local health departments and affiliated with national partner NACCHO. In the pilot test, the average time to complete the survey, including time for reviewing instructions, by state health department respondents was 29 minutes. The average time to complete the survey by local health department respondents was 26 minutes. Based on these results, the estimate time range for actual respondents to complete the survey is 15-40 minutes. Reviewers who represent our target population responded that they felt it was likely that other preparedness coordinators at state, territorial, and local health departments would be willing to dedicate this amount of time to the completion of the survey. For the purposes of estimating burden hours, the average time for completion (i.e., 30 minutes) is used.

Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) National Compensation Survey estimate for management occupations – medical and health services managers in state government (<http://www.bls.gov/ncs/ocs/sp/nctb1349.pdf>). Based on DOL data, an average hourly wage of \$47.77 is estimated for all 262 respondents. Table A-12 shows estimated burden and cost information.

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

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
PHEP Assessment	State and Local Health Department Preparedness Director or designee (50 states, 8 territories, 4 cities, 200 localities)	262	1	30/60	131	47.77	6257.87
	TOTALS	262	1		131		6257.87

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 the survey.

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 the CDC staff during data collection and analysis activities. The estimated cost to the federal government is \$14,622.78. Table A-14 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
Program Director/Deputy III: Oversight for data collection.	16	343.68	5498.88
Research Assistant III: Data collection, data coding and entry, quality control.	50	100.26	5013.00
Research Assistant II: Survey programming and data collection.	30	69.30	2079.00
Computer Programmer II: Survey programming support.	15	135.46	2031.90
Estimated Total Cost of Information Collection			14622.78

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

NORC will conduct preliminary analyses with the data. Both quantitative and qualitative analyses will be performed. Quantitative analyses may include descriptive statistics as well as a comparison between responses of state and local health department respondents; a comparison of local health department responses based on health department characteristics (e.g., geography, population served, and governance structure); and a comparison among state health department responses based on health department characteristics (e.g., population, governance structure, and scope of services). Qualitative analyses will be performed on open-ended questions to compile additional recommendations for important PHR topics and research questions that were not included in the assessment.

The analyses will be used to inform a final project report, which will be delivered to CDC. The ultimate objective of the final report is to indicate which PHR questions are most important to state, territorial, and local public health respondents. CDC will use this information to lay out a prioritized agenda for future PHR research. CDC will also use this information to provide input in other program areas related to the development of a

research agenda for preparedness, response, and recovery practice. The report will be used internally by CDC leadership and staff and may be shared with a group of external experts in the field. NORC will provide CDC with the raw assessment data. CDC will use these data to conduct additional analyses related to the project goals.

Project Time Schedule

Design instrument.....	Complete
Pre-test instrument.....	Complete
Prepare OMB package.....	Complete
Submit OMB package.....	Complete
OMB approval.....	TBD
Launch assessment.....	Open 3 weeks
Reminder partial- and non-responders.....	Week 1 and 2 of assessment open
Collect and quality control data.....	3 weeks after assessment close
Code, enter, and analyze data.....	5 weeks after assessment close
Prepare final data set, codebooks, and data dictionaries.....	7 weeks after assessment close
Prepare final report.....	9 weeks after assessment close
Deliver final data set, codebooks, and data dictionaries.....	10 weeks after assessment close
Delivery final report.....	10 weeks after assessment close

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. Ten Essential Public Health Services**
- B. PHAB Standards and Measures**
- C. ESF 08**
- D. 2013 PHEP Funding**
- E. CDC PHPR Capabilities**
- F. Research Priorities Report**
- G. PERRC Fact Sheet**
- H. PERLC Fact Sheet**
- I. PERRC Updates**
- J. APC Products**
- K. RWJF PBRN Report**
- L. Evidence Report Mass Casualty Event**
- M. PHAP Legal Checklist**
- N. PHEP Assessment – Word Version**
- O. PHEP 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.