Healthy Community Design: Assessment of Local Health and Planning Departments

OSTLTS Generic Information Collection Request

OMB No. 0920-0879

SUPPORTING STATEMENT – Section A

Submitted: 3/3/2015

Program Official/Project Officer

Name: Dee Merriam, FASLA
Title: Community Planner
CIO: Office of Non-communicable Diseases, Injury, and Environmental Health, National Center for Environmental Health/ Agency for Toxic Substances and Disease Registry
Division: Division of Emergency and Environmental Health Services
Branch: Built Environment and Health Initiative
Address: 4770 Buford Highway, NE, MS E-70, Atlanta, GA 30341
Phone: 770-488-3981
Email: dmerriam@cdc.gov

Section A. JUSTIFICATION

- **Goal of the study:** Determine what progress has been made in the last ten years in planning and public health collaboration to create healthy, sustainable communities and identify gaps in training and resources needed to move inter-sectorial work.
- **Intended use of the resulting data:** CDC will also use this information to inform future activities to support the healthy community design field.
- **Methods to be used to collect:** Web-based assessment; convenience sampling
- **The subpopulation to be studied:** 500 local health department officials and 630 local government planning directors, acting in their official capacities at governmental local health departments and planning departments or agencies
- **How data will be analyzed:** Descriptive statistics

1. Circumstances Making the Collection of Information Necessary

Background

This information 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 information collection aligns with that of the O2C2. Data will be collected from 500 local health department officials and 630 local government planning directors, acting in their official capacities at governmental local health departments and planning departments or agencies. Local health departments (LHDs) cannot address all issues impacting public health alone, especially those that stem from land use and planning decisions. According to the County Health Rankings and Roadmaps, environmental conditions determine up to 25% of a population's health status. Decisions made by local planners contribute to residents' health either positively or negatively. Collaboration with local planners increases the institutional capacity of local health departments to engage in decisions related to healthy community design. In order to gauge the extent to which LHDs are currently working with their planners to bring health concerns to the table and the extent to which planners are reaching out to LHDs for their input, this project will collect information from both sets of professionals.

This information 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 service of 1) mobilizing community partnerships to identify and solve health problems, 2) development of policies and plans that support individual and community health efforts, and 3) assuring a competent public health and personal health care workforce.[1]

With a growing understanding of the need to address the root causes of health impacts, public health has increasingly been investing in efforts to intervene in social and environmental determinants of health and wellbeing. The need to infuse health considerations into how planning decisions are made are paramount.[2,3] Improving the built environment may be an essential component of a comprehensive public health strategy to address the epidemic of chronic diseases, such as obesity and cardiovascular disease, through the creation of environments that support safer and easier healthy choices.[4,5,6,7]

The Built Environment and Health Initiative, also known as the Healthy Community Design Initiative, is housed with CDC's Division of Emergency and Environmental Health Services.[8] CDC's Healthy Community Design Initiative provides funding and support to advance the ability of health departments and other stakeholders and partners to increase the consideration of health in land use, built environment, transportation, and planning decisions. The Initiative works to improve public health by linking public health surveillance with community design decisions, improving community design decisions through tools such as health impact assessment (HIA), educating decision makers about the health impacts of community design, building partnerships with community design decision makers and their influencers, and translating research into best practices.[9] CDC has been committed to forming new partnerships and seeking solutions to community-wide public health problems through fostering and promoting thoughtful, accessible, safe, and well-designed structures and landscapes.

The National Prevention Strategy and the Institute of Medicine also agree that community design efforts are important strategies to support and encourage healthier behaviors and improved health outcomes. [10,11] HCD is also supported by other national partners, including the American Public Health Association (APHA), the Association of State and Territorial Health Officials (ASTHO), and the American Planning Association (APA). Further, the role of public health in policy development that support individual community health efforts is set forth in the Ten Essential Public Health Services, and was recently articulated in the Public Health Accreditation Board (PHAB) Standards and Measures for national accreditation of public health agencies.[12, 13]

Additionally, the Healthy Community Design Initiative has been advancing the use of health impact assessment (HIA) to support HCD efforts by funding and providing technical assistance to state and local health departments to complete HIA projects of built environment, community design, land use, and transportation-related topics. CDC also provides supplemental funding to the National Association of County and City Health Officials (NACCHO) through cooperative agreement to further to support and fund additional local HIA projects. The Healthy Community Initiative has also funded an online course, developed by NACCHO and APA, which explains the value of conducting HIA and the steps involved.[14]

Furthermore, the Healthy Community Design Initiative supports the field by providing an online repository of resources and sponsoring meetings related to this topic. They have also helped to create a number of health planning tools such as the Healthy Community Design Checklist Toolkit and the Transportation Health Impact Assessment Toolkit.[15,16] CDC's Office of the National Prevention Strategic and the Healthy Community Design Initiative supported the creation of

Georgia Tech's Built Environment and Public Health Clearinghouse, which is an online resource for trainings and resources at the intersection of community design and health.[17]

Local health departments (LHDs) play a key role in developing built environment policies and programs that encourage healthier communities at the local and regional levels. [18] LHDs are working strategically across sectors in partnerships with local planning agencies and departments to build healthier communities. Numerous LHDs are already involved in efforts to develop system and environmental changes to support improved health outcomes, and many are working with their local planning agencies or departments to increase the consideration of health in planning and built environment decisions.[19,20] As a new and burgeoning field, building the capacity of public health and planning professional groups to work together to integrate built environment and public health will require new and expanded access to information, resources, trainings, and collaborative models as each organization has its own mission, objectives, and unique jurisdictional challenges.[21]

In 2004, NACCHO and APA conducted an online assessment of planners and local health departments with a total of 723 responses from governmental jurisdiction employees. The objectives of the assessment were to discern the state of the practice in planning and public health collaboration and to study and disseminate ideas and examples of how planners and public health advocates and professionals can collaborate on shared goals of creating healthy, sustainable communities and enhancing quality of life. The assessment consisted of question categories related to thoughts about planning and public health integration, collaboration, plans, data, and public health and planning involvement in activities. This assessment was the first such assessment of planning and local health department staff at the local jurisdictional level. The results of the 2004 assessment were used to create strategies, informational and training materials to facilitate the connections between the two professions to promote collaboration which would lead to positive health outcomes (see **Attachment A—2004 Assessment Report**).

For this information collection request, CDC intends to follow up on the 2004 assessment, for the purposes of 1) determining what progress has been made in the last ten years in collaborations and 2) identifying gaps in training and resources that are needed to move inter-sectorial work forward to improve health outcomes. It will be conducted by NACCHO in conjunction with APA and the CDC. While the questions on the two assessments are similar, new ways of measuring the impacts of planning decisions on public health outcomes have become more prevalent in recent years, such as health impact assessment and Health in All Policies that were not taken into account in the 2004 study. It will again be a data collection from LHDs and planning departments regarding efforts to integrate health and planning activities and work across sectors to improve health outcomes. The goals are to discern trends in practice and needed resources to address gaps in bridging the two fields.

Overview of the Data Collection System

The information collection system consists of a web-based questionnaire (**Attachment B – LHD Instrument: Word version, Attachment C – LHD Instrument: Web version, Attachment D – Planner Instrument: Word version,** and **Attachment E – Planner Instrument: Web version**) designed to assess local health department and planning department staff collaboration and

capacity building needs around collaborating to address health. The information collection instrument will be administered as a web-based instrument through Qualtrics software. Qualtrics software enables users to collect and analyze data from a large number of respondents. Qualtrics has been used extensively by NACCHO during recent years. The information collection instrument was pilot tested by nine public health and planning practitioners. 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 information collection instrument.

Items of Information to be Collected

The data collection instrument consists of 19 questions in the LHD instrument and 24 questions in the Planner instrument. The questions are of various types, including multiple choice responses, and matrix of choices (Likert-scale response options). The online instrument also employs skip-logic and display-logic programming that will lead respondents through the instrument depending on how they respond to particular questions and whether the respondents are planners or LHD staff. The content and purpose of each question are the same, however in some cases, question prompts and responses are slightly different based on the respondent affiliation to either an LHD or planning department. Each instrument is organized into two parts:

Demographic questions

a. Zip code
b. Description of jurisdiction
c. Primary jurisdiction
d. Size of population served
e. Number of FTEs employed
f. Working on HCD issues
g. Extent of partnership with LHD or planning department
h. Other governmental agencies or departments engaged in HCD

2. Questions on topics regarding integration of health in planning activities and collaboration between LHDs and planning departments, falling under the following parts:
    a. Activities involving planners and LHDs – questions regarding list of processes and activities engaged collaboratively and the extent of involvement.
    b. Resources for collaboration – questions on whether and how much they have dedicated budgets and the allocation of staff time and resources towards HCD-related activities.
    c. Facilitators and barriers – questions regarding and relative importance of barriers and facilitators of collaboration.
    d. Training and technical assistance resources – questions regarding the types of training, technical assistance opportunities, and tools and resources that would be of most value.

2. Purpose and Use of the Information Collection

There are four purposes for the data collection. *Purpose 1: Identify the extent to which LHDs are infusing planning into their processes. Purpose 2: Identify the extent to which planning departments are infusing health into their processes.* This data collection effort is a 10 year follow up to a similar data collection opportunity that was conducted in 2004 of planners and LHDs, and sponsored by CDC. Respondents will be asked whether, and to what extent, they are working on HCD topics to integrate health and planning activities and decisions. *Purpose 3: Understand how LHDs and*

planning departments are engaging in HCD efforts. Respondents will be asked whether, and to what extent, they are collaborating with their respective LHD and planning departments on HCD-related activities. Questions will also ask what resources and budgets are being allocated to this work, and barriers and facilitators to collaboration. *Purpose 4: Understand the training and technical assistance needs of LHDs and planning departments.* Respondents will be asked to identify the training and technical assistance needs to further foster the HCD activities and collaboration between planning and public health professionals.

Ultimately, results will be shared in a final report, which will be delivered to CDC by NACCHO, including APA input. The primary outcomes are to inform CDC, NACCHO, and APA and external stakeholders about the current state of practice among planning departments and LHDs, trends and issues, the needs for capacity building assistance for practitioners to build or sustain partnerships. NACCHO and CDC will also use this information to inform future activities to support the HCD field.

3. Use of Improved Information Technology and Burden Reduction

Data will be collected via a web-based data collection instrument called Qualtrics that allows respondents to complete and submit their responses electronically. This method was chosen to reduce the overall burden on respondents. The information collection instrument was designed to collect the minimum information necessary for the purposes of this project (i.e., limited to 22 questions). Respondents will not be asked to provide their agency name. Data will be kept secure and shared only with NACCHO and APA staff, for analysis.

4. Efforts to Identify Duplication and Use of Similar Information

This assessment represents a 10 year follow-up effort to a similar effort conducted by NACCHO and APA in 2004 of collaboration between local planning and health department and HCD-related activities. The results of the 2004 assessment were used to create strategies, informational and training materials to facilitate the connections between the two professions to promote collaboration which would lead to positive health outcomes.

This assessment will be a ten year follow-up to the 2004 effort which includes questions about new methods and processes. While the questions on the two assessments are similar, new ways of measuring the impacts of planning decisions on public health outcomes have become more prevalent in recent years, such as health impact assessment and Health in All Policies that were not taken into account in the 2004 study. It will further allow the CDC, NACCHO, and APA to understand and identify resources and tools needed to further support HCD efforts at the local level highlight trends and differences between the state of the field in 2004 and today. NACCHO will use this information to inform future activities, programs and training provided to LHDs and APA will use it for the same purposes for local planners. No information is currently available to provide this perspective, and NACCHO and APA are unaware of any plans to collect similar information by other agencies.

5. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this information collection.

6. Consequences of Collecting the Information Less Frequently

The data collection is a response to the need to understand the current trends in collaborative efforts between LHDs and planning departments and the integration of health and planning activities and decisions at the local level. The data collection instrument will also highlight needed resources and tools to further support the field. By seeking to understand the areas where additional knowledge and resources can advance the HCD field, as reported by practitioners, we will gain an understanding of the changing context in which the planning and public health systems operate.

The consequence of not collecting this information would be:

- Failure to systematically identify and understand the extent to which LHDs and planning departments are working together to connect health and planning activities
- Failure to understand how LHDs and planning departments are engaging in HCD efforts
- Failure to identify and understand the training and technical assistance needs of LHDs and planning departments.

This request is for a one time information 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 information 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 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 information collection instrument by nine public health and planning professionals. In the pilot test, the average time to complete the instrument including time for reviewing instructions, gathering needed information and completing the instrument, was approximately 15 minutes. Based on these results, the estimated time range for actual respondents to complete the instrument is 10-30 minutes. For the purposes of estimating burden hours, the average time (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 $57.11 is estimated for all 9 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
LHD Instrument	Local Planning Directors	630	1	15/60	158	$57.11	$9,023
Planner Instrument	Local Health Directors	500	1	15/60	125	$57.11	$7,139
	TOTALS	1130	1		283		$16,162

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 information 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 the CDC staff during the preparation of the assessment, data collection and analysis activities. The cost to the federal government is estimated to be $103,500. 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
Project Officer (GS-13): Support the development of instrument, pilot testing, review and oversee OMB package preparation, data analysis, and report preparation	70	$50	$3,500
NACCHO Contract	0	0	$100,000
Estimated Total Cost of Information Collection			$103,500

15. Explanation for Program Changes or Adjustments

This is a new information collection.

16. Plans for Tabulation and Publication and Project Time Schedule

The data collection instrument will be fielded to planners in early winter 2015 and to LHDs in spring 2015. This timeline aligns with organizational priorities of APA and NACCHO, respectively, and was intentionally designed to minimize assessment fatigue. After a suitable response rate has been reached, data collection will ensue and take approximately 3-4 weeks. Data cleaning will take 2-3 weeks. Once data are cleaned, analysis will begin and will be led by a Lead Research Scientist on NACCHO staff. The data will be analyzed using Stata. Program staff will provide subject matter expertise throughout the analysis, which will take 5-8 weeks after which time a draft report will be developed.

Project Time Schedule

- ✓ Design questionnaire..... (COMPLETE)
- ✓ Develop protocol, instructions, and analysis plan..... (COMPLETE)
- ✓ Pilot test questionnaire..... (COMPLETE)
- ✓ Prepare OMB package..... (COMPLETE)
- ✓ Submit OMB package..... (COMPLETE)
- ❑ OMB approval..... (TBD)
- ❑ Gather responses..... (questionnaire available online for 4 weeks)
    - Reminder email at 10 and 15 days for non-response and partial response at 15 days

- ❑ Collect, code, quality control, and analyze data.....(3 weeks)
- ❑ Prepare report.....(3 weeks)
- ❑ Disseminate results/publication of findings.....(4 weeks)

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. **2004 Assessment Report**
B. **LHD Instrument: Word version**
C. **LHD Instrument: Web version**
D. **Planner Instrument: Word version**
E. **Planner Instrument: 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.
[2] Friedan TR. A Framework for Public Health Action: The Health Impact Pyramid. *Am J Public Health.* 2010; 100(4):590-595.
[3] Institute of Medicine. The Future of the Public's Health in the 21st Century. Available at http://www.iom.edu/Reports/2002/The-Future-of-the-Publics-Health-in-the-21st-Century.aspx. Published 11/2/02. Accessed 10/24/14.
[4] Frank LD, Andresen MA, Schmid TL. Obesity relationships with community design, physical activity, and time spent in cars. *Am J Prev Med.* 2004; 27(2):87-96.
[5] Frank LD, Engelke PO. The built environment and human activity patterns: exploring the impacts of urban form on public health. *J Plan Lit.* 2001; 16(2):202-218.
[6] Sallis JF, Glanz K. Physical activity and food environments: solutions to the obesity epidemic. *Milbank Q.* 2009; 87(1):123-154.
[7] Dannenberg AL, Jackson RJ, Frumkin H, Schieber RA, Pratt M, Kochtitzky C, Tilson HH. The Impact of Community Design and Land-Use Choices on Public health: A Scientific Research Agenda. *Am J Public Health.* 2003; 93:1500-1508.
[8] CDC. Designing and Building Healthy Places. Available at http://www.cdc.gov/healthyplaces/factsheets/designing_and_building_healthy_places_factsheet_final.pdf. Accessed 11/6/14.
[9] CDC. About Healthy Places. http://www.cdc.gov/healthyplaces/about.htm. Accessed November 3, 2014.
[10] National Prevention Council. National Prevention Strategy: America's Plan for Better Health and Wellness. Washington, DC: U.S. Department of Health and Human Services. Office of the Surgeon General, 2011.
[11] Transportation Research Board. Does the Built Environment Influence Physical Activity? Examining the Evidence. Washington, DC: The National Academies Press. The National Academies Press, 2005.
[12] 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.
[13] Public Health Accreditation Board (PHAB). "Public Health Accreditation Board Standards & Measures." Available at http://www.phaboard.org/wp-content/uploads/SM-Version-1.5-Board-adopted-FINAL-01-24-2014.docx.pdf. Accessed 11/3/14.
[14] CDC. Health Impact Assessment. http://www.cdc.gov/healthyplaces/hia.htm. Accessed November 3, 2014.
[15] CDC. Healthy Community Design Checklist Toolkit. http://www.cdc.gov/healthyplaces/toolkit/default.htm. November 3, 2014.
[16] CDC. Transportation Health Impact Assessment Toolkit: For Planning and Health Professionals. http://www.cdc.gov/healthyplaces/transportation/hia_toolkit.htm. Accessed November 3, 2014.
[17] Georgia Tech. Built Environment and Public Health Clearinghouse. http://www.bephc.gatech.edu/about. Accessed November 3, 2014.
[18] Rube K, Veatch M, Huang K, Sacks R, Lent M, Goldstein GP, Lee KK. Developing Built Environment Programs in Local Health Department: Lessons Learned from a Nationwide Mentoring Program. *Am J Public Health.* 2014; 104(5):e10-18.
[19] Morris M, Rogers V, Solomon J, Roof K. Planning and Public health Reunited: Exploring Shared Objectives and Opportunities for Collaboration. In Morris M. Integrating Planning and Public Health: Tools and Strategies to Create Healthy Places. Chicago, IL: American Planning Association. American Planning Association, 2006.
[20] National Association of County and City Health Officials. 2013 National Profile of Local Health Departments. Washington, DC: National Association of County and City Health Officials. National Association of County and City Health Officials, 2014.
[21] Rube K, Veatch M, Huang K, Sacks R, Lent M, Goldstein GP, Lee KK. Developing Built Environment Programs in Local Health Department: Lessons Learned from a Nationwide Mentoring Program. *Am J Public Health.* 2014; 104(5):e10-18.