Public Health Preparedness Capabilities Assessment

OSTLTS Generic Information Collection Request
OMB No. 0920-0879

Supporting Statement – Section A

Submitted: 6/12/15

Program Official/Project Officer
Name: Shoukat Qari
Title: Sr. Scientific Program Official
Organization: OPHPR (OSPHP)
Address: Williams Building, 2877 Brandywine Rd. Atlanta, GA 30341
Phone number: 770 488 8808
Fax Number: 770 488 8688
Email: SQari@CDC.Gov

Table of Contents

- Goal of the study
    - The purpose of this study is to assess the effectiveness and usefulness of the Public Health Preparedness Capabilities from the perspective of Public Health Emergency Preparedness (PHEP) grantees, and to determine what aspects of health department structure may contribute to differences in perceptions and use of the Capabilities.

- Intended use of the resulting data
    - The resulting data will be used to provide recommendations for improving the next iteration of the Capabilities, as well as improve guidance and technical assistance to grantees.

- Methods to be used to collect
    - We will use a web-based information collection instrument to collect data from PHEP grantees.

- The subpopulation to be studied
    - The sub-population to be studied is PHEP grantees, which consists of Directors of Public Health Preparedness in state, local, tribal, and territorial health departments.

- How data will be analyzed
    - Once initial descriptive and bivariate analyses are run to reveal response frequencies and variation, qualitative data will be coded to identify covariant patterns and common themes or interests based on the project objectives.

Section A – Justification

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 62 PHEP grantees, which consist of Directors of Public Health Preparedness in 62 state, local, and territorial health departments (50 states, 4 major metropolitan areas, and 8 U.S. territories) acting in their official capacities. [1]

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(s) of development of policies and plans that support individual and community health efforts and assuring a competent public health and personal health care workforce.

- ☐ 1. Monitoring health status to identify community health problems
- ☐ 2. Diagnosing and investigating health problems and health hazards in the community
- ☐ 3. Informing, educating, and empowering people about health issues
- ☐ 4. Mobilizing community partnerships to identify and solve health problems
- ☒ 5. Development of policies and plans that support individual and community health efforts
- ☐ 6 Enforcement of laws and regulations that protect health and ensure safety
- ☐ 7. Linking people to needed personal health services and assure the provision of health care when otherwise unavailable
- ☒ 8. Assuring a competent public health and personal health care workforce
- ☐ 9. Evaluating effectiveness, accessibility, and quality of personal and population-based health services
- ☐ 10. Research for new insights and innovative solutions to health problems [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. [2]

Since 2002, federal funding for public health preparedness has been provided by the Centers for Disease Control and Prevention's (CDC's) Division of State and Local Readiness (DSLR) to state, local, tribal, and territorial public health departments through the Public Health Emergency Preparedness (PHEP) cooperative agreement. The PHEP cooperative agreement is the main source of funding that state, tribal, local, and territorial (STLT) health departments use to develop and maintain their ability to effectively respond to public health threats.[1] These funds have also been used to address specific threats, such as the 2009 H1N1 novel influenza A pandemic.[4]

In March 2011, to help guide awardees' PHPR activities, CDC published 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. This document, *Public Health Preparedness Capabilities: National Standards for State and Local Planning* [5], provides STLT public health departments with guidance on organizing their preparedness activities, planning their priorities, and deciding which Capabilities they have the resources to build or sustain. The Capabilities also help ensure that federal preparedness funds are directed to priority areas within individual jurisdictions. According to application and budget information provided by the 62 PHEP awardees and compiled by CDC, nearly one-half of all activities and funding take place around two Capabilities: public health laboratory testing and public health surveillance and epidemiological investigation. Most technical assistance requests received by CDC from the PHEP awardees were in the areas of public health laboratory testing, medical materiel management and distribution, and public health surveillance and epidemiological investigation.[5]

Many PHEP grantees have used the Capabilities to identify and fill gaps in their preparedness plans. Funds have been used to support a broad range of programs to complement and extend existing preparedness activities. In several cases, preparedness activities were in place before the

dissemination of the Capabilities, which allowed organizations to map current activities to the Capabilities. This in turn allowed them to identify gaps in preparedness activities and prioritize scarce resources where they were most needed. However, not all preparedness plans contain support for all 15 Capabilities, and the use of particular Capabilities often are correlated with both the type of event and the organizations that are involved in the plan.[5] Responding organizations often will collaborate to cover more Capabilities in the response.[6]

A recent search of the published literature and available grey sources did not provide sufficient detail about how the grantees are using the capabilities or perceptions of the Capabilities themselves. However, the literature identified does provide a window into a subset of grantees. There are several examples of grantees and other organizations using the Capabilities as a framework for organizational assessment, which facilitates measuring an agency or region's preparedness. An annotated bibliography related to public health measurement issues classified a range of assessments mapped to public health preparedness Capabilities. They found that early assessments related to cooperative agreement benchmarks and funding expenditures, whereas later efforts use exercises or events to assess progress against Capabilities.[7] In addition, organizations are mapping existing preparedness activities to the Capabilities. In these cases, assessment focuses more on the activity itself rather than using the Capability as a measurement tool. No information was available on PHEP grantees' perceptions of the Capabilities as useful and effective.

The purpose of this study is to assess the effectiveness and usefulness of the Public Health Preparedness Capabilities from the perspective of Public Health Emergency Preparedness (PHEP) grantees, and to determine what aspects of health department structure and administration may contribute to differences in perceptions and use of the Capabilities. We seek to answer these questions by collecting information from all 62 PHEP grantees using a web-based instrument.

Overview of the Information Collection System

Data will be collected via a web-based questionnaire allowing respondents to complete and submit their responses electronically (**see Attachment A—Instrument: Word version** and **Attachment B —Instrument: Web version**). As a data collection method, web-based assessments offer the benefit of cost effectiveness, flexibility and efficiency in questionnaire development and branching patterns, and minimize respondent burden, while conserving financial resources.[8] The online instrument will be used to gather information from STLT officials from each PHEP grantee organization regarding their perceptions about the effectiveness and usefulness of the Capabilities. The information collection instrument was pilot tested by 9 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 information collection instrument.

Items of Information to be Collected

The online data collection instrument consists of 20 main questions of various types, including dichotomous (yes/no), multiple response, interval (rating scales), and open-ended. An effort was

made to limit questions requiring narrative responses from respondents whenever possible. The data collection instrument is organized into three parts:

- Section 1 Effectiveness of the Public Health Preparedness Capabilities: will assess how effective the PHEP grantees perceive the Capabilities and whether any gaps currently exist within the Capabilities.
- Section 2 Utility of the Public Health Preparedness Capabilities: will assess how PHEP grantees use the Capabilities.
- Section 3 Structure of PHEP Program: will assess the structure of the PHEP programs, including organization, administration, funding, partnerships, and leadership characteristics.

2. Purpose and Use of the Information Collection

The purpose of this study is to assess the effectiveness and usefulness of the Public Health Preparedness Capabilities from the perspective of Public Health Emergency Preparedness (PHEP) grantees, and to determine what aspects of health department structure and administration may contribute to differences in perceptions and use of the Capabilities.

This assessment will serve to build upon CDC's existing data to obtain a better picture of how grantees see the Capabilities as effective standards, as well as how grantees are integrating the Capabilities into preparedness activities. Ultimately, findings from this information collection will be summarized in a report to be used internally by CDC leadership and staff. Findings will be used to inform possible updates to the 15 Capabilities. The Capabilities will continue to help ensure that federal preparedness funds are directed to priority areas within individual jurisdictions. The key findings from this assessment may also be summarized in an additional published manuscript.

3. Use of Improved Information Technology and Burden Reduction

Data will be collected via a web-based questionnaire 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. The information collection instrument was designed to collect the minimum information necessary for the purposes of this project (i.e., limited to 20 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 options was minimized to reduced burden on respondents.

4. Efforts to Identify Duplication and Use of Similar Information

This assessment represents a new effort to systematically assess how grantees perceive the effectiveness and utility of the Capabilities, and how they use the Capabilities in practice in such areas as planning, training and exercising. By informing possible updates to the next version of the Capabilities, this assessment will contribute to the availability of the best available guidance for STLT health departments to organize their preparedness activities, plan their priorities, and decide which Capabilities they have the resources to build or sustain.

Avar Consulting, the CDC contractor for this project, conducted a targeted literature review focused specifically on grantee use of the Capabilities. [9] In addition to reviewing published information, the literature review included "grey" literature obtained from CDC funded projects, and literature obtained through the use of Internet and other search engines (such as Google and Medline). This project builds on the information found through the literature review, but the information currently available has significant gaps and does not adequately address the topics of interest. There is no other project that duplicates the proposed efforts.

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

This data collection is a direct response to CDC's need to assess how the Capabilities are perceived as useful and effective by PHEP grantees, which in turn should contribute to more effective and more efficient public health preparedness practice.

If no data are collected, CDC will be unable to:

- Understand how and to what extent grantees perceive the Capabilities as effective standards for public health preparedness and use them in actual practice.
- Understand what aspects of health department structure contribute to differences in grantee perception and use of the Capabilities

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 information collection. STLT governmental staff will be speaking from their official roles and will not be asked, nor will they provide individually identifiable information.

This information collection is not research involving human subjects.

10.1 Privacy Impact Assessment Information

No individually identifiable information (IIF) will be collected. No sensitive data are 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.

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 up to 9 public health 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 55 minutes. Based on these results, the estimated time range for actual respondents to complete the instrument is 45 to 60 minutes. For the purposes of estimating burden hours, the upper limit of this range (i.e., 60 minutes) is used.

Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) National Compensation Survey estimate for [job title] (http://www.bls.gov/ncs/ocs/sp/nctb1349.pdf). Based on DOL data, an average hourly wage of $47.77 is estimated for all 62 respondents. Table A-12 shows estimated burden and cost information.

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

Information 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	Directors of Public Health Preparedness in across state health departments	50	1	60/60	50	47.77	$2,388.50
PHEP Assessment	Directors of Public Health Preparedness in major metropolitan areas	4	1	60/60	4	47.77	$191.08
PHEP Assessment	Directors of Public Health Preparedness in U.S. territories and freely associated states	8	1	60/60	8	47.77	$382.16
	TOTALS	**62**	**1**		**62**		**$2961.74**

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. Contractors, however, are being used to support development of the assessment tool, data collection, and data analysis. The only cost to the federal government would be the salary of CDC staff and contractors. The total estimated cost to the federal government is **$247,494.24**. 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 Official (GS 14)	24	59.26	$1,422.24
Contractor			$246,072.00
Estimated Total Cost of Information Collection			**$247,494.24**

15. Explanation for Program Changes or Adjustments

This is a new information collection.

16. Plans for Tabulation and Publication and Project Time Schedule

A preliminary analyses of the data will be conducted. Quantitative analysis will consist of initial descriptive and bivariate analysis to describe general frequency and variation among the variables. Qualitative data from open-ended responses will be reviewed and coded to identify common themes among respondents and will be joined with related variables. To ensure information is secure, non-identifying unique ID codes will be incorporated into the coding process, which will be retained in the final data set.

As a deliverable, Avar will provide the data dictionary and electronic Excel files (standard and read-only versions) of a cleaned, de-identified data set of completed responses. Data cleaning includes programming codes to check for accuracy, detecting and removing errors and inconsistencies in the data (i.e., misspellings, missing information, invalid data), and ensuring consistency in data items prior to defining the analytic variables. Findings will be summarized in an internal report that provides recommendations on possible improvements to the Capabilities.

Project Time Schedule [Please see example template below and adjust as needed]

- ✓ 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)
- ❑ Conduct assessment ..... (Assessment open 20 weeks)
- ❑ Code, quality control, and analyze data..... (4 weeks after assessment closes)
- ❑ Prepare reports ..... (6 months)
- ❑ Disseminate results/reports ..... (8 months)

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

A. PHEP Assessment – Word Version
B. PHEP Assessment – Web Version

REFERENCE LIST

1. Centers for Disease Control and Prevention, Office of Public Health Preparedness and Response (2013). *Funding and guidance for state and local health departments*. Accessed July 30, 2013 at http://www.cdc.gov/phpr/coopagreement.htm

2. Centers for Disease Control and Prevention, Office of Public Health Preparedness and Response (2011, July). *Public health preparedness capabilities: National Standards for state and local planning.* Accessed July 30, 2013 at http://www.cdc.gov/phpr/capabilities/DSLR_capabilities_July.pdf

3. Centers for Disease Control and Prevention (CDC). *National Public Health Performance Standards Program (NPHPSP): 10 essential public health services*. Accessed august 14, 2014 at http://www.cdc.gov/nphpsp/essentialservices.html

4. PHPR. (2013). *Division of state and local readiness*. Accessed July 30, 2013 at http://www.cdc.gov/phpr/documents/DSLR_fact_sheet.pdf

5. Boedigheimer, S., et al. (2012, September 25). *Public health and healthcare preparedness: A national overview of current capabilities and strategies for moving forward.* Accessed July 30, 2013 at www.astho.org/Programs/Preparedness/PHEP-and-HPP-Capabilities/

6. Hunter, J. C., Crawley, A. W., Petrie, M., Yang, J. E., & Aragon, T. J. (2012). Local public health system response to the tsunami threat in coastal California following the Tohoku earthquake. *PLoS Curr*, *4*, e4f7f57285b804.

7. Stoto, M. A., Piltch-Loeb, R., Potter, M. A., & Links, O. H. (2012). Annotated bibliography of research resources for measurement of public health preparedness: Published September 9, 2012.

8. Dillman, D. A. (2000). Procedures for conducting government-sponsored establishment surveys: Comparisons of the Total Design Method (TDM), a traditional cost-compensation model, and Tailored Design. *Proceedings of Second International Conference on Establishment Surveys (ICESII)*, Buffalo, NY, 343-352.

9. Avar Consulting, Inc. (2014). Improving operational efficiency and effectiveness of public health emergency preparedness and response systems: literature review report.