County Health Policy Implementation Assessment

OSTLTS Generic Information Collection Request
OMB No. 0920-0879

Supporting Statement – Section A

Submitted: 5/19/2016

Program Official/Project Officer
Carol Pierannunzi
Senior Research Methodologist
Division of Public Health
4770 Buford Highway MS F-78
Atlanta, Georgia 30341
770-488-4609
770-488-5964
Ivk7@cdc.gov

Table of Contents

- Goals of the study:
  The purpose of this information collection is to learn which (and to what extent) public health policies related to tobacco, nutrition, physical activity, clinical and community linkages, and excessive alcohol consumption are in place in counties in North Carolina and Washington. Additionally, the information collection aims to learn about the role of local health departments (LHDs) in developing policies; LHD's community partners in policy development; and communication channels used by LHDs to increase awareness of health policies. The purpose of the information collected is not to develop or influence policy, but rather to learn from the experiences in two states.

- Intended use of the resulting data:
  Data will be used to increase CDC's awareness of the policy environment at the LHD level and to inform improvements in training materials and tools for states and CDC personnel who work with LHDs. The understanding of the role of LHDs as a partner in policy development and implementation is of paramount importance, if CDC is to provide meaningful guidance for demonstration projects, community health programs, post-disaster relief action, and strategic

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 120 local health directors within two states (North Carolina and Washington) acting in their official capacities as LHD officials. These respondents hold the title of County Health Director/ Health Administrator or similar title authorizing them as the head of the public health agency for a single or multiple LHD jurisdiction within these states - 85 in North Carolina and 35 in Washington (see listing in **Attachment A – List of counties and subjects**). If a local Health Director/Health Administrator feels there is someone else within the LHD better suited to complete the assessment, they can have the task delegated to another official who: 1) serves in a leadership position such as a department head, such as Director of Nursing, Director of Environmental Health, Chronic Disease Department, 2) has at least 3 years' experience in a leadership role with the local health department, and 3) has broad knowledge of the local health department's role in the local policy environment, especially in chronic disease prevention and health promotion policies and practices. This information collection is authorized by Section 301 of the Public Health Service Act (42 U.S.C. 241)[1]. This information collection falls under the essential public health service(s) of: (4) Mobilizing community partnerships to identify and solve health problems and (5) Development of policies and plans that support individual and community health efforts:

- ☐ 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]

Understanding the role of local health departments in policy development and implementation is of paramount importance if CDC is to provide meaningful guidance for demonstration projects, community health programs, post-disaster relief action, and strategic planning related to mobilizing community partnerships. Counties are the most common jurisdiction of all local health departments. However, counties exist in a complex jurisdictional landscape.

Government structures that develop and implement health policy at the local level are diverse. The National Profile of Local Health Departments[2] indicates that most (68%) are single county jurisdictions, with another 8% serving multiple counties. Twenty percent serve cities/towns with 4 percent governing other jurisdictions. Small states (RI, HI) have statewide health jurisdictions, without any local governance at all. Within the local structure there is a great deal of variation based on the presence of local boards of health (in 76% of all LHDs)[2] and the degree to which state governments permit local control and cross-jurisdictional sharing of services. The ability to tax, retain reserve funding, and flexibility in expenditures also increases the variability across LHDs.

Moreover, previous data collection informs us that LHDs do not operate in policy silos. [2 3] LHDs must work with zoning and planning departments over issues such as green spaces, recreation, bicycle paths, sidewalks and other like issues. Departments of parks and recreation or senior and aging services have public health policy implications and operate outside the authority of LHDs. Public safety services may work with LHD agencies on injury programs, teen drinking or alcohol and drug use prevention programs. School systems may also be partners on any number of programs on which the LHDs are working, including nutrition, physical activity, and health risk behaviors. Programs on a single issue, such as alcohol misuse, may require partnership with multiple partners, such as zoning and planning agencies, public safety, schools and municipalities within the county as well as nonprofit agencies active in the community. Even private companies with power and influence within the jurisdiction make powerful allies for the LHD. In order to be successful, the LDH must partner with all these departments, organizations and jurisdictions.

The CDC promotes the activities of LHDs by providing community guides (such as the Community Health Assessment and Group Evaluation (CHANGE), tool kits for assessment and strategic planning (such as the Community Health Improvement Plans or The Prevention Impacts Simulation Model (PRISM)), demonstration project support, post disaster assessment and support (such as Community Assessment for Public Health Emergency Response (CASPER)) and a number of other services and tools for local jurisdictional use. The Division of Population Health is involved in a number of these initiatives.

Given that CDC resources are being expended to promote public health at the local level, and there is sufficient data to support the fact that policy development activities differ greatly by locality, a greater understanding of LHDs role as a partner in the development, implementation and support for public health policy is needed. There are a number of data collection instruments that cover the questions of what policies are extant in which localities.[3] What is not known is the degree to which

the LHD plays a role in the development and implementation of policy, and how the LHDs build and sustain partnerships with other organizations to develop and implement health policy within their jurisdictions.

The purpose of this information collection is to learn which (and to what extent) public health policies related to tobacco, nutrition, physical activity, clinical and community linkages, and excessive alcohol consumption are in place in counties in North Carolina and Washington. Additionally, the information collection aims to learn about the role of LHDs in developing policies; LHD's community partners in policy development; and communication channels used by LHDs to increase awareness of health policies. The purpose of the information collected is not to develop or influence policy, but rather to learn from the experiences in two states.

Data will be analyzed to identify general themes and trends on the role of the LHD in the development and implementation of health policy including establishing partnerships with other organizations, perceptions of barriers to policy partnerships, taking initiative in policymaking, implementing policies and communicating policies to constituents. Data will be used to increase CDC's understanding of public health policy and partnership development at the local level. Additionally, results will be used to inform training material content and tools for states and CDC personnel who work with LHDs. Specifically, examples of how LHDs have developed policy in the two sampled states will be showcased in the training and tools so that other state/local health departments can learn from these examples.

Although the information collection will only yield data about two specific states, the LHDs in these states operate under very different organizational structures. This variability will allow CDC to better understand the policy environment at the LHD level under these types of structures. The Division of Population Health will partner with a vendor, the Research Triangle Institute International (RTI)[4] to assist with website development and data collection. RTI International provides research and technical services to governments and businesses in more than 75 countries in the areas of health, assessment s and statistics, among other services. They have been contracted for a single year for data collection services on this project.

Overview of the Information Collection System

The data collection instrument will be a questionnaire (see **Attachment B - Instrument: Word version, Attachment C – Instrument: Web version for single county LHDs and Attachment D - Instrument: Web version for multi-county health districts**). Initially, all respondents will be given access to complete the questionnaire online via a secure website. If the online questionnaire is not completed within 8 weeks, a mailed questionnaire (see **Attachment B - Instrument: Word version**) will be sent as a follow-up. Multi-county health districts that do not complete the online assessment will also receive a mailed supplement for each additional county within their district (see **Attachment E - CHPIA Additional County Supplement**).

A pilot of the web- and paper-based instruments was conducted with a total of 8 public health professionals.

Items of Information to be Collected

The data collection instrument consists of about 20 main questions for single county LHDs (see **Attachment B – Instrument: Word version and Attachment C – Instrument: Web version for single county LHDs**). The questions are grouped into 3 main areas - organizational structure, partnerships and communication, and specific policy areas. Each section requests information on key areas related to the overall purpose.

- Questions 2 through 3 focus on the organizational structure of the LHD.
- Question 4 relates to the impact of the LHD on the policy making process
- Questions 5 through 9 focus on LHD partnerships, perceived barriers to partnerships, as well as connecting with the public through communication networks.
- Questions 10 through 21 deal with specific public health policy areas to determine the status of policy activities within several topic areas (tobacco, nutrition, physical activity, clinical-community linkages, and excessive alcohol consumption) and the leadership role that the LHD would take in policy development in each policy area.

Multi-county health districts can choose to complete one assessment on behalf of all the counties served by their LHD or complete questions 4 through 21 separately for each county within their health district. For the districts that choose to complete a separate set of partnership and policy questions for each county, if using the web-based assessment, these questions will automatically be repeated for each additional county (see **Attachment D - Instrument: Web version for multi-county health districts**). If using the paper-based assessment, a county supplement will be provided for each additional county (see **Attachment E - CHPIA Additional County Supplement**).

2. Purpose and Use of the Information Collection

The purpose of this information collection is to learn which (and to what extent) public health policies related to tobacco, nutrition, physical activity, clinical and community linkages, and excessive alcohol consumption are in place in counties in North Carolina and Washington. Additionally, the information collection aims to learn about the role of LHDs in developing policies; LHD's community partners in policy development; and communication channels used by LHDs to increase awareness of health policies. The purpose of the information collected is not to develop or influence policy, but rather to learn from the experiences in two states.

Data will be used to make improvements in training materials and tools for states and CDC personnel who work with LHDs as well as contribute to their understanding of the policy environment at the LHD level. Specifically, examples of how LHDs have developed policy in the two sampled states will be showcased in the training and tools so that other state/local health departments can learn from these examples. The understanding of the role of LHDs as a partner in policy development and implementation is of paramount importance, if CDC is to provide meaningful guidance for demonstration projects, community health programs, post-disaster relief

action, and strategic planning related to mobilizing community partnerships to identify and solve health problems.

3. Use of Improved Information Technology and Burden Reduction

An online data collection method is included in this information collection as the primary data collection mode in an effort to reduce burden on the participant. This method will allow respondents to complete the questionnaire and submit responses electronically. The information collection instrument was designed to collect the minimum information necessary for the purposes of this project. A secondary, paper-based method is also included as a follow-up for non-responders. There are some people who choose paper assessments as a personal preference or because of a distrust of online assessments related to a perceived lack of security on a website. Persons who have these characteristics may not respond to online assessments, but may be willing to respond to mailed (paper and pencil) assessment formats. Moreover, the practice of follow-up contact is well established among data collection methodologists.[5] Multiple studies have shown that follow-up contacts increase response rates. Incorporating a secondary method will assist in ensuring that response rates will be optimal for the targeted group. However, although a paper-based questionnaire will be available to those who do not respond to the online assessment, we do not expect this mode of data collection to be used often.

4. Efforts to Identify Duplication and Use of Similar Information

We have conducted a comprehensive review of assessments and other forms of data collection of local level policy, policy review policy level databases and professional organizational databases on local level policy and found that a number of information collections have been conducted which tabulate policies that are in place. One such data collection, the National Profile of Local Health Departments collected by NAACHO,[2] includes a limited number of questions on partnerships, and was last collected in 2013. These ICs tend to provide information on state or local law, zoning ordinances, tax structures, land use and similar policy. The National Network of Public Health Institutes conducted a comprehensive review of all local policy databases in 2013[3]. They found that there were a number of databases that provided information on a single topic (such as tobacco policy) or provided information on laws, but did not provide information on activity or action toward policymaking. Several professional organizations (the International City Managers Association and the National Association of Counties) have publications on health policies by local governments on a sporadic basis or as a minor portion of periodic IC of members[6 7]. We found very little information that described how local public health agencies were part of the process of policy adoption, implementation, partnership or leadership.

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 request is for a one-time information collection. There are no legal obstacles to reduce the burden. If no data are collected, CDC will be unable to:

- Enhance the understanding of the role of LHDs in the policy development and implementation process;

- Advance CDCs training materials/tools for LHDs;
- Increase understanding of complexity of jurisdictional policy layers for project officers and other CDC officials who oversee demonstration projects at local/county levels.

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. Protection of the Privacy and Confidentiality of Information Provided by Respondents

The Privacy Act does not apply to this information collection. Local governmental staff will be speaking from their official roles. Although RTI will collect some individually identifiable information (IIF), the dataset that RTI will send to CDC at the conclusion of the project will not include any IIF. Furthermore, RTI is storing all IIF on a secure RTI system and this information will be deleted at the end of the project. CDC will store all received data (not to include IIF) on the Division of Population Health's secure shared drive. Data will only be presented in aggregate form.

This information collection is not research involving human subjects.

11. Institutional Review Board (IRB) and Justification for Sensitive Questions

No information will be collected that is 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 web-based and paper-based versions of the information collection instrument by 8 local 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 review instructions, gather needed information and complete the instrument.

Respondents will either complete the assessment from the perspective of a single county LHD or a multi-county health district (whichever is applicable for their jurisdiction). The majority of respondents are in a single county LHD (n=111). Time to complete the assessment identified during the pilot test was as follows:

Single County LHD:

- Web-based: 13 minutes (range: 10-16 minutes)
- Paper-Based: 15 minutes (range: 10-20 minutes).

Multi-County Health District:

If the respondent represents a multi-county health district, he/she will have the option to complete the Partnership and Policy Questions once on behalf of the entire district or separately for each county within the district. If responding to these questions separately for each county, the average time to complete the Partnership and Policy Questions was 7.5 minutes (range: 7-8 minutes) for each additional county. The maximum number of times these additional questions could be answered is 7 (as 1 of the 9 multi-county health districts represents 7 counties). Therefore, the maximum burden possible to be incurred by completing the multi-county assessment is 68 minutes. This reflects the 20 minutes needed to complete the assessment for the first county within the health district (i.e., upper limit for a single county LHD) and the 48 minutes (8 minutes per county) for each of the additional 6 counties.

Note: In pilot testing, the time to complete the additional Partnerships and Policy Questions was the same for both web-based and paper-based modes (range: 7-8 minutes).

Although a paper-based assessment will be available to those who do not respond to the online assessment, we do not expect this mode of data collection to be used often. For establishment data collections, follow-up contacts generally increase response rates by 10-30%.[8] However, most of these studies have been conducted with private industries. Our experience with responses from state agencies suggests that requests from the CDC for information on public health practice generally results in higher initial response rates making follow-ups less necessary. Therefore we have estimated on the lower end of the range suggested by research on this topic and do not expect more than 10% of the respondents to complete the paper-based version of the assessment.

Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) Bureau of Labor Statistics for occupational employment for each local health official (titles include County Health Director, County Health Supervisor, Chronic Disease Director, and Board of Health Director). http://www.bls.gov/oes/current/oes_nat.htm. Based on DOL data, an average hourly wage of $50.99 is estimated for all 120 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
County Health Policy Implementation Assessment: Single County Web Version	Local Health Directors of single county districts	100	1	20/60	33	$50.99	$1,703
County Health Policy Implementation Assessment: Multi-County Web Version	Local Health Directors of Multi-county districts	8	1	68/60	9	$50.99	$464
County Health Policy Implementation Assessment: Single County Word Version	Local Health Directors of single county districts	11	1	20/60	4	$50.99	$189
County Health Policy Implementation Assessment: Multi-County Word Version	Local Health Directors of multi-county districts	1	1	68/60	1	$50.99	$61
	TOTALS	120			47		$2,417

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. In addition to the contact costs, costs to the federal government would be the salary of CDC staff. The total estimated cost to the federal government is $317,142. Table A-14 describes how this cost estimate was calculated. Because this is a fixed-cost contact with a single vendor (Research Triangle Institute), all contract costs are taken in whole from the vendor's costs for all tasks, and appear on the first row of the table.

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

Staff (FTE)	Average Hours per Collection	Average Hourly Rate	Average Cost
Contract costs (RTI)			$236,000
GS-14	603	62.00	$37,386
GS-13	603	52.00	$31,356
GS-14	200	62.00	$12,400
Estimated Total Cost of Information Collection			**02**

15. Explanation for Program Changes or Adjustments

This is a new information collection.

16. Plans for Tabulation and Publication and Project Time Schedule

Publication plans include internal dissemination for use by project officers and others who deal with local public health officials. Publications may also include conference presentations.

Project Time Schedule

- ✓ Design questionnaire ..... (COMPLETE)
- ✓ Develop protocol, instructions, and analysis plan ..... (COMPLETE)
- ✓ Pilot test questionnaire ..... (COMPLETE)
- ✓ Prepare OMB package ..... (3 Weeks)
- ✓ Submit OMB package ..... (2 Weeks)

OMB approval ..... (8 Weeks)
Conduct assessment ..... (12-16 Weeks)
Code, quality control, and analyze data..... (12 Weeks)
Prepare reports ..... (8 Weeks)
Disseminate results/reports ..... (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

A. List of counties and subjects
B. Instrument: Word version
C. Instrument: Web version for single county LHDs
D. Instrument: Web version for multi-county health districts
E. CHPIA Additional County Supplement

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. National Association of County & City Health Officials (NAACHO). "2013 National Profile of Local Health Departments." Available at http://www.naccho.org/topics/infrastructure/profile/upload/2013-National-Profile-of-Local-Health-Departments-report.pdf.

3. National Network of Public Health Institutes. "Local Policy Database Scan Final Report/ October 2013" Available at http://nnphi.org/wp-content/uploads/2015/08/local-policy-database-scan-1.original.pdf.

4. Research Triangle Institute. http://www.rti.org/

5. AAPOR, "Current Knowledge and Considerations Regarding Survey Refusals," 2014.

6. International City Managers Association, The Municipal Yearbook 2014. (Multiple years) Available at http://icma.org/en/press/print/municipal_yearbook_2014.

7. National Association of Counties. 2012 Operations Survey Results. Available at www.naco.org.

8. Petroni, et al., "Response Rates and Nonresponse in Establishment Surveys – BLS and Census Bureau"