Preventive Health and Health Services Block Grant Assessment

OSTLTS Generic Information Collection Request
OMB No. 0920-0879

Supporting Statement – Section A

Submitted: August 11, 2017

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- **Purpose of the data collection:** The purpose of this data collection is to describe select cross-cutting outputs and outcomes of the grant, as defined by the newly developed performance measures, and demonstrate the utility of the program on a national level. Please note: this data collection will describe the grant as a whole—not individual grantee activities or outcomes.

- **Intended use of the resulting data:** Data will be used to 1) describe the outcomes and achievements of grantees' public health efforts and identify how the use of PHHSBG funds contributed to those results and 2) provide evidence to support future budgetary requests and inform program planning or a performance monitoring strategy at the national level.

- **Method to be used to collect data:** Data will be collected using a web-based instrument created in collaboration with the Association of State and Territorial Health Officials (ASTHO) using Qualtrics®.

- **The subpopulation to be studied**: The respondent universe includes 61 PHHSBG coordinators, or their designees, across 61 (50 states, the District of Columbia, 2 tribes, 5 U.S. territories, and 3 freely associated states) health departments funded under the Preventive Health and Health Services Block Grant, acting in their official capacities.

- **How data will be analyzed**: Responses will be analyzed using Microsoft Excel to aggregate responses for each measure and quantify the use of PHHSBG funds across the nation. Descriptive statistical analyses on responses to multiple-choice questions and qualitative analyses on

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 a total of 61 PHHSBG coordinators, or their designees, across 61 (50 states, the District of Columbia, 2 tribes, 5 U.S. territories, and 3 freely associated states) health departments (see **Attachment A – List of PHHSBG Grantees**), funded under the Preventive Health and Health Services Block Grant, acting in their official capacities.

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

☐ 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]

For more than 30 years, the Preventive Health and Health Services Block Grant has provided flexible funding for all 50 states, the District of Columbia, two American Indian tribes, five U.S. territories, and three freely associated states to address the unique public health needs of their jurisdictions in innovative and locally defined ways. First authorized by Congress in 1982 through the Public Health Service Act (Public Law 102-531), the fundamental and enduring purpose of the Block Grant program has been to provide grantees with flexibility and control to address their priority public health needs. To that end, the law combined several categorical grants covering various areas of health-related funding (e.g., emergency medical services, hypertension, home health services, health education and risk reduction, urban rodent control, and community water fluoridation) into one prevention block grant. Congress later amended the law to align PHHSBG funding priorities with the 22 chapters specified in Healthy People 2000, a set of national objectives designed to guide health promotion and disease prevention efforts. Amendments also included set-aside funds specifically dedicated to sex offense prevention and victim services, thus requiring that grantees receiving this support include related objectives and activities as part of their PHHSBG-funded local programs.

Rationale

Throughout the PHHSBG's 30 years of congressionally appropriated funding, aggregate achievements of grantees have never been quantified. This has made appealing to Congress for continued support difficult. To date, anecdotal evidence has been the strongest advocate for the flexible funding provided by the PHHSBG.

While the Block Grant Monitoring Information System (PHHS Block Grant ICR OMB No: 0920-0106 Exp. 7/31/2019) monitors individual grantee performance and compliance, this information collection intends to enhance that system by describing the cross-cutting utility of grantee programs. The purpose of this data collection is to describe select cross-cutting outputs and outcomes of the grant, as defined by the newly developed performance measures, and demonstrate the utility of the program on a national level. Please note: this data collection will describe the grant as a whole—not individual grantee activities or outcomes.

Findings from this assessment will be used to 1) describe the outcomes and achievements of grantees' public health efforts and identify how the use of PHHSBG funds contributed to those

results and 2) provide evidence to support future budgetary requests and inform program planning and a performance monitoring strategy at the national level.

Framework

To generate aggregate-level program achievements, the Office for State, Tribal, Local, and Territorial Support (OSTLTS) first conducted an evaluability assessment (EA) in November 2014. Specifically, the team was interested in:

1) Understanding and describing the current state of the program in terms of program design, operations, monitoring and evaluation systems, and data quality.
2) Describing the intended program theory or logic, and describing the plausibility of the program to achieve intended outcomes given the reality of program operations, resources, and context of program implementation.
3) Identifying opportunities for useful evaluation and selection of a recommended approach.

Using the results collected from the PHHSBG EA project, the PHHSBG Framework v1.0 was developed. The Framework includes four measures capturing three cross-cutting outcomes considered to be most important, relevant, measureable, and feasible:

1. Public Health Infrastructure
    1.1 Information Systems Capacity Improved
    1.2 Quality Improved
2. Emerging Public Health Needs
3. Evidence-Based Public Health Practice

The PHHSBG Framework v1.0 as well as the four measures were have been vetted extensively with Block Grant representatives serving on the PHHSBG Evaluation Workgroup as well as with CDC leadership and project officers within the Office of State, Tribal, Local and Territorial Support (OSTLTS).

Implementation

To conduct this assessment, CDC is collaborating with the Association of State and Territorial Health Officials (ASTHO) through a cooperative agreement to program the instrument in Qualtrics® and collect data through administration of the web-based questionnaire. The CDC team developed the Measurement Framework and data collection instrument and will be conducting the data analysis and reporting.

Overview of the Information Collection System

Data will be collected from a total of 61 PHHSBG coordinators, or their designees, across 61 (50 states, the District of Columbia, 2 tribes, 5 U.S. territories, and 3 freely associated states) health departments (see **Attachment A – List of PHHSBG Grantees**) via a web-based data collection instrument (**see Attachment B – Instrument: Word version** and **Attachment C – Instrument: Web version**). The instrument will gather information on the newly developed

performance measures and describe the outcomes and achievements of grantees' public health efforts and identify how the use of PHHSBG funds contributed to those results.

The instrument was created in collaboration with ASTHO using Qualtrics®. This method of data collection was chosen to allow respondents to complete and submit their responses electronically, reducing the overall burden on respondents. The data collection instrument was pilot tested by 3 grantees selected from the PHHSBG evaluation workgroup. Feedback from this group was used to refine questions as needed, ensure accurate programming and skip patterns, and establish the estimated time required to complete the data collection instrument.

Items of Information to be Collected

The web-based data collection instrument (**see Attachment B – Instrument: Word version** and **Attachment C – Instrument: Web version**) consists of 14 main questions and 43 sub-questions (57 possible questions in total) of various types, including dichotomous (yes/no), multiple response, and open-ended questions. In an effort to minimize response burden, the instrument was designed with particular focus on streamlining questions to allow for skipping questions based on responses to previous questions. Also, an effort was made to limit questions requiring narrative responses from respondents whenever possible. The instrument will collect data on the following:

I. Respondent demographic information related to official role (1 main question)

- Grantee jurisdiction

II. Measure 1 - Public Health Infrastructure (7 main questions, 28 sub-questions)

Measure 1.1- Information Systems Capacity Improved

- Type and number of organizations/health departments that used PHHSBG funds to support information systems
- The type and number of information systems supported
- The name/title of each information system
- How the funds were used to support each information system

Measure 1.2 – Quality Improved

- Type and number of organizations/health departments that used PHHSBG funds to support a quality improvement initiative
- A count of operations, programs, or services for which a quality improvement was achieved
- The name/title of the operation, program, or service
- The type of improvement achieved
- How the PHHSBG funds were used to support the improvement
- Whether a deliberate and defined quality improvement method was used
- One example of a quality improvement achieved
- How the grantee used PHHSBG funds to address national standards or conduct accreditation-related activities

III. Measure 2 - Emerging Needs (2 main questions, 6 sub-questions)

- Type and number of organizations/health departments that used PHHSBG funds to support an emerging public health need
- The name/title of the emerging public health need addressed
- How the emerging need is categorized
- How the emerging need was identified
- The size of the population potentially affected by the emerging need
- How PHHSBG funds were used to address the emerging need

VI. Measure 3 – Evidence-Based Public Health (4 main questions, 9 sub-questions)

- Type and number of organizations/health departments that used PHHSBG funds to support the implementation of public health interventions
- The name of intervention(s) implemented
- The level of evidence supporting the intervention
- What Healthy People 2020 health topic area(s) the public health intervention implemented addressed
- How PHHSBG funds were used to implement the intervention
- How PHHSBG funds were used to support building the evidence base for public health
- How the grantee used PHHSBG funds to support evidence-based decision making

2. Purpose and Use of the Information Collection

The purpose of this data collection is to describe select cross-cutting outputs and outcomes of the grant, as defined by the newly developed performance measures, and demonstrate the utility of the program on a national level. Please note: this data collection will describe the grant as a whole—not individual grantee activities or outcomes.

Findings from this assessment will be used to 1) describe the outcomes and achievements of grantees' public health efforts and identify how the use of PHHSBG funds contributed to those results and 2) provide evidence to support future budgetary requests and inform program planning and strategy at the national level.

3. Use of Improved Information Technology and Burden Reduction

Data will be collected via a web-based data collection instrument (**see Attachment B – Instrument: Word version** and **Attachment C – Instrument: Web version**) allowing respondents to complete and submit their responses electronically. This method was chosen to reduce the overall burden on respondents. The data collection instrument was designed to collect the minimum information necessary for the purposes of this assessment (i.e., limited to a total of 57 possible questions). Additionally, skip patterns were included to allow respondents to only answer questions that apply to his/her jurisdiction, streamlining responses and further reducing burden on respondents.

4. Efforts to Identify Duplication and Use of Similar Information

The information gathered through the PHHSBG assessment is not available from other data sources or through other means nor does it duplicate any information currently being collected from PHHSBG coordinators. Although a grant monitoring system is in place for the PHHSBG and collects data on individual grantee performance and compliance (PHHS Block Grant ICR OMB No: 0920-0106 Exp. 7/31/2019), it does not collect data on cross-cutting outcomes or demonstrate the utility of programs to inform planning and strategy efforts at a national level. Therefore, the information collected is not duplicative.

This assessment will be the first of its kind to collect data enabling analysis of the PHHSBG's value, strengthen performance and accountability, and describe and measure select outputs and outcomes of the grant as defined by the four draft performance measures. Efforts were made to identify duplication and use of similar information, including an environmental scan to identify any other evaluations conducted on PHHSBGs. The results produced no performance measures that have ever been implemented and no measures implemented specifically to evaluate the PHHSBG.

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 data collection. There are no legal obstacles to reduce the burden. If no data are collected, CDC will be unable to:

- Describe and measure select cross-cutting outputs and outcomes of the PHHSBG
- Demonstrate results associated with the use of PHHSBG flexible funds to address public health needs prioritized by their jurisdictions
- Strengthen the PHHSBG's performance and accountability
- Support future budgetary requests

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

There are no special circumstances with this data 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 May 16, 2014, Vol. 79, No. 95; pp. 28513. 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 data collection. STLT governmental staff will be speaking from their official roles. No personally identifiable information (PII) will be collected. All responses collected will be kept on secure, password protected servers accessible only to project team members. No PII will be publicly distributed.

This data collection is not research involving human subjects.

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

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

12. Estimates of Annualized Burden Hours and Costs

The estimate for burden hours is based on a pilot test of the data collection instrument by 3 grantees selected from the PHHSBG evaluation workgroup. In the pilot test, the average time to complete the instrument including time for reviewing instructions and completing the instrument, was approximately 40 minutes (range: 15 – 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) Bureau of Labor Statistics for occupational employment for Medical and Health Services Managers (http://www.bls.gov/oes/current/oes_nat.htm). Based on DOL data, an average hourly wage of $51.59 is estimated for all 61 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
PHHSBG Assessment	PHHSBG Coordinators, or designee	61	1	60 / 60	61	$51.59	$3,147
	TOTALS	**61**	**1**		**61**		**$3,147**

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

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

14. Annualized Cost to the Government

There are no equipment or overhead costs. The only cost to the federal government would be the salary of CDC staff and two contractors. Contractors are being utilized to support the development and programming of the data collection instrument, conduct the data collection activities, and perform data analysis. Specifically, the ASTHO contractor is responsible for programming the instrument in Qualtrics® and collecting data through administration of the web-based questionnaire. The Deloitte contractor assisted in the development of the OMB package and will assist with data management and analysis. The total estimated cost to the federal government is $28,156.40. 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	Total Average Cost
Health Scientist – GS-14, Step 8; OMB package development, questionnaire development, pilot testing	80	$62.87 /hour	$5,029.60
Health Scientist – GS-14, Step 8; Data management and analysis (cleaning, analysis, reporting)	160	$62.87 /hour	$10,059.20
Association of State and Territorial Health Officials (contractor); Web-based instrument programming, data collection	80	$55.52 /hour	$4,441.60
Deloitte Consulting LLP (contractor); OMB package development, data management and analysis	200	$43.13 /hour	$8,626.00
Estimated Total Cost of Information Collection			**$28,156.40**

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

Once the 4-week data collection period has closed, responses will be downloaded, exported to an Excel® spreadsheet, and saved to a secure database maintained by ASTHO. ASTHO will then share the data with CDC. Data will be analyzed using Microsoft Excel® to produce charts and data visualizations that describe the PHHSBG as a whole. Descriptive statistical analyses will be conducted on responses to multiple-choice questions and qualitative analyses on response to open-ended questions. Upon completion of data analysis, CDC will develop an aggregated report summarizing the results. The report will then be shared with CDC leadership, ASTHO, and PHHSBG coordinators.

Project Time Schedule

- ✓ Design instrument ..... (COMPLETE)
- ✓ Develop protocol, instructions, and analysis plan ..... (COMPLETE)
- ✓ Pilot test instrument ..... (COMPLETE)
- ✓ Prepare OMB package ..... (COMPLETE)
- ✓ Submit OMB package ..... (COMPLETE)
- ❑ OMB approval ..... (TBD)
- ❑ Conduct data collection ..... (4 weeks)
- ❑ Code data, conduct quality control, and analyze data..... (4 weeks)
- ❑ Prepare summary report(s) ..... (2 weeks)
- ❑ Disseminate results/reports ..... (1 week)

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. Attachment A – List of PHHSBG Grantees
B. Attachment B – Instrument: Word Version
C. Attachment C – 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.