Asthma Information Reporting System (AIRS)

OMB Control No. 0920 - 0853 (Expiration Date: 5/31/2016)

Revision

Supporting Statement Part A –

Justification

Project Officer: Elizabeth Herman, MD, MPH
Title: Senior Scientist
Phone: 770-488-3711
Email: ehh9@cdc.gov
Fax: 770-488-1540

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Table of Contents

Part A. Justification

Goal of the study: The purpose of this information collection (IC) is for CDC to monitor state programs' planning and delivery of public health activities and the programs' collaboration with health care systems. AIRS is the system by which state asthma programs report their progress on National Asthma Control Program developed performance measures (PM), as well as state-level asthma emergency department (ED) visit and hospital discharge (HD) data. Awardees receive funding to implement a variety of public health strategies and activities. CDC plans to collect information related to each awardee's strategies and activities, and the process and outcome PM outlined by the cooperative agreement program.

Intended use of the resulting data: Information will be used for multiple purposes: 1) monitoring state and national progress toward achieving the outcomes identified in the National Asthma Control Program's logic model; 2) facilitating aggregate reporting of outcomes to state and national stakeholders; 3) identifying and responding to technical assistance needs; and 4) promoting continuous quality improvement at the state program and CDC level.

Methods to be used to collect: A dedicated electronic mailbox (asthma1404@cdc.gov) has been created to receive the completed reporting spreadsheets for 18 PM. A SharePoint site has been created to receive reports on state-level ED visit and HD surveillance data. Information will be collected annually as indicated in the awardees Notice of Award.

Subpopulation to be studied: 23 funded state health department cooperative agreement awardees.

How data will be analyzed: Information will be aggregated by staff at the CDC using simple tabulations and displayed in tables and charts. Statistical methods are not used in the analysis of the information.

A.1. Circumstances Making the Collection of Information Necessary

Since 1999, the U.S. Congress has provided funding for the Centers for Disease Control and Prevention (CDC) National Asthma Control Program (NACP) to support state-based public health asthma programs. As funding allows, NACP administers five-year cooperative agreements to state and territorial asthma programs. The NACP helps its awardees maximize the reach, impact, efficiency, and sustainability of comprehensive asthma control services. Attaining this goal will entail providing a seamless alignment of the full array of services across the public health and health care sectors to ensure people with asthma receive all, not just some, of the services they need. Information from evaluations and performance measures (PM) are necessary to monitor and facilitate this alignment. The current cooperative agreement entitled, *Comprehensive Asthma Control Through Evidence-based Strategies and Public Health-Health Care Collaboration* (CDC-RFA-EH14-1404, program period: September 2014 – August 2019) funds 23 awardees.

All funded states are required to submit continuation applications and annual progress reports consistent with federal requirements in response to the Government Performance and Results Act of 1993 (GPRA). All funded states provide work plans, evaluation plans, and report minimum data elements that are used to evaluate the program at the national level.

The CDC requests to revise the "Asthma Information and Reporting System (AIRS)" (OMB Control No. 0920-0853; expiration date 5/31/2016) and obtain approval for a 3-year Paperwork Reduction Act (PRA) clearance. AIRS was initially approved in 2010 and extended in 2013 to support reporting from 36 NACP awardees.[1] In addition to reducing the number of awardees from 36 to 23 and decreasing the requested burden hours from 288 to 82, the following revisions are requested:

1) The web-based reporting platform previously used for AIRS is no longer supported by CDC. Excel software used in the revision is available and used regularly by the state's program and staff. Thus, there is no need for additional training or technical support for the software.
    a. The AIRS information will be collected annually using 3 Excel spreadsheets. The PM are reported using the spreadsheet in Attachment 3a and instructions in Attachment 3a1. The ED visit and HD data will also be reported using Excel spreadsheets in Attachments 3b and 3c and instructions in Attachments 3d1 and 3d2.
2) In collaboration with state asthma programs, reporting requirements have been prioritized.
    a. In the previous version of AIRS, states were required to enter information on all activities. With this revision, states are asked to provide specific information on the two main strategies in the Funding Opportunity Announcement (FOA): services strategies (home visits and school-based self-management education) and health systems strategies (improving quality of medical management, improving referrals to and communication with school and home-based providers and increasing provision or reimbursement for non-clinical asthma services by health plans).
    b. To improve consistency in reporting across states, the reporting elements have been reduced, variables more clearly defined, and the reporting format specified in the Excel reporting spreadsheets (Attachment 3a). There are also specific instructions for completing the spreadsheets (Attachment 3a1). Awardees are also able to submit questions regarding the elements or the process through the dedicated e-mail address (asthma1404@cdc.gov).
3) CDC now endorses decreasing reporting by cooperative agreement awardees from twice a year to once a year.

[1] Including 34 states, District of Columbia, and Puerto Rico under cooperative agreement titled *Addressing Asthma from a Public Health Perspective* (CDC-RFA-EH09-901)

a. This change in reporting frequency is made at the request of state asthma program awardees. State asthma program awardees are also monitored through monthly calls with project officers and evaluation technical advisors, thus one yearly written report is sufficient for monitoring purposes. This significantly reduces the reporting burden.
b. Since its inception, annual progress reports pursuant to GPRA requirements have been, and will continue to be, collected by the NACP. A mid-year report will no longer be required.
c. During a given five-year cooperative agreement program, all funded states will continue to submit annual continuation applications, which include project narratives and work plans.

4) In addition, asthma state awardees already collect state emergency department (ED) visit and hospital discharge (HD) data (Attachments 3b and 3c) as part of their annual surveillance activities and these forms were included in the previously approved AIRS package.
    a. In this revision, the NACP would like to continue the use of these two surveillance forms.
    b. There has been no change to the reporting content or format for state-level surveillance of ED visit and HD data since 2010.
    c. Obtaining aggregate counts data, including overall age-adjusted rates on these indicators are vital to program planning and performance monitoring.
    d. Instructions for completing and uploading these reporting forms are found in Attachments 3d1 and 3d2.

The NACP is authorized under sections 301(a) and 317b (k) (2) of the Public Health Service (PHS) Act, [42 U.S.C. sections 241(a) and 247b (k) (2)] (see Attachment 1). The 60-day Federal Register Notice was published on 01/20/2016 (see Attachment 2) and is further discussed in Section A.8.

A.2. Purpose and Use of the Information Collection

The information collected will enable CDC to monitor states' program planning and delivery of public health activities and the programs' collaboration with health care systems. AIRS is the system by which state asthma programs report their progress on NACP-developed PM as well as state-level asthma ED visit and HD data. The states' reports also inform CDC evaluation staff about program evaluation efforts and technical assistance needs. Some of the PM include: documentation that surveillance findings are used to target populations with a disproportionate burden of asthma; evidence that programs are identifying and leveraging opportunities available through health care reform; and documentation that the services and health systems strategies as implemented by the states lead to better asthma control and reduced hospitalizations and ED use.

In the past three-years, AIRS data was used to:

- Serve as a resource to the branch, division, and center when addressing congressional, departmental and institutional inquiries
- Help the branch align its current interventions with CDC goals and allowed the monitoring of progress toward these goals
- Allow the NACP and the state asthma programs to make more informed decisions about activities to achieve objectives
- Facilitate communication about interventions across states, and enable inquiries regarding interventions by populations with a disproportionate burden, age groups, geographic areas and other variables of interest

Aggregated data from AIRS was presented at the 2015 State Asthma Grantee in Atlanta for the purposes of providing feedback to the state programs, clarifying CDC's expectations of the awardees and obtaining feedback to CDC on the measures and the process of submitting information. Also, a presentation about the performance measure development and implementation process was given in Chicago at the 2015 American Evaluation Association (AEA) annual meeting.

AIRS will continue to serve as a progress reporting system for the 23 funded state asthma programs. AIRS enables NACP staff to provide better technical assistance to funded programs; they can look across states and facilitate linkages of state programs. This will save state staff time in cases where the states are about to embark on work that is similar to that being done elsewhere. These linkages allow state programs to learn from one another, share program resources, and jointly publish their work and program results in peer reviewed journals or via presentations at national conferences.

The NACP worked with 23 awardees in the first year (2014) of the cooperative agreement to estimate state-specific targets for each measure as appropriate (some measures do not have targets). For example, measures B, E, F, and J (Attachment 3a) do not have targets. The NACP will use this information to encourage state asthma programs to follow-through on strategic initiatives and to monitor the management of program operations.

This information will be used along with annual progress reports to ascertain whether or not the state awardees are linking NACP strategies with actual activities promoted and provided by the state asthma programs. Evaluation and technical advisors in the NACP will use this information collection to hold state asthma programs accountable to stated strategic evaluation plans. Furthermore, the information collected will be used to identify training and technical assistance needs, monitor compliance with cooperative agreement requirements, and evaluate progress made in achieving national and state specific goals, and respond to inquiries regarding program activities and effectiveness.

Additionally, evaluation and PM help demonstrate achievement of program outcomes, build a stronger practice base for specific program strategies, clarify applicability of the evidence-based interventions to different populations, settings, and contexts, and support continuous quality improvement (CQI). Evaluation and performance measurement also can determine if program activities are scalable and effective at reaching target populations (people with a disproportionate burden of asthma as determined by each state's surveillance data).

A.3. Use of Improved Information Technology and Burden Reduction

AIRS consists of the AIRS Reporting Spreadsheet in Excel format (Attachment 3a), as well as Excel templates for the ED visit and HD surveillance data (Attachments 3b and 3c). The instructions (Attachments 3a1, 3d1, and 3d2) clarify the procedures for filling out the PM spreadsheets. As use of Excel, Word and similar Microsoft products is common, these interfaces will provide the awardees with a user-friendly platform that will require very little training. The revision of AIRS allows for simple electronic reporting that (in contrast to the previous web-based platform) does not require internet access, training on a new platform, or acquisition of new software. The templates and instructions promote consistency across states and less burden for the respondents. Additionally, the AIRS revision requires reporting annually whereas the previously approved package required reporting twice a year.

The revised system has the following objectives:

- Shorten the time to enter data
- Standardize the information collection and dissemination processes
- Identify promising practices
- Measure progress on program objectives
- Share knowledge and experience

No special data/information collection platforms will be used for the PM or the surveillance data. As stated above, reporting spreadsheets using Excel software will be used. Awardees will submit their reports electronically via a dedicated email address (asthma1404@cdc.gov for PM) and a SharePoint site (for ED visit and HD surveillance data). The reporting spreadsheets will be attached to the emails sent by state asthma program awardees to the NACP. Submitting the spreadsheets electronically will improve information quality by minimizing errors and redundancy. SharePoint will save burden hours since it eliminates the need to copy or transfer the data from email. Further, standardization will enhance the consistency of plans and reports, enable cross-program analysis, and will facilitate a higher degree of reliability by ensuring that the same information collected on all PM and surveillance data.

A.4. Efforts to Identify Duplication and Use of Similar Information

The collection of this information is part of a federal reporting requirement for funds received by awardees. AIRS does not cause duplication. There are no current data/information systems that meet the needs of the proposed data/information collection.

Asthma state awardees collect state ED visit and HD data and report them using the data collection instruments (Attachments 3b and 3c) previously approved by OMB. Aggregate counts

for ED visit and HD are then compiled, and aggregated as part of CDC's regular surveillance tracking. There is no duplication of the data/information collection.

A.5. Impact on Small Businesses or Other Small Entities

No small businesses participate in this data collection.

A.6. Consequences of Collecting the Information Less Frequently

Reports are collected annually in fulfillment of requirements outlined in Program Announcements CDC-RFA-EH14-1404 *Comprehensive Asthma Control Through Evidence-based Strategies and Public Health—Health Care Collaboration*. Less frequent reporting would negatively impact monitoring progress of national and state efforts to reduce the burden of asthma, and undermine accountability efforts at both levels. Asthma awardees routinely collect asthma ED visit and HD data annually. Requesting data at the same interval minimizes additional burden on asthma awardees. The yearly reporting rate allows the NACP to respond in a timely manner with up-to-date information to inquiries from Congress and other stakeholders. In terms of negative consequences, without this information the NACP will be less effective at helping state programs reach their target goals. There are no technical or legal obstacles to reducing burden.

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

There are no special circumstances related to AIRS, and this request fully complies with the regulation 5 CFR 1320.5.

A.8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A 60-day Federal Register Notice was published in the Federal Register on January 20, 2016, Vol. 81, No. 12, pp. 3144-3145 (Attachment 2). One public comment was received (Attachment 2a). No changes were made to the ICR based on this response, as the public comment did not relate to the utility and scope as proposed.

Consultation efforts have occurred throughout the system development process. A list of the selected data elements, necessary for program management and oversight, was developed by

the NACP internal workgroup with consultation and input from state partners in Oregon, California, Minnesota, New York and Connecticut.

Usability testing was completed for the data elements and the AIRS reporting spreadsheets. The spreadsheets were tested for usability by state volunteers: Montana, New Mexico, New York, Pennsylvania and Rhode Island. State program staff attempted to insert information into the spreadsheets and reported any technical problems, lack of clarity in the instructions, limitations in space, or other problems through the asthma1404@cdc.gov email address. CDC staff made adjustments accordingly before distributing final versions of the profiles, spreadsheets and instructions to all the awarded states.

Table 1: AIRS Performance Measure Consultations

Name	Title	Affiliation	Phone	Email
Rodney Garland	Epidemiologist	Oregon State Asthma Program	*(971) 673-1348*	Rodney.Garland@state.or.us
Meredith Milet	Epidemiologist	California State Asthma Program	*(510) 620-3634*	Meredith.Milet@cdph.ca.gov
Pam York	Principal Investigator	Minnesota State Asthma Program	*(651) 201-5659*	Pam.York@state.mn.us
Trang Nguyen, MD, DrPH	Epidemiologist	New York State Asthma Program	*(518) 474-2543*	Trang.Nguyen@health.ny.gov
Ava Nepaul	Evaluator	Connecticut State Asthma Program	*(860) 509-8239*	Ava.Nepaul@ct.gov

A.9. Explanation of Any Payment or Gift to Respondents

Respondents will not receive payments or gifts for providing information.

A.10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

This ICR was reviewed on 12/11/2015 by the NCEH/ATSDR ISSO (Information Systems Security Officer) who determined that the Privacy Act does not apply. Controls described are adequate for protecting aggregate and non-sensitive data. The data collection does not involve collection of sensitive and/or personally identifiable information. As this system does not collect personally identifiable information, there is no need for respondent consent. Information collected through progress reports is used to identify training and technical assistance needs; monitor compliance with cooperative agreement requirements; evaluate progress made in

achieving national and program-specific goals; and to respond to inquiries regarding program activities and effectiveness.

The respondents completing the reporting spreadsheets are the state asthma program staff, The AIRS reporting spreadsheets will be sent to a dedicated mailbox (asthma1404@cdc.gov). The spreadsheets will be stored on the Air Pollution and Respiratory Health Branch (APRHB) shared (S) drive along with narrative reports and other information that awardees submit annually. Each state asthma program awardee has access to its own information and surveillance data. The state decides the level of access for each user, and to what extent local partners may access that information. State cooperative agreement recipients are required to report periodically as a condition of their award from CDC. The information collected will be neither sensitive nor proprietary in nature. Reporting spreadsheets containing ED visit and HD data will be uploaded and stored on the APRHB's SharePoint site.

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

The AIRS does not collect sensitive information. No personal information is requested and no personal identifiers are reported. The NCEH/ATSDR Human Subjects Contact has determined that the data collection is not research involving human subjects and IRB approval is not required. (Attachment 4).

A.12. Estimates of Annualized Burden Hours and Costs

a) Estimated annualized burden hours

The respondents are identified as State Asthma Program Awardees. The number of respondents has been reduced from 36 to 23. Also, the frequency of reporting has been reduced from biannually to annually. Further, the total burden hours have been reduced from 288 to 82. Table 2 (below) displays the annualized report burden computations.

Table 2**:** Estimated Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
State Asthma	AIRS Performance	23	1	150/60	58

Program Awardees	Measures Reporting Spreadsheets				
	AIRS Emergency Department Visits Reporting Form	23	1	30/60	12
	AIRS Hospital Discharge Reporting Forms	23	1	30/60	12
Total					82

b) Estimated annualized cost to respondents

Estimates for the average hourly wage for respondents are based on the U.S. Department of Labor Bureau (DOL) of Labor Statistics May 2014 National Industry-Specific Occupational Employment and Wage Estimates (http://www.bls.gov/oes/current/oes_nat.htm#13-0000). Based on DOL data, the average hourly wage for a Management Analyst is estimated to be $38.89. The total estimated annualized cost is summarized in Table 3.

Table 3: Estimated Annualized Burden Hours

Type of Respondent	Form Name	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
State Asthma Program Awardees	AIRS Performance Measures Reporting Spreadsheets	58	$38.89	$2,256
	AIRS Emergency Department Visits Reporting Form	12	$38.89	$467
	AIRS Hospital Discharge Reporting Forms	12	$38.89	$467
Total				$3,190

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

The information system is designed to use existing hardware within funded sites. No capital or maintenance costs are expected. Additionally, there are no start-up, hardware or software costs.

A.14. Annualized Cost to the Federal Government

The annualized cost to the federal government of the total cooperative agreement is $14,894,400 as summarized in Table 4. The estimated annualized cost to the federal government of implementing AIRS, based on program experience in the previous three years is 5% of the total, or $744,720.

Major cost factors for AIRS, including application design and development costs, and system modification costs based on pilot testing and feedback from system users, have already been incurred with the initial implementation of the system. Currently, AIRS costs factors include, reviewing reports, providing feedback, synthesizing and analyzing the information, and making program recommendations and adjustments.

Table 4: Estimated Annualized Cost to the Federal Government

Category	Number of staff	% effort	Average Yearly salary	Total Costs
Cooperative agreements per year	n/a	n/a	n/a	$13.9M
Effort of project officers per year	5	100%	$73,900	$369,500
Effort of evaluation technical assistants per year	5	100%	$73,900	$369,500
Effort of epi/surveillance staff per year	1	80%	$88,000	$70,400

Effort of principal investigator per year	1	50%	$150,000	$75,000
Effort of senior management per year	2	25%	$150,000	$75,000
Travel for site visits per year	n/a	n/a	n/a	$35,000
Total costs of the cooperative agreement per year				$14,894,400
Costs of the AIRS component of cooperative agreement per year				$744,720

A.15. Explanation for Program Changes or Adjustments

This ICR was approved in 2010 and extended in 2013 for the previous cooperative agreement, *Addressing Asthma from a Public Health Perspective* (CDC-RFA-EH09-901). The awardees were required to develop and implement state-specific strategic and individual evaluation plans and to share findings with the NACP.

The current cooperative agreement, *Comprehensive Asthma Control Through Evidence-based Strategies and Public Health-Health Care Collaboration* (CDC-RFA-EH14-1404) includes the requirement that awardees report on NACP-developed PM.

These measures represent a subset of the information reported through the original AIRS as they focus on a limited number of strategies and activities, not all activities undertaken by the state. These measures also define criteria more specifically than the previous versions, so as to enable more meaningful aggregation of the information. The revised data collection will help state awardees demonstrate positive outcomes, build support for specific program strategies, monitor the effectiveness of interventions in different contexts, and support continuous quality improvement.

A revision to this data collection is necessary because: 1) the web-based reporting platform is no longer supported by CDC; 2) in collaboration with state asthma programs, reporting

requirements have been prioritized to provide specific information on the two main strategies in the associated Funding Opportunity Announcement (FOA): services and health systems strategies; 3) CDC now endorses limiting state program reporting to once a year; and 4) the number of awardees has been reduced from 36 to 23.

A.16. Plans for Tabulation and Publication and Project Time Schedule

a) Time schedule for the entire project

OMB approval is requested for three years and this request for revision would permit data collection to continue the duration of the program period (August 2019). A schedule for the collection of information is provided in Table 4 below.

Table 5: Timeline

Activity	Time Schedule
Performance measures, state-level ED visit and HD data	October 2016 – 2017
Performance measures, state-level ED visit and HD data	October 2017 – 2018
Performance measures, state-level ED visit and HD data	October 2018 - 2019

b) Publication plan

Information collected through AIRS is reported in internal NACP documents and shared with state programs. Aggregated information may also be included in reports to CDC leadership, Congress, and other stakeholders.

c) Analysis plan

The NACP does not use complex statistical methods for analyzing the PM. All PM information is aggregated and reported in internal documents. Statistical analyses are limited to simple tabulations.

The ED visit and HD data collection and analysis timeline begins with notifications sent to asthma state awardees outlining the data collection process one to two months after

OMB approvals. These notifications include instructions on submitting ED visit and HD data and details on the new process of using SharePoint to submit the data.

Three to eight months after OMB approval, the ED and HD datasets submitted through SharePoint will be downloaded, archived, and validated by CDC. Any issues/discrepancies will be resolved with states.

In the time period 10-12 months after OMB approval, final analysis occurs. In the final analysis, age-adjusted ED and HD visit rates per 100,000 population automatically calculated in the data collection templates are tabulated by state over time. Additionally, the overall aggregated HD age-adjusted rate per 100,000 population for all asthma state awardees is calculated and trended over time. These rates are then compared to the overall US HD rates per 100,000 values referenced from the National Hospital Discharge Survey (NHDS).

A.17. Reason(s) Display of OMB Expiration Date is Inappropriate

The display of the OMB expiration date is not inappropriate.

A.18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification statement.

List of Attachments

Attachment 1. Authorizing Legislation

Attachment 2. 60-day Federal Register Notice

Attachment 2a. Public Comment

Attachment 3a. AIRS Performance Measures Reporting Spreadsheets

Attachment 3a1. AIRS Performance Measures Reporting Spreadsheet Instructions

Attachment 3b. AIRS Emergency Department Visits Reporting Form

Attachment 3c. AIRS Hospital Discharge Reporting Forms

Attachment 3d1. AIRS Instructions for HD ED Data Submission

Attachment 3d2. AIRS Instructions for HD ED HowtoDocSharing

Attachment 4. AIRS Research Determination Form