State Oral Health Program Assessment

OSTLTS Generic Information Collection Request
OMB No. 0920-0879

Supporting Statement – Section A

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- **Purpose of the data collection:** CDC's Division of Oral Health (DOH) currently funds 21 states to build and/or maintain effective public health capacity for implementation, evaluation, and dissemination of best practices associated with oral disease prevention and improvement of oral health through Cooperative Agreement DP13-1307, State Oral Disease Prevention Programs. The proposed information collection will help DOH Identify needs and gaps in implementing state oral health programs in key areas, determine what resources state health departments need to improve state oral health program implementation, and provide insights into ways in which the technical assistance provided to state health departments can be improved.

- **Intended use of the resulting data:** The information collected will be used by DOH to inform resource development to support future state oral health program activities and improve technical assistance provided to states by DOH.

- **Methods to be used to collect data:** Data will be collected using an online survey and follow-up telephone interviews with a subset of survey respondents.

- **Respondent Universe:** The respondent universe for this information collection consists of 42 state oral health program staff (21 state oral health program directors and 21 state oral health program staff such as epidemiologists, community water fluoridation staff or school-based sealant program administrators) across 21 states funded by Cooperative Agreement DP13-1307. A subset (n=9) of the 21 state oral health program directors who participated in the online survey will be invited to participate in follow-up telephone interviews.

- **How data will be analyzed:** Statistical analyses of quantitative data and thematic analysis of qualitative data.

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 42 state oral health program staff (21 state oral health program directors and 21 state oral health program staff, such as epidemiologists, community water fluoridation staff or school-based sealant program administrators) across 21 states funded by Cooperative Agreement DP13-1307. A subset (n=9) of the 21 state oral health program

directors who participated in the online survey will be invited to participate in follow-up telephone interviews.

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]

Poor oral health has an impact on people's lives in many ways. Social, economic, psychological, and physical health are all influenced by oral health status. Tooth decay is one of the most common chronic conditions among children. More than 23% of children (ages 2 to 11 years) have untreated decay, which if left untreated can cause pain and infection and may lead to problems in eating, speaking, and learning.[1] Children from low-income households are more than twice as likely to have untreated tooth decay as children from high-income households. Similar disparities exist for racial/ethnic minorities. By age 15, nearly 60% of all adolescents will have experienced dental decay.[2] It has been estimated that approximately 51.7 million school hours annually are missed by school-aged children due to a dental problem or visit.[3]

The burden of oral disease is not limited to children and adolescents. The presence of extensive tooth loss, untreated caries, and untreated periodontal disease among older adults indicates that a sizable number may not have access to interventions effective for preventing and controlling oral disease. Among dentate adults aged 65 years and older, 25% have lost all their teeth. Racial and ethnic minorities were about twice as likely to have at least one tooth with a cavity in need of a restoration as were their non-minority counterparts. Older adults may have more difficulty accessing effective interventions to prevent and control oral disease than younger adults. One major barrier is lack of insurance, and many state Medicaid programs do not cover dental services for adults.[4] More than $100 billion is spent on oral health services each year.[5] Individuals and families bear much of the burden of costs of oral health care, spending $30 billion out-of-pocket on dental services, which ranks second only to prescription drug expenditures.[6]

Most oral diseases and conditions are preventable. Underutilized evidence-based preventive interventions exist and have been identified by the Community Preventive Services Task Force (Community Guide).An example is community water fluoridation, which prevents tooth decay among people of all ages, and is the most cost effective way to deliver the benefits of fluoride to all residents of a community. One CDC study found that in communities with more than 20,000 residents, every $1 invested in community water fluoridation yields about $38 in savings each year from fewer cavities treated. Another intervention highlighted in the Community Guide is the use of dental sealants—plastic coatings applied to the chewing surfaces of the back teeth where most decay occurs. These interventions remain underutilized because barriers exist to their implementation. Such barriers include lack of state basic capacity to support oral health, lack of dental insurance and access to clinical and community preventive services, low awareness of effectiveness and safety of these interventions, and costs associated with sustaining preventive programs, such as maintaining community water systems that deliver fluoridated water.

CDC's DOH currently funds 21 states to build and/or maintain effective public health capacity for implementation, evaluation, and dissemination of best practices associated with oral disease prevention and improvement of oral health through Cooperative Agreement DP13-1307, State Oral Disease Prevention Programs. As a part of this Co-Ag, there are two funding components. Three states (Hawaii, Idaho and New Hampshire) are funded under Component 1. These states implement the follow strategies: 1) develop program leadership and capacity; 2) develop and coordinate partnerships; 3) develop or enhance oral health surveillance; 4) build evaluation capacity; 5) assess facilitators/barriers to advancing oral health; 6) develop plans for state oral health programs and activities; and 7) implement communication activities to promote oral disease prevention. Eighteen states (Colorado, Connecticut, Georgia, Iowa, Kansas, Louisiana, Maryland, Michigan, Minnesota, Mississippi, New York, North Dakota, Rhode Island, South Carolina, Vermont, Virginia, West Virginia, and Wisconsin) are funded under Component 2. Component 2 states were required to conduct all the strategies for Component 1, in addition to implementing and maintaining delivery of evidence-based community and clinical preventive interventions to reduce tooth decay. These additional Component 2 strategies target vulnerable and underserved populations that could include Medicaid enrolled children and adolescents, rural populations, persons with low socio-economic status, and other identified groups that have inadequate access to community and clinical preventive services.

The proposed information collection will help DOH Identify needs and gaps in implementing state oral health programs in key areas, determine what resources state health departments need to improve state oral health program implementation, and provide insights into ways in which the technical assistance provided to state health departments can be improved.

The information collected will be used by DOH to inform resource development to support future state oral health program activities and improve technical assistance provided to states by DOH.

Overview of the Information Collection System

Data will be collected from 42 state oral health program staff via two methods: an online survey administered via Survey Monkey (see **Attachment A – Instrument: Online Survey – Word Version and Attachment B – Instrument: Online Survey – Web Version)** and follow-up telephone interviews (see **Attachment C — Instrument: Telephone Interview Guide**). These instruments will be used to gather information from state oral health program directors and program staff such as epidemiologists, community water fluoridation staff or school-based sealant program administrators regarding needs and gaps in implementing state oral health programs and barriers and facilitators to implementing and expanding state oral health programs.

For the online survey, the information collection instrument was pilot tested by 2 public health professionals. Feedback from this group was used to refine the questions and establish the estimated time required to complete the information collection instrument.

For the telephone interviews, input on the interview guide was obtained from 6 public health professionals. Feedback from this group was used to ensure questions were relevant and expanded upon information collected by the online survey. Because of our intent to limit the telephone interview to 60 minutes, we did not pilot test the telephone interview questions for time.

Items of Information to be Collected

Online Survey

The online survey instrument (see **Attachment A – Instrument: Online Survey – Word Version and Attachment B – Instrument: Online Survey – Web Version**) consists of 27 main questions of various types, including multiple response, interval (rating scales) and open-ended. The instrument will collect data on the following:

- Program leadership and staff capacity.
- Oral health coalitions.
- State oral health plan.
- Oral health surveillance.
- School-based/linked Sealant Programs.
- 3rd grade Basic Screening Survey.
- Community Water Fluoridation.
- CDC technical assistance

Telephone Interviews

The telephone interview guide (see **Attachment C – Instrument: Telephone Interview Guide**) consists of 11 open-ended questions. The telephone interview builds upon topics previously discussed in the online survey. It provides an opportunity for state oral health program staff to elaborate on the following:

- Oral health coalitions (and challenges with implementation).
- School-based sealant programs.

- Community water fluoridation facilitators and barriers.
- Impact of CDC funding on state oral health program.

2. Purpose and Use of the Information Collection

The proposed information collection will help DOH identify needs and gaps in implementing state oral health programs in key areas, determine what resources state health departments need to improve state oral health program implementation, and provide insights into ways in which the technical assistance provided to state health departments can be improved.

The information collected will be used by DOH to inform resource development to support future state oral health program activities and improve technical assistance provided to states by DOH.

3. Use of Improved Information Technology and Burden Reduction

Data will be collected via two methods: online survey and telephone interviews.

Online Survey

An online survey method was chosen because it allows respondents to complete and submit their responses electronically, reducing the overall burden on respondents. This information collection instrument (**see Attachment A – Instrument: Online Survey – Word Version and Attachment B – Instrument: Online Survey – Web Version**) was designed to collect the minimum information necessary for the purposes of this project (i.e., limited to 27 questions). Skip patterns have been incorporated to streamline the survey, further reducing overall burden on respondents**.**

Telephone Interviews

Telephone interviews can solicit in-depth, qualitative data. Staff will be able to ask clarifying questions in real time as needed during the information collection process. The data collection instrument (see **Attachment C – Instrument: Telephone Interview Guide**) was designed to collect the minimum information necessary for the purposes of this project (i.e., limited to 11 questions)**.** Additionally, the telephone interview will be limited to 60 minutes, minimizing the overall burden on respondents. Permission to record telephone interviews will be obtained prior to the start of the interview.

4. Efforts to Identify Duplication and Use of Similar Information

The information being collected through this activity has not been comprehensively or systematically collected via another activity. Every effort has been made by CDC's DOH to avoid duplication of data collection. DOH staff conducted an extensive review of related data collections previously administered including the Annual Synopsis of Association of State and Territorial Dental Directors (ASTDD) State Synopsis questionnaires from 2013 - present (see 1.

below), Basic Screening Survey (BSS) (see 2. below), Water Fluoridation Reporting System (WFRS) (see 3. below) and Chronic Disease Management Information System (CDMIS) (see 4. below). DOH evaluation staff identified and removed all duplicate questions from the Online Survey and Telephone Interview to ensure questions included in this proposed data collection are unique.

Relevant Data Collections by CDC and Other Agencies:

- **Annual Synopsis of Association of State and Territorial Dental Directors Survey** (herby referred to as State Synopsis): The State Synopsis is an annual questionnaire sent by ASTDD to state dental directors for all 50 states. The purpose is to collect information about human resources, programs and infrastructure in oral health departments within a state health department.[8]

- **Basic Screening Survey:** CDC-funded states are required to conduct at least one BSS every 3-5 years among third graders. State personnel conduct an open mouth examination of the status of the dentition (the arrangement or condition of the teeth in a particular species or individual) in a large sample of third graders from several schools in the state. BSS data is reported by CDC funded states to ASTDD. ASTDD manages the data, and reports select performance measures data to CDC. CDC displays this data on the Oral Health Data Portal.[9]

- **Water Fluoridation Reporting System:** States send these data directly to CDC. CDC analyzes the data and reports the data in several formats-on the general CDC, Division of Oral Health website, in the web application Oral Health Data, in a different application on the CDC website called My Waters Fluoride (MWF) and also reports this indicator to HP2020 every two years.[10]

- **Chronic Disease Management Information System (CDMIS) 0920-0739:** CDMIS is an online data reporting portal for administrative, performance measures, and evaluation data for CDC grantees. CDMIS does not provide key information about questions asked in the survey, in the areas of program leadership and staff capacity, oral health coalitions, state oral health plans, oral health surveillance, school-based/linked sealant programs, 3rd grade Basic Screening Survey, community Water Fluoridation and CDC technical assistance. Each state has access to their state-specific data only. Data from the CDMIS portal is not accessible to the general public.[11]

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:

- Identify needs and gaps in implementing state oral health programs in key areas (e.g., program leadership and staff capacity, oral health coalitions, state oral health plan, oral health surveillance, 3rd grade Basic Screening Survey, Community Water Fluoridation, CDC technical assistance)
- Develop resources for future state oral health program activities based on state-level information
- Provide targeted technical assistance to state oral health programs based on identified gaps and needs

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 April 27, 2017, Vol. 82, No. 80, pp 19371-19373. One non-substantive comment was received. CDC sent forward the standard CDC response.

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 and / or delegates will be speaking from their official roles.

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

This data collection is not research involving human subjects. No information will be collected that are of personal or sensitive nature.

12. Estimates of Annualized Burden Hours and Costs

Online Survey

The estimate for burden hours is based on a pilot test of the data collection instrument by 2 of 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 26 minutes (range: 20 – 32). For the purposes of estimating burden hours, the upper limit of this range (i.e., 32 minutes) is used.

Telephone Interviews

In order to reduce the burden to respondents, we will limit the telephone interviews to 60 minutes. Thus, we did not pilot test the data collection instrument for the telephone interviews. The maximum burden for the data collection instrument, including reviewing instructions, gathering needed information, and completing the instrument will be 60 minutes.

Estimates for the average hourly wage for all respondents are based on the Department of Labor (DOL) Bureau of Labor Statistics for occupational employment for dentists and epidemiologists http://www.bls.gov/oes/current/oes_nat.htm. Based on DOL data, an average hourly wage of $ $83.71 is estimated for state oral health program directors and an average hourly wage of $36.65 for state oral health program staff. Table A-12 shows estimated burden and cost information.

There will be a total of 42 respondents and 51 responses.

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
Online Survey	State Oral Health Program Directors	21	1	32 / 60	11	$83.71	$921
	State Oral Health Program Staff	21	1	32 / 60	11	$36.65	$403
Telephone	State Oral	9	1	60 / 60	9	$83.71	$753

Interview Guide	Health Program Directors						
	TOTALS	**51**	**1**		**31Hours**		**$2,077**

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 Deloitte contractors. The total estimated cost to the federal government is $37,900. 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
CDC Evaluator (GS-13, Step 4) Project oversight, lead on development of OMB package, instrument development, data collection, data analysis, dissemination; Consultation and oversight of evaluation team	300	$48	$14,400
CDC ORISE Fellow Instrument development, data collection, data analysis, quality control and report preparation.	125	$28	$3,500
Deloitte Contractors (n=2) Pilot testing, Quality control, data analysis, report preparation for telephone survey.	200		$20,000
Estimated Total Cost of Information Collection			**$37,900**

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

Online Survey

Information collected from the online survey will be stored in a secure environment maintained by the evaluation team within DOH. Once the survey is closed, responses will be downloaded from Survey Monkey into an Excel spreadsheet file. Data will be reviewed for completion and simple descriptive statistics will be run examining response frequencies. Depending on the response distribution, frequencies may be cross-tabulated to identify response similarities and differences between subgroups of respondents (e.g. Component 1 vs. Component 2 funded state health departments).

Telephone Interviews

All telephone interviews will be recorded and transcribed. Verbal permission to be recorded will be obtained from the participant prior to the beginning of the interview. Information from the telephone interviews will be stored in a secure environment maintained by the evaluation team within DOH. Each of the transcribed interviews will be compared against the recording to ensure accuracy. Thematic analysis will be used to analyze data. The qualitative software management program MAXQDA or a similar software will be used to code the interviews.

Following analysis of responses to all information collection instruments, key findings will be shared in aggregate form with project staff, partner organizations and the respondents who participated in this information collection. Additionally, staff at CDC will condense key findings from the online survey and telephone interviews, refine them into a manuscript format, and submit for publication in a scientific journal.

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 (online survey)..... (3 weeks)
- ❑ Conduct data collection (telephone interview)..... (5 weeks)
- ❑ Code data, conduct quality control, and analyze data..... (3 months)
- ❑ Prepare summary report(s) ..... (4months)
- ❑ Disseminate results/reports ..... (2months)

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. Attachment A – Instrument: Online Survey- Word Version
B. Attachment B – Instrument: Online Survey- Web Version
C. Attachment C – Instrument: Telephone Interview Guide

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.
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