Public Health Emergency Response: Needs Assessment of Leadership Training and Exercises in Incident Management

OSTLTS Generic Information Collection Request
OMB No. 0920-0879

Supporting Statement – Section A

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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 762 respondents. Specifically, the respondent universe includes 730 preparedness leads of state,

territorial, and local health departments, including Program Directors of the 62 Public Health Emergency Preparedness (PHEP) cooperative agreement jurisdictions and 668 preparedness coordinators representing distinct local health departments (one preparedness coordinator per local health department). The respondent universe includes 32 additional participants drawn from registered attendees at the 2019 NACCHO Preparedness Summit representing state/territorial and local health department officials who have served or will serve in public health emergency response leadership roles (see **Attachments A – Respondent Universe** and **Attachment B – Sample of Respondents**).

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]

Among the highest priorities at the Centers for Disease Control and Prevention (CDC) are the core missions to inform, educate, and empower audiences regarding health issues and to ensure a competent public health and personal health care workforce. In accordance with these aims, the CDC has, for over fifteen years, supported efforts to enhance the ability of state, territorial, and local health departments to respond effectively to public health emergencies. A major component of these efforts has focused on training public health staff to carry out specialized job duties and serve in key roles during emergencies. In this context, training and exercise programs have also served as key educational methods for conveying and cultivating the appropriate emergency management knowledge, skills, abilities, and attitudes (KSAA) among public health emergency responders.

Although there is a solid evidence base for leadership training in public health, there is scant information to describe training needs for cohorts of current or future public health emergency response leaders. The limited evidentiary basis for developing public health emergency response leaders emphasizes technical skills and competencies, but also points to growing recognition for character and "soft skills" (e.g., resilience, decision-making under stress) in developing dynamic and adaptable leaders.[2, 3, 4, 5] While leadership development frameworks, models, and initiatives are available to some state, territorial, and local health departments through public, private, and academic partnerships (i.e., Public Health Leadership Institute [PHLI], Preparedness and Emergency Response Learning Centers [PERLC]), it is important to point out that not all agencies have direct access to these programs and partnerships.[6,7,8,9] Knowing where to seek reliable, high

quality educational or related professional development opportunities related to public health emergency response is a challenge in many state, territorial, and local health departments. Furthermore, crisis/emergency management is often just one of several established training priorities of such programs. Few offer specialized and dedicated focus on incident management leaders that are widely accessible to all state, territorial, and local health departments. [10, 11, 12]

This CDC-led information collection effort will gather data on state, territorial, and local health department needs related to training and exercises for public health personnel who will serve in a leadership role during a public health emergency response. This data collection is also intended to directly highlight barriers and facilitators to developing, delivering, supporting, or accessing training and exercises by health department staff as well as to identify current and emerging trends, knowledge, and professional opinions about training for public health emergency response leadership. Information collected will be used by CDC to develop strategic priorities and practical recommendations to improve leadership training for public health emergency responders at the state, territorial, and local levels. This may include using information to design, leverage, or modify existing trainings to meet identified leadership training needs, emphasizing those strategies and activities that are deemed most viable and cost-effective.

CDC, in collaboration with the Institute for Public Research at the CNA Corporation (CNA), Johns Hopkins University (JHU), and the National Association of County and City Health Officials (NACCHO) will conduct this information collection. CNA, the funded prime contractor for this project, will be responsible for the overall organization, conduct, and analysis of focus groups, as well as report preparation for this component of the information collection. JHU, a CNA sub-contractor, will be responsible for the overall organization, conduct, and analysis of the web-based assessment, as well as report preparation from this component of the information collection. NACCHO, a sub-contractor of JHU, will be responsible for recruiting respondents for the web-based assessment, serving as the clearinghouse for communication with potential local health department respondents, and collating and de-identifying web-based assessment data. In addition, NACCHO will recruit participants and provide the venue for in-person focus groups.

Overview of the Information Collection System

Information will be collected through a web-based assessment instrument and focus groups (see **Attachment C – Web-Based Assessment, Word Version** and **Attachment D – Web-Based Assessment, Web Version**) and (see **Attachment E– Focus Group Facilitation Guide, Word Version**).

In total, the combined respondent universe across both information collection methods is 762. The respondent universe for the *web-based assessment* consists of 730 preparedness leads of state, territorial, and local health departments that include Program Directors of the 62 Public Health Emergency Preparedness (PHEP) cooperative agreement jurisdictions (50 states, eight territories and freely associated states, and four large metropolitan areas); and 668 preparedness coordinators representing distinct local health departments (one preparedness coordinator per local health department).

The respondent universe for the *focus groups* includes 32 participants, separately recruited and drawn from registered attendees at the 2019 NACCHO Preparedness Summit representing

state/territorial and local health department officials who have served or will serve in public health emergency response, not exclusively in leadership roles, and voluntarily wish to participate. Informed by published peer-reviewed literature suggesting that three to six focus groups are sufficient to discover 90% of key themes and reach thematic saturation, a total of four in-person focus groups will be conducted at the 2019 NACCHO Preparedness Summit. [13] This will include two in-person focus groups with state/territorial health department officials and two in-person focus groups with local health department officials; each focus group will include up to eight participants.

A total of nine public health professionals pilot tested the web-based assessment instrument and participated in a pilot focus group discussion. Feedback was used to refine the instruments as needed, and in the case of the web-based instrument, ensure accurate programming and skip patterns. Feedback was also obtained to establish the estimated time required to complete the information collections.

Items of Information to be Collected

Web-based Assessment

The web-based assessment instrument will collect data on key areas that link to state, territorial, and local health department needs related to training and exercise for public health personnel who will serve in a leadership role during a public health emergency response. It will also collect data on barriers and facilitators to developing, delivering, supporting, or accessing training and exercises by health department staff. Accordingly, the web-based assessment instrument incorporates structured questions and responses, and is divided into four sections that encompasses organizational demographics, the desired state of training and exercises among state and local health departments, the current state of training and exercises among state and local health departments, and key barriers to training and exercises for developing public health emergency response leaders. Structurally, the web-based assessment instrument consists of 23 questions of various types, including multiple response and interval evaluation (rating scales).

- **Section I – Demographics (organizational)**
  Questions 1-9 will collect information related to governance structure, type of agency, size of population served, and size of agency, as well as frequency of activations for real-world events and exercises and the level of importance of various criteria used by the agency in selecting emergency response leadership.
- **Section II - Desired State of Training and Exercises among State/Territorial and Local Health Departments**
  Questions 10-13 will collect information pertaining to the level of importance to the agency of particular types of technical, role-specific, and leadership/management training requirements.
- **Section III - Current State of Training and Exercises among State/Territorial and Local Health Departments**
  Questions 14-18 will collect information pertaining to the current availability of leadership training programs or curricula, as well as the current availability of technical, role-specific, and leadership/management training.

- **Section IV - Key Barriers to Training and Exercises for Developing Public Health Emergency Response Leaders**
  Questions 19-23 will collect information on agency perspectives regarding the suitability and accessibility of training and exercise as well as factors that limit the ability of agency's staff to participate or limit the ability of the agency to provide emergency response leadership training and exercises.

Focus Group Facilitation Guide
The focus group facilitation guide consists of nine main questions, along with supporting probing questions to prompt organic, dynamic, and interactives discussions for identifying key themes with contextual descriptions. Focus groups will collect data on key areas that link to barriers and facilitators to developing, delivering, supporting, or accessing training and exercises by health department staff; and current and emerging trends, knowledge, and professional opinions about training for public health emergency response leadership.

2. Purpose and Use of the Information Collection

The purpose of this information collection is to: 1) Identify state, territorial, and local health department needs related to training and exercises for public health personnel who will serve in a leadership role during a public health emergency response; 2) Highlight barriers and facilitators to developing, delivering, supporting, or accessing training and exercises by health department staff and; 3) Identify current and emerging trends, knowledge, and professional opinions about training for public health emergency response leadership.

Information collected will be used by CDC to develop strategic priorities and practical recommendations to improve leadership training for public health emergency responders at the state, territorial, and local levels. This may include using information to design, leverage, or modify existing trainings to meet identified leadership training needs, emphasizing those strategies and activities that are deemed most viable and cost-effective.

3. Use of Improved Information Technology and Burden Reduction

Data will be collected via a web-based data collection instrument administered through Qualtrics (Provo, UT, 2009). This method was chosen to reduce the overall burden on respondents by enhancing ease of completion through simple, but secure, access to the assessment tool and allowing for completion at a time convenient to the respondent. Data will also be collected through focus groups, which will be conveniently held during two days of the 2019 NACCHO Preparedness Summit. The data collection instruments were designed to collect the minimum information necessary for the purposes of this project (i.e., limited to 23 questions for the web-based assessment and nine focus group questions).

It is necessary and important to collect information using both formats given the key distinctions between the substantive content of the information collected. Specifically, while both instruments have scripted questions, responses to the web-based assessment are limited to structured choices to aid data aggregation and interpretation for *quantitative analysis* (i.e., descriptive reporting,

statistical inferences), whereas the focus groups provide a platform to facilitate organic and dynamic discussions with context to identify and distill key themes through *qualitative analysis*.

4. Efforts to Identify Duplication and Use of Similar Information

Efforts were made to identify duplication and use of similar information, including a comprehensive literature review on the topic of leadership training for public health emergencies as well as an environmental scan to identify any other assessments conducted on PHEP. The information gathered through this data collection request is not available from other data sources or through other means nor does it duplicate any information currently being collected. Although 0920-0879 has been utilized to approve related collections (e.g., MCM-Needs), these collections differed in purpose and scope. No assessments past or planned have examined needs related to training, exercises, or professional development opportunities for public health emergency response leaders.

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 state, territorial, and local health department needs related to training, exercise, or related professional development opportunities for public health personnel who have served or will serve in a leadership role during a public health emergency response;
- Characterize barriers and facilitators in developing, delivering, supporting, or accessing training, exercises, and related professional development opportunities by health department staff;
- Develop evidence- and needs-based strategic priorities and practical recommendations to improve leadership training for public health emergency responders at the state, territorial, and local levels.

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, including its National Center for Health Statistics, 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) 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 or participants.

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

The Privacy Act does not apply to this data collection. State, territorial, and local health department staff will be speaking from their official roles.

Only the project's contractor team—CNA, JHU, and NACCHO—will collect and have access to some business contact information. The collection of this information is exclusively for the purpose of scheduling and providing reminders for participation in focus groups.

Business contact information will not be shared with CDC. Information collected will be stored on the contractor team's password-protected computers and destroyed upon conclusion of the project.

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

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

12. Estimates of Annualized Burden Hours and Costs

The estimate for burden hours is based on a pilot test of both data collection instruments by a total of nine public health professionals.

For the web-based assessment, in the pilot test, the time to complete the instrument including time for reviewing instructions, gathering needed information and completing the instrument, ranged between 15 – 20 minutes. For the purposes of estimating burden hours, the upper limit of this range (i.e., 20 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 Manager** at state (https://www.bls.gov/ncs/ocs/sp/nctb1480.pdf) and local (https://www.bls.gov/ncs/ocs/sp/nctb1481.pdf) governments. Based on DOL data, a median hourly wage of **$51.10 (State Medical and Health Services Manager)** is estimated for a maximum of 58 respondents from 50 PHEP states and 8 PHEP territories. An average hourly wage of **$41.90 (Local Medical and Health Services Manager)** is estimated for a maximum of 672 local health department (4 PHEP metropolitan jurisdictions and 668 additional local health departments) respondents.

For focus groups, in the pilot test, the time to complete a review of focus group instructions and discussions of questions within the guide ranged from 60 – 75 minutes. For the purposes of estimating burden hours, the upper limit (i.e., 75 minutes) was used.

Estimates for the average hourly wage for participants are based on the DOL Bureau of Labor Statistics for occupational employment for **Medical and Health Services Manager** at state (https://www.bls.gov/ncs/ocs/sp/nctb1480.pdf) and local (https://www.bls.gov/ncs/ocs/sp/nctb1481.pdf) governments. Based on DOL data, a median hourly wage of **$51.10 (State Medical and Health Services Manager)** is estimated for state- and territorial-level participants; and an average hourly wage of **$41.90 (Local Medical and Health Services Manager)** is estimated for local-level participants.

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
Web-based Assessment	Directors of Public Health Preparedness across state/territorial health departments	58 (50 PHEP states and 8 territories)	1	20/60	19	$51.10	$971
Web-Based Assessment	Directors of Public Health Preparedness across local health departments	672 (4 PHEP metropolitan and 668 local health departments)	1	20/60	224	$41.90	$9,386
Focus Group	Directors of Public Health Preparedness across state health departments	16 (separate from web-based assessment respondents)	1	75/60	20	$51.10	$1,022
Focus Group	Directors of Public Health Preparedness across local health departments	16 (separate from web-based assessment respondents)	1	75/60	20	$41.90	$838
	TOTALS	**762**	**1**		**283**		**$12,217**

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 and benefits of CDC staff and contractors to develop the data collection instrument, collect data, and perform data analysis. The total estimated cost to the federal government is **$292,319.**

Table A-14 describes how this cost estimate was calculated.

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

Staff (FTE) (May 2018 – April 2019; 52 weeks)	Average Hours per Collection	Average Hourly Rate (Assuming Step 5)	Average Cost
CDC Staff Time			
Science Officer (GS-15) Project oversight; review report	208 (4 hours/week)	$69.17	$14,387
Behavioral Scientist (GS-14) Provide input for survey methodology and instrument development; lead PRA package development coordination; review report	104 (2 hours/week)	$58.80	$6,115
Emergency Management Specialist (GS-12) Provide input for survey methodology and instrument development; overall project management and coordination, review report	260 (5 hours/week)	$41.85	$10,881
Medical Officer (GS-14) Provide input for survey methodology and instrument development; lead coordination with NACCHO partnership, review report	208 (4 hours/week)	$58.80	$12,230
Subtotal			$43,613
Contractor Staff Time			
CNA (3 staff members) (minus JHU subcontract)			$136,889
JHU (3 staff members) (minus NACCHO subcontract)			$99,817
NACCHO (1 staff member)			$12,000
ESTIMATED TOTAL COST OF INFORMATION COLLECTION			**$292,319**

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

CDC, in collaboration with CNA and JHU, will analyze the de-identified data from CNA, JHU, and NACCHO through a mix of quantitative methods, including descriptive and statistical analysis, as appropriate, with emphasis on the *organizational/programmatic* level for the web-based assessment responses and qualitative methods and thematic analysis for focus group responses. For the web-based assessment, analyses will explore at the *organizational/programmatic* level (1) differences in opportunities for leadership training/exercises for public health emergency response among health departments based upon type of governance structure, size of population served, and geographic location; and (2) differences in barriers to leadership training/exercises for public health emergency response among health departments based upon type of governance structure, and size of population served, and geographic location. For the focus groups, thematic analyses will center on (1) existing public health emergency response leadership training and exercises; (2)

types of additional trainings and resources that are needed in the field; and (3) ways in which public health emergency response leadership training can be supported.

CDC will use findings to develop strategic priorities and practical recommendations to improve leadership training for public health emergency response leaders at the state, territorial, and local levels. These will directly facilitate essential public health services to inform, educate, and empower people, as well as to ensure a competent public health workforce. In support of the designated essential public health services, specific products will include short- and long-term strategies and approaches to foster the growth and development of public health emergency response leaders in the future. CDC intends to use information collected during this project to design, modify, or enhance existing resources or trainings to meet identified leadership training needs, emphasizing those strategies and activities that are deemed most viable and cost-effective.

All information collected will be kept on secure, password-protected servers. Any reporting products will only include aggregate information.

Project Time Schedule

- ✓ Design instruments ..... (COMPLETE)
- ✓ Develop protocol, instructions, and analysis plan ..... (COMPLETE)
- ✓ Pilot test instruments ..... (COMPLETE)
- ✓ Prepare OMB package ..... (COMPLETE)
- ✓ Submit OMB package ..... (COMPLETE)
- ❑ OMB approval ..... (TBD)
- ❑ Conduct data collection ..... (Open 6 weeks)
- ❑ Code data, conduct quality control, and analyze data.....(8 weeks after assessment closes)
- ❑ Prepare summary report(s) ..... (4 months)
- ❑ Disseminate results/reports ..... (TBD)

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

Attachment A – Respondent Universe
Attachment B – Sample of Respondents
Attachment C – Web-Based Assessment, Word Version
Attachment D – Web-based Assessment, Web Version
Attachment E – Focus Group Facilitation Guide, Word Version

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