

Asthma Information Reporting System (AIRS)

OMB Control No. 0920 - 0853 (Expiration Date: 6/30/2019)

Request for 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

Date: February 6, 2019

Table of Contents

A.1. Circumstances Making the Collection of Information Necessary.....	3
A.2. Purpose and Use of the Information Collection.....	5
A.3. Use of Improved Information Technology and Burden Reduction.....	6
A.4. Efforts to Identify Duplication and Use of Similar Information.....	7
A.5. Impact on Small Businesses or Other Small Entities.....	7
A.6. Consequences of Collecting the Information Less Frequently.....	7
A.7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5.....	7
A.8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency.....	8
A.9. Explanation of Any Payment or Gift to Respondents.....	8
A.10. Protection of the Privacy and Confidentiality of Information Provided by Respondents.....	8
A.11. Institutional Review Board (IRB) and Justification for Sensitive Questions.....	9
A.12. Estimates of Annualized Burden Hours and Costs.....	9
A.13. Estimates of Other Total Annual Cost Burden to Respondents and Record Keepers.....	11
A.14. Annualized Cost to the Federal Government.....	11
A.15. Explanation for Program Changes or Adjustments.....	12
A.16. Plans for Tabulation and Publication and Project Time Schedule.....	13
A.17. Reason(s) Display of OMB Expiration Date is Inappropriate.....	14
A.18. Exceptions to Certification for Paperwork Reduction Act Submissions.....	15
List of Attachments.....	16

Part A. Justification

Goal of the study: The purpose of this information collection (IC) is to continue CDC's monitoring of grantee 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 collects 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 Funding Opportunity (NOFO) Announcement.

Subpopulation to be studied: 25 cooperative agreement awardees (24 state health departments and one territory health department).

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. In September 2016, two additional awardees were funded under the cooperative agreement entitled, *Comprehensive Asthma Control Through Evidence-based Strategies and Public Health-Health Care Collaboration* (CDC-RFA-EH16-1606, program period: September 2016 – August 2019), bringing the total number of awardees to 25.

All funded states and territories 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 and territories provide work plans, evaluation plans, and report minimum data elements that are used to evaluate the program at the national level. The purpose of this revision is to provide continuity of information collection for the remainder of the fifth and final year of CDC-RFA-EH14-1404, *Comprehensive Asthma Control Through Evidence-based Strategies and Public Health—Health Care Collaboration*, and the third and final year of CDC-RFA-EH16-1606, *Comprehensive Asthma Control Through Evidence-based Strategies and Public Health—Health Care Collaboration*. This revision ICR will be discontinued at the end of the program period.

The CDC is requesting to revise the information collection request (ICR) titled *Asthma Information and Reporting System (AIRS)* (OMB Control No. 0920-0853, expiration date 6/30/2019) and obtain approval for a 12-month Paperwork Reduction Act (PRA) clearance. In addition to increasing the number of awardees from 23 to 25 and increasing the requested burden hours from 82 to 89, the following revisions are requested:

- 1) While keeping the same 18 performance measures (PMs) 5 that were most useful early in the funding cycle are now optional, to be reported at the discretion of the grantee. This is in accordance with language in both Notice of Funding Opportunity (NOFO) announcements that “To ensure that data collection resources are used effectively, CDC will periodically review the use of performance measures and discontinue collection of any that are not informative.”
- 2) The instructions for the data collection instruments have been updated to reflect the new optional status of some PMs and to clarify certain instructions that were commonly misinterpreted.
- 3) The Emergency Department Data and Hospital Discharge Data reporting forms have been updated to include example data submission templates for each awardee. A tab labeled “Technical Notes” was added to collect clarifying information about the data from each awardee.
- 4) Examples of Emergency Department Data and Hospital Discharge Data reporting forms have been added to provide clarity on how data should be reported within the forms.
- 5) Respondent costs were updated to reflect current wage data from 2017.

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 Attachments 1a and 1b). The 60-day

Federal Register Notice was published on 12/06/2018 (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 continue 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. For example the PM allow us to report the number and age distribution of people reached with intensive asthma self-management education through the grantees and their partners
- Help the branch align its current interventions with CDC goals and allowed the monitoring of progress toward these goals. For example, grantee efforts to establish public health –health care collaboration has been integrated into CDC's 6|18 initiative which connects healthcare purchasers, payers, and providers with CDC researchers, economists, and policy analysts to find ways to improve health and control costs with the 6|18 interventions
- Allow the NACP and the state asthma programs to make more informed decisions about activities to achieve objectives. For example, PM information identified a problem with enrolling patients most in need of intervention into grantee programs. This lead to cross-state discussions and changes in recruitment strategies.
- 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.
- Provide feedback to the grantees about their performance relative to others through the distribution of two written reports and several presentations (webinar and in-person) summarizing the results.
- Motivate use of data and evaluation findings. For example, the requirement to report actions taken based on evaluation findings encourages program managers and health departments officials to act on recommendations in evaluation reports.

Over the past three years, CDC reviewed all PM information provided by awardees and worked with awardees to ensure internal consistency of information, and consistency in reporting

across states. A report of aggregated data from AIRS was prepared for each funding cycle and distributed to the awardees and other stakeholders. CDC held webinars with awardees to present key findings and answer questions.

CDC used each awardees' performance measures and evaluation findings in one-on-one technical assists with a focus on action planning for program improvement. The analysis of performance measures and synthesis of evaluation findings across awardees guided CDC's technical assistance approach and supported the creation of a data-driven community of practice in which awardees shared successful models as well as program challenges.

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 and examples for the ED visit and HD surveillance data (Attachments 3b, 3b1, 3c and 3c1). The instructions (Attachments 3a1, 3d1, and 3d2) clarify the procedures for filling out the PM spreadsheets. AIRS allows for simple electronic reporting that 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.

AIRS 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 and CDC-RFA-EH16-1606, *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

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 12/06/2018, Vol. 83, No. 234, pp. 62866 (Attachment 2).

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 A.8.1: 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 12/06/2018 by the NCEH/ATSDR Information Systems Security Officer (ISSO) 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 Asthma and Community Health Branch (ACHB) shared (S) drive along with narrative reports and other information that awardees submit annually. Each state and territory asthma program awardee has access to its own information and surveillance data. The state/territory decides the level of access for each user, and to what extent local partners may access that information. State/territory 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 ACHB'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 State and Territory Asthma Program Awardees. The number of respondents has been increased from 23 to 25 due to increased funding, which allowed the addition of two awardees. Past experience with awardees funded by the Program informed the estimate of burden hours for the responses listed in Table A12.1. Data will

be collected annually. Table A12.1 (below) displays the annualized report burden computations.

Table A12.1: 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 Program Awardees	AIRS Performance Measures Reporting Spreadsheets	25	1	150/60	63
	AIRS Emergency Department Visits Reporting Form	25	1	30/60	13
	AIRS Hospital Discharge Reporting Forms	25	1	30/60	13
Total					89

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 2017 National Industry-Specific Occupational Employment and Wage Estimates (https://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 \$44.92. The total estimated annualized cost is summarized in Table A12.2.

Table A12.2: 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	63	\$44.92	\$2,830

	AIRS Emergency Department Visits Reporting Form	13	\$44.92	\$584
	AIRS Hospital Discharge Reporting Forms	13	\$44.92	\$584
Total				\$3,998

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 \$15,894,400 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 \$794,720.

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	\$14.9M

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				\$15,894,400
Costs of the AIRS component of cooperative agreement per year				\$794,720

A.15. Explanation for Program Changes or Adjustments

In September 2016, two additional awardees were funded under the cooperative agreement entitled, *Comprehensive Asthma Control Through Evidence-based Strategies and Public Health-Health Care Collaboration* (CDC-RFA-EH16-1606, program period: September 2016 – August 2019), bringing the total number of awardees to 25.

In addition to increasing the number of awardees from 23 to 25 and increasing the requested burden hours from 82 to 89, the following revisions are requested:

- 1) Five of the 18 required PMs are now optional, to be reported at the discretion of the grantee. This is in accordance with language in both NOFOs that “to ensure that data collection resources are used effectively, CDC will periodically review the use of performance measures and discontinue collection of any that are not informative.”
- 2) The instructions for the data collection instruments have been updated to reflect the new optional status of some PMs and to clarify certain instructions that were commonly misinterpreted. Changes from the previous instructions to the current instructions are outlined in attachments 3d1a and 3d2a (tracked changes versions of the instructions).
- 3) The Emergency Department Data and Hospital Discharge Data reporting forms have been updated to include example data submission templates for each awardee. A tab labeled “Technical Notes” was added to collect clarifying information about the data from each awardee.
- 4) Examples of Emergency Department Data and Hospital Discharge Data reporting forms have been added to provide clarity on how data should be reported within the forms.
- 5) Respondent costs were updated to reflect current wage data from 2017.

A revision to this data collection is necessary because: 1) the number of awardees has been increased from 23 to 25; 2) the burden hours have increased from 82 to 89 as a result of the two additional awardees; 3) in an effort to reduce burden on awardees, the program has reduced the number of PMs that are required and increased the number of optional PMs to 5 out of the 18; and 4) instructions for data collection instruments have been updated to reflect changes in PM requirements and to increase clarity based on feedback from awardees.

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

- a) Time schedule for the entire project

OMB approval is requested for twelve months and this request for revision would permit data collection to continue through 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 2018 – October 2019

b) Publication plan

Information collected through AIRS is reported in internal NACP documents and shared with state programs. Results are presented during webinars with grantees during which the implications of the finding are discussed and questions answered. 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 month 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 six 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 six-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 1a. Authorizing Legislation – 42 USC Section 241
- Attachment 1b. Authorizing Legislation – 42 USC Section 247b
- Attachment 2. 60-day Federal Register Notice
- Attachment 3a. AIRS Performance Measures Reporting Spreadsheets
- Attachment 3a1. AIRS Performance Measures Reporting Spreadsheet Instructions
- Attachment 3b. AIRS Emergency Department Visits Reporting Form
- Attachment 3b1. AIRS Emergency Department Visits Reporting Example
- Attachment 3c. AIRS Hospital Discharge Reporting Form
- Attachment 3c1. AIRS Hospital Discharge Reporting Example
- Attachment 3d1. AIRS Instructions for HD ED Data Submission_clean
- Attachment 3d1a. AIRS Instructions for HD ED Data Submission_tracked changes
- Attachment 3d2. AIRS Instructions for HD ED HowtoDocSharing_clean
- Attachment 3d2a. AIRS Instructions for HD ED HowtoDocSharing_tracked changes
- Attachment 4. AIRS Research Determination Form