Synopses of State Dental Public Health Programs

Supporting Statement A

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JUSTIFICATION SUMMARY

Goal of the project: To assist states in tracking state oral health programs' efforts and challenges to inform program and policy planning and to improve oral health and general health of Americans.

Intended use of the resulting data: The Synopses of State Dental Public Health Programs collects data on state oral health programs' infrastructure and capacity, with summary data report and state responses published on CDC's partner hosted website and with state responses on selected questions published on CDC's public-facing website. The data are intended to: 1) facilitate state monitoring of oral health program infrastructure and capacity and compare to other states; 2) track program changes and challenges to inform planning and evaluation of oral health programs and policies; 3) measure state progress towards the Healthy People oral health objective; and 4) educate the public and policy makers regarding cross-cutting public health programs. CDC also uses the data to evaluate performance of CDC oral health funding recipients.

Methods to be used to collect: Each year, state oral health programs from 50 states and Washington, D.C., are invited to complete the synopsis questionnaire and submit responses through email or online to CDC's partner, the Association of State and Territorial Dental Directors (ASTDD). ASTDD administers data collection, data entry and verification, and email state data to CDC. Every three years, CDC and ASTDD will review and update the questionnaire.

The subpopulation to be studied: Not applicable to this information collection. This questionnaire is sent to all states with dental public health programs to get feedback on their respective programs and progress.

How data will be analyzed: Verification on state responses (e.g., logic errors) is performed by ASTDD; follow-ups are conducted with states as needed to make corrections. CDC and ASTDD perform simple analyses to summarize program characteristic distributions and changes over time.

A. JUSTIFICATION

A1. Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) requests a three-year OMB approval for an existing collection in use without an OMB control number to collect information about human resources, programs, and infrastructure in oral health departments within a state health department for all 50 states and D.C. CDC and is authorized to collect the information under the Public Health Service Act, Title 42, Section 247b–14, Oral Health Promotion and Disease Prevention, and Section 301, copies of which can be seen in Attachment 1.

Oral health affects our ability to eat, speak, smile, and show emotions. Oral health also affects a person’s self-esteem, school performance, and attendance at work or school (HHS, 2000). Oral diseases—which range from cavities and gum disease to oral cancer—cause pain and disability for millions of Americans and cost taxpayers billions of dollars each year (Manski and Rohde, 2017). CDC supports states in their efforts to reduce oral disease and improve oral health by using effective interventions. CDC provides state and territorial health departments with funding, guidance, and technical assistance to monitor oral disease across populations and to implement and evaluate oral health interventions.

The Association of State and Territorial Dental Directors (ASTDD) is a national non-profit organization representing the dental directors and staff of state public health agency programs for oral health. ASTDD was organized in 1948 and is one of 20 affiliates of the Association of State and Territorial Health Officials (ASTHO). ASTDD activities include: formulating and promoting the establishment of national dental public health policy; assisting state dental programs in the development and implementation of programs and policies for the prevention of oral diseases; building awareness and strengthening dental public health professionals' knowledge and skills by developing position papers and policy statements; providing information on oral health to health officials and policy makers; and conducting conferences for the dental public health community. Note: The word “state” is used to indicate states, the District of Columbia, US territories, and other US-associated jurisdictions, except where explicitly noted otherwise.

In 1994, ASTDD originated the annual Synopses of Dental Programs to share information among dental directors and partners. The Synopses of State Oral Health Programs (herby referred to as State Synopses or questionnaire) described program activities and successes and the challenges that programs faced during the previous year. In 1997, ASTDD changed the format to a more structured questionnaire. Since 1998, ASTDD has been supported to collect data through cooperative agreements with CDC. This collection includes questions regarding general state dental public health information, workforce updates, program administration details, budget statuses, dental sealant program information, oral health surveillance efforts, and additional programs facilitated by state oral health programs but does not share any private or sensitive information about respondents. This collection is necessary because no other agency or entity produces similar analyses or reports, and the State Synopsis is the only national

data collection source tracking states' efforts to improve oral health and contributions to progress toward the national targets for Healthy People objectives for oral health.

A2. Purpose and Use of the Information Collection

The purpose of the State Synopses is for CDC and ASTDD to obtain current information from each state annually on demographic, infrastructure, workforce, and administrative factors that impact the state's oral health program. In addition, each state is asked to provide detailed information on the services they provide to their constituents. The State Synopsis collects demographic information on the population served, state oral health infrastructure (i.e., population served by community water fluoridation), workforce (i.e., dental hygienists in state), administration, oral health surveillance, and programs funded by state. Information is collected by ASTDD annually, through a State Synopsis in MS Word format or an online survey. A copy of the Word version of the questionnaire with instructions for respondents can be seen in Attachment 2a. A copy of the online version of the survey with instructions can be seen in Attachment 2b.

There is a need for CDC to gain insights on issues or inconsistencies in the results of their funding. Additionally, there is a need for states to be able to share information and develop learnings from one another to improve programs and share knowledge. Without this comprehensive set of information, ASTDD and CDC would not have the data points and feedback necessary to maximize the utility of funding to reach the aforementioned program goals and states would not have insight on how to improve efforts internally. States, ASTDD, federal agencies, and other stakeholders would no longer have a data source to compare states' progress from year to year for a given state or for a set of states. Data that has previously been used to inform grant writing, program planning, policy making, budget appropriations, and evaluation will no longer be available. Some Healthy People objectives would no longer have a source to measure progress. Therefore, the information collected is used to assess trends in budget, staffing, infrastructure, and programs. States use the data to compare their services to the services offered by other states and a portion of the data is used to develop indicators that are used to populate the data visualization tools on the CDC Oral Health Portal.

The State Synopsis includes select indictors, which are included in the National Oral Health Surveillance System (NOHSS) established in 1999 through a collaboration with ASTDD, CDC, and the Council of State and Territorial Epidemiologists (CSTE). NOHSS helps states identify standardized oral health surveillance indicators based on data available to most states and aligned with Healthy People measures to understand their burden and facilitate state comparisons.

CDC launched a public-facing web portal in 2001 to display state-level data of select NOHSS indicators including Synopsis data through a centralized platform (https://www.cdc.gov/oralhealthdata). Since 2015 this website has evolved into

CDC's Oral Health Data (OHD) portal to incorporate data visualization and customization tools to better facilitate states to compare data and monitor trends. CDC currently displays select indicators from the State Synopses as seen in Attachment 4 (https://chronicdata.cdc.gov/browse?category=Oral+Health).

A3. Use of Improved Information Technology and Burden Reduction

In January of each year, ASTDD emails the State Synopses questionnaire to the 50 state and D.C. dental directors, or the designated program contact if a state does not have a dental director. The questionnaire is distributed entirely electronically as a fillable MS Word document and in 2021 also included the option to fill out the questionnaire using an electronic link through the online platform SurveyMonkey. A virtual call via Zoom is held to provide respondents with information on resources that will help complete the questionnaire, review the questions asked within the questionnaire, and answer any questions to increase efficiency and decrease time and efforts spent on the questionnaire which can be accessed here 01-28-2021 State Synopses webcast.mp4 (dropbox.com) . A copy of the email sent to states detailing the questionnaire with directions and mention of the informational Zoom call can be seen in Attachment 2c. The message sent to states with further instructions along with the Zoom call link and link to the online questionnaire can be seen in Attachment 2d and the slides used at the informational Zoom call can be seen in Attachment 2j.

Providing the questionnaire electronically (i.e., soft copy) as a MSWord document and through a SurveyMonkey link rather than a paper copy ensures that staff complete the questionnaire using the same format, categorization for responses is standardized, and burden is reduced in not having to print/package and return a physical document.

Additionally, the online SurveyMonkey system is built with skip patterns that will automatically pass-through questions not applicable based on earlier responses to decrease burden.

The return rate for the State Synopses questionnaire varies by year. During the last five years the response rate ranged from 96%–100%. Data, as reported by states, is entered into an MS Access database. Once entered, the database is evaluated for logic errors such as total budget percentages not equaling 100. If logic errors are detected, or data completeness does not reach 80%, states are contacted to make edits (this has yet to occur). Once all data are entered and complete, states are sent their individual data and are asked to verify accuracy.

The OHD portal is part of the CDC's public-facing website. It brings together data for select NOHSS indicators from various state-level data sources including State Synopses and integrates various automated functions and visualization tools. A screen shot of this tool can be seen in Attachment 4. Users can view data by indicator, state, year, or data source. The OHD portal displays data in visual maps, graphs, and tables to facilitate users to compare data and monitor trends. Users can sort the data, further customize the data view, export the maps, graphs, tables, and full or filtered dataset. The indicators from the synopsis included on

this portal include information regarding the existence of a dental director, their tenure, requirements, and statutory requirement for their position, as well as information on the number of health agencies and related populations they oversee, how many have dental programs, and the level of experience of the individuals in charge of the dental programs and finally indicators relating to the number of employees that support these programs. A full detail of the indicators included can be accessed at this link (CDC | Synopses of State Oral Health Programs | Overview | Oral Health Data | Division of Oral Health). The OHD portal is accessible by different browsers with no special hardware or software.

A4. Efforts to Identify Duplication and Use of Similar Information

No other agency or entity produces similar analyses or reports, and the State Synopsis questionnaire is the only national data collection source tracking states' efforts to improve oral health and contributions to progress toward the national targets for Healthy People objectives for oral health. The State Synopses is unique in that it not only collects oral health indicators (i.e., dental carries and sealants) to determine trends, but it provides a broad snapshot of the entire oral health landscape at the state level. It is the only nationally representative data source providing demographic information on the population served, state oral health infrastructure (i.e., population served by community water fluoridation), workforce (i.e., dental hygienists in state), administration, oral health surveillance, and programs funded at a state level.

Other oral health surveys, such as the Basic Screening Survey (BSS), collect data on dental caries and sealants at a state-level. The National Health and Nutrition Examination Survey (NHANES) collects national data based on clinical examination, but it is not designed to provide state-level representative data. Although the National Survey of Children's Health (NSCH) provides national- and state-level data, and the National Health Interview Survey (NHIS) provides national-level data of some oral health measures, both are based on parent/caretaker-reported data and not a clinical examination. None of the surveys mentioned above collect comprehensive, state-level information on oral health infrastructure and programming.

A5. Impact on Small Businesses or Other Small Entities

The proposed collection does not include any small entities, only state governments.

A6. Consequences of Collecting the Information Less Frequently

Conducting the State Synopses less frequently than every year will inhibit the quality of trend data such as the number of states with a surveillance system or the number of states with oral health plans. State oral health departments are generally small teams and have frequent staff turnover. For states experiencing staff turnover, collecting the state synopses data less frequently could mean that

state oral health with programmatic knowledge are no longer available to contribute to the State Synopsis, impacting the quality of the synopsis data. It also will reduce states' ability to have timely data to make program and funding decisions.

A7. Special Circumstances Relating to the Guidelines of 5 CRF 1320.5

This request fully complies with the regulation 5 CFR 1320.5.

A8. Comments in Response to the FRN and Efforts to Consult Outside the Agency

Part A: PUBLIC NOTICE
A 60-day Federal Register Notice was published in the *Federal Register* on, May 6, 2022,
vol. 87, No. 88, pp 27151-27152 to obtain comments from the public and affected agencies. CDC received one comment. See attachment 3b. PDF for comment and 3b. docx for response.

Part B: CONSULTATION
Each year the State Synopsis questionnaire is reviewed by ASTDD's Board of Directors, Data Committee, and CDC staff. These groups review the questions prior to the questionnaire being sent to ensure that burden on respondents was reduced and only required information is requested in the collection.

For the 2021 survey, a webcast via Zoom to provide information on how to answer the questionnaire, changes to the questionnaire, and to answer questions about the questionnaire was presented to all states in January 2021, slides seen in attachment 2j. Additionally, states will be given the opportunity to provide feedback on the questionnaire itself which may be considered for revision of submission for renewal of OMB package.

Several changes were made to the 2022 questionnaire based on these reviews. Changes included the elimination of questions for which there is another data source, that provide information that is not being used, or questions that provided data of poor quality. If the 2022 questionnaire regarding the 2020–2021 FY is approved by OMB, there are no planned changes for subsequent years. If any changes are made, they will be reflected as revisional submissions of this information collection request to the OMB.

Below in Tables A. 8B1. and A. 8B2. can be found the individuals consulted to finalize the questionnaire to ensure that it contained only pertinent information necessary to achieve the goals of the collection.

Table A. 8B1. Respondent Consultations: ASTDD Board Members

Name	Title	Affiliation to ASTDD Board	Phone	Email	State Health Department
Christine M. Farrell, RDH, BSDH, MPA	Oral Health Program Director	President	(517) 335-8388	farrellc@michigan.gov	Michigan Department of Health & Human Services
Julia Wacloff, RDH, MS	Chief	President-elect	(602) 364-1474	waclofj@azdhs.gov Julia.Wacloff@azdhs.gov	Office of Oral Health Arizona Department of Health Services
Jason M. Roush	State Dental Director	Immediate Past President	304-558-3060	Jason.M.Roush@wv.gov	DHHR Office of Maternal, Child and Family Health Oral Health Project
Secretary Samuel R Zwetchkenbaum, DDS, MPH	Chief	Secretary	(401) 222-6079	Samuel.Zwetchkenbaum@health.ri.gov	Oral Health Division Rhode Island Department of Health
Robin N Miller, RDH, MPH	Oral Health Director	Treasurer	(802) 863-7272	robin.n.miller@vermont.gov	Office of Oral Health Vermont Department of Health
Jayanth Kumar, DDS, MPH	State Dental Director	Director	(916) 449-5363	Jayanth.Kumar@cdph.ca.gov	California Department of Public Health
Mona Van Kanegan, DDS, MPH	Division Chief	Director	(217) 557-5322	Mona.Vankanegan@Illinois.gov	Division of Oral Health Illinois Department of Public
Adam Barefoot, DMD, MPH	Oral Health Director	Director	(470) 717-8534	adam.barefoot@dph.ga.gov	Department of Public Health

John Welby, MS	OHLC Project Director DHMH	Associate Member Director	(410) 767-6735	john.welby@maryland.gov	PHPA, Office of Oral Health

Table A. 8B2. Respondent Consultations: ASTDD Data Committee Members

Name	Title	Affiliation	Phone	Email	State Health Department
Adam Barefoot, DMD, MPH	Director of Oral Health	Data Committee Member	(517) 335-8388	farrellc@michigan.gov	Department of Public Health
Chelsea Fosse, DMD, MPH	Senior Health Policy Analyst	Data Committee Member	(231) 740-6023	chelseafosse@gmail.com	American Dental Association
Ariana Goertz, MPH	Data Director	Data Committee Member	702 521 4550	ariana@futuresmiles.net	Future Smiles
Matthew Horan, DMD, MPH	Dental Director	Data Committee Member	617 624 5943	matthew.horan@mass.gov	Office of Oral Health Massachusetts Department of Public Health
Beverly Isman, RDH, MPH	ELS Dental Public Health Consultant	Data Committee Member	530 758 1456	bev.isman@comcast.net	Self Employed
Bob Isman, DDS, MPH	Consultant	Data Committee Member	530 758 1456	bob.isman@comcast.net	Self Employed
Bilquis Khan Jiwani, MSc. (Epi), MBA, MSc. (Stats)	Independent Consultant	Data Committee Member	630 776 6233	Bilquis.khan@state.mn.us	Analytical Partners
Prudence Kunyangna	Asthma and Oral Health Epidemiologist	Data Committee Member	517 897 8723	kunyangnap@michigan.gov	MDHHS
Jordyn Learman,	Epidemiologist	Data Committe	401 222 2839	Jordyn.Learman	Oral Health Program

MPH, CPH		e Member		@health.ri.gov	Rhode Island Department of Health
Mei Lin, MD, MPH, MSc	Epidemiologist SIRT	Data Committee Member	770 488 5109	hru3@cdc.gov	Division of Oral Health National Center for Chronic Disease Prevention and Health Promotion Centers for Disease Control
Michael Manz, DDS, MPH, DrPH	Surveillance Consultant	Data Committee Member	734 930 9765	mmanz@astdd.org	ASTDD
Kathy Phipps, DrPH	Data & OH Surveillance Coordinator	Data Committee Member	805 776 3393	kathyphipps1234@gmail.com	ASTDD
Terence Robinson, MPH	Chronic Disease Epidemiologist	Data Committee Member	910 336 5820	Terence.Robinson@la.gov	Louisiana Department of Health Office of Public Health
Mona Van Kanegan, DDS, MS, MPH	Division Chief	Data Committee Member	217 557 5322	Mona.Vankanegan@Illinois.gov	Division of Oral Health Illinois Department of Public
Frances Wise, PHD	Public Health Specialist	Data Committee Member	907 269 7378	frances.wise@alaska.gov	State of Alaska Oral Health Program

A9. Explanation of Any Payment or Gift to Respondents

Respondents do not receive an incentive.

A10. Protection of the Privacy and Confidentiality of Information Provided by Respondent

Compared to previous versions of the questionnaire, the 2022 Synopses questionnaire no longer collects sensitive or protected information i.e., dental director's name, degrees/credentials, and race/ethnicity.

Data submitted by the states via email to ASTDD or via SurveyMonkey, is entered/transferred into an Access database which is stored on ASTDD's secure server. ASTDD's secure server, along with the State Synopses database, are password protected and only the Executive Director, Grants Manager, and Data Consultants have access. The database will be stored on ASTDD's server for 10 years.

Once data is submitted and analyzed, ASTDD shares free public access to aggregate data. ASTDD also allows restricted access to non-PII state-specific data from previous years to members of ASTDD. ASTDD does not release state specific information on overall budget. Aggregate data is available as a PDF on ASTDD's public facing website. State specific data for all variables except overall budget are available as a PDF on the member's only section of ASTDD's website, which requires special log in credentials (www.astdd.org). If an individual or organization requests additional state specific information, ASTDD provides that information as an Excel spreadsheet with a data dictionary and a copy of the questionnaire used to collect the information as appropriate. Datasets released to outside organizations do not contain any personal identifiers or information on financials/overall budget.

ASTDD also submits data with the CDC to be posted on CDC channels. ASTDD sends an Access file with the full State Synopsis dataset to the Division of Oral Health (DOH), within CDC, the first week of June. Data sent to DOH are stored on the DOH's password protected drive. Only authorized DOH personnel will have access. Data will be archived according to Records Management Policy of the federal government. All laws, regulations, and rights regarding data will be complied with. CDC will store and maintain the data set as long as the data is being used for surveillance and program needs or other research. CDC retains the data in accordance with the applicable CDC records control schedule. Within one year of data collection, a subset of state-specific State Synopses data, including information on leadership, policies, programs, and staffing, is publicly available on CDC's Oral Health Data portal as seen in Attachment 4. (https://www.cdc.gov/oralhealthdata/).

A11. Institutional Review Board (IRB) and Justification for Sensitive Questions

CDC's NCCDPHP determined that this project does not constitute research with human subjects as defined by the US Code of Federal Regulations (45 CFR 46.102). This is a non-research public health program evaluation and surveillance, see Attachment 5 for the determination of research status. There are no questions

of a sensitive nature, in the 2021 questionnaire, all name, race, and ethnicity data are stripped from all shared datasets. The 2022 questionnaire does not collect any of this information.

A12. Estimates of Annualized Burden Hours and Costs

This collection only involves the state questionnaire, therefore the sum of the time and cost spent by each respondent jurisdiction team on this questionnaire is equal to the total burden. Also, since the questionnaire occurs annually, the time and cost estimations are automatically in annual terms.

As the wages of dental directors and other program members are not reflected exactly in the Bureau of Labor Statistics, in order to obtain accurate burden information, DOH sent an MSWord form to nine state dental program representatives with three questions, which three of the nine responded. The questions asked for the time that respondents spent in completing the questionnaire, the wages of these individuals, and details on how respondents use the 2021 State Synopsis report to inform program decisions for the (FY 2019‒2020) state questionnaire collection. The form can be seen in Attachment 2f along with a copy of email requests for this information and directions in Attachment 2i.

Since there were no formal pretests and the information collection took place within a calendar year, the sum of the hours reported by each state team was used to get an average total time burden for a given respondent jurisdiction.

Therefore, the 3 totals were averaged to obtain time burden of the questionnaire per jurisdiction/respondent. This average was then multiplied by 51, the number of respondent jurisdictions, to get a total time burden of the questionnaire. As seen in Table A. 12A. below, the total annual time burden is 299 hours. Detailed calculation of this burden estimate can be seen in attachment 2k.

Table A. 12A: Estimated Annualized Burden (Hours)

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
State Oral Health Director or designated program contact	Synopses of State Dental Public Health Programs	51	1	5.86	299

The average hourly wage of a given respondent was developed by weighting the wage of each reported respondent to the fraction of the time they spent on their

jurisdiction’s completion of the state survey and summing those values for a given jurisdiction. (I.e. If a director spent 60% of the time and an assistant spent 40% of the time, (0.6) x (Director wage) + (0.4) x (Assistant wage) = weighted average wage for that jurisdiction.)

This resulted in 3 average hourly wages between the 3 respondent jurisdictions which were then averaged again to develop an average hourly wage of the overall respondent population which came out to be $61.09.

Therefore, the total cost to respondents can be seen in Table A. 12B. below as the total hours from Table A. 12A. multiplied by this average wage ($61.09) which equals $18,265.91

Table A.12B. Estimated Annualized Burden Costs

Type of Respondents	Form Name	Total Annual Burden Hours	Average Hourly Wage Rate	Total Respondent Labor Cost
State Oral Health Director or designated program contact	Synopses of State Dental Public Health Programs	299	$61.09	$18,265.91

A13. Estimates of Other Total Annual Cost Burden to Respondents and Record Keepers

The collection of information involved in the synopsis requires no special hardware or software to generate, maintain, or store the information. The data entry is basic, and SurveyMonkey, if chosen as the submission method by respondent, is free to use. There is no unique software needed to analyze or sort the data. Therefore, there are no additional cost burden to respondents and record keepers.

A14. Annualized Cost to the Federal Government

There were no additional costs for the State Synopses above the funds included in the budget for the CDC Cooperative agreement with ASTDD. In the overall budget for the 2020/2021 cooperative agreement, $38,250 was included for the ASTDD Data and Surveillance consultant who is responsible for the development and fielding of the synopses as well as the data analysis and reporting. The consultant billed ASTDD for $6,332.50 for hours devoted to the 2021 state synopses (74.5 hours). The consultant uses their own computer. There are no printing costs. Conference calls are hosted on a CDC conference line for which ASTDD is not

charged or on a Zoom account for which ASTDD pays a flat rate per year and that ASTDD uses for multiple committee calls, board calls and webinars.

In addition to the ASTDD team support, the CDC utilizes four contracted individuals that support the data uploading and ingestion process. First, a contracted data uploader supports for four hours with an annual salary of $96,668 which equates to an hourly wage of $48.33/hr adding a total of $193.32 to the overall labor cost. Additionally, the database administrator oversees the data upload, charging two hours totaling $102.80 in labor cost. The data standardization specialist also supports this process for two hours totaling $69.33 in labor cost. Finally, the project manager overseeing the database coordination supports for two hours totaling $116.50 in labor cost.

Additionally, there were 3 FTE CDC staff members that supported the review and collection of the information. The first was a GS-14 Grade 10 employee and supported for 1 hour, the second was a GS-14 Grade 5 employee and supported for three hours and the third was a GS-14 Grade 10 employee and supported also for three hours. The hourly wages of these individuals are $71.45, $62.30, and $71.45 respectively. Therefore, the total work billed by the CDC staff amounts to $71.45 + $62.30(3) + $71.45(3) = $472.70 cost of CDC staff.

This collection took place over the course of one year, so all sums represent annual costs. There are no additional operational or maintenance costs, therefore, the total cost to the federal government is equal to the sum of the cost of wages from the three aforementioned staff groups. As seen in Table A. 14. below, the total annualized cost to the federal government is $7,287.15 per year.

Table A.14. presents the labor costs to the government the program proposes to incur.

TableA.14. Annualized Federal Government Cost Distribution

Staff Costs	***Annualized Cost***
ASTDD Data and Surveillance consultant	$6,332.50 (74.5 Hours)
Contractor 1 (Data Uploader)	$193.32
Contractor 2 (Data Administrator)	$102.80
Contractor 3 (Data Standardization Specialist)	$69.33
Contractor 4 (Data Project Manager)	$116.50
CDC Staff	$472.70
Total	$7,287.15

A15. Explanation for Program Changes or Adjustments

This request is an existing collection without approval.

A16. Plans for Tabulation and Publication and Project Time Schedule

This clearance request concerns approval for the reoccurring annual questionnaire distribution and data collection for the next three years. The information collection request is sent out on January 1st of each year, therefore the 2022 questionnaire

regarding the 2020–2021 fiscal year will be sent out in January of 2022. After the information collection takes place from January until the end of February, ASTDD enters information from the State Synopses questionnaire into an Access database. Once entered, the database is evaluated for logic errors such as total budget percentages not equaling 100. If logic errors are detected, or data completeness does not reach 80%, states are contacted to make corrections, though this has not occurred. Once all data are entered, states are sent their individual data and are asked to verify that it is accurate by May 15th when the data collection is closed. A copy of this message sent to states can be seen in Attachment 2e.

A full report with state specific data tables is posted as a PDF document on the members only section of ASTDD's website. A summary report with aggregated information is posted as a PDF document on the public portion of ASTDD's website. An Excel file with the full Synopses dataset is sent to CDC/DOH the first week of June; CDC/DOH then creates the subset of Synopses data to be included on CDC's Oral Health Data website.

The OHD portal is part of the CDC's public-facing website. It brings together data for select NOHSS indicators from various state-level data sources including State Synopses and integrates various automated functions and visualization tools as seen in Attachment 4. Users can view data by indicator, state, year, or data source. It displays data in visual maps, graphs, and tables to facilitate users to compare data and monitor trends. Users can sort the data, further customize the data view, export the maps, graphs, tables, and full or filtered dataset. It is accessible by any browser with no special hardware or software.

Table A.16. Estimated Time Schedule for Project Activities

Activity	Timeline
Invitation/request emailed; reminders sent	January of each year
Questionnaire Due	2 Months after request sent (Due February 28th)
Follow-ups sent to unresponsive states	2-4 months after request sent (Due May 15th)
Data analysis and report preparation	4 months after request sent (During May)
Publication	5 months after request sent (First week of June)

A17. Reason(s) Display of OMB Expiration Date is Inappropriate

The display of the OMB expiration date is appropriate.

A18. Exceptions to Certification for Paperwork Reduction Act Submission

There are no exceptions to the certification.

REFERENCES

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Manski RJ and Rohde F. *Dental Services: Use, Expenses, Source of Payment, Coverage and Procedure Type, 1996–2015*: Research Findings No. 38. November 2017. Agency for Healthcare Research and Quality, Rockville, MD. https://meps.ahrq.gov/data_files/publications/rf38/rf38.pdf.