SUPPORTING STATEMENT
PART A

FOR

OMB INFORMATION COLLECTION REQUEST

National Public Health Performance Standards Program
Local Public Health Governance Performance Assessment Instrument
(OMB Control Number: 0920-0580)

July 19, 2010

Centers for Disease Control and Prevention
Division for Public Health Performance Improvement
Office of State, Tribal, Local and Territorial Support (OSTLTS)
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A. JUSTIFICATION

The Office of Chief of Public Health Practice is requesting a extension without changes or adjustments for OMB No. 0920-0580, National Public Health Performance Standards Program, Local Public Health Governance Performance Assessment instrument.

1. Circumstances Making the Collection of Information Necessary

The mission of the Centers for Disease Control and Prevention (CDC) is to promote health and quality of life by preventing and controlling disease, injury, and disability. The National Public Health Performance Standard Program (NPHPSP) information collection is intended to contribute to this mission by providing optimal standards for public health practice and by measuring the achievement of those standards at the state and local levels. The Local Public Health Governance Performance Assessment queries respondents and generates data for use in health policy development, resource allocation, and quality improvement efforts.

State and local public health practice form the backbone of the nation's health system, but little is known about capacity and performance. The NPHPSP was established to address this problem and is based on the following three principles:

- Public health must be accountable to its constituents.
- Public health professionals need a system for assessing the provision of Essential Public Health Services.
- The public health decision-making process must be based on strong scientific evidence and assessment of current needs.

The NPHPSP is a volunteer data collection effort. The assessment instruments are designed to collect the evidence necessary to refine the domestic public health infrastructure. During the past decade, CDC has worked with other Department of Health and Human Services (DHHS) agencies, key national public health associations, state and local health officials, boards of health, and academic institutions to explore and better articulate the state and local public health infrastructure. Through the identification of infrastructure objectives for Healthy People 2010, the development of a national public health systems research agenda, and other related efforts, these organizations and constituencies have identified the need for better data on the status of the public health infrastructure. The NPHPSP was designed, in part to address this urgent need. These assessments facilitate development of a strong national infrastructure that will result in improved national, state, and local capacity to detect and effectively respond to public health threats.

The NPHPSP is intended to help users answer questions such as, "What are the components, activities, competencies, and capacities of our public health system and local board of health?" and "How well are the Essential Services being provided?" The dialogue that occurs in answering these questions will identify strengths and weaknesses; this information can be used to improve and better coordinate public health activities at the state and local levels. Lastly, the results gathered will provide an understanding of how state and local public health systems and

governing entities are performing. This information will help local, state, and national policymakers make better and more effective policy and resource decisions that will improve the nation's public health as a whole.

The NPHPSP is intended to improve the quality of public health practice and the performance of public health systems by:

- Providing performance standards for public health systems and encouraging their widespread use;
- Engaging and leveraging national, state, and local partnerships to build a stronger foundation for public health preparedness;
- Promoting continuous quality improvement of public health systems; and
- Strengthening the science base for public health practice improvement.

The NPHPSP is a collaborative effort of seven national partner organizations:

- Centers for Disease Control and Prevention, Office of State, Tribal, Local and Territorial Support (CDC/OSTLTS) [1],
- American Public Health Association (APHA),
- Association of State and Territorial Health Officials (ASTHO),
- National Association of County and City Health Officials (NACCHO),
- National Association of Local Boards of Health (NALBOH),
- National Network of Public Health Institutes (NNPHI), and
- Public Health Foundation (PHF).

The NPHPSP includes three instruments:

- The State Public Health System Performance Assessment Instrument (State Instrument) focuses on the "state public health system." This system includes state public health agencies and other partners that contribute to public health services at the state level. The instrument was developed under the leadership of ASTHO and CDC. (OMB Control Number 0920-0557)
- The Local Public Health System Performance Assessment Instrument (Local Instrument) focuses on the "local public health system" or all entities that contribute to the delivery of public health services within a community. This system includes all public, private, and voluntary entities, as well as individuals and informal associations. The local instrument was developed under the leadership of CDC and NACCHO. (OMB Control Number 00920-0555)

1? The original clearance package was submitted from CDC's Public Health Practice Program Office and previous extension and revision packages were submitted by CDC's Office of Chief of Public Health Practice. Due to most recent CDC reorganization activities,the National Public Health Performance Standards Program is now housed in the CDC Office of the State, Tribal, Local and Territorial Support.

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- The Local Public Health Governance Performance Assessment Instrument (Governance Instrument) focuses on the governing body ultimately accountable for public health at the local level. Such governing bodies may include boards of health or county commissioners. The governance instrument was developed under the leadership of CDC and NALBOH. (OMB Control Number 0920-0580)

Although each instrument was developed under the collaborative leadership of a specific partner organization and CDC, all partners were involved throughout the entire process. Additionally, the instruments were collectively reviewed to ensure that each is complementary and supportive of the others and includes consistent terminology and concepts.

The national partners represent many of the organizations and individuals that use the assessment instruments. Through working groups and field test activities, representatives from these organizations have been continuously involved in developing, reviewing, testing, and refining the instruments. A peer-guided development process occurred during 1998-2002 during the development of the original instruments; this process was replicated recently during the recent revision activities of each instrument.

During 2005-2006, the three NPHPSP instruments were updated based on experience from the field and new developments in public health practice. Updates were undertaken for each of the three NPHPSP instruments: the state public health system assessment, local public health system assessment and local governance assessment. Three work groups of practitioners (representing ASTHO, NACCHO, and NALBOH constituencies) were convened to oversee each set of updates. The general purpose of the process was to assure the standards remain current and also to improve the language and user-friendliness of the instruments. During the revision process, CDC also worked with subject matter experts and key organizations to determine content areas that needed to be updated or modernized. Expert input was solicited in areas such as preparedness, informatics, health marketing, partnerships, workforce, public health law, and laboratory issues. As a result of this entire process, new versions of the instrument (subsequently referred to as "Version 2") were developed.

A limited field testing process, using eight repeat local sites, was undertaken to identify areas for improvement within the instruments, assess the extent to which improvements in utility have been achieved, demonstrate a longitudinal linkage to the currently available instruments, assess the impact of changes made, and gather an understanding of the implementation process related to the updated instruments (including information to inform a revised time burden for OMB clearance). The Version 2 instruments received a three-year OMB approval for data collection August 24, 2007.

The use of the NPHPSP instruments is intended to result in numerous benefits, including:

- Improving organizational and community communication and collaboration, by bringing partners to the same table.

- Strengthening the diverse network of partners within state and local public health systems, which can lead to more cohesion among partners, better coordination of activities and resources, and less duplication of services.
- Providing a mechanism for measuring public health practice and performance.
- Identifying strengths and weaknesses that can be addressed in quality improvement efforts.
- Providing a benchmark for public health practice improvements, by setting a "gold standard" to which public health systems can aspire.

There are four concepts that have helped frame the National Public Health Performance Standards into their current format:

1. The standards are designed around the ten Essential Public Health Services. The use of the Essential Services framework assures that the standards cover the gamut of public health action needed at state and community levels. [2],
2. The standards focus on the overall public health system and the board of health's role in supporting the public health system._A public health system includes all public, private, and voluntary entities that contribute to public health activities within a given area. This ensures that the contributions of all entities are recognized in assessing the provision of essential public health services.
3. The standards describe an optimal level of performance rather than provide minimum expectations. This ensures that the standards can be used for continuous quality improvement.
4. The standards are intended to support a process of quality improvement. In responding to the questions, system partners determine which elements of the model standards they do/ do not meet. They then should develop action plans for improving their performance in the low-scoring areas.

2. Purposes and Use of the Data Collection

This is an extension without changes request for OMB approval of the Local Public Health Governance Performance Assessment Instrument (Attachment E). This data collection is authorized under Section 301 of the Public Service Act (42, USC 241) (Attachment A). The Centers for Disease Control & Prevention (CDC) and local public health jurisdictions will use this instrument to assess the capacity of local boards of health in overseeing the delivery of the ten Essential Public Health Services. The instrument provides a self-assessment related to the necessary legal authority, resources, and policies for each of the ten Essential Public Health Services.

The NPHPSP is applied as part of a public health system self-assessment process. Local boards of health voluntarily conduct data collections for infrastructure self-assessment and quality

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2The Essential Public Health Services are: Monitoring Health Status; Diagnosing and Investigating Health Problems; Informing, Educating, and Empowering People; Mobilizing Community Partnerships; Developing Policies and Plans; Enforcing Laws and Regulations; Linking People to Needed Services; Assuring a Competent Workforce; Conducting Evaluations; and Conducting Research.

improvement. CDC and NPHPSP partners support the process by providing technical assistance and training tools, computer-generated data analysis and reports of results.

Local jurisdictions and boards of health self-select and participate voluntarily. Local sites can choose to undertake this individually, but the process is also encouraged to be undertaken through a statewide approach coordinated by a statewide association (e.g., state association of local boards of health), state institute or the state health department. The concept of using the governance instrument through a statewide process can assist participating boards of health in identifying common strengths and weaknesses and maximizing the assessment results for planning and improvement.

Regardless of whether the instrument is supported through a statewide approach or by a local jurisdiction volunteering to undertake the assessment individually, the assessment and data collection are accomplished in the same manner. Technical assistance resources, such as the training workshops, the User Guide and NPHPSP staff, instruct responding jurisdictions in how to complete the assessment. Boards of health are also informed that they will need a User ID and survey password to enter data into the limited-access website. If they are completing the assessment through a statewide approach, CDC provides the User IDs to the state coordinator. Other jurisdictions can contact CDC and PHF (a partner that assists in providing technical support for the limited-access website and reporting system) directly at 1-800-747-7649 or by email at phpsp@cdc.gov or nphpsp-support@phf.org. The User IDs are disseminated with an instruction sheet (see Attachment G).

The Governance instrument has great strategic value as a quality improvement tool to boards of health and NALBOH (CDC's partner organization which co-developed and co-supports the Governance instrument). Usually appointed or elected, board members serve as the oversight and governing body for the local health department with little to no formal training in public health principles or practices. NALBOH uses the NPHPSP Governance Instrument to improve board members' understanding and knowledge of public health, as a foundation for a board of health member certification program, and to encourage accountability in their oversight and governance responsibility for the local health department.

NALBOH also heavily uses the Governance Instrument in its training and educational materials. The NALBOH publication, *Being an Effective Local Board of Health Guide,* addresses the public health principles and its intersection with board responsibility. It has an introduction to the core functions, 10 Essential Public Health Services, and the NPHPS Program. This guide, in turn, is the framework upon which NALBOH's in-person Board Member Orientation program is constructed. Further, NALBOH is using the structure and metrics of the standards within the Governance Instrument to create board of health competencies and a board of health member certification program.

In sum, the Governance Instrument has been used for dual purposes: first, it serves as a tool for boards of health to assess their strengths and weaknesses and to create a performance improvement plan, and; second, it serves as a much-needed educational and orientation tool for

board members to use in more fully realizing their roles and responsibilities to the local health department.

Since the approval of the Governance Instrument in December 2002, the instrument has been formally used in approximately 200 boards of health. Also during this time, the landscape of public health has continued to change considerably. The attention of public health leaders – at the national, state, and local levels – has been significantly diverted to bioterrorism preparedness and planning, in addition to other emerging public health issues such as West Nile Virus, SARS and more recently, the H1N1 Novel flu virus and economic challenges in state and local jurisdictions, . This series of unanticipated challenges for public health slowed the early opportunities to use the NPHPSP after their initial launch. However, despite this diverted attention, it is vitally important to recognize and acknowledge the substantial and invaluable contributions the NPHPSP has made in providing public health leaders, policy makers, and program staff in a multitude of jurisdictions with an effective and efficient assessment and quality improvement process. In fact, many of the sites that voluntarily chose to use the NPHPSP did so in an effort to better respond to the changing landscape of public health.

Since its original release in December 2002, it is clear that the NPHPSP has proven itself an important step toward achieving more consistently effective, high-performing public health systems in the United States. By providing national performance standards, a means for jurisdictions to assess their performance, and a catalyst for improvement strategies, the NPHPSP supports performance improvement and accountability of public health practice at both the state and local levels. The continued availability of these tools and the data collection instrument is critical to sustaining our ability to support these efforts and to build our understanding of public health practice. .

3. Use of Improved Information Technology

To minimize respondent burden, this survey is web-based. Data collection, analysis, and reporting are automated. The web-based survey is the preferred method of choice; however, CDC recognizes that compliance depends on the availability of appropriate technology at the local level. In areas with limited access to technology, CDC and NALBOH will provide technical assistance using hard copy surveys. The coordinated efforts of CDC, NALBOH, and state liaisons along with automated data processing will minimize the burden to respondents.

4. Efforts to Identify Duplication

Extensive literature searches were conducted using online databases such as Medline, Psychinfo, and Sociofile. National organizations, like ASTHO and NACCHO, have published profiles of state health departments. These profiles do not contain in-depth information on local boards or governing bodies. According to literature searches and evidence from public health systems research, no duplicative assessment has been conducted. Although several states have developed performance assessment tools, none of the efforts duplicate the ability to collect and compare national data on local boards of health.

CDC is submitting similar extension requests for the State Public Health System and Local Public Health System instruments within the NPHPSP. The difference between the instruments is the scope. The Local Public Health Governance Instrument focuses on the governing body at the local level. The local instrument focuses on the local public health system or all the entities that contribute to the delivery of public health services within a community. The state instrument focuses on the state public health system.

5. Impact on Small Business or Other Small Entities

The respondents for this survey will be local boards of health or other governing bodies. CDC acknowledges that there are some small entities involved in this process. This assessment is being conducted in conjunction with local health departments and other organizations within local public health systems.

6. Consequences of Collecting the Information Less Frequently

It is critical to assure the instruments remain viable for the field of public health practice and for the jurisdictions that are seeking to use these tools to understand their local boards of health. Local jurisdictions in numerous states are planning for use of the NPHPSP Instruments and, if not available, will not have a viable tool for health improvement planning. Some have incorporated the use of the NPHPSP instruments into their legislation or regulation and therefore require its use during prescribed times. Other states have written the use of NPHPSP instruments into grant timelines and require their use during particular time periods; there will be consequences for these states' ability to comply with their grant deliverables if the instruments are not available for use. Finally, the NPHPSP instruments are mentioned within the voluntary consensus standards developed as part of the national voluntary accreditation program by the Public Health Accreditation Board (PHAB) and many jurisdictions will seek to use the instruments as a component of their accreditation preparation activities. Additionally, if the information collection is undertaken on a less frequent basis, there will be consequences to the availability of current knowledge about state and local public health systems and boards of health.

There are no legal obstacles to reduce burden.

7. Special Circumstances

Survey completion requires 5 hours. The table below explains why that amount of time is necessary.

Explanation of Burden Hours

TASK	Time Needed (in Hrs)	Explanation
Time for reviewing instructions and preparing for the assessment	1	Based on previous experience, it requires 1 hour to review the instructions and prepare the board members for undertaking the assessment process. This assessment is a group effort, therefore this step includes orientation of the board of health members regarding the effort.
Review data sources, discuss, and respond to questions	3	This assessment will require input from the local health official and/or other senior health department staff and the board of health members. During this step, the participants compile information based on their own knowledge and data sources and then discuss the input in order to make a well-informed decision.
Complete and submit the responses	1	Based on field test and previous experiences, it takes about 1 hour to review and finalize the responses and enter this information into the on-line database for analysis
Total Hours	5	

8. Consultation outside the Agency

8a: Federal Register Notice

The 60-day Federal Register Notice was published on March 18, 2010, Vol. 75, No. 52, page 13134. No public response was received.

8b: Consultations

Representatives from the following organizations reviewed and guided the original development and recent revision of the data collection instrument and have worked with CDC since 2002 to support its use in local jurisdictions. Refer to Attachment C for a list of these individuals.

National Association of Local Boards of Health (NALBOH)
National Association of County and City Health Officials (NACCHO)
Association of State and Territorial Health Officials (ASTHO)
American Public Health Association (APHA)
National Network of Public Health Institutes (NNPHI)
Public Health Foundation (PHF)

9. Payments to Respondents

None

10. Assurance of Confidentially

This submission has been reviewed by ICRO, who determined that the Privacy Act does not apply.. While names and titles of contact persons are being collected, individuals will not be providing personal individually identifiable data, but instead speaking from their professional roles as being capable of collecting data to measure the capacity of the local board of health to assure the delivery of the 10 Essential Public Health Services. Demographic information requested deals not with the point of contact but with information on the local board of health. Therefore, the data for the project do not meet the definition of a Privacy Act system of records. A password protected electronic database has been created to store survey results at CDC. Access is limited to individuals with a bona fide need to know for official duties. Respondents will be identified by unique identifiers developed under a National Public Health Registry. Data management procedures have not changed since previous approval.

11. Questions of a Sensitive Nature

The Local Public Health Governance Instrument does not contain questions that are sensitive in nature.

12. Estimates of Annualized Burden Hours and Costs

12a:
Local boards of health or other governing bodies will complete the Governance Tool. The Governance Tool completion will consume approximately 5 hours of staff time. This includes time necessary to conduct an orientation, collate responses and submit data for analysis.

CDC and its partners estimate that 175 local boards of health will complete the Governance Tool in each year (525 total during the three-year approval timeframe). Although there are an estimated 2,315 entities that serve as local boards of health in the United States, the great majority are unpaid volunteers with limited time and resources for governance activities or serve in an advisory capacity. The annual estimate of users takes into account those that serve as governing (rather than advisory) bodies, are more actively involved in educational / orientation activities, and, although not trained public health professions, are more inclined to utilize the Instrument to assess and improve performance and as a learning and educational resource. This estimate is based on past use of the Version 1 and Version 2 instruments as well as the expert opinion of NPHPSP staff and partner organizations who are working with jurisdictions preparing to undertake the assessment. Burden hours are shown in table A.12.a.

Although some states have provided funding to their local boards of health for use of this instrument, there is no dedicated grant funding for this activity. For that reason, it is critical to support states and local jurisdictions in this effort at a time that best meets their needs and resources. Therefore, CDC and its partners consider it important that this data collection instrument be available to be used on a voluntary and rolling basis.

Table A.12.a: Estimates of Organizational Hourly Burden

National Public Health Performance Standards Program Local Public Health Governance Assessment Annualized Burden Table			
Respondents	Response per respondent	Hours/Responses (per year)	Total Burden Hours
175	1	5	875

Table A.12.2 Estimates of Cost Burden

National Public Health Performance Standards Program Local Public Health Governance Assessment Instrument Annual Cost Burden Per Respondent					
Local Public Health Systems	Number of Annual Respondents	Responses per respondent	Total Burden per response	Wage rate* (per hour)	Total cost
Annualized Estimate	175	1	5	$19.23	$ 16,826

A senior local health department staff person will coordinate completion of the instrument by local board members. Using estimated wages for local health department staff and the calculated burden hours, this study represents an estimate annual cost of $16,853.

** Most local board of health members are volunteer and do not have a salary therefore we used NACCHO's estimate for local health department staff to determine the cost to respondents. Due to the current economic climate impacting the public health workforce and governmental agencies, the average salary and compensation for local health department staff remains the same as reported in our ICR three years ago. Economic surveys conducted by NACCHO report that most health departments have been facing salary freezes, cutbacks and furloughs during the last

three years. Therefore, per consultation with NACCHO experts in this area, the estimated average annual salary remains $40,000 for respondents. The total cost to respondents was calculated by multiplying the number of respondents, the total burden hour per response, and the wage rate (175 x 5 x $19.23 =$16,826).

Basis for Burden

The universe of possible respondents and estimated users are represented in Tables A.12.1 and A.12.2. The response estimates are based on past use as well as the expert opinion of the NPHPSP staff and partner organizations who are working with states and localities to undertake the assessment.

13. Estimates of Annualized Capital and Maintenance Costs

There are no annualized capital and maintenance costs to the respondents.

14. Estimates of Annualized Cost to the Government

Four FTEs are dedicated to implement the NPHPSP within CDC, Office of State, Tribal, Local and Territorial Support Based on time allocations for the program, an average annual salary of $90,000 per FTE (including benefits), is dedicated to the NPHPSP and its three data collection instruments (OMB control numbers: 0920-0555, 0920-0557, and 0920-0580). This is a cost of $360,000 per year. In addition to the salary, the cost of attending and presenting at national, state and regional meetings is estimated to be approximately $15,000 in travel expenses each year.

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Office of State, Tribal, Local and Territorial Support

Number of FTEs For Program Implementation	Annual Salary charged to NPHPSP- Including Benefits (per FTE)	Total Salary Cost (per year)	Number of FTEs attending Regional Meeting	Total Cost of Travel for each meeting	Number of Trips	Total cost of Travel
4	$90,000	$360,000	1	1000	15	$15,000

Grand Total = $375,000

15. Explanation for Program Changes or Adjustments

This is a three year extension request without changes or adjustments of a formerly approved data collection instrument. There are three components to this data collection effort – the performance standards instrument, a Respondent Information Form which elicits basic information about the responding site, and an optional priority questionnaire. These three components are part of one information collection that is implemented at the same time by the same respondents. These are found in Attachment E.

16. Time Schedule, Publication, and Analysis Plan

CDC (and its partners through a grantee and contractor support the limited-access website) accept data from respondents participating in a statewide process as well as from those who elect to complete the assessment outside of a statewide approach. Ideally, state and local public health agencies and local boards of health will choose to conduct the performance assessment through a coordinated statewide approach. CDC and the NPHPSP partner organizations provide training to orient personnel that play key roles in coordinating a statewide process. Generally these personnel include representatives from state health department, state or regional public health institutes, universities, or state associations of local boards of health. CDC and NPHPSP partner organizations also provide statewide “kickoff” training at state conferences, if requested.

Task	Estimated Time Frame
Make instruments and technical assistance resources available for all local boards of health, so that any site interested in completing the process is able to do so (even outside of a statewide coordinated approach).	Within first month of approval and ongoing throughout the three years of approval
Identify first set of states for implementation; obtain an indication of commitment from the state	Within two months after approval
Provide training and/or work with the state liaison to plan the assessment	2-4 months after approval
Provide access to web-based assessment; provide support to the state liaison and local jurisdictions in using the assessment; conduct orientation and kick-off activities, if CDC or partner presence is requested at a state conference	4-7 months after approval
Receive and analyze data; provide automated reports to responding jurisdictions; provide aggregate report to the state	7-9 months after approval
Encourage states and local jurisdictions to use the results for performance improvement	9-11 months after approval
Select second set of states for implementation; obtain an indication of commitment from the state	12 months after approval
Provide training and/or work with the state liaison to plan the assessment	14-16 month after approval
Provide access to web-based assessment; provide support to the state liaison and local jurisdictions in using the assessment; conduct orientation and kick-off activities, if CDC or partner presence is requested at a state conference	16-19 months after approval
Receive and analyze data; provide automated reports to responding jurisdictions; provide aggregate report to the state	19-21 months after approval
Encourage states and local jurisdictions to use the results for performance improvement	21-23 months after approval
Select third set of states of implementation. Obtain an indication of commitment from the state	24 months after approval

Provide training and/or work with the state liaison to plan the assessment	24-26 months after approval
Provide access to web-based assessment; provide support to the state liaison and local jurisdictions in using the assessment; conduct orientation and kick-off activities, if CDC or partner presence is requested at a state conference	26-29 months after approval
Receive and analyze data; provide automated reports to responding jurisdictions; provide aggregate report to the state	29-31 months after approval
Encourage states and local jurisdictions to use the results for performance improvement	31-33 months after approval
Publication	36-48 months after approval

Publication

Results generated by the NPHPSP assessment instruments will be primarily used for national public health infrastructure improvement. Results will also be presented to the public health community at professional and CDC-sponsored conferences. Further, results from this collection will be prepared for publication in professional reports and journals. To date, manuscripts utilizing results from the NPHPSP assessment instruments have been published in journals including the *Journal of Public Health Management and Practice*, *Milbank Quarterly*, *Public Health Reports*, *Health Affairs, American Journal of Preventive Medicine*, and the *American Journal of Public Health*. Similar publication opportunities will be sought for disseminating future data.

Analysis Plan

The governance tool is a qualitative self-assessment designed to provide local boards of health with a "point-in-time" analysis of their capacity to support the delivery of the Essential Public Health Services. Data collected using the governance instrument are analyzed according to standardized algorithms that generate electronic reports. These reports will illustrate strengths, weaknesses, opportunities for improvement, and barriers to infrastructure development for local boards of health. Data analysis and reporting are fully automated.

After local boards of health complete the assessment, results are submitted to the limited access data collection website. CDC recommends that the governmental public health agency or local board of health serve as the lead organization in submitting the instrument responses, although in some jurisdictions other entities, such as a state association of local boards of health, have been empowered with this authority. Technical assistance resources, such as the training workshops, the User Guide and NPHPSP staff, instruct responding jurisdictions that they will need a User ID and survey password to enter data into the limited-access website. If they are completing the

assessment through a statewide approach, CDC provides the User IDs to the state coordinator. Other jurisdictions can contact CDC and PHF directly at 1-800-747-7649 or by email at phpsp@cdc.gov or nphpsp-support@phf.org. The User IDs are disseminated with an instruction sheet. (See Attachment F for the Meeting Guide; Attachment G for the data entry instruction sheet; and Attachment H for example screen shots of the web-based system for submitting data and accessing reports).

Based on field testing and sound statistical methods, a detailed scoring methodology was developed for the NPHPSP. It is applicable to all three instruments. It was used for the previously-approved instruments and has been tested with the new Version 2 instruments, with the necessary slight alterations (such as inclusion of the new 5th response option). It is described, in brief, below:

Scores are developed for four different levels:

I. **First-tier or "stem" question scores –** This score is developed by establishing the weight value for each question, and then multiplying the weight value by the response value. The weight value of each question grouping totals 1 point – lead-in questions are given 0.3 weight while subquestions are assigned 0.7 weight collectively. The weight of each question is multiplied by its response value ("no" responses are given a zero value; "minimal activity" is 0.25; "low partial" is 0.50; "high partial" is 0.75; and "yes" is 1.0). The scores for each question in the question grouping are totaled up to produce the "stem" question score.

II. **Model Standard scores –** the average of all stem question scores found within this indicator section.

III. **Essential Service scores –** the average of all indicators found within this Essential Service section.

IV. **Overall Score –** the average of all ten Essential Service scores.

Local public health systems should strive for scores of 75% or above to "fully meet" the model standard. The 75% level was determined by consensus agreement between CDC and national partner organizations. In addition to the numerical scores provided in the reports, respondents are heavily encouraged to record qualitative discussion points that will help to describe areas of weakness in the delivery of the Essential Services. Local boards of health are encouraged to review the scores and qualitative data to identify opportunities for performance and infrastructure improvement planning. CDC and NPHPSP partner organizations provide technical assistance resources and training to assist states and local jurisdictions with using the results for performance improvement. Such technical assistance includes linking the state and local agencies with peers to improve sharing of best practices and providing web-based resources that provide practice models for making improvements in weaknesses identified in their assessment.

An automated sample report is generated for each respondent. Sample reports are available on the CDC website so that potential users can view the reports prior to submitting data.

17. Expiration Date Display Exemption

CDC is not seeking an exemption for displaying an expiration date.

18. Exemptions to Certification

There are no exemptions.

List of Attachments

Attachment A: Public Health Service Act, Section 301
Attachment B: Federal Register Notice
Attachment C: List of Project Consultants at Partner Organizations and List of State, Local, and Governance Work Group Members
Attachment D: Spreadsheet of Possible Respondents by State
Attachment E: Local Public Health Governance Performance Assessment Instrument, Respondent Information Form, and Optional Priority Questionnaire
Attachment F: National Public Health Performance Standards Program (NPHPSP) Meeting Guide (for Governance Instrument)
Attachment G: Web-based Data Entry Instruction Sheet
Attachment H: Screen Shots of Example Pages from Web-based System – Submitting Data and Accessing Reports