Supporting Statement (Part A: Justification) of the Request for OMB Review and Approval for Community Assessment for Public Health Emergency Response (CASPER)

0920-NEW

Generic Clearance

December 2014

Health Studies Branch (HSB)
Division of Environmental Hazards and Health Effects (DEHHE)
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Table of Contents

List of Attachments

Attachment A. Authorizing Legislation
Attachment B. 60-day Federal Register Notice
Attachment C. Sample CASPER Questionnaires
Attachment D. Sample CASPER Tracking Form
Attachment E. Sample Referral Form
Attachment F. Sample Final Report
Attachment G. Request for Approval under Generic Clearance for CASPER
Attachment H. Burden Memo
Attachment I. Step-by-Step How to Use the Generic Clearance for CASPER
Attachment J. Sample Introduction and Consent Script
Attachment K. Sample Sampling Frame and Cluster Map
Attachment L. Sample CASPER Press Release
Attachment M. Sample CASPER Publication
Attachment N. CASPER Toolkit, Sections 5.2 Weighted Analyses and 5.3 Calculation of 95% Confidence Intervals

A.1 Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) is seeking Office of Management and Budget approval for three years for a new generic information collection request (ICR) for Community Assessment for Public Health Emergency Response (CASPER). Prior to this request, CASPERs were conducted as Epi-Aids and as such, were covered under the previously OMB-approved Emergency Epidemic Investigations ICR (OMB No. 0920-0008; expiration 7/31/2014), which applied specifically to information collections conducted by CDC under the Epi-Aid mechanism (a specific administrative mechanism enacted to support a field response). The Emergency Epidemic Investigations ICR was not reinstated following expiration, and the ICR submitted in its place will no longer cover CASPERs; therefore, we are requesting a Generic ICR Clearance for the CASPER activities conducted in the context of emergency situations. The purpose of this Generic ICR Clearance is to facilitate the use of CASPER to quickly provide low-cost, household-based information about a community's perceived needs in a simple, easy-to-understand format to requesting state and local agencies to respond to emergency situations. Note that in an emergency situation, it is often more useful for local health officials and emergency responders to have immediate feedback on perceived needs than it is to wait for more precise characterizations of actual health conditions, access limitations, and infrastructure problems.

The law authorizing data collection using CASPER is Section 301 of the Public Health Service Act (42 U.S.C. 241) (Attachment A). The 60-day Federal Register Notice is provided as Attachment B.

Background

HSB Disaster-related Expertise

Important areas of expertise within Health Studies Branch (HSB), National Center for Environmental Health, Centers for Disease Control and Prevention, are disaster epidemiology and disaster response (in all four phases of a disaster--mitigation, preparedness, response, and recovery). Our role is often to gather knowledge about the community as it progresses through these four disaster phases. Both natural (e.g., tornado, earthquake, hurricane) and man-made (e.g., chemical spill, radiation event) disasters are environmental. Disasters destroy homes; damage local infrastructure such as the water distribution systems, power production and distribution systems, and health facilities. Disasters also interrupt services and social support networks, thus negatively affecting community well-being. A number of public health issues may arise from exposure to the environmental impacts of a disaster. For example, morbidity and mortality results from exposure to chemicals, flood waters, falling debris, and structure collapse.[1,2]

What is a CASPER?

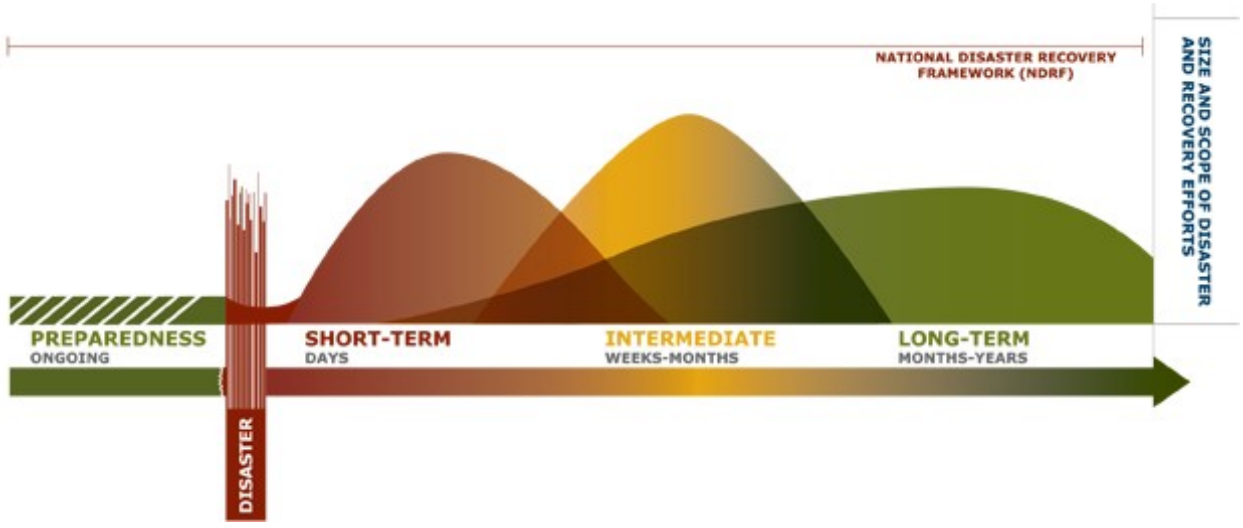
Following disasters or other public health emergencies, public health and emergency management professionals must be prepared to quickly identify and meet the needs of the affected community. To respond appropriately, these professionals need timely and accurate information.

CASPER is a public health tool (i.e., one of the many options that a public health professional can use to gather information) originally developed by the World Health Organization (WHO) and adapted by HSB for use in mitigating, preparing for, responding to, and recovering from disasters. The purpose is to quickly gather information about the current situation and assess a community's immediate needs by

conducting a survey of a representative sample of the community. The CASPER's method is to identify the community's perceived needs and infrastructure status during all phases of a disaster has been validated via use and review by epidemiologists and statisticians from WHO and CDC over the last few decades.[3,4] Reviewers concluded that the CASPER method provides critical information needed to allow emergency response officials to prioritize emergency response activities and to make informed decisions regarding the distribution of resources.

Each time a CASPER is used, it is tailored to the current needs of public health and, if appropriate, emergency managers. For example, during disaster preparedness, a CASPER survey may be used to assess whether people are prepared to remain at home for a prolonged period by having sufficient emergency supplies available. During disaster response, a CASPER survey may be used to assess whether people have electricity or whether people are receiving and understanding critical public health messages. The results of CASPER surveys are shared through the local public health or incident command structure with a wide variety of professionals, including city planners, emergency medical personnel, public health officials, and engineers. HSB developed the CASPER toolkit to explain what a CASPER is and to standardize the process for conducting one. The CASPER toolkit can be found on the web and is freely available for use by state and local jurisdictions (see http://www.cdc.gov/nceh/hsb/disaster/casper.htm). *In this ICR, we focus only on CASPERS done in the context of an immediate emergency disaster response and recovery; CASPERS designed only for capacity building, preparedness, and post-event evaluations are not covered in this generic ICR.* Urgent public health needs can occur both in the response and short- and intermediate-term recovery phases of a disaster (see figure below).[5] The recovery phase of a disaster involves moving the community back towards normal functioning. Recovery is immediate and overlaps with response. It includes actions such as providing essential public health and safety services, restoring interrupted utility and other essential services, reestablishing transportation routes, and providing food and shelter for those displaced by the incident.[6]

Figure A.1.1. The Recovery Continuum



What are the objectives of a CASPER done during an emergency disaster response?

In the disaster setting, the main objectives of CASPER are to:

- determine the perceived health needs and assess the immediate infrastructure impact of the disaster (e.g., characterizing the availability of public utilities and sanitation services for the population) and
- characterize the population residing in the affected area (e.g., assessing basic demographic characteristics such as age, ethnicity, sex, and number of households with pregnant women).

Who can request a CASPER?

At the request of a state, tribal, local, or territorial government agency (STLT) or an international health authority, HSB will conduct a CASPER to assess current or emerging community needs during a disaster emergency response. This does not require a federally- or state-declared disaster; this only requires an official request from the public health authority of an STLT or an international health authority. Domestic CASPERs will follow prescribed Incident Command System (ICS) or Incident Management Structure (IMS) procedures described below. CASPERs conducted internationally, such as the CASPER conducted for the Turkey Earthquake in 1999, will be managed through the CDC emergency operations center and follow prescribed IMS for CDC staff.[7, 8] The jurisdiction will determine the level of CDC's involvement and the particular objectives of the CASPER they would like to conduct.

How does a CASPER fit in to the overall emergency disaster response?

HSB will assist with a CASPER survey when requested by a state or other Public Health Partner. HSB's disaster-related CASPER surveys will only collect information that is not available from other disaster response entities. The notice that HSB has been invited by a state to conduct a CASPER will be shared by our public health contact (e.g., the State Epidemiologist) with other agencies responding to the event through the ICS or IMS -- entities activated by the emergency management coordinating agency in the affected state. The ICS and IMS are designed to promote efficient communication and integration across responding entities.[9] A liaison officer will act as the point of contact for agency representatives, including the state health official requesting a CASPER, and will track assisting and cooperating agencies, and aid in setting up interagency contact.[9] The individual filling this role will change from event to event. For more information please see the following site: http://training.fema.gov/EMIWeb/IS/ICSResource/assets/reviewMaterials.pdf. HSB will work through the requesting state agency if contact with any other entities active in the disaster is required.

How is HSB involved in CASPER surveys?

CDC developed the CASPER toolkit as a guidance document for use by external partners. The toolkit provides options on the best methods available for conducting CASPERs. Sometimes, CDC provides technical assistance with sampling methodologies or questionnaire development and is not involved in data collection or analysis. In these cases, CDC does not receive the data nor do we request to keep the data. Thus for these types of technical assistance requests, OMB approval would not be required. In other cases, CDC employees are deployed to the field to assist in some or all of the operations of the CASPER, including interviewing household members. This is considered a sponsored project in the context of the PRA.

A.2 Purpose and Use of Information Collection

Information collected through CASPER questionnaires and their corresponding reports is designed to be used by public health department personnel, emergency management officials, academics, or other entities with responsibility for disaster response that must rapidly assess household-level public health needs.

The information collected characterizes the population residing in the affected area and is not intended for use outside of that local area nor to inform activities in other areas. CDC may also provide recommendations to state or local decision makers, but ultimately it is the state or local jurisdiction's decision to act on the recommendations presented. CDC also plans to analyze the data collected during the CASPERs that are federally sponsored to provide insight into how disaster related emergencies affect communities and to assess community preparedness.

It is important for the information collected to be applicable specifically for the affected jurisdiction. Negative impacts of not conducting CASPER include not having information to understand and take action to address immediate community needs during disaster-related emergencies.

The information collected during a CASPER meets the a priori objectives determined by the requesting public health entity. Information is gathered to identify the community's perceived needs and infrastructure status during the response or recovery phase of a disaster. Depending on the objectives, information can be collected in the following categories: demographic and functional needs; housing damage and repair; general utilities; carbon monoxide exposure; animal safety; supplies, relief, and emergency preparedness; health status; medical care and prescriptions; and communications. For more detail please see Table A-10.1. Household-level information that may be collected using a CASPER survey in section A.10.1. Privacy Impact Assessment Information.

A.3 Use of Improved Information Technology and Burden Reduction

CASPER interviews are conducted in person and there are two options for data collection: paper forms and handheld electronic devices. Both the paper and the electronic formats have their advantages and disadvantages; therefore, it is important to carefully consider both options prior to making a decision and producing the questionnaire. Generally, while the paper forms can be labor-intensive in the data entry process, the electronic format can be labor-intensive in the development stage. In addition, electronic forms may be more resource intensive to conduct.

In order to reduce burden on the participant, CASPER questionnaires are generally limited to two pages. In general, yes/no and multiple choice questions are utilized to capture the needed information more efficiently. While the CASPER questionnaire is usually completed using pen and paper, there may be instances where the questionnaires may be completed using CDC-approved electronic devices, such as digital pens. Digital pens are encrypted and the databases that information is entered into are password protected. State and local CASPER partners may own other electronic equipment that can range in type (e.g., various handheld devices). Use of these devices is up to the local jurisdiction conducting the CASPER. The responses potentially collected via electronic equipment are currently approximated at 1% of all CASPERs conducted. Referral forms that contain PII will not be collected using electronic devices.

Regardless of how information is collected, data is analyzed with CDC-approved software, such as Epi Info 7. Epi Info 7 is publically available statistical software that stores data in a Microsoft Access

Database file (http://wwwn.cdc.gov/epiinfo/). Data is stored as a flat file and the databases are password protected.

A.4 Efforts to Identify Duplication and Use of Similar Information

The purpose of CASPER is to assess the health status and needs of an affected community at the household level and to provide information specific to the event being addressed at that time. While there may be health information known about an area before a disaster or public health threat occurs, a community's perceived needs will be directly affected by a disaster-related emergency event. As a result, CDC and its partners may decide to conduct CASPERs to assess the changing situation by collected data that are immediately relevant to the emergency. Without this event-specific information on the community, public health officials cannot respond to the most current community needs.

It is important to note that CASPERs are unique data collection events. CASPERs are used to assess current needs of community members. By contrast, the Federal Emergency Management Agency (FEMA) formerly conducted rapid needs assessment (RNAs) as part of their disaster emergency response activities.[10, 11] FEMA's RNAs focus on high level key infrastructure assessments (e.g., hospitals, bridges, emergency operation centers) to assist in determining Federal involvement and funding in a disaster/emergency. The new concept of these assessments used by FEMA is known as the Incident Management Assistance Team (IMAT).[12]Different from a FEMA RNA or IMAT, CASPER focuses on assessing household-level public health needs (e.g., household access to utilities, generator use/exposure to carbon monoxide, receipt and understanding of public health communications). CDC does not consult with FEMA before conducting a CASPER. CASPERs are done at the request of our STLT partners, who then coordinate with other agencies that may be responding to the same disaster-related emergencies.

A.5 Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this data collection.

A.6 Consequences of Collecting the Information Less Frequently

The purpose of this request for generic clearance is to ensure the collection of data that provides valuable, time sensitive information on critical health needs and impacts of an event, characterize the affected population, provide primarily household-based information to decision-makers, and potentially to use this information after the event to assess the effectiveness of relief efforts. These data are not otherwise available prior to a disaster or other event occurring. Without this data, public health officials may make decisions based on anecdotal information; such decisions may not accurately reflect the perceived needs of the entire community.

A majority of CASPERs are one-time assessments related to a specific event. Respondents will most likely never have to report information more than once. If follow up studies are conducted in the community (under separate OMB clearances or by local organizations), efforts will be made to minimize the extent to which the same individuals are contacted (See Section B.2 for more information on the sampling methodology).

There are no legal obstacles to reduce the burden.

A.7 Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

There are no special circumstances with this information collection package. This request fully complies with the regulation 5 CFR 1320.5.

This ICR only covers CASPERs are requested by STLTs or an international health authority under emergency situations (e.g., hurricane response, oil spill). A strength of the CASPER tool is its ability to be quickly initiated and conducted once a state has requested CDC assistance in the field.

Figure A.7.1 and A.7.2 below are examples of past response timelines for disaster/emergency CASPERs. In both instances CDC teams were conducting CASPER surveys within 48-96 hours of a formal request for assistance from states. Necessary changes to sampling frames and data collection instruments took place 12-24 hours before data collection began.

Figure A.7.1. CASPER response timeline for Hurricane Ivan, 2004

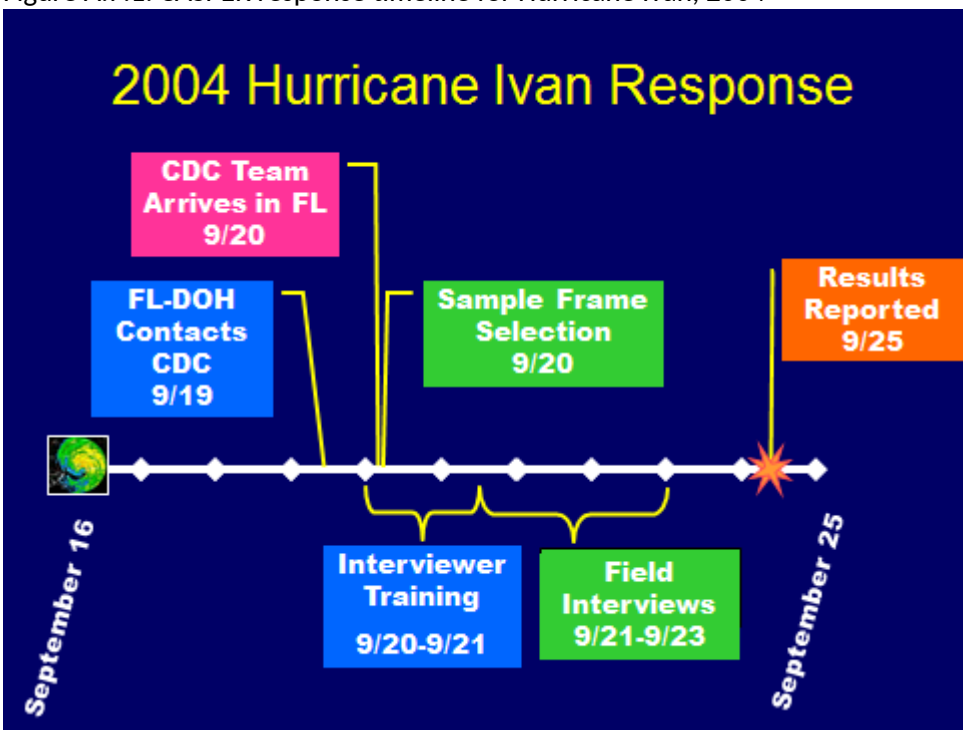
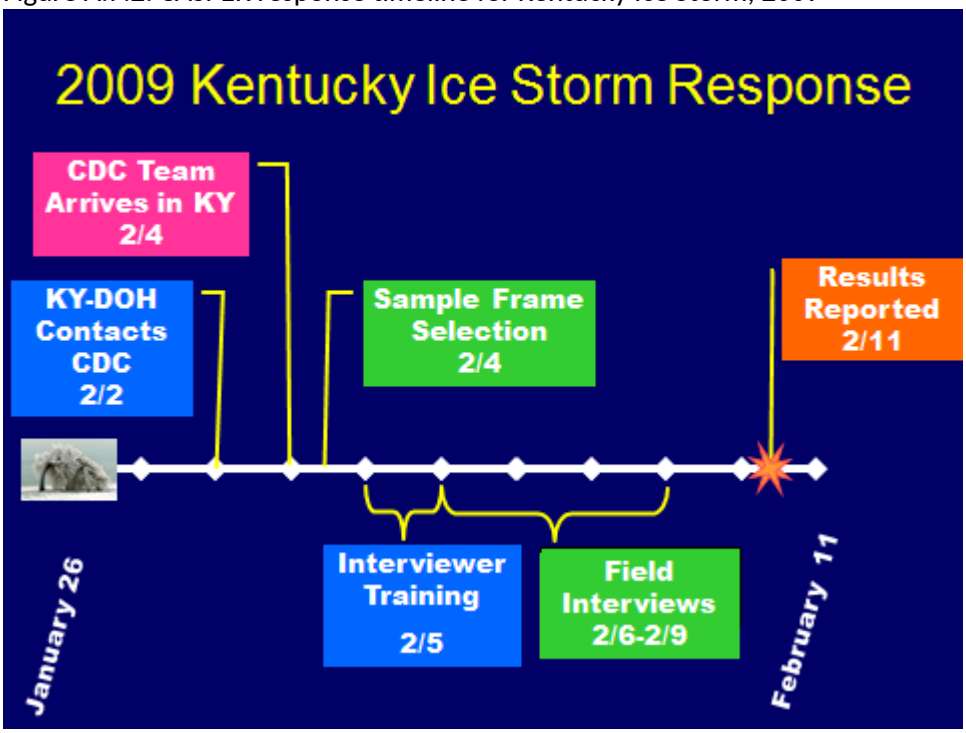


Figure A.7.2. CASPER response timeline for Kentucky Ice Storm, 2009



The time critical nature of CDC's response to these situations can be addressed through the use of this generic OMB submission, under which individual CASPER Gen ICRs can be submitted for expedited review and approval. To facilitate effective and timely response to public health events, CASPERs often need to be initiated within hours or days of the request. Because of the need to rapidly obtain information to appropriately respond to the urgent public health need, data collection will usually be completed within 180 days.

To ensure that public health data are collected in a timely manner as necessary to protect the health of the public, CASPERs will adhere to the following timeline and processes:

1. At the request of a STLT or international health authority, NCEH decides to organize and deploy a team to conduct or assist with a CASPER.
2. The OMB Desk officer is notified of the CASPER immediately via e-mail from CDC.
3. Draft data collection instrument(s), a letter of invitation from an STLT or international health authority (sensitive information in the Letter of Invitation not appropriate for public dissemination should be redacted prior to sending), and the generic information collection (Gen ICR) "Request for Approval under Generic Clearance for CASPER" form (Attachment G) describing the problem and the planned response will be submitted to OMB.
4. CDC staff may deploy to the field and begin planning the CASPER and finalize the collection instrument based on the requesting organization's CASPER objectives before the request is submitted to OMB. Once the data collection instrument has been finalized, submit the final version to OMB.
5. The OMB desk officer responds with approval or comments on the proposed CASPER within 5 business days of receipt of the final data collection instrument, unless the request is for a shorter time frame (i.e., 24 or 72 hours). *If a 24- or 72-hour approval is requested, an explanation must be provided as to why it is needed. Specifically, CDC must make a case as to why collection must begin within 24 to 72 hours, and it must be related to a public health*

need. Data collection cannot begin until OMB has approved the information. OMB may provide approval and comments orally (followed by e-mail for written documentation) or e-mail directly to CDC. This may occur before the Gen ICR request is submitted and received by OMB through the official ICR tracking system.

6. At the completion of the CASPER, the investigators submit the final data collection instrument(s) and associated burden using the "Burden Memo" form (Attachment H) to the Information Collection Request Liaison (ICRL).
7. CDC maintains a library of data collection instruments that includes all final data collection instruments conducted under this generic ICR. This library and the updated burden numbers based on data collected via the "Burden Memo" (Attachment H) submitted to OMB quarterly as a non-substantive change to the generic ICR.

A CDC staff person serves in the role of CASPER ICRL. The ICRL oversees the clearance process for individual Gen ICRs. Information about the generic ICR and how to submit a Gen ICR is distributed to CDC program officials (Attachment I). The ICRL maintains a library of data collection forms that may be accessed by CDC programs initiating new CASPERs. Upon the completion of a CASPER, the ICRL places the data collection instruments into the library.

Each CASPER request is closely reviewed by the ICRL. The "Request for CASPER" form (Attachment G) serves as the Gen ICR package for each individual CASPER investigation.

A.8 Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A. The 60-day Federal Register Notice was published in the *Federal Register* on April, 2, 2014, Vol. 79, No. 63, pp. 18553–18554 (See Attachment B). Public comments were not received.

B. CDC partners with professional state, tribal, local, and territorial organizations (STLT), such as the Council for State and Territorial Epidemiologists (CSTE), and national groups, such as the CDC Disaster Epidemiology Community of Practice. The CDC Disaster Epidemiology Community of Practice includes internal and external partners to ensure that the collection requests under Gen ICRs are not in conflict with collections they have or will have in the field within the same timeframe.

Below is a list of individuals outside the NCEH who were consulted to obtain their views on the availability of data, the clarity of instructions and information, and the completeness of the material.

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Consulted January 2014

A.9 Explanation of Any Payment or Gift to Respondents

CDC will not provide payments or gifts to respondents.

A.10 Assurance of Confidentiality Provided to Respondents

A.10.1. Privacy Impact Assessment Information

An overview of the data collection system

Supporting Statements A and B outline CDC's standard procedures for conducting CASPERs. The goal during a standard CASPER is to complete 210 interviews within the assessment area. To provide the basis for sufficiently accurate population estimates the interviews must be conducted according to an appropriate sampling method. The two-stage cluster sampling design used in CASPER provides a representative sample of households within the sampling frame that will allow the generation of sufficiently accurate population estimates during data analysis (see Part B).

CASPER questionnaires gather information through in-person interviews with one adult (≥18 years of age) from each household identified through the cluster sampling procedure. The particular adult in any given household would be chosen based on whether they are able to communicate fluently with the interviewer, are present at the home when he/she is approached, and are willing to be interviewed. Questionnaire responses are recorded on a paper or electronic form by the interviewer. In general, interviews take approximately 30 minutes and consist of two-page questionnaires. The majority of the time information on the CASPER questionnaire is collected at the household level, meaning that the respondent is answering questions for the household, not just for her- or himself.

Table A-10.1. Household-level information that may be collected using a CASPER survey

Information Collection Categories	Examples of Needed Information
Demographic and functional needs (See example CASPER questions provided in the CASPER Toolkit, Appendix B – use of these questions is optional)*	Age, sex, race, ethnicity
Housing damage and repair (See example CASPER questions provided in the CASPER Toolkit, Appendix B – use of these questions is optional)	Home physically safe for habitation, presence of mold, presence of floodwater
General utilities (See example CASPER questions provided in the CASPER Toolkit, Appendix B – use of these questions is optional)	Access to running water, gas, electricity, garbage pickup
Carbon monoxide exposure (See example CASPER questions provided in the CASPER Toolkit, Appendix B – use of these questions is optional)	Generator use, working carbon monoxide detector
Animal safety (See example CASPER questions provided in the CASPER Toolkit, Appendix B – use of these questions is optional)	Exposure to mosquitoes or wild animals, animal bites
Supplies, relief, and emergency preparedness (See example CASPER questions provided in the CASPER Toolkit, Appendix B – use of these questions is optional)	Adequate drinking water, adequate food, first aid supplies
Health status (See example CASPER questions provided in the CASPER Toolkit, Appendix B – use of these questions is optional)	Physical injuries, mental or behavioral health issues, illness (e.g., fever, diarrhea, vomiting)
Medical care and prescriptions (See example CASPER questions provided in the CASPER Toolkit, Appendix B – use of these questions is optional)	Access to medical care, need for urgent care, access to prescription medication
Communications (See example CASPER questions provided in the CASPER Toolkit, Appendix B – use of these questions is optional)	Receipt of warnings, reliable sources of information, mode of communication

* Demographic characteristics, such as sex, age, race and ethnicity, etc., assist public health and emergency responders in understanding the makeup of the population affected. This allows for the determination of specific risk factors and social vulnerabilities and a more tailored response. For example if you found there was a large non-English speaking Hispanic population, translation of your public health communications into Spanish would be appropriate. It is very typical for any epidemiology study or assessment to collect demographics.[13]

While CASPER questionnaires primarily collect household-level information, there may be instances where the questionnaires are modified to collect information on the individual level. In this circumstance, the adult who is interviewed regarding household-level information is also asked individual-level questions. This adult would be chosen the same way adults are chosen for household-level interviews. Categories of individual level information include the following:

- Demographics
- Personal needs (e.g., first aid, food, water, ice, and medicine)
- Physical and behavioral health status
- Perception of and response to public health communications

See Attachment C for sample CASPER questionnaires. These are examples of questionnaires used for CASPERs conducted in the past. There is a list of example questions in the CASPER Toolkit (http://www.cdc.gov/nceh/hsb/disaster/casper.htm) which provides guidance on what questions to ask and how they can be asked.

A description of the information to be collected

Tracking forms

Tracking forms are utilized by interview teams to record households approached. This form is used to document if a chosen household was successfully interviewed, needs revisited because there was no one present to complete an interview, or was never interviewed and the reason for that [abandoned, not approachable (aggressive dog, no trespassing sign)]. This information never includes a complete mailing address (e.g., house number, street name, city, state, and zip code) or GPS coordinate information. Information used to identify households for return visits is never retained by CDC or entered into any database. The tracking forms do not contain direct PII. CASPERs are not recommended for communities with less than 800 housing units. Descriptive information of housing units is only recorded if a household must be revisited (e.g., no one answered the door after first try). In rare cases, 210 households may be a large portion of some communities thus even without direct PII, the location of a household could be identifiable; however, it is not possible to link the tracking form from a given household to that household's questionnaire. Only teams working with in a cluster will access this information, and any descriptive information beyond access, type of dwelling, damage, whether door was answered, and whether interview was conducted is not recorded. All tracking forms are destroyed after data collection and entry is complete. Information regarding number of households approached, number of interviews completed, and reasons for not completing an interview at a household from these forms will be entered into an Excel file on a CDC password protected computer.

Referral forms

To protect privacy, PII is rarely collected. The few instances where PII may be collected are in situations where households are identified during the CASPER to have urgent, life-threatening needs. In these instances, PII is collected on separate referral forms (Attachment E) which are immediately transferred to a local coordinator (e.g., local public health staff). A local coordinator uses the information on the referral form to rapidly follow-up with the participant and to communicate with health service providers in the area or response agencies to address any immediate needs. The referral form and the information contained in it is never retained by the CDC or entered into any database. The forms will be given immediately to the local jurisdiction. There is no way to link specific questionnaires to any PII that may be collected. Field teams are trained in the handling of referral forms during a training conducted in advance or the morning of the first day of data collection in the field. This training helps to ensure that interviewers properly handle and safeguard any information collected, minimizing the possibility of unauthorized access, use, or dissemination.

A description of how the information will be shared and for what purpose

After the data is analyzed by CDC, the results of the CASPER are shared in two main ways: a preliminary report or presentation provided to key stakeholders within a day or two after data collection and a cleared final report that may be more widely distributed at a later time (Attachment F). Reports of CASPER results are distributed by the requesting state or local. Politicians occasionally sit in on exit

presentation that CDC presents to the state public health officials, and CDC sometimes receives information requests directly from Congress (e.g., progress reports on CASPERs currently being conducted and results from or questions about CASPERs previously conducted). We always consider the media a potential audience. The state often releases the information publicly, and CDC often receives questions directly from the media after the information is released.

Reports only present responses in aggregate form and there is no way to identify households or individuals from reported information or data sets. The report results from CASPER questionnaires are shared in order to prompt public health action (e.g., prioritization of resources or public health interventions) in response to the current health status or needs of the population affected by the disaster-related emergency.

We intend to share CASPER results by presenting at professional conferences and by publishing manuscripts in peer-reviewed journals. This is a common practice in public health; responses to outbreaks, isolated cases, and emergency responses are often published as they provide lessons learned and examples for others in public health.

A referral form may be used when an interview team identifies households with urgent needs that present an immediate threat to life or health. These forms are given immediately to the local jurisdiction, will not be entered into any CDC database, and will not be in custody of CDC after collection. Further, there is direct identifier that links either the tracking forms or referral forms back to a specific household's questionnaire answers.

A statement detailing the impact the proposed collection will have on the respondent's privacy

When a person is asked if they would like to participate in a CASPER interview, they are informed that the survey is voluntary and anonymous and that they can refuse to answer any of the questions or refuse to participate at any time. We do not gather PII.

Whether individuals are informed that providing the information is voluntary or mandatory

Participation in a CASPER interview is voluntary. In an introductory script, the interviewer will provide information including:

- A description of any anticipated discomfort or inconvenience to the respondent, particularly if some questions may be of a sensitive nature (e.g., race and ethnicity, mental health, pregnancy, or disability).
- An explanation that the questionnaire is anonymous and will not be linked to PII.
- A statement that taking part in the study is voluntary and that there will be no penalty or loss of benefits if household members do not wish to participate and that they can stop participating at any time with no penalty.
- Name and phone number or e-mail of the person(s) a resident can contact if s/he has any questions about the CASPER or would like to verify interview team identification.
- A clear participation request or invitation that requires an explicit answer.

Opportunities to consent, if any, to sharing and submission of information

Participants must give explicit verbal consent before a questionnaire is administered. Signed consent is not required for a CASPER because obtaining signatures leads to an increased privacy risk for the participant (i.e., the signed consent will be the only record linking the participant to the questionnaire). See Attachment J for sample CASPER introduction and consent language.

How the information will be secured

Responses to CASPER questionnaires will be entered into an Epi Info database (data is stored in a Microsoft Access Database file) and stored on a CDC-approved, encrypted, password-protected computer. The project computers will be kept in locked offices and access to the study data will be password-protected. All electronic data will be maintained by CDC. Data will not include any identifiers. Statistical data analysis and interpretation will be provided by CDC using Epi Info or SAS. Hardcopies of the recorded responses on questionnaires will be given to the local jurisdiction and will not be brought back to CDC Atlanta.

All records are subject to the CDC Comprehensive Record Control Schedule (CRCS), B-371, which contains authorized disposition instructions for CDC's administrative and program records. CDC is legally required to maintain its program-related records in accordance with disposition instructions contained in this comprehensive records control schedule. These retention periods have a direct impact on completing Freedom of Information Act requests and in applying the requirements of the Privacy Act.

Whether a system of records is being created under the Privacy Act

This submission has been reviewed by the NCEH/ATSDR PRA Coordinator who has determined that the Privacy Act does not apply to this information collection. PII is never stored or retained by the CDC, and a System of Records is not required for this generic clearance.

IRB Approval

Disaster CASPERs are a non-research activity, as they are conducted as part of local public health response or recovery activities for the purposes of informing local public health action. All CASPER Gen ICRs will be submitted for a research determination the determination will be made on a case-by-case basis.

A.11 Justification for Sensitive Questions

We will submit appropriate documentation within the individual Gen ICR packages for each CASPER to OMB for approval. See Attachment C for examples of CASPER questionnaires. Sometimes, information that can be considered of a sensitive nature (e.g., race and ethnicity, mental health, pregnancy, or disability) may be included in CASPER questionnaires if they can help provide a clearer understanding of what the population being assessed needs and thus help decision makers respond appropriately to the situation at hand.[15-19] States may request that we collect information on how a disaster has impacted their communities in regard to specific issues, such as mental and behavioral health issues, so they can provide information and resources if they find there is a need. Questions regarding physical health issues, such as those inquiring if any household members may be blind or deaf, can help to better understand specialized outreach or communication methods that may be needed in that community.

A.12 Estimates of Annualized Burden Hours and Costs

A. CDC estimates that it will conduct an average of 6 emergency CASPERs per year, generally interviewing 210 households per CASPER. Each household interview is estimated to require 30 minutes, which includes time to give an introduction, obtain consent, and administer the questionnaire. The estimates in Table A-12.1 are based on previous CASPERs conducted in the past few years (OMB No. 0920-0008; expiration 7/31/2014). The respondent universe is described further in section B.1. The total estimated annual burden hours are 631 hours.

Table A-12.1 Total Annualized Burden Hours

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
Households in the selected geographic area to be assessed	CASPER Questionnaire	1,260	1	30/60	630
	Referral Form	24	1	2/60	1
				Total	631

B. The average national hourly salary is assumed for all respondents, based on the Department of Labor May 2012 National Occupational Employment and Wage Estimates for the United States (http://www.bls.gov/oes/current/oes_nat.htm#00-0000). With the total estimated burden hours of 631 hours, the overall annual cost of respondents' time for the proposed collection is estimated to be $13,888. There will be no costs to the respondents other than their time.

Table A-12.2 Estimated Annualized Burden Costs

Type of Respondents	Form Name	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
Households in the selected geographic area to be assessed	CASPER Questionnaire	630	$22.01	$13,866
	Referral Form	1	$22.01	$22
			Total	$13,888

A.13 Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

There are no anticipated costs to respondents other than time.

A.14. Annualized Cost to the Federal Government

There are no equipment or overhead costs. The only cost to the federal government is the salary of CDC staff supporting the data collection activities. Typically up to five FTEs or EIS Officers (GS-13) participate on a CASPER. The estimated cost to the federal government is $98,328 based on an average hourly rate of $40.97 for a GS-13 in Atlanta obtained from the Office of Personnel Management's website (http://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/2013/general-schedule/atlanta-sandy-springs-gainesville-ga-al-hourlyovertime-rates-by-grade-and-step/). It is expected that six CASPERs will occur each year. Table A-14 below describes how this estimate was calculated.

Table A-14 Estimated Annualized Cost to the Federal Government

Staff or Contractor	Average Number of Staff per CASPER	Average Hours per CASPER	Average Hourly Rate	Average Cost
FTE (GS-13)	5	32	$40.97	$6,555
Estimated Total Average Annual Cost of 6 in-person Information Collections				$39,330

A.15. Explanation for Program Changes or Adjustments

This is a new data collection.

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

Time schedules for individual CASPERs vary based on situation and site specific conditions. Due to the urgent circumstances under which CASPER can be requested, it is important for CASPERs to be ready to initiate within 72 hours of a request if necessary, and sometimes within 24 hours of a request. The duration of the data collection varies for each CASPER, but does not exceed 180 days. If it is determined an investigation will extend beyond 180 days, the lead investigator will submit a new Gen ICR. For each CASPER, the lead investigator is responsible for developing an analysis plan and conducting the data analysis. Table A.16 represents a general schedule anticipated for most CASPERs.

Table A-16

Project Time Schedule	
Activity	**Time Schedule**
Data collection (field work)	1-14 days after OMB approval
Analyses	1-4 weeks after OMB approval
Reporting	1-8 weeks after OMB approval
Publication	6-12 months after OMB approval

A.17. Reason(s) Display of OMB Expiration Date is Inappropriate

We are not requesting exemption from display of the OMB expiration date.

A.18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

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