Supporting Statement for Paperwork Reduction Act Submissions for the Division of National Healthcare Preparedness Programs

Hospital Preparedness Program Data Collection

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OMB SUPPORTING STATEMENT

A. JUSTIFICATION (SECTIONS 1 – 18)

1. Circumstances Making the Collection of Information Necessary

The Hospital Preparedness Program (HPP), part of the Department of Health and Human Services (HHS) Assistant Secretary for Preparedness and Response (ASPR) Office of Preparedness and Emergency Operations (OPEO) Division of National Healthcare Preparedness Programs, is seeking an Office of Management of Budget (OMB) clearance to conduct a data collection effort as part of their assessment of state cooperative agreements. Data will be gathered from Mid-Year Progress Reports and End-of-Year Reports for the Hospital Preparedness Cooperative Agreement (CA) Program. This data collection effort is crucial to HPP's decision-making process regarding the continued existence, design and funding levels of this program. Results and analyses will enable HPP to monitor healthcare emergency preparedness and progress towards national preparedness goals. HPP supports priorities outlined by the National Preparedness Goal (The Goal) established by the Department of Homeland Security (DHS) in 2005.[1] The Goal guides entities at all levels of government in the development and maintenance of capabilities to prevent, protect against, respond to and recover from major events. Additionally, the Goal will assist entities at all levels of government in the development and maintenance of the capabilities to identify, prioritize and protect critical infrastructure.

This data collection effort is authorized by section 2802(b) of the Public Health Service (PHS) Act, as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA) (P.L. 109-417).[2] PAHPA authorizes HHS to award cooperative agreements to enable eligible organizations to improve surge capacity and enhance community and hospital preparedness for public health emergencies (the full text of PAHPA is included in Appendix I). HPP defines surge capacity as the "accommodation by the health system to a transient sudden rise in demand for health care following an incident with real or perceived adverse health effects."[3] This law outlines administrative and financial annual reporting requirements for awardees, so that HHS can monitor the performance of awardees and assure proper

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1 U.S. Department of Homeland Security. (2005, Mar. 31). *Interim National Preparedness Goal*. Retrieved September 25, 2007 from http://www.ojp.usdoj.gov/odp/docs/InterimNationalPreparednessGoal_03-31-05_1.pdf.

2 U.S. Congress. (2006, Jan.). *Pandemic and All-Hazards Preparedness Act S.3678.* Retrieved September 28, 2007 from http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:s3678enr.txt.pdf

3 National Bioterrorism Hospital Preparedness Program. (2004, July 1). *FY 2004 Continuation Guidance,* pg. 48. Retrieved September 25, 2007 from www.gnyha.org/397/File.aspx

expenditure of funds. In addition, Section 201 mandates the achievement of measurable evidence-based benchmarks and objective standards:

> ‘‘(g) ACHIEVEMENT OF MEASURABLE EVIDENCE-BASED BENCHMARKS AND OBJECTIVE STANDARDS.— ‘‘(1) IN GENERAL.—Not later than 180 days after the date of enactment of the Pandemic and All-Hazards Preparedness Act, the Secretary shall develop or where appropriate adopt, and require the application of, measurable evidence-based benchmarks and objective standards that measure levels of preparedness with respect to the activities described in this section and with respect to activities described in section 319C– 2. In developing such benchmarks and standards, the Secretary shall consult with and seek comments from State, local and tribal officials and private entities, as appropriate. Where appropriate, the Secretary shall incorporate existing objective standards. Such benchmarks and standards shall— ‘‘(A) include outcome goals representing operational achievement of the National Preparedness Goals developed under section 2802(b); and ‘‘(B) at a minimum, require entities to— ‘‘(i) measure progress toward achieving the outcome goals; and ‘‘(ii) at least annually, test, exercise, and rigorously evaluate the public health and medical emergency preparedness and response capabilities of the entity, and report to the Secretary on such measured and tested capabilities and measured and tested progress toward achieving outcome goals, based on criteria established by the Secretary.”

Performance measure data will represent the extent to which awardees have met outcome goals and objectives and will be demonstrated through exercises and drills. This data will allow HPP to identify strengths and gaps in healthcare emergency preparedness and distribute best practices and lessons learned to all awardees. The PAHPA law also gives HPP authority to withhold funds to recipients who fail to meet performance benchmarks:

> ‘‘(5) WITHHOLDING OF AMOUNTS FROM ENTITIES THAT FAIL TO ACHIEVE BENCHMARKS OR SUBMIT INFLUENZA PLAN.—Beginning with fiscal year 2009, and in each succeeding fiscal year, the Secretary shall— ‘‘(A) withhold from each entity that has failed substantially to meet the benchmarks and performance measures described in paragraph (1) for the immediately preceding fiscal year (beginning with fiscal year 2008), pursuant to the process developed under paragraph (4), the amount described in paragraph (6).”

As a result, HPP must collect the data elements proposed in this data collection effort to measure benchmarks and standards and to determine future funding amounts.

Program Description

The Hospital Preparedness CA Program provides funds to all 50 states; the District of Columbia; the three metropolitan areas of New York City, Los Angeles County and Chicago; the Commonwealths of Puerto Rico and the Northern Mariana Islands; the territories of American Samoa, Guam and the U.S. Virgin Islands; the Federated States of Micronesia; and the Republics

of Palau and the Marshall Islands. The Hospital Preparedness CA Program has provided funding since fiscal year 2002 to help increase the capacities and capabilities of hospitals and supporting healthcare entities to plan for, respond to and recover from mass casualty events. These funds will be used to help states, territories and the specified municipalities to meet the National Preparedness Goal and the following goals as outlined in section 319C-2 of the PAHPA:

- **Integration:** Insure the integration of public and private medical capabilities with public health and other first responder systems
- **Medical capacity and capability:** Increase the preparedness, response capabilities and surge capacity of hospitals, other health care facilities (including mental health facilities), trauma care and emergency medical service systems, with respect to public health emergencies
- **At-risk individuals:** Be cognizant of and prepared for the medical needs of at-risk individuals in their community in the event of a public health emergency
- **Coordination:** Minimize duplication of, and ensure coordination between, Federal, State, local and tribal planning, preparedness, response and recovery activities (including the State Emergency Management Assistance Compact)
- **Continuity of operations:** Maintain vital public health and medical services to allow for optimal Federal, State, local and tribal operations in the event of a public health emergency.

Developing medical surge capability is a complicated process that includes many different components, referred to as "sub-capabilities." These funds will support the awardees' ability to meet the following five sub-capabilities by August 2008:

- Interoperable communication system
- Bed tracking system
- Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP)
- Fatality management plans
- Hospital evacuation plans.

Description of Data Collection Effort

This program has specific reporting requirements as part of the funding agreements with awardees. Each awardee is required to provide Mid-Year and End-of-Year Progress Reports that requires demographic information (such as the number of facilities and hospital beds within a state), administration and sub-capability information as well as performance

measure data. Administrative data includes a description of activities and progress as well as proposed, obligated and spent funds related to required emergency preparedness capabilities. In addition, the reports collect additional data elements necessary for further analysis. Table 1 provides a summary of the data elements in these data collection tools.

Table 1. Summary of CA Program Mid-Year and End-of-Year Report Elements

Administration and Capability Elements	Performance Measure Elements
Demographic Information Administration Level I sub-capabilities Level II sub-capabilities Additional considerations and emerging items of interest	Bed tracking system reporting capacity Redundant and two-way communication Emergency volunteer system reporting capabilities Fatality management Hospital evacuation Timely completion of reporting requirements Additional data elements

The Mid-Year and End-of-Year Reports are included in Appendix II.

2. Purpose and Use of the Information Collection

In March of 2007, The National Bioterrorism Hospital Preparedness Program, established in FY 2002 and administered by the Health Resources and Services Administration (HRSA), was transferred to the Office of Assistant Secretary for Preparedness and Response (ASPR) Office of Preparedness and Emergency Operations (OPEO), as a result of language in the Pandemic and All Hazards Preparedness Act (PAHPA), enacted in December 2006. Now known simply as the Hospital Preparedness Program (HPP), it is now administered by in the Division of National Healthcare Systems Preparedness Programs within ASPR. In earlier years, the program did not realize that data obtained from grantees on midyear and final progress reports for routine monitoring and performance measurement purposes, was covered by the Paperwork Reduction Act (PRA). A Federal Register 60-day notice was published on January 26, 2007, while the program was in the process of being transferred from HRSA to ASPR. Work on new data collection instruments began shortly thereafter, but could not be completed until the new legislation could be fully reviewed to ensure compliance with the new provisions.

In the past, HPP used a variety of templates to capture indicator data from grantees. Indicators varied from year to year as the new field of healthcare emergency preparedness began to mature. Each year's template incorporated lessons learned from prior years. The current data collection instrument included in this package represents a concerted effort to develop a uniform system for reporting, which will improve the program's ability to monitor

progress in healthcare system preparedness, and report program accomplishments. HPP will use the information gained from the administration of this tool to monitor awardees compliance with program requirements and the development of selected healthcare preparedness capabilities.

HPP will also use collected data to provide technical assistance. Data currently collected by HPP include indicators used to calculate performance measures, such as the number of surge beds, or the number of preparedness exercises and drills conducted during the project period, and other information needed to assess preparedness. Appendix III provides an example of how the data from similar collection efforts were used in the past. This sample table shows the status of Bed Tracking Systems for all awardees across the country. Reflecting the PAHPA law's increased emphasis on performance measurement and accountability, this data collection effort will help determine healthcare emergency response capabilities. While previous data collection efforts have focused on capacity, describing the number of beds or personnel available or types of equipment and systems purchased, this data effort aims at measuring demonstrable performance during a simulated or actual disaster.

The data will provide HPP with the ability to review progress and generate reports on financial and programmatic objectives. The measure of impact of the CA Program will inform future decisions regarding funding and expectations of awardees. In addition, the reporting will increase HPP's ability to quickly and efficiently analyze data, identify trends, provide technical assistance, make timely program decisions and provide HHS, Congress and other Federal agencies with data about the CA Program. This data collection effort will also provide information for the OMB Performance Assessment Rating Tool to measure progress against program performance measures.

3. Use of Information Technology and Burden Reduction

All of the data will be collected and submitted electronically in order to reduce burden on the awardees. The Mid-Year and End-of-Year Reports are user-friendly Microsoft Excel workbooks that include drop-down menu boxes, pre-populated cells and data validation features to facilitate data entry and to increase data accuracy, quality and completeness. Respondents can download and upload the data collection forms online from GrantSolutions.gov and/or submit them electronically to their HPP Project Officers. In addition, HPP can easily migrate the data submitted electronically into a data warehouse for archival purposes which can be used to conduct trend analysis over time. This data collection effort will reduce the possibility of lost and missing data that could result from paper submission. Additionally, it will allow for timely and accurate data analysis that is not

possible with paper submission. The data collection tools have been developed to increase the utility, integrity and objectivity of the data and will be collected and maintained consistently with OMB and HHS information quality guidelines.

4. Efforts to Identify Duplication and Use of Similar Information

HPP is the only Federal program that provides preparedness funds to healthcare facilities, through State Departments of Health. The States collect data from participating facilities on activities undertaken, and equipment purchased with HPP funds, aggregate it up to the State level, and report it to ASPR. During the development of the data collection templates, HPP researched similar programs, conducted key stakeholder interviews, and performed searches of relevant literature to identify potential duplication of the data. While other government agencies provide grants related to emergency preparedness, they focus on entities other than healthcare facilities. For example, the Centers for Disease Control and Prevention (CDC) issues grants to increase public health preparedness, but does not fund healthcare preparedness. HPP also participates in interagency working groups with other Federal preparedness organizations, including DHS, CMS, and CDC. Participation in these groups fosters interagency communication, and increases awareness of other agencies' activities, minimizing the potential for duplication.

5. Impact on Small Businesses or Other Small Entities

The data collection is aimed at state and jurisdiction health departments, not small businesses. However, the awardees will need to collect information from hospitals and other healthcare organizations, which may be small businesses, non-profits, or other small entities. To minimize the impact on these groups, data will be collected only twice during the year. HPP has allocated between 2 percent and 5 percent of funding for administrative costs to support efforts such as data collection.

6. Consequences of Collecting the Information Less Frequently

This will be an ongoing data collection effort, and awardees will be asked to participate biannually. Collecting data twice during the year allows HPP to monitor progress throughout the year and enables awardees to plan more efficiently. By collecting data every year, HPP can analyze trends over time and plan strategically for long-term outcomes. If this collection is not conducted or is conducted less frequently, HPP will not be able to accurately measure and assess the impact of the CA Program against the stated objectives. Since healthcare resources are scarce, collecting timely data is important to prevent weaknesses in healthcare

preparedness and to allow corrections in performance as necessary. Due to the constantly evolving threats (including terrorism and natural disasters), ongoing data collection is essential to reassess risks and vulnerabilities.

7. Special Circumstances Relating to the Guidelines of 5 CFR § 1320.5(d)(2)

The proposed data collection efforts fully comply with all guidelines of 5 CFR § 1320.5 (d) (2). The information collection will not be conducted in a manner:

- Requiring respondents to report information to the agency more often than quarterly;
- Requiring respondents to prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Requiring respondents to submit more than an original and two copies of any document;
- Requiring respondents to retain records, other than health, medical, government contract, grant-in-aid, or tax records, for more than three years;
- In connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of the study;
- Requiring the use of a statistical data classification that has not been reviewed and approved by OMB;
- That includes a pledge of confidentiality that is not supported by authority established in statute or regulation, that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or,
- Requiring respondents to submit proprietary trade secrets, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

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

A 60-day information collection notice for the Hospital Preparedness CA Program was published in the *Federal Register*, Volume 72, Number 17, January 26, 2007, pages 3865-3866, while the program was in the process of being transferred from HRSA to ASPR. This notice can be found in Appendix IV. We have checked periodically with HRSA over the course of the year, but have not received any public comments on this notice.

HPP has received comments from awardees regarding data reporting templates during previous years of the program. In the past, the awardees have understood the need to collect and report on data and have been appreciative of the HPP's attempts to standardize data collection and pre-populate as many data fields as possible in advance. In addition, HPP holds monthly conference calls with awardees to address any questions or concerns they may

have about these data collection efforts. Awardees can also discuss their views on the availability of data, frequency of data collection, the clarity of instructions and recordkeeping, disclosure, reporting format and on data elements to be recorded, disclosed or reported.

HPP has hired Booz Allen Hamilton Inc. (Booz Allen), a firm that is experienced in managing and conducting program evaluations and developing and collecting performance measurement data. The Booz Allen team assisted in development of the data collection instruments and provided expertise on issues including the availability of data, the ability of hospitals to provide it, the clarity of instructions, record keeping, confidentiality, disclosure of data, reporting format and the identification of necessary data elements.

9. Explanation of Any Payment or Gift to Respondents

HPP will not provide any payment, gifts or reimbursement to respondents for time spent completing data collection forms.

10. Assurance of Confidentiality Provided to Respondents

The Privacy Act does not apply because the data to be collected do not involve individuals.. The data only capture program funded activities and equipment purchases made by hospitals participating in HPP. Data from individual hospitals are aggregated up to the State level prior to be submitted to ASPR. A statement of confidentiality is not required, since the program does not request any data that is personally identifiable.

To increase data privacy and security, responses will be stored in a secure, password-protected online location, which can only be accessed by authorized individuals. HPP will store all data collected in a database located within their secure facilities. HPP will ensure that no confidential or identifying information is shared with any entities outside of ASPR.

11. Justification of Sensitive Questions

This data collection effort does not involve questions related to private matters or personal sensitive information.

12. Estimates of Annualized Burden Hours and Costs

The Mid-Year and End-of-Year Reports will be completed by all awardees (i.e., one response per grantee organization). Each report will be administered once during the year. A small

group of awardees were polled on the amount of time required to gather and enter the information. Table 2 indicates the estimated annual burden for each data collection activity and the total burden across all activities in terms of time. The Hospital Preparedness CA Program reports will take approximately 16 hours to complete. Based on 62 total respondents, the total annual burden is estimated to be 1984 hours.

Table 2. Estimated Annual Burden Hours for CA Program Data Collection Activities

Data Collection Activity	Number of Respondents	Number of Responses	Response Time (hours)	Total Annual Burden Hours
Mid-Year Report	62	1	16	992
End-of-Year Report	62	1	16	992
TOTAL				1984

For the Hospital Preparedness CA Program, HPP provides funding for the Hospital Bioterrorism Coordinator, who will be responsible for collecting and reporting this data. Salaries for these personnel range from $40,000-$80,000. The average hourly rate of $28.85 was calculated using the average of this annual salary range ($60,000) divided by the number of typical work hours in a year (40 hours/week x 52 weeks/year = 2,080 hours). The rate and cost burden for the data collection activities are summarized in Table 3. The total annualized cost burden for the respondent for data collection is $57,238.40.

Table 3. Estimated Annualized Cost Burden for CA Program Data Collection Activities

Data Collection Activity	Total Burden Hours	Average Hourly Wage Rate	Total Respondent Costs
Mid-Year Report	992	$28.85	$28,619.20
End-of-Year Report	992	$28.85	$28,619.20
		Total	$57,238.40

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

Time and effort will be the only burden to respondents who participate in the evaluation. Awardees will not incur any other direct financial costs related to start-up or maintenance for these data collection initiatives. Awardees do not have to purchase any additional equipment or computer systems for this data collection effort.

14. Annualized Cost to the Federal Government.

The following table outlines the cost for each data collection activity. These costs were estimated by multiplying the number of hours to complete each task by the wage rate of the staff responsible for the task. The overall cost is approximately $86,312.50 for developing and collecting the Mid-Year Reports and $86,312.50 for the End-of-Year Reports. This includes developing the Mid-Year Report templates, distributing the templates and collecting, analyzing and reporting survey results. The estimated annual cost to the Federal Government for the administration of this data collection effort for three (3) years is $517,875.00. In future years, the number of awardees and the number of questions on the Mid-Year and End-of-Year reports may change, so these estimates of burden and cost may vary.

Table 4. Cost of the Proposed Data Collection Effort

Data Collection Activity	Cost
Mid-Year Report	
Develop Mid-Year Report tool	$31,250
Distribute Mid-Year Report and collect results (44.05 Avg. Hourly Wage x 560 hrs)	$24,668.00
Analyze and report Results (44.05 Avg. Hourly Wage x 560 hrs)	$30,394.50
Subtotal	$86,312.50
Three (3) year Annualized Subtotal	**$258,937.50**
End of Year Report	
Develop End-of-Year Report tool	$31,250
Distribute End-of-Year Report and collect results (44.05 Avg. Hourly Wage x 560 hrs)	$24,668.00
Analyze and report results (44.05 Avg. Hourly Wage x 560 hrs)	$30,394.50
Subtotal	$86,312.50
Three (3) year Annualized Subtotal	**$258,937.50**
Grand Total	**$517,875.00**

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

HPP has plans for both tabulation and publication of the results and performance of the CA Program. Overall, the steps in the evaluation plan are as follows:

- Assess data validity
- Assess data for completeness
- Review data state by state to assess changes from one time period to the next
- Assess data from states in aggregate at the regional and national levels for changes in the data from one time period to the next
- Summarize and report data for standard reports, congressional briefings and other special reports as required by HPP or other Federal agencies.

Tabulation

HPP will aggregate data and perform simple descriptive and summary statistical analyses on the data. Using funding data from the Mid-Year and End-of-Year Reports, proposed and obligated funding will be compared to funding spent to ensure compliance with the awardees' applications and program requirements. In addition, HPP will analyze spending over time, spending by capability and spending by state. The performance measure data will be monitored over time to determine if awardees are meeting benchmarks and objectives and to identify trends in preparedness planning.

Publication

The progress reports and performance measure results will be consolidated in a comprehensive report for HPP. Additional reports for OPEO, ASPR, HHS, Congress and other Federal agencies will be provided as necessary. The data will also be made publicly available online, as required in Section 201 on *Improving State and Local and Public Health Security* in the PAPHA law:

> "COMPILATION AND AVAILABILITY OF DATA.—The Secretary shall compile the data submitted under this section and make such data available in a timely manner on an appropriate Internet website in a format that is useful to the public and to other entities and that provides information on what activities are best contributing to the achievement of the outcome goals described in subsection (g).''

, the Project Time Schedule, outlines the major milestones in the data collection timeline.

Table 5. Data Collection Schedule

Activity	Schedule
Submit Federal Register Notice and Obtain OMB Clearance	February. 2008 – May, 2008
Project and Budget Period	Sept. 1, 2007 – Aug. 8, 2008
Data Collection	
Mid Year Report	Two (2) months after clearance
End of Year Report	Six (6) months after clearance
Data Analysis	
Mid Year Report	Four (4) months after clearance
End of Year Report	Eight (8) months after clearance
Provide Evaluation Report	
Mid Year Report	Five (5) months after clearance
End of Year Report	Seven (7) months after clearance

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

OMB expiration dates will be displayed on all data collection materials.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification statement identified in item 19 "Certification for Paperwork Reduction Act Submissions," of OMB Form 83-I.

B. STATISTICAL METHODS

1. Respondent Universe and Sampling Methods

The applicable population (universe) is all of the awardees for the program (i.e., 62 awardees). All awardees will be asked to participate because data on each entity is integral for monitoring progress and measuring national preparedness. Sampling is not appropriate and there are too few recipients to employ a psychometrically sound sampling strategy. The

anticipated response rate is 100 percent, since participation is a requirement for receiving funding from HPP (please see B.3 for further justification of this expected response rate).

2. Procedures for the Collection of Information

For the 2007 HPP funding period, data and information for HPP funded programs will be collected via the Grant Solutions Webpage. The appropriate HPP Project Officer will send each awardee an email requesting that they complete the Mid-Year and End-of-Year Reports, directing them to the online link on GrantSolutions.gov to download the files. The email will include detailed instructions on how to complete the reports and the time frame for completion. Awardees will have approximately 3 months to gather the requested information and complete and submit the report. Throughout this time, the Project Officers will be actively involved and will provide technical support as needed.

Data will be reported and collected using Microsoft Excel spread sheets and exported into the National Healthcare Preparedness Program Evaluation and Planning Interface (PEPI). The data in PEPI will be checked for accuracy (validity and completeness). After the accuracy is assessed, the data will be transformed into variables that are usable for analysis. Standard analytic techniques and simple descriptive analyses will be conducted to draft reports on data status before completing a comprehensive data analysis using a standard statistical program, Statistical Analysis System (SAS).

HPP will employ descriptive statistics to describe the basic features of the data. They will use univariate analysis to examine: distribution (frequency), central tendency (mean, median, and mode) and dispersion (range, variance, and standard deviation). In some cases, HPP will perform correlations to describe the degree of relationship between two variables. These methods, together with simple graphics analysis, serve as the basis for the analysis. This data collection effort does not require any statistical method for sample stratification, sample selection or estimation, since all of the awardees will be completing the reports.

3. Methods to Maximize Response Rates and Deal with Nonresponsiveness

One of the conditions for receiving HPP funding is completing appropriate reporting requirements as outlined in the program guidance. This requirement will increase the likelihood of achieving a response rate of 100 percent. In addition, HPP designed the electronic data collection tools for ease of use. Clear and concise instructions will be included with the reports to help maximize response rates. HPP personnel will also discuss reporting requirements during monthly conference calls with awardees, answering any

questions and providing reminders for the due dates of the reports. They will provide instructions and guidance on how to complete the report and tools and answer general questions as needed throughout the data collection effort. HPP Project Officers will monitor response rates and work with awardees to ensure completion of reports.

4. Test of Procedures or Methods to be Undertaken

Several sections of the Mid-Year and End-of-Year reports have been previously utilized by HPP during past years of the program, so length of time for completion was estimated from previous awardee experience. The reports have evolved over the years based on awardee and Project Officer feedback about the ease of data entry and analysis. The performance measure section of the reports was reviewed by a small subset of awardees to determine the amount of time it would take to complete.

5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data

Statistical Aspects of Design and Data Collection/Analysis Contacts

Dr. Janet Schiller, Ed.D.
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ATTACHMENT I.

PANDEMIC AND ALL-HAZARDS PREPAREDNESS ACT (PAHPA)

ATTACHMENT II.

HOSPITAL PREPAREDNESS COOPERATIVE AGREEMENT (CA) PROGRAM MID-YEAR AND END-OF-YEAR PROGRESS REPORT

ATTACHMENT III.

SAMPLE TABLE FOR DATA ANALYSIS

National Bioterrorism Hospital Preparedness Program FY 06 Applications Summary: Bed Tracking Systems

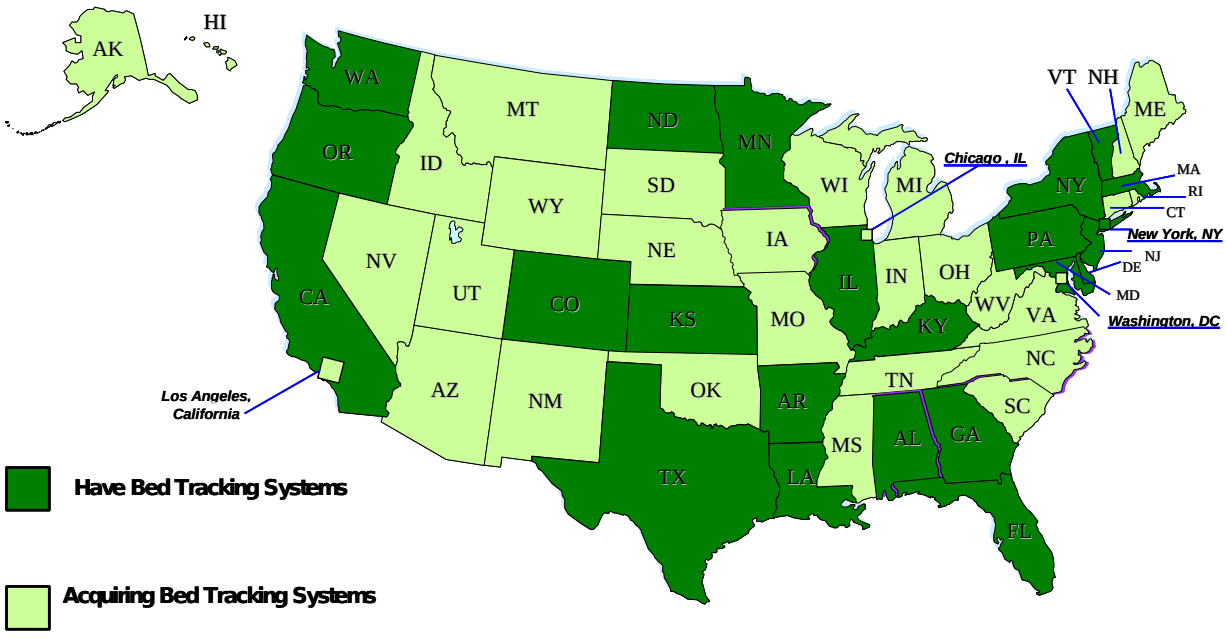
Bed Availability Tracking Systems (BTS)-Fiscal Year 2006 Guidance for the National Bioterrorism Hospital Preparedness Program (NBHPP) required applicants to develop bed tracking systems capable of reporting aggregate State level data to the HHS Secretary's Operation Center (SOC) according to HAvBed Categories. HAvBed categories are: staffed vacant / available bed count, emergency department divert status, decontamination facility availability and ventilator availability. Applicants were asked to include in their applications information on the status of current data collection systems relating to bed availability. An analysis of the applicant bed tracking system data revealed the following:

Bed Tracking Systems (BTS) Established by NBHPP FY 2006 Awardees

Bed Tracking	Percentage (n=62)
Awardees with BTS	38 (24)
Awardees with plans to acquire BTS	62 (38)

Note: 27 of the 38 awardees have the ability to report BTS using the HAvBed System Categories.
Source: Booz, Allen, Hamilton Summary Review of FY 2006 National Bioterrorism Hospital Preparedness Program Awardees Grant Applications.

Bed Tracking Systems (BTS) Established by NBHPP FY 2006 Awardees



States with HAvBed compliant systems account for over 65% of the US Population.

ATTACHMENT IV.

60-DAY FEDERAL REGISTER NOTICE