

Supporting Statement for Paperwork Reduction Act

Submission for Division of National Healthcare Preparedness Programs
on behalf of the Hospital Preparedness Program

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) within the Division of National Healthcare Preparedness Programs (NHPP), in the Office of Emergency Management (OEM), Office of Assistant Secretary for Preparedness and Response (ASPR), in the Department of Health and Human Services is seeking clearance by the Office of Management of Budget (OMB) for an extension with change on Generic Data Collection Form. The Generic Data Collection Form will serve as the foundation for assessment and evaluation for HPP stakeholders, recipients, and sub-recipient programs and performance under the HPP Cooperative Agreement (CA) Program. Program data are gathered from recipients for required reporting as part of the HPP Cooperative Agreement as well episodic reporting. Episodic reporting provides information about hospital preparedness and network building. Required reporting includes: Mid-Year and End-of-Year Progress Reports and other similar information collections (ICs) that account for recipient spending and program performance on all activities conducted in pursuit of achieving the HPP Cooperative Agreement goals. Ad hoc reporting will be collected in cases of Pandemic Activity, a major public health emergency (e.g., Ebola, measles, severe flu season), with widespread and significant health concerns. These surveys will address issues specific to that emergency (e.g., practices used to treat patients, resources running low). These surveys may include some of the questions in the ongoing collections survey plus incident-specific questions.

As The goal of the HPP data collection is to monitor health care preparedness and response, and support the U.S. public health and health care systems' ability to prepare for and to respond effectively to public health emergencies within the United States and associated territories and freely associated states. Recent public health threats of potentially catastrophic proportion underscore the importance of effective planning and response capabilities that can be applied to all hazards. As new threats to public health and health care emerge, ASPR must ensure that health and medical systems are not only integral parts of emergency response activities but also part of emergency preparedness planning with all relevant partners. Increased cooperation among responders, including state and

local public health officials, emergency medical services (EMS), health care coalitions (HCCs), and private health care organizations, ensure the nation is better prepared to respond to all hazards. State public health departments and the mostly private sector health care delivery systems are now recognized as essential partners in emergency response and they have increased abilities to identify and mitigate potential threats to the public's health. The HPP data collection provides key health care and public health data to support technical assistance. The data collections also help to identify resources to support state, local, and territorial public health departments, HCCs, and health care organizations, and they help to show measurable and sustainable progress toward achieving the preparedness and response capabilities that promote prepared and resilient communities.

This generic data collection effort is crucial to HPP's decision-making process regarding the continued existence, design and funding levels of this program. Results from these data analyses enable HPP to monitor health care emergency preparedness and progress towards national preparedness and response 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 collection is authorized by section 2802(b) of the Public Health Service (PHS) Act, as amended by the updated Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPA); with specific guidelines outlined in Sec. 201.² 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 A).

1 U.S. Department of Homeland Security. (2005, Mar. 31). *National Preparedness Goal*. Retrieved February 1, 2018 from https://www.fema.gov/media-library-data/14437996151712aae90be55041740f97e8532fc680d40/National_Preparedness_Goal_2nd_Edition.pdf

2 U.S. Congress. (2013, Mar. 13). *Pandemic and All-Hazards Preparedness Reauthorization Act of 2013*. Retrieved February 1, 2018 from <https://www.gpo.gov/fdsys/pkg/PLAW-113publ5/pdf/PLAW-113publ5.pdf>

Medical surge, as defined by the Medical Surge Capacity and Capability Handbook (MSCC), states that surge capacity is the ability to provide adequate medical evaluation and care in events that severely challenge or exceed the normal medical infrastructure of an affected community (through numbers or types of patients).³ PAHPA outlines administrative and financial annual reporting requirements for recipients, so that HHS can monitor the program of recipients and ensure proper expenditure of funds. In addition, Section 201 of PAHPA mandates the achievement of measurable evidence-based benchmarks and objective standards:

Program measure data represent the extent to which recipients have met outcome goals and objectives that can be demonstrated through exercises and drills. These data allow HPP to identify strengths and gaps in health care emergency preparedness and supply it with a ready source to distribute “promising practices” and ‘lessons learned”, a request made by recipients so that they can learn from each other. PAHPA also gives HPP authority to withhold funds to recipients who fail to meet the program benchmarks specified in Section 201.

HPP recipients are expected to use their cooperative agreement funding to build and sustain their health care preparedness and response capabilities, ensuring that federal preparedness funds are directed to priority areas within their jurisdictions as identified through their strategic planning efforts, including drills, exercises, and measurement and evaluation plans. As a result, HPP must collect the data elements proposed in this data collection effort to measure recipient program against benchmarks and standards and to determine future funding amounts.

³ U.S. Department of Health and Human Services. (2009). *Medical Surge Capacity and Capability: The Healthcare Coalition in Emergency Response and Recovery*. Retrieved June 3, 2011 from <http://www.phe.gov/Preparedness/planning/mscc/Documents/mscctier2jan2010.pdf>.

Program Description

As the only source of federal funding that supports regional health care system preparedness, HPP promotes a sustained national focus to improve patient outcomes, minimize the need for supplemental state and federal resources during emergencies, and enable rapid recovery. HPP prepares the health care system to save lives through the development and sustainment of regional health care coalitions (HCCs) that incentivize diverse and often competitive health care organizations with differing priorities and objectives to work together.

In 2002, the U.S. Department of Health and Human Services (HHS) established the National Bioterrorism Hospital Preparedness Program (NBHPP) “to enhance the ability of hospitals and health care systems to prepare for and respond to bio-terror attacks on civilians and other public health emergencies, including pandemic influenza and natural disasters”. Administered initially by the Health Resources and Services Administration (HRSA), in March 2007, the NBHPP was transferred to ASPR, as required by PAHPA. Now known simply as the Hospital Preparedness Program (HPP), it is administered by the Division of National Healthcare Preparedness Programs within ASPR.

Since FY 2002, the Hospital Preparedness Program has provided funding 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. Originally, the cooperative agreement helped to increase the capacities and capabilities of hospitals and other supporting health care entities to plan for, respond to and recover from mass casualty events.

In FY 2012, HPP evolved from providing funding to support hospitals, to the development and strengthening of HCCs and Healthcare Preparedness Capabilities, to the current state of HCCs operationalized to respond. While HPP continues to focus on the development of HCCs and diversity and inclusion of the response community, the current focus is on operationalizing HCCs for effective response by optimizing their membership, as well as population and geographic coverage.

Description of Data Collection Effort

Generic Form

Two type of survey collections will be conducted.

1: Annual Grant Reporting Activities: Generic data collection form (i.e., End-of-Year Progress Reporting template – see Appendix B). For this, each recipient is required to provide responses related to demographic information, administration, budget and capability information as well as program measure data, including medical surge and coalitions. The information will be used to provide situational awareness of HPP awardees and direct strategies for surge, preparedness, mitigation, resource allocation, and best practices. These reports will be collected once per year at the end of the year.

2: Ad hoc Reporting Activities: Reporting will be collected in cases of Pandemic Activity, a major public health emergency (e.g., Ebola, measles, severe flu season), with widespread and significant health concerns. These surveys will addresses issues specific to that emergency (e.g., practices used to treat patients, resources running low). These surveys may include some of the questions in the ongoing collections survey plus incident-specific questions that gather more details about the specific incident. The data collected will help HPP define, develop, and implement a tiered process to assess what impact an incident is having on the healthcare delivery system, assess stress. These surveys will be fielded as pandemic and major public health emergencies occur which disrupt access and delivery of healthcare. Previous Ad Hoc Reporting has included: TRACIE Technical Assistance User Feedback Survey, HPP Needs Assessment Questionnaire, Healthcare System Stress Pulse Query, Partnership Questionnaire / Survey, HPP Data Display, Crisis Re-Entry Survey, ASPR Medical Supply Chain Interviews, HPP Coalition Assessment Tool, HPP Aligned Application Process “Hotwash”, HPP Impact Survey, HPP Trauma Center Association Survey, Urgent Care Interviews, and Healthcare Center Surveys.

Results will be shared annually, and as situational knowledge to any respondent who indicates interest in receiving an aggregate summary of findings when completing the query. If information would be valuable to employees of State, local, tribal or territorial health departments or others, as determined by ASPR, findings will be disseminated through the website for The Health and Human Services (HHS) ASPR Technical Resources, Assistance Center, and Information Exchange (TRACIE). TRACIE aims to provide audiences and stakeholders better access to information, promising practices, and technical assistance through three mechanisms available on the TRACIE website: (1) a technical resources database; (2) a direct-service technical assistance center; and (3) an information exchange discussion board. As a health care emergency preparedness information gateway, ASPR TRACIE ensures that all stakeholders, to include HPP recipients—at the federal, state, local, tribal, and territorial government levels; in nongovernmental organizations; and in the private sector—have access to information and resources to improve preparedness, response, recovery, and mitigation efforts. ASPR TRACIE meets the information and technical assistance needs of HPP recipients, regional ASPR staff, health care coalitions, health care entities, health care providers, emergency managers, public health practitioners, and others working in disaster medicine, health care system preparedness, and public health emergency preparedness.

2. Purpose and Use of the Information Collection

The current generic data collection instrument, sample included in Appendix B represents a concerted effort to develop a uniform system for reporting, which serves to improve the program's ability to monitor progress in health care system preparedness, and report program accomplishments. HPP uses the information gained from the administration of this tool to monitor recipients' compliance with program requirements and the development of selected health care preparedness capabilities.

Results from these data analyses help HPP to better coordinate effective communication, share information, and monitor progress of its health care emergency preparedness and progress of national preparedness goals. These data analyses will also help HPP to better coordinate effective communication, share information, and monitor

progress of its health care emergency preparedness and progress of national preparedness goals. Both traditional and innovative approaches to situational awareness are needed to enable transmission of data and to develop timely public risk communications. This data collection effort will improve coordination and enhance integration to help create a better common operating picture among our HPP recipients.

The data will be used to inform:

- a. HPP presentations, reports, and other stakeholder communications
- b. NHPP budget justification documents
- c. NHPP's responses to various stakeholder inquiries
- d. NHPP TA efforts
- e. Inform HPP decision-making, help communicate progress to stakeholders, and respond to various stakeholder inquiries
- f. Inform HPP use of joint application tools and technical assistance to identify strengths, benefits, and improvements

Reflecting PAHPA's emphasis on program measurement and accountability, this data collection effort also helps determine health care emergency response capabilities. The information gathered from the responses will be summarized via yearly data reporting summaries, promising practices, and success stories. ASPR will then decide the implications these themes have for health care practice. Information will be used to provide situational awareness of HPP recipients and direct strategies for surge, preparedness, mitigation, resource allocation, and promising practices. NHPP may use submitted, de-identified data in communications (e.g., presentations, talking points, one-pagers, etc.); to respond to various stakeholder inquiries (e.g., Questions for the Record, etc.); and for budget justification documents (e.g., Congressional budget justifications, etc.) to educate stakeholders on HPP's impact.

The data provides HPP with the ability to review progress and generate a variety of analytical reports on financial and programmatic objectives, including comparisons of recipient-specific, and HCC supported program data relative to a recipient's federal region, the nation and the 50 States. Financial analyses allow project officers to see intra-regional distribution of the extent to which spending aligns with program goals. The measure of impact of HPP informs future decisions regarding funding and expectations of recipients.

Consequently, the reporting increases HPP's ability to quickly and efficiently analyze data, identify trends, provide technical assistance, make timely program decisions and provide HPP stakeholders, HPP recipients, HCCs, HHS, Congress and other federal agencies with data about HPP, including information for HHS Response efforts, Government Accountability Office (GAO) inquiries, and overall progress against program measures.

3. Use of Information Technology and Burden Reduction

All of the data are collected and submitted electronically in order to reduce burden on the recipients. The Ad hoc, Mid-Year, and End-of-Year Reports are submitted via an identified Excel template, or user-friendly online interface that includes drop-down menu boxes, some pre-populated cells, and data validation features to facilitate data entry and to increase data accuracy, quality, and completeness. 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 reduces the possibility of lost and missing data that could result from paper submission, and allows for timely and accurate data analysis that is not possible with paper submission. The data collection tools are 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. These methods facilitate improved community preparedness and response nationwide, reduces recipient burden, and increases federal efficiency.

4. Efforts to Identify Duplication and Use of Similar Information

The states collect data from HCC 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 HCCs, hospitals and other health care facilities.

For example, the Centers for Disease Control and Prevention (CDC) issues Public Health Preparedness (PHEP) cooperative agreements that ultimately serve local public health

departments in order to increase public health preparedness, but does not fund health care preparedness, such as in hospitals, etc. Keenly aware of the potential for duplication, HPP participates actively in interagency working groups with other federal preparedness organizations, including DHS, Centers for Medicare and Medicaid Services (CMS), Department of Transportation (DOT), Health Resources and Services Administration (HRSA), Department of Veterans Affairs (VA), Department of Defense (DoD), and CDC. Participation in these groups generally fosters interagency communication, and increases awareness of other agencies' activities, minimizing the potential for duplication.

Additionally, HPP actively collaborates with CDC and other federal partners in joint metrics working groups in order to maximize efficiency between HPP and PHEP, and align program definitions and measurement approaches, which results in a much more united federal face to our data collection efforts. Improved planning and response coordination across all levels will present new opportunities to leverage resources while maximizing effort, resulting in increased efficiency.

5. Impact on Small Businesses or Other Small Entities

The data collection is aimed at jurisdictional health departments administered by the 50 states, DC, the three major cities, and the eight U.S. territories and freely associated states, which do not constitute small businesses. However, the 62 recipients will need to collect information on the activities of their participating HCCs, which may be small businesses, non-profits, or other small entities. To minimize the impact on these groups, data are collected, at a required minimum, during Mid-Year and End-of-Year intervals.

6. Consequences of Collecting the Information Less Frequently

This is an ongoing data collection effort, and recipients are requested to participate at least semi-annually. This reporting frequency allows HPP to monitor progress throughout the year and enables recipients to demonstrate their ability to plan and spend their allotted funding more efficiently and with less risk of returning unused money. By collecting data every year, HPP can analyze trends over time and plan strategically for long-term outcomes. If this collection is conducted less frequently, HPP will not be able to accurately measure and assess the impact of the program against the stated objectives.

Since health care preparedness financial resources are slowly diminishing over time, collecting timely data is important to prevent weaknesses in health care preparedness and to allow corrections in program 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 Federal Register Notice was published in the Federal Register Volume 83, Number 71, Pages 15852-15853, on Thursday April 12, 2018. There were no public comments.

During previous years of the program, HPP has solicited feedback. Recipients have reported understanding the need to collect and report on data and are appreciative of 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 recipients to provide technical assistance on the measures and address any questions or concerns they may have about these data collection efforts.

The evaluation branch, SHARPER (Science Healthcare Preparedness Evaluation and Research) collaborates with recipients in various capacities, including the creation of a Metrics and Measures Work Group and coordination with the HPP executive working groups whose members include recipient stakeholders and organizations that represent health care and preparedness. Additionally, SHARPER participates in regular calls, meetings, and conferences with several stakeholder organizations, including the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the American Hospital Association (AHA). SHARPER leverages these relationships to obtain views on the availability of data, frequency of collection, the clarity of instructions and record keeping, disclosure, reporting format and 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 (i.e., citizens, patients, etc.). The data only capture aggregated program funded activities and equipment purchases made by state, territorial, and city health departments, hospitals and other health care entities participating in HPP in the administration of HPP, and using federal HPP funds for preparedness activities. All of this type of information is

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subject to FOIA disclosures. A statement of confidentiality is not required, since the program does not request any data that are identifiable to any individual.

To increase data privacy and security, responses are stored in a secure, password-protected online location, which can only be accessed by authorized individuals. HPP stores all data collected in a database located within secure facilities. HPP ensures that no confidential or pre-decisional 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 End-of-Year Reports are completed by all HPP award recipients. Each end-of-year report will be administered once during the year. The coalitions (HCC) as the operation “arm” of HCC awardees, provide data roll-ups that are captured in the 62 HPP Awardees’ annual monitoring progress and measuring national preparedness. Ad-hoc reports will be collected as needed as pandemic and major public health emergencies occur. These information collections are required to support program goals. Ad hoc reports will be collected from HCCs, which are a primary recipient of HPP technical assistance, which we need to assess the impact of HPP on their response operations, which are the type of entities directly involved with HPP. We estimate one ad hoc report per year.

A small group of recipients were polled on the amount of time required to gather and enter the information. Table 2 indicates the total estimated annual burden for both the Annual HPP data collection activity and for Ad Hoc HPP-PHEP activities in terms of time. Based on 62 total respondents, the total annual burden is estimated to be 14,973 hours for HPP recipients.

Table 2. Estimated Annual Burden Hours for the Generic HPP and Future Collection Activities

Data Collection Activity	Number of Respondents	Number of Responses	Response Time (hours)	Total Annual Burden Hours (for all recipients)	3-year Total (for all recipients)
Annual Reporting: HPP Generic	62	1	58	3,596	10,788
Ad Hoc Reporting	5599	1	2.0	11,377	34,131
TOTAL	5661	1		14,973	44,919

To estimate cost of the burden, we know that HPP provides funding for the HPP Coordinators, who will be responsible for collecting and reporting HPP data. Salaries for these personnel range from \$40,000-\$120,000; with a \$55,000 US average. The average hourly rate is \$26.44. The average hourly rate was calculated by dividing the US average of \$55,000 by the number of typical work hours in a year (40 hours/week x 52 weeks/year = 2,080 hours) or \$55,000/2,080. 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 \$395,886.12.

Table 3. Estimated Annualized Cost Burden for the Generic HPP and Future Collection Activities

Data Collection Activity	Total Burden Hours	Average Hourly Wage Rate	Annual Respondent Costs	3-year Total
HPP Generic and Future Program Data Information Collection(s)	14,973	\$26.44	\$395,886.12	\$1,187,658.36
		Total	\$395,886.12	\$1,187,658.36

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. Recipients will not incur any other direct financial costs related to start-up or maintenance for these data collection initiatives. Recipients do not have to purchase any additional equipment or computer systems for this data collection effort. For ad hoc reports the number of respondents was based on the Awardees and HCCs combined.

14. Annualized Cost to the Federal Government.

The following table outlines the cost for each data collection activity. These costs are 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 each for developing and collecting the End-of-Year Reports. This includes developing the 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 recipients, the number of questions on the progress and reporting form, and the number of agencies using the form may be updated which may impact burden and cost. It is the goal of the program to change the forms as minimally as possible.

Table 4. Cost of the Proposed Data Collection Effort

Data Collection Activity	Cost
Episodic Reports	
Develop Episodic Reporting tool	\$31,250
Distribute Episodic 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 an extension (3 year) of the current generic data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

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

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

Results from these data analyses help HPP to better coordinate effective communication, share information, and monitor progress of its healthcare emergency preparedness and progress of national preparedness goals. Both traditional and innovative approaches to situational awareness are needed to enable transmission of data and to develop timely public risk communications. This data collection effort will improve coordination and enhance integration to help create a better common operating picture among our HPP awardees and HCCs.

Tabulation

HPP will aggregate data and perform simple descriptive and summary statistical analyses on the data. Using funding data from the End-of-Year Reports, and other information collections as related, the proposed and obligated funding will be compared to funding spent to ensure compliance with the recipients’ applications and program requirements. In addition, HPP will analyze spending over time, spending by capability and spending by state. The program measure data will be monitored over time to determine if recipients are meeting benchmarks and objectives and to identify trends in preparedness planning. Our current analyses summarize each element in regards to the number of participating HCCs or recipient participation for the nation and each recipient and region.

Publication

The progress reports and program measure results will be consolidated in a comprehensive report for HPP. Additional reports for OEM, 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).”

Table 5, the Data Collection 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	March 2018 – May 2018

<p>Project and Budget Period</p>	<p>July 1, 2018 - June 30, 2019</p>
<p>Data Collection</p> <p>End of Year 2017 Report (collected in Sept. 2018)</p>	<p>Four (4) months after OMB clearance</p>
<p>Data Analysis</p> <p>End of Year 2017 Report</p>	<p>8-10 months after clearance</p>
<p>Provide Evaluation Report</p> <p>End of Year Report</p>	<p>10-12 months after clearance</p>

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

Not Applicable. 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.