Paul Coverdell National Acute Stroke Program

Revision: 0920-1108 09/30/2022

Supporting Statement A

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JUSTIFICATION SUMMARY

Goal of the project: CDC's Paul Coverdell National Acute Stroke Program (PCNASP) seeks to improve quality of care for acute stroke patients through systematic approaches to quality improvement activities. PCNASP recipients will focus on state-wide assessment and improvement in stroke care while also implementing strategies to close the gap on stroke disparities. The goal of this information collection is to revise OMB approval reflecting recent programmatic changes under a new Notice of Financial Opportunity (NOFO); new PCNASP cooperative agreements will be awarded on or about July 1, 2021.

Intended use of the resulting data: Data reporting will allow for continuous program monitoring, identification of successes and challenges for awardees, and assessment of the overall effectiveness and influence of PCNASP. Specifically, resulting data will be used to improve the quality of care for acute stroke patients, improve recovery, improve adherence to stroke care guidelines, and reduce complications, readmissions, and early mortality for acute stroke patients. Lessons learned from the awardees will also help inform stroke care in settings across and outside of PCNASP.

Methods to be used to collect: Data from awardees include hospitals, and EMS agencies. De-identified files will be electronically transmitted to CDC. When possible, existing data collection systems are utilized to avoid unnecessary duplication of data collection.

The subpopulation to be studied: PCNASP-funded awardees will report all cases of acute hemorrhagic stroke (subarachnoid hemorrhage and intracerebral hemorrhage), acute ischemic stroke, acute ill-defined stroke, and transient ischemic attack (TIA) among patients age 18 and over from participating hospitals.

How data will be analyzed: CDC will perform annual data validation of select and highly important data elements, as well as quarterly data quality review and performance monitoring.

A. JUSTIFICATION

A1. Circumstances Making the Collection of Information Necessary

Overview

The Centers for Disease Control and Prevention's (CDC's) Paul Coverdell National Acute Stroke Program (PCNASP) requests a three-year approval for revision of existing OMB (OMB No. 0920-1108; expiration 09/30/2022). PCNASP is authorized under Section 317 of the Public Health Service Act (PHSA), 42 U.S.C. 247b(k)(2) as amended (**Attachment 1**).

Under the current OMB approval PCNASP collects information from nine state health departments (awardees) to administer its state-based quality improvement program. PCNASP collects data from awardees, who work with their partners to conduct organized quality improvement activities for acute stroke patients from stroke onset when the victim contacts the emergency medical service

(EMS) through after they discharged from the hospital. Awardees' partners can include hospitals, emergency medical service (EMS) agencies, and other healthcare providers (e.g., stroke rehabilitation facilities). Current data collection spans the entire continuum of stroke care, including pre-hospital quality data, in-hospital quality data, and post-hospital quality data. In addition, PCNASP was approved to collect hospital inventory data, which includes information on hospital demographics (e.g., number of hospital beds) and their capacity to treat stroke patients.

This revision request details the proposed continued data collection for PCNASP, and describes changes to the pre-hospital, in-hospital, and hospital inventory data collection instruments, including discontinuing patient level post-hospital data collection. The changes are needed due to the following: revised programmatic activities reflected in a new cooperative agreement under a new NOFO, a need to reduce overall burden of data collection, and keep PCNASP current with scientific guidelines and research. Thus, CDC seeks to revise OMB approval for data collected by PCNASP for three years.

Background

Stroke is largely preventable, yet nearly 800,000 strokes and transient ischemic attacks (TIAs) occur each year, leading to approximately 145,000 deaths annually [1]. To address this public health burden, CDC has initiated and progressively expanded PCNASP from 2001 to the present to conduct organized quality improvement activities for acute stroke patients from stroke onset through hospital discharge. There remains a national need to understand best practices of stroke systems of care, which includes prevention and awareness, use of EMS, in-hospital care, and rehabilitation and recovery. During previous funding cycles, awardees worked with selected partners in their jurisdictions to collect information for the following three phases of stroke care: pre-hospital, in-hospital, and post-hospital care. Since acute stroke patient outcomes are influenced by rapid initiation of appropriate care in the pre-hospital setting, followed by effective communication and coordination during transitions to in-hospital and post-hospital care, a systems approach that addresses the entire continuum of care is needed to improve outcomes for patients [2]. PCNASP uses quality improvement and systems analysis techniques to add value to information routinely collected for patient care.

A comprehensive evaluation of the 2015-2020 PCNASP program found that fostering partnerships between hospitals and EMS agencies improved the sharing of information and helped them gain a better understanding of their role in improving their state's stroke systems of care. Facilitating the linking and sharing of data across the stroke system of care helped to identify areas for improvement during transitions of care which helped lead to improved timeliness and quality of stroke care. Additionally, the work of PCNASP awardees has also highlighted the critical need to improve stroke quality of care and outcomes, among priority populations. Sociodemographic differences in meeting stroke program performance measures and outcomes have been consistently identified [3]. Findings from PCNASP studies reveal the continued need to identify disparities and implement stroke interventions, such as community education and quality improvement activities, focused on priority populations [4].

A new NOFO for PCNASP builds on the accomplishments and outcomes achieved in the previous cycles of the program. Awardees will focus on implementation of comprehensive stroke systems for individuals, both at highest risk for stroke events and for stroke patients, across the

continuum of care. This will be achieved via enhancing and improving the quality of stroke care across the continuum of care in states with high burden populations. For this NOFO, high burden populations are those that state-level data indicate are disproportionately impacted by stroke outcomes, including stroke hospitalizations and stroke mortality, and have disproportionately high prevalence for those at highest risk for stroke events, including individuals with high blood pressure and/or high blood cholesterol, which may be a result of socioeconomic factors, such as living in underfunded urban and rural communities, being uninsured/underinsured, having limited access to routine medical care, or other related factors. Awardees will use data-driven methods to analyze and use data in order to identify areas for quality improvement activities, along with evidence-based strategies to measure, track, and improve access to and quality of care for those individuals at highest risk for stroke events and for stroke patients, and work to improve transitions of care within EMS and hospital settings. Therefore, this information collection request includes the collection of pre-hospital data, in-hospital data, and hospital inventory survey data.

Pre-hospital data focuses on improving pre-hospital care for acute stroke by working with EMS agencies to develop pre-hospital data collection systems. Linking this pre-hospital and in-hospital data will enable EMS and emergency department hospital staff to collaboratively identify opportunities to improve early acute stroke care transitions. This is particularly important to ensure that patients who are eligible to receive time-sensitive therapies, such as intravenous tPA (tissue plasminogen activator) (alteplase), receive appropriate care within a timely manner.

While current data collection includes patient level post-hospital data, data collection under the new cooperative agreement will not include this collection instrument. Post-acute transitions of care will be assessed by aligning quality improvement with existing Division for Heart Disease and Stroke Prevention priorities and strategies. Thus, these activities are not part of this information collection request.

This information collection request also includes the collection of hospital inventory data that is important to more fully understanding settings involved and improving the quality of stroke care within states. Awardees currently work directly with their partners to place evidence-based quality improvement activities in the context of their states' capabilities, health care structure, and needs. To supplement patient data collected across the continuum, hospital inventory data helps to understand hospitals' capacity for delivering stroke care. This data is not routinely collected outside of PCNASP.

A2. Purpose and Use of the Information Collection

PCNASP has three main program strategy categories as demonstrated in the logic model in **Attachment 2**. Progress is assessed based on a variety of information sources that include both process performance measures and patient-level quality of care performance measures. **Attachment 3** provides an overview of these strategies, program measures, and their relationship to short-, intermediate-, and long-term measures. Information that is collected is used to assess whether short-term and intermediate-term project activities are leading to intended long-term outcomes, as well as the reach and impact of the program; these are critical to enabling CDC to work with awardees to ensure appropriate dissemination of program impact and lessons learned. Process performance measures include

information such as the number of partnerships between awardees and stroke-related entities, monitoring of stroke care disparities, assessment of workforce development efforts to improve clinical knowledge, and protocols and interventions implemented as a result of quality improvement efforts. Process-related measures are principally addressed by awardees through annual reports of activities that are not part of this information collection request. However, some process-related measures will be derived from quality of care data described in the information collection request.

Under the currently approved OMB package, PCNASP has approval to collect pre-hospital, in-hospital care, and post-hospital care data elements, as well as hospital inventory data. PCNASP has used the collected data to track performance measures for in-hospital quality of care, such as receipt of time-sensitive therapies at a national and state-level through quarterly reports. Hospital inventory data has been used to understand processes of care by the capacity level of various hospitals (e.g., availability of a dedicated stroke unit for patients at a comprehensive stroke facility). These data also provided PCNASP the ability to track changes in stroke-focused quality improvement activities over time. Additionally, PCNASP has worked closely with awardees to collect pre-hospital data and understand where gaps, challenges, and priorities in data collection lie. PCNASP has also worked with awardees to modify and strengthen the sources of pre-hospital information collection that can now be obtained from EMS agencies or hospitals. The choice of method varies according to the states' capacity to access this type of data.

For post-hospital data collection, PCNASP has worked with awardees and their partners to pilot this information collection. However, this information collection will not be a focus of the new cooperative agreement, therefore this OMB revision does not request approval for this data collection.

Requested Information Collection

PCNASP is requesting an additional three years of data collection to continue work with awardees and their partners on improving quality of care and linking data across the system to improve stroke outcomes. Specifically, pre-hospital quality of care data (**Attachment 4a**) will continue to support analysis and performance on metrics measuring rapid transport and adherence to guidelines for early management of potential stroke patients, identify gaps in pre-hospital patient care, and drive improvement in care as needed. In-hospital quality of care data (**Attachment 4b**) will be used to support identification of opportunities for improvement in acute care. Together, information obtained from pre-hospital and in-hospital data elements will reflect the critical components of the continuum of care for stroke patients and provide opportunities to assess quality and establish opportunities for improvement across this continuum. Thus, the collection of this information is a critical component to track the progress and completion of meeting essential program aims and outcomes. Additionally, the collection of this patient-level quality of care information is vital to assessing some of the process performance measures that help determine success of the program and inform lessons learned.

CDC also requests OMB approval to continue to collect information through a hospital inventory survey (**Attachments 5a and 5b**). Many of the hospital inventory data elements are not part of routine data collection by hospitals, and thus are important for program monitoring and included in the information collection request. These data are specific to the capabilities of hospitals to provide stroke treatments, and this detailed information is not available from other national datasets. Data

captured in the hospital inventory survey, such as facility size and capacity, will continue to be used in data analyses to stratify patient-level quality improvement performance measures.

A3. Use of Improved Information Technology and Burden Reduction

All data that will be submitted to CDC for PCNASP will be electronically reported and skip logic/patterns are built into data collection instruments and systems when possible. Awardees have the option to utilize existing data systems of their choosing to collect required data elements. Significant reductions in the number of required data elements have been made with this data collection request to reduce overall burden. Also, to further reduce data collection burden awardees are allowed to use an existing data platform that is available through the AHA (known as "Get With The Guidelines"). This system is currently widely used by thousands of hospitals and automatically transmits data from participating hospitals to the awardee. Furthermore, to ensure data reporting burden is minimized, CDC will also provide remote technical assistance to awardees upon request.

A4. Efforts to Identify Duplication and Use of Similar Information

In-hospital quality data and quality indicators are based on standards and recommendations set forth by national partner organizations, such as The Joint Commission and the AHA, to reflect evidence-based stroke care strategies. PCNASP quality indicators will continue to align closely with these recommendations. PCNASP pre-hospital data elements are currently collected by EMS providers via the National Emergency Medical Services Information System (NEMSIS) and an AHA data collection platform (GWTG). Additionally, awardees may use existing state-based programs and/or methods that currently collect pre-hospital data elements that will overlap with those collected by PCNASP. Methods to use existing data collection systems for PCNASP are discussed with awardees to avoid data duplication and pre-existing state-based programs and/or methods can be continued if the awardee believes this is beneficial. PCNASP works with the AHA to harmonize efforts when appropriate, such as data elements, element names, and performance measures.

The hospital inventory data is unique to PCNASP and is not available through alternative programs or databases. This information is important to understand if and how certain elements of stroke capacity influence quality of care and outcomes, and in the assessment and evaluation of program strategies. To our knowledge, similar information about hospital stroke capacity and quality improvement initiatives are not captured by partner organizations.

Occasionally, PCNASP data elements may need to be updated to maintain alignment with research findings, guidelines, or recommendations from partner organizations. CDC anticipates that technical adjustments will be consistent with currently defined PCNASP objectives, burden estimates, and information collection methods. CDC will submit change requests to obtain OMB approval of updates to the data elements. If substantive changes are needed, CDC will submit a revision.

A5. Impact on Small Businesses or Other Small Entities

This data collection will not involve small businesses.

A6. Consequences of Collecting the Information Less Frequently

Awardees will transmit pre-hospital and in-hospital data to CDC quarterly and hospital inventory data annually. Improvements in quality of stroke care will be measured by adherence to established guidelines for care and quality metrics. This requires consistent review of the data with careful monitoring so that quality improvement can take place efficiently and effectively. Thus, the ability of CDC to monitor and improve quality of care would be compromised if data were collected less frequently.

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

This request fully complies with the regulation 5 CFR 1320.5.

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

Part A: PUBLIC NOTICE

A 60-day Notice was published in the *Federal Register* on December 3, 2020, Vol. 85, No.233, pp.78133-35 (see **Attachment 6**). No public comments were received.

Part B: CONSULTATION

PCNASP is in close and continuous consultation with the AHA, a non-profit organization that currently collects data on the quality of stroke care using an electronic data platform that awardees and their partners often use to collect in-hospital data. During the past three years, PCNASP has continued to work with AHA to harmonize in-hospital data elements to avoid data duplication and minimize burden. Furthermore, PCNASP has worked with AHA to leverage their data platform to also include pre-hospital data elements that are collected by PCNASP. This gives awardees the opportunity to use AHA's platform to collect this data more easily.

Consultations occur through monthly conference calls between AHA and CDC, as well as email (when needed). These consultations have occurred throughout the current cooperative agreement, which began in July 2015 and will continue with similar frequency for this new agreement which will begin July 2021.

Table 1. External Consultations

Name	Title	Affiliation	Phone	Email	Role
OUTSIDE CONSULTANTS					
Christine Rutan	National Director Quality and Health IT	American Heart Association	914-475-0955	christine.rutan@heart.org	

A9. Explanation of Any Payment or Gift to Respondents

PCNASP will not provide any payments or gifts to individuals.

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

A privacy narrative is included in **Attachment 7.** CIO Privacy Officer has reviewed and determined that the Privacy Act does not apply. PCNASP activities do not involve the collection of individually identifiable information. The PCNASP data collection will continue to be conducted primarily for continuous quality improvement of patient care, evaluation, and assessment of short-term patient health outcomes and transition of care from hospital to home. CDC will continue to not collect direct patient identifiers or hospital identifiers. All patient, hospital, and emergency medical service (EMS) agency identifiers will continue to be de-identified in the data collected by PCNASP. While PCNASP does collect some date and time-based data elements (e.g., date and time of EMS arrival at the hospital), without direct identifiers it is not possible to use this data in combination with other data elements (e.g., age in years) to identify the patient.

PCNASP does not maintain an Information Technology (IT) system used for the data collection. It also does not require that state awardees or their partners use a specific IT system. Data is transmitted from state awardees to CDC through the Secure Access Management Servers (SAMS). SAMS is operating under an approved security plan. De-identified data is maintained by CDC in secure servers, which only select program staff have access to (statistician, data analyst).

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

The primary intent of the cooperative agreement and information collection is quality improvement. However, PCNASP data do provide opportunities for research as a secondary use. CDC has IRB approval for secondary research uses of the information collection (**Attachment 8**).

PCNASP, along with national partner organizations, collects patient data about race and ethnicity (**Attachment 4b**). The collection of this information for acute stroke patients is central to the aims of this cooperative agreement as it is important to assess disparities in access to care across the care continuum as well as quality of care. The American Heart Association/American Stroke Association released a scientific statement in 2011 that stated the importance of understanding features of the health care system that affect existing racial-ethnic disparities in stroke care [5]. Thus, the recognition of these disparities are an essential component of improving the quality of stroke care. PCNASP does not have any other potentially sensitive questions incorporated into the program.

A12. Estimates of Annualized Burden Hours and Costs

OMB approval is requested for three years.

There are three categories of information collection: pre-hospital (**Attachment 4a**), in-hospital (**Attachment 4b**), and hospital inventory (**Attachments 5a and 5b**). Pre-hospital and in-hospital quality of care data will be transmitted by awardees to CDC on a quarterly schedule. Hospital inventory data will be collected and transmitted annually. Awardees use their selected data systems to electronically receive or extract data from their partners.

The burden of primary data collection of in-hospital data is not assessed for hospitals, because it is routine but strengthened through PCNASP. Additionally, the burden of data transmission from hospitals to their respective awardee is not assessed because it is an electronic and automated process. The average burden per response is 30 minutes for awardees to compile and transmit in-hospital data to CDC quarterly. Thus, the total average burden for the collection and transmission of in-hospital data is 26 hours annually (Table A.12.a).

Pre-hospital data will be collected by awardees from their partners by two possible methods, depending on their state's access to data sources: from hospitals or from data systems used by EMS agencies. For the awardees that will collect pre-hospital data from hospital partners, data will be electronically received by the awardee and then compiled and transmitted on a quarterly basis to CDC for an average burden per response of 30 minutes. Based on current data and expected number of awards under new NOFO, we anticipate the number of awardees utilizing this method to increase from 2 to an estimated 3 awardees. The awardees that extract pre-hospital data from EMS agencies will have an average burden per response of 1 hour, which accounts for the time needed to extract the data and then compile and transmit it to CDC. We anticipate the number of awardees utilizing this method to increase from 7 to an estimated 10 awardees. Thus, the total average burden for the collection and transmission of pre-hospital data will be 46 hours annually (Table A.12.a).

All pre-hospital and in-hospital data files that are sent to the CDC will be in the form of a SAS (Statistical Analysis System) data set. The transmission will occur through the Secure Access Management Services (SAMS) web portal (**Attachment 9**). SAMS is operating under an approved security plan.

Finally, burden is assessed for the total number of estimated hospital partners (n=650 hospitals; estimating 50 hospitals per awardee) to collect and transmit hospital inventory data annually to their awardee. This average burden per response is 30 minutes. Based on current data and expected number of awards under new NOFO, we are estimating the number of hospital partners per awardees to be 50 hospitals (estimated total number is 650). Additionally, burden is assessed for each PCNASP awardee to annually compile the hospital inventory information for its jurisdiction and transmit its aggregate file to CDC. This average burden per response is 8 hours. Awardees then transmit a de-identified file to CDC (**Attachment 5b**). The total average burden for the collection and transmission of hospital inventory data will be 104 hours annually (Table A.12.a). Data will be submitted as an Excel file through the SAMS web portal. **Attachment 10** has a diagram of the collection and transmission process.

Thus, the total estimated annualized burden to respondents is 501 hours, as summarized in Table A.12.a.

Table A12.a. Estimated Annualized Burden (Hours)

Type of Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
PCNASP Awardee	Hospital inventory	13	1	8	104
	In-hospital care data	13	4	30/60	26
	Pre-hospital care data	3	4	30/60	6
		10	4	1	40
PCNASP Hospital Partners	Hospital Inventory	650	1	30/60	325
Total					501

The total estimated annualized cost to respondents will be $18,727.64 (Table A.12.b). This estimate is based on data from the United States Department of Labor's Bureau of Labor Statistics (BLS). The estimate of costs to awardees' partners is $12,103.00 and is based on an average hourly wage of $37.24 for staff (Registered Nurses; BLS occupation code 29-1141) to collect and transmit hospital inventory data to their awardee. Additionally, the estimate of costs to awardees is $6,624.64, and is based on an average hourly wage of $37.64 for awardee staff (epidemiologists; BLS occupation code 19-1041) to compile pre-hospital, in-hospital, and hospital inventory data received from hospitals and transmit the information to CDC. Costs to awardees are paid under terms of the cooperative agreement.

Table A.12.b. Estimated Annualized Burden Costs to Respondents

Type of Respondent	Form Name	Total Annual Burden Hours	Average Hourly Wage (dollars)	Total Respondent Labor Cost
PCNASP Awardee	Pre-hospital care data	46	$37.64	$1,731.44
	In-hospital care data	26	$37.64	$978.64
	Hospital inventory data	104	$37.64	$3,914.56
PCNASP Hospital Partners	Hospital inventory data	325	$37.24	$12,103.00
Total				$18,727.64

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

The computer hardware and software needed for an electronic data submission of information to awardees and CDC are readily available to hospitals and awardees since they collect and distribute these data for state and other purposes. Hence, no additional capital or maintenance costs are anticipated.

A14. Annualized Cost to the Federal Government

The data collection will be funded under cooperative agreements to each of the awardees and Funding Opportunity Announcement No. CDC-RFA-DP15-1514 (Paul Coverdell National Acute Stroke Prevention). The annualized cost of the cooperative agreement is $7.7 million. The total estimated annualized cost to the federal government includes CDC personnel costs for a statistician/data manager and data analyst. This estimated annualized cost is $62,280.86 for a GS-12 data statistician at 67% FTE, $9,143.16 for a GS-14 at 7% FTE, and $43,103.45 for a GS-14 at 33% FTE. Thus the total annualized cost (annual cooperative agreement plus CDC personnel) is $7,814,527.47.

A15. Explanation for Program Changes or Adjustments

The total annual burden for this data collection is being requested to increase from 361 to 501 (Table A.15). **Attachment 10** describes the change in burden. Under new cooperative agreement, data collection will remain similar compared to current collection. However, significant reductions in the number of data elements have been made for pre-hospital and in-hospital data collections. This includes removing data collection for the post-hospital phase of the care continuum. Under scope of the new NOFO, patient level quality of care post-hospital data will not be collected, therefore burden will not be assessed for this (Table A.15; net decrease 22 hours).

Total burden for the collection and transmission of in-hospital data elements has increased from 18 to 26 (net increase of 8 hours), due to added program awardees under the new cooperative agreement. The total burden per respondent is 26 hours.

Total burden for pre-hospital collection will decrease from 60 to 46. This is due to decrease in the number of required data elements for awardees. Pre-hospital data will continue to be collected similar to two current methods, depending on awardee's access to data sources. Awardees will still be able to utilize the existing AHA electronic data platform to collect and automatically transmit PCNASP pre-hospital data elements. For the estimated 3 awardees who are able to use the AHA's platform, the average burden per response remains 30 minutes (Table A.15). For the estimated 10 awardees, additional burden is assessed for them to extract data from their respective state EMS data systems. This average burden per response is 1 hour, a decrease of 1 hour from previously estimated 2 hours per response. Thus, there is a net decrease in burden of 14 hours for awardees. For awardees and partners combined, the total burden for pre-hospital data is decreasing from 60 hours to 46 hours (total net decrease of 14 hours).

Total burden hours for hospital inventory will also increase due to the increased number of awardees (and therefore hospital partners) under new NOFO (Table A.15.a; net increase 32 hours). The average burden per response for awardees' hospital partners remains at 30 minutes (15 minutes collection + 15 minutes for transmission). For hospital inventory data, PCNASP currently accounts for 378 hospitals to collect and transmit this data annually to their respective awardees. Based on current data and the expected number of awardees under the new NOFO, we are estimating the number of hospital partners per awardee to be 50 hospitals. Due to the increase in awardees, the estimated number of hospital respondents is anticipated to increasing from 378 to 650 (50 hospitals per each of 13 awardees). Thus, there is a net increase of 136 hours for hospitals to collect and transmit this data (Table A.15). PCNASP also accounts for awardees to compile and transmit hospital inventory data to CDC. For the same reasons stated above, net increase in total burden for awardees is 32 hours (estimated 8 hours per each of 13 awardees). Thus, for awardees and partners combined, the total burden for hospital inventory data is increasing from 189 to 325 hours (total net increase 136 hours).

As stated previously, total burden will increase due to the increase in number of awardees under new NOFO. Therefore, as shown in Table A.15, the result of these changes is a total net increase in average burden from 361 to 501 hours.

Although PCNASP does not account for burden under routine data collection by hospitals for pre-hospital and in-hospital data, we are requesting modifications to the data dictionaries as we have worked to reduce the overall number of required reportable data elements and to ensure continued alignment with existing data collection systems (AHA's GWTG, NEMSIS) (see crosswalks in **Attachments 11a, 11b**). Additionally, we are requesting modifications to the hospital inventory survey to understand advances in stroke care capabilities, adapt to new scientific advances, and clarify questions based on awardees' requests (**Attachment 11c**).

Table A.15 Net Change in Average Burden Hours

Type of Respondent	**Form Name**	**Current approval (OMB No. 0920-1108)**		**Proposed changes**		**Net Change (hours)**
		Description of burden	**Total Burden Hours**	**Description or reason for change**	**Total Burden Hours**	
PCNASP Awardees	Hospital inventory data	Data compiling and transmission	72	Addition of program awardees under new NOFO	104	+32
	In-hospital care data	Transmission	18	Addition of program awardees under new NOFO	26	+8
	Pre-hospital care data	Data extraction and transmission	60		46	-14
	Post-hospital care data	Transmission	22	No data collection for	0	-22

				this under new NOFO		
PCNASP Partners	Hospital inventory	Collection and transmission	189	Addition hospital partners with increase in number of awardees	325	+136
	Pre-hospital data	Transmission automatic	0	Transmission automatic	0	0
	Post-hospital data	Data transmission	0	No data collection for this under new NOFO	0	0
Total			361		501	+136

A16. Plans for Tabulation and Publication and Project Time Schedule

PCNASP's current OMB approval expires 9/30/2022. CDC is requesting approval to continue collecting data for 3 years, which will cover the remaining time in the current cooperative agreement (July 1, 2015-June 30 2020) as well as the cooperative agreement under new NOFO beginning July 1, 2021.

Pre-hospital and in-hospital transition of care data will be transmitted to CDC quarterly. Awardees work with their partners to assure that data is transmitted to them in a timely manner to meet CDC deadlines. This information will be submitted from awardees to CDC within 2 weeks of the quarter ending; PCNASP staff will then clean the data and provide feedback necessary to ensure that the data is of high-quality. Within 3 months of the quarter ending, CDC will provide a data cleaning report back to awardees. There is a 6 month lag between the awardee's quarterly data submission and CDC's performance measure summary reports (see **Attachment 12** for example table shells) to allow for data to be aggregated across an appropriate amount of time. Additional delays may occur if there are technical issues with AHA's data platform. In these cases, PCNASP will work with AHA and awardees to identify the cause of the issue and minimize the additional time needed to collect the data. Performance measures will be assessed over time to detect trends in improvement in quality of stroke care within states; additionally, data across all awardees will be aggregated to current national-level estimates.

For example, quarter 1 2020 data (January 1, 2020-March 31, 2020) will be submitted by awardees within 2 weeks of quarter 1 2020 ending. A data cleaning report for this quarter will be provided by CDC to the awardees by the end of quarter 2 2020 (June 30, 2020), and the performance measure summary report will be provided by the end of quarter 3 2020 (September 30, 2020). Hospital inventory data will be submitted annually by awardees. Publications occur on an ad-hoc basis and are coordinated and supported by the PCNASP Scientific Writing Committee.

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

The display of the OMB expiration date is appropriate. The OMB expiration date and burden statement will continue to be displayed on data dictionaries provided to respondents (**Attachments 4a, 4b, 4c, 5a, 5b**) as well as the PCNASP Resource Guide, which is provided to all awardees (**Attachment 13**). Awardees use the Secure Access Management Services (SAMS) web portal to securely upload data to the CDC. The SAMS portal is used by other data collection programs within the CDC, so the display of the burden statement is not possible and would become confusing to other users.

A18. Exceptions to Certification for Paperwork Reduction Act Submission

There are no exceptions to the certification.

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