Trip Report: CDC/ASTHO BIOTERRORISM GRANT REPORTING INDICATORS MEETING
October 29-31, 2002, at CDC Jerry Gibson

I attended this meeting as a representative of the ASTHO Management Committee, CSTE and South Carolina. The meeting was the result of a long discussion between CDC/Office of Terrorism Preparedness and Response (OTPR, the new name for the CDC Bioterrorism Office) and ASTHO on what the BT Cooperative Agreement wanted their biannual reports (i.e. their standard indicators of progress toward the BT grant objectives) to include. Over this summer the ASTHO Management Committee and Executive Committee had perceived the need for a practical, specific, quantitative every-6-month (i.e. biannual) accountability report for our funders that would provide information to track states' steady progress toward preparedness and readiness for a BT incident or other public health threat/emergency. Therefore, the ASTHO Mangement Committee and staff went ahead to develop and field test such a document. This Bioterrorism Accountability Indicators Process document (BTAIP) has now been piloted in three states successfully and received the support of the ASTHO Executive Committee and membership. But for it to be used by CDC as the shorter-term accountability section of their biannual progress reports, it must be accepted by CDC staff. It must be seen as providing more specific, quantitative, relevant and reproducible accountability data than other CDC-developed surveys, which were written for other purposes such as long-term performance indicators and are very non-quantitative, nonspecific and vague. Such a reporting document should also provide data useful to state BT management for state-level accountability, and be easy to fill out and to compile and analyze. The BTAIP (based on its pilot studies) is all of those things.
During the opening session it became clear however that CDC intended this meeting to produce a somewhat different document, i.e. indicators for a long-term BT program outcome evaluation rather than for accountability to our funders. At this point it is not clear if CDC will use the ASTHO BTAIP for the short-term accountability data-gathering, although to all the state and city participants there was no clear alternative to it. Some effective report that provides quantitative reporting information on progress on grant activities must be completed and analyzed by each state by March 2003, in time for the congressional appropriations process in Washington as well as for the states' legislative processes. The state representatives agreed that the CDC BT progress report that all grantees delivered November 1 would not do that adequately.

This meeting was attended by representatives from NY State, Los Angeles, Chicago, IN, NC, MS, Mo, CA, IL, WA and SC, and by 6 ASTHO and NACCHO staff as well as many CDC staff including Joe Henderson, Gary Hogelin, and Ed Thompson (who is the new CDC Deputy for Public Health Programs.)
The CDC OTPR timeline for this BT outcome evaluation document includes: a) Feb. 03, regional workshops with states on the document from this meeting; b) March 03, IOM review of the document; c) April 03, incorporation of the resulting indicators from this process into the FY 03-04 BT Continuation Proposal Guidance; d) August 03, states/cities receive FY 03-04 BT awards; e) June 04, CDC initiates a web-based grant reporting system for BT. In addition, CDC/OTPR plans to do site visits to all state

programs in the coming year at whuch they will gather more detailed information on progress toward grant objectives. ASTHO Management Committee will continue to advocate for the use of a practical accountability reporting document.

Other useful information:

1. The IOM has recently published an excellent and very useful detailed report on how to evaluate the MMRS system grant program, which provides very specific evaluation indicators, data sources and analytic methods. This is available at www.nas.gov or from Dr Pomeroy Sinnock at CDC/PHPPO and is worth our looking at.
2. New York City's Hospital Emergency Readiness Data System (HERDS) could be available to states and is a powerful and reliable electronic data system for getting regular reports from all hospitals during a crisis (or during an exercise). Includes data such as available bed capacity, ER readiness, ER diversion status, number of ER visits by diagnostic category (i.e. syndromic surveillance), etc. It does require that data be keyed in at the hospital, so it cannot be a routine reporting system.
3. Most of the state and city BT staff attending had procured and were using Blackberries or some similar remote messaging and email system for senior staff. Blackberries (about $800/year if buy on contract) and the Motorola T 900 seemed the favorites.
4. Everyone agreed that this is really all about performance of health department and other partner staff, and that must be tested by repeated exercises at state and local levels and by after-action reports e.g. of infectious disease outbreak investigations, which must be assessed.
5. There is a CDC/PHPPO "lending library" of best practice documents etc. on their web site, which Louise Barton can direct us to.
6. The next round of the DOJ Survey will happen this Spring and will include public health sections, which may not be in a separate section but scattered through the survey document. In that case, we will have to take action to be sure that we are the ones to respond to the public health questions. The representative from Washington state Department of Health said (not in public) that they were probably not going to participate in the survey.