Form Description for the Information Collection "National Disease Surveillance Program - II. Disease Summaries," OMB No. 0920-0004

DIARRHEAL DISEASE SURVEILLANCE

The three most common bacterial causes of diarrhea in the United States are *Salmonella*, *Campylobacter*, and *Shigella*. The Council of State and Territorial Epidemiologists has endorsed the need for CDC to maintain surveillance for all three infections. The data are essential to measure trends, recognize multi-state or international outbreaks, and evaluate effectiveness of prevention efforts.

The surveillance system involves entry of data into an electronic reporting system which was implemented in 1990, the Public Health Laboratory Information System (PHLIS) by State Health Departments. PHLIS is a PC-based reporting system for local, county, or State organizations to enter, edit and analyze data and to transmit data electronically to other State or federal offices. PHLIS was developed by CDC, and is potentially capable of handling any data types (epidemiologic, laboratory, hospital, special studies, etc.). The laboratories are asked to enter information on human and nonhuman isolates. Data requested include: species/serotype, patient's name (which are encrypted prior to coming to CDC, see justification below), age, sex, county of residence, residence type at onset, and specimen from which isolate was obtained (stool, blood, other). Cooperating State Health Departments report to CDC, by phone if there is something felt to be urgent. Currently, information concerning isolates is electronically reported each week through PHLIS from all 50 states and selected territories. Patient name or other identifiers are maintained at the state health department and are stripped electronically before information is transmitted to CDC. The switch to electronic entry and reporting also improved the function of the systems in other ways, reducing time needed for data entry and transmission and analysis, and giving the participants more ready access to the data.

Form name	No. of respondents	No. of responses/respondent	Hrs/response	Total burden in hrs.
Campylobacter (Electronic) (PHLIS)	53	52	3/60	138
Salmonella (Electronic) (PHLIS)	53	52	3/60	138
Shigella (Electronic) (PHLIS)	53	52	3/60	138

Form Description for the Information Collection "National Disease Surveillance Program - II. Disease Summaries," OMB No. 0920-0004

MONTHLY REPORT OF LABORATORY CONFIRMED CASES OF RABIES (CDC 55.28)

Because of the severity of the disease, prevention of rabies is essential. The acute encephalomyelitis is usually fatal. Most exposures are caused by the bite of an infected animal. Changes in patterns of animal rabies are detected by monthly reporting. An accurate assessment of the occurrence of rabies is essential for determining if post exposure prophylaxis is necessary. Surveillance of the raccoon rabies epizootic in the mid-Atlantic states has led to efforts to develop control measures for rabies in wildlife. The number of cases of rabies in domesticated cats has exceeded the number of cases in dogs each year since 1981, except 1987. This observation has led to greater efforts to develop more stringent vaccination requirements for cats. During the period from 1990 through 1998, 20 of 22 human rabies deaths caused by infections acquired within the United States were the result of variants of the rabies virus known to be associated with rabid bats. Resulting increased awareness of risk associated with bat bites and enhanced reporting of taxonomic descriptions of the species of bats involved with human exposures to better understand the natural history of rabies in bats have resulted in increases in rabies surveillance activity. Human rabies cases are reported with the same form, with human filled in the other species category. With only 2-3 cases a year, these are usually presented individually as case reports in *MMWR.*

Information collected in this surveillance system is published annually in the *MMWR* and tabulated in the *MMWR Annual Summary*.

Since the 1989 report and in all subsequent reports, CDC first publishes in the *Journal of the American Veterinary Medicine Association* to reach practicing veterinarians.

Form name	No. of respondents	No. of responses/respondent	Hrs/response	Total burden in hrs.
Rabies (Paper)	3	12	15/60	9
Rabies (Electronic)	50	12	8/60	80

II. Disease Summaries," OMB No. 0920-0004

NATIONAL RESPIRATORY AND ENTERIC VIRUS SURVEILLANCE SYSTEM (NREVSS) - Forms 55.83A-D

Respiratory viruses reported using this form include RSV, PIV, Res. Adenovirus and influenza, and Enteric viruses include Rotatvirus and Adenoviruses 40 and 41. Respiratory syncytial virus (RSV) is the most important viral respiratory tract pathogen of infants and young children, and may cause serious disease in immunocompromised patients and the elderly. Annual epidemics are associated with increased rates of pneumonia and bronchiolitis hospitalization among infants and young children. The human parainfluenza viruses (HPIV) are also important respiratory pathogens in children, and epidemics are associated with increases in physician visits for bronchiolitis, croup, and pneumonia. RSV, HPIV, and adenoviruses are important causes of nosocomial pneumonia and other lower respiratory tract illness. Rotavirus is the most common cause of severe diarrhea in children in the United States, with an estimated 3 million cases and 70,000 hospitalizations per year.

Since January 1989, selected clinical and public health laboratories have reported to CDC the number of specimens tested and number of specimens positive for RSV, HPIV, adenovirus, and rotavirus. The purpose of this surveillance system is to track temporal and geographic trends for these viruses and to make the findings available to public health care professionals and health-care providers in a timely fashion. The primary objective of the system is to identify epidemics geographically, and not to enumerate cases.

In July 1990 the reporting was changed from monthly to weekly reporting with a computerized telephone polling system and results were collected by diagnostic testing method (antigen detection testing, virus isolation, electron microscopy and PCR added in 2004). In 2002, the system was changed again to transfer all data entry to the online system. Weekly electronic reporting allows immediate processing and analysis of national trends and allows for data correction by participating centers. Influenza data collection was added July 1997 to increase reporting to influenza surveillance systems, and allows the reporting of influenza during non-influenza surveillance season.

Annual summaries and alerts are published periodically in the *MMWR* and in medical journals. NREVSS data have been used to better define the epidemiology of RSV, HPIV, and rotavirus. Compiled data are made available over the Internet for infection control practitioners and other health care providers to use in planning and implementing effective control measures, and for researchers to assess in the effectiveness of new vaccines.
(URL: http://www.cdc.gov/ncidod/dvrd/revb/nrevss/index.htm).

Form name	No. of respondents	No. of responses/respondent	Hrs/response	Total burden in hrs.
NREVSS	90	52	10/60	780

Form Description for the Information Collection "National Disease Surveillance Program - II. Disease Summaries," OMB No. 0920-0004

NATIONAL ENTEROVIRUS SURVEILLANCE SYSTEM (CDC 55.9)

Since 1964, state health departments have reported to CDC all enteroviruses isolated in their laboratories, regardless of clinical syndrome. This project, known as the Enterovirus Surveillance Program, was initially undertaken through the auspices of the Joint Committee of the Conference of State and Territorial Public Health Laboratory Directors. Reports are generally sent directly from the laboratory to CDC. Information solicited on the previously approved reported form (CDC 55.9) included demographic data (age, sex, state, year); clinical data (date of onset, syndrome, outcome); and laboratory data (enterovirus type isolated, anatomic source(s) if isolation) on all cases with one or more enterovirus isolated.

The present reporting form has been developed in Microsoft Excel to reduce the reporting burden. Clinical data is not requested, because in most cases this information is not available to the reporting laboratories, and the date of specimen collection is requested in lieu of onset date.

The purpose to undertaking national enteroviral surveillance was to monitor trends in the circulation of these viral agents, many of which are associated with severe clinical illness. Through analysis of the national database, one may approach more immediate problems of outbreak recognition and etiologic diagnosis. Ultimately, these data may provide insight leading to better control and prevention practices. Results of these reports are published periodically in the *MMWR* and peer-reviewed journals.

Form Name	# Participating Sites	# Reports per Site per year	Hrs/response	Response Burden
National Enterovirus Surveillance Form	25	12	15/60	75

Form Description for the Information Collection "National Disease Surveillance Program - II. Disease Summaries," OMB No. 0920-0004

INVESTIGATION OF A FOODBORNE OUTBREAK (CDC 52.13)

This report provides for the systematic entry of basic data from an epidemiologic investigation of an acute foodborne disease outbreak of any etiology, including bacterial, parasitic, viral or chemical causes. Foodborne illnesses are due to a multitude of pathogens, toxins, and chemicals that may contaminate food. Outbreaks occur in a variety of population groups such as schools, camps, general dining halls, institutions of various types, as well as in the general community. This report form also serves as a training device and a guide to health departments that routinely investigate foodborne outbreaks. State and local health departments send completed reports on outbreaks they have investigated to CDC to be tabulated and analyzed and summarized. Data are published periodically in the *MMWR* and the *Foodborne Disease Surveillance Report*. Historically, use of data collected by this system had been slowed because of the long time required for data entry and coding once the forms are received. In 2001, CDC introduced electronic reporting of foodborne outbreak data through the Electronic Foodborne Outbreak Reporting System (EFORS). EFORS is a web-based reporting system that collects the same information as the paper forms, and can be used by local, county, or State organizations to enter, edit and analyze data and to transmit data electronically to other State or federal offices. All reports beginning with 2001 data are entered into EFORS. Instructions for completing the form and posted on the internet. The form includes the OMB approval number and the burden advisement. EFORS ended and the National Outbreak Reporting System (NORS) began in 2009. NORS will allow the continual reporting of foodborne-associated illnesses, in addition to the following modes of transmission: person-to-person, animal contact, and envrironmental contamination other than food/water. The burden increased slightly due to the number of responses per respondent increasing and a slight increase in time for the response.

Form name	No. of respondents	No. of responses/respondent	Hrs/response	Total burden in hrs.
Foodborne Outbreak Investigation	54	31.5	20/60	567

Form Description for the Information Collection "National Disease Surveillance Program - II. Disease Summaries," OMB No. 0920-0004

WATERBORNE DISEASES OUTBREAK REPORT FORM (CDC 52.12)

The Waterborne Disease Outbreak Surveillance System is a collaboration between CDC, the Council of State and Territorial Epidemiologists, and the Environmental Protection Agency (EPA). This system is the only surveillance system for tracking and analyzing waterborne disease outbreaks in the United States and it has compiled data on over 1300 outbreaks since 1971. The data are used routinely to inform CDC recommendations and the system supplies critical data for EPA decision-making regarding existing and new regulations related to drinking water safety.

This form is used to summarize the data collected in investigations of waterborne disease outbreaks caused by drinking water or recreational water. The form captures the etiologic agents responsible for the outbreaks and identifies the water system deficiencies associated with outbreaks in order to improve prevention efforts. Data collected include: type of exposure, location of outbreak, date of outbreak, number of persons exposed and ill, symptoms, incubation period, duration of illness, etiologic agent, epidemiologic results such as attack rates, laboratory results of human specimens and water samples, characteristics of the water system and its deficiencies, and factors contributing to the contamination of the water. The form ensures the systematic collection of data by state and local health departments, which routinely investigate these outbreaks. No personally identifiable data are collected on this form. The data collected on this form are maintained in a database which resides on a CDC server and access is restricted.

Data on reported waterborne outbreaks are analyzed and published every two years in the Morbidity and Mortality Weekly Report Surveillance Summaries (MMWR-SS). These Surveillance Summaries are the most comprehensive account of waterborne disease outbreaks in the United States and have been cited in scientific publications more than 450 times over the past 15 years.

This has also been included in the National Outbreak Reporting System (NORS). This will simplify data collection and entry for state partners. Many of the waterborne outbreak disease coordinators already report foodborne disease outbreaks to CDC. It has been possible to develop a shared section of common outbreak questions. NORS has improved the quality of the data and its usability by local, state, and national partners.

Form name	No. of respondents	No. of responses/respondent	Hrs/response	Total burden in hrs.
Waterborne diseases outbreak investigation	57	1	20/60	19

Form Description for the Information Collection "National Disease Surveillance Program - II. Disease Summaries," OMB No. 0920-0004

OVERVIEW OF CDC INFLUENZA SURVEILLANCE
Increase in burden due to increase in cases. Two new formats introduced for Internet reporting.

This group contains descriptions of the following four forms:
WHO Collaborating Center for Influenza Surveillance, Influenza Virus Surveillance: CDC 55.31 (facsimile/internet), US WHO Influenza Collaboration Laboratories Address Update CDC 55.31A (annual survey)
U.S. Influenza Sentinel Provider Surveillance: CDC 55.20E (work folder), Sentinel Provider Reports of Influenza-Like Illness (ILI) CDC 55.20 (facsimile)

The Centers for Disease Control and Prevention has responsibility for surveillance of influenza with the goal of determining the impact of the disease on the U.S. population and developing improved control measures. It has been estimated that influenza is responsible for approximately 36,000 deaths and more than 200,000 hospitalizations during an average influenza season. The continuing emergence of new strains of influenza necessitates annual virologic and epidemiologic surveillance.

Surveillance data are used to determine vaccine composition for the following year. Influenza virus type A (H3N2), A (H1N1), and B circulate worldwide, but with differing intensities each year. Influenza virus type A (H3N2) infections have been associated with reports of outbreaks among all age groups. Influenza A (H1N1) infections have been recognized predominately among children and young adults and are associated with school outbreaks. Influenza type B virus has caused outbreaks of influenza in schools as well as other institutions, such as nursing homes. Surveillance permits rapid detection of influenza virus circulation and the degree to which vaccine virus strains match circulating wild type virus strains. It provides data used in determining influenza-associated morbidity, mortality, and economic loss. Furthermore, it may assist in the control of the disease by affording the opportunity for rapid preventive action, for example, by chemoprophylaxis of high-risk persons who have not received vaccine.

In addition to monitoring annual influenza epidemics, this system is in place to detect viruses with pandemic potential and track the course of the next influenza pandemic.

Influenza Virus Surveillance (Form CDC 55.31)

Form CDC 55.31 is a single fax form used to collect summary influenza virus data from collaborating laboratories around the country. The web interface for labs that choose to report their data over the Internet is identical to the paper fax form. For laboratories that utilize the electronic method of reporting data, there is no reporting form since a connection is established between the laboratory and a CDC server.

State, county, city, or university laboratories that collaborate with the World Health Organization (WHO) Influenza Surveillance Program report numbers of throat or nasopharyngeal swab specimens submitted for influenza diagnosis and the number positive for influenza. All laboratories report these data weekly from October through mid-May and a subset of these laboratories are reporting these data all year. These reports are used to assess and report the distribution of influenza virus strains throughout the United States.

Weekly data are transmitted to CDC by facsimile (23 laboratories), over the Internet (37 laboratories), or electronically using the Public Health Information System (PHLIS) (23 laboratories). Transmission of data via PHLIS, an electronic system that can be corrected and updated with the latest, most accurate influenza isolate information, improves the timeliness and quality of the data. Most of the 23 state laboratories using PHLIS have elected to develop an interface between their laboratory computer and PHLIS to transmit their data. In these instances, their previous weekly burden of summarizing this information and transmitting it by facsimile or Internet has been reduced. No patient identifiers are received at CDC.

Form Name	No. of Respondents	No. of Responses per Respondent	Hrs/response	Total Burden in hrs.
Influenza Virus (fax, Oct-May) (CDC 55.31)	8	33	10/60	44 hours
Influenza Virus (fax, year round) (CDC 55.31)	15	52	10/60	130 hours
Influenza Virus (Internet, Oct-May) (CDC 55.31)	13	33	10/60	72 hours
Influenza Virus (Internet, year round) (CDC 55.31)	24	52	10/60	208 hours
Influenza Virus (Electronic,	9	33	5/60	25 hours

Oct-May) (PHLIS)				
Influenza Virus, (electronic, year round) (PHLIS)	14	52	5/60	61 hours

Influenza Virus Surveillance Survey (Form CDC 55.31A)

Once a year a survey is sent to each participating laboratory to obtain information used in analyzing and interpreting data obtained from year-to-year.

Form Name	No. of Respondents	No. of Responses per Respondent	Hrs/response	Total Burden in hrs.
Influenza Annual Survey (CDC 55.31A)	83	1	15/60	21 hours

Sentinel Provider Weekly Surveillance for Influenza-like Illness (CDC 55.20)

Form CDC 55.31 is a single fax form used to collect summary influenza-like illness data from participating sentinel providers. Providers have the option of faxing this data in via a toll-free fax number or reporting data over the Internet. The web interface is identical to the fax form.

The workfolder (CDC 55.20E) is used by the provider to track their own data submitted throughout the season.

Because state health department morbidity estimates are imprecise and generally untimely, a system was developed in 1982 to collect influenza-like illness data directly from practicing family physicians who voluntarily participated without remuneration. Prior to 1997, CDC and state health departments maintained separate influenza sentinel provider surveillance systems. In 1997, CDC collaborated with state health departments to reduce duplication of efforts and allow resources to be focused on expanding the number of providers reporting in order to improve the geographic representation and completeness of the data. Over the years, the system has continued to evolve and expand. For the 2005-06 season, approximately 1,320 regularly reporting health care providers in all 50 states will participate.

Participating providers report the following data each week from October through mid-May: influenza-like illnesses by age group, and the total number of patients seen for any reason. These data are shared by CDC and state health departments. A subset of providers has volunteered to report these data year round. Year-round influenza surveillance data will provide a baseline level of influenza activity during the summer months and will also have the potential to become an important component of early detection for an influenza pandemic, or other unusual occurrences of influenza-like illness.

The primary method of reporting is Internet (83%) using form 55.20E as a work folder. A few providers still prefer to transmit their data via facsimile (17%) (CDC55.20). Due to the discontinuation of the touch tone phone system for data transmission, the facsimile form is now part of the work folder.

Form Name	No. of Respondents	No. Responses per respondent	Hrs/response	Total Burden in hrs.
Influenza-like Illness (Oct-May) (CDC 55.20)	824	33	15/60	6,798 hours
Influenza-like Illness (year round) (CDC	496	52	15/60	6,448 hours

55.20)				

Form Description for the Information Collection "National Disease Surveillance Program - II. Disease Summaries," OMB No. 0920-0004

Arboviral Diseases (including West Nile Virus) (100% electronic collection)

Prior to the first detection of West Nile virus (WNV) in the United States in September 1999, arboviral diseases - along with other nationally notifiable diseases - were electronically reported to the CDC through the National Electronic Telecommunications System for Surveillance (NETSS), whose publication of disease activity lags from several months to a year behind the date of disease reporting. No endemic arboviruses are currently reported through NETSS. At one time, reporting to NETSS was via the Human Arboviral Encephalitis Surveillance system on CDC form 55.3, which is now obsolete.

The public health concern over the anticipated geographic spread of WNV within in the United States led CDC in 2001 to begin accepting reports of WNV via ArboNET, an enhanced, web-based electronic reporting system for closely monitoring national WNV activity in humans, non-human mammals, birds and mosquitoes. The inclusion of other nationally notifiable arboviruses into ArboNET occurred in 2003**.** If needed, CDC ArboNET staff can also receive arboviral activity reports by telephone, fax, or e-mail. This unique, multi-faceted surveillance system has proven essential for the early detection of arboviral disease activity and for monitoring the spread of epidemic transmission of WNV. The arboviral transmission season begins in early summer with peak activity generally occurring in August-September when vector mosquito populations are at their peak. Information on nationwide transmission is disseminated weekly on electronic bulletin boards during the transmission season. In addition, periodic reports and an annual summary are published in the *MMWR*. Access to ArboNET requires a Digital Certificate to assure restricted access to sensitive data.

Form name	No. of respondents	Average no. of responses/respondent	Hrs/response	Total burden in hrs.
Arboviral Diseases (including West Nile Viruses)	57	1421	4/60	5,400

Form Description for the Information Collection "National Disease Surveillance Program - II. Disease Summaries," OMB No. 0920-0004

Cholera and other *Vibrio* Illness Surveillance Report (CDC 52.79)

In 1988, Gulf Coast State Health Departments agreed to voluntarily report laboratory confirmed *Vibrio* illnesses to CDC. *Vibrio* species are naturally occurring marine bacteria and an important cause of seafood-borne and wound associated illnesses. Certain *Vibrio* species (e.g., *V. cholera, V. parahemolyticus*) cause dehydrating diarrheal illnesses. In addition to endemic cholera in the United States, illnesses caused by epidemic strains of cholera are reported among travelers returning from southern Asia and Latin America.

Other *Vibrio* species (e.g., *V. vulnificus*) result in septicemia and even death in individuals with underlying diseases such as liver disease or congestive heart failure. Since the 1970's, CDC has identified *V. vulnificus* as an emerging foodborne pathogen.

Beginning with data collected in 1999, an annual summary of results has been provided to CSTE and distributed to all state epidemiologists and directors of state public health laboratories. The data provide important information on the public health impact of vibriosis in the Gulf Coast States.

The collection of information does not involve the use of automated, electronic, mechanical, or other technological collection techniques or other forms of information technology. The paper form is necessary because public health nurses at the local level often perform initial data collection. Data collection is focused on relevant clinical and epidemiologic features of *Vibrio* illnesses. Use of the form is more efficient than the review of medical records to capture this information.

The following are changes to the form:

1. Enlarged the mailing address on top right hand corner of form to make sure submitters see where they need to submit the form.
2. Revised OMB number to 0920-0004. Previous form had 0920-0322.

Respondents	No. of respondents	No. of responses/respondent	Hrs/response	Total Burden in hrs.
Local Health Department staff	270	1	20/60	90
Health care facility staff	135	1	20/60	45
Physicians	45	1	20/60	15

Total				150

Form Description for the Information Collection "National Disease Surveillance Program - II. Disease Summaries," OMB No. 0920-0004

Outbreak Report of Suspected Viral Gastroenteritis

(Outbreaks of viral gastroenteritis are usually caused by norovirus or sapovirus which collectively are referred to as caliciviruses)

Noroviruses are estimated to cause 23 million cases (33%) of all cases of gastroenteritis annually. Norovirus disease occurs as sporadic disease or as outbreaks of diarrhea and vomiting, in all age groups.

Noroviruses can be transmitted via contaminated food, contaminated water or directly from person to person. Many outbreaks involve several modes of transmission such as initial foodborne followed by person to person. In many cases the source of infection is unknown. The diverse modes of transmission are reflected in the diverse settings in which outbreaks occur such as restaurants, nursing homes, hospitals and schools. Historically however, diagnosis of noroviruses has been very difficult. Recent development of RT-PCR techniques has revolutionized the detection and characterization of norovirus strains, and testing for norovirus in outbreaks of gastroenteritis is gradually becoming more frequent.

CDC has been testing outbreaks for noroviruses for over 10 years, most recently using RT-PCR. Increasingly state public health laboratories have been testing for noroviruses and currently three quarters of all norovirus outbreaks are diagnosed by the states and a quarter by CDC. RT-PCR has allowed for norovirus strains to be sequenced and the development of CaliciNet, a nationwide database of norovirus sequences has allowed comparison of norovirus sequences from different outbreaks.

For effective interpretation of the significance of similar sequences, however, some epidemiological information is required. Currently, epidemiological information on norovirus outbreaks that are linked to food contamination is reported to the foodborne branch electronically via EFORS. However, there is no collection of epidemiological data of non-foodborne outbreaks of norovirus.

Data collected will include suspected source, setting, number exposed, and number of cases. This will allow CDC to link outbreaks together and assist in the development of control measures. This information will eventually be collected through a web-based reporting system which is being developed. The information will be accessible to states investigating outbreaks, initially by contact with the viral gastroenteritis section at CDC, and in the future via the Internet.

Form name	No. of respondents	No. of responses/respondent	Hrs/response	Total burden in hrs.

Outbreak Report of Suspected Viral Gastroenteritis	20	5	5/60	8

Form Description for the Information Collection "National Disease Surveillance Program - II. Disease Summaries," OMB No. 0920-0004

LISTERIA CASE FORM

Listeria monocytogenes is a facultative intracellular pathogen that causes serious illness among newborns, elder, and immunocompromised persons. It is usually acquired through ingestion of contaminated food, and it is a leading cause of death due to foodborne diseases in the United States. In 1999, the Council of State and Territorial Epidemiologists (CSTE) adopted a position statement making listeriosis a nationally notifiable disease. The Listeria Case Form, a standardized case questionnaire which contains detailed questions on the consumption of high-risk foods, was developed by CSTE and CDC. Prompt interviewing of case patients using this form has lead to improvements in detecting and investigating listeriosis outbreaks, and the reduction of resources required to investigate listeriosis outbreaks. Data obtained from this form has lead to the timely identification and recall of contaminated foods.

The collection of information does not involve the use of automated, electronic, mechanical, or other technological collection techniques or other forms of information technology. The paper form is necessary because public health nurses at the local level often perform initial data collection. Data collection is focused on relevant clinical and epidemiologic features of listeriosis collecting through medical chart review and patient interview.

Personal identifiers collected by state or local public health officials; this information is removed from the form and maintained at the state health department before submission to CDC. Data are reported to CDC monthly.

Form name	No. of respondents	No. of responses/respondent	Hrs/response	Total burden in hrs.
Listeria Case Form	53	1	30/60	27

Form Description for the Information Collection "National Disease Surveillance Program - II. Disease Summaries," OMB No. 0920-0004

Harmful Algal Bloom-Related Illness Surveillance System (HABISS)

The extent of human illness caused by environmental exposure to algal toxins in drinking and recreational waters is an unknown, but emerging, public health concern. We do know that algal toxins include some of the most potent natural chemicals known and there is potential for exposure in any community using surface water for drinking or recreation. Harmful algal blooms (HABs) occur when an overgrowth of algae creates and environmental or health threat. Symptoms often occur from immersion, inhalation, and ingestion to water and/or food containing the toxin. The adverse health effects from HABs include the known shellfish poisonings, ciguatera fish poisoning, respiratory effects from aerosolized brevetoxins from Florida red tide, and other illnesses associated with exposure to the potent cyanobacterial (blue-green algal) toxins. There is evidence that the frequency and geographic distribution of HABs is increasing, and further increases in HABs are one of the most likely consequences of global climate change.

HABISS is a web-based surveillance system that allows collection of both human and animal health data as well as environmental data about the harmful algal blooms themselves. Data collection is organized in a modular format that can be expanded to suit the needs of state and local health and environmental protection agencies.

Public health agencies are provided with digital certificates that allow them to enter data into HABISS online. The system is presently being used in pilot programs by Florida, North Carolina, and Virginia.

Surveillance items to be collected include agency point of contact(s), geographic coordinates of algal event (s), laboratory algal identification results, time of algal events, time of human or animal exposure, case identifying information of those experiencing human illness (e.g. age/gender/mailing address/phone), route(s) of exposure, clinical signs and symptoms, medical review (s), clinical laboratory results, case definitions, case assessment, diagnosis, and follow-up data. Personal identifiers will be discussed in further detail, in Section A.10. CDC will ensure that several safeguards remain in effect throughout the duration of the surveillance system. These safeguards are also discussed in Section A.10. Screen shots of the web-based surveillance instrument can be found in Attachment 3 of this supporting statement.

Identification of Website and Website Content Directed at Children Under 13 Years of Age

This information collection will involve web-based data collection methods. Only state public health staff in the states who have successfully applied for and obtained funding from CDC and who have obtained digital certificates will be able to enter data into HABISS online. No content is directed to children under 13 years of age.

Form name	No. of respondents	No. of responses/respondent	Hrs/response	Total burden in hrs.
HABISS Data Entry	10	12	8	960
HABISS Monthly Reporting	10	12	30/60	60
Total				1020