Centers for Disease Control and Prevention (CDC) Secure Public Health Emergency Response Communications Network (Epi-X) 0920-0636

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A. Justification

1. Circumstances Making the Collection of Information Necessary

Background

The classification of this Information Collection (IC) is as a revision of the *State-Based Evaluation of the Alert Notification Component of CDC's Secure Communication Network, Epidemic Information Exchange (Epi-X) OMB Control No.*0920-0636. We are requesting a title change to read -- *Centers for Disease Control and Prevention (CDC) Secure Public Health Emergency Response Communications Network (Epi-X).*

This IC is also being revised into a generic IC to improve the effectiveness of CDC communications with its public health partners during public health incident responses. These partners include public health officials and agencies at the state, local, territorial and tribal level.

From 2005-2009, CDC conducted incident specific, public health emergency response operations on average of four public health incidents a year with an average emergency response length of 48 days for each incident. The effectiveness and efficiency of CDC's response to any public health incident depends on information at the agency's disposal to characterize and monitor the incident, make timely decisions, and take appropriate actions to prevent or reduce the impact of the incident.

Available information during many public health incident responses is often incomplete, is not easily validated by state and local health authorities, and is sometimes conflicting. This lack of reliable information often creates a high level of uncertainty with potential negative impacts on public health response operations.

Secure communications with CDC's state, local, territorial, and tribal l public health partners is essential to de-conflict information, validate incident status, and establish and maintain situation awareness. Reliable, secure communications are essential for the agency to gain and maintain accurate situation awareness, make informed decisions, and to respond in the most appropriate manner possible in order to minimize the impact of an incident on the public health of the United States.

The Epidemic Information Exchange (Epi-X) is CDC's Web-based communication system for securely communicating in immediate anticipation of and during public health emergencies that have multi-jurisdictional impact and implications. The incidents of September 11, 2001 illustrated the need for an encrypted and secure communications system that would permit CDC to communicate urgently with partners at the state and local levels, and to notify them 24/7, when necessary. Similarly, *Epi-X* was specifically designed to provide public health decision-makers at the state and local levels a secure, reliable tool for communicating sensitive, unusual, or urgent public health incidents to neighboring jurisdictions as well as to CDC. The system was also designed to generate a request for epidemiologic assistance (Epi-Aid) from CDC using a secure, paperless environment.

Epi-X designers have developed functionalities that permit targeting of critical outbreak information to specific public health authorities who can act quickly to prevent the spread of diseases and other emergencies in multi-jurisdictional settings, such as those that could occur during an influenza pandemic, infection of food and water resources, and natural disasters.

CDC has recognized a need to expand the use of *Epi-X* to collect specific response related information during public health emergencies. Proposed data collection instruments under this generic ICR will be designed to ensure ready access to public health and disease epidemiology information following a public health incident emergency response. Respondents will be informed of this data collection first through an *Epi-X* Facilitator, who will work closely with *Epi-X* program staff to ensure that *Epi-X* incident specific IC is understood. The survey instruments will contain specific questions relevant to the current and ongoing public health incident and response activities.

Authorized Officials from state and local health departments impacted by the public health incident will be surveyed only by *Epi-X* as a web-based communication system.

Dissemination of information during public health emergencies is an integral part of the overall mission of the CDC and is authorized by the Public Health Service Act (42 USC 241) (Attachment 1).

This generic clearance request is intended to answer questions of immediate public health importance during public health emergency responses. Proposed surveys will, in every ICR, go first to data already collected by CDC or its partners. It is important to note that CDC efforts under this generic clearance will not be duplicative of information collections already conducted by ASTHO, NACCHO and other public health organizations. The resulting burden is an upper-bound estimate and will be adjusted as appropriate as CDC uses the collection.

This generic ICR will be used only when CDC activates its Public Health Response Incident Management System (IMS). This system is based on FEMA's National Incident Managements System (NIMS) and the Department of Homeland Security's 2008 National Response Framework. Only CDC's Director can activate CDC's IMS.

Providing support to State, Local, Territorial, and Tribal public health officials in the event of a public health incident is a major part of CDC's mission. Most of CDC's public health responses are managed by CDC's many disease specific scientific Divisions or National Centers. However, if the size, scope, and emergent nature of a public health incident exceed a Center's resources it may request activation of CDC's IMS and move necessary staff into CDC's Emergency Operations Center (EOC). When a CDC scientific program response effort moves from one of the National Centers into CDC's EOC it transitions to a CDC-wide Agency response and the IMS is stood up.

After CDC's Director activates the IMS, CDC will delegate to one of its employees in the IMS the functional role of "Epi-X IMS Information Collection Request Liaison (EIMSICRL). It is highly likely this functional responsibility will be assigned to the IMS Associate Director for Science. The EERICRL will manage the EPI -X Emergency Response questionnaire Clearance Process during that specific response.

The EIMSICRL will manage development and distribution of Processes and Procedures to CDC program official explaining the public health emergency response application associated with the Epi-X Emergency Response Clearance Request. The EIMSICRL also will manage development and distribution of guiding principles for CDC programmatic and scientific staff use in formulating concepts when they are assigned to CDC's IMS during a response.

The IMS ADS acting as the EIMSICRL will manage the requisition process between the CDC Information Collection Review Office, the numerous and diverse CDC Program Officials involved in the emergency response and the State/Local/Tribal Points of Contact (primarily State Epidemiologists, State Health Officers, County Health Employees, and Tribal/Territorial Health Officials/Employees).

The EIMSICRL will coordinate the development of questions to be utilized under this emergency response generic clearance request. Questions will be specific to roles, to specific public health incidents and those responsibilities, and/or functions associated with state/local/tribal public health infrastructure, services, policies, and management such as those noted in the purpose and use section above. The questions will be cleared through CDC IMS leadership. Each request will be closely reviewed by the EIMSICRL based on a predefined set of criteria to include but may not be limited to: 1) Scope of Request, 2) Burden/Impact at State/Local/Tribal level and 3) Relevance to CDC Response Priorities.

An escalation process will be developed for requests of concern or in need of additional clarification.

The information collection request process will include but may not be limited to: 1) Description of a sample (e.g., all 50 states or some sample),); 2) Description of Need and Purpose Proposed Work (or SOW); 3) Sampling methods and the target respondent (e.g., Food Safety Officer), 4) Data Collection instruments and 5) Estimate of response burden.

For example when CDC's Influenza Division works on seasonal influenza, it operates in its own spaces within CDC's National Center for Immunization and Respiratory Diseases. However, in the event such as the 2009 H1N1 influenza pandemic, CDC's

Response	**Start Date**	**End Date**
Iowa Mumps	4/29/06	12/6/06
Tropical Storm Ernesto	8/27/06	8/31/06
Botulism Outbreak-Carrot Juice	9/15/06	9/22/06
E. coli Outbreak (spinach)	9/15/06	12/1/06
E. coli 057 (Restaurant Chain)	12/6/06	12/26/06
R.I. Mycoplasma Pneumonia	12/23/06	1/9/07
XDR-TB	5/24/07	6/8/07

Hurricane Dean	8/13/07	8/23/07
US Satellite de-orbit	1/28/08	2/21/08
E.coli 0157 Multi-State	6/18/08	6/24/08
Salmonella Saintpaul	6/23/08	7/31/08
Hurricane Dolly	7/20/08	7/25/08
Tropical Storm Edouard	8/2/08	8/6/08
Hurricane Hanna	8/28/08	9/4/08
Hurricane Gustav	8/29/08	9/4/08
Hurricane Kate	9/1/08	9/26/08
Salmonella Typhimurium	1/15/09	1/26/09
NSSE-Presidential Inauguration	1/17/09	1/22/09
2009 Pandemic H1N1 Influenza Virus	4/23/09	5/10/10
New Hampshire Anthrax Event	1/5/10	1/20/10
2010 Haiti Earthquake	1/12/10	ongoing
Deepwater Horizon Incident	5/10/10	8/19/10
2010 Haiti Cholera	10/22/10	3/15/11
2011 Japan Earthquake	3/11/11	ongoing

Program response transitions into a CDC Agency–wide response by physically moving into CDC's EOC and activating the IMS.

CDC's Division of Emergency Operations manages CDC Emergency Operation Centers and provides core operational staff during a Public Health Emergency in areas such as logistics, planning, operations and situation awareness. Scientific programs avail themselves of this operational expertise during an emergency response to maximize CDC's ability to respond as an Agency rather than as a Program. The numbers and types of activations are of course unpredictable, however, Table 1 provides a list of CDC IMS activations for the past five years.

Table 1. CDC EOC and IMS Activations January 1, 2006 to March 16, 2011

Privacy Impact Assessment

The most recent PIA for *Epi-X* was completed in 2009.

Overview of the Data Collection System

Data collected under the *Epi-X IC* will use a web-based tool. This tool already is established for the current IC and has been in use since 2003. It will be adapted as needed to accommodate the data collection instruments developed as part of this generic IC. Respondents will receive the survey instrument as an official CDC email, which is clearly labeled, "*Epi-X* Emergency Public Health Incident Information Request" The e-mail message would be accompanied by a link to an *Epi-X Forum* discussion web page. Respondents could choose to provide their answers to the survey questions by posting information within the discussion.

The information collected will be maintained indefinitely. Issues related to data security, confidentiality and informed consent are described below.

Items of Information to be Collected

This generic IC covers organizational or jurisdictional level data elements (i.e. data elements collected from state, local, tribal, and territorial levels of government and non-governmental organizations) that may be qualitative or quantitative. These data elements may be collected during the emergency (data elements related to response phase of the emergency) and after the emergency (data elements related to the recovery phase of the emergency) for intentional and non-intentional public health threats.

Categories of data elements that may be collected under this revised IC may include, but are not limited to: data elements pertaining to infectious diseases, natural or manmade mass casualty incidents, environmental health, informatics, biosurveillance, evaluation of health communication messaging, and Strategic National Stockpile materiel. Examples of data elements categories includes:

Communicable Diseases: signs and symptoms questions (e.g. signs and symptoms of influenza-like illness or other signs and symptoms of the disease of interest, symptom onset), exposure history, travel history (including commercial conveyance information), vaccination status, medical history, plans for further travel during infectious period, travel companion information including vaccination status, plans for further travel during the incubation period; flight or vessel information; tracking of treatment or prophylactic measures and adverse incidents to vaccination or medications; laboratory results; disease outcomes.

Manmade Mass Casualty Incidents: circumstances of incident (e.g., explosion, structural collapse, fire, plane crash and train crash); mechanisms of injury (e.g., inhaled: toxic gas/fumes, particulate matter; burned by: explosion, secondary fire, chemical, unknown; and struck by fixed object: pushed or knocked against object).

Environmental Health: shelters (e.g., security/law enforcement availability, hot water availability, safety of food source, availability of hand-washing facilities, adequacy of water supply, safety of water source, reported outbreaks, unusual illness/injuries, adequate number of toilets, sewage system type, adequate number of collection receptacles, adequate child/caregiver ratio, adequate number of cots/beds/mats, adequate spacing, presence of companion animals, and handicap accessibility); chemical exposures (e.g., proximity to the site of release, personal exposure description, medical history, occupational history, description of

acute health effects immediately after release, personal protection equipment worn by responders or hospital workers); radiological exposures (e.g., exposure location, potential routes of contamination, radiation assessment, prodromal symptoms, radiation countermeasures; rapid response registry: (e.g., registrant information, proxy or close friend/relative information, exposure information); exacerbation of chronic medical conditions; availability of routine pharmaceutical supplies (e.g., medications for chronic medical conditions).

Informatics: demographics (e.g. location, size, geographic coverage) of healthcare entities (e.g. hospitals, emergency departments, laboratories, pharmacies); healthcare entity information/data transfer resources and capabilities; types and volume of data available.

Biosurveillance: syndrome definitions and algorithms, number of outpatient and emergency department visits; demographic information of cases, including geocoded data; patient disposition; hospitalization rates, ICU utilization, medical supplies availability, hospital census reports; mortality rates; laboratory test orders and results; treatment protocols, types of surveillance systems, surveillance methods (e.g., telephone) and tools (e.g., secured data network (SDN) used.

Evaluation of Health Communication Messaging: receipt of CDC communications (including messages and guidance) by partners during emergency incidents, helpfulness of messages and guidance, clarity of messages and guidance, how and if messages and guidance were used.

Strategic National Stockpile[1] Materiel: types of adverse reactions to countermeasures, number of adverse reactions in the affected area, number of cases, types of symptoms, Investigational New Drug (IND) patient information for hospitalized patients (e.g. laboratory results and medical history), medical countermeasure dashboard activity (e.g., pharmaceutical and medical supply manufacturers, distributors and retailers), current inventory on hand, disposition of the inventory, how inventory was stored, sub recipients of the materiel (e.g., Indian Health Service, community health centers, local public health departments, other health facilities), which sites were delivered to, and how many people received the materiel.

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

Epi-X as a secure web-based communication has limited access to only authorized federal, state, and local public health officials. *Epi-X* doesn't use cookies to store any user info. The Secure Data Network (SDN) uses SM cookies for authentication persistence, which are destroyed immediately after a user logs out or times out. The *Epi-X* privacy policy and user agreement are on the *Epi-X* webpage (Attachment 2).

2. Purpose and Use of the Information Collection

[1] The Strategic National Stockpile is a national repository of antibiotics, antivirals, chemical antidotes, antitoxins, life-support medications, IV administration equipment, airway maintenance supplies, and medical/surgical items managed by CDC. During a public health emergency, State and local public health systems and resources may become overwhelmed. The SNS is designed to supplement and re-supply state and local public health agencies in the incident of such an emergency.

The purpose of this generic IC will be to create an accurate, reliable knowledge base related to an ongoing public health emergency incident, to ensure situation awareness by CDC, other federal agencies, and state, local, territorial and tribal[1] public health officials, to facilitate communication that will inform appropriate decision making, and to execute effective and efficient response activities. Ultimately, information acquired from this process will strengthen the public health communications infrastructure and the nation's ability to respond to multi-jurisdictional disease outbreaks, natural disasters, and bioterrorism threats. There are positive benefits of collecting the data:

1) The public health emergency involves one jurisdiction or more than one jurisdiction and uniform data are needed to drive response (e.g., which and how many resources were deployed after a hurricane affected multiple states, clinical symptoms of patients with a novel virus, etc.?)

2) Data collected may be of benefit to other Agencies (e.g., Food and Drug Administration).

There are negative public health consequences of not having the data:

1) A delay in data collection may result in the loss of information that could potentially a) compromise CDC's ability to effectively respond to the emergency, b) be used to assist with the response or answer research questions (e.g., how many and which staff were deployed, what duties were performed, by whom, and when during the response, and what was the impact of their involvement in the response?), c) impair public health efforts to identify and implement lessons learned from the emergency.

2) A delay in data collection may significantly inhibit data sharing and coordination across Federal, State and local agencies, causing a delay in an emergent response.
CDC will conduct surveys, across a range of public health topics, using standard questionnaire administration approaches (e.g., online, phone, in person, focus groups). CDC is requesting a three-year approval for a generic clearance to assess information related to a myriad of public health emergencies response issues that affect State, Local, Territorial, and Tribal health agencies.

Information will be used to assess situational awareness of current public health emergencies, make decisions that will affect planning, response and recovery activities of subsequent emergencies, and fill gaps in knowledge that will strengthen surveillance, epidemiology, and laboratory science; better supporting efforts in states and communities.

Respondent universe is comprised of state, tribal, local and territorial governmental officials/employees that are employed by an agency involved in provision of public health services in the United States. That agency is represented by local, state, tribal or territorial health departments or any governmental entity with primary mission to improve public health. The list of state, local, territorial and tribal governments, as defined by the US. Bureau of Census is available at http://harvester.census.gov/gid/gid_07/options.html.

The scope of data collection is limited to responsibilities and duties of governmental employees acting in their official capacity. Thus individual data collections that require IRB review are not

covered. OMB will decline individual data collection requests if it includes respondents that are governmental employees with official duties other than public health.

The collection will include the following categories of governmental officials: 1) State, Territorial, Local, or Tribal Officials/Employees; 2) Municipal/City Employees.

State, territorial and tribal health officers are in a unique position to provide CDC information on jurisdiction's public health threats, status of public health infrastructure work force and financing at state, local, territorial and tribal level. For that reason CDC will survey that category if, for example, the assessment of the magnitude of a particular public health problem is needed (surveillance), or when evaluation of the jurisdiction's capacity to respond to a particular health problem (assessment and performance management) is warranted.

County and municipal/city health employees are at the forefront of public health service delivery and emergency response. Examples of surveys for that category may include, but not be limited to assessment of their performance in provision of public health services, progress they are making in accreditation process, and new policy development initiatives.

In general, CDC expects that these collections will be solicited from either all officials/employees in a category (e.g., all epidemiologists, or to the geographic subset of professional officials/employees for which a particular health emergency was thought to be relevant (e.g., all county health employees whose counties had been affected by a disease outbreak). This collection of information will employ statistical methods for data collection as described in section B.

Surveys will be organized for the purpose of gathering information on administration, quality, quantity, improvement, inputs, activities, outputs, and outcomes related to delivery of public health services.

Specific questions will be formulated around one or more of the three themes of the ten essential public health services listed below:

Assessment:

- Monitoring health status to identify community health problems
- Diagnosing and investigating health problems and health hazards in the community
- Evaluating effectiveness, accessibility, and quality of personal and population-based health services

Policy Development:

- Development of policies and plans that support individual and community health efforts
- Enforcement of laws and regulations that protect health and ensure safety.
- Research for new insights and innovative solutions to health problems

Assurance:

- Linking people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assuring a competent public health and personal health care workforce

- Informing, educating, and empowering people about health issues
- Mobilizing community partnerships to identify and solve health problems

In general, CDC does not expect these collections to yield data that can be generalized, but will produce needed information regarding important health topics that affect state and local public health emergency issues. CDC expects to use these findings to understand better the range of experiences among state, local, tribal, and territorial governmental officials/employees and as one of many inputs into decision making and/or program management or evaluation.

CDC will submit the specific information collections (e.g., individual surveys) to OMB for review as individual Information Collections (ICs) under this general Generic clearance framework. Individual submissions will include the purpose of the collection, a description of sample (e.g., all 50 states or some sample), the target respondent (e.g., food safety officer), the questions to be asked, and the response burden. These specific information collections will be included in the PRA public docket prior to their use. OMB will review and approve an individual IC in an expedited manner. However, if the specific information collection falls outside the scope of the generic clearance or is otherwise inconsistent with the terms of the generic clearance, OMB will return the proposed information collection to the agency for additional consideration or require that the full PRA process be followed, including public notice and comment, for the review and approval

Privacy Impact Assessment Information

The information is being collected to provide CDC with information for all-hazards public health emergencies. The information may be used to provide answers to the following questions:

- How are public health emergencies coordinated and handled by the state, local government, tribal and territorial governments?

- Are the Strategic National Stockpile assets being deployed in a reasonable period of time following a public health emergency?

- From a public health systems perspective, how are the entities involved working together to improve recovery and response during a public health emergency?

- During a public health incident, how are data being integrated and exchanged to provide accurate information?

- How are unstructured data being implemented and validated during a public health emergency?

- How are multiple forms of data and information resources being used to inform health intelligence?

Respondents will be advised of the nature of the activity, the length of time required for participation and that their participation is voluntary. The purpose is to organize the information collected and use this information during and after (including a possible follow-up) a public health emergency.

No IIF is being collected**.**

3. Use of Improved Information Technology and Burden Reduction

In past years, land-line telephone conversations were viewed as the only "secure" means of communication between epidemiologists, health officers, and the CDC. *Epi-X* is CDC's first and only secure, encrypted network being used to convey urgent public health information between key state health officials, CDC, and HHS. The prospect of bioterrorism has heightened the importance and necessity of this network, as has the multi-jurisdictional public health impact of natural disasters and infectious disease outbreaks.

Epi-X was designed as a web-based network to communicate urgent public health information securely, in a paperless environment. All authorized public health officials must apply for, and be granted a digital certificate through CDC's Secure Data Network to access *Epi-X*.

Epi-X will enable state and local respondents to communicate clearly, securely, and specifically the information CDC requires to respond effectively to public health emergency incidents.

4. Efforts to Identify Duplication and Use of Similar Information

Every effort will be made to avoid duplication by other Federal Agencies and partner organizations (not limited to the following examples: Council of State and Territorial Epidemiologists (CSTE), National Association of City and County Health Officials (NACCHO), and Association of State and Territorial Health Officials (ASTHO).
An *Epi-X* incident specific survey instrument will only be used during a specific public health incident where secure and time sensitive communications are needed. Information from the survey instrument would be for that incident.

5. Impact on Small Businesses or Other Small Entities

There will be no impact to the business sector or other small entities during the collection of information. Information will be collected only from authorized *Epi*-X public health officials.

6. Consequences of Collecting the Information Less Frequently

Data collection covered under this generic IC will be related to a specific all-hazards public health emergency. The frequency of data collection as it relates to consequences to the federal government or policy activities will depend on the specific public health incident.
The information to be collected will be for specific public health emergency incidents. The information may serve as a baseline for future public health incidents response surveys. Data collection instruments used during a public health emergency response would enhance the

acceptance and use of *Epi-X* as a tool for the collection and dissemination of critical and ongoing emergency response public health information. There are no legal obstacles to reduce the burden.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

Because public health emergency response incidents are unpredictable, there may be circumstances that would require the respondents to collect information as soon as possible to assist CDC and other public health agencies to mitigate the impact of an incident and report information more than quarterly. Such situations would include for example, a hurricane disaster response incident and an on-going foodborne outbreak response in the same state at the same time.

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

A. A 60-Day Federal Register Notice was published in the Federal Register on , July 8, 2010, Vol. 75, No. 130, pp. 39259- 39261 (Attachment 2). There were no public comments.

The program at times may consult with individuals outside of the agency on this data collection instrument for a specific public health incident. Within CDC, design architects, medical epidemiologists, program analysts, and health communicators are consulted regarding the design of the survey instruments. When necessary other Federal agencies will be consulted (e.g., Department of Homeland Security, Environmental Protection Agency, Federal Bureau of Investigation, United States Department of Agriculture and Food and Drug Administration).

9. Explanation of Any Payment or Gift to Respondents

Respondents will not receive gifts for their responses or participation in the *Epi-X* system.

10. Assurance of Confidentiality Provided to Respondents

The survey will collect information from public health officials of the CDC Secure Communications Network (*Epi-X*) on incident specific information related to public health emergency response. The purpose of the information will be to gain and maintain accurate situation awareness, make informed decisions, and respond in the most appropriate manner possible to minimize the impact of an incident on the public health of the United States. The information gathering process will occur through web-based technology that connects authorized state and local public health officials, which is deemed to be secure and adheres to standard security protocols.

IRB Approval

IRB approval is not required.

Privacy Impact Assessment Information

A. This submission has been reviewed by ICRO, who determined that the Privacy Act is not applicable.

B. Data will be treated in a secure manner and will not be disclosed. *Epi-X is* a secure, electronic communication system that enables local, state, and federal public health officials to share information about recent outbreaks and other health events in a rapid manner. Advisement information for *Epi-X* users in the form of a Privacy Policy Notice is located in Attachment 3. Data collection instruments will not involve collecting sensitive and/or personal identifiable information. Data collected through use of this generic IC s will be stored as all information in *Epi-X* is stored: in an SQL database that resides behind the CDC firewall. The physical security where the servers reside requires special CDC Security clearance to enter the room. Cleared individuals must pass through a double door system that is electronically controlled by a pass key. The servers are locked in separate locked cages that only the system administrators (SA) can access. The servers require server-side strong security passwords to enter the server. Written rules of behavior for SAs are enforced by recording and monitoring access logs and through training. A designated Security Steward monitors and enforces all security concerns. ITSO scans computers regularly to ensure that adequate protection is maintained on the servers.

"Least privilege" rule (need to know access) is enforced for all authorized users. Only authorized users with a valid VeriSign digital certificate have access to data collected through *Epi-X*. Users of *Epi-X* are authorized by a state public health department official (usually the State Epidemiologist), through their affiliation with a partner organization (e.g., CSTE, APHL, NACCHO, ASTHO), or through their affiliation with a government agency (e.g., CDC, HHS, DHS, DoD, DoS). Authorized users are required to read and abide by the *Epi-X* User Agreement, which delineates their roles and responsibilities with regard to the use of *Epi-X* information. Authorized users are subject to the terms of the privacy policy (Attachment 3).

All information collected through *Epi-X* is retained in perpetuity. Data collected through use of these generic IC instruments will be available on the secure website as an *Epi-X* report, *Epi-X Forum* discussion posting, or as an attachment to a report or discussion posting. Data added as attachments are not searchable, but data added to an *Epi-X* report or *Epi-X Forum* discussion posting are searchable. None of the data collection instruments ask for names of individuals so these would not be available as parameters for searching *Epi-X* reports or *Epi-X Forum* postings.

C. Respondents will be notified of the voluntary nature of their response and asked if there are any limitations or time embargoes as to how the information should be shared or disseminated. The Epidemic Information Exchange's (*Epi-X*) purpose is to create an accurate, reliable knowledge base related to an ongoing public health emergency incident, to ensure situation

awareness by CDC and state local, territorial and tribal public health officials, to facilitate communication that will inform appropriate decision making, and to execute effective and efficient response activities. As many public health emergency incidents are multi-jurisdictional, information acquired from this process will be shared with appropriate, federal, state, and local partners to strengthen the public health communications infrastructure and the nation's ability to respond to multi-jurisdictional disease outbreaks, natural disasters, and bioterrorism threats.

Based on a respondent's limitations on the data collected, it may be shared with other appropriate Federal Agencies (e.g., Food and Drug Administration) and local or state jurisdictions who are *Epi-X* subscribers.

D. No IIF is being collected.

11. Justification for Sensitive Questions

Information collectEd under this generic IC will not contain questions of a sensitive nature.

12. Estimates of Annualized Burden Hours and Costs

A. Because most public health emergency responses are multistate and multijurisdictional, each incident specific survey instrument would be sent to appropriate public health officials/offices that are responsible for a specific incident response in each jurisdiction affected.

State Epidemiologist: The number of respondents and the number of responses per respondent reflects an upper limit and the uncertainty of predicting public health emergencies. A population based estimate was used that would reflect a states epidemiologist whose jurisdiction covered a large population over a large geographic area and would receiving a maximum of 2 surveys per week. This rate was used for all states regardless of their population or geographic size.

County Health Officials: The number of respondents and the number of responses per respondent again reflects an upper limit and the uncertainty of predicting public health emergencies. Some county health officials may receive more than one survey, some may receive none. However, as subdivision of the states, the maximum estimated was set at 1 survey per month.

50 states x 104 questionnaires (52 weeks x 2) / year x 1 hour/questionnaire = 5200 burden hours for state health officials

12 questionnaires /year x 1 hour questionnaire x 1600 county health officials (approximately half of US counties) = 19,200 burden hours for health officials

Total = 24,400 burden hours x three years = 73,200 for the full 3 year approval period

Exhibit 1. Estimated Annualized Burden Hours

Type of Respondent		No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
State Epidemiologists		50	104	1	5, 200
County Health Officials		1600	12	1	19,200
Total					24,400

The mean hourly wage is based on the United States national average for 2009 taken from the Bureau of Labor Statistics website (www.bls.gov).

Exhibit 2. Estimated Annualized Burden Costs

Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
24,400	$20.90	$509,960

May 2009 National Occupational Employment and Wage Estimates for All Occupations

13. Estimate of Other Total Annual Cost Burden to Respondents or Record Keepers.

There are no capital or maintenance costs to the respondents.

14. Annualized Cost to the Government

The government costs include personal costs for federal staff and contrator staff involved in operating and mainitaining the Epi-X web system, the staff involved in project oversight and development of this IC, and project staff engaged in the deployment of an information collection tool during a specific public health response. IC development involves input from across the agency and equals approximatley 10% of a GS-13 public health analyst, 10% of a GS-14 scientist, and 10% of a GS-15 scientist. Project oversight, survey intiation, data analysis, results compilation, and report writing during one 48 day incident response involves approximatley: 10% of 2 GS-14 Scientist and 10% of one GS-15 scientist during an average 48

day response period, times 4 response per year. (48 days is 13% of 365 days x 10% of time during that 48 days). Calculation based on a GS grade Step 5 base + locality pay 5 x 25% for benefits) . The total cost to the Federal government is $503,246.00.

Exhibit 3. Annualized Cost to the Federal Government

Labor:	
CDC personnel for *Epi-X* system management 100% GS-13	$121, 123.00
Contractor labor for *Epi-X* system management	$96,500.00
CDC personnel for ICR development including contribution from programs for survey tool development	$42,000.00
CDC personnel for response incident project oversight base 2.6% of GS-14 scientist (2.6% is 1.3% x 2 GS-14) and 1.3% of a GS-15 scientist is approximately $6000.00 x 4 responses per year	$24,000.00
Annualized cost to the Federal government	$283,623.00

15. Explanation for Program Changes or Adjustments

This is a program change request for an IC request for revisions. We are requesting a title change to read -- *Centers for Disease Control and Prevention (CDC) Secure Public Heatlh Emergency Response Communications Network (Epi-X).* The prior IC was distributed to individual users for their 10 minute burden evaluation of the *Epi-X* system. The program change is that *Epi-X* surveys tools will request specific technical information from one public health official reporting from each public health jurisdiction with information relevant to a specific public health incident that has impacted their location. Estimated burden has increased from 10 minutes to one hour.

The total number of burden hours has increased from 167 to an estimated 24, 200 hours using the following calculation 50 states x 100 questionnaires/ year x 1 hour/questionnaire = 5000 burden hours for state health officials and 12 questionnaires /year x 1 hour questionnaire x 1600 county health officials (approximately half of US counties) = 19,200 burden hours for county health officials. This figure is a worst case figure reflecting multiple or long term public incidents such as an influenza pandemic where there is a requirement for CDC to stay up-to-date and it contact with state and local health partners on the current status and epidemiology of a public health incident.

The original program was based on a once a year event evaluation. This IC request for revisions is based on the number of potential public health incidents that would impact a public health jurisdiction at the state or county level. The burden increases from $3,340 to an estimated $491,744. This increase represents the burden of compiling and validating public health incident specific data from that jurisdiction with up to 100 requests per year at the state level and 12 requests per year estimated for a local county public health office.

16. Plans for Tabulation and Publication and Project Time Schedule

The data collected under this generic IC will be used to provide information that is necessary in understanding and responding to specific public health incidents. The Program/Project Officer working with the incident specific epidemiologists will outline plans for tabulation and publication of incident specific data collection as well as the incident specific project time schedule. The collection of data, as soon as possible after the public health emergency, is critical and is the responsibility of the Program/Project Officer. Any publication derived from the public health emergency is subject to review by the State or local health departments, CDC or foreign countries. The Activities and Time Schedule begins when CDC's Director activates CDC's Emergency Operations Center to coordinated CDC's activities in regards a specific public health incident.

Exhibit 4: Individual Public Health Incident ICR Project Time Schedule bases on the average length of a CDC Public Health Response of 48 days

Activity	Time Schedule
Pre-notification Epi-X e-mail sent to Public Health Officials potentially impacted by the incident	Within 1 week of CDC's Director activating CDC's Emergency Operations Center (EOC)
Epi-X Initial Incident Specific data collection initiated	Within 2 weeks after CDC's EOC is activated (Day 14 of an average 48 day response))
Preliminary data analysis and assessment	
Follow-up with Epi-X Public Health Officials engage in Incident Specific Public Health Response	Within 3 weeks after CDC's EOC is activated (Day 21)
Epi-X Second Incident Specific Data Collection – (if needed)	Within 4 weeks after CDC's EOC is activated (Day 28)
Data analysis and assessment	Within 5 weeks after CDC's EOC is activated (Day 35)
Epi-X Third Incident Specific Data Collection (if needed)	Within 6 weeks after CDC's EOC is activated (Day 42)
All data collection completed	1 month after CDC EOC is deactivated – work reverts to program
Data cleaning, coding and analysis	5-7 months after CDC EOC is deactivated
Completion of Evaluation Reports and Review	8-10 months after CDC EOC is deactivated
Publication and Dissemination of Incident Epidemiology Summary	11-12 months after CDC EOC is deactivated

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

We are not requesting an exemption to the display of the expiration date.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.