Prevalence Survey of Healthcare-Associated Infections and Antimicrobial Use in U.S. Hospitals

Nonsubstantive Change to

OMB No. 0920-0852
(Expires 12/31/2016)

Contact:

Project Officer: Amy McMillen, MPH

National Center for Emerging and Zoonotic Infectious Diseases
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road
Atlanta, GA 30333

Telephone: 404-639-1045

Email: auh1@cdc.gov

June 10, 2014

Prevalence Survey of Healthcare-Associated Infections and Antimicrobial Use in U.S. Hospitals

A1. Circumstances making the collection of information necessary

This request is for a nonsubstantive change to an approved data collection (OMB No. 0920-852) (expires 12/31/2016). OMB approved the Prevalence Survey of Healthcare-Associated Infections and Antimicrobial Use in U.S. Hospitals in October 2013, for two survey data collection to commence in 2014. Changes to the public data collection and to the government data collection were approved in October 2013. Because of the late availability of funds, the full-scale survey cannot proceed as planned in 2014. A nonsubstantive change request is now submitted to request permission to perform a more limited data collection in 2014 and the full scale survey in 2015.

Changes

This change request seeks approval to:

- Delay the full scale survey till 2015 (and therefore perform only one full scale survey during the three year approval period).
    - The full scale survey approved by OMB in October 2013 consists of a healthcare facility assessment of facility characteristics, infection control and antimicrobial stewardship, a data collection on patient characteristics, healthcare-associated infections, and antimicrobials prescribed and administered at the time of the survey, and an antimicrobial prescribing quality assessment.

- Conduct a limited data collection in 2014 in place of the full scale survey.
    - The limited data collection in 2014 will consist of a healthcare facility assessment of facility characteristics, infection control and antimicrobial stewardship using the data collection tool approved by OMB in October 2013, and the antimicrobial prescribing quality assessment.

Because the full scale prevalence survey is not taking place in 2014, we needed to develop another approach that would identify a group of hospitals and patients eligible for inclusion in the limited data collection in 2014. EIP sites will determine the catchment areas from which hospitals will be selected for the 2014 data collection. No more than the currently approved number of hospitals will be engaged. Patients included in the antimicrobial prescribing quality assessment will be identified using pharmacy and admission/discharge/transfer or other similar hospital databases, based on presence of selected diagnosis codes and selected antimicrobial agents. We anticipate including approximately 2800 patients in the antimicrobial prescribing quality assessment. This

number is lower than the number of patients approved for inclusion in each of the two surveys approved by OMB in October 2013.

A2. Purpose and use of information collection

Based on available data, inappropriate antibiotic use is widespread throughout hospitals in the United States (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6309a4.htm?s_cid=mm6309a4_w). Inappropriate antimicrobial use is a primary driver of antibiotic resistance, and antibiotic resistance is a public health crisis.

We are at a point where there are nightmare bacteria causing infections for which we have no effective treatments—and this is largely due to overuse of antibiotics. As stated in the CDC's recent antimicrobial resistance threat report, "Perhaps the single most important action needed to greatly slow down the development and spread of antibiotic-resistant infections is to change the way antibiotics are used." It is estimated that more than 20,000 people die each year due to antibiotic misuse (http://www.cdc.gov/drugresistance/threat-report-2013/pdf/ar-threats-2013-508.pdf).

In March, 2014, CDC for the first time called on all U.S. acute care hospitals to institute antibiotic stewardship programs to improve antibiotic use. For this to succeed, we need to rapidly increase our knowledge about improving the quality of antibiotic prescribing. The proposed limited data collection in 2014 addresses this need and will allow us to translate knowledge into tools for hospitals to use as they implement these programs in 2015, and develop quality measures to evaluate hospital performance.

Furthermore, lessons learned during administration of the healthcare facility assessment and the training and implementation of the antimicrobial prescribing quality assessment in 2014 will inform improvements to the 2015 full scale survey data collection.

A8. Consultation Outside the Agency

There has been no additional consultation outside the agency for this nonsubstantive change request, with the exception of seeking input from the Emerging Infections Program investigators.

A12. Estimates of Annualized Burden Hours and Costs

Implementation of this nonsubstantive change request reduces the burden of the public data collection from 6325 hours and $206,574.50 to 5350 hours and $191,451.00.

Currently approved burden (October 2013):

Type of Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Responses (in hours)	Total Burden Hours
Infection preventionist	Healthcare Facility Assessment (HFA)	500	1	45/60	375
Infection preventionist	Patient Information Form (PIF)	500	42	17/60	5950
Total					**6325**

Changes anticipated to the burden with nonsubstantive change request:

Type of Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Responses (in hours)	Total Burden Hours
Infection preventionist	Healthcare Facility Assessment (HFA)	500	1	45/60	375
Computer systems analyst	NA (provision of patient lists)	500	1	240/60	2000
Infection preventionist	Patient Information Form (PIF)	500	21	17/60	2975
Total					**5350**

In the proposed limited data collection in 2014, the hospital is the respondent as it was in the ICR approved by OMB in October 2013.The antimicrobial prescribing quality assessment in 2014 involves identifying eligible patients from hospital databases, and will require that hospitals provide lists of patients who received selected antimicrobial drugs or who had selected types of infections (e.g., pneumonia, urinary tract infection) during a certain period of time (e.g., during a particular calendar year). The EIP site personnel (agents of the government) would then randomly select patients from these lists of eligible patients to be included in the antimicrobial use audit data collection.

The employee within the hospital who would typically generate line listings of patients from a hospital database would be a computer/data analyst rather than an infection preventionist/nurse. Again, the hospital remains the respondent, but the specific individual within the respondent entity who provides a list of eligible patients may differ from hospital to hospital.

There is no data collection form to be completed by hospital staff for the antimicrobial prescribing quality assessment.

Infection preventionists (or other designated staff, such as computer/data analysts) in participating healthcare facilities will be asked to do the following: 1) complete the healthcare facility assessment (HFA) on a one-time basis in 2014 and in advance of the survey in 2015, 2) provide lists of patients to EIP staff for the antimicrobial prescribing assessment in 2014, 3) participate in training for the 2015 survey, and 3) collect survey patient data, limited to basic demographic and clinical information on the Patient Information Form (PIF).

For the HFA, respondents will be infection preventionists (or other designated healthcare facility staff). We anticipate a total of no more than 500 respondents, one for each participating facility, who will complete the assessment one time in 2014 and in 2015 prior to the survey. The time required to complete the assessment is estimated to be 45 minutes.

For the provision of patient lists in 2014 for the antimicrobial prescribing quality assessment, respondents will be computer systems analysts or other designated healthcare facility staff (such as pharmacy staff or billing/administrative staff). We anticipate a total of no more than 500 respondents. The time required in each facility to generate the patient lists is estimated to be 4 hours.

If 1 HFA and antimicrobial prescribing data collection and 1 full scale survey are conducted during the 3-year approval period, the estimated annualized burden associated with the HFA (with 2 responses from 500 respondents over 3 three years) is the burden associated with 0.67 responses per year (rounded to 1 response per year), for each of the 500 respondents, or 375 annual burden hours.

If 1 HFA and antimicrobial prescribing data collection and 1 full scale survey are conducted during the 3-year approval period, the estimated annualized burden associated with the provision of patients lists (2014, 1 response per respondent, 4 hours per response) and training and completion of PIFs (2015, with 62 responses for 1 survey from 500 respondents annualized over 3 years) is the burden associated with 0.33 responses per year for the provision of patient lists, rounded to 1 response per year (4 hours per year for each of 500 respondents, or 2000 hours) plus the burden associated with 20.7 responses per year for the 2015 PIFs, rounded to 21 responses per year (6 hours per year for each of the 500 respondents), or 2975 hours.

The overall burden to the public (i.e., infection preventionists, hospital computer systems analysts or other designated healthcare facility staff) for the HFA, provision of patient lists, survey training, and PIF combined is 5350 hours when annualized over the 3 year approval period.