

## Appendix 2b

### Comments from the Association of State and Territorial Health Officials (ASTHO)

Comments were from Blumenstock, Jim (CDC astho.org) and included comments from members of ASTHO's Infectious Disease and Preparedness Policy Committees and were received on Friday, January 02, 2015 8:45 AM

General comments were:

- ASTHO appreciated the chance to provide comment and reaction to a series of helpful tools for use in monitoring persons returning to the U.S. from West Africa.
- Many of the forms could be combined or used for multiple categories of people (the specific examples of forms 5a-c seem duplicative and might easily be confused with one another given the subtle differences among them).
- Jurisdictions have already developed tools and wondered if there would be a need to switch to these new forms.
- A question was to the audience for some of the forms, i.e. who will be filling out the form (e.g. health department staff, the individual returning home or a traveler from West Africa) - where different end-users may require different verbiage to explain how to complete the form appropriately.
- Internal inconsistency was noted on one form, where the first part of the questionnaire asked questions about the patient, then switched to asking the patient directly.
- There is a sense that the time burden and start-up estimates are accurate.

Verbatim comments:

In the past, CDC Ebola monitoring documents in general show a lack of understanding for the travelers we are monitoring. Many do not speak English very well; others have never left their native countries before this experience and do not read or write in any language. Some have never before seen a thermometer. Furthermore, a general comment for prior documents is that some CDC authors do not seem to understand the issues and day-to-day problems involved with monitoring and the tremendous burden placed on health departments. On any given day states may be monitoring about 50 travelers.

On the other hand, this specific batch of forms implies that the forms would only be used on U.S. contacts to an Ebola patient in the United States rather than on travelers. However, this is somewhat confusing because some of these same forms appeared in part of a package two weeks ago that was released via EpiX. In that package were some forms that related to travelers as well as some of the forms in this set. If these forms are solely for U.S. contacts and not for travelers, then it is unclear why we would need a different set of monitoring protocols and forms than we already have in place for travelers. The specific forms for monitoring lab workers, environmental service workers, and health care workers make sense but not the others. Clearly labeling which form to be used when would help, if it is decided that the specific additional form is needed. One missing form that would be useful is one for monitoring EMS workers (separate from HCWs).

A general comment is that the amount of funding for monitoring that we will receive is miniscule

compared to the amount that we have already spent and will spend. Monitoring and potentially investigating a case is already labor intensive, adding these forms would require dedicated full-time staff to report numbers and complete forms. In addition, these forms would likely only be used with a hospitalized Ebola case in our state, when our resources would already be stretched very thin.

States have already developed and been using their own materials and currently send a daily report of all people under direct active monitoring and a weekly report of everyone who is being monitored. To see all these new forms and reports is discouraging when they can use what they already have, in many circumstances.

In general, the proposed information for collection seems appropriate, though some of the information might be excessive for state purposes (e.g., CDC currently is not asking states for detailed PUI information, and many times, states do not need to collect all the requested data in the draft PUI form for purposes of working up the report). However, it is our assumption, that the forms are templates and generally optional, recognizing that these forms are primarily designed to standardize data that are sent to CDC when applicable. To enhance data quality/utility, particularly when launching new data collection forms, it is suggested that CDC also work through CSTE to host a conference call with state epidemiologists to clarify data fields/data collection expectations. Regarding minimizing information collection through use of information technology, states currently transmit reportable disease data to CDC via NETSS. Many states have their own reportable disease databases that they use to track investigation-related data. As with other emerging multi-state investigations in the past, states have asked CDC to consider using NETSS mechanisms for sharing data from states versus use of one-off investigation forms that are sent to CDC through a variety of mechanisms including fax and e-mail. We again ask that CDC consider looking at existing mechanisms to minimize duplicative data sharing efforts at the state-level.

#### Specific comments:

1. Some States with an interactive online database for HD employees to fill out forms might not want to duplicate efforts for some of these, as they might already have forms of their own that are working just fine for them.
2. One form was asking for a summary of people being monitored; since states are already completing weekly on-line surveys for CDC, we would just want to ensure that monitoring surveys will not be duplicated.
3. Daily White House Report form. Questions 1-4 are doable but answering question 5 every day does not seem to have any utility, and could be extremely burdensome. A range of days (days 1-7, 8-12, 13+) could make the data more useful.
4. End of monitoring letter. Minnesota already has one that they developed for travelers and prefer it to this one.
5. 21-day fever and symptom log. This form is of questionable utility. First, we keep a log of their symptoms through our daily phone calls. Second, we want the person to contact

us when they symptoms develop rather than keep a log of it. Third, given the background of many of the travelers, including inability to read or write in any language, this type of log would be overwhelming and difficult to them.

6. Form 3c Guidance for evaluation and triage of contacts. The recommendation is for states/LHDs to contact the primary care provider (PCP) of each traveler/contact. Most travelers have not had PCPs, if they did, this would add a burdensome time commitment on the part of the state/LHD. Clinic physicians are not easy people to contact; and most of the travelers have not seen their PCP in the first 21 days. The patients talk with their doctor if they need to be seen for routine care and public health can intervene if there is a need or concern on the clinic's/PCP's part. The same holds true for non-travelers; if the symptoms are consistent with Ebola we hope they will call us. Health departments can help, but not mandate individuals to go to a specific PCP for routine care.
7. Attachment 3c: My only comment is that according to Texas health officials, for persons who were getting home visits, the first assessment is actually done PRIOR to arriving at their front door—they said that they would call ahead, and ask over the phone if the contact was symptomatic, before arriving at the door. Then, once they got to the door, they would review and ask again.
8. Att 4a Guidance for contacts of Ebola. It's not clear why this would be used for contacts within the United States but not for incoming travelers. We would use the same "Day Zero/First Monitoring" phone script that we use for all travelers since it is more complete and has been used many times.
9. Attachment 4: Generally looks great. One sentence is a little strange—perhaps the word "in" should be removed:
  - Take your temperature orally (by mouth) with a digital thermometer 2 times a day **in**: once in the morning and again in the evening.
10. Attachment 4b: Wherever XXXX occurs, I would remove the words "Health department" after them and just let local jurisdictions put their name in. Many local health departments don't use the term "health department" for their agencies— for example in Idaho, <http://www.idahopublichealth.com/81-home/132-idaho-health-districts> -- "Panhandle Health District 1"—the word Department does not appear.

I would reword to say "This monitoring will take place for 21 days from after your last contact with an Ebola patient while they had symptoms" to avoid any confusion over whether the last day of contact with the patient is considered day 1.

11. Attachment 5a: "patient" misspelled in first row; "clean" misspelled in last row I am surprised there is no row for any breach in protocol eg "Noted any breach in PPE protocol" or more detailed PPE questions such as is found in attachment 5b.

12. Attachment 5b: Line 28: “Any issues with PPE” is very imprecise language. Do you mean “Any suspected breach in PPE protocol” or “any possible exposure” or something like that?  
Also the way the questions are set up, sometimes “Yes” is a good answer and sometimes “No” is the good answer. It would be helpful to set them all up the same, so for example “Yes” always means that things went well, so a “No” really stands out as a possible problem being identified.
13. Attachment 5c: I’m not clear on the purpose of this form, as much of the information is redundant to the other forms (5a, 5b). Perhaps that is clear with instructions, but could the redundancy be eliminated?
14. Attachment 6: Instead of just recording temperature on this form, there should be a separate row for “fever” since there could be normal temp at time of visit but a self-reported fever within the past 24 hours that should be noted somewhere.
15. Attachment 7: looks great—no comments.
16. Attachment 8: I’m not sure who is supposed to complete this report—presumably CDC staff? This form seems not finalized. For example, I would find the first question confusing—is this supposed to be number of persons with EVD currently under treatment in the U.S.? Is it cumulative? Do you count persons diagnosed overseas and transported to the U.S.? Question 2 seems incomplete and there is no space to fill out answers etc.

Document Name	Is the proposed collection of information necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility?	Are estimates of the burden of the proposed collection of information accurate?	Are there ways to enhance the quality, utility, and clarity of the information to be collected?	Are there ways to minimize the burden of the collection of information on respondents?	Are estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information accurate?
Att1 – EVD Case Investigation Form	Yes. This looks like a good summary of the exposure information and contact information that we would need to be able to respond to an EVD case effectively.	No. Depending on the patient’s responses, this could take much longer than 30 minutes (perhaps hours). Collecting a list of occupational contacts treating the EVD patient in a hospital setting may take several hours in itself.	<p>The question “Did symptoms become more severe” should include a frame of reference – become more severe since when? Onset?</p> <p>In Section V., “Symptom onset information,” the same question is asked twice.</p> <p>In Section VI., the footnote following the table makes reference to the table it follows, but says the table should be located on page 9-10.</p>	Have the hospital create a comprehensive list of staff caring for the EVD patient when the case is first identified.	Costs of completing this form will depend almost solely on staff time needed. The cost estimate for completing this form is likely too low due to an underestimate of the number of hours required to complete the form.
Att1b EVD Person Under Investigation	Yes	Yes	Spell out the meaning of the acronym “LRN” upon first use.	Automated or other electronic surveys could be useful.	Yes

n Form					
Att2 EVD Contact Tracing Form	Yes. Consistent with current VDH documents.	No. Estimated time to complete form would be 20-30 minutes.	No suggestions.	A fillable form or web-entry with encrypted electronic transmission of the data to CDC would be a manner in which data could be sent efficiently to CDC using IT solutions.	Costs of completing this form will depend almost solely on staff time needed. The cost estimate for completing this form is likely too low due to an underestimate of the number of hours required to complete the form.
Att3a Guidance for HD DA-AM of Returned Travelers	Yes. Consistent with current VDH documents.	N/A; no estimate given	Should have a section on the monitoring log for notes to be recorded if needed.	N/A; guidance document only – no respondent burden required.	N/A; no estimate given
Att3b Guidance for Eval Triage of Ebola Contacts	Yes. Recommendations for management look reasonable and consistent with current VDH plan.	N/A; no estimate given	No suggestions.	N/A; guidance document only – no respondent burden required.	N/A; no estimate given
Att3c Guidance for Eval Triage of Ebola Contacts	Same document as attachment 3b	Same document as attachment 3b	Same document as attachment 3b	Same document as attachment 3b	Same document as attachment 3b
Att4a	Yes, but document	N/A; no estimate	Document should be tailored	N/A; guidance	N/A; no estimate

Guidance for Contacts of Ebola Patients	should be tailored to each risk category instead of utilizing one form for all categories	given	to each risk category, as different public health actions and recommendations will be made depending on the risk category identified.	document only – no respondent burden required.	given
Att4b Info for HCWs Treating Ebola Patients	Yes, but may need to include health department guidance established by the jurisdiction investigating the case.	N/A; no estimate given	Active monitoring definition includes video as an appropriate means of conducting monitoring; however, not all health departments will have policies in place to use this method. Suggest clarifying by adding language like “according to established policies.”	N/A; guidance document only – no respondent burden required.	N/A; no estimate given
Att5a EVD Tracking Form for HCWs	Yes	Yes -- for each time (day/shift) that HCW completes form	May need to provide clarity on who would be completing this form (e.g., public health, the healthcare facility, or the employee).  Move the “notes” section to the bottom row so that notes can be associated with each day separately.  Provide extra row to fill in other patient care duties not previously mentioned.	To minimize time needed to complete the form, employee should fill in information at the end of each shift and Occupational Health should review all forms each day.  Automated or other electronic surveys could be useful.	Yes
Att5b Ebola Tracking form for Lab	Yes, will help determine what specific breach in PPE protocol	Probably -- for each time (day/shift) that Lab Personnel completes form	No suggestions	Automated or other electronic surveys could be useful.	Probably

Personnel	occurred, if any.				
Att5c Ebola Tracking Form for Environ Services Personnel	Yes	Probably	The sheet titled “landscape” seems repetitive with Form 5a.	Automated or other electronic surveys could be useful.	Probably
Att6 Symptom Monitoring Form	Yes	Probably	Could add a box for “other symptoms” and a checkbox for “no symptoms.” Should re-format to prevent “spillover” onto next page.	Automated or other electronic surveys could be useful.	Probably
Att7 Generic End-of Monitoring Letter	Yes. Consistent with current VDH End of Monitoring Letter.	N/A; no estimate given	No suggestions	N/A; letter only – no respondent burden required.	N/A; no estimate given
Att8 White House Evening Report	Not entirely	No, significantly underestimated. It would also be challenging to roll up this data in real time, as implied by the form. Would need a built in delay in order to gather required data from the local health districts.	For #4, should clarify which contacts (i.e., cumulative or only for a particular case, etc). For #6, add the phrase “how many are” before PUI. For #5, could give numbers of contacts under monitoring by week rather than by day.	Automated or other electronic surveys could be useful.	The cost estimate for completing this form is likely too low due to an underestimate of the number of hours required to complete the form.



CERT responses:

- Solicitation for ASTHO comments was delayed until Friday, December 19<sup>th</sup>. Documents had already been revised in consideration for CSTE comments.
- Upon receipt, CERT expressed gratitude for the comments and clarified the objective of the tool kit was supportive and to be used as a resource if needed by health departments.
- The purpose of these forms is for a U.S. Ebola case and their US contacts. There is indeed, overlap with forms in EpiX because earlier versions of the forms were sent out as resources and for feedback.
- We appreciate the advice regarding the traveler's language and knowledge skills. We added the topic in CERT training materials to improve awareness among CDC staff and partners.
- We understand there are a different set of monitoring protocols and forms States already have in place for travelers vs contacts of US cases. To clarify the purpose of these forms, we added the purpose to the header of each.
- The intent of these forms is to serve as a resource and are not intended to replace forms that health departments already have. ASTHO is correct in that the forms are templates and optional. In addition, CSTE was consulted and their feedback already taken into account.
- We acknowledge duplication of information across forms and consider that some duplication is needed since efforts to identify contacts and exposures are largely similar. Consolidation of forms would require extensive revision, and because of the advanced stage of review would be difficult to implement. However, clarification of instructions and errors identified will be corrected.
- CERT is not planning to use existing reporting infrastructure such as NNDSS/NETSS because of the delay in reporting and the preference for ebola virus disease to have better timeliness.

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