

**Ebola Virus Disease in the United States:
CDC Support for Case and Contact Investigation**

**Request for OMB Approval for an
Emergency Information Collection Request**

January 23, 2015

**Supporting Statement A
Justification**

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**Ebola Virus Disease in the United States:
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A. Justification

This is an emergency request for 180-day OMB approval to allow the Centers for Disease Control and Prevention (CDC) to provide uninterrupted emergency support for domestic Ebola virus disease (EVD) case investigation and contact tracing activities on behalf of state, territorial, and local public health authorities in the United States (U.S.). As of December, 2014, continued federal assistance in West Africa indicates that domestic screening and monitoring of travelers from Ebola-affected countries and their contacts here in the U.S. remains a public health priority.

1. Circumstances making the Collection of Information Necessary

Beginning in March 10, 2014, West Africa experienced the largest known Ebola virus disease (EVD) epidemic with approximately 13,000 persons infected by the end of October (1,2). This international outbreak quickly became a domestic one when a 45-year-old male with a recent history of air travel from Liberia presented to a Dallas County, Texas, emergency department. He became the first imported case of EVD diagnosed in the U.S. on September 30, 2014 (3). Subsequently, two nurses who provided hospital bedside care to this patient in Texas were later diagnosed with EVD. One of the nurses traveled by commercial airline between Dallas, Texas, and Cleveland, Ohio, prior to diagnosis upon her return to Texas (4). Both the Texas Department of State Health Services and the Ohio Department of Health requested the CDC to assist with their respective investigations. The CDC collected case investigation and contact tracing information and reviewed plans for triaging and diagnostic testing and infection control (3,4).¹

This sentinel incident demonstrated how the federal government and state, tribal, and local (STL) public health authorities coordinate and exercise their isolation and quarantine² powers to protect the public (5,6). The federal government acts to prevent the entry of communicable diseases into the U.S. where its control methods may be used at U.S. ports of entry. In order to facilitate these functions, the CDC has previously obtained OMB approval for Quarantine Officers to work with the U.S. Customs and Border Patrol (CBP) to screen, detect, and refer potential persons at risk for communicable diseases to STL public health authorities.³ As of October 11, 2014, the objective of this screening

¹ Information collected under a 90-day Office of Management and Budget (OMB) approval titled “Emergency Epidemic Investigation Data Collections - Expedited Reviews” (OMB Control No. 0920-1011; expiration date: December 30, 2014).

² Isolation is used to separate sick people with a contagious disease from people who are not sick. Quarantine is used to separate and restrict the movement of people who were exposed to a contagious disease to see if they become sick.

³ These two OMB approval mechanisms are updated to include specific data collection forms and materials recently developed to detect and control the introduction and spread of EVD in the U.S. “Quarantine Station Illness Response

was modified to identify travelers who may be sick with EVD or may have had an exposure to Ebola when they arrive in the U.S., and to ensure that these travelers are directed to appropriate care and monitoring, if needed, to protect the health of all Americans.

The CDC released its “Interim Guidance for Monitoring and Movement of Persons with Potential Ebola Virus,” which provides STL public health authorities and other partners with a framework for determining appropriate public health actions based on risk factors and clinical presentation (7). Included are criteria for domestic monitoring of people who may have had an exposure to Ebola and for evaluating their intended travel, including the application of movement restrictions when indicated. As of November 16, 2014, this interim guidance recommends public health actions based on high, some, low (but not zero), and no identifiable risk exposure categories; and adds recommendations for specific groups and settings.⁴

This information collection request (ICR) will allow the CDC to conduct specified data collection activities that support STL public health authorities when they exercise their own police power functions to protect the health, safety, and welfare of persons within their borders. These powers include laws to enforce the use of isolation and quarantine. These laws can vary from state to state and can be specific or broad. In some states, local health authorities implement state law. Tribes also have police power authority to take actions that promote the health, safety, and welfare of their tribal members. Tribal health authorities may enforce their own isolation and quarantine laws within tribal lands, if such laws exist. It is possible for federal, state, tribal, and local public health authorities to have and use separate but coexisting legal quarantine power in certain events all at the same time (5).

Thus, the CDC is seeking an emergency 180-day OMB approval to support and to conduct field data collection activities related to EVD case investigations and contact tracing on behalf of and within the jurisdictions of requesting STL public health authorities. In addition, CDC would like to collect daily updated active case and contact monitoring information from all STL jurisdictions whether CDC is conducting the investigations or not. As CDC assistance to the STL authorities, these information collections are authorized by Section 301 of the Public Health Service Act (42 U.S.C. 241) (**Appendix 1**).

Forms: Airline, Maritime, and Land/Border Crossing” (OMB Control No. 0920-0821; expiration date: August 31, 2015); “Contact Investigation Outcome Reporting Forms” (OMB Control No. 0920-0900; expiration date: October 31, 2017).

⁴ Periodically updated, it is available at <http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html>.

2. Purpose and Use of Information Collection

The CDC has used its experience in Texas and Ohio to develop a toolkit of standardized forms and guides for STL public health authorities to consider using whenever and wherever active monitoring for EVD must occur. CDC developed toolkit as a resource and not as a requirement for the STL public health authorities to use. The CDC's goal for the use of these forms is to encourage uniformity, and thus efficiency in federal EVD information collections in support of STL public health authorities. CDC is seeking OMB approval to use these forms whenever the agency is requested by STL public health authorities or by another federal agency to assist in the control and prevention of future EVD outbreaks. Keeping this ready inventory of pre-approved forms for emergency domestic investigations will reduce administrative time currently spent seeking a separate OMB approval for each investigation conducted by the CDC. This, in turn, will greatly enhance the CDC's ability to begin collecting data rapidly when STL authorities request assistance during public health emergencies to control and reduce EVD illness and death.

Because the global 2014 case fatality rate averages about 50% (8), the urgency for CDC to quickly respond to STL requests for assistance and to efficiently receive uniform monitoring information are of the utmost importance to control transmission from foreign countries to the U.S. The information collected on the forms will enable the STL public health authorities to rapidly implement appropriate control measures to prevent the introduction and spread of EVD into and within their borders. Data collected on these forms will be used by STL public health authorities to make decisions about risks for illness among people with potential exposure to the Ebola virus as well as its communicability.

A uniform information collection is also necessary to improve information quality for public health surveillance across STL jurisdictions and for tracking and follow-up purposes among people under monitoring until diagnosis or until 21 days of monitoring has past.

3. Use of Improved Information Technology and Burden Reduction

In the field, the data needed to complete the forms may be collected by CDC staff (in-person, fax, email or phone) from persons under investigation and confirmed EVD cases on behalf of the STL public health authorities. Because the signs and symptoms of EVD may appear from 2 to 21 days after exposure to the Ebola virus, there is often only a short window of opportunity to collect data on illnesses and deaths as well as information on those persons who may have been exposed to the ill or deceased person. From the CDC Emergency Operations Center (EOC), the CDC also requests the STL public health authorities to submit their daily summary statistics for situational awareness reports for entities such as the Department of Health and Human Services (HHS) and White House reports via fax, email, or phone. In this role, STL public health authorities are also respondents who also incur reporting burden to the federal government.

Therefore, in the event of a U.S. Ebola case, the CDC plans to collect data related to the case and case contacts. Data collected will be entered into Epi-Info, or a database designed by the STL, to be able to track and identify ill patients. Data will be aggregated and a summary shared with CDC. Epi-Info is a suite of software tools for public health professionals which includes a screen form design module, data entry module, analysis module, reporting module, and a mapping module as well as several utilities. The modules can be used independently for ad hoc data gathering and analytical needs, or they can be used as a rapid development environment for quickly programming public health focused outbreak and surveillance data applications. When information technology is not available, hardcopy forms will be completed and transmitted through fax, email, or other means when data bases are not available and will be treated in a secure manner and will not be disclosed, unless otherwise compelled by law.

We estimate that the percentage of estimated annualized burden hours that will be conducted using improved information technology such as Epi-Info by the CDC is approximately 20 percent.

4. Efforts to Identify Duplication and Use of Similar Information

STL public health authorities are notified by the CBP of people with potential Ebola exposure arriving in their borders. Each investigation will be unique because each scenario of potential cases, their contacts, their personal lifestyles and habits, and their movements will be unique. As a result, CDC and any federal, state, or local partner will be part of a coordinated effort to collect unique case investigation and contact tracing information related to each introduction and transmission of EVD into a STL jurisdiction.

5. Impact on Small Businesses or Other Small Entities

Some of the respondents may be small businesses or other small entities. However, the number of variables collected is kept to the fewest number necessary to minimize burden on small businesses. We estimate that 5 percent of the respondents will be associated with small businesses.

6. Consequences of Collecting the Information Less Frequently

On an individual basis, it is anticipated that each general public respondent (case, PUI, contact) will be requested to provide information at most 57 times (15 times during care for Ebola case plus at least daily over a 21-day monitoring period after last exposure). Likewise, healthcare workers, laboratory personnel, and environmental services personnel will be requested to provide information at most 57 times (15 times during care for Ebola case plus at least daily over a 21-day monitoring period after last exposure).

Over a 180-day period, it is also anticipated that each STL public health authority will be requested to provide information at most 336 times by assuming daily reporting for 42 days for up to 8 Ebola cases (21 hospitalization days and 21 days post discharge active monitoring). These estimates are based on CDC's current experience in the EOC.

If data are not collected at the above recommended frequency, there is a risk of introduction and spread of EVD to the U.S. public. There are no legal obstacles to reducing the burden.

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

This request fully complies with the regulation 5 CFR 1320.5.

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

A. OMB has waived the requirement to publish a 60-day and a 30-day Federal Register Notice seeking public comment.

B. The CDC is the nation's leading federal public health agency making recommendations for developing and applying disease prevention and control, health promotion, and health education activities to improve the health of the U.S. public. It also provides consultation and assistance to other nations and international agencies to assist in improving their disease prevention and control. In addition, CDC is responsible for controlling the introduction and spread of communicable diseases by providing program expertise and assistance in responding to federal, state, territorial, local, and private entities.

On November 6-11, 2014, the CDC requested review and comments on the draft "CDC Domestic EVD Toolkit" from the Council of State and Territorial Epidemiologists (CSTE). Four CSTE members responded to this request, representing health departments in Massachusetts, Oklahoma, New Jersey, and New York City (Appendix 2a). CDC took these comments in advisement in revising the EVD Toolkit.

On December 19, 2014, the revised draft "CDC Domestic EVD Toolkit" was then submitted to the Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO) for review and comment. Both organizations sought review and comment from their membership and submitted responses presented in Appendix 2b (ASTHO) and Appendix 2c (NACCHO).

The forms and guidance documents in the toolkit were improved based on their suggestions. Specifically, the numbering in the heading of the forms was corrected and the label of the form was added to distinguish forms that are used for traveler assessments from those in this toolkit, that is, for a US case and contacts. In addition, there was a word that was redundant ("in") on one of the guidance forms.

9. Explanation of Any Payment or Gift to Respondents

There is no payment or gift to respondents.

10. Assurance of Confidentiality Provided to Respondents

This ICR has been reviewed by the OMB PRA Advisor for the CDC emergency response who determined that the Privacy Act does apply.

In addition, the Human Subjects Regulatory Advisor for the CDC emergency response has reviewed the proposed information collection, which is determined to be public health response and not research. CDC Institutional Review Board (IRB) review and approval is not required.

10.1. Privacy Impact Assessment

10.1.1. Overview of the data collection system

CDC has developed forms to collect case and contact information on types of respondents that may require monitoring for EVD [confirmed EVD cases, persons under investigation (PUI), contacts of an EVD case, healthcare workers (HCWs) with direct EVD patient contact, laboratory personnel, and environmental services personnel] (**Attachment 1-2, 5a-6**). In addition, the CDC requests that STL public health authorities provide daily reports of active surveillance updates (**Attachment 8**).

Each of these forms is listed in Table A.12.A. The CDC anticipates that one-half of the data collections will be conducted by the STL public health authorities. Their reports are reported in aggregate back to the CDC for daily reporting and situational awareness (Attachment 8). CDC anticipates it will collect one-half of the data collections at the request of the STL public health authorities (Attachments 1-7). Its field officers can provide the daily situational awareness reporting back to CDC (Attachment 8); the STL public health authorities will incur no reporting burden in this situation.

When a health department already has, and is comfortable with, its own forms, it can use these forms. In these cases, if CDC is requested to use STL-customized forms at the request of STL public health authorities, the forms will be submitted to OMB for PRA clearance as a change request. Burden tables will be adjusted to subtract hours from the standard EVD Toolkit requested herein and accounted for by the use of the STL-customized forms.

The estimates presented in Table A.12.A are the numbers of respondents reflecting one-fourth of the annual national estimates described below, limited to the 6-month approval and the assumption that CDC will conduct one-half of the data collections on behalf of the STL public health departments.

Methods for annual national Ebola case and contact tracing estimates used for the 180-day estimates

Respondents from the general public

We used our current experience to base our estimated number of respondents from the general public and their required number of responses per form. For example, current CDC Ebola prediction models estimate 25 U.S. cases per year. In Dallas, TX, there were 15 contacts that developed symptoms requiring evaluation for Ebola (patient under evaluation form) and we used this number to estimate the number of contacts that will need to fill out this form. For community contacts, in Dallas there were 17 community contacts for one case, and in New York City, 2 community contacts for one case. With enhanced screening at entry into the U.S. and enhanced contact tracing, we now estimate fewer contact investigations will be necessary, approximately 5 contacts per case.

It is impossible to know how many future cases will be investigated and treated in the U.S. In order to assure that we request sufficient burden hours from OMB for future activities, we increased our estimate to 30 cases in the U.S. per year with 20 PUIs per case (30 times 20 = 600 PUIs). We also slightly overestimate the number of contacts per case to 7 to assure we request sufficient burden hours (30 times 7 = 210 contacts). Each of these contacts will be required to monitor their temperature twice-a-day and report at least once a day for 21 days (42 responses). In a 180-day period, the total burden hours for EVD case investigations and contact tracings for the general public would be approximately 224 hours, rounding to whole numbers.

- Group 1 attachments are forms for EVD cases and PUI.
- Attachment 2 is a form for tracing contacts of EVD cases.
- Attachment 4a is guidance for contacts of EVD patients in the U.S.
- Attachment 6 is a template to facilitate twice daily measurements during the 21-day follow-up, which may be used for general population respondents.

Worker respondents

Based on reports from Ebola cases cared for in the U.S., we estimate that each case will be hospitalized for three weeks and cared for by as many as 120 hospital staff (30 times 120 = 3,600). As a simplifying assumption, we evenly divide the staff into 40 healthcare workers with direct patient contact, 40 laboratory personnel, and 40 environmental services personnel (1,200 in each worker group for 30 cases). We also assume that each hospital staff will have 5 exposures to a case per week for three weeks (5 times 3 = 15 exposures). For a 180-day period, we are requesting approval for a total of 5,400 burden hours for worker respondents.

The estimated burden hours for EVD case investigations and contact tracings for healthcare workers would be approximately 1,800 hours.

The estimated burden hours for EVD case investigations and contact tracings for laboratory personnel would be approximately 1,800 hours.

The estimated burden hours for EVD case investigations and contact tracings for environmental services personnel would be approximately 1,800 hours.

- Attachment 4b is guidance for healthcare workers who may be returning from countries with widespread Ebola transmission or who may be treating Ebola patients in the U.S. See Section A.8.B for discussion of CDC's efforts to seek public comment outside the federal government.
- Group 5 attachments are data collection templates for prospective monitoring of the three healthcare respondent groups caring for Ebola patients.
- Attachment 6 is a template to facilitate the 21-day follow-up which may be used for the three healthcare respondent groups.

STL respondents

The CDC provides updates for daily situational awareness reports to requesting federal departments such as HHS and the White House. Often, CDC field personnel can gather this information and report it back to the CDC EOC without imposing any reporting burden on the STL public health authority. In order to request sufficient burden hours, here, we presume that one-half of the daily reporting back to CDC is performed by the STL authorities.

CDC receives one report per day for each case while in hospital for 3 weeks and for 21 days after discharge (42 days of update reports). The report length varies (15 minutes while hospitalized and 5 minutes after discharge). Therefore, the median reporting burden is 10 minutes per daily report.

In a given 180-day period, the estimated burden hours for reporting daily updates on EVD case investigations and contact tracings for STL public health authorities and their delegates⁵ would be approximately 56 hours.

- Group 3 attachments are guidance for health departments. See Section A.8.B for discussion of CDC's efforts to seek public comment outside the agency.
- Attachment 8 shows the data elements STL public health authorities report to CDC for its daily White House Evening Report.

10.1.2. Items of information to be collected

This data collection includes the following information in identifiable form:

Name
Date of Birth
Mailing Address
Phone Numbers

⁵ For healthcare workers under direct active monitoring, public health authorities can delegate the responsibility for direct active monitoring to the healthcare facility's occupational health program or the hospital epidemiologist.

Medical Information and Notes
Medical Records Numbers
Biological Specimens
Email Address
Employment Status
Foreign Activities – citizenship, and address in foreign country of residence
Other – list of personal identities of community and worker contacts at time of onset of EVD case symptoms

10.1.3. How information will be shared and for what purpose

In addition to providing assistance for the STL public health authorities, CDC seeks to obtain this information either for or from the STL authorities to be included in daily situational awareness reports to the U.S. Department of Health and Human Services (HHS) and the White House (Attachment 8). The data will not be shared except in de-identified or aggregate formats.

10.1.4. Impact on the respondent's privacy

Data are treated in a private manner, unless otherwise compelled by law. Highly sensitive information is being collected and would affect a respondent's privacy if there were a breach of confidentiality. CDC will make every effort to secure the information as described in Section A.10.1.7.

10.1.5. Whether individuals are informed that providing the information is voluntary or mandatory

Respondents are informed about the voluntary nature of their response. However, STL public health authorities may have local requirements that are different. If an illness of public health concern is suspected based on the information collected using these forms, the individual in question may be required to undergo further assessment and questioning.

10.1.6. Opportunities to consent, if any, to sharing and submission of information

Respondents do not have to participate in any surveys to collect data. Participation is voluntary.

10.1.7. How the information will be secured

Stringent safeguards are in place to ensure a respondent's privacy including restriction of access to authorized users, physical safeguards, and procedural safeguards. Authorized users: A database security package is implemented on CDC's computer systems to control unauthorized access to the system. Attempts to gain access by unauthorized individuals are automatically recorded and reviewed on a regular basis. Access is granted to only a limited number of physicians, scientists, statisticians, and designated support staff of CDC or its contractors as authorized by the system manager to accomplish the stated purposes for which the data in this system have been collected. Physical safeguards: Access to the CDC facility where the mainframe computer is located is controlled by a cardkey system. Access to the computer room is controlled by a

cardkey and security code (numeric code) system. Access to the data entry area is also controlled by a cardkey system. Guard service in buildings provides personnel screening of visitors. The computer room is protected by an automatic sprinkler system, numerous automatic sensors are installed, and a proper mix of portable fire extinguishers is located throughout the computer room. Computer files are backed up on a routine basis. Hard copy records are stored in locked cabinets at CDC headquarters. Procedural safeguards: Protections for computerized records includes programmed verification of valid user identification code and password prior to logging on to the system, mandatory password changes, limited log-ins, virus protection, and user rights/file attribute restrictions. Password protection imposes user name and password log-in requirements to prevent unauthorized access. Each user name is assigned limited access rights to files and directories at varying levels to control file sharing. There are routine daily back-up procedures, and secure off-site storage is available. To avoid inadvertent data disclosure, measures are taken to ensure that all data are removed from electronic media containing Privacy Act information. Finally, CDC and contractor employees who maintain and use records are instructed to check with the system manager prior to making disclosures of data. When individually identified data are being used in a room, admittance at either CDC or contractor sites is restricted to specifically authorized personnel. Privacy Act provisions are included in contracts, the CDC Project Director, contract officers and project officers oversee compliance with these requirements, and CDC employees and contractors are required to be trained on the Privacy Act and receive information security awareness training at least annually.

10.1.8. Whether a system of records is being created under the Privacy Act. Records are covered under CDC Privacy Act System Notice 09-20-0113, “Epidemic Investigation Case Records Systems Notice” (**Appendix 3**). These data are being collected to fulfill regulatory requirements under the Public Health Service Act, Section 301, “Research and Investigations, (42 U.S.C. 241); Sections 304, 306, and 308(d), which discusses authority to maintain this data (**Appendix 1**). The data will not be shared except in de-identified or aggregate formats. The personal information will be maintained according to CDC Records Control Schedule B-321 (<http://intranet.cdc.gov/maso/RM/pdfs/rmcontrol.pdf>).

11. Justification for Sensitive Questions

These forms collect three types of data (**Attachment 1-2, 5a-6, 8**): 1) Epidemiologic data such as additional travel plans after arrival to the U.S., clinical signs and symptoms, exposure to ill people or animals, history of illness are essential to accurately determining the public health risk; 2) Demographic data such as age, race, sex, and geographic location are routinely collected as part of standard public health surveillance; and 3) identifying and contact information such as name, telephone number, address for follow-up or contact tracing. All of these data elements are essential to efficiently detect a public health threat and rapidly implement appropriate public health control measures to prevent the introduction and spread of communicable disease into and within the U.S.

12. Estimates of Burden Hours and Costs

As a “worst-case” scenario, the CDC is presuming that the agency will conduct one-half of the nation’s data collections related to EVD case and contact investigations on behalf of the STL public health authorities as described in Section A.10.1.A (Overview of the Data Collection System). The STL authorities will conduct the other one-half of the EVD case and contact investigations in their own jurisdictions. Therefore, in 180-days, CDC is requesting OMB approval for one-fourth of the annual national estimates outlined in Section A.10.1.1.

For CDC, this includes contacting 2,072 respondents who will incur 5,680 burden hours at a cost and wage burden of \$163,214 in a 180-day period.

A. Estimated Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
General public	Ebola Virus Disease Case Investigation Form – United States	8	1	30/60	4
	Ebola Virus Disease Person Under Investigation (PUI) Form	150	1	10/60	25
	Ebola Virus Disease Contact Tracing Form – United States	53	1	10/60	9
	Symptom Monitoring Form	53	42	5/60	186
Healthcare Workers	EVD Tracking Form for Healthcare Workers with Direct Patient Contact	300	15	10/60	750
	Symptom Monitoring Form	300	42	5/60	1,050
Laboratory Personnel	Ebola Tracking Form for Laboratory Personnel	300	15	10/60	750
	Symptom	300	42	5/60	1,050

	Monitoring Form				
Environmental Services Personnel	Ebola Tracking Form for Environmental Services Personnel	300	15	10/60	750
	Symptom Monitoring Form	300	42	5/60	1,050
State, Territorial, and Local Public Health Authorities and Their Delegates	White House Evening Report	8	42	10/60	56
Total					5,680

B. Estimated Burden Costs

Type of Respondent	Form Name	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
General public	Ebola Virus Disease Case Investigation Form – United States	4	\$22.33	\$89
	Ebola Virus Disease Person Under Investigation (PUI) Form	25	\$22.33	\$558
	Ebola Virus Disease Contact Tracing Form – United States	9	\$22.33	\$201
	Symptom Monitoring Form	186	\$22.33	\$4,153
Healthcare Workers	EVD Tracking Form for Healthcare Workers with Direct Patient Contact	750	\$35.93	\$26,948
	Symptom Monitoring Form	1,050	\$35.93	\$37,727
Laboratory Personnel	Ebola Tracking Form for Laboratory Personnel	750	\$28.59	\$21,443
	Symptom Monitoring Form	1,050	\$28.59	\$30,020
Environmental Services Personnel	Ebola Tracking Form for Environmental Services Personnel	750	\$21.86	\$16,395
	Symptom Monitoring Form	1,050	\$21.86	\$22,953
State, Territorial,	White House Evening	56	\$48.72	\$2,728

and Local Public Health Authorities and Their Delegates	Report			
Total				\$163,215

May 2013 National Occupational Employment and Wage Estimates: United States available December 1, 2014 at http://www.bls.gov/oes/current/oes_nat.htm#00-0000. Job Series 00-0000; 29-0000; 29-2011; 19-4091; 11-9111.

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

There are no capital and maintenance costs incurred by respondents.

14. Cost to the Government

The cost to the federal government is estimated at \$165,686. This estimate represents the amount of time for the CDC staff to complete the information collections on behalf of the STL public health authorities in the field, in addition to the time spent managing the response in the EOC. We presume that the CDC will conduct data collections among 2,072 respondents and 5,680 burden hours over a given 180-day emergency approval period.

Breakdown of costs:

<u>Respondents:</u>	
Respondents Interviewed per year	2,072
Staff Time	5,680 hours
CDC GS-12 FTE Hourly rate	\$29.17
<u>Total annual salary costs:</u>	\$165,686

15. Explanation for Program Changes or Adjustments

This is an emergency information collection request.

16. Plans for Tabulation and Publication and Project Time Schedule

Over the course of a year, these will be recurring data collections, the time schedules for which are determined by the frequency that travelers in applicable Ebola risk categories or death reports from conveyances or at land border crossings are received by Quarantine Stations at ports of entry. In addition, these arriving travelers may become cases that later come in contact with others locally, who in turn will also require contact investigation. While the CDC EOC is activated, it is anticipated that daily reports will be generated for situational awareness. In addition, NCEZID plans to use the de-identified, aggregated data, to provide partners and other stakeholders information about CDC's EVD response activities and to evaluate and improve CDC's EVD screening and

monitoring activities at ports of entry and in its notification process to the STL public health authorities.

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

The display of the OMB expiration date is appropriate.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

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List of Appendices

Appendix 1. Authorizing Legislation

Appendix 2. Consultations

2a. Council of State and Territorial Epidemiologists (CSTE)

2b. Association of State and Territorial Health Officials (ASTHO)

2c. **National Association of County and City Health Officials (NACCHO)**

Appendix 3. CDC Privacy Act System of Records Notice 09-20-0113

List of Attachments for CDC Domestic Ebola Virus Disease Toolkit

Forms for Cases and Persons Under Investigation

Attachment 1. Ebola Virus Disease Case Investigation Form – United States

Attachment 1b. Ebola Virus Disease Person Under Investigation (PUI) Form

Forms for Contacts

Attachment 2. Ebola Virus Disease (Ebola) Contact Tracing Form – United States

Guidance for Health Departments

Attachment 3a. Guidance for Health Departments for Travelers (Not Health Care Workers*) Arriving in the U.S. from Countries with Widespread Ebola Transmission

Attachment 3b. Guidance for the Evaluation and Triage of Contacts of Confirmed Ebola Virus Disease (Ebola) Cases for Routine or Urgent Medical Concerns, including Symptoms Compatible with Ebola

Attachment 3c. Guidance for Health Departments for Identifying and Monitoring Community Contacts of Persons Under Investigation (PUI) for Ebola Virus Disease (Ebola) or Ebola Cases

Guidance for Individuals

Attachment 4a. Guidance for Contacts of Ebola Virus Disease (Ebola) Patients, United States

Attachment 4b. Information for Healthcare Workers Returning from Countries with Widespread Ebola Transmission or Treating Patients with Ebola in the United States

Templates to facilitate data collection during prospective monitoring of health care personnel caring for Ebola patients

Attachment 5a. EVD Tracking Form for Healthcare Workers with Direct Patient Contact (e.g. nurses, physicians, respiratory therapists, others)

Attachment 5b. Ebola Tracking Form for Laboratory Personnel

Attachment 5c. Ebola Tracking Form for Environmental Services Personnel

Template to facilitate twice daily 21-day follow-up

Attachment 6. Symptom Monitoring Form

Generic end-of-monitoring letter

Attachment 7. Generic End-of-Monitoring Letter

Data requests by federal government

Attachment 8: White House Evening Report