

**Non-substantive Change Request to OMB Control # 0920-1011  
Emergency Epidemic Investigation Data Collections**

**Date Submitted: August 24, 2020**

This is a non-substantive change request for the Emergency Epidemic Investigations (EEI) Generic ICR, (OMB Control No. 0920-1011, Expiration 01/31/2023). This allows the Centers for Disease Control and Prevention (CDC) to continue to conduct EEIs in response to acute public health emergencies resulting from outbreaks or events with undetermined agents, undetermined sources, undetermined modes of transmission, or undetermined risk factors. CDC frequently is called upon to conduct EEIs at the request of one or more external partners (e.g., local, state, tribal, military, port, other federal agency, or international health authorities, or other partner organizations) seeking support to respond to urgent public health problems. In response to external partner requests, CDC readily provides necessary epidemiologic support to facilitate appropriate engagement in epidemiological investigations. Such investigations often are dependent on rapid and flexible data collection that evolves during the investigation period.

This non-substantive change request is submitted to request additional burden hours which are necessary to ensure CDC's ability to respond to the COVID-19 pandemic. The burden for the currently approved EEI Generic ICR is calculated based on CDC's routine response activities. The estimated annual burden of 6000 hours is based on the average reported burden for EEIs conducted during the two years prior to submission of the EEI Generic ICR Request for Extension, which was approved by OMB on 1/21/2020.

Because of the magnitude and scope of the COVID-19 pandemic, the burden for CDC's COVID-19-related data collections conducted under the EEI generic ICR is expected to greatly exceed the estimated burden hours which are based on routine CDC response activities. The first case of COVID-19 was first detected in the United States in late January 2020. As of August 20, 2020, the current U.S. case count is greater than 5.5 million and rising. While most case investigation and contact tracing is conducted by state and local jurisdictions, when response needs exceed states' capacity or federal coordination of data collection is needed, CDC is available to support, augment, or coordinate state and local responses. If CDC conducts federally sponsored data collections for 1% of COVID-19 cases and their contacts annually, based on current estimates this could represent 55,000 cases and approximately 880,000 close contacts, assuming 16 close contacts per case<sup>1</sup>. The estimated burden per data collection is .5 hours. Therefore, the new estimated annual burden for COVID-19 data collections is 467,500 hours. Adding the already approved 6,000 burden hours for routine EEI data collections with 12,000 respondents annually results in a total annual burden of 473,500 hours.

The approved and requested burden is summarized in Table 1.

Table 1. Approved and Requested Estimated Annualized Burden Hours

|                             | <b>Type of Respondents</b>                    | <b>Form Name</b>   | <b>No. of Respondents</b> | <b>Avg. Burden per Response (in hrs.)</b> | <b>Total Burden (in hrs.)</b> |
|-----------------------------|---|--|---------------------------|---|-------------------------------|
| Approved Burden             | Emergency Epidemic Investigation Participants | Emergency Epidemic Investigation Data Collection Instruments | 12,000                    | 0.5                                       | 6,000                         |
| Additional Requested Burden | Emergency Epidemic Investigation Participants | Emergency Epidemic Investigation Data Collection Instruments | 935,000                   | 0.5                                       | 467,500                       |
| <b>Total Burden</b>         |   |  | <b>947,000</b>            | <b>0.5</b>                                | <b>473,500</b>                |

\*It is difficult to estimate the number of close contacts per case. One large surveillance study found the number of close contacts ranged from 1 to 201.<sup>1</sup> As a reasonable estimate, we cite here an investigation of a case that found 16 close contacts per case.<sup>2</sup>

<sup>1</sup>Burke RM, Midgley CM, Dratch A, et al. Active Monitoring of Persons Exposed to Patients with Confirmed COVID-19 — United States, January–February 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:245–246. DOI: <http://dx.doi.org/10.15585/mmwr.mm6909>

<sup>2</sup>Scott SE, Zabel K, Collins J, et al. First Mildly Ill, Nonhospitalized Case of Coronavirus Disease 2019 (COVID-19) Without Viral Transmission in the United States-Maricopa County, Arizona, 2020. *Clin Infect Dis*. 2020;71(15):807-812. doi:10.1093/cid/ciaa374