

# **National Healthcare Safety Network (NHSN)**

**OMB Control No. 0920-0666**

Expiration 6/30/2025

Reinstatement ICR

## **Supporting Statement A**

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- **Goal of the study:** The proposed revisions included in this ICR are designed to (1) increase the overall attainment of CDC’s NHSN healthcare-associated infection (HAI) surveillance goals and event reporting coverage for all facility types that are active and reporting data to NHSN, and (2) to enhance NHSN surveillance and data quality practices exercised by NHSN users and facilities alike. Lastly, the proposed revisions will further improve the overall quality of existing data collection forms, which are intended to ensure complete data reporting into CDC’s NHSN by all participating facilities.
- **Intended use of the resulting data:** Resulting data are intended to estimate the magnitude of HAIs, monitor HAI trends, and facilitate inter-facility and intra-facility comparisons with risk-adjusted data that can be used for local quality improvement activities. Data reported to NHSN enables healthcare facilities to report HAI and prevention practice adherence data via NHSN to CMS in fulfillment of CMS’s quality programs. In addition, CDC provides state agencies, at their request, facility level data for surveillance, prevention, or mandated public reporting.
- **Methods to be used to collect:** The data for NHSN is collected via a secure internet application.
- **The subpopulation to be studied:** NHSN participation is open to all U.S. healthcare facilities.
- **How data will be analyzed:** Reporting institutions can access their own data at any time and analyze it through the internet interface. Reports containing aggregated data is published annually by the CDC and posted on the NHSN website at <https://www.cdc.gov/nhsn>. The report is published in various scientific journals, to increase the scope of data that is made available by NHSN. Other types of in-depth analysis from NHSN are published in peer-reviewed journals and presented at scientific and professional meetings and conferences annually.

**1. Circumstances Making the Collection of Information Necessary**

Overview

The Centers for Disease Control and Prevention (CDC) is requesting a 3-year approval for revisions made to OMB Control No. 0920-0666 for the National Healthcare Safety Network (NHSN). Three diseases (Influenza A (H5), Marburg, and Oropouche) were added to the “Pathogens of High Consequence” form through an Emergency Information Collection Request (ICR) in December 2024. This ICR originally expired 12/31/2027, but when the new data elements were added through the emergency submission, the new expiration date became 5/31/2025 and later 6/30/25. This reinstatement is to request three-year approval for the changes made to the “Pathogens of High Consequence” form in addition to the remaining 84 forms in this package. CDC requests OMB approval for an estimated 4,509,135 annual burden hours. This Reinstatement ICR provides complete discussion and justification of the information collection plans.

Background

The Division of Healthcare Quality Promotion (DHQP), National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Centers for Disease Control and Prevention (CDC) collects data from healthcare facilities in the National Healthcare Safety Network (NHSN) under OMB Control Number 0920-0666. During the early stages of its development, NHSN began as a voluntary surveillance system in 2005 managed by DHQP. NHSN provides facilities, health departments, states, regions, and the nation with data necessary to identify problem areas, measure the progress of prevention efforts, and ultimately eliminate healthcare-associated infections (HAIs) nationwide. NHSN also allows healthcare facilities to track blood safety errors and various HAI prevention practice methods such as healthcare personnel influenza vaccine status and corresponding infection control adherence rates.

Enrollment in NHSN has continuously increased, with over 37,000 actively reporting healthcare facilities across the U.S. Of the total enrolled healthcare facilities, there are over 6,000 acute care facilities; 8,400 dialysis facilities; 600 long-term acute care facilities; 400 inpatient rehabilitation facilities; 800 inpatient psychiatric facilities; nearly 20,000 long-term care facilities; and 6,000 ambulatory surgery facilities. NHSN currently has eight components: Patient Safety (PS), Healthcare Personnel Safety (HPS), Biovigilance (BV), Long-Term Care Facility (LTCF), Outpatient Procedure (OPC), Dialysis, Neonatal, and Medication Safety Component.

Data reported under the Patient Safety Component are used to determine the magnitude of the healthcare-associated adverse events and trends in the rates of the events, in the distribution of pathogens, and in the adherence to prevention practices. Data will help detect changes in the epidemiology of adverse events resulting from new medical therapies and changing patient risks. Additionally, reported data is being used to describe the epidemiology of antimicrobial use and resistance and to better understand the relationship of antimicrobial therapy to this rising problem.

Under the Healthcare Personnel Safety Component, protocols and data on events—both positive and adverse—are used to determine (1) the magnitude of adverse events in healthcare personnel, and (2) compliance with immunization and sharps injuries safety guidelines.

Under the Biovigilance Component, data on adverse reactions and incidents associated with blood transfusions are reported and analyzed to provide national estimates of adverse reactions and incidents.

Under the Long-Term Care Facility Component (LTCF), data is captured from skilled nursing facilities. Reporting methods under the LTCF component have been created by using forms from the PS Component as a model with modifications to specifically address the specific characteristics of LTCF residents and the unique data needs of these facilities reporting into NHSN.

The Outpatient Procedure Component (OPC) gathers data on the impact of infections and outcomes related to operative procedures performed in Ambulatory Surgery Centers (ASCs). The OPC is used to monitor two event types: Same Day Outcome Measures and Surgical Site Infections (SSIs).

The Dialysis Component offers a simplified user interface for dialysis users to streamline their data entry and analyses processes as well as provide options for expanding in the future to include dialysis surveillance in settings other than outpatient facilities.

The Neonatal Component includes one module, Late-Onset Sepsis/ Meningitis (LOS/MEN). This module will track late-onset sepsis and meningitis events in very low birthweight neonates housed in Level II/III, Level III, and Level IV nursery locations.

The Medication Safety Component tracks medication safety and adverse drug events (ADEs) that are among the most common causes of iatrogenic harm in U.S. hospitals.

NHSN has increasingly served as the operating system for HAI reporting compliance through legislation established by the states. As of March 2019, 36 states, the District of Columbia, and the City of Philadelphia, Pennsylvania have opted to use NHSN as their primary system for mandated reporting. Facilities can report their data directly to NHSN or they can report through their state or municipality. Reporting compliance is completed by healthcare facilities in their respective jurisdictions, with emphasis on those states and municipalities acquiring varying consequences for failure to report facilities data to NHSN. Additionally, healthcare facilities in five U.S. territories (Puerto Rico, American Samoa, the U.S. Virgin Islands, Guam, and the Northern Mariana Islands) are voluntarily reporting to NHSN. Additional territories are projected to follow with similar use of NHSN for reporting purposes.

NHSN's data is used to aid in the tracking of HAIs and guide infection prevention activities/practices that protect patients. The Centers for Medicare and Medicaid Services (CMS) and other payers use these data to determine incentives for performance at healthcare facilities across the US and surrounding territories, and members of the public may use some protected data to inform their selection among available providers. Each of these parties is dependent on the completeness and accuracy of the data. CDC and CMS work closely and are fully committed to ensuring complete and accurate reporting, which are critical for protecting patients and guiding national, state, and local prevention priorities.

CMS collects some HAI data and healthcare personnel influenza vaccination summary data, which is done on a voluntary basis as part of its Fee-for-Service Medicare quality reporting programs, while others may report data required by a federal mandate. Facilities that fail to report quality measure data are subject to partial payment reduction in the applicable Medicare Fee-for-Service payment system. CMS links their quality reporting to payment for Medicare-eligible acute care hospitals, inpatient rehabilitation facilities, long-term acute care facilities, oncology hospitals, inpatient psychiatric facilities, dialysis facilities, and ambulatory surgery centers. Facilities report HAI data and healthcare

personnel influenza vaccination summary data to CMS via NHSN as part of CMS's quality reporting programs to receive full payment. Still, many healthcare facilities, even in states without HAI reporting legislation, submit limited HAI data to NHSN voluntarily.

NHSN's data collection updates continue to support the incentive programs managed by CMS. For example, survey questions support requirements for CMS's quality reporting programs. Additionally, CDC has collaborated with CMS on a voluntary National Nursing Home Quality Collaborative, which focuses on recruiting nursing homes to report HAI data to NHSN and to retain their continued participation. This project has resulted in a significant increase in long-term care facilities reporting to NHSN.

The NHSN is currently comprised of 84 information collection forms that may be updated over time to improve HAI surveillance and inform public health action. The collection of information is authorized by the Public Health Service Act (42 USC 242b, 242k, and 242m (d)), (*Attachment A1-A3*).

## **2. Purpose and Use of Information Collection**

The data collected under OMB Control No. 0920-0666 are used for the following purposes:

- Estimation of the magnitude of healthcare-associated infections (HAIs)
- Monitoring of HAI trends to identify problem areas and measure the progress of prevention efforts.
- Facilitation of inter-facility and intra-facility comparisons with risk-adjusted data that can be used for local quality improvement activities.
- Assistance to facilities in developing surveillance and analysis methods that permit timely recognition of patient safety problems and prompt intervention with appropriate measures.
- Development of clinical quality measures that can be used as a benchmark for healthcare facilities reporting data to NHSN to measure their own performance. One of the goals is to eventually—as a result, measure experience, and measure enhancements or other changes as needed—as summary statistics that can be publicly reported for multiple healthcare facilities and serve as metrics for externally evaluating their care and incentivizing quality and patient safety.
- Comply with legal requirements – including but not limited to state or federal laws, regulations, or other requirements – for mandatory reporting of healthcare facility-specific adverse event, prevention practice adherence, and other public health data.
- Enable healthcare facilities to report HAI and prevention practice adherence data via NHSN to the Centers for Medicare and Medicaid Services (CMS) in fulfillment of CMS's quality measurement reporting programs including those data.
- Provide state and local health departments with information that identifies the healthcare facilities in their state that participate in NHSN.
- Provide to state and local agencies, at their request, facility specific, NHSN patient safety component and healthcare personnel safety component adverse event and prevention practice adherence data for surveillance, prevention, and/or mandatory public reporting.

NHSN is used to determine the magnitude of various healthcare-associated adverse events and trends in the rates of these events among patients and healthcare personnel with similar risks or exposures. The healthcare institutions participating in NHSN are required to collect data regularly and report them monthly, seasonally, or annually to CDC based on the specific data element being reported. NHSN provides facilities with risk-adjusted data that can be used for inter-facility comparisons and local quality improvement activities. CDC also assists facilities in developing surveillance and analysis methods that permit timely recognition of patient and healthcare personnel safety problems and prompt intervention with appropriate measures. Finally, facilities can conduct collaborative research with NHSN member facilities. For example, facilities can describe the epidemiology of emerging HAIs and pathogens, assess the importance of potential risk factors, further characterize HAI pathogens and their mechanism of resistance, and evaluate alternative surveillance and prevention strategies. In aggregate,

CDC analyzes and publishes surveillance data annually to estimate and characterize the national burden of healthcare-associated infections. These publications can be accessed here:

<https://www.cdc.gov/nhsn/dataStat.html>.

Further, CDC DHQP is actively engaged with the CMS Center for Clinical Standards and Quality (CCSQ) in working to reduce healthcare-associated infections and improve the quality of care within U.S. healthcare facilities. Suggested revisions and enhancements for NHSN definitions and surveillance criteria were received from external partners such as CMS CCSQ, the Healthcare Infection Control Practices Advisory Committee (HICPAC), and the Infectious Diseases Society of America (IDSA). The revisions, which are proposed to NHSN by external partners, are further evaluated, developed, and vetted by internal CDC NHSN subject matter experts. Prior to CMS CCSQ adopting a new NHSN measure for requirement in a CMS Quality Reporting Program (QRP), they require that the proposed measure is endorsed by a CMS consensus-based entity (CBE); CBE endorsed measures are considered the gold standard for quality measurement. Further, changes to the number of respondents and responses per respondent for NHSN forms are directly related to the expansion of CMS QRPs. Use of Improved Information Technology and Burden Reduction

### **3. Use of Improved Information Technology and Burden Reduction**

As stated in previous submissions to OMB, 100% of the data for NHSN are collected via a secure internet application. Only the minimum amount of information necessary for data collection is requested. Institutions that participate in NHSN are required to have a computer and Internet Service Provider (ISP), and they must provide the salaries of the data collectors and data entry personnel. These expenses would not exceed what is normally expended for a typical healthcare facility infection surveillance program. While the paper forms are provided for data collection, facilities are not required to use them for entry of data into NHSN. There is no manual entry available to users for the new neonatal component. Both numerator and denominator data will be imported into the Clinical Document Architecture (CDA) via electronic data transfer. This will allow users to obtain data submitted via CDA and focus on prevention activities within their respective hospitals or facilities.

Clinical Document Architecture (CDA) is a Health Level 7 (HL7) standard that provides technical specifications for electronic formatting documents for interoperable data exchange and re-use. Currently, NHSN can accept data for the following event types/summary data via CDA:

- Central line-associated bloodstream infections (CLABSI)
- Catheter-associated urinary tract infections (CAUTI)
- Central line insertion practices (CLIP)
- Surgical site infections (SSI)
- Laboratory-identified (LabID) events
- Summary data for Intensive Care Units (ICU)/Other Locations (not NICU and SCA)
- Summary data for Neonatal Intensive Care Units (NICU)
- Summary data for Specialty Care Areas (SCA)
- Surgical procedures
- MDRO and CDI Prevention Process and Outcome Measures Monthly Monitoring
- Antimicrobial use (AU)
- Antimicrobial resistance events (AR)
- Antimicrobial resistance (AR) summary data
- Dialysis events
- Dialysis summary data
- Late-onset sepsis/ Meningitis (LOS/MEN) data electronically via CDA

In alignment with CDC's Data Modernization Initiative, NHSN is developing a new approach to the collection of surveillance data for healthcare safety with the goal to minimize reporting burden of facilities and providers. To that end, NHSN is designing and developing new fully electronic definitions for healthcare-acquired events that adopt new healthcare data exchange standards (Fast Healthcare

Interoperability Resources i.e. FHIR) that will be collected via new collection methods (NHSNLink). This new model is based on submission of FHIR bundles that contain up to 18 unique FHIR resources (such as Patient and Encounter) which contain specific FHIR data elements that can be used to calculate metrics and provide patient-level risk adjustment. With this single stream of data, metrics for multiple healthcare associated events can be calculated. Because of the shift to new healthcare data exchange standards (FHIR) and fully electronic definitions for metrics, FHIR measures will require very little human time to input answers to a traditional form. FHIR is not fully implemented but will be effective for the following measures Respiratory Pathogens Surveillance, Hospital-Onset Bacteremia & Fungemia (HOB), Healthcare facility-onset, antibiotic-Treated Clostridioides difficile Infection (HT-CDI), Venous Thromboembolism (VTE), Adult Sepsis, Non-Ventilator Associated Pneumonia (NVAP), Late Onset Sepsis Meningitis (LOSMEN), Hypoglycemia (Hypo), Hospital Acute Kidney Injury (HAKI), and Opioid Related Adverse Event (ORAE).

#### **4. Efforts to Identify Duplication and Use of Similar Information**

NHSN is the only modern national system that collects surveillance data on healthcare-associated infections, infection prevention process measure data, data on healthcare personnel safety measures such as blood and body fluid exposures and vaccination practices, and adverse events related to the transfusion of blood and blood products.

There are other organizations within the Department of Health and Human Services (HHS) (e.g., Patient Safety Task Force, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, and the Centers for Medicare and Medicaid Services) that work to improve patient safety and healthcare outcomes. In many cases, these agencies use the information generated from the NHSN to support their mission, and currently, the data collections do not overlap.

For the data collection of Billing Code Data: 837I Upload, data received from this collection will be like data collected by CMS (UB-04 CMS-1450 form approved under OMB Control No. 0938-0997), however, CDC NHSN will receive additional respondents as CMS data is only collected on Medicare patients and the CDC NHSN data will be collected for all patients.

#### **5. Impact on Small Businesses or Other Small Entities**

There are several vendors, some of which may be considered small businesses, which sell data management tools with similar capabilities as NHSN. However, since NHSN is a voluntary system, facilities are free to choose a vendor product over NHSN. Exceptions are within those states that have mandated the use of NHSN. Mandates are required to help participants meet their public reporting laws in facilities that participate in the following programs listed below. However, in order to minimize any negative impact on vendors (i.e., loss of potential market share); CDC actively assists all vendors with facility data submission into NHSN.

- CMS Hospital Inpatient Quality Reporting Program (IQR)
- CMS Prospective Payment System (PPS)
- End-stage renal disease (ESRD) Quality Incentive Program (QIP)
- CMS Inpatient Rehabilitation Facility Quality Reporting Program (IRFQR)

#### **6. Consequences of Collecting the Information Less Frequently**

Many adverse events associated with healthcare, such as HAIs, occur in both endemic and epidemic patterns. It is in the best interest of the healthcare institution to conduct routine prospective surveillance in an ongoing manner to identify trends in endemic rates as well as outbreaks so that potential problems may be identified in a timely manner and appropriate measures instituted to minimize the number of affected patients or healthcare personnel. Collecting the data sporadically or less often than required by NHSN could potentially place patients at risk. In addition, CMS and state mandates require monthly reporting of HAI data via NHSN.

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

The healthcare institutions participating in NHSN are required to collect data in an ongoing manner and report them monthly to the CDC. Such a schedule will not cause undue burden in most facilities, since data are usually collected daily or at least several times per week, and denominator data are tallied monthly. The data are usually entered into the computer at least monthly for a facility's analysis. Given these practices, it is advantageous to CDC to maintain a monthly reporting frequency. In NHSN, once the data are entered into the internet-based application, they are transmitted electronically to CDC with no additional data preparation.

The majority of facilities active in NHSN are participating in CMS reporting programs for specific infection types. In 2011, the CMS' Hospital Inpatient Quality Reporting (HIQR) began for all acute care facilities with intensive care units. Further, in 2013, the CMS HIQR expanded its requirements to include reporting of facility-wide inpatient (FacWideIN) Methicillin-Resistant *Staphylococcus aureus* (MRSA) blood specimen (Bacteremia) laboratory-identified (LabID) event data, facility-wide Inpatient (FacWideIN) *Clostridium difficile* infection (CDI) laboratory-identified (LabID) event data, and healthcare personnel (HCP) Influenza vaccination data. As very few acute care facilities opt out of these additional CMS reporting requirements, NHSN data are generalizable to all U.S. acute care facilities.

In 2012, CMS ESRD Quality Incentive Program was implemented for all dialysis facilities, therefore dialysis event data are generalizable to all outpatient dialysis facilities. Furthermore, CLABSI and CAUTI data from long-term acute care facilities, and CAUTI data from inpatient rehabilitation facilities are considered generalizable to those facility and infection types as CMS reporting programs for those facility types went into effect in October 2012.

As part of the national COVID-19 response, CMS began requiring that all nursing homes report counts of COVID-19 cases and deaths among nursing home residents and personnel to NHSN. The data is used by CDC, the White House Coronavirus Task Force, and by CMS to respond to the pandemic. There are additionally plans for the data to be publicly displayed on a CMS website.

(<https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf>.) Further, because NHSN membership is now open to any healthcare facility and is increasingly being used to satisfy mandated reporting requirements at both the federal and state levels, we expect that over time the results will be more representative of all healthcare facility and infection types.

#### CDC/NHSN Justification for Sensitive Questions (Race, Ethnicity)

NHSN collects secondary source data from healthcare facilities rather than primary source data directly from patients/individuals. Therefore, NHSN is limited to collecting only what Race and Ethnicity data that exist in the electronic health record (EHR) and is dependent on national data exchange standards to drive updates to the way the data are collected and made available for reporting to NHSN. CDC/NHSN continually works with the HL7 organization, ONC, and EHR vendors to evolve the standards to incorporate recommended best practices for collection of data, including Race and Ethnicity data. However, until the OMB standards and best practices are adopted and implemented by EHR vendors, NHSN is constrained by the data that is currently available, which includes Race and Ethnicity as separate data fields.

Certified EHR systems are required to comply with federal interoperability standards for health information technology. To minimize data collection burden on healthcare facilities, NHSN collects data for Race and Ethnicity in alignment with base Health Level Seven (HL7) and The Office of the National Coordinator for Health Information Technology (ONC) United States Core Data for Interoperability (USCDI) standardized terminology that is implemented in EHRs. CDC NHSN is working to implement the new OMB guidance as soon as possible, but no later than the required date of March 28, 2029. NHSN is working with the Office of the National Coordinator (ONC) to update their standards to coincide with OMB's directives, but this takes time to work through the process. We are in the process of complying with the guidelines and data fields in the OMB packages with the first step being the addition of MENA as a Race choice on the data collection forms. Due to NHSN's heavy dependency on secondary source data (i.e., data collected within electronic health record [EHRs] vendors) we cannot collect data according to OMB guidance until EHR vendors comply with this directive. EHR vendors (e.g. Epic, Cerner) have until January 1, 2026, to meet Cures Act requirements, and implement the United States Core Data for Interoperability (USCDI) version 3, which includes CDC Race and



Ethnicity Code Set Version 1.2 that complies with OMB guidance. NHSN will continue to collect Race and Ethnicity data separately until such time when EHR vendors are able to align with OMB guidance. NHSN’s target is to update data collection forms to comply with the OMB directive by January 1, 2026.

USCDI Core represents a standardized set of health data elements defined by the Office of the National Coordinator (ONC) for interoperability. This is a set of essential health data elements that should be included when exchanging patient information electronically, ensuring a minimum level of data is always available across different systems. VSAC (Value Set Authority Center) is a repository for public value sets of standardized codes used to define clinical concepts. Provided by the National Library of Medicine, in collaboration with the Office of the National Coordinator for Health Information Technology (ONC) and Centers for Medicare & Medicaid Services (CMS), VSAC is a repository where sets of standardized clinical codes (from standard clinical terminologies like SNOMED CT, LOINC) are stored and curated, allowing for consistent interpretation of data elements, which supports effective and interoperable health information (data) exchange. CDA (Clinical Document Architecture) is a standardized format for structuring and exchanging clinical documents, like progress notes or discharge summaries, ensuring that the data elements (defined by USCDI and coded using VSAC) are presented in a consistent and organized manner when exchanged between healthcare providers. EHR vendors utilize CDA to electronically transmit data to the NHSN.

USCDI, VSAC, and CDA work together to ensure consistent and meaningful exchange of patient health information across different healthcare systems and public health entities; essentially, USCDI specifies the core data needed, VSAC provides the standardized codes to represent these data, and CDA provides the structure to package and transmit the data.

VSAC is a repository and authoring tool for public value sets created by external programs. Value sets are lists of codes and corresponding terms, from NLM-hosted standard clinical vocabularies (such as SNOMED CT®, RxNorm, LOINC® and others), that define clinical concepts to support effective and interoperable health information exchange. The VSAC provides downloadable access to all official versions of value sets specified by the Centers for Medicare & Medicaid Services (CMS) electronic Clinical Quality Measures (eCQMs). The VSAC does not create value set content and requires a license to obtain access to the value sets. For information on CMS eCQMs, visit the eCQI Resource Center. The VSAC is provided by the National Library of Medicine (NLM), in collaboration with the Office of the National Coordinator for Health Information Technology (ONC) and CMS. <https://vsac.nlm.nih.gov/>.

Reference websites

HealthIT.gov Interoperability Standards Platform

<https://www.healthit.gov/isp/uscdi-data-class/patient-demographicsinformation#uscdi-v2>

[Representing Patient Race and Ethnicity | Interoperability Standards Platform \(ISP\)](#)

**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 January 17, 2025, Vol. 90, No. 11, pp. 5885-5887 - (Attachment B). CDC received one public comment related to this notice (Attachment B); the comment was non-substantive.
- B. The Healthcare Infection Control Practices Advisory Committee (HICPAC) provides advice and guidance to the CDC Director and the Director of NCEZID regarding strategies for surveillance, prevention, and control of adverse events associated with healthcare in the United States. Committee members represent experts in the field of infection control. They are kept abreast of NHSN methodologies and results, and proposed studies related to NHSN. The committee has the authority to make recommendations on the conduct of the surveillance systems and studies by DHQP.

Further, participating NHSN facilities are invited to make suggestions on how NHSN can help them more effectively use their own and national surveillance data. Many of the surveillance personnel in participating institutions are experts in the field of preventing adverse events such as hospital-associated infections and have extensive experience in the field. CDC personnel are available on a priority basis by e-mail to NHSN users. Member meetings for NHSN users are held each year in conjunction with annual

professional meetings such as the International Conference of the Association for Professionals in Infection Control and Epidemiology (APIC) and the International Conference on Healthcare-Associated Infections.

Also, DHQP actively interfaces with CMS and Agency for Healthcare Research and Quality (AHRQ) as well as state and local health departments to ensure adequate but minimal data collection as well as effective data sharing mechanisms to meet the purposes and surveillance needs of each agency using NHSN to operationalize HAI reporting mandates.

## **9. Explanation of Any Payment or Gift to Respondents**

No monetary incentive is provided to NHSN participants.

## **10. Protection of the Privacy and Confidentiality of Information Provided by Respondents**

This submission has been reviewed by NCEZID who determined that the Privacy Act does not apply and that there are no changes to the Privacy aspects of this package. The CDC Office of General Counsel (OGC) has also determined that the Privacy Act does not apply to this data collection. The CDC OGC believes that NHSN, as it is currently being utilized by CDC, is not a Privacy Act system of records and provides case law to support this determination (*Henke v. U.S. Department of Commerce* and *Fisher v. NIH*). Specifically, the OGC stated that "The CDC NHSN system is similar to the computerized information in both the *Henke* and *Fisher* cases. While CDC can retrieve data by personal identifier, CDC does not, as a matter of practice or policy, retrieve data in this way. Specifically, the primary practice and policy of CDC regarding NHSN data are to retrieve data by the name of the hospital or another non-personal identifier, not an individual patient, for surveillance and public health purposes. Furthermore, patient identifiers are not necessary for NHSN to operate, and the CDC does not regularly or even frequently use patient names to obtain information about these individuals."

An Assurance of Confidentiality is granted for all data collected under NHSN. NHSN's Assurance of Confidentiality, states the following.

*"the voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d))."*

See Attachments F1 and F2.

The use of NHSN is both voluntary and mandated. State legislatures and some local health departments have mandated the use of NHSN for public reporting of HAIs by healthcare facilities in their jurisdiction.

While the Privacy Act is not applicable, in accordance with the stringent safeguarding that must be in place for 308(d) assurance of confidentiality protected projects, all the safeguarding measures described in previous Section A.10 are still in effect. These include the use of a password issued via CDC's Secure Access Management System for access to the application; data encryption using Secure Socket Layer technology; and lastly, storage of data in password protected files on secure computers in locked, authorized-access-only rooms.

This data collection effort is consistent with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA), which expressly permits disclosures without individual authorization to public health authorities authorized by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability, including but not limited to public health surveillance, investigation, and intervention.

The surveillance data is typically obtained by designated and trained staff, primarily registered nurses in infection control or occupational health or transfusion medicine laboratory personnel who routinely access administrative and clinical services reports and medical records, make observations during ward

and patient rounds, and verbally discuss patients’ conditions with direct caregivers. Persons with training in other healthcare disciplines such as medical technology and microbiology also perform surveillance. Information on antibiotic resistance of clinical isolates and antimicrobial use is reported from the clinical laboratory and pharmacy, respectively. In most institutions, the data are recorded on a hard-copy data collection forms and later entered into the NHSN via a web interface. However, approximately 7,500 NHSN facilities submit data electronically directly from a vendor system using Clinical Document Architecture (CDA).

Items of information to be collected include surveillance data related to various healthcare-associated adverse events and trends. Examples of these items are medical information and notes, medical records numbers, date of birth, and biological specimen information. Personal identifying information is collected for one of two purposes. The information is used to either a) enumerate a specific event and minimize duplication (e.g., medical record number) or b) analyze risk factors related to the event data being collected (e.g., date of birth). Data are reported to the CDC, and CDC aggregates the data for national surveillance and public health practice evaluation purposes. Data will be kept private to the extent allowed by law.

A signed Privacy Impact Assessment is included with this submission (Attachment G1 & G2).

**11. Institutional Review Board (IRB) and Justification for Sensitive Questions**

Institutional Review Board (IRB)

For the participating healthcare institutions, data are collected in this system for the purposes of local surveillance and program evaluation. DHQP aggregates the data for national surveillance and public health practice evaluation purposes. No primary research will be conducted as part of this data collection effort, and no patient consent forms will be used. Although this is not a research project, this Protocol was submitted for ethical review to the CDC Institutional Review Board (IRB) and was approved (Protocol #4062, exp. 05/18/05.) The most recent request for amendment and continuation was approved on 08/29/06 and expired on 05/18/07. Subsequently, in consultation with NCEZID senior staff, the program was advised that the activities of the NHSN are surveillance and evaluation of public health practice (Attachment E3), and that IRB review is no longer required, therefore the protocol has been closed (Attachment E1, E2). There have been no changes to the project related to a research determination.

Justification for Sensitive Questions

The reporting of adverse events associated with healthcare can be sensitive unless the institution is assured that the data aggregating organization will provide security for the data and maintain the institution’s confidentiality. As discussed in item A.10 above, NHSN is authorized to assure confidentiality to its participating individuals and institutions for voluntarily submitted data.

**12. Estimates of Annualized Burden Hours and Costs**

The tables below provide the burden hours and cost estimates for the proposed NHSN data collection tools.

A. Estimated Annualized Burden Hours

The tables below provide the burden hours and cost estimates for the proposed NHSN data collection tools. Completion of the NHSN data collection tools is required for participation in NHSN, participation in a CMS reporting program, or to fulfill state or local reporting mandates. To estimate annualized burden hours and costs, the number of respondents is first determined by the number of facilities that report to NHSN by component and includes projected growth or reductions in facilities reporting during the ICR period. For forms that are required for participation in NHSN or a CMS reporting program, CDC calculates burden based on a 100 percent response rate, whereas an estimated response rate less than 100 percent is calculated for those forms that are voluntary or optional. CDC then considers the burden associated with surveillance, data entry, analysis, and validation to determine the amount of time required for each form to be considered complete. Annual labor rates reported by

the U.S. Department of Labor are used to calculate the annual burden costs based on the hourly rate of pay for health professionals most qualified to complete NHSN data submission.

The proposed changes in this ICR includes revisions made to three approved NHSN data collection tools; there are a total of 84 proposed data collection forms in this package, with a total estimated annual burden of 4,509,135 hours. There is no cost to respondents other than their time to participate. The total cost burden will be \$263,651,599. The burden table below shows the effect of the additional changes requested by CDC.

B. Estimated Annualized Burden Costs

The average salary of the professional discipline expected to perform surveillance is used in the calculations of burden and is based on data from the Department of Labor, Bureau of Labor & Statistics, 2023 (latest available). Those most likely to complete this surveillance are health practitioners at a mid (50th percentile average wage) or senior (75th percentile average wage) level. That personnel and their estimated hourly wages are shown below.

May 2023 Department of Labor Salary Estimates		
Professional Labor Category	Percentile	Hourly Wage
Microbiologist (IP)	75th	\$58.60
Clinical Laboratory Technologists and Technicians	75th	\$38.81
Pharmacist	50th	\$69.36
Registered Nurse (RN)	50th	\$46.55
Epidemiologists	50th	\$50.85
Information Technologists	50th	\$56.50
Occupational Health and Safety Specialists	50th	\$46.60
Facility Managers	50 <sup>th</sup>	\$52.69

[Occupational Employment and Wage Statistics \(bls.gov\)](#). Accessed: 7/12/2024.

**CMS Program Definitions:**  
End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) - ESRD QIP  
Hospital Inpatient Quality Reporting Program - IQR  
Hospital Outpatient Quality Reporting Program - OQR  
Long-Term Care Hospital\* Quality Reporting Program - LTCHQR  
Meaningful Use Stage 3- MU3  
Inpatient Rehabilitation Facility Quality Reporting Program - IRFQR  
Ambulatory Surgery Centers Quality Reporting Program - ASCQR  
PPS-Exempt Cancer Hospital Quality Reporting Program - PCHQR  
Inpatient Psychiatric Facility Quality Reporting Program - IPFQR

Estimated Annualized Burden Hours and Cost								
Form Number & Name	No. of Respondents	No. of Responses per Respondent	Avg. Burden per Response (Min./Hour 60)	Total Burden (Hours)	To calculate respondent cost Total Burden (Hours)	Hourly Wage Rate	Total Respondent Cost	Type of Respondents
57.100 NHSN Registration Form	2,000	1	5/60	167	167	\$58.60	\$9,786	Infection Preventionist/Microbiologist
57.101 Facility Contact Information	2,000	1	10/60	333	333	\$58.60	\$19,514	Infection Preventionist/Microbiologist
57.102 NHSN Help Desk Customer Satisfaction Survey	26,400	1	2/60	880	880	\$58.60	\$51,568	Infection Preventionist/Microbiologist
57.103 Patient Safety Component--Annual Hospital Survey	5,400	1	137/60	12330	12330	\$58.60	\$722,538	Infection Preventionist/Microbiologist
57.104 NHSN Facility Administrator Change Request Form	800	1	5/60	67	67	\$58.60	\$3,926	Infection Preventionist/Microbiologist
57.105 Group Contact Information	1,000	1	5/60	83	83	\$50.85	\$4,221	Epidemiologists
57.106 Patient Safety Monthly Reporting Plan	7,821	12	15/60	23463	23463	\$58.60	\$1,374,932	Infection Preventionist/Microbiologist
57.108 Primary Bloodstream Infection (BSI)	6,000	12	42/60	50400	50400	\$58.60	\$2,953,440	Infection Preventionist/Microbiologist
57.111 Pneumonia (PNEU)	1,800	2	34/60	2040	2040	\$58.60	\$119,544	Infection Preventionist/Microbiologist
57.112 Ventilator-Associated Event (VAE)	5463	8	32/60	23309	23309	\$58.60	\$1,365,907	Infection Preventionist/Microbiologist
57.113 Pediatric Ventilator-Associated Event (PedVAE)	334	1	34/60	189	189	\$58.60	\$11,075	Infection Preventionist/Microbiologist
57.114 Urinary Tract Infection (UTI)	6000	12	24/60	28800	28800	\$58.60	\$1,687,680	Infection Preventionist/Microbiologist
57.115 Custom Event	600	91	39/60	35490	35490	\$58.60	\$2,079,714	Infection Preventionist/Microbiologist
57.116 Denominators for Neonatal Intensive Care Unit (NICU)	1,100	12	240/60	52800	52800	\$58.60	\$3,094,080	Infection Preventionist/Microbiologist
57.117 Denominators for Specialty Care Area (SCA)/Oncology (ONC)	500	12	300/60	30000	30000	\$58.60	\$1,758,000	Infection Preventionist/Microbiologist
57.118 Denominators for Intensive Care Unit (ICU)/Other locations (not NICU or SCA)	5500	60	300/60	1650000	1650000	\$58.60	\$96,690,000	Infection Preventionist/Microbiologist
57.120 Surgical Site Infection (SSI)	3,800	12	14/60	10640	10640	\$58.60	\$623,504	Infection Preventionist/Microbiologist
57.121 Denominator for Procedure	3,800	12	14/60	10640	10640	\$58.60	\$623,504	Infection Preventionist/Microbiologist

57.122 HAI Progress Report State Health Department Survey	55	1	50/60	46	46	\$50.85	\$2,339	Epidemiologists
57.123 Antimicrobial Use and Resistance (AUR)-Microbiology Data Electronic Upload Specification Tables-Initial Set-up	2200	1	4800/60	176000	176000	\$69.36	\$12,207,360	Pharmacist
57.123 Antimicrobial Use and Resistance (AUR)-Microbiology Data Electronic Upload Specification Tables-Yearly Maintenance	3300	2	120/60	13200	13200	\$69.36	\$915,552	Pharmacist
57.123 Antimicrobial Use and Resistance (AUR)-Microbiology Data Electronic Upload Specification Tables-Monthly	5,500	12	5/60	5500	5500	\$69.36	\$381,480	Pharmacist
57.124 Antimicrobial Use and Resistance (AUR)-Pharmacy Data Electronic Upload Specification Tables-Initial Set-up	1,500	1	2400/60	60000	60000	\$69.36	\$4,161,600	Pharmacist
57.124 Antimicrobial Use and Resistance (AUR)-Pharmacy Data Electronic Upload Specification Tables-Yearly Maintenance	4,000	1	120/60	8000	8000	\$69.36	\$554,880	Pharmacist
57.124 Antimicrobial Use and Resistance (AUR)-Pharmacy Data Electronic Upload Specification Tables-Monthly	5,500	12	5/60	5500	5500	\$69.36	\$381,480	Pharmacist
57.125 Central Line Insertion Practices Adherence Monitoring	500	213	26/60	46150	46150	\$39.54	\$1,824,771	Infection Preventionist/Microbiologist
57.126 MDRO or CDI Infection Form	720	12	34/60	4896	4896	\$58.60	\$286,906	Infection Preventionist/Microbiologist
57.127 MDRO and CDI Prevention Process and Outcome Measures Monthly Monitoring	5,500	29	15/60	39875	39875	\$58.60	\$2,336,675	Infection Preventionist/Microbiologist
57.128 Laboratory-identified MDRO or CDI Event	4800	12	24/60	23040	23040	\$58.60	\$1,350,144	Infection Preventionist/Microbiologist
57.129 Adult Sepsis	50	12	28/60	280	280	\$58.60	\$16,408	Infection Preventionist/Microbiologist
57.130 Infectious Diseases of Public Health Concern	3650	365	35/60	777146	777146	\$58.60	\$45,540,756	Infection Preventionist/Microbiologist
57.132 Patient Safety Component Digital Measure Reporting Plan (HOB, HT-CDI, VTE, Adult Sepsis, RPS, NVAP)-IT Initial Set up	5500	1	1620/60	148500	148500	56.50	\$8,390,250	Information Technology

57.132 Patient Safety Component Digital Measure Reporting Plan (HOB, HT-CDI, VTE, Adult Sepsis, RPS, NVAP)-IT Yearly Maintenance	5500	1	1200/60	110000	110000	56.50	\$6,215,000	Information Technology
57.132 Patient Safety Component Digital Measure Reporting Plan (HOB, HT-CDI, VTE, Adult Sepsis, RPS, NVAP)-Infection Preventionist	5500	4	10/60	3667	3667	\$58.60	\$214,866	Infection Preventionist/Microbiologist
57.132 Patient Safety Digital Reporting Plan (RPS CSV)	5500	365	2/60	66917	66917	\$58.60	\$3,921,336	Infection Preventionist/Microbiologist
57.133 Patient Safety Attestation	3500	1	10/60	583	583	\$58.60	\$34,164	Infection Preventionist/Microbiologist
57.137 Long-Term Care Facility Component – Annual Facility Survey	6,270	1	135/60	14108	14108	\$58.60	\$826,729	Infection Preventionist/Microbiologist
57.138 Laboratory-identified MDRO or CDI Event for LTCF	286	24	23/60	2631	2631	\$58.60	\$154,177	Infection Preventionist/Microbiologist
57.139 MDRO and CDI Prevention Process Measures Monthly Monitoring for LTCF	738	12	10/60	1476	1476	\$58.60	\$86,494	Infection Preventionist/Microbiologist
57.140 Urinary Tract Infection (UTI) for LTCF	373	24	38/60	5670	5670	\$58.60	\$332,262	Infection Preventionist/Microbiologist
57.141 Monthly Reporting Plan for LTCF	546	12	5/60	546	546	\$58.60	\$31,996	Infection Preventionist/Microbiologist
57.142 Denominators for LTCF Locations	724	12	35/60	5068	5068	\$58.60	\$296,985	Infection Preventionist/Microbiologist
57.143 Prevention Process Measures Monthly Monitoring for LTCF	434	12	5/60	434	434	\$58.60	\$25,432	Infection Preventionist/Microbiologist
57.145 Long Term Care Antimicrobial Use (LTC-AU) Module- Digital Upload Specification Tables	16,500	12	5/60	16500	16500	\$58.60	\$966,900	Infection Preventionist/Microbiologist
57.150 LTAC Annual Survey	395	1	102/60	672	672	\$58.60	\$39,379	Infection Preventionist/Microbiologist
57.151 Rehab Annual Survey	395	1	102/60	672	672	\$58.60	\$39,379	Infection Preventionist/Microbiologist

57.211 Weekly Healthcare Personnel Influenza Vaccination Cumulative Summary for Non-Long-Term Care Facilities-Manual	117	12	25/60	585	585	\$46.60	\$27,261	Occupational Health RN/Specialist
57.211 Weekly Healthcare Personnel Influenza Vaccination Cumulative Summary for Non-Long-Term Care Facilities-.CSV	3,080	12	20/60	12320	12320	\$46.60	\$574,112	Occupational Health RN/Specialist
57.214 Annual Healthcare Personnel Influenza Vaccination Summary-Mannual	22,440	1	120/60	44880	44880	\$46.60	\$2,091,408	Occupational Health RN/Specialist
57.214 Annual Healthcare Personnel Influenza Vaccination Summary-.CSV	1,920	1	55/60	1760	1760	\$46.60	\$82,016	Occupational Health RN/Specialist
57.215 Seasonal Survey on Influenza Vaccination Programs for Healthcare Personnel	15,426	1	45/60	11570	11570	\$46.60	\$539,162	Occupational Health RN/Specialist
57.300 Hemovigilance Module Annual Survey	63	1	86/60	90	90	\$38.81	\$3,493	Medical/Clinical Laboratory Technologist
57.301 Hemovigilance Module Monthly Reporting Plan	108	12	1/60	22	22	\$38.81	\$854	Medical/Clinical Laboratory Technologist
57.302 Hemovigilance Module Monthly Incident Summary	9	12	30/60	54	54	\$38.81	\$2,096	Medical/Clinical Laboratory Technologist
57.303 Hemovigilance Module Monthly Reporting Denominators	102	12	70/60	1428	1428	\$38.81	\$55,421	Medical/Clinical Laboratory Technologist
57.305 Hemovigilance Incident	13	77	10/60	167	167	\$38.81	\$6,481	Medical/Clinical Laboratory Technologist
57.306 Hemovigilance Module Annual Survey - Non-acute care facility	20	1	35/60	12	12	\$38.81	\$466	Medical/Clinical Laboratory Technologist
57.307 Hemovigilance Adverse Reaction - Acute Hemolytic Transfusion Reaction	8	2	22/60	6	6	\$38.81	\$233	Medical/Clinical Laboratory Technologist
57.308 Hemovigilance Adverse Reaction - Allergic Transfusion Reaction	50	11	22/60	202	202	\$38.81	\$7,840	Medical/Clinical Laboratory Technologist
57.309 Hemovigilance Adverse Reaction - Delayed Hemolytic Transfusion Reaction	9	2	20/60	6	6	\$38.81	\$233	Medical/Clinical Laboratory Technologist
57.310 Hemovigilance Adverse Reaction - Delayed Serologic Transfusion Reaction	19	5	20/60	32	32	\$38.81	\$1,242	Medical/Clinical Laboratory Technologist
57.311 Hemovigilance Adverse Reaction - Febrile Non-hemolytic Transfusion Reaction	85	13	20/60	368	368	\$38.81	\$14,282	Medical/Clinical Laboratory Technologist
57.312 Hemovigilance Adverse Reaction - Hypotensive Transfusion Reaction	23	3	20/60	23	23	\$38.81	\$893	Medical/Clinical Laboratory Technologist
57.313 Hemovigilance Adverse Reaction – Infection	2	2	20/60	1	1	\$38.81	\$39	Medical/Clinical Laboratory Technologist
57.314 Hemovigilance Adverse Reaction - Post Transfusion Purpura	2	1	20/60	1	1	\$38.81	\$39	Medical/Clinical Laboratory Technologist



57.315 Hemovigilance Adverse Reaction - Transfusion Associated Dyspnea	18	3	20/60	18	18	\$38.81	\$699	Medical/Clinical Laboratory Technologist
57.316 Hemovigilance Adverse Reaction - Transfusion Associated Graft vs. Host Disease	2	1	20/60	1	1	\$38.81	\$39	Medical/Clinical Laboratory Technologist
57.317 Hemovigilance Adverse Reaction - Transfusion Related Acute Lung Injury	2	1	20/60	1	1	\$38.81	\$39	Medical/Clinical Laboratory Technologist
57.318 Hemovigilance Adverse Reaction - Transfusion Associated Circulatory Overload	40	4	21/60	56	56	\$38.81	\$2,173	Medical/Clinical Laboratory Technologist
57.319 Hemovigilance Adverse Reaction - Unknown Transfusion Reaction	15	3	20/60	15	15	\$38.81	\$582	Medical/Clinical Laboratory Technologist
57.320 Hemovigilance Adverse Reaction - Other Transfusion Reaction	39	3	20/60	39	39	\$38.81	\$1,514	Medical/Clinical Laboratory Technologist
57.400 Outpatient Procedure Component — Annual Ambulatory Surgery Center Survey	350	1	10/60	58	58	\$58.60	\$3,399	Infection Preventionist/Microbiologist
57.401 Outpatient Procedure Component - Monthly Reporting Plan	350	12	10/60	700	700	\$58.60	\$41,020	Infection Preventionist/Microbiologist
57.402 Outpatient Procedure Component Same Day Outcome Measures	50	1	43/60	36	36	\$58.60	\$2,110	Infection Preventionist/Microbiologist
57.403 Outpatient Procedure Component - Denominators for Same Day Outcome Measures	50	400	20/60	6667	6667	\$58.60	\$390,686	Infection Preventionist/Microbiologist
57.404 Outpatient Procedure Component - SSI Denominator	300	100	23/60	11500	11500	\$58.60	\$673,900	Infection Preventionist/Microbiologist
57.405 Outpatient Procedure Component - Surgical Site (SSI) Event	300	36	40/60	7200	7200	\$58.60	\$421,920	Infection Preventionist/Microbiologist
57.408 Monthly Survey Patient Days & Nurse Staffing	2500	12	300/60	150000	150000	\$58.60	\$8,790,000	Infection Preventionist/Microbiologist
57.500 Outpatient Dialysis Center Practices Survey	6900	1	150/60	17250	17250	\$58.60	\$1,010,850	Infection Preventionist/Microbiologist
57.501 Dialysis Monthly Reporting Plan	7400	12	5/60	7400	7400	\$58.60	\$433,640	Infection Preventionist/Microbiologist
57.502 Dialysis Event	7400	30	50/60	185000	185000	\$58.60	\$10,841,000	Infection Preventionist/Microbiologist

57.503 Denominator for Outpatient Dialysis	7400	12	10/60	14800	14800	\$58.60	\$867,280	Infection Preventionist/Microbiologist
57.504 Prevention Process Measures Monthly Monitoring for Dialysis	1730	12	60/60	20760	20760	\$58.60	\$1,216,536	Infection Preventionist/Microbiologist
57.507 Home Dialysis Center Practices Survey	550	1	65/60	596	596	\$58.60	\$34,926	Infection Preventionist/Microbiologist
57.600 Neonatal Component FHIR Measure-Late Onset Sepsis Meningitis (LOSMEN) Module-IT Initial Set up	5500	1	1620/60	148500	148500	56.50	\$8,390,250	Information Technology
57.600 Neonatal Component FHIR Measure-Late Onset Sepsis Meningitis (LOSMEN) Module-IT Yearly Maintenance	5500	1	1200/60	110000	110000	56.50	\$6,215,000	Information Technology
57.600 Neonatal Component FHIR Measure-Late Onset Sepsis Meningitis (LOSMEN) Module-Infection Preventionist	5500	6	6/60	3300	3300	\$58.60	\$193,380	Infection Preventionist/Microbiologist
57.600 Neonatal Component Late Onset Sepsis Meningitis (LOSMEN) Module CDA Data Collection-Infection Preventionist	5500	12	2/60	2200	2200	\$58.60	\$128,920	Infection Preventionist/Microbiologist
57.601 Late Onset Sepsis/ Meningitis Denominator Form: Late Onset Sepsis/ Meningitis Denominator Form: Data Table for monthly electronic upload	300	6	5/60	150	150	\$58.60	\$8,790	Infection Preventionist/Microbiologist
57.602 Late Onset Sepsis/ Meningitis Event Form: Data Table for Monthly Electronic Upload	300	6	6/60	180	180	\$58.60	\$10,548	Infection Preventionist/Microbiologist
57.700 Medication Safety-Digital Measure Reporting Plan (HYPO, HAKI, ORAE) -IT Initial Set up	5500	1	1620/60	148500	148500	56.50	\$8,390,250	Information Technology
57.700 Medication Safety-Digital Measure Reporting Plan (HYPO, HAKI, ORAE) -IT Yearly Maintenance	5500	1	1200/60	110000	110000	56.50	\$6,215,000	Information Technology
57.700 Medication Safety-Digital Measure Reporting Plan (HYPO, HAKI, ORAE)-Infection Preventionist	5500	4	10/60	3667	3667	\$58.60	\$214,886	Infection Preventionist/Microbiologist
57.701 Medication Safety Component-Annual Hospital Survey	10	1	180/60	30	30	\$58.60	\$1,758	Infection Preventionist/Microbiologist
57.800 Billing Code Data: 837I Upload	5500	4	5/60	1833	1833	\$46.55	\$85,326	Registered Nurse
57.801 External Validation Summary Report	20	2	15/60	10	10	\$50.85	\$509	Epidemiologist
57.802 Bed Capacity-IT Initial Set Up	25	1	20/60	8	8	56.50	\$452	Information Technology
57.803 All Hazards	540	365	5/60	16425	16425	56.50	\$928,013	Information Technology
<b>Total Estimated Annual Burden (Hours)-4,509,135</b> <b>Total Estimated Cost-\$263,651,599</b>								

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

There is no change in the estimates of the annual cost burden to respondents. Capital and start-up cost: Healthcare institutions participating in NHSN are responsible for choosing the specific computer brand and model to purchase. Minimum system requirements are as follows: 3 GHz processor – Intel Pentium IV or AMD K6/Athlon/Duron family or compatible processor; 512 MB of RAM; sound card; speakers or headphones; hard disk minimum 40 GB; Microsoft Internet Explorer 7 or higher; 17” Super VGA (800 X 600) or higher resolution video adaptor and monitor; Windows XP, Windows 2000, Windows Vista, or Windows 7 Operating system; laser printer; high-speed internet access >200 Kbs (e.g., T1, cable, DSL or ADSL); and e-mail account. It is expected that most institutions will have met or exceeded these recommendations for other business purposes. Recurring costs: Healthcare facilities participating in NHSN must have access to high-speed Internet, which most have for other business purposes. No other recurring costs are anticipated.

### 14. Annualized Cost to the Government

A total of 127 FTE/contractor personnel are actively involved in the enhancement and maintenance of NHSN. The estimated cost to the government of this OMB reinstatement of NHSN is based on expenses incurred in the following categories: personnel and programming contracts. The items and their costs relevant to the proposed modifications to NHSN are shown in the table below. The total cost to the government in 2024 is estimated to be **\$49,992,135**.

#### NHSN Estimated Annual Cost to the Government

Expense Item	Description	Estimated Annual Cost
Personnel	The personnel categories and their FTE contributions are as follows:	FTE annual compensation in FY2024 will be \$6,595,430
	Supervisory Medical Officer	1
	Business Support Specialist	1
	IT Specialist	1
	IT Project Manager	1
	Medical Epidemiologist	1
	Statistician	1
	Epidemiologist	1
	Health Scientist	11
	Nurse Consultant	8
	Public Health Analyst	2
	Senior Service Fellow	3
	Public Health Informatics Fellow	2
Programming contracts	Design, develop, and deploy enhancements to NHSN	\$43,396,705

Expense Item	Description	Estimated Annual Cost
Total		\$49,992,135

**15. Explanation for Program Changes or Adjustments**

CDC is requesting three-year approval for the changes made to the “Pathogens of High Consequence” form through the previous emergency submission. CDC is also requesting the addition of polio to the Pathogens of High Consequence” form as well as corrections to two other forms. See Attachment D1 and second Explanation of Program Changes form for a summary of the changes.

**16. Plans for Tabulation and Publication and Project Time Schedule**

NHSN is an ongoing data collection system and as such does not have an annual timeline. The data are reported on a continuous basis by participating institutions and aggregated by CDC into a national database that is analyzed for two main purposes: to describe the epidemiology of healthcare-associated adverse events, and to provide comparative data for populations with similar risks. Comparative data can be used by participating and by non-participating healthcare institutions that collect their data using NHSN methodology.

The reporting institutions will be able to access their data at any time and analyze them through the internet interface. Reports containing aggregated data will be produced annually and posted on the NHSN website, <http://www.cdc.gov/nhsn>. The report is also published annually in a scientific journal to make NHSN data widely available. Other in-depth analysis of data from NHSN will be published in peer-reviewed journals and presented at scientific and professional meetings. The proposed modifications to NHSN will not alter the plans for tabulation, publication, nor the schedule.

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

The display of the OMB Expiration date is not inappropriate.

**18. Exceptions to Certification for Paperwork Reduction Act Submissions**

There are no exceptions to the certification.

## **Attachments**

- A. Authorizing Legislation (The Public Health Service Act)
  - 1. 42 USC 242b
  - 2. 42 USC 242k
  - 3. 42 USC 242m
- B. Published 60-day Federal Register
  - 1. Public Comment #1
- C. NHSN Forms Submitted for Approval
- D. Explanation for Program Changes or Adjustments
- E. Notice of IRB Closure
  - 1. Closure of NHSN IRB Protocol
  - 2. NHSN - Report of End of Human Research Review 0.1253
  - 3. Human Subjects Determination
- F. NHSN Assurance of Confidentiality Documentation
  - 1. NHSN final version of 308(d) Amend/Extension
  - 2. NHSN memo requesting extension/amendment
- G. Privacy Impact Assessment