June 16, 2020

Jeffrey M. Zirger
Information Collection Review Office
U.S. Centers for Disease Control and Prevention
1600 Clifton Road NE, MS-D74
Atlanta, GA 30329


Dear Mr. Zirger:

The Association for Professionals in Infection Control and Epidemiology (APIC) wishes to thank the Centers for Disease Control and Prevention (CDC) for the opportunity to provide feedback on the National Healthcare Safety Network (NHSN) Patient Module for Coronavirus (COVID-19) Surveillance in Healthcare Facilities. APIC is a nonprofit, multidisciplinary organization representing nearly 16,000 infection preventionists (IPs) whose mission is to create a safer world through prevention of infection. Our members work to prevent infection transmission in healthcare facilities and educate healthcare providers and the public about patient safety. As the primary NHSN users in our facilities, we are uniquely qualified to provide comments based on our use of the COVID-19 module.

1. **Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility.**

APIC supports this data collection and agrees that it is beneficial. Daily reporting of patient volume, bed capacity, Emergency Department/Overflow, ventilator utilization, etc. helps to inform government agencies on availability, use, and allocation of resources, infection transmission rates, community needs and other risk factors in order to better understand this novel virus and plan for additional needs and learn how to reduce transmission, as well as treat and protect infected patients.

However, the immediate practical utility has not been as apparent to healthcare facilities that have been struggling with inadequate supplies of personal protective equipment (PPE), medications, ventilators, and other resources. In addition, without patient-level data, the information has not been actionable at the facility level, so the time spent at this data collection has not yet been beneficial.

2. **Evaluate the accuracy of the agency’s estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used.**

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Because the information collection project has already been implemented, we have the advantage of several months of use in order to accurately assess the burden. We can, therefore, provide actual, rather than estimated burden hours. The CDC estimates 292,500 burden hours for this information collection project, based on daily reporting from 3,900 facilities for six months, and an estimated 25 minutes per response. However, our real-time experience in using the COVID-19 module has shown a more accurate time of 35 minutes for the collection, assessment, and submission of the data. Therefore, actual burden hours for 3,900 facilities spending 35 minutes to report daily for six months would be 407,160. In addition, there has been an upfront productivity cost to the organization to create a data analytics tool to facilitate reporting and the additional burden of adjusting the tool when the requirements are modified.

3. Enhance the quality, utility, and clarity of the information to be collected:

APIC agrees that the quality of the data is critical. This depends on all data, regardless of the source, being reviewed and validated to ensure accuracy. The experience of the IP community has shown disparate numbers depending on who, where, and when the data are collected. Some of the data are collected manually whereas other data elements are collected electronically. In some cases, the data may be collected via the electronic health record (EHR), but electronic resources may not be available in every instance. In addition, this data will also require validation.

4. Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

Collecting the data electronically is crucial to minimize the burden and increase the reliability of the data on a routine basis. Because SARS CoV-2 was a novel virus, many of the data elements are new as well. Information technology departments have been deployed to write programs to electronically access, validate, and optimize the accuracy of the data for the infection preventionists; however, the variation and novelty of the data has resulted in disparate and inconsistent data elements. Therefore, many facilities must still collect the data manually. This is time consuming and labor intensive. It is further complicated by the disorder of patient bed placements to accommodate surges in COVID-19 patients, and the associated NHSN location mapping variations that have resulted.

But when calculating the burden of the information collection project, we must also consider the people doing the information collection and the facilities for whom they work. IPs are the primary NHSN users in their facilities. Like other healthcare providers during this public health emergency (PHE), IPs have been stretched beyond their regular infection prevention and control routines with responsibilities to respond appropriately to the COVID-19 pandemic. These include: staying current with daily updates to CDC COVID-19-related recommendations and guidelines, serving on their healthcare system’s Incident Command Centers, reviewing use and availability of PPE, developing and delivering education for front
line healthcare personnel, evaluating patient and employee exposures to COVID-19, contact tracing, writing facility infection control guidelines and policies, and observing the clinical environment to ensure safe care of COVID-19 patients.

Healthcare facilities are currently reporting COVID-19 data to several different agencies on a daily basis, including FEMA and state and local health departments in addition to CDC/NHSN. But with so many competing priorities, IPs must often delegate data collection and entry to other hospital staff, who must be cross trained to do the data collection but do not have training on or access to NHSN. Once hospitals reopen to non-COVID-19 care, many of these staff people will no longer be available to assist with data collection.

APIC suggests that the data collection burden could be significantly reduced by consolidating requests for COVID-19 data from all agencies into one data submission, with the data then made available to the various government agencies who need the data for their various but critical missions.

5. **Assess information collection costs.**

According to the 2015 APIC MegaSurvey,\(^1\) the largest-ever survey of the infection prevention workforce, the average wage of an Infection Preventionist (2015 data) was $76,933, or $36.98/hour. According to our experience noted above, data submission to the NHSN COVID-19 Patient Impact and Hospital Capacity module takes approximately 35 minutes (.58 hours) per submission so the cost per submission would be approximately $21.45. Therefore, the human resource expense for 180 responses from 3,900 facilities at $21.45 per submission would total $15,057,900 during the data collection period.

As the primary NHSN users, IPs have unique knowledge of both the challenges and benefits the information collection project. APIC thanks CDC for the opportunity to provide input by sharing the experiences of IPs. Responses to crises such as the COVID-19 pandemic must always be evidence-based, and this depends on accurate and timely reporting of data. We rely on the government agencies collecting that data to ensure that the data they request is actionable and that it is being used in real time to assist and support state and local health departments and healthcare facilities in the fight against COVID-19. Streamlining reporting requirements across agencies will assist healthcare facilities in reducing burden.

Sincerely,

Connie Steed, MSN, RN, CIC, FAPIC
2020 APIC President

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