

**WEEKLY AND ANNUAL MORBIDITY AND MORTALITY REPORTS
0920-0007**

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**National Center for Health Marketing
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**SUPPORTING STATEMENT
WEEKLY AND ANNUAL MORBIDITY AND MORTALITY REPORTS
(0920-0007)**

A. JUSTIFICATION

A.1. Circumstances of Information Collection

The Centers for Disease Control and Prevention (CDC) is responsible for the collection and dissemination of nationally notifiable diseases' information and for monitoring and reporting the impact of epidemic influenza on mortality. The Public Health Service Act (42 USC 241) authorizing these reports is included as **Attachment 1**.

In 1878, Congress authorized the U. S. Marine Hospital Service (later renamed the U.S. Public Health Service) to collect morbidity reports on cholera, smallpox, plague, and yellow fever from U.S. consuls overseas; this information was to be used for instituting quarantine measures to prevent the introduction and spread of these diseases into the United States. In 1879, a specific Congressional appropriation was made for the collection and publication of reports of these notifiable diseases. The authority for weekly reporting and publication was expanded by Congress in 1893 to include data from state and municipal authorities throughout the United States. To increase the uniformity of the data, Congress enacted a law in 1902 directing the Surgeon General of the Public Health Service (PHS) to provide forms for the collection and compilation of data and for the publication of reports at the national level.

Reports on notifiable diseases were received from very few states and cities prior to 1900, but gradually more states submitted monthly and annual summaries. In 1912, state and territorial health authorities-- in conjunction with PHS-- recommended immediate telegraphic reports of five diseases and monthly reporting by letter of 10 additional diseases, but it was not until after 1925 that all states reported regularly. In 1942, the collection, compilation, and publication of morbidity statistics, under the direction of the Division of Sanitary Reports and Statistics, PHS, was transferred to the Division of Public Health Methods, PHS.

A PHS study in 1948 led to a revision of the morbidity reporting procedures, and in 1949 morbidity reporting activities were transferred to the National Office of Vital Statistics. Another committee in PHS presented a revised plan to the Association of State and Territorial Health Officers (ASTHO) at its meeting in Washington, D.C., October 1950. ASTHO authorized a Conference of State and Territorial Epidemiologists (CSTE) for the purpose of determining the diseases that should be reported by the states to PHS. Beginning in 1951, national meetings of CSTE were held every two years until 1974, then annually thereafter.

In 1961, responsibility for the collection of data on nationally notifiable diseases and deaths in 122 U.S. cities was transferred from the National Office of Vital Statistics to CDC.

This revision request is for a three-year extension, with a decrease in the burden, of the currently approved collection of weekly and annual morbidity reports from the 57 respondents (50 state, 2 cities, and 5 territorial health departments) and mortality reports from 122 U.S. cities and

metropolitan areas. Neither the respondent base or the time it takes to complete the instruments involved have decreased, however, the initial submission was approved for 424 hours more than what is currently being requested. Due to the reorganization and shift in positions, we were unable to locate the original project officer and therefore, we're not able to specifically pinpoint what caused the decrease in burden hours.

A.2. Purpose and Use of Information

As of January 1, 2003, over 60 infectious diseases and conditions were designated by CSTE as nationally notifiable and were approved by the state and territorial health departments for reporting to the CDC (**Attachment 2**; and <http://www.cdc.gov/epo/dphsi/PHS/infdis.htm>).

Weekly morbidity reports from state and territorial epidemiologists are sent electronically to CDC each week no later than 12:00 noon Eastern Time on the Tuesday following the reporting week. These data are used for weekly publication in the *Morbidity and Mortality Weekly Report (MMWR)* which is released electronically on Thursday, with a Friday publication date. The dates of the reporting week have been established by CSTE to correspond to the usual work week. The number of cases of nationally notifiable diseases reported to state health departments by local city or county health departments during the preceding "reporting week" are included in the morbidity report. In instances where the report of a case (or cases) has been delayed by the physician or the city or county health department, the case/s/ are not included in the total for the current week, but are added to the cumulative total for previous weeks. U.S. Public Health Service facilities and military installations report to the local or state health departments in compliance with local and state reporting requirements.

The National Center for Public Health Informatics (NCPHI), CDC, is responsible for the collection of descriptive epidemiologic data for all notifiable infectious diseases. A summary presenting incidence data for these diseases is also published each year as the last issue of each volume of the *Morbidity and Mortality Weekly Report (MMWR)* entitled *Summary of Notifiable Diseases, United States*. The National Center for HIV, STD, and TB Prevention (NCHSTP), CDC, provides annual incidence data for AIDS, chancroid, chlamydia, congenital syphilis, gonorrhea, syphilis, and tuberculosis. All cases of paralytic poliomyelitis are reviewed and verified annually by a panel of consultants to the National Immunization Program (NIP), CDC. These annual reports from other CDC program areas are reported to NCPHI for official publication in the *Summary of Notifiable Diseases*.

The timeliness of the provisional weekly reports provides information which CDC and state or local epidemiologists use to detect and more effectively interrupt outbreaks. Also, reporting provides the timely information needed to measure and demonstrate the impact of changed immunization laws or new therapies. Reports of an increased number of cases of diseases which are no longer endemic in the United States facilitate recognition of a disease's resurgence. The finalized annual data also provide information on reported disease incidence that is necessary for the evaluation of epidemiologic trends and the development of disease prevention policies. CDC is the sole repository for these national, population-based data. The data are widely used by

schools of medicine and public health, communications media, and pharmaceutical or other companies producing health-related products, as well as local, state, and federal health agencies and other agencies or persons concerned with the trends of reportable conditions in the United States.

A.3. Use of Improved Information Technology

CDC has worked with CSTE to improve the efficiency of the reporting procedures; all changes in reporting procedures are made in collaboration with CSTE.

In April 1984, the CDC Epidemiology Program Office (EPO) in cooperation with CSTE and epidemiologists in six states began a pilot project, the Epidemiologic Surveillance Project (ESP), designed to demonstrate the efficiency and effectiveness of computer transmission of surveillance data between CDC and the state health departments. Each state health department used its existing computerized disease surveillance system to transmit specific data concerning each case of a notifiable disease, and CDC technicians developed computer software to automate the transfer of data from the state to CDC.

In June 1985, CSTE passed a resolution supporting ESP as a workable system for electronic transmission of notifiable disease case reports from the states/territories to CDC, and as the program was extended beyond the original group of states, EPO began to provide software, training and technical support to state health department staff overseeing the transition from hard-copy to automated transmission of surveillance data. By 1989, all 50 states were using this computerized disease surveillance system, which was then renamed the National Electronic Telecommunications System for Surveillance (NETSS) to reflect its national scope. Core surveillance data are transmitted to CDC by the states and territories through NETSS. NETSS has a standard record format for data transmitted and does not require the use of a specific software program. The ability of NETSS to accept records generated by different software programs is what makes it useful for the efficient integration of surveillance systems nationwide. Notifiable infectious disease incidence data reported through NETSS support the National Notifiable Diseases Surveillance System (NNDSS), the CDC-based information system and data base that maintains current and historical data on nationally notifiable infectious diseases (1951 to present) and provides data to support weekly and annual morbidity reporting in the *MMWR*.

Case reports transmitted via NETSS are verified for accuracy and uploaded to the CDC mainframe computer by CDC staff on Monday and Tuesday each week, and statistical tables and a figure are produced for publication in the *MMWR* each Friday. A summary report detailing the content of the weekly data transmission is generated from each state's data transmission and mailed (or e-mailed) to reporting states. This summary tallies the number of records received, indicates how many records were updates or duplicates, and indicates records containing errors. Year-to-date summaries of morbidity data by disease are also included in this report to the states.

To provide a setting for exchange of information about the operation of NETSS and the use of NETSS data at the state level, CDC planned and conducted three workshops--one in September 1989 for state notifiable disease reporters/coordinators responsible for NETSS data transmission; one in February 1990 for epidemiologists responsible for data analysis; and a video conference in

November 1993 for NETSS reporting teams. In June 1995, EPO updated and distributed the *Manual of Procedures for the Reporting of Nationally Notifiable Diseases to CDC* (last printed in 1985). In 1997, EPO prepared and distributed the *National Electronic Telecommunications System for Surveillance User's Guide*, designed to assist surveillance specialists, database administrators, and technical support staff in the installation, customization, use and maintenance of NETSS, an Epi Info-based surveillance software application developed by the CDC and used on a voluntary basis by more than 40 states. CDC continues to provide telephone and occasional field support to state NETSS reporters and information technologists on an ongoing basis.

In 1991, the NETSS record layout was revised for the following reasons: to provide for additional variables needed to maintain unique case identification; to allow the reporting of aggregate case counts for some diseases to accommodate the reporting needs of states; and to conform to recommendations of the CDC Surveillance Coordination Group and CSTE for the development of compatible electronic surveillance systems for use by public health agencies at local, state, and national levels. These recommendations included the use of standard core variables and coding schemes. The NETSS record layout is provided to each reporting area using the NETSS system (**Attachment 3**).

Since 1999, CDC staff has worked with CSTE, state and local public health system staff, and other CDC disease prevention and control program staff to identify information and information technology standards to support integrated disease surveillance. That effort is now focused on development of the National Electronic Disease Surveillance System (NEDSS). When completed, NEDSS will electronically integrate and link together a wide variety of surveillance activities and will facilitate more accurate and timely reporting of disease information to CDC and state and local health departments. Consistent with recommendations supported by our state and local surveillance partners and described in the 1995 report, *Integrating Public Health Information and Surveillance Systems* (<http://www.cdc.gov/od/hissb/docs/katz.htm>), NEDSS will include data standards, an internet based communications infrastructure built on industry standards, and policy-level agreements on data access, sharing, burden reduction, and protection of confidentiality. To support NEDSS, CDC is supporting the development of an information system, the NEDSS Base System, that will use NEDSS technical and information standards (<http://www.cdc.gov/od/hissb/docs/NEDSSBaseSysDescription.pdf>). As such, the NETSS information system application will be phased-out state-by-state. The state implementation process for NEDSS began in the fourth quarter of 2002. It was anticipated that the NETSS system would be phased out within three years; however, because of budget constraints and unforeseen circumstances, at the present time only 15 states have transitioned to NEDSS. NETSS' functionality will be replaced by the NEDSS functionality, either through the NEDSS Base System in states who choose to use it, or through their own information systems developed to conform to NEDSS architectural standards. At the time that a state transitions from NETSS to NEDSS, the common descriptive epidemiologic data collected for NEDSS will be modified for the following reasons: to accommodate revised OMB guidance on collection of race and ethnicity data; to include confirmatory lab information when available; and to support the collection of socioeconomic information (**Attachment 4**). By necessity, the transition from NEDSS reporting using NETSS to NEDSS reporting via use of the NEDSS technical architecture and standards will occur state-by-state and, often, by public health prevention

program within a state. Technical assistance for the local and state public health systems is provided via federal funding.

Reporting of nationally notifiable disease incidence data to NNDSS to support weekly and annual morbidity reporting in the *MMWR* is voluntary. CDC and CSTE have recommended the modification of the descriptive data currently reported to NNDSS (**Attachment 4**) to better describe the epidemiologic characteristics of disease incidence to focus the public health system's prevention and control efforts. CDC does recommend that NEDSS data standards be used when states are collecting information similar to that described in Attachment 4. However, reporting of these data elements (and use of the NEDSS technical architecture and standards) continues to be voluntary. As such, we anticipate that states will transition from NETSS to NEDSS based upon their surveillance and information needs. This process may take several years to complete. Definition of the modified data content was done collaboratively with input from local and state public health departments, CSTE, and staff in the National Center for Infectious Diseases (NCID), the National Center for Immunization and Respiratory Diseases (NCIRD), and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) at CDC. In addition to supporting collection of data directly relevant for disease prevention and control, the transition to the NEDSS notifiable disease data content allows CDC to tangibly support compliance with the most recent (1997) OMB revisions to the standards for classification of federal data on race and ethnicity (both directly via information system support and indirectly via development of standard guidance). CDC acknowledges that the actual receipt and *MMWR* dissemination of notifiable infectious disease incidence data in the modified data format will be phased in over time since it requires state-by-state implementation of modifications at the point of data collection at both the local and State level. For example, modification of the race and ethnicity variables requires that States agree to change their data collection protocols (including state data collection forms or computer software) in accordance with the recent OMB revisions and implement the proposed change -- some states have already incorporated these changes in their information systems.

A.4. Efforts to Identify Duplication

Information maintained in NNDSS serves as a centralized, integrated source of common (or core) descriptive epidemiologic data on notifiable infectious disease incidence and distribution in the United States, and it is not available from any other source. NNDSS data are linked at the local and state level during routine surveillance information management to additional disease-specific surveillance data collected by other NCID, NCIRD, and NCHHSTP programs that are primarily responsible for the prevention and control of the notifiable diseases reported to NNDSS. This linkage purposively avoids duplication of data entry and reporting effort for local and state public health program staff. Additionally, the use of NETSS for the weekly provisional morbidity reporting process eliminates the need for duplicate reporting of information for the *MMWR Summary of Notifiable Diseases*. Weekly provisional NNDSS data are finalized to support the *MMWR Summary of Notifiable Diseases*. Over the last 10 years, this consolidated system of disease surveillance permitted some reduction in personnel efforts used for data reporting. All 50 states, two cities, and Puerto Rico are now participating in NETSS and NNDSS and have eliminated the use of these hard-copy annual report forms since 1990. The transition to NEDSS will further decrease the duplication of reporting through its use of a single secure portal

for transmission of electronic public health notifications which are then imported and merged into a single integrated database – avoiding duplicate reporting from state health departments.

A.5. Involvement of Small Entities

This collection of information does not involve small businesses or other small entities.

A.6. Consequences if Information Collected less Frequently

The timeliness of these data is one of the most critical factors in the collection process.

Weekly reporting of national morbidity data is essential to the rapid identification of disease epidemics and more timely and complete understanding of disease trends. The usefulness of these weekly reports is enhanced by the NETSS reporting formats, which include case-specific characteristics. Changes in disease distribution by age, sex, race/ethnicity, and geographic locations can be continuously monitored, and, if necessary, appropriate investigation or intervention may be rapidly undertaken. In addition, by having surveillance data available in a consolidated data base, state health departments are better able to monitor both intrastate and interstate disease trends.

Weekly reporting of mortality data by health officers and vital registrars in 122 U.S. cities and metropolitan areas is used with data reported from collaborating laboratory and epidemiologic surveillance to identify national and regional influenza outbreaks.

The annual report is also used to update annual tables published by the World Health Organization, the Pan American Health Organization, the U.S. Bureau of the Census, and the National Center for Health Statistics.

There are no legal obstacles to reducing the burden.

A.7. Special Circumstances

As explained in item "A.6", weekly reporting of national morbidity data is essential to the rapid identification of disease epidemics and more timely and complete understanding of disease trends. Weekly reporting of mortality data by health officers and vital registrars in 122 U.S. cities and metropolitan areas is used with data reported from collaborating laboratory and epidemiologic surveillance to identify national and regional influenza outbreaks.

A.8. Consultations outside the Agency

A.8.A.

The agency's notice of proposed data collections as part of the weekly and annual morbidity and mortality reports was printed in the Federal Register on Tuesday, May 15, 2007, Volume 72, pages 27317-27319. (**Attachment 5**) One public comment was received in response to the notice and has been included in the supporting statement as **Attachment 11**. The program did not feel a response to the comment was appropriate.

A.8.B.

As mentioned previously in A.1, consultations with the state epidemiologists and the state health officers are conducted routinely through their respective professional organizations, CSTE and the Association of State and Territorial Health Officers (ASTHO). CDC has collaborated with CSTE since CSTE's inception in 1951, and it is through the CSTE annual conference that the cooperation of all states is maintained. Although formal CSTE meetings are usually held only once a year, communication between CDC and CSTE groups and individual members of those organizations continue on a regular basis. Issues related to conditions of national public health importance were discussed at the 1994 National Surveillance Conference jointly sponsored by CSTE and CDC. The names and telephone numbers of CSTE members are listed in **Attachment 6**. No major surveillance reporting problems exist that could not be resolved through consultation with CSTE and ASTHO.

The only other public contacts concerning the publication of the weekly summary involve the dissemination strategy for this publication. There are currently four options for receiving copies of this publication. Paper copies are available through the U.S. Government Printing Office (GPO) or the Massachusetts Medical Society (MMS) Publications. Volumes 33-44 of the *MMWR* are available on microfilm from University Microfilms, International. Volumes 1-51 are available electronically through the Internet at <http://www.cdc.gov>. Persons querying *MMWR* data tables via the World-wide Web (<http://158.111.4.28/mmwr/mmwr.htm>) are also able to post questions and comments directly to the Division of Informatics Shared Services (DISS), NCPHI via an e-mail link (soib@cdc.gov).

A.9. Payments to Respondents

No payment or gift, other than remuneration of grantees, is provided to respondents.

A.10. Assurance of Confidentiality

The OMB application has been reviewed and it has been determined that the Privacy Act is not applicable. Personal identifiers such as name and address are not transmitted through NETSS to CDC. Respondents are state and local governments and the unique Case ID assigned by the State for columns 7-12 specified in the NETSS format (Individual) Case Records Specifications is not a number (like a SSN) that in and of itself can lead to identification of an individual. Data release guidelines developed in collaboration with CSTE is attached (**Attachment 7**). This policy on dissemination of data ensures data are adequately safeguarded.

A.11. Questions of a Sensitive Nature

There are no questions of a sensitive nature.

A.12. Estimates of Annualized Burden Hours and Costs

A12-A. Estimates of Annualized Burden Hours				
Weekly Morbidity Report Respondent Burden				
Respondents	Number of Respondents	Number of Responses per Respondent	Average Burden per Respondent (In Hours)	Total Burden (In Hours)
States	50	52	1	2600
Territories	4	52	1	260
	1	52	30/60	
Cities	2	52	1	104
Subtotals	57	--	--	2964
CDC 43.5 Weekly Mortality Report Respondent Burden				
City health officers or Vital statistics registrars	122	52	12/60	1269
Summary Respondent Burden				
States	50	1	14	700
Territories	5	1	14	70
Cities	2	1	14	28
Subtotals	--	--	--	798
Totals	179	--	--	5031

Reports from respondents replying via FAX are more consolidated than those replying via NETSS. **Attachment 8** is an example of a table routinely produced by a territorial health department. Since this table provides information needed for the weekly notifiable diseases report, a copy is sent by FAX to CDC.

A-12B. Estimates of Annualized Cost Burden

Weekly Morbidity Report Respondent Cost				
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Type of Respondents	Number of Respondents	Frequency of Response	Average Time per Response	Hourly Wage Rate	Respondent Cost
States	50	52	1	\$ 11.45	\$29,770.00
Territories	1	52		\$ 11.45	\$595.00
	4	52	30/60	\$11.45	\$1,191.00
Cities	2	52	1	\$ 11.45	\$ 1,190.80
Subtotals	57	--	--	--	\$32,747.00
Weekly Mortality Report Respondent Cost					
City health officers or Vital statistics registrars	122	52	12/60	\$ 11.45	\$14,527.76
Annual Summary Respondent Cost					
States	50	1	14	\$ 11.45	\$8,015.00
Territories	5	1	14	\$ 11.45	\$801.50
Cities	2	1	14	\$ 11.45	\$320.60
Subtotals	--	--	--	--	\$9,137.10
Totals	179	--	--	--	\$56,411.86

Weekly Morbidity and Mortality Reporting

Weekly morbidity reporting is briefly described in A.3. The weekly mortality report is made by city health officers or vital statistics registrars from 122 major cities and metropolitan areas, using CDC 43.5 (**Attachment 9**). The form may be emailed or faxed, or the numbers reported by phone. It is a report in which total deaths by age categories are cross-classified by number of deaths assigned to pneumonia and influenza. In preparing the report, the number of total deaths for all causes is entered for each age category: less than 28 days of age, 28 days to 1 year, and for succeeding age groupings; then the number of pneumonia and the number of influenza deaths are entered for each age category. Thus, the total number of deaths shown for any age category includes the number of deaths assigned to pneumonia and/or influenza.

The data submitted weekly by the states and cities for the morbidity and mortality reports are computer-entered and the tables are sent to the Division of Creative Services, National Center for Health Marketing by electronic file transfer each week on Wednesday to meet the publication deadline for the *Morbidity and Mortality Weekly Report*.

Summary of Notifiable Diseases

During the four (4) months following the close of the calendar year, most health departments review the accumulated case report data for the previous year, deleting misdiagnosed cases or allocating reported cases to the correct disease etiologies, collecting missing items of information necessary for completion of the final report, and cross-checking with the file of surveillance case reports to determine whether each reported case of a disease under surveillance has been epidemiologically investigated. CDC retrieves needed information from the NETSS data base and sends each state a state-specific annual report of each disease by month, county, age group, and race (i.e., the data variables used for tables published in the *Summary of Notifiable Diseases*). State data are verified by state surveillance staff comparing reports from the CDC NETSS data base with reports produced from the state data base.

Errors are corrected by transmission of deletions/updates to the CDC NETSS data base. Based on information from several states, we estimate that it takes each NETSS state 14.5 hours to verify the preliminary and final annual morbidity reports (**Attachment 10**, which includes sample letters sent to state reporters for verification of data and to the state epidemiologist to confirm the state’s final annual data.). The territorial health departments report annual data by month and age group by using forms (**Attachment 8**) which are mailed to CDC.

The data stored in the NETSS data base and the annual summary forms received from the territorial health departments are consolidated and published annually as the last issue of each volume of the *Morbidity and Mortality Weekly Report* entitled *Summary of Notifiable Diseases, United States*. This *MMWR* issue is widely used by schools of medicine and public health, communications media, and pharmaceutical or other companies producing health-related products, as well as by local, state, and federal health agencies and other agencies or persons concerned with communicable disease epidemiology in the United States.

A.13. Estimate of Other Total Annual Cost Burden to Respondents or Recordkeepers

There are no other annual costs to respondents or recordkeepers.

A.14. Annualized Cost to the Federal Government

Item	Cost to Federal Government
Weekly Morbidity and Mortality Reporting	
Personnel - Software development and support	\$230,375
Personnel - Data management and analysis	\$249,720
Subtotal	\$480,095
Annual Summary	
Personnel - Software development and support	\$57,594
Personnel - Data management and analysis	\$83,240
Subtotal	\$140,834

Total	\$620,929
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The cost to the government of the morbidity and mortality statistics published weekly in the *MMWR* is estimated to be \$ 480,095.00.

The annualized cost of the *Summary of Notifiable Diseases* Series is estimated to be \$140,834.00.

A.15. Explanation for Program Changes or Adjustments

The burden estimates in this submission (0920-0007) have not changed from the currently approved burden.

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

Weekly reports

The weekly *MMWR* report of notifiable diseases covers the week preceding the report's publication. The beginning and ending dates of the reporting week are those established by CSTE, and correspond with the usual work week. The reporting period is constant from week to week. The report should be received electronically in Atlanta as soon as possible after the close of the reporting week, and no later than noon on the following Tuesday.

When a Federal holiday falls on Monday, the statistical tables are issued as if no holiday has occurred. Reports from the state health departments should therefore be received in Atlanta no later than Tuesday noon. If the holiday falls on Tuesday, reports should be received in Atlanta no later than Monday 4:00 P.M.

The weekly mortality report from 122 U.S. cities covers a period of 7 days. The beginning and ending dates of the reporting week are established by the city or county health officer or vital statistics registrar, preferably dates which correspond with the usual work week. Their reporting period should be constant from week to week. The report should be received in Atlanta as soon as possible after the close of each weekly reporting period, and no later than noon on the following Tuesday. Approximately 20% of the city reporters are using the voice messaging system to report, which extends their deadline for completing the report from Friday to Tuesday. City health officers or vital registrars who do not use the voice messaging system fax the report form (**Attachment 9**) after the close of the weekly reporting period. If a city's weekly mortality report is not received in Atlanta by Tuesday noon, a staff member from the Influenza Division (ID) in NCIRD telephones that city's reporter and collects the necessary data, as available.

The data collected by Tuesday noon are published electronically on Thursday in the *Morbidity and Mortality Weekly Report (MMWR)* with a publication date of Friday and are available electronically through the Internet at <http://www.cdc.gov>.

Annual Summary

FEBRUARY - Mail annual summary forms to Territorial Epidemiologists for reporting final notifiable disease totals for the previous year. Send tables to states, cities, and territories participating in NETSS for verification and correction of data prior to publication (**Attachment 10**).

Hold planning meeting with personnel in NCPHI to discuss changes or additions to the year's annual summary.

MARCH - JULY - Verify data on NETSS data base and create an annual summary data base by merging NETSS data with data from annual report forms and data reported by CDC programs. Print approximately 13 tables, including United States disease summaries and disease-specific tables by geographic area. Update Annual Summary graphics file to produce approximately 70 graphs and maps.

AUGUST - Publish the table of final annual data by state in the *Morbidity and Mortality Weekly Report*. Coordinate typesetting of tables; production of computer graphics and coordinate editing, proofing, and layout of all tables, graphs, and text with editorial and publications graphics staff.

OCTOBER - NOVEMBER - Submit copy to the Management Information and Services Branch, MASO for printing.

Distribute annual summaries based on CDC mailing list and list provided by the Superintendent of Documents. These summaries are for use by local, state, and federal health agencies, schools of medicine and public health, communications media, and other agencies or persons interested in notifiable disease surveillance and epidemiology in the United States.

A.17. Reasons Display of OMB Expiration Date is Inappropriate

As previously approved, the CDC requests approval to not display the expiration date for OMB approval of the information collection (**Attachments 8 & 9**). The content and format of the data collection forms have not changed from the previous application. In addition, these forms are reproduced locally -- for weekly transmission of morbidity data from four territories and, in large quantities, for weekly transmission of mortality data from 122 cities. The territories and cities would prefer to avoid the destruction of unused forms.

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

No exceptions are requested.

B. Collections of Information Employing Statistical Methods

Because of the nature of this national population-based passive surveillance activity, this data collection does not involve statistical methods.

List of Attachments

- Attachment 1** **Public Health Service Act (42 USC 241) excerpt**
- Attachment 2** **Nationally Notifiable Infectious Disease List as of January 1, 2002.**
- Attachment 3** **National Electronic Telecommunications System for Surveillance (NETSS) core record layout for voluntary nationally notifiable disease reporting from states to CDC.**
- Attachment 4** **National Electronic Disease Surveillance System (NEDSS) core record layout for voluntary nationally notifiable disease reporting from states to CDC (recommended to be implemented in 2002)**
- Attachment 5** **60-Day Federal Register Notice**
- Attachment 6** **Council of State and Territorial Epidemiologists (CSTE) membership**
- Attachment 7** **Data Release Guidelines of the Council of State and Territorial Epidemiologists for the National Public Health Surveillance System, June 1996**
- Attachment 8** **Example of notifiable disease report form used by a territorial health department for weekly reporting to CDC**
- Attachment 9** **Weekly mortality report form, 122 Cities Mortality Reporting System**
- Attachment 10** **Example of a report to a state epidemiologist to verify annual NNDSS disease incidence data for that state**
- Attachment 11** **Public Comment to 60-Day Federal Register Notice**