2800 Rockcreek Parkway
Kansas City, MO 64117
Direct: (816) 201-1024
Fax: (816) 474-1742

February 19, 2021

Ms. Sherrette Funn
U,S, Department of Health and Human Services
Re: HHS Teletracking COVID-19 Portal (U.S. Healthcare COVID-19 Portal), Document ID 202101-0990-002

Dear Ms. Funn,

Cerner Corporation (Cerner), a leading supplier of electronic health record, clinical and revenue cycle information systems, appreciates the opportunity to submit comments on the project titled *HHS Teletracking COVID-19 Portal (U.S. Healthcare COVID-19 Portal, document ID 202101-0990-002.*

General

Cerner has been involved in helping its hospital clients report both operational and COVID-19 related incidence and treatment data since the beginning of the voluntary hospital data collection efforts initiated by the CDC early in the pandemic through the current mandatory reporting of the COVID hospital data set.

Cerner understands that the pandemic necessitated swift movement and action to respond to COVID-19. We also understand the health care provider community and the burden that "extra" reporting creates during high volume, high stress times. In order to effectively automate the data needed for a federal response, Cerner recommends that in the future, HHS and other federal agencies utilize a HIT vendor/developer council to discuss options for automation before new data requests affect our clients and us. . This helps HIT vendors/developers approach their clients with a solution that conveys the understanding that HHS is keenly aware of the burdens they face. It also leverages the HIT that hospitals have adopted in the most effective manner to help them meet mandated compliance requirements for COVID reporting.

As we will detail more in our comments, there are several other general challenges to emphasize:

- The hospital data set is comprised of information that must be obtained from multiple sources that may be from disparate electronic (or even manual) data that requires compilation and consolidation for reporting whether in a manual or an automated method. The data also crosses between patient care and employee health for purposes of extraction and preparation and has required most hospitals to develop new data management procedures to prepare the data set. The burden of the reporting requirement should include consideration for this process.
- For many hospitals, much of the data set is redundant to data that is reported through state or local jurisdictions. We urge that everywhere possible HHS consider how best to leverage existing reporting channels to the states to reduce reporting burden for hospitals.
- While the HHS data set includes descriptive information for the data elements that are subject to collection, we encourage development of more standardized or standards-based definition of

these data elements that can be harmonized between state and federal authorities that seek its collection. We understand that states often are collecting additional or different data (or meanings of the data) than the federal level adjunct to the hospital data collection, but we urge harmonization of data collection requirements where that is possible to reduce reporting burden.

- This includes the need to define common meaning of what is being collected between federal and state or local jurisdictions. As an example, the federal collection effort may ask how many days of Personal Protective Equipment (PPE) is on hand, and a state may ask how many actual boxes of PPE are on hand. To assess both available supply and the duration of the supply available, both contexts may be needed and the concept of what should be reported to accurately predict both the duration of available supply and the quantity of what is needed to support adequate levels of supply should be considered.
- It also should be useful to state the purpose of collection behind the data elements as a part of any data collection requirements or guidelines.

We also urge HHS to consider what ongoing surveillance looks more generally not only for future pandemics but also other health emergencies including large scale incidents like the recent severe winter storm that has ravaged Texas and many parts of the Midwest and the South, and other natural or manmade disasters and public health emergencies that place significant demand on planning and response needs for health system resource availability and utilization monitoring. The COVID-19 pandemic points to the need for a more sustainable flow of data in the future for other such emergencies. Health system resources are critical national infrastructure and the post-pandemic paradigm should be that we have a structured, modern, and interoperable data and reporting process to support both ongoing and intermittent monitoring of what is available for response.

The current manual and fragmented process is a stopgap; it is not sustainable. The data that hospitals need to operate daily and during a crisis should help define the data sets needed at a national level in as many ways as possible. Automation for daily operations that can be repurposed for national, state, and local reporting during a crisis response.

Necessity and Utility of the Proposed Information Collection

Any hospital admission or treatment data should include additional information that allows for examining questions of disparity along racial and ethnic lines. For example, while HHS is requesting admission information that is broken down by age (item 17 in the hospital data set), HHS should consider asking for race and ethnicity to also be collected in the context of admission data. A major concern that has been raised is the disparity of access to treatment for certain racial or ethnic groups. While that may impose additional burden for hospitals to provide, it is an important opportunity for hospitals to report data within racial or ethnic breakdown to help policymakers evaluate potential disparities in care. That may be beyond the original purpose of collection but is a significant policy question to consider. It is a capability that hospitals that have benefited from participation in Promoting Interoperability who use Certified EHR Technology (CEHRT) have the systems in place to capture. It should also be information already available as collected and so should not place undue burden to request.

Further, similar consideration should be given to other data collection of the Social Determinants of Health made better to the extent such data collection is informed by development of standards that help to codify SDOH data elements. We understand that there is often significant variance in this data collection but to the extent feasible it merits consideration.

As is noted in the next section of this letter, HHS should consider providing a purpose of collection as to the policy intent for the collection of each data element.

HHS should seek to standardize data collection intervals with the states as much as possible, and as is discussed later in this comment letter, seek to leverage state and local data collection for hospital data to reduce the need for hospitals to submit similar data to multiple levels of jurisdiction.

Accuracy of the Estimated Burden of Collection

We believe the burden that HHS estimates for each reporting hospital of 1 ¾ hours per day is understated when one considers the current burdens of extracting, consolidating and manually entering the required data set each day. It seems the burden estimate may only consider the time and effort for reporting the data once the data is in a form that can be manually reported to HHS through the Teletracker portal.

As we detail elsewhere in our comment letter, there are multiple data sources that must be drawn from that cross between supply chain management, bed capacity management, direct patient care within an electronic health record, immunization administration, employee health, human resource or workforce management systems, equipment management and potentially other data sources. This information may be available in non-integrated and non-interfaced sources each requiring some manner of extraction process. This data may also need to be reported to one or more state and local jurisdictions through whatever reporting means prevail at those levels. The estimated burden also does not seem to consider any data quality/review or approval processes hospitals may want to apply to assure that the data reported is complete and accurate.

Ways to Enhance the Quality, Utility and Clarity of the Information Collected

To date, HHS has provided a descriptive form of the data collection requirements but has not really provided a semantically interoperable data dictionary or a normative basis for hospitals to use to be certain that the data they submit is interoperable with that submitted by other hospitals. HHS should consider providing a more standards-based approach to the data set that includes providing appropriate description of the characteristics and attributes of the data.

HHS should consider how its data collection requirements compare with state and local jurisdictions that are seeking the same kinds of data from hospitals. HHS should consider how hospitals may benefit from submitting through their state or local jurisdiction such that they can submit once for the satisfaction of multiple levels of jurisdiction by having the states submit data in common between the federal and state levels to the federal level. To do this, one assumes that there needs to be a sound normalization of the data dictionary between the state and federal level for the sake of the same data elements. HHS should work with the states to relieve hospitals of any burdens of redundant data collection for the same data. HHS should also consider any distinct data collection requirements that occur at the state level whether to find more common use of them or to determine their necessity for planning and analytic purposes or

to drive out differences in collection requirement that do not seem to add value or serve purpose given the intent of collection.

HHS should also consider making available a purpose of collection for the data elements that are included in the data set.

Use of Automated Collection Techniques or Other Information to Reduce Burden

We urge HHS to consider how more direct engagement with electronic health record systems (and vendors/developers) can be leveraged for automating data collection for the COVID hospital data reporting requirements. For an individual hospital, such a data collection approach should recognize that the data set requested by HHS crosses between operational, patient care, supply chain, human resource/workforce management and employee health data sources. A major source of burden for hospitals is the extraction, preparation and consolidation of the required data for reporting. An end to end process to automate what is currently a laborious semi-manual process should address this consolidation and insulate the submitter from having to perform that consolidation. HHS should consider how the reporting should enable related data sets to be reported that can be sourced from the same data source on an automated basis. HHS should also consider a data integration capability on its end to allow for submission of subsets of related data based on the common nature of that data and its source. This includes:

- Operational data on bed utilization and capacity that may come from a bed management and tracking data source
- Admission and care delivery statistical information for both COVID and Influenza that may come from an electronic health record system that may have modules for registration management, emergency care and critical care that may be supported through one or multiple clinical systems
- Staffing information that may come from a staff management data source
- Supply chain information on therapeutic stocks and PPE and their use that may come from multiple supply management data source
- Ventilator availability and use information that may come from an equipment management or inventory data source including distinct systems for materials management, pharmaceutical supplies and major medical equipment tracking
- Vaccination information for the hospital's workforce that may come from an employee health or different immunization management data source than what is used for documenting and recording vaccinations given to patients

HHS should consider how to provide automated support for this data reporting process that reduces the complexity and burden for the submitting hospital to have to consolidate this data set into a singular reporting system. Rather, HHS should consider establishing a data ingestion process that does this consolidation for its purposes of analysis.

We also urge HHS to consider the development of Application Programming Interfaces s) that can support the information collection as a means to reduce the current burden of many hospitals having to do manual data entry. While we understand that the data collection may not be able to be based on API interoperability standards such as those based on HL7 Fast Healthcare Interoperability Resource (FHIR)

standards, we urge that HHS give consideration to an API based approach to data collection that can harmonize data collection approaches over time.

We hope these comments are worthy of consideration by HHS, and we appreciate the opportunity to submit them. As mentioned before, we stand ready to discuss any of them.

Thank you for your consideration.

Sincerely.

John Travis
Vice President, Regulatory Research and Strategy
Cerner Corporation