PREMIER TRANSFORMING HEALTHCARE TOGETHER®

February 22, 2021

Norris Cochran
Acting Secretary
Office of the Secretary (OS)
Department of Health and Human Services
Washington, DC

Submitted electronically via www.reginfo.gov/public/do/PRAMain

Re: Agency Information Collection Request; 30-Day Public Comment Request; OS-0990-New; 2021-01323

Dear Acting Secretary Cochran:

On behalf of the 4,100 U.S. hospitals and health systems and more than 200,000 other providers and organizations in the Premier healthcare alliance, we are pleased to submit these comments in response to the Agency Information Collection Request; 30-Day Public Comment Request; OS-0990-New; 2021-01323 relating to the HHS Teletracking COVID-19 Portal (U.S. Healthcare COVID-19 Portal). Premier has extensive experience providing clinical, financial and supply chain technologies and data analytics approaches to diverse stakeholders, including hospitals, health systems and physician practices, retail pharmacies and life-sciences companies across the country.

Housing the nation's largest and most comprehensive comparable dataset on clinical, financial, supply and operational outcomes data, Premier also provides a one-stop shop for information on medical supplies, inventory, staffing, resource allocation, clinical surveillance, syndromic surveillance, clinical decision support, and medical utilization at the local, state, and national levels. Premier has deployed technology and tools at provider sites across the US to manage real-time data extraction and transmission from clinical, financial and supply chain systems used by our health systems.

With integrated data and analytics, collaboratives, supply chain solutions, and advisory and other services, Premier enables better care and outcomes at a lower cost. Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide.

Premier appreciates HHS' efforts to reduce regulatory burden on hospitals during the ongoing public health emergency (PHE) by providing regulatory flexibilities. These flexibilities have allowed providers and their clinicians to meet the needs of their patients and communities during the PHE and many of these flexibilities have led to improved care delivery. However, we have ongoing concerns with the mandated extensive hospital data collection given the vast amount of data hospitals are already required to report each day to state and local officials, while continuing to treat COVID-19 patients and vaccinate consumers.

Our recommendations and comments are based on our work with and feedback from our hospital system members. These comments re-enforce our recommendations in response to the prior IRC and address additional concerns based our experience working with members submitting data to HHS. We first offer general comments about the existing data collection and reporting approach and then focus comments on automating and enhancing the processes.

13034 Ballantyne Corporate Place
Charlotte, NC 28277
T 704.357.0022
F 704.357.6611

444 North Capitol Street, N.W.
Suite 625, Washington, DC 20001
T 202.393.0860
F 202.393.6499

PREMIERINC.COM

General Comments

Having robust and timely data is critical to tracking, monitoring, and evaluating the impact of COVID-19 and designing adequate local and national public health responses for the management, mitigation, and containment of this pandemic. In March 2020, the Administration notified hospitals of the requirement to report daily data that HHS said was critical to support the fight against COVID-19. In July 2020, HHS changed reporting procedures for hospitals (from using the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN)) to report directly to HHS through TeleTracking or to state health departments or state hospital associations, which then share data with HHS.[1] Regardless of the data flow, TeleTracking has its own set of rules to flag and/or reject records, further complicating data submission.

HHS has issued and updated several guidances on hospital data submissions and in September 2020, established that the penalty for not reporting the data is termination from the Medicare program[2]. **We urge HHS to consider incenting providers to report data rather than apply penalties.**

The current approach is cumbersome and duplicative with other existing reporting requirements. A multitude of data reporting requests from numerous federal, state, local, and private entities continue to place a significant burden on hospitals whose resources are stressed during the COVID-19 PHE. Ongoing challenges to report the enormous amount of data at the required frequency may be due to inadvertent or unintentional technical or logistical errors, including ambiguous or vague questions and evolving data reporting requirements.

The HHS notice for comment oversimplifies the data collection and reporting requirements and greatly underestimates the complexities involved and thus has underestimated the additional burdens and impacts on providers. The current HHS reporting requirements necessitates data collection from at least three major data domains and sources (supply, inventory, and bed data; clinical, patient level data; and laboratory data).

Although instructions on how to enter data directly into the HHS TeleTracking portal can be found on the TeleTracking website, HHS has not clearly explained how the data are used within the federal government or how the data may be accessed by external entities. HHS should improve communications about how it is using the data to guide the federal government's response to the pandemic. Greater transparency about the reasons for collecting the information and how the data is being used within the Administration as well as consideration and plans for additional or different uses of the data. Although HHS offers public access to COVID data sets[3] [4] there is no detailed description of processes taken to protect specific data nor detailed information about use cases for data access.

We recommend that HHS develop and widely disseminate "rules of the road" about data access, use and possible re-use. At a minimum, the rules should confirm that supply data (currently questions 26-31) will only be used by local/state/federal agencies for the purpose of identifying potential supply shortages and deploying response efforts to benefit the hospital community. HHS should:

- Ensure and deploy clear and efficient mechanisms for healthcare entities to report data in an emergency that supports supply chain management and surge re-deployment;
- Clearly articulate permitted and prohibited government data access and uses;

[1] https://www.hhs.gov/about/news/2020/07/20/hhs-protect-frequently-asked-questions.html
[2] Termination of the Medicare provider agreement enacts the regulatory requirements at 42 CFR 455.416, which directs state Medicaid agencies to deny or terminate enrollment of any Medicaid or Children's Health Insurance Program (CHIP) provider who is terminated from the Medicare program.
[3] https://protect-public.hhs.gov/
[4] https://healthdata.gov/search/type/dataset?query=covid-19&sort_by=changed&sort_order=DESC

- Ensure that any information that is shared or publicly posted protects confidential, proprietary, commercial and/or trade secret information as well as intellectual property;
- Ensure that federal data collection is for monitoring and effective allocation; not to remove inventory from organizations;
- Confirm that data cannot be used by suppliers for commercial and/or contractual purposes; and
- Confirm that reported data will not be used to advantage or disadvantage any institution over another or to undermine the competitive marketplace.

Premier urges HHS to recognize the true impacts to and administrative burdens incurred by hospitals and health systems in complying with these reporting requirements. Since the beginning of the data reporting process, the administration has required quick turnaround times for hospital reporting without carefully considering the time hospitals need to implement changes. Health systems and their associated clinicians face ongoing and increasing challenges providing high-quality, safe, and efficient care for their COVID and non-COVID patients. These data reporting requirements increase provider administrative and reporting burdens during an unprecedented, challenging time.

In the next sections, we focus most of our recommendations on ensuring a resilient, responsive, and robust supply chain for the next emergency and to strengthen coordination of the supply chain response.

Enhance the Quality, Utility, and Clarity of Collected Information

As HHS works to deploy data collection approaches and systems for future scenarios, including public health emergencies, pandemics, and natural disasters, we recommend that HHS leverage existing diverse data sources, digital health technologies, and health information data technology infrastructure to automate data collection and reporting. We recommend that HHS implement real-time feeds from existing clinical care systems, including electronic health records (EHRs), infection prevention, enterprise resource systems and clinical surveillance applications.

The current approach to reporting is time consuming and difficult for hospitals to interpret, analyze, gather, and submit data. Hospitals report on dozens of data points that contain multiple sub-elements without a clear reason for the need for reporting. A significant amount of time was expended to set up for efficient reporting. Questions that may seem easy to answer require interpretation and create variation in the data across the country. For example, question 26 asks if supplies are managed at the facility level or system level. Most health systems manage asset inventory supplies (stock) at the ‘system’ level, but likely manage non-asset supplies (non-stock) at the facility level. Most personal protective equipment (PPE) supplies are stock supplies; however, many times ventilator supplies are managed as non-stock supplies. This required the health system reporting team to create manual recording data intake processes to collect both facility reports and system reports. This is manual and is typically housed in a spreadsheet. Regardless, consistent interpretation and reporting of this data puts the reported results in doubt.

Another example, question 29 asks “Are you able to obtain these items” with sub-bullets containing sub-categories like “Ventilator Supplies.” While this seems straight forward, this requires an analysis of every key supply related to ventilators including masks, tubing, filters, and other accessories. Due to different sizing or clinical uses, our experience tells us that there may be as many as 1600 stock-keeping units (SKUs) from more than 70 suppliers, each item requiring analysis of service levels and availability. Each health system also needs to interpret “able to obtain.” The question is open to interpretation: Does this mean two days, seven days, or immediately market available? These vague questions create significant additional work and likely contribute to data and reporting inconsistencies.

Complying with the daily reporting requires hospitals to redirect staff to interpret the question, analyze and make a judgment call on how to source the data, format it, accommodate changes in reporting

requirements and, finally, develop a report suitable for submission. In addition to capacity, utilization and supply data reporting, there are also data reporting requests about vaccination of hospital staff and reporting requirements for testing data from hospitals that perform COVID-19 tests using an in-house laboratory. Premier surveyed our hospital and health system members about the challenges they face in complying with the HHS mandated daily reporting and found that their experiences range significantly when considering start up, ongoing, and changing reporting requirements.

HHS allows for multiple reporting pathways, including via state or regional health information exchanges (HIEs) and state hospital associations. Differences in the data definitions between HHS and some state-level data reporting requirements are significant, which continue to add to the burden of data collection and data inconsistencies and incomparability. HHS should recognize that these federal reporting requirements are in addition to those required of hospitals at the state and local levels. Increased reporting combined with inconsistent requirements, data definitions, reporting timeframes (frequency and cycles), variation in underlying data sources, and desired data granularity adds to the confusion on what and to whom to report. These reporting obligations are further complicated for health systems that span more than one state. **We strongly believe that the government should harmonize federal, state and local reporting requirements and automate the data collection and reporting processes.**

We offer the following recommendations to enhance quality, utility, usability, understandability, and clarity of collected information:

- Address and remedy current shortcomings, challenges, and gaps with the current approach to minimize opportunities for mis- interpretation, reduce ambiguity of the data collection effort, and help improve data validity.
    - Improve the design and address the unintended consequences of potentially ambiguous, vague, or biased current questions. Automating the collection and reporting of data minimizes additional hospital burdens; increases consistency and data quality from manual reporting; and provides greater opportunity for meaningful and robust analytics.
    - Improve weaknesses in the existing data collection process, including the wording of questions (such as avoiding vague or imprecise terms) to further ensure that respondents interpret the question the same way. Several questions in the form require qualitative analysis to produce the requested data element. For example, as previously mentioned, field 29 is an inquiry regarding a facility's ability to order and obtain specific items. We believe the intent of the inquiry is to understand latency of days on order, thus signaling a potential item shortage. To clarify the intent of the question, we recommend that quantitative criteria be included as part of the question and/or the data element definition(s) to address qualitative questions in the data collection form.
    - Develop and deploy approaches for data standards within the healthcare supply chain to improve data consistency, integrity, reliability, and comparability.
    - Review and assess the existing data points to minimize the rework that is required in reporting processes when HHS deploys revisions.
- HHS should ensure that any additional or revised data elements, template changes, and other data collection and reporting requirements are clearly explained and directly connected to mitigating COVID-19.
- Provide more comprehensive and robust technical guidance and clarifications, including a more robust data dictionary with clearer definitions for each data element.

- Improve communication to ensure consistent guidance and more accurate data. The most current set of FAQs is dated January 12, 2021[1]; however, updates or revisions are not identified. HHS should indicate changes to prior information and FAQs to alleviate ambiguous, vague, and/or conflicting guidances and/or directions.

The next section provides additional recommendations to automate data collection and reporting.

Use of Automated Collection Techniques

HHS states that the data collected informs the federal government's understanding of disease patterns and furthers the development of policies for prevention and control of disease spread and impact related to COVID-19. One of the most important uses of the data collected is to determine critical allocations of limited supplies (e.g., PPE, syringes, and medications). We recommend that HHS implement an automated and seamless data collection and reporting approach that is consistent with the internal operations and processes of reporting organizations to help alleviate provider reporting burdens and improve efficiency and reliability of data collection and reporting. HHS should focus data collection on detailed information that can be captured via clinical surveillance and enterprise resource planning (ERP) systems for ease of collection and appropriate granularity.

We recommend replacing Teletracking by building an on-call, nimble automated data collection infrastructure that the nation can call upon in any future crises similar in magnitude to COVID-19. Automating data collection and reporting will help address data reliability, quality, and consistency issues and improve trust in the data. It would provide visibility of supplies in hospital inventories with detailed information that would enable accurate and intelligent decisions about supply allocation and needs at the local, state, regional and national levels. We recommend a system that could exist behind the scenes and be ready to be “turned on” in a moment’s notice and provide granular information on specific critical products in hospital inventory. Such a system could be pressure-tested biannually or annually to ensure the system remains in place and operational. Expanding the scope of data collected will enable HHS to understand stress signals and predict utilization, demand, and burn rates at a localized level and to leverage inventory data to inform and justify dynamic supply allocation to facilities based upon the priority of needs.

As part of ongoing and future emergency preparedness, HHS should identify products and secure a clear vision of suppliers and raw materials. Part of this preparedness is having visibility into product availability - from the raw materials, to manufacturer, to distribution, to hospital inventory. We recommend collecting more detailed transaction-level provider ERP data. Such an approach offers flexibility and adaptability beyond today’s COVID-19 pandemic to ensure preparedness for future disasters, attacks, or other unforeseen events. We recommend that **HHS leverage existing supply chain data and technology infrastructure to develop and deploy an electronic, ready to go supply chain system**. Supply chain data can inform intelligent decisions on what products are available and needed from manufacturer to distributor to hospital inventory (allocation and resourcing).

Automating data collection and reporting will enhance the supply, capacity and utilization data collected to better understand and predict demand and burn rates at a localized level and to leverage inventory data to inform and justify dynamic supply allocation to facilities based upon the priority of needs. Automation will also provide real-time insights into device supply, demand, and utilization.

[1] https://www.hhs.gov/sites/default/files/covid-19-faqs-hospitals-hospital-laboratory-acute-care-facility-data-reporting.pdf

We strongly recommend that **HHS provide meaningful and actionable data and feedback to and share information with healthcare facilities** to inform them about their data (insights and trends) along with national, regional, and local data. Ideally data used for public reporting should be useful inside the facility for management of patients, provision of quality of care and the elimination of waste. HHS should enable timely feedback loops so that data informs decision-making by the reporting healthcare providers and the greater healthcare and public health eco-system.

CONCLUSION

The Premier healthcare alliance appreciates the opportunity to submit comments to this request for information. We urge HHS to consider our recommendations as soon as practicable. Ongoing and future improvement to public health infrastructure, data collection and data systems is critical to ensuring preparedness and responsiveness to emergences. If you have any questions regarding our comments or need more information, please contact me or Meryl Bloomrosen, Senior Director, Federal Affairs, at meryl_bloomrosen@premierinc.com or 202.879.8012. We look forward to continued dialogue. Thank you again for providing us the opportunity to offer comments.

Sincerely,

Blair Childs
Senior Vice President, Public Affairs
Premier healthcare alliance