

February 22, 2021

Submitted electronically via reginfo.gov

Ms. Sherrette A. Funn,
Paperwork Reduction Act Reports Clearance Officer, Office of the Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

**Re: 0990–New–30D| Agency Information Collection Request; 30-Day Public Comment
Request: HHS Teletracking COVID–19 Portal (U.S. Healthcare COVID–19 Portal)**

Dear Ms. Funn,

We appreciate this opportunity to provide feedback to the Office of the Secretary regarding the hospital reporting burden associated with the collection of data for assorted disease monitoring and resource allocation purposes during the COVID-19 pandemic.

Baylor Scott and White Health (BSWH) is the largest not-for-profit healthcare system in Texas and one of the largest in the United States (US) with over 1,100 access points. Our organization employs more than 48,000 and affiliates with more than 7,500 physicians, attending to more than 7 million patient encounters annually. As a fully-integrated delivery system, our accountable care organization (ACO) and Scott and White Health Plan cover over 900,000 lives through both public and commercial contracts. In 2018 and 2019, BSWH received an *exceptional performance adjustment* in the Quality Payment Program (QPP). It is our ambition to be a trusted leader, educator, and innovator in value-based care delivery.

The pandemic has laid bare some underlying deficiencies in the infrastructure and process to gather data. Reporting requirements and systems have been instituted by diverse health care authorities at the local, state, and federal levels, applying inconsistent definitions for key variables, such as what counts as a “COVID-19 case” or a “COVID-19” death,¹ and differing practices for reporting (for example, whether a new case is counted towards the date on which it is reported or the date on which the sample was drawn). Additionally, even when the definitions and reporting practices align, there may be substantial differences in testing patterns between jurisdictions – or even in the same jurisdiction over time, driven by availability of supplies as well as variable priorities for testing (for example, setting out to

¹ C. Morris and A. Reuben, "Coronavirus: Why Are International Comparisons Difficult?," <https://www.bbc.com/news/52311014>.

capture a random sample of the community vs targeting high risk settings such as nursing homes or prisons)² that invalidate comparisons, if data elements such as age are not captured to enable risk adjustment.

Texas has not been immune to these. Entering 2020 with a version of the National Electronic Disease Surveillance System (NEDSS) which had not been updated in three years – and lacking the technology to even support the most current version – and COVID-19 test reporting system heavily reliant on fax machines and manual data entry,³ (5, 6) backlogs and discrepancies were inevitable, and of grave concern given that they impacted key metrics such as case counts, positivity rates, and hospital volumes to which the reopening plans and masking orders are tethered.⁴ Moreover, the workarounds and adaptations needed to force old reporting systems to handle new demands for which they were not designed has created a substantial burden for both health departments and health care providers trying to meet the need for timely, accurate data to inform a range of decisions relevant to managing the COVID-19 pandemic.

BSWH used the Teletracking site to report required data related to bed capacity, staffing, supplies, etc, until June 2020. Thereafter, to avoid duplicative reporting to federal and state health authorities, we switched to the option offered of submitting the data to the state, which was certified to then submit the data to the Department of Health and Human Services (HHS) on our behalf. In Texas, this route of data submission was through EmResources, the data reporting system used by the Regional Advisory Councils (RACs), which are the administrative bodies responsible for trauma system oversight within the bounds of a given Trauma Service Area in Texas.⁵ Below, we provide a holistic view of our experience with COVID-19 reporting, beyond our use of the Teletracking portal and the data elements it captures, because solutions to ease the reporting burden on healthcare providers must be designed with all the data reporting requirements in mind.

COVID-19 Data Reporting Systems

Table 1 summarizes our COVID-19 reporting streams. In October, reporting efforts were expanded to include confirmed cases of influenza, admissions, ICU utilization, confirmed cases of patients with both influenza and COVID-19, and previous day's deaths, in compliance with the Centers for Medicare and Medicaid Services requirements for these additional data.

² D. F. Gudbjartsson et al., "Spread of Sars-Cov-2 in the Icelandic Population," *N Engl J Med* 382, no. 24 (2020); D. Lee and J. Lee, "Testing on the Move: South Korea's Rapid Response to the Covid-19 Pandemic," *Transportation Research Interdisciplinary Perspectives*. 5 (2020); P. Romagnani and S. Romagnani, "A Tale of Two Testing Strategies in Italy for Covid-19," <https://blogs.bmj.com/bmj/2020/05/22/a-tale-of-two-testing-strategies-in-italy-for-covid-19/>.

³ J. Blackman and C. Harris, "Unreliable Texas Covid Data Spotlights 'Decades Worth of Underfunding'," <https://www.houstonchronicle.com/politics/texas/article/unreliable-texas-covid-data-funding-abbott-tx-15591523.php>; L. Dryda, "Fax Machines, Old Tech Slow Covid-19 Test Results and Data Reporting," <https://www.beckershospitalreview.com/healthcare-information-technology/fax-machines-old-tech-slow-covid-19-test-results-and-data-reporting.html>.

⁴ Blackman and Harris, "Unreliable Texas Covid Data Spotlights 'Decades Worth of Underfunding'".

⁵ Texas Department of State Health Services, "Regional Advisory Councils," <https://www.dshs.texas.gov/emtraumasystems/etrarac.shtm>.

Table 1. BSWH COVID-19 reporting streams (volumes and frequency)

Data Stream Name	Number of data Elements	Frequency	How Reported	Manual/Electronic	Gov Entity	Ongoing
HHS bed capacity, supplies, staffing, Remdesivir, etc*	90-100/ per hospital/reporting entity	Daily**	1. Teletracking (until June 2020); 2. EmResources (RAC portal) (since July 2020)	1. CSV upload 2. Manual	HHS, TX DSHS	Yes
COVID 19 testing volume	24-32 (per CCN provider number)	Daily	Web page access for each individual hospital	Web page, manual data entry	HHS, TX DSHS	Yes
COVID 19 + testing patient demographics and provider information	18 for each COVID-19 positive test conducted in our internal labs***	Daily	Laboratory Information System (LIS) interface daily	Electronic	HHS, TX DSHS	Yes
FDA COVID 19 testing	1/per hospital	Weekly	Manual excel via e-mail	Manual	FDA Research	No

*Automation of this data file will take approx 500 technical staff hours

** Some sections of this data change to weekly, or become optional after Nov 4th

*** Commercial labs (like Medfusion) submit their own data directly

The EmResources portal being used for the greatest volume of this reporting is the system historically used by the RACs to track capacity daily for trauma management purposes. Prior to the COVID-19 data collection efforts, only 3 data elements had to be entered for the relevant hospitals. When Texas decided to use this system to collect the daily data required to be reported to HHS (plus some additional data elements Texas collects), they added 6 tabs of fields that need to be entered but did not upgrade the system to make it user friendly for such volumes of data entry. To get from one field to the next in which data must be entered requires pressing the “Tab” key three times – not a huge inconvenience if one is entering only 3 data elements per hospital, but frustratingly inefficient when it is ~100 elements per hospital. For large, geographically diverse healthcare systems such as BSWH, there is the added issue that data must be entered separately for each of the 5 RACs in which BSWH hospitals fall.

The data elements required must be drawn from multiple different hospital clinical and administrative systems; most come from a combination of the electronic medical record and the financial databases and are entered by the BSWH central reporting team, but a minority of elements has to be drawn and entered locally at each facility.

There is currently no way to “import” a file with the relevant data. Aside from the manpower (500 technical staff hours) and associated costs of automating the data file on the BSWH end, updates are needed at the EmResources end to make this approach feasible. Additionally, as further measures are added to reporting requirements (or definitions of required measures revised) automation efforts quickly become obsolete or require retooling, so that automation cannot be thought of as a one-time effort.

Ambiguous and inconsistent definitions and data requirements

The HHS Interim Final Rule does not provide the detailed definitions of the required data elements needed to pull these data (eg. What should be counted as an “occupied bed” or a “suspected COVID patient”?). In the case of elements pulled from the electronic health record (EHR), BSWH is reliant on the vendor’s (EPIC’s) interpretation.

In addition, changes to definitions and required data elements have been made frequently since COVID-19 data reporting started. This adds substantially to the data reporting burden – both in terms of the poor communication of the changes (most have simply been added to updates of HHS’ Frequently Asked Questions document) and in re-specifying and validating the data pulls.

There has also been substantial confusion over what needs to be reported, and how it should be reported, where a facility that has a single Medicare provider number includes more than one location.

Finally, for the influenza-like illness reporting requirements, the data elements requested by HHS differ from those requested by local health departments; additionally, data requests and reporting processes differ between the different local health departments.

Need for coordination among federal, state, and local authorities

Ideally, a standardized minimum set of clearly-defined data elements and reporting structures would have been implemented at the national level, avoiding inefficiencies related to inconsistent and/or duplicative reporting. In the absence of a national plan, a well-run state level reporting system which local health authorities could access and filter for data relevant to their jurisdictions would reduce the burden on healthcare providers and provide consistent timely data to leaders.

Even though HHS, Texas DSHS, and the Texas RACs are all using the same data reported through EmResource for tracking and modelling purposes, they do not have consistent deadlines (even taking into account time zone differences between Washington DC and Texas). For example, HHS requires all data entered by 5pm the next day, but Texas DSHS requires it by 1pm, some of the RACs require it by noon, and some of the counties or cities want the data even earlier (eg, 10am) to update their local websites or dashboards.

Given that BSWH has centralized much of the EmResource data entry (which takes 4 hours per day) across its over 1,100+ facilities (in order to ensure accurate and standardized reporting), tracking and meeting individual county deadlines is not always possible; for central reporting an internal decision has therefore been made to have reporting completed by noon. However, some of the EmResource data are entered locally at each facility, where there might be greater pressure to meet a local county deadline – thus, for a 10am deadline, the data for the “local” fields may have been updated while the “central fields” still have only the previous day’s data, creating potential mismatches at the facility level.

In addition to the data being submitted through the EmResource data portal (and used by the RACs, state health department, HHS) some local health departments request additional data directly from the infection prevention personnel at facilities located within their jurisdictions, with these requests differing between local health departments. For example:

- County A requests daily list of hospitalized COVID-19 patients
- County B requests the number people from the COVID-19-positive (PCR test) list that are currently in the hospital
- City/ County C: periodically requests copies of the positive PCR lab reports (which we are unable to provide during periods of high volume)
- County D and E: periodically request information on deaths.
- County F: requests data on pre-procedural positivity rates, discharged patients, and deceased patients.

Some of the larger county health departments have access to EPICare Link, which securely connects referring providers and public health staff to select patient information in the Baylor Scott & White Health Epic electronic health record, and so have been able to look up additional information needed themselves.

Recommendations

The need for a functional national reporting system, and associated disease surveillance and resource monitoring systems, will outlast the current pandemic. As current systems are revised and replaced, the following key attributes should be considered to ensure data can be reported accurately and in a timely manner without detracting from healthcare providers' ability to focus on their primary role of providing care:

1. All electronic reporting systems should:
 - a. Facilitate automated reporting
 - b. Standardize reporting processes and data elements and definitions across federal, state, and local health jurisdictions
 - c. Be designed for large volume data collection and reporting
2. Phased approaches should be used to implement new data reporting requirements
 - a. While understanding that early in the COVID-19 pandemic everyone wanted as much information as possible immediately, the process would have gone more smoothly had a smaller number of high priority elements been required initially, and further items added only after the necessary processes and infrastructure established and adopted

In addition to these practical considerations, transparency regarding how the data being reported are used to allocate supplies – PPE, remdesivir, vaccines, etc – is needed.

Conclusion

We appreciate this opportunity to provide feedback to HHS regarding data reporting requirements and the associated burdens. BSWH values the partnership the HHS has built with providers and would be happy to answer any questions that may arise from our comments here.

Sincerely,



Kristi Sherrill

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